South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors
Meeting to be held in public.

14 March 2024
Crawley HQ, McIndoe Rooms 1 & 2
1000-1230

Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
066/23	10:00	Chair's Introduction	-	-	Chair
067/23	10:01	Apologies for Absence	-	-	Chair
068/23	10:01	Declarations of Interest	-	-	Chair
069/23	10:02	Minutes from the previous meeting, Action Log and Matters Arising	Y	-	Chair
Statutory duties: performance and holding to account					
070/23	10:05	Chief Executive Update	Y	Information	Simon Weldon
071/23	**Area of assurance:** To inform the discussion on the agenda items listed in this section, included is the Integrated Quality Report, Board Assurance Framework and Board Committee Escalation Reports.		Y	Assurance	
	10:20	**Financial Plan 2024-25**	Y		Simon Weldon
		Strategy • Agreed Direction • Implementation - Funding & Structure	Y Verbal		Max Puller Simon Weldon
		People • Improving Culture; Staff Survey Results • Health & Safety	Y Verbal		Subo Shanmuganathan
		Well Led • External Review	Verbal		David Astley
		Recovery Support Programme Update	Verbal		Simon Weldon
11:45 - COMFORT BREAK					
Statutory duties: Member and public engagement					
72/23	11:55	Membership Development Committee Report	-	Information	David Romaine
Committees and reports					
73/23	12:00	Nomination Committee Report	Y	Information	David Astley
74/23	12:10	Governor Development Committee Report	Y	Information	Leigh Westwood

75/23	12.20	Governor Development Committee ToR	**Y**	Decision	Leigh Westwood
76/23	12:25	Governor Activities and Queries Report	**Y**	Information	Leigh Westwood
General					
	12:30	Any Other Business (AOB)	**-**	-	Chair
	12:22	Questions from the public	**-**	Accountability	Chair
	12:23	Areas to highlight to Non-Executive Directors	-	Assurance	Chair
	12:24	Review of meeting effectiveness	**-**	-	Chair
Date of Next Meeting: **27 June 2024**					Chair

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

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

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

Status Key Code: C- Complete, IP - In progress, S - Superseded

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST
Trust Council of Governors Action Log

Key

Closed
Due

Meeting Date	Agenda item	AC ref	Action Point	Owner	Completion Date	Report to:	Status: (C, IP, R)	Comments / Update

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 28th November 2023

Present:

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

In attendance:

David Ruiz Celeda	(DRC)	Executive Director of Strategic Partnerships

Apologies:

Ann Osler	(AO)	Public Governor
Simon Dobinson	(SD)	Appointed Governor
Leigh Westwood	(LW)	Public Governor
Peter Lee	(PL)	Company Secretary
Chris Gonde	(CG)	NED

Minute takers:

Richard Banks	(RB)	Assistant Company Secretary

Item No.	Introduction and matters arising
045/23	**Introduction** DA welcomed all to the meeting and confirmed new governor appointees following recent elections.
046/23	**Apologies for Absence** As referenced above.
047/23	**Declarations of Interest** None.
048/23	**Minutes from the previous meeting, action log, and matters arising.** The minutes of the previous COG held on 14th September 2023 were recorded as a true and accurate record, with slight amendments. BC commented that sections in the previous meeting were missing discussing the MDC report. Action Log was reviewed and updated.
	Statutory duties: performance and holding to account
049/23	**Strategy Update** DRC shared a presentation explaining that the needs of our population are changing. We expect to see a 15% growth in the next five years as our population grows, ages and increases in complexity. We are seeing significant NHS challenges with funding and system pressures. The ICBs have been set up to help improve working relationships with our partners and to help deliver more effective care. We are currently not sufficiently linked up with our partners to deliver integrated care due to our operating boundaries which impacts leadership capacity, and due to the systems currently in place. We need to fundamentally define our role as an ambulance service. Our current model has not evolved enough to meet our current patient needs. Only 13% of patients now need critical or emergency care support yet a majority of patients receive the same response. We are not matching our skills sets to attend to the changing needs of patients such as end of life care, falls, mental health an minor injuries. DRC talked through the strategy and timeline of what has happened so far, reflecting on the seven items that came out of the previous sessions with CoG. 1. Develop a clinically led strategy. 2. Develop for and by our people.

	3. Inclusive engagement. 4. Financially sustainable envelope. 5. Innovative. 6. Working in partnership. 7. Executable and be delivered in 3-5 years. It was confirmed that we are currently at the end of the diagnostic phase. Phase two of the design phase starts next week. The design phases in December and January reflected the original timetable. The board will receive the conclusion and recommendation on 8 February 2024 with a full publication expected at he end of March. DRC relayed to CoG the feedback that has been collated so far from patients, staff and partners. DRC confirmed that If we do nothing over the next five years our model of care will fail to meet the requirements of the population. It was noted that we spend 33% longer with patients now than in 2018. Staffing is also impacted by SECAmb having the lowest staff satisfaction in the NHS. In summary, DRC noted that we are running out of road. Our operating model needs to change to improve how we deal with increasingly complex patients and how we improve our partnerships. It was noted that if we do continue our existing model, an additional 600 people would be required and this is not a sustainable model. DRC noted the engagement that has been underway and confirmed that 300-400 colleagues have been engaged with, reflecting that a lot of the engagement sessions have been locally led. DRC confirmed 62 letters to ICB leaders and partner organisations have been distributed asking them to be involved. 30 have responded and have been part of the workshops or interviews. We have had just under 300 responses from our patient surveys. We are working on ensuring that all groups are fully represented and have the opportunity to feedback. DA reflected that the role of the board is to set strategy after consultation and noted that we need to draw a line as an Ambulance Trust and force this conversation. DA commended the executive for inputting feedback from staff and the wider healthcare and social community. DA invited any questions from the Council. MB asked: 1. It is important we do not over-promise and under-deliver and can we ensure a sense of realism. How can you be assured that NHS organisations work together with SECAmb and don't move goalposts? 2. Is there a disconnect in planning timetables? It was confirmed that the strategy final plan will be ready for March 2024 however NHS timetable for planning is January. This is a disconnect. SW responded:

	1. SW advised a lot of his time is spent meeting colleagues. He is going to be talking to the Sussex ICB Board to ensure we proceed in lockstep. The critical question we have is that we can dream of what we want however if the rest of the system can not deliver those aspirations we will not succeed. ICB colleagues are locked into this process with us to ensure we have come up with something realistic. At the end of each stage we are signing it off internally and externally. The question SW is asking the boards is do you recognise this as our reality? If not, we may not be able to offer you the same for the amount we are being paid. If they are going to pick up the demand, how do they do that. 2. Planning assumptions are already in for next year. SW advised he has spoken about right-sizing the organisation and can plan now for what we need to do in terms of the cost envelope we can continue to operate in. SW further commented what we are discussing today is not the future we are asking what the challenge is and how do we respond to it. In March we will create the implementation model to include system leads. MR noted within the Fire Service we are looking at population growth especially in urban areas with climate change in mind, and the impact on health and society with severe weather events. The Fire Service are looking at how they operationalise, are there things that can be shared going forward? HG responded who DA confirmed has championed this issue. HG advised we do have a sustainability plan, however we have not specifically picked up the impact on patients. DRC commented that the green plan was approved earlier this year which is an integral part of the strategy. Looking at the forecast it has limited impact for coastal areas. We need to think about what this means with our resilience in mind. DRC commented on we can build resilience. We need to have a strong vision and narrative from the board about what the final goals and long term outcomes look like. TQ asked when discussing with wider health system, how are public health colleagues planning to mitigate risks as part of the larger effort on this. DA advised the board are taking this point forward. VW commented that the ICB discussion is paramount as social care is paramount and without social care in place, patients will be back in hospital. Social services is the third sector and represents so many people in the home. VW commented currently this is not integrated. VW's customer age base has reduced to 40+. VW commented that if the referral process for paramedics was better it would help. SW responded that at the recent Kent Board that conversation was held. The next stage is understanding who is caring for these patients so that they do not need to be conveyed to hospital. Radical thinking is needed as traditionally the ambulance service responds to a crisis really well, but we need to get on the front foot and try and be proactive.

	NH agreed adding that the ambulance service is proactive but doesn't currently have the right support network, noting that we need to align ourselves as cannot be a band aid to all. NH commented he was disappointed with the survey response from partners of roughly 50% not engaging with us and only 10% of staff being engaged. NH commented that in Hertfordshire a lot of universities are offering paramedic courses which are not fit for purpose and often students have a warped perspective of what we need to do. As an employer, why aren't we engaging with universities? DA noted that the challenge to the executive is to make sure what we are doing is relevant, advising that those points are being addressed. We are engaging with all parties to make sure the strategy is relevant. AG commented that in terms of engagement for strategy, they have received the letter and have responded online and more meaningfully than that by linking in with the team to speak the students. As we have an education partnership with SECAmb, all colleges and universities have been invited. AG commented that the curriculum is driven by regulatory and statutory bodies, college of paramedics, are they currently reviewing the curriculum. It is an ongoing partnership and AG commented at the previous meeting no SECAmb representatives were in the room. NH noted that this is not a direct criticism to the university. What the regulatory bodies are telling you to teach is 20 years out of date. A new and generalist approach is needed. NH noted his disappointment that the meetings aren't being attended by SECAmb as engagement is key in making changes. DA commented that it was disappointing nobody attended the meeting and confirmed SW would pursue representation. MB reflected on public engagement and the importance of asking them focused questions. DA noted that there is a briefing for governors to help them steer conversations. DA summarised that today was a progress report with timescales noting the board are working collectively on the strategy noting we need to be able to support our governors and look at wider engagement with the public. We need to ensure we are not all things to all people. DA thanked DRC for his presentation.
050/23	**Chief Executive Report** SW confirmed that Amanda Pritchard (AP), NHS England Chief Executive, visited the Medway Centre and was very pleased to host the CEO of the NHS. We are the only ambulance service to have all three services under one roof.

	AP was extremely grateful to us to host and take her out in an ambulance and saw the patients, and what we do and what we do well. SW drew attention to the volunteer conference which was the first of its kind. SW reflected on how great it was to talk to over 200 people and see a sea of red, all of whom give their time to us in so many ways. The feedback was extremely positive, and this will not be the last event of its kind. SW thanked all volunteers for all the hard work that they do. 2023 Awards season was a huge success. SW reflected that he has been to many in his career but this by far was the best he has attended. It was an astonishing experience because SW met so many who have made such a difference. The national backdrop for the NHS is going to be challenging. Money this year is tight, and we know that NHS England are battling for an extra £1bn going into winter and to cover the cost of strike action. SW noted that difficult times are ahead however we remain on track and to deliver our control total and we remain on track to do so. We need to maintain the ability to balance and be viable as an organisation going forward. How to right size the organisation to be able to live within the financial constraints. The strategy is our opportunity to get ahead of this and SW expects us to do so. SW noted we are one of a few ambulance services that remain to achieve C2 mean. The other ask for us is to hit the 30-minute standard. This is what we have been asked to deliver. As we think about the strategy, we need to think about how we maintain this going forward. Recently, SW went out with AL in his CFR role and thanked AL for hosting him on that day. SW noted that the work that the CFRs do is of real value and importance. DA confirmed that the volunteer event was first class and the awards ceremony also hosted blue light colleagues which was a great display of joint work. What was pleasing for DA is the award presented to both fire and police colleagues. DA invited any questions for any clarity. DR Asked: In the CEO report, 7 priorities/key objectives are outlined. Is there any assurance that can be given to the COG that we can make these priorities objectives over the next 2-3 years. Response: CEO is performance managed by the Chair and these are monitored by the appointment and remuneration committee. DA confirmed regular conversations are held with SW around this. SW does have stretch targets and DA provided assurance of the excellent work CEO is doing. DA commented he has more assurance now than 5 years ago.

	DA confirmed SW has full support of the board and it is the role of the board to oversee through its sub-committees. BC Asked SW: At COG this time last year questions were asked over the quality of the IT after a major outage. Your report of 05 October refers to an extension of the investigation that has taken place. At an earlier COG, there was a brief reference to it within the Finance and Investment Committee Report. Noting we are now end of November could you clarify when we could expect a coherent and understandable report? Response: An independent review has been completed and some important recommendations have been made. A need for better leadership and a digital strategy to be input. MW and PB have seen the report and this is going to the Audit Committee on 14 December 2023. MW confirmed he feels it does cover the root cause of the issue and confirmed that the Audit Committee would be monitoring this carefully. View is NEDs are assured but need to change the leadership of that function. PB confirmed that the scope of the report was broad and was conducted by the recent head of LAS who also worked here previously. PB confirmed he is pleased with the report and the actions already undertaken. It was noted that this has not yet been to the board however the report is being implemented and the Council will have an update at the next COG Meeting. MB asked within the IQR in July and August Hospital Handovers and Call Answering times and with winter pressures in mind is achieving these targets still achievable. SW confirmed that yes, the ability to hit C2 mean across English ambulance services is not an insignificant achievement to be going into winter with. We have the best hospital handover times in the country. That is a great tribute to our teams within stations. No small matter to continue to achieve that. Regarding call Answering is a systemic weakness and we have included interim steps in the run-up to winter to use virtual capacity and technology advances to support. Call Answering has stabilised but is not where we would like it to be. This comes then to a strategic view for this building in this area. Looking across other ambulance trusts as we go into winter, we are in a strong position however SW noted we will face challenges. DA confirmed that the board will endorse that and that matters raises shall be reviewed at committees also. NH queried that we have a reciprocal agreement for call answering across the UK and are aware we are supported by West Midlands. How much is that costing us per call in relation to us paying for more staff to answer? Services in the SE and East of the country struggle to recruit call handlers. Call Handlers are currently paid at Band 3 rate, and this has an impact on what

	people look to do. SW paid tribute to the call handlers who have one of the most difficult jobs in the organisation. NHSE have supported in our phases in call handling and there is a few for service arrangement that kicks in after 1m30s if we are unable take the call. We need to do more to either grow our capacity or look to a different solution over time.
051/23	**QPSC** TQ gave a report of the headlines from 19 October committee. Medicines issues are continuing and QPSC are keeping a close eye on this. They are gathering options that have now been proposed to EMB but wanted to reassure governor colleagues, we have been focussed on this and now receive detailed integrated patient safety reports which allow detailed discussions. TQ advised that in August, our biggest area of worry was call answering and staffing levels. SS has agreed that the remaining focus of this shall be through the People Committee. This was a board escalation following the meeting. Police are moving towards a different approach for Mental Health patients, the executive confirmed we are in close contact with a solution to how we do this safely. An update has been requested for the next QPSC. Rachel Oaten (RO) talked to this issue in the previous CoG and is now confirmed the executive lead for this. NE Ambulance Service had a difficult report from the coroner, and we asked the question please can we receive assurance we are not in a similar position? This followed with a detailed review with our legal team and engagement with PSIRF. How do we overlap with our three ICSs and engage with them? The next annual cardiac arrest report is due at the next QPSC. Maternity Care is a very high-profile area currently and it was noted that we are very lucky to have Dawn Kerslake, Consultant Midwife, on board to upskill our colleagues who may face maternity-related emergencies. It was noted we are asking for more detail of the number of staff receiving this training and by when this is coming back to us. We receive annual reports on controlled drugs and learning from deaths and are pleased to see we are working with ambulance services and secondary care partners to learn from deaths. As a sector, we have more work to do. It was noted that we received a superb report from the research team which confirmed how they are using evidence-based approaches to support patients. Colleagues were invited to ask any questions.

	PS asked: Within the August report noting the takeaways from Lucy Letby case he understands this is not just whether staff had the confidence to raise issues and when they were raised, it is how they were dealt with. Do you have assurance there a process for complaints to be evaluated and the relevant intelligence when serious issues are raised? TQ responded that he has received assurance for the work in broader terms. Workaround NIAS and implementation of PSIRF will allow us to take a different approach. It is important to ensure that the incident teams are going to be around the region and that nothing is second-guessed to ensure integrity to the process. The process is being codified and does provide us with reassurance. SS commented that the FTSU team are better staffed than they have been previously. We need to increase support in terms of data and to look at the amount of detriment when colleagues do speak up which is very important. SS confirmed that reports do come to the audit committee. Training is in place to ensure that colleague have a psychologically safe space to speak up, noting that training is a very important piece to support spreading the word. The FTSU lead and CEO meet monthly. We are trying to ensure investigations do move at pace and we are moving away from blame. DA commented that it is important that staff comfortable with their manager and that their manager should support them. More work to be done but we confident this area is working. MB questioned if you are assured now around call handling, is there a robust plan to ensure cover over the next months? MB read about the issue at HART noting there are two teams who should have six operatives to be on duty 24/7 but this was only met 43% of time in August due to sickness. DA confirmed will be at the next board. TQ commented there is no assurance on call handling as this is about recruitment and retention and the challenges we discussed earlier. SW confirmed that this was discussed at the board's last public meeting where John O'Sullivan confirmed what we needed to do. Is there a plan? Yes. Do we understand the issues? We will be receiving updates at the next board meeting on the progress of actions. SW is assured there is a plan in place and is being addressed.
052/23	**People** SS commented that the paper received refers to a committee held in September and that we held another committee in November. SS commented that there were governors observing both committees.

	SS summarised the paper. Time to hire is running at 109 days with a target of 60 days for ad hoc recruitment. The NHS Average is 44 days. SS noted that 60 days is too long and there is a challenge against reducing that target. Appraisals are running at 58% completion again target of 85%. 85% is not achievable by the end of the year and SS is not assured because the data is not robust nor reliable. SS has asked for reliable data which has been verified. SS has confirmed that our view is that we will be off target and that this will be a board escalation. SS confirmed that we have a 60% response rate from staff survey which is positive. Conversation took place about the professional standards unit which to reflect is multi-professional workforce. There is no assurance on how this is operating but Rachel has confirmed a review is being undertaken and assurance will be coming back to the People Committee. We also looked at EOC 111 culture which SS is also not assured. A paper was deferred from September to come back to the November committee which it did not. SS confirmed she would like to see it but has not seen it yet. There is currently a lot of attention focussed on getting the culture right but at the moment there is no assurance. There is a 43% achievement rate around housekeeping items which has come out of staff surveys previously. Looking at grievance and disciplinaries there has been an increase in the informal resolution effort to resolve much earlier and informally before they escalate. In terms of IQR and BAF, looking at data there is a discrepancy between IQR and BAF. Going forward SS would like to see more alignment from IQR to BAF SS confirmed that there has been a recent Health and Safety Inspection and SECAmb has been issued with both a notice of contravention and an improvement notice. The improvement notice relates to the training for bariatric equipment. The notice of contravention relates to bariatric training, manual handling training and de-escalation training online vs face to face. Similarly we are not curious and informed enough around risk assessments. SS has looked into this and found we haven't done risk assessment training for around three years. Margaret has undertaken a review and SS has asked to see an outcome report at the next People Committee in January. MB asked are you assured there is a plan in place for retention as this seems ambitious. SS has assurance we have a plan SS however she did not gain assurance it would deliver what it said it would. SS will take this away to look into. What we have now is a robust retention plan which has engaged staff. Webinars are being run where staff are being involved. KB asked:

	1. As a directorate with regards to our appraisals, there is an integrity and data issue. We know that our Critical Care Team Leaders appraisals data are not showing up, and would like to think that more than 60% have been completed. As a directorate we know that the figure is higher than ESR BI states. Why do we have this discrepancy? If we are seeing this in medical it is likely other directorates will be the same. 2. The training for bariatric patients is complex. We have had the equipment since 2012. KB would like assurance that they will take the training seriously. SS Responded: 1. This comes with some frustration. SS expects the data that comes to the People Committee to be accurate. What SS has heard is that there are technical difficulties. Can you therefore now produce the paperwork? Have the papers been counted? How many appraisals have been scheduled? The data has to be checked and agreed upon before it comes to the committee. 2. An action plan is being produced for bariatric training. We need to understand who needs to be trained and ensure that the Policy is fit for purpose. The People Committee will oversee the action plan. DA commented that we are receiving executive HR support in respect of these matter. In the time to hire in an environment we have a huge deficit. AL asked if SS is receiving the support and truthful answers from HR that you would expect as a NED? SS responded that one of the issues is the quality of papers that come to the committee. SS now holds pre-meetings with executive colleagues to go through papers and to make sure the link is between risk and assurance. How are they trained and supported to understand risk and assurance? We are not there yet and have improved considerably from 18 months ago. An organisational challenge is to focus on data. SS likes to ask for the evidence in the figures. The Culture Dashboard is starting to look good, but it has taken time to be data driven to HR issues. A CEO improvement plan in place and from that point of view NED are assured. DA commented that the HR department are often blamed the failures for other parts of the organisation where managers not doing their role properly. We are working with the leadership culture in SECAmb as people not doing their roles and blaming HR. DA confirmed to have assurance as the CEO is working on this. SW asked respectfully to remember time is needed to turn around issues in SECAmb. It is going to take that time to turn around and measure progress. What we need to do is stay focused on longer journey. HN commented that in the time before the last report data was supposed to be provided for all the team and therefore have assurance for all people to have

	meaningful objectives. HN further commented that the form is not the issue but the quality of the conversations. SW responded that change is not sustainable if he just tells them to do something, people need to believe it is the right thing to do. HN asked if SS was assured that in the training our leaders are getting the importance of 121 dialogues, are being emphasised. Is the programme is course and being given priority. SS responded that the evaluation papers have been seen and management training is moving to the next level. SS confirmed she is assured of the training rollout and the content of the training. SS does not have assurance, as SW has commented, that we are all doing this. KB commented that the fundamentals course is the best course she have done in 20 years in NHS on the basis that having conversations brings out the best of the person. DA noted the positive feedback. NH asked SS had assurance and understanding on trust position on the longevity of grievances and disciplinaries. Some are still not resolved over 12 months. Can you have assurance process is good if it is taking that long for issues to be resolved. SS commented she does not have assurance it is coming down as fast as we would like it to but it is going in right direction. SS is assured of real effort in bringing the time down. SS believes that what influences what impact that is the number of cases keeps rising. SS thinks that with the arrival of a new Head of Operations there is some real expertise to upskill and restructure the team which means we will start to see more speed in bringing that down. NH It was noted that this does have a negative impact on colleagues Mental Health and colleagues go off sick. DA commented that both he and SW network with other colleagues in the ambulance sector. This is a common theme within the service and is a cultural challenge noting it does need to improve.
053/23	**Finance** HG summarised the report. It was noted that the report received was for the committee held in September and another meeting was planned later in the week. HG commented we are still forecasting to meet the plan and breakeven, in order to do that the efficiency target was £9m. £5.3 million latest estimate. It was noted we are falling short however we can meet break even using reserves. HG also said we are in a good position. HG highlighted other key points:

	• Benchmarking paper on patient level costing was useful and interesting, analysing cost base. A revised update paper is due to the upcoming committee. • Medway benefits the realisation of plan and structure framework. • Estates – assured on statutory compliance for repairs. • Hear and treat is at 12% and looks good. • The challenge we have for recruitment of vehicle maintaining technicians, MR noted it was not just ambulance service. We are outsourcing maintenance and looking at apprenticeship programme. MB asked what is the extent of the use of reserves? Are we breaking even because we are using reserves therefore it was not part of the financial planning but is it now a necessity? Are you assured at the extent of the reserve depletion or are we going to be looking at more? HG responded that we have enough reserves to cover shortfall, it was not in the plan originally but was aware of the existence of the reserves. MB questioned the process around the efficiency programme always failing. We need to revisit the process as it was identified in year. Are you assured that there are plans in place to re-engineer the planning process for the efficiency programme? HG responded that we could raise it and be assured as can be. It is an ambitious target. If we deliver £6.4m savings that will be largest saving since he has worked at SECAmb. Efficiencies for next year now need to be formulated. MW commented that there are a number of things which are strategic issues in the organisation. Control total is important appropriate system player but assures that at a board this should not be at the extent of the patient. SIP efficiencies are not effective, are transactional and are demotivating for staff. We need to get to a strategic vision and as we heard from both SW and DA, how we look at operating model to get more to get more strategic approach to move forward to a sustainable position. It may be this year we need to use reserves. This organisation has now been challenged as other NHS trusts. As NEDs we can go to that position and Saba Sadiq, our CFO, now needs to look at 24/25 for a sustainable approach to drive the efficiencies across SECAmb. That is where we are trying to get organisation to, and this will take time. DA commented that all directorates and team have a role to play to support efficiencies. HN asked that at the October Finance Investment Committee there was mention of 600 invoices which have not been matched, totalling £4m. Whilst there was talk to address this can we have assurance this plan has come to fruition and been addressed? HG advised that the update has been received and this has come down substantially.

	KB asked if we can ensure we take learning from the education apprenticeship programme as in 2019 we were in hot water. KB would like assurance that we are taking learning from that experience to ensure we get it right this time. SS confirmed she has been assured. This is why Clinical Education is so important to capture learning and take it onboard. SW commented that with vehicle technicians are short nationally, it is important we support training our own through a vocational offer. There will be a section on this in the strategy for emerging workforce.
054/23	**Audit and Risk** MW summarised that we need to ensure that we spend public money appropriately and deliver health care appropriately. Risk management is improving in the organisation, but we need to go further. We still have some work to do to be a learning organisation to ensure a sustainable solution. Managers are to tackle fraud, poor behaviour and bad use of public money. Systemic issues still need to be addressed. Overall the last year's report from procurement is not as good as could be. Some of the issues which come out were the anti-fraud team which lack of coherent policies in HR. The organisation has still got some way to go. The role of the audit committee is to see reviews and identify ways to improve actions taken by the audit committee going forward. We are on a journey, and we know what we need to do and across management learning and having a sustainable learning culture.
Statutory duties: member and public engagement	
055/23	**Membership Development Committee Report** **MDC ToR for CoG Approval** CoG approved MDC ToR.
Committees and reports	
056/23	**Nomination Committee Report** MW thanked the governor's colleagues involved in the recent recruitment process.
057/23	**Governor Development Committee Report** Received and noted. KB noted that the training plan has been published to all governors and asked for full attendance at these sessions. KB also encouraged all governors to pick up the shadowing shifts and link in with Jodie re QAV visits.

	It was noted it is difficult to move any dates in diaries.
058/23	**Governor Activities and Queries Report** Received and noted.
059/23	**Annual Members Meeting Minutes** Approved.
	General
062/23	**Any other business** None.
063/23	**Questions from the public** None.
064/23	**Areas to highlight to Non-Executive Directors** None.
065/23	**Review of meeting effectiveness** **-**
	Date of next Formal Council of Governors Meeting: 14 March 2024

South East Coast Ambulance Service NHS Foundation Trust

Item No	70-23

Name of meeting	Council of Governors
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.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	71-23

Name of meeting	Council of Governors
Date	14.03.2024
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

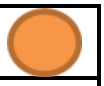
QI project is ongoing and while some improvement has been made this objective will not deliver within the timeframe.

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.

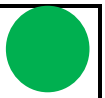
- **Update February –** We have now completed phase 2 “Design options and evaluate”, and the Board at a development workshop on the 23rd January reviewed the evaluation and indicated a preferred direction of travel in option 2. We are now in phase 3 “implementation planning” where we will be further 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	RESPONSIVE CARE	PEOPLE & CULTURE	SUSTAINABILITY & PARTNERSHIPS
	- *SI, Incidents and Harm* - *Patient care – Cardiac* - *Patient care - Stroke* - *Medicines Management* - *Safeguarding* - *Safety in the workplace* - *Patient Experience*	- *Ambulance Quality Indicators* - *Call Handling EOC* - *Utilisation* - *999 Frontline Efficiency* - *Supporting the system* - *111 Operation* - *Support Services*	- *Employee Experience* - *Culture* - *Workforce* - *Wellbeing* - *Development*	- *Delivery against Plan*

Annual Plan

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

Quality Improvment

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
CFR Attendances	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.

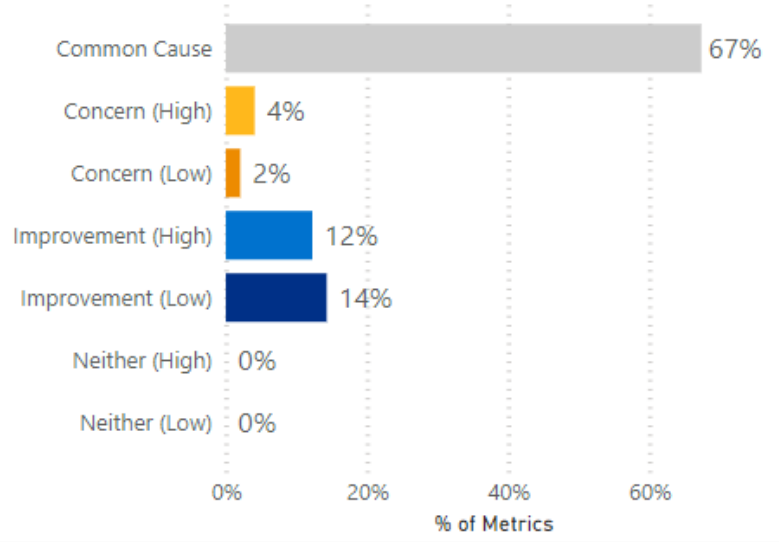
NHS
South East Coast Ambulance Service
NHS Foundation Trust

Quality & Safety

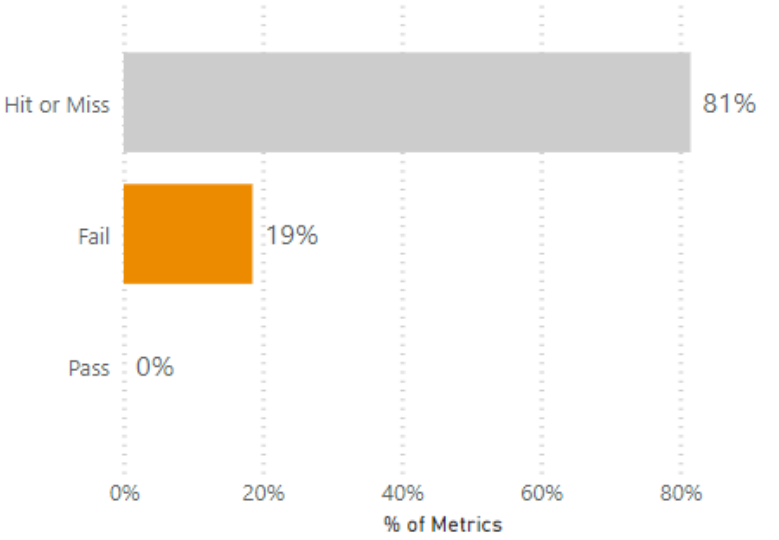
QUALITY & SAFETY

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

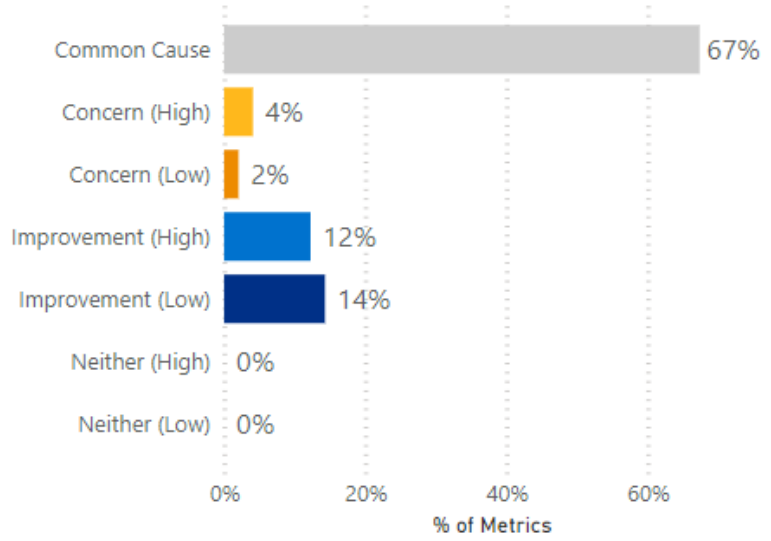
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Cardiac Survival ALL % Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Required NHS Pathways Audits Completed (Clinical) % Duty of Candour Compliance % Complaints Reporting Timeliness % Organisational Risks Outstanding Review %	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.

