South East Coast Ambulance Service
NHS Foundation Trust

Trust Board Meeting to be held in public

3 October 2024

10.00-13.30

Trust HQ, Nexus House, Crawley

Agenda

Item No.	Time	Item	Purpose	Lead
Board Governance				
47/24	10.00	Welcome and Apologies for absence	-	UK
48/24	10.01	Declarations of interest	To Note	UK
49/24	10.02	Minutes of the previous meeting: 08 August 2024	Decision	UK
50/24	10.03	Matters arising (Action log)	Decision	PL
51/24	10.05	Chair's Report	Information	UK
52/24	10.10	Audit & Risk Committee Report	Information	MW
53/24	10.15	Update to Constitution	Decision	PL
54/24	10.20	Chief Executive's Report	Information	SW
		Southern Ambulance Collaboration – Manifesto	Decision	SW
Strategy & Performance				
55/24	10.40	Digital Strategy	Decision	SBr
56/24	10.55	HR Improvement Plan	Decision	SWa
57/24	11.10	Board Story	-	RQ
58/24	11.20	**Strategic Aim: We Deliver High Quality Care**	Assurance	
		Supporting Papers: a) Quality & Patient Safety Committee Report b) BAF – Progress / Risks c) Integrated Quality Report		
59/24	11.50	Winter Planning	Information	MD
	12.00	Break		
60/24	12.10	**Strategic Aim: Our People Enjoy Working at SECAmb**	Assurance	
		Supporting Papers: a) People Committee Report b) BAF – Progress / Risks c) Integrated Quality Report		
61/24	12.30	**Strategic Aim: We are a Sustainable Partner as Part of an Integrated NHS**	Assurance	

		Supporting Papers: a) Finance & Investment Committee Report b) BAF – Progress / Risks c) Integrated Quality Report d) Month 5 Finance Report		
62/24	12.50	SFIs	Decision	SB
63/24	13.00	Procurement Strategy	Decision	SB
Board Meeting Effectiveness Review				
64/24	13.10	Trust Values ▪ Courage ▪ Kindness ▪ Integrity		UK
Closing				
65/24	13.15	Any other business		UK

After the meeting is closed any questions received[1] from members of the public / observers of the meeting will be addressed.

[1] Only questions submitted at least 24 hours in advance of the Board meeting will be taken. Please see website for further details: Trust Board

South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting

08 August 2024

Nexus House, Crawley

Minutes of the meeting, which was held in public.

Present:

Usman Khan	(UK)	Chair
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)	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
Simon Bell	(SB)	Chief Finance Officer
Richard Quirk	(RQ)	Acting Chief Medical Officer
Mojan Sani	(MS)	Independent Non-Executive Director
Karen Norman	(KN)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Company Secretary
Stephen Bromhall	(SBr)	Chief Digital & Information Officer
*Steve Lennox	(SL)	Improvement Director
Matt Webb	(MWe)	Associate Director of Strategic Planning & Transformation
Andrea Vigille	(AV)	Deputy Director of HR

*joined via MST

30/24 Welcome and Apologies for absence

UK welcomed members, in particular KN to her first meeting, and those in attendance and observing.

UK addressed the recent public disturbances and the statement from the Trust that was supported by Trade Unions.

The following apologies were noted:

Simon Weldon	(SW)	Chief Executive
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Sarah Wainwright	(SWa)	Interim Director of HR & OD
Rachel Oaten	(RO)	Chief Medical Officer
Janine Compton	(JC)	Head of Communications

31/24 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.

32/24 Minutes of the meeting held in public 06.06.2024.

The minutes were approved as a true and accurate record.

33/24 Action Log [10.06-10.07]

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

34/24 Chair's Report [10.07–10.13]

UK outlined the approach to the meeting and welcomed the formal launch of our new values and strategy. The Board considers a richness of data through the IQR and new Board Assurance Framework that helps provide assurance to the public that we are working to the right values in delivery of our strategy. The way the Board does this will likely evolve over time to ensure we get this as smooth as possible.

UK also mentioned the most recent Board development session reflecting on how we have spent our time as a Board to ensure we are as effective as we can be. And made the connection between Board and COG, highlighting the value of the COG in our governance structure, as a critical voice of our local communicates.

Lastly, UK referred to the external focus and outlined the engagement he has had with system partners since the last Board meeting.

35/24 Audit & Risk Committee Report [10.13–10.20]

MW summarised the output of the most recent meeting, which included approval of the annual report and accounts. There is some learning from the year end process, which the committee will review in September.

The Board noted BDO have started as our new internal auditors, and MW reflected on the committee's current assessment of our internal controls. The executive is providing a glide path to a more positive Opinion this year through improved controls.

The committee also reviewed the Cyber risk, and the new national evaluation process starting in Q3. The Digital strategy aims to strengthen our cyber security and this is scheduled to come to the Board in October, for approval.

In terms of the committee's review of risk. MW explained the focus on process to ensure we capture and ensure robust mitigation. Overall there is good work to strengthen our risk management arrangements, but more to do especially with our risk culture. MW reinforced the need to take risk with innovation, within a framework. The committee also looked at strategic risks and feel these are comprehensive. It is assured currently with the improvement priorities and will keep these under review.

The Board acknowledged the new Resilience sub-committee established to help ensure greater Board oversight of the issues identified last year.

KN asked MW what issues are most significant. MW responded that cyber is critical and while we can't mitigate completely it is important we do all we can. The other issue is to strengthen our internal control environment to ensure we deliver better value for money. There is a clear plan on how we do this and so it is about holding the executive to account for delivery.

UK thanked MW and the committee for its work. There were no further questions.

36/24 Chief Executive's Report [10.20–10.37]
In SW's absence DR highlighted the following from the CEO's report.

- New strategy: launch here but work to deliver against the priorities has already started as set out in the BAF. He thanked all for their contributions to the strategy, which has been very much co-designed to adapt to changing needs of patients.
- SE regional leaders meeting highlighted a need for a new NHS operating model; our strategy puts us in a good position to align with this.
- SH ICB visited the Ashford Hub to help reinforce how this approach aligned with strategy will benefit system and patients.
- JPF approved the uplift of ECSWs from band 3 to Band 4, which is good news and is a key mitigation to the related BAF risk.

UK thanked DR and opened to questions.

LS asked about how we interlink our strategy with others. DR confirmed that SH ICB is joining in Part 2 to present its strategy, which has been developed with our input. There is also work to embed us in the system, demonstrated by the Sussex delivery plan which goes hand in hand with delivery of our Hubs. In addition, system partners were fully engaged in our strategy. The new BAF risk relates to system collaboration acknowledging the risk of ensuring engagement continues across ICBs.

PB asked about 111 and how this supports system flow. EW responded by setting out how we have approached delivery of 111 in collaboration with partners such as GPs and emergency departments to ensure patients are managed in the right place. The 111 Clinical Assessment Service is central to this.

This led to a discussion about whether we celebrate enough our successes, such as this.

KN asked about sexual safety and if we have all the support in place. MD responded that our plan for the session in November will be to determine what zero tolerance means. In terms of support, we are getting into areas of specialism, and so need to help re frame our own thinking with some more specialist help. We are thinking this through now to establish some dedicated resource. In the meantime, our people are on board with the direction.

UK confirmed that as a Board will continue to return to this important area.

37/24 & 39/24 Trust Values and Board Story [10.37-10.57]
EW introduced the new values outlining the approach and reinforcing how integral the values are but needs to be seen in action. These have been well engaged with our people alongside the development of our strategy. The feedback was strong about the need for fewer more meaningful values. We have landed with three – Kindness; Courage; and Integrity.

EW confirmed that today is the start and as we implement the values and embed these in how we do things, there will be specific actions as set out in the paper. The challenge for the Board is how this relates to our work and how we bring them to life. Against this background, EW then introduced the video (Board Story) showing staff describe what the values will mean to them.

UK thanked the executive for all the work that has gone into this; it is clear there has been a real process which will help ensure the values are embedded. The Board's effectiveness review following each meeting will from October be framed by these values. UK then opened up for comments, thoughts and reflections.

MP commented that this has been great work. He is keen to understand the sequencing of all the embedding activities so we maximise the opportunity. DR responded that we have described a number of activities and this can't be separate from our people plan or clinical plan; we need collective leadership to bring this to life. In September we will look at the People Plan in detail and how we integrate appraisals, recruitment etc. AV added that in September we will be exploring how we get the whole Board behind this.

MW reflected that we do sometimes revert to compliance, e.g. appraisal completion, and asked in the context of the values that we focus more on quality of conversation. A softer holistic approach would be better. DR gave the example of how the staff awards will be framed against the new values.

LS asked how on behalf of patients we are going to communicate the messaging and how will they see and feel it as part of our service delivery. DR suggested we come to this later in the agenda.

KN takes heart from the video and people she has met demonstrating that people are clearly committed to this already.

UK summarised that the Board is fully supportive of the values which will inform board reporting and its ongoing development programme.

38/24 Launch of Strategy [10.57–11.23]

MWe introduced the strategy which builds on the values and he outlined some of the key drivers, in addition to the extensive engagement both internally and externally. Our Purpose is restated underpinned by three strategic aims, which frames the new BAF and Board agenda. The strategy aims to deliver care differently to better meet the changing needs of patients. The BAF sets out the clear deliverables for the next year and MWe highlighted some of these which will bring the strategy to life, underpinned by the Values.

UK confirmed how engaged the Board has been over the last 12 months. The time taken has been critical to engage and get to the right outcomes for SECAMB, the system and our people and patients. UK clarified that the strategy has already been approved and so this is about its formal launch.

MS wondered if we will have a strategy on a page and/or a road map. DR confirmed that we will have both and published on our website. DR added that we are also working as an executive team on the enabling strategies we need, such as digital and procurement.

MW reflected that we are in period of significant change and he asked what we would say to member of the public to describe how the strategy will make a difference to them. And what would we say to Government on how this helps achieve their ambitions.

MWe responded by explaining the wasted resources in sending an ambulance to see if an ambulance is needed; the strategy seeks to align the skills of clinicians with the needs of patients to ensure we provide the right response at the right time. The strategy supports the provision of a consistent response for all emergencies; fast and prompt to get patients to the right place for ongoing treatment. But for other patients with complex needs who won't benefit from such a standard response, then core to the strategy is our 'virtual' response. This will ensure access to the right pathways, which will improve clinical outcomes.

MWe referred to the Darzi review which confirms the national model is strained. Our strategy helps to position the ambulance service in the urgent and emergency care space.

MD drew a link to health inequalities, and explained how we will monitor and evaluate using health inequalities tools to ensure parity of response and outcomes.

KN noted the assumptions underpinning the strategy, such as collaboration and resourcing. She asked if we have 'plan b' if these assumptions do not materialise. DR responded that as part of the engagement and development we presented a range options, which were subsequently discarded including not collaborating. Therefore, we don't have a 'plan b', but we accept that not all the things we will do will work first time. The way we shift the clinical model might change as we learn over time, using our value of courage and integrity.

UK felt that what this shows is flexibility on the principles of the strategy.

MWe agreed. The strategy has allowed us to be seen a UEC system leader. Collaboration has already been demonstrated through development of the Hubs. On resourcing, this strategic option does not require us to increase resource but instead realign skills with patient need; in fact, our workforce over time is likely to reduce / become more efficient.

There were some questions of clarity on the Hubs and their core hours and alignment with the availability of care pathways. The discussion then moved on to the comms plan and two overriding key messages; patients will receive a reliable service / response when in an emergency; and those with an unscheduled healthcare need will be supported to get the care they need.

UK summarised that this discussion has captured the essence of strategy well. This strategy will be transformational and will require continual engagement with our people, patients and partners to deliver.

40/24 We Deliver High Quality Care [11.23-12.03]

UK reminded the Board that this is an iterative process of connecting the strategy and values and the Board's governance, using the new BAF and existing IQR.

MD and RQ then covered the key issues confirming there are no exceptions to highlight from the IQR. The Board noted the work on the metrics aligned to PSIRF, and how we can better assess patient safety.

MD celebrated the QI project 'safety in the waiting list' and the new automated text message service in place which has seen significant benefits. RQ talked to the unscheduled care navigation hubs, which is a really ambitious programme. Significant work has been undertaken by the clinical leadership across the trust, ICBs, and provider organisations to get these established. From a patient perspective this is about getting the right care at the right time, as discussed already. Pace is the biggest risk, to get these live for October. This is presenting significant challenges for all involved but robust plans are in place.

RQ then touched on the clinical models and pathways of care, explaining that we have taken patients groups and aligned them into 11 health conditions. We can't make this happen on our own as pathways of care involves multiple partners, but we are working together. ICBs are key to driving this and we have good relations with all four in our region. Later in the agenda the Sussex ICB Plan includes Hubs within their priorities.

On patient experience, MD confirmed the ambition to develop a new strategy by December. This connects with a number of organisations and harder to reach communities, to get feedback. Community forums continue but the risk is that this is led by two people. Next year will need a discussion about resource. Patient experience questionnaires show small numbers of responses, but nonetheless helpful feedback is coming through.

UK asked LS to provide the quality committee's view on the key issues. LS highlighted right care right person which is now rolled out, with good assurance there are no significant issues currently. The issue arising from the staff survey and feedback about how we manage deceased patients; the committee took this seriously with a look back review and while this demonstrated good care it helped identify a gap in the feedback loop

to staff. The committee is monitoring any adverse impact of the decision to stop using PAPs. Nothing of concern to-date. Lastly, there was good assurance related to the work on acute behavioural disorder where we are now one of the leading ambulance trusts in this clinical area.

UK thanked LS for this which helps to see at committee level how this strategic aim is being driven. UK then asked in light of the executive overview and oversight of QPSC, for any questions / comment on how the areas within the BAF are supporting the assurance of the Board.

MW felt that the Board is focussed on patient outcomes and suggested we start with outcomes rather than input and process. In this context he asked how we are meeting patient need, currently, for example stroke patients given the data in the IQR. RQ responded on stroke that this is a Quality Account priority, and we acknowledge the need to do better. Telemedicine is being rolled out nationally with the aim to take patients to the right hospital, not necessarily the nearest. We need to consult with hospitals, which in theory could extend on scene and travel times, but should improve outcomes. The national data is providing good evidence of this. RQ agreed on the broader point that we are not good in the NHS at focussing on patient outcomes. Especially in the community and ambulance services. The 11 models of care priority mentioned earlier provides clinical leaders the opportunity to design models that are aligned with what we think will improve outcomes. So RQ agrees this is the way round we should approach this in terms of Board focus and assurance.

MW is interested too in what the cost of patient outcomes are as this will then inform resource allocation. He encouraged the executive to draw more clearly the link between quality cost and outcome. MD responded that quantifying outcome for ambulance services is difficult for reasons we have discussed many time previously, e.g. lack of data from providers on the patients we pass on. However, the ARP targets are based on patient outcomes.

PB asked about the BAF risk related to the multiyear plan. DR explained that this connects our ability to deliver the strategy with the ability to become sustainable. We can't transform by ourselves, and the models describe our view on what good looks like for patients. Aligned to the multiyear plan assumptions is the clinical workforce, so it is complex but why models of care are a priority for this first year of the strategy. DR reinforced that this has to be seen in this wider context rather than what SECAMB can do alone.

HG also asked about patient outcomes, and wondered if we are missing the benchmarking for patient outcomes, in addition to the performance data. DR agreed to review this as part of the ongoing review of the IQR.

MWe explained that it is recognised by ICBs that this requires significant change in clinical culture and we are now part of different provider collaboratives at community level. Also, we are part of the national strategy and transformation group reviewing the benchmarking of care pathways.

Action
QPSC to review the evaluation /outputs of the provider collaborative**s** we are involved with and the national transformation group reviewing care pathways.

MS could not see any clear activity to achieve the priority for health inequalities. MD confirmed this is captured by the Quality Account priorities, and this will be reported through QPSC. DR added that there is more work to be done to assess the impact of all our activities on reducing inequalities, and how we reflect progress through data in the BAF. The Board noted this will be a focus of the Board development session in November.

Before closing this item, UK reflected on how this discussion has worked as an assurance process. What has come out has been a focus on patients and from NEDs we need to ensure both the patient voice and experience comes through the reporting against our strategy.

[break 12.02 – 12.10]

41/24 Our People Enjoy Working at SECAmb [12.10-12.26]

AV highlighted from the BAF / IQR the work to prioritise employee relation, culture and retention and the HR operating model. She then outlined some of the work ongoing, for example the additional resource to manage ER cases. Linked to the BAF risk AV summarised the work with trade unions to improve partnership working. A new culture group has been established to ensure progress with the actions and steps are in place to refresh the Retention Plan, using data to focus where we can make the biggest difference for our people.

The Board noted that the IQR is showing sickness rates improving although still remain below target; QV confirmed the focus on long term sickness. In terms of appraisals work is ongoing to improve compliance and there is a focus on quality conversations.

In SS's absence, MP then summarised the outputs of the most recent People Committee meeting, highlighting the areas of assurance set out in the report. There was a good discussion on the diagnostic AV referred to and the committee will return to this in September. The meeting helped to demonstrate clear executive alignment on the issues, reinforcing this is not just a matter for the HR Director.

UK thanked the committee for its oversight and opened the discussion.

MD added on the Retention Plan that things have moved on since it was agreed last year, and so a refresh is needed to ensure we are focussing on the right areas.

HG reflected the evidence within the IQR that demonstrates a number of areas are close to target. This positive movement in the metrics should be congratulated especially given there has not been such improvement in the recent past.

KN asked about trade union relations and how we are approaching this. AV set out some of the steps being taken.

42/24 Sustainable Partnerships [12.26-12.54]

SB drew out the conclusion of the planning for the year with an agreed control total of £10.5m deficit. He outlined the review of financial controls and the work to implement the changes. The Recovery Plan is being drafted and is due for review by the Executive Management Board in August and will then come to the Board via FIC. SB confirmed the likely one-year settlement next year.

The Board noted that the month 3 Finance Report shows the plan is on track to deliver. SB clarified the timing issues leading to the report still showing the initial plan of £16.5m; the £6m additional income will help us get down to the revised plan of £10.5m. This will be formally corrected at month 4.

SBr then updated the Board on the development of the digital strategy and outlined the key elements to help enable the clinical strategy and related priorities. This is due to come to Board in October for approval.

MWe updated on partnership working, referring back to earlier discussion on Hubs. Related to productivity and collaboration and the SE regional review, a governance framework is now established with a SE regional steering group. There was a good design workshop with SCAS to assess what is feasible this year on areas of

collaboration. There will likely be minimal cost savings in year but some opportunities in the wider collaboration in the South of England, e.g. procurement, education and training. An update will come to the Board in October.

HG summarised the outputs of the last meeting of the finance committee. It has good assurance with the plan to-date. Further assurance on the non-cash releasing CIP (£19m) has been requested. The committee is encouraged by the work on strengthening the financial controls and procurement. On performance, the activity level is much higher than assumed, which is a concern and represents a risk if this continues. But to-date and despite this the C2 mean target is being achieved, supported by the non-recurrent additional summer funding provided by the centre.

UK asked for comments on activity levels and the related risks. EW responded that there is ongoing discussion internally and with commissioners. Other providers are also seeing an increase and some emergency departments are seeing more walk ins too.

UK reflected that despite being on plan there are a number of variations and asked for any comment from the committee members on this. HG responded that the principal variation is overspend in operations, but this is matched by the additional income.

MW asked about the drivers behind the recovery plan and what it will entail in the context of the Government's spending review. SB responded that we have agreed with commissioners the plan will be a three-year process. The shape of recovery is important, and this is materiality impacted by the settlement of NHSE next year, so there are some unknowns.

MW noted the good work we are doing with SCAS and the wider collaboration. While he accepts this will provide little benefit this year, he asked for some more precision going forward on benefits, as much will need a lead time requiring planning. DR agreed. A formal collaboration report will come to Board in October, and he reinforced the main aim here is to remove variation and agree a more coherent operating model between us and SCAS.

UK acknowledged the achievement in terms of financial and operational performance; both of which is good for our people and patients. Work on Digital is key, and this will help us grab the opportunities. The Board looks forward to receiving the strategy in October.

43/24 Sussex ICB Delivery Plan [12.54-12.58]
MWe confirmed that this is the joint forward plan refresh. The Board endorsed the plan last year and is asked to do the same for this refresh. MWe outlined how this aligns with our strategic aims re quality of care and improvement in response times. And included is growing the ICS workforce linking to our people aim. It also looks at how UEC and community services integrate to improve patient outcomes, by introducing the community teams that will support the Hubs. We have contributed to this via our clinical and operational leads and MWe recommends the Bord endorses this plan.

The Board endorsed this plan.

44/24 Recovery Support Programme [12.58-12.59]
DR outlined the remaining areas of focus linked to the RSP exit criteria and referred the Board to the update in the BAF. The Board noted the other 11 criteria have formally been closed.

45/24 Review of Board Effectiveness [13.00-13.01]
UK is keen to get feedback and asked for this in coming days directly or via PL.

46/24 AOB
This is EW's last meeting and UK acknowledged her role at the trust and thanked her and wished her the best for the future.

There being no further business, the Chair closed the meeting at 13.02.

