Trust Board Meeting to be held in public

04 April 2024
10.00-12.45

Trust HQ, Nexus House, Crawley

Agenda

Item No.	Time	Item	Paper	Purpose	Lead
Board Governance					
01/24	10.00	Welcome and Apologies for absence		-	DA
02/24	10.01	Declarations of interest		To Note	DA
03/24	10.02	Minutes of the previous meeting: 08 February 2024		Decision	DA
04/24	10.03	Matters arising (Action log)		Decision	PL
05/24	10.05	Chair's Report		Information	DA
06/24	10.15	External Well Led Review – Final Report & Next Steps		Decision	PL
07/24	10.25	Audit & Risk Committee Report		Information	MW
08/24	10.30	Chief Executive's Report		Information	SW
Strategy					
09/24	Primary Board Papers		a) **Board Assurance Framework** b) **Integrated Quality Report**		
Sustainability & Partnerships – *Developing partnerships to collectively design and develop innovative and sustainable models of care*					
10/24	10.40	Board Story		-	MD
		New Trust Strategy		Decision	DR
		M11 Finance Report		Information	SB
		Operating Plan for 2024/25		Discussion	SB
		Finance & Investment Committee Report		Information	HG
People & Culture – *Everyone is listened to, respected and well supported*					
11/24	11.20	Cover Paper		Discussion	TW
		Staff Survey Results		Discussion	TW
		Sexual Safety Charter Gap Analysis [action 65-23b]		Assurance	MD
		People Committee Report		Information	SS
	11.50	**Break**			

Quality & Safety – *We listen, we learn and improve*				
12/24	12.00	Cover Paper	Discussion	MD
		Learning from Deaths Report	Information	RQ
Responsive Care – *Delivering modern healthcare for our patients*				
13/24	12.20	Cover Paper	Discussion	EW
		NARU Review – Progress Update	Assurance	EW
		Digital – Priorities for 2024-25	Information	SB
Board Effectiveness				
14/24	12.40	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		DA
Closing				
15/24	12.43	Any other business		DA
After the meeting is closed questions will be invited from members of the public				

South East Coast Ambulance Service NHS FT Trust Bo

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP)
15.12.2022	70 22c	As part of the continuous improvement of the IQR, establish how we might evolve from the focus on Categories of patients (e.g. C1 C2 etc.) to reflect more clearly patient groups / pathways, such as stroke, cardiac arrest, fallers etc.	DR	Q2 2024/25	Board	IP
15.12.2022	70 22e	The executive to assess the extent to which we are set up / have the capacity to work effectively with multiple stakeholders across four ICSs, and then bring to a future Board development session.	SW	2024/25	Board	IP
03.08.2023	41 23	Noting the People Committee has to-date focussed on the operational workforce plan, the Board asks that it considered the wider workforce plan to ensure clarity on support services and any related risks to operational or corporate delivery.	AM	Q4	People Committee	C
07.12.2023	63 23b	At its meeting in March the Audit & Risk Committee to receive the outputs of the EMB risk workshop.	MD	21.03.2023	Audit Committee	C
07.12.2023	65 23a	In addition to its role in overseeing delivery of the Retention Plan, the People Committee will help to ensure the plan evolves in an increasingly ambitious way over time.	AM	2024/25	People Committee	C
07.12.2023	65 23b	The outputs of the Sexual Safety Charter Steering Group gap analysis and definition of zero-tolerance to be report back to Board in April 2024. Along with suggestions on the support the Board will need to address the challenges.	MD	Apr-24	Board	C
07.12.2023	67 23	Delivery of the improvements identified by the IT external review to be overseen by the audit committee. With a report to the Board in 2024-25 (date tbc) confirming all the actions have been closed and assurance on their impact.	SxS	TBC	Audit Committee / Board	IP

Key

Not yet due
Due
Overdue
Closed

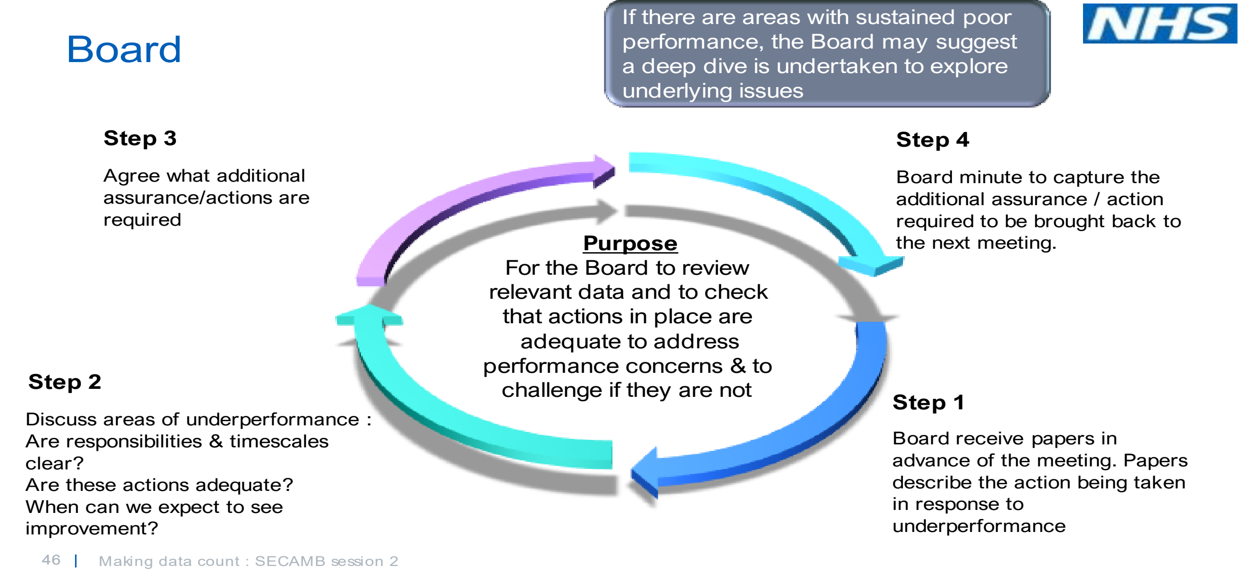
oard Action Log

Comments / Update
July Update: While this was initially planned for Q1 it is suggested that we defer this until early next year, as a better time to do this will be once we have developed our clinically focused Trust strategy as this should revolve around patient outcomes. We will in any event need to refresh the IQR then so it will be sensible to do it all at once.
Added to the BD plan for 2023/24 - this will be rolled in to the plan for 2024/25
The workforce plan was reviewed in March where it agreed the action to bring back the plan for non-operational staff - see Board report. It will report the output of this review to the Board.
Complete - see report to Board. A review of the strategic risks arising from this workshop will form part of the board dev session in May.
Added to COB - in addition, as part of the review being undertaken by the executive to align the priorities and in year objectives with the new strategy, the retention plan will be revised to ensure it takes account of the feedback from staff from the recent staff survey.
On agenda

	Item No	05-24
Name of meeting	Trust Board	
Date	04.04.2024	
Name of paper	Chair Board Report	
Report Author	David Astley, Chairman	

Board Meeting Overview

Meetings of the Board continue to be framed against the current strategic goals, as set out in the Board Assurance Framework (BAF). In June we will be using the new version of the BAF, which is being aligned with the strategy that is on today's agenda. The BAF helps provide the Board with greater clarity on progress against the organisational objectives and the main risks to their achievement. The BAF together with the Integrated Quality Report are the Board's primary documents used to inform the Assurance Cycle and where there are gaps in assurance.



This will be my last meeting of the Board held in public and the two main areas of focus this month will be our new strategy, and the outcome of the Staff Survey that was published in March.

The development of our new strategy, with the support and engagement of our internal and external stakeholders, has been a great achievement. It helps to respond to the clear feedback from our people about ensuring clarity of purpose and direction and I thank the 1,200 or so staff that engaged with this.

The current challenges we are facing across the NHS places even greater significance in having a clear strategic direction. In June we will consider our plan for implementation.

I am pleased by the improvements reflected in the feedback from the staff survey. It helps to demonstrate progress with all the things we have put in place over the last 12-24 months, but at the same time the Board continues to acknowledge the need to do more to listen and take action to further improve the experiences of our people.

The external well led review is also on the agenda. This was very much a developmental review to help the Board and executive team to continue the journey of improvement. This is informing the trust's new priorities and objectives for the coming year which will be considered by the Board at it's June meeting.

The outcome of this review and the improvements in the staff survey reflect positively on the delivery of our priorities this year, as set out in the BAF. As will be discussed at the meeting, despite all the challenges, we are on track to achieve our financial goal for breakeven and to deliver the national performance target (C2 mean); we are one of only 2-3 ambulance trusts in England to do this, which is a significant achievement and something all our people should be proud of.

Board Succession

Since our last Board meeting in February we have said goodbye to Ali Mohammed, Director of HR and Saba Sadiq, Chief Finance Officer (CFO). I wish them well for the future.

The Board has made two interim appointments, in Sarah Wainwright, HR Director, and Simon Bell, CFO. They will be supporting the Trust during 2024-25 and I welcome them both to our Board of Directors.

As the Chief Executive has confirmed in his Board Report, Stephen Broomhall Chief Digital Information Officer will be joining as a member of the executive team later in April. Stephen will attend meetings of the Board to provide advice and support.

Council of Governors

The Council of Governors met on 14 March. It was a very constructive meeting with the governors focussing on the following areas:

- Planning for 2024-25 in the context of the financial constraints
- The emerging strategy and how the planning round might impact how we approach the implementation of the strategy.
- And following the receipt of the draft report from the Well Led Review, how this in the context of the overall improvement plan and recently published staff survey feedback, informs our exit readiness from the Recovery Support Programme.

As ever there was good challenge and debate. The discussion on the planning round and the likely difficult decisions that will need to be taken, helped to formulate how we might use the joint Board & COG in April. We will plan to use this opportunity together to synthesise views on how we

balance the competing priorities in relation to the money, performance and safety of our people and patients.

I would like to place on record by thanks to the Council of Governors for the work they do and their support to me in my time as Chair.

Engagement

Along with my normal duties I have met with colleague NHS Trust Chairs and of NHS Sussex, NHS Kent and NHS Surrey to discuss and oversee the contract discussions for the financial year 2024/25. The Executive are currently discussing the detail with our commissioners of what will be a challenging process given the financial assumptions.

I have also contributed to a development programme for Trust Chairs and NEDs.

I was also particularly pleased along with David Ruiz-Celada to meet with and listen to presentations from some of our Trust leaders who were participating in the Fundamentals Programme. It was encouraging to listen to and participate in the future development of our first line leadership who have the challenging task of leading our colleagues and serving our patients every day, 24/7. Our future looks promising given the commitment of these and other leaders who are all participating in the Fundamentals Programme.

With the Chief Executive I have also met with colleague Ambulance Trust Chairs and CEOs to scope opportunities for future collaboration and sharing of expertise.

Conclusion

This is my last Chairs report before I stand down at the conclusion of my second term on 31 May. It has been a privilege to lead the Board over the last six years and face up to and overcome some significant challenges, not least the COVID Pandemic. I am confident that provided the Board keeps developing in the manner it has over the last two years the future for SECAmb and its workforce looks positive. I thank all those Executive and Non-Executive colleagues who have served SECAmb with such dedication and at some personal cost in what has been a challenging period.

It would also be appropriate to acknowledge the help and support of Trust leaders in our partner NHS organisation and colleagues from the South East Region of NHS England.

		Agenda No	06-24
Name of meeting	Trust Board		
Date	04.04.2024		
Name of paper	Well Led Review		
Responsible Executive	Chief Executive		
Author	Peter Lee, Company Secretary		

This review was jointly commissioned with NHSE / ICB, as one of the requirements of the RSP Exit Criteria. It was undertaken between November 2023 and February 2024.

It was commissioned as a developmental review, with the aim of assessing our current position against the well led key lines of enquiry, and the journey of improvement since the CQC's well led inspection in 2022.

Overall, it reflects positively with the improvements the Trust has made in the last two years and reinforces the challenging year that lays ahead.

Between now and June the recommendations from the review will inform the new version of the Board Assurance Framework and Board Development Plan for 2024-25. Both are scheduled to be formally received by the Board at its next meeting in June.

Recommendations, decisions or actions sought	The Board is asked to formally accept this final report from the external well led review, and to note the work ongoing to use the outputs / recommendations, which will be considered as part of the development of the corporate objectives (BAF) and separate Board development plan for 2024/25.

Well-led review

Date of report: March 2024

Jointly commissioned by: NHS England, Surrey Heartlands ICB, and South East Coast Ambulance Service NHS Trust.

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Improving outcomes through values-based consultancy, coaching, and training

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Well-led review

The brief and the approach

The brief was to conduct an independently led well-led review of SECAmb in order to identify progress made since the CQC inspection in 2022 and to help identify further actions to be taken in support of continued progress of the organisation. It follows the outgoing regime of 8 well-led KLOEs in order to enable comparisons back to the CQC report.

The approach taken was developmental, adopting a coaching style of open curious questions and feedback throughout, in order to deepen people's awareness of how the organisation looks and feels from different perspectives. The intention is to be clear and practical.

What follows is a summary of findings. It takes each KLOE in turn, setting out the standards, followed by SECAmb's self-assessment, a summary of comments from the stakeholder survey and workshops with staff and governors, key observations from the reviewers, and ending with recommendations.

The findings and recommendations will be presented to the board in a facilitated workshop to enable the board to reflect in a meaningful way and develop actions in response.

About us

Governance Coach UK brings a coaching and governance focussed approach to individual and organisational development. We provide bespoke coaching, facilitation, training, and consultancy support to help individuals and teams tap into their natural resourcefulness and become more successful.

W1: Leadership | Standard

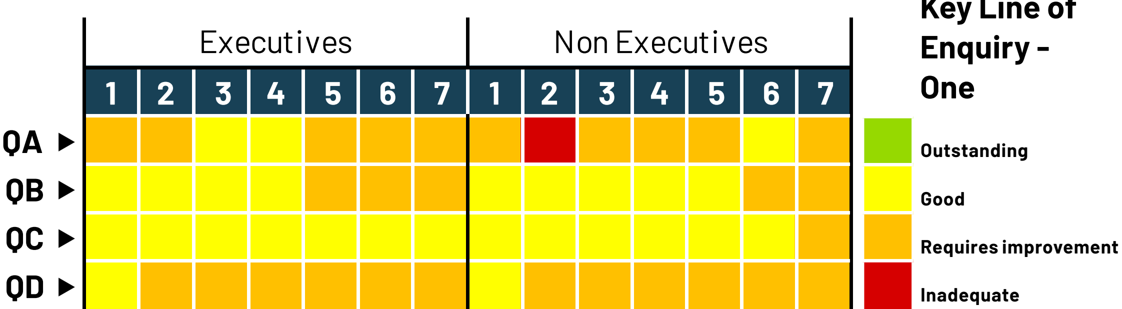
QA Do leaders have the skills, knowledge, experience, and integrity that they need – both when they are appointed and on an ongoing basis.

QB Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?

QC Is there a clear vision and a set of values, with quality and sustainability as the top priorities?

QD Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?

You said



Stakeholders said

More respondents (45% vs 8%) disagree than agree that the leadership has the necessary skills and experience to lead the organisation well.

Most people (50%) neither agree nor disagree that the leadership act with integrity.

What advice would you give to the leadership?
Emphasise the importance of building on initial efforts but moving forward purposefully and at a faster pace. Identify the real top priorities for change, avoiding the risk of hastily addressing too many issues and doing so poorly.

Focus on transparent leadership, involving the entire organisation in the change process, and treating staff with respect and fairness to retain experienced and committed employees.

Anything else:
Highlight the need to reconstitute the top team for effective delivery.

Emphasise the importance of cohesion, teamwork, and cooperation within the leadership team, with a focus on listening more than speaking.

Express concerns about historical problems and the potential for failure due to ineffective leadership and lack of commitment to the organisation's vision.

We observed

The organisation is going through significant change. The new CEO is widely appreciated although there is further work to be done to ensure that this is as universal as possible.

While there has been a steadying of the ship, leaders are clear that next year will be tough. The need for leaders to draw on their own resilience and supportively challenge each other will be crucial.

There is a risk that if positive agents for change leave before the leadership team has been further strengthened then this could destabilise the organisation.

There is a notable change in culture towards a much more listening and engaging approach.

It is crucial that the new chair and the CEO forge a positive and mutually supportive relationship with appropriate challenge.

Recommendations

1. Focus on board development to enable the incoming chair to establish positive relationships quickly and for the incoming chair to build a common sense of purpose and clear values for the board.
2. Skills audit of NEDs to ensure recruitment of the right new NEDs to complement the existing skills and experiences.
3. All directors to reflect on their role in supporting the Chief Executive in leading change.
4. A conversation between the Board and the Council of Governors to better understand each others' roles and any development required to enhance effectiveness. Conversation to include what information and in what format the CoG would find useful and the kinds of questions the CoG should be asking of the board to enhance governance and accountability.
5. Actively seek out parts of the organisation that have yet to feel the positive impact of recent changes, listening to and acting on concerns / questioning with open curiosity where perceptions have come from.
6. Consistently and clearly communicate the organisation's priorities to staff.
7. Challenge the narrative of repeating where the organisation has been: the past is a place of reference, not a place of residence.

W2: Vision & Strategy | Standard

QA Is there a clear vision and a set of values, with quality and sustainability as the top priorities?

QB Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?

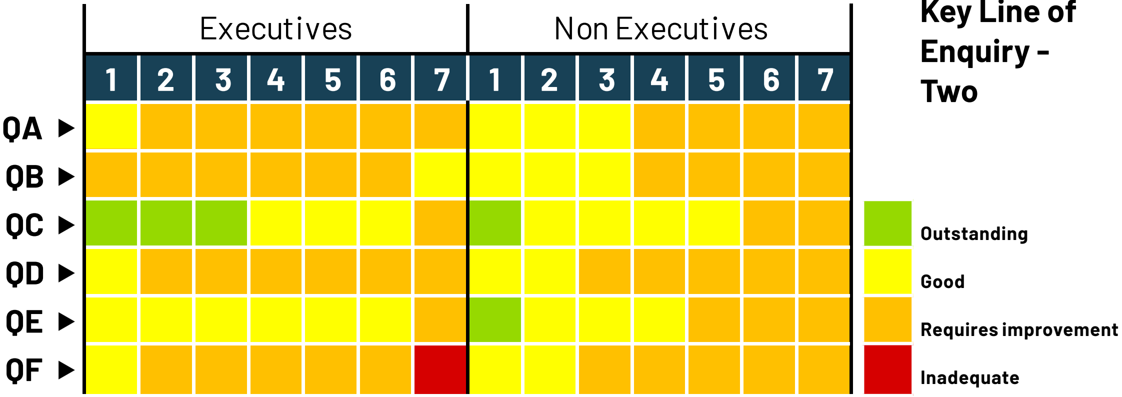
QC Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?

QD Do staff know and understand what the vision, values and strategy are, and their role in achieving them?

QE Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?

QF Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this

You said



Stakeholders said

There was a range of responses when asked if they felt they had been appropriately engaged with in the development of strategy with very few strong feelings either way.

The majority (67%) think SECAmb is somewhat aligned to the wider system priorities.

What do you think the priorities are?

Across stakeholders there is some confusion and lack of clarity about the organisation's goals, with a perception that the organisation had lost its sense of purpose and is now making positive steps in regaining it.

Respondents said that goals are currently focused on publicising efforts to get out of NOF 4, establishing a service consistent with funding levels, and developing a longer-term strategy aligned with environmental considerations and collaboration with partner organisations.

Respondents acknowledged that a new strategy is under development, emphasising addressing CQC report findings, culture change, recruitment, retention, achieving budgeted workforce targets, financial balance and performance targets.

What do you think the priorities should be?

Prioritise the delivery of performance standards to become the most effective ambulance service in England.

Clearly define and communicate priorities with wide input from the staff, gaining support in terms of funding and integration within the wider system.

Enhance policy, process, and governance in operations, address inefficiencies, and conduct a thorough review of mistakes and existing practices. Empower, enable, and invest in staff while focusing on staff retention and career development opportunities.

We observed

The Trust was in an active process of developing their strategy and had already developed a clear set of priorities through their Improvement journey. The strategy was due to be completed in spring 2024 and the team described the values and vision for the organisation developing in tandem with this work.

When asked about the Trust's values, there was a broadly consistent response in terms of the behaviours and culture that was being developed. Staff expressed a strong emphasis on the need for a unified mission, values, transparent priorities, and clear communication with the workforce.

We observed a positive reception of the new CEO's vision and recent organisational changes.

We heard concerns from focus groups about a perception of rushed decision-making, not enough scrutiny, and inconsistent priorities. We observed a tension between wanting faster-paced change and rushed decision-making.

Recommendations

1. Revisit the Trust's values and ensure there is clarity on what they are and what behaviours are expected as a result.
2. Leaders at all levels to commit to living the values.
3. Consider a simpler way of communicating the trust's priorities to staff and wider stakeholders to ensure greater consistency of awareness.

W3: Culture | Standard

QA Do staff feel supported, respected and valued?

QB Is the culture centred on the needs and experience of people who use services?

QC Do staff feel positive and proud to work in the organisation?

QD Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?

QE Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?

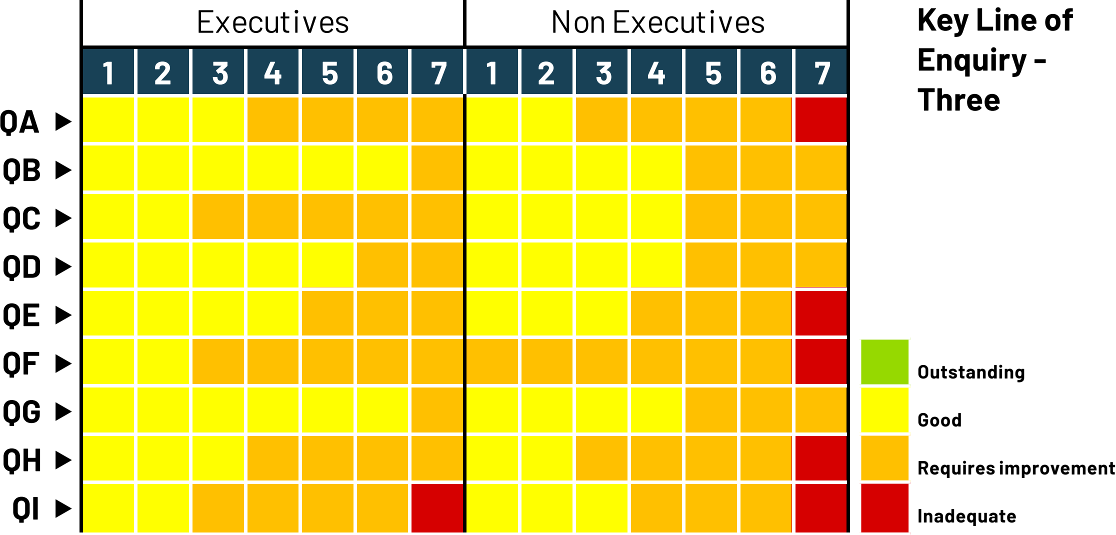
QF Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?

QG Is there a strong emphasis on safety and well-being of staff?

QH Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

QI Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

You said



Stakeholders said

How would you describe the culture of SECAmb?

The organisational culture is described as highly unionised and more empathetic to physical health needs than mental health needs.

The culture is undergoing a significant transition, moving away from a command and control approach, addressing challenges in unifying legacy trust cultures.

The culture is perceived as evolving, challenged, disparate, and varying based on roles and ranks, with concerns about bullying, harassment, and a need for a more inclusive and co-created identity.

There was a broad range of responses to the question about ease of raising concerns ranging from very easy to very difficult. The highest category was neither agree nor disagree at 33%.

Stakeholders generally expressed concern that little changes after raising a concern, although it is dependent on the supportiveness of line managers. It was commented that the CEO is very approachable and responsive.

There was a broad range of responses to the question of how satisfied you are with the response to raising a concern; the highest category (50%) feeling neutral.

50% say SECAmb is somewhat collaborative in its approach.

50% either agree or strongly agree that interactions with SECAmb staff are respectful, professional, and sensitive to individuals and their needs.

We observed

During the review, the team heard a strong message that culture change was taking place and this is warmly welcomed and needed. It felt that there had been a positive change in the culture compared to that described in the previous CQC visit. The senior leaders who had been present during that inspection described the outcome as a 'wake-up call'. There was a clear sense of a change occurring, albeit in its infancy, but many people we spoke with referred to 'green shoots', when asked to describe changes since the last inspection. Leaders spoke with enthusiasm about the development of the Trusts' strategy, changes which had been implemented and those yet to come. It was clear they were cognisant of the amount of work ahead of them, but described the challenges in a positive way. There was a shift from a culture of being task focused to one of a professional curiosity, where staff were interested in the changes being made and how they would both benefit from and contribute to this.

Feedback from workshops emphasised the areas where they thought the leaders should focus on. The key points raised were:

The need to pay attention to psychological safety: while Freedom to Speak Up was acknowledged as a force for good, there were observations that it was sometimes being used instead of speaking to line managers.

Instances of poor behaviour were referenced linked to a lack of shared purpose and inconsistent priorities.

There was a reported reliance on unions to support disengaged colleagues; team and line management support could be strengthened.

Staff turnover among call handlers is relatively high.

FTSU

We observed that there was a mature and well-resourced model in place at the Trust, and the past year has seen an expanded team from 1 to 3 WTE, clinical and non clinical. This was a confident and articulate senior team and impressive senior FTSU Guardian.

In terms of how FTSU was being experienced, most spontaneously noted a significant improvement in the level of board support following the appointment the CEO and his personal and visible support to the function. The FTSU team is well networked across the system, identifying similar issues to other organisation's profiles, e.g. HR and bullying/harassment issues in the highest categories.

Excellent work in progress to reduce risk of detriment to staff who use FTSU by creating education and training resources for both line managers and staff, located within FTSU pages on trust intranet and targeted at respectful working practices. This approach has been modelled on earlier work in Australia and has already been shared with the national guardians office as innovative working.

Recommendations

1. Continue to support the Freedom to Speak Up Guardian so that they can continue to provide an excellent service. Continue to deliver feedback on FTSU outcomes and provide feedback and support to areas where the process is being used in place of open and honest conversations at team level..
2. Review training for managers on fostering an open speak-up culture and growing courage to hold important conversations that ultimately enhance patient care.

AMBULANCE
473

W4: Governance | Standard

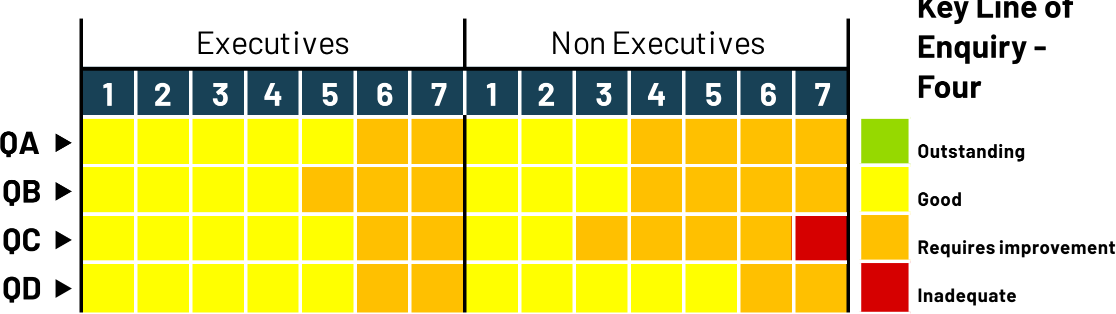
QA Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?

QB Do all levels of governance and management function effectively and interact with each other appropriately?

QC Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?

QD Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?

You said



Stakeholders said

The majority, 67%, think SECAmb is somewhat good at holding themselves and others to account. Comments included that an improvement had been noticed over the past 12 months.

The majority of stakeholders, 82%, think SECAmb's governance arrangements somewhat support their governance arrangements.

More people agree than disagree that SECAmb and their staff take ownership of their collaborative obligations: 42% agree and 8% strongly disagree.

We observed

Changes had been made to governance processes, which would be further amended on the completion of the executive restructure. The governance processes would be aligned to the executive portfolio.

A key part of the Trust's decision making governance processes was the Executive Management Board (EMB), which met weekly. The EMB regularly reviewed the Trust's top strategic risks, quality, operational and financial performance. This group also have scrutiny of the culture programme and drive the process of the Trust's strategy. We saw attendance at the EMB of the Trust's senior management group, the two groups meeting regularly to oversee the delivery of the Improvement Journey.

The Board Assurance Framework and Integrated Quality report are items on the board agenda and were not discussed in themselves. Instead NEDs in particular cross refenced other papers with relevant information in those reports and raised questions where there appeared to be evidence that did not correlate. This led to some good challenge questions at the board meeting.

In some meetings there was more challenge than others. It was observed that some people either didn't say much at meetings, or focussed their contributions when topics in their direct sphere of expertise came up.

Active listening was apparent in meetings although some displayed more than others. Typing and taking notes can provide a useful aide memoire but can give the impression of focussing on something else.

An assurance map, setting out what assurances went where and with what frequency was shared when we asked and it is evident that it requires review and strengthening.

Staff commented that some policies were out of date and addressing this would help give assurance that they were following the most up-to-date approaches.

Recommendations

1. Attention has clearly been paid to strengthening governance at the board and executive levels. The well-led self-assessment highlighted lower levels of confidence that governance and clear lines of accountability permeated the organisation as robustly as they might. A review of what assurances go where at directorate levels and how robust these are could be advantageous.
2. Annual committee reviews to take place including personal reflection on contributions to ensure that members are adding the best value they can and committees are asking good questions that explore topics and deepen understanding and lead to stronger decisions.
3. A review of out of date policies to be carried out with a view to identifying and mitigating areas of biggest risk on a prioritised basis.

W5: Management of risks, issues, and performance | Standard

QA Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?

QB Are there processes to manage current and future performance? Are these regularly reviewed and improved?

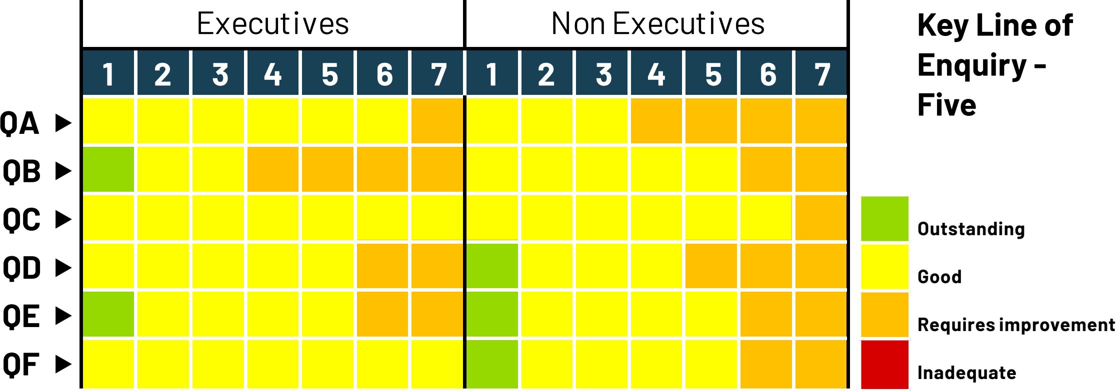
QC Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?

QD Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

QE Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?

QF When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?

You said



Stakeholders said

When asked what they thought the top risks facing the organisation were, the top three that emerged were:

Sustainability and Operational Inefficiency:

The organisation cannot continue with current practices. There is a risk of "running out of road".

Inefficiencies, pose a risk to effective operations.

Staff Culture, Recruitment, and Retention:

Challenges related to staff culture and compliance, including issues with treating operational staff well, pose a risk to staff retention.

The risks associated with staff recruitment, turnover rates, and too many inexperienced staff were highlighted.

IT Infrastructure and Digital Strategy:

IT-related risks, such as serious outages and IT management that doesn't always meet staff needs, pose a threat.

The need for revisiting the digital strategy to ensure that IT and AI is used well.

When given a choice between compliance with targets, quality, or finance, the majority, 67%, said the focus of SECAmb is Compliance with performance targets. 42% said quality, and 42% said finance. Other responses included: staff well-being.

People said that the overarching focus should be on ensuring high-quality emergency care by investing in people and their well-being, fostering collaborative partnerships, maintaining financial sustainability, optimising the operational model, and prioritising staff retention and development.

75% said that environmental sustainability was either somewhat important or not so important. When asked how important it should be, 83% said it should be very important or somewhat important.

We observed

The Trust had undertaken significant amounts of work relating to risk management with a comprehensive training plan. The BAF and directorate reports produced for the Trust Board has also been refreshed to ensure a risk based approach to all areas of the business, which was an improvement from the CQC inspection.

Improvements in tackling underperformance of staff were noted as was the need to be more consistent in doing so.

Staff recommended looking at staff retention at a local level in order to understand localised risks and tailor local responses.

A perceived imbalance in attention and resources between operational and corporate priorities was raised indicating that priorities were either not being judged appropriately or that the reasons for prioritisation were not being communicated clearly (or somewhere in between).

Some operational staff spoke of colleagues feeling unheard and turning to unions for support.

Recommendations

1. Continue the journey to develop the risk maturity of the organisation.
2. Increase consistency in the way poor performance is challenged and addressed.

W6: Information Management | Standard

QA Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?

QB Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?

QC Are there clear and robust service performance measures, which are reported and monitored?

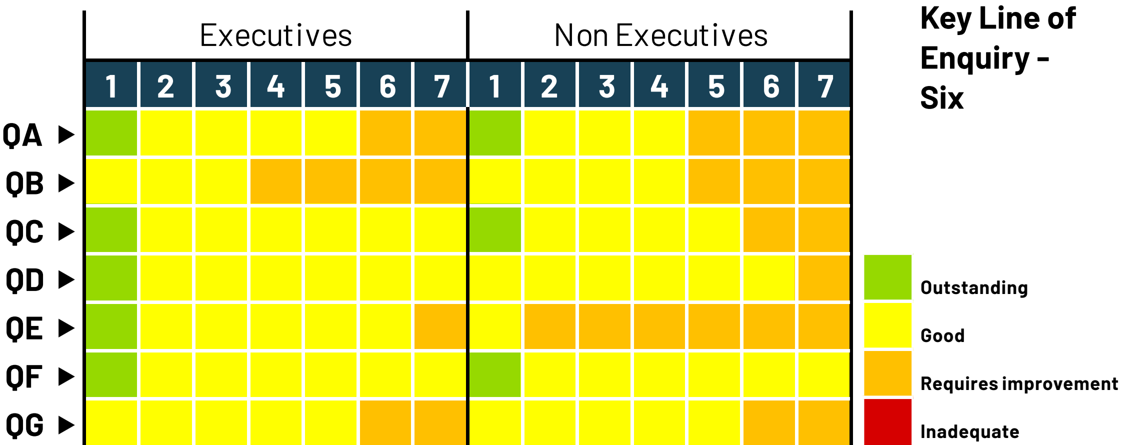
QD Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

QE Are information technology systems used effectively to monitor and improve the quality of care?

QF Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

QG Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

You said



Stakeholders said

When asked about how useful information provided by the Trust was to people, 75% said it was useful.

When asked what information they would like to receive that they don't get, comments were around headline performance and risk information.

We observed

Data was used effectively by the senior leadership team to understand performance and make decisions.

The Trust used a computer-based system to plan to analyse demand and in response to the changing needs of a system or community. This information was used to inform the development of their strategy.

The Trust had worked on improving the quality information to the board and made improvements to the Integrated Quality Report (IQR). They had introduced assurance grids for every pillar of the Improvement journey. The addition of Bullying and Harassment metrics in order to strengthen the board's visibility of how swiftly employee relations cases were being addressed was noted. In order to aid understanding in data trends, a technical narrative had been added to the SPC chart. A key change was that the BAF Risk report was refreshed to include a direct link to the key assurance metrics and SPC icons to strengthen how the reports are considered together.

A review of reports demonstrated that the recent 'Making the data Count' training had had a positive impact on how data was used intelligently. Indeed, in the week of the visit, on 16th January, the Trust received confirmation that it had been identified as *"...one of only 12 Trusts that the Making Data Count team assess as having an exemplary IPR."*

The consistency of how data is used throughout the organisation was raised in the focus groups with comments including, *"We capture all this great information. I don't get the sense that it is being used effectively."* and *"We should use information better to look at the signals that things are starting to go off course and intervene early."*

Recommendations

1. Review IT risks, and opportunities, of using AI and technology, in order to increase the resilience of IT systems and maximise efficiencies of automation.

2. Continue the good foundation of the Integrated Quality Report and encourage more leaders to use it in triangulating information to further strengthen decision-making.

3. Noting that more board members assessed 'requires improvement' than 'good' for standard 6G: Explore as a board the robustness of assurances that your arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards are robust. A review of risks, issues, and near misses could be beneficial.

W7: Engagement | Standard

QA Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

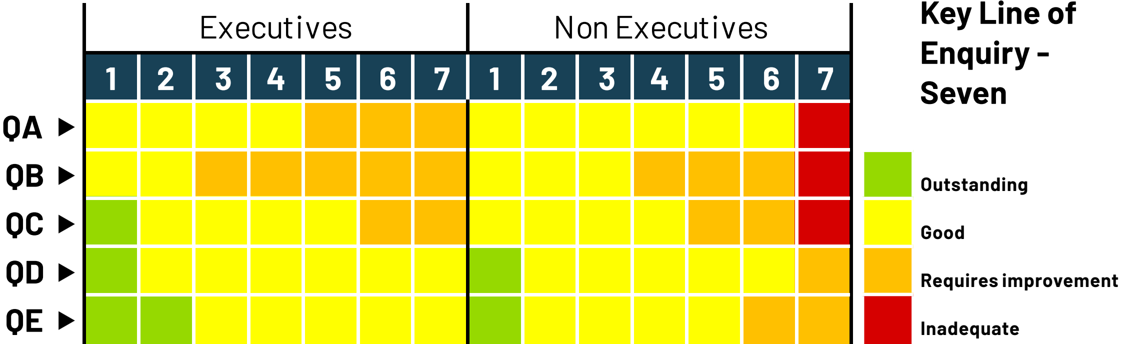
QB Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

QC Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

QD Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

QE Is there transparency and openness with all stakeholders about performance?

You said



Stakeholders said

58% said that they thought their views were either very important or somewhat important to the leaders of SECAmb.

Half of respondents said they could think of examples where they had given feedback and change had happened as a result. Examples given were:

111 service delivery

Feedback from external auditors taken on board

Changes to the way governors are elected and inducted on election

A change agreed at Workforce Planning meeting about booking accommodation after feedback requesting more clarity.

75% said thoughts from stakeholders were 'sometimes' actively sought to aid decision-making.

70% said that the Trust is somewhat successful in seeking views from people with protected characteristics. It was commented that the staff networks were often asked to engage in change processes. One comment questioned how well such views were being heard in the strategy review.

More people agreed than disagreed that SECAmb is open and transparent about performance, quality, and sustainability issues, 42% versus 25%.

We observed

The senior leadership team engaged with staff via a regular program of visits which they described to us and reported on in board committee papers. Big Conversations occurred on a monthly basis. Reward and recognition was spoken about enthusiastically by the team who were keen to recognise the work of their operational colleagues. The Trust engaged with regional and national system partners including, the Chief Constable of Sussex Police, St John's Ambulance, MPs, as well as attending meetings of the Surrey Heartlands Delivery Oversight Group, the Sussex ICB System Oversight Board and NHS Providers Chair and Chief Executives Network meeting. The new strategy was under development at the time of the review, and included a comprehensive programme of engagement.

An improvement in engagement with staff has been noticed and welcomed. We observed mixed perceptions of engagement effectiveness, with a recommendation for more meaningful involvement at local levels.

Challenges in reaching and engaging hard-to-reach groups within the organisation were reported and there is a recognition that different people and groups like to engage with the organisation in different ways and the impact of leadership styles on staff engagement and the need for transparent communication was referenced.

As well as official channels of communicating information and engaging, unofficial channels on social media exist which may or may not support official messaging.

Recommendations

1. Promote positive examples of where engagement has led to change to help encourage others to contribute.
2. Check with staff networks asking if they feel their voices are heard within the organisation, and respond accordingly.

W8: Learning, continuous improvement and innovation | Standard

QA In what ways do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?

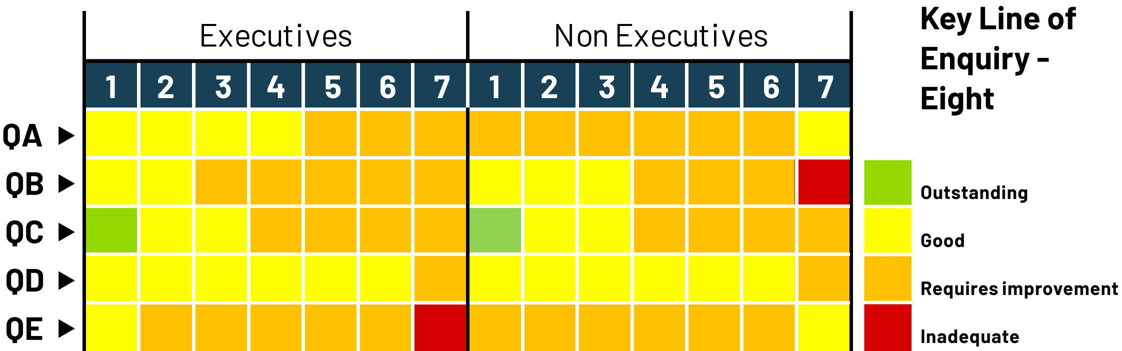
QB Are there standardised improvement tools and methods, and do staff have the skills to use them?

QC How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?

QD Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?

QE Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?

You said



Stakeholders said

Most respondents, 58% were ambivalent as to whether there is a culture of continuous improvement and learning at the Trust; a third said there wasn't.

When asked, 'How well does SECAmb contribute to system-wide learning and the development of new solutions to system challenges?' the most popular response was 'not so well' at 42%.

When asked what could be done to improve the culture of learning continuous improvement, and innovation, the common theme expressed was the importance of time. Providing staff with dedicated time for reflection, learning opportunities, and sponsored CPD is seen as crucial for building a positive culture and ensuring competency development without relying solely on staff's personal time investment.

The survey ended with the question, *'Have you ever thought of something you'd like to share with SECAmb but have not found the right time to express it? Now is a fabulous time to share your thoughts….'*. A selection of answers are replicated below:

"There is a huge amount of untapped and undervalued talent within the people who are the organisation. Whilst the difficulties that the Trust faces are huge, there is the potential for it to surmount and overcome these if it finds effective ways of retaining the talent that it has, whilst enabling its people to more fully participate in shaping the work that it does."

"I have spent the last five years sharing my thoughts to no great avail, and I do not see that changing hence my imminent departure."

"…I think if the organisation invests in its people who work 'on the ground' the confidence, improvement ideas and innovation will draw out of this."

We observed

The organisation has experienced changes in leadership and positive front-line initiatives within the past year.

The organisation tends to adopt a reactive approach to problem-solving rather than proactive intervention.

Despite the desire for learning and development, there are perceived shortcomings in opportunities, time, structures, and resources which has an impact on retention of good staff.

Whilst it is recognised that good learning is happening, it could be better connected and shared across the organisation for even greater impact.

Recommendations

1. Ensure time and appropriate resource is made available to enable staff to develop and grow themselves and their careers at the Trust..
2. Prompted by the self-assessment, we recommend an exploration of current systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work.

Summary findings

In summary, we found an organisation that is going through significant change, led by the new CEO. While there has been a steadying of the ship, leaders are clear that next year will be tough. Finalising the new strategy will provide a much need map and clear direction. It felt that there had been a positive change in the culture compared to that described in the previous CQC visit.

Staff spoke of the need to pay attention to psychological safety. Instances of poor behaviour were referenced, linked to a lack of shared purpose, and there was a reported reliance on unions to support disengaged colleagues.

We observed an organisation that has made progress since the previous CQC visit, and staff and leaders spoke of 'green shoots' of improvement. A concerted effort from leaders at all levels is required to maintain the improvement, focusing on areas of the organisation that are less engaged.

Overall, the team gained the impression that this was an organisation that had improved from the previous CQC visit and that has a plan and the determination to make necessary further progress.

Concluding remarks

The team at Governance Coach UK would like to extend a huge thank you to everyone who supported the process of the review and to those who gave of their time and responded with such open-heartedness to the process. It was a wonderful opportunity to immerse ourselves in the organisation and see the evidential progress that has been made and we wish you well in your journey of continued service to the people of south east England.

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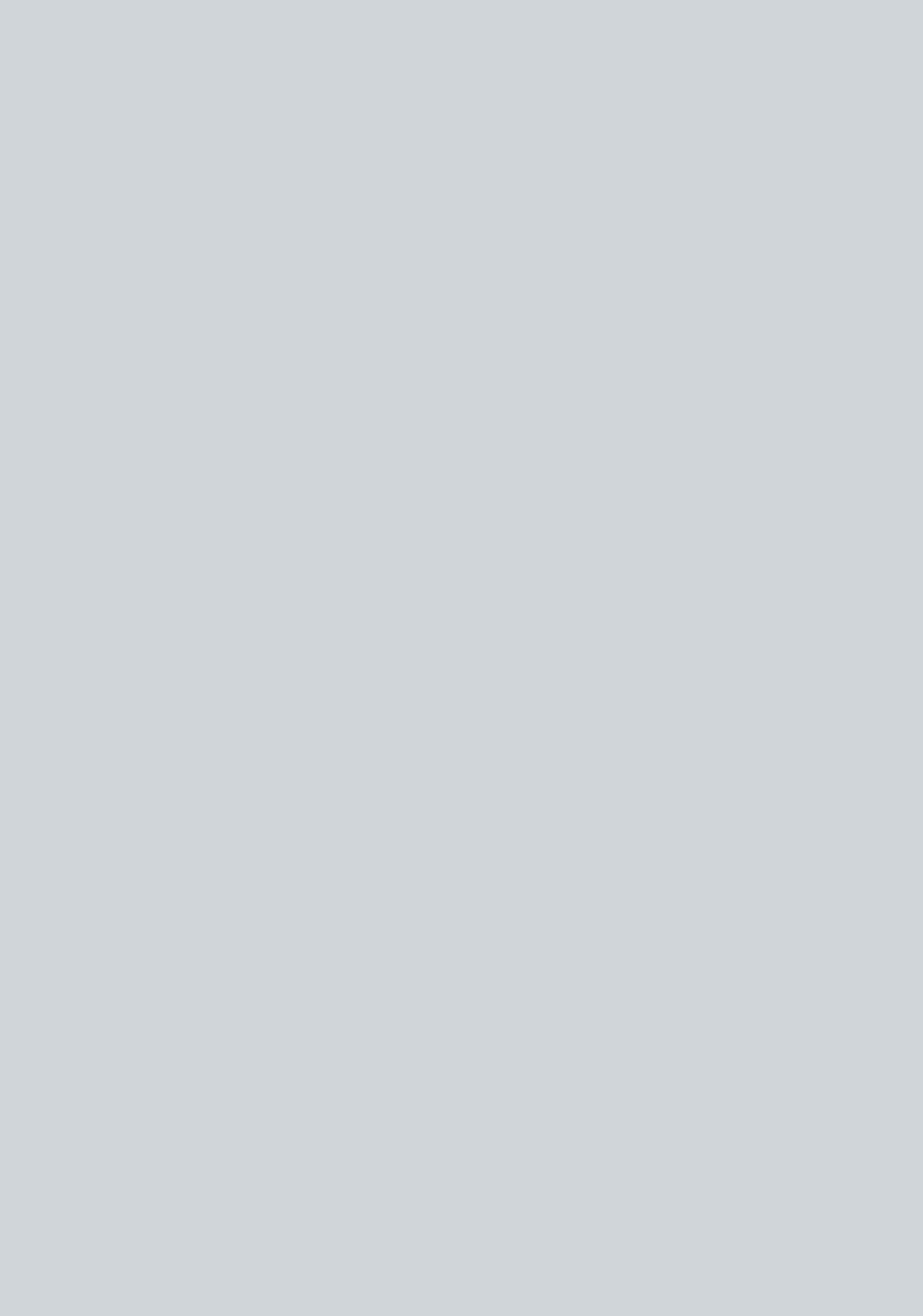


	Agenda No	07-24
Name of meeting	Trust Board	
Date	04 April 2024	
Name of paper	Audit & Risk Committee Escalation Report – March 2024	
Author	Michael Whitehouse, Independent Non-Executive Director – Committee Chair	

This report provides an overview of issues covered at the meeting on 21.03.2024.

Under matters arising the committee received a positive update on the work to strengthen the controls for declaring interests. RSM, who provide Internal Audit and Counter Fraud services, provided independent assurance noting that our current level of compliance compares favourably with other providers. Further work is needed to increase the declaration of secondary employment which the People Committee will pick up as part of its overview of the appraisal process.

External Audit

The external audit plan was reviewed noting the approach to be taken by KPMG. There continues to be confidence in delivery of the plan within the timetable. The issue related to how the CQC's well led assessment from 2022 might impact the value for money assessment was considered again; KPMG will be assessing the trust's improvement journey and how embedded the changes are.

Internal Audit

There was one final report – Financial Management, which was Reasonable Assurance. This was a positive outcome and the committee supported the actions agreed to ensure further improvement, related to engagement and training for budget holders. The remaining four reviews from the internal audit plan will be received by the committee in May, when it will consider the Head of Internal Audit Opinion for 2023-24.

One of the key drivers that informs this opinion is the closure of the agreed management actions. There remains concern about the completion of some actions, in particular where they relate to HR. The People Committee has been asked to follow this up to seek assurance timely completion of these actions.

The committee welcomed BDO who will provide internal audit and counter fraud services from 2024-25. They provided their internal audit plan for the year ahead which the committee supported.

Counter Fraud

The overall assessment of our Local Counter Fraud Specialist is that the Board that continue to take reasonable assurance with the controls in place to manage fraud. The Counter Fraud Annual Return was received where all bar one of the 13 requirements are rated Green. The one relates to fraud awareness

training; this has been offered throughout the year targeting specific teams, but the committee learned that take up has been quite low. It asked the executive to ensure better attendance in the future.

NARU Review Action Plan

The CEO and Director of Operations presented a helpful update on the progress against the action plan. Given the profile of this review, the Board will also receive the update in April. The committee supported the realistic timeframe and was broadly assured with progress to-date.

The committee has agreed the need for a time limited EPRR sub-committee that will be established during Q1.

Operation Carp Closure Report

The independent external review into Operation Carp (the Police code name into the sophisticated diversion and theft of Controlled Drugs undertaken by two members of SECAmb staff) made seven recommendations and the committee received a further report setting out the actions taken. Assured by the learning from this, the committee supported the closure of this action plan with all save two actions complete; the remaining two are moved into business as usual.

Risk Management

The committee has a good level of assurance with the way risk is being managed. The committee reinforced the principle of risk management is to improve patient care and experience; the golden thread CQC referred to during their inspection in 2022. There is more still to do to embed the improvement, especially with ensuring a culture of risk management throughout the organisation. For example, the committee noted the fragility of risk reviews, with too many risks being overdue their review date. The executive is fully aware of this and through the Head of Risk are taking the right corrective actions.

Policy Management

There is now greater assurance with the internal controls in place to ensure management of the trust's policies; specifically that our policies are up to date. In the 12 months since the concerns were noted about this, 91% of policies are now in-date (from 35%). The improved controls will help maintain this position and prevent recurrence of the issues from last year.

Specific Escalation(s) for Board Action	There are no specific escalations requiring Board intervention, but the Board is asked to note: 1. The committee's escalation to the executive related to fraud awareness training. 2. The decision to establish a EPRR sub-committee.

	Item No	08-24

Name of meeting	Trust Board
Date	04.04.2024
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 January and February 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: • Reviewing the 2023 NHS Staff Survey results and agreeing how we will use them to shape our focus areas moving forwards • Discussing the emerging Operating Plan for 2024/25, including the regional perspective • Driving forwards the development of our new Trust Strategy, with a focus on delivery
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	**Changes to our senior leadership team** As we continue to build and strengthen the leadership of the organisation, we have recently made a number of changes to our senior leadership team.
7	Executive Director of HR and Organisational Development, Ali Mohammed, has taken up a secondment elsewhere and we wish him well with this opportunity.

