South East Coast Ambulance Service
NHS Foundation Trust

Trust Board Meeting to be held in public

6 June 2024

10.00-12.45

Trust HQ, Nexus House, Crawley

Agenda

Item No.	Time	Item	Purpose	Lead
Board Governance				
16/24	10.00	Welcome and Apologies for absence	-	UK
17/24	10.01	Declarations of interest	To Note	UK
18/24	10.02	Minutes of the previous meeting: 04 April 2024	Decision	UK
19/24	10.03	Matters arising (Action log)	Decision	PL
20/24	10.05	Chair's Report	Information	UK
21/24	10.15	Audit & Risk Committee Report	Information	MW
22/24	10.20	Chief Executive's Report	Information	SW
Strategy & Performance				
23/24	10.35	Board Story	-	MD
24/24	10.45	Board Assurance Framework 2024-25 – Structure	Decision	PL
25/24	10.50	**Strategic Aim: We Deliver High Quality Care**	Assurance	
		Supporting Papers: a) BAF – 2024/25 Priorities b) Integrated Quality Report (starting from Page 7) c) Quality & Patient Safety Committee Report d) SECAmb Quality Account 2023/24		
	11.20	Break		
26/24	11.30	**Strategic Aim: Our People Enjoy Working at SECAmb**	Assurance	
		Supporting Papers: a) BAF – 2024/25 Priorities b) Integrated Quality Report (Starting from P35) c) People Committee Report		
27/24	11.50	**Strategic Aim: We are a Sustainable Partner as Part of an Integrated NHS**	Assurance	
		Supporting Papers: a) BAF – 2024/25 Priorities b) Integrated Quality Report (Starting from Page 48)		

		c) Month 1 Finance Report d) Finance & Investment Committee Report e) Southern Ambulance Service Collaboration f) Partnerships Report		
Board Effectiveness Review				
28/24	12.20	Our Leadership Way: ▪ Compassion ▪ Curiosity ▪ Collaboration		UK
Closing				
29/24	12.25	Any other business		UK
After the meeting is closed questions will be invited from members of the public				

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 04 April 2024

Nexus House, Crawley

Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Simon Weldon	(SW)	Chief Executive
David Ruiz-Celada	(DR)	Executive Director of Strategic Planning & Transformation
Emma Williams	(EW)	Executive Director of Operations
Howard Goodbourn	(HG)	Independent Non-Executive Director
Liz Sharp	(LS)	Independent Non-Executive Director
Margaret Dalziel	(MD)	Interim Executive Director of Quality & Nursing
Max Puller	(MP)	Independent Non-Executive Director
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Richard Quirk	(RQ)	Acting CMO
Saba Sadiq	(SxS)	Chief Finance Officer
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Richard Quirk	(RQ)	Acting Chief Medical Officer
Sarah Wainwright	(SWa)	Interim Director of HR & OD

In attendance:

Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary

Chairman's introductions

DA welcomed members, in particular SB and SWa to their first meeting, those in attendance and those observing.

01/24 Apologies for absence

Rachel Oaten	(RO)	Chief Medical Officer
Steve Lennox	(SL)	Improvement Director

02/24 Declarations of conflicts of interest

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

03/24 Minutes of the meeting held in public 08.02.2024.

The minutes were approved as a true and accurate record.

04/24 Action Log [10.01-10.03]

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

05/24 Chair's Report [10.03–10.09]
DA highlighted the key issues from his report, reminding the Board about how we use the key source documents (BAF & IQR) to inform questions, discussion and challenge. He summarised the main agenda items, including the approval of the new Trust strategy.

DA then reflected on the results of the annual staff survey, which included positive feedback and a number of green shoots. Linked to the strategy, the challenging planning round and financial position will require the Board focus over the next few weeks.

06/24 External Well Led Review [10.09–10.11]
PL summarised the outcome of the well led review, which is before the Board to formally accept. The review was jointly commissioned with NHSE / ICB, as one of the requirements of the RSP Exit Criteria – as set out in the BAF. It was approached as a developmental review, to help us assess our journey of improvement since the CQC's well led inspection in 2022. The recommendations are being used to develop our priorities for the coming year. Overall, the review helps provide assurance with the positive improvements the Trust has made in the last two years. But it also reinforces the challenging year that lays ahead, as will be discussed today. Lastly, PL confirmed that after the Board today there is a session to review the RSP Exit Criteria so the Board can agree the approach to the national RSP meeting next month.

DA reflected that this shows an improving organisation with work still to do. He asked the Board for its support and agreement of the findings and recommendations; the Board accepted both. DA thanked everyone that contributed.

07/24 Audit & Risk Committee [10.11–10.15]
MW summarised the key issues from the last meeting as set out in the report. He highlighted the resilience issue and the related proposal for a sub-committee to review progress with implementing the recommendations. On risk management MW explained that there has been lots of good work, but the committee recognises there is more to do to ensure risks is embedded and at heart of decision making. There is however no underlying concern, and this is more about building on the good work to-date.

There were no questions.

08/24 Chief Executive's Report [10.15–10.32]
SW drew out the following from his report, noting that this is the pivot point in the year where we take time to look back at the year just ended and forward to the year ahead:

- We ended the year as the second-best performing ambulance trust in England related to the C2 mean. We need to be proud of this given the context of the challenges in the past 12 months. This remains a marker of confidence in the ambulance service, although it is not the end point, as we must go further, which we will address as part of the new strategy.
- Ended the year delivering our breakeven financial plan, while improving quality. Framing both in this way is important as the current planning round will require us to carefully balance money and quality which will be increasingly difficult especially as it will be flat cash / rising demand. There will be a further discussion about this in private given the timing.
- The planning guidance requires a C2 mean of 30 mins as well as balancing the money and improving quality and safety. 2 May is currently the final submission date.
- There has been great engagement in the development of the strategy. We are confident this commands the support internally and externally notwithstanding the challenges in implementation given financial challenges.
- Reinforced the importance of staff recognition and how well this is being received.

- Thanked commissioners for supporting the HART uplift, which is a commitment we now need to honour with delivery of improved capability and resource.
- Sexual safety – we are committed to using experiences to improve safety of our people. Hearing directly from everyone affected and paying attention to particular communities who are vulnerable, such as students.

MW noted the the support the executive will need, as the challenges today are different to a year ago. We need to acknowledge the progress with a really good strategy to take us forward, but we mustn't be complacent. The Board agreed.

DA ended by reflecting the discussion at the finance committee where it accepted that while the C2 performance compares well, we are still not at the standard we want and so must push for even more.

09/24 Primary Board Papers

These primary board papers will be used as reference documents to inform the areas of focus within the agenda.

10/24 Sustainability and Partnerships [10.32-11.35]

Board Story

MD introduced the story which demonstrates how patients are at heart of what we do. In the development of the strategy we consulted the public and moving forward it will become even more important to seek their views so we can improve services. The film illustrates how we have engaged.

After the film was shown, there was a discussion about the role of the Patient Experience Team to seek feedback from our communities, and how the new strategy and leadership arrangements will help local partnerships. For example, the system-based quality groups and local quality leads will help improve connections.

Trust Strategy

SW introduced Andy Collen, Consultant Paramedic, and Matt Webb, Associate Director of Strategy, who joined for this item. He felt that we can be confident in this strategy as it has been subject to wide and continuing engagement. A key message is that we need to find a way to continue to protect our core patient offer (to get to patients quickly when they need an ambulance) and work with patients so when they don't need an ambulance, we can support them to get to where their needs can be better met.

DR then reflected on the journey in establishing the strategy, which started with a very clear recognition that it needed to be clinically led with engagement across the four systems we cover in the Southeast and also with our people, to provide a clear vision that we could all align behind, for the benefit of people patients and partners.

The strategy before Board is therefore the product of all this work over the past nine months. Over two thousand colleagues have provided feedback and/or engaged directly. DR thanked everyone for their support with this, including system partners. We need to continue this engagement as we implement the strategy; the first step is to agree in year objectives which as stated earlier comes via the BAF in June.

Matt then tabled some slides reminding the Board of the journey, process and underlying principles underpinning the case for change and subsequent development of a new strategy. He gave assurance that this strategy aligns closely with the recently published planning guidance. Andy then talked the Board through the clinical service delivery model, which relies on good quality triage using validated data to ensure people needing an immediate ambulance response do so quickly. And, for other patients with less urgent

conditions we are clearer about how we use other responses. Therefore, differentiating clinical need better than we do currently where we often send an ambulance to see if the person needs one.

In summary, Matt and Andy confirmed that we have a strong case for change and a co-designed strategy with our partners, staff and communities that will help enable us to deliver better patient care over the coming years.

Lastly, DR confirmed that subject to Board endorsement we plan to publish a public facing strategy in an easy-to-read format, in May 2024.

DA tanked Matt, Andy and DR for this excellent summary.

RQ reiterated that clinical engagement and leadership will be key to the success of this; our clinicians on the ground are supportive.

PB asked about the building blocks for implementation. SW responded that this is subject to a later discussion on the planning round, i.e. how we implement this in the context of the financial challenge.

MP reflected that the breadth of engagement and depth of data analysis gives confidence in this strategy. It is also really good to see in this paper the outcomes so we know what will feel and look different as a consequence of delivery. MP is hugely supportive.

HG felt it has been a great process and product. He asked about the increase in referral to other services and specifically whether those services aware and prepared. DR responded that the capacity isn't there currently. The key message is we can't do this by ourselves and so it will be a real test of integration of care, to the benefit of meeting patient need. This is our case for change which the system has accepted. The next step as part of implementation will be redesign of care pathways.

EW reminded the Board that we are not starting from scratch and there have been some improvements in pathways in the past year.

MW is really supportive, but noted a real risk of, having got to this point, how we will demonstrate the difference so our people can see and feel it. Otherwise we risk losing them. Also, in implementation we need to explore more carefully to really ascertain what AI / Digital can help us achieve through the strategy, e.g. explore as a board the opportunities.

SW agreed and this is why we are investing in a CDIO, so we have thought leadership in leading this debate so we can take the opportunities. There will be other capabilities we need to create that will help us implement the strategy. On MW's first point, SW referred to the Ashford Board Story and how local teams take ownership; phase 1 delivery includes the roll out of local hubs. This will directly address the point about seeing a difference.

SS asked about public engagement and comms, in preparing them for what will feel like a different service. DR reinforced the point that we can't do this alone and it will require support of the system, staff and public. JC added that feedback from the public is that the current service doesn't meet their needs (given the long waits) and so this strategy acknowledges this and aims to fix it. MD is also confident in landing this strategy we will address the main feedback from complaints, as per the Board story.

DA asked the Board to endorse the strategy, which it did. He looks forward to the implementation plan arising from the planning round. In the meantime he noted the great work and on behalf of the Board thanked everyone involved.

M11 Finance Report

SB confirmed that we are on plan and expect to achieve the year end breakeven plan, albeit with an element non recurrently, which brings challenges to the current year position.

DA felt that while we can celebrate the year end position we must do so with caution for the coming year, which will require us to address our cost base to ensure as we are efficient as possible.

Operating Plan 2024-25

SB referred to the presentation in the pack, which summarises where we are with the plan in line with the planning guidance just published. Our submission in March was a £28.1 deficit (in the absence of the guidance) which achieves a C2 30-minute mean, but with an increase in H&T and reduced handover delays. So comes with some key risks. We have refined our assumptions and are working through further mitigations to help close the gap. The final submission is on 2 May and there will be much discussion between now and then.

DA noted the challenges ahead and while we are in the midst of discussion with commissioners, we are limited in what we can say now in public.

SW asked that we hold in our heads the balance between what it is a high-pressure environment to deliver money and maintain performance and quality. It will be hard to land all three but this is our task. The Board is asked to note this and the variables in play for the discussions in the weeks ahead. Currently, we are being asked to up our levels of CIP and clearly there will come a point where this eventually comes at a cost; this is the pivot point of discussions. How we are framing this debate will be covered in Part 2. The key thing to be wary of is not ending up with too many assumptions that will not likely deliver, as we are already approaching the limit of the number of things we can believe that will inform a credible plan.

DA summarised that it is a tough balance and we as a Board must not make false promises.

FIC Report

HG summarised his report from the last meeting. There were no questions.

Break at 11.37-11.47

11/24 People & Culture [11.47-12.20]

SWa summarised the progress with our culture programme, highlighting the successful launch of the reward and recognition platform, and 51% completion of fundamentals training. She thanked staff who took time to give feedback as part of the staff survey. On appraisals, while this is steadily improving, we are still below our target and so we need focus on this; we have asked Internal Audit to review our appraisal process including the system for recording appraisals and the effectiveness of the appraisals themselves.

TI added that in relation to the staff survey, while we have seen statistically significant improvement in all the areas, we have also gone through the free text comments which highlight a sense of change. Themes have shifted too, and more positivity coming through.

SS confirmed that the people committee has asked the team to cross reference the feedback to the housekeeping priorities. SWa confirmed that she will come back to the committee with areas of priority for next period.

On appraisals, DA asked SW to ensure the executive really focus on ensuring all our people have constructive meetings with their manager and not get stuck on process. SW responded that the engagement of Internal

Audit on this will help to get a more precise view of the issues. The executive commitment is to consider this report in due course. SW highlighted that we have to make this something people want to do, rather than feeling forced and there are some signs in the data that people are starting to have these conversations. For example, more positive comments about the immediate line manager in the staff survey.

Sexual Safety Charter Gap Analysis

MD explained that following the board sign off of the Charter the Steering Group undertook a gap analysis and the report is before the Board. This has informed the five workstreams. MD is really impressed with the drive from the staff involved; there is great engagement so far with this. MD also confirmed that the unique vulnerability of students has been identified and much work is going into this; not a separate workstream but using existing forums to ensure we hear from this group.

MD is confident we will be compliant with the Charter by July with the policy due to be signed off in next couple of weeks. There are currently no concerns to escalate to the Board.

LS asked if there is resource to take this forward. MD responded she is confident she has resources and there has been no concern expressed from the staff involved related to the milestones set.

DA asked if the programme of training (sexual safety) will continue. MD responded that we intend to plug in to the education and training that is right for our people. This is currently being looked at to ensure continued education.

SS referred to zero tolerance, and asked what support is needed to ensure clarity on what this means. MD responded that we can provide evidence where we have taken action to support zero tolerance; the policy sets out the definition. The challenge will be in the response. Part of the cultural work is a re set of the moral compass on what is acceptable. Suspension numbers doubled in last few weeks so this is one of the consequences. But different levels of response are needed taking each case based on specific context but ensuring consistency.

DA noted that the role of Board is to be the guardian of the process not setting a tariff; but we must ensure a fair and appropriate process.

SW explained that the Board will have a chance to look in June at programme of work for culture, and while we need focus on sexual safety, we need to see it within the broader culture programme. SW added that this is something endemic in all emergency services and there is a risk this becomes a narrative around detriment; asking people to speak up when they have had a bad experience. What we need to also ensure is that we celebrate diversity in our workforce, and what different communities bring to the trust.

SW summarised that the Board notes the work, which is a board-level issue and will be tracked through the culture work. The expectation is that our people follow the same values and behaviours.

People Committee

The report was noted.

12/24 Quality & Safety [12.20-12.35]

RQ drew the Board's attention to the Medicines Distribution Centre update and explained the T&F Group was paused to ensure A dedicated project manager. He assured the Board we have addressed the immediate safety issues, and the next step is to include a new lift. We will come back with firmer timeframe in the coming weeks. The second areas to highlight was the critical care department and the assurance data / same day review of our CCPs in managing patients; this real time feedback helps the roll out of the clinical supervision model.

MD then drew out from the report, incident reporting and duty of candour performance, which has dipped slightly as a consequence of bringing in Datix Cloud and early technical issues. On Infection Prevention and Control (IPC) there has been variable compliance with the audits, the quality assurance visits have consistently exposed a lack of IPC culture. The IPC team have in response introduced an improvement from April to help increase understanding and compliance and make it an easier via a continuous process. They are also reinforcing local IPC champions.

SS asked about medicines governance and PGD compliance. In the IQR for example CD breakages and PGD compliance are both below targets RQ responded that we are concerned about CD breakages as they are higher than our peers; a review has been undertaken but we are still not clear why, other than careless behaviour rather than anything underhand. But this is still being explored. We have a new medicines safety officer recruited and this is their first priority. Re PGD, RQ explained the work to improve reporting compliance / register on the system is why this is showing in the IQR, rather than any issue with non-compliance. EW confirmed a 9% increase in compliance in the past two months following more scrutiny across the teams.

Action
QPSC to seek further assurance re CD breakages and PGD compliance (IQR)

PB asked about the theme of staff attitude from complaints. MD explained that a paper is scheduled for the net People Committee; the themes were attitude to care home staff (some hotspots) and attitude to patients where they felt they have been sent incorrectly by 111; so we are targeting actions.

Learning from Deaths Report
The report was noted.

HG asked about his concern about marking our own homework; last time we said we might include external partners to support the reviews. RQ responded that we did bring in colleagues from East Midlands to undertake a peer review and they were satisfied we were following national policy. RQ confirmed that he will look again at how we might include an independent person on the panel.

13/24 Responsive Care [12.35-12.48]
EW highlighted from her paper the improvements in performance. This has been a great achievement made possible by the hard work and expertise of a number of people cross directorate. Absolute performance improvements are aligned to the new strategy as discussed earlier.

DA congratulated EW and her team and everyone who contributed to this achievement.

HG referred to the SPC charts in the IQR which are broadly in the right direction, save for the emergency crew advice line mean response time on page 44. EW confirmed that this is when crews require more specific support from advanced practitioners. She explained some of the reasons for this and how we support decision making in different way on scene.

Action
QPSC to seek further assurance related to the governance and effectiveness of the emergency crew advice line given the IQR identifying a downward trend related to timeliness.

NARU Review Action Plan

SW explained that the Board previously received a paper with the problem statement and this is the update setting out the solution. The Board noted the update and the plan to oversee this going forward more closely via the sub-committee MW mentioned earlier. It also noted the new leadership team out to recruitment and that the plan will take 12-24 months to ensure we become fully compliant.

Digital Priorities

AG, Head of IT, joined for this item. He set out for the Board the priorities for Digital over thew next 12-18 months, some of which are mandated.

DA thanked AG for the update, noting how tech rich we are as an ambulance service.

PB asked if we have capacity to deliver and how we sustain the good work into the future. SW responded that this paper sets out what you would call the day job, before the things we need to do as implied in the strategy. It is however important to acknowledge that the day job is big enough and so how we resource the big strategic things is critical. This will inform the decisions we take going forward informed by the review of our new CDIO.

14/24 Review of Board Effectiveness [12.48-12.56]

The Board reflected on the meeting, agreeing that there was good discussion. Lots of positive things and so it is important we celebrate achievements. There was good curiosity demonstrated, e.g. questions about the IQR and some further assurance remitted to a committee of the Board.

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

One observer asked about the deficit and fundraising initiatives to support this, specifically how we might advertise on ambulances. DA reinforced that questions should not be about a commercial pitch and agreed to take any questions about this off-line.

A governor observing congratulated everyone at SECAmb for the achievements over the past year. He asked how we ensure public assurance that we are as focussed on C1 (the discussion today was mostly about C2). EW responded that we are focussed on C1, 2, 3 & 4 – all patients are important to us and we report against each. C1 3 and 4 have also improved both in time and in relation to our peers.

15/24 AOB

This is DA's last formal meeting as Chair, and MW and SW paid tribute to him for his achievements across his career, reflecting his focus on patients and people and empathy as a leader. DA has left a good legacy given the improvements discussed today.

There being no further business, the Chair closed the meeting at 13.15.

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

Date _____

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP)
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.	SB	18.07.2024	Audit Committee / Board	IP
08.02.2024	79 23	Once the remedial work at the MDC at Paddock Wood is complete, the Board will receive an update giving assurance it is operating effectively.	RQ	Q2	Board	IP
04.04.2024	12 24	QPSC to seek further assurance re CD breakages and PGD compliance (IQR)	PL	Q1	QPSC	IP
04.04.2024	13 24	QPSC to seek further assurance related to the governance and effectiveness of the emergency crew advice line given the IQR identifying a downward trend related to timeliness.	PL	Q1	QPSC	IP

Key

	Not yet due
	Due
	Overdue
	Closed

ɔard Action Log

Comments / Update
Report to audit committee scheduled for the next meeting in July.
To be added to the annual COB which will come to the Board on 1 August along with the revised TOR.
To be added to the annual COB which will come to the Board on 1 August along with the revised TOR.

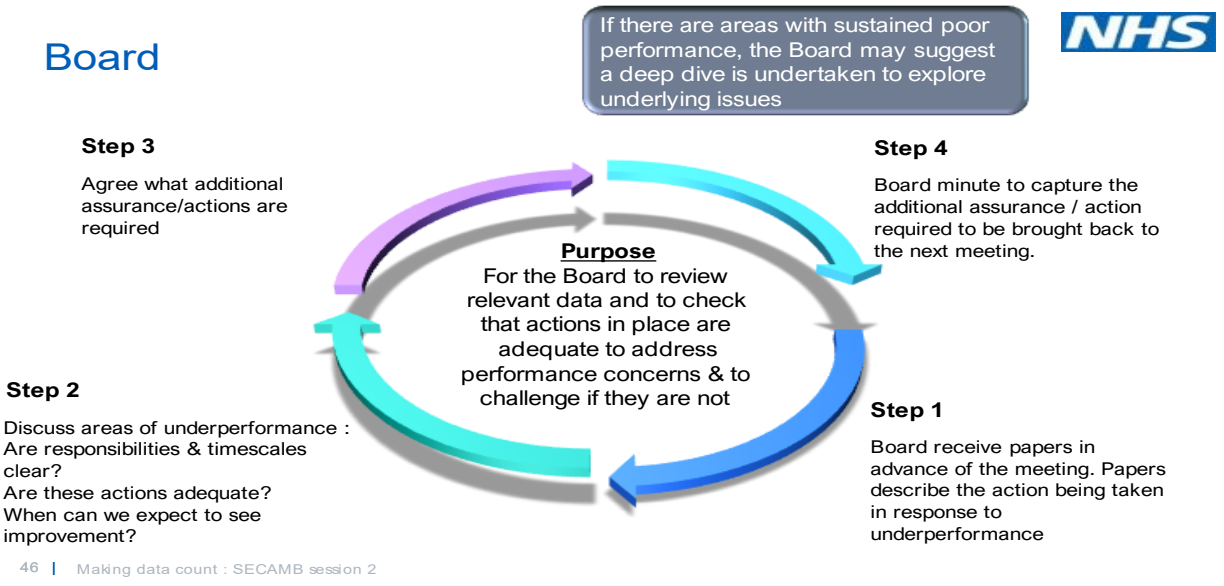
	Item No	20-24
Name of meeting	Trust Board	
Date	06.06.2024	
Name of paper	Chair Board Report	
Report Author	Usman Khan, Chair	

Board Meeting Overview

Meetings of the Board continue to be framed against the current strategic goals, as set out in the Board Assurance Framework (BAF).

This helps provide the Board with greater clarity on progress against the organisational objectives and the main risks to their achievement. The BAF together with the Integrated Quality Report are the Board's primary documents used to inform the Assurance Cycle and where there are gaps in assurance.

The BAF helps provide the Board with greater clarity on progress against the organisational objectives and the main risks to their achievement. The BAF, together with the Integrated Quality Report, are the Board's primary documents used to inform the Assurance Cycle and where there are gaps in assurance.



I also very much welcome the inclusion of a Board Story at each Board meeting, where we hear directly from our patients and our people about their experiences and interactions with SECAmb. I look forward to seeing this grow to become a focal point for the Board.

Board Succession

Since formally joining SECAmb on 1 June, I am very much looking forward to chairing my first Board meeting on 6 June.

I would like to thank David Astley for his stewardship of the Board during his tenure and for his guidance and handover during the past few weeks.

I would also like to thank everyone for the warm welcome I have had so far. I am very much looking forward to getting out and about over coming weeks across the Trust to meet more of our people.

Since the last Board meeting in April, we have seen a couple of additions to strengthen the EMB team:

- Stephen Bromhall has now started with us as Chief Digital Information Officer
- Margaret Dalziel has been appointed substantively as Director of Quality & Nursing

These are both portfolio areas for us and I am sure we will benefit from Stephen and Margaret's experience and expertise.

I am also very pleased to welcome Mojgan Sani to her first Board meeting as a newly appointed Non-Executive Director and look forward to working with her.

Council of Governors

I would like to thank the Council of Governors (CoG) for their on-going support to the Trust and very much look forward to working with all of our Governors throughout my tenure at SECAmb

Our CoG recently held an online constituency event to be able to hear the views of their constituents. For the first event of this type it was well attended, and I was pleased to hear that good discussions were had on a range of issues.

Subject to discussion at the upcoming Membership Development Committee, this may well continue to be a focus for our Governors moving forwards.

Engagement

As I have said above, I am very much looking forward to meeting our people over coming weeks, including our volunteer teams who I know provide much-needed support to both our patients and our people in a range of ways.

I was delighted to learn that David Wells, our Head of Community Resilience and his team are working in partnership with Junior Citizen to deliver lifesaving CPR skills to Year 6 children.

Junior Citizen is a multi-agency safety event designed to provide children with the life skills that will, in the future, help to keep themselves and others safe.

Conclusion
I am very much looking forward to working with you and supporting the Trust move forward.

Agenda No	21-24

Name of meeting	Trust Board
Date	06 June 2024
Name of paper	Audit & Risk Committee Escalation Report – May 2024
Author	Michael Whitehouse, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 30 May 2024. This was the year end meeting focussing on the annual report and accounts.

Internal Audit

The audit plan has been completed and the committee reviewed the last of the reviews:

- Financial Systems – Reasonable Assurance
- Risk Management (7.23/24) – Partial Assurance
- Appraisals, Career Development and Succession Planning (9.23/24) – Partial Assurance

A draft report has been issued for the audit of Performance and Data Quality, which concluded Reasonable Assurance.

There were some concerns expressed about some of the follow up actions not being completed in a timely way, and the committee will give this a specific focus for the coming year.

Concerns were also raised about annual appraisals, which the committee assesses as a systemic trust wide issue which is yet to resolved. It has been a focus of this committee and the People Committee and was raised at the Board last.

The Head of Internal Audit Opinion was below the line and the committee will consider in September how the executive plans to improve this for 2024/25.

Financial Statements and The Annual Report

The committee reviewed the draft annual report and accounts and will take a final review at the meeting on 20 June along with the final audit report.

The annual governance statement was also reviewed, and feedback was provided which will inform the final draft for the meeting in June.

Specific Escalation(s) for Board Action	The Board is asked to note the Head of Internal Audit Opinion is like last year below the line – the expectation is that this will be a positive opinion for 2024-25 as the improvements being made continue.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	22-24

Name of meeting	Trust Board
Date	06 June 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 April and May 2024 to date.

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:

- Discussing the emerging Operating Plan for 2024/25, including the regional perspective
- Review of our approach to Risk, including the on-going development of our Risk Register and alignment with the Board Assurance Framework (BAF)
- The development of the Transformation Management Office (TMO) which will support the delivery of our new strategy
- Close attention to operational performance, noting our strong start to the year

5 EMB also continues to hold a meeting each month as a joint session with the Trust's Senior Management Group to discuss a range of leadership issues, including delivery of our Cost Improvement Programme and the key risks on our Corporate Risk Register.

6 **Substantive Director of Quality & Nursing appointed**
On 18 April 2024, we were pleased to announce the appointment of Margaret Dalziel as the substantive Executive Director of Quality & Nursing, following a competitive recruitment process.

7	Margaret joined SECAmb in April 2022, initially as the Deputy Director of Quality & Nursing and had been the Interim Director since April 2023.
8	By background, she is a paediatric nurse and leader who has worked in the NHS for more than 40 years and who has extensive experience in senior operational and professional leadership roles across all healthcare systems and sectors including acute, community & mental health providers.
9	I am sure will join me in welcoming Margaret's appointment into the substantive director role. Her commitment in support of our patients and our colleagues has been significant and I look forward to her continuing to drive forwards the patient safety and quality improvement agendas, among other important areas of work.
10	We are also recruiting currently for the new role of Chief Paramedic Officer and I am pleased to see that there has been strong interest so far. Following the conclusion of the recruitment process, we hope to be able to announce an appointment at the end of June.
11	**Engagement** I am pleased to continue to host regular 'Big Conversations' for colleagues, where we have a great opportunity to discuss key issues and opportunities that are important to us. I really value the opportunity they provide to engage directly with our people.
12	On 24 May, the Big Conversation focussed on our new emerging Trust values and how we can ensure they are fully 'lived' throughout the Trust. It was a really great session, with some fantastic suggestions made on practical ways that we can bring the values to life, and I look forward to seeing this progress over coming weeks.
13	On 29 May, I was delighted to meet with Rosie Bright, our April Star of the Month winner! Rosie works as an Emergency Medical Advisor (EMA) at our Emergency Operations Centre in Crawley and was nominated by her colleagues for her kind and compassionate nature. It was a pleasure to meet Rosie and present her with her certificate – congratulations again!
14	I am pleased to see that, since we launched in February, we are continuing to see strong nominations each month for our Star of the Month award and good use of The Star Zone, our online Reward and Recognition platform.
	B. Regional Issues
15	**New electric ambulance vehicles hitting the road** I have been pleased to see the first of three fully electric vehicles we are trialling out and about during May 2024.
16	The Mercedes-Benz e-Vitos are being trialled as part of NHS England's Zero Emission Electric Vehicle (ZEEV) Pathfinder project and the Single Responder Vehicles (SRVs) are initially based at three of our sites – Polegate, Thanet and Gatwick - where heavy-duty vehicle chargers are installed.

17	During the past couple of years, we have been working with our people and our partners to reduce our carbon emissions – through our Green Plan, launched in 2023, we aim to reduce our emissions by 50 per cent by 2032 and achieve net zero by 2040. Using electric vehicles, where we can ensure they work operationally for us, will be a key part of the delivery of the Plan.
18	I look forward to seeing how well our people find the new SRVs work for them during the trial.
	C. National Issues
19	**Southern Ambulance Services Collaboration (SASC)** On 22 May, the Southern Ambulance Services Collaboration (SASC) between SECAmb and East of England Ambulance Service NHS Trust (EEAST), London Ambulance Service NHS Trust (LAS), South Central Ambulance Service NHS Foundation Trust (SCAS) and South Western Ambulance Service NHS Foundation Trust (SWAST) was launched.
20	All partner Trusts believe that the Collaboration provides us with a much-needed opportunity to work together more closely to collectively address some of the big challenges facing us all including evolving patient demand, a constrained financial environment and ongoing recruitment and retention issues; these are difficult for small Trusts such as ourselves to tackle individually.
21	We collectively feel that now is the right time to formalise how we work together to respond to these shared challenges and deliver the best possible care to patients, whilst operating in a constrained financial climate
22	The Collaboration will allow all member Trusts to choose to work together on particular initiatives that they feel best meets their needs. These areas will be identified by our people with current ideas for consideration including shared procurement to reduce costs, harnessing technology, and AI to improve our services and care.
24	One of the first pieces of work that the Collaboration will undertake will be to identify which trusts perform certain functions particularly well and where shared learning can make a real difference to the care we provide and to colleagues working lives. I look forward to seeing this develop over coming months.
25	**Positive feedback from National Freedom to Speak Up Guardian** We were delighted to receive recognition during April from Dr Jayne Chidgey-Clark, the National Guardian for Freedom to Speak Up, for the real progress we are making in improving our ‘speaking up’ culture.
26	Dr Chidgey-Clark wrote to us to acknowledge that the 2023 NHS Staff Survey results, published in March, showed that we had seen the biggest improvement in our FTSU scores of any Trust in the country!
27	This means that our staff not only feel safer speaking up but also feel that they are being listened to and that action will be taken in response where needed.

28	Well done to our FTSU team and to colleagues throughout the organisation for committing to speaking up and listening. We know we have more to do but it’s great to see recognition of the progress we’re making.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	23/24

Name of meeting	Trust Board
Date	6 June 2024
Name of paper	Introduction to Board Story
Responsible Manager	Margaret Dalziel, Executive Director of Quality & Nursing
Author	Janine Compton, Head of Communications

The Board story for this month focuses on a compliment which was sent to the Trust in April 2024.

We have chosen to feature this as our Board Story this month as it clearly illustrates the joint decision-making process created through the development of our Clinical Hubs and how the Hubs are a valuable and useful tool in delivering our new Trust Strategy.

The manager of the Hythe View Nursing Home in Hythe, Kent, wrote to thank us for the support we provided to a patient who appeared to be having a mental health crisis.

The crew - Inese and Gavin - were praised for the collaborative approach they took, which involved a range of clinicians based in the Clinical Hub at Ashford Make Ready Centre making joint decisions together.

With the support of A&E Consultant, Mr Shadhaker and Advanced Paramedic Practitioner Laura in the Hub, Inese and Gavin were able to safely avoid an unnecessary emergency A&E attendance which would have been distressing to the patient.

Thanks to the Hythe View staff for their kind words and to the colleagues involved in delivering compassionate and tailored care to this patient.

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

Agenda No	24/24

Name of meeting	Trust Board
Date	06 June 2024
Name of paper	Board Assurance Framework 2024-25
Author	Peter Lee, Company Secretary

The Board Assurance Framework (BAF) is being revised to align with the new Trust strategy the Board approved in April. Since then a number of workshops have been held to define the priorities for Phase 1 (2024-2026), culminating with the Board session in May.

The BAF is designed to bring together in a single place all of the relevant information to help the Board assess progress against its strategic vision and the principal risks to delivery.

Appendix 1 illustrates the new structure which will support the Board's assurance on both the longer-term vision and in-year delivery:

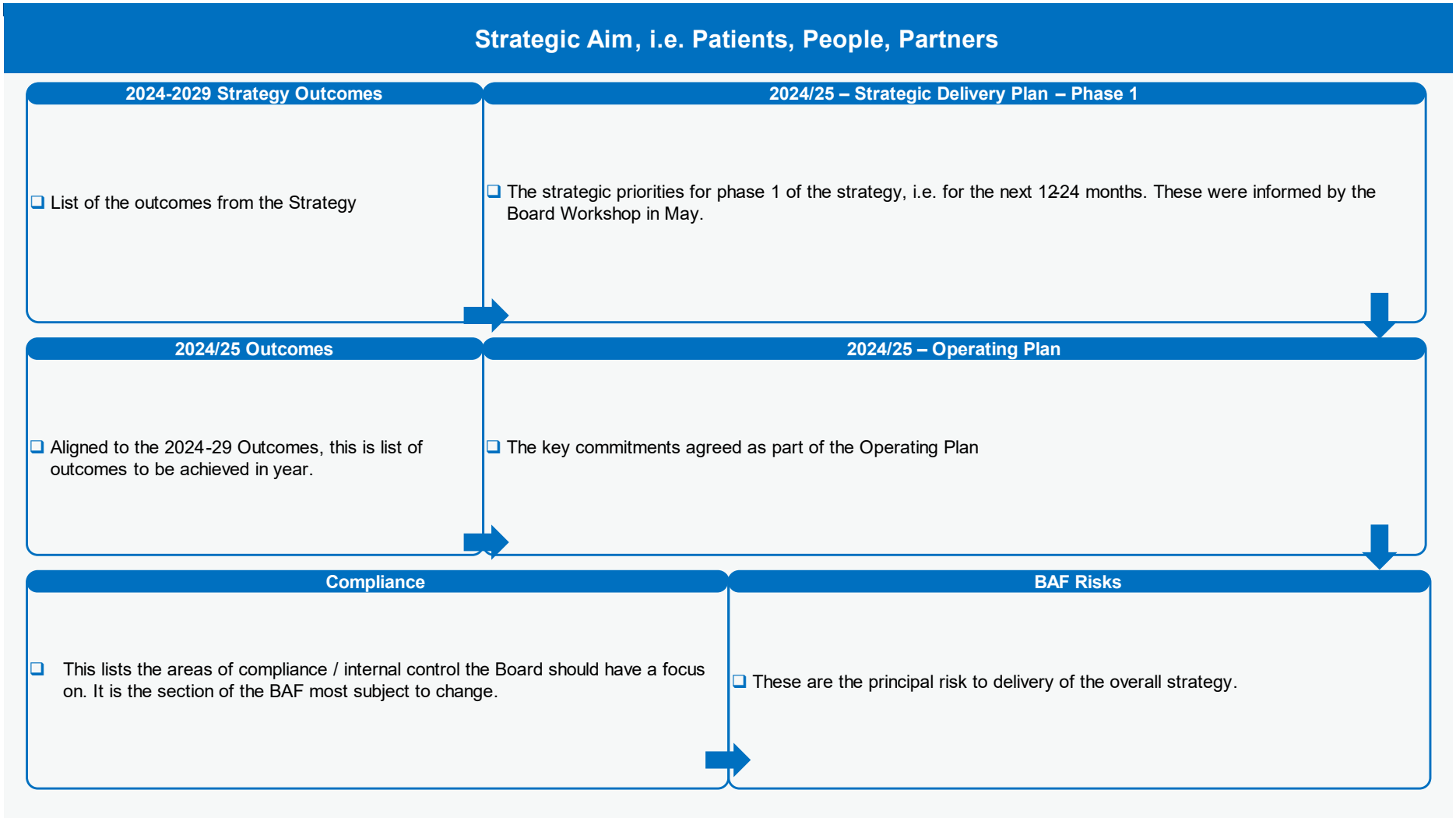
- **Strategic Priorities** – this sets out the key priorities for the coming 12-24 months that will help set the foundations for delivery of the overall strategic vision *to transform patient care by delivering prompt, standardised emergency responses while enhancing care navigation with seamless, accessible virtual services for non-emergency patients.*
- **Operating Plan** – this section of the BAF will include the key commitments the Board has made for the current financial year.
- **Compliance** – lastly, these will be the internal control issues that are either most critical, or where the Board has greatest concern; they may therefore change over the course of the year subject to the level of the Board's assurance.

The BAF will guide the focus of the Board and its committees; the cycle of business for each committee will be updated during June. The BAF and its supporting papers, such as the Integrated Quality Report, will be used to help frame a rounded discussion at each Board meeting against the three strategic aims, in the context of both the longer-term vision and in-year delivery, given their intrinsic links. As illustrated by the June agenda (Appendix 2).

The Board is asked to agree the specific areas of priority and focus related to the three strategic aims – Patients, People, and Partners. Progress will then be reported from July.

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**

Appendix 1 – BAF Structure



South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	25/24

Name of meeting	Board
Date	6th June 2024
Name of paper	New BAF – We deliver high quality of care
Strategic Aim	**We deliver high quality of care**
Author / Lead Director	Margaret Dalziel, Executive Director of Quality & Nursing

New BAF – 2024/2025

During 2023/24 the Board has developed its new Trust-wide strategy. As part of the development of this strategy, the Trust has refreshed its purpose, strategic aims, and priorities.

From 2024/25, the Executive will seek to assure the Board against our new strategy, doing so with a reviewed BAF structure that supports the Board in overseeing both long-term vision and in-year delivery. This will also involve and update our approach to reporting for compliance and BAF risks, both of which are being re-defined through the lens of our new strategy and in the context in which the Trust now operates.

Our priorities for the year ahead have been co-developed with input from senior leaders in the organisation, and a Board development session early in May, aiming to bring together the following key principles:

- *Continuation of the "Improvement Journey" to ensure exit from RSP*
- *Meeting our planning commitments regarding quality of care, performance, and finance*
- *Assuring compliance against regulatory bodies and other statutory obligations*
- *Using our BAF and extreme risks to help us shape the Board discussion around mitigation and assurance.*

We aim to re-align our IQR and BAF reporting fully to this new format by the Board meeting in October 2024, and we will adopt a continuous quality improvement approach to the new BAF to ensure it remains effective to our strategic and operational context.

Our agendas in the forward cycles of business for public Board and Committees will align to these objectives to ensure the Board has appropriate time to consider progress across all areas set out in our plan.

Strategic Transformation Plan

The 2024/25 Strategic Transformation Plan - Phase 1 outlines key initiatives to deliver high-quality patient care. This includes designing and implementing an Unscheduled Care Navigation Hub, with the scope of hub models agreed upon by ICBs by June 2024 and new hubs implemented by October 2024, so that we can learn and inform the future scope of virtual care ahead of year 2 of the strategy. To support the implementation of a new clinical delivery model, our strategic commissioning framework will need to evolve to reflect our new operational model.

Determining Clinical Models (pathways) of Care with ICBs, incorporation outputs of the AACE Health inequalities initiatives and developing our Patient Experience and Engagement strategy for 2025-2030, will ensure we remain centred around the needs of our patients as we design the changes required in our services. This strategic transformation aims to enhance the quality and efficiency of care delivery while improving patient outcomes and satisfaction.

These areas of priority delivered through transformation will ensure the Board starts making meaningful changes in 24/25 to drive productivity and efficiency, to deliver a more sustainable model of care that deliver better outcomes for our most critically unwell patients, and better meets

the needs of our non-emergency patients.

Operating Plan

The 2024/25 Operating Plan translates our strategic aim of delivering high-quality patient care into actionable in-year objectives. The plan focuses on continuous monthly monitoring of operational performance against the following standards:

- C2 Mean of 30 minutes
- Call Answer of 5 seconds
- Improve Hear and Treat to 16%
- Improve our cardiac arrest survival rates by 25/26
- Reduce on-scene times for stroke patients by 15% to improve outcomes

We will also be delivering on our three Quality Account priorities: all discharges on scene are supported or undergo a post-discharge reviews, reducing health inequalities with a focus on maternity and mental illness, and improvements in quality of and feedback on Patient Care Records.

The plan also aims to expand the number of volunteers from 435 to 580, with an emphasis on expanding their role by Q4. Additionally, following the Board approval of PSIRF in 23/24, we will aim to complete 80% implementation of our NHSE PSIRF Standards/Principles by Q4. This supports our long term workforce ambitions for our volunteers and is consistent with the NHS Long-Term Workforce Plan.

Finally, we will have 2 QI priorities supporting this strategic aim of providing high-quality care to our patients, building on the QI work plan for 23/25:

- Safety in our waiting list in EOC
- Inter-Facility Transfers

Our plans are consistent and meet expectation set out by the Year 2 objectives set our in the UEC Recovery Plan and NHS planning guidance for 24/25.

Compliance and Risk

As part of our well-led journey, we have reviewed our compliance and risk management environment. Our compliance priority areas for which we will be seeking to provide assurance against will be as follows:

- Compliance to CQC standards
- Compliance against our EPRR assurance cycle – including delivery of HART/Specialist Operations Improvement Plan
- Deliver improvements in medicines management
- Improvements in the NHS Impact self-assessment
- Deliver the Patient Safety Incident Review Plan
- Compliance to Incident Management Cycle and The Statutory Duty of Candour

However, we recognise that there are inherent risks associated with our objectives and plans for 23/24. We have identified 3 new BAF Risks:

- There is a risk that our vision and the vision of our partners are not sufficiently aligned to available funding, leading to inability to deliver strategy as planned.
- There is a risk that either we have insufficient levels of leadership capacity to deliver our strategy, or that our leadership structure does not allow for effective strategic delivery.
- The risk that without an agreed organisational risk appetite aligned with the appetites of our partners, we are risk averse and unable to affect the required changes to the operational clinical model.

To mitigate these risks, we will engage in proactive risk management, and will score and provide mitigations as part of our BAF reporting at the Public Board in August 2024.	
Recommendations, decisions, or actions sought	The Board is requested to approve the 2024/25 Operating Plan and objectives outlined in this report, which have been developed to support our strategic aim of delivering high-quality patient care.

We deliver high quality patient care

2024-2029 Strategy Outcomes

- ❑ Deliver virtual consultation for 55% of our patients
- ❑ Answer 999 calls within 5 seconds
- ❑ Deliver national standards for C1 and C2 mean and 90th
- ❑ Improve outcomes for patients with cardiac arrest and stroke
- ❑ Reduce health inequalities

2024/25 – Strategic Transformation Plan – Phase 1

- ❑ Unscheduled Care Navigation Hub - Design & implementation
  - Define scope of hub models agreed by the ICBs **by June 2024**
  - Implement new hubs, first **by October 2024**
  - Evaluation to inform future scope of virtual care **by March 2025**
- ❑ Clinical Models of Care – Design and Agreement with ICBs
  - Scope to be determined with ICBs **by Q2**
- ❑ Patient Experience and Engagement enabling strategy for 2025-2030 **by end of Q3**, including AACE Health Inequalities recommendations

2024/25 Outcomes

- ❑ C2 Mean 30 mins **for the full year**
- ❑ Call Answer 5 secs **for the full year**
- ❑ H&T 16% **by Q4**
- ❑ Cardiac Arrest outcomes improved by 25/26 – increase in survivability by 2% **vs a 9.5% baseline**
- ❑ Improving stroke outcomes – we will reduce our on scene time for patients with stroke by 15% **by Q4**

2024/25 – Operating Plan

- ❑ Operational Performance Plan – **continuous monthly monitoring**
- ❑ Deliver our three Quality Account priorities (all discharges on scene are supported or undergo a post-discharge reviews, reducing health inequalities with a focus on maternity and mental illness, and improvements in quality of and feedback on Patient Care Records) **by Q4**
- ❑ Expand number of volunteers from 435 by 150, with an expansion of their role **by Q4**
- ❑ Implementation of 80% of our NHSE PSIRF Standards/Principles **by Q4**
- ❑ Deliver 2 clinical QI priorities (Safety in the waiting list, IFTs) **by Q4**

Compliance

- ❑ Compliance to CQC standards
- ❑ Compliance against our EPRR assurance cycle – including delivery of HART/Specialist Operations Improvement Plan
- ❑ Deliver improvements in medicines management
- ❑ Improvements in the NHS Impact self-assessment
- ❑ Deliver the Patient Safety Incident Review Plan
- ❑ Compliance to Incident Management Cycle and The Statutory Duty of Candour

BAF Risks

- ❑ There is a risk that our vision and the vision of our partners are not sufficiently aligned to available funding, leading to inability to deliver strategy as planned.
- ❑ There is a risk that either we have insufficient levels of leadership capacity to deliver our strategy, or that our leadership structure does not allow for effective strategic delivery
- ❑ The risk that without an agreed organisational risk appetite aligned with the appetites of our partners, we are risk averse and unable to affect the required changes to the operational model.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board – June 2024

Reporting Period: March & April 2024

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

Contents

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

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

Alignment Framework

Trust Priorities for 23/24

Note the Board in June covers the last period to the end of FY 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*

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	Apr-2024	1236		1165.5		
Harm Incidents per 1000 Incidents	Feb-2024	1.12		1.43		
Count of No Harm Incidents	Feb-2024	1320		1131.39		
Count of Low Harm Incidents	Feb-2024	113		162.78		
Count of Moderate Harm Incidents	Feb-2024	11		5		
Count of Severe & Death Harm Incidents	Feb-2024	8		2.33		

People & Culture

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Sickness Absence %	Apr-2024	6.1%	5%	7.43%		
Statutory & Mandatory Training Rolling Year %	Apr-2024	69.9%	85%	75.75%		
Appraisals Rolling Year %	Apr-2024	61.2%	85%	59.95%		
Freedom to Speak Up: Total Open Cases	Feb-2024	24		24.56		
Freedom to Speak up: Cases Opened in Month	Apr-2024	20	3	9.25		
Freedom to Speak up: Cases Closed in Month	Apr-2024	16		10.6		
Time to Hire - Volume (Days)	Feb-2024	92	60	146.43		

Responsive Care

Metric	Latest Date	Value	Target	Mean	Variation	Assurance
Hear & Treat %	Apr-2024	13.5%	14%	11.25%		
999 Frontline Late Finishes/Over-Runs %	Apr-2024	40.8%	45%	47.85%		
Average Late Finish/Over-Run Time	Apr-2024	00:37:00		00:38:30		
999 Call Answer Mean	Apr-2024	00:00:04	00:00:05	00:00:36		
Cat 2 Mean	Apr-2024	00:23:54	00:30:00	00:30:06		

Sustainability & Partnerships

Metric	Latest Date	Value	Target	Mean	Variation	Assurance

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

NHS
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Quality & Safety

QUALITY & SAFETY

Summary

April 2024

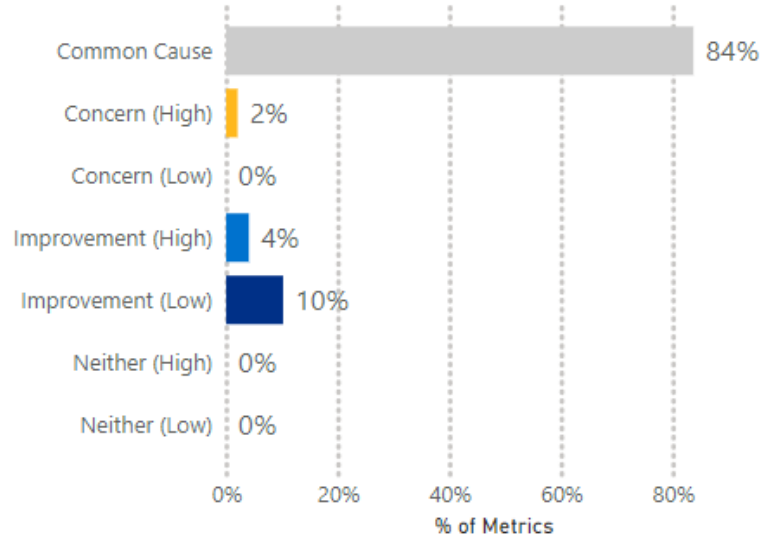
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		Complaints Reporting Timeliness % Resilience Stock Holding of Medicines in the Trust	Single Witness Signature Use CDs Non-Omnicell	Harm Incidents per 1000 Incidents Complaints per 1000 999 Calls Answered Outstanding Actions Relating to SIs,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

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.