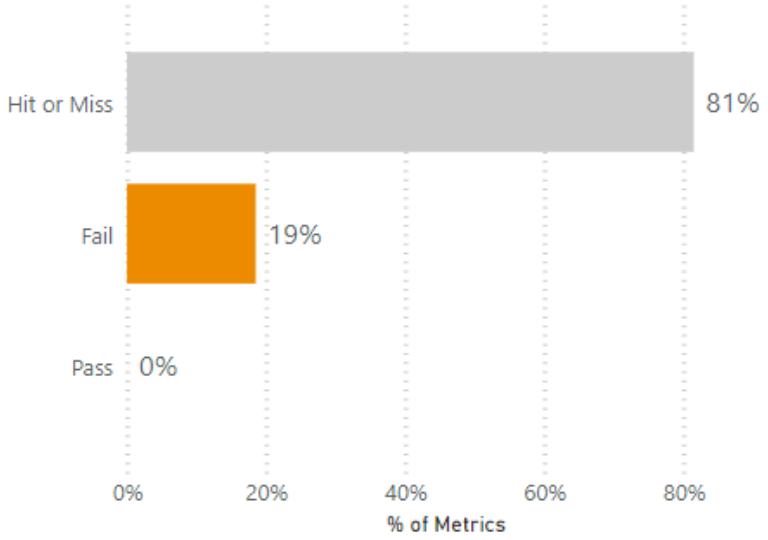
QUALITY & SAFETY

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

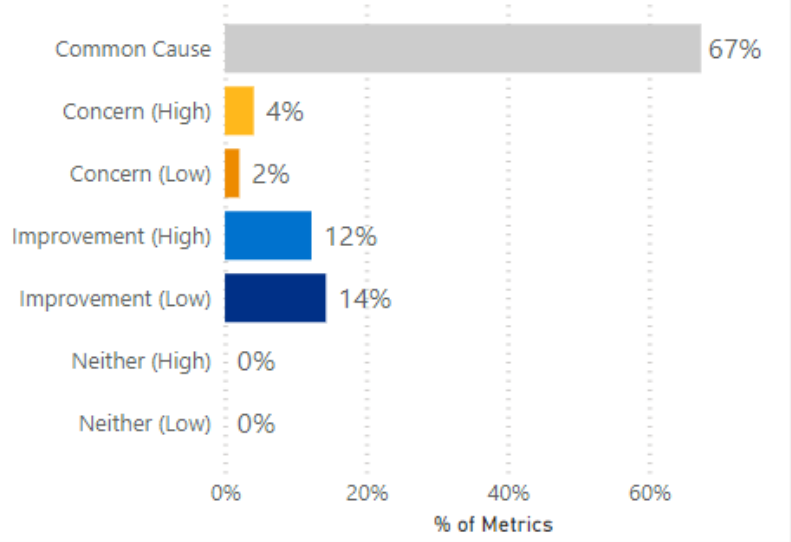
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Nov-2023	62.9%	45.1%	30.28%	49.29%	68.31%		
**Cardiac ROSC ALL %	Quality Improvement	Nov-2023	29.1%	23.8%	18.13%	27.09%	36.04%		
**Sepsis Care Bundle %	Quality Improvement	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%		

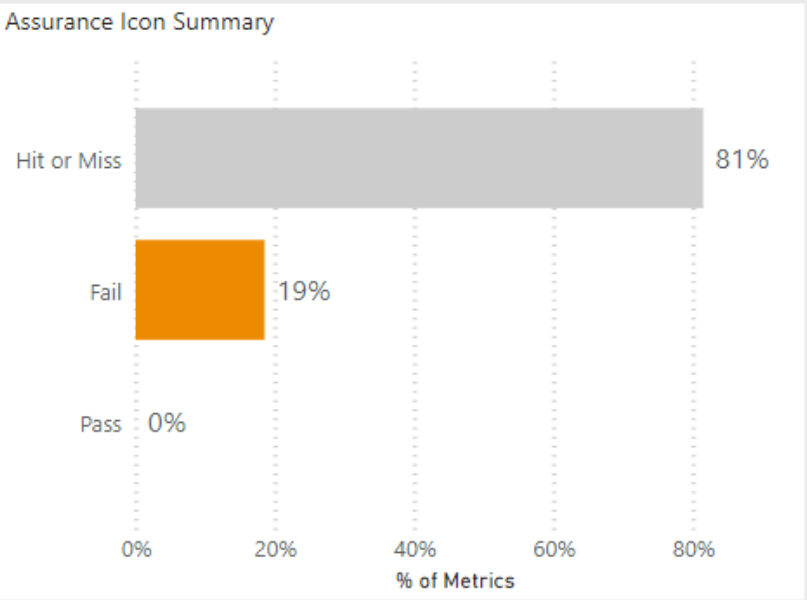
Infection Prevention Control

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

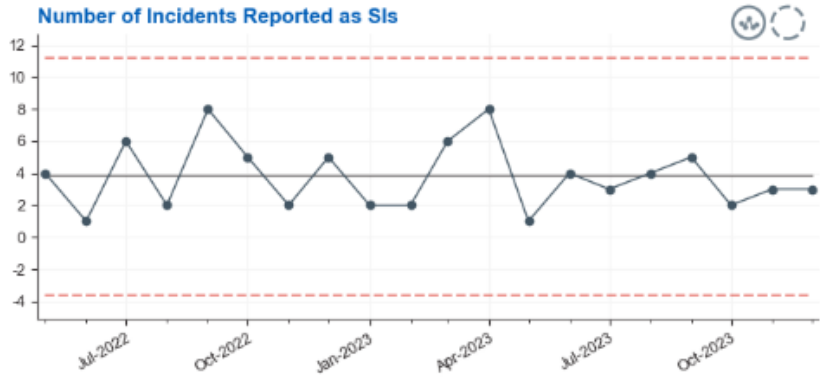
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Manual Handling Incidents	Quality Improvement	Dec-2023	21		9.16	27.5	45.84		
Organisational Risks Outstanding Review %	Quality Improvement	Dec-2023	30%	30%	-8.22%	35.78%	79.79%		

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

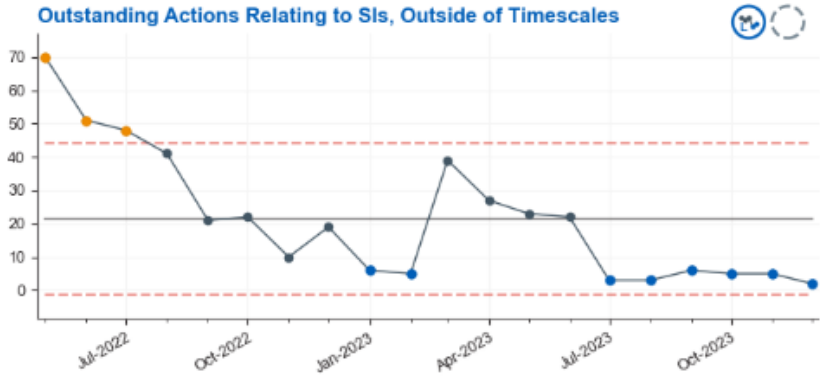
Dept: Quality & Safety
IP: Quality Improvement
Latest: 3

Common cause variation, no significant change.

QS-1

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

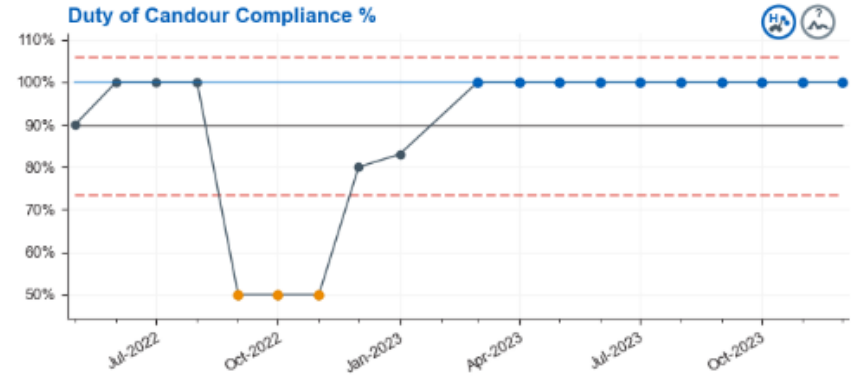
Common cause variation, no significant change.



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 wider 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

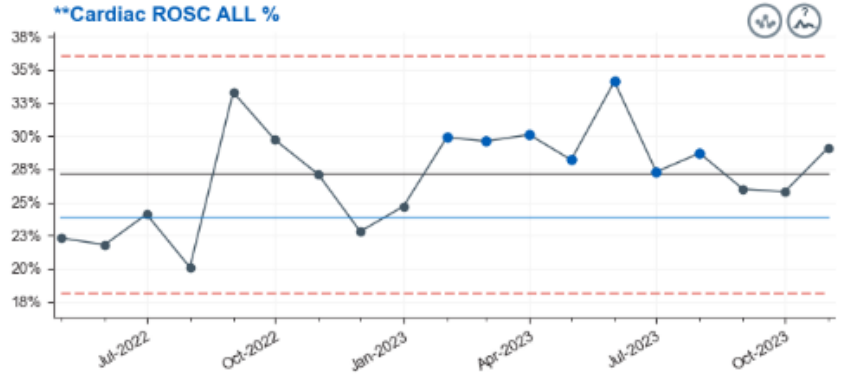
QS-29 Harm incidents per 1000 incidents - the number of these Incidents shows a downward trend; with a steep fall in December 2023. This is encouraging as the reduction did not coincide with a drop in overall incident reporting as seen in QS-1.

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

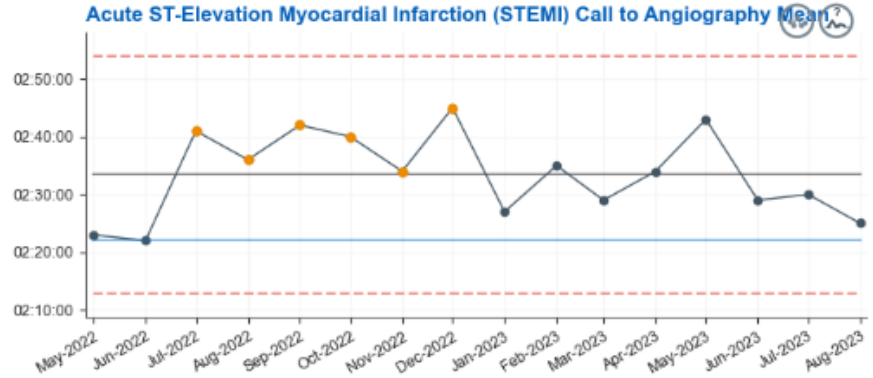
QUALITY & SAFETY

Impact on Patient Care - Cardiac



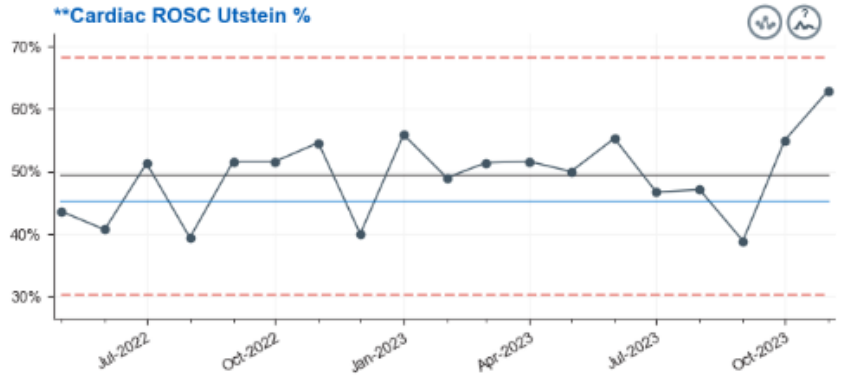
M-2

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.



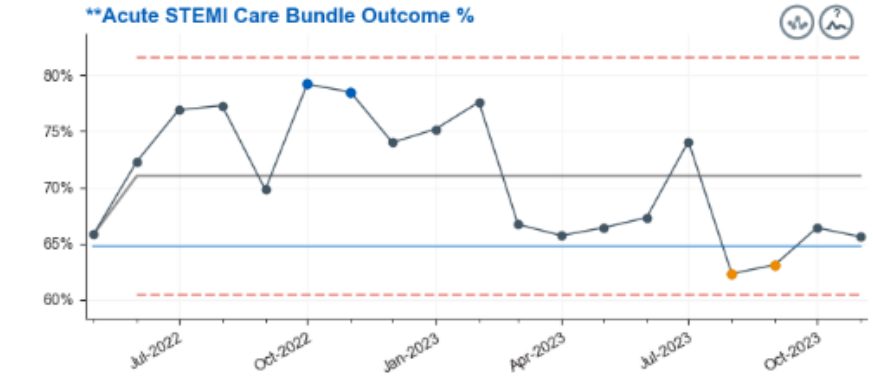
M-6

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?

STEMI call to Angiography

There is a transformation review beginning to look at the viability of another pPCI centre in Kent. This will address the long travel times there (up to 60 minutes in some areas). Reducing time on scene is consistently taught during Keyskills, CPD. 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.

Acute STEMI care bundle outcome

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

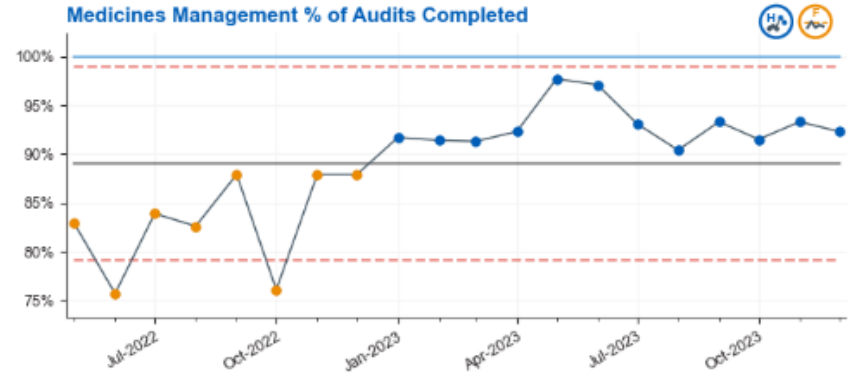
QUALITY & SAFETY

Medicines Management (1 of 2)

MM-1

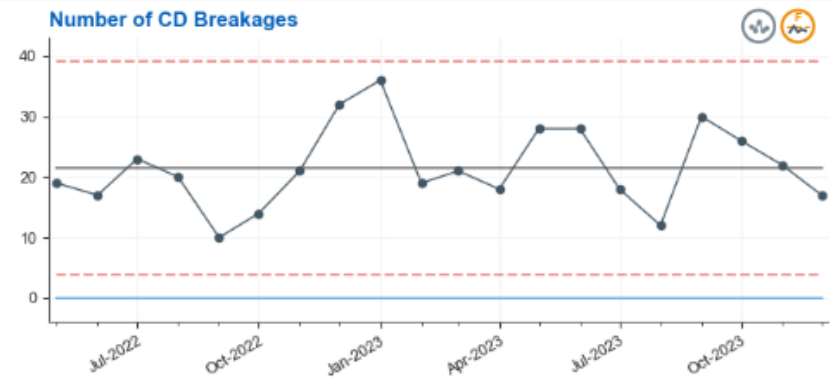
Dept: Medicines Management
IP: Quality Improvement
Latest: 167

Common cause variation, no significant change.



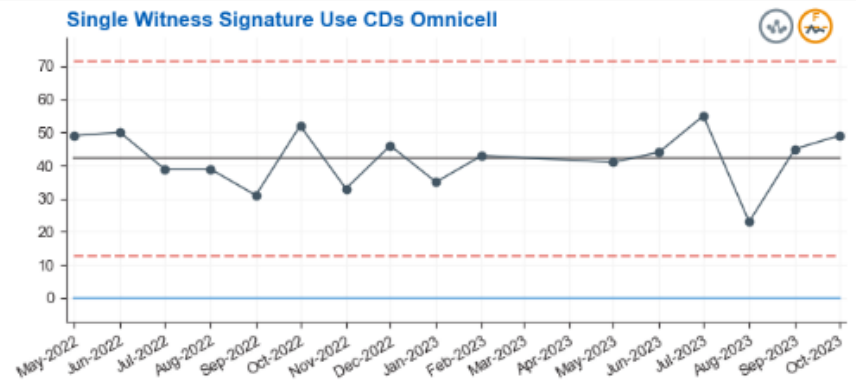
MM-7

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.

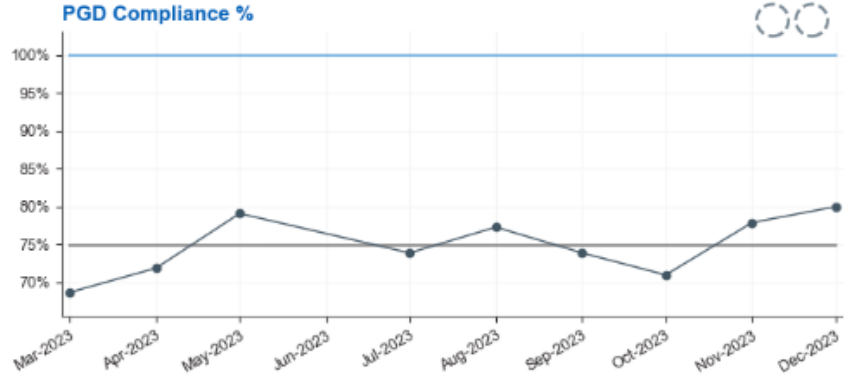
In relation to Single Witness signature for CDs work continues to address this area of activity and the reporting of it is going to go onto the weekly OTL checks making it easier around reporting which is partial manual currently.

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.

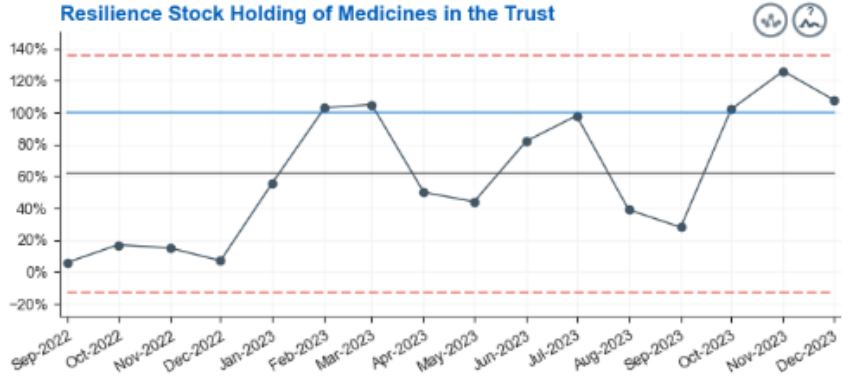
QUALITY & SAFETY

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

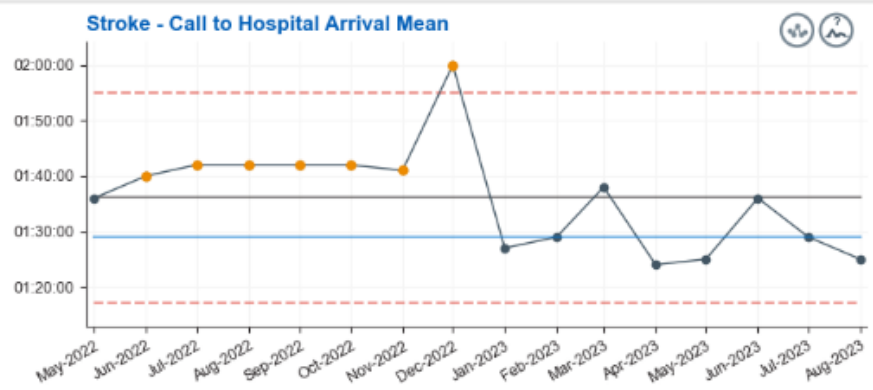
Patient Group Direction (PGD) compliance is at 80%. OUMs receive a report every two months on PGD compliance for their registered staff. Currently OUMs disseminate to their OTLs for management amongst their Paramedic teams. Colleagues are being encouraged to undertake the PGD eLFH module on discover (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.

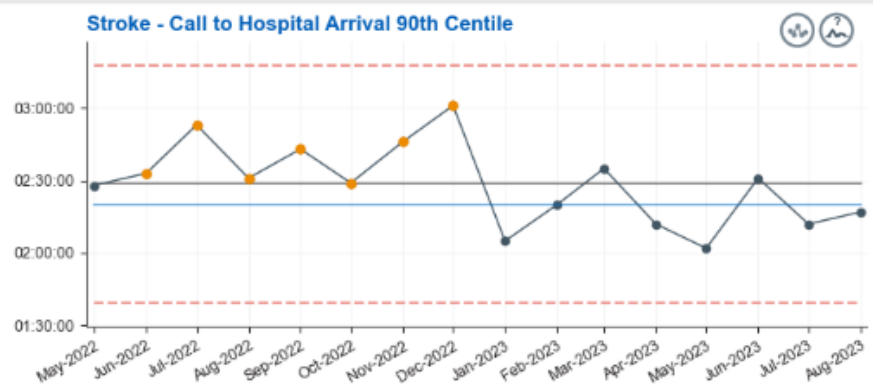
QUALITY & SAFETY

Impact on Patient Care – Stroke



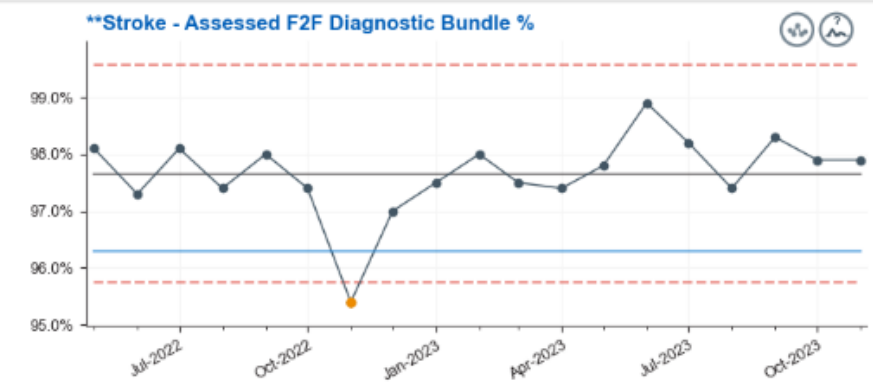
M-8

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.



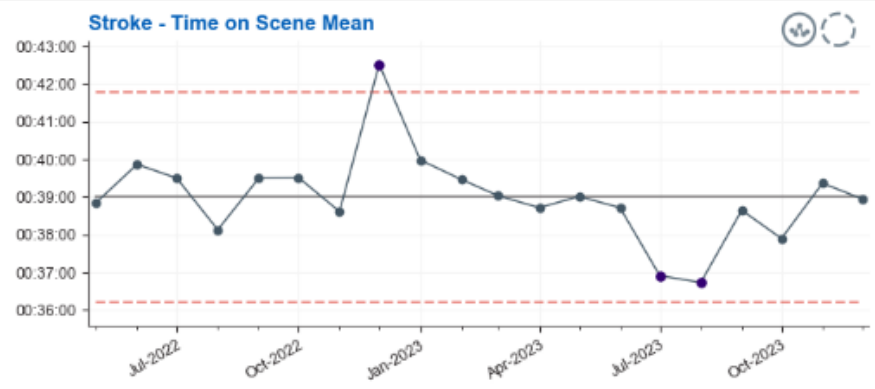
M-9

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.

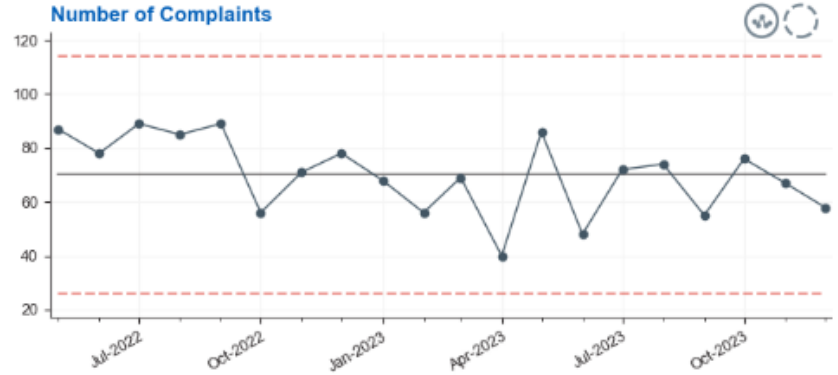
Stroke Time on scene mean. Common Cause variation.

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

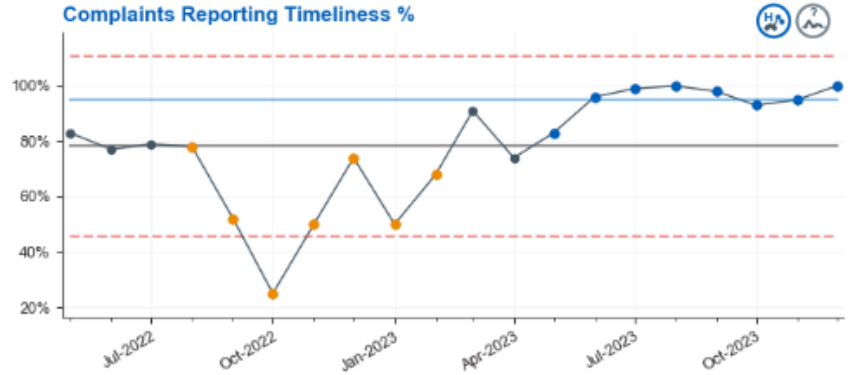
Patient Experience



QS-5

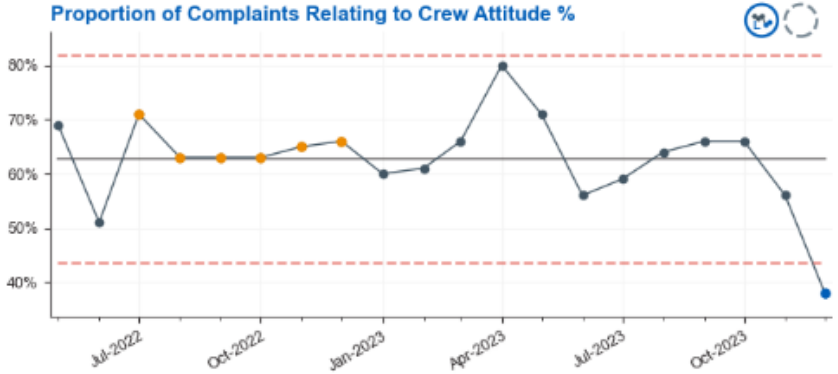
Dept: Quality & Safety
IP: Quality Improvement
Latest: 58

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

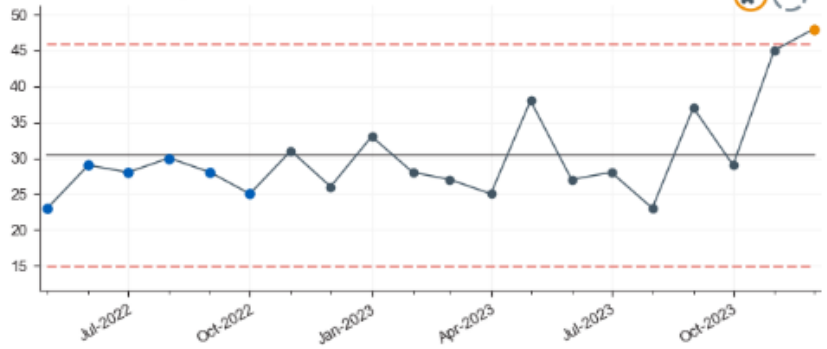
- The number of complaints received is showing normal variation. No concerns / issues.
- The number of complaints relating to crew attitude reduced to 56% in November and 38% in December. It is not known why this is as the overall numbers of complaints have not decreased significantly, but a deep dive 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.

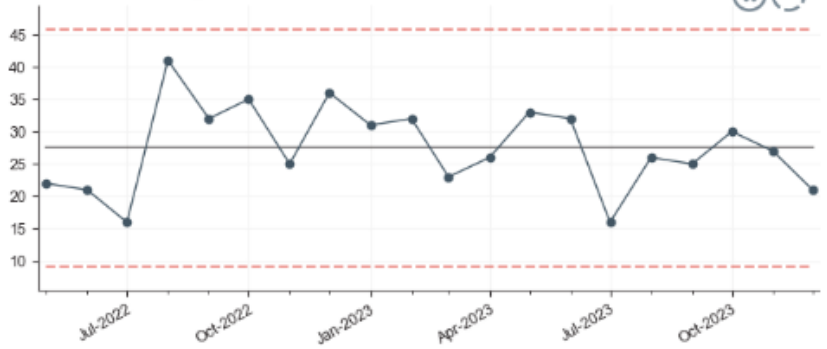
QUALITY & SAFETY

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.