8	Sarah Wainwright, currently Deputy Director of People & Workforce Transformation at NHS England, will be joining us at the beginning of April on a 12-month secondment as Director of HR & OD. Sarah is an extremely experienced HR leader and I'm sure the Trust will benefit significantly from her experience and focus.
9	Following Saba Sadiq's decision to take up a new role at Blackpool University Hospitals Simon Bell has now joined us as Interim Chief Finance Officer. Simon is an experienced NHS Director of Finance will provide strong financial leadership and work closely with our system partners.
10	Finally, we are also pleased that Lara Waywell has been appointed to the role of Deputy Director of Operations and will be joining us during the next few weeks.
11	A nurse by background, Lara will be joining us on a 12-month basis and brings with her a wide variety of experience, having operated in board level operational and improvement roles within community and acute trusts both in the UK and Qatar.
12	Looking ahead, we will shortly be looking to begin a competitive process to recruit to the Executive Director of Nursing & Quality role.
13	We have also appointed to a new role of Chief Digital Information Officer (CDIO), which will provide significant, Board-level focus on IT. Stephen Broomhall, currently CDIO at East of England Ambulance Service, joins us in mid-April, initially on a six month secondment. Stephen has overseen the digital transformation at East of England and leads the national digital leaders group for the Association of Ambulance Chief Executives (AACE).
14	**Engagement** I am continuing my programme of visiting different SECAmb sites and teams across our area each week and recently enjoyed an informative visit to Chertsey Make Ready Centre. It was great to meet some of the team there and hear more about the key issues affecting them.
15	I have also been pleased to host two 'Big Conversations' for colleagues recently – one in February on the important topic of Sexual Safety in the ambulance sector and the other in March to discuss the most recent staff survey results and gain colleagues' views on the areas they feel we should focus on moving forwards.
16	Each Big Conversation – open calls where any colleague can join, ask questions, and give their views – generates strong attendance from right across the Trust and I really value the opportunity they provide to engage directly with our people.
17	Both of the recent sessions provided a real chance to spend quality time focusing on the issues in question and generated valuable feedback that is directly influencing our plans as we move forwards.
18	I have also continued to spend time with a number of our key regional and system partners including regional and national ICS Chief Executives. 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 and the part SECAmb can play as a system partner.
19	**Development of our new Trust Strategy** As we continue to work hard to develop our new Trust Strategy, during March we have completed the strategic planning process, developing the preferred Board option – Option 2 Care Navigation**.**
20	This option will see SECAmb pursue a leading role in helping patients to navigate the unscheduled urgent and emergency care landscape and, by integrating and collaborating with partners, we believe we will be able to help one in three patients who contact us currently, receive the care they need without needing to send an emergency ambulance response.
21	We will do this by ensuring we are integrated with other parts of the health and social care system, investing in technology and data to help us make better decisions and learn, maximising the impact of our people by aligning clinical need to skillsets, as well as expanding on the role of our volunteers to help us have even better responses to patients in the community.
22	For example, by delivering this strategy, over the next three years we expect we will be able to meet emergency care needs within the national standards of 7 minutes for C1 and 18 minutes for C2, and we will do so in a way that is sustainable for the NHS, and supportive of our people.
23	To move the strategy into action, we have developed a transformation plan with Phase 1 – 'setting up for success' – expected to run over the next 18-24 months.
24	During phase 1 we expect to be focusing on: • Creating capacity and capability where we need it in the organisation, aligning our operating model to the ICB footprints • Working with system partners to develop the detail behind the models of care that will underpin future commissioning frameworks and help us design the pathways that will need to be strengthened to ensure non-emergency patients receive the right care • Expanding on the outcomes we have seen delivered in East Kent through the implementation of the care navigation hubs, giving us immediate benefits from year 1 and creating valuable learning for the future • Detail further our workforce plans ensuring they align to the future patient needs, as well as a continued emphasis on making SECAmb an enjoyable place to work. We expect we will need to invest in wellbeing, retention, and developing new career pathways for our people, clinically and non-clinically. • Preparing ourselves for a period of digital transformation which we will see start from phase 2.
25	As an important strand of developing our Strategy, we are now engaging in a Trust-wide debate on what are the values and mission statement that will help us

	see this transformation through, alongside a corporate re-branding that will help us to set the tone for SECamb in the coming years.
26	We expect to publish our new Strategy in May 2024.
27	As we conclude discussions on our Trust strategy, we are beginning work on the Operating Plan for 2024/25; these discussions are integral to successfully being able to implement the strategy.
28	It would be fair to say that the national backdrop to these discussions is extremely challenging. At the time of writing, planning guidance has yet to be formally published but it can be expected that we will be asked to maintain current performance standards for the year ahead. However, that expectation comes in the context of an increasingly constrained financial environment: systems will be expected to submit breakeven plans. To deliver breakeven as a system will require some very difficult decisions to be made.
29	Work is ongoing and a final submission is due at the beginning of May
30	**Recognising our first 'Stars of the Month'** On 1 March 2024, I was pleased to join the first virtual judging panel – consisting of colleagues representing our staff networks, staff governors, the Senior Management Group, Volunteer Team and the FTSU team – to choose the first winners of our new 'Star of the Month' award.
31	It was an enjoyable session, working through the 30 nominations we'd received for this new award, made via The Star Zone, our new Reward & Recognition Platform.
32	And whilst we all agreed how difficult it was to pick any one colleague over another, it was also enjoyable to share such positivity from those who had made the nominations.
33	After some incredibly close voting, the Panel could not choose between two winners, so heartfelt congratulations to our first joint Stars of the Month – Meghan Wilcox, Newly Qualified Paramedic at Dartford and Jonny Bates, Operational Team Leader at Thanet. The Panel also wanted to award a Highly Commended Award to Resource Dispatcher Jessica Cobb so a big well done to Jess too!
34	Meghan and Jonny have each received £50 to spend via The Star Zone, with Jess getting £25. I am looking forwarding to catching up with Meghan, Jonny and Jess shortly, to present them with their certificates and congratulate them in person.
35	I am also delighted to learn that we have seen another strong set of nominations made for our March Star of the Month and look forward to congratulating our next set of winners shortly.
	B. Regional Issues

36	**Recognising our academic achievers** On 21 March, I was delighted to join colleagues to celebrate the academic achievements of both our paramedic graduates and our newly qualified associate ambulance practitioners and ECSWs.
37	The Celebrating Success event - the first of its kind on this scale - took place at the Crowne Plaza Hotel in Crawley where attendees gathered to celebrate the completion of colleagues' degrees and diplomas.
38	I was honoured and proud to present certificates along with the Principle of Crawley College, Sally Challis Manning and Principal Lecturer in Paramedic Apprenticeships from the University of Cumbria, Matt Bridgeman.
39	A big thank you and well done to the team who organised this event, including Associate Director of Operations (West), Andy Rowe and the wider Operations and Clinical Education team who have also supported our learners.
40	I wish each and every one of them a successful and fulfilling career.
41	**Support for Hazardous Area Response Team (HART) capability** Following the external review into the Resilience and Specialist Operations department delivered in 2023 and the action plan developed subsequently to address the findings and recommendations contained in the review, I am pleased that we have reached agreement with our regional commissioners to 'right size' this important area moving forwards.
42	An uplift of £2.4m in funding has been agreed, to be delivered in a phased approach, to scale up staffing, improve training and improve management of specialist equipment and a detailed plan has been developed to support the delivery of this work.
43	I am continuing to work closely with the leadership team for this area and will be holding the latest workshop with the whole team in March, to ensure we continue to focus on improving our responsiveness and supporting our colleagues.
	C. National Issues
44	**Staff Survey results published** On 7 March, the 2023 NHS Staff Survey results were published by NHS England, and we were pleased to see significant improvements in our results compared to last year including: • Improvements across all nine themes explored by the survey's questions • Improved scores to almost all individual questions • SECAmb's scores have also improved more, year-on-year, than others in the ambulance sector
45	Close to 2,800 colleagues, (some 60 per cent of staff), completed the survey – the fourth consecutive year that more than 60 per cent of our people have participated – and I'd like to thank each and every colleague who took the time to complete the survey. Their feedback really is making a difference.

46	While welcoming the marked improvements in results, we also recognise however that there is still much to be done to ensure we are where we need to be as an organisation for both our staff and patients.
47	Using the results as a basis for discussions, we have already begun the conversation with our people to identify the areas that that are important for them and are building these into existing programmes of work, including the delivery of our People & Culture Strategy, to ensure we are focussing on the right areas.
48	**National culture review published** On 15 February, NHS England published a national review they commissioned into culture in the ambulance sector, undertaken by Siobhan Melia, previously Interim CEO at SECAmb from July 2022 to March 2023.
49	The review makes recommendations for ambulance services to take forwards in six key areas – speaking up, addressing bullying & harassment and sexual harassment, tackling barriers to recruitment, balancing operational performance with 'people' performance, investing in leadership and management training, and ensuring access to wellbeing support.
50	We are pleased that we have made progress in some of these areas, to improve our culture and to make SECAmb a better place for everyone through initiatives including the A Kinder SECAmb programme, investment in leadership and management development and our commitment to sexual safety.
51	However, we recognise that there remains far more to be done to ensure we are where we want to be as an organisation.
52	Recent media coverage has also highlighted the particular vulnerabilities faced by students in the ambulance sector and this will be a key area of focus for us through our culture work.
53	During the Summer term, I will be meeting with our undergraduate students to understand from them directly their experiences of undergoing placements in SECAmb and what more we can do to support them.
54	As always, we would urge everyone to speak up and raise concerns to ensure that unacceptable behaviours don't go unchallenged.
55	**Success for QI Team** I was pleased to hear that our Quality Improvement (QI) team has been shortlisted to exhibit at the prestigious Quality and Improvement Conference hosted by NHS Providers in London.
56	The conference, which takes place on 22 May, provides the team with a fantastic opportunity to showcase and exhibit the Trust's QI work.
57	The work of the QI team is vital in ensuring we provide quality care that is safe, right for our patients and financially viable.

58	Representing SECAmb at the event will be our Head of QI, Amy Igweonu alongside Clinical Operations Manager, Emma Webber. They will be joined by Executive Director for Quality and Nursing, Margaret Dalziel and Joanne Turner, Deputy Director for Quality Improvement.
59	As we aim to adopt a more proactive approach that focuses on preventing problems rather than simply reacting to them, a robust and productive QI approach is absolutely key and will form an important part of the transformation needed to deliver our new Strategy.
60	Congratulations to everyone involved in this important work and I look forward to hearing about the event.
	D. Escalation to the Board
61	**Operational Performance** Through working in close collaboration with our partners, we continue to deliver responsive and good quality care to those we serve.
62	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. At this stage, it looks like we will be one of the only ambulance provides to hit the current C2 mean target for the year – a significant achievement.
63	Our 999 Emergency Operations Centres are seeing a steady improvement in relation to recruitment to vacancies, with us continuing to see a positive impact of the improved environment and working conditions at the new Medway site. As a result of this, call answering performance and hear and treat rates continues to improve.
64	We have recently moved to REAP 2, in light of the reasonably stable performance climate at present, although continue to keep this under close review.

		Agenda No	09-24
Name of meeting	Trust Board		
Date	04.04.2024		
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.

There has been significant progress in the last 12 months. For example:

- QI starting to embed.
- Introduction of PSIRF.
- Action taken in response to staff feedback that has improved the experience of our people, as demonstrated by the staff survey.
- Positive operational performance, with delivery of the C2 mean; an achievement matched by only one other ambulance trust in England. Improvement in other ARP quality metrics.
- Development of a new trust strategy.
- Achievement of our control total – breakeven.

The BAF is currently under review. The new version is being aligned with the new Trust strategy; strategic priorities and in-year objectives. The Board will receive the first draft at its development session in May, when it will also assess the proposed new risks. It will then start to be used by the Board from June 2024.

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 several 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.

Quality & Safety

Goal 1		Build and embed an approach to Quality Improvement at all levels	(Green)
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 patient's vs 22/23 baseline	Q4
	QI 2	**A QI Strategy to take the organisation forward and empower those closest to patients to lead improvements.**	
	Measure	Signed off Strategy at the Board	Q2
	QI 3	**Training and engagement in QI for our people**	
	Measure	For 10% of all staff to have completed 'Introduction to QI' in 23/24 Provide QI team support, coaching and facilitation to at least 5 local QI projects in 23/24	Q4

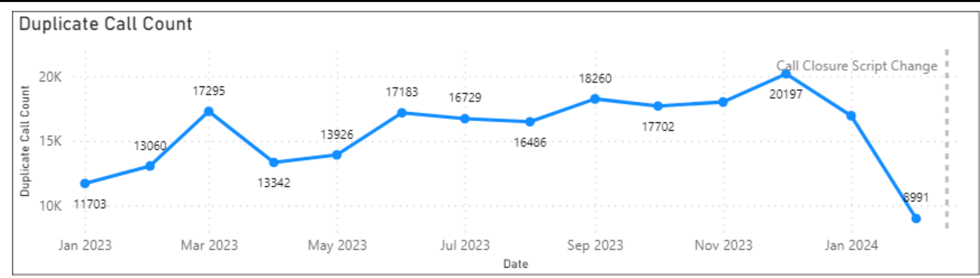
In year progress with the achievement of the Strategic Goal is Green as all actions are on track with no concerns except for some of the improvements within the Keeping Patients Safe in the Stack QI project being delayed due to the dependency on cleric to deliver these as described below.

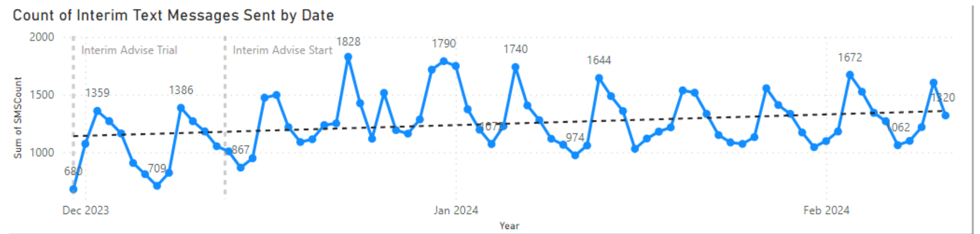
Any risks have been identified and mitigations are either in place or being discussed.

Progress to-date:

QI 1:
The Keeping Patients Safe in the Stack project team have made good progress in implementing improvements identified during the Analyse phase of the project. Interim Care Advice, a new call closure script, and the addition of Estimated Time of Arrival (ETA) to Categories 2, 3, and 4 calls have been successfully implemented. Additionally, a dashboard has been operationalised to track the impact of these changes. Current data shows that there is a steady increase in the delivery of interim care advice to patients via text and the team are tracking performance to establish if there is a corresponding decrease in duplicate calls into the service. The graphs below show current performance.

There have been delays in implementing automated duplicate call closure, automated welfare text messaging, and a separate queue for patients who have called the service multiple times. These delays are primarily due to the dependency on Cleric to develop these solutions. The team will continue to collaborate with Cleric to implement these outstanding developments in the new financial year 2024/25.





QI 2:
This objective is complete – the strategy was signed off by the Trust Board in August 2023 and is being embedded across the organisation. The QI team have hosted several virtual sessions with colleagues across the organisation to discuss the strategy and how the team can be supported to deliver it.

QI 3:
This is on track for completion. Year to Date, 404 colleagues have been trained (8.0% of all staff) in 'Introduction to Quality Improvement (QI)' Additionally, seven more sessions have been scheduled for the remainder of March 2024. With these sessions, the team anticipates achieving the 10% target. 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.

The team have introduced a virtual training session on 'Measurement for improvement' for colleagues who require support in utilising data in their improvement projects. The QI team have additionally commenced delivery of a QI induction session at the corporate induction for operational colleagues. From April, the QI team will be delivering this session to all new starters.

QI training is being embedded into the wider Education and Training Group 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	4 x 2 = 8
	Mitigation				
	• Project team has identified high impact easy to implement initiatives to implement imminently. These initiatives have now been operationalised. • 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 delivered several Intro to QI sessions for 111 & EOC colleagues in Q4. Some of the sessions have been virtual to accommodate different shift patterns. • The team have attended several 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 with further sessions planned to be delivered to all staff.				

Goal 2		Become an organisation that Learns from our patients, staff, and partners.	(green)
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 - **completed** - *Added Dec 2023:* PSIRF Launched and SI Framework (STEIS) ceased to be in use in **Q2 2024/25 - on track** - *Added Jan 2024:* Plan and policy live, and Trust will transition to PSIRF on **29th January 2024 - completed**	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:

- PSIRF has now launched and the SI Framework is no longer applied to new incidents.
- Trust patient safety priorities identified and PSIRP agreed by the Board in Oct 2023.
- The Patient Safety Oversight Group (PSOG) is now established with commissioners in attendance, and TOR approved by QGG.
- Monthly Systems-based Incident review groups (IRG) are now established replacing the centralised Serious Incident Group – this is attracting wider multidisciplinary team and team leaders involvement. TOR approved at PSOG on behalf of QGG.
- 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. Training will take place after PSIRF is launched - whilst this has been identified as a risk, mitigations are in place 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. This is now also a focus of the Trust Board,
- 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. An effective working group is now in place which includes EOC leadership with a primary focus on telephone CPR.

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.

<table>
<tr><th colspan="2">Goal 2</th><th>Risk Description</th><th>Initial Score C + L</th><th>Current Score C + L</th><th>Target Score C + L</th></tr>
<tr><td rowspan="12">In Year Risks to achieving the objectives</td><td>QI 4</td><td>Lack of engagement with PSIRF from Trust colleagues</td><td>4x3=12</td><td>4X2=8</td><td>4X1=4</td></tr>
<tr><td colspan="5">Mitigation</td></tr>
<tr><td colspan="5">• 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.</td></tr>
<tr><td></td><td>Risk Description</td><td>Initial Score C + L</td><td>Current Score C + L</td><td>Target Score C + L</td></tr>
<tr><td>QI 5</td><td>Lack of engagement and joint working between directorates to implement the out of hospital cardiac arrest plan 23-24</td><td>4x3=12</td><td>4x1=1</td><td>4x1=4</td></tr>
<tr><td colspan="5">Mitigation</td></tr>
<tr><td colspan="5">Joint priority setting across the directorates, joint planning meetings, shared responsibility for delivery.</td></tr>
<tr><td></td><td>Risk Description</td><td>Initial Score C + L</td><td>Current Score C + L</td><td>Target Score C + L</td></tr>
<tr><td>QI 6</td><td>Pressure on front line operations withdrawing staff from training to focus on operational duties.</td><td>4x2=8</td><td>4x1=4</td><td>4x1=4</td></tr>
<tr><td colspan="5">Mitigation</td></tr>
<tr><td colspan="5">At the moment staff are coming to training in their own time which mitigates the risk but is not sustainable</td></tr>
</table>

<table>
<tr><td colspan="2">Goal 3</td><td>Strengthen how we work together at all levels of the Trust to ensure appropriate oversight of patient safety and mitigation of risk.</td><td></td></tr>
<tr><td rowspan="4">In Year Objective</td><td>QI 7</td><td colspan="2">A Quality and Performance Management Framework that runs from our Patients to the Board (QAF)</td></tr>
<tr><td>Measure</td><td>- 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</td><td>Q4</td></tr>
<tr><td>QI 8</td><td colspan="2">A Quality Assurance and Engagement Framework through local visits, that helps us assure the improvement we are making (QAE visits)</td></tr>
<tr><td>Measure</td><td>- 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.</td><td>Q4</td></tr>
</table>

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.

- Nine successful visits have now taken place since commencement in April 2023; Banstead, Chertsey, Thanet, Worthing, Ashford, Guilford, Polegate, Paddock Wood and West EOC 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 has been received regarding this.
- The 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 has been demonstrated within the visits, providing increased collaboration and assurance to the ICB’s.
- Two thematic analysis papers have been completed highlighting common themes and identified areas of improvement across the operating units.
- Feedback is now delivered to SMG monthly with specific areas of concern highlighted to the relevant head of department or SME.
- A peer review of the QAV process is being conducted in April by LAS at the Gatwick Quality Assurance Visit.
- End of year summary paper completed and aligned with the new CQC single assessment framework.

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

<table>
<tr><th colspan="2">Goal 1</th><th>Getting our foundations right consistently</th><th></th></tr>
<tr><td rowspan="8">In Year Objectives</td><td>PC1</td><td colspan="2">Respond to issues raised in Staff survey and recent reviews (housekeeping)</td></tr>
<tr><td>Measure</td><td>>95% of housekeeping actions completed</td><td>Q3</td></tr>
<tr><td>PC2</td><td colspan="2">Implement new leadership visit process consistent with C&E Strategy</td></tr>
<tr><td>Measure</td><td>>90% compliance</td><td>Q1</td></tr>
<tr><td>PC3</td><td colspan="2">Rapid on-boarding QI project</td></tr>
<tr><td>Measure</td><td>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</td><td>Q3</td></tr>
<tr><td>PC4</td><td colspan="2">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</td></tr>
<tr><td>Measure</td><td>Engagement, safety and morale scores improved Pulse and Staff Surveys</td><td>Q4</td></tr>
</table>

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.

In Year Risks to achieving the objectives

Goal 1	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
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 25mins 50secs (February), YTD (to 29/02/24) C2 to of 28mins 12secs.
- Remaining on trajectory to achieve C2 men of 30mins max across the 2023-24 FY.

RC2: Call answering mean 7secs (February).

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 100.8%, with a maximum variation at 38.0% with a consistent pattern of those areas who both 'export' and 'import' resource.

- This workstream is unlikely to deliver in the timeline proposed due to the complexity of the contributory factors, however noting that progress has been made against sub-actions such as the dispatch improvement programme and with additional learnings to be clarified from the Ashford dispatch desk 'perfect month'.

Goal 1		Risk Description	Initial Score	Current Score	Target Score
In Year Risks to achieving the objectives	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 February was 13.7% in - this places SECAmb 7th out of the 11 English ambulance trusts, a consistent position.
- 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. Further expansion of this will be dependant on the strategy-led delivery model redesign.

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 presented to ICBs in April 2024 – 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.

<table>
<tr><th colspan="2">Goal 2</th><th>Risk Description</th><th>Initial Score</th><th>Current Score</th><th>Target Score</th></tr>
<tr><td rowspan="11">In Year Risks to achieving the objectives</td><td>RC4</td><td>Inability to create additional capacity to support the delivery of the increase in ‘hear and treat’ rate.</td><td>4 x 3 = 16</td><td>4 x 2 = 8</td><td>4 x 2 = 8</td></tr>
<tr><td colspan="5">Mitigation</td></tr>
<tr><td colspan="5">• 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.</td></tr>
<tr><td>RC5</td><td>Inability to meet the recommendations from the Manchester Arena Inquiry</td><td>TBC</td><td>TBC</td><td>TBC</td></tr>
<tr><td colspan="5">Mitigation</td></tr>
<tr><td colspan="5">• A business case being worked up for presentation to commissioners in early 2024 – risk being reviewed to quantify mitigations, controls, and scoring.</td></tr>
<tr><td></td><td>Risk Description</td><td>Initial Score</td><td>Current Score</td><td>Target Score</td></tr>
<tr><td>RC6</td><td>Limited quantitative and qualitative reporting on activity and impact of all specialists and volunteers – linked to agreeing meaningful metrics and ease of accurate reporting.</td><td>3 x 4 = 12</td><td>3 x 4 = 12</td><td>3 x 2 = 6</td></tr>
<tr><td colspan="5">Mitigation</td></tr>
<tr><td colspan="5">• Working with clinical leads on scoping the need and developing options/improvements for implementation</td></tr>
</table>

Goal 3		Provide exceptional support for our people delivering patient care	(Amber)
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.
- (Update March) – We have completed the road-shows and will be submitting the business case in Q1, in line with a reviewed fleet replacement cycle that adapts to the new strategy and capital planning constraints. Colleagues across SECAmb engaged positively in the selection process of the new DCA options, and a full evaluation and responses with recommendations paper will be forthcoming in April 2024.

Goal 3		Risk Description	Initial Score	Current Score	Target Score
In Year Risks to achieving the objectives	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	● (Green)
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**

Progress to date:

- Key Groups engaged:
  - Councill of Governors
  - Board
  - Senior Management Groups
  - All directorates (pending finance which is scheduled)
  - Volunteers
  - OUMs (Field Ops and EOC)
  - Staff Networks
  - Trade Unions
- Over 350 patients, 20 ICB workshops and interviews, 2000 colleagues, and 400 volunteers have been involved in the development of th strategy.
- Development of a Clinical Case for Change following 4 workshops (1x with ICBs and 3x with our clinical and operational managers)
- 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.
- **Update April** – We have completed the implementation planning phase of the strategy and the contract with our consultancy provider has now finished.
- A transformation plan has been developed to move from strategy to action, with phase 1 focusing on setting up for success over the next 18-24 months.

- Phase 1 priorities include aligning the operating model to ICB footprints, developing models of care and pathways with system partners, expanding on the outcomes delivered in East Kent, detailing workforce plans, and preparing for digital transformation.
- The organisation is engaging in a Trust-wide debate on values and mission statements to support the transformation, alongside a corporate re-branding.
- The Strategy is expected to be published in May.

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 we have seen strong uptake in alternative pathways as reflected through our increase in H&T (up to c. 14% in line with Trust targets, with examples of higher performance where integrated care hubs have been established in East Kent, up to 16%).

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:

- (Update March) - A high level workforce plan has been developed that aligns to our 5 year strategic plan. This workforce model assumes changes in the skill mix of our workforce over time, as we transition towards an increasingly virtual model of delivery of care, whilst preserving our blue-light emergency response.
- A detailed workforce plan and integration with system workforce plans will be taken into 24/25 objectives as part of the preparation for implementation of the strategy, as well as creating links to enabling strategies such as clinical education or recruitment.

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.

(Update March) – The ADS is now online and we will start to use the data to help inform the transformation activities which will take place from 24/25, in particular in setting up the Care Navigation Hubs and maximising learning from the navigation hubs in east kent.

	Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
SP4	There is a risk that the governance of the system does not support SECAmb in delivering 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.

(Update March) – The governance has been working effectively for 9 months, and we still believe it is the right approach for the organisation to engage across multiple systems. Further refinement will need to be done to continuously improve in 24/25 to:

- Support delivery of the strategy and transformational activities
- Confirm alignment with emerging regional organisational structure to align with ICB footprints and this governance model we have introduced.

	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.

Goal 3		Risk Description	Initial Score C + L	Current Score C + L	Target Score C + L
In Year Risks to achieving the objectives	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			Feb 23	Apr 23	Jun 23	Aug 23	Oct 23	Dec 23	Feb 24	Apr 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	08	⇔	08	April 24
348	*Culture & Leadership*	PC	-	1-3	-	-		16	16	16	16	16	16	16	16	16	⇔	08	Mar 25
16	*Financial Sustainability*	FIC	-	-	-	3		16	16	12	12	12	12	12	12	12	⇔	08	April 24
	Cyber Security	FIC											20	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.		
	Accountable Director	Executive Director of HR
	Committee	People Committee
	Initial Risk Score	**20** (Consequence 4 x Likelihood 5)
	Current Risk Score	**08** (Consequence 4 x Likelihood 2)
	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**
Workforce Plan 2023-24 Delivered, with retention being better than assumed. 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.	**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**
(+) Operational Performance in line with plan re C2 (one of best performing amb trusts) (-) Time to Hire (+) Retention (+) Frontline recruitment has been very successful this past year and we are currently 52.5FTE (2.2%) above our planned FTE as at end Jan 24. This is likely to remain over established until year end. Contact centre recruitment is only 3.4FTE below planned (1.3%) Vacancy rate for Trust as at end of Jan 24 overall is 2.39% showing a marked reduction over previous months.	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)

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.

Integrated Quality Report Metrics for Assurance	Variation	Assurance
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 (+)	Longer term recurrent overall budget right-sized to meet the organisational need in light of strategic, regional and national ambulance service requirements (-)

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 (+)	

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	6	1	Chief Medical Officer
Summary of Controls: Four doctors have now been recruited to the SMA rota and a further two posts are out to advert. There is currently cross cover between the four SMAs to ensure the rota is covered adequately. **Board Oversight**: EMB have received regular updates as evidenced in the EMB minutes.					
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 (March)	Forecasted by May 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 - Board have formally approved a direction of travel Plan to exit: - By Q4 we will have to develop a comprehensive strategy that covers a 5-year delivery plan, workforce plan, target operations model, and a sustainable financial plan. - Our next steps include moving into implementation planning and ICBs agreeing on affordability. It's important to note that the Green 'end' rating is dependent on this plan. - Publication of the strategy		

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, an interim CFO, DoS, interim 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 2023 - A new Chair will be appointed in December 2023 and take up post in May 2024. Induction has commenced.		
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 • The ToR for the pre-exit Well-Led Review were approved by the Strategic Advisory Meeting (SAM) in September. • Pre-exit well led review completed in Q3. • The external WLR commissioned by the Trust has concluded and a draft report shared with all parties in February. • The review did not highlight any significant issues not already known to the Board. • The WLR work is on track, reflected in the current green risk rating. Plan to exit: • Clear plan in place for enacting any further findings post Well-Led review in February 2024 • The Trust needs to develop its response to the review recommendations for a green 'end' rating.		

RSP-D3 (New)	There is sustained improvements in executive cohesion and collaboration as measured through the well-led review.	Achieved: • An Executive Development plan was initiated at the end of September 2023. • Informal executive meetings have been taking place and encouraging proactive engagement • Seeing cross referencing through board papers and in the execution of the Quality Summit • Well-Led report completed for review February 2024 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. Risk: • Successful implementation of the new executive team structure is a key success factor for long-term sustainability of the leadership team		
RSP-C1 (previously RSP-L5)	To move towards a more open and transparent culture that values partnership and collaboration. Evidenced by improved transparency and timeliness of reporting and information sharing with ICB partners and with patients.	Achieved: • Arrangements for evidence and data sharing in place since July 2022. • Have agreed a new governance oversight model incorporating contract quality and strategic oversight. This new model became operational in Sept/Oct 24. • Furthermore, we have appointed Quality Leads, a System Lead and Clinical Leads for each system to better align with the ICB structure Plan to exit: • We have improved transparency with our system partners by aligning our key focus areas for the next 9 months through a joint forward plan. • System SMEs to participate in our internal weekly steering group meetings. • We have already embedded a strong governance framework, and our commitment to continuous		

		improvement is reflected in our collaborative efforts in designing this approach, including engagement at the local level with CEOs and the System Assurance Meeting (SAM). • Proposed executive structure includes implementation of regional delivery teams align with ICB boundaries to improve collaborative working • Quality Leads roles to be clarified and defined and made substantive		
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: • Investment in FTSU team, increasing their number from one to three. • Extensive internal training on FTSU for the Board and consultation stage of Speak Up Policy, aligning it with National FTSU guidance. • Ongoing discussions emphasising the importance of evidence of speaking up across various organisational levels and focusing on reducing the trend in numbers of grievances, and the ability to measure and respond to detriment. • Regular meetings between CNO & HR Directorate, CEO and FTSU Guardian to discuss this area of focus. • Leadership training programme for first-line managers in place for 12 months, with over 30% managers completing the programme and over 80% booked. • Staff Survey Results (autumn 2023) – raising concerns improvement from 5.3 to 5.7 year on year. • Data is now available to all managers and the Board to monitor themes and trends, including anonymous concerns and detriment. 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 and focus on reducing the trend in numbers of grievances. • The Trust recognises that it is difficult to get to a stage where it would assess itself as Green in this area, but		

		assures that sustained progress is being made and that it is committed to continuous improvement. • The plan to exit explains how the Trust will measure impact regularly through the implementation of a FTSU dashboard, which will be received by the Board, and ongoing employee pulse surveys that include a tailored question on confidence in speaking up. • The implementation of Building a Kinder SECAmb workshops focuses on using line management safely and behaviors in the workplace, sexual safety workshops, and a charter to foster a culture of inclusivity, safety, and mutual respect within the Trust.		
RSP-C3 (previously RSP-P3)	The Trust has a vision for clinical leadership that is supported by a Board approved clinical education strategy.	Achieved: • 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 and subject to approval with ICBs and Commissioners • Appointment of Band 8b Head of Clinical Education subject to internal approval		
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 will be completed in Q4 to align with 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 • External recommendations from WLR will be included in the Board development plan for 24/25		
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 assurance cycle by Q3 of the quality assurance framework and IQR and assess its effectiveness		

		and update in line with the new strategy (i.e. aligned to new strategic objectives)		
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 Risk: • The Trust is currently (March 2024) showing a planned deficit for 24/25. This is a plan that includes in-year CIP. • The trust is working with system partners to identify a long-term roadmap to achieve sustainability through the lens of the new strategy. • Achieving the changes in the operating model will require full system support in implementation of new clinical care models, in particular for non-emergency patients		
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:		

		• 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. • As of January EOC was 263 WTE vs 266 trajectory planned • In core field services, we have been above plan due to a reduction in attrition sitting at 2436 WTE vs 2386 WTE plan 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, with a detailed workforce plan to be published in 24/25.		
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. • As of January EOC was 263 WTE vs 266 trajectory planned • In core field services, we have been above plan due to a reduction in attrition sitting at 2436 WTE vs 2386 WTE plan 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, with a detailed workforce plan to be published in 24/25.		
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. • A daily sitrep for reporting to the regional team is being setup for sickness reporting		
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. • Staff Survey completed by >60% respondents • NQPS Engagement Scores improved 4.3 to 5.3 July 22 to 23. • Staff Survey Results Engagement Scores improved 5.4 to 5.9 autumn 22 to 23. • Completion of year 1 of the People and Culture implementation plan with c. 40 issues identified by colleagues being completed. Plan to exit: • 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		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
						Likelihood
Catastrophic 5		5	10	15	20	25
Major 4		4	8	12	16	20
Moderate 3		3	6	9	12	15
Minor 2		2	4	6	8	10
Negligible 1		1	2	3	4	5

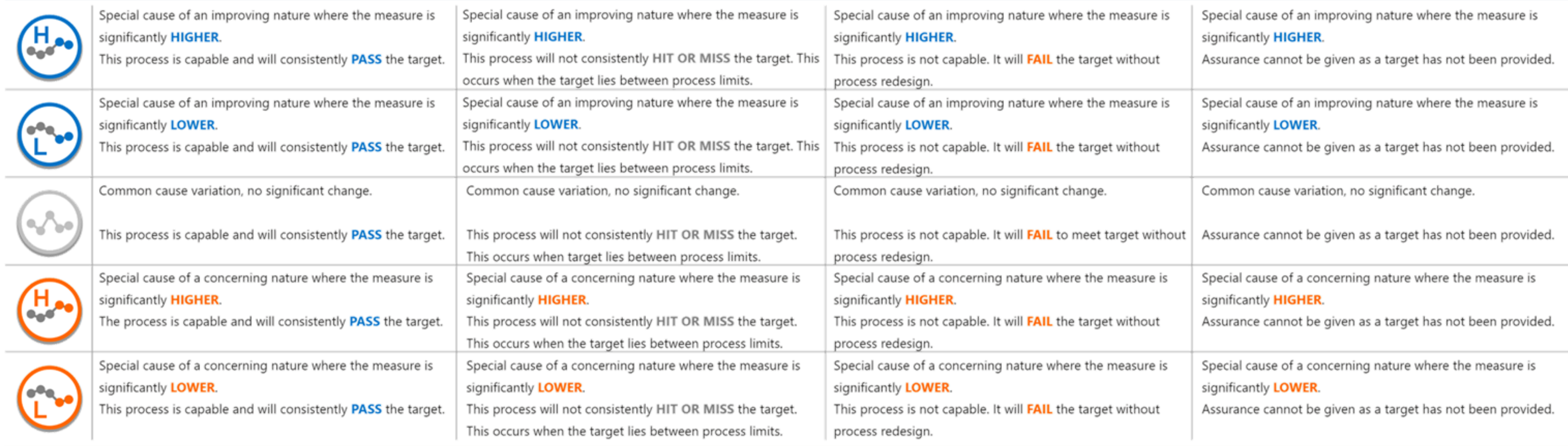
Low	Moderate	High	Extreme

Table of Consequences					
	Consequence Score and Descriptor				
	1	2	3	4	5
Domain:	Negligible	Minor	Moderate	Major	Catastrophic
Injury or harm Physical or Psychological	Minimal injury requiring no / minimal intervention or treatment No Time off work required	Minor injury or illness requiring intervention Requiring time off work < 4 days Increase in length of care by 1-3	Moderate injury requiring intervention Requiring time off work of 4-14 days Increase in length of care by 4-14 days RIDDOR / agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days	Incident leading to fatality Multiple permanent injuries or irreversible health effects
Quality of Patient Experience / Outcome	Unsatisfactory patient experience not directly related to the delivery of clinical care	Readily resolvable unsatisfactory patient experience directly related to clinical care.	Mismanagement of patient care with short term affects <7 days	Mismanagement of care with long term affects >7 days	Totally unsatisfactory patient outcome or experience including never events.

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

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

Appendix 2 - SPC Icon Description



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

Colour	Definition
Blue	**For Exit Criteria** - Exit Criteria achieved and embedded **For Risk** – Only to be used once risk has been mitigated
Red	**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
Amber	**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
Green	**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
Grey	**For Exit Criteria -** Resources just deployed; too early to tell - **can be used for only 1 quarter** **For Risk** – Not applicable

Integrated Quality Report

Trust Board – April 2024

Reporting Period: January & February 2024

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Improving Quality of Information to Board – April 2024

- 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 in the latest period. A review of the IQR will be due in 24/25 to align to the updated BAF and aligned to the new strategic objectives for the organisation.**

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

QUALITY & SAFETY

RESPONSIVE CARE

PEOPLE & CULTURE

SUSTAINABILITY & PARTNERSHIPS

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	Feb-2024	1134		1192.6		
Harm Incidents per 1000 Incidents	Feb-2024	0.6		1.38		
Count of No Harm Incidents	Feb-2024	677		1094.1		
Count of Low Harm Incidents	Feb-2024	60		161.3		
Count of Moderate Harm Incidents	Feb-2024	2		4.95		
Count of Severe & Death Harm Incidents	Feb-2024	3		1.75		

People & Culture

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Sickness Absence %	Feb-2024	6.6%	5%	7.75%		
Statutory & Mandatory Training Rolling Year %	Feb-2024	76.3%	85%	74.79%		
Appraisals Rolling Year %	Feb-2024	63.7%	85%	59.25%		
Freedom to Speak Up: Total Open Cases	Feb-2024	24		23.4		
Freedom to Speak up: Cases Opened in Month	Feb-2024	19	3	8.95		
Freedom to Speak up: Cases Closed in Month	Feb-2024	5		9.55		
Time to Hire - Volume (Days)	Feb-2024	92	60	146.43		

Responsive Care

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Hear & Treat %	Feb-2024	13.6%	14%	10.9%		
999 Frontline Late Finishes/Over-Runs %	Feb-2024	44.8%	45%	48.93%		
Average Late Finish/Over-Run Time	Feb-2024	00:37:00		00:38:57		
999 Call Answer Mean	Feb-2024	00:00:07	00:00:05	00:00:39		
Cat 2 Mean	Feb-2024	00:25:50	00:30:00	00:31:28		

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.

Quality & Safety

QUALITY & SAFETY

Summary

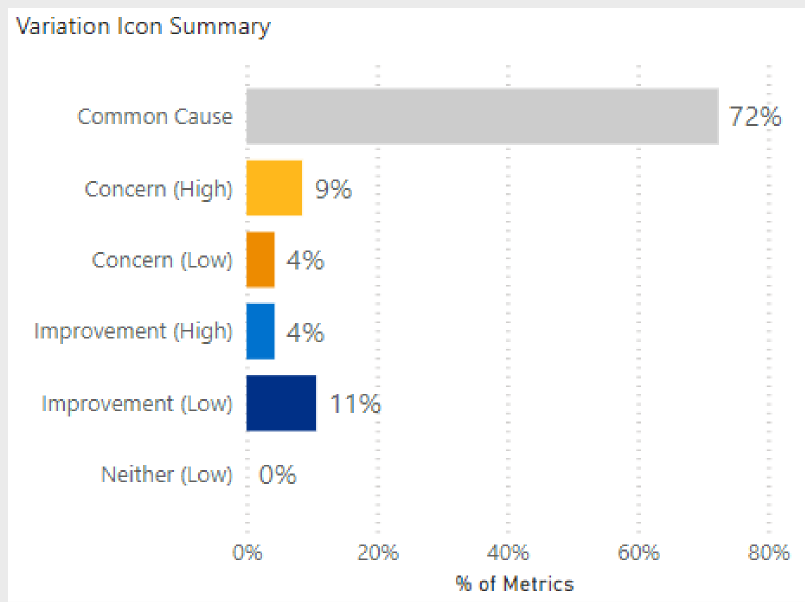
February 2024

	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Complaints Reporting Timeliness %	Medicines Management % of Audits Completed	Harm Incidents per 1000 Incidents Complaints per 1000 999 Calls Answered Proportion of Complaints Relating to Crew Attitude % Outstanding Actions Relating to SIs, Outside of Timescales
Common Cause		Acute ST-Elevation Myocardial Infarction (STEMI) Call to A... Stroke - Call to Hospital Arrival Mean Duty of Candour Compliance % Hand Hygiene Compliance % Deep Clean Compliance %	Compliant NHS Pathways Audits (EMA) % Number of CD Breakages	Number of Medicines Incidents Number of Incidents Reported as SIs Health & Safety Incidents Manual Handling Incidents Number of Complaints Number of Compliments No Harm Incidents per 1000 Incidents Count of Low Harm Incidents Count of Moderate Harm Incidents
Special Cause Concern		Compliant NHS Pathways Audits (Clinical) % **Acute STEMI Care Bundle Outcome %		Count of Severe & Death Harm Incidents Count of No Harm Incidents Violence and Aggression Incidents (Number of Victims - St... Number of Datix 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 (1 of 3)



Assurance Icon Summary

Hit or Miss 88%

Fail 12%

Pass 0%

0% 20% 40% 60% 80%

% of Metrics

Incidents

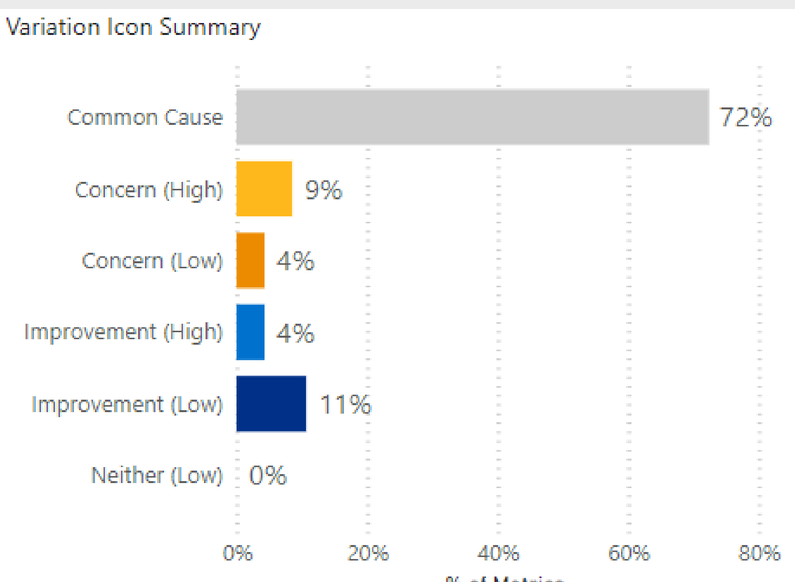
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Feb-2024	166		113.87	172.25	230.63		
Number of CD Breakages	Quality Improvement	Feb-2024	16	0	3.82	21.6	39.38		
Number of Datix Incidents	Quality Improvement	Feb-2024	1452		1058.77	1434.25	1809.73		
Number of Incidents Reported as SIs	Quality Improvement	Feb-2024	0		-3.94	3.9	11.74		
Duty of Candour Compliance %	Quality Improvement	Feb-2024	83%	100%	71.08%	88.37%	105.66%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Feb-2024	125		85.86	117.5	149.14		
Number of RIDDOR Reports	Quality Improvement	Feb-2024	8		2.48	11.3	20.12		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Feb-2024	6		-4.21	15.95	36.11		
Health & Safety Incidents	Quality Improvement	Feb-2024	26		13.06	30.7	48.34		

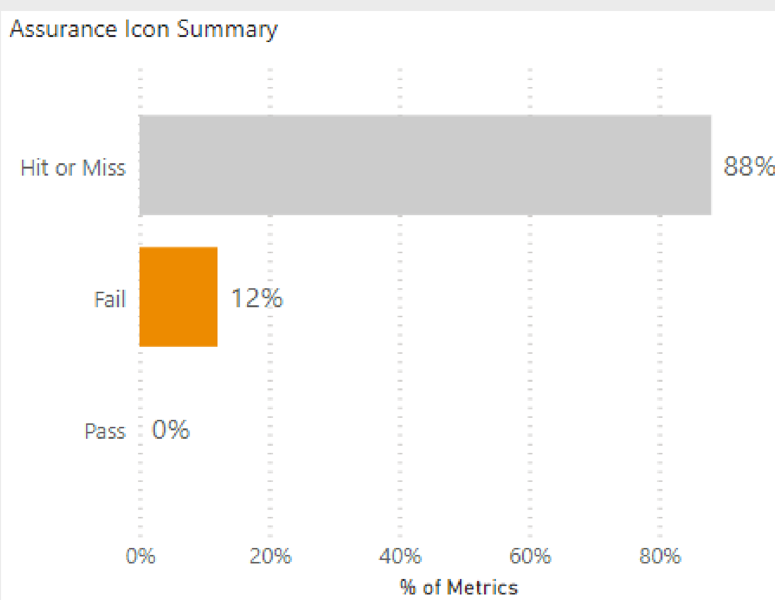
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Feb-2024	0%		0%	0%	0%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Feb-2024	38%		41.12%	61.7%	82.28%		
Complaints Reporting Timeliness %	Quality Improvement	Feb-2024	94%	95%	47.31%	79.65%	111.99%		
Number of Complaints	Quality Improvement	Feb-2024	44		19.09	67.95	116.81		
Complaints per 1000 999 Calls Answered	Quality Improvement	Feb-2024	0.55		-188.98	104.5	397.97		
Number of Compliments	Quality Improvement	Feb-2024	145		14.73	166.67	318.6		
No Harm Incidents per 1000 Incidents	Quality Improvement	Feb-2024	11.17		8.08	10.51	12.93		
Harm Incidents per 1000 Incidents	Quality Improvement	Feb-2024	1.12		0.68	1.41	2.15		

QUALITY & SAFETY

Overview (2 of 3)





Clinical Effectiveness & Patient Outcomes

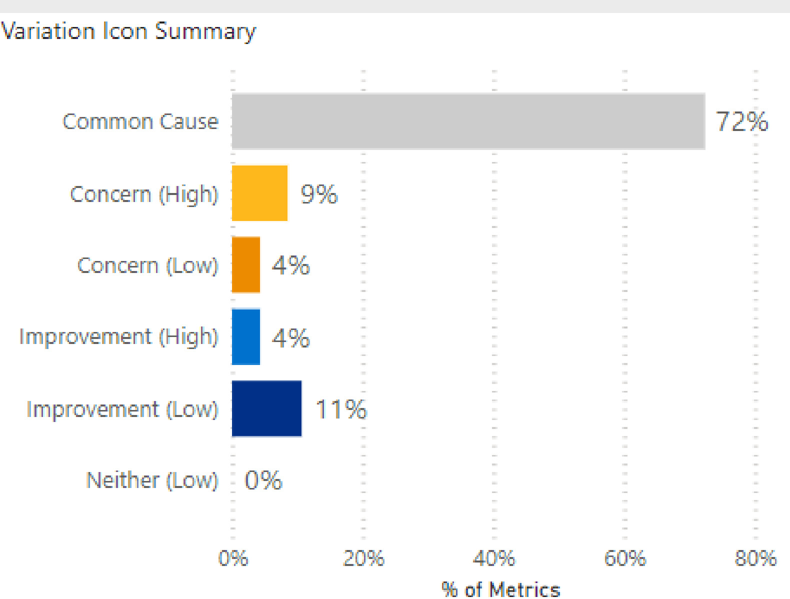
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Jan-2024	54.6%	45.1%	30.34%	50.3%	70.26%		
**Cardiac ROSC ALL %	Quality Improvement	Jan-2024	25.2%	23.8%	17.85%	27.35%	36.85%		
**Sepsis Care Bundle %	Quality Improvement	Jan-2024	86.9%	85%	82.39%	87%	91.61%		
**Cardiac Survival Utstein %	Quality Improvement	Nov-2023	11.4%	25.6%	2.57%	15.67%	28.77%		
**Cardiac Survival ALL %	Quality Improvement	Nov-2023	42.9%	9.6%	0.89%	24.25%	47.61%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Jan-2024	78.5%	76.8%	61.56%	72.19%	82.81%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Jan-2024	70.2%	64.7%	60.77%	70.89%	81.01%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Sep-2023	02:36:00	02:22:00	02:14:44	02:35:04	02:55:24		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Sep-2023	03:30:00	03:14:00	02:58:47	03:36:36	04:14:25		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Sep-2023	01:36:00	01:29:00	01:14:35	01:35:52	01:57:09		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Sep-2023	02:29:00	02:20:00	01:38:14	02:28:24	03:18:34		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Jan-2024	96.7%	96.3%	95.75%	97.61%	99.47%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Jan-2024	93.4%	93.8%	87.27%	92.84%	98.41%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Jan-2024	77.3%	77.9%	68.63%	78.71%	88.78%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Feb-2024	108%		85%	103.06%	121.12%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Feb-2024	78.8%	100%	76.58%	83.81%	91.03%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Feb-2024	79.7%	100%	69.3%	87.21%	105.12%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Feb-2024	101.8%	100%	91.88%	100.06%	108.23%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Feb-2024	34.5%		15.95%	56.34%	96.73%		

Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Feb-2024	81.8%	90%	73.17%	86.36%	99.55%		
Deep Clean Compliance %	Quality Improvement	Feb-2024	84%	100%	65.16%	86.34%	107.53%		

QUALITY IMPROVEMENT

Overview (3 of 3)



Assurance Icon Summary

	% of Metrics
Hit or Miss	88%
Fail	12%
Pass	0%

Health & Safety

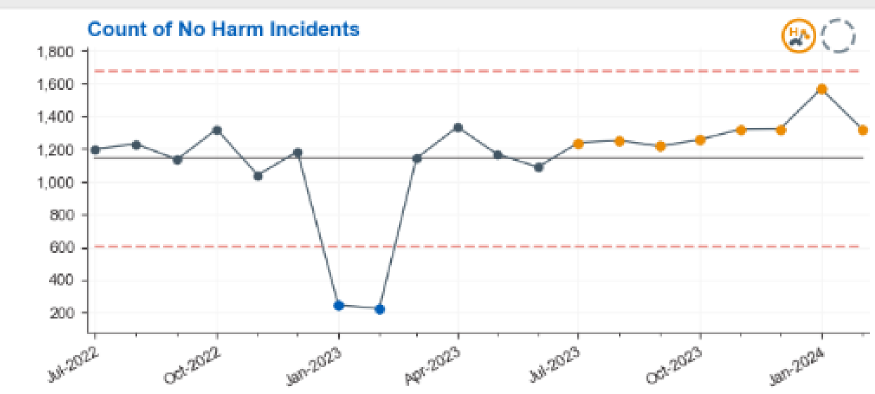
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Manual Handling Incidents	Quality Improvement	Feb-2024	21		9.03	27.65	46.27		
Organisational Risks Outstanding Review %	Quality Improvement	Feb-2024	37%	30%	-2.5%	32.05%	66.6%		

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		41.07			
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Oct-2023	36	0		52.57			
Medicines Management % of Audits Completed	Quality Improvement	Feb-2024	96.2%	100%	82.21%	90.74%	99.27%		
PGD Compliance %	Quality Improvement	Feb-2024	88.9%	100%		77.05%			
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Feb-2024	128%	100%	-5.75%	67.17%	140.08%		

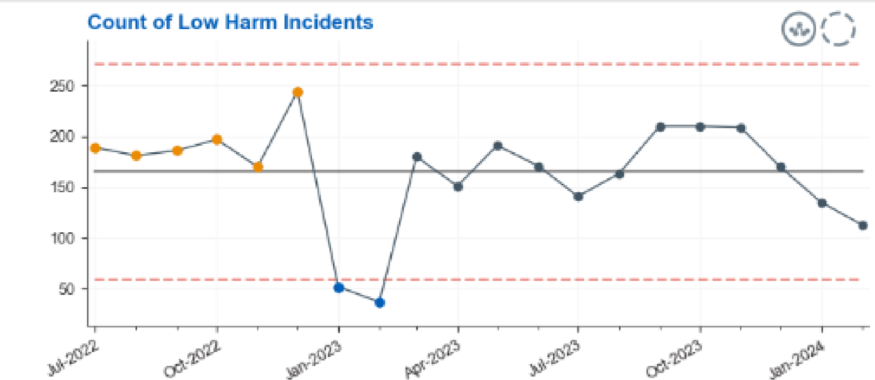
QUALITY & SAFETY

SIs, Incidents, & Duty of Candour



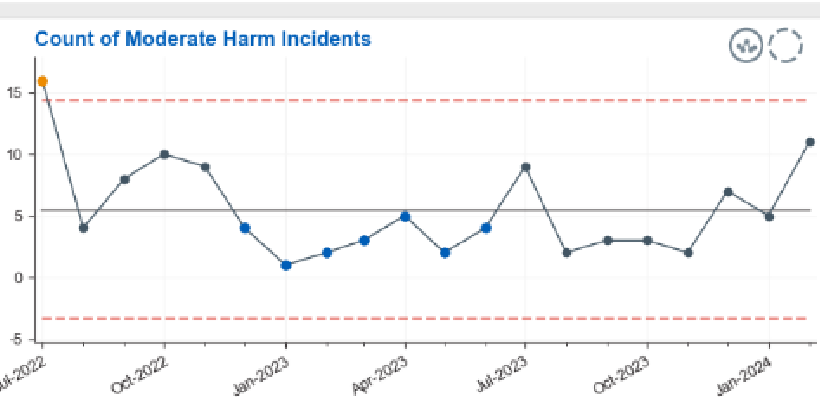
QS-30
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1320

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



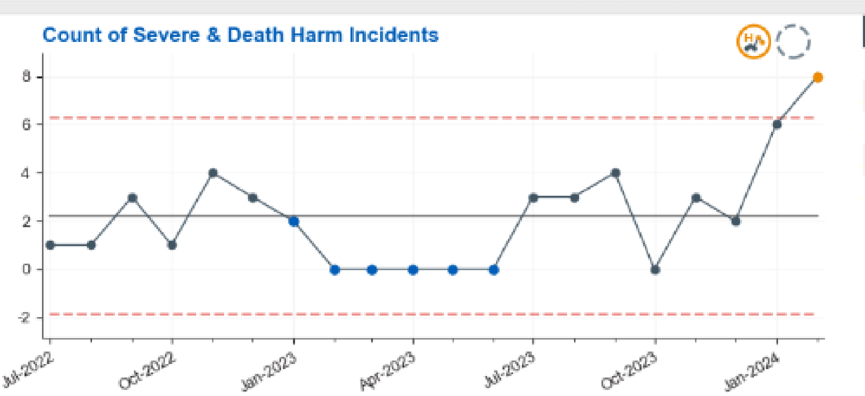
QS-31
Dept: Quality & Safety
IP: Quality Improvement
Latest: 113

Common cause variation, no significant change.



