South East Coast Ambulance Service
NHS Foundation Trust

Trust Board Meeting to be held in public

08 February 2024
10.00-12.45

Banstead MRC, Banstead, Surrey

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
71/23	10.00	Welcome and Apologies for absence		-	DA
72/23	10.01	Declarations of interest		To Note	DA
73/23	10.02	Minutes of the previous meeting: 07 December 2023		Decision	DA
74/23	10.03	Matters arising (Action log)		Decision	PL
75/23	10.05	Chair's Report		Information	DA
76/23	10.15	Audit & Risk Committee Report		Information	MW
77/23	10.20	Chief Executive's Report		Information	SW
Strategy					
78/23	Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report**		
Quality Improvement – *We listen, we learn and improve*					
79/23	10.35	**Keeping patients safe**	Board Story		MD
			QI Projects / Keeping Patients Safe in the Stack		MD
			Quality & Patient Safety Committee Report		TQ
Responsive Care – *Delivering modern healthcare for our patients*					
80/23	11.15	**Operational Performance & Efficiency**	Winter Performance		EW
			EPRR Resilience and Special Operations Action Plan		EW
	11.30	**Break**			
People & Culture – *Everyone is listened to, respected and well supported*					
81/23	11.40	**Improving Culture**	FTSU Guardian Report		MD
			People Committee Report		SS
Sustainability & Partnerships – *Developing partnerships to collectively design and develop innovative and sustainable models of care*					
82/23	12.05		Strategy Development		DR

		Achieving Sustainability / Working with Partners	M9 Finance Report Planning for 2024/25	SxS
			FIC Report	HG
Board Effectiveness				
83/23	12.35	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
84/23	12.40	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, 07 December 2023

Banstead MRC, Banstead, Surrey

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Simon Weldon	(SW)	Chief Executive
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
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
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

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

Chairman's introductions

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

58/23 Apologies for absence

Ali Mohammed	(AM)	Executive Director of HR & OD
Max Puller	(MP)	Independent Non-Executive Director

59/23 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.

60/23 Minutes of the meeting held in public 05.10.2023

The minutes were approved as a true and accurate record.

61/23 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.

62/23 Chair's Report [10.02–10.10]

DA summarised 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. He drew particular attention to the volunteer conference, which he described as an uplifting event celebrating this important work. A theme of today's meeting is staff welfare and engagement.

DA then asked PL to update the Board on the Fit and Proper Persons Test Framework.

Fit and Proper Persons Test Framework

PL summarised the key points from the paper, which is to help provide assurance to the Board that we are putting in place robust measures to ensure compliance with the Framework. The key points highlighted included:

- The Framework supplements / strengthens the existing FPP Test. It helps standardise the approach across the NHS.
- ARC is the Board Committee responsible for oversight and it considered the approach at its last meeting.
- It requires more open reporting e.g. to Board, COG and in the Annual Report.
- While much focus is on how to apply the Test on an annual cycle, linked to year end appraisals, the Test remains ongoing and continuous.
- New templates / approach will be used when we apply the Framework as part of the year end appraisals. A Report to Board will then follow.
- Lastly, PL explained that to reflect the local nuances in approach, a local Policy is being drafted to clarity how we will apply it.

DA added that, at its heart, this is about holding appropriate standards for public life. It needs to open and transparency to ensure the ongoing integrity of leaders. Beyond the mechanics therefore are the guiding principles.

The Board supported this.

63/23 Chief Executive's Report [10.10–10.33]

SW thanked front line crews who despite the current pressures are still able to deliver the C2 mean standard; we are the only ambulance trust, save Isle of Wight, to do so. SW however is under no illusion just how much it takes to deliver this and so it is important for the Board to recognise this achievement. The Board agreed.

In the context of the discussions the Board will be having today, SW drew out the following:

- Retention Plan – this is the third part of the debate from the NHS Long Term Plan and SW encourages the Board to explore in this discussion whether we are being ambitious enough.
- IT and HART / NARU reports – there are lots of different 'front lines' and as we think of this SW asked the Board to consider if we have right support services to support our front line. The reports on the agenda identify challenges and issues and SW confirmed that these and other gaps are being picked up as part of executive structure review.
- Finances / Strategy – we are also landing a financial year and while we will almost certainly achieve our control total the proverbial road is running out, and so we need a new model which leads on to our strategy. We have reached the end of phase 1 and are asking ICB CEOs to endorse the description of the problem so we can move in to design phase. SW thanked ICB colleagues for their engagement.

- Sexual Safety Charter - it is important we make a public statement about our commitment to this, but then critically we must pay close attention to delivery on an ongoing basis.
- Lastly, SW referred to the visit of Amanda Pritchard to Medway recently, who fed back how impressive the facility it and on the quality of staff in demonstrating what can be done when we integrate services.

DA thanked SW for this summary and opened to questions.

SS referred to the Charter noting that while the sexual safety training is having some impact, there are still some incidents of inappropriate behaviours. SS asked how we will ensure impact of the Charter. SW responded by reinforcing this is definitely about what 'we' are going to do. He suggested deferring this until we get to the agenda item but explained this is now an issue visible across the NHS. There is no quick or easy answer and felt that we should avoid thinking that training will be the thing that solves it; instead it will likely be the work of some years and sustained effort.

HG referred to the issues identified by the H&S Executive (HSE) and reflected that there are some basic things as a Board we would expect to be happening routinely. So when we learn that bariatric training has stopped, the question then is what else is not happening in the way it should. SW responded that the findings are yet to go through process of our Board governance but assured HG that these are the questions being explored by the executive. We are working on our response to the HSE which is required by 13 January 2024. SW also confirmed that we are exploring what other gaps exist and so will be commissioning a review of whole H&S framework. SW suggested holding this debate therefore until more of the facts are available to us. DA agreed, noting this is receiving the right level of attention and will be tracked by the Board.

Action
The People Committee to review the actions agreed in response to the HSE inspection and the additional review being commissioned by the executive to test the whole H&S framework.

Following on from HG's question, MW reflected that there are a number of things consuming Board time that should be routine, such as EPRR / IT / H&S. These should be dealt with in usual assurance framework and so as we resolve the issues, we need to be confident that the overall assurance programme is effective, including how we identify emerging risks. MW stated that this is not to be critical but more of an observation for the next part of our improvement journey. SW explained that at EMB yesterday he asked for an executive-led workshop to review the risks at year end and what is upcoming, on the horizon.

Action
At its meeting in March the Audit & Risk Committee to receive the outputs of the EMB risk workshop.

MW asked for assurance that we have the resources needed to deliver our new strategy. DR confirmed we are making progress and are in a strong position. We will have a plan and direction of travel and a published strategy by the end of March, but this will be the start of the journey.

DA acknowledged the efforts in developing our new strategy and the engagement with our people and system partners has been really good. We are being able to clarify our role in supporting how to manage in the future.

64/23 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.

65/23 People & Culture [10.33-11.35]

Board Story

SW introduced this story which summarises the 2023 staff awards held in November. He thanked the comms team and reflected that this was the best awards he has ever been to. It is the first time they have been filmed so this shares some of the joy we all experienced.

The video was played and after JC shared her view that one of the main takeaways was the power of the patient storied in the room(s). Also, it helped as a positive reminder as we head into Winter and the ongoing challenges just how much positivity there is out there among our people.

DA agreed and the upcoming agenda items reinforce this. He thanked the Lord Lieutenancy for their ongoing support to these events.

Before moving on to the specific agenda items TW summarised the cover paper to help inform the discussion, linking to the key issues and risk from the IQR and BAF, and focussing in particular on recruitment and the process to ensure improved time to hire, which is reducing. He noted that sickness absence is also down to 6% which is a significant improvement and much closer to our target. Lastly, in terms of employee relations, TW explained that while there is still a high volume of outstanding grievances, there has been much improvement in the past six months or so, supported by ACAS and better ways of working with our trade union colleagues.

DA opened to questions and SS asked about ER cases and the mean length of time which seems to be going up. TW responded that there are some outstanding grievances which have been outstanding for a long time and when they are resolved this will help reduce the mean time.

MW referred to statutory and mandatory training and asked for assurance that there is no adverse risk to our people or patients, by the lower levels of compliance. EW responded that we have a robust programme for training, but there are some challenges with reporting due to aspects that require manual upload. A paper will be coming to People Committee in January that sets out the training plan for all our people, over the next three years. EW added we are on track to deliver this year, which is monitored by the Education Training and Development Group.

Retention Plan

TI summarised the plan and drew attention specifically to the Principle and Pledges, and how it aligns with the P&C priorities in the BAF, e.g. 'housekeeping'. This will continue to be a live plan and picks up what matters most to our people. TI also mentioned that reverse mentoring is due to start in Q1 linked to the 'housekeeping' actions.

SS asked how this links to the equality action plan and reinforced the importance of ensuring meaningful 1:1s. TI responded that our diversity lead has been close to the development of this plan as have our staff networks. In regard to 1:1s we are working on improving appraisals and in the context of rotas ensuring time is made available. TI agreed that if we are going to ensure connection with our people both are critical.

EW explained that she met an OTL recently who is taking a role in creating a template and process to ensure a more constructive approach o 1:1s; one example of our people taking autonomy.

DA noted the ongoing role of the People Committee is seeking assurance 1:1s / appraisals are taking place, as set out in the relevant objectives in the BAF.

DR explained how this plan supports the strategy and on the challenge from SW on its ambition, felt that while it could be more ambitious, we must start with achievable deliverables and then iterate as we go to become increasingly more ambitious.

Action
In addition to its role in overseeing delivery of the Retention Plan, the People Committee will help to ensure the plan evolves in an increasingly ambitious way over time.

SW explained that at the core of this, is the pledges and action, which are endorsed by our Trade Unions. The next step is to implement the actions in a way that has the impact of improving retention. SW thanked the Trade Unions for their support in the development of this plan.

DA echoed this and reinforced that this time, we need to make it stick, acknowledging the balance between ambition and realism; first and foremost we need to get the basics right. The Board supported the plan and will ensure regular Board oversight and triangulation with the leadership visits.

Reward & Recognition

JC set out this new framework which builds on some of things we have in place already e.g. the staff awards shown earlier. The new mechanisms take account of feedback from our people, and she summarised some of the key aspects.

DR asked for assurance that this will help to ensure support teams are also recognised, given some of feedback about this. JC explained that we will broaden the scope to ensure this. DA welcomed this noting 'team secamb' includes all our people, staff and volunteers.

The Board welcomed and wholly supported this new framework.

Sexual Safety Charter

In turning to this next item DA reinforced the importance of this Charter in changing our culture. MD then read out the Charter and each of the ten principles asking the Board to become signatory and to commit to enforcing a zero-tolerance approach. The Steering Group will set out how we define this, following the gap analysis to help inform what good looks like.

DA referred to previous statements by the Board about zero-tolerance and this helps to strengthen this commitment.

Action
The outputs of the Sexual Safety Charter Steering Group gap analysis and definition of zero-tolerance to be report back to Board in April 2024. Along with suggestions on the support the Board will need to address the challenges.

The Board supported the Charter acknowledging the additional accountability around this table to have challenging conversations and address issues as they are identified, which might require some additional support and mentoring. SW responded that it is good to admit it will be difficult, and that we will all need support. We should not rush to action but think through carefully our approach and what we actually mean by zero-tolerance. For today though it is about making a commitment as a Board to then remit to the Executive to agree a way of approaching the challenges as part of a board development programme.

The Board agreed to become a signatory to the Sexual Safety Charter.

People Committee Report
SS confirmed that there is nothing further to add from the report that hasn't been covered by this discussion.

66/23 Responsive Care [11.35-11.55]
EW provided an overview using the cover paper in the pack, highlighting in particular the good news story related to C2 performance, as SW referred to earlier. EW then reinforced the range of collaboration across our operating units to help meet patient need as a system, given the shared challenges.

SS asked about See and Treat which has gone down and the dependency on community care pathways. EW responded by explain that, as we see Hear and Treat increase, See and Convey should decrease. But what is actually happening is most of Hear and Treat is coming from See and Treat; so we not seeing any change in conveyance. Therefore, the challenge is in accessing pathways which is more challenging than is sometimes evident. EW went on to explain that in light of this we need to go back to review the targets as this was initially based on data at the start of year.

DA asked about our wellbeing provision for our people over next period to ensure all reasonable support is in place. MD confirmed we are launching the 'your mind matters' signposting campaign, which helps set out how we can support our own metal health.

Winter Plan
The Board noted that this is the latest iteration of a plan that is live. EW explained that a tabletop exercise was held to test various aspects and learning from this has been included this version. We have a robust command structure that operates 24/7 anyway and there has been good engagement with local acute trusts and support at emergency departments to support patient flow.

There were some questions about the plan which the Board agreed is comprehensive. For example, how we are planning for the impact if the junior doctor industrial action, and how we inform patients at periods of high demand, to manage expectations about when they will receive a response. The executive set out the mitigating actions related to industrial action, working with system partners, and also how we inform patients when delays are expected, and the role of welfare calls to ensure patient safety.

Call Handling
EW updated the Board on the improvement actions, many of which are being delivered resulting in marked improvement, despite still be an outlier when compared with our peers. Recruitment is positive especially in Medway where the next four courses are fully booked. There is a lead in time but this is positive, nonetheless. EW confirmed that the last three actions in the plan have now been started, since the paper was drafted.

DA thanked EW for this update on the detailed plan the Board received in October; there is a good level of assurance in its implementation and that we are moving in the right direction.

In overall summary, having reviewed operational performance and resilience as part of our planning for winter, to ensure patient safety, we are in a relatively strong position noting the work to further improve call handling which continues to be a risk.

[Break 11.55-12.05]

67/23 Sustainability & Partnerships [12.05-12.42]

Strategy Development

DR confirmed that we have come to the end of phase 1 having engaged hundreds of stakeholders, both internal and external. The findings in the case for change include:

- Our population will change so vital we adapt.
- SECAmb's role is not as well understood in the system as we had thought; there is unfulfilled potential.
- Our delivery model needs change to meet current and future needs of patients, staff and volunteers.
- Do nothing puts us in a really difficult position over the coming years, so is not an option.

DE then explained that Phase 2 will be to explore the strategic options.

DA noted how well engaged the Board have been in this and is looking forward to the next phase over the coming weeks.

IT Review & Action Plan

DA explained that when he joined SECAmb, he thought he understood the ambulance service, but it is only when you work here do you realise how reliant we are on IT. This review and our response therefore it so important.

SxS introduced the review reminding the Board of the context and reason for it. The scope included some technical elements as well as human factors. A number of issues have been identified, but it is also important to note the good work of the team, which itself has been underinvested over time. The recommendations have been accepted and the focus now is on the short/medium term actions; agreed by EMB and reviewed by the finance committee.

PB added his perspective as the NED that has been close to this review. He reinforced the need for clarity on a prioritised work plan, which is supportive of.

Through the lens of governance, MW agreed the need to prioritise. He reflected the importance that the executive sets a clear timescale which is then overseen by the Board to seek assurance the actions are resolved, initially via the audit committee. The Board agreed and highlighted the link with the strategy and how we make digital central to our delivery model and invest in this appropriately.

Action
Delivery of the improvements identified by the IT external review to be overseen by the audit committee. With a report to the Board in 2024-25 (date tbc) confirming all the actions have been closed and assurance on their impact.

DA summarised that the Board formally receives the report, acknowledging there is something in this for us all starting with how the Board leads and sets direction and ensures appropriate allocation of resources. It is agreed that this needs to link directly to the new strategy. The Board remit oversight of the action plan to the audit committee with a report back to Board in due course to confirm all actions have been taken and their impact.

NARU Review & Action Plan

SW explained that this report is a result of an external review by NARU related to our ability to respond through HART / SORT / EPRR capabilities. It is important we are open in our response to the concerns we have heard. There is a degree of complexity and sensitivity that require proper scrutiny and SW asked that

the audit committee receives the report (on the agenda for 14 December) and reviews the recommendations, and the associated learning. In the meantime, SW asked the Board to note the report and remit to the audit committee for a detailed discussion. An update will then come to the Board in February.

SW added that he has had discussions with ICB CEOs including on how to remedy the funding deficit in HART. These are ongoing to agree the steps needed to take and when to address the challenges in the report.

DA thanked SW for the update, noting the work underway which EW is leading. The Board will come back to this in February and thereafter to ensure the corrective actions are taken.

M7 Finance Report

SxS summarised the position, highlighting that we are on track to deliver breakeven at year end, despite being behind plan on out efficiency programme; the shortfall will be made up by non-recurrent means.

DA noted the good financial management, but warned there is no room for complacency.

Linking again to strategy, SW explained that the financial forecast for the NHS is going to be strained; next year there will be flat cash and 4% efficiency, so our new strategy needs to right size the Trust so we move away from an annual cost improvement programme and instead generate headroom to invest in areas some of which we have discussed e.g. IT/Digital. In the meantime however, we are confident this year on two key asks, delivery of C2 mean and a breakeven financial position.

SS asked about the overspend in 111 and some of the drives for this. SXs responded that this is salary and EOC agency; the aim is to always reduce agency and as we reach the end of the year, we will complete this work. EW added that agency increased due to the short term funding, but we are also driving down long term use as SxS says.

FIC Report

HG summarised the report from the meeting last week. He drew out the interesting analysis related to the (high) cost of our ambulance response, which reinforces the opportunities in our strategy to ensure the right response every time. HG expressed some concern about the reliance on our new strategy, given the likely not insignificant lead in time. It certainly won't be in place for 2024-25 so the committee will be exploring the interim position at the next meeting and any transition arrangement.

SW agreed with the part of the report that references a need to grow our own vehicle technicians as part of workforce plan for next year and as part of our strategy, e.g. using the apprenticeship levy. On the position for 2024-25, SW explained that we know the planning assumptions and strategy team have cast a number related to the headcount differential at a gross level if we were to meet the challenge.

DA summarised that we are well tuned to the challenges which is not without risk. We have confidence in the delivery of position both financial and operational for this year. We need a transition plan for 2024-25, while the strategy is agreed / implemented.

68/23 Quality Improvement - Keeping Patients Safe [12.42-12.55]

RO and MD summarised the key issues from the report. Including Right Care Right Person and change in approach by Police in responding to mental health patients. RO is overseeing and engaged with system and positively navigating safely to protect patients and staff. We are engaged at tactical and strategic meetings.

MD asked the Board to note a slight delay to PSIRF due to a change in expectation related to Board approval of the policy which will aim to do in January.

SS expressed concern about Right Care Right Person and supporting all our staff to ensure they are safe. She asked for timescales and impact on the strategy. RO acknowledged the risks to staff and has lived experience of this. She added that meetings in the last few days have shared these experiences and the SLT at the Police is not changing immediately, so there will be no imminent impact. But we are working through the data to establish any likely impact given the mixed messaging within the Police. We are also working to understand the escalation structures. RO felt that there has been rapid progress in discussions in the past two weeks. There is a multi-partner case review meeting to flesh out how to manage this effectively.

SW reflected that this is a national issue and AACE are picking this up too to ensure a consistent approach to this patient group.

DA felt the Board can be assured the executive are top of this. He asked that it is followed up by the quality committee.

Action
QPSC to seek assurance on the mitigations arising from Right Care Right Person.

Medicines Distribution Centre
RO confirmed Phase 1 addresses the immediate H&S and other risks, and the aim is to deliver this by May 2024. Phase 2 includes the whole MRC estate. The Board noted this update.

QPSC Report
TQ summarised his report much of which has been covered.

69/23 Review of Board Effectiveness [12.55-12.59]
The Board reflected on the meeting.

Compassionate – there was much focus on staff wellbeing / patient safety.

Curious – a number of issues were explored some of which requiring further assurance were referred to the relevant committee. There was good insight and cross reference between papers. DA encouraged the executive directors to be more curious of each other.

Collaborative – good focus on strategy / performance and cross directorate working.

More generally, the Board noted that we could have more overt reference to QI and the related projects, acknowledging there is much going on in this area.

70/23 AOB
None

There being no further business, the Chair closed the meeting at 12.59

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

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

Date _____

South East Coast Ambulance Service NHS FT Trust Bo

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP)
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	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	C
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
07.12.2023	63 23a	The People Committee to review the actions agreed in response to the HSE inspection and the additional review being commissioned by the executive to test the whole H&S framework	MD	Q4	People Committee	C
07.12.2023	63 23b	At its meeting in March the Audit & Risk Committee to receive the outputs of the EMB risk workshop.	MD	21.03.2023	Audit Committee	IP
07.12.2023	65 23a	In addition to its role in overseeing delivery of the Retention Plan, the People Committee will help to ensure the plan evolves in an increasingly ambitious way over time.	AM	2024/25	People Committee	IP
07.12.2023	65 23b	The outputs of the Sexual Safety Charter Steering Group gap analysis and definition of zero-tolerance to be report back to Board in April 2024. Along with suggestions on the support the Board will need to address the challenges.	MD	Apr-24	Board	IP
07.12.2023	67 23	Delivery of the improvements identified by the IT external review to be overseen by the audit committee. With a report to the Board in 2024-25 (date tbc) confirming all the actions have been closed and assurance on their impact.	SxS	TBC	Audit Committee / Board	IP
07.12.2023	68 23	QPSC to seek assurance on the mitigations arising from Right Care Right Person	RO	Q4	Quality Committee	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 - this will be rolled in to the plan for 2024/25
People Committee received the full training plan in January and QPSC considered the clinical aspects - see both Board Reports
Update provided at its January meeting (see Board report) and added to the COB
Added to agenda
Added to COB
Reviewed in February - see report

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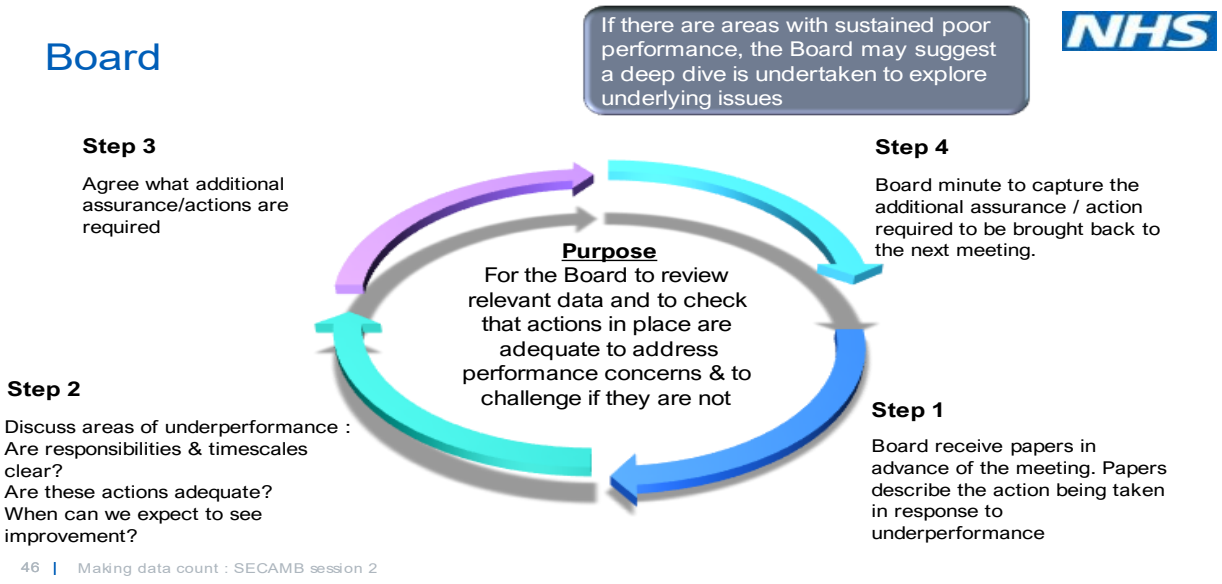
	Item No	75-23
Name of meeting	Trust Board	
Date	08.02.2024	
Name of paper	Chair Board Report	
Report Author	David Astley, Chairman	

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). The Executive is undertaking a review of the BAF to align it with the new emerging strategy and related risks for 2024 and beyond. The BAF 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.



I was really pleased to learn of the recognition the Trust received last month related to the development of the Integrated Quality Report. The Board will recall the work that was undertaken following the Making Data Count session in 2022. As requested by the Board, the new IQR was developed ensuring that our narrative, focus on actions for improvement, and consistent methodology was applied to how we use data at the Board to inform discussions and make decisions. This has been a key enabler for other improvements, such as the adoption of DMAIC as our QI methodology.

NHSE's Making Data Count team undertook an assessment of every Trust's integrated performance report (IPR) in England with the primary aim of identifying the very best examples. They looked at a range of factors such as whether SPC charts have appropriate re-calculation of process limits; whether the report contains visualisations to focus discussion, e.g. summary matrix; and whether the narrative is reflective of the data and action focussed. As a result of this review of 208 board papers, SECAmb is one of only 12 Trusts that the Making Data Count team assess as having an exemplary IPR.

On behalf of the Board I would like to thank the executive and their teams for this and in particular to the BI team.

A key focus of the meeting this month will be on how our approach to quality improvement (QI) is helping to improve patient care and safety. Against this background we will also be looking back over the challenging past few weeks to assess how our planning helped to achieve good outcomes for patients and then looking forward to review how our new strategic direction will ensure we are able to provide quality care sustainably for our people.

External Well Led Review

The external well led review is reaching its conclusion. The Board will be considering the draft findings as part of a Workshop to agree the areas of improvement to prioritise over the coming year. This will then help to inform the Board Development Programme for 2024/25. I will include the final report with my Board update in April.

Board Succession

I thank Michael Whitehouse, Senior Independent Director, and the Council of Governors for their diligence in appointing my successor, Usman Khan. Usman has already started to engage and there will be a formal handover from April, to ensure a seamless transition.

On behalf of the Board, I would also like to thank Tom Quinn, NED, for his role in helping SECAmb in its improvement journey. Tom will be stepping down after this Board meeting and we wish him well for the future. The Council of Governors is in the process of starting its search for Tom's replacement.

And congratulation to Chris Gonde who has been appointed as NED at Dartford and Gravesham NHS Trust. Chris will therefore leave SECAmb at the end of March, having joined in 2021 as part of NHS England's NExT Director scheme. Chris has made a valuable contribution to the Board and he will no doubt continue this with our colleagues at Dartford and Gravesham.

Engagement

I was pleased to spend time earlier this month at the Medway EOC/111 and Make Ready Centre. The CEO and I welcomed the Chair and CEO of Medway Hospital NHS Foundation Trust for a tour of the facility and to discuss relations between SECAmb and the local NHS in Medway. Relations

between our teams are excellent and good work has been undertaken to reduce Hospital handover times. The Board has heard recently from Laurence Sopp the Medway Operating Unit Manager about the work he has undertaken with the hospital teams. That work has continued and will develop with joint clinical education between SECAmb and hospital clinicians.

Michael Whitehouse and I recently visited Frimley Park Hospital in Surrey. It was good to hear from their staff how they value the working relationship with SECAmb clinicians. It was also a welcome reminder to hear of the hospital's daily challenge to give their patients the best possible care in the face of unrelenting demand.

I have continued to represent the Ambulance sector on the NHS Providers Board. The pressures on the NHS nationally are significant and it has been reassuring the extent NHS Providers as our representative body has reached out to validate their media statements and their representations to Government Ministers.

I have also been reviewing a new training package for Non Executive Directors produced by the NHS Leadership Academy. Non Executive positions are part time with the expectations that new colleagues will be able to quickly assimilate a considerable amount of information about the NHS in a short period of time. Whilst there has been ad hoc events and briefings there has not been a comprehensive package for NEDs that complements what has been available for Executives. The new package will be released soon and is to be welcomed.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	76-23

Name of meeting	Trust Board
Date	8 February 2024
Name of paper	Audit & Risk Committee Escalation Report – 14 December 2023
Author	Michael Whitehouse, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 14.12.2023.

Internal Audit Progress Report

There were no final reports to consider at this meeting; the remaining reviews from the annual audit plan will come to the meeting in March. The focus therefore was on the progress with the outstanding management actions.

The committee was particularly keen to seek assurance with the outstanding HR actions, for example those from the review into stat man training. Some of the updates were considered too vague and so did not demonstrate the required grip and focus. A detailed review will take place in March with the expectation that progress will have been made to positively inform the end of year Head of Internal Audit Opinion.

The committee also noted the work to ensure improved controls in procurement. It acknowledged the time needed to get this right and asked for the finance committee to undertake an interim review of the improvement plan.

Counter Fraud

The overall assessment of our Local Counter Fraud Specialist is that the Board can take reasonable assurance with the controls in place to manage fraud. SECAmb achieved an overall rating of Green from the most recent Counter Fraud Functional Standards Return. However, as reported previously to the Board, the committee continues to explore the controls in place for declaring interests, in particular where this relates to secondary employment. The compliance with the policy for the declaring of interests has improved, but secondary employment is not always captured. Concerns were expressed about this and the committee asked the executive to review the potential adverse impacts on our staff and patients.

External Audit

An early draft of the external audit plan was discussed, given the early stage of planning. Some of the risks were explored and the approach to the assessment on value for money, linked to the current CQC ratings. As is the case each year there is a tight timetable but KPMG and the management team are confident it will be delivered.

Financial Governance
The committee undertook its annual review of the **accounting policies**, noting there have been no fundamental changes. There was also the annual review of **bad debt write offs**, which the committee supported. There is nothing of significance to raise with the Board. Lastly, a helpful paper was received on the **financial control environment**. The committee supported the assessment of the CFO that while there are appropriate controls in place, improvements are needed in documentation and awareness. A number of actions have been agreed. This will help inform the Internal Audit review due to be completed in Q4.
Risk Management
The committee is increasingly assured with the way we are managing risk at SECAmb. All the actions from last year's audit review have been completed and work continues to ensure better awareness so that risk is really embedded and becomes a key driver for the organisation. There is however more to do and this continue to be a key focus over the coming year. The committee notes the initial review the executive will undertake of the strategic risks as we head in to 2024-25, which the Board will consider to then inform the Board Assurance Framework.
Corporate Governance
The committee reviewed the actions agreed in response to the **IT and NARU / EPRR external reviews**. The meeting in March will consider the detailed plan in response to the IT review. This will pick up the separate cyber security incident plan that the executive completed, which also identified a requirement for additional investment. The action from this will include a capacity and capability gap analysis. As the Board is aware, the NARU review was commissioned following some concerns raised by staff about our ability to respond robustly to a major incident. The review helped to identify an urgent need to improve staffing levels which the executive is in discussions with commissioners to resolve. This is an accepted system-wide risk and the committee is assured by the positive engagement with ICB colleagues and by the ownership of staff in addressing this issue. The committee acknowledges this is a specialist area and so will be taking steps to establish a sub-committee to ensure timely action in improving the governance.

Specific Escalation(s) for Board Action	There are no specific escalations requiring Board intervention, but the Board is asked to note the areas of concern that the committee will keep under close review. In addition, the committee made the point that over the last year we have had a number of eternal reviews (procurement, NARU, Digital, and HR) and while some of the issues identified were picked up by our governance, some were not. We will need to reflect on this in the spirit of continuous improvement as we continue our improvement journey.

South East Coast Ambulance Service NHS Foundation Trust

Item No	77-23

Name of meeting	Trust Board
Date	08.02.2024
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 December 2023 and January 2024 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:

- Conflict Resolution Training
- Review of our Cost Improvement Programme (CIP)
- Consideration of the David Fuller Inquiry
- Development of the Education and Training Plan for next year

5 EMB also continues to hold a meeting each month as a joint session with the Trust's Senior Management Group to discuss a range of leadership issues, including oversight of our Trust Strategy and of our Corporate Risk Register.

6 **Engagement**
I am continuing my programme of visiting different SECAmb sites and teams across our area each week. Last week, I spent the day with the 9s and 111 staff at Medway. I was so impressed with the calls that I heard our staff take and their calm professionalism and care were evident at all times. Particular thanks to Lori, Dom and Mel for hosting me. It was also great to see a real sense of community and team building up in the new building.

7 On 24 January 2024, I was pleased to participate in a 'Building a Kinder SECAmb' workshop alongside our Executive Team and our trade union colleagues. The

	workshops focus on culture and values as part of our cultural transformation programme and aim 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.
8	It was an excellent and thought-provoking session, with practical tips on how we can all improve our interactions with each other in the workplace. We have already seen more than 220 colleagues attended these workshops so far, and I am looking forward to see the positive impact as more and more colleagues attend.
9	On 25 January 2024, I was very pleased to join my fellow Chief Executives from East Kent Hospitals Trust and from Kent & Medway Integrated Care Board in meeting Helen Whately, MP for Faversham and Minister of State for Social Care when she visited the A&E Department at the William Harvey Hospital at Ashford.
10	This was a great chance to discuss the opportunities the system has to improve care for patients by more integrated working and I was very proud to share with the Minister some of the early and very positive findings from the Ashford Clinical Hub pilot, on which you can read more separately in this report.
11	On the partnership front, I have also continued to spend time with a number of our key regional and system partners including regional and national ICS Chief Executives, colleagues from other ambulance Trusts including London, Yorkshire, South Central and South Western and from our local partner NHS Trusts, including Surrey and Sussex Healthcare whom I visited on 4 January.
12	Given the significant financial and operational pressures affecting the NHS nationally, and the particular challenges within the south east region, I feel that these meetings have growing importance as vital opportunities to discuss areas of joint working.
13	**Development of our new Trust Strategy** Following extensive engagement during the last six months with our patients, our people and our system partners on the development of a new Trust Strategy, during December 2023 and January 2024 we have continued to engage with our clinical teams to utilise all of the feedback provided and specifically develop three emerging strategic options for the future: • Option 1: Core Ambulance • Option 2: Core Ambulance and Care Navigator • Option 3: Integrated Community UEC Healthcare Partner (essentially options 1 and 2 above)
14	Following evaluation of each option, our Trust Board have indicated a preferred direction of travel in “Option 2: Core Ambulance and Care Navigator”. Under this model, we expect to deliver improvements in our ability to triage and clinically validate callers, enabling us to differentiate need and preserve field ambulance

	responses for those patients that really need us in a way that keeps patients safe and protects the systems.
15	This option will see SECAmb collaborating and developing models of care and pathways that ensure that our patients that are in most need of an emergency ambulance response can reliably get one when needed in the future.
16	We are now progressing into Phase 3 – planning for implementation – which will run during February and March, with a full strategy ready for publication at the beginning of April 2024.
17	**Appointment of new Chair** I was pleased to welcome the announcement in early January that, following a thorough recruitment and selection process, the Council of Governors had approved the appointment of Usman Awais Khan as our new Trust Chair, Usman will join us at the end of May 2024 when our current Chair, David Astley, steps down; I am looking forward to working closely with him and am sure his experience will be of huge benefit to us.
18	Ahead of Usman joining us, I know that David remains as committed to the Trust as when he first started. I am very grateful for his service and look forward to carrying on the work of the Trust with him until then.
19	**New Reward & Recognition Platform** On 31 January 2024, I was delighted to see our new digital Reward & Recognition Platform – The Star Zone – go live across the organisation.
20	The new Platform allows for peer-to-peer recognition through a social feed and the use of customisable e-cards which will support the values and achievements we want to prioritise and recognise as an organisation.
21	The platform also allows managers and leaders to praise and financially reward colleagues within a set framework and we're investing into the creation of a Trust-wide 'rewards pot' to fund this.
22	The Platform is a key component of our new Recognition Framework and I am pleased to see how use of the Platform has over time and the impact it has on our colleagues.
23	**Nurses Conference a great success** The two SECAmb Nurses' Conferences held in late 2023, provided a fantastic opportunity for our 137 registered nurses to come together and a great platform for learning and recognition of their role and future opportunities.
24	The agenda for the conferences provided a mix of speakers from different disciplines, with key topics covered including the introduction of the Patient Safety Incident Response Framework (PSIRF), the effective management of risk, autonomy and clinical decision making, changes to the NMC revalidation process were discussed and the scope of practice for nurses at SECAmb.

25	It was great to hear positive feedback from those who attended, and I look forward to seeing these repeated in the future as we grow and expand our multi-disciplinary clinical workforce.
	B. Regional Issues
26	**Ashford Clinical Hub pilot continued** I'm very pleased to see that the trial to establish a better response to patients in Ashford has been extended after it was found to have made a significant difference to the care we deliver to patients.
27	Known locally as the 'perfect month, the pilot has seen advanced paramedic practitioners at Ashford Operating Unit leading a clinical hub at the Make Ready Centre since it got underway in November 2023.
28	With the support of clinicians from across the Kent healthcare system, including clinicians from East Kent Hospitals University NHS Foundation Trust and Kent Community Health NHS Foundation Trust, evaluation of the results so far has shown that the Hub has directly improved the overall system response to patients in the Ashford area.
29	Through reviewing appropriate 999 calls before an ambulance response was made, from November to mid-January, analysis shows that nearly 800 patients avoided a trip to the emergency department, 580 patients were safely discharged at the scene and the Hub supported 100 medical same day emergency care referrals – a provision which means that patients who would otherwise be admitted to hospital are assessed and treated elsewhere on the same day;
30	All of this has also helped to deliver direct improvements in ambulance response times in the Ashford area.
31	We have agreed to extend the pilot beyond its original four-week period, as the results so far clearly indicate that through having a multi-disciplinary approach to reviewing 999 calls, we can improve the response and ultimately the care we provide the local community.
32	**Medicines Distribution Centre** Following on from previous updates, the Medicines Distribution Centre Phase 1 Task and Finish Group are focused on addressing the health and safety and clinical risks.
33	To support addressing these identified risks, the Trust is investing £1.3m into the site; the work will be starting shortly and will be completed by the end of May 2024.
34	The Phase 2 task and finish group is focused on two key aspects. The first is developing options for our longer-term solution for the Medicines Distribution Centre. The work underway will identify various options, including a stand-alone Medicines Distribution Centre. The second focus is on developing options for the Paddock Wood Make Ready Centre as our lease will expire in 2031.

35	**2024/25 Operating Plan** The Trust's planning process is already underway for the 2024/25 operating plan although NHS England has yet to issue its detailed national planning guidance.
36	However, we are working with our system, Surrey Heartlands Integrated Care Board, to develop our operating plan, including our financial, activity and workforce plans. As we continue to develop our operating plan the Board will be kept informed, and we remain on track to meet the first planning submission of 29 February 2024.
	C. National Issues
37	**National recognition for our approach to data** Congratulations to all those involved, especially the BI (Business Intelligence) Team, who received national recognition recently for the significant work put in to ensure that the data we use at Board level is of the highest standard.
38	Almost two years ago, we took a decision to take a "data vacation", to give space to the BI team to adopt and develop a new approach to our Integrated Quality Report (IQR). This was followed by significant work by the team, but also by every department to ensure that our narrative, focus on actions for improvement, and consistent methodology was applied to how we use data at the Board to inform discussions and make decisions.
39	This work has also enabled the development of Integrated Quality Reports for all of our operational teams so that the approach of Board can be replicated throughout the organisation.
40	On 16 January 2024, the NHS England 'Making Data Count' Team informed us that, after assessing more than 200 data reports from every NHS Trust in England, SECAmb were one of only 12 Trusts nationally considered to have an exemplary IQR. This is a significant step forwards for us and a real credit to the work undertaken.
41	**Latest episodes of 999:Emergency Call Out** I'm pleased that the latest in a run of new episodes of 999: Emergency Call out, which follows the work of our Joint Response Unit (JRU) with Kent Police is currently being shown on Channel 5's 5 Star channel on Tuesdays at 9pm.
42	This second half of the second series was filmed last year and is on each week through to the final episode of the series on 27 February.
43	I would like to thank members of the JRU who were happy to have cameras out with them on a shift as well as everyone involved in ensuring this second series builds on the success of the first.

44	The series highlights not just excellent the work of the JRU but the expert care and compassion shown by teams across SECAmb every day.
	D. Escalation to the Board
45	**Operational Performance** The transition into early 2024 has seen the national ambulance position remain in a challenged position and overall across health and care providers in the South East, demand has remained high, with increased complexity of patient presentations.
46	However, through working in collaboration with our partners, we continue to deliver responsive and good quality care to those we serve.
47	The national focus on the NHS England Category 2 mean response time continues with SECAmb performance remaining positive in absolute terms and in comparison, to other ambulance services and we remain on track to hit the C2 mean target for the year.
48	This position is strongly linked to continued good hospital handover times, and stable staffing within field operations. Our 999 Emergency Operations Centres are seeing a steady improvement in relation to recruitment to vacancies, with us seeing a positive impact of the significantly improvement environment at the new Medway site. As a result of this, call answering performance continues to improve.
49	Whilst the Trust moved to REAP 4 for the period of the recent industrial action by junior doctors, we have since de-escalated to REAP 3.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	78-23

Name of meeting	Trust Board
Date	08.02.2024
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.

The Board is asked to note that over the next two months, and informed by the executive risk workshop in February, there will be a full review of the BAF to align with the new strategic direction and priorities for 2024/25. The next round of Board committee meetings will consider the relevant objectives and make an assessment on which can move into business as usual and which need to be rolled over to next year.

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

Quality & Safety		
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 & Safety

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 Amber because not 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:
This is not on track due to a delay with Phase 2, as reported to the quality committee (see separate report).

Interim Care advice went live on 1st December 2023 as planned;

- Patients can now access advice on their mobile phones. This is expected to have a positive impact on the Average Handling Time (AHT) and the reduction of duplicate call volumes. The team are currently monitoring the impact of the change.
- A new call closure script for C3 & C4 calls was trialled in November 2023 in the contact centres with positive feedback from staff. A patient forum was held on the 6th of December 2023 to understand patients' perspective and feedback on the script and other changes. The revised script will be implemented this month (January 2024).
- Advising patients of the ETA for C2 - C4 calls is also planned to go live by the end of January 2024, the functionality already exists within the CAD to support this change.

Phase 2 improvements will not be going live by end of March 2024 as originally planned due to delays in supporting the required system changes by Cleric, a risk previously highlighted in Board reports. The project team is currently awaiting revised timescales and proposed costs.

QI 2:
This objective is complete – the strategy was signed off by the Trust Board in August and is being embedded across the organisation. Since then the QI team have hosted four 30-minute virtual sessions to introduce the QI strategy across the organisation. 74 colleagues have attended these sessions.

QI 3:
This is on track for completion. Year to Date, 289 colleagues have been trained (5.8% 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 20 local QI projects across the Trust. In January 2024 the team delivered four virtual sessions to 111 and EOC staff which was well attended.

The QI team have commenced delivery of a QI induction session at the corporate induction for operational colleagues.

QI training is being embedded into the wider ETDG 3-year plan to support the ongoing building of QI capacity and capability across the Trust.

Goal 1	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
QI 1	Lack of progress in implementing Phase 2 developments in the KPSITS QI project due to delays in system development with Cleric.	4 x 4 = 16	4 x 4 = 16	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. • Several discussions are ongoing with Cleric to agree revised timescales for Phase 2 developments. Some of the developments are already being considered in house by Cleric and so will be developed much quicker.				
	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 have started delivering Intro to QI for 111 & EOC colleagues in Q4. Some of the sessions are virtual to accommodate different shift patterns. • The team have attended a number of 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 999 staff only 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	- 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 **– on track.** Long-term training plan in development. - *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** - *Added Jan 2024:* Plan and policy live and Trust will transition to PSIRF on **29th January 2024.** -	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:
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 9 months from 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 actions taken to relevant teams to resolve within BAU and report back - Themes being collated across OU's and Quarterly assurance reports presented to JLF. - Action log being submitted to the compliance team to align information with other data sets collected.	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

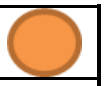
QI 8:
ON TRACK.

- Eight successful visits have now taken place since commencement in April, to Banstead, Chertsey, Thanet, Worthing, Ashford, Guilford, Polegate and Paddock Wood with very positive evaluations of the process 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.
- One paper presented at joint leadership forum on the above thematic analysis with recommendations shared with the second thematic analysis to follow.
- 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 plan to be implemented in Q4 and shared with all directorates.
- External review of the Quality Assurance and Engagement Visits to be completed in Q4 to evaluate effectiveness.

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.			

People & Culture

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

In year progress with the achievement of the Strategic Goal is Amber because the actions are not on track to deliver within the timeframe agreed.

Progress to-date:

PC1

This objective has not delivered within the timeframe initially agreed (Q3). All the remaining actions are being progressed.

PC2

This action is complete as we have implemented a new leadership visit process consistent with Comms & Engagement Strategy. An annual calendar of visits is published and tracking of attendance and themes reported to EMB.

PC3

QI project is ongoing and while some improvement has been made this objective will not deliver within the timeframe.

PC4

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. A joint workshop between the executive and Trade Unions was held in January.

The NHS Sexual Safety Charter was launched in September 2023 and adopted by the Board in December. A Steering Group has been convened led by Margaret Dalziel to develop an action plan to achieve the Charter by July 2024. As reported to the Board, the OD team is currently undertaking a gap analysis against the Charter.

	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	2x1=2	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	Delivery of the actions	3x3= 9	3x3=9	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.				

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 Amber because the actions are not on track to deliver within the timeframe agreed.

Progress to-date:
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	This action is now linked with RC7			
	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
Mediation meetings have been held and JPF re-established. A joint workplan has been developed

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

Progress to-date

RC1: C2 mean response time

- C2 mean of 31mins 21secs (December), YTD (to 31/12/23) C2 to of 28mins 46secs.
- Remaining on trajectory to achieve C2 men of 30mins max.

RC2: Call answering mean 19secs (December).

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 – running to end FY.
- Baselining of psychometric testing has commenced to support improved recruitment and retention.

RC3: Mean activity on own dispatch desk 100.3%, with a maximum variation at 39.8% 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	RC1	Inability to meet C2 mean target of 30mins	2 x 3 = 6	2 x 3 = 6	2 x 2 = 4
	Mitigations				
	• Nil at this time				
	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 December was 13.7% in - this places SECAmb 6th 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 who 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

- 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 3 = 16	4 x 2 = 8	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				
	• A 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:

- Evaluation and learnings from the Ashford trial relating to LSO are being examined and understood.
- ODOOS is an area being considered as part of a wider workstream relating to tactical hub/management – further details to be provided later, 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 • Support for findings from the Ashford pilot.				
		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.

- **Update February –** We have now completed phase 2 “Design options and evaluate”, and the Board at a development workshop on the 23rd January reviewed the evaluation and indicated a preferred direction of travel in option 2. We are now in phase 3 “implementation planning” where we will be further developing the detail behind the 5-year transformation roadmap.

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.~~ Risk retired	~~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 commissioners. 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**	**Current Score**	**Target Score**

		C + L	C + L	C + L
SP4	There is a risk that the governance of the system does not support SECAmb in delivering its 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 M9 (December) year-to-date the Trust's financial performance is slightly ahead of the financial plan. The plan was £41k deficit and the Trust has delivered a £34k deficit. The efficiency programme has delivered £5,447k of efficiencies against a plan of £5,788k (an adverse variance of £341k) with the Trust's target being £9m. The Trust has mitigations in place, including the use of non-recurrent measures to deliver the 2023/24 financial plan of breakeven.

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			Dec 22	Feb 23	Apr 23	Jun 23	Aug 23	Oct 23	Dec 23	Feb 24			
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	12	12	12	12	12	12	⇔	08	April 24
	Cyber Security	FIC												20	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 Building a Kinder SECAMB workshops being delivered Priority areas for 2023/24 agreed as part of the delivery plan Reward & Recognition Platform started in January 2024	**WF-44** "Grievance mean case length days"	•	
	WF-41 "Count of Until it Stops (Sexual Safety) Cases"	•	

Gaps in Control
▪ Pace of delivery due to inadequate resources, vacancies and under-resourced for volume of work

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 survey (green shoots) (-) Exit interview data	

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. QI project underway Clinical Education Resourcing – Phase 1 Agreed.

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

Sources of Assurance: Positive (+) or Negative (-)	**Gaps in assurance**
(-) WTE gap carried forward from 2022/23 (+) Operational Performance in line with plan re C2 (one of best performing amb trusts) (-) Time to Hire (+) Retention	Sustainability of International Recruitment

Mitigating actions planned / underway	**Executive Lead**	**Due Date**	**Progress**
Review of Workforce Plan for 2024/25	HRD	Q4 2023/24	Part of the discussion with the system arising from our strategy and planning for 2024-25

	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)

- A break-even plan has been signed off by the Board for 23/24 – and confident in delivery at M9.
- 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.
- Monthly directorate meetings to ensure focus on financial delivery and develop culture of delivery against plan
- Sustainability & Partnerships Programme within the Improvement Journey established

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

CIP under delivering

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. This is part of the discussions with the system on the new strategy and planning for 2024-25.