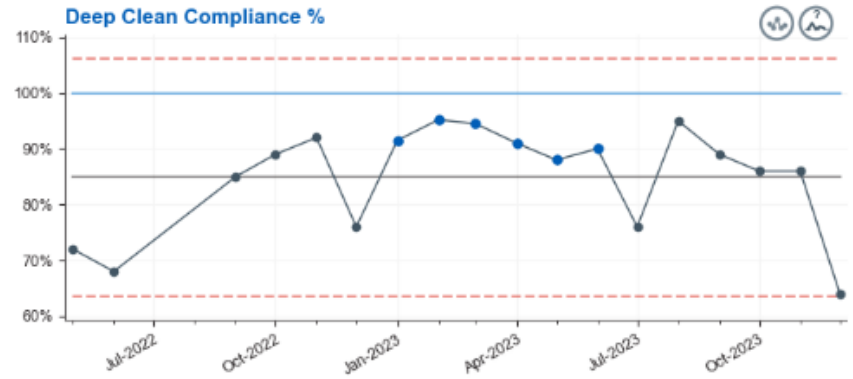
Manual Handling Incidents

No significant variation

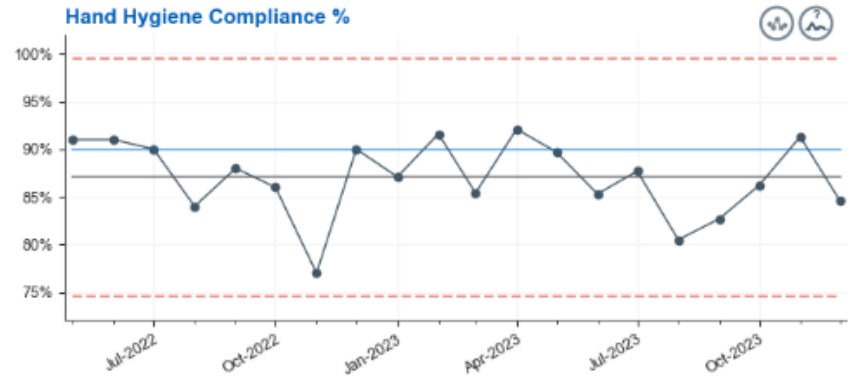
What are we doing
- A task & finish group has been initiated to lead on actions from the recent HSE visit which includes a review of manual handling training, specifically in relation to the manual handling and use of specialist equipment for Bariatric patients.
- The Local and Trust-wide Health & Safety 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

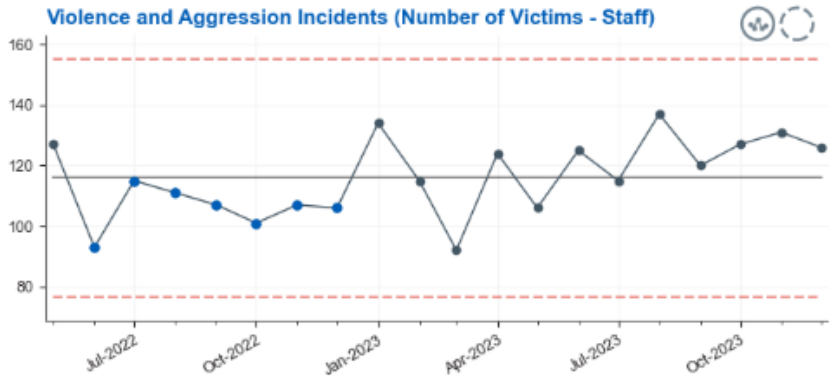
The data for hand hygiene compliance is showing normal variation but with a drop in compliance for December 2023 following a previous upward trend. The lowest compliance was seen in two areas of the Trusts and the IPC team have planned visits to these sites to discuss the results with the local management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

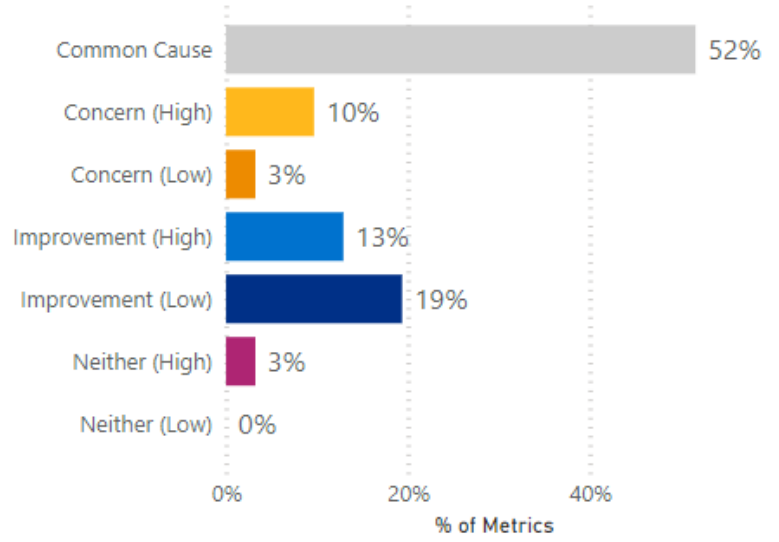
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Collective Grievances Open Bullying & Harrassment Internal 999 Frontline Late Finishes/Over-Runs % Active Suspensions	Number of Staff WTE (Excl bank and agency) Sickness Absence % Current licence details held for Operational Staff %	Finance 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.

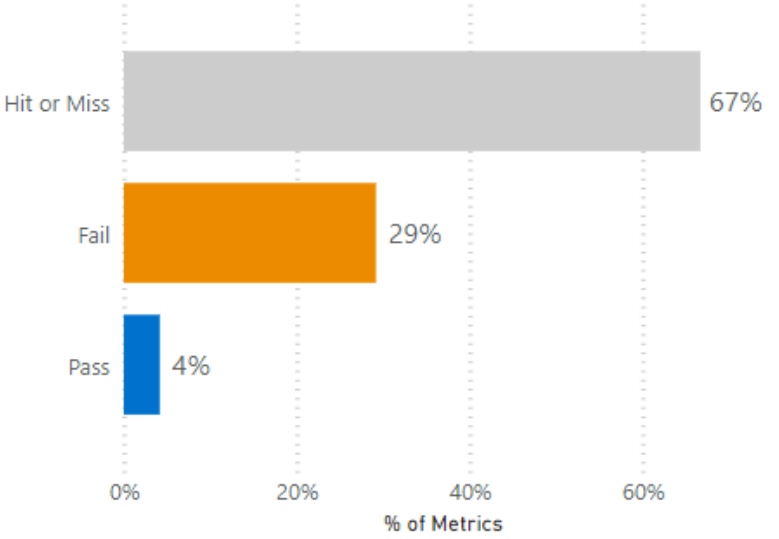
PEOPLE & CULTURE

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

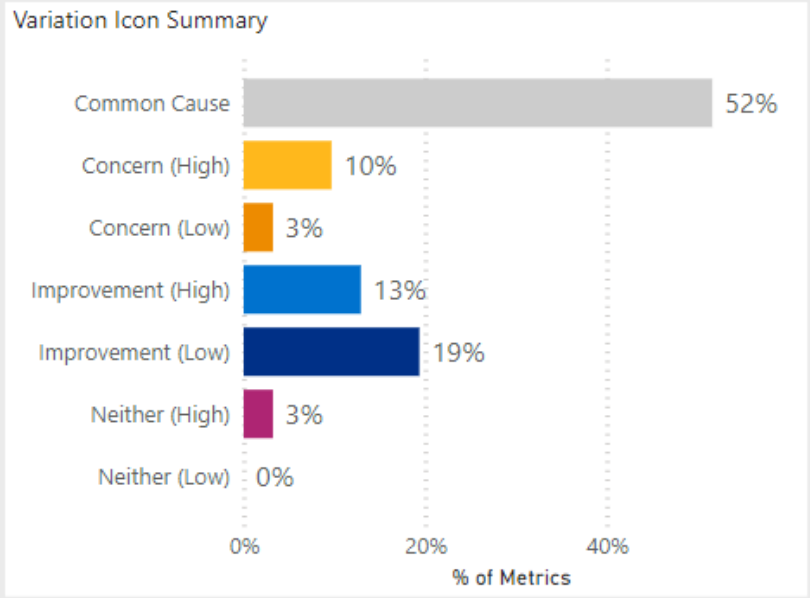
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Dec-2023	75.2%	85%	67.03%	73.39%	79.75%		
Appraisals Rolling Year %	People & Culture	Dec-2023	60.8%	85%	49.84%	58.39%	66.93%		

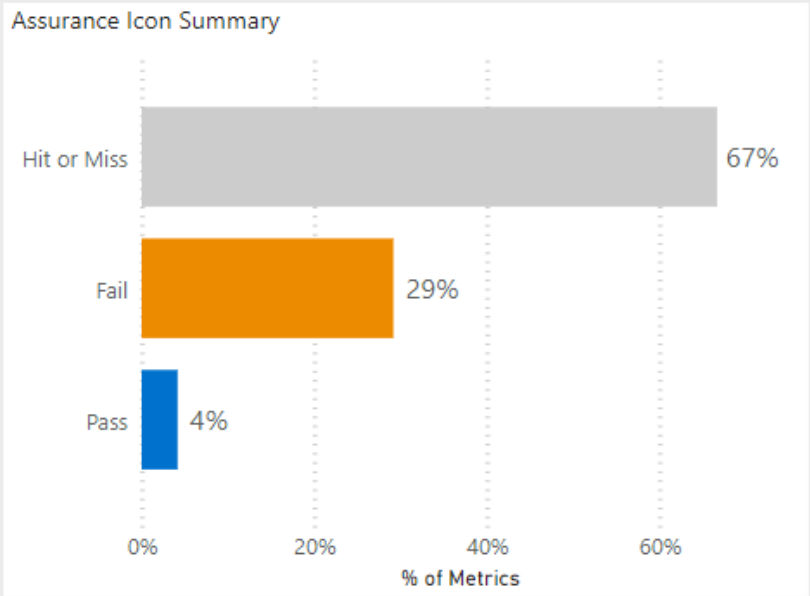
Employee Experience

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)





Culture

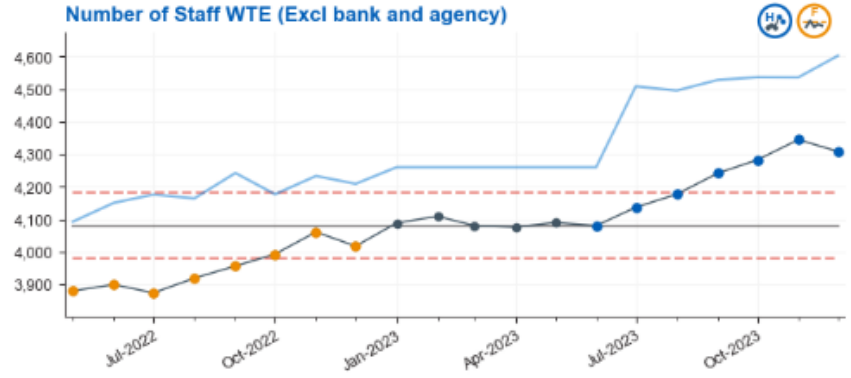
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Dec-2023	12	5	0.9	12.8	24.7		
Collective Grievances Open	People & Culture	Dec-2023	1	1	-1.86	1.5	4.86		
Count of Grievances Closed	People & Culture	Dec-2023	8	3	0.25	12.15	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		

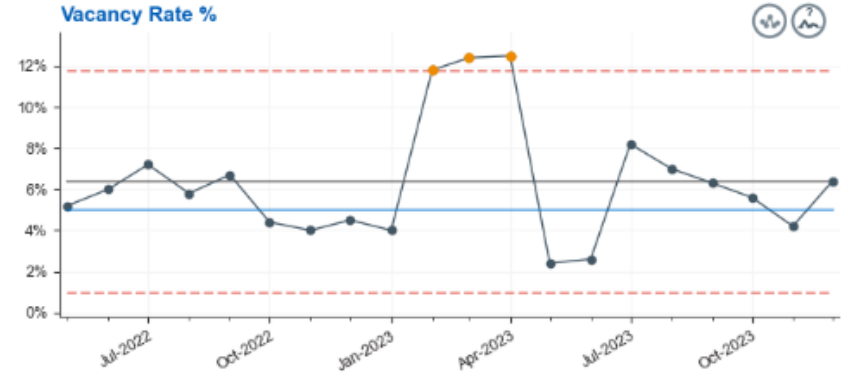
PEOPLE & CULTURE

Workforce (1 of 3)



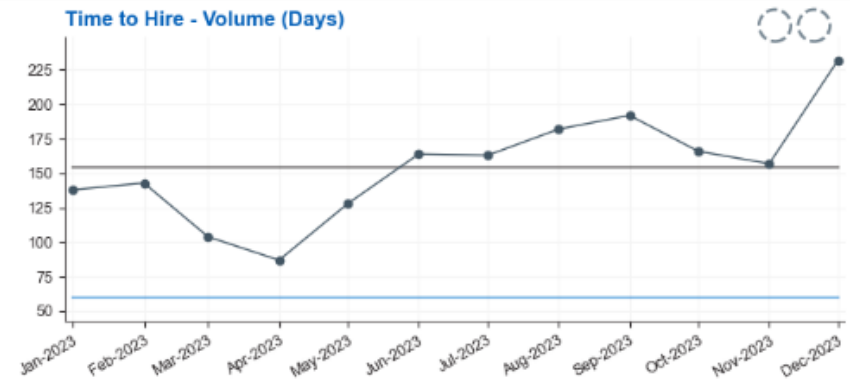
WF-1

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.



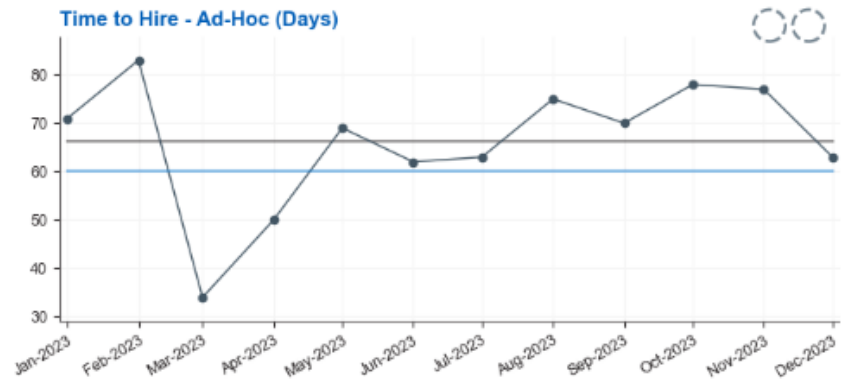
WF-4

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?

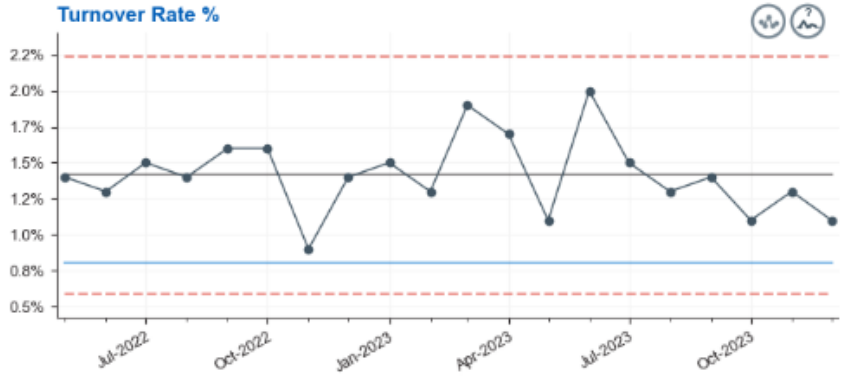
The Quality Improvement recruitment and onboarding project continues with processes being reviewed and changes implemented at each stage. The improvements made are intended to not only reduce TTH when possible *, but also increase candidate engagement, improve the overall experience and reduce attrition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

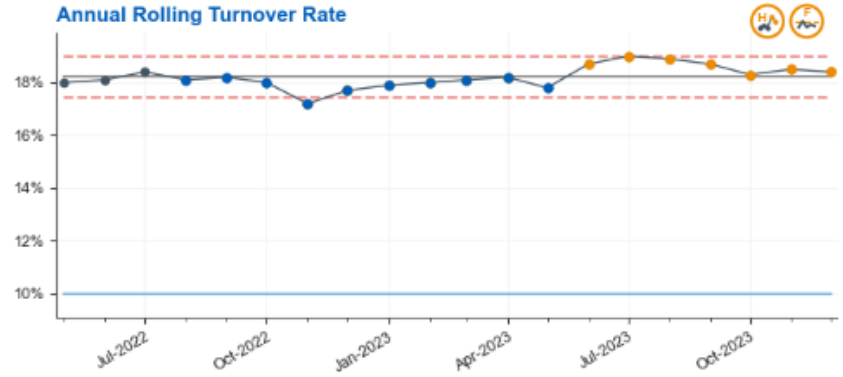
*Certain cohorts such as NQPs will have no room to reduce the TTH as the campaigns are in line with university end of course dates. Attraction and targeted recruitment of NQPs starts months in advance of hire dates.

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.

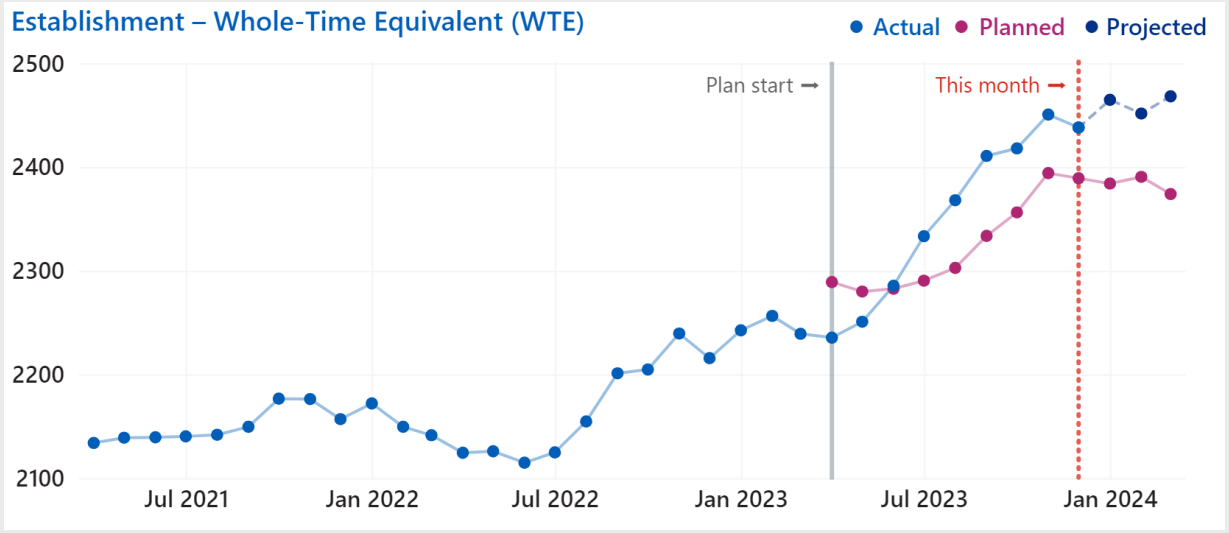
Work is underway on the development of an Improvement Case for funding for the initiatives.

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)

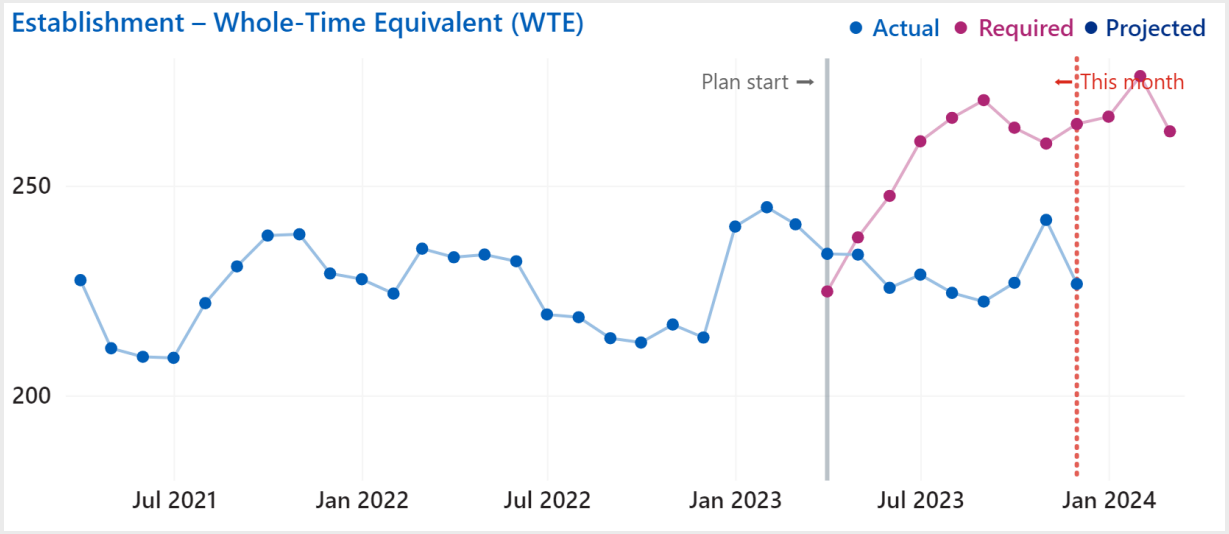


Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
December's data shows an increase in WTE ahead of the workforce plan (48.9WTE). Attrition again was lower than planned which has contributed to the difference.
December showed no further NQP recruitment planned before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

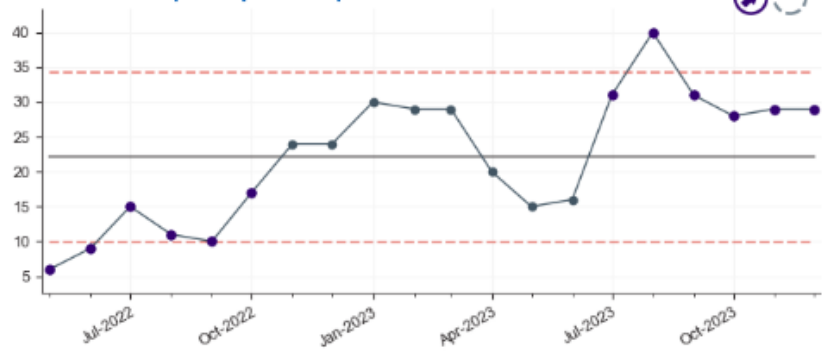
Additional Information
The workforce projection is currently based on confirmed recruits who currently have an offer of employment. As EMA recruitment typically only has a lead time of 2 months, no additional recruitment is factored into the projection beyond this point, which results in the chart only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

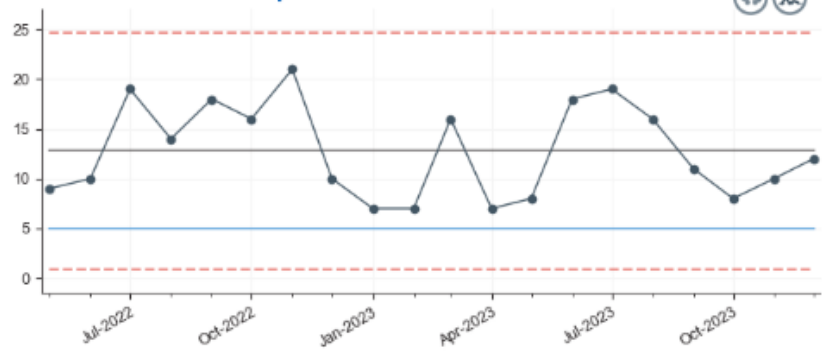


QS-27

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

Special cause variation where UP is neither improvement or concern

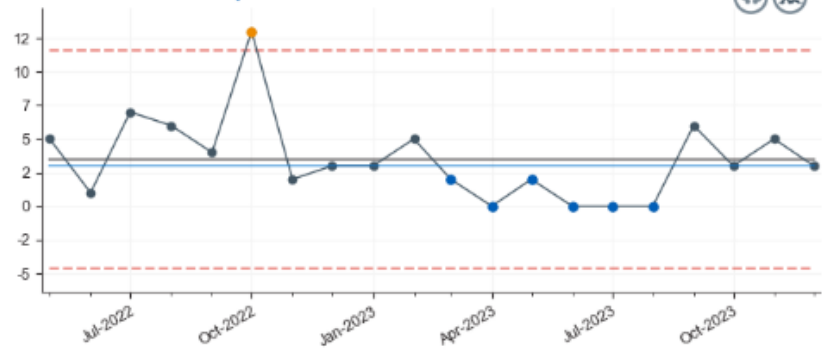
Individual Grievances Open



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.

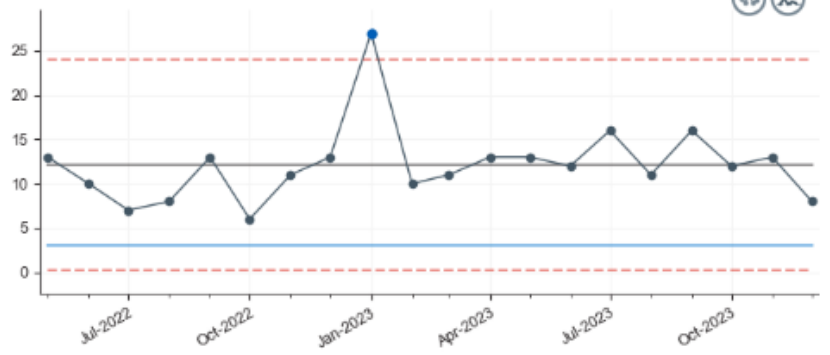
Count of Until it Stops Cases



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.

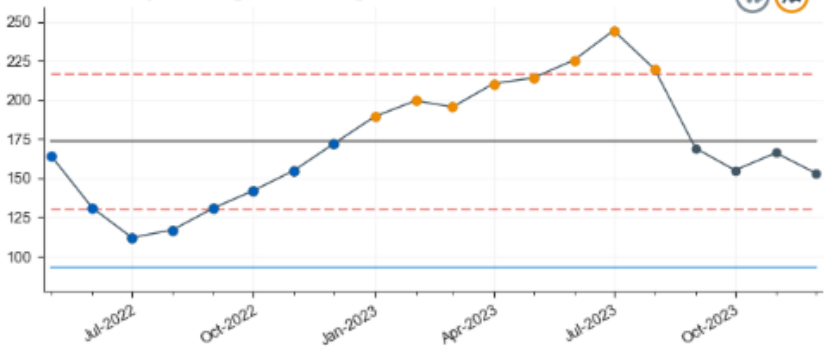
Count of Grievances Closed



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.

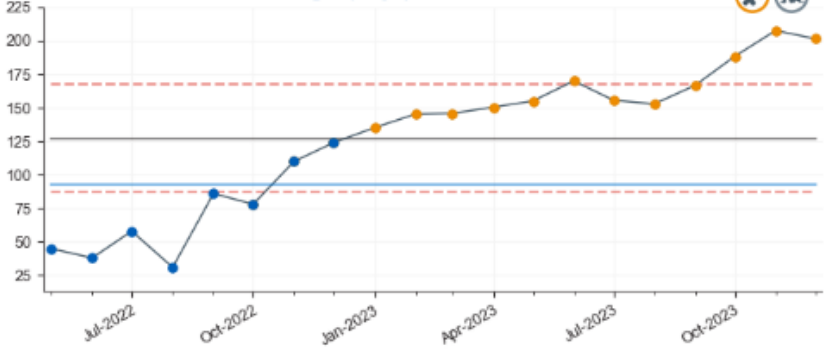
Until it Stops Average Case Length



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.

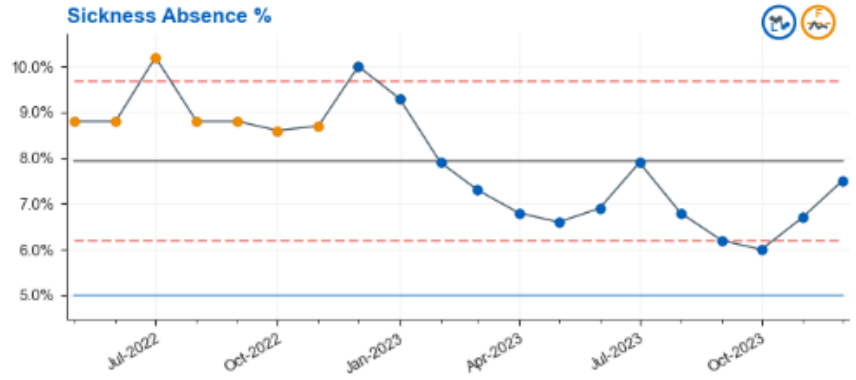
The FTSU team and the National Guardian will be hosting a development session for OUM's in March 2024, this will focus on the core the principles behind Speaking Up, the role and process of FTSU and why it is nationally structured as it is, and the barriers to seeking learning and simply being curious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

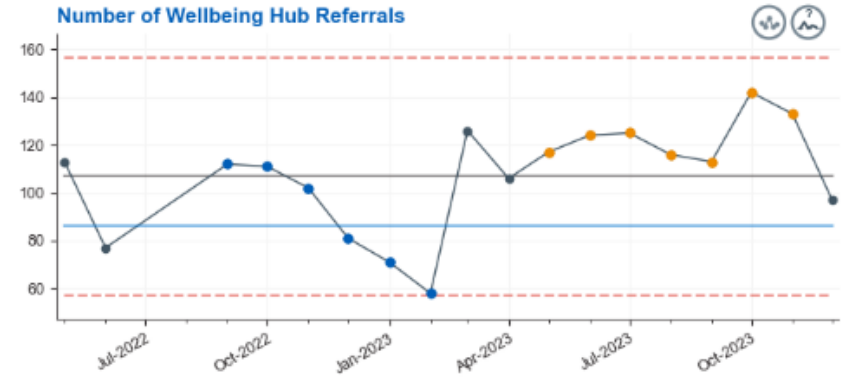
FTSU team is collaborating with our linked universities to meet with year two students and delivering a speak up workshop to reiterate the importance of speaking up at SECAmb.

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.