QS-32
Dept: Quality & Safety
IP: Quality Improvement
Latest: 11

Common cause variation, no significant change.



QS-33
Dept: Quality & Safety
IP: Quality Improvement
Latest: 8

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

Summary

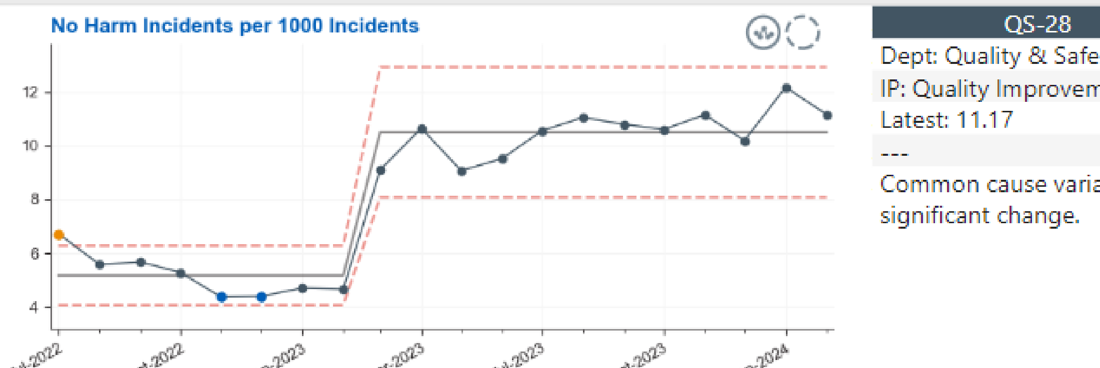
(QS-1) Number of Datix incidents - The Trust continues to evidence an effective culture of incident reporting and management in line with policy. However, February's reporting number does reflect a drop, which could be attributed to the switch over to the new DCIQ incident module and the software issues that followed which resulted in using two systems in the period. Additionally, February is a shorter month which could equate to approximately 200 less incidents.
(QS-17) Outstanding actions relating to SIs– Regular monitoring and scrutiny of actions continues to help keep them on track.
(QS-2) Number of incidents reported as Serious Incidents– The number of incidents reported as SIs is within normal variation. During February, no SIs were recorded as the Trust transitioned to the new PSIRF model 29 January 2024 Moving forward, this metric will not appear on the IQR.
(QS-3) Duty of Candour Compliance – Duty of Candour for declared Serious Incidents saw a slight dip as the transition to PSIRF saw a change in processes and responsibilities. This process is now a standard process for review at the weekly IRG's, so we now expect to see 100% compliance consistently applied.

What actions are we taking?

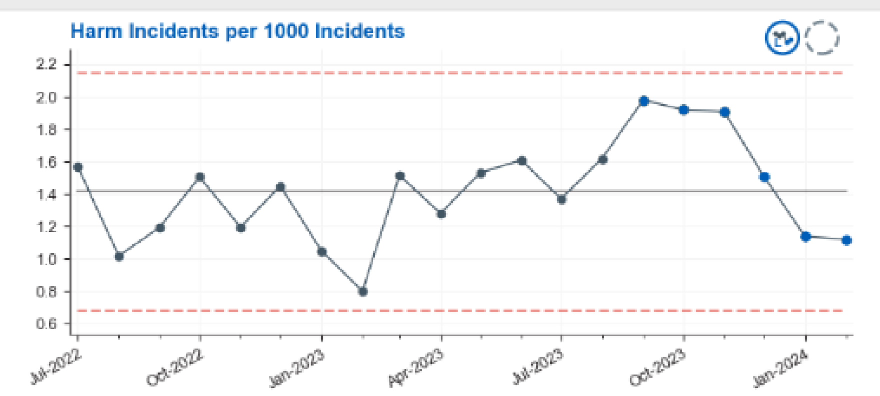
(QS-1) Non-SI incidents and (QS-2 / 17) SI actions

- The new DCIQ incident module went live on 29th January but had some software issues which resulted in the temporary return to DatixWeb. The issues were resolved and DCIQ relaunched on 19th February, without issue.
- It is known that 29 incident records submitted by AAPs/Techs were lost. OUMs were contacted and asked to reach out to this group so they could re-submit their incidents. Unfortunately, it is not possible to identify if these incidents have been resubmitted; unless the reporters specifically highlight them.
- The last of the outstanding SI reports and actions are being progressed and reviewed by all teams. SI action holders are held to account by PS Team. There are a few SI reports from SIs declared in January that are still being investigated as per the SI Framework. Consequently, the actions identified from these reports will also need to be added to the outstanding action list so this will potentially increase before improving. We aim to have all actions completed and closed for SIs by the end of 2024 in line with our transition plan to PSIRF.

Harm



QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 11.17
Common cause variation, no significant change.



QS-29
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1.12
Special cause of an improving nature where the measure is significantly LOWER.

Summary

QS-28 No Harm incidents per 1000 incidents – the number of these incidents reported has remained relatively static since July 2023. However, there has been a steep decline for February which could be as a result of the changes in system and the shorter reporting month.

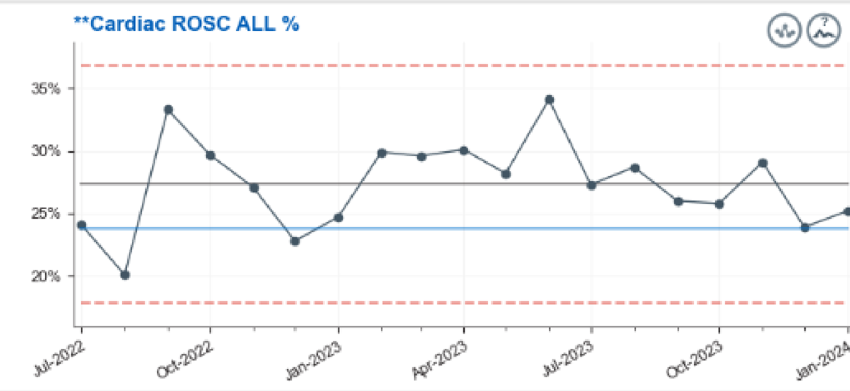
QS-29 Harm incidents per 1000 incidents - the number of these Incidents shows a continuing downward trend since November. Until now this reduction had not coincided with a reduced number of incidents reported, but in February it has.

What actions are we taking?

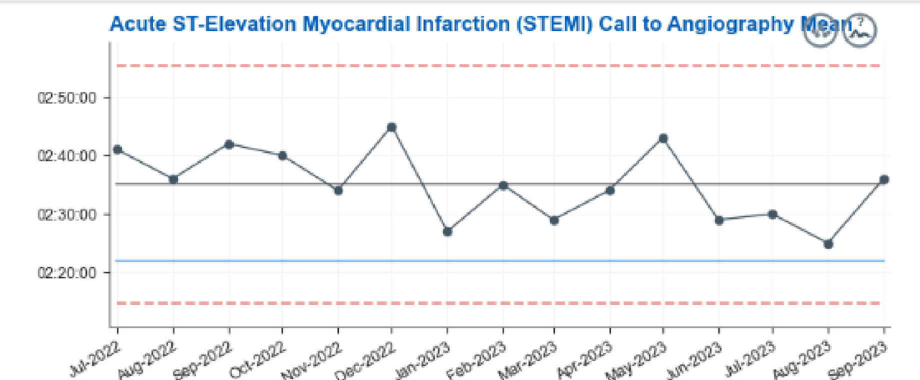
- As PSIRF has now launched all patient safety incidents are being reviewed by the Patient Safety Team, irrelevant of harm. This allows for any new trends to be identified, monitored and investigated.
- Harm attributed to incidents will be monitored to ensure the change to DCIQ and the introduction of Learning From Patient Safey Events (LFPSE) does not impact the previous consistent approach.
- Developing our organisational approach to establishing a learning framework (OLF). The OLF stakeholder engagement commences in the coming month. This will support the further development of the framework ready for a rollout during the Summer.

QUALITY & SAFETY

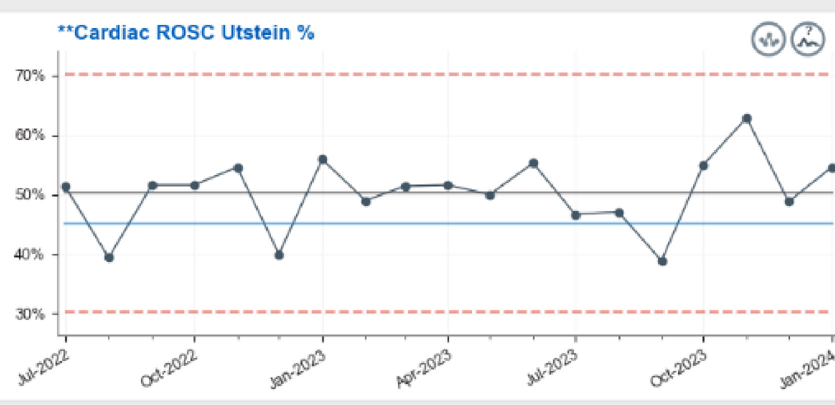
Impact on Patient Care - Cardiac



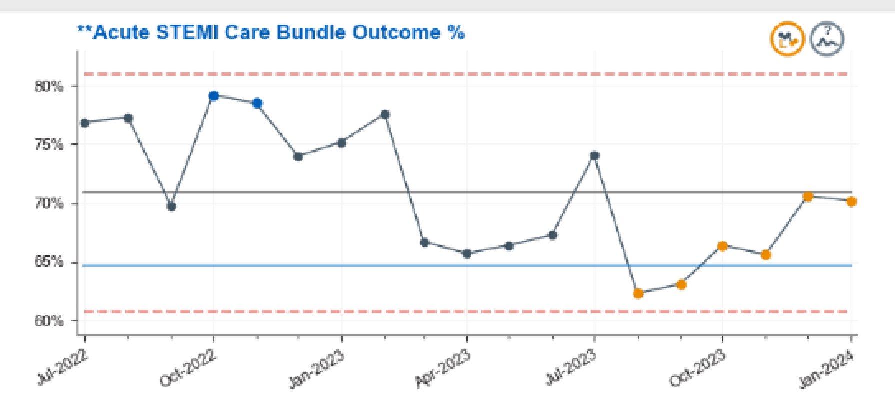
M-2
Dept: Medical
IP: Quality Improvement
Latest: 25.2%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-6
Dept: Medical
IP: Quality Improvement
Latest: 02:36:00
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: 54.6%
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: 70.2%
Target: 64.7%
Special cause of a concerning nature where the measure is significantly LOWER. 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.

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

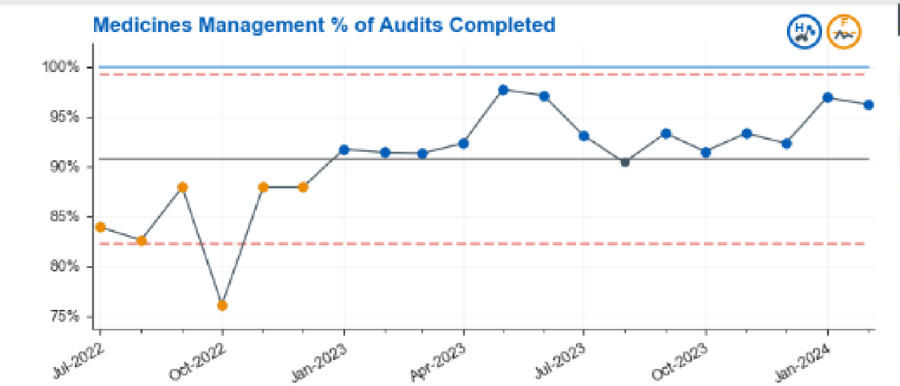
STEMI care bundle is currently being reviewed nationally and it is hoped that a bundle that has more evidence of patient benefit is forthcoming

QUALITY & SAFETY

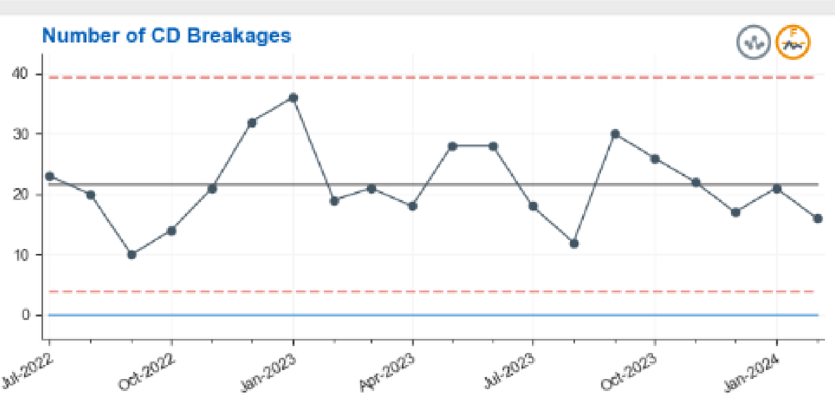
Medicines Management (1 of 2)

MM-1
Dept: Medicines Management
IP: Quality Improvement
Latest: 166

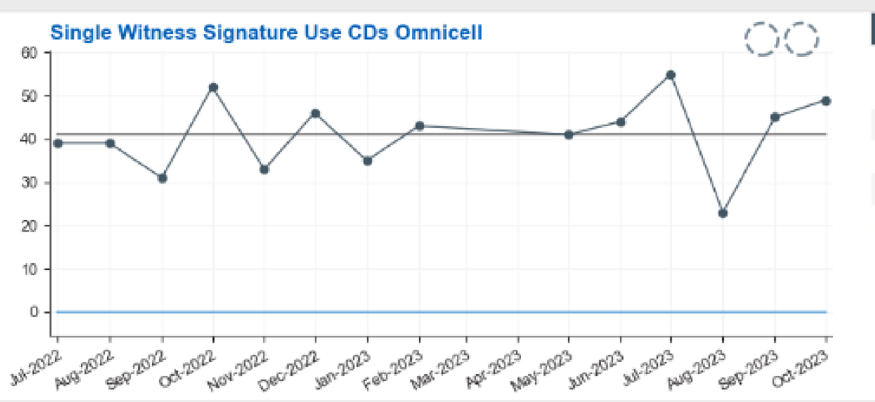
Common cause variation, no significant change.



MM-7
Dept: Medicines Management
IP: Quality Improvement
Latest: 96.2%
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: 16
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
Special cause or common cause cannot be given as there are an insufficient number of points.

Summary

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 continues to show positive special cause variation.

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?

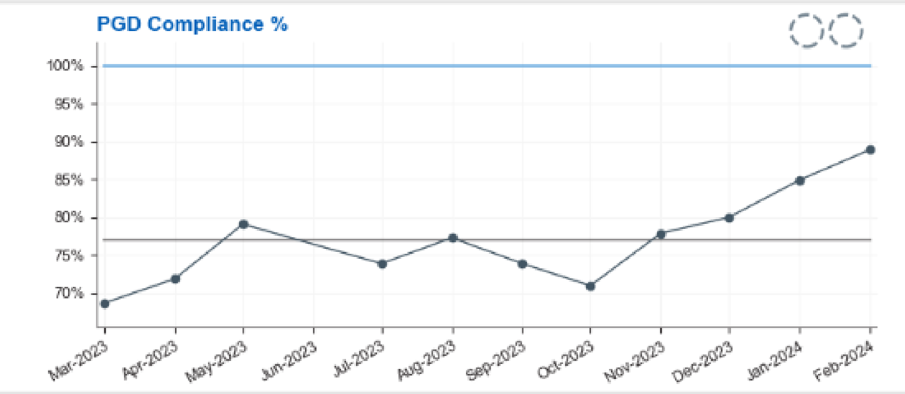
The new compliance audit system is going live.

The new MedX software on our Omnicell units has successfully gone live allowing us greater monitoring and tracking of medications.

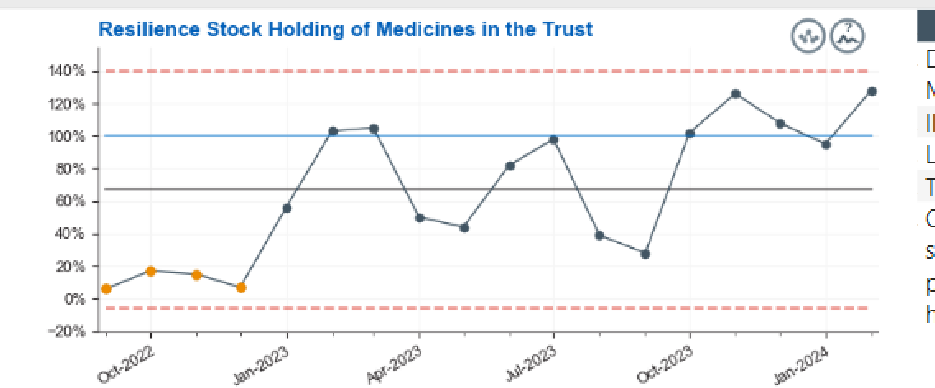
The new Medicines Safety Officer is in post and has started the review of incidents and how we can learn from them.

QUALITY & SAFETY

Medicines Management (2 of 2)



MM-8
Dept: Medicines Management
IP: Quality Improvement
Latest: 88.9%
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: 128%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

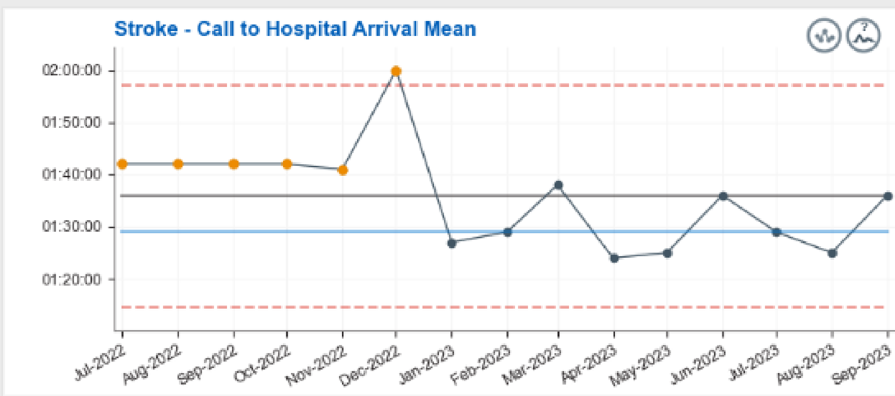
Patient Group Directions (PGDs) compliance is at 88.9% and showing an improving picture following focussed work with operational teams. Resilience stock continues to remain high

What actions are we taking?

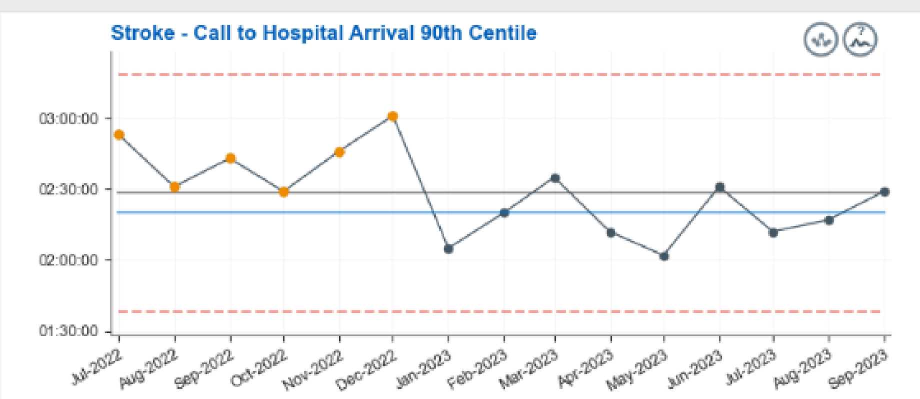
Operational Managers are now receiving data on PGD compliance for all of their individual staff enabling them to provide local targeted support to colleagues to complete their PGD training and compliance.

QUALITY & SAFETY

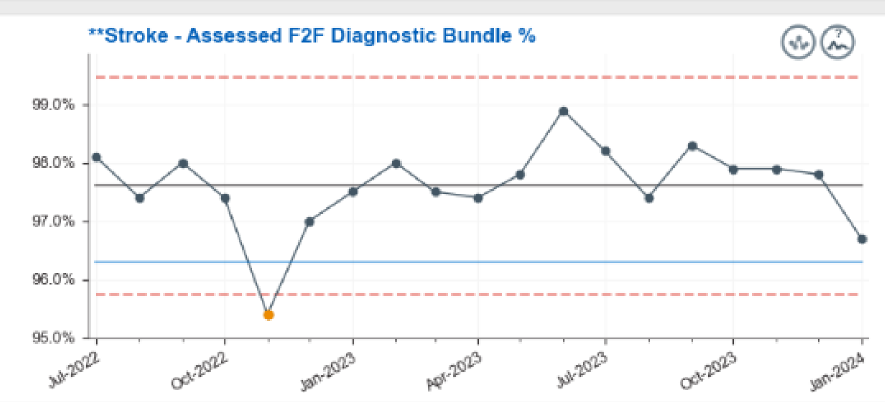
Impact on Patient Care – Stroke



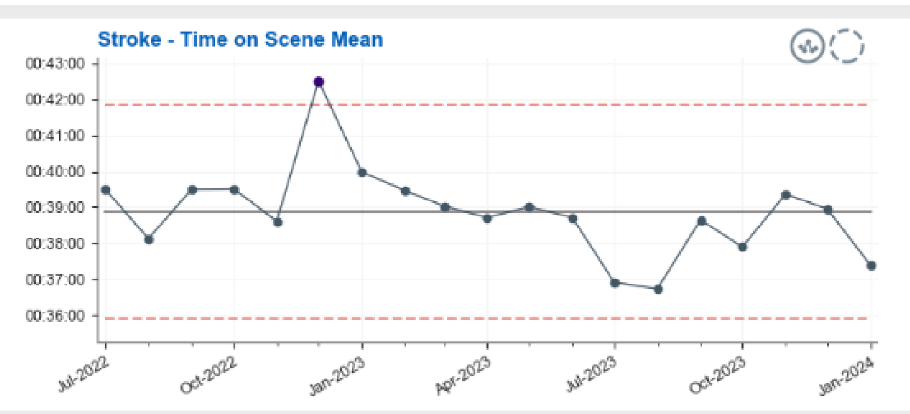
M-8
Dept: Medical
IP: Quality Improvement
Latest: 01:36:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-9
Dept: Medical
IP: Quality Improvement
Latest: 02:29:00
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: 96.7%
Target: 96.3%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-28
Dept: Medical
IP: Quality Improvement
Latest: 00:37:23
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.

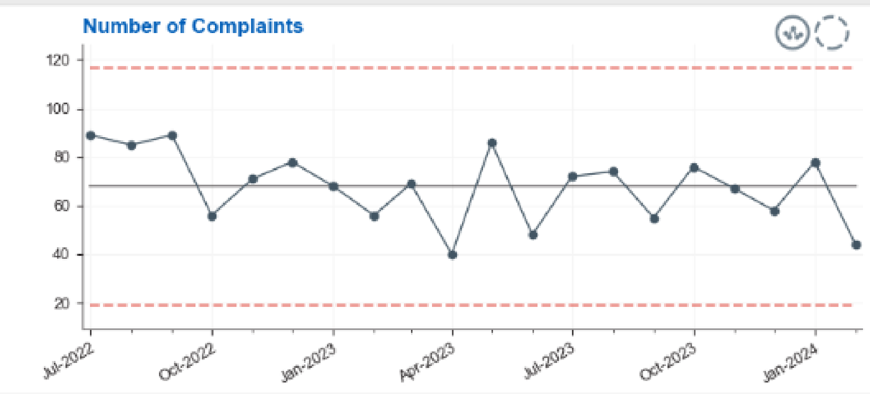
Stroke Time on scene mean. Common Cause variation.

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



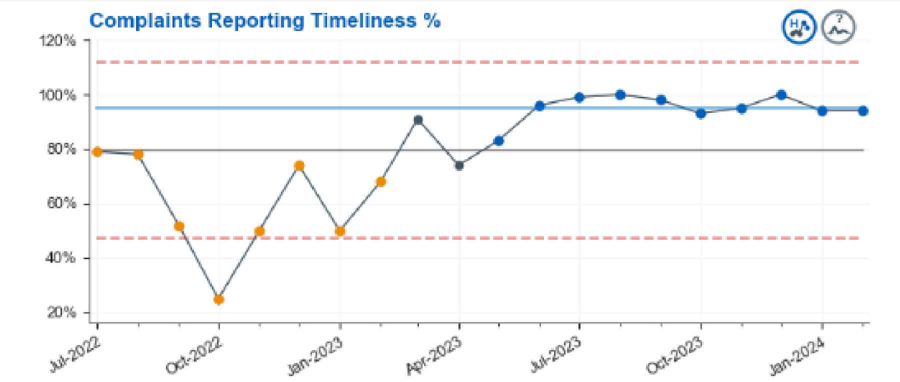
QS-5

Dept: Quality & Safety

IP: Quality Improvement

Latest: 44

Common cause variation, no significant change.



QS-4

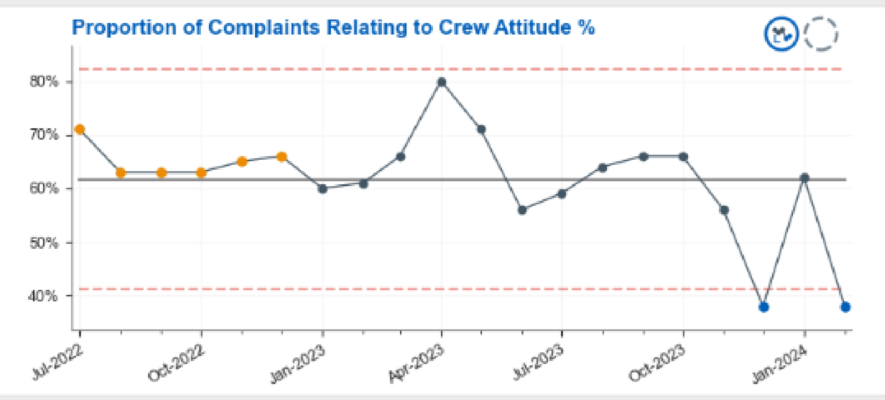
Dept: Quality & Safety

IP: Quality Improvement

Latest: 94%

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

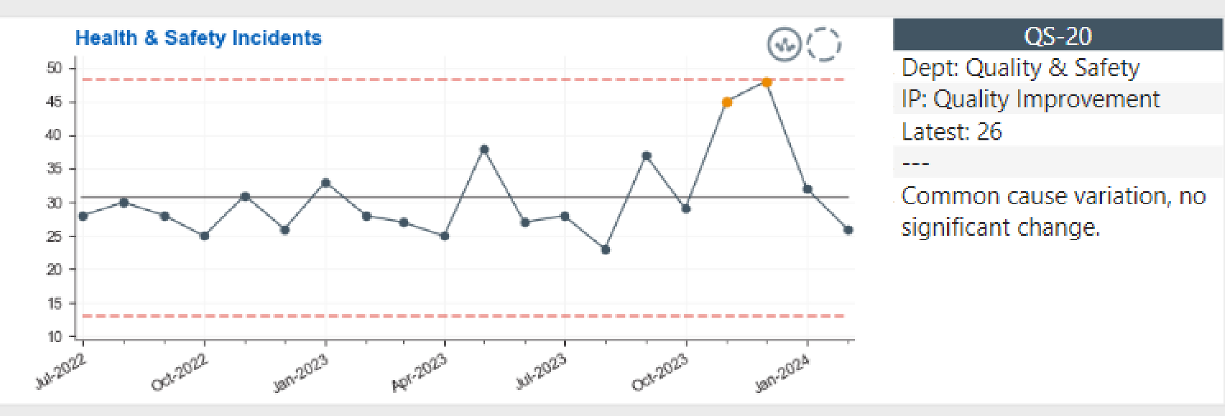
- The number of complaints received is showing normal variation. No concerns / issues.
- The number of complaints relating to crew attitude was within normal parameters in January but reduced again in February to under 40%. This variation in the no. of complaints is attributable to the work that has been done through a deep dive into staff conduct / attitude complaints over the past three years. The deep dive has been shared with the PALS team who are now seeking to categorise complaints more effectively. The reduction is also likely to have been impacted by the migration to DCIQ which has meant that there is likely to be less errors in categorisation. He improvement actions recommended following the deep dive, the proportion of complaints relating to crew attitude is expected to decrease. This will be monitored by the PALS team over the next 6 months.
- Timeliness in responding to complaints has now seen consistent improvement since June 2023 and was just below the 95% target for January and February 2024 due to delays in operational teams returning complaint reports due to staff sickness. This has been discussed with the relevant teams to avoid reoccurrence in the future.

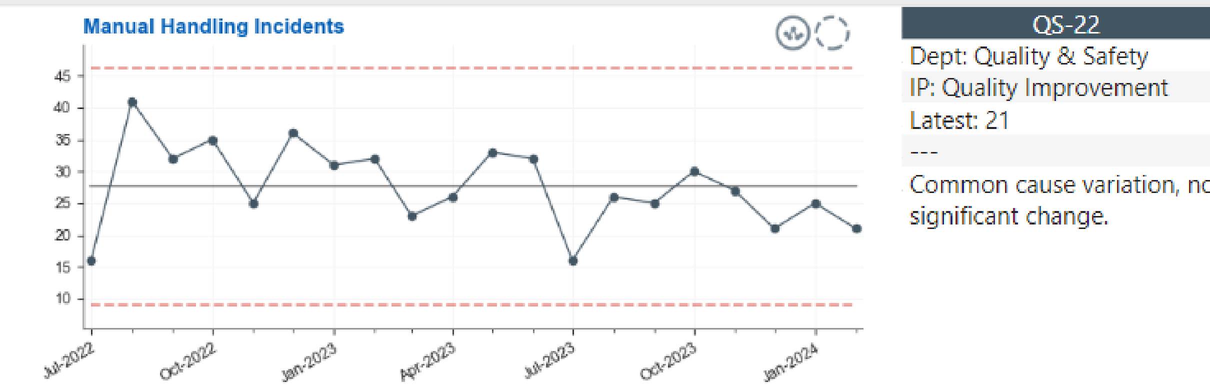
What actions are we taking?

- The deep dive into crew conduct / attitude complaints has been completed and the report is to be presented at the next QGG and People Committee on the 09 July 2024.. There were several areas identified for learning for the Trust which have begun to be implemented.

QUALITY & SAFETY

Safety in the Workplace (1 of 3)





Health & Safety Incidents

Health & Safety incidents are showing normal variation with no concerns / issues identified.

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

- Cuts and Abrasions
- Slips, Trips and Falls
- Environmental issues

What are we doing

- The regional and Trust-wide Health & Safety groups will continue monitoring incident trends and identifying opportunities for improvement.
- The H&S Managers have started a deep dive review into slips, trips and fall incidents to identify learning and actions to improve.
- 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.
- 2- minute internal video was published on the staff intranet reminding staff about the requirements for RIDDOR
- The H&S team are currently reviewing governance processes to ensure the Trust receives assurance on all H&S matters.
- A comprehensive review of the Trust's H&S function is planned.

Manual Handling Incidents

No significant variation

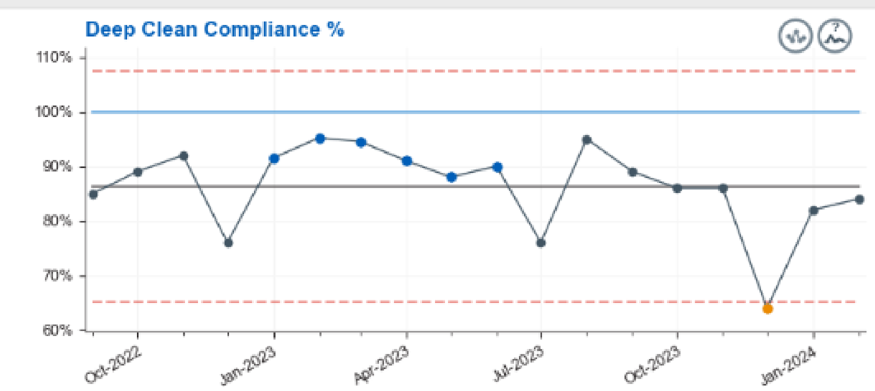
Paramedics and ECSW reported the highest number of manual handling incidents during this period.

What are we doing

- The regional and Trust-wide Health & Safety groups will continue monitoring incident trends.
- The H&S team are currently reviewing governance processes to ensure the Trust receives assurance on all H&S matters.

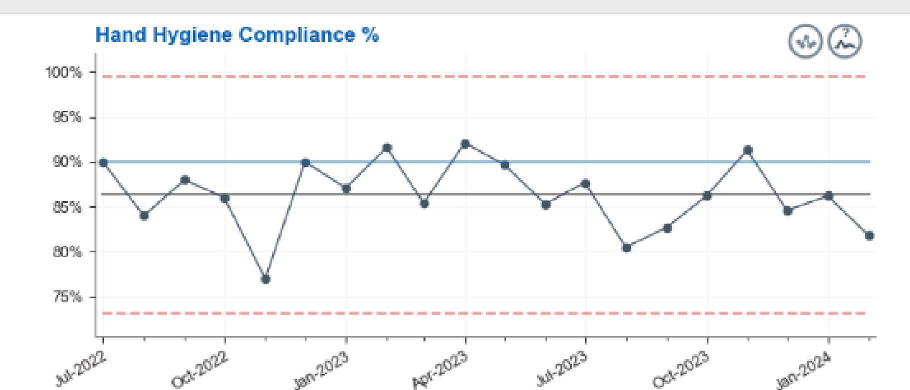
QUALITY & SAFETY

Safety in the Workplace (2 of 3)



QS-19

Dept: Quality & Safety
IP: Quality Improvement
Latest: 84%
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: 81.8%
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 February 2024. During the previous two months the IPC Team have sought stakeholder engagement and shared the new IPC Practice Reviews with local teams. These will be implemented to replace the old style of audits from the 1st April 2024.

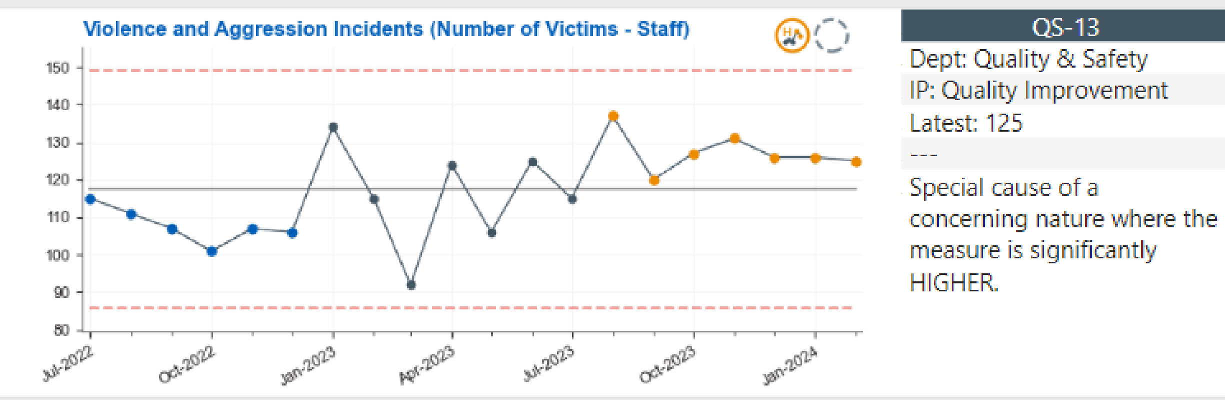
The new reviews have received positive feedback from staff, and it is hoped that the information collected will provide a truer reflection of compliance with all IPC practices, providing the team with data to drive improvements across the Trust.

What Actions are we taking?

- New IPC Practice Reviews to commence from the 1st April 2024. The new single MS Form will cover the 4 previous IPC audits that were completed by the OTLs. Each month there will be between 3 and 6 questions depending on what treatment is given and the infection risk of the patient. These will rotate every quarter. The hope is that this will improve staff compliance with IPC practice and improve staff infectious related sickness which will continue to be monitored by the team.
- New dashboard for local Dispatch Desks will also be introduced to monitor compliance locally
- Full review of the new system to take place at the end of Q1.

QUALITY & SAFETY

Safety in the Workplace (3 of 3)



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 125

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

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 119 per month. Assaults have not risen significantly over the last 6 months. There is a rise in verbal abuse in January that can be attributed to incidents reported by call handling centres.

Staff reported 136 violence and aggression related incidents in January 2024.
The sub-categories of these incidents are shown below:

- 70 verbal abuse
- 36 Anti-Social Behaviour
- 25 assaults

Staff reported 123 violence and aggression related incidents in February 2024.
The sub-categories of these incidents are shown below:

- 58 verbal abuse
- 32 Anti-Social Behaviour
- 24 assaults

What actions are we taking?

- A task & finish group has concluded the action from the HSE visit in relation to violence and aggression.
- Face to Face Conflict Resolution Training (CRT) is scheduled to commence for road staff in April 2024. Two new Trainers have been recruited into post to deliver this and resilience is provided through four other staff members also 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 providing increased coverage and support across the Trust.
- Monthly partnership meetings are held with police to provide updates on cases involving our staff.
- Carriage of Body Worn Cameras (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 violence and aggression 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.

People & Culture

PEOPLE & CULTURE

Summary

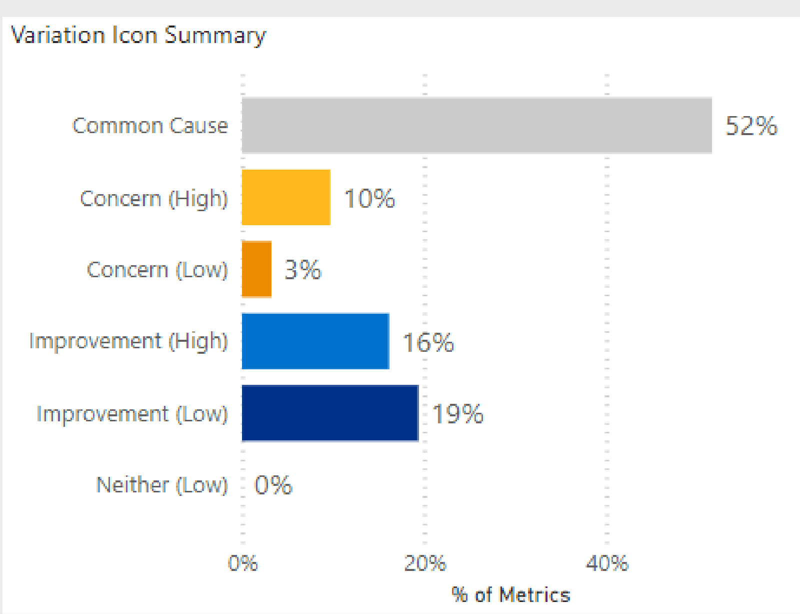
February 2024

	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Turnover Rate % Bullying & Harrassment Internal 999 Frontline Late Finishes/Over-Runs % Count of Until it Stops Cases	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 % Sexual Safety Workshop Completion %
Common Cause		Vacancy Rate % Individual Grievances Open Count of Grievances Closed % of Meal Breaks Taken Suspension Closures Number of Wellbeing Hub Referrals	Annual Rolling Turnover Rate Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Until it Stops Average Case Length	Freedom to Speak Up: Total Open Cases
Special Cause Concern	DBS Compliance %	Freedom to Speak up: Cases Opened in Month Disciplinary Cases	Grievances Mean Case Length (Days)	

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

PEOPLE & CULTURE

Overview (1 of 2)



Assurance Icon Summary

Hit or Miss 63%

Fail 33%

Pass 4%

0% 20% 40% 60%

% of Metrics

Workforce

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Feb-2024	4398.53	4489.07	4022.43	4131.82	4241.22		
Vacancy Rate %	People & Culture	Feb-2024	2%	5%	0.28%	6.02%	11.76%		
Turnover Rate %	People & Culture	Feb-2024	1%	0.8%	0.52%	1.4%	2.28%		
Annual Rolling Turnover Rate	People & Culture	Feb-2024	17.9%	10%	17.33%	18.18%	19.03%		
Sickness Absence %	People & Culture	Feb-2024	6.6%	5%	6.07%	7.75%	9.43%		
DBS Compliance %	People & Culture	Feb-2024	93.2%	90%	96.07%	98.7%	101.33%		
Current licence details held for Operational Staff %	People & Culture	Feb-2024	98.7%	100%	95.72%	97.18%	98.64%		
Time to Hire - Volume (Days)	People & Culture	Feb-2024	92	60		146.43			
Time to Hire - Individual Recruitment (Days)	People & Culture	Feb-2024	85	60		70.79			

Employee Development

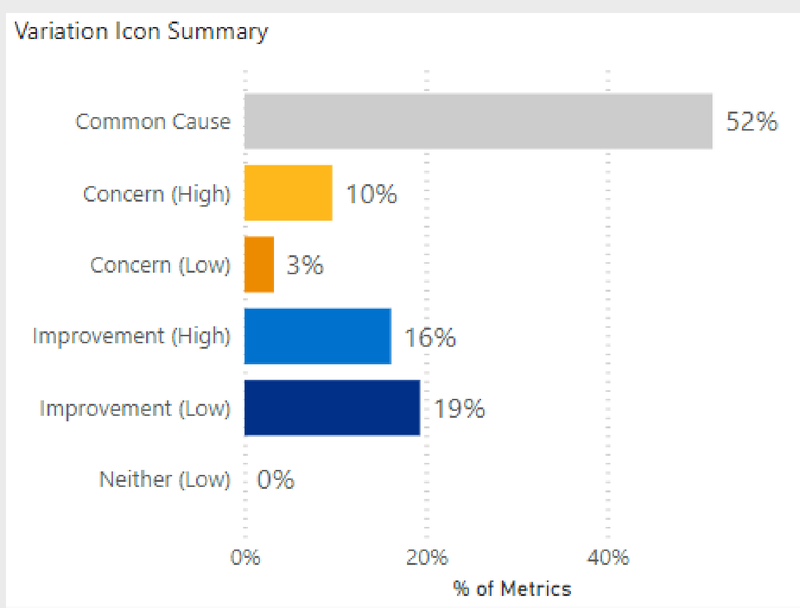
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Feb-2024	76.3%	85%	68.86%	74.79%	80.71%		
Appraisals Rolling Year %	People & Culture	Feb-2024	63.7%	85%	51.64%	59.25%	66.85%		

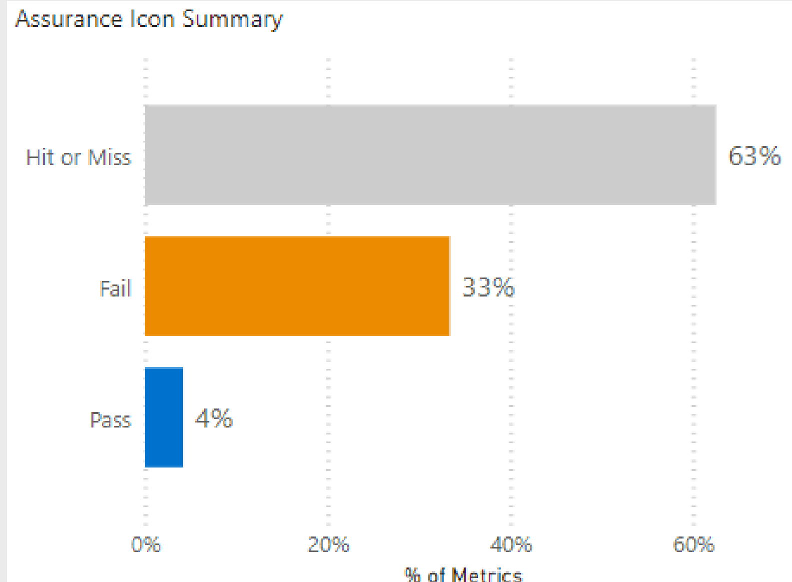
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Feb-2024	44.8%	45%	43.73%	48.93%	54.12%		
Average Late Finish/Over-Run Time	People & Culture	Feb-2024	00:37:00		00:35:27	00:38:57	00:42:27		
% of Meal Breaks Taken	People & Culture	Feb-2024	97.8%	98%	96.87%	98.19%	99.51%		
% of Meal Breaks Outside of Window	People & Culture	Feb-2024	46.6%		42.9%	55.99%	69.08%		

PEOPLE & CULTURE

Overview (2 of 2)





Culture

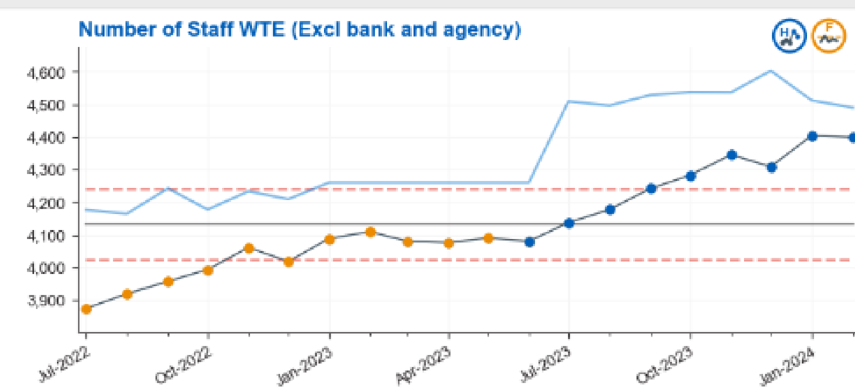
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Feb-2024	12	5	1.63	13.25	24.87		
Collective Grievances Open	People & Culture	Feb-2024	2	1	-1.81	1.55	4.91		
Count of Grievances Closed	People & Culture	Feb-2024	16	3	0.42	12.6	24.78		
Grievances Mean Case Length (Days)	People & Culture	Feb-2024	189	93	104.11	142.3	180.48		
Bullying & Harrassment Internal	People & Culture	Feb-2024	1	2	-2.41	1.65	5.71		
Disciplinary Cases	People & Culture	Feb-2024	14	3	-1.18	6.1	13.38		
Freedom to Speak Up: Total Open Cases	People & Culture	Feb-2024	24		9.54	23.4	37.26		
Freedom to Speak up: Cases Opened in Month	People & Culture	Feb-2024	19	3	-0.43	8.95	18.33		
Freedom to Speak up: Cases Closed in Month	People & Culture	Feb-2024	5		-4.03	9.55	23.13		
Count of Until it Stops Cases	People & Culture	Feb-2024	1	3	-3.6	2.25	8.1		

Health & Wellbeing

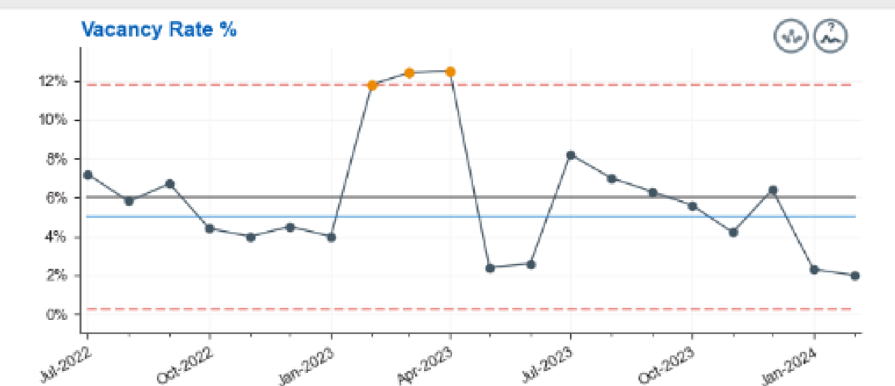
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Feb-2024	127	86	67.05	110.39	153.73		

PEOPLE & CULTURE

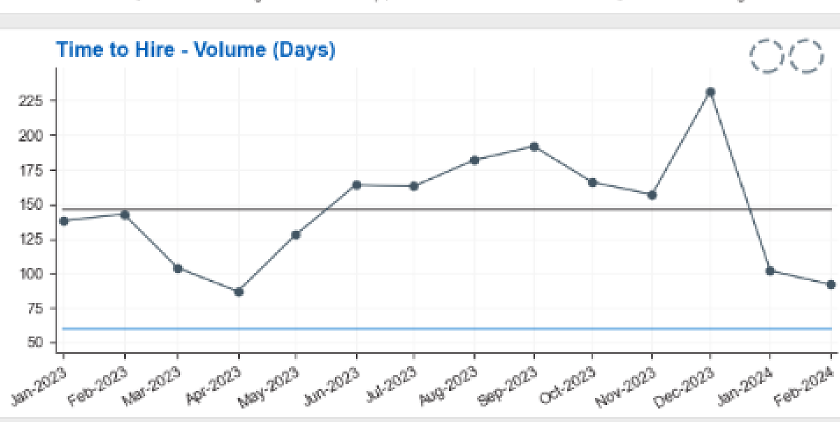
Workforce (1 of 3)



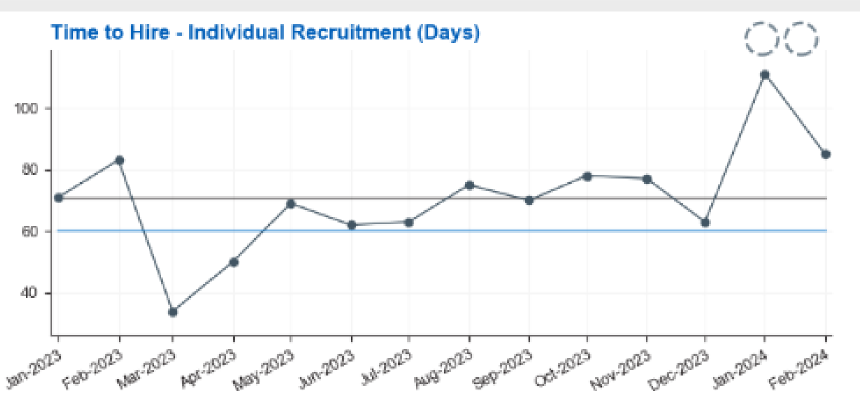
WF-1
Dept: Workforce HR
IP: People & Culture
Latest: 4398.53
Target: 4489.07
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.



WF-4
Dept: Workforce HR
IP: People & Culture
Latest: 2%
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: 92
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: 85
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 and now working days can be referred to when needed. February TTH (working days) was 67, and individual recruitment was 62.

The vacancy rate for February reports the lowest since March 22 and this is a combination of ongoing recruitment and a small decrease in turnover (0.8%)

What actions are we taking?

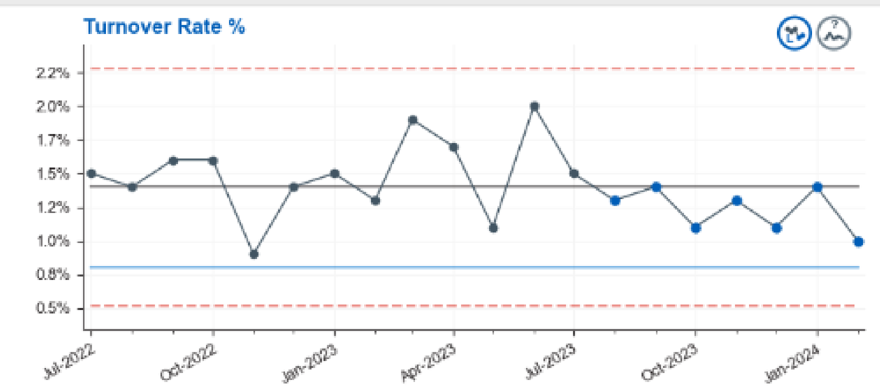
The Quality Improvement recruitment and onboarding project draws to a close at the end of March and new processes identified throughout this will move to BAU. The improvements made are intended to not only reduce TTH when possible *, but also increase candidate engagement, improve the overall experience and reduce attrition longer term.
Enhanced reporting and accurate data now available will ensure that monitoring of changes can continue, along with any future changes.

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.

*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.

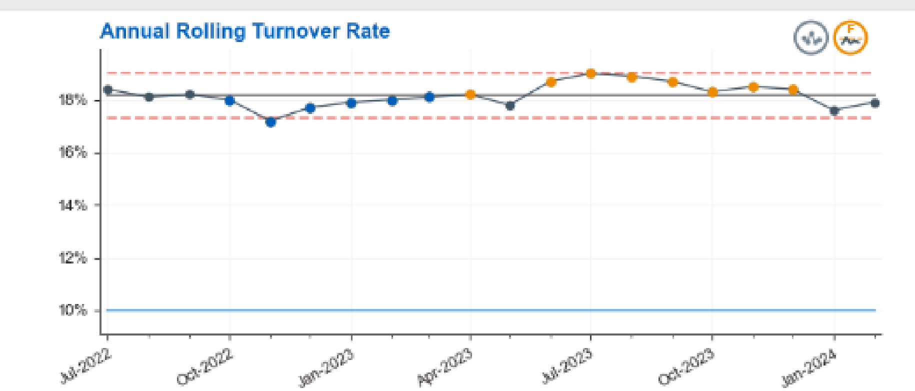
PEOPLE & CULTURE

Workforce (2 of 3)



WF-48

Dept: Workforce HR
IP: People & Culture
Latest: 1%
Target: 0.8%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-7

Dept: Workforce HR
IP: People & Culture
Latest: 17.9%
Target: 10%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary:

The significant decline in the turnover rate is a positive trajectory. There may be several factors which have contributed to this reduction, e.g. a cyclical downturn, improved staff satisfaction (as evidenced by the Staff Survey results).

The next 3 months will reveal whether this improvement is sustainable, recognising the current initiatives should support this trend.