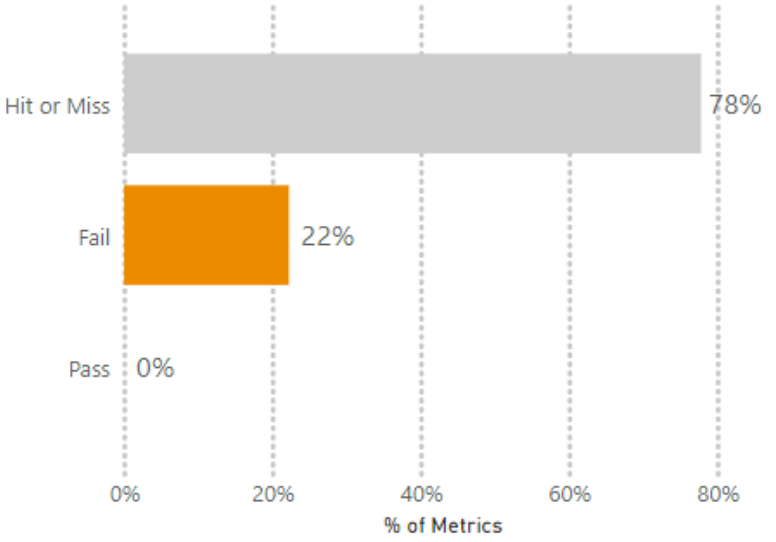
QUALITY & SAFETY

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Apr-2024	158		118.37	170.45	222.53		
Number of CD Breakages	Quality Improvement	Apr-2024	15	0	3.52	21.3	39.08		
Number of Datix Incidents	Quality Improvement	Apr-2024	1656		1083.5	1462.9	1842.3		
Number of Incidents Reported as SIs	Quality Improvement	Apr-2024	2		-3.02	3.7	10.42		
Duty of Candour Compliance %	Quality Improvement	Apr-2024	83%	100%	76.68%	86.58%	96.48%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Apr-2024	129		83.19	120.15	157.11		
Number of RIDDOR Reports	Quality Improvement	Apr-2024	3		1.9	10.3	18.7		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Apr-2024	5		-4.47	12.05	28.57		
Health & Safety Incidents	Quality Improvement	Apr-2024	35		11.81	31.55	51.29		

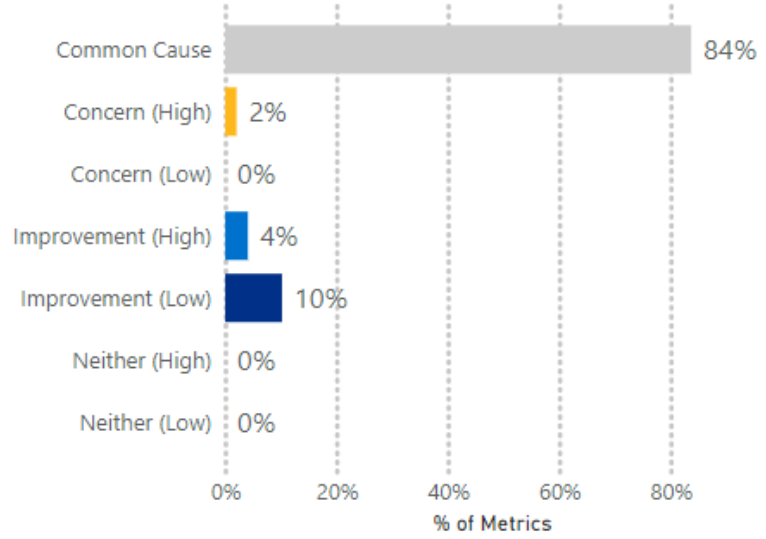
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Apr-2024	0%		0%	0%	0%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Apr-2024	52%		35.56%	60.9%	86.24%		
Complaints Reporting Timeliness %	Quality Improvement	Apr-2024	86%	95%	50.66%	80.9%	111.14%		
Number of Complaints	Quality Improvement	Apr-2024	60		14.35	65.45	116.55		
Complaints per 1000 999 Calls Answered	Quality Improvement	Apr-2024	0.77		-188.94	104.56	398.06		
Number of Compliments	Quality Improvement	Apr-2024	134		20.72	165.2	309.68		
No Harm Incidents per 1000 Incidents	Quality Improvement	Apr-2024	7.83		7.31	10.11	12.91		
Harm Incidents per 1000 Incidents	Quality Improvement	Apr-2024	0.9		0.72	1.38	2.04		

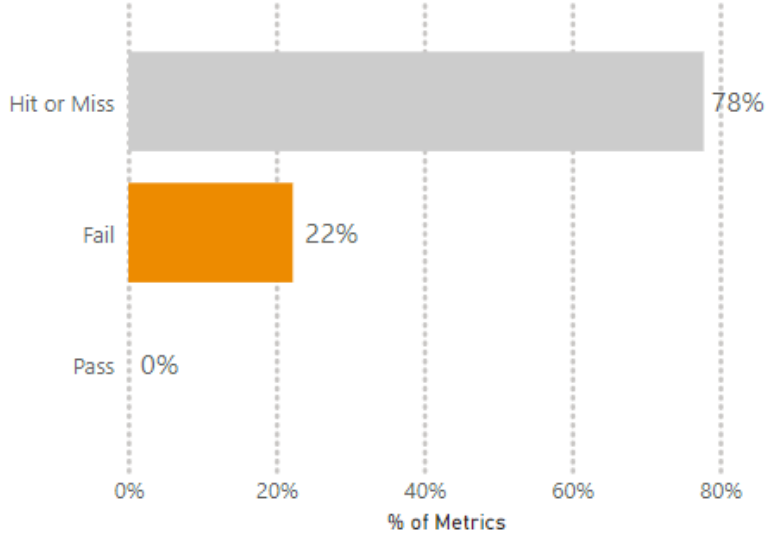
QUALITY & SAFETY

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Clinical Effectiveness & Patient Outcomes

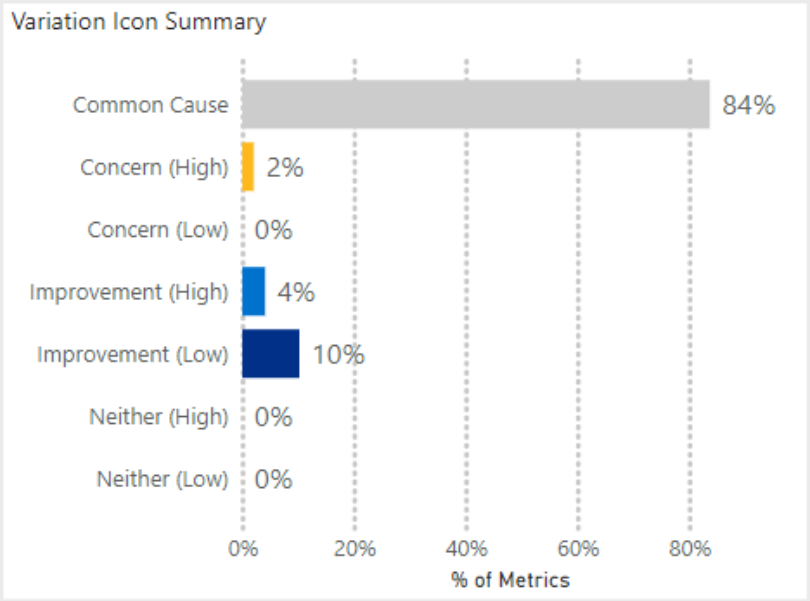
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
**Cardiac ROSC Utstein %	Quality Improvement	Feb-2024	53.9%	45.1%	33.57%	51.05%	68.53%		
**Cardiac ROSC ALL %	Quality Improvement	Feb-2024	36.2%	23.8%	19.34%	28.43%	37.52%		
**Sepsis Care Bundle %	Quality Improvement	Mar-2024	86.4%	85%	82.61%	86.88%	91.15%		
**Cardiac Survival Utstein %	Quality Improvement	Jan-2024	8.1%	25.6%	1.47%	12.86%	24.25%		
**Cardiac Survival ALL %	Quality Improvement	Jan-2024	27.7%	9.6%	0.26%	26.01%	51.76%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Feb-2024	73%	76.8%	61%	71.92%	82.84%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	Mar-2024	65.8%	64.7%	60.23%	69.83%	79.44%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Dec-2023	02:41:00	02:22:00	02:12:44	02:34:11	02:55:39		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Dec-2023	04:07:00	03:14:00	02:50:30	03:33:04	04:15:37		
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Dec-2023	01:28:00	01:29:00	01:09:45	01:33:53	01:58:00		
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Dec-2023	02:08:00	02:20:00	01:28:06	02:24:19	03:20:32		
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Feb-2024	98.6%	96.3%	95.58%	97.65%	99.72%		
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Feb-2024	92.2%	93.8%	87.32%	92.58%	97.84%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Feb-2024	77.1%	77.9%	68.83%	78.62%	88.42%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Apr-2024	104.8%		85.42%	103.37%	121.32%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Apr-2024	80.4%	100%	76.32%	83.44%	90.55%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Apr-2024	85.9%	100%	70.31%	85.86%	101.41%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Apr-2024	100.6%	100%	94.11%	100.39%	106.66%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Apr-2024	27.2%		11.96%	51.89%	91.82%		

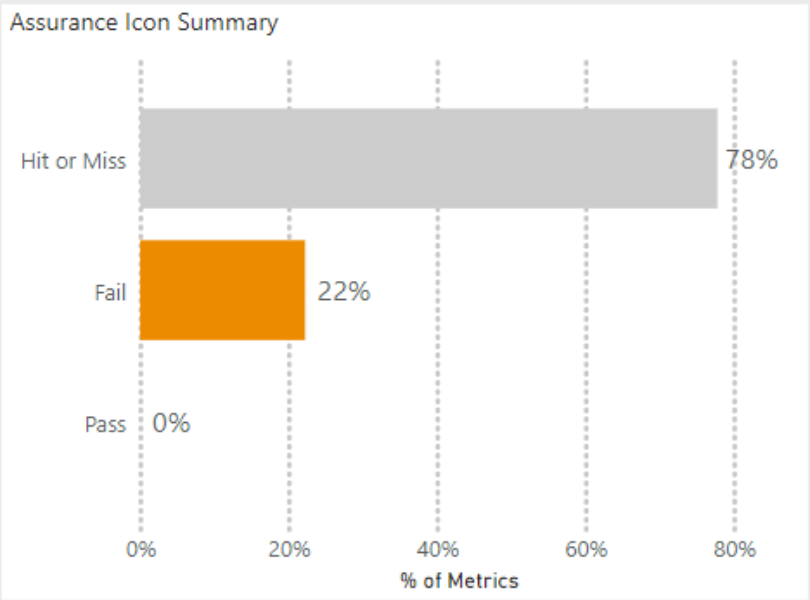
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Apr-2024	86.3%	90%	72.99%	85.97%	98.94%		
Deep Clean Compliance %	Quality Improvement	Apr-2024	92%	100%	66.68%	86.76%	106.84%		

QUALITY IMPROVEMENT

Overview (3 of 3)





Health & Safety

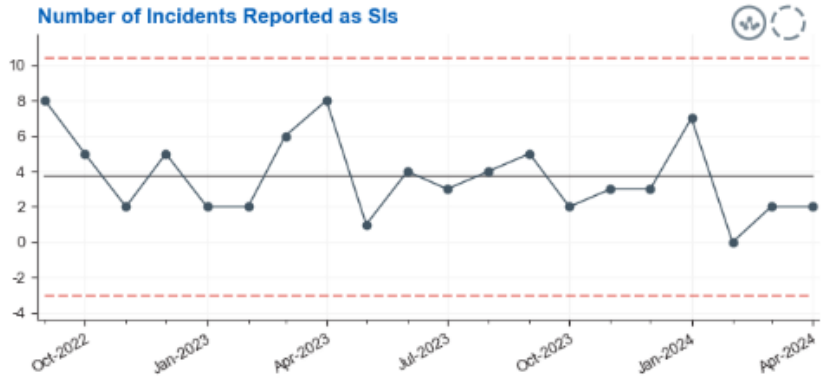
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Manual Handling Incidents	Quality Improvement	Apr-2024	25		12.19	27.45	42.71		
Organisational Risks Outstanding Review %	Quality Improvement	Apr-2024	20%	30%	-1.47%	32.78%	67.04%		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Mar-2024	35	0	6.29	38.83	71.38		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Mar-2024	17	0	6.62	38.22	69.83		
Medicines Management % of Audits Completed	Quality Improvement	Apr-2024	95.4%	100%	82.89%	91.75%	100.61%		
PGD Compliance %	Quality Improvement	Apr-2024	91.8%	100%		79.09%			
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Apr-2024	151%	100%	2.31%	73.85%	145.39%		

QUALITY & SAFETY

SIs, Incidents, & Duty of Candour



QS-2

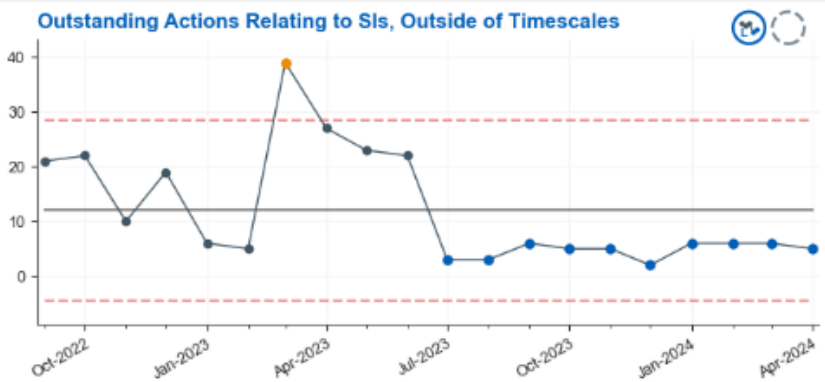
Dept: Quality & Safety
IP: Quality Improvement
Latest: 2

Common cause variation, no significant change.

QS-1

Dept: Quality & Safety
IP: Quality Improvement
Latest: 1656

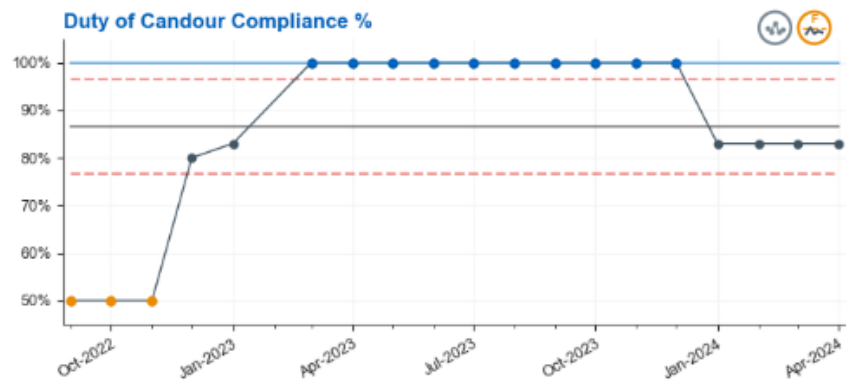
Common cause variation, no significant change.



QS-17

Dept: Quality & Safety
IP: Quality Improvement
Latest: 5

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



QS-3

Dept: Quality & Safety
IP: Quality Improvement
Latest: 83%
Target: 100%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

(QS-1) Number of Datix incidents - Incident reporting numbers are back to where we would hope them to be after the previous drop. The impact of the transition to DCIQ seems to have passed and is not preventing reporting. The impact on incident management is noted and is being addressed.
(QS-17) Outstanding actions relating to SIs– Regular monitoring and scrutiny of actions continues to help keep them on track. Updates on longer term actions are regularly sought.
(QS-2) Number of incidents reported as Serious Incidents– We are no longer declaring SIs having transitioned to PSIRF. **(QS-3) Duty of Candour Compliance** – One incident per each of these months missed their deadline. The new process is gradually embedding through the Incident Response Groups (IRGs), with operational representatives becoming familiar with and taking ownership of the actions to ensure the contact is made appropriately and within time. The IRGs continue to monitor weekly.

What actions are we taking?

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

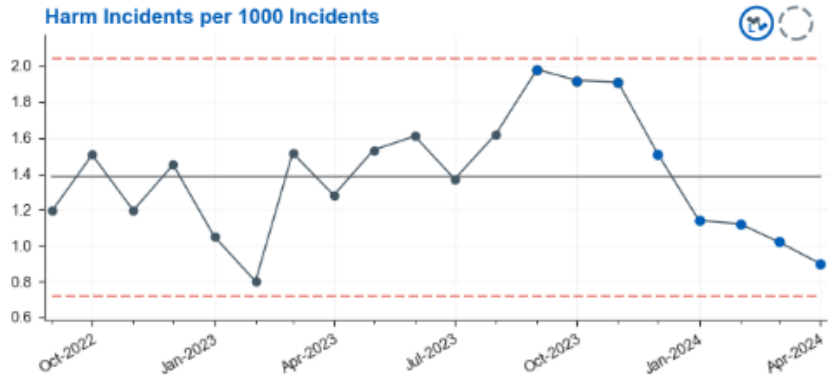
- Requirement to amend the SI metric to PSII
- Ongoing actions around incident reporting relate more to their timely management.
- The last of the outstanding SI reports and actions are being progressed and reviewed by all teams. SI action holders are held to account by the Patient Safety Team. There 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.

QUALITY & SAFETY

Harm

QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 7.83

Common cause variation, no significant change.



QS-29
Dept: Quality & Safety
IP: Quality Improvement
Latest: 0.9

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

Summary

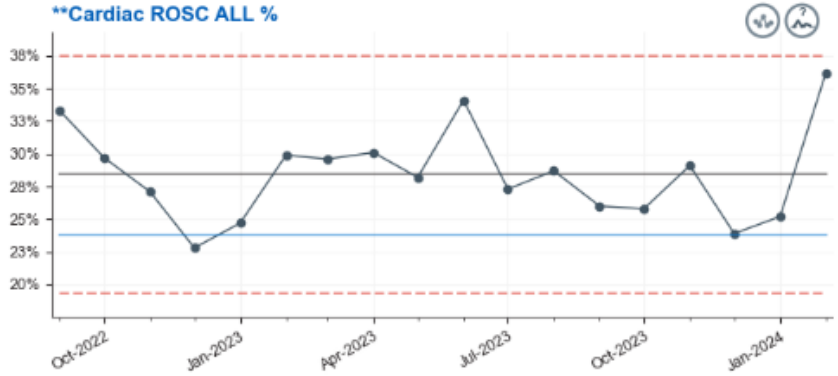
QS-28 No Harm incidents per 1000 incidents – We have seen a reduction in the number of no harm incidents per 1000 incidents. The number of Datix incidents reported has slightly increased and we are seeing a reduction in the number of harm incidents so there is no concern in relation to this metric.
QS-29 Harm incidents per 1000 incidents - the number of these Incidents shows a continuing downward trend since November which is positive as it has continued to reduce even with an increase in overall reporting this month.

What actions are we taking?

- PSIRF continues to embed across the Trust, and the function of the Incident Review Groups remains effective and responsive to development when required.
- Engagement and attendance of the IRGs is encouraged and continues to improve. The feedback regarding the Groups' effectiveness is positive from internal and external stakeholders.
- The development of our organisational learning framework continues, along with the commencement of an organisational learning forum which is due to launch shortly. The Group's terms of reference has been drafted. There is a good appetite for this forum with many staff interested in attending.

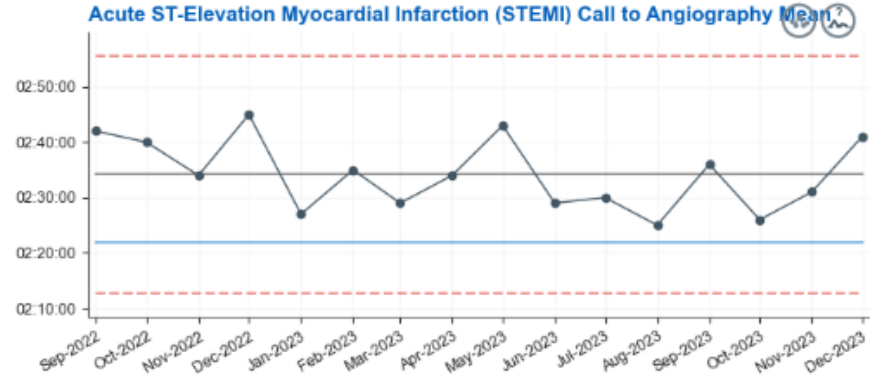
QUALITY & SAFETY

Impact on Patient Care - Cardiac



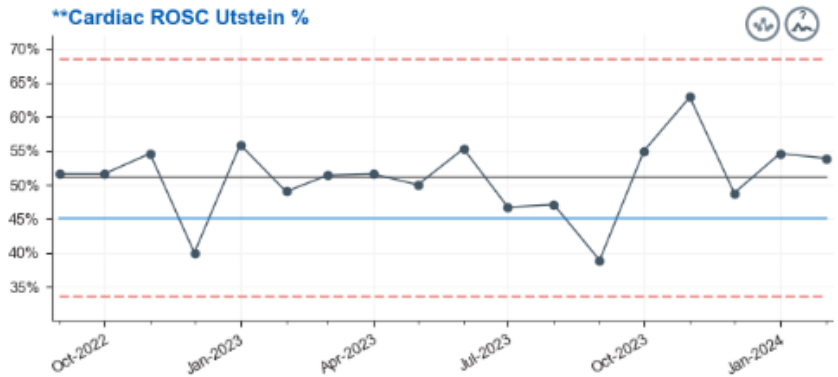
M-2

Dept: Medical
IP: Quality Improvement
Latest: 36.2%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



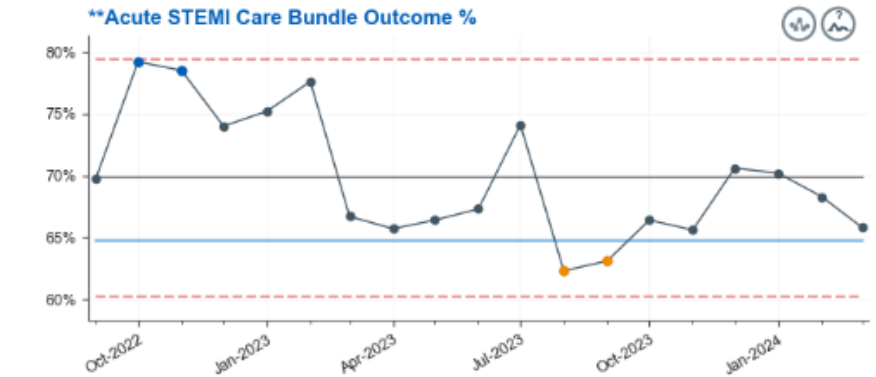
M-6

Dept: Medical
IP: Quality Improvement
Latest: 02:41:00
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: 53.9%
Target: 45.1%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-5

Dept: Medical
IP: Quality Improvement
Latest: 65.8%
Target: 64.7%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Cardiac Arrest Survival: – continues to demonstrate common cause variation, but is consistently above the national average. Up until March 2024, SECAmb continues to focus on several key initiatives to improve outcomes and are implemented via the Cardiac Arrest Outcome Improvement Group. The annual Cardiac Arrest Report, published in Q4, provides a validated retrospective one-year sample, offering greater accuracy and insight into Trust performance and benchmarking against other ambulance services.

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

A transformation review continues to evaluate the feasibility of establishing an additional primary PCI (pPCI) centre in Kent, addressing the current long travel times of up to 60 minutes in some areas. Continuous Professional Development (CPD) and Keyskills training consistently emphasise the importance of reducing on-scene time. Additionally, dashboards for local Operational Units (OUs) are being developed to audit on-scene times and assess inappropriate requests for back-up. A Quality Improvement (QI) project is also in progress to enhance communication and reduce on-scene times for pPCI cases. Further improvements will require direct engagement with staff members when extended on-scene times lack documented explanations.

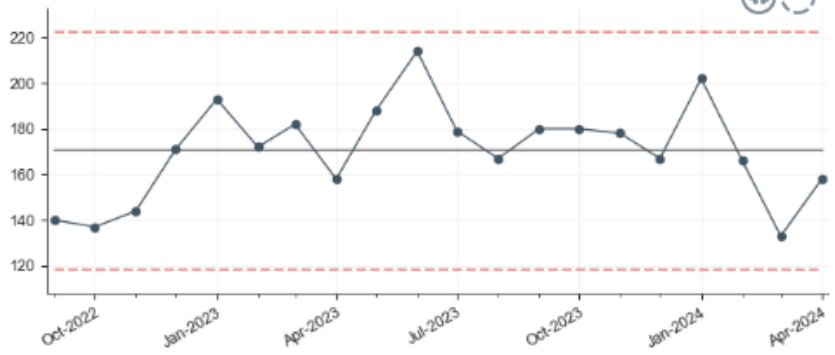
Acute STEMI care bundle outcome

The STEMI care bundle is currently being reviewed nationally.

QUALITY & SAFETY

Medicines Management (1 of 2)

Number of Medicines Incidents

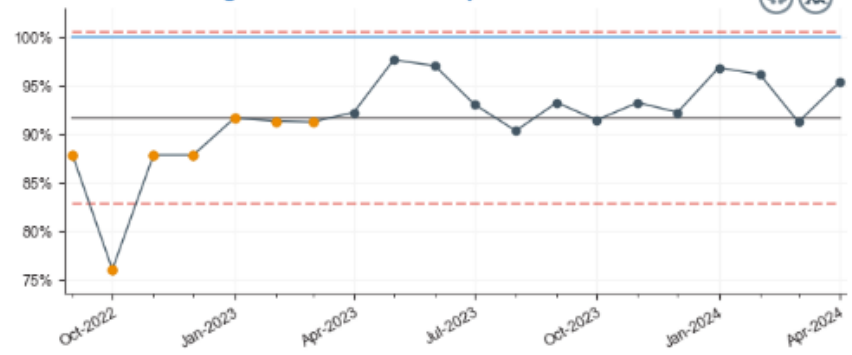


MM-1

Dept: Medicines Management
IP: Quality Improvement
Latest: 158

Common cause variation, no significant change.

Medicines Management % of Audits Completed



MM-7

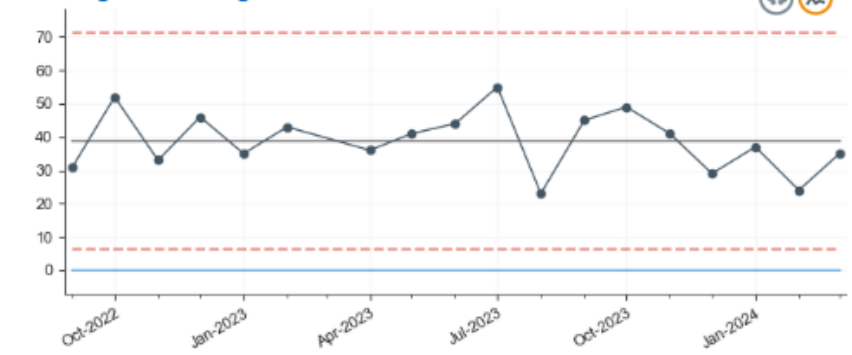
Dept: Medicines Management
IP: Quality Improvement
Latest: 95.4%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Number of CD Breakages

MM-5

Dept: Medicines Management
IP: Quality Improvement
Latest: 15
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Single Witness Signature Use CDs Omnicell



MM-3

Dept: Medicines Management
IP: Quality Improvement
Latest: 35
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

All medicines incidence are being reviewed by the Trusts Medicines Safety Officer which plays a vital role in learning on the back of investigations to prevent further incidences occurring.

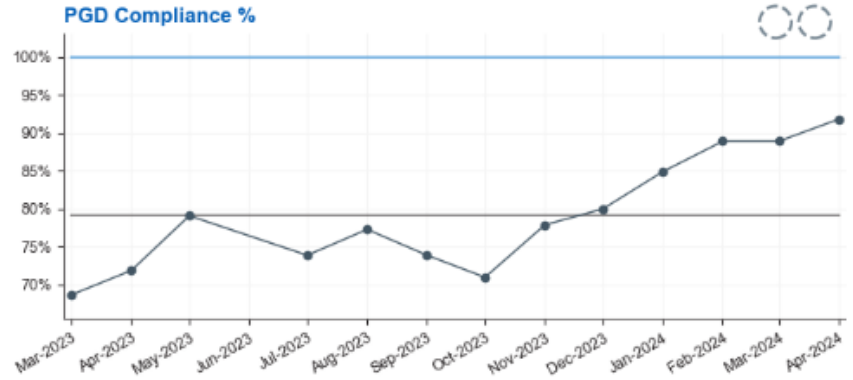
Single Witness signature for CDs work continues to address this area of activity and the reporting of it is going to go onto the weekly OTL checks making it easier around reporting which is partial manual currently.

What actions are we taking?

The new weekly/monthly check dashboard is still to go live, however work is ongoing to get this ready.

Preparation work is underway for the Phase 2/3 roll out of MedX which will ensure greater single sign out reporting and visability at all non-omnicell sites.

QUALITY & SAFETY Medicines Management (2 of 2)



MM-8

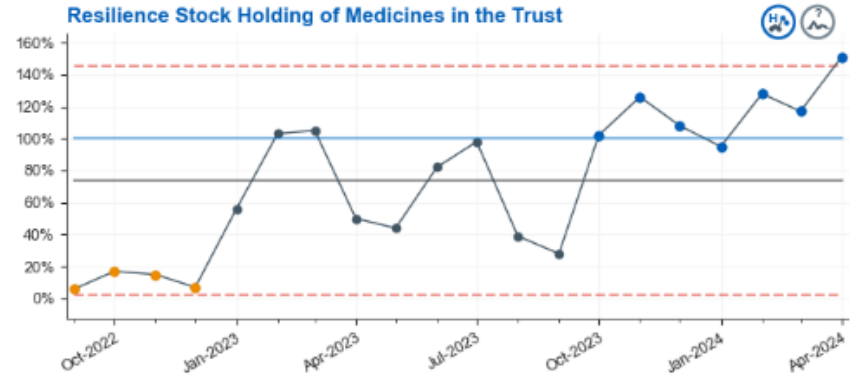
Dept: Medicines Management

IP: Quality Improvement

Latest: 91.8%

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: 151%

Target: 100%

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

Summary

Patient Group Directions (PGDs) compliance is at 91.8% and has steadily been improving over the past few months. A new PGD dashboard has been introduced showing this compliance and how it is broken down (e.g. by site, role etc) which has been made available to senior local managers to know which staff may or may not be compliant.

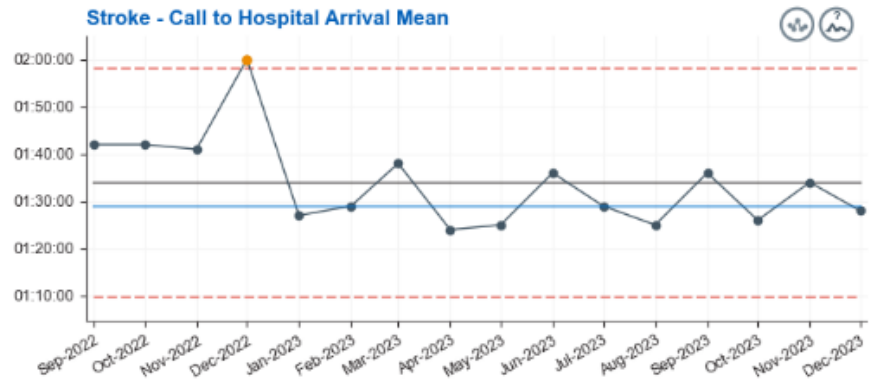
Resilience stock at the MDC is remaining high. This was in preparation for the two May bank holidays where there would be in a reduction in the hours in the month to pack stock.

What actions are we taking?

The medicines lead subgroup has added a new standing agenda item in their bimonthly meeting to inform local medicines leads which PGDs have been updated in the previous two months to ensure they can increase local compliance when changes happen.

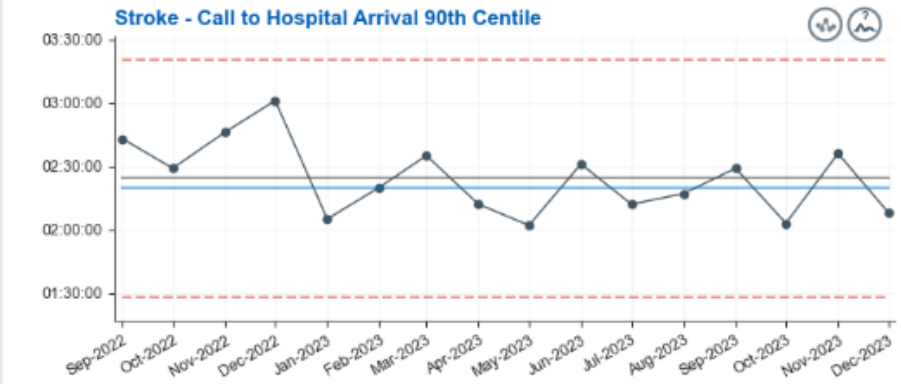
QUALITY & SAFETY

Impact on Patient Care – Stroke



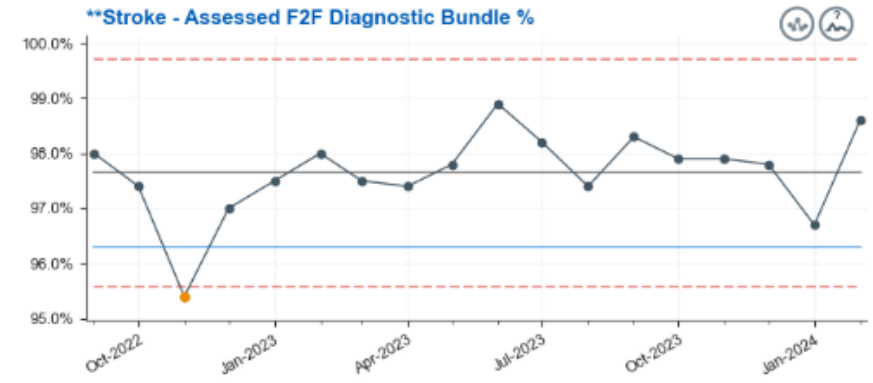
M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:28:00
Target: 01:29:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



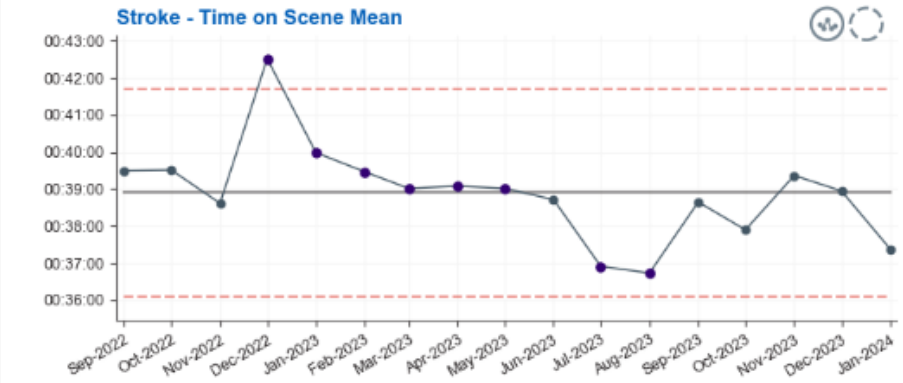
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:08:00
Target: 02:20:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-10

Dept: Medical
IP: Quality Improvement
Latest: 98.6%
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. – continues to show common cause variation with SECAmb hovering just above the target. A nationally mandated move towards Telemedicine will further challenge the Trust's ability to meet this target.

Stroke: diagnostic bundle: Compliance against the Diagnostic Bundle continues to remain above the target in most months, with common cause variation shown..

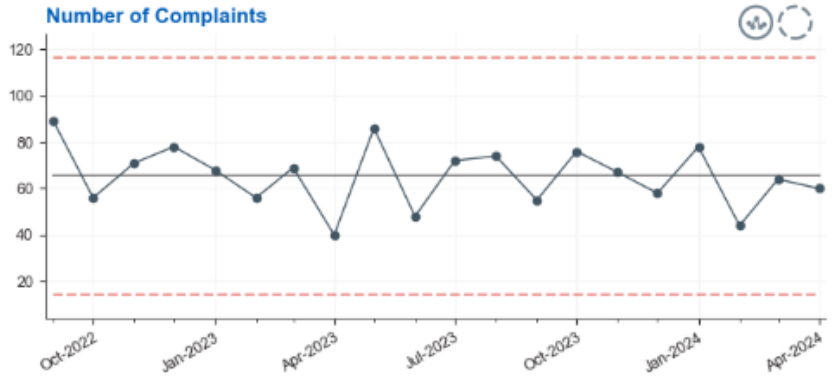
Stroke Time on scene mean. Common Cause variation but with an improving trend, though the nationally mandated move to Telemedicine in all areas will continue to challenge this.

What actions are we taking?

An ongoing UCL study will provide data on the impact of Telemedicine on these metrics, whilst integration in to the key skills curriculum continues to remind front line crews in the importance of time in these incidents. A continued improvement in the Trust's C2 response times should reflect in the 'call to hospital arrival' metrics, whilst enhanced ePCR functionality should aid in 'diagnostic bundle %' performance.

QUALITY & SAFETY

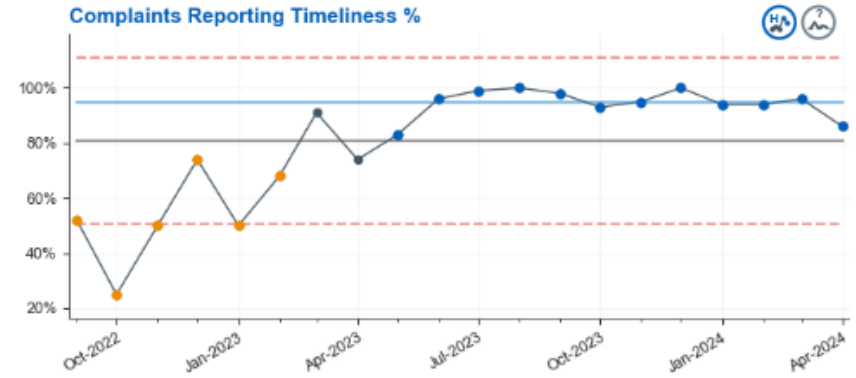
Patient Experience



QS-5

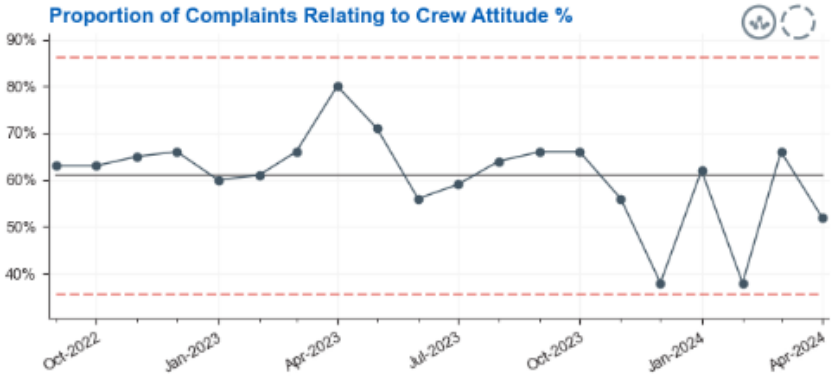
Dept: Quality & Safety
IP: Quality Improvement
Latest: 60

Common cause variation, no significant change.



QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 86%
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: 52%

Common cause variation, no significant change.

Summary

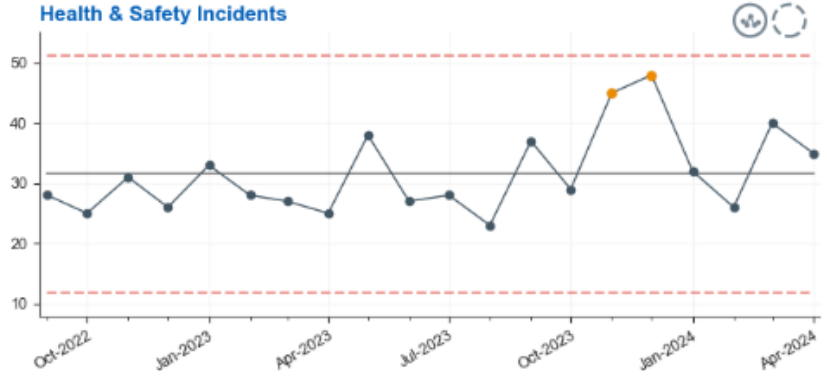
- The number of complaints received is showing normal variation. No concerns / issues.
- The number of complaints relating to crew attitude is within normal parameters. We are seeing significant variation in this process currently which is expected due to the actions taken because of learning from the deep dive review into staff conduct / attitude which was undertaken. We expect this to stabilise and reduce over the next 3 months.
- Timeliness in responding to complaints has now seen consistent improvement since June 2023 and was just below the 95% target for April 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 PALS annual report for the 2023 / 2024 year has been drafted and will be shared with QPSC in June 2024.

QUALITY & SAFETY

Safety in the Workplace (1 of 3)



QS-20
Dept: Quality & Safety
IP: Quality Improvement
Latest: 35

Common cause variation, no significant change.

QS-22
Dept: Quality & Safety
IP: Quality Improvement
Latest: 25

Common cause variation, no significant change.

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

- Internal H&S review to commence in June 24 for 6 months across 21 sites.
- IOSH Training to be delivered internally to 38 Managers.
- The regional and Trust-wide Health & Safety groups will continue monitoring incident trends and identifying opportunities for improvement.
- 2- minute internal video was published on the staff intranet reminding staff about the requirements for RIDDOR

Manual Handling Incidents

No significant variation.

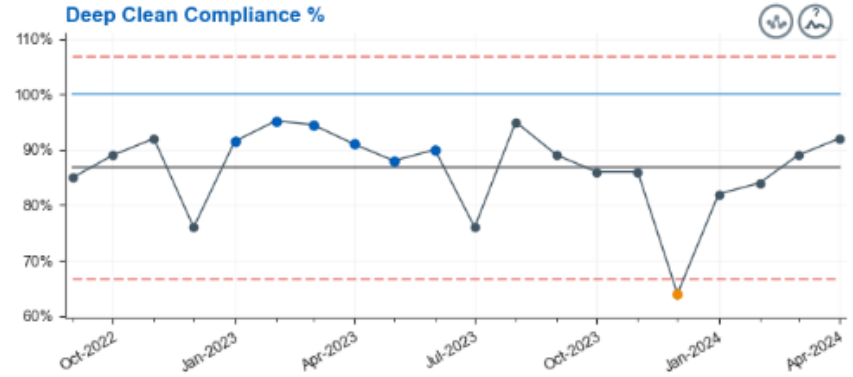
Paramedics and ECSW reported the highest number of manual handling incidents during this period.

What are we doing

- Task & Finish group to be created Q2 2024 to identify ways to reduce Manual Handling injuries.
- 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: 92%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

QS-7
Dept: Quality & Safety
IP: Quality Improvement
Latest: 86.3%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Deep Clean Compliance %

Deep Clean is provided by Churchill as part of the Make-Ready service. We have had a performance improvement plan in place however this has not resulted in a marked improvement in performance, driven primarily by workforce challenges and productivity challenges within the operating model for Churchill.

Other key indicators include the % of vehicles made ready which stands at 75% for Q4 23/24 and remains as such in April 2024, and this is driven by the hours provided by the contractor against our contract of 80% (flat trend since June 2023).

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?

Contract Management and cost control: Churchill wages were increased in April 23 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%. We are in contractual and performance negotiations with Churchill at this moment as there is further cost pressure due to living wage increased in 2024.

Patient harm and risk: We have commissioned a harm review to identify the risk to patient safety. Feedback is the incidents are very little harm / low harm coming through.

Quality auditing: 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.

In addition to the measures above, we are reviewing our overall approach to provisioning services for Make-Ready as part of the review of the operating model for operational support. The contract with Churchill has now been extended on a 3-month rolling basis giving us the opportunity to maintain current arrangements whilst we work with them on improvement plans, or changes to how we supply this service as a whole. We are reviewing our options and plan to bring these to FIC no later than Q2 2024.

Hand Hygiene Compliance

The data for hand hygiene compliance is showing normal variation and with the introduction of the new IPC Reviews we have seen a rise in the previous month's compliance levels for April.

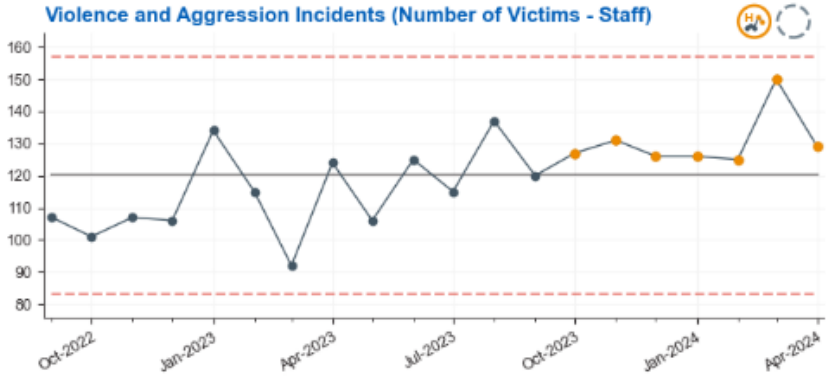
The new reviews are still receiving positive feedback from staff, and it is hoped that the information collected will continue to provide a truer reflection of compliance with all IPC practices, providing the team with data to drive improvements across the Trust.

What Actions are we taking?

- New IPC Practice Reviews have started to be rolled out across the Trust and it is anticipated that we will have a full set of data to show by Q2.
- New dashboard for local Dispatch Desks will also be introduced to monitor compliance locally, but this is still in development.
- Full review of the new system to take place at the end of Q2.

QUALITY & SAFETY

Safety in the Workplace (3 of 3)



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 129

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

Violence & Abuse

There has been an increase in the number of violence and aggression incidents reported since October 2023 and this is considered a positive response to an increased reporting culture.

Reported incidents have risen to be on average 125 per month. Assaults have not risen significantly over the last 6 months though there was a spike in March 2024 to 37. This has returned to 25 in April 2024. There is a continued rise in verbal abuse that can be attributed to incidents reported by call handling centres.

