South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public

07 December 2023
10.00-13.00

Banstead MRC, Banstead, Surrey

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
58/23	10.00	Welcome and Apologies for absence		-	DA
59/23	10.01	Declarations of interest		To Note	DA
60/23	10.02	Minutes of the previous meeting: 05 October 2023		Decision	DA
61/23	10.03	Matters arising (Action log)		Decision	PL
62/23	10.05	Chair's Report		Information	DA
		Fit and Proper Persons Test Framework		Assurance	PL
63/23	10.20	Chief Executive's Report		Information	SW
Strategy					
64/23	Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report**		
People & Culture – *Everyone is listened to, respected and well supported*					
65/23	10.35	**Improving Culture**	Board Story		SW
			NHS Long Term Workforce Plan – Retention Plan		AM
			Reward and Recognition		JC
			Sexual Safety Charter		MD
			People Committee Report		SS
Responsive Care – *Delivering modern healthcare for our patients*					
66/23	11.15	**Operational Performance & Efficiency**	Winter Plan Update		EW
			Call Answer Performance Update		EW
	11.40	**Break**			
Sustainability & Partnerships – *Developing partnerships to collectively design and develop innovative and sustainable models of care*					
67/23	11.50	**Achieving Sustainability / Working with Partners**	Strategy Development		DR
			IT Review & Action Plan		SxS
			NARU Review & Action Plan		EW
			M7 Finance Report		SxS
			FIC Report		HG
Quality Improvement – *We listen, we learn and improve*					

68/23	12.25	**Keeping patients safe**	Medicines Distribution Centre	RO SS
			Quality & Patient Safety Committee Report	TQ
Board Effectiveness				
69/23	12.50	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
70/23	12.55	Any other business		DA
After the meeting is closed questions will be invited from members of the public				

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 05 October 2023

Trust HQ, Nexus House

Minutes of the meeting, which was held in public.

Present:

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

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Steve Lennox	(SL)	Improvement Director

Chairman's introductions

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

44/23 Apologies for absence

Christopher Gonde	(CG)	Associate NED
Subo Shanmuganathan	(SS)	Independent Non-Executive Director

45/23 Declarations of conflicts of interest

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

46/23 Minutes of the meeting held in public 03.08.2023

The minutes were approved as a true and accurate record.

47/23 Action Log [10.01-10.02]

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

48/23 Chair's Report [10.02–10.08]

DA used his report to set the context for the meeting, reinforcing the approach to the BAF and IQR which are used as guide for discussion and challenge. The main theme of this meeting is demand management and

winter planning and the Board will be seeking assurance that we have robust plans as part of the wider system. Another feature of the meeting is the emerging work on the Trust strategy, which again is to be undertaken in collaboration with system partners.

With there being no question DA asked MW to summarise the report from the last meeting of the audit committee.

49/23 Audit & Risk Committee Report [10.08–10.15]
MW firstly highlighted the committee's focus on systemic issues, ensuring learning is captured and implemented. It has asked for more assurance on this, working with the quality committee.

On Counter Fraud, this is generally positive but there are some issues requiring stronger controls, which the executive is implementing.

There continues to be good progress with risk management, which is becoming increasingly more embedded. However, there is still work to do.

MW also referred to FTSU and the outstanding issue related to detriment, which it will be keeping under review.

DA thanked MW for this update acknowledging the wide range of issues. There were no questions.

50/23 Chief Executive's Report [10.11–10.30]
SW drew out five items from his report:

1. FTSU Month – he thanked the team for their work and the compassion and commitment they show. Beyond FTSU month, this is about creating a speak up culture. Everyone needs to feel able to speak up. SW confirmed his pledge which is to make SECAmb a place where all leaders as a core part of their job, speak up, listen, and act.
2. Medway – SW acknowledged the achievement of this project and thanked all involved for the successful opening. It is a great facility, and an envy of most other ambulance services. We now need to maximise the benefits.
3. Strategy – we have a real opportunity to set a course for the future, despite the challenging times. We have heard that we need to be clear on the purpose of the Trust as we have over recent years become all things to all people. We also need to establish the workforce we need to support that purpose and also have honest conversations with the system about the true cost of the ambulance service.
4. Performance – noting the winter plan and call handling papers on the agenda, SW reflected that the public judge us on how quickly we pick up the phone and when needed how quickly we send an ambulance. We perform well on Category but challenged on call answer performance.
5. Lastly, SW acknowledged DA's lifetime contribution to the NHS and during the last five years to SECAmb, he will be a hard act to follow.

DA reflected on the recent Annal Members Meeting, which was really uplifting, with so much positivity for the future. He then took questions.

LS asked about system partners and whether SW believes there is good understanding that we are all things to all people. SW believed there is and he explained it is how we take the conversation forward in relation to what we can offer and the cost of this. In other words, how we reset our offer will drive the conservation as part of the strategy.

HG asked about the St John ambulance arrangement and SW responded that we have made progress and using them as part of the winter offer to help us be as resilient as possible. Discussions have been positive and will use them as much as we can.

PB asked about how the system work dovetails with strategy. SW explained that we have agreed with system partners that they will be part of the development and design. In January, our aim will be to have a good idea of direction / emerging model. Allied to that, we also aim to have the senior structure agreed and both will be in play by April 2024.

Following a question about the Medicines Distribution Centre, SW confirmed that work is in hand to address the immediate H&S concerns, which includes the installation of a new lift and other remedial work; this is scheduled to be completed by May 2024, which will stabilise issues until we agree a longer-term plan.

There were no further questions.

51/23 Primary Board Papers

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

52/23 Responsive Care [10.30-11.45]

Board Story

EW introduced Sean Edwards, Practice Development Lead, who has been invited to join the Board to give an overview of the pilot in Maidstone. Sean explained the Hub trial where we co-locate clinicians to aid joint decision making for crews on scene. The aim us to reduce unnecessary conveyance to emergency departments. Sean talked the Board through the slides that were tabled, explaining this is a 4-week trial; 326 crews contacted and 128 admissions to emergency department has been avoided (judged by crews initial plan to take to hospital).

EW thanked Sean for his leadership in this. It is a good example of doing it the right way, pausing to evaluate and demonstrate what is was being delivered for staff patients and system, working with the research team.

The Board explored the plan to extent the pilot to increase the sample size, as this will help determine if it is sustainable. It noted the use of the QI framework and the engagement with the acute trust, all of which will help as a good source of information as we develop our new strategy.

Sean then addressed some questions about the positive impact on our people / crews, and how clinicians are being supported in their decision making.

DA thanked Sean, the team involved and all the colleagues at the hospital and community trusts for their joint efforts with this. He reflected that it is good to see we are a trusted partner and using our operating unit as a link to local provision.

EW then provided an overview of Responsive Care to inform the Board's discussion. She highlighted the following:

- C2 mean – we are under the target of 30 minutes and in a good position relative to others.
- Call handling – concerned about this which is covered in a separate paper.
- Hear & Treat – the data is showing 12.1% which is supported through additional funding, more clinicians within Ous, and implementing C2 segmentation.
- Major incident training day has been ongoing since April and we are on track to deliver. Feedback is that 92% are more confident than before responding to a major incident.

- Shift overruns – clear focus and at the People Committee last month we demonstrated improvements.

Winter Plan

EW introduced the plan and the approach being taken as a trust and a system, which includes learning from previous years related to battle rhythm and how we escalate. The expectation re activity is a 10% increase in key periods during December. With C2 mean we are in a good place with a reduction in duplicate calls. Resourcing is better than planned, and all this helps to mitigate winter pressures. EW added that the biggest challenge will be call handling.

MW referred to flu/COVID, and asked to what extent we are protected through vaccination. MD responded on flu that the national CQUIN is 78% herd immunity. Vaccines were received a couple of days ago and we have an incentive in place. Clinics are starting next week. TQ noted that we can't mandate COVID vaccines, but asked what we are doing to promote this. MD responded that the focus is on flu and we will then link messaging with COVID; there is no internal vaccination but we will be messaging to encourage take up with GPs etc.

SW confirmed that the primary assurance for the Board related to performance, which is reflective of the nation expectation, is the extent to which we think we can maintain our C2 performance over the next six months. There was a meeting of all ambulance trust CEOs recently on this, as the core deliverable. The Board noted the reasonable level of confidence the executive has in maintaining C2 performance. Acknowledging the national focus, it did however express concern about C1, as performance is less good. SW reassured the Board that we do focus on this and clarified that there is also national concern about C1 too. SW linked this to the next item as the longer it takes to answer the phone the less likely it will be to meet C1 standards. SW expressed some confidence in making sustainable improvement in call handling, but acknowledged we are currently a national outlier.

Call Answer Performance

John O'Sullivan, Associate Director of 111 / EOC joined for this item. He took the Board through the slides in the pack setting out the hypothesis, challenges and the various actions being taken to ensure improvement. DA thanked John for this, noting the clarity there is on the challenges within EOC. He then opened to questions.

MW agreed with DA that the level of precision gives confidence on the way forward. He asked two questions. The first about capacity to deliver and the second about our strategic thinking with recruitment, given Gatwick is an area much harder to recruit to than Medway. John responded on location that other ambulance services with similar issues are reviewing whether to move. This is a decision ultimately for the Board. In the meantime, the likely solution is that we over recruit at Medway and use this as the primary location. On first question, John explained that some parts of day we have the right capacity, which links to the rota issues and the solution being the routing platform. MW asked how quickly we can we do this and John confirmed that it has to happen in the next couple of weeks before we get in to Winter.

SW made the link again to these actions and our C1 response. He commends the work and the analysis and confirmed the support being provided by the executive team to deliver the short-term actions.

The Board then explored what works elsewhere related to recruitment and the pros and cons of initiatives such as retention premiums.

DA thanked John again for the all the work in hand. The Board will need to monitor progress to ensure safe services over the winter period, and longer term the Board encouraged collaboration and strategic decision

making on things like location and pay. DA asked for a further update in December, on both the winter plan and call handling.

Action
Update in December on the Winter Plan and Call Handling.

53/23 Achieving Sustainability / Working with Partners [11.45-12.30]

DR reminded the Board that we started the year wanting to work better with partners and the Board Story is a good example of this. We also said we needed to strengthen our governance and alignment with ICBs. These are the success factors to empower clinicians locally to take forward partnerships with system colleagues to drive changes. The work we are doing on the strategy, supported by Moorhouse, continues with the diagnostic phase building on the clinical case for change. Then gateway into the options and design phase through December and into January when there will be more targeted discussion to inform decisions.

Clinical Case for Change

The Board saw this at the development session last month. RO introduced the paper giving the context that has driven this clinical case for change, which is supported by a level of data we have not had before. For example we have mapped deprivation to call volume and clinical grade of staff to NEWS score, to name a just a few. The richness of data is really driving the strategic discussions.

RO added that we are seeing increasing complexity in patients, some of which might not be picked up in paramedic education. Currently, we respond as one size fits all, i.e. we don't differentiate our response. The approach to developing a new strategy allows us to be bold in collaboration with the system. Ultimately, we will need to redefine our approach with much more focus on patient outcomes.

TQ asked for assurance on the data validity / cleansing as it is vital to have complete data sets as they will inform strategic decisions. Also, we need a shared understanding of the demographic footprints of our services, as they might not align with the ICB footprint. DR responded that we have three ICB workshops in the next 10 days where we will share data to overlay with clinicians on both sides, to understand the ICS joint plans and how they inform what type of ambulance service they want/need.

The Board reinforced the importance of taking people on the journey and balancing this with the need to complete this in a timely way to provide the certainty people are seeking.

Partnerships Report

DR highlighted the challenging landscape related to Right Care Right Person and the work ongoing to establish the impact on SECAmb. The Board acknowledged this and the need to ensure a consistent service to patients.

Following a question from TQ about the 111 service in Surrey and NE Hampshire and the ambulance revalidation rates, the Board explored how this is being picked up with the provider, and commissioners. EW is in dialogue with commissioners to help ensure consistency across the region.

[Break 12.07-12.17]

Finance Report

SxS summarised report, confirmed that at month 5 we delivered the plan with a small surplus and are on track to deliver the breakeven control total. However, there is a shortfall and related ongoing risk to delivery

of the efficiency programme. We are aiming to recover the position and SxS set out the steps being taken including the workshop next week with the leadership team.

Before opening to question DA summarised that we on track to deliver but with underlying risks / issues, in particular the efficiency programme.

MW expressed confidence in the executive focus for this financial year, to ensure we breakeven. He went on to suggest that when we get to the new strategy, this will define more clearly what operating model we need, and so then we need to embed within this a strategic approach to cost improvement. SW responded that in the development of the strategy we have emphasised the importance of understanding our cost base. Before we design a future, we need to know what our cost base is, triangulated with quality and staff experience.

LS asked for assurance that there is no adverse impact on quality, by meeting the control total. SxS responded by explaining that the financial plan delivers quality via the proxy of C2 mean; this is what was agreed with commissioners at the start of the year. SW added his assurance that we are committed balancing both finance and quality.

FIC Report

HG outlined the key conclusions from the most recent meeting, including the impact of non-recurrent savings this year putting us on the back foot next year, which will be mitigating by the strategy discussions.

54/23 Improving Culture [12.30-13.10]

AM introduced this item by highlighting from his cover paper the following issues:

1. There is a continuing downward trend on sickness, 6.8% down from 11% last year.
2. ER cases have much improved in terms of timeliness to resolve cases.
3. Sexual harassment cases - we do have some less serious cases but none resulting in suspension.
4. P&C webinar is due next week with focus on sexual safety at work. NSHE launched its sexual safety charter.
5. Staff survey is live and for the first time there are questions on sexual misconduct which will help give a baseline.
6. Mediation with unions continues. JPF re-established and there has been positive feedback from this.
7. Pulse Survey provides some green shoots, as per the People Committee report. This is the highest response rate to-date, with improvements in engagement scores.

NHS Long Term Plan – Retention Plan

AM then talked to the slides in the pack setting out the development of the retention plan, which the Board agreed would be the key focus in our response to the Long Term Plan. As we build our approach, we need to link this to the data for why people leave SECAmb. AM confirmed that we have sought the views of our people and will continue to do so to ensure the plan reflects what people think we should focus on, some of which forms the engagement to-date as listed on slide 5.

SW welcomes this and getting it right will be really important, as every other provider is having the same conversations. He asked the Board to challenge on whether we are ambitious enough.

MW agreed we should be more ambitious, but we also need to take in to account that much of this needs to be underpinned by trust e.g. trust to self-roster. Trust and command and control don't go hand in hand and so MW suggested that we need to be confident we have established trust, to ensure what we plan is deliverable.

MP also agreed we should be bolder. He reflected that at the bord development session we said we had good insights from other organisations, but we should look outside NHS too, to understand how they retain e.g. geographical and call centre challenges. Otherwise, the risk is that it is just an NHS perspective.

AM thanked colleagues for their feedback which he will continue to feed into the plan and inform the principles and pledges. The final version will come to the Board in December.

DA summarised that we need a time costed plan, where probably less is more. We need to demonstrate we listen and act on the top three big initiatives, so we should aim not to try and do too much and ensure inclusion is central to this.

P&C Delivery Plan

Tina Ivanov, Culture Project Director, updated on the delivery plan much of which is has been covered in the earlier discussions. She reminded the Board the underlying purpose of the priorities in the plan is to engage and improve trust. On the so-called 'housekeeping', this is all about listening to the key things people are telling us and this links directly to the retention plan.

The EOC culture sessions are really positive and early signs of positive impact; some of our actions have come from the feedback from these sessions, e.g. how to increase communications.

Lastly, Tina updated on the work to develop a culture dashboard which will be presented in draft to the People Committee next month. We have worked through the Pulse Survey free text comments and there is good alignment with our priorities.

DA thanked Tina for this update which highlights how we are taking a programme management approach to ensure we deliver against our promises.

TQ noted the comment that no tasks are at risk and asked of there is any risk to delivery overall. Tina responded that there is no overarching risk at this point but we aware of the high number of initiatives happening at once and so need to ensure they compliment each other; this is a work in progress.

People Committee Report

In SS's absence, LS highlighted the focus on training evaluation and access for our people. There is an inconsistent approach currently. The committee also noted a lack of assurance on roles and responsibilities for the professional standards function, which it is following up.

HG referred to the metric in the IQR and BAF on time to hire. It is showing a target of 60 days and actual of 200. AM outlined some of the actions being taken including the QI project which is due to deliver in Q3.

55/23 Keeping Patients Safe [13.13-13.33]

MD summarised her cover paper drawing the link to the IQR where it sets out sustained improvement across a number of metrics. There is a slight delay in phasing of the QI project – keeping patients safe in the stack, but we still expect the end results to be delivered in the timeframe initially agreed.

The Board noted that there are 14 active cases Sis, with only three breaches, each one has a clear rationale, Datix out of date breaches is now down to 7%, with the threshold being 10%.

MD then highlighted the positive progress with risk management; over 97% compliance with reviews and recording the controls in place.

RO then highlighted end of life care, where we have established a dashboard which we will share with the system to help improve patient care and experience.

As mentioned earlier, MDC phase 1 relates to works to make a safe environment. Phase 2 is the review of the whole estate for the longer term solution. We are using BI data to establish the options.

On Operation Carp RO confirmed that all the actions are progressing. We now have a confidentiality code policy approved and the training set out in the report is ongoing. TQ asked about a policy on relationships at work. SW responded that we are working on this.

MW added that notwithstanding the policy we must always ensure relationships are disclosed; SW agreed. MW also reinforced the point made at the audit committee about needing further assurance that we implement lessons in a timely way. SW agreed with this too and is confident we are now ensuring learning from this incident.

PSIRF Plan

Neil Salmon, PSIRF Lead, joined and summarised the plan and the role of the Board to ensure oversight of patient safety, as he believes has been demonstrated through this meeting. ICB panel is scheduled for 17 November, where we will present our Plan.

SW supports the work done and endorsed the plan. SW confirmed that Neil hosted a Big Conversation on this which was well received by staff, who welcomed the change to how we approach this. The report links to themes for learning and Board is asked to note this is the focus.

TQ confirmed that this has been to the quality committee and is supported.

The Board approved the Plan.

QPSC Report

TQ summarised his report much of which has been covered. The escalation was the agenda item today on call handling. There were no questions.

The Board formally received the three annual reports in the pack.

42/23 Review of Board Effectiveness [13.33-13.38]

The Board reflected that the papers were of good quality, but the executive could do more still to bring out the key headlines, balancing the need to introduce the items for discussion and not repeating what is written.

Overall, reflecting on the journey in the past 12 months the Board agreed there has been much improvement related to oversight of the range of issues we need to be across as a Board.

43/23 AOB

Reinforced Autoclaved Aerated Concrete

SxS confirmed the review establishing that there are no issues for our estate.

There being no further business, the Chair closed the meeting at 13.38.

DA then asked if there were any questions from the public in attendance, related to today's agenda.

A Governor observing suggested that related to retention, we need to move away from a command and control culture. He then asked about management training and the plan for line managers as they will be key to implementation. Tina responded that we have the 'essentials' programme for middle managers and 'fundamentals' for front line managers. We also have a draft development plan for OUMs.

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

Date _____

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP, R)
15.12.2022	70 22c	As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.	DR	Q4 2023/24	Board	IP
15.12.2022	70 22e	The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.	SW	Q4 2023/24	Board	IP
03.08.2023	33 23	H&T trajectory to be set out in the relevant paper in October.	EW	05.10.2023	Board	C
03.08.2023	38 23a	The Board to consider the response to the National EDI Plan.	AM	07.12.2023	Board	IP
03.08.2023	40 23	QPSC to seek assurance that appropriate training, mentoring and supervision is consistently in place for Band 6 paramedics who are being expanded in the local hubs, linked to EOC.	RO	Q4	QPSC	IP
03.08.2023	41 23	Noting the People Committee has to-date focussed on the operational workforce plan, the Board asks that it considered the wider workforce plan to ensure clarity on support services and any related risks to operational or corporate delivery.	AM	Q4	People Committee	IP
05.10.2023	52 23	Update in December on the Winter Plan and Call Handling.	EW	07.12.2023	Board	C

Key

Not yet due
Due
Overdue
Closed

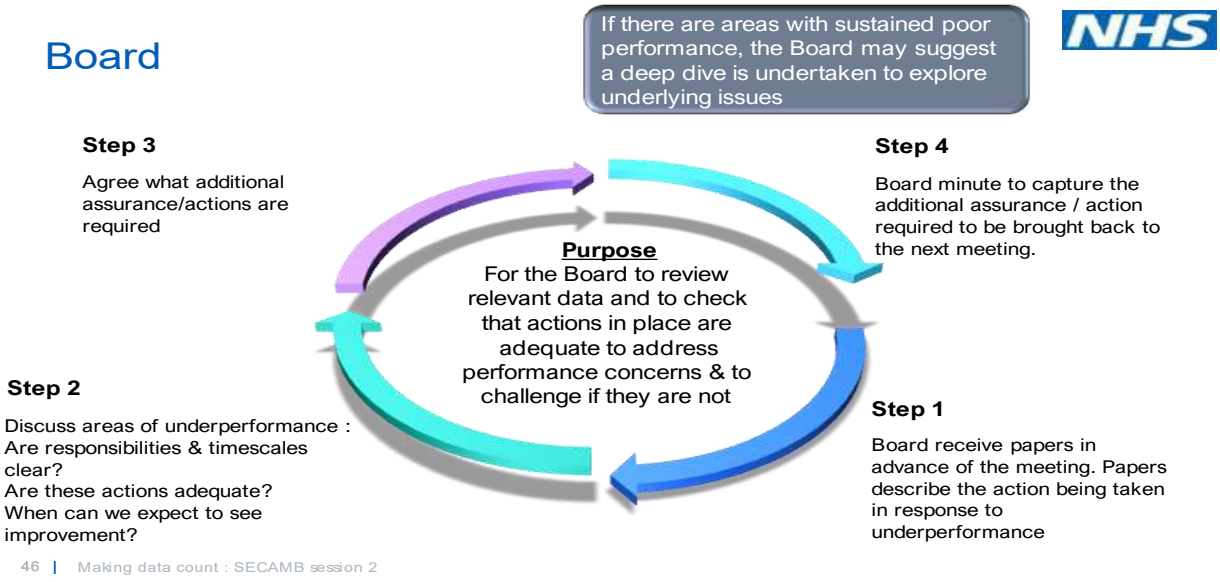
ɔard Action Log

Comments / Update
July Update: While this was initially planned for Q1 it is suggested that we defer this until early next year, as a better time to do this will be once we have developed our clinically focused Trust strategy as this should revolve around patient outcomes. We will in any event need to refresh the IQR then so it will be sensible to do it all at once.
Added to the BD plan for 2023/24.
See RC agenda item - Minute from 05.10.2023
To be covered under the P&C item.
On agenda

		Item No	62-23
Name of meeting	Trust Board		
Date	07.12.2023		
Name of paper	Chair Board Report		
Report Author	David Astley, Chairman		

Board Meeting Overview

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



In light of the ongoing pressures, it is sometimes easy to take for granted all the great work that goes on at SECAmb. The recent Staff Awards which were attended by most of the Board, was a timely reminder of the positive impact our people have in the delivery of services to the public. The welfare of our people remains a top priority for the Board and the Board Story this month provides an overview of the way our people and our partners have recognised each other. This will help to set the context for the other items we lead off on at the meeting, related to people and culture.

As I mentioned last time, we acknowledge our operating model, which is one of the main strategic risks, will not enable us to meet the changing demands and patient need in the medium

to longer term. We are making good progress in the development of a new clinically led, patient focussed, trust strategy.

In the meantime, we must continue to focus on using our resources to best effect in meeting the needs of our people and, with winter fast approaching, the Board will need to seek assurance that we are well prepared.

Board Development / Well Led Review

We focussed our last development session in November, on strategy. In addition to operational managers, the Board was joined by a number of clinical leaders. It considered the clinical case for change and what this means for our patients, people and partners. There was a really constructive workshop on the strategic choices, assumptions and constraints that has informed the current phase of designing the strategic options / models of care.

An external well led review is being undertaken and the Board will receive the outputs of this in Q4. Its aim is to help confirm the progress we have made in our improvement journey, and what areas of improvement we should focus on in the coming year. This will then help to inform the Board Development Programme for 2024/25.

Council of Governors

Our Governors have a key role in our governance structure, holding the Board to account for the performance of the Trust. They do so on behalf of the Trust's members, who include our staff and our public. The Council of Governors last met in November, where the good engagement on the strategy was noted. The key areas of concern / ongoing assurance included the following:

- IT Resilience
- Medicines distribution centre
- Call Handling
- Appraisals – quality and completion

These are all issues within the focus of the Board and will be discussed during the meeting.

Engagement

The recent **Volunteer Conference** was a great success, reinforcing the important role of volunteers as we shape our new strategy. On behalf of the Board I thank all our volunteers for their support. I am pleased to confirm that I am now a member of the Oversight Group steering the National Ambulance Volunteering Strategy

In early November I spent an afternoon at the Ashford MRC meeting the "Perfect Month" team who are piloting a new way of working to reduce inappropriate patient conveyances in the Ashford, Kent area by offering different pathways to A&E conveyance. A formal review will be undertaken but from my brief visit there seemed to be a positive impact on both patient care and staff wellbeing. This is a great example of the SECAmb innovation and "can do" culture.

In addition to the three Staff Award ceremonies I mentioned earlier I also attended the NHS Providers Conference in Liverpool; represented the Ambulance sector on the NHS Providers October Board meeting; welcomed Andrea Lewis, the recently appointed Regional Chief Nurse on a visit to SECAmb; and with Simon I welcomed Amanda Pritchard, Chief Executive, NHS England on a visit to our new Medway Development. Amanda met numerous SECAmb colleagues as well as understanding the work of our colleagues who work in the 999 and 111 service. Amanda also shadowed a front-line crew for part of their shift.

South East Coast Ambulance Service NHS Foundation Trust

Item No	62-23

Name of meeting	Trust Board
Date	07 December 2023
Name of paper	Fit and Proper Person Test (FPPT) Framework
Board Lead	Chairman
Author name and role	Peter Lee, Company Secretary

On 2 August 2023 NHS England published the FPPT Framework, which was in response to the recommendations made by Tom Kark KC. The aim is to strengthen and reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework applies to the board members and is effective from 30 September 2023 for all new Board appointments and annual appraisals from this point. It does not require organisations to collect historic information to populate ESR / local records.

The Appointment & Remuneration Committee is the committee of the Board that will oversee the effective implementation of the Framework and, at its meeting in October, supported the approach being taken. This paper highlights the key changes that we will take forward at SECAmb, which include:

- Additional references to cover a six-year continuous employment history for all new board appointments (including promotions) – and a new reference pro-forma and procedure to be followed when a board director leaves the Trust.
- The implementation of a national self-attestation pro-forma as part of the annual FPPT checks on board members.
- Mandating that DBS checks are undertaken every three years for board members.
- New checks on the training and development of executive directors, to be undertaken alongside the annual appraisal.
- Improved local recording of FPPT checks on the Electronic Staff Record (ESR) and clearer auditing requirements.
- A new NHS Leadership Competency Framework (LCF) is due to be published imminently for implementation by 31 March 2024. The LCF will reference six competency domains needed to be included in all JDs and recruitment processes. It will inform a new Board appraisal framework to be used for the 2023/24 appraisals, which will be undertaken at the end of this financial year.

A new FPPT Policy will be written to cover the requirements of this Framework, which will be in place by April 2024.

ARC has agreed the following:

1. That the initial implementation will include just Board members (as required by the Framework), with a reviewing during 2024-25 to determine whether the scope should be expanded to others.
2. An annual report from ARC setting out compliance with the Framework will be presented to the Trust Board and Council of Governors.
3. Outcomes of the FPPT assessments will be included in the Annual Report and on the Publications section of the Trust website.
4. The Internal Audit Plan will at least once every three years include a review of our compliance against the Framework.
5. The new Board appraisal framework incorporating the NHS Leadership Competency Framework will be used for the 2023/24 end of year appraisals.

Fit and Proper Persons Framework

1. Introduction

The government commissioned a review of the scope, operation and purpose of the Fit and Proper Person Test as it is set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This review was undertaken in 2019 by Tom Kark KC – the Kark Review.

NHS England developed the FPPT Framework in response to the recommendations made in the Kark Review. This paper describes the key changes arising from this Framework.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. The Framework however does not require any retrospective action and specifies that it is for all new board appointments or promotions and for future annual assessments.

The Chair is ultimately responsible for the implementation of the Framework. This applies to all board members, however, deputies are included within the scope of the Framework if they act up to cover a board member's role for a period of six weeks or more.

2. The FPPT Framework

The Framework includes additional checks, such as references to cover a six-year (previously three) continuous employment history, using a standard board member reference template Appendix 2. The reference template also must be completed as soon as a board member leaves the organisation, regardless of whether another organisation requested one. As references need to cover a six-year continuous employment history, it must be retained for six years after departure.

If a director does not agree with the contents of the reference, they are permitted a right of reply. The new Policy will include a section that outlines this process.

The Council of Governors need to be informed of a satisfactory FPPT assessment for the Chair and Non-Executive Director appointments (and then annually), with any assessment for a new Chair appointment first requiring the NHS England Appointments Team approval.

The Framework includes a new annual self-attestation Appendix 3. This is similar to the annual self-assessment we have had in place. This will be undertaken each year alongside the annual appraisal.

The Framework requires additional annual checks for executive directors related to training and development, and this too will be undertaken during the appraisal process, as part of the assessment of core skills compliance and the personal development plan.

In line with our current Policy, the Framework requires DBS checks to be conducted for Board members at least every three years. We are taking steps to align the renewal dates of DBS checks to coincide with the annual appraisal process.

ESR will be used for the collection of data related to the requirements of the new Framework. Additional fields are being added to ESR to support the implementation and to standardise recording of checks across the NHS.

Once the FPPT checks have been completed, the Chair will be responsible for ensuring board members are, and remain, suitable for their role. The Chair will sign-off the FTTP checks for all directors, and the Senior Independent Director will review the Chair's FPPT check to ensure compliance with the FPPT.

The details of all the FPPT checks will be added to ESR, and the annual NHS FPPT submission reporting template Appendix 5 is sent to the NHS England Regional Director.

3. Information Governance

The processing of data to undertake the FPPT is covered by GDPR and a board member FPPT privacy notice is provided Appendix 6. The framework requires that board members are made aware that they may object to their data being processed for the FPPT. However, due to the Trust's legal obligation to undertake the data processing, any objection is likely to be incongruous with continued employment. Steps are being taken to update contracts for Board members to cover this requirement.
The Framework requires no changes to existing data controller arrangements. Information held in ESR about board members is accessible by a limited number of senior individuals within the Trust only.

Personal data is exempt from the Freedom of Information Act, but the Trust can expect to receive requests for anonymised data, which will be shared in accordance with our Information Governance Policy.

4. Reporting & Audit

The recording of FPPT checks in ESR will allow reports to be run on a regular basis to show compliance with requirements. A annual report from the Trust Chair to both the Board and COG will be provided giving assurance that we have complied with the annual requirements of the Framework.

In addition, a summary report will be provided on the outcomes of the FPPT assessments in the Annual Report.

Internal Audit will be asked to schedule a review of the processes, controls and compliance with the FPPT, at least every three years. The first will be included in the Internal Audit Plan for 2024/25.

Lastly, an assessment against the Framework will be included in the scope of any external well led review, and our preparedness for implementing this Framework has been included in the review being undertaken currently.

5. Next Steps

i. A new FPPT policy will be drafted to cover the requirements of this new Framework.
ii. The company secretary and director of HR & OD will work with the Chair and other key stakeholders to ensure implementation of the Framework.
iii. The new NHS Leadership Competency Framework (LCF) / Board Appraisal Framework will be used for the 2023/24 Appraisals and will be included in all new JDs and future recruitment processes.
iv. The first annual report confirming compliance with Framework will be scheduled for Board and COG in Q1 2024-25.

South East Coast Ambulance Service NHS Foundation Trust

Item No	63-23

Name of meeting	Trust Board
Date	07.12.2023
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 October and November 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:

- On-going close consideration of the findings from Phase 1 of our Strategy Development and the development of Phase 2
- The development of our Retention Plan
- Approval of the annual WRES/WDES reports
- Review of our Cost Improvement Programme (CIP)

5 EMB continues to hold a meeting each month as a joint session with the Trust's Senior Management Group to oversee feedback from the on-going programme of leadership visits, development of our Trust Strategy and oversight of the Risk Register.

6 **Engagement**
During October and November 2023, I have enjoyed continuing my programme of visiting different SECAmb sites and teams across our area each week. As well as being enjoyable, these are great opportunities to meet some of our people and learn more about the fantastic work going on across the Trust.

7 I found it incredibly useful to spend time on 24 October with the operational, Fleet & Logistics and Medicines Distribution teams at Paddock Wood and learn more

	from them directly about some of the specific challenges they face there, due to the nature of the building and the site.
8	On 30 November, I enjoyed my time with the operational team at Brighton Make Ready. Whilst in Brighton I also had the privilege of meeting Professor Douglas Chamberlain, who has played such an instrumental role in the evolution of ambulance services in this country and around the world.
9	On 21 November 2023, I spent time with two of our Community First Responders – Andrew Latham and Andrew Clark – on a CFR shift. As always, it was inspiring to spend time with our dedicated volunteers, whose commitment to support our patients and our people is always striking.
10	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 – are continuing to provide a forum for lively discussion.
11	Together with our regular People & Culture webinars, it has been good to engage with a wide range of colleagues through these mechanisms on important topics including retention and speaking up.
12	On the partnership front, I have also continued to spend time with a number of our key regional and national system partners including regional and national ICS Chief Executives, colleagues from other ambulance Trusts and from our local partner NHS Trusts. These meetings have all provided good opportunities to discuss areas of joint working, particularly as we enter the busy winter period.
13	**Development of our new Trust Strategy** As we continue the development of our new Trust Strategy, during October and November 2023, we have carried out an extensive programme of engagement with our people, patients and partners to gain their views on our clinical case for change, the emerging findings from our diagnostic work and analysis of wider system forward plans.
14	This has seen hundreds of views given so far, through a wide range of different mechanisms. All of the feedback is incredibly useful in helping us to ensure our new Strategy is shaped by what is important to our key stakeholders.
15	Our analysis and the feedback received show that population growth, an ageing population, and increased health inequalities are driving a projected 15% increase in demand over the next five years, yet only 13% of our patients have critical or emergency needs.
16	This means that unless we change how we work, our response times will increase significantly during the next five years and will not meet the evolving needs of our patients. Phase 1 has confirmed that our current model is becoming unaffordable, unsustainable, and unacceptable for our patients, our people, and our partners.

17	As we move forwards into Phase 2 of our Strategy Development process, we will co-design the future models of care that better meet the needs of our patients, support our people and partners, and make us sustainable in the long term.
18	**Latest 'poppy' ambulance unveiled** For the sixth year running, we were pleased to show our support once again for the Royal British Legion's Poppy Appeal by unveiling special 'poppy ambulances' in early November in each of our operational areas.
19	The ambulances feature a large remembrance design on the side and, given that many of our people have strong links with the armed forces, I am pleased that, once again, we were able to show our support for the Poppy Appeal in this way.
20	**'Building a Kinder SECAmb' workshops** As part of our 'Getting things right for our people' programme, we each have a responsibility to create and build a kinder culture here at SECAmb. To support us in this aim, I am pleased that we have partnered with renowned healthcare culture experts 'A Kind Life' and invested in creating and delivering a bespoke workshop that all colleagues will be able to attend.
21	Each 'Building a Kinder SECAmb' workshop focuses on culture and values as part of our cultural transformation programme and aims to help us all to consider how we can be respectful of each other, create safe and positive approaches to providing feedback and raising concerns, establish kinder ways to talk to each other for a resolution and avoid escalation of issues.
22	We have recently seen the conclusion of the first phase of these workshops, which has seen more than 200 colleagues attend one of 11 sessions.
23	The feedback from attendees has been overwhelmingly positive, and having attended a session myself, I can confirm that it was a powerful and useful day, as well as being very enjoyable.
24	The next phase of the workshops will start in January 2024 and, over the next two years, we have committed to every single member of staff attending.
25	I look forward to seeing further positive feedback as the programme continues, as well as the emerging impact of our people learning how they can individually make a difference to the culture around them.
26	**Review of Executive portfolios** To ensure that we are structured in the right way to enable us to fully deliver our new Strategy, in October 2023 we started a review of how portfolios are organised at an Executive level to ensure that there is sufficient capacity within each area.
27	With support from our NHS England Improvement Director, the review is considering how portfolios are arranged in other ambulance and NHS Trusts, as well as using input from the current team to develop a proposed new structure that will support the implementation of the new strategy.

28	We are aiming for the new structure to in place by April 2024.
	B. Regional Issues
29	**SECAmb Volunteers Conference** On 18 November 2023 we held our first ever Volunteers Conference and I was delighted that more than 200 of our volunteers were able to attend.
30	The conference recognised and celebrated the contribution of all of our 400 volunteers, who support us in a variety of roles including Community First Responders, Chaplains, Welfare Volunteers and Governors.
31	Guest speakers at the conference included Helen Vine, the Association of Ambulance Chief Executives (AACE) National Volunteer Lead for Ambulance Services and the author of the National Ambulance Volunteering Strategy.
32	This was the first conference of this scale we have held for volunteers, and it was a real success. We were able to explore topics including the benefit and vital role volunteers bring to both patient care and their staff colleagues and how we want to continue to expand the role of volunteers within SECAmb.
33	I'm delighted that we are able to celebrate their contribution in this way and thank each and every one of them for their ongoing support.
34	**The 'Perfect Month' trial** During November 2023, we are trialling a new approach to ensure 999 calls receive the most appropriate response.
35	Known locally as the 'perfect month', the four-week trial sees Advanced Paramedic Practitioners lead a clinical hub at the Trust's Ashford Make Ready Centre with paramedics joining a multi-disciplinary team from across the Kent healthcare system including Emergency Department consultants and clinicians from East Kent Hospitals University NHS Foundation Trust and Kent Community Health NHS Foundation Trust.
36	The clinicians, representing SECAmb, hospital, community, frailty, and Urgent Treatment Centre teams, are working together to review 999 calls to establish whether an ambulance is the most appropriate response or if the patient's needs can be better met by other parts of the NHS.
37	We hope that the trial will help to inform a more integrated, partnership approach to delivering patient care that will better support people who need urgent help, but who don't necessarily need to be admitted to an acute hospital.
38	I was pleased to spend time with the team at Ashford on 7 November and enjoyed chatting with those involved. The feedback has been positive so far and I look forward to seeing full evaluation of the trial in due course.
40	**Annual Staff Awards**

	Throughout November 2023 I had the privilege to attend our annual awards ceremonies and witness colleagues receive extremely worthy recognition for both their long service and for special achievements.
41	The dedication of staff and volunteers in attendance was clearly evident and I was very proud to be involved across our three ceremonies. To celebrate with and speak to colleagues who have provided so many years' service was extremely humbling.
42	I was also delighted we were able to be joined at each ceremony by members of the public whose lives have been saved by the treatment provided by our teams. This is as good a reminder as there is for why people work for the ambulance service and why their roles are so vital to patient care.
43	The commendations I presented represent just a small selection of the amazing work which goes on each and every day across our region and I would like to thank everyone at SECAmb for their continued hard work.
44	I was also pleased that we were able to take a moment at our final awards ceremony to mark the service of our Chair, David Astley, ahead of his retirement in May 2024.
45	David has dedicated more than 50 years' service to the NHS, and I would like to thank him, once again, for this extraordinary public service. His passion and commitment for making improvements for our patients and colleagues is clear to see.
46	I look forward to continuing to work closely with him ahead of his well-deserved retirement next year.
47	**External review of HART/SORT/Resilience** We have now received the final version of the external review into the Resilience and Specialist Operations department that I commissioned earlier this year.
48	An action plan has been developed to address the findings and recommendations contained in the review and discussions are underway at a regional level to agree how we can 'right size' this important area moving forwards.
49	**External IT Review** As shared in my last Board report, 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.
50	The review has now been finalised, including making a number of recommendations, which will be discussed at today's Board meeting and next steps agreed.
51	**Medicines Distribution Centre** Following the update in my last Board update regarding the future provision of our Medicines Distribution facility, Phase 1 of the Medicines Distribution Centre (MDC)

	programme has seen representation from key stakeholders across the Trust working with an external organisation to design options to mitigate health and safety and clinical risks and improve the environment for those staff working in the MDC.
52	A design has now been agreed and costings worked up that will address known risks. The design includes fitting of a trade lift, provision of desk space to allow for effective packing and IT/security capability required.
53	A business case was presented at the Executive Management Board on 22 November 2023 and approved for progression. We will look to get the works started as soon as possible following a procurement process, with completion of the Phase 1 project by end of May 2024.
54	Phase 2 and the wider consideration of the Paddock Wood estate remains ongoing alongside this work
	C. National Issues
55	**Visit by Amanda Pritchard** On 22 November 2023, we were delighted to welcome Amanda Pritchard, Chief Executive of NHS England, to our Medway site, where she spent time meeting Emergency Operations Centre (EOC) and 111 staff, before joining an ambulance crew for part of their shift.
56	It was great to be able to show Amanda the fantastic new facilities at Medway, which bring together a Make Ready Centre for 999 frontline operations, a 111-contact centre and a 999 EOC under one roof.
57	She was extremely complimentary about all of our people that she met and chatted with and thanked everyone for their on-going hard work and commitment.
58	**NHS Staff Survey 2023** The completion period for the most recent NHS Staff Survey closed at midnight on 24 November 2023 and I am pleased to share that we had responses from 2,790 of our colleagues, including 74 who hold bank contracts.
59	This is the highest number of our people we have ever heard from through the Survey, and I'd like to thank all of those who took the time to share their views. I am also pleased to report that the Trust hit the 60% response rate for the fourth year in a row. This continuing level of engagement from our staff is really pleasing and means that we can use the feedback with confidence in developing our action plan.
60	We look forward to the results of the Survey being published in Spring 2024 when we will use the findings to shape and prioritise our areas of focus for the year ahead.
61	**Health & Safety Executive (HSE) Inspection** As part of their national programme, between 2018 and 2022 the HSE inspected 60 NHS Trusts, focussing on the management of musculoskeletal (MSK) and

	Violence & Aggression (V&A). This resulted in 38 organisations (64%) having enforcement action taken against them, 26 (44%) of which were for both MSK and V&A issues.

62	As part of the local follow-up to this programme, SECAmb received visits from the HSE to two of our sites on 26 & 27 October 2023, resulting in two enforcement notices:
	
	• an Improvement Notice for Bariatric training
	• a Notice of Contravention that covers four material breaches requiring attention:
	  ○ training for lifting bariatric patients to align to policy (basis of Improvement Notice)
	  ○ content of curriculum training in relation to manual handling
	  ○ restructuring and implementation of conflict resolution training
	  ○ quality assurance of risk assessments in relation to manual handling
	  ○ realignment of policies and structure for assurance across Health & Safety with buy-in from Directors

63	A Task & Finish group has been commissioned by the Executive Director of Quality & Nursing, to be led by the Chief of Staff and involving a multi-disciplinary team of senior colleagues and staff side representatives.
64	This group is accountable to the Executive Director of Quality & Nursing but reports into EMB on a weekly basis due to the short timescales involved for delivery of the notice requirements.
	D. Escalation to the Board
65	**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 overall.
66	Year to date, SECAmb continues to perform well with regard to the NHS England Category 2 target. This is an excellent achievement given the national context. Further, our hospital handover times continue to be among the best in the country.
67	Although we know we have more to do, we have also seen relative improvements against the wider response time targets and again, are not an outlier when compared to our colleagues nationally.
68	I am also pleased that we have noticeable improvement in our call handling performance during recent months, due to improved recruitment of Emergency Medical Advisors (EMAs) and targeted support from our colleagues at West Midlands Ambulance Service. This is an area which we continue to keep under close review.
69	We remain at REAP Level 3 but continue to keep this under close review.

70	**Regional financial position** Our host commissioner, Surrey Heartlands ICB, has performed a reforecast of the financials for the whole system and is forecasting a deficit of £24.1m.
71	As part of the wider system, we are committed to achieving our control total and, as above, continuing to meet the NHS England Cat 2 target.

South East Coast Ambulance Service NHS Foundation Trust

		Agenda No	64-23
Name of meeting	Trust Board		
Date	07.12.2023		
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 updates since October:

- PC Objective 5 (Appraisals) will not be met.
- A strategic risk related to retention will be added to the next version of the BAF.

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**	

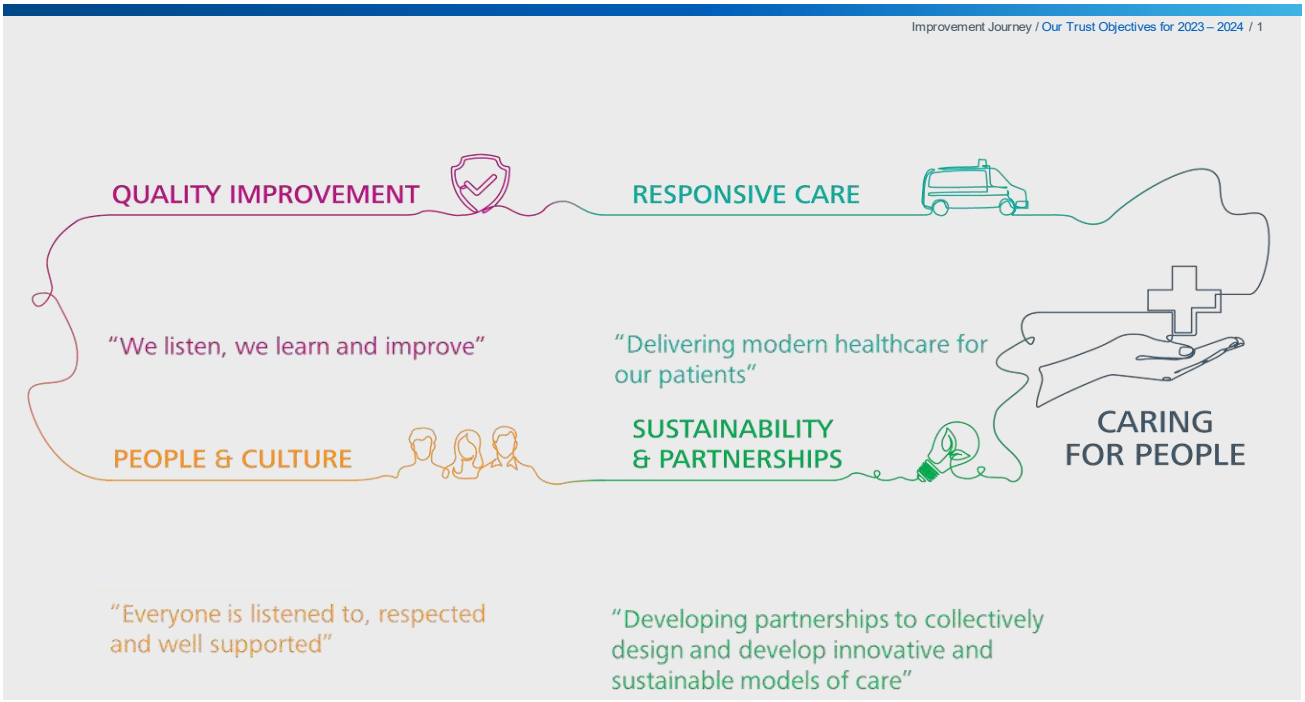
Goal 3	Become a Sustainable Urgent and Emergency healthcare provider	

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 the 2022 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.

Board Assurance Framework
Section 1: Strategic Goals - Delivery

Quality Improvement

Goal 1		Build and embed an approach to Quality Improvement at all levels	
In Year Objective	**QI 1**	**Quality Improvements on how we keep patients safe in the EOC stack during periods of escalation and at points of discharge**	
	Measure	Reduce level of harm experienced by our patients vs 22/23 baseline	Q4
	QI 2	**A QI Strategy to take the organisation forward and empower those closest to patients to lead improvements.**	
	Measure	Signed off Strategy at the Board	Q2
	QI 3	**Training and engagement in QI for our people**	
	Measure	For 10% of all staff to have completed 'Introduction to QI' 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:
ON TRACK

Progress has been made in rolling out the Phase 1 improvements as per below with these planned to go live before the start of Q4 as planned. A new call closure script for C3 & C4s has been trialled this month in the contact centres with good feedback. A patient forum has been scheduled for December to discuss the script and other changes. The project team is working with Cleric to ensure that Phase 2 improvements go live by Q4.

Improvement	Implementation Date
EMA's to deliver ETA for C2 to C4's	1st November 2023
Call Closure script	30th November 2023
Interim Care advice	1st December 2023
Cessation of Welfare Calling	After Implementation of Automated Welfare Texting

Improvement	Implementation Date
Automation of Duplicate Call closure	1st March 2024
Automation of Welfare Text messaging	1st March 2024

QI 2:
COMPLETE: strategy signed off by Trust Board in August.
Following the sign-off of the QI strategy, the QI team have hosted three 30-minute virtual sessions to introduce the QI strategy across the organisation. 52 colleagues so far have attended these sessions. Additional sessions are being planned as the team has had good feedback with mini projects identified following the sessions.

QI 3:
ON TRACK

Year to Date, 202 colleagues have been trained (4.1% of all staff) in 'Introduction to Quality Improvement (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. In Q4 from January, we will be increasing our delivery and enhancing training offer to 111 & EoC staff that will include virtual sessions.

QI training is being embedded into the wider ETD plan being developed for planning of the next 3 years training requirements across the Trust.

In Year Risks to achieving the objectives

Goal 1	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
QI 1	Lack of time / capacity for operational support of QI projects	3 x 4 = 12	3 x 4 = 12	3 x 2 = 6

Mitigation

- Project team has identified high impact easy to implement initiatives to implement imminently. These initiatives are on track.
- 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 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

- The team are due to deliver Intro to QI training to key skills sessions for 111 & EOC colleagues in Q4.
- The team have been attending Team C meetings within this financial year to support training for operational leadership teams.
- The team have attended several induction sessions for field Ops Staff. This has been delivered to 65 staff to date.

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	Overall, on track - PSIRF Plan agreed at Board in Q3 - **Completed** - Central Incident review panel established by end of Q3 - **Completed** - System-level Incident review groups established by end of Q3 - **Completed** - Training programme in place for and attended by core facilitators. - Q4 - *Added Dec 2023:* PSIRF Policy approved, and sighted by Board - *Added Dec 2023:* PSIRF Launched and SI Framework (STEIS) ceased to be in use in **Q2 2024/25**	Q4
	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	Further areas of focus following a tripartite review between the Operations, Medical and Quality & Nursing Directorates: • Through live listening in to calls where the patient may be in cardiac arrest or obviously deceased, support from the CCP desk to support dispatch decision making regarding the number of resources to allocate to each incident. • To improve the number and appropriateness of tasking of CCP resources, CCP Desk staff to contact the caller and seek clarifying details to establish whether to task a CCP – both to high and lower acuity calls. Note – this does not impact the triage and/or disposition outcome.	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:
Slight delay to launch date but remains ON TRACK

- Trust patient safety priorities identified and PSIRP agreed by the Board in Oct 2023 but still to be sighted of the Policy which is under Trust-wide consultation.
- The Patient Safety Oversight Group (PSOG) is now established, and TOR approved by QGG. The Group have now met.

- 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 were approved at PSOG on behalf of QGG.
- These groups have met and undertaken 'dummy runs' to test the methodology.
- National standards for training and competencies have been established and a paper has been presented to Education Training and Development Group. An external provider will be required, and funding has been identified through Clinical Education although we expect to go live with PSIRF prior to the training being delivered. Identified as a risk but mitigated utilising SMEs within the Trust to support transition.

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.
- Tripartite review of ongoing progress and challenges identifying four areas to refocus attention (see above)

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	4x1=4

	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 from full commencement. - Integrated Quality & Performance Reviews at dispatch-desk level underway in Q2 – 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 Assurance and Engagement Framework through local visits, that helps us assure the improvement we are making (QAE visits)**	
	Measure	- We will evaluate effectiveness and impact after 6 months (well led review) - 12-month cycle of planned visits available with Units informed and prepared - 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~~. *October 2023 – changed to:* Corporate actions taken to relevant teams to resolve within BAU and report back – themes being collated - 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:
ON TRACK.

- October has seen a significant shift as the first three stages of the building blocks all launched in full in October 2023.
  - October has seen the successful launch of the Quality and Governance platforms within the Quality Assurance Framework, with intelligence from the Quality Assurance and Engagement Visits underpinning each platform.
  - Internal Quality and Performance reviews commenced weekly at the latter point in October.

- The System Clinical and Quality Groups were initiated in early October and have since conducted two meetings per system, followed by debrief sessions. The meeting agendas are designed to be flexible, promoting unrestricted conversation.

- Initial feedback from attendees regarding the System Clinical Quality Group and Quality Governance Group has been predominantly positive, effectiveness will be evaluated at the end of Q4.
- Securing seamless connectivity between platforms currently presents a challenge, but is being tested through cross-attendance of Quality, Clinical and Operational Leads and Executives

QI 8:
ON TRACK.

- Seven successful visits have now taken place since commencement in April, to Banstead, Chertsey, Thanet, Worthing, Ashford, Guilford and Polegate with very positive evaluations from staff and visitors alike.
- Further iterative co-design changes have been made to the format of the QA&EV; Positive feedback off the back of this.
- Full year's 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.
- More involvement from system partners with the visits, demonstrating assurance to the ICB's.
- Thematic Analysis completed on the first four visits undertaken to identify common themes, trends, and challenges at a systemic level. Second thematic analysis underway with the last three quality assurance visits to provide assurance to EMB.
- Paper presented at joint leadership forum on the above thematic analysis with recommendations shared.
- The proposed model for feedback to corporate functions is under development. Discussions had with HR directorate to clarify actions process from leadership visits and QAEV. Live action plan to be implemented in Q4, feedback currently shared through thematic analysis papers to EMB.

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]	4X1=4	4X1=4

		Lack of engagement from Directorates to provide ‘visitors’ to the Units	[3X4=12]	3X3=9	3X1=3
	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. • Ensuring that the message of support and engagement, during the visit brief is clearly communicated. • 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 Currently at 52% completion of actions. The 5% was built-in due to some of the evaluation criteria expected to roll into Q1 post policy change and education program implementation, as well as the completion by all staff of the 'Building a Kinder SECAmb' program. Recent updates have suggested that the following actions are potentially at risk for completion in year, and mitigation is currently being developed: - Appraisals for 85% of our people - All Firstline managers completing the fundamentals program - Management essentials modules available to all managers - Review of HR policies (agile and remote working; process for annual leave)	Q3
	PC2	**Implement new leadership visit process consistent with C&E Strategy**	
	Measure	>90% compliance A review of the process is currently underway and will be shared with SMG and EMB members in January.	Q1
	PC3	**Rapid on-boarding QI project**	
	Measure	Time to Hire<60 days TT-WFE TBC – now confirmed as 60 days plus training for appropriate course (e.g 60 days + 9 weeks EMA) Increased % people passing probation SPC chart now showing. Part of QI project overall they have it as part of their wider strategy but not be linked to HR	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 Awareness Days – The Building a Kinder SECAmb Workshop commenced in October 2023. The Workshop focuses on culture and values as part of our cultural transformation programme and aims to help us all to consider how we can be respectful of each other as well support us in creating safe and positive approaches to providing feedback and raising concerns. The NHS Sexual Safety Charter was launched in September 2023. A Steering Group has been convened led by Margaret Dalziel to develop an action plan to achieve the Charter by July 2024. The OD team is currently undertaking a gap analysis against the Charter.	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 approved 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)	3x3= 9	3x2=4	3x1= 3
	Mitigation				
	Integrated programme of visits (LV and QAV) now in place				
		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 To be checked as part of leadership / QAVs as too complex to maintain a central system of 1-1 meetings.	Q1-4
	PC7	**Project to analyse and make changes to improve compliance against overruns**	
	Measure	Reduction in LSO% and Mean overrun time [see RC Objective 7]	Q2
	PC8	**Continue to deliver the fundamentals leadership training for first-line managers**	
	Measure	>95% completion of first line management fundamentals On track for completion in Q1 24/25.	Q4

In year progress with the achievement of the Strategic Goal is Green because most of the actions are on track 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.

PC5: Significant risk to this objective. The L&D team are undertaking an Appraisal performance inquiry to identify actions that directorates can take to achieve 85% compliance by March 2024 and to plan the resources required to achieve the actions identified by the appraisal working group. Target now expected to be achieved in Q1 24/25.

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
In Year Risks to achieving the objectives	PC5	Protected time unable to be facilitated due to operational pressures	3x3=9	3x3=9	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	3x2=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				

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 On track	Q4
	PC10	**Bring our Policies in-date and make them fit-for-purpose**	
	Measure	>95% up to date policies by end of the year On track	Q4
	PC11	**Management essentials to be rolled out (building on Fundamentals)**	
	Measure	95% of identified managers completed management essentials On track	Q4
	PC12	**ACAS mediation process**	
	Measure	Positive feedback from TU and Trust in the post-mediation evaluation On track	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.

PC 12 – all initial mediation meetings completed. Joint workplan developed and agreed at JPF on 30.11.23

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	4x3=12	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	4x2=8	4x1=4
	Mitigation				
	Policies have been shared across management groups, to share workload. Meeting with ACAS to improve relationship with Trade Unions, and a new overarching Policy is in place. JPF has re started.				
		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

Summary notes

- RC1: C2 mean response time
  - C2 mean of 28mins 02secs (October), YTD (to 31/10/23) C2 to of 28mins 38secs.
  - Remaining on trajectory to achieve C2 men of 30mins max.
- RC2: Call answering mean 22secs (October).
  Comprehensive action plan presented at previous Trust board, with actions including:
  - Additional call answering support commenced on 18th October from WMAS contributing to an immediate improvement in call answering performance.
  - Targeted incentivised overtime shifts.
  - 'Big event' recruitment at Medway and Crawley – significantly more interest resulting in a higher number of applications than seen more recently.
  - Dual-trained health advisors to support EOC – 16 staff completed so far with more courses planned.
  - Baselining of psychometric testing has commenced to support improved recruitment and retention.
- RC3: Mean activity on own dispatch desk 100.4%, with a maximum variation at 47.0% with a consistent pattern of those areas who both 'export' and 'import' resource.
  - This workstream is unlikely to deliver in the timeline proposed due to the complexity of the contributory factors, however noting that progress has been made against sub-actions such as the dispatch improvement programme and with additional learnings to be clarified from the Ashford dispatch desk 'perfect month'.

Goal 1		Risk Description	Initial Score	Current Score	Target Score
In Year Risks to achieving the objectives	RC 2	Inability to meet call answering target and improvement plan.	4 x 4 = 16	4 x 3 = 12	4 x 2 = 8
	Mitigations				
	• Actions including planned support from WMAS and targeted incentivised overtime. • Overall improvements in recruitment and retention required – additional actions identified in call answering report yet to be commenced (pay mechanisms, EMA to SEMA as a default position for all EMAs after 12-18months).				
	RC 3	Inability to achieve the improvements in dispatch and resource efficiencies	4 x 3 = 12	4 x 3 = 12	4 x 1 = 4
	Mitigations				
	• Focus on delivery of phase 1 Dispatch Improvement actions.				

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	• Improvements in tasking of Specialist Practitioners (linked to QI5) • Improvements in CFR utilisation, particularly relating to falls management • Improved tasking of HART	Q1-4

Progress to-date:

RC4: Hear & Treat

- 'Hear & Treat' for October was 12.6% in - this places SECAmb 5th 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: Key national programmes

- 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. A business case is being worked up ahead of presentation to ICBs – this is aligned with other English ambulance services.

RC6: Utilisation of specialist resources

- HART desk staffing is being reviewed, recognising the benefit to improving the utilisation of these resources.
- Increased attention to address the need for improved tasking of CFRs to CFR appropriate and falls calls.

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				
	• Whilst improvements are being seen, the sustainability of this is dependent on longer term workforce plans for both specialist practitioners and registered Paramedics working at local MRCs/stations.				
	RC5	Inability to meet the recommendations from the Manchester Arena Inquiry	TBC	TBC	TBC
	Mitigation				
	• Business case being worked up for presentation to commissioners in early 2024 – risk being reviewed to quantify mitigations, controls, and scoring.				
		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. Workstream closed.	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 2 papers to the people Committee in January and September demonstrating improvements in both % of shifts and durations of these over-runs
  - 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, in addition to learning from other Trusts.
- RC8: All services are now live at the Medway site – EOC moved in – workstream now closed.
- 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 John Ambulance 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	Inability to deliver the required improvements for both LSO & ODOOS – due to capacity to progress the work and complexity of contributing issues.	3 x 4 = 12	3 x 4 = 12	3 x 2 = 6
	Mitigation				
	• Focus on one workstream item – LSO initially				
		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	4 x 4 = 16	4 x 2 = 8	4 x 2 = 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 The scope for the Clinical and Quality Strategy has been included as part of SP2 and the development of a clinically led Trust-wide strategy.	~~Q2~~ Q4
	SP 1	**A new long-term mission, vision and strategy, based on collaboration and co-design with our patients, people and partners**	
	Measure	Evaluating successful involvement of our people, patients and partners Strategy sign-off in Q4 at Board	Q4

In year progress with the achievement of the Strategic Goal is **Green.** Despite a delay in the start of the programme due to delays associated with the award of the contract, we have mitigated the previously reported 7 week delay and are able to present the case for change (end of phase 1 report) to the Board in December. We also remain on-track to present a recommended direction of travel to the Board on the 8th of February Board, 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).

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.
- (Update December) – We have completed phase 1 “Diagnostic and Forecast” and we are presenting this to the Board on the 7th of December. This is setting the foundations of the patient, people, system, and financial challenges we are facing in the next 5 years and we will be using these as we go into phase 2 to ensure we have a sustainable plan and clear role for the organisation going forward.

Goal 1	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L

In Year Risks to achieving the objectives

	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
SP1/SP2	Compressed timeline for design impacting our ability to develop comprehensive engagement and evaluation of options to support the Board in making a decision about the. This is compounded by a period of heightened winter pressures and annual leave through Christmas.	4x4=16	4x3= 12	4X2=8

Mitigation

- We have shifted our recommendation to the Board to the w/c 21st January (1 additional week)
- We have adapted our design process to be driven by early design sessions in early December with the Executive, and 6 multidisciplinary teams taking part in a co-design sessions around our emerging strategic options
- The level of detail of the evaluation of the options will be planned in December for early January with key groups (finance, clinical advisory group, executive) – and detail modelling will be done in phase 3 as part of developing the 5-year plans across workforce, transformation, investment, etc.

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
- (Update December) – the ICB-aligned governance is now live. A full evaluation will be conducted in Q4 in line with the original plan. 3 Executive leads have now been nominated for our 3 main systems (Surrey and Frimley have the same lead), ensuring we have good representation at a system level.

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 ADS has been delayed, and the BI team continue to monitor the progress, however the capacity of the team has been diverted to support the Strategy. This is not having an impact of the progress done operationally, as SPOCs are in place and the impact is being monitored through the patient flow group and has regular system assurance with our commisisoners. 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 Green 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 M7 (October) year-to-date the Trust's financial performance is slightly ahead of the financial plan with a surplus of £465k against a plan of £415k. The efficiency programme has delivered £3.8m of efficiencies which is £420k behind plan. The efficiencies are being delivered non-recurrently and there continues to be a focus on ensuring that the Trust delivers its efficiency target of £9m by year end.

Overall, the Trust is forecasting to land its break-even financial plan for 2023/24.

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 result in an overall deficit.	4X3=12	4X3=12	4x2=8

Mitigation

Deep dives into financial variances in ops budgets are being performed which includes the development of action plans with mitigations to bring budgets back on track. In addition, the CFO meets with the Director of Ops to ensure that budgets are discussed and mitigations developed and monitoring is performed.

	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. A workshop was held in October 2023 with the Joint Leadership Team where further efficiency ideas were identified and are being taken forward. The efficiencies are being delivered non-recurrently but overall the efficiency target of £9m will be met.

	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			Sep 22	Dec 22	Feb 23	Arp 23	Jun 23	Aug 23	Oct 23	Dec 23			
14	*Operating Model*	QPSC	-	-	1-3	1-3		20	20	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	16	⇔	08	April 24
348	*Culture & Leadership*	PC	-	1-3	-	-		16		16	16	16	16	16	16	16	⇔	08	Mar 25
16	*Financial Sustainability*	FIC	-	-	-	3		16	16	16	16	12	12	12	12	12	⇔	08	April 24
	Cyber Security	FIC													20	20	⇔	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 in 23 May 2023.
Clinical Education resourcing plan for 2023/24	Chief Medical Officer	TBC	Phase 1 agreed by EMB on 31 May 2023

	BAF Risk ID 16 Financial Sustainability	Target Date: March 2024

Underlying Cause / Source of Risk:

The Trust is unable to plan to deliver safe quality and effective services in the medium or long-term due to uncertainty over future funding arrangements in both 999 and 111.

Accountable Director	Chief Finance Officer
Committee	Finance & Investment
Initial Risk Score	**16** (Consequence 4 x Likelihood 4)
Current Risk Score	**12** (Consequence 4 x Likelihood 3)
Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)

- For 22/23, the Trust delivered a break-even result following remedial action plans with each directorate to deliver recurrent savings.
- A break-even plan has been signed off by the Board for 23/24.
- In order to continue the focus on financial delivery the Monthly review meetings for each directorate are continuing ensuring each area delivers on plan and its efficiencies.

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

Gaps in Control

Sources of Assurance: Positive (+) or Negative (-)	Gaps In Assurance
(+) financial management: achieving plan (-) underlying funding gap / deficit (-) Cost Improvement Plan	We have a break-even plan signed off which relies on non-recurrent means (£4.5m) to achieve that plan. The plan is based on delivering Category 2 mean performance of 30 minutes. In accordance with the guidance this is expected to improve to the 18 minute target in future years, which presents a risk either to financial sustainability or performance if further funding is not available or significant improvements are found.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Robust Cost savings plan developed and delivery tracking	Chief Finance Officer	Q1	Update included in the finance report
Monthly Directorate meetings to ensure focus on financial delivery and develop culture of delivery against plan.	Chief Finance Officer	Ongoing	
Sustainability & Partnerships Programme within the Improvement Journey established	Chief Finance Officer	Ongoing	Programme now in operation and delivering in line with the S&P plan.

	BAF Risk ID 14 Operating Model	Target Date: March 2024

Underlying Cause / Source of Risk:		
Our operating model is not suitably designed to consistently ensure efficient and effective management of demand and patient need, and there is a risk that until we address this, we will be unable to achieve the Ambulance Response Programme standards and therefore deliver safe and effective patient care.	**Accountable Director**	Executive Director of Operations
	Committee	Quality & Patient Safety
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**20** (Consequence 4 x Likelihood 5)
	Risk Treatment (tolerate, treat, transfer, terminate)	**Treat**
	Target Risk Score	**08** (Consequence 4 x Likelihood 2)

Controls in place (what are we doing currently to manage the risk)	Integrated Quality Report Metrics for Assurance	Variation	Assurance
The current model: •Does not support clarification as to what the function of an ambulance service is in the post-Covid environment, including its role/interaction with the UEC pathway. •Does not meet contractual (ARP) response times with the current workforce – any increase in staffing levels is not realistically deliverable in the current financial envelope and considering the wider workforce economy in the South-East. •Cannot respond to the need for differentiated care to different patient groups/needs. •Does not allow the Trust to provide a clear direction to our people in terms of career development and workplan delivery, causing morale and well-being issues. The focus for the 2023-24 financial year is on the four IQR metrics listed to the right (with hospital handover time used in addition to hours lost). A plan for delivering these metrics has been developed and submitted to NHSE and commissioners.	**999-1** 999 Call answer mean		
	999-9 Hear and Treat		
	999-4 C2 mean		
	999-24 Hours lost at hospital handover		
	Specific risks relating to EMA recruitment and retention are on the risk register and have been reviewed in light of the on-going staffing and performance challenges.		

Gaps in Control
Strategy in development

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

Mitigating actions planned / underway	Executive Lead	Due Date	Progress

Trust strategy under development – following the completion of this a delivery plan will be drawn up that will fully address this BAF risk going forward. This will include a clear purpose for the service, a target clinical delivery model to meet that purpose, and associated workforce and delivery plan (5yr horizon) to deliver that vision.	Exec. Dir. Strategy & Transformation	Q4	Initial scoping underway ahead of formal appointment of consultancy partner to assist in the development of the Trust strategy. Programme due to start by end of July and extensive pre-engagement completed.
In year actions related to the UEC Recovery Plan, focusing on the KPIs listed above.	Exec. Dir. of Operations	Q4	Call answer remains challenged due to significant ongoing staffing issues. Delivery against plan for the other metrics are on track.
As of 21/07/23, the Trust was successful in bidding for an additional £2.5m for use during Aug-Oct, focusing on call answering, EOC Clinical and Field Operations provision.	Exec. Dir. of Operations		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 considered by the Board in August.					
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 this is on the Board agenda in December.					
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 to the Board in October. 999 call handling was a specific Board agenda item in October and is again in December.					
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. Reviewed throughout 2023 and the Board reviewed progress with the MDC in October and it is an item on the agenda in December.				
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

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
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. **Board Oversight**: Quality & Patient Safety Committee. Reviewed throughout 2023 and the Board reviewed progress with the MDC in October and it is an item on the agenda in December.					
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. Reviewed throughout 2023 and the Board reviewed progress with the MDC in October and it is an item on the agenda in December.					
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**: FIC to review the business case which is in development.					

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.

The October 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 (October)	Forecasted by March 2024
RSP-S1	To have developed, through a rigorous system of engagement, a Board approved strategy that reaches beyond the next 5 years.	**Achieved:** - 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. - Aligned 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 - Selected a partner to help deliver the plan for 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		
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 - In addition, a substantive CFO, DoS, MD and DOO are in post **Plan to exit:** - An Executive structure review is scheduled to start in Q3 in support of implementing the strategy. - Exec and senior lead development programme to commence in September - A new Chair will be appointed in December 2023 and take up post in May 2024.		

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 pre-exit Well-Led Review were approved by the Strategic Advisory Meeting (SAM) in September. **Plan to exit:** - Pre-exit well led review completed in Q3. - Chair appointed in December 2023 - Clear plan in place for enacting any further findings post Well-Led review		
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. - Informal executive meetings have been taking place and encouraging proactive engagement without requiring CEO prompts. **Plan to exit:** - Trust index as measured by the development programme will show improvement - Development plan for the executive team will clearly show how it will support cohesion of the executive team structure resulting from the structure review.		
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 oversight. This new model became operational in Sept/Oct 24.		

		- 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 have improved transparency with our system partners by aligning our key focus areas for the next 9 months through a joint forward plan. - 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 System Assurance 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 have invested in our Freedom to Speak Up (FTSU) team – 1 WTE to 3. - Extensive internal training has taken place, including for the Board, and the consultation stage of our Speak Up Policy, aligning it with National FTSU guidance. - Ongoing discussions emphasise the importance of evidence of speaking up across various organisational levels. - CEO meets monthly with FTSU guardian - Leadership training for first line managers programme in place for 12 months. Over 30% managers completion with >80% booked. **Plan to exit:** - In support of the above, we need to make freedom to speak up everyone's business. We have planned significant leadership development for first-line and middle management this year to empower our workforce to address concerns locally.		

		- The Trust recognises this is not a short term fix, and will require continued focus from the Executive and CEO, with a view of positive evidence being available from the Staff Survey 24/25. - The Trust will include a focus on this area through the Pulse Survey.		
RSP-C3 (previously RSP-P3)	The Trust has a vision for clinical leadership that is supported by a Board approved clinical education strategy.	**Achieved:** - We've now approved investment for Phase 1 of our Clinical Education investment program is currently underway with phase 2 in planning - The Clinical Education Strategy has been presented and approved by Board, providing the necessary support for the investment in the Clinical Education team. **Plan to exit:** - 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.		
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:** - The Trust has taken its own assurances that progress has been made against the Warning Notices. - The WNs expired on the 18th of November 2022. **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" **Note: CQC have not been back to inspect the organisation yet**		

RSP-G1 (previously RSP-L2)	Clear lines of responsibility and accountability for individual executives.	**Achieved:** - An Executive structure review has started in Q3 and will be completed to align with the new strategy. **Plan to exit:** - In support of the above review 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. - The executive structure review completed and new structure in place from April 2024 to align with implementing the new strategy		
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:** - Updated BAF in place. 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. - 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. **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.		
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 at Board development sessions. Our leadership development plan will support our Executives based on this feedback. **Plan to exit:** - Continued focus on Board engagement with OUMs to ensure the embedding of meaningful autonomy		
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:** - **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. **Plan to exit:** - Continued implementation of the plan		
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:** - In developing our strategy, the Trust will agree a cost model in support of its proposed operating model with system leads		
RSP-G8 (previously RSP-F3)	Trust can evidence delivery of financial trajectories for at least two most recent quarters.	**Achieved:** - 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:** - Continued implementation of the in year plan		

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 retention challenges, which affect call handling times. **Plan to exit:** - A key deliverable of our strategy is a workforce plan aligned with the clinical model which is also consistent with the projected financial envelope. This will be delivered as a part of the 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. **Plan to exit:** - Bespoke plan for most challenged area of recruitment – call centres – currently in development.		
RSP-HR3 (previously RSP-P5)	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	**Achieved:** - HR reporting improved with clear understanding of ER caseload and challenges. - Re-structure underway to create dedicated ER case management team. **Plan to exit:** - Continue restructure and recruitment for ER team - Improvement in board oversight with consistent reporting and engagement - A follow-up external HR review will be conducted in Q3 to track progress against the original HR review in Q4.		