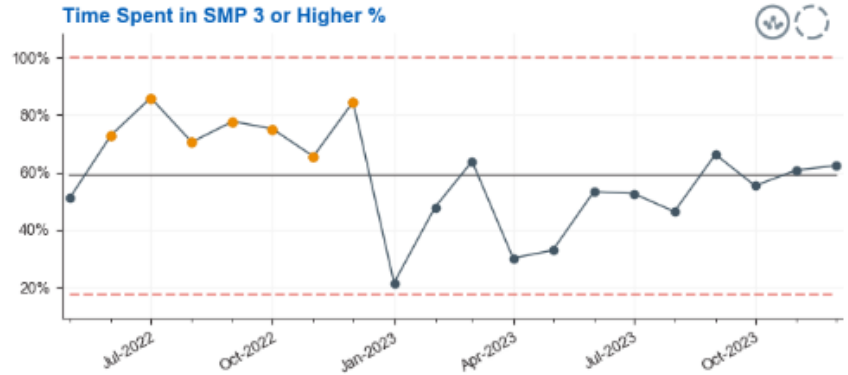
PEOPLE & CULTURE

Employee Experience

999-15

Dept: Operations 999
IP: People & Culture
Latest: 47.3%
Target: 45%

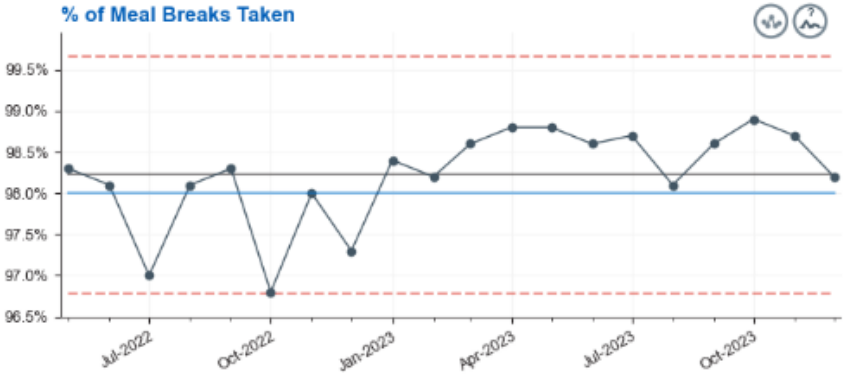
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



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

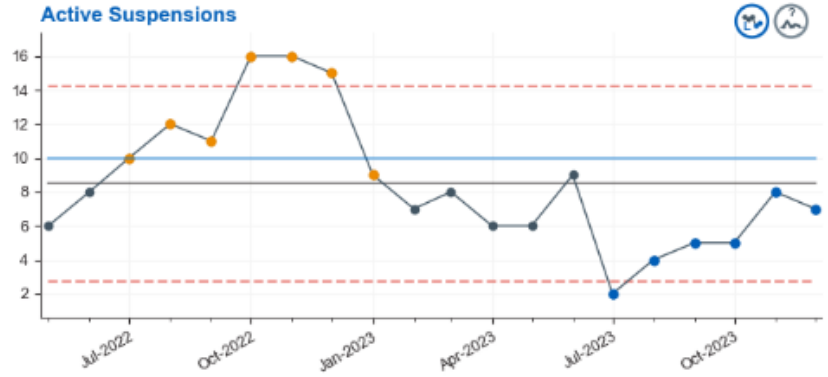
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- Whilst the late finishes and meal break metrics related directly to field operations, the impact of time spent at higher levels of SMP has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

What actions are we taking?

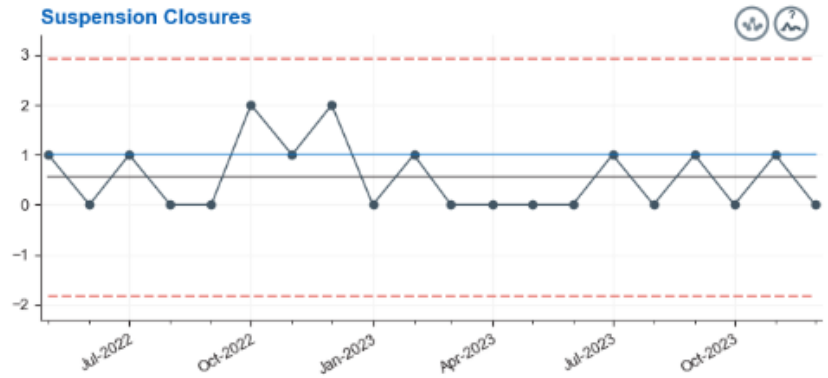
- Review and update of the Meal break policy.
- Learning from the Ashford pilot in terms of cross-border working, meal break compliance etc.

PEOPLE & CULTURE

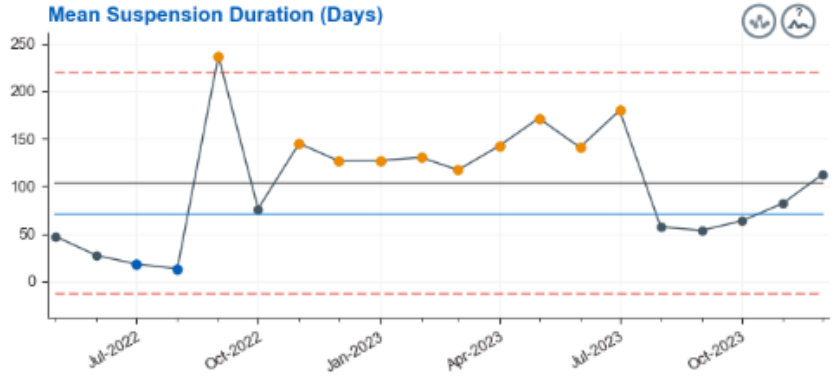
Employee Suspensions



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-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.



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.

Summary

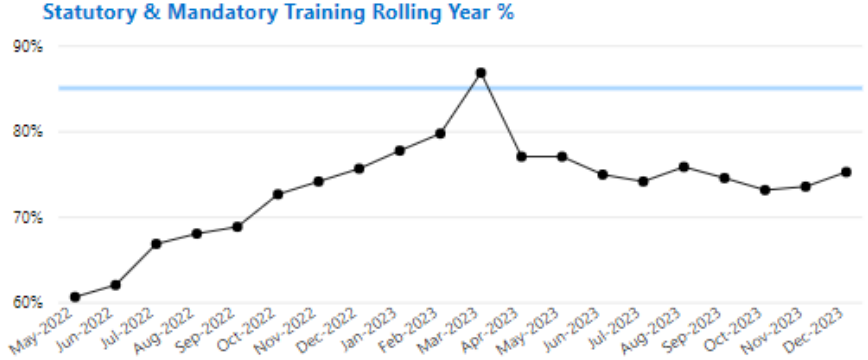
Suspensions remain under close monitoring, all these cases are related to potential gross misconduct charges (ie sexual harassment, criminal matters, threatening behaviours, patient safety). The cases remain a high priority and continue to be progressed through formal disciplinary procedures to reach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

What actions are we taking?

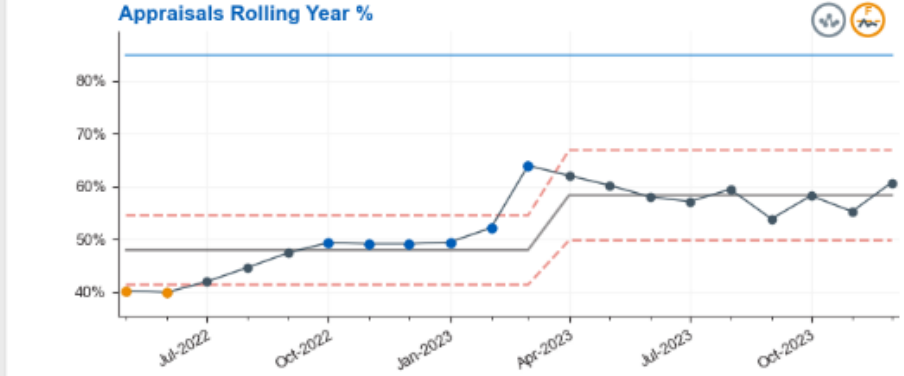
Current /new suspensions are tracked and reviewed on a weekly basis by the HR Team with the Executive Directors of HR & OD and Operations. This also gives an opportunity to consider those cases which may be identified initially for suspensions where it may not be appropriate or a proportionate action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

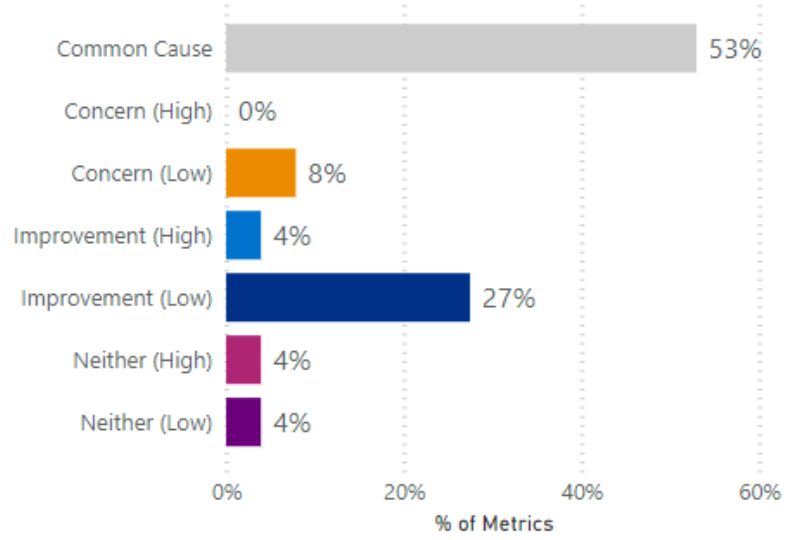
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	Cat 1T Mean Cat 1T 90th Centile	999 Frontline Hours Provided % A&E Dispositions %	Hear & Treat % See & Convey % Average Wrap Up Time Cat 1 Mean	JCT Allocation to Clear at Scene Mean JCT Allocation to Clear at Hospital Mean Hours Lost at Handover 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.

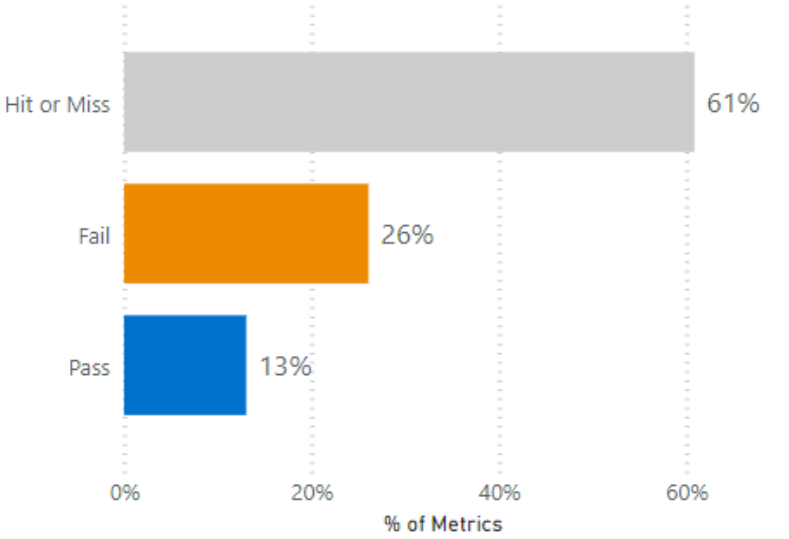
RESPONSIVE CARE

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		

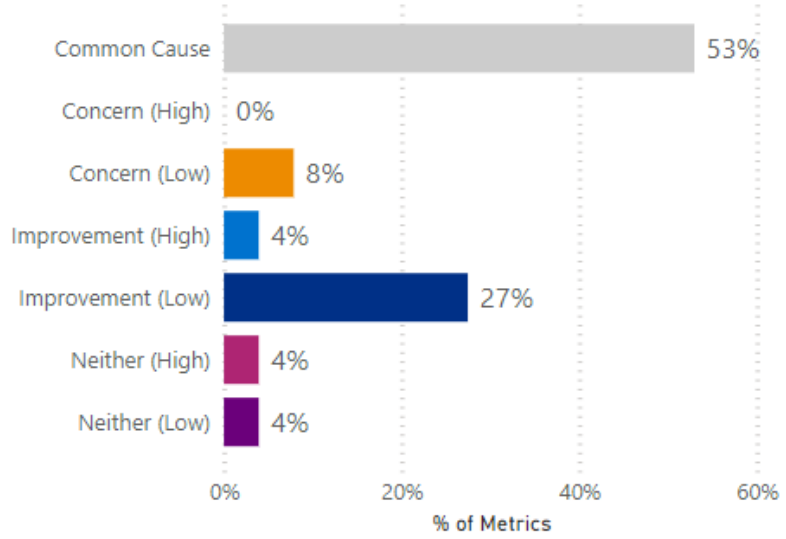
Emergency Operations Centres (EOC)

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		

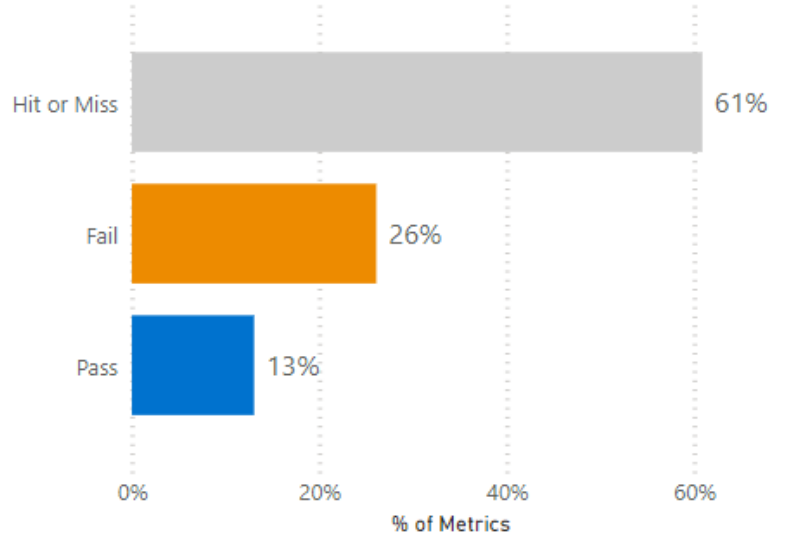
RESPONSIVE CARE

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		

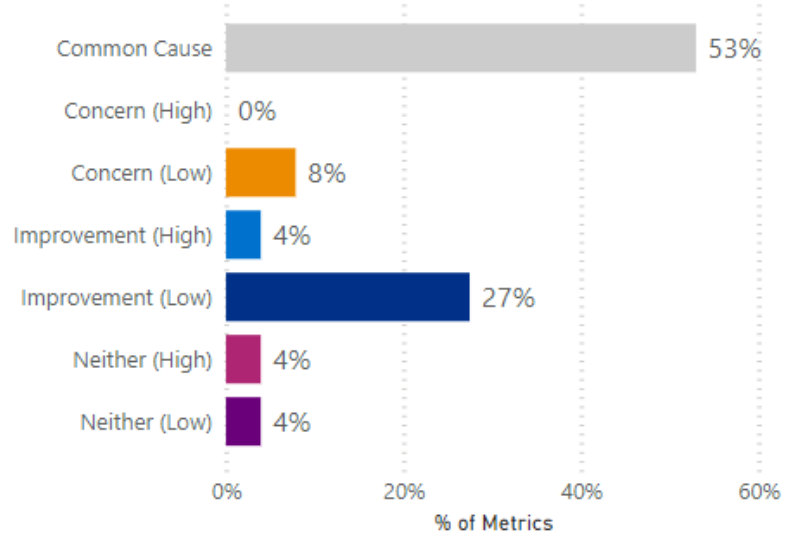
111

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		

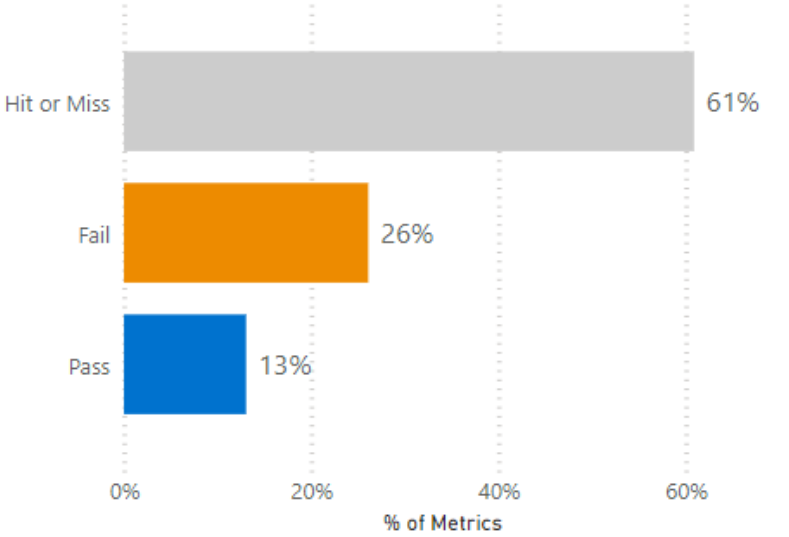
RESPONSIVE CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

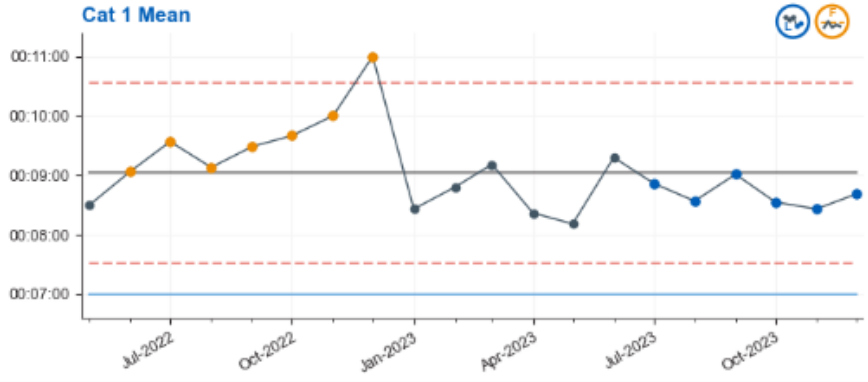
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Dec-2023	01:17:18		01:15:40	01:17:23	01:19:07		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Dec-2023	01:53:34		01:49:59	01:54:15	01:58:31		
Responses 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

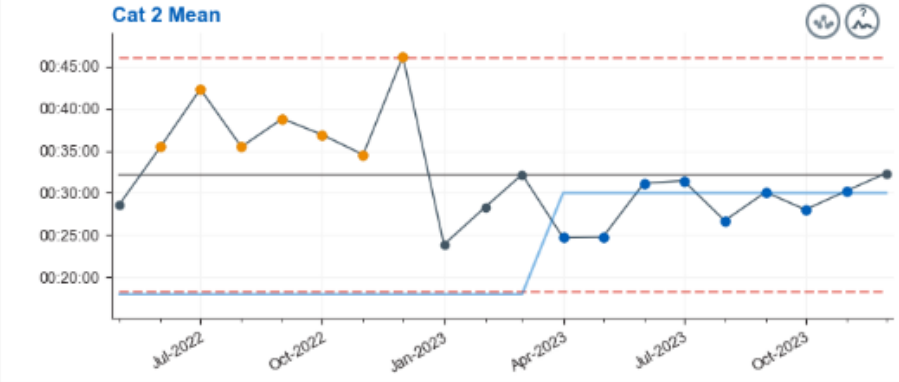
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Dec-2023	13.7%	14%	9.05%	10.58%	12.11%		
See & Treat %	Responsive Care	Dec-2023	31.4%	35%	30.05%	31.49%	32.93%		
See & Convey %	Responsive Care	Dec-2023	54.8%	55%	55.48%	57.8%	60.12%		
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

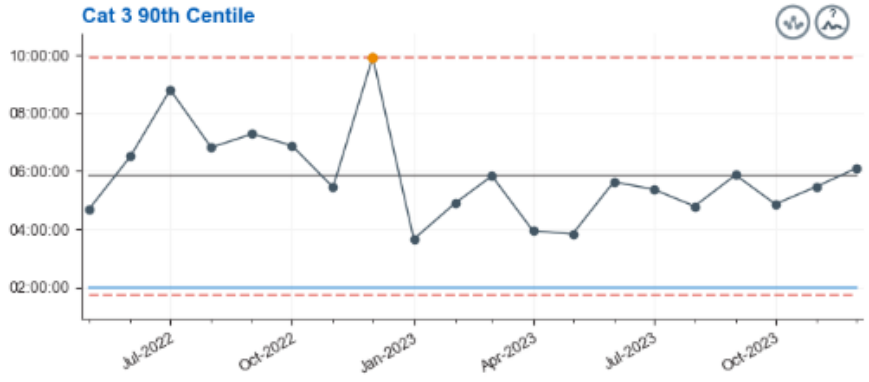
Response Times



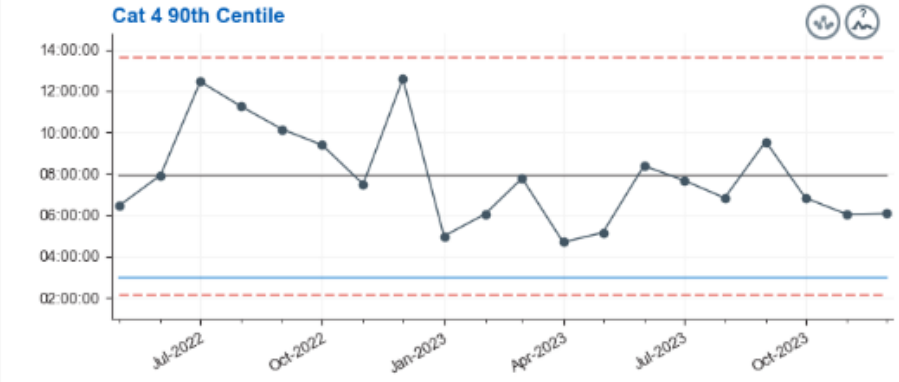
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:41
Target: 00:07:00
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



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.

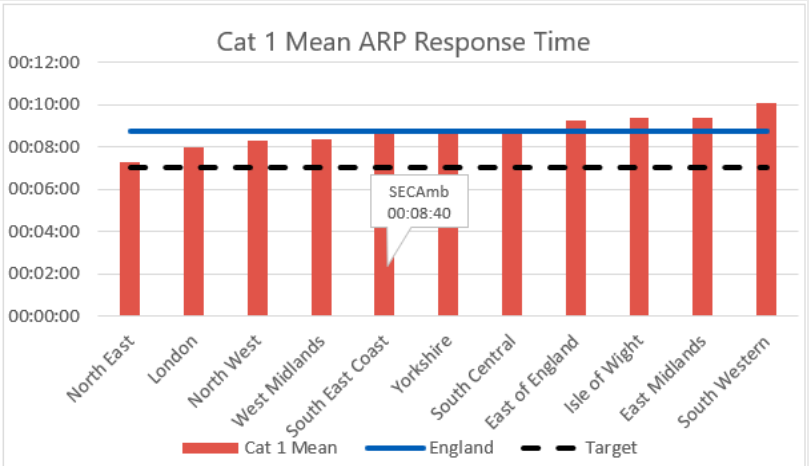
Summary

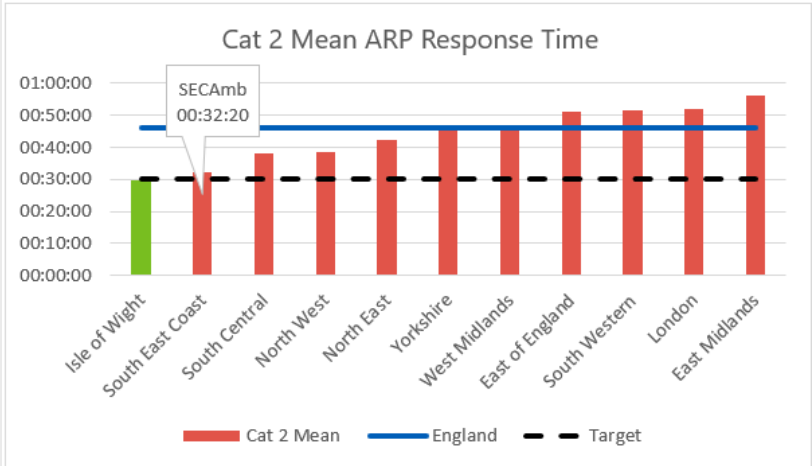
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against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

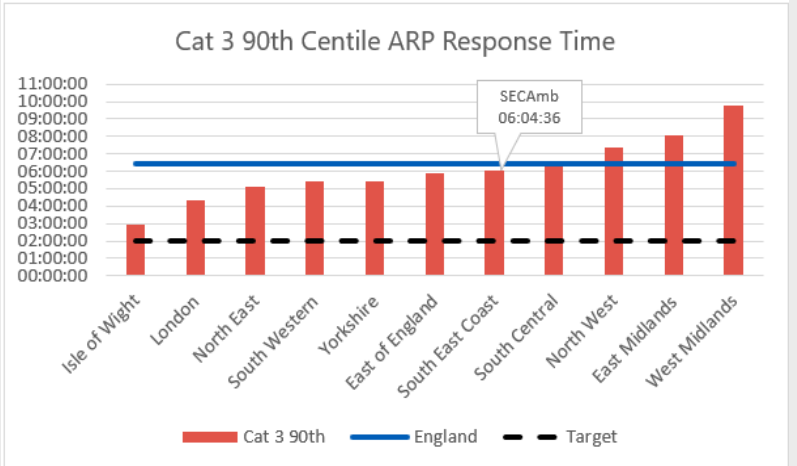
What actions are we taking?

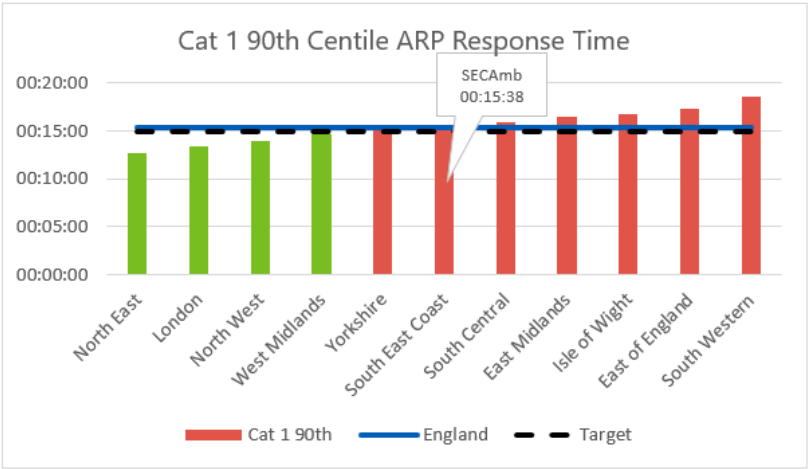
- Continuation of C3 & C4 validation, with a high proportion being validated in either the Trust's 111 (KMS 111) or 999 services. The aim remains to clinically assess every C3 or C4 call prior to ambulance dispatch.
- Continued focus on clinical staffing in EOC to maintain patient safety and support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

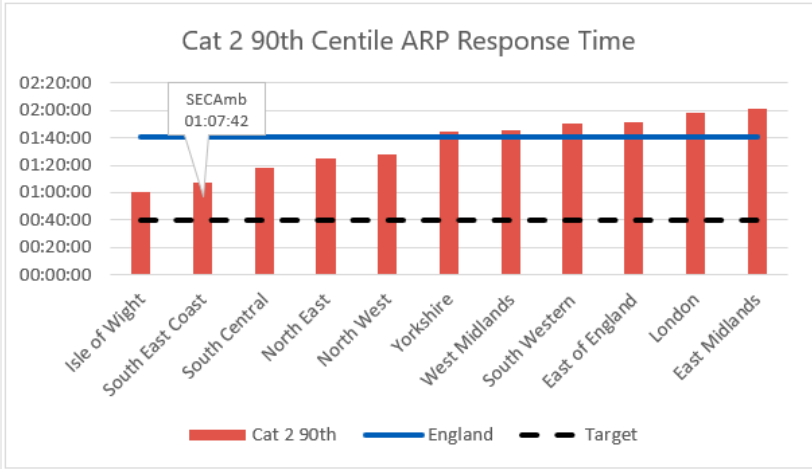
ARP Response Time Benchmarking (December 2023)

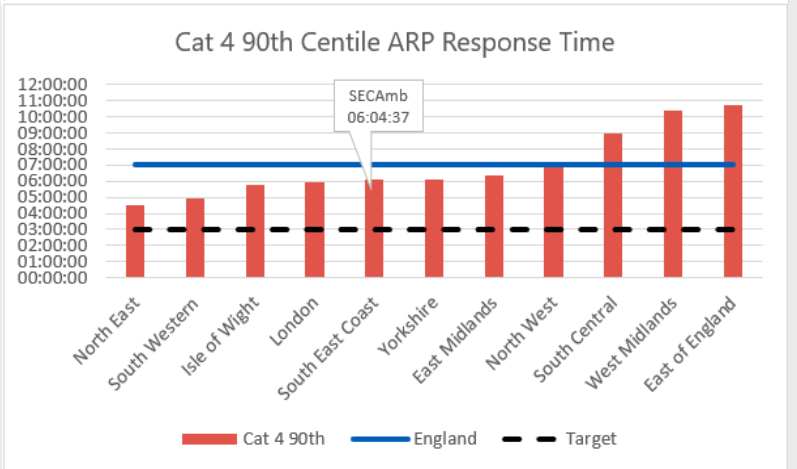










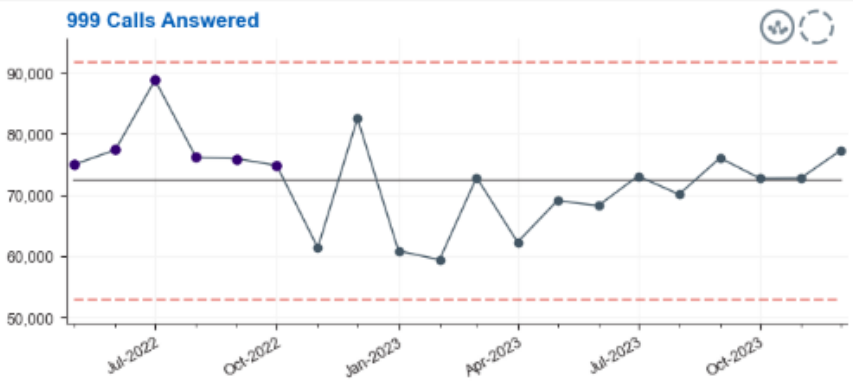


Summary

- 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

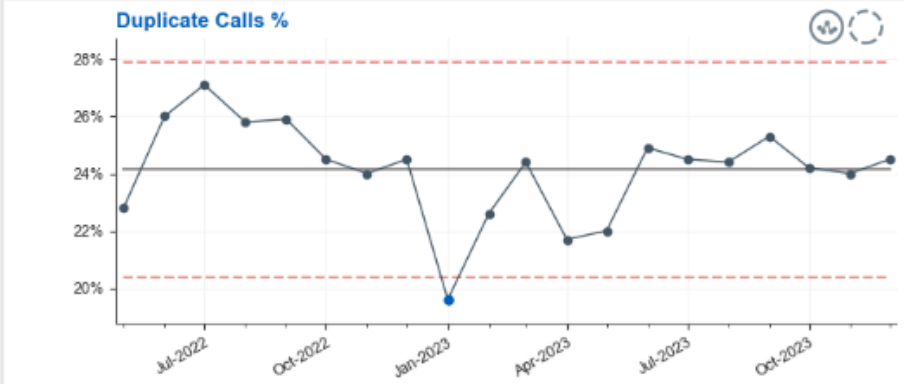
EOC Emergency Medical Advisors



999-10

Dept: Operations 999
IP: Responsive Care
Latest: 77252

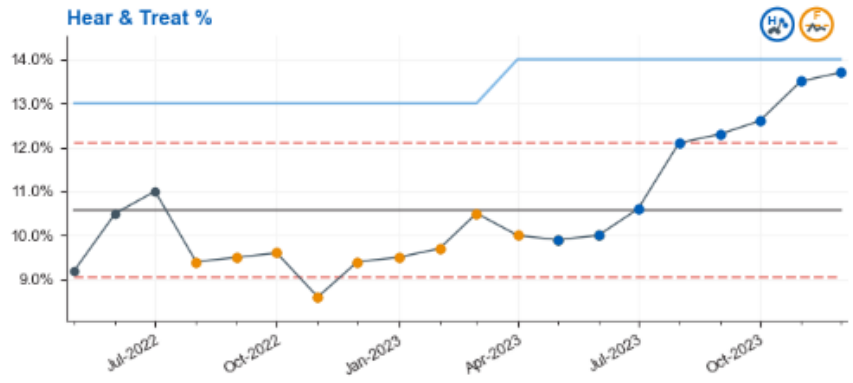
Common cause variation, no significant change.