We continue to see improvement in historically high turnover OU's. Most notable are Brighton 7.41% v 8.21% in November, Guildford 6.15% v 8.85%, Polegate and Hastings 7.38% v 8.20%.

What actions are we taking?

A working group has been established to scope the ECSW banding issue, acknowledging that this is a complex piece of work involving key stakeholders and Trade Union colleagues. Affected staff have been communicated with regarding this important work which has received an optimistic response.

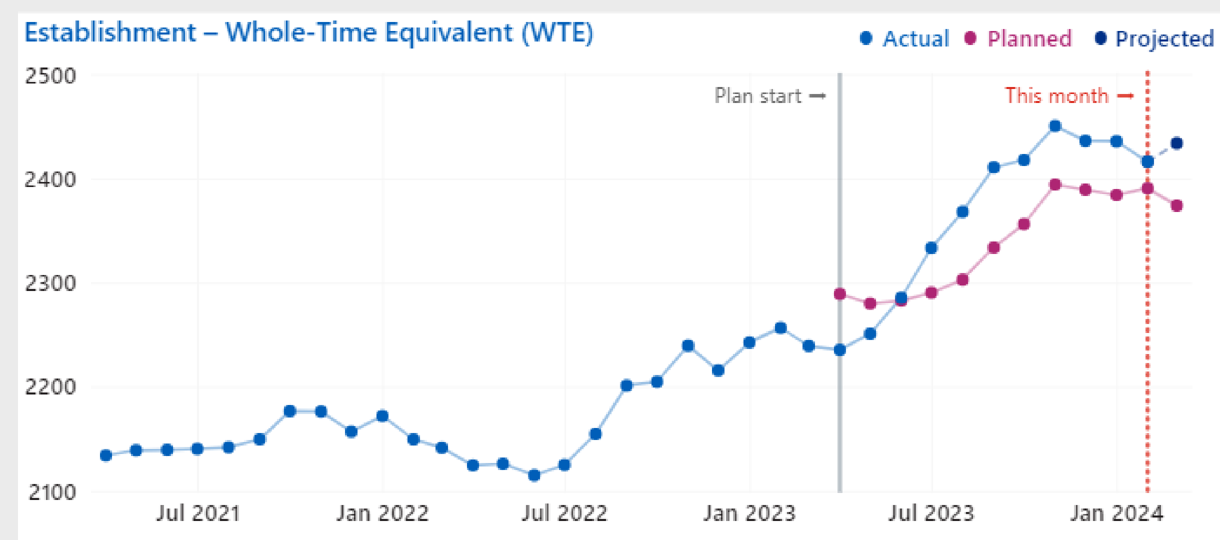
Section 2 USH rectification payments: We have agreed with trade union colleagues that we will develop a methodology to identify and review those affected who may have been negatively impacted.

This is also a complex piece of work and will involve contacting affected individuals in person, over coming months, to work through what this means for them. We will be meeting with trade union colleagues on a fortnightly basis to provide an update on the progress being made and will share regular updates after these meetings.

PEOPLE & CULTURE

Workforce (3 of 3)

(999 Frontline)

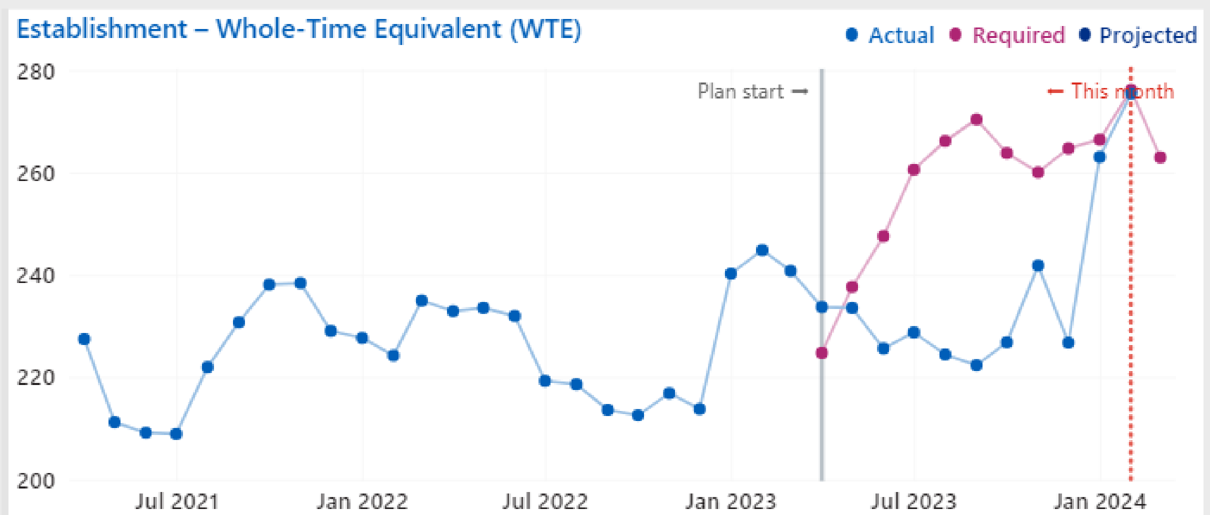


Summary – 999 Frontline
Total budget for field ops is remaining at 2555 for 2023/24.
February's data shows an increase in WTE ahead of the workforce plan (25.7WTE). Attrition again was lower than planned (by 0.64WTE) which has contributed to the difference.
February showed no further NQP recruitment 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. Frontline attrition has been lower than planned and has helped the overall projected figures. Attrition for February was planned at 13.25WTE and actual was 12.61WTE.

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 February showed an increase of WTEs with a difference of -0.3% to plan against last month's difference of -1.28%. There were 53 new starters for January against a planned 23.

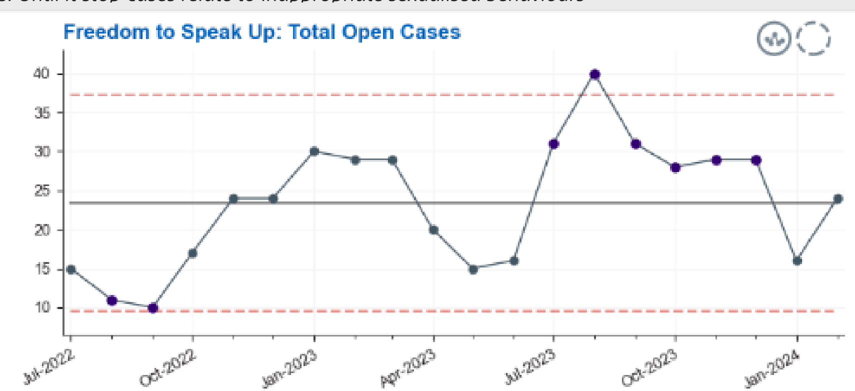
Mitigating actions – EOC EMA
EMA recruitment has been increased with focus on courses being filled to capacity. The compliance team resource has been increased to ensure that candidates are cleared in a timely manner and contact with them is consistent to minimise dropouts. This is in place for both frontline and contact centre roles. Open days have attracted a large number of interested candidates and plans to hold more are underway.

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

PEOPLE & CULTURE

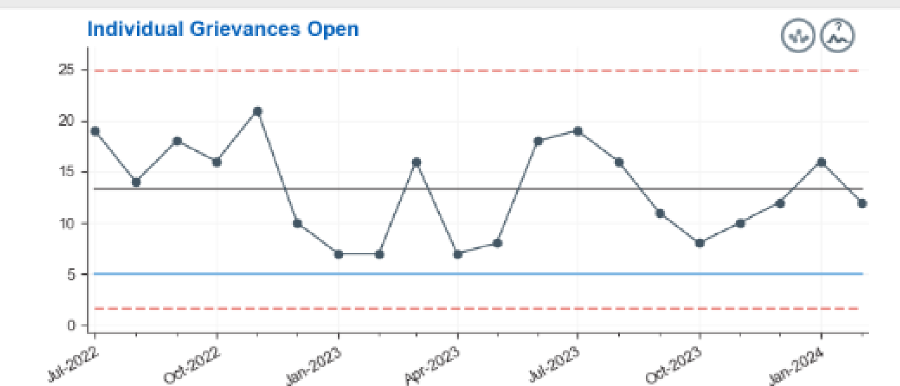
Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

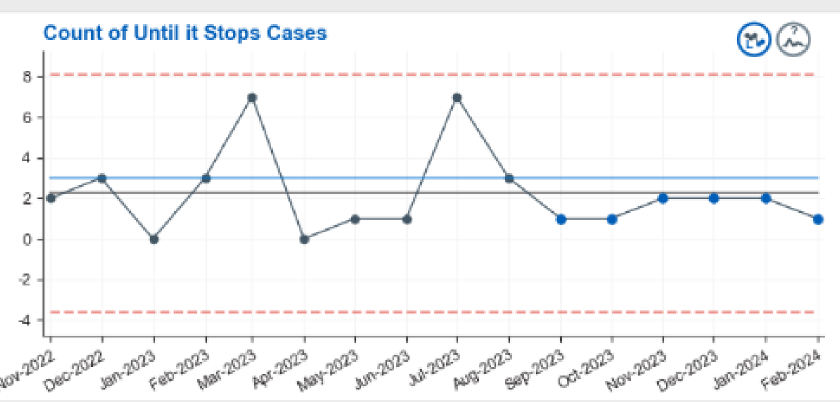


QS-27
Dept: Quality & Safety
IP: People & Culture
Latest: 24

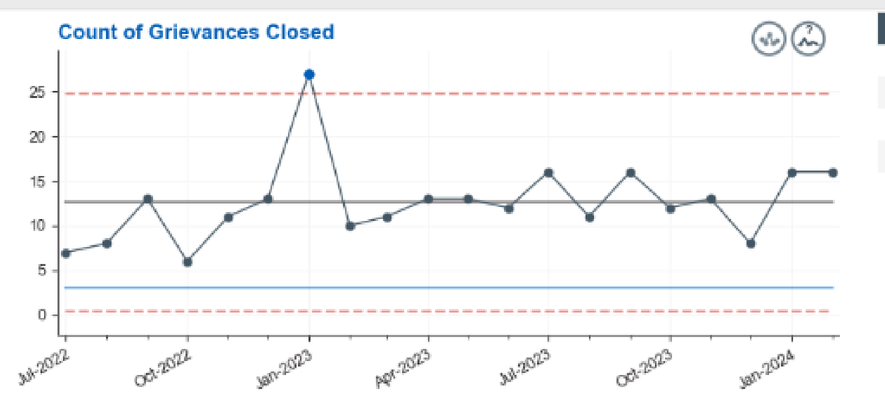
Common cause variation, no significant change.



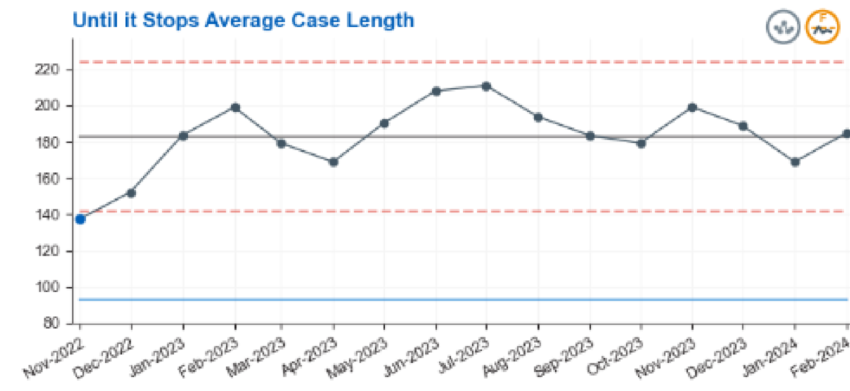
WF-10
Dept: Workforce HR
IP: People & Culture
Latest: 12
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.



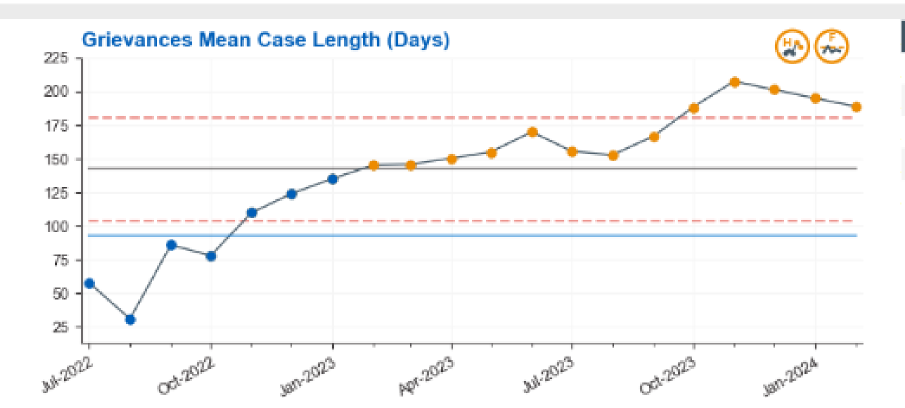
WF-41
Dept: Workforce HR
IP: People & Culture
Latest: 1
Target: 3
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-42
Dept: Workforce HR
IP: People & Culture
Latest: 16
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-50
Dept: Workforce HR
IP: People & Culture
Latest: 184.87
Target: 93
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-44
Dept: Workforce HR
IP: People & Culture
Latest: 189
Target: 93
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

PEOPLE & CULTURE

Culture (2 of 2)

Summary

Grievances

The HR team are focusing on reducing formal grievances, currently there are 43 open cases at the end of February 2024 which continues to show a reduction and is a huge improvement from 2023.

The team are triaging new cases to ensure all informal resolutions are explored prior to commencing formal processes. Legacy cases (i.e. historic open grievances pre August 2023) continue to be tracked each week, and we can currently report that we have 6 legacy grievances which originally stood at 39.

FTSU

40 concerns were raised during Jan/Feb 24 this is consistent with the same period in 2023.
During Jan/Feb 2023 the number of anonymous concerns was reported at 34%, in Jan/Feb 2024 there was a significant improvement as the percentage has decreased to 15%. In Jan/Feb 2024, 15% of colleagues reported experiencing detriment, which is also a decrease, from 44% in the same period of the previous year. This reflects positively on the culture of speaking up, showing an improvement in people feeling safe and encouraged to speak up openly at SECAmb.

What actions are we taking?

Grievances

Grievances overall are reducing and, with the additional support of the ER managers in place, we can continue to track and manage open cases more effectively.

We have prioritised the long standing/legacy cases and whilst some are challenging and complex, we are continuing to see a significant reduction every month. We anticipate the last 6 remaining grievances to be closed soon.

There a number of complex grievances related to pay and conditions of employment (eg section 2 unsocial hours) which we continue to consult with unions and management representatives given their wider impact.

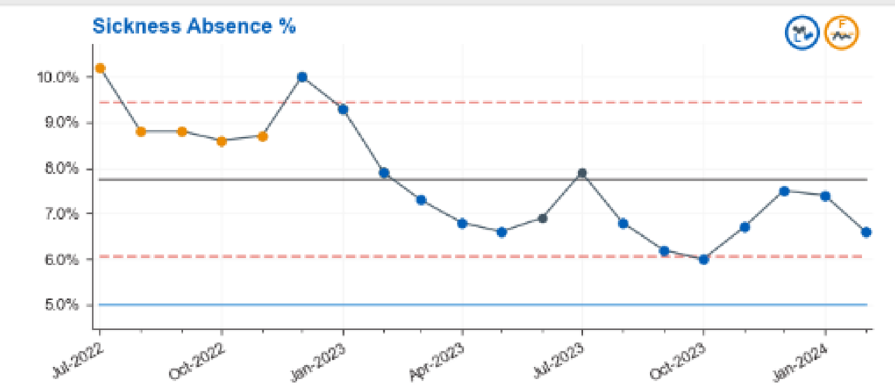
The average grievance open time is around 4.5 months which has reduced slightly from the previous month (5 months).

FTSU

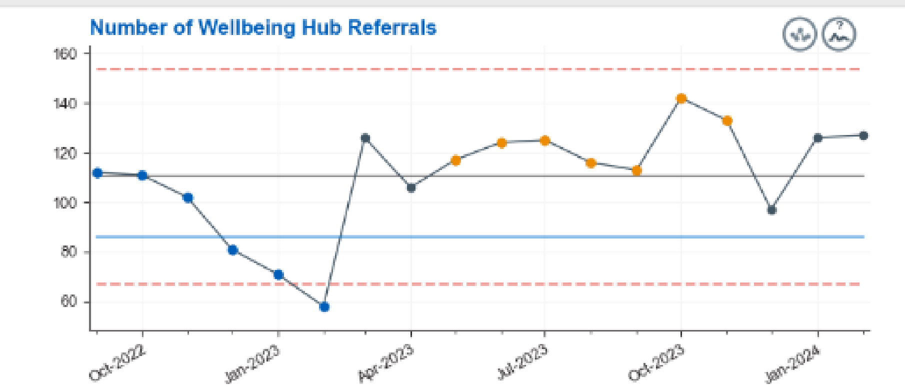
The FTSU team and the National Guardian hosted a development session for the Board and senior leaders, including OUM's in March 2024, the focus was on providing a safe space for leaders to explore their role in creating and enabling an environment where colleagues feel safe to speak up.
Also, during March, the FTSU Guardian attended Brighton university to meet with year 2 students, to trial a FTSU workshop. The feedback has been positive, and the FTSU team will look to link in with all our universities on an ongoing basis.
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.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 6.6%
Target: 5%
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



WF-25
Dept: Workforce Wellbeing
IP: People & Culture
Latest: 127
Target: 86
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Compared to the same period last year, there is a downward trend in non-attendance. For February 2023 sickness levels were 9.4%, in February 2024 they are 6.6%.

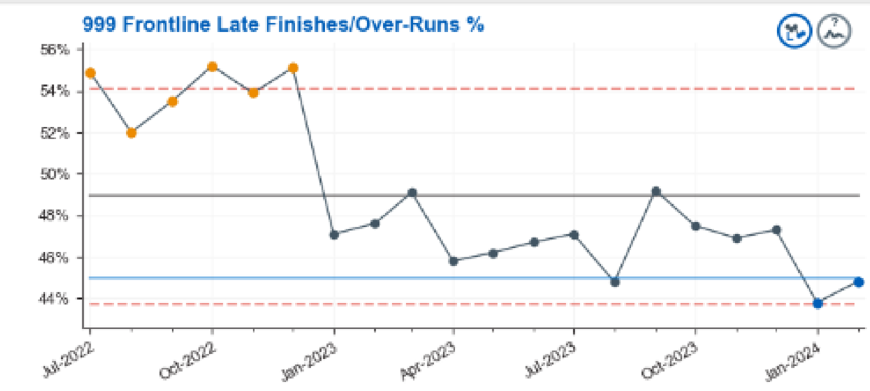
This may be attributed to staff feeling more engaged and the decline in instances of Covid 19.

What actions are we taking?

Our Wellbeing Hub improvement case has been temporarily paused whilst the organisational restructure implications are considered. In the meantime, the team are looking at ways to fill the gaps in our current pathways; for example, we do not currently provide counselling for our colleagues who need it. We will then look to amend and re-submit our improvement case once Trust restrictions are removed.

PEOPLE & CULTURE

Employee Experience



999-15

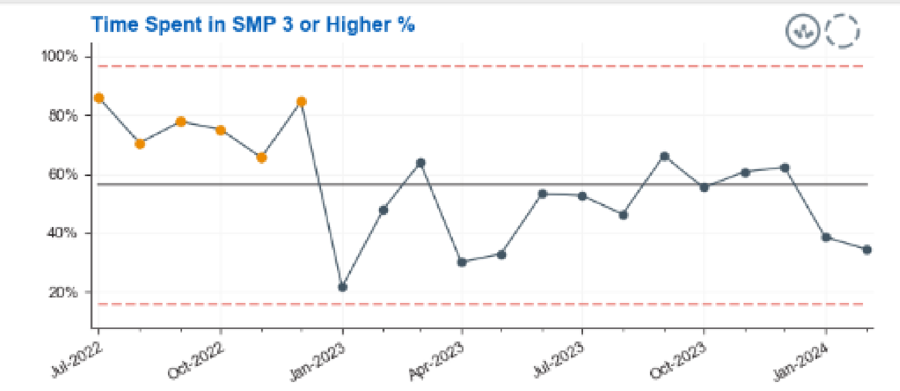
Dept: Operations 999

IP: People & Culture

Latest: 44.8%

Target: 45%

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



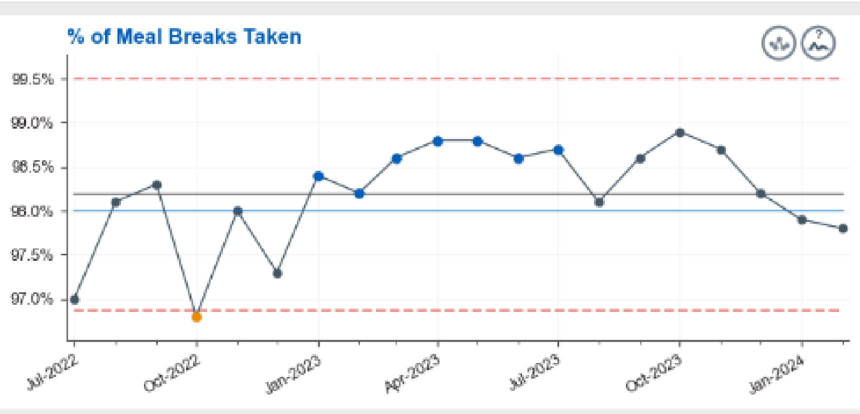
999-14

Dept: Operations 999

IP: Quality Improvement

Latest: 34.5%

Common cause variation, no significant change.



999-27

Dept: Operations 999

IP: People & Culture

Latest: 97.8%

Target: 98%

Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

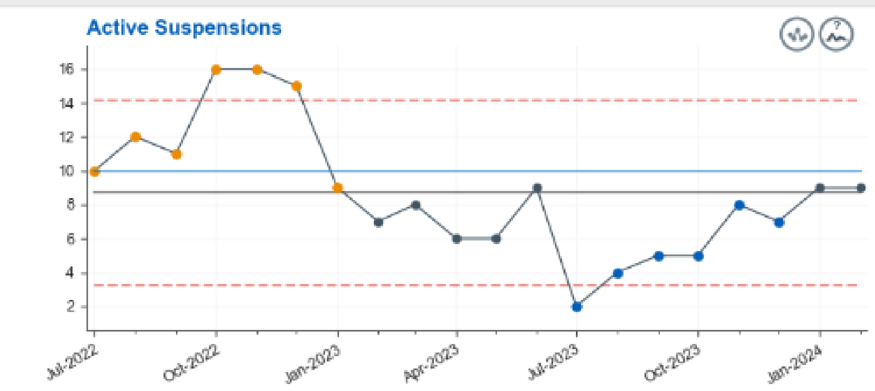
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- Whilst the late finishes and meal break metrics related directly to field operations, the impact of time spent at higher levels of SMP has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

What actions are we taking?

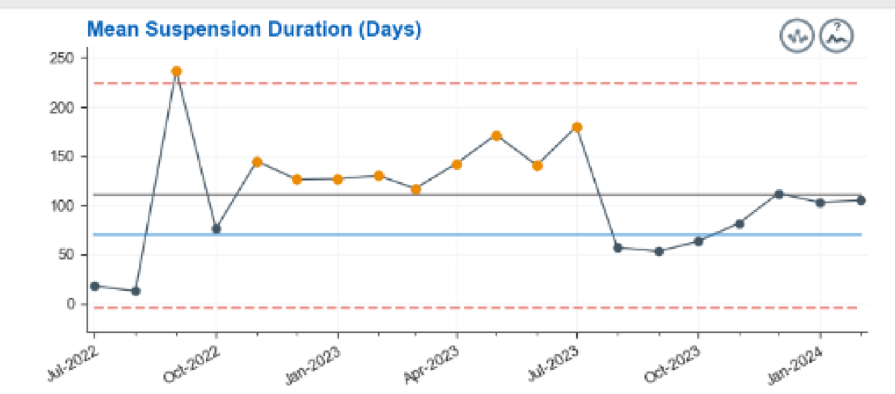
- Review and update of the Meal break policy.
- Learning from the Ashford pilot in terms of cross-border working, meal break compliance etc.

PEOPLE & CULTURE

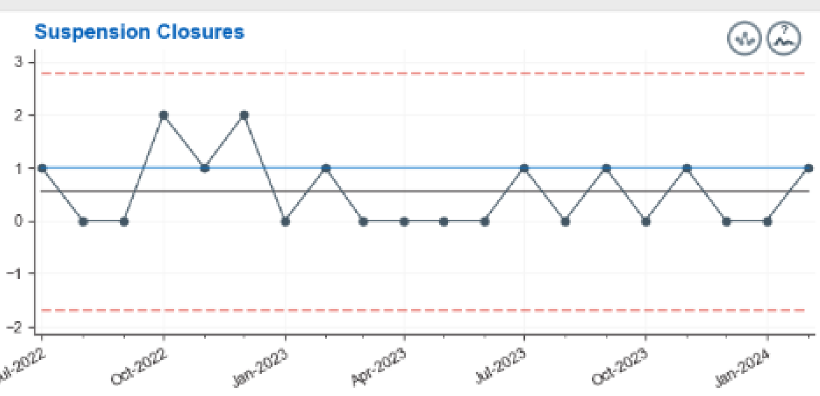
Employee Suspensions



WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 9
Target: 10
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-47
Dept: Workforce HR
IP: People & Culture
Latest: 105
Target: 70
Common cause variation, no significant change. This process will not consistently hit or miss the target.



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

Summary

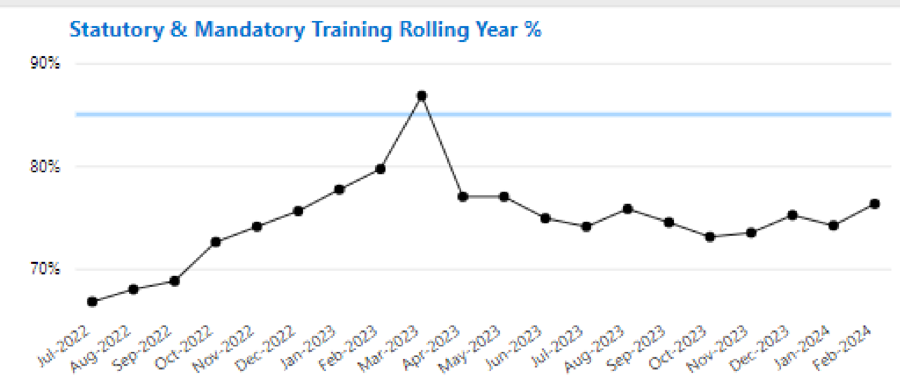
Suspensions are monitored for all serious/ gross misconduct cases. The HR team continue to prioritise these investigations so that suspension for the employee is kept to a minimum.

What actions are we taking?

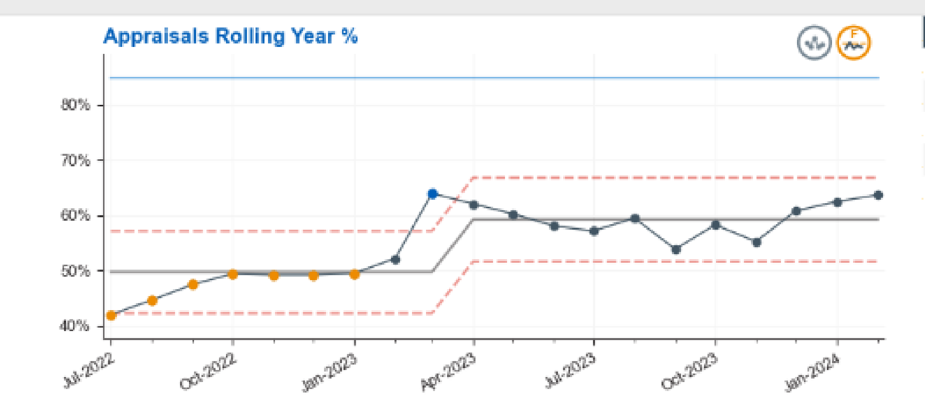
All suspension are risk assessed and tracked each week by Human resources. Existing suspensions are reviewed by two executive Directors to consider if is proportionate to continue with the suspension for the individual.

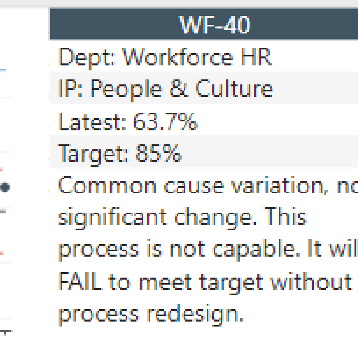
PEOPLE & CULTURE

Employee Development



WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 76.3%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.





Summary

There was a fluctuating trend in both appraisal and statutory and mandatory training completion over the year.

The reported appraisal rate has improved to **65.5%** (as of 18 March 2024) from 63.7% in the last two months but continues to remain below the Trust's compliance target of 85%. The current completion rate compares favourably against the 62.92% for March 2023.

As of 18 March 2024, the rolling overall compliance rate for statutory and mandatory training stands at **78%**, a 3% increase in two months and below the 84.58% compliance rate for a March 2023. The trend from last year above, given completion pushes towards the end of financial years, indicate we are likely on track to achieve the Trust's compliance target of 85% by April 2024.

Current reporting includes both the equivalent subjects to the NHS Core Skills Training Framework (CSTF) for statutory and mandatory training, and SECAmb-specific courses, including Classroom Key Skills, Driver Training, Patient Group Directions and Speak Up. Excluding non-CSTF subjects, the compliance rate increases to **81.4%**.

Several implemented and ongoing projects have improved statutory and mandatory training data integrity since the resourcing of the Digital Learning Manager role in December 2023. However, there are still data entry issues from dispersed manual transference of completion data from the Moodle-based Discover learning platform to employee's learning records in ESR. This is done by OU and other administrators across the organisation. This is a risk identified on the risk register. New reporting tools are now helping to identify OU and time-period gaps in data transference.

What actions are we taking?

Statutory and mandatory training

The Digital Learning Manager has initiated projects with the following objectives:

- Investigating issues and identifying users outside L&D responsible for adding new users to Discover that are causing downstream data issues, and providing training, guidance and support
- Bringing master data for job roles/positions and business areas up-to-date, whilst maintaining legacy data.
- Investigating and testing mass update of user data within Discover to benefit data transference by administrators
- Supporting targeted business areas and their administrators to bridge legacy transference gaps due to staff changes and gaps in transition training
- Collaborating with the HR Workforce Information & Planning team to ensure reporting accuracy

Appraisals

The Trust has appointed RSM Internal Auditors to undertake a review of appraisal processes to understand how the organisation currently supports staff and managers through appraisals; consider the processes in place, the systems used for recording them, how appraisals are used from a practical perspective to consider performance and career progression and how effective they are deemed to be. As part of this RSM will also seek to understand the link to wider career development. The review will assess the extent to which the Trust has measures in place to ensure that the organisational culture supports staff development through appraisals and succession planning.

A scoping exercise is underway to understand the functionality needed overall for a learning management and appraisal system.

Responsive Care

RESPONSIVE CARE

Summary

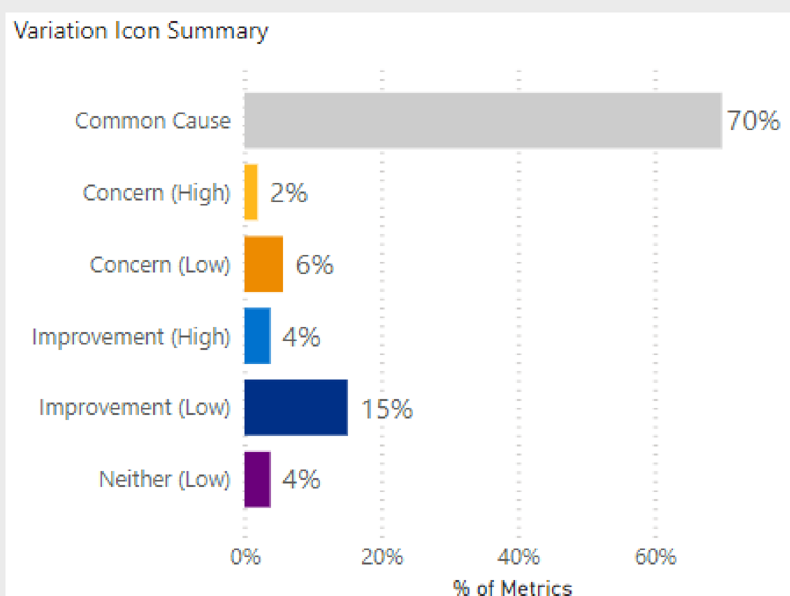
February 2024

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



Assurance Icon Summary

Hit or Miss 57%

Fail 30%

Pass 13%

0% 20% 40% 60%

% of Metrics

Response Times

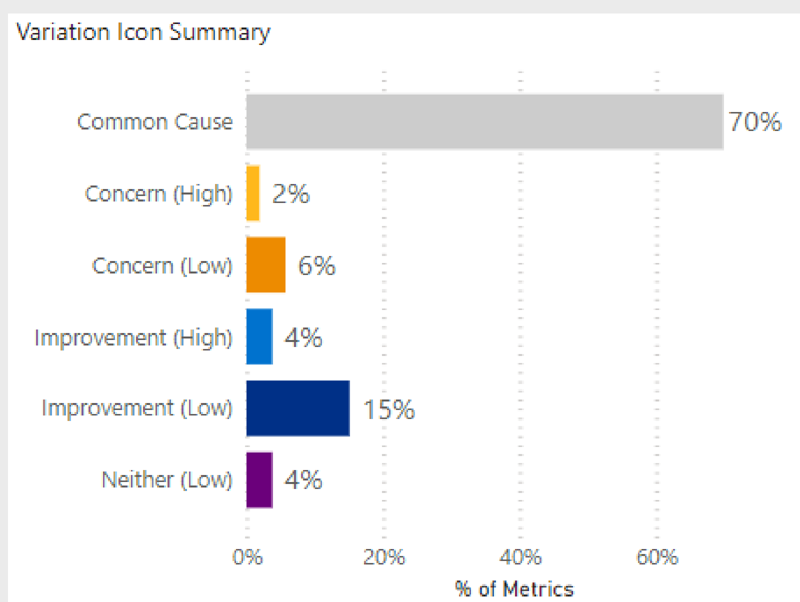
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Feb-2024			01:20:29		02:13:28		
Section 136 Mean Response Time	Responsive Care	Feb-2024	00:22:19		00:14:30	00:26:19	00:38:09		
Cat 1 Mean	Responsive Care	Feb-2024	00:08:18	00:07:00	00:07:29	00:08:59	00:10:28		
Cat 1 90th Centile	Responsive Care	Feb-2024	00:15:01	00:15:00	00:13:55	00:16:17	00:18:39		
Cat 1T Mean	Responsive Care	Feb-2024	00:09:37	00:19:00	00:08:56	00:10:36	00:12:16		
Cat 1T 90th Centile	Responsive Care	Feb-2024	00:17:51	00:30:00	00:16:25	00:19:28	00:22:32		
Cat 2 Mean	Responsive Care	Feb-2024	00:25:50	00:30:00	00:18:32	00:31:28	00:44:25		
Cat 2 90th Centile	Responsive Care	Feb-2024	00:51:38	00:40:00	00:35:48	01:04:22	01:32:56		
Cat 3 90th Centile	Responsive Care	Feb-2024	03:58:59	02:00:00	01:50:48	05:40:12	09:29:36		
Cat 4 90th Centile	Responsive Care	Feb-2024	04:27:53	03:00:00	02:31:32	07:39:32	12:47:33		
HCP 3 Mean	Responsive Care	Feb-2024	01:36:11		01:05:42	02:30:42	03:55:41		
HCP 3 90th Centile	Responsive Care	Feb-2024	03:24:08		01:36:44	05:46:15	09:55:46		
HCP 4 Mean	Responsive Care	Feb-2024	02:02:31		01:31:07	03:12:59	04:54:51		
HCP 4 90th Centile	Responsive Care	Feb-2024	04:44:29		02:40:28	07:35:01	12:29:33		

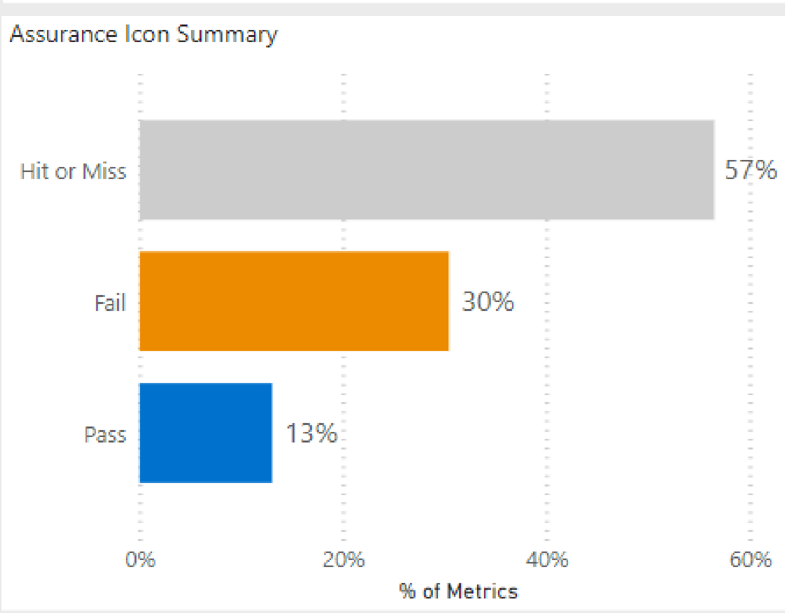
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Feb-2024	21.2%		20.22%	23.85%	27.48%		
999 Calls Answered	Responsive Care	Feb-2024	66506		52867.66	71833.6	90799.54		
999 Call Answer Mean	Responsive Care	Feb-2024	00:00:07	00:00:05	00:00:27	00:00:39	00:01:45		
999 Call Answer 90th Centile	Responsive Care	Feb-2024	00:00:18	00:00:10	00:00:51	00:02:06	00:05:04		

RESPONSIVE CARE

Overview (2 of 3)





Utilisation

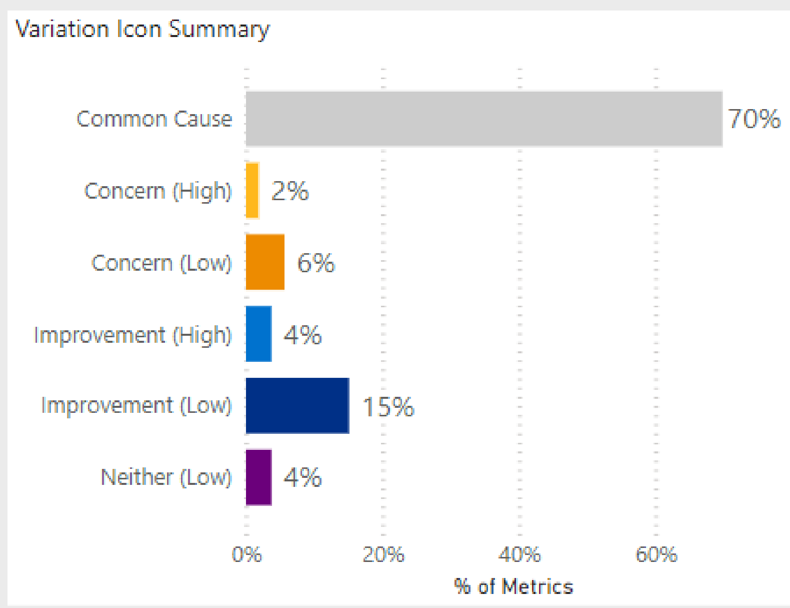
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Feb-2024	110.4%	100%	85.91%	96.06%	106.21%		
Provided Bank Hours %	Responsive Care	Feb-2024	0.7%		0.56%	0.72%	0.88%		
Provided Overtime Hours %	Responsive Care	Feb-2024	9.2%		5.47%	8.04%	10.61%		
Provided PAP Hours %	Responsive Care	Feb-2024	3.3%		4.16%	5.12%	6.08%		
Data being validated									
999 Remaining Annual Leave FY	Responsive Care	Feb-2024	13.7%		12.57%	26.08%	39.59%		
Vehicles Off Road (VOR) %	Responsive Care	Feb-2024	13.8%	10%	10.16%	12.92%	15.67%		
% of DCA vehicles off road (VOR)	Responsive Care	Feb-2024	14.3%		11.53%	14.01%	16.48%		
% of SRV vehicles off road (VOR)	Responsive Care	Feb-2024	10%		-7.19%	6.7%	20.58%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Feb-2024	115		63.8	133.8	203.8		
Number of RTCs per 10k miles travelled	Responsive Care	Feb-2024	1.12		0.2	0.74	1.27		
% of planned vehicle services completed	Responsive Care	Feb-2024	77%		51.55%	71.89%	92.23%		
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	Feb-2024	95%	95%		91.68%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Feb-2024	63.3%		60.14%	63.51%	66.88%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Feb-2024	6.5%	13%	5.31%	6.56%	7.8%		
Incidents	Responsive Care	Feb-2024	63118		54213.59	61224.65	68235.71		

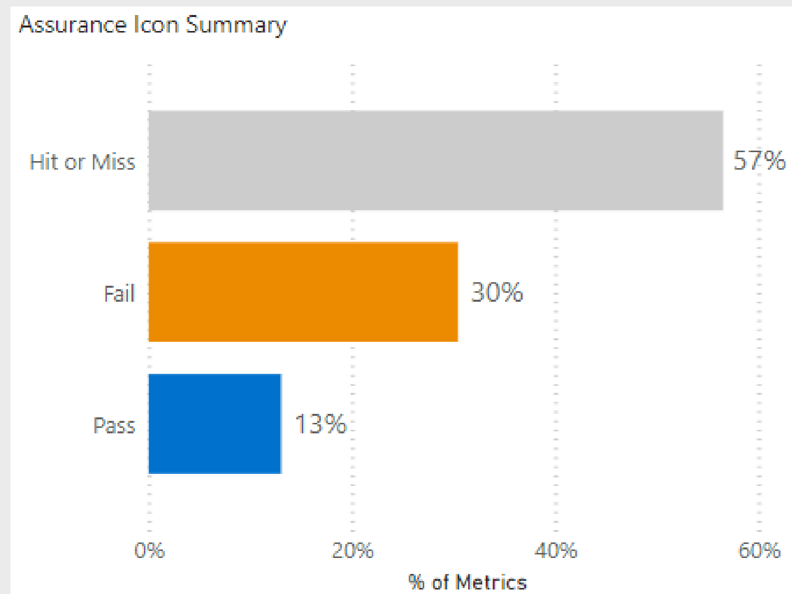
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Feb-2024	94953		65361.58	102520.8	139680.02		
111 Calls Answered in 60 Seconds %	Responsive Care	Feb-2024	34.1%	95%	8.61%	35.16%	61.7%		
111 Calls Abandoned - (Offered) %	Responsive Care	Feb-2024	15.3%	5%	1.95%	17.92%	33.89%		
999 Referrals	Responsive Care	Feb-2024	4798		3593.67	4929.55	6265.43		

RESPONSIVE CARE

Overview (3 of 3)





999 Frontline

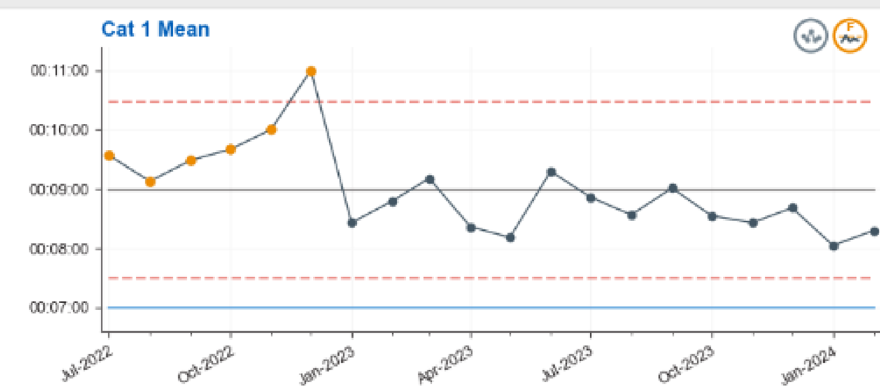
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Feb-2024	01:18:20		01:15:41	01:17:27	01:19:13		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Feb-2024	01:53:10		01:49:59	01:54:03	01:58:08		
Responses Per Incident	Responsive Care	Feb-2024	1.09	1.09	1.09	1.1	1.11		
CFR Attendances	Responsive Care	Feb-2024	1134		736.9	1192.6	1648.3		
FFR Attendances	Responsive Care	Feb-2024	79		58.79	148.95	239.11		
ECAL Mean Response Time	Responsive Care	Feb-2024	00:26:47		00:22:05	00:24:05	00:26:04		

111/999 System Impacts

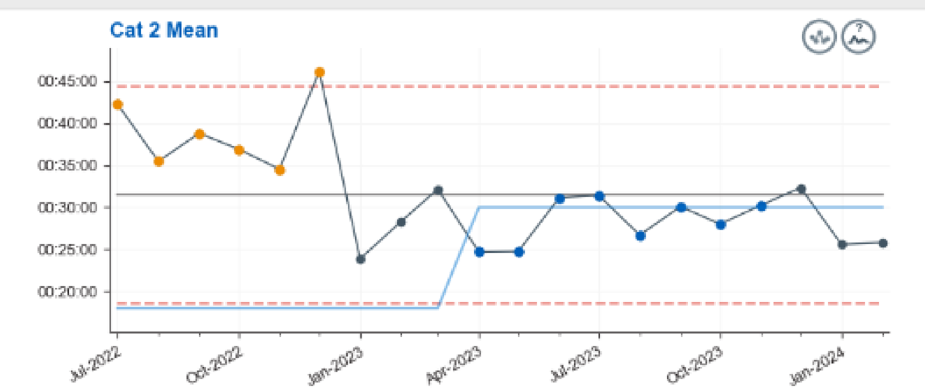
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Feb-2024	13.6%	14%	9.3%	10.9%	12.5%		
See & Treat %	Responsive Care	Feb-2024	30.8%	35%	29.94%	31.48%	33.02%		
See & Convey %	Responsive Care	Feb-2024	55.4%	55%	55.42%	57.48%	59.54%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Feb-2024	1%		0.6%	1.22%	1.84%		
Number of Hours Lost at Hospital Handover	Responsive Care	Feb-2024	3374.8		1740.05	3533.46	5326.88		
Average Wrap Up Time	Responsive Care	Feb-2024	00:16:49	00:15:00	00:16:35	00:17:11	00:17:48		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Feb-2024	43.5%		43.15%	46.19%	49.23%		
A&E Dispositions %	Responsive Care	Feb-2024	8.1%	9%	6.53%	8.24%	9.95%		
A&E Dispositions	Responsive Care	Feb-2024	5957		4467.92	6209.8	7951.68		
Clinical Contact %	Responsive Care	Feb-2024	47.7%	50%	45.44%	50.39%	55.33%		
Ambulance Validation %	Responsive Care	Feb-2024	45.5%	85%	70.3%	80%	89.7%		

RESPONSIVE CARE

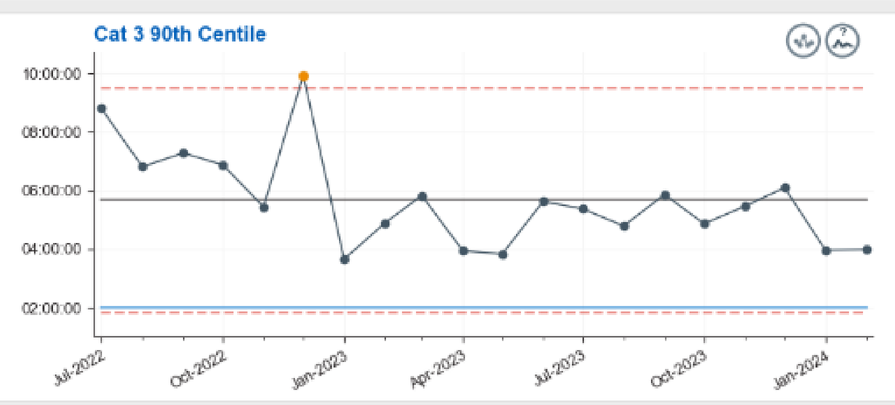
Response Times



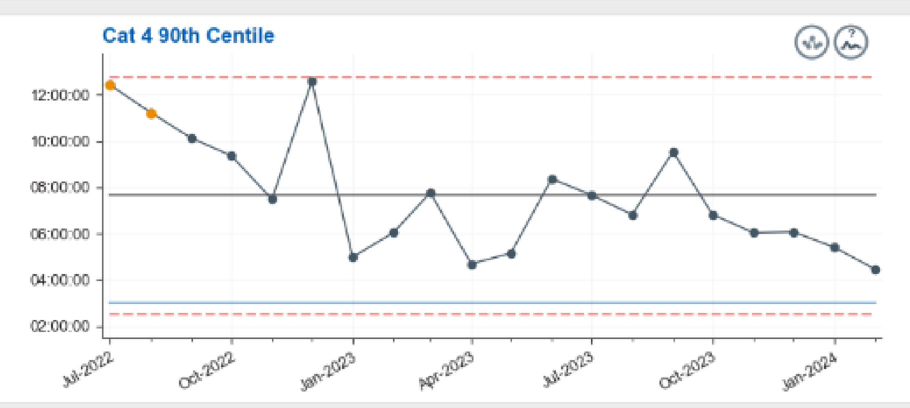
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:18
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:25:50
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: 03:58:59
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: 04:27:53
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 February 2024, performance was 25min 50sec, against a national average of 36min 20sec.

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 ambulance dispatch, with a cohort of international clinicians now undergoing induction within the Trust.
- 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, and more recently a lice portal, 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 (February 2024)

Cat 1 Mean ARP Response Time

00:12:00
00:10:00
00:08:00
00:06:00
00:04:00
00:02:00
00:00:00

SECAmb
00:08:19

North East, London, North West, Yorkshire, West Midlands, South East Coast, South Central, East Midlands, East of England, South Western, Isle of Wight

Cat 1 Mean, England, Target

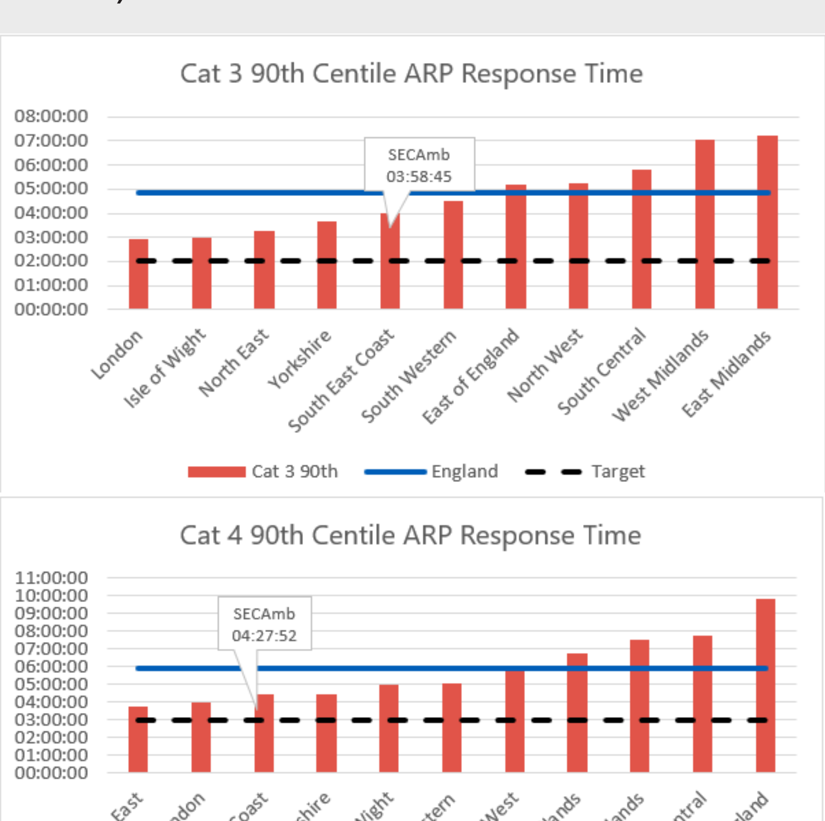
Cat 2 Mean ARP Response Time

01:00:00
00:50:00
00:40:00
00:30:00
00:20:00
00:10:00
00:00:00

SECAmb
00:25:49

Isle of Wight, South East Coast, North West, Yorkshire, South Central, North East, West Midlands, London, South Western, East of England, East Midlands

Cat 2 Mean, England, Target



Cat 1 90th Centile ARP Response Time

00:20:00
00:15:00
00:10:00
00:05:00
00:00:00

SECAmb
00:15:01

North East, London, North West, Yorkshire, West Midlands, South East Coast, South Central, East Midlands, East of England, Isle of Wight, South Western

Cat 1 90th, England, Target

Cat 2 90th Centile ARP Response Time

02:00:00
01:40:00
01:20:00
01:00:00
00:40:00
00:20:00
00:00:00

SECAmb
00:51:38

South East Coast, Isle of Wight, North West, South Central, North East, Yorkshire, West Midlands, London, South Western, East of England, East Midlands

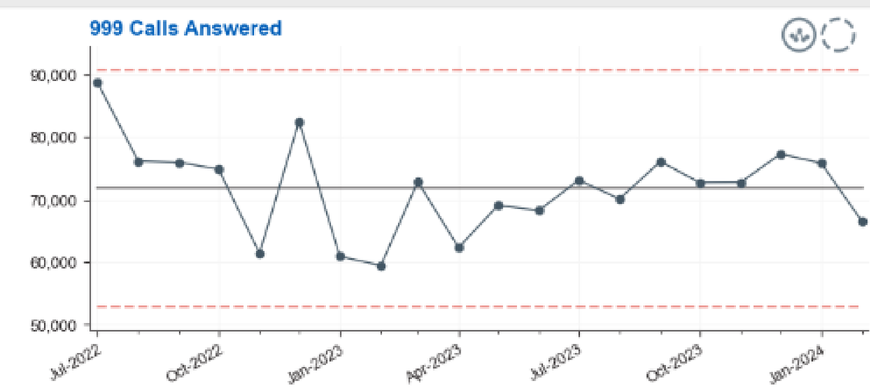
Cat 2 90th, England, Target

Summary

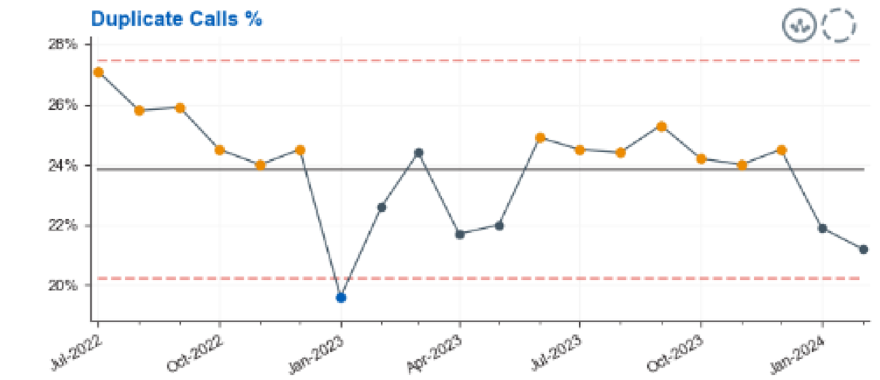
- C2 mean (a focus for the UEC recovery plan) is on track against the plan for 2023-24.
- Other ARP metrics continued to be notably under-performing against ARP target metrics but are under the English mean for all measures.