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:** - Enhanced communication channels and accessibility for our workforce through the development of a Communications and Engagement. - Additionally, we've successfully implemented leadership visits, quality and performance management, and quality assurance visits. - Investment in the Communications Team has been agreed to improve internal comms **Plan to exit:** - Recruit to additional comms posts - Align comms activity to key change programmes e.g. housekeeping		
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. F - 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 No or minimal impact of statutory guidance	Coroners verdict of misadventure Breech of statutory legislation	Police investigation Prosecution resulting in fine >£50K Issue of statutory notice	Coroners verdict of neglect/system neglect Prosecution resulting in a fine >£500K	Coroners verdict of unlawful killing Criminal prosecution or imprisonment of a Director/Executive (Inc. Corporate Manslaughter)
Business / Finance & Service Continuity	Minor loss of non-critical service Financial loss of <£10K	Service loss in a number of non-critical areas <6 hours Financial loss £10-50K	Service loss of any critical area Service loss of non- critical areas >6 hours Financial loss £50-500K	Extended loss of essential service in more than one critical area Financial loss of £500k to £1m	Loss of multiple essential services in critical areas Financial loss of >£1m
Potential for patient complaint or Litigation / Claim	Unlikely to cause complaint, litigation or claim	Complaint possible Litigation unlikely Claim(s) <£10k	Complaint expected Litigation possible but not certain Claim(s) £10-100k	Multiple complaints / Ombudsmen inquiry Litigation expected Claim(s) £100-£1m	High profile complaint(s) with national interest Multiple claims or high value single claim .£1m
Staffing and Competence	Short-term low staffing level that temporarily reduces patient care/service quality <1day Concerns about skill mix / competency	On-going low staffing level that reduces patient care/service quality Minor error(s) due to levels of competency (individual or team)	On-going problems with levels of staffing that result in late delivery of key objective/service Moderate error(s) due to levels of competency (individual or team)	Uncertain delivery of key objectives / service due to lack of staff Major error(s) due to levels of competency (individual or team)	Non-delivery of key objectives / service due to lack/loss of staff Critical error(s) due to levels of competency (individual or team)
Reputation or Adverse publicity	Rumours/loss of moral within the Trust Local media 1 day e.g. inside pages or limited report	Local media <7 days' coverage e.g. front page, headline Regulator concern	National Media <3 days' coverage Regulator action	National media >3 days' coverage Local MP concern Questions in the House	Full public enquiry Public investigation by regulator
Compliance Inspection / Audit	Non-significant / temporary lapses in compliance / targets	Minor non-compliance with standards / targets Minor recommendations from report	Significant non-compliance with standards/targets Challenging report	Low rating Enforcement action Critical report	Loss of accreditation / registration Prosecution Severely critical report

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

Probability	Less than 10%	11 – 30%	31 – 70 %	71 - 90%	> 90%

Appendix 2 - SPC Icon Description

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

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

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

BRAGG Rating definitions

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – December 2023

Reporting Period: September & October 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**

Icon Descriptions

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

Trust Priorities for 23/24

Quality Improvement

We listen, we learn and improve

Responsive Care

Delivering moderns healthcare

People & Culture

Everyone is listened to, respected and well supported

Sustainability & Partnerships

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

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

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	Oct-2023	1035		1228.9		
Harm Incidents per 1000 Incidents	Oct-2023	1.92		1.41		
Count of No Harm Incidents	Oct-2023	1255		1097.85		
Count of Low Harm Incidents	Oct-2023	210		172		
Count of Moderate Harm Incidents	Oct-2023	3		5.4		
Count of Severe & Death Harm Incidents	Oct-2023	0		1.9		

People & Culture

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Sickness Absence %	Oct-2023	6%	5%	8.32%		
Statutory & Mandatory Training Rolling Year %	Oct-2023	73.1%	85%	73.02%		
Appraisals Rolling Year %	Oct-2023	58.3%	85%	58.49%		
Freedom to Speak Up: Total Open Cases	Oct-2023	28		19.55		
Freedom to Speak up: Cases Opened in Month	Oct-2023	9	3	8.6		
Freedom to Speak up: Cases Closed in Month	Oct-2023	11		9.05		
Time to Hire - Volume (Days)	Oct-2023	132	60	126.6		
Time to Hire - Ad-Hoc (Days)	Oct-2023	159	60	79.72		

Responsive Care

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Hear & Treat %	Oct-2023	12.6%	14%	10.24%		
999 Frontline Late Finishes/Over-Runs %	Oct-2023	47.5%	45%	50.02%		
Average Late Finish/Over-Run Time	Oct-2023	00:37:00		00:39:33		
999 Call Answer Mean	Oct-2023	00:00:22	00:00:05	00:00:41		
Cat 2 Mean	Oct-2023	00:28:01	00:30:00	00:32:38		

Sustainability & Partnerships

Metric	Latest Date	Value	Target	Mean	Variation	Assurance

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

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Quality Improvement

QUALITY IMPROVEMENT

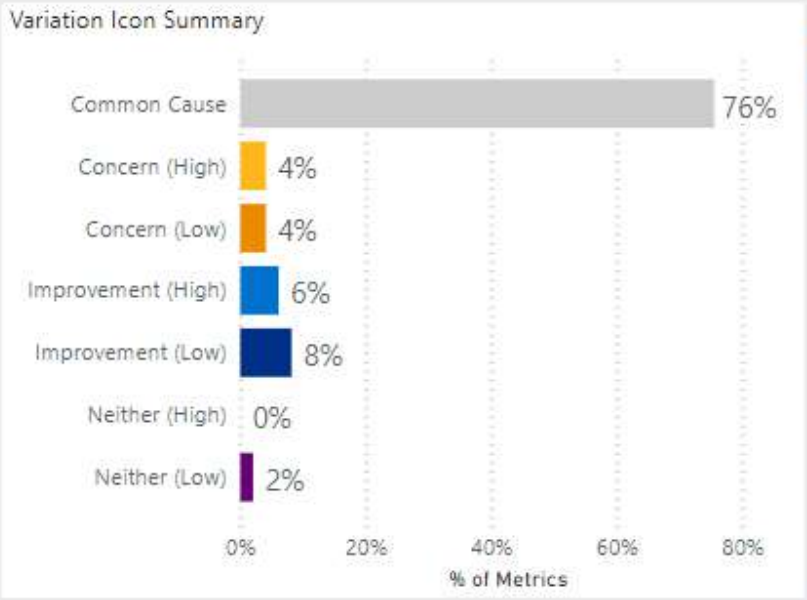
Summary

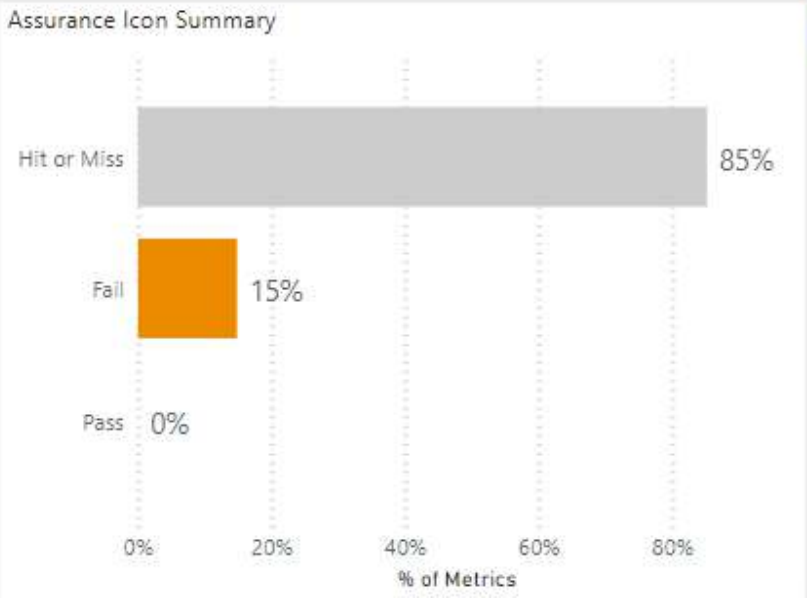
October 2023	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Medicines Management % of Audits Completed Duty of Candour Compliance % Complaints Reporting Timeliness %	Single Witness Signature Use CDs Non-Omnicell	Complaints per 1000 999 Calls Answered Complaints relating to privacy and respect % 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 % Safeguarding Training Completed (Children) Level 2 % Deep Clean 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 Count of No Harm Incidents Count of Low Harm Incidents Count of Moderate Harm Incidents Count of Severe & Death Harm Incidents
Special Cause Concern		**Cardiac Arrest - Post ROSC % **Cardiac Survival Utstein %		Harm Incidents per 1000 Incidents Number of Medicines Incidents

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

QUALITY IMPROVEMENT

Overview (1 of 3)





Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Oct-2023	180		105.34	166.1	226.86		
Number of CD Breakages	Quality Improvement	Oct-2023	26	0	4.89	21.55	38.21		
Number of Datix Incidents	Quality Improvement	Oct-2023	1539		971.22	1398.5	1825.78		
Number of Incidents Reported as SIs	Quality Improvement	Oct-2023	2		-5.68	4.4	14.48		
Duty of Candour Compliance %	Quality Improvement	Oct-2023	100%	100%	66.15%	88.32%	110.48%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Oct-2023	127		66.05	112.25	158.45		
Number of RIDDOR Reports	Quality Improvement	Oct-2023	13		-0.2	11	22.2		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Oct-2023	5		4.99	29.35	53.71		
Health & Safety Incidents	Quality Improvement	Oct-2023	29		11.9	28	44.1		

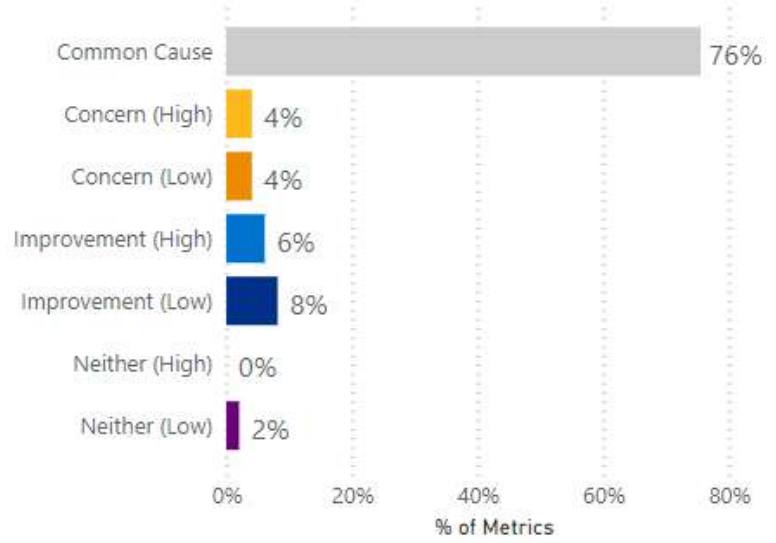
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Oct-2023	0%		-0.07%	0.02%	0.1%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Oct-2023	66%		48.62%	65%	81.38%		
Complaints Reporting Timeliness %	Quality Improvement	Oct-2023	93%	95%	35.23%	74.15%	113.07%		
Number of Complaints	Quality Improvement	Oct-2023	76		28.67	71.65	114.63		
Complaints per 1000 999 Calls Answered	Quality Improvement	Oct-2023	0.87		-189.22	104.41	398.03		
Number of Compliments	Quality Improvement	Oct-2023	235		47.5	164.22	280.95		

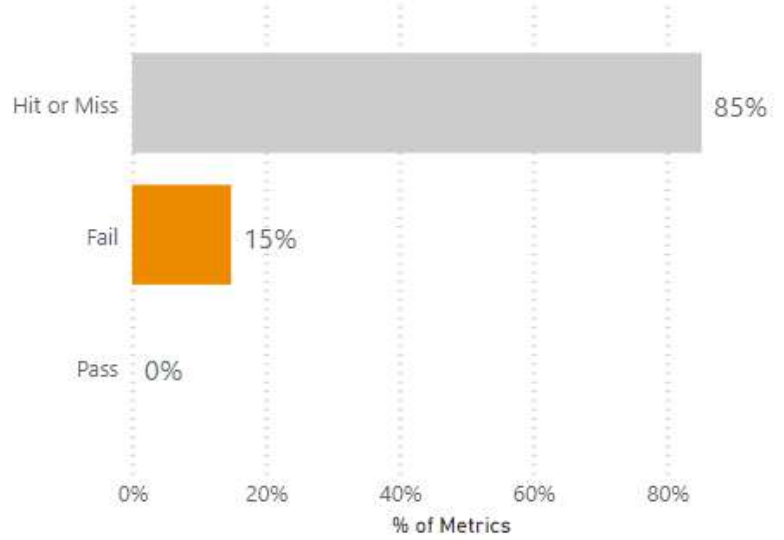
QUALITY IMPROVEMENT

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

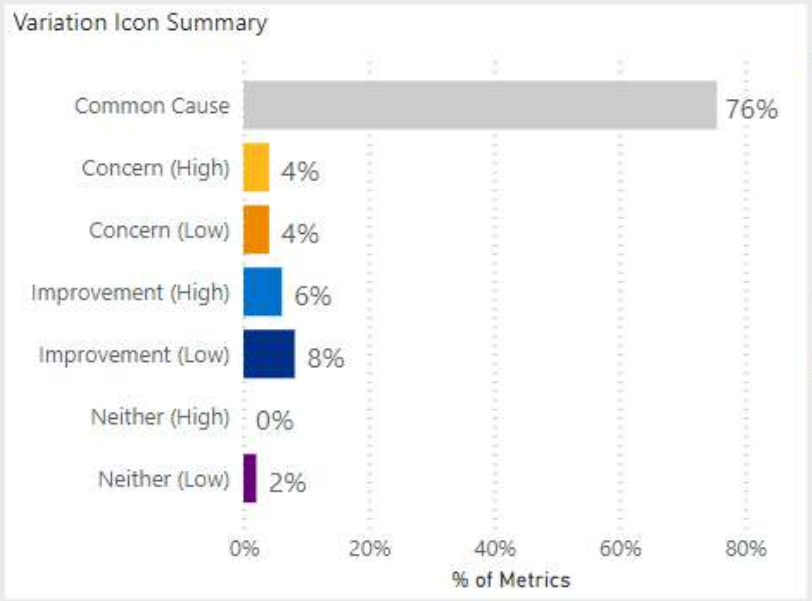
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Sep-2023	38.9%	45.1%	28.64%	47.72%	66.79%		
**Cardiac ROSC ALL %	Quality Improvement	Sep-2023	26%	23.8%	17.53%	26.72%	35.91%		
**Sepsis Care Bundle %	Quality Improvement	Sep-2023	87.5%	85%	82.27%	86.63%	90.99%		
**Cardiac Survival Utstein %	Quality Improvement	Jul-2023	11.3%	25.6%	4.84%	19.3%	33.76%		
**Cardiac Survival ALL %	Quality Improvement	Jul-2023	22.6%	9.6%	-0.18%	18.45%	37.09%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Sep-2023	67.9%	76.8%	60.59%	71.5%	82.41%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Sep-2023	63.1%	64.7%	60.37%	71.65%	82.93%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Jun-2023	02:29:00	02:22:00	02:12:22	02:35:04	02:57:46		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Jun-2023	03:26:00	03:14:00	02:53:36	03:39:00	04:24:24		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Jun-2023	01:36:00	01:29:00	01:19:50	01:37:45	01:55:40		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Jun-2023	02:31:00	02:20:00	01:42:45	02:30:38	03:18:30		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Sep-2023	98.3%	96.3%	95.47%	97.54%	99.61%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Sep-2023	90.8%	93.8%	86.36%	92.97%	99.57%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Sep-2023	81%	77.9%	68.01%	78.78%	89.56%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Oct-2023	103.2%		84.81%	103.38%	121.94%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Oct-2023	85.3%	100%	78.39%	85.38%	92.37%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Oct-2023	77%	100%	70.68%	88.74%	106.8%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Oct-2023	102.4%	100%	92.15%	99.85%	107.55%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Oct-2023	55.4%		14.77%	60.57%	106.36%		

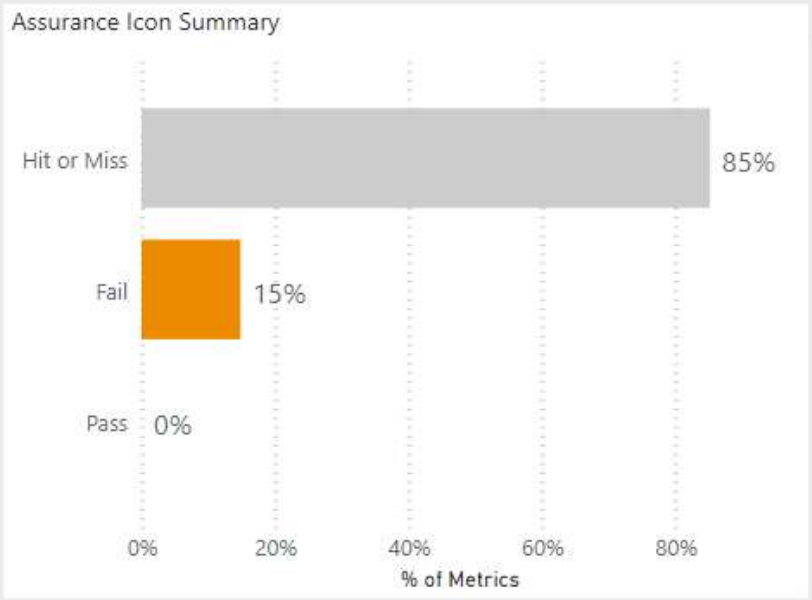
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Oct-2023	86.2%	90%	76.07%	87.47%	98.86%		
Deep Clean Compliance %	Quality Improvement	Oct-2023	86%	95%	65.31%	87.12%	108.93%		

QUALITY IMPROVEMENT

Overview (3 of 3)





Health & Safety

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Manual Handling Incidents	Quality Improvement	Oct-2023	30		9.35	27.55	45.75		
Organisational Risks Outstanding Review %	Quality Improvement	Oct-2023	31%	30%	-4.79%	39.36%	83.52%		

Medicine Management

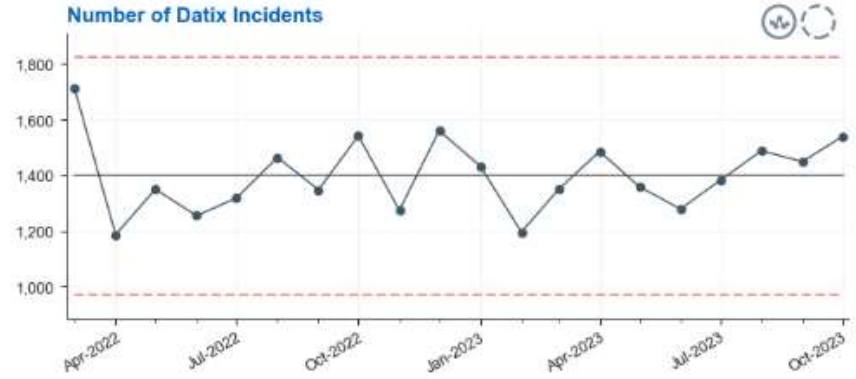
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Aug-2023	23	0	12.33	42.13	71.92		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Aug-2023	49	0	6.52	63.63	120.73		
Medicines Management % of Audits Completed	Quality Improvement	Oct-2023	91.5%	100%	76.95%	88.49%	100.02%		
PGD Compliance %	Quality Improvement	Oct-2023	71%	100%		73.69%			
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Oct-2023	102%	100%		53.71%			

QUALITY IMPROVEMENT

SIs, Incidents, & Duty of Candour

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

Common cause variation, no significant change.



QS-1
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1539

Common cause variation, no significant change.

QS-17
Dept: Quality & Safety
IP: Quality Improvement
Latest: 5

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, are completed in a timely manner. They are also a standing agenda item on SMG now for escalation.
(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 8 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 due to launch January 2024 in line with PSIRF.

QUALITY IMPROVEMENT

Harm

QS-28

Dept: Quality & Safety

IP: Quality Improvement

Latest: 10.61

Common cause variation, no significant change.

QS-29

Dept: Quality & Safety

IP: Quality Improvement

Latest: 1.92

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

Summary

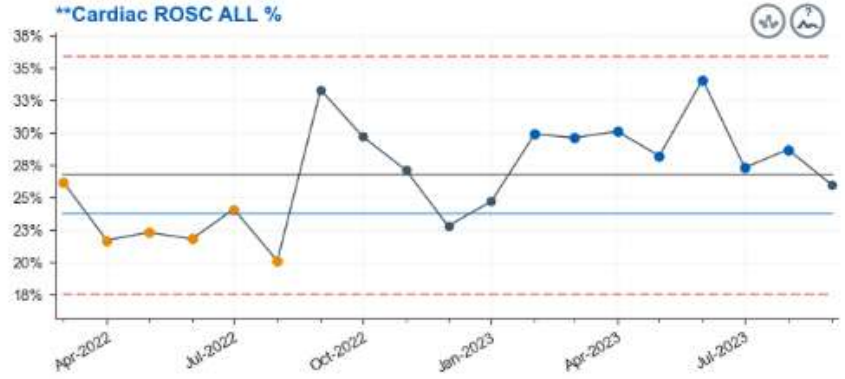
- The number of No Harm per 1000 incidents reported has remained at relatively same level for past 4 months.
- The significant increase in the number of no harm incidents seen in March 2023 was due to a process change whereby NHS 111 incidents were included into the data having not been included previously. 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 September/October 2023, the main theme/trend of incidents reporting No Harm was "Issues with Other Emergency/Health Services" (mostly Pharmacy pathways)
- The number of Harm Incidents per 1000 incidents indicate a two month point increase moving it to statistical significance with this month showing a downward trend again.

What actions are we taking?

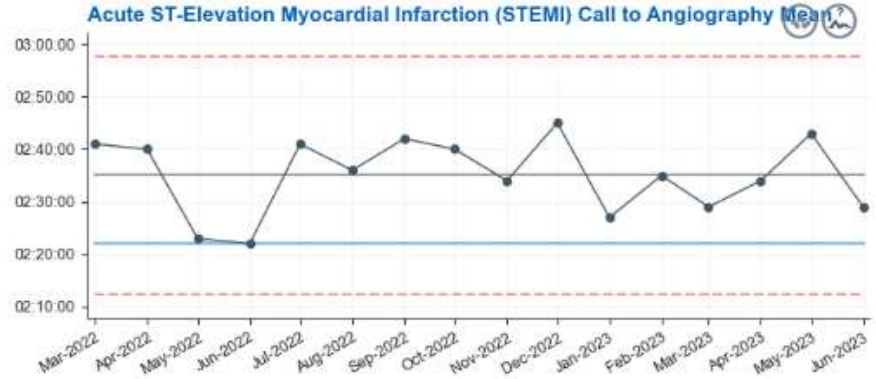
- Developing a robust mechanism of meaningful feedback to individuals / team and organisational wide learning.
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support continuous improvement.
- Continue to monitor 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
- Linking with BI to further validate the data and preparing for a deep dive if the pattern continues

QUALITY IMPROVEMENT

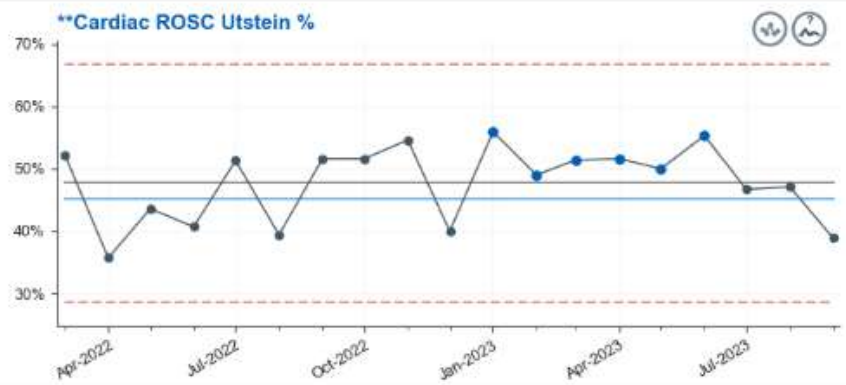
Impact on Patient Care - Cardiac



M-2
Dept: Medical
IP: Quality Improvement
Latest: 26%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:29:00
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: 38.9%
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: 63.1%
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: 180

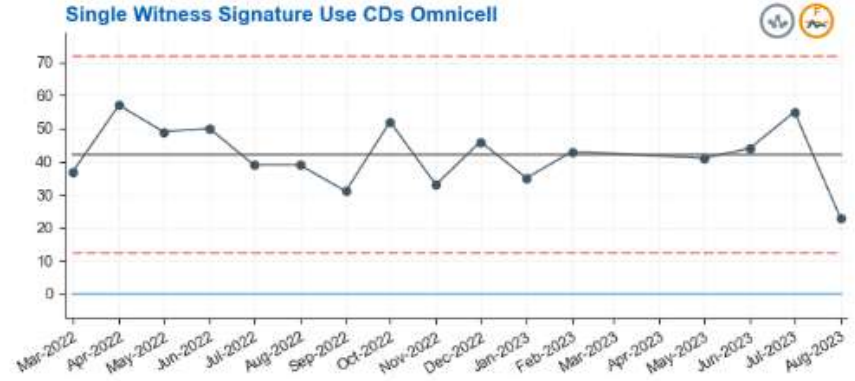
Special cause of a concerning nature where the measure is significantly HIGHER.

MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 91.5%
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: 26
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: 23
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

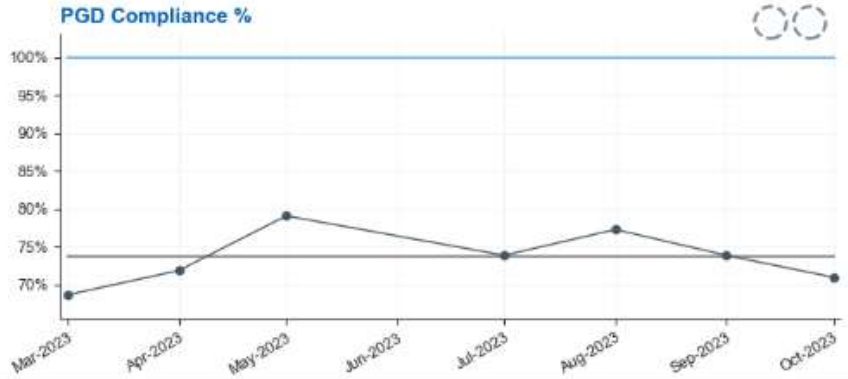
Note: Work is ongoing around reporting medicines incidents. Key skills 2023/24 has medicines in its lesson plan and operational team leaders (OTL) Op Carp Reconciliation training has medicines has been completed by medicines team November 2023. No single area of reporting is responsible for the consistent rise. Good reporting seen around medicines incidents. Non-compliance to medicines audits has improved over time. Whilst completing the OTL OpCarp Reconciliation training, the team are emphasising the importance of completing these and investigating the areas of non-compliance. The new system is nearly ready for go live which will hopefully be in the next month.

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 OTL checks. Training has now been completed (November 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 February 2024, this will support single signature witness checks at Omnicell

What actions are we taking?

The new compliance audit system is nearly ready to go live (awaiting final approval and roll out plan).
Work is ongoing to get MedX rolled out as soon as possible at Omnicell sites and a Task & Finish group set up.
Medicines Safety Officer (MSO) role has been recruited and will start February 2024. This post holder will focus on patient safety and medicines incidents and learning.
Third Pharmacy Technician role has been recruited and has started. This will help with the day to day running of the Medicines Distribution Centre.
MedX training has been completed in all OUs with over 76% of OTLs being trained. Discussion are taking place regarding an ongoing training plan to train all OTLs that have missed the sessions or any new starters to the role.

QUALITY IMPROVEMENT Medicines Management (2 of 2)



MM-8

Dept: Medicines Management
IP: Quality Improvement
Latest: 71%
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: 102%
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 sharp increase over the last month. This is due to an increase in recruitment into the unit alongside the help of alternative duties staff. 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 one month resilience across the Trust. Currently storing two weeks supply
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. Several 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 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

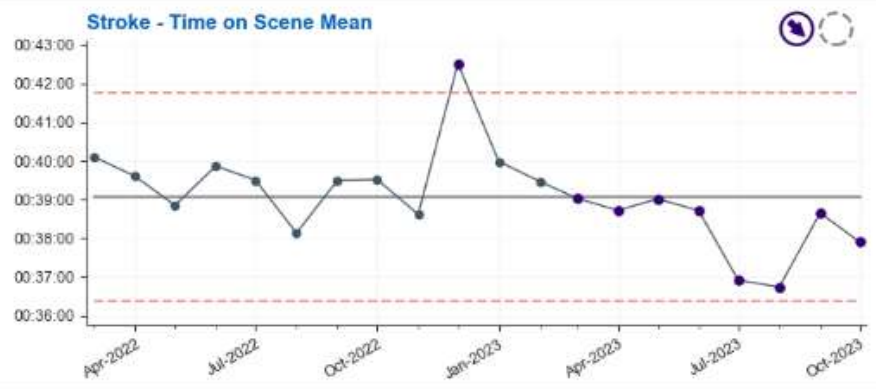
Dept: Medical
IP: Quality Improvement
Latest: 01:36:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:31:00
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: 98.3%
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: 00:37:54

Special cause variation where DOWN is neither improvement or concern

Summary

Stroke – Call to hospital Arrival mean. This standard should be 120 minutes (as **overall** call to needle time is 180 minutes allowing 60 minutes for 'door to needle'). Time on scene is 39 minutes mean, so 71 minutes should account for response and **travel** time. Most stroke units are within about minutes of call location, so we are not meeting the national targets for Stroke patients due to overall delays in arrival at scene.

Stroke: diagnostic bundle: Compliance against the Diagnostic Bundle has largely been above target since August 2021.

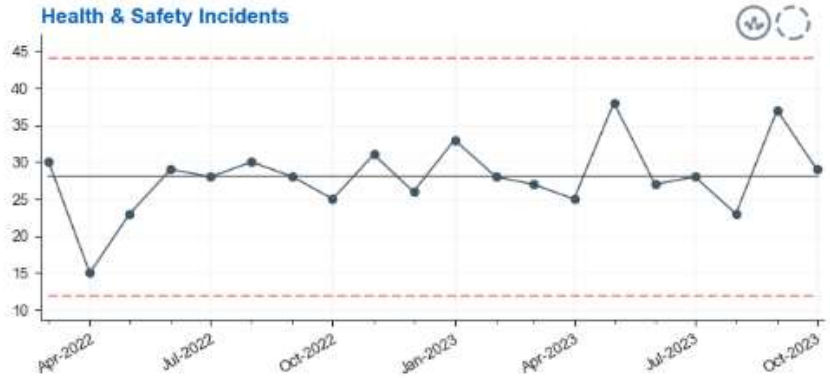
Stroke Time on scene mean. Special Cause variation.

What actions are we taking?

Ongoing two year UCL study of stroke telemedicine partly 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 39. 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. The downward trend in time on scene will be watched to see if it sustains, and explore reasons for this for learning.

QUALITY IMPROVEMENT

Safety in the Workplace (1 of 3)



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 29

Common cause variation, no significant change.

QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 30

Common cause variation, no significant change.

Health & Safety Incidents

No significant variation, with themes and trends remaining static

What are we doing

- The regional and Trust-wide Health & Safety groups will continue monitoring incident trends.
- The H&S team are planning to meet with all Team Cs across the organisation and Union colleagues to improve relationships and support a culture of H&S being everyone's business.
- The H&S team are working with the QI team to review and improve the RIDDOR reporting process.
- See MH and Conflict resolution narrative

Manual Handling Incidents

No significant variation

- Manual handling incidents reported in September 2023 were 25.
- Manual handling incidents reported in October 2023 were 30.

What are we doing

- A task & finish group has been initiated to lead on actions from the recent HSE visit which includes a review of manual handling training, specifically in relation to the manual handling and use of specialist equipment for Bariatric patients.
- The Local 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 that assurance is provided on all regulatory aspects and action plans agreed and acted on.

QUALITY IMPROVEMENT

Patient Experience

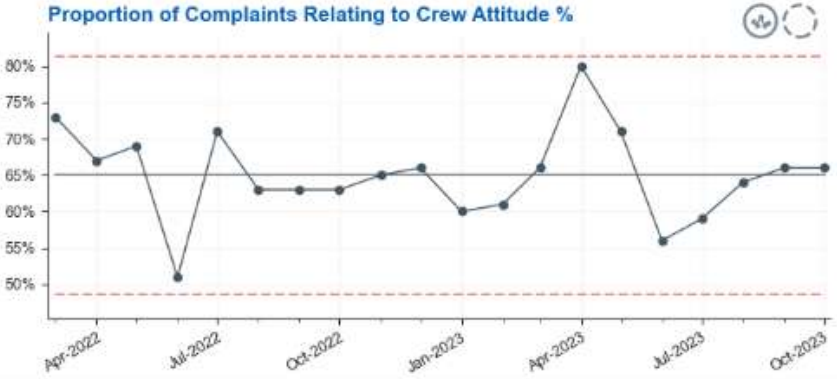
QS-5

Dept: Quality & Safety
IP: Quality Improvement
Latest: 76

Common cause variation, no significant change.

QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 93%
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: 66%

Common cause variation, no significant change.

Summary

- Timeliness for complaint responses fell below the 95% target last month for the first time since June 2023 at 93%. We are currently on course to have this back above target of 95% for November.
- 66% of our complaints relate to crew attitude and this continues to be the highest identified theme of complaints received. Data for the period 01/11/22-31/10/23 identifies that in total, 256 complaints were received regarding crew attitude out of 645,302 incidents.

What actions are we taking?

- There were two areas that were slow in responding to complaints causing a slight dip in timeliness, these have been escalated to Executive level to ensure this does not occur in the future.
- The PALS Manager has now completed complaints training with all operating units other than one which will be completed in early December.
- Operating units have been asked to confirm when new OTL's are in post so that they can receive complaints training. A plan is also currently being developed for refresher training during 2024.
- In relation to staff attitude, following discussion at the Patient Experience Group (PEG), it has been agreed that the following actions will be taken:
    - A deep dive will be undertaken into complaints relating to crew attitude to identify specific areas of concern, this will be completed by the end of January 2024.
    - Data and information regarding crew attitude complaints will be shared in a one page newsletter/briefing with all Teams C to highlight this issue and promote discussion at operational level.
    - Communications will be planned with the Communications team in relation to crew attitude aligned with our cultural transformation work and Building a Kinder SECAmb.
    - Plans are in place to utilise the new reward & recognition platform to highlight compliments received and highlight these across the organisation.

QUALITY IMPROVEMENT

Safety in the Workplace (2 of 3)

QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 86%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 86.2%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Deep Clean Compliance %

September 2023 – 100 % vs 100% target
October 2023 – 98% vs 100% 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 example the VPP sites (non full MRCs) along with sites where the contractors have higher staff vacancies. This is driven by the infrastructure of the VPP sites (need to move vehicles to delivery Make Ready), and workforce challenges, due to a 21% vacancy rate against Churchill establishment(updated November 2023)

What actions are we taking?

The Deep Clean reporting should now become more consistent due to the updated vehicle numbers and more aligned methods of reporting.
Churchill wages were increased in April above the contract to meet the national living wage uplift – this has seen a slight improvement from a vacancy rate of 25% to a current vacancy rate of 21%.
A harm review is being commissioned and close to completion, to identify the level of risk associated and driven by contractor vacancies. This is nearly upon completion, but the initial feedback is the incidents are very little harm / low harm coming through.
The Joint vehicle audit regime has been reviewed and improved upon significantly. We are now seeing high returns of joint audits between MRCMs and Churchill. Churchill are reporting a 78% compliance score 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.
Datix data for October shows a total of 99 Incident reports with 71 no harm ,13 being low harm and 15 near miss events.(some of October incidents are currently being reviewed. September shows a total of 74 Incident reports with 47 no harm 7 being low harm and 20 near miss events. The quality of the Datix reporting process has been reviewed and improvements are in progress – the MRC Lead is escalating any that are determined to require escalation , the MRCMs are discussing shared learning of any incidents with the Churchill account managers and the joint vehicle audits should start to highlight any discrepancies.
Churchill are currently 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 but is suggestive of improvement over the last two months. However, this is still below the target of 90%. The work carried out to date by the IPC Team has supported improvement and further actions being undertaken as part of the IPC improvement plan are detailed below.

What Actions are we taking?

- The team has attended the recent Quality Assurance Visits (QAV) to support the work around CQC compliance and have used the opportunity to focus on IPC compliance at the same time. They will continue to support these as an opportunity to engage and focus on IPC.
- The main themes from QAVs have been hand hygiene and Bare Below the Elbows compliance which has now been the focus of the last two months work, and this will continue.
- The IPC team are 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.
- The 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.
- The IPC Lead attended Ashford OU in support of the Perfect Month early in November and spoke to the team about thoughts on revised IPC audits and the feedback was very positive. The plan is for each month just to look at a couple of key items such as 'decontaminating their hands pre and post procedure'. The team will look to break down the audits to make them quicker and easier to complete whilst still focusing on the key requirements. The issue will be that the team need to liaise with BI regarding this to amend the reporting. The IPC team then plan to trial this with one or two OUs.

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 120 violence and aggression related incidents in September 2023.
The sub-categories of these incidents are shown below:

- 41 verbal abuse
- 34 Anti-Social Behaviour
- 22 assaults

Staff reported 127 violence and aggression related incidents in October 2023.
The sub-categories of these incidents are shown below:

- 41 verbal abuse
- 44 Anti-Social Behaviour
- 22 assaults

What actions are we taking?

- A task & finish group has been initiated to lead on actions from the recent HSE visit which includes implemetation of conflict resolution training as proposed by Security Officer and submitted to ETDG.
- 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.

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.
- The Trust is reviewing Conflict Resolution Training with external providers.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

October 2023

Pass | Hit and Miss | Fail | No Target

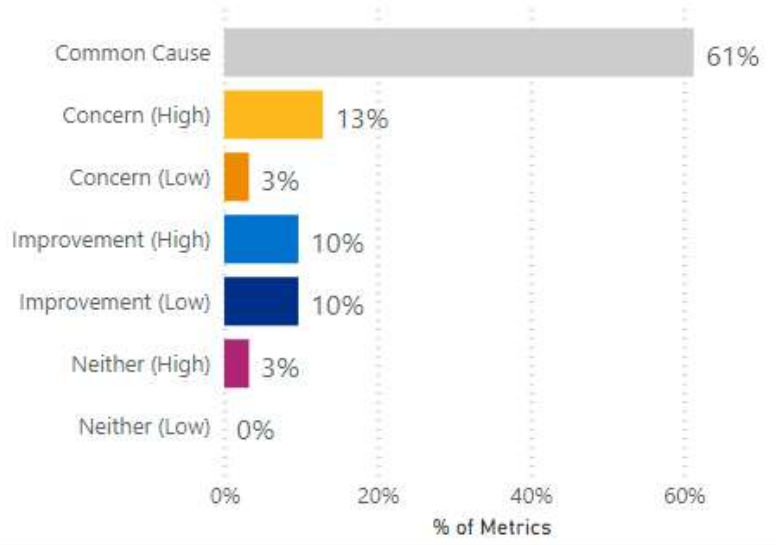
Special Cause Improvement		999 Frontline Late Finishes/Over-Runs %	Number of Staff WTE (Excl bank and agency) Sickness Absence % Statutory & Mandatory Training Rolling Year % Current licence details held for Operational Staff %	Average Late Finish/Over-Run Time
Common Cause		Vacancy Rate % Turnover Rate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

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.

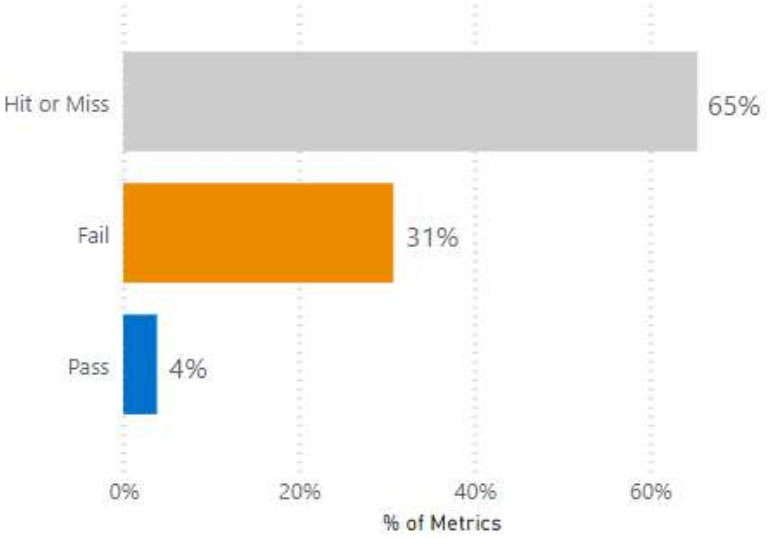
PEOPLE & CULTURE

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	Oct-2023	4282.46	4536.69	3944.74	4039.26	4133.78		
Vacancy Rate %	People & Culture	Oct-2023	5.6%	5%	0.53%	6.11%	11.68%		
Turnover Rate %	People & Culture	Oct-2023	1.1%	0.8%	0.63%	1.48%	2.32%		
Annual Rolling Turnover Rate	People & Culture	Oct-2023	18.3%	10%	17.33%	18.13%	18.93%		
Sickness Absence %	People & Culture	Oct-2023	6%	5%	6.42%	8.32%	10.22%		
DBS Compliance %	People & Culture	Oct-2023	99.4%	90%	99.84%	99.93%	100.03%		
Current licence details held for Operational Staff %	People & Culture	Oct-2023	98.8%	100%	93.12%	95.69%	98.26%		
Time to Hire - Volume (Days)	People & Culture	Oct-2023	132	60	83.9	126.6	169.3		
Time to Hire - Ad-Hoc (Days)	People & Culture	Oct-2023	159	60	48.01	79.72	111.43		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Oct-2023	73.1%	85%	64.16%	73.02%	81.88%		
Appraisals Rolling Year %	People & Culture	Oct-2023	58.3%	85%	50.86%	58.49%	66.11%		

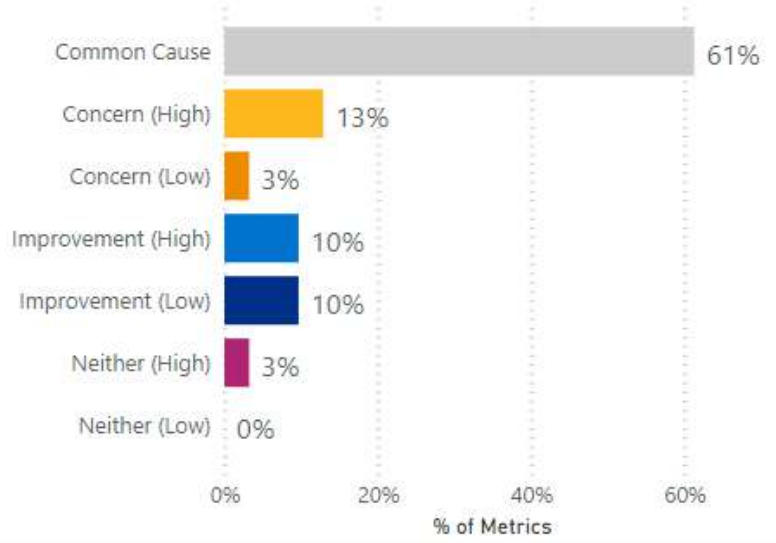
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Oct-2023	47.5%	45%	44.68%	50.02%	55.35%		
Average Late Finish/Over-Run Time	People & Culture	Oct-2023	00:37:00		00:35:55	00:39:33	00:43:11		
% of Meal Breaks Taken	People & Culture	Oct-2023	98.9%	98%	96.72%	98.17%	99.61%		
% of Meal Breaks Outside of Window	People & Culture	Oct-2023	56.3%		28.48%	55.07%	81.66%		

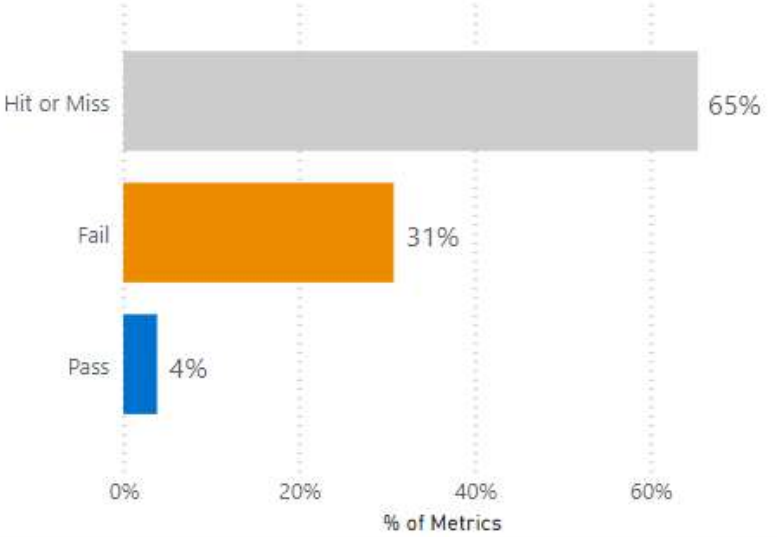
PEOPLE & CULTURE

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	Oct-2023	8	5	-0.33	12.55	25.43		
Collective Grievances Open	People & Culture	Oct-2023	1	1	-1.62	1.6	4.82		
Count of Grievances Closed	People & Culture	Oct-2023	12	3	-0.82	12.2	25.22		
Grievances Mean Case Length (Days)	People & Culture	Oct-2023	188.41	93	64.62	113.59	162.56		
Bullying & Harrassment Internal	People & Culture	Oct-2023	0	2	-3.79	1.95	7.69		
Disciplinary Cases	People & Culture	Oct-2023	14	3	-1.86	5	11.86		
Freedom to Speak Up: Total Open Cases	People & Culture	Oct-2023	28		7.09	19.55	32.01		
Freedom to Speak up: Cases Opened in Month	People & Culture	Oct-2023	9	3	-1.06	8.6	18.26		
Freedom to Speak up: Cases Closed in Month	People & Culture	Oct-2023	11		-4.81	9.05	22.91		
Policies & Procedures Outstanding Review %	People & Culture	Oct-2023	11%	0%		51.97%			
Count of Until it Stops Cases	People & Culture	Oct-2023	3	3	-4.95	3.45	11.85		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Oct-2023	142	86	59.13	104.67	150.2		

PEOPLE & CULTURE

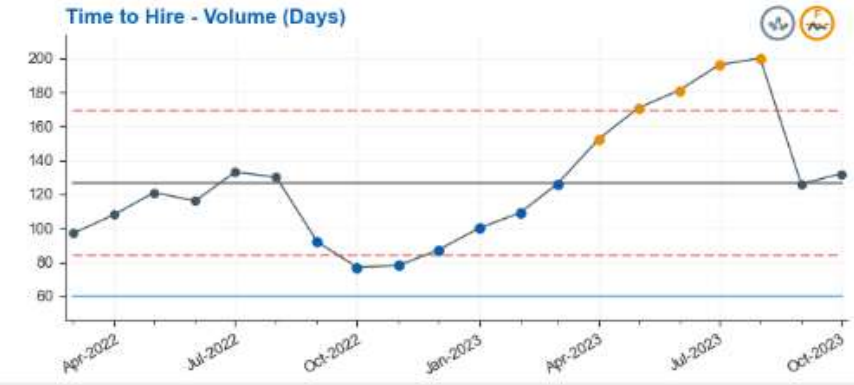
Workforce (1 of 3)

WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 4282.46
Target: 4536.69
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.

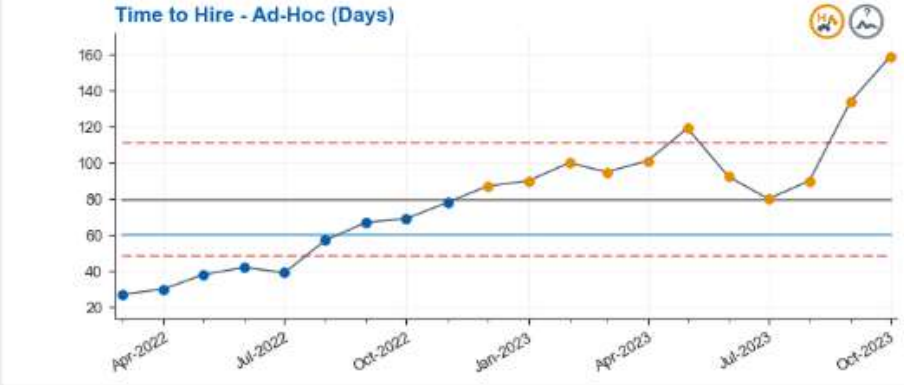
WF-4

Dept: Workforce HR
IP: People & Culture
Latest: 5.6%
Target: 5%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-43

Dept: Workforce HR
IP: People & Culture
Latest: 132
Target: 60
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-51

Dept: Workforce HR
IP: People & Culture
Latest: 159
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 not been consistent as shown in the charts. The data has been incomplete in parts or held incorrect information which has then reflected as an increased TTH. An example of this is a blank date will calculate as of todays date, however it may be because the data hasn't been added, not that the candidate hasn't started, which will increase the TTH. Work continues to ensure the data feeds are accurate and sourcing the correct information. This will likely be reflected in the next IQR report with an expected drop in days. Part of this work is to separate cohorts out so that campaigns such as NQP recruitment* do not warp overall figures. TTH will also be available in both calendar and working days to allow for the relevant benchmarking against other Trusts when needed.

The vacancy rate has reduced slightly, following a small decrease in turnover, and continuing efforts to recruit and fill every course for Operations to capacity.

What actions are we taking?

The Quality Improvement recruitment and onboarding project continues with processes being reviewed and changes implemented at each stage. The improvements made are intended to not only reduce TTH when possible *, but also increase candidate engagement, improve the overall experience and reduce attrition longer term.

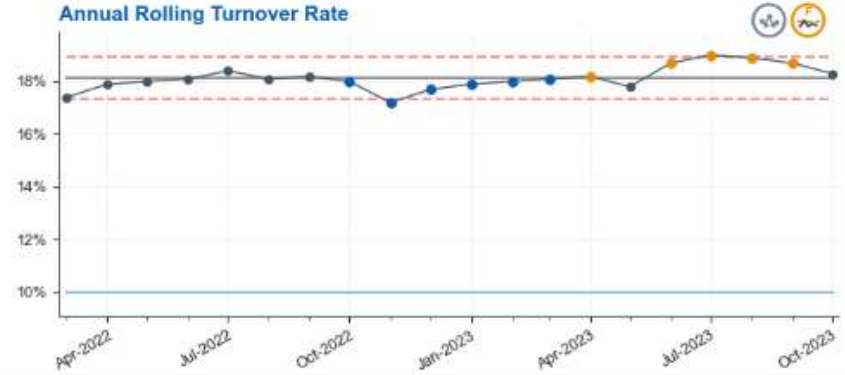
New ways of showcasing the Trust vacancies and career pathways are being trialled, such as open days at our Crawley and new Medway sites. The most recent event held at Crawley attracted 82 people, 24 of which have now submitted an application. Work will continue to encourage other applications from the attendees.

*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: 1.1%
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: 18.3%
Target: 10%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet 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. These concerns are reflected in two risk register entries, Risk 84 (Medway) current grading 12, and Risk 365 (Trust wide) current grading 16. Risk 84 will soon dissipate as the move has been completed and trial periods are coming to an end.

Even factoring in the Medway move, we are still showing a decline in turnover for the fourth consecutive month. The Medway move accounts for approximately 2% of our Trust turnover.

We are seeing some positive improvements (declines) in turnover. Most notable is Ashford OU (10.47% in June to 9.20% in October), Brighton OU (9.71% in July and 7.87% in October), Medway OU 12.1% in July and 8.33% in October). 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 10.39% in October, Strategy & Planning 10.04% in July to 8.49% in October.

What actions are we taking?

We are in the final stages of the development of the new Trust Retention Plan.
Our engagement with EMB, SMG, PC, Unions, Networks, Operations (OTL's) and Human Resources helped develop and refine the 22 initiatives (from 56) that form the finalised plan.

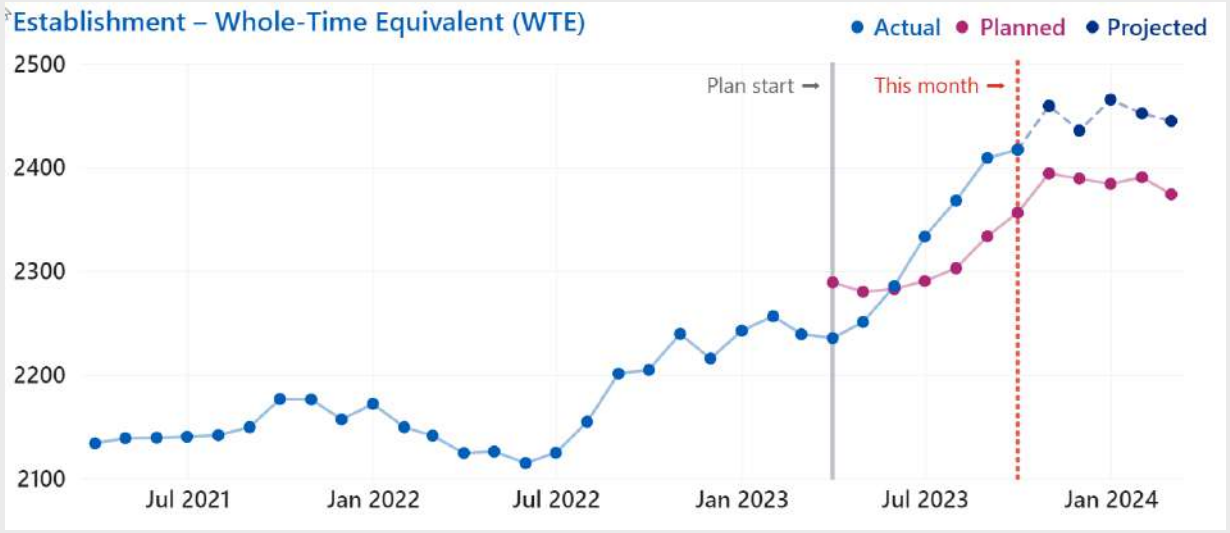
Aligned to our 5 top reasons for leaving, we have a way forward for the next 18 months that will deliver a targeted c.5% improvement. We have aligned the retention plan to the People and Culture Delivery Plan and anticipate the need for flexibility as the Trust Strategy is developed.

The plan will be presented to EMB towards the end of November 23 and then to Board for assurance in early December 2023.

PEOPLE & CULTURE

Workforce (3 of 3)

(999 Frontline)

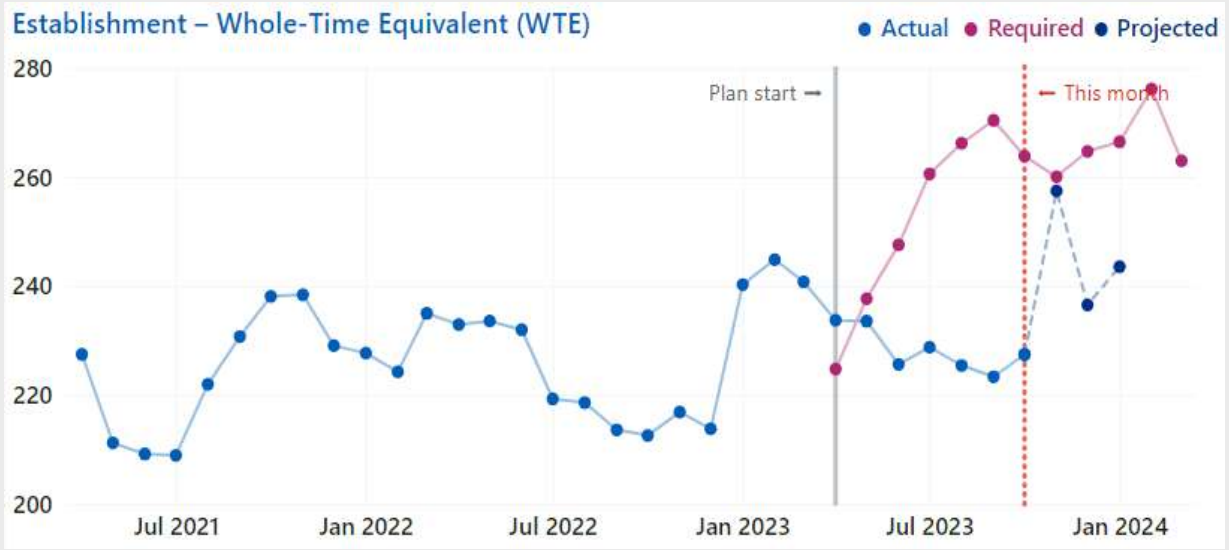


Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
October's data shows an increase in WTE ahead of the workforce plan (60.70FTE) Attrition again was lower than planned which has contributed to the difference.
NQP recruitment continues and this month's actual recruitment mirrors the planned more closely with only 0.39 FTE difference.

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 in-line with this year's turnover rate, along with an overall recruitment target of 371 WTE. October showed a gap between actual and planned for ECSW with a difference of 13.69WTE, however attrition has been lower than planned and will help the overall projected figures. Attrition for October was planned at 9.77WTE and actual was 4.11WTE.

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 October showed a reduction of WTEs with a difference of -36.4% to plan. New starters were higher than planned with a difference of 4.0 WTE more.
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 at Crawley was also hosted in October and had 82 people attend. 24 applications have now been received because of this event. Follow up contact is to be made with the other attendees to help increase this number of applications. The next open day is planned for Jan 24 at Gillingham.

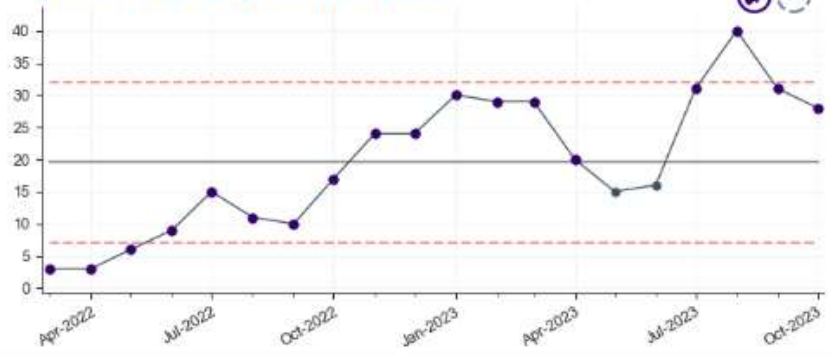
Additional Information
The workforce projection is currently based on confirmed recruits who currently have an offer of employment. As EMA recruitment typically only has a lead time of 2 months, no additional recruitment is factored into the projection beyond this point, which results in the chart only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

PEOPLE & CULTURE

Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

Freedom to Speak Up: Total Open Cases



QS-27

Dept: Quality & Safety
IP: People & Culture
Latest: 28

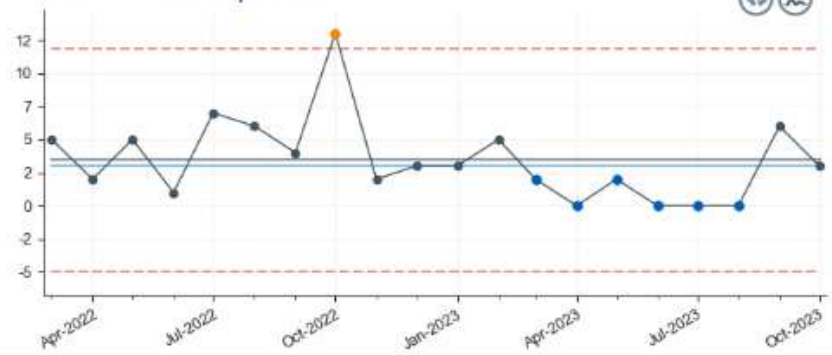
Special cause variation where UP is neither improvement or concern

Individual Grievances Open

WF-10

Dept: Workforce HR
IP: People & Culture
Latest: 8
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.

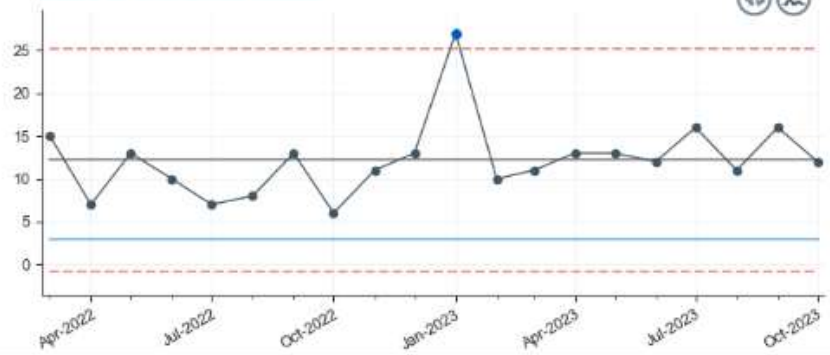
Count of Until it Stops Cases



WF-41

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

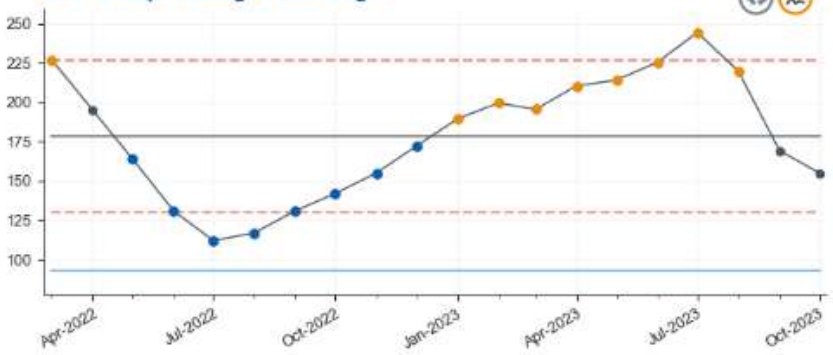
Count of Grievances Closed



WF-42

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

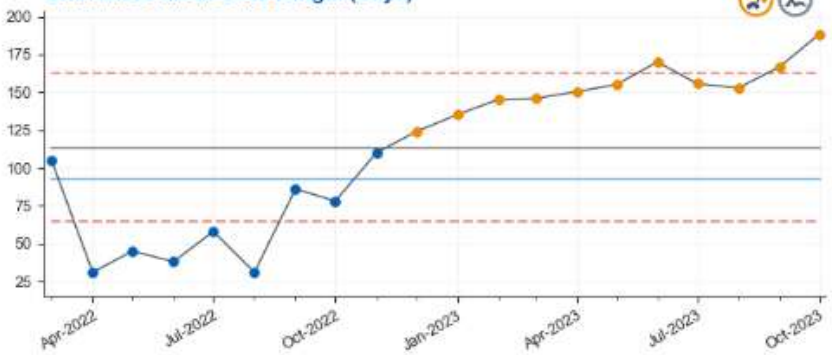
Until it Stops Average Case Length



WF-50

Dept: Workforce HR
IP: People & Culture
Latest: 155.03
Target: 93
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Grievances Mean Case Length (Days)



WF-44

Dept: Workforce HR
IP: People & Culture
Latest: 188.41
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
The downward trend since July has continued which indicates that early interventions, seeking informal resolution, has been successful. TU colleagues continue to engage with the process which also contributes to this trend.

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.

There are several cases which have been live for a long period of time.

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?

Grievances
Nadeem Issa (NI), the new Head of Employee Relations has been in post since the beginning of October and has already started to establish his reputation as the subject matter expert which has supported the downward trend. It is recognised that there is some way to go to bring the caseload to a reasonable and manageable level. Two new employee relations managers are expected to be in post by mid-January. At that point, the ER team will be created and this resource will enable us to reduce the formal activity. The projected timeline to see a significant improvement will be by the end of March.

The pilot training for hearing managers is underway and a structured plan to train other managers will be rolled out over the next two months. There is also a pilot in-house training course aimed at HR colleagues focusing on investigations. This will also be rolled out across the trust. These interventions will support our strategy to upskill HR colleagues and managers.

The long-standing cases have been given high priority to be dealt with by NI. It is anticipated that most, if not all, will be closed by the end of January.

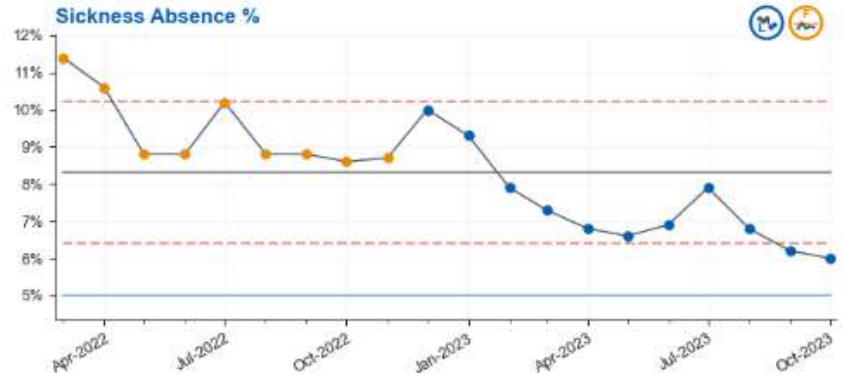
FTSU team have strong plans underway with Director of Ops and Director of Q&N, for an Ops-focused SLT Speaking Up workshops to be undertaken in the new year. This will explore the principles behind Speaking Up, the role and process of FTSU and why it is nationally structured as it is, and the barriers 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.

Until it Stops: In response to the release of the NHS Sexual Safety Charter, a cross-functional steering group has been formed. Margaret Dalziel, Executive Director of Quality & Nursing is leading the Group to collaboratively determine and implement actions to achieve compliance with the Charter by July 2024.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 6%
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: 142
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 continue to see a positive improving trend in sickness absence – moving us closer towards our Trust target.

All Operational Units are showing an improving trend, including Polegate which has often been an outlier. There is still much to do at Polegate to address the 10.11% absence and we will have some further actions to improve after the November Quality Assurance Visit. It is still however good news, as at its peak absence was 14.26%.

Wellbeing service demand is increasing, however, this is key to supporting a reduction in absence overall.

What actions are we taking?

The Health and Wellbeing actions in the new retention plan are developing well and we expect to have a final iteration in early December 23 for delivery by April 25.

HR and OD are supporting Quality Assurance Visits and using the opportunity to review Wellbeing in each OU, as well as sickness absence management.

We undertook a re-assessment of our wellbeing provision against the NHS Health and Wellbeing Framework. We improved in all metrics and we have a plan to address opportunities identified. We reported on this to the People Committee in early November.

HR Business Partners, supported by HR Advisors, continue to drive attendance management, providing Managers with accurate data and support interventions.

A paper was presented to Senior Management Group following the Attendance Management Deep Dive review that HR undertook using the NHS diagnostic tool.

PEOPLE & CULTURE

Employee Experience

999-15

Dept: Operations 999
IP: People & Culture
Latest: 47.5%
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: 55.4%

Common cause variation, no significant change.

999-27

Dept: Operations 999
IP: People & Culture
Latest: 98.9%
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

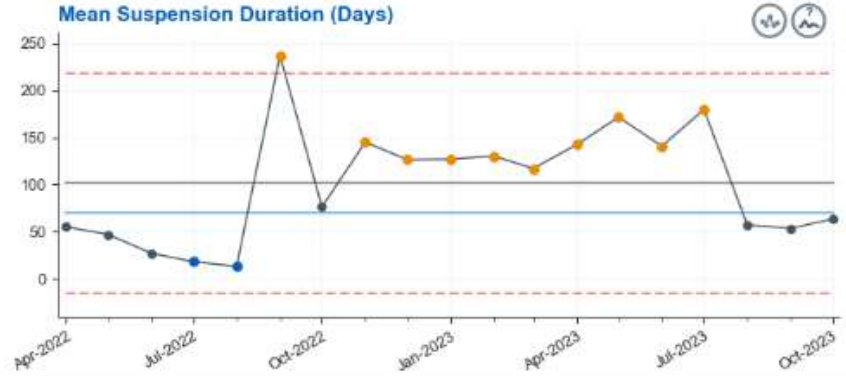
What actions are we taking?

- 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: 5
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: 63.31
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

Suspensions have increased during September and October due to several potential gross misconduct allegations coming to light where alternatives were considered but not thought appropriate. The HRBPs/ER advisors are focused on resolving these investigations as a priority so that impact on the staff member is minimised, with suspensions under weekly review.

What actions are we taking?

All live and new staff suspensions are tracked and reviewed on a weekly basis by the HR Team with the Executive Directors of HR & OD and Operations. This also gives an opportunity to consider those cases which may be identified initially for suspensions where it may not be appropriate or a proportionate action to suspend the staff member.

PEOPLE & CULTURE

Employee Development

WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 73.1%
Target: 85%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

WF-40
Dept: Workforce HR
IP: People & Culture
Latest: 58.3%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Overall, the Trust continues to underperform in meeting the established compliance targets for statutory and mandatory training and appraisals.

Statutory & mandatory training compliance: All directorates are under-performing. The HR & OD and Strategic Planning and Transformation Directorates have attained a compliance level above 75%. Currently, all other directorates fall below the Trust's average. The Chief Executive's Office shows the lowest current compliance for statutory & mandatory training, standing at 53%.

Appraisals: Appraisal rates have shown consistent improvement each month since April 2023. Nevertheless, unless specific interventions are implemented to address low compliance, this target will not be met by the end of March 24. Low appraisal rates can have adverse effects on overall employee engagement. Disengaged employees may present reduced motivation to actively engage in statutory & mandatory training, as well as educational opportunities for personal growth and improved performance. This disengagement could further impact the Trust's ability to retain talented employees.

What actions are we taking?

The accuracy of the appraisal data has been a source of concern of the past few months. Both the workforce information team and the IT data engineering team have conducted thorough investigations into the issues and are currently testing a resolution to enhance the quality of information available to managers on the Power BI dashboard. Improvements are now in train to resolve outstanding data issues in December.

Line managers must address compliances gaps within their teams to uphold the Trust's commitment to ensuring the health, safety and wellbeing of employees. The appraisal rolling target is most likely to be achieved in Q1 24/25 based on current run rate and data improvement.

The HR & OD teams continue to support colleagues by providing advice & guidance, self-help resources through the Appraisal Hub and the improvements to the Appraisal dashboard on Power BI.

Leadership influence is crucial to underscore the significance of both appraisals and statutory & mandatory training to employee engagement and the organisation's success.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

October 2023

Pass 

Hit and Miss 

Fail 

No Target 

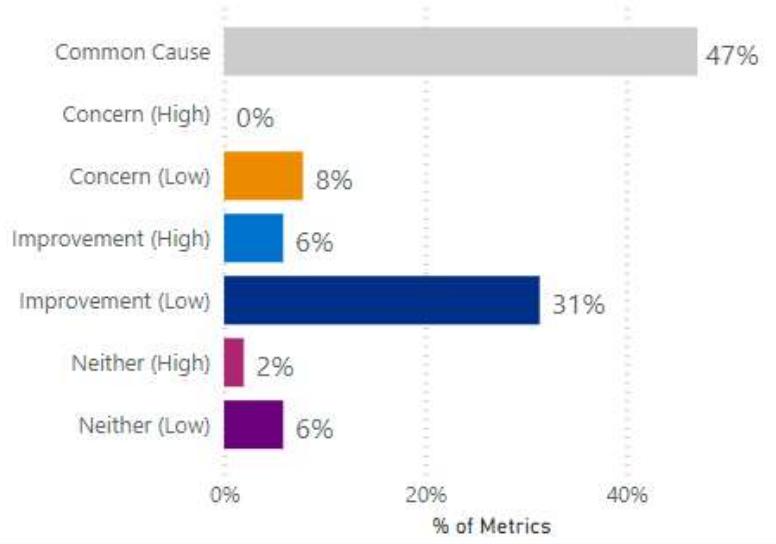
Special Cause Improvement 	111 to 999 Referrals (Calls Triaged) %	999 Frontline Hours Provided % 111 Calls Abandoned - (Offered) % A&E Dispositions % Cat 2 Mean Cat 2 90th Centile Cat 3 90th Centile	Hear & Treat % 111 Calls Answered in 60 Seconds %	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Section 136 Mean Response Time Hours Lost at Handover as a Proportion of Provided Hours... Number of Hours Lost at Hospital Handover % of SRV vehicles off road (VOR) Critical Vehicle Failure Rate (CVFR) 999 Referrals A&E Dispositions HCP 3 90th Centile
Common Cause 	Cat 1T 90th Centile Cat 1T Mean	Cat 4 90th Centile	See & Convey % Average Wrap Up Time 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 CFR Attendances

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

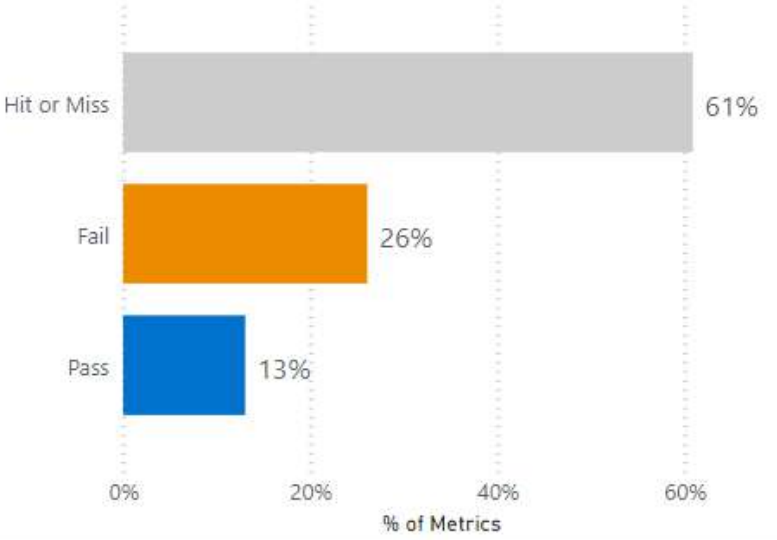
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Oct-2023	00:00:00			00:23:05			
Section 136 Mean Response Time	Responsive Care	Oct-2023	00:24:42		00:14:11	00:26:34	00:38:56		
Cat 1 Mean	Responsive Care	Oct-2023	00:08:33	00:07:00	00:07:29	00:09:05	00:10:42		
Cat 1 90th Centile	Responsive Care	Oct-2023	00:15:20	00:15:00	00:13:58	00:16:29	00:18:59		
Cat 1T Mean	Responsive Care	Oct-2023	00:10:08	00:19:00	00:08:57	00:10:49	00:12:40		
Cat 1T 90th Centile	Responsive Care	Oct-2023	00:18:15	00:30:00	00:16:21	00:19:49	00:23:18		
Cat 2 Mean	Responsive Care	Oct-2023	00:28:01	00:30:00	00:17:48	00:32:38	00:47:29		
Cat 2 90th Centile	Responsive Care	Oct-2023	00:55:20	00:40:00	00:34:22	01:06:52	01:39:22		
Cat 3 90th Centile	Responsive Care	Oct-2023	04:52:04	02:00:00	01:32:21	05:56:23	10:20:24		
Cat 4 90th Centile	Responsive Care	Oct-2023	06:49:36	03:00:00	02:07:30	08:04:55	14:02:20		
HCP 3 Mean	Responsive Care	Oct-2023	02:27:45		01:00:46	02:43:42	04:26:39		
HCP 3 90th Centile	Responsive Care	Oct-2023	05:22:54		01:03:39	06:20:26	11:37:13		
HCP 4 Mean	Responsive Care	Oct-2023	03:02:49		01:20:57	03:27:43	05:34:29		
HCP 4 90th Centile	Responsive Care	Oct-2023	06:25:23		02:18:09	08:10:18	14:02:28		

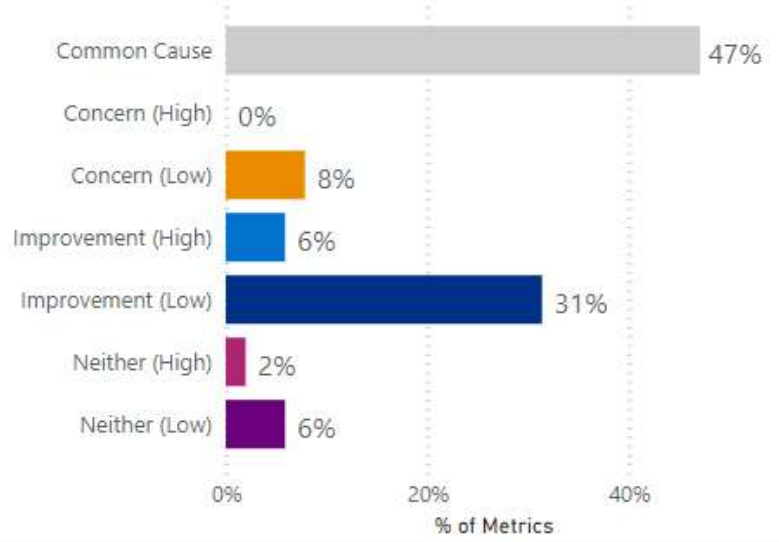
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Oct-2023	24.2%		19.88%	24.36%	28.84%		
999 Calls Answered	Responsive Care	Oct-2023	72723		51825.98	72819.4	93812.82		
999 Call Answer Mean	Responsive Care	Oct-2023	00:00:22	00:00:05	00:00:30	00:00:41	00:01:52		
999 Call Answer 90th Centile	Responsive Care	Oct-2023	00:01:24	00:00:10	00:00:56	00:02:13	00:05:21		

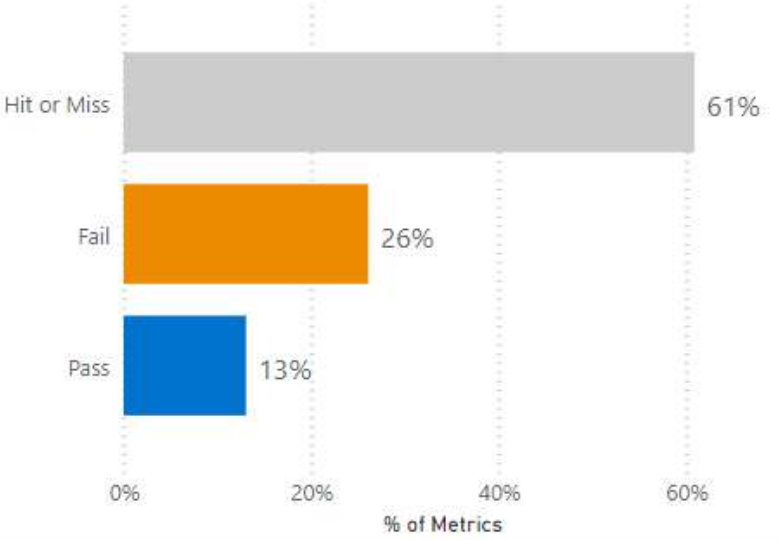
RESPONSIVE CARE

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	Oct-2023	107.6%	100%	82.42%	91.72%	101.02%		
Provided Bank Hours %	Responsive Care	Oct-2023	0.9%		0.6%	0.73%	0.85%		
Provided Overtime Hours %	Responsive Care	Oct-2023	7.7%		6.94%	9.19%	11.44%		
Provided PAP Hours %	Responsive Care	Oct-2023	5.1%		4.64%	5.44%	6.24%		
999 Operational Abstraction Rate %	Responsive Care	Oct-2023	34%	28%		35.75%			
999 Remaining Annual Leave FY	Responsive Care	Oct-2023	26.3%			30.14%			
Vehicles Off Road (VOR) %	Responsive Care	Oct-2023	13%	10%	9.77%	12.61%	15.45%		
% of DCA vehicles off road (VOR)	Responsive Care	Oct-2023	14.2%		11.07%	13.73%	16.39%		
% of SRV vehicles off road (VOR)	Responsive Care	Oct-2023	3.9%		-6.11%	7.35%	20.8%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Oct-2023	98		71.18	145.8	220.42		
Number of RTCs per 10k miles travelled	Responsive Care	Oct-2023	0.88		0.22	0.68	1.14		
% of planned vehicle services completed	Responsive Care	Oct-2023	78%		50.84%	71.33%	91.83%		
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	Sep-2023	83.3%	95%		90.22%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Oct-2023	63.5%		59.03%	63.01%	66.98%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Oct-2023	6.6%	13%	5.56%	6.77%	7.97%		
Incidents	Responsive Care	Oct-2023	65212		53303.54	60253.7	67203.86		

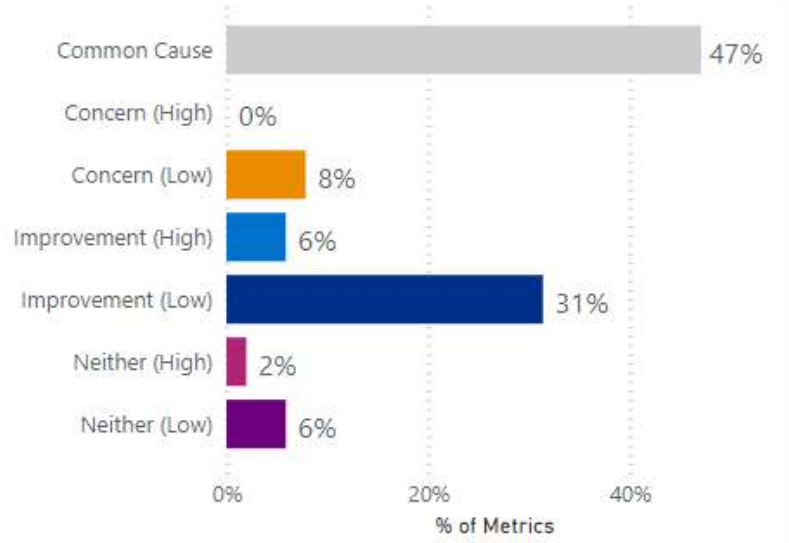
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Oct-2023	89412		71141.38	104916.8	138692.22		
111 Calls Answered in 60 Seconds %	Responsive Care	Oct-2023	41.8%	95%	6.57%	34.53%	62.48%		
111 Calls Abandoned - (Offered) %	Responsive Care	Oct-2023	13.7%	5%	2.71%	18.38%	34.04%		
999 Referrals	Responsive Care	Oct-2023	4587		3991.5	5206	6420.5		

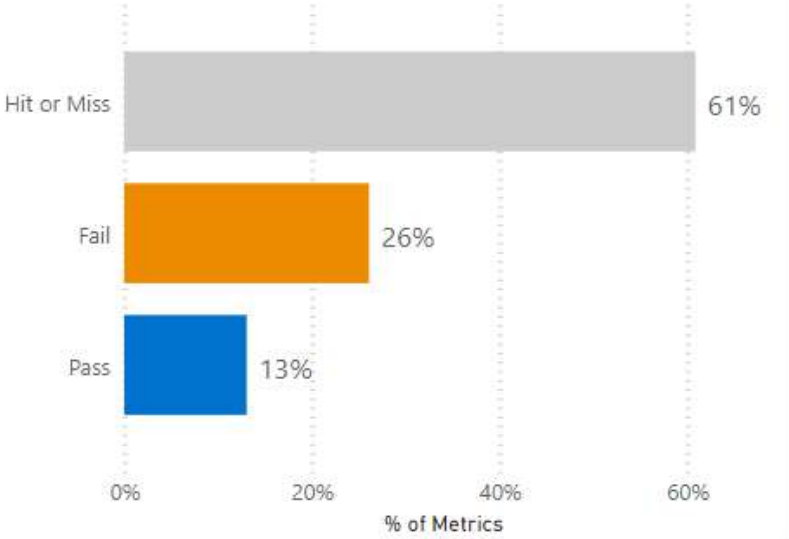
RESPONSIVE CARE

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	Oct-2023	01:16:38		01:15:41	01:17:30	01:19:19		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Oct-2023	01:52:10		01:50:12	01:54:35	01:58:58		
Responses Per Incident	Responsive Care	Oct-2023	1.09	1.09	1.08	1.1	1.11		
CFR Attendances	Responsive Care	Oct-2023	1035		769.42	1228.9	1688.38		
FFR Attendances	Responsive Care	Oct-2023	69		70.9	189.2	307.5		
ECAL Mean Response Time	Responsive Care	Oct-2023	00:25:04		00:21:25	00:23:35	00:25:44		

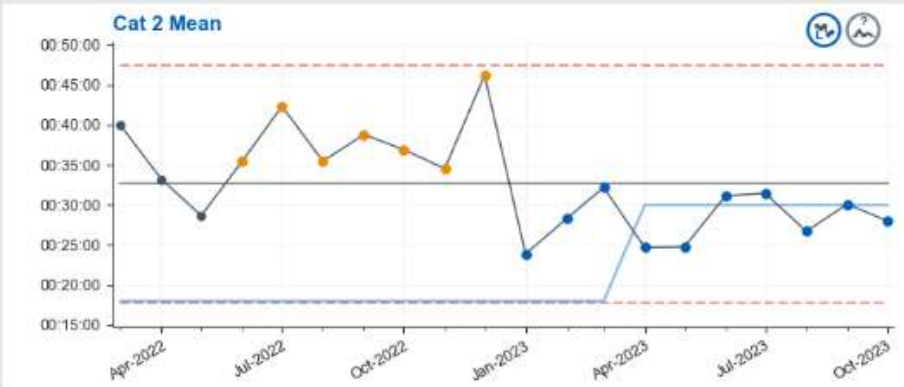
111/999 System Impacts

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Oct-2023	12.6%	14%	8.7%	10.24%	11.78%		
See & Treat %	Responsive Care	Oct-2023	30.6%	35%	30.08%	31.57%	33.05%		
See & Convey %	Responsive Care	Oct-2023	56.7%	55%	55.75%	58.07%	60.39%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Oct-2023	1%		0.69%	1.35%	2%		
Number of Hours Lost at Hospital Handover	Responsive Care	Oct-2023	3229.89		1929.61	3741.17	5552.72		
Average Wrap Up Time	Responsive Care	Oct-2023	00:17:07	00:15:00	00:16:43	00:17:20	00:17:57		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Oct-2023	45.9%		44.43%	47.26%	50.08%		
A&E Dispositions %	Responsive Care	Oct-2023	6.8%	9%	6.65%	8.36%	10.07%		
A&E Dispositions	Responsive Care	Oct-2023	4715		4971.97	6440.15	7908.33		
Clinical Contact %	Responsive Care	Oct-2023	50.8%	50%	46.52%	50.48%	54.44%		
Ambulance Validation %	Responsive Care	Oct-2023	53.4%	85%	81.02%	88.96%	96.89%		

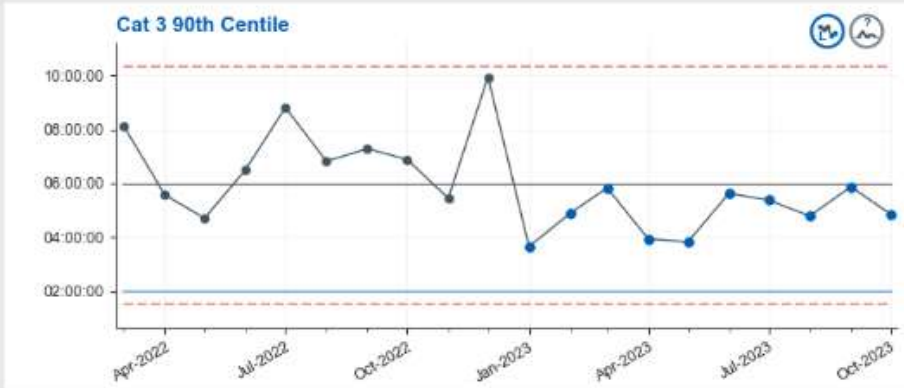
RESPONSIVE CARE

Response Times

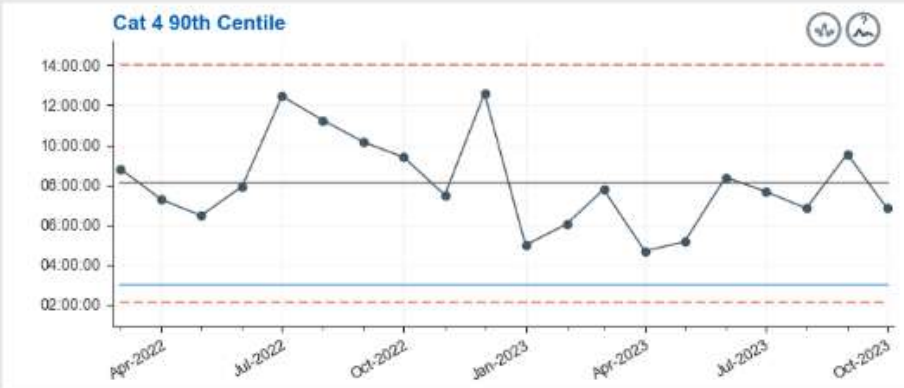
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:33
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:28:01
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: 04:52:04
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: 06:49:36
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

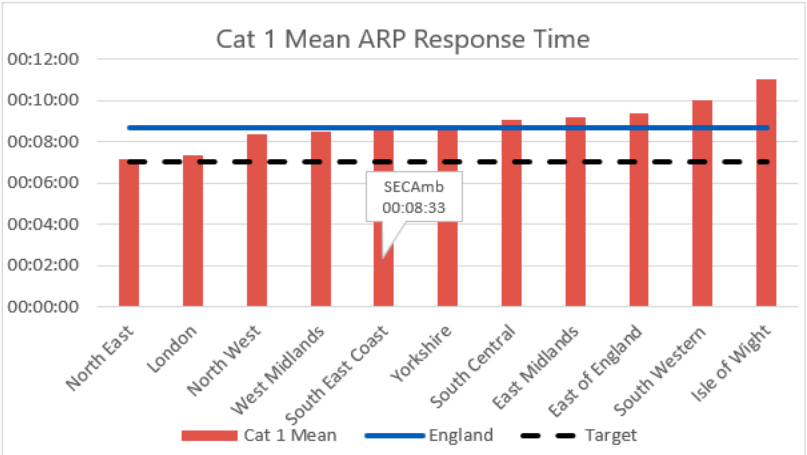
Summary

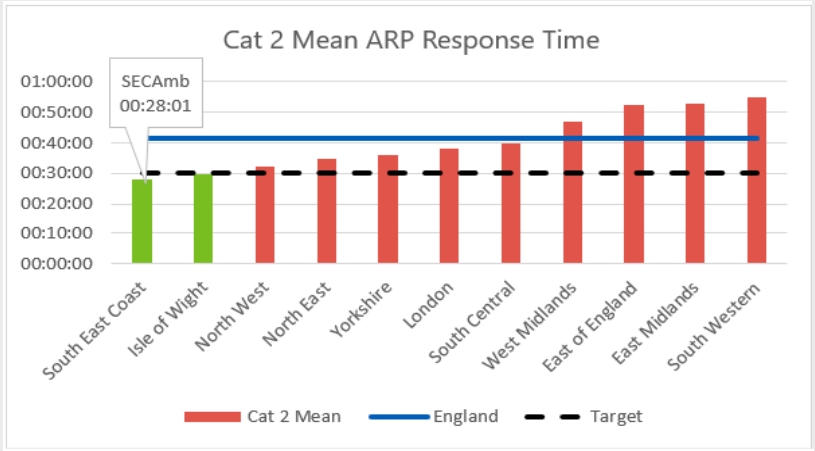
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against the delivery plan – in October 2023, performance was 28mins 02sec, against a national average of 41min 40sec.