999-33

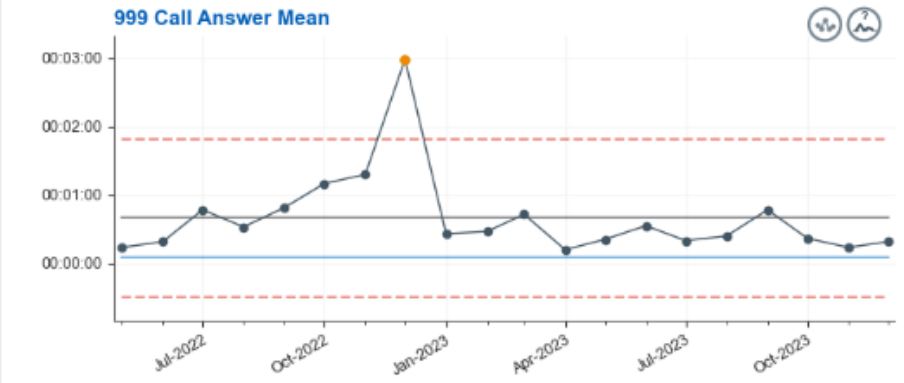
Dept: Operations 999
IP: Responsive Care
Latest: 24.5%

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

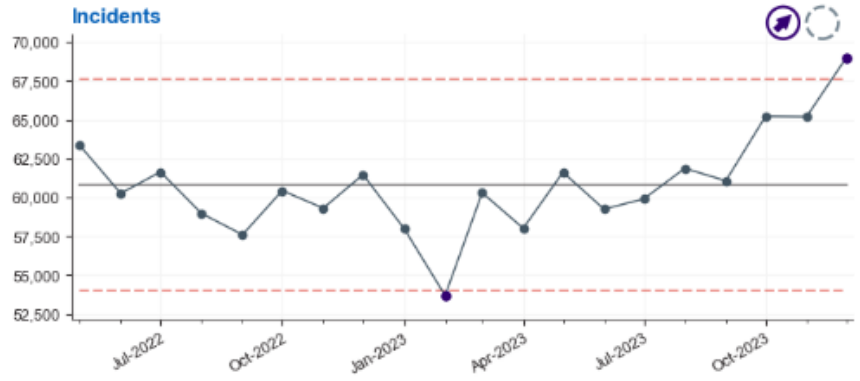
- Call answer mean time continues to fluctuate, underpinned by ongoing staffing challenges and rota inequalities, with a higher proportion of newer staff who are developing, although noting that there has been a general trend in increasing the number of ***calls answered*** over the same period.
- EMA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

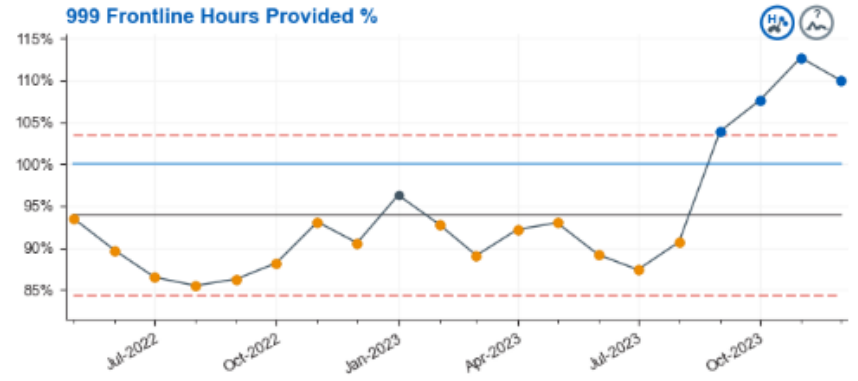
RESPONSIVE CARE

Utilisation

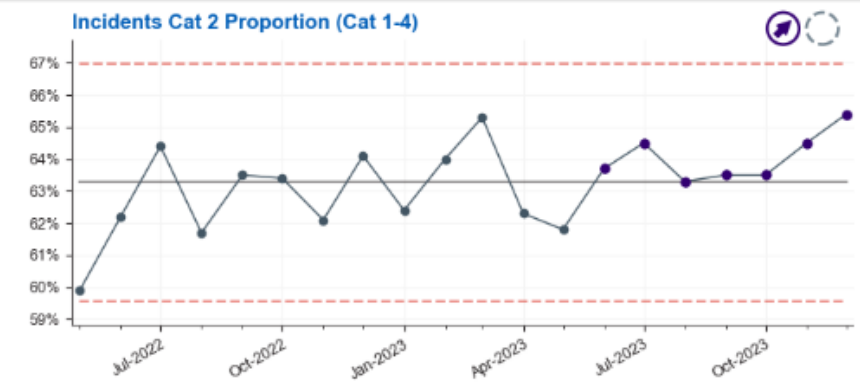


999-10
Dept: Operations 999
IP: Responsive Care
Latest: 68989

Special cause variation where UP is neither improvement or concern

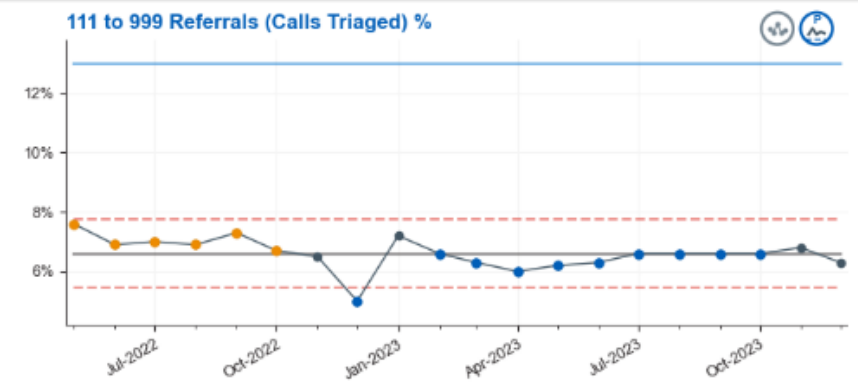


999-12
Dept: Operations 999
IP: Responsive Care
Latest: 110%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



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

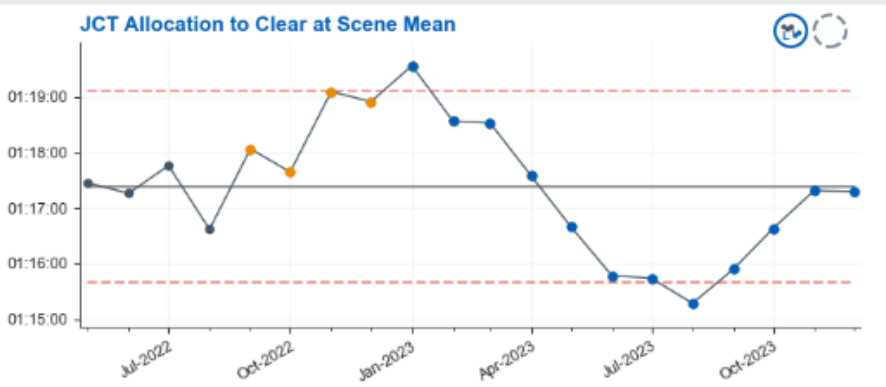
999-17

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

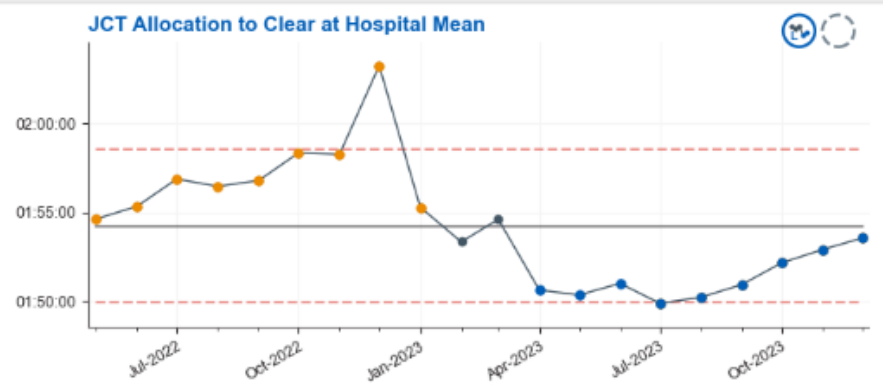
Common cause variation, no significant change.



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

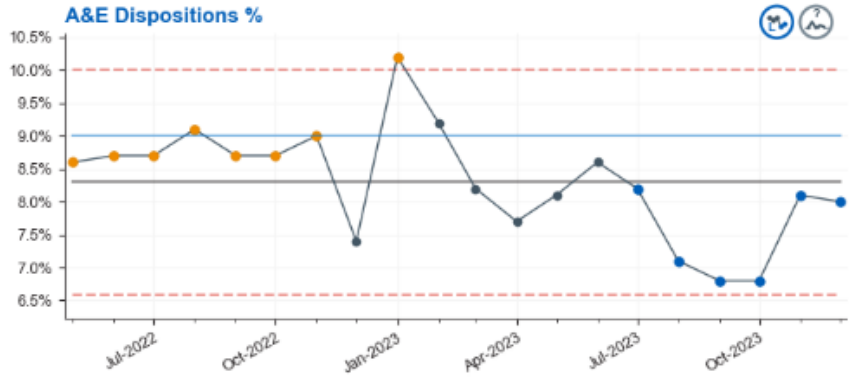
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been above target for several months, with common cause variation.
- ***Job cycle time*** (JCT) provides a single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

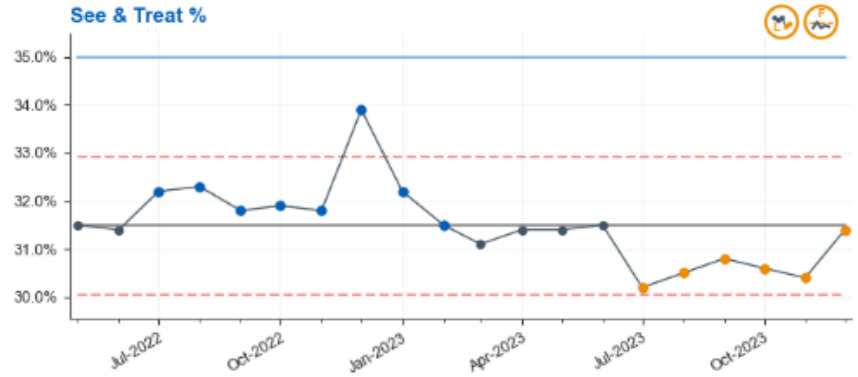
- The Trust commissioned an external ***AACE review of the Dispatch function***, and the recommendations are currently being addressed as part of the Responsive Care Group plan. Phase 1 of this plan was completed at the end of October – phase 2 commences in early 2024.
- Continued focus on delivery of ***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



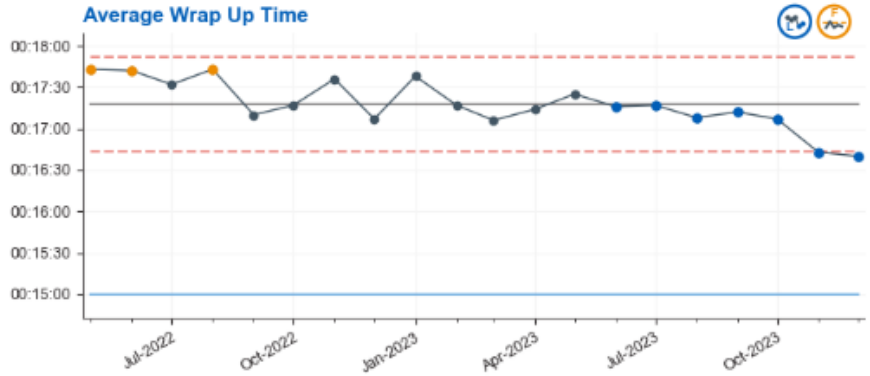
111-5
Dept: Operations 111
IP: Responsive Care
Latest: 8%
Target: 9%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



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

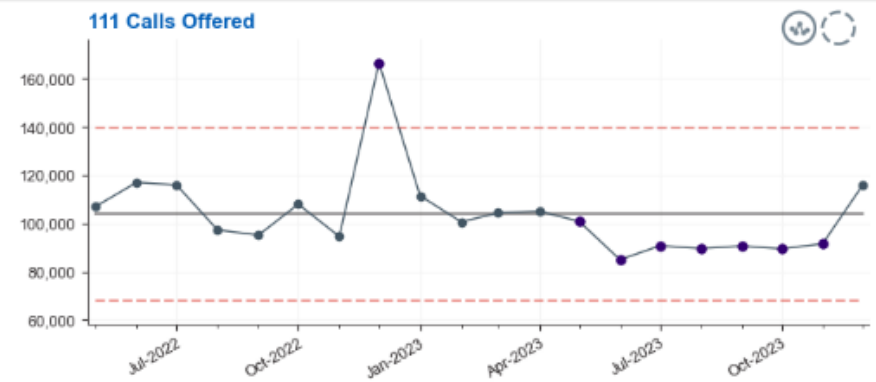
- The ***111 to ED disposition rate*** has been maintained at a very low level since the introduction of "111 First", Direct Access Booking (DAB) and ED validation. The Trust's 111 service has excelled at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111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

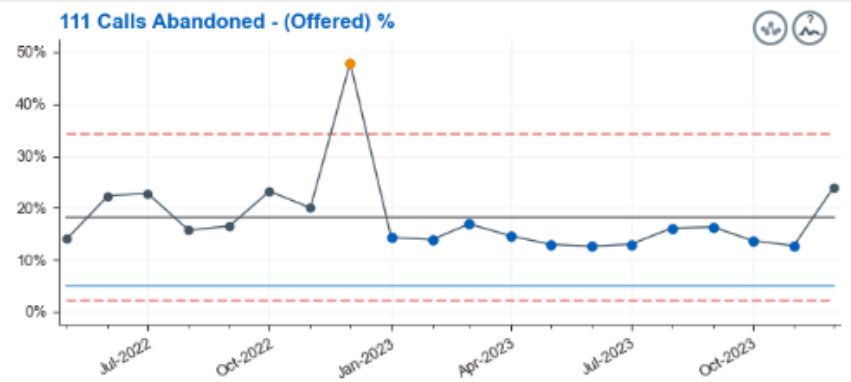
111



111-1

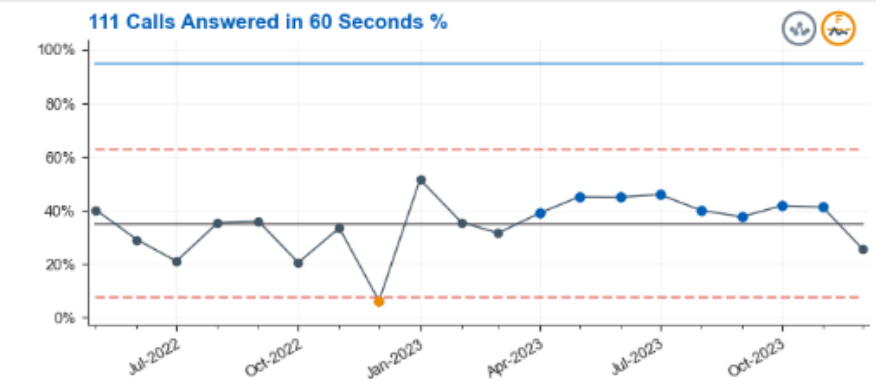
Dept: Operations 111
IP: Responsive Care
Latest: 115609

Common cause variation, no significant change.



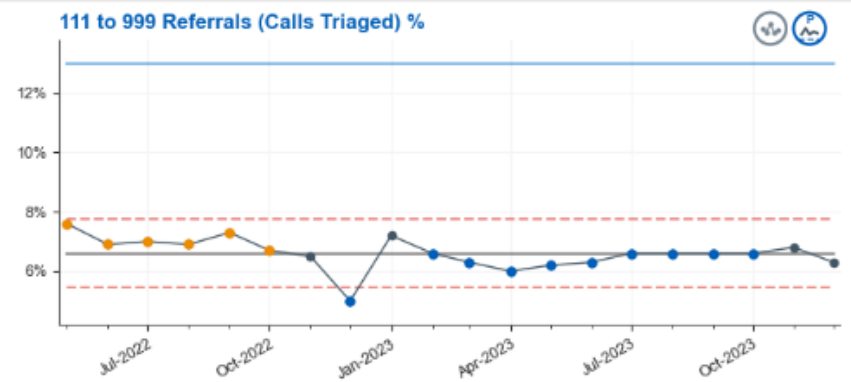
111-3

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

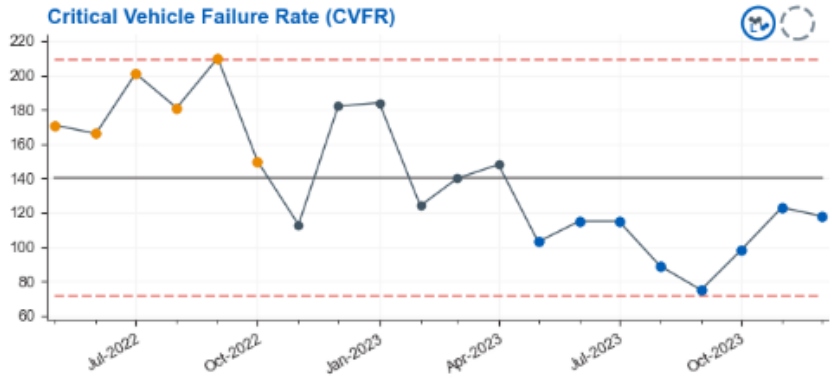
- The service's ***operational responsiveness*** remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned calls.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment 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

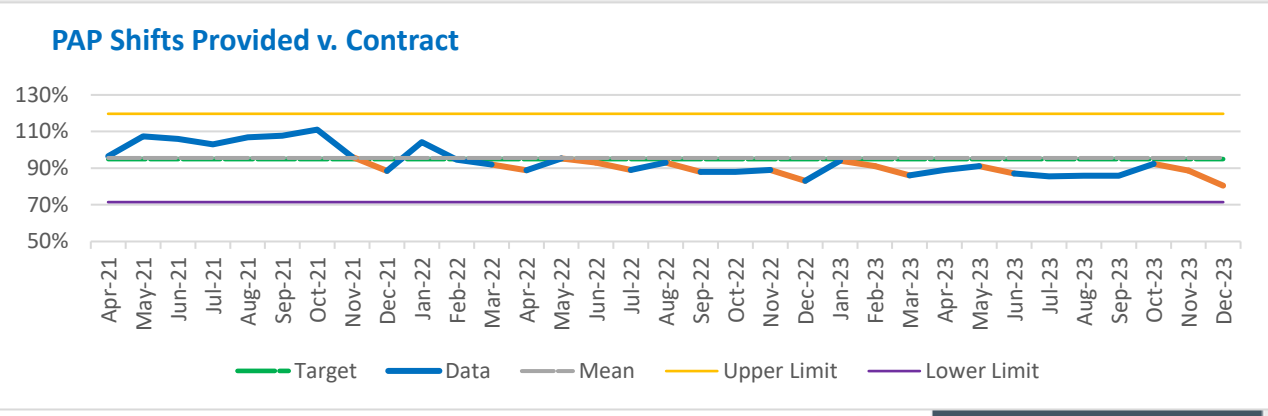
Support Services
Fleet and Private Ambulance Providers

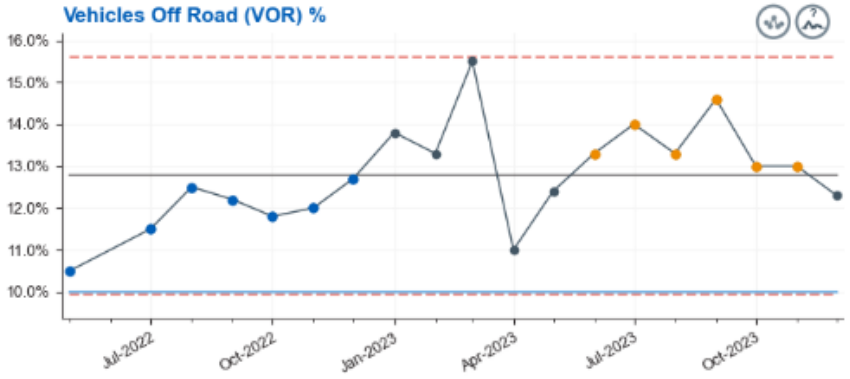


FL-12

Dept: Fleet
IP: Responsive Care
Latest: 118

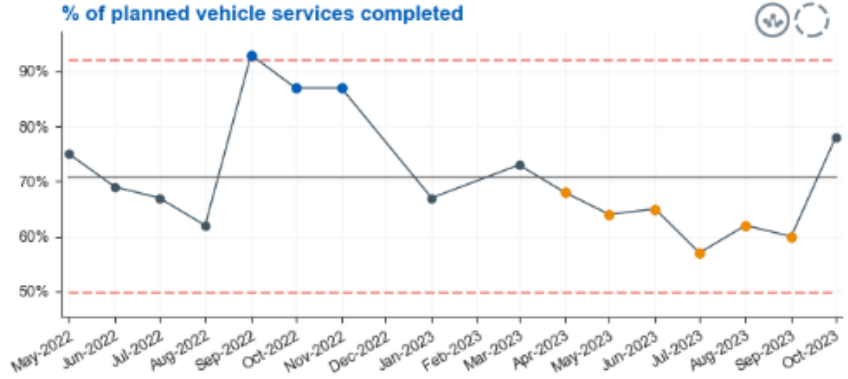
Special cause of an improving nature where the measure is significantly LOWER.





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
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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.

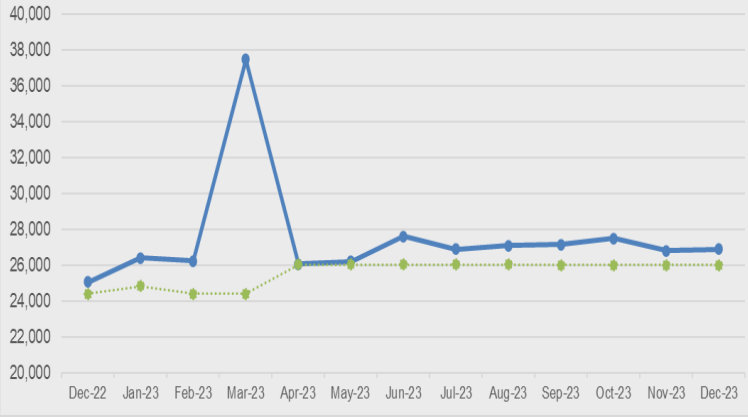
6. In addition, the Trust is developing its 2024/25 operating plan.

SUSTAINABILITY & PARTNERSHIPS

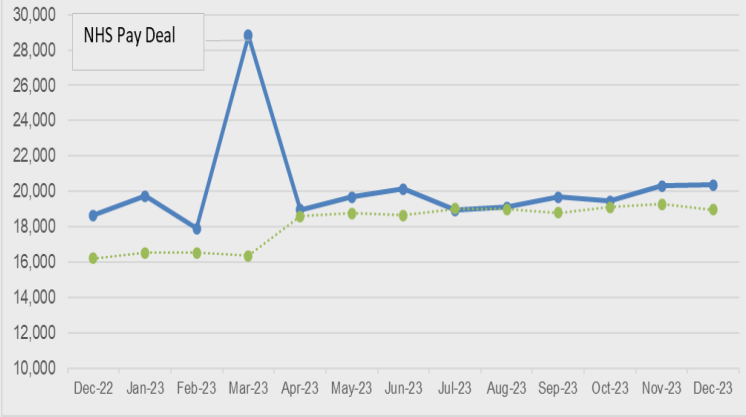
Delivered Against Plan

Actual Plan

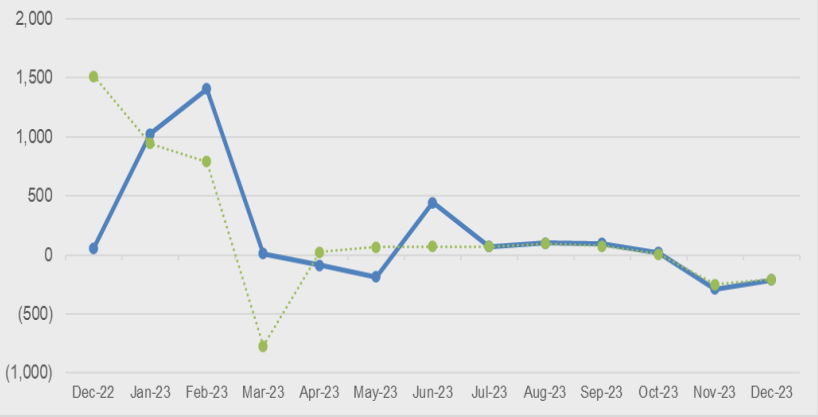
Income £000s



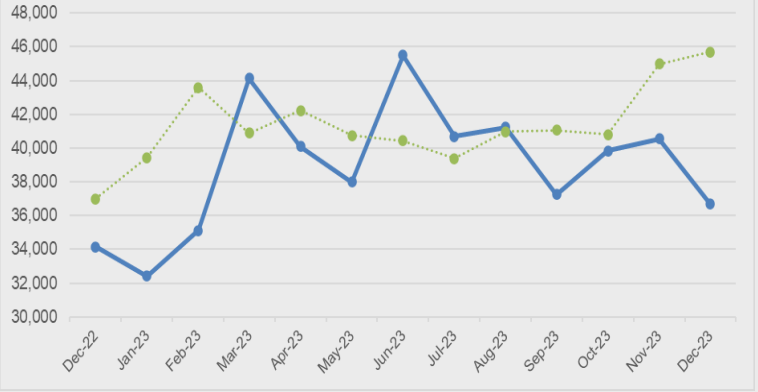
Pay £000s



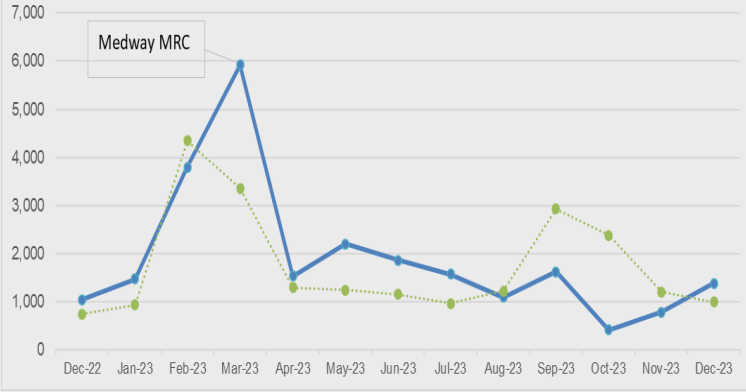
Reported Surplus / (Deficit) £000s



Cash £000s



Capital Expenditure £000s



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.

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	71-23

Name of meeting	Council of Governors
Date	14 March 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.

	Agenda No	71-23
Name of meeting	Council of Governors	
Date	14 March 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.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	71-23

Name of meeting	Council of Governors
Date	14 March 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	71-23

Name of meeting	Council of Governors
Date	14.03.2024
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

24/25 Operating Plan

COG Update 14/March/2024

National Context

NHS England Board Update, Key Priorities and Challenges

- Focus on trust, collaboration, and ICBs as key to NHS success
- Improving mental health services and stroke care (thrombectomy)
- Enhancing maternity and neonatal services, with focus on equality of access
- Growing UK talent pool and working closely with universities

Financial Outlook

- Demonstrate efficiency improvements before requesting additional funds, NHS has scope for productivity gains

Performance Targets

- 76% of A&E patients treated within 4 hours, 30 minutes for Category 2 Ambulance response
- Focus on use data effectively to drive operational improvements

Quality Improvement and Digital Transformation

- Adopt organization-wide quality improvement approach
- Focus on digital opportunities to unlock productivity

Leadership and Workforce

- Reduction in staff turnover rate and participation in People Promise program, nationally we are seeing a reduction of leavers from 8.5% to 7.7%. This trend is followed by SECAmb.

Recover - Strengthen – Reform

2024/25 Planning Context

Planning without guidance

- NHS England (NHSE) has yet to publish its annual operating plan guidance as discussions continue to take place.
- NHSE has issued a brief assumptions document which is the basis on which the NHS is currently basing its operating plan.

Conflicting goals

- The key target will be to continue to deliver a 30-minute C2 mean in the context of financial envelopes tightening as demand is increasing.
- Whilst NHSE is pushing for no reduction in frontline workforce.