RESPONSIVE CARE

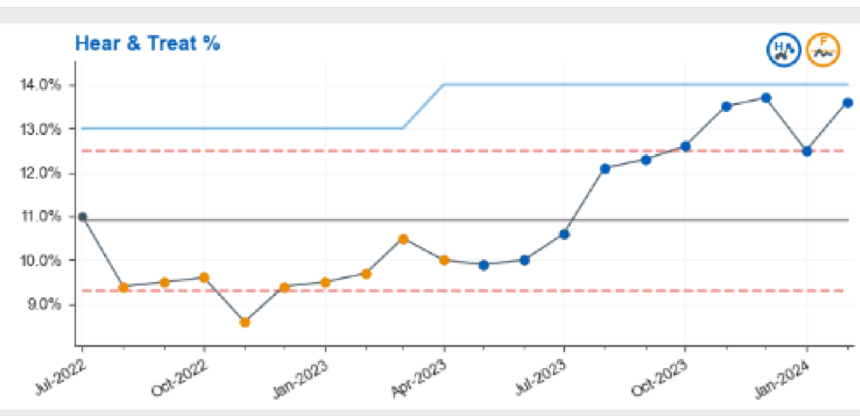
EOC Emergency Medical Advisors



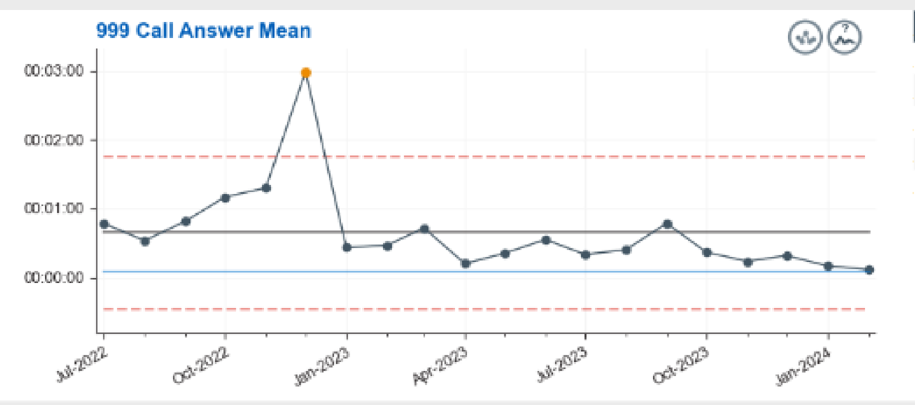
999-10
Dept: Operations 999
IP: Responsive Care
Latest: 66506
Common cause variation, no significant change.



999-33
Dept: Operations 999
IP: Responsive Care
Latest: 21.2%
Common cause variation, no significant change.



999-9
Dept: Operations 999
IP: Responsive Care
Latest: 13.6%
Target: 14%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.



999-1
Dept: Operations 999
IP: Responsive Care
Latest: 00:00:07
Target: 00:00:05
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

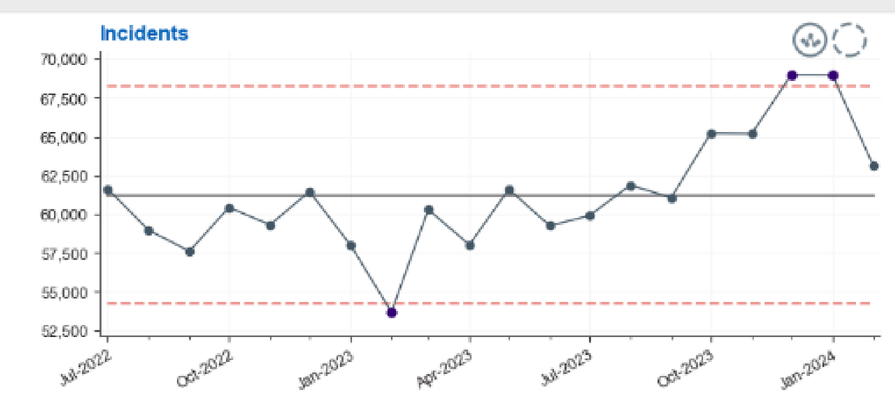
- Call answer mean time continues to fluctuate, underpinned by ongoing staffing challenges and rota inequalities, with a higher proportion of newer staff who are developing, although noting that there has been a general trend in increasing the number of ***calls answered*** over the same period.
- EMA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

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 252.6 WTE and dependent on attrition v recruitment rate with the current position being 265.5WTE of which 237.5WTE are live and 28WTE 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.

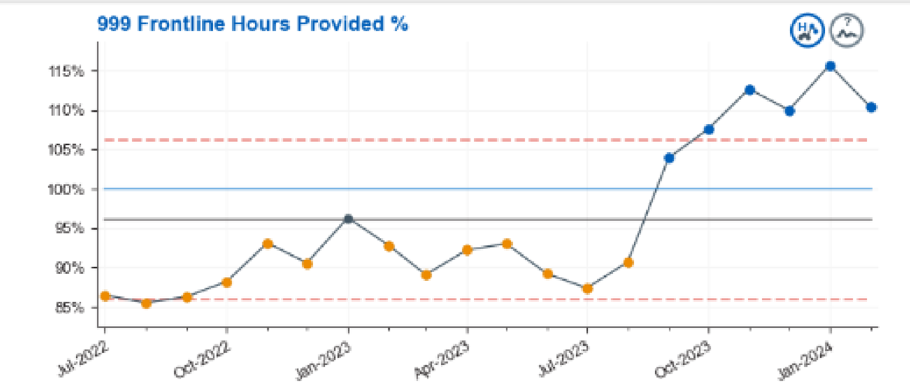
RESPONSIVE CARE

Utilisation

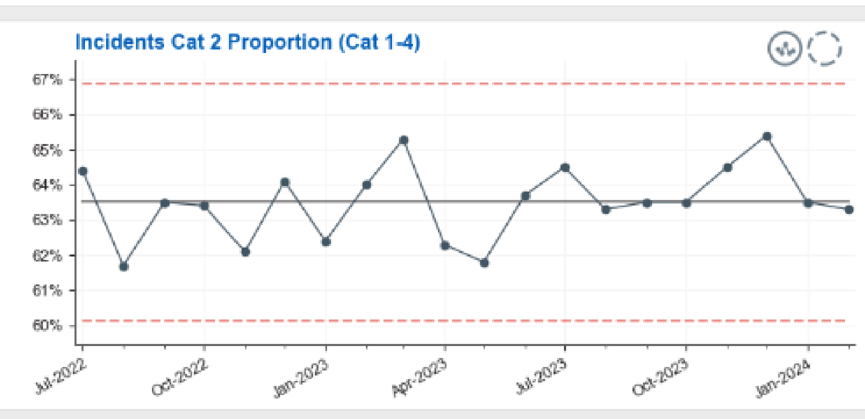


999-10
Dept: Operations 999
IP: Responsive Care
Latest: 63118

Common cause variation, no significant change.

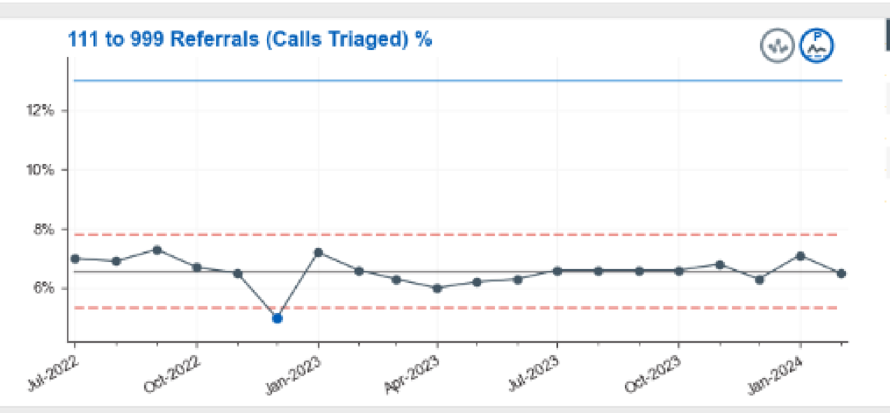


999-12
Dept: Operations 999
IP: Responsive Care
Latest: 110.4%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



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

Common cause variation, no significant change.



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.5%
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 has improved 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).
- 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.

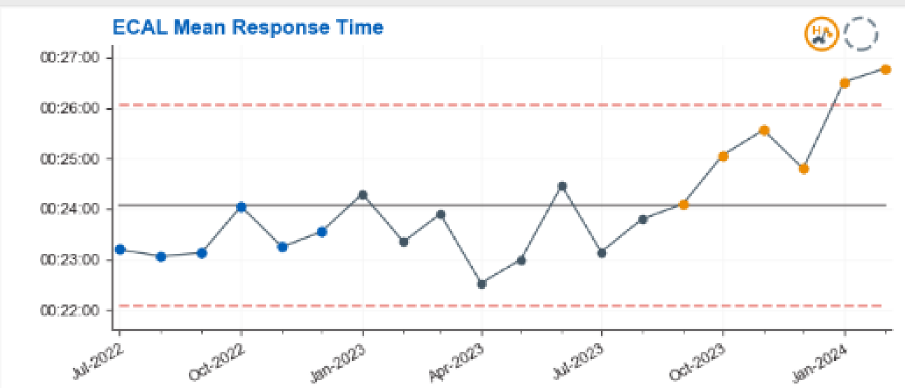
What actions are we taking?

- 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. This has been supported with the publication of a web-portal to support community services 'pulling' suitable incidents from the stack – this is live in areas of Sussex.

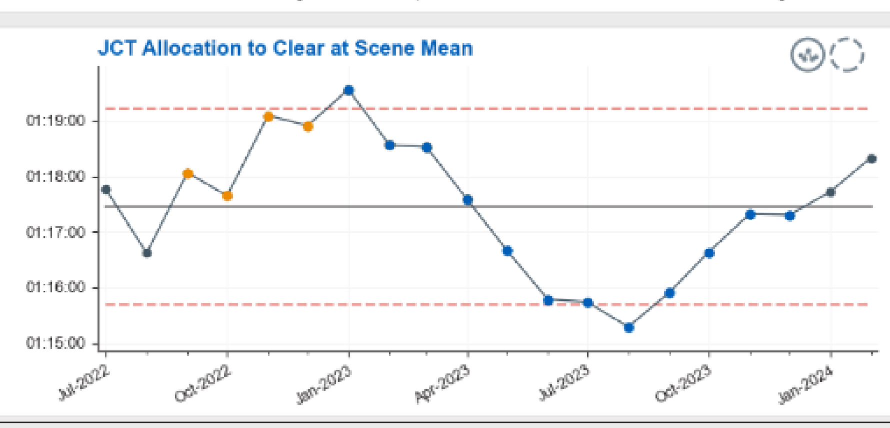
RESPONSIVE CARE

999 Frontline

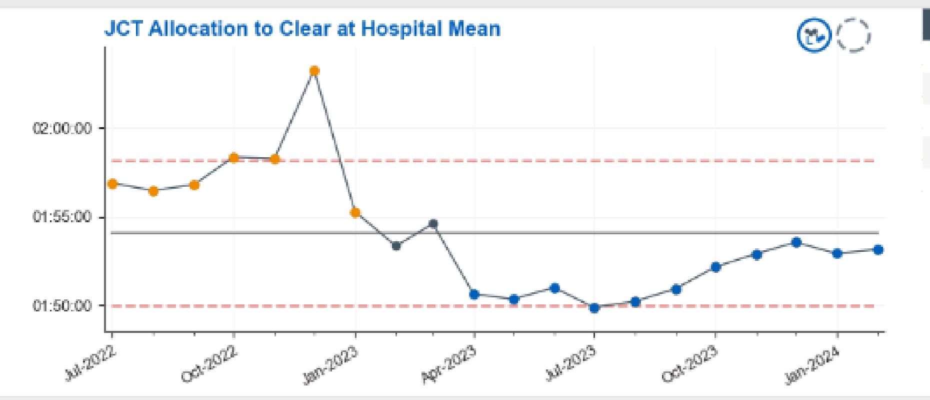
999-17
Dept: Operations 999
IP: Responsive Care
Latest: 1.09
Target: 1.09
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-13
Dept: Operations 999
IP: Responsive Care
Latest: 00:26:47
Special cause of a concerning nature where the measure is significantly HIGHER.



999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:18:20
Common cause variation, no significant change.



999-11
Dept: Operations 999
IP: Responsive Care
Latest: 01:53:10
Special cause of an improving nature where the measure is significantly LOWER.

Summary

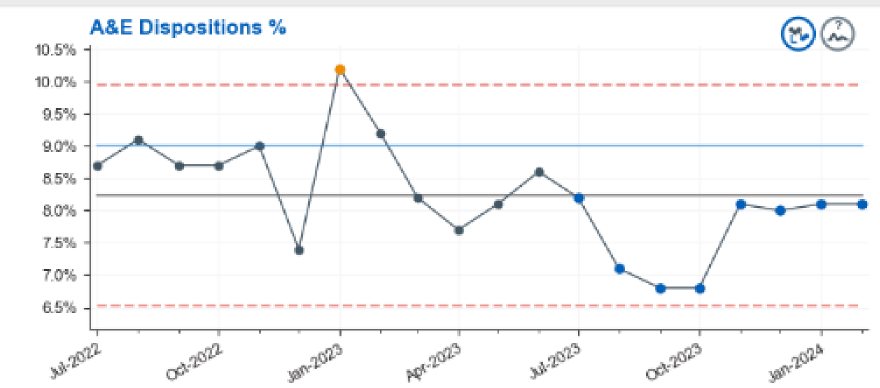
- The number of ***resources allocated per incident*** is an ambulance industry standard which provides an overview of dispatch efficiencies – as can be seen from the above the performance has been below target for several months, with common cause variation.
- ***Job cycle time*** (JCT) provides a single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

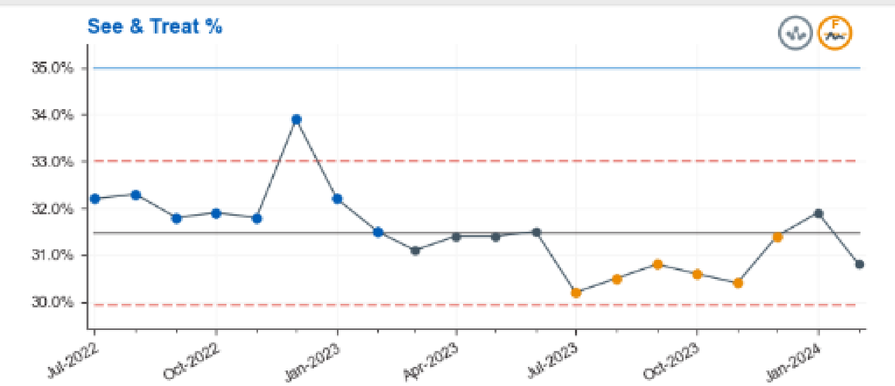
- The Trust commissioned an external ***AACE review of the Dispatch function***, and the recommendations are currently being addressed as part of the Responsive Care Group plan. Phase 1 of this plan was completed at the end of October – phase 2 commences in early 2024.
- Continued focus on delivery of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

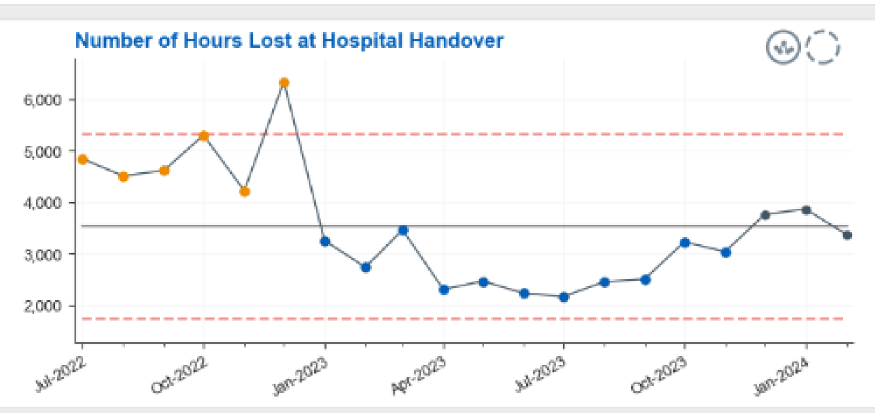
111/999 System Impacts



111-5
Dept: Operations 111
IP: Responsive Care
Latest: 8.1%
Target: 9%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

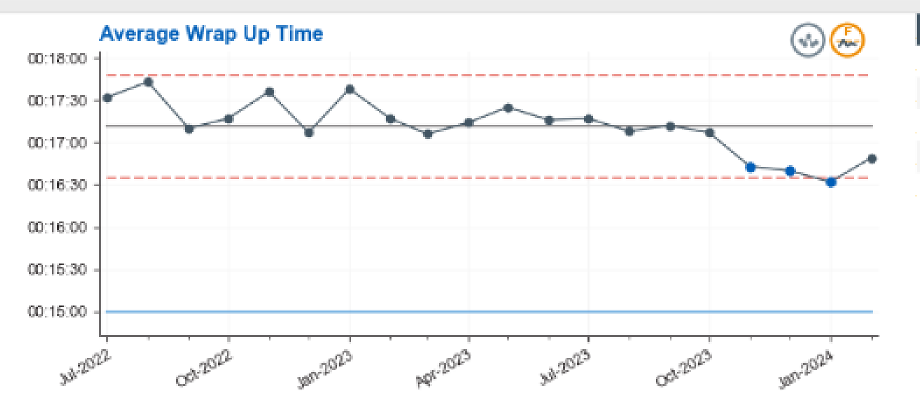


999-9
Dept: Operations 999
IP: Responsive Care
Latest: 30.8%
Target: 35%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-24
Dept: Operations 999
IP: Responsive Care
Latest: 3374.8

Common cause variation, no significant change.



999-31
Dept: Operations 999
IP: Responsive Care
Latest: 00:16:49
Target: 00:15:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

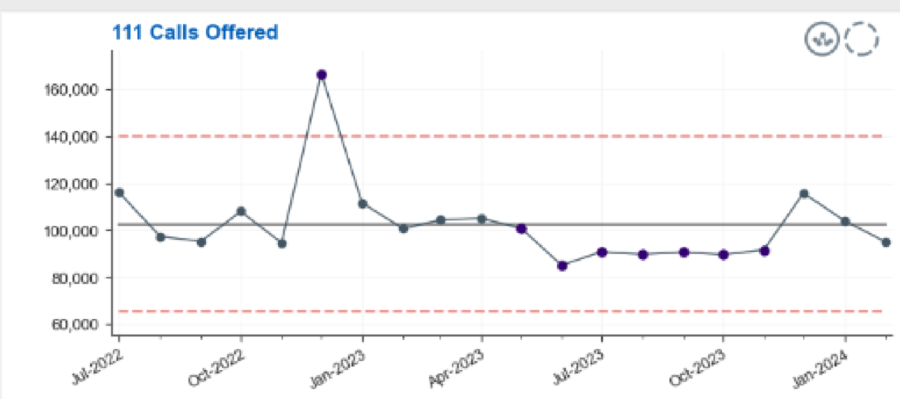
- The ***111 to ED disposition rate*** has been maintained at a very low level since the introduction of "111 First", Direct Access Booking (DAB) and ED validation. The Trust's 111 service has excelled at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111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

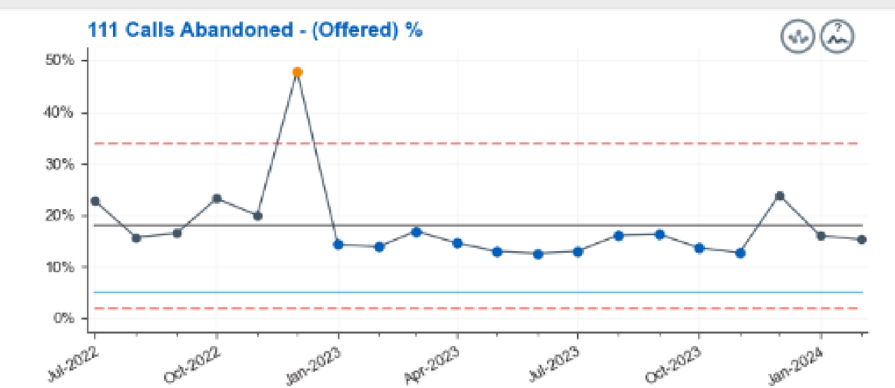
- The Trust has embarked on a programme to lead collaboration with local teams regarding the engagement with local systems and utilisation of community pathways of care i.e., ***Urgent Community Response (UCR)*** and other services.
- Daily calls, held by Operations Managers Clinical (OMC) are held across 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

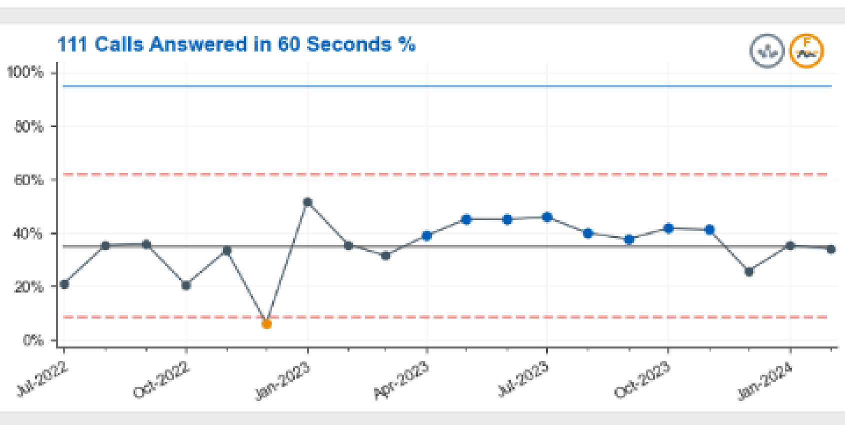
111



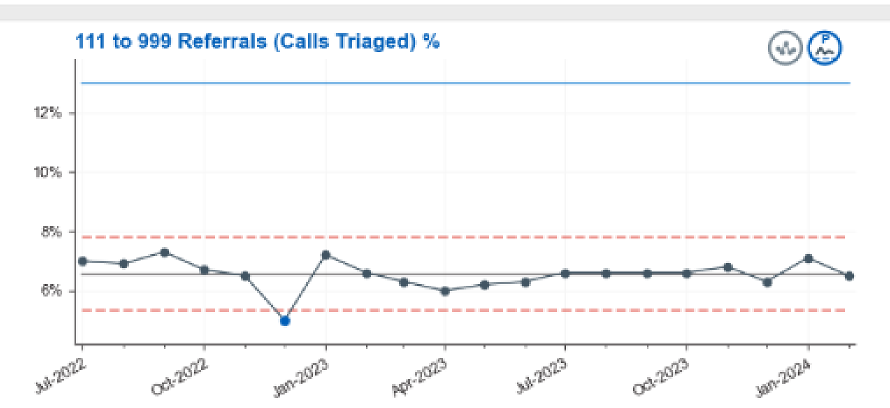
111-1
Dept: Operations 111
IP: Responsive Care
Latest: 94953
Common cause variation, no significant change.



111-3
Dept: Operations 111
IP: Responsive Care
Latest: 15.3%
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: 34.1%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.5%
Target: 13%
Common cause variation, no significant change. This process is capable and will consistently PASS the target.

Summary

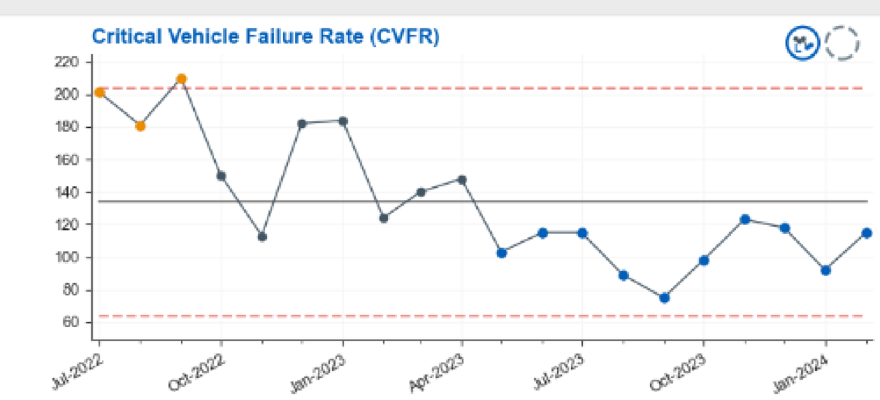
- The service's ***operational responsiveness*** remains poor, as reflected in the sustained low level of performance for calls answered in 60 seconds and high levels of abandoned calls.
- The performance of the service is directly related to the resourcing provision and due to high turnover, recruitment 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 from March 2023, and this has been confirmed to extend to Sept 2024 starting at 10% capacity and reducting to 5% in September.
- 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.

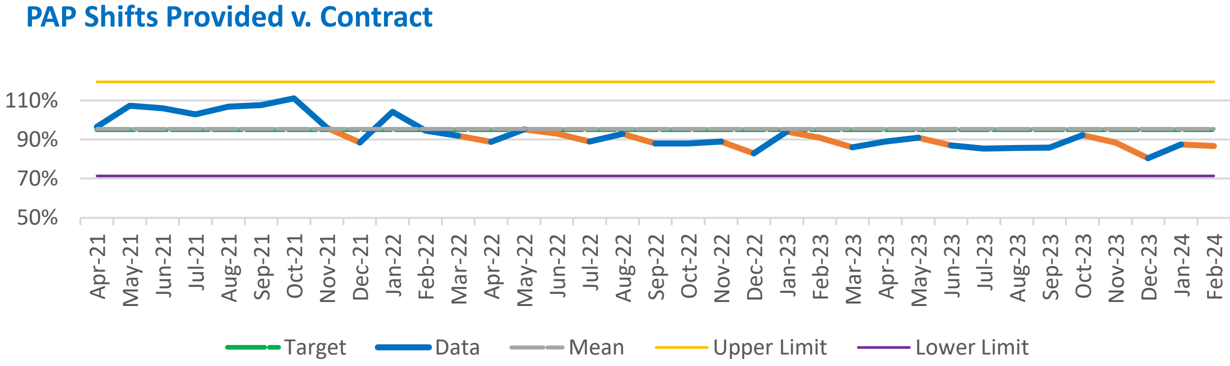
RESPONSIVE CARE

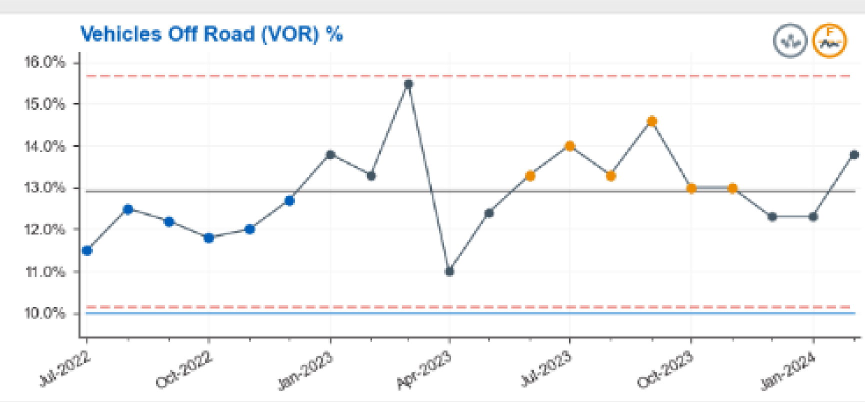
Support Services
Fleet and Private Ambulance Providers



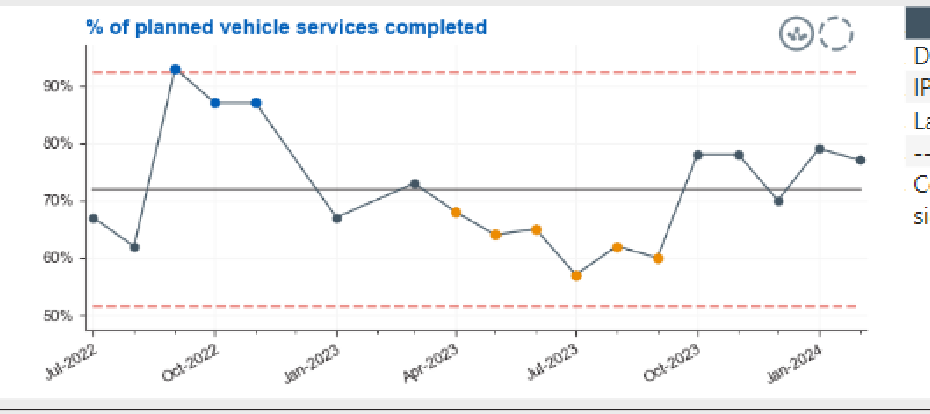
FL-12
Dept: Fleet
IP: Responsive Care
Latest: 115

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





FL-13
Dept: Fleet
IP: Responsive Care
Latest: 13.8%
Target: 10%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



FL-3
Dept: Fleet
IP: Responsive Care
Latest: 77%

Common cause variation, no significant change.

Summary and Action Plans

Critical Vehicle Failure Rate and VOR Currently 23% 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, 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 2%). We have now completed recruitment for 3 additional Vehicle Maintenance Technicians. The first starts on the 20/03, the second is going through the HR onboard process and we have yet to find the successful candidate for the third. We are also exploring the use of the apprenticeship scheme to increase our capacity. This is aligned to Risk ID 333.
The planned vehicle services has deteriorated since the last period. This could be due to increased annual leave and sickness of VMT's

Concerns around parts supply continue to be raised nationally by Fleet Managers and escalated to suppliers regularly..
A vehicle roadshow to showcase potential new vehicles took place between Feb 19th – 1 March 2024 and visited 16 sites across the Trust The aim was to promote staff engagement and gather feedback. Every site was well supported, and early indications show that we have received 368 survey responses from staff including Paramedics, Paramedic NQP, Trainee AAP & Student paramedics.
74% have favoured the MAN box body with the wedge ramp system (as per our current fleet ramp system). The average time to complete the survey with 10 questions was 19 ½ minutes, indicating that staff took time to give thought in their replies The detailed responses will be collated into a paper for presenting.
A further draft of the Business improvement templates is being worked on to include recruitment and retention in addition to increasing Fleet workforce in line with 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. **PAP contract** on target to deliver >5% CIP return.

Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

	February 2024 In the month			April 2023 to February 2024 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	26,779	26,467	(311)	295,171	295,947	776	321,984	322,771	787
Operating Expenditure	(26,761)	(26,450)	311	(295,401)	(296,164)	(763)	(321,986)	(322,771)	(785)
Trust Surplus/(Deficit)	***18***	***17***	***(1)***	***(230)***	***(217)***	***13***	***(2)***	***0***	***2***
Reporting adjustments:									
Remove Impact of Donated Assets	*0*	*1*	*1*	*2*	*2*	*0*	*2*	*2*	*0*
Reported Surplus/(Deficit)	**18**	**18**	**(0)**	**(228)**	**(215)**	**13**	**0**	**2**	**2**

	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Cash	50,788	37,773	(13,015)	50,788	37,773	(13,015)	50,401	35,177	(15,224)
Capital Expenditure	1,853	3,588	(1,735)	16,591	17,156	(565)	27,055	19,847	7,208
Efficiency Target	1,100	816	(284)	7,888	7,345	(543)	8,988	8,988	0

*values subject to rounding

Summary

1. The Trust's financial performance is £13k better than plan year-to-date (YTD) at M11 compared to the planned deficit of £215k. Financial pressures in 111 and HR were mitigated by profit on disposal of Trust assets, mainly Redhill and Leatherhead Ambulance Stations and higher than planned bank interest received on cash balances held in the bank.

2. The efficiency programme has delivered £7,345k worth of savings at M11 YTD, which represents an under delivery of £543k compared to the £7,888k plan. 72.3% of the schemes have been generated recurrently. There is continued concerted effort being made by the Trust to identify further schemes. However, there is a 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 £37,773k that is £13,015k lower than plan due to the payment of supplier invoices. The Trust is forecasting a cash position at the end of March 2024 of £35,177k, which is 30.2% 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 £17,156k is £565k above the YTD plan. The capital forecast is £19,847k for the year, which is £7,208k 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 continues to work with budget holders to ensure that Trust delivers its plan for the year.

2. Weekly check and challenge reviews have taken place to identify new efficiency schemes and to drive progress on current schemes. This included 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.

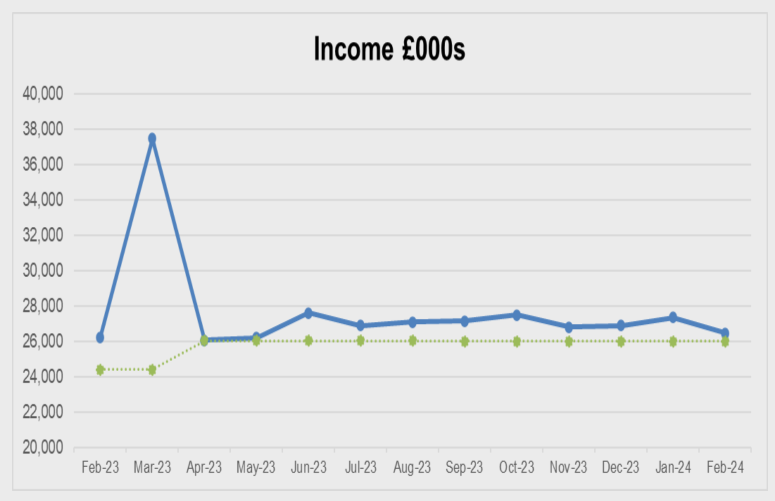
3. Monthly executive led directorate financial performance meetings are continuing to take place to ensure that each directorate delivers their element of the financial plan e.g., budget and efficiency target.

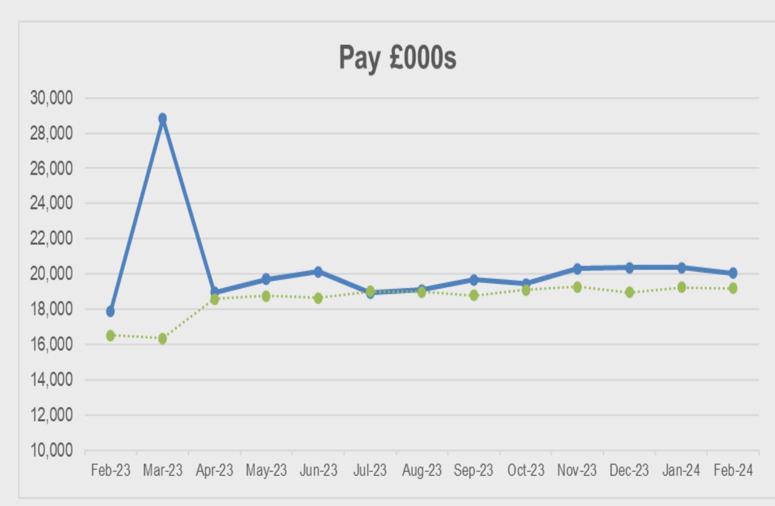
4. The Trust is confident that it will be able to deliver it 2023/24 using non-recurrent measures.

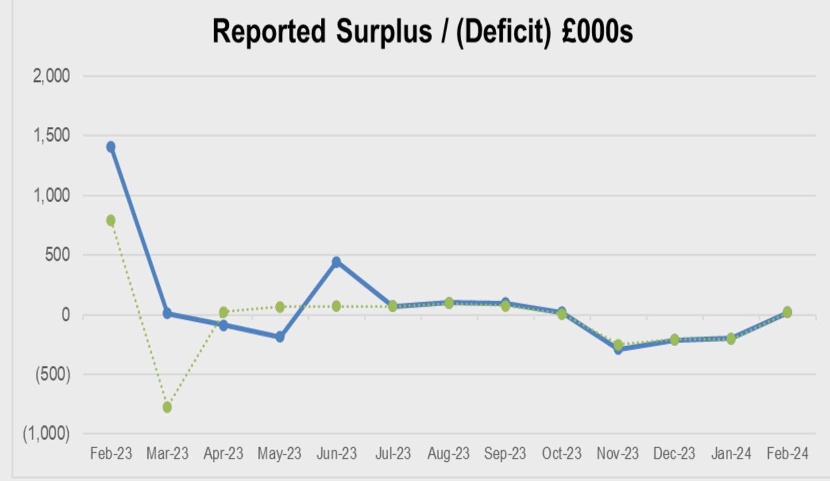
5. In addition, the Trust is developing its 2024/25 operating plan.

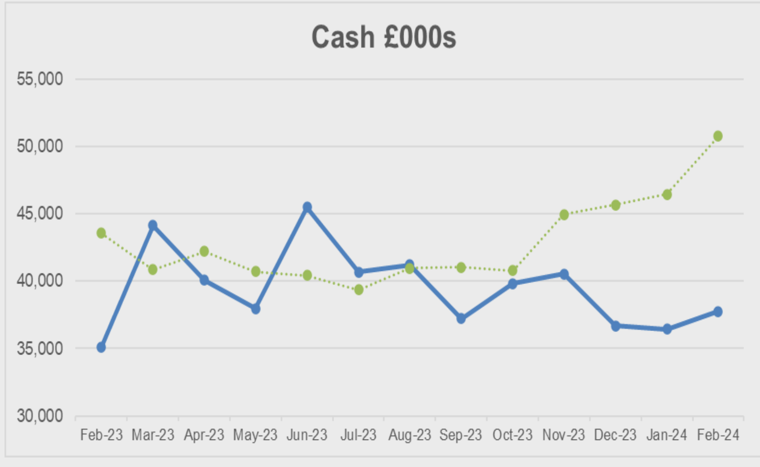
SUSTAINABILITY & PARTNERSHIPS

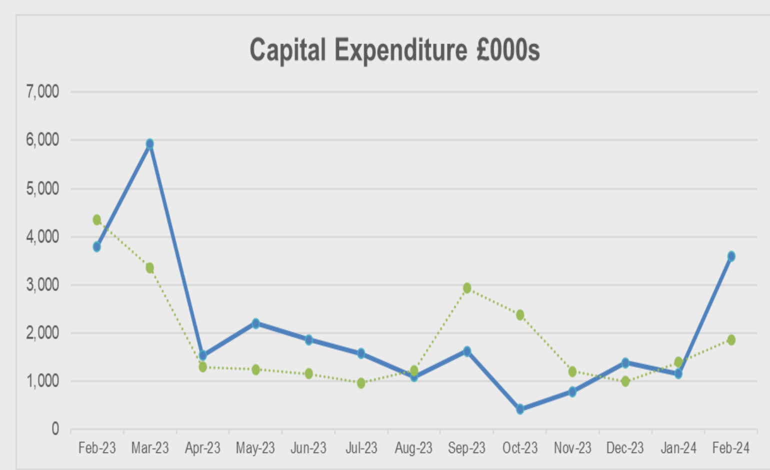
Delivered Against Plan











Summary

- The Trust's YTD M11 financial performance is on plan and the reported deficit of £217k represent a £13k favourable variance.
- Financial pressures, notably in 111and HR are mitigated by non-recurrent means, mainly through profit on sale of Trust assets including Redhill and Leatherhead Ambulance Stations 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 ahead of plan due to timing of IT projects.

Appendix

Appendix 1: Glossary

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations

F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

Agenda No	10/24

Name of meeting	Board
Date	4 April 2024
Name of paper	Achieving Sustainability & Working with Partners
Strategic Theme	**Sustainability & Partnerships**
Author / Lead Director	David Ruiz-Celada, Executive Director for Strategy and Transformation
Executive Summary	

Trust Strategy

1. SECAmb has completed the strategic planning process, with the Board selecting the preferred "Care Navigation" option in February 2024 and the implementation plan having been completed in March 2024.

2. This strategy aims to position SECAmb as a leader in navigating the unscheduled urgent and emergency care landscape, collaborating with partners to ensure that up to 1 in 3 patients in the future receive appropriate care without the need for an emergency ambulance response.

3. Key elements of the strategy include:

   - Expanded integration and collaboration with the health and social care system
   - Investment in technology and data for better decision-making and learning
   - Aligning clinical needs to skillsets to maximise the impact of our people
   - Expanding the role of volunteers to improve community response

4. By implementing this strategy, SECAmb expects to meet national standards for emergency care (7 minutes for C1 and 18 minutes for C2) in a sustainable model that meets patient' critical emergency health needs, and supports colleagues at SECamb in delivering the best possible care.

5. A transformation plan has been developed to move from strategy to action, with phase 1 focusing on setting up for success over the next 18-24 months. Priorities include aligning the operating model to ICB footprints, developing models of care and pathways with system partners, expanding on the outcomes delivered in East Kent, detailing workforce plans, and preparing for digital transformation.

6. We are aligning our 24/25 delivery plans and priorities to the transformation programme. This will be the basis of the Board plan which we will be presenting to Audit Committee in May and ready for the 1st Public Board of the 24/25 FY in early June 24. The timeline has been driven by the delayed national planning round.

7. SECAmb is engaging in a Trust-wide debate on values and mission statements to support the transformation, alongside a corporate re-branding.

8. The New Strategy is expected to be published in May 2024.

Recommendations, decisions or actions sought	For decision

Our strategy 2024-29

April 2024

Foreword from Simon Weldon, CEO

I am pleased to present our strategy to the Board on behalf of the Executive Team for the future of South East Coast Ambulance Service.

As the CEO of SECAmb it is both a privilege and responsibility to steer our organisation towards a future that meets the evolving needs of our patients and the healthcare landscape.

Nationally, regionally and locally, the NHS is facing rising operational and financial challenges. A growing and aging population with more complex health needs will lead to a 15% growth in patient demand for SECAmb over the next 5 years.

We have been on a journey of change over recent years, and much progress has been made, evidenced by our improving results in the staff survey and innovations such as the Ashford integrated care hub pilot. Yet to secure a long-term, sustainable future we need to continue to change to best meet the needs of our patients, staff and volunteers, and system partners.

Our new vision for SECAmb is rooted in what an ambulance service does: **saving lives and serving our communities.**

Our strategy is to differentiate our response to best meet patient needs. We will provide a consistent physical ambulance response for our emergency patients while offering a virtual response for those patients who do not require an ambulance. This will involve integrated care hubs with experienced clinicians and local knowledge who will treat, refer or direct some patients to other appropriate services. This will be enabled by the right technology, supporting and developing our people and working more closely with our system partners.

Our case for change is urgent and we must start now. We have developed detailed and costed implementation plans to start in 2024-25 and then continuing over the remaining years of this strategy.

I extend my heartfelt thanks to all our patients, people, partners and the communities we serve who have been involved in shaping this strategy. As we continue our transformative journey, I would invite you to engage actively in helping us deliver a stronger SECAmb that is ready to meet the challenges of the future head-on.

Simon Weldon
Chief Executive Officer

Executive Summary

The case for change

We are running out of road and cannot continue to do things the same way

1. Population growth, ageing, and increased complexity of health needs will lead to a 15% growth in demand over the next 5 years.
2. Nationally, the NHS is facing significant operational, financial and workforce challenges and ambulance services are under significant pressure - no ambulance service is currently responding to category 2 patients within 18 minutes.
3. We need to continue developing our people so that they have fulfilling careers and the right skills to meet evolving patient needs.
4. To meet the predicted demand with our current model of care, we would need to recruit an additional 600 people, which is unaffordable.

A clinically-led strategy co-designed by staff

This strategy has been developed through engagement with over 2,000 staff, 400 volunteers, 350 members of the public and 20 sessions with system partners.

Our new service model

Our vision is 'saving lives, serving our communities'

Our strategy is to **differentiate our response** to best meet patient needs.

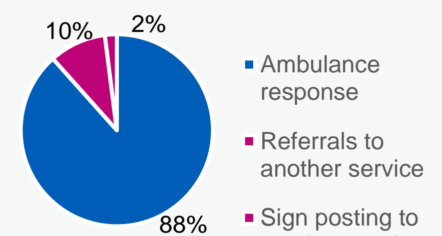
We will provide a **consistent physical ambulance response** for our emergency patients while offering a **virtual response** for non-emergency patients. This may involve **signposting** some patients to other appropriate services. This will be enabled by new, advanced technology and by developing our people.

How will our response mix change?

NOW

Over 70% of our patients come to us with social, urgent or unmet care needs.

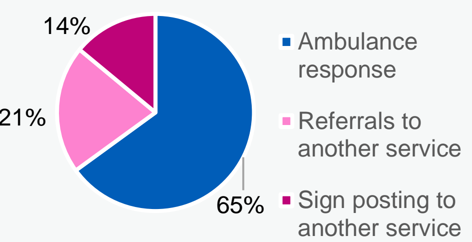
Yet only **12%** of our patients are referred or signposted to another service.



IN 5 YEARS TIME

Our responses will meet the changing needs of our patients.

This means **35%** of all our patients will be referred and signposted to another service.



What are the outcomes?

For our patients Timely responses and high-quality care. Our strategy will deliver a C2 and C1 mean of 18 and 7 minutes, respectively.

For our people Our people will be more empowered with the right skills, support and tools to care for patients and will have better career opportunities. We expect to improve our retention as a result.

For our partners A closer working relationship that bridges the gap between ambulance response and other health services. This will help us deliver a 30% improvement in productivity and cost per patient.

Delivering these changes

We are committed to delivering these changes

We have developed a costed five-year transformation roadmap including a detailed plan for 2024-25 (year 1) and medium and long-term time horizons.

Summary of key actions for 24/25

In 24/25, we will focus on designing for the future and running our current service model with some strategic improvements, including a focus on virtual consultation

Our plans

We have three phases of transformation. In 24/25 we will deliver Phase 1.

Phase 1 – Design & set-up *(short term)*	**Phase 2 –Implement & change** *(medium term)*	**Phase 3 – Embed & improve** *(long term)*
We will set up the organisation to successfully implement change.	We will implement transformational change at scale.	We will embed final changes into our new operating model and continuously improve.

The first year of transformation is critical to the success and sustainability of this strategy. In our first year of transformation, we will:

- ✓ Re-structure leadership (executive, operations & support)
- ✓ Establish a Transformation Management Office (TMO)
- ✓ Design new models of care
- ✓ Design and implement five integrated care hubs
- ✓ Review commissioning arrangements in the Southeast
- ✓ Mobilise a collaboration across partners to deliver transformation together
- ✓ Develop a data and digital strategy

Our partners

24/25 will be a step change in collaboration with our partners

We serve 4 ICSs with diverse populations across a large geographical area. This means we cannot deliver our strategy successfully without working in collaboration with our system partners.

How we will achieve our plans *(Core work packages)*

1. Leadership Structure and Operating Model

Ensure the right capacity and capability to support the delivery of our new clinical model, and we are structurally aligned with our partners.

2. Workforce Plan

Develop a detailed workforce plan that ensures our people have the right skill set, in the right structure, with the right support to care for our patients within the new clinical model.

3. Models of Care

Re-design specific models of care for our patient groups, identifying where further capacity is needed across other providers, and gaps in the skills of our workforce.

4. Care Navigation Hub Expansion

Implement the first iteration of our five new integrated care hubs - validating our workforce and clinical assumptions and stepping into virtual care.

5. Productivity, Sustainability and Collaboration

Make our organisation more productive, reducing waste, and maximising the benefits of working in collaboration with other providers.

6. Digital Enablement

Develop a data and digital strategy that identifies how we will deliver the technology improvements we need to enable our clinical model.

7. Getting Things Right for our People

Deliver our People & Culture Strategy by investing in training and education, developing our leaders, fostering a positive speak-up culture, and focusing on wellbeing and retention.

01

Strategic context

We are SECAmb

We are a provider of Urgent and Emergency Care through our 999 Ambulance Service across Kent & Medway, Surrey, Sussex and Frimley and our NHS 111 Service across Kent & Medway and Sussex.

Our organisation

5.1 million
Population served

1 million
999 calls received per year

1.3 million
111 calls received per year

650,000
Incidents attended per year

13 million
Miles driven

4,300
Total workforce (WTE)

400
Volunteers

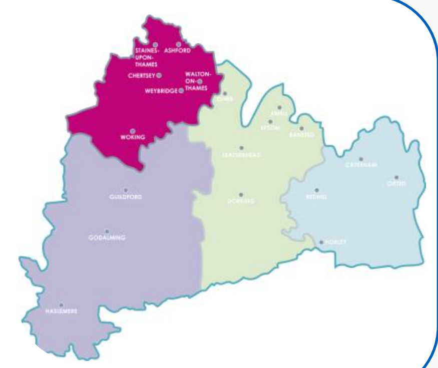
4 systems
Spanning 3,670 sqm

Serving four Integrated Care Systems

Population: 1.1 million

Number of Places: 4

Average patient age: 66



Population: 1.9 million

Number of Places: 4

Average patient age: 61

Frimley Health and Care

Population: 0.4 million
(within SECAmb footprint)

Number of Places: 2
(within SECAmb footprint)

Average patient age: 64

Sussex
Health&Care

Population: 1.7 million

Number of Places: 3

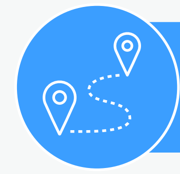
Average patient age: 66

Our strategy needs to account for complex national and regional context

National context

Urgent and Emergency Care, including ambulance services, are under pressure nationally and the financial environment is constrained

- Pressure on Urgent and Emergency Care (UEC) services across the UK has been increasing steadily year-on-year. In January 2024, only 55% of patients attending a major A&E department were admitted, transferred or discharged within the 4-hour standard.[1]
- This pressure on the wider UEC system impacts ambulance services through long handover delays and increased demand as patients cannot reach other forms of care. In January 2024, SECAmb was the only ambulance trust to delivery category 2 response times under 30 minutes.[2]
- The NHS is under significant financial challenges with many systems nationally forecasting a deficit.



Regional context

We serve a diverse, ageing, and growing population, within a changing regional landscape

- Over the next five years, the population across the Southeast of England will grow by 2.5% and the number of people aged over 65 will increase by 12%. This will lead to more patients with complex health needs.
- Our four ICSs are currently undergoing a period of significant change as 'place' and provider collaboratives are being developed to deliver care closer to patients. Each system has a different maturity level with the development of provider collaboratives, setting different paces at which SECAmb can deliver change.
- There remains inconsistency across the Southeast of England on how ambulance and 111 services are commissioned, and care is delivered.

1. https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2023-24/
2. https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2023-24/

We are on an improvement journey, but face rising challenges

Sustainable progress has been challenging to achieve and maintain

2006
Formation

SECAmb was established in 2006 through the merger of Kent, Surrey, and Sussex ambulance services.

2016
Special Measures

Following a Care Quality Commission (CQC) inspection, the Trust entered special measures due to quality concerns.

2019
Recovery

SECAmb successfully exited special measures, signifying progress in addressing quality issues.

2022
RSP

A CQC inspection resulted in an 'inadequate' rating in the Well Led domain, leading to SECAmb being placed into the NHS England Recovery Support Programme (RSP).

2023
Improvement

With national support, changes have been made to reflect CQC and NHSE recommendations.

Improvements were seen in the NHS staff survey results, but much more remains to be done.

* Measure using the Category 2 response time mean

Today the trust faces significant challenges from:

- Rising demand and changing needs of our patients
- Wider challenges in the NHS
- Our model of care, which is no longer fit for purpose
- Financial and environmental constraints

We need a new strategy that allows us to face the challenges

We are running out of road. Doing nothing is not an option.

The needs of our patients are changing and becoming more complex. Population growth, ageing and increased complexity will lead to a 15% growth in patient demand 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 demand.