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

Martin, Governor, commented on the work that has gone into the strategy. He asked about the relationship between 111 and the Hubs. And also, what we mean by virtual as some people don't have access to broadband. EW responded that we need to continue to ensure people use services at the right time. In reality lower acuity patients should use 111. They can for example direct book into GPs who are commissioned to do this. MWe added re virtual response that there are a number of options which will be implemented by the digital enablement as part of the strategy.

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	05.12.2024	Audit Committee / Board	IP
08.08.2024	40 24	QPSC to review the evaluation /outputs of the provider collaboratives we are involved with and the national transformation group reviewing care pathways.	DR	Q4	QPSC	IP

Key

	Not yet due
	Due
	Overdue
	Closed

ɔard Action Log

Comments / Update
A report to audit committee was received in July - see escalation report.
Added to COB

	Item No	51-24
Name of meeting	Trust Board	
Date	03.10.2024	
Name of paper	Chair Board Report	
Report Author	Usman Khan, Chair	

Board Meeting Overview

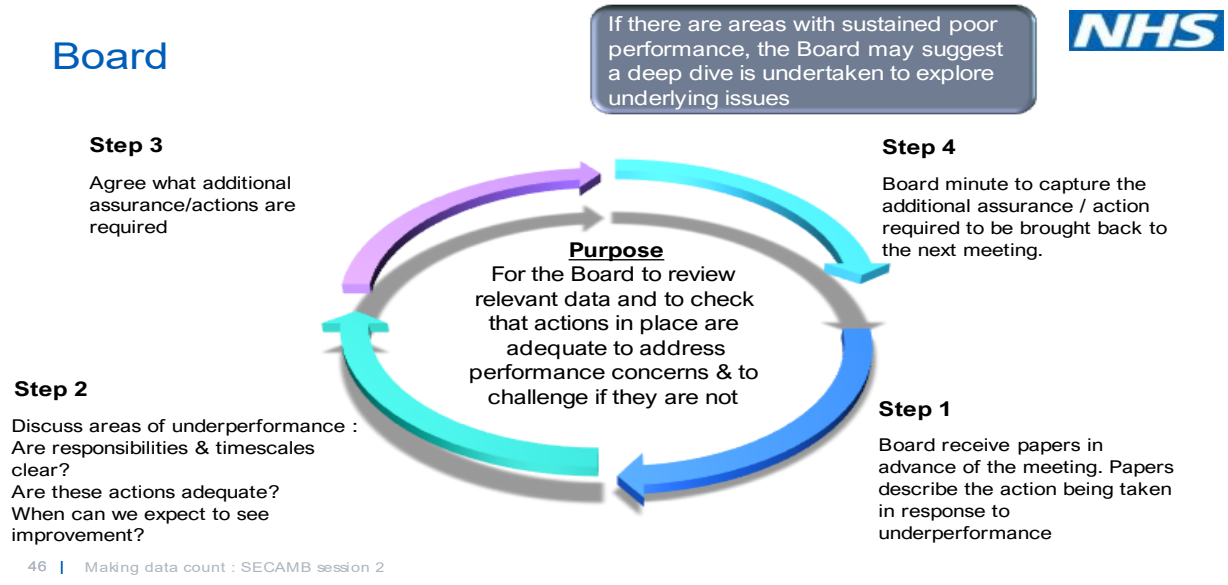
Meetings of the Board are framed by the Board Assurance Framework (BAF), against the three strategic aims:

We deliver high quality patient care

Our people enjoy working at SECAmb

We are a sustainable partner as part of an integrated NHS

The BAF has been revised to reflect the new strategy, ensuring Board oversight of the delivery of our strategic priorities; in year planning commitments; and compliance. Providing the Board with clarity on progress against the organisational objectives and the main risks to their achievement, thereby informing the Assurance Cycle.



Having formally launched the new Trust strategy at the last meeting in August, today we will be approving the digital strategy, one of the key enablers. Another key enabler is our HR function, and the Board welcomes the development of a robust HR Improvement Plan. This has had much focus in recent weeks, including at the Board development session in September.

Ensuring sustainability underpins all we do, and the audit and finance committees have been overseeing the strengthening of our financial controls. Later in the agenda the Board will be asked to approve both the revised SFIs and a new procurement strategy.

Board Development

We had another constructive board development session in September, where were joined again by our operational and clinical leaders, to help strengthen the Board's connection to the wider organisation.

The focus of this was the HR Improvement Plan and it was good to hear such openness from our people about the impacts when we get it wrong. This was a great opportunity to input into the priorities and, as I have mentioned, one of the main items for the Board today is to approve the Plan.

Council of Governors

At the most recent meeting of the COG, there was as ever good challenge from Governors. This included:

- Seeking assurance that we are working effectively with system partners to manage demand, especially as we come into the winter period, acknowledging the role of the ICSs.
- Understanding where we are with the development of the Unscheduled Care Navigation Hubs and how the Board is managing the funding risk.
- The approach to the HR Improvement Plan and how the Board is ensuring the right priorities and pace of delivery.
- How the Board is ensuring relations with Trade Unions improves.
- Progress with the steps being taken in light of the Sexual Safety Charter
- And lastly, hearing about the confidence from the Board in delivering the financial plan for this year, how it is working with commissioners to ensure a longer-term sustainable plan.

After the meeting of the COG, we had a really successful Annual Members Meeting. It was a good opportunity to showcase all the great work of SECAmb, engaging with our members, both public and staff.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	52/24

Name of meeting	Trust Board
Date	3 October 2024
Name of paper	Audit & Risk Committee Assurance Report – 19 September 2024
Author	Michael Whitehouse Independent Non-Executive Director – Committee Chair

INTRODUCTION

This assurance report provides an overview of the most recent meeting on 19 September 2024 and is one of the key sources that the Board relies on to inform its level of assurance. It is set out in the following way:

- **Assure**: where the committee is assured
- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Advise**: items for the Board's information

ASSURE

Internal Audit Review - FTSU

One review (FTSU) was completed which confirmed a positive conclusion, supported by a strong policy, effective controls, and a view that awareness throughout the organisation was good. The review also identified areas for further improvement, especially related to how we cascade learning. This will be picked up by the FTSU Guardian in her next report to the Board, in December.

Year End Audit Process

As previously reported to the Board there were a number of issues identified related to the audit process for 2023-24. The committee received a helpful paper from the CFO, supported by our External Auditors, which described the learning and how this will improve the process for this coming year, with a particular focus on training and development. This provided a good level of assurance to the committee. A half year review will take place in December including a plan for the year end.

ALERT

Standing Financial Instructions

The committee undertook a review of the amendments to the SFIs, which it recommends to the Board for approval. The annual cycle of business will ensure these are reviewed on an annual basis going forward. This is one part of the wider suite of financial controls being put in place that the Board is sighted on. Internal Audit will be testing some of these controls as part of the Plan.

Constitution
Noting the agreement of the Council of Governors, the committee reviewed and supported the proposed changes to the Constitution. It recommends their approval by the Board.

ADVISE

Internal Audit Management Follow Up
The committee sought further assurance that management were giving sufficient focus to the follow up actions. Linked to the HR Improvement Plan, it will review in December the outstanding actions from previous HR-related reviews.

Counter Fraud
Whilst overall the committee continues to be assured with the counter fraud controls in place, in the context of overpayments, it has asked for further assurance on the management processes for starters and leavers.

Risk Management
The ongoing work to improve our risk management processes is progressing well. The committee has asked that our key governance groups ensure more overt mapping to the risk register, to ensure their focus is driven by the risk register.

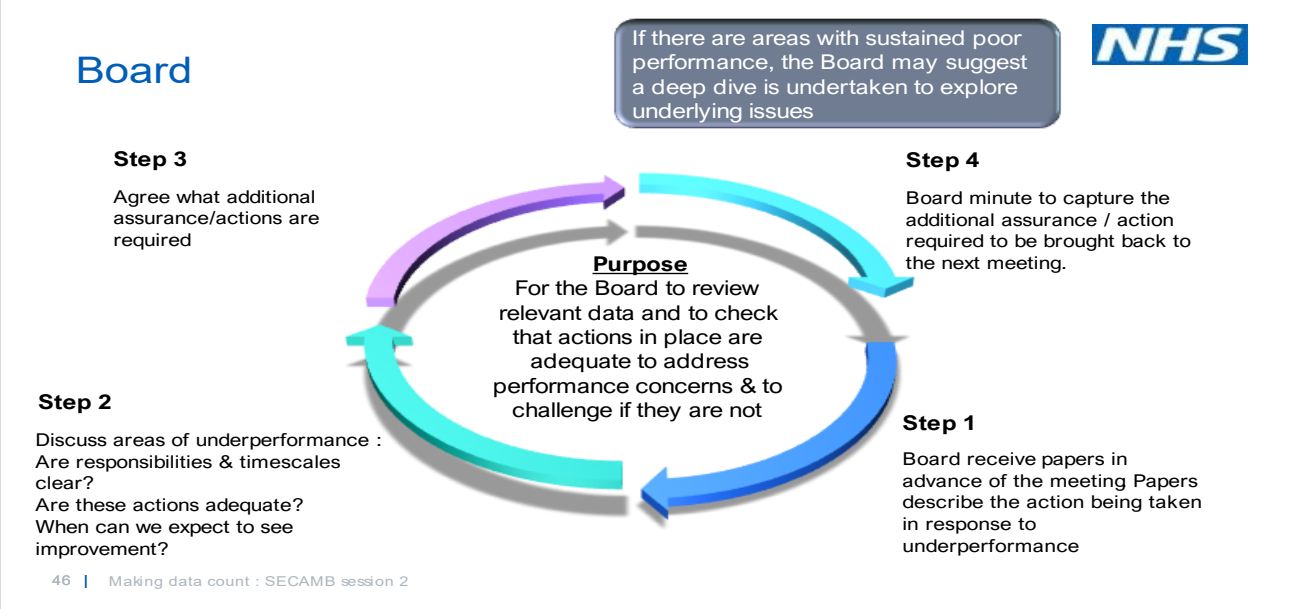
The risks in the Board Assurance Framework were reviewed and save for a new risk to be added related to the HR function (and related Improvement Plan), the committee is satisfied that the risks ensure the Board is sighted on the right priorities.

PMO
The executive has brought in some time-limited external support to help establish a PMO to oversee the governance and delivery of the key programmes of work within the BAF. This will strengthen the oversight and assurance to the Board.

Resilience Sub Committee
The first report from this sub committee was received. The first meeting focussed on the annual assurance cycle, and the trajectory of assurance looks positive. A further review against the standards will be undertaken at the next meeting in October.

Recommendation

The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle



South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	53-24

Name of meeting	Trust Board
Date	03.10.2024
Name of paper	Amendment to Trust Constitution
Author	Peter Lee, Director of Corporate Governance

This is a proposal to make three changes to the SECAmb-Constitution.pdf

1. Firstly, at paragraph 22 (see below), to remove the restriction of an upper limit for the number of executive directors. Instead, this will confirm a minimum number and continue to ensure the right balance between non-executive and executive directors, consistent with the NHS Act and Code of Governance.

22. **Board of Directors - composition**

22.1. The Trust is to have a Board of Directors, which shall comprise both Executive and Non-Executive Directors.

22.2. The Board of Directors is to comprise:

22.2.1. a Non-Executive Chairman; and

22.2.2. Non-Executive Directors of such other number which will exceed the number of Executive Directors; and

22.2.3. ~~up to 7 Executive Directors.~~ A minimum of four Executive Directors

22.3. For the avoidance of doubt, there must never be more Executive Directors than there are Non-Executive Directors.

22.4. One of the Executive Directors shall be the Chief Executive.

22.5. The Chief Executive shall be the Accounting Officer.

22.6. One of the Executive Directors shall be the finance Director.

22.7. One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

22.8. One of the Executive Directors is to be a registered nurse or a registered midwife.

2. The second change amends the way we name the governor constituencies, following feedback that the current naming convention is confusing. Instead of “lower East” “upper East” “lower West” and “upper West”, the proposal is to revert back to the relevant Counties, which will be clearer for governors and members.

3. Lastly, the document has been amended to ensure neutral gender references, for example “Chairman” is now Chair.

Recommendations, decisions or actions sought	Changes to the Constitution requires approval of both the Council of Governors and Board of Directors. The Council approved these changes at its meeting on 17 September, and they were also considered by the Audit & Risk Committee who were supportive.
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

Item No	54-24

Name of meeting	Trust Board
Date	03.10.2024
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 August and September 2024.

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 been the issues most affecting our people, our financial plans and the HR Improvement Plan.

5 Other actions taken include:

- Developing our new planning approach, to ensure we prioritise our investments during the year
- Agreeing investment in our digital strategy

6 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.

7 **Delivery of our new Strategy**
Following the formal launch of our new Trust Strategy at the August Board meeting, I am pleased that we are already making good progress in delivering our year one priorities.

8 As a reminder, our key priorities are arranged into the three key areas – We deliver high quality patient care, Our people enjoy working at SECAmb and We are a sustainable partner – and include, amongst others:

- Collaborating with our partners to advance the implementation of five new Clinical Hubs, while continuing discussions around securing the necessary funding to fully deliver these

	• Implementing the new leadership structure, including a move to a regional model for operational management • Developing a Digital Strategy
9	I am looking forward to working with our people to deliver these important developments, amongst others, which will make our new Trust Strategy real and hopefully bring it to life for everyone.
10	**HR Improvement Programme** One of the key priorities within year one of our strategy is to deliver a significant HR Improvement Programme, to ensure that all of our people are properly supported throughout all stages of their employment journey.
11	Under Sarah Wainwright's strong leadership, the team have pulled together a robust Improvement Plan, which uses the very honest and thorough assessments of the current situation to identify the areas of key focus. We have shared the Plan with a range of external partners, and I am grateful for their scrutiny and input.
12	We need to be under no illusion that this plan will take time to deliver and cannot be delivered all at once. Indeed, a key piece of feedback from partners was to be realistic about what could be achieved and by when.
13	A key focus of the Improvement Plan is Employee Relations – an area that I recognise, as an organisation, we need to find a new way of addressing moving forwards. We are committed to using a wider range of approaches to resolving issues, including mediation for example, to ensure these can be resolved in a proportionate and timely way.
14	Work is currently underway to finalise the Improvement Plan, which includes ensuring we resource it properly, as for me, ensuring HR operates effectively is probably the most important factor in helping us to continue to deliver the improvements we want to see.
15	**Sexual Safety in the workplace** I am pleased that we are continuing to make good progress in addressing this important issue, recognising that we need to take a new lens to issues that may have been tolerated in the past.
16	I am especially keen that we continue to focus on our student population, as part of the wider programme, recognising the particular vulnerabilities they have. Working with our Clinical Education team and our partner universities, we continue to offer additional support to this cohort, and I look forward to this work progressing.
17	During the past few weeks, we have continued our awareness campaign, including a series of really informative podcasts and a hard-hitting poster campaign designed to challenge people's behaviours and encourage self-reflection. Our posters have received national recognition and are now being used by a number of other organisations as part of their work on this issue.

18	I and the whole Board are absolutely committed to doing better in this area and, with the introduction of a new dashboard to track cases, we will now have greater transparency, helping our people to hold us to account for the progress we are making.
	Engagement
19	During the past couple of months, I have been pleased to attend a number of national and regional meetings on behalf of the organisation.
20	On 17 July and 11 September, I attended Sussex Leadership Development events, together with Chief Executives from across the county. These were useful events to discuss the key challenges and opportunities facing us all, including the development of clinical hubs which we are keen to progress.
21	On 19 July 2024, I attended a meeting with my fellow regional ambulance Chief Executives, as part of the Southern Ambulance Services Collaboration. You can read more about the Collaboration and the emerging work programme in my report below.
22	On 19 September 2024, I was pleased to launch our new 'Connect with the Chief' programme with the first visit to Sheppey.This new programme, where I will also be joined by the Chair for some visits, will see me visit lots of our sites where colleagues will be able to meet for a one-to-one session, attend informal roundtable discussions and showcase anything they would particularly like to share.
23	I thoroughly enjoyed my visit to Sheppey, and it was good to discuss with the local team some of their key issues including access to pathways, follow ups for mental health patients and the positive impact of the place-based educators.
24	Thank you to everyone I met there for their openness and for making me so welcome.I am looking forward to the next Connect with the Chief session will take place in Medway on 15 October.
	AMM showcases great work
25	On 13 September 2024, we held our Annual Members Meeting (AMM) at the South of England Showground in West Sussex and, once again, it was a great opportunity to showcase the fantastic work of the organisation.
26	A wide range of colleagues produced stalls for the event, taking the chance to promote their achievements to the members of the public who attended and to their colleagues. Thank you also to members of the Surrey Retirement Association who attended with some great examples of equipment from bygone days.
27	For me, the highlight of the day was unexpectedly hearing from former patient, Ian Marples, who shared his story of how SECAmb had helped to save his life after he suffered a cardiac arrest in March 2021. Hearing from him directly really helped to bring home the massive difference we make to people's lives.

28	Thank you to everyone involved in such a successful AMM. A particular thank you to the Corporate Governance team for their hard work in arranging such a great event.
	B. Regional Issues
29	**Southern Ambulance Services Collaboration (SASC)** The Southern Ambulance Services Collaboration (SASC) is a Collaboration between SECAmb and our colleagues at East of England (EEAST), London (LAS), South Central (SCAS) and South Western (SWAST) ambulance services.
30	We have agreed to work collaboratively together to support the delivery of consistently high-quality frontline care and enhance the wellbeing of our staff, in the current constrained financial climate and have developed a manifesto which sets out the specific actions to be delivered during year one.
31	The Chief Executives who are part of SASC meet regularly; we are all looking forward to seeing the collaboration in action and to see the delivery of tangible projects get underway.
32	See separate document outlining the SASC manifesto.
	C. National Issues
33	**HSJ Awards Success** I am extremely proud that we have seen two of our teams enjoy national recognition through the prestigious HSJ Awards.
34	I was delighted to see that our work with our regional partners to maximise the support provided by Urgent Community Response (UCR) teams to patients who have called 999 and who may not need an emergency response, was shortlisted in this year's Health Service Journal (HSJ) Patient Safety Awards, announced in the Summer.
35	Our UCR Ambulance Service Optimisation Programme, 'Pulling from the stack', was shortlisted in two awards categories - Best Use of Integrated Care and Partnership Working in Patient Safety and Safety Improvement through Technology – and while the team did not take home an award following the Awards Evening held in Manchester on 16 September, being recognised as a finalist is a significant achievement and testament to the hard work and dedication of the team involved.
36	Well done to Kieran Cambell, Clinical Lead for Integrated Care (999 & 111) and everyone involved in this truly collaborative project.
37	We were also delighted to be made aware recently that the East Kent Integrated Clinical Hub, involving SECAmb, East Kent Hospitals University NHS Foundation Trust and Kent Community Health NHS Foundation Trust, has also been

38	shortlisted for a 2024 Health Service Journal (HSJ) Award in the Performance Recovery Award category The Clinical Hub model is a key part of how we will deliver our new Trust Strategy, and the East Kent Hub has already delivered proven results in terms of avoidable A&E admissions and significant increases in use of alternative pathways.
39	Congratulations to Nick Keech and the whole team involved in setting up and running the Hub and the very best of luck for the Awards judging, which will take place later this month.