Staff reported 146 violence and aggression related incidents in March 2024.
The sub-categories of these incidents are shown below:

- 76 verbal abuse
- 28 Anti-Social Behaviour
- 37 assaults

Staff reported 129 violence and aggression related incidents in April 2024.
The sub-categories of these incidents are shown below:

- 81 verbal abuse
- 17 Anti-Social Behaviour
- 25 assaults

What actions are we taking?

- Face to Face Conflict Resolution Training (CRT) commenced for road staff in April 2024. Up to eight sessions per week are being conducted. 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 incidents and provide contact and support to staff if appropriate in reporting to police for investigation.
- Monthly partnership meetings are held with police to provide updates on cases involving our staff.
- Carriage of Body Worn Cameras (BWC) has increased by 266% since the completion of the expansion across the entire Trust.
- Increased partnership working internally with frequent caller team and 111 supervisors to understand the recent spike in verbal abuse and identify possible interventions that may be available.

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.
- 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 significantly over the last 5 years, it is the reporting of verbal aggression by staff that has increased, particularly in call handling centres.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Responsive Care

RESPONSIVE CARE

Summary

April 2024

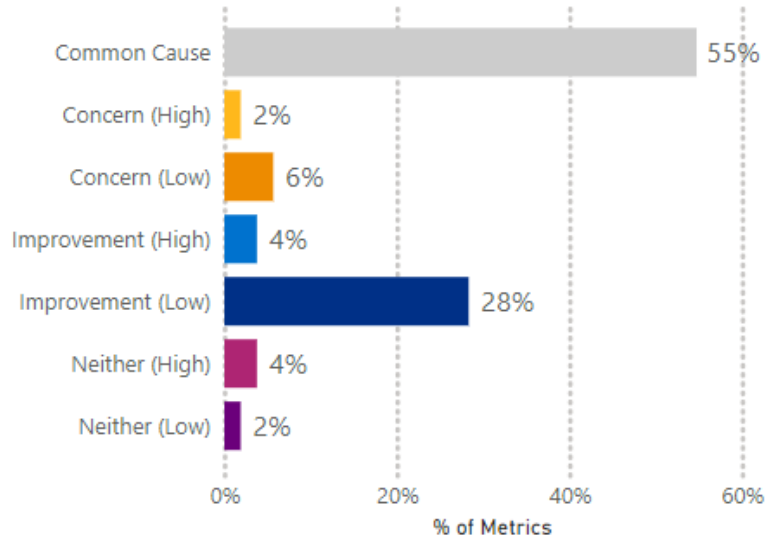
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	Cat 1T Mean Cat 1T 90th Centile	999 Frontline Hours Provided % Responses Per Incident 999 Call Answer Mean 999 Call Answer 90th Centile Cat 1 90th Centile Cat 4 90th Centile	Hear & Treat % See & Convey % Average Wrap Up Time Cat 1 Mean	JCT Allocation to Clear at Hospital Mean Hours Lost at Handover as a Proportion of Provided Hours... Critical Vehicle Failure Rate (CVFR) Proportion of Wrap Up Times > 15 minutes HCP 3 90th Centile
Common Cause	111 to 999 Referrals (Calls Triaged) %	111 Calls Abandoned - (Offered) % A&E Dispositions % Cat 2 Mean Cat 3 90th Centile	See & Treat % Vehicles Off Road (VOR) % 111 Calls Answered in 60 Seconds %	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
Special Cause Concern		Ambulance Validation % Clinical Contact %		ECAL Mean Response Time FFR Attendances

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

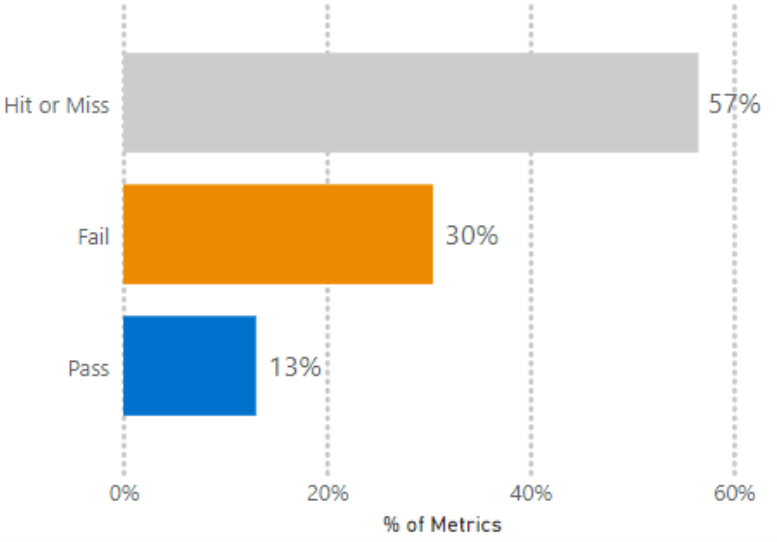
RESPONSIVE CARE

Overview (1 of 3)

Variation Icon Summary



Assurance Icon Summary



Response Times

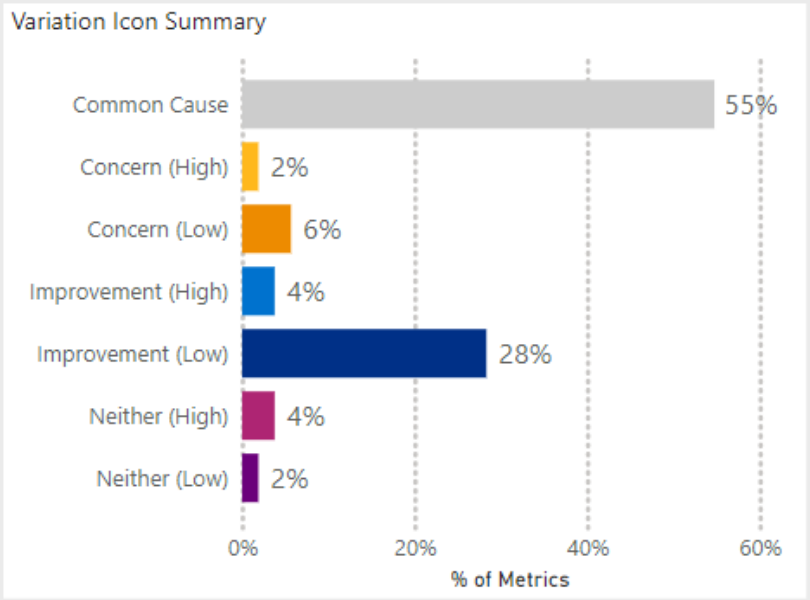
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Section 135 Mean Response Time	Responsive Care	Apr-2024	00:11:11		01:22:01	00:24:58	02:11:56		
Section 136 Mean Response Time	Responsive Care	Apr-2024	00:25:24		00:14:42	00:25:09	00:35:35		
Cat 1 Mean	Responsive Care	Apr-2024	00:07:59	00:07:00	00:07:25	00:08:52	00:10:19		
Cat 1 90th Centile	Responsive Care	Apr-2024	00:14:44	00:15:00	00:13:47	00:16:07	00:18:28		
Cat 1T Mean	Responsive Care	Apr-2024	00:09:03	00:19:00	00:08:47	00:10:24	00:12:02		
Cat 1T 90th Centile	Responsive Care	Apr-2024	00:16:39	00:30:00	00:16:02	00:19:10	00:22:17		
Cat 2 Mean	Responsive Care	Apr-2024	00:23:54	00:30:00	00:18:10	00:30:06	00:42:02		
Cat 2 90th Centile	Responsive Care	Apr-2024	00:48:36	00:40:00	00:34:59	01:01:18	01:27:37		
Cat 3 90th Centile	Responsive Care	Apr-2024	03:38:50	02:00:00	01:40:52	05:17:02	08:53:12		
Cat 4 90th Centile	Responsive Care	Apr-2024	04:28:12	03:00:00	01:54:53	06:57:52	12:00:51		
HCP 3 Mean	Responsive Care	Apr-2024	01:30:43		01:01:48	02:18:38	03:35:29		
HCP 3 90th Centile	Responsive Care	Apr-2024	03:13:41		01:29:27	05:11:10	08:52:54		
HCP 4 Mean	Responsive Care	Apr-2024	01:53:23		01:15:47	02:56:51	04:37:55		
HCP 4 90th Centile	Responsive Care	Apr-2024	04:45:27		02:17:58	06:53:53	11:29:49		

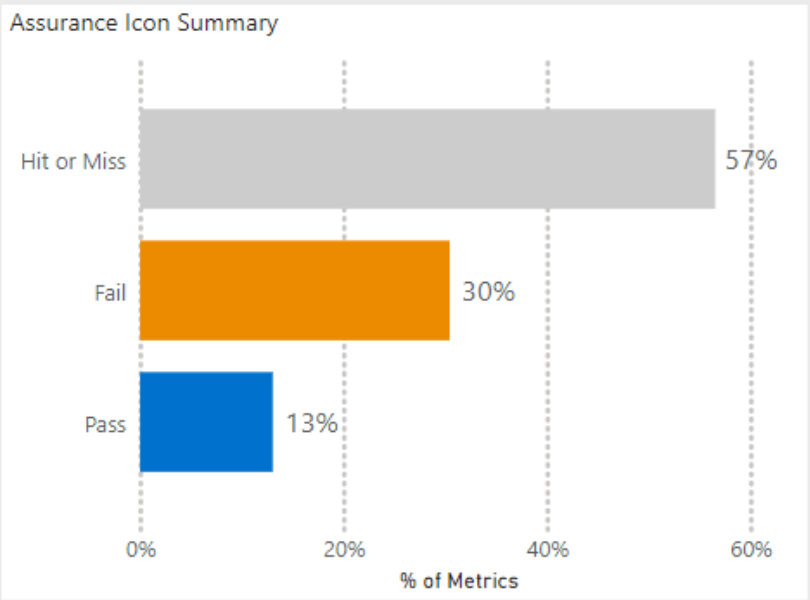
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Apr-2024	20.4%		19.72%	23.29%	26.86%		
999 Calls Answered	Responsive Care	Apr-2024	65306		51269.36	70520.9	89772.44		
999 Call Answer Mean	Responsive Care	Apr-2024	00:00:04	00:00:05	00:00:27	00:00:36	00:01:38		
999 Call Answer 90th Centile	Responsive Care	Apr-2024	00:00:02	00:00:10	00:00:55	00:01:53	00:04:41		

RESPONSIVE CARE

Overview (2 of 3)





Utilisation

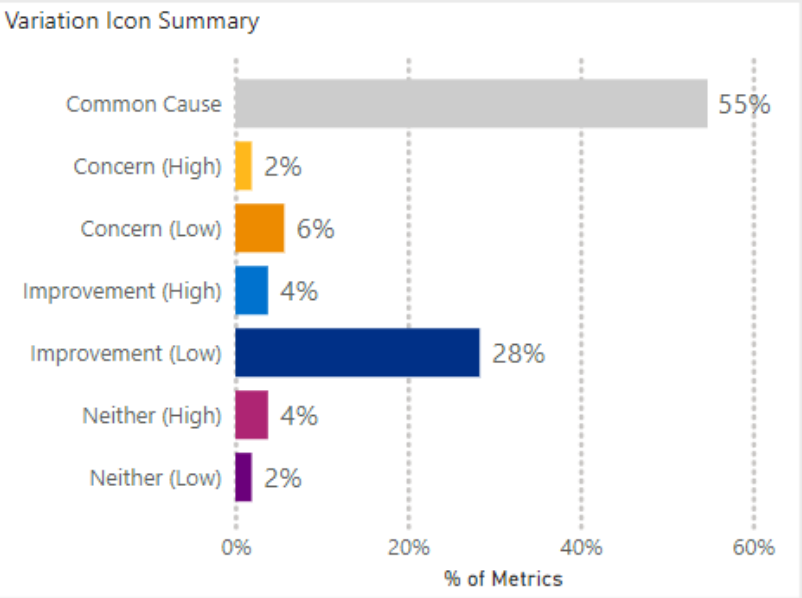
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Apr-2024	105.7%	100%	86.29%	97.85%	109.41%		
Provided Bank Hours %	Responsive Care	Apr-2024	0.9%		0.57%	0.74%	0.92%		
Provided Overtime Hours %	Responsive Care	Apr-2024	5.6%		4.43%	7.66%	10.88%		
Provided PAP Hours %	Responsive Care	Apr-2024	3%		3.81%	4.73%	5.65%		
Data being validated									
999 Remaining Annual Leave FY	Responsive Care	Apr-2024	48.1%		6.68%	25.93%	45.17%		
Vehicles Off Road (VOR) %	Responsive Care	Apr-2024	14.3%	10%	10.22%	13.21%	16.19%		
% of DCA vehicles off road (VOR)	Responsive Care	Apr-2024	15.6%		11.33%	13.98%	16.63%		
% of SRV vehicles off road (VOR)	Responsive Care	Apr-2024	4%		-14.84%	8.04%	30.91%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Apr-2024	85		56.31	123.65	190.99		
Number of RTCs per 10k miles travelled	Responsive Care	Apr-2024	0.69		0.2	0.71	1.22		
% of planned vehicle services completed	Responsive Care	Apr-2024	76%		58.36%	73.22%	88.09%		
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	Apr-2024	95%	95%		92.64%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Apr-2024	62.2%		60.51%	63.5%	66.48%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Apr-2024	6.3%	13%	5.25%	6.49%	7.72%		
Incidents	Responsive Care	Apr-2024	63465		54237.99	61717.35	69196.71		

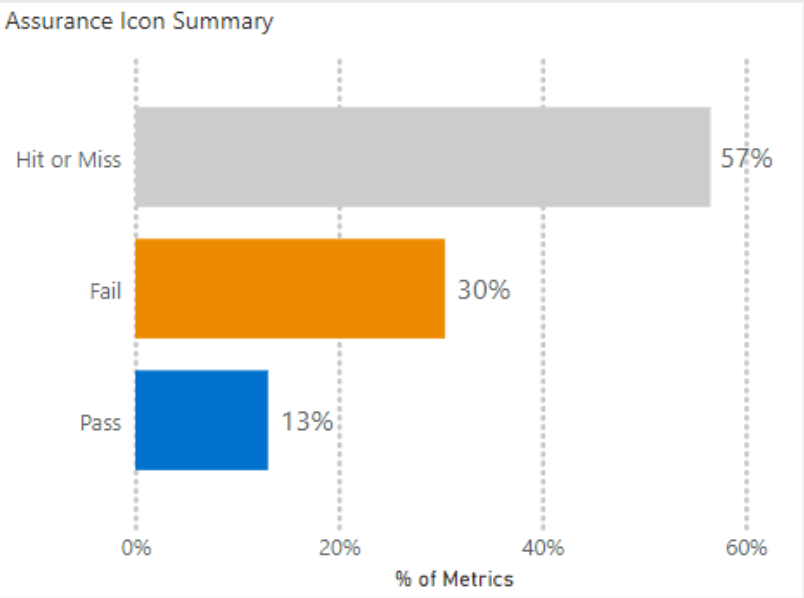
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Apr-2024	92293		63289.29	101945.95	140602.61		
111 Calls Answered in 60 Seconds %	Responsive Care	Apr-2024	61.9%	95%	8.79%	37.14%	65.49%		
111 Calls Abandoned - (Offered) %	Responsive Care	Apr-2024	8.4%	5%	1.29%	17.13%	32.96%		
999 Referrals	Responsive Care	Apr-2024	4873		3545.13	4888.15	6231.17		

RESPONSIVE CARE

Overview (3 of 3)





999 Frontline

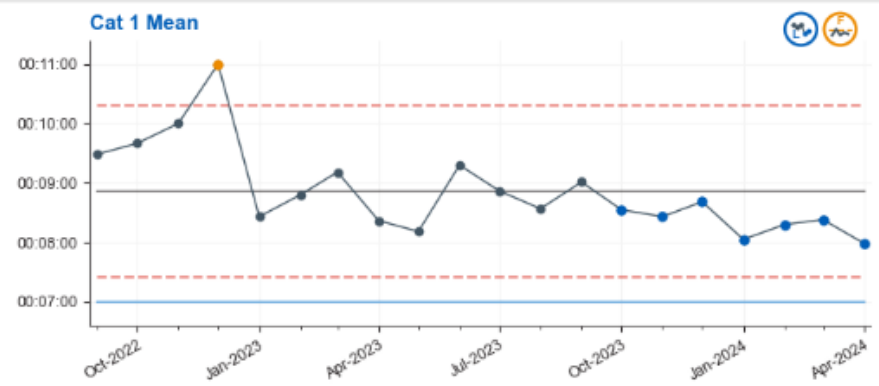
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Apr-2024	01:18:15		01:16:00	01:17:32	01:19:05		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Apr-2024	01:52:24		01:49:22	01:53:36	01:57:50		
Responses Per Incident	Responsive Care	Apr-2024	1.09	1.09	1.09	1.1	1.11		
CFR Attendances	Responsive Care	Apr-2024	1236		663.74	1165.5	1667.26		
FFR Attendances	Responsive Care	Apr-2024	84		62.18	141	219.82		
ECAL Mean Response Time	Responsive Care	Apr-2024	00:24:57		00:22:05	00:24:19	00:26:32		

111/999 System Impacts

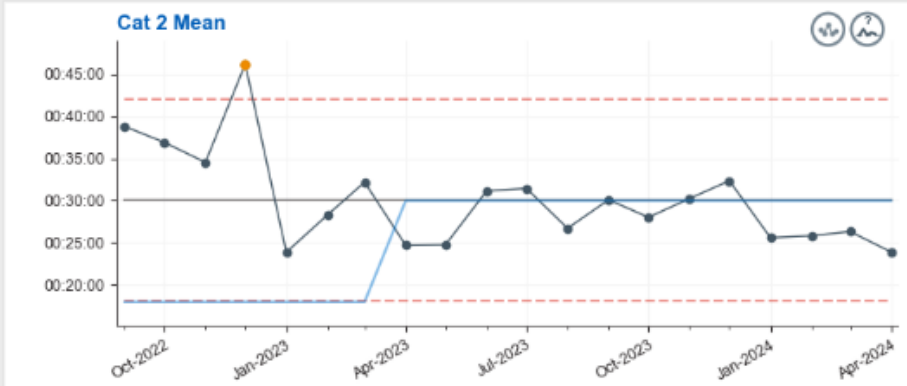
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Apr-2024	13.5%	14%	9.79%	11.25%	12.71%		
See & Treat %	Responsive Care	Apr-2024	30.6%	35%	29.77%	31.31%	32.85%		
See & Convey %	Responsive Care	Apr-2024	55.8%	55%	55.46%	57.31%	59.15%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Apr-2024	1%		0.56%	1.15%	1.73%		
Number of Hours Lost at Hospital Handover	Responsive Care	Apr-2024	3282.4		1635.41	3392.29	5149.16		
Average Wrap Up Time	Responsive Care	Apr-2024	00:17:00	00:15:00	00:16:33	00:17:07	00:17:41		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Apr-2024	42.5%		42.86%	45.59%	48.32%		
A&E Dispositions %	Responsive Care	Apr-2024	7.9%	9%	6.46%	8.17%	9.87%		
A&E Dispositions	Responsive Care	Apr-2024	6046		4242.38	6167.1	8091.82		
Clinical Contact %	Responsive Care	Apr-2024	44.4%	50%	44.82%	50.04%	55.26%		
Ambulance Validation %	Responsive Care	Apr-2024	51%	85%	65.11%	75.29%	85.46%		

RESPONSIVE CARE

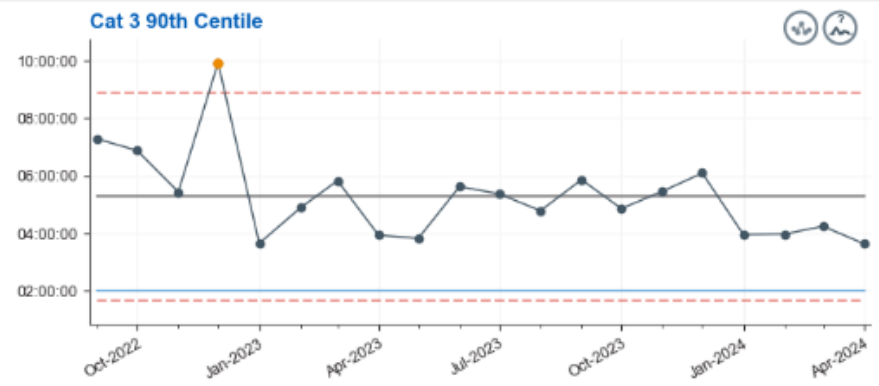
Response Times



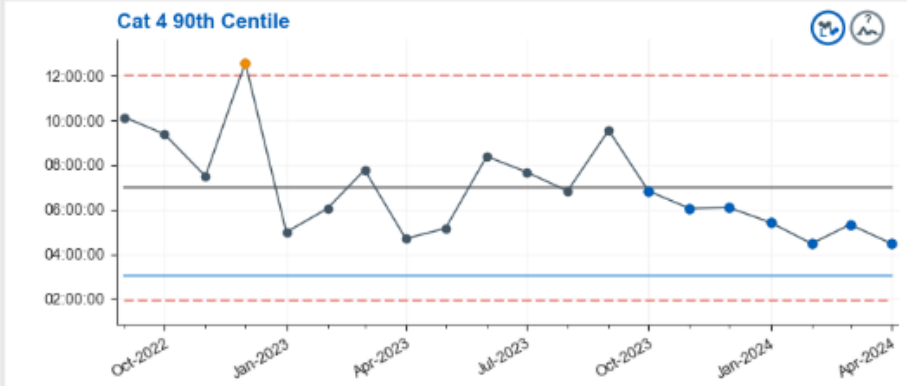
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:07:59
Target: 00:07:00
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:23:54
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: 03:38:50
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: 04:28:12
Target: 03:00:00
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

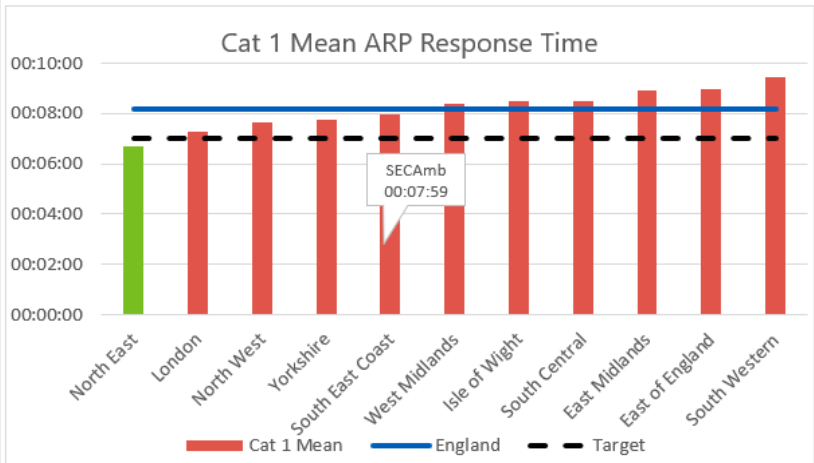
Summary

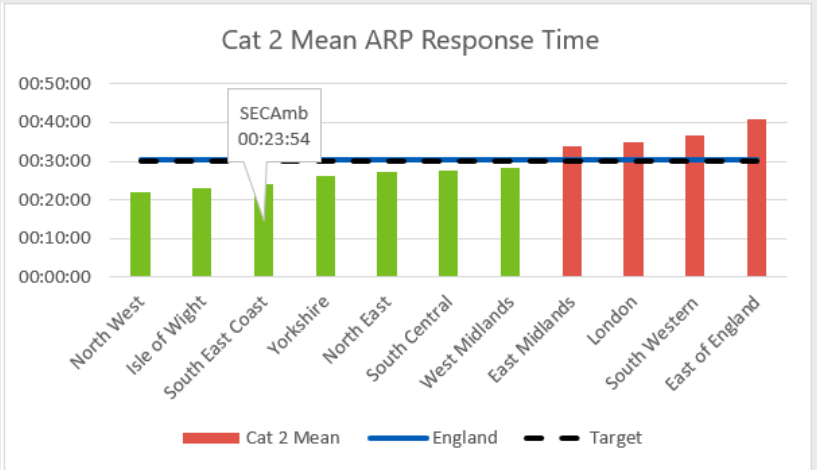
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against the delivery plan – in April 2024, performance was 25min 50sec, against a national average of 36min 20sec.

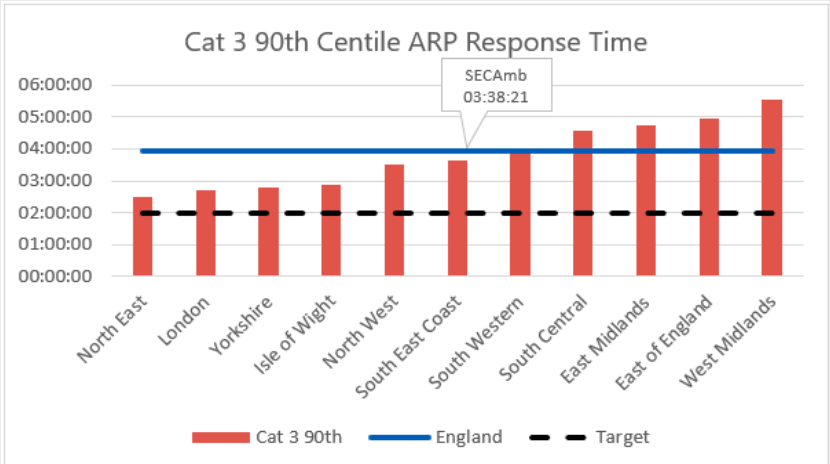
What actions are we taking?

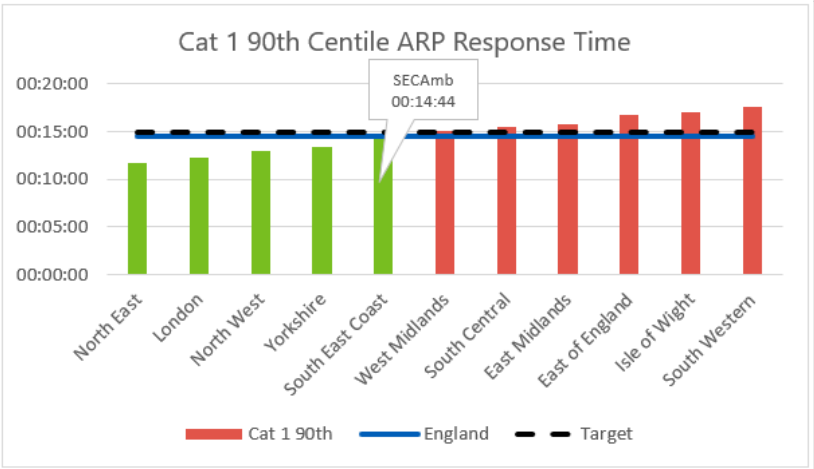
- Expansion of PACCs across Field Ops to support appropriate alternative pathways for C3 & C4 validation,
- Continued focus on recruitment for clinical staffing in EOC to maintain patient safety and support ambulance dispatch, with a cohort of international clinicians now undergoing induction
- Focused attention on abstraction management for sickness management & training planning.
- Lower than planned attrition and over 100 new starters arriving for Firled Ops
- 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. Specific work at Royal Sussex University Hospital ongoing between Brighton OU team, Sussex ICB & Hospital clinical leaders

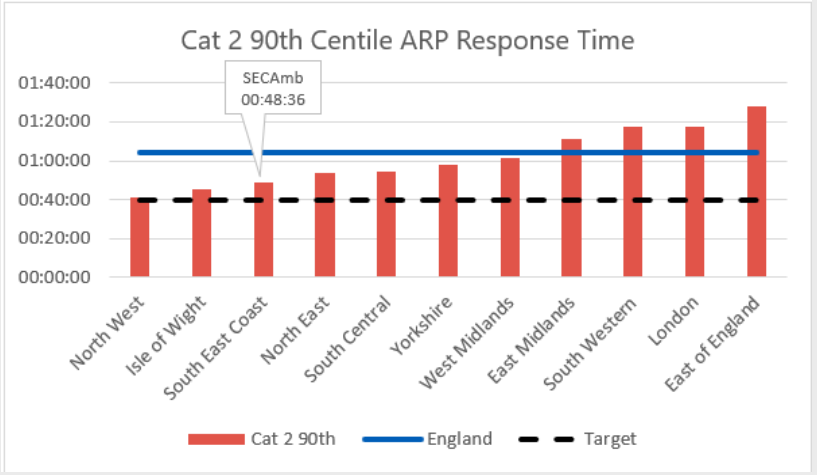
ARP Response Time Benchmarking (data provided for February 2024)

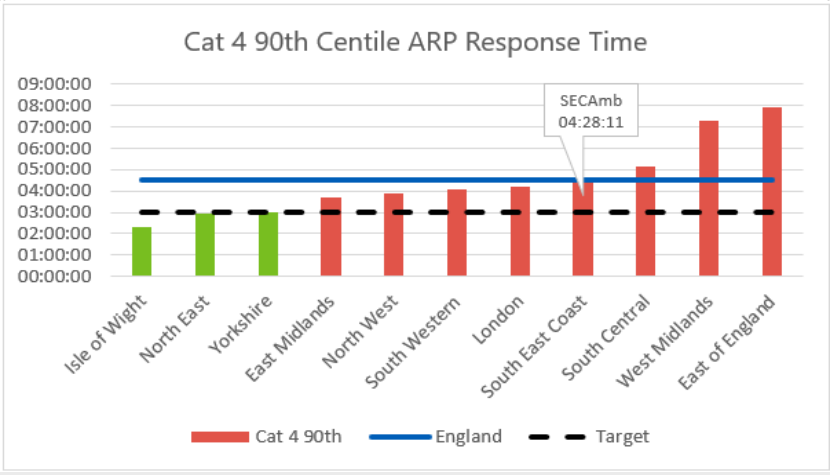










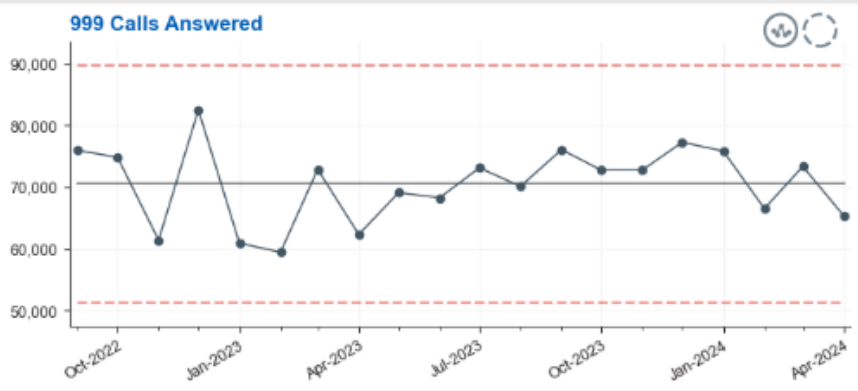


Summary

- 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 and we are working on Dispatch Phase two to improve performance .

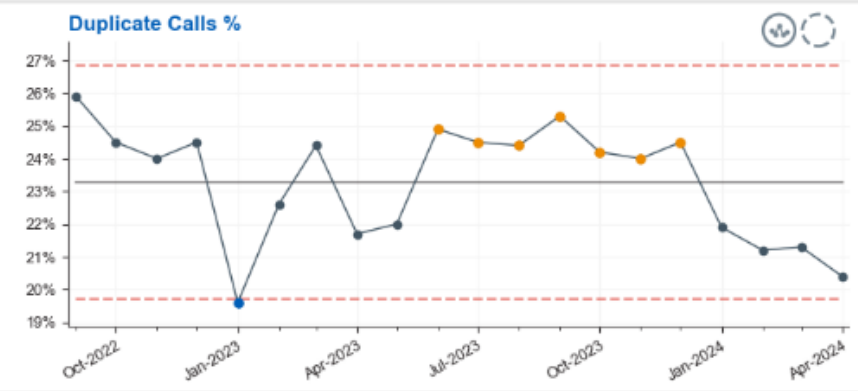
RESPONSIVE CARE

EOC Emergency Medical Advisors



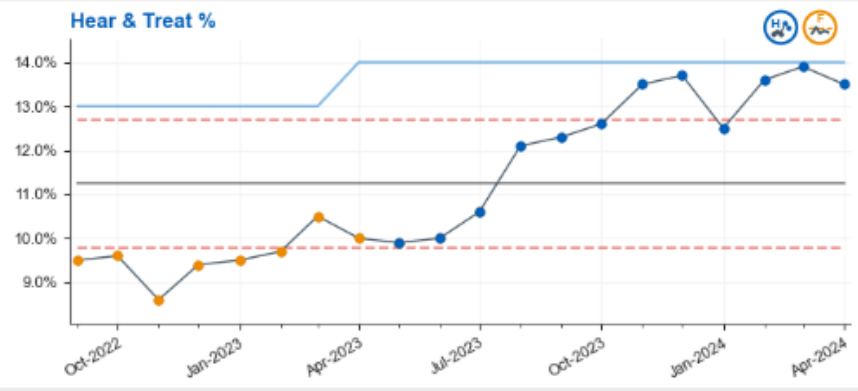
999-10
Dept: Operations 999
IP: Responsive Care
Latest: 65306

Common cause variation, no significant change.

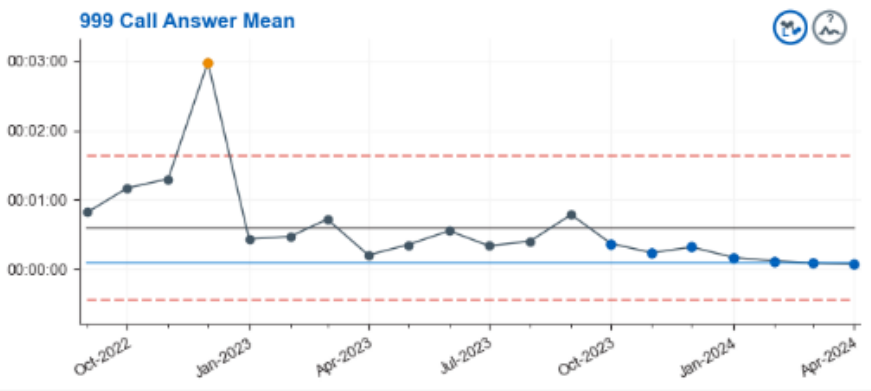


999-33
Dept: Operations 999
IP: Responsive Care
Latest: 20.4%

Common cause variation, no significant change.



999-9
Dept: Operations 999
IP: Responsive Care
Latest: 13.5%
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: 00:00:04
Target: 00:00:05
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Summary

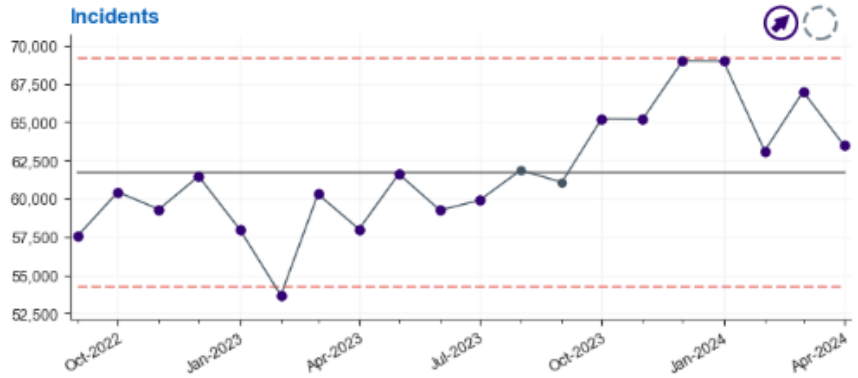
- Call answer mean time consistently line with National AQI targets, some on the day fluctuation due to ongoing staffing challenges and rota inequalities, with a higher proportion of newer staff who are developing.
- EMA recruitment and the retention remain the service's key area of focus, to improve performance and create 999 call handling resilience.
- ***Hear and Treat*** performance fluctuates due to two factors. 1) significant numbers of new overseas clinicians in training and requiring mentoring and support. 2) The Trust has performed well operationally, and the improved ARP metrics has resulted in less time to clinically assess cases because of more timely ambulance dispatch.

What actions are we taking?

- EMA establishment is only marginally below plan for the funded establishment of 265WTE– 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 current position being 280WTE of which 250WTE are live and 30WTE in training and/or mentoring.
- ***C3 & C4 clinical validation model*** and ***C2 segmentation continues.***
- The ***Hear and Treat*** trajectory is for 16% end of Q4 and the service is on track with these milestones. As the overseas nurses go-live on the phones, this will augment clinical capacity in EOC with circa. 20 WTEs expected to be fully operational by the end of H1. The Hear & Treat project phase 2 has started, with a suite of actions and milestones to ensure the service remains on track with achieving 16% H&T by the end of Q4

RESPONSIVE CARE

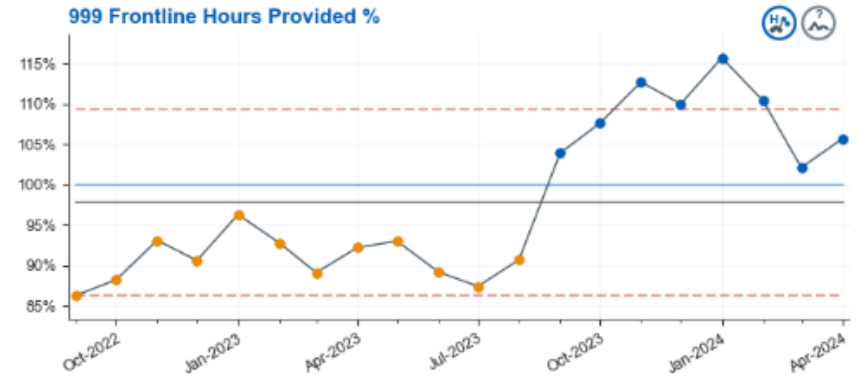
Utilisation



999-10

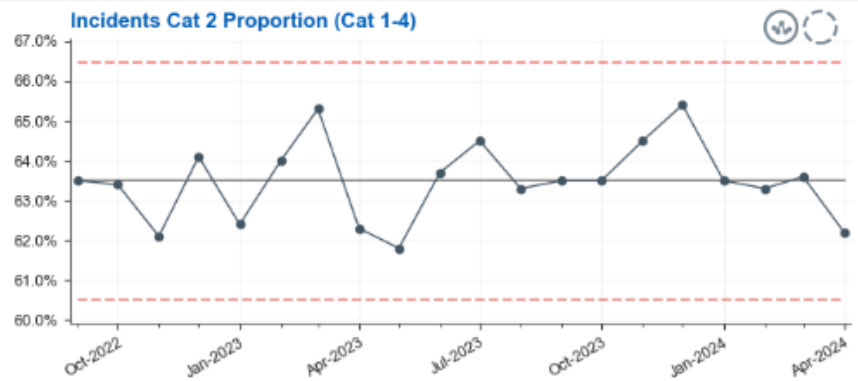
Dept: Operations 999
IP: Responsive Care
Latest: 63465

Special cause variation where UP is neither improvement or concern



999-12

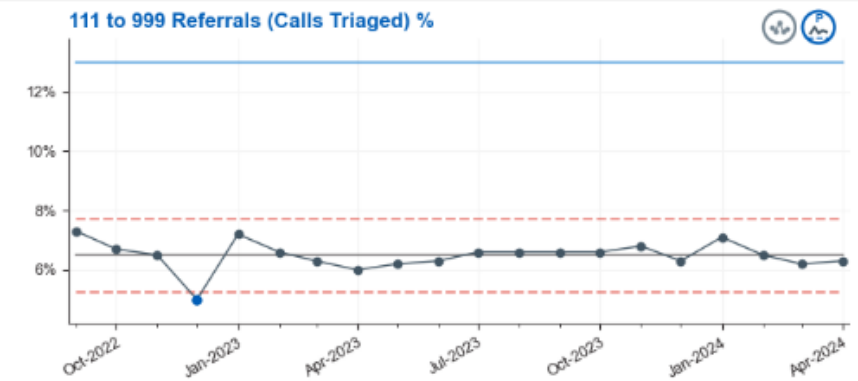
Dept: Operations 999
IP: Responsive Care
Latest: 105.7%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



999-32

Dept: Operations 999
IP: Responsive Care
Latest: 62.2%

Common cause variation, no significant change.



111-4

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

Summary

- Continued high 111 ***validation rates*** for all calls being proposed to be passed to 999 (contractual requirement of 50%) 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 over the past 12 months, however with reduction in abstraction (sickness) and turnover, staffing is more stable overall.
- Training continues to be delivered against plan.

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.
- Ongoing 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.
- Urgent Community Response (UCR) Portal is fully live for Sussex however, the service is still having to undertake time consuming MS Teams calls daily for UCR providers across Kent and Surrey. Looking ahead, the focus is on extending the roll-out of the UCR Portal across the other ICSs and optimising this digital solution.

RESPONSIVE CARE

999 Frontline

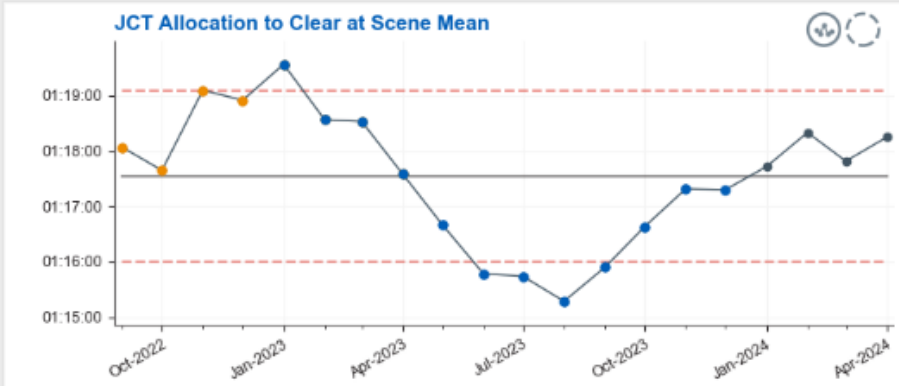
999-17

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: 00:24:57

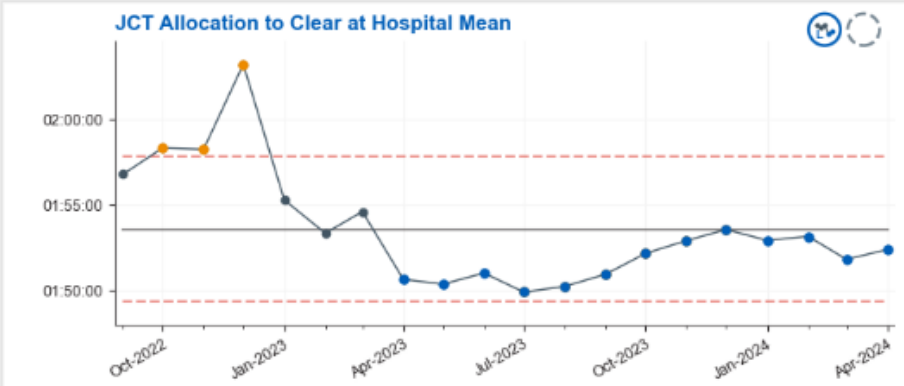
Special cause of a concerning nature where the measure is significantly HIGHER.



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:18:15

Common cause variation, no significant change.



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:52:24

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 with winter illnesses that are more complex.

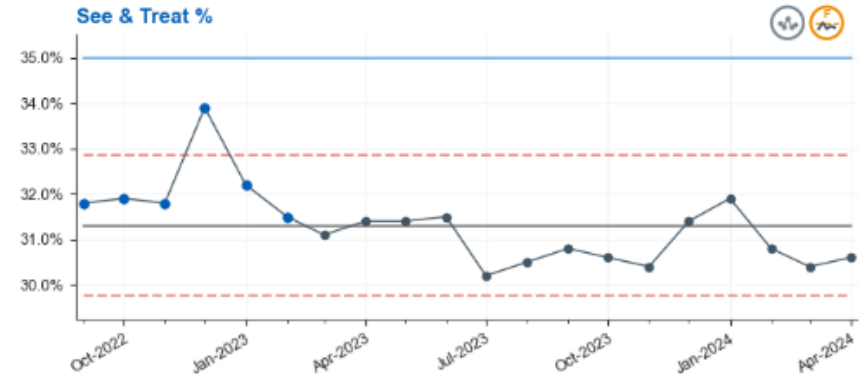
What actions are we taking?

- 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 2024-25.
- 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; this has been impacted in some areas by the implementation of new care navigation hubs.
- 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

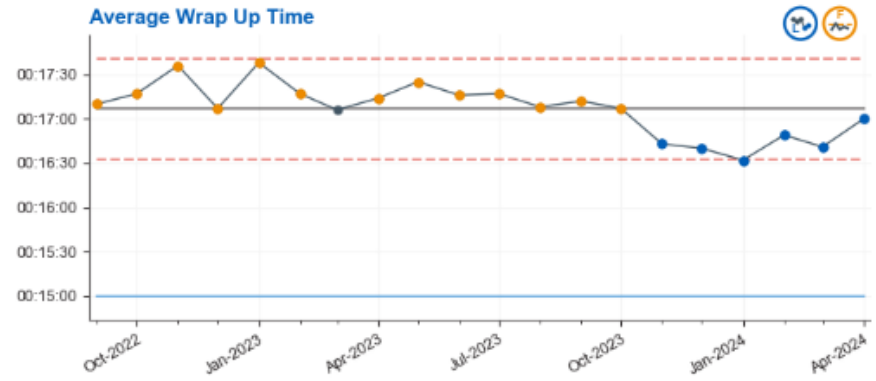
111-5
Dept: Operations 111
IP: Responsive Care
Latest: 7.9%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-9
Dept: Operations 999
IP: Responsive Care
Latest: 30.6%
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: 3282.4

Common cause variation, no significant change.



999-31
Dept: Operations 999
IP: Responsive Care
Latest: 00:17:00
Target: 00:15:00
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.

Summary

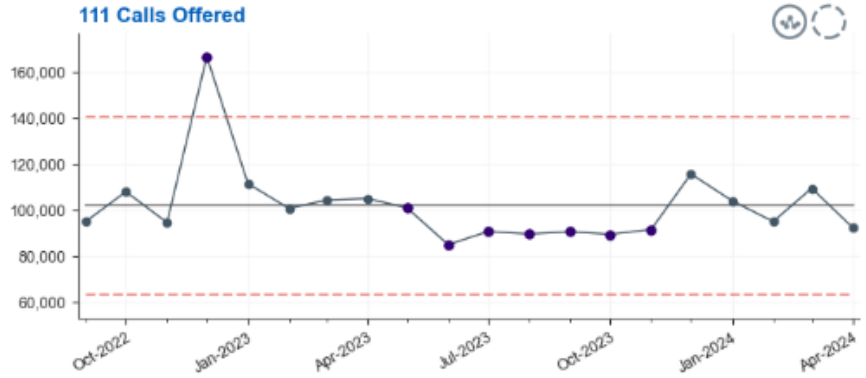
- The ***111 to ED disposition rate*** has been maintained at a very low level since the introduction of "111 First", Direct Access Booking (DAB) and ED validation. The Trust's 111 service has excelled at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111 national average
- The Trust ***See and Treat*** rate has improved to a level of 30.6%, noting that there is significant variation between geographical dispatch desk areas heavily influenced by the availability and accessibility of ***community care pathways*** as alternatives to Emergency Depts. This variation will be influenced by the availability and accessibility of the services, and the confidence of local teams to use them.
- ***Wrap-up time*** had shown some improvements, however, there has been some deteoriation in the most recent months.