Mitigating actions planned / underway	Executive Lead	Due Date	Progress
Use of non-recurrent measures to close the gap in the CIP	Chief Finance Officer	Q4	Update included in the finance report
Planning discussions with ICBs	Chief Finance Officer	Ongoing	

	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. Additional £2.5m for use during Aug-Oct, focusing on call answering, EOC Clinical and Field Operations provision.	**999-1** 999 Call answer mean		
	999-9 Hear and Treat		
	999-4 C2 mean		
	999-24 Hours lost at hospital handover		

Gaps in Control
New strategy to be agreed

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.

	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	Plan agreed – short term actions taking priority as reported to Board and Audit Committee.
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. Last formally reviewed in June in the context of EPS – see Escalation Report considered by the Board in August 2023.					
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**: An external review was commissioned and reported to the Board in December. An update is scheduled in February with a full review in April 2024. The Audit & Risk Committee is in the process of establishing an EPRR subcommittee – see its report to Board on the agenda.					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
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 performance. This results in risks to patient safety, clinical effectiveness, patient experience, colleague experience and Trust reputation.*	16	16	04	AD of 111 / EOC
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. Targeted incentivised overtime within rota gaps. Call overflow arrangements with WMAS for calls waiting longer than 1m45s. This is in place for 6 months until end of March 2024. **Board Oversight**: Improvement Plan reviewed by the Board in October and December.					
451	**Strategic Medical Advisor Rota** *There is a risk that due to the delay in developing the on call only contract the availability of staff to cover the rota required may be impacted.*	16	16	08	HR Director
Summary of Controls: Medical and HR are working to finalise the contracts for on-call doctors. The rota is managed to ensure short notice changes can be dealt with and that there are adequate rest periods for on-call doctors. **Board Oversight**: EMB is due to receive a paper in February that will aim to mitigate this risk.					
472	**Training on Bariatric moving and handling equipment** *There is a risk that staff are not being trained or competent in the manual handling equipment within the bariatric ambulance provision. This may create a risk to both staff and patients or a delay in patient care/transportation.*	16	16	04	Head of Clinical Education
Summary of Controls: New Policy has been agreed and a training plan put in place. **Board Oversight:** People & Quality Committees received a paper in January setting out the actions being taken – see report to Board.					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
488	**Retention** There is a risk that the continuing high levels of turnover, particularly within key operational (patient facing and patient impact) roles that poses a significant risk to the delivery of high-quality patient care.	15	**15**	12	HR Director
Summary of Controls: The Retention Plan was agreed by the Board in December. **Board Oversight**: Board in December agreed the retention plan.					
27	**Clinical Risk at Medicines Distribution Centre due to Increasing Demand and Lack of Space in the Unit** *The medicines distribution unit (MDC) at Paddock Wood MRC is insufficient in size to support the volume of activity now being processed through the unit. There is insufficient space to allow at times of high demand segregation between receipt and dispatch areas and processes to maintain control inbound/outbound goods are unmanageable. There is a risk that due to this lack of space and segregation of processes at the MDC, out of date medicines can be sent back out to station sites which may lead to potential harm to our patients. This risk is also linked to Health and Safety risk ID 760.*	15	15	03	Chief Pharmacist
Summary of Controls: Acquired uniform room downstairs at Paddock Wood MRC to try and address some of the capacity issues with space. Some of the packing is now done in this room but significant inefficiencies. (linked to risk ID 760). 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. Phase 1 of the MDC estates project is underway to deliver by May 2024. This will address the identified H&S risks until the longer terms solution (new site) is established. This is Phase 2 of the project. **Board Oversight**: Finance & Investment Committee reviewed progress in January – see Board report.				
136	**Process of tagging medicines pouches is not working effectively** *There is a risk medicines will not be available for the patient if paramedics are incorrectly completing paperwork following their daily assurance checks. Incomplete or incorrect paperwork leads to pouch tagging errors and there is a risk that the medicine will not be in the right place at the right time for the next Paramedic and patient due to incorrect tagging.*	15	15	03	Chief Pharmacist
Summary of Controls: Monthly report on tagging errors are presented to MGG; Due to operational activity and skill mix there is usually more than one pouch available on scene thereby reducing the risk that medicines is not available for patients; Business case approved to resource a fixed term Pharmacist in					

ID	Title / *Description*	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Risk owner
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 December, and via FIC in January 2024.					
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.

Update February: The planned exit meeting will now be in May 2024. The recovery programme team will continue to monitor progress weekly through our assurance framework through February, and we are taking a final stock of progress on the 1st week of March, after which we will collate our evidence base ready for submission to the national team.

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.	**Achieved:**		

	Evidenced by improved transparency and timeliness of reporting and information sharing with ICB partners and with patients.	- 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

Impact		Likelihood 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	Moderate injury requiring intervention Requiring time off work of 4-14 days	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

		Increase in length of care by 1-3	Increase in length of care by 4-14 days RIDDOR / agency reportable incident		
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.
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				Special cause variation where **UP** is neither improvement nor concern.
				Special cause variation where **DOWN** is neither improvement nor concern.
				Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

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 – February 2024

Reporting Period: November & December 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 & Safety

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 & SAFETY

- *SI, Incidents and Harm*
- *Patient care – Cardiac*
- *Patient care - Stroke*
- *Medicines Management*
- *Safeguarding*
- *Safety in the workplace*
- *Patient Experience*

RESPONSIVE CARE

- *Ambulance Quality Indicators*
- *Call Handling EOC*
- *Utilisation*
- *999 Frontline Efficiency*
- *Supporting the system*
- *111 Operation*
- *Support Services*

PEOPLE & CULTURE

- *Employee Experience*
- *Culture*
- *Workforce*
- *Wellbeing*
- *Development*

SUSTAINABILITY & PARTNERSHIPS

- *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	Dec-2023	999		1209.8		
Harm Incidents per 1000 Incidents	Dec-2023	1.51		1.45		
Count of No Harm Incidents	Dec-2023	1321		1101.3		
Count of Low Harm Incidents	Dec-2023	170		172.9		
Count of Moderate Harm Incidents	Dec-2023	7		5.2		
Count of Severe & Death Harm Incidents	Dec-2023	2		1.65		

People & Culture

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Sickness Absence %	Dec-2023	7.5%	5%	7.93%		
Statutory & Mandatory Training Rolling Year %	Dec-2023	75.2%	85%	73.39%		
Appraisals Rolling Year %	Dec-2023	60.8%	85%	58.39%		
Freedom to Speak Up: Total Open Cases	Dec-2023	29		22.15		
Freedom to Speak up: Cases Opened in Month	Dec-2023	5	3	8.45		
Freedom to Speak up: Cases Closed in Month	Dec-2023	10		9.65		
Time to Hire - Volume (Days)	Dec-2023	232	60	135.8		
Time to Hire - Ad-Hoc (Days)	Dec-2023	63	60	83.87		

Responsive Care

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Hear & Treat %	Dec-2023	13.7%	14%	10.58%		
999 Frontline Late Finishes/Over-Runs %	Dec-2023	47.3%	45%	49.62%		
Average Late Finish/Over-Run Time	Dec-2023	00:38:00		00:39:15		
999 Call Answer Mean	Dec-2023	00:00:19	00:00:05	00:00:40		
Cat 2 Mean	Dec-2023	00:32:21	00:30:00	00:32:07		

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.

NHS
South East Coast Ambulance Service
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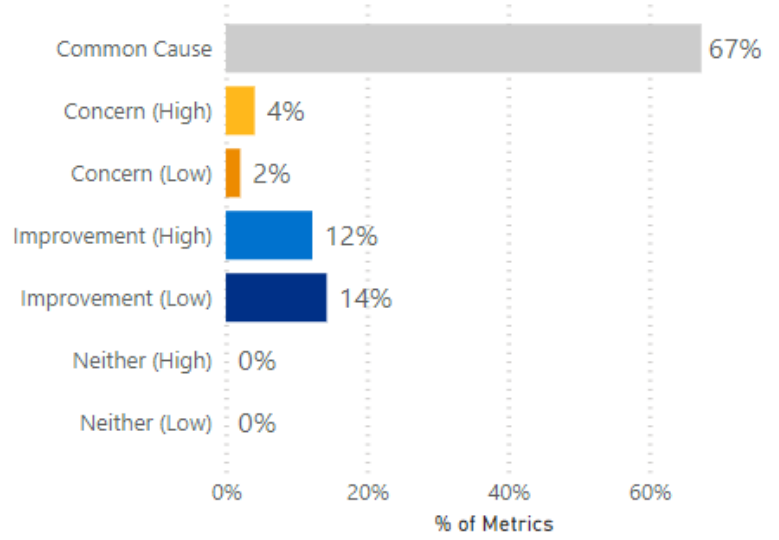
Quality & Safety

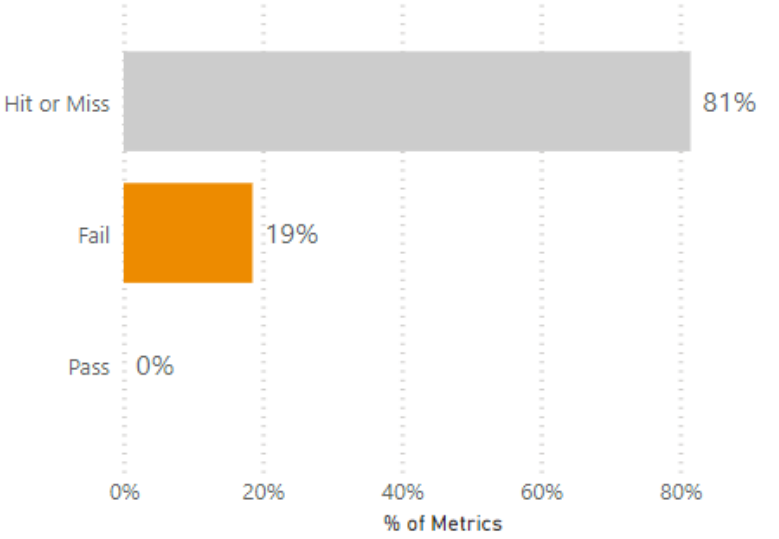
QUALITY & SAFETY

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Dec-2023	167		110.95	168.35	225.75		
Number of CD Breakages	Quality Improvement	Dec-2023	17	0	3.91	21.55	39.19		
Number of Datix Incidents	Quality Improvement	Dec-2023	1518		1072.26	1406.3	1740.34		
Number of Incidents Reported as SIs	Quality Improvement	Dec-2023	3		-3.62	3.8	11.22		
Duty of Candour Compliance %	Quality Improvement	Dec-2023	100%	100%	73.38%	89.63%	105.89%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Dec-2023	126		76.61	115.95	155.29		
Number of RIDDOR Reports	Quality Improvement	Dec-2023	10		1.22	11.3	21.38		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Dec-2023	2		-1.28	21.4	44.08		
Health & Safety Incidents	Quality Improvement	Dec-2023	48		14.86	30.4	45.94		

Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Dec-2023	0%		-0.02%	0.01%	0.03%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Dec-2023	38%		43.52%	62.7%	81.88%		
Complaints Reporting Timeliness %	Quality Improvement	Dec-2023	100%	95%	45.63%	78.25%	110.87%		
Number of Complaints	Quality Improvement	Dec-2023	58		26	70.1	114.2		
Complaints per 1000 999 Calls Answered	Quality Improvement	Dec-2023	0.63		-188.98	104.42	397.83		
Number of Compliments	Quality Improvement	Dec-2023	129		40.19	165.06	289.92		

QUALITY & SAFETY

Summary

December 2023

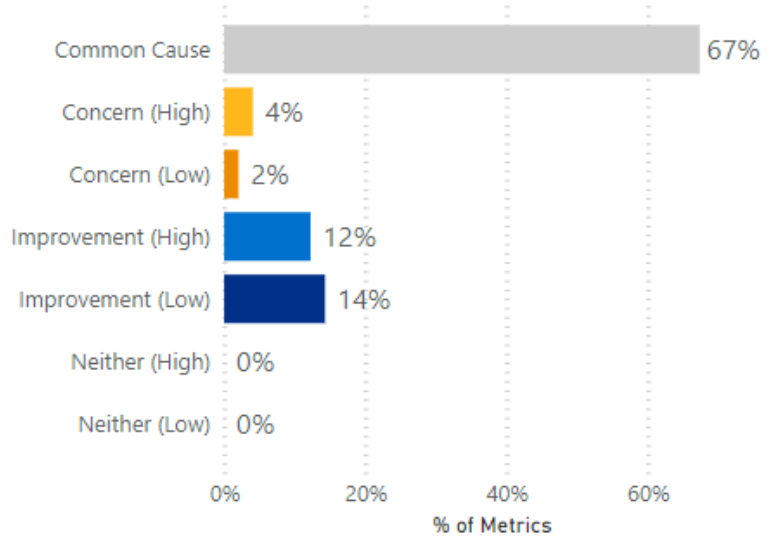
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Cardiac Survival ALL % Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Required NHS Pathways Audits Completed (Clinical) % Duty of Candour Compliance % Complaints Reporting Timeliness % Organisational Risks Outstanding Review %	Single Witness Signature Use CDs Non-Omnicell Medicines Management % of Audits Completed	Complaints per 1000 999 Calls Answered Proportion of Complaints Relating to Crew Attitude % Complaints relating to privacy and respect % Outstanding Actions Relating to SIs, Outside of Timescales Required NHS Pathways Audits Completed (EMA) %
Common Cause		Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Stroke - Call to Hospital Arrival Mean Hand Hygiene Compliance % Deep Clean Compliance %	Compliant NHS Pathways Audits (EMA) % Number of CD Breakages Single Witness Signature Use CDs Omnicell	Number of Medicines Incidents Number of Datix Incidents Number of Incidents Reported as SIs Violence and Aggression Incidents (Number of Victims - St... Manual Handling Incidents Number of Complaints Number of Compliments No Harm Incidents per 1000 Incidents Harm Incidents per 1000 Incidents Count of Low Harm Incidents Count of Moderate Harm Incidents Count of Severe & Death Harm Incidents
Special Cause Concern		**Cardiac Survival Utstein %		Count of No Harm Incidents Health & Safety 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.

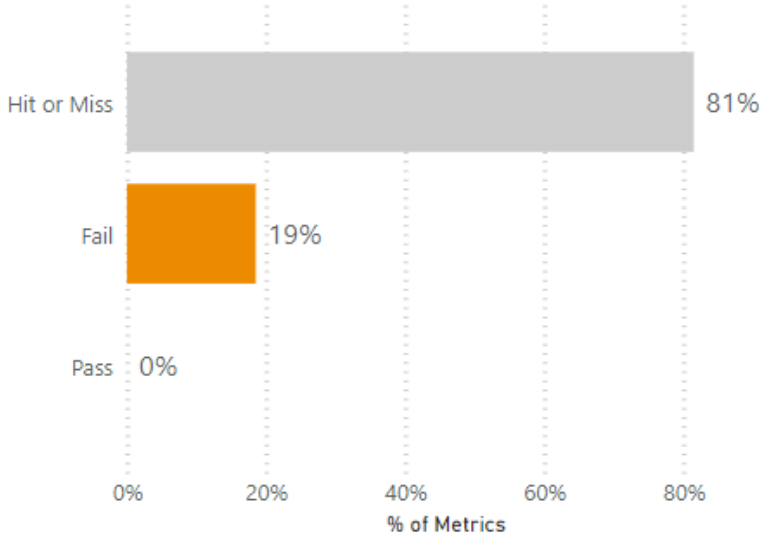
QUALITY & SAFETY

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

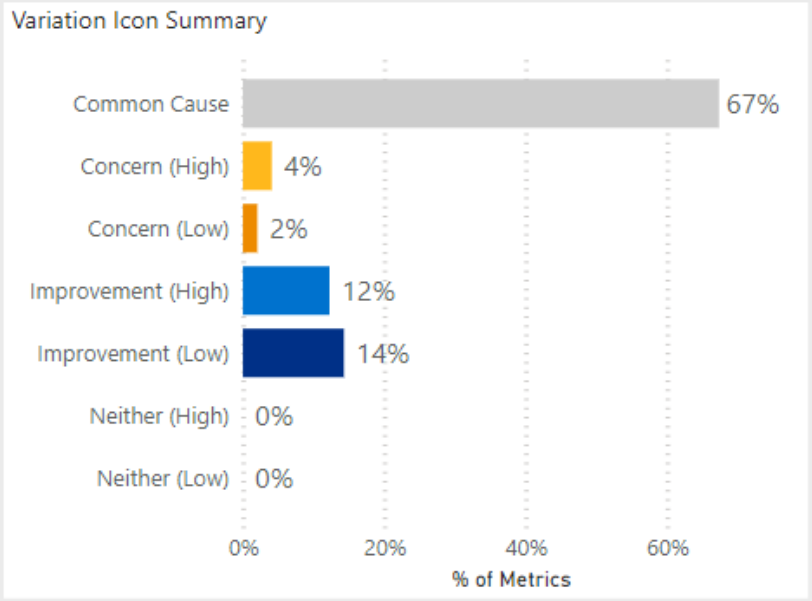
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Nov-2023	62.9%	45.1%	30.28%	49.29%	68.31%		
**Cardiac ROSC ALL %	Quality Improvement	Nov-2023	29.1%	23.8%	18.13%	27.09%	36.04%		
**Sepsis Care Bundle %	Quality Improvement	Nov-2023	87.2%	85%	82.3%	86.77%	91.25%		
**Cardiac Survival Utstein %	Quality Improvement	Sep-2023	7.8%	25.6%	2.98%	17.23%	31.48%		
**Cardiac Survival ALL %	Quality Improvement	Sep-2023	24.3%	9.6%	-0.62%	20.76%	42.14%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Nov-2023	72.5%	76.8%	61.3%	71.71%	82.11%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Nov-2023	65.6%	64.7%	60.43%	71.02%	81.62%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Aug-2023	02:25:00	02:22:00	02:12:52	02:33:26	02:54:00		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Aug-2023	03:17:00	03:14:00	02:50:31	03:35:34	04:20:36		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Aug-2023	01:25:00	01:29:00	01:17:09	01:36:08	01:55:06		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Aug-2023	02:17:00	02:20:00	01:39:30	02:28:38	03:17:45		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Nov-2023	97.9%	96.3%	95.74%	97.66%	99.58%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Nov-2023	92.6%	93.8%	87.35%	92.94%	98.52%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Nov-2023	81.9%	77.9%	68.82%	79.05%	89.27%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Dec-2023	106%		84.34%	102.82%	121.3%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Dec-2023	83.6%	100%	77.39%	84.79%	92.18%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Dec-2023	82.2%	100%	70.48%	88.26%	106.04%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Dec-2023	100%	100%	91.83%	99.9%	107.96%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Dec-2023	62.4%		17.55%	58.9%	100.24%		

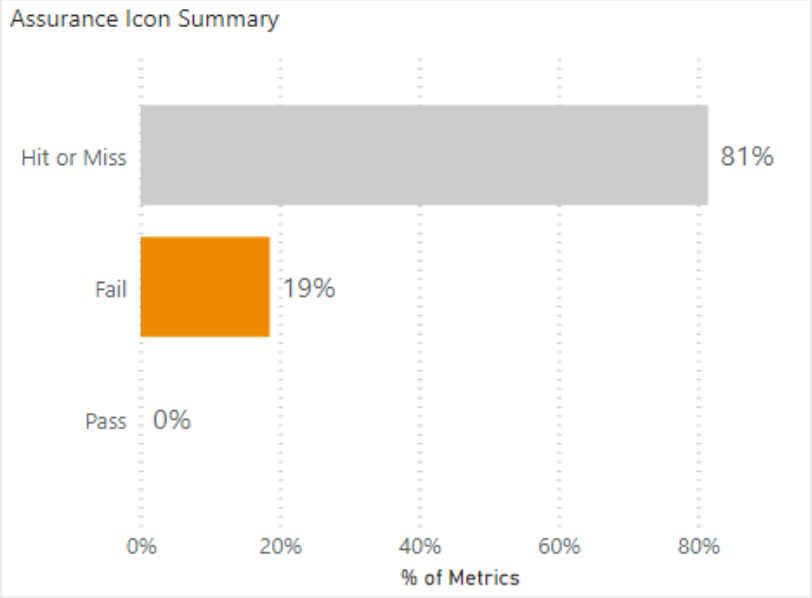
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Dec-2023	84.6%	90%	74.57%	87.06%	99.55%		
Deep Clean Compliance %	Quality Improvement	Dec-2023	64%	100%	63.56%	84.9%	106.24%		

QUALITY IMPROVEMENT

Overview (3 of 3)





Health & Safety

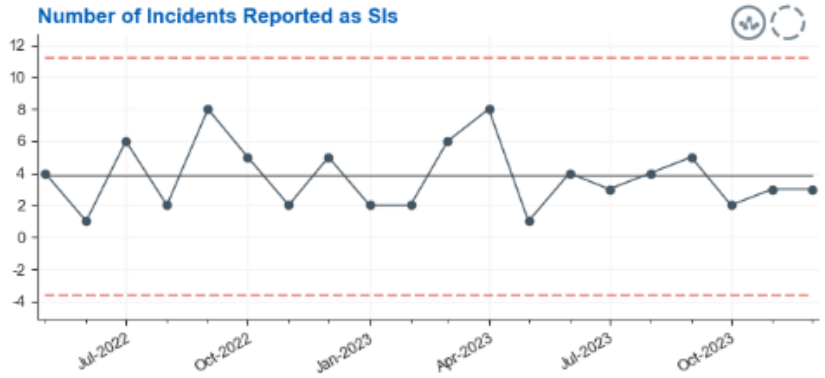
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Manual Handling Incidents	Quality Improvement	Dec-2023	21		9.16	27.5	45.84		
Organisational Risks Outstanding Review %	Quality Improvement	Dec-2023	30%	30%	-8.22%	35.78%	79.79%		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Oct-2023	49	0	12.69	42.13	71.56		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Oct-2023	36	0	1.64	56.44	111.23		
Medicines Management % of Audits Completed	Quality Improvement	Dec-2023	92.3%	100%	79.08%	89.02%	98.96%		
PGD Compliance %	Quality Improvement	Dec-2023	80%	100%		74.86%			
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Dec-2023	108%	100%	-12.86%	61.63%	136.11%		

QUALITY & SAFETY

SIs, Incidents, & Duty of Candour



QS-2

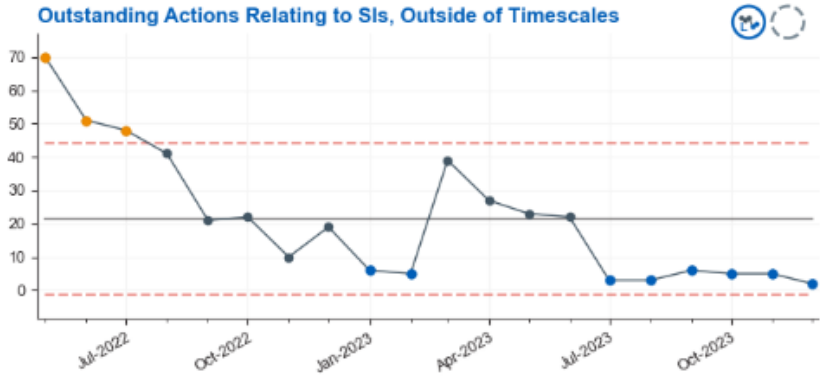
Dept: Quality & Safety
IP: Quality Improvement
Latest: 3

Common cause variation, no significant change.

QS-1

Dept: Quality & Safety
IP: Quality Improvement
Latest: 1518

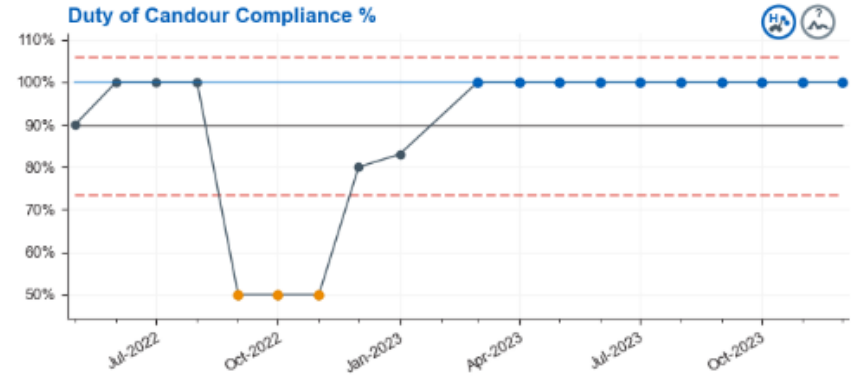
Common cause variation, no significant change.



QS-17

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

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) Number of Datix incidents - The Trust continues to evidence an effective culture of incident reporting in line with policy that is more consistent now (over past 5 months) and not fluctuating as previously witnessed.
(QS-17) Outstanding actions relating to SIs– An improved accountability process has been enacted to embed local ownership and responsibility which is yielding positive changes in timely responses to completing actions. This involves bi-weekly reminders to owners, BSM oversight in each directorate, a standing agenda item on SMG for escalation, and clear escalation to managers.
(QS-2) Number of incidents reported as Serious Incidents– The number of incidents reported as SIs is within normal variation.
(QS-3) Duty of Candour Compliance – Duty of Candour for declared Serious Incidents has remained at 100% compliance for the past 9 months.

What actions are we taking?

(QS-1) Non-SI incidents and (QS-2 / 17) SI actions

- Ensuring feedback to individuals / team is provided and organisational wide learning is captured following from "housekeeping" actions identified as part of culture programme
- Work continues for the implementation of PSIRF which is due to go live on 29th January 2024
- Work is ongoing on the development of the new incident module on DCIQ due to launch January 2024 in line with PSIRF.

(QS-3) duty of Candour Compliance

- Duty of Candour compliance has routinely been tracked for SIs with non-SIs being more challenging to monitor. The introduction of PSIRF and the new DCIQ incident module brings a more robust way of identifying the woder cohort of incidents that require DoC, execution and recording of these.

QUALITY & SAFETY

Harm

QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 10.2

Common cause variation, no significant change.

QS-29
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1.51

Common cause variation, no significant change.

Summary

QS-28 No Harm incidents per 1000 incidents – the number of these incidents reported has remained relatively static since July 2023

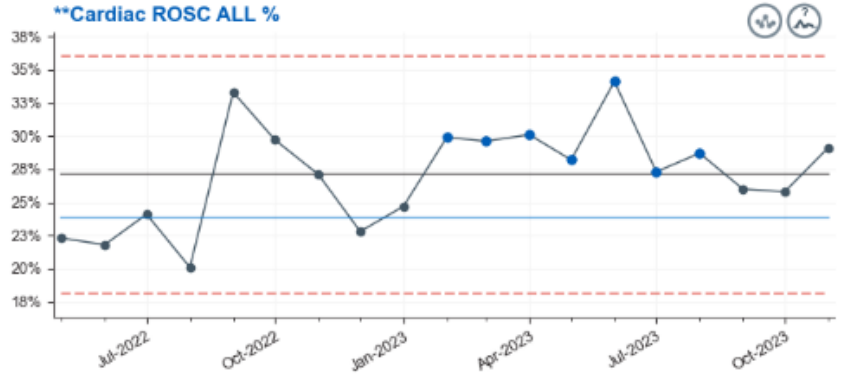
QS-29 Harm incidents per 1000 incidents - the number of these Incidents shows a downward trend; with a steep fall in December 2023. This is encouraging as the reduction did not coincide with a drop in overall incident reporting as seen in QS-1.

What actions are we taking?

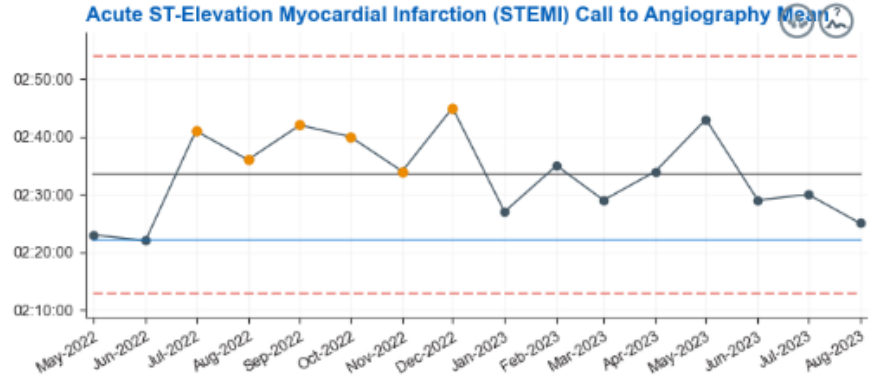
- Developing our organisational approach to establishing a learning framework
- Where themes or trends are identified in incident reporting, specific actions will be identified at team, service or organisational level to support continuous improvement.
- Continue to monitor grade of harm in relation to the trend or theme of incident that is being reported and raise concerns or arising issues with all OUs when completing the initial checks

QUALITY & SAFETY

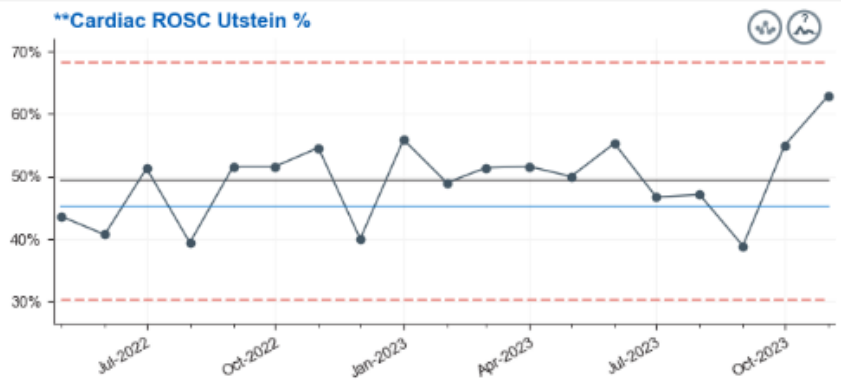
Impact on Patient Care - Cardiac



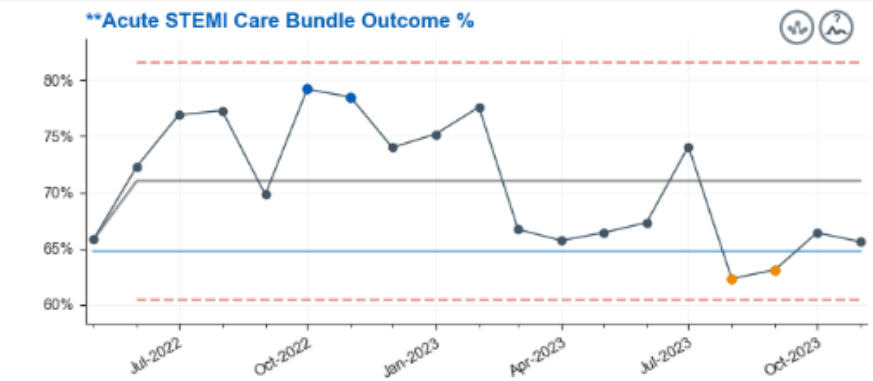
M-2
Dept: Medical
IP: Quality Improvement
Latest: 29.1%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:25:00
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: 62.9%
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: 65.6%
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?

<u>STEMI call to Angiography</u>

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. Dashboards for local OUs are still in development to audit time on scene and inappropriate requests for back-up. 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.

<u>Acute STEMI care bundle outcome</u>

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

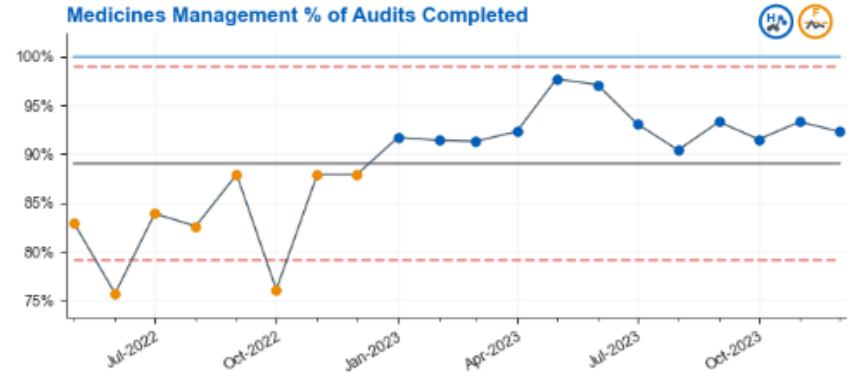
QUALITY & SAFETY

Medicines Management (1 of 2)

MM-1

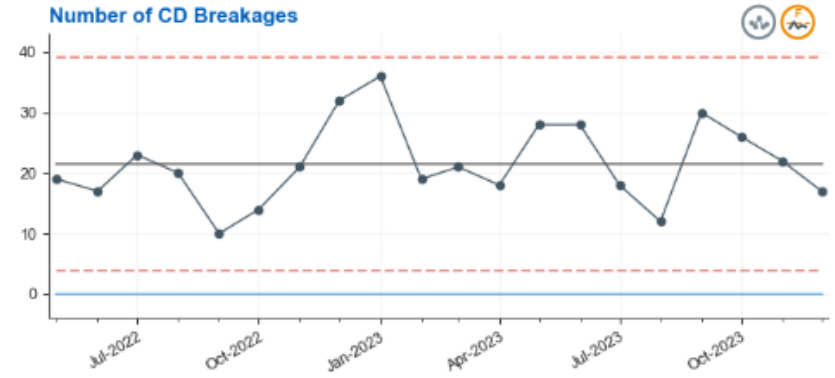
Dept: Medicines Management
IP: Quality Improvement
Latest: 167

Common cause variation, no significant change.



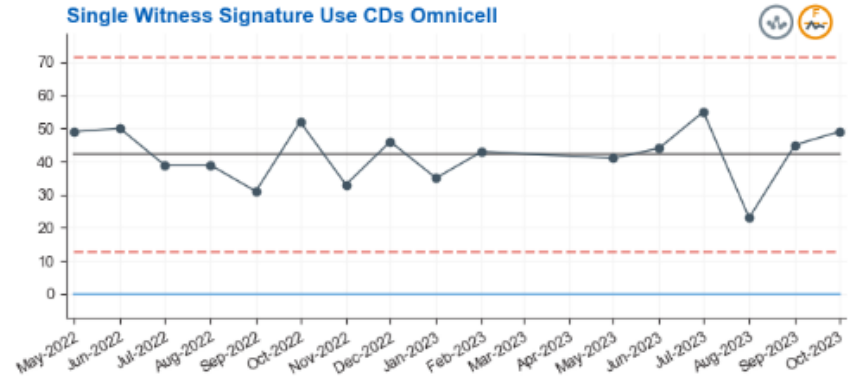
MM-7

Dept: Medicines Management
IP: Quality Improvement
Latest: 92.3%
Target: 100%
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.



MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 17
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: 49
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Reporting around medicines incidents has declined. Staff are encouraged to report medicines incidents including near misses.

CD breakages are monitored by the medicines team and presented into Medicines Governance Group (MGG) for discussion.

Percentage of audits around safe and secure handling of medicines at station sites has declined.

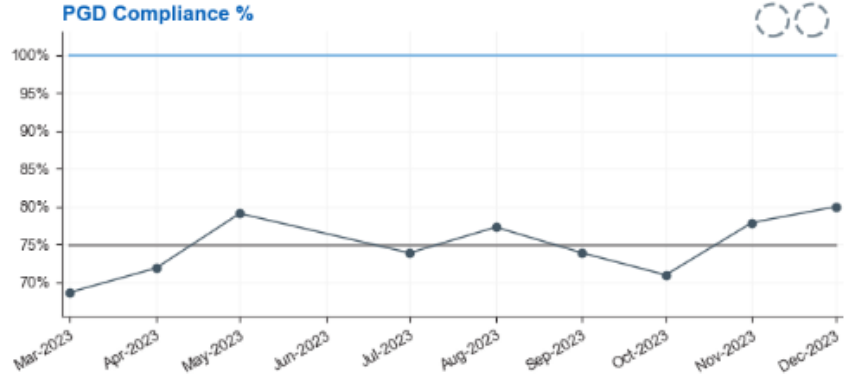
In relation to Single Witness signature for CDs work continues to address this area of activity and the reporting of it is going to go onto the weekly OTL checks making it easier around reporting which is partial manual currently.

What actions are we taking?

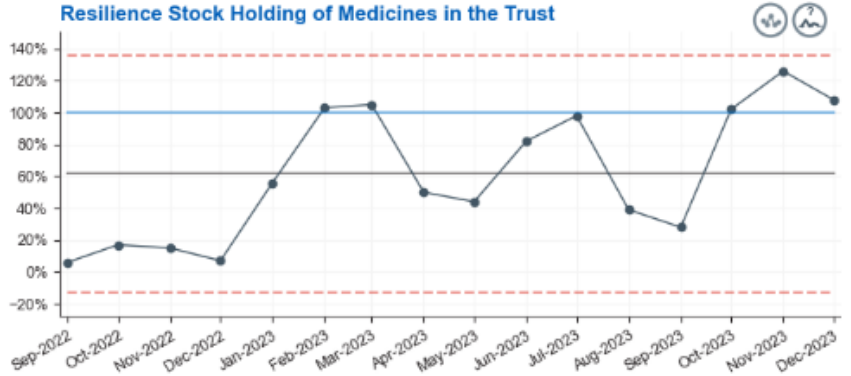
The new compliance audit system is nearly ready to go live (awaiting final approval and roll out plan).
Work is ongoing to roll MedX out as soon as possible at Omnicell sites and a Task & Finish group has been set up. Current 'go live' date of 11th March 2024. MedX training has been completed in all OUs with over 80% of Operational Team Leaders (OTLs) completed
Medicines Safety Officer (MSO) role has been recruited to and will start end February 2024. This post holder will focus on patient safety and medicines incidents and learning.
Medicines team supporting in targeted areas around weekly checks and compliance, expect to see this percentage rise in next month.

QUALITY & SAFETY

Medicines Management (2 of 2)



MM-8
Dept: Medicines Management
IP: Quality Improvement
Latest: 80%
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: 108%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Patient Group Direction (PGD) compliance is at 80%. OUMs receive a report every two months on PGD compliance for their registered staff. Currently OUMs disseminate to their OTLs for management amongst their Paramedic teams. Colleagues are being encouraged to undertake the PGD eLFH module on discover (currently 62% completed) as this is mandatory. Further training is required which is under development by medicines and clinical education teams

Resilience stock remains within safe limits however capacity at Medicines Distribution Centre (MDC) is critical. Phase 1 of the improvements is to be complete by 31 May 2024.

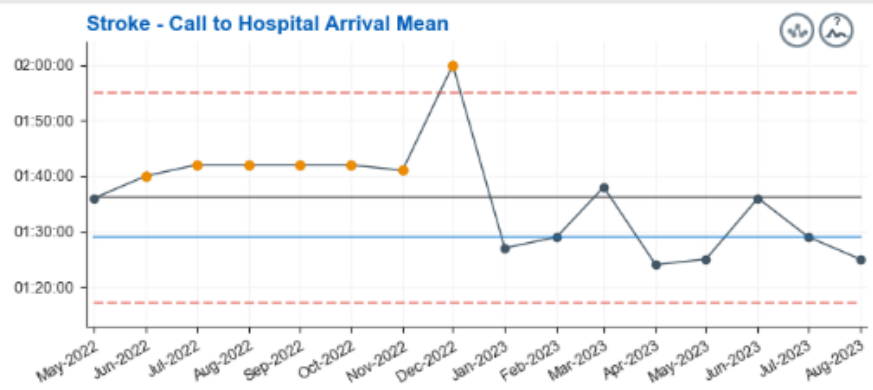
What actions are we taking?

A PGD report down to practitioner level is 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).

Third Pharmacy Technician role has been recruited and has started at MDC. This will help with the day to day running of the Medicines Distribution Centre and stock management for the Trust.

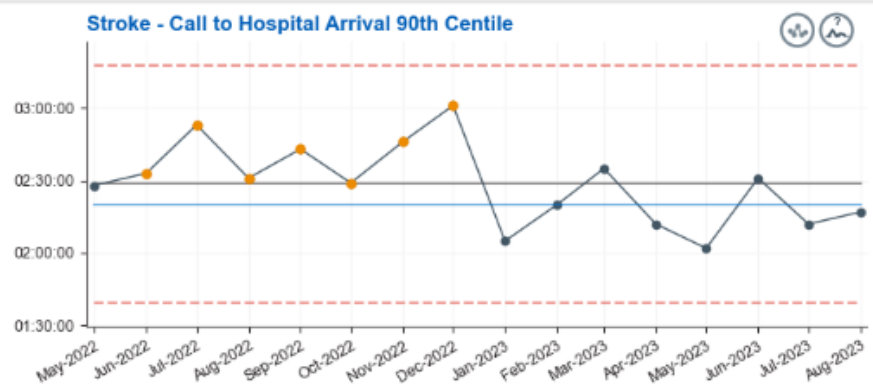
QUALITY & SAFETY

Impact on Patient Care – Stroke



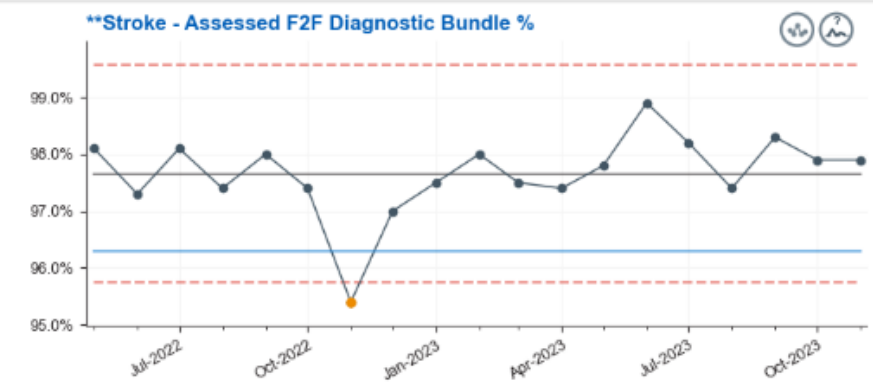
M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:25:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



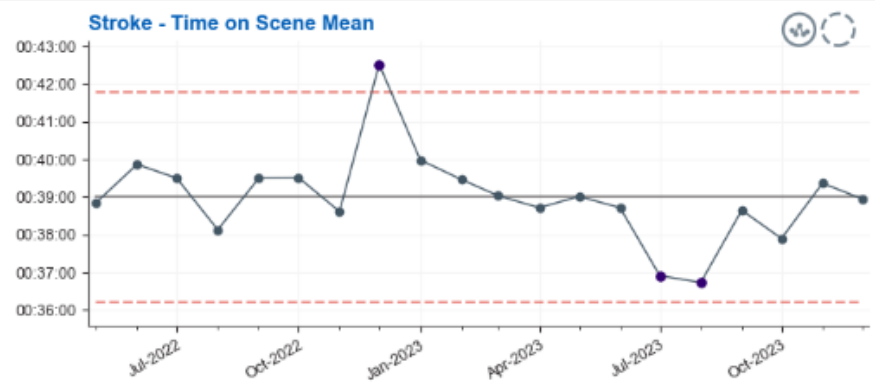
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:17:00
Target: 02:20:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-10

Dept: Medical
IP: Quality Improvement
Latest: 97.9%
Target: 96.3%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-28

Dept: Medical
IP: Quality Improvement
Latest: 00:38:57

Common cause variation, no significant change.

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 30 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.

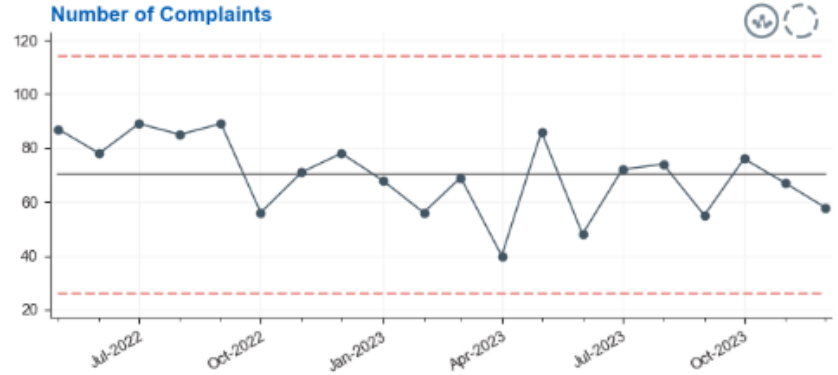
Stroke Time on scene mean. Common Cause variation.

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, possibly due to local initiative to feed back directly to crews. 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 & SAFETY

Patient Experience



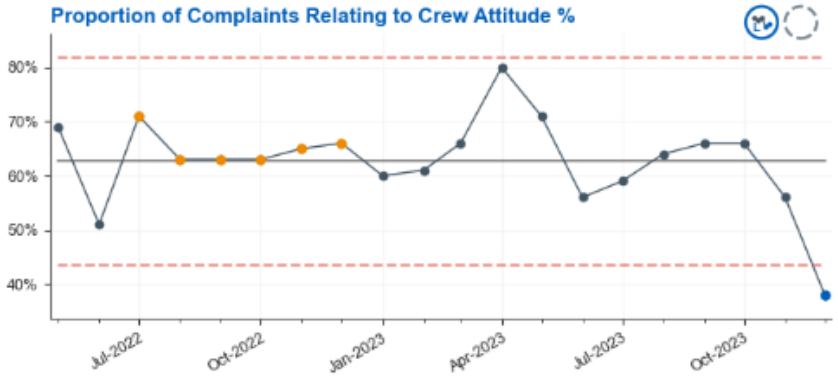
QS-5

Dept: Quality & Safety
IP: Quality Improvement
Latest: 58

Common cause variation, no significant change.

QS-4

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



QS-10

Dept: Quality & Safety
IP: Quality Improvement
Latest: 38%

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

Summary

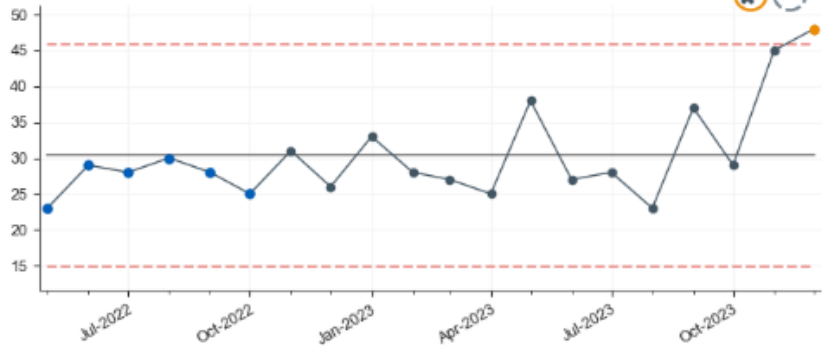
- The number of complaints received is showing normal variation. No concerns / issues.
- The number of complaints relating to crew attitude reduced to 56% in November and 38% in December. It is not known why this is as the overall numbers of complaints have not decreased significantly, but a deep dive into complaints relating to crew conduct/attitude is underway, to report to DOQ&N by end of January 2024.
- Timeliness in responding to complaints has now seen consistent improvement since June 2023 and was 95% in November and 100% in December.

What actions are we taking?

- The deep dive into crew conduct / attitude complaints is underway with the initial findings due to be completed by the end of January 2024.

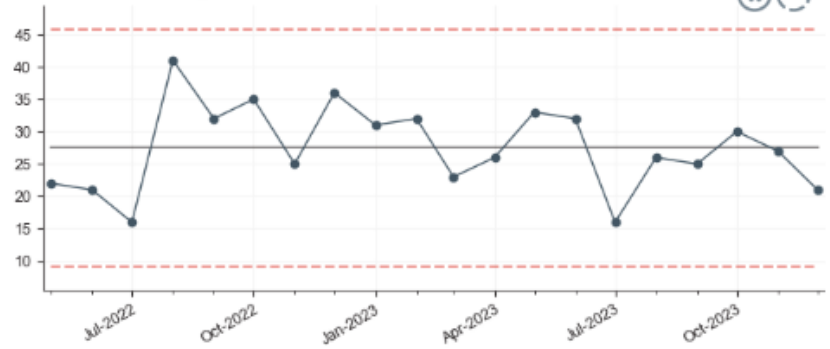
QUALITY & SAFETY

Safety in the Workplace (1 of 3)



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 48

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



QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 21

Common cause variation, no significant change.

Health & Safety Incidents

The key trends for Health & Safety related incidents reamin are the following:

- Slips, trips and falls
- Environmental issues

The increase in incidents reported seen in December is related to Slips, trips and falls incidents occurred during the cold weather period. The majority are from slips, trips and falls outside of SECAmb sites, e.g. patient footpaths, homes etc.

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.