NHS
Southern Ambulance Services Collaboration

Southern Ambulance Services Collaboration (SASC) 2024/25 Manifesto – Board Paper

SASC

Working together for our patients, people and communities

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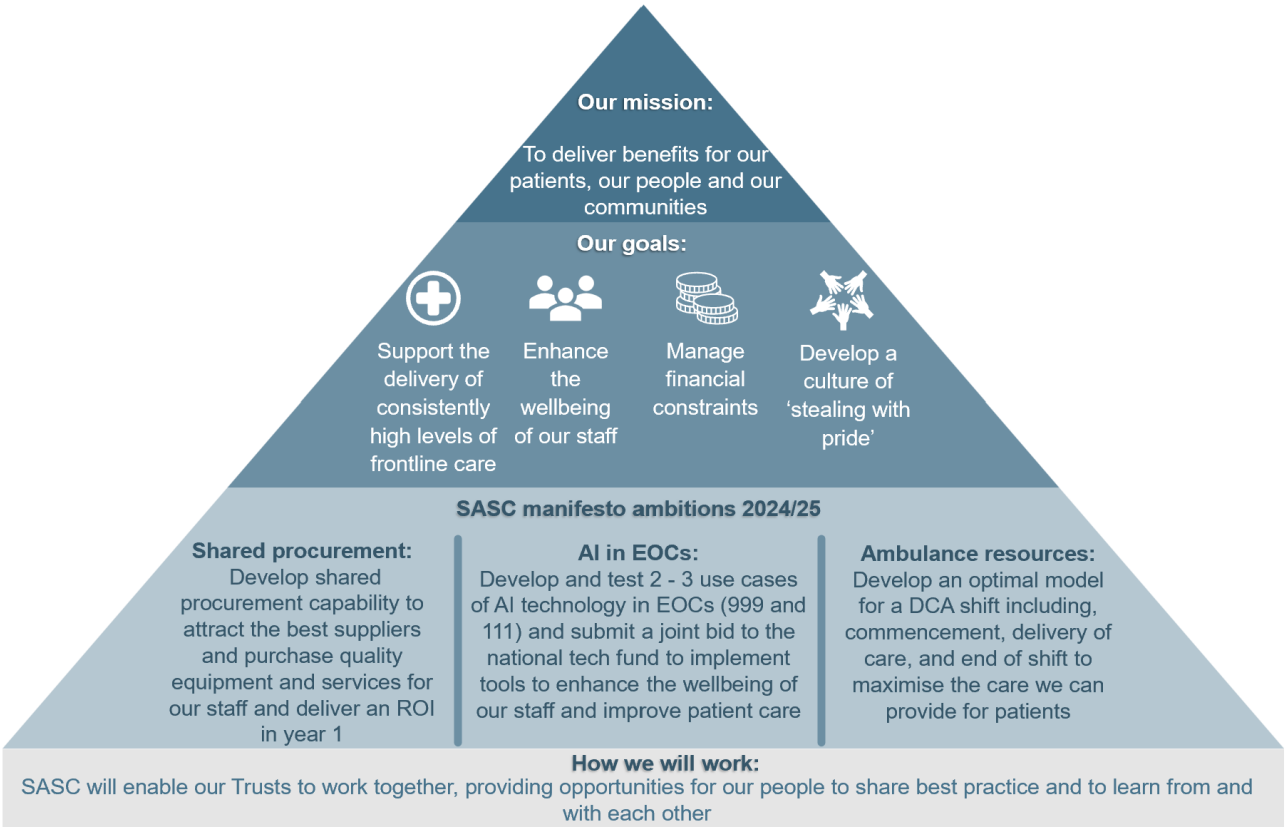
Southern Ambulance Services Collaboration

Board summary

Purpose	The purpose of this paper is to outline the Southern Ambulance Services Collaboration (SASC) 2024/25 Manifesto.
Manifesto summary	**The Southern Ambulance Services Collaboration (SASC)** is a Collaboration between East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services. **SASC's foundational goals are to**: ▪ Support the delivery of consistently high-quality frontline care ▪ Enhance the wellbeing of our staff ▪ Manage financial constraints ▪ Develop a culture of 'stealing with pride' **To develop the manifesto, SASC has engaged over 100 people across our five Trusts.** The engagement sessions included individual and group CEO and Chair working sessions, problem solving sessions with each Trust executive team, and a workshop with ~100 colleagues across our five Trusts, on the 7th of June 2024. The workshop included five breakout groups each generating 1 - 2 initiatives. Following the workshop the CEO group selected three immediate year 1 priorities to deliver improvements for our people, patients, and communities. **SASC's year 1 ambition is to:** ▪ **Develop shared procurement capability to purchase the highest quality products and services at the best price and provide a return on investment (ROI) in year 1.** The overarching principles are (1) the default is shared procurement, and (2) when procuring items, we will first consider how to maximise the net benefits for the collective. The expected year 1 cost to establish the framework and develop a business case to submit to all Trust boards is £100k. ▪ **Identify and develop two to three use cases of AI technology in EOCs** and submit a joint bid to the national tech fund. Examples of use cases could include: transcription and summary tools, sentiment analysis, clinical audits, pre-caller ID, etc. It is anticipated that the costs of establishing the bid will be predominantly in-house, with support and expert advice from external agencies provided "gratis". The bid will include project and start-up costs, and an additional amount of £20k may be available to support this. ▪ **Develop an optimal model for a DCA shift.** The focus will be to improve the availability of our ambulance resources by (1) developing best practice processes (e.g., start and end of shift processes, break policies, etc), and (2) optimising how we use and deploy our resources (e.g., what resources and how many we deploy to certain jobs). The expected year 1 cost of this work is circa £330k to ensure a complete and timely review of all Trust's operating practices and develop an optimal model.

	The Collaboration will be driven through a governance structure that includes a Collaboration Director, CEO group, and Collaboration board (CEOs & Chairs) *(see appendix 3)*. Through the CEO group and Collaboration board, SASC will be open to and actively seek out opportunities as they arise. Each workstream will be driven forward by a CEO SRO, a director level Lead from one of the five Trusts, and support team where necessary. The total 2024/25 budget is estimated to be circa £450k. The level of contribution has been identified based on organisational size, budget and therefore likely ROI.
Risks	Several risks have been identified with mitigations as summarised below: *Risk 1: Insufficient budget allocated to 2024/25* Mitigation: The group of five CEOs have maintained balance between optimism and realism. Likely costs per project have been estimated based on experience and engagement with SASC partners. *Risk 2: Individual Trusts cannot meet the agreed budget contributions* Mitigation: The agreed contributions have been developed through the SASC governance process, involving CEOs, and Chairs. *Risk 3: Limited executive time and capacity* Mitigation: The CEO SROs have been nominated to lead specific workstreams based on their specific experience, and capacity. Each CEO SRO will be supported by a director level lead. Additionally, SASC has appointed a Collaboration Director to support driving forward the programmes of work. *Risk 4: Distraction from core business* Mitigation: Colleagues across our five Trusts, led by the CEOs have invested time to select initiatives which are synergistic with furthering current work and strategies, and solving major challenges. Each programme of work will involve team members from each Trust to ensure initiatives deliver for both the collective and individual organisations.
Recommendation	The recommendation is for the board to: ▪ Approve the Manifesto entailing the three target workstreams ▪ Note the SASC 2024/25 operating budget of £450k, of which SECAMB's contribution is £75k

Figure 1: Summary of year one Manifesto – programme areas and governance structure



Appendix: SASC 2024/25 Manifesto poster

The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

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What is the Collaboration?

The Southern Ambulance Services Collaboration (SASC) is a collaboration between the East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services.

SASC
Working together for our patients, people and communities

The goals of the Collaboration are to:

- Support the delivery of consistently high-quality frontline care
- Enhance the wellbeing of our staff
- Manage financial constraints by sharing best practice
- Develop a culture of 'stealing with pride'

Our year one manifesto has been co-developed by our people and focuses on three areas of improvement

Our engagement over the past six months

- CEO and Chair working sessions
- Sessions with each Trust's executive team
- Workshop pre-meets for five priority areas involving ~80 staff across the five Trusts
- Workshop with ~100 staff across the five Trusts

From this engagement we identified three priority areas of improvement:

Shared procurement
Develop shared procurement capability

Ambulance resourcing
Implement a best practice model for a DCA shift

AI in EOCs
Implement AI tools in our EOCs to improve patient care and staff wellbeing

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The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

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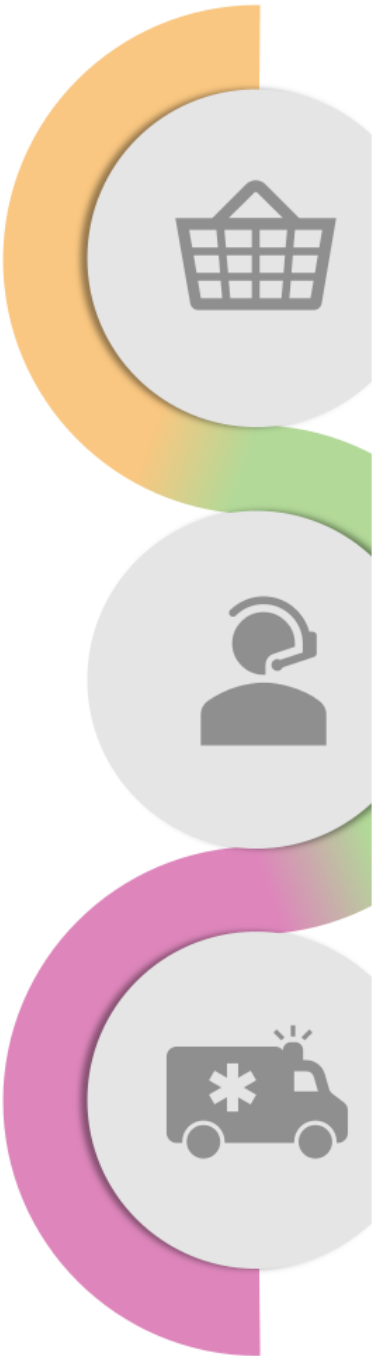
For each area, there are 3-4 priority deliverables…



Shared procurement

Our mission: Develop shared procurement capability, to purchase the best quality products and services at the best price across our five Trusts, and provide an ROI in year 1

Our deliverables:

- **Develop shared procurement approaches** by mapping and aligning our procurement data, systems and processes
- **Identify the items** that will return the highest value and will generate a return on investment in year one
- **Begin joint procurement** in the 2024/25 financial year

AI in EOCs

Our mission: Identify and develop two to three use cases of AI technology in EOCs (999 and 111) and submit a joint bid to the national tech fund to implement tools to enhance the wellbeing of our staff and improve patient care

Our deliverables:

- **Map opportunities** for AI in EOCs to improve patient care and staff wellbeing
- **Develop 2-3 use cases** for AI in EOCs and test across 5 Trusts
- **Place a bid to the National Tech Fund** on behalf of all 5 Trusts
- **Implement at least one AI support mechanism** (e.g., pre caller ID) across all 5 Trusts

Ambulance resourcing

Our mission: Develop an optimal model for a DCA shift including, commencement, delivery of care, and end of shift to maximise the care we can provide for patients

Our deliverables:

- **Map out how time is spent on a DCA shift to** develop a collective understanding of current ways of working
- **Develop a 'common language'** of agreed metrics
- **Identify the priority components** to deliver the greatest collective benefit for patients and staff
- **Develop proposals** to improve these components

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	55-24

Name of meeting	Trust Board
Date	03 October 2024
Name of paper	Emerging Digital Strategy
Responsible Executive	CDIO
Authors	Stephen Bromhall
Purpose	The Digital and Data Strategy is attached in Annexe A to this document. The strategy has been reviewed at the joint leadership team and FIC in September and FIC, comments have been incorporated.
Recommendations, decisions, or actions sought	The board is asked to approve the strategy.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes - completed

1. Background

The Trust has appointed a Chief Officer for Digital and Information to lead the development of a Digital and Data strategy. This will enable the existing Internal IT and Data functions to migrate to an enhanced Digital and Data organisation supporting the wider Trust ambition, as outlined in the formal Trust Strategy.

2. Summary and the Case for Change

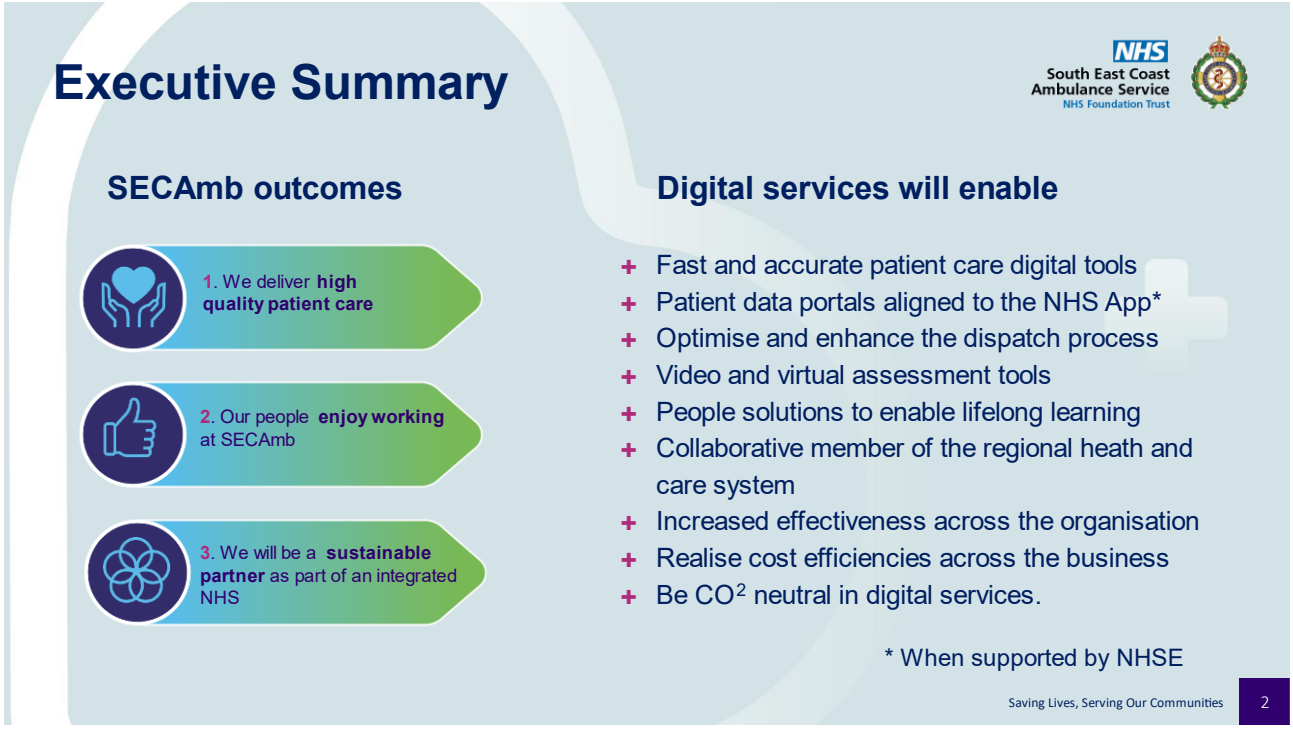
The Digital and Data Strategy has been developed to support our clinically led SECAmb Trust Strategy as approved at the August 2024 Public Board. The strategy has considered the wider Trusts requirement for our new models of Care. Digital and Data is a key underpinning component which will enable our transition over time to align to our wider strategic intent and deliver effective care to our patients. Digital and Data will support our people deliver health outcomes with consistent digital and data solutions, plus enabling technology to support their lifelong learning.

The final focus is to position SECAmb as a strategy system partner at a region, place and community.

The Digital and Data strategy will enable SECAmb to be fit for future models of care underlining the Lord Darzi recommendations. It will support the fundamentals of the NHS Digital long-term plan and the wider Southern Ambulance Collaboration.

Several pages from the strategy are included within this paper, to provide the key principles.

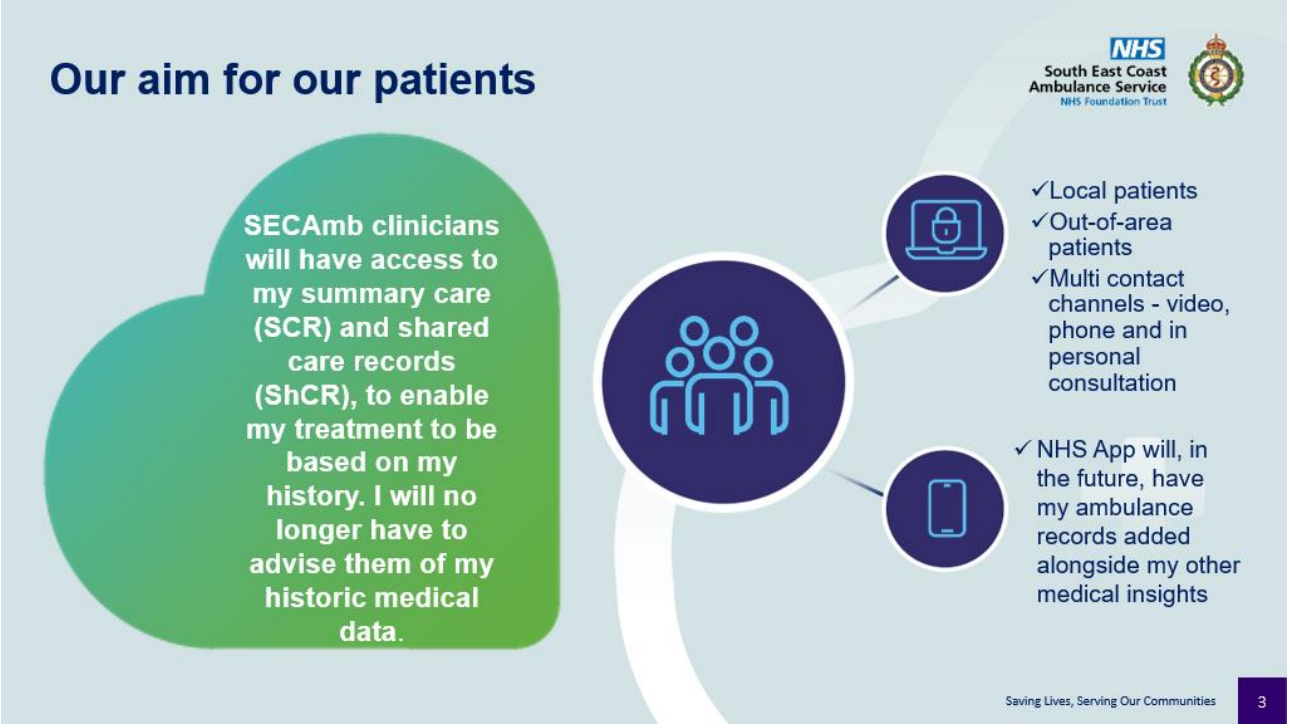
The strategy will enable: -



In the development of the strategy a diagnostic was undertaken to consider the patient needs from digital technology, our clinicians' requirements, the wider organisation and our people's readiness to support the new operating model based on the feedback from the Board Development session.

The strategy has an assured position that no Digital Exclusion or Health Inequalities will be introduced within the strategy which may impact our citizens. The strategy has been designed around personas for our patients and people.

The personas of our strategy are shared below.



Our aim for our people

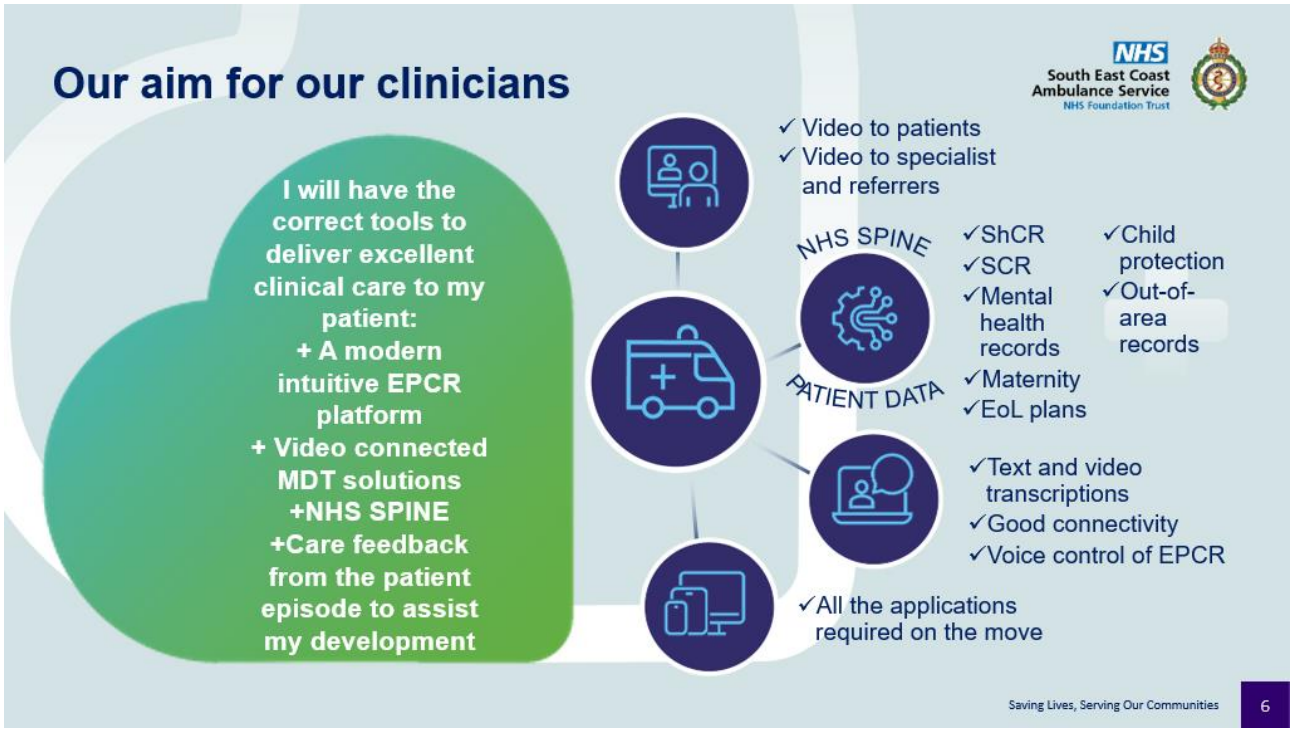
My digital experience will be enhanced, with the correct tools and services available to support me to undertake my role effectively.

- ✓ Cyber resilient services
- ✓ Best possible digital processes and workflows
- ✓ AI to support me
- ✓ Automation and Augmentation to help me
- ✓ Modern future staff learning and support
- ✓ Technology that just works
- ✓ Good connectivity
- ✓ Audio visual and other services appropriate for my role

Our aim for our contact centre teams

In my role in the 111 and 999 teams, I will be supported with the correct technology to improve patient experience and provide enhanced care.

- ✓ Assistance in the call process
- ✓ Prompting further engagement with the patient
- ✓ Wellbeing support
- ✓ Turning voice into text for the CAD record in real time
- ✓ Technology platforms to augment and support the existing processes



The core of the strategy will enable the Trust to be digital fit for the future with the necessary building blocks to support the future operating model which underpins our future transformation by providing our people with the correct tools and technology to be undertake their role.