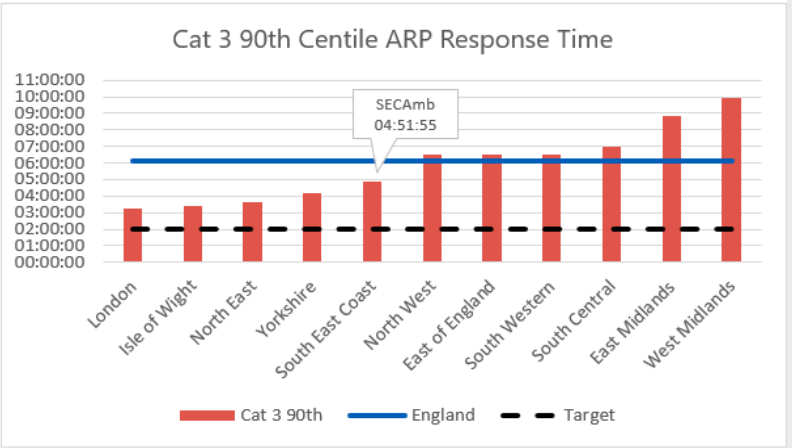
What actions are we taking?

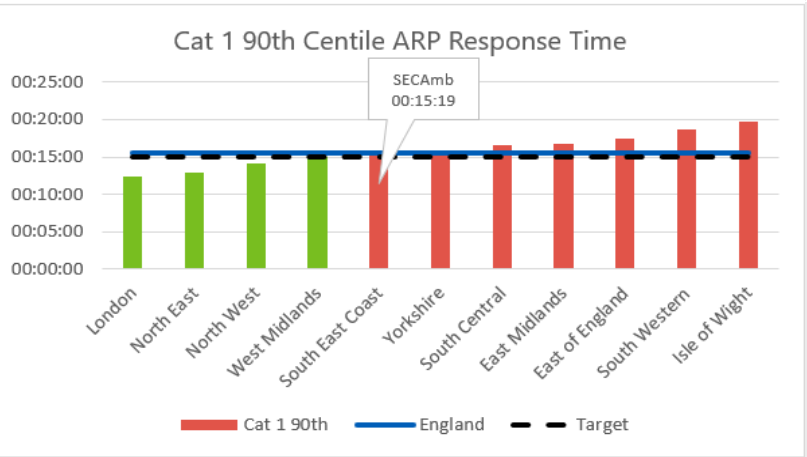
- Continuation of C3 & C4 validation, with a high proportion being validated in either the Trust's 111 (KMS 111) or 999 services. The aim remains to clinically assess every C3 or C4 call prior to ambulance dispatch.
- Continued focus on clinical staffing in EOC to maintain patient safety and support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

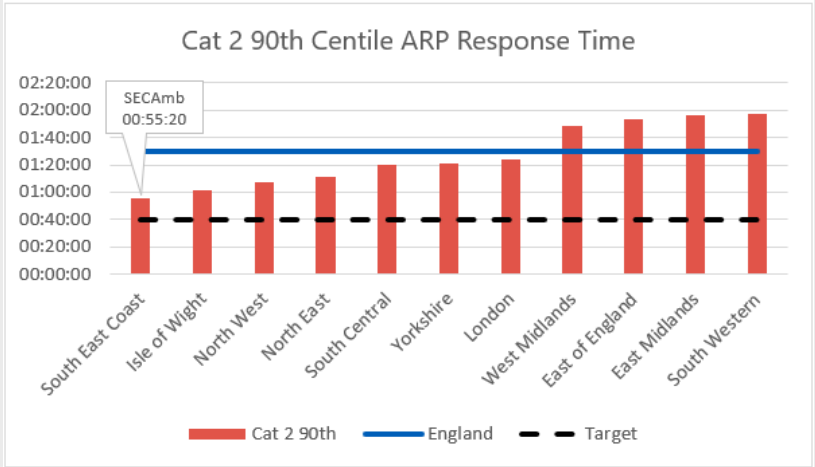
ARP Response Time Benchmarking (October 2023)

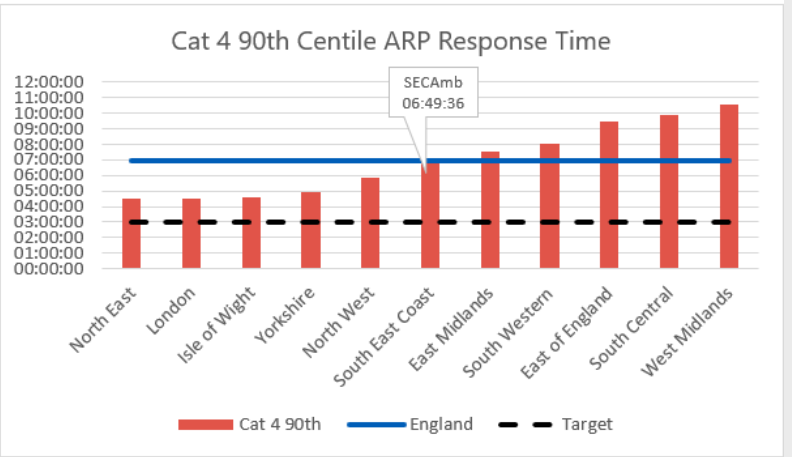












Summary

- 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.

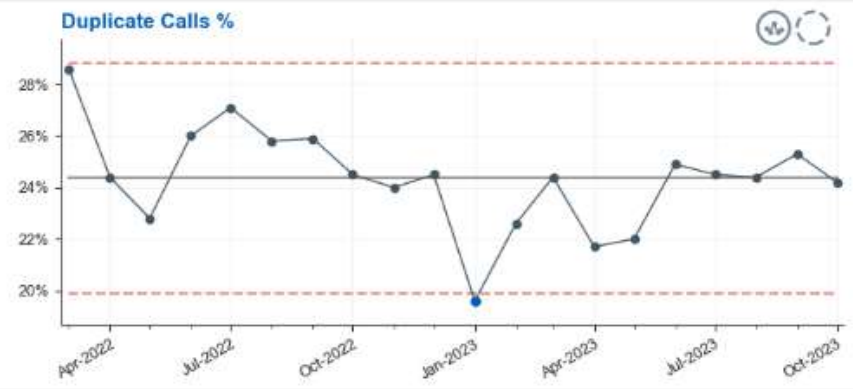
RESPONSIVE CARE

EOC Emergency Medical Advisors

999-10

Dept: Operations 999
IP: Responsive Care
Latest: 72723

Common cause variation, no significant change.



999-33

Dept: Operations 999
IP: Responsive Care
Latest: 24.2%

Common cause variation, no significant change.

999-9

Dept: Operations 999
IP: Responsive Care
Latest: 12.6%
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: 00:00:22
Target: 00:00:05
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

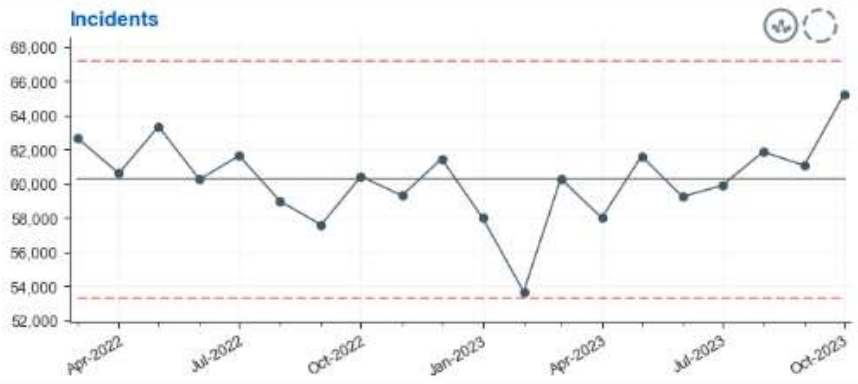
- Call answer mean time continues to fluctuate, underpinned by ongoing staffing challenges and rota inequalities, with a higher proportion of newer staff who are developing, although noting that there has been a general trend in increasing the number of ***calls answered*** over the same period.
- EMA 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 (in line with plan), with October reflecting the service's best monthly performance for Hear & Treat (top half of national English ambulance league table).
- Recruitment of Paramedics, especially via overseas continues and the Trust is utilising additional NHS E funding to source agency clinicians to support clinical assessment – this finishes at the end of October.

What actions are we taking?

- EMA establishment is currently significantly below required levels – impacted by the recent move to Medway. This gap is attributable to attrition being higher than planned this year, and an inability to recruit EMAs at the planned numbers. The end of year target is 264 WTE and dependent on attrition v recruitment rate.
- ***C3 & C4 clinical validation model continues*** and ***C2 segmentation*** is live.
- 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.
- A programme of larger recruitment events progresses with noticeable successes for the Medway call centres.

RESPONSIVE CARE

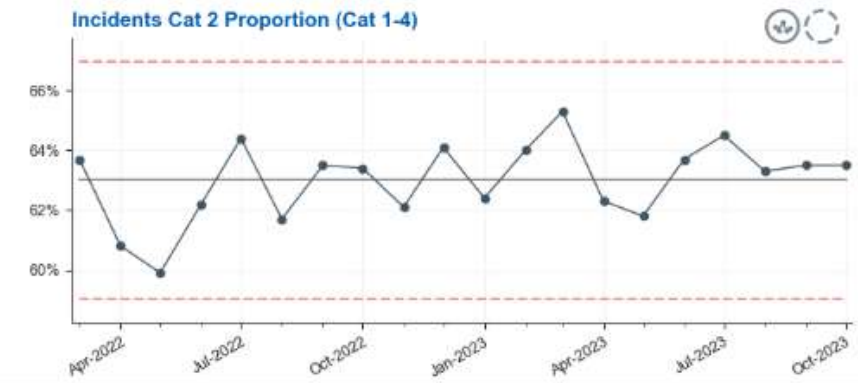
Utilisation



999-10
Dept: Operations 999
IP: Responsive Care
Latest: 65212

Common cause variation, no significant change.

999-12
Dept: Operations 999
IP: Responsive Care
Latest: 107.6%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



999-32
Dept: Operations 999
IP: Responsive Care
Latest: 63.5%

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 monthly 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?

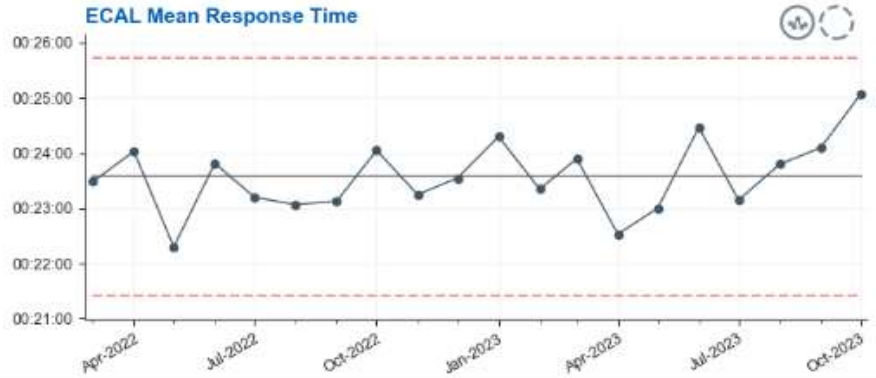
- The 999 referral rate from the Trust's 111 service remains amongst the best nationally.
- Greater flexibility between the Trust's 111 and 999 services to flex clinicians to maintain C3/C4 validation at a high level, prior to ambulance dispatch.
- Continued focus on ***optimising resources*** through abstraction management and optimisation of overtime to provide additional hours – continued management of sickness and reduction in annual leave levels have improved resourcing.
- 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: 00:25:04

Common cause variation, no significant change.

999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:16:38

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

999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:52:10

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

Summary

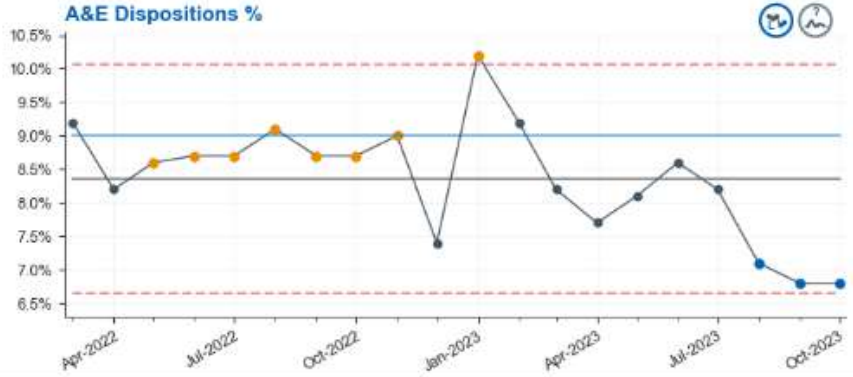
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with common cause variation.
- ***Job cycle time*** (JCT) provides a single 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 seen a recent increase, potentially associated with increasing complexity of clinical presentations as autumn/winter approaches.

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. Phase 1 of this plan was completed at the end of October – phase 2 commences in early 2024.
- 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: 6.8%
Target: 9%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

999-9

Dept: Operations 999
IP: Responsive Care
Latest: 30.6%
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: 3229.89

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

999-31

Dept: Operations 999
IP: Responsive Care
Latest: 00:17:07
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 Trust ***See and Treat*** rate has improved to a level of 30.6%, 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: 89412

Special cause variation where DOWN is neither improvement or concern

111-3

Dept: Operations 111
IP: Responsive Care
Latest: 13.7%
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: 41.8%
Target: 95%
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.

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 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 6 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.

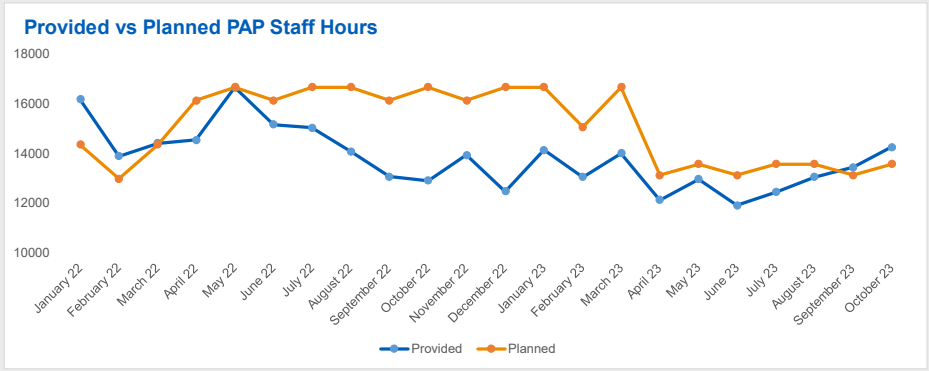
RESPONSIVE CARE

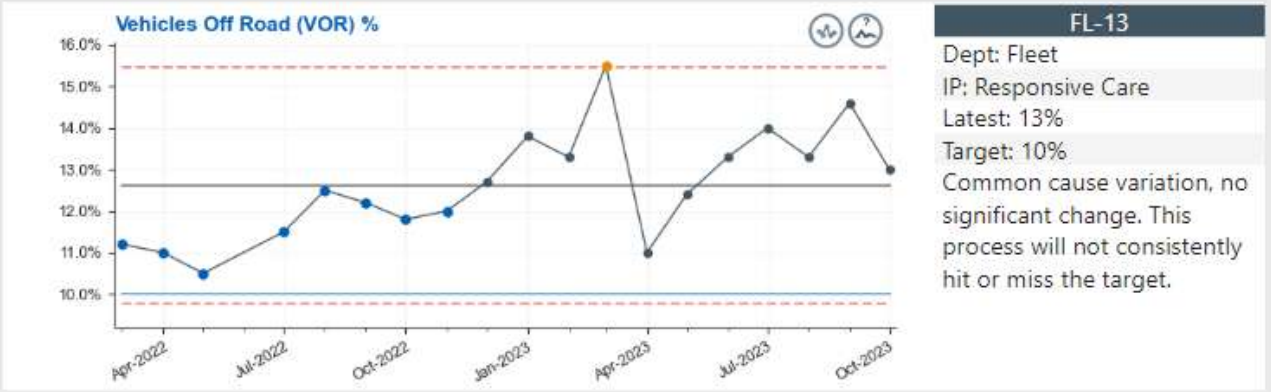
Support Services
Fleet and Private Ambulance Providers

FL-12

Dept: Fleet
IP: Responsive Care
Latest: 98

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





FL-13

Dept: Fleet
IP: Responsive Care
Latest: 13%
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: 78%

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. In addition, high vacancies within the Vehicle Maintenance Technicians (VMT) team are impacting the capacity we have to address issues within our workshops (vacancies down from c. 10% to 6% in December). **(Update December 23)** We have now completed recruitment for 3 additional Vehicle Maintenance Technicians and we are exploring the use of the apprenticeship scheme to increase our capacity. This is aligned to Risk ID 333.
The planned vehicle services has been recovered since the last period. This has been achieved through the use of agency staff.

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. A recommendation is due to EMB on the 8th of February with a view to place orders early in April 2024 once the national contract is in place. In the meantime, we will be engaging extensively with colleagues to get their views on the preferred fleet for the future.

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.

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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

	October 2023 In the month			April to October 2023 Year-to-date			Forecast to March 2023		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income	26,587	27,478	891	186,096	188,447	2,351	319,066	321,386	2,321
Operating Expenditure	(26,579)	(27,457)	(878)	(185,682)	(187,983)	(2,301)	(319,068)	(321,388)	(2,321)
Trust Surplus/(Deficit)	***8***	***21***	***13***	***414***	***464***	***50***	***(2)***	***(2)***	***0***
Reporting adjustments:									
Remove Impact of Donated Assets	*0*	*0*	*0*	*1*	*1*	*0*	*2*	*2*	*0*
Reported Surplus/(Deficit)	**8**	**21**	**13**	**415**	**465**	**50**	**0**	**0**	**0**

Cash	40,805	39,838	(967)	40,805	39,838	(967)	50,400	45,935	(4,465)
Capital Expenditure	2,379	409	1,970	11,168	10,260	908	27,055	27,055	0
Efficiency Target	938	999	61	3,788	3,368	420	8,988	8,988	0

*values subject to rounding

Summary

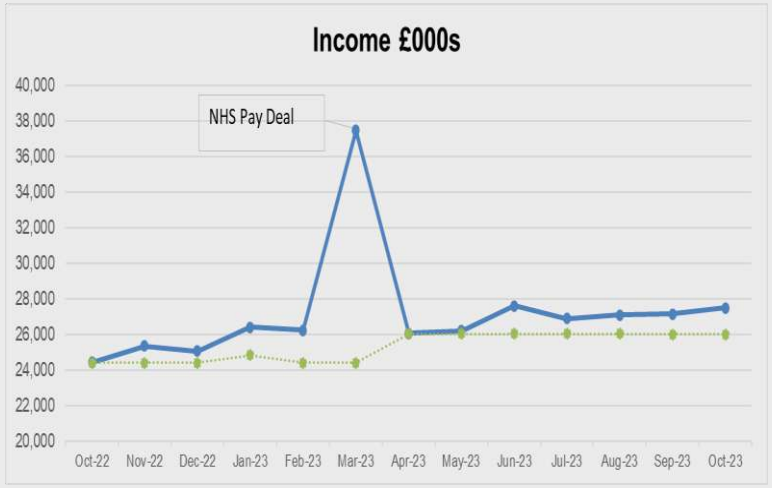
1. The Trust's financial performance is in line with plan with a surplus of £465k being reported YTD M7 (October 2023). Financial pressures in 111 and HR were mitigated by profit on disposal of Trust assets, mainly Redhill Ambulance Station and higher than planned interest rate received on cash balances held in the bank.
2. The efficiency programme has delivered £3,368k worth of savings at M7 YTD, which is a shortfall of £420k compared to the £3,788k plan. 79% of the schemes have been generated recurrently. There is continued concerted effort being made by the Trust to identify further efficiencies. However, there is a risk that the efficiencies will not deliver the full £9.0m target.
3. Cash position was £39,838k that is £967k lower than plan due to the timing of settling supplier invoices. The Trust is forecasting a cash position at the end of March 2024 of £45,935k, which is 8.9% below plan. This is driven by additional expenditure over the latter months.
4. Capital expenditure of £10,260k is £908k below plan mainly due to the delay in Ambulance purchases (right of use assets). The Trust is confident that it will deliver its capital departmental expenditure limit (CDEL).
5. The Trust is forecasting to achieve the breakeven at year end through non-recurrent means.

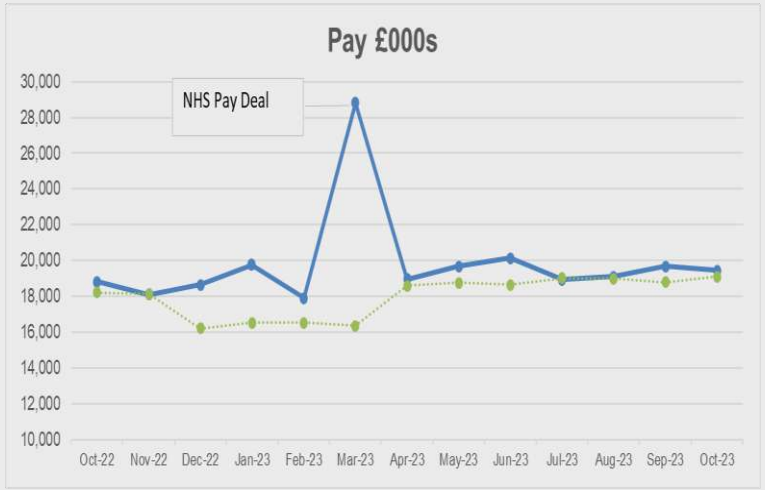
What actions are we taking?

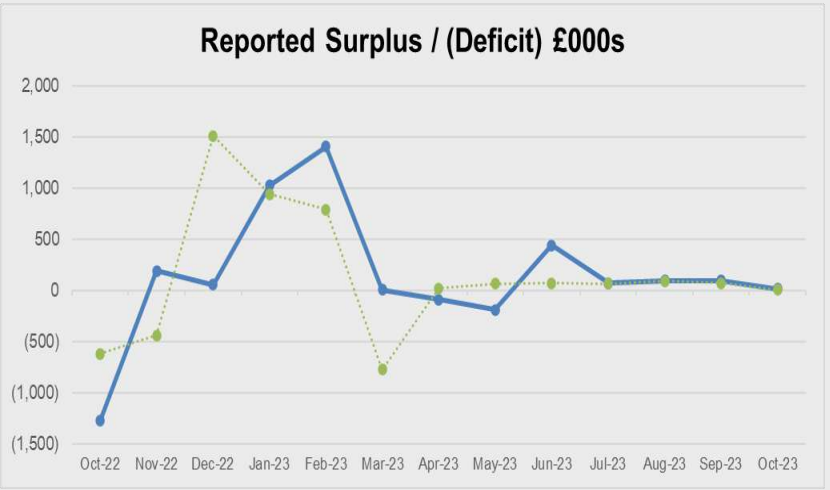
1. Finance is working with budget holders to ensure that any overspends are brought back into line with the allocated budget allocation.
2. Weekly Check and Challenge reviews are in place to identify new schemes and drive progress on current schemes. This includes identification and recognition of non-recurrent underspends to support the Trust achieving its efficiency target. 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 ensure that each directorate delivers their element of the financial plan e.g., budget and efficiency target.
4. The Finance and Investment Committee will be undertaking deep dives into those directorates are overspending.
5. The Executive Management Board have discussed how the Trust's Control Total will be landed. This will be presented to the December Trust Board.

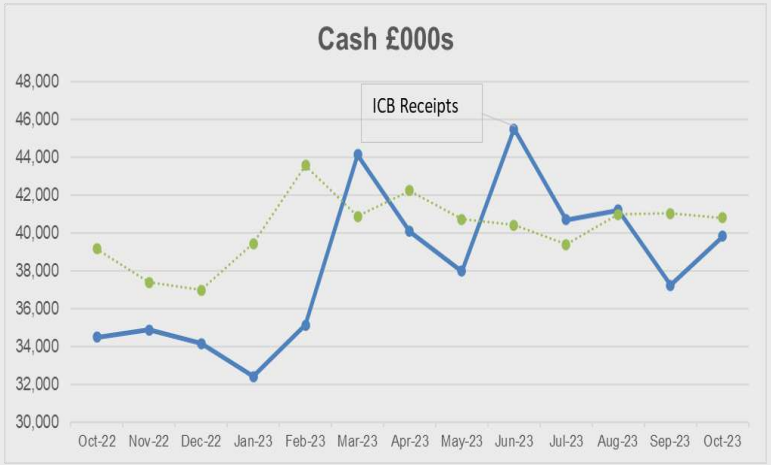
Delivered Against Plan

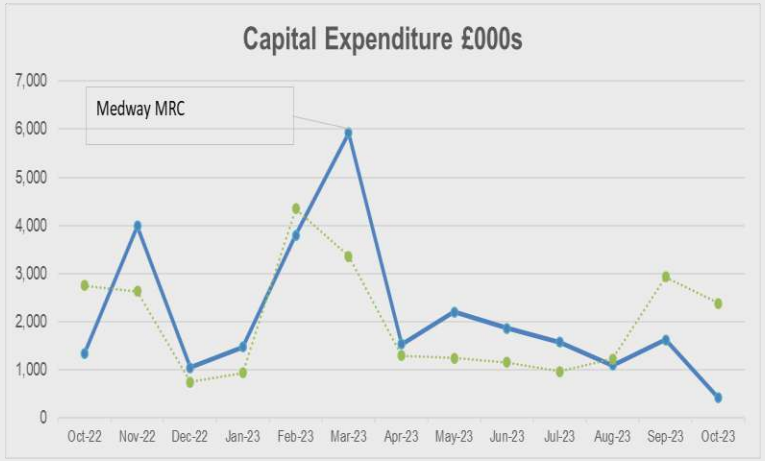
Actual Plan











Summary

- The Trust's YTD M7 financial performance of £465k surplus is on plan.
- Financial pressures, notably in 111 were mitigated by non-recurrent measures, including vacancies across the Trust, profit on sale of Trust assets including Redhill Ambulance Station, higher than planned interests received on cash in bank.
- The main areas to highlight from the graphs are the surge in March 2023 relating to the additional cost and income due to the NHS pay deal, cash received in June 2023, when payments were made to staff. Capital expenditure is slightly behind plan due to delays in ambulance purchase (right of use assets).

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Appendix

Appendix 1: Glossary

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations
F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	65-23

Name of meeting	Trust Board
Date	7 December 2023
Name of paper	People and Culture - Executive Summary to the Board
Strategic Goal	Focus on People and Culture
Lead Director	Ali Mohammed, Executive Director of HR and OD
Author	Ali Mohammed, Executive Director of HR and OD

Executive Summary

Risk Overview

The previous combined risk of retention, culture and leadership has been split into two risks with one now specifically focusing on retention and the other now confirmed as Culture and Leadership (risk 348). The Recruitment risk has now been relabelled as Workforce Plan.

The IQR is reflective of the current risks (except for industrial action) through the key metrics set out in the Overview.

Industrial action has been paused by most unions now and is not anticipated to be a major risk in the short term. Accordingly, the Trust Industrial Action Management Group has now been stood down until further notice.

Workforce Plan

The SPC charts within the IQR now show both 'volume' or cohort and 'ad hoc' recruitment. The former are to fill spaces on both contact centre and field operations planned courses, whilst the latter are to fill vacancies in other positions that arise throughout the year.

371 WTE in staff will be recruited by end of 23/24 with the following breakdown.

- 139 NQPs
- 87 International Paramedics
- 110 ECSWs
- 35 AAPs

A Quality Improvement project to improve Time to Hire (TTH) and onboarding commenced in May 2023 and an update on the work is provided in the IQR.

The People and Culture Strategy makes a commitment to **reduce TTH** and onboarding to achieve the 60 days target for ad hoc recruitment as one of a number of priority areas identified for people and cultural change.

Retention

Staff retention remains a high concern. The NHS has launched a new **Long-Term Workforce Plan** and, in common with other NHS providers, retention is the most immediate section which we are focusing on as this is the most influenceable area locally. A **Retention Plan** is the subject of a separate paper

for Board approval at this meeting. This has been the subject of extensive engagement already and received **EMB approval** on 22 November 2023.

Sickness absence has **reduced** since the last Board report and now stands at 6% - just above our target of 5%. We are **not an outlier** compared to other ambulance Trusts. Monthly scrutiny of action plans at Operations Senior Leadership meetings continues with support from HR Advisors.

Culture and Leadership

Further to previous reports, progress against the **People and Culture Delivery Plan** continues to be monitored at EMB under the leadership of the Programme Director (Culture Transformation). Circa 50% of the tasks within the plan are now complete with a further third in progress.

An **executive team development programme** has been commissioned under the leadership of the CEO. Two development days have now taken place with the Trusted Executive (external support partner).

The number of suspension cases remains steady at a much lower rate now 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 six open cases. Importantly, the continuation of the focus on sexual misconduct means that we currently do not have any sexual harassment cases within the open suspensions.

An Improvement Case has been fully approved to increase employee relations capacity by creating a specialist ER team separate to the HR Business Partner team. We have **successfully recruited the new Head of ER** role and they started with the Trust in October 2023.Two specialist ER managers have now been recruited to complete the senior tier within the new team. The team will be fully in place in Q4.

The initial phase of the **mediation process with our recognised unions** has been completed as per ACAS proposal agreed with the Trust and its five recognised unions. This comprised two days with the GMB, one half day with UNITE and two full days with all unions. A **joint workplan** has been developed for discussion and progression via JPF. A **joint development day** on Trust values and culture ('Building a Kinder SECAmb') has been commissioned for the executive team and unions to jointly undertake – 24 January 2024. It is recognised that this will take time and sustained effort over several years to build trust and working relationships.

The latest **Staff Survey** closed on 24 November. Pending validation of our final numbers, these are the key known data points:-

- Our final Trust response rate was **60%** - the national mean average for all 125 trusts using IQVIA was **48%** as at 24 November.
- **2716** staff members took part in the core Trust survey, an increase of **107** on 2022, and the **largest number of staff to ever take part in the survey at SECAmb.**
- Our final **bank worker response rate** was **35%** - the national mean average for all trusts using IQVIA was **19%** as at 24 November.

	• **74** bank workers took part in the bank survey. This is in addition to the 2716 staff members taking part in the core survey. This follows the highest ever number of our people completing the National Quarterly Pulse Survey. Concerns raised through the FTSU team remain high with continuing concerns about detriment. The themes appear to be similar to previous months including **bullying and harassment, inappropriate behaviours and safety/wellbeing**.
Recommendations, decisions or actions sought	We continue to face a number of operational and workforce challenges. These are reflected with the BAF and Trust Risk Register and by the scale of the work set out in the strategic objectives and associated delivery plans. The work set out in the People and Culture delivery plan focused initially on those areas within the CQC warning notices but has now importantly moved to address the **deeper issues in respect of culture, leadership and staff experience**. It is recommended that the Board **discuss** and **endorse** the actions taken to date and **individually and collectively own and support** the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience. The Board is also asked to **endorse** the re-adoption of the Retention Risk on to the Board Assurance Framework as a **strategic risk** and **to note** that the Retention Plan together with the People and Culture Delivery Plan are the Trust's primary responses to the retention risk.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	65-23

Name of meeting	Trust Board
Date	07.12.2023
Name of paper	Board story
Trust Priority Area	People & Culture
Lead Director	Chief Executive

Throughout November 2023, we had the privilege of hosting our annual awards ceremonies and witness colleagues receive extremely worthy recognition for both their long service and for special achievements.

Across the three ceremonies, we welcomed more than 400 colleagues, families and friends and it was both enjoyable and humbling to celebrate their achievements.

For the first time, we filmed during each of the ceremonies and are pleased to share a flavour of the evenings, to help frame this part of the Board agenda which focusses on how we support our people to make SECAmb a better place to work.

Recommendations, decisions or actions sought	For Information.

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65-23

Name of meeting	Trust Board
Date	7 December 2023
Name of paper	Retention Plan
Responsible Executive	Ali Mohammed, Executive Director of HR and OD
Authors	Ali Mohammed, Executive Director of HR and OD Ian Jeffreys, Assistant Director of Wellness and HR

This paper presents a final version of the Trust's Retention Plan for assurance and approval.

The retention of our people is one of the most critical issues on our people agenda as it is a difficult recruitment market and it can take time and effort to recruit and onboard new colleagues. It is also expensive and this adds to the business case for retaining people wherever possible.

People leave SECAmb for a number of reasons, but the most common reasons given are because of the hours and intensity of work, a lack of career development and health and wellbeing. It was critical therefore to develop an evidenced-based plan which directly addressed the issues causing people to leave. It was also important to ensure that existing actions within other plans such as our People and Culture Delivery Plan are not duplicated and this plan is therefore consistent with other actions such as those planned to address meal breaks and late finishes.

This plan has been through extensive consultation as set out in the accompanying slide deck and is therefore grounded in issues which our people have said matter to them. This includes a number of Trust wide webinars in and out of office working hours, engagement meetings with unions, a variety of management groups and staff networks.

The Board is particularly asked to note the principles upon which the plan has been developed and the pledges which it is felt will address the major reasons for leaving. Clearly, there are additional actions proposed to those in the pledges, but the commitment to and communication of the primary pledges forms a clear offer to help transform our levels of staff turnover from current levels at just under 17% to c.12% within the next 18 months.

A number of elements of the plan will require investment. This will be managed through a single integrated Improvement Case.

Recommendations, decisions or actions sought	The Board is asked to **approve** the Retention Plan.

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

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SECAmb Retention Plan

2023-25

GETTING THINGS RIGHT
FOR OUR PEOPLE

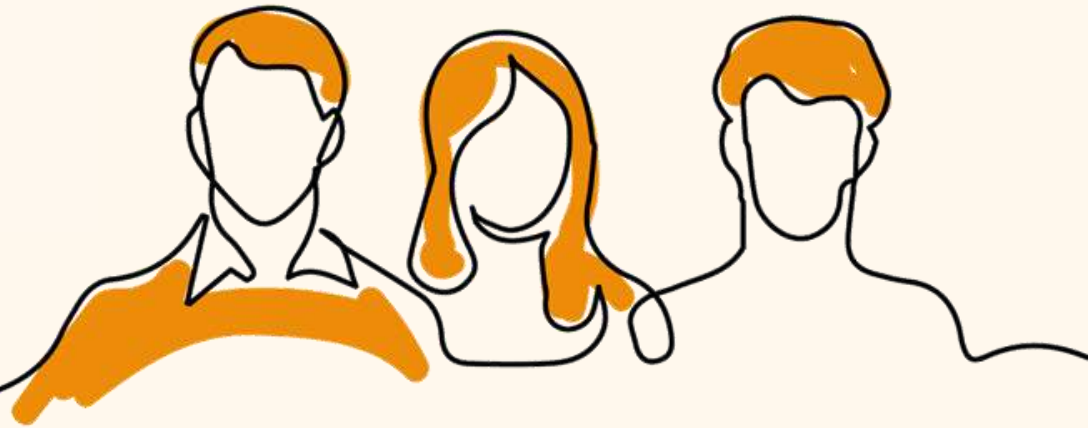


Table of Contents

South East Coast Ambulance Service NHS Foundation Trust

Introduction

The rationale for our new retention plan

- Our turnover continues to be a risk for the Trust, and despite the introduction, and delivery, of a Trust retention plan in 2022, turnover continues to increase. Currently 18.35% (Oct 23).

NB: *The Medway move has had an impact of 1.66% on turnover with 89 leavers. Suggesting our turnover is closer to 16.69% when discounted.*

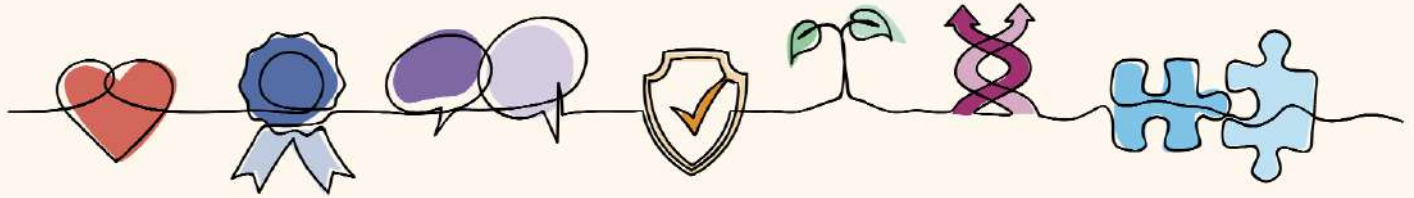
- Since the development of the initial retention plan, NHS England has launched its Long-Term Plan, and the Trust has launched its People and Culture Delivery Plan. The latter aimed at addressing the comments/concerns identified in the 2023 Staff Survey and previous surveys.

- A timely review of Trust strategies and plans against the NHS long-term plan, with a focus on workforce, has identified opportunities where we can focus further on retention, taking ambitious and innovative approaches that will really make an impact.

The National Retention Programme

South East Coast Ambulance Service NHS Foundation Trust

Delivering the People Promise



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

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

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

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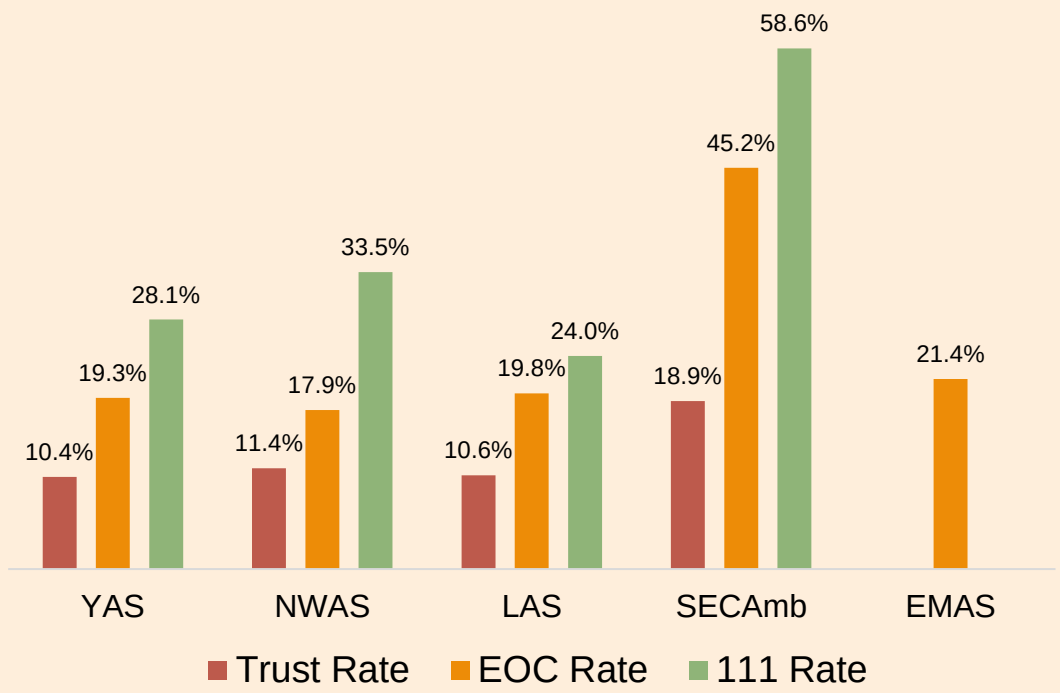
Life at SECAmb Now

Trust Retention Data

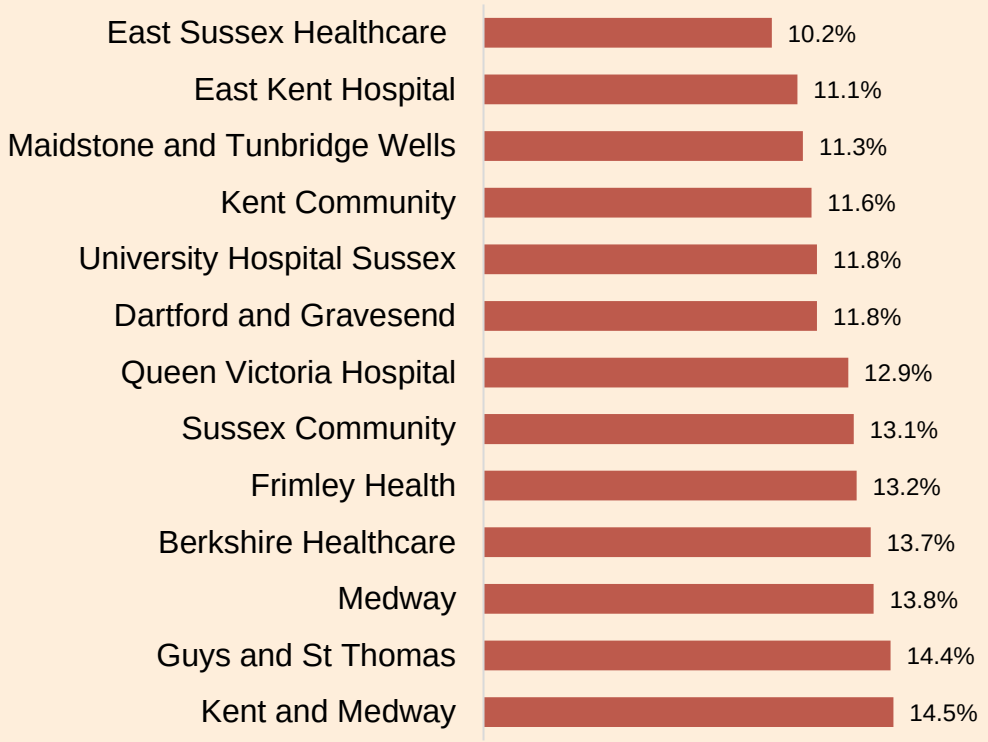
Understanding the wider context

South East Coast Ambulance Service NHS Foundation Trust

Ambulance Trust Comparison



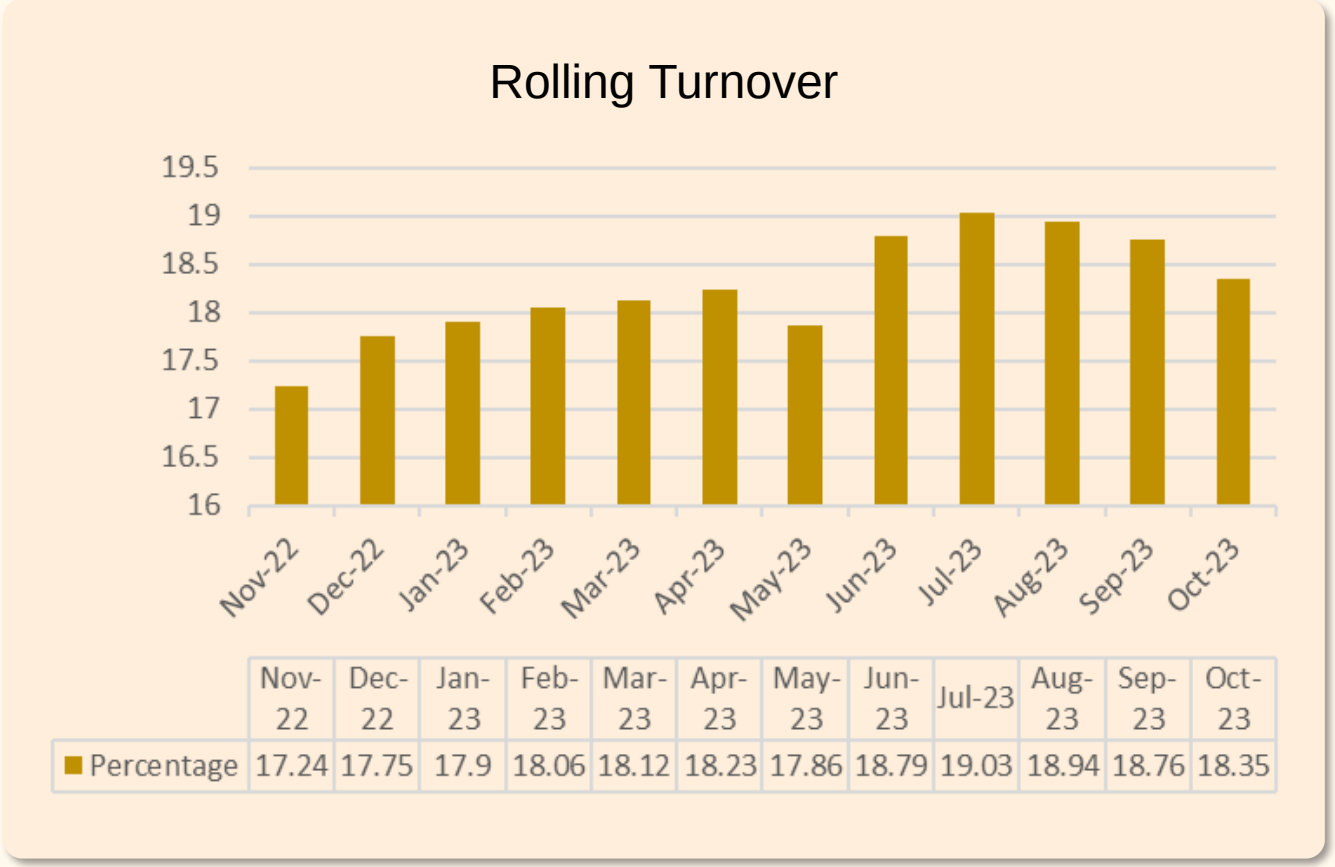
South East Comparison



Target for Improvement

Deriving a target for 2024/25

South East Coast Ambulance Service NHS Foundation Trust



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Percentage	17.24	17.75	17.9	18.06	18.12	18.23	17.86	18.79	19.03	18.94	18.76	18.35

Improvement Target

"By April 2025 our aim is to be in line with the median turnover data point for both Ambulance Trusts and NHS South East Hospital Trusts"

Target 12.35%

Best Practice

Initiatives across the NHS

NHS
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NHS Foundation Trust

South Central Ambulance Service

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

London Ambulance Service

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

NHS Retention Community of Practice

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

Best Practice

National Retention Programme Case Studies

South East Coast Ambulance Service NHS Foundation Trust

West Midlands Ambulance Service

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

The Royal Free London

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

Milton Keynes University Hospital

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

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

Our Principles

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

The plan is based on the following principles:

1. Address the principal reasons for leaving
2. Promote inclusion and diversity
3. Creative and brave ideas
4. The impact must be measurable

Our Pledges

South East Coast Ambulance Service
NHS Foundation Trust

1. Provide you with more control over your working time
2. Become a more flexible employer
3. Take a proactive approach to career development
4. Promote health, happiness, and joy at work
5. Take a total value approach to reward (pay, pension, benefits, and development)
6. Improve pay accuracy, finishing times, and meal breaks

Our Pledges In Action

South East Coast Ambulance Service NHS Foundation Trust

I will be able to manage my own annual leave by September 2024*

Provide you with more control over your working time

I'll be clear on how I can access flexible working arrangements by April 2024

Become a more flexible employer

I will be able to access the new SECAmb Careers Service by October 2024

Take a proactive approach to career development

I will be able to receive overtime and bank pay in advance of payday by April 2024*

Improve pay accuracy, finishing times, and meal breaks

I'll be able to access the new reward and recognition platform from Jan 2024

Take a total value approach to reward (pay, pension, benefits, and development)

I will have access to one protected day per year for my wellbeing by April 2024*

Promote health, happiness, and joy at work

Our Engagement Journey

- Trust Board, including the Operational Management Team
- Senior Management Group
- Trade Union Partners
- HR & OD Directorate
- EOC Culture Change Group
- Staff Networks
- Joint Leadership Team
- Shortlisting Actions – EMB & SMG
- Local Level Engagement

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

Joint Leadership Team

Supporting Our People & Culture Strategy

South East Coast Ambulance Service
NHS Foundation Trust

READY FOR WORK

- We will work with partners to recruit diverse talent from our communities.
- We will train and equip our people with the tools and skills they need to do the best for our patients.
- We will ensure people joining us are set up for success with a great recruitment and onboarding experience.
- We will promote SECAmb as the local employer of choice in our communities and roles in our services as aspiring careers.

HAPPY AT WORK

- We will offer creative and flexible career pathways in collaboration with system partners.
- We will promote diversity in all its forms and eradicate discrimination, harassment, bullying and incivility.
- With our patients at the centre, we will be flexible so that our people can achieve their work/life balance.
- We will recognise good work and celebrate achievements and excellent practice.

SUPPORTED BY WORK

- We will actively engage and listen to our people's concerns and respond to them in a timely way.
- We will ensure our working environments are safe and that the wellbeing of our people is paramount.
- We will be an organisation that learns and shares the findings from events and incidents and help those involved to do the same.
- We will invest in our managers so that they can effectively and compassionately lead our people.

CONTRIBUTING AT WORK

- We will have patient care and safety at the forefront of everything we do.
- We will all make a personal commitment to each other to act with kindness, compassion, and respect.
- We will strive to create a one team approach, eliminating silo working and increasing collaboration.
- We will encourage and support the delivery of change at a local and organisational level.

Aligning With Our Housekeeping Actions

South East Coast Ambulance Service NHS Foundation Trust

Completed Actions	In Progress / Future Actions				
We have confirmed and agreed a 2-hours abstraction, for every Operations Team member, to support appraisal completions	We are looking at ways to minimise overruns.	We will be more ambitious with meal breaks taken will be sustained at 98%.	We are focusing on providing 121s for all our people.	We are conducting a thorough review of how effective our occupational health process is.	We are reviewing further opportunities for avenues and access points for support in the current cost of living crisis.
We have reviewed themes and trends in our Employee Relations cases, such as grievances, to focus our interventions.	We're enhancing our Reward & Recognition prog. with an electronic platform all our people can access	We are improving communication, developing a two-way conversation to improve listening and keep all well informed	We are delivering leadership and management development to ensure our leaders are well-equipped to support our people.	Executive Leadership development is underway, and we are working with the Trust Board to enhance collaboration through Board Development sessions	We will establish a working group to create a cohesive and supportive approach to family-friendly working.
We have approved a £40,000 annual investment to support TRiM.	Conduct a deep dive into the policy and process for annual leave.				

Communication Plan (next steps)

South East Coast Ambulance Service NHS Foundation Trust

Stakeholder Group	Objects (Actions Desired)	Message Content	Delivery Method / Venue	By Whom? / By When?
EMB / Board	EMB approve the Retention Plan for submission to Board. Board approves the final plan.	As for HR Senior Management Team. Strategic awareness. Link to overarching SECAmb strategy. Engagement with the Board	Presentation at EMB/Board	7th December 2023
Operations Team Leaders (Drop- in)	Awareness of the Retention Plan and its content. Final opportunity for contribution.	Present draft plan and take commentary on the effectiveness of the actions.	TEAMS drop-in session.	14th November 2023
Operations Teams A	Awareness of the Retention Plan and its content. Understanding their role in the delivery of the plan. Understanding the impact of the plan on Operations retention.	As for HR Senior Management Team. Strategic awareness. Engagement with Teams B	Presentation at Teams A Self-Learning with support/coaching from HRBP's	First available meeting after 7th December 2023
Operations Teams B	As for Operations Teams A, plus: Promoting plan to Teams C and wider Operations colleagues	As for HR Senior Management Team. Strategic awareness. Engagement with Teams C Raising awareness Operational leadership as ambassadors	Presentation at Teams B Self-Learning with support/coaching from HRBP's Through Teams C	First available meeting post Teams A

Communication Plan (continued)

Stakeholder Group	Objects (Actions Desired)	Message Content	Delivery Method / Venue	By Whom? / By When?
Operations Teams C	Awareness of the retention plan and its content. Understanding their role in the delivery of the plan. Understanding the impact of the plan on Operations retention. Promoting plan to Operations colleagues	As for HR Senior Management Team. Strategic awareness. Engagement with Operations colleagues Raising awareness	Cascade via Teams A	First available meeting post Teams B
Union JPF	Awareness of the finalised plan and its content. Understanding their role in the delivery of the plan. Understanding the impact of the plans on the Trust. Promoting plan to members	Raising awareness	Union JPF	December 2023
Communications Team	Promoting plan on the Zone	Raising awareness	Via the Zone	December 2023

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Life at SECAmb Now

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A Brighter Future Ahead

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	65-23

Name of meeting	Trust Board
Date	07.12.2023
Name of paper	Rewarding & Recognising Our People
Executive sponsor	Simon Weldon, Chief Executive
Author name and role	Janine Compton, Head of Communications

Our *People & Culture Strategy 2023-25* reflects our ambition as a Trust to create an inclusive culture and working environment where all of us can feel safe, healthy, recognised for what we do and positive and proud to be part of the SECAmb team.

We know currently that:

- The majority of our people don't feel recognised for good work or feel valued by the Trust
- Some of our existing recognition mechanisms, like the Staff Awards, are really popular but people don't feel there are on-going opportunities for recognition throughout the year
- Our managers want to be able to do more locally to recognise their teams

The proposed Integrated Recognition Framework provides a range of mechanisms through which we can reward and recognise our people, and which are:

- Available and on-going throughout the year, providing regular opportunities for recognition
- Accessible to all staff and volunteers, regardless of role or location
- Transparent and evidence-based and
- Measurable in terms of output and impact

Recommendations, decisions or actions sought	The Board is asked to support this approach

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Rewarding & Recognising Our People

What we know

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Only a third of our people feel they are recognised for good work

Only a fifth of our people feel the Trust values their work

Staff who attend really love the Annual Awards

Support services staff often feel overlooked for recognition

Our Christmas Stars initiative is really popular – but only happens once a year!

Our managers want to be able to do more to recognise their teams locally

People don't feel there are on-going opportunities for recognition throughout the year

People feel we don't properly recognise those who are retiring

We need to do more to recognise education and academic achievements

The Strategic framework

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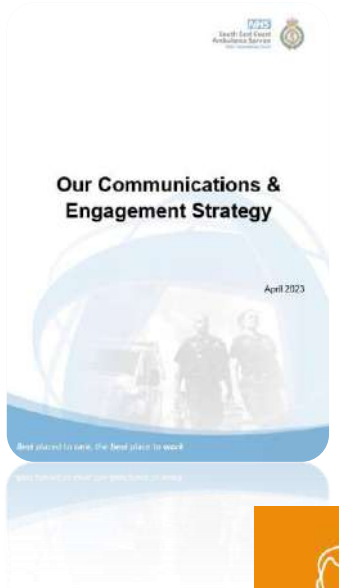
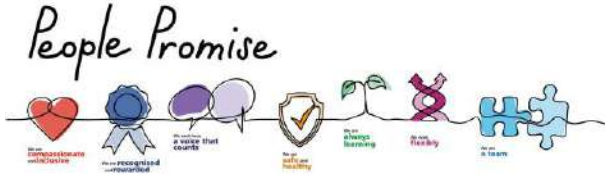


NHS England



Shaping the future of *our service* for *our people* and *our patients*

An Integrated Recognition Framework

NHS
South East Coast Ambulance Service
NHS Foundation Trust

- ONLINE REWARD & RECOGNITION PLATFORM
- ANNUAL AWARDS
- MONTHLY SPOTLIGHT AWARD
- CHRISTMAS STARS
- RETIREMENT RECOGNITION
- END OF COURSE/ACADEMIC ACHIEVEMENT RECOGNITION
- OTHER INITIATIVES

That is:

- Available and on-going throughout the year, providing regular opportunities for recognition
- Accessible to all staff and volunteers, regardless of role or location
- Transparent and evidence-based
- Measurable in terms of output and impact

The Star Zone

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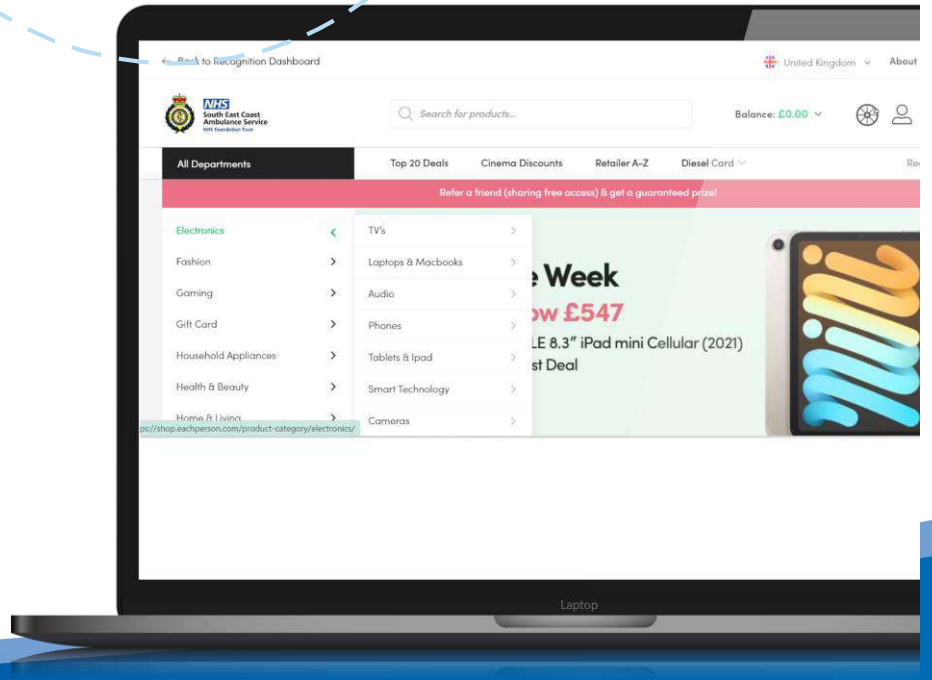
NHS Foundation Trust

Launching in January 2024!

- An **online Reward & Recognition Platform** that allows for peer-to-peer recognition through a social feed and the use of customisable e-cards which will support the values/achievements we want to prioritise.
- The platform also allows managers and leaders to praise and financially reward colleagues within a set framework and **we're investing £150,000 into a 'rewards pot'** to fund this.
- These financial rewards can be spent through the reward and recognition platform's extensive catalogue of outlets including high street retailers and Amazon as well as discounts on everyday items such as fuel.
- We're working with a national partner to deliver the new platform and are delighted that we will be **the first ambulance Trust** to introduce it.



‘Spotlight’ Award

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- A new **monthly recognition award**, open to nominations from all staff and volunteers for those colleagues who they feel need recognition
- Submission will be made by our people, based on our Trust values and a small virtual panel will pick a winner each month
- The winner will be announced on the last day of the month and receive a £50 voucher through the Star Zone.

Improved recognition for our people who are retiring

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Introduce an improved and consistent approach to include:

- An improved range of ‘gifts’ that colleagues can choose from
- A farewell/thank you letter from the Chief Executive
- An invitation to meet with the Chief Executive/Chair on an individual/group basis

Improved recognition of course completion/academic achievements:

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Introduce a standardised approach to include:

- Consistent internal and external promotion of all achievements via all our social media channels
- Improved senior leadership recognition of achievements e.g. by attending course presentations, relevant Exec leads writing to colleagues involved
- Two ‘graduation’ ceremonies per year to which all relevant colleagues are invited
- Corporate recognition with a letter from the Chief Executive and a small gift

SECAmb Stars Awards

- Celebratory events which recognise the long service and outstanding achievements of our people at three, county-based events held each year.
- Nominations for Commendations are values-based and are judged ‘blind’ by a panel of colleagues from across the organisation, with recommendations made to the Chief Executive for final approval.
- We also recognise the long service of our colleagues (20-, 30- and 40-year awards) and of our volunteers (10 and 20 years)

Christmas Stars

- A popular seasonal initiative which provides an opportunity for informal peer to peer recognition during December.
- Colleagues submit a short nomination for a ‘Star’ to appear each day of the month.
- Out of all the ‘Stars’ featured winners are picked out of a hat on Christmas Eve who each receive a (donated) prize.

Other

A range of other ways in which colleagues can be recognised:

- ‘Compliment of the month’ – managed through the Star Zone, with the winner receiving a voucher
- ‘Hello’ to new starters – welcome email/card from Chief Executive
- Pin badges to mark different years of service from five years upwards (10, 15 & 20 years)
- Existing local recognition initiatives e.g. EOC badges/existing volunteer recognition
- External awards – utilise outputs of other mechanisms to create a database of potential nominees for:
  - AACE Annual Award
  - Nominations for Royal Garden Parties
  - Nominations for Kings Ambulance Medal

How will we measure the impact?

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South East Coast Ambulance Service
NHS Foundation Trust

- ✓Through the Staff Survey & Pulse Survey scores
- ✓Through feedback from our people
- ✓Through Leadership visits
- ✓Though feedback from trade unions
- ✓Through use of the Star Zone
- ✓Through the numbers of nominations – annual awards, Christmas Stars, spotlight of the month

South East Coast Ambulance Service
NHS Foundation Trust

Item No	65-23

Name of meeting	Trust Board
Date	7th December 2023
Name of paper	Sexual Safety in Healthcare: organisational charter
Executive sponsor	Margaret Dalziel, Executive Director Quality & Nursing (interim)
Author name and role	Margaret Dalziel, Executive Director Quality & Nursing (interim)
Synopsis	On 4 September 2023, NHSE launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. The charter is an agreement with 10 pledges, to address sexual misconduct in healthcare through clear reporting mechanisms, training and support. All trusts, integrated care boards (ICBs) and Royal Colleges are being urged to become signatories to this charter. In addition, every NHS trust and local health system in England will also have a is expected to have a named Executive Lead for Domestic Abuse and Sexual Violence, and an operational lead to support patients and staff to report incidents and access support. Signatories commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate, and or/harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected all ten commitments will be implemented by July 2024. The Executive Lead for Domestic Abuse and Sexual Violence is Margaret Dalziel, Director for Q&N, and the joint operational leads are Yvette Bryan, (sexual safety) and Gareth Knowles (domestic abuse).
Recommendations, decisions or actions sought	The Board is asked to **AGREE** to become a signatory to the charter, with a view to have all the principles in place by July 2024.

Sexual safety in healthcare – organisational charter

Introduction

Over the past months there has been extensive media coverage and high-profile reports around sexual violence across all sectors including the NHS, an issue arguably embedded culturally in our society with women, LGBT+ and Black, Asian and minority groups disproportionately affected. It is becoming increasingly evident that the NHS needs to take further action to better understand and address this issue, including taking prompt action against perpetrators regardless of their role, and adopting a zero-tolerance approach to sexual misconduct and violence to keep our patients and staff safe.

In response to this growing body of evidence, on 4 September 2023 NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system including clinical experts and those with lived experience. The charter is an agreement with 10 pledges, to address sexual misconduct in healthcare through clear reporting mechanisms, training, and support. It is expected all ten commitments will be implemented by July 2024.

Data capture is a key commitment in the charter. To help the NHS have a clearer understanding and view of the prevalence of sexual misconduct in each organisation and inform policies in this areas, NHS England has included a new question in the NHS Staff Survey which is now live:

> *'In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault.'*

All trusts, integrated care boards (ICBs) and Royal Colleges are being urged to become signatories to this charter. In addition, every NHS trust and local health system in England will also have a named Executive Lead and an Operational Lead for Domestic Abuse and Sexual Violence, to support patients and staff to report incidents and access support.

Signatories of the charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate, and or/harmful sexual behaviours within the workplace, and to the ten core principles and actions to help achieve this.

The Sexual Safety Charter

Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.

Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.

We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.

3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.

4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.

5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.

6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.

7. We will ensure appropriate, specific, and clear training is in place.

8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.

9. We will take all reports seriously and appropriate and timely action will be taken in all cases.

10. We will capture and share data on prevalence and staff experience transparently.

These commitments will apply to everyone in our organisation equally.

Where any of the above is not currently in place, we commit to work towards ensuring it is in place by **July 2024.**

Implementation of the charter

NHS England have cascaded a toolkit with information for teams to support conversations in relation to sexual safety in the workplace and are creating gold-standard policies and support to use to address this issue. It is suggested thy will also provide extra training for managers to improve awareness and ensure allegations are appropriately investigated.

The network of NHS DASV leads across the system will be used by NHSE to help share and promote good practice, identify issues, and develop practicable solutions in relation to implementation of the charter. The Executive Lead for Domestic Abuse and Sexual Violence for SECAmb is Margaret Dalziel, Director for Q&N, and the joint operational leads are Yvette Bryan, (sexual safety) and Gareth Knowles (domestic abuse).

At SECAmb the Exec Lead for DASV has set up a Task group drawing together the leads of the current sexual safety programme, the Trust-wide culture programme, Safeguarding lead, FTSU, professional standards, communications and other key staff. Progress so far includes scoping what is in place already for Domestic Abuse and Sexual Violence within the trust, undertaking a full gap analysis of the sexual safety charter that will inform an action plan and the focus of work going forwards to meet the July 2024 deadline, and networking with other organisations and ambulance trusts who are further on in their journey who have willingly shared resources with us such as the staff charters used by LAS and WMAS (Appendix 2).

Recommendation

The Board is asked to join the other 155 NHS Trusts in becoming a signatory to the Sexual Safety charter, supporting and tasking the Executives to implement the 10 commitments by July 2024.

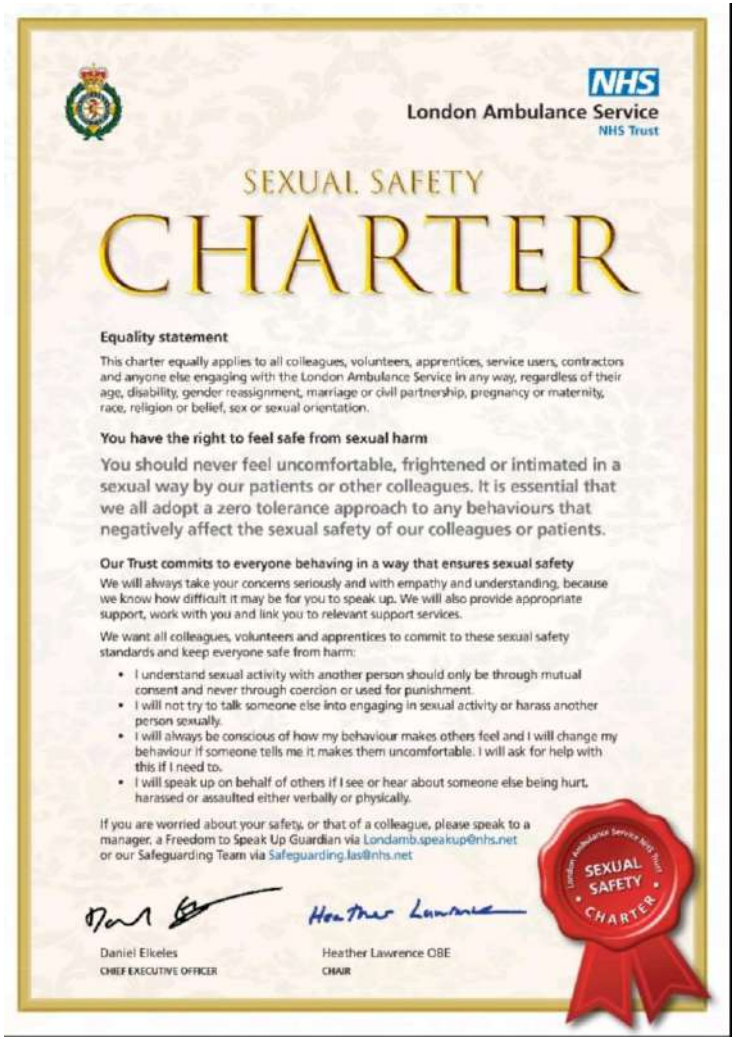
Appendix 1: Organisations that have signed the Sexual Safety charter up to 10th Nov 2023

1. Absolute Care Homes (Central) Limited
2. Alder Hey Children's NHS Foundation Trust
3. Allied Health Professionals Suffolk, Community Interest Company
4. Association of Ambulance Chief Executives
5. Association of Anaesthetists
6. Barts Health NHS Trust
7. Berkshire Healthcare NHS Foundation Trust
8. Black Country Health Care Foundation Trust
9. Black Country Integrated Care Board
10. Blackpool Teaching Hospitals
11. Bradford District Care NHS Foundation Trust
12. Bridgewater Community Healthcare
13. British and Irish Orthoptic Society
14. British Dietetic Association
15. Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board
16. Calderdale and Huddersfield NHS Foundation Trust
17. Cambridgeshire Community Services NHS Trust
18. Central London Community Healthcare NHS Trust
19. CHEC
20. Circle Health Group
21. College of Operating Department Practitioners
22. County Durham and Darlington NHS Foundation Trust
23. Coventry and Warwickshire Integrated Care Board
24. Coventry and Warwickshire Partnership NHS Trust
25. Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust
26. Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
27. Dorset County Hospital NHS Foundation Trust
28. Dorset Healthcare University NHS Trust
29. Dudley Integrated Health and Care NHS Trust
30. East Cheshire NHS Trust
31. East Kent Hospital NHS Foundation Trust
32. East Lancashire Hospitals NHS Trust
33. East London NHS Foundation Trust
34. East of England Ambulance Service NHS Trust
35. Epsom and St Helier University Hospitals Foundation Trust
36. Faculty of Intensive Care Medicine – Member of Academy of Medical Royal Colleges
37. First Community Health and Care
38. Frimley Heath NHS Foundation Trust
39. Gateshead NHS Foundation Trust
40. George Eliot NHS Trust
41. Great Ormond Street Hospital
42. Hampshire Hospitals NHS Foundation Trust
43. Harrogate and District NHS Foundation Trust
44. Health Services Safety Investigations Body
45. Hertfordshire Partnership NHS Trust
46. HomeLink Healthcare
47. Horder Healthcare
48. Humber Teaching NHS Foundation Trust
49. Independent Healthcare Providers Network
50. Kent and Medway NHS and Social Care Partnership Trust
51. Kettering General Hospital NHS Foundation Trust

52. Leeds and York Partnership NHS Foundation Trust
53. Leicestershire Partnership NHS Trust
54. Lewisham and Greenwich NHS Trust
55. Lincolnshire Integrated Care Board
56. Lincolnshire Partnership NHS Foundation Trust
57. Liverpool Women's NHS Foundation Trust
58. London Ambulance Service NHS Trust
59. London North West University Healthcare NHS Trust
60. Manchester University NHS Foundation Trust
61. Medway Community Healthcare
62. Mersey and West Lancashire Teaching Hospitals NHS Trust
63. Mersey Care NHS Foundation Trust
64. Mid Yorkshire Teaching NHS Trust
65. Newcastle upon Tyne Hospitals NHS Foundation Trust
66. NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board
67. NHS Dorset
68. NHS Employers
69. NHS England
70. NHS North East London Integrated Care Board
71. NHS Somerset Integrated Care Board
72. NHS South East London Integrated Care Board
73. NHS West Yorkshire Integrated Care Board
74. North Bristol NHS Trust
75. North Cumbria Integrated Care NHS Foundation Trust
76. North East Ambulance Service
77. North East and North Cumbria Integrated Care Board
78. North East London NHS Foundation Trust
79. North Tees and Hartlepool NHS Foundation Trust
80. North West Anglia NHS Foundation Trust
81. Northampton General Hospital
82. Northamptonshire Healthcare NHS Foundation Trust
83. Northern Care Alliance NHS Foundation Trust
84. Northumbria Healthcare NHS Foundation Trust
85. Nottingham and Nottinghamshire Integrated Care Board
86. Oxford Health Foundation Trust
87. Oxford University Hospitals
88. Pennine Care NHS Foundation Trust
89. Queen Elizabeth Hospital
90. Rotherham, Doncaster and South Humber NHS Foundation Trust
91. Royal College of Anaesthetists
92. Royal College of General Practitioners
93. Royal College of Nursing
94. Royal College of Obstetricians and Gynaecologists
95. Royal College of Ophthalmologists
96. Royal College of Paediatrics and Child Health
97. Royal College of Physicians
98. Royal College of Physicians of Edinburgh
99. Royal College of Podiatry
100. Royal College of Psychiatrists
101. Royal College of Radiologists
102. Royal College of Surgeons of England
103. Royal Cornwall Hospital Trust
104. Royal National Orthopaedic Hospital
105. Royal Surrey NHS Foundation Trust
106. Royal United Hospitals Bath NHS Foundation Trust

107. Sandwell and West Birmingham NHS Trust
108. Sheffield Health and Social Care NHS Foundation Trust
109. Sheffield Teaching Hospitals
110. Shropshire, Telford, and Wrekin Integrated Care Board
111. Solent NHS Trust
112. Somerset NHS Foundation Trust
113. South Central Ambulance Service
114. South Tees Hospitals NHS Foundation Trust
115. South Tyneside and Sunderland NHS Foundation Trust
116. South Warwickshire NHS Foundation Trust
117. South West Yorkshire Partnership NHS Foundation Trust
118. South Western Ambulance Service Foundation Trust
119. South Yorkshire Integrated Care Board
120. Southwest London and St George's Mental Health NHS Trust
121. Spencer Private Hospitals Limited
122. Spire Healthcare Limited
123. St George's University Hospitals NHS Foundation Trust
124. Staffordshire and Stoke-on-Trent Integrated Care Board
125. Suffolk and North East Essex Integrated Care Board
126. Sussex Community NHS Foundation Trust
127. Sussex Partnership NHS Foundation Trust
128. Tees Esk and Wear NHS Foundation Trust
129. The Christie NHS Foundation Trust
130. The Dudley Group NHS Foundation Trust
131. The Faculty of Public Health
132. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Trust
133. The Royal College of Surgeons of Edinburgh
134. The Royal Orthopaedic Hospital NHS Foundation Trust
135. The Royal Wolverhampton NHS Trust
136. The Shrewsbury and Telford NHS Trust
137. The Society of Radiographers
138. The Tavistock and Portman NHS Foundation Trust
139. The University of Manchester (Faculty of Biology, Medicine and Health)
140. The Walton Centre NHS Foundation Trust
141. Tower Hamlets GP Care Group Community Interest Company
142. University College Hospitals London
143. University Hospital Dorset
144. University Hospital Plymouth NHS Trust
145. University Hospital Southampton
146. University Hospitals Birmingham NHS Foundation Trust
147. University Hospitals Coventry and Warwickshire NHS Trust
148. University Hospitals of Derby and Burton NHS Foundation Trust
149. University Hospitals of Leicester NHS Trust
150. University Hospitals Sussex NHS Foundation Trust
151. Vascular Society of Great Britain and Ireland
152. Walsall Healthcare NHS Trust
153. West Midlands Ambulance Service University NHS Foundation Trust
154. York and Scarborough Teaching Hospitals NHS Foundation Trust
155. Yorkshire Ambulance Service

Appendix 2: Examples of LAS and WMAS Staff Charter



NHS
London Ambulance Service
NHS Trust

SEXUAL SAFETY
CHARTER

Equality statement

This charter equally applies to all colleagues, volunteers, apprentices, service users, contractors and anyone else engaging with the London Ambulance Service in any way, regardless of their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation.