Manual Handling Incidents

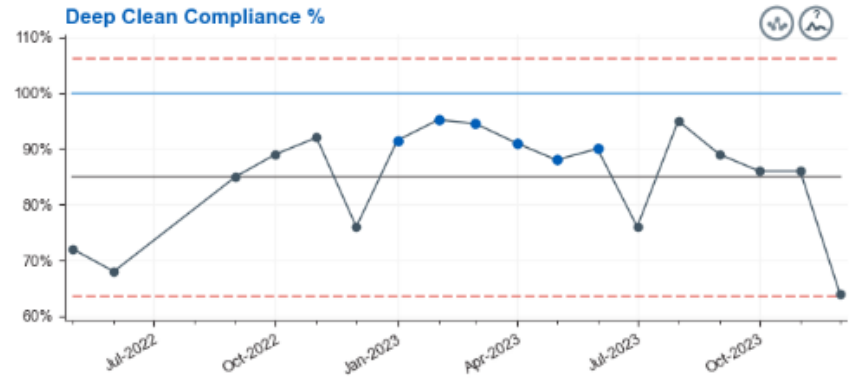
No significant variation

What are we doing

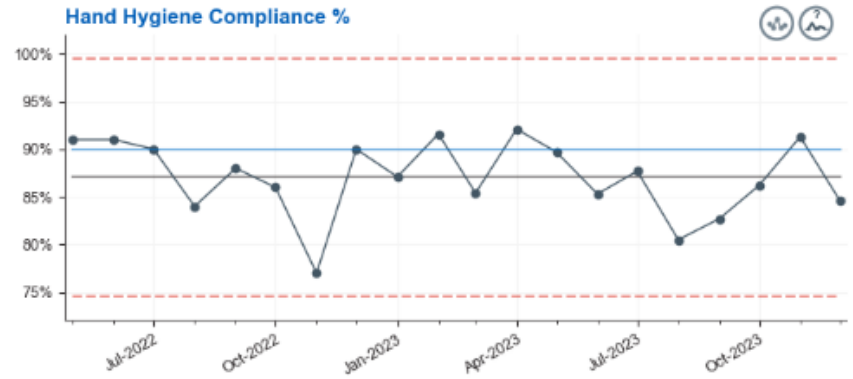
- A task & finish group has been initiated to lead on actions from the recent HSE visit which includes a review of manual handling training, specifically in relation to the manual handling and use of specialist equipment for Bariatric patients.
- The Local and Trust-wide Health & Safety groups will continue monitoring incident trends.
- The H&S group is led by the Executive Director Q&N with attendance by other Executives, 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 & SAFETY

Safety in the Workplace (2 of 3)



QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 64%
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: 84.6%
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
November 2023 – 99% Vs 100% target
December 2023 – 70% 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)
The drop in deep clean compliance for December is partially due to some VPP sites now operating at a VPP spec.rather than the MR spec. and therefore the Deep clean frequency is every 6 weeks rather than 12 causing a spike in required deep cleans

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

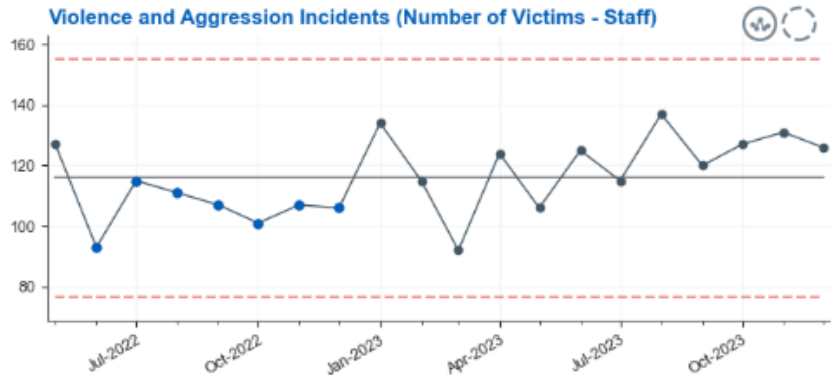
The data for hand hygiene compliance is showing normal variation but with a drop in compliance for December 2023 following a previous upward trend. The lowest compliance was seen in two areas of the Trusts and the IPC team have planned visits to these sites to discuss the results with the local management teams and staff.

What Actions are we taking?

- 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 has reviewed the audit tool and specifically the questions asked to ensure effective understanding to enable reporting that is reflective of current practice.
- The new audit tool will be shared with the IPC Champions and OTL's across the Trust for comment and feedback and a proposed start date of 1st April 2024 is planned for the new range of IPC audits will help support some of the key messages and understanding around IPC practices.

QUALITY & SAFETY

Safety in the Workplace (3 of 3)



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 126

Common cause variation, no significant change.

Violence & Abuse

There is a slight upward trend within the data, though not statistically significant at this point.
Reported incidents have risen to be on average 118 per month. ASB is not significantly higher in November, with 33 recorded in September and lower than 44 in October. Assaults have not risen significantly over the last 4 months. There is a rise in verbal abuse both in November and December that can be attributed to incidents reported by call handling centres.

Staff reported 131 violence and aggression related incidents in November 2023.
The sub-categories of these incidents are shown below:

- 60 verbal abuse
- 33 Anti-Social Behaviour
- 24 assaults

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

- 56 verbal abuse
- 22 Anti-Social Behaviour
- 26 assaults

What actions are we taking?

- A task & finish group has concluded the action from the HSE visit. Face to Face Conflict Resolution Training (CRT) is scheduled to commence for road staff in April 2024. Two new Trainer posts will be advertised to be responsible for delivering training. Resilience is built into the training through four other staff members being trained to deliver the course content.
- Monthly monitoring at the Violence Reduction working group and Health & Safety group continues.
- We continue to triage all incidents and provide contact and support to staff if appropriate in reporting to police for investigation. The Trust now has two Violence Reduction Security officers to manage incidents and support staff.
- Monthly partnership meetings are held with police to provide updates on cases involving our staff.
- Carriage of BWC has increased by 266% since the completion of the expansion across the entire Trust..
- 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.
- Increased contact and support for staff from having an additional Violence Reduction Security Officer.
- A possible shift in trend during 2024. Comparison of data continues to show steady increases month by month in comparison to last year. Data suggests that assaults have not increased over the last 5 years, it is the reporting of verbal aggression by staff that has increased, particularly in call handling centres.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

People & Culture

PEOPLE & CULTURE

Summary

December 2023

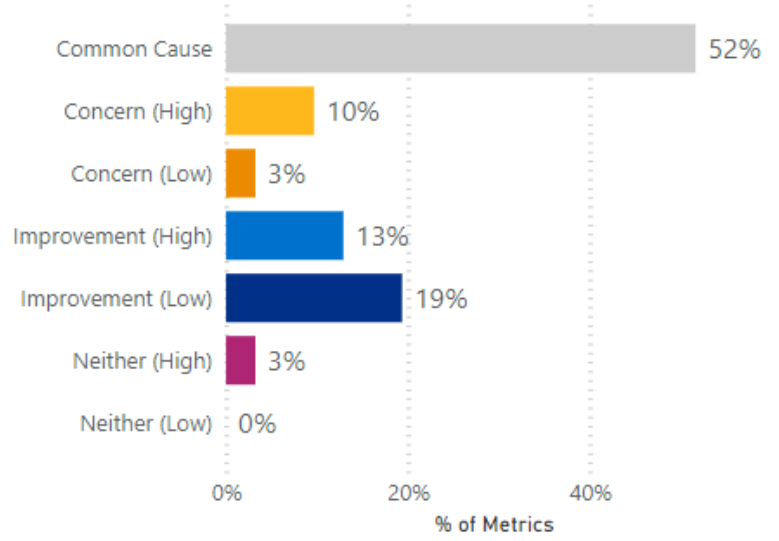
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Collective Grievances Open Bullying & Harrassment Internal 999 Frontline Late Finishes/Over-Runs % Active Suspensions	Number of Staff WTE (Excl bank and agency) Sickness Absence % Current licence details held for Operational Staff %	Finance Establishment (WTE) Average Late Finish/Over-Run Time Fundamentals Training Completion %
Common Cause		Vacancy Rate % Turnover Rate % Individual Grievances Open Count of Grievances Closed % of Meal Breaks Taken Suspension Closures Number of Wellbeing Hub Referrals	Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Until it Stops Average Case Length	
Special Cause Concern	DBS Compliance %	Disciplinary Cases Grievances Mean Case Length (Days)	Annual Rolling Turnover Rate	

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

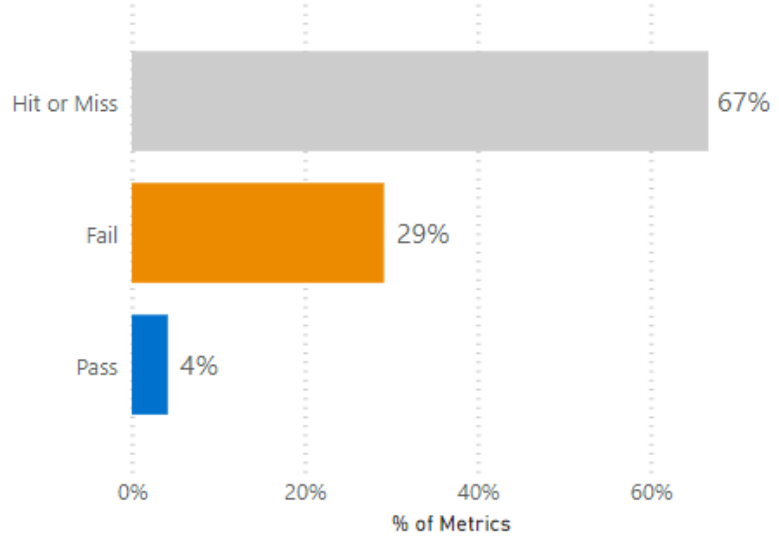
PEOPLE & CULTURE

Overview (1 of 2)

Variation Icon Summary



Assurance Icon Summary



Workforce

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Dec-2023	4308.3	4602.75	3979.09	4080.65	4182.21		
Vacancy Rate %	People & Culture	Dec-2023	6.4%	5%	0.96%	6.36%	11.76%		
Turnover Rate %	People & Culture	Dec-2023	1.1%	0.8%	0.59%	1.42%	2.24%		
Annual Rolling Turnover Rate	People & Culture	Dec-2023	18.4%	10%	17.45%	18.21%	18.97%		
Sickness Absence %	People & Culture	Dec-2023	7.5%	5%	6.18%	7.93%	9.68%		
DBS Compliance %	People & Culture	Dec-2023	92.6%	90%	98.05%	99.21%	100.37%		
Current licence details held for Operational Staff %	People & Culture	Dec-2023	98%	100%	94.49%	96.44%	98.38%		
Time to Hire - Volume (Days)	People & Culture	Dec-2023	232	60		154.67			
Time to Hire - Ad-Hoc (Days)	People & Culture	Dec-2023	63	60		66.25			

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Dec-2023	75.2%	85%	67.03%	73.39%	79.75%		
Appraisals Rolling Year %	People & Culture	Dec-2023	60.8%	85%	49.84%	58.39%	66.93%		

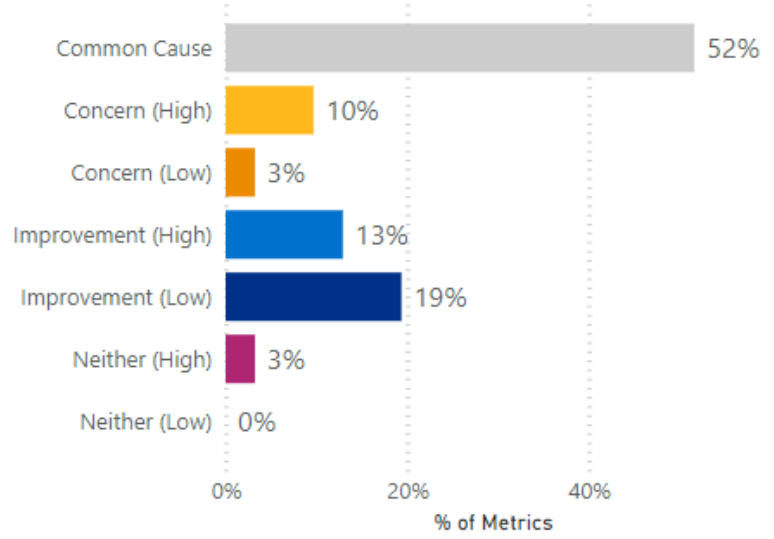
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Dec-2023	47.3%	45%	44.34%	49.62%	54.89%		
Average Late Finish/Over-Run Time	People & Culture	Dec-2023	00:38:00		00:35:37	00:39:15	00:42:53		
% of Meal Breaks Taken	People & Culture	Dec-2023	98.2%	98%	96.78%	98.23%	99.67%		
% of Meal Breaks Outside of Window	People & Culture	Dec-2023	56.9%		43.46%	57.05%	70.64%		

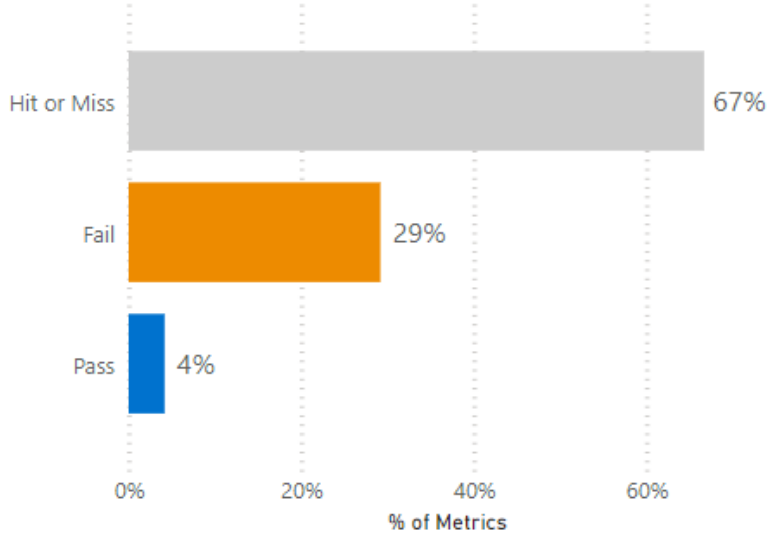
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

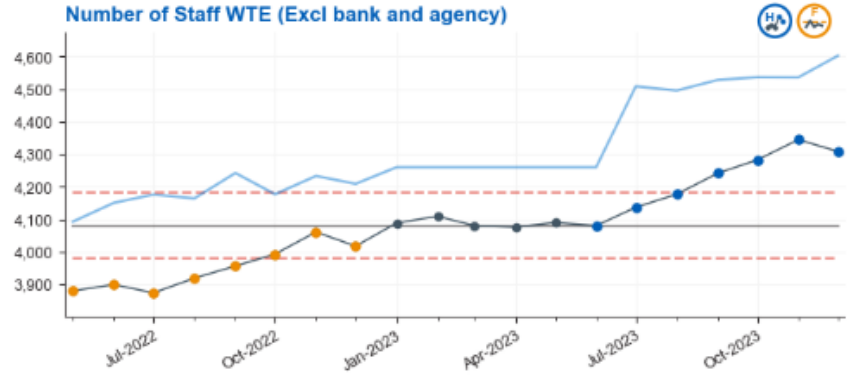
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Dec-2023	12	5	0.9	12.8	24.7		
Collective Grievances Open	People & Culture	Dec-2023	1	1	-1.86	1.5	4.86		
Count of Grievances Closed	People & Culture	Dec-2023	8	3	0.25	12.15	24.05		
Grievances Mean Case Length (Days)	People & Culture	Dec-2023	201.45	93	87.03	127.25	167.46		
Bullying & Harrassment Internal	People & Culture	Dec-2023	0	2	-3.15	1.75	6.65		
Disciplinary Cases	People & Culture	Dec-2023	8	3	-1.26	5.6	12.46		
Freedom to Speak Up: Total Open Cases	People & Culture	Dec-2023	29		9.97	22.15	34.33		
Freedom to Speak up: Cases Opened in Month	People & Culture	Dec-2023	5	3	-0.23	8.45	17.13		
Freedom to Speak up: Cases Closed in Month	People & Culture	Dec-2023	10		-4.21	9.65	23.51		
Count of Until it Stops Cases	People & Culture	Dec-2023	3	3	-4.62	3.5	11.62		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Dec-2023	97	86	57.13	106.89	156.65		

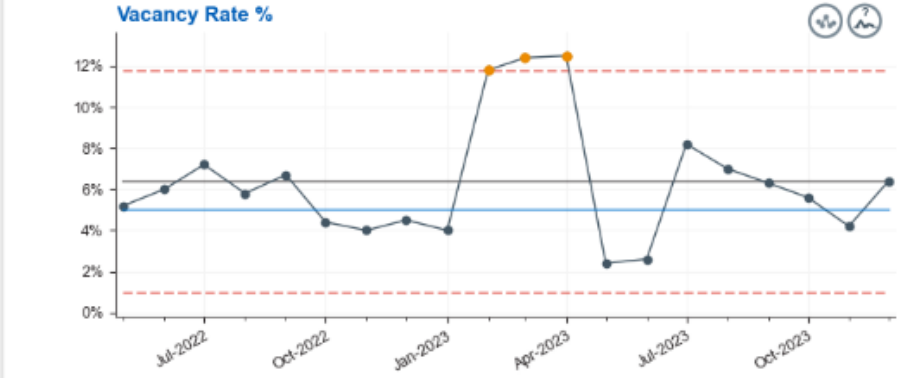
PEOPLE & CULTURE

Workforce (1 of 3)



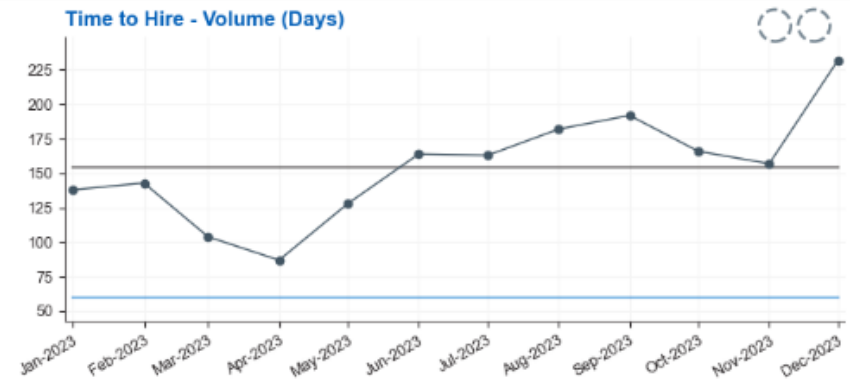
WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 4308.3
Target: 4602.75
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.



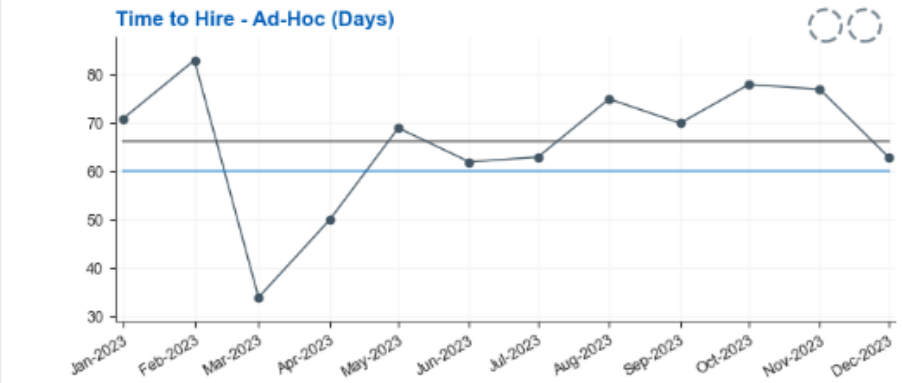
WF-4

Dept: Workforce HR
IP: People & Culture
Latest: 6.4%
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: 232
Target: 60
Special cause or common cause cannot be given as there are an insufficient number of points.



WF-51

Dept: Workforce HR
IP: People & Culture
Latest: 63
Target: 60
Special cause or common cause cannot be given as there are an insufficient number of points.

Summary

TTH has been adjusted with a new logic to avoid inflation to the figures. Previously if dates were not entered into the booked start date on Trac, this would then use today's date. However, the adjustment has been made to find the date in offered start date if no booked start date, reflecting a more accurate TTH. Filters have also been adjusted to ensure that all relevant vacancies are being captured.
This work has been completed by the Workforce Information and Planning Team and the Predictive Analytics team to ensure the TTH is as accurate as possible.

The vacancy rate has increased slightly in December following a reduced number of new starters over the December period.

What actions are we taking?

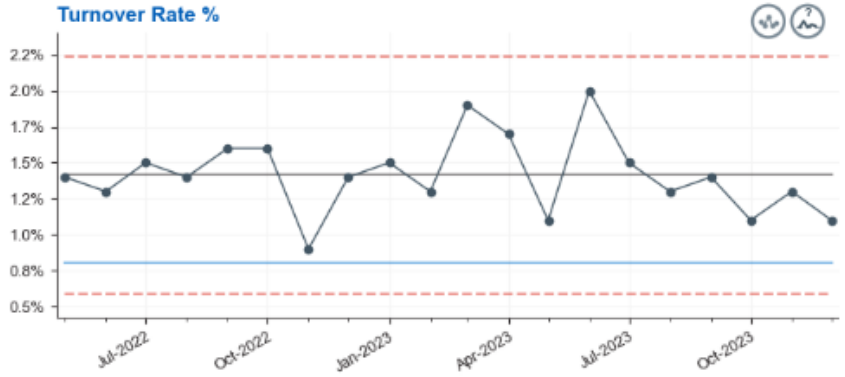
The Quality Improvement recruitment and onboarding project continues with processes being reviewed and changes implemented at each stage. The improvements made are intended to not only reduce TTH when possible *, but also increase candidate engagement, improve the overall experience and reduce attrition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

The Recruitment Team have agreed KPIs for 2024, aimed at focusing on quality, TTH and ensuring that candidates have a positive onboarding experience. Initial results have shown an improvement in the quality of Data held within both Trac and ESR. Recruitment Events are ongoing last two events have yielded 35 new starters. Next event scheduled for 27th Jan with 140 visitors planned over a 6-hr period with collaboration from all areas of trust.

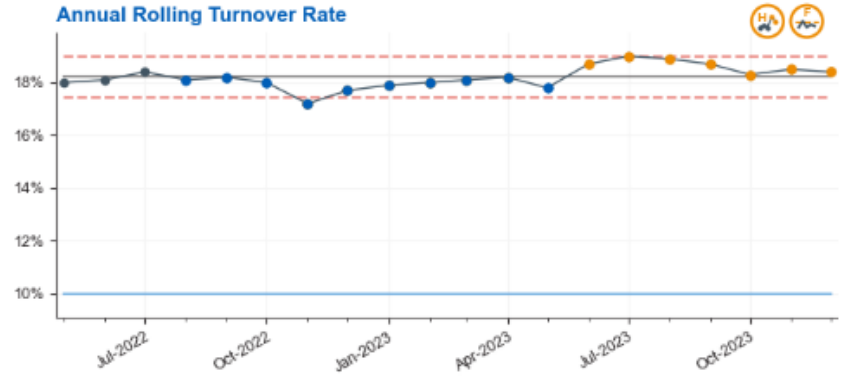
*Certain cohorts such as NQPs will have no room to reduce the TTH as the campaigns are in line with university end of course dates. Attraction and targeted recruitment of NQPs starts months in advance of hire dates.

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: 18.4%
Target: 10%
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

Summary:

Whilst we remain concerned with the high levels of turnover, we are beginning to see some green shoots from all the retention plan engagement work, with December seeing the lowest number of leavers since May 23.

As reported previously, we have two risk register entries, Risk 84 (Medway) current grading 12, and Risk 365 (Trust wide) current grading 16. Risk 84 will soon go as the move has been completed and trial periods have come to an end.

We continue to see improvement in historically high turnover OU's. Most notable are Brighton 7.82% v 8.21% in November, Guildford 7.79% v 8.85%, Polegate and Hastings 7.53% v 8.20%.

Now that Medway has finished all its trial periods it saw 6.13% v 8.28% in November.

What actions are we taking?

The Retention Plan has been signed off at Board following an extensive engagement process.

Two action planning meetings have been had with the action owners responsible for delivery of the initiatives. These were to ensure we had the most appropriate action owners, and to discuss resource and financial requirements for delivery.

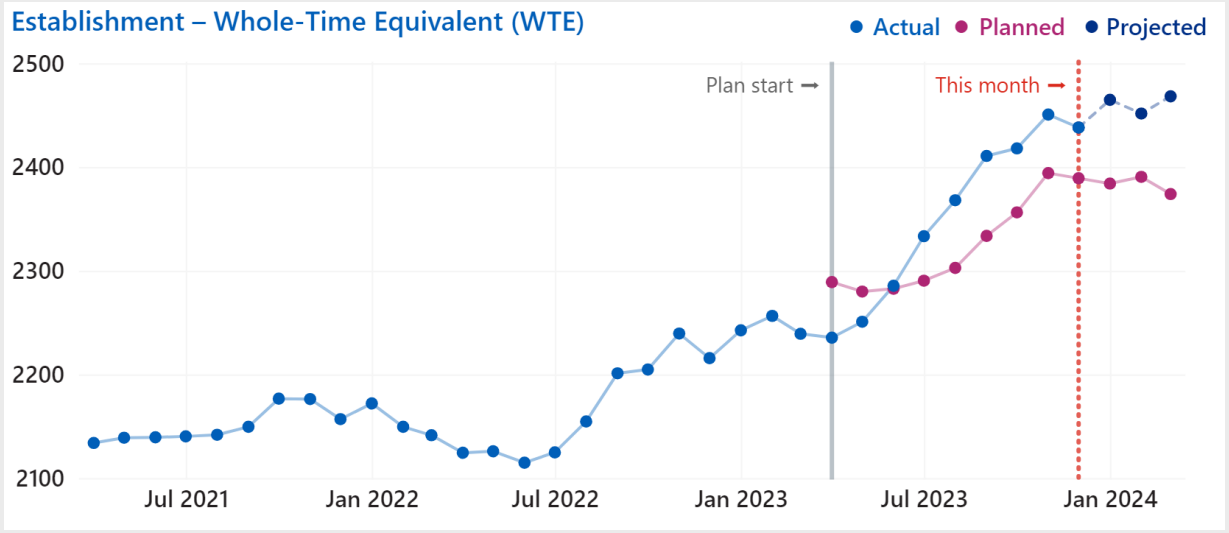
Work is underway on the development of an Improvement Case for funding for the initiatives.

Joint leadership (EMB and SMG) are now considering the requirements and implications for reevaluating the band 3 Emergency Care Support Workers and Trainee Associate Ambulance Practitioners. This is to brings these roles into alignment with LAS and SCAS.

PEOPLE & CULTURE

Workforce (3 of 3)

(999 Frontline)

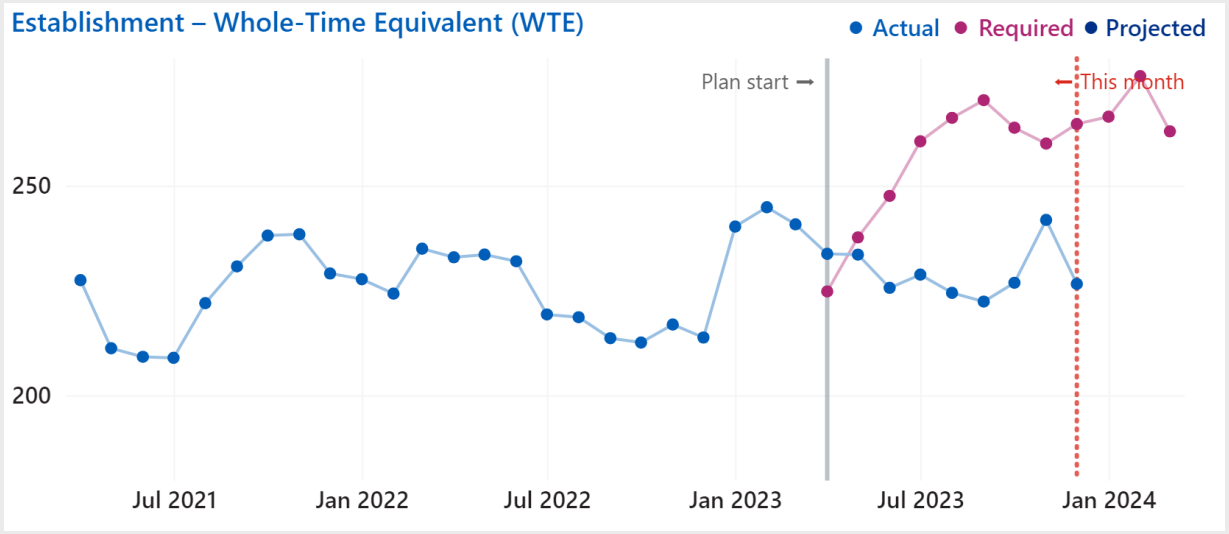


Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
December's data shows an increase in WTE ahead of the workforce plan (48.9WTE). Attrition again was lower than planned which has contributed to the difference.
December showed no further NQP recruitment planned before April 2024.

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. December showed that ECSWs were 0.2WTE over planned. Attrition has been lower than planned and has helped the overall projected figures. Attrition for December was planned at 11.87WTE and actual was 3.0WTE.

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 December showed an increase of WTEs with a difference of -14.4% to plan. There were no new starters for December against a planned 23WTE.
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.

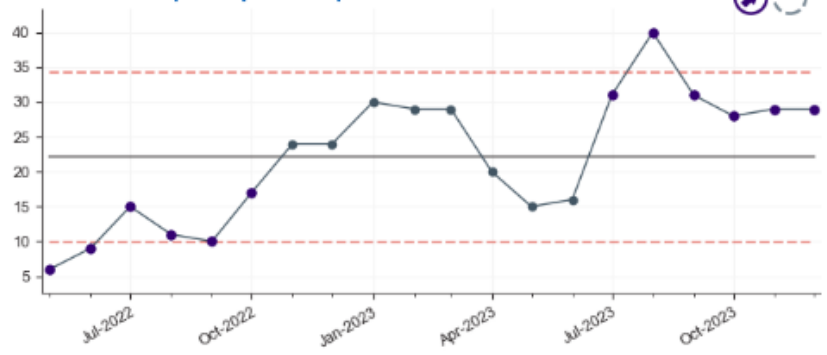
Additional Information
The workforce projection is currently based on confirmed recruits who currently have an offer of employment. As EMA recruitment typically only has a lead time of 2 months, no additional recruitment is factored into the projection beyond this point, which results in the chart only 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

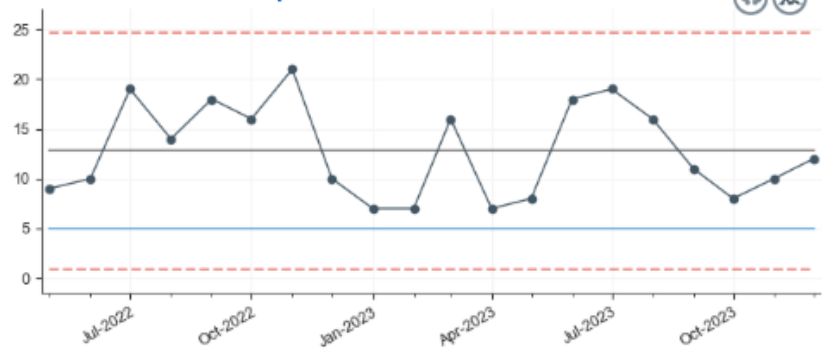


QS-27

Dept: Quality & Safety
IP: People & Culture
Latest: 29

Special cause variation where UP is neither improvement or concern

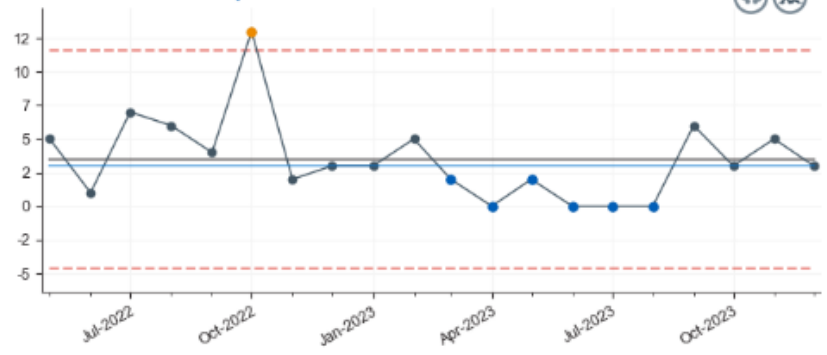
Individual Grievances Open



WF-10

Dept: Workforce HR
IP: People & Culture
Latest: 12
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.

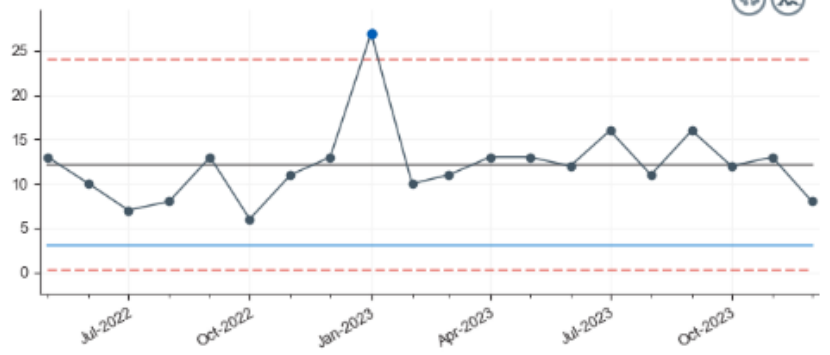
Count of Until it Stops Cases



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.

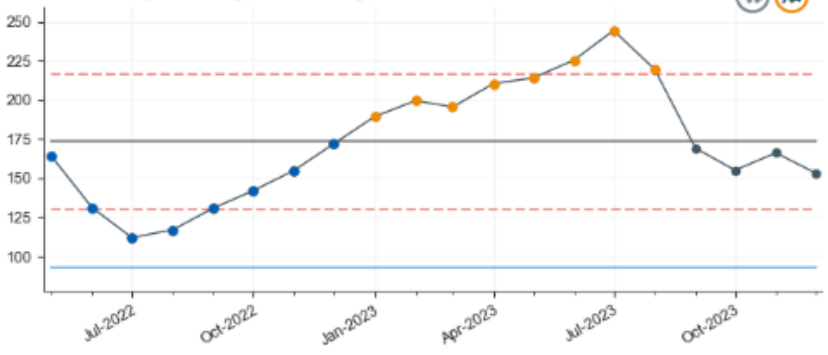
Count of Grievances Closed



WF-42

Dept: Workforce HR
IP: People & Culture
Latest: 8
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

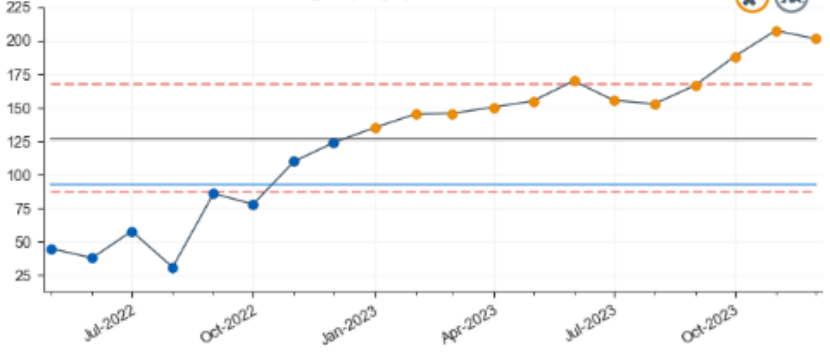
Until it Stops Average Case Length



WF-50

Dept: Workforce HR
IP: People & Culture
Latest: 153.26
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: 201.45
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

Cases are steadily reducing overall. At the end of December 2023, open grievance cases reduced to 62 - the lowest number for the year to date. This improvement work is supported by HR and trade union colleagues working together to seek pragmatic solutions including informal interventions at an early stage. .

HR colleagues are maintaining a high focus on reducing case length of time and we have prioritised reviewing all legacy grievance cases as an urgent action. In December there were 39 legacy cases identified that have been open longer than 6 months - swift action and resolution of these cases is monitored with the HR case worker each week with the aim to bring legacy cases to closure in the next few months.

FTSU

41 concerns were raised to FTSU in Nov/Dec 23 this is a 37% increase from the previous year. In Nov/Dec 2022 37% of the concerns raised were anonymous, in Nov/Dec 2023 10% were raised anonymously. This reflects positively on the culture of speaking up, showing an improvement in people feeling safe and encouraged to speak up at SECAmb.

What actions are we taking?

Grievances

We have two new ER managers who have recently started within the HR team, Ore Ediale and Jennie Fitzsimons. They will support and share their expert case knowledge with the HR advisory team to help support with cases and reduce formal cases to reasonable levels. We are already seeing a downward trajectory with grievance case numbers at the end of 2023 numbers and our aim is this is sustained throughout 2024 with the help of the ER team and ER subject experts.

A priority for ER in the new year are open legacy cases which continue to be tracked with the HR team so we expect to see a significant reduction in these cases which will also reduce the overall length of time cases are open. Focused work with the team has been established and legacy cases are reviewed every week to ensure actions are delivered thoroughly/robustly by the HR representative e.g. interview dates, evidence analysis, management report writing , etc.

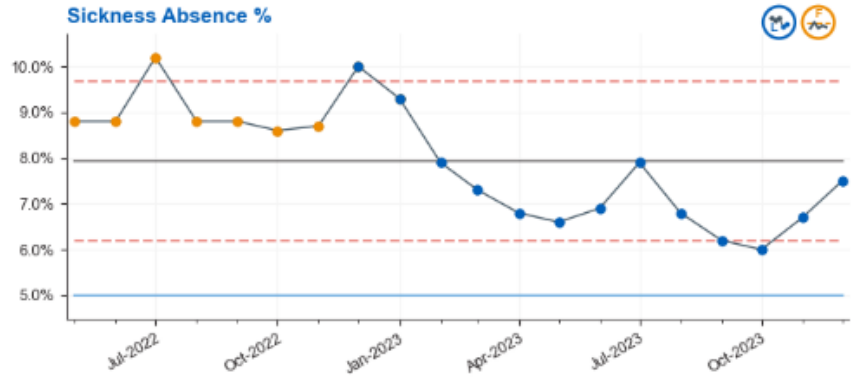
The FTSU team and the National Guardian will be hosting a development session for OUM's in March 2024, this will focus on the core the principles behind Speaking Up, the role and process of FTSU and why it is nationally structured as it is, and the barriers to seeking learning and simply being curious and compassionate.

In 2024 the FTSU team will explore the development of a network of FTSU advocates in line with guidance and recommendations set out in the NGO speak up review of Ambulance services published in 2023.

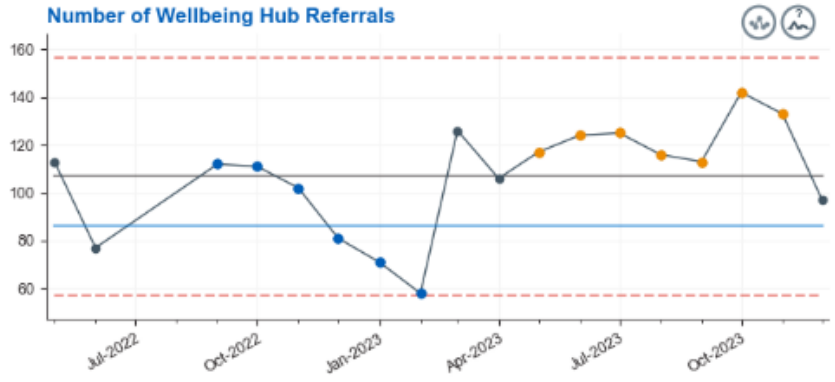
FTSU team is collaborating with our linked universities to meet with year two students and delivering a speak up workshop to reiterate the importance of speaking up at SECAmb.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 7.5%
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: 97
Target: 86
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

The slight spike in sickness absence for November and December is indictive of previous years. Some of the trend relates to operational annual leave being declined, and so colleagues go absent instead. Others may be related to the psychological impact of returning to a very busy and often stressful environment following a period of leave.

The wellbeing hub saw a slight decline in referrals. This is predominately due to leave.

What actions are we taking?

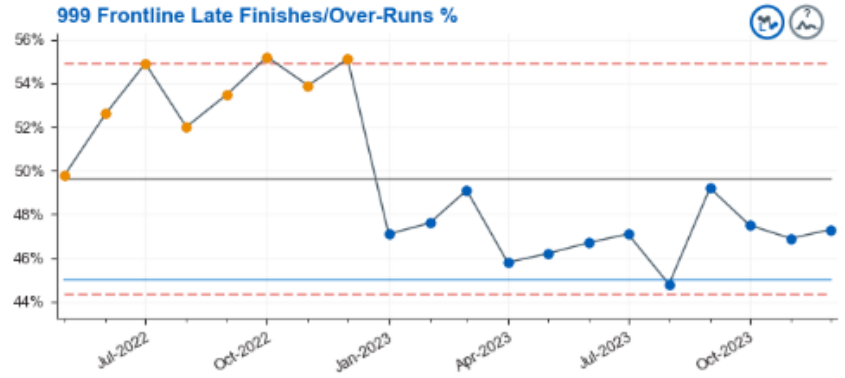
As part of the work within the Retention Plan, we are looking at systems and mechanisms that give our colleagues greater control over the leave, and therefore reducing the need to go sick.

With the change in the HRBP/ER structure we can do more to support managers with attendance management and getting to the heart of absence. We therefore expect to see an improvement from February onwards, particularly when considered alongside the Attendance Management Deep Dive that we have reported on previously.

Our wellbeing hub improvement case has been temporarily paused whilst the organisational restructure implications are considered.

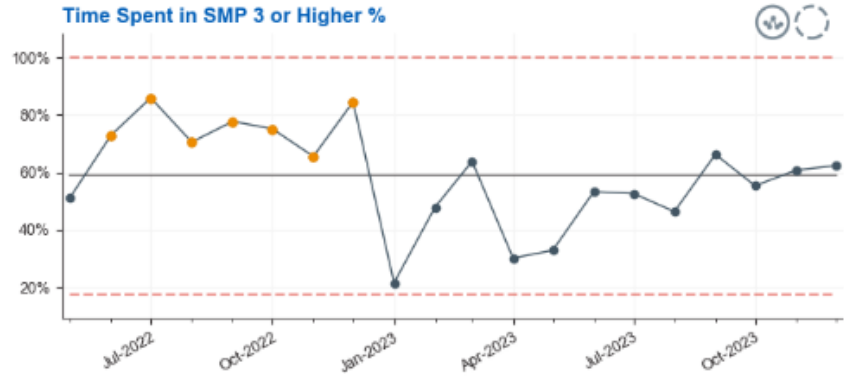
PEOPLE & CULTURE

Employee Experience



999-15

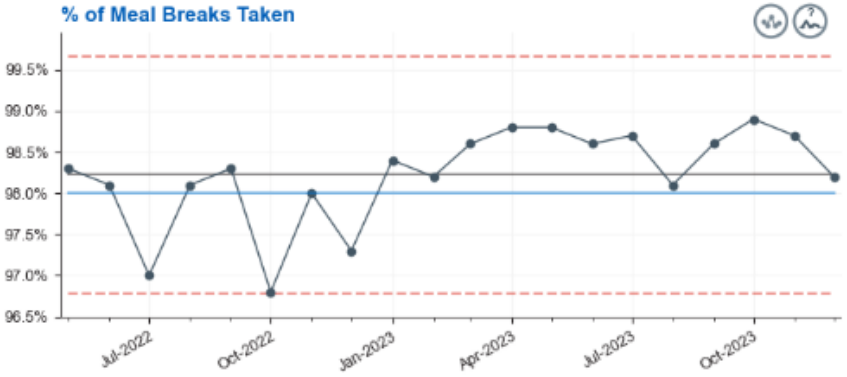
Dept: Operations 999
IP: People & Culture
Latest: 47.3%
Target: 45%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-14

Dept: Operations 999
IP: Quality Improvement
Latest: 62.4%

Common cause variation, no significant change.



999-27

Dept: Operations 999
IP: People & Culture
Latest: 98.2%
Target: 98%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

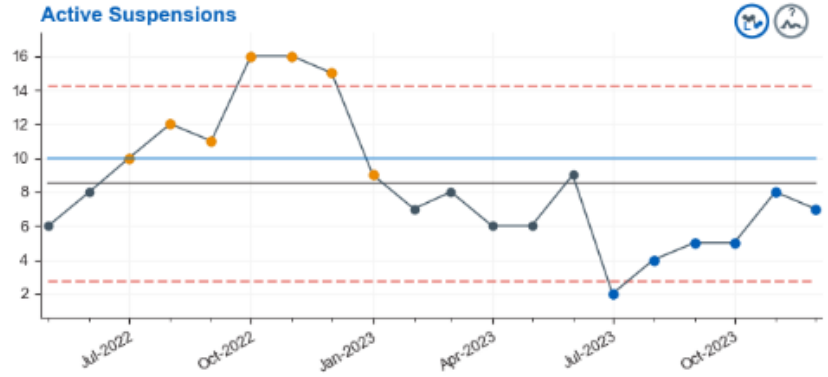
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- Whilst the late finishes and meal break metrics related directly to field operations, the impact of time spent at higher levels of SMP has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

What actions are we taking?

- Review and update of the Meal break policy.
- Learning from the Ashford pilot in terms of cross-border working, meal break compliance etc.

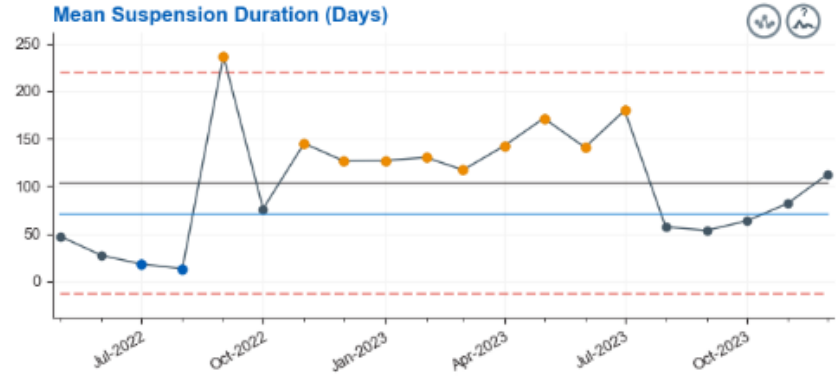
PEOPLE & CULTURE

Employee Suspensions



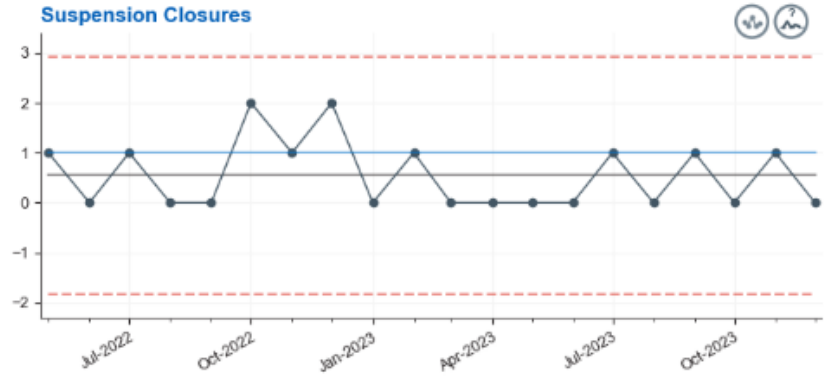
WF-46

Dept: Workforce HR
IP: People & Culture
Latest: 7
Target: 10
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-47

Dept: Workforce HR
IP: People & Culture
Latest: 112.14
Target: 70
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-45

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

Summary

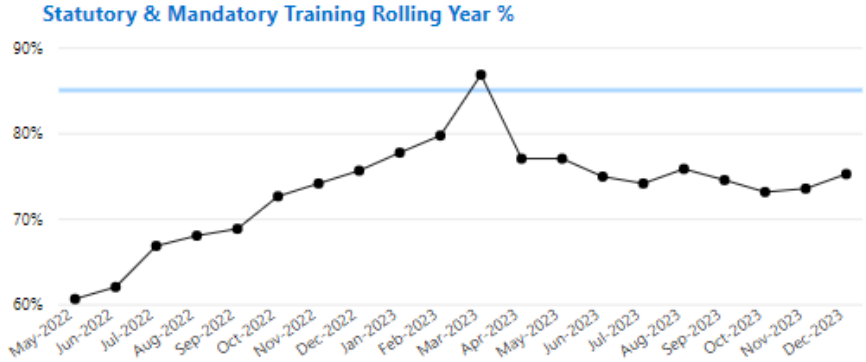
Suspensions remain under close monitoring, all these cases are related to potential gross misconduct charges (ie sexual harassment, criminal matters, threatening behaviours, patient safety). The cases remain a high priority and continue to be progressed through formal disciplinary procedures to reach an outcome which will then determine next steps and/or an appropriate sanction.