The strategy will provide over the next eighteen months a set of patient, organisation and technology building blocks to enable future transformation. It is envisaged that by the start of the financial year 2026/2027 our organisations will be fit to enter the second phase of our transformation aligned to our future EPCR platform identified and contracted, AI in use, and National/Regional patient data accessibility at the point of need. The visual representation of the transformed outcome is below in a simplified form.

Digital Together
Sharing and consuming patient data across the health and social care system.

Data Transformation
Adding tools and process to support our people deliver.

Digital Infrastructure
Doing the basics better, within our vehicles and estate.

Digital Workforce
Support our staff experience differently.

Digital Care
Utilising transformational best practice to change the way we do things.

Digital AI
All projects are Agile and will be reviewed monthly aligned to business value.

3. Recommendation

The recommendation to the board is to support the strategy. The board are asked to note this will require investment, this will be set out separately as part of the annual planning cycle. Staff consultation will formally commence aligned to a developed delivery plan on approval of the strategy.

This will enable a Modernised Digital and Data Directorate to provide our patients and people with modern digital tools, all underpinned by a set of repeatable process and technology focussed to support our staff deliver clinical excellence.

The Trust will be ready for the National Automation Funding and have the foundations in place to bid for the £3.5BN funding streams for technology efficiency to embrace AI to augment our clinicians and transform our staff experience.

We will further protect our enterprise from cyber threats, simplify our technology and operational model and complete our data centre rectifications. Our Data environments, data platforms will provide consistency and a one team model with staff having the right access to their data to optimise our performance.

4. Annexe A – Documents to be added.

Digital Strategy.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Clinically Led Digitally Enabled Digital and Data Strategy

2024-2026

Version FINAL 1.0

Executive Summary

NHS South East Coast Ambulance Service NHS Foundation Trust

SECAmb outcomes

1. We deliver **high quality patient care**

2. Our people **enjoy working** at SECAmb

3. We will be a **sustainable partner** as part of an integrated NHS

Digital services will enable:

+ Fast and accurate patient care digital tools
+ Patient data portals aligned to the NHS App*
+ Optimise and enhance the dispatch process
+ Video and virtual assessment tools
+ People solutions to enable lifelong learning
+ Collaborative member of the regional heath and care system
+ Increased effectiveness across the organisation
+ Realise cost efficiencies across the business
+ Be CO^2 neutral in digital services.

* When supported by NHSE

Our aim for our patients

South East Coast Ambulance Service NHS Foundation Trust

SECAmb clinicians will have access to my summary care (SCR) and shared care records (ShCR), to enable my treatment to be based on my history. I will no longer have to advise them of my historic medical data.

- ✓Local patients
- ✓Out-of-area patients
- ✓Multi contact channels - video, phone and in personal consultation

- ✓ NHS App will, in the future, have my ambulance records added alongside my other medical insights

Our aim for our people

South East Coast Ambulance Service NHS Foundation Trust

My digital experience will be enhanced, with the correct tools and services available to support me to undertake my role effectively.

- ✓ Cyber resilient services
- ✓ Best possible digital processes and workflows
- ✓ AI to support me
- ✓ Automation and Augmentation to help me
- ✓ Modern future staff learning and support
- ✓ Technology that just works
- ✓ Good connectivity
- ✓ Audio visual and other services appropriate for my role

Our aim for our contact centre teams

South East Coast Ambulance Service NHS Foundation Trust

In my role in the 111 and 999 teams, I will be supported with the correct technology to improve patient experience and provide enhanced care.

- ✓ Assistance in the call process
- ✓ Prompting further engagement with the patient
- ✓ Wellbeing support

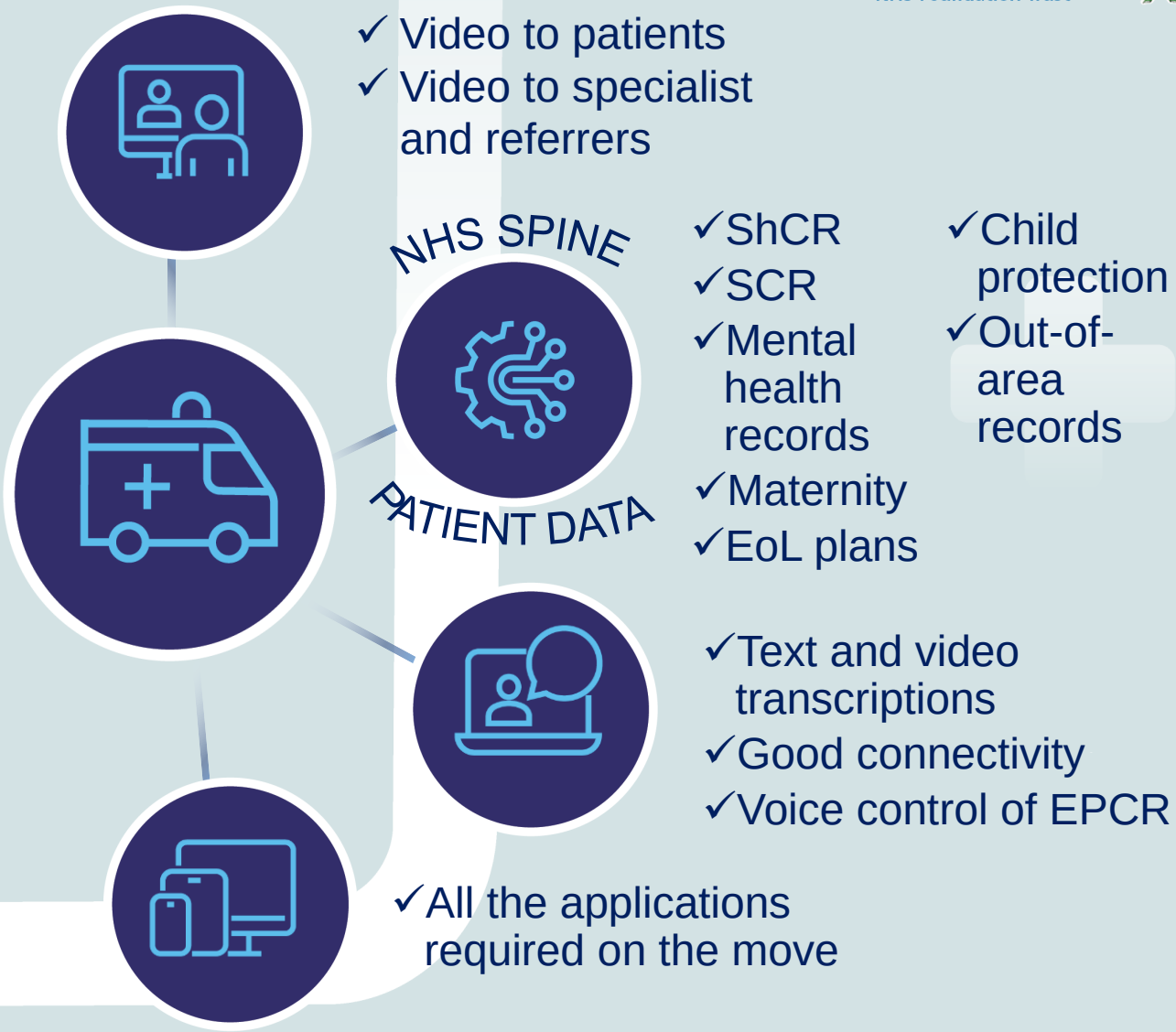
- ✓ Turning voice into text for the CAD record in real time

- ✓ Technology platforms to augment and support the existing processes

Our aim for our clinicians

NHS South East Coast Ambulance Service NHS Foundation Trust

I will have the correct tools to deliver excellent clinical care to my patient:
+ A modern intuitive EPCR platform
+ Video connected MDT solutions
+NHS SPINE
+Care feedback from the patient episode to assist my development



Executive Summary

NHS South East Coast Ambulance Service NHS Foundation Trust

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+ Solutions to enable lifelong learning
+ Collaborative member of the regional heath and care system
+ Increased effectiveness across the organisation
+ Realise cost efficiencies across the business
+ Be CO^2 neutral in digital services.

* When supported by NHSE

NHS England's Digital Vision

- Digitise all patient-facing services
- Connect services to support integration
- Enabling service transformation and remove all paper-based processes
- Ambition for all organisations to have digital foundations in place, including full electronic records, by March 2025
- Efficiency funding in 2025/2026.*

- **Only 20% of NHS organisations are digitally mature**
- **Over 85% have a form of electronic patient record in place**

*Subject to NHSE spending review

Southern Ambulance Collaboration Context

Future opportunities to think differently

- Work with other ambulance trusts to create economies of scale in digital
- Support patient's access to care
- Shared technology visions and priorities
- Combining core resources
- Appropriate data exploitation
- Economies of scale in procurement

SASC

Working together for our patients, people and communities

SECAmb Context

South East Coast Ambulance Service NHS Foundation Trust

Analysis of the digital situation in SECAmb

+ Our Digital services are changing to underpin our Trust strategy and evolving models of care
+ Our patients expect our clinicians to have access to their care records, which we will provide
+ We are transforming our digital services to more effectively support patients and people

The NHS 2024 Digital Maturity Assessment (DMA) gave us 2.0 against a national target of 5.0

+ We will need to modernise to a new operating model on “Business Value Streams”
+ Paper based and traditional working practices will be modernised with AI and automation
+ We will pivot to a set of new secure foundations.

+ **But we have over 170 live projects as well**
+ **We will need to transform our digital offerings to deliver the future model of the Trust**

Executive Summary

South East Coast Ambulance Service NHS Foundation Trust

SECAmb outcomes

1. We deliver **high quality patient care**

2. Our people **enjoy working** at SECAmb

3. We will be a **sustainable partner** as part of an integrated NHS

Digital services will enable

+ Fast and accurate patient care digital tools
+ Patient data portals aligned to the NHS App*
+ Optimise and enhance the dispatch process
+ Video and virtual assessment tools
+ Staff solutions to enable lifelong learning
+ Collaborative member of the regional heath and care system
+ Increased effectiveness across the organisation
+ Realise cost efficiencies across the business
+ Be CO^2 neutral in digital services.

* When supported by NHSE

Digital & Data Strategy – on a page

Where we aim to be in 18 months

NHS South East Coast Ambulance Service NHS Foundation Trust

Aspirations	Together	Connected	Activation	Understand	Innovate
Priorities	To work in a more integrated way with a renewed digital organisation	To share information securely across the Trust and partners (shared care records, NRL or national records services)	Make sure our people have access to the right tools to do their job	To access data for better health outcomes	To leverage innovative technology and skills, AI and automation.
Strategic objectives	To leverage innovative technology and skills	Digitally connected working	Use technology to drive outcome improvements	Leverage data for better health decisions	Leading innovative digital practices in healthcare
Focus	To create a shared regional technology capability which supports the best care options	Connected and working with a single version of the truth access across our data sources	To use digital tools support and enhance our staff deliver results	To create exceptional, secure and accessible data so our Trust can plan and operate effectively	To create and redesign out digital delivery models
Future vision	A nationally recognised care system	Connected region working as one	Access to always on, single versions of the truth	Access to secure and timely information	Award winning digital services with a high NHS DMA score
Other considerations	• Staff with digital confidence and skills • Improving how technology supports our staff	• Simple technology • Device agnostic • Cyber secure • Resilient • WAN or mobile	• Support our people • Digital inclusion with patients and public • Streamlined access to insights	• Addressing health pathway redesigns • Reducing unwarranted variations	• Remove health inequalities • Net zero • Sustainable

Digital and Data Strategy

Strategic Objectives

Digital Together
Sharing and consuming patient data across the health and social care system.

Data Transformation
Adding tools and process to support our people deliver.

Digital Infrastructure
Doing the basics better, within our vehicles and estate.

Digital Workforce
Support our staff experience differently.

Digital Care
Utilising transformational best practice to change the way we do things.

Digital AI
All projects are agile and will be reviewed monthly aligned to business value.

Digital Together our Aspirations

NHS South East Coast Ambulance Service NHS Foundation Trust

Next steps for SECAmb Digital

- Improve care to our communities and reduce cost
- Build secure foundations
- Cloud first where appropriate
- Unlock our data, build our data fabrics and our data lake
- Refresh our processes and invest in the Digital and Data team.

Enabling SECAmb Digital to…….

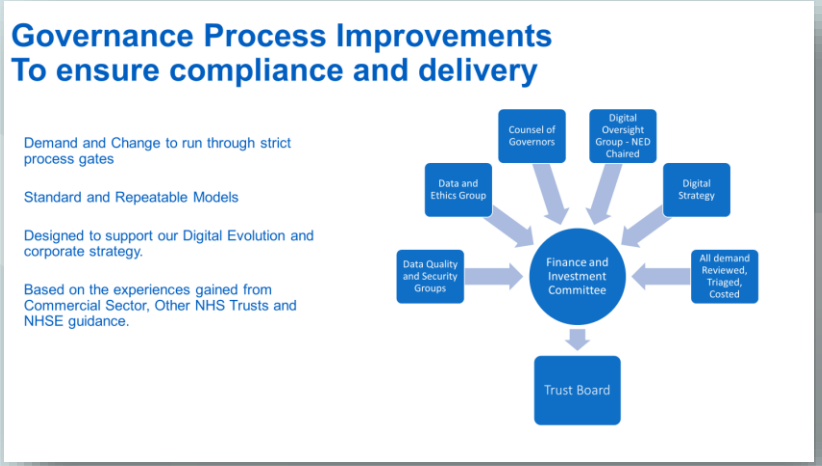
- Provide technological solutions to help reduce conveyance ratios, improve patient care and take cost out
- Integrate using healthcare standards
- Give staff access to clinical records, facilitating improving outcomes
- Automate process over time, where possible, with AI and robotics.

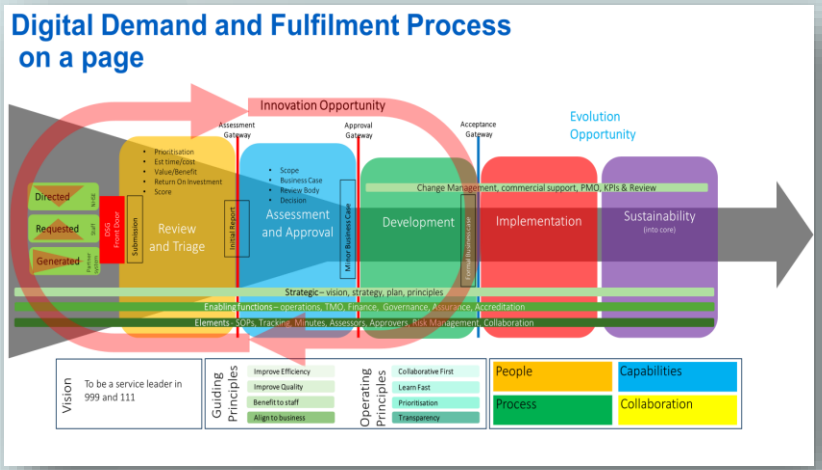
Build Secure Foundations

18-month plan

Together with our customers:

- Establish business partnering and governance forums
- EPCR of the future to be specified
- Shared care and National Spine Services
- HR and training solutions modernisation plan.





Future Services

18-month plan

Understand the future basics principles

- NHSE guidance will be followed
- Undertake a digital training needs analysis for our whole organisation
- Future architecture model will be cloud first with data moved off site where possible but following hybrid principles.

Innovation

18-month remediation plan

AI and automation

- Pilot AI in call handling and dispatch
- Automation in support functions
- Automation in digital service desk
- Automate and digitise legacy process.

Understand our Data

18-month plan

Data transformation

- Data needs to exploited and relevant insights extracted
- We need to integrate our data and improve the quality
- We will automate to standard services
- Our staff will have access to their own data.

Technical debt

18-month remediation plan to be determined

Connected future

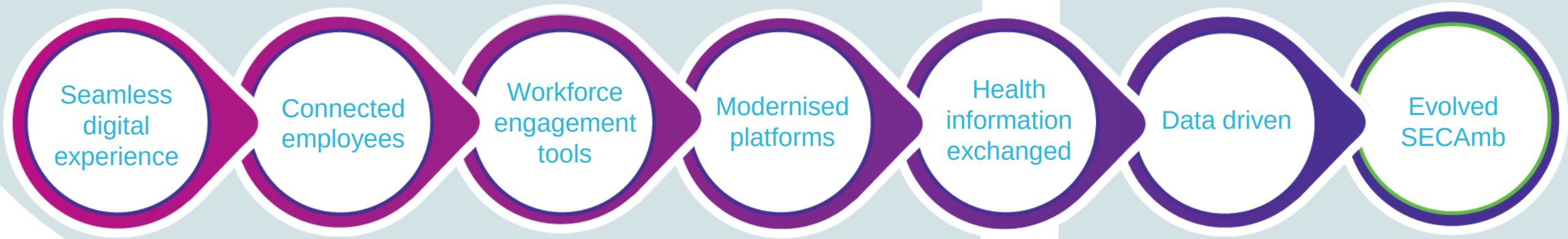
- Cyber safe connected SECAmb
- Modernised Nexus House
- Power and resilience (generators and UPS)
- Automate and digitise legacy process.

Outcomes to be delivered

South East Coast Ambulance Service NHS Foundation Trust

- Technology enabled patient care
- Improvement of the basics
- Governance
- Data and insights available to all
- Healthcare industry aligned

The digital strategy enables ……



Glossary of Abbreviations/Terms

South East Coast Ambulance Service NHS Foundation Trust

App	Application
AI	Artificial Intelligence
Automation	Technology to automate a function previously undertaken by a person
CAD	Computer aided despatch platform
DMA	Digital Maturity Assessment
EoL	End of life
Data Lake	Data hosting environment
Data Fabric	A method to connect data
DMA	Digital Maturity Assessment
EPCR	Electronic Patient and Care Record
ITIL	Best practice for IT Service Management
MDT	Mobile Data Terminal
LAN	Local Area Network
NCRS	National Care Record Service
NHSE	NHS England
NRL	National Record Location Service
SCR	Shared Care Records
SHCR	Shared Care Records (patient care information)
UPS	Uninterruptable Power Supply
WAN	Wide Area Network

Clinically Led Digitally Enabled
Digital and Data Strategy

2024-2026
Version Final 1.0

Chief Officer for Data and Information

Stephen Bromhall

NHS
South East Coast Ambulance Service
NHS Foundation Trust

HR Improvement Plan

Trust Board Update - 03/10/2024 V1.0

Executive Summary

South East Coast Ambulance Service NHS Foundation Trust

- Creating a fit for purpose "People Services" Directorate is fundamental to realising the Strategic Commitment **'Getting things right for our People**' as part of the overall Trust Strategy. Following this, an Integrated People Plan was developed to deliver the strategic objectives with a series of priority areas included.

- During the first half of FY24-25 a series of diagnostics were carried out to undertake a root and branch assessment of the prevailing issues relating to the HR Directorate. Common themes included:

  - A difficulty with understanding the position of formal casework due to various factors including staff turnover, lack of robust case management, issues with data quality and compliance, the volume of legacy cases, audit controls and lack of lessons learnt or shared.
  - HR service offering is unclear - SLAs, what does each service does, managing expectations, KPIs, and monitoring performance.
  - Role and responsibilities of the ER Team not fully understood and the interface with existing HR team blurred - created as well as resolved some issues.
  - Current HR function operating model does not allow appropriate support for the current organisational challenges and future needs e.g. the role of the HRBP and HRA's, accessibility to advice and visibility on site.
  - Managers have not had appropriate development or access to essential HR support, training or skills assessment/development.
  - 'Partnership Working' is immature and there is lack of understanding of the role of Trade Unions by some individuals and groups

- As a result of these thematic issues and further engagement with a variety of stakeholders, a decision was taken in September 2024 to reprioritise the Integrated People Plan to a much more targeted HR Improvement plan.

- The following slides provide a summary of the proposed approach to delivering the first part of the HR Improvement plan in the remainder of FY24-25, including proposed milestone plan, risks and resource requirements.

Our approach to the Integrated People Improvement Plan has had to change to ensure we focus on areas we absolutely must address

NHS South East Coast Ambulance Service NHS Foundation Trust

- The Integrated People Improvement Plan was developed in response to the diagnostic work done by Sarah Wainwright (Interim Director of HR & OD), building upon several previous reviews
- The plan has been reviewed by the SECAmb Board, the People Committee and Senior NHS South East Regional team. A consistent theme of feedback is that the plan was ambitious but trying to achieve too much in a short timeframe
- In September a revised plan which sets four in year priorities to make up the HR Improvement Plan has been agreed by EMB. This reprioritisation aligns with general feedback from managers across the Trust (including Operations).