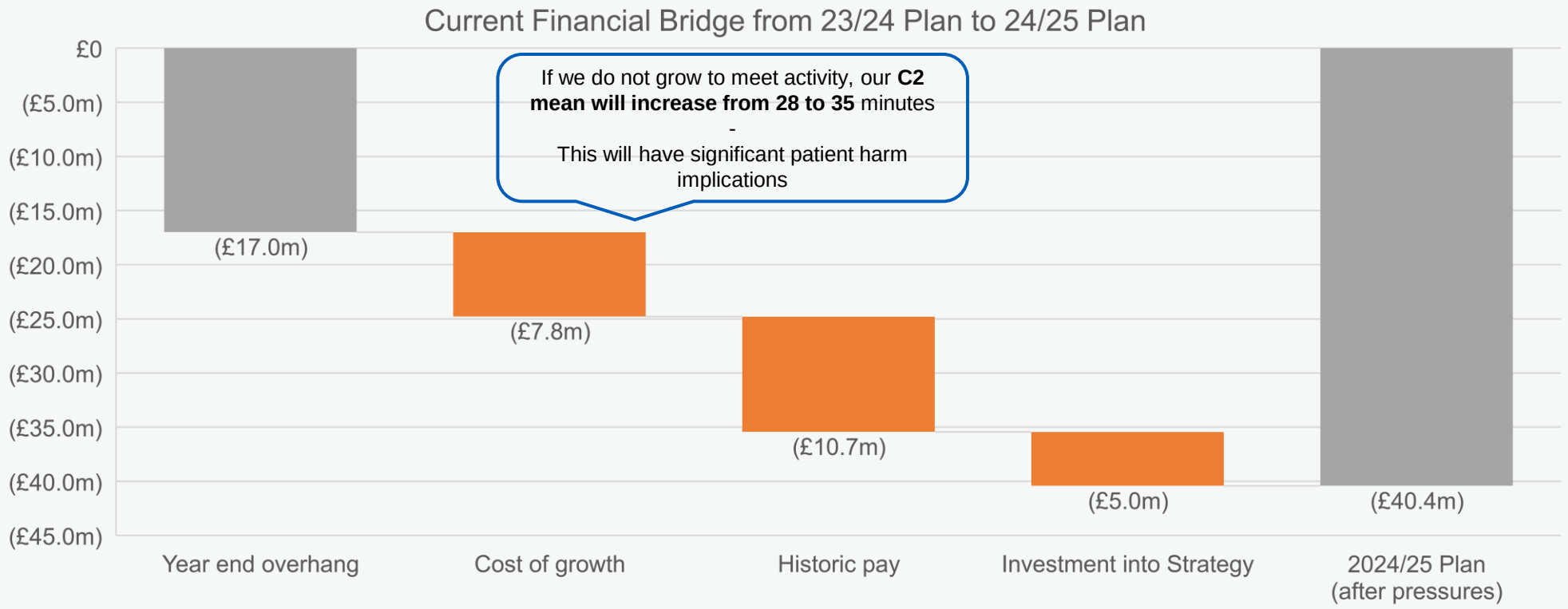
Delivering a strategy

- We have developed our preferred strategic option which focusses on delivering a more sustainable and better for patients'.
- Year 1 will not deliver immediate cash savings as it will need to be a transitional year to ensure long term success and a sustainable exit from RSP.

Longer term approach to planning

- Our strategy will deliver long term financial sustainability and high-quality patient care, but it will be a 5 year journey to fully realise all of the anticipated benefits.
- A longer-term view on planning (3 years minimum) is needed to allow SECAmb to embark in a transformation journey that allows it to successfully implement a more sustainable model.

Initial draft plans



Our initial position shows a £40.4m deficit in 2024/25. This is driven by:

- £17m year-end overhang due to technical guidance changes and non-recurrent funding income position driven by 23/24
- £7.8m required to deliver a C2 mean of 30 minutes in 24/25.
- £10.7m a result of historic pay issues from national challenges that must be resolved (inc. HART)
- £5m invested into our strategy to ensure we can sustainably deliver high quality care to our patients in the long term.

Summary

Summary

- We do not yet have planning guidance – however there is a National requirement to break-even.
- 24/25 is expected to be challenging for all systems – all providers working with ICB to understand finance plans for next year
- All our ICBs currently showing deficits, Surrey Heartlands' initial submission has £140m deficit of which SECAmb is £40m
- A focus on keeping substantive workforce flat or reduced whilst maintaining quality of care and performance standards
- An expectation to deliver transformation activities within envelopes
- A clear focus on productivity

Our plan

- 24/25 needs to be a year of stabilising leadership and setting up for a successful change in our delivery model
- Efficiencies can be released by starting our transformation roadmap and focussing on QI, in particular productivity, but this will require investment to ensure we maintain our performance
- Organisations in RSP will not be allowed to exit if they are not in financial balance
- We expect on-going iterations on our plan and further submission until May

South East Coast Ambulance Service
NHS Foundation Trust

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

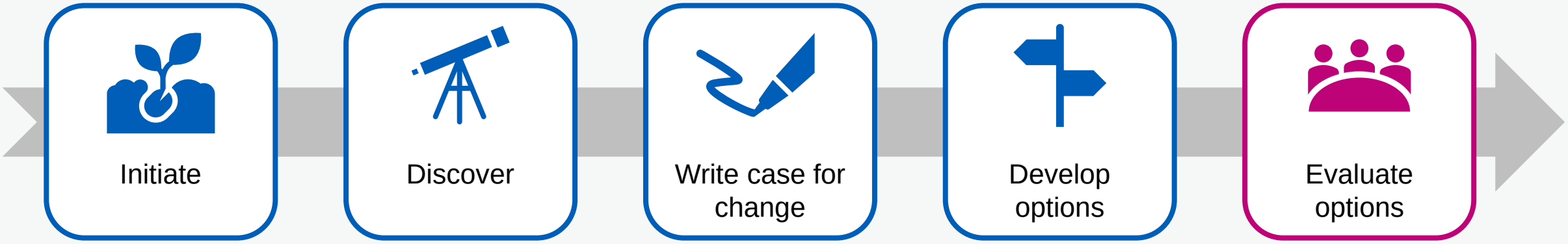
Patient Engagement

- **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**

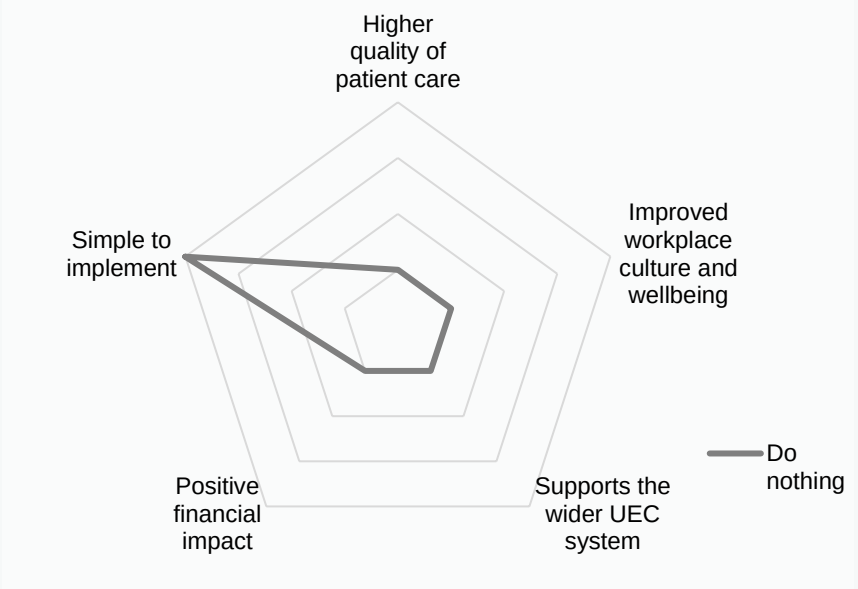
"I can access care with any of my urgent or emergency needs and the staff are able to provide comprehensive and differentiated care"

"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

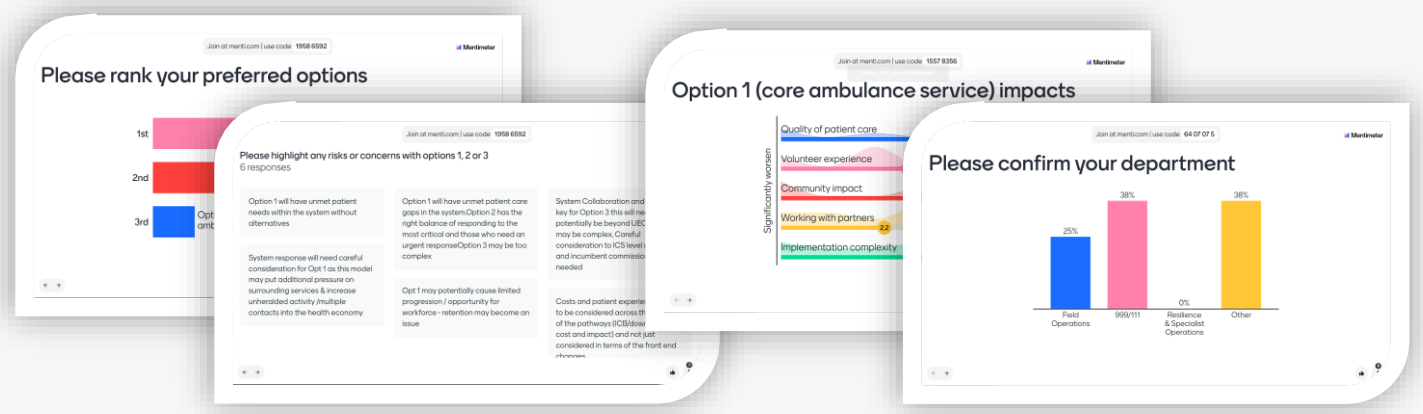
'Do nothing' assessment against the five criteria



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

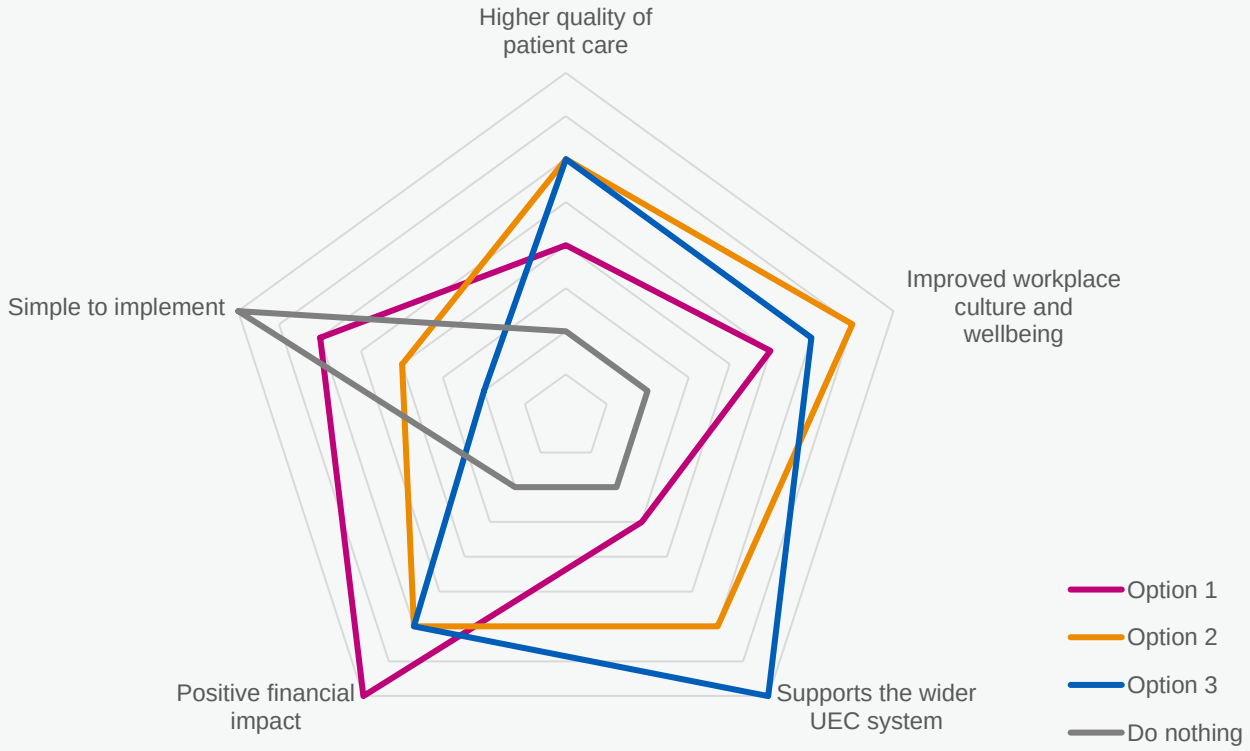
Evaluators include:

- ✓ 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
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"

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

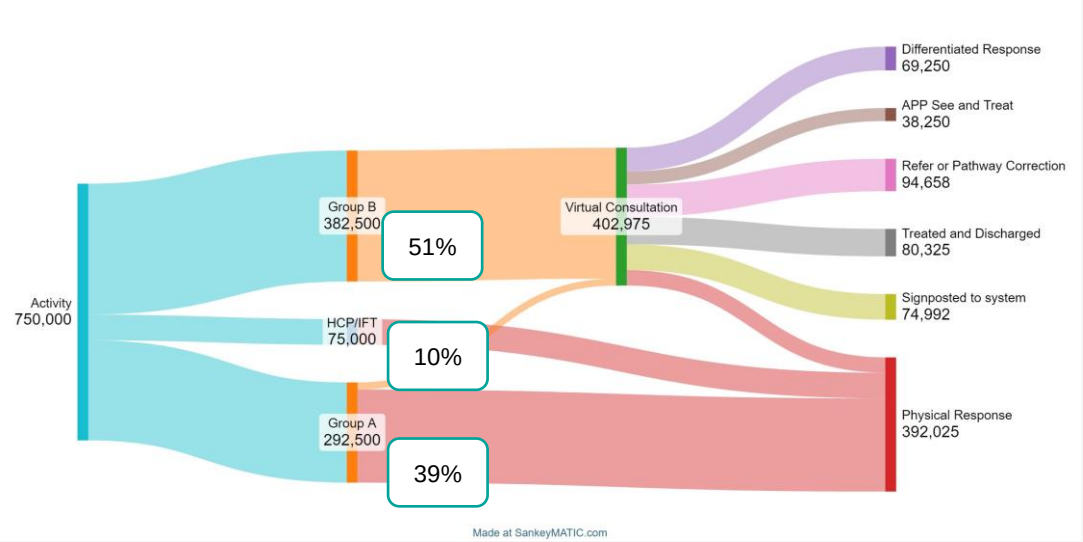
Signposting non-UEC activity

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

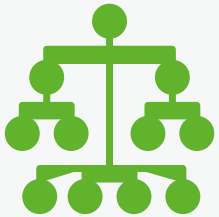
Group A: Existing resources are refocused to provide a better response to patients with emergency and critical conditions.

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.

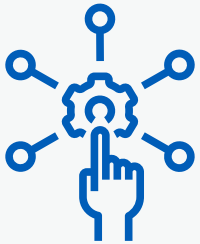
Any option will be complemented by ‘no regrets’ initiatives

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.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Shaping our Future Together

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

Find out more and get involved in shaping our strategy

SCAN ME

We 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

NHS Staff Survey 2023

For the fourth consecutive year we heard from 60% of the organisation through the Survey

2,790 colleagues, including 74 who hold bank contracts, took the time to provide their views

Our scores have **improved more, year on year,** than those of our ambulance colleagues

Every one of the nine theme scores has **shown a statistically significant improvement** compared to last year

And we **saw improved scores** to almost all of the individual questions

2020 vs 2021

2021 vs 2022

2022 vs 2023

Improved Worsened

Person-Centred Care

60%

of staff said that **care of patients/ service users** is the organisation's **top priority**.

Improved 8% since 2022

62%

of staff said that if a friend or relative needed treatment they would be **happy with the standard of care provided** by the organisation.

Improved 10% since 2022

Motivation

62%

of staff said they are **enthusiastic about their job**.

Improved 5% since 2022

Speaking Up About Concerns

53%

of staff **feel safe to speak up about anything** that concerns them in the organisation.

Improved 8% since 2022

We know we have lots more to do and are committed to continuing to make SECAmb a better place to work for everyone but it's great to see positive improvement!

CONFIDENTIAL – Contains information still under embargo

South East Coast Ambulance Service
NHS Foundation Trust

2023 NHS Staff Survey

Overview of Results

February 2024

Inclusion, Learning & Organisation Development

NSS 2023 Headlines

South East Coast Ambulance Service NHS Foundation Trust

01 We reached our target of hearing from at least 60% of the workforce for the 4th year in a row.

02 Every theme score has shown a statistically significant improvement year on year.

03 Our results place us equal to or just below average across all themes when compared with our benchmarking group.

NSS 2023

04 Whilst our scores remain at or below average, they have improved more year on year than the scores of our peers.

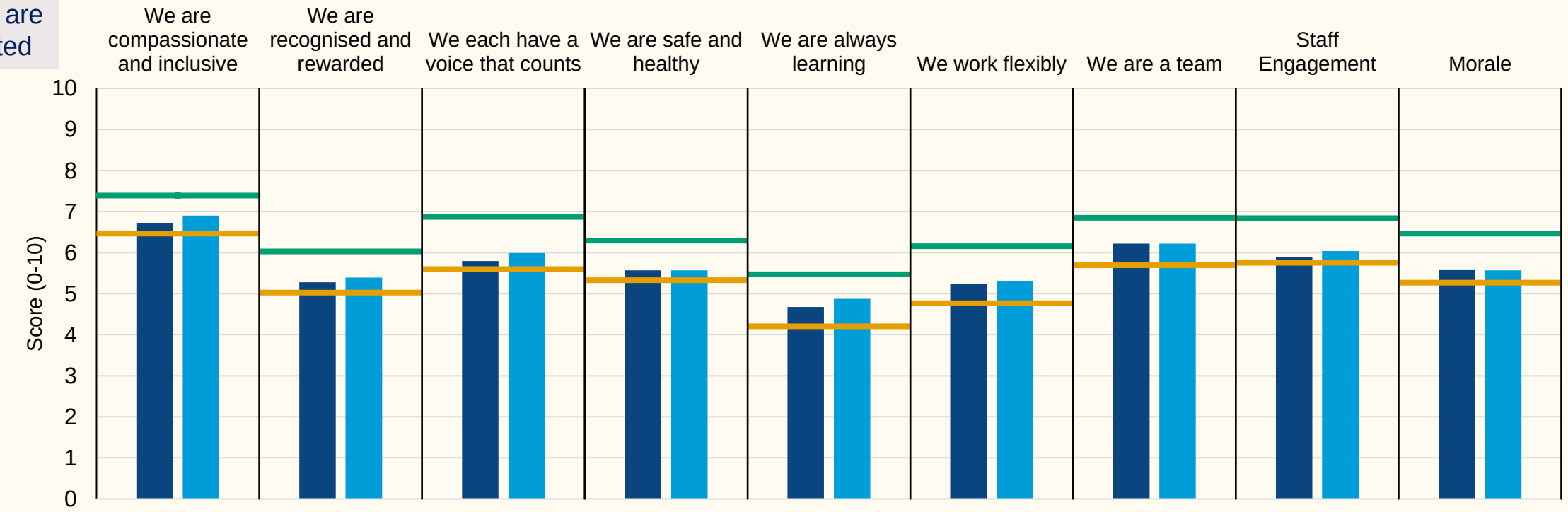
05 Approximately 74% of our scores at a question level improved by a statistically significant amount.

06 Scores in the Operations directorate improved significantly compared to other SECAmb directorates.

Ambulance Benchmarking Chart

South East Coast Ambulance Service NHS Foundation Trust

Scores are weighted



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
SECAmb	6.71	5.27	5.79	5.57	4.67	5.23	6.22	5.90	5.57
Best Amb	7.39	6.03	6.87	6.29	5.47	6.15	6.85	6.84	6.46
Average Amb	6.90	5.39	5.99	5.57	4.87	5.32	6.22	6.03	5.57
Worst Amb	6.46	5.02	5.60	5.33	4.20	4.77	5.69	5.75	5.27

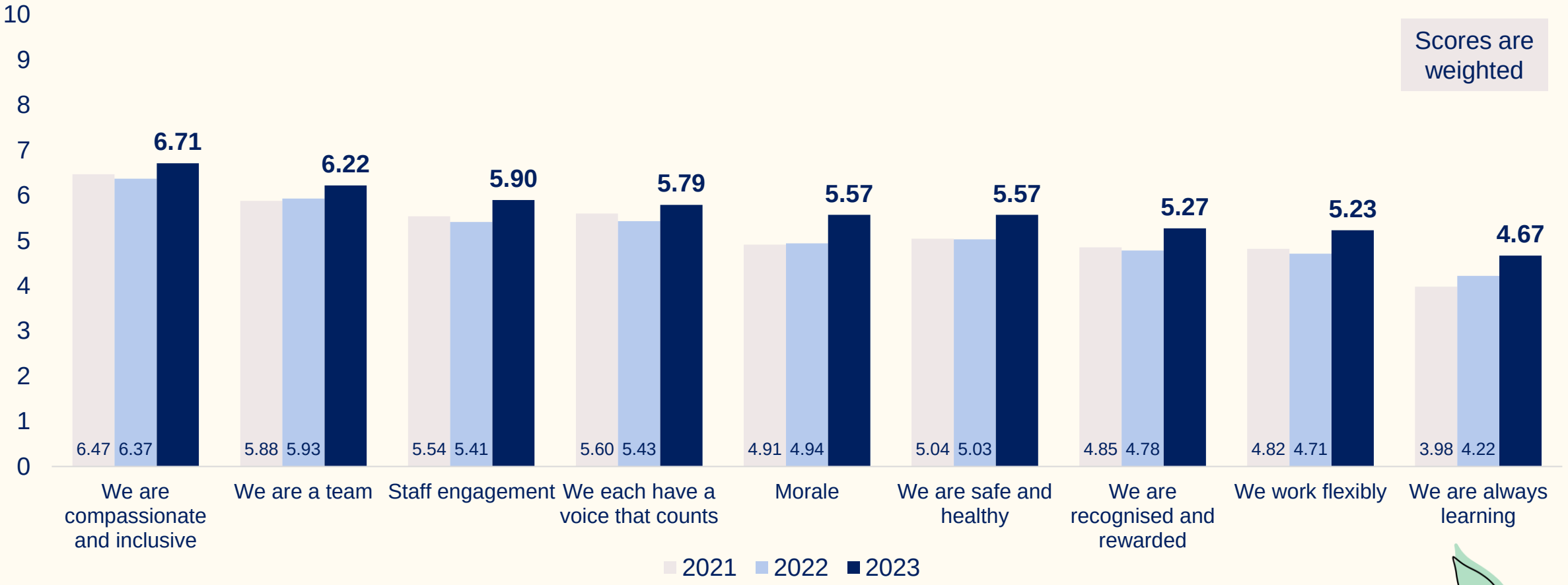
People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.

All SECAmb scores are equal to or slightly below average in 2023. However, our scores have improved more on average than those of our peers since 2022 when 3 of our scores were the worst in our peer group.

Score Type	Avg. improvement in Theme score (22 to 23)
SECAmb	+0.46
Ambulance Trusts - Best	+0.39
Ambulance Trusts - Median	+0.22
Ambulance Trusts - Worst	+0.30

SECAmb Theme Scores - 2021 to 2023

South East Coast Ambulance Service NHS Foundation Trust



Every theme score has increased year on year.

(All themes are scored on a scale of 0-10 where 10 is the best possible score.)

SECAmb Theme Scores – Change YoY

South East Coast Ambulance Service NHS Foundation Trust

Note: These are our weighted scores used for benchmarking against other organisations

People Promise / Theme	2022	2023	Change YoY	Statistically significant change?
We are compassionate and inclusive	6.37	6.71	+0.34	Significantly higher
We are recognised and rewarded	4.78	5.27	+0.49	Significantly higher
We each have a voice that counts	5.43	5.79	+0.36	Significantly higher
We are safe and healthy	5.03	5.57	+0.54	Significantly higher
We are always learning	4.22	4.67	+0.45	Significantly higher
We work flexibly	4.71	5.23	+0.52	Significantly higher
We are a team	5.93	6.22	+0.29	Significantly higher
Staff Engagement	5.41	5.90	+0.49	Significantly higher
Morale	4.94	5.57	+0.63	Significantly higher

The Survey Coordination Centre carries out statistical significance testing using a two-tailed t-test.

This year, every one of our theme scores was found to have increased by a statistically significant amount.

Sub-Theme Scores Ranked

South East Coast Ambulance Service NHS Foundation Trust

Note: These are our weighted scores used for benchmarking against other organisations

Theme	Sub-Theme	2021	2022	2023	Change YoY
We are compassionate and inclusive	**Diversity and equality**	7.22	7.03	7.40	+ 0.37
We are safe and healthy	**Negative experiences**	6.66	6.62	7.06	+ 0.44
We are compassionate and inclusive	**Compassionate leadership**	6.37	6.51	6.75	+ 0.24
We are a team	**Line management**	5.98	6.16	6.44	+ 0.28
We are compassionate and inclusive	**Compassionate culture**	6.06	5.77	6.35	+ 0.58
We are compassionate and inclusive	**Inclusion**	6.22	6.14	6.33	+ 0.19
Staff Engagement	**Motivation**	5.84	5.86	6.22	+ 0.36
We are a team	**Team working**	5.76	5.72	6.01	+ 0.29
We are always learning	**Development**	5.44	5.55	5.99	+ 0.44
Staff Engagement	**Advocacy**	5.59	5.24	5.97	+ 0.73
We each have a voice that counts	**Autonomy and control**	5.57	5.57	5.86	+ 0.29
Morale	**Stressors**	5.42	5.48	5.84	+ 0.36
Morale	**Thinking about leaving**	5.10	5.08	5.78	+ 0.70
We each have a voice that counts	**Raising concerns**	5.63	5.29	5.73	+ 0.44
Staff Engagement	**Involvement**	5.18	5.14	5.52	+ 0.38
We work flexibly	**Support for work-life balance**	4.85	4.79	5.30	+ 0.51
We are safe and healthy	**Health and safety climate**	4.58	4.58	5.26	+ 0.68
We work flexibly	**Flexible working**	4.80	4.64	5.17	+ 0.53
Morale	**Work pressure**	4.23	4.28	5.10	+ 0.82
We are safe and healthy	**Burnout**	3.88	3.88	4.40	+ 0.52
We are always learning	**Appraisals**	2.53	2.89	3.35	+ 0.46

Average Theme Scores Across SECAmb

South East Coast Ambulance Service NHS Foundation Trust

Team	2021 Avg	2022 Avg	2023 Avg
CCP	5.6	5.9	**6.3**
111 Urgent Care	5.8	5.6	**6.3**
Medway Dispatch Desk	5.2	5.3	**6.0**
EOC	4.9	4.9	**5.8**
Dartford Dispatch Desk	4.9	5.2	**5.5**
Tangmere Dispatch Desk	4.7	4.8	**5.5**
Worthing Dispatch Desk	4.8	4.8	**5.5**
Ashford Dispatch Desk	4.7	4.8	**5.4**
Banstead Dispatch Desk	4.9	4.9	**5.4**
Thanet Dispatch Desk	4.8	5.0	**5.4**
HART	4.9	4.6	**5.3**
Chertsey Dispatch Desk	4.8	5.0	**5.3**
Polegate Dispatch Desk	4.0	4.6	**5.2**
Guildford Dispatch Desk	4.7	4.8	**5.1**
Brighton Dispatch Desk	4.6	4.3	**4.9**
Gatwick Dispatch Desk	4.5	4.3	**4.9**
Paddock Wood Dispatch Desk	5.1	4.6	**4.9**
Hastings Dispatch Desk	3.7	3.7	**4.3**

Directorate	2021 Avg	2022 Avg	2023 Avg
Chief Executive's Office	7.0	6.7	6.5
HR & OD	6.4	6.3	6.4
Finance & Corporate Services	6.6	6.2	6.2
Medical	5.7	6.0	6.1
Strategic Planning & Transformation	6.2	6.3	6.1
Quality & Nursing	6.6	5.9	6.0
Operations	5.0	5.0	**5.5**

An average theme score has been calculated for each team to provide an indication of variance in overall employee experience between teams.

The majority of operational teams have seen significant improvement year on year, whereas scores in other directorates have improved less significantly or have declined slightly.

(These scores are unweighted)

Question Results - Overview

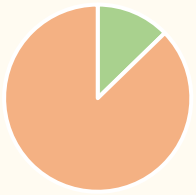
South East Coast Ambulance Service NHS Foundation Trust

- 101 questions improved YoY.
- Improvements ranged from 0.1% to 13.5%.

- 3 questions worsened YoY.
- Declines ranged from 0.4% to 1.32%.