What actions are we taking?

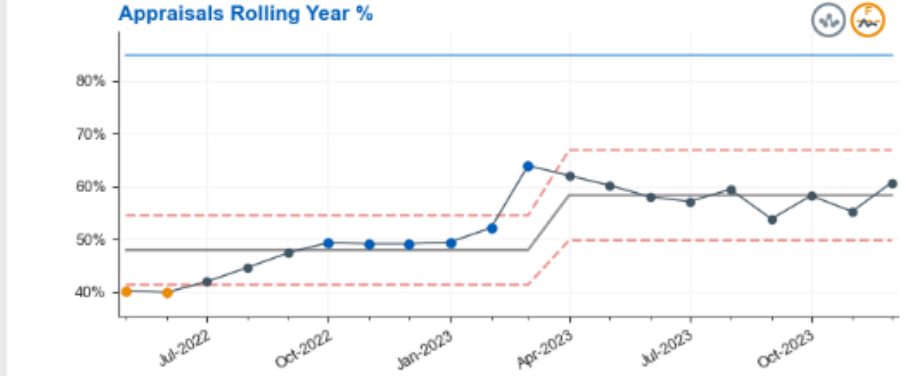
Current /new suspensions are tracked and reviewed on a weekly basis by the HR Team with the Executive Directors of HR & OD and Operations. This also gives an opportunity to consider those cases which may be identified initially for suspensions where it may not be appropriate or a proportionate action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

PEOPLE & CULTURE

Employee Development



WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 75.2%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-40
Dept: Workforce HR
IP: People & Culture
Latest: 60.8%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Statutory & Mandatory Training

Since October 2023, there has been a consistent increase in compliance rates, and as of 17 January 2024, our rolling overall compliance rate stands at 75%. It is important to note that the current report encompasses topics beyond the NHS Core Skills Training Framework (CSTF) for statutory and mandatory training, including Classroom Key Skills, Driver Training, Patient Group Directions and Speak Up – core training for all workers. Excluding these non-CSTF subjects, our compliance rate increases to 79%.

The chart above highlights that the Trust successfully achieved the compliance target for statutory and mandatory training in March 2023. With the ongoing upward trend in completions, there is a high likelihood of reaching our target by March 2024.

Attention should be drawn to a concern regarding data accuracy stemming from the manual transference of completion data from the Discover platform to employee's learning records in ESR. To mitigate this, it has been identified as a risk and duly included it on the risk register.

Appraisal

Reported appraisal rates have improved but continue to remain below the Trust's compliance target.

What actions are we taking?

Statutory and mandatory training

The recently appointed Digital Learning Manager has initiated a project with the following objectives:

- Investigating and resolving internal data issues within the sphere of L&D's control
- Collaborating with users outside of L&D to address and resolve data input issues
- Addressing the manual data input process from Discover to ESR to eliminate issues and enhance overall efficiency with the current limits of ESR

Appraisals

To strengthen the accuracy of data reporting from ESR to the Appraisal dashboard on Power BI, several enhancements have been implemented:

- Transitioning to daily automated downloads
- Excluding new starters until their first appraisal is due and non-executive directors from the substantive staff reporting process
- Appraisal status information to offer a clearer overview to managers on the Power BI dashboard
- Introduced a rolling status review tab
- Incorporated exclusions such as career breaks and maternity/paternity leave to ensure comprehensive reporting

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

December 2023

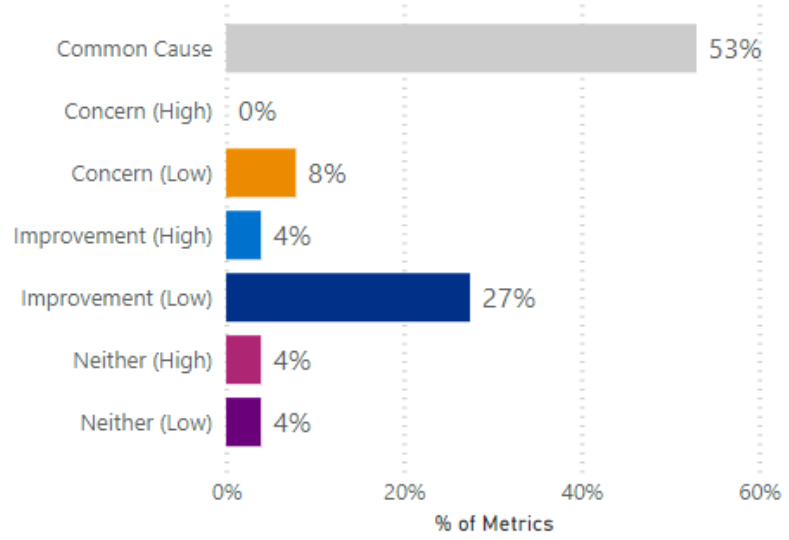
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	Cat 1T Mean Cat 1T 90th Centile	999 Frontline Hours Provided % A&E Dispositions %	Hear & Treat % See & Convey % Average Wrap Up Time Cat 1 Mean	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as a Proportion of Provided Hours... % of SRV vehicles off road (VOR) Critical Vehicle Failure Rate (CVFR) Proportion of Wrap Up Times > 15 minutes 999 Referrals A&E Dispositions
Common Cause	111 to 999 Referrals (Calls Triaged) %	111 Calls Abandoned - (Offered) % Cat 2 Mean Cat 3 90th Centile Cat 4 90th Centile	111 Calls Answered in 60 Seconds %	Number of Hours Lost at Hospital Handover ECAL Mean Response Time % of planned vehicle services completed Duplicate Calls % 999 Calls Answered
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.

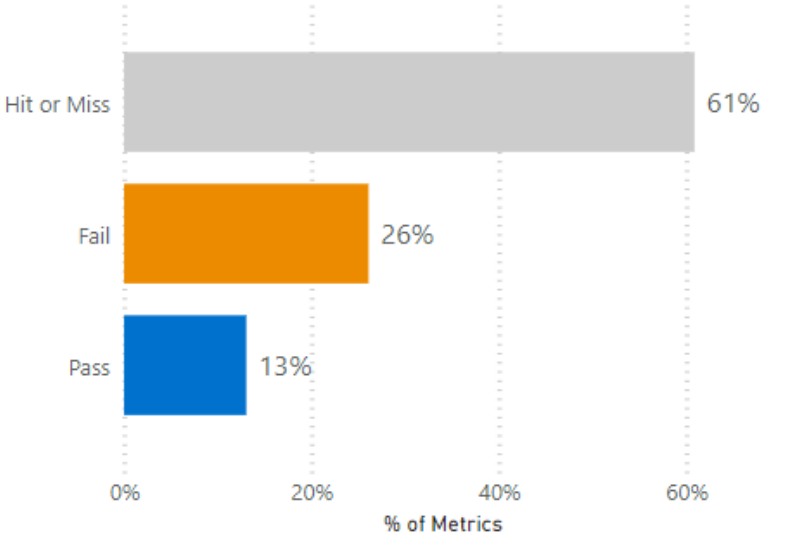
RESPONSIVE CARE

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	Dec-2023	01:27:32			00:28:15			
Section 136 Mean Response Time	Responsive Care	Dec-2023	00:23:22		00:13:27	00:26:38	00:39:48		
Cat 1 Mean	Responsive Care	Dec-2023	00:08:41	00:07:00	00:07:32	00:09:02	00:10:33		
Cat 1 90th Centile	Responsive Care	Dec-2023	00:15:37	00:15:00	00:14:02	00:16:24	00:18:46		
Cat 1T Mean	Responsive Care	Dec-2023	00:10:01	00:19:00	00:09:00	00:10:43	00:12:26		
Cat 1T 90th Centile	Responsive Care	Dec-2023	00:18:11	00:30:00	00:16:28	00:19:39	00:22:50		
Cat 2 Mean	Responsive Care	Dec-2023	00:32:21	00:30:00	00:18:14	00:32:07	00:45:59		
Cat 2 90th Centile	Responsive Care	Dec-2023	01:07:45	00:40:00	00:35:04	01:05:47	01:36:30		
Cat 3 90th Centile	Responsive Care	Dec-2023	06:05:57	02:00:00	01:44:15	05:50:01	09:55:47		
Cat 4 90th Centile	Responsive Care	Dec-2023	06:04:37	03:00:00	02:08:24	07:53:05	13:37:45		
HCP 3 Mean	Responsive Care	Dec-2023	02:18:55		01:03:28	02:37:23	04:11:17		
HCP 3 90th Centile	Responsive Care	Dec-2023	05:00:14		01:15:43	06:01:12	10:46:42		
HCP 4 Mean	Responsive Care	Dec-2023	03:05:38		01:29:03	03:21:23	05:13:44		
HCP 4 90th Centile	Responsive Care	Dec-2023	07:33:23		02:29:26	07:57:48	13:26:10		

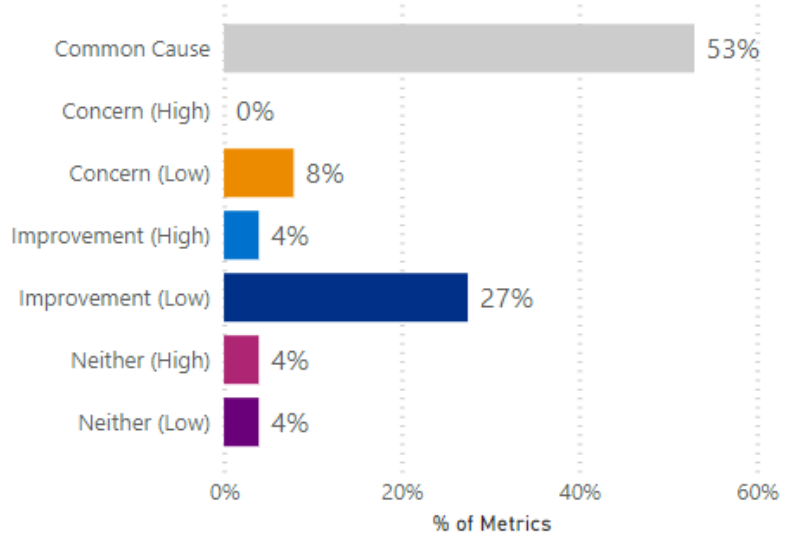
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Dec-2023	24.5%		20.37%	24.14%	27.9%		
999 Calls Answered	Responsive Care	Dec-2023	77252		52945.84	72334.3	91722.76		
999 Call Answer Mean	Responsive Care	Dec-2023	00:00:19	00:00:05	00:00:29	00:00:40	00:01:49		
999 Call Answer 90th Centile	Responsive Care	Dec-2023	00:01:15	00:00:10	00:00:55	00:02:10	00:05:14		

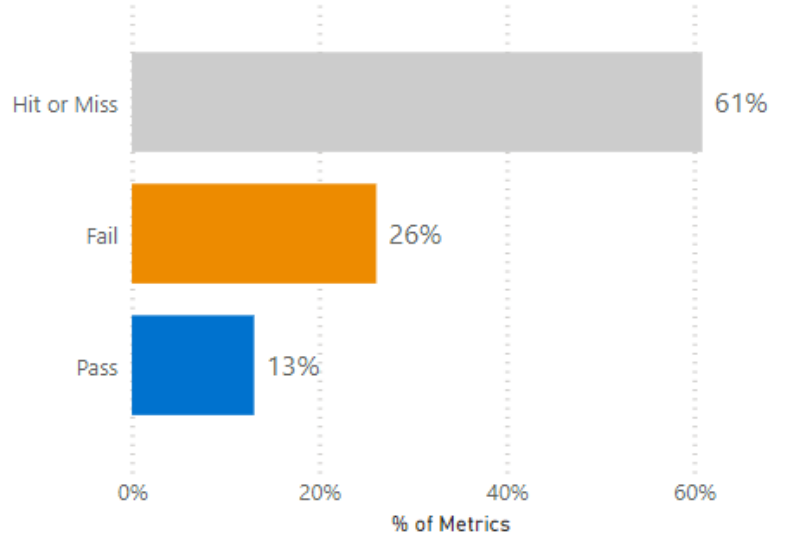
RESPONSIVE CARE

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	Dec-2023	110%	100%	84.33%	93.92%	103.51%		
Provided Bank Hours %	Responsive Care	Dec-2023	0.8%		0.54%	0.72%	0.9%		
Provided Overtime Hours %	Responsive Care	Dec-2023	5.1%		6.27%	8.36%	10.46%		
Provided PAP Hours %	Responsive Care	Dec-2023	4.8%		4.6%	5.36%	6.13%		
999 Operational Abstraction Rate %	Responsive Care	Dec-2023	22.8%	28%		33.69%			
999 Remaining Annual Leave FY	Responsive Care	Dec-2023	16.2%			27.98%			
Vehicles Off Road (VOR) %	Responsive Care	Dec-2023	12.3%	10%	9.94%	12.77%	15.61%		
% of DCA vehicles off road (VOR)	Responsive Care	Dec-2023	13.8%		11.53%	13.97%	16.41%		
% of SRV vehicles off road (VOR)	Responsive Care	Dec-2023	0%		-6.55%	6.5%	19.54%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Dec-2023	118		71.56	140.3	209.04		
Number of RTCs per 10k miles travelled	Responsive Care	Dec-2023	0.65		0.22	0.68	1.13		
% of planned vehicle services completed	Responsive Care	Dec-2023	70%		51.35%	71.22%	91.09%		
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	Dec-2023	100%	95%		91.02%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Dec-2023	65.4%		59.57%	63.28%	66.99%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Dec-2023	6.3%	13%	5.44%	6.6%	7.76%		
Incidents	Responsive Care	Dec-2023	68989		53984.71	60800.05	67615.39		

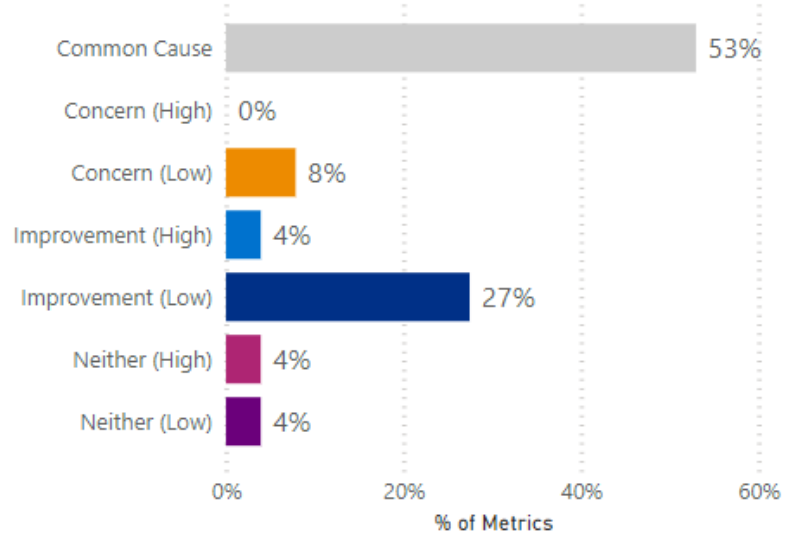
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Dec-2023	115609		67958.13	103771.95	139585.77		
111 Calls Answered in 60 Seconds %	Responsive Care	Dec-2023	25.8%	95%	7.45%	35.16%	62.86%		
111 Calls Abandoned - (Offered) %	Responsive Care	Dec-2023	23.9%	5%	2.17%	18.17%	34.17%		
999 Referrals	Responsive Care	Dec-2023	4956		3807.85	5011.15	6214.45		

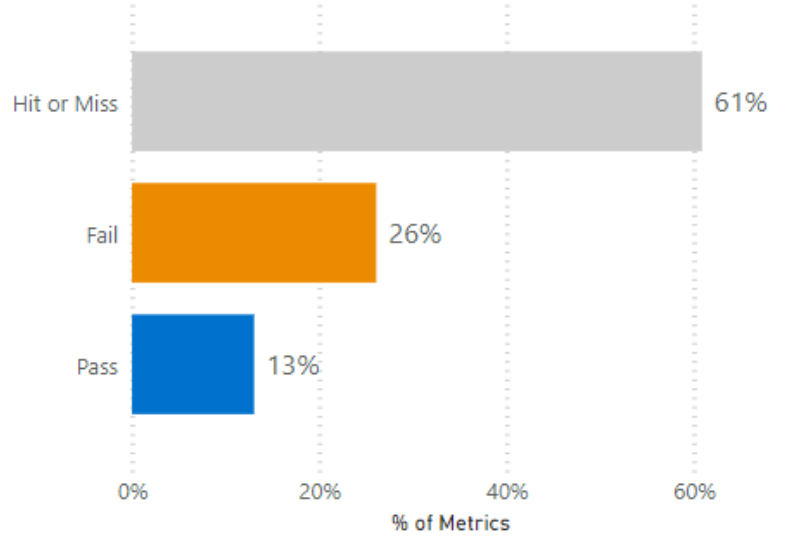
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

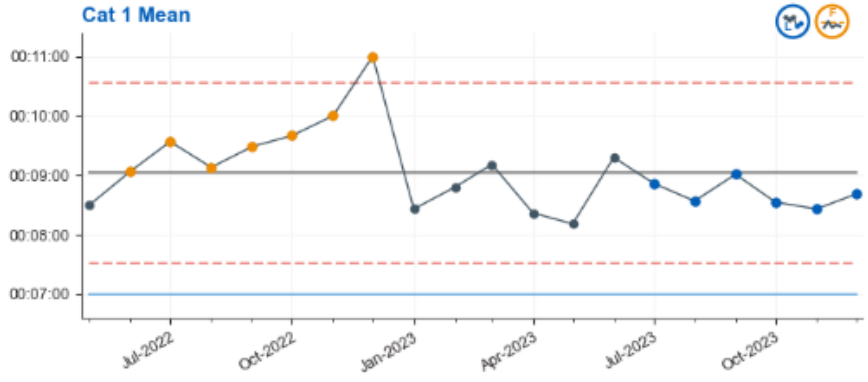
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Dec-2023	01:17:18		01:15:40	01:17:23	01:19:07		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Dec-2023	01:53:34		01:49:59	01:54:15	01:58:31		
Responses Per Incident	Responsive Care	Dec-2023	1.09	1.09	1.09	1.1	1.11		
CFR Attendances	Responsive Care	Dec-2023	999		723.16	1209.8	1696.44		
FFR Attendances	Responsive Care	Dec-2023	95		67.39	167.35	267.31		
ECAL Mean Response Time	Responsive Care	Dec-2023	00:24:48		00:21:42	00:23:43	00:25:44		

111/999 System Impacts

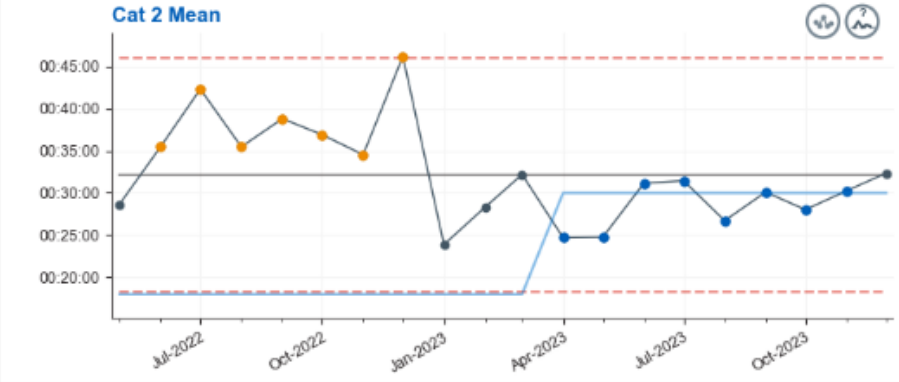
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Dec-2023	13.7%	14%	9.05%	10.58%	12.11%		
See & Treat %	Responsive Care	Dec-2023	31.4%	35%	30.05%	31.49%	32.93%		
See & Convey %	Responsive Care	Dec-2023	54.8%	55%	55.48%	57.8%	60.12%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Dec-2023	1.1%		0.62%	1.27%	1.91%		
Number of Hours Lost at Hospital Handover	Responsive Care	Dec-2023	3758.7		1758.12	3594.01	5429.9		
Average Wrap Up Time	Responsive Care	Dec-2023	00:16:40	00:15:00	00:16:43	00:17:18	00:17:52		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Dec-2023	42.7%		43.98%	46.87%	49.75%		
A&E Dispositions %	Responsive Care	Dec-2023	8%	9%	6.59%	8.3%	10%		
A&E Dispositions	Responsive Care	Dec-2023	6256		4649.38	6313.7	7978.02		
Clinical Contact %	Responsive Care	Dec-2023	53.1%	50%	46.15%	50.52%	54.89%		
Ambulance Validation %	Responsive Care	Dec-2023	51.4%	85%	76.5%	84.61%	92.71%		

RESPONSIVE CARE

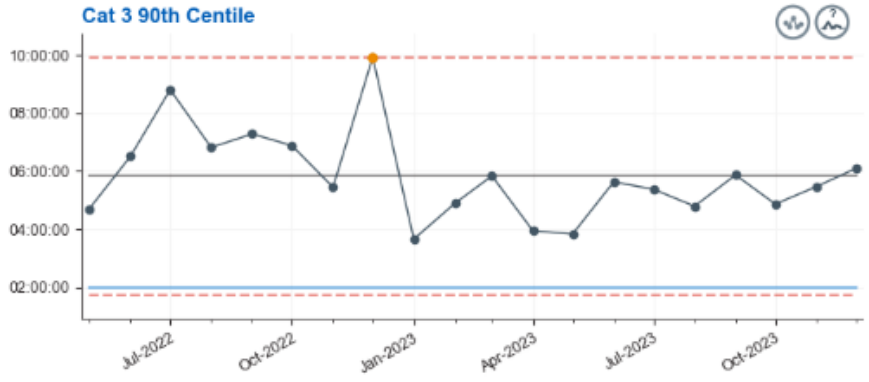
Response Times



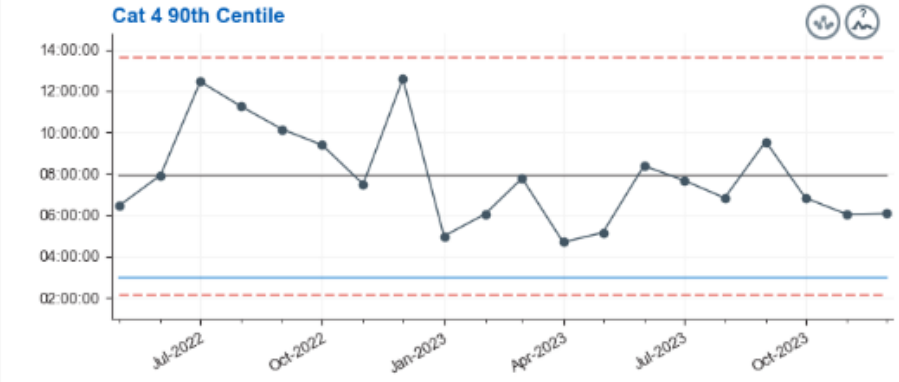
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:41
Target: 00:07:00
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:32:21
Target: 00:30:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-5
Dept: Operations 999
IP: Responsive Care
Latest: 06:05:57
Target: 02:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-6
Dept: Operations 999
IP: Responsive Care
Latest: 06:04:37
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

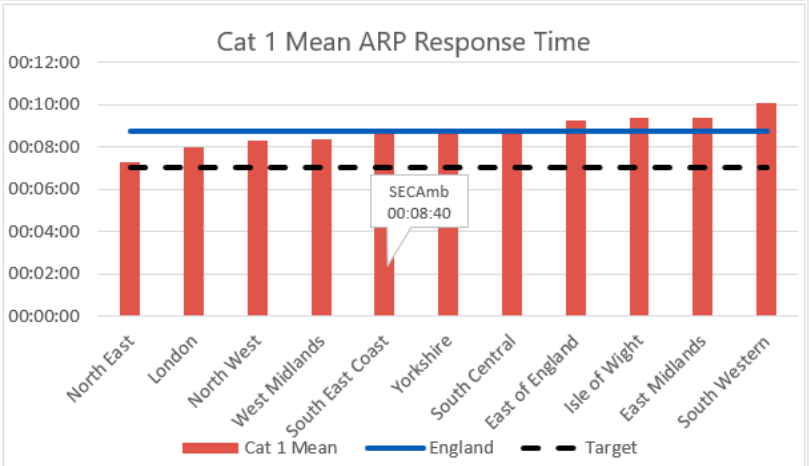
Summary

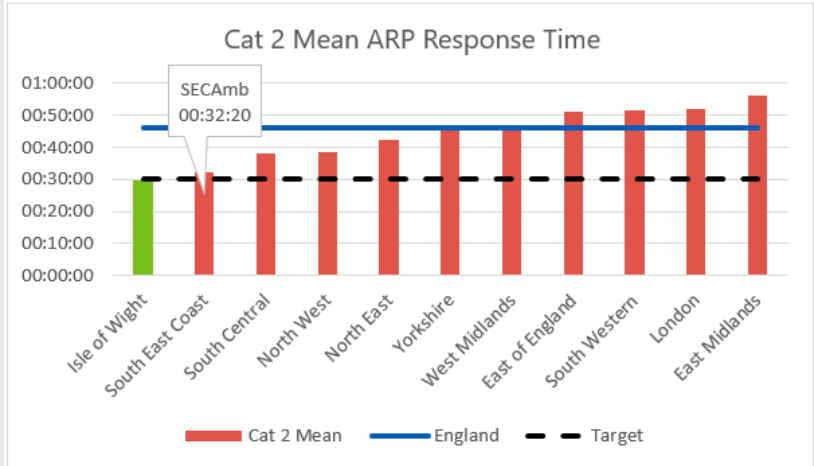
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against the delivery plan – in December 2023, performance was 32mins 20sec, against a national average of 45min 57sec.

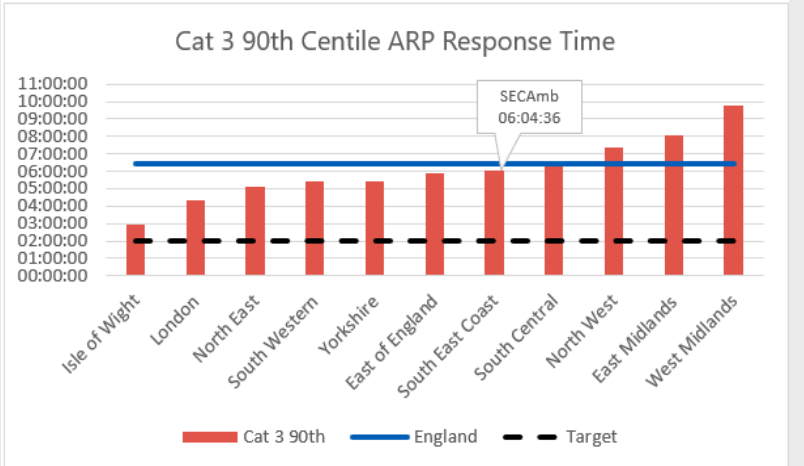
What actions are we taking?

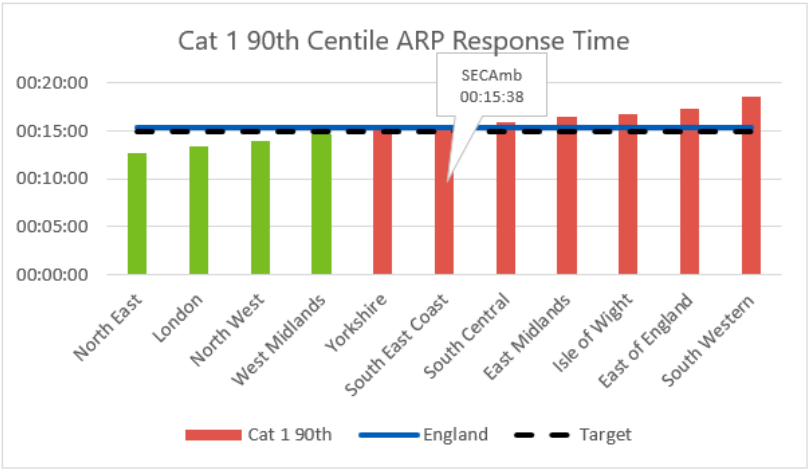
- Continuation of C3 & C4 validation, with a high proportion being validated in either the Trust's 111 (KMS 111) or 999 services. The aim remains to clinically assess every C3 or C4 call prior to ambulance dispatch.
- Continued focus on clinical staffing in EOC to maintain patient safety and support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

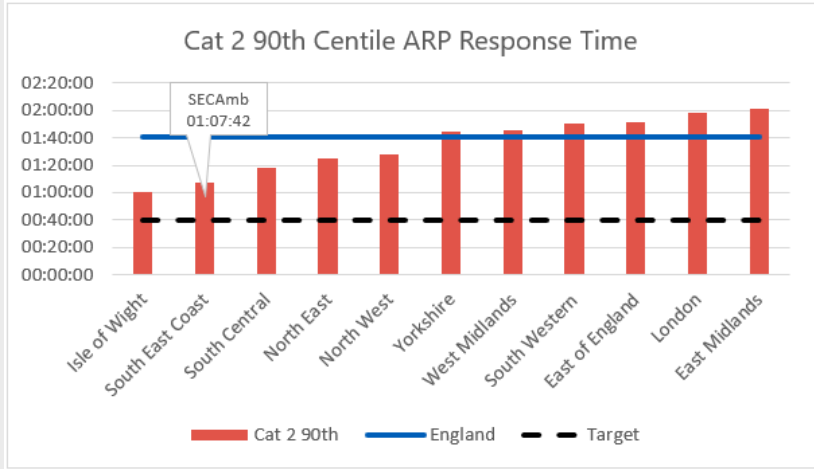
ARP Response Time Benchmarking (December 2023)

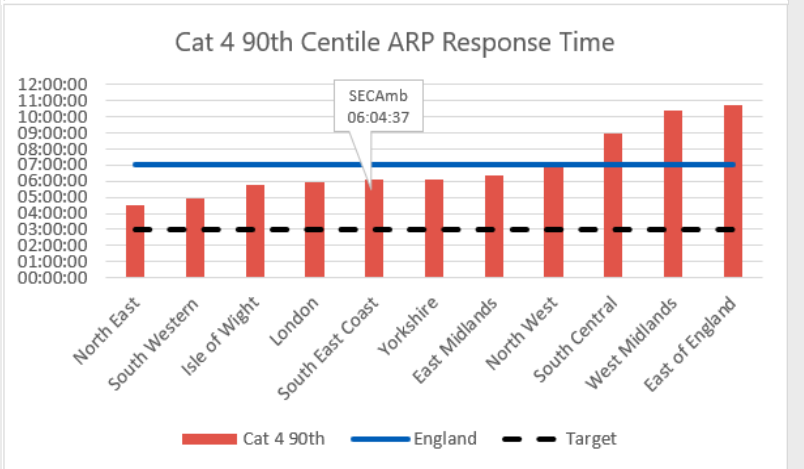










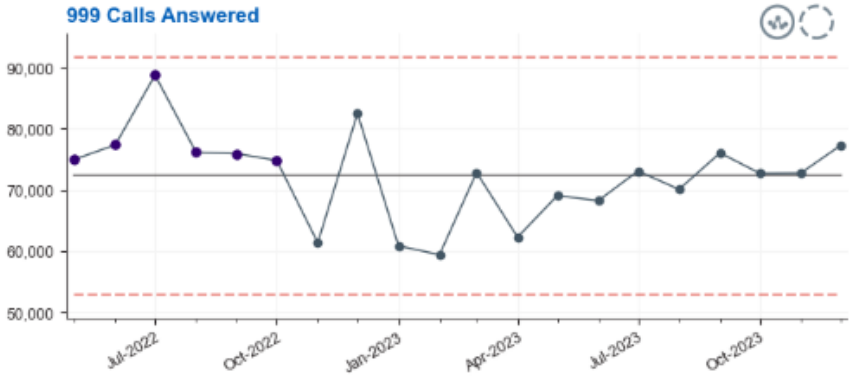


Summary

- 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

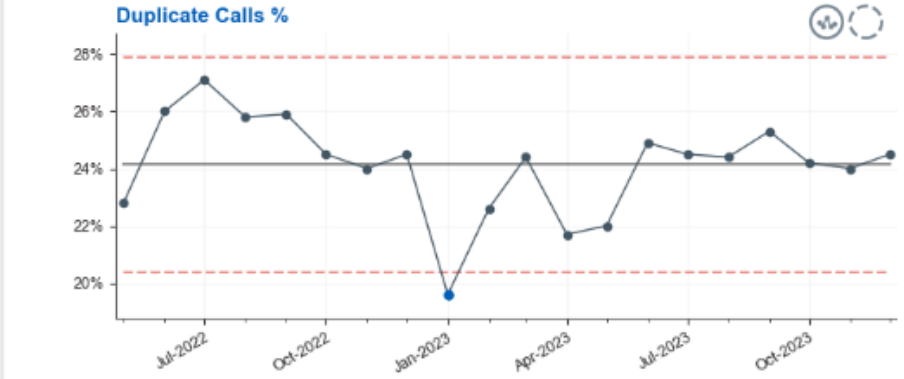
EOC Emergency Medical Advisors



999-10

Dept: Operations 999
IP: Responsive Care
Latest: 77252

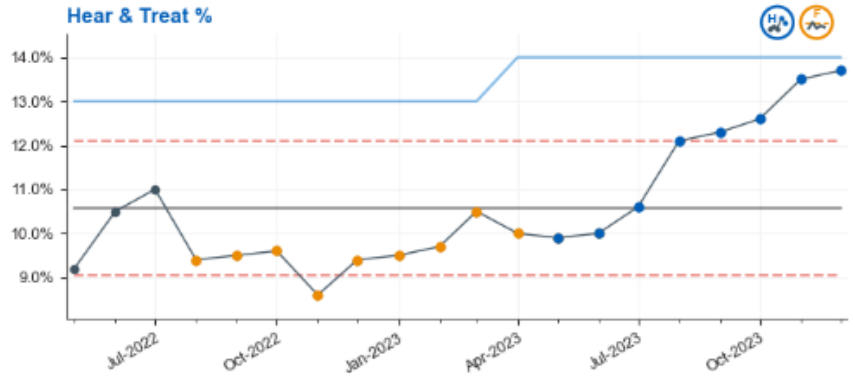
Common cause variation, no significant change.



999-33

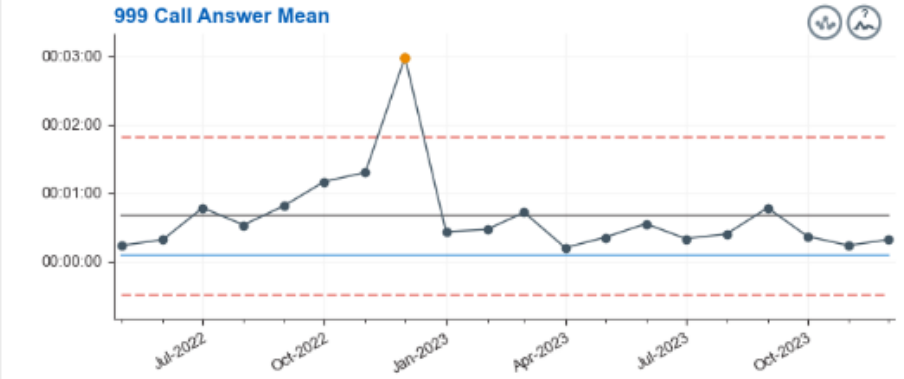
Dept: Operations 999
IP: Responsive Care
Latest: 24.5%

Common cause variation, no significant change.



999-9

Dept: Operations 999
IP: Responsive Care
Latest: 13.7%
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: 00:00:19
Target: 00:00:05
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

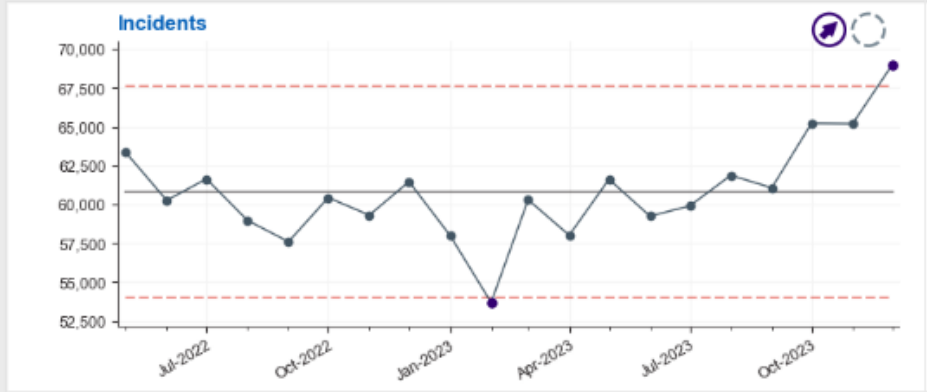
- Call answer mean time continues to fluctuate, underpinned by ongoing staffing challenges and rota inequalities, with a higher proportion of newer staff who are developing, although noting that there has been a general trend in increasing the number of ***calls answered*** over the same period.
- EMA 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).

What actions are we taking?

- EMA establishment is currently below required levels – impacted by the recruitment challenge in the Gatwick area, but with more recent mitigations through the positive impact because of the move to Medway. The end of year target is 264 WTE and dependent on attrition v recruitment rate with the current position being 251.5WTE of which 214 are live and 37.5WTE in training and/or mentoring.
- ***C3 & C4 clinical validation model continues*** and ***C2 segmentation*** is live.
- The ***Hear and Treat*** trajectory is for 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 with tangible enthusiasm to do more!
- A programme of larger recruitment events progresses with noticeable successes for the Medway call centres.#

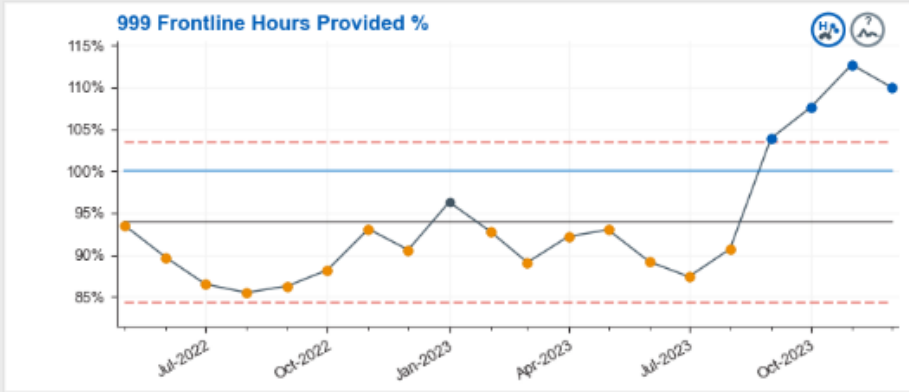
RESPONSIVE CARE

Utilisation

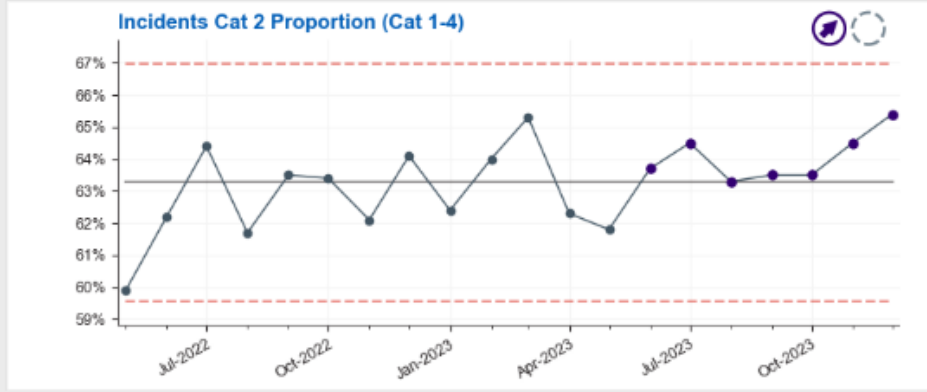


999-10
Dept: Operations 999
IP: Responsive Care
Latest: 68989

Special cause variation where UP is neither improvement or concern

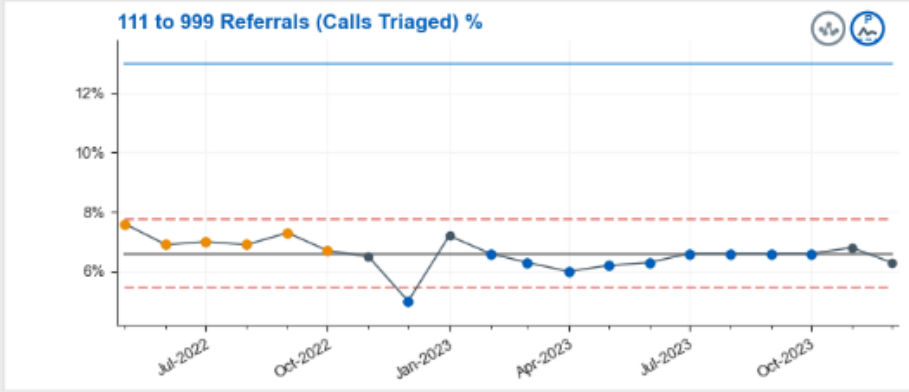


999-12
Dept: Operations 999
IP: Responsive Care
Latest: 110%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



999-32
Dept: Operations 999
IP: Responsive Care
Latest: 65.4%

Special cause variation where UP is neither improvement or concern



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.3%
Target: 13%
Common cause variation, no significant change. This process is capable and will consistently PASS the target.

Summary

- There is a high 111 ***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. Agreement has been reached to continue these additional shifts to the end of the financial year.

What actions are we taking?

- 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

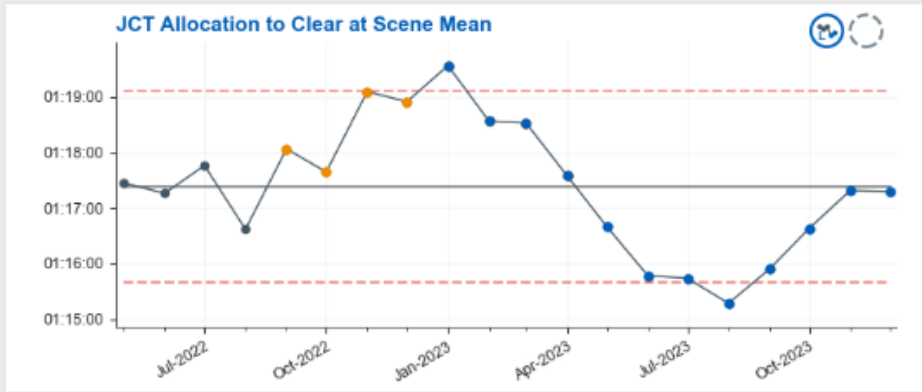
999-17

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: 00:24:48

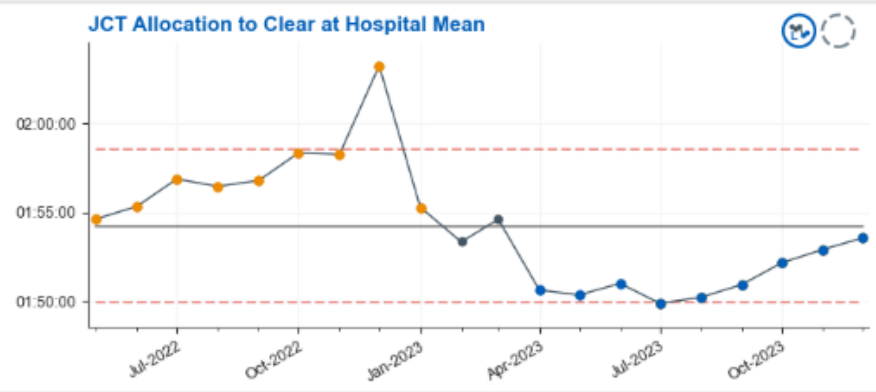
Common cause variation, no significant change.



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:17:18

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



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:53:34

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

Summary

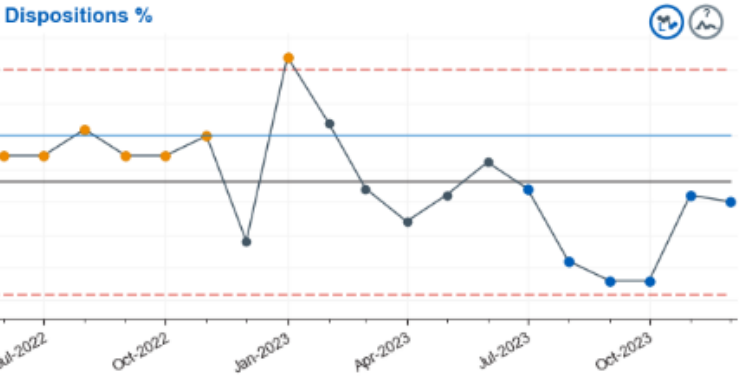
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with common cause variation.
- ***Job cycle time*** (JCT) provides a single 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?

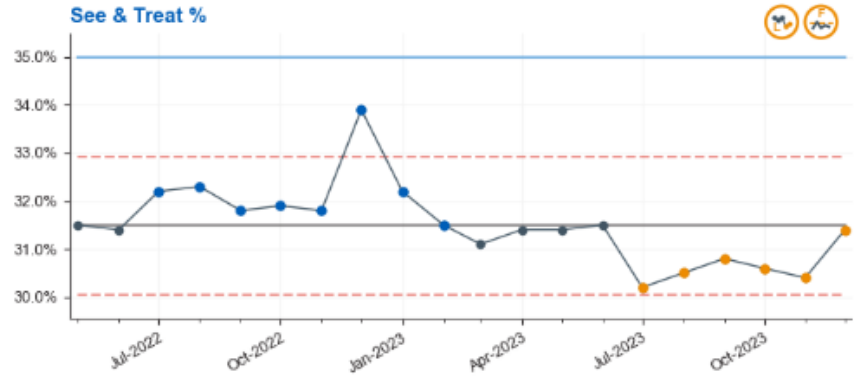
- The Trust commissioned an external ***AACE review of the Dispatch function***, and the recommendations are currently being addressed as part of the Responsive Care Group plan. Phase 1 of this plan was completed at the end of October – phase 2 commences in early 2024.
- Continued focus on delivery of ***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. As system pressures increase, as do hospital handover time across multiple acute trust sites – this is expected over the winter period.

RESPONSIVE CARE

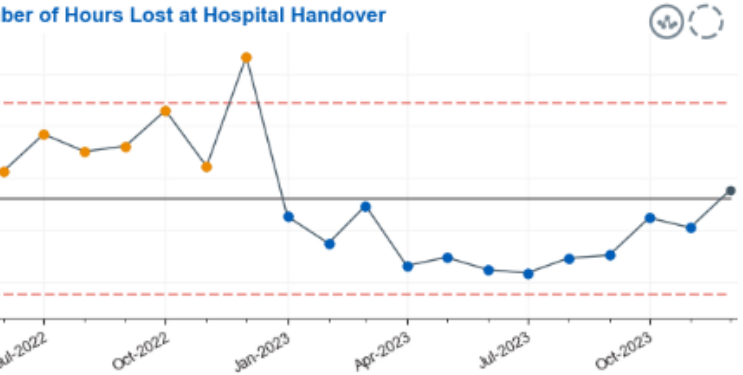
111/999 System Impacts



111-5
Dept: Operations 111
IP: Responsive Care
Latest: 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.

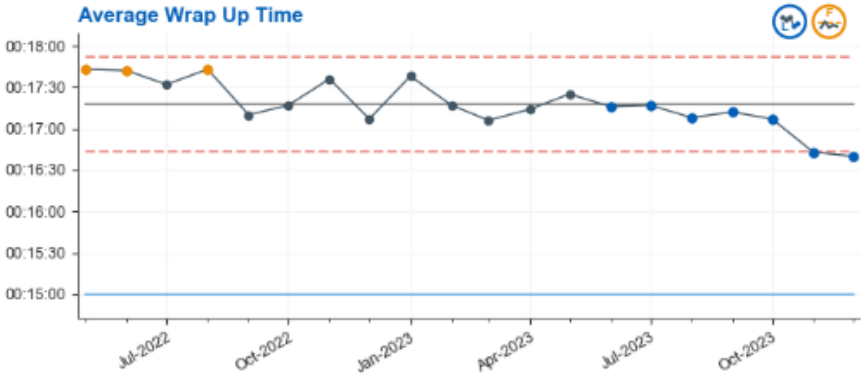


999-9
Dept: Operations 999
IP: Responsive Care
Latest: 31.4%
Target: 35%
Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.



999-24
Dept: Operations 999
IP: Responsive Care
Latest: 3758.7

Common cause variation, no significant change.



999-31
Dept: Operations 999
IP: Responsive Care
Latest: 00:16:40
Target: 00:15:00
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.