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

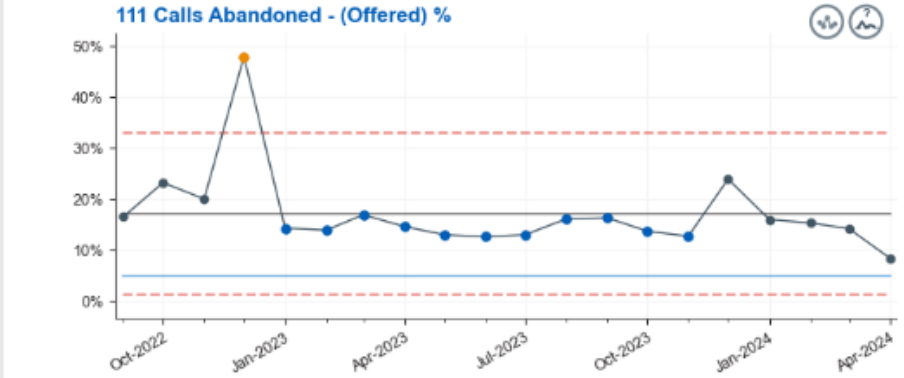
111



111-1

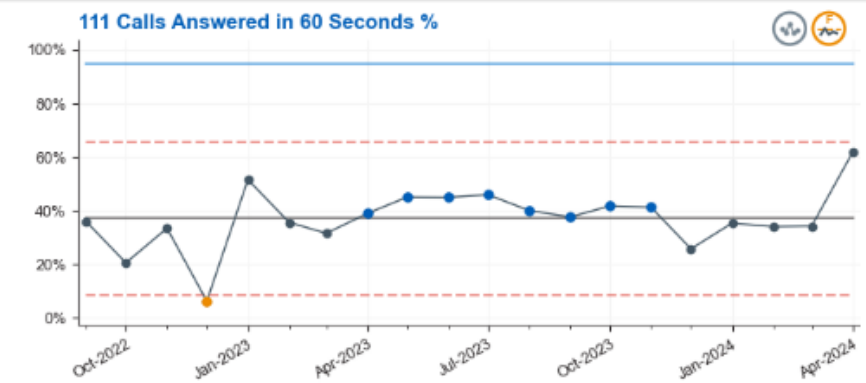
Dept: Operations 111
IP: Responsive Care
Latest: 92293

Common cause variation, no significant change.



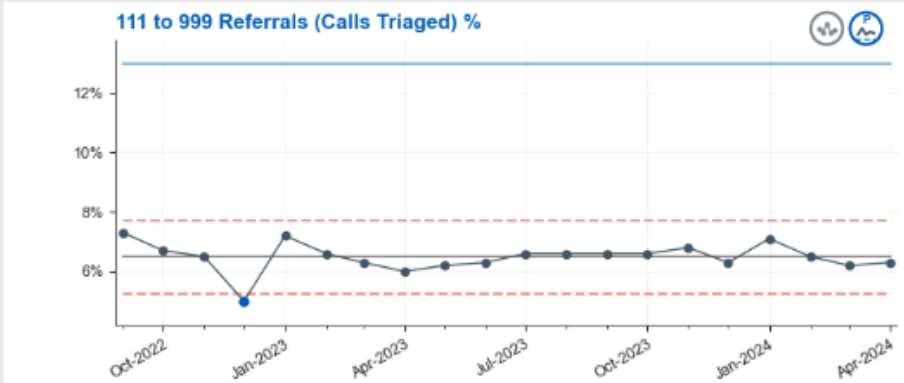
111-3

Dept: Operations 111
IP: Responsive Care
Latest: 8.4%
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: 61.9%
Target: 95%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



111-4

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

Summary

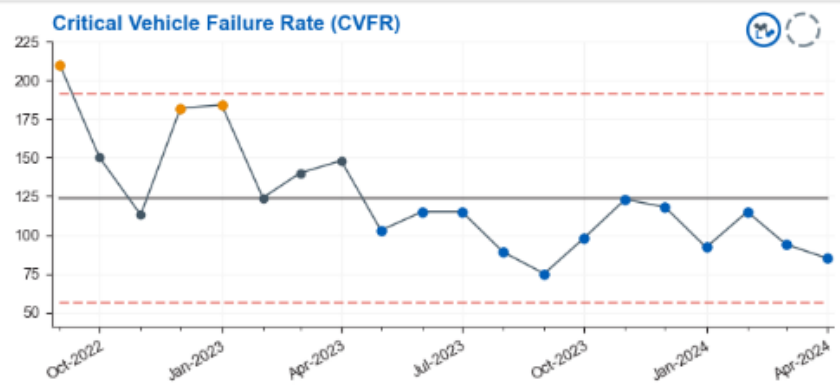
- The service's ***operational responsiveness*** has noticeably improved in April , as reflected in the increase of calls answered in 60 seconds and lower percentage of abandoned calls.
- The performance of the service is directly related to the increased Health Advisor numbers, due to lower attrition and good recruitment numbers as well as lower call activity.
- 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 reducing to 5% in September.
- The service has rapidly bridged its Health Advisor shortfall, target of 252.6WTE, following the move to Medway in July, with a current establishment of 268 WTE's made up on 250 WTE live on the phones and 18WTE in training or mentoring.

RESPONSIVE CARE

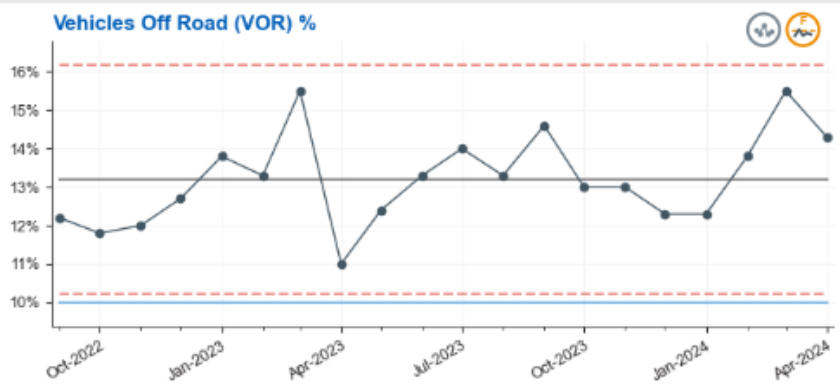
Support Services
Fleet and Private Ambulance Providers



FL-12

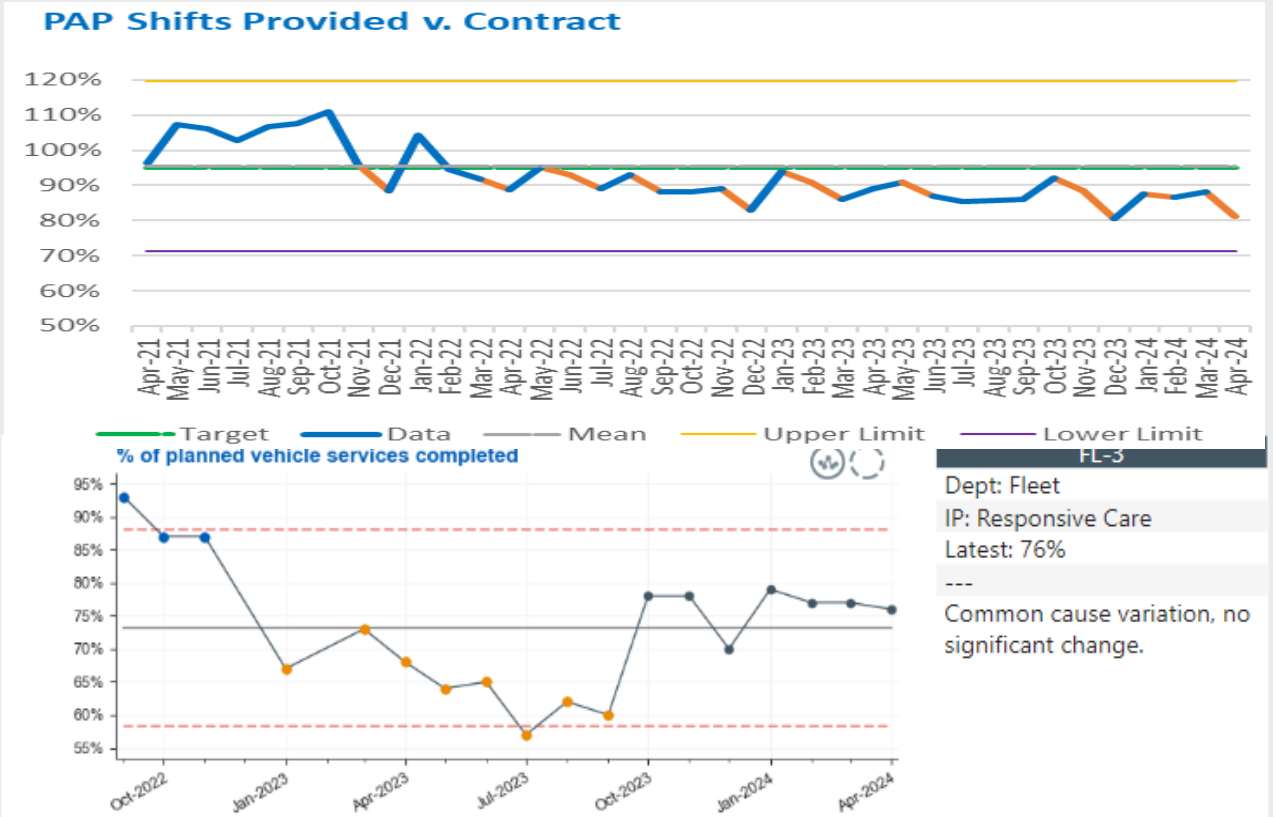
Dept: Fleet
IP: Responsive Care
Latest: 85

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



FL-13

Dept: Fleet
IP: Responsive Care
Latest: 14.3%
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: 76%

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 currently have 3 vacancies as of May 2024. We are still 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 is due to current vacancies, increased annual leave and sickness of VMT's. There is a requirement to increase VMT workforce to increase available workshop hours to meet the required demand of hours required to complete planned vehicle maintenance. Recruitment remains a challenge and a apprenticeship scheme is to be introduced in 24/25.

Concerns around parts supply continue to be raised nationally by Fleet Managers and escalated to suppliers regularly

A recommendation paper for a replacement Trust DCA has now been written post vehicle options roadshow including all staff feedback.

PAP contract as part of the 24/25 plan, the Trust has decided to cease its Private Ambulance provision as of 1st July 2024. This is because the Trust is over established with substantive workforce and timing of renewals for contracts and expected uplifts in PAP costs means it is no longer sustainable to continue with the existing provision. PAP make up around 5% of our hours on the road, and we are over established by c. 1%. The plan is to backfill with substantive NHS staff over the course of the year, and expected increases in Overtime during the Summer months ahead of winter to maintain our C2 Mean trajectory under 30 minutes. In addition, efficiencies brought about by the increase in H&T are expected to reduce pressures on physical responses.

Appendix 1: Glossary

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

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	25c/24

Name of meeting	Trust Board
Date	6 June 2024
Name of paper	Quality & Patient Safety Committee Escalation Report – April 2024
Author	Liz Sharp, Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 11.04.2024 and confirms whether any matters require specific intervention by the Trust Board.

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

1. **Chief Pharmacist Recruitment**
   A new Chief Pharmacist has been appointed and starts with SECAmb on Monday 03 June 2024, her name is Shani Corb. There are two interim Chief Pharmacists covering three days per week, Louise Maunick (Chief Pharmacist at SCAS) and Vikki Bray (Deputy Chief Pharmacist at LAS).
   Interviews for the Deputy Chief Pharmacist are planned for early May with Shani being a member of the panel ahead of her start date.

2. **Medicines Distribution Centre**
   The planned completion date has now moved to 31 October 2024. A new Portfolio Manager has started with the sole responsibility of progressing this project. The lift has a 12-week lead time. The colleagues that work at the MDC were briefed by Dr Richard Quirk on 10 April, they have acknowledged the delay and are okay if the project is completed properly.

Item	**Link to BAF**
Management Responses	

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

- **Right Care Right Person (RCRP)**

Kent & Sussex went live on 02 April, Kent with all four phases, whereas Sussex went live with phase 1. To date the Trust has not seen any increase in activity.

Joint Operating Procedures are in development across the three county Police Forces with a view to these being complete during May 2024.

The Committee has asked that RCRP be a standing agenda item for the next 12 months to ensure that any impact on service can be reviewed.

- **Development of the Learning Framework**

This is still in the early stages, however, has been tested with the Quality & Nursing SLT, where feedback will support in developing the next steps.

The framework will support the Trust strategy development.

The team are working to a September 2024 go live, with the caveat that this framework will develop over time and adapt.

Safeguarding	N/A

The Committee received the Safeguarding report that identified good areas of practice across all areas.

There were gaps identified by both the team and the committee in the following areas:

- Quality of safeguarding referrals from 111
- Lower uptake of safeguarding training across NHS111 than the rest of the organisation
- DBS Panel isn't always sighted on risk assessments where there is a self-disclosure for prospective employees who are looking to commence without a DBS check in place.

Except for the gaps identified above the committee were assured of the Safeguarding provision in the Trust.

Integrated Patient Safety Report	Quality & Safety Goals 1-3

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

The committee were informed that although the Patient Safety Incident Response Framework (PSIRF) has gone live, there are still ongoing Serious Incidents being investigated, the team were currently combining both the old and new systems and linking any learning into the Trust learning Framework.

The findings and subsequent improvement plan from the deep dive into staff attitudes cited in complaints will be presented at the People Committee and the Quality & Clinical Governance Group (QCGG) in May 2024.

Strategic Objectives End of Year Review	Quality Improvement - Objectives 1 - 4 Risk 14 – Operating Model

QI Objective 1 - *Quality Improvements on how we keep patients safe in the Waiting Room:*

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

QI Objective 2 – *Quality Improvement Strategy:*

The initial 2-year strategy was approved in August 2023. The QI team are currently in the year 2 deliverables. There will not be an updated strategy as QI will be included in the Trust Strategy.

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

To date the team have trained 436 colleagues across the Trust in QI methodology, this equates to 8.6%, this is slightly less than the 10% target but is linked to the difficulties the team have had in abstracting colleagues from our Contact Centres. This has been resolved now as the QI training is included within the EOC/111 key skills programme. The committee is really pleased to see that our people across different parts of the Trust are embracing QI and keen to utilise the methodology to address local issues.

QI Objective 4 - Capacity and capabilities to deliver changes to the SI process through the implementation of the national framework for PSIRF.

This has been fully implemented. The Patient Safety Oversight Group has been established and has met twice.

Feedback from the region is positive. The Incident Review groups are being met with positivity, attendance at these meetings is averaging 15-18 colleagues who would not historically have had any oversight of the incidents process. Learning from these groups is being shared across the region.

The PSIRF training target has not been achieved, however there is a plan with the core team being trained in a train the trainer course to deliver key investigation methodology to investigation managers.

Risk: The Trust are yet to meet the NHSE standard in ensuring all those involved in the oversight of patient safety incidents receive Oversight of learning from patient safety incidents training.

Mitigation: The Trust have secured an NHSE approved supplier to deliver this training. It is expected to be delivered once all Executive and Non-Executive roles are recruited to following the Executive restructure and recruitment currently underway. Subject matter experts and those who have completed the training are members of the PSOG and IRG.

Strategic Objectives End of Year Review	Quality Improvement - Objectives 5-6

QI Objective 5 - Improvements in Out of hospital cardiac arrest survival rates from point of initial contact through to deployment of volunteers and specialist resources.

This work is overseen by the Cardiac Arrest Outcomes Improvement (CAOI) programme and has seen some challenges in making progress in some areas:

- GoodSam – A focus in Q1 will be to address the ongoing challenges with the governance and dispatch processes to fully realise the potential of this project.
- Increasing numbers of CFRs in the community – this is led outside of the CAOI programme, to date there have been an extra 128 CFRs recruited, how they are utilised is still work in progress with less than 10% of cardiac arrests having a CFR allocated and less than half of that number arriving first on scene. A key driver is to improve how they are dispatched in 2024-25, a National Mobilisation App (a dispatch tool) workstream is due to go live in the summer, it is hoped that this will improve the efficiency of CFR dispatch.
- Telephone CPR continues to be a challenge with the mean compliance of 53.11% of the recognition of cardiac arrest. A working group is in place that is reviewing this and has already identified themes from clinical audits that is informing the development of training for EMAs.
- The committee noted a link to the location of Public Access Defibrillators and areas of deprivation, it was felt that this will link into some of the health inequalities work that will commence shortly.

QI Objective 6 - Building on existing pre-hospital maternity education and training in response to local and national cases/reports to enhance patient care and experience.

During 2023-24 1354 colleagues have been trained, the 2024-25 key skills programme includes a three-hour session on managing maternity incidents.
Joint training between local maternity services and SECAmb is in place across Kent & Sussex, training in Surrey is yet to commence but is likely to go live within the year.
The Trust now has two Out of Hospital Newborn Life Support Instructors with a further colleague completing in July 2024. The aim of this is to have our own faculty within 12 months, this will allow the Trust to deliver courses internally and to look for opportunities to income generate in the future.

A Maternity Training Lead has been recruited to support the Consultant Midwife in delivering this training.

The committee noted the good progress that has been made in this area.

Strategic Objectives End of Year Review	Quality Improvement - Objectives 7-8

QI Objective 7 - A Quality and Performance Management Framework that runs from our Patients to the Board (QAF)

The committee noted that this work has progressed well. The system quality groups have been established and are embedding within the regions.

Quality Leads will be in place by the end of Q1.

The Quality Management System has been embedded and forms part of the QCGG agenda with a section on focussed care a set item.

The system will take a further year to fully embed but the committee noted that they had seen a tangible change in the way the teams are working and how the information is flowing in both ways through the QAF.

QI Objective 8 - A Quality Assurance and Engagement Framework through local visits, that helps us assure the improvement we are making (QAE visits)

Three quarters of the Operating Units including EOC/111 have had their initial review, themes have been identified across all areas and this is being shared across the region.

The Committee have suggested that the team look to work with the Quality Committees at local hospitals to share any learning.

The QAV now incorporates the new CQC Framework and have incorporated "We" quality statements.

The committee felt that we need to maintain the focus on Well led and Safe domains, with continued focus on IPC.

Strategic Objectives End of Year Review	Responsive Care - Objectives 6

RC Objective 6 - To improve the effectiveness of resource utilisation (RPI)

The Trust continues to utilise all specialist resources effectively. PP hubs continue to make an impact to the resources within their areas. Critical Care Paramedic (CCP) teams continue to provide station support time, demonstrating the value-added benefit of having these specialist and advanced clinicians.

Further work is required to understand why Community First Responders are not doing as many calls as before.

The new strategy will develop how the Trust uses specialist resources going forwards.

Strategic Objectives End of Year Review	Sustainability & Partnerships - Objectives 3

SP Objective 3 - Optimised Urgent and Community referral pathways, avoiding conveyance to EDs, and improving the use of the ICS SPOAs

The Patient Flow Programme continues to support with getting our patients to the right place at the right time using the Urgent Community Response Single Point of Access.

This programme has supported the Trust improving the Hear & Treat rate and has supported the reduction in conveyances.

This programme is our new strategy in action.

Serious Incident Annual Report 2022-23	

The annual report was presented and discussed. It was acknowledged that with PSIRF now in place the Trust has moved on significantly since the period included in the report.

Specific Escalation(s) for Board Action	The only escalation noted was the concerns that the Trust no longer has a nominated CQC Relationship Manager. The Interim Executive Director of Quality & Nursing is trying to control access routes into the Trust as request for information are coming in to different people. If there is no progress with this then the Trust will raise their concerns to NHS providers for support.

	The committee welcomed the quality and timeliness of the papers, which helped support discussion and scrutiny of assurance. It was also good to see different colleagues attend to present papers.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Quality Account
2023/24

Introduction

The Quality Account is a report on the quality of our services over the 2023/24 financial year. The quality of the services is measured by looking at:

- **Patient safety**
- **• Effectiveness of patient care**
- **Patient feedback about care provided**

This report also provides information on improvements we have made over this period and gives us the opportunity to share our successes with those that matter most, our patients.

The Quality Account is broken down into three parts:

- **Part 1** of the report contains a statement of quality from our Chief Executive.
- **Part 2** reports on our progress over 2023/24 and outlines our priorities for improvement for 2024/25. This section also details 'statements of assurance from the board' and 'reporting against core indicators'. These statements contain mandated wording to ensure we have provided a sufficient update on each aspect of the service provided over 2023/24.
- **Part 3** of the Quality Account is an opportunity to share other aspects of quality from across the Trust that have not already been discussed. This includes any other information relevant to the quality of health services provided or subcontracted during the reporting period.

Contents

Part 1

Statement of Quality from Our Chief Executive

I am pleased to introduce our annual Quality Account for 2023/24. This report outlines the work we have carried out in the past year to ensure the quality and safety of the care we provide to our patients is maintained and where required, improved. The report also details our priorities for the 2024/24 as we look to ensure the improvements we have made are cemented across the organisation.

During 2023/24 we remained in the national Recovery Support Programme (RSP) – a programme run by NHS England to support challenged Trusts. SECAmb was placed in RSP in 2023 as a result of concerns raised around leadership and governance the CQC's Well Led Inspection and our on-going Improvement Journey is focussed on addressing these concerns. Working together with NHS England and our local partners, our aim is to exit RSP during 2024/25.

As part of our overall improvement programme and despite the challenges, we have continued to make real progress during this period in a broad range of areas. We have developed new ways of partnership working across our local NHS system and improved the responsiveness of the service we provide to our patients.

2023-24 continued to see significant pressure on the ambulance service and on the wider healthcare system. Despite this, we were one of only two ambulance services nationally to meet the temporary 2023-24 Category 2 call response time target of 30 minutes, with patients being responded to in an average 28 minutes and 2 seconds.

This is an extremely important category of call where some 60 per cent of all our calls fall. We also performed well against the national average in other call categories, but we recognise the need to build on this further and deliver improved performance across all categories of call in order to achieve the performance rightly expected by our patients. I am also pleased to see that we have made significant improvements in consistently delivering improved call answer times.

I welcome the progress we have made in delivering against our quality priorities set out last year. You can read more in the report about how we continue to improve training in maternity/obstetric emergencies, our closer working with Urgent Community Response (UCR) teams across our region, and how we are developing and improving our listening and engaging opportunities with patients, and their families and carers.

Our closer working with UCR teams is very much about making sustainable long-term change. This is really important work which is seeing more patients across our region receiving specialist care in their own homes instead of being admitted to hospital.

A key partner in this project, and the first to go live on a new portal providing its clinicians with secure access to information on our computer aided dispatch (CAD), system was Sussex Community NHS Foundation Trust in March. It now has all seven of its UCR teams live across the county.

Through this work, we expect to see a growing number of patients assisted via the portal and managed by local UCR teams without further support from the ambulance service. This not only ensures our patients are receiving appropriate care in their homes but also helps free up our teams to be as available as possible to attend higher priority and life-threatening calls.

I am pleased with the work which has taken place in the last year as we look to improve our listening and engagement opportunities with our patients and the public. October 2023 saw us launch a new 999 patient experience questionnaire, which in turn has been supported by a leaflet and a business-style card with a link to the questionnaire to be handed out to patients and at events. We have also installed stickers on our ambulances encouraging patients and their families to feed back on their experience of our service.

This year also saw us launch a Community Forum which is held virtually on a bi-monthly basis. The insights gained from the forum will continue to feed into various projects and workstreams to help inform their progress with the views of our patients.

We have set out our proposed priorities the 2024/25 Quality Account for 2024/25. These include work to improve on the feedback colleagues receive on patient clinical records (PCRs). We aim to improve the quality of PCR completion and support meaningful supervision to colleagues.

We will also provide further support to colleagues by building on previous work to ensure that all patient discharges are either directly supported by a senior clinical decision maker, most commonly an Advanced Paramedic Practitioner working in one of our Urgent Care Hubs, or receive a 'post discharge review', also undertaken within the Urgent Care Hub.

Our final QA priority will involve working to address health inequalities. A two-year programme, structured in two phases will focus on patients with maternity and/or severe mental illness presentations with the intention to improve clinical care and outcomes through the reduction in health inequalities.

I recognise that we have much work to do to ensure we are delivering the service our patients expect. I and the whole leadership team are committed to ensuring improvements are sustainable and deliver real change.

I can confirm that the Board of Directors has reviewed this Quality Account and can confirm that it is an accurate description of the Trust's quality and performance.

Simon Weldon
Chief Executive Officer

South East Coast Ambulance Service
NHS Foundation Trust

Part 2

Priorities for Improvement and Statements of Assurance from the Board

This section of the Quality Account is divided into two parts; the first sets out progress made against the priorities for 2023/24 and the second details the key areas of development for the next 12 months.

2.1 Quality Priorities for Improvement

Looking back – report on the 2023/24 Quality Priorities

There were three priorities during this period:

- **Priority 1** (Domain: Clinical Effectiveness) – Learning from Reviews to Improve Safety in Maternity Obstetric and Neonatal Care
- **Priority 2** (Domain: Patient Safety) – Utilising Urgent Community Response Services to Improve Safety for Patients in the Clinical Stack
- **Priority 3** (Domain: Patient Experience) - Listening and Engaging with our Patients, their Families and Carers

Domain	Clinical Effectiveness
Priority Title:	Learning From Reviews to Improve Safety in Maternity Obstetric and Neonatal Care
Review of 2022/23 report	Historically ambulance crews have received little or no training in maternity/obstetric emergencies and we know this can cause anxiety for staff. Maternity calls often involve caring for two patients (Parent and Child) who can become very unwell very quickly. SECAmb has been proactive in addressing this by employing a consultant midwife who is responsible for training colleagues and supporting maternity care in the pre-hospital setting. Whilst this is extremely positive, we are keen to continually improve and having been involved in 13 Healthcare Safety Investigation Branch (HSIB) maternity investigations over 2022/23, we wanted to focus on this area to ensure that we are maximising our opportunity to get it right for all patients and their babies.
The aim for 2023/24	• Joint training session with ambulance crews and midwives relating to the management of maternal emergencies in the community. This will be facilitated through the use of immersive mannequins and simulation to replicate real life scenarios. • Work with Joint Royal College Ambulance Liaison Committee (JRCALC) to amend and update national ambulance guidance. Currently three areas of the guidance have already been updated with five outstanding. • Areas we have completed in Include breech birth, haemorrhage and care of the newborn. We are working on these in order of prevalence first. • Development of quick view videos on how to respond to medical emergencies for JRCALC to support the new guidance. • Working with Resuscitation Council UK (RCUK) to develop a specific pre-hospital newborn resuscitation course. • Work with acute trusts to deliver joint training on pre-hospital maternity emergencies. • Meet with partners at NHS Pathways to review and collaboratively amend guidance based on data relating to harm/incidents/near misses.
Our performance	• Joint training session with ambulance crews and midwives relating to the management of maternal emergencies in the community. This is ongoing and continues to run every month with different trusts across the geographies of Kent, Surrey and Sussex. • We are aiming to hold a session every quarter in each County. For SECAmb, this will be monthly as we cover 3 counties. Every session we hold includes 15 midwives and 15 ambulance clinicians. • Work with Joint Royal College Ambulance Liaison Committee (JRCALC) to amend and update national ambulance guidance. Ongoing work with the maternity national leads group/AACE. By the end of 2024 it is hoped that all maternity guidance will be based on best practice and recent evidence base. • Development of quick view videos on how to respond to medical emergencies for JRCALC to support the new guidance. Due in 2024. This work is yet to be commenced. • Working with Resuscitation Council UK (RCUK) to develop a specific pre-hospital newborn resuscitation course. This is now a recognised course with RCUK and 6 have been delivered across the 4 nations. • Work with acute trusts to deliver joint training on pre-hospital maternity emergencies. See above (Point 1) • Meet with partners at NHS Pathways to review and collaboratively amend guidance based on data relating to harm/incidents/near misses. Ongoing work with pathways and more recently it has been discussed at Clinical advisory group (CAG) re senior clinicians interrupting module 1 on pathways to advise on time critical care/interventions. This will be new for SECAmb.
Did we achieve this priority	We have achieved all of the actions we intended to carry out except for JRCALC videos which will hopefully be completed by the end of 2024 – early 2025.
Actions to be carried forward to 2024/25	Silent videos on JRCALC.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Domain	Patient Safety
Priority Title:	Utilising Urgent Community Response Services to Improve Safety for Patients in the Clinical Stack
Review of 2022/23 report	When an individual calls 999 or 111 their call is triaged by an Emergency Medical Advisor (EMA) or a Health Advisor (HA) who will run through an assessment and either reach an outcome or pass the caller over to a Clinical Supervisor / Clinical Advisor (CA) for further assessment. In some cases, the EMA / HA may be able to transfer the caller straight through to a clinician, however many calls will be transferred into the clinical stack, where they await a call back from a CA. For calls that result in a Category 3 (C3)[1] / Category 4 (C4)[2] ambulance disposition (outcome) this will generally be the case and under periods of service pressure the clinical stack will become very large despite internal processes to mitigate this. This means patient call backs will be delayed and thus result in delays to their care, which poses a risk to patient safety.
The aim for 2023/24	• Reduce the number of calls in the clinical stack to provide capacity for more timely call backs. • Consider referring patients to services more appropriate for their needs. • Upskilling SECAmb Clinicians through training and education to support appropriate referrals to UCR services. • Work on falls referrals pathways and introduce referral guidance to SECAmb clinicians to support referrals for patients to Urgent Community Response (UCR) services, which may include "Remote callers". [3] • Partnership working to introduce daily contact with Key UCR providers to support patient referrals from the 999 C3/C4 validation Clinical Support Desk (CSD) queue and introduction of the Computer Aided Dispatch (CAD) 'Portal' functionality to facilitate UCR direct support to 999.
Our performance	On the 9th May 2023, the Trust commenced daily calls with the Urgent Community Response services that respond within our footprint. Starting on this date with one team, these calls grew, with teams from across the SECAmb footprint joining a half hour meeting at lunchtime where an opportunity was given for them to review incidents awaiting an ambulance response and saw incidents being sent directly to them for their attendance, saving the need for an ambulance response. On the 6th February 2024, the Trust went live with its first UCR team having access to a Cleric portal which sees incidents within the C3 / C4 validation list being sent directly to them between the hours of 10:00am and 16:00pm every day. Since this date the Trust has seen the launch of 7 teams using the portals within the Sussex boundary, where calls are able to be sent directly to the UCR teams. Since the go live of the portals, 364 cases have been passed to the UCR teams with 73 accepted and completed by them (20.05%). 43.62% of these cases have been auto rejected with 36.85% deemed clinically inappropriate and 13.48% rejected due to no capacity within the teams to manage. These last two reasons also include times when there is not a clinician available to manage the patient available i.e. only physiotherapist available rather than an Advanced Care Practitioner. The ongoing meetings and review with each individual team is supporting a system approach to understanding where there are gaps in provision within each team / locality. Although the acceptance rates for the teams appears low, it is this capturing of rejection reasons that is supporting understanding how a wider system review could support the development of individual teams in the future, as well as supporting the Trust's delivery of care to our communities.
Did we achieve this priority	This priority is currently partially achieved, however continues to be a primary focus for delivery teams. Engagement continues with service managers to support the completion of required governance steps as well as training requirements for individuals to allow for the go live of individual portals. Remaining teams are at differing stages within this process. Regular engagement sessions continue with the UCR teams already on board with the portals to review and learn from cases, as well as continuing to support the daily hosted calls for teams who are not yet ready for the portal.
Actions to be carried forward to 2024/25	To continue the delivery of a sustainable approach to UCR use across the Trust footprint, which will involve onboarding all teams in the early months of 2024/25.

1 Category 3 – urgent calls. Patients may be treated by ambulance staff in their own home. We aim to respond within two hours 90% of the time.

2 Category 4 – less urgent calls. Some of these patients will be given advice over the telephone or referred to another service such as a GP or pharmacist. These less urgent calls will be responded to at least nine out of 10 times within 180 minutes.

3 Remote callers – an individual that calls 111 / 999 and is not with the patient at the time of calling.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Domain	Patient Experience
Priority Title:	Listening and Engaging with our Patients, their Families and Carers
Review of 2022/23 report	Good patient experience is associated with better clinical safety and effectiveness, and we know that a successful organisation must listen to its patients' needs and design products and services accordingly. We also know that whilst we think we know what patients want, we often fail to ask or engage them directly.
The aim for 2023/24	• Development of a Patient Experience Questionnaire (PEQ) for our 999 service in which service users will have the opportunity to submit anonymous feedback on the service they received. • We will work with the communications team to 'spread the word' about the work we are undertaking and how the public can get involved. This will include updating our website, advertising the information on social media platforms and putting QR codes in the back of ambulances which link to a digital survey. • A Community Forum will be launched for service users or representatives to attend to share experiences following contact with our 111 and 999 services. We will use this opportunity to share with patient, family or community representatives an overview of current projects we are working on with the aim of seeking feedback and partnership to get these right. • A patient volunteer programme will be available to invite the public to work with us on Quality Improvement projects, identified through the above two points to support co-production and meaningful partnerships with patients, their families and carers or those that represent them. • Engaging with external stakeholders and Trusts to share the programme of work as it develops with sufficient oversight and seek ongoing feedback and opportunity for collaboration and improvement.
Our performance	We successfully achieved what we set out to do over 2023/24 and accomplished the below aims: • We launched a 999 Patient Experience Questionnaire in October 2023. • We have been working with our communications team and external partners to spread the word of all patient involvement opportunities. • We have developed a leaflet and a business style card with a link to our PEQ to hand out to patients and at events. We also added this information to the care advice leaflets which are given to patients we do not transport to another care facility which states the treatment carried out. We have also had some A5 stickers produced to go in the back of ambulances with this link. • We launched a Community Forum which is held virtually on a bi-monthly basis. The insights gained from these groups is fed into various projects and workstreams to help inform them with the patient voice. • We have developed a QI project based on patient feedback from the Community Forum and other engagement sessions with the support of patient representatives. This is a digital booklet which advises what happens when you use our services and when to use them. • We have held multiple focus groups to support Trust wide projects such as the Quality Improvement group for Keeping Patients Safe in the Stack (KPSitS). This group worked with patients to develop the wording used within a script used by call handlers to deliver Estimated Time's of Arrival for ambulances. • • We developed a volunteer agreement to begin recruiting patient representatives to work on QI projects with us. • We are regularly collaborating with other NHS Trusts and seeking feedback and assurance from our external stakeholders such as Healthwatch and National Ambulance Service Patient Experience Group (NASPEG).
Did we achieve this priority	We achieved the majority of this priority as detailed in our performance over 2023/24 above. This workstream has evolved and there are plans in place to ensure this area is given continuous focus to move forward in a proactive way supporting ongoing improvement. One area we partially achieved relates to the number of surveys we had hoped to receive back each month from our PEQ. In hindsight, the planning involved to launch the various materials with the QR code and link to our PEQ took longer than expected. Once the A5 stickers have been fitted in ambulances we expect to achieve our goal of receiving 100 responses a month. It should be noted that these stickers are being added to ambulance from March 2024 and this is expected to help us see this improvement within the first quarter of 2024/25.
Actions to be carried forward to 2024/25	In 2024/25 we are planning to further develop our patient involvement and inclusion, this will include the below actions: • Achieve a 999 Patient Experience Questionnaire (PEQ) response rate of at least 150 responses per month. • Deliver 6 patient engagement sessions, these could include: – Community Forums – Focus Groups – Mind mapping sessions. – Panel / review session with patient representative • Gain 4 diverse patient representatives in patient engagement sessions from the below groups: – BAME – Lived experience, mental health, – Lived experience, physical health. – LGBTQ+

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Looking forward – report on the 2024/25 Quality Priorities

Identification of the 2024/25 priorities was undertaken following a new agreed process to enhance our stakeholder engagement with multi-professional groups at different levels of the organisation and the wider public.

The new process involved two surveys; one for our professional stakeholders which included staff, Integrated Care Board (ICB), Health Oversight and Scrutiny Committee (HOSC) and Healthwatch, the other was for the public. The surveys provided opportunity for people to share what is important to them to help us improve over 2024/25 and from the feedback we formed a long list of 23 potential priorities.

We then met with key internal stakeholders. The long list of priorities was discussed as well as other areas for consideration that had not already been identified through the stakeholder engagement. The shortlisted priorities were discussed in detail regarding alignment to the Trust strategy, consideration of interdependencies and alignment to the three priority domains of patient experience, clinical effectiveness, and patient safety.

The final proposed priorities for the Quality Account for 2024/25 are as detailed below:

- **Priority 1** (Domain: Clinical Effectiveness) – Feedback to staff on PCR
- **Priority 2** (Domain: Patient Safety) – Unsafe discharge
- **Priority 3** (Domain: Patient Engagement) – Health Inequalities

Domain	Clinical Effectiveness
Priority Title:	Feedback to staff on Patient Care Records (PCR)
Why is this a priority?	Patient Care Records (PCR) are integral to safe and effective patient care affording an opportunity to ensure smooth transition of care across the patients care journey. They also support the Trust in measuring effectiveness and development of our clinical care through audit. The quality of patient care records are variable as identified through central audit and there is no defined and consistent process that supports PCR review and feedback at a local level. Feedback to colleagues on the quality of PCR completion will support the supervision agenda aligned to the Trust's developing strategy. This will improve the quality of documentation; as a result, promoting safe and effective patient care and support the Trust in measuring effectiveness and development of clinical care.
Aims and objectives	To improve the quality of patient care record completion and support meaningful supervision to our colleagues.
How will we achieve this?	• Review learning following supervision project that supports needs for improved feedback • Define/scope the problem statement/hypothesis. • Identify and engage with key stakeholders. • Baseline current practice; obtaining feedback from Clinical Audit, Legal Services. • Generate options to drive improvements. • Test/implement option(s). • Monitor & continue to adjust options. • Monitor outcomes
How will we know if we have achieved the quality measure?	• An approved procedure within the Trust outlining our approach to PCR review and feedback. • Evaluation of the Quality Improvement process followed (Define Measure Analyse Improve and Control (DMAIC)) • Improved quality of PCR completion evidenced through Clinical Audit.

Domain	Patient Safety
Priority Title:	Unsafe Discharge
Why is this a priority?	Discharging patients on scene creates risks for a variety of reasons. These include factors such as: • The nature of out-of-hospital care • The lack or immediate support and supervision • The variety of conditions patients present with • The inherent and ever-present reality of the fallibility of clinical decision making • The risk of diagnostic error. We know from audit and other lines of enquiry that our staff are clinically effective and comply with policy and guidance when undertaking discharge. However, there are factors that limit this and so we need to consider measures that support clinicians to ensure that patients are not harmed should an unsafe discharge occur.
Aims and objectives	The aim is to ensure that all discharges are either directly supported by a senior clinical decision maker, most commonly an Advanced Paramedic Practitioner (Urgent & Emergency Care) – APPUEC - working in an Urgent Care Hub, or receive a "post discharge review", also undertaken within the Urgent Care Hub setting undertaken by APPUEC teams.
How will we achieve this?	We have trialled a post-discharge review system in our Tangmere Urgent Care Hub. This saw over 100 discharges reviewed during the project. The process requires an APPUEC to review all discharges within 1 hour of the episode of care taking place. The purpose of the PDR is to appraise the care documented and check that adequate advice and safety netting is in place, along with checking that the clinical impression is correct. The APPUEC can either follow-up with the crew to gain more information, or in cases of significant concern contact the patient by telephone to follow-up. During the pilot, 3 cases were deemed unsafe and some required crew follow-up. The entire process is based on learning, supervision, and good leadership. It accepts that humans make mistakes for a variety of reasons, and that the post-discharge review system is there to trap any errors before they reach a consequential stage, such as the patient deteriorating. The data captured in the system is aggregated and on full roll out will be used to inform local and regional organisation clinical learning and system design/development. There are also opportunities for Quality Improvement activities using the data.
How will we know if we have achieved the quality measure?	• Increase number of post-discharge reviews undertaken • Monitoring of staff access to discussing discharge on scene (using the Emergency Clinical Advice Line (ECAL) system – emergency care advice line to speak to an APPUEC) • An overall increase to as near to 100% in the total of post-discharge reviews and ECALs combined. • Reduction in complaints relating to discharge. • Reduction in legal claims and coronial concerns relating to discharge. • Increased education and supervisory activity utilising data from post-discharge review.

Domain	Patient Experience
Priority Title:	Health Inequalities
Why is this a priority?	Health inequalities are 'unfair and avoidable differences in health across populations and between different groups within society' (The King's Fund 2020). 80% of health inequalities arise due to the different conditions which we are born into, live, work and age. Health inequalities are affected by the factors that determine a person's ability to access healthy choices equally. Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. There are five clinical areas of focus, for children and 5 for adults, which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims. These adult priorities are: 1. Maternity 2. Mental illness (SMI) 3. Chronic respiratory disease 4. Early cancer diagnosis 5. Hypertension case-finding and optimal management and lipid optimal management The priorities for children are: 1. Asthma 2. Diabetes 3. Epilepsy 4. Oral health 5. Mental health
Aims and objectives	This is a 2-year programme structured in 2 phases focusing on patients with maternity and/or severe mental illness presentations with the intention to improve clinical care and outcomes through the reduction in health inequalities.
How will we achieve this?	• Engage with colleagues to implement two specific task & finish groups for this work. • Define/scope the problem statement/hypothesis. • Identify and engage with key stakeholders. • Work with the ambulance health inequalities group to identify others working on the same priorities. • Baseline current practice across a range of measures/metrics. • Validate and visualise the data. • Generate options to drive improvements. • Test/implement option(s). • Monitor & continue to adjust options. • Monitor outcomes. • Communications.
How will we know if we have achieved the quality measure?	Quality metrics related to the care delivered to patients with maternity and/or severe mental illness – exact details will need to be worked up and quantified during the define stage.

References

NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities.
AACE documents - Ambulance Services helping to reduce Health Inequalities - aace.org.uk

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.2 Statements of Assurance from the Board

This section of the quality report includes a series of statements of assurance from the Trust Board on particular points of the service, set out by the 'detailed requirements' document provided by NHS England and NHS Improvement. The exact form of each of these statements, as specified by the quality accounts regulations, is laid out below with full details included.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

	Prescribed information	Form of statement
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	**Provided and/or sub-contracted services** During 2023/24 the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provided two relevant health services: 999 Accident & Emergency Services and NHS 111 Integrated Urgent Care (IUC) service.
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	The South East Coast Ambulance Service NHS Foundation Trust has reviewed all of the data available to them on the quality of care in two of these health services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2023/24 represents 96% of the total income generated from the provision of relevant health services by the South East Coast Ambulance Service NHS Foundation Trust for 2023/24.

	Prescribed information	Form of statement
2.	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts.	**Clinical Audit** During 2023/24 ten national clinical audits and nil national confidential enquiries covered relevant health services that South East Coast Ambulance Service NHS Foundation Trust provides.
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period South East Coast Ambulance Service NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits that South East Coast Ambulance Service NHS Foundation Trust was eligible to participate in during 2023/24 are as follows: Cardiac Arrests Return of Spontaneous Circulation (ROSC) at Hospital (All patients) ROSC at Hospital (Utstein) Post ROSC Care Bundle Survival to 30 days (All patients) Survival to 30 days (Utstein) STEMI Care Bundle STEMI Timeliness Stroke Diagnostic Bundle Stroke Timeliness Falls Care Bundle (Pilot)

Part 2: Priorities for Improvement and Statements of Assurance from the Board

	Prescribed information	Form of statement
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	**Provided and/or sub-contracted services** During 2023/24 the South East Coast Ambulance Service NHS Foundation Trust (SECAmb) provided two relevant health services: 999 Accident & Emergency Services and NHS 111 Integrated Urgent Care (IUC) service.
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	The South East Coast Ambulance Service NHS Foundation Trust has reviewed all of the data available to them on the quality of care in two of these health services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2023/24 represents 96% of the total income generated from the provision of relevant health services by the South East Coast Ambulance Service NHS Foundation Trust for 2023/24.
2.	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts.	**Clinical Audit** During 2023/24 ten national clinical audits and nil national confidential enquiries covered relevant health services that South East Coast Ambulance Service NHS Foundation Trust provides.
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period South East Coast Ambulance Service NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits that South East Coast Ambulance Service NHS Foundation Trust was eligible to participate in during 2023/24 are as follows: Cardiac Arrests Return of Spontaneous Circulation (ROSC) at Hospital (All patients) ROSC at Hospital (Utstein) Post ROSC Care Bundle Survival to 30 days (All patients) Survival to 30 days (Utstein) STEMI Care Bundle STEMI Timeliness Stroke Diagnostic Bundle Stroke Timeliness Falls Care Bundle (Pilot)

Part 2: Priorities for Improvement and Statements of Assurance from the Board

	Prescribed information	Form of statement
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	The national clinical audits that South East Coast Ambulance Service NHS Foundation Trust participated in during 2023/24 are as follows: Cardiac Arrests ROSC at Hospital (All patients) ROSC at Hospital (Utstein) Post ROSC Care Bundle Survival to 30 days (All patients) Survival to 30 days (Utstein) STEMI Care Bundle STEMI Timeliness Stroke Diagnostic Bundle Stroke Timeliness Falls Care Bundle (Pilot)
2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that South East Coast Ambulance Service NHS Foundation Trust participated in, and for which data collection was completed during 2032/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. Cardiac Arrests 100% ROSC at Hospital (All patients) 100% ROSC at Hospital (Utstein) 100% Post ROSC Care Bundle 100% Survival to 30 days (All patients) 100% Survival to 30 days (Utstein) 100% STEMI Care Bundle 100% STEMI Timeliness 100% Stroke Diagnostic Bundle 100% Stroke Timeliness 100% Falls Care Bundle (Pilot) 100%

	Prescribed information	Form of statement
2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of ten national clinical audits were reviewed by the provider in 2023/24 and South East Coast Ambulance Service NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	Improvement actions taken this year are: 1. We joined the national technical guidance committee for developing the new falls audit. This audit aims to improve care for elderly fallers. We also participated in discussions regarding possible new national audits in respect of non conveyance and end of life care 2. We expanded the feedback trial with Medway OU, audit data for national audits is now circulated monthly across all Trust sites. 3. We developed an audit dashboard that is sent to all OUs so they can identify non-compliant incidents and trends in non-compliance. 4. We have expanded the feedback project to send “Thank You” letters to all clinicians after their patient survives an Out-of-Hospital cardiac arrest. 5. We continue to improve the Cardiac Arrest Annual Report. This year, it was sent to external audiences via the Communications Dept.
2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

	Prescribed information	Form of statement
		The reports of thirteen local clinical audits were reviewed by the provider in 2023/24. This year, we focussed on the quality of drug administration, 8/13 audits this year were drug related. Clinical Audit and Medicines Governance have worked closely this year to implement the following improvements: 1. Audit data has been used to inform the Medicines Administration module on Key Skills 2. A PGD audit tracker has been developed so that audits are available during the review phase of a PGD. 3. Audit has improved the wording of PGDs such as removing contradictory exclusions/ inclusions, changing sedation management plans and removing the ambiguous term "shocked" from post-ROSC PGDs. 4. Audit results highlighted the practice of seeking "Top Cover" to administer drugs outside of the PGD, leading to a reduction in non-compliance. 5. Audit highlighted that drug box labels were giving patients the wrong dosage information; the labels have now been changed.
3.	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	**Research & Development** The number of patients receiving relevant health services provided or subcontracted by South East Coast Ambulance Service NHS Foundation Trust in 2023/24, who were recruited during that period to participate in research approved by a research ethics committee was 157.

	Prescribed information	Form of statement
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	**Commissioning for Quality & Innovation (CQUIN)** A proportion of South East Coast Ambulance Service NHS Foundation Trust income in 2023/24 was conditional on achieving quality improvement and innovation goals agreed between South East Coast Ambulance Service NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2023/24 and for the following 12- month period are available electronically at NHS England » Commissioning for Quality and Innovation.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	
4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	
5	Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	**Care Quality Commission (CQC)** South East Coast Ambulance Service NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered with CQC with no conditions attached to registration. The Care Quality Commission has not taken enforcement action against South East Coast Ambulance Service NHS Foundation Trust during 2023/24.
5.1	If the provider is required to register with CQC: (a) whether at end of the reporting period the provider is: i. registered with CQC with no conditions attached to registration ii. registered with CQC with conditions attached to registration (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	
6	Removed from the legislation by the 2011 amendments	
6.1		

Part 2: Priorities for Improvement and Statements of Assurance from the Board

	Prescribed information	Form of statement
7	Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
7.1		
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	N /A acute services
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	N /A acute services
9	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.	**Information Governance** The Trust is currently working towards the Data Security and Protection Toolkit (DSPT) 2023/2024 submission which is due on the 30 June 2024. For the 2022/2023 return the overall score was 'Approaching Standards', the DSPT was submitted with an Improvement Plane which was received and approved by NHS England. This plan has now been completed.
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	**Payment by Results (PbR)** South East Coast Ambulance Service NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	
11	The action taken by the provider to improve data quality.	**Data Quality** South East Coast Ambulance Service NHS Foundation Trust will be taking the following actions to improve data quality: • Developing a digital and data strategy, of which data quality will be a critical pillar. This will ensure that data quality is aligned with the strategic vision and goals of the Trust, and that the Trust leverages the potential of digital technologies and data analytics to improve service delivery and patient outcomes. • Expanding scope and reach of data quality teams within SECAmb. This will involve increasing the capacity and capability of the data quality staff, enhancing their training and development opportunities, and establishing clear roles and responsibilities for data quality across the Trust. • Agreeing data quality improvement plans with commissioners. This will entail working collaboratively with the commissioners to identify and prioritise data quality issues, set realistic and measurable targets, and monitor and report on progress and outcomes.