Priority 1 | Developing a new HR model and re-structuring in alignment with the development of our county-based model, inc. MARS

Priority 2 | Resolving legacy ER cases and moving towards a culture of resolution

Priority 3 | Supporting frontline leaders & HR staff with focused training and development that empowers them to manage with confidence

Priority 4 | Agreeing JPF Terms of Reference (ToR) and improving relations

We need to prioritise in FY24/25 to ensure the right foundations are in place upon which to build our People Services Directorate

South East Coast Ambulance Service NHS Foundation Trust

- These building blocks are the Tier 1 priorities, phased over 2-3 years to move us from fixing and stabilising to transformation. It means there will be some things we cannot focus on in the short term
- Enabling work (Stage 0) is underway to release capacity of HR leadership to deliver the priorities

A set of **four priorities** to the end of FY 24/25 has been agreed by the Executive team –these are the **building blocks to enable longer term transformation**

1

People Operating Model - Phase 1

ER | Wellbeing | Retention | L&D | OD

ER Casework & ER Training

Trade Union Relationship

Next steps | 1 – 6 months (OCT 24 – MAR 25)

We will **embed the priory work completed in FY 24/25 alongside a targeted focus on leadership development** (identified as a key priority by Snr Leaders and Board during the Board Development Day)

2

Embedding Phase 1 Operating Model, ER processes and effective Trade Union partnership

Leadership Development

Medium term | 6 – 12 months (APR 25 – SEP 25)

From Oct 25 onwards we will **drive Transformational change in key People Services** areas including Payroll, Recruitment, Digital Systems and Talent Management – **digital transformation and collaboration will be key**

3

People Operating Model – Phase 2

Transactional Services incl. Recruitment | Payroll

Transformation

Talent Management | Digital transformation | People Service Delivery

Long term | 12 – 24 months (OCT 25 – SEPT 26)

TIER 1 PRIORITIES & MILESTONES (Oct 24– Apr 25)

NHS South East Coast Ambulance Service NHS Foundation Trust

Milestone 08 Nov 24 | Milestone DEC 24 | Milestone DEC 24 | Milestone JAN 25

	Oct	Nov	Dec	Jan	Feb	Mar	IN-YEAR DELIVERABLES	OUTCOMES (BY END YR 2)
TIER 1 PROGRAMME	Governance and reporting agreed and embedded Finalise and agree in-year KPI targets	Monitor plans, risks, issues, dependencies and escalate to Steering Group as required. Provide assurance to EMB and Trust Board					Track delivery and benefits realisation	Successful delivery of HR Improvement Plan Programme
Priority 1 - Operating Model	**MARS outcomes confirmed** "Lean-In" plan confirmed People Operating Model Phase 1 (ER/Wellbeing/Retention/L&D/OD) design and integration aligned with Trust Operating Model (central vs regional services) Transition/resource plan design	HR service specification, KPIs, structures and resource plan developed	**Phase 1 Operating Model Business Case Approved** Pre consultation engagement	Restructure consultation and implementation period (People)			Adoption of Phase 1 People Services model to support county-based structure	Transformed People Services Directorate that supports our people effectively
Priority 2 - ER Casework	Selenity re-configured for up-to-date recording, complaince and reporting of ER cases Legacy and complex cases reviewed and resources allocated with on-going review process to address backlog	KPIs and targets defined (Selenity) and users trained Improved triage process (proactive panel review) signed off and implemented	Selenity new dashboards released Mediation training (Cohort 2) **Mediation approach agreed & mediators trained**	Selenity reporting implementation and updating **Mediation service launched**	Effective and tailored ER triage investigations operating procedure agreed	Embedding learning from events for continuous improvement	Legacy caseload reduced – cases over 12 months by 50% Casework data accuracy imp roved to 95% compliance	Effective management of ER Casework with greater focus on informal resolution
	Complex/ specialist ER investigations undertaken by external provider Capsticks (specification & delivery)							
	Legacy case management undertaken by Hunters (specification & delivery)							

TIER 1 PRIORITIES & MILESTONES (Oct 24– Apr 25)

NHS South East Coast Ambulance Service NHS Foundation Trust

Milestone Jan25

Milestone Jan25

	Oct	Nov	Dec	Jan	Feb	Mar	IN-YEAR DELIVERABLES	OUTCOMES (BY END YR 2)
TIER 1 PROGRAMME	Governance and reporting agreed and embedded Finalise and agree in-year KPI targets	Monitor plans, risks, issues, dependencies and escalate to Steering Group as required. Provide assurance to EMB and Trust Board					Track delivery and benefits realisation	Successful delivery of HR Improvement Plan Programme
Priority 3 – ER Training	Staff identified for ER training and cohorts agreed. Abstraction plan agreed with Operations. ER Training package designed in collaboration with Hunters ER Training KPIs designed and agreed	ER Training package socialised with SMG & Trade Unions	Training delivered Cohort 1 – Managers/Ops Develop plan for Action Learning sets Training delivered Cohort 2 ER/HR Cohort 1 Training Feedback gathered and reviewed	Training delivered Cohort 3 – Ops	**Full ER Training roll-out completed**	Review performance (target vs realised benefits/KPIs) Action Learning sets (quarterly)	40 managers ER trained Two action learning sets completed Continuous improvement framework in place	Managers trained to lead with confidence (Measures of success (KPIs) TBC)
Priority 4 – Trade Unions	Review JPF Terms of Reference - inc. Ways of working / clarifying the role of JPF and other TU meetings Trade Union JPF ToR review meeting – 10.10.24	Trade Union JPF ToR review meeting – 05.11.24	Trade Union JPF ToR review meeting – 03.12.24	**Revised JPF ToR Approved**	Implementation of JPF ToR	Review of JPF effectiveness	JPF ToR agreed Agreed workplan for 25/26 in place	Effective partnership working with Trade Unions

In order to restructure and re-build the HR Directorate, we will need additional support over a two year period to develop our People Services

NHS South East Coast Ambulance Service NHS Foundation Trust

- We will need to put in place a range of temporary resources to ensure we can carry on delivering core HR services whilst driving delivery on the HR Improvement plan
- A resource plan is in development to mitigate some of the gaps in current leadership and bolster where additional capacity or specialist skills are required short-term

1 Executive 'Lean-in' Plan

- The Executive team has agreed a 'Lean In' plan for Oct 24-Mar 25 which will see a number of HR teams aligned with other Directorates temporarily
- The 'Lean In' plan is to create capacity, and enable the HR SLT to focus on the four key priorities in FY 24-25

2 Additional leadership capacity and capability

- A number of transitional posts are required to provide the support needed to deliver the foundations within FY24-25
- As part of the People Services Operating Model design, consideration will be given to the leadership structure required to meet the strategic commitments to 'effectively serve our people'

3 Specialist external support

- It is recognised that additional targeted specialist support for some of the key priorities, particularly for legacy and complex ER cases, is required to reduce the backlog
- At present, external contractors have been contracted to undertake some legacy/ complex ER work, specialist investigations and provide some bespoke ER training support to design and deliver an ER Training package

Effective delivery of the HR Improvement plan

There are high level **risks** that need to be mitigated to keep us on track to deliver our in-year priorities – these will be aligned with the BAF

NHS South East Coast Ambulance Service NHS Foundation Trust

Priority Area	Key Risks	Mitigations
Overall Programme	▪ Morale may be impacted during the HR operating model change process which may affect delivery of the priorities and broader BAU ▪ Insufficient leadership capacity or specialist capability to drive delivery of the plan	▪ Develop communications and engagement plan for the HR Improvement Plan which aligns with activities and milestones ▪ Transitional resource plan developed to bolster leadership to support delivery
Operating Model	▪ The Phase 1 Operating Model doesn't meet the end of March 25 milestone due to delays in the consultation process and/or capacity to drive the process ▪ There is a risk that without sufficient OD input the operating model may not deliver the outcomes	▪ Clearly defined and tested plan mapped to milestones with risks mitigated / close monitoring through Steering Group ▪ Ensure OD is incorporated into the design thinking and sufficient engagement with Ops leaders
ER Casework	▪ The Resolution Policy may be delayed pending approval ▪ Delivery of key milestones may be delayed due to resource gaps in the ER team as a result of resignations/sickness	▪ Engagement with key stakeholders to address concerns ▪ Transitional resource plan developed to bolster leadership to support delivery
ER Training	▪ Training can't be delivered due to abstraction limitations (rota constraints / winter pressures) ▪ Training isn't properly embedded, and ways of working don't change	▪ Work with OUMs to develop implementation plan that doesn't impact performance ▪ Incorporate continuous learning approach to implementation/ OP input to roll out
Trade Unions	▪ There is a risk that the JPF Terms of Reference (ToR) are not agreed by the end of March 2025	▪ Regular engagement on the JPF ToR to mitigate against potential concerns

Our proposed Governance structure – this will be established immediately to drive delivery of the plan and provide assurances to the organisation

NHS South East Coast Ambulance Service NHS Foundation Trust

ASSURANCE

Role | Ensure that Tier 1 priorities are on track to deliver the intended benefits and outcomes.

Documentation/Reporting
- Highlight report

Frequency:
- **EMB |** monthly
- **Trust Board |** every 6 weeks

EMB → Trust Board / People Committee

ESCALATION

Role | Oversee and make recommendations for the direction of the HR Improvement Plan; report into EMB

Documentation/Reporting
- Highlight report
- RAID log

Frequency | Weekly to end Dec 24. Fortnightly Jan 25 onwards

HR IMPROVEMENT PLAN STEERING GROUP

SRO/Chair: Sarah Wainwright
Programme Lead: Roxana Oldershaw
Core Membership:
- Andrea Vigile
- Ruth McCall
- Tina Ivanov
- Comms TBC
- Ops rep TBC
- Finance rep TBC

Governance: Victoria Cole

DELIVERY

Role | Monitor Action Plan, risks, dependencies, change requests and escalate issues to Steering Group

Documentation/Reporting
- Action Plan
- RAID log

Frequency | Weekly

OPERATING MODEL WORKING GROUP	ER CASEWORK WORKING GROUP	ER TRAINING WORKING GROUP	TRADE UNIONS
Lead: Andrea Vigille **Membership:** • Finance TBC • Comms TBC	**Lead:** Ruth McCall **Membership:** TBC	**Lead:** Tina Ivanov **Membership:** TBC	**Lead:** Sarah Wainwright **Membership:** TBC

Next steps for the HR Improvement Plan

South East Coast Ambulance Service NHS Foundation Trust

- Confirm support from Board on Tier 1 in year priority areas for the HR Improvement Plan
- Mobilise governance including establishing Steering Group/Working Groups
  - Detailed programme plan (four priority areas)
  - Risks and dependencies identified and tracked
  - Regular reporting of progress to EMB
- Finalise and agree in-year KPI targets
- Enact ‘Lean in’ plan following support from EMB
- Re-alignment of Tier 1 priorities (HR Improvement Plan) with BAF
- Finalise resource requirements (immediate transition support and longer-term leadership roles)

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	/24

Name of meeting	Trust Board
Date	3 October 2024
Name of paper	Quality & Patient Safety Committee Assurance Report – 19 September 2024
Author	Liz Sharp Independent Non-Executive Director – Committee Chair

INTRODUCTION

The Quality & Patient Safety Committee is guided by a cycle of business that algins with the Board Assurance Framework – strategic priorities; operating plan commitments; compliance; and risk.

This assurance report provides an overview of the most recent meeting on 19 September 2024, which was initially scheduled for August, but needed to be rearranged. The next meeting is therefore coming up next month on 17 October.

Acknowledging that committees are an extension of the Board, this report is one of the key sources that the Board relies on to inform its level of assurance. It is set out in the following way:

- **Assure**: where the committee is assured
- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Advise**: items for the Board's information

ASSURE

Right Care Right Person

The committee continues to be assured on the roll out, with Surrey the last to go live in September. Specifically, while it is still too early to fully assess the impact, there is currently no increase in calls considered inappropriate and no adverse impact on activity.

Quality Account Priority - Unsafe Discharge

The aim of this is to ensure that all discharges are either directly supported by a senior clinical decision maker or receive a "post discharge review". The committee received a demonstration on how the reviews are undertaken; when concerns are identified with a discharge we send another resource to make contact with the patient. This has been tested first in Tangmere with 100 incidents reviewed by an Advanced Paramedic leading to the identification of six discharges requiring more information to assess as safe, and one found to be unsafe.

The committee is really supportive of this positive and proactive approach to patient safety, which used as an adjunct to clinical supervision also supports the development of our clinicians.

Quality Account Priority - Patient Care Records (PCR)
This two-year priority focusses on PCR reviews aimed at improving quality and supporting meaningful clinical supervision for our people. It is early days, but this is progressing well and taken together with Unsafe Discharges informs an overarching package of feedback for our clinicians which ultimately will improve patient outcomes.

ALERT

Volunteers - CFRs / Emergency Responders
Increasing both the numbers and scope of our CFR volunteers is a key enabler of our strategic direction. There is still no agreed way forward / plan for this, highlighted by the range of views expressed at the meeting. The Emergency Responder pilot exemplified this with the relevant leads not able yet to reach a shared conclusion, following the initial review of the project. With the new Chief Paramedic Officer joining in October, the three clinical directors will work this through and report back to the committee early in Q4.

ADVISE

Four annual reports were considered by the committee, each one having gone through the relevant quality governance group, summarising the work in the past 12 months.

1. **Controlled Drugs Accountable Officer (CDAO)**
   In their capacity as CDAO, the chief medical officer confirmed how the data in this report demonstrates good assurance with the safety and security of controlled drugs. There are no significant issues identified requiring escalation to the Board. There were some recording issues linked to earlier discussion about PCR documentation.

2. **Infection Prevention & Control (IPC)**
   The controls in place for IPC are broadly effective. A key highlight was the take up of the flu vaccine (72.9% for patient facing staff), which was the highest for any ambulance trust. The relaunch of IPC champions also helped to embed good practice.

3. **Safeguarding**
   The 85% compliance with level 3 training for registered staff was a great achievement. The national requirements for next year (2025-26) have changed when all frontline staff will require this; the executive is working through how this will be achieved.

   Multiagency working is strong, and the trust completed 15 external assessments with positive feedback. 95% of referrals met the relevant thresholds, indicative of a high functioning team. The investment last year in two extra team members has helped this, given the increase in activity.

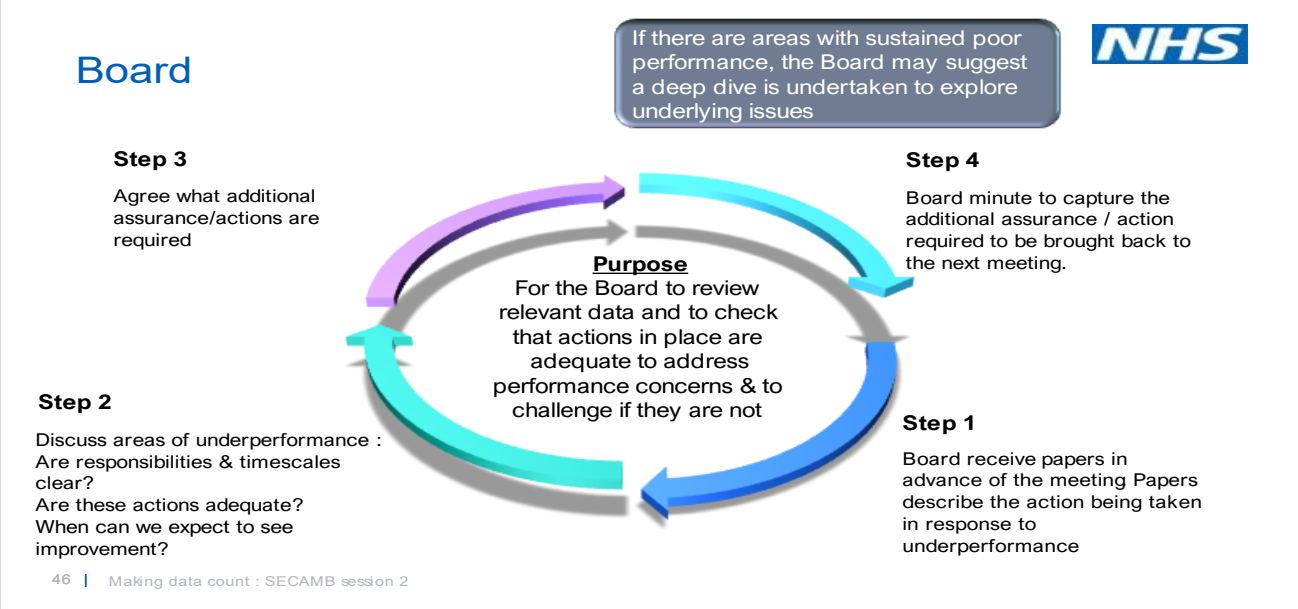
   The committee noted the great support to operations and the volume of activity and what they cover is really quite impressive.

4. **Learning from Deaths Q3 2023-24**
   This is the usual quarterly report with findings consistent with the norm. There is nothing to escalate. In general, the majority of care is judged to have been appropriate. One of the issues identified related to a poor quality of

documentation. As these reviews are so retrospective they are not fed back to the individuals but have informed the Quality Account priority covered earlier.

Recommendation

The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle



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Board Assurance Framework

15 July 2024

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Our Strategy 2024-2029

- **Our Vision:** To transform patient care by delivering prompt, standardised emergency responses while enhancing care navigation with seamless, accessible virtual services for non-emergency patients

- **Our Purpose:**

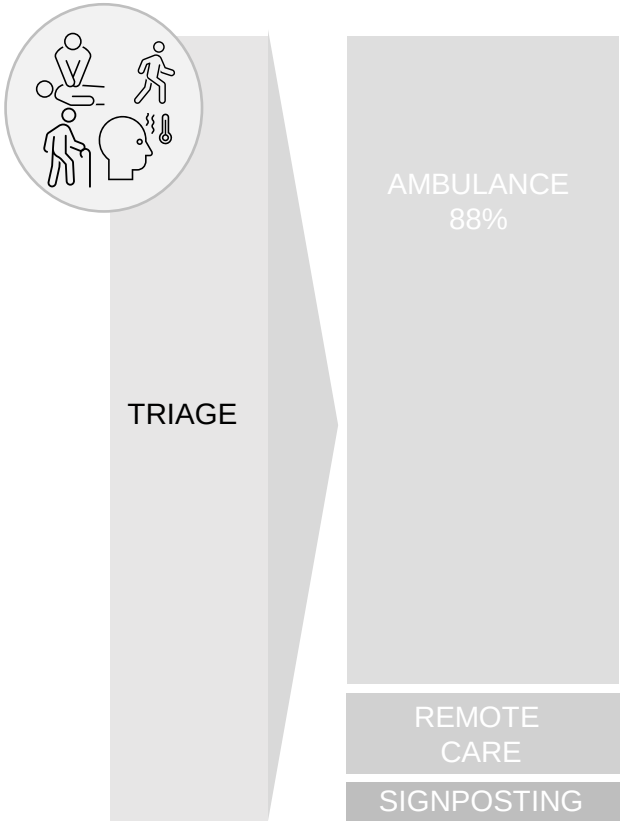
Saving Lives,

Serving Our Communities

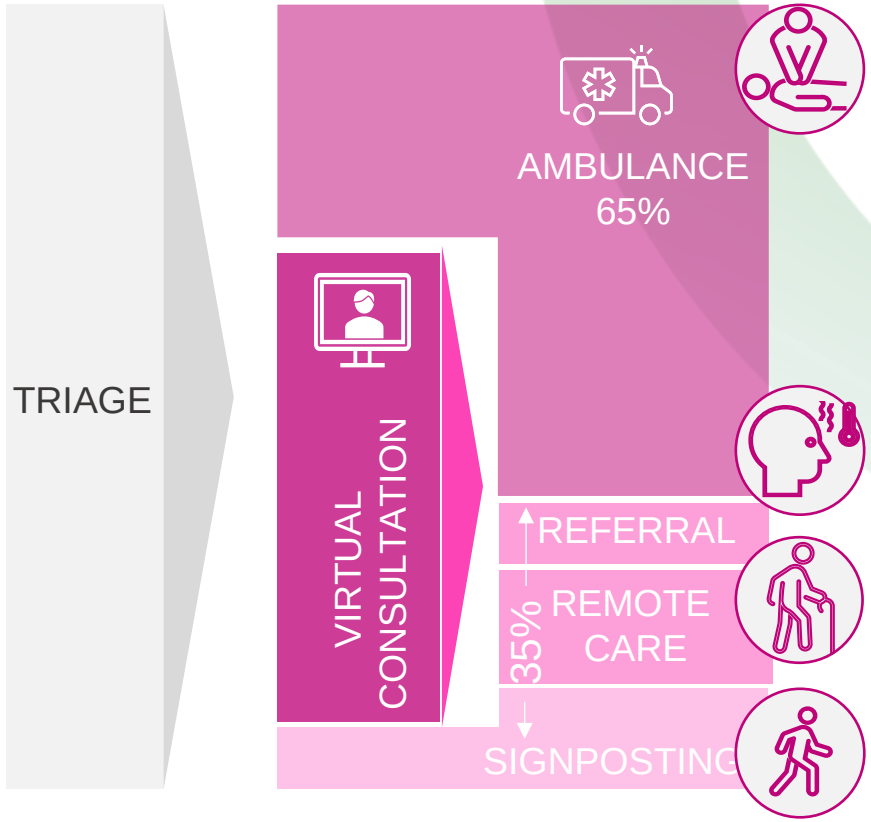
Our Strategy 2024-2029

South East Coast Ambulance Service NHS Foundation Trust

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



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



Timely care for emergency patients:

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

Virtual care for non-emergency patients:

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

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

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

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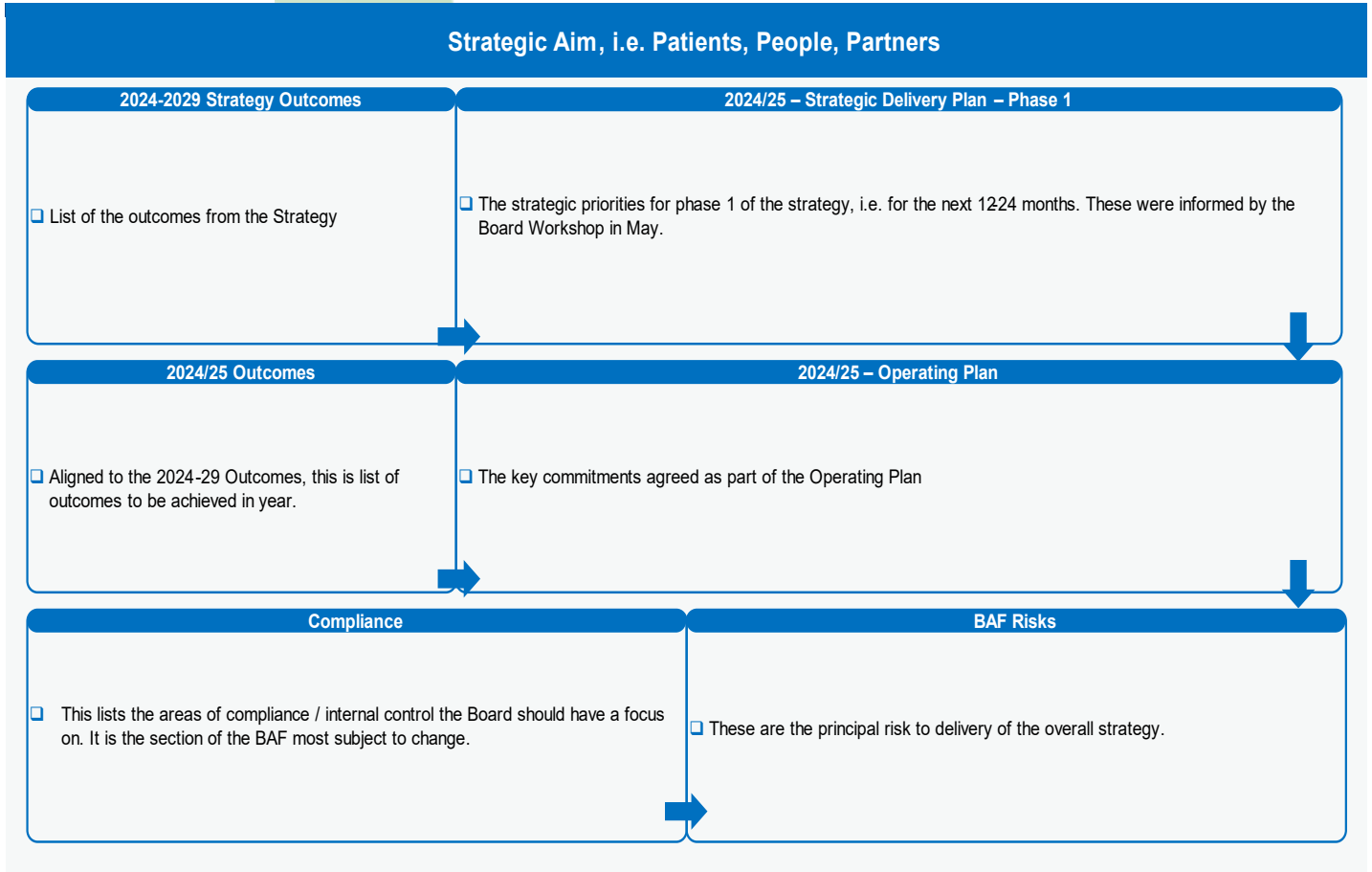
How our Board Assurance Framework (BAF) Works

Our BAF:

- The BAF is designed to bring together in a single place all the relevant information to help the Board assess progress against its strategic vision and the principal risks to delivery. This 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.
- **Operating Plan** – this section of the BAF includes the key commitments the Board has made for the current financial year.
- **Compliance** – these are 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.



How our BAF reflects our Strategy :

- The Trust's priorities are aligned with three strategic aims, which help frame each meeting agenda of the Trust Board.
- Taken together with the related risks and sections of the IQR, The BAF provides the Board with the data and information to help inform its level of assurance in meeting the agreed aims:

Delivering High Quality Care

We are committed to delivering high quality care, ensuring every patient receives the best possible treatment and onward health management.

Our People Enjoy Working at SECAmb

We strive to make SECAmb a great place to work by promoting a supportive and rewarding work environment where all team members feel valued and motivated.

We are a Sustainable Partner

We are committed to being a sustainable partner within an integrated NHS, focusing on practices that enhance system integration and promote long-term resilience and efficiency.

We deliver high quality patient care

2024/25 – Strategic Transformation Plan – Phase 1

Project	Milestone	Baseline Target	Forecast Target	Current RAG	Previous RAG	Executive Lead	Oversight Committee
Unscheduled Care Navigation Hub – Design & Implementation	Define scope of hub models agreed by ICBs	June 2024				Director of Operations	Quality & Patient Safety
	Implement first new hub	October 2024					
	Evaluation to inform future scope of virtual care	March 2025					
Clinical models of Care – Design and Agreement with ICBs	Scope determined with ICBs	Q2				Chief Medical Officer	Quality & Patient Safety
Patient Experience & Engagement	Enabling strategy for 2025 – 2035 developed	End of Q3				Director of Quality / Chief Nurse	Quality & Patient Safety

2024/25 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Oversight Committee	Date last reviewed at Committee
Operational performance plan					
Deliver the three Quality Account Priorities	Post-discharge reviews				
	Reduction in Health Inequalities				
	Patient Care Records Review Implementation				
Expand number of volunteers by 150					
Implementation of 80% of NHSE PSRIF Standards/Principles					
Deliver 2 Clinical QI priorities	Safety in the Waiting List				
	IFTs				

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
There is an ongoing, multi-year risk that the financial environment for the NHS prevents local commissioners from supporting our clinical strategy	20	04	SP&T
There is a risk that, as a consequence of the NHS funding environment we have insufficient levels of leadership capacity to deliver our strategy and/or that our leadership structure does not allow for effective strategic delivery.	12	08	CEO

Exception reporting will be provided as required following committee oversight

Board Highlight Report – Unscheduled Care Navigation Hubs

Progress Report Against Milestones:	SRO / Delivery Lead:	Previous RAG	Current RAG
Key achievements against milestone • • •	Emma Williams		
Upcoming activities and milestones • • •	**Risks & Issues:**	**Score**	**Mitigation**
Escalation to Board of Directors • • •	Funding & Financial Stability		
	Stakeholder Engagement and Buy In		
	IT & Estates Infrastructure		

Q1	Q2	Q3	Q4
◆ Define scope of hub models ◆ Develop evaluation & ROI model & programme governance	◆ Completion of final evaluation model ◆ Governance structures & stakeholder engagement approaches confirmed ◆ Go/No-Go criteria developed & reviewed to ensure readiness	◆ Staggered GO LIVE of 5 new hubs ◆ QI / Evaluation Phase 1 (Local ICB Level – continuous monitoring)	◆ QI / Evaluation Phase (Local ICB Level – continuous monitoring)

Each of our strategic delivery programs will receive a Board-Level highlight report at every meeting

BAF Risk 537 – Funding

There is an ongoing, multi-year risk that the financial environment for the NHS prevents local commissioners from supporting our clinical strategy

Controls, assurance and gaps

Controls: we have the vision and a strategy which has been signed off by the Board. There is an agreed financial plan, with enhanced financial controls to be implemented. Our partners have signed up to the vision, however the available funding has not yet allowed them to commit to delivery.

Gaps in control: there is no agreement in place with commissioners for the 2024/25 financial year. No agreed multi-year plan with associated funding to support implementing our clinical model.

Positive sources of assurance: ICB clinical plans and strategy delivery plans refer to our strategy e.g.: Surrey Heartlands, shared delivery plan for Sussex. Strategic Commissioning group set up as formal governance route between SECAmb and ICB partners to develop a multi-year plan. NHSE through RSP has an expectation that we will develop this multi-year plan as part of our exit criteria. Our strategic delivery plan derives from our Strategy and is reflected in the BAF for 2024/25.

Negative sources of assurance: This year we are planning for a £16.5 million deficit. Current plans for ICBs do not support a multi-year funding arrangement to get SECAmb to financial sustainability.

Gaps in assurance: The Board has not yet seen the plan between June 2024 and December 2024 to develop the multi-year plan to exit RSP. There is a significant challenge in coordinating and aligning the multiple stakeholders involved in developing the multi-year plan, given the complexity and scale of the work. The Board has not yet seen the recommendations from the Southeast Ambulance Commissioning review or how the recommendations will affect the ability to deliver the multi-year plan.

Accountable Director	Strategic Planning and Transformation
Committee	Finance and Investment Committee
Initial risk score	Consequence 5 X Likelihood 4 = 20
Current Risk Score	Consequence 5 X Likelihood 4 = 20
Target risk score	Consequence 4 X Likelihood 1 = 04
Risk treatment	Treat
Target date	Q4 2024/25

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
We are developing a multi-year plan to exit RSP in collaboration with ICB partners and our region	SP&T, CFO	Q3 2024	The work is due to commence at the end of June, once the year one funding round is resolved.

Each of our BAF Risks has a detailed risk page

Delivering High Quality Patient Care

Delivering High Quality Patient Care Executive Summary

South East Coast Ambulance Service NHS Foundation Trust

- There are no exceptions to highlight from the Quality & Safety section of the IQR, only to note that the Patient Safety and BI teams are in the process of completing new metrics that reflect the shift to PSIRF from the SI framework.
- 71% compliance to PSIRF standards can now be evidenced (90% for core standards).
- The only Quality Account priority off track is health inequalities (slide 12) – this is due to delay in attending Board development session, now booked for November setting plans back on track.
- The Board are asked to note the limitations and impact a lack of securing funding for the unscheduled hubs will pose (refer to slide 13). Our system partners have now confirmed in writing that they will provide the clinical resources at risk to support us to go live from October, reducing the risk from 16 to 12.

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**.

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 – increase in survival by 2% **in year 2 vs a 9.5% baseline**
- ❑ Work with partners to improve stroke outcomes by improving diagnostic accuracy and reduce time to definitive intervention **by Q4**

2024/25 – Operating Plan

- ❑ Operational Performance Plan – **continuous monitoring**
- ❑ Deliver our three Quality Account priorities (post-discharge reviews, reduction in health inequalities focus on maternity and mental illness, and implement Patient Care Records review and feedback) **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 Response Plan
- ❑ Compliance to Incident Management Cycle and The Statutory Duty of Candour

BAF Risks

- ❑ **Delivery of our Clinical Strategy:** There is a risk that we are unable to achieve improved patient outcomes through delivery of our clinical strategy, due to the impact of the challenging financial environment on local commissioning decisions.
- ❑ **Clinical Model:** There is a risk that the leadership structure needed to support delivery of our long-term strategic aims and clinical model is not adequately implemented, as a consequence of the NHS funding environment.

We deliver high quality patient care

2024/25 – Strategic Transformation Plan – Phase 1

Project	Milestone	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Unscheduled Care Navigation Hub – Design & Implementation	Define scope of hub models agreed by ICBs	June 2024	Complete	Kate Mackney	EMB for reporting SMG for delivery	Yes	Director of Quality / Chief Nurse (tbc)	Quality & Patient Safety
	Implement first new hub	October 2024	October 2024					
	Evaluation to inform future scope of virtual care	March 2025	March 2025					
Clinical models of Care – Design and Agreement with ICBs	Scope determined with ICBs and Region as part of the strategic commissioning review	Q2	Q3	Rosie Bucknall	EMB	Yes	Chief Medical Officer	Quality & Patient Safety
Patient Experience & Engagement	Enabling strategy for 2025 – 2035 developed	End of Q3	December 2024	Victoria Baldock	EMB	No	Director of Quality / Chief Nurse	Quality & Patient Safety

2024/25 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Programme Manager	EMB / SMG	PMO	Oversight Committee	Date last reviewed at Committee
Operational performance plan								
Deliver the three Quality Account Priorities	Post-discharge reviews			Andy Collen	EMB	No	QPSC	19/09/24
	Reduction in Health Inequalities			Julie Ormrod	EMB	No	QPSC	Due 17/10/24
	Patient Care Records Review Implementation			Nicola Brooks	EMB	No	QPSC	19/09/24
Expand number of volunteers by 150								
Implementation of 80% of NHSE PSRIF Standards / Principles				Neil Salmon	SMG	No	QPSC	06/2024
Deliver 2 Clinical QI priorities	Safety in the Waiting List			Amy Igweonu	SMG	No	QPSC	03/2024 Due Nov & Jan
	IFTs		N/A	Amy Igweonu	SMG	No	QPSC	Due Nov & Jan

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Delivery of our Clinical Strategy: There is a risk that we are unable to achieve improved patient outcomes through delivery of our clinical strategy, due to the impact of the challenging financial environment on local commissioning decisions.	20	04	SP&T
Clinical Model: There is a risk that the leadership structure needed to support delivery of our long-term strategic aims and clinical model is not adequately implemented, as a consequence of the NHS funding environment.	12	08	SP&T

Board Highlight Report – Unscheduled Care Navigation Hubs

Progress Report Against Milestones:

Key achievements against milestone

- **Phase 2:** Successfully delivered a comprehensive communications and engagement plan, which includes key briefings for both forums and stakeholders. These briefings provide essential updates on operational and clinical developments.
- **Phase 3 Progress:** All relevant governance documents have been completed and are now in draft, ready for final review. The target deadline of **end of September 2024** is on track to be met.
- **Phase 4 Decision:** A Go-No-Go decision meeting has been scheduled for **4th October**. This session will scrutinise the collective system's readiness and preparedness for the next phase.
- **Financial Agreement:** All system Integrated Care Boards (ICBs) have agreed to proceed at risk, irrespective of the outcome of the NHS England funding decision.

Upcoming activities and milestones

- **Phase 3:** Implementation Planning to be completed by the end of September 2024, with all governance approvals secured.
- **Phase 4:** Phased Go Live scheduled for October 2024, adhering to the agreed Go/No Go criteria established by the Programme Board.
- **Phase 5:** Continuous Quality Improvement & Evaluation beginning November 2024, with local ICB teams overseeing implementation and quality governance, while the Strategic Commissioning Group monitors benefits and improvements for 2025/26.

Escalation to Board of Directors

- **Funding Concerns:** Addressing the feasibility of the Go Live without secured funding as outlined in the Business Case.

SRO / Executive Lead:

Margaret Dalziel

Previous RAG	Current RAG

Risks & Issues:	Score	Mitigation
Funding & Financial Stability	12	▪ ICB Agreement allocates funds from existing budgets via 'invest to save' initiatives, anticipating savings from reduced conveyances, ED visits, and fewer admissions and discharges of decompensated patients to community services. – Plan B scope based on affordability being developed. ▪ ICBs have agreed to proceed at risk ▪ SECAmb completed Business Case for funding of Yr1 – submitted to region.
Stakeholder Engagement and Buy In	9	▪ ICB/SECAmb are providing support for conversations with provider partners to ensure adequate staffing. ▪ Comprehensive joint communication and engagement plans are being developed to secure stakeholder buy-in and collaboration
IT & Estates Infrastructure	12	▪ Confirmation of the clinical delivery model early in the process to inform and guide the formulation of a robust IT infrastructure plan. ▪ ICB Digital lead involved in project.

Q1	Q2	Q3	Q4
◆ Define scope of hub models ◆ Develop evaluation & ROI model & programme governance	◆ Completion of final evaluation model ◆ Governance structures & stakeholder engagement approaches confirmed ◆ Go/No-Go criteria developed & reviewed to ensure readiness	◆ Staggered go-live of 5 new hubs ◆ QI / Evaluation Phase 1 (Local ICB Level – continuous monitoring)	◆ QI / Evaluation Phase (Local ICB Level – continuous monitoring)

Board Highlight Report – Clinical Models and Pathways of Care

Progress Report Against Milestones:

Key achievements against milestones

Integrated Pathways of Care (external):

- Inaugural external Clinical Advisory Group set up to engage clinical leads (SCAS & SECAmb) & kick off programme setup
- High level articulation of FY24/25 scope, structure & delivery approach complete

Clinical Models of Care (internal):

- 11 of 11 Models of Care (MoC) developed and completed initial governance: Professional Practice Group (PPG) and SECAmb's Clinical Advisory Group (CAG). 3 of 11 MoC presented to Quality & Clinical Governance Group (QCGG)
- Internal MoC team is dependent on SECAmb establishing external Pathways of Care (PoC) programme with NHSE & SCAS to inform MoC prioritisation and implementation approach/plan

Upcoming activities and milestones

- 3 October: Inaugural Pathways of Care (external) Clinical Advisory Group
- SECAmb to complete MoC data analysis at Place level (to inform SCAS data analysis and overall MoC prioritisation decision by NHSE Region)

Escalation to Board of Directors

- N/A

SRO / Executive Lead:	Previous RAG	Current RAG
Richard Quirk		

Risks & Issues:	Score	Mitigation
Dependency on and complexity of external integrated partner engagement (prioritisation, funding, implementation)	12	▪ Conduct stakeholder mapping exercise to develop external engagement approach ▪ Develop change control framework to clarify permitted variance/implementation at each level of the ecosystem
Local urgent care capacity restraints	9	▪ Work will be required with the data & analytics team to understand the workforce requirements to deliver this work ▪ Close work with the workstream lead for Urgent Care Navigation Hubs
Patient safety risk of new clinical pathway definition	12	▪ Communication both internally and externally about what these Pathways of Care are not, including what is in scope or not.
Transition from current model to new Pathways of Care	9	▪ Communicating clearly the difference between the service models
Capacity of Medical team to deliver this workstream	12	▪ Review of current work streams to pause what it is not required ▪ Two senior vacancies uncovered with workstreams being reviewed

Q1 (Apr-Jun 24)	Q2 (Jul-Sep 24)	Q3 (Oct-Dec 24)	Q4 (Jan-Mar 25)
◆ 3 of 11 MoC developed and presented to QCGG ◆ 11 of 11 MoC have completed the first PPG checkpoint	◆ External engagement initiated (NHSE SE Region, SCAS, ICBs) ◆ Complete MoC data analysis down to Place level to inform prioritisation for implementation ◆ FY24/25 scope and high level programme plan completed	◆ Identify top 3 priorities for implementation of Models of Care / Pathways of Care ◆ Develop implementation plan with Programme lead ◆ Implementation of prioritised Pathways of Care to be informed by overall integrated system delivery approach, plan and timelines ◆ Prepare funding & approvals for FY25/26 scope and requirements	◆ Progress Pathways of Care implementation & planning ◆ Establish feedback loops to review early Pathways of Care implementation

Board Highlight Report – Patient Engagement & Experience

Progress Report Against Milestones:

Key achievements against milestone

- Planning workshop held to support development of the patient and public engagement strategy.
- Literature review, review of other provider strategies and gap analysis undertaken to support development of the patient and public engagement strategy.
- Launched patient and public survey to inform the patient and public engagement strategy – 84 response received within the first week.
- A desktop review has been undertaken and key internal stakeholders are currently being engaged to determine the one Quality Account priority for next year. We only have one new priority to determine for the next financial year because we are carrying two over from this year as two-year priorities (Health Inequalities & Feedback on PCR).

Upcoming activities and milestones

- Once a shortlist of potential priorities has been collated for the one Quality Account priority, in Q3, a meeting with key internal stakeholders (Ops, Medical, Q&N, S&P), will be arranged to discuss and agree a final list of 3-5 priorities that we would be fully happy to support. It is then proposed that this list of 3-5 is shared with wider internal and external stakeholders to vote on their preferred option, enabling wider stakeholder engagement.
- Final Quality Account priority to be agreed at CQGG on 21st November.
- First draft of Patient and Public Engagement Strategy 2025-2029 to be ready for review by end of Q3.
- A business case is being developed for additional investment in the PE team to enable effective delivery of the patient and public engagement strategy

Escalation to Board of Directors

- None

SRO / Executive Lead:	Previous RAG	Current RAG
Margaret Dalziel		

Risks & Issues:	Score	Mitigation
There is a risk that due to the patient engagement team being only a team of two people, there will not be capacity to support all the plans for patient and public engagement across the Trust and our local communities..	8	• Urgency vs importance matrix completed to support prioritisation. This has been translated into a Gantt chart to map out plan for actions over next 3 months.
There is a risk that the lead for patient engagement cannot fulfil the role and meet the plan as Quality Accounts are held in that portfolio, taking 25-30% of capacity of small team.	8	▪ As above ▪ Review of the team and expected workload to be undertaken in Q3 for consideration into Directorate workforce.

Q1	Q2	Q3	Q4
◆ Publish 2023/24 Quality Account ◆ Network with VCSEs to boost inclusion and diversity from seldom heard voices in engagement sessions and involvement opportunities ◆ Initiatives to increase PEQ responses ◆ Gather examples of patient and public engagement strategies from other ambulance and NHS Trusts nationally.	◆ Initial workshop for planning patient and public engagement strategy ◆ Literature review and gap analysis to support strategy ◆ Develop MS Forms survey to gain views of patients and stakeholders to inform the patient and public engagement strategy ◆ Meet with key internal stakeholders to agree 3-5 potential priorities for 2024/25 QA ◆ Agreed QA priorities aligned to Trust strategy and objectives to be shared with stakeholders for consultation.	◆ Final QA priority discussed to be agreed at CQGG (21st November) ◆ First draft of Patient and Public Engagement Strategy 2025-2029 to be available for review.	◆ Identify three indicators per domain (clinical effectiveness, patient safety and patient experience) for the 2024/25 QA ◆ Submit working draft of Quality Account to EMB for review ◆ Publish final version of patient and public engagement strategy and share widely.