Summary

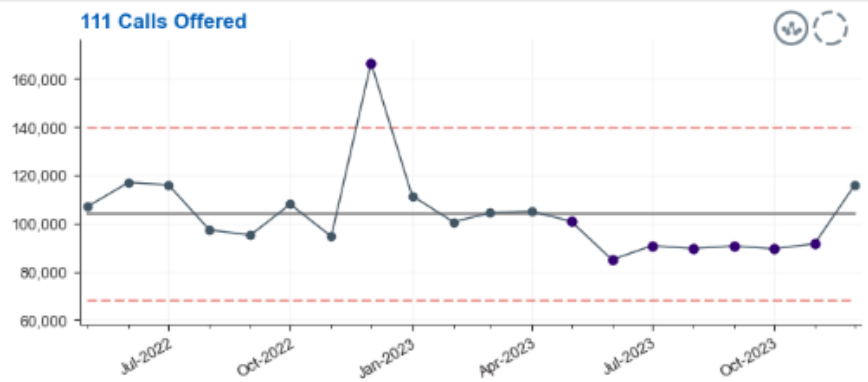
- The ***111 to ED disposition rate*** has been maintained at a very low level since the introduction of "111 First", Direct Access Booking (DAB) and ED validation. The Trust's 111 service has excelled at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111 national average
- The Trust ***See and Treat*** rate has improved to a level of 31.4%, 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

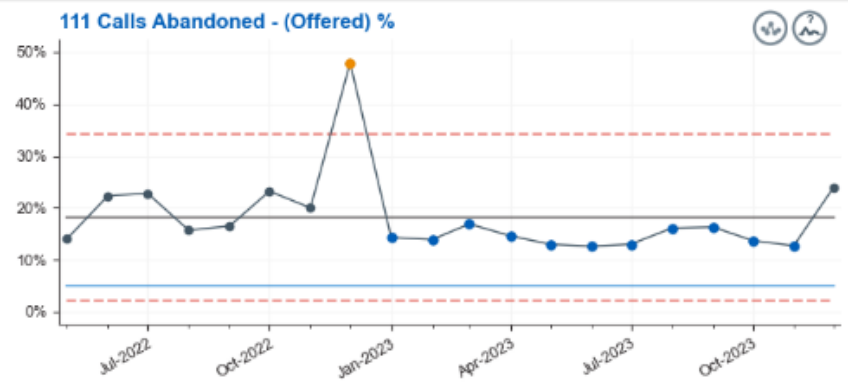
111



111-1

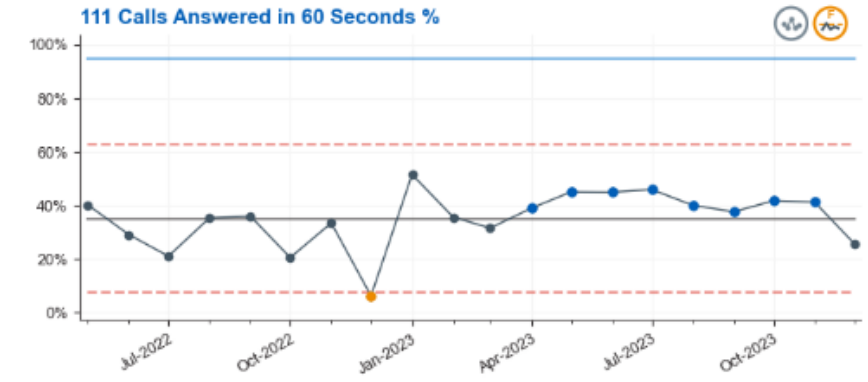
Dept: Operations 111
IP: Responsive Care
Latest: 115609

Common cause variation, no significant change.



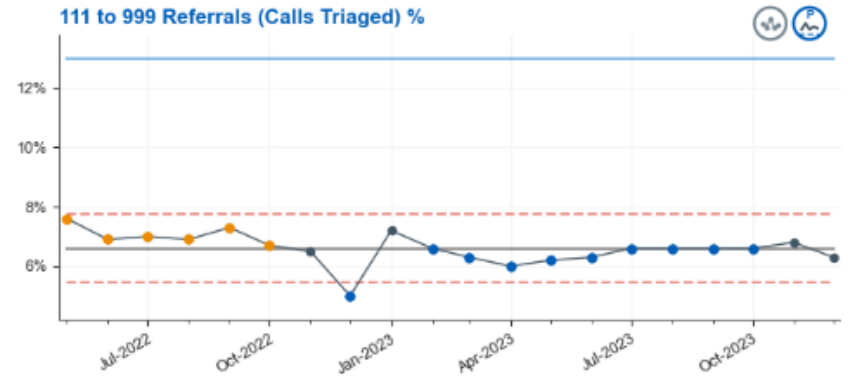
111-3

Dept: Operations 111
IP: Responsive Care
Latest: 23.9%
Target: 5%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



111-2

Dept: Operations 111
IP: Responsive Care
Latest: 25.8%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



111-4

Dept: Operations 111
IP: Responsive Care
Latest: 6.3%
Target: 13%
Common cause variation, no significant change. This process is capable and will consistently PASS the target.

Summary

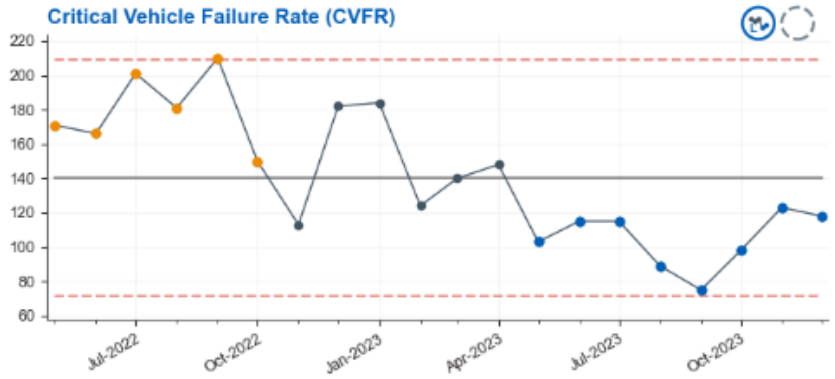
- The service's ***operational responsiveness*** remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned calls.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment 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 over 40 new Health Advisors passing NHS Pathways starting training or going live on the phones over the past two months.

RESPONSIVE CARE

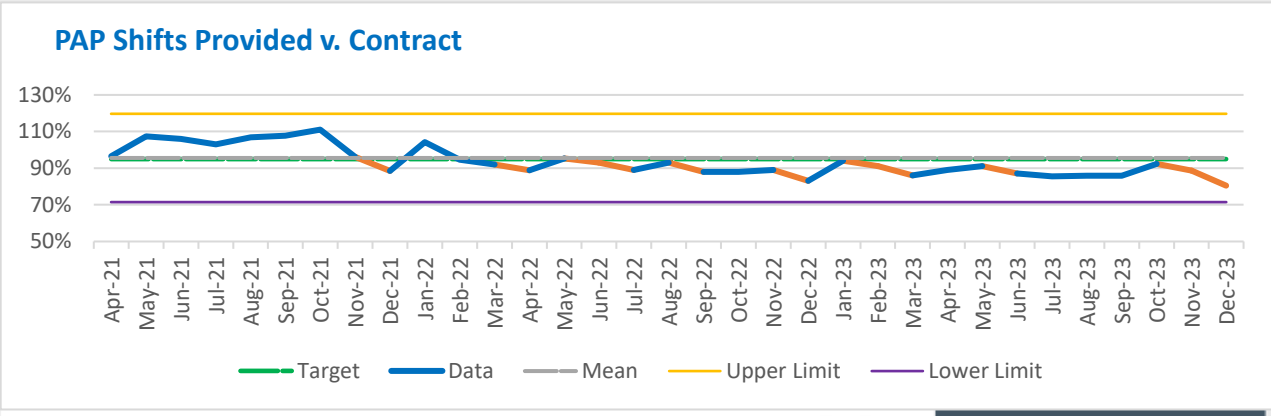
Support Services
Fleet and Private Ambulance Providers

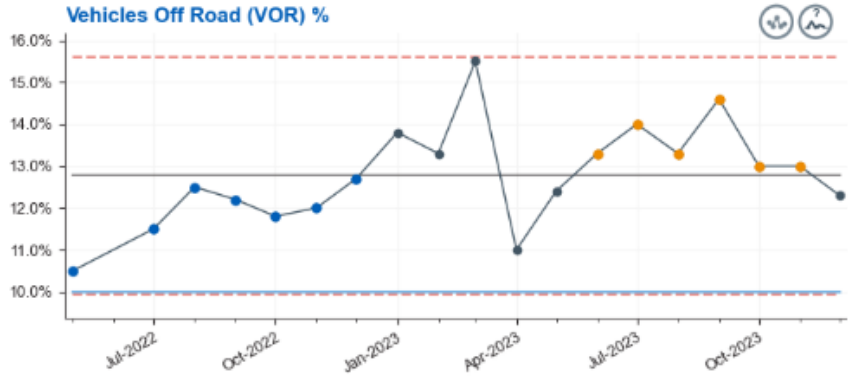


FL-12

Dept: Fleet
IP: Responsive Care
Latest: 118

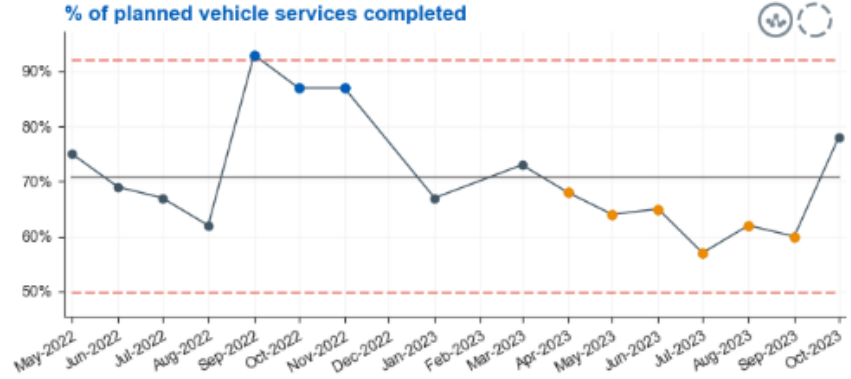
Special cause of an improving nature where the measure is significantly LOWER.





FL-13

Dept: Fleet
IP: Responsive Care
Latest: 12.3%
Target: 10%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



FL-3

Dept: Fleet
IP: Responsive Care
Latest: 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 and reliability of older Mercedes Fleet. 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?

Concerns around parts supply continue to be raised nationally by Fleet Managers and escalated to suppliers regularly..
A vehicle roadshow will take place towards the end of February for staff engagement and feedback of a New DCA the Trust can procure from the new awarded contracts. This vehicle can be either a FIAT or MAN van conversion or a MAN or Ford Transit light weight Chassis conversion (BOX). Business improvement templates have been submitted to increase Fleet workforce in line with required maintenance hours required to carry out planned scheduled maintenance events that will improve VOR and CVFR. These additional staff will be made up of apprentices and WTE vehicle maintenance Technicians.

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. The roll-out of iPads to PAPs was completed in Q3. We continue working with **St John Ambulance (SJA)** to provide additional DCA capacity, however, to date SJA have provided 12 operational shifts in November and 10 in December. under the NHSE/I national surge support initiative. This is due to limited number of SJA staff being able to evidence necessary compliance with relevant qualifications (clinical/driving/DBS etc) for safe deployment to our patients. Engagement with SJA is ongoing to increase staffing levels.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

	December 2023 In the month			April 2023 to December 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	26,579	26,880	302	239,253	242,127	2,874	319,066	322,653	3,588
Operating Expenditure	(26,786)	(27,093)	(307)	(239,295)	(242,162)	(2,867)	(319,068)	(322,655)	(3,588)
Trust Surplus/(Deficit)	***(207)***	***(213)***	***(6)***	***(42)***	***(35)***	***7***	***(2)***	***(2)***	***0***
Reporting adjustments:									
Remove Impact of Donated Assets	*0*	*0*	*0*	*1*	*1*	*0*	*2*	*2*	*0*
Reported Surplus/(Deficit)	**(207)**	**(213)**	**(6)**	**(41)**	**(34)**	**7**	**0**	**0**	**0**

Cash	45,694	36,692	(9,002)	45,694	36,692	(9,002)	50,401	40,376	(10,025)
Capital Expenditure	989	1,381	(392)	13,350	12,422	928	27,055	19,525	7,530
Efficiency Target	1,000	714	(286)	5,788	5,447	(341)	8,988	8,988	0

*values subject to rounding

Summary

1. The Trust's financial performance is £7k favourable year-to-date (YTD) at M9 and it is in line with the planned deficit of £34k. Financial pressures in 111 and HR were mitigated by profit on disposal of Trust assets, mainly Redhill Ambulance Station and higher than planned bank interest received on cash balances held in the bank.

2. The efficiency programme has delivered £5,447k worth of savings at M9 YTD, which represents an under delivery of £341k compared to the £5,788k plan. 73% 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 significant risk that the efficiencies will not deliver the full £8,988k target. This risk will be mitigated against through the delivery of the financial plan of breakeven through non-recurrent measures.

3. The Trust's cash position was £36,692k that is £9,002k lower than plan due to the payment of supplier invoices. The Trust is forecasting a cash position at the end of March 2024 of £40,376k, which is 19.9% below plan. This is due to the increase in making payments to the Trust's suppliers in relation to non-pay and capital.

4. Capital expenditure of £12,422k is £928k below the YTD plan. The capital forecast is £19,525k for the year, which is £7,530k lower than plan. The main driver is the delay in the supply of conversion and customisation of ambulances (right of use assets) – this is a national issue impacting upon the ambulance sector.

What actions are we taking?

1. Finance is working with budget holders to ensure that Trust delivers its plan for the year.

2. Weekly check and challenge reviews are in place to identify new efficiency 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 financial performance 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 e.g. the 111 service.

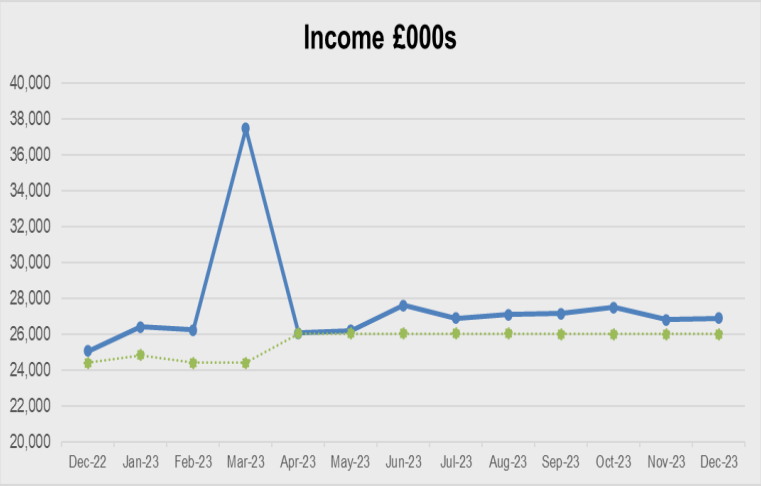
5. The Trust is confident that it will be able to deliver it 2023/24 through the use of non-recurrent measures.

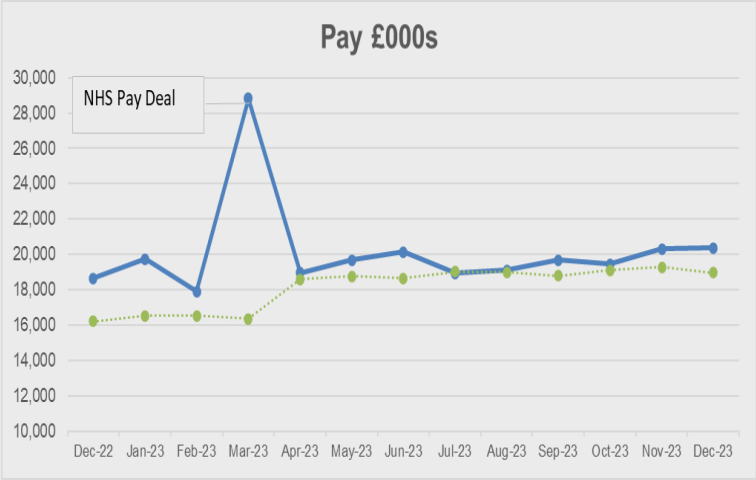
6. In addition, the Trust is developing its 2024/25 operating plan.

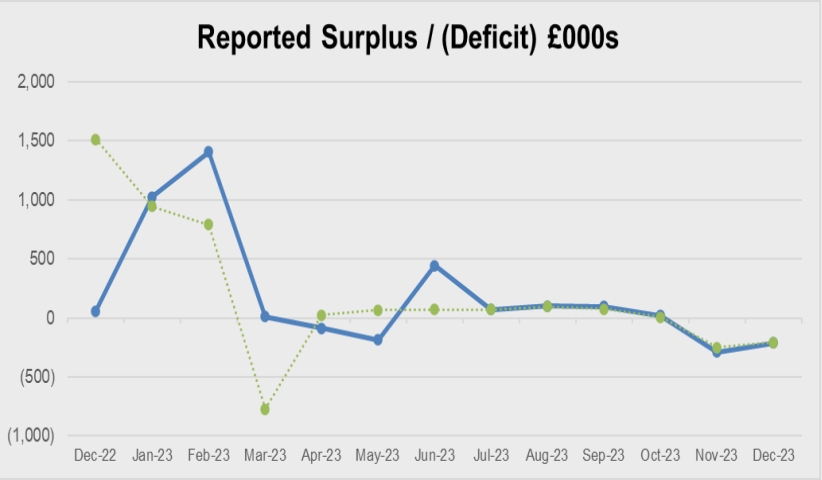
SUSTAINABILITY & PARTNERSHIPS

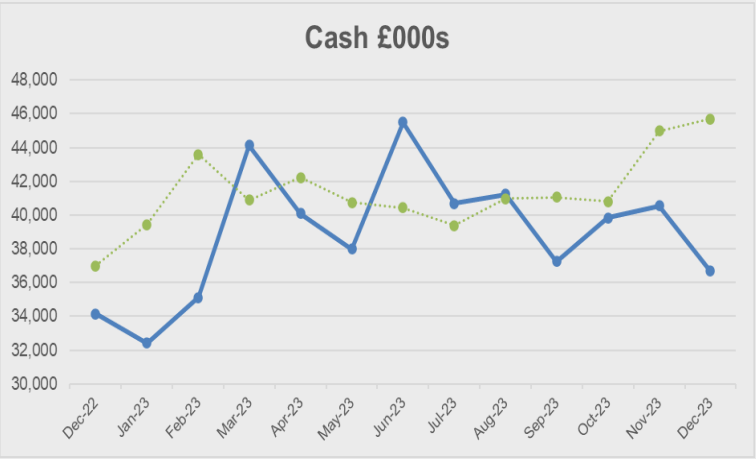
Delivered Against Plan

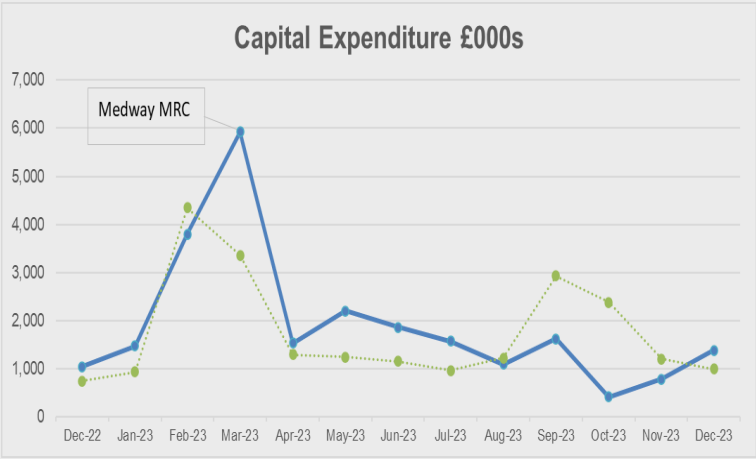
Actual Plan











Summary

- The Trust's YTD M9 financial performance of £34k deficit is on plan.
- Financial pressures, notably in 111and HR are mitigated by non-recurrent means, mainly through profit on sale of Trust assets including Redhill Ambulance Station and higher than planned interest 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 for this was received in June 2023, when payments were made to staff. Capital expenditure is slightly behind plan due to delays in the delivery of new ambulances.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Appendix

Appendix 1: Glossary

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

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	79-23

Name of meeting	Board
Date	8th February 2024
Name of paper	Keeping Patients Safe
Strategic Theme	**Quality & Safety**
Author / Lead Director	Margaret Dalziel, Executive Director Quality & Nursing (interim) Kirsty Booth, Business Manager, Medical Directorate Richard Quirk, Acting 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.

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 being highlighted specifically in this paper are:

- Removal of HSE Notice of Improvement and contraventions.
- Final implementation phase of Datix Cloud and of PSIRF (Patient Safety Incident Response Framework)
- Quality Summit stocktake as we approach exit of RSP
- Medicines Management
- Right Care Right Person
- Cardiac Arrest Outcomes Improvement Project

In addition, the Board is asked to note that the annual Risk audit will be undertaken in February 2024, the results of which will be presented at the Audit & Risk committee. The Executive team are also going to be undertaking an exercise with the wider leadership team in March to review the status and nature of risks held by the Trust in 2023/24 and assess our understanding and alignment to the risks articulated for the coming year as we enter 2024/25. This will encapsulate risks emerging from the strategy, and the journey through RSP. Feedback from this exercise will be reported through the relevant sub-committees to the Board as well as the full Board itself in April 2024.

2. **Health & Safety Executive (HSE) notices – Risk 465** (managing violence and aggression towards frontline staff including CFRs) & **Risk 466 (**managing violence and aggression towards call handling staff)

I am delighted to announce that following the evidence submitted to the HSE on 12th January 2024

in response to the work undertaken to address the areas of concern raised by the HSE resulting in a Notice of Contravention, and an Improvement Notice in October 2023, these notices have now been removed in totality. These were specifically in relation to Manual Handling training, bariatric equipment, and processes, and to Violence & Aggression training and processes for our staff.

The Task & Finish group are to be commended for the unitary approach taken across all directorates and with our staff side colleagues to understand the issues raised, set out solutions to address these and implement them at pace and with the focus and collaboration required to ensure the rest of the organisation were on board.

The group has now commenced a phase 2 which will look to embed sustainable changes in the fields identified, oversee the implementation of Manual handling and violence & aggression training, and then respond to an external review that is currently being commissioned to look at all areas (including the area) of health and safety across the Trust.

3. **Implementation of Datix Cloud and PSIRF – Risk 359 (**Incident and Investigation Management - workstream delays to implementation of DCIQ)

    3.1. The launch for Datix Cloud Incident and Safeguarding modules) occurred on 29 January 2024. The team have worked tirelessly over the past two years to get this set up working alongside the Datix manufacturers to ensure appropriate system that works for our people is the outcome.

    3.2. Complaints module will be launched on 01 February 2024, and the final two modules Learning from Deaths and Claims are to follow.

4. Quality Summit 2024 – Preparing for RSP and sustainability

The Quality Summit takes place on 2nd February 2024, focused on a stocktake of Quality and Safety, Responsive Care and People & Culture in relation to the improvement journey following the CQC report of February 2023. It will encapsulate discussions on the direction of the strategy and how Quality & Safety will remain a joint area for oversight, governance, and improvement. A verbal update will be provided at Board with key points that arose from that day.

5. Medicines Management – Risk 34 (score of 16 in BAF paper) & Risk 27 (score of 15 in BAF paper)

5.1. Update on Medicines Distribution Centre (MDC) Estates Programme

- MDC Phase 1 meetings are progressing with representation from all Directorates and dedicated programme management support now assigned to this project to expedite progress. Phase 1 is due to complete by 31 May 2024, a revised build timeline is due to be presented to the next task & finish group.
- Phase 2 meetings (complete relocation to bespoke area) have commenced with initial discussions being held on potential locations within the Region. Milestones to be set at the next task & finish group.
- In December 2023, the front roller shutter doors became defective. An interim solution working with the Estates team and Rydon has been put in place to allow for medicines deliveries to continue at Paddock Wood MDC, and to meet H&S requirements.

5.2. Changes in the Medicines Leadership Team

- The Chief Pharmacist and Deputy Chief Pharmacist are due to leave the organisation in March 2024.
- Recruitment is underway for the Chief Pharmacist with planned interviews by the end of February, the Deputy Chief Pharmacist post will be out to advert within two weeks with a

view to the interviews being held after the new Chief Pharmacist has been appointed so that they can be part of the recruitment process.
- A risk is being submitted into the corporate register to reflect the status of this change.

6. **Right Care Right Person – Risk 457 (**police withdrawal of response to mental health crisis incidents)

An update on progress to date was submitted to the QPSC on 01 February 2024. Work is progressing with all three Police Forces, cross directorate attendance at these meetings is crucial to SECAmb understanding and being able to address potential risks. Assurance has been given from all Police Forces that if Crews require Police for threats of and actual physical violence a response will still be sent.

7. **Cardiac Arrest Outcomes Improvement Project – Risk 140 (**risk of avoidable death arising from failing to provide resuscitation advice in a timely manner)

This project is looking at all areas of improving outcomes for cardiac arrest patients. One of the projects within this wider programme of works is improving telephone CPR (tCPR), although some improvements have been evidenced, the expected improvements are below trajectory. This is due to limited capacity within the EOC (Emergency Operations Centre,) training team. An alternative representative is being sought to ensure that we can continue to progress this important workstream.

To help the programme get back on track a separate group has been set up with the Critical Care Paramedics, representatives from EOC training, EOC Practice Development and members of the EOC leadership team, to look at improving hands-to-chest times. Representatives from the EOC Practice Development team are supporting this work through audit and are publishing monthly briefing papers on cardiac arrests to understand and improve EMA (Emergency Medical Advisors) responses to address the delays to hands-to-chest.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	79-23

Name of meeting	Trust Board
Date	08.02.2024
Name of paper	Board story
Trust Priority Area	Quality and Safety
Lead Director	Director of Quality & Nursing

This Board Story will help to frame the Quality and Safety section of the agenda, which has a focus on Quality improvement and how our approach leads to better patient care and staff / volunteer experience.

Colleagues from our Ashford Operating Unit will be joining the Board to describe how they used the Trust's Quality Improvement methodology in their approach to the Perfect Month. They will explain the process and the key outcomes.

The Board will then use this to help inform its discussion on the separate quality improvement paper and the section on Responsive Care where some of the approaches have helped provide a relatively good response to patients through the challenging period between December and January.

Recommendations, decisions or actions sought	For Information.

South East Coast Ambulance Service
NHS Foundation Trust

		Agenda No	79-23
Name of meeting	Trust Board		
Date	08 February 2024		
Name of paper	Update on QI		
Trust Priority Area	Keeping Patients Safe		
Lead Director	Margaret Dalziel, Executive Director of Quality & Nursing		
Author	Jo Turner, Deputy Director of QI & Patient Experience		

This paper reflects on progress made over the last year since the Trust's inception of an organisational wide QI approach and its alignment to NHS IMPACT (Improving Patient Care Together) which is the term for the new single, shared NHS improvement approach.

The QI team have successfully developed a systematic and continuous QI approach (QMS and DMAIC) across the organisation over the last year, supporting SECAmb to deliver on our strategy aims and importantly, improve patient care (Keeping Patients Safe in the Stack and Recruitment QI projects). The Trust has seen a positive uptake in the building of QI capability across the organisation and engagement of several early adopters, particularly frontline staff.

The Trust must now ensure that the systematic improvement approach is interwoven in everything that we do. To do this, QI needs to be applied holistically with leadership buy in. It needs to be led and driven by the Board, creating the conditions for success.

As the Trust moves to delivering on the organisational strategy, there is an opportunity to further create the conditions for continuous improvement and high performance, building on what has been achieved over the last year and taking the time required to implement meaningful change.

The Board is asked to reflect on the achievements and success of implementing a QI approach at SECAmb over the last year and consider its role in creating the right conditions for success moving forward, utilising the NHS IMPACT self-assessment tool to generate discussion and action planning.

The Board are also asked to consider the focus of the Board development session on QI on 07 March 2024 and what would be most helpful to facilitate delivery of the next steps proposed within this paper.

Introduction

This paper reflects on progress made over the last year since the Trust's inception of an organisational wide QI approach and its alignment to NHS IMPACT (Improving Patient Care Together) which is the term for the new single, shared NHS improvement approach.

To achieve our strategic goals, we are adopting a Quality Improvement (QI) approach. QI is a systematic and continuous process that aims to solve problems, enhance service delivery, and produce better outcomes for both patients and staff.

This paper particularly focuses on the impact of having implemented a QI approach on patient care and the next steps required to ensure a systematic approach to fundamentally different ways of working.

The Trust's implementation of QI began in January 2023 with the full QI team commencing in post in July 2023. The organisational QI strategy was approved by the Board in August 2023. A timeline depicting the QI journey to date can be viewed in Appendix 1.

Organisational change is a process, not an event. Effective implementation of a Quality Management System (QMS) and QI relies on our people to lead a continually improving system as part of their role. Some colleagues have already identified with this already (early adopters) and some require support to encourage collective motivation to improve. This involves creating the right conditions for continuous improvement which is achievable through delivery of three key enablers as outlined in the QI Strategy:

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

Background

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

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

DMAIC was the framework identified as part of a wider quality management system (QMS). A QMS is a whole organisation pursuit of quality that facilitates knowledge exchange and leadership principles to foster a culture of learning. It integrates a trilogy of quality activities, Quality Planning, Quality Control and Quality Improvement.

Development of QI Capability

There is strong evidence that to support a culture of QI, colleagues need to be empowered with the skills, knowledge and understanding of QI methodologies to feel confident to implement change.

Year to date, 305 colleagues have been trained (6.1% of all staff) in 'Introduction to Quality Improvement (QI)'. Training evaluation (Appendix 2) suggests that this is significantly improving people's motivation, confidence, and competence in QI. This is further evidenced in requests for the team to support over 20 local QI projects (Appendix 3) across the Trust.

The QI team have commenced delivery of a QI induction session at the corporate induction for operational colleagues and in January delivered four virtual key skills QI sessions to 111 and EOC staff. 43% of all Band 8s across the organisation are now trained in QI.

The team have commenced a 10-minute QI taster at the corporate induction to 99 new starters and a QI 'Introduction to Data' one hour masterclass has been developed and these sessions will be available for staff to book on to from February 2024, jointly delivered with the BI team.

A Focus on Patients

Keeping Patients Safe in the Stack (KPSITS)

Between April 2022 and March 2023, within the Emergency Operations Centre (EOC), clinicians closed over 100,000 duplicate calls. Duplicate calls make up 26% of call volume into the service. To address the high volume of duplicate calls that the service receives, impacting our telephone response times, the QI team, working with colleagues from EOC and other directorates have trialled, a revised call closure script. This is designed to better manage patient's expectations regarding a call back, thus reducing the likelihood of patients having to telephone the service to chase a callback or to ask for an update.

The project team have also trialled providing patients with an estimated time of arrival (ETA). The call script utilised to provide this information has been updated to reflect the feedback provided by staff and patient representatives and the functionality to implement this improvement is available within the Computer Aided Dispatch (CAD) system enabling the ETA to be displayed. The EOC Call Handling Procedure has been revised to reflect the required changes and both improvements will be implemented across the organisation at the end of January 2024.

Texting of interim care advice to help support the reduction in the overall handling time for incoming 999 calls, thus allowing a quicker response for patients, commenced on 01 December 2023. Following a call with the service, patients now have the interim care advice sent to them by text. This means that patients have access to this information to refer to post call completion. It is anticipated that this will reduce duplicate call volumes as well as reducing the Average Handling Time (AHT) of incoming emergency calls, meaning that the service can answer calls more quickly and respond to patients more efficiently and effectively. Data is currently being monitored to review this.

Between January to April 2023 over 14,000 welfare calls were made with each call lasting two minutes on average. This equates to 469 hours spent on welfare calls over the period. Text messages are currently manually sent out to cases awaiting a clinical response. A change request has been submitted to enable the CAD to automate these texts regularly throughout the duration of a patient's wait for a response, again allowing increased capacity for clinicians to undertake value adding activity with patients.

A review of duplicate call data also showed that when patients call back within a 24-hour period, they are most likely to be upgraded following a 3rd and 4th call back into the service and the risk of deterioration increases. To address this, a change request has been submitted to create a separate queue for these patients to ensure that they are prioritised.

The automation to close duplicate calls, creation of a separate queue and automated welfare messaging improvements will unfortunately not be going live by end of march as planned due to delays by Cleric. The project team are currently awaiting revised timescales and costs.

Recruitment of EMA's and HA's

Timely call answering is critical to our most acutely unwell patients to provide life-saving advice and ensure safe and effective health outcomes. To support timely call answering for patients, the organisation needs to ensure effective resourcing within the contact centre. A QI project to support improvement in the recruitment of Emergency Medical Advisors (EMA's) and Health Advisors (HA's) was commenced in July 2023.

Several inefficiencies were identified in the recruitment process for EMA's and HA's using baseline data between 1st April 2022 to 31st March 2023. Three main issues were identified.:

- **Low volume of applicants:**
  For the baseline period, there were 1586 HA applications and 1193 EMA applications, totalling 2779 applications. To meet our head count target, the group established that between 150-200 applications are required per month per role, meaning that at the time, the Trust had a shortfall of at least 600 applications for EMA's and over 200 for HA's.
- **Poor Candidate quality:**
  During the same period, 33% of leavers for both roles (160 in total) were dismissed due to not being capable to undertake the role. At the recruitment phase only 14%-19% were recruited out of over 2000 applicants.
- **Drop off rates between stages:**
  In addition to the number of applicants lost due to poor quality, several candidates are lost between various stages of the recruitment process particularly the interview to conditional offer and accepting the conditional offer phases.

In addition to the TTH (Time to Hire) metric several process measures have been identified to ensure that each phase of the recruitment process is as efficient as possible. A dashboard has been developed to monitor these. The tables below provide an overview of metrics that have been added to the IQR and are being monitored by the team.

Baseline period is April 2022-March 2023

Metric	Role	Baseline	Target
Count of Applications	EMA	115 per month	150 per month
	HA	134 per month	156 per month
How long we take to shortlist candidates	EMA	6days	5 days
	HA	6 days	5 days
How long we take to confirm interviews	EMA	12 days	10 days
	HA	10 days	10 days
How long we take to offer the job	EMA	3 days	2 days
	HA	4 days	2 days

Stage	Role	Baseline April 22 to March 2023	Target
% of applicants that apply and progress to shortlisting	HA	77.60%	82.60%
	EMA	83.3%	88.30%
% of applicants that are shortlisted and progress to interview	HA	61.00%	66.00%
	EMA	64.2%	69.20%
% of applicants that pass interview and had a conditional offer	HA	45.00%	50.00%
	EMA	55.4%	60.40%
% of applicants who had a conditional offer and accepted offer	HA	64.60%	69.60%
	EMA	63.1%	68.10%
% applicants that accept conditional offer and pass training *	HA	71.00%	71.00%
	EMA	58.70%	58.7%
% Applicants that apply and then pass training	HA	9.80%	13.50%
	EMA	11.7%	14.70%
% Applicants that are shortlisted and then pass training	HA	12.60%	16.30%
	EMA	13.20%	16.7%

By way of example, shortlisting to interview and the count of applicants for both EMA and HA roles are both suggesting early signs of improvement as the graphs (Appendix 4) demonstrate an improving trend.

Several improvements have been identified and have been implemented. These include:

1. Open days at Crawley & Medway: Three open days to date have led to an increase in applications and this opportunity provides candidates with an improved understanding of the role, organisation, and recruitment process.
2. Targeted social media campaigns are underway including advertising of roles on additional platforms including Tik Tok and Facebook.
3. Unique Trac identifier to be added to all reporting providing the ability to link recruitment and training data. This provides the training, recruitment, and operational teams with the ability to seamlessly track the candidates journey though the recruitment process and beyond.
4. Psychometric testing to improve candidate quality. Baseline data is currently being gathered with launch imminent.
5. Case studies of employees that have progressed from EMA/HA roles to be included in adverts to increase interest for candidates that would like to progress their careers.
6. Portal has been set up to make the process of uploading right to work documentation and other key documentation more efficient leading to a reduction in delays and drop offs between stages of the process.

Clinical Quality Governance Group (CQGG)

Many credible leaders of quality have been attributed to stating that ‘every system is perfectly designed to get the results it gets’. Joseph Juran, a professor in quality management suggested that the key to pursuing quality holistically and embedding it into the health system requires positioning it at the centre of organisational strategy and working to move from the quality as expected to the quality as provided. Closing this gap requires change.

Creating the right conditions for whole system quality requires a shared commitment for continuous learning which is established through shared behaviours and social norms. To support development of this, changes have been made to the agenda framework for the Clinical Quality Governance

Group (CQGG). Utilising a QMS approach, the group are now able to evaluate the performance of the 'quality system', gain assurance and identify and improve any gaps.

Organisations that practice whole system quality look deeply within and beyond themselves to learn how to meet the evolving needs of patients, populations, and communities continually, reliably, and sustainably.

NHS IMPACT

Good progress has been made in implementing and embedding a QI approach at SECAmb. The focus on two key organisational QI projects and the building of QI capability across the organisation has successfully supported a shift in the culture of improvement at SECAmb and delivery of improvements in patient care.

The next steps in the QI journey require full embodiment of improvement across all levels of the organisation starting with the Board. This will enable QI to move from a more transactional support service to a fully integrated approach to everything that that organisation does, from delivery of the Trust strategy to caring for patients on the frontline.

In 2022, NHSE undertook a Delivery and Continuous Improvement Review. The review considered how the NHS, working in partnership, can both deliver effectively on its current priorities and continuously improve quality and productivity in the short, medium, and long term.

The review's recommendations were consolidated into three actions:

1. Establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work.
2. Launch a single, shared 'NHS improvement approach'.
3. Co-design and establish a Leadership for Improvement programme.

NHS IMPACT (Improving Patient Care Together) is the term for the new single, shared NHS improvement approach. NHS IMPACT's five components form the 'DNA' of all evidence-based improvement methods, these principles underpin a systematic approach to continuous improvement:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

The above aligns with SECAmb's QI strategy and the QMS approach being implemented. The NHS IMPACT team have developed a self-assessment tool based on the five components designed to allow organisations to identify their strengths and opportunities for development when applying an organisational wide approach to improvement.

It is timely for SECAmb, a year into implementation of our QI approach, to undertake this assessment to generate discussion and action plan for the next year.

To support commencement of a wider conversation, the Deputy Director of QI & Patient Experience and Head of QI have reviewed the NHS IMPACT self-assessment tool and translated this into a excel spreadsheet (Appendix 6), identifying as highlighted in green, the level where they feel SECAmb is currently delivering organisational improvement.

SECAmb, overall, is delivering on systematic improvement at a level of 'developing' with some areas where the organisation is 'progressing' and some where the organisation is 'starting'. This is to be expected and celebrated after one year of implementation of a QI approach. However, this also provides opportunity to consider what is required to move to a position of 'progressing' or 'spreading' over the next few years. To achieve this, Board level ownership and leadership buy in is required to move the improvement agenda and QI to the next level, providing the organisation with the best possible chance for positive and sustained improvement.

Next steps

1. Over the next year the QI team will focus on delivering the year two objectives of the QI strategy. These include training up to 20% of staff as a critical mass to build improvement capacity and capability. The team also plan to coach and facilitate additional QI projects across the organisation.
2. A Board development day has been planned for 07 March 2024 with biannual updates on the QI programme to be provided to the Board. Board sponsorship and driving of the improvement agenda across the organisation is fundamental.
3. The QI team will work in partnership with the strategy team to determine organisational priorities and areas of focus for improvement work over the next financial year, proposing two new key organisational QI priority projects by the end of March 2024.
4. The QI team will be supporting the PSIRF implementation and reviewing thematic analysis of safety investigations to determine where a QI approach can be utilised to implement effective and sustained improvement.

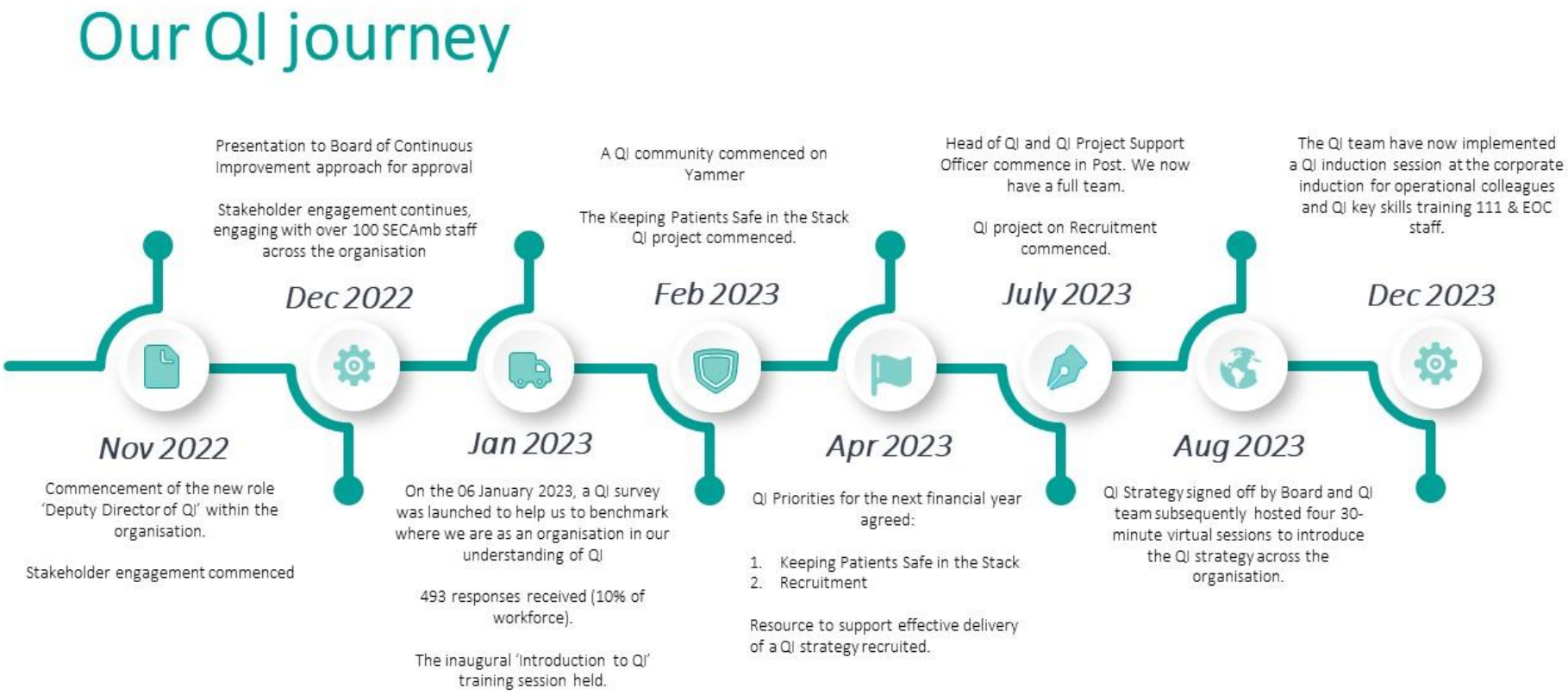
Conclusion

The QI team have successfully developed a systematic and continuous QI approach across the organisation over the last year, supporting SECAmb to deliver on our strategy aims and importantly, improve patient care. The Trust has seen a positive uptake in the building of QI capability across the organisation and engagement of several early adopters, particularly frontline staff.

The journey of fully embedding a QMS and QI approach across the organisation now needs to continue, moving from a more transactional approach to ensuring that the systematic improvement approach is interwoven in everything that we do. To do this, QI needs to be applied holistically with leadership buy in. It needs to be led and driven by the Board, creating the conditions for success.

As the Trust moves to delivering on the organisational strategy, there is an opportunity to further create the conditions for continuous improvement and high performance, building on what has been achieved over the last year to embed meaningful change.

Appendix 1 – Our QI Journey

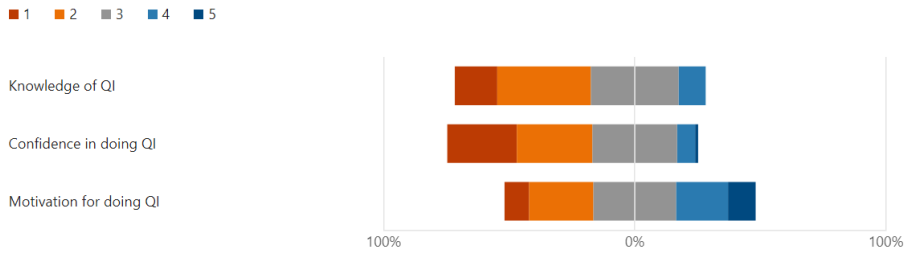


Appendix 2 – Evaluation from Introduction to QI Training

Feedback from participants has been **very positive**. Post training evaluation as demonstrated below indicates **significant increase** in knowledge of QI, Confidence in doing QI and motivation for doing QI. This supports the view that staff understand and are engaging with the training but also are very keen to use what they have learnt in implementing improvements within their teams and directorates.

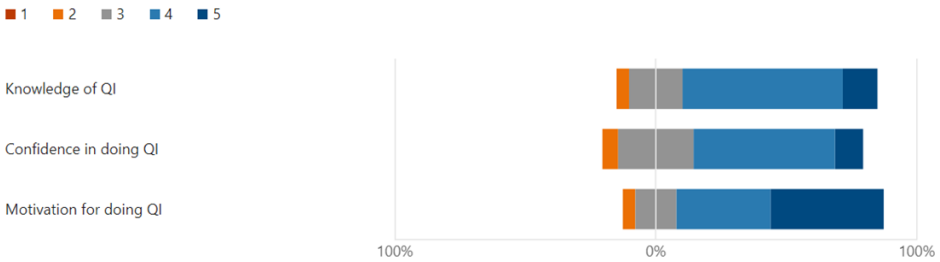
6. Before you completed this training session, please indicate below on a scale of 1-5 (1= no knowledge, confidence or motivation and 5 = high levels of knowledge, confidence and motivation) your current knowledge, confidence and motivation for Quality Improvement (QI)?

More Details



7. Now you have completed this training session, please indicate below on a scale of 1-5 (1= no knowledge, confidence or motivation and 5 = high levels of knowledge, confidence and motivation), your current knowledge, confidence and motivation for Quality Improvement (QI)?

More Details



Appendix 3 – Examples below of some of the QI projects being supported across the organisation.

Medicines prompt card	Developing a medicines preparation guide for all the drug ranges SECAmb administer, due to lack of any current guidance available to frontline staff. This is needed to increase skills and confidence in clinical drug preparation, whilst reducing ambiguity and clinical errors. Lack of guidance could also result in clinical variability in drug administration.
Datix process	End to end process review to identify and reduce any non-value adding steps.
Placement Expansion project	Exploration of contemporary (non-patient facing) ambulance service placements to facilitate support of projected paramedic student numbers. Current practice education model will have insufficient Peds to support student increase – alternate, contemporary ambulance placements need to be developed to address this problem.
Review of 1:1's	Project to review how we undertake 1-1's. Stakeholder engagement is currently underway following feedback from the Staff Survey.
RIDDOR	The Trust has an issue with on time reporting to the HSE for RIDDOR related incidents. This workstream is utilising a QI approach to review the reasons for this and how to address the issues identified.
SECAmb MSc University Students	Currently supporting over 32 student paramedics with submission of their Quality Improvement Project for their MSc University Dissertation.
Logistics/MRC Waste Workshop	This project is reviewing the significant increase in stock holdings at a local level leading to increased expenditure, lack of visibility of trust-wide stock holdings, increased waste, and poor overall management of key items such as PPE.