Learning from Deaths

	Prescribed information	Form of statement
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2023/24 8626 of South East Coast Ambulance Service NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 2091 in the first quarter; 1875 in the second quarter; 2416 in the third quarter (22/23); 2244 in the fourth quarter (22/23).
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31/03/2024, 341 case record reviews have been carried out in relation to 341 of the deaths included in item 27.1. In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 60 in the first quarter; 161 in the second quarter; 60 in the third quarter; 60 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 0 representing 0%for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. These numbers have been estimated using the Subjective Judgemental Reviews of a panel of Clinicians.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3. .	• The standard of care provided at the time of death by our staff is excellent in the majority of cases. • Clinicians are compassionate when caring for the relatives of those deceased. • The attempts to resuscitate patients are in line with policy and standards of practice. • In a small number of cases staff could improve their documentation on the patient records. • In a small number of cases the ambulance service should have got to the scene quicker (in line with Ambulance Response Programme targets) but the panel did not find evidence that any delays contributed to the death of the patient for the random selection of cases that were audited.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	• Staff education on writing clearly within the patient record. • Advice to staff not to include photos of the deceased in the patient record. • Education of staff regarding being clearer on why resuscitation has been stopped.
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	• Less incidents where the patient records include photos of the deceased. • Greater number of patient records which have clearly described rationale for ceasing resuscitation.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	0 case record reviews and 0 investigations completed after 31/03/2023 which related to deaths which took place before the start of the reporting period.
27..8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	0 representing 0% of the patient deaths during are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.3 Reporting against Core Indicators

Since 2012/13 NHS foundation Trusts have been required to report performance against a core set of indicators using data m

The Ambulance Response Programme (ARP) set a suite of performance targets for call answering and operational response to a range of categories of call. These metrics are collated from all ambulance services and are proxy measures for patient care where the speed of response required is assigned according to clinical need according to triage.

The table below shows the overall performance against all ARP targets as well as call outcomes between 01 April 2022 and 31 March 2023.

	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	55339	00:09:19	00:16:55
C1T	00:19:00	00:30:00	35307	00:11:09	00:20:28
C2	00:18:00	00:40:00	390093	00:34:50	01:12:22
C3		02:00:00	171161	02:43:55	06:15:39
C4		03:00:00	4886	03:14:30	08:10:53
HCP 3			10887	02:53:30	06:28:48
HCP 4			9718	03:40:43	08:44:20
IFT 3			5510	03:17:48	08:15:35
IFT 4			1279	03:41:37	08:46:51
HCP 60				0:0:0	0:0:0
HCP 120				0:0:0	0:0:0
HCP 240				0:0:0	0:0:0
ST	All Incidents		229803	31.96%	
SC	All Incidents		418434	58.19%	
HT	All Incidents		70850	9.85%	
Count of Incidents			719087		
Count of Incidents with a Response			648237		
999 Mean	Call Answer Target 00:05		891915	00:51	
999 90th	Call Answer Target 00:10			02:54	
Trust EOC 999 Abandoned Calls			42225	4.5%	
UHU	Calls Answered		1010519		

Part 2: Priorities for Improvement and Statements of Assurance from the Board

The table below shows the overall performance against all ARP targets as well as call outcomes between 01 April 2023 and 31 March 2024.

		Target		AQI		
Category		Mean	90th Centile	Incidents	Mean	90th Centile
C1		00:07:00	00:15:00	57100	00:08:33	00:15:39
C1T		00:19:00	00:30:00	35832	00:09:59	00:18:28
C2		00:18:00	00:40:00	406542	00:28:02	00:57:07
C3			02:00:00	170493	02:09:11	04:46:31
C4			03:00:00	5574	02:32:10	05:52:34
HCP 3				12457	02:07:48	04:35:55
HCP 4				10117	02:45:07	06:21:22
IFT 3				6151	02:19:20	05:17:25
IFT 4				1408	02:46:18	06:44:39
HCP 60					0:0:0	0:0:0
HCP 120					0:0:0	0:0:0
HCP 240					0:0:0	0:0:0
ST	All Incidents			236196	30.99%	
SC	All Incidents			433065	56.83%	
HT	All Incidents			92828	12.18%	
Count of Incidents				762089		
Count of Incidents with a Response				669261		
999 Mean	Call Answer Target 00:05			871230	00:20	
999 90th	Call Answer Target 00:10				01:15	
Trust EOC 999 Abandoned Calls				21172	2.4%	
UHU	Calls Answered			984681		

The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:

- National guidance and definitions for Ambulance Quality Indicators (AQI) submissions to NHS digital when producing category performance information.
- This information is published every month by NHS England.
- This information is reported to the Board of Directors monthly in the integrated Quality and Performance report.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve these indicators, and so the quality of its services, by

- In line with national ambulance guidelines, SECAmb assesses its level of escalation according to the Resource Escalation Action Plan (REAP). This is a document that provides a structure under which to assess current pressures, linked to a suit of recommendations of appropriate actions to manage associated risk against quality and performance issues. REAP is reviewed on a weekly basis at the Senior Management Group with final agreement of the REAP level reached by the Executive Management Board.
- In addition to the use of REAP, the Trust uses a Surge Management plan (SMP) to manage much more dynamic fluctuations in service challenge – often across hours rather than days. This plan has a structured stepped process with clearly defined actions to be taken to dynamically manage and/or mitigate risks/issues.
- Implementation of new operational rotas has been completed and the success has ensured the demand profile is being met, which has led to a reduced reliance on the use of private ambulance providers.
- In addition, this has led to the Trust spending less time at SMP level 4 and the current REAP level is 2.
- There is a reduction in sickness levels.
- Driving forward a recruitment programme for both front line operational areas and the Emergency Operations Centre (EOC). The recruitment has been successful and the operational areas are now at full establishment. The EOC recruitment has proven positive with good progress made. Whilst the drive for the EOC is still in place the ongoing success has meant the pace has been slowed and the required number of onboarding training reduced.
- Within the EOC the C3/C4 validation process was moved from being tested throughout implementation into business as usual from 9th January 2024. To gain assurance of this process harm reviews of patients have been carried out. These reviews have found the process does support patients in reaching the most appropriate disposition or service referral for their need and helps to prevent unnecessary delays.
- Additionally, on 6th September 2023 the Trust joined the NHS England national C2 Segmentation pilot. This approach enabled the validation of C2 calls and their segmentation depending on their defined symptom group / discriminator. This is intended to support in times of higher demand and reduced operational hours so initially was in place daily between 12 noon to 20:00. As the pilot progressed the times were extended and as of 23rd October 2023 was fully implemented from 08:00 to 02:00.
- Local commissioners and providers have developed a range of pathways including 2-hour Urgent Care Response (UCR), virtual wards and frailty pathways, all of which provide care and treatment support for specific clinical presentations. The regional focus on the use of community pathways as an alternative to conveying patients to emergency departments. This has been fully implemented across the Sussex Integrated Care Systems (ICS) and engagement is underway with Kent and Surrey ICS'.

Stroke

This table demonstrates the percentage of patients with suspected stroke, assessed face to face, who have received an appropriate diagnosis bundle. The diagnostic bundle includes completing a face, arm, and speech test, testing the patient's blood pressure and testing the patient's blood glucose level. This data is published quarterly by NHS England.

Month	SECAmb Stroke Diagnostic Bundle Compliance	SECAmb Mean	National Average	Highest National	Lowest National
Mar-23	98%	97%	97%		
Apr-23	97%	97%	98%		
May-23	98%	97%	98%	100%	93%
Jun-23	98%	97%	98%		
Jul-23	98%	97%	98%		
Aug-23	97%	97%	98%	100%	94%
Sep-23	98%	97%	98%		
Oct-23	98%	97%	98%		
Nov-23	98%	97%			
Dec-23	96%*	97%			
Jan-24	92%*	97%			
Feb-24	91%*	97%			

* This measure has shown a steep performance drop since November 2023. This is because we have been using auto-compliance figures due to staff shortages. Auto-compliance figures are only used for months where data is not required for national reporting. We are in the process of recruiting an analyst and will ensure that the next NHSE submission has audited figures, therefore this will not affect our national audit performance.

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described because 85% of records are now electronic patient care records.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- Telemedicine for stroke where a stroke doctor triages the patient in the patient's home or in the ambulance and decides if the patient should be conveyed to a stroke unit. This has already significantly improved stroke patient flow in Kent, but benefits to stroke patients as an individual group are difficult to quantify given the overall subsuming of this group into Category 2 ambulance response calls.
- Operating Unit (OU) level audit data has begun to identify individual OUs and clinicians to feedback compliant and non-compliant incidents.

The annual data set, at the time of writing this report, is incomplete as NHSE submissions are 3 months in arrears. Therefore, full analysis and interpretation cannot be completed until all data is validated. It is expected that the full data set will be available by the end of June 2024, which will then require verification, analysis and reporting. This is in-line with national timelines.

ST elevation myocardial infarction (STEMI)

A STEMI occurs when a coronary artery becomes blocked by a blood clot, causing the heart muscle supplied by the artery to die. It belongs to a group of heart conditions known as acute coronary syndromes.

The table below demonstrates the percentage of patients with a pre-existing diagnosis of ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period. The care bundle includes administration of aspirin, glyceryl trinitrate (GTN), analgesia (pain relief) and the recording of two pain scores. This data is published quarterly by NHS England.

Month	SECAmb STEMI Care Bundle Compliance	SECAmb Mean	National Average	Highest National	Lowest National
Mar-23	67%	74%	73%		
Apr-23	67%	67%	77%	95%	52%
May-23	66%	67%	77%		
Jun-23	67%	67%	77%		
Jul-23	73%	67%	77%	95%	60%
Aug-23	62%	67%	77%		
Sep-23	63%	67%	77%		
Oct-23	65%	67%	77%	96%	57%
Nov-23	66%	67%			
Dec-23	71%	67%			
Jan-24	70%	67%			
Feb-24	66%	67%			

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described because 85% of records are now electronic patient care records.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- A deep dive into the reason for non-compliance found that the most common areas of non-compliance continue to be the administration of analgesia and the documentation of two pain scores. This part of the care package needs to be balanced against the need to keep on scene times short.
- Joint Royal Colleges Ambulance Liaison Committee (JRCALC) to review Acute Coronary Syndrome (ACS) national guidelines to simplify analgesia guidance.
- OU level data on STEMI is being circulated to OUs and feedback to OUs is being planned.
- OU STEMI platform allows OUs to look at their STEMI performance.

The annual data set, at the time of writing this report, is incomplete as NHSE submissions are 3 months in arrears. Therefore, full analysis and interpretation cannot be completed until all data is validated. It is expected that the full data set will be available by the end of June 2024, which will then require validation, analysis and reporting. This is in-line with national targets.

Sepsis (Retired as a National Audit, Reported at Trust-level only)

This table demonstrates the percentage of patients with sepsis, assessed face to face, who have received an appropriate care bundle. This measure only includes patients with an infection NEWS2 (National Early Warning Score) of 7 or above. The patient must have a respiratory rate, level of consciousness, blood pressure and oxygen saturations documented. High flow oxygen and fluids must be administered where appropriate, and a hospital pre alert call made.

No further national submissions are required as Sepsis has been replaced as a Clinical Outcome Indicator by a Falls indicator in 2023/24. The Trust will continue to locally monitor Sepsis Care Bundle compliance, although not report the data nationally following its withdrawal.

Month	SECAmb STEMI Care Bundle Compliance	SECAmb Mean	National Average	Highest National	Lowest National
Mar-23	88%	87%	No longer a national reporting requirement		
Apr-23	86%	87%			
May-23	84%	87%			
Jun-23	87%	87%			
Jul-23	88%	87%			
Aug-23	85%	87%			
Sep-23	88%	87%			
Oct-23	85%	87%			
Nov-23	87%	87%			
Dec-23	88%	87%			
Jan-24	87%	87%			
Feb-24	88%	87%			

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described because 85% of records are now electronic patient care records.

Actions being taken

No actions to improve this element has been made this year. Instead, we have been working with internal colleagues to update the sepsis guidance now that we have more autonomy over the care bundle. Once sepsis care guidelines are agreed we will change the audit criteria and continue to audit as a local audit only.

Patient Safety Incidents

The number of patient safety incidents reported within the Trust during 2023/24 was 3,496 and the number of such patient safety incidents that resulted in severe harm or death was 31 (0.9%).

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described for the following reasons:

- Monitoring of data reported on Datix
- Information from Integrated Quality Report (IQR)
- Data reporting on the National Reporting and Learning System (NRLS)

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- Establishing and progressing with the Patient Safety Strategy
- Building of the DatixCloudIQ[4] (DCIQ)
- Implementation of Patient Safety Incident Response Framework (PSIRF) and Learning From Patient Safety Events (LFPSE) and incident workflow
- Auditing all incidents awaiting allocation and being investigated and chasing up the owners of these incidents
- Extensive work on clearing incident backlogs and breaches
- Focus on incident reporting in Serious Incident Group (SIG) and feedback in Quality Governance Group (QGG) 111/999 and Operations meetings
- Monthly Trust incident reporting training sessions for staff at all levels of the organisation

4 DatixCloudIQ (DCIQ) is a digital system that enables healthcare organisations to understand adverse events and implement strategies to enhance the delivery of care

ROSC

This table demonstrates the percentage of patients, where return of spontaneous circulation (ROSC) was achieved following a cardiac arrest, who received an appropriate care bundle. This data is published quarterly by NHS England.

Month	SECAmb ROSC Care Bundle Compliance	SECAmb Mean	National Average	Highest National	Lowest National
Mar-23	70%	74%	77%		
Apr-23	72%	72%	76%	99%	68%
May-23	69%	72%	76%		
Jun-23	70%	72%	76%		
Jul-23	69%	72%	76%	99%	37%
Aug-23	65%	72%	76%		
Sep-23	68%	72%	76%		
Oct-23	80%	72%	76%	100%	65%
Nov-23	73%	72%			
Dec-23	79%	72%			
Jan-24	78%	72%			
Feb-24	73%	72%			

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described because 85% of records are now electronic patient care records.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- The 2022/23 Annual Cardiac Arrest Report was circulated in Q3 of 2023/24.
- There has been a slight decline in performance between year start and year to date, with variable performance throughout the year. The reporting of the bundle requires clinicians to document the care they've provided. The below figures show that ROSC and patient survival is improving and so it is likely that this dip in performance is due to lack of documentation rather than lack of clinical care. SECAmb is contributing to improvement work at national level, looking at the efficacy and limitation of the care bundle. We have worked closely with the Cardiac Arrest Outcome Improvement Board and Operating Units to understand the barriers facing clinicians and will await national changes before implementing local improvement work.

The annual data set, at the time of writing this report, is incomplete as NHSE submissions are 3 months in arrears. Therefore, full analysis and interpretation cannot be completed until all data is validated. It is expected that the full data set will be available by the end of June 2024, which will then require validation, analysis and reporting. This is in-line with national targets.

South East Coast Ambulance Service
NHS Foundation Trust

Part 3

Other Information

Part 3 of the quality account is an opportunity to share other aspects of quality from across the Organisation that have not already been discussed. This includes any other information relevant to the quality of health services provided or subcontracted during the reporting period.

The information will be presented as a number of indicators within the following sections:

Freedom to Speak Up (FTSU)

Patient Safety

Clinical Effectiveness

Patient Experience

Freedom to Speak Up (FTSU)

The Freedom to Speak Up (FTSU) Team work independently within South East Coast Ambulance Service NHS Foundation Trust (SECAmb). The FTSU Guardian has direct access to the Board through regular meetings with the CEO and presentation of board report bi-annually. Leadership of the FTSU service is overseen by the Executive Director of Quality & Nursing, support is also provided by a Non-Executive Director (NED).

The FTSU team consist of a full time FTSU Guardian and two full time deputy FTSU Guardians. The team work collaboratively with leadership throughout the organisation to support the development of a culture where speaking up is seen as a valuable opportunity to improve services for staff, patients and the public, creating a supportive workplace with a focus on learning and improvement, allowing staff to raise their concerns without fear of reprisal.

Staff can raise concerns to the FTSU Team in several ways including a team email address, individually by email to the guardian or deputies, by phone using the whistleblowing hotline or in person. Staff can also raise concerns via a form available on the staff intranet, this route provides an option to do so anonymously.

The details on how to contact the FTSU team are shared on the staff intranet page, on posters around the Trust and on merchandise given out to SECAmb staff during FTSU engagement visits and events such as October FTSU awareness month. Our SECAmb intranet is available to all staff members and gives clear advice on raising concerns on a dedicated FTSU page and is where the Trust stores its 'Freedom to Speak up Policy.' This policy has been recently updated to align with national guidance.

The FTSU Team attend meetings, sites, universities and events to promote the work of FTSU as well as identify and break down potential barriers that might prevent staff members from feeling able to speak up.

SECAmb use FTSU data to triangulate with other areas of the organisation such as SI's, HR data and leavers surveys to enable early support to be put in place where necessary.

Aims and Objectives

- FTSU will support the organisation in improving the responses to staff survey questions relating to speaking up, including how safe staff feel to speak up.
- Our Trust will be establishing a network of FTSU ambassadors and aim to increase diversity amongst our FTSU network to support all staff to feel safe to speak up.
- FTSU webinars and university visits will continue, expanding this work to capture year two and three students.
- We will continue to look to improve the way in which we share learning within our organisation.

A FTSU dashboard enables the team to report on and present anonymised data about concerns received by the FTSU team, including number/type/area/theme to the organisation. The database records information that is required to be submitted quarterly to The National Guardians Office (NGO), making it easier to collate the figures and submit them via the online NGO portal.

Concerns raised to FTSU Team by Year/Quarter:

2021-2022	Number of FTSU Concerns Raised	2022-2023	Number of FTSU Concerns Raised	2023-2024	Number of FTSU Concerns Raised
Q1	19	Q1	20	Q1	46
Q2	19	Q2	35	Q2	51
Q3	60	Q3	52	Q3	62
Q4	46	Q4	60	Q4	69
Total	144	Total	167	Total	228

The FTSU Guardian has open access to and meets regularly with the Executive Team and reports quarterly to the Board on key themes and learning from concerns raised.

3.1 Our indicators

Patient Safety

Indicator 1: Keeping Patients Safe in the Clinical Stack (KPSitS) Quality Improvement Project

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

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

Texting of interim care advice to help support the reduction in the overall handling time for incoming 999 calls, thus allowing a quicker response for patients, commenced on 01 December 2023. Following a call with the service, patients now have the interim care advice sent to them by text. This means that patients have access to this information to refer to post call completion.

It is expected that this will reduce duplicate call volumes as well as reducing the Average Handling Time (AHT) of incoming emergency calls, meaning that the service can answer calls more quickly and respond to patients more efficiently and effectively. A recent review of data suggests that the implementation of interim care advice appears to have stabilised after an initial period of growth, indicating that it has become a routine part of business operations. This plateau in usage may suggest that staff members have integrated interim care advice into their workflows and are utilising it as intended. The improvement does not appear to have had a positive impact on callbacks and AHT as initially anticipated. The project team will continue to monitor this in the months ahead.

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

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

Indicator 2: Patient Safety Incident Response Framework (PSIRF) implementation and prioritisation

This indicator has been selected to showcase the developments within patient safety that have been progressed over 2023/24.

We have successfully implemented the Patient Safety Incident Response Framework (PSIRF)[5] ahead of the 1st of April deadline, with several key highlights:

- The publishing of our first Patient Safety Incident Response Plan (PSIRP).
- Delivery of the Trusts training plan in line with the National Patient Safety Syllabus.
- Re-structure of the Trusts governance groups to provide supportive oversight, mirroring each Integrated Care System (ICS) footprint in our region.

What we plan to do next:

Throughout 2024/25 we aim to develop a Trust wide safety improvement plan prioritising five key high-risk areas:

- Missed ST elevation myocardial infarction (STEMI)
- Harm following discharge on scene
- Safety during conveyance
- Delays to hands on chest
- Inter-facility transfer (IFT)

We also aim to increase the support we offer patients and/or their representatives following a patient safety incident, using open and honest conversations. We aim to continuously improve by using patient (or their representative) feedback.

We are committed to working with system partners to create Patient Safety Partners roles in our region, ensuring patients have a voice as we develop our patient safety agenda.

If you are interested in working with us as a patient representative or would like more information on how you can get involved, please contact engagementteam@secamb.nhs.uk

5 PSIRF: The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Indicator 3: Out of Hospital Newborn Life Support (OH-NLS) Course Development

What is it?

Resuscitation Council UK (RCUK) have created a new version of the one day Newborn Life Support Course (NLS) that addresses the needs of practitioners working in the out of hospital environment. This course has all of the key learning outcomes of "in-hospital" NLS, but also addresses the human factors, transport considerations, equipment and team working that is a feature of community resuscitation faced by ambulance service clinicians.

Why this is important?

The national maternity safety ambition is to halve the 2010 rate of stillbirths and neonatal deaths by 2025. Babies born out of hospital require good maternity care, skilled stabilisation, and in a small number of cases, more advanced resuscitation at birth and high-quality ongoing neonatal care. This has been raised in recurrent maternity reviews and the Ockenden enquiry and is a theme in many cases reviewed by the Maternity and Neonatal Safety investigation team (MNSI, previously HSIB). Deficits in neonatal resuscitation are a feature of some of the ambulance service cases, which this course will help to address.

The need for newborn resuscitation is unpredictable. The public rightly expects all ambulance clinicians dealing with the birth of their baby outside of hospital to be able to assist their newborn if they do not start to breathe after birth. There is clear evidence that resuscitation skills can degrade over time and that paramedics are not always confident in this skill due to infrequent exposure, so recertification of these skills combined with regular update training is vital.

SECAmb's role in this process

Dawn Kerslake (Consultant Midwife) has been part of the national team that has written and designed the course, championing fit for purpose education for paramedics that is designed to meet their needs and those of the patients they attend. A pilot version of the course was run within the SECAmb area in 2023, in collaboration with Air Ambulance Kent Surrey Sussex and is now being run at multiple sites across the UK.

Benefits to the Quality of Newborn Care in SECAmb

- SECAmb clinical staff gained experience in developing and improving the course, as well as receiving free practical training in the process.
- Development of some SECAmb staff as future OH-NLS Instructors who will continue to deliver and facilitate training for clinical staff locally.
- Helping to showcase SECAmb as an innovative and clinically focused service that is willing to collaborate and support national developments, helping with recruitment and retention into the service which will benefit patient care.

Indicator 4: Infection Prevention Control (IPC)

What is it?

The key aim for 2023/24 was to implement an Improvement Plan including all of the lessons learnt from the COVID-19 pandemic.
The main elements of the plan that have been completed are as follows:

- Introduction of the new NHS IPC Manual to replace the old Trust format in line with national guidance
- Development of Standard Operating Procedures specific to ambulance services
- Review and change to the old IPC audit tools, which are now IPC Practice Reviews
- Refresh all of our IPC Champions in field operations with the first training day planned for 22nd of April 2024
- Platform for a new IPC App in development to assist staff access relevant IPC tools
- Development of a Dispatch Desk Dashboard to help the leadership teams with compliance issues for IPC practices
- IPC Team attending all ICB forums for IPC as well as Post Infection Review meetings

This year the Trusts flu vaccination programme was managed by the IPC Team with support from relevant teams. A full Programme Plan was implemented, with the first planning meeting taking place in May 2023.

After the low uptake last year likely due to nationally acknowledged vaccination fatigue, the good news is that our Frontline Staff uptake improved by 16% to 72.9% and the Total Staff uptake was up slightly by 1.7% to 59.5%.

Lessons learnt have been added to next year's programme and the first meeting of the flu vaccination programme team has been scheduled for July 2024.

Clinical Effectiveness

Indicator 1: Category 3 / Category 4 Validation

On the 25th May 2021, the Trust joined the NHS England national pilot related to Category 3 & 4 validation. This process was introduced as a proof of concept to support the direction of patients to the most appropriate care pathways for their needs. Individual calls would present to a Clinical navigator for review and if it was felt that the patient would benefit from an enhanced assessment, the call would be passed to a clinician for an assessment.

Following an independent review, guidance was given to all services to develop and implement a validation process that serviced the needs of their communities.

In January 2023, the Trust amended the principles of Category 3 & 4 validation and commenced with current processes. All Category 3 & 4 calls taken by SECAmb now present for navigation and are reviewed and sent for clinical intervention if appropriate. This enables us to undertake enhanced clinical assessments for an even larger number of patients than before.

Since April 2023, we have seen a steady increase in the number of incidents where clinical intervention has taken place, with a total of 74% of Category 3 & 4 calls across the financial year, which have been through clinical validation (101,079 patients who have been assessed by a clinician to ensure we are supporting their care needs).

32% of these calls have been directed away from an ambulance response (32,341 patients) into other areas of the healthcare system or given advise on managing their own symptoms, with a further 24.08% of calls that have been assessed and subsequently upgraded to a higher response category (16,158 patients).

The Trust continues to review and monitor its performance in this clinical intervention process to ensure we continue to meet the needs of all our patients.

Indicator 2: Out of Hospital Cardiac Arrest

The Cardiac Arrest Outcomes Improvement Programme is made up of eight discrete projects all with the over-arching objective of improving survival from out of hospital cardiac arrest. The projects for 23/24 either build on the successful projects of 22/23 or provide ongoing focus to longer terms projects. Of note within the year we have seen the successful conclusion of a resuscitation feedback pilot, ensuring our clinical teams have the tools to learn and improve, as well as an enthusiastic drive to improve the delivery of high-quality telephone CPR by our Emergency Call Advisors.

The programme continues to drive engagement and innovation in improving outcomes from cardiac arrests and following ongoing development of our cardiac arrest registry we are now better placed to use data to drive improvement. This has helped us fully appreciate the value of bystander interventions, especially starting CPR and using a defibrillator prior to the ambulance arriving and this will be our primary focus for the coming year, along with tackling healthcare inequalities that influence outcomes.

For the period April to November 2024 (it takes time to collect and check outcome data and so this is always behind) we have a return of spontaneous circulation rate (return of a heartbeat not requiring CPR) of 29.9% and a survival rate of 11.7%, compared to the average for ambulance services in England of 29% and 9.7%.

For further information on resuscitation in SECAmb please read our Annual Cardiac Arrest Report available on our website Annual cardiac arrest report - bystander CPR key to improving survival rates - NHS South East Coast Ambulance Service (secamb.nhs.uk)

Indicator 3: Quality Assurance Visits (QAV)

This indicator has been chosen to demonstrate the advancements in Quality Assurance made during the 2023/2024 period. We have effectively established a Quality Assurance framework throughout the organisation, fostering connectivity from the operational level to the board in a regulated manner. Key highlights include:

- Establishment of the Trusts quality governance groups to establish a platform for overseeing and assuring quality at local, regional, and trust-wide levels.
- Development of localised Quality Assurance and Engagement visits, covering areas of excellence and areas for improvement, aligned with the CQC's key domains. The five key questions we ask - Care Quality Commission (cqc.org.uk)

What we plan to do next:

As we move into 2024/25, our next steps entail finalising the cycle of business for all Quality Assurance and engagement visits, with a keen focus on evaluating their effectiveness and analysing sustained improvement.

Additionally, Quality Leads will be established at a system level to support operational leaders in integrating a quality-focused agenda aligned with current best practices and the CQC Key domains.

Furthermore, we aim to deepen the embedding of a learning culture within our organisation, ensuring continuous sharing of best practices within patient services. This effort will be underpinned by robust quality improvement methodologies.

Patient Experience

Indicator 1: Urgent and Emergency Care (UEC) Hubs

In June 2023 Maidstone and Tunbridge Wells NHS Trust (MTW) approached SECAmb with a funded proposal to co-locate Advanced Paramedic Practitioners (APP) with hospital ACPs (Advanced Clinical Practitioner) and community Geriatricians or ACPs from Kent Community Health Foundation Trust (KCHFT) in one room, with the shared goal to support SECAmb crews on scene with patients to get their patients the right care, first time. The main driver

was to support admission avoidance and joint decision making for West Kent patients in the MTW catchment area and avoid unnecessary Emergency Department (ED) admissions.

This project began in September 2023 and has been ongoing since. The West Kent Hub, based at Paddock Wood MRC as seen over 2,500 patient discussions take place, often involving complex and frail patients, to understand their needs and wishes, and ensure their care is provided in the right place, first time.

As a direct result of this collaboration, we have avoided over 850 unnecessary admissions to ED. Instead, patients have been directly referred or signposted to other more suitable pathways, such as: Same Day Emergency Care (SDEC, 114), Surgical Assessment Unit (27), Urgent Community Response, known locally as the Home Treatment Service (324), Urgent Treatment Centres (53), GP in ED (127) or discharged safely with advice (388). Other pathways including Hospices or community services are also referred into.

Paddock Wood OU has seen a sustained 5% reduction in conveyance rates to ED since this project has started and seen an almost 33% increase in shared decisions being undertaken, which means our patients are directly benefiting from the safety and quality of these multi-disciplinary discussions.

Indicator 2: Strategy Clinical Case for Change and Models of Care

The strategy programme was established to create an ambitious and innovative, clinically-lead and patient centred, long-term strategy that ensures the Trust can sustainably deliver high-quality, equitable and efficient care to patients. Whilst maintaining our financial envelopes, enhancing the experience of our people, supporting our partners, and protecting our environment.

To enable the programme to achieve this a development framework was created which consisted of three core phases – Phase 1 Diagnose & Forecast, Phase 2 Generate Options & Prioritise and Phase 3 Deliver & Evolve.

Throughout all phases an extensive programme of engagement has been undertaken. This effort has involved our people, patients, and partners, gathering their invaluable insights on the clinical case for change, diagnostic work, and an analysis of our wider health and care systems' joint forward plans.

Why We Need to Change: Demand is projected to increase by 15% in 5 years due to ageing and complex health needs. Current models are unsustainable with increasing NHS operational, financial, and workforce challenges.

What We Are Suggesting: Align services with patient needs: differentiated physical response for emergencies, virtual response for non-emergencies. Introduce advanced technology, such as AI, for smarter triage and integrated virtual response.

Alignment with National Policy: Prioritisation of enhanced response times, staff experience, and system productivity; aligning with NHS recovery aims. Digital healthcare initiatives support national goals, ensuring operational effectiveness and financial sustainability.

We need a new strategy that allows us to face our challenges, doing nothing is not an option. A new strategy will enable us to deliver outstanding patient care, build a more sustainable organisation within the wider NHS and enhance the experience of our people.

Our strategy is to differentiate our response to best meet patient needs, by providing:

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 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.

Indicator 3: Learning from Deaths / End of Life Care (EoLC)

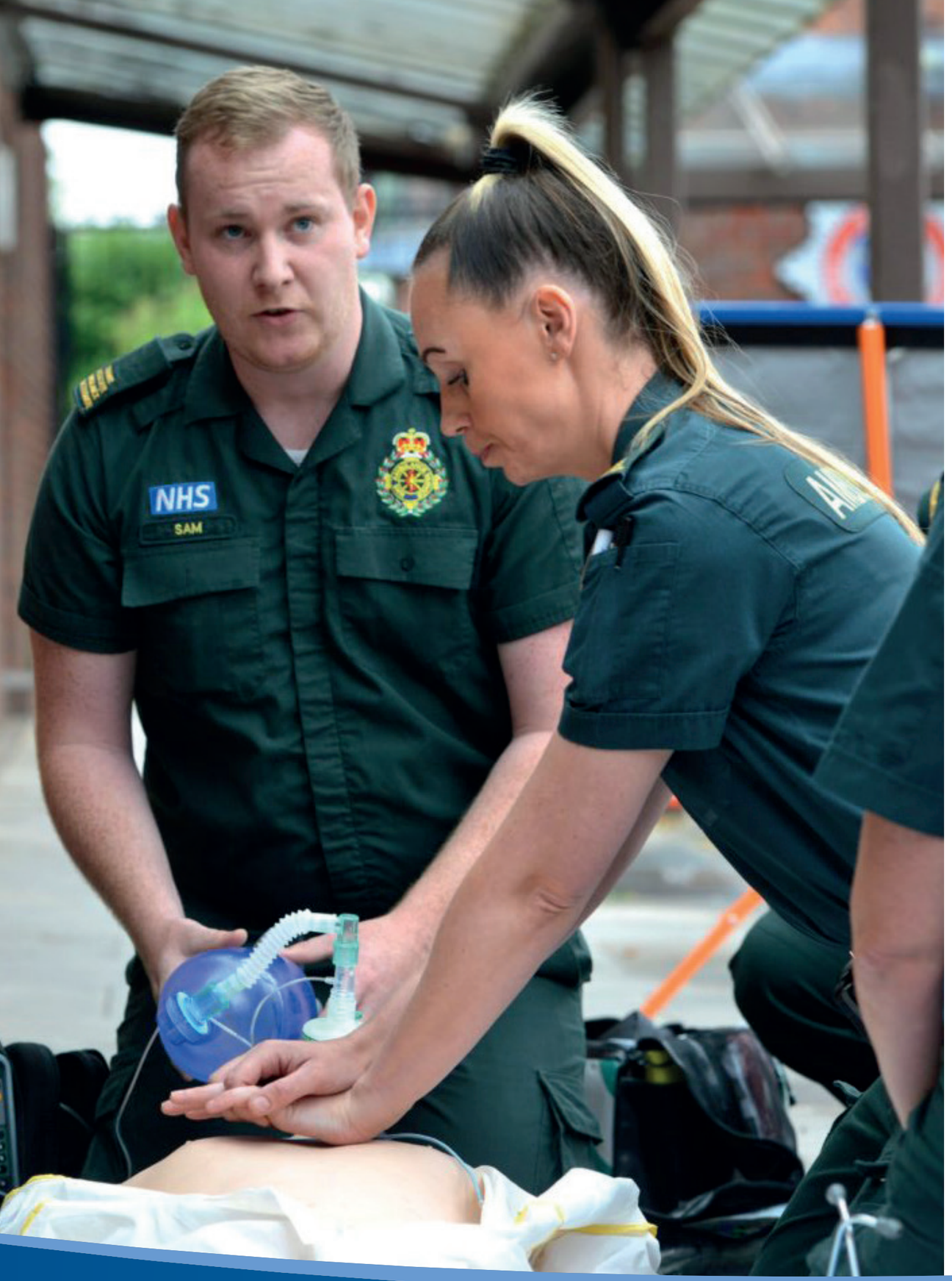
Managing acute crisis for patients at the end of their lives can be complex, difficult and often lead to outcomes that patients and families would not have initially wished for. Compounded by funding and capacity issues across the NHS and charity sectors, the ambulance service is being increasingly called upon to deliver care to patients who have a terminal diagnosis. SECAmb has for many years been one of the leading ambulance trusts in the UK for End of Life Care (EOLC), by being one of only a handful of trusts having a dedicated clinical EOLC Lead.

Our EOLC Lead works collaboratively with partner organisations who deliver both specialist and generalist palliative care across the four Integrated Care Systems covered by SECAmb. A significant amount of work in the 2023/24 financial year has been to collate and share the data we hold to enable a shared understanding of the needs of the patients the ambulance service see. This has led to several discussions across the system about improvements that could be made to care services. Further developments are planned that will improve the way in which we identify, code and document our interactions with EOLC patients. This improvement in data will identify any gaps in commissioning or service delivery.

Over the previous few months, significant work has taken place in developing a Model of Care for Palliative, End of Life and dying patients. This aspirational work will set out the innovations planned over the next five years. This has detail for several areas for development, including building on our offers of education for staff, referral pathways and new ways to access care and support for patients.

The Trust has also been working in collaboration with University of Southampton on a Marie Curie funded research project. The Paramedic Delivery of End of Life Care (ParAid) study aims to explore the experience of paramedics across England in delivering EOLC. Looking at what factors influence professional decision making to help shape practice, policy and service development in the future.

We move into the new financial year with excitement for the developments to come. Our priorities will be to deliver the Model of Care strategy and planning on how we operationalise those priorities. The EOLC Lead continues to work with partners across the trust and this will become increasingly important as we progress to new ways of working.



3.2 Mandatory Reporting Indicators

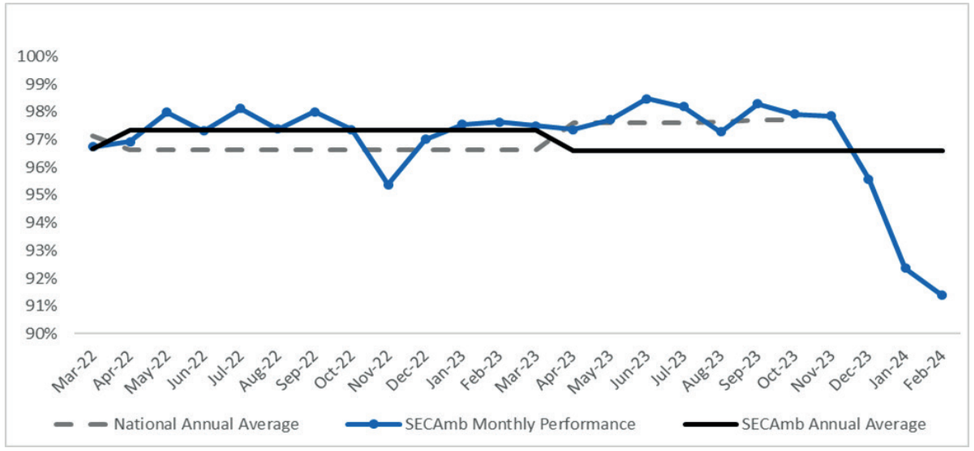
Ambulance Response Programme: Response Times

South East Coast Ambulance Service NHS Foundation Trust performance against the National Ambulance Response Programme (ARP) response times are reported in Part 2.3

Stroke

During 2023, the Trust continued to focus on several key strategic partnership initiatives, these included extensive involvement with stroke reconfiguration work to support revised pathways across Kent and Medway, Surrey and Frimley and developing pathways across Sussex. New technology developments (telemedicine) in Kent are shared widely to enable best practice region-wide and engagement with the Integrated Stroke Development Networks (ISDNs) will ensure this continues.

The percentage of suspected stroke or unresolved transient ischaemic attack patients, who received the stroke diagnostic bundle are as below:

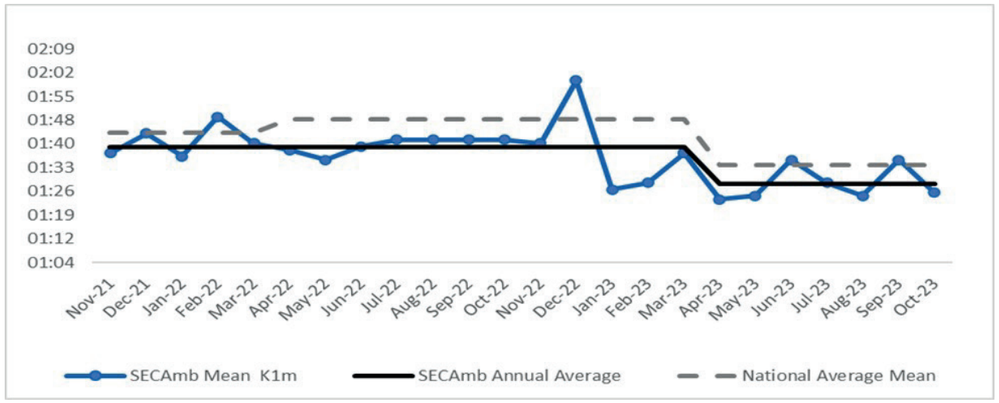


During the first half of 2023/24, the Trust saw broadly consistant perfomance that was in-line with the national average, however there has been a sharp decline in performance since November 2023. This is because we have been using auto-compliance figures due to staff shortages. Auto-compliance figures are only used for months where data is not required for national reporting. We are in the process of recruiting an analyst and will ensure that the next NHSE submission has manually audited figures, therefore this will not affect our national audit performance.

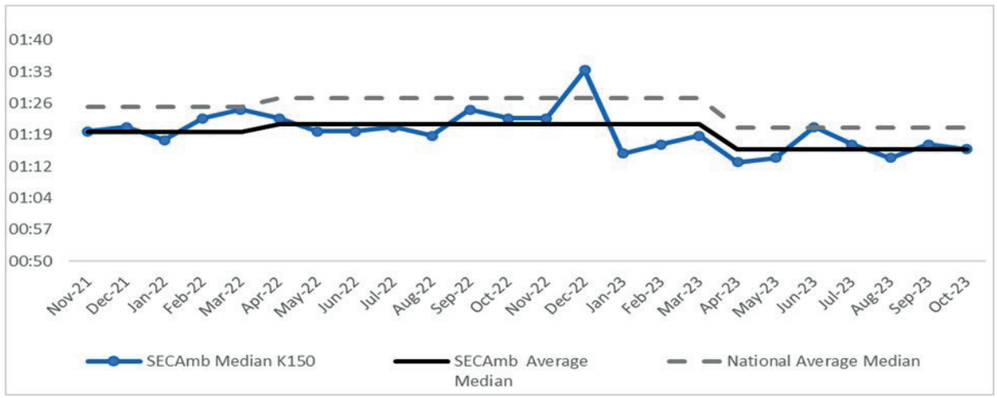
The diagnostic bundle includes recording of a Face, Arm, Speech Test (FAST) andassessment of blood glucose and blood pressure levels. Stroke audit identifies the documentation of blood glucose levels as contributing to a lowering of documentation audit compliance.

Part 3: Other Information

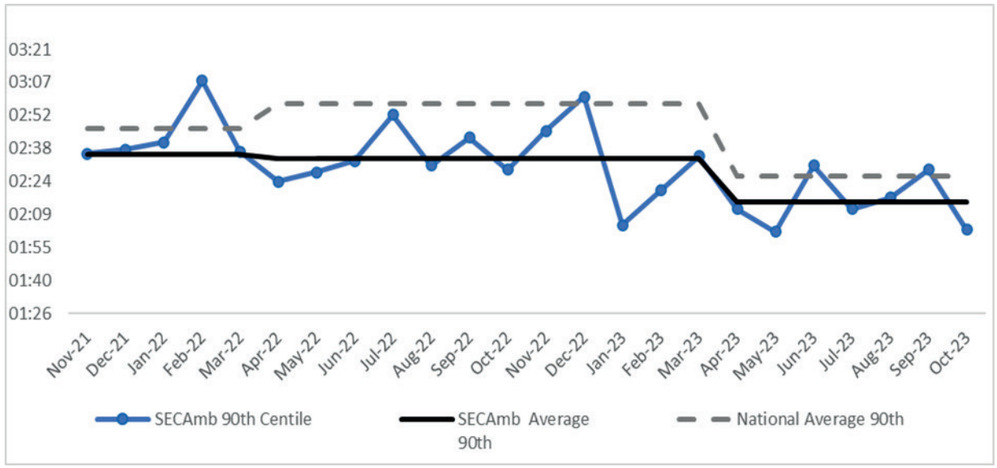
Mean time from call to hospital door for patients with confirmed stroke:



Median time from call to hospital door for patients with confirmed stroke:



90th centile time from call to hospital door for patients with confirmed stroke.



The oposite graphs, for Stroke timeliness indicators, show performance has improved from year start to year to date.

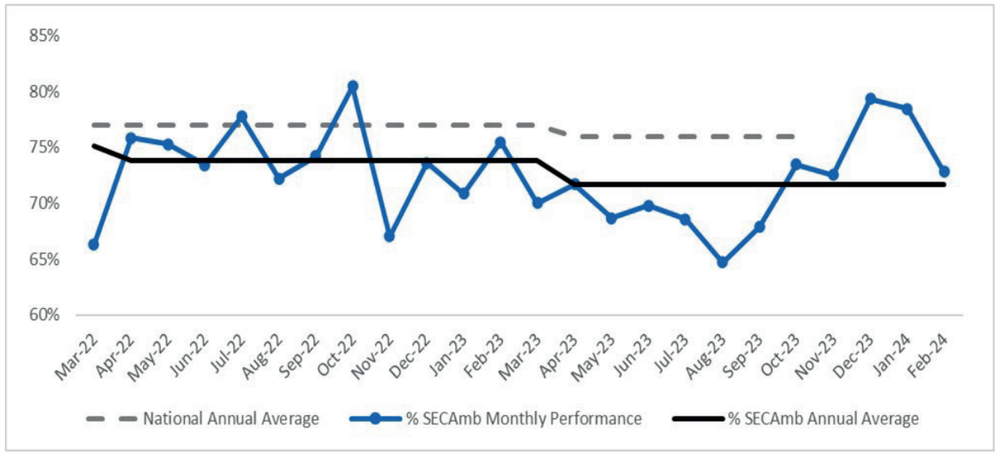
The introduction of telemedicine for FAST+ (suspected stroke) patients added around 6-7 minutes onto every on-scene time, but correspondingly shortened hospital treatment times by a greater degree after hospital arrival.

The timeliness figures remain faster than the national average.
A service evaluation has been undertaken by University College London which will help inform some of these information gaps.

Actions that are underway to improve stroke performance include a detailed audit to identify OU (Operational Unit) level performance and data, which will then inform further service improvement initiatives and sharing of best practice.

Return of Spontaneous Circulation (ROSC) after cardiac arrest

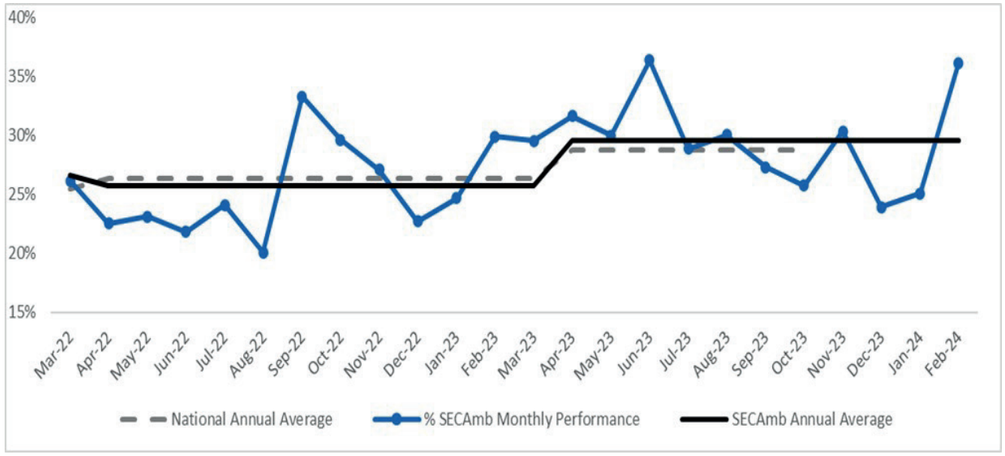
Percentage of patients where ROSC was achieved, who, where applicable, received a full bundle of care:



There has been a slight decline in performance between year start and year to date, with variable performance throughout the year. The reporting of the bundle requires clinicians to document the care they've provided. The below figures show that ROSC and patient survival is improving and so it is likely that this dip in performance is due to lack of documentation rather than lack of clinical care. SECAmb is contributing to improvement work at national level, looking at the efficacy and limitation of the care bundle. We have worked closely with the Cardiac Arrest Outcome Improvement Board and Operating Units to understand the barriers facing clinicians and will await national changes before implementing local improvement work.