BAF Risk 537 – Delivery of our Clinical Strategy

There is a risk that we are unable to achieve improved patient outcomes through delivery of our clinical strategy, due to the impact of the challenging financial environment on local commissioning decisions.

Controls, assurance and gaps

Controls: we have the vision and a strategy which has been signed off by the Board. We have a financial plan and enhanced controls that achieves delivery of the priorities for year one of the strategy. Partners have signed up to the strategy.

Gaps in control: While we have agreed with commissioners a financial plan for 2024/25, there is no agreed multi-year plan with associated funding to support implementing our clinical model. This includes lack of a multi-year investment strategy that assures the Board of having credible plans to deliver changes needed (i.e. digital, clinical pathways, etc)

Positive sources of assurance: ICB clinical plans and strategy delivery plans refer to our strategy e.g.: Surrey Heartlands, shared delivery plan for Sussex. Strategic Commissioning group set up as formal governance route between SECAmb and ICB partners to develop a multi-year plan. NHSE through RSP has an expectation that we will develop this multi-year plan as part of our exit criteria. Our strategic delivery plan derives from our Strategy and is reflected in the BAF for 2024/25. The Executive team are developing the plans for 25/26 as part of the financial recovery, including the development of an investment pipeline 25/26 which will be done during the Autumn 24.

Negative sources of assurance: This year we are planning for a £10 million deficit. Current plans for ICBs do not support a multi-year funding arrangement to get SECAmb to financial sustainability.

Gaps in assurance: The Board has not yet seen the multi-year plan to exit RSP. There is a significant challenge in coordinating and aligning the multiple stakeholders involved in developing the multi-year plan, given the complexity and scale of the work.

Accountable Director	**Strategic Planning and Transformation**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 5 X Likelihood 4 = 20**
Current Risk Score	**Consequence 5 X Likelihood 4 = 20**
Target risk score	**Consequence 4 X Likelihood 1 = 04**
Risk treatment	**Treat**
Target date	**Q4 2024/25**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
We are developing a multi-year plan to exit RSP in collaboration with ICB partners and our region	SP&T, CFO	Q3 2024	We have developed a 25/26 baseline and EMB have reviewed the initial scenarios for 25/26. We have received a consolidated view on income from commissioners.
Effectively influence via the Strategic Commissioning review the development of alternative to ED pathways that will support delivery of our workforce trajectories	SP&T	Q4 2024	A clinical reference group has been established by region and we are embedded with the programme team designing the scope of the pathway re-design work.

BAF Risk 538 – Clinical Model

There is a risk that the leadership structure needed to support delivery of our long-term strategic aims and clinical model is not adequately implemented, as a consequence of the NHS funding environment.

Controls, assurance and gaps

Controls: the Executive structure for 2024/25 has been agreed to meet today's challenges. The following appointments have recently been completed: Director of Nursing and Quality, Director of HR and OD (FTC), Director of Operations (FTC), Chief Paramedic and Chief Digital Information Officer (FTC.)

Gaps in control: work is underway to review the wider leadership structure. The Trust has launched a MARS scheme ahead of considering the wider re-structuring needs of the organisation. The design work for the regional model in operations and HR is at the core of the future model and the design process is underway

Positive sources of assurance: Appointments and Remuneration Committee support the new Executive Structure.
Leadership competency framework – refreshed appointments process has been developed.
A project and delivery leads have been identified, multiple design workshops have taken place with key SMEs, EMB are receiving the first update in October.

Negative sources of assurance: none currently identified.

Gaps in assurance: none currently identified.

Accountable Director	**Strategic Planning and Transformation**
Committee	**People Committee Audit and Risk Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12**
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q3 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Posts critical for strategic delivery are open, namely Programme and Regional Directors	CEO, SP&T	Q3 2024	Programme team appointed. Delivery of Regional model is FY 24/25.
Define Operating model	CEO, Operations, HR	Q3 2024	Design work underway. MARS Scheme launched to close by 20 October.

Version	Noted Changes	Date
V.1.0	First Submission of BAF	Aug-24
V.1.1	Review & Update of first submission Changes: - Virtual Care Hubs Executive Lead updated (DoO to DoQ/CN) - Strategic Transformation Plan Overview updated to reflect decision of 4 key priorities under people improvement and removal of "Getting Things Right for Our People" objectives - Highlight report – Getting things right for our people removed as all elements now out of scope except ER which has been added to People Improvement Plan	Sep-24

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Integrated Quality Report

Trust Board – October 2024

Reporting Period: July & August 2024

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Improving Quality of Information to Board – August 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

	P	?	F	
H	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.
L	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.
H	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.
L	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.

Our Objectives for 24/25

South East Coast Ambulance Service NHS Foundation Trust

We deliver high quality patient care

- Delivery of Performance Targets
- Increase our volunteer workforce by 150
- Improve Cardiac Arrest outcomes and Stroke outcomes
- Implement 5 unscheduled care navigation hubs
- Rollout of Clinical Supervision
- Quality Account and Patient Safety Framework
- Quality Improvement

Our people enjoy working at SECAmb

- Leadership Re-structure
- Leadership Development
- Review our HR and OD Model
- New engagement framework
- Culture Improvement
- Honour the forward liabilities for legacy pay issues

We are a sustainable partner as part of an integrated NHS

- Improve our internal controls and deliver our deficit plan
- Develop an agreed multi-year plan to break-even
- Progress collaboration opportunities with partners
- Refresh our strategic commissioning framework supported by our new models of care
- Develop and begin to deliver on a digital strategy

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Quality of Care

QUALITY OF CARE

Summary

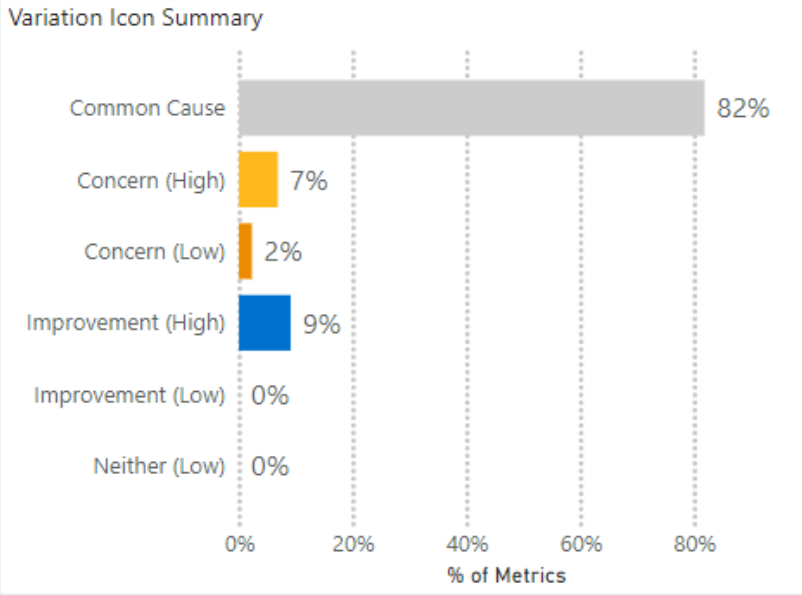
August 2024

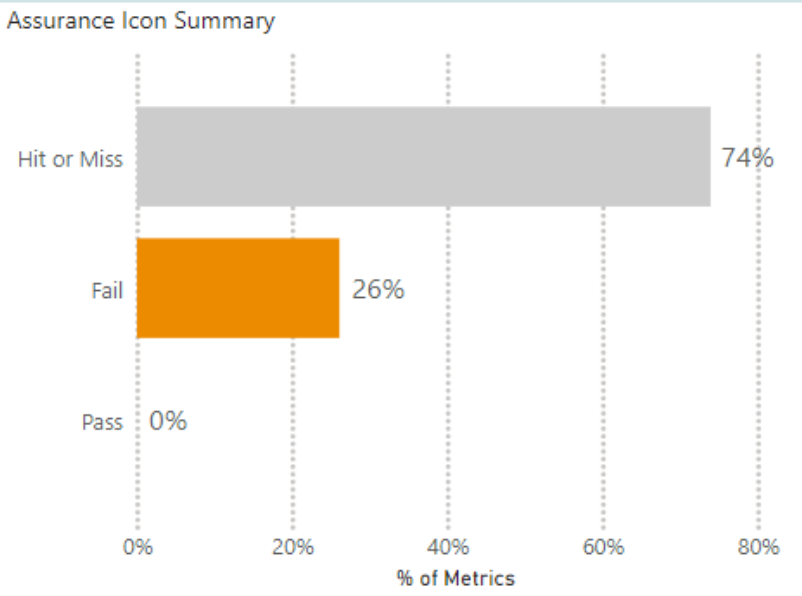
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement		**Sepsis Care Bundle % **Cardiac Arrest - Post ROSC % Resilience Stock Holding of Medicines in the Trust	PGD Compliance %	
Common Cause		Medicines Management % of Audits Completed Duty of Candour Compliance % Hand Hygiene Compliance % Deep Clean Compliance % Complaints Reporting Timeliness %	Compliant NHS Pathways Audits (Clinical) % Number of CD Breakages Single Witness Signature Use CDs Non-Omnicell Single Witness Signature Use CDs Omnicell	Number of Medicines Incidents Number of Datix Incidents Number of Incidents Reported as SIs Violence and Aggression Incidents (Number of Victims - St... Outstanding Actions Relating to SIs, Outside of Timescales Manual Handling Incidents Proportion of Complaints Relating to Crew Attitude % Number of Complaints Number of Compliments No Harm Incidents per 1000 Incidents Harm Incidents per 1000 Incidents Count of No Harm Incidents Count of Low Harm Incidents Count of Severe & Death Harm Incidents
Special Cause Concern		Organisational Risks Outstanding Review %	Compliant NHS Pathways Audits (EMA) %	Count of Moderate Harm Incidents Health & Safety Incidents

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

QUALITY OF CARE

Overview (1 of 3)





Incidents

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Medicines Incidents	Quality Improvement	Aug-2024	147		120.71	173.35	225.99		
Number of CD Breakages	Quality Improvement	Aug-2024	8	0	3.07	20.15	37.23		
Number of Datix Incidents	Quality Improvement	Aug-2024	1228		1143.39	1480.65	1817.91		
Number of Incidents Reported as SIs	Quality Improvement	Aug-2024			-2.95		8.95		
Duty of Candour Compliance %	Quality Improvement	Aug-2024	100%	100%	82.33%	94%	105.67%		
Violence and Aggression Incidents (Number of Victims - Staff)	Quality Improvement	Aug-2024	164		81.74	127.1	172.46		
Number of RIDDOR Reports	Quality Improvement	Aug-2024	7		1.1	9.5	17.9		
Outstanding Actions Relating to SIs, Outside of Timescales	Quality Improvement	Aug-2024	5		-4.68	10.3	25.28		
Health & Safety Incidents	Quality Improvement	Aug-2024	41		15.48	33.4	51.32		

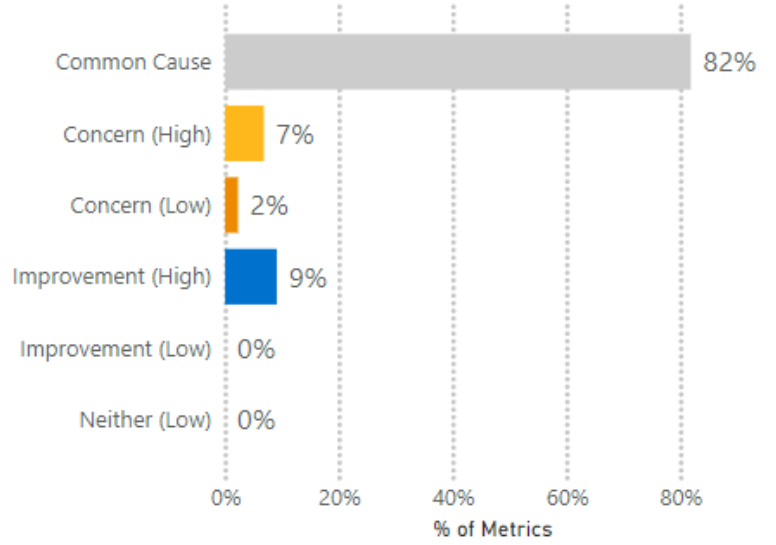
Patient Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Complaints relating to privacy and respect %	Quality Improvement	Aug-2024	0%		0%	0%	0%		
Proportion of Complaints Relating to Crew Attitude %	Quality Improvement	Aug-2024	43%		31.46%	58.2%	84.94%		
Complaints Reporting Timeliness %	Quality Improvement	Aug-2024	96%	95%	71.06%	90.1%	109.14%		
Number of Complaints	Quality Improvement	Aug-2024	55		14.19	64.45	114.71		
Complaints per 1000 999 Calls Answered	Quality Improvement	Aug-2024	0.66		0.23	0.8	1.37		
Number of Compliments	Quality Improvement	Aug-2024	104		43.63	171.45	299.27		
No Harm Incidents per 1000 Incidents	Quality Improvement	Aug-2024	9.32		6.56	10.11	13.66		
Harm Incidents per 1000 Incidents	Quality Improvement	Aug-2024	1.09		0.61	1.35	2.08		

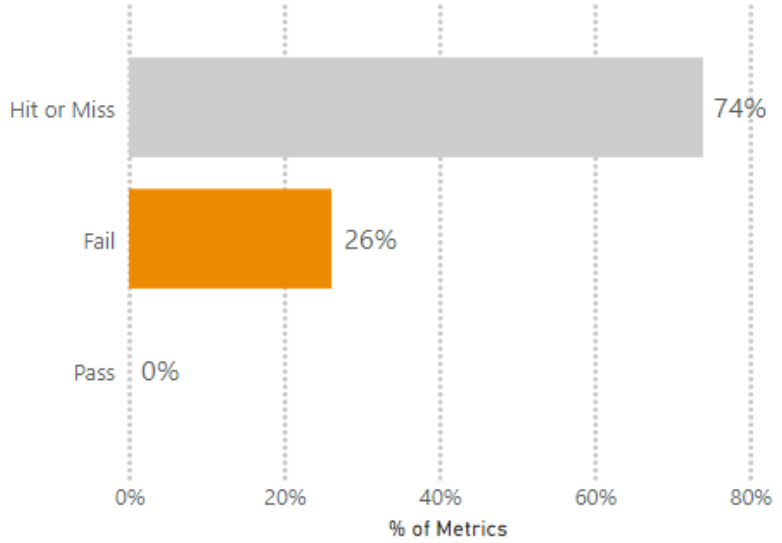
QUALITY OF CARE

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	Jun-2024	50%	45.1%	34.46%	52.28%	70.11%		
**Cardiac ROSC ALL %	Quality Improvement	Jun-2024	30.6%	23.8%	18%	28.66%	39.31%		
**Sepsis Care Bundle %	Quality Improvement	Jun-2024	100%	85%	81.67%	87.9%	94.13%		
**Cardiac Survival Utstein %	Quality Improvement	May-2024	33.3%	25.6%	7.38%	30.86%	54.33%		
**Cardiac Survival ALL %	Quality Improvement	May-2024	11.7%	9.6%	3.63%	11.51%	19.39%		
**Cardiac Arrest - Post ROSC %	Quality Improvement	Jun-2024	81.5%	76.8%	63.57%	72.19%	80.81%		
**Acute STEMI Care Bundle Outcome %	Quality Improvement	May-2024	67.6%	64.7%	57.9%	68.67%	79.44%		
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Quality Improvement	Dec-2023	02:41:00	02:22:00		02:32:10			
Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	Quality Improvement	Dec-2023	04:07:00	03:14:00		03:29:35			
Stroke - Call to Hospital Arrival Mean	Quality Improvement	Dec-2023	01:28:00	01:29:00		01:29:45			
Stroke - Call to Hospital Arrival 90th Centile	Quality Improvement	Dec-2023	02:08:00	02:20:00		02:17:30			
**Stroke - Assessed F2F Diagnostic Bundle %	Quality Improvement	Feb-2024	98.6%	96.3%		97.85%			
**Sensitivity of Cardiac Arrest Detection During Telephone Triage %	Quality Improvement	Jun-2024	92.3%	93.8%	87.81%	92.46%	97.1%		
**Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	Quality Improvement	Jun-2024	79.5%	77.9%	71.02%	78.58%	86.13%		
Required NHS Pathways Audits Completed (EMA) %	Quality Improvement	Aug-2024	100.6%		78.94%	101.52%	124.1%		
Compliant NHS Pathways Audits (EMA) %	Quality Improvement	Aug-2024	82%	100%	76.69%	82.98%	89.26%		
Compliant NHS Pathways Audits (Clinical) %	Quality Improvement	Aug-2024	86.2%	100%	71.29%	85.34%	99.38%		
Required NHS Pathways Audits Completed (Clinical) %	Quality Improvement	Aug-2024	100%	100%	93.9%	100.23%	106.56%		
Time Spent in SMP 3 or Higher %	Quality Improvement	Aug-2024	68.7%		15.95%	48.5%	81.05%		

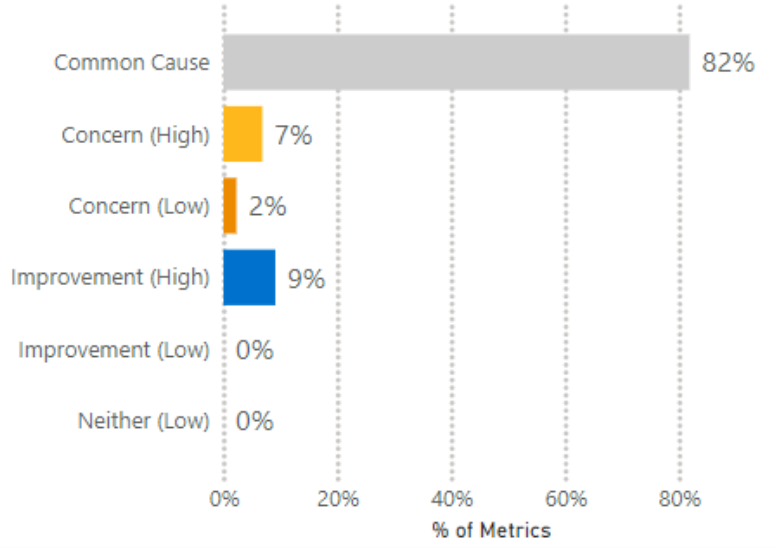
Infection Prevention Control

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hand Hygiene Compliance %	Quality Improvement	Aug-2024	77%	90%	73.02%	85.22%	97.41%		
Deep Clean Compliance %	Quality Improvement	Aug-2024	88.4%	100%	68.33%	86.43%	104.53%		

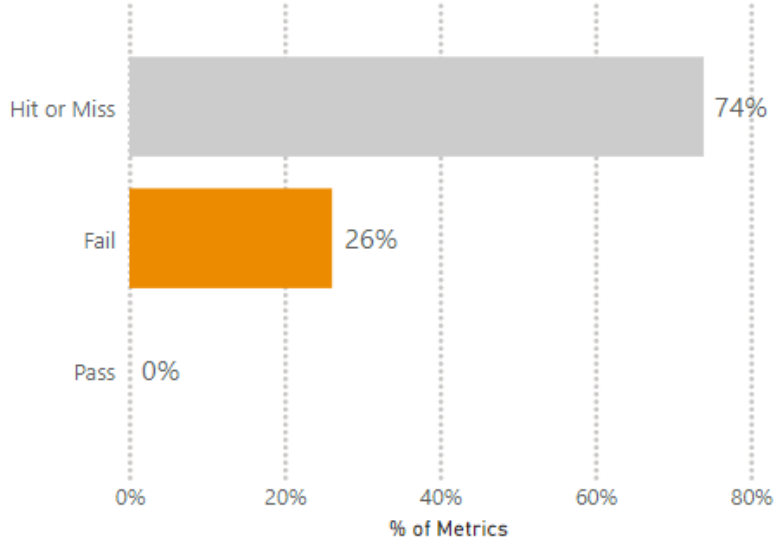
QUALITY OF CARE

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



Health & Safety

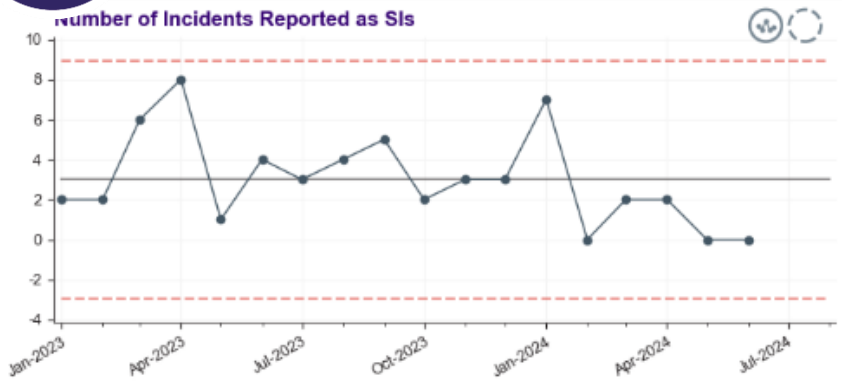
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Manual Handling Incidents	Quality Improvement	Aug-2024	22		10.46	26	41.54		
Organisational Risks Outstanding Review %	Quality Improvement	Aug-2024	94%	30%	2.44%	36.86%	71.28%		

Medicine Management

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Single Witness Signature Use CDs Omnicell	Quality Improvement	Jun-2024	39	0	4.16	37.41	70.66		
Single Witness Signature Use CDs Non-Omnicell	Quality Improvement	Jun-2024	21	0	5.39	26	46.62		
Medicines Management % of Audits Completed	Quality Improvement	Aug-2024	91.3%	100%	86.8%	93.88%	100.96%		
PGD Compliance %	Quality Improvement	Aug-2024	91.6%	100%	72.68%	81.58%	90.47%		
Resilience Stock Holding of Medicines in the Trust	Quality Improvement	Aug-2024	190%	100%	31.11%	103.35%	175.59%		

QUALITY OF CARE

SIs, Incidents, & Duty of Candour



QS-2

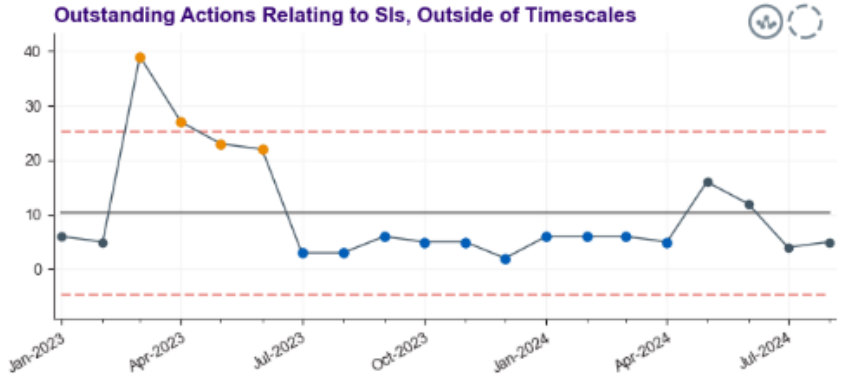
Dept: Quality & Safety
IP: Quality Improvement
Latest:

Common cause variation, no significant change.