Appendix 4 – Data from Recruitment QI Project

Figure 1: **Shortlisting to Interview (EMA's)**

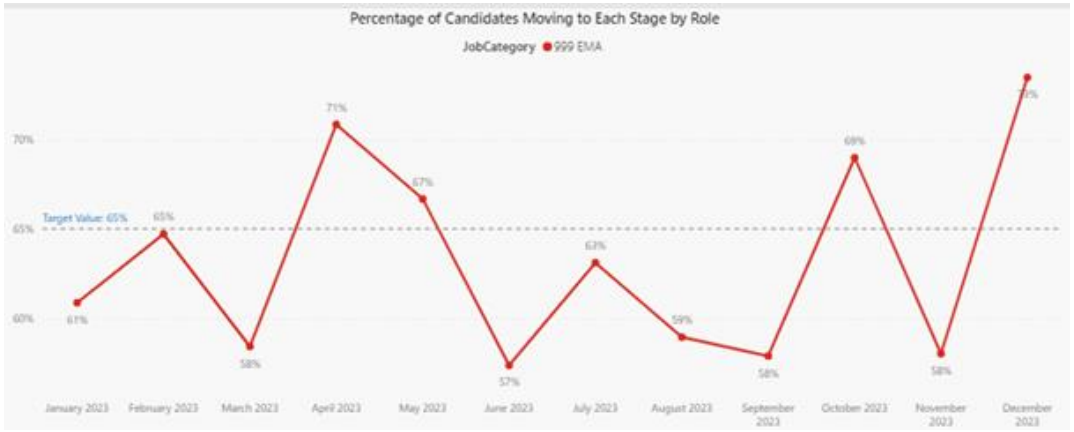


Figure 2: **Shortlisting to Interview (HA's)**

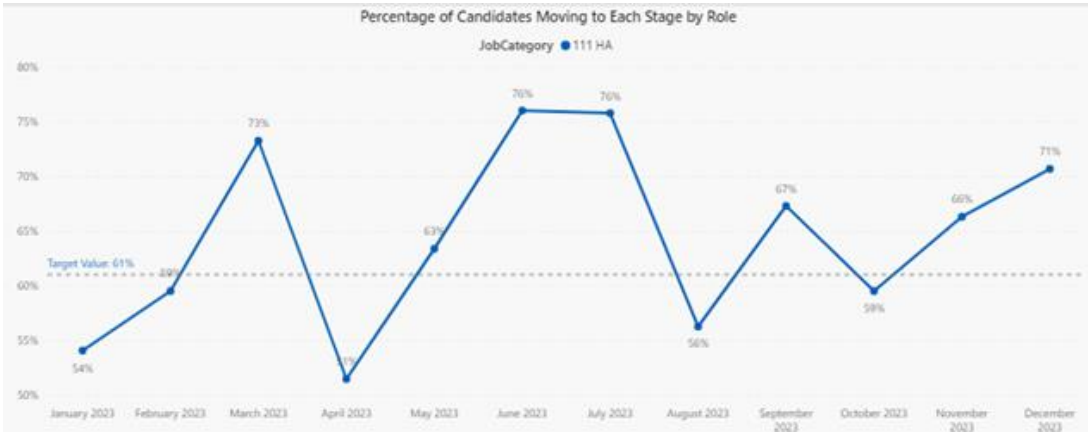
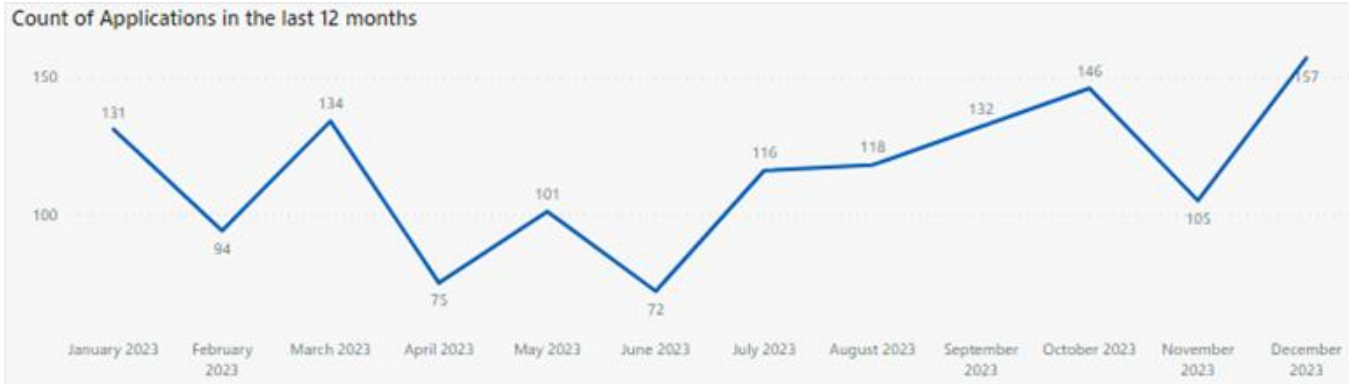
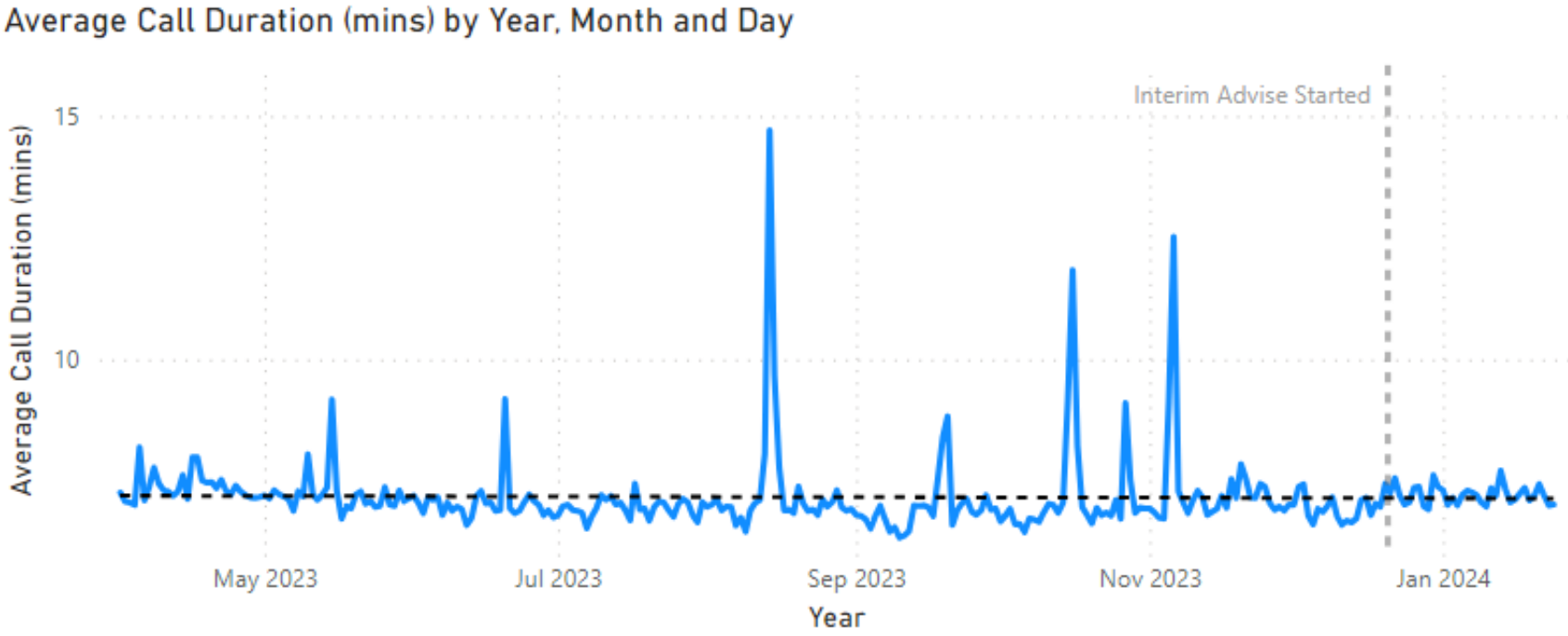


Figure 3: **Count of Applications (EMA's)**



Appendix 5 – AHT data



Appendix 6 – NHS IMPACT (assessment as identified by DDQI & Head of QI – Jan 2024)

	Starting	Developing	Progressing	Spreading	Improving & Sustaining
BUILDING A SHARED PURPOSE AND VISION					
Board and executives setting the shared purpose and vision	We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our Board. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.	Our Board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Our Board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (for example, operations, quality, financial and people/workforce)	Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated with and understand our shared vision in a way that means something to them.	Our vision and shared purpose is well embedded and often referred to by the board and all leaders, who can bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.
Improvement work aligned to organisational priorities	Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all our teams.	Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.	Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.
Co-design and collaborate - celebrate and share successes	We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused at Board level.	The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Our improvement goals are developed and refined through a collaborative engagement process, which at least involves senior leaders and most managers and a two-way feedback process.	We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Our senior leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.
Lived experience driving this work (patients, staff, communities)	There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.	People using services, unpaid carers, staff and the community are involved in the design and communication of our shared purpose and vision and may have a role in setting improvement priorities.	Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.	Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at Board level, including setting the strategic direction of the organisation and any working with the wider system.
INVESTING IN PEOPLE AND CULTURE					

Pay attention to the culture of improvement	There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.	Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (for example, using a cultural survey or the NHS staff survey) and readiness for improvement.	Our improvement approach considers culture as an integral aspect involving all functions of the organisation, recognising the value they bring to enabling organisational improvement. Most improvement activity starts with ways to actively engage staff and teams from all areas in supporting improvement goals and effective delivery of care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	Senior leaders and managers at all levels understand their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to senior leaders and managers when they are 'walking the floor'.	We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (for example, NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits people using services and carers. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.
What matters to staff, people using services and carers	Our ways of understanding what matters most to staff, people using services and carers tend to be reliant on formal mechanisms (for example, surveys) and the link to improvement is not strong or systematic.	We understand well as an organisation what matters most to staff, people using services and carers, and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Most of our services and functions have a good understanding of what matters most to staff, people using services and carers, and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (for example, through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patients and carers into improvement priorities or goals.	Most of our teams have a good understanding of what matters most to staff, people using services and carers, and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have available to participate in improvement activity which matters to them.	Most of our staff can describe what matters most to them, people using services and carers, and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for people using services. People with lived experience often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.
Enabling staff through a coaching style of leadership	There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (for example, through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities	A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities to help unblock issues. Senior leaders participate in improvement celebration and learning events on a regular basis. Staff generally feel supported and empowered.	Senior leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers/clinicians/staff participate in improvement celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.	A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our senior leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.
Enabling staff to make improvements	Improvement activity is limited and may be centralised (for example, led by a discrete 'improvement team' operating independently). Staff do not generally feel able to make improvements in their own area of work.	Some staff and teams feel able to make improvements (for example, if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.	Most staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	Most teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative) and can solve problems effectively.	Staff and teams are systematically engaged in improvement activity as part of their day-to-day work and are proactive in sharing the learning, and in looking for ways to collaborate with people with lived experience and other teams and organisations in improvement programmes.
DEVELOPING LEADERSHIP BEHAVIOURS					
Leadership and management development strategy	Our Board, executive and senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.	Our executive and senior leadership team have started to develop their improvement knowledge and are gaining an understanding of how it can impact their role.	Our executive and senior leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.	Our executive and senior leadership and management teams actively enable staff to own improvement as part of their everyday work, and all teams and staff have had training in improvement.	Our Board focus on constancy of purpose through a multi-year journey and executive hiring and development, including succession planning. Our Board is visibly linked to future planning at a system level.

Board, executive and senior leadership and management values and behaviours	Our executive and senior leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach. Existing behaviours could do more to promote the health and wellbeing/psychological safety of staff.	Executive and senior leadership values and behaviours (that acknowledge the health and wellbeing/psychological safety of staff) are agreed across our organisation.	Executive and senior leadership values and behaviours (that acknowledge the health and wellbeing/psychological safety of staff) are agreed, and role modelled by leaders and managers across the organisation.	Executive and senior leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to. Existing behaviours actively promote the health and wellbeing/psychological safety of staff.	A clear framework and expectations for executive and senior leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.
Senior leadership and management acting in partnership	The goals our executive and senior leadership are working to could benefit from greater clarity and alignment.	Most of our executive and senior leaders work in partnership with their fellow leaders and managers.	Our executive and senior leadership team have shared goals with the organisations they work with in their wider systems.	Our executive and senior leadership team has shared longer-term goals with network partners and/or commissioners, as well as collaborative involvement over the wider health economy	Our Board and wider system focus on constancy of purpose through multi-year journey with improvement at its core.
Board development to empower collective improvement leadership	Our Board discusses improvement at Board meetings, but it is not a regular occurrence.	Our Board has received some improvement training and visits parts of the organisation at least monthly. Improvement is discussed at every board meeting.	Our executive and senior leadership works with managers and teams across the organisation to enable and co-ordinate improvement.	Our executive and senior leadership and management teams actively enable staff to own improvement as part of their everyday work.	Our leaders – chief executive officer and chair through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care/operational work is delivered.
Go and see' visits	Some senior leaders spend time engaging directly with staff from time to time, but it is not routine or widely practised. This can be in person during 'go and see visits' or virtually.	Our executive and senior leaders understand the importance of engaging directly with staff, but we have variation in leader participation; some leaders and managers use our improvement tools.	Our executives regularly engage directly with staff; they incorporate the tools and methods into their meetings, strategic planning, and daily management.	All levels of leadership and management engage directly with staff as a matter of routine and the insights they gain inform decision making and problem solving to support improvement.	All levels of leaders and managers undertake regular learning or 'go and see' visits at external bodies to visit their site and to observe different ways of working.
BUILDING IMPROVEMENT CAPABILITY AND CAPACITY					
Improvement capacity and capability building strategy	We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (for example, academic health science networks and Institute for Healthcare Improvement Open School).	Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.	Training is a balance of technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing improvement capability	Sustainability is addressed via 'in-house' training and development approaches including train the trainer models. Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.	There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with more than 80% coverage. Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation shares capability, building learning with other sites, regionally and nationally.

Clear improvement methodology training and support	No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development and training needs for NHS IMPACT components, alongside a dosing formula and training strategy to support capability building ambitions.	Clarity exists on which improvement methodology and approach is being consistently applied. There is a longer-term commitment to training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.	Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, people with lived experience and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.	Learning from improvement activity is driving continuous improvement. There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.
Improvements measured with data and feedback	Our organisational approach to reviewing and tracking progress against goals has yet to be defined. At present improvement doesn't feature in whole organisational measures.	We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad hoc, and stakeholders do not feel it supports them to deliver	We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.	Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required. Data analysts and business intelligence teams are integral to tracking improvement.	Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer-term sustainability are reviewed regularly at organisational level.
Co-production	We have small discrete teams with relevant skills operating independently from one another. They are working in silos reporting to various senior leaders with no lived experience partners co-producing improvement.	People with lived experience are infrequently co-producing improvement. Learning is captured when doing improvement, but this is rarely shared across departments	People with lived experience and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, people with lived experience and other stakeholders have access to improvement capability development.	Stakeholders including people with lived experience are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively together.	Stakeholders are both supported and challenged to ensure success. People with lived experience and wider stakeholders are embedded within teams and are an integral part of the capability building process.
Staff attend huddles	Any huddles are only traditional legacy mechanisms (for example, shift change clinical handovers).	There is a plan in place for team huddles to focus on continuous improvements in some areas with clinical and operational staff in attendance.	The majority of areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all clinical/operational/support areas.	All clinical/operational/support areas have continuous improvement team huddles established.	There is a cascade of huddles for all teams from executive to frontline teams (clinical/operational/support) which hold regular continuous improvement huddles using a standardised format and process.
EMBEDDING INTO MANAGEMENT SYSTEMS AND PROCESSES					
Aligned goals	Where improvement plans exist they are very locally determined and driven. Our strategic planning is an activity conducted at Board and senior leadership level but executives' and functions goals are often not well aligned with each other.	We do not share improvement planning across our organisation with departments and directorates feeling siloed. Our business planning is an activity conducted at executive leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Our organisational goals are established to support our overall vision; our department/team goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.

Planning and understanding status	Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Our business planning and performance management processes give the executive leadership team reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.	Our business planning and performance management processes give the executive and senior leadership team and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff from enabling services (for example, human resources, finance, communications, information) understand our improvement priorities and embed them within and across their work across the organisation.	Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff from enabling services understand our improvement priorities and embed them within and across their work across the organisation.	Our business planning and performance management processes give good visibility of status and progress against our goals across all teams and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.
Responding to local, system, and national priorities	We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead, it is perceived as reactive or firefighting.	Across the organisation, we believe having a management method (for example, lean) is important to our success. Some of our leaders are using management methods, which is recognised to be helping.	Most senior leaders and managers in the organisation use our management methods to manage and run their areas, including responding to problems that may arise or to take account of changing priorities.	Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG (red, amber, green - a risk management rating system) or tables. Our business decisions are aligned with our management system goals.	All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (for example, SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.
Integrating improvement into everything we do	Improvement is seen as separate to the day-to-day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply and may be sending conflicting signals within the organisation.	Improvement is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some areas.	Improvement is generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many areas across the organisation.	As part of our management system, all parts of the organisation are using improvement methods, and learning occurs between areas (for example, to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not just month-to-month variation.	The way we understand, manage and improve performance across the organisation, including how we use and report data, is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	79-23

Name of meeting	Trust Board
Date	08.02.2024
Name of paper	Quality & Patient Safety Committee Escalation Report – February 2024
Author	Tom Quinn, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 01.02.2024 and confirms whether any matters require specific intervention by the Trust Board.

The meeting started with Executive Escalation, which is where the committee is made aware of any new / emerging issues. This may lead to the committee asking for more information / assurance at a future meeting. There were three issues:

1. **Medicines Distribution Centre**
   As confirmed at the finance committee, Phase 1 is on track to deliver by May 2024, which addresses the urgent people-related issues that impact quality. A key driver of this work is the Chief Pharmacist who leaves the Trust shortly. The deputy is also leaving and the recruitment for both is in progress to help mitigate any gap.

2. **Bariatric Care**
   The HSE Improvement Notice is now closed following the immediate action taken in response to the issues identified. With regards bariatric care, there is an evaluation of our approach which is on track. This is an opportunity to better establish the true number of bariatric patients to inform the model going forward; we will likely see an increase over time. The committee has asked for a scrutiny paper in Q1 of 2024-25. In the meantime, the People Committee will continue to oversee the H&S controls.

3. **Right Care Right Person**
   An update was provided highlighting the risks with police services not being aligned with the implementation dates. There is assurance on the plans we have in place but this is in the context of some unknowns. A written update on this risk will be considered at the next meeting.

Item	**Link to BAF**
Management Responses	QI Goal 2 - Become an organisation that Learns from our patients, staff, and partners.

There were two management responses, addressing gaps in assurance from previous meetings:

- **Operation Carp**

Only a small number of actions remain in progress and a closure report will be considered by the Audit Committee in Q1. However, the committee noted that the policy covering personal relations at work is still not concluded. The executive were asked to follow this up.

- **Anti-Microbial Stewardship**

A helpful paper was received giving details of the antimicrobial stewardship activities in the Trust and our compliance with the standards outlined in the code of practice for the Health and Social Care Act (Regulated Activities) Regulations 2014. In summary, there are good processes in our 999 service where we compare strongly with our peers, for example, we are able to demonstrate how we use electronic data of patient interactions to monitor and evaluate antimicrobial usage. However, there is more to do in 111 CAS where actions have been identified.

The committee was assured that the baseline assessment will inform the improvement in controls. The development of an antimicrobial policy for the Trust is a priority.

Clinical Supervision	N/A

The clinical supervision pilot project (Guildford OU) ended on the 31 December 2023. The project has led to the development of a model of clinical supervision that can be rolled out at organisational level. This paper described the extrapolated impact on job planning for staff as part of an implementation plan that is recommended to be aligned to the Trust strategy operating model. The committee highlighted that clinical supervision is a regulatory requirement for all registrants and so the option to delay implementation to align with a currently undefined future state carries risk. The paper focused on Filed Operations, and the committee requested further information on how clinical supervision will be applied to other relevant staff e.g. our nurses.

The committee also challenged the pace of roll out with 5 years being considered too long. The executives responded that this will be expedited, but reinforced that maturity of the model will take 3-5 years. It was agreed that the priority was to get supervision in place and that the quality will grow over time.

The committee reinforced that clinical supervision is about improving the quality and safety of patient care through reflection and learning – the paper didn't emphasise this enough, which the executive accepted and will address.

In summary, the committee felt it was good to get to this point as this aspect of our 'Golden Thread' has been a long time coming. It is very keen to see this implemented as soon as possible.

Integrated Patient Safety Report	Quality & Safety Goals 1-3

This integrated report continues to develop and helps to bring all the work together. Improvements are being maintained overall across all patient safety metrics within the Trust, with ongoing plans in place to continue this momentum and embed changes. The themes remain consistent, which enables the learning from investigations to feed into the Trust wide improvement programmes. The Patient Safety Incident Response Framework (PSIRF) went live in January, with the new Learning Framework to be rolled out from July 2024

The committee was particularly assured with the way risk is being triangulated which helps to identify improvements in patient care. The analysis of the data from complaints related to 'staff attitude' is informing different interventions e.g. through training, via the clinical education team. Another example from the report related to the care for patients with asthma (extract below).

The Trust identified a theme relating to cases of life-threatening asthma with 14 Datix incidents raised in relation to asthma patients, five of which reported the patient as having died.

Two of the above cases were declared SIs and one had an after-action review commissioned. The findings of the investigations resulted in learning for the EOC and have resulted in:

- *Changes to NHS Pathways (subsequently implemented) and further recommended changes under review by NHSP.*
- *Changes to the 'Nature of Call' element of Cleric that are currently being developed.*
- *Review and understand whether there is a need for the PGD for magnesium to be changed.*
- *Review the wording for the use of thoracostomies within acute life-threatening cases of asthma.*

Establishing a 'learning from events' platform and framework is a focus of this year with the Head of Patient Safety leading on this development collaborating with Medical and Operations Directorates to ensure clear coordination and distribution/accessibility of learning as a catalyst for change.

Clinical Key Skills Plan 2024-25	
Noting the review by the People Committee of the full training plan, this focussed on the clinical key skills element, the committee receiving assurance regarding the process for identifying and prioritising content and ensuring quality and consistency through the planned delivery mechanism.	

Strategic Objectives	Quality Improvement - Objectives 1 & 3 Risk 14 – Operating Model

QI Objective 1 - *Quality Improvements on how we keep patients safe in the EOC stack during periods of escalation and at points of discharge:*

One of the central aims of this objective is to reduce the volume of duplicate calls to give more time to assess patients. There are some system improvements needed requiring the support of the CAD provider, which have seen some delays that will result in this objective not being completed by Q4, e.g. automated duplicate call closure and welfare text messaging. The executive is helping to ensure all the parties are supported in implementation of the required developments.

QI Objective 3 - *Training and engagement in QI for our people:*

To date, 13 'Introduction to QI' training sessions have been delivered to 202 colleagues with further sessions planned for the rest of the 23/24 financial year. In addition, the team have facilitated other QI activities and training for another 188 colleagues, with 20 QI projects are being supported. The committee is really pleased to see that our people across different parts of the Trust are embracing QI and keen to utilise the methodology to address local issues.

Serious Incident Management Plan – Internal Audit	QI Objective 4 – SI processes
The committee noted the update on the management actions agreed following the Internal Audit earlier in the year. Each one is on track to be delivered with the final one being the updated policy by June 2024.	

Annual Reports

As part of its annual cycle, the committee considered at this meeting two annual reports.

1. Clinical Audit 2023-24

This comprehensive report provided a good level of assurance with delivery of the clinical audit plan. The committee explored how we use outcomes to improve services and the recent Quality Summit is a good example where audit outputs have informed the focus on health inequalities.

The trust is good at using data at a high level, but the executive acknowledged there is more work to do to improve how we use data to inform local priorities; the approach to having more local quality leads will help to address this. In addition, there are discussions on how we use system quality collaboratives to ensure learning.

2. Cardiac Arrest 2022-23

This is the second annual report which is a year in arrears to due to the need for data validation. The report demonstrates greater clarity on the different links in the chain on survival e.g. the association between use of public access defibrillators results and markedly improved survival but highlights the need to increase availability and use of these devices. Mobilising system and communities is also a focus of the Quality Summit.

The committee reinforced the important focus on areas with greater social deprivation, where cardiac arrest patients are less likely to receive bystander CPR or have access to a public access defibrillator, with correspondingly lower survival; we need to work as a system to help address these inequalities.

The work of all those involved in the audit, and the clinicians attempting resuscitation is commended. In the reporting period 271 lives were saved for a condition where survival was rare only a couple of decades ago.

Specific Escalation(s) for Board Action	There are no specific areas requiring escalation to the Board. The committee welcomed the quality and timeliness of the papers, which helped support discussion and scrutiny of assurance. It was also good to see different colleagues attend to present papers.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	80-23

Name of meeting	Trust Board
Date	08 February 2024
Name of paper	Operational Performance & Efficiency
Strategic Theme	**Responsive Care**
Author / Lead Director	Emma Williams, Executive Director of Operations

Executive Summary

Introduction

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. The data and narrative within the IQR also provide evidence of service line improvement and areas of continued challenge.

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

1. 999 Call answering.
   Whilst December performance remains consistent with that seen in the previous months, impacted by the increase in calls answered, delivery of the agreed actions continues focusing on recruitment, retention, optimising efficiencies, and external call handling support.
   Associated risk: Operating model to meet ambulance quality and performance standards *[Risk 14, BAF risk].*

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

1. Continued working on national programmes – Manchester Arena Recommendations.
   Current focus is on working up a full business case to cover all recommendations for ambulance services across England. This has been benchmarked against proposals from other ambulance services and is due for presentation to regional ICB commissioners in early 2024.
2. Improved utilisation of clinical resources.
   Renewed focus on utilisation of falls-trained CFRs to support patients who are on the floor having fallen. Advanced Paramedic Practitioners continue to further enhance their support of local patients suitable for 'hear and treat', and clinical decision making for on-scene crews, particularly when considering pathways alternate to the Emergency Department.

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

1. Late shift over-runs and on-day out-of-service
   Initial evaluation results from the Ashford trial are showing some local improvements in both late sign-offs and on-day out-of-service losses. Contributing factors will be considered to ensure that learnings can be incorporated into service delivery models in other areas.
2. The move to Medway for 111 & EOC from Ashford & Coxheath
   Whilst the physical move has been completed, the following risk remains. However, feedback is that the 'trial' period to a cohort of staff to enable them to test the feasibility of the move

and/or supporting remote delivery options has been more successful than initially considered resulting in lower numbers of staff departures. It is therefore expected that this risk will be closed shortly.

Associated risk: Implications of the move to Medway on staff morale and turnover [Risk 84] – The risk that the move from Ashford and Coxheath may negatively impact staff due to the need for relocation and hence the impact on service delivery & performance.

Resilience & Specialist Operations

- HART: Recruitment uplift plans are in place for the upcoming financial year, recognising some additional challenges as NARU transitions from the previous host in the West Midlands Ambulance Service to the London Ambulance Service.
- SORT: Delivery plan on track with sustainable strong performance, with the improvement programme now transitioning into maintenance and sustainability.
- ***Associated Resilience & EPRR risks***

  EPRR Incident Response [Risk 29]: *The Trust may not be able to guarantee an appropriate response to an incident of an EPRR nature and therefore may fall short of the requirements outlined in the Major Incident Plan and NHS EPRR Framework primarily due to ongoing capacity and demand.*

  Adverse Weather conditions [Risk 45]: *Recognition of the increasing number of adverse weather events including wildfires, storms, and excessive temperatures, all of which may affect the Trust's ability to provide an effective service.*

  National Security Risk Assessment (NSRA) - Pandemic/Infectious disease outbreak [Risk 120]*: There is a risk that a pandemic/disease outbreak may overwhelm the Trust's ability to respond effectively.*

  Aging equipment will compromise the Trust's CBRN response [Risk 467]: *A national issue relating to the age of equipment and availability of replacements.*

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
- ***Associated Risk: Clinical Demand and Long waits in clinical queues [Risk 95]*** – If demand outstrips clinical resources in 111, patient call-back performance will outside the NHS Pathways timeframe for response which may lead to patient harm and poor experience.

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	80-23

Name of meeting	Trust Board
Date	08 Feb 2024
Name of paper	Summary of SECAmb delivery over winter 2023-24
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Emma Williams, Executive Director of Operations
Update summary	This paper provides an update on the Trust's service delivery over the winter period (December & January), particularly in consideration of the winter plan shared through the autumn 2023.
Recommendations, decisions, or actions sought	For Information

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

Summary

South East Coast Ambulance Service (SECAmb) has thus far successfully navigated a mild winter characterized by intermittent cold snaps, storms, and isolated flooding. Despite these challenges, the implementation of the Winter Plan was well received, providing assurance to the wider system about consistency of care and response.

Throughout the season, SECAmb's performance has faced continuing operational challenges, however, it has consistently tracked well against national Ambulance Quality Indicators in the C2 field. (See Supporting information) Call answering remains a challenge, but the trend is improving with January 2024 showing a 10 second mean. Through continued collaborative working across all localities, promotion of local pathways as alternates to emergency departments continues for both clinicians within SECAmb Emergency Operations Centres, and those within field operations. This has been exemplified within the Maidstone and Ashford pilots which have had a significant impact on patients, providers and the wider system – lessons and best practice are being identified and quantified through the reviews and evaluations being undertaken.

SECAmb 111 service and its Clinical Assessment Service (CAS) has continued to protect the 999 service and wider healthcare economy during this winter period, deflecting demand and activity away from our 999 service and the local emergency departments. In particular, the capability to direct appointment book (DAB) patients to alternative outcomes/destinations has assisted in minimising unheralded demand across the regions Emergency care service providers. The CAS and its-multi disciplinary clinical team can meet the varied urgent care needs of the regions' patients with a focus on achieving a rapid response to most high acuity patients, for which the service again leads nationally on benchmarking, providing assurance, high quality care and safety for its patients.

A key strength of the winter period has been the ongoing partnership and engagement across the four Integrated Care Boards. ICB's are going through their first iterative winter as organisations with increased delegated authority, and SECAmb has been at the core of that response as it has formed. Notable challenges have been addressed through weekly system calls, offering a proactive approach to risk management and collaborative problem-solving. This ongoing process has proven to be an effective methodology, allowing early intervention in identified issues having a direct impact on the ambulance sector.

The wider NHS has faced ongoing industrial action across the winter period, with a combination of both Junior Doctor and Consultant strikes, along with Allied Health Care action. SECAmb has continued to collaboratively manage this disruption within the wider system with minimal impact on its own response through system working and comprehensive contingency plans. This ability to adapt to external challenges ensures that SECAmb maintains service continuity while upholding patient care standards.

Throughout the winter season, SECAmb has remained vigilant in monitoring quality and harm through its established processes and procedures. This commitment to oversight ensures that patient safety issues are swiftly identified and addressed, safeguarding the well-being of patients. In conclusion, SECAmb's response to the winter period has illustrated its resilience, adaptability, and dedication to delivering high-quality patient care. By leveraging effective partnerships,

proactive risk management strategies, and close system collaboration, SECAmb has effectively navigated the Winter season while ensuring patient safety.

Supporting information

Demand

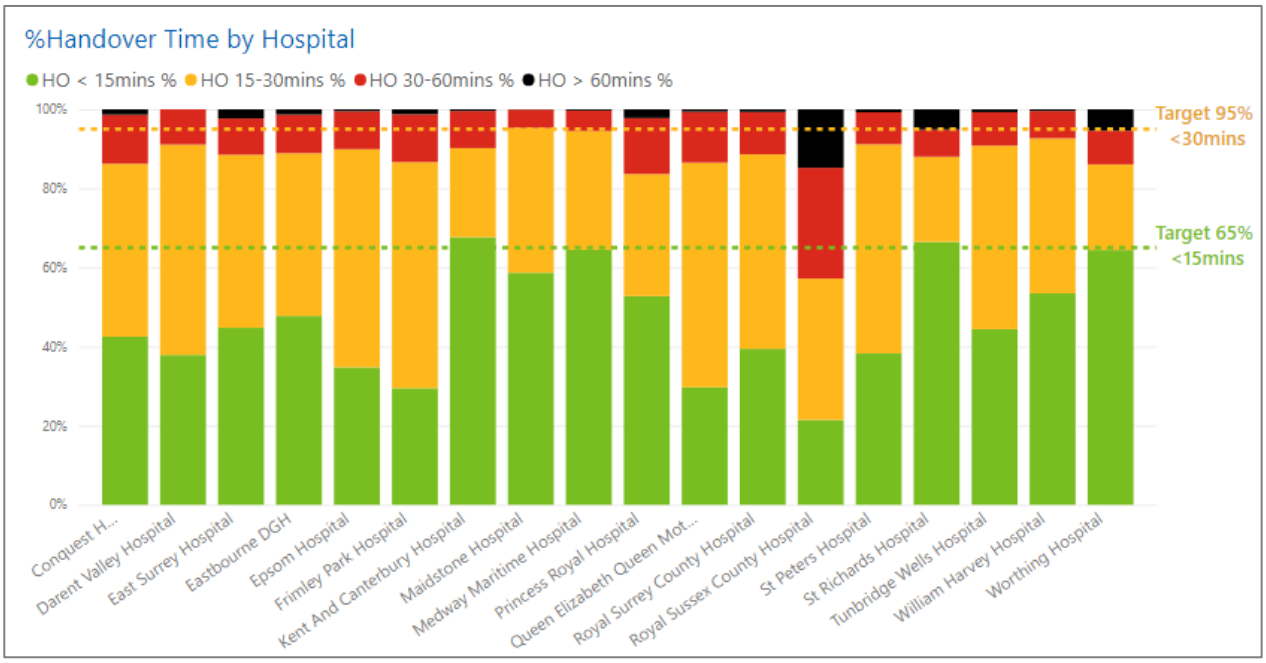
- December – 4.3% above plan
- January – 8% up on plan

Performance

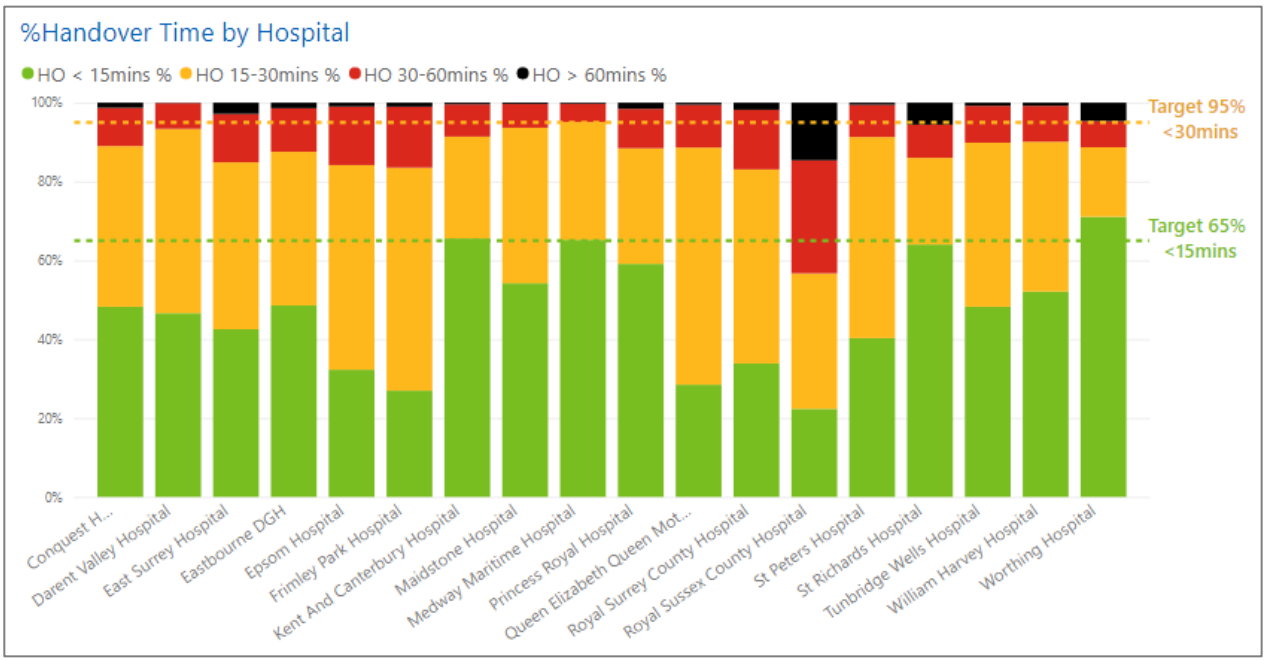
Metrics		Dec 2023	Jan 2024
Call answering	Mean	00:00:18	00:00:10
	90th centile	00:01:14	00:00:39
C1	Mean	00:07:47	00:08:04
	90th centile	00:13:57	00:14:40
C2	Mean	00:24:54	00:25:38
	90th centile	00:48:34	00:51:40
C3	90th centile	06:06:11	03:58:01
C4	90th centile	05:08:43	04:55:09
Hear & treat		12.35%	12.49%
See & treat		33.18%	31.97%
See & convey		54.46%	55.55%
Hospital Handover time (avg)		00:19:30	
Wrap-up time (avg)		00:16:45	

Hospital handover data

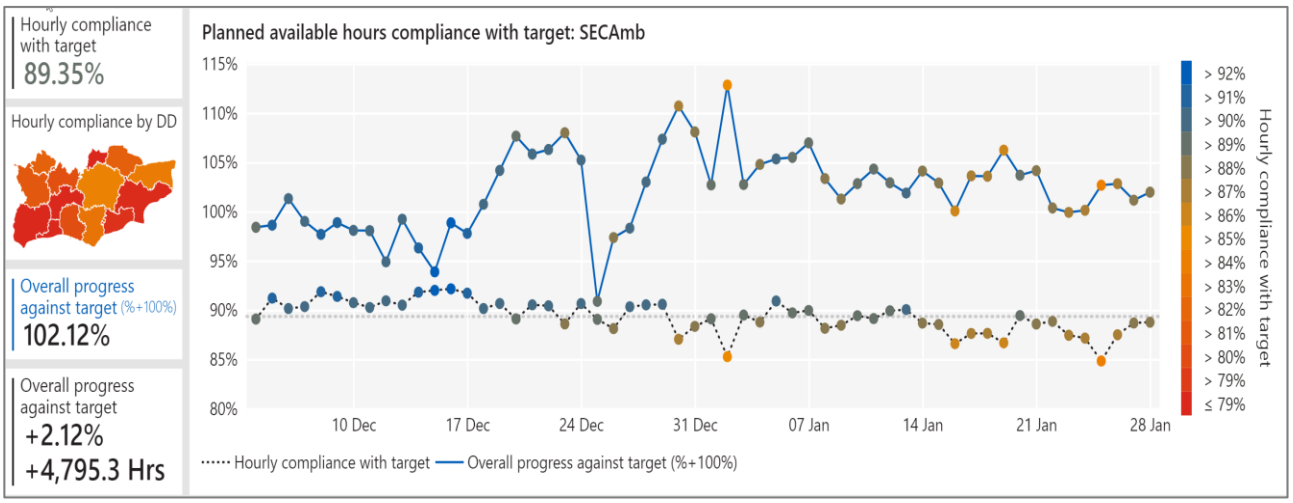
1. December



2. January



Field Ops resourcing



South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	80-23

Name of meeting	Trust Board
Date	08-02-24
Name of paper	Resilience & Specialist Operations Action Plan Update
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Emma Williams, Executive Director of Operations

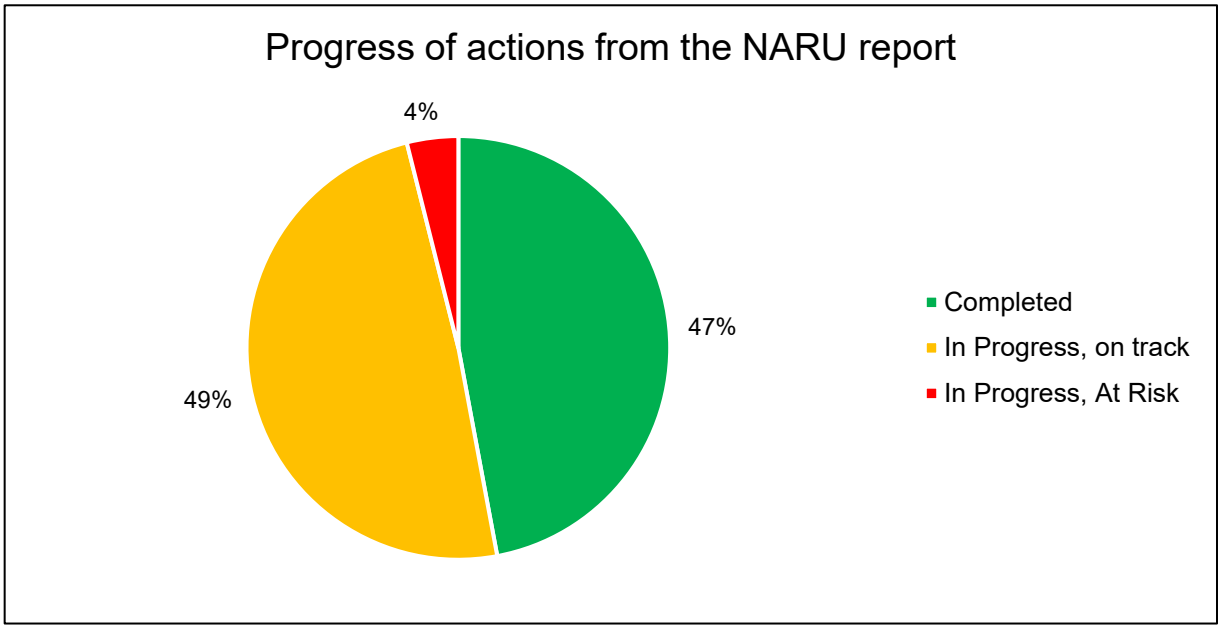
This paper is a follow up to that presented at the SECAmb Trust Board on 07 December 2023 that summarised the findings, recommendations and next steps following the delivery of the review undertaken by the National Ambulance Resilience Unit (NARU) in September 2023.

A follow-up meeting between the CEO, EDO, plus leadership and members of the Resilience & Specialist Ops was held on 31/01/24 to review progress on the actions within the NARU report and those identified by the team themselves at the previous meeting. Also present was Paul Woodrow, who on behalf of the Association of Ambulance Chief Executives has been working with the Trust with regards to this workstream, providing professional challenge and assurance as appropriate. He is currently reviewing the action plan and associated information/evidence to provide further feedback. To inform the Board's level of assurance, the outputs of this will be presented to the Board in April as part of a detailed update on the action plan.

In the meantime, the Board is asked to note the progress that has been made against the actions, as illustrated below.

Position as of 01/02/24

Row Labels	NARU report actions	Internal additional actions	Grand Total
Completed	**24**	**7**	**31**
EPRR	7	6	13
HART	5	1	6
SORT	12	0	12
In Progress, on track	**25**	**15**	**40**
EPRR	19	2	21
HART	3	13	16
SORT	3	0	3
In Progress, At Risk	**2**	**0**	**2**
EPRR	2	0	2
Grand Total	**51**	**22**	**73**



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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	81-23

Name of meeting	Trust Board
Date	8th February 2024
Name of paper	Freedom to Speak Up
Executive sponsor	Margaret Dalziel – Executive Director of Quality & Nursing
Author name and role	Kim Blakeburn Freedom to Speak up Guardian
Executive Summary	The purpose of this paper is to provide the Trust Board with an overview of the progress and development of the FTSU service. The paper also includes hotspots and themes arising from the cases received by the Freedom to Speak Up Guardian (FTSUG) from 1st June 2023 to 31st December 2023. Finally, the paper highlights key risks and actions planned for the coming year. **Key highlights from the paper are follows:** • The FTSU process at SECAmb has improved significantly over the past 6 months for our staff. • Concerns relating to leadership continues to be a key theme. • Detriment for staff following raising concerns and the number of anonymous cases needs to be reduced.
Recommendations, decisions or actions sought	**The Board is asked to:** ➢ Continue in their support of speaking up at SECAmb and encouraging learning from concerns. ➢ Commit to supporting the FTSU service in establishing a network of Speak Up Champions/Advocates during 2024-25.

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).	**No**

South East Coast Ambulance Service NHS Foundation Trust

Trust Board – 8th February 2024

Freedom to Speak Up Guardians Board report.

1. Introduction and Background

The National Guardian's Office (NGO) was established in October 2016 at the same time as it became a contractual obligation for every NHS provider organisation to have an appointed FTSU Guardian.

The importance of raising concerns is not just to ensure that patients receive the best care but also to protect the safety of workers. The Trust is committed to providing outstanding care to service users and staff to achieve the highest standards of conduct, openness, and accountability. There are many routes avaible to speak up at SECAmb, these include line management, Human Resources, Datix, The whistleblowing hotline, union reps and FTSU.

Speaking up is about anything that gets in the way of doing a good job. If we think something might go wrong, it's important that we all feel able to speak up to stop potential harm. Even when things are good, but could be even better, we should feel able to say something and be confident that our suggestion will be taking seriously and used as an opportunity for learning and improvement.

The Director of Quality & Nursing is the named Executive Lead for FTSU and is accountable for ensuring that FTSU arrangements meet the needs of the staff across the Trust. The Non-Executive Director (NED) responsible for FTSU is available to the Guardian to seek second opinions and support as required.

The Guardian has direct access to the CEO, NED, and Chair, with regular meetings scheduled to discuss all elements of FTSU activity.

The FTSU Guardian is co-chair for the National Ambulance Network and a member of the South East Regional FTSU network. These provide opportunities for learning to be shared and national themes to be addressed, alongside guardian peer support.

The Guardian is up to date with the National Guardian refresher training to ensure the team are working in line with suggested best practice.

SECAmb has made exceptional progress in its FTSU systems over the past year and this report will highlight the key improvements made.

2. Summary of Improvements to the FTSU Service

a. Increased capacity to FTSU team

In October 2022 two deputy FTSU Guardians were employed into the team on a temporary contract. These positions were made substantive in November 2023, and successfully appointed into, reiterating the importance that SECAmb gives to our people's voice.

b. Escalation process with RAG status and priority risk assessment

When a concern is first bought to the attention of the FTSU team, a risk assessment is done to ensure the right support is offered. At times during this triage process, the person raising the concern may disclose something that would determine the concern as a priority, identifying an immediate risk to patient or worker safety, this ensures the concern is fast tracked for an immediate response.

Standard concerns sit within the 93-day tracker. It is worth noting that 93 days is in line with other Trust policies where there are clear timelines for completion.

The table below gives an overview of how the escalation process works at SECAmb.

	93-day Overview			
Days/ratings	***0 to 31 days***	***32-75 days***	***76 to 93 days***	***Over 93 days***
Escalations	**Concern Open** Pass to first appropriate manager	Escalation to next level manager	Escalation to senior manager level (for example: AD/DD)	Escalation to Exec
FTSU lead	Deputy FTSUG	Deputy FTSUG & FTSUG	FTSUG	FTSU Executive
Reporting	Managed through monthly reporting to teams		Escalation to safeguarding sub-group	QGG

c. Improved data collection

Historically the SECAmb service at FTSU has collected data using national guidance/best practice. These are themes the FTSU Guardian is asked to report on nationally. These themes are:

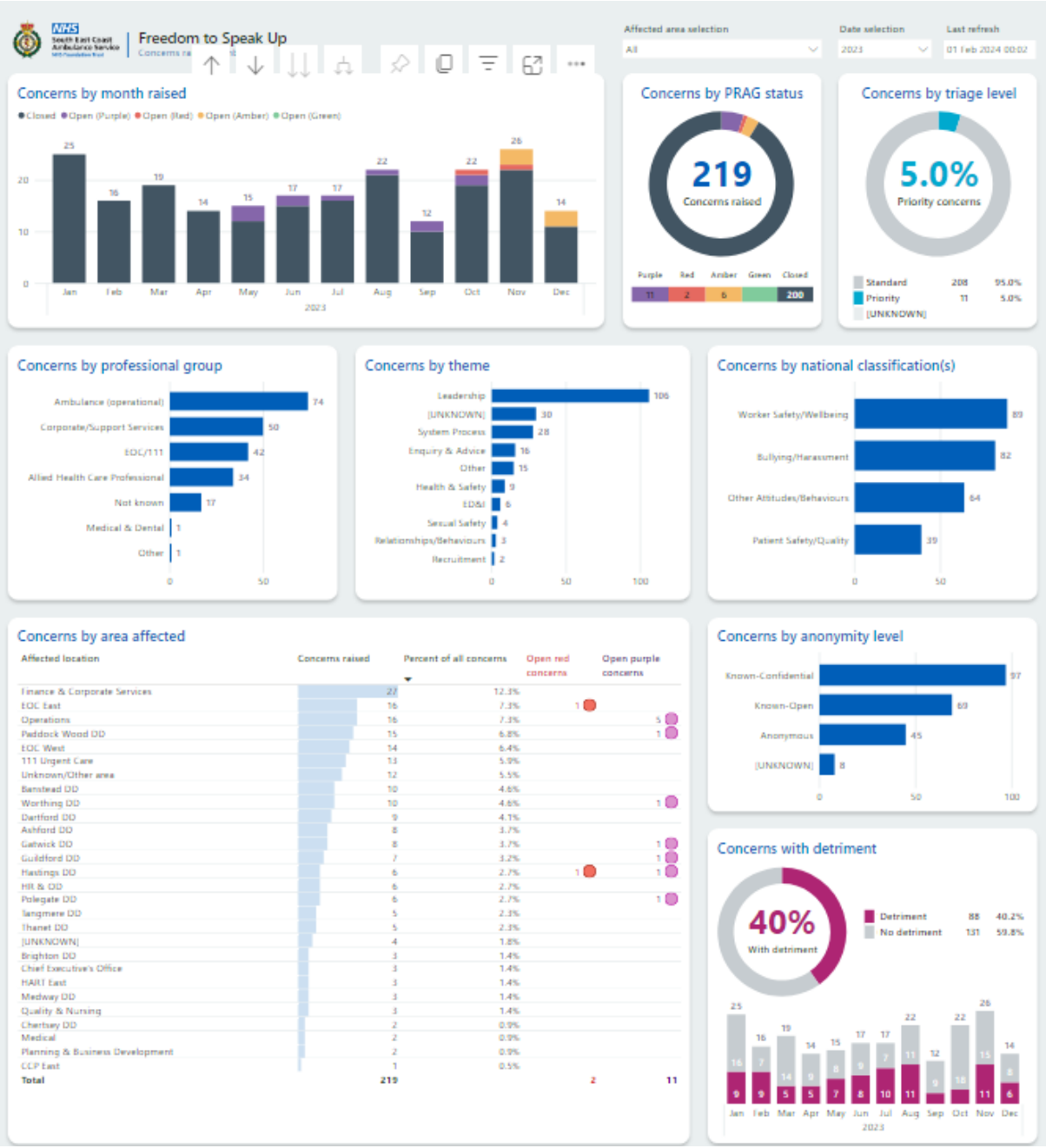
- Patient safety/quality
- Worker safety or wellbeing
- Bullying & harassment
- Other inappropriate attitudes or behaviours.