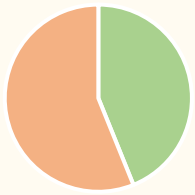
77 scores increased by 3% or more, suggesting potentially significant improvements in 74% of comparable questions

2020 vs 2021



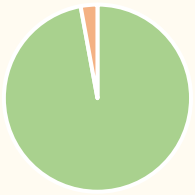
Improved Worsened

2021 vs 2022



Improved Worsened

2022 vs 2023



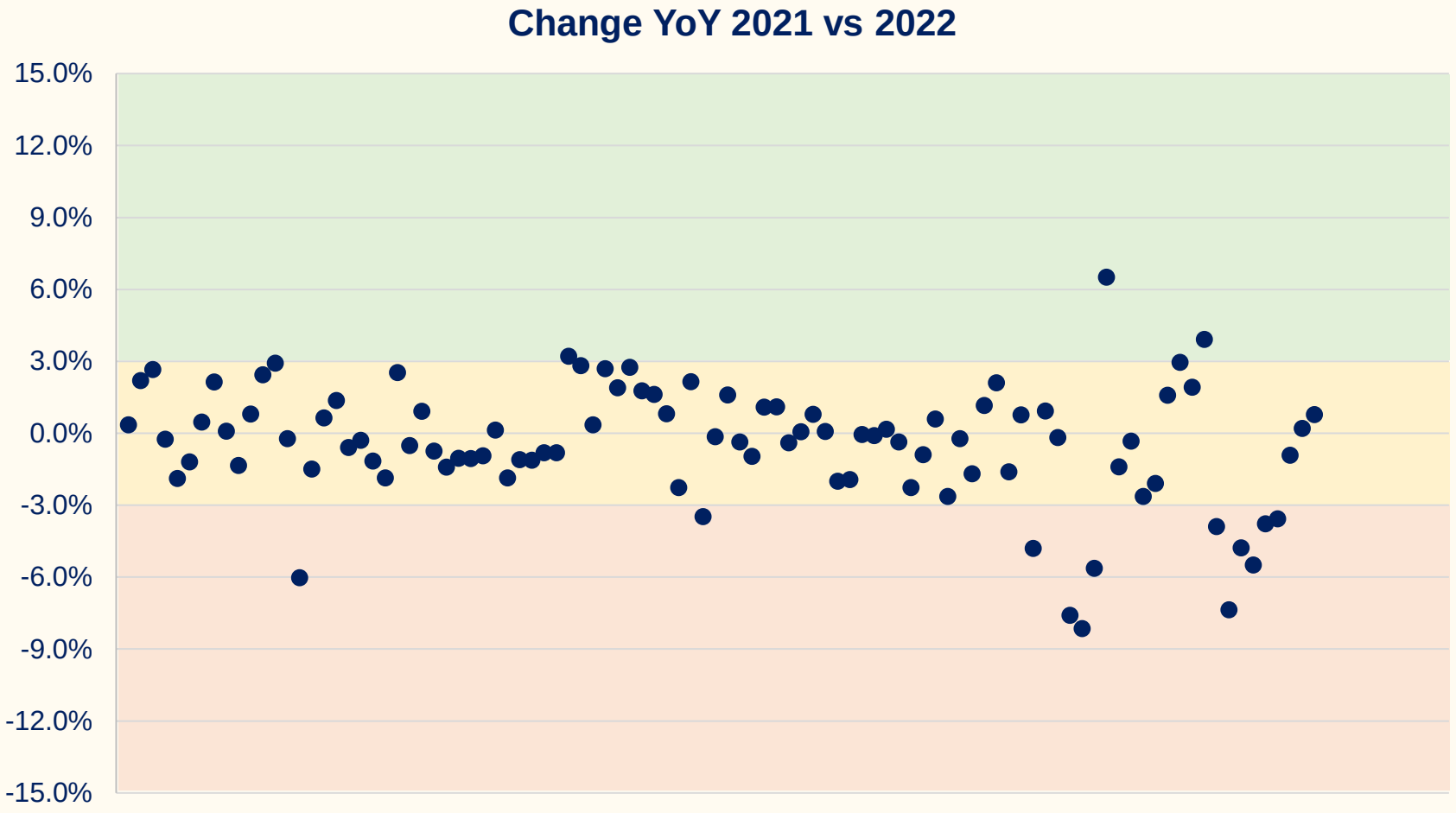
Improved Worsened

Theme/Measure	Ques. Improved	Ques. Worsened	Avg. Change
Staff Engagement	9	0	+ 6.9%
Morale	13	0	+ 6.8%
We work flexibly	4	0	+ 6.8%
Always learning	9	0	+ 6.2%
Safe & healthy	22	1	+ 5.5%
Compassionate & inclusive	17	0	+ 5.2%
Recognised & rewarded	5	0	+ 5.0%
Voice that counts	11	0	+ 4.9%
No Theme	14	2	+ 4.7%
We are a team	12	0	+ 4.3%

* All question scores within this presentation are unweighted

Change Year on Year

South East Coast Ambulance Service
NHS Foundation Trust

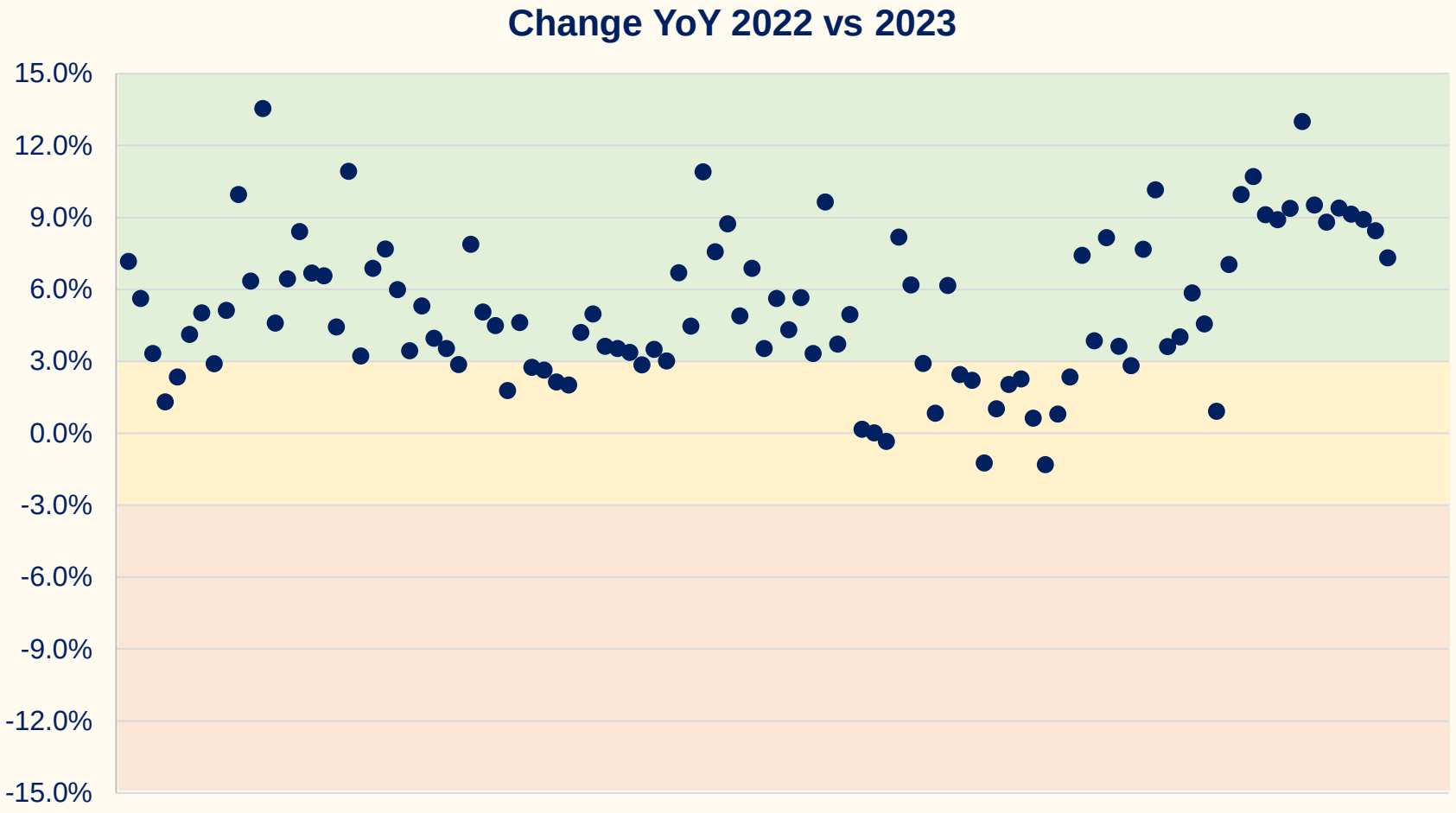


This graph shows the increase or decrease in positive score for each comparable question. The positive score is calculated from the number of respondents who answered each question favourably.

The greater the increase, the greater the improvement year on year.

Change Year on Year

South East Coast Ambulance Service
NHS Foundation Trust



The vast majority of questions in 2023 have increased by a significant amount.

No questions in 2023 have worsened significantly.

Most Improved Questions

South East Coast Ambulance Service NHS Foundation Trust

Question (Top 10 Most Improved)	Change
There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	13.5%
I would recommend my organisation as a place to work (Agree/Strongly agree).	13.0%
Relationships at work are strained (Never/Rarely).	10.9%
My organisation takes positive action on health and well-being (Agree/Strongly agree).	10.9%
I feel supported to develop my potential (Agree/Strongly agree).	10.7%
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	10.1%
I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	10.0%
I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	10.0%
How often, if at all, do you feel that every working hour is tiring for you (Never/Rarely).	9.6%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	9.5%

Question (Worsened)	Change
The last time you experienced physical violence at work, did you or a colleague report it (Yes).	- 0.4%
On what grounds have you experienced discrimination? Ethnic background (No).	- 1.3%
On what grounds have you experienced discrimination? Age (No).	- 1.3%

All changes are calculated from the ‘positive score’ for each question’ (the % of respondents who answered the question favourably).

An increase in score always reflects an improved result.

Top 15 Highest Performing Questions

South East Coast Ambulance Service NHS Foundation Trust

Question	Positive Score
In the last 12 months how many times have you personally experienced physical violence at work from managers (Never).	99.2%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (Never).	98.5%
In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (No).	87.5%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (No).	85.3%
My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).	84.8%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (Never).	84.6%
I always know what my work responsibilities are (Agree/Strongly agree).	82.2%
I feel that my role makes a difference to patients / service users (Agree/Strongly agree).	81.9%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (Never).	81.2%
I enjoy working with the colleagues in my team (Agree/Strongly agree).	80.0%
I am trusted to do my job (Agree/Strongly agree).	79.2%
Have you felt pressure from your manager to come to work (when unwell) (No).	74.8%
Team members understand each other's roles (Agree/Strongly agree).	73.6%
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (Never).	71.8%
The last time you experienced physical violence at work, did you or a colleague report it (Yes).	71.3%

Bottom 15 Lowest Performing Questions

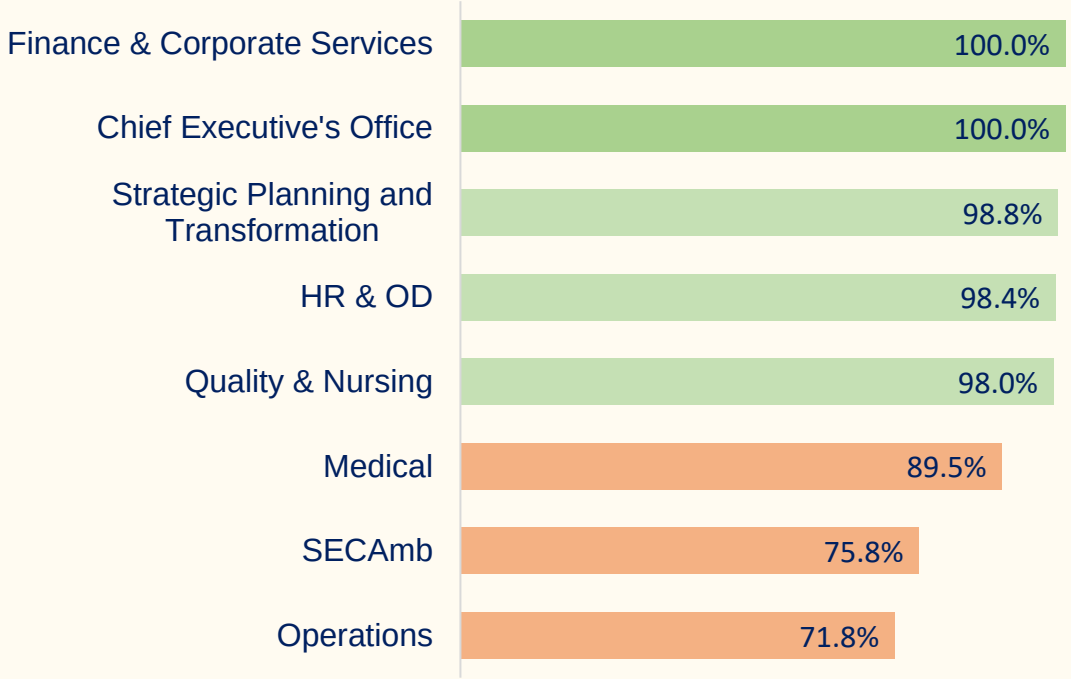
South East Coast Ambulance Service NHS Foundation Trust

Question	Positive Score
My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	29.6%
There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	28.6%
I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	27.5%
The extent to which my organisation values my work (Satisfied/Very satisfied).	27.4%
It (my appraisal) helped me agree clear objectives for my work (Yes, definitely).	26.4%
My level of pay (Satisfied/Very satisfied).	26.2%
How often, if at all, are you exhausted at the thought of another day/shift at work (Never/Rarely).	25.9%
How often, if at all, do you not have enough energy for family and friends during leisure time (Never/Rarely).	25.4%
I have unrealistic time pressures (Never/Rarely).	25.2%
How often, if at all, do you feel burnt out because of your work (Never/Rarely).	23.3%
It left me feeling that my work is valued by my organisation (Yes, definitely).	20.3%
It helped me to improve how I do my job (Yes, definitely).	17.0%
How often, if at all, do you find your work emotionally exhausting (Never/Rarely).	15.6%
How often, if at all, does your work frustrate you (Never/Rarely).	12.9%
How often, if at all, do you feel worn out at the end of your working day/shift (Never/Rarely).	10.4%

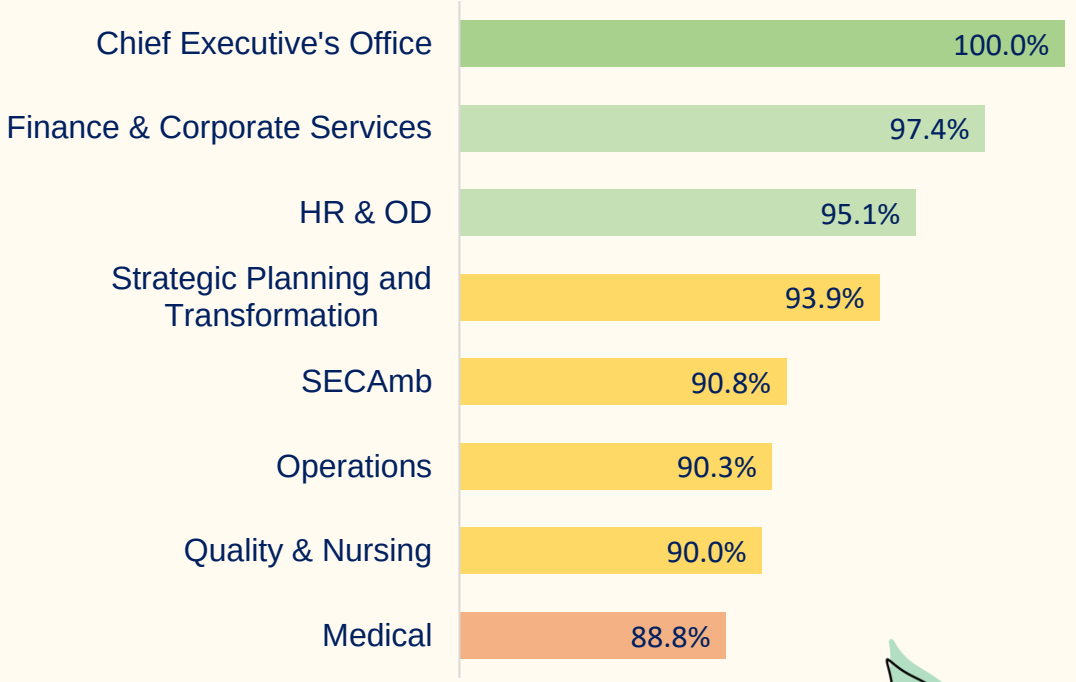
Sexual Behaviour at Work - Directorate

South East Coast Ambulance Service NHS Foundation Trust

In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users / public (Never)



In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues (Never)

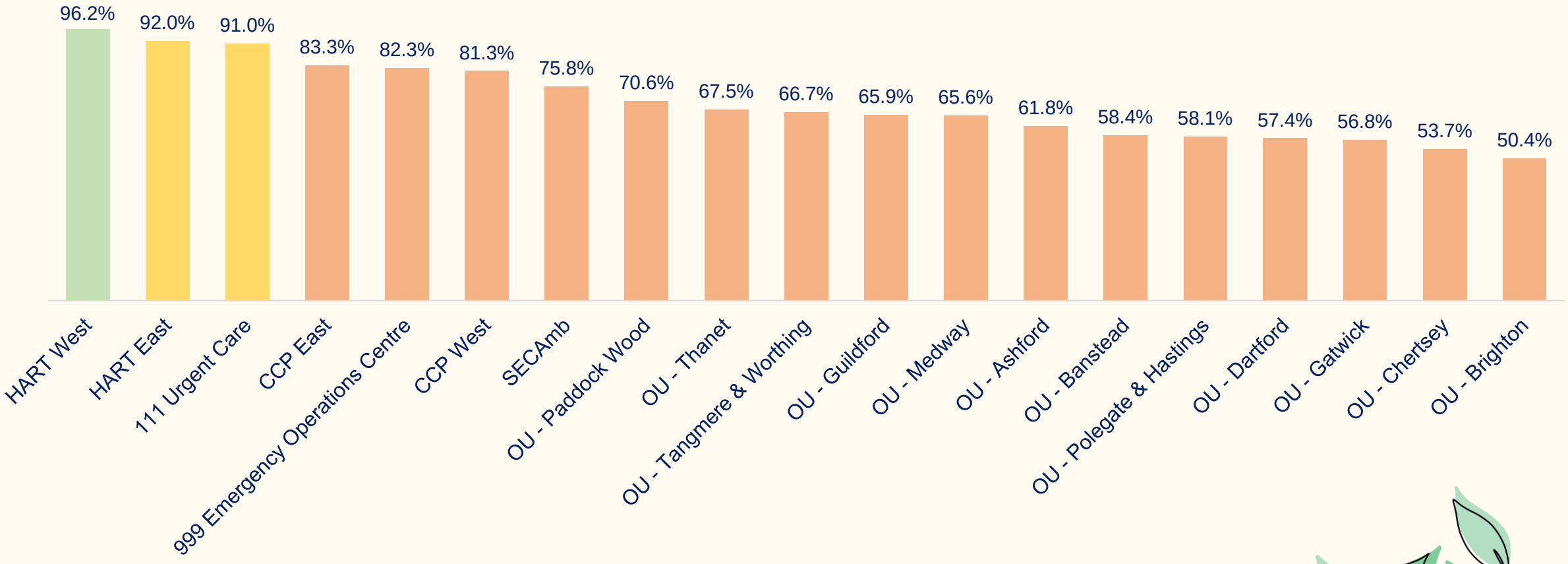


The 'positive score' for each directorate is displayed in each graph (the % who, in the last 12 months, have **never** been the target of unwanted behaviour of a sexual nature). Therefore, the higher the score, the better the result.

Sexual Behaviour at Work - OU / Team

South East Coast Ambulance Service NHS Foundation Trust

In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from patients / service users / public (Never)



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South East Coast Ambulance Service NHS Foundation Trust

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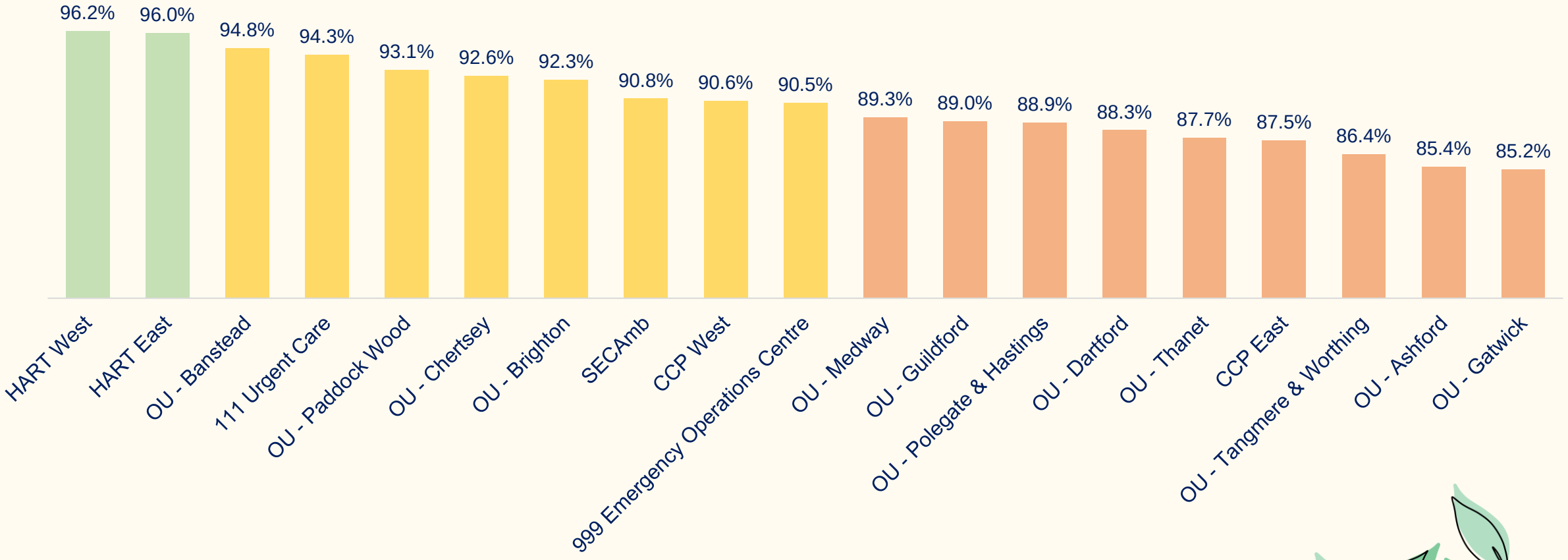

The ‘positive score’ for each OU/Team is displayed in each graph (the % who, in the last 12 months, have **never** been the target of unwanted behaviour of a sexual nature). Therefore, the higher the score, the better the result.

Next Steps

South East Coast Ambulance Service
NHS Foundation Trust

OD Team receive free-text comments	**Expected 29th Feb**
Comments analysed by AI and Board report, including recommendations, completed	**Expected 1st March**
National and local results published	**09:30am 7th March**
OD Team and HRBP's on hand to support managers and teams with their results	**From 7th March onwards**

- All survey results are now available on our Power BI app here.
- Question heatmaps are available here.
- An early release copy of our benchmarking report can be found here, and our breakdown report here.

Person-Centred Care

60%

of staff said that care of patients/ service users is the organisation's top priority.

Improved 8% since 2022.

62%

of staff said that if a friend or relative needed treatment they would be happy with the standard of care provided by the organisation.

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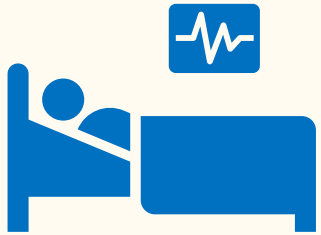

Motivation

62%

of staff said they are enthusiastic about their job.

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Speaking Up About Concerns

53%

of staff feel safe to speak up about anything that concerns them in the organisation.

Improved 8% since 2022.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

NHS Staff Survey 2023

The NHS Staff Survey gathers views on staff experience at work and it is the largest collection of feedback from people working in the NHS.

In 2021 the survey was redeveloped to align with the NHS People Promise and provides us with an indication of how close we are to delivering on the most important aspects of a positive experience at work.

In 2023, 2715 SECAmb staff members (60% of our workforce) took part.

South East Coast Ambulance Service
NHS Foundation Trust

NHS Staff Survey 2023

Retention

37%

of staff said they often think about leaving the organisation.

Improved 10% since 2022.

Work-Related Stress

53%

of staff have felt unwell as a result of work-related stress during the last 12 months.

Improved 10% since 2022.

Bullying, Harassment and Abuse

15%

of staff said they had experienced bullying, harassment or abuse from managers in the last 12 months

Improved 6% since 2022.

19%

of staff said they had experienced bullying, harassment or abuse from colleagues in the last 12 months

Improved 3% since 2022.

Discrimination

13%

of staff said they have experienced discrimination from a manager or colleague in the last 12 months.

Improved 2% since 2022.

South East Coast Ambulance Service
NHS Foundation Trust

NHS Staff Survey 2023

Development

67%

of staff said they have opportunities to improve their knowledge and skills.

Improved 10% since 2022.

Flexibility

41%

of staff said they are satisfied with the opportunities for flexible working patterns.

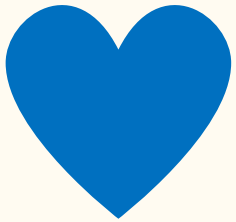
Improved 10% since 2022.

Team Working

67%

of staff said their immediate manager cares about their concerns.

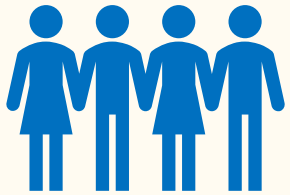
Improved 3% since 2022.



60%

of staff said they felt valued by their team.

Improved 4% since 2022.



Staffing Levels

29%

Said there are enough staff at the organisation for them to do their job properly.

Improved 13% since 2022.

South East Coast Ambulance Service NHS Foundation Trust

Membership Development Committee Report

14 March 2024

1. Introduction

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

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

2. Membership update

2.1. The total staff number as of February 2024 is 4796, total number of staff members, meaning staff that have been employed with SECAmb for a year and over, is 3948. This is not including bank staff which is 396, this figures do not include volunteers.

2.2. Current public membership by constituency (as of 27th February 2024) is 9424. Break down data provided as follows.

Constituency	Members	% of Membership	Base	% of Area	Index
Total Membership	**9242**	**100.00**	**13872904**	**100.00**	
Lower East SECAmb	1820	19.69	828238	5.97	330
Lower West SECAmb	1437	15.55	893980	6.44	241
Upper East SECAmb	3358	36.33	6201763	44.70	81
Upper West SECAmb	2198	23.78	5948923	42.88	55
Out of Trust Area	429	4.64	0	0.00	0

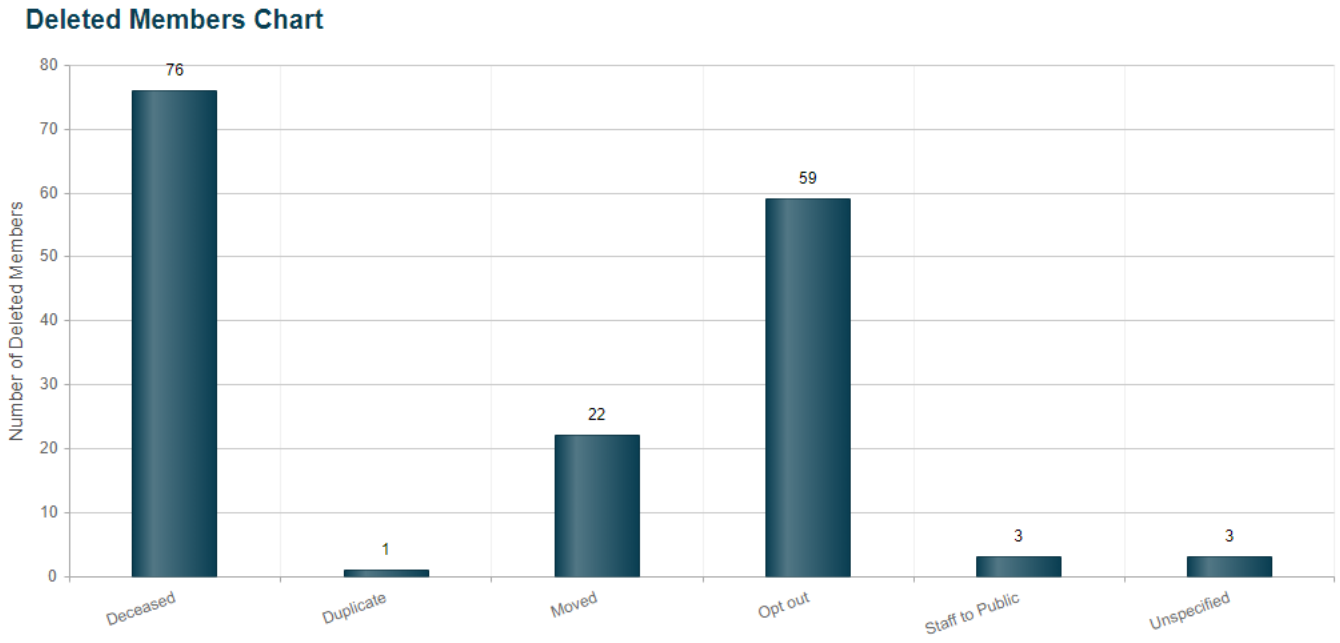
Key: % of membership = Percentage of members within the constituency. Base = Population of people within each constituency. % of Area = Total percentage of members within the constituency which have not joined. Index = A figure indicating how represented the membership by using the percentage of membership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

3. Membership history report

The table below shows the number of memberships that have been deleted since 27th February 2023 to 27th February 2024

Category or Consituency	Deleted (excluded from PR)
Total Membership	**278**
Public Constituencies	**164**
Out of Trust Area	3
Lower East SECAmb	34
Lower West SECAmb	24
Upper East SECAmb	63
Upper West SECAmb	40

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



4. Membership recruitment update

4.1. The trust has circa 9000 members.
4.2. All staff, after 12 months with the trust are automatic members.
4.3. Governors supported the trust with local engagement regarding the strategy.

5. Membership Engagement Update

- All Council of Governor meetings are held in person with the majority in Nexus House. The public, members and staff are welcome to join and observe these meetings with time for questions at the end.
- The trust communications team supports by advertising this on our website and on the trusts social media.
- Our existing members are informed by e-mail when an upcoming COG is taking place.
- We have moved the GDC and MDC to in-person and on the same day to encourage more attendance and have just agreed to re-work the timings to support continued attendance.

- It has been agreed that our Governors will attend 3-4 large-scale events this year to support member engagement and recruitment.
- The Assistant Company Secretary will work with trust colleagues to ensure appropriate resources are allocated.

6. Membership Strategy

6.1. It was agreed to pause the new membership strategy while the trust evolves its wider strategy.

6.2. The current membership strategy will be refreshed with engagement through the existing EDI strategy. This is where our current strategy sits.

7. Annual Members Meeting

7.1. The MDC have agreed that the 2024 AMM will be held at the South of England Showground on Friday 13th September 2024.

7.2. A working group has been set up consisting of Sam Bowden (Staff Governor), Peter Shore (Public Governor), Leigh Westwood (Lead Public Governor), Ann Osler (Public Governor).

7.3. Any other governor is welcome to attend and support the working group.

8. Equality, Diversity and Inclusion

8.1. Carolanne L'etendrine, EDI Manager (Programme Lead) presented to the MDC explaining the legislative requirements the Trust have.

8.2. Carolanne explained the area of concerns that have been raised over the last year including Inclusive leadership, reasonable adjustments for colleagues who have long term health conditions and the recruitment processes.

8.3. In 2023 SECAmb achieved a positive programme action to support the gender pay gap, a new Equality Impact Assessment process was made and is now user friendly. The reasonable adjustments process and reduced the time colleagues were waiting, from 6 – 12 months. This year 71 requests have come through and 69 have already been closed. SECAmb have started celebrating events with staff such as International Women's Day, 6th March. SECAmb have also managed to get on to a highly competitive programme of Diversity in Health and Care Programme which supports in our inclusion journey.

8.4. Carolanne explained what the plans are for 2024, with the start of the reverse mentoring programme. SECAmb will continue to work with the positive actions programme, the staff network groups are now working together and there has been a noticeable positive change with this. Finally, there will be a focus on inclusive recruitment and retention.

9. Wellness and HR

9.1. Ian Jeffreys, Assistant Director of Wellness and HR presented the current priorities of SECAmb which include mental health advising that out of the 3.66% that are off on long term sickness, 2% of that is with mental health sickness. There have been seven suicides since a formal tracking has been put into place. There has been a lot of work around suicide prevention within the last 12 months, training people as Mental Health First Aiders and more advanced Applied Suicide Intervention Skills Training. There is a good team managing the Trauma Risk, Trim Service with a £40k investment via the Trust to boost the training. SECAmb are now looking at procuring an Employee Assistance Programme to offer six counselling sessions over 12 months to further support to staff. A lot of work has been carried out to map pathways to support people better in alternate duties, making decisions

around pay to make it fair for everyone including re-evaluating pay protection and getting people back to work.