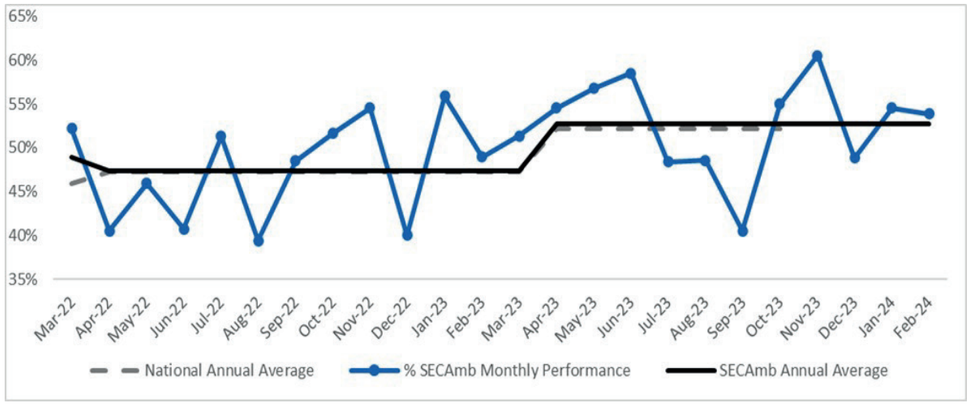
Part 3: Other Information

ROSC at time of arrival at hospital (all patients):



A detailed Annual Cardiac Arrest Report was published in 2023/24. ROSC at hospital continues to improve and is now higher than the national average. This provides reassurance that the ROSC care bundle compliance is likely to be a documentation issue and clinical care is improving.

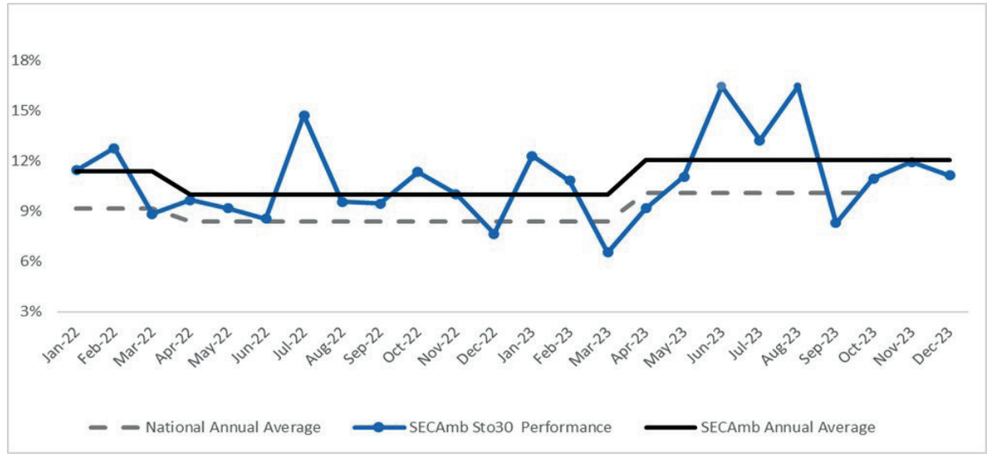
ROSC at time of arrival at hospital for Utstein Comparator Group:



The 'Utstein[6] comparator group' refers to patients who had a bystander witnessed cardiac arrest, in a VF/VT rhythm and cardiac in origin. Therefore, a higher rate of ROSC would be expected. This is a small subset and so variation between months is anticipated, however performance for the year remains within the normal variables and shows improvement aligned to the national picture.

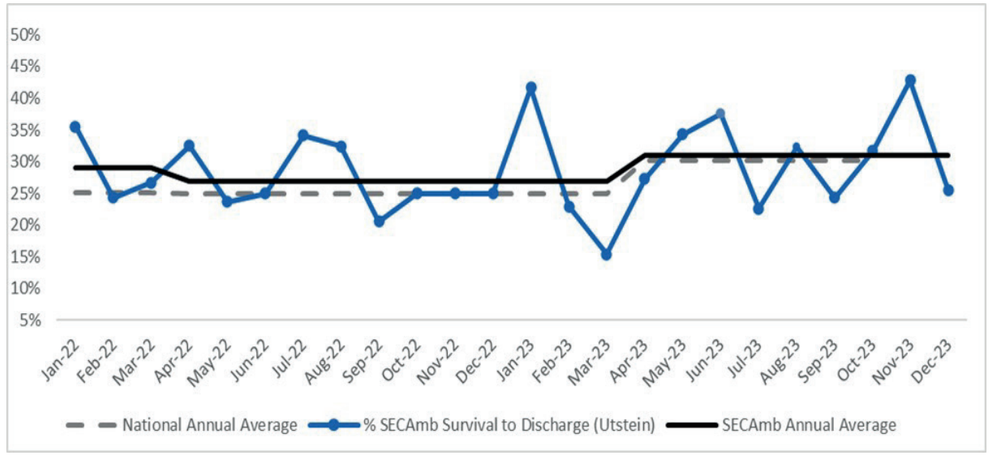
6 The Utstein style is a set of guidelines for unform reporting of cardiac arrest.

Survival to 30 days (Sto30) after cardiac arrest:



Performance in respect of this element has remained above the national average from year start to year to date, and the SECAmb year to date average is higher than recorded in 2022/23. A detailed Annual Cardiac Arrest Report was published in 2023/24. Improvement work continues to be co-ordinated by the Cardiac Arrest Outcome Improvement Programme Board.

Survival to 30 days after cardiac arrest for Utstein Comparator Group:

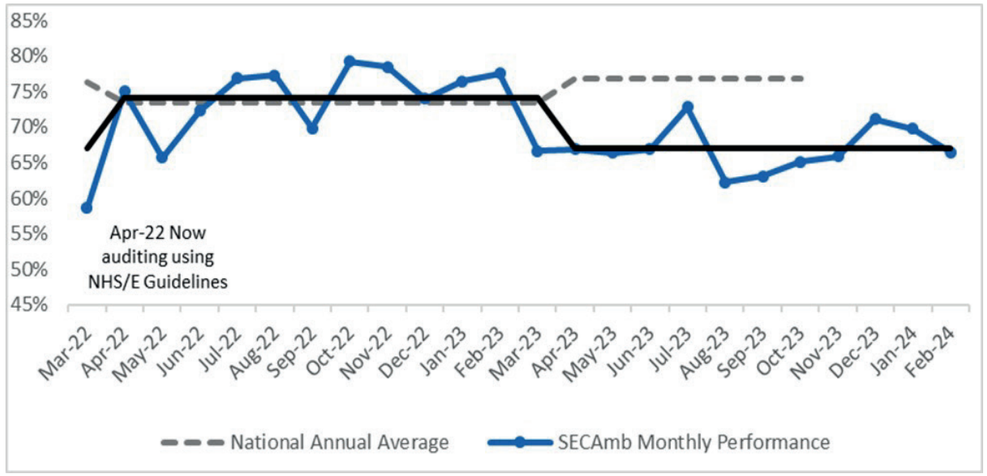


- The 'Utstein comparator group' refers to patients who had a bystander witnessed cardiac arrest, in a VF/VT rhythm and cardiac in origin. Therefore, a higher rate of ROSC would be expected.
- Due to the nature of the group being reported there is a higher probability of survival.
- Performance for the year has improved and remains within the normal national variables for this indicator. There is liable to be a degree of fluctuation due to the small number of incidents eligible for inclusion in this element.

ST Elevation Myocardial Infarction (STEMI)

The Trust aims to identify and measure its performance in 100% of the ST elevation myocardial infarctions (STEMI) cases that it attends. The Trust measures the quality of care provided to patients who are suffering a suspected STEMI by the proportion of patients who receive a bundle of care that is shown to improve outcomes for patients for this patient group.

The percentage of suspected STEMI patients, who received the STEMI care bundle is as below:



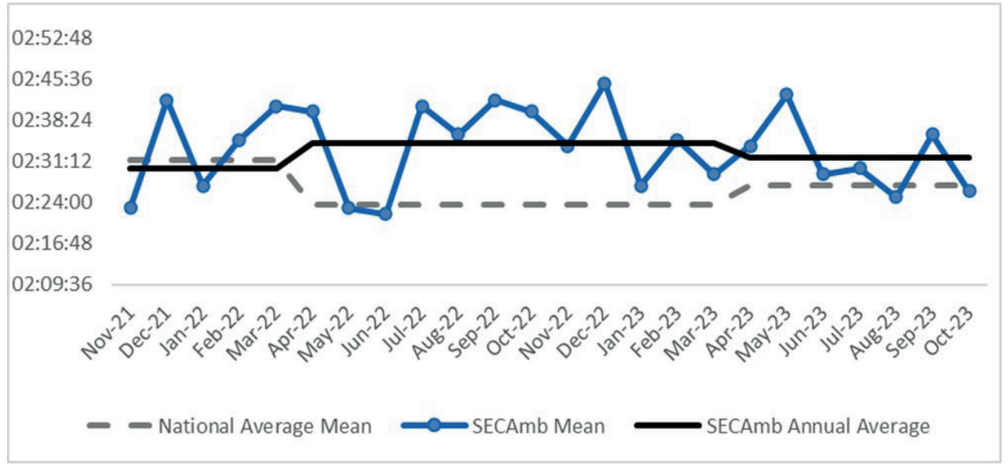
The percentage of patients experiencing a STEMI who received a full bundle of care:

- The Trust saw improvement in this care bundle in 2022/23, however this has not been sustained with a performance decline and SECAmb running below national annual averages.
- The diagnostic bundle includes administration of aspirin, glyceryl trinitrate (GTN), analgesia (pain relief) and the recording of two pain scores.
- The most common areas of non-compliance continue to be the administration of analgesia and the documentation of two pain scores.

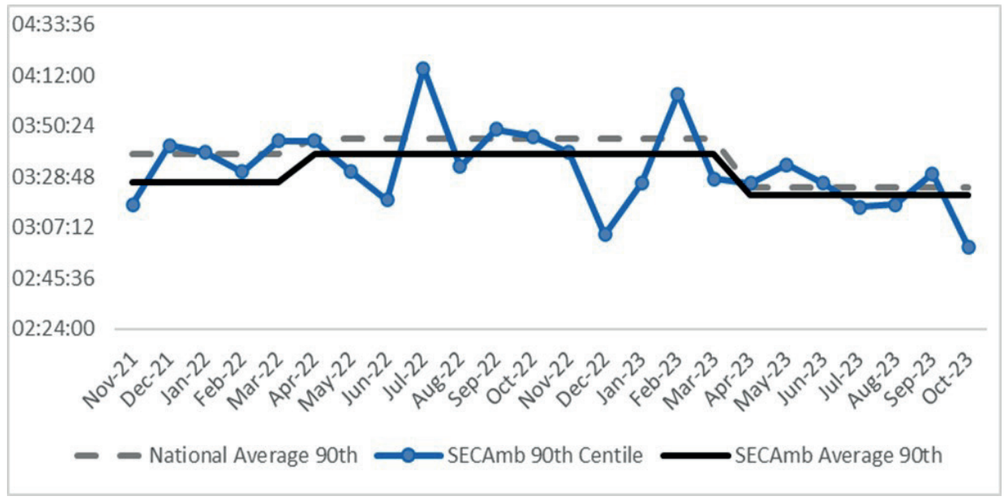
Improvement work will focus on joint working partnerships with the OUs to drive improved compliance on analgesia and 2 pain scores.

The Trust also records the call to angiography time for patients presenting with a STEMI, this is compared as the mean and the 90th centile against other trusts.

Mean time from call to angiography for patients with confirmed STEMI:



90th centile time from call to angiography for patients with confirmed STEMI:



The above graphs for STEMI timeliness indicators show expected levels of variance from year start to year to date.

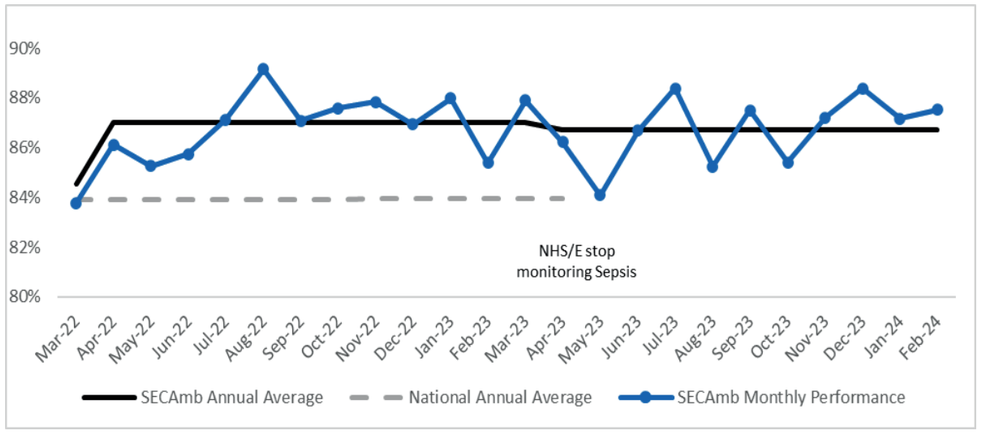
- Trust STEMI mean performance has improved but is currently longer than national averages, which have also improved.
- Trust STEMI 90th centile performance has improved and is broadly in line with national averages.
- A communication campaign previously took place to focus attention on reducing time on scene for STEMI. Focussed service improvement measures arose out of a detailed audit and service evaluation on STEMI care.

Sepsis care bundle (Internal reporting only)

The Trust aims to identify and measure its performance in 100% of the sepsis cases that it attends. The Trust measures the quality of care provided to patients who are suffering from sepsis by the proportion of patients who receive a Sepsis Care Bundle that is shown to improve outcomes for this patient group. This measure only includes patients with an infection NEWS2 (National Early Warning Score) of 7 or above. The patient must have a respiratory rate, level of consciousness, blood pressure and oxygen saturations documented. High flow oxygen and fluids must be administered where appropriate, and pre-alert call made to the receiving hospital.

In November 2022, NHS England advised no further submission was required as Sepsis was to be replaced as a Clinical Outcome Indicator by a Falls indicator in 2023/24. The Trust will continue to locally monitor Sepsis Care Bundle compliance, although not report the data nationally following its withdrawal.

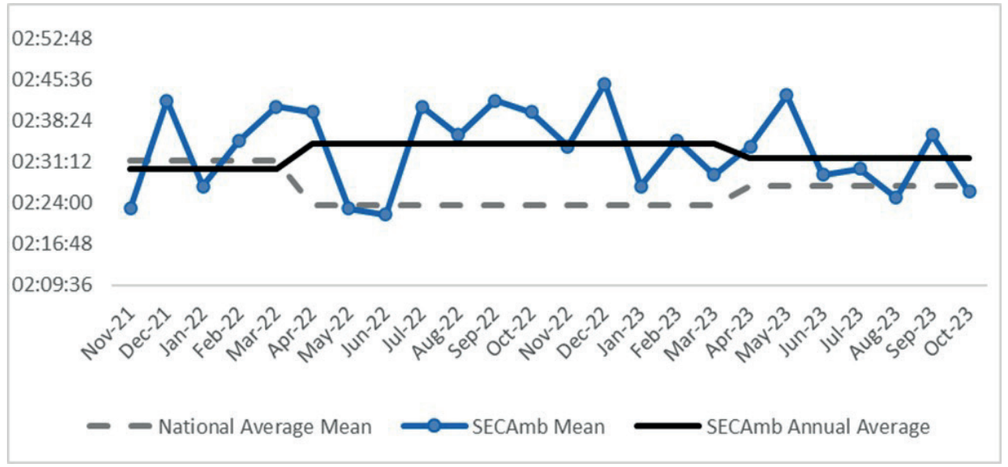
The percentage of sepsis patients, who received the sepsis care bundle are as below:



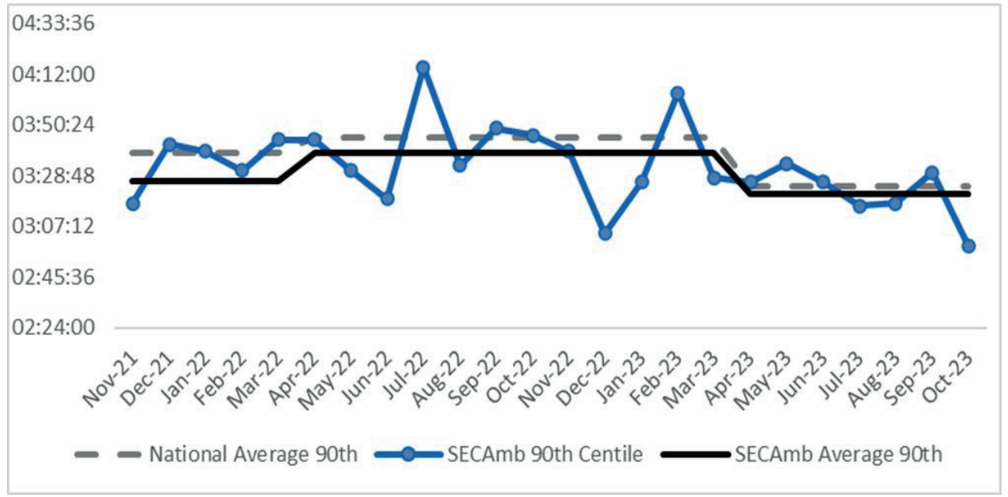
- The number of patients with suspected or confirmed sepsis (National Early Warning Score (NEWS2) of 7 or above), who received the sepsis care bundle remained broadly the same compared to 2022/23.
- In November 2022, NHS England advised no further submission was required as Sepsis was to be replaced as a Clinical Outcome Indicator by a Falls indicator in 2023/24.
- The Trust will continue to locally monitor Sepsis Care Bundle compliance, although not report the data nationally following its withdrawal.

The Trust also records the call to angiography time for patients presenting with a STEMI, this is compared as the mean and the 90th centile against other trusts.

Mean time from call to angiography for patients with confirmed STEMI:



90th centile time from call to angiography for patients with confirmed STEMI:



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South East Coast Ambulance Service
NHS Foundation Trust

Annex 1:

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

We thank our external stakeholders for taking the time to review the Quality Account in its various stages of development. We have noted all suggestions for improvements. Where possible, these have been incorporated into the final version of the Quality Account. If we have been unable to do this, we have documented all improvements for consideration in next year's Quality Account, supporting our journey of continuous improvement.

Annex 1: Statements from Commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Joint Commissioner Statement from NHS Surrey Heartlands ICS on behalf of Kent, Medway, Surrey, and Sussex regions

NHS Surrey Heartlands ICS (SH ICS) is the lead Commissioner for the South East Coast Ambulance 999 Service (SECAmb 999) covering the ICSs that make up the Kent, Medway, Surrey, and Sussex regions. Following engagement with the constituent ICSs, SH ICS, welcomes the opportunity to review and support the SECAmb Quality Report and Account.

As the lead Commissioner we can confirm that the Trust consulted with us and invited comments regarding the annual Quality Account (QA). This has occurred within the agreed timeframe, and the ICS and its constituent ICSs are satisfied that the QA incorporates the mandated elements.

Having reviewed the QA document the ICS is satisfied that it gives an overall accurate account and analysis of the quality of services provided. The detail is in line with the data supplied by SECAmb during the year 1st April 2023–31st March 2024 and reviewed as part of performance under the contract with SH ICS as the lead Commissioner.

We acknowledge the Trust's continued improvement journey relating to care quality, especially the progress it has made towards key must do areas within the Care Quality Commission (CQC) report in 2022. For example, the strengthened thread of quality between senior leaders and the rest of the Trust and an improved governance process concerning safety incidents. This improvement has coincided with the introduction of the SECAmb's Patient Safety Incident Response Plan and local Incident Review Groups (IRG), forming part of the national Patient Safety Incident Response Framework (PSIRF). The Trust has evidenced a greater focus on engagement and learning, both from success and when care falls below expectations.

We know there has been considerable focus on keeping people safe at times of increased demand. It is encouraging to see the Quality Improvement methodology that has been applied to this work, and we look forward to seeing the benefits for both patients and staff once the outputs are fully in place.

The priorities identified within the QA for the year ahead reflect topics that require significant work by the Trust. However, there are aspects of these priorities that system partners will work with SECAmb to enable, for example, successful out-of-hospital cardiac arrest outcomes requiring a concerted effort from all system partners to increase access and education for community defibrillators.

We look forward to working with the Trust on all aspects of its journey, most importantly in sustaining the improvements already being made. This joint working will, in part, be supported and strengthened within the Integrated Care System (ICS) Collaborative for Clinical Quality – a supra-ICS forum that brings together Chief Nurse counterparts, including NHS England. This forum will act as platform for SECAmb and associates to enable oversight of and early warnings about care quality success, risks, and issues.

The ICS Commissioners supports the QA report and priorities, and are looking forward to working with SECAmb on the developments planned for 2024/25 to deliver sustainable change as outlined in the QA.

As lead Commissioner we encourage the Trust to maintain a collaborative and open relationship with us. This is fundamental to our collective responsibility for the safe and effective care for our citizens.

Healthwatch Surrey

Thank you for the opportunity to comment on South East Coast Ambulance Service NHS Foundation Trust's 2023 -24 Quality Account. Over the past year, we have maintained a collaborative working relationship with South East Coast Ambulance Service NHS Foundation Trust. We have continued to share the voice of local people in the form of themes arising from our collection of insight along with other Healthwatch organisations. This year we have seen a renewed focus on how to make sharing insight from people who have used South East Coast Ambulance Services (SECAmb) more meaningful. We look forward to continuing this relationship and working on improving ways in which the trust can learn from the insight that we share.

At Healthwatch Surrey, we are committed to obtaining the views of Surrey residents about their needs and experience of local health and social care services. As such, we were pleased to note the progress achieved towards the priority "Listening and Engaging with our Patients, their Families and Carers." We have had discussions about the importance of providing a range of non-digital ways for people to share their feedback and we look forward to hearing about progress towards this as outlined in the actions for 2024-25.

Healthwatch Surrey will continue to gather experiences from service users and share these with SECAmb to ensure people are given a voice to shape, improve and get the best from local health and care services. As an independent statutory body, we are always happy to help SECAmb access lived experiences that can inform service development for improved patient outcomes.

West Sussex County Council - Health and Adult Social Care Scrutiny Committee

Thank you for offering the Health & Adult Social Care Scrutiny Committee (HASC) the opportunity to comment on South East Coast Ambulance Service NHS Foundation Trust's Quality Account for 2023-24.

I would like to make the following comments on behalf of HASC.

Recovery Support Programme

Following a Care Quality Commission inspection in August 2022 when the Trust was rated as 'Requires Improvement', HASC was pleased with the updates it received on the Trust's improvement journey in November 2022, March 2023 and March 2024, but is surprised that there is no mention of the Trust coming out of the Recovery Support Programme as expected in May 2024 in the 2023-24 Quality Account – is this on track?

Progress against Quality Priorities for Improvement 2023-24

The Committee is pleased with the progress against the 2023-24 priorities and with the actions to be carried forward to 2024-25.

Quality Priorities for Improvement 2024-25

The Committee will be happy with the three priorities for 2024/25, especially Health Inequalities which has been of concern to the Committee. However, the Committee would like to see people with a disability included in the areas of focus for this priority.

Annex 1: Statements from Commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

East Sussex Health Overview and Scrutiny Committee

Thank you for providing the East Sussex Health Overview and Scrutiny Committee (HOSC) with the opportunity to comment on your Trust's draft Quality Account report 2023/24.

The HOSC recognises the Trust's efforts over the past year to maintain its high standards of care whilst dealing with the impact of workforce pressures and pressures on the health and care system in general. The Committee, therefore, welcomes the progress SECAmb has achieved in 2023/24 in tackling staff recruitment, improving call answering times and improving ambulance response times.

The HOSC has invited SECAmb to attend its meetings during 2023/24 to continue its scrutiny of the actions SECAmb is taking in response to the CQC inspection report and to receive further updates on the joint work to reduce hospital handover times. The Committee has also explored the Trust's performance through its examination of the NHS Sussex Winter Plan. The Committee thanks those Trust officers who gave their time to attend the HOSC meetings during the last year.

The Committee notes the work that has been undertaken to successfully address front line operational staff vacancies, with the operational areas now at full establishment, and the good progress that is being made on Emergency Operations Centre staff vacancies. It also notes the further actions that are being undertaken to improve Ambulance Quality Indicators where they do not currently meet national targets. Performance against the other Core Indicators and the Mandatory Reporting indicators also shows consistent performance and improvement.

The HOSC welcomes the work SECAmb has undertaken on the Trust's indicators. For Patient Safety this includes the Keeping Patients Safe whilst waiting in the Clinical Stack Improvement Project; the Patient Safety Incident Response Framework; and the Out of Hospital Newborn Life Support training. Under Clinical Effectiveness, the Category 3 and 4 Validation pilot has shown success in diverting some of these calls away from and Ambulance response and the Out of Hospital Cardiac Arrest improvement programmes are helping to deliver higher survival rates compared to the England average. Under the Patient Experience category, the joint working with the Maidstone and Tunbridge Wells Trust on Urgent and Emergency Care Hubs has also helped with admission avoidance and a 5% reduction in conveyance rates to Emergency Departments.

The HOSC sees the development of a new long-term Strategy for the Trust (Strategy Clinical Case for Change and Models of Care) as demonstrating a forward thinking, patient centred and engaged organisation which is keen to improve and innovate.

2023/24 Quality Priorities

The HOSC notes that the majority of two of the priorities on Learning from Reviews to Improve Safety in Maternity Obstetric and Neonatal Care, and Listening and Engaging with our Patients, their Families and Carers, have been achieved with a few follow up actions and more work planned on patient involvement and inclusion. The work on the priority on Utilising Urgent Community Response Services to Improve Safety for Patients in the Clinical Stack is still ongoing and is linked to other indicator work. The work with Urgent Community Response Teams has the potential to help the wider system with admission and conveyance avoidance, which can help with hospital patient flow, handover times and ambulance response times. Consequently, HOSC is keen to see a continued approach to the work with of Urgent Community Response teams.

Quality Priorities for 2024/25

The HOSC notes the Trust's Quality Priorities for 2024/25 which are:

- Priority 1 (Domain: Clinical Effectiveness) – Feedback to staff on Patient Care Records
- Priority 2 (Domain: Patient Safety) – Unsafe discharge
- Priority 3 (Domain: Patient Engagement) – Health Inequalities

The Committee welcomes the Priorities for 2024/25 and in particular the Trust's work on Unsafe Discharge which uses the work from the Tangmere Urgent Care Hub pilot as a basis which will support staff to make safe discharge decisions on scene. The work on Health Inequalities is interesting and HOSC suggests the Trust works with Public Health teams as they may have data from their Joint Strategic Needs Assessments and respective Joint Health and Wellbeing Strategies which may be helpful, and the wider work on the NHS Sussex Integrated Care Plan, Shared Delivery Plan that may have some cross over with this work.

In reviewing the Quality Account for 2023/24, the HOSC welcomes the improving performance of the Trust during this period and the Committee looks forward to meeting representatives of the Trust at future HOSC meetings.

South East Coast Ambulance Service
NHS Foundation Trust

Annex 2:

Statement of directors' responsibilities for the quality report

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed requirements for quality reports 2019/20. NHS Trusts were not given an updated version of this guidance for 2023/24, as with the previous year's quality account, therefore the most recent version was used.
- The contents of the quality report are not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period 01 April 2023 to 31 March 2024.
- Papers relating to quality reported to the board over the period 01 April 2023 to 31 March 2024.
- Feedback from commissioners dated 22/05/2024.
- Feedback from one local Healthwatch organisation dated 22/05/2024.
- Feedback from two overview and scrutiny committees dated 09/05/2024 and 13/05/2024.
- The last Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, went to Board in July 2023, and was published in August 2023. The next report will be published in the summer of 2024.
- The national patient survey was not undertaken in 2023/24. The last national patient survey was in 2018.
- The national staff survey ran from 18th September 2023 – 24th November 2023.
- CQC inspection report dated 22nd June 2022.
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the quality report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

Additional Note:

By order of the board

.....

Chairman

Date: 23 May 2024

.....

Chief Executive

Date: 23 May 2024

South East Coast Ambulance Service
NHS Foundation Trust

Glossary:

Glossary:

Acronym	Term
ACP	Advanced Clinical Practitioner
ACS	Acute Coronary Syndrome
AHT	Average Handling Time
APP	Advanced Paramedic Practitioners
APPUEC	Advanced Paramedic Practitioner Urgent & Emergency Care
AQI	Ambulance Quality Indicators
ARP	Ambulance Response Programme
C3	Category 3
C4	Category 4
CA	Clinical Advisor
CAD	Computer Aided Dispatch
CAG	Clinical advisory group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSD	Clinical Support Desk
DCIQ	DatixCloudIQ
DMAIC	Define Measure Analyse Improve and Control
DSPT	Data Security and Protection Toolkit
ECAL	Emergency Clinical Advice Line
ED	Emergency Department
EMA	Emergency Medical Advisor
EOC	Emergency Operations Centre
EoLC	End of Life Care
ETA	Estimated Time of Arrival
FAST	Face, Arm, Speech Test
FTSU	Freedom to Speak Up
GTN	Glyceryl Trinitrate (GTN)
HA	Health Advisor
HOSC	Health Oversight and Scrutiny Committee
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board
ICS	Integrated Care System
IFT	Inter-Facility Transfer
IPC	Infection Prevention Control
IQR	Integrated Quality Report

Acronym	Term
ISDN	Integrated Stroke Development Network
IUC	Integrated Urgent Care
JRCALC	Joint Royal College Ambulance Liaison Committee
KCHFT	Kent Community Health Foundation Trust
KPSitS	Keeping Patients Safe in the Clinical Stack (KPSitS)
LGBTQ+	Lesbian, gay, bisexual, transgender and queer
LFPSE	Learning From Patient Safety Events
MHFA	Mental Health First Aid
MNSI	Maternity and Neonatal Safety investigation team
MTW	Maidstone and Tunbridge Wells NHS Trust
NASPEG	National Ambulance Service Patient Experience Group
NED	Non-Executive Director
NEWS2	National Early Warning Score
NGO	National Guardians Office
NLS	Newborn Life Support Course
OH-NLS	Out of Hospital Newborn Life Support
OU	Operating Unit
PbR	Payment by Results
PCR	Patient Care Records
PEQ	Patient Experience Questionnaire
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
QAV	Quality Assurance Visits
QGG	Quality Governance Group
QI	Quality Improvement
RCUK	Resuscitation Council UK
REAP	Resource Escalation Action Plan
ROSC	Return of Spontaneous Circulation
SDEC	Same Day Emergency Care
SECAmb	South East Coast Ambulance Service
SGIG	Serious Incident Group
SMP	Surge Management plan
STEMI	ST elevation myocardial infarction
Sto30	Survival to 30 days
UCR	Urgent Community Response
UEC	Urgent and Emergency Care

NHS
South East Coast Ambulance Service
NHS Foundation Trust

South East Coast Ambulance Service NHS Foundation Trust is your NHS ambulance service covering Kent & Medway, Sussex and Surrey and provides:

- 999 services across Kent & Medway, Surrey, Sussex and parts of Hampshire
- NHS 111 services across Sussex, Kent & Medway

Contact us at Head Office: Nexus House, Gatwick Road, Crawley, West Sussex, RH10 9BG

0300 1230999 enquiries@secamb.nhs.uk www.secamb.nhs.uk @SECAmbulance facebook.com/SECAmbulance

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	26/24

Name of meeting	Board
Date	6th June 2024
Name of paper	New BAF – Our people enjoy working at SECAmb
Strategic Aim	**Our people enjoy working at SECAmb**
Author / Lead Director	Sarah Wainwright, Executive Director of HR

New BAF – 2024/2025

During 2023/24 the Board has developed its new Trust-wide strategy. As part of the development of this strategy, the Trust has refreshed its purpose, strategic aims, and priorities.

From 2024/25, the Executive will seek to assure the Board against our new strategy, doing so with a reviewed BAF structure that supports the Board in overseeing both long-term vision and in-year delivery. This will also involve and update our approach to reporting for compliance and BAF risks, both of which are being re-defined through the lens of our new strategy and in the context in which the Trust now operates.

Our priorities for the year ahead have been co-developed with input from senior leaders in the organisation, and a Board development session early in May, aiming to bring together the following key principles:

- *Continuation of the "Improvement Journey" to ensure exit from RSP*
- *Meeting our planning commitments regarding quality of care, performance, and finance*
- *Assuring compliance against regulatory bodies and other statutory obligations*
- *Using our BAF and extreme risks to help us shape the Board discussion around mitigation and assurance.*

We aim to re-align our IQR and BAF reporting fully to this new format by the Board meeting in October 2024, and we will adopt a continuous quality improvement approach to the new BAF to ensure it remains effective to our strategic and operational context.

Our agendas in the forward cycles of business for public Board and Committees will align to these objectives to ensure the Board has appropriate time to consider progress across all areas set out in our plan.

Strategic Transformation Plan

The 2024/25 Strategic Transformation Plan - Phase 1 outlines key initiatives to enhance staff satisfaction and career development at SECamb. This will be done by continuing our Culture Improvement Programme "Getting Things Right for our People", which started in 23/24 following the Board approval of the People and Culture Strategy. Our focus will be on the roll-out of new organisational values, leadership development for all managers, and improving retention via our retention and recognition initiatives.

To set our workforce up for success in the future, we will also seek to establish clear career pathways and talent management schemes, and following the development of our Clinical Models (pathways) of Care as part of our strategic aim to delivery high quality of patient care, we will update our long-term workforce plan 2025-2029 to better align to the needs of our patients.

Finally, we will be restructuring the senior leadership structure, including defining a new regional operating model for the Operations Directorate to better align with our ICBs, bolstering our capability in the digital space by appointing a CDIO, and designing a clinical triumvirate made up of our Chief Nurse, Chief Medic and a newly appointment Chief Paramedic.

Operating Plan

The 2024/25 Operating Plan translates our strategic aim of creating a supportive work environment into actionable in-year objectives. The plan focuses on continuous monthly monitoring of workforce metrics, including sickness, retention, and recruitment trajectories.

Key objectives include improving staff retention to 15% by April 2025 and enhancing staff reporting of concerns, as reflected in the NQPS and Staff Survey. We aim to increase the percentage of staff recommending SECamb as a place to work, against our 2023/24 survey results.

Additionally, we will improve the response to ER casework and reduce the backlog by Q3 2024. This will be supported by delivery of our HR improvement plan to increase capacity and capability.

Over 85% of staff will have an annual appraisal by Q4 2024, and more than 85% of identified managers will have completed or commenced their leadership development programs by Q4 2024.

The delivery of a comprehensive education, training, and development plan will be monitored on a quarterly basis, and we plan to achieve 80% rollout of clinical supervision by Q1 2025/26, align with our ambition to support our people in both clinical and non-clinical roles.

Finally, we will have 1 QI priority supporting this strategic aim of ensuring we create a workplace our people enjoy working in:

- EOC Clinical Audit Process

Our plans are consistent and meet expectation set out by the Year 2 objectives set our in the UEC Recovery Plan and NHS planning guidance for 24/25, as well as the review into Ambulance Culture published in 23/24 by NHSE and the NHS Long-Term Workforce Plan.

Compliance and Risk

As part of our commitment to a well-led organisation, we have identified key compliance areas for 2024/25. These include:

- Delivery of EDI Plan - WRES/DES: Ensuring compliance with equality, diversity, and inclusion standards.
- Meeting Sexual Safety Charter commitments: Upholding standards to ensure a safe working environment.
- Meeting HSE obligations: Adhering to health and safety regulations.
- Improvement in the FTSU Plan: Measured by a reduction in anonymous reporting and perceived detriment, reflecting improvements in the Freedom to Speak Up culture.

We recognise inherent risks associated with our objectives and plans for 2024/25. We have identified three new BAF Risks:

- Partnership Alignment: Without effective internal and external partnerships, we risk not delivering our strategy as planned.
- Capacity for Change: There is a risk that we lack the capacity or capability to deliver large-scale organisational changes.
- Historic Pay Issues: Historic pay issues (related to ECSW pay and section two concerns) may significantly impact morale and industrial relations.

These strategic transformation efforts and operating plans aim to enhance staff satisfaction, retention, and development, ensuring SECamb remains an attractive and supportive place to work.

To mitigate these risks, we will engage in proactive risk management, and will score and provide mitigations as part of our BAF reporting at the Public Board in August 2024.

Recommendations, decisions, or actions sought	The Board is requested to approve the 2024/25 Operating Plan and objectives outlined in this report, which have been developed to support our strategic aim of delivering high-quality patient care.

Our people enjoy working at SECAmb

2024-2029 Strategy Outcomes

- Career development opportunities for all staff across the Trust – 70% staff surveyed agree
- Our staff recommend SECAmb as place to work – over 60% staff surveyed agree
- Staff turnover reduced to 10%
- Our Trust is an open and inclusive place to work - demonstrate improvements in workforce race and disability standards indicators

2024/25 – Strategic Transformation Plan – Phase 1

- Restructure
  - Implement new senior leadership structure **by Q2**
  - Defined the operating model for Ops Directorate – structure under exec / regional model **by Q3**
- Getting things right for our people
  - Rollout leadership development programmes **by Q3**
  - Roll out of values **(quarterly)**
  - Deliver retention plan 24/25– **(quarterly)**
  - Establish clear career pathways and talent management **by Q4**
- Definition of workforce plan from 2025
  - Scope to be developed **by Q3** following the development of our Clinical Models of Care

2024/25 Outcomes

- Improve retention **to 15% by April 25**
- Improve staff reporting they feel safer in speaking up – **NQPS and Staff Survey**
- Improve staff recommending SECAmb as a place to work **(23/24 survey)**
- Improve response to ER casework and reduce backlog **by Q3**
- Over 85% of staff have an annual appraisal **by Q4**
- over 85% of identified managers have completed or commenced their leadership development program **by Q4**

2024/25 – Operating Plan

- Deliver 24/25 education, training and development plan **(quarterly)**
- 80% rollout clinical supervision **by Q1 25/26**
- Deliver workforce plan, including sickness, retention and recruitment trajectories – **continuous monthly monitoring**
- Deliver HR Improvement plan to increase capacity and capability **by Q4**
- Deliver 1 People QI priority (EOC Clinical Audit process) **by Q4**

Compliance

- Delivery of EDI Plan - WRES/DES
- Meet our Sexual Safety Charter commitments
- Meet our HSE obligations
- Delivery of Improvement in the FTSU Plan – measured by a reduction in anonymous reporting and perceived detriment

BAF Risks

- Without effective internal and external partnerships, we won't be able to deliver our strategy as planned.
- There is a risk that we do not have the capacity or capability to deliver large-scale organisational changes.
- There is a risk that historic pay issues (in relation to ECSW pay and section two concerns) could have a significant impact on morale / IR.

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People & Culture

PEOPLE & CULTURE

Summary

April 2024

Pass | Hit and Miss | Fail | No Target

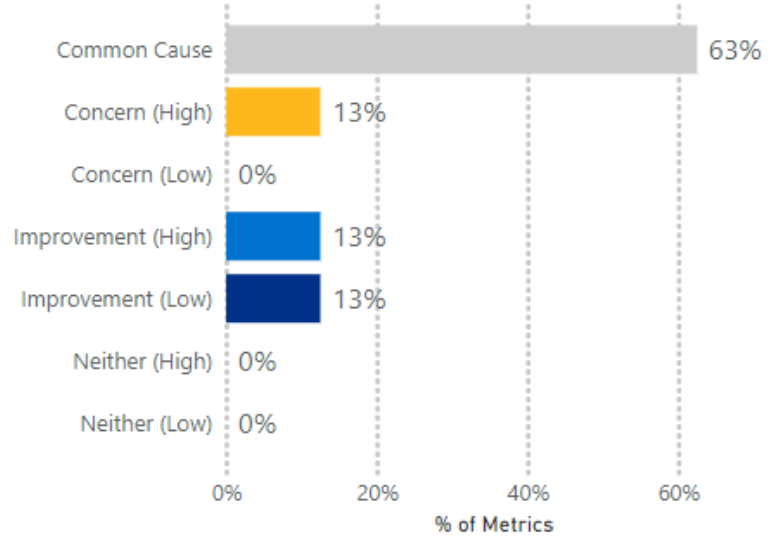
Special Cause Improvement		999 Frontline Late Finishes/Over-Runs % Mean Suspension Duration (Days)	Number of Staff WTE (Excl bank and agency) Grievances Mean Case Length (Days) Current licence details held for Operational Staff %	Average Late Finish/Over-Run Time Fundamentals Training Completion % Sexual Safety Workshop Completion %
Common Cause	DBS Compliance %	Vacancy Rate % Turnover Rate % Individual Grievances Open Count of Grievances Closed % of Meal Breaks Taken Suspension Closures Number of Wellbeing Hub Referrals	Annual Rolling Turnover Rate Sickness Absence % Statutory & Mandatory Training Rolling Year % Appraisals Rolling Year % Until it Stops Average Case Length Time to Hire - Volume (Days)	Freedom to Speak Up: Total Open Cases
Special Cause Concern		Active Suspensions Count of Until it Stops Cases Freedom to Speak up: Cases Opened in Month Disciplinary Cases		

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

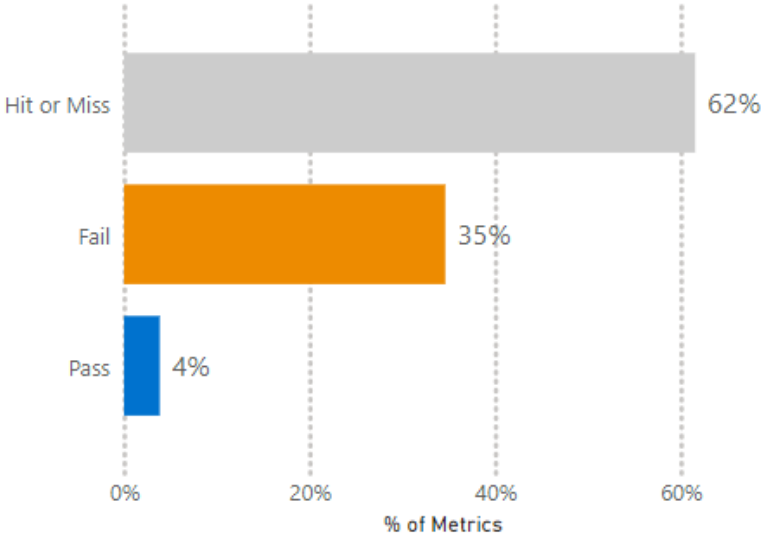
PEOPLE & CULTURE

Overview (1 of 2)

Variation Icon Summary



Assurance Icon Summary



Workforce

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Staff WTE (Excl bank and agency)	People & Culture	Apr-2024	4445.69	4503.25	4080.43	4184.87	4289.31		
Vacancy Rate %	People & Culture	Mar-2024	2.1%	5%	0.02%	5.76%	11.49%		
Turnover Rate %	People & Culture	Apr-2024	1.2%	0.8%	0.46%	1.39%	2.31%		
Annual Rolling Turnover Rate	People & Culture	Apr-2024	17.4%	12%	17.24%	18.11%	18.97%		
Sickness Absence %	People & Culture	Apr-2024	6.1%	5%	5.88%	7.43%	8.98%		
DBS Compliance %	People & Culture	Apr-2024	100%	90%	95.53%	98.83%	102.13%		
Current licence details held for Operational Staff %	People & Culture	Apr-2024	98.8%	100%	96.43%	97.59%	98.75%		
Time to Hire - Volume (Days)	People & Culture	Apr-2024	115	60	62.86	141.06	219.27		
Time to Hire - Individual Recruitment (Days)	People & Culture	Apr-2024	90	60	30.41	72.44	114.47		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Apr-2024	69.9%	85%	67.02%	75.75%	84.47%		
Appraisals Rolling Year %	People & Culture	Apr-2024	61.2%	85%	51.86%	59.95%	68.04%		

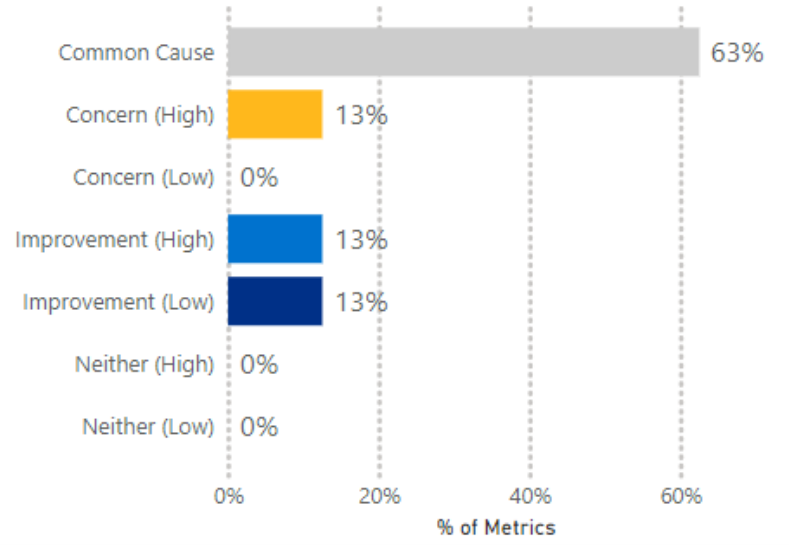
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Apr-2024	40.8%	45%	42.71%	47.85%	52.99%		
Average Late Finish/Over-Run Time	People & Culture	Apr-2024	00:37:00		00:35:17	00:38:30	00:41:43		
% of Meal Breaks Taken	People & Culture	Apr-2024	98.4%	98%	96.93%	98.23%	99.53%		
% of Meal Breaks Outside of Window	People & Culture	Apr-2024	43.8%		42.69%	54.12%	65.54%		

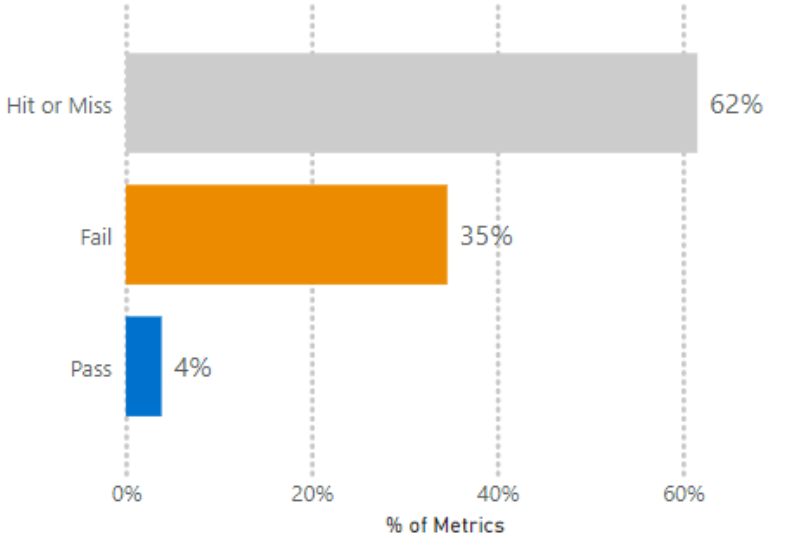
PEOPLE & CULTURE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

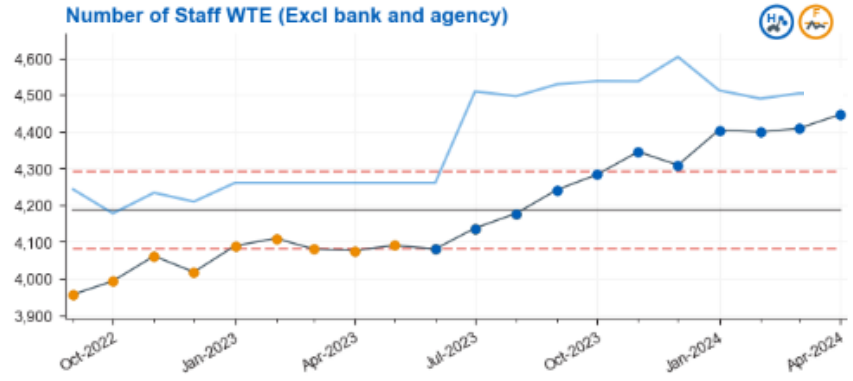
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Apr-2024	16	5	1.09	12.85	24.61		
Collective Grievances Open	People & Culture	Apr-2024	0	1	-1.78	1.3	4.38		
Count of Grievances Closed	People & Culture	Apr-2024	12	3	0.82	13	25.18		
Grievances Mean Case Length (Days)	People & Culture	Apr-2024	126	93	115.99	151.5	187		
Bullying & Harrassment Internal	People & Culture	Apr-2024	3	2	-2.52	1.4	5.32		
Disciplinary Cases	People & Culture	Apr-2024	12	3	-0.76	6.8	14.36		
Freedom to Speak Up: Total Open Cases	People & Culture	Apr-2024	14		9.19	23.75	38.31		
Freedom to Speak up: Cases Opened in Month	People & Culture	Apr-2024	20	3	-1.53	9.25	20.03		
Freedom to Speak up: Cases Closed in Month	People & Culture	Apr-2024	16		-2.56	10.6	23.76		
Count of Until it Stops Cases	People & Culture	Apr-2024	10	3	-3.74	2.83	9.41		

Health & Wellbeing

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Apr-2024	142	86	67.63	112.15	156.67		

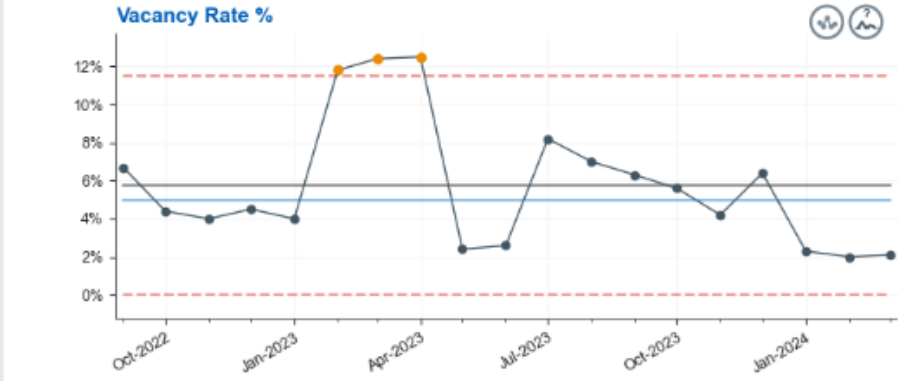
PEOPLE & CULTURE

Workforce (1 of 3)



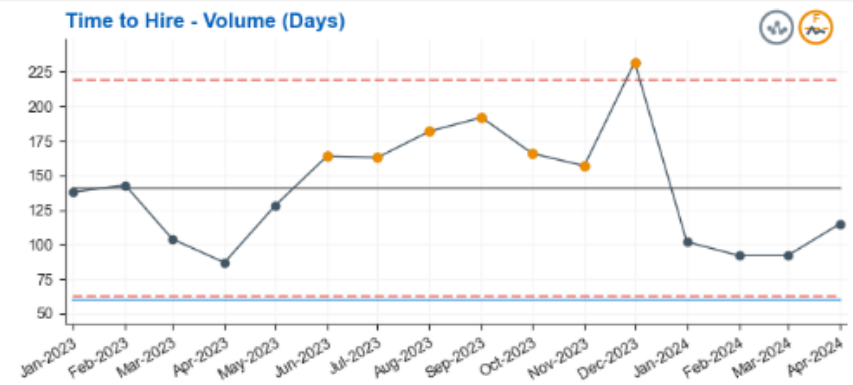
WF-1

Dept: Workforce HR
IP: People & Culture
Latest: 4445.69
Target: 4503.25
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: 2.1%
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: 115
Target: 60
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

WF-51

Dept: Workforce HR
IP: People & Culture
Latest: 90
Target: 60
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

The vacancy rates for February (2.02%) and March (2.12%) report the lowest since March 22 and this is a combination of ongoing recruitment and a small decrease in turnover (0.8%)

Time to Hire (TTH) for volume recruitment has increased slightly from the previous month as we move into the NQP recruitment cycle for this year. This is an anticipated rise and not due to any processes failing*.