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

We need a new strategy that enables us to:

02

Approach to developing the strategy

Principles for strategy development

The development of our strategy has been:

Clinically-led and patient-centred

Co-designed with our patients, people and partners

Evidence-based and data-driven

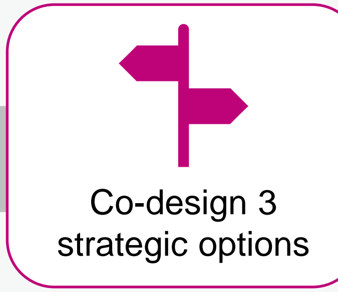
Pragmatic, implementable and sustainable

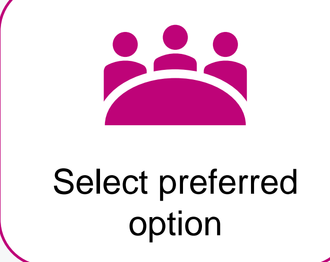
Focused on creating benefits for the wider systems

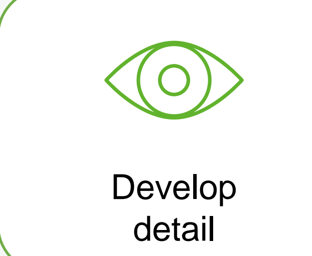
We have co-designed a clinically-led strategy

Key steps in strategy development

Understand progress to date


Develop case for change


Co-design 3 strategic options


Select preferred option

Develop detail

Planning

We analysed internal and external data and understood we needed to change because:

- Demand will increase by 15% by 2029
- ICSs are under significant financial and workforce pressure
- We must make SECAmb a place where people can thrive at work
- We must break even whilst addressing increasing cost pressures

We developed three options and selected one:

Option 1
Deliver a consistent emergency ambulance response for our emergency patients only

Selected option

Option 2
Focus on delivering a consistent emergency ambulance response for our emergency patients, while assuming a lead role in care navigation for our non-emergency patients through virtual response

Option 3
As per option 2, plus providing new community-based services with our partners

We defined how the strategy will be implemented:

Outcomes	Supports the delivery of our vision, and defines what it will mean for our people, patients and partners
Strategic commitments	Explains **what** are we going to change to deliver the outcomes
Roadmap	Explains our plan for **how** we are going to change over the short, medium and long term

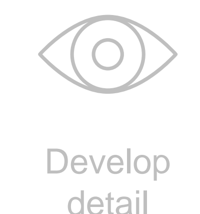
Our patients, people and partners have co-designed the strategy

Understand progress to date

Develop case for change

Co-design 3 strategic options

Select preferred option



Develop detail

Planning

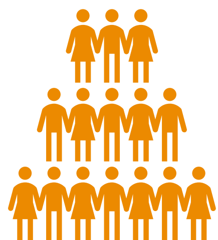
Our communities

We have heard from **over 350** patients

Our partners

We have engaged ICBs and partners in **20 sessions**

Our people



We have individually engaged with **over 2,000** colleagues

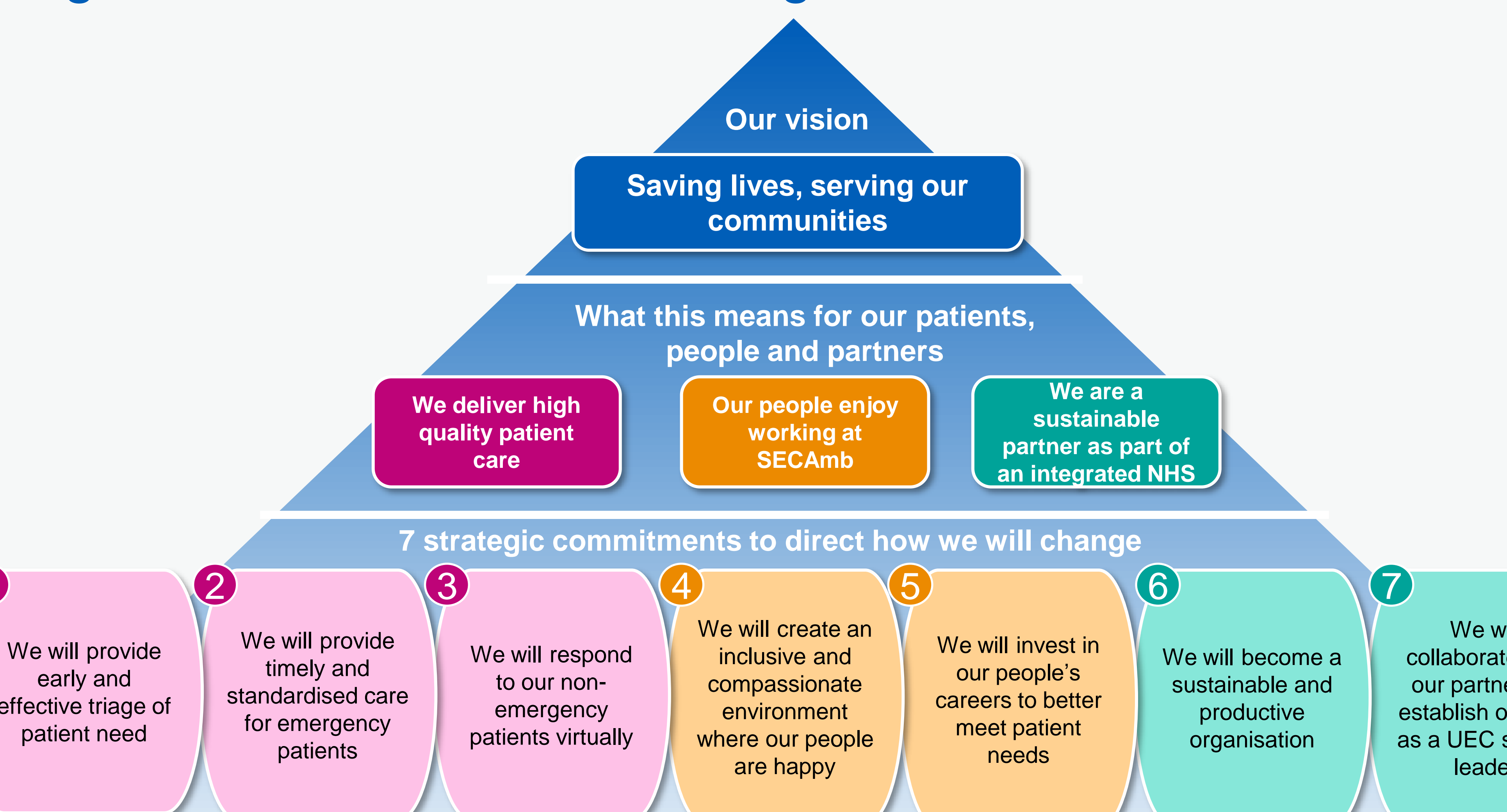
Our volunteers

We have engaged with **400 of our volunteers**

03

Our vision and service model

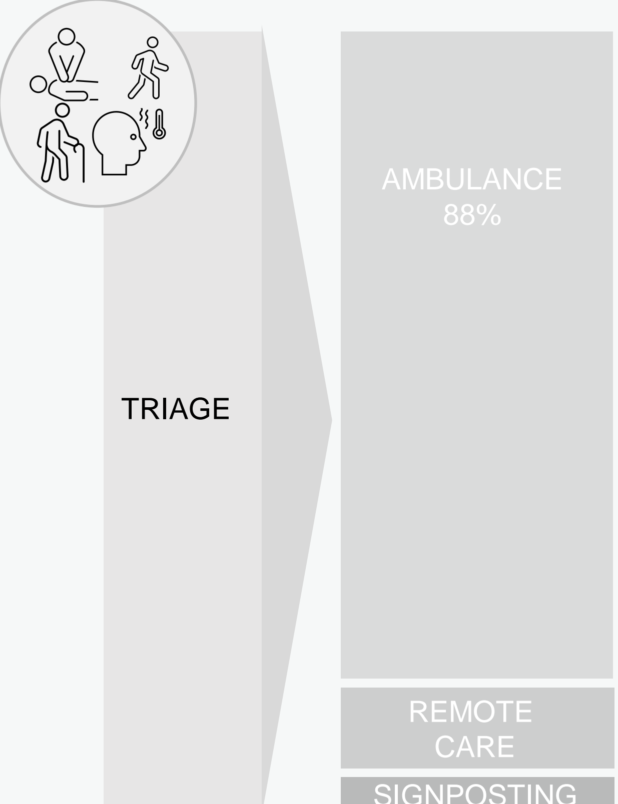
A strategic framework to direct and guide our transformation



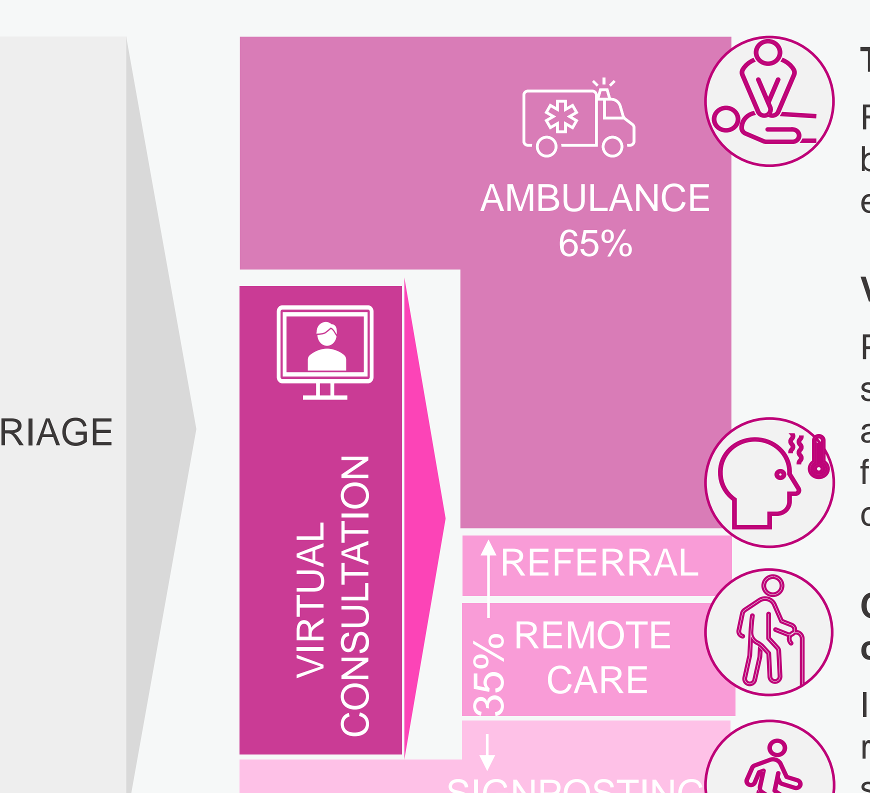
Our strategy is to differentiate our response to best meet patient needs

To use our resources effectively, we are moving away from a 'one size fits all' approach. This will ensure all our patients receive the most appropriate response for their needs.

NOW: We have the same response for most of our patients - we send an ambulance.



FUTURE: We will provide a different response according to patient need.



Timely care for emergency patients:

Resources will be refocused to provide a better and faster response to our emergency patients.

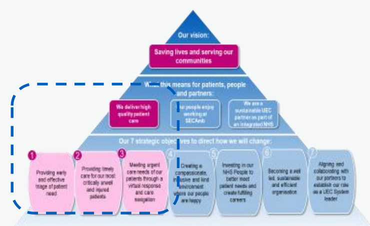
Virtual care for non-emergency patients:

Patient needs are thoroughly assessed by a senior clinician remotely. This clinical assessment will enable patients to be cared for directly or referred to the most appropriate care provider.

Connecting other patients with the right care, if they don't need us:

If, once assessed, the patient's needs do not require a SECAmb response, they will be signposted to an appropriate agency or service.

Outcome 1: We deliver high quality patient care



We deliver high quality patient care

Strategic commitments we need to achieve to deliver the outcome:

1 We will provide early and effective triage of patient need

We will set up a smart triage function that will enable us to determine the level of emergency for a patient's needs, using data and AI. This will ensure patients receive the right response from us.

2 We will provide timely and standardised care for emergency patients

We will ensure patients who need an emergency physical response will have their care led by a paramedic who has the right skills to deliver the most appropriate treatment.

3 We will respond to our non-emergency patients virtually

We will set up a virtual consultation capability, led by senior clinicians, who will ensure all non-emergency patients receive the right care at the right time.

How will we know we have achieved the outcome:

Improved call answering times

Improved duplication of calls

Improved emergency response times (C2 mean within 18 minutes)

Improved time from call to hospital arrival for stroke and heart attack patients

Increased cardiac arrest survival

Reduced time to virtual clinical assessment (C5 mean)

Increased proportion of calls resolved through virtual response

Increased referrals to appropriate non-ED care pathways

Outcome 2: Our people enjoy working at SECAmb

Our people enjoy working at SECAmb

Strategic commitments we need to achieve to deliver the outcome:

We will create an inclusive and compassionate environment where our people are happy

We will create a supportive and flexible culture where all our people feel safe, are able to speak up, and benefit from compassionate leadership.

We will invest in our people's careers to better meet patient needs

We will implement a new workforce model and training. This will enable our people to develop their skills to better meet the changing needs of the populations we serve.

How will we know we have achieved the outcome:

Improved retention rates

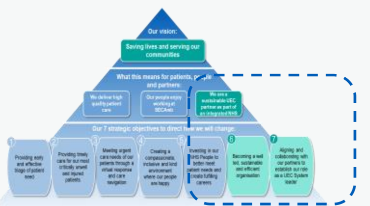
Improved proportion of staff recommending SECAmb as 'a great place to work'

Improved mandatory and non-mandatory staff training completion

Improved opportunities for staff to develop their careers

Improved quantity of staff feeding back on rewarding careers

Outcome 3: We are a sustainable partner as part of an integrated NHS



We are a sustainable partner as part of an integrated NHS

Strategic commitments we need to achieve to deliver the outcome:

6 We will become a sustainable, and productive organisation

We will build an organisation that is financially and environmentally sustainable. We will reduce waste and optimise our corporate and operational functions to ensure we can deliver a service that can sustain itself financially in the long term.

7 We will collaborate with our partners to establish our role as a UEC system leader

We will work with our place, system and regional partners to co-design our role as the navigator of care across UEC. This will ensure that we are seen as a leading partner for assessing, referring and signposting non-emergency patients for further care.

How will we know we have achieved the outcome:

Achieve a balanced budget whilst achieving national standards

Meet midpoint carbon reduction Green Plan targets for 2029

Reduced percentage of avoidable conveyance to emergency departments and subsequent bed days

Improved utilisation of community and primary care pathways for onward care

Improved percentage of referrals accepted by partner providers on the first attempt

Delivery of the strategy will be over three phases, and take place alongside wider Trust transformation

Phase 1 – Design and set-up
(Short term)

We will set up the organisation to successfully implement change.

- Build capabilities and structures for the future – aligned to ICBs
- Detailed design of our new services (models of care) and workforce
- Implementation of five local integrated care hubs
- Get ready for digital transformation

Phase 2 – Implement and change
(Medium term)

We will implement transformational change at scale.

- Implementation of technology to augment core capabilities
- Transition to new models of care
- Align our workforce to the new service model

Phase 3 – Embed and improve
(Long term)

We will embed final changes into our new operating model and continuously improve.

- Evaluation and optimisation of the new service model
- Locally owned Quality Improvement
- Further strategic change (inc. new service development)

There is a road to a sustainable future

In summary, our strategy will differentiate our response to best meet patient needs. We will provide a consistent physical ambulance response for our emergency patients while offering a virtual response for those patients who do not require an ambulance.

We are running out of road. Doing nothing is not an option.

Implementing our strategy will tackle our challenges and lead to a sustainable future.

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

We will be able to cope with **demand** and **complexity** and the **risk of harm** for our **patients** will decrease

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

We will support our systems by assuming a **system leadership** role **within UEC**

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.

We will have an **empowered** and motivated workforce, with the right model of care in place

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

We will operate an **environmentally and financially** sustainable organisation

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Item No	10/24
Name of meeting	Trust Board		
Date	04.04.2024		
Name of paper	M11 (February 2024) Financial Performance		
Executive sponsor	Simon Bell – Interim Chief Finance Officer		
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Rachel Murphy (Financial Manager - Projects, Business, and Investments)		
Synopsis	This report provides the M11 year-to-date (YTD) financial performance of the Trust. The Trust reported a £13k favourable variance against its planned deficit of (£228k) at M11 YTD. YTD actuals as at M11, were (£215k) that includes pressures in Operations (mainly 111 services) and an under delivery of the planned efficiency programme, which is £543k below plan. The Trust has mitigations in place and is on track to deliver its financial, break-even plan for the year ending 31 March 2024. The Trust's cash position of £37,773k was £13,015k lower than plan. This is driven by the reduction of the Trusts trade payables that includes a £5.8m decrease in capital debt outstanding. This is a result of timelier invoicing by suppliers and payment made by the Trust. The Trust is forecasting a cash position of £35,177k at the end of March 2024, which is £15,224k below plan, because of anticipated reduction in trade payables and borrowings.		
Recommendations, decisions, or actions sought	The Board is asked to note the following: a) The M11 YTD financial performance b) Mitigations in place to address overspends and under-delivery of the efficiency programme to deliver the break-even plan. c) The Trust remains on track to deliver its financial plan of break-even using non-recurrent means. In addition, the Board is asked to consider the separate paper summarising the current position with the **operating plan for 2024-25**. The planning guidance was published on 28 March 2024. There will be a further discussion in Part 2.		
Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		N/A	

2023/24

Finance Report to the Board of Directors

11 Months to 29 February 2024

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Executive Summary

The Trust reported a £215k deficit for the eleven months to February 2024 that is £13k better than plan. The Trust's forecast remains at the planned break-even position.

	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	295,171	295,947	776	321,984	322,771	787
Expenditure	(299,560)	(299,248)	312	(326,486)	(325,855)	631
Planned Profit on Sale of Assets	4,159	3,084	(1,075)	4,500	3,084	(1,416)
Trust Surplus / (Deficit)	**(230)**	**(217)**	**13**	**(2)**	**0**	**2**
Reporting adjustments:						
Remove Impact of Donated Assets	2	2	0	2	2	0
Remove Impact of Impairments	0	0	0	0	0	0
Reported Surplus / (Deficit)*	**(228)**	**(215)**	**13**	**0**	**2**	**2**

Efficiency Programme	7,888	7,345	(543)	8,988	8,988	0
Cash	50,788	37,773	(13,015)	50,401	35,177	(15,224)
Capital Expenditure	16,591	17,156	(565)	27,055	19,847	7,208

*Reported Surplus / (Deficit) represents what the Trust is held to account for by the ICB/NHSE

Year to Date (YTD)

- For the YTD ending February 2024, the Trust is reporting a financial position in line with plan. The overall financial performance consists of adverse and favourable variances. The adverse variances are driven by pressures in our frontline operations of £1,243k, increased energy and premises costs of £1,338k, overspend of £445k in the NHS 111 service, and a net £497k pressure in HR. These are outlined more in detail further on. Favourable variances include £2,033k higher than planned interest on its cash held at bank and £2,321k due to back-office vacancies.

- The Trust has confirmed to NHSE that it will achieve the £8,988k efficiency target for the year that will include non-recurrent savings to achieve the target. Year to date at month 11 (February 2024), we have identified £8,174k (91%) worth of efficiency plans.

    - YTD achievement of £7,345k efficiencies is 6.9% below plan. The shortfall is driven by the challenges in the delivery of our planned cash releasing savings of £4,204k that was £3,677k and £527k lower than the plan.
    - The recurrent schemes and non-recurrent ratio at M11 are 72% and 28% respectively compared to the target of 100% recurrent schemes. The Full Year Risk adjusted forecast ratio remains 74%:26% (recurrent / non-recurrent). Further reliance on non-recurrent budget underspends is likely to dilute the ratio.
    - Our total risk adjusted forecast improved by £133k this month (February 2024) to £8,102m, which represents 90% of the efficiency target. The improvement was within the "Hear and Treat" scheme, leading to the achievement of our non-cash releasing target for the year.
    - The Trust must deliver £1,643k worth of efficiencies in March to achieve its target. Although this remains challenging with the increasing operational pressures there are mitigations in place to bridge the shortfall. This includes the recognition of

budgetary underspend, the development of validated and scoped schemes at a value of £280k and utilisation of unplanned contingencies.

- Forecast includes both the income and expenditure relating to the £2,500k additional operational capacity funding. £2,330k already spent for the year to date.

- The cash position increased by £1,333k this month to £37,773k due to the sale of Leatherhead Ambulance Station. The cash balance is £13,015k below plan, mainly due to the reduction in our accounts payable through better supplier invoicing and the Trust's responsiveness of settling these in line with payment terms.

- Capital expenditure of £17,156k is £565k above plan. This is due to the early completion of some IT proposals., these were originally expected to be delivered in March.

Forecast Outturn

- The Trust is forecasting to achieve a breakeven at year-end. This is in line with the expectations of NHS England and Surrey Heartlands ICB.

- The Trust is focused on delivering its financial plan for the year, this includes reviewing the Trusts Statement of Financial Position, to ensure our provisions are adequate to meet our obligations.

- The Directorate financial position check and Executive challenge reviews continues to ensure all directorates deliver their allocated plan, including reducing overspend, run rates, maintaining, and releasing YTD underspends as non-recurrent measures to meet the breakeven forecast position.

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

1. Income

	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	264,455	264,910	455	288,519	288,971	452
111 Income	24,663	24,799	136	26,905	27,055	150
HEE Income	2,271	2,453	182	2,474	2,759	285
Other Income	3,782	3,785	3	4,086	3,986	(100)
Total Income	**295,171**	**295,947**	**776**	**321,984**	**322,771**	**787**

- 999 income is £455k greater than planned YTD, following confirmation of the contractual out-turn.
- 111 income is £136k above plan, following review and confirmation of the contractual out-turn for 2023/24 and additional income to match costs of providing doctors personal learning days (PLDs) cover for the Kent and Medway ICB.
- HEE (Health Education England) income is £136k above plan. This reflects the most recent funding schedules received for 2023/24 a covers specific funding expenditure, namely course fees for the Level 7 Advanced Clinical Practitioners.
- Other income is slightly above plan YTD, however forecast deteriorated since last month due to Recovery Support Program funding from NHS England confirmed to be lower than predicted.

2. Expenditure

The below table shows expenditure plan and outturn by directorate. The below is offset by corresponding funding the Trust receives and recognised under income.

Expenditure By Directorate*	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(4,504)	(4,351)	153	(4,918)	(4,771)	147
Finance	(21,599)	(22,274)	(675)	(23,626)	(24,550)	(924)
Quality and Safety	(3,177)	(3,030)	147	(3,462)	(3,338)	124
Medical	(17,273)	(16,462)	811	(18,957)	(17,949)	1,008
Operations	(169,444)	(170,687)	(1,243)	(184,974)	(186,919)	(1,945)
Operations - 111	(24,591)	(25,036)	(445)	(26,824)	(27,320)	(496)
Strategic Planning & Transformation	(25,772)	(25,344)	428	(28,120)	(27,974)	146
Human Resources	(5,278)	(5,983)	(705)	(5,739)	(6,455)	(716)
Total Directorate Expenditure	**(271,638)**	**(273,167)**	**(1,529)**	**(296,620)**	**(299,276)**	**(2,656)**
Depreciation	(17,353)	(16,545)	808	(19,066)	(18,155)	911
Financing Costs	(2,146)	140	2,286	(2,342)	151	2,492
Corporate Expenditure	(8,423)	(9,676)	(1,253)	(8,457)	(8,576)	(119)
Total Expenditure	**(299,560)**	**(299,248)**	**312**	**(326,486)**	**(325,855)**	**631**
Planned Profit on Sale of Assets	4,159	3,084	(1,075)	4,500	3,084	(1,416)
Total Trust Expenditure	**(295,401)**	**(296,164)**	**(763)**	**(321,986)**	**(322,771)**	**(785)**

*Excludes Income

YTD performance against plan

- Total expenditure at M11 YTD was £296,164k, which is £763k higher than plan.

- The key pressures include net overspend in frontline operations of £1,243k, higher premises costs, £445k overspend in NHS 111 and increased costs in HR of £706k including the funded projects supported by £209k of income. The net cost pressure is £497k of the latter which relates to wellbeing. These are offset by non-recurrent benefits including favourable variance against financing costs of £2,286k explained below.

- The higher than planned spend continues in Operations, and currently exceeds plan by £1,243k YTD. The main driver is the adverse variance of £1,664k in our frontline operations that is partly offset by underspends across the directorate including £336k savings due to the timing of placement training, and £85k underspent in Specialist Operations relating to delays to planned vehicle leases.
  - The overspend of £1,664k in frontline operations is marked by the 4.9% increase in productive hourly rate (based on hours 'on the road') of £37.48 against the plan of £35.73. The main factors include the following:
    - We continue to see progressive overprovision of hours in our frontline operations since November with 5.7% hours more than plan provided in February. This means, the overall YTD provision of staff hours including the contribution of 64.5k hours relating to the 12-hour DCA and mid shifts was 0.7% below plan. The main driver is that the substantive staffing levels are over established by 107 WTE, of which circa 50 additional WTE relating to the accelerated recruitment at the beginning of the financial year, that is generating additional cost of £1,869k.
    - This is attributable to 27% better than anticipated attrition level whilst planned recruitment remains on track. Moreover, the YTD abstraction levels remain positive at 29.2% compared to the plan of 31.9%, although sickness level is 8.3%, against the target of 7.0%.
    - The provision of overtime currently represents 7.5% of the YTD total hours compared to the plan of 5.0% leading to an increase cost of £112k. However, significant reduction in time of in lieu of £166k due to increased substantive staffing levels in the Trust and the £297k savings (3.3%) from Private Providers mitigate this.
    - Other pressures include increased travel and hotel costs of £149k. A review is in place with Procurement to source out a suitable contract with a preferred supplier.

- We are reporting an adverse variance of £445k in the financial performance of NHS 111 service YTD. This is a combination of our sub-contractor, IC24 taking a higher proportion of calls compared to plan at an extra cost of £255k. The further pressure is due to the requirement for the utilisation of additional GP services together with incentivising targeted shifts to improve performance to facilitate a safe service delivery. This is partly due to the increased sickness abstraction levels of 12.1% compared to the target of 7.0%, although the overall YTD abstraction of 29.4% tracks below the plan of 31.9%. Recruitment continues to be challenging, particularly in the West but steadily building up in Medway and gradually bridging the shortfall in establishment.

- The net £497k overspent in HR is due to the higher than planned relocation expenses associated with the international recruitment of £284k. The remaining £213k adverse variance is a combination of extra capacity requirement for the provision of core services and higher external investigation costs.

- Finance costs is contributing an additional £2,286k of favourable variance, through bank interest received of £2,033k reflecting the high interest rates.

- Other favourable variance across other directorates includes vacancies in support and back-office functions of £2,033k, partly due to delays in restructures and the timing of training related spend is contributing to £322k savings. These are offsetting the increased energy and premises cost driving the overspend in Finance directorate the requirement for specialised external professional support costs in CEO.

- Depreciation is below plan by £808k due to timing. The forecasted position for total depreciation is to be less than plan by year end because of delays in assets going live compared to the original plan timing.

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

NHSE Categories	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Pay/Staff Costs	(210,889)	(211,782)	(893)	(230,076)	(232,278)	(2,202)
Depreciation	(17,353)	(16,544)	809	(19,066)	(18,154)	912
Premises Costs	(16,897)	(18,235)	(1,338)	(18,478)	(20,057)	(1,579)
Transport Costs	(16,138)	(15,427)	711	(17,599)	(17,025)	574
Purchase of Healthcare (PAPs;IC24;HEMS)	(12,674)	(11,711)	963	(13,800)	(12,690)	1,110
Supplies and Services	(8,728)	(9,004)	(276)	(9,560)	(9,929)	(369)
Establishment	(4,984)	(5,625)	(641)	(5,420)	(6,063)	(643)
Education Costs	(2,116)	(1,794)	322	(2,320)	(2,031)	289
Operating Lease Expenditure	(1,853)	(1,606)	247	(2,022)	(1,779)	243
Finance Costs	(2,147)	142	2,289	(2,342)	155	2,497
Clinical Negligence (CNST)	(1,769)	(1,735)	34	(1,929)	(1,893)	36
Other	(4,012)	(5,927)	(1,915)	(3,874)	(4,113)	(239)
Total Expenditure	**(299,560)**	**(299,248)**	**312**	**(326,486)**	**(325,857)**	**629**
Planned Profit on Sale of Assets	4,159	3,084	(1,075)	4,500	3,084	(1,416)
Total Trust Expenditure	**(295,401)**	**(296,164)**	**(763)**	**(321,986)**	**(322,773)**	**(787)**

Full year performance against plan

- Despite some overspends for the year, mainly in pay, which includes the additional expenditure to deliver operational capacity. The Trust is planning to achieve financial breakeven, subject to mitigating actions put in place to reduce and eliminate risk associate with under delivery against efficiency programme and budgetary overspends.

3. Workforce

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

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

WTE* By Directorate	Analysis to February 2024			Month of February 2024		
	Jan-24	Feb-24	Movt	Plan	Actual	Variance
Chief Executive Office	58.7	58.9	0.2	60.4	58.9	1.6
Finance	85.3	87.4	2.0	95.9	87.4	8.6
Quality and Safety	58.6	59.5	0.9	58.7	59.5	(0.8)
Medical	197.2	194.7	(2.5)	204.5	194.7	9.8
Operations	3,655.0	3,637.4	(17.6)	3,504.5	3,637.4	(132.9)
Operations - 111	371.6	408.4	36.8	436.1	408.4	27.7
Strategic Planning & Transformation	131.8	127.9	(3.9)	135.5	127.9	7.6
Human Resources	77.0	77.2	0.2	76.6	77.2	(0.6)
Total Whole Time Equivalent (WTE)	**4,635.2**	**4,651.4**	**16.2**	**4,572.1**	**4,651.4**	**(79.2)**

*Excludes 3rd Party Providers (PAPs)

- WTE for February 2024 increased slightly by 16.2WTE, compared to January 2024 and we were 79.2WTE above plan.

- 16.2WTE more was provided in February compared to last month, mainly in 111 through increased provision.

- The Trust is 79.2WTE above plan for February, Operations has provided 132.9 additional WTE, as the Trust provided an additional 65,000+ hours over plan. NHS 111 is 27.7 WTE lower than planned, due to call handlers and clinicians vacancies, hence recruitment continues.

4. Service Line

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

Trust Position	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	295,171	295,947	776	321,984	322,771	787
Expenditure	(295,401)	(296,164)	(763)	(321,986)	(322,771)	(785)
Surplus / (Deficit)	**(230)**	**(217)**	**13**	**(2)**	**0**	**2**

999 (Emergency Services)	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	266,321	267,173	852	290,524	291,388	864
Expenditure	(266,179)	(266,847)	(668)	(290,110)	(290,753)	(643)
Surplus / (Deficit)	**142**	**327**	**184**	**414**	**635**	**221**

111 (KMS)	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	24,663	24,799	136	26,905	27,054	149
Expenditure	(24,877)	(25,050)	(172)	(27,137)	(27,360)	(223)
Surplus / (Deficit)	**(214)**	**(250)**	**(36)**	**(232)**	**(306)**	**(74)**

Other	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	4,187	3,974	(213)	4,554	4,328	(226)
Expenditure	(4,344)	(4,268)	77	(4,739)	(4,658)	81
Surplus / (Deficit)	**(158)**	**(294)**	**(136)**	**(185)**	**(330)**	**(145)**

- Assumptions:
  - 999 includes the Hazardous Area Response Team (HART) and Helicopter Emergency Medical Service (HEMs) as well as core functions.
  - 111 reflects the direct cost, including depreciation for delivering the 111 and Clinical Advice Service (CAS) for Kent, Medway, and Sussex.
  - Other includes directly commissioned services and funded projects, including Neonatal, Commercial Events, International Paramedic Recruitment, Specialist Operations Response Team (SORT) and specific HEE Education projects e.g., Placements and development of the Level 7 Advanced Clinical Practitioners.

- 999 is £184k better than planned for the year to date, mainly driven by the additional property sales.

- 111 is £36k worse than plan for the year to date, this is a combination of the confirmation of 111 income for 2023/24 and increased staff expenditure for February, the forecast reflects a small deterioration. Service line value above also includes depreciation.

- Other is £136k worse because of the adjustment to RSP funding as noted earlier.

5. Efficiency Programme

- The Trust submitted a breakeven financial plan for 2023/24 based on delivery of a £8,988k efficiency target, which represents 3% of operating the expenditure.

- As at the end of Month 11, ending February 2024, 54 schemes equalling £8,341 have been recognised on the Pipeline Tracker YTD. This represents 93% of the total target.

- We have developed efficiency plans of £8,174k YTD, which represents 91% of the target. This comprises 50 fully validated schemes transferred to the delivery phase, totalling £8,061k and 2 validated schemes equalling £113k in IT and Make Ready.

- The latter, at a value of £90k transferred from scoped to validated during the month, reducing “scoped” schemes to 2 totalling £167k.

- The existing “validated” and “scoped” schemes totalling £280k are expected to be developed and moved to delivery in March after Director sign off and/or QIA review.

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

2023-24 M11 YTD Efficiencies Status	Plan	Actuals YTD M11				Plan	Risk Adjusted Forecast			
	YTD M11 Total	Recurrent	Non Recurrent	Total	Variance	Full Year Total	Recurrent	Non Recurrent	Total	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cash Releasing Efficiencies	4,204	1,648	2,028	3,677	(527)	4,807	1,853	2,065	3,917	(890)
Non-Cash Releasing Efficiencies	3,684	3,662	7	3,669	(15)	4,181	4,178	7	4,185	4
Total Efficiencies	**7,888**	**5,310**	**2,035**	**7,345**	**(543)**	**8,988**	**6,030**	**2,072**	**8,102**	**(886)**
Recurrent /Non recurrent percentage		***72.3%***	***27.7%***				***74.4%***	***25.6%***		

- The annual plan of £8,988k comprises of 53.5% or £4,807k of cash releasing and £4,181k cost avoidance to improve operational performance.

- The YTD delivery of £7,345k savings, is £543k below the plan of £7,888k. The shortfall worsened compared to last month’s adverse variance of £259k due to the underperformance in the delivery of our planned cash releasing schemes efficiencies.

- The YTD cash releasing savings of £3,677k is 12.5% lower than plan, even though more than half of the total savings were recognised from non-recurrent budget underspends. This is because of under achievement of the planned operations efficiencies, and the shortfall created by the Procurement contracts review scheme that has been risk rated red and delivering only 3% of the anticipated £380k worth of savings.

- Recurrent schemes currently represent 72% of the YTD savings, and 69% or £3,669k of this was realised from non-cash releasing efficiencies. 74% of the total forecast risk adjusted schemes are expected to be generated recurrently with 26% on a non recurrent basis.

- Further reliance on non-recurrent underspends to mitigate the shortfall in the efficiency programme will impact on the recurrent and non-recurrent ratio.

Efficiency Delivery YTD February and Forecast Outturn by Directorate

Directorate	2023/24 M11 YTD Plan	2023/24 M11 YTD Actual	2023/24 M11 YTD Variance			2023/24 Annual Plan	2023/24 Risk adjusted FOT	2023/24 Risk adjusted FOT vs. Plan Variance		
	£000	£000	£000			£000	£000	£000		
Chief Executive Office	34	40	6	17%	✓	37	40	3	7%	✓
Finance & Corporate Services	613	497	(115)	(19%)	✗	632	632	(0)	(0%)	✗
HR	144	76	(68)	(47%)	✗	189	92	(96)	(51%)	✗
Medical	489	588	100	20%	✓	583	599	16	3%	✓
Operations	4,950	4,798	(152)	(3%)	✗	5,979	5,285	(694)	(12%)	✗
Quality & Nursing	14	26	12	87%	✓	27	27	0	0%	✓
Strategic Planning and Transformation	1,286	1,319	34	3%	✓	1,084	1,427	342	32%	✓
Unidentified	358	0	(358)	(100%)	✗	457	0	(457)	(100%)	✗
Total	**7,888**	**7,345**	**(543)**	**(7%)**	✗	**8,988**	**8,102**	**(886)**	**(10%)**	✗

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

- We are currently reporting a full year forecast risk adjusted efficiency savings of £8,102k, compared to last month's total of £7,969k, which is 90% of the annual target. The improvement of £133k was generated from our "Hear and Treat" scheme, which means the annual non cash releasing efficiency target has been met.

- The shortfall of 10% or £886k is within the expected cash releasing efficiencies. This is due to underperformance in planned efficiencies in Operations of £694, which was subject to underlying changes to HR policies, unidentified gap of £457k and £96k unrealised allocated savings in HR. These are partly offset by overachievement in other directorates, notably £342k in Strategic Planning & Transformation.

- The overall efficiency delivery risk remains amber. The Trust must deliver efficiency savings of £1,643k, which is 18.3% of the annual target in March to achieve the underlying efficiency plan.

- Delivery remains challenging, but mitigations are in place to achieve the underlying efficiency target and to meet the financial break-even plan through a combination of using unplanned contingency, and non-recurrent benefits.

- Engagement with stakeholders progresses across the Trust to drive the development of proposed schemes and to explore new opportunities including non-recurrent savings to facilitate the delivery of the £8,988k target in the financial year 2023/24 and to build a pipeline of sustainable schemes beyond.

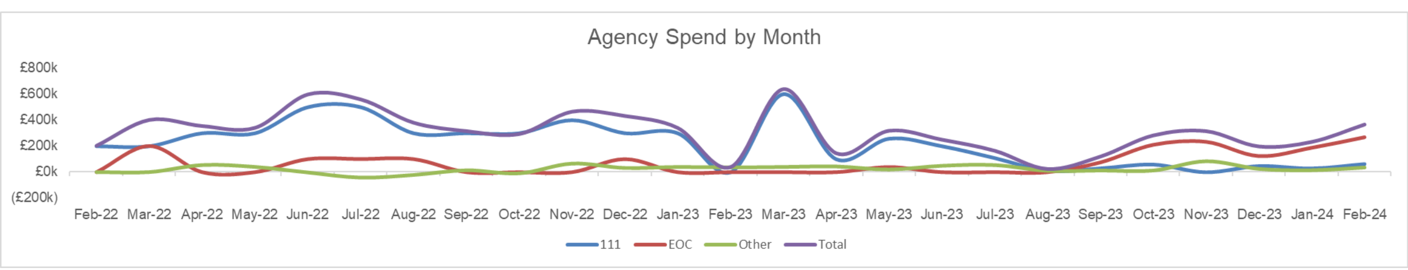
- All Budget holders are required to make a concerted effort to work with their FBP to support delivery of their identified efficiencies, to achieve their directorate allocated targets. This is facilitated through the weekly Check and Challenge and monthly Executive reviews.

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

6. Agency

	Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Agency Expenditure	**(1,649)**	**(2,384)**	**(735)**	**(1,792)**	**(2,598)**	**(806)**

- Overall spend with agencies is over plan by £735k, and includes expected additional agency spend to support operational performance and governance. Majority of the agency spend YTD was in NHS 111 (£907k) and EOC (£1,132k).



7. Statement of Financial Position and Cash

	£000 Previous Month	£000 Change	£000 Current Month	£000 31 March 2024
NON-CURRENT ASSETS				
Property, Plant and Equipment	111,371	2,115	113,486	114,963
Intangible Assets	2,193	100	2,293	1,904
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**113,564**	**2,215**	**115,779**	**116,867**
CURRENT ASSETS				
Inventories	2,656	36	2,692	2,645
Trade and Other Receivables	9,013	(1,447)	7,566	12,664
Asset Held for Sale	2,174	(221)	1,953	1,953
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	36,440	1,333	37,773	35,177
Total Current Assets	**50,283**	**(299)**	**49,984**	**52,439**
CURRENT LIABILITIES				
Trade and Other Payables	(39,669)	(1,299)	(40,968)	(44,655)
Provisions for Liabilities and Charges	(10,114)	(1,699)	(11,813)	(10,114)
Borrowings	(5,910)	892	(5,018)	(5,838)
Total Current Liabilities	**(55,693)**	**(2,106)**	**(57,799)**	**(60,607)**
Total Assets Less Current Liabilities	**108,154**	**(190)**	**107,964**	**108,699**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(9,528)	0	(9,528)	(9,528)
Borrowings	(20,347)	207	(20,140)	(20,326)
Total Non-Current Liabilities	**(29,875)**	**207**	**(29,668)**	**(29,854)**
TOTAL ASSETS EMPLOYED	**78,279**	**17**	**78,296**	**78,845**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,204	0	109,204	109,536
Revaluation reserve	6,871	0	6,871	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(37,562)	0	(37,562)	(37,562)
Income and expenditure reserve - current year	(234)	17	(217)	0
TOTAL TAX PAYERS' EQUITY	**78,279**	**17**	**78,296**	**78,845**

- Non-Current Assets are up by £2,215k in the month represented by new assets under construction of £3.6m net of monthly depreciation of £1.4m.

- Trade and other receivables are down by £1,447k. This is predominantly driven by a £0.6m decrease in prepayments and £0.6m decrease of accrued income, both which are in line with expectation towards the end of the financial year.

- The assets held for sale decreased by £221k that relates to the Leatherhead Ambulance Station property sale, which was completed in February 2024. The remainder is unchanged and showing the value of three pending property disposals.

- Cash increased by £1,333k that relates to the above-mentioned property that was sold for £1.3m with a Net Book Value (NBV) of £0.2m. Overall income/cash received was £2.1m

higher, compared to last month that was offset by a £0.8m increase in spend. The latter is showing the combined effect of £1.7m cash paid towards capital investment offset by a £0.9m decrease in pay and non-pay spend. It is anticipated that the cash balance will decrease next month when the Trust further invests in capital schemes and when there will be no income / receipts from property sales. Please note that all three assets / properties held for sale are now expected to complete during the next financial year.

- Trade and other payables were down by £1,299k which relates to the decrease in accruals.

- The provision balances are up £1,699k during the month following review of provision adjustments from last year end that had incorrectly been reported under trade and other payables.

- Borrowings decreased by £892k after payments/PO receipts on property rent, vehicle and DCA leases in the month.

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

8. Cash Flow Position

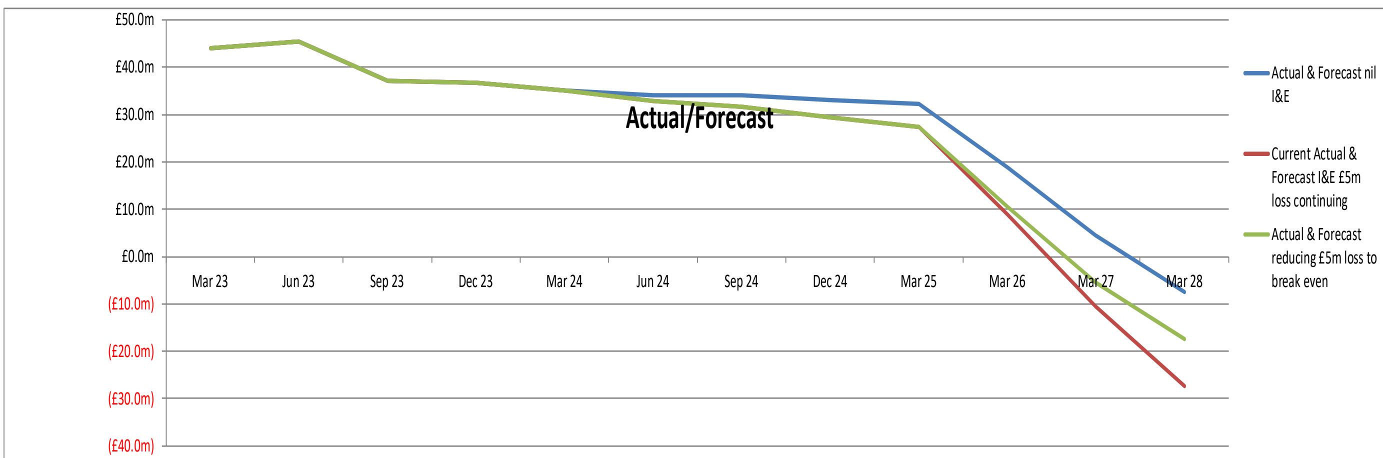
Cash Flow	**Year to February 2024**			**Forecast to March 2024**		
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
	Plan	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
EBITDA	19,272	13,104	(6,168)	21,407	14,964	(6,443)
Working Capital / IFRS 16	13,248	1,902	(11,346)	13,788	(2,953)	(16,741)
Capital Payments	(17,305)	(19,548)	(2,243)	(18,413)	(18,734)	(321)
Proceeds from disposal of assets	0	4,231	4,231	0	4,216	4,216
IFRS 16 Lease Payments	(7,325)	(7,365)	(40)	(8,369)	(7,690)	679
Net PDC and interest	(1,239)	1,312	2,551	(2,149)	1,237	3,386
Cash Movement	6,651	(6,364)	(13,015)	6,264	(8,960)	(15,224)
Opening Cash Position	44,137	44,137		44,137	44,137	
Closing Cash Position	50,788	37,773	(13,015)	50,401	35,177	(15,224)

- The Trust's cash balance as at M11 2023/24 was 37,773k. The receipts for the year-to-date were £318.9m including proceeds from sale of Trust assets of 4.3m. Total payments for the same period were £325.2m resulting in a £6.3m overall reduction in cash and cash equivalents since 31 March 2023.

- The actual cash balance was £13,015k lower than plan primarily due to the reduction in trade payables since year end along with increased net operating costs partially offset by lower cash spend on PDC dividend of £0.6m. The Trust continues to benefit from the higher interest rates with unplanned interest income of £2.0m year to date along with sales proceeds of £4.3m also benefitting the cash to plan.

- The net operating deficit of £1.2m on the I&E position is being covered by the disposal proceeds from asset sales and higher interest receivable net of PDC dividend.

9. Cash Forecast



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

- The upside case is indicated by the top blue line above, where a break-even I&E position has been assumed for all future years. This means of the Trust will be required to borrow £7.4m by 2027/28 due to significant planned capital investment per the 2023/24 5-year plan.

- The middle green line predicts the eroding cash position if the Trust reports a £5.0m deficit in 2024/25 and then report break-even for future years. The red line shows the impact of what happens should the trend of deficits continue.

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

10. Working Capital Ratios

Working Capital ratios

Ratio	Target	Actual	Risk status
Debtor days	30	9	
Debtor % > 90 days	5.0%	6.0%	
Trade creditor days	30	20	
BPPC - value of inv's paid within target (YTD)	95.0%	88.0%	
Cash (£m)	50.8	37.8	

- Receivable days at month end are 21 days ahead of the target and represent a reduction of 2 days in cycle from last month.

- The proportion of Receivables over 90 days was 6%, which is slightly above target. This is due to a delay in receiving payment for £75k from St Georges University of London and matching of an £89k invoice from Connect Wise Control LLC to prepayment. Both will be processed in March 2024. During February 2024, the historic overdue invoices of £104k from NHS Horsham and Mid-Sussex CCG for divert charges and £64k from NHS Lewes High Weald Havens CCG for disputed A&E charges were written off as per recommendation and approval from Audit Committee.

- Payables days are below target by 10 days for the month. The level of payables has decreased by £4.0m in the month after the processing payments following GRNI and non-PO invoices reviews. This is spread across several suppliers including IC24 and Private Ambulance Providers (PAPs).

- The BPPC for value of invoices paid has improved in the month to a YTD rate 88% and is still short of the target of 95% YTD. In-month actuals were 95%, achieving the target, but due to the historic late payments to IC24 and Omnicell invoices earlier in the year had an adverse impact on the YTD performance. There were 12 IC24 invoices valued at £3.7m and 5 Churchill invoices for £1.8m where delays in processing the invoices against the purchase orders led to failing terms. Without these invoices the BPPC would have been 94%.

11. Capital

The in-month capital spend is £3,588k which is £1,965k higher compared to the plan of £1,623k. The year-to-date capital spend is £17,156k which is £565k higher than planned compared to the planned £16,591k. This is due to the early completion of some IT proposals., these were originally expected to be delivered in March. The table below sets out the detailed spend and forecast against plan for the year.

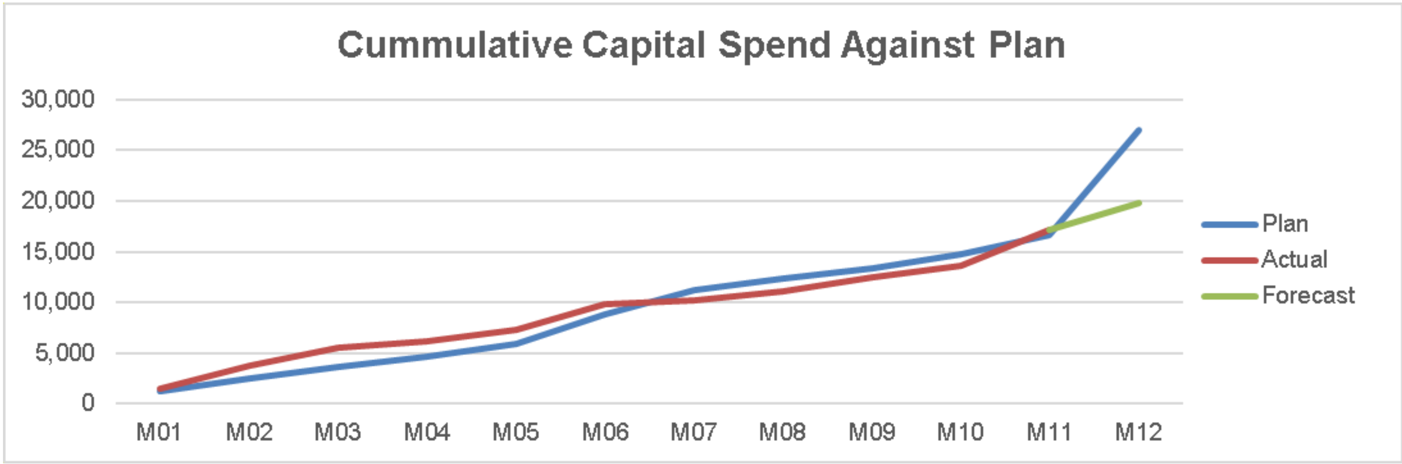
	In Month February 2024			Year to February 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Original Plan									
Estates	0	53	(53)	600	183	417	600	183	417
Strategic Estates	0	(161)	161	2,044	2,248	(204)	2,044	2,248	(204)
IT	917	2,584	(1,667)	3,789	5,674	(1,885)	5,072	5,696	(624)
Fleet	191	909	(718)	4,074	3,748	326	4,187	3,748	439
Medical	0	0	0	424	452	(28)	424	452	(28)
Total Original Plan	**1,108**	**3,384**	**(2,276)**	**10,931**	**12,305**	**(1,374)**	**12,327**	**12,327**	**(0)**
Extra Allocation*									
Estates	0	70	(70)	0	545	(545)	1,188	824	364
IT	0	323	(323)	0	365	(365)	0	365	(365)
Total Extra Allocation	**0**	**393**	**(393)**	**0**	**910**	**(910)**	**1,188**	**1,188**	**(0)**
CDEL Credit**									
Total Sales Income	0	(221)	221	0	(1,153)	1,153	0	(1,510)	1,510
Estates	0	8	(8)	0	32	(32)	0	40	(40)
IT	0	107	(107)	0	224	(224)	0	1,470	(1,470)
Total CDEL Credit	**0**	**(106)**	**106**	**0**	**(897)**	**897**	**0**	**(0)**	**0**
PDC									
IT	**0**	**18**	**(18)**	**0**	**280**	**(280)**	**0**	**332**	**(332)**
Total PDC	**0**	**18**	**(18)**	**0**	**280**	**(280)**	**0**	**332**	**(332)**
Total Purchased Assets	**1,108**	**3,690**	**(2,582)**	**10,931**	**12,598**	**(1,667)**	**13,515**	**13,847**	**(332)**
Leased Assets									
Estates	223	(144)	367	2,443	1,918	525	2,666	1,918	748
Fleet	292	42	250	2,669	2,447	222	8,206	3,889	4,317
Specialist Ops	0	0	0	548	193	355	2,668	193	2,475
Total Leased Assets	**515**	**(102)**	**617**	**5,660**	**4,558**	**1,102**	**13,540**	**6,000**	**7,540**
Total Capital Plan	**1,623**	**3,588**	**(1,965)**	**16,591**	**17,156**	**(565)**	**27,055**	**19,847**	**7,208**

*The Trust received an extra allocation via the ICB of £1,188k in October 2023. This increases our purchased assets allocation.
**The Trust will receive a CDEL increase for the net book value of any sales completed in the year, this could be up to £1,510k in total, as per the below table the Redhill and Leatherhead NBV has already been incorporated. This has reduced from M10 reporting as two sales have slipped into 2024/25, Medway and Coxheath.
***The Trust has received £332k of Public Dividend Funding for IT projects.

The Trust anticipates meeting its purchased CDEL by year end but is forecasting that it will underspend on the leased plan by £7,540k. The ICB has, in November, been issued a lease assets allocation, this is £8,514k lower than the M07 FOT for the area. SECAmb's underspend of

£7,540k will assist the ICB in meeting their reduction. In year changes to the CDEL are detailed in the table below.