You have the right to feel safe from sexual harm

You should never feel uncomfortable, frightened or intimated in a sexual way by our patients or other colleagues. It is essential that we all adopt a zero tolerance approach to any behaviours that negatively affect the sexual safety of our colleagues or patients.

Our Trust commits to everyone behaving in a way that ensures sexual safety

We will always take your concerns seriously and with empathy and understanding, because we know how difficult it may be for you to speak up. We will also provide appropriate support, work with you and link you to relevant support services.

We want all colleagues, volunteers and apprentices to commit to these sexual safety standards and keep everyone safe from harm:

- I understand sexual activity with another person should only be through mutual consent and never through coercion or used for punishment.
- I will not try to talk someone else into engaging in sexual activity or harass another person sexually.
- I will always be conscious of how my behaviour makes others feel and I will change my behaviour if someone tells me it makes them uncomfortable. I will ask for help with this if I need to.
- I will speak up on behalf of others if I see or hear about someone else being hurt, harassed or assaulted either verbally or physically.

If you are worried about your safety, or that of a colleague, please speak to a manager, a Freedom to Speak Up Guardian via Londamb.speakup@nhs.net or our Safeguarding Team via Safeguarding.las@nhs.net

SEXUAL SAFETY CHARTER

Daniel Elkeles
CHIEF EXECUTIVE OFFICER

Heather Lawrence OBE
CHAIR

NHS
West Midlands Ambulance Service
University NHS Foundation Trust

Sexual Safety Charter

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If you are worried about your safety, or that of a colleague, please speak to a manager, a Freedom to Speak Up Guardian or our Safeguarding Team via safeguarding@wmas.nhs.uk.

Trust us to care.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	65-23

Name of meeting	Trust Board
Date	7 December 2023
Name of paper	People Committee Escalation Report – November 2023
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 09.11.2023 and confirms whether any matters require specific intervention by the Trust Board.

Item	**Link to BAF**
Before the main part of the meeting started the executive updated the committee on the positive progress with the **ACAS Mediation.** Management and Trade Unions are developing a joint action plan and the Joint Partnership Forum is now re-established. The committee also heard about the **Leadership Visits** and the overlap with the Quality Assurance Visits to ensure a more integrated process. People do welcome the engagement and opportunity to talk to leaders and so this needs to be used to hear about the issues affected our people.	
Retention Plan	P&C Goals 1-3 Risks 13, 14, 255 and 348.
The committee supports the plan which is scheduled for Board in December. Some feedback included ensuring more focus on the actions (not too many) and clarity on how we will assess the impact. The primary focus of the plan must resonate with people in terms of making SECAmb a better place to work. The committee also supported a dynamic plan, learning from the past where the plans have been too rigid.	
Response to Staff Survey / Feedback	P&C Objective 1- Respond to issues raised in Staff survey and recent reviews (housekeeping) Risk 348 – Culture & Leadership
53 of 111 actions are complete. The committee challenged progress with some of the actions still outstanding. An update will be provided next time on progress with some of the key HR policies, following the ACAS mediation and re-establishment of JPF. The committee reviewed the development of a new culture dashboard, linked to the aims of the People & Culture strategy. This is a good example of cross directorate working and plans to go live in Q4.	
Rapid Onboarding	P&C Objective 3 – Rapid Onboarding QI Project
The level of understanding on recruitment practices is improving and the benefits of the QI project are starting to come through. There are regular joint recruitment meetings, between operations and HR helping	

to keep this objective on track. This has seen an overall reduction, however, time to hire is still too high at 109 days. The QI project is helping to further streamline our processes.

The committee has pushed for a clearer target and trajectory to help assess the changes made and their impact. This will help assurance that we are implementing the right interventions. The executive confirmed that a reasonable target is 56-63 days (8-9 weeks).

Training for Managers	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 Risk 348 – Culture & Leadership

There are good levels of compliance with the training in place. 97% for sexual safety training; the committee challenged the need for 100%. 60% of the cohorts for first line managers and this is on track to deliver all 29 cohorts. The feedback from this training has been positive.

The committee noted a slight increase in cases of bullying and harassment, but small numbers in sexual safety. The current plan is to deliver awareness days that focus on bullying and harassment and sexual misconduct and this is in line with the timetable and is a key mitigation to the BAF risk.

It is too early to measure the impact of the Building a Kinder SECAmb Workshops but the monitoring of cases and feedback via mechanisms such as the annual staff survey will inform whether there has been a positive impact on the organisation.

Appraisals	P&C Objective 5 Supporting our leaders completing appraisals by actively removing blockers. Risk 348 – Culture & Leadership

The committee expressed concern about progress and the need to better explain the reporting issues, with a sense that the position might be slightly better than is recorded. That said, the executive confirmed that notwithstanding the recording issues, it is unlikely we will meet the 85% target until Q1 2024/25.

The committee reinforced the importance of appraisals as a key plank in how we will shift the culture in SECAmb, and also the accountability for both the appraiser and appraisee. It explored the reasons and was not assured by the clarity provided by the executive. This is simply about having conversations with your manager and so we need to make it simpler to achieve.

The committee also noted the lack of confidence in the data, which is not good enough. Before formally escalating to the Board is has asked for greater clarity at the next meeting in January, with more robust analysis of the issues and how they will be resolved.

Employee Relations / Management Essentials	PC Objective 9 Improve capacity and capability of our formal processes (ER and FTSU) PC Objective 11 Management essentials to be rolled out (building on Fundamentals)

The newly formed team in place is having a positive impact. With the support of unions half of grievances are now resolved informally which is significant change. There were 120 live cases last year compared to between 60-70 now. The team is closing cases more promptly too.

The executive has agreed with unions an MDT process for disciplinary cases to manage them in a more constructive way. Overall, the data is showing definite improvement.

In addition to the discussion earlier on management essentials, the committee noted the progress in the development of a comprehensive annual training plan for all staff, operational and support. Most of the content is now established (some further workshops planned) and this will be drawn into a full plan, to include how it will be delivered. This approach is commended as few do it in this complete way. The committee acknowledged the inclusive approach to engaging staff in the development of the plan to help capture the right areas of training.

Workforce Plan	S&P Objective 5 We will give our managers the time to prioritise 1:1s. Risk 255 – Workforce Plan

A helpful paper written jointly by the director of strategy and director of HR was considered, setting out how we are engaging the system on a joint workforce plan, linked to the development of our new strategy. Despite some challenges we are on track to develop model of care and high-level workforce plan which will be a key enabler of the strategy.

Annual Reports	

The committee received two reports.

Annual Wellbeing Report - Linked to the retention plan there is lots of wellbeing support on offer to our people, more than most but we can do more to promote it internally. The report linked the risks and how our actions are aiming to address them. The committee is assured by our wellbeing offering.

Equality Action Plan - The Equality Action Plan for 2023-2024 was concluded and ratified in June 2023, after an extensive and inclusive engagement process with key stakeholders. This year's action plan encapsulates our adherence to several legislative standards, specifically, the Workforce Race Equality Standards (WRES), the Workforce Disability Equality Standards (WDES), the measures addressing the gender pay gap, and the Equality Delivery System (EDS) for 2022. A fundamental imperative in shaping the action plan was ensuring its link with the overarching NHS England Equality, Diversity, and Inclusion (EDI) Improvement Plan.

The committee is assured by the progress with the actions, some of which are integrated such as the P&C strategy. We have launched the BME development programme, as reported to the Board in October, which now has a waiting list. Reverse mentorship is due to be launched in April 2024, focused on under-represented groups. And progress is being made with the reasonable adjustment process.

Specific Escalation(s) for Board Action	The meeting generally was constructive. However, there are a few things for the Board to note: 1. The paper on EOC Culture paper was not received. 2. We need to ensure data presented, e.g. appraisals, is accurate so we have right discussion. 3. Papers continue to improve and are significantly better than this time last year. However, there could be further improvement in drawing a clearer link between risk and assurance, and on the mitigating actions being taken. 4. The committee will be pushing the executive to focus less on developing plans, and more on how we are testing their impact / outcomes.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	66-23

Name of meeting	Trust Board
Date	7 Dec 2023
Name of paper	Operational Performance & Efficiency
Strategic Theme	**Responsive Care**
Author / Lead Director	Emma Williams, Executive Director of Operations

Executive Summary

Overview

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

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

Primary areas of focus:

- Call answering performance.
  Whilst October shows improvement in overall performance, SECAmb remains an outlier. Several additional actions have been implemented as per the report presented at the Trust board in October with particular focus on planned call taking support from WMAS, targeted incentivised shifts and two big recruitment events.
- C2 mean performance.
  SECAmb remains on track to deliver a 30min C2 mean performance – currently the only ambulance service predicting to do so. This is strongly influenced by the improved resourcing in field operations and strong hospital handover performance across the region.
- Dispatch improvements.
  Completion of phase of the dispatch improvement programme is complete, focusing on updating processes and improving consistency. The 'perfect month' that has been run during November on the Ashford Dispatch Desk – one of the areas of focus is improved dispatch/tasking of resources.
- Other ARP performance.
  Overall other ARP metrics have improved in October in both absolutely times as well as relatively to other ambulance services. However it is recognised that C1 performance continues to be significantly off target – the BI team are supporting analysis of the data to provide a greater understanding of this performance.

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

- Hear and treat outcomes.
  The delivery of hear and treat outcomes continues to meet the planned trajectory through a range of actions including C2 segmentation, C3/C4 revalidation and collaborative working with

local Urgent Care Response services across all ICBs.

- Continued working on national programmes.
  Current focus is on working up a full business case to cover all recommendations for ambulance services across England. This is due for presentation to regional ICB commissioners in early 2024.
- Improved utilisation of clinical resources.
  Recent collaborative working across the Operations, Medical and Quality & Nursing Directorates to focus on the improved tasking/utilisation of specialist resources through specific agreed actions.

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

- Late shift over-runs and on-day out-of-service
  Whilst progress on LSOs has been demonstrated since the start of 2023 via two papers to the Performance Committee, work on lost hours due to on-day out-of-service reasons has stalled due to capacity and conflicting priorities at this time.
- Integration of services at the new Medway site
  This workstream is now fully complete.

Resilience & Specialist Operations

- NARU report response.
  NARU undertook a review of 42 KLOE's relating to interoperability standards, with the findings showing that significant actions need to be undertaken to improve the compliance against this standards – this item is covered separately on the Trust Board agenda.
- HART staffing compliance
  In October, only on 4 days did HART achieve 24 staff on duty, however on 23 days 20 or more staff were on duty across each day.
- SORT staffing compliance
  SORT staffing continues to deliver strongly with 29 days in October meeting the KLOE of having a minimum of 35 staff on duty between 06:00 and 02:00 each day.

111

- Contract performance
  111 performance remains stable but still significantly under the contract levels for call answering and abandonment rate. Outcomes are strong in 111 with nationally some of the strongest performance for both conversion to 999 and direct booking into ED.

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

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	66-23

Name of meeting	EMB & Trust Board
Date	December 2023
Name of paper	2023/24 Winter Plan
Responsible Executive	Emma Williams, Executive Director of Operations

Each year, NHS providers are required to produce a winter plan that outlines the response to the Winter period. The initial version of this plan was published in October as version 1.0 as a live document, with the recognition that it would alter as more information and intelligence became available.

Following Exercise Boreas (a winter tabletop exercise) the plan has now been updated and is in the process of being further reviewed. The current version (1.2) has had the following alterations:

- Updated EOC element with revised expectations and more details on leadership and clinical expectations.
- Included several lessons that have been identified from Exercise Boreas
- Included the strategy and planning departments updated slides.

The revised live document version 1.2 will be further revised following further discussions with NHSE and will include the latest winter operating model.

Recommendations, decisions or actions sought	For Assurance

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

SECAmb Winter Plan 2023-24

v1.2 30/11/23

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

Contents

1a. Context: Regional

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

1b. Context: Trust

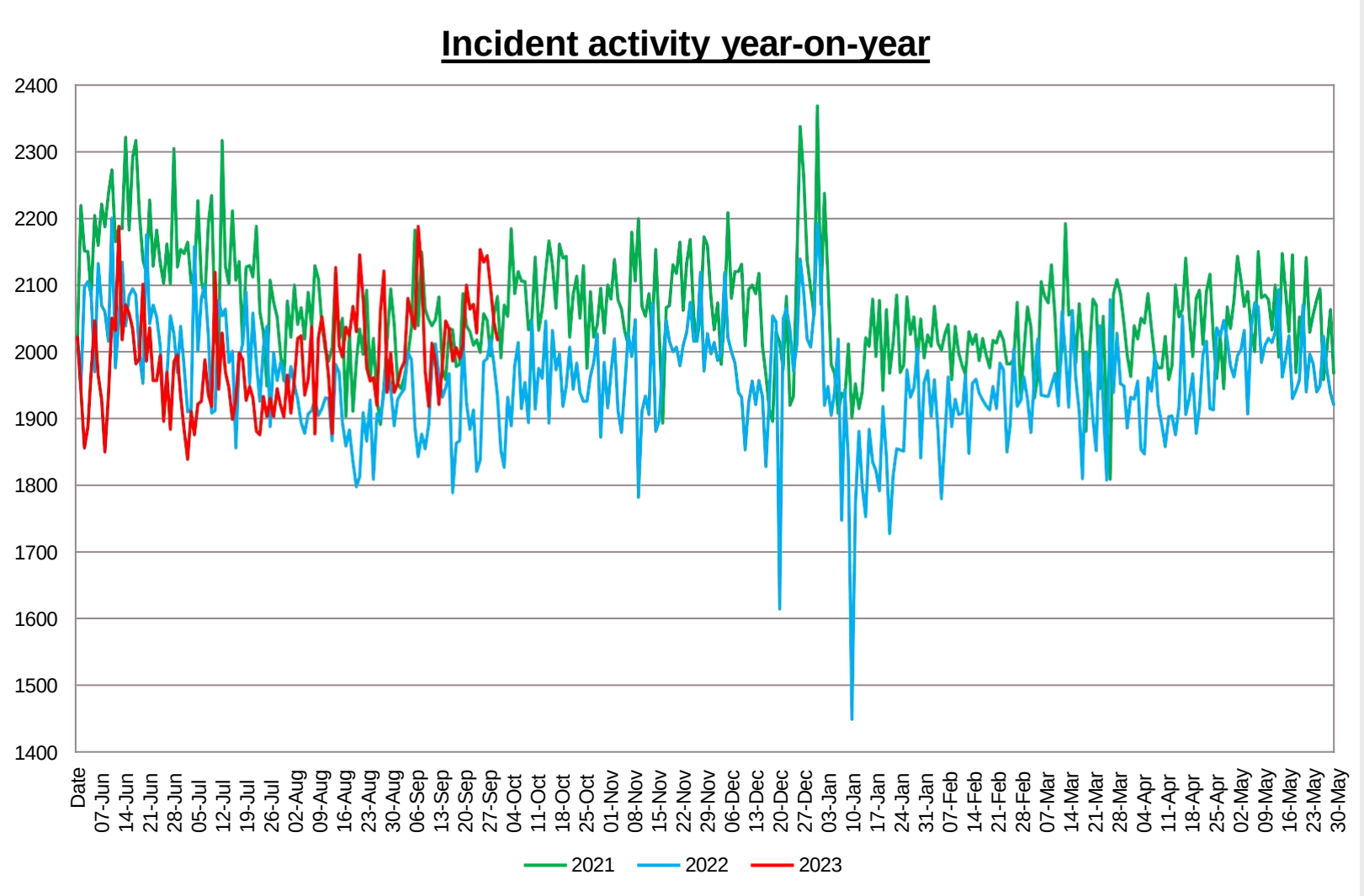
- The Trust is currently not meeting ARP performance standards for either the previous month or YTD. NHSE have stipulated that there are 2 priority metrics for 2023-24:
  1. Call answering mean – SECAmb is significantly off track for this metric. A full review and comprehensive suite of additional actions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

2. Learnings from winter 2022-23

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

3. Year on year activity

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



4. Objectives

999 Objectives

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

111 Objectives

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

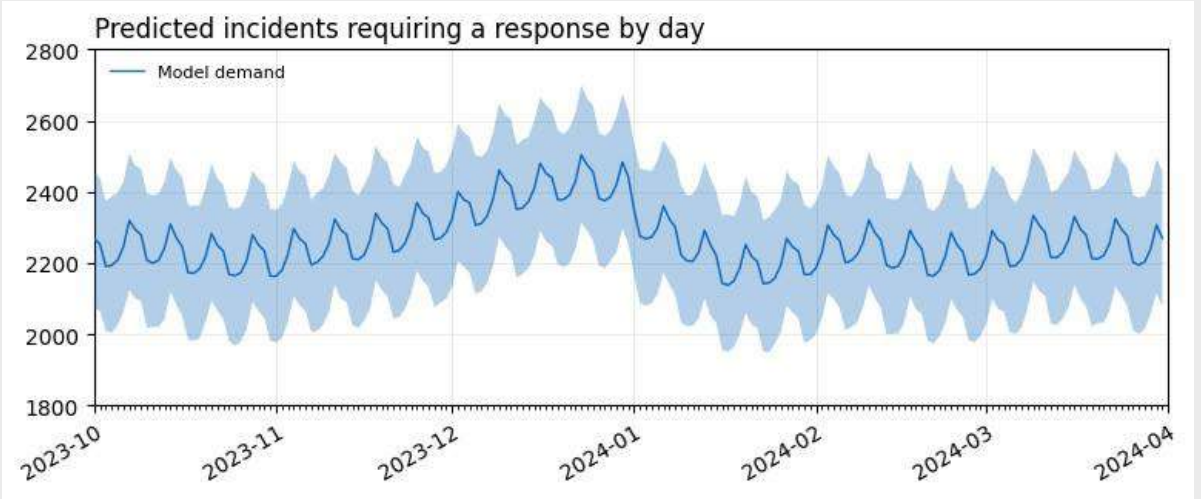
Staff Welfare Objectives

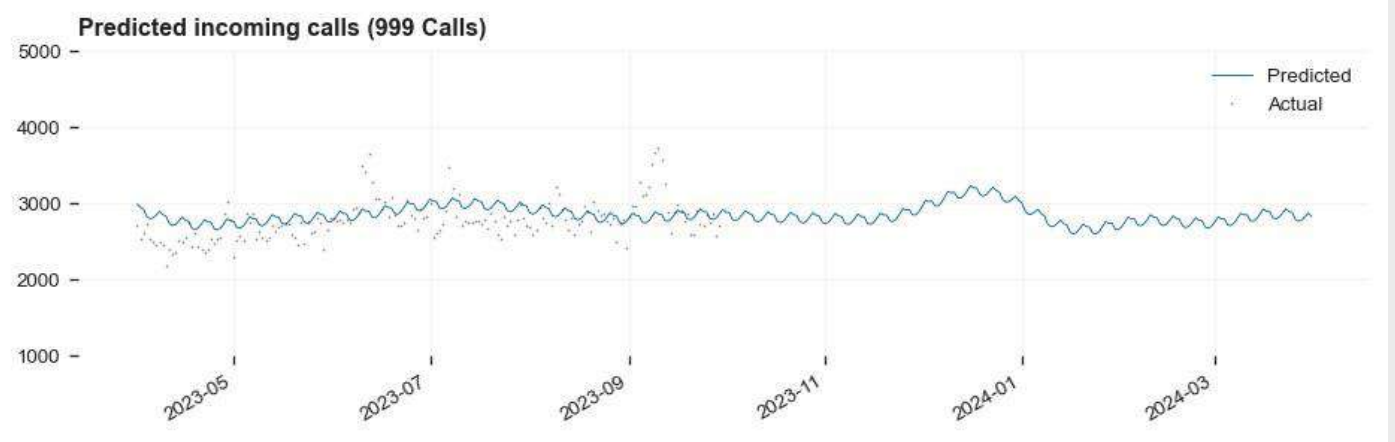
- Monitoring of meal break compliance.
- Continued improvements in late sign off.
- Christmas period additional welfare support.

5a. Winter '23-'24 – 999 Predicted Activity

- Demand for field operations is expected to increase 10% across December, following pre-covid winter trends, with a decline back to normal demand volumes in January.

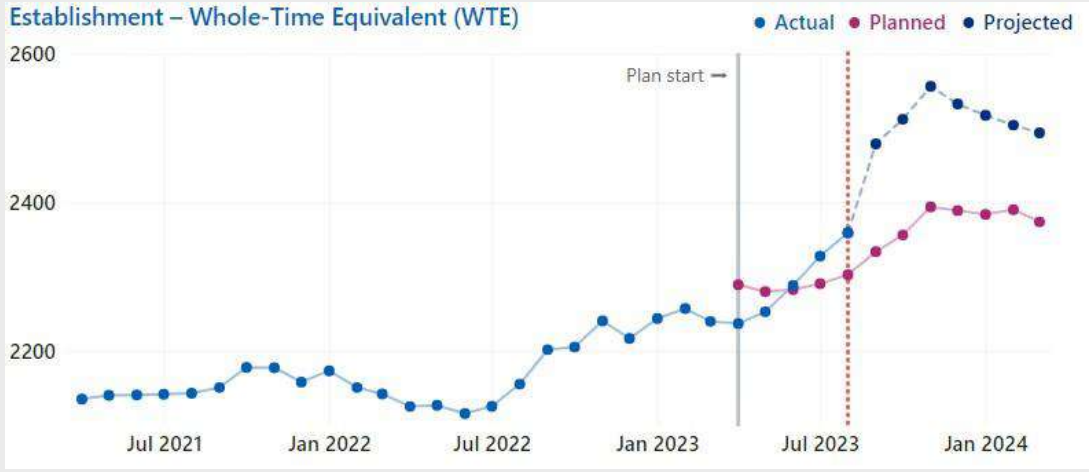
- 999 Call volumes are expected to be slightly below 22/23 periods due to the significantly improved C2 mean position the Trust is in, reducing the duplicate call volume received.

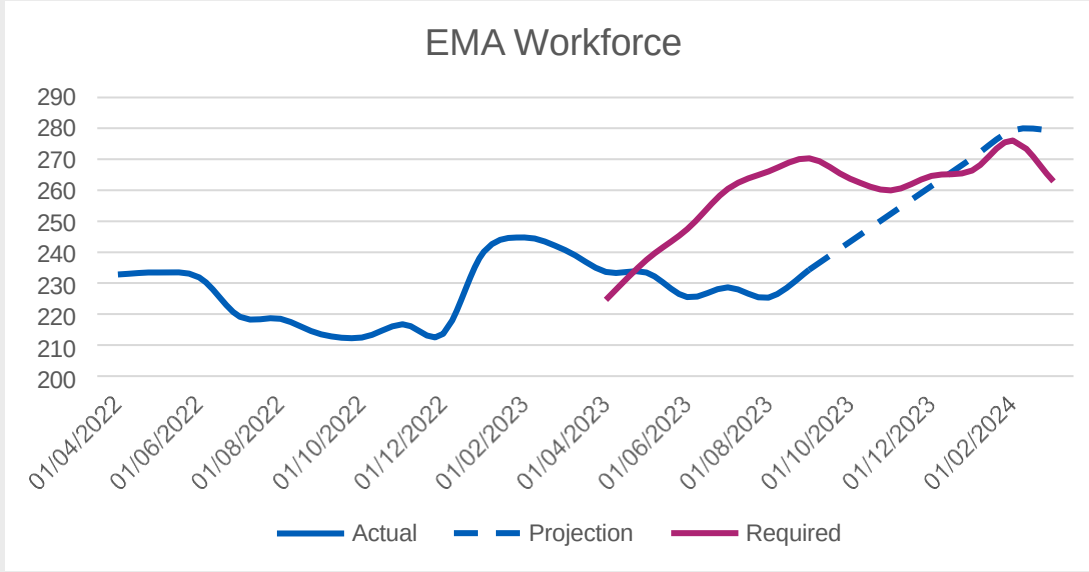




5b. Winter '23-'24 – 999 Predicted Resourcing

- Whilst it is too early to know the resources planned across the winter period, the workforce plans for each staff group provide a useful overview of expected capacity.
- Field operations are in a strong position and are currently 50 WTE ahead of the plan, with this expected to continue throughout winter. This will provide additional resilience through the winter period and reduce the reliance on overtime.
- EMA recruitment has been challenging and is currently 18% down on the planned workforce levels. Since the move to the new EOC, it is anticipated that the EMA workforce will grow by a net 9 WTE each month, and reach planned levels by December 2023.

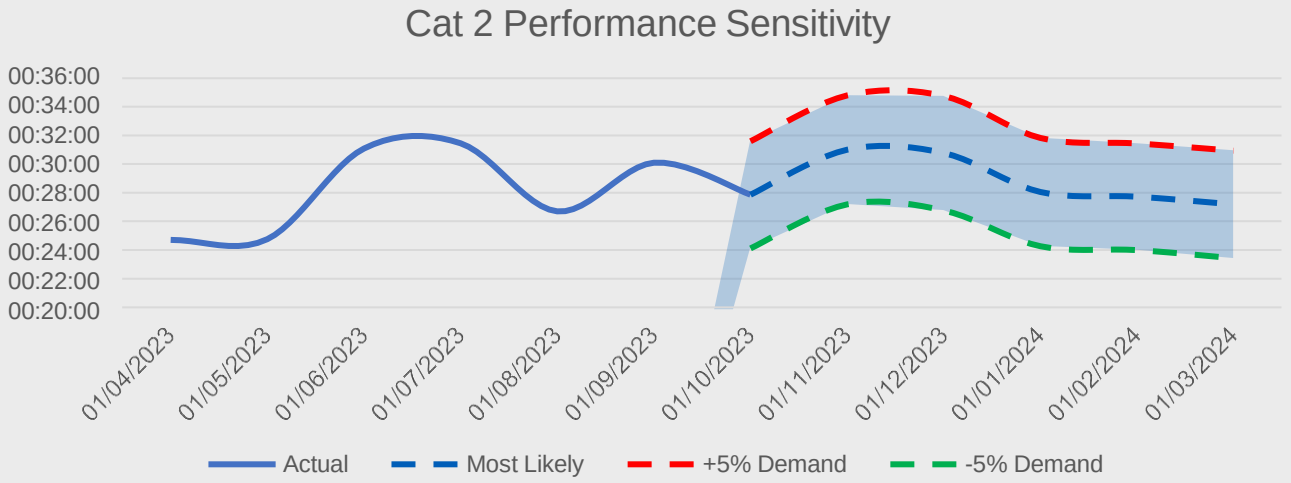


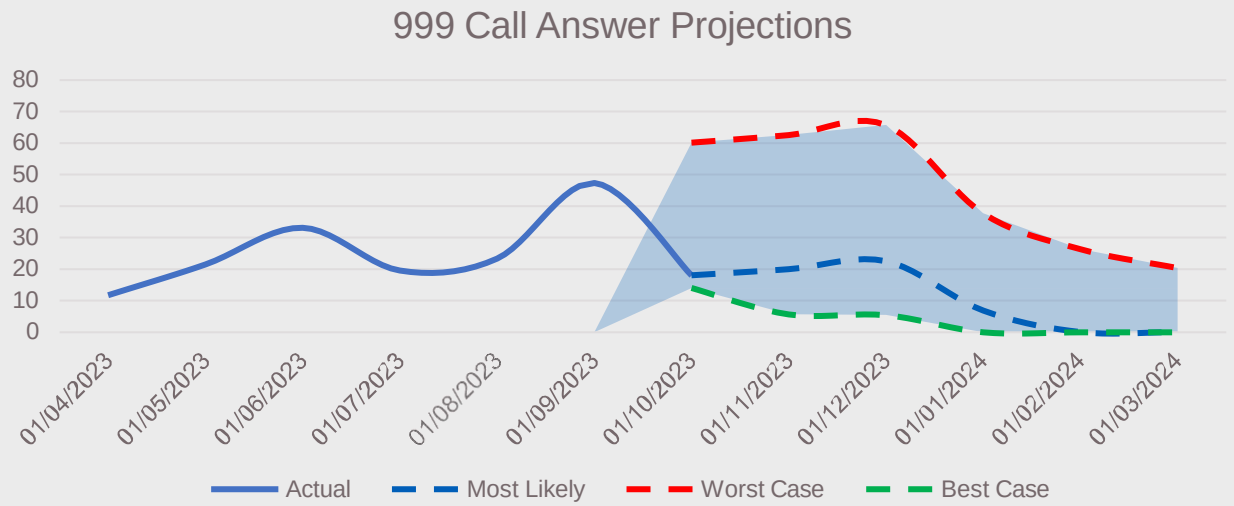


5c. Winter '23-'24 – 999 Predicted Performance

- The Category 2 mean is anticipated to reach circa 31 minutes in November and December, reducing in January to 28 minutes.
- With a 5% +/- demand sensitivity applied, the C2 mean could fluctuate between 27 minutes and 35 minutes over winter depending on trends.

- 999 Call answer mean is anticipated to be at 20 seconds until December, reducing to 6 seconds in January.
- Additional worst- and best-case scenarios have been included which demonstrates that call answer could be achieved as early as November if the net workforce increase reaches 13 WTE per month and overtime is maximised.
- In the worst-case scenario, call answer times average 60 seconds until the new year.





Most likely – additional capacity from other services purchased, net workforce increase of 9 WTE per month.
Best Case – net workforce increase of 13 WTE per month, 10% overtime filled.
Worst Case – No external support, 4% increase abstraction rate, 30s increase in ACHT.

5e. Winter ‘23-’24 – Staff Welfare & Support

- Annual leave across the period will be granted in alignment with Trust policy – over the 2 weeks of Christmas (W/C 25/12/23 and 01/01/24) this is set at a lower level considering predicted significant additional pressures over this winter.
- Additional welfare support is planned for the Christmas period, or if there is particularly inclement weather. This is to include the provision of welfare vans and additional consumables at base stations.
- The Trust’s welfare hub will continue to provide signposting and access to physical and mental services such as physiotherapy and counselling for staff who self-refer for support.
- The Trust influenza vaccination programme is underway with the intention maximise the uptake of the vaccinations across the Trust – linked with promotion of Covid vaccinations available elsewhere. A programme of incentives has been implemented to optimise take up of vaccines this year.

5f. Winter '23-'24 – Command oversight & Escalation

- The Trust operates a 24/7 command team that is in place at all levels (Operational, Tactical and Strategic) to:
  1. Oversee the standard functions of the Trust ensuring resilient safe delivery of the services.
  2. Provide a structure for the management of specific incidents within the Trust footprint.
  3. Provide a response partner for incidents/issues that arise in/with partner organisations.
- Over winter this model will continue to operate with representatives of all operational service lines.
- SECAmb has a formal escalation processes within the Trust based on the volumes of calls being held and the potential risk that creates. Within this framework are specific actions that are implemented at agreed points (escalation and de-escalation) to enable the command team to dynamically manage delivery.

6. System Partnerships

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

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

7. Expected/predicted challenges

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

8. SECAmb winter specific actions

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

Appendices

Version control

Version No.	Comments
0.1	Initial draft by Dave Williams, Head of Resilience & Specialist Operations
0.2	Updates following presentation of initial plan at EMB on 27/09/23
0.3	Additional content relating to predictions on activity, resourcing and performance for the 999 service added
0.4	Additional content following feedback from Trust Board
1.0	Published version including appendices from each team
1.1	Updated EOC section
1.2	Updated Strategy and Partnerships slide

Team/area specific content
under development

List of Appendices

EOC	Call handling
	Dispatch
	Clinical
	Leadership

Surrey & Frimley	Banstead
	Chertsey
	Guildford

111	Call handling
	Clinical
	Leadership

Directorates	Finance, IT & Estates
	HR
	Medical
	Quality & Nursing
	Strategy & Partnerships

Kent	Ashford
	Dartford
	Medway
	Paddock Wood
	Thanet

Sussex	Brighton
	Gatwick
	Hastings
	Polegate
	Tangmere
	Worthing

Ops - Other	Resilience
	HART
	Volunteers
	PAPs

EOC Call Handling

Demand

999 Call volumes are expected to be slightly below 22/23 periods due to the significantly improved C2 mean position the Trust is in, reducing the duplicate call volume received.

Capacity

EMA recruitment has been challenging and is currently 18% down on the planned workforce levels. Since the move to the new EOC, it is anticipated that the EMA workforce will grow by a net 9 WTE each month and reach planned levels by December 2023.

Performance

999 Call answer mean is anticipated to be at 20 seconds until December, reducing to 6 seconds in January.

Additional worst- and best-case scenarios have been included which demonstrates that call answer could be achieved as early as November if the net workforce increase reaches 13 WTE per month and overtime is maximised.

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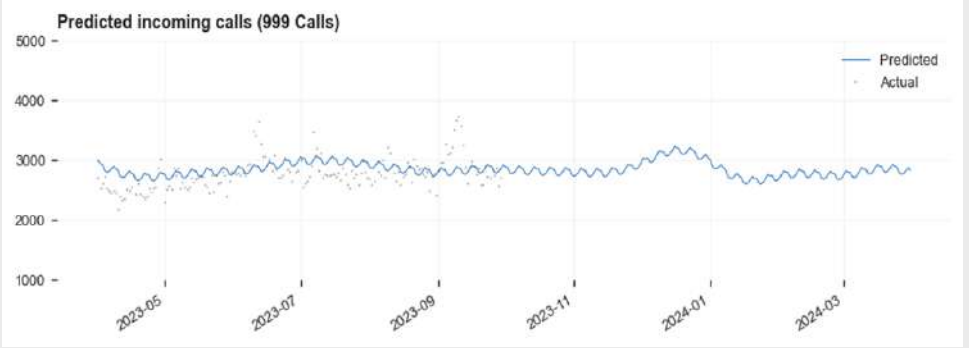
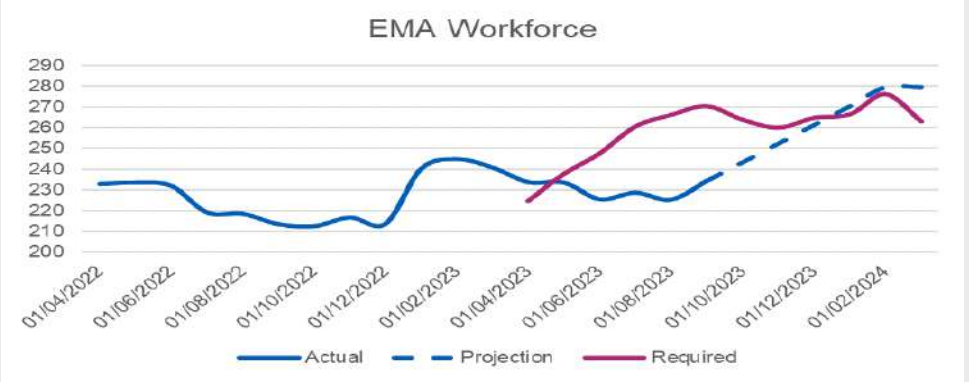
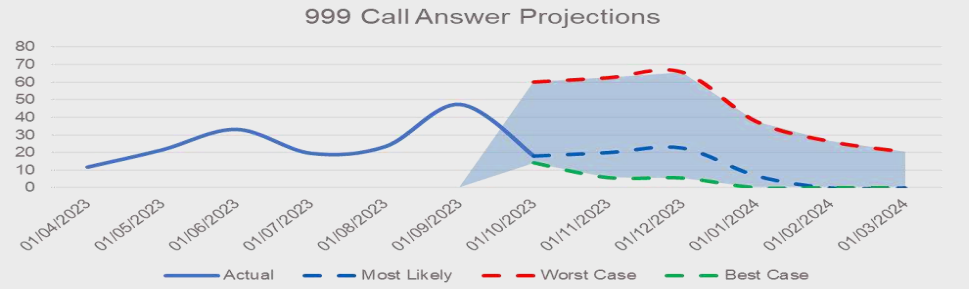






Most likely – additional capacity from other services purchased, net workforce increase of 9 WTE per month.
Best Case – net workforce increase of 13 WTE per month, 10% overtime filled.
Worst Case – No external support, 4% increase abstraction rate, 30s increase in ACHT.

EOC Clinical

System Working

- Utilisation of Urgent Community Response Streaming within increased touchpoint calls for key demand dates
- Implemented CAD Integrated Portal Solution to facilitate UCR pull of cases to optimise joint working
- Optimisation of DoS to ensure utilisation of appropriate alternative patient pathways

Demand

- Ensure utilisation of all current risk mitigation measures in accordance with the Trust Clinical Safety Plan (CSP/SMP)
- Ensure full Clinical In-line Support (CIS) to call handling and dispatch roles to support apposite ambulance prioritisation and dispatch

Capacity

- Optimisation of rotas for clinical establishment in all roles in focus to work toward 14% Hear and Treat
- Weekly and daily management of abstractions
- Continue use of agency staffing to supplement rota shortfalls and increase staffing on peak demand dates
- Utilisation of NHS PaCCS Paramedic Practitioners and Paramedics within locality hubs under EOC Clinical Safety Navigator
- Continued C2 Segmentation and Category 3 / Category 4 Validation
- Additional support in cross-site/service integrated working, to optimise resource across all EOC clinical roles

EOC Dispatch

Resource Dispatchers

- Current WTE 107.47 (Funded 104 WTE)
- Effective WTE 94.52
- 14 in training / mentoring with the majority due to be signed off by December
- Currently running at an average of 2 leavers per month. This will bring establishment to 119.47 WTE and a predicted effective WTE of 104
- Sickness has currently reduced to 8% from highs of 20%+ earlier in year
- Clinical In-line Support (CIS) in place to support dispatchers with decision making, especially for anticipated increased waiting queue versus field ops resource availability. Additional actions from AACE dispatch review also in place
- Live Quality Assurance in place – 1 audit per colleague per month. Outcome should see consistent dispatch teams, adherence to processes and improvements in KPIs
- Robust contingency paper working model for ambulance dispatch now in place and tested, following learning from last winter and previous BCIs
- DTL Refresher – Focus on RPI – Meal break compliance – SSP compliance – Resource sharing across

EOC Leadership

On-Site Representation

- Senior leadership availability on-site on all weekdays
- Planned senior rota for key demand activity dates and times

On-Call Representation

- EOC/111 Tactical A and B representation 24/7 with ability to attend site if necessary
- EOC/111 Clinical Tactical A and B representation 24/7 with ability to attend site if necessary

Participation

- Tactical representation on Surge Management Plan (SMP) Calls
- Tactical representation on any NHS England Service Review Conference Calls held around public holidays
- Strategic oversight linking into ICBs and regional daily calls
- Utilisation of Trust REAP status to support leadership actions across all command levels
- Guidance on use of Clinical Safety Plan (CSP) and SMP extraordinary actions at times of high demand
- Liaising with NHS England and BT with regards to Intelligent Routing Platform (IRP) utilisation
- EOC Clinical Tactical leading UCR optimisation calls and other external stakeholder engagement

111 Call Handling

Demand

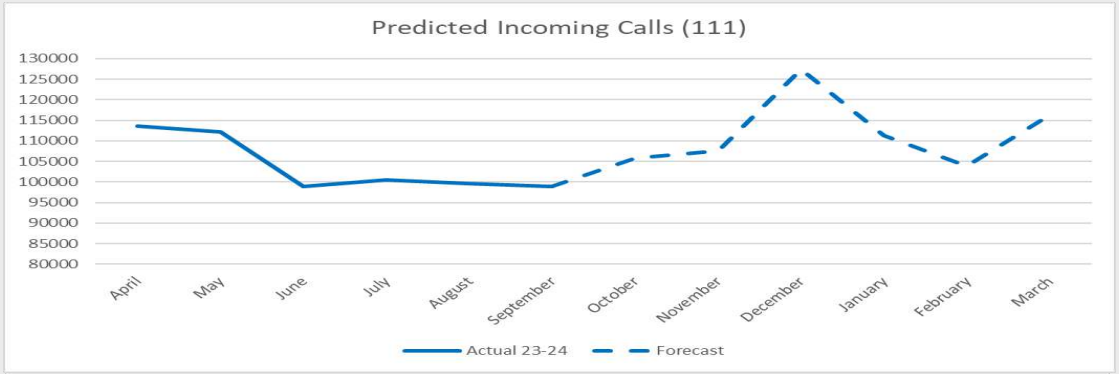
- Activity is tracking 3-4% lower than 22/23.

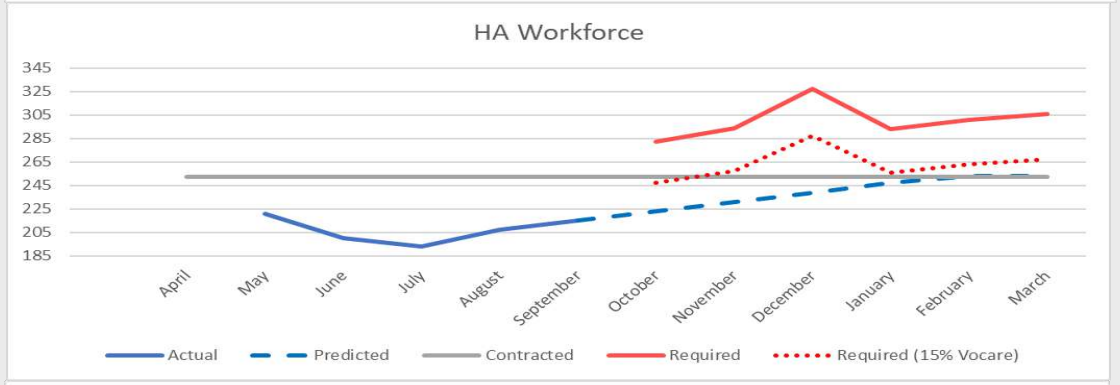
Capacity

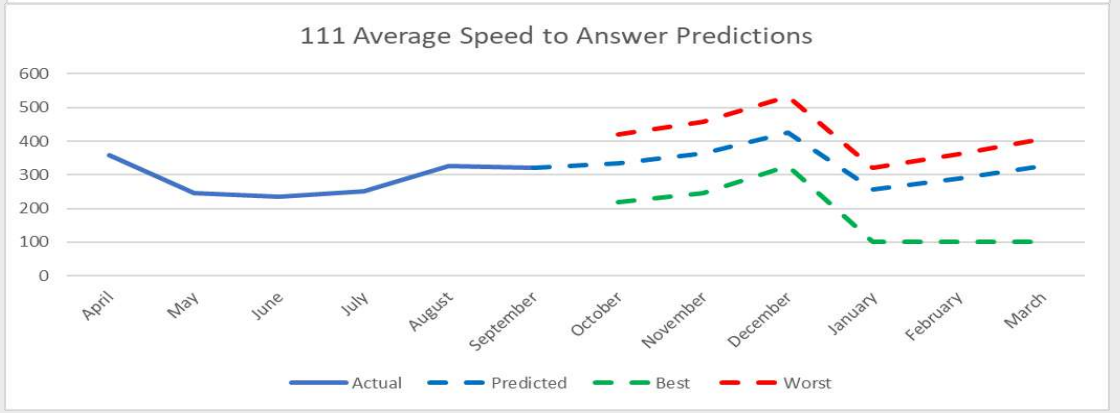
- Currently we are funded to provide 252.6 WTE. Current activity forecast requires up to 327 WTE but if current 15% National Contingency continues, this requirement falls to 287WTE. Following the Medway move, HA numbers dipped to 24% below funded levels, but have since risen to 16% below. Forecast WTE based on a growth of 8 WTEs p/month, reaching funded levels by early 2024.

Performance

- 111 call answer performance is expected to peak at 425s average speed to answer in December, stabilising at approx. 300s in the new year
- Best case scenario is based on 15% National Contingency continuing and recruitment targets being met
- Worst case scenario is based on no National Contingency and 4 WTE growth p/month







111 Clinical

Joint Working

- 'Streaming' of patients from the 111 Clinical Assessment Service (CAS) clinical queue to GP federations, in accordance with agreed criteria
- GP 'Fast Tracking' of patients by a senior clinician to downstream providers, where it can be determined by initial assessment that a face-to-face assessment/treatment is likely to be required
- Maintain ED validations as far as possible, to minimise impact on acute services

Demand

- Utilise existing DoS profile capacity management systems to manage incoming CAS volume

Capacity

- Optimisation of rotas for clinical establishment in all roles
- Revised operational model with subcontractor to support specialist clinical staffing (GP & ANP)
- Use of agency staff across key clinical skillsets to support times of high demand
- Dynamic movement of staff between 111 and 999 clinical queues to optimise staffing in areas where case acuity and/or risk is highest

111 Leadership

On-Site Representation

- Senior leadership availability on-site on all weekdays
- Planned senior rota for key demand activity dates and times

On-Call Representation

- EOC/111 Tactical A and B representation 24/7 with ability to attend site if necessary
- EOC/111 Clinical Tactical A and B representation 24/7 with ability to attend site if necessary

Participation

- Tactical representation on Surge Management Plan Calls
- Tactical representation on any NHS England Service Review Conference Calls held around public holidays
- Strategic oversight linking into ICS and region daily calls
- Guidance on use of 111 Service Operational and Clinical Escalation Plan actions at times of high demand
- Resilience planning with NHS England with regards to National Contingency support
- Utilisation of Trust REAP status to support leadership actions across all command levels

Directory of Services and Digital Interoperability

CAS Capacity Management

- Adopt proactive capacity management of KMS 111 CAS DoS profiles by skillset (e.g., Dental, Repeat Prescription, Mental Health)

ICB Engagement

- DoS and Digital Lead to work with ICBs and individual providers to resolve any emerging issues caused by incongruence of DoS profiles with perceived service provision (minimise hand-backs).

Provider Utilisation Balancing

- Optimise system utilisation, i.e., activity directed appropriately across the spectrum of downstream providers.

Wider Capacity Management and Comms

- Collaborate with ICBs and other providers to ensure effective prior communication of loss of capacity in the wider system.

Field Ops: Ashford (Kent)

Local challenges

- East Kent Health and Care Partnership remains in tier 1 status regarding Acute performance. Available alternatives to ED, patient flow and discharge profiles. A-Ted and GIRFT meetings have identified a lack of SECAmb accessible pathways with deficient DOS information on Service finder. UTC national profiles are not embedded across all sites which causes inconsistent access.
- Increased winter activity and ICS partnership staffing has the potential to affect handover compliance and capacity within primary care, community and acute setting.
- Continued congestion at channel tunnel and short straits has the potential to impact on response times in the Dover and Folkstone areas.
- Cross border activity remains a factor in the Ashford DD regarding inefficient resource utilisation affecting JCT, Long runs and C2 performance.
- Small boat crossings continue to impact non predicted activity however winter weather should see a reduction in this traffic.

Field Ops: Ashford (Kent)

Mitigations

- Development of the Advanced Paramedic Practitioner led Integrated Care Hub with fully PACCs trained APP team by November will provide key focus in conjunction with key HCP partners to improve H&T, UCR referrals and response, utilisation of appropriate alternatives to ED and consistent, uniform access to UTCs
- Ongoing engagement meetings via Acute liaison & U&ECDG identifying an integrated support and delivery system to meet winter pressure. The anticipated Perfect month will be utilised to test the system, identify learning and action plan.
- Resourcing will be maximised to meet predicted demand in line with predictive analysis. Ashford OU is currently fully established with consistent abstraction compliance.
- Folkstone ARP will remain a reporting station to mitigate congestion issue relating to operation BROCK
- Command & Control via increased operational commander rota will manage on day resource issues in conjunction with EOC
- Continue to engage with Med-event in the provision of support to Small boats response SLA

Field Ops: Dartford (Kent)

Predicted challenges

- Handover delays due to cpacity within the ED and particularly as cross border with LAS
- High frequency of ED attendances with one of the highest attendance rate in the UK (250-300 per 100k) one of the top 4 places of highest attendances in the country.
- High deprivation rate in the area
- Lack of alternate pathways and challenges within staffing levels to develop these.

What are we doing

- Focus on PACCs clinician courses
- Focus on JCT, wrap up and handover delays with operational team leader support
- Utilisation of alternative pathways

Field Ops: Dartford (Kent)

Relevant info

- Continue to recruit as nearing full establishment however significantly short in experienced band 6 staff and a number of staff on secondments
- Actively engaing with stake holder meetings – urgent care, SDEC, frailty, GIRTH and care homes.
- Focus on local performance such as JCT, wrap up times and out of service report
- Minimal abstractions

Field Ops: Medway (Kent)

Challenges

- Handover performance has significantly improved over the last year (12 min avg YTD) but increased focus now needed to ensure wrap up times improve and reach target (17 min avg YTD).
- Pathways availability – improvements being made but opportunities exist to stream further crews away from ED, particularly in Swale where the full co-located UTC has been delayed for some time. At-ED, Frail-tED, Men-SAT have all identified opportunities for improved crew access to community pathways.
- Violence & aggression – Medway remains a significant outlier for assaults on our crews, which moving into winter is a concern and needs to be improved.
- Significant road improvements by National Highways at M2 Junction 5 and protracted closures of the A249 continue to impact response time reliability in Swale and prolonging job cycle time.

Field Ops: Medway (Kent)

Mitigations

- Senior team committed to maintaining improved relationship and culture with colleagues at MFT. Ensure significant gains in job cycle time (JCT) through handover improvements are maintained. Senior presence on daily site calls, System Oversight Resolution calls and fortnightly ED Liaison meetings moving into winter. Team by team review of JCT with relevant performance improvement plans introduced where needed regarding poor wrap up.

- Continue to support Hospital Ambulance Reception Improvement System (HARIS) workstream, working with community partners to develop Care Coordination Centre which was an original HARIS recommendation. PP team all now booked to be trained in virtual patient assessment to support this work. New clinical leadership meetings with advanced paramedics driving pathways awareness in the OU – now the best S&C in the trust at 54%.

- On day feedback from duty team leader regarding use of body warn video, with further education from line manager thereafter. Ensure Joint Response Unit is well resourced.

Field Ops: Medway (Kent)

Other relevant information

- Successful full occupation of our new Make Ready site, along with with colleagues from 999 and 111. Response time reliability has been stable with marginal improvements despite the 1.6 mile move to the East of the OU. New site well received by staff, with rolling attrition rate ↓ from 12.6% to 9.95% and rolling sickness ↓ from 10.8% to 7.1%.

- Unit is near full establishment.

- Job cycle time improvements largely driven by hospital handover but scene times and wrap up times benchmark well with other OUs.

- See & treat / Hear & Treat highest in the trust (April – to date), driven by UCR Optimisation with MCH and Pathways promotion and development.

- Senior leadership team fully engaged with our partners from MFT and community partners to ensure we are strongly positioned to address winter challenges with capacity.

Field Ops: Paddock Wood (Kent)

Predicted challenges

- West Kent hospitals are sitting in Tier 1 with GIRFT meetings highlighting a high conveyance rate with around 40% of alternate ED pathways either not being in commission or do not appear on the DOS.
- There is a high level of conveyances across the region from care homes
- Acute sites have seen a relative increase in the number of walk-in patients the year however these are lower than the figures for 22/23.
- 4-hour ECS compliance fell in July – August and has continued to decline, falling further below the trajectory. This is consistent with the historical trends for September- December and puts us in a better position ahead of winter.
- The 15-minute handover has also continued to decrease, with west Kent remaining one of the highest performing acute trusts in the country. Despite this improvement there has been a 3-month period of decline with MTW significantly falling behind with 61% compliance and TWH at 51% causing a significant challenge.

Field Ops: Paddock Wood (Kent)

What are we doing

- Local services are doing work with services to focus on the top 10%
- Local PP's have worked with care homes to avoid admissions.
- West Kent navigation hub pilot was a successful trial with 326 clinicial calls, 242 onward referals (not ed), 84 conveyances and 128 ED admission avoidances (20 bed days on average) over the 4-week period.
- Focus on local staffing levels to maximise resourcing, inclusive of operational commanders with a focus on acute Trust engagement
- Prioritising of PACCS clinician courses to ensure alternative pathways use.

Field ops: Paddock Wood (Kent)

Relevant info

- Paddock Wood OU is nearing full establishment
- Actively engaging with stake holder meetings – urgent care delivery board, urgent and emergency care, SDEC, GIRTH, Frailty etc
- Focus on local performance, JCT and OOS.
- Minimal abstractions

Field Ops: Thanet (Kent)

Local Challenges

- East Kent hospitals covering the Thanet OU currently within tier 1 status with a recent Getting It Right First Time (GIRFT) review identifying that there is a lack of pathways available for SECAmb clinicians to access directly.
- The A-TED review identified that over 40% of alternate pathways to ED were not available within the East Kent footprint. This causes a funnel affect to Accident and Emergency resulting in handover delays. This will also be impacted by increased Winter activity.
- UTC sites are plentiful within the East Kent footprint, however, they all have varied profiles for acceptance. This inconsistency leads to a lack of choice and confusion.
- Recent recruitment has been productive and means that the unit is reaching full establishment, however crewing skill mix will be difficult for an initial period over the next few months to ensure preceptorship hours are completed.

Field Ops: Thanet (Kent)

Mitigations

- Maximising PP Hub cover to ensure specialist support available to our clinicians to undertake shared decision making and conveyance reduction. PaCCs training for all PP clinicians to maximise hear and treat potential as well as care home frequent attendance monitoring to support admission avoidance.
- Business case proposal submitted to patient flow steering group to co-locate with local Home Visiting Service and Complex Acute Response Team to maximise potential for alternated pathway use and admission avoidance.
- Regular acute site engagement meetings and attendance at UCDB meetings to ensure partnership working is maximised.
- Rota review underway to mitigate against PAP reduction and ensure we are meeting our hourly demand needs accurately with monitoring of abstraction to ensure hours provision is not compromised. Consideration of crewing issues to ensure preceptorships are completed may result in placing one band 6 clinician to support 2 clinicians undertaking preceptorship.

Field Ops: Banstead (Surrey)

Predicted challenges, (internal) and actions

- Lack of Churchill MRO cover and loss of available DCA hours as a result of non made ready vehicles. Addressed through Datix, escalation and regular meetings/reporting through MRCM and Lead director. Local plans in place for HOT loading at times of no MRO availability.
- Lack of suitable facilitated ACRPs putting pressure on Gatwick and Banstead stations at peak times for meal breaks. Some current sites workable but still at risk of closure. Alternatives being sought though estates.
- Challenged operational hours due to high abstractions (Sickness/Secondments/Alternative duties). Managing sickness in line with policy and utilising HWB for alternative duties where possible.

Predicted challenges - Hospital Handover and capacity (External) and actions

- We address concerns over handover and trolley availability through the monthly handover meetings.
- The use of alternative pathways are regularly promoted locally, and we have a QR code on the vehicle to report issues where they were unable to gain a referral and we feed this back. This would include SDEC at Epsom General.
- London ambulance are instigating their version of the 45 min handover in SW London hospitals now and this is discussed at the monthly handover meetings (Epsom and St Helier)
- Challenges with diverts have been dealt with via the London surge HUB.
- Challenges with they view of our resources arriving at ED I have liaised with our Information team who are talking to them separately.

Field Ops: Guildford/Tongham (Surrey & Frimley)

- Acutes will see significant pressure compounded by industrial action over the festive period.
  - We will ensure maximum use of appropriate care pathways, continuing to push them via our single point of access number and our targeted communications strategy.
  - We continue to work with partners to ensure that risk based decisions actually consider patients in the community, that corridor care is superior to no care.
  - We have twice the PP hub capacity that we had this time last year.
- Demand will outstrip supply on an increasing basis as the cold weather sets in.
  - Optimise resourcing and ensure good PACCS & Hub cover.
  - Limited capacity to improve on resourcing due to the budgetary constraints this year.
- Lack of cover for our VPP (Churchills)
  - No mitigation – vehicles are often not prepared for an oncoming crew – we do not hold Churchill to account as an organisation. Crews experience down time replenishing vehicles.

Field Ops: Chertsey (Surrey)

Predicted challenges

- Occasional Handover delays (although they manage very well each year).
- Overflow from Kingston. Kingston is more of a concern with the difficulty engaging with London hospitals. ASPH normally see's increased conveyances as a result.

What are we doing

- Admission avoidance through use of Alternative pathways. UCR, SDEC, FRAILTY all very well established.
- Established relationship between OM and ASPH Matron. Good route for escalation
- Delayed handover process is well accepted at ASPH.

Other relevant Information

- We really need PAACs clinicians to use the alternative pathways in the OU, and not just ask patients to MOW. This will cause increased pressures on the A&E departments .

Field Ops: Brighton (Sussex)

Predicted Local Challenges

- Capacity issues at RSCH and handover delays.
- Diverts to PRH causing occasional knock on delays.
- Building work at RSCH ongoing.
- Large events within local footprint that may cause additional strain on Trust resources and wider NHS partners.
- Estates issues from flooding at Brighton MRC, including lack of robust IT infrastructure at MRC.
- Small room at MRC for PP / CCP / PACCS clinicians meaning some PACCS trained staff not able to work in own area and requirement to travel to HQ.

Field Ops: Brighton (Sussex) cont....

Local Actions / Mitigations

- Regular meetings with hospital teams looking at handovers and mitigations regarding ongoing rebuild.
- Wider ICB meetings being attended to ensure joined up approach to winter planning.
- Safety Advisory Group attendances for all events with scrutiny on event medical plans. Additional command support in place for larger events, eg Brighton Football, Lewes Bonfire Parades.
- Regular meetings with Trust estates team to ensure MRC issues are on track for resolution.
- Reconfiguration of MRC to move hub into larger room.
- Promotion of alternative pathways and shared decision making encouraged with support from PP's and OTL's on scene or via call clinical backs.
- Daily reviews of operational hours, including front line staff, specialist paramedic and leadership cover.

Field Ops: Brighton (Sussex) cont....

Other Relevant Information

- Staff recruitment going well, establishment at capacity.
- CFR recruitment is strong, with good local teams across the Brighton and Mid-Sussex area to support responses to 999 calls.
- Weekly Senior Leadership Team meetings focussing on staff welfare, on scene times, wrap up times and rota compliance.
- Monthly Operating Unit Leadership meetings with additional focus on key areas such as sickness and welfare reviews, appraisals, training, and key skills compliance.

Field Ops: Polegate & Hastings OU (East Sussex)

Local Picture:

- Polegate and Hastings Operating Unit is within the East Sussex ICB catchment area
- Serves a population of around 555,400 across two Make Ready centres
- 347 clinicians providing approximately 6000 responses per month
- Transporting 3700 patients per month to East Sussex Healthcare Trust (Conquest and EDGH)

Resourcing & Performance:

- Six-week planning and forecast with a seven-day review of vacant shift availability
- Weekly and daily review of demand profile and abstractions to maximise resourcing
- On day management of operational hours, on scene times and hospital delays
- Weekly performance reviews

Conveyance Reduction:

- Promote alternative care pathways and UTC / SDEC utilisation
- Access to virtual ward admission
- Review of local Pathways and update service finder
- Engagement and data sharing with system partners

Field Ops: Polegate & Hastings OU (East Sussex)cont..

Urgent Care HUB:

- 24/7 Specialist Paramedic support
- PaCCs trained clinicians providing virtual response
- Frequent caller nursing and care home support
- Promote clinical supervision and discharge / referral support

Hospitals:

- Weekly hospital engagement meetings
- Improve hospital handover delays
- Ability to facilitate extra ambulance furniture to release crews

Command:

- 24/7 Operational Commander cover
- Optimise clinical supervision and OTL support
- Leadership team to provide operational hour resilience
- Command resilience at peak times (HALO, OTL Support)
- Ensuring resilience within command / leadership roles

Field Ops: Gatwick (Sussex)

Predicted challenges

- Handover delays East Surrey sees one of the highest conveyances of the region – seasonal pressures have the ability to destabilise the system.
- Expectation of increased sickness due to seasonal illnesses.
- Adverse weather limiting staff getting to the site
- Increased travel through Gatwick Airport during winter breaks

What are we doing

- Well established escalation processed at East Surrey Hospital
- Direct conveyance to ESDC will reduce conveyance to ED
- Regular pathway meetings with Sussex ICB and external stakeholders
- Ongoing work with Crawley MIU and CAU
- Regular Senior Leadership Team meetings reviewing issues and triggers
- Proactive staff education and engagement relating to winter pressures and alternative pathways
  PACC training for all PPs to support with clinical validation of incidents

Field Ops: Polegate & Hastings OU (East Sussex)cont..

Resilience:

- Eleven CFR teams
- Specialist CFR falls team
- Liaison with the local Safety Advisory Group for numerous events
- Private Ambulance Provider support

Leadership Key Priorities:

- Engagement with ICB and external partners
- Hour provision
- Hospital handover task and finish group
- Shared learning to increase patient safety
- Staff engagement, welfare and support to optimise retention
- Bolster CFRs and explore emergency responder teams

Field Ops: Tangmere and Worthing (Sussex)

- There are a number of challenges split broadly into 3 areas;
  - Staffing provision: Recruitment challenges across ambulance, the acute and social care are a barrier in being able to meet demand in line with the constitutional standards.
  - Demand: Current demand outstrips resource provision and capacity. The area has an older population, there is consequently a lot of issues surrounding more frail, complex and comorbid patients.
  - Acute Hospital Flow: The local acutes, Worthing and St Richards hospital have experienced more challenges recently with flow, seeing an increase in the amount of ambulance hours lost awaiting handover. This in part is hospital capacity, ED capacity but a key contributor is a number of medically ready for discharge
  - Average transport (to both acute sites) and Average hours lost
  - Local system work to maximise UCR pathways

Field Ops: Tangmere and Worthing (Sussex)

Mitigation Action	Benefits Realisation
•OTL attendance at ED safety Huddles •Senior OU representation at Daily System calls and Daily 'OPEX' calls	Ensures a common operating picture and shared situational awareness, allowing real time update and dynamic mitigations/escalations. Allows oversight also of any extra-ordinary external events/impacts
•Refreshing the use of Alternative pathway utilisation via the 'one call' service and using 'service finder'. •PP and OU pathways leads working with newly in post community matrons. •Launch of UCR 'champions' locally	Supporting the use of the most appropriate resource and demand reduction at source.
•Increasing utilisation of virtual response/Hear and Treat via our paramedic practitioner hubs using the PACS software system	Reducing demand on DCA deployment by providing the most appropriate clinical response (which may be virtual response). Most appropriate use of limited staffing/resource availability allowing us to get patients more quickly.
•Planned Non-Emergency Transport, 'NET' provision to allow a response to HCP booked journeys or those lower acuity emergency responses where a 'NET' response is suitable.	Reducing demand on DCA deployment by providing the most appropriate clinical response (which may be virtual response). Most appropriate use of limited staffing/resource availability allowing us to get patients more quickly.
•Local Workforce and Wellbeing actions including drop in sessions with Consultant MH Nurse to supplement the SECAmb wide Wellbeing hub	Supporting Workforce to stay healthy and promote wellbeing, as a secondary impact reducing absence.

Ops Other: Resilience and Specialist Operations

- The Wider Resilience Department is responsible for ensuring that the trust is able to respond to patients in times of pressure, or during extreme events such as severe weather or declared major incidents.

- The expectation this year is that winter is expected to be initially mild (Met Office prediction), with the greater than 3 month prediction being that the South East is set for disrupted and unpredictable weather.

- That being said, this season has started with disruptive events such as Industrial Action ,a rise in Covid and RAAC issues stretching the capacity of the health system and causing challenges for all providers.

- The Integrated Care Boards are facing their first real winter with true delegated authority, and this may prove particularly problematic with all of the other issues that are building up in the systems.

- The increased attention surrounding the Hazardous Area Response Team and other specialist operations elements of the trust has resulted in SECAmb reviewing and updating the support provided to operations by those teams.

Ops Other: Resilience and Specialist Operations

Mitigations

- The EPRR Team will review and update a winter operating model for the trust, to ensure that SECAmb is linked in with system conversations. This will allow for pro-active management of hospital delays and addressing developing issues as they are identified.

- The HART units have moved to recruit to full establishment by end November, ensuring that staffing numbers will be more robust through December and into the new year. A plan to increase the pool of HART staff available for short notice eventualities will be in place by the end of March.

- The Resilience team will work to ensure that all system partners are informed through formal processes and early escalations, using the SBAR format through the appropriate routes.

- The SECAmb Operations Room (SOR) will manage generic communications across the entire system, leading Tactical discussions with both Local Resilience Forum and Health partners.

- The Tactical Advisors on call will work with the LRF's to manage escalations around disruptive events.

Ops Other: Volunteers (Community Resilience)

Current Picture/Resilience

- 350 Community First Responders available across the Trust
- CFR 4X4 Support list with Operational Support Team
- 40 volunteers trained to drive Trust vehicles routinely
- 2 x CFR Emergency Responder Teams Gatwick and Ashford OU's

Conveyance Reduction

- 163 CFRs trained in assisting patients that have fallen with model of care in place to support conveyance reduction.
- **Welfare Support**
- 18 Chaplains across the Trust to support staff
- EOC Welfare Support in place for December to March 23/24
- From January/February 2024 provision of staff welfare vehicles (Limited to start with)

Ops Other: Private Ambulance Providers

- Contracted hours budget for PAPs 2023/2024 equivalent to 120 WTE, with potential for small uplift if funding available and sufficient notice (3-4 weeks).
- Contract secured with PAPs for the next 2yrs.
- Focus on providers compliance with contracted hours via scheduled monthly/quarterly contract quality & safety reviews.
- Agreement with St John Ambulance to provide 3-5 shifts per day to support winter surge (as per NHSE/I funded national contract with St John).

Directorates: Finance, IT & Estates

Finance has nothing significant outside of their current BC Plans, to affect Winter Plans.

Directorates: HR

BCI Plan

- Review and update BCI plan **(Sally Parr)** by end October 23
- Test communication cascade process **(Assistant Directors)** by end October 23

Staff Welfare

- Continued trust welfare hub provision supported by mental health practitioners in EOC and 111 (reassignment of roles as appropriate) **(Ian Jeffreys)** in event of REAP 4
- New staff welfare vehicles and trollies to be activated during REAP 4 escalation, BCI and Critical Incidents and Major Incidents declared. **(Ian Jeffreys)**
- Optimising breaks on shift. **(OM/OUM/Duty OTL)** daily review
- Continued recruitment against agreed trajectories for call handling and field operational staff and ad-hoc requests **(Nicky Burgess)** Ongoing

Directorate Plans: Medical

Information

- This briefing relates to the central medical directorate team function, the administrators and clinicians that work to support frontline Operational staff.
- This brief covers normal winter pressures coupled with potential additional pressures of new variants of COVID-19, seasonal and holiday activities, adverse weather, spontaneous serious incidents and other disruptions.

Intent

- To provide a high-quality support service to the Trust throughout the winter months.
- SECAmb provides access to a range of wellbeing services through the Wellbeing Hub.
- Regular 121s with team members and appropriate levels of supervision are key to ensuring that all members feel supported in the workplace.

Directorate Plans: Medical

Method

- The Medical Directorate comprises of the following teams:
  - Medical Senior Leadership Team (MSLT)
  - Urgent & Emergency Care including Professional Standards, Practice Development, End of Life Care & Frequent Caller leadership)
  - Critical Care Operating Unit
  - Clinical Education
  - Clinical Audit, Health Records & EOC Practice Development
  - Clinical Pathways
  - Research
  - Medicines Governance

Administration

- Our approach will include:
  - Continuing to work agilely as per Trust guidance
  - Supporting the Trust at times of escalation with clinical support both frontline and in our contact centres
  - Supporting through remote clinical working (PaCCs)
  - Continuing to lead on Clinical Governance, ensuring that the Trust continues to follow the Trust governance process for any changes to clinical practice
  - Using our Urgent & Emergency Care teams to maintain an oversight of National policy that could affect the way our staff work (e.g., EOLC & Frequent Caller guidance)

Directorate Plans: Medical

Risks

- This period presents a higher-than-normal risk profile due to most teams working remotely and the potential additional pressures of new variants of COVID-19, seasonal and holiday activities and adverse weather for those teams not working remotely.
- Staff availability and sickness absence may pose a potential risk, this will be managed through the Trust processes already in place.
- Our risks for the central teams is mitigated by the majority of staff able to work remotely, this is balanced by the need to maintain good communication with all our teams.

Initiatives

- The central teams will continue to work agile, balancing this with a need to be visible to the whole workforce
- As required and in periods of escalation all teams will be expected to support the Trust, this could be providing Loggist duties when required, supporting in the Medicines Governance area or if clinical provide either frontline or EOC/111 shifts.

Communication

- The MSLT meets weekly to ensure any areas for escalation are raised in a timely manner, there is also a weekly huddle every other week as well as MSLT. This enables updates from the central team to be cascaded through normal reporting channels.
- There is a Medical Directorate Teams meeting every month where information is cascaded throughout and with an opportunity for any member of staff to ask the MSLT questions.
- Each team meets weekly/bi-weekly to ensure that our staff whilst most are working remotely are supported and feel part of the team.

Directorate Plans – Medical

Humanitarian

- SECAmb provides access to a range of wellbeing services through the Wellbeing Hub.
- Regular 121s with team members and appropriate levels of supervision are key to ensuring that all members feel supported in the workplace.

Directorate Plans: Medical – Medicines

Risks:

- Be aware of the impact of the potential building works that may be taking place over the winter months, try to mitigate any impact on the Medicines Distribution Centre (MDC) team
- If Resilience stock drops to below 7 days, then look at options for overtime/TOIL
- Operating hours of the MDC
- Access lift functionality
- Current MDC is not fit for purpose

Opportunities:

- Work closely with recruitment to ensure vacancies are recruited as soon as possible.
- Move teams from corporate areas to support medicines packing at the MDC.
- Utilise space available throughout Paddock Wood Make Ready Centre to pack/check medicines
- Consultation on operating hours of MDC to begin as soon as possible. (delayed due to lack of space)
- Task & finish group set up to review phase 1 relocation

Communications:

- Regular team meetings planned throughout the period
- Registered Pharmacy staff support on site throughout MDC operating hours

Directorate Plans – Medical Critical Care Operating Unit

Risks

- Increased demand leading to increased operational pressure and risk of missed calls
- Increased seasonal illness leading to increased sickness
- Ongoing vacancies leading to dropped shifts or increased reliance on overtime
- CCD continues to be at risk due to un-established staffing (on risk register)
- Maintaining key skills delivery during period increased demand

Initiatives

- Additional cover with our RCMs
- The CCD and on duty CCPs will continue to monitor the CAD to identify cases where clinical risk is identified due to response delays or clinical skillmix
- The CCD will work in partnership with the HEMS desk to ensure a timely response to our high acuity case load
- CCPs will be auto dispatched via the CAD to C1 calls

Communication

- The CCP leadership team will maintain a presence on briefing and surge calls as required and communicate with our teams as appropriate.
- The Leadership team deliver a weekly brief to all our CCPs to highlight key points and escalations and receive feedback.
- The Duty Manager is available 24/7 to cascade urgent messages.
- Face to face contact with team through governance weeks

Directorate Plans – Medical - Clinical Education 1

Risks

- Operational demand impacting upon course delivery; TtP, Int TtP, Clin Conv Course and Driver Training all being delivered (annual training plan on the Zone), already under-staffed for course delivery and relying upon external instructors (driving) and bank facilitators (operational staff).
- Seasonal illness affecting (teaching staff and learners), impact upon either core delivery and or 'catch up'. Workforce pipeline at RISK.
- Clin Ed may be asked for short notice additional core activity similar to MACA or FRS training which not resourced for.
- Cancellation of abstractions for FE and HEI learners (SECAmb staff) risking contractual external course delivery (and workforce plan). A deferral could equal one-year deferral.
- Risk of recalling secondments (external to HEI/FE) would jeopardise programme delivery.
- Cancellation or deferral of any training (including Key Skills) would risk staff currency and non-compliance with CSTF.
- Risk to continuing to deliver undergraduate placements, would be in contractual challenge with HEE (NHSEWTE) Education Contract.

Directorate Plans – Medical - Clinical Education - 2

Initiatives

- Clin Ed restructure (phase 1 approved and being enacted)
- No current initiatives in place, however a strong track record of identifying solutions to short notice challenges (i.e. MACA).

Communications

- Weekly Senior team meeting (Mondays)
- Weekly team meetings conducted by SEMs with 1:1s delivered monthly
- Ability to step up weekly summary communication (End of Week roundup)

Directorate Plans – Medical – EOC Practice Development

Risks

- Capacity to audit the additional agency staff that have been recruited into EOC
- Departmental sickness (long/short term sickness and risk of seasonal illnesses)
- Operational demand/EOC capacity issues results in the team being pulled onto the phones
- Adverse weather prohibiting staff attending main sites for live auditing (Crawley/Medway)

Initiatives

- NHSE underspend secured internally to end March 2024 for 2 WTE posts. Currently offered via overtime whilst recruitment to fixed term posts concludes
- Longer term capacity requirements to be included in the current NHSE funding proposals (5,10,13) and bids.
- Active sickness monitoring and management in accordance with Trust policy.
- Escalation SOP in place with predetermined triggers agreed
- Team equipped to undertake agile working and retrospective (as opposed to live) auditing if required

Communications

- Twice weekly senior team meetings,
- Weekly whole team meetings

Directorate Plans – Medical – Health Records

Risks

- ePCR/CAD outages resulting in the move from electronic to paper patient report forms – causes a delay in records processing and validations
- Currently a small team – risk of unplanned sickness/absence due to seasonal illnesses
- Private provider delays in submitted paper records for scanning/validation during winter period
- Introduction of new patient related data system(PRDS) solution during Q4 – migration may adversely impact on scanning/validation lead in times initially

Initiatives

- Staff within the Clinical Audit department have been trained to support at times of increased demand
- Alternative duties staff utilised whenever available
- Planning underway for increased resilience within establishment
- Private provider records submissions monitored and managed via formal contract arrangements
- PRDS project implementation plan in place, including communications and escalations if required

Communication

- Twice weekly senior team meetings,
- Weekly whole team meetings
- Ongoing dialogue with corporate teams that are dependent on records – legal, safeguarding, risk etc to prioritise specific records processing if necessary

Directorates: Quality & Nursing

Predicted Challenges	Mitigations
Threat of another endemic/pandemic	
Out of date IPC equipment	
Risk of colleagues not utilising appropriate PPE	
No formally agreed process for management of the Monica system	
Potential increase of slips/trips/fall in staff	
Increased fractures post covid for elderly patients	
Increased mental health concerns / suicide. Risk to an already challenged mental health provision	
Risk regarding how we keep patients safe in the stack. Potential delay in work on QI project due to system development requirements.	
C2 segmentation, by virtue of when it commenced, has not yet had opportunity to be fully evaluated	
Risk that we are not yet managing falls patients as effectively as we could	
We will just be implementing PSIRF. The risk is that we fall into the trap of investigating all incidents based on level harm rather than committing to approved PSIRP.	
Continuation of development of risk portfolio, maintaining focus alongside winter pressures.	
Minimum staffing level to be identified to agree where we could utilise staff in the two areas of slips, trips and falls and keeping patients safe in the stack.	