To improve our data systems, we now also collect the following themes:

- Leadership
- sexual safety
- recruitment
- system process
- ED&I
- enquiry or advice
- health & safety
- relationships/behaviours
- fraud
- training/education
- conflict of interest and other.

This information alongside the dashboard and the RAG rated escalation process, has enabled the FTSU team to have constructive conversations with all levels of leaderships and encourage curiosity in terms of what our data is showing us.

d. Power BI dashboard



This image shows a recent screen grab of the FTSU data provided by our power BI dashboard. This information can be isolated down to area/themes etc. This enables the FTSU team to bring non identifiable data to team management conversations and work proactively with these teams on how to respond to and understand concerns/themes in their areas.

e. Updated FTSU policy

A new FTSU/Speak Up policy was written in line with the national speak up policy. This was published in September 2023.

f. Managers toolkit

https://secamb-nhs.pagetiger.com/ftsu-manager-toolkit/v1

An interactive Managers toolkit has been created to provide advice and guidance on how to handle concerns. This toolkit is sent to managers that have had concerns raised in their areas or that have contacted FTSU to ask for advice on how to handle concerns.

g. FTSU - Statutory & Mandatory training

Module	Staff grade/level	Time allocated	Frequency	Compliance to date
Speak Up	All workers/Managers/Senior Leaders	1.5hrs	Occurring every 2 years	57%
Listen Up	Managers/Senior Leaders	1.5hrs	Occurring every 2 years	56%
Follow Up	Senior Leaders	1.5hrs	Occurring every 2 years	65%

FTSU training is part of the statutory & mandatory training requirements for all our people at SECAmb. These training modules, created in collaboration between the National Guardians office and Health Education England, are important to help us understand the vital role we all play in creating a healthy speak up culture which protects both patient and worker safety. Compliance figures are regularly monitored by the Guardian. The FTSU training modules have been active at SECAmb since October 2022. For the 2024-25 programme we are aiming for an 85% compliance target although this is reliant on an effective ESR platform.

FTSU Concern Summary 2023

2023	Number of concerns raised	% of priority	% of anonymous	% of detriment
January	25	20	36	36
February	16	19	31	56
March	19	0	26	26
April	14	7	26	36
May	15	0	27	47
June	17	0	12	47
July	17	0	18	59
August	22	4	9	50
September	12	0	9	25
October	22	0	23	18
November	26	4	12	42
December	14	0	7	43
Total	**219**	**5%**	**20%**	**40%**

The table provides a breakdown of the numbers of cases raised to FTSU from 1st Jan 2023 to 31st December 2023. Information is also provided on the percentage of those concerns that met the criteria for being a priority, raised anonymously or experiencing detriment from raising concerns. A high number of concerns raised isn't necessarily an indicator of poor culture. Nationally it is recognised that high numbers of anonymous cases and those siting detriment indicate poor culture. At SECAmb we have added in an additional matrix regarding immediate wellbeing to enable us to establish a clearer picture.

In the last annual report published by the National Guardians Office, 9.3% of concerns raised nationally through FTSU were anonymous and 3.9% highlighted a feeling of detriment. At SECAmb the table above indicates the reduction of concerns raised anonymously over the past 12 months, from 36% in January 2023, to 7% in December 2023.

Cases of detriment at SECAmb are high and this is something that is being addressed in planned works for the next 6 months as detailed in section 5.b. of this report.

Concerns by area affected

Affected location	Concerns raised	Percent of all concerns	Open red concerns	Open purple concerns
Finance & Corporate Services	27	12.3%		
EOC East	16	7.3%	1	
Operations	16	7.3%		5
Paddock Wood DD	15	6.8%		1
EOC West	14	6.4%		
111 Urgent Care	13	5.9%		
Unknown/Other area	12	5.5%		
Banstead DD	10	4.6%		
Worthing DD	10	4.6%		1
Dartford DD	9	4.1%		
Ashford DD	8	3.7%		
Gatwick DD	8	3.7%		1
Guildford DD	7	3.2%		1
Hastings DD	6	2.7%	1	1
HR & OD	6	2.7%		
Polegate DD	6	2.7%		1
Tangmere DD	5	2.3%		
Thanet DD	5	2.3%		
[UNKNOWN]	4	1.8%		
Brighton DD	3	1.4%		
Chief Executive's Office	3	1.4%		
HART East	3	1.4%		
Medway DD	3	1.4%		
Quality & Nursing	3	1.4%		
Chertsey DD	2	0.9%		
Medical	2	0.9%		
Planning & Business Development	2	0.9%		
CCP East	1	0.5%		
Total	**219**		**2**	**11**

The image above shows a breakdown for areas and includes a RAG status to show how many cases are open, also highlighting those outside of the 93-day timeline.

3. Most commonly occurring themes

a. Leadership

The consistently predominant theme for concerns raised at SECAmb link to local leadership. The following information gathered from concerns raised in the last year, may

help to provide an explanation for why this is seen as the most significant issue raised by our people.

In most concerns raised, staff had initially spoke up through their local leadership routes before approaching the FTSU team. The principal reasons for approaching FTSU regarding leadership are,

- not receiving a reply,
- receiving what is seen as an inappropriate reply,
- a feeling of detriment after speaking up.

The response from local leadership to concerns raised through FTSU is at times one of defensiveness rather than an opportunity for improvement. This is improving as the FTSU Guardians establish their relationships and links with the local leaders, with support from the Executives.

b. Worker safety wellbeing

Concerns raised in this category include an element that indicate a risk of adverse impact on worker safety or wellbeing. The term should be interpreted broadly, and the focus should be on the perception of the individual raising the concern.

Examples of worker safety or wellbeing includes:

- Lone working arrangements,
- Insufficient risk assessment/access to PPE,
- Stress at work

At SECAmb, the main reason for citing worker safety and wellbeing relates to stress at work following on from an adverse event. This is often seen when someone has been waiting long periods of time for an investigation to conclude or has had elements of their grievance upheld but not seen any changes made to the situation it relates too.

In more recent months, fewer new cases relating to HR processes have been made. There are still some ongoing historical cases.

c. Bullying & Harassment

Most concerns raised regarding Bullying & Harassment are linked to local leadership. As with all categories, the focus should be on the perception of the person raising the concern.

Examples of bullying include:

- Spreading malicious rumours about someone
- Consistently putting someone down
- Excluding someone from team social events

There is still some concerns raised relating to sexual safety, whilst not predominate in numbers, it's important to highlight cases are still being raised and the anecdotal evidence coming through the FTSU team. FTSU have asked the question of what Zero tolerance means to us as an organisation following the very different and often confused responses to sexual safety concerns from local leadership. It is promising to see the work being done to explore this and other aspects of sexual safety through the work being led by our Executive and Operational Leads responsible for Domestic Abuse and Sexual Violence, aligned to the Sexual Safety charter signed off by the Board in December 2023.

d. Additional note – Patient safety

Whilst patient safety and quality was not a principal theme for concerns, it is noted that almost 18% of the concerns raised in 2023 had an element of patient safety to it. In the last annual report published by the National Guardians Office, 19% of cases raised nationally through FTSU had an element of patient safety.

At SECAmb we encourage and promote our staff to raise concerns of patient safety through routes such as Datix. This is largely working well. There are occasions when the response received from Datix is seen as inappropriate and these are often when they are then raised to FTSU. An example of this was a rise in patient safety concerns when the new C3/C4 validation process was implemented at SECAmb.

4. Learning from FTSU

As part of the improvements we are making to the FTSU service at SECAmb, we are always looking to establish opportunities for improvements from concerns raised and to embed these improvements into our organisation. Following several concerns raised to FTSU relating to service vehicle collisions (SVC), an investigation was commissioned led by two of our Consultant Paramedics.

This scope of the investigation included:

- Overview of the reference events
- Analysis of the actions of key actors in reference event
- Analysis of the management of staff involved in the incidents.
- Analysis of approach to investigations (relating to the reference events)

Staff who had spoken up about their experiences following a SVC, and managers were interviewed to gather views. This included staff who had reported into FTSU.

The investigation highlighted several recommendations that the FTSU Guardian and the consultant paramedic authors of the report presented to the Senior leadership Team, including a review of the welfare process following a SVC. Subsequently, a task and finish group is being set up with subject matter experts to ensure these recommendations are followed through and result in improvements for our organisation.

5. Planned improvements to FTSU at SECAmb

a. Speak Up toolkit.

Following on from feedback received from staff, the FTSU team are creating a speak up toolkit. This will be an interactive document to guide staff on all the routes available at SECAmb to speak up. The FTSU team are gathering information from several different sources, including but not limited to, HR, Union colleagues and the Datix team. The purpose of the document is to help make the process of speaking up less daunting and provide a type of glossary of terms to help staff feel more informed during the speak up process, whichever route they chose to use.

b. Action on detriment

Many organisations have attempted to address cases of detriment within their organisations. These are mostly focussed on reacting to cases once reported. The FTSU team at SECAmb are looking to take a two-pronged approach to cases of detriment after coming across some international research that highlighted the success of this approach.

This will mean working with managers to address fears that detriment may be experienced, as well as working collaboratively with the Executive lead and HR to address concerns where cases of detriment have been experienced – a bi-weekly meeting will commence focused on this.

In addition, improvements to our managers toolkit are being made which will include a chapter on detriment and will give guidance and support to managers on how to reduce the numbers of detriment in their areas and promote an environment of psychological safety. It will also give support on what measures can be taken if cases of perceived detriment have been reported in their area.

c. University Workshops

The FTSU Guardian was contacted by senior leadership at one of our connected universities, following anecdotal evidence raised directly to university support staff about the fear of speaking up about power imbalances at SECAmb and the student experience of sexual safety in our organisation.

Sadly, this student experience is one known to FTSU teams across all Ambulance organisations. The FTSU team at SECAmb has developed a FTSU/speak up awareness workshop focussing on sexual safety case studies to deliver to Year 2 students. This will be trialled at one university initially with a plan to roll this out to all our universities.

Additionally, in the role of National Ambulance Co chair, the FTSU Guardian is coordinating a data collection for all Ambulance organisations to identify the numbers of these concerns nationally and feed this information into National Education Network of Ambulance Service (NENAS), a subgroup of AACE.

d. OUM board session

In March 2024, the FTSU Guardian and the national FTSU Guardian Dr Jayne Chidgey-Clark will attend a board session at SECAmb. This session will focus on understanding and awareness of FTSU for operational leadership focussing on Operating Unit Managers.

e. Speak Up champions

One of the recommendations made in the 2023 Ambulance Speak Up review, is to develop a network of FTSU champions/advocates. Recruiting a network of FTSU champions will help to promote freedom to speak up locally and in addition support aspects of the FTSU policy by signposting staff to the right places to resolve their concerns. Over time. this may help to reduce the number of direct referrals to the FTSU service.

6. Update from recommendations made to NGO 'Listening to Workers – A Speak Up review of ambulance trusts in England.

a. **Recommendation 1: review broader cultural matters in ambulance trusts:** This action calls for an independent cultural review amongst other suggestions. At SECAmb specifically our actions to this recommendation have included assigning our Executive Director of Quality and Nursing as the domestic abuse and sexual violence lead. We have signed up to the national sexual safety charter and established a working group to ensure all principles are met and delivered. We have launched a reverse mentoring scheme with a focus on diversity and inclusion. We will commissioning an independent review of our senior leadership recruitment. We will shortly launching a resolution policy with a focus on a Just and restorative culture.

b. **Recommendation 2: Make speaking up in ambulance trusts business as usual:**
We have included all speak up, listen up and follow training modules to our statutory and mandatory requirements. We have had several board development sessions and planned sessions for FTSU awareness training with senior leadership in March 2024. A manager's toolkit to support and guidance when handling concerns has been published. FTSU has been included in all our recent culture improvement works and FTSU representation is sought in appropriate working groups such as addressing sexual safety at SECAmb. A new speak up toolkit for all staff is in developing to encourage all our people to speak up.

c. **Recommendation 3: Effectively regulate, inspect and support the improvement of speaking up culture in ambulance trusts.**
For system wide/national attention

d. **Recommendation 4: Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers.**
SECAmb have three permanent, full time FTSUG's. The recruitment process for all guardians followed and met the principles for national best practice recruitment process. All three guardians receive monthly 1:1 independent supervision. The FTSU team will start recruitment for a network of FTSU advocates in April 2024.

7. Conclusion

Our Dashboard, alongside the way we now collect our FTSU data, the new RAG rated escalation process, our actions to meeting the recommendation set out from the NGO review and our approach to learning from concerns has meant that we are at the vanguard of development for FTSU. We have regular requests to share our developments from other organisations both in the ambulance sector and the wider NHS.

Much has been achieved, but there is more to do as outlined above. The FTSU team seek the support of the Board to identify, develop and support Speak Up champions over the course of this year.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	81-23

Name of meeting	Trust Board
Date	8 February 2024
Name of paper	People Committee Escalation Report – January 2024
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 23.01.2024 and confirms whether any matters require specific intervention by the Trust Board.

Before the main part of the meeting started, the executive updated the committee on the positive progress between Management and Trade Unions regarding the Joint Action Plan, which is underway, the Wellbeing winter plan regarding deployment of vehicles, which is now organised by Volunteer Services, and the impact of the recent Junior Doctor Strike, which was low due to mitigations put in place.

Item	**Link to BAF**
People & Culture Update	P&C Goals 1-3 Risks 255 and 348.

There was an update on the actions from the P&C plan and all 41 are now progressing and blockers identified. HR Policies were discussed as there was concern over the delay. Additional resource is being identified to help accelerate this work.

Regarding Flexible working, Agenda for Change Section 35, which is a new directive, was discussed. The Trust is planning on promoting a hybrid working model for the majority of staff.

EOC Culture Update against Moorhouse recommendations	Risk 348 – Culture & Leadership

Currently concentrating on the actions and a Culture Change Group has been set up to oversee this with set reporting mechanisms for staff feedback. One thing noted was the subject of visibility, which was explored further with staff and found to mean accessibility.

There is a staff led prioritisation plan in place which is reviewed at Teams C meeting and now includes Band 5 Team Leaders, who have been overlooked previously and it is hoped this will give them further knowledge and skills. Autonomy is now being encouraged across all areas.

To enable good recruitment and retention of EMAs, Progression Groups are now in place for career pathways, plus around 50% of staff are working flexibly, although this does come with its own problems.

Health & Safety: HSE Inspection and response	N/A
HSE confirmed on 18.01.2024 that it was satisfied with our response and the Improvement Notice has been removed. There is still further work planned by undertaking an external review to look into embedded issues, which are expected to highlight culture and training issues. A fundamental change is needed to ensure that all are responsible for Health and Safety across the Trust. The Committee requested more granular reporting on H&S until the reviews and recommendations from them are complete.	
Violence Prevention and Reduction Strategy	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
Four strategic aims along with KPIs have been added to the strategy. Roles have been reviewed to avoid silo working. Encouragement and support will now be given to speak up and report hate crime, which is not reported well as remains the individual's choice. Plan is to look at anonymous reporting to see if that is more successful and it was asked that Staff Networks be involved in this. Camera demand is high, but we are running out of stock, so there may be a future request for additional equipment and resources to support this work.	
Pastoral support to clinical staff	N/A
An interesting and informative presentation by Paul Fermor, Senior Chaplain and Tim Murrell, Chaplain. Many at the meeting were not fully aware of the excellent support they give to front-line staff in both a faith and non-faith capacity. It was discussed that this is possibly an untapped resource currently and visibility should be raised, for Corporate staff as well. Caution was advised as this is a purely volunteer role with limited resources; however it was important to quantify support in some way to ensure adequate resources were provided elsewhere. We are the only Trust in the UK who offer such a structured approach.	
ETD Annual Training Plan 2024/25	Risk 15 – Abstracting staff for training and development
We are the only Trust to undertake this large piece of work to map every bit of training across the Trust. The committee is assured with the focus across all staff groups and links to the retention plan the Board agreed in December. This work will take two years to complete and is a big investment in staff that will require additional resources to ensure its implementation and success. The committee will oversee its delivery.	
Draft ER Dashboard	Risk 361 - Capacity of HR to resolve employee relations (ER) cases within timescales
The ER Team has now been established and the HRBP team will start a re-structure soon. There has been progress in the last 6 months to develop data that wasn't available before, such as average days to resolution. This is broken down to show the complex core legacy cases highlighted separately. We have reduced down to 26 and are confident we will reach 0 in a few months. Also reducing average days to resolve as we're intervening in the early stages and working well with the Unions.	

Specific Escalation(s) for Board Action	The meeting was constructive and the papers were good. However, there are a few things for the Board to note: 1. The appraisal data shows a 61% completion rate and will not reach the target of 85% by end of Q4. Data accuracy remains a concern. 2. Highlight the need for support resources for the Trust Training Plan. 3. Papers continue to improve and are significantly better than this time last year. 4. The committee has continued to push 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	82-23

Name of meeting	Board
Date	8 February 2024
Name of paper	Achieving Sustainability & Working with Partners
Strategic Theme	**Sustainability & Partnerships**
Author / Lead Director	David Ruiz-Celada, Executive Director for Strategy and Transformation
Executive Summary	

Trust Strategy (BAF Sustainability and Partnerships Goal 1 – SP1 and SP2)

1. In April 2023 the Board approved moving forward with the development of a new clinically led strategy for the organisation, following the expiry of the previous strategy at the end of 2022.

2. Over the last 6 months, we have engaged extensively across Kent, Surrey, Sussex and Frimley with our patients, our people and our system partners, to develop a case for change for the organisation. The case for change was reviewed by the Board in December, and shows how we have significant challenges ahead of us. The key findings in our case for change are as follows:

    a. We are expecting a 15% grown in activity driven by population, aging and associated increased complexity in the presentation of our patients
    b. There are integration challenges across how SECAmb is working across the healthcare system and local authorities to maximise the opportunity for patients to receive the right care at the right time
    c. Our model of care is no longer sustainable, as we are failing to meet the full needs of our patients and not giving our people the right training and development to meet the evolving future needs of our population

3. During December 2023 and January 2024 we have continued to engage with our clinical teams to develop 3 emerging strategic options for the future:

    a. Option 1: Core Ambulance
    b. Option 2: Care Navigator
    c. Option 3: Integrated Community UEC Healthcare Partner

4. Following evaluation of each option, the SECAmb Board have indicated a preferred direction of travel in “Option 2: Care Navigator”.

5. Option 2 Care Navigator is an direction of travel that builds on much of what we have heard from our clinicians, patients and partners. Under this model, we expect to improvements in our ability to triage and clinically validate callers, enabling us to differentiate need and preserve field ambulance responses for those patients that really need us in a way that keeps patients safe and protects the systems. This option will see SECAmb step into the system leadership space of providing a much more integrated UEC service to the systems, and will require us to collaborate and develop models of care and pathways that ensure that our patients that are in most need of an emergency ambulance response can reliably get one when needed in the future.

6. We are now progressing into Phase 3 which will run during February and March, with a full strategy ready for publication at the beginning of April 2024. In phase 3 we will be developing a 5 year transformation roadmap, aligning our plans in year 1 to the 24/25 annual planning, and developing a new vision, values and brand identity for the organisation that reflects our new direction of travel.	
Recommendations, decisions or actions sought	Trust Strategy: The Board are asked to publicly endorse the preferred direction of travel in the emerging option 2 “Care Navigation”, allowing for the implementation planning phase to be continued with the aim to fully develop the strategy and associated delivery framework in time for 24/25.

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Trust Strategy

Public Board

08 February 2024

Our journey so far

We have engaged with, and listened to, staff, patients and system partners…

Staff Engagement

- **950+** people engagement
- **19** workshop/ focus groups
- **9** local engagement events
- **2000+ views** Strategy Programme Community

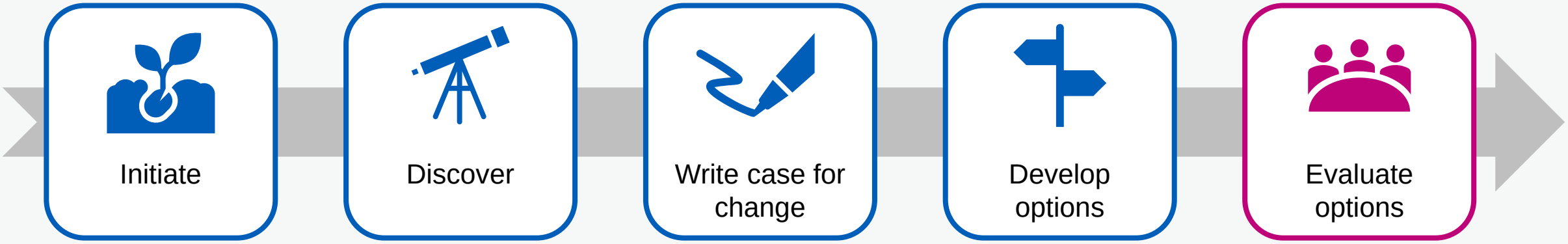
Patient Engagement

- **350+** responses to public survey
- **5** patient engagement sessions

System Engagement

- **6** ICB workshops
- **8** ICB interviews
- **13** ICB meetings

…and together we have been on a journey to develop our new strategy



There is a clear case for change

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.

Three options have been considered

We will focus on delivering a…

Option 1: Core ambulance

Consistent **emergency ambulance response** for our most critical patients only

"When I really need an ambulance, I will be seen in a timely manner"

"I love my job now because I'm only attending patients who really need an emergency ambulance"

Option 2: Care navigation

1) Consistent emergency ambulance response, while
2) assuming a lead role in **care navigation for our systems**

"I will reliably receive initial urgent or emergency care from SECAmb if I need it"

"I will now have the right training and more ways to care for the patients I respond to"

Option 3: Integrated Community UEC Healthcare Partner

1) Consistent emergency ambulance response,
2) care navigation, and
3) **partnered services / community-based urgent care**

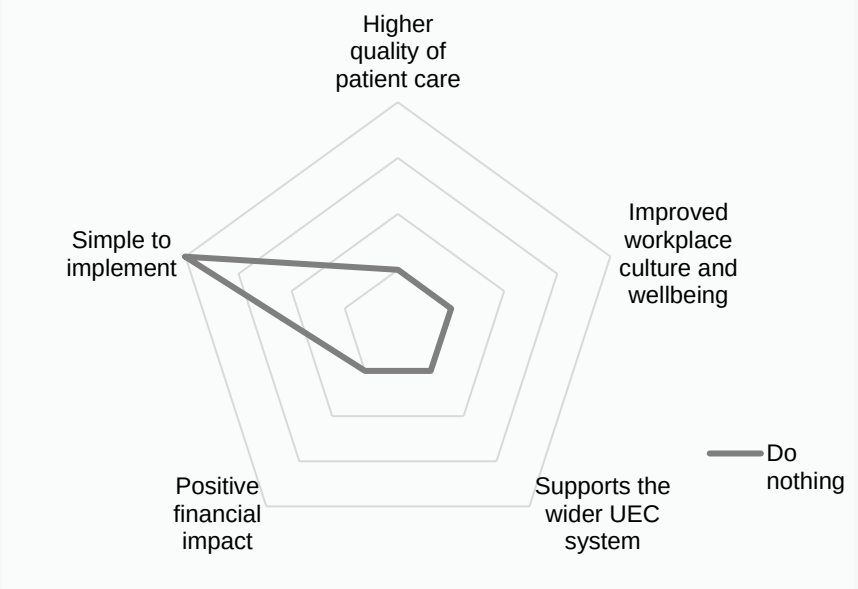
"I can access care with any of my urgent or emergency needs and the staff are able to provide comprehensive and differentiated care"

"I will have greater opportunities to develop my career while remaining at SECAmb"

We have evaluated each option against five criteria

- Quality of Patient Care
- System Impact
- Workforce Impact
- Implementation Complexity & Cost
- Running Cost

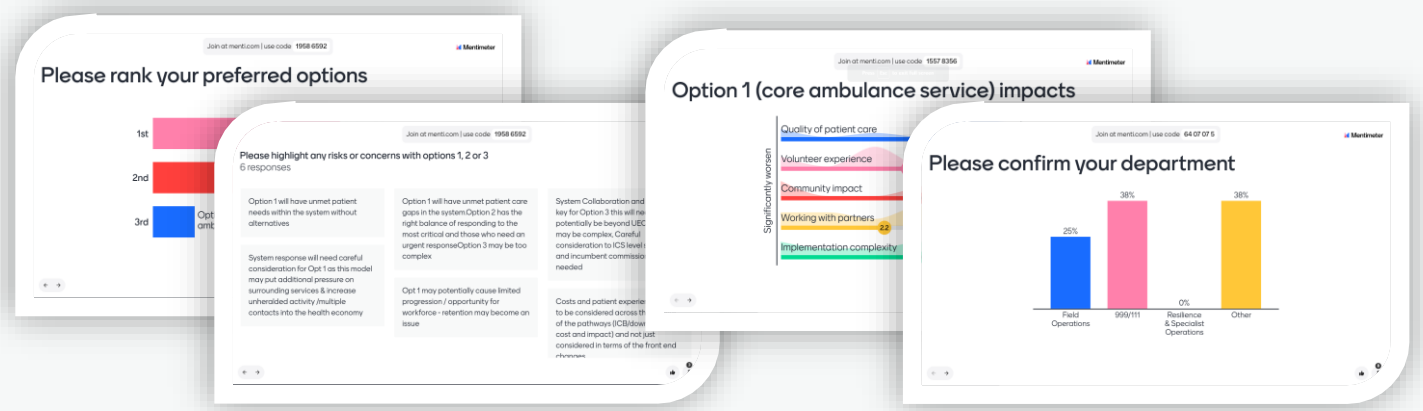
‘Do nothing’ assessment against the five criteria



The scores provided by a broad range of groups, qualitatively and quantitatively

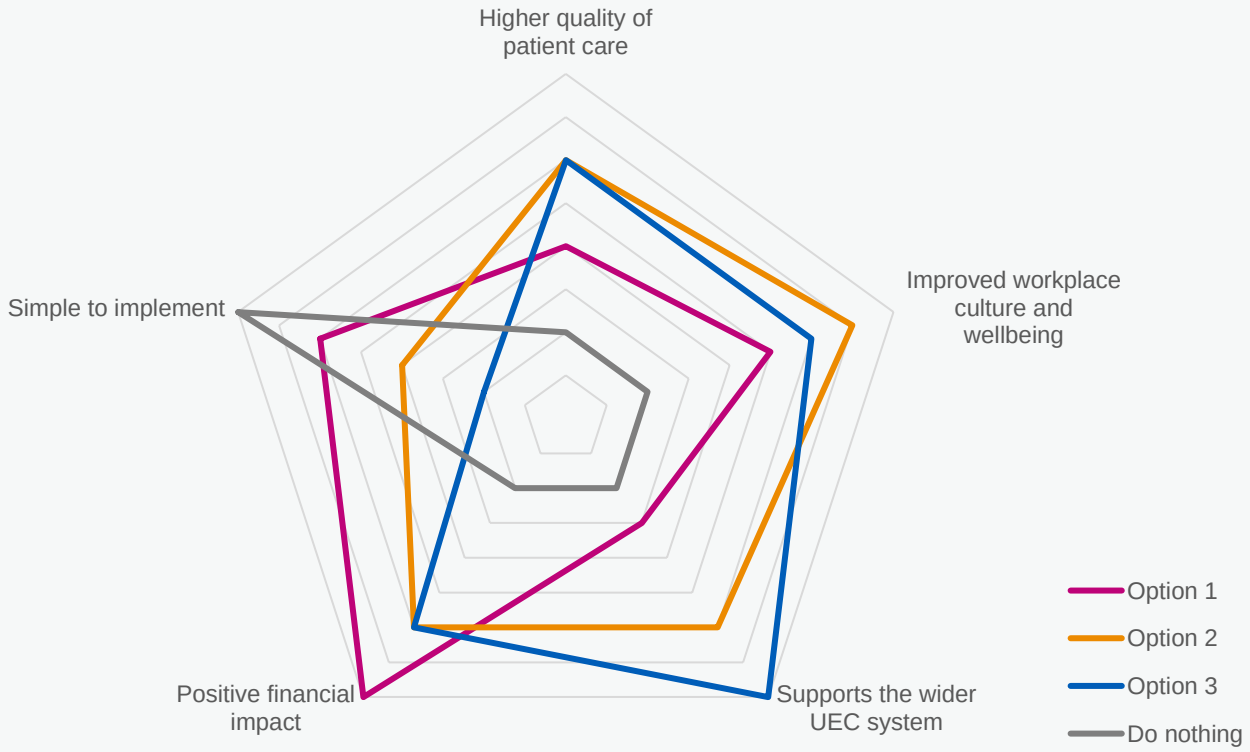
Evaluators include:

- ✓ Clinical Advisory Group
- ✓ Executive / SLT
- ✓ Trade unions
- ✓ Integrated care boards
- ✓ Volunteers
- ✓ Operational leaders



How do each of the strategic options compare to each other?

Each of the strategic options have been compared to each other and the ‘do nothing’ option to understand the impact against each of the evaluation criteria. Scores have been generated following extensive stakeholder engagement.



What does this tell us?

Through evaluation of all the strategic options, options 1, 2 and 3 score much higher than the ’do nothing’ option.

Option 2 scores highest overall, including strongest scores for improved workplace culture and wellbeing.

Three options have been considered

We will focus on delivering a…

Preferred option

Option 1: Core ambulance

Consistent **emergency ambulance response** for our most critical patients only

"When I really need an ambulance, I will be seen in a timely manner"

"I love my job now because I'm only attending patients who really need an emergency ambulance"

Option 2: Care navigation

1) Consistent emergency ambulance response, while
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Option 3: Integrated Community UEC Healthcare Partner

1) Consistent emergency ambulance response,
2) care navigation, and
3) **partnered services / community-based urgent care**

"I can access care with any of my urgent or emergency needs and the staff are able to provide comprehensive and differentiated care"

"I will have greater opportunities to develop my career while remaining at SECAmb"

In option 2, we will focus on assuming a lead role in care navigation through virtual consultation

Care Navigation

We will focus on delivering a consistent emergency ambulance response for our most critical patients while assuming a lead role in care navigation through virtual consultation

Comprehensive triage

Emergency care response*

Virtual consultation of Group B patients

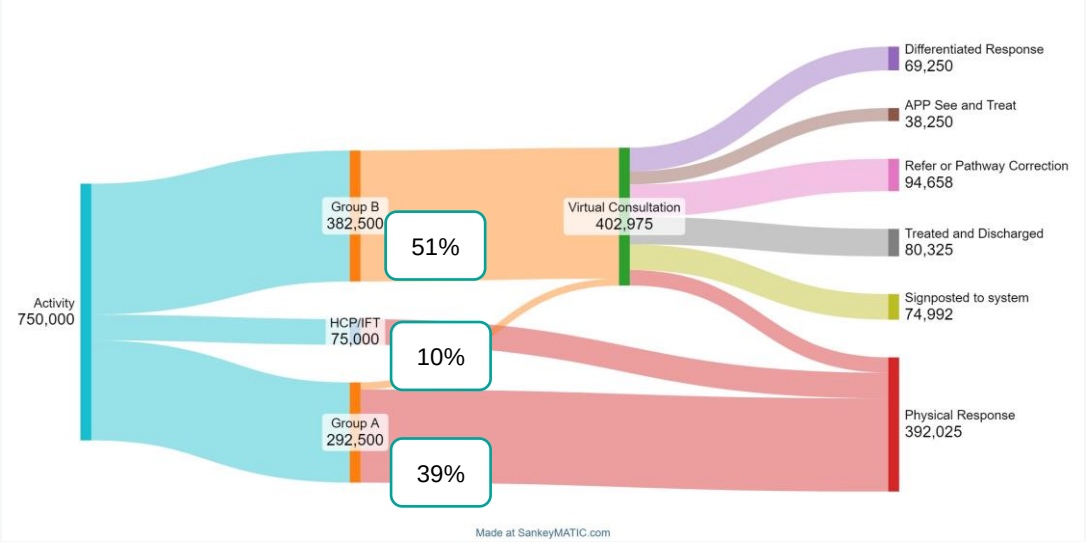
Signposting non-UEC activity

Direct referral into UEC services for Group B patients

Systems Collaboration

*Including legal obligations under the Civil Contingencies Act (CCA) 2004

15% of existing activity will have a referral for the right healthcare provider



Impact on patient experience

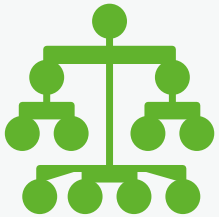
Group A: Existing resources are refocused to provide a better response to patients with emergency and critical conditions.

Group B: Patient needs are thoroughly assessed by a clinician. Once assessed, patients have a referral to the most appropriate care provider. This provides a more seamless experience for patients.

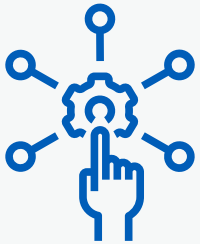
Any option will be complemented by ‘no regrets’ initiatives

Operations

Support Services



Digital & Data



Workforce & Culture

System collaboration

Summary

Recommendation

- Following a Board Development session on the 23 January 2024, the Executive Team are recommending the Board approve “Option 2: Care Navigation” as the preferred direction of travel.
- To safely deliver this new model of care, we will need to transform our services working closely with our clinicians and patients.
- As identified in our case for change, we will also need to ensure there is alignment across our Integrated Care Boards, so that we can better integrate and collaborate across providers to help us deliver a sustainable model in the future.

Next Steps

- We are now in phase 3 of the strategy programme which is focussed on implementation planning. This phase will run to the 14th of March.
- During implementation planning we will be developing the detail under Option 2:
  - A strategic delivery framework that the Trust can use to monitor progress against the outcomes set out in option 2, including the development where required of more detailed enabling plans, such as digital, workforce, etc.
  - A 5 year transformation roadmap and associated model for transformation, including investment requirements.
  - A new vision statement, brand identity and values which we will use to launch the final strategy.
- In addition, we are working closely with commissioners as part of the planning round for 24/25 to ensure that we can start making progress in our transformation journey right away, creating alignment and balance between our operational plans and the emerging transformation plans.
- The governance and oversight of the transformation programme will be developed in phase 3, alongside the executive structure review, to ensure there is clarity on the roles and accountabilities different members of the executive team will be taking to support delivery of our new strategy.
- A final, ready for publication strategy is expected to be presented to the Board in April 2024, with an associated updated Board Assurance Framework built around the strategic delivery plan at the first Board of the 24/25 Financial Year during the first week in June.

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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 are co-designing 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

Item No	82-23

Name of meeting	Trust Board
Date	08th February 2024
Name of paper	M09 (December 2023) Financial Performance
Executive sponsor	Saba Sadiq - Chief Finance Officer
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Kevin Steer (Head of Financial Accounting & Compliance), Rachel Murphy (Financial Manager - Projects, Business, and Investments)
Synopsis	This report provides the M9 year-to-date (YTD) financial performance of the Trust. The Trust reported a £7k favourable variance against its planned deficit of (£41k) at M9 YTD. YTD actuals as at M9, were (£34k). The Trust has mitigations in place, including the use of non-recurrent measures to improve financial performance and is on track to deliver its financial, break-even plan for the year ending 31 March 2024. . The YTD deficit includes under achievement of the planned efficiency programme, which is £341k below plan coupled with adverse variances in our Operations directorate (e.g., 111) and increasing premises costs. The Trust's cash position of £36,692k was £9,002k lower than plan. This is due to the reduction of the Trusts trade payables clearing invoices for several suppliers for non-pay and capital. The Trust is forecasting a cash position of £40,376k at the end of March 2024, which is £10,025k below plan, because of anticipated reduction in trade payables. The financial risks outlined above would result in an adverse impact on the cash position and under delivery against the target. A discussion took place on the Trust's financial performance and the FIC were assured that the Trust was on track to deliver its 2023-24 financial plan.
Recommendations, decisions, or actions sought	The Trust Board is asked to note the a) The M9 YTD financial performance b) The challenges facing the Trust in delivering its efficiency programme; and c) Mitigations in development to address overspends and under-delivery of the efficiency programme to deliver the break-even plan. d) The Trust remains on track to deliver its financial plan of break-even through the use of non-recurrent means.

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
9 Months to 31 December 2023

Contents

Executive Summary

The Trust reported a £34k deficit for the nine months to December 2023 (YTD) that is £7k better than plan. The Trust's forecast remains at the planned break-even position.

	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	239,253	242,127	2,874	319,066	322,653	3,588
Expenditure	(242,764)	(244,114)	(1,350)	(323,568)	(324,607)	(1,040)
Planned Profit on Sale of Assets	3,469	1,952	(1,517)	4,500	1,952	(2,548)
Trust Surplus / (Deficit)	**(42)**	**(35)**	**7**	**(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)*	**(41)**	**(34)**	**7**	**0**	**0**	**0**

Efficiency Programme	5,788	5,447	(341)	8,988	8,988	0
Cash	45,694	36,692	(9,002)	50,401	40,376	(10,025)
Capital Expenditure	13,350	12,422	928	27,055	19,525	7,530

*Reported Surplus / (Deficit) represents w hat 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 (£353k) overspend in NHS 111, higher electricity costs (£493k) and a net (£502k) pressure in HR. These are outlined more in detail further on. Favourable variances The Trust received £1,659k 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. For the nine months ending December 2023, we have identified efficiency plans of £7,569k, which is 84% of the target.

    - Delivery of £5,447k efficiencies YTD is £341k lower than plan. This is worse than the £55k adverse variance that we reported last month. The shortfall is largely driven by the challenging delivery of cash releasing savings, which is £518k below plan despite circa 52% of the savings being generated non recurrently. This is partially mitigated by overachievement in our Hear and Treat non-cash releasing scheme.
    - Recurrent schemes represent 73% of the total YTD efficiency savings, with non-recurrent schemes at 27%. (Full Year Risk adjusted forecast is 79%:21%).
    - One scheme at a value of £86k was fully validated during the Month of December, this means 46 schemes totalling £7,537k are now fully validated and transferred to delivery phase YTD. As a result of the significant emerging risk associated with the planned Procurement contracts review initiative, this is likely to deliver only 3% of £370k planned savings. The risk adjusted forecast reduces to £7,446k, £1,542k or 83% of the efficiency target of £8,988k. This is an improvement of £216k compared to the £1,758k gap reported last month.
    - The Trust must achieve £3,541k worth of efficiencies in the last quarter to deliver the efficiency target of the year, in part due to the savings profile. This remains challenging with the increasing winter operational pressures. Mitigations in place to

bridge the gap, includes the recognition of budgetary underspend, the development of validated and scoped schemes with a value of £605k and utilisation of unplanned contingencies.

- Forecast includes both the income and expenditure relating to the £2,500k additional operational capacity funding. £1,938k already spent for the year to date.

- The cash position decreased by £3,846k this month to £36,692k. The cash balance is £9,002k below plan, mainly due to the reduction in our accounts payable.

- Capital expenditure of £12,422k is £928k 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, of which the Trusts allocation is £1,188k that has been incorporated in the above mentioned. 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 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 remains focused on ensuring all directorates deliver their allocated plan, including reducing overspend, run rates, maintaining and releasing YTD underspends as non-recurrent measures to meet the breakeven forecast position.

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

1. Income

	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	214,451	216,497	2,046	286,019	288,566	2,547
111 Income	20,179	20,209	30	26,905	26,937	32
HEE Income	1,866	1,987	121	2,474	2,871	397
Other Income	2,757	3,434	677	3,668	4,279	612
Total Income	**239,253**	**242,127**	**2,874**	**319,066**	**322,653**	**3,588**

- 999 income is £2,046k greater than planned YTD, mainly from additional capacity funding (£1,938k) matching expenditure.

- 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 £121k above plan. This reflects the most recent funding schedules received for 2023/24 a covers specific funding expenditure, namely course fees for the Level 7 Advanced Clinical Practitioners.

- Other income is £677k above plan, £418k is linked to additional expenditure associated with international paramedic recruitment and £172k 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 December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(3,385)	(3,480)	(95)	(4,590)	(4,731)	(141)
Finance	(17,510)	(17,755)	(245)	(23,626)	(23,413)	213
Quality and Safety	(2,687)	(2,582)	105	(3,614)	(3,533)	81
Medical	(14,147)	(13,215)	932	(18,971)	(17,722)	1,249
Operations	(136,643)	(138,238)	(1,595)	(182,885)	(184,748)	(1,864)
Operations - 111	(20,124)	(20,731)	(607)	(26,824)	(27,317)	(493)
Strategic Planning & Transformation	(21,090)	(20,797)	293	(28,120)	(28,469)	(349)
Human Resources	(3,846)	(4,864)	(1,018)	(5,186)	(6,273)	(1,087)
Total Directorate Expenditure	**(219,432)**	**(221,662)**	**(2,230)**	**(293,816)**	**(296,206)**	**(2,391)**
Depreciation	(13,897)	(13,464)	433	(19,066)	(18,319)	747
Financing Costs	(1,756)	58	1,814	(2,342)	99	2,441
Corporate Expenditure	(7,678)	(9,046)	(1,367)	(8,344)	(10,182)	(1,839)
Total Expenditure	**(242,764)**	**(244,114)**	**(1,350)**	**(323,568)**	**(324,607)**	**(1,040)**
Planned Profit on Sale of Assets	3,469	1,952	(1,517)	4,500	1,952	(2,548)
Total Trust Expenditure	**(239,295)**	**(242,162)**	**(2,867)**	**(319,068)**	**(322,655)**	**(3,588)**

*Excludes Income

YTD performance against plan

- Total expenditure at M9 YTD was £242,162k, which is £2,867k adverse to plan.

- The above expenditure includes £1,937k for additional operational capacity, that is offset by income to the same value.

- Further pressures include £607k overspend in NHS 111 together with higher costs in HR of £1,018k including the funded projects supported by £513k of income, notably the drive on

International Paramedic Recruitment, with a net cost pressure of £505k. These are offset by non-recurrent benefits in financing costs of £1,659k explained below.

- Excluding the £1,937k for additional operational capacity, Operations is £342k underspent YTD.
    - The net favourable variance is a combination of underspends across the directorate of £1,052k including £557k in EOC, due to challenges in the recruitment of clinical staff, £342k savings relating to timing of placement training, and £153k underspent in Specialist Operations because of timing of planned vehicle leases and training.
    - Offsetting these are adverse variance of £710k in Frontline operations because the productive hourly rate (based on hours 'on the road') increased by 5.9% to £37.67, against the plan of £35.59. This is driven by the following factors:
    - We saw an 8.9% overprovision of hours in December, leading to an improvement in the overall YTD provision of staff hours to 3.9% below plan. Although the YTD abstraction levels remains positive at 30.0% compared to the plan of 31.9%, sickness levels in the month rose to 8.9%, resulting in YTD higher sickness rate of 7.5% against the target of 7.0% at a cost £303k.
    - Furthermore, while attrition is in line with plan, substantive staffing levels are over established by 7.2%, in part due to the accelerated recruitment at the beginning of the financial year, at an additional cost of £635k.
    - The impact of the six bank holidays on the planned annualised average Unsocial Hours percentage continues to be regularised and tracks at £276k above plan.
    - Further pressures include increased travel and hotel costs of £216k. This is being reviewed by Procurement to ensure an appropriate contract is established with a preferred supplier.
    - Although the provision of overtime increased substantially during the festive period and currently represents 7.3% of total hours YTD compared to the plan of 5.0%, the steady reduction in both overtime and time of in lieu in previous months due to the higher substantive staff levels in the Trust, means the overall cost is below plan by £526k. In addition, planned provision of Private Provider's hours were also 7.1% lower than plan, contributing to a savings of £195k.

- The financial performance of our NHS 111 service is overspent by £607k YTD. The main drivers are the overspent of £254k in December, relating to the requirement to provide incentivised overtime internally and higher GP services with our sub-contractor IC24 to facilitate the delivery of safe service during the festive period while sickness abstraction levels rose to 15.8% in the month. The controls implemented to reduce the over reliance on agency clinicians and overtime at higher premium rates during Q1 is progressing as planned and tracks at £353k adverse to plan YTD. The YTD abstraction of 30.0% is slightly below the plan of 31.9%, however sickness level of 12.3% remains higher than the target of 7%. Recruitment continues to be challenging but steadily stabilising since the Medway move in June and gradually bridging the shortfall in establishment.

- Over half (£319k) of the net £505k overspent in HR is due to higher than planned relocation expenses relating to the international recruitment. The remaining £182k adverse variance is a combination of additional resources and higher external investigation costs. Approval has been secured to fund £90k of the additional resources from reserves and this will be recognised in the January accounts.

- Finance costs is contributing an additional £1,814k of favourable variance, mainly through bank interest received of £1,659k reflecting the high interest rates.

- Underspends across other directorates are largely driven by vacancies in support and back-office functions of £1,233k, partly due to delays in restructures, the timing of training related spend is contributing to £312k savings, which will largely be spent by year end. These are offsetting the increased energy cost driving the overspend in Finance directorate and the requirement for specialised external professional support spend in CEO.

- Depreciation is below plan by £433k 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 December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Pay/Staff Costs	(171,017)	(172,799)	(1,782)	(228,137)	(229,845)	(1,708)
Depreciation	(13,896)	(13,464)	432	(19,066)	(18,318)	748
Premises Costs	(13,677)	(14,175)	(498)	(18,460)	(18,879)	(419)
Transport Costs	(13,207)	(12,883)	324	(17,590)	(17,694)	(104)
Purchase of Healthcare (PAPs;IC24;HEMS)	(10,381)	(9,893)	488	(13,800)	(13,001)	799
Supplies and Services	(6,999)	(7,058)	(59)	(9,341)	(9,403)	(62)
Establishment	(3,879)	(4,399)	(520)	(5,187)	(5,772)	(585)
Education Costs	(1,765)	(1,453)	312	(2,335)	(2,181)	154
Operating Lease Expenditure	(1,517)	(1,326)	191	(2,022)	(1,842)	180
Finance Costs	(1,756)	59	1,815	(2,342)	102	2,444
Clinical Negligence (CNST)	(1,447)	(1,413)	34	(1,929)	(1,887)	42
Other	(3,774)	(5,841)	(2,067)	(3,359)	(5,887)	(2,529)
Total Expenditure	**(243,315)**	**(244,645)**	**(1,329)**	**(323,568)**	**(324,607)**	**(1,040)**
Planned Profit on Sale of Assets	3,469	1,952	(1,517)	4,500	1,952	(2,548)
Total Trust Expenditure	**(239,846)**	**(242,693)**	**(2,846)**	**(319,068)**	**(322,655)**	**(3,588)**

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. Workforce

- Focus has been given by both the ICB and NHS England on our workforce numbers, as a response to that we will be adding some context on the workforce, expressed as whole-time equivalents (WTE).