Capital Delegated Expenditure Limit (CDEL)			
	£000		£000
		Funded by:	
Plan CDEL		Depreciation	10,158
Purchased	12,327	Cash Reserves	3,357
Leased	13,540	Lease Liability	13,540
		NBV from sales	1,153
Adjsutment - Redhill Sale	916	PDC Funding	332
Adjsutment - Vehicles Sales	16		
Adjustment - Leatherhead Sale	221	Expected CDEL	28,540
PDC Funding	332		
Additonal allocation	1,188		
Expected CDEL			
Purchased	**15,000**		
Leased	13,540		
	28,540		



12. Risks and Opportunities

Risk	Impact	Likelihood	Score
Issue raised by Staff/Unions that Agenda for Change, Pay, Section 2 (maintaining round the clock services) has not been correctly applied.	>£2.0m	Likely >50%<=80%	20
The Trust's future capital expenditure plans could be constrained by capital limits (CDEL) imposed on our host ICB.	>£2.0m	Likely >50%<=80%	20
Depletion of Trust Reserves to support future years improvement, requiring further funding	>£1.0m <=£1.5m	Likely >50%<=80%	12
While the Trust currently has adequate liquid resources to meet its short-term plans, there is a need to generate cash surpluses to ensure sufficient funds for future investment to sustain and improve our services.	>£1.0m <=£1.5m	Likely >50%<=80%	12
The Trust has a challenging cash releasing efficiency target. Slippage in achieving this target could have an impact on the Trusts ability to meet its I&E target	>£0.5m <=£1.0m	Unlikely >20% <=50%	4

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

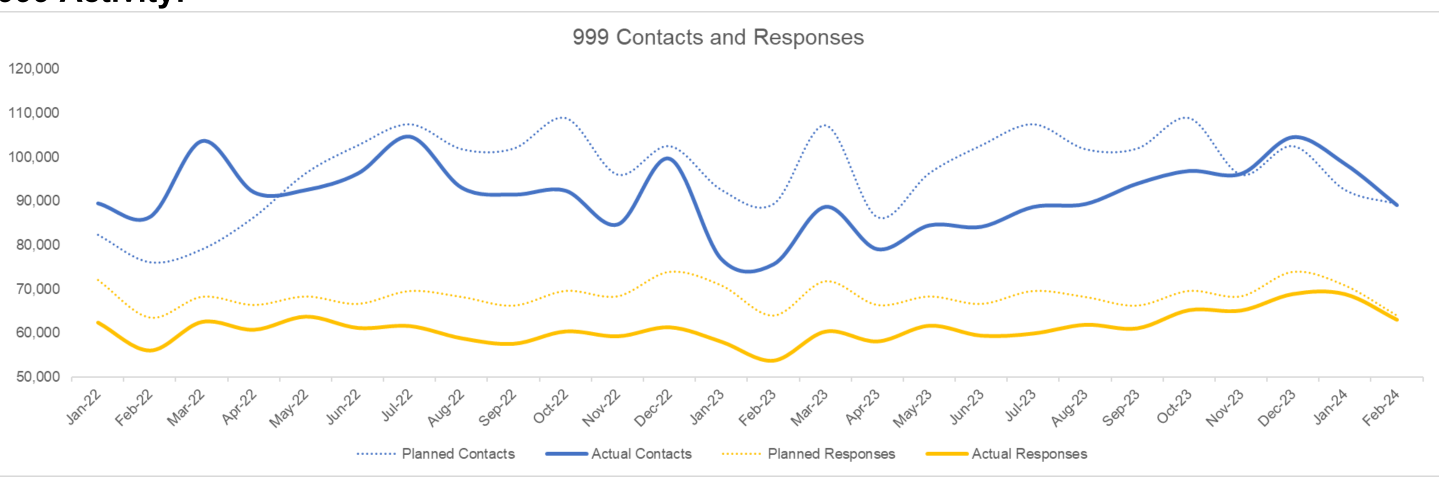
Opportunities	Impact	Likelihood
Additional sales of Trusts unused properties would improve the I&E position and increase the capital expenditure (CDEL) limit, which would allow the Trust to invest further than planned	>£0.5m <=£1.0m	Possible 50/50

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

Appendices

Activity

999 Activity:



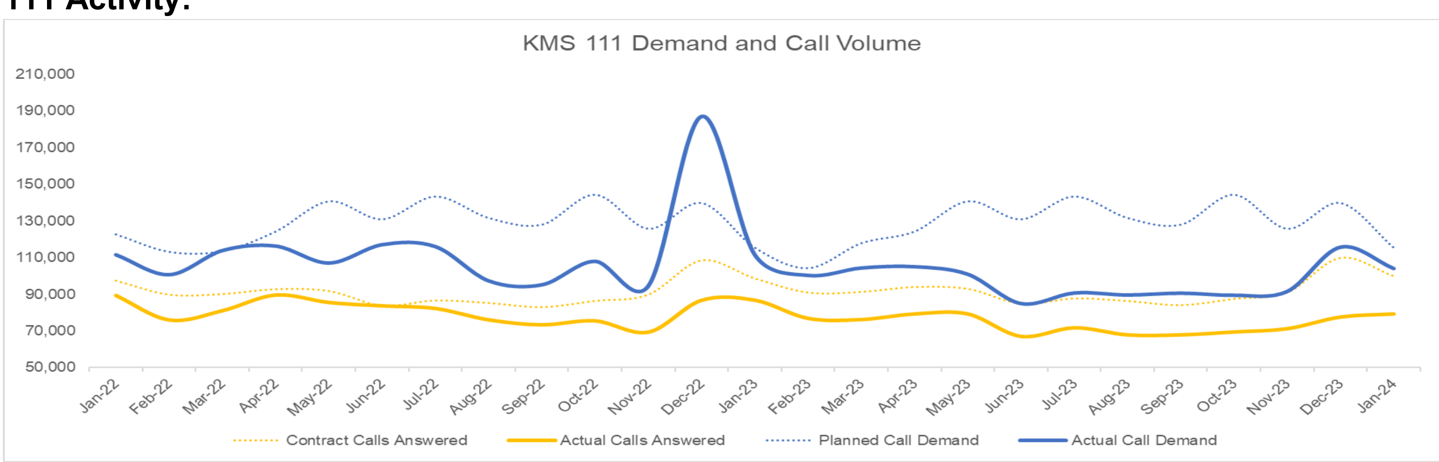
999 contacts (demand) 0.6% above against last year to date, with response activity being 5.6% greater, daily demand (-3.3%) was down and responses dropped by 2.2% against the previous month.

Increased Hear & Treat rates (12.0% vs .9.8%) and improved handover delays has contributed to an improvement in Category 2 mean response times versus last year to date, with the C2 mean improving to 28.2 minutes year to date compared to 35.1 minutes last year as at M11 (YTD).

Handover delays have an impact on the availability of crews to reach patients in time, 20,958 hours less were lost in the 11 months to February 2024 compared to last year, this would be the equivalent of around 5 extra ambulance shifts per day, helping to improve performance times.

C2 Mean currently stands at 28.2 minutes year to date against a plan of 30.1 minutes.

111 Activity:



February 2024 saw demand (calls offered) decrease by 8.7% compared to January, as we come out of the winter period.

Both demand and activity are down versus the same period last year (YTD) with demand 15.4% lower and activity (calls answered) 9.3% percent down. As some calls are being moved to the national contract with Vocare the total demand is more than shown here.

Calls answered in 60 seconds performance dropped slightly to 34.2% for February. National KPIs have changed for the 111 service, with proportion of calls abandoned and average speed to answer being the main KPIs being monitored going forward. SECAmb currently sits at 15.9% (9.5%) and 332 (177) seconds for these metrics (national) for the year to date. Standard target is 3.0% and 20 seconds.

24/25 Operating Plan

Part 1 Summary for Board

Planning Guidance 24/25 (published 28 March)

- **Urgent and Emergency Care**:
  - Improve Cat 2 response times to 30min average in 2024/25
  - Maintain 2023/24 ambulance capacity levels
  - Increase clinical assessment of calls to prioritize sickest patients
  - Support development of services reducing conveyance to hospitals
  - Implement recommendations from ambulance trust culture review
- **Collaboration with Wider System:**
  - Utilize alternative services (UCR, virtual wards) to reduce conveyance
  - Develop clear pathways from 111/999 to integrated care coordination
  - Support collaborative decision-making practises to support
- **Workforce:**
  - Focus on staff experience, retention, and attendance best practices
  - Reduce temporary staffing reliance; eliminate off-framework agencies
  - Align clinical training with Core Skills Training Framework by June 2024
- **Digital & Data:**
  - Improve digital maturity; deploy electronic health records by March 2025
  - Maximise and mature opportunities for productivity delivered through Digital

Planning 24/25 Update

Plan submissions

- Our initial submission at the end of February was **£40.1m.**
- We have since submitted an updated position in March of **£28.1m deficit**, that incorporates **£12.1m CIP** which consists of the following.
  - £4.3m – productivity unlocked through delivery of the strategy
  - £3.5m – activity growth assumptions changed
  - £4.3m – Other cash-releasing CIP
- **£2.4m** funding for HART has now been agreed, taking the effective position to **£25.7m**
- We are now preparing for the **next submission** which will be **due by the 2 May 2024**.
- **Note:** Planning guidance was published on 28 March, which was one week after the draft submission of £28.1m.

Planning 24/25

Operating Assumptions

- **2.3% Activity Growth** in line with our long-range historic forecast
- The plan delivers a **C2 Mean response of 30 min,** maintaining patient safety levels of 23/24
- We are assuming through the implementation of our strategy that we will improve productivity by:
  - Increasing **H&T to 16%** through scaling the outcomes of the pilots in East Kent
  - **Reducing handover** times further with Acute hospitals by **2 minutes**, getting closer to the national target for handover
- **Reduction** in reliance on Private Ambulance Providers (**PAP**)
- The plan includes:
  - Increase in training and development time (+0.4%)
  - £1m self-funding wellbeing and retention fund, with assumed improvement by 17.3% attrition in EOC and 0.4% in field operations
  - Sickness reduction to <7%

Planning 24/25

Key Risks

- Delivery of this plan requires accelerated delivery of key components of SECAmb's strategy from year 1
- We will require working in collaboration with system partners and investment into the delivery of our transformation plans
- Activity growth may exceed planned growth. Up to £3.2m risk has been flagged in our draft submission.

Delivery of our plan requires a whole-system approach to help us start delivering our transformation plans, improving productivity, and supporting a sustainable exit of RSP

	Agenda No	82-23
Name of meeting	Trust Board	
Date	4 April 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 28 March 2024.

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

At Month 11 the committee is assured that we will deliver the planned year end breakeven position. In the context of the challenges faced across the system, the committee believes this is a great achievement, especially also taking into account delivery of the Cat 2 30-minute mean. That said, with the non-recurrent measures there is concern with the current planning discussions, where we are trying to land a sustainable financial position.

Much of the discussion related to how we are approaching the significant funding issues for next year and beyond. There is a good understanding of the risks and what is within our control. The executive believes the commissioners also recognise the wicked issues and there is a willingness on both sides to find a way through what will be a really difficult path. The Board is well-sighted on this and will have further discussions at the meeting in April.

The Capital Plan is underspent mostly due to timing of leased assets; these are vehicles that we have been aware of and which does not present a problem. Otherwise it is where we expected. The plan for next year is being finalised; we will have £2m less than we were hoping for but expect to make progress in line with our strategy. The committee will consider the 2024-25 plan at the next meeting to seek assurance it meets the key strategic priorities.

Fleet Update	S & P Objective 8

The committee explored the activities of the fleet department in supporting operational delivery, focussing in particular on the recruitment challenges; KPIs and Risks; and the DCA option including timeline and engagement. It was assured with the way we are engaging our people in the selection of new fleet vehicles; undertaking roadshows to help ensure transparency and informed decision making.

The committee reflected on a recent leadership visit where the commitment of the team to deliver the right fleet for our people was really evident. The new retention and recognition approach is welcomed.

<table>
<tr><td>Private Ambulance Providers</td><td>Risk 14 – Operating Model</td></tr>
<tr><td colspan="2">The committee tested the approach being taken to reduce reliance on PAPs, which is consistent with the new strategy and workforce plan. It also aligns with the recently published planning guidance, to reduce agency provision. The committee explored in particular the extent to which the transition risks are well understood and being managed, acknowledging the reduction in PAPs in any event over recent years. The committee received good assurance and with the robustness of the workforce plan, the risk will be that we are over, not under-established.

It did however express some concern about the Paddock Wood and Guildford where PAP usage is high and asked for assurances that these areas will not be adversely impacted.</td></tr>
<tr><td>Adult Critical Care Transfer Service</td><td>Risk 14 – Operating Model</td></tr>
<tr><td colspan="2">The committee reviewed the proposal for SECAmb provide, as a sub-contracted partner to an Acute Trust host, vehicle / driver for the NHSE ACCTS contract within the Kent, Surrey and Sussex. Phase 1 has been agreed to start from 1 April under an MOU while a new contract is agreed with NHSE.

This will be good for patients and while there are some issues until a contract is agreed, the committee supported the approach taken by the executive.</td></tr>
<tr><td>Operational Performance</td><td>RC Goal 1 - Safe, effective, timely patient care</td></tr>
<tr><td colspan="2">The committee congratulated the executive on the improvements in performance through the year, ending with us achieving the Cat 2 30-minute mean. The national comparison is really positive, especially with Cat 3 and 4, where we have historically been outliers. Call handling is also much improved with a positive trajectory.

HART compliance is better although as the Board is aware, full compliance will come over the next 12-24 months linked to the new funding recently agreed.

There was a helpful discussion about CFRs, and the committee challenged the executive to ensure we do more over the coming period to utilise this important resource more effectively.</td></tr>
<tr><td>Legal Services Costs</td><td></td></tr>
<tr><td colspan="2">The committee receives this report once a year to ensure visibility of the costs related to our claims, including the level of provisions being held. It explored the benchmarking where we compare favourably with our peers, in terms of the level of claims.</td></tr>
<tr><td>Specific Escalation(s) for Board Action</td><td>There are no specific issues requiring the intervention of the Board. There was a good set of papers that clearly set out the issues and risks and actions being taken.</td></tr>
</table>

	Agenda No	11-24

Name of meeting	Trust Board
Date	4 April 2024
Name of paper	Improving Culture
Strategic Theme	**People & Culture**
Author / Lead Director	Tim Widdowson, Acting Executive Director of HR and OD
Executive Summary	

Culture Transformation Program
The Culture Transformation program continues to focus on the 3 aims of 'Building Trust', 'Increasing Communications and Engagement' and 'Developing our Leaders'.

Progress has occurred in all areas of the program, including:
- 85% (93 actions and sub-actions) from the housekeeping are complete
- Launched Rewards and Recognition platform
- Held 4 'The Big Conversation' webinars with an average of ~200 participants/views per session
- 51% of our Firstline managers have completed the Fundamentals Leadership Training
- Management Essentials Modules have been launched online
- The Executive Leadership Development and the Operational Managers (OUM+) Leadership Development programs has commenced

As we near the end of Year 1, the National Staff Survey results have been published (discussed below), and show a positive change within our organisation.

National Staff Survey Results 2022/23 – Employee Engagement
The 2023 NHS Staff Survey was open for responses for 10 weeks, launching on September 18th and closing on November 24th. Results will be published nationally on March 7th 2024.

For the fourth year in a row, we achieved our goal of receiving feedback from at least 60% of the workforce. 2716 substantive staff members and 74 bank workers took part, which is the highest number to date.

In 2023, our scores remain below the average for our benchmarking group in the majority of themes, and in line with the average score in 'We are safe and healthy', 'We are a team', and 'Morale'. None of our scores are the worst in our benchmarking group which is an improvement on 2022 when three of our scores were in line with the worst performing ambulance trust. Furthermore, the Survey Coordination Centre has carried out statistical significance testing on our results and has found that every one of our theme scores has shown a statistically significant improvement. Our theme scores can be seen in the table below:

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 significance of the improvements at SECAmb, when compared with the improvements seen across our peer group, is further cause for cautious celebration, as our average theme score has improved by more than double that of the ambulance trust median score. The table below shows how we compare to our peers:

NHS Staff Survey 2023 — Ambulance Trust Theme Scores — NHS South East Coast Ambulance Service NHS Foundation Trust

We are compassionate & inclusive	We are recognised & rewarded	We each have a voice that counts	We are safe & healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
IoW 7.39	IoW 6.03	IoW 6.87	Unknown	IoW 5.47	IoW 6.15	IoW 6.85	IoW 6.84	IoW 6.46
SCAS 7.02	NWAS 5.48	YAS 6.10	Unknown	YAS 5.08	EMAS 5.63	LAS 6.49	YAS 6.21	YAS 5.72
YAS 7.00	SCAS 5.46	LAS 6.07	Unknown	NWAS 5.06	LAS 5.61	SCAS 6.49	EMAS 6.17	NWAS 5.67
EMAS 6.93	EMAS 5.46	EMAS 6.06	Unknown	LAS 5.03	YAS 5.52	YAS 6.29	LAS 6.15	SECAmb 5.57
NWAS 6.93	LAS 5.41	NWAS 6.03	Unknown	SCAS 4.99	EEAST 5.47	NWAS 6.24	NWAS 6.15	EMAS 5.57
LAS 6.90	YAS 5.39	SCAS 5.99	Unknown	SWASFT 4.87	SCAS 5.32	SECAmb 6.22	SCAS 6.03	WMAS 5.57
SWASFT 6.78	SECAmb 5.27	SWASFT 5.89	Unknown	WMAS 4.87	NWAS 5.24	EMAS 6.15	SWASFT 5.97	LAS 5.48
SECAmb 6.71	SWASFT 5.25	WMAS 5.89	Unknown	EMAS 4.82	SECAmb 5.23	SWASFT 6.03	SECAmb 5.90	SCAS 5.41
NEAS 6.61	WMAS 5.10	SECAmb 5.79	Unknown	SECAmb 4.67	WMAS 5.16	WMAS 5.95	NEAS 5.85	NEAS 5.41
WMAS 6.56	EEAST 5.03	EEAST 5.63	Unknown	NEAS 4.57	SWASFT 5.03	NEAS 5.78	WMAS 5.79	SWASFT 5.40
EEAST 6.46	NEAS 5.02	NEAS 5.60	Unknown	EEAST 4.20	NEAS 4.77	EEAST 5.69	EEAST 5.75	EEAST 5.27

NHS Staff Survey 2023 1

At a sub-theme level, 5 sub-theme scores are slightly above average for our benchmarking group. Another positive sign that, whilst we are not yet where we want and need to be, we are moving in a positive direction.

At a question level, 101 showed improvements, and just 3 worsened. Of the 101 questions that improved, approximately 75% showed a significant improvement, whereas none of the declining questions worsened significantly. Our lowest performing questions concerned workload, work/life balance, burnout, recognition and reward, and effectiveness of appraisals.

763 staff members chose to leave a free-text comment during the 2023 survey. An analysis of the proportion of comments that were positive vs negative suggested that 79.5% of comments were mostly negative, and 20.5 were mostly positive.

Power BI also calculated a sentiment score using Text Analytics which utilises a machine learning classification algorithm to generate a sentiment score between 0 and 1. Scores closer to 1 indicate positive sentiment. Scores closer to 0 indicate negative sentiment.

The overall sentiment score for the comments in 2023 was 0.26 out of 1, which is an improvement of 0.07 since 2022. This sentiment score is also broadly in line with the analysis completed by Microsoft Copilot, which suggested that 20.5% of comments were mainly positive.

The improvement in sentiment score since 2022 is also broadly in line with the improvement seen across our question and theme scores.

Next Steps:
The results of the survey has been presented to the Audit and People Committees, and to the Executive Management Board. 'The Big Conversation' on the 18th March focused on the results, seeking input live online and via online form from our people about the areas of focus for the next 12 months. The Senior Leadership will now participate in a series of workshops to identify the key workstreams in conjunction with the ongoing strategy work and culture transformation program, and local teams will be supported to create local plans where applicable to address concerns within their own areas.

Statutory and Mandatory Training and Appraisals

There was a fluctuating trend in both appraisal and statutory and mandatory training completion over the year.

The reported appraisal rate has improved to **65.5%** (as of 18 March 2024) from 63.7% in the last two months but continues to remain below the Trust's compliance target of 85%. The current completion rate compares favourably against the 62.92% for March 2023.

As of 18 March 2024, the rolling overall compliance rate for statutory and mandatory training stands at **78%**, a 3% increase in two months and below the 84.58% compliance rate for a March 2023. The trend from last year above, given completion pushes towards the end of financial years, indicate we are likely on track to achieve the Trust's compliance target of 85% by April 2024.
Current reporting includes both the equivalent subjects to the NHS Core Skills Training Framework (CSTF) for statutory and mandatory training, and SECAmb-specific courses, including Classroom Key Skills, Driver Training, Patient Group Directions and Speak Up. Excluding non-CSTF subjects, the compliance rate increases to **81.4%**.

Several implemented and ongoing projects have improved statutory and mandatory training data integrity since the resourcing of the Digital Learning Manager role in December 2023. However, there are still data entry issues from dispersed manual transference of completion data from the Moodle-based Discover learning platform to employee's learning records in ESR. This is done by OU and other administrators across the organisation. This is a risk identified on the risk register. New reporting tools are now helping to identify OU and time-period gaps in data transference.

Statutory and mandatory training actions/next steps

The Digital Learning Manager has initiated projects with the following objectives:

- Investigating issues and identifying users outside L&D responsible for adding new users to Discover that are causing downstream data issues, and providing training, guidance and support
- Bringing master data for job roles/positions and business areas up-to-date, whilst maintaining legacy data.

- Investigating and testing mass update of user data within Discover to benefit data transference by administrators
- Supporting targeted business areas and their administrators to bridge legacy transference gaps due to staff changes and gaps in transition training
- Collaborating with the HR Workforce Information & Planning team to ensure reporting accuracy

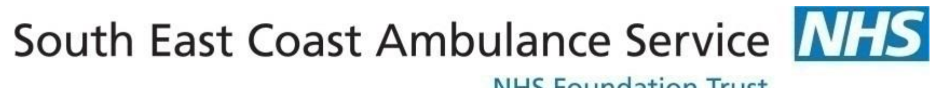
Appraisals actions/next steps

The Trust has appointed RSM Internal Auditors to undertake a review of appraisal processes to understand how the organisation currently supports staff and managers through appraisals; consider the processes in place, the systems used for recording them, how appraisals are used from a practical perspective to consider performance and career progression and how effective they are deemed to be. As part of this RSM will also seek to understand the link to wider career development. The review will assess the extent to which the Trust has measures in place to ensure that the organisational culture supports staff development through appraisals and succession planning.

A scoping exercise is underway to understand the functionality needed overall for a learning management and appraisal system.

Frontline recruitment has been very successful this past year and we are currently 52.5FTE (2.2%) above our planned FTE as at end Jan 24. This is likely to remain over established until year end. Contact centre recruitment is only 3.4FTE below planned (1.3%) Vacancy rate for Trust as at end of Jan 24 overall is 2.39% showing a marked reduction over previous months.

Recommendations, decisions or actions sought	It is recommended that the Board **discuss** the actions taken to date and **individually and collectively own and support** the organisational development programmes aimed at improving organisational culture, leadership practice and staff experience.



		Agenda No	11-24
Name of meeting	Trust Board		
Date	04.04.2024		
Name of paper	NHS Staff Survey 2023 Results		
Responsible Executive	HR Director		
Author	Janine Compton, Head of Communications		
Synopsis	This paper provides assurance to the Board that the Staff Survey results for 2022/23 have been received, and outlines the next phase of actions. This paper includes a summary of the results from the survey, highlighting changes from previous results, and identifies key themes. Of note, 60% of staff responded, and nearly 800 free text comments were made. Overall there was a statistically significant improvement in every theme, and an improvement in almost all sub-theme questions. Whilst the results are promising, there is still much more that needs to be done. We have commenced direct conversations with our leaders and we have hosted a webinar to allow our people to influence the areas of focus for the coming year.		
Recommendations, decisions or actions sought	For Information.		

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

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

1.Introduction

1.1. The 2023 NHS Staff Survey, the results of which were published on 7 March 2024, was carried out between September and November 2023. The attached 'NHS Staff Survey Results 2023' Presentation provides further detail.

1.2 Within SECAmb, it was completed by close to 2,800 colleagues across the Trust. The total represents 60 per cent of staff – the fourth consecutive year the percentage has been reached.

1.3 74 Bank staff completed the survey.

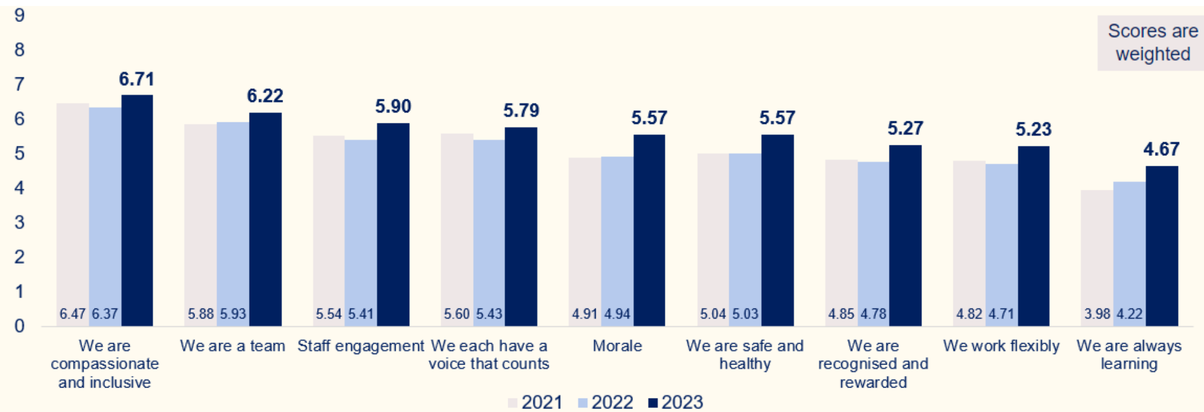
1.4 Nearly 800 staff provided free text responses, in addition to the structured questions.

1.5 Key headlines from the survey results are below. The attached 'NHS Staff Survey Results 2023' Presentation provides further detail.

2. Results

2.1 The results of the survey are shown by the answers to individual question, as well as being grouped into the nine 'theme' areas contained in the NHS People Promise:

- 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 flexibility
- We are a team
- Staff Engagement
- Morale



2.3 As well as recording improvements across each of the nine themes, the Trust's scores improved in almost all individual questions. Scores recorded by SECAmb also improved more, year-on-year, than others in the ambulance sector. 77 scores increased by 3% or more, suggesting potentially significant improvements in 74% of comparable questions.

2.4. Whilst it's disappointing that our benchmarked theme scores remain at or below average, this is the first time in many years that we have seen statistically significant improvements across all People Promise elements and theme scores. Some specific areas of improvement include:

- 62% said they were enthusiastic about their job – an increase of 5% on 2022
- 60% of staff said that care of patients/service users is a top priority – an improvement of 8% since 2022
- 53% said they felt safe to speak up about anything that concerns them – also an 8% improvement on 2022
- 62% of staff said that, if a friend or relative needed treatment, they would be happy with the standard of care provided – a 10% improvement on 2022
- 41% of staff said they are satisfied with the opportunities for flexible working patterns. Improved 10% since 2022
- 67% of staff said they have opportunities to improve their knowledge and skills. Improved 10% since 2022.

3. Free text comments

3.1 In addition to the question answers, the survey also provides colleagues with the opportunity to provide 'free text' comments. These provide an additional rich source of feedback which, after closer analysis, allows for key recurring themes to be identified.

3.2 123 of the comments were complimentary, recognising positives in regards to their colleagues, their management, patient care, the Trust overall and the changes that have been made over the past year.

3.3 The majority of comments focused on areas of concern, themed into 7 main topics:

- Ways of working and rotas
- Support and wellbeing
- Leadership and management, and relationships between teams
- Education and Development
- Career progression and recruitment
- Culture: policies, processes, inclusion, grievances
- Safety

4. Engaging with our People

4.1 The Staff Survey is a point in time, and we must continue to engage across the Trust to hear from all our people and remain connected.

4.2 On the 18th March 2024, The Big Conversation webinar, hosted by our CEO Simon Weldon, discussed the results of the staff survey, with 130 colleagues. In particular, attendees were invited to discuss what they felt were the areas to prioritise for the coming year.

4.3 There were many suggestions on what we should focus our attentions. This has moved to an online poll and discussion for our people, with greater access to funded and supported training and development nominated as the top priority.

4.4 Further sessions are being planned to meet with our people to discuss the survey results and identify the prioritises.

5. Summary

5.1 The Staff Survey show a positive improvement, however we recognise there is much more work to be done to address the concerns. We will continue to engage with our leaders and their teams to prioritise actions to positively impact how it feels to work in SECAmb.

5.2 The Executive will collate the feedback from the webinar and poll and the analysis of the staff survey and other reviews, to develop the culture transformation plan for 2023/24 aligned with the Trust strategy.

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

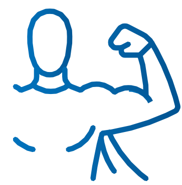
60% of staff said that **care of patients/ service users** is the organisation's **top priority.**

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!

2023 NHS Staff Survey

Overview of Results

February 2024

Inclusion, Learning & Organisation Development

NSS 2023 Headlines

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

Scores are weighted

Score (0-10)

	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

Scores are weighted

Theme	2021	2022	2023
We are compassionate and inclusive	6.47	6.37	6.71
We are a team	5.88	5.93	6.22
Staff engagement	5.54	5.41	5.90
We each have a voice that counts	5.60	5.43	5.79
Morale	4.91	4.94	5.57
We are safe and healthy	5.04	5.03	5.57
We are recognised and rewarded	4.85	4.78	5.27
We work flexibly	4.82	4.71	5.23
We are always learning	3.98	4.22	4.67

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
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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

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

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

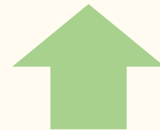
Directorate	2021 Avg	2022 Avg	2023 Avg
Chief Executive's Office	7.0	6.7	6.5
HR & OD	6.4	6.3	6.4
Finance & Corporate Services	6.6	6.2	6.2
Medical	5.7	6.0	6.1
Strategic Planning & Transformation	6.2	6.3	6.1
Quality & Nursing	6.6	5.9	6.0
Operations	5.0	5.0	5.5

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

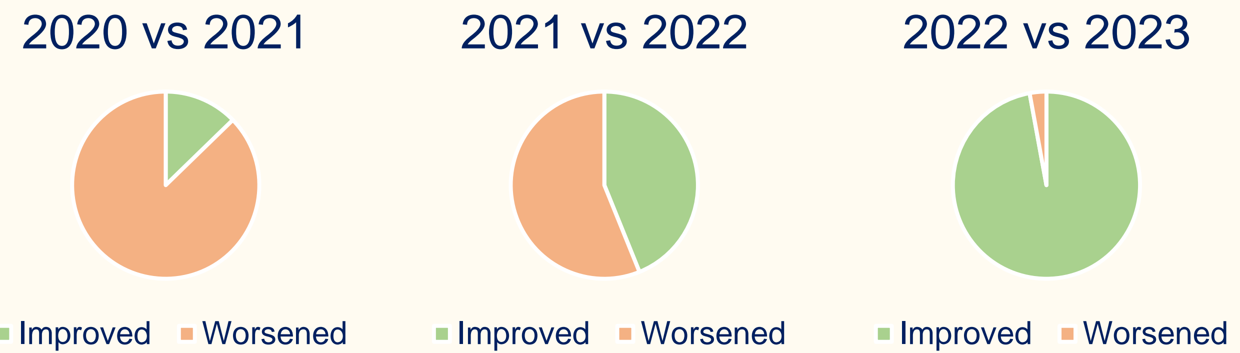


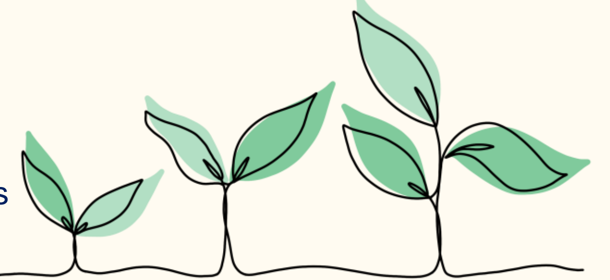
- 101 questions improved YoY.
- Improvements ranged from 0.1% to 13.5%.

- 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

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

Change YoY 2021 vs 2022

15.0%
12.0%
9.0%
6.0%
3.0%
0.0%
-3.0%
-6.0%
-9.0%
-12.0%
-15.0%

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

Change YoY 2022 vs 2023

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

No questions in 2023 have worsened significantly.

Most Improved Questions

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.

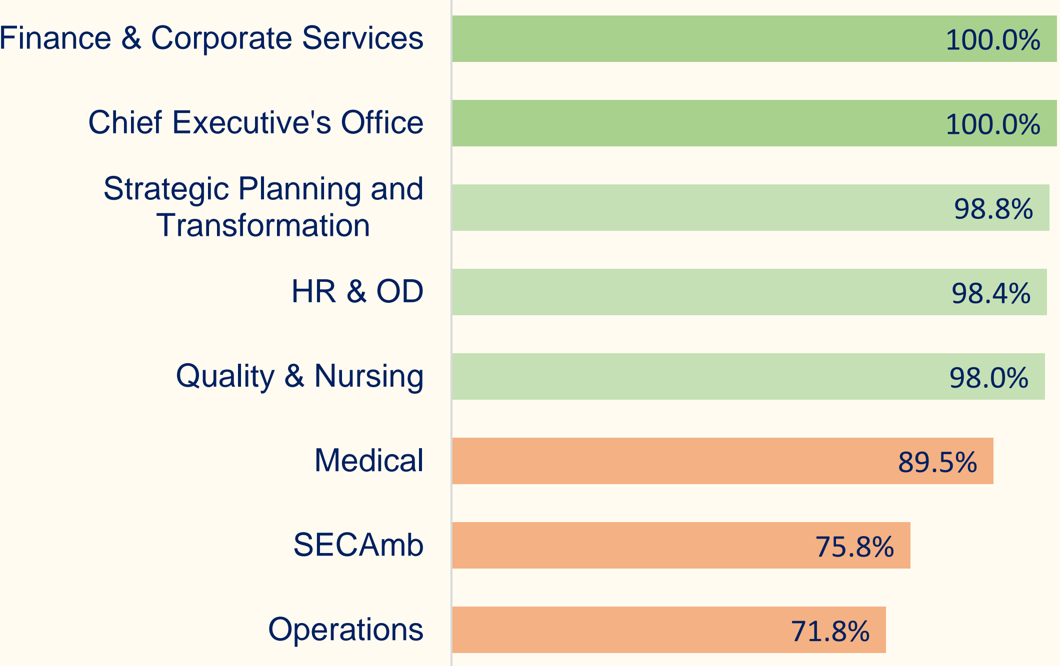
Top 15 Highest Performing Questions

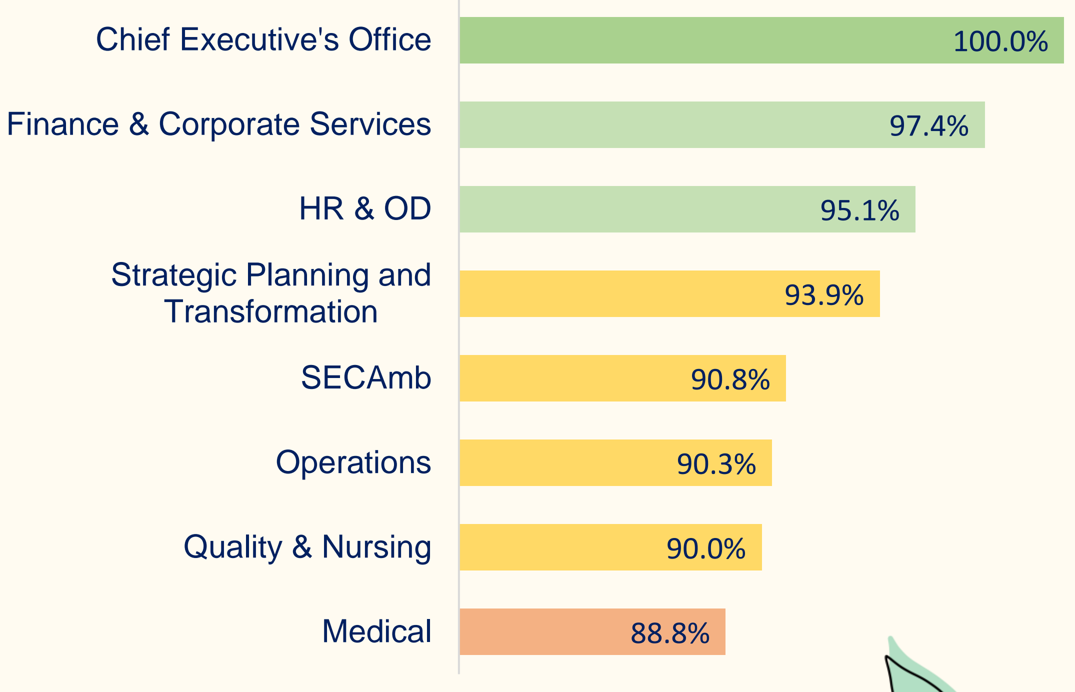
Question	Positive Score
In the last 12 months how many times have you personally experienced physical violence at work from managers (Never).	99.2%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (Never).	98.5%
In the last 12 months 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

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





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

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)

OU / Team	%
HART West	96.2%
HART East	92.0%
111 Urgent Care	91.0%
CCP East	83.3%
999 Emergency Operations Centre	82.3%
CCP West	81.3%
SECAmb	75.8%
OU - Paddock Wood	70.6%
OU - Thanet	67.5%
OU - Tangmere & Worthing	66.7%
OU - Guildford	65.9%
OU - Medway	65.6%
OU - Ashford	61.8%
OU - Banstead	58.4%
OU - Polegate & Hastings	58.1%
OU - Dartford	57.4%
OU - Gatwick	56.8%
OU - Chertsey	53.7%
OU - Brighton	50.4%

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.

Sexual Behaviour at Work - OU / Team

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)

OU / Team	%
HART West	96.2%
HART East	96.0%
OU - Banstead	94.8%
111 Urgent Care	94.3%
OU - Paddock Wood	93.1%
OU - Chertsey	92.6%
OU - Brighton	92.3%
SECAmb	90.8%
CCP West	90.6%
999 Emergency Operations Centre	90.5%
OU - Medway	89.3%
OU - Guildford	89.0%
OU - Polegate & Hastings	88.9%
OU - Dartford	88.3%
OU - Thanet	87.7%
CCP East	87.5%
OU - Tangmere & Worthing	86.4%
OU - Ashford	85.4%
OU - Gatwick	85.2%

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.

Person-Centred Care

60%

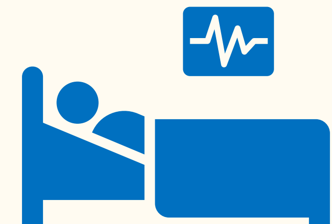
of staff said that care of patients/ service users is the organisation's top priority.

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.

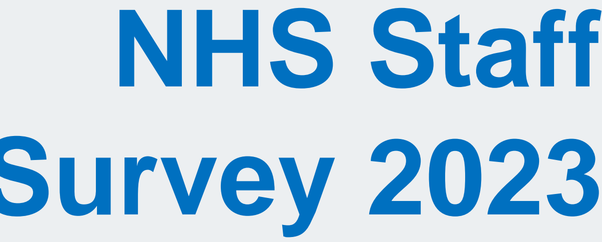
NHS Staff Survey 2023

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.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

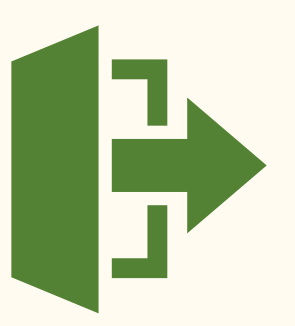


Retention

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.

NHS
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%

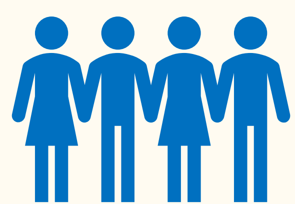
of staff said their immediate manager cares about their concerns.

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.

		Agenda No	11-24
Name of meeting	Board		
Date	04 April 2024		
Name of paper	Sexual Safety Charter Gap Analysis and workstream update		
Trust Priority Area	Sexual Safety in the Workplace		
Lead Director	Margaret Dalziel, Interim Executive Director of Quality & Nursing		
Author	Margaret Dalziel, Interim Executive Director of Quality & Nursing		
Recommendations, decisions, or actions sought.	This paper outlines the gap analysis undertaken in December 2023, and progress made in achieving compliance to the NHSE Sexual Safety Charter signed by the Board in December 2023. The Board are asked to note the progress made by the Sexual Safety Working Group, informed by the gap analysis undertaken at the start of the programme. Current progress across all 5 workstreams indicates that we will achieve compliance with the sexual safety charter by the end of July 2024. A further workstream is to be established focusing on Students experience linking in with our feeder Universities.		

1. INTRODUCTION

The Trust Board signed up to the NHSE Sexual Safety Charter in December 2023, at which point a working group was established to implement the charter with key representatives from across the organisation. The purpose of the group is to be complaint to the sexual safety charter by the end of July 2024 as expected for all NHS organisations by NHSE.

The sexual safety charter is depicted below, and comprises of 10 pledges, aimed at addressing sexual misconduct in healthcare through clear reporting mechanisms, training, and support.

The Sexual Safety Charter

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

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

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

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

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

The first task of the working group was to undertake a gap analysis and set out priorities. This paper outlines the output of that exercise and sets out the workstreams thus established, progress to date and next steps.

A 'Big Conversation' focused on Sexual Safety in the context of Speaking Up and Zero Tolerance was held in February 2024 facilitated by the Chief Executive, Director of Quality & Nursing, and the Associate Director of Organisational Change & Culture, with good engagement from across all levels of the organisation. Subsequently we have seen a rise in formal actions being taken as allegations of this nature have been reported indicating a raised awareness and a serious intent to mitigate wilful blindness and tackle this issue in a transparent and consistent manner.

It is worth noting that AACE have this month established a Sexual Safety Community of Practice that we are members of to share progress, best practice as well as challenges taking a case-based approach.

2. GAP ANALYSIS of the Sexual Safety Charter (NHSE Sept 2023)

1) We will actively work to eradicate sexual harassment and abuse in the workplace.

What good looks like:

- Everyone in the Trust should be able to say what we are doing, who to contact, what help is available and will also agree that we are actively working to eradicate sexual harassment and abuse in the workplace.

Strengths:

- The Dignity at Work policy has been updated.
- The Until it Stops campaign has been undertaken which focused on sexual safety but is limited.
- The board supports the ambition to work to eradicate sexual harassment and abuse in the workplace.

Gaps:

- Momentum in the awareness campaign is not always kept outside of webinars and initial communications and we do not have any literature or posters indicating our ambition to tackle and eradicate sexual harassment and abuse.
- We don't have a dedicated sexual harassment and abuse policy or specific sexual safety training for all staff.
- Current training for line managers ends in February 2024 and was done in isolation from wider culture change work.
- There is no transparent support or enforcement of policies which may lead to underreporting.
- We have not defined what our tolerance level is (e.g., zero-tolerance)
- Not all colleagues have the skills and knowledge to know how to spot sexual harassment and abuse and know how to respond to it.

Actions:

- Define tolerance level.
- Process/Policy reviewed.
- Implement a SPOC.
- Navigation tools in place to help people follow the process and access support.
- Implement training.
- Review current bystander toolkit and implement new resources.
- Implement awareness campaign.
- Posters with SPOC across the trust.

2) We will promote a culture that fosters openness and transparency [Speaking Up], and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.

What good looks like:

- Everyone in the trust should feel able to speak up if they experience harassment but also feel they are able to spot signs of sexual harassment and abuse in colleagues and know how to respond. Everyone should feel that the response to speaking up will be serious, supportive, and proportionate.

Strengths:

- The dignity at work policy is in place.
- Over the next two years all staff will be attending the 'Building a Kinder SECAmb' workshops. Within these workshops there are discussions around speaking up and giving feedback to colleagues when you witness or experience inappropriate behaviours more broadly.
- Specific information is included in the direct entry student induction regarding speaking up and sexual safety. This includes information on the 'PACE' method to support students in speaking up.
- Information on speaking up and sexual safety is included in the wider trust induction.

Gaps:

- We do not have a code of conduct/staff charter integrated with contract for all staff and nothing is currently mentioned in employment contract.
- Building a Kinder SECamb doesn't specifically focus on sexual behaviours and the momentum from the sexual safety awareness campaign may not be reaching all areas such as operations.

- There is a lack of transparency in number of cases and the consequences for perpetrators. This means there is no transparency in how seriously we take it.
- There is also a lack of transparency in what support is available and what will be done if you speak up.
- There still may be a fear of reporting or speaking up due to fear of retaliation and/or lack of confidentiality. We don't currently fully understand the scope of this.
- It is currently unclear what 'zero-tolerance' means at SECamb.

Actions:

- Understand the scope of the issue for the different groups within our workforce – link in with staff networks and carry out focus groups with identified groups.
- With the Board, clearly define what zero tolerance means at SECamb and what the support for victims and consequences for perpetrators look like.
- Implement a sexual safety charter that all staff sign up to with clear consequences for breaching it.
- Update policies and clearly communicate the support given to all staff.
- Transparently share data and outcomes with staff.

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

What good looks like:

- The organisation is not blind to the challenges faced by those in certain groups that face disproportionate abuse due to certain characteristics and talk to it. We will have specific strategies built into our programme of work to address intersectionality.

Strengths:

- We have staff networks representing some staff groups that we can access for support and input. As an organisation we have strong relationships with these networks.
- Our staff networks run sessions around specific topics and issues for members to attend.
- We have access to some limited data broken down from the staff survey on bullying and harassment experiences (more broadly) at work and whether they reported it in the last 12 months.
- The 650 direct entry student paramedics who train at SECamb, receive specific information on sexual safety and speaking up during their trust induction.

Gaps:

- We don't fully understand the experience of certain groups in speaking up at SECamb (e.g., students, new starters, international paramedics, disabled colleagues, BAME, LGBTQ+ etc.)
- Outside of the reported incidents, we don't hold anonymous data (e.g., from staff surveys) on the experiences of sexual harassment and abuse specifically for these groups and the data we do have is from a limited sample size. Therefore, we don't know how many people from these groups may be experiencing it but are not speaking up.
- We don't have a clear picture of the full demographics within our workforce e.g., not everyone declares protected characteristics on ESR.
- We have not linked with any SME or with all staff networks to start the conversation.
- Our current training and resources do not acknowledge or address intersectionality, nor the fact that this is not solely male on female as currently assumed but will impact same sex, and female on male abuse.

Actions:

- We will hold focus groups with identified groups to better understand their experiences.
- Review and update current resources/training to include information around intersectionality.
- Work with staff networks and identified groups to identify and implement any further strategies to support these groups.

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

What good looks like:

- There will be appropriate support available for all staff who experience unwanted, inappropriate and/or harmful sexual behaviours and this will be clearly signposted and embedded in all related processes.

Strengths:

- There is a strong and robust Safeguarding team and processes with open access and 24/7 on-call facility.
- FTSU Guardians are available for all areas and are well advertised and known.
- There is wellbeing support provided through the wellbeing hub e.g., TRiM, talking therapy and wellbeing directory.
- The Dignity at Work Policy is in place.

Gaps:

- Safeguarding isn't always signposted as a channel for support and not everyone refers to them for support. Safeguarding is currently more focused on Domestic Abuse but could be widened as a single access point for referral and self-referral.
- Training and resources available may not be robust enough in supporting wider staff to have the right expertise to provide support to colleagues.
- Support provided throughout the current processes may not always be from someone with the right expertise.
- Wellbeing support isn't always clearly signposted within the current campaign. We need to sure all staff who experience unwanted, inappropriate and/or harmful sexual behaviours are aware of both the internal and external services that are provided. E.g., the bystander toolkit doesn't signpost any specific wellbeing or safeguarding support.

Actions:

- Widen use of safeguarding.
- Review current processes and policy.
- Review current resource and NHSE resource pack to ensure safeguarding and wellbeing is signposted.
- Implement training for all staff.
- Recruit or train key staff as there should be someone with right expertise that is the dedicated person victims can go to for support throughout the process.

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

What good looks like:

- We will have clear standards of behaviour that everyone in the trust is aware of and has agreed to.

Strengths:

- The dignity at work policy is in place.
- We have introduced a bystander toolkit.
- There is a page on the zone about sexual safety.
- There is some information included in the freedom to speak up section of the corporate induction.
- All direct entry student paramedics have received information on FTSU and until it stops during their induction week. This covers a range of material including definitions and types of behaviours and has a section on consensual personal relationships.
- All staff are also attending Building a Kinder SECamb which focuses on this more broadly.

Gaps:

- We do not have a code of conduct/staff charter integrated with contract and nothing mentioned in employment contract.
- Not everyone knows about the zone page or bystander toolkit and where to find them. It is also quite long therefore having the time to read it will be an issue.
- The 'Until it Stops' awareness campaign is time limited, not well advertised, the 'so what' follow up plan is still to be confirmed.
- Lack of sexual safety specific training on expected behaviours and how to respond for all staff.

- Policies and current resources may not be using the same definitions/terms as we want to have going forward.
- Online resources may not be accessible for everyone as it assumes everyone has access to certain technology and knowledge (e.g. knows where they are).
- Not all staff fully understand the seriousness of the issue. For example, it can be referred to as just 'banter'.

Actions:

- Integrate a staff charter for all colleagues to sign with clear consequences for breaching it.
- Update policy to ensure clear support and consequences are set out.
- Implement specific and consistent training for all staff.
- Review the bystander toolkit and adapt the new NHS England Sexual Safety resource pack.
- Review the information included in trust inductions.
- Review awareness campaign and communications to ensure they are accessible all staff. Including implementing posters.

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

What good looks like:

- We will have a clear policy that clearly defines expected behaviours, what zero tolerance means and the action that will be taken against perpetrators. There will also be consistency and integration across our policies.

Strengths:

- Have the dignity at work policy in place, though may require strengthening/clarity.

Gaps:

- We don't have a specific sexual safety policy.
- There is a lack of clarity in current policies regarding what 'zero tolerance' means at SECamb and there is also a lack of specificity in the expected outcomes for perpetrators and the expected support for 'victims'.
- The definitions and terminology included in the current policy may also not be in line with the terminology we want to use going forward e.g., it only defines sexual harassment.
- There is a lack of consistency across policies e.g., overlap between 'Dignity at Work policy' and 'managing safeguarding allegations policy.'

Actions:

- Agree whether to implement a new policy or to integrate and join up existing policies.
- Decide what zero tolerance is and ensure this is clearly communicated in our policies with clearly defined support for victims and consequences for perpetrators.
- Decide the terminology the trust wishes to use going forward/
- Review and update our policies to ensure they are robust and consistent.

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

What good looks like:

- All staff will have consistently received clear and specific training and there will be clear expectations on how often this should be refreshed.

Strengths:

- There is training in place for managers (ends in Feb). This has currently been attended by 574 managers.
- Some elements are embedded in corporate induction.
- Sexual safety is specifically covered in the direct entry student induction. This section of the induction covers a range of material including definitions and types of behaviours and has a section on consensual personal relationships.
- There is information available on the staff internet including a bystander toolkit.
- All staff complete some safeguarding training as part of statuary and mandatory training.

Gaps:
- Not all staff have consistently been provided with clear and specific training in relation to sexual harassment and abuse. Not all staff are aware of the intranet page or bystander toolkit.
- Of the current training for managers there are no recommendations regarding refreshers to ensure they are up to date with current policies.
- Evaluation of training offered through campaign has been variable.
- The 'until it stops' line manager training has not been fully evaluated at this stage.
- The 'until it stops' line manager is coming to an end, therefore there will be no training in place for new managers or managers who have yet to complete the training.

Actions:
- Evaluate the current training that is in place for line managers.
- Agree on the mode of delivery of training for next phase of training all staff, the content and how often it should be refreshed.
- Develop and roll out consistent training for all staff to complete.
- Review and adapt the bystander toolkit and new NHS resource pack ensuring resources are adequately signposted.
- Look to bring in specialist training for key senior personnel who will be leading Responses/MDT/HR process.

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

What good looks like:
- There will be clear reporting mechanisms in place that are clearly signposted and everyone in the trust knows how to access. Processes will mean all concerns are channelled down the right avenue.

Strengths:
- Safeguarding referrals are well known and used for domestic abuse but less so for sexual violence.
- There are various reporting mechanisms outside of colleague's direct line manager (e.g., FTSU, HR).
- FTSU also has a Microsoft form that allows for anonymous reporting.

Gaps:
- There isn't always referral access to Safeguarding for staff experiencing these behaviours.
- Momentum of communication about these channels slows outside of webinars and initial communications on the zone. We don't have any posters with this information.
- Some pages on the zone do not have up to date contact information. E.g., HRA contacts are out of date (last updated at the end of 2022).
- Given there are many ways to report we need to ensure they are all being channelled down the correct avenues, but we do not currently have a SPOC.
- There currently is not clear and accessible information available on that support that will be given when you report these behaviours.

Actions:
- Agree and implement a single point of contact for concerns to be channelled through.
- Once processes and reporting mechanisms have been reviewed update communications/current resources to clearly set out to staff the process that will be followed and the actions that will be taken when they report behaviours.
    - Ensure all zone pages have updated information.
    - Implement posters across the trust which clearly communicate reporting avenues.

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

What good looks like:
- All reports are taken seriously, with appropriate support provided and appropriate action taken in the shortest time possible. As a trust we will prioritise our response to these reports to ensure a timely response.

Strengths:

- An MDT takes places for all allegations within 24 hours.
- We keep good records when they are reported through channels such as HR, Safeguarding and FTSU.
- Universities all have link PDLs ensuring communication and access is available.

Gaps:

- There is not a specifically aware or trained MDT, and it varies in who attends – needs standardisation and to be led by Safeguarding.
- All investigations are taking too long to be completed – processes need to be streamlined to policy, undertaken by trained staff and consistent. The process is not currently separate from other grievances/allegations/investigations.
- There is currently a lack of clarity and consistency in how we respond if it goes into a formal process, for example through the police.
- We have not always responded appropriately when receiving reports from third parties such as Churchill.

Actions:

- Review and update our current processes to ensure they are consistent and streamlined.
- Review current expertise of MDT and investigating staff.
- Update policy to ensure clarity and consistency in processes.
- Implement flow chart/navigation tool to help staff and managers navigate processes.

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

What good looks like:

- We will regularly share data on the number of cases, outcomes and with all staff and stakeholders. This data will be easy for people to access and understand.