Directorates: Strategic Planning & Transformation - Strategic Partnerships

Patient Flow Programme - Bringing together key Trust directorate representation (Field Operations, Clinical, Quality, Strategic Partnerships, Integrated Urgent Care and Business Intelligence) to monitor and map key UEC pathways, initiatives and support of regional programmes for admissions avoidance.

- **Monitoring** - Supporting whole-system development of Single Points of Access (SPoA) for access to community and other appropriate out-of-hospital services; aiming to reduce avoidable conveyance (See & Convey) through increased See & Treat. Also supporting the development of daily touchpoints with Urgent Community Response (UCR) providers to ensure appropriate proactive pathway utilisation (i.e., increasing Hear & Treat), with plans for the digital transfer of incidents underway.
- **Mapping** - Using NHSEs Alternative to Emergency Department (A-tED) methodology to map existing pathways, i.e. UCR, Urgent Treatment Centre (UTC), Same Day Emergency Care (SDEC), and Mental Health, identifying service gap, opportunities and any divergence from Directory of Services and/or national standards.

ICS Governance Alignment - Continuation of Trust governance alignment with ICS boundaries for enhanced UEC coordination, strategic alignment, and quality and performance oversight across the Trust's four ICSs. Supra-ICS strategy, clinical and contractual meetings established to enhance regional UEC service delivery, together with three ICS-aligned system clinical quality meetings to ensure localised care coordination across each ICS.

Right Care, Right Person – The Trust has asked each of the three Police Forces to populate a baseline data template. This will enable the Trust to understand the impact and the risk that the implementation of RCRP will have on our service.

Strategic Partnerships – Cont.

Enhanced Support for Patient Flow Programme:

- **Winter 2023/24 prep:** Regional Ageing Well Collaborative funds - additional project and programme management support.
  - Programme Manager (8b)
  - Senior Project Officer (6)
- **Duration:** Q3 & Q4 (six months).

Six month funded ICB secondments from August 2023 to January 2024 to support the Patient Flow Programme and the Regional Ageing Well Agenda, including admissions avoidance pathways mapping in preparation for winter resilience.

Directorates: Strategy & Partnerships

Please add notes here about predicted challenges, what you are doing to address them and any other relevant information.

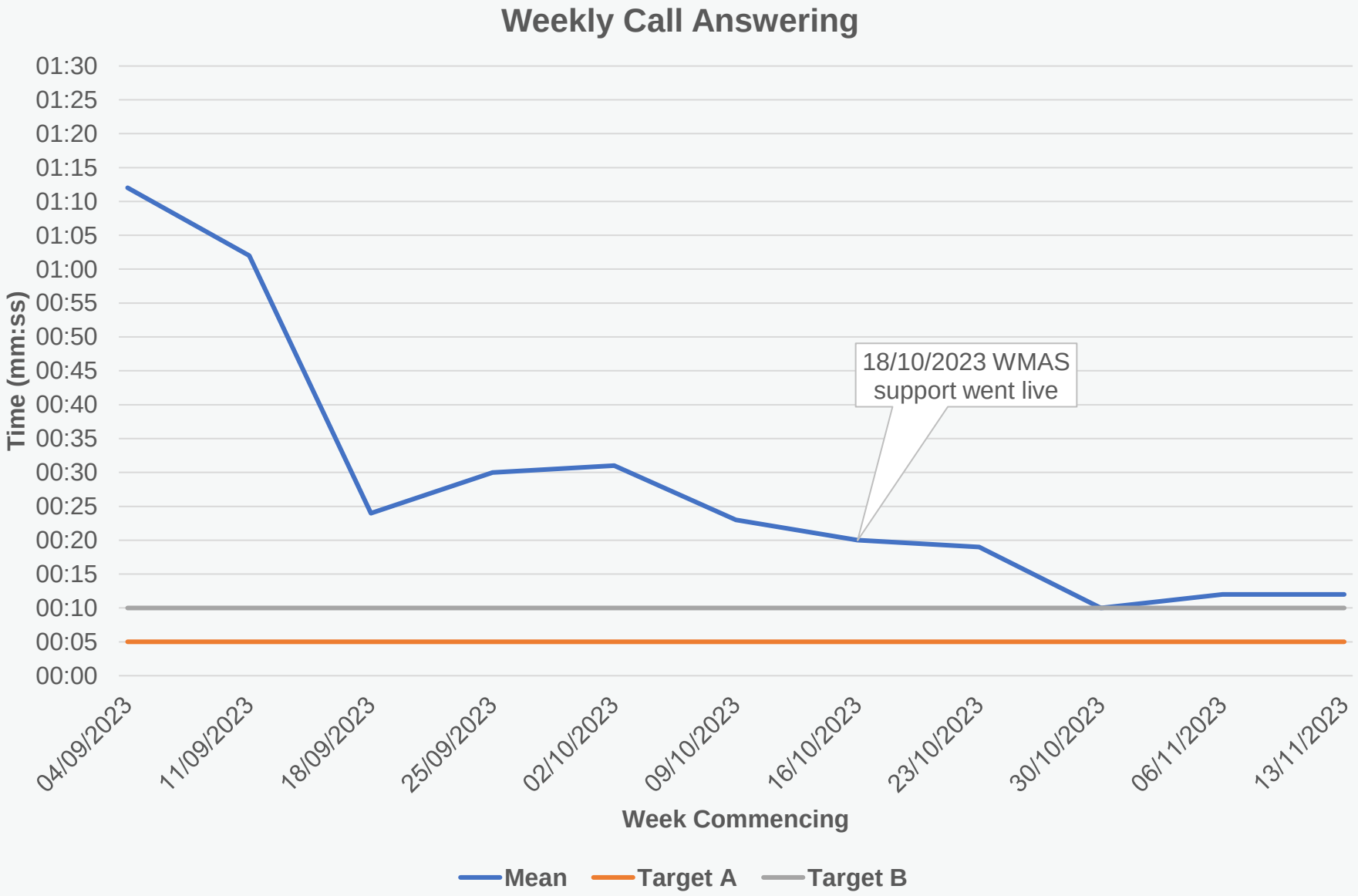
NHS
South East Coast Ambulance Service
NHS Foundation Trust

999 Call answering update

November 2023

Recent performance

Weekly mean call answering shows by increments the most recent improvements, with a mean of 10 seconds w.c. 30th October, and a mean of 12 seconds w.c. 6th November and 13th November.



Current progress on actions (1/2)

Description	Status	Notes
Buying call handling resource from other 999 providers	Complete	This commenced 18th October and will be in place until the end of March 2024. During the initial 5 days, there was a mean call answer improvement from the previous week of 22secs to 15secs.
Targeted incentivised overtime	Complete	This has been in place and has been successful in filling shifts at key pinch points, thereby reducing call stacking.
“Big event” recruitment	Ongoing	Open Day events for 111/EOC/Ops took place 2nd Sep (Medway) and 21st Oct (Crawley). Further events scheduled for January and March at both sites.
Dual Skilling 111 Health Advisors	Ongoing	16 dual trained HAs in place with more training courses planned to flex with staff requirements to support EMA rotas.

Current progress on actions (2/2)

Description	Status	Notes
Psychometric testing	In progress	Benchmarking in progress. 299 colleagues received invitation to complete benchmark test, 59 completed and 28 in progress. Will be engaging after the NHS Staff Survey close. Target to deploy the testing from February 2024 cohort onwards.
EMA to SEMA	Not started	Proposal has been raised with Assistant Director of HR Services and plan is to get the workstream fully completed by March 2024.
Scheduling tool	Not started	Group due to be set up to look at learns across the wider ambulance community. End date Q3 25/26.
Pay mechanisms	Not started	Part of the Draft Retention Plan (PTC 7) due for sign off in December.

Finances

Call handling support

- Lower activity overflowing to WMAS at 1m 45s, 3,625 calls vs. forecast 11,893 from 18th Oct – 21st Nov.
- Cost so far estimated at £49,880 vs. a forecast of £160,648.
- Estimated cost for the duration of support, based on current overflow is £170,000 (if recruitment and call activity forecasts are achieved).

Incentivised EMA shifts

- 256 of the 375 (68%) incentivised overtime shifts have been filled with at an additional cost of £25,000.

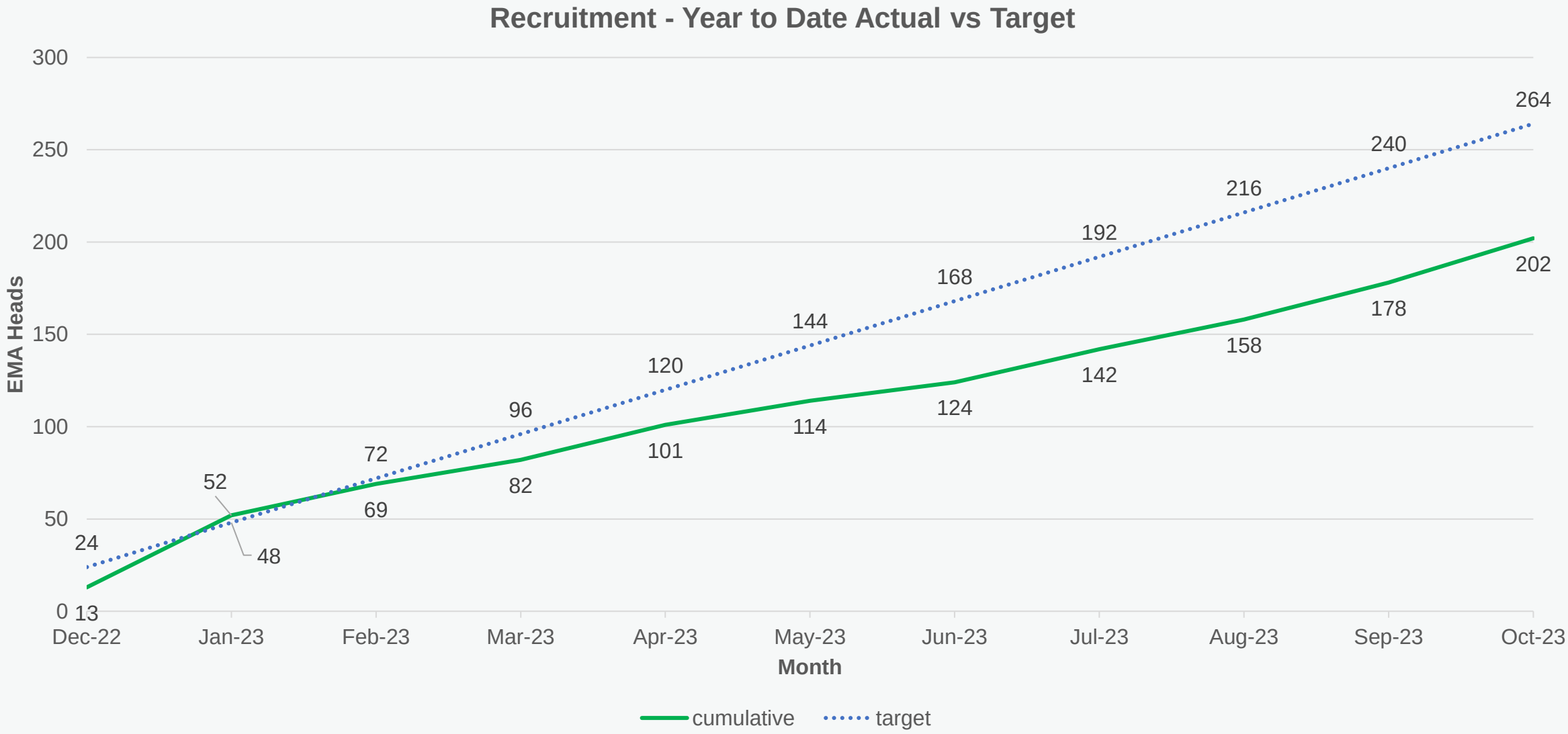
Dual Trained Cost

- We have provided 726 hrs of dual trained 111 call handlers at the cost of £10,628

Additional Funding

- Allocation of circa £850K "underspend" from NHS England 14-week intervention funding redirected for SECAmb to use for 999 call answering and Hear and Treat (C3/C4 validation and C2 Segmentation).

Workforce


Recruitment - Year to Date Actual vs Target
EMA Heads
300
250
200
150
100
50
0
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Month
13
24
48
52
69
72
82
96
101
120
114
144
124
168
142
192
158
216
178
240
202
264
cumulative
target

Risks & Interventions

Risks:

- Recruitment remains challenging, especially in Crawley, in terms of quantity and quality. (Controls: Project to improve recruitment with QI)
- Retention (Controls: EOC Culture Change Group, psychometric testing, other measures to improve)
- EMA rota review may lead to staff turnover (Controls: EMA Rota Review plan undertaken with engagement of colleagues and unions)
- Winter pressures affecting sickness (Controls: Sickness and absence management; wellbeing, health and safety and IPC measures)

Interventions:

- Additional funding provided to HR Recruitment to support advertising
- New agencies approached to facilitate better recruitment
- 2 x Band 5 staff provided from 111/999 to support recruitment team for next 6 months

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	67-23

Name of meeting	Board
Date	07 December 2023
Name of paper	Shaping the Future of SECAmb – Our Case for Change
Strategic Theme	Sustainability & Partnerships
Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning and Transformation

Executive Summary

SECAmb provides urgent and emergency care to over 5 million people across Kent, Surrey, Sussex and Frimley. However, population growth, an ageing population, and increased health inequalities are driving a projected 15% increase in demand over the next 5 years.

Moreover, the NHS faces significant funding and capacity challenges, hampering care coordination and the ability to meet patient needs. As the ambulance service, SECAmb is often the last resort when patients cannot access other NHS services.

While only 13% of SECAmb's patients have critical or emergency needs, 90% receive an ambulance response regardless of care requirements. This is now an outdated operating model that no longer meets the evolving needs of our patients, and is impacting our workforce wellbeing and satisfaction.

If unchanged, our response times could up to double by 2029 unless we recruit an additional 600 colleagues, increasing the amount of avoidable harm to our patients. The current model is becoming unaffordable, unsustainable, and unacceptable for our patients, our staff, and our partners.

A radical shift is needed to reshape our role supporting integrated health and social care. This will require better alignment with ICS boundaries, differentiating responses based on patient needs, and integrating better with partners to address whole-system challenges.

Our goal is to co-design a strategy that delivers equitable and sustainable patient care in the future, continues to respond to the evolving needs of our communities, enhances the experience of our people, and fosters integration and collaboration with our partners.

Recommendations, decisions or actions sought	The SCG is asked to note the contents of this case for change as we enter phase 2 of the strategy programme, where we will be co-designing the future models of care that meet the needs of our patients, support our people and partners, and make us sustainable in the long term.

Shaping the Future of SECAmb
Our Case for Change

1. We are SECAmb

1.1. SECAmb is the 999 ambulance and NHS 111 service providing urgent and emergency care to over five million people across Kent, Surrey, Sussex and North East Hampshire. This represents 9% of England's population over 7% of its land area, and every year we provide care to over three-quarters of a million patients, with our vehicles travelling over 15 million miles; enough to travel to the moon and back 50 times.

1.2. At the beginning of 23/24, our Board set out on a journey to develop a new clinically-led vision and strategy.

1.3. We aim to co-design this strategy with our people, partners and patients, so that we can deliver equitable and sustainable patient care in the future and continue to respond to the evolving needs of our communities.

2. The needs of our population are changing

2.1. The communities we serve span a broad range of urban and rural settings, socio-economic backgrounds, deprivation, and age, with significant variance across the Kent & Medway, Surrey, Sussex and Frimley ICSs. The health needs of our communities are, as a result, different in different parts of our region.

2.2. We expect to see an increase in population of 2.5% by 2029, or 125,000 people. This growth will be disproportionately higher in Kent & Medway. In addition to this population growth, 130,000 more people will be living over the age of 65 by 2029; a 12% net increase.

2.3. This will place increased demands on our service, as we already see 50% of our demand coming from the over 65s age group today.

2.4. The more deprived parts of our region will continue to see inequalities and increased ill-health, as 30% of our activity comes from the 20% of communities that are most deprived.

2.5. As a result of population growth, aging, and ill-health, projections show that we will see an increase of 111,000 calls a year by 2029, or a 15% cumulative increase vs. 2023. A higher proportion of this growth will be non-emergency, bringing additional complexity to our services.

3. The NHS is facing significant challenges

3.1. The health and social care sector is struggling to meet patient needs, and we are expecting a significantly challenging 24/25 financial planning round, in particular across the Southeast region. This is a result of years of mismatch between funding and demand.

3.2. The analysis of our current model shows that we are not sufficiently joined with our partners to deliver integrated care, with examples of excellent collaboration existing but being limited to certain localities. As an urgent and emergency care service, we will often still be the last port of call for patients struggling to access NHS services.

3.3. Part of our integration challenge is a result of our operational and organisational structure. Despite working across four ICSs, each with its own strategy, population health needs, and models for collaboratives, we are organised in a legacy East-West configuration, and the boundaries of our operating units do not naturally align with those of our partners, making effective collaboration more difficult.

3.4. As a result of being regionally commissioned and not adequately aligned with our partners, the role we should play in the future is not well defined, and we are not maximising our full potential to support healthcare systems to address the population health challenges they face. This is evidenced by the fact that across four recently published ICS strategies, the ambulance service is mentioned only twice.

3.5. If we do nothing, inadequate care coordination and system strains will result in further unmet patient needs and poor quality of care. We have a responsibility and an opportunity to reshape our role in supporting the health and social care system.

4. Our operating model has not evolved enough and is impacting our people

4.1. As a result of the changing population needs and challenges the NHS faces, we are increasingly seeing patients turn to our services with social, urgent, or other unmet care needs.

4.2. This is reflected in our activity profile, where only 13% of our patients are in need of critical or emergency care. A majority of our patients do not require a conveying response; however, we will dispatch an ambulance to 90% of incidents.

4.3. Our people report dissatisfaction with a lack of upstream differentiation, meaning we are responding in a similar way regardless of patient needs, and often providing an inadequate response with clinicians whose skillset do not align with the increasing complexity of needs we are seeing as a service.

4.4. As this trend is set to continue, our current model of care no longer meets the full needs of our patients, and it will continue to deteriorate in the next 5 years. This is adversely affecting the workplace experience and impacting on the wellbeing of our people.

5. Our model is no longer sustainable

5.1. The result of the increase in demand, complexity, and the wider healthcare environment, means that our current model no longer meets the needs of our patients, our people, and our partners.

5.2. Since 2018, the time needed for each patient has increased by 33%, and we are taking 42% longer to get stroke patients to hospital.

5.3. Furthermore, our people report amongst the lowest staff satisfaction in the NHS.

5.4. If we do nothing, modelling suggests that our response times will double by 2029 unless we recruit an additional 600 colleagues, increasing the amount of avoidable harm to our patients. Our model will therefore become unaffordable, unsustainable, and unacceptable to our patients, our people, and our partners.

6. Our Case for Change

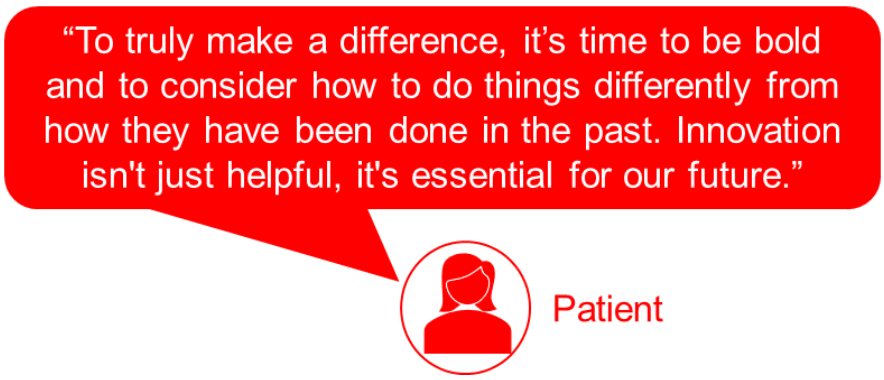
6.1. The needs of our patients are changing and becoming more complex. Population growth, ageing and increased complexity will lead to a +15% growth over the next 5 years.

6.2. The NHS is facing significant challenges. We have a responsibility to reshape our role to support the health and social care system.

6.3. Our model of care no longer meets the full needs of our patients. This is adversely affecting their experience and impacting the wellbeing of our people.

6.4. If we continue with the current model of care, we will need to recruit an additional 600 people over the next 5 years to respond to our most critical patients in a timely manner.

6.5. Doing nothing is not an option, and we must radically change our approach.

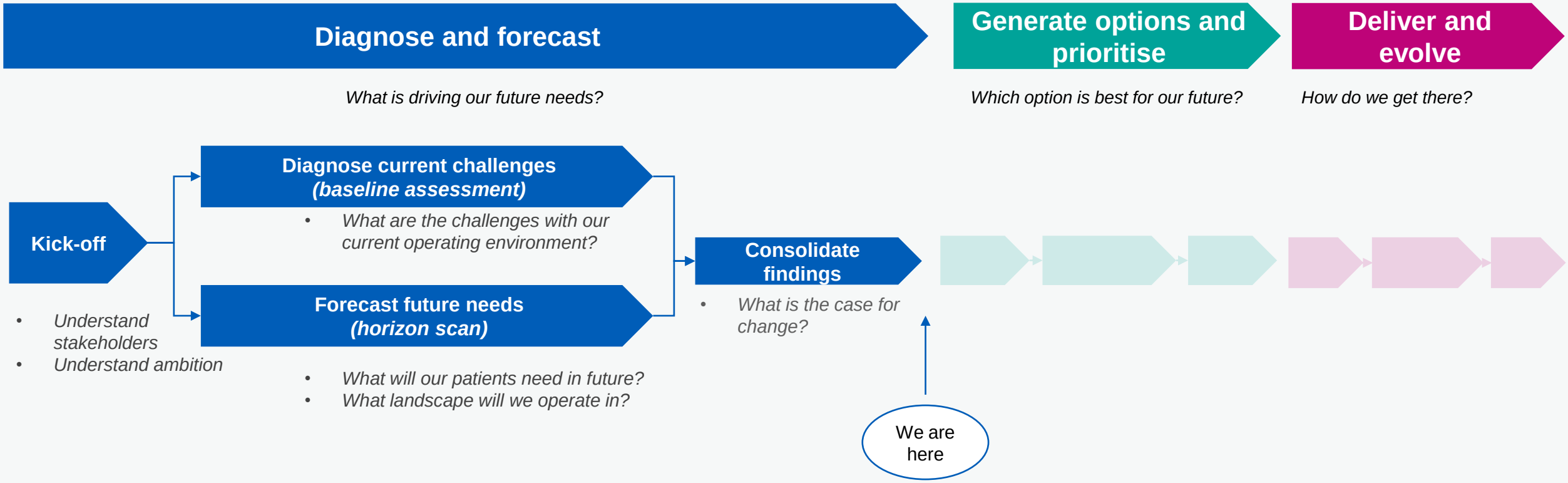


NHS
South East Coast Ambulance Service
NHS Foundation Trust

Trust Strategy

07/12/2023

In Phase 1 we diagnosed the current state at SECAmb and developed a case for change



Our findings have been developed into three levels of analysis

These three levels have different purposes, audiences and formats. The story is the same across all levels.

Level 1
The high-level narrative for the case for change

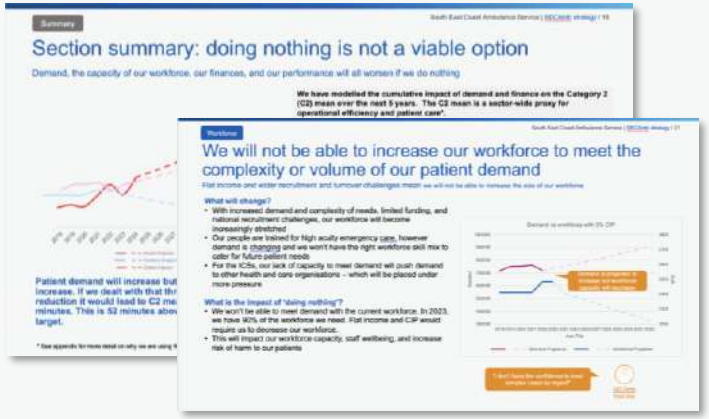
Audience: All. Including the public.

Purpose: A concise story, that can be used with any audience to communicate why SECAmb needs to change.

Length: 6 pages

For discussion today and publication

Level 2
The detailed narrative with evidence for the case for change



Audience: ICB colleagues, trust board members and our people at SECAmb

Purpose: A detailed narrative on the case for change, backed up by evidence, that can support in-depth discussions on the development of the strategy.

Length: 30 pages.

Signed off at EMB

Level 3
Detailed reference data that supports the development of the strategy

Audience: SECAmb executive team and programme team

Purpose: A supporting pack of data that can be used by the strategy programme team to aid the development of the strategy.

Length: 60 pages

(Evidence repository)

Our engagement so far…

… with our people

We have actively engaged with >300 colleagues throughout the organisation

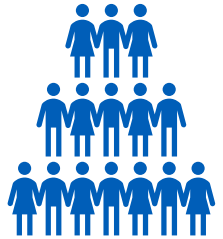
… with our partners

Over 40 ICB and partner organisation colleagues have involved so far

… with our communities

We have heard from >300 patients and people living in our patch

… with our volunteers



Over 200 of our volunteers have shared with us their ideas for the future

Phase 2 and 3 further engagement: Our data shows that we have more to ensure underrepresented groups are engaged in a way that reflects our communities and our people. We also will be looking to extend our patient engagement, and involve more of our colleagues during the next phase in co-design

"We want everybody who wants to, to have an opportunity to have their voice heard in our new strategy"

Board

NHS
South East Coast Ambulance Service
NHS Foundation Trust

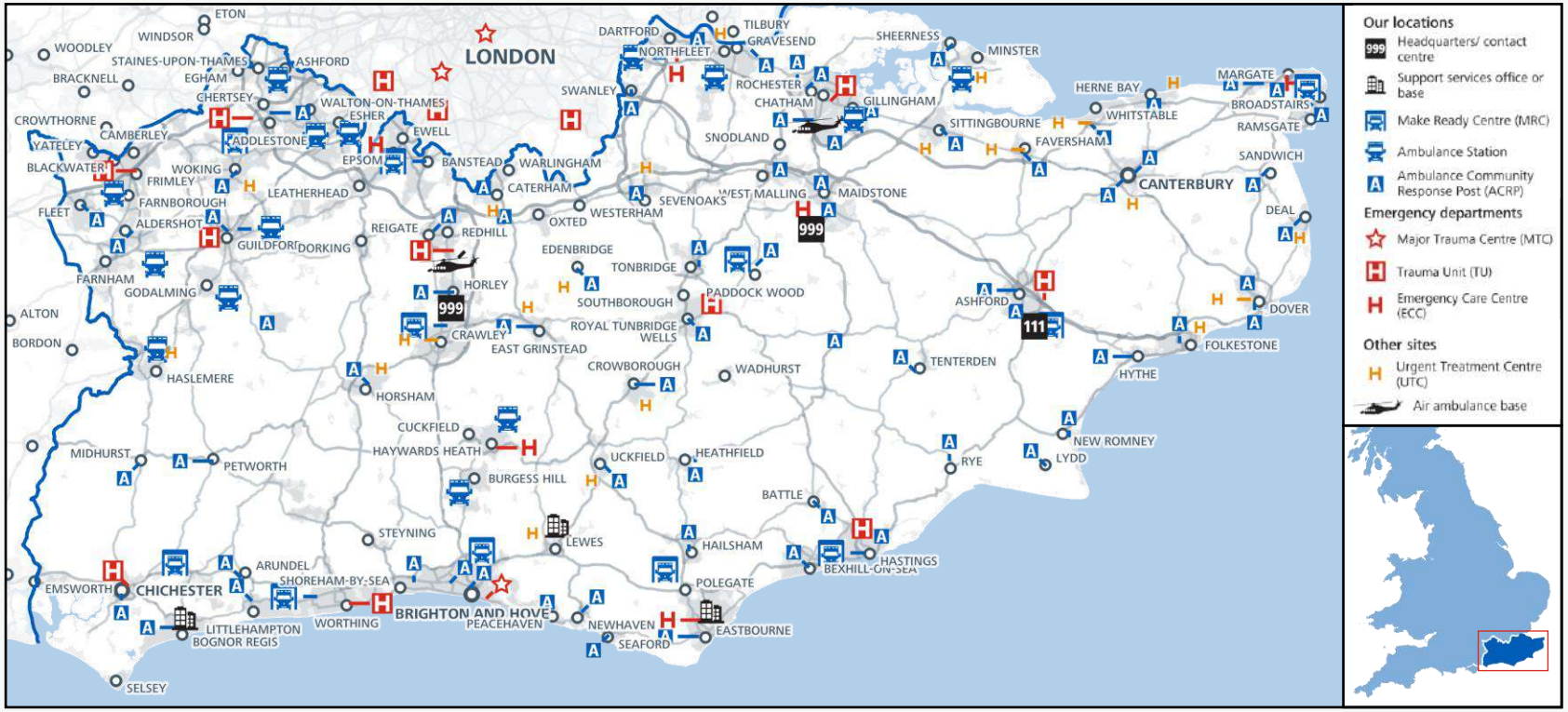
Shaping our Future Together

Level 1 – Our Case for Change

December 2023

We are **SECAmb**

We provide Urgent & Emergency Care to over five million people across 3,670 miles²; 9% of England's population.



2022-23
Financial year:

894,156
999 calls received

1,312,726
111 calls received

718,443
Incidents generated

648,238
Incidents attended

13,148,147
Miles driven

We aim to co-design a strategy that meets the evolving needs of our patients and communities, enhances our people's experience, and supports our partners

The needs of our population are changing…

Growing

We will serve an additional 125,000 people by 2029 (2.5% increase)

Ageing

130,000 more people will be over 65 years by 2029 (12% increase)

More complex

67% of our patients have two or more conditions and this will increase

Deprivation

Almost 30% of our activity comes from 20% of our most deprived communities

Projection: Together these will cause an additional 111,000 calls a year by 2029 (15% increase over five years).

The needs of our patients are changing and becoming more complex. Population growth, ageing and increased complexity will lead to a +15% growth over the next 5 years.

…As the NHS is facing significant challenges…

System Pressures

Health and social care is under increasing operational pressures nationally, regionally and locally

Funding

Funding has not been able to keep pace with increases in demand and inflation

Integration

We are not sufficiently joined up with our partners to deliver integrated care.

Role

Our role is not well defined, and we are not being used to our full potential.

Projection: If we do nothing, inadequate care coordination will result in unmet patient needs and poor quality of care.

"If our relationships with other providers were more mature, we could do so much better for our patients in the community"

Staff Network Chair and Operational Team Leader

"The ambulance service needs to work with other providers to ensure the right care at the right time"

Patient

"The ambulance service feels like a silent partner within the system"

Integrated Care Board Leader

The NHS is facing significant challenges. We have a responsibility to re-shape our role to support the health and social care system.

But our current model of care hasn't evolved enough...

Patient Needs

Increasingly our patients come to us with social, urgent or unmet care needs…..

Severity

….with only 13% needing critical or emergency care…

Response

… and yet we send the same response to patients with vastly different needs…

Skills

…with our staff whose skillsets do not align to their increasingly complex needs.

Projection: If we do nothing over the next five years, our model of care will fail to support our people in meeting the changing needs and complexity of our patients.

"We don't feel that we have the right training to care for the patients we serve"

Experienced Paramedic

"We have to make sure our patients have the heating on and that there's food in the fridge"

Emergency Care Support Worker

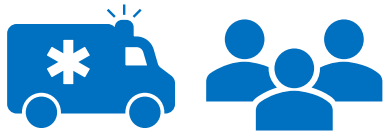
Our model of care no longer meets the full needs of our patients. This is adversely affecting their experience and impacting on the wellbeing of our people.

…And the mismatch has a real impact on…

… Our service

We need 33% more time per patient compared to 2018

… Our patients



We are taking 42% longer to get stroke patients to hospital compared to 2018

… Our people

We have amongst the lowest staff satisfaction in the NHS

"We find it frustrating when we can't do the right thing for a patient"

Advanced Paramedic Practitioner

"We are trying to be all things to all people, which we can't sustain"

Community First Responder

Projection: If we do nothing, our response times will double by 2029. This will increase the amount of avoidable harm to our patients. Our model will be unaffordable, unsustainable and unacceptable to our patients, our staff and our partners

If we continue with our current model of care, we will need to recruit an additional 600 People (23%) over the next 5 years to respond to most critical patients in a timely manner.

We are running out of road

The needs of our patients are changing and becoming more complex. Population growth, ageing and increased complexity will lead to a +15% growth over the next 5 years.

The NHS is facing significant challenges. We have a responsibility to re-shape our role to support the health and social care system.

Our model of care no longer meets the full needs of our patients. This is adversely affecting their experience and impacting on the wellbeing of our people.

If we continue with our current model of care, we will need to recruit an additional 600 people over the next 5 years to respond to most critical patients in a timely manner.

Doing nothing is not an option – we must radically change our approach.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Shaping our Future Together

Now is the time for change – we are developing a new strategy, and welcome the opportunity to better serve our patients and communities.

Find out more and get involved in shaping our strategy

SCAN ME

We aim to co-design a strategy that delivers outstanding patient care, enhances the experience of our people, and supports our partners.

“To truly make a difference, it’s time to be bold and to consider how to do things differently from how they have been done in the past. Innovation isn't just helpful, it's essential for our future.”

Patient

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	67-23

Name of meeting	Trust Board
Date	7th December 2023
Name of paper	External IT Review
Responsible Executive	Saba Sadiq – Chief Finance Officer
Author	Saba Sadiq – Chief Finance Officer

The finalised external review and recommendations is attached at Appendix 1.

This review has a defined governance route, i.e. the Executive Management Board (EMB), Finance and Investment Committee, Audit Committee and Trust Board.

The review's key findings are that

- there has been a lack of leadership within the IT team;
- the Trust suffered from 3 significant IT outages over a period from November 2021, November 2022 and June 2023 and was unable to quickly recover from each of these significant events nor has it identified the causes of each of these outages fully and therefore cannot implement plans to address the causes of the outages;
- the IT team's way of working with each other and across teams in the Trust needs to be improved and more collaborative and the team would benefit from further support and development;
- lack of digital and cyber strategies; and
- turnover at Board level in recent years has hampered the Trust's digital agenda.

This review has been shared with all members of the IT team. Under the CFO's leadership the team is implementing the recommendation in the report.

Regular updates on progress in implementing these recommendations will be brought back to the Executive Management Board (EMB), the Finance and Investment Committee, the Audit Committee and the Trust Board.

Recommendations, decisions, or actions sought	The Trust Board are asked to note the contents of this paper, the attached report and the CFO's response to the recommendations in the report.

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

EXTERNAL REVIEW OF THE IT FUNCTION

30TH SEPTEMBER 2023

FOREWORD

Since the work started some 3 months ago things have already begun to move on under the leadership of the Chief Finance Officer (CFO) and some of the points of governance and communication have already been absorbed into the day to day running of the department.

The key question of likelihood of failure of critical systems through the winter period is difficult to quantify as any system, under a set of given circumstances, may fail. The likelihood of a failure in SECAMB remains the same, it may happen, but what is important is the Trust's ability to recover and restore services quickly and seamlessly. On that point, it is apparent that a) Trust systems are in a better state and b) staff are becoming more vocal about continuing the improvement in disaster recovery and business continuity. Plans to upgrade Crawley are evidence of that change of approach and I believe that the Trust are in a stronger position than they have been for some considerable time under the CFO's leadership.

Latterly in this programme of work, discussions have focussed on the Trust's digital strategy. The work with the third party supplier on the Trustwide strategy is a good step forward. It must also be noted that the IT department will not be able to produce a digital strategy without the overarching Trustwide strategy and other enabling strategies. The Trust have commissioned a third party to help in the development of core strategies in the Trust including opertions and clinical and it would be natural for the digital strategy, along with estates and fleet to be developed to support those core strategies. However, a digital strategy has to be owned by the whole Trust and not just the IT department. The IT component of that strategy should be flexible enough to not constrain the Trust should a need to change arise in the future. Without a strategy it is difficult to define the departmental structure or the systems required to support that strategy and ultimately establish a culture of continuous improvement and learning.

There must also be recognition that SECAMB is a relatively immature orgnisation that has no formal mechanisms in place for initiative prioritisation or management of change. This and the lack of enabling and supporting strategies makes the production of an effective digital strategy and associated forward plans difficult. Consideration must be given by SECAMB to the establishment of a digital/change committee to support its growth towards a continuous learning culture that's required for a mature organisation.

Finally, this report is wide ranging to address the issues that I have found during my discussions with the IT department and stakeholders.

EXECUTIVE SUMMARY

1. The interviews with the IT staff at South East Coast Ambulance (SECAMB) were conducted over the months of August and September 2023. During this time several staff were heavily engaged in the mobilisation of the new control room at Medway Make Ready Centre (MRC). During the process staff were open and honest in their conversations and, whilst most felt that a change was necessary, there were different views of how radical those changes needed to be.

2. A significant amount of time was spent talking to many staff across the various IT teams. There are several issues that need to be resolved although they are neither difficult to resolve nor complex. In fact, even before the review was completed, changes were being made indicating a high degree of self-awareness under the leadership of the new substantive Chief Finance Officer. Staff that I spoke to were open and transparent about their issues but saw its impact in different ways. There were a few who saw no issues in the department and felt improved communication would address most of their problems whilst others saw the issues in the department as more deep-seated.

3. In my experience, SECAMB's position regarding IT is not significantly different to other ambulance Trusts in terms of their problems and challenges. IT departments are busy delivering transformational change whilst trying to maintain existing systems within an operational environment that is increasingly coming under pressure to deliver performance with no system downtime. At the same time the work and environment are becoming increasingly complex and the NHS, in general, struggles to compete financially for the technical skills they need. Staff in post lack time and encouragement to upgrade their skillsets due to lack of "on the job mentorship", capacity and available budget for such training and the opportunity to practice in a safe environment.

4. What is unusual, however, is the department's inability to quickly recover from a significant event, evidenced by three catastrophic failures occurring in the last three years (November 2021, November 2022, and June 2023), all resulting in significant downtime for the Trust's control room operations and consequently a potential impact on patient safety. It is not immediately clear why this is the case, but I suspect that if different decisions were made leading up to each of the failures, then it's likely that the outcome at the point of failure would have been different. Simplistically, decision making is or was flawed in not considering, more widely, the longer-term impact of actions being taken, or they lacked engagement with the appropriate subject matter experts to inform the process.

5. The IT department operates in a siloed manner, although that is not always true, sometimes teams, for example, service desk and critical systems, collaborate to achieve a goal but rarely does collaboration and an integrated way of working become a departmental wide objective. Medway MRC is a good example of this approach where it's clear some departments and some individuals have had less engagement than others. This is not that unusual but overall control at senior IT level, bringing the teams together, on a day-to-day basis as appropriate and ensuring communication takes place is significantly lacking. It feels like an orchestra with no conductor.

6. It would also be true to say that it is apparent that those silos exist within some IT teams. Job descriptions are unclear, work distribution is unfairly distributed across and within teams and some working relationships are less than effective.

7. The department's relationship with other parts of the Trust seems to be an issue and, again, whilst this not uncommon there does seem to be a lack of understanding within IT on what critical aspects of IT need engagement with the Board, for example, the risks around the Board Assurance Framework (BAF). From discussions, the risk of a cyber-attack was removed from the BAF (by the Corporate Governance team) without reference to the Chief Finance Officer or the cyber team and a remediation plan for a catastrophic failure was closed without being completed. Prior to the Chief Finance Officer, there was a lack of 'grip and control' on the department's work with no senior management review of work and decisions made. Discussions with the Trust's internal auditors indicated that no work had taken place in the IT department for several years despite significant catastrophic failures. The Chief Finance Officer and Internal Audit have agreed to include IT in the 2024/25 annual workplan.

8. It was noted that there has been significant turnover at Board level in the last few years and therefore an element of continuity has been lost. Digital representation at Board is important and it is likely that in the past, the director responsible for IT/digital has been more comfortable with their own area of expertise to the detriment of IT. That is clearly changing now with the Trust's new Chief Finance Officer both championing IT/Digital at Board and sub-committees as well as responding to early findings from this report. In addition, staff feel confident in approaching the Chief Finance Officer for support which she provides. Her leadership and proactivity is having a positive impact on the department.

9. On the key issue of whether the Trust are at risk of further failures the response must be that the risk of failure remains the same although with a higher level of assurance about the environment in which the Trust's systems sit. To understand this, whilst the failures in November 2021 and November 2022 were related, the June 2023 was entirely different although the outcome was the same e.g., significant control room impact. Any system can fail, and any failure should be treated as a learning experience so progressively the system becomes more resilient, however, the Trust capability and capacity to recover from a catastrophic event is another factor that must be reviewed. The department has not, for any of the three failures, identified fully the causes of the failures nor addressed them in full, simply moving to new technology as a solution. The Trust's processes in terms of Emergency Preparedness, Resilience and Response (EPRR) Team could be strengthened. The EPRR team lead the debrief process through the Resilience Group. Although the Resilience Group prepares a structured debrief document which includes recommendations this is not monitored by the Resilience Group. The debriefs for November 2021 and November 2022 were shared with the Executive Management Team. The debrief for June 2023 was shared with the then Chief Finance Officer. However, none of the 3 debriefs had management responses. There is no evidence that the Board nor the Executive Management Team, despite knowing that there were three failures have asked for further updates to be provided to them on a regular basis. The Board should consider this reflection further in its own performance. In addition, the Trust was allocated funding from NHSE to address the first outage and therefore the Board should further consider why it did not follow up on how this funding was spent and what work would be performed.

10. The other aspect considered in the failures was whether underfunding was a factor in the failures and could they have been mitigated by spending more money in key areas. There is no evidence to support that claim directly as significant money had been invested in the Trust's network, first with the initial system, Fortinet, and then secondly with its replacement, Cisco. The third failure resulted from preparation work for the migration to Medway.

11. What might be argued is the question as to whether the Trust have the appropriate level of skills at the capacity needed to operate critical systems. As an example, the critical systems team, when initially set up some 4 years or so ago comprised of a head and two assistants and today they are now around 8 whole time equivalents of who are heavily reliant on the technical skills of networks, systems, telephony, database administration which have by and large not expanded to the same degree and certainly not at the same technical level. There remain several single points of failure in some key areas including in telephony, database administration and some areas of cyber, networks and systems where a Technical Design Authority (TDA) would help.

12. In addition to addressing the ongoing risk to the Trust and the potential impact of a perceived underfunding the other factor to be addressed was a broad review of IT and how the department is doing. The review found that there are several issues with the department, including:

    - A silo working culture
    - Some levels of animosity and resentment between teams
    - Lack of physical management presence on site
    - "Land grabbing"
    - Lack of understanding of change management
    - Work is being not being completed.
    - Issues with job descriptions, including these being out of date
    - Lack of professional development for staff
    - Confusion about IT risks and issues
    - Lack of a cyber strategy
    - Lack of a digital strategy
    - Lack of regular engagement with technology suppliers which the Trust is using. This includes the Trust not taking up paid training from its technology suppliers but instead letting the training allocation expire.
    - No annual work plan (including more detailed plans) that are prioritised and jointly owned by the whole department and therefore no monitoring of work as a matter of routine.

13. The details in the report will draw out many of these issues although it would also be appropriate to acknowledge that discussions with staff have indicated that they have seen a number of these things already and are looking to address these. However, I am

unconvinced that the department would have addressed these issues without the external review shining a light on these issues.

14. The fundamental issue has been a lack of leadership within and outside of the department for several years (this includes at working and executive levels), allowing the department to work without the required and necessary leadership which supports and challenges, no effective governance in place, no controls framework, no prioritisation of programmes of work, no management review of work with teams being left to their own devices to make their own decisions which have been sub-optimal. In addition, communications and collaboration are always a challenge and they have been features of SECAMB IT for some time and an absence of a Head to hold things together has resulted in those gaps widening. There are, however, green shoots under the leadership of the new substantive Chief Finance Officer.

INTRODUCTION

15. The Board raised concerns about the three IT failures in November 2021, November 2022, and June 2023. This culminated in an external review being commissioned by the Chief Executive Officer in June 2023.

16. An initial term of reference was drafted that focused on the network outages and on the Computer Aided Despatch (CAD). The Chief Finance Officer, on her arrival in July 2023, widened the terms of referenced to include a fuller scope that focused on the technical as well as the human factors to be able to provide a full picture of the issues within the department.

17. The following report addresses the points raised in the Terms of Reference (Appendix A).

18. Regular discussions have taken place with the Chief Finance Officer and the Non-Executive Director with digital experience during this assignment.

Network Infrastructure Outage

19. The Fortinet system implementation, carried out in 2018, from memory was not without its implementation challenges and arguably was a brave decision at the time. It was noted that probably at the time of rolling out the system it was not an enterprise solution, lacking several features that the Trust needed and requiring workarounds. It was put forward that there was a reluctance on the part of the Trust's operational team to agree downtime for firmware updates on the network equipment which meant that, progressively the system became more and more out of date and therefore far more complex to upgrade when you are multiple versions behind. Operational reluctance to agree to downtime is not uncommon in a 24/7 environment and normally results in escalation within the Trust. In addition to bug fixes, patching and upgrading offers significant protection against cyber events. Responsibility for escalation lies with the IT department which has clearly not happened.

20. Technical staff believe that the network end equipment was fundamentally sound and that the firmware and attempts to correct it were the reasons behind the failure. Following the first failure in November 2021, an action plan to remediate the problems was drawn up which was, according to Internal Audit, submitted to the Audit Committee. However, those actions were never fully delivered and sometime early in 2022 a decision was made that there would be a move away from Fortinet onto Cisco. This decision was driven by the lack of engagement by Fortinet in trying to remediate all the issues and provide further assurance around resilience. It is not clear what assurances or actions the Audit Committee took related to the plan and how the action was closed. The Audit Committee may wish to reflect on its own performance in relation to this.

21. By November 2022 whilst the decision remained, to migrate to Cisco, very little progress had been made and the Trust were still on Fortinet with an unfinished action plan to remediate the system. I suspect that the decision to move to Cisco meant that much of the Fortinet remediation work was parked but conversely the plan to enact the Cisco change seems not to have been a particular priority. This evidences, in the department, a lack of leadership, ownership and completion of work that is vital for SECAMB to operate effectively.

22. There are several views why the failure occurred in 2022 but all are unlikely to ever be proven one way or another as the decision was taken not to fix the existing Fortinet system but to

prioritise the deployment of the Cisco system which was held in store in the Trust following the decision earlier in the year to switch providers. The system had developed a network loop somewhere creating broadcast storms on the network that made it impossible for normal work to continue. This was a different problem to that experienced the year before. The most credible reason for the failure in 2022 is the work that was taking place at the time on the Trust's corporate telephone system. Switching to Cisco at the time in November 2022 was a desperate act and was driven by a complete lack of engagement by Fortinet in supporting the Trust in trying to find a solution to the failure or at least to restore a level of service that would allow a controlled migration to a new infrastructure. These decisions evidence a lack of leadership and escalation within the Trust as well as the IT ability to make a recommendation.

23. At the time very little existed in the way of documentation, plans or diagrams and relied heavily on support from Cisco and their partner, SoftCat, to deliver the solution which was readily given by both parties and work commenced. The engineer from SoftCat was working on his own, supported by Trust staff, and indicated that he believed that the work could be completed in a day but made clear that he had a cut off time whereby he had to leave due to other planned work that weekend. His cut off was 2230 hours on Friday night. At 2230 the work remained unfinished due to several unforeseen issues during the day and the engineer left site. Attempts to bring in other companies or individuals failed because the system and the work undertaken by the engineer was undocumented and nobody was confident enough, on a critical system, to try to continue the work. At the same time the internal team, already having worked for 16 hours were also at risk of making errors through tiredness and the decision was made to close and restart when appropriate engineers were available.

24. It is difficult to argue what anybody would or could have done differently under the circumstances, but this was a desperate move and like many catastrophic events there are generally multiple issues at play.

    Points to consider:

    a) The initial failure occurred over 12 months previously and whilst the two failures had different cause and effect what happened in the intervening time to improve relationships that might have helped solve the second failure. The relationship with Fortinet was already known to be problematic so it is unclear why this had not progressed.
    b) What had happened from the time a decision was made to migrate to Cisco earlier in the year to prepare the Trust. The failure occurred in November, coming into winter pressures, so clearly there were no plans to migrate in 2022. This is also evidenced by the lack of plans, documents available e.g., had this been work in progress you might expect it to have moved beyond being kit in a box.
    c) IT staff are generally optimistically biased in assessing timelines so what would have been plan B on the day. It's clear that reassurance was being given by Cisco and SoftCat that somebody would help but it's not clear at what point that was going to be put in place. Knowing that such a critical timeline was key to the success of the work and having no alternative arrangements in place as a fallback is worrying.
    d) The Trust were supported by other Trusts in delivering the solution which indicates a lack of capacity in the Trust. There have been other instances where work was stopped in the Trust due to exhaustion of IT staff which suggests lack of resource, poor planning, or more likely, a combination of the two.

25. The failure in 2022 was almost inevitable following on from the failure in 2021 due to the Fortinet action plan being incomplete and a decision to move off Fortinet onto Cisco. The Trust knew they had a problem but 12 months later had still not resolved it. There will, no doubt, be reasons why this happened but the Trust need to reflect on how such a critical issue could have been allowed to continue for such a long period with no clarity on a timeline.

26. The June 2023 failure is unrelated to the previous outages and involved equipment between Crawley and Coxheath that provided guaranteed network capacity for voice and data and was prioritised as work critical to supporting the migration to Medway. Following implementation, a cybersecurity scanning tool was activated as part of routine checks, unrelated to the planned works, however this flooded the network with traffic so great as to reach the maximum number of concurrent sessions that the network design could handle. The problem was resolved by regression to the last working version of the system and remains that way to date. Discussions with several staff have not established why this work was critical to the migration to Medway.

27. The overall conclusion that can be reached on the Trust's current risk profile regarding critical systems is that the risk remains as high as it was prior to the failure in June 2023. In many respects this is not different to other Trusts who will have catastrophic failure of critical systems as part of their Board Assurance Framework (BAF) simply because the impact will always be catastrophic and therefore the only element that can be controlled is the likelihood of failure. Whilst SECAMBs work on Medway is likely to give the Trust much more confidence about the robustness of the infrastructure, there is still work to do and likely to be other disruptive work at Coxheath to retire systems connected to the network. It should also be considered that the term critical systems refer to a collection of systems including network, CAD, telephony, radio, clinical pathways, and mobile data with failures each having its own significant impact on controls and each requiring its own disaster recovery/business continuity arrangements.

Network and IT Infrastructure

28. The staff in the department believe that the system is in a far more robust state since the removal of Fortinet from the critical system environment and its replacement with Cisco switches. Due to the November 2022 outage the Cisco implementation in Crawley was rushed during the incident.

29. IT staff still talk about work that was never finished or systems that behave oddly (since the Cisco migration) but there is never time to revisit to understand and correct and therefore the likelihood of further failures remain significant. With Medway successfully up and working, mirrored by an upgraded Crawley (this element has yet to be programmed into the department's work programme) will begin to reduce the likelihood of failure on the network.

30. The situation that the Trust are now in is that its Crawley site is a mix of providers, both Cisco and Fortinet with Cisco primarily in use across the critical systems although not exclusively. Outside of the critical areas Fortinet is still in use, for example, across Make Ready Centres. In addition, the work to migrate from Fortinet to Cisco was completed in a rush in 2022 and the solution has not been revisited since and has been described as a minimum viable product, but "bombproof" according to the Trust's network manager. On successful implementation of Medway there will be an urgent requirement to bring Crawley up to the same standard and is likely to require a period of significant downtime, amounting to a significant number of days.

31. Conclusion is that whilst the Trust are in a far more robust position, until all the remaining work at Crawley is appropriately remediated then assurance will still be limited.

32. The Chief Finance Officer is aware of this concern and is working with her team to develop a detailed plan, including liaison with Ops, to be able to bring Crawley up to the same standard.

Redundancy

33. Redundancy in a business continuity arrangement is the duplication of critical systems and resources to ensure that the business can continue to operate even if some of its systems or resources are unavailable. Rather than just redundancy, the work should focus on the wider requirement of business continuity and disaster recovery.

34. Redundancy can be implemented in several ways, such as:

- Data redundancy: This involves backing up data regularly and storing the backups in a different location from the original data. This ensures that the data is still available if the primary storage location is damaged or destroyed.
- System redundancy: This involves duplicating critical systems and running them in different locations. This ensures that the business can continue to operate even if one of the systems fails.
- Resource redundancy: This involves having multiple sources of critical resources, such as power and internet connectivity. This ensures that the business can continue to operate even if one of the resources is unavailable.

35. Redundancy is an important part of any business continuity arrangement. By having redundant systems and resources in place, businesses can minimise the impact of disruptive events and recover more quickly. However, it is one aspect of disaster recovery.

36. Disaster recovery and business continuity are two closely related concepts, but they have different focuses.

- Disaster recovery is the process of restoring business operations after a disruptive event, such as a natural disaster, cyberattack, or power outage. It focuses on restoring critical IT systems and data so that the business can resume operations as quickly as possible.
- Business continuity is the process of keeping a business running during and after a disruptive event. It focuses on developing plans and procedures to ensure that the business can continue to operate, even if some of its systems or resources are unavailable.

37. In short, disaster recovery is about getting back to normal after a disaster, while business continuity is about keeping the business running even during a disaster.

38. The key differences between disaster recovery and business continuity are as follows:

Characteristic	Disaster recovery	Business continuity
Focus	Restoring business operations after a disruptive event	Keeping a business running during and after a disruptive event
Scope	Typically focuses on IT systems and data	Typically covers a wider range of business functions, including processes, people, and facilities
Timeframe	Short-term (typically days to weeks)	Medium- to long-term (typically weeks to months or years)

39. Both disaster recovery and business continuity are important for businesses of all sizes. By having a plan in place, businesses can minimise the impact of disruptive events and recover more quickly.

40. Examples of disaster recovery and business continuity measures are:

    - Disaster recovery:
        - Backing up data regularly
        - Having a plan for restoring critical systems
        - Testing the disaster recovery plan regularly
    - Business continuity:
        - Having a plan for identifying and responding to threats
        - Having a plan for communicating with employees and customers during a disruptive event
        - Having a plan for relocating operations if necessary

41. Conclusion is that in each of the failures the department failed on both disaster recovery and business continuity from a technical perspective although it's not clear that during any of the failures the controls could have continued to operate in a reduced technical capacity. For each system, both critical and non-critical, business continuity plans should exist and should be owned by the relevant departments.

Cyber Threat

42. The Trust are not Data Security and Protection Toolkit (DSPT) compliant for the current year although in August 2023 the Trust reported that they were approaching standards. For clarity DSPT covers both information governance (IG) as well as information security (IS). DSPT is also about education, training and development of all staff and not just about technical solutions. Internal Audit perform a mandatory annual review of the DSPT but only of a limited number of assertions as advised by NHSE.

43. Approaching standards would normally indicate that a Trust have acknowledged that they have work to do to achieve compliance and have submitted a plan for compliance, however, the position for the Trust over the past 5 years is as follows:

2022-23 (version 5) Approaching Standards	**02/08/2023**
2022-23 (version 5) Standards Not Met	**28/06/2023**
2022-23 (version 5) Baseline	**28/02/2023**
2021-22 (version 4) Approaching Standards	**29/06/2022**
2021-22 (version 4) Baseline	**04/03/2022**
2021-22 (version 4) Baseline	**27/02/2022**
2020-21 (version 3) Approaching Standards	**29/06/2021**
2020-21 (version 3) Baseline	**26/02/2021**
2019-20 (version 2) Standards Met	**28/09/2020**
2019-20 (version 2) Baseline	**01/11/2019**
2019-20 (version 2) Baseline	**30/10/2019**
2018-19 (version 0) Standards Met	**29/03/2019**
2018-19 (version 0) Baseline	**30/10/2018**

44. The Trust have been approaching standards in 2020/21, 2021/22 and 2022/23 without ever actually achieving the standard which suggests that the Trust are submitting action plans each year but not delivering on them.

45. Reporting is quarterly and the last time the Trust were fully compliant was in 2019/20. This is a poor performance from the Trust.

46. The Trust's cyber team, responsible for the IS element of DSPT, consist of a team of three which includes a manager, senior technical resource, and a part technical, part administrative assistant. There is insufficient challenge and support of the cyber team by the senior leadership within the department to be able to support them to achieve full compliance with the DSPT.

47. The team have received little to no formal cyber training. Formal cyber training provides a more comprehensive understanding of cyber security. Technical staff may have a strong understanding of the technical aspects of cyber security, but formal cyber training will provide them with a more comprehensive understanding of the threats, risks, and best practices for protecting against them.

    - Formal cyber training helps to develop critical thinking skills. Cyber security is a constantly evolving field, and technical staff need to be able to think critically about new threats and risks. Formal cyber training can help them to develop these skills.
    - Formal cyber training helps to build confidence. Cyber security can be a daunting task, and technical staff may feel overwhelmed by the complexity of the threats. Formal cyber training can help them to build confidence in their ability to protect against cyber-attacks.
    - Formal cyber training can help to identify and address gaps in knowledge. Even technical staff may have gaps in their knowledge of cyber security. Formal cyber training can help to identify these gaps and provide the necessary training to fill them.
    - Formal cyber training can help to create a culture of cyber security. When all staff are aware of the importance of cyber security and have the skills to protect against cyber-attacks, it creates a culture of cyber security within the organisation. This can make it more difficult for attackers to succeed.

48. The last point is borne out by the recent social engineering penetration test which identified significant gaps in understanding both in the technical and non-technical staff.

49. Overall, formal cyber training can provide many advantages over just using technical staff to manage cyber issues. It can help to provide a more comprehensive understanding of cyber security, develop critical thinking skills, build confidence, identify, and address gaps in knowledge, and create a culture of cyber security.

50. Whilst there is little wrong with the work being undertaken by the cyber team the issues for the Trust lie in the work not being addressed, such as training and education of all SECAMB staff. There is no evidence of a co-ordinated Trust response to the problem of a cyber threat which should be an integrated plan involving more than one department and a leadership arrangement that will ensure that that co-ordinated plan is delivered across the organisation. My view is that the cyber team should be doing more but they do not see it as their responsibility. As there has been a consistent lack of leadership in the department, the view of the cyber security team has remained unchallenged.

51. Board sub committees play a key role in the Trust's cyber position, and it should be expected that IS/IG including DSPT compliance is reported and tracked at the Audit Committee. The Trust's Internal Auditors have indicated that they have undertaken no work in IT apart from mandatory audit of certain elements of DSPT assertions including the voracity of Trust reporting. A recent note from NHSE indicates an expectation that Trusts should include cyber risks on its board assurance framework (BAF). The Trust's risk register did indicate that the risk of a cyber-attack was on the BAF, but further investigation indicated that it had been removed at some point, but no feedback had been given to either the Chief Finance Officer or those managing the risk who were unaware of its removal from the BAF

52. Cyber will remain a key threat to the Trust, evidence is already available that the threat is very real with the denial-of-service events at Advanced (Adastra and finance systems) and, currently, Mobimed (ePCR). The Trust should ensure that the Board are well informed about current threats, programmes of work and compliance with national standards through regular reporting to sub-committees.

Medway

53. Medway went live as planned at 0609 hours on 14th September 2023 in a well organised and well executed event. The interesting aspect of the day was that it began to reflect the self-awareness in the department to improve its efficiency and work in a more collegiate and collaborative manner.

54. Medway has set a high bar in the Trust and IT staff engaged in the work are rightly proud of their achievement. The work on the ground has been completed by Trust staff from critical systems, service desk, networks, telephony, radio, and systems and supported by a range of the senior team, particularly in the latter stages. The technical design work and implementation has been undertaken by the Trust's third-party support, SoftCat. The downside is that senior technical staff are concerned that they need appropriate training to help in the day-to-day management of the infrastructure, more so networks and telephony.

55. It is rare that IT staff can spend time in an environment that is not live doing their best work, Medway is such an example. As previously indicated, it is imperative that Crawley, as the other half of the configuration is given a similar opportunity to be raised to the same standard as Medway.

56. The Trust should also be aware that an unsupported version of the Avaya telephone system is still in use in both the 999 and 111 environments and should be upgraded to the latest, supported version as soon as possible.

Digital Strategy

57. The question regarding whether the Trust is making best use of resources can be addressed by considering that there is no current digital strategy, so the overall aims and objectives of

the department lack clarity. At a tactical level the department deal with day-to-day problems but take the approach that if something is working then leave it alone. Medway, like many large projects in most Trusts, override the business as usual and force collaboration. However, this approach is rarely conducive to good project management, and it is likely that Medway is over budget and late in delivery.

58. Inevitably the department needs to consider its structure and establish its capacity and capability to deliver the Trust's agenda over the next 5 years whilst it migrates from being an IT Team to a Digital Team – there will continue to be a need for both for the foreseeable future and no reason why existing staff cannot adapt to the change.

59. The main difference between a digital team and an IT team is their focus. A digital team focuses on the use of technology to improve the patient experience, while an IT team focuses on the infrastructure and security of the organisation's IT systems. The IT team has performed work on shared care records with external partners. What has been clear is that there is a lack of clinical ownership of this work. Therefore the Trust should consider the need for Chief Clinical Information Officer to support this work.

60. The difference between an IT department and a digital team can be summarised as follows:

Characteristic	Digital team	IT team
Focus	Using technology to improve the patient experience	Maintaining the organisation's IT infrastructure and security
Roles and responsibilities	Develop and implement digital solutions, such as electronic patient records and telemedicine	Manage the organisation's IT systems, including servers, networks, and security
Skills and expertise	Technical skills, such as software development and data analysis	IT skills, such as networking and security
Typical tasks	Design and develop new digital solutions, test, and deploy new solutions, and support existing solutions	Troubleshoot IT problems, maintain IT systems, and ensure that they are secure

61. The above would support the view that both "teams" have a place in the Trust, neither of which need to be mutually exclusive. Other Trusts are solving this by having a strategic presence at Board level with governance (including Cyber) and programmes directly accountable to that role along with a Chief Technical Officer (CTO) who is responsible for the

day to day running of the department which covers service desk and infrastructure including networks, systems, and radios.

The IT Department

62. The IT department consists of several sections including Service Delivery (Service Desk, Desktop and ICT Field), Critical Systems, Infrastructure and Networks (responsible for Network, Systems, Telephony and Cybersecurity), Data Engineering and IT Services. The department has been much the same for several years with discussions as long ago as 2017 talking about a restructure. It seems that a restructure has taken place at some point but has not really changed the overall structure.

63. Briefly departments are made up as follows:

- **Infrastructure and Networks** consists of cybersecurity (discussed in the previous section), consists of networks, systems, and telephony each with a designated manager leading the work. There is a difference of view of what the role is with senior managers in the department believing the roles to have day to day responsibility for staff. In contrast the managers believe that they are responsible for delivering the work plan and not staff management. The lack of leadership within the team has meant that this view not been challenged.

  Several staff reported that prior to Medway they were not being stretched and, in some cases, had looked to developing their own skills within Trust time. This also indicates that there is an inequitable distribution of work allocation within the department and little manager overview and oversight of work being performed (or not as in this instance).

  Staff in the department would welcome training opportunities and believe that they are not ideally equipped to deal with some of the systems being implemented by the Trust. Staff are proud of the work undertaken at Medway but have concerns about their own ability to support the solutions and believe that the Trust, will instead, rely on third party providers. A similar story exists with the Trust's new planned telephone system, CM10, where further training for the telephony support team will be critical to ongoing development and support.

- **Service Delivery.** The Service Delivery team consists of two sections – field service and service desk (incorporating Desktop). In the main, Field Service look after themselves as they have always done, tending to vehicle-based issues and station IT problems. The Service Desk is a flat structure with a single manager reporting to a senior manager.

  Staff were critical of senior and middle management stating that there was insufficient presence on site. The senior team managing the desk were very clear that their role was different and did not require them to be on site. Whilst this point does miss the value of visible leadership I believe staff are now beginning to address this point. They also stated that whilst rotas were in place to balance working from home and coming into work, a few staff abused the situation (lack of management presence) and repeatedly were able to work from home with little to no challenge. This has created a sense of inequity within the team which does not support collaboration and team working.

  The Service Desk typically is a natural area from which to recruit into other technical roles within the Trust but for around 3 years the team has been relatively stable, with some internal promotions and external recruitment. Recently, service desk staff have been interviewed for various roles but have been unsuccessful and feedback has either not

been given or has been critical and disjointed e.g., lack of communications between managers. Service desk staff have also indicated that there is a lack of development opportunities to improve.

There is a view that the role of the service desk is about clearing tickets lodged by SECAMB staff although their approach has been criticised by other departments. There is a belief that tickets are sometimes closed without resolution for administrative purposes to the dissatisfaction of the users.

To balance the debate, the department receive a high level of satisfaction with the service provided and would argue that they do achieve this on a significantly high level of feedback on which to base their position.

In addition, it was described by a manager in the team that all staff are given an hour per week off the rota to undertake development in an area of their choosing, agreed with their manager which staff rarely undertook. In addition, the Trust subscribe to an online training system, CBT Nuggets, which is made available to staff, but very little training has been undertaken in the current year which raises both value for money concerns as the training product remains unutilised and that the staff either do not wish or do not have capacity to upskills themselves.

- **Critical Systems Team.** The critical systems team support the main functions around the control room, covering such work as Computer Aided Dispatch (CAD) system, electronic patient care record (ePCR) and other operational systems as well as being the point of contact for issues developing with those systems.. The team have been key to the day to day running of the Medway project. The department has grown significantly from its inception sometime around 2017 and are now headed up by a technical resource. that supports level 2 and 3 IT technicians and senior technicians in Networks and Infrastructure to resolve more complex problems.

  All departments were complimentary about the impact of the department and their impact on the IT workload although there was a view in departments that critical systems were “land grabbing” e.g., taking much of the “interesting” work and leaving the service desk to generally service the corporate queue. This should be addressed so that all members of the department feel that there is an equitable allocation of work and development opportunities. The Service Delivery and Critical Systems teams should be brought together as there are synergies in these teams and this will create resilience in service provision.

  The team are still hugely dependent upon expertise from the IT department such as telephony, networks and systems who often lack the depth of the critical systems team and have not grown at the same rate. At the coalface there is a respect and acknowledgement between the service desk and critical systems but there are some frustrations between managers. This will need to be addressed to ensure that teams collaborate in a positive manner to support SECAMB achieving its objectives.

- **IT Services.** This team consists of a manager, an administrator, and a Mobile Device Management (MDM) specialist. This is a historical role in the Trust that generally sits within procurement in other Trusts. The addition of the MDM specialist is likely to be historic and will be related to a particular project in the Trusts past that has never really found another home although typically elsewhere it would be part of an End User support department.

A value that the individual within the role brings to the department is both senior manager capacity and an understanding of the change management process.

Consideration should be given to moving IT procurement into the procurement team.

- **Cyber.** Cyber has been discussed in a previous section.

- **Business Intelligence (BI) team and Data Engineering Team**. Through some recent history, the Data Engineering Team have remained within the IT department although the BI team formed in the Strategy team a number of years ago (this situation arose out of a discussion with the previous substantive CFO and the current Director of Strategy and Transformation). Discussions had previously gone on since that split for the Data Engineering Team to move across to BI for a number of reasons. The Data Engineering Team spend much of their time building environments within which the BI team can operate, and the Data Engineering Team have a reliance on the IT department, particularly networks and systems to help create those physical and virtual environments. Like IT, with a move towards digital teams, software development is moving towards data engineering and whilst strong coding skills are crucial to both areas their outputs are different. The Trust BI department have a roadmap that in the future will make use of techniques such as Machine Learning/Artificial Intelligence (ML/AI), Natural Language Programming (NLP) and Real Time Analytics which requires the development team to remap their direction to support the BI approach. The BI and Data Engineering Teams do not collaborate with each other leading to some confusion and conflict.

- Logically it would make sense to bring together development and BI as originally planned, however, the larger question is whether it should be BI moving into IT or Data Engineering Team moving out of IT and into BI under a different directorate. This does differ around the country in ambulance services but a personal view would be that under a strong strategic leader at board there should be a Chief Technical Officer leading technology/digital and a performance/business intelligence counterpart leading BI/digital.

- There are many opportunities to improve patient outcomes through a cohesive, collaborative digital strategy which the Trust are currently missing. Equally important is that this approach must be clinically led through either a clinical director having this within their portfolio or the appointment of a senior clinician, a Chief Clinical Information Officer (CCIO), accountable to a clinical director. It should be noted that this role is different to that of a Clinical Safety Officer (CSO) which I believe exists in the Trust.

64. **Staffing issues in the IT Department**: Some staff believe that they are not being managed (as expected by senior managers). Job descriptions are unclear, work distribution is unfairly distributed across and within teams and some working relationships are not effective.

SECAM IT Profile

65. I described SECAMB IT earlier as an orchestra without a conductor but if it was a person, you would describe him/her as aimless, surviving, and uncertain of his/her future and unsure of what's next.
66. SECAMB's IT issues are not considerably different to other Trusts but what does seem to be an issue is their inability to recover from a catastrophic outage. In my significant time working in ambulance technology, I have no recollection of a Trust managing without critical systems for "days" at a time let alone three events at the same Trust in three years. This may be related to the position the Trust found itself in by poor decision making, including cost based

decisions, leading up to the outage or an inability to plan a recovery compounded by a lack of leadership.

67. The Trust have a home working policy that allows staff to arbitrarily work from home and live out of the area. This does potentially compromise the Trust's business continuity arrangements as staff are clearly not going to be able to attend site quickly in the event of an emergency. The Trust should seriously consider which roles need to be based locally (within the region it operates in) as often a catastrophic failure requires highly visible leadership from IT, both to give the Trust confidence and to lead and co-ordinate the business continuity and disaster recovery plans. In some cases, staff employed by the Trust are not even UK based.

68. What is apparent is that there is a lack of leadership throughout the department, not just at senior level but at all levels that ensure that a) work that is identified as critical is completed in a timely fashion, b) that there is somebody looking at the gaps between what each section are doing and ensuring that steps are taken to plug the gaps either internally or through third party or from other areas of the Trust itself and c) that work is reviewed at appropriate levels to ensure that it is fit for purpose.

69. The department lacks a vision, a strategy, a reason for its existence, an idea and an objective that is sold to staff so that they understand why they are doing what they are doing. That is not to say that some of this doesn't happen locally in each section but there is a lack of a collective imperative that understands what the Trust needs and how it can help deliver that Trust wide future.

70. It is important to identify that the Board could have been more engaged in the understanding of how IT was coping given the long-term absence of the Associate Director of IT, particularly knowing that the department lacked a depth of vocal, "lead from the front" individuals. The Board should look to reflect on its own performance in relation to the issues and severity of these within the IT department.

Conclusion

71. The IT department has a strong foundation of talented and experienced technical staff, but it is lacking in leadership and direction. To reach its full potential, the department needs a clear plan, a strong and visible leader, and a renewed focus on its purpose of delivering local transformation and the Trust's planned Digital agenda. The appointment of the substantive Chief Finance Officer is providing strong, visible leadership and direction to the team and this is being felt throughout the department.

72. The Trust should invest in leadership training for the IT department and identify and develop the next generation of technical leaders. The Trust should also develop a clear plan for the department's future, with specific goals and objectives, including how the department can support local transformation and support the delivery of high quality and safe patient care. Finally, the Trust should ensure that the department has organisational structure, clarity, which will allow it to flourish and become an enabler for the wider Trust strategy.

Recommendations

Short Term (To March 2024)

a. Establish a clear leadership team that is in touch with staff and not seen as remote.
b. Set clear expectations at every level through the IT department, especially at manager levels about behaviours, values, reviewing work, escalation processes and start to develop a culture where collaboration and information sharing is the norm.
c. Look internally at the capability of service desk staff and identify individuals that are likely to be able to step up to level 2 and 3 positions and offer development through secondment or other training.
d. This will be long and many of the things I have no doubt we will say that we already do them, but do we do it consistently, regularly and across all areas. We really need to be saying “show me” with a lot of these areas.
e. We need to instigate formal weekly meetings – an hour a week for senior managers, 2 hours every 4 weeks and half day each quarter face to face. Agendas, action plans and minutes should be taken. Consider PDRs, statutory and mandatory training, and recruitment as standard items. Consideration should be given to awaydays to support the one team culture.
f. All managers need to be onsite far more than they are – I would strongly advise up to 2 days a week (minimum) for each manager and there should always be at least one senior manager visible every day.
g. Virtual staff meetings once a month for an hour, properly focussed on the business of the department, announcements etc. Useful also for other departments to attend – staff welfare, freedom to speak up as examples. Use as an opportunity to thank staff for contributions where expectations were exceeded.
h. Revisit risks and issues and make sure the mitigating actions and ownerships are clear and are being addressed in the agreed timeline. Consider BAF risks and develop a feedback loop from sub-committees and the Board.
i. Sort out job descriptions where there is confusion – be clear about what we are asking team leaders to do and what we are asking managers to do. This should also include on-call rotas.
j. Develop a prioritised annual workplan that is shared across the department and is supported by strong project management skills to deliver the annual workplan.
k. Implement post project debriefs to ensure learning is obtained across the department.
l. Develop a culture that supports collaborative working across and within teams and effective working relationships, at all levels, across the IT team..
m. Resolve the issues within the development team by better integration with the Trusts BI function.

Medium Term (April 2024 – March 2025)

n. Review structure of the department in the medium term and plug gaps. This reivew should include the requirement for a Chief Clinical Information Officer (CCIO).
o. Plan for closure of Crawley with a clear plan to upgrade the site to the same standard as Medway. This should also include a clear plan for redundancy.
p. Consider the future of BI and IT as a combined function under strong leadership at board.
q. Consider the future of the Service Desk and Critical Systems teams as a combined team to ensure sufficient coverage and resilience.
r. Consider the use of Marval going forward as well as project management tools to support IT to better deliver its service.Run monthly performance meetings where team leaders present performance against KPIs to the whole senior team.

s. Complete the work on the 3 outages to identify why they happened, what action has been taken to address the issue so that the 3 outages can be closed down. In addition, to this, there should be a review of how the Emergency Preparedness, Resilience and Response (EPPR) team take forward debriefs of EPPR incidents.
t. The IT team to have a documented approach to a major outage including which staff need to return to the workplace and how debriefs should be handled via a Standard Operating Procedure.
u. Training needs analysis to identify specific requirements and development of a training plan, including consideration of a panel to evaluate training requests. Invest in Pluralsight licenses (or similar) and encourage staff to spend some of their own time learning.
v. Look at leadership training and how we engage with each other to make the team more productive.
w. A cyber security working group (led by the IT team) that includes relevant stakeholders across the Trust to push forward with the cyber security agenda.
x. Appropriate level Cyber training for all IT staff at the right level – Daniel Oliver, the Trust's NHSE Cyber Rep, can assist.
y. More in depth training for those with cyber responsibilities e.g., Head of Cyber.
z. Provide time and space once a month for a technical workshop that all tech staff are invited to and bring in a mixture of internal and external SMEs to talk about topics.
aa. Set up an internal Technical Design Authority (TDA) or Enterprise Architecture Council (EAC) with the right attendance to oversee future changes to ensure that they fit with the Trust's digital strategy. This should include planned outages communicated Trustwide.
bb. Set out clear workplans across the department and make sure they are complimentary and aren't conflicting with other team's work and ensure progress is monitored.
cc. Active strategy to manage supplier relationships to benefit the Trust, including access to supplier training.
dd. The department should look to develop networks across the Ambulance Trusts in England.
ee. Cyber-attacks are on the increase and the Trust must have a Cyber incident response plan – the Board need to be clear that the arrangements for monitoring are appropriate and at the right level.
ff. Sort out the reasons why DSPT was not achieved – we all talk about the fact that 95% IG training is an issue but there will be several other reasons which may prove to more difficult to achieve. For example, has it been considered in the build of Medway. Have an action plan that will enable achievement of the DSPT in 2024/25.
gg. Each IT sub-team to produce a business continuity plan (BCP)/disaster recovery (DR) to feed into an overarching BCP/DR for the IT department.. This should be reviewed by a sub-committee of the Board. In addition, IT should ensure that BCPs for all business areas are collaboratively developed to ensure that all IT elements are addressed in the BCPs.
hh. Develop sustainable working digital relationships with SECAmb's ICSs.
ii. Develop a Digital Strategy.

Long Term (April 2025 onwards)

jj. Look to establish the capacity and capability that the Trust will need to deliver its longer-term strategy.

Barry Thurston
AACE Consultant
30th September 2023

Appendix A

IT External Review: Terms of Reference

This document sets out the terms of reference for the IT review that will be led by Barry Thurston and supported by Dan Gore. Barry Thurston will report into the Chief Finance Officer for the purposes of this assignment.

The scope of this work will cover the areas identified below. Additional elements may be added to during the assignment subject to agreement by the Chief Finance Officer.

1. Network infrastructure outage

To perform an in-depth technical review of the Trust's network outage. This review should determine the technical cause of the outage, how that relates to previous technical failures and what mitigating actions the Trust has taken to prevent a similar occurrence going forward. As part of this work, a review of how this incident was managed and what lessons can be learned in managing a similar failure in the future should also be performed.

2. Network infrastructure and IT infrastructure

To conduct a technical in-depth review of the network infrastructure and IT infrastructure (traditional and cloud). This work should include a review of the design and configuration to ensure that it is optimal, resilient and supports the critical elements of the Trust's business. This work should include a review of the support and maintenance arrangements in place (internal Trust resources and third-party resources) to deliver the Trust's critical IT systems.