9.2. The Wellbeing Plan is coming to an end and good progress has been made, Ian will be reporting to the Peoples Committee. The plan for 2025 has started with a focus on mental health challenges as a priority. A module is being put together in the Leadership plan to ensure consistency is in practice.

9.3. The NHS Attendance Management Deep Dive found we weren't supporting our managers when it came to our sickness absence and an action plan is being built. This is being worked through by reviewing policies, welfare checks with colleagues, improving appraisals and the time for wellbeing conversations. Ian is looking into redoing the Deep Dive as the data was collated a while ago.

9.4. The retention plan has been approved, currently SECAmb is trying to source £1.9 million funding to bring this to life, the initiatives that are going to make a difference going forward. When Ian attends the next MDC he will present the Retention Plan. There is a lot of work going on with the unions to rebrand the ECSWs to a band 4, as well as a lot of work on retaining our people.

9.5. The Leadership Programme is now working on the next level middle management course and building specialist modules, two of which are on retention and wellbeing.

9.6. There is a look at training the mediators at how we resolve the issues before they turn into grievances. There are currently 77 grievances, which is the lowest figure for a long time but is still too many. Some of these are inconsistent practice and others are around leadership. SECAmb is looking at getting an external agency to investigate and support, as don't have enough trained people in the organisation and if we didn't we wouldn't have enough work hours available. Having the external agency would mean the process would speed up, it currently takes up to six months to resolve a grievance which is a stressful process for everyone involved.

10. New Chair and Deputy

David Romaine our current Chair of MDC is standing down from the role of Governor meaning a new Chair was sought. Peter Shore nominated himself and this was agreed by MDC members.

As Brain Chester is also standing down from Governor it was asked for a volunteer to be deputy chair. Sam Bowden (Operational Staff Governor) nominated himself and this was agreed by MDC members.

11. Recommendations:

11.1. The Council is asked to: Note this report.

11.2. All governors are invited to join the next meeting of the MDC on 13th June 2024 at Nexus House, Crawley.

Appendix One

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Membership Development Committee

28 September 2023

Present:

David Romaine (Chair)	(DR)	Lower East Public Governor
Leigh Westwood	(LW)	Lower East Public Governor, Lead Governor
Brian Chester	(BC)	Upper West Public Governor
Martin Brand	(MB)	Upper West Public Governor
Ann Osler	(AO)	Upper West Public Governor
Kirsty Booth	(KB)	Non-Operational Staff Governor
Victoria Baldock	(VB)	Quality and Safety Lead
Yvette Bryan	(YB)	Assistant Director of Culture and Organisation Development

Apologies

Angela Glynn	(AG)	Appointed Governor
Mark Rist	(MR)	Appointed Governor
Andrew Latham	(AL)	Lower West Public Governor
Nick Harrison	(NH)	Operational Staff Governor
Harvey Nash	(HN)	Lower West Public Governor
Sam Bowden	(SB)	Operational Staff Governor
Peter Shore	(PS)	Upper West Public Governor
Colin Hall	(CH)	Upper East SECAmb Public Governor
Linda Caine	(LC)	Upper East Public Governor
Amanda Cool	(AC)	Upper East Public Governor
Vanessa Wood	(VW)	Appointed Governor
Barbara Wallis	(BW)	Upper East Public Governor
Ian Jeffreys	(IJ)	Assistant Director of Wellness and HR Excellence

Minute Taking

Richard Banks	(RB)	Assistant Company Secretary

Item No.	Item
13/23	**Welcome and introductions**. Welcome and Introductions were made.
14/23	**Apologies for Absence** Apologies were noted as above.
15/23	**Declarations of Interest** None declared.
16/23	**Minutes of the last meeting and matters arising and action log** The minutes of the previous meeting were agreed as approved with no amendments.

	The action log was updated. **Action** Performance data for each constituency. MB is looking for performance data per ICB which he has asked for previously. RB to seek to obtain.
17/23	**Retention and Wellbeing** **Action** IJ sent his apologies, and this section will be added as an agenda item to our next MDC.
18/23	**Terms of Reference** Discussion held with colleagues. **Action** TOR agreed to be approved with one amendment regarding purpose of MDC. RB to add in one point, and to share with DR as chair before taking to the next COG for approval. It was agreed that we would keep and ask the EDI Lead to be a standing member of this committee. **Action** RB to speak to EDI lead and ensure this is ok with her.
19/23	**AMM Feedback** **Please note it was agreed that as part of this discussion occurred during GDC it would be reflected in this section.** NED attendance at the AMM was poor. It was noted that the location of the venue was not adequate, and colleagues found it very hard to get too and did not make it easy for members of the public to attend. It was not noted however there was very good public attendance. KB suggested that for the next AMM we could look to stage a SI response, possibly a joint response noting our Appointed Governor from the police force and fire service. AG has taken an **action** away to speak to Dean of Guildford university of the possibility of using that as a venue to host 2024 AMM. AG also suggested having guest speakers to present to the AMM. It was noted that the date of the AMM proved challenging for attendance due to it being holiday season. It was discussed and agreed that the AMM may be better suited to the end of September to support increased attendance. It was noted that the comms team within SECAmb need to support the AMM event more and KB mentioned that she did not see anything on social media running up to the event. MB queried if the trust did not adhere to statutory responsibilities as the accounts were not laid before COG prior to the AMM. It was noted that they did not feel they had the ability to review or comment on the accounts. **Action** RB to liase with Peter Lee to clarify and respond.
20/23	**Membership Strategy** DR outlined the purpose of this agenda item and that it was a working document to aid discussions and that this document was in its infancy. This document was circulated to all Governors for comments however only a few commented. After a good conversation, it was agreed that:

	• As we are in the midst of writing a trust wide strategy, we should link into this piece of work to ensure shared resource. **Action** KB and RB to link in with the relevant Executive Directors. • Trust wide communications support needs to be increased and support provided. • Work with VB / EDI Lead, Carolanne L'etendrine on ensuring EDI focus embedded into membership strategy. • Agreed that we should try and focus on three or four events in the year and do them well. This should be written and agreed with the trust within the membership strategy. **Action** It was requested by KB that we have an agenda item on joint board/COG on "developing the membership". RB will confirm with PL. RB to see if we can get demographic data/membership data to inform membership strategy.
21/23	**Membership Benefit Leaflet** RB presented the proposed membership leaflet, and it was agreed that we would go forward with the leaflet titled "Being a trust member" noting we would amend slightly and bring back for approval. It was agreed that this could be done on e-mail rather than await the next meeting. Amendments agreed were: Include photo of our new 73 plate ambulance. Add in, as a benefit, "be a voice in developing your ambulance service". **Action** Amendments to take place and RB to recirculate for approval/comments.
22/23	**Membership Engagement and Recruitment**
23/23	**Being "a kinder" SECAmb** YV gave an overview on this workstream. This will be ongoing now for 18 months and will be starting 19 October 2023. The aim is to ensure culture / values / behaviours are worked on following feedback from the staff survey which has told us SECAmb does not always feel like the best place to work. This will support culture change. The group shall be a mix of workforce from across the organisation which will ensure we have meaningful conversations in one room, During the workshop we will ensure it is conversational, not teaching sessions, and we are designing the workshops in this way. These were co designed with colleagues to be discussive and focus on resolving issues and how we work together to create the "kinder culture". Part of the work is ensuring respectful conversations and ensuring respectful feedback, both ways. It was confirmed that we are working with an external company, "A kind life" whose motto is "Spreading kindness throughout healthcare". YB extended the invitation to our governors to attend the workshops and confirmed that they are also extended to Executives and Non-Executives. KB gave a lovely example of how this work has supported another colleague manage a difficult scenario. YB thanked KB for the positive feedback.

	DR queried if HR would also attend and from his own personal experience, HR are not always kind. YB confirmed all HR colleagues would be invited to attend the workshops and YB confirmed that HR were involved in design of the workshops. It was noted that this is a culture change for all – not some.
24/23	**Patient Engagement** VB provided an overview on her work and projects. Work on patient safety action plan is working well. Launch of the community forum and supporting QI for keeping patients safe in the stack. Improvements are being made. 13 July 2023 a focus group was held, and we had 7 members attend. VB commented that this was a very good number and due to the AMM had increased from 2. The feedback gained from the focus group was fed back into the QI group. Feedback summary of the group is: • Patients need more information regarding patient demand. • Information on what type of ambulance is being organised. • What is the difference between category 1 and category 3. • What happens when you call 999 documents. It was noted a lot of trusts have this currently. • What advice is being given to patients? • ETA updates should be provided on the ambulance. VB is keen to encourage more input from the public. **Action RB and VB to link in and work with our members to support this.** BC commented that patient feedback to crew is very beneficial. VB will look into this however it was noted that the lack of a region wide information sharing agreement is currently preventing this work. KB suggested asking this to the NEDs. VB confirmed that the patient experience questionnaire will be going live very soon and currently awaiting DPIA sign off. VB will be working with our comms team to support the message going out and with the BI team to get a dashboard created. It was noted that currently, patients can only log formal complaints or compliments. The first Community Forum was held last night (27/09/2023). These will be held, bi-monthly on MS Teams initially to hear firsthand on the important work we are doing on the trust strategy. VB noted the importance of keeping it about the patient voice and mentioned that in the future they will be inviting SECAMB guest speakers for a short 10 min slot to update on their project work. The discussions were meaningful, and feedback shared with 999 / 111 colleagues. Harder to reach groups. DR commented that most patients are disinterested in what SECAmb are doing and are only concerned in an emergency on what they are supposed to do or go, such as GP surgery/111/pharmacist. How do we go about correcting that?

	It was noted that the trust is not doing enough to educate patients, except for when demand has peaked. It was noted that adding details onto ambulance wraps could support the messaging.
25/23	**Areas of focus for Member newsletter** Ahead of the meeting, colleagues were asked to bring article suggestions for future editions. None were forthcoming so as an **Action** Colleagues were asked to provide information for the newsletter to Jodie Simper/RB by start of November for inclusion within the December newsletter.
26/23	**Any other Business** It was confirmed that on future agenda items, the OD team (YB) would have a standing slot. KB raised that it would be more effective to only have in person meetings and not have a dual dial in option. This was agreed by all. **Action** – RB to remove links to MS Teams and confirm all meetings will be in person moving forward.
27/23	Review of Meeting Effectiveness Did the meeting run to time? - Was the meeting useful? - Suggestions for improvement?
Date of Next Meeting: **8th February 2024** **At** **Haywards Heath College, Harlands Rd, Haywards Heath RH16 1LT**	

SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST
Council of Governors
Nominations Committee Report

14 March 2024

1. Introduction

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

1.2. This report provides an overview of the most recent nominations committee activity.

2. Recruitment

2.1. Usman Khan has been appointed as trust chair and will be starting with the trust in May 2024.

2.2. The Council approved Usman's appointment on 20 December 2023.

2.3. Following the departure of both Tom Quinn and Chris Gonde, the nominations committee has appointed Gatenbysanderson to support the recruitment.

2.4. Planning for this is currently underway.

3. Next Steps

3.1. Planning for this is in progress.

3.2. It is anticipated final selection will be concluded w/c 22 April 2024.

3.3. An extraordinary COG will be held to receive the recommendation from the panels.

3.4. COG will be invited to be part of a stakeholder group.

4. Recommendation

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

David Astley

Chair (on behalf of the Nominations Committee)

South East Coast Ambulance Service NHS Foundation Trust
Council of Governors
Governor Development Committee Report

14 March 2024

1. Introduction

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

1.2. The duties of the GDC are to:

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

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

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

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

1.6. The minutes are attached as an appendix of the most recent GDCs held 16 November 2023. These minutes are confirmed as an accurate record.

1.7. The GDC meeting held in November 2023 covered feedback from the previous CoG, agenda setting for the upcoming CoG, and Governor training and development requirements.

2. Items of note

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

2.2. Governors were reminded of the opportunity to shadow ambulance shifts and listen in to calls for 999 / 111 and were encouraged to do three per annum so to ensure our Governors are Understanding SECAmb and fulfilling their roles as Governors.

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

2.4. Governors have a full training schedule for 24/25 published and are asked to ensure attendance.

2.5. Governors have been invited to the NED Committees for observation, they were asked to complete the NED Observation Form and return with dates they are available to attend. The final dates have been sent out confirming two dates per each committee with a maximum of 4 Governors observing. The aim of the observation is for the Governors to see and understand the assurance NEDs seek in action.

2.6. Governors are reminded of the NHS Providers training, four dates have been booked, 9th April 2024, 8th July 2024, 1st October 2024, 4th February 2025. The Governors at the GDC meeting confirmed the topics they would like to see on the agreed dates. It was also agreed we would seek a representative from SECAmb's finance to give an update regarding SECAmb's finances.

3. Recommendations:

3.1. The Council is asked to:

3.1.1.1. Note this report.

3.2. All governors are invited to join the next meeting of the GDC on 13 June 2024 at Nexus House, Crawley.

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

Appendix One

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Banstead Make Ready Centre 16/11/2023.

Present:

Leigh Westwood	(LW) Lower East Public Governor & Lead Governor
Harvey Nash	(HN) Lower West Public Governor
David Romaine	(DR) Lower East Public Governor
Martin Brand	(MB) Upper West Public Governor
Jodie Simper	(JS) Corporate Governance and Membership Manager
Richard Banks	(RB) Assistant Company Secretary
Anne Osler	(AO) Appointed Governor
Simon Dobinson	(SD) Appointed Governor

Apologies

Kirsty Booth	(KB) Non-Operational Staff Governor (Chair)
Angela Glynn	(AG) Appointed Governor
Brian Chester	(BC) Upper West Public Governor
Andrew Latham	(AL) Lower West Public Governor
Peter Shore	(PS) Upper West Public Governor
Mark Rist	(MR) Appointed Governor

Minute taker

Kelly Marlow	(KM) Corporate Governance Officer

Item No.	Item
Introduction and matters arising	
153/23	**Welcome and introductions.**

	LW welcomed everyone to the meeting. Introductions were made
154/23	**Apologies for Absence** As above
155/23	**Declarations of interests** None
156/23	**Minutes of the Meeting 28/9/2023 & Action Log and Matters Arising** MB advised a typo at the bottom of Page 2 – advised it should say "highlighting areas" and not Highlight. HN advised the same section does not read well and to amend the NEDS accountability section, there appears to be too many "nots". RB explained this section was about the Governors not feeling like they were holding the NEDs to account effectively. RB went on to explain this is why GDC is now being used instead of a pre-meet to discuss the assurance paper. RB advised IT failure on the next CoG wasn't picked up as an action. It has been placed on the agenda for today. The minutes were a true and accurate reflection of the meeting with the above amends.
Business for discussion	
157/23	**Governor development requirements:24/25 Forward Plan** RB confirmed that the forward plan for 24/25 has now been circulated and diary holds have been issues. A copy of all dates has been sent to all governors. They will try not to change the dates, however, there still needs to be some flexibility at times. They are currently searching for a venue for next year's annual members meeting (AMM) and Council of Governors (CoG). The date may need to be changed; hence no diary hold for this has yet been sent. SD asked if all meetings were in person and if there an opportunity of dialling in to the meetings and asked to highlight the meetings that can be attended remotely so they are more visible. RB asked for colleagues to consider standing as chair/co-chair of the MDC as both David and Brian are sadly stepping down from the Governor role at the end of March. 2 new Governors joining, Ray Rogers who is the Lead Governor of Surrey and Zac Foley, who is based in Brighton. There is a new Staff Governor, Chris Burton. **24/25 Governor Training Dates** JS explained that as governors, SECAmb need to provide support and training. NHS Providers are providing Core Skills, Accountability and Holding to Account, Effective Questioning and Challenge, Member and Public Engagement, Finance and Business Skills and Recruitment. Recruitment is optional for members on the Nominations Committee (NomCom). There are 4 dates for training in the diary, they are on the forward planner. There will be one subject held in the morning and another in the afternoon. JS urged Governors to attend, the training is costing a lot of money. The details were sent out with the papers, explaining the core skills and other courses that governors will be trained on. **Governor Attendance Record** RB wanted to confirm all governors were happy with the attendance record. RB reminded Governors on the Constitution and CoG, there is an expectation that CoG is attended as a minimum. If 3 CoG meetings in a row are missed, then it will be voted on in the next CoG regarding your standing as Governor. MB also queried attending recruitment events on other people's territory. He was under the impression that he would be staying in his own territory.
158/23	**Council of Governors** LW spoke about the recent GDC and asked if there was anything that needed to be raised? CoG discussed the issue of information being 3 to 4 months out of date. It was explained that the meetings are aligned as much as possible with Board. But unfortunately, there will always be a lag with papers.

	it was requested that an up-to-date summary of financial facts and figures be put together so questions asked to NEDs will be more meaningful. It was pointed out that there was conflicting information within the plan also. CoG felt it was concerning that this has been happening for a long time, but nothing has been done to remedy it. **Review Assurance Pack** DR stated 20% of staff responded to the monthly survey and explained staff are apathetic, half the staff who did respond, responded positively. RB stated that he will share with NEDs what he feels governors may raise. Rather than fixed questions put to NEDs. It would be useful for highlights and lowlights on reports and updates. **Audit and risk committee** MB asked if Michael assured learning from past significant incidents has been addressed and embedded or is there a plan in place to do so? **Board assurance framework** GDC held a discussion around slipping milestones and how does that fit with the business planning process? The clinical case for change was taken to commissioners in October. Are they assured that by slipping the milestones, it'll connect any way to the planning process and the commissioners have signed up to the business case for change? If slipping the milestones are having any impact on operations and business planning? How are they collecting that data? Are they on the right path to have the strategy at the right time going forward? Rather than having the strategy ready by the end of January, it's now been planned for the end of march. Given that, you have to submit business plans to the wider NHS by the end of January. How will the business planning process pick up on the strategy, which won't be fully agreed until March? Does that impact on what can be implemented from the strategy? **Finance and investment** MB asked if they are assurance that they are going to meet the delivery of financial plan without having to dip into reserves? Is there assurance there are plans in place to revise the process of the efficiencies programme so that in future they don't consistently fail to achieve target? DR asked if we are assured that it is the NEDs that are holding the execs to account? RB explained that the governors hold the NEDs to account who hold the Execs to account. **Operational performance** GDC discussed what should be done with the reports? MB advised they should forewarn NEDS that there may be asked questions on reports they are not directly linked to. MB queried page 67 why there was sustained improvement in handover times and are they assured the handover times are sustainable during winter pressures? Also, on page 70, KPI for HART. Only 43.5% of the time for sickness levels, they have had to achieve 2 teams of 6 operatives on duty 24/7. Are they assured they can keep HART with those numbers. HN stated SECAmb have been at the top regarding C2 response times. However, are C1s and C3s being overlooked with the amount of focus on C2s? **Sustainability** None. **People and culture** GDC had a discussion around the survey results and how some staff are quite apathetic according to the results. It was discussed that maybe they need to look into results from "normal companies" and see if there are differences. On 74, the objective is to recruit 371 staff – are they assured they will achieve the target of 371 whole time equivalent staff? It was discussed when this target was set and if it was still relevant? LW pointed out 20% in pulse survey was the highest in the NHS. SD spoke about industry standard regarding the survey and advised the average was around 15 – 30%. SD asked if this paper goes to the NEDs for them to seek assurance and clarity around whether the risk is being appropriately managed, which allows for a deeper dive. If not, there is so much information missing in relation to risk and how it's being managed. There are multiple questions that he would like to ask around the workforce plan around managing risk, contingencies, how things are progressing? Where are they in relation to industry standard, benchmarking? SD asked, for example, what are the contingencies for not meeting the workforce plan for the end of 24, bearing in mind, we are only 4 months away, you would expect the NEDs to be able to have the answers to all of that? Any progress on training, appraisals? RB suggested that GDC colleagues pick up SD assurance query on his behalf due to him having to give apologies to the upcoming COG. SD asked on page 75, the focus on sexual misconduct and

	sexual harassment, there's no sexual harassment cases in place. To suspend is a drastic step. What is leading to the suspensions? what are the common occurrences, traits, complaints? What is SECAmb doing about it? Are they linked? **Quality improvement** None **People committee** MB page 86, development of a retention plan, scheduled to go to board in October. Is Subo assured there was a plan that will have an impact on retention? **Quality and patient safety** MB queried call answering delay on the 10 second target. Can Tom assure there is a plan in place to improve this? **IQR** None RB asked if there were any requests for GDC to do their role as Governor, please bring them up here. AO would like to do an observer shift. JS will advise what training is needed.
PART 2 – Other business	
159/23	**Any other business** **Held to account summary.** RB advised Governors to observe the committees. LW stated poor turn out of governors during the last CoG. MB queried if those who have been elected know who their membership is? RB suggested GDC could do monthly online meetings with each constituency? It's not mandatory. There was an email sent yesterday with a choice of 2 dates for the Well Led Review. There was a discussion held around the possibility of 111 being discontinued, RB advised to raise these queries at COG to gain assurance.
160/23	**Review of meeting effectiveness** **Did the meeting run on time?** Yes **Was the meeting useful?** Yes **Suggestions for improvement?** RB stated they will review this meeting after CoG and adapt. RB advised all meetings next year are in Crawley, currently by default. JS Stated that colleagues have asked for a 30-minute meeting before CoG to discuss and agree on questioning format etc. JS advised this would be arranged for GDC.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Governor Development Committee (GDC)

Terms of Reference

1. Constitution

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

2. Purpose

2.1. The purpose of the Committee is to provide advice to the Trust on Governors' wishes in relation to the Council of Governors, including but not restricted to proposing Council agenda items, advising on ways of working, and advising and planning to address Governors' training and development needs in order to fulfil the Governor role.

2.2. The Committee will not be expected to act on proposals from meetings, but will work with the wider Council and Corporate Governance Team to enact proposals as necessary.

3. Membership

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

3.2. The Lead Governor shall Chair the Committee meetings. In the Lead Governor's absence the Deputy Lead Governor shall Chair the Committee meetings. In the absence of both Lead and Deputy Lead, the Committee shall select another member to Chair the meeting.

3.3. The Trust Chair shall attend the Committee when relevant.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be three members and shall include at least two Governors.

5. Attendance

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

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

5.3. Members and officers unable to attend a meeting are requested to provide an update to the Committee members, when relevant, at least two working days beforehand. Members and officers are expected to attend these Committee meetings.

5.4. The Chair of the Committee will follow up any issues related to the unexplained non attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

6. Frequency

6.1. Meetings of the Committee will be held at least quarterly. Meeting dates will be diarised on a yearly basis and Extraordinary meetings may be called between regular meetings to discuss and resolve any critical issues arising.

6.2. The venue for the face to face meetings will rotate around the region or be central to the Members. Some meetings may take place using phone or video conferencing facilities.

7. Authority

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

8. Duties

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

8.1.1. Advise on and develop strategies for ensuring Governors have the information and expertise needed to fulfil their role, including training and development for Governors;

8.1.2. Propose agenda items for Council meetings;

8.1.3. Advise on the content of development sessions of the Council;

8.1.4. Review Governor attendance at Council meetings; and

8.1.5. Advise on and develop strategies for effective interaction between Governors and NEDs, and other Trust staff as required to fulfil Governor and Council responsibilities.

9. Reporting

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

10. Support

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

10.1.1. Agreement of the meeting agendas with the members of the Committee;

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

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

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

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

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

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

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

11. Review

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

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

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

Due for review: March 2023

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Governor Activities and Queries

March 2024

1. Governor activities

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

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

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

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

Date	Activity	Governor
28/11/2023	Council of Governors	Martin Brand Brian Chester Linda Caine Kirsty Booth Harvey Nash Peter Shore Andrew Latham Barbara Wallis Colin Hall David Romaine Vanessa Wood Mark Rist Angela Glynn Sam Bowden Nicholas Harrison
28/11/2023	Holding to Account NHS Providers training	Martin Brand Brian Chester Linda Caine Kirsty Booth Harvey Nash Peter Shore Andrew Latham David Romaine

		Vanessa Wood Mark Rist Angela Glynn Nicholas Harrison
30/11/2024	Finance and Investment Committee Observation	Andrew Latham
01/12/2023	External Well-Led Review Webinar	Brian Chester Harvey Nash Leigh Westwood Kirsty Booth Peter Shore
02/12/2023	Strategy Engagement – Light water	Brian Chester
07/12/2023	Board	Peter Shore Harvey Nash Linda Caine
13/12/2023	Chair Recruitment Panel	Peter Shore David Romaine
13/12/2023	Chair Interview Panel	Angela Glynn Nic Harrison Andrew Latham
16/12/2023	Strategy Engagement – Waitrose Dorking	Martin Brand
20/12/2023	Extraordinary COG	Linda Caine Martin Brand Kirsty Booth Harvey Nash Peter Shore Andrew Latham Nicholas Harrison David Romaine Mark Rist Angela Glynn Sam Bowden An Osler Simon Dobinson
16/01/2024	QAV – Paddock Wood	Mark Rist
17/01/2024	Well Led Review	Angela Glynn Sam Bowden Mark Rist Peter Shore Andrew Latham David Romaine Martin Brand Ann Osler Kirsty Booth
23/01/2024	The People Committee Observation	Martin Brand
31/01/2024	111 & 999 Shadow Shift	Peter Shore

01/02/2024	QPSC Observation	Martin Brand
20/02/2024	Extraordinary CoG	Leigh Westwood Linda Caine Nichola Harrison Ann Osler Kirsty Booth Mark Rist Peter Shore Andrew Latham
23/02/2024	GDC	Leigh Westwood Peter Shore David Romaine Ann Osler Mark Rist Andrew Latham Sam Bowden Martin Brand
23/02/2024	MDC	Leigh Westwood Peter Shore David Romaine Ann Osler Mark Rist Andrew Latham Sam Bowden

2. Governor Enquiries and Information Requests

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

Date	Query	Response
30/01/2024	Leigh Westwood emailed - I am slightly surprised this has appeared in the media but nothing was shared directly by the Trust to colleagues, unless of course I missed it? https://www.kentonline.co.uk/sittingbourne/news/driver-admits-causing-colleague-s-death-after-fatal-ambulanc-300911/#qf1hi4rllft I am aware a number of colleagues have not taken too kindly to finding this article, which does appear to validate no internal comms were shared beforehand.	Janine Compton called Leigh to explain the approach. 30/01/2024 *"I've spoken to Leigh and explained – he is absolutely on board with our approach."*

30/01/2024	Leigh Westwood emailed - Are you able to perhaps direct this to the correct party for me – Someone known to me was involved in an accident at the weekend, where the PT's Apple watch made a call to emergency services automatically. We were on scene relatively quickly to a serious RTC, so the feature was valuable in this instance. I was though researching on the internet, and found that there are often a number of false activations of this feature, or accidental activations by the user. Given the pressures we are consistently under, is there any data that indicates how many times we receive calls from these automated devices that ultimately result in being invalid but a resource was sent to the location? Let me know if you are able to pass this onto someone who might have an answer, I am unsure if such data can be extracted from our systems.	Emailed sent to John O'Sullivan 30/01/2024. John replied: *"Regrettably, I am unaware of any data collated by the Trust with regards to false activations. However, I have copied in Chris Evans as the Head of Critical Systems in case he may be aware of something I am not"* Chris Evans replied 30/01/2024 – "*Probably important to highlight that we don't receive such calls directly. They come via BT. So it is possible for a false activation to put pressure on them rather than us, with the caller still cancelling the requirement before it ever reaches this point. Data on false activations may be available but would be from the BI team for consistency. I have copied in Alex Croft*."

01/02/2024	Harvey Nash emailed – *On my PC, though not on my iPad, I am being asked to sign-in to Secamb email etc using Microsoft Authenticator. This in addition to giving email, password and one-time code! I have no wish to install additional software on my PC and have yet another time-wasting step in getting to emails etc, so is this really required or as so often just another Microsoft bug (and if so how do I kill it)?*	Jodie Simper raised a Marvel ticket and advised Harvey to call the IT service Helpdesk. (REQ-438283 Ticket Ref) Marvel response – 06/02/2024. Sent to Harvey Nash 06/02/2024 *"Microsoft Auth is taking over from all the other systems we user. So you will need to set this up. you will need to download the app to your phone or ipad and then when you sign in using the email address and password it will then push a auth request to the app to which you open up and enter the number shown on screen. The code system will not work any more as we have been advised by NHS digital to change over to this app and auth process"*

Recommendations

2.2. The Council is asked to note this report.

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

Jodie Simper
Corporate Governance Manager

Richard Banks
Assistant Company

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Quality and Patient Safety Committee

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

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

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

Date of meeting: 01 February 2024

Governors present: Martin Brand

The following report is from Martin Brand, noting his observations.

1. Prior to the meeting: Due to a communication breakdown as to Governor attendance the papers were received by the latter twenty-four hours before the meeting.

2. Introductions: The Chair open the meeting, welcoming those present.

3. Attendance: Tom Quinn (Chair, on Teams), Liz Sharp, Subo Shanmuganathan (on Teams), Peter Lee, Richard Quirk, Margaret Dalziel, David Astley, Jo Turner, Amy Igweonu, Emma Williams, Kirsty Booth (Business Support Manager – Medical and Staff Governor – Non-operational)

3. Agenda: The agenda was comprehensive for the three-hour long meeting giving clear timings, indication as to whether each item would focus on a paper, presentation or verbal update and stating who would lead each item. As a non-clinician the papers were easy to read.

4. Discussion during meeting: There was adequate time for full discussion of each item. It was a good meeting with lots of challenge and assurance seeking by all the NEDS, for example and in particular in relation to risks around 'Right Care Right Place', 'Anti-Microbial Stewardship', 'Clinical Supervision', the 'Integrated patient Safety Report' and 'Cardiac Arrest'.

5. Chair: The Chair provided exactly the right balance between moving things along but giving everyone the opportunity to make their points. The meeting focus was maintained and to time, ensuring the debate flowed without unnecessary tangential discussion. The chair provided appropriate challenge where required balanced with complementing people on the quality of their papers, suggesting improvement opportunities or the need for additional information as appropriate and requesting follow up reports to future meetings. It was the Chair more than anyone else who orientated the items and debate towards the patient and outcomes not just process and what might be called management issues.

6. De-brief: The Chair offered an on-line de-brief to the attending Governor but this did not take place as the meeting invite was not seen in time. The Governor fed back via email thoughts on the meeting process, the level of challenge provided by NEDS and the issues of concern.

7. Conclusion: A good well chaired meeting with full debate of all agenda items and appropriate assurance and challenge provided by the NEDs present with risks highlighted.