Strengths:

- We keep records and data of reports and investigations. As such accurate
- FTSU and ER cases form part of boarding reporting and are also discussed at people committee.

Gaps:

- We don't regularly share data with all staff.
- We don't transparently share information on outcomes of cases.
- Data is not accessible from a single source. If you go to different data sources, you will get different answers.
- Reports may be being made using different terminology and definitions depending on the source.

Actions:

- Identify current data that is held across the trust in relation to number of cases and outcomes.
- Review mechanisms for storing the data to ensure data is consistent across sources and update the terminology and definitions being used when reporting across the trust.
- Define how much and how frequently we will share this data.
- Implement a process for sharing the data with all staff.

3. PRIORITIES & WORKSTREAMS

Drawing on the gap analysis the five priority areas have been identified as Data, Communications, Policy/Process and Reporting, Training and MDT/Welfare process.

The workstreams have been organised as follows, reporting into the monthly steering group chaired by the Exec Lead for Domestic Abuse and Sexual Violence:

1. Data group – Alex Croft, Assistant Director of Data and Analytics
2. Communications – Liz Spiers, Communications Manager
3. Training: Yvette Bryan, Assistant Director of Organisational Change and Culture

4. Policy/Process/Reporting: Nadeem Issa, Head of ER /Karen Lavender, HR Policy Manager
5. MDT/Welfare process: Gareth Knowles, Safeguarding Lead

Each group is established and have set out clear objectives, timelines, and interdependencies.

4. PROGRESS

At the time of inception, the working group decided not to undertake a **survey** on staff experience with regards to sexual safety noting that this was an element being picked up through the National Staff Survey for the first time, and acknowledging a lot of engagement was underway with our staff in relation to the strategy, quality accounts and the staff survey. The assumption has been made that SECAmb will be facing the same level of poor behaviours as experienced in all the other Ambulance Trusts that are ahead of us, and as evidenced through concerns raised within our organisation already. It is accepted that as awareness is raised across the Trust and responses are seen and experienced as being taken in timely manner, with consistency and low threshold of tolerance that reported cases will increase. This is being borne out since the conversations have increased and is regularly refreshed.

All workstreams have been dependant on the **Sexual Safety Policy** being developed and ratified. This is now in consultation phase and covers all aspects of concerns, allegations, and responses. It offers a definition for 'zero-tolerance' acknowledging that this needs to be proportionate, fair but consistent and clear on our intent to not tolerate unwanted, inappropriate of harmful sexual behaviours towards our workforce. It also provides clear guidance for all staff including students.

The **Communications** workstream is well developed and are drawing on resources widely available from other Trusts as well as professional graphic designers to achieve strong clear communication that will be widely distributed in several different formats. There is also an interdependency with the Data group, in developing the communications for transparently sharing of data to inform all staff on progress, cases and outcomes, whilst preserving confidentiality and the confidence of staff. Currently all **sources of Data** are being identified and collated, and the staff survey will inform this work.

A **Training** specification has been developed for all staff at all levels, volunteers and students and is being finalised prior to submission. By the end of the training, participants should feel equipped to recognise, respond to, and report instances of sexual harassment effectively while contributing to a safer and more respectful work environment for all colleagues. There is an online training package developed specifically for HR personnel, Ambulance People Profession Development Programme 2024 (Sexual Safety), that is being proposed is made mandatory for all HR staff who are involved in these cases.

As the policy progresses through consultation the **MDT /Welfare** group can set out final proposals from work undertaken thus far. The proposal at this stage is to mirror the allegations process, and keeping the panel as an advisory group, due to parity for sexual safety/safeguarding.

We will be adding a workstream focused specifically on the **Student Experience** to be led by Clinical Education and FTSU as we have moved into providing forums within universities and setting up

appropriate communication channels and welfare support. There is a unique vulnerability to student paramedics who are also employed by the trust (rather than being full-time university students) that we need to recognise.

5. RECOMMENDATIONS

The Board are asked to note the progress made by the Sexual Safety Working Group, informed by the gap analysis undertaken at the start of the programme.

Current progress across all workstreams indicates that we will achieve compliance with the sexual safety charter by the end of July 2024.

	Agenda No	11-24

Name of meeting	Trust Board
Date	4 April 2024
Name of paper	People Committee Escalation Report – 21 March 2024
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 21.03.2024 and confirms whether any matters require specific intervention by the Trust Board.

Before the main part of the meeting started, the executive updated on the Culture Review of ambulance trusts and how we are responding. Firstly, the committee welcomed this review as it is a critical issue we need to address as a sector. There are six recommendations and the executive is undertaking a review against the related actions; for the most part we have already started to take action as part of our People & Culture Strategy and this review will help to inform the new priorities for the coming year.

Item	**Link to BAF**
Appraisals	P&C Objective 5 - Supporting our leaders complete appraisals by actively removing blockers

The executive has acknowledged a gap in assurance with the reliance of the appraisal data and the committee has asked for an update next time setting out how this is going to be addressed and how the executive is seeking its own assurance that appraisals are being scheduled and taking place.

It is clear that we will not achieve the 85% target (currently at 64%) and the committee explored the factors underlying this. While it accepts there is a problem with how the ESR system is being used, the committee does not believe this is the main issue. There seems to be a deeper-rooted cultural issue with appraisal completion.

EOC Culture Update	Risk 348 – Culture & Leadership

The specific assurance sought here arising from the discussion in January, is how the executive intends to ensure momentum of the culture improvement plan especially from May when the secondment of the Lead comes to an end. The committee received good assurance by the confirmation that the role of the Lead is to be made substantive. There are a number of positive actions such as reward and recognition, and the recent staff survey results reflected well on the impact of the actions with a high number of metrics being better than the trust average.

People & Culture Strategy – End of Year Review of the BAF Priorities	P&C Goals 1-3
As part of the transition to the new priorities for 2024-25 the committee undertook a review of the current People & Culture objectives set out in the Board Assurance Framework. It reflected on the achievements in the past year, which was supported by the feedback in the staff survey, and welcomed the current refresh of the P&C strategy to take account of the new trust strategy. It reinforced the importance of prioritising the right things given the pressure on resources in the coming year.	

Workforce Plan	Risk 255 – Workforce Plan
The plan for this year was over-delivered due to better recruitment and less people leaving. The focus of this meeting was on the plan for 2024-25, although this was in the absence of published planning guidance, which is expected to require a Cat 2 30-minute mean. The workforce plan delivers this level of performance, in addition to call handling, and has informed our first submission which includes a £28.1m deficit. It also includes an increase in H&T to 16% to offset activity growth. There are a number of risks, and this multi-year plan aligns with our new strategy and the new operating model. There was a constructive discussion about the difficult choices to balance money, staff welfare and patient safety / experience. And also the partner collaboration risk with us being able to deliver this change as part of the new strategy, i.e. ensuring pathways are available. There is currently no separate workforce plan for support services, but as part of Phase 1 of the strategy the executive will be reviewing support services and this will then be included a three-year whole workforce plan from 2025-26. The committee is assured by the current (operations) workforce and has much confidence in delivery.	

Clinical Education Strategy	Risk 255 – Workforce Plan
A helpful paper was received setting out progress against the priorities within the strategy. This has becomes well incorporated into trust business, as demonstrated by the workforce plan. The main challenge to delivery relates to capacity and resource. The committee has asked for assurance next time on the mitigations flowing from the estates risk, with the lease at Haywards Heath College ending in October 2025. Overall, the committee is assured by the main aim of the strategy helping to deliver the workforce plan. It explored the plan to ensure local education is more embedded and the adaptation that will be needed to the strategy with the changes in our operating model over the coming years.	

Staff Survey Results	Risk 348 – Culture & Leadership
The committee really welcomed the positive improvements in the feedback from our people. There was another good response rate (over 60%); every theme score has improved by a statistically significant amount since 2022; and our scores have improved more, on average, than those of our benchmarking group.	

In terms of next steps, the executive will be using this feedback to inform the new priorities for the coming year, engaging with our people on the choices we need to make as we will not be able to do everything. While the committee reflected positively on these results, it guarded against over-optimism and challenged the executive to do even more next year. It also noted that there is a mixed picture emerging from support services so we must ensure care and attention to this group of staff.	
Specific Escalation(s) for Board Action	The meeting was very constructive with good papers to help the focus of discussion. There was a better balance between the current and future. The Board is asked to note the continuing concern about Appraisals, which is being followed up.

		Agenda No	12-24
Name of meeting	Board		
Date	4th April 2024		
Name of paper	Keeping Patients Safe		
Strategic Theme	**Quality & Safety**		
Author / Lead Director	Margaret Dalziel, Executive Director Quality & Nursing (interim) Kirsty Booth, Business Manager, Medical Directorate Richard Quirk, Acting Chief Medical Officer		

Executive Summary

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

There are six areas we wish to bring to the attention of the Trust Board:

- Medicines Governance Leadership changes
- Paddock Wood Medicines Distribution Centre progress
- Quality Assurance of Critical Care provision
- Patient Group Directions Dashboard Development
- Short-term impact on performance with planned transition to DXC (Datix Cloud) and PSIRF (Patient Safety Incident Response Framework)
- IPC Handwashing Audit improvements
- Update on progress in Floor to Board connectivity through Quality Forums

1. Introduction

Both the IQR and the BAF QI Priorities outline progress being made in all areas across Quality and Clinical metrics and goals, with the ongoing maintenance of improvements made over the past 18 months. The areas being highlighted specifically in this paper are:

- Medicines Governance Leadership changes
- Paddock Wood Medicines Distribution Centre progress
- Quality Assurance of Critical Care provision
- Patient Group Directions Dashboard Development
- Short-term impact on performance with planned transition to DXC and PSIRF
- IPC Handwashing Audit improvements
- Update on progress in Floor to Board connectivity through Quality Forums

2. Medicines Governance Leadership changes

Both the Chief Pharmacist (CP) and Deputy Chief Pharmacist have now left the Trust. We have recruited substantively to the new CP and are expecting them to start in June 2024 once pre-employment checks are complete. The Deputy Chief Pharmacist post has been advertised and is awaiting shortlisting, the new CP will be involved in this process.

Two interim Chief Pharmacists have been appointed working 3 days per week between them, both are from our neighbouring Ambulance Trusts. A comprehensive handover has taken place to ensure that the risks within this portfolio are known to the two external CPs.

3. **Paddock Wood Medicines Distribution Centre Phase 1**

   Phase 1 task & finish groups have been paused whilst a stocktake of the current position is completed by the Portfolio Manager – Medical.

4. **Quality Assurance of Critical Care provision**

   In Q3 2023/24 the Critical Care Team developed and launched a new Quality Assurance Procedure which included the use of daily contemporaneous audit, the first area of practice within the Trust to do this. The audits use clinical performance indicators (CPIs) to provide assurance on the quality of care provided by CCPs (Critical Care Paramedic). CPIs are a set criterion used to measure compliance on a specific aspect of care. They follow a criterion-based methodology and derive if an aspect of care is compliant or non-compliant with a specified standard.

   Each day, the duty Critical Care Team Leader undertakes a review of all incidents over the past 24 hours that were attended by a CCP and included any of the following interventions: cardiac arrest with ROSC (Return of Spontaneous Circulation), administration of ketamine, administration of midazolam and surgical procedures. Each of these case types have a set of CPIs against which they are audited. The outcomes of these CPI audits are used to inform individual feedback and which cases are selected for consultant led case review.

5. **Patient Group Directions Dashboard Development**

   A dashboard has been developed that pulls data from ESR and the JRCALC (Joint Royal College Ambulance Liaison Committee) App that shows the compliance to PGDs (Patient Group Direction). The App is in the initial stages and is due to be presented to the next available Teams B meeting. It is anticipated this will go live early in Q1 2024/25.

6. **Impact on performance with planned transition to DXC and PSIRF**

   The Board are asked to note the performance dip depicted on the IQR for Incident reporting, and Duty of Candour during January and February 2024. This was also noted in compliance to reviews of risks on the register at that period as noted by a recent audit to be discussed at the next Audit committee. These are all now recovering or have recovered, and were directly related to the major IT software transition to Datix Cloud (which coincidentally occurred at the same time as the departure of the Datix Manager reducing capacity and technical knowledge), and the challenging transition to PSIRF that caused disruption in procedure due to the delays occurred for final sign off by the ICB (Integrated Care Board). No issues have been detected through careful monitoring during this period and since, and the performance is returning to expected position as the changes are now embedding. The teams continue to be vigilant on monitoring these through the established governance routes (i.e. System-based Incident Review Groups, PSOG (Patient Safety Oversight Group) and Risk Assurance Group respectively).

7. **IPC**

   The IQR illustrates variation in the consistency of IPC Audit compliance, though remains mostly within tolerance levels. However, the Quality Assurance and Engagement visits that have now been undertaken in 75% of our Units have consistently exposed understanding, compliance, approach, and attitude towards IPC audits as an issue at local level.

   There are 6 audits that need to be undertaken across all Units throughout the year these being:
   - Hand Hygiene
   - Aseptic Non-Touch Technique

- Post Patient Care
- Vehicle Visual Cleanliness
- Vehicle Adenosine Triphosphate (ATP) Swabbing
- Premises Cleanliness

Through their QI plan the IPC team have introduced improvements in the design, application and relevance of audits, and been reinstating the local IPC champions with the support of local teams to raise awareness, understanding and maintain consistent compliance to these mandatory audits. The results will continue to be monitored through the System governance groups with the expectation that regardless of pressures on the service compliance will be maintained throughout the year.

8. Complaints related to the theme of poor staff attitude

The PALS team have undertaken a deep dive into this area as it continues to be the largest proportion of reason for complaints. This has surfaced interesting system, process and human factor issues that will be presented at the People Committee in May 2024, alongside a targeted plan for improvement now we are clear of the issues and areas of concern. The expectation of the actions planned are a reduction in complaints in relation to staff attitudes, and increased motivation amongst our frontline staff and partners.

9. Update on progress in Floor to Board connectivity through Quality Forums

The Board are asked to note the update on the Quality Assurance Framework implemented over Q1-Q3 23/24 on the BAF paper Trust priorities section.

The diagram below is a reminder of the architecture of this process.

All elements are now in place and are to be evaluated over the Q1 and Q2 2024/25 at appropriate times as the first three elements are in different stages of maturity.

A review of all 9 QAEV now undertaken was presented to EMB on 27/03/24 and aligns to the indicators arising from the staff survey in relation to Well-Led/Leadership metrics.

<table>
<tr><td colspan="2">The evaluations will track through data and narrative to assess how information is flowing up through the relevant stages but already we have continuity of members linking each group, reports coming through from one to the next, and triangulation of information evident in conversations being held through the Improvement Journey Steering Group. So there is confidence that the information being discussed at each level is relevant, identifiable to local staff and cascading up through the forums.</td></tr>
<tr><td>Recommendations, decisions, or actions sought</td><td>The Board is asked to test whether there is sufficient progress with the corporate objectives, and the controls and mitigating actions against the relevant risks, as set out in the Board Assurance Framework and Integrated Quality Report. Where the Board identifies gaps in assurance, agree what corrective action needs to be taken by the Executive.</td></tr>
</table>

South East Coast Ambulance Service NHS
NHS Foundation Trust

		Agenda No	12/24
Name of meeting	Trust Board		
Date	04.04.2024		
Name of paper	Learning from Deaths Q2 Report 2023-24		
Responsible Executive	Chief Medical Officer		
Author	Dr Richard Quirk, Acting Chief Medical Officer		
Synopsis	The national policy requires quarterly reports to be considered by the Board. This independent random review patients who have died in our care has continued to demonstrate compassionate care in the majority of cases. The main reason for the panel to judge care as 'adequate' or 'poor' is once again related to delays in getting to the patient.		
Recommendations, decisions or actions sought	The Board is asked to note the report and the actions that the Trust is taking.		
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**		

Learning from Deaths Report – Quarter 2 – 2023/24

1. Introduction

1.1. When deaths occur, it is important that we review the care to understand if there is anything that we could have done differently before the death, during the death or following the death. This review of care should then improve future care. If carers, relatives, staff or other organisations raise concerns to SECAmb, about the care of a patient at the time of their death, they will be fully involved in any review of the death.

1.2. SECAmb Trust Board approved the Learning from Deaths Policy in November 2019. This policy sets out the national standards of randomly reviewing the care of 20 patients per month (from across the 10 Operating Units) and must include deaths during a C1/C2 delayed response, deaths during a C3/4 delayed response, deaths following hand over of the patient to another provider and deaths where the initial decision was to leave the patient at home and then they subsequently died.

1.3. There are additional statutory requirements to provide information to the Child Death Overview Panel for all children who die, a requirement to report deaths of people with Learning Disabilities to LeDeR (Learning Disabilities Mortality Reviews), a requirement to report all deaths of people with serious mental health conditions to their mental health trust and a requirement to report all obstetric incidents (which meet their criteria) must be reported to the Healthcare Safety Investigations Branch (HSIB).

1.4. This quarter, the Learning from Death Group commissioned a 'deep dive' into the care of patients who died whilst we were present on scene. This was to identify, specifically, if there were any care issues on scene that could have contributed to the death of the patient.

2. Overview of Quarter 2 (23/24) mortality data

2.1. Table 1 shows the total number of deaths per month broken down into sex. Where the sex of the patient has not been recorded or staff have been unable to identify the sex, this is categorised as 'unknown sex'.

Table 1

	2020				2021				2022				2023			
Month	F	M	U	Total Deaths	F	M	U	Total Deaths	F	M	U	Total Deaths	F	M	U	Total Deaths
Jan	277	377	7	661	406	543	0	949	312	425	1	739	318	467	1	786
Feb	265	369	4	638	286	378	1	665	254	355	1	610	279	423	1	703
March	285	413	9	707	248	383	0	631	288	429	0	717	323	430	2	755
April	341	466	11	818	254	366	0	620	275	389	1	665	300	408	4	712
May	265	347	5	617	207	335	1	543	244	389	0	633	299	416	6	721
June	214	325	13	552	204	323	1	528	240	357	1	598	247	404	7	658
July	223	367	2	592	229	403	0	632	294	413	2	709	**201**	**357**	**0**	**559**
Aug	266	370	3	639	208	336	0	544	263	374	3	640	**245**	**377**	**3**	**625**
Sept	204	333	3	540	238	346	0	584	262	345	0	607	**275**	**416**	**0**	**691**
Oct	240	354	0	594	305	406	0	711	280	400	0	680				
Nov	225	380	1	606	254	426	2	682	275	412	8	695				
Dec	334	464	0	798	341	432	1	774	461	579	1	1041				

2.2. Table 2 shows the breakdown of the number of people who died in each age bracket:-

Table 2

Age Range (Yrs)	No. of patients who died – July 2023	No. of patients who died – August 2023	No. of patients who died – September 2023
Under 1 year	4	1	3
1-18	4	3	4
18 – 29	18	13	16
30 – 39	17	18	21
40 – 49	26	31	36
50 – 59	51	66	67
60 – 69	84	86	104
70 – 79	131	140	158
80 – 89	142	166	169
90 – 99	72	94	105
100+	5	3	5
Age unknown	4	4	4

2.3. Table 3 shows the numbers of patients who had an Advance Care Plan (ACP)/Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place, those who were 'dead on arrival' and those on whom we attempted resuscitation:-

Table 3

	No. of patients who died – July 2023	No. of patients who died – August 2023	No. of patients who died – September 2023
Dead on arrival	250 (45%)	297 (48%)	303 (44%)
Resuscitation attempted	151 (27%)	168 (27%)	191 (28%)
Advance Care Plan/Do not attempt resus (DNACPR)	131 (23%)	130 (21%)	175 (25%)
Professional Decision not to Resuscitate	23 (4%)	24 (4%)	18 (3%)
End of Life	3	3	6

3. Review process

3.1. In accordance with the Trust's Learning from Deaths policy, 20 random cases have been selected to be reviewed per month (60 reviews per quarter). The 20 cases were from across the 10 Operating Units. The Structured Judgemental Review (SJR) is the nationally approved review process and SJRs were carried out on the 60 cases.

3.2. His quarter the review panel has been expanded to include the Practice Development Leads as well as the Chief Medical Officer, Deputy Medical Director, Assistant Medical Director (Critical Care), both Consultant Paramedics (Urgent Care) and the End of Life Care Lead.

3.3. Table 4 shows the outcomes of the Structured Judgemental Reviews of the 60 randomly selected deaths in Quarter 2 23/24.

Table 4

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	19 (36%)	24 (45%)	7 (13%)	3 (6%)		
On scene handling (Care)	24 (45%)	26 (49%)	2 (4%)	1 (2%)		
Transfer and Handover (Including discharge and worsening care advice)	10 (19%)	11 (21%)				32 (60%)
Other Aspects of Care (quality and legibility of records)	20 (38%)	25 (47%)	8 (15%)			
Overall Assessment of Care	24 (45%)	24 (45%)	4 (8%)	1 (2%)		

3.4. **Learning from each phase of care**

Most judgemental reviews undertaken identified good or excellent care. Of particular note is the level of compassionate care provided to families and carers. There is some identified learning from each phase of the care as detailed below:-

3.4.1. Initial Management

In the 10 cases where care was seen to be 'adequate' or 'poor', the reason for the majority of these ratings was a delay in reaching the scene. The majority of calls are classed as Category 1 and should receive a response within 7 minutes (on average). For all of those incidents where the Trust has taken longer than 7 minutes to arrive on scene, the reviewers have not identified any significant harm caused to those patients as they were either already dead, were receiving adequate bystander CPR/defibrillation or getting there sooner was unlikely to make a difference to the outcome.

The specific delays are as follows:-

- 36 minutes to attend a C2 call.
- A short delay to attend a C1 call.
- A delay of 10 minutes to attend a C1 call. Insufficient information passed from control to the crew.
- Call backs made to the patient but no escalation when no response was received.
- 14 minute delay in attending a C1 call.
- A more than 1 hour response to attend a C2 call.
- 9 minute delay in attending a C1 (but no harm caused as patient had a DNACPR).
- 2 minute delay from control assigning a C1 to the crew being allocated.
- Delay in getting to a C1 call – but expected death when arrived.
- Only 1x Double Crewed Ambulance sent to a C1 arrest when policy says two should be sent.

The reviewers also assessed the likelihood of success of resuscitation if the crews had arrived any earlier and felt that in the majority of cases, the outcome is unlikely to have been any different.

3.4.2. On Scene Handling

Most cases reviewed this quarter were found to have excellent or good care on scene.

The adequate care identified in the 'on-scene' element was related to:

- Resus was interrupted when moving the patient from the house to the ambulance.
- A complication with achieving an airway by the crew, which was resolved when the Critical Care Paramedic arrived.

The poor care identified in the 'on-scene' element was related to:

- No Basic Life was started by the crew on arrival even though there was no DNACPR present in the property.

3.4.3. Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying.

3.4.4. Other aspects of care (including documentation)

The 'other' care issues that were graded as 'adequate' were as follows:-

- Lack of detail about the incident.
- Not enough documented on the shocks given and the time of those shocks. Also the wrong clinician name was documented as intubating the patient.
- No photo of the DNACPR was uploaded to the ePCR.
- Limited clinical notes written in the ePCR.
- Limited notes written in the ePCR.
- Critical Care Paramedic's notes were good in the ePCR but limited notes written by the crew.
- Lack of information written in the clinical notes and no ECG completed.

3.4.5. Overall Care

Where the overall care has been judged as 'adequate' or 'poor' this is related to the concerns written above in the other elements of care provided.

4. Referrals to the Learning from Deaths panel

4.1. During this reporting period, no cases were referred to the Serious Incident Group for assessment.

5. Learning from the random review of 53 deaths

5.1. In the majority of the 53 reviews undertaken, the care of the patient was good or better. In most cases, our policies were correctly followed, thorough history taking was completed, examinations were robustly recorded and the outcomes for the patient were clearly documented.

5.2. In a small number of reviews there was a delay in attending the patient. The reviewers have not found evidence that these delays significantly impacted on the outcome for these patients.

5.3. Crew members are making sensible and compassionate judgements when talking to relatives and carers about resuscitation attempts and are clearly documenting these conversations.

5.4. Support from Operational Team Leaders (OTLs) and Critical Care Paramedics (CCPs) in the management of complex arrests is clearly documented and it is evident that everything that could be done to save life is being attempted.

5.5. Consistent with other ambulance trusts, we do not have a system to identify patients who have died within 24-48 hours of admission to hospital to be able to review their pre-hospital care. NHS Improvement are looking into ways of identifying these patients.

5.6. A theme this quarter is the depth of documentation written by the crew in the ePCR. This learning will be shared at the Learning from Deaths Group to ensure crews are reminded about the need to thoroughly document the care in the ePCR.

6. Deep Dive – The care of patients who die in our presence

6.1 The Learning from Deaths Group commissioned the panel to do a deep dive into the care of patients who die whilst we are with them on scene.

6.2 The panel reviewed every death in July, August and September 2024 where the patient was alive when we arrived on scene, but subsequently died. There were 101 patients who met this criteria. The results of this review are set out below.

6.3 Table 5 shows the summary of the standards of care provided to those patients who died in our presence.

Table 5

	Excellent Care	Good Care	Adequate Care (good enough)	Poor Care	Very Poor Care	N/A
Initial Management and/or Pre-scene (initial call handling, categorisation; response time, appropriateness if vehicle and staff dispatched)	40 (40%)	40 (40%)	10 (10%)	10 (10%)	1 (1%)	
On scene handling (Care)	46 (46%)	41 (41%)	9 (9%)	5 (5%)		
Transfer and Handover (Including discharge and worsening care advice)	26 (26%)	22 (22%)				53 (53%)
Other Aspects of Care (quality and legibility of records)	46 (46%)	39 (39%)	14 (14%)	2 (2%)	1 (1%)	
Overall Assessment of Care	40 (40%)	38 (38%)	19 (19%)	4 (4%)		

6.1. Learning from each phase of care – deep dive into patients who die in our presence

6.1.1. Initial Management

In the 101 cases where care was seen to be ‘adequate’ or ‘poor’, the reason for the majority of these ratings was a delay in reaching the scene.

The specific delays are as follows:-

- A 1 hour 5 minute response to a C2
- Delay to a C1 call
- 16 minute response to a C1 with no harm
- 12 minute response to a C1
- 10 minute response to a C1
- Delay to a C1 call
- More than an hour response to a C1
- Delay to a C1
- Concerns that a C1 response was allocated to a patient who was end of life

- 1 hour 35 minute response to a C2 call.
- A patient with end of life care was given a C1 disposition
- A C1 response was allocated to a patient at end of life.
- 13 minute delay to a C1 patient
- Delay to responding to a C1
- Delay to responding to a C1
- Delay to responding to a C1
- Significant delay to a C2
- More than 1 hour before a CFR responded followed by a crew
- 9 minute delay to a C1
- Care line call – control did not do a 1st party call back so did not give haemorrhage advice
- 3 hours response to a C2
- 60 minute response to a C2

6.1.2. On Scene Handling

Most cases reviewed this quarter were found to have excellent or good care on scene.

The adequate care and poor care identified in the 'on-scene' element was related to:

- Oxygen was given to a patient who was end of life which was inappropriate
- The patient had severely deranged observations but the crew stayed on scene for 35 minutes
- Patient had deranged observations – delay in managing this
- Dying patient was given observations and assessments which were unnecessary
- Limited notes about on scene care
- No comfort measures documented
- Crew did an ECG in a patient at end of life
- No Basic Life Support given despite no DNACPR
- Delay in resus due to moving patient to the vehicle
- Poor documentation
- Exerting the patient may have contributed to their collapse

6.1.3. Transfer and Hand over

Transfer and Hand over judgements are not relevant in every review as the crew may not convey/transfer a patient who has died/dying.

6.1.4. Other aspects of care (including documentation)

The 'other' care issues that were graded as 'adequate' or 'poor' were as follows:-

- 12 cases had poor documentation
- Post Return of Spontaneous Circulation – patient had obs but they were not documented
- No picture taken of the DNACPR for the notes
- Missing phot of DNACPR
- Crew on scene for 2 hours after Recognition of Life Extinct

6.1.5. Overall Care

Where the overall care has been judged as ‘adequate’ or ‘poor’ this is related to the concerns written above in the other elements of care provided. There were two cases where care was judged as poor due to the lack of ability to secure an airway by the crew until the Critical Care Paramedic arrived. These two cases will be reviewed further to understand why this occurred.

7. Conclusions

The panel have identified many examples of very good compassionate care. Delays in getting to the patient continues to be the leading cause of concern related to care of people at the end of their life or care of relatives when the patient.

The deep dive review into the care of patients who died whilst we were on scene showed a very similar picture to our random reviews. The most common cause of adequate or poor care was a delay getting to scene. There were two issues where the crews struggled to secure an airway until the Critical Care Paramedic arrived and the panel will review why this occurred. The care of patients at whose death was expected (e.g. those patients at the end of life with a diagnosed terminal condition) sometimes involved unnecessary assessments and observations. The Panel will work with our end of life care specialists to adapt training for crews to reinforce correct procedure.

Dr Richard Quirk
Deputy Medical Director/Acting Chief Medical Officer
March 2024

Agenda No	13-24

Name of meeting	Board
Date	04.04.2024
Name of paper	Operational Performance & Efficiency
Strategic Theme	Responsive Care
Author / Lead Director	Executive Director of Operations

Executive Summary

Introduction

This paper provides an overview of the operational delivery functions of the Trust, particularly those linked to the goals within the Responsive Care strategic priority and is aligned to the risks identified in the Board Assurance Framework. The data and narrative within the IQR also provide evidence of service line improvement and areas of continued challenge.

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

1. 999 Call answering.
   February's performance shows a continued improvement compared to previous months, primarily due to increased resourcing levels (and therefore calls answered), in conjunction with other priority actions continues including a focus on retention, optimising efficiencies, and external call handling support.
   Associated risk: Operating model to meet ambulance quality and performance standards *[Risk 14, BAF risk].*

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

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

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

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

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

Resilience & Specialist Operations

- HART: Recruitment uplift plans are in place for the upcoming financial year, recognising some additional challenges as NARU transitions from the previous host in the West Midlands Ambulance Service to the London Ambulance Service.
- SORT: Delivery plan on track with sustainable strong performance, with the improvement programme now transitioning into maintenance and sustainability.
- ***Associated Resilience & EPRR risks***
  EPRR Incident Response [Risk 29]: *The Trust may not be able to guarantee an appropriate response to an incident of an EPRR nature and therefore may fall short of the requirements outlined in the Major Incident Plan and NHS EPRR Framework primarily due to ongoing capacity and demand.*
  Adverse Weather conditions [Risk 45]: *Recognition of the increasing number of adverse weather events including wildfires, storms, and excessive temperatures, all of which may affect the Trust's ability to provide an effective service.*
  National Security Risk Assessment (NSRA) - Pandemic/Infectious disease outbreak [Risk 120]*: There is a risk that a pandemic/disease outbreak may overwhelm the Trust's ability to respond effectively.*
  Aging equipment will compromise the Trust's CBRN response [Risk 467]: *A national issue relating to the age of equipment and availability of replacements.*

111

- Contract performance
  111 performance remains stable but still significantly under the contract levels for call answering and abandonment rate. Outcomes are strong in 111 with nationally some of the strongest performance for both conversion to 999 and direct booking into ED
- ***Associated Risk: Clinical Demand and Long waits in clinical queues [Risk 95]*** – If demand outstrips clinical resources in 111, patient call-back performance will outside the NHS Pathways timeframe for response which may lead to patient harm and poor experience.

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	13-24

Name of meeting	Trust Board
Date	4 April 2024
Name of paper	Resilience & Specialist Operations Action Plan Update
Responsible Executive	Emma Williams, Executive Director of Operations
Authors	Emma Williams, Executive Director of Operations
Update summary	Following publication of the NARU review of the Resilience & Specialist Operations Department, an action plan was drawn up to address the specific concerns detailed in the report. This paper provides an update on the progress made against this action plan and other associated activities.
Recommendations, decisions or actions sought	This update is aimed at providing assurance to the Board on the progress made to-date in line with the improvement plan.
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	No

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Introduction

This paper will provide an update on three specific areas relating to the Resilience & Specialist Operations department:

- Governance and oversight
- Action plan update
- NARU service update

Governance and oversight update

In line with the items identified in the slide deck produced as a response to the NARU report, an update on four actions can be found below:

1. A review of the Resilience Forum terms of reference has been completed with an updated cycle of business supporting an agenda where alternate months focus on either delivery or assurance. This approach provides an improved oversight through a more consistent repeating schedule with a longer time allocation to enable both those presenting and meeting attendees to provide the challenge and scrutiny required.
2. In addition, the first quarterly assurance meeting with the NHS England Deputy Director of Performance for EPRR was held on 23rd Jan 2024 where Discussions relating to both strategic issues and details with the plan was discussed. The discussion focused on the recent agreement by regional commissioners to increase core funding to allow additional HART recruitment to commence, and the recognition that SORT staffing numbers remain very positive and stable. With all the work ongoing regarding the plan, an earlier meeting was agreed for the end of March at which a detailed update of the plan supported by this accompanying paper would be shared.
3. The SECAmb Contract Review Meeting with commissioners from all ICBs that was held on 1st Feb 2024 had a refreshed agenda with a greater focus on performance across all areas. At this meeting the latest Operational Performance Report was shared and discussed – this contains specific content relating to compliance and performance of HART and SORT services within the Trust.
4. Progress is being made on the terms of reference required to support the set-up and implementation of the Resilience Committee – a Board Committee expected to commenced in April 2024 and run during the 2024-25 financial year to provide greater board oversight and understanding of all aspects of the Resilience and Specialist Operations portfolio.

Action plan update

<u>General</u>

Considerable work continues to progress the actions within the plan, with noted focus on:

- Ensuring all actions are accurately described, with reviewed dates for delivery and status updates.
- An additional evidence column has been added to the spreadsheet to provide evidential assurance that will enable the action/objective to be signed off as completed/closed as per the requirements of the oversight and governance framework developed.
- Review of target dates to ensure then are aligned with completion of the milestone rather than completion of the action, i.e. reporting outcome rather than input.

EPRR

- Policies, plans and procedures – eight documents have been reviewed and updated. These were presented to the Resilience Forum on 21/02/24 as part of the approval process prior to wider engagement with key stakeholders as prescribed in the Trust 'Policy on Policies'. These documents progress through a final period of consultation before being taken to the Trust Joint Partnership Forum on 18 April.
- Commander training, CPD and exercise compliance – The live database has been updated with certificates and evidence of exercise attendance is being captured. Reporting on this will be provided to the resilience forum bimonthly.
- Trust compliance with the Resilience & Specialist Operations training has been reported to the Resilience Forum, and more recently via the Education, Training & Delivery Group, with additional sessions being put on over the final 2 months of the financial year to ensure the target of 85% compliance is achieved. Performance as of mid-February was 71%.
- The largest cohort of actions required relate to training and competence of commanders and the wider staff group. It is the latter group of actions that are ongoing with particular focus on the recording and reporting of training and appropriate CPD, and multiagency JESIP (Joint Emergency Services Interoperability Programme), and Tactical Advisor/NILO (National Interagency Liaison Officer) training.
- Additional actions identified by the team include a focus on team structure (roles & responsibilities), training and development, on-call equipment, and shared learning.

HART

- The KPI that is monitored closely relates to staffing levels – 6 HART operatives must be on duty 24/7 at each site at least 90% of the time. The recently agreed uplift in funding is now being used to recruit an additional 14 Paramedics to join the HART teams to deliver this requirement – there will be open recruitment for these posts for both internal and external qualified Paramedics. There are some concerns relating to NARU's capability to provide sufficient training capacity to support this additional training requirement – this is addressed in a later section.
- Other recruitment continues with the second Training Manager post now filled and implementation of new roles including Team Educator to support Team Leaders under way. Additional logistics and administrative support roles are being worked up as part of the additional funding allocation.
- A greater focus on training delivery and assurance – the NARU report identifies some good practice but with areas particularly relating to auditable recording and assurance processes that needs additional work.
- The team have identified that several of the job descriptions used have not been reviewed in many years and so have prioritised this, particularly considering the updated training delivery requirements/assurance and ambition to provide additional clinical training to HART operatives to enhance their skills and bring them back in line with national best practice. These JDs will be prioritised with initial focus on the HART Operational Team Leader and Training Manager roles. In light of the earlier comment, it is expected that the HART operative JD review will not be completed until the end of Q1 of the 2024-25 financial year.
- The culture of the HART department has been an issue over many years. Whilst it is recognised this is not an isolated position within SECAmb, it is essential that the HART staff at all levels engage with the Trust culture improvement programme. Initial discussions have commenced with the HART leadership team, and in partnership with the Programme Director of Culture Improvement and considering the most recent staff survey results an initial

scoping meeting on 12 March will commence the development of this programme of work. In addition, the second HART Training Manager has been allocated a specific portfolio to lead on the coordination and support for culture improvement work within the HART teams.

SORT

- SORT staffing compliance against the national standard of a minimum of 35 operatives on duty between 06:00 – 02:00 across the trust is monitored closely via a national reporting system called PROCLUS (overseen by NARU). Whilst SECAmb were delayed at commencing the implementation of a recruitment and training programme to meet this requirement, the Trust is now consistently compliant with this target.
- Management of the SORT related PPE (body armour) has had additional focus to ensure its management and monitoring is now done using logbooks – a recommendation from the report and in line with current equipment data sheet requirements.
- Updates of the CBRN and MTA plans were presented at the Resilience Forum on 21st Feb 2024 with feedback received – they now move into the final phase of consultation rior to going to the Trust's Joint Partnership Forum for final approval.

Action status & Due date	EPRR	HART	SORT	Grand Total
Completed	**4**	**4**	**8**	**17**
N/A	4	4	8	17
In Progress	**7**	**3**	**2**	**12**
Mar-24	1	.	.	1
Apr-24	4	1	2	7
Jun-24	1	.	.	1
Sep-24	.	1	.	1
Oct-24	1	.	.	1
Dec-24	.	1	.	1
Grand Total	**11**	**7**	**10**	**28**

NARU service update

The National Ambulance Resilience Unit has been delivered by the West Midlands Ambulance Service University NHS Foundation Trust (WMAS) for the past 13 years on behalf of NHS England. Its remit has been as a central support unit for all UK ambulance services, to ensure that they can respond to a variety of hazardous and challenging incidents in the safest and most effective way possible. To do this, NARU provides a range of services including but not limited to:

- Training aids and publications.
- Training programmes for Hazardous Area Response Teams.
- Command training programmes.
- Tools for sharing best practice such as the PROCLUS reporting and information sharing platform.

- Audit/review visits and programmes of work.
- Delivering the function of the National Ambulance Coordination Centre.

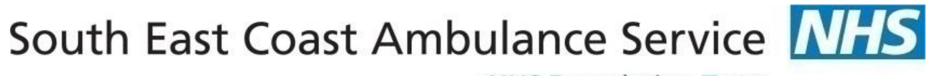
In the autumn of 2023, NHS England went out to procure an updated NARU based on a refreshed specification and as a result the London Ambulance Service NHS Trust (LAS) was the successful bidder.

From early 2024, the transition of NARU from WMAS to the LAS commenced, however as many of the NARU staff were hosted by WMAS and/or located at the national training site at Winterbourne Gunner, it was clear that the transition for many of the employed staff was going to be complex. At this time, it became clear that the forward schedule of training programmes for both HART and command training did not show beyond the end of March (the contract formally changes hands at the end of the financial year) due to the perceived instability in the training faculty after that time.

This issue was discussed at both the National Directors of Operations Group (NDOG) in December, and the Emergency Preparedness, Resilience and Response Group (EPRRG) in January. At NDOG on 14th Feb 2024 there was a presentation and subsequent discussion with the executive lead from the LAS who presented their initial plan and steps being taken to mitigate the risks identified. As NARU does not directly employ trainers but rather each ambulance service commits to supporting courses with suitable qualified instructors, a specific ask is being formulated by the LAS team to ensure that training delivery can be maintained to the level required for bot HART and command training.

Conclusion

Continuing progress is being made in line with the agreed timelines to address the issues and recommendations identified within the NARU report as well as against additional supportive actions agreed by the Trust. The performance of the HART and SORT teams continues to improve, and the steps to ensure enhanced oversight and governance are being implemented.



		Agenda No	13-24
Name of meeting	Trust Board		
Date	4 April 2024		
Name of paper	Digital Transformation & Strategic Portfolio		
Responsible Executive	Simon Bell – Chief Finance Officer		
Authors	Amaraghosha Carter – Associate Director of IT		

The purpose of this paper is to update the Board on the current prioritised Digital workplan for 2024/25. The workplan includes strategic business as usual (BAU) activities alongside key projects.

The projects, once completed, aim to deliver the following initiatives in line with Trust strategic objectives and long-term strategy themes for fulfilling the Department's delivery programme.

- Implementing future proof systems to support in the reduction of technical complexities to prepare the Trust for the future emergency service network.
- Improve interoperability within Ambulance services; dispatch efficiently; enhance resilience in our existing services and the introduction of new critical and infrastructure systems / services.
- Improve clinical quality and operational capabilities by addressing legacy solutions and end of life equipment risk, in line with key nationally mandated projects across the Ambulance Trusts.

Recommendations, decisions, or actions sought	For information

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

Introduction

Historically, our IT operations have navigated without the structure of formalised annual workplans. However, in recognition of the need for strategic direction and efficient resource allocation, this document presents a comprehensive plan outlining the key priorities for the forthcoming 12 months. Emphasising high-priority items, this plan is crafted to strike a balance, ensuring ample capacity remains dedicated to essential business-as-usual activities while also facilitating the execution of additional projects throughout the year.

It is imperative to note that the assessment and determination of these priorities have been conducted exclusively by the IT team at this point. This document serves as a pivotal guide to steer our IT endeavours towards achieving overarching organisational objectives in the coming year.

Priorities for 2024/25

There are currently 134 projects across all Digital portfolios. Of these, 43 have been prioritised and are being concurrently worked on. Several of the remaining projects are also in progress, but paused, whilst resources are allocated to higher priority programmes of work or BAU activity.

Several of the projects are nationally mandated, including:

- Avaya CM10 upgrade (999/111 telephony)
- Control Room Solution (CRS) – EOC dispatch
- Mobile Data Vehicle Solution (MDVS)
- Data Security Protection Toolkit (DSPT)
- Multi Factor Authentication (MFA)

Other projects are also nationally led but not yet mandated. However, NHSE are mandating vendors comply with the emerging standards, which in turn means we will be mandated to adopt them as more vendors support the new standards. These include:

- National Record Locator (NRL)
- Booking & Referral Service (BaRS) – to replace legacy ITK

Current projects by Digital portfolio:

Portfolio	# of Projects
Cyber	42
Critical Systems	25
Data Engineering	17
Infrastructure	16
Networks	15
Service Desk	12
Telephony	7

The table in Appendix 1 provides more detail on the prioritised projects mentioned above.

All projects are now documented and managed through Asana, ensuring that all of IT – and other areas, as required – have complete visibility of all elements of the project lifecycle. This has been aided by the introduction of contractor Technical Implementation Manager resource. Without permanent resources to

assist in managing the large number of projects it will be difficult to maintain this level of oversight consistently.

The Trust has, historically, struggled to consistently prioritise, manage, and resource projects. A single strategy and a common approach Trust-wide to prioritisation, reporting and managing initiatives will be of great benefit.

CAD & EPR

The procurement – via the G-Cloud 13 framework – for Cleric Respond-2 and EPR is in progress, following recent EMB approval. This will provide continuity of system for staff and enable us to work with Cleric over the coming months to introduce new features across both the CAD and EPR platforms.

For EPR, we are looking to introduce the following over the next 12 months:

- Shared Care records access (Kent & Surrey)
- Summary Care Record access
- Service Finder / Mobile DOS
- Hospital Handover
- LifePak integration (subject to discussions on changing devices)
- Coroner Portal
- Dictation into EPR

For CAD, work continues with Sussex on developing access to their Shared Care Record (Plexus). This is being undertaken by Cleric on our behalf and will also apply to EPR.

Our existing iPad estate, procured through national funding almost three years ago, will be due for replacement by 2025/26. With upcoming changes in technology (MDVS introduction, for example) and the significant costs involved with replacing 3,500+ iPads and the associated licenses, discussions need to take place around whether SECAmb continue with personal issue devices or take the route of some other Ambulance Trusts and move to a vehicle-based solution which is significantly cheaper.

Generators

A paper was submitted to EMB outlining critical issues within the power infrastructure across several sites, including Medway, Brighton, Gatwick, and Banstead, which pose significant risks of power failures and safety hazards. These challenges stem from various factors, including improper installation, lack of remote monitoring, deficiencies in electrical infrastructure design and a lack of a second generator at Medway.

A proposal was made to undertake comprehensive assessments and implement remote monitoring systems to address these vulnerabilities. This option entails a holistic consultancy process and remote monitoring implementation to establish a resilient foundation for long-term infrastructure stability.

Although progress is already underway on remote monitoring, a decision is yet to be reached as to whether to progress with the needed consultancy for the remaining sites. Without this, Medway will be at risk of power failure with only a single generator on site and now 2 failures within 1 year of the generator having been identified. Medway will also be at risk of being unusable due to the exhaust venting into EOC/111, putting staff at risk of carbon monoxide poisoning.

Brighton will continue to experience unnecessary power failures on a regular basis, as it has done for years. At Gatwick and Banstead, similar issues exist to those at Brighton, albeit to date these have yet to cause operational impact.

Digital Programme Board

A Terms of Reference is currently in draft for a Technology, Data and Digital Programme Board. This was a recommendation from the external IT review. We are aiming to have this Board in place by the end of June 2024.

Outage Remediation

Since November 2021, there have been four significant service-impacting unplanned outages. The progress on completing the recommendations from these incidents is summarised below:

Incident	% Complete	Notes
November 2021	98%	1 action remaining: ongoing development from third-party to enhance functionality of Cleric fall-back laptop data.
November 2022	70%	3 x IT actions, 4 x EPRR actions remaining.
June 2023	100%	
November 2023	33%	Incident caused by third-party in hosted datacentre. Ongoing discussions and remediation planning with multiple third parties. Remaining actions will be resolved by proposed future changes in the Crawley and Medway datacentres.

External Review update

The external IT review undertaken in September 2023 made several recommendations. These are being tracked and monitored through Asana. Some of the short-term recommendations, relating to departmental structure, have not yet been started due to ongoing departmental senior management changes.

Procurement

There are some significant Digital procurement activities that need to be undertaken in 2024/25 and 2025/6, including:

- CAD / EPR – Procurement will potentially need to begin in late 2024 / early 2025. However, if the Trust remains content with the existing solutions, we can direct award using G-Cloud 13 / 14 in 2025.
- Wide Area Network (WAN) – October 2025. Procurement will need to start in Summer / Autumn 2024.
- Marval (Service Desk) – Procurement will be commencing imminently.
- Microsoft – we are in the last year of our existing 3-year agreement and will need to start procurement in Autumn 2024.

Digital Strategy

Work on the Digital Strategy will commence once the overarching Trust strategy is defined and shared appropriately.

Appendix 1: Prioritised project list 2024/25

Project Title	Key Objectives & Deliverables	Due Date
CAD / EPR renewal	Procure a CAD/EPR solution that aligns with the Trust strategy. If this results in a different solution to the current provider, a project will be formed to oversee its implementation.	November 2024
Control Room Solution (CRS)	Deliver the replacement for the legacy Capita ICCS (Integrated Command and Control System) platform, which facilitates radio communications within the EOC. This is nationally mandated and will be conducted working in conjunction with the Ambulance Radio Programme to install the replacement Frequentis LifeX CRS.	May 2024
Mobile Data Vehicle Solutions (MDVS)	Deliver the replacement for the legacy Terrafix Mobile Data Terminals, which facilitate the digital communication between EOCs and vehicles, enabling them to respond to incidents. This is nationally mandated.	Dec 2024
Multi-Factor Authentication (MFA)	Multi-Factor Authentication is an electronic authentication method in which a user is granted access to a website or application only after successfully presenting two or more pieces of evidence to an authentication mechanism. This is an NHSE mandate.	June 2024
Data Security and Protection Toolkit (DSPT)	Responding to the NHSE national mandate for Data Security.	June 2024
Avaya CM10	Delivery of required updates to the existing telephony platform, Avaya, for EOC & 111. Will bring with it the ability to move staff onto softphones running on the desktops and improved licensing arrangements, making it easier to introduce additional agile workers.	April 2024
EPR ADS NHSE Data feed	The Ambulance Data Set (ADS) aims to provide CAD and EPR data to produce a more equitable and clinically focused response from the ambulance service and achieve the following objectives: • Accessible data warehouse to inform national clinical and operational policy. • Provide a single consistent and comparable data set for benchmarking. • Reduce the informatic burden on Ambulance services by replacing the multiple requests that ambulance services currently receive. • Provide services with linked data from other supporting data sets to provide better information about the patient journey.	May 2024
Reporting / Data Warehouse Infrastructure	Currently all servers for reporting are hosted in Crawley. In the event of a site outage, reporting functionality for Power BI, Info,	March 2024

	external data feeds etc. will not be available until the site is back up and functioning. Mitigation Plan: • As part of Reporting server resilience phase 3, this risk will be addressed. • Timelines are dependent on having failover clusters available in Coxheath/Medway.	
EPCR Developments	A series of key developments for the ePCR platform, enabling integration hardware and software platforms, such as sharing data with hospitals, booking appointments, or receiving information from Lifepaks.	March 2025
EPR External Services	Implementation of key integrations with bordering NHS Trusts.	March 2025
Generator & UPS improvements	Ensuring all generators and uninterruptable power supplies are fit for purpose and properly maintained and tested.	November 2024
Social Engineering Remediation	Cybersecurity Social Engineering Testing was carried out at Crawley, Medway, and Gatwick. The identified weaknesses now require remediation activities.	May 2024
Penetration Testing Remediation	Penetration Testing carried out and weaknesses identified.	May 2024
HSCN Resilience	Implementation of a resilient HSCN Connection for both Medway & Crawley datacentres. The HSCN connectivity provides access for services such as GP Connect, Care Connect, hospital inbound screens and the ITK (passing of incidents digitally between services).	April 2024
External IT Review	Implementation of recommendations following a full review of IT. Short-, Medium- and Long-term actions identified.	March 2025
Marval End of Contract Procurement	Procurement and implementation of a new service desk solution. The current solution has been deemed not fit for purpose as part of the external review and alternative options require consideration.	November 2024
WorkSpace One MDM	Implementation of a fit for purpose design and configuration for the mobile device management solution (MDM).	
CCTV Replacement	Replacement of the current Hikvision CCTV solution with a new, Verkada cloud-based solution, resolving cybersecurity concerns, a government ban on Hikvision devices, and introduces a suite of features that will bring great benefit to operations teams and the security team alike.	November 2024
Access Control - datacentres	Implementation of Verkada access control to maximise Data Centre security and Access Control.	March 2024
Screencloud – GRS integration	Integration between ScreenCloud & GRS to allow crewing information to be shown on the Digital Signage screens.	
Outage Remediation	Work to implement recommendations following the outages in 2021, 2022 and 2023 respectively.	April 2025
Paddock Wood Medicines Reconfiguration – Phase 1	New cabling throughout the offices once the building work has commenced and Implementation of networking equipment to support the building reconfiguration work.	September 2024

Teams Rooms Reconfiguration and Improvements	Improvements and enhancements to the Teams meeting hardware in meeting rooms across the Trust.	September 2024
Airwave Signal Boosting	Implementation of Airwave Signal Boosters in multiple buildings	April 2024
Paddock Wood – Phase 2	Assisting with the relocation of the Paddock Wood site	April 2025
iPad Patching	Improving the operating system update process across the iPad estate.	March 2024
Android Enrolment Environment	Improving the process for issuing Android smartphones.	May 2024
Crawley Internet Enhancements	Project to migrate Crawley away from reliance on Telehouse for internet connectivity, including outbound services, as well as transitioning inbound services onto site resilient load balancing using Azure traffic manager and other technologies.	June 2024
WAN Enhancements	Core Wide Area Network (WAN) enhancements.	April 2024
NMA for Staff Responders	Moving SECAmb staff responders/Response Capable Managers from SMS responding to smartphone application (National Mobilisation Application).	January 2025
CFR smartphone & NMA rollout	Mobile device upgrade from standard mobile to smartphone, move from SMS responding to smartphone application (National Mobilisation Application). Being rolled out to 350+ Community First Responders (CFR).	July 2024
Windows Server 2012 EOL	Removal of the remaining Windows 2012 Servers that are now end of life.	March 2024
AOVPN	Removal of Cisco AnyConnect VPN from all Laptops.	April 2024
Decommission Mitel	Removal of all Mitel servers across all sites. These provided backend for the old Mitel telephony system, which has since been replaced by Teams calling.	April 2024
Agile Cloud Resilience	Provide resilience within the Agile Cloud 999 Backup phone system. Focus on the following areas listed below: • Agile FourNet DC Resilience (Manchester ad London). • IP Office • LV Call Recording, • SECAmb local DC connectivity resilience (Crawley and Medway). • Admin Connectivity via P2P VPN with FourNet • Telephony Specialist Home Connectivity via Fortigate	June 2024
Gatwick MRC improvements	IT Improvements to be implemented in the Gatwick MRC to accommodate changes in the operation of various areas of the building and resolve long-standing IT concerns.	June 2024
Telford Place Improvements	A series of required improvements to be implemented at Telford Place to resolve long-standing IT concerns.	July 2024

Worthing Improvements	IT Improvements to be implemented in the Worthing MRC to accommodate changes in the operation of various areas of the building and resolve long-standing IT concerns.	June 2024
IT Hub website	Implementation of an IT Hub detailing IT Service status for all users.	May 2024
Brighton MRC	IT Improvements to be implemented in the Brighton MRC.	May 2024
Crawley Datacentre	Data Centre enhancements to be carried out in Crawley to further improve resilience with Medway.	July 2024