TTH reporting is now available for both working and calendar days. This will allow us to benchmark appropriately with other Trusts, as there is an inconsistency with what is used and disparity for comparison. April TTH (working days) for volume was 81, and individual recruitment was 65.

**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.*

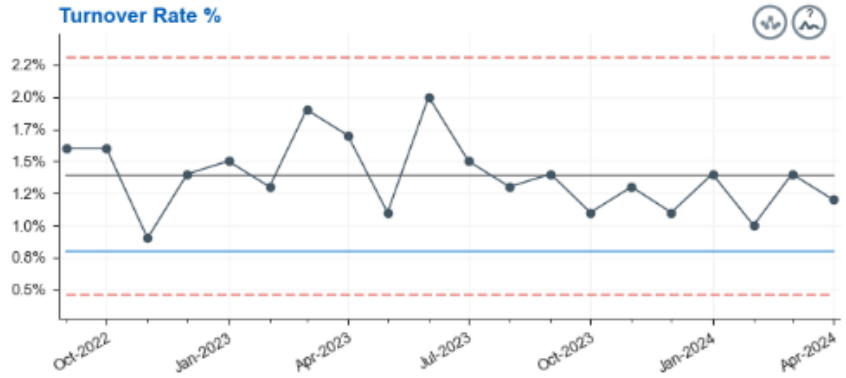
What actions are we taking?

The Recruitment Team have agreed KPIs for 2024, with a focus on quality, TTH and ensuring that candidates have a positive onboarding experience. The KPIs are supported by the metrics identified and developed from the QI project are now part of BAU. Initial results have shown an improvement in the quality of Data held within both Trac and ESR. Enhanced reporting and accurate data now available will ensure that monitoring of changes can continue, along with any future changes.

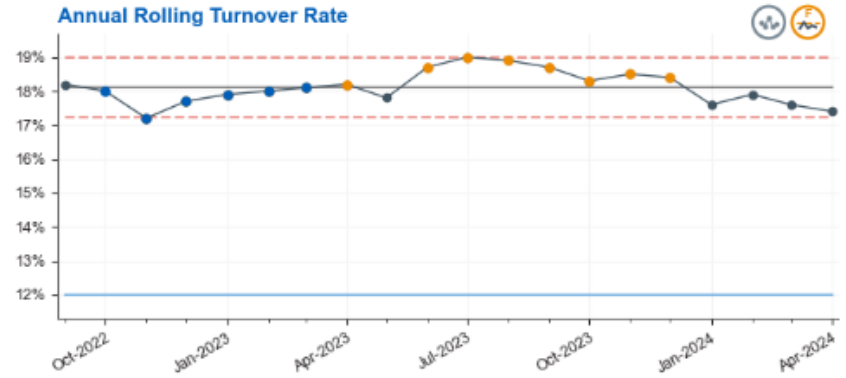
Courses will continue to have a target of fill to capacity and align with the workforce plan.

PEOPLE & CULTURE

Workforce (2 of 3)



WF-48
Dept: Workforce HR
IP: People & Culture
Latest: 1.2%
Target: 0.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-7
Dept: Workforce HR
IP: People & Culture
Latest: 17.4%
Target: 12%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary:

The continuing decline in the turnover rate is a positive trajectory. The next 3 months will reveal whether this improvement is sustainable, recognising the current retention initiatives should support this trend.

Given the nine consecutive months of improvement in turnover suggests it is sustainable, however the current rate of decline will not achieve our 12% target by December 25.

A review of the Retention Plan is underway to address this.

The Trust continues to focus on leadership development, compassionate leadership and engagement with staff. The communication and positive engagement on the Trust strategy all contribute to improved morale, as seen in the latest improved staff survey results.

What actions are we taking?

Working with our Trade Unions, we continue to scope the ECSW banding issue, acknowledging that this is a complex piece of work involving key stakeholders. We continue to communicate with affected staff on progress.

Section 2 USH rectification payments: We are working closely with Trade Union colleagues and subject matter experts to develop an approach. Meetings with Trade Unions are progressing well and the resolution of this will aid retention of staff.

May 24 will see a complete review and refresh of the Retention Plan to enable a more focused and segmented approach to our biggest retention challenges. We are will aim to focus on high impact initiatives and a working group has been set up with key stakeholders to complete this work by end June 24.

PEOPLE & CULTURE

Workforce (3 of 3)

(999 Frontline)

Summary – 999 Frontline
Total budget for field ops is 2448 for 2024/25.
April's data shows an increase in WTE ahead of the workforce plan (8.3WTE).
15 NQPs joined in April, with no plans to recruit until July.

Mitigating actions – 999 Frontline
The main risk for this financial year is not related challenges in meeting the workforce plan, but rather that attrition continues to reduce and the Trust meets its recruitment goals, resulting in an over establishment, and therefore an overspend. To mitigate this, the workforce plan will be re-forecasted quarterly with recruitment plans being adjusted accordingly to partially compensate for this scenario if it were to occur.

Additional Information
Attrition for field operations is planned to be 9.2% in 24/25 which is a 0.5% reduction on the 23/24 plan. The Trust has also seen positive trends, with attrition rates in field operations consistently falling below plan in 23/24. However, if this trend continues it may result in further over establishment in some areas, creating a financial challenge in an already pressured year. The workforce plans will be revisited quarterly through 24/25, and recruitment plans will be adjusted accordingly if attrition does continue to reduce, in an attempt to correct the financial challenge this will create.

(EOC EMA)

Summary – EOC EMA
EMA establishment for April showed a small decrease of WTEs with a difference of -1.4% (3.8WTE) to plan against last month's end of financial year difference of +3.1%.

Mitigating actions – EOC EMA
The main risk for this financial year is not related challenges in meeting the workforce plan, but rather that attrition continues to reduce and the Trust meets its recruitment goals, resulting in an over establishment, and therefore an overspend. To mitigate this, the workforce plan will be re-forecasted quarterly with recruitment plans being adjusted accordingly to partially compensate for this scenario if it were to occur.

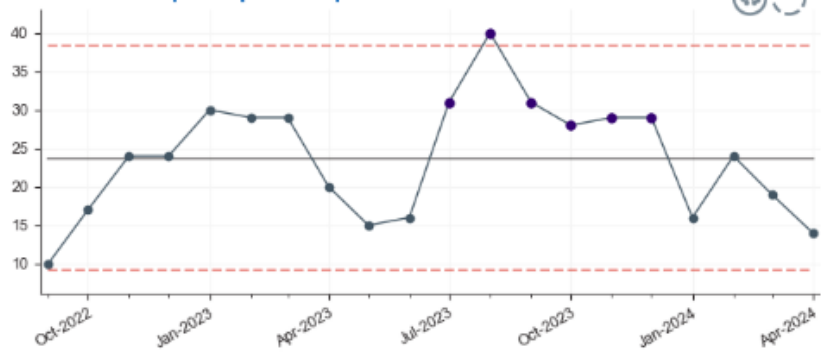
Additional Information
Attrition is planned at 55.3% across 24/25, representing a 17% reduction on 23/24. However, it is worth noting that 23/24 also factored in an increase in attrition as a result of the Emergency Operations Centre move from Coxheath to Medway, which has now completed and no further attrition is expected as a result of this. Similarly to field operations, EMA attrition also fell below plan by 17%, a potential early indicator that we can expect attrition to fall below plan again for this year.

PEOPLE & CULTURE

Culture (1 of 2)

Note: Until it stop cases relate to inappropriate sexualised behaviours

Freedom to Speak Up: Total Open Cases

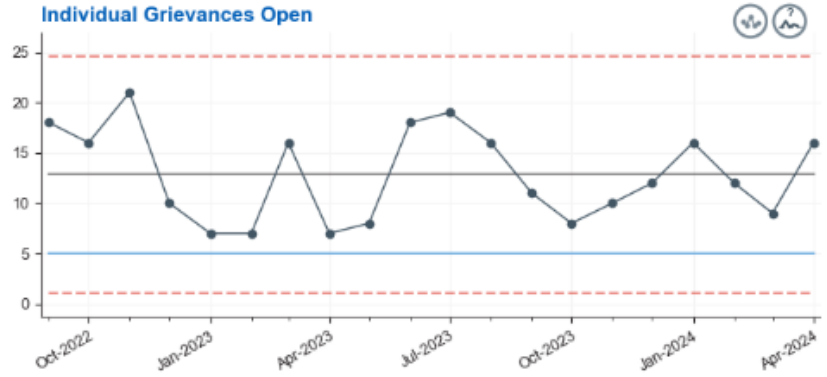


QS-27

Dept: Quality & Safety
IP: People & Culture
Latest: 14

Common cause variation, no significant change.

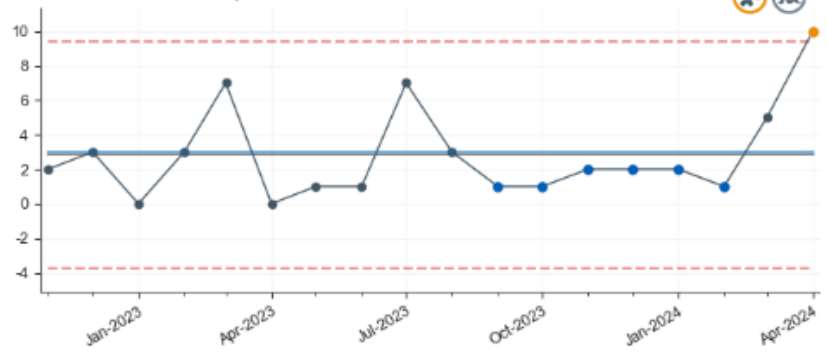
Individual Grievances Open



WF-10

Dept: Workforce HR
IP: People & Culture
Latest: 16
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.

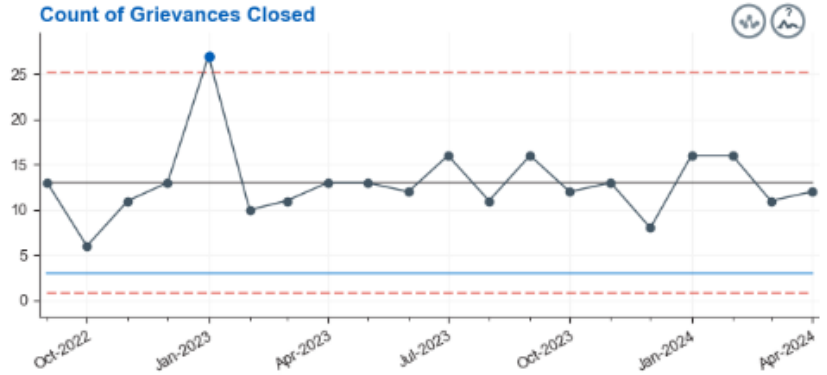
Count of Until it Stops Cases



WF-41

Dept: Workforce HR
IP: People & Culture
Latest: 10
Target: 3
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

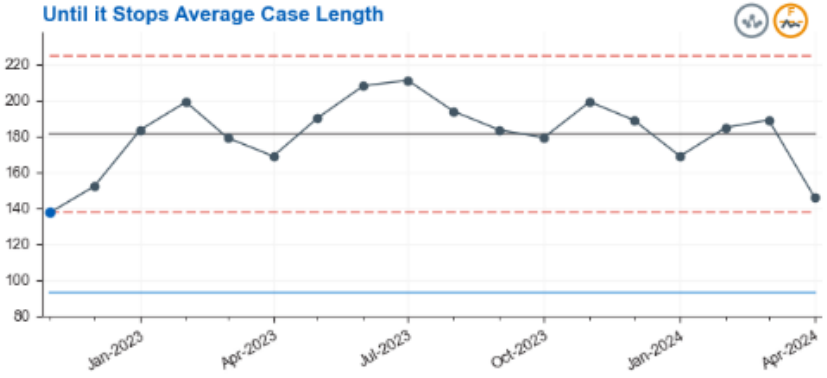
Count of Grievances Closed



WF-42

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

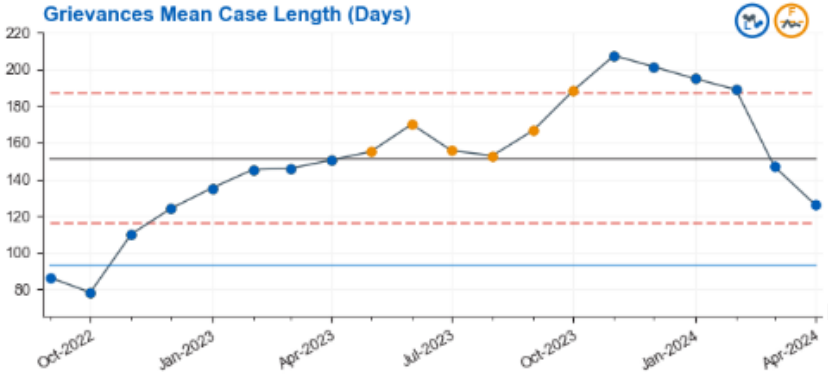
Until it Stops Average Case Length



WF-50

Dept: Workforce HR
IP: People & Culture
Latest: 146
Target: 93
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Grievances Mean Case Length (Days)



WF-44

Dept: Workforce HR
IP: People & Culture
Latest: 126
Target: 93
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.

PEOPLE & CULTURE

Culture (2 of 2)

Summary

Grievances

We currently have 41 cases unresolved, 2 of which are legacy cases (previously 39).

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 2 legacy grievances which originally stood at 39.

FTSU

65 concerns were raised during March and April 24 which has increased significantly from the previous year when 33 concerns were raised for the same period..
Whilst the number of concerns have increased, it is promising to see that both anonymous reporting and cases of detriment have decreased. In 2023, 30% of the concerns raised were anonymous and 30% of those raising concerns reported detriment. In 2024 around 10% of the concerns raised to FTSU were done so anonymously and 20% reported experiencing detriment.

What actions are we taking?

Grievances

Weekly meetings take place with HR colleagues and ER colleagues to ensure that appropriately action is taken in a timely manner. EOC/111 have the highest number of grievances - we are arranging for additional support to manage the case work in this area and will include coaching and training that is required.

There are 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.

There are 2 outstanding complex legacy cases which we anticipate will be closed by the end of quarter 2, however this is reliant on full engagement of parties involved.

The average grievance open time for cases is– 126 days, this has been skewed due to the outstanding legacy cases.

We have also commenced phase one of a diagnostics review with the purpose to identify a plan for improvement in the employee relations function with regards to areas of good practice, gaps and risks.

The commitment to creating a mediation service across the Trust has been supported by EMB with agreement to finance the accreditation of 24 new mediators. It is anticipated that the mediation service will go live at the same time as the launch of the Resolution Policy (September).

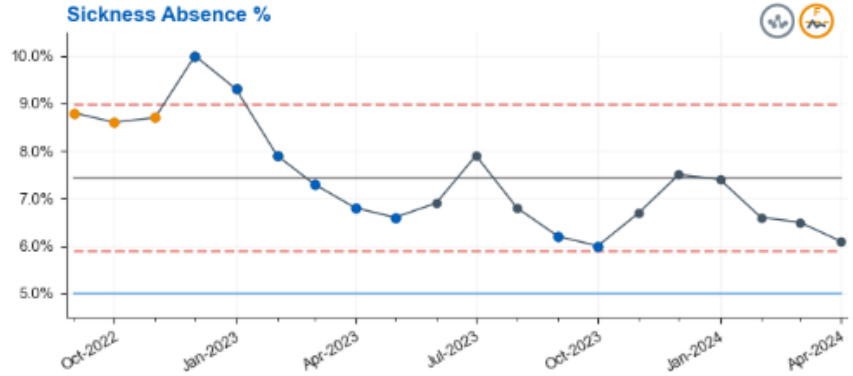
FTSU

Feedback from Brighton University was positive and FTSU have now delivered to year 2 and year 3 students. Dates have been identified for both Surrey and CCCU university. The plan from September 24 is to ensure FTSU/Speak Up workshops are delivered for year 2 and year 3 students as BAU.

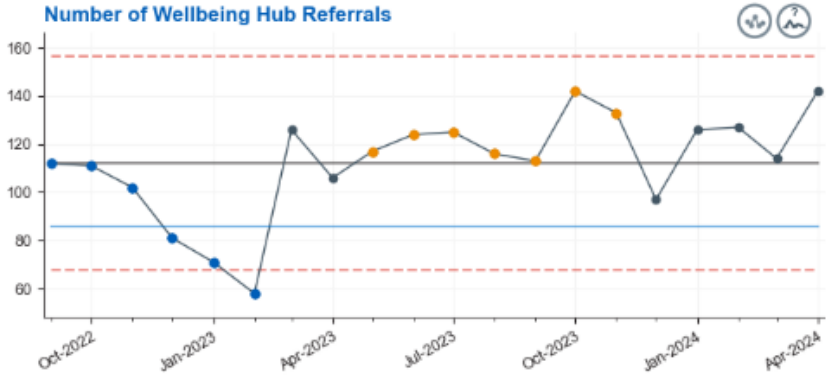
The FTSU team have connected to our Networks. We plan to deliver speak up sessions during network meetings to ensure we address possible barriers to speaking up, this work is also being carried out with CRF's.

PEOPLE & CULTURE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 6.1%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-25
Dept: Workforce Wellbeing
IP: People & Culture
Latest: 142
Target: 86
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Sickness absence is reducing across the board, and all indicators are that we will achieve our target of 5% this financial year.
Compared to the same period last year, there is a downward trend in non-attendance. For February 2023 sickness levels were 9.4%, in April 2024 they are 6.76%.

Managers, supported by HR Business Partners, have worked hard to support colleagues from a more compassionate leadership perspective. The freeing up of HR Business Partners from ER work has enabled a high level of focused support where it is needed.

We are currently exploring approaches to managing long term sickness as this accounts for 3.63% of the absence.

We still have pockets of the Trust that require more focused support were both absence and turnover are significantly above Trust averages. The Wellbeing Team will work with HR Business Partners to mitigate this risk.

Demand in the Wellbeing Hub continues to increase,. Currently 22% of all sickness in the Trust (1.49%) is mental health related. This is higher than at the peak of COVID-19 and presents a significant risk to the Trust.

What actions are we taking?

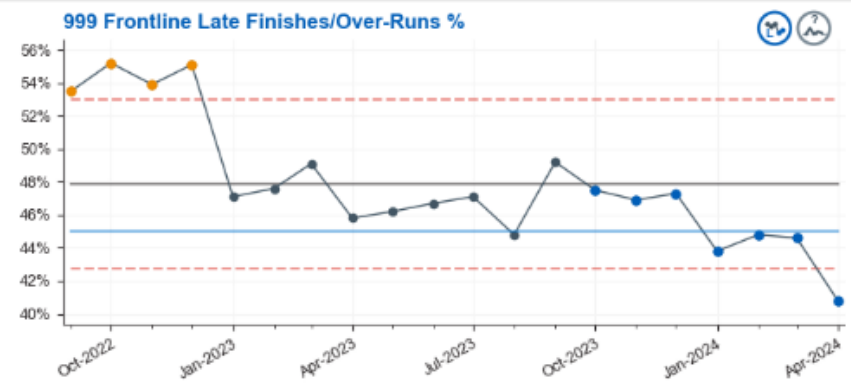
We are currently exploring approaches to managing long term sickness as this accounts for 3.63% of the absence. To support this, we have reviewed all the Alternative Duties Pathways to ensure they meet the need, and that they are easier to understand in terms of eligibility and pay protection. Alternative duties is an important tool in supporting colleagues back to work.

The Wellbeing Hub, working with Director of Nursing and her team of Mental Health Specialists, are working with us using the Quality Improvement methodology to review processes to help mitigate the increase in demand and free up capacity to provide support in a timelier way.
In the meantime, we continue to work with external providers to help manage the increasing demand for mental health services/support.

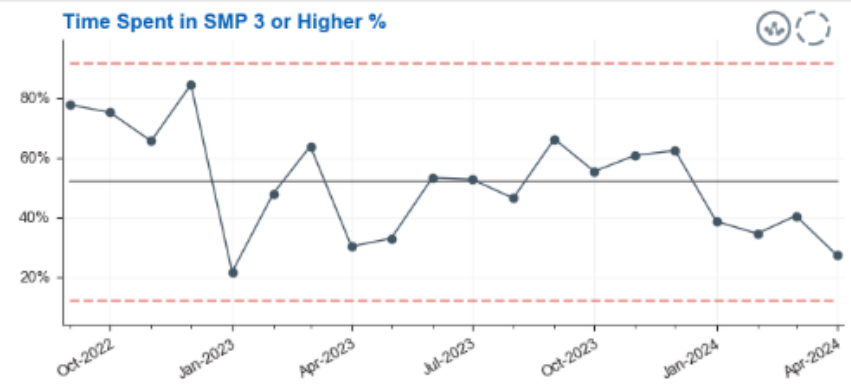
A separate piece of work is also under way to review the function and its operating model.

PEOPLE & CULTURE

Employee Experience

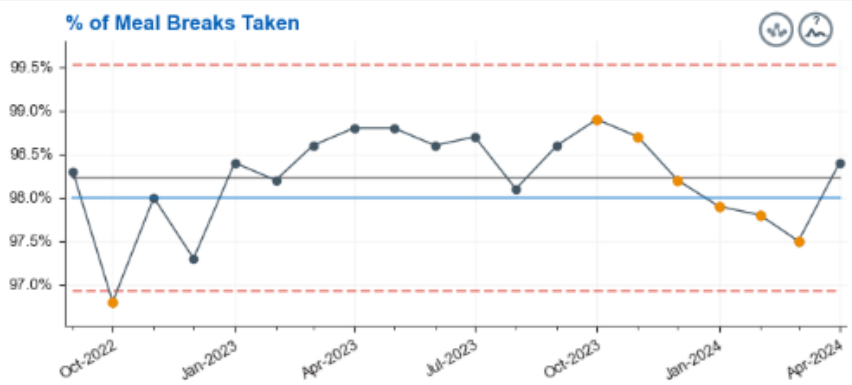


999-15
Dept: Operations 999
IP: People & Culture
Latest: 40.8%
Target: 45%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-14
Dept: Operations 999
IP: Quality Improvement
Latest: 27.2%

Common cause variation, no significant change.



999-27
Dept: Operations 999
IP: People & Culture
Latest: 98.4%
Target: 98%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

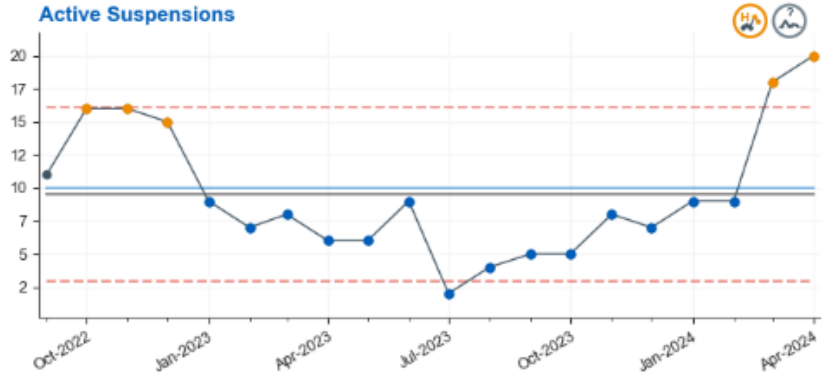
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- Whilst the late finishes and meal break metrics related directly to field operations, the impact of time spent at higher levels of SMP has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

What actions are we taking?

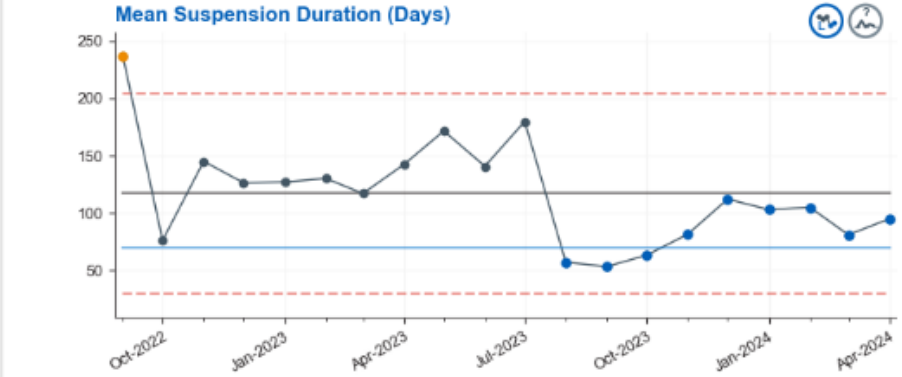
- Continue to review and update of the Meal break policy.
- Implemented 'Ready to Respond' a programme to ensure all front-line staff have all relevant PPE, Uniform & equipment to undertake their role
- Introduced a pilot of placed based educators to deliver an enhanced key skills programme
- Invited interested staff to attend T&F groups to address concerns they have raised

PEOPLE & CULTURE

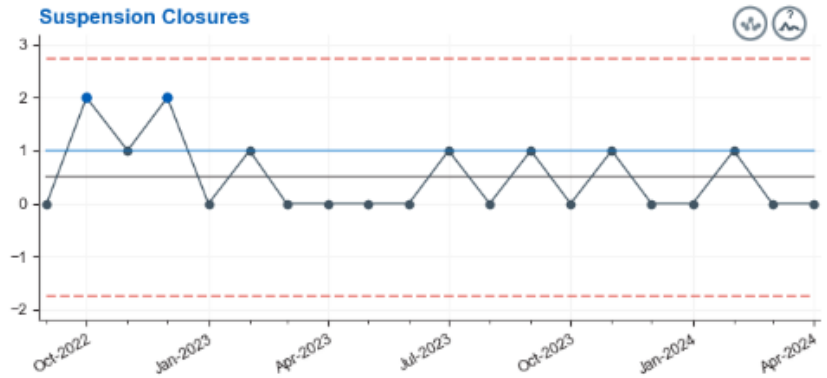
Employee Suspensions



WF-46
Dept: Workforce HR
IP: People & Culture
Latest: 20
Target: 10
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



WF-47
Dept: Workforce HR
IP: People & Culture
Latest: 95
Target: 70
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-45
Dept: Workforce HR
IP: People & Culture
Latest: 0
Target: 1
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

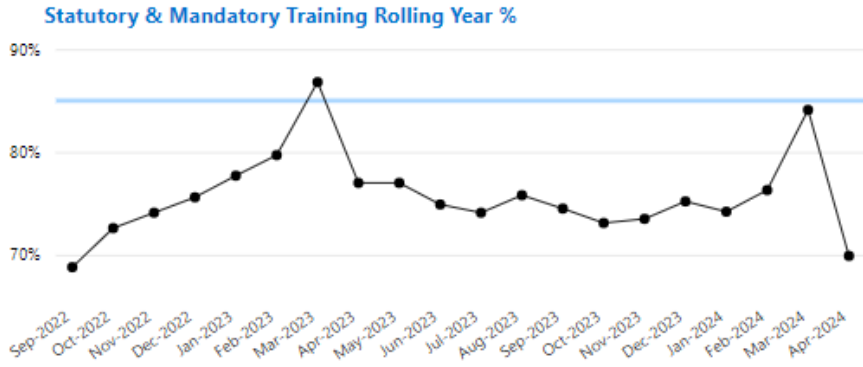
Staff suspension over the past few months have increased over the past 2 months, this increase is mainly due to allegations of sexual misconduct and serious police investigations.

What actions are we taking?

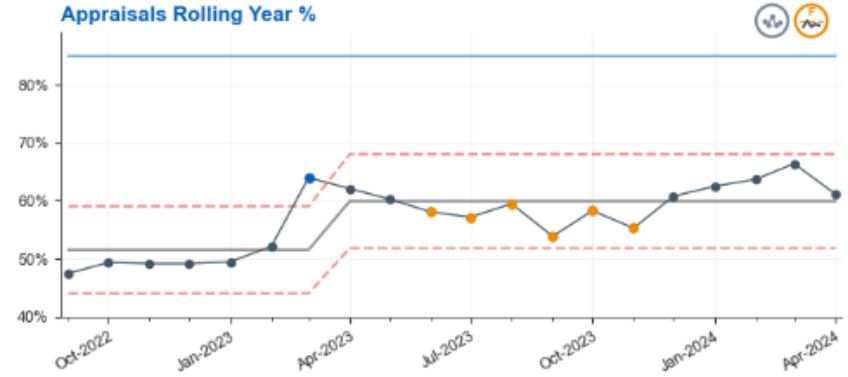
All suspension are risk assessed and tracked each week by Human resources. Existing suspensions are reviewed by two executive Directors to consider if is proportionate to continue with the suspension for the individual.

PEOPLE & CULTURE

Employee Development



WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 69.9%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-40
Dept: Workforce HR
IP: People & Culture
Latest: 61.2%
Target: 85%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary

Statutory & Mandatory Training

As of the 31st March 2024, the rolling overall compliance rate for statutory and mandatory training stands at 82.36%, a 4.95% increase from previous month.

The compliance percentage has fluctuated over the year peaking in April 2023. In April 2024, the Trust's compliance rate for statutory and mandatory Training was 69.93%, significantly lower than the target of 85%. Recent changes to the refresh periods of some subjects have impacted the compliance rate. All subjects are now reported in line with Core Skills Training Framework (CSTF) refresh periods. For example, Fire Safety, the Trust was previously reporting on a 3-year refresh rather than the CSTF's 2-year requirement. As a result, the compliance % reduced from 84.92% to 63.32% due to some colleagues falling into non-compliance earlier than previously expected.

Additionally, the Trust was previously not reporting on Resuscitations Level 1,2, 3, From April 2024, all levels of Resuscitation are now reported in line with the CSTF, providing greater assurance of the accuracy of accuracy of Statutory and Mandatory Training compliance.

Appraisals

Appraisal completions continues to be below the Trust's target of 85%, indicating that significant changes to the process are necessary to achieve and exceed the target.

In April 2024, an internal review was conducted by the Trust's auditors, RSM. The review considered appraisals, career development and succession planning. The final internal audit report was received on 23 May 2024. The report states; "taking into account the issues identified, the board can take Partial Assurance that that they are meeting the requirements for appraisals, succession planning and career development."

What actions are we taking?

Statutory and mandatory training

1. Socialising the new Power BI Dashboard: We are introducing the new Power BI Dashboard to key stakeholders to ensure that the entire organisation understands how statutory and mandatory training is measured and reported. The dashboard provides managers with the necessary information to effectively manager, engage and empower their colleagues to complete their statutory and mandatory training in a timely and meaningful manner.
2. Ongoing monitoring: We continue to monitor training compliance rigorously to ensure that any implemented changes lead to sustainable improvement.

Appraisals

1. **Internal audit review**: The report highlights that there is evidence to show that the rates of appraisals taking place across the Trust are increasing in line with wider strategic priorities, however, significant issues remain. There is evidence to suggest that generally the appraisal process is regarded negatively across the organisation and seen as a 'tick box exercise'. A substantial cultural shift is needed to emphasize the value of appraisals, to ensure that they are perceived as beneficial for individual development and team performance.
2. **Action plan**: In total 10 management actions are made as a result of the audit. An action plan will be presented to the Education, Training and Development Group in June 2024.

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
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HRBP	Human Resources Business Partner
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Incidents	See AQI A7
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South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	26c/24

Name of meeting	Trust Board
Date	6 June 2024
Name of paper	People Committee Escalation Report – 09 May 2024
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

This report provides an overview of issues covered at the meeting on 09.05.2024 and confirms whether any matters require specific intervention by the Trust Board.

Before the main agenda the HR Director updated on the review being undertaken with a focus on the ER function given the high number of cases, and the systems approach and skills in the team to determine the right delivery model. This will inform an overarching improvement plan which the committee will review at its meeting in July.

Also in July the committee will receive the approach we are planning to take to define career pathways and talent management that is fit for the ambulance sector.

Item

International Paramedics

The learning review had been paused but is now re started and is seeking the views of a wide range of stakeholders involved in the recruitment process. The final report is due to be completed in Q1 and the outcomes and learning will be shared with the People Committee, for assurance.

People & Culture

This was an integrated paper covering:

- Our 'housekeeping' actions and how we intend to respond to the feedback in the Staff Survey, and how this links to the people and culture priorities for the year ahead, including the review of the Retention Plan.
- Our assessment of the Ambulance Culture Review and how this feeds into our related priorities.
- Management & Leadership Development – what we have completed and what is planned for the next period.

86% of the housekeeping actions are complete against the 95% target; the remainder are expected to be met by the end of June 2024. The committee reinforced the importance of full delivery as these were the things our people asked us to address.

The ambulance culture review included seven actions and the committee asked the executive to absorb these into one improvement plan for culture.

As agreed when the retention plan was established last year, the committee is asking for a review to ensure we are focussed on the right things that will have the greatest impact on the experience of our people. The improved retention figures are encouraging as we get closer to the 12% target, but the committee has challenged the executive to look deeper into what motivates people to want to stay; not just doing what would be considered expected management practice.

We are coming to the end of the two-year plan for the Fundamentals Training. The executive is reviewing the content to then rescope using the learning, with a focus on new and aspiring managers. The committee expressed concern that only two thirds of first line managers completed the Fundamentals Training, asking the executive as a whole to lean in more so that they are assured their teams are attending.

There is good work on the development of a middle leaders' programme, working with NHS professionals academy to design this.

In the coming months the committee will focus on delivery of the people priorities agreed as part of the new trust strategy.

Employee Relations

A helpful dashboard was received to help the committee assess the impact of the actions; some areas are moving in the right direction, such as grievances. The team are working collaboratively with unions and local managers in triaging new grievances to consider early resolution and continue the work to build stronger relationships. Feedback has been extremely positive to our approach of doing the right thing.

The committee will continue to track progress noting this all links to living our values.

QI Project – Recruitment

A QI project to support improvement in the recruitment of Emergency Medical Advisors (EMA's) and Health Advisors (HA's) was commenced in July 2023. It has progressed well with several improvements having been implemented in December 2023 and January 2024. The project team are monitoring the impact of these improvements and initial data suggests improvement in the number of applications received and the quality of candidates applying. The completion date for the project has been extended for an additional three months (to June 2024) to complete the embedding of psychometric testing and the full implementation and benefits realisation of the other actions. The QI team are in the process of creating a control document which will handed over to the recruitment team to formally close the project and return to the control phase of the Quality Management system and business as usual with an improved process.

The committee welcomed this progress and the positive impact of the QI methodology in practice.

Organisational Change

The committee supports the work to establish a new executive structure and the next steps that will be needed related to wider organisational change to align with the new operating model as part of the trust's strategy.

The committee explored how the risk of this change related to leadership stability will be mitigated by the ongoing development programme and coaching.

H&S Action Plan

Excellent progress has been made with completion of 26 of the 33 actions. The seven are on track and there were no concerns raised or escalated. The related T&F Group will be closed once all the actions are complete.

A separate internal review into H&S management and culture is due to commence from 1 June and the committee will receive the regular updates before this is completed in November 2024.

Complaints Deep Dive - Staff Conduct / Attitude

Whilst the number of complaints relating to staff conduct / attitude is comparatively low to the number of incidents attended (1 complaint for every 3,711 incidents), the findings of this deep dive identified some concerning themes / trends that have been validated through triangulation with other quality and governance mechanisms.

Several actions and recommendations have been suggested to support organisational learning from this deep dive review. Implementation of these will aim to reduce the number of complaints in relation to staff conduct / attitude, increasing the likelihood of providing a positive experience for all our patients and ensuring that all SECAmb staff practice is in line with the Trust values.

The committee noted the role of the professional standards team and clinical education; they have shared a synopsis with our higher education partners to inform their curriculum. It also drew the link to 1:1s and appraisals where we must ensure there is discussion about values and behaviours.

The committee found this paper really helpful in understanding the deeper the reasons behind these types of complaints; it is assured with the actions being taken.

It asked the executive to review the role of the professional standards unit and what we need from this team in the future and to reports its findings to this committee.

Specific Escalation(s) for Board Action	This was a constructive meeting. The papers were helpful in informing the discussion and the committee has encouraged further improvement, with shorter more concise papers, with more overt reference to the risks and a better balance between the narrative and data to show evidence / assurance.

South East Coast Ambulance Service
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Agenda No	27/24

Name of meeting	Board
Date	6th June 2024
Name of paper	New BAF – We are a sustainable partner as part of an integrated NHS
Strategic Aim	**We are a sustainable partner as part of an integrated NHS**
Author / Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning and Transformation

New BAF – 2024/2025

During 2023/24 the Board has developed its new Trust-wide strategy. As part of the development of this strategy, the Trust has refreshed its purpose, strategic aims, and priorities.

From 2024/25, the Executive will seek to assure the Board against our new strategy, doing so with a reviewed BAF structure that supports the Board in overseeing both long-term vision and in-year delivery. This will also involve and update our approach to reporting for compliance and BAF risks, both of which are being re-defined through the lens of our new strategy and in the context in which the Trust now operates.

Our priorities for the year ahead have been co-developed with input from senior leaders in the organisation, and a Board development session early in May, aiming to bring together the following key principles:

- *Continuation of the "Improvement Journey" to ensure exit from RSP*
- *Meeting our planning commitments regarding quality of care, performance, and finance*
- *Assuring compliance against regulatory bodies and other statutory obligations*
- *Using our BAF and extreme risks to help us shape the Board discussion around mitigation and assurance.*

We aim to re-align our IQR and BAF reporting fully to this new format by the Board meeting in October 2024, and we will adopt a continuous quality improvement approach to the new BAF to ensure it remains effective to our strategic and operational context.

Our agendas in the forward cycles of business for public Board and Committees will align to these objectives to ensure the Board has appropriate time to consider progress across all areas set out in our plan.

Strategic Transformation Plan

The 2024/25 Strategic Transformation Plan - Phase 1 outlines key initiatives to ensure SECamb operates as a sustainable partner within an integrated NHS. This includes developing a multi-year plan, agreed with ICBs, to deliver our strategy and achieve break-even within three years by Q3 2024. Refreshing our strategic commissioning framework with our commissioners will support our sustainability plan.

We will be developing an enabling Digital Strategy by Q3 2024 will facilitate the delivery of our Trust-wide Strategy and ensure we remain technologically prepared to support our new clinical vision, including the introduction and expansion of Virtual Consultation.

Finally, as part of our collaborative efforts, we will be engaging in opportunities with other services to improve productivity by at least £0.5m. Furthermore, we will be refreshing our core enabling strategies by Q4 2024 to underpin and support our 2024 – 2029 Trust-wide Strategy, helping us refine and identify requirements across our digital, estates, fleet, logistics, medical, and other core support functions.

Operating Plan

The 2024/25 Operating Plan translates our strategic aim of sustainability into actionable in-year objectives. The plan focuses on continuous monthly monitoring of financial performance, ensuring adherence to our planned out-turn.

Our objectives include improving our efficiency as part of a broader health-case system. We will measure this by monitoring with our partners the following joint KPIs

- Maintaining a handover delay mean of 18 minutes for the full year
- Maximising the utilisation of existing Urgent Community Response and alternative to ED capacity.
- Managing growth in activity under 2.4% year-on-year

We will also implement our six priority “Green Plan” initiatives by Q4 2024. And conduct a review to improve how we deliver Make-Ready services to ensure our vehicles are well prepared to deliver care to patients.

Finally, we will have 1 QI priority supporting this strategic aim of ensuring we become a sustainable organisation:

- Reduction in consumables waste through our Logistics function

Our plans are consistent and meet expectation set out by the Year 2 objectives set our in the UEC Recovery Plan and NHS planning guidance for 24/25.

Final financial position depends on on-going negotiations with commissioners and NHSE, which are due to complete through the month of June.

Compliance and Risk

As part of our commitment to robust governance, we have identified key compliance areas for 2024/25. These include:

- Recovery Support Programme: Meeting priorities to exit NOF4.
- Environmental Sustainability Report: Ensuring transparent reporting of our environmental impact.
- FT License: Maintaining compliance with our Foundation Trust license requirements.

We recognise inherent risks associated with our objectives and plans for 2024/25. We have identified three new BAF Risks:

- Leadership Capacity: There is a risk that the Board has insufficient leadership capacity to collaborate effectively with system partners.
- Financial Uncertainty: Due to uncertainty over medium to long-term funding (3-5 years), there is a risk that the Trust may be unable to agree on a sustainable financial plan with Commissioners.
- Cybersecurity: There is a risk of data loss or system outage due to a cyber-attack, resulting in significant service disruption and/or patient harm.
- Digital Alignment: There is a risk that we are not able to align digitally with our system partners, hindering integration efforts.
- Financial Controls: There is a risk our internal financial controls are not robust enough to ensure we are managing within our financial envelope.

To mitigate these risks, we will engage in proactive risk management, and will score and provide mitigations as part of our BAF reporting at the Public Board in August 2024.

These strategic transformation efforts and operating plans aim to ensure SECamb remains a sustainable and integrated partner within the NHS, delivering high-quality and cost-effective services.

Recommendations, decisions, or actions sought	The Board is requested to approve the 2024/25 Operating Plan and objectives outlined in this report, which have been developed to support our strategic aim of delivering high-quality patient care.

We are a sustainable partner as part of an integrated NHS

2024-2029 Strategy Outcomes

- ❑ Breakeven / 8% reduction in cost base relative to 2023/24. Cost-avoid impact of growth.
- ❑ Increase utilisation of alternatives to ED from 12 to 31%
- ❑ Reduce conveyance to ED 54 to 39%,
- ❑ Saving 150-200k bed days per year
- ❑ Reduce direct scope 1 CO2e emissions by 50%
- ❑ Achieve a top-quartile Digital Maturity Assessment

2024/25 – Strategic Transformation Plan – Phase 1

- ❑ Develop a multi-year plan that is agreed with ICBs, delivers our strategy, and achieves break even within 3 years, **by Q3**
- ❑ Refresh our strategic commissioning framework to support our sustainability plan **by Q3**
- ❑ Develop an enabling Digital Strategy that support delivery of our Trust-wide Strategy **by Q3**
- ❑ Engage in collaboration opportunities with other services to improve productivity by at least £0.5m **by Q4**
- ❑ Refresh our core enabling strategies to support our '24-'29 Trust-wide Strategy, **by Q4**

2024/25 Outcomes

- ❑ Deliver our agreed financial plan
- ❑ Handover delay mean of 18 min for the full year, with no single site exceeding 19 min (S)
- ❑ Maximise utilisation of UCR services, measured against available capacity (S)
- ❑ Manage growth in activity under 2.4% Y-o-Y (S)

S – indicates this is a jointly owned target with partners

2024/25 – Operating Plan

- ❑ Deliver financial plan **continuous monthly monitoring**
  - Meet our CIP Plan
  - Deliver 1 Sustainability QI priority (Logistics Waste reduction) **by Q4**
- ❑ Review our service delivery model for Make Ready
- ❑ Deliver 6 priority Green Plan initiatives **by Q4**

Compliance

- ❑ Meet our Recovery Support Programme priorities to exit NOF4
- ❑ Environmental sustainability report
- ❑ FT License

BAF Risks

- ❑ There is a risk that the Board has insufficient leadership capacity to collaborate effectively with system partners
- ❑ There is a risk that due to uncertainty over medium to long term funding (3-5 years), that the Trust is unable to agree with Commissioners a sustainable financial plan which delivers safe and effective services and improves value for money.
- ❑ There is a risk of loss of data or system outage due to a cyber-attack resulting in significant service disruption and/or patient harm.
- ❑ There is a risk that we are not able to align digitally with our system partners.
- ❑ There is a risk our internal financial controls are not robust enough to ensure we are managing within our financial envelope.

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Sustainability & Partnerships

SUSTAINABILITY & PARTNERSHIPS

Delivered Against Plan

	March 2024 In the month			April 2023 to March 2024 Year to date		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	26,813	26,702	(110)	321,984	322,649	665
Operating Expenditure	(26,585)	(41,921)	(15,337)	(321,986)	(338,085)	(16,100)
Trust Surplus/(Deficit)	***228***	***(15,219)***	***(15,447)***	***(2)***	***(15,437)***	***(15,435)***
Reporting adjustments:						
Remove Impact of Donated Assets	*0*	*0*	*0*	*2*	*2*	*0*
Remove Impact of Impairments	*0*	*15,439*	*15,439*	*0*	*15,439*	*(15,439)*
Reported Surplus/(Deficit)	**228**	**220**	**(8)**	**0**	**4**	**4**

Cash	50,401	35,568	(14,833)	50,401	35,568	(14,833)
Capital Expenditure	10,464	1,221	9,243	27,055	18,387	8,668
Efficiency Target	1,100	1,643	543	8,988	8,988	0

Summary

1. The Trust's financial performance was £4k better than planned for 2023/24 compared to the planned break-even. 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 in full, £8,988k worth of savings, which represents an under delivery of £543k compared to the £8,988k plan. 67.8% of the schemes have been generated recurrently.