3. Redundancy

To perform work that will identify gaps in the redundancy of the Trust's IT systems and that the redundancy that is in place to support the intention of increasing the reliability of the system is appropriate and in line with best practice in the NHS and more specifically to ambulance trusts.

4. Cyber security

Review the Trust's response to cyber security to ensure that it is aligned with best practice within the NHS and more specifically to ambulance trusts. This work should include identifying vulnerabilities and understanding how to overcome areas of cyber security high risk.

5. Resilience including IT emergency preparedness

The Board has requested an update on the Trust's current IT resilience position. This work will establish whether the IT systems are resilient and whether these are tested by the IT team on a regular basis. As part of this work review the IT team's business continuity plans to ensure that they are fit for purpose and in line with best practice to keep the service running with the least disruption.

6. Medway Make Ready Centre (MRC)

To perform work that will establish whether the IT work is ready to support the anticipated go live date of 19th September 2023 for the 999 and 111 services without disruption, including sufficient IT resilience to support the go live date. This work should also cover the IT timetable for closing the Coxheath site by end of December 2023.

7. IT use of its financial resources

Review how the IT team plan and use their financial resources, both capital and revenue, to support delivery of a first-class IT service for an ambulance trust, benchmarking against other ambulance trusts.

8. IT governance

The Trust will be developing a digital strategy in the next 6 months. This work should include a review of the current governance in place for IT projects from business cases to approval processes, project management and change management etc. The governance process should be in line with best practice within the NHS and more specifically ambulance trusts.

9. IT service delivery

Review the service provided by the IT team to support the business and to end users, for example, processes, timescales for resolution of issues etc, to establish if it is in line with best practice in the NHS and more specifically ambulance trusts.

10. Resources (people)

Review the Trust's existing IT function to determine its current strengths, weaknesses and make recommendations as to what needs to be done to ensure a resilient set up which can meet the Trust's digital needs.

11. Digital Strategy

Describe at a high level the key components for a digital strategy for the next 3 to 5 years (plan on a page) that the Trust should be seeking to enact to future proof its digital IT provision and service in line with best practice across the NHS and more specifically in ambulance trusts and wider from international best practice to set itself up for success. This work should look to include how can the Trust support our data, insights and business intelligence to strengthen management information.

12. Support to the Chief Finance Officer and Associate Director of IT

Part time support to the Chief Finance Officer in support of her digital portfolio, the Associate Director of IT and the general IT team for 16 hours a week over a period of some 3 months from August to end October 2023.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	67-23

Name of meeting	Trust Board
Date	07 December 2023
Name of paper	NARU Review of Interoperable Capabilities
Responsible Executive	Emma Williams, Executive Director of Operations

An external review was commissioned by the SECAmb CEO within involvement from the National Ambulance Resilience Unit (NARU) and representatives from the Association of Ambulance Chief Executives (AACE).

NARU had undertaken an audit in January 2022. Following the development of a new series of core standards, NARU used these to develop an updated series of KLOEs on which to base their visit. This visit occurred over 3 days at the end of September 2023.

Whilst the review identified no safety critical areas, it did show an overall deterioration against these new KLOEs.

Following the visit an action plan has been developed by the SECAmb Resilience Team in conjunction with the lead ICB commissioner.

Additional governance and oversight considerations have been proposed as part of an annual cycle of business for both internal and external stakeholders.

A suite of documents have been submitted as part of a comprehensive response to the NARU review and ongoing HART delivery concerns.

Recommendations, decisions, or actions sought	• Support for the findings, recommendations, and response to the NARU review. • Agreement for ongoing governance and monitoring to ensure progress is being achieved against all KLOEs.

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

National Ambulance Resilience Unit
NARU

NHS

REVIEW OF INTEROPERABLE CAPABILITIES

2023 – Follow Up Report

South East Coast Ambulance Service NHS Foundation Trust

SECAMB

[Final – Preceding Trust Challenge Period]

Front Sheet

Trust		Review Team	
Trust	South East Coast Ambulance Service NHS Foundation Trust (SECAMB)	SRO / Lead	Christian Cooper (HO)
AEO	Executive Director of Operations – Emma Williams	SME	Nicholas Spence (SM)
EPRR Lead	Head of EPRR – Dave Williams	SME	Andrew Lloyd (OO)
Key Review Documents 2023 Follow Up		SME	Jenna Davies (IM)
		SME	Parsyab Khan (SM)
		SME	Graham Finnigan (OM)
		Biographies of review team members available as part of the review paperwork.	

- SECAmb Annual Review of Interoperable Capabilities 2021/22 Final Report (18/04/22).
- NHS England EPRR Core Standards (interoperable capabilities) 2022/23
- SC30 NHS Ambulance Service Standard Conditions (contract obligations).
- Initial follow up review letter to AEO (19/06/23).
- Follow up letter confirming Key Lines of Enquiry and call for evidence (23/06/23).
- Review methodology and preparation of evidence guidance 2023 (v1.1).
- Biographies of national subject matter experts and members of the review team.

Key Dates	
Initial letter	19/06/23
Follow up letter and issue of KLoE	23/06/23
Evidence submission	14/07/23
Return of initial evidence review	21/07/23
Confirm and challenge (review) date	26/07/23 to the 28/07/23
Submission of report to CEO	21/08/23

Trust challenge period open until the end of September 2023.

Grading Key: Initial Evidence Review					
	[Green] Appears of show an appropriate level of compliance.		[Amber] Some evidence has been provided but requires further information or interrogation.		[Grey] No evidence submitted or no evidence required.

Grading Key: Final Report (Post Confirm and Challenge)					
	[Green] Safe and complainant with the national standard.		[Amber] Improvement required, but through appropriate mitigation is considered safe to operate at this time though may not be sufficiently operationally effective.		[Red] Non-compliant or falls below the national standard. May also represent unsafe practice or operations.

Executive Summary

5	**Twenty-four red gradings and thirteen amber gradings. Five lines of enquiry deemed to be compliant at the time of the review.**
13	
24	**Currently a very low level of compliance and a significant deterioration from the previous position in April 2022.**

Background

Subject matter experts from the NARU Operations Team are periodically asked to support NHS England and the Care Quality Commission in assurance reviews of the interoperable capabilities specified under the NHS England EPRR Core Standards. These capabilities are highly specialised in nature and include nationally specified safety critical systems to protect staff and patients.

In 2021/22, NHS England commissioned the NARU Operations Team to conduct a comprehensive review of the interoperable capabilities in each English Ambulance Trust. These reviews were conducted in accordance with approved audit methodology in a nationally consistent way. Reports were provided to each Trust, the Care Quality Commission and NHS England Regional Performance Leads. A national comparison report was also provided to the National Resilience Team at NHS England.

This is a follow up report for a single organisation. It therefore sits outside of the national NHS assurance process. It has been conducted 14 months after the previous review of interoperable capabilities in SECAmb at the request of the Trust's Chief Executive. This follow up review has been conducted using the same methodology as the original review and is presented in the same format to allow direct comparisons to be made. However, due to changes in the national EPRR core standards which occurred in 2022/23, an adjustment has been necessary to the overall number of lines of enquiry used in this report. The previous report included 51 lines of inquiry. This follow up report uses 42 lines of enquiry as a result of the national merger of CBRN and MTA capabilities. The lines of enquiry used in this report do allow direct comparisons to be made to equivalent lines in the previous report but caution should be exercised if undertaking an aggregated comparison.

How to view this follow up report

- The main body of the report contains three principal columns.

- The first provides the Key Line of Enquiry (KLoE) reference and a cross-reference to the contractual standard defined within the NHS England EPRR Core Standard provisions (part of the SC30 standard ambulance contractual obligations on NHS Ambulance Trusts in England).

- The second column is used by the review team to summarise the evidence they have reviewed and the initial grade it was given prior to the on-site confirm and challenge element of the review. The grade in this column should be viewed only as an interim position and not part of the final grading. It is provided to aid full transparency of the review and provides justification for the questioning and activity undertaken during the on-site element of the review. It also summarises evidence subsequently obtained whilst the team were onsite.

- The third column summarises the overall findings of the review team after reviewing the final submissions of evidence, any follow up evidence provided during the on-site element of the review and the interviews conducted with frontline staff and service managers. The RAG grading shown in the far-right column is the final grading post review for each key line of enquiry. It is these grades which are summarised above.

- To understand what the findings of this review, it is best to read the third column of the report.

For reference purposes, the full key lines of enquiry used for this 2023 follow up review have been set out in this report at **Appendix 1** (page 63).

The review team biographies have also been provided in this report at **Appendix 2** (page 79).

Executive Summary of Findings

The Trust engaged positively and fully cooperated with the review.

This follow-up report evidences a significant decline in compliance with the required standards and in the state of readiness of the interoperable capabilities since the last report. The Trust now has a very low level of compliance for the interoperable capabilities.

Although several areas of non-compliance have been identified, it was not necessary for the review team to advise any suspension of services on safety grounds and, at the end of the onsite review, it was fed back to the Trust that there were no safety critical issues which required immediate action to protect staff. During the feedback session, the Trust was advised to take urgent steps to confirm the competence of its commanders in line with the findings set out in the relevant key lines below and that should be done before the release of this report.

Several of the red findings in this report represent serious compromises in the effectiveness of the interoperable capabitlies which would negatively affect the response to major or complex incidents in the South East region or in the provision of mutual aid to a national emergency. As a result, urgent and prioritised action is needed.

Overall, there has been insufficient progress to address the recommendations and findings of the previous report. Furthermore, several lines of enquiry show declines in compliance and performance.

During interviews, there were some signs of potential improvement. Managers described a restructure and positive plans to make significant improvements at some point in the future. Unfortunately, at the time of this follow up review, very little improvement could be evidenced and most of the positivity related to rhetoric around future plans rather than fully implemented measures. Several key documents and plans were very new and still in draft so could not be considered as live and embedded on the date of the on-site element of this review.

Lack of progress was linked by some managers during interviews to commissioning challenges, problems in the wider healthcare system and internal staffing issues. There was evidence that these themes have impacted on compliance and performance in some key lines. However, they do not adequately explain the lack of improvement or deterioration in several other key lines.

Movement Summary

2022 SECAmb Report – Grading Summary		2023 SECAmb Follow Up – Grading Summary	
	7 Reds		**24** Reds
	23 Ambers		**13** Ambers
	21 Greens		**5** Greens
Out of 51 lines of enquiry		Out of 42 lines of enquiry	
The reduction in lines of enquiry reflects the 2022/23 changes to the EPRR core standards and the merger of MTA and SORT capabilities.			

National Benchmarking

The table below allows a comparison to be made between the results of this follow up report and the grading results for every other English Ambulance Trust at the time of the last review in 2022, noting that follow up reports have not been conducted for other Trusts at this stage.

Trust	Performance by Gradings	Compliance Summary for 2022
[Redacted]	**47**	Very high level of compliance.
[Redacted]	**47**	Very high level of compliance.
[Redacted]	**40**	High level of compliance.
[Redacted]	**34**	High level of compliance.
[Redacted]	**27**	Moderate level of compliance.
[Redacted]	**25**	Moderate level of compliance.
[Redacted]	**19**	Low level of compliance.
[Redacted]	**17**	Low level of compliance.
SECAmb (in 2022)	**14**	Low level of compliance.
[Redacted]	**9**	Low level of compliance.
SECAmb (2023 Follow Up Position)	**-19**	Very low level of compliance

Performance calculated by adding all grades as follows:
Green = 1 point / Amber = 0 points / Red = -1 point.
The number of grades is out of a total of 51 but the SECAmb grade for this follow up report is out of 42 using the same method of calculation.

Recommendations
This is a follow up report, conducted at the request of the SECAmb Chief Executive and sits outside of the national assurance programme. Recommendations have not therefore been provided in this follow up report. It is for the SECAmb Chief Executive to determine the response to this report.

Challenge Period
The Trust has until the end of September 2023 to review the content of this report and challenge any of its findings. Challenges must be supported by evidence that was available to the review team at the time of the on-site review. Challenges must not seek to have findings changed based on any new evidence or improvements made after the on-site inspection period, in this case the 26th to the 28th of July 2023. Challenges should be made in writing to the Senior Responsible Owner (SRO) of the reviews, Christian Cooper (christian.cooper@nhs.net), before the end of September 2023. On receipt of any challenges, the SRO will reconvene the review team to consider the challenge(s) and any supporting evidence. The review team will then reconsider the relevant areas of the report. An account of the review team's consideration and decisions will be provided in this section of the final report as a 'post challenge period addendum'. Given that this is a follow up report was commissioned by a single Trust, it sits outside of the nationally agreed NHS assurance process. As a result, following the challenge period, there will be no subsequent option for the Trust to appeal the findings of the report with NHS England. The report will then finally sit with the Trust CEO and it will be for them to determine appropriate next steps, though copies of the report will be shared with NHS England.

[Page Intentionally Left Blank]

Trust Initial KLoE Evidence Ratings **Name of Trust: SECAmb**

No	KLoE	Evidence submitted and Review Team Initial findings NB Coloured text (green, amber, and grey) shows the NARU Review team notes on the evidence submitted. This if for NARU use and reference only.	Initial Grade	Review Team findings following on site visit and review of all evidence provided by the Trust at the time of the last day of the review period (28 July 2023).	RAG
		HART			
01	**Standard Operating Procedures** *H3*	• **01 KLoE SOP List** - Excel spreadsheet includes 94 names. Mix of HART Operatives, Trainers, and Managers. Dip sample of the following names (initials only) identifies last recorded access to SOPs (as of the 18/07/2023): (NP) (HART TL as per Proclus) – last accessed NXGen SOP 20/07/2022. (JQ) (HART TL as per Proclus) – last accessed ATV Operations 21/07/2022. (AJ) (HART TL as per Proclus) – last accessed NXGen, BA, HCID, Con Space, Water, SSO on 22/07/2022. Names include those identified as Trainers and/or Team Leaders.		Following discussions with operational staff, managers, and training managers, it became apparent to the Review Team that there is a lack of clarity regarding who has responsibility within individual teams for ensuring Standard Operating Procedures are checked, or who is responsible for ensuring the relevant staff are checking the Standard Operating Procedures. Dip sampling identified some staff who hadn't accessed SOPs in the past 12 months. This is concerning, and places operational staff at risk of deploying to incidents using outdated information, which is unsafe. National Standard Operating Procedures and indeed all elements of the Safe System of Work held on Proclus are live, and regularly updated against new information and intelligence. SECAmb has identified a shortage of HART Team Leaders (due to sickness and other reasons), and it is therefore recommended that they seek to review internal processes to ensure SOPs are accessed regularly.	

02	**Staffing Levels** *H8* *H15*	**1) 02 KLoE HART Staffing** - Evidence provided covers date range 01/07/2022 – 01/07/2023. Filter of column E identifies 4x incidences of team at 3, all at Ashford, on 17/09/22, 18/09/22, 21/12/22, and 25/6/23. 206 x incidences identified of team at 4 which, on some occasions, was across both teams at the same time (e.g., 05/07/2022 – both teams at 4). 446 x incidences of team(s) at 5. 1x incidence of team at 0 – Ashford on 18/11/2022 (inputted at 19:56). Evidence submitted identifies not only non-compliance, but unsafe levels of staffing on some occasions, and a heavy reliance on the opposite team being sufficiently staffed and available, to provide a safe system of work. **Follow-Up Request:** • Confirmation required of exactly how many operational HART staff there are in SECAmb, and who they are. **Additional Evidence Provided:** **28/07/2023** • **HART Degradation Plan September 2022 –** Refers to "*agreed HART deployment procedures."* Relates to *HART Deployment Procedure* which is out of date. Includes strategic relocation options for team if <4 to provide SSoW. Anecdotal evidence from HART operational staff suggests they were unaware of this and/or had no experience of it being implemented since Covid.		The Review Team are concerned about HART staffing levels in SECAmb. Interviews with managers and staff have explored the potential causes for this, with sickness being cited as a key concern, but also the impact this is having on operational staff members' wellbeing, for example a shortage of Team Leaders resulting in difficulties ensuring activities requiring line management support (e.g., annual leave booking) are easily completed. These shortages also risk impeding the ability to ensure safe systems of work are deployed within a suitable timeframe.	
03	**Staff Competence** H6 H4	**1) NARU Compliance report** – Dip sample indicates the following: **(AB):** Non-compliance across multiple areas of training, e.g., NXGen (TIS NH-03) – with refresher expiry date of 14/12/2022. Within recert date of 14/12/2023. BA refresher expired 12/07/2023, with recertification due to expire 09/2024. Elements of SWaH and Confined Space also expired frequency training, but still in-date for recertification.		A pattern was identified throughout the evidence review of several members of staff being out of date for frequency training, while still being in-date for recertification. It was made clear to relevant staff that all mitigations relating to HART as a result of COVID were formally ended in May 2022, as per the National Position Statement *Maintaining HART Services & SORT Enhancement*. This included the following actions for Trusts:	

		(AC): Similar pattern as AB, i.e., appears to show that refresher training has expired (e.g., ATV-related training expired 06/2022, but still in-date for recertification). **(AJ):** Showing recert date for TIS NH 04 competencies as 02/2022. Evidence indicates refresher training has been completed since then, with expiries in various months throughout 2024. **(GC):** Similar situation re: TIS NH 04 competencies as AJ. **(DL)**: Safe Operation in Trenches last refreshed 10/22. Recert due to expire 10/2024. TIS NH 08 competencies – multiple incidences of recertifications with no date on them (set at 01/01/2000 which is what Proclus defaults to) – last refresher date was 09/21. **(HM):** Last refresher for PRPS (TIS NH-02) was 01/22, with refresher expiry between Oct 2023 and April 2024. **(NW):** Elements TIS NH 04 last recertified 03/2022, and last refreshed Nov 2021-Jan 2022. All mitigations relating to HART as a result of COVID were formally ended in May 2022, as per the National Position Statement *Maintaining HART Services & SORT Enhancement*. This included the following actions for Trusts: *"**4.1.** Remove any internal reliance on previously issued mitigation options for HART, SORT (MTA / CBRN) and Command.* ***4.2.** For Trusts that have utilised mitigation options, action plans must be put in place to recover the Trust's position to full compliance, particularly in relation to HART training and the SORT Enhancement training programme."* (Page 3). • **Capability Appendix V.1.1** (not submitted by SECAmb against this KLoE but deemed of relevance to it by the Review Team). Submitted as part of evidence for KLoE 05 is also relevant here.		*"**4.1.** Remove any internal reliance on previously issued mitigation options for HART, SORT (MTA / CBRN) and Command.* ***4.2.** For Trusts that have utilised mitigation options, action plans must be put in place to recover the Trust's position to full compliance, particularly in relation to HART training and the SORT Enhancement training programme."* (Page 3). No action plan was provided relating to post-Covid measures and, regardless of that, it is now in-excess of 1 year since the revocation of any mitigation options. SECAmb has been through a turbulent period in recent months with the loss of two established Training Managers. One has now been substantively recruited, and it is evident that he is already aware of the issues and is seeking to put plans in place to rectify this. The Review Team are concerned about the challenges he will face in achieving this as a sole Training Manager across two HART units – which both face similar issues. The reason training mitigations were rescinded as soon-as-possible post the peak of Covid was in-recognition of their safety-critical nature. Frequency training is determined by groups of Subject Matter Experts (both practitioners and training deliverers) as the minimum amount of times a skill/skills need to be practiced to prevent skills-fade. One example was identified of a staff member whose recertification in BA had expired but was still shown as on-duty on GRS with no restrictions in-place during that time. For these reasons, the Review Team have graded the Trust's current position against this KLoE as red.	

		Document indicates that any expiry of frequency training would instigate a plan to complete within 28 days – suggesting that the individual can still be operational for HART within those 28 days and while being out-of-frequency. Only if they then miss additional training opportunities within the 28 days are they temporarily redeployed (see page 4). This is only applicable for national capabilities as per "Modules 1-3," namely PRPS, NXGen, BA, and MTA. Module 4 capabilities (SWaH, Confined Space, and Unstable Terrain) are dealt with separately and are left to the Training Manager to arrange, with no set timeframe given. This document does not mention what would be required for the remaining capabilities not covered by Modules 1-4, namely ATV Operations, HCID, SSO, or Water Operations. **Follow-Up Request:** • What restrictions in practise any of the above (and any subsequently identified) have. • A greater understanding of why some staff appear out of date for refresher training. • In the case of recertification anomalies with no date on them, what other evidence can be provided to show that an individual is in-date for their recertification, and; • What steps are being undertaken to address areas in the training records where there are anomalies? **Evidence Gathered During Visit:** **27/07/2023 –** names submitted to HART Training Manager as per column on left. For each name, training records are requested for Con Space, SWaH, Water, and BA. **(AB)** = on secondment – TL role in Trust. **(AC)** – agree re: refresher training. **(GC)** – Interrogated and electronic version of recert paperwork found – is in-date for recert.			

		(DL) – confirmed OOD for refresher training. Is off sick, as per Staff LIVE Capability Working doc. Updated by individual TLs. **Confirm when taken off duty.** **(HM)** – interrogated and confirmed this is not the case, and that training has been completed in 04/2023. **(NW)** – Off active duty and relocated to 111, but this is due to PCA failure. **Confirm when (NW) was taken off duty. This was 30/5/2023, meaning there was a period of time when BA recert had expired, and staff member still live (03/23 – 05/23). Confirm with GRS if staff member was still on active duty = Confirmed he was on shift as per GRS records.** Names above cover 4x Ashford and 3x Gatwick 1x further name selected for dip sample – (**LB)** (Gatwick). Confirmed live as per Staff LIVE Capability Working doc. Compliant for BA. Out of date for refresher for con space – trench (in date for recert). No specific action plan produced in SECAmb to rescind Covid Mitigations as per NARU paper. **(AJ)** – records interrogated. Evidence of recert 14/08/2022, meaning he would be in date as of the time of auditing. Paper record indicates recert done, believe recorded on Proclus in error.			
04	**Protected Training Time** H5	• **04 KLoE Protected Training Time by individual** - 90 names present. Evidence provided is ambiguous at this stage, with no corresponding description of what it is showing. Suspect it identifies the training hours individuals have completed/been offered between 01/06/2022 and 30/06/2023. This will need further investigation to clarify. Dip sample indicates sufficient training hours are being provided across a 12-month period. It is unclear what red boxes mean. This document alone does not show how training is protected, which would more likely be via an internal policy, using Trust rostering systems, etc.		Sufficient evidence was provided to demonstrate that HART staff are provided with the required level of protected training time, and that this is robustly managed through both GRS and cross-collaboration with training records and associated paperwork. The Training Manager was able to articulate the options given to staff to prevent loss of training time through Annual Leave, such as use of swaps, relief hours, etc., but also how this would be managed if time off during training was required and unavoidable.	
05	**Physical Competence**			Evidence submitted and discussed during the Review identified that SECAmb have robust procedures in-place for ensuring that:	

	H9	• **05 KLoE PCA report** - 80 names in-total. Inconsistency in names listed between this and 01 KLoE SOP List names (94 in-total), and also 04 KLoE Protected Training Time by individual (90 names in-total). • **Capability Appendix V.1.1** - presented on an unbadged document, with no specific version control beyond what it is saved as. Is this a policy, i.e., has it been signed-off with relevant Board approval and/or is it a formally accepted appendix of the Trust's wider capability policy? Flowchart on p.8 gives a clear plan for managing the PCA process, which includes temporary redeployment in the event of failure, and the opportunity to re-test, alongside PT support and action plan. **Evidence Gathered During Visit:** • **28/07/2023:** Confirmed during visit that this (Capability Appendix V.1.1) is a draft process and therefore cannot be included as evidence. It is recommended that this document is reviewed, with a view to submitting it for HR consideration, and that it needs to include capabilities that fall outside of Modules 1-4.		• All operational staff have an in-date PCA record. • Staff who fail the PCA are not used for live deployments or training, until such time as they have been re-tested and passed.	
06	**Response Time Standards** H22 H23 H16	• **06 Response Time Standards** – Comprehensive, well laid-out data set that indicates 96.5% of all HART calls achieve the 15-minute response time standard. Data also appears to imply that 100% of confirmed HART incidents, between Jan-June 2023 achieved the "25-minute" standard. **Evidence Gathered During Visit:** **27/07/23:** Confirmed with AEO that the figures provided as part of the slide deck are what she presents to the board. **28/07/23:** Discussed slide deck with (DW). Confirmed that 25 minute standard reflects that 6 staff were mobilised in accordance with standard 100% of the time. This was only achievable on most occasions by using both teams to make up the numbers. Slide deck is not able to delineate occasions when both teams have to be merged to achieve this. January to June data shows 20x incidents outside the 15-minute response time requirements of H22. No evidence of patient safety issues as a result of the 20x jobs that missed the 15-minute standard.		The Review Panel wish to note that the data presented to them, and the manner in which it was presented, mark a significant improvement since the last visit, and would like to acknowledge the efforts of the author of it. Evidence was identified of 20x occasions between January and June 2023 where the 15-minute response time standard (EPRR core standard H22) was not met, representing non-compliance. On the basis of assurance from the Head of Resilience and Specialist Operations that none of these incidences had resulted in harm to patients (e.g., via evidence from a datix, Coroner's inquest, etc.), an amber grading was deemed appropriate in this case. The data set provided as evidence was discussed in-detail with the Head of Resilience and Specialist Operations. It is understood that the headline figures from this document are presented by the AEO to the Trust's Senior Management as an indicator of HART performance. Concerns remain that the entitled "25-minute/SSOW" data is not filtered sufficiently to prevent an incident where less than 6 HART staff were required for a Safe System of Work (e.g., ATV operations, or stretcher support to frontline operations) being recorded as a "Hit" against EPRR core standard H23, which would then lead to a false impression being given to Senior Managers of their true performance	

				against this standard. This was articulated to the author of the document, who will look into it.	
07	**State of Readiness** H24 H25	• **HART Deployment Procedure** – document is currently version 1.0 and was issued in 2019. It was due a review in March 2022, however this does not appear to have taken place. On the presumption that this is a live document (given that it has been submitted as evidence): **Section 1.7** does not accurately reflect current HART capabilities. **Section 2.2** does include the national response time standards, including those relating to Sites of Strategic Interest. **Section 2.5** indicates that support to operations will be provided by HART for Cat 1 calls when a team is >4 on duty (within a 6-mile radius as per **section 2.7**), and that this will also include response to Cat 2 calls and Cat 3 calls (Cat 3 calls subject to command decision) when the Trust is at Surge Management Plan 4. Document also indicates that core HART can be used to back-up those HART staff already deployed to a Cat 3 call. **Section 2.8 – 2.10** Confirm that HART responses to support operations must be backed-up so that HART can be released, but that the duty Strategic Commander may change this. The primary concern with the wording of this document is that, at SMP4, there is a greater risk that some or all HART staff could be committed to supporting wider operations, making it harder to ensure national response time standards can be met. As was previously raised at the last audit when this document was submitted as evidence, there is no mention of mitigations in this document when one or other of the teams is below 6 on duty, nor does it clearly prevent the risk of both HART units being deployed in support of wider operations at the same time. • **HART Deployment Procedure Review doc.** Identifies that a review is scheduled to take place, including a 4-month trial, however neither the trial or review have commenced yet. **Follow-Up Request:** 1) Confirm whether HART Deployment Procedure v1.0 is still in-use given it has exceeded its review date by over 1 year.		There are several areas of concern that have led to a grading of red against this KLoE: • The HART Deployment Procedure that underpins SECAmb's ability to maintain a service capable of deploying staff to sites of strategic interest within 45 minutes is out of date and, in its current format includes out-dated references to interoperable capabilities, for example. • Ongoing staffing level issues across both units affect their ability to ensure 6 staff can be placed on-scene within 45 minutes. • Ashford HART hold no stock of live NXGEn PPE (with the exception of their own respirators). For an incident where this would be required, the expectation is that either PPE would be driven to Ashford from Gatwick, or Ashford staff would mobilise to Gatwick first. This risks introducing unreasonable and/or unnecessary delays into a deployment requiring this level of PPE.	

		2) Ascertain why (if document is still live despite being overdue a review) this has not yet taken place. 3) Liaise with Finance representatives to ascertain how HART funds are being used to finance the joint HART Tasking and Clinical Care Desk. 4) Clarify under what circumstances a Strategic Commander would seek to change the decision to back-up the HART team supporting wider operations, and what process is undertaken if this happens. 5) Liaise with HART staff re: use of HART assets to support wider operations. 6) Seek further evidence that demonstrates State of Readiness, such as no-notice testing of the 30-minute reaction and mobilisation time, or data on the number of HART responses to Sites of Strategic Interest/Model Response sites in the last 12 months.			
08	**Risk Assessments** H17	• Local RA ATV Ops • Local RA CBRN HAZMAT • Local RA HCID • Local RA SWAH • Local RA Unstable Terrain • Local RA Water All of the above risk assessments are in-date, however, appear to be generic in terms of the identified hazards, additional control measures, etc. The requirement of H18 is for risk assessments to be local, and in addition to what has been nationally produced. **Follow-Up Request:** Further evidence of any locally specific risk assessments, e.g., site-specific that include control measures for HART.		The Review team were presented with several examples of robust, in-date, and well laid-out risk assessments. Over the course of the on-site visit, gaps were identified, for example there is no risk assessment as part of the 'SECAmb Degradation Plan,' resulting in concerns that a plan and procedures have been developed to articulate and describe the actions required when HART units are understaffed, including combining two partly staffed teams in a central location; but no assessment of risk associated with this. For this reason, the Review Team felt that an amber grading was appropriate.	

09	**Safety Reporting** H19	• **Proclus Access list –** Demonstrates that staff within SECAmb have access to the National Safety Alert system. • **Safety Alert Tracker –** A good example of documentation to track national safety alerts, however, neither the tracker, or flowchart process provide information on how SECAmb ensure alerts are responded to within 7-days, or locally-identified issues are reported nationally within 7-days. **Follow-Up Request:** Evidence that demonstrates the 7-day reporting and response requirements of H20.		The Review Panel were unable to find any further evidence that the issue regarding evidence that the 7-day reporting and response requirements of Core Standard H20 are met has been rectified. There still does not appear to be a written process.	
10	**Change Management** H22	• **NARU Compliance report** – Same evidence as submitted against KLoE 03. Provides evidence that staff are being trained against national standards. Does not cover equipment and procedures specifically. **Follow-Up Request:** Evidence that demonstrates compliance with national equipment standards, and that any locally derived equipment, training, and procedures are clearly identifiable as non-national.		SECAmb have moved to a position re: body armour that logbooks will be managed electronically via D4H. This is not in-accordance with current Equipment Data Sheet requirements. Although a Change Management Entry re: electronic records is live on Proclus, it has not reached its final stages and is therefore may/or may not be approved, but is not authorised or operational nationally. Not all HART operational staff who were present during the inspection were able to confirm they had the relevant D4H app access that would have showed when the last annual inspection of armour was performed. Their current stance therefore contravenes the requirements of Core Standard H21, and physical log books will need to be reinstated.	
11	**Safety Critical Equipment** H2	• **Evidence SEC 11-12** – Evidence clearly demonstrates how assets are aligned to national Equipment Data Sheet requirements. Also demonstrates that the system (that was demonstrated at the last inspection) has continued to be worked on and improved and includes a running total of numbers of each asset.		It is evident since the last Review that a significant amount of time and effort has been put into updating the D4H system. There is now a team of 7 people responsible for this, and each should be commended for their work on this. The Review Panel remain impressed with the capabilities of the D4H asset management system and identified it as an area of good practice. Through the demonstration of the software, SECAmb were able to demonstrate compliance with the requirements of this KLoE.	

12	**Equipment Specification** H27 H28	• **Evidence SEC 11-12** – Evidence clearly demonstrates how assets are aligned to national Equipment Data Sheet requirements. **Evidence Gathered During Visit:** **27/07/23** No specific written process for kit that's not nationally specified (i.e., not identified as such on D4H). There are verbal processes.		The Review Team identified two areas of concern against the specific core standards related to this KLoE: **For core standard H27** – *minimum levels of interoperable equipment* it was identified that, at Ashford, none of the operational staff have access to live NXGen PPE (with the exception of the FM53 respirator individually issued to them), which is all kept at Gatwick. **For core standard H28**, specifically the section relating to locally-procured equipment, SECAmb have a number of items of equipment that do not feature on national equipment data sheets. These are used for the purposes of training delivery, such as a tripod, and SWaH equipment for moving/handling training manikins. These items are secured in dedicated storage areas when not in-use, and are identified via D4H as for training purposes. What is lacking is a clear, documented process for managing local equipment, that captures all of the work that has been done by staff to-date. Processes as described were verbal only, meaning there is a risk that someone could inadvertently use a non-specified item of equipment without knowing. No evidence was provided that this has happened, hence a grading of amber, and not red.	

13	**Equipment Maintenance** *H31* *H27* *H28* *H30*	• **Sec 13 Evidence** – BA Logbook 1404 – indicates daily and (1x) monthly being conducted. SWaH Logbook – codes being used that do not align to those as detailed at the bottom of the logbook (i.e., M). 6-monthly inspection identifiable on 2/3/2023, however no other obvious 6-monthly/LOLER inspection record identifiable 6-months prior to that (i.e., during 10/2022) – but this may be on the previous page. Vehicle check sheet appears to indicate that MIBS, including Bariatric MIBS were still on operational vehicles in July 2023 (should have been removed in May 2023). = **Confirmed on 27 and 28/07/2023 that these are not on operational vehicles.** **Evidence Gathered During Visit:** Dip sampling of equipment and results: **A02** (SWaH Kit) – all ok. **A04** (SWaH Kit) – all ok. **A03** (SWaH Kit) – most recent LOLER = 14/2/23. Prior LOLER = 11/8/22. LOLER checks exceeded by 3 days, with no evidence provided that kit was quarantined during that time period (D4H was checked on our behalf). **S01** (Con Space Harness) – in-date for LOLER. Identified gap between previous LOLER checks – 20/7/2022 and 28/1/2023 = 8 days overdue. Evidence indicates it was used on 20/1/2023, i.e., date of LOLER expiry. No evidence provided that kit was quarantined during that time period (D4H was checked on our behalf). **S03** (Confined Space Harness) – in-date for LOLER. Identified gap between previous LOLER checks – 20/7/2022 and 27/1/2023 = 1 week overdue. Evidence indicates it was used on 20/1/2023, i.e., date of LOLER expiry. No evidence provided that kit was quarantined during that time period (D4H was checked on our behalf). **M09** (Confined Space Harness) – in-date for LOLER. Identified gap between previous LOLER checks – 20/7/2022 and 28/1/2023 = 8 days overdue. Evidence indicates it was used on 20/1/2023, i.e., date of LOLER expiry. No evidence provided that kit was quarantined during that time period (D4H was checked on our behalf). **BA sets 1205, 1213, 1207** – all ok.		Although all equipment examined was in-date for operational use when viewed on the 27th and 28th July 2023, evidence was found that identified equipment that had not been sufficiently maintained as per national Equipment Data Sheet requirements (which, in the case of SWaH equipment are based on regulatory requirements) in the past 12 months, with no clear indication that it has been suitably managed as a result. Possible causes as the result of discussions with staff members during the audit include: - No clear, documented quarantine process that is consistent across both HART units. - A reliance on set individuals having responsibility for checking certain equipment, with no clear plan of what happens when that person is sick/on annual leave. - D4H still being at the embed stage, with not all HART Team Leaders/relevant staff having confirmed they have access to the app yet, which would allow them to signpost items to quarantine, for example. As a result of the above, the Review Team are of the opinion that unsafe practice has continued to be demonstrated in relation to safety-critical PPE since the last review.	

		Local MTA & SSO Training Information Sheets were provided for SS, VS, and RC. Each of these staff members was signed off against the competence *recognise and demonstrate applicable PPE inspection regimes*. This is insufficient further evidence to demonstrate that associated log books were completed as well.			

14	**Estate** *H32*	• No submission prior to visit. **Evidence Gathered During Visit:** **27/07/23 – Ashford observations** Parking witnessed to be at full capacity, with both live and training team members in. Several spaces taken up by make ready. Audit team had to park their 2x cars, as did the Head of RSO, inside the HART garage due to lack of space. All vehicles in marked bays, however bays marked out as per 1st generation of fleet. It is not believed that the meeting room would be capable of supporting up to 42x operations staff plus 2-3 trainers, however this is mitigated to some degree by the Gatwick site which does have that space. There was a strength of feeling amongst operational staff that the building did not feel like it belonged to them. The example of the Covid memorial tribute, which does not include their names, was given. **28/07/2023 – Gatwick observations** Parking for HART staff does not appear to be protected. HART staff unofficially designate the parking at the front of the building for them, however it was demonstrated that this can result in them being blocked in by other vehicles due to there being insufficient space. The training team are required to park offsite at a nearby commercial premises. There are two good-sized training rooms adjacent to each other, which can be converted into a sizeable single room. Previously these had been solely under the ownership of HART, however one of these rooms has been given over to operational training; booked and managed by operational admin (i.e., not HART admin). This can cause issues when both Gatwick and Ashford teams need to train together – reducing the space they have available, and anecdotally causing conflict in terms of room bookings that then has to be dealt with during the training day. Each locker is shared by two people – accessed via a single lock, as opposed to the requirement of 1x locker per member of staff.		Both Gatwick and Ashford sites were audited against the current HART Estate Specification (v 7.9). Areas of non-compliance were identified across both sites, predominantly due to the buildings reaching capacity with other shared services. Although presently these were not deemed to be unsafe breaches, with the impending staff uplift requirements, there are concerns that these breaches will become more severe as HART staffing increases.	

		SORT		
15	**Standard Operating Procedures** S2	• KLOE SORT 15 – 2023 Joining Instructions – Course SORT 2023F01 – Shows alignment and ref no.s to national TISs and required pre-learning of SOPs on Proclus. • KLOE SORT 15 -Current SORT staff to compare to PROCLUS access – list of 180x staff. • KLOE SORT 15 -Lesson 1 – Joint Operating Procedures updated 250123 – Powerpoint showing Proclus SOP slide. – Discuss Command by Rank (not role), not all Tac lel trained and role of Critical Care Paras in CCPs (Slide 5). • KLOE SORT 15 -PROCLUS system SORT users – list of 180x staff showing they have access to Proclus. • KLOE SORT 15 -SORT staff training in JOPs – list presentations in MS Teams showing JOPs as first presentation. • KLOE SORT 15 – Training Record example 2 – (AC) 2022-2023 Initial – Individual training record cover sheet for one staff member – discuss content against national SOPs? **26/07/23 – SECAmb TIS aligns to national TIS. Grey = national sub-comeptencies, white = local requirements.** **Review team's lines of enquiry during visit included:** • Dip test access to Proclus from second submission (180x staff list). • Discuss content of presentation (evidence submission no 3) re Command ranks identification (versus roles). **SB: SORT Training Manager** **26/07/2023** Names dip-sampled confirming access rights to Proclus. CCPs were MTA-trained as part of their CCP training. Will run Cas Collection Points, but training in MTA no longer part of their set curriculum. Re: not all OMs or OUMs trained in MTA command – no one has specific ownership of MTA command training at the moment. Role identified via GRS.		Evidence gathered throughout the audit process indicated that SORT staff have access to Proclus and can view the national SOPs. It was also clear that work had been done to ensure clearer delineation between locally specific and national training competencies, which was a concern at the last audit. The previous audit also highlighted concerns that SECAmb were operating to an outdated MTA plan, including outdated references to national SOPs and Joint Operating Principles, which may lead to confusion against the training delivered as part of the SORT course. Despite this, the revised plan, now entitled the 'Incident Response Plan' was approved the week before the Review Teams visit and has not been operationally rolled out. The version available to staff on the Trusts internal system ('Zone') at the time of the visit remained the 2018 Major Incident Plan. For these reasons, the Review Team feel an amber grading is appropriate, until such time as the Trusts can demonstrate that the new, updated plan has been embedded through training delivery.	

16	**Staffing Levels** S5	• KLOE SORT 16 – PROCLUS staff on duty report 202375124426 See Spreadsheet in NARU Teams folder with colour coded data. • Proclus Dashboard Completion V1.1 – good briefing note = who is this distributed to? SORT weekly updated summary July v.1. – Dashboard report for 29/01/23 = shows SORT staffing at 100x pax - request one for June 2023 **Review team's lines of enquiry during visit included:** Despite all other English Trusts now having reached and, in some cases, exceeded the SORT required numbers (in both total and numbers required on duty). • Multiple breaches in staff on duty – discuss levels of safety. • Discuss staff who were available and staff who responded to recent Op P incident.(09/07/23 at 14:40hrs – NARU Log 00455). • Good Dashboard report – HOWEVER, evidence submitted for Januarys figures showing 100x SORT staff operational – REQUEST for JUNE 2023 and discuss against S5 requirement for 290x. **Evidence Gathered During Visit:** **26/07/23 –** SORT staff – aware that there are vacancies that need filling. Numbers on their way up since at least April 2023 and nearly at the required numbers. It is anticipated this will be completed by the end of August 2023. During Command interview the (ST) was the Strategic Commander on the recent Op P incident. Learning included not activating SORT as quickly as would have liked. (28x were o that day). SECAmb acknowledge that they are behind the delivery of the SORT staffing recruitment and training. The spreadsheet provided shows multiple breaches: **Total Min**		Despite extensions granted, SECAmb have yet to achieve the staffing levels required to ensure sufficient operational capacity to deliver this interoperable capability. This was highlighted at a declared Op PLATO incident within SECAmb, where only 28 out of the required 35 staff were listed as available via Proclus Dashboard. Reporting of numbers less than the required 35 on duty have been a regular feature of the Spec Ops Reporting that NARU is sent over the past 12 months. For this reason, the Review Team remain of the opinion that, at the time of the review, staffing levels are both non-compliant and unsafe.	

		<25 170 2 <20 102 Max <15 38 57 <10 4 <5 1 >25, <30 69 >35 94 Including significant number of which below 20x staff on duty, as a result the Review team found this KLoE non-compliant. The situation appears to be improving and the SORT Lead put into post 2 months ago appears to have had a positive impact with the team delivering the program. Using the data provided the staffing trajectory appears to be improving.			
17	**Staff Competence** S8	• KLOE SORT 17 – Cut and paste location of scanned training records – Screenshot of MS Teams files with example of archived records (last year). • KLOE SORT 17 - Training record example 1 – (AT) 2022-2023 Requalification – Good layout of a sign off sheet - Submission describes 'requalification' however, it appears to be an 'initial' due ti the admin requirements at end (Proclus etc) • KLOE SORT 17 – Training Record example 3 – (AJ) 2022-2023 Requalification – as above but with only first page. • KLOE SORT 17 - Training records Line 31 / Line 141 / PCA? **Review team's lines of enquiry during visit included:** • Dip test training records against the 180x staff list • Evidence no 4 (Spreadsheet) shows the 180x staff :		Evidence provided by the SORT Training Delivery team shows a comprehensive system of training records, with improvements included based on recommendation from the last audit. This comprehensive approach to training was further corroborated by speaking to SORT staff, who feel confident that they will be able to use their acquired skills to a good standard should the need arise. All elements required under the EPRR core standard S8 were demonstrated to the Review Team.	

		○ not all are live and completed qualifications (no cert etc) i.e. Lines 5, 6 & 24 etc) ○ Discuss PCA completed months after initial training? (i.e., Lines 2, 8 & 14 etc) **Evidence Gathered During Visit:** **26/07/23 –** will be some staff on GRS who are OOD for frequency. Internal decision to keep them on until they can undertake this. **26/07/23 – SORT staff** – 1x new staff member – not attended any exercises yet, but confident with the training itself and feels would be able to make a positive contribution should an incident occur. Feels like training has been appropriate. 1x experienced staff member: Within last 12 months feel like training better, more structured, and facilities improving (was previously done on Ambulance stations). Feels more confident in role now. Were MAI/London Bridge to occur – are you confident response would be effective? As an ops member of staff – no, as SORT, yes. Unsure how staff would be deployed in the event a job came in and SORT staff were on frontline duties. Concerns re: how they would be relieved from a job if SORT required (breakaway). Comms on this unclear. Experienced staff seconded into EPRR during covid – this was a concern then, with no real plan to deal with it, other than saying "it will happen." PPE has been reallocated centrally. 1x van is at Hazelmere which is an unstaffed/satellite station. No clear procedure as to how PPE will be sent to scene. Move from individual PPE to central PPE is of concern. Lack of clarity re: MTA policy/procedure. Raised issue of removal of SORT SRVs as a concern. Deployment process not explained beyond "it will be brought to scene." Monthly Teams meetings with SORT Manager raised as positive, plus update e-mails distributed. Highlighted SORT is well promoted and proactive now – with positive interest from ops crews. Highlighted how positive the changes Dom has made have been. Confident that, once deployed, procedures are in-place for SSoW. Both aware of Proclus and have access to it.			

		A dip sample of training records were provided – **TA, CA and LB** – all records were comprehensive and compliant.			
18	**Wider Staff Competence (MTA)** S10	• 18 (EW) Key Skills Video – Intro video by EW • KLoE 18 Non-spec Responders Key Skills – Three slides? Video did not play? • Staff who have completed Key Skills – Staff list, presume American date style (Mth/Day/Year) showing YTD 22% undertaken Key Skills – REQUEST 2021-22 for fuller picture? **Review team's lines of enquiry during visit included:** **See Core Standard S10 (80% requirement).** • Unable to determine from evidence submitted what is covered for MTA awareness for wider staff. Presume to be in the 'Key Skills' training for 642 staff(of 2861 staff) listed in evidence no 3 but requires checking and confirmation. • In addition, the data provided appears to be YTD from April 2023. Request and examine what was delivered to who for 2021-22? **Evidence Gathered During Visit:** **26/07/23 – SORT staff –** No overall confidence in commanders who will be deploying staff. Feel there is a culture of negativity/tension within command towards SORT. OTLs are general ops commanders, not MTA commanders. Did raise request for epaulettes to identify roles etc. to DW. Feel there is a lack of understanding from commanders of the role of SORT. Do not train with commanders at the moment, and unaware who MTA/CBRN commanders in Trust are.		Concerns were raised at the last audit that SECAmb were unable to provide sufficient evidence that the requirements of EPRR core standard S10 were being met. This remains the case as of this audit, with the Review Team remaining unclear whether or not the 80% compliance target has been reached, or precisely what percentage of staff are currently trained in the event of an MTA incident. The Trust's internal Action Plan and Updates (2022-23 version 2.1) assesses themselves as partially compliant (amber) against this as plans are in place, however the Review Team disagrees on the basis of evidence provided to-date and the position SECAmb are in now, versus where they are aiming to be. The key concern is that SECAmb are unable to clearly demonstrate that non-specialist staff have received the requisite training to ensure they are able to operate safely at an MTA incident, which has the potential to put them, and any patients they encounter, at risk.	
19	**Protected Training Time** S7 S8	• KLOE SORT 19 – 2022-2023 SORT Training and Development Planner Draft v0.4 – significant number of planned courses cancelled (inc Frequency courses) • KLOE SORT 19 – Course Planner MTA Practical's (1 per instructor) – Training event plan for 7 hrs (inc lunch and breaks) 0900-1600hrs.		Significant improvements were identified by the Review Team in the way training is protected – with close dialogue between central scheduling teams, and use of GRS all playing a part in this. The absence of a formal policy to cover this remains a concern as there is technically nothing in-writing that would prevent future cancellation of training.	

		• KLOE SORT 19 – Course Planner MTA Theory (1 per instructor) from 030723 - Training event plan for 7 ½ hrs (inc lunch and breaks) 0900-1630hrs. • KLOE SORT 19 – Course Planner NHS Decontamination - Training event plan for 8 hrs (inc lunch and breaks) 0900-1700hrs. • KLOE SORT 19 – Course Planner PRPS – SORT 2023 2024 v1.3. - Training event plan for 7 ½ hrs (inc lunch and breaks) 0900-1630hrs. • KLOE SORT 19 – New 5 day SORT initial course (previously 4 days without PCA) - Training event plan for 7 ½ hrs (inc lunch and breaks) 0900-1630hrs. **Review team's lines of enquiry during visit included:** This KLoE area requires further expansion and dip testing • Discuss cancelled Frequency courses (for example Feb 23 courses in Evidence submission 1). • Training plans show Initial course of 7, 7½. 7½, 8 hr days (including lunch and breaks etc) NB does not show Day 1 and hours for PCA. Discuss ongoing Frequency training for protected 7 days (min 52.5 hours) every 12 months as per Core Standard S7 **Evidence Gathered During Visit:** **26/07/23 –** re: cancellations – some relating to IA. Early 2022 – SORT recruitment paused due to rota review and associated grievances. See comments from Dom re: cap that was in-place. Cancellations mainly due to other training coming in. Would not do initial and frequency at same time. Info from training records collated to ensure hours are being completed. Hours do not include travel time. No formal policy or procedure to protect training time. 6 weeks' notice required to abstract, however some instances of release of staff being denied due to operational pressures (less than in previous times). Abstractions is main way of releasing staff (overtime for instructors or for, e.g., exercises that exceed training hours).		It was also unclear by the end of the review process who is responsible for, and therefore how, the minimum of 7 days training (minimum of 52.5 hours) every 12 months is being captured and assured internally. For these reasons, the Review Team feel an Amber grading is suitable for this KLoE.	

20	**Physical Competence** S6	KLOE SORT 20 – Training Records – PCAs - Spreadsheet appears to only show Initial (none older than Sept 2022)– No 'frequency' column (as there is for MTA and CBRN). There appear to be 2x operational SORT staff with no PCAs (highlighted in yellow) **Evidence Gathered During Visit:** **26/06/23 –** No records for these staff. Must have completed one to do the training. Have not had to re-take the PCA as a result.		Gaps still remain in PCA records for certain staff (these were also present at last year's review; however data management has clearly improved in that time). The evidence that was supplied ahead of the physical visit identified 2x staff with no PCAs. Further discussions were had during the physical visit, which resulted in no additional evidence that these staff members had completed a PCA. The Trust places itself at significant risk training and deploying staff into high-risk environments without in-date records of their physical competence to do so, meaning this KLoE must be graded as red, with a recommendation that any staff member without a record, regardless of the reason, be removed from operational SORT duties until such time as this can be rectified.	
21	**State of Readiness** S28 S29 S8	• Risk Site Matrix – good table showing identified sites, Trust leads, plans and review dates. Discuss Matrix no 23 Dover Eastern Docks as identified as RAG Red 1 and no plan? **26/07/2023 – confirm with Anna Sexton who is linked as responsible for this.** • 20. Bluewater Shopping Centre (1) – No SHA identified, NO CBRN Decon sites identified?**26/07/2023 – confirm with Anna Sexton who is linked as responsible for this.** • 24. Channel Tunnel (1) – Good site specific ref plan. • MTA Dispatch-DTL Actions V1.1 Mar 23 -b Good checksheet for EOC – requires 3x MTA trained Managers • RE Communications Exercise – SORT MTA – Good that exercises and testing is taking place - Recall to duty exercise – does include stats on staff on duty as well. Shows 14 SORT staff on duty **Review team's lines of enquiry during visit included:** **S29 refers to the response time of a team.** Evidence 2 & 3 re site specific plans nice but not against the evidence required for the Core Standards in the KLoE. Review against the recent live deployment to the declared Op P incident SECAmb attended. Re evidence no 3 – EOC Checksheet requires 3x MTA Managers for the command team – how may do SECAmb have on/available – how many went to the declared Op P incident?		With SECAmb's continued issues with staffing levels, the Review Team do not feel that an acceptable state of readiness can be demonstrated. This was highlighted at a declared Op PLATO incident within SECAmb, where only 28 out of the required 35 staff were listed as available via Proclus Dashboard. Reporting of numbers less than the required 35 on duty have been a regular feature of the Spec Ops Reporting that NARU is sent over the past 12 months. At the time of the Review, the majority of staff only had access to outdated plans relating to CBRN and MTA. Although this has been rectified, it will take time to implement the new plan. Live, in-date EOC action cards relating to MTA response fall short of providing clarity as to who exactly would be collecting and delivering the required Incident Support Vehicles to scene. There appear to be 2x action cards available to EOC covering the same fleet of vehicles that adds further confusion: - MTA EOC Action Card – MTA Dispatch. - ISV Deployment Guide Discussions with staff members also indicated there is a lack of clarity from an operational perspective, and the ISV deployment plan (which does provide greater clarity re: vehicle mobilisation) that was presented as evidence was still in draft at the time of the review. With questions outstanding re: the competence of non-specialist staff in the response to an MTA incident, as well as the wider competence	

		Re evidence no 5 – Recall to duty exercise, SORT funded for staff on duty and any recall is not included. SORT staff on duty for the exercise appears to be 14x. **Evidence Gathered During Visit:** **26/07/23 –** SORT staff **–** aware of response time standards. **Check with EOC that GRS showing staff as SORT qualified.** Little confidence that SECAmb will necessarily be able to identify SORT-required incidents. Feel like integration with wider Trust is beginning to happen, particularly since arrival of Dom, but that it was stagnant beforehand. Key Skills = 4 days. 4th day cancelled recently. Major incident-orientated. 1x staff member been in Trust 5 years, but yet to attend JESIP or IOR-related training. Out of date CBRN plan available online for staff only.		of Commanders, particularly at the Tactical and Operational levels, the picture presented to the Review Team is of a Trust that is unable to demonstrate a sufficient state of readiness that is safe, hence the red grading.	
22	**Risk Assessments** S21	• 0. Risk Site Matrix good table showing identified sites, Trust leads, plans and review dates. RAG rated risk versus site. • 20. Bluewater Shopping Centre (1) – no risk assessment but includes box for 'known risks and hazards'. • 24. Channel Tunnel (1) – no risk assessment but includes box for 'known risks and hazards'. • KLOE SORT 22 – Example 1 – General Training Environments – SORT – risk assessment for SORT activity including scoring and identified score table. • KLOE SORT 22 – Example 2 – Powered Respirator Protective Suit – Training Suit – risk assessment for SORT activity including scoring and identified score table. • KLOE SORT 22 – Example 3 – Sheffield Park Site – Training – risk assessment for SORT activity including scoring and identified score table.		The requirements of S21 are for the following risk assessment categories to be accounted for: 1) Specific local training venues or local activity The Review team were provided sufficient evidence that these were in-place. 2) Pre-identified local high-risk sites. These must be for/or include MTA and CBRN specific risks. Although high risk sites have been identified, there is no specific inclusion of MTA and/or CBRN-specific risks that has been presented to the Review Team. 3) A local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment. Dynamic Risk Assessment (DRA) is included in the Incident Response Plan, however it is not expressly stipulated who would undertake it,	

		• KLOE SORT 22 – Example 4 – Railway – Sheffield Park – risk assessment for SORT activity including scoring and identified score table. • KLOE SORT 22 – Risk assessments overview – list of risk assessments – appears light if designed to cover all SORT activity, but the ones within (if as above) appear good. **Review team's lines of enquiry during visit included:** S21 requires the Trust to maintain SORT Risk Assessments for high risk sites – SECAmb has identified these through the Matrix (evidence 1) but requires discussion on what constitutes a risk assessment for SORT attending these sites as evidence 2 and 3 light on that subject? 2x examples of risk assessments submitted – request ones for MTA live activity? SORT activity Ras submitted risk assessments appear good, but review team to determine if they all of the SORT activities? In addition, no evidence on any local process to regulate how SORT staff conduct Dynamic Risk Assessments?		but rather the actions they would take if required to complete a DRA. Also, as the plan had only been approved the week before the audit, it will take time to implement. Due to the absence of specific MTA/CBRN risk assessments for high-risk sites, the Review Team do not feel that safety measures have been adequately considered, and are therefore grading this as red.	
23	**Safety Reporting** S23	• KLOE SORT 15 -PROCLUS system SORT users – list of SORT staff that have access to Proclus.		SECAmb were unable to demonstrate a robust system (beyond the fact that relevant staff have access to Proclus) to ensure that any safety alerts raised internally, or nationally, are: 1) Dealt with within the relevant timeframe. 2) Clearly managed and co-ordinated (including during times when key staff are unavailable, e.g., due to sickness or annual leave). No evidence was provided that showed this had, to-date, had an adverse impact on staff or patient safety, and therefore the Review Team have graded this amber, with a recommendation to ensure a suitable procedure and/or policy governing risk and safety management for SORT is created.	
24	**Change Management** S1 S2	• 2023-2024 SORT Providers 140723 Capability matrix for Adam – SORT staff list. • 2023 2024 SORT Providers Awaiting Training Capability Matrix for Adam – list of 6x staff awaiting training?		SECAmb have moved to a position re: body armour that log books will be managed electronically via D4H. This is not in-accordance with current Equipment Data Sheet requirements. Although a Change Management Entry re: electronic records is live on Proclus, it has not reached its final stages and is therefore may not be approved.	

	S3	• KLOE SORT 24 – CMS request by SECAmb – Good example of the use of the CMS directly relating to SORT.		The purpose of the physical log book for body armour is so that, in the event of Mutual Aid (SECAmb are highly likely to be drawn into LAS should the need arise, for example), meaning non-SECAmb staff requiring use of that equipment need to be able to quickly check that it is compliant and safe to use, without reliance on access to an asset management system they may not use.	
25	**Safety Critical Equipment** S1	• D4H Ballistics PPE Asset Register – appears a complete reg. however, appears all SORT BPPE is at Shoreham EPRR Stores?		SECAmb have moved to a position re: body armour that logbooks will be managed electronically via D4H. This is not in-accordance with current Equipment Data Sheet requirements and demonstrates non-compliance against EPRR Core Standard S1. The purpose of the physical log book for body armour is so that, in the event of Mutual Aid (SECAmb are highly likely to be drawn into LAS should the need arise, for example), meaning non-SECAmb staff requiring use of that equipment need to be able to quickly check that it is compliant and safe to use, without reliance on access to an asset management system they may not use. This is especially important with the pooled PPE used by SORT than it would be by HART (who have personal issue PPE). This is deemed to be a risk to the national interoperability of the equipment. Concerns were also raised about the location of 1x SORT vehicle – containing ballistic PPE and other items, which was described as being at an "unstaffed satellite station, with no permitter fencing and possibly no CCTV." The Review Team were unable to personally verify the location this vehicle is kept, however recommend this is reviewed to ensure equipment of this nature is not at risk of theft or loss.	
26	**Equipment Specification** S1 S31 S32	• KLOE 26 Notes – SECAmb statement saying that they are moving its ISV and CBRN vehicles onto D4H. • MTA Vehicle Inventory – comprehensive inventory list for MTA Veh (callsign 4055) – includes BPPE (contrary to above storage location listed on Asset Register?). • OneDrive_1_ 06-07-2023 (1) – links to docs including a good CBRN Load lists (in Booklet).		SECAmb have moved to a position re: body armour that logbooks will be managed electronically via D4H. This is not in-accordance with current Equipment Data Sheet requirements. Although a Change Management Entry re: electronic records is live on Proclus, it has not reached its final stages and is therefore may not be approved. This goes against the requirements of EPRR Core Standard S31. The purpose of the physical log book for body armour is so that, in the event of Mutual Aid (SECAmb are highly likely to be drawn into LAS should the need arise, for example), meaning non-SECAmb staff requiring use of that equipment need to be able to quickly	

				check that it is compliant and safe to use, without reliance on access to an asset management system they may not use.	
27	**Equipment Maintenance** S31 S32 S33 S34	• KLOE SORT 27 – cut and paste of asset register for training suits – asset register list for training PRPS suits. • KLOE SORT 27 – cut and paste of retired training PRPS suits - cut and paste of asset register for training suits – asset register list for RETIRED training PRPS suits.		Equipment is not being maintained in accordance with National Equipment Data Sheets which, in the case of Ballistic PPE, require a physical logbook to be present with each set of armour. For this reason, and previous reasons stated relating to the issues this may pose at a mutual aid incident, the Review Team feel a red rating is appropriate, as this constitutes unsafe non-compliance.	
28	**Access to Scientific Advice** S4	• Action Card Specialist Scientific Advice – EOC Action Card directing towards TacAd/NILO as well as contact details for advice. CBRN plan final draft V1.0 – Within sec 13 of plan, that advice is available for the NILO?HART via NCBRNC. – Could be interpreted that Rad advice is via the NCBRNC and AWE as the provider, which is not the case for the ambulance service who will use the RPA UKHSA route. – Plan in draft and not agreed/signed off. **Review team's lines of enquiry during visit included:** Review team to discuss the CBRN Plan not signed off and in draft. Contents (sec 13 misleading, as per comments in evidence box). Review team to ascertain if TacAd/NILOs have Scientific Advice numbers and how/when they access them? *(Contact details and numbers are on the EOC Action Card Evidence no1)* **Evidence Gathered During Visit:** Discussed with (ME) TacAD/NIILO who demonstrated that he knows how to contact scientific advice when required. However, concerns were raised on the shortage of staff for the TacAd/NILO rota. CBRN Plan signed off the week before the visit.		The TacAd/NILO demonstrated that they were able to access scientific advice. The Review team found that the CBRN Plan signed off the week before the on site visit included in Sec 13 (page 18) the action to gain advice via the NCBRN Centre for all CBRN incidents. However, all ambulance trusts should be using UKHSA RPAs for advice for Radiation incidents (not AWE as the NCBRNC would use). This would may cause issues interoperability of safe working limits with other HART units.	

29	**Wider Staff Competence (IOR)** S14	• 29 Cover note – SECAmb position that they are training staff on revised IOR (RAR) throughout this year. – good are being that they are undertaking some of these (in the East) with FRS partner agencies. • IOR Key Skills 2324 – Powerpoint presentation showing IOR . • Recognise – Assess – React (3)_Preflight – IOR material. • Staff who have completed Key Skills – List and chart of staff who have completed their Key Skills to date (YTD) showing 22% completed thus far. **Review team's lines of enquiry during visit included:** IOR appears to be within Keys Skills training for all operational staff, however, review team to ascertain how this is being delivered (on-line or a days training, and if the later how long a session is it?) In addition what percentage of operational staff were trained in previous IOR |(i.e. in 2022-23)? **Evidence Gathered During Visit:** SECAmb Head of EPRR and Resilience ()DW) stated that for the year 2022-23, 89.9% of staff had completed the annual Trust refresher program.		The requirements under S14 is that the Trust must ensure for all frontline staff that may have contact with a contaminated patient are sufficiently trained in IOR and that organisations must maintain records to demonstrate how many staff are trained. The Review team were not presented with appropriate records to demonstrate this. It was reported that the previous financial year (2022-23) 89.9% of staff hd completed Key Skills training, however, the organisation was not able to provide a breakdown of how many were operational frontline staff against the percentile.	

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30	**Exposure Monitoring** S11	• Action Card Post Incident Procedure – Exposure to substance – 2019 EOC Action Card process. -No progress from 2021/22 ICR? **Review team's lines of enquiry during visit included:** As per Core Standard S11 - Review team to ascertain of there are any exposure at scene monitoring, exposure monitoring as well as the post incident monitoring described in the EOC Action Card. Appears no change from position in 2021/22 ICR. **Evidence Gathered During Visit:** 26/07/23 – (SB) unsure of procedure. H&S session covered on 1st day of SORT course. Reporting/monitoring not covered. Discussed with (DW) and no change since last Review. No change in position of capturing Logs, Entry Control Board information and staff groups attending any HazMat or CBRN incidents. Review team recommended that (DW) liaised with LAS who had a system that may be transferable.		Datix would be used for staff either exposed or potentially exposed to hazardous materials (including CBRN). However, there is no current system for occupational monitoring for all CBRN staff who attend an incident. The Review Team found no change in process from the position the Trust were in at the previous Review. It is now included within the CBRN Plan approved the week before the on site visit, but this does not include robust procedures to document staff, including attendance at scene monitoring, exposure monitoring and post exposure management. It remains reliant of a member of staff completing a Datix.	
31	**PRPS Suit Stock** S35	• D4h-inspection-checklist-20230711 (1) – Inspection checklist. But not completed or filled out in any way? • D4h-inspection-checklist-20230711 - – Inspection checklist. But not completed or filled out in any way? • PRPS (Gen 1) D4H Report – inventory of 56x PRPS suits. • PRPS (Gen 2) D$H Report – inventory of 183x PRPS suits.		Stock numbers provided by SECAmb have been corroborated with those held by NARU (via the NARU PRPS & Logistics Coordinator) and confirm that the requisite number of suits are held to demonstrate compliance against this KLoE.	
	COMMAND & CONTROL				
32	**Strategic Commander Competence** C18 C19	• **Authorised command and CPD paper v0.3.** This is a paper to the Resilience Forum (25.05.2022) rather than a policy document. No minutes of meeting or action log so unclear whether this was agreed and implemented into policy. Section 3.5 requires the Resilience Dept to undertake a yearly review of Strategic Commanders CPD portfolio.		**Qualification:** The EPRR Command Training Records evidence submitted listed all Strategic Commanders as having completed the MAGIC course, including dates. However, the EPRR and Resilience Department does not keep records of commanders qualifications (such as certificates) and is reliant on the Commander keeping these records as part of their CPD	

	C24 C25	Section 4.3 lists action required when commanders fail to meet requirements – removal from response rota. No evidence matching C25 where a command role required to undertake training exercise every 18 months inc reflective practice. Document does list role training requirements or period of time for preceptorship and No CPD portfolio has bene submitted so difficult to see what the evidence submitted relates to. • **EPRR Command Training Records NARU** All staff have completed a MAGIC (PNC) course. The evidence (Tab 2) suggested that only one Strategic commander has undertaken a tabletop exercise which is the most recently qualified (PT). No evidence that any Strategic have undertaken a JESIP course. Only one (ME) has undertaken a SECAmb Strategic course. If you use the CPD tracker and filter (course completed to JESIP Comm, MAGIC, Tabletop Ex and current role – strategic: No CPD is evidenced. No evidence that the Resilience dept had checked Strategic CPD portfolios as per above doc, section 3.5 • **Exec Rota** Evidence submitted covers 10th July to 30th July, 1x Executive staff member on duty over period. The IRP and MI Plans below both set out role of on call exec – working outside but alongside the STO levels providing a "guiding mind" to the Strategic Commander. • **Incident Response Plan V0.4_final** Filename IRP v0.4_final, P2 lists doc as v1.00. This replaces below MI Plan - missing Exec approval, issue date and next review date and on P2 – missing date for SM group and Exec management group approval. What I couldn't find was a section on the activation of the Strategic, there is a PDA for MI Standby and MI declared, neither include activation of Strat Comm but a Strategic is required to stand down a MI (p13, 7.3 & p.19, section 8.2)		portfolio. This is as a result of certificates from providers going directly to the individual. The CPD that was provided on request, did not include qualification certificates. **CPD:** The Review team found recent progress in Strategic Commanders recording CPD on the national template. There was no evidence submitted of CPD checks conducted by the EPRR department, contrary to the SECAmb submitted 'Authorised Command CPD paper v0.3' (Sec. 3.5) which requires the Resilience Dept to undertake a yearly review of Strategic Commanders CPD portfolios. The interviewed Strategic Commander was unaware that the EPRR and Resilience Department should undertake an annual review. The requested and provided CPD consisted of completed national NOS templates. One of the Commanders (JP) only had thee further entries following their initial MAGIC course in June 2021. This is despite the Trust describing how Strategic Commanders were undertaking a 6 weekly CPD update day (until the commencement of the Industrial Action over the past 6 months). The Review Team discussed with the Head of EPRR and Resilience options such as the LAS annual CPD declaration system, and advised them to contact and discuss this with their opposite number to inform changes and improvements. Within the Trusts Action Plan following the previous Review, this area was identified and a planned action of 'Strategy to be discussed/agreed' was scheduled for planned completion by September 2022. This is followed up by a further Action, described as 'Part of the restructure to ensure staff are in place to undertake this' (annual review of CPD); and is self-assessed as 'Partially compliant'. The Review team note that a member of staff has been recruited and is in post to assist in the management of Command records and compliance, but is still new in role and as such many of the required governance systems are not in place yet. **Doctrine:** The On Call Command cadre are still using the Trust's 'Major Incident Plan and Additional Contingencies 2018 V5.0' which was due review an update in August 2021. This is replaced with the Trust's 'Incident Response Plan' which was approved the week before the Review teams visit, but has not been operationally rolled out and the version	

		Section 11.2 clearly state command structure must be staffed by competent and credible personnel; that have been trained and exercised to discharge these functions to a suitable standard. Clear role requirements for strategic at a MI. Section 21 (p.53) lists NARU action cards as supporting documentation, Section 11.2 (p.23) refers to their use. No evidence as to the number required for each role to be compliant (SECAmb). • **SECAmb Major Incident Plan and Additional Contingencies 2018 V5.0.** Official Plan document dated 20th August 2018 and was due an update August 2021. Section 3.1 sets out Strategic intention. Section 23.2 lists NARU action cards as supporting documentation, Section 14.10.2 (p.36) refers to their use in a MI but sits under the TacAd role title. Again, what I couldn't find was a section on the activation of the Strategic, there is a PDA for different levels of incident. A Lv4 (highest) incident does not include Strategic (p.64, section 4.2), but a Strategic is required to stand down a MI (p.21, section 8.8.14) • **Strategic Commander** This is the NARU Strategic action card - Section 21 (p.53) lists NARU action cards as supporting documentation, Section 11.2 (p.23) refers to their use. • **Strategic Rota** Evidence submitted covers 10th July to 30th July, 1x strategic commander on duty over period. **Review team's lines of enquiry during visit included:** What Major Incident Plan are the commanders working to? Is this a live document embedded within the Command Policy? Dip sample request CPD portfolio's for staff. Request information on exercising undertaken by the Trust including attendee list showing Strategic attendance to at least one exercise live or tabletop in appropriate role within last 18 months. Need to examine Strategic CPD portfolio and evidence CPD has been audited within last 12 months. Would suggest (JP) and (JG).		available to Commanders on the Trusts internal system ('Zone') at the time of the visit remained the 2018 Major Incident Plan. **Exercising:** In the EPRR Command Training Records evidence submitted it was recorded that only one Strategic Commander (ME) had participated in an exercise. **JESIP:** The EPRR Command Training Records evidence submitted showed only one of the eight Strategic Commanders as having completed JESIP training, although it is acknowledged that completion of a MAGIC course includes JESIP elements. The Review team were informed that the commnaders would have completed the JESIP element annually as part of their Trust Annual update, however, the system does not allow for filtering who has completed the training by role, and not all staff completed the training in the past year; so no assurances could be given that this did include all Strategic Commanders at the time of the Review. **Suspension of a Commander from role:** The Review team were informed that they do not suspend a Commander from their command role in the event of them becoming non-compliant for the role. This was described as being directed from SECAmb HR (Human Resources), as such a suspension from role would trigger their Capability process and have a negative financial impact on the Commanders income as affects their unsocial percentage (if attributed to an on-call allowance).	

		SECAmb Major Incident Plan and Additional Contingencies 2018 V5.0 section 6.3.6 states: "Details of all Major Incident response training will be held on the Trust's training database.", One area of evidence to ask for when looking at training records? Review team to ask a question as to how conflicts between Exec and Strategic are dealt with and who ultimately holds the responsibility for a decision that may impact a patient or staff member? SECAmb IRP section 11.2 (p.23) states "The Ambulance Strategic Commander has responsibility for the overall command, response and recovery from any significant/major incident and is responsible for setting the Trust's strategic aims for the incident, providing a framework for the Tactical Commander to work within. **Evidence Gathered During Visit:** **Interview with Strategic Commander (ST) 26/07/23** Working to 2018 MI Plan, has this printed off within command pack. Believe there may be a more up to date version on the internal 'Zone'; but at the request of the Review team they were unable to find it during the meeting. (ST) was the Strategic Commander on the recent 'Op P' incident. Learning included not activating SORT as quickly as would have liked. (28x were on that day, but were stood down within minutes of activation of them). Strategic has an option A and B loggist (in case A in uncontactable). Could not quote what the response time standards are but would access them via HART Action Cards. Demonstrated a clear understanding that the duty Strategic is in Command of the incident and not the 'Exec'. Execs role to act as a conduit re BAU and to keep the Board informed. JESIP – Haven't done any training with JESIP partners outside national course (recent CBRN Strategic); but now looking to do some as EOC Manager. Believes that JESIP training should occur every 6 months. Good relationship with JESIP partners on an operational basis. CPD - had seen and requested a template from (DW) about a month ago. And has started pulling CPD together this past month. Shared screen and standard national Framework doc now being used (and emailed though for info). He has shared this with the other Strategic Commanders for info. And their own personal use.			

Unaware that EPRR should undertake an annual review of CPD.

Further evidence during visit included:
CPD requested for Strategic Commanders:

- (JP) = provided. Inc, four entries, MAGIC courses in June 2021 and Jan 2022, Exercise in Nov and a Training day in Dec 2022.
- (JG) = unable to provide, alternative provided for (PT).
- (PT) = provided.
- (ST) = provided.

All Strategic Commanders are showing on SECAmb spreadsheet as MAGIC trained.

Commanders record CPD. It has previously been left to the individual to determine the way they record their own CPD rather than a template, this has been amended recently with the circulation of the national template to which the commanders have and are transferring over to.

There was no evidence submitted of CPD checks conducted by the EPRR department.

Strategic Commanders were undertaking a 6 weekly CPD update day (until the commencement of the Industrial Action over the past 6 months).

The Strategic Commander when interviewed confirmed that they are working to the 2018 Major Incident Plan.

JESIP: SECAmb Command spreadsheet shows no records of Commanders JESIP training as per extract:

JESIP

Category	***No of staff***
No record	7
<1 yr	0
1-2 yrs	0
2-3 yrs	0
3-5 yrs	0
>5 yrs	1
	8

33	**Tactical Commander Competence** C20 C21 C24 C25	• **Authorised command and CPD paper v0.3.** This is a paper to the Resilience Forum (25.05.2022) rather than a policy document. No minutes of meeting or action log so unclear whether this was agreed and implemented into policy. Section 3.4 requires the Resilience Dept to "undertake a review of a random selection of from each OU of Operational and Tactical commanders' portfolios." Section 4.3 lists action required when commanders fail to meet requirements – removal from response rota. No evidence matching C25 where a command role required to undertake training exercise every 18 months inc reflective practice. Document does list role training requirements or period of time for preceptorship and training lines. No CPD portfolio has bene submitted so difficult to see what the evidence submitted relates to. • **EPRR Command Training Records NARU** All but two staff have completed a Tactical course mixed between NARU and local SECAmb. Alex Darling and Stephanie Howard-Beesley are listed within the Tactical Command tab but have not undertaken any Tac Comm course (NARU or SECAmb). 21/38 have undertaken a 'yearly tactical command update' and that was in 2021. No evidence pointing to a course in 2022 or 2023. 9/38 (24%) of Tactical commanders have undertaken a JESIP course. 18/38 (47%) has undertaken a tabletop or live exercise. If you use the CPD tracker and filter (course completed to JESIP Comm, MAGIC, Tabletop Ex and current role – strategic: No CPD is evidenced. No evidence that the Resilience dept had checked Strategic CPD portfolios as per above doc, section 3.5 • **Incident Response Plan V0.4_final** Filename IRP v0.4_final, P2 lists doc as v1.00.		**Command qualifications:** The EPRR and Resilience Department does not keep records of commanders qualifications (such as certificates) and is reliant on the Commander keeping these records as part of their CPD portfolio. This is as a result of certificates from providers going directly to the individual. Of the two Commanders who are listed within the SECAmb Command Training spreadsheet, but not showing as having completed a command course, one was on duty the following day of the review (over the coming weekend). SECAmb could not provide any evidence of their qualification as they do not hold records (as previously described above). The Review team advised that they should not be using a member of staff in a command role if they have them listed within their own Command Training spreadsheet as not qualified and could not provide any evidence that they have successfully completed a command course. **Suspension of a Commander from role:** The Review team were informed that they do not suspend a Commander from their command role in the event of them becoming non-compliant for the role. This was described as being directed from SECAmb HR (Human Resources), as such a suspension from role would trigger their Capability process and have a negative financial impact on the Commanders income as affects their unsocial percentage (if attributed to an on-call allowance). **CPD:** The Review team were informed that the Trust was having some challenges in providing CPD at request, this was due to a Commander who had been requested to provide their CPD gaining Union advice who took the opinion that CPD requests must be made in the same timeframe as the HcPc (with 4 months given to be able to provide it within.) There was no evidence submitted of CPD checks conducted by the EPRR department, contrary to the SECAmb submitted 'Authorised Command CPD paper v0.3' (Sec. 3.5) which requires the Resilience Dept to undertake a yearly review of Strategic Commanders CPD portfolios. The interviewed Tactical Commander was unaware that the EPRR and Resilience Department should undertake an annual review. The Review Team discussed with the Head of EPRR and Resilience options such as the LAS annual CPD declaration system, and advised them to contact and discuss this with their opposite number to inform changes and improvements.	

This replaces below MI Plan - missing Exec approval, issue date and next review date and on P2 – missing date for SM group and Exec management group approval.
There is a PDA for MI Standby and MI declared, neither include activation of Strat Comm but a Strategic is required to stand down a MI (p13 7.3 & p.19, section 8.2)
Section 11.2 clearly state command structure must be staffed by competent and credible personnel; that have been trained and exercised to discharge these functions to a suitable standard.
Clear role requirements for strategic at a MI.
Section 21 (p.53) lists NARU action cards as supporting documentation, Section 11.2 (p.23) refers to their use.

- **SECAmb Major Incident Plan and Additional Contingencies 2018 V5.0.**
  Plan is of date and has been superseded by IRP above?

- **Tactical Commander**
  This is the NARU Tactical action card - Section 21 (p.53) lists NARU action cards as supporting documentation, Section 11.2 (p.23) refers to their use.

- **Tactical East GRS**
  Evidence submitted covers 10th July to 30th July, period mostly covered, however 24-26th appears uncovered with no additional on call supported in West Tac rota.
  (MK) appears to be covering Tac West 14/15th July but does not appear in EPRR Command Training records anywhere.
  (MH) appears to be covering Tac East 18/19th July but does not appear in EPRR Command Training records anywhere.

- **Tactical West GRS**
  Evidence submitted covers 10th July to 30th July, 1x tactical commander for West division on duty over period.
  (DW) appears to be covering Tac West 14/15th July but does not appear in EPRR Command Training records anywhere.

Review team's lines of enquiry during visit included:
What Major Incident Plan are the commanders working to?

Is this a live document embedded within the Command Policy?

Any evidence that the inspection of CPD portfolios has been carried out?
Have any staff been restricted from being on call due to lack of evidence?