- The following table shows the analysis of the movement in WTE by directorate and comparison to the month plan:

WTE* By Directorate	Analysis to December 2023			Month of December 2023		
	Nov-23	Dec-23	Movt	Plan	Actual	Variance
Chief Executive Office	58.8	57.3	(1.5)	56.9	57.3	(0.4)
Finance	86.0	87.7	1.7	95.9	87.7	8.2
Quality and Safety	56.0	57.8	1.8	61.7	57.8	3.9
Medical	196.8	203.2	6.4	204.5	203.2	1.2
Operations	3,612.2	3,675.7	63.6	3,618.1	3,675.7	(57.6)
Operations - 111	348.7	386.6	37.9	436.1	386.6	49.5
Strategic Planning & Transformation	125.9	132.9	7.0	135.5	132.9	2.6
Human Resources	78.5	80.2	1.6	75.6	80.2	(4.6)
Total Whole Time Equivalent (WTE)	**4,563.0**	**4,681.4**	**118.4**	**4,684.3**	**4,681.4**	**2.9**

- WTE for December has risen by 118.4 and we were only 2.9WTE below plan.
- An additional 118.4WTE was provided in December compared to last month, mainly in Operations, as expected during the winter period.
- The Trust is 2.9WTE below plan for December, Operations has provided 57.6 additional WTE, as the Trust provided an additional 25,000 hours over plan. 111 is 49.5 lower than planned, from vacancies in both call handlers and clinicians, recruitment continues.

4. Service Line

- The table below shows the Income and Expenditure attributable to our key service lines, this excludes reporting (system) adjustments.

Trust Position	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	239,253	242,127	2,874	319,066	322,653	3,588
Expenditure	(239,295)	(242,162)	(2,867)	(319,068)	(322,655)	(3,588)
Surplus / (Deficit)	**(42)**	**(35)**	**7**	**(2)**	**(2)**	**0**

999 (Emergency Services)	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	216,040	218,281	2,240	288,024	290,871	2,846
Expenditure	(215,798)	(217,896)	(2,098)	(287,610)	(290,540)	(2,930)
Surplus / (Deficit)	**242**	**384**	**143**	**414**	**331**	**(83)**

111 (KMS)	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	20,179	20,209	30	26,905	26,936	30
Expenditure	(20,359)	(20,742)	(384)	(27,137)	(27,408)	(271)
Surplus / (Deficit)	**(180)**	**(533)**	**(353)**	**(232)**	**(473)**	**(241)**

Other	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	3,034	3,637	603	4,136	4,847	711
Expenditure	(3,138)	(3,523)	(386)	(4,321)	(4,708)	(387)
Surplus / (Deficit)	**(104)**	**114**	**217**	**(185)**	**139**	**324**

- 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 £143k 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 £353k worse than plan for the year to date, a £227k decline in expenditure for December as the service increased resources to mee the additional demand over December period, the forecast reflects a small improvement. Service line value above also includes depreciation.

- Other income is as £217k better than plan for the year to date, through additional HEE funding for placements.

5. Efficiency Programme

Summary of Pipeline Tracker schemes

Scheme Category	Fully Validated	Validated	Scoped	Total Schemes	Proposed	Total
	£000	£000	£000	£000	£000	£000
Discretionary Non Pay	234	-	-	234	-	234
EOC Efficiency	500	-	-	500	-	500
Estates and Facilities optimalisation	383	-	-	383	-	383
External consultancy & contractors	29	-	-	29	-	29
Fleet - Fuel: Bunkered Fuel & Price Differential	763	-	-	763	-	763
Fleet -Other Efficiencies	191	-	-	191	40	231
Income generation	205	-	-	205	-	205
IT Productivity and Phones	-	-	142	142	-	142
Make Ready Process	-	-	90	90	-	90
Medicines Management - Consumables	135	-	-	135	-	135
Medicines Management - Equipment	68	-	-	68	-	68
Operations Efficiencies	2,840	-	212	3,052	-	3,052
Optimisation in establishment - clinical	100	-	-	100	-	100
Optimisation in establishment - non clinical	57	-	-	57	-	57
Optimisation in Training	81	-	-	81	-	81
Policy & service reviews	1,490	-	129	1,619	-	1,619
Procurement contracts review	446	23	-	469	-	469
Taxi & Other Vehicle Hire	-	9	-	9	-	9
Travel and subsistence	17	-	-	17	39	55
Unidentified	-	-	-	-	767	767
Grand Total	7,537	32	573	8,142	846	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.

- As shown in the above table, 53 schemes at a value of £8,142k have been recognised on the Pipeline Tracker YTD. This represents 91% of the total target.

- We have identified efficiency plans of £7,569k YTD, which is 84% of the target. This comprises 46 fully validated schemes transferred to the delivery phase YTD, valuing £7,537k, including 1 non recurrent budget underspends scheme of £86k in Medical within the month of December, and 2 schemes at a value of £32k are validated from last month.

- There are currently 5 “scoped” schemes totalling £573k together with the “validated” schemes above awaiting Director sign off and/or QIA review.

- More work is required to develop the £846k proposed schemes to meet the efficiency target for the financial year.

Efficiency Delivery YTD December and Forecast by Cash realising and Non-Cash releasing

2023-24 M9 YTD Efficiencies Status	Plan	Actuals YTD M09			Variance	Plan	Risk Adjusted Forecast			Variance
	YTD M09 Total	Recurrent	Non Recurrent	Total		Full Year Total	Recurrent	Non Recurrent	Total	
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cash Releasing Efficiencies	3,300	1,325	1,457	2,782	(518)	4,807	1,844	1,550	3,394	(1,413)
Non-Cash Releasing Efficiencies	2,488	2,658	7	2,665	177	4,181	4,045	7	4,052	(129)
Total Efficiencies	**5,788**	**3,983**	**1,464**	**5,447**	**(341)**	**8,988**	**5,888**	**1,557**	**7,446**	**(1,542)**
Recurrent /Non recurrent percentenge		***73.1%***	***26.9%***				***79.1%***	***20.9%***		

- Out of the £8,988k annual efficiency target, 53.5% or £4,807k was cash releasing and £4,181k cost avoidance to improve operational performance.

- The Trust has delivered £5,447k savings YTD, compared to the plan of £5,788k. The underachievement of £361k, is worse than the £55k adverse variance we reported last month because the efficiency programme under performed in the Month of December against plan by £286k.

- The overall shortfall in the YTD savings is because delivery of cash releasing schemes remains challenging. The YTD savings of £2,782k is £518k below plan, despite more than half of the total savings being generated from non-recurrent budget underspends. This is partly mitigated by over achievement in the Hear and Treat non-cash releasing scheme.

- 73% of the YTD savings were delivered on a recurrent basis with 27% non-recurrently. 66% of the £3,983k savings were generated from non-cash releasing schemes and a third from cash releasing schemes.

Efficiency Delivery YTD November and Forecast Outturn by Directorate

Directorate	2023/24 M09 YTD Plan	2023/24 M09 YTD Actual	2023/24 M09 YTD Variance		2023/24 Annual Plan	2023/24 Risk adjusted FOT	2023/24 Risk adjusted FOT vs. Plan Variance		2023/24 Fully Validated Schemes	2023/24 M09 Annual Plan vs. FVS Variance	
	£000	£000	£000		£000	£000	£000		£000	£000	
Chief Executive Office	28	40	12	43%	37	40	3	7%	40	3	7%
Finance & Corporate Services	505	322	(182)	(36%)	632	648	16	3%	1,031	399	63%
HR	125	76	(49)	(39%)	189	110	(79)	(42%)	119	(70)	(37%)
Medical	411	569	158	38%	583	602	19	3%	608	25	4%
Operations	3,620	3,302	(318)	(9%)	5,979	4,602	(1,377)	(23%)	4,297	(1,683)	(28%)
Quality & Nursing	14	23	9	62%	26	26	0	0%	25	(0)	(0%)
Strategic Planning and Transformation	1,085	1,114	29	3%	1,084	1,418	333	31%	1,418	333	31%
Unidentified	0	0	(0)	(100%)	458	0	(458)	(100%)	0	(458)	(100%)
Total	**5,788**	**5,447**	**(342)**	**(6%)**	**8,988**	**7,446**	**(1,542)**	**(17%)**	**7,537**	**(1,450)**	**(16%)**

**Note rounding difference on YTD is <£1k>*

- We are current reporting a full year efficiency savings risk adjusted forecast of £7,446k, which is 83% of the full year target and £92k less than the fully validated schemes value of £7,537k. The shortfall is due to risk associated with the delivery of the planned, Procurement contracts review scheme initially anticipated to deliver £380k worth of savings, but currently risk rated red and forecasted to deliver £10k. This is partly being offset by the overachievement in the "Hear and Treat" scheme.

- The present risk adjusted forecast of £7,446k is £1,542k below the £8,988k efficiency target for the year. This is an improvement of £216k compared to last month due to the additional Medical directorate scheme in the month and increase of £130k in Hear and Treat scheme.

- The shortfall of £1,542k is largely due to underachievement of planned efficiencies in Operations of £1,377 dependent on HR policy changes and hence delayed, unidentified gap of £458k and £79k adverse variance in HR. These are partly offset by overachievement in other directorates, notably £333k in Strategy & Planning & Transformation.

- 92% of the £1,542k shortfall is required to be generated as cash releasing efficiency schemes. This will be challenging but mitigations are in place to achieve the underlying efficiency target and to meet the financial break-even plan through a combination of using unplanned contingency, development of identified schemes and non-recurrent benefits.

- Recurrent schemes reduced further to 79% of the total risk adjusted schemes of £7,446k compared to last month. More reliance on non-recurrent underspends to mitigate the shortfall in the efficiency programme is expected to impact the recurrent and non-recurrent ratio.

- The overall efficiency delivery risk remains red because the efficiency saving is profiled to achieve over 39% of the Trust's full year target of £8,988k in the last quarter of the year. This is expected to be challenging to achieve during the winter when operational pressures are high.

- Engagement with stakeholders progresses across the Trust 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.

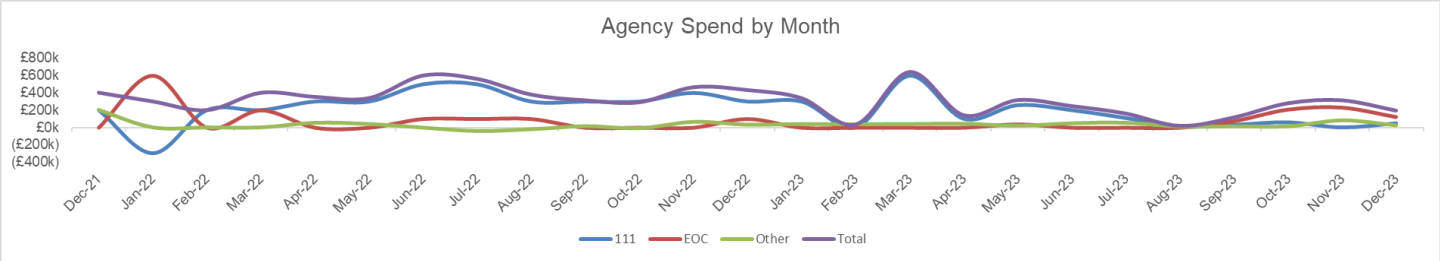
- All Budget holders are required to make a concerted effort to work with their FBP to support delivery of their identified efficiencies, to achieve their directorate allocated targets. This is facilitated through the weekly Check and Challenge and monthly Executive reviews.

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

6. Agency

	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Agency Expenditure	**(1,373)**	**(1,790)**	**(417)**	**(1,792)**	**(2,329)**	**(537)**

- Overall spend with agencies is over plan by £417k, and includes expected additional agency spend to support operational performance and governance. Majority of the agency spend YTD was in NHS 111 (£887k) and EOC (£705k).



7. 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	113,071	(1,502)	111,569	116,434
Intangible Assets	2,482	(146)	2,336	1,901
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**115,553**	**(1,648)**	**113,905**	**118,335**
CURRENT ASSETS				
Inventories	2,512	105	2,617	2,674
Trade and Other Receivables	9,107	167	9,274	9,630
Asset Held for Sale	657	1,517	2,174	2,174
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	40,538	(3,846)	36,692	40,376
Total Current Assets	**52,814**	**(2,057)**	**50,757**	**54,854**
CURRENT LIABILITIES				
Trade and Other Payables	(42,921)	3,000	(39,921)	(49,473)
Provisions for Liabilities and Charges	(10,201)	0	(10,201)	(10,201)
Borrowings	(5,635)	(96)	(5,731)	(5,255)
Total Current Liabilities	**(58,757)**	**2,904**	**(55,853)**	**(64,929)**
Total Assets Less Current Liabilities	**109,610**	**(801)**	**108,809**	**108,260**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(9,528)	0	(9,528)	(9,528)
Borrowings	(21,392)	589	(20,803)	(20,221)
Total Non-Current Liabilities	**(30,920)**	**589**	**(30,331)**	**(29,749)**
TOTAL ASSETS EMPLOYED	**78,690**	**(212)**	**78,478**	**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	177	(212)	(35)	(2)
TOTAL TAX PAYERS' EQUITY	**78,690**	**(212)**	**78,478**	**78,511**

- Non-Current Assets are down by £1,648k in the month represented by new assets under construction of £1,381k net of monthly depreciation of £1,513k. In addition, Coxheath, Leatherhead and Medway properties have been moved to assets held for sale (AHFS) as they are no longer in use and awaiting disposal. Coming back from AHFS is Dover which is no longer being sold. The net impact of these transfers was a reduction of £1,517k.

- Trade and other receivables are up by £167k. The major movements were a £413k increase in VAT recoverable where the refund has returned to more usual levels after the

reduction last month and a decrease of £617k on prepayments. The balance is an increase in accrued income.

- The contra to the movement mentioned in non-current assets above represents the £1,517k increase in assets held for sale. Three properties have been classified as held for sale and one has been declassified as held for sale.

- Cash was down £3,846k which was a combination of reduced income from last month where the Trust received no additional income plus the major reduction in trade payables as a result of clearing invoices for a number of suppliers for non-pay and capital.

- Trade and other payables were down by £3.0m which was primarily a decrease in trade payables of £3.2m. The balance is made up of an increase in accruals of £300k and a decrease in taxes payables of £100k.

- The provision balances are unchanged during the month.

- Borrowings decreased by £493k after payments/PO receipts on property rent, vehicle and DCA leases in the month.

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

8. Cash Flow Position

Cash Flow	Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
EBITDA	15,611	11,419	(4,192)	21,407	16,265	(5,142)
Working Capital / IFRS 16	8,553	(1,735)	(10,288)	13,788	2,338	(11,450)
Capital Payments	(15,406)	(15,096)	310	(18,413)	(17,718)	695
Proceeds from disposal of assets	0	2,895	2,895	0	2,895	2,895
IFRS 16 Lease Payments	(6,028)	(5,958)	70	(8,369)	(8,400)	(31)
Net PDC and interest	(1,173)	1,030	2,203	(2,149)	859	3,008
Cash Movement	1,557	(7,445)	(9,002)	6,264	(3,761)	(10,025)
Opening Cash Position	44,137	44,137		44,137	44,137	
Closing Cash Position	45,694	36,692	(9,002)	50,401	40,376	(10,025)

- The Trust's cash balance as at M9 2023/24 was £36,692k. The receipts for the year-to-date were £262,363k including proceeds from sale of Trust assets of £2,895k.

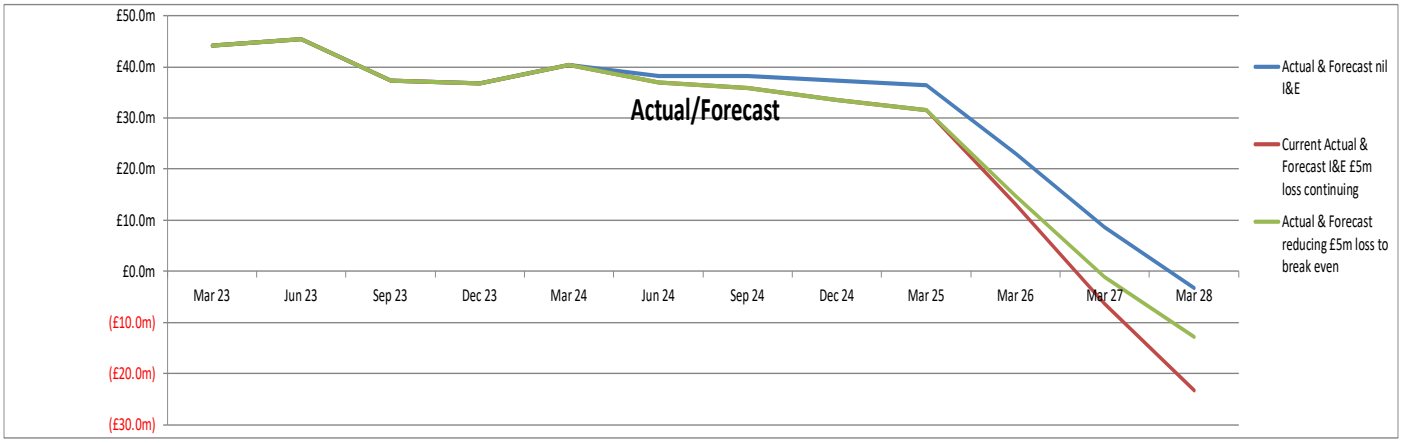
- Capital cash payments were £15,096k for the year to date along with other expenditure of £254,714k meaning the net decrease of £7,445k for the year in the table above.

- The actual cash balance was £9,002k lower than plan primarily due to the reduction in trade payables since year end along with increased net operating costs partially offset by lower

cash spend on capital of £310k and PDC dividend of £580k. The Trust continues to benefit from the higher interest rates with unplanned interest income of £1,659k year to date along with sales proceeds of £2,895k also benefitting the cash to plan.

- This decrease in the surplus on the I&E position of £4,192k is being covered by the disposal proceeds from asset sales of £2,895k and higher interest receivable net of PDC dividend of £2,203k.

9. 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 a deficit of £3.2m by 2027/28 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.

10. Working Capital Ratios

Working Capital Ratios

Ratio	Target	Actual	Risk Status
Debtor Days	30	11	
Debtors % > 90 Days	5.0%	53.6%	
Trade Creditor Days	30	26	
BPPC - Value of inv's pd within target (ytd)	95.0%	86.9%	
Cash (£000)	45,694	36,692	

- Receivable days at month end are 19 days ahead of the target unchanged from last month. New invoices to Kent Air Ambulance, University of Cumbria and Chichester College have slightly increased the trade debt with some smaller receipts partially offsetting.

- 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 NHSE from an invoice related to income back in May plus some July & August recharges awaiting payment.

- Payables days are below target by 4 days for the month. The level of payables has decreased in the month after the processing of invoice payments meaning a decrease of £3,191k of trade payables, GRNI and non-PO invoices awaiting review. This is spread across several suppliers including Churchill, Department of Health, IC24, Elite Medical services among others. Excluding accruals, the measure would be even further below the target of 30 days.

- The BPPC for value of invoices paid has improved in the month to a YTD rate 86.9% with the month itself at 96.7% but is still short of the target of 95% YTD. 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 5 Churchill invoices for £1,782k where delays in processing the invoices against the purchase orders led to failing terms. Without these invoices the BPPC would have been 93.1%.

- Cash is below plan at month end by £9,002k. This reduction links to the reduction in trade payables since year end along with increased operating costs net of income being £14,446k adverse to plan partially offset by lower cash spend on capital of £310k and PDC dividend of £580k. The Trust continues to receive unplanned interest income, due to higher bank interest rates, of £1,659k year to date along with sales proceeds of £2,895k also benefitting the cash to plan.

11. Capital

The in-month capital spend is £1,381k which is £392k higher compared to the plan of £989k. The year-to-date capital spend is £12,422k which is £928k lower than planned compared to the planned £13,350k. 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.

	In Month December 2023			Year to December 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	0	0	0	151	(151)	0	151	(151)
Sheffield Park	0	0	0	0	44	(44)	0	44	(44)
Thameside	0	0	0	0	6	(6)	0	6	(6)
Make Ready - Gatwick	0	6	(6)	0	14	(14)	0	14	(14)
Make Ready - Banstead	0	0	0	0	7	(7)	0	7	(7)
Farnborough	0	4	(4)	0	9	(9)	0	9	(9)
Make Ready - Chichester	0	0	0	0	6	(6)	0	6	(6)
Brighton MRC alterations	0	2	(2)	300	47	253	300	59	241
MDC alterations	100	10	90	300	36	264	300	290	10
Total Estates	100	22	78	600	334	266	600	600	(0)
Strategic Estates									
Make Ready - Medway	0	136	(136)	2,044	1,946	98	2,044	2,100	(56)
Total Strategic Estates	**0**	**136**	**(136)**	**2,044**	**1,946**	**98**	**2,044**	**2,100**	**(56)**
IT									
IT Hardware	42	34	8	374	448	(74)	500	525	(25)
Cyber Security - 2022/23	0	4	(4)	763	767	(4)	763	884	(121)
Network Project	0	0	0	0	(0)	0	0	(0)	0
Resilience - 2022/23	0	154	(154)	0	446	(446)	587	446	141
IT Telephony - 2022/23	0	0	0	508	510	(2)	517	517	0
Data Centre CCTV	0	0	0	0	(4)	4	0	(4)	4
Cleric Developments	0	0	0	0	23	(23)	23	23	(0)
ePCR	0	5	(5)	0	57	(57)	100	100	0
Replacement of CCTV	0	0	0	0	0	0	250	250	0
Frontline Mobile Comms	183	0	183	183	0	183	183	183	0
Desktop Replacements	0	0	0	0	0	0	364	364	0
Laptops	112	0	112	208	0	208	1,785	1,785	0
Total IT	**337**	**197**	**140**	**2,036**	**2,245**	**(209)**	**5,072**	**5,072**	**0**
Fleet									
Fleet engines	13	0	13	111	148	(37)	150	154	(4)
57 Purchased DCAs - 22-23	300	979	(679)	1,600	1,364	236	2,178	2,568	(390)
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	0	0	0	417	20	397	417	20	397
Vehicle Equipment AWD SRVs - Bronze	0	0	0	56	2	54	56	2	54
Buy out of HART Vehicle and IGT lease	0	0	0	0	2	(2)	0	2	(2)
DCA lease buy outs	0	0	0	1,386	1,245	141	1,386	1,245	141
Total Fleet	**313**	**979**	**(666)**	**3,570**	**2,786**	**784**	**4,187**	**4,103**	**84**
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	**750**	**1,334**	**(584)**	**8,674**	**7,764**	**910**	**12,327**	**12,327**	**(0)**

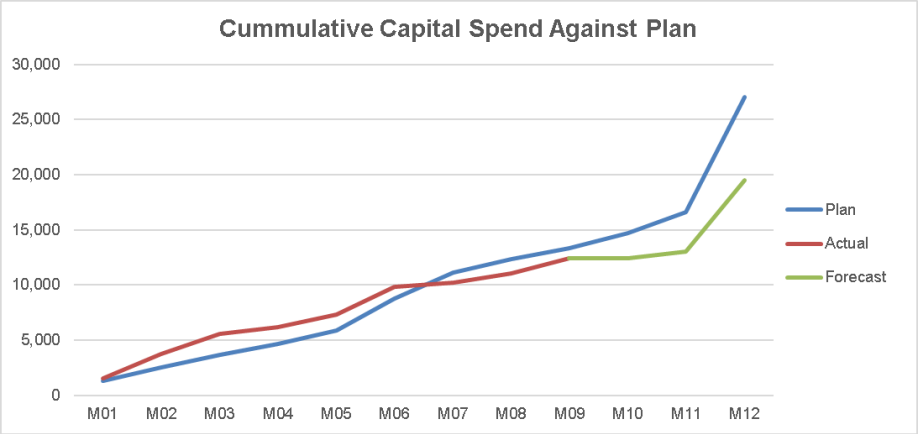
	In Month December 2023			Year to December 2023			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Extra Allocation									
Thanet MRC	0	7	(7)	0	14	(14)	191	191	0
Dartford	0	0	0	0	0	0	110	110	0
Thameside	0	0	0	0	0	0	50	50	0
Tongham	0	0	0	0	7	(7)	7	7	(0)
Paddock Wood Parking	0	0	0	0	0	0	350	350	0
Lewes AS	0	0	0	0	69	(69)	69	69	(0)
East Grinstead	0	0	0	0	15	(15)	15	15	(0)
Make Ready - Chertsey	0	0	0	0	33	(33)	33	33	(0)
Logistics Location - Unit 27	0	0	0	0	11	(11)	11	11	0
Make Ready - Worthing	0	6	(6)	0	16	(16)	16	16	(0)
MDC at PW	0	0	0	0	0	0	336	335	2
Total Extra Allocation	**0**	**13**	**(13)**	**0**	**166**	**(166)**	**1,188**	**1,188**	**0**
CDEL Credit									
Redhill AS - NBV of disposals	0	0	0	0	(916)	916	0	(916)	916
Leatherhead AS - NBV of idsposal	0	0	0	0	0	0	0	(222)	222
Crawley AS - NBV of idsposal	0	0	0	0	0	0	0	(357)	357
Coxheath AS - NBV of idsposal	0	0	0	0	0	0	0	(1,019)	1,019
Medway AS - NBV of idsposal	0	0	0	0	0	0	0	(583)	583
Vehicles - NBV of disposal	0	0	0	0	(16)	16	0	(16)	16
Total Sales Income	**0**	**0**	**0**	**0**	**(932)**	**932**	**0**	**(3,113)**	**3,113**
NMA Kits	0	5	(5)	0	153	(153)	0	250	(250)
Station IT Upgrades	0	2	(2)	0	628	(628)	0	645	(645)
Crawley HQ	0	3	(3)	0	15	(15)	0	40	(40)
ICCS	0	0	0	0	0	0	0	1,018	(1,018)
Crawley IT equipment	0	0	0	0	0	0	0	1,160	(1,160)
Total Spend	**0**	**10**	**(10)**	**0**	**796**	**(796)**	**0**	**3,113**	**(3,113)**
Total CDEL Credit	**0**	**10**	**(10)**	**0**	**(136)**	**136**	**0**	**0**	**(0)**
Total Purchased Assets	**750**	**1,357**	**(607)**	**8,674**	**7,795**	**879**	**13,515**	**13,515**	**0**
Leased Assets									
Estates									
Lewes VMC	157	0	157	157	559	(402)	620	559	61
Haywards Heath College	0	0	0	327	158	169	327	158	169
Sheffield Park	0	0	0	310	931	(621)	310	931	(621)
Telford Place	0	0	0	0	0	0	205	0	205
Bognor South	0	0	0	25	131	(106)	25	131	(106)
Staines West	0	0	0	25	12	13	25	12	13
Cranleigh	0	0	0	25	34	(9)	25	34	(9)
Paddock Wood ACRP	0	0	0	25	59	(34)	25	84	(59)
Medway ACRP	0	0	0	25	0	25	25	0	25
Gatwick MRC Car Park	0	0	0	25	0	25	25	0	25
Arundal ACRP	0	0	0	0	38	(38)	0	38	(38)
Folkstone ACRP	0	0	0	0	0	0	0	0	0
Peacehaven	0	0	0	475	121	354	475	121	354
Birdham	0	0	0	83	10	73	83	10	73
Brighton	0	0	0	83	0	83	83	0	83
Epsom	0	0	0	83	0	83	83	100	(17)
Heathfield	0	0	0	83	0	83	83	0	83
Hailsham	0	0	0	83	0	83	83	79	4
East Grinstead	0	0	0	82	0	82	82	0	82
Redhill ACRP	65	0	65	82	9	73	82	9	73
Total Estates	**222**	**0**	**222**	**1,998**	**2,062**	**(64)**	**2,666**	**2,266**	**400**

	In Month December 2023			Year to December 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	933	4,387
AWD SRVs - CCP	0	0	0	2,040	1,961	79	2,040	1,961	79
eVito SRVs - 3	0	0	0	171	0	171	171	0	171
Driver Training Vans	0	0	0	0	0	0	475	0	475
Lease Cars	17	24	(7)	149	411	(262)	200	429	(229)
Total Fleet	**17**	**24**	**(7)**	**2,360**	**2,372**	**(12)**	**8,206**	**3,323**	**4,883**
Specialist Ops									
HART	0	0	0	0	0	0	1,900	0	1,900
SORT Vans - 3	0	0	0	90	193	(103)	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	0	450
Total Specialist Ops	**0**	**0**	**0**	**318**	**193**	**125**	**2,668**	**421**	**2,247**
Total Leased Assets	**239**	**24**	**215**	**4,676**	**4,627**	**49**	**13,540**	**6,010**	**7,530**
Total Capital Plan	**989**	**1,381**	**(392)**	**13,350**	**12,422**	**928**	**27,055**	**19,525**	**7,530**

*The Trust received an extra allocation via the ICB of £1,188k in October 2023. This increases our purchased assets allocation.
**The Trust will receive a CDEL increase for the net book value of any sales completed in the year, this could be up to £3,113k in total, as per the below table the Redhill NBV has already been incorporated.

The Trust anticipates meeting its purchased CDEL by year end but is forecasting that it will underspend on the leased plan by £7,530k. The ICB has, in November, been issued a lease assets allocation, this is £8,514k lower than the M07 FOT for the area. SECAmb's underspend of £7,530k will assist the ICB in meeting their reduction. 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		



12. Risks and Opportunities

Risk	Impact	Likelihood	Score
Issue raised by Staff/Unions that Agenda for Change, Pay, Section 2 (maintaining round the clock services) has not been correctly applied.	>£2.0m	Highly Likely >80%	25
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
Depletion of Trust Reserves to support future years improvement, requiring further funding	>£1.5m <=£2.0m	Likely >50%<=80%	16
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.

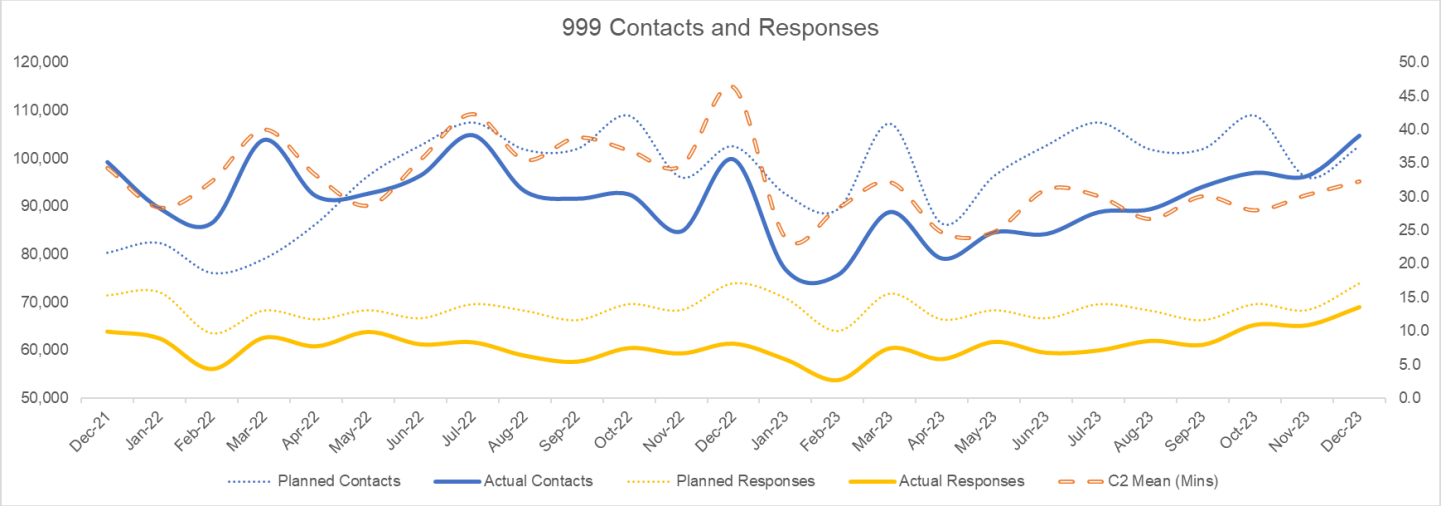
Opportunities	Impact	Likelihood
Additional sales of Trusts unused properties would improve the I&E position and increase the capital expenditure (CDEL) limit, which would allow the Trust to invest further than planned	>£2.0m	Possible 50/50

- 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:



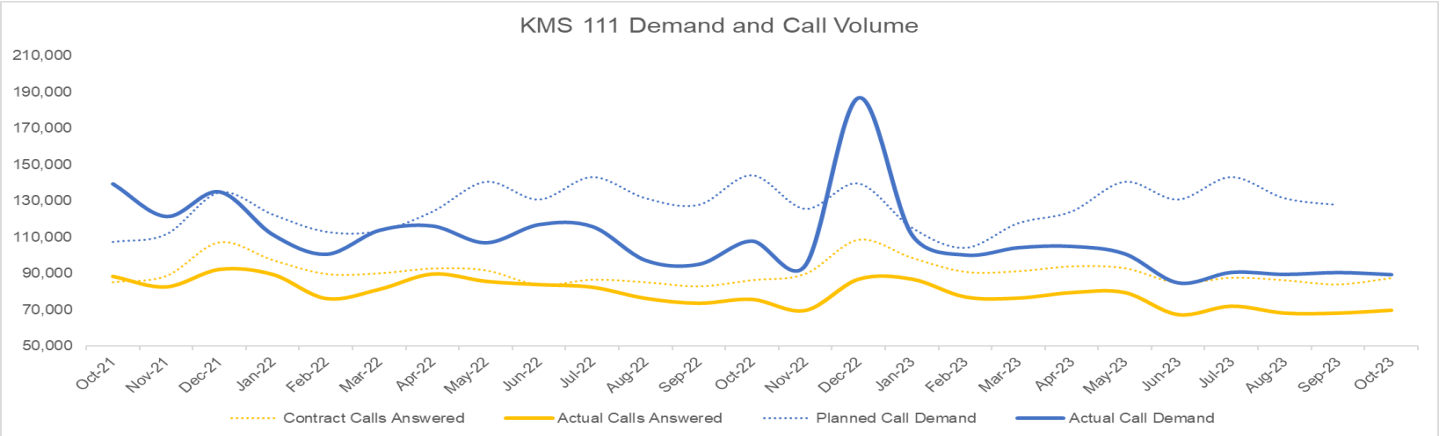
999 contacts (demand) 3.5% down against last year to date, with response activity being 3.1% greater, daily demand (+5.2%) and responses (+2.3%), was up against the previous month as expected over December.

This reduction in demand, increased Hear & Treat rates (11.8% vs .9.8%) 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 28.8 minutes year to date compared to 36.9 minutes last year as at M9 (YTD).

Handover delays have an impact on the availability of crews to reach patients in time, 21,902 hours less were lost in the 9 months to December 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 28.8 minutes year to date against a plan of 30.6 minutes.

111 Activity:



December 2023 saw demand (calls offered) increase by 26.4% more than December, as the winter takes hold.

Both demand and activity are down versus the same period last year (YTD) with demand 17.3% lower and activity 9.8% 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 declined to 25.8% for December. 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 15.9% (9.4%) and 333 (172) 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

		Item No	82-23

Name of meeting	Trust Board
Date	08th February 2024
Name of paper	2024/25 Operating Plan
Executive sponsor	Saba Sadiq – Chief Finance Officer
Author name and role	Saba Sadiq – Chief Finance Officer Graham Petts - Head of Reporting and Financial Planning Judit Friedl - Deputy Chief Finance Officer Alex Croft - Assistant Director of Data and Analytics

This report provides a progress update on Trust's 2024-25 Operating plan.

NHS England has issued a brief assumptions document that forms the basis of the Trust's draft operating plan.

Draft and final plans are due to be submitted to NHS England on 29 February and 21 March 2024 respectively.

There will be further iteration of the plan as further guidance is issued by NHS England (next is anticipated at the end of January 2024) and the Trust refines its operating plan for final submission.

Recommendations, decisions, or actions sought	The Trust Board is asked to note this update ie that the operating plan is in development.

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).	NA

NHS
South East Coast Ambulance Service
NHS Foundation Trust

2024/25 Operating Plan

Trust Board

8th February 2024

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

Introduction to the 2024/25 Operating Plan

- NHS England (NHSE) has yet to publish its annual operating plan guidance as discussions continue to take place between the Department of Health and Social Care, NHS England and HM Treasury. The guidance is anticipated to be issued at the end of January 2024.

- NHSE has issued a brief assumptions document which is the basis on which the NHS is currently basing its operating plan.

- A further complexity in the development of the operating plan is that the Trust's strategy continues to be developed. The strategy has the potential to significantly change the direction of the Trust and therefore the development of the 2024/25 operating plan.

- A key facet of the operating plan will be to maintain the Category 2 (C2) 30 minute mean. This is set against a backdrop of financial envelopes tightening and ever-increasing levels of demand. A further facet of the operating plan is that it assumes flat cash.

- NHSE will continue to look for systems to achieve breakeven in 2024/25 which will be challenging both at system and at provider level.

Development of the 2024/25 Operating Plan

- The Trust has an established annual planning process which supports the development of the operating plan. There is a multi-disciplinary team, the annual planning group (APG), that meets on a weekly basis to develop the Trust plan with a particular focus on activity, workforce and financials. The operating plan development also includes development of the Trust's 5-year capital programme.

- APG reports to Strategy Executive Management Board (EMB) via the Chief Finance Officer (CFO) and Executive Director of Strategy.

- Oversight of the development of the plan is performed by the CFO and the Executive Director of Strategy through weekly meetings with key members of the APG to provide support and direction to its developments.

- The Executive Management Board (EMB) is being updated on key elements of the operating plan on a fortnightly basis.

- The Finance and Investment Committee are being updated on a bi-monthly basis and the Trust Board will also be updated on the same basis.

2024/25 Planning Timetable

Action/Governance	Deadline	Owner (oversight)	Lead (action)
Joint Leadership Team - Top-down Plan drafted - Define high level income and expenditure to identify gap	17/01/24	SS	JF
Update to FIC	25/01/24	SS	JF
Planning assumptions to be reconfirmed by NHS England	31/01/24	SS	GP / JF
Strategy option for Board sign off	07/02/24	CEO	Board
Draft Capital complete - refresh of 3–5-year plan	07/02/24	JF	RM/GP
SMG review of draft plan	14/02/24	JF	SMG
EMB update vs 1 of plan for peer review	14/02/24	SS	EMB
EMB approval of draft plan	14/02/24	SS	EMB
Draft plan Submission to ICB	21/02/24	SS	JF
Peer review of draft systems plans	23/02/24	SS	CFOs
1ST Plan submission to NHS England	29/02/24	SS	JF
Revision and update of plan	10/03/24	JF	Finance team
999 Financial Contract negotiations 2024/2025 agreed	10/03/24	SS	JF
JLT final review of plans	13/03/24	SS	JLT
EMB approval of plan	13/03/24	SS	EMB
Update to FIC	21/03/24	SS	FIC
Board approval of plan	21/03/24	SS	Board
Plan Submission to ICB	21/03/24	SS	JF
Final submission to NHS England	28/03/24	SS	JF

2024/25 Working Operational Assumptions

- As previously mentioned the Trust has developed working level operational assumptions to develop its operating plan pending the publication of national planning guidance.

- Working assumption of a target C2 (Category 2) Mean of 30 minutes

- Internal activity projections show a 2.4% growth
- NHS England currently planning for a 3% growth in activity nationally
- Additional growth of 0.5% projection from Right Care Right Person

- National focus on ensuring field operations hours are maintained

- Expectation to improve hear and treat (H&T), without additional funding
- Push to increase Single Point of Access and Urgent Community Response usage with no increase in capacity, availability, scope or funding

- Reduction on reliance on Private Ambulance Providers (PAP) and overtime as per NHS long term workforce plan

Operational Plan: Workforce assumptions

- We are currently projecting to achieve a **C2 mean of 33 minutes in 24/25** if we "do nothing".

- To achieve a 30-minute C2 mean within our current operating model, we will need to increase our field operations capacity by 90 WTE, increasing the total effective workforce from 2485 to 2575.

- Year to date, **attrition has fallen 30%** below planned levels with 138 WTE of leavers vs a planned 198 WTE and has contributed to a strong establishment position with field operations **currently 49 WTE above plan**.

- This results in the Trust requiring a **recruitment pipeline of circa 300 – 320 WTE in 24/25**. This should be achievable given that we have recruited 347 WTE YTD, with an additional 50 WTE projected to be recruited within Q4.

- This recruitment pipeline could be pushed further to mitigate the requirement for PAPs in 24/25, combined with a short-term reliance on additional overtime until the full workforce requirements are met.

- The full detail of the workforce plan is currently being developed and will be shared in a further update.

Operational Risks/Issues

- There are several risks that have become prevalent within the 24/25 planning round that will impact on the delivery of plan. A few prominent risks have been highlighted below.

- Contracts with our Private Ambulance Providers (PAP) are due to expire in July 2024 and a decision will need to be rapidly made as to whether we continue utilising PAPs. There is also an anticipated 20-30% cost increase associated with the renewal as current costs are below market average.

- If field operations capacity is to be increased in 24/25, the capacity of our Double Crewed Ambulance (DCA) fleet becomes a potential issue as we may require **up to 43 additional DCAs.**

- Experienced Paramedic capacity has been escalated as a risk within the Annual Planning Group as there is an intense need for these staff with trainee associate ambulance practitioners and student paramedics needing circa 450 hours per year with mentors, whilst there is a push to increase the number of staff undertaking remote clinical assessment which reduces their capacity to support students. Quantification of this risk is currently underway, and an update will be provided in due course.

2024/25 Operating Plan: Financial Assumptions

- The financial assumptions which the Trust is using are based on NHSE guidance. The key points are:

- Ambulance funding of £200m issued in 2023/24 will be added to 2024/25 ICB core programme allocations, including an uplift to recognise the Cost Uplift Factor (CUF) and general efficiency requirement. In 2023/24, this funding was distributed to the lead commissioner (ICB). For 2024/25, it will be recurrently added to the core programme allocations of all ICBs, with each ambulance trust's total funding issued to its commissioning ICBs based on the weighted population of the ICBs. This is anticipated to have a neutral impact on ambulance trust income.

- 0.2% growth on 0.9% for all trusts providing acute and ambulance services (we need to ensure we get this as in 2023/24 no growth was shared out by Surrey Heartlands ICB)

- Cost uplift factor (CUF) will be net at 1.2% (gross CUF is 2.3%, there is an efficiency requirement at 1.1% hence the net of 1.2%)

Cost	Estimate	Cost weight	Weighted estimate
Pay	2.7%	69.3%	1.8%
Drugs	0.6%	2.4%	0.0%
Capital	1.7%	7.6%	0.1%
Unallocated CNST	0.6%	2.2%	0.0%
Other	1.7%	18.4%	0.3%
Total			2.3%[1]

2024/25 Operating Plan: Financial Assumptions

- Depreciation: Dynamic funding model based on actual expenditure will be implemented.
- Pay funding identified as recurrent will continue into 24/25 and 2.0% headline pay growth across all staff groups with 0.1% drift.
- Agency staff expenditure reductions will continue to be required.
- 23/24 additional inflation will be recurrent for 24/25 planning purposes.
- NHS employer pension rate will be 23.7%. Central payments will be made for the difference between employee contributions as in previous years (rate for employees above the threshold will continue to be 14.38%). The Trust received these in 23/24.
- IFRS16 revenue (leases) will continue at the same 23/24 levels.

2024/25 Financial Plan: Capital

- As part of the Trust's financial plan the Trust will be developing a 5-year capital programme. This will need to be aligned to the Trust's strategy.

- The system is allocated a capital allocation which is distributed amongst each of the provider organisations.

- Capital continues to be constrained across the NHSE and there will be more requirements than the capital allocation made to SECAmb.

- The Trust is looking to hold workshops for stakeholders across the organisation who wish to make capital investment decisions. This will be prioritised by the stakeholders so that as part of the development of the operating plan the Trust has a prioritised capital programme aligned to the Trust's strategy.

2023/24 Operating Plan: System

- Weekly, Integrated Care System (ICS) meetings are taking place and SECAmb is attending.
- Joint forward plan meetings with ICS partners take place where discussion about operational performance, activity and workforce take place. This feeds into the Trust's Operating Plan.
- ICS CFO meetings and are taking place on a weekly basis to develop the financial plan.
- A system level financial plan is currently being developed. Surrey Heartlands has requested all Providers to confirm by 26 January 2024 what their underlying, recurrent financial position is to establish the 2024/25 baseline.
- The 2024/25 baseline will be used for agreeing / negotiating resource allocation to Providers.

2023/24 Operating Plan: Next Steps

- The Trust Board are asked to note that the work to develop its 2024/25 operating plan is underway but detailed guidance is awaited.

- The Annual Planning Group (APG) will meet weekly to develop the operating plan and will triangulate activity, workforce and financial assumptions.

- APG will provide weekly updates to the CFO and Executive Director of Strategic Planning and Transformation.

- Budget Holders and Finance Business Partners will meet with budget holders to support the budget setting process.

South East Coast Ambulance Service
NHS Foundation Trust

	Agenda No	82-23
Name of meeting	Trust Board	
Date	8 February 2024	
Name of paper	Finance and Investment Committee Escalation Report	
Author	Howard Goodbourn, Independent Non-Executive Director – Committee Chair	

This report provides an overview of issues covered at the meetings on 25 January 2024.

Under matters arising, and in the context of the facilities management system, the committee explored the need for a data strategy to help provide clarity on the approach to system procurement and how we store data. The recent external IT review includes recommendations about bringing the data and digital teams together, which the committee supports. The executive has this in hand and have engaged a person suggested by AACE as a sector expert. Our digital strategy will then be developed in line with our new clinical strategy.

Item	**Link to BAF**
Financial Performance & Planning	SP Objective 6 – Meeting our Financial Plan S&P Objective 7 - Cost Efficiency BAF Risk 16 – Financial Sustainability

The committee undertook a holistic review of performance and planning. At Month 9 the committee is assured that we will deliver the planned year end breakeven position, albeit supported by a range of non-recurrent measures. In the context of the challenges faced across the system, this is a really positive position.

Looking further forward to the risks next year and beyond, there are lots of moving parts with the new strategy and the likely transition period. Ideally, the committee would like to see our strategy helping to drive better value, starting with the need to right size the organisation so we can start to take a more strategic approach to efficiencies. Discussions with system partners are ongoing. In the meantime, the summary is that we will meet our plan for the year both in terms of finances and operation performance (C2 30-minute mean).

111 Deep Dive	Risk 16 Financial Sustainability

There was a really constructive review of 111, through the lens of both finance and operational performance. The committee is assured that we continue to deliver a safe and effective service within the funding received, which the Board will recall was reduced by commissioners at the very start of the financial year by £3.3m. Call handling is still very challenged, but the service is clinically led and towards the top end of national performance.

The Board will need consider the strategic alignment of 111 CAS as part of its ongoing review with the system.

Estate: Medicines Distribution Centre (MDC): Project Update	Risk 27 Clinical Risk at Medicines Distribution Centre Risk 34 Sustainability in the Medicines Governance Team
An update was provided on the £1.3m investment that was agreed last in Q3 to address the clinical and H&S risks at the MDC. This is Phase 1. Primarily, this relates to a new lift and other remedial works and the executive restated its expectation that this will be completed by 31 May 2024. Phase 2 is looking at a longer-term solution acknowledging that the site is not suitable for the MDC. The options appraisal will come back to the committee and then to Board as part of the estates strategy and this will include consideration of the MRC at Paddock Wood too. The committee also noted the emerging risk linked to the Chief Pharmacist leaving the organisation at the end of February. The executive set out the mitigation of this to ensure cover until a substantive replacement is found. This aspect was referred to the quality committee.	
Procurement	Risk 16 Financial Sustainability
A helpful paper was received setting out the priorities for improvement arising from the Internal Audit last year. There is some concern about the pace of progress especially linked to the earlier discussion about efficiencies and the impact from next year. This update was requested by the Audit Committee who will follow up at its next meeting in March.	
Environmental Sustainability	S&P Objective 8 - De-Carbonisation Extreme Risk 304 – Net Zero
There is good progress being made in some of the areas within the plan. The committee discussed how we should report this going forward given the links to a range of different groups. Once established the new transformation team will hold the plan and report regularly to Board via the strategy. There is more capability needed to improve our reporting and being clearer how the actions are impacting carbon emissions.	
999 Operational Performance	RC Objective 1 A Category 2 Mean response time that is improved and closer to National Standards RC Objective 2 A Call Answer Mean time of 10 seconds Risk 14 – Operating Model
Call answer continues to be challenged, but there is an improving trajectory as part of the improvement plan the Board saw in Q3. Recruitment has increased, mostly due to the impact of the new Medway site. C2 performance remains strong, and as mentioned earlier, the expectation is that we will meet our target of 30-minute mean for the year; we are likely to be the only ambulance trust to achieve this. Comparatively, we also have stronger performance in C1 and C3 and H&T is improving too. So, overall, a generally positive picture which is good for patients and our people. However, this is tempered with the need to use the discussions with our commissioners and system partners to strive to do better. HART is improving with more days with full staffing and SORT is also in a stronger position.	

Specific Escalation(s) for Board Action	There are no specific issues requiring the intervention of the Board.