3. The Trust's cash position was £35,568k that is £14,833k lower than plan. due to the payment of supplier invoices. This is mainly driven by the reduction of current liabilities, including trade payables that has a favourable variance of £15,171k includes offset by a favourable variance of £2,158k on current assets, including inventories and trade receivables. This is a result of timelier invoicing by suppliers and payment made by the Trust.

4. Capital expenditure of £18,387k is £8,668k below plan. This is due to the delay in receiving DCA lease vehicle that were caused by the delay in building these. 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 future years.

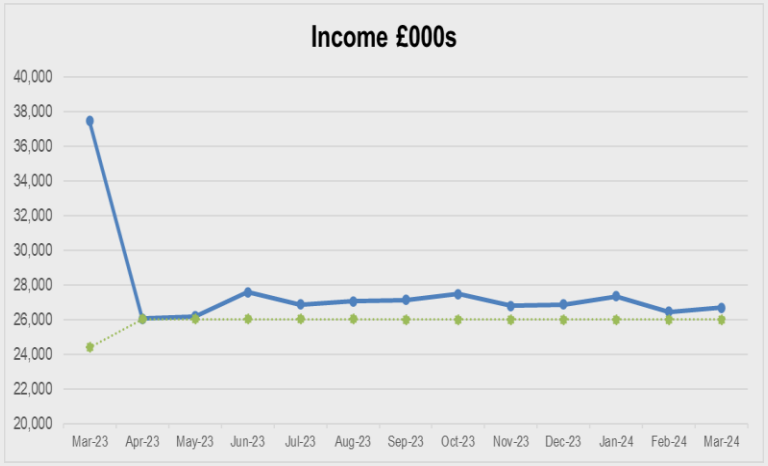
2. Regular updates are being provided to the Joint Leadership Team meetings and Finance and Investment Committee on financial performance, including delivery of the efficiency plans.

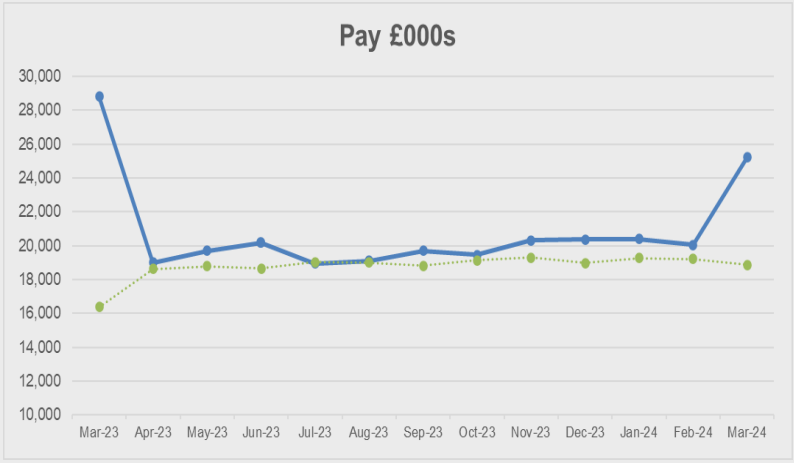
3. Monthly executive led directorate financial performance meetings are continuing to take place to ensure that each directorate delivers their element of the financial plan e.g., budget and efficiency target.

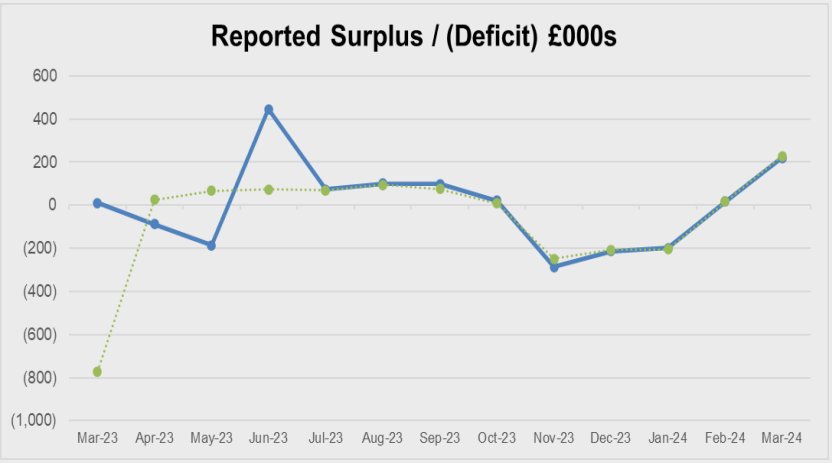
4. The Trust has developed its 2024/25 operating plan that aligns with strategy and partnership working.

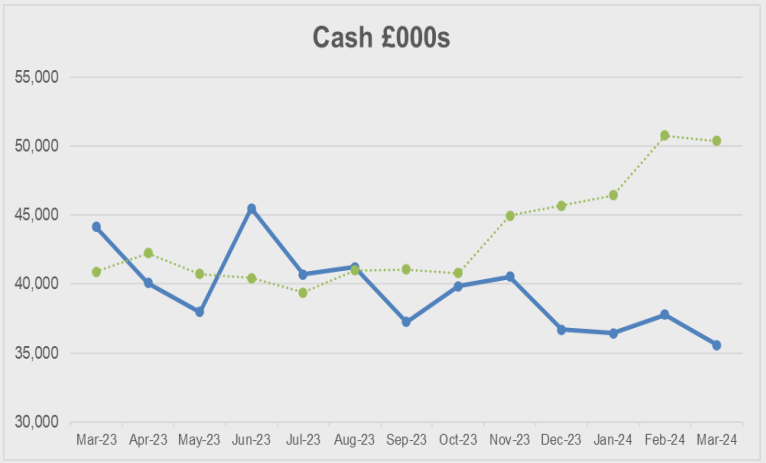
Delivered Against Plan

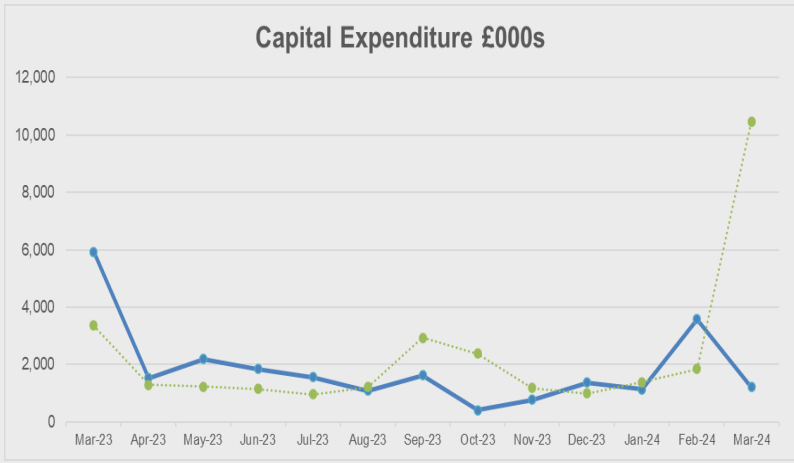
Actual Plan











Summary

- The Trust's financial performance was £4k better than planned for 2023/24 compared to the planned break-even.
- Financial pressures, notably in field operations, 111 services and 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 was behind plan due to delays in receiving DCA vehicles.

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Appendix

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Item No	27c/24

Name of meeting	Trust Board
Date	06 June 2024
Name of paper	M01 (April 2024) Financial Performance
Executive sponsor	Simon Bell – 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 year to date (YTD) and full year forecast (FY) financial performance of the Trust. The Trust reported a £1k favourable variance against its planned deficit of (£1,654k) at M01 2024/25. Actuals as at M01, includes pressures of £745k in Operations (field operations mainly and 111 services) offset by £376k underspend in Corporate due to vacancies and £70k lower financing cost than planned due to favourable interest rates. The planned efficiency programme has delivered against the £855k YTD target. The Trust has mitigations in place and is on track to deliver its financial, break-even plan for the year ending 31 March 2025. The Trust's cash position of £30,210k was £1,092k lower than plan. This is driven by £1,019k higher than planned salary payments due to over provision of operational hours and higher than planned overtime. A deep dive is being carried out to understand key drivers and to enable informed decision making on remedial actions. The Trust is forecasting a cash position of £24,026k at the end of March 2025, which is £11,542k lower than of 31 March 2024, because of the planned deficit for the year.
Recommendations, decisions, or actions sought	The Committee is asked to note the following: a) The financial performance for M01 of the 2024/25 financial year b) The Trust £19.7m deficit plan is still a draft and will be revised and resubmitted in June.

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

2024/25

Finance Report to the Board of Directors

1 Month to 30 April 2024

Contents

Executive Summary

The Trust reported a £1,653k deficit for April 2024 in line with plan. The Trust's forecast remains as planned.

	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	26,732	26,778	46	322,247	322,247	0
Expenditure	(28,386)	(28,443)	(57)	(341,992)	(341,992)	0
Planned Profit on Sale of Assets	0	12	12	0	0	0
Trust Surplus / (Deficit)	**(1,654)**	**(1,653)**	**1**	**(19,745)**	**(19,745)**	**0**
Reporting adjustments:						
Remove Impact of Donated Assets	0	0	0	2	2	0
Remove Impact of Impairments	0	0	0	0	0	0
Reported Surplus / (Deficit)*	**(1,654)**	**(1,653)**	**1**	**(19,743)**	**(19,743)**	**0**
Efficiency Programme	855	855	0	20,673	20,673	0
Cash	31,302	30,210	(1,092)	24,026	24,026	0
Capital Expenditure	196	373	(177)	22,410	22,410	0

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

Year to April 2024 (YTD)

- For April 2024, the Trust is reporting a financial position in line with plan. However, the overall financial performance consists of adverse and favourable variances. The adverse variances are due to pressures in Operations of £696k and overspent of £49k in the NHS 111 service. These are mitigated by favourable variances across other directorates, notably in Medical, Strategic Planning & Transformation (SP&T) and higher than planned interest received on its cash held at bank. These are outlined more in detail further on.

- The Trust's deficit of £19,743k is based on the delivery of £20,673k recurrent efficiencies, which is 5.7% of the Trust's operating expenditure.
    - The annual target comprises 20.8% cash releasing and 79.2% non-cash releasing plans.
    - Delivery of £855k efficiencies in Month 1 (April 2024) is in line with plan. These are all non-cash releasing as anticipated.
    - Senior Management Group (SMG) is currently developing the cash releasing schemes, which are expected to start achieving from July 2024.
    - Delivery of the 2024/25 efficiency target would be challenging but in roads are being made and SMG will be presenting Executive Management Board (EMB) with a delivery plan for approval on the 26th of June after their Efficiency Workshop on the 5th of June 2024.

- The cash position decreased by £5,358k this month to £30,210k due to the planned deficit and associated cash outflows not covered by income. The cash balance is £1,092k below plan, mainly due to higher than planned salary payments relating to provision of operational hours and higher than planned overtime. A deep dive is being carried out to understand key drivers and to enable informed decision making on remedial actions.

- Capital expenditure of £373k is £177k above plan. This is due to the estates work slippage that were originally expected to be delivered in March 2024.

Full Year Forecast

For the year ending March 2024, the Trust is still expecting to meet its plan.

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

1. Income

	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	24,006	24,026	20	289,618	289,618	0
111 Income	2,314	2,300	(14)	27,763	27,763	0
HEE Income	224	165	(59)	2,605	2,605	0
Other Income	188	287	99	2,261	2,261	0
Total Income	**26,732**	**26,778**	**46**	**322,247**	**322,247**	**0**

- 999 income is £20k greater than plan, following the latest iteration of the expected contractual value.
- 111 income is £14k below plan, following the latest iteration of the expected contractual value.
- HEE (Health Education England) income is £59k below plan. This reflects the most recent funding schedules received for 2024/25 for which phasing information was incomplete at the time of plan submission and is a timing issue.
- Other income is £99k above plan, and as per above is a timing issue.

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 April 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(369)	(337)	32	(4,217)	(4,217)	0
Finance	(2,185)	(2,217)	(32)	(27,344)	(27,344)	0
Quality and Safety	(290)	(310)	(20)	(3,471)	(3,471)	0
Medical	(1,599)	(1,456)	143	(20,044)	(20,044)	0
Operations	(15,777)	(16,472)	(696)	(189,816)	(189,817)	(1)
Operations - 111	(2,355)	(2,404)	(49)	(28,260)	(28,260)	0
Strategic Planning & Transformation	(2,483)	(2,349)	134	(29,894)	(29,894)	0
Human Resources	(472)	(460)	12	(5,680)	(5,680)	0
Total Directorate Expenditure	**(25,530)**	**(26,005)**	**(476)**	**(308,726)**	**(308,727)**	**(1)**
Depreciation	(1,447)	(1,475)	(28)	(19,196)	(19,198)	(2)
Financing Costs	(71)	(1)	71	(854)	(855)	0
Corporate Expenditure	(1,338)	(962)	376	(13,215)	(13,213)	2
Total Expenditure	**(28,386)**	**(28,443)**	**(57)**	**(341,992)**	**(341,992)**	**0**
Planned Profit on Sale of Assets	0	12	12	0	0	0
Total Trust Expenditure	**(28,386)**	**(28,431)**	**(45)**	**(341,992)**	**(341,992)**	**0**

*Excludes Income

Month performance against plan

- Total expenditure at Month 1 April 2024 was £28,431k, which is £45k higher than plan.

- The net overspent is a combination of adverse variances in operations of £696k and overspent of £49k in our NHS 111 service. These are partly offset by favourable variances across other directorates, notably in Medical and SP&T together with financing costs explained below.

- The higher than planned spend in Operations for the month of £696k is made up of 58.6% increased costs in our Field Operations. Other pressures include £157k adverse variance in EOC due to international clinicians not yet operational and the requirement to support the service with additional agencies and overtime and £78k in Specialist Operations relating to earlier than planned procurement of clinical equipment.
  - The overspend of £408k in field operations is driven by the following factors:
    - We saw a slight over provision of operational hours, which was 1.6% above plan. This is because the overall abstraction level is positive at 24.2% against the plan of 32.3%, whilst sickness level of 6.7% is below the target of 7.0%. In addition, planned recruitment is in line with anticipation, and attrition is 45% better than plan.
    - The provision of overtime was higher, in part due to the bank holiday in April, representing 5.9% of the total hours compared to the plan of 1.9% leading to an increased cost of £367k.
    - Other pressure includes higher travel and hotel costs of £56k. Procurement has secured a hotel contract with preferred suppliers which is expected to reduce potential overspent when operational.

- The financial performance in our NHS 111 service in April is 2.1% adverse to plan. The is due to £20k increased overtime and TOIL to provide a safe service delivery during the bank holiday in April. Although the overall abstraction of 28.3% is below the plan of 32.3%, sickness levels remain high at 11.3% compared to the target of 7.0%. The sub-contract with IC24 charges was slightly higher by £29k.

  - These are partly mitigated by favourable variance across other directorates, notably £143k underspent in Medical due to lower than planned clinical supplies, reflecting the low activity and vacancies. Whilst underspend due to improved vehicle preparation performance capacity levels of £70k and 3% favourable fuel rate against a plan of £1.60p are largely contributing to the savings of £134k in SP&T.

  - Finance costs is contributing an additional £71k of favourable variance, mainly through bank interest received reflecting the high interest rates.

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

NHSE Categories	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Pay/Staff Costs	(20,262)	(20,428)	(166)	(248,069)	(248,069)	0
Depreciation	(1,447)	(1,475)	(28)	(19,197)	(19,197)	0
Premises Costs	(1,817)	(1,696)	121	(22,284)	(22,284)	0
Transport Costs	(1,498)	(1,308)	190	(17,966)	(17,966)	0
Purchase of Healthcare (PAPs;IC24;HEMS)	(1,267)	(1,248)	19	(10,591)	(10,591)	0
Supplies and Services	(853)	(859)	(6)	(10,238)	(10,238)	0
Establishment	(474)	(569)	(95)	(5,816)	(5,816)	0
Education Costs	(157)	(175)	(18)	(2,191)	(2,191)	0
Operating Lease Expenditure	(177)	(122)	55	(2,128)	(2,128)	0
Finance Costs	(71)	(1)	70	(855)	(855)	0
Clinical Negligence (CNST)	(164)	(175)	(11)	(1,967)	(1,967)	0
Other	(199)	(388)	(189)	(690)	(690)	0
Total Expenditure	**(28,386)**	**(28,443)**	**(57)**	**(341,992)**	**(341,992)**	**0**
Planned Profit on Sale of Assets	0	12	12	0	0	0
Total Trust Expenditure	**(28,386)**	**(28,431)**	**(45)**	**(341,992)**	**(341,992)**	**0**

Full year performance against plan

- As of April 2024, the Trust is forecasting achievement of plan. This will be updated and reviewed from the end of quarter 1 (June 2024) in line with resubmitted plans.

3. Workforce

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

WTE* By Directorate	Analysis to April 2024			Month of April 2024		
	Mar-24	Apr-24	Movt	Plan	Actual	Variance
Chief Executive Office	43.5	44.2	0.6	50.8	44.2	6.7
Finance	86.7	88.3	1.6	95.4	88.3	7.1
Quality and Safety	59.2	62.6	3.4	53.7	62.6	(8.9)
Medical	194.0	197.4	3.3	224.0	197.4	26.7
Operations	3,637.2	3,651.1	13.9	3,600.4	3,651.1	(50.7)
Operations - 111	399.7	435.0	35.3	428.3	435.0	(6.7)
Strategic Planning & Transformation	133.3	133.9	0.5	136.5	133.9	2.6
Human Resources	77.8	77.1	(0.7)	73.6	77.1	(3.5)
Total Whole Time Equivalent (WTE)	**4,631.6**	**4,689.5**	**57.9**	**4,662.8**	**4,689.5**	**(26.7)**

*Excludes 3rd Party Providers (PAPs)

- WTE for April 2024 increased slightly by 57.9WTE, compared to March 2024 and we were 26.7WTE above plan.

- 57.9WTE more was provided in April compared to last month, mainly in 111 through increased provision.

- The Trust is 26.7WTE above plan for March, Operations has provided 50.7 additional WTE. Medical was significantly under plan by 26.7WTE.

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 April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	26,732	26,778	46	322,247	322,247	0
Expenditure	(28,386)	(28,431)	(45)	(341,992)	(341,992)	0
Surplus / (Deficit)	**(1,654)**	**(1,653)**	**1**	**(19,745)**	**(19,745)**	**0**

999 (Emergency Services)	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	24,144	24,220	76	291,193	291,193	0
Expenditure	(25,736)	(25,781)	(45)	(309,946)	(309,946)	0
Surplus / (Deficit)	**(1,592)**	**(1,561)**	**31**	**(18,753)**	**(18,753)**	**0**

111 (KMS)	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	2,314	2,300	(14)	27,763	27,763	0
Expenditure	(2,355)	(2,404)	(49)	(28,259)	(28,259)	0
Surplus / (Deficit)	**(41)**	**(104)**	**(62)**	**(496)**	**(496)**	**0**

Other	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	274	258	(16)	3,291	3,291	0
Expenditure	(295)	(247)	48	(3,786)	(3,786)	0
Surplus / (Deficit)	**(20)**	**12**	**32**	**(496)**	**(495)**	**0**

- 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 £31k better than plan for the month.

- 111 is £62k worse than plan, through increased staff expenditure for the month.

- Other is £32k better than plan from reduced planned expenditure on the Recovery Support Program.

5. Efficiency Programme

- The Trust submitted a draft financial plan deficit of 19,743k for 2024/25 predicated on the delivery of a £20,673k efficiency target, which represents 5.7% of operating the expenditure.

- The annual target of £20,673k are mostly expected to be delivered on a recurrent basis. Cash releasing efficiencies represent 20.8% or £4,300k of and 79.2% or £16,373k non-cash releasing as shown in the table below.

Summary of Efficiency Delivery Cash realising and Non-Cash releasing

2024-25 Efficiencies Status	Month 1			Full Year		
	Plan	Actuals	Variance	Plan	Forecast	Variance
	£000	£000	£000	£000	£000	£000
Cash Releasing Efficiencies	0	0	0	4,300	4,300	0
Non-Cash Releasing Efficiencies	855	855	0	16,373	16,373	0
Total Efficiencies	**855**	**855**	**0**	**20,673**	**20,673**	**0**

- Delivery of £855k non-cash releasing savings in month 1, April 2024 is in line with plan.

- Achievement of the £4,300k cash releasing efficiencies are planned to commence from the beginning of quarter two. SMG leads are currently working with their Finance Business Partners (FBPs) to identify and develop schemes to support the delivery of their directorate allocated targets.

- Efficiency workshop is scheduled on the 5th of June 2024 with SMG, FBPs and relevant efficiency representatives to agree the pipeline of schemes for the year.

- SMG will present an efficiency report and delivery plan to EMB for approval on 26th June 2024.

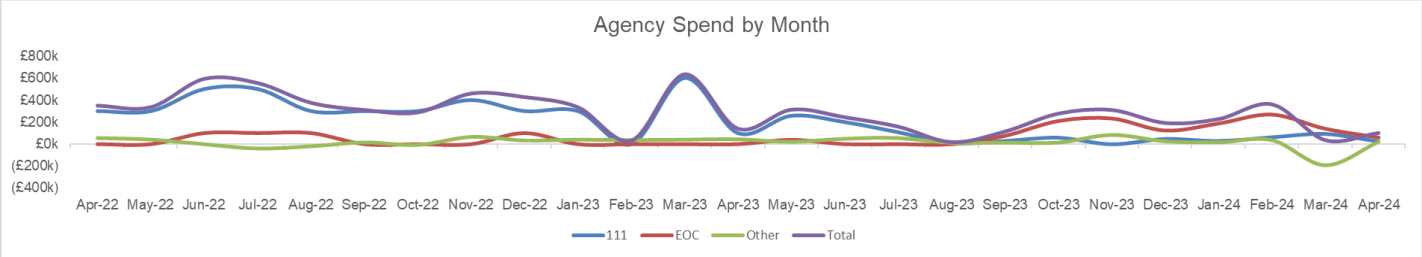
- Delivery of the 2024/25 efficiency target would be challenging and engagement with stakeholders progresses across the Trust to drive the development of sustainable schemes and to explore new opportunities to ensure achievement.

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

6. Agency

	Year to April 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Agency Expenditure	(161)	(103)	58	(1,932)	(1,932)	0

- Overall spend with agencies is under plan by £58k. Majority of the agency spend in April was in NHS 111 (£25k) and EOC (£60k).



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	97,966	(939)	97,027	102,069
Intangible Assets	2,131	(163)	1,968	1,241
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**100,097**	**(1,102)**	**98,995**	**103,310**
CURRENT ASSETS				
Inventories	2,684	19	2,703	3,088
Trade and Other Receivables	7,169	4,197	11,366	6,636
Asset Held for Sale	1,953	0	1,953	1,953
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	35,568	(5,358)	30,210	24,026
Total Current Assets	**47,374**	**(1,142)**	**46,232**	**35,703**
CURRENT LIABILITIES				
Trade and Other Payables	(35,506)	(650)	(36,156)	(47,313)
Provisions for Liabilities and Charges	(14,270)	217	(14,053)	(11,334)
Borrowings	(5,213)	774	(4,439)	(5,755)
Total Current Liabilities	**(54,989)**	**341**	**(54,648)**	**(64,402)**
Total Assets Less Current Liabilities	**92,482**	**(1,903)**	**90,579**	**74,611**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(9,528)	0	(9,528)	(10,757)
Borrowings	(19,545)	250	(19,295)	(20,190)
Total Non-Current Liabilities	**(29,073)**	**250**	**(28,823)**	**(30,947)**
TOTAL ASSETS EMPLOYED	**63,409**	**(1,653)**	**61,756**	**43,664**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,537	0	109,537	109,537
Revaluation reserve	6,871	0	6,871	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(37,562)	(15,437)	(52,999)	(52,999)
Income and expenditure reserve - current year	(15,437)	13,784	(1,653)	(19,745)
TOTAL TAX PAYERS' EQUITY	**63,409**	**(1,653)**	**61,756**	**43,664**

- Non-Current Assets down by £1,102k in the month which represented by new assets under construction of £373k net of monthly depreciation of £1,475k.

- Trade and other receivables are up by £4,197k. This is predominantly driven by a £2,900k prepayment for services and the remainder relating to accruals, including £471k for VAT. The actuals are £2,551k higher than plan, however over future periods there will be a decrease in prepayments and accrued income, and in line with forecast.

- Cash decreased by £5,358k that relates to the above-mentioned planned deficit and higher than planned salary payments. Overall income/cash received was £5,358k lower than spend. The latter is showing the combined effect of £1,019k higher than planned pay and in line with plan non-pay spend. The cash forecast for the year ending 24 March 2025 is £24,026k in line with plan.

- Trade and other payables were up by £650k which relates to the increase in accruals.

- The provision balances are up £217k during the month and relate to pension provisions.

- Borrowings decreased by £1,024k after payments/PO receipts on property rent, vehicle and DCA leases in the month.

- The movement on the I&E reserve represents the Trust's reported deficit for the month and the Full Year.

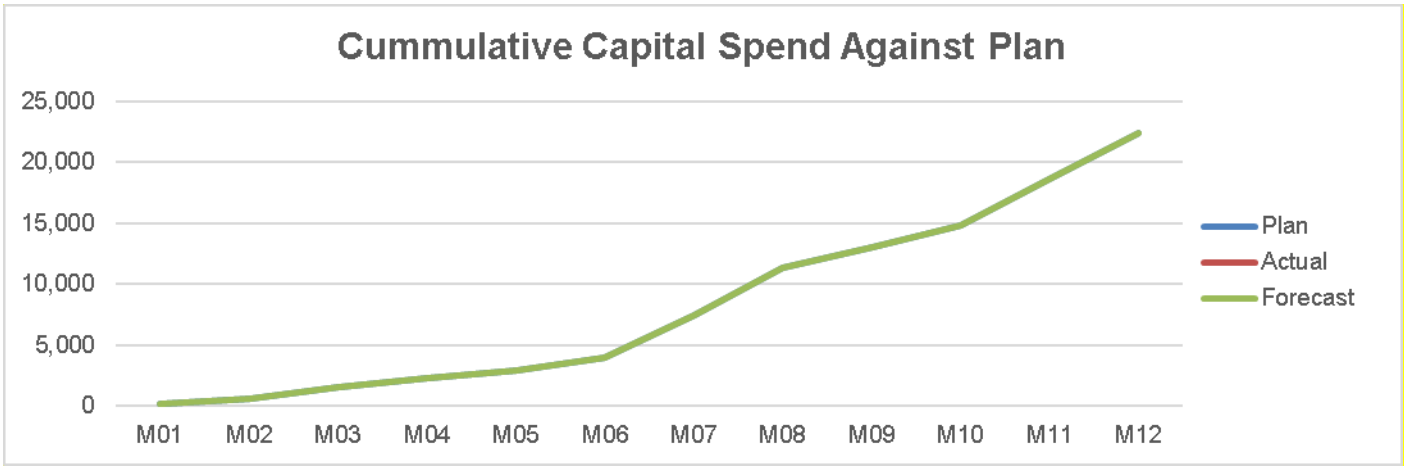
8. Capital

The in-month capital spend is £373k which is £177k lower compared to the plan of £196k.

	In Month April 2024			Year to April 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Original Plan									
Estates	20	228	(208)	20	228	(208)	4,573	4,563	10
Strategic Estates	0	10	(10)	0	10	(10)	0	10	(10)
IT	41	(17)	58	41	(17)	58	3,907	3,907	0
Fleet	62	153	(91)	62	153	(91)	3,058	3,058	(0)
Medical	0	0	0	0	0	0	45	45	0
Total Original Plan	**123**	**373**	**(250)**	**123**	**373**	**(250)**	**11,583**	**11,583**	**(0)**
Extra Allocation*									
Total Extra Allocation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
CDEL Credit**									
Total Sales Income	0	0	0	0	0	0	(1,903)	0	(1,903)
Total Spend	0	0	0	0	0	0	1,903	0	1,903
Total CDEL Credit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PDC									
Total PDC	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Purchased Assets	**123**	**373**	**(250)**	**123**	**373**	**(250)**	**11,583**	**11,583**	**(0)**
Leased Assets									
Estates	25	0	25	25	0	25	674	674	0
Fleet	48	0	48	48	0	48	7,825	7,825	0
Specialist Ops	0	0	0	0	0	0	2,328	2,328	0
Total Leased Assets	**73**	**0**	**73**	**73**	**0**	**73**	**10,827**	**10,827**	**0**
Total Capital Plan	**196**	**373**	**(177)**	**196**	**373**	**(177)**	**22,410**	**22,410**	**(0)**

The Trust has overspent on the YTD capital plan of £196k by £177k, this is due to slippage from 23/24 and will be offset by future underspends.

The Trust is forecasting to meet its capital plan of £22,410k by year end.



9. Risks and Opportunities

Risk Title	Impact	Likelihood	Scoring
New procurement Regulations (Procurement Act 2023)	4	4	16
Lack of insight to procurement pipeline	4	4	16
Procurement Team Capacity/Resourcing	4	3	12
eProcurement Platform	4	3	12
Non-compliance with current PCR	5	4	20
Procurememt Contract management	4	3	12
Financial Sustainability (BAF)	4	3	12
Counter Fraud	3	2	6
Financial capability to deliver the Executive Re-structure	4	3	12
Resourcing the Finance Team	5	3	15
Section 2 Pay Inaccuracies	4	4	16
Uplift of ECSW and TAAP Staff from Band 3 - 4	5	4	20
Re-configuration of Nexus House and compliance with the Equality Act	5	3	15
Insurance Claim for flooding at Chertsey	4	3	12
Chertsey Fleet Workshop	3	2	6
Inadequate security measures at Paddock Wood Make Ready and Medicines Packaging Centre	4	2	8
SoD, SFIs, SOs update	4	3	12

- 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.

	Agenda No	27d/24
Name of meeting	Trust Board	
Date	6 June 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 23 May 2024.

Item

Financial Performance & Planning

The M12 financial position was reviewed, with the planned breakeven achieved and delivery of the £9m efficiency programme. This includes some pressures in operations with a £3.3m adverse variance that was offset by additional income. A proportion of the efficiency programme was non-recurrent which will impact the plan for 2024-25.

Capital was £8m behind plan due to a planned delay in the fleet build, following staff feedback. There was no adverse impact on operations as we increased the lease of existing vehicles. The new DCAs arrived in April 2024. The capital plan for 2024-25 was supported.

The committee congratulated the executive on this positive achievement in challenging circumstances.

The 2024-25 deficit plan was considered in the context of the system financial plan. The projected deficit has clear rationale and the committee does not consider this related in any way to suboptimal financial control. It reinforced the need to not take short term decisions to the detriment of long-term value for money. The detail of this will be discussed in Part 2 of the Board.

The M1 position was also considered showing an overspend in operations pay. There is a need to understand the detail so the executive can better predict demand and balance the provision of hours in line with budget. The complex levers were noted which EMB is in the process of exploring; the outputs of this will come back to the committee at its next meeting.

The committee noted that some HR policies need reviewing to better support more dynamic planning of hours. It asked that the executive confirm the list of these policies and a plan for dealing with them, in a way that treats people fairly while getting the best productivity and value for money.

Lastly the committee explored the action needed to further improve financial controls, e.g. contract management. It reinforced the need to ensure better productivity, especially given the national challenge to all providers, acknowledging that some productivity is already really strong e.g. the approach to frequent callers; handover delays; and the trust strategy is to ensure overall more efficient services.

Commissioned Contracts

There was a good review of the contracts, noting the decision to serve notice on the private ambulance providers (PAPs) and the Neonatal contracts. The decision on PAPS aligns with the trust's long term workforce plan and strategy and is consistent with the current workforce plan where we are now over-established.

The 999-contract for 2024/25 has yet to be signed - expected in the second quarter of 2024/25 further to the discussions on the operating plan. The service specification (Schedule 2 of the 999-contract) is under review.

Medicines Distribution Centre

This paper updated the committee on progress with the estates work. A refreshed project board with new ToR has been launched. And improved design features have subsequently been agreed adding further flexibility, security and resilience. A procurement 'route to market' for construction has been agreed, with the tender beginning in late May. Due to extended lead times, the procurement for a goods lift has already been initiated and is nearing completion. The broad timings are to start construction in late July/early August and hand over/go live in October. Progress to date in is line with the revised delivery plan.

From October will we need to review the strategic approach to the plan for both the MDC and the MRC, in light of the new strategy. This will be considered in Q3 as part of the Estates Strategy.

The committee is assured this is now back on track despite some challenge on the timeframe, linked to our reliance on the tender process / supplier availability etc.

DCA Selection / Fleet Strategy

The Trust operates a total DCA fleet of 414 DCA's currently made up of Mercedes Sprinter Box Body and Fiat Ducato van conversions. As part of the yearly rolling vehicle replacement plan there is a requirement to procure new DCAs and replace the oldest ones on the Fleet that are at the end of their useful planned life cycle. Currently these replacement cycles are set at 7 years for a Box conversion DCA and 5 years for a van conversion DCA. Ahead of the business case to be developed in June, the committee reviewed the process of engagement and criteria to be used to inform the recommendation. It is assured there is good engagement supported by the vehicle user group, which includes key stakeholders.

Procurement

A helpful paper set out the procurement activity which the Procurement Team anticipates over the coming year or so, based on a review of the contract register and spend data. The executive is undertaking a review to ensure it is accurate as this is the first time we have had this in place. It will cover all procurement activity to ensure compliance with SFIs and procurement and tender thresholds.

The committee felt this is a good start and has asked for an assessment on the link to the trust strategy and delivery of our priorities. So that we can be assured of its relevance to business delivery. Good start.

The committee noted the plan for an assurance paper to be considered by the audit committee in July, related to governance and compliance.

Digital Update

A verbal update provided by CDIO on his initial assessment, including the work on a targeted operational model and digital strategy, which is one of the strategic priorities.

Operational Performance Performance continues to be positive, with achieving the C2 mean target of 30 minutes (currently 24 mins) and call handling within ARP standards. The committee is assured with the level of performance, noting as discussed in the finance item, the analysis needed to ensure our processes are flexible enough to balance demand and resource, given the deficit we are planning.	
Specific Escalation(s) for Board Action	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.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Southern Ambulance Services Collaboration (SASC)

1.Introduction

1.1 On 22 May 2024, a new collaboration between five ambulance trusts - the Southern Ambulance Services Collaboration (SASC) - was launched.

1.2 SASC has five member Trusts – SECAmb, East of England Ambulance Service NHS Trust (EEAST), London Ambulance Service NHS Trust (LAS), South Central Ambulance Service NHS Foundation Trust (SCAS) and South Western Ambulance Service NHS Foundation Trust (SWAST).

2. Background

2.1 Against a background of growing pressure on both NHS finances and performance, recent years have seen strong national encouragement for NHS Trusts to work together more closely to improve efficiencies and maximise benefits for patients and staff.

2.2 The NHS has already relied on collaboration between organisations, and, over the years, this collaboration has covered a wide spectrum, including the creation of group models and full mergers in some instances.

2.3 Following the pandemic and building on lessons learnt, NHS England provided guidance on the role that provider collaboratives can play in delivering better care. Most acute and mental health providers are in at least one collaborative and have delivered benefits for patients that would not have been delivered by working alone.

2.4 All ambulance trusts in England already work together on a range of topics at different times. Some of this is through NHS England and some is through the Association of Ambulance Chief Executives (AACE).

2.5 However, in 2016 a formal alliance - the Northern Ambulance Alliance (NAA) was formed by North East Ambulance Service, North West Ambulance Service and Yorkshire Ambulance Service – was created. East Midlands Ambulance Service subsequently joined the NAA in 2017.

2.6 The remaining five southern ambulance Trusts in England have worked together informally in a range of different ways but there has previously been no formal agreement or alignment.

3. Creation of the Southern Ambulance Services Collaboration

3.1 In Autumn 2023, the Chief Executives of the five southern Ambulance Services began to discuss how we could work together more closely to collectively address some of the big challenges facing them all.

3.2 The challenges facing all of us include evolving patient demand, a constrained financial environment and ongoing recruitment and retention issues . Additionally, the complexity of patient demand is resulting in a framework that encourages specialism in services and reconfiguration of hospitals and primary care services.

3.3 We collectively feel that now is the right time to formalise how we work together to respond to these shared challenges and deliver the best possible care to patients, whilst operating in a constrained financial climate.

4. How will the Collaboration work

4.1 The Collaboration will allow all member Trusts to choose to work together on particular initiatives as they feel best meets their needs.

4.2 The specific areas that will be worked on jointly will be identified by our people. Current ideas for consideration include shared procurement to reduce costs, harnessing technology, and AI to improve our services and care, identifying where we can learn from each other (particularly in the 999 operations and contact centre environments), training and education, and well-being.

4.3 One of the first pieces of work that the Collaboration will undertake will be to identify which trusts perform certain functions particularly well and where shared learning can make a real difference to the care we provide and to colleagues working lives.

5. Updates

5.1 As the work of the Collaboration progresses, I will ensure that regular updates are provided to the Trust Board and that any decisions required are taken through our Trust governance processes.

Simon Weldon, Chief Executive

May 2024

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	27f-24

Name of meeting	Trust Board
Date	06.06.2024
Name of paper	Strategic Partnerships Update
Strategic Goal	**Sustainability & Partnerships**
Lead Director	David Ruiz-Celada, Executive Director for Strategic Planning & Transformation
Author(s)	Matt Webb, Associate Director of Strategy & Partnerships
Primary Board Papers	BAF Risk 257

This report updates the Board on key regional Urgent & Emergency Care (UEC) priority areas as reported to the Executive Management Board in Q1 (2024/25). It covers ICS governance alignment, Health Overview and Scrutiny Committees, Right Care Right Person (RCRP) implementation, care coordination hubs, community provider access to category 3 & 4 incidents, and provider collaboratives.

Key Sections

1. Integrated Care Systems (ICS) Governance Alignment

The Trust revised its governance structure through 2023/24 to align with its Integrated Care Systems (ICSs). Key initiatives include the Joint Chief Executives Meeting, a Strategic Commissioning Group (SCG), and an ICS Collaborative for Clinical Quality, improving coordination, communication, and patient safety oversight.

2. Health Overview and Scrutiny Committees (HOSCs)

The Trust provides regular updates to six HOSCs, covering operational performance, quality and patient safety, and strategic developments. Recent topics include 111 and 999 performances, the Improvement Journey, the Strategy Development Programme, and community pathway optimisation.

3. Right Care Right Person (RCRP) Implementation

RCRP improves responses to mental health-related calls with four pillars: Concerns for Welfare, AWOL/Missing from Hospital, Section 136, and Transport to a Health Based Place of Safety. All three police forces have now gone live with the first phase of the implementation.

4. Care Coordination Hubs

Care coordination hub pilots undertaken in Kent & Medway have shown reduced emergency department conveyance with improved community pathway utilisation, improved patient outcomes, and enhanced collaboration.

5. Community Provider Access to Category 3 & 4 Incidents

The Trust has launched a portal for community trusts to access category 3 and 4 incidents, enhancing timely support. The Sussex ICS went live first, followed by Kent & Medway, Surrey Heartlands, and Northeast Hampshire.

6. Provider Collaboratives

The Trust is actively collaborating with its four ICSs to support the establishment of provider collaboratives in alignment with their joint forward plans. This strategic approach ensures that the Trust engages in initiatives that are most relevant and beneficial to the communities it serves.

Recommendations, decisions or actions sought	The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in August (2024).

1. Introduction

This report updates the Board on the following key ongoing regional Urgent & Emergency Care (UEC) priority areas, as reported to the Executive Management Board throughout Q4 (2023/24) and Q1 (2024/25).

1) ICS Governance Alignment
2) Health Overview and Scrutiny Committees
3) Right Care Right Person (RCRP) Implementation Status
4) Care Coordination Hubs
5) Community Provider Access to Category 3 & 4 Incidents
6) Provider Collaboratives

2. ICS Governance Alignment

2.1. Governance Revision

In response to the evolving healthcare landscape, the Trust revised its governance structure through 2023/24 to align with its Integrated Care Systems (ICSs). This framework ensures robust representation at regional (supra-ICS), system (ICS), and place levels.

2.2. Regional (Supra-ICS) Collaboration

- Introduction of a Joint Chief Executives Meeting and Strategic Commissioning Group (SCG) with ICB executives.
- Establishment of an ICS Collaborative for Clinical Quality with ICS executive clinical leads and provider partners.

2.3. System-Level Governance

- Refinement of the System Assurance Meeting and contract review meetings for the 999 and 111 services.
- Trust executive directors designated to each ICS for direct representation and enhanced decision making.
- Introduction of internal System Governance Groups (SGGs) for cross-directorate collaboration.

2.4. Benefits

This revised governance framework has improved coordination with commissioners and provider partners, enhanced communication, and integrated strategic planning activities. Furthermore, it has strengthened patient safety initiatives, quality governance, and empowered local leadership, with enhanced data-driven decision-making, and reduced duplication of efforts.

2.5. SGG Highlights

The SGGs have focused on critical topics such as Interfacility Transfers (IFTs), Health Care Professional (HCP) requests, access to shared care records, and patient safety measures. Discussions have emphasised improving patient safety and operational effectiveness, including community pathway optimisation.

3. Health Overview and Scrutiny Committees (HOSCs)

3.1. HOSC Overview

Health Overview and Scrutiny Committees (HOSCs) play a vital role in holding healthcare providers accountable and ensuring services meet community needs. With the implementation of ICSs, HOSCs continue to review and scrutinise health services while increasingly examining the operations of Integrated Care Boards (ICBs), integrated care partnerships (ICPs), and ICSs.

The Trust is accountable to six HOSCs across its service area, providing regular updates and presentations to contribute to whole system assurance facilitated by each system's ICB and UEC Board.

3.2. 2023/24 Updates

Over the past year, the Trust has delivered comprehensive updates on operational performance, quality and patient safety, workforce and wellbeing, compliance with regulatory requirements, winter preparedness, and the ongoing development of the Trust Strategy, with the most recent updates taking place at the Surrey, West Sussex, and Medway councils during Q4, 2023/24. The Trust has been commended on its progress and the informative updates on several occasions.

During the pre-election period, the Trust is working with local councils to defer planned HOSC updates, in accordance with pre-election guidance for NHS organisations and approaches being taken by partner providers. It has been agreed that the East Sussex and Kent committees scheduled during the next month will be deferred accordingly.

4. Right Care Right Person (RCRP) Implementation Status

4.1. Pillars

Right Care, Right Person (RCRP) is a national initiative to improve responses to mental health-related calls by ensuring the appropriate agency handles these incidents. This model aims to enhance outcomes, reduce demand, and ensure the right care is provided by the right professionals. The initiative is structured around four key pillars: Concerns for Welfare, AWOL/Missing from Hospital, Section 136, and Transport to a Health Based Place of Safety.

4.2. Implementation by Region

- Kent Police: Launched all four RCRP pillars on the 2nd of April 2024.
- Sussex Police: Went live on the 2nd of April 2024 with the Concern for Welfare pillar. Working groups are addressing any emerging risks and gaps.
- Surrey Police: Implemented the Concern for Welfare and AWOL/Missing from Hospital pillars on the 11th of April 2024. Section 136 and Transport to a Health Based Place of Safety are scheduled for September, focusing exclusively on adults until further review.

4.3. Regular Meetings and Review

Regular meetings with tactical and strategic ICS and policing partners include lessons learned sessions and deep dives to evaluate decisions and ensure continuous improvement throughout the implementation period.

4.4. Trust Position

The Trust is committed to ensuring individuals with health and social care needs receive appropriate services through active participation in the RCRP initiative. The initiative has shown positive results with no notable increase in calls or incidents. Trust-supported activities include assisting in police control rooms, joint communications, evaluating scenarios and collaborating closely with partners, including mental health providers.

5. Care Coordination Hubs

5.1. New Models of Working

The Trust has been piloting multidisciplinary care coordination hubs within the Kent & Medway ICS, supported by Trust advanced paramedic practitioners and clinicians from Urgent Community Response (UCR), acute, mental health, and primary care services.

5.2. Pilot Hubs

- East Kent (Ashford) Hub: This 'pre-dispatch' model focuses on 999 calls coming into the Trust with real-time assessment and coordinated clinical responses.
- West Kent (Maidstone) Hub: This 'post-dispatch' model contacts ambulance crews at the patient's side to provide a coordinated clinical response and identify appropriate referral pathways if ED transport is not necessary.

5.3. Early Results

Both pilots show early evidence of reduced conveyance to emergency departments, improved patient outcomes, and enhanced collaboration among partner healthcare providers.

5.4. Evaluation and Expansion

A working group of subject matter experts is working with the Trust's ICBs to review the success and sustainability of these models, ensuring alignment with the Trust's strategic direction and the ICBs joint forward plans. Discussions are underway with the ICBs and partner providers to progress similar hubs across Surrey and Sussex to support resilience in Winter 2024/25.

6. Community Provider Access to Category 3 & 4 Incidents

6.1. Daily Touchpoint Calls

The Trust, in collaboration with commissioners, NHS England, and community partner providers, established daily 'touchpoint' calls in 2023/24. These calls have allowed community providers to view the Trust's clinical stack of category 3 and 4 incidents and discuss potential direct referrals to Urgent Community Response teams or Virtual Wards.

6.2. Portal Access Initiative

Building on the success of the touchpoint calls, the Trust recently launched a portal access initiative. This allows community trusts to directly access the clinical stack of category 3 and 4 incidents through a secure web browser, enabling Urgent Community Response teams to view and identify applicable incidents for self-referral throughout their operational hours.

6.3. Expansion and Impact

The Sussex ICS was the first to go live with portal access, followed by the Kent, Surrey, and Northeast Hampshire ICSs.

This initiative enhances the ability to provide timely and appropriate support for patients in the right setting.

7. Provider Collaboratives

Provider collaboratives are partnerships that bring together two or more NHS trusts to work together at scale, benefiting their populations through shared services and integrated care pathways.

7.1.1. Sussex ICS

Primary and Community Care Collaborative: Recently established as a formal collaborative, this initiative builds on an existing network and now has the capacity to plan and

progress delivery at the place level. It aligns with the development of Integrated Care Teams (ICTs), aimed at identifying and meeting population health needs and addressing inequalities.

7.1.2. Surrey Heartlands ICS

Acute Provider Collaborative Partnership: This partnership involves four Acute Trusts and the Surrey and Borders Partnership (SABP) Mental Health Foundation Trust. It focuses on acute specialist pathways with the formation of a Clinical Reference Group. Initial engagement meetings are being scheduled, with Trust engagement through the Partnerships Team.

Community Collaborative Partnership: Two initial workshops have been attended by the Trust, with a third workshop scheduled for the 19th of June 2024. This collaborative is focused on establishing provider engagement and identifying key areas to optimise community-based care. Focus areas include funding consistency, addressing place variation, shared system risk, pathway profiling, trusted assessor agreements, and information governance.

7.1.3. Kent & Medway ICS

Mental Health, Learning Disability and Autism (MHLDA) Provider Collaborative: This partnership aims to tackle complexities within MHLDA services, including a focus on mental health urgent and emergency care. The Trust is actively involved in developing this collaborative, with governance arrangements currently being finalised. Additionally, the Trust is collaborating with the Kent & Medway ICB to clarify the scope of its emerging community and acute care collaboratives and will provide an update during the August Board meeting.

7.1.4. Frimley ICS

An update on the Frimley ICS provider collaborative opportunities and the confirmation of the final operating model is awaited, with details expected in June 2024.

8. Recommendation

The Board is asked to note the contents of this report and to identify any additional key lines of enquiry for the subsequent Board update in August (2024).