Within the Trusts Action Plan following the previous Review, this area was identified and a planned action of 'Strategy to be discussed/agreed' was scheduled for planned completion by September 2022. This is followed up by a further Action, described as 'Part of the restructure to ensure staff are in place to undertake this' (annual review of CPD); and is self-assessed as 'Partially compliant'. The Review team note that a member of staff has been recruited and is in post to assist in the management of Command records and compliance, but is still new in role and as such many of the required governance systems are not in place yet.

Doctrine:
The On Call Command cadre are still using the Trust's 'Major Incident Plan and Additional Contingencies 2018 V5.0' which was due review an update in August 2021. This is replaced with the Trust's 'Incident Response Plan' which was approved the week before the Review teams visit, but has not been operationally rolled out and the version available to Commanders on the Trusts internal system ('Zone') at the time of the visit remained the 2018 Major Incident Plan.

Exercising:
In the EPRR Command Training Records evidence submitted it was recorded that the majority of Tactical Commanders have not participated in an tabletop or a live exercise. Due to the lack of CPD records available it was not possible for the Review team to corroborate if this was a issue with the administration of the Command Training records (spreadsheet), or if the Commanders have not participated in an exercise in the past 18 months (as per the requirements within Core Standard C25).

JESIP:
The EPRR Command Training Records evidence submitted showed only
nine of the Tactical Commanders as having completed JESIP training (as per the requirements within Core Standard J10). The Review team were informed that the commanders would have completed the JESIP element annually as part of their Trust Annual update, however, the system does not allow for filtering who has completed the training by role, and not all staff completed the training in the past year; so no assurances could be given that this did include all Tactical Commanders at the time of the Review.

		Request CPD portfolio's for a couple of staff as per last two evidence documents. Request information on exercising undertaken by the Trust including attendee list showing Tactical attendance to at least one exercise live or tabletop in appropriate role within last 18 months. Re MTA Command = KLoE 15 (3rd item) powerpoint presentation shows Command by 'rank' NOT 'role, and that all Tac level commanders are trained in MTA? • MTA commanders - Operations Manager or Operating Unit Manager Not all OM or OUM's are trained in MTA command EPRR Command Training Records does not corroborate this – only x2 of Tac (F.Ops) C'ders are trained in MTA (SECAmb) Tac Comm, both 1.6yrs ago (PB and JT). Provide further evidence as to why (AD) and (S H-B) are listed within the Tactical Command tab but have not undertaken any Tac Comm course (NARU or SECAmb) – are they in a training position? The tab does not have any way of understanding who is qualified or training? **Request evidence of JESIP training.** Request CPD portfolio's for a couple of staff as per last two evidence documents. Clarification required over gaps in rota 24-26th July. Further review of (MK) and (MH) CPD portfolio and training records. Further review of (DW) CPD portfolio and training records. **Evidence Gathered During Visit:** **26/07/23 Interview with on duty Tactical Commander (HD):** Has been acting up for the past 6 months, just been substantiated into role. Completed NARU Tactical Command course before acting up. (HD) Not on Command Training spreadsheet = 'EPRR Command Training Records NARU' Found under Maiden name as 'Knight' (changed in 2022) in Operational Commander tab. Has not completed: • SECAmb Tac Foundation cse • JESIP command			

		• No exercises (tabletop or live) in the past 18 months = However, they have attended EOC for 2x live incidents as Tac Command (Op P went to EOC and a CAD failure). MI Plan available on the online app the command team use called the 'Zone' = V5 (15 August 2018). Recently trained and good baseline knowledge of capabilities and HART functions. Not commanded at a live incident yet, but did go into EOC at recent Op P incident (as two Tac MTA Commanders went to scene). Requested test of who duty TacAd/NILO (ME) is and checked and confirmed. Unaware of any recent changes to IOR, would expect any changes/updates to be emailed from EPRR. West rota is 14x pax. Issues at the time included issues on deployment of vehicles. SORT staff – more staff deployed than actually made it to incident (as the incident was stood down quite quickly). If went to a TCG, would a Loggist be available? = (HD) happy that they have Loggist on call (admin staff). CPD- spreadsheet – requested to email = received 26/07/23 Basic spreadsheet with three entries in thre last 6 months (but only been in post in this in role for that time period) – not in national format (as used by the Strategic Commander), appears to be no consistency in the format that SECAmb Commanders records CPD. **Further evidence during visit included:** 3.4 of 'Authorised Command and CPD paper' states that EPRR will undertake annual random Op and Tac Command Portfolio reviews. Have not yet started annual dip testing yet. SECAmb unable to pull the command qualification for a commander from a dip test, would have to go to the individual to get a copy of their CPD. 26/07/23 CPD requested for 3 of the 38 listed Tactical Commanders: • (M(N)K) = Tac East rota (MK) is currently off long term – so now not on the rota. Unable to ascertain records as they are not held by the Trust but by the individual as part of their CPD.			

		• (MH) is confirmed as on the rota = Tactical Command training (NARU) Certificate located and provided to the Review team. • (DW) = unable to provide CPD to the Review team. Re: MTA command. – no rota staffed by the on duty/call tactical Commanders, only one required to mobilise. From the cadre of three Tac Commanders on duty there may be a qualified MTA Commander (if not Everbridge recall to duty). Working towards a position of all Tac Commanders to be trained (currently 20 trained out of 26).			

34	**Operational Commander Competence** C23 C24 C25	• **Authorised command and CPD paper v0.3.** This is a paper to the Resilience Forum (25.05.2022) rather than a policy document. No minutes of meeting or action log so unclear whether this was agreed and implemented into policy. Section 3.4 requires the Resilience Dept to "undertake a review of a random selection of from each OU of Operational and Tactical commanders' portfolios." Section 4.3 lists action required when commanders fail to meet requirements – removal from response rota. No evidence matching C25 where a command role required to undertake training exercise every 18 months inc reflective practice. Document does list role training requirements or period of time for preceptorship and training lines. No CPD portfolio has bene submitted so difficult to see what the evidence submitted relates to. • **EPRR Command Training Records NARU** General feeling that a there is a lack of evidence across the Op Commanders cadre as to CPD activity – see below. 19/196 (>1%) staff have no evidence of undertaken a tabletop or live exercise. Apart from the two listed below – all Op commanders have undertaken a NARU / SECAmb Op comm course. (JL) has no record of either NARU or SECAmb Op commanders course, was on shift 10th July as DTL 1800-0600. (KT) on Tab, no command course completed however not showing on 10th rota at all so ?training? • **Incident Response Plan V0.4_final** Filename IRP v0.4_final, P2 lists doc as v1.00. This replaces below MI Plan - missing Exec approval, issue date and next review date and on P2 – missing date for SM group and Exec management group approval. activation of the Strategic, there is a PDA for MI Standby and MI declared, neither include		**Command qualifications:** The EPRR and Resilience Department does not keep records of commanders qualifications (such as certificates) and is reliant on the Commander keeping these records as part of their CPD portfolio. This is as a result of certificates from providers going directly to the individual. As a result, SECAmb could not provide evidence that the Commanders were appropriately qualified. **Suspension of a Commander from role:** The Review team were informed that they do not suspend a Commander from their command role in the event of them becoming non-compliant for the role. This was described as being directed from SECAmb HR (Human Resources), as such a suspension from role would trigger their Capability process and have a negative financial impact on the Commanders income as affects their unsocial percentage (if attributed to an on-call allowance). **CPD:** The Review team found that Operational Commanders were unaware that they are required to maintain CPD for their command role. As a aresult a number were unable to provide evidence of CPD when requested. The Review team were informed that the Trust was having some challenges in providing CPD at request, this was due to a Commander who had been requested to provide their CPD gaining Union advice who took the opinion that CPD requests must be made in the same timeframe as the HcPc (with 4 months given to be able to provide it within.) There was no evidence submitted of CPD checks conducted by the EPRR department, contrary to the SECAmb submitted 'Authorised Command CPD paper v0.3' (Sec. 3.5) which requires the Resilience Dept to undertake a yearly review of Strategic Commanders CPD portfolios. The interviewed Operational Commander was unaware that the EPRR and Resilience Department should undertake an annual review; and described their CPD as 'keeping bits of paper'. The Review Team discussed with the Head of EPRR and Resilience options such as the LAS annual CPD declaration system, and advised	

		activation of Strat Comm but a Strategic is required to stand down a MI (p13, 7.3 & p.19, section 8.2) Section 11.2 clearly state command structure must be staffed by competent and credible personnel; that have been trained and exercised to discharge these functions to a suitable standard. Clear role requirements for Op Comm at a MI within Sec 11.2 inc functional roles. Section 21 (p.53) lists NARU action cards as supporting documentation, Section 11.2 (p.24) refers to their use. • **SECAmb Major Incident Plan and Additional Contingencies 2018 V5.0.** Plan is useful to see as to how they have progressed, but it is out of date and has been superseded by IRP above. • **Internal SECAmb Ops Command – Day One** • **Internal SECAmb Ops Command – Day two** A well put together two day presentation covering large aspects of an Operational Commanders role. No mention of 'CPD' or 'portfolio' in either PowerPoint. • **Operational Commander** This is the NARU Operational action card - Section 21 (p.53) lists NARU action cards as supporting documentation, Section 11.2 (p.24) refers to their use. • **Operational Command Roll Call 100723** Evidence submitted covers only the 10th July. **Review team's lines of enquiry during visit included:** What Major Incident Plan are the commanders working to? Is this a live document embedded within the Command Policy? Any evidence that the inspection of CPD portfolios has been carried out? Have any staff been restricted from being on call due to lack of evidence? Request CPD portfolio's for a couple of staff as per last two evidence documents. Request information on exercising undertaken by the Trust including attendee list showing Tactical attendance to at least one exercise live or tabletop in appropriate role within last 18 months.		them to contact and discuss this with their opposite number to inform changes and improvements. Within the Trusts Action Plan following the previous Review, this area was identified and a planned action of 'Strategy to be discussed/agreed' was scheduled for planned completion by September 2022. This is followed up by a further Action, described as 'Part of the restructure to ensure staff are in place to undertake this' (annual review of CPD); and is self-assessed as 'Partially compliant'. The Review team note that a member of staff has been recruited and is in post to assist in the management of Command records and compliance, but is still new in role and as such many of the required governance systems are not in place yet. **Doctrine:** The On Call Command cadre are still using the Trust's 'Major Incident Plan and Additional Contingencies 2018 V5.0' which was due review an update in August 2021. This is replaced with the Trust's 'Incident Response Plan' which was approved the week before the Review teams visit, but has not been operationally rolled out and the version available to Commanders on the Trusts internal system ('Zone') at the time of the visit remained the 2018 Major Incident Plan. **Exercising:** In the EPRR Command Training Records evidence submitted it was recorded that only 19 of the 197 Operational Commanders listed had undertaken a tabletop or live exercise. Due to the lack of CPD records available it was not possible for the Review team to corroborate if this was a issue with the administration of the Command Training records (spreadsheet), or if the Commanders have not participated in an exercise in the past 18 months (as per the requirements within Core Standard C25). **JESIP:** The EPRR Command Training Records evidence submitted showed only nine of the Tactical Commanders as having completed JESIP training (as per the requirements within Core Standard J10). The Review team were informed that the commanders would have completed the JESIP element annually as part of their Trust Annual update, however, the system does not allow for filtering who has completed the training by role, and not all staff completed the training in the past year; so no assurances could be given that this did include all Tactical Commanders at the time of the Review.	

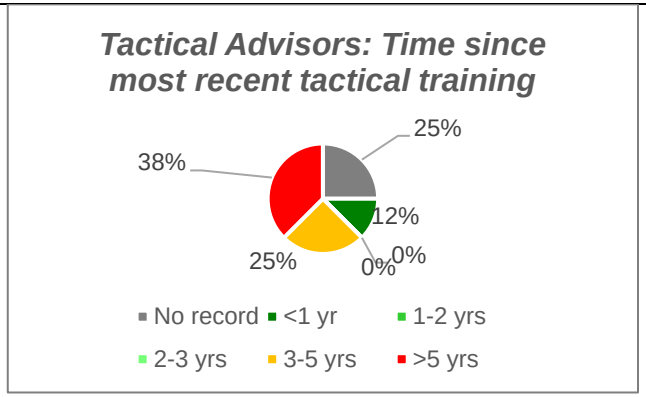
		Provide further evidence as to why (JL) (on night shift 10th July) and (KT) are listed within the Op Command tab but have not undertaken any Commander course (NARU or SECAmb) – are they in a training position? The tab does not have any way of understanding who is qualified or training? **Request evidence of JESIP training.** Request CPD portfolio's for the above staff as well as a couple of randoms as too many to check against CPD list. Confirm how Operational Commanders understand the requirements to undertake CPD activities and the implications of not undertaking the training? Need to understand the numbers of Op Com required each shift to know whether enough were on duty. Request further information on totals per staffing period for dates 10th – 30th July for consistence across all command roles. **Further evidence requested in advance of site visit:** Rota covering same time period as submitted for all commanders requested in advance. **26/07/23 Interview with on duty Operational Commander:** SECAmb Foundation and NARU Operational Command courses completed. Undertook TTX as part of university table top up course (doing a degree top up – not a SECAmb course). No live exercises recently as difficult to attend as notices come out late notice so Commanders find it difficult to attend at short notice. Confident with smaller type incidents (RTCs etc). Would feel tested by a large incident (such as Manchester or a bladed weapon attack); would like to do more (training/preparation) but difficult with all of the operational day to day work commitments. Do have access to Action Cards etc as have resources such as iPads etc- but lacking the physical training to feel confident. Have been on a couple of firearms incidents and have really struggled with them, as balancing staff and clinical management with scene safety etc. Now putting the OTLs through SORT training, which will be a massive help as they get regular training.			

		Based in remote part of SECAmb (Margate) and feel that there could be better cover with MTA Commanders. Closest HART would be Ashford which would be 1hr drive. Would get to Canterbury within 20 mins. Nearest MTC = London (1 ½ hours). Not aware of recent changes in IOR. Would normally be aware though a Bulletin or Email. Some elements come though mandatory training, first time this year will have a day dedicated to EPRR, first time this has happened. Spoken to people that have undertaken the package, mixed views as some felt it went well and impressed with it and and others not so. JESIP – last JESIP last week – 2x in past 10 days at incidents (1x house fire and 1x standoff in Margate). Police leading on the Margate and although not notified until hours in, it went well. Feels more engaged and the meetings went well and it is working. JESIP training, did a bit on Uni of Cumbria (Disaster response course he is doing). **Can't remember a SECAmb (regional) session.** Opportunities with partner agencies few and far between as difficult balance with the right 'notice' against other commitments (a week's notice not enough). Any concerns? Mixed response from Commanders above (Tactical and Strategic – hit and miss some very good and others not….). But if cannot get hold of Tac Commander, can speak to the TacAd and NILO plus Tac On Call as well, so there are people you can get hold of such as the OCMs. Do you have the resource/equipment for role? Yes, have a couple of command bags. Used to have two cars so have two complete sets of command packs but now only running one car – checked on handover. In the Car have 1x yellow pouch of duo-dotes and red packs as well. Rota in the ROU there are 14x Op Commanders providing 24/7 cover. Discussed CPD – Op Commander described keeping bits of paper – no SECAmb proforma. Keep elements and relate them back to the standards – describes as got one (CPD portfolio) but needs updating. Did get some info from the then Head of EPRR (DW) last December who contacted all asking when last attended any exercises. Asked about exercise frequency – did not know and expect to be about every 12 months – informed it was 18 months. Did an incident last Dec (Dover) so within time period required.			

		Further evidence during visit included: CPD requested for Operational: • (KT) (and confirmation they are live operational commander) = CPD requested – none submitted. • (SB) = responded to email requesting CPD with: *I'm afraid I do not have a command CPD portfolio, and the template you have attached makes no sense to me?* *Other than completing my role as an OTL, I have not been afforded the opportunity to complete any command training in recent years.* *I have received no input from the trust regarding command CPD, and no warning that I may be required to produce evidence.* *To request this information with 48hrs notice is somewhat unreasonable, particularly as I will now be on days off and have plans that will not allow me time to complete this.* *I am sure that I will be told that this is part of my role and my responsibility to do so, however, I have no recollection of any input for years from the trust regarding command CPD, what is required or how to collate that information, and I know of no other OTL locally that is in a different position.* *Apologies for this email, but I feel rather put on the spot* • (MC) = Completed national template submitted on request – poor content with internal Op Command course completed in 04/05/23 and previous entries from 2017 and 2018. Summary shows 0% progress in completion. • (LE) = Completed national template submitted on request. • (MH) = CPD requested – none submitted. • (G M-N) = CPD requested – none submitted. (KT) and (JL) - requested qualifications for = none submitted. There is a pool of staff who undertake a TL role (rather than Op Commander) and wear two pips, they have not all undertaken an Op Commander course, but do not act in that role. They undertake other managerial duties (staff welfare etc) but in the event of an incident an on duty Operational Commander would be sent. Re: exercises every 18 months – SECAmb Command Training spreadsheet not yet showing dates. SECAmb unable to draw down centrally, is only available as part of their CPD; so the SECAmb management team unable to provide evidence for this requirement and it is only available by reviewing			

		individuals CPD when requested (and provided). However, no system in place within SECAmb to do this.			

35	**NILO/Tactical Advisor Competence** *C28* *C29*	• **Authorised command and CPD paper v0.3.** This is a paper to the Resilience Forum (25.05.2022) rather than a policy document. No minutes of meeting or action log so unclear whether this was agreed and implemented into policy. Section 3.4 requires the Resilience Dept to "undertake a review of a random selection of from each OU of Operational and Tactical commanders' portfolios." NILO / TacAd not specifically listed although document also says "each allocated commander must undertake Continuing Professional Development (CPD)." Section 4.3 lists action required when commanders fail to meet requirements – removal from response rota. No evidence matching C25 where a command role required to undertake training exercise every 18 months inc reflective practice. Document does list role training requirements or period of time for preceptorship and training lines. No CPD portfolio has bene submitted so difficult to see what the evidence submitted relates to. • **EPRR Command Training Records NARU** Two staff have no evidence that they have completed a NILO course: (SB) and (DW), both appear on the rota – 20th/21st July and 16th/17th July. General feeling that a there is a lack of evidence across the NILO cadre as to CPD activity – see graph. 3/8 (38%) staff have no evidence of undertaken a tabletop or live exercise. • **TacAd GRS** Evidence submitted covers 10th July to 30th July, 1x tactical commander on rota for the dates shown. **Review team's lines of enquiry during visit included:** Find out the organisational understanding of the requirement to maintain competence within the NILO / Tac Ad role.		The Review Panel found that the information provided on the review day indicates that all NILOs are suitable qualified, however the Trust acknowledges that it does not have an effective way to manage CPD for commanders currently (including TacAd/NILOs). In addition, although not a Core Standard the Review Team note the pressure of the NILO cadre may result in safety concerns due to additional shifts they are currently having to undertake to cover shifts. This concern (of short staffing) was also raised by the Head of Resilience and Special Operations (DW) during their interview as part of the onsite visit.	



Further review of (SB) and (DW) CPD portfolio and training records.

Further evidence during visit included:

27/07/23 Interview with TacAd/NILO (ME):

Rota very under staffed and all on the rota feeling a lot of pressure with a large geographical area to cover.
Currently don't always have the two rotas covered (East/West) and rota shred had examples of just one available. On the 1st day of the review there was only one TacAd/NILO (ME) covering all of the Trust.

- TacAd rota - internal placement onto the rota (EPRR staff selected by DW) – no formal qualification. -have 2x staff who are not NILOs but are Tac Ads. Will have a further three joining.
- Thye should be opposite (as two rotas East/West a qualified NILO, but cannot guarantee that this will never happen.
  If a Tac Ad is called, it is their personal opinion as to if they need to refer to NILO as there is no written differentiation of calls or incidents and staff will not know the difference.
- NILO rota – Has a national pre-requisites and national course.

NILOs have access to the NILO area of Proclus.

Not automatically informed about incidents and reliant on EOC or Tac to inform the TacAd/NILO.

CPD left to own staff to manage, no formatted approach within Cadre. Opportunities of attendance at specific events (such as SF days) described as going to a select few within the team.

		Rest of the team maintain with local activity with FRS or through personal contacts in certain areas – described as no equality of opportunity across cadre. Some resource concerns as only one Airwave radio set, which makes comms across multiple agencies etc challenging. Reliant of HART attending and them have a spare radio. (SB) and (DW) CPD portfolio CPD has been requested from (ME) (to be with the Review team by Friday morning). Tac/AD NILO CPD requested: • (SD) = Spreadsheet submitted with a list of 2022 and 2023 activity. • (SB) = Spreadsheet submitted with a list of 2023 activity. • (DW) = National CPD NOS template submitted (2022/23).			
36	**Loggist Competence** C30 C31	• **EPRR Command Training Records NARU** All staff have completed a loggist course mixed although within this evidence it does not describe which course provider. No evidence other than initial course, no evidence of CPD, no column for table top or live incident experience. All staff appearing on rota are note in Loggist lab **Loggist On Call** Evidence submitted covers 26th June to the 16th July period mostly covered, however 16th July appears uncovered? This rota is different to all others submitted. • **Loggist Training Presentation** Course PowerPoint which seems quite through, but unknown whether this is a recognised course? **Review team's lines of enquiry during visit included:** Clarification required over gap in rota 16th July. Request loggist rota 10th – 30th July to allow a comparison across all command functions and the same dates. What re-training or annual refresher (CPD) do loggist undertake? Request and confirm that Loggists names on the Rota meet the requirement for CPD as per Core Standard C31.		The Review Panel found that the Trust has two loggists available at any one time and that the Trust acknowledges that it does not have an effective way to manage CPD for loggists currently. No loggists CPD was provided. It is recommended that the Trust reviews it's on call system for loggists to be able to provide three loggists as per Core Standard C16 and that loggist CPD (as per Core Standard 31) is included in the actions the Trust will need to take to manage commander CPD opportunities and records. The Trusts is non-complaint against this KLoE but is graded as amber (rather than Red) only as the absence of a suitable trained loggist at an incident is deemed that it would not be detrimental to the safety of responders or patients.	

		Further evidence during visit included: **CPD requested for:** • (JS) = not submitted. • (CP) = unable to contact to request CPD as not at work during visit period. No records or evidence of any CPD checks by the EPRR and Resilience dept. • (DH) = unable to contact to request CPD as not at work during visit period. No records or evidence of any CPD checks by the EPRR and Resilience dept. • (SP) = unable to contact to request CPD as not at work during visit period. No records or evidence of any CPD checks by the EPRR and Resilience dept.			
		JESIP			
37	**Doctrine** J1 J2 J4	• **Incident Response Plan V0.4_final** Good section (5) on JESIP (J1) and the JDM (J5) including model, section on Methane (J4). • **Ops Key Skills 2024 JESIP** This covers the JESIP video, encourages staff to download the JESIP app and has a section on the actions at a MI inc NARU FPOS action card. • **SECAmb Major Incident Plan and Additional Contingencies 2018 V5.0.** Plan is useful to see as to how they have progressed, but it is out of date and has been superseded by IRP above. • **Trust IPAD – Cover Note** Screen shot explaining all staff have access to an iPad with the JESIP app 'pushed' to device as well as access to Major incident actions cards and Major Incident Plan. • **Trust IPAD Screenshot – JESIP App** Screen shots of JESIP app, MI action cards and page of Resilience and Specialist Operations plans. • **Trust IPAD Screenshot – NARU Action Cards** Screen shots of MI action cards. • **Trust IPAD Screenshot – Resilience and Specialist Ops** Screen shots of Resilience and Specialist Operations plans.		The Review Team found that the Trust was still operationally using their 2018 Major Incident Plan, which contains out of date JESIP products. However, it was noted that the new Incident Response Plan (IRP) had been approved the week prior to the onsite visit and contained up to date JESIP material. In addition, the Trust staff have access to the JESIP App via their iPads and other products such as JESIP informatic stickers have been utilised. Therefore, although breaching Core Standard J4, there is mitigation via the use of the JESIP App resulting in the grading of Amber.	

		The screen shot shows the SECAmb MI Plan v5.0 and not the newer IRP plan. **Review team's lines of enquiry during visit included:** J6 standard requires a timed review process for all procedures covering complex incidents – ITP does not have a review date. Need to ascertain which of the two plans is active as one was written a number of years ago (2018) is out of date by a number of years (MI Plan v5.0 review date Aug 2021) and the other does not seem to be implemented into use although it was 'approved' in March'23. **Further evidence during visit included:** The On Call Command cadre are still using the Trust's 'Major Incident Plan and Additional Contingencies 2018 V5.0' which was due review an update in August 2021. This is replaced with the Trust's 'Incident Response Plan' which was approved the week before the Review teams visit, but has not been operationally rolled out and the version available to Commanders on the Trusts internal system ('Zone') at the time of the visit remained the 2018 Major Incident Plan. The 2018 Plan includes outdated JESIP rpoducts, although, the Trust has taken steps to keep staff informed of updated products with links to the current JESIP App, and a JESIP sticker (although now showing out of date IOR) for the rear of Trust iPads. **26/07/23 Interview with JESIP Tactical Lead (ME):** IRP believed to have been signed off last week – however, during Command Interviews the Plan within the Trusts electronic system ('Zone') is understood to be the 2018 Plan still in place and contains out of date JESIP products. Last full multi-agency training was in 2019 – 3 ½ hours. So slightly out due to Covid and partner agency catch up, potentially restarting in November/December 2023. To include a scenario that is appropriate to HMCG partners. JESIP video included on Key Skills (currently being delivered 2023-24).			
38	**Competence** J5	• **JESIP Train the Trainer days 17th and 18th July** Email sent to command levels asking to see who might be interested in attending a TTT course. Course arranged for 17th/18th July so after evidence drop – could be one to follow up on.		The Review team found that although JESIP training was included within the 2023-24 Key Skills training covering this coming year.	

J6
J7
J8
J9
J10
J12
J13

- **Ops Key Skills 2324 JESIP**
  This covers the JESIP video, encourages staff to download the JESIP app and has a section on the actions at a MI inc NARU FPOS action card.
  Only one of the Command staff requested to provide further information on training records has undertaken a JESIP Key Skills day (DW).

- **Staff who have completed Key Skills**
  Evidence list staff within the two divisions (East / West) and their compliance against undertaking Key Skills

JESIP: SECAmb Command spreadsheet shows no records of Strategic Commanders JESIP training as per extract from their Command Training spreadsheet:

JESIP

Category	***No of staff***
No record	7
<1 yr	0
1-2 yrs	0
2-3 yrs	0
3-5 yrs	0
>5 yrs	1
	8

Review team's lines of enquiry during visit included:

Require evidence of JESIP training 22-23 as none provided. Standard J13 – annual refresh of JESIP principles, EPRR command Training records is very sparse on JESIP course attendance.

Does this include EOC Ops Commanders as EPRR command Training records does not have them listed and requiring to undertake it – J9 standard suggest all control room staff (dispatchers and managers) need to have knowledge and understanding of JESIP.

According to the spreadsheet – only 18% of staff have completed the session – 82% (2869 staff) have not. What is the action plan to get these

JESIP was also included within the previous year (2022-23) 89.9% of staff had completed the training. This falls only very short of the requirement for 90%. However, the Review Team found that the Trust could not provide any details on the cadres of staff who have completed the training, so were unable to provide evidence on how many Commanders, ambulance control staff (dispatchers and managers) had completed JESIP training.

In addition, of the tactical Commanders sampled, only one specified JESIP training (rather than multi-agency exercises etc); but that had last been conducted in April 2018.

The SECAmb Command Training spreadsheet included multiple commanders showing as no record of JESIP training. This amy be an administrative issue, but the Trust was not able to provide evidence of the who completed what training and when.

		untrained staff trained? Presume included in the Key Skills training for 2023-24 – if so what was the position in 2022-23? J20 Standard requires 90% of operational staff are familiar with JESIP and an construct a METHANE message. **Further evidence during visit included:** **26/07/23 Interview with JESIP Tactical Lead (ME):** Requested 2022-23 eLearning stats to ascertain of 90% were covered. J8 = All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course. Review Panel interviewed a Tactical Commander who has not undertaken JESIP course. Will have covered some JESIP as part of NARU Tac Command (included in elearning but unknown of completed as back from maternity). Difficult getting partners to the table. On live exercises only get limited places for participants. Not yet running the JESIP one day (6hr) JESIP courses, but planning to do so. Throughout of Tac Commanders on Spreadsheet shows majority of Tac Commanders not completed the JESIP Command (SECAmb). Discussed that a surge in training will be required in the delivery of the Key Skills courses to achieve the required percentiles. **JESIP training records requested for:** *Tac Commanders:* • *(GS)* = Submitted stating: *I have completed the following training which included JESIP:NARU Operational Command course – 19th November 2020NARU Tactical Command course – 12th December 2020Exercise Holman – new JOPS familiarisation – 30th June 202* • *(JF) = no evidence submitted.* • *(GM) = no evidence submitted.* • (JC) = evidence of participation in an exercise and day 3 of key skills on the 28th April 2023 which covered JESIP training • (GW) = evidence submitted showing CPD including multi-agency exercises and JESIP training in Feb 2014 and April 2018. Re: J8 - Strategic Commanders training records spreadsheet show no records of JESIP training:			

		JESIP **Category** / **No of staff** No record: 7 <1 yr: 0 1-2 yrs: 0 2-3 yrs: 0 3-5 yrs: 0 >5 yrs: 1 8 Discussed with (DW), believes they will all have undertaken the one day JESIP course, but unable to provide evidence of this. 2022-23 – 2550 staff from which 2869 completed the in-person training package which included IOR, MTA and JESIP = 89.9% From this, the Trust is unable to provide the specific data on who of which are commanders or EOC (Dispatchers and Managers). (DW) intends to liaise with the Trust for future data requirements to include the ability to report against Commanders and EOC in the future. **26/07/23 Interview with JESIP Tactical Lead (ME):** Last full multi-agency training was in 2019 – 3 ½ hours. So slightly out due to Covid and partner agency catch up, potential starting in November/December 2023. To include a scenario that is appropriate to HMCG partners.			
39	**Exercising** J3 J11	• **Exercise Apollo – Debrief Report** Dartford tunnel ex (Sept'22), multi veh RTC involving hazardous chemicals. One +ve outcome was JESIP meetings were quickly established, took place on a regular basis and there was good interagency working. Windscreen reports and METHANE passed promptly on scene. • **Exercise Big Top De-Brief Report V1.1.** Ex at Dreamland (music venue), deliberate release of chemicals in crowded space. Again, Amb Op Comm established JESIP meeting "very quickly". Mini JESIP meetings held, NARU action cards used on iPads.		No timed review process for the review of procedures, evidenced by the Trusts use of a 2018 Major Incident Plan (overdue review date), therefore not meeting the requirements of Core Standard J3. Trust not able to provide evidence that all Commanders have participated in a joint exercise every three years. No records held centrally outside the Trusts Command Training Spreadsheet, which showed a significant number of Commanders as not attending either a Live or Tabletop exercise. The review of Commanders CPD was limited as some not submitted/available/accessible and others that had submitted showed in part limited content and participation in multi-agency exercises.	

		Inconsistencies with Event provider using TST and SECAmb using NASMED. One note explaining FRS not using JDM and inconsistent in their approach in the use of JESIP. • **Exercise Schedule.** Good range of exercises with different levels of command and staff involved. NOS included into exercise schedule, CC AG1 (Strategic) listed in a number of exercises (column I) although in the required box (column J) the staff attending is a DCA and OTL/s (Row 12, row 15) • **Kent MTA Exercises SCAS&BTP – Debrief Report** 3 dates across Feb / March with BTP and SCA. On the JESIP side – little to glean from the report apart from it being multiagency. Police commanders didn't collocate with Ambulance commanders with the likely result of poor communication although that is not listed as a lesson. • **MTA JPOPS – Debrief Report** 5 dates across Nov, Dec '22 and Jan '23 with Kent Police ARV unit. On the JESIP side – little to glean from the report apart from it being multiagency and used HART and SORT. • **Multi-Agency Conference Call (TEMP)** Print out of an email from ?LRF for a multiagency teleconference (11/07/2023) **Review team's lines of enquiry during visit included:** Review team to discuss EPRR plans review process of procedures. Review and dip test Commanders (j11) requirements **Further evidence during visit included:** Requirement for Tabletop ex (or live incident) every 18 months, will be part of the CPD dip test. (DW) checking on attendance to MAI days that were undertaken. **26/07/23 Interview with JESIP Tactical Lead (ME):** Last full multi-agency training was in 2019 – 3 ½ hours.		Last full multi-agency training was in 2019 – 3 ½ hours. Described as slightly out due to Covid and partner agency catch up, potential starting in November/December 2023. It is noted and with credit that this is planned to include a scenario that is appropriate to HM Coastguard partners in addition to Police and Fire & rescue Services. The Trust have a proactive team working with partner agencies to provide opportunities for exercises, however it was noted that there is not a system to manage who attends the exercises or governance to identify Commanders who have not (and take appropriate action as a result) through CPD review and support.	

		So slightly out due to Covid and partner agency catch up, potential starting in November/December 2023. To include a scenario that is appropriate to HMCG partners. (DW) = Re J3 requirement for: a timed review process?? Concern raised that 2018 MI plan will have out of date JESIP products. = JESIP App updated and JESIP Aide Memoirs updated and Sticker for the back of IPad is JESIP. SECAmb are still breaching on the requirement for multi-agency training every 3 years. Check against CPD for all Commanders submitted.			
		MASS CASUALTIES			
40	**Planning** V1 V4	• DRAFT Version 6.1 Feb 23 – NHS England and NHS Improvement Mass Casualty Framework 09.02.23. – NHS England DRAFT doc revised in Jan 2023, includes Mass Cas requirements as per CSV4 • Incident Response Plan V0.4_final – Plan not approved so therefore still Draft? – Mass Cas in Sec 7.4 **Review team's lines of enquiry during visit included:** Review team to ascertain when NHSE Mass Cas Framework will be coming out of Draft and in the meantime (currently) what are SECAmb working to? Review team to ascertain when the Incident Response Plan will be approved and in the meantime what are SECAmb working to? **Further evidence during visit included:** IRP described as 'signed off' the week before the Review team on site visit was submitted as evidence during the visit, but at the time was not 'issued' or within operational use in the Trust.		NHS England Mass Casualty Framework submitted as evidence, although containing the required information is still in Draft and therefore cannot be considered by the Review team. In its absence, the Trust has a section on Mass Casualties within its Incident Response Plan (IRP), which was approved the week before the onsite visit. However, the Review team found that the IRP, although approved, is not yet operational and Commanders were still using the 2018 Major Incident Plan (which at the time of the visit was live on the Trusts 'Zone' system).	

		Document Sign off Version: 1.0 Name of originator/ author: Resilience Department Responsible management group: Resilience Forum Directorate/team accountable: Executive Management Board **Incident Response Plan** Approved by: Resilience Forum Date approved: Fit for purpose according to: Executive Management Board Date approved: 19/07/23 Date issued: Date next review due: Target audience: All Trust staff Replaces (version number): SECAmb Major Incident Plan and Additional Contingencies V5.0 Commanders operationally using the SECAmb 2018 Major Incident Plan.			
41	**Response Arrangements** V3 V4 V5 V6	• 02 Major Incident DECLARED Action Card V3.0 July 2022 – EOC Action Card for notification of partner agencies and stakeholder. • 03. Major Incident DECLARED Subsequent Actions V1.0 Jun 20 – EOC Action Card includes use of VAS and PTS as per Core Standard V6. • 05. Major Incident HALO DEPLOYMENT Action Card v1.0 June 2020 – EOC Action Card Blank HALO deployment Log. • Deployment of Mass Casualty Vehicle (MCV) - EOC Action Card for deployment of MCV. • EOC Deployment of Incident Support Vehicles - EOC Action Card for deployment of ISVs - clear and concise. • Incident Response Plan V0.4_final – Not approved – Mass Cas in Sec 7.4 – Sec 15 (page 35) is Triage = not revised TST and MITT. • ISV Deployment Plan – Marked as DRAFT (watermark) – Access to keys via Make Ready (are these 24/7)? • ISV Vehicle Action Card – lists to start the vehicle before de-isolating the vehicle (is this possible)? • Mass Casualty Vehicle Deployment Plan V0.2 - Marked as DRAFT (watermark)		The newly published Incident Response Plan acknowledges the location of SECAmb's 2x MCVs but provides no further detail re: their deployment. The Review Team were shown an MCV Deployment Guide during their visit (on the wall at Gatwick). Elements of it were successfully tested (e.g., obtaining the key code from EOC and accessing the vehicle). It is unclear from other submitted documentation how this guide comes into play, as it is not mentioned in any live MCV-related documentation (it is in the draft MCV Deployment Plan). Although an MCV Deployment Plan (v0.1, April 2023) was presented as evidence, this remains in draft and therefore cannot accepted as the current position SECAmb are in until such time as it is formally published and operationally implemented. The absence of a clear, in-date, cohesive plan means the Review Team could consider this to be a red grading; however, with the new key presses and the ability shown by EOC to be able to provide the code, the Review Team believe a MCV can be deployed at this time, and notes the additional work underway to support this and ensure it is in a timely and effective manner.	

		Review team's lines of enquiry during visit included: V3 – have EOC arrangements been 'tested' as per Core Standard V3 requirements? Discuss use of ACCTS and other resources. Was an Equipment ISV deployed to the recent Op P incident (involving multiple casualties)? OSD (Operational Support Desk) have the codes for the Keys to the MCVs (located at Make Ready Centres) – Review team to test calling them and requesting codes (as per Mass Casualty Vehicle Deployment Plan V0.2 page 5) and ascertain what happens if the Make Rady Manager is not on site. **Review team's lines of enquiry during visit included:** **28/07/27** Test conducted with EOC re: obtaining keysafe codes for bases with MCVs stationed on them. Code given was correct, and access was gained to the vehicle. Deployment plan present on vehicle (v0.1 April 2023) is only in draft, and therefore cannot be counted as submissible evidence of an existing plan. MCV at Gatwick is situated in such a position that gym equipment in front of it has to be moved before the vehicle can be safely manoeuvred User guide in vehicle was in draft and cannot be submitted as evidence of a live, in-date guide. EOC Action card for MCV doesn't stipulate how vehicle will be brought to scene.			
42	**Mass Casualty Vehicle (MCV) and Assets** V9 V10	• D4h-inspection-checklist-20230711 (2) – Blank monthly audit checklist. • Equipment Vehicle Booklet – includes load list • ISVMCV Vehicle Status – good overview of vehicles and their status – no description for the unavailable resources (as to why they are unavailable).		The following points were noted against each of the relevant EPRR core standards: V9 – Maintenance of MCVs: SECAmb have the requisite number of MCVs, and evidence demonstrates that these are maintained to the required standard. V10 – Mechanical performance checks and stowage of vehicle: Vehicles are run regularly and tested. The Review Team were able	

	V11 V12	• Vehicle Check reports – spreadsheet sowing LOLER for equipment and monthly Mass Cas Veh. Checks **Review team's lines of enquiry during visit included:** Review team to Dip Test - completed monthly audit checklist as per the blank ones submitted for evidence. Discuss Vehicle Status spreadsheet and lack of descriptors on why vehicles are not available? Vehicle check reports – dip test/request **May 2023** Mass Cas vehicle monthly checks. **Further evidence during visit included:** **28/07/2023** **Gatwick:** Vehicle, including tail lift operated. Vehicle has a marked bay, and shoreline. Dip test of monthly vehicle checks indicates; January, February, March, June and July tests completed, but gaps in checks were evident and checks did not pick up on some major compliance issues. MPUs – last record of service came from Flogas – done in 2021, expired 2022. No one has been specifically allocated to oversee this as far as we can determine from those we discussed this with. All Trust MPUs currently quarantined. Confident on location of 11 of them, however 18 are registered to the Trust. Only 1x MPU in-date (borrowed from LAS).		to access and test the mechanics of an MCV during their visit. The MCV housed at Gatwick is parked in a manner that would prevent rapid mobilisation due to the gym equipment that blocks its path and has to be moved beforehand. V11 – MCV mobilisation arrangements: A deployment plan was provided as evidence that was in-date (as of June 2023), and includes an EOC action card which identifies criteria for deployment. V12 – Mass Oxygen delivery systems: Significant concerns have been highlighted by the Review Team regarding the care and maintenance of Mass O2 in SECAmb. At time of review, only one Mass Oxygen delivery system within the Trust, out of 18 registered to them, was compliant. All others were out of service. The one which was compliant had been borrowed from London Ambulance Service prior to this review. This is now being picked up but leaves SECAmb in a highly vulnerable state regarding its ability to provide large quantities of O2 at an incident should the need arise. For this reason, the Review Team are satisfied that a red grading is appropriate.	

Appendix 1: 2023 Key Lines of Enquiry

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
HART	01	**Standard Operating Procedures**	Trusts must ensure their HART deployments remain compliant with the national standard operating procedures (SOPs).	All HART staff and managers must have access to the Proclus system and relevant SOPs. Requires retrospective review of operations against the standard operating procedures. HART staff must be familiar with the content of the national SOPs and associated provisions.	*Intentionally Blank*	*H3*	H3
	02	**Staffing Levels**	Minimum of 6 HART staff on duty per unit at all times.	The number of HART staff in the establishment is set locally by the Trust or Commissioners but it must yield six on duty at all times per unit. The Trust is obligated to maintain records of staffing levels. Data analysis: Number / percentage of HART shifts over the last 6 months where the staff on duty was less than 6. Twice daily reporting requirement (Proclus System) and short fall reports.	*Intentionally Blank*	*H8* *H15*	H8 H16
	03	**Staff Competence**	HART staff must maintain the minimum standards of competence defined in the Training Information Sheet.	Trust must keep training records for each HART operative. Training records can be cross checked against the training information sheets on the Proclus system to ensure compliance and consistency. Training records for active / fully operational HART staff. No gaps in both the mandated refresher and recertification training elements. Total number of active HART staff in the unit. Number of HART staff on 'restrictive practice'. Number of staff fully compliant against TIS frequency and re-certification dates (which should equate to the number of active HART staff less the number on restrictive practice.	*Intentionally Blank*	H6 H4	H6 H4

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
	04	**Protected Training Time**	HART staff must be given a minimum of 37.5 hours protected training time every 7 weeks.	Unit training programme or plan. Training records. 37.5 hours of training is taking place each week (where 7 teams rotate onto training once every seven weeks).	*Intentionally Blank*	H5	H5
	05	**Physical Competence**	All HART staff must have completed a Physical Competency Assessment (PCA) every 6 months.	Establishment list and PCA records. Active / operational HART staff names – cross checked against individual PCA records. Total number of active / operational HART staff. Total number of PCAs completed in the last 6 months.	*Intentionally Blank*	H9	H9
	06	**Response Time Standards**	4 HART staff deployed within 15 minutes of a call being received by the Trust which potentially requires the HART capability. The remaining 2 staff (6 in total) must be deployed within 10 minutes of it being confirmed that a HART response is required.	Assess both key measures. Full description of the standard is in the EPRR Core Standards at H22, and H23. Trusts are required to keep accurate records of their compliance with these standards and make those records available for inspection. Data analysis (CAD or equivalent): • Total number of HART responses over a set period (e.g. last 6 months). • Percentage of those calls where 4 staff were deployed within 15mins. • Number of calls over the same period where a full HART deployment was required (all 6 staff)? • Percentage of those calls requiring 6 staff where the further two were deployed within 10mins.	*Intentionally Blank*	H22 H23 H16	H23 H24 H17
	07	**State of Readiness**	Each HART unit must maintain a state of readiness to be on scene and able to deploy at their pre-identified local strategic sites of interest (model response sites) within 45-minutes.	The Trust should have protective policies and procedures in place to ensure the HART resources do not become overly committed for anything other than HART responses requiring the full team. Policies or procedures are in place to maintain this.	*Intentionally Blank*	H24 H25	H25 H26

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			Each HART unit must maintain a 30-minutes notice to move anywhere in the UK at all times.	No notice testing of the 30-minute reaction and mobilisation time. Total number of HART responses to 'Strategic sites of interest' response locations in any 12-months period. Percentage of HART deployments where the on-scene time for all six staff was less than 45 mins (should be 100%).			
	08	**Risk Assessments**	In addition to nationally produced risk assessments, each Trust must maintain a set of local risk assessments covering HART capabilities and activities. The assessments must facilitate HART staff performing dynamic risk assessments at the scene and they must be consistent with JESIP principals.	It is acceptable for local assessments to reference the national risk assessments (GRAs) providing staff can demonstrate they know how to access and use them. Local risk assessment documentation should reference the JESIP principals. Review risk assessments for various aspects of the capabilities.	*Intentionally Blank*	H17	H18
	09	**Safety Reporting**	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.	HART personnel and managers can access the national safety alert system on Proclus and know how to complete a report. Each HART Unit should be able to access the last national safety alert issued by NARU and demonstrate what steps were taken locally in response to it. Records or system reports to show compliance with the 2-day requirements.	*Intentionally Blank*	H19	H20
	10	**Change Management**	All HART capabilities, procedures, equipment and training must conform to the national specification. Any local changes or variance must have been approved through the national Change Management System (CMS).	HART capabilities are defined in Capability Matrices which can be provided by HART personnel and managers. Procedures are defined in the SOPs on the Proclus system. Each item of HART equipment must have a national Equipment Data Sheet (EDS). HART training is specified in the national Training Information Sheet (TIS). Any local variance to these national specifications must be supported by a corresponding approval in the Change	*Intentionally Blank*	H22	H21

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
				Management System – access to which can be provided by HART personnel and managers. Variance must be justified with local Trust governance procedures and the Trust AEO must be familiar with these variances.			
	11	**Safety Critical Equipment**	Trust's must maintain the capabilities to the specification defined in the relevant matrices. This includes maintaining the minimum levels of safety critical equipment.	The safety critical equipment is defined in Equipment Data Sheets. Asset registers – cross referenced to national EDS's.	*Intentionally Blank*	H2	H2
	12	**Equipment Specification**	The safety critical equipment listed in the Equipment Data Sheets must be available and must comply with the national specification.	Each item of equipment used by HART to deliver the national capabilities has a corresponding national Equipment Data Sheet (EDS). Asset registers – cross referenced to national EDS's.	*Intentionally Blank*	H27 H28	H2 H28
	13	**Equipment Maintenance**	Trusts must maintain an asset register which covers all the nationally specified HART equipment (equipment listed in the matrices and those with an EDS). The asset register must include regulatory requirements associated with the equipment (i.e the required checks) and must include replacement dates, any defects and fault rectification. All equipment that is subject to regulatory inspections or inspections defined within the Equipment Data Sheets (EDSs) must be compliant with those requirements.	An asset register should be available for inspection. The asset register should include all items of equipment listed in the Equipment Data Sheets. The local asset register should include replacement dates, records of any defects / repairs and the dates of any mandatory inspections that may be required. The EDS for certain items of equipment require a separate, equipment specific logbook to be maintained which is used to record usage, mandatory maintenance and inspections. Live equipment checks and entries on the asset register and relevant logbook. Regulatory inspection records. Asset register reports. Equipment defect reports.	*Intentionally Blank*	*H31* *H27* *H28* *H30*	H32 H31 H28

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
				Quarantine procedures.			
	14	**Estate**	Trusts must maintain the HART estate (bases) in accordance with the national HART estate specification.	Original capital estate funding provision for HART bases. HART estate specification checklist, visual inspection and interviews with HART staff. Where the Trust has collocated wider Trust services and provisions at the HART base / location, HART services must take priority and compliance must be maintained with all aspects of the national HART estate specification.	*Intentionally Blank*	*H32*	H33
SORT	15	**Standard Operating Procedures**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).	SORT staff and managers have access to the Proclus system and the SORT SOPs. Requires retrospective review of operations against the standard operating procedures. SORT staff (including MTA Commanders) must be familiar with the content of the national SOPs and associated provisions.	*Intentionally Blank*	S2	M4
	16	**Staffing Levels**	Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year).	This 35 on duty is in addition to HART staff. HART staff should not be included in this figure. The Trust is obligated to maintain records of staffing levels. Data analysis: Number / percentage of shifts over the last 6 months where the SORT staff on duty was less than 35 (excluding HART). Twice daily reporting requirement (Proclus System) and short fall reports. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant.	*Intentionally Blank*	S5	M5

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
				• Less than 25 = non-compliant.			
	17	**Staff Competence**	SORT staff must maintain the minimum standards of competence defined in the Training Information Sheet.	Trust must keep training records for each SORT operative. Training records cross checked against the training information sheets on the Proclus system. Total number of active SORT staff in the Trust. Number of SORT staff fully compliant against TIS frequency and re-certification dates (which should equate to the number of active SORT staff).	*Intentionally Blank*	S8	M5 M8
	18	**Wider Staff Competence**	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements.	There is no frequency set against this standard but safe practice would dictate that it should include major updates, including changes in the national JESIP MTA Joint Operating Procedures. Trusts are free to develop their own local familiarisation packages or briefings. Trust needs to be able to demonstrate how it monitors and confirms that the familiarisation training has been appropriately facilitated and provide evidence. Data analysis: Percentages for each staff group showing the number that have completed the required training. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.	*Intentionally Blank*	S10	M11
	19	**Protected Training Time**	All SORT staff and commanders must undertake SORT refresher training bi-annually (twice a year) and they must undergo a re-certification every 2 years. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training	Training programme and records. Trusts can develop their own training packages. However, it must be sufficient to deliver all the competencies defined in the national Training Information Sheet (TIS) which all SORT staff and managers should have access to via the Proclus system. Number of courses run per annum.	*Intentionally Blank*	S7 S8	M7 M8

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).	Number of staff trained within the last 12 months (should equate to the total number of SORT staff) including percentage compliance against overall declared staff number. Clear delineation of HART and SORT trained staff.			
	20	**Physical Competence**	All SORT staff must have completed a Physical Competency Assessment (PCA). All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually).	SORT establishment list and PCA records. Number of operational SORT staff. Number of PCA's completed.	*Intentionally Blank*	S6	M6
	21	**State of Readiness**	Trusts must ensure that at least 30 SORT staff are released and available to respond within 60 minutes of an MTA or CBRN incident being declared to the Trust. The SORT team needs to be on scene and ready to deploy at preidentified strategic sites of interest within 45 minutes of an MTA or CBRN incident being declared to the Trust.	These responses are rare. The Trust may not have evidence of any recent deployments. The Trust is obligated to maintain records of their response times for all 35 SORT staff in the event they are deployed to a declared MTA or CBRN incident. Local policies and procedures that provide sufficient protection and management of the assets to ensure their state of readiness. No notice testing. Trust must be able to identify the number of SORT staff available at the current time that could be released and mobilised within 60 minutes. Response time metrics against the number the incidents. The results of local system and deployment testing or exercising to assurance against availability and response time standards.	*Intentionally Blank*	S28 S29 S8	M22 M23 M15
	22	**Risk Assessments**	In addition to nationally produced risk assessments, each Trust must maintain a set of local risk assessments covering SORT capabilities and activities.	It is acceptable for local assessments to reference the national assessments (GRAs) providing staff can demonstrate they know how to access and use them. Local risk assessment documentation should reference the JESIP principals.	*Intentionally Blank*	S21	M18

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			The assessments must facilitate SORT staff performing dynamic risk assessments at the scene and they must be consistent with JESIP principals. Each Trust must maintain a set of additional risk assessments that specifically cover high risk sites in their area.	Risk assessments for SORT activities. Local risk assessments for individual high-risk sites in the service geographical area. To include CBRN sites or those involving hazardous materials. The risk assessment should include controls covering Ambulance service deployments at these sites. Risk assessment review process. Register of local sites (HazMat / COMAH) etc. Links to LRF registers and plans.			
	23	**Safety Reporting**	NHS Ambulance Trusts have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the SORT service as soon as is practicable and no later than 24-hours of the risk being identified.	SORT personnel and managers can access the safety alert system on Proclus and know how to complete a report. Trust managers responsible for SORT operations should be able to access the last national safety alert issued by NARU and demonstrate what steps were taken locally in response to it. Records or system reports to show compliance with the 24-hour requirement.	*Intentionally Blank*	S23	M20
	24	**Change Management**	The SORT capability, procedures, equipment and training must conform to the national specification. Any local changes or variance must have been approved through the national Change Management System (CMS).	The SORT capability is defined in a capability matrix which can be provided by NARU or local SORT managers. Procedures are defined in the SORT SOPs on the Proclus system. Each item of nationally specified SORT equipment has a national Equipment Data Sheet (EDS). SORT training is specified in the national Training Information Sheet (TIS). Any local variance to these national specifications must be supported by a corresponding approval in the Change Management System – access to which can be provided by NARU or the local SORT Manager.	*Intentionally Blank*	S1 S2 S3	M1 M2 M3 M4 M14

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
	25	**Safety Critical Equipment**	Trust's must maintain the SORT capability to the specification defined in the SORT matrix. This includes maintaining the minimum levels of safety critical equipment.	The safety critical equipment for the SORT capability is listed in the national Equipment Data Sheets. SORT equipment required by the matrix and relevant EDS's is all available within the Trust. Asset register.	*Intentionally Blank*	S1	M1
	26	**Equipment Specification**	SORT equipment must comply with the national specification set out in the relevant Equipment Data Sheets (EDSs).	Each item of nationally specified SORT equipment has a national Equipment Data Sheet (EDS). SORT equipment should be on a local asset register.	*Intentionally Blank*	S1 S31 S32	M1 M24 M25
	27	**Equipment Maintenance**	Trusts must maintain an asset register which covers all the nationally specified SORT equipment. The asset register must include regulatory requirements associated with the equipment (i.e the required checks) and must include replacement dates, any defects and fault rectification. All equipment that is subject to regulatory inspections or inspections defined within the Equipment Data Sheets (EDSs) must be compliant with those requirements.	An asset register should be available for inspection. The asset register should include all items of equipment listed in the national equipment data sheets. The local asset register should include replacement dates, records of any defects / repairs and the dates of any mandatory inspections. The EDS for certain items of equipment require a separate, equipment specific logbook to be maintained which is used to record usage, mandatory maintenance and inspections. The ballistic vests require a logbook to be maintained as well as the asset register. Entries on the asset register and relevant logbook match.	*Intentionally Blank*	S31 S32 S33 S34	M24 M25 M26 M27 M28

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
	28	**Access to Scientific Advice**	The Trust must have a process in place which provides their Tactical and Operational Commanders with 24/7 access to specialist scientific advice.	Ensure the process is effective – i.e. telephone numbers are known and available to the people facilitating access to the advice. The advice should be coming from organisations including: • UKHSA • The National CBRN Centre Local procedure. Testing arrangements.	*Intentionally Blank*	S4	B4
	29	**Wider Staff Competence**	All operational frontline staff must be sufficiently trained in Initial Operational Response (IOR).	Note, this standard applies to all frontline Ambulance staff, not just the specialist responders. There is no frequency set against this standard but safe practice would dictate that it should include major updates, including changes in the IOR, Step 1,2,3 procedures and to CBRN doctrine nationally. Trusts are free to develop their own local familiarisation packages or briefings. Trust needs to be able to demonstrate how it monitors and confirms that the familiarisation training has been appropriately facilitated and provide evidence. Most Trusts achieve this through the annual mandatory training process for their operational staff. Percentage of current frontline staff that have received the required training. Training packages.	*Intentionally Blank*	S14	B13
	30	**Exposure Monitoring**	Trusts must have systems in place to monitor and record details of each individual responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination	Trusts should have a clear written process for how this is done. Exposure records for individuals. Trust monitoring system or process. Policies and procedures. Link to HR related staff records.	*Intentionally Blank*	S11	B7

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			activities, this must include the duration of their deployment (time committed).				
	31	**PRPS Suit Stock**	Each Trust is required to maintain a minimum stock of operational PRPS suits.	The PRPS stock holding is currently set by NHS England at 120 suits per Trust. Number of operational PRPS suits. Asset register including operational status, service and replacement dates.	*Intentionally Blank*	S33	B30 B31
Command & Control	32	**Strategic Commander Competence**	Every active Strategic Commander must have completed a nationally recognised Strategic Commander course. The specific command role must be included in the individual's contract of employment. Every active Strategic Commander must maintain a record of continued professional development. Every active Strategic Commander must perform the role as a 'player' in an exercise at least every 18 months or have acted as Strategic Commander for a real incident (which required the application of the skills described in the C2 guidance). Every active Strategic Commander must be sufficiently senior to commit the entire organisation to a course of action without the need to gain	Number of Strategic Commanders within the Trust and corresponding number of CPD records. Strategic command rota. Percentage of Strategic Commanders that have performed the role of a 'player' in an exercise in the last 18 months. Initial course and attendance at the minimum number of exercises should be recorded in the CPD record. Employment contracts for individual commanders include the specific command role they perform. Seniority and autonomy to act on behalf of the Trust Board during an incident. Deconfliction with any 'Executive' on-call rota and a clear policy showing who is in charge of the organisation during a major incident. Major incident plan. Associated procedures. Training materials and records. Registers or records of CPD portfolios checked and appraised.	*Intentionally Blank*	C18 C19 C24 C25	C18 C19 C24 C25

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			permission or authority from another.				
	33	**Tactical Commander Competence**	Every active Tactical Commander must have completed a nationally recognised Tactical Commander course. The specific command role must be included in the individual's contract of employment. Every active Tactical Commander must maintain a record of continued professional development. Every active Tactical Commander must perform the role as a 'player' in an exercise at least every 18 months or have acted as Tactical Commander for a real incident (which required the application of the skills described in the C2 guidance). Every active Tactical Commander must have a good understanding of the specialist interoperable capabilities.	Number of Tactical Commanders and corresponding number of CPD records. Tactical command rota. Percentage of Tactical Commanders that have performed the role of a 'player' in an exercise in the last 18 months. CPD records of selected Tactical Commanders from the Trust cadre / on-call rota. Employment contracts for individual commanders include the specific command role they perform. Initial course and attendance and the minimum number of exercises should be recorded in the CPD record. Major incident plan. Associated procedures. Training materials and records. Registers or records of CPD portfolios checked and appraised. Knowledge check: Tactical Commanders should fully understand the content of each matrix for the interoperable capabilities (the capability matrices on Proclus). They do not need a detailed understanding of the SOPs, but they should know the tactical options available for each capability and the limitations.	*Intentionally Blank*	C20 C21 C24 C25	C20 C21 C24 C25
	34	**Operational Commander Competence**	Every active Operational Commander must have completed a nationally recognised Operational Commander course. The specific command role must be included in the individual's contract of employment.	Number of Operational Commanders and corresponding number of CPD records. Operational command rota. Percentage of Operational Commanders that have performed the role of a 'player' in an exercise in the last 18 months. CPD records of selected Operational Commanders from the Trust cadre / on-call rota.	*Intentionally Blank*	C23 C24 C25	

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			Every active Operational Commander must maintain a record of continued professional development. Every active Operational Commander must perform the role as a 'player' in an exercise at least every 18 months or have acted as Operational Commander for a real incident (which required the application of the skills described in the C2 guidance).	Employment contracts for individual commanders include the specific command role they perform. Initial course and attendance and the minimum number of exercises should be recorded in the CPD record. Major incident plan. Associated procedures. Training materials and records. Registers or records of CPD portfolios checked and appraised.			
	35	**NILO / Tactical Advisor Competence**	Every active NILO and Tactical Advisor must have completed a nationally recognised NILO or Tactical Advisor course. Every active NILO and Tactical Advisor must maintain a record of continued professional development.	Number of NILOs and corresponding CPD portfolios. Confirmation of NILO qualification for recorded NILOs. Associated procedures. Training materials and records. Process for checking competence and verification of CPD maintenance. Delineation with Tactical Advisors. Tactical Advisor process / procedures. NILO and Tactical Advisor rotas.	*Intentionally Blank*	*C28* *C29*	C28 C29
	36	**Loggist Competence**	Every active Loggist must have completed a formal Loggist course. Every active Loggist must maintain a record of continued professional development.	Number of Loggist in the Trust and corresponding number of CPD records. Process for checking competence and verification of CPD maintenance. Number of Loggists is sufficient to maintain the required level of support to commanders during a major incident (number on duty / on-call day and night).	*Intentionally Blank*	C30 C31	C30 C31

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
JESIP	37	**Doctrine**	JESIP doctrine has been incorporated into key plans and procedures. Joint Decision Model is embedded in operational and command practice. JESIP materials are available to all Commanders.	JESIP incorporation within major and critical incident plans and procedures. JDM included with action cards or similar aid memoires. Commanders and frontline staff aware of JESIP principals and can access relevant JESIP materials.	*Intentionally Blank*	J1 J2 J4	J1 J2 J5 J7
	38	**Competence**	All frontline staff (operational and control room dispatchers and managers) receive JESIP training. Training records for all staff that should receive JESIP training are being maintained. All Commanders include JESIP competence within the CPD portfolios (including repeating a JESIP course every 3 years). An appropriate number of JESIP trainers are maintained within the Trust.	Records showing 90% of operational and control room staff have received JESIP familiarisation. Training packages. Number of JESIP trainers and their training / CPD records. Commander's CPD records include specific provisions for JESIP. Training records showing all commanders JESIP training.	*Intentionally Blank*	J5 J6 J7 J8 J9 J10 J12 J13	J8 J9 J10 J11 J12 J13 J14 J16 J18
	39	**Exercising**	JESIP is specifically and explicitly included within the exercise programme.	Evidence of multi-agency exercises and the utilisation of JESIP. Lessons recorded on LID and JOL. Lessons relating to JESIP have been actioned with demonstrable improvements to local arrangements.	*Intentionally Blank*	J3 J11	J6 J15 J21
Mass Casualties	40	**Planning**	Mass casualty plans align to the NHS England national arrangements.	Mass casualty plan – cross referenced to NHS England and NHS Improvement national mass casualty concept of operations and framework.	*Intentionally Blank*	V1 V4	V6 V9

Service Line	No	KLoE	Requirement (Summary)	Enquiries and Evidence	[Intentionally Blank]	2023 Core Standard Ref:	Previous Core Standard Ref.
			Casualty Management Plan.	Provision under major incident arrangements for developing and implementing a casualty management plan (included within action cards or aide memoires).			
	41	**Response Arrangements**	Patient distribution and coordination arrangements. Coordination arrangements between Control Rooms and other patient receiving NHS locations. Resources to staff and manage a Casualty Clearing Station (CCS). Arrangements to access and coordinate private and voluntary service providers.	Trust casualty distribution model. Control room protocols or action cards. CCS provisions within the major incident plan or associated procedures. Standing arrangements for accessing and coordinating private and voluntary agencies within Trust mass casualty arrangements.	*Intentionally Blank*	V3 V4 V5 V6 V7	V8 V9 V10 V11 V12
	42	**Mass Casualty Vehicle (MCV) and Assets**	MCVs stored undercover and shore-lined. MCVs appropriately maintained and insured. Appropriate mobilisation arrangements. Mass O2 delivery systems maintained.	Asset / fleet inventory – number of MCVs held by the Trust. Contents inventory for each vehicle – formal link to national stock management arrangements. Checking schedule and records. Estate provision. Insurance confirmation. Mass O2 delivery system maintenance records.	*Intentionally Blank*	V9 V10 V11 V12	V1 V2 V3 V4

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Appendix 2: Assessment Team Biographies

Inspection of the interoperable capabilities in England is conducted by a panel of national subject matter experts who are independent of the individual ambulance trusts delivering these services.

As part of the agreed process with NHS England and the Care Quality Commission, the panel of experts must be credible and must encompass a range of specialist knowledge and experience to comprehensively evaluate the safety, effectiveness and compliance of these highly specialist capabilities. At least one member of each inspection panel must also be a qualified auditor.

The biographies for the members of the team used to conduct this 2023 follow up review are provided here:

Christian Cooper JP MSc PGDipLaw SIRM

National Head of Operations

Senior Responsible Owner (SRO) for Annual Assessments

Christian has extensive strategic management experience in the NHS, holding dual qualifications in clinical and legal practice. He has led the health response to several major incidents and served as a special advisor to the NHS and the UK Government during national emergencies.

Christian was recently instructed to act as an independent expert for the Manchester Arena Inquiry and has supported the ambulance sector during various Coroner's Inquests and legal proceedings.

As NARU's Head of Operations, Christian's portfolio includes standards, planning, operations and improvement. He was also the principal architect of the safe system of work now in use across the interoperable capabilities in England.

He is a qualified auditor with the Charted Quality Institute and chaired the previous confirm and challenge sessions for each of the 10 English ambulance trusts in 2022.

Nicholas Spence

National Standards Manager

Nick is an experienced operations manager who has worked for the ambulance service since 1994. Prior to his current role he undertook regional roles including managing Air Operations in the Southwest where he was responsible for six helicopters, critical care practitioners and associated safety critical systems.

As a qualified and experienced ambulance commander, he has commanded several major incidents in the UK and has also managed local training for a Hazardous Area Response Team and patient safety for a regional Ambulance Trust.

Nick has worked internationally, responding to disasters overseas as part of a technical rescue organisation, for which he was Director, and he has further experience delivering CBRN training on behalf of the United Nations and World Health Organisation.

Nick is currently the NARU Standards Manager, responsible for national guidance, safe systems of work and assurance activities. Nick is a qualified auditor and coordinated the inspection process for the 2023 follow up review including managing each of the confirm and challenge sessions.

Andrew Lloyd FdSc

National Operations Officer

Andy brings a wealth of operational experience from both the ambulance and fire service sectors, having worked as an on-call Fire & Rescue Service Crew Manager, and Ambulance Service HART Educator for several years.

Before making the move to the Operations Department, Andy previously worked for NARU's Education Department as a breathing apparatus instructor and was the lead instructor for the national Urban Search and Rescue training of Paramedics.

Under Operation Gritrock, Andy was deployed to West Africa at the height of the Ebola outbreak to develop training and operational guidance alongside UKHSA colleagues for Cameroon's inaugural Ebola Rapid Response Team.

Andy has worked as both Safe System Coordinator, and Operations Officer within the NARU Operations Department, with risk management playing a key part in both those roles. He works closely with Partner Agencies to ensure key stakeholders remain engaged with, and informed of the Ambulance Service's national interoperable capabilities; seeking out opportunities to streamline and enhance multi-agency operational response.

Andy is a qualified auditor and coordinated the bundles of evidence for the follow up inspection in 2023. He also led on the evaluation of safety critical system compliance.

Jenna Davies CertEd MCPara

National Improvement Manager

As NARU's Improvement Manager, Jenna's portfolio is wide, covering; quality, research, change management and projects.

Jenna has an operational and training background rooted in the interoperable capabilities. In addition to being a qualified and experienced Ambulance Commander, Jenna has been a residential instructor at the National CBRN Centre and the Training Manager for HART Units serving London and the Southwest.

Jenna maintains instructor level qualifications for safe working at height and confined space.

As the department lead for improvement and research, Jenna works with a team of external researchers to deliver the annual Resilience and Capability survey. This is a comprehensive survey of staff performing the interoperable capabilities and provides a quantitative and qualitative analysis of practitioner's performance delivering these high-risk and specialised capabilities.

Jenna is also a qualified project manager and auditor. The multimillion-pound projects within Jenna's improvement portfolio are centred on making the interoperable capabilities safer and more operationally effective.

Graham Finnigan BSc (Hons) PGCert MCPara

National Operations Manager

Graham is an experienced Paramedic Officer at tactical and strategic command levels. Prior to his current appointment, Graham was Special Operations Manager for a regional ambulance service with responsibility for HART units, air operations and motorcycle response teams.

Retired from the Royal Army Medical Corps in late 2015, after 23 years' service where he specialised in the provision of medical preparedness, training and intimate support to global operations, including the domestic counter terrorism medical response.

Graham continues as an active Army reservist and provides specialist training and assurance to units as part of their pre-deployment process.

Graham was also a specialist consultant for the World Health Organisation (WHO) providing medical response training (including CBR) and incident management advice for Non-Governmental Organisations (NGO's) operating in northern Syria.

Graham is currently the NARU Operations Manager and the National Ambulance NILO Coordinator, responsible for monitoring states of readiness and engagement with partner agencies. Graham also manages a national logistics team overseeing NARU's operational equipment and national reserves of NHS protective equipment.

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Parsyab Khan PGCertEd MCPara

National Planning Manager

As NARU's Planning Manager, Parsyab is responsible for national emergency planning and pre-planned operations involving the interoperable capabilities. He has recently overseen the national deployment of interoperable assets within England and Scotland for political summits and international sporting events.

Parsyab has a background managing the training for specialist capabilities. He has worked in both the Ambulance Service and private industry. He recently joined the Operations Department after working for several years as Training Manager within NARU's Education Centre. In his former role, Parsyab oversaw the national training for HART and SORT capabilities as well as developing international training programmes with partner agencies. Before joining NARU he gained frontline operational experience as a HART Team Leader and Paramedic Assessor in the Yorkshire region. He was also one of the original group of paramedics that piloted the Urban Search and Rescue program before the national roll out of HART.

In addition to being a qualified and experienced Ambulance Commander, Parsyab holds a Post Graduate Certificate in Education and multiple instructor qualifications. He is currently working towards the MSc in Emergency Management with Wolverhampton University.

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NHS
South East Coast Ambulance Service
NHS Foundation Trust

SECAmb response to NARU Review of Interoperable Capabilities

October 2023

The Resilience & Specialist Operations Dept.

The Resilience and Specialist Operations Department is composed of the following 3 elements:

1. **Emergency, Preparedness, Resilience and Response (EPRR).** This element of the team ensures that SECAmb is compliant with the EPRR core standards, meets the duties placed on the organisation by the Civil Contingencies Act and provides the main pool of preparedness SMEs for the trust. The team provides the plans, policies and procedures to support both specialist operations and the wider SECAmb operations.
2. **Hazardous Area Response Team (HART).** Provides the response arm for Specialist Operations, ensuring that care is available for patients in hazardous and challenging environments, as well as providing support to the wider SECAmb operations on more complex incidents.
3. **Specialist Operations Response Team (SORT).** The SORT manager and training team in Resilience are responsible for providing oversight and training for those wider trust operational staff who have volunteered to take on extra skills for MTA and CBRN incidents. (Required 290 Volunteers) This uplift in staff and capability has presented a significant challenge for the trust.

Contents

- The Resilience & Specialist Operations Dept. delivery elements
- Overarching observations of the report
- Reflections and learning on our current position
- NHSE Annual assurance rating v NARU audit result - explanation
- HART Historic funding consideration
- Key Challenges identified in the report
- Short term actions to stabilise the Dept.
- Actions to achieve sustainable compliance – EPRR & SORT
- Actions to achieve sustainable compliance – HART
- Additional HART funding requirement breakdown
- SORT Delivery
- Current & Proposed structures for the Resilience & Specialist Operations Dept.

Overarching observations of the report

- The findings of the report present a critical assessment against the interoperable capability KLOEs set by NARU. The overall ratings of these KLOEs are worse than the ratings achieved following the NARU visit in January 2022, however it must be noted that these two sets of KLOEs are substantially different and therefore direct comparison is complicated.
- No safety critical findings were identified during the 2023 visit.

- ***Following a review of the report findings, currently the proposal is that the Trust does not challenge any of the published findings based on factual accuracy.***

2022 SECAmb Report – Grading Summary		2023 SECAmb Report – Grading Summary	
	21 Green rated KLOEs		5 Green rated KLOEs
	23 Amber rated KLOEs		13 Amber rated KLOEs
	7 Red rated KLOEs		24 Red rated KLOEs
Out of 51 lines of enquiry		Out of 42 lines of enquiry	
The reduction in KLOEs reflects the 2022/23 changes to the EPRR core standards & the merger of MTA & SORT capabilities.			

Reflections and learning on our current position

- Over the past 2-3 years there has been significant turnover in the leadership of this team. The current Head of Resilience & Specialist Operations (RSO) commenced permanently in post in May 2022 following a secondment to that position for approx. 1 year.
- There has been a general lack of support for RSO at all levels of the Trust over several years – impacted by other Trust priorities and significant turnover in Executive level roles.
- Over the last 12 months the Resilience Department has had to deal with significant additional challenges contributing to capacity to deliver all aspects of resilience:
  - High staff turnover – 6 staff in the previous 2yrs (through retirement, promotion etc). As the dept. required restructuring vacant roles were not immediately filled.
  - Complex incidents over prolonged periods have required very significant additional resource to meet the Trust and regional demand, e.g. Industrial Action including Military Aid to the Civilian Authorities (MACA) between Nov ‘22 to May ‘23, and Covid response and inquiry preparation.
- Whilst the current structure has increased the capacity in EPRR, it is worth noting that there is little resilience in the team for dealing with any extraordinary events. (e.g. further Industrial Action, a prolonged Major Incident or similar.)

Why is there a difference between the Substantially compliant NHSE Assurance rating and the NARU Audit result

- In the 21/22 NHSE Annual Assurance process, SECAmb and the four ICB commissioners agreed that the rating for SECAmb was Substantially compliant against the 184 core and interoperable standards.
- The Audit by NARU in 2023 measured SECAmb's compliance against 42 Key Lines of Enquiry, rather than the full list of Core Standards. While these KLOEs are based on core standards, they are tailored by NARU to address particular areas of concern – in this case staffing, equipment and training in HART / SORT.
- The audit process utilised by NARU is a different methodology than the assurance methodology employed by the ICBs:
  - The NHSE annual assurance process involves SECAmb meeting with the ICB commissioners across the year, identifying issues, and working together to ensure that compliance can be attained.
  - The NARU audit is a snapshot in time, based around the evidence that can be provided at or before the point in time.
- In the current round of NHSE assurance SECAmb is showing as partially compliant with the standards for this year. Validation for this outcome will be completed during the autumn 2023.

HART – Historic funding considerations

- As per the letter of 07/03/23, the requirement has been to uplift the funding for HART to provide additional capacity to achieve compliance with the standards, undertake training, purchase equipment.
- The direction to the ICBs was to increase the SECAmb funding from £3.7m to £4.9m per team, recognising that there are 2 teams which equates to a £2.4m total uplift.
- HART base funding has not changed in 10 years – previous discussions at EMB and with commissioners have not changed this position. In April 2022, a paper was presented to EMB to raise awareness of this position – the view at that time from the CFO & CEO was that no additional funding from the core budget would be provided.
- Following a discussion at the National Directors of Operations Group is clear that there is a variety of approaches that have been taken by each ambulance service in terms of actions taken to either consider how to meet the HART uplift requirement.
- A externally-led forensic review of HART funding has commenced at the request of the CEO.

	2018-19	***2019-20***	***2020-21***	***2021-22***	***2022-23***
Total Income Budget	£ 6,500,004	£ 6,670,008	£ 6,907,752	£ 6,942,288	£ 7,296,662
Total Income Actual	£ 6,501,550	£ 6,719,393	£ 6,907,752	£ 6,982,553	£ 7,296,691
Total Expenditure Actual	£ 5,909,382	£ 6,332,997	£ 6,435,267	£ 6,949,474	£ 7,371,926
Total[Surplus/(Deficit)] Actual	£ 592,168	£ 386,397	£ 472,485	£ 33,080	-£ 75,235

Key challenges identified in the report

1. HART staffing
   - The number of HART staff is insufficient to ensure the 100% compliance against the core standard of 6 members of staff on shift at each of the 2 sites (Gatwick & Ashford).
   - Each HART team currently consists of 42 Staff (6 teams of 7 consisting of 1 Team Leader + 6 Operatives per team = 84 in total).
2. Record keeping
   - Inability to provide appropriate evidence of training and equipment records duty to poor record keeping processes and governance.
   - This governance issue has been a consistent element identified through numerous reports but has proved challenging to complete with the current workload and staffing.
3. Training
   - Inconsistency in the level of clinical training and associated enhanced competencies within the SECAmb HART teams as compared to the majority of HART teams within other ambulance services. This position is as a result of historical decisions within the Trust based on the structure of other specialist teams.
4. Equipment issues
   - There is no dedicated resource/role whose sole function is the management of equipment, in the SECAmb HART units this is done voluntarily by HART staff. This has led to inconsistent management of damaged equipment.

What do we need to do to stabilise the Trust – Short Term?

1. <u>HART staffing</u>
   a) Recruit Paramedics to fill all current HART vacancies (9 on the next 10-week course completing mid-Nov).
   b) Recruit additional Paramedics to HART 'pool' positions, to enable training completion, back-filling of shifts on overtime and a planned pathway into HART.
   c) Recruitment of second HART Training Manager – Due for completion by end October
   d) Discussions have commenced with LAS/SCAS around a local MOU to support when HART team compliance levels fall below an agreed level.

2. <u>Record keeping</u>
   In HART a concentrated effort on governance and requisite documentation.
   a) Consistent implementation of procedure to weekly upload data/evidence to Proclus (national data system) underway through implementing the Clinical Educator Role.
   b) HART Deployment Plan – requires updating, to be complete by end Oct '23.
   c) Engage with the EPRR Governance Manager to ensure that there is consistent oversight.

What do we need to do to stabilise the Trust – Short term?

3. <u>Training</u>
   a) Project to address the training of enhanced clinical skills and competencies has commenced in collaboration with the Medical Directorate – proposal is with the Medical Team for comment.
   b) HART training compliance and assurance reporting via the Education, Training & Development Group, with consideration for a HART trainer to be included as a core member on the Clinical Education Steering Group.

3. <u>Equipment issues</u>
   a) Recruitment of 2 stores persons to support equipment and records management. Plan in place for recruitment.

What do we need to get us sustainably compliant – EPRR & SORT?

- Currently the team are working through a comprehensive action plan to address the specific requirements within the report. Priority has initially been given to those KLOEs scored as 'Red' but the plan will include the 'Amber' findings as well.
- A proportion of the actions (EPRR & SORT) are within the capability of the team to deliver, however, with the current and upcoming demands on capacity, there is a significant risk that sustainable implementation will be challenged. Regular review of the priority of actions within this plan against business-as-usual actions is led by the Head of Resilience & Specialist Operations and overseen via the Resilience Forum.
- There is recognition that one of the key components to assure compliance with all the actions (as evidenced in the NARU report) is the requirement to increase governance and oversight of the interoperable capabilities.
- This needs to include raising awareness of the interoperable capabilities amongst the most senior groups of the Trust (SMG, EMB & Board). Steps to support this have been taken and include:
    1. Appointment of an EPRR Manager with the portfolio of governance for the department.
    2. The monthly EMB Performance Report now contains key HART & SORT information and KPIs.

What do we need to get SECAmb sustainably compliant – HART

NHSE Core Standard: 100% compliance of 6 HART staff on duty at both sites 24/7

Not compliant
(currently 65-70% compliant)

Current position

Ashford
42 HART Staff

Gatwick
42 HART Staff

Notes:
Total = 84 staff
Budget = £7,367,600

Not compliant
(Predicted 90% compliant)

Phase 1

Ashford
49 HART Staff

Gatwick
49 HART Staff

2 additional Team Leaders + 1 additional Training Manager + 1 x admin + 2 logistics + set-up costs

Notes:
Total = 98 staff

Learning from other Trusts – this will not achieve 100% compliance.

Compliant

Phase 2

Ashford
56 HART Staff

Gatwick
56 HART Staff

Notes:
Total = 112 staff

Additional HART funding requirement breakdown

In summary:

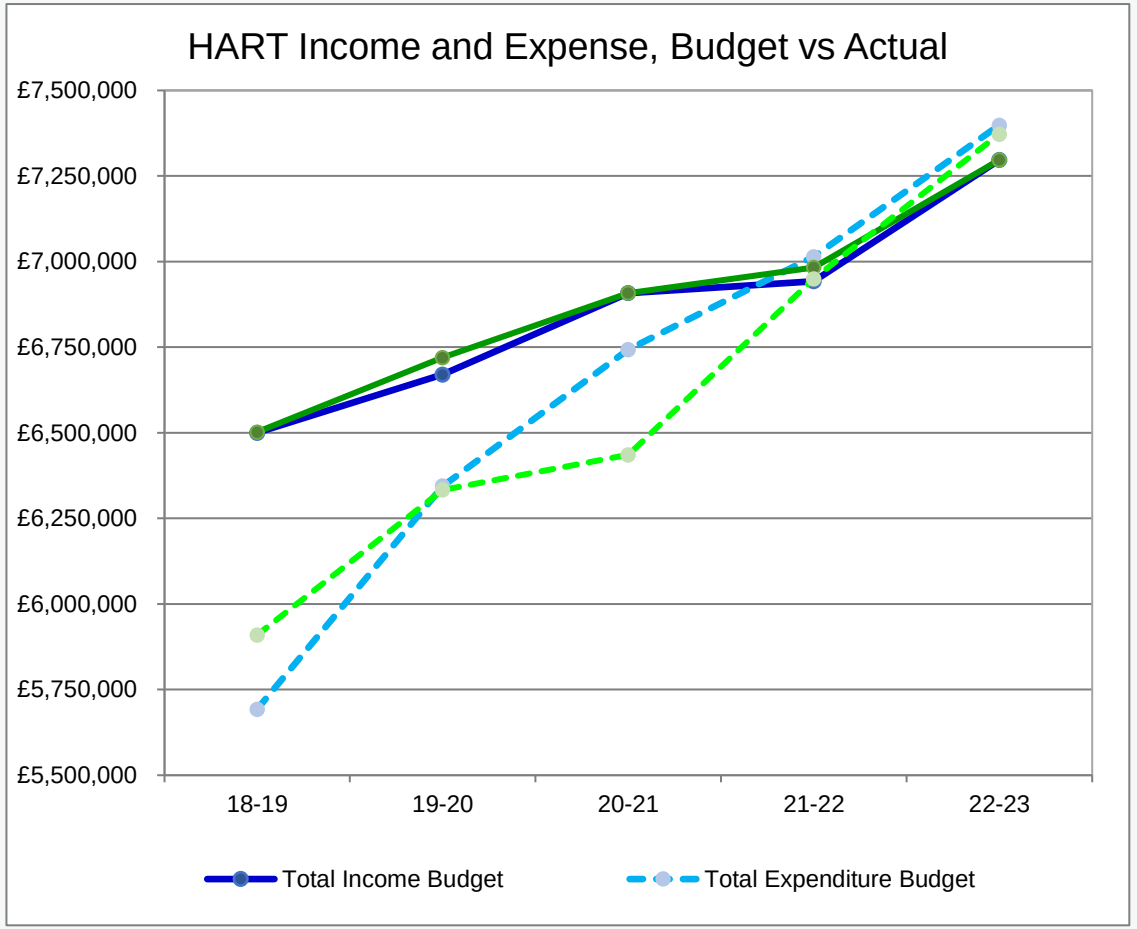
- Current funding = 2 x £3.65m = £7.3m
- Required funding = 2 x £4.85m = £9.7m

So required recurrent uplift = 2 x £1.2m = £2.4m

		No of extra staff	***Banding***	Whole year costs			
				2023-24	***Phase 1***	***Phase 2***	***Recurrent beyond phase 2***
	Current Budget			£ 7,367,600	£ 7,367,600	£ 7,367,600	£ 7,367,600
Phase 1	HART staff	14	6		£ 945,971	£ 945,971	£ 945,971
	Tranining manager	1	8a		£ 75,562	£ 75,562	£ 75,562
	Team leaders	2	7		£ 146,049	£ 146,049	£ 146,049
	Administrator	1	4		£ 34,117	£ 34,117	£ 34,117
	Logistics officer	2	3		£ 59,876	£ 59,876	£ 59,876
	Training uplift (Ongoing competence training)				£ 42,000	£ 42,000	£ 42,000
	Set-up costs (Non-recurrent: Equipment & Initial qualification training)				£ 293,986	£ -	£ -
	Phase 1 uplift				£ 1,597,561	£ 1,303,575	£ 1,303,575
	Current Budget + Phase 1				£ 8,965,161	£ 8,671,175	£ 8,671,175
Phase 2	HART staff	14	6			£ 945,971	£ 945,971
	Training uplift (Ongoing competence training)					£ 42,000	£ 42,000
	Set-up costs (Non-recurrent: Equipment & Initial qualification training)					£ 293,986	£ -
	Phase 1 + Phase 2 uplift					£ 2,585,532	£ 2,291,546
	Current Budget + Phase 1 + Phase 2					£ 9,953,132	£ 9,659,146

HART Budget breakdown and trends

	18-19	19-20	20-21	21-22	22-23
Total Income Budget	£ 6,500,004	£ 6,670,008	£ 6,907,752	£ 6,942,288	£ 7,296,662
Total Pay Budget	£ 4,341,299	£ 4,814,057	£ 5,314,732	£ 5,585,393	£ 5,885,279
Total Non-Pay Budget	£ 1,350,998	£ 1,530,298	£ 1,428,298	£ 1,428,298	£ 1,512,579
Total Expenditure Budget	£ 5,692,297	£ 6,344,355	£ 6,743,030	£ 7,013,691	£ 7,397,858
Total[Surplus/ (Deficit)] Budget	£ 807,708	£ 325,653	£ 164,722	-£ 71,403	-£ 101,196
Total Income Actual	£ 6,501,550	£ 6,719,393	£ 6,907,752	£ 6,982,553	£ 7,296,691
Total Pay Actual	£ 4,557,722	£ 4,818,003	£ 5,217,926	£ 5,376,195	£ 5,885,885
Total Non-Pay Actual	£ 1,351,660	£ 1,514,994	£ 1,217,341	£ 1,573,279	£ 1,486,041
Total Expenditure Actual	£ 5,909,382	£ 6,332,997	£ 6,435,267	£ 6,949,474	£ 7,371,926
Total[Surplus/ (Deficit)] Actual	£ 592,168	£ 386,397	£ 472,485	£ 33,080	-£ 75,235



HART – Leadership

- Acknowledging that this has been a turbulent period for the entire Resilience team, it has been recognised that the team needs to work closer and more effectively to ensure that the Resilience Department is a great place to work. This journey has commenced and in November several team away days are scheduled to consolidate the entire management team, recognising 4 new starters into the wider Resilience department.
- The Trust is focusing on improving leadership at all levels and there are 3 separate elements that will play into the HART team development:
    1. Local leadership visibility & coherence – OTL, OMs & Training team. Introduction of the Clinical Educator model will expand the leadership visibility in each team. This role will act as a 2ic when the Team Leader is not on shift. The addition of two Team Leaders
    2. Trust-wide leadership programmes (e.g. Fundamentals)
    3. National leadership – recognition nationally that HART culture can be challenging, so NARU are introducing addition training for HART leaders.
- Recent sharing of benchmarking data relating to UK ambulance service HART teams (shared by Zeal Technology – a third party commissioned by NARU when the HART programme was commenced) has shown that SECAmb ranks as ‘average/low average’ in most of the core fields.

SORT Delivery

- SORT is on an improving trajectory with strong performance in August. The Red that is recorded on the NARU report against SORT is a historical one, based on the challenges described below.
- The SORT uplift programme has encountered several complexities over the past 2 years. This has included:
  1. Significant delays in the central team confirming funding arrangements and therefore associated reluctance to implement a programme at risk.
  2. The business case requirement took an extended period to be approved delaying commencement within SECAmb.
  3. As a result of the proposed national change of model, challenge was raised by the Trust Trade Unions and several individual staff submitted grievances. The change of approach moved SORT staff off SRVs and only DCAs – this took time to progress.
  4. The final contributing factor to the delay was the rota change that completed in July 2023 – without this, the required scheduling of shifts would not support the Trust meeting the daily requirement.
- During the late summer of 2022, meetings with NHSE and the Trust Commissioners were held to present the plan for implementation of the Trust SORT Uplift Programme. All parties were in support given the other challenges that the Trust faced at this time.

Enhanced Governance & Oversight

SECAmb

- [New] Resilience Forum to move to monthly meetings with a bimonthly alternating agenda to cover assurance and delivery. SH ICB EPRR lead to continue to attend.
- [New] Compliance team/function within SECAmb being drawn together – EPRR assurance to be included in their cycle of business and oversight. Compliance team reporting through the Executive Director of Quality & Nursing.
- [New] Quarterly report to EMB – to supplement monthly performance report.
- [New] Scheduled report to FIC quarterly/twice yearly (TBC)

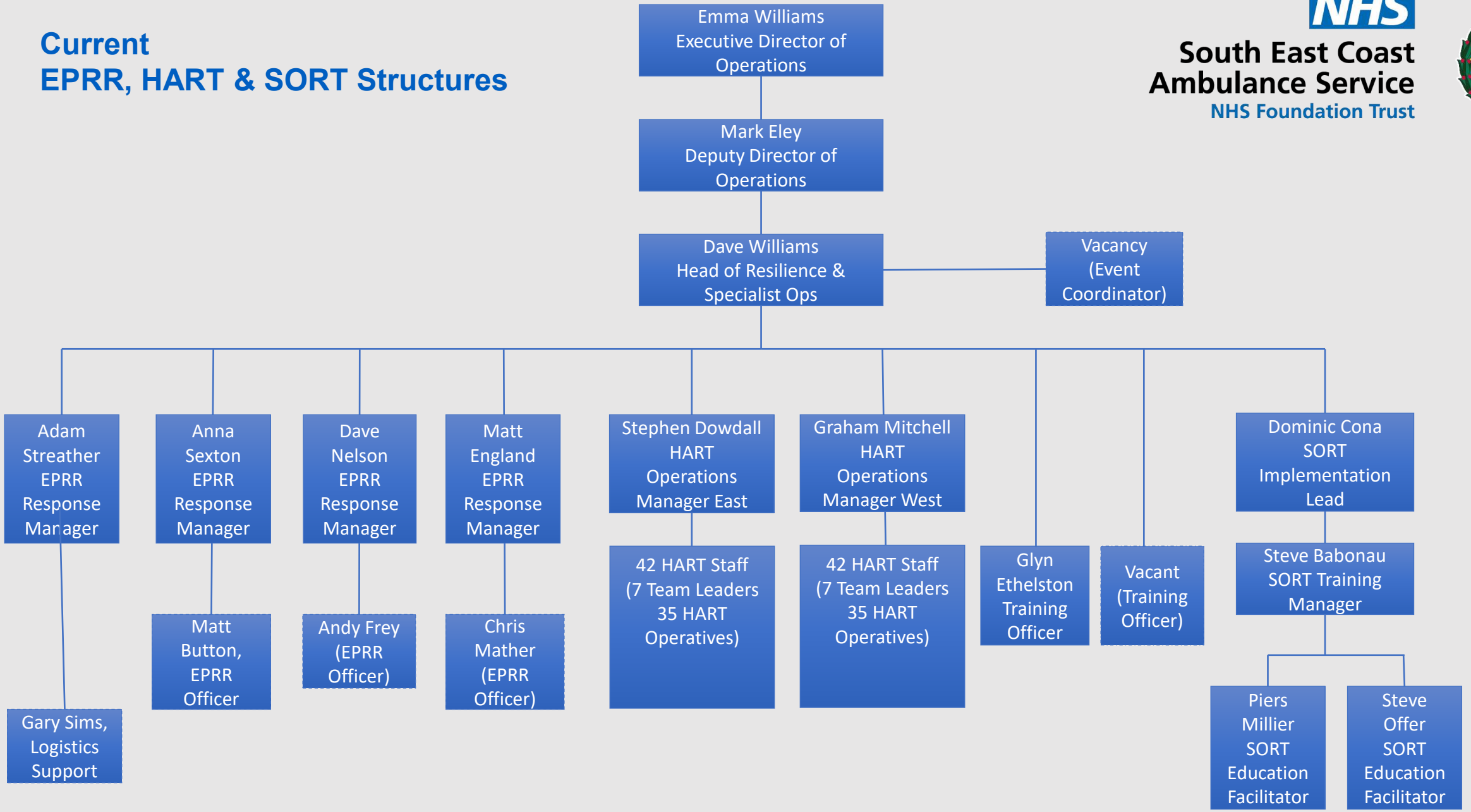
External

- [New] NHSE quarterly assurance with regional Deputy Director of Performance – EPRR.
- [Ongoing] 6-weekly meeting between HRSO and Surrey Heartlands ICB EPRR team.
- [New] Enhanced agenda for 999 contract meeting to include specific Resilience, EPRR & Specialist Operations.
- [New] AACE team who completed a review of the RSO function to continue to support and engage with SECAmb team going forward.

Current and proposed future structure of the Resilience & Specialist Operations Team

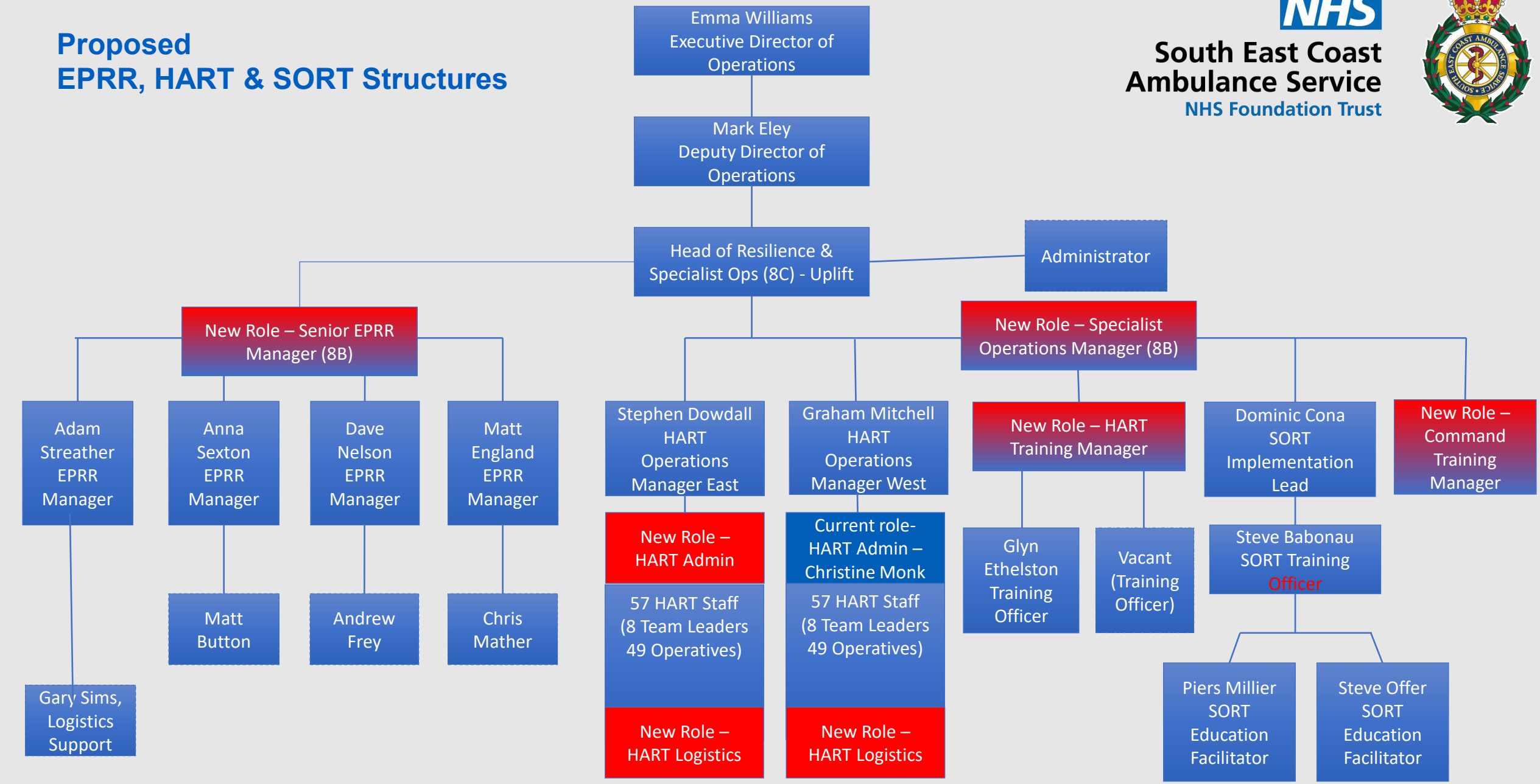
Current
EPRR, HART & SORT Structures

South East Coast Ambulance Service
NHS Foundation Trust



Proposed
EPRR, HART & SORT Structures

South East Coast Ambulance Service
NHS Foundation Trust



South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	67-23

Name of meeting	Trust Board
Date	7th December 2023
Name of paper	M07 (October 2023) Financial Performance
Executive sponsor	Saba Sadiq - Chief Finance Officer
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Kevin Steer (Head of Financial Accounting & Compliance), Rachel Murphy (Financial Manager - Projects, Business, and Investments)

This report provides the M7 year-to-date (YTD) financial performance of the Trust.

At M7 YTD the Trust is reporting a £465k surplus in line with plan. As part of this, there are emerging financial risks that may impact upon delivery of the financial plan, including efficiencies programme which under delivered by £420k and adverse variances in our Operations directorate (e.g., 111) as well as increasing premises costs.

Mitigations are being developed to address these emerging financial risks. Consequently, the Trust is forecasting achieving financial breakeven at year-end.

Our cash position of £39,838k was £967k lower than plan. This is due to the timing of invoice payments to our key suppliers IC24 and Omnicell. The Trust is forecasting a cash position of £45,935k at the end of March 2024, which is £4,465k below plan, driven by the decrease in trade payables. The financial risks outlined above would result in an adverse impact on the cash position and under delivery against the target.

Recommendations, decisions, or actions sought	The Trust Board are asked to note: a) The M7 YTD financial performance b) The challenges facing the Trust in delivering its efficiency programme; and c) The mitigations in development to address overspends and under-delivery of the efficiency programme.

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

2023/24
Finance Report to the Board of Directors
7 Months to 31 October 2023

Contents

Executive Summary

The Trust reported a £465k surplus for the seven months to October 2023 (YTD) that is in line with plan.

	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	186,096	188,447	2,352	319,066	321,386	2,321
Expenditure	(187,824)	(189,893)	(2,069)	(323,568)	(323,299)	268
Planned Profit on Sale of Assets	2,143	1,910	(233)	4,500	1,911	(2,589)
Trust Surplus / (Deficit)	**414**	**464**	**50**	**(2)**	**(2)**	**0**
Reporting adjustments:						
Remove Impact of Donated Assets	1	1	0	2	2	0
Remove Impact of Impairments	0	0	0	0	0	0
Reported Surplus / (Deficit)*	**415**	**465**	**50**	**0**	**0**	**0**

Efficiency Programme	3,788	3,368	(420)	8,988	6,363	(2,626)
Cash	40,805	39,838	(967)	50,400	45,935	(4,465)
Capital Expenditure	11,168	10,260	908	27,055	27,055	0

*Reported Surplus / (Deficit) represents what the Trust is held to account for by the ICB/NHSE

Year to Date (YTD)

- The financial performance consists of adverse and favourable variances. Adverse variances included (£498k) overspend in NHS 111 and a net (£398k) pressure in HR. These are outlined more in detail further on. Favourable variances The Trust received £1,265k higher than planned interest on its cash held at bank.

- The Trust has submitted to NHSE that it will achieve the £8,988k efficiency target for the year.

- Delivery of £3,368k efficiencies YTD is £420k below plan. However, this is an improvement of £61k compared to last month due to overachievement in-month. 79% of the schemes were recognised on a recurrent basis, whilst 21% were non-recurrent. Six more schemes at a value of £383k were transferred to delivery phase during the month. This represented two recurrent schemes of £235k and four non-recurrent budget underspends of £148k. At M7 the value of schemes in delivery phase is £6,832k, or 76.0% of the £8,988k efficiency target. However, due to the emerging risks notably to the Procurement contracts review (£380k), which is risk rated red, the current risk adjusted efficiency savings forecast reduces by 6.9% to £6,363k. This is £2,626k below the £8,988k target. The Trust must deliver £5,620k worth of efficiencies by the end of this year. This will be challenging with winter when operational pressures are high. However, there are mitigations in place to bridge the gap, which include recognising budgetary underspend and the development of validated and scoped schemes with a value of £834k.

- Forecast does not include any further income or expenditure relating to the £2,500k additional operational capacity funding beyond the £1,636k already spent. NHSE have confirmed that we can utilise the remaining funds for call handling and additional clinicians to support H&T.

- The cash position decreased by £2,593k this month to £39,838k. The M7 cash balance is £967k below plan, mainly due to the timing of invoice payments to large suppliers IC24 and Omnicell.

- Capital expenditure of £10,260k is £908k below plan due to timing of asset purchases, mainly in IT. The Trust is confident that it will deliver its capital departmental expenditure limit (CDEL) for the year. Additional capital allocation of £932k (net book value) from the sale of Trust assets is being matched by additional capital spend, mainly IT upgrades. The host ICB has confirmed that it received further capital allocation at M7, of which the Trusts allocation is £1,188k. An additional estate improvement has been allocated to achieve this increased allocation.

Forecast Outturn

- The Trust is forecasting to achieve a breakeven at year-end. As required by NHS England and the Surrey Heartlands ICB, the Trust is continuing to report an overall forecast breakeven.

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

- Other measures include reviewing the Trusts Statement of Financial Position, to ensure our provisions are adequate to meet future obligations.

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

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

1. Income

	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	166,739	168,461	1,722	286,019	287,742	1,723
111 Income	15,695	15,728	33	26,905	26,940	35
HEE Income	1,459	1,439	(20)	2,474	2,490	16
Other Income	2,203	2,819	617	3,668	4,214	547
Total Income	**186,096**	**188,447**	**2,352**	**319,066**	**321,386**	**2,321**

- 999 income is £1,722k greater than planned YTD, mainly from additional capacity funding (£1,636k) matching expenditure.
  - Only £1,636k of the additional £2,500k of support funding has been spent. The Trust has agreed with NHS England that the remaining £864k can be used for call handling

and additional clinicians to support H&T delivery. A confirmation email is expected imminently, and the expenditure is expected to be spent by the end of the year.

- 111 income is slightly above plan, from additional income to match costs of providing doctors personal learning days (PLDs) cover for the Kent and Medway ICB.

- HEE (Health Education England) income is slightly lower than planned. This reflects the most recent funding schedules received for 2023/24.

- Other income is £617k above plan, £418k is linked to additional expenditure associated with international paramedic recruitment and £165k relates to the sale of obsolete equipment.

2. Expenditure

The below table shows expenditure plan and outturn by directorate. The below is offset by corresponding funding the Trust receives and recognised under income.

Expenditure By Directorate*	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(2,634)	(2,620)	14	(4,590)	(4,712)	(122)
Finance	(13,456)	(13,303)	153	(23,620)	(23,490)	130
Quality and Safety	(2,086)	(2,031)	55	(3,614)	(3,575)	39
Medical	(11,037)	(9,861)	1,176	(18,997)	(17,700)	1,297
Operations	(105,144)	(106,039)	(895)	(182,835)	(184,057)	(1,222)
Operations - 111	(15,640)	(16,138)	(498)	(26,806)	(27,193)	(387)
Strategic Planning & Transformation	(16,396)	(16,065)	331	(28,129)	(28,462)	(333)
Human Resources	(2,952)	(3,768)	(816)	(5,186)	(6,050)	(864)
Total Directorate Expenditure	**(169,345)**	**(169,825)**	**(480)**	**(293,777)**	**(295,239)**	**(1,462)**
Depreciation	(10,418)	(10,469)	(51)	(19,066)	(18,520)	546
Financing Costs	(1,366)	(74)	1,292	(2,342)	(3)	2,339
Corporate Expenditure	(6,695)	(9,525)	(2,830)	(8,382)	(9,539)	(1,157)
Total Expenditure	**(187,824)**	**(189,893)**	**(2,069)**	**(323,568)**	**(323,299)**	**268**
Planned Profit on Sale of Assets	2,143	1,910	(233)	4,500	1,911	(2,589)
Total Trust Expenditure	**(185,682)**	**(187,983)**	**(2,301)**	**(319,068)**	**(321,388)**	**(2,321)**

*Excludes Income

YTD performance against plan

- Total expenditure at M7 YTD was £187,983k, which is £2,301k adverse to plan.

- Expenditure includes £1,636k for additional operational capacity, matched by income.

- Further pressures include £498k in NHS 111 whilst the increased costs in HR of £816k is attributed to the focus on International Paramedic Recruitment, which is supported by £418k of income, resulting a net cost pressures of £398k. These are offset by non-recurrent benefits in financing costs of £1,292k explained below.

- Excluding the £1,636k for additional operational capacity, Operations is £741k underspent YTD.

- This is a combination of £1,278k favourable variances across other business areas, notably £822k in EOC due to challenges in recruiting clinicians, £236k relating to delays in placement training and £220k in Specialist Operations because of the timing of planned vehicle leases and training.
- This is negating a £537k overspend in Frontline operations and is a reduction of £280k compared to last month. The main driver is 11% higher than planned productive hourly rate (based on hours 'on the road') of £39.41, against plan of £35.47.
- The overall provision of staff hours slightly improved compared to last month, though is still 7.2% below plan. In addition, the YTD abstraction levels remains positive at 30.8% compared to the plan of 31.9% including high levels of sickness (7.3% compared to a target of 7.0%). However, this contrast with the overspend in costs due to the following factors:
- Additional costs from the circa 50 accelerated recruitments together with better than planned recruitment and attrition at a value of £545k whilst over 20% of the new recruits are awaiting training and yet to become operational.
- The impact of the planned annualised average Unsocial Hours percentage due to the six bank holiday continues to be normalised and currently tracks at £338k.
- These are partly offset favourable productive hourly rate of 2.9% generating a savings of £106k and reduction in Time of in Lieu hours of £240k.

- The overspent in NHS 111 continues to steadily improve and stands at £498k higher than plan YTD. This is driven by the £189k reduction in the month as the agency spend controls embeds in. The YTD overspent is largely driven by the requirement to utilise increased GP services and reliance on agency clinicians and overtime at higher premium rates to facilitate a safe service during Q1. The YTD abstraction of 30.5% is better of the plan of 31.9%. However, sickness level remains higher than planned, (11.5% against a target of 7%). Recruitment is still challenging but steadily stabilising since the Medway move in June to bridge the shortfall in establishment.

- Finance costs contributing an additional £1,292k of favourable variance, mainly through bank interest received of £1,265k reflecting the high interest rates.

- Further underspends relate to the timing of training, which is contributing to £588k, lower than planned vehicle related spend of £410k, including timing of leases and lower fuel cost together with vacancies in support and back-office functions of £268k relating to timing of restructures.

- Depreciation is slightly above plan by £51k due to timing. The forecasted position for total depreciation is to be less than plan by year end because of delays in assets going live compared to the original plan timing.

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

NHSE Categories	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Pay/Staff Costs	(131,528)	(132,506)	(978)	(227,524)	(229,942)	(2,418)
Depreciation	(10,418)	(10,469)	(51)	(19,066)	(18,520)	546
Premises Costs	(717)	(941)	(224)	(1,615)	(2,006)	(391)
Transport Costs	(10,216)	(9,806)	410	(17,519)	(17,505)	14
Purchase of Healthcare (PAPs;IC24;HEMS)	(8,087)	(8,203)	(116)	(13,800)	(14,068)	(268)
Supplies and Services	(5,345)	(5,541)	(196)	(9,376)	(9,631)	(255)
Establishment	(2,984)	(3,431)	(447)	(5,187)	(5,756)	(569)
Education Costs	(1,372)	(784)	588	(2,338)	(1,864)	474
Operating Lease Expenditure	0	0	0	0	0	0
Finance Costs	(1,136)	190	1,326	(1,947)	428	2,375
Clinical Negligence (CNST)	(1,125)	(1,104)	21	(1,929)	(1,894)	35
Other	(14,896)	(17,298)	(2,402)	(23,267)	(22,541)	726
Total Expenditure	**(187,824)**	**(189,893)**	**(2,069)**	**(323,568)**	**(323,298)**	**269**
Planned Profit on Sale of Assets	2,143	1,910	(233)	4,500	1,910	(2,590)
Total Trust Expenditure	**(185,682)**	**(187,983)**	**(2,301)**	**(319,068)**	**(321,388)**	**(2,321)**

Full year performance against plan

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

3. Service Line

- The table below shows the Income and Expenditure attributable to our key service lines.

999 (Emergency Services)	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	168,051	169,889	1,838	288,024	289,971	1,946
Expenditure	(167,443)	(169,166)	(1,723)	(287,628)	(289,480)	(1,852)
Surplus / (Deficit)	**607**	**722**	**115**	**397**	**491**	**94**

111 (KMS)	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	15,695	15,728	34	26,905	26,939	34
Expenditure	(15,822)	(16,147)	(325)	(27,119)	(27,333)	(214)
Surplus / (Deficit)	**(128)**	**(419)**	**(291)**	**(214)**	**(394)**	**(180)**

Other	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	2,350	2,830	480	4,136	4,477	341
Expenditure	(2,416)	(2,669)	(254)	(4,321)	(4,576)	(255)
Surplus / (Deficit)	**(66)**	**161**	**226**	**(185)**	**(99)**	**86**

- Assumptions:

- 999 includes the Hazardous Area Response Team (HART) and Helicopter Emergency Medical Service (HEMs) as well as core functions.
- 111 reflects the direct cost, including depreciation for delivering the 111 and Clinical Advice Service (CAS) for Kent, Medway, and Sussex.
- Other includes directly commissioned services and funded projects, including Neonatal, Commercial Events, International Paramedic Recruitment, Specialist Operations Response Team (SORT) and specific HEE Education projects e.g., Placements and development of the Level 7 Advanced Clinical Practitioners.

- 999 is £115k better than planned for the year to date, mainly driven by the additional bank interest from the favourable interest rates on the Trusts bank balance.

- 111 is £291k worse than plan for the year to date, this is due to the high reliance on agency staff and increased GP spend as the service transitioned to a new operating model to reflect the change in contract funding, the run rate has now been brought under control and the forecast reflects a small improvement.

- Other is as £226k better than plan for the year to date, through additional HEE funding for placements.

4. Efficiency Programme

Proposed schemes

Scheme Category	Fully Validated	Validated	Scoped	Total Schemes	Proposed	Total
	£000	£000	£000	£000	£000	£000
Discretionary Non Pay	234	-	-	234	-	234
Efficiency target	464	-	-	464	437	901
Estates and Facilities optimalisation	383	-	-	383	-	383
External consultancy & contractors	29	-	-	29	-	29
Fleet - Fuel: Bunkered Fuel & Price Differential	323	-	-	323	-	323
Fleet -Other Efficiencies	191	-	-	191	40	231
Income generation	205	-	-	205	-	205
IT Productivity and Phones	-	-	165	165	-	165
Make Ready Process	-	-	240	240	-	240
Medicines Management - Consumables	100	-	-	100	-	100
Medicines Management - Equipment	68	-	-	68	-	68
Operations Efficiencies	2,752	-	211	2,963	-	2,963
Optimisation in establishment - clinical	100	-	-	100	-	100
Optimisation in establishment - non clinical	17	-	14	32	-	32
Optimisation in Training	81	-	-	81	-	81
Policy & service reviews	1,490	-	129	1,619	-	1,619
Procurement contracts review	380	66	-	446	-	446
Taxi & Other Vehicle Hire	-	9	-	9	-	9
Travel and subsistence	15	-	-	15	38	52
Unidentified	-	-	-	-	807	807
Grand Total	6,832	75	759	7,666	1,322	8,988

- The Trust submitted a breakeven financial plan for 2023/24 predicated on the delivery of a £8,988k efficiency target, which represents 3% of operating the expenditure.

- 53.5% or £4,807k of the total target was expected to be cash releasing with the remaining £4,181k, cost avoidance but improving operational performance.

- The efficiency plans identified YTD comprises 76% of the target. This includes fully validated and validated schemes of £6,832k and £75k respectively shown in the above table.

- The overall number of identified schemes remains 49 schemes on the Pipeline Tracker at a value of £7,666k and is 85% of the total target.

- 6 schemes representing £383k were fully validated in the month and transferred to the delivery phase. This included “validated” and “scoped” schemes totalling £108k and £275k respectively. 4 of the schemes were non recurrent at a value of £148k and 2 of the schemes were recurrent for £235k. One scheme has been split into two. This means 41 schemes have progressed to delivery phase YTD, totalling £6,832k.

- The transfer of the 6 validated and scoped schemes to delivery phase led to a reduction in both the “validated” and “scoped” to 2 and 6 totalling £75k, and £759k respectively currently awaiting Director sign off or QIA review.

- Work continues to progress with the development of identified schemes and to scope further opportunities to achieve the remaining £1,322k proposed schemes on the Pipeline Tracker.

Efficiency Delivery YTD October and Forecast Outturn by Directorate

Directorate	2023/24 M07 YTD Plan £000	2023/24 M07 YTD Actual £000	2023/24 M07 YTD Variance £000		2023/24 Annual Plan £000	2023/24 Risk adjusted FOT £000	2023/24 Risk adjusted FOT vs. Plan Variance £000		2023/24 Fully Validated Schemes £000	2023/24 M07 Annual Plan vs. FVS Variance £000	
Chief Executive Office	18	22	4	21%	37	22	(15)	(40%)	22	(15)	(40%)
Finance & Corporate Services	343	203	(140)	(41%)	632	595	(37)	(6%)	965	333	53%
HR	77	0	(77)	(100%)	154	119	(35)	(23%)	119	(35)	(23%)
Medical	250	437	188	75%	499	486	(13)	(3%)	486	(13)	(3%)
Operations	2,473	1,729	(744)	(30%)	5,979	3,697	(2,283)	(38%)	3,797	(2,183)	(37%)
Quality & Nursing	21	21	0	0%	25	25	0	0%	25	0	0%
Strategic Planning and Transformation	584	956	372	64%	1,084	1,418	333	31%	1,418	333	31%
Unidentified	22	0	(22)	(100%)	577	0	(577)	(100%)	0	(577)	(100%)
Total	**3,788**	**3,368**	**(420)**	**(11%)**	**8,988**	**6,363**	**(2,626)**	**(29%)**	**6,832**	**(2,156)**	**(24%)**

- The YTD efficiency savings delivery of £3,368k is £420k adverse to the planned target of £3,788k. This is £61k improvement compared to last month. 79% of the YTD savings were recognised on a recurrent basis and 52% or £1,750k of the total schemes were cash releasing.

- We are forecasting a full year efficiency savings of £6,363k from the fully validated schemes which have a plan value of £6,832k. The £469k decrease is largely due to the risk associated with the delivery of the planned, Procurement contracts review scheme that was anticipated to deliver £380k worth of savings at the beginning of the year, but currently rated red and forecast to deliver £10k. There are two other schemes, “Reduction in sickness” and “Hear and Treat” which are rated amber, and the value of risk is of £75k and

£24k respectively. Mitigations are progressing to achieve the milestones, consequently we are reporting a gap of £2,626k against the £8,988k efficiency target for the year.

- SMG has been tasked by EMB in July to find a further £2.5m worth of savings. SMG has carried out a deep dive and confirmed to EMB on 08 November 2023 that all options have been exhausted and there is no further savings which can be made without deciding on slowing down or stopping expenditure. This means the Trust may have to rely on its reserves to bridge the gap to meet its financial break-even plan.

- Recurrent schemes currently represent 86% of the total risk adjusted schemes of £6,363k. Greater reliance on non-recurrent underspends to mitigate the shortfall in the efficiency programme will impact on the recurrent and non-recurrent ratio.

- Cash releasing efficiency forecast represents £2,689k of the total risk adjusted schemes compared to the £4,807k planned target. £3,673k or 57.7% of the schemes are cost avoidance schemes and therefore non-cash releasing. This represents 87.9% of the planned £4,181k total non-cash releasing target.

- The overall efficiency delivery risk remains red. The efficiency saving is back phased, and the Trust is required to deliver 62.5% of the £8,988k efficiency target within the next five months. This is anticipated to be challenging to achieve during the winter when operational pressures are high.

- Engagement continues with stakeholders across the Trust is required to drive the development of proposed schemes and to explore new opportunities including non-recurrent savings to facilitate the delivery of the £8,988k target in the financial year 2023/24 and to build a pipeline of sustainable schemes beyond.

    - All Budget holders are required to make a concerted effort to work with their FBP to support delivery of their identified efficiencies, including the schemes identified during the Joint Leadership Team held a workshop in October.
    - The weekly Check and Challenge reviews proceeds to track the delivery of schemes.

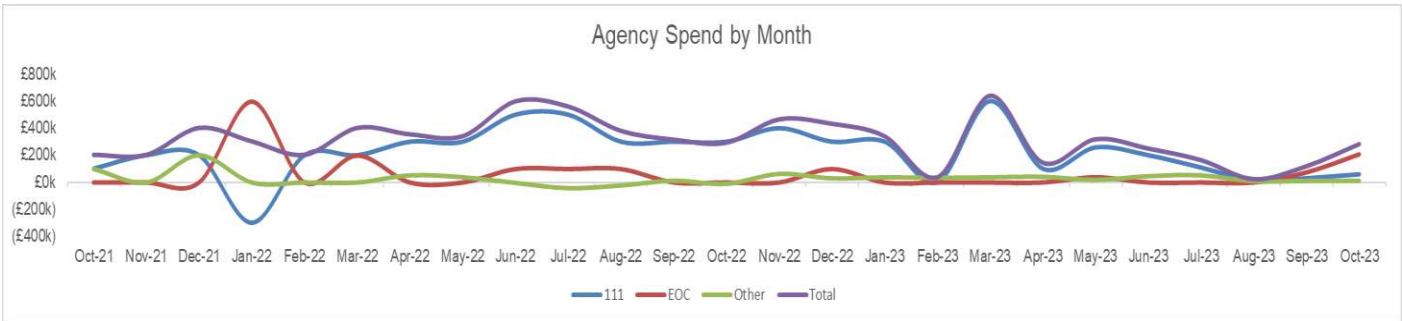
- SMG has met on 22 November 2023 to discuss and will send its recommendations to EMB by the end of the month on which EMB needs to give a direction on.

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

5. Agency

£000	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Agency Expenditure	(1,087)	(1,283)	(196)	(1,792)	(2,115)	(323)

- Overall spend with agencies is slightly over plan by £196k. and includes expected additional agency spend to support operational performance. Majority of the agency spend YTD was in NHS 111 (£842k).



6. Contingency and Reserves

- The Trust holds £1,100k of contingency against its financial performance.

- £987k of approved improvement cases have been supported by the Trusts reserves so far in this financial year and it is anticipated that the contingency will be fully utilised.

- The Trust identified £8,597k of non-recurrent reserves. This can be used for supporting improvement cases and achieve financial break-even if the efficiency programme under delivers. However, some are subject to external factors, such as, agreement on dilapidations for Orbital House. Excluding this the value of reserves is £7,304k.

- Statement of Financial Position and Cash

	£000 Previous Month	£000 Change	£000 Current Month	£000 31 March 2024
NON-CURRENT ASSETS				
Property, Plant and Equipment	116,211	(2,585)	113,626	115,559
Intangible Assets	1,765	863	2,628	1,898
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**117,976**	**(1,722)**	**116,254**	**117,457**
CURRENT ASSETS				
Inventories	2,524	63	2,587	2,575
Trade and Other Receivables	12,695	(3,123)	9,572	7,753
Asset Held for Sale	657	0	657	657
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	37,245	2,593	39,838	45,935
Total Current Assets	**53,121**	**(467)**	**52,654**	**56,920**
CURRENT LIABILITIES				
Trade and Other Payables	(43,851)	1,870	(41,981)	(50,463)
Provisions for Liabilities and Charges	(10,289)	88	(10,201)	(10,201)
Borrowings	(6,681)	157	(6,524)	(5,416)
Total Current Liabilities	**(60,821)**	**2,115**	**(58,706)**	**(66,080)**
Total Assets Less Current Liabilities	**110,276**	**(74)**	**110,202**	**108,297**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(9,528)	0	(9,528)	(9,528)
Borrowings	(21,791)	94	(21,697)	(20,258)
Total Non-Current Liabilities	**(31,319)**	**94**	**(31,225)**	**(29,786)**
TOTAL ASSETS EMPLOYED	**78,957**	**20**	**78,977**	**78,511**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,204	0	109,204	109,204
Revaluation reserve	6,871	0	6,871	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(37,562)	0	(37,562)	(37,562)
Income and expenditure reserve - current year	444	20	464	(2)
TOTAL TAX PAYERS' EQUITY	**78,957**	**20**	**78,977**	**78,511**

- Non-Current Assets are down by £1,722k in the month represented by new assets under construction of £287k, plus new Right of Use assets of £122k net of monthly depreciation of £2,129k which included some catch up on capitalised items going live.

- Trade and other receivables are down by £3,123k. The major movement was a reduction in accrued income of £1,009k after receipt of cash from Surrey Heartlands, prepayments dropping £1,157k primarily clearing Platinum invoice payments plus a £815k decrease in

trade receivables with receipts received from WMAS of £633k and Chichester College of £182k in the month.

- Cash was up £2,593k after receipt of Surrey Heartlands £1,458k additional income and education money from NHSE of £909k. The balance was a reduction in non-pay expenditure in the month.

- Trade and other payables were down by £1,870k which was primarily a decrease in accruals of £1,027k. The balance is made up of a decrease in trade payables of £591k and in deferred income of £252k.

- The provision balances are down by £88k representing payments to NHS Pensions during the month.

- Borrowings decreased by £251k after payments on property rent and DCA leases in the month net of the asset additions of £122k.

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

7. Cash Flow Position

Cash Flow	Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
EBITDA	12,199	9,098	(3,101)	21,407	16,609	(4,798)
Working Capital / IFRS 16	3,368	(707)	(4,075)	13,788	9,220	(4,568)
Capital Payments	(13,242)	(12,029)	1,213	(18,413)	(19,443)	(1,030)
Proceeds from disposal of assets	0	2,843	2,843	0	2,843	2,843
IFRS 16 Lease Payments	(4,550)	(4,206)	344	(8,369)	(8,199)	170
Net PDC and interest	(1,108)	702	1,810	(2,150)	768	2,918
Cash Movement	(3,333)	(4,299)	(966)	6,263	1,798	(4,465)
Opening Cash Position	44,137	44,137		44,137	44,137	
Closing Cash Position	40,804	39,838	(966)	50,400	45,935	(4,465)

- The Trust's cash balance as at M7 2023/24 was £39,838k. The receipts for the year-to-date were £207,723k including proceeds from sale of Trust assets of £2,843k.

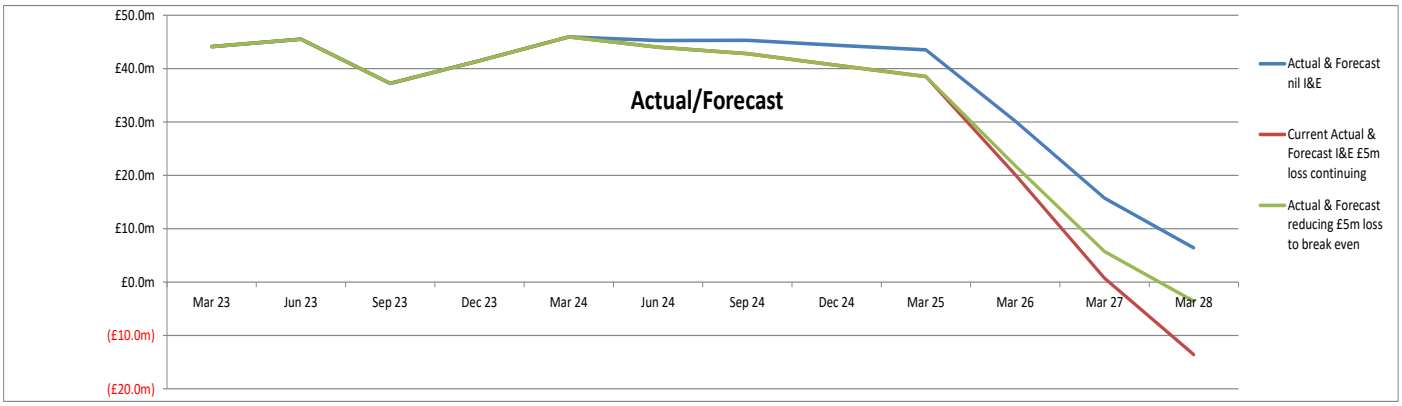
- Capital cash payments were £12,032k for the year to date along with other expenditure of £199,990k meaning the net decrease of £4,299k for the year in the table above.

- The actual cash balance was £966k lower than plan primarily due to the reduction in trade payables since year end along with increased pay costs partially offset by lower cash spend on capital of £1,213k and PDC dividend of £580k. The Trust continues to benefit from the

higher interest rates with unplanned interest income of £1,265k year to date along with sales proceeds of £2,843k also benefitting the cash to plan.

- This decrease in the surplus on the I&E position of £3,101k is being covered by the disposal proceeds from asset sales of £2,843k and higher interest receivable net of PDC dividend of £1,810k.

8. Cash Forecast



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

- The upside case is indicated by the top blue line above, where a break-even I&E position has been assumed for all future years. This means our cash position will be around £6,411k by 2026/27 due to significant planned capital investment.

- The middle green line predicts the eroding cash position if the Trust reports a £5,000k deficit in 2024/25 and then report break-even for future years. The red line shows the impact of what happens should the trend of deficits continue.

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

9. Working Capital Ratios

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	12	
Debtors % > 90 Days	5.0%	57.9%	
Trade Creditor Days	30	26	
BPPC - Value of inv's pd within target (ytd)	95.0%	83.9%	
Cash (£000)	40,804	39,838	

- Receivable days at month end are 18 days ahead of the target and down by 3 days from last month. Receipts of £633k from West Midlands AS and £182k from Chichester College in the month have decreased the ratio.

- Receivables % over 90 days are above target due to historic overdue invoices of £104k from NHS Horsham and Mid-Sussex CCG for divert charges and £64k from NHS Lewes High Weald Havens CCG for disputed A&E charges. Both CCGs are no longer operating, and both have been absorbed into NHS Sussex ICB. In addition, there is £105k due from NHS E from an invoice related to income back in May.

- Payables days are under target by 4 days for the month. The level of payables has decreased in the month after the clearance of £736k of Platinum ambulance Services invoices being matched to the prepayment made earlier in the year.

- The BPPC for value of invoices paid was 96.8% that has improved the YTD rate to 83.9% from 81.8% since last month. However, performance remains below the target of 95%. The historic late payments to IC24 and Omnicell earlier in the year continue to bring the YTD rate down. There were 12 IC24 invoices valued at £3,659k and 4 Churchill invoices for £1,740k where delays in processing the invoices against the purchase orders led to failing terms. Without these invoices the BPPC would have been 91.8%.

- Cash is below plan at month end by £966k. The adverse variance links to the decrease in trade payables since year end along with increased pay costs being £6,865k adverse to plan which partially offset by lower cash spend on capital of £1,213k and PDC dividend of £580k. The Trust continues to benefit from the higher interest rates with unplanned interest income of £1,265k year to date along with sales proceeds of £2,843k also benefitting the cash to plan.

10. Capital

The in-month capital spend is £409k which is £1,970k lower compared to the plan of £2,379k. The year-to-date capital spend is £10,260k which is £908k lower than planned compared to the planned £11,168k. This is due to delays in the supply of the 57 DCAs currently in build, these were originally expected to be delivered by the converters by the end of November 2023. The table below sets out the detailed spend and forecast against plan for the year.

Capital Programme 2023/24 - as at M07	In Month October 2023			Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Original Plan									
Estates									
Fleet Location - Telford Place	0	0	0	0	13	(13)	0	13	(13)
Make Ready - Hastings	0	56	(56)	0	151	(151)	0	151	(151)
Sheffield Park	0	0	0	0	39	(39)	0	39	(39)
Brighton MRC alterations	0	0	(0)	300	48	252	300	97	203
MDC alterations	100	0	100	100	26	74	300	300	0
Total Estates	100	57	43	400	276	124	600	600	0
Strategic Estates									
Make Ready - Medway	0	42	(42)	2,044	1,784	260	2,044	2,148	(104)
Make Ready - Banstead	0	(0)	0	0	(1)	1	0	(1)	1
Total Strategic Estates	**0**	**41**	**(41)**	**2,044**	**1,783**	**261**	**2,044**	**2,147**	**(103)**
IT									
IT Hardware	42	95	(53)	290	414	(124)	500	506	(6)
Cyber Security - 2022/23	0	1	(1)	763	763	(0)	763	763	(0)
Network Project	0	0	0	0	(0)	0	0	(0)	0
Resilience - 2022/23	0	0	0	0	283	(283)	587	586	1
IT Telephony - 2022/23	0	0	0	355	510	(155)	517	517	0
Data Centre CCTV	0	0	0	0	(4)	4	0	(4)	4
MRC Remediation Work	0	0	0	0	0	0	240	240	0
Cleric Developments	0	0	0	0	0	0	120	120	0
Incident transfer for working on paper	0	0	0	0	0	0	24	24	0
ePCR	0	2	(2)	0	20	(20)	100	100	0
Software development fees	0	0	0	0	0	0	150	150	0
VPN for iPads and Android	0	0	0	0	0	0	40	40	0
EOC and 111 reconfiguration	0	0	0	0	0	0	444	444	0
Migration of ARP CRS	0	0	0	0	0	0	36	36	0
Replacement of CCTV	0	0	0	0	0	0	600	600	(0)
Airwave handsets	0	0	0	0	0	0	144	144	0
Airwave for PAPs	0	0	0	0	0	0	96	96	0
Mobile Tools	0	0	0	0	0	0	18	18	0
Frontline Mobile Comms	0	0	0	0	0	0	431	431	0
Internet circuit at Crawley	0	0	0	96	0	96	250	250	0
GovRoam	0	0	0	0	0	0	12	12	0
Total IT	**42**	**98**	**(56)**	**1,504**	**1,985**	**(481)**	**5,072**	**5,072**	**(0)**
Fleet									
Fleet engines	13	0	13	85	80	5	150	154	(4)
57 Purchased DCAs - 22-23	500	73	427	800	386	414	2,178	2,522	(344)
8 Purchase DCAs 21-22	0	0	0	0	2	(2)	0	2	(2)
3 e-Vitos	0	0	(0)	0	2	(2)	0	109	(109)
Vehicle Equipment AWD SRVs - CCP	117	(0)	117	417	20	397	417	20	397
Vehicle Equipment AWD SRVs - Bronze	0	0	0	0	2	(2)	56	2	54
Buy out of HART Vehicle and IGT lease	0	0	0	0	2	(2)	0	2	(2)
DCA lease buy outs	528	0	528	1,386	770	616	1,386	1,244	142
Total Fleet	**1,158**	**73**	**1,085**	**2,688**	**1,265**	**1,423**	**4,187**	**4,056**	**131**
Medical									
MedX Software	0	0	0	126	154	(28)	126	154	(28)
Omnicell Units	0	0	0	298	298	(0)	298	298	(0)
Total Medical	**0**	**0**	**0**	**424**	**452**	**(28)**	**424**	**452**	**(28)**
Total Original Plan	**1,300**	**269**	**1,031**	**7,060**	**5,762**	**1,298**	**12,327**	**12,327**	**(0)**

	In Month October 2023			Year to October 2023		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Extra Allocation*						
Thanet MRC	0	0	0	0	0	0
Dartford	0	0	0	0	0	0
Tongham	0	0	0	0	7	(7)
Hastings	0	0	0	0	0	0
Brighton	0	0	0	0	0	0
Gatwick	0	0	0	0	0	0
Burgess Hill	0	0	0	0	0	0
Lewes AS	0	0	0	0	67	(67)
East Grinstead	0	13	(13)	0	13	(13)
Make Ready - Chertsey	0	0	(0)	0	36	(36)
Logistics Location - Unit 27	0	0	0	0	11	(11)
Make Ready - Worthing	0	0	0	0	10	(10)
MDC at PW	0	0	0	0	0	0
Total Extra Allocation	**0**	**13**	**(13)**	**0**	**144**	**(144)**
CDEL Credit**						
Redhill AS - NBV of disposals	0	0	0	0	(916)	916
Vehicles - NBV of disposals	0	0	0	0	(16)	16
Total Sales Income	**0**	**0**	**0**	**0**	**(932)**	**932**
NMA Kits	0	0	0	0	87	(87)
Station IT Upgrades	0	2	(2)	0	626	(626)
Crawley HQ	0	3	(3)	0	11	(11)
Total Spend	**0**	**5**	**(5)**	**0**	**723**	**(723)**
Total CDEL Credit	**0**	**5**	**(5)**	**0**	**(209)**	**209**
Total Purchased Assets	**1,300**	**287**	**1,013**	**7,060**	**5,698**	**1,362**
Leased Assets						
Estates						
Lewes VMC	0	0	0	0	559	(559)
Haywards Heath College	0	0	0	327	158	169
Sheffield Park	13	0	13	310	931	(621)
Telford Place	0	0	0	0	0	0
Bognor South	0	0	0	25	131	(106)
Staines West	0	0	0	25	12	13
Cranleigh	0	0	0	25	34	(9)
Paddock Wood ACRP	0	0	0	25	59	(34)
Medway ACRP	0	0	0	25	0	25
Gatwick MRC Car Park	0	0	0	25	0	25
Arundal ACRP	0	0	0	0	38	(38)
Folkstone ACRP	0	0	0	0	0	0
Peacehaven	0	0	0	475	121	354
Birdham	83	0	83	83	10	73
Brighton	0	0	0	83	0	83
Epsom	83	0	83	83	0	83
Heathfield	43	0	43	43	0	43
Hailsham	0	0	0	0	0	0
East Grinstead	0	0	0	0	0	0
Redhill ACRP	0	0	0	0	9	(9)
Total Estates	**222**	**0**	**222**	**1,554**	**2,062**	**(508)**

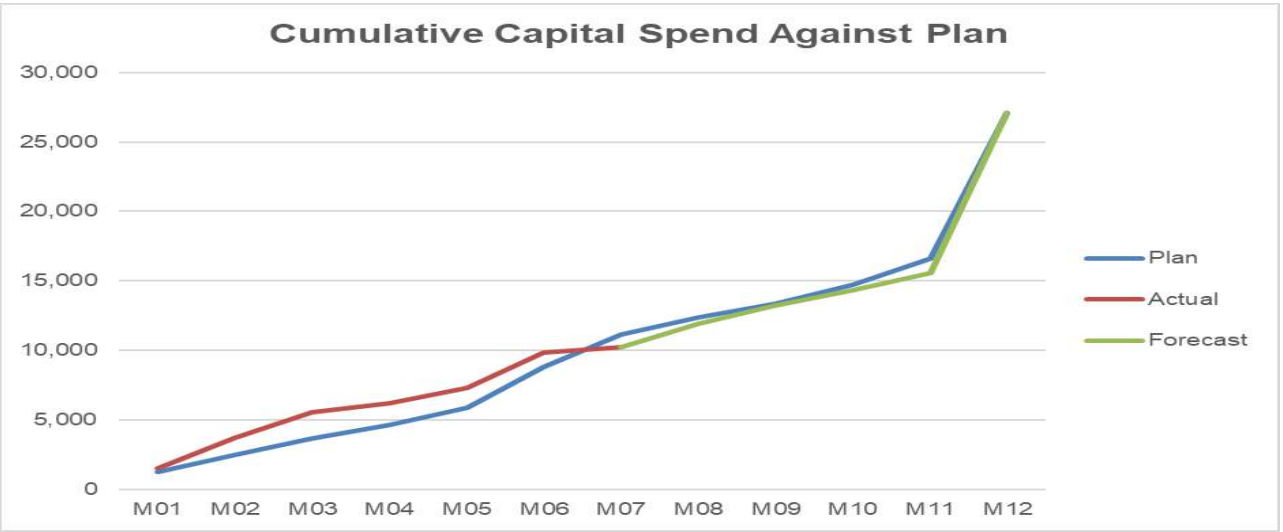
	In Month October 2023			Year to October 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Fleet									
DCAs	0	0	0	0	0	0	5,320	5,320	0
AWD SRVs - CCP	840	0	840	2,040	1,961	79	2,040	1,961	79
eVito SRVs - 3	0	0	0	171	0	171	171	171	0
Driver Training Vans	0	0	0	0	0	0	475	475	0
Lease Cars	17	122	(105)	115	346	(231)	200	426	(226)
Total Fleet	**857**	**122**	**735**	**2,326**	**2,307**	**19**	**8,206**	**8,353**	**(147)**
Specialist Ops									
HART	0	0	0	0	0	0	1,900	1,900	0
SORT Vans - 3	0	0	0	0	193	(193)	90	193	(103)
Mass Casualty Vehicles - 2	0	0	0	228	0	228	228	228	0
CBRN Vehicles - 3	0	0	0	0	0	0	450	450	0
Total Specialist Ops	**0**	**0**	**0**	**228**	**193**	**35**	**2,668**	**2,771**	**(103)**
Total Leased Assets	**1,079**	**122**	**957**	**4,108**	**4,562**	**(454)**	**13,540**	**13,540**	**0**
Total Capital Plan	**2,379**	**409**	**1,970**	**11,168**	**10,260**	**908**	**27,055**	**27,055**	**(1)**

*The Trust received in October an extra allocation via the ICB of £1,188k. This increases our purchased assets allocation.

**The Trust will receive a CDEL increase for the net book value of any sales made in the year, this could be up to £3,400k in total, as per the below table the Redhill NBV has already been incorporated.

The Trust anticipates meeting its CDEL by year end, in year changes to the CDEL are detailed in the table below.

Capital Delegated Expenditure Limit (CDEL)			
	£000		£000
		Funded by:	
Plan CDEL		Depreciation	10,158
Purchased	12,327	Cash Reserves	3,357
Leased	13,540	Lease Liability	13,540
	25,867	NBV from sales	932
Adjustment - Redhill Sale	916		
Adjustment - Vehicle Sales	16	**Expected CDEL**	**27,987**
Additional allocation	1,188		
Expected CDEL			
Purchased	14,447		
Leased	13,540		
	27,987		



11. Risks and Opportunities

Risk	Impact	Likelihood	Score
The Trust's future capital expenditure plans could be constrained by capital limits (CDEL) imposed on our host ICB.	>£2.0m	Likely >50%<=80%	20
While the Trust currently has adequate liquid resources to meet its short-term plans, there is a need to generate cash surpluses to ensure sufficient funds for future investment to sustain and improve our services.	>£1.0m <=£1.5m	Likely >50%<=80%	12
The Trust has a challenging cash releasing efficiency target. Slippage in achieving this target could have an impact on the Trusts ability to meet its I&E target	>£2.0m	Unlikely >20% <=50%	10

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

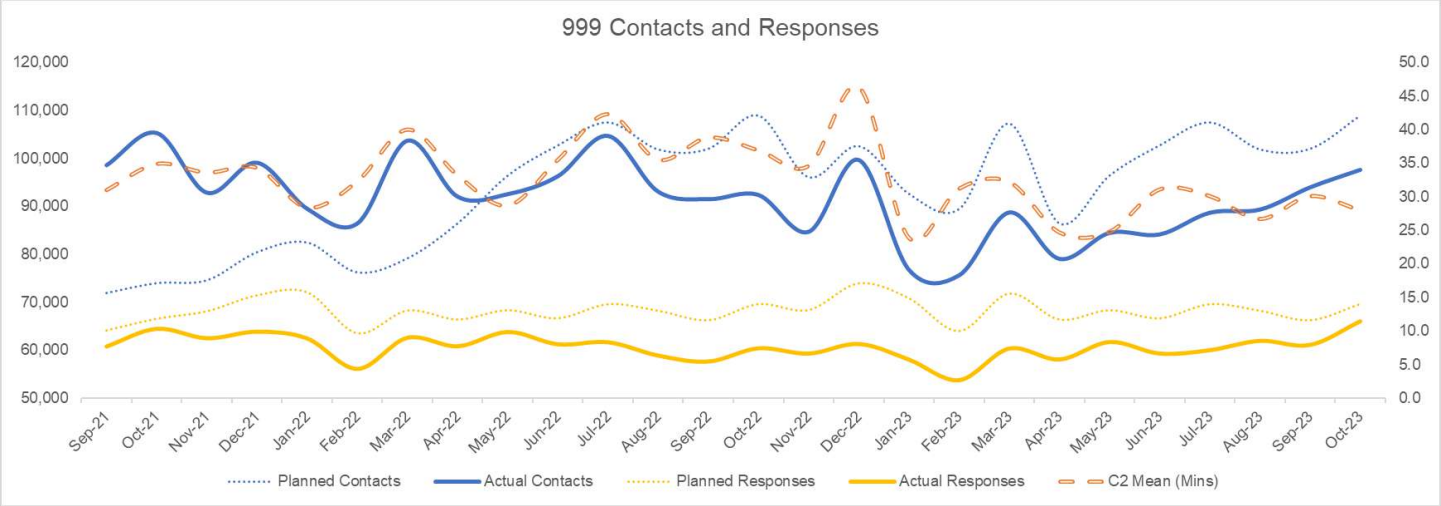
Opportunities	Impact	Likelihood
Additional sales of Trusts unused properties would improve the I&E position and increase the capital expenditure (CDEL) limit, which would allow the Trust to invest further than planned	>£2.0m	Possible 50/50

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

Appendices

Activity

999 Activity:



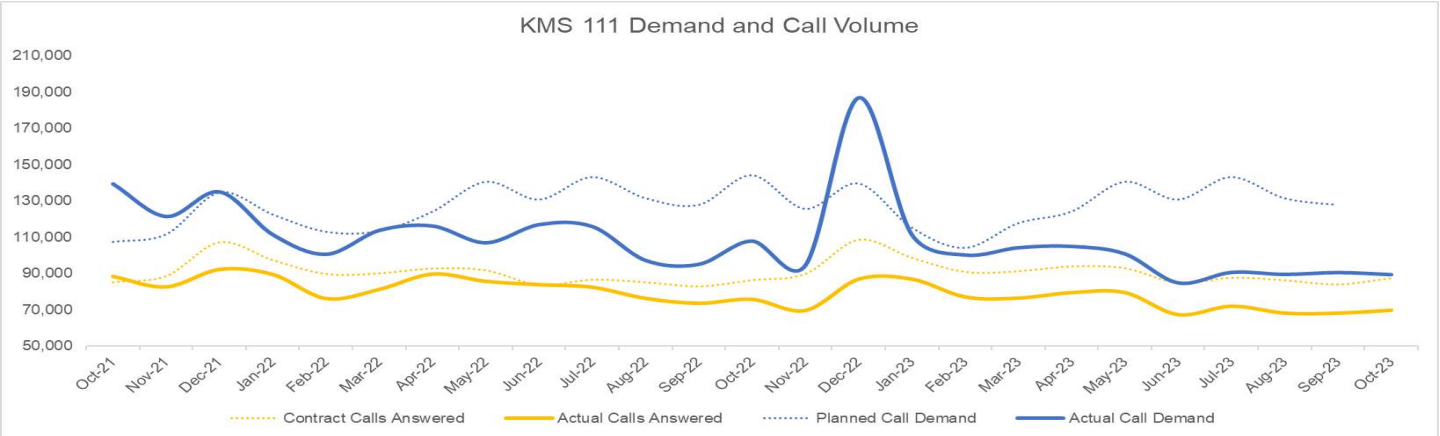
999 contacts (demand) 6.8% down against last year to date, with response activity being 0.9% greater, daily demand (+0.5%) and responses (+4.6%), was significantly up against the previous month.

This reduction in demand, increased Hear & Treat rates (11.2% vs .9%) and improved handover delays has contributed to an improvement in Category 2 mean response times versus last year to date, with the C2 mean improving to 28.0 minutes year to date compared to 35.9 minutes last year as at M7 (October).

Handover delays have an impact on the availability of crews to reach patients in time, 16,705 hours less were lost in the 7 months to October 2023 compared to last year, this would be the equivalent of around 7 extra ambulance shifts per day, helping to improve performance times.

C2 Mean currently stands at 28.0 minutes year to date against a plan of 30.1 minutes.

111 Activity:



October 2023 saw demand (calls offered) fall slightly by 1.3% than September, despite 1 additional day.

Both demand and activity are down versus the same period last year with demand 13.9% lower and activity 11.2% percent down. This trend would indicate the Trust requires less staff to meet future demand, however the service is supported from national contingency as some calls are being moved to the national contract with Vocare and therefore the total demand on the service is more than shown here.

Calls answered in 60 seconds performance improved to 41.8% for October against 37.7% in September. National KPIs have changed for the 111 service, with proportion of calls abandoned and average speed to answer being the main KPIs being monitored going forward. SECAmb currently sits at 14.5% (9.5%) and 286 (171) seconds for these metrics (national) for the year to date. Standard target is 3.0% and 20 seconds.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	68-23

Name of meeting	Trust Board
Date	7th December 2023
Name of paper	Keeping Patients Safe
Strategic Theme	**Quality Improvement**
Author / Lead Director	Margaret Dalziel, Executive Director Quality & Nursing (interim) Kirsty Booth, Business Manager, Medical Directorate Rachel Oaten. Chief Medical Officer

Executive Summary

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

The BAF report reflects the expected progress made across all three priority Goals. All goals are green as all actions are on track for completion at the current time. The only delay that does not affect overall delivery is to **full launch of PSIRF**, as highlighted below.

The IQR reflects the continuous improvement across all the Quality areas, and most of the clinical areas in relation to service delivery.

Further additional activity captured below are:

- Progress on the **patient engagement** plan.
- Update in relation to addressing the significant BAF risks from the **Medicines Distribution Centre** (MDC) at Paddock Wood.
- **Maternity Training**
- **Right Care Right Person**

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

1 Introduction

Both the IQR and the BAF QI Priorities outline progress being made in all areas across Quality and Clinical metrics and goals, with the ongoing maintenance of improvements made over the past 18 months.

The areas to highlight specifically in this paper are:

1. PSIRF delay to full launch
2. Progress with patient engagement strategy
3. Update on Medicines Distribution Centre
4. Maternity training linked to the Ockenden report
5. Right Care Right Person

1.1 PSIRF delay to full launch

The ICBs signed off the Trusts PSIRP as agreed by the Board in October 2023. It has since been made clear that the Board is being asked to formally approve transition to PSIRF having had sight of the PSIRF Policy. This has resulted in a delay in 'go live' date as Board is now being asked to approve transition having had sight of plan and policy.

1.2 Patient Engagement

Considerable progress has been made over the past months on enactment of our patient engagement plan (see embedded document) in response to CQC Must-Do 7: '*The Trust must ensure it seeks and acts on feedback from relevant persons and other persons on the service provided for the purpose of continually evaluating and improving services.'*

IJSG MD7 November 2023 Upd

Activity so far includes:

- Focus groups for involvement of the pubic into QI projects (specifically 'Keeping Patients Safe in the Stack' – July 2023
- Community forum commenced - September 2023
- Attendance at the Annual Members Meeting – October 2023
- NHSE Public & Patient Voice Member (Mental Health) Visit to Medway – November 2023
- The 999 Patient Experience Questionnaire went live on 9th October 2023: 49 responses received in the first month.
- The patient & public survey in relation to the Trust Strategy launched on 3rd November 2023: 244 responses received within two weeks. Follow up is being planned.
- Stakeholder engagement for next year's Quality Accounts being planned, with a survey developed for both patients and public, and wider stakeholder groups. Face to face engagement will occur in February 2024.

1.3 Update on Medicines Distribution Centre

MDC Phase 1 has seen representation from key stakeholders across the Trust working with an external organisation to design options to mitigate health and safety and clinical risks and improve the environment for those staff working in the MDC.

A design has now been agreed and costings worked up that will address known risks. The design includes fitting of a trade lift, provision of desk space to allow for effective packing and IT/security capability required. A business case was presented at the Executive Management Board on 22*nd* November 2023 and approved for progression.

We will look to get the works started as soon as possible following a procurement process with completion of the MDC Phase 1 project by end of May 2024.

Phase 2 and the wider consideration of the Paddock Wood estate remains ongoing alongside this piece.

1.4 Maternity training linked to the Ockenden report

A job description has been developed to support with the training requirement as an outcome of the

Ockenden report, this role will support the delivery of multi professional training across both Ambulance and community midwife teams.

1.5 Right Care Right Person

Right Care, Right Person (RCRP) is an operational model developed by the Police that changes the way the emergency services respond to calls involving concerns about mental health. It is in the process of being rolled out across the UK as part of ongoing work between police forces, health providers and Government.

It is aimed at making sure the right agency deals with health-related calls, instead of the police being the default first responder as has been the case in a number of areas around the Country. It has been shown to improve outcomes, reduce demand on all services, and make sure the right care is being delivered by the right person.

It does not stop the police continuing to perform their key role of keeping people safe and where there is a real and immediate risk to life or serious harm – whether that be a person seeking to harm themselves or to harm others.

SECAMB are engaged with system partners and our local Police forces and have an Executive (Rachel Oaten) overseeing this work to ensure that our Patients receive the most appropriate and timely resource and also our Colleagues are supported with access to pathways/specialists and still receive a timely Police response should it be required e.g. aggressive / violent Patient. This is an emerging piece of work that is in its early stages (data analysis, current processes/pathways etc) across all our Systems.

2 Recommendations

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

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	68-23

Name of meeting	Trust Board
Date	07.12.2023
Name of paper	Quality & Patient Safety Committee Escalation Report – October 2023
Author	Tom Quinn, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 19.10.2023 and confirms whether any matters require specific intervention by the Trust Board.

Under actions arising the committee received a verbal update on Right Place Right Person (Police response to mental health calls). The ICB is coordinating our response as a system. Police services are approaching this slightly differently and so we are working through potential gaps in provision. There are no immediate issues / risks for patients or our people.

Item	Link to BAF
Learning Framework	QI Goal 2 - Become an organisation that Learns from our patients, staff, and partners.

This management response was in response to the discussion last time and the work to implement an effective learning framework as key enabler of PSIRF. The approach will enable us to do deeper analysis of why things happen and is being developed in collaboration with all directorates. The framework is due to be in place by April 2024 and four learning models are being considered. Currently they are conceptual and academic and so by April we need to funnel the information and create a framework that is practical and relatable for all.

The committee tested the thinking of the executive to ensure we have an umbrella framework that is part of a quality management system. It needs to fit together with the strategy.

Currently, the committee acknowledges there are pockets of learning but this framework is needed to ensure it is more systemic. Few Trusts have such a framework and so this is aiming for a really high standard.

The committee is assured with work ongoing and it will keep this under close review.

NEAS Report / Action	QI Objective 4 - Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF.

The Report of the Independent Review into alleged failures of patient safety and governance at the Northeast Ambulance Service (NEAS), by Dame Marianne Griffiths, was published in summer 2023. A paper was provided giving a critical review and gap analysis of patient safety elements identified within the NEAS Independent Review, compared to the status within SECAMB. This provided good assurance that there are no significant gaps; the main issues relate to changes to governance with PSRIF and the shift to a system-based approach to incidents. Specifically, the link between the legal team and the new Incident Review Groups (IRGs), where a new system is being introduced.

The committee also explored how we ensure curiosity and check and challenge at the IRGs, to avoid 'group think'. There is confidence that this will be mitigated.

End of Life Care	CQC Must Do: The trust must collect and analyse the End of Life (EoL) calls and share the analysis with ICS stakeholders, with the objective of reducing the needs for unanticipated EoL care by emergency and urgent care services (Regulation 17, (1) (2) (a) (b) (c)). '

A new dashboard is being developed as reported to the Board in October. This has been developed with other trusts on a national issue related to data quality. There is a short pause while we conclude procurement of a new EPCR.

In the meantime, process mapping is ready to be rolled out to stakeholders. Once the data issues resolved we will be in a good place by the end of Q4. The committee expressed some concern about timescales and asked for clarification next time so it can hold to account for delivery.

Quality Improvement - Objective 5:	Improvements in Out of hospital cardiac arrest survival rates from point of initial contact through to deployment of volunteers and specialist resources

Most of the project streams are now making progress and there has been some recent improvement in engagement, resourcing and prioritisation. However, some projects remain challenged and the paper provided lacked some of the data needed to really understand the issues. What is clear is that we need to do more to ensure CFRs are dispatched more often. There was also a concern about the time taken for telephone CPR; the executive was asked to bring further information on this for the next meeting in January. The issues re call handling and staffing in the EOC is well understood, as reported to Board in October.

Quality Improvement - Objective 6:	Building on existing pre-hospital maternity education and training in response to local and national cases/reports to enhance patient care and experience

The committee is assured that this objective is on track for delivery by the end of Q4. Our Consultant Midwife is an active member of the national ambulance maternity leads group and is about to lead on two new projects nationally; to assist with delivery of silent videos that crews can watch on scene to assist deliveries; and a national procurement related to maternity packs so all ambulance trusts have one pack that gives us a cost saving and standardisation across all services.

The last two quarters have seen significant strides in developing meaningful maternity training to all community staff and the development of a nationally recognised RCUK newborn resuscitation course has been the first of its kind to be endorsed which is fantastic for pre-hospital clinicians nationally.

The committee does note the reliance on the Consultant Midwife and is pleased to learn of additional national funding to provide support.

Quality Improvement - Objective 8	A Quality Compliance Surveillance Framework that helps us assure the improvement we are making

The committee is assured that we are on track to deliver this objective in the timeframe; the executive has concluded the thematic analysis from the first quarter and the learning was set out in the report and shared with OUMs. This included:

- Communication and Information Sharing emerged as a common challenge across all units, with issues ranging from inconsistent feedback quality to limited Trust-wide learning and strained relationships between ambulance crews and hospital staff. There were positive initiatives happening locally regarding information sharing however this was limited as there was a feeling of local empowerment by leadership teams.

- Risk awareness and management was another prominent theme, highlighting concerns about site safety, risk understanding, and mitigation. Each unit faced unique challenges related to risk assessment processes and risk awareness, emphasising the importance of comprehensive risk management practices.

- Leadership and Management were pivotal in shaping staff satisfaction and overall quality of care. Challenges included limited internal progression opportunities, frustrations about career development, and the need for appropriate management training programs to equip leaders with essential skills. Clear delegation of decision-making authority and transparent communication were also vital for boosting staff confidence in leadership.

- Staff Support and Welfare played a crucial role in maintaining staff effectiveness and satisfaction. While some positive aspects of support were noted, concerns included delays in well-being requests, mixed views on absence meetings, and safety concerns, particularly for female crew members. Building a robust support system and nurturing a positive work environment were highlighted as essential.

- Alternative Pathways and Continuous Professional Development (CPD) were emphasised, with some units successfully implementing alternative care pathways and providing opportunities for CPD. However,

challenges related to collaboration, delivery of key skills, and flexibility in engaging in CPD during staff's own time were noted.

The committee welcomes the progress with the QAVs each month and the follow up clinics to work alongside OUs to help them deliver improvements that were agreed as part of the QAV. Although it noted that the follow ups have yet to take place due to capacity. These will start from January and in addition to the quality and performance framework will follow up any issues.

Responsive Care – Objective 3	Implementation of dispatch improvement actions to improve effectiveness of resource utilisation (RPI, cross-border working).

This objective is also due to deliver as planned, and while the committee is confident in this it did express some concern about sustainability. The work includes training dispatchers to support more efficient use of resources. There was a good discussion about the need for the strategy to focus on outcomes rather than proxy measures such as RPI. For example, the use of specific clinicians who we need for specific patients. This is being picked up as part of the strategy development.

Sustainability & Partnerships – Objective 3	Optimised Urgent and Community referral pathways, avoiding conveyance to EDs, and improving the use of the ICS SPOAs

The Patient Flow Steering Group is progressing as planned and is expected to deliver the initiatives and actions requested of the Patient Flow Programme for Q3 and Q4. A comprehensive programme plan and success criteria are in place and actively monitored.

All ICSs have successfully introduced a variation of the nationally requested SPoA, enhancing frontline clinician connectivity to UCR services; however, further attention is required by the ICBs to ensure these are clinically led and centralised within each ICS.

The introduction of daily touchpoint calls with 9 out of the 10 UCR providers is facilitating the early re-direction of patients to suitable pathways, consequently minimising unnecessary physical responses, and associated conveyance.

The Trust has secured additional funding for additional programme management support to reinforce the progression of the initiatives outlined. This support aims to optimise urgent and community referral pathways in the lead-up to and during Winter 2023/24.

The committee explored the representation the executive is making to increase pathways. Directors attend A&E delivery Boards and clinical teams are working with pathway leads. The main issue is that we are users of a pathway, and so we need ICBs to establish population need. We are informing this with our data and using it to inform our clinical case for change. The outputs of this will come back to the committee in Q4.

Annual Reports

As part of its annual cycle, the committee considered at this meeting two annual reports.

1. Controlled Drugs Accountable Officer

There were 737 controlled drugs incidents, mostly related to breakages and mitigations are in place to reduce this. The report highlights areas of improvement but also makes recommendations on areas for further development, which the committee will track to ensure delivery. Including the analysis of incidents between different OUs.

2. Learning from Deaths Q4

There has been a 'sense check' review where we are in discussion with three other ambulance trusts to understand how they are approaching these reviews. As reported to Board previously the reviews are providing limited value. This also dovetails with PSIRF. The committee is assured by the number of cases being reviewed and like most quarters there are no cases in this period of poor care.

The committee explored how we identify trends for individual clinicians and noted the work ongoing to establish how the data can establish early warning signs, e.g. concerns and/or where targeted support might be needed.

3. Research & Development

A helpful report was reviewed leading to good assurance with our research function.

Specific Escalation(s) for Board Action	No escalations