QS-1

Dept: Quality & Safety
IP: Quality Improvement
Latest: 1228

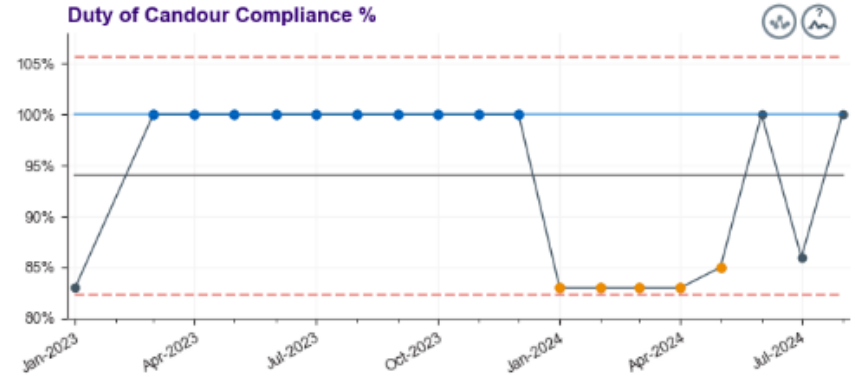
Common cause variation, no significant change.



QS-17

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

Common cause variation, no significant change.



QS-3

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

Summary

(QS-1) Number of Datix incidents - The number of incidents reported is showing normal variation. The targeted approach to the management of breached incidents is ongoing and good progress is being made.
(QS-17) Outstanding actions relating to SIs–.The last of SI actions have now been added to Datix. These are being reviewed, and individual support offered to get the last actions closed off. We aim to have all actions completed and closed for SIs by the end of 2024 in line with our transition plan to PSIRF.
(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 – In July, a case was investigated, and findings were presented to support DoC not being relevant. The decision to overturn the initial decision was supported but out of time, thus the deadline breached. However, August was back to 100% compliance. The Incident Review Groups (IRGs) monitor the completion of DoC and adherence to required timescales.

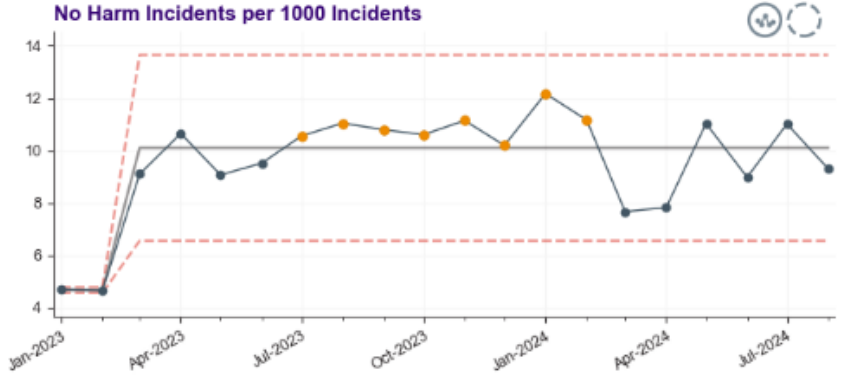
What actions are we taking?

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

- The BI team have the new approved metrics for PSIRF and IQR dashboards now need to be updated.
- The last SI report has now been signed off by the ICB for closure and SECAmb is the first Trust within the Surrey Heartlands ICS to have closed all SIs. .
- DOC training has started to be rolled out across the Trust to all OU's and EOC. This should support sustained improved compliance.

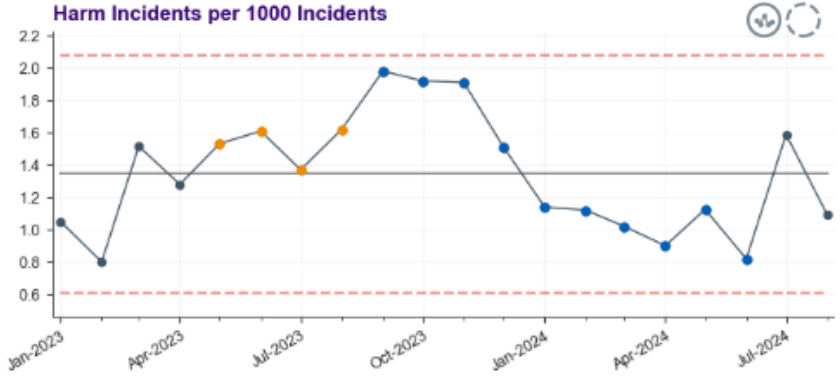
QUALITY OF CARE

Harm



QS-28
Dept: Quality & Safety
IP: Quality Improvement
Latest: 9.32

Common cause variation, no significant change.



QS-29
Dept: Quality & Safety
IP: Quality Improvement
Latest: 1.09

Common cause variation, no significant change.

Summary

QS-28 No Harm incidents per 1000 incidents – This data is showing normal variation with no significant change. As incidents progress through the PSIRF process, the grade of harm will be completed on the incident record upon closure. The complete management process delay has now caught up, meaning the breach rate is now under target of 10% and the final grade of harm is reflective of the current state.

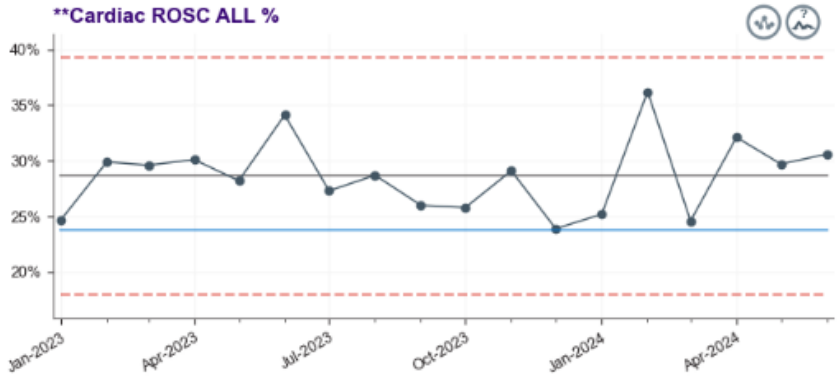
QS-29 Harm incidents per 1000 incidents – Harm incidents are showing normal variation and no significant change. However, overall, the number of harm incidents is a reduction on the number seen at the same time last year. The team will be closely monitoring this moving forward and are developing ways to support learning from incidents and embedding this across the organisation.

What actions are we taking?

- PSIRF is now embedded across the Trust, and the function of the Incident Review Groups is effective and responsive to iteration as our PSIRF maturity grows.
- Engagement and attendance of the IRGs continues to improve. Feedback is gleaned from all those involved and continues to suggest the meetings are both effective and positive.
- The development of our organisational learning framework continues, along with the commencement of an organisational learning forum which has recently launched. The Group's terms of reference have been drafted. With the support of Comms, a new learning magazine is in development.
- Discussions are being held between Operations and Patient Safety to find a way to ensure that incident learning outcomes are completed in a timelier manner to allow for quicker learning, family updates, and to provide a contemporaneous depiction of harm.

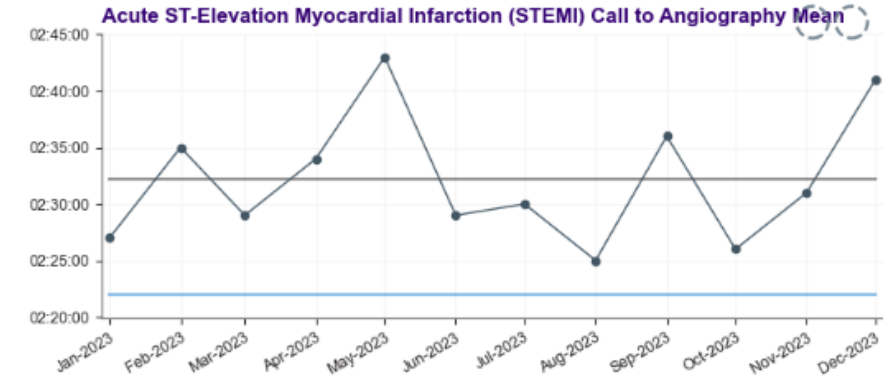
QUALITY OF CARE

Impact on Patient Care - Cardiac



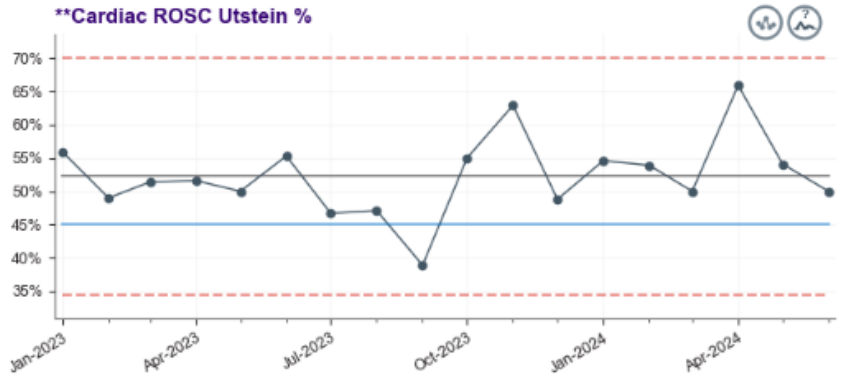
M-2

Dept: Medical
IP: Quality Improvement
Latest: 30.6%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



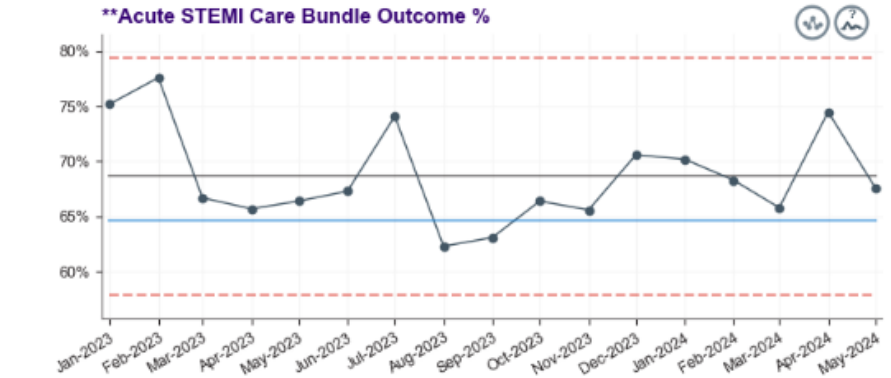
M-6

Dept: Medical
IP: Quality Improvement
Latest: 02:41:00
Target: 02:22:00
Special cause or common cause cannot be given as there are an insufficient number of points.



M-1

Dept: Medical
IP: Quality Improvement
Latest: 50%
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: 67.6%
Target: 64.7%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Cardiac Arrest Survival: – The survival rates for cardiac arrest patients show a positive trend, remaining consistently above the national average. This reflects the impact of our focused initiatives on improving cardiac arrest outcomes. The annual report published in Q4 will provide a comprehensive overview of our performance and offer valuable benchmarking data against other services, allowing us to continually refine our strategies for even better results.

STEMI Call to Angiography – Our data indicates that the time from STEMI call to angiography is influenced by a variety of factors, including scene arrival delays and crew actions on scene. Despite these challenges, our performance remains within expected variations. Understanding and addressing these factors is critical to enhancing the timely delivery of care to STEMI patients.

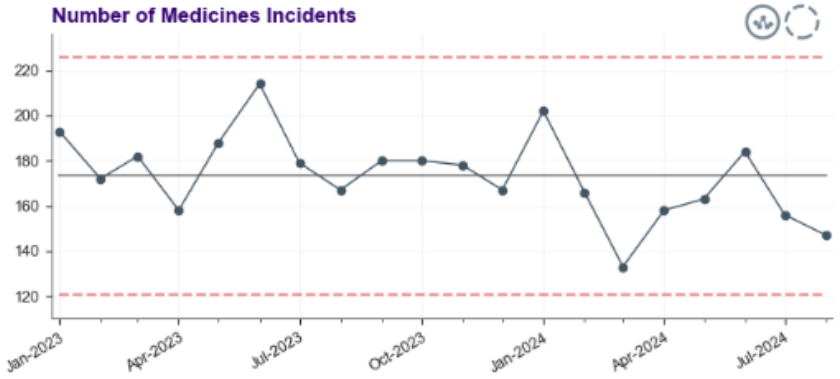
What actions are we taking?

STEMI call to Angiography and Care Bundle outcomes

To address the delays in STEMI call to angiography times, we are exploring the establishment of an additional primary PCI centre in Kent to reduce travel times. We are also enhancing training programs to minimise on-scene time and developing dashboards for local units to monitor performance closely. Our Quality Improvement project aims to improve communication and efficiency during pPCI cases. Additionally, the national review of the STEMI care bundle will ensure that our practices align with the latest standards and best practices, ultimately improving patient outcomes.

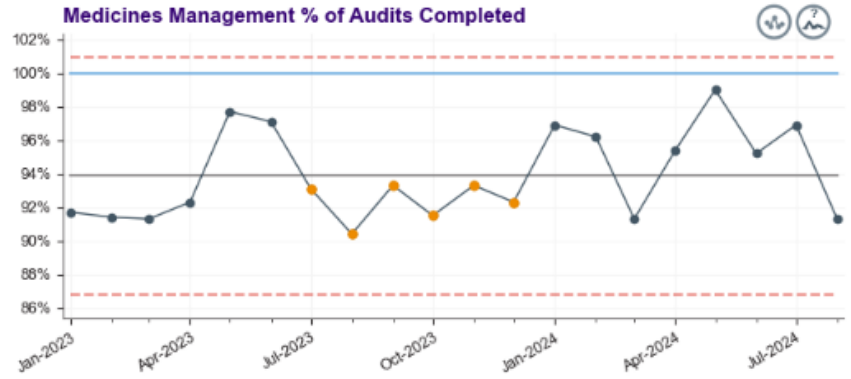
QUALITY OF CARE

Medicines Management (1 of 2)

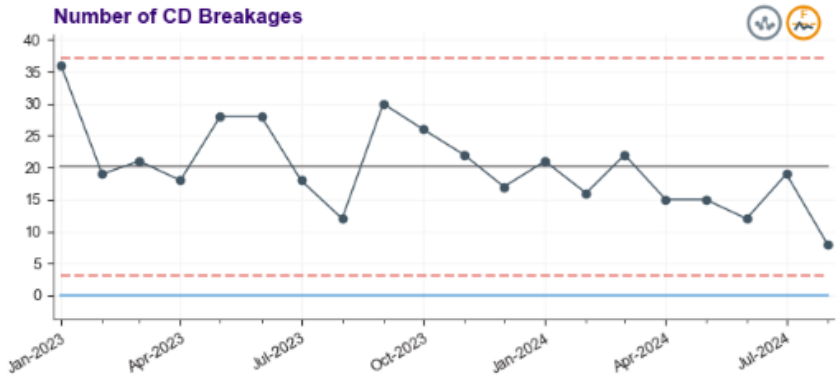


MM-1
Dept: Medicines Management
IP: Quality Improvement
Latest: 147

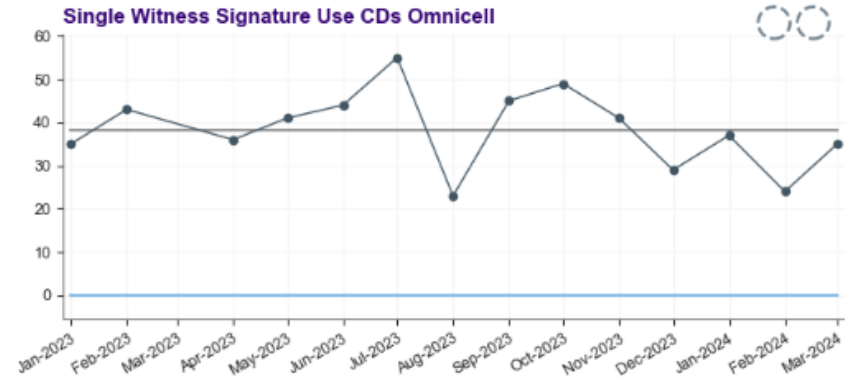
Common cause variation, no significant change.



MM-7
Dept: Medicines Management
IP: Quality Improvement
Latest: 91.3%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



MM-5
Dept: Medicines Management
IP: Quality Improvement
Latest: 8
Target: 0
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



MM-3
Dept: Medicines Management
IP: Quality Improvement
Latest: 35
Target: 0
Special cause or common cause cannot be given as there are an insufficient number of points.

Summary

MM-1: The process by which medicines incidences are reviewed by Medicines Governance has changed and is the likely reason for the reduction in medicines incident reports. This figure is now more reflective of DCIQ.
MM-3: The metric around Single Witness signature for CDs needs refining as it is not capturing the correct information. The number of *unauthorised* single witness CD transactions for April and May were both 0, and there were 2 incidents in June. This is an excellent result.
MM-5: The presence of human factors means that a target of 0 for CD breakages is unachievable and therefore this metric needs to be reviewed. There were 8 breakages amongst a dataset of 1752 issues of CDs from Omnicells This represents a breakage of 0.5% and is an excellent result.
MM-7: The medicines management audits dipped to <95% during August. This dip is likely due to reduced staffing over the summer period and is consistent with the same trend seen in 2023.

What actions are we taking?

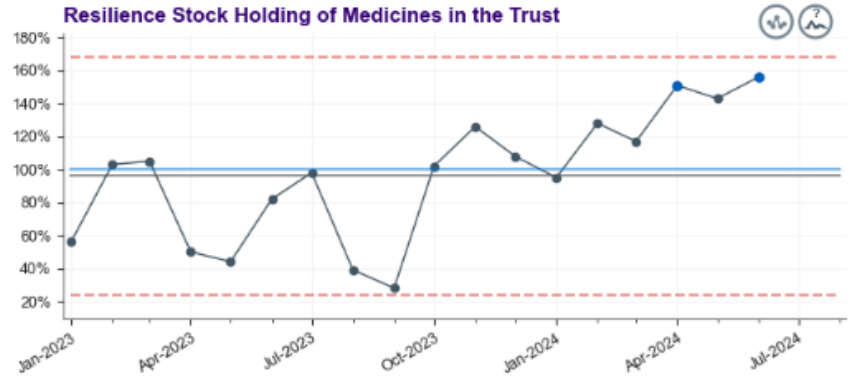
MM-1: Meeting planned to explore new report identifying common medicines involved in incidents; to facilitate organisational learning from these incidents.
MM-3: Reporting the metric associated with the number of *unauthorised* single returns is more meaningful. These can then be matched with Datix reports to establish the reasons and identify any learning to be shared.
MM-5: The level of breakages is very low and isn't cause for concern.
MM-7: We will raise this at the Medicines Leads meeting to ensure compliance returns to >95% for September and October.

QUALITY OF CARE

Medicines Management (2 of 2)

MM-8

Dept: Medicines Management
IP: Quality Improvement
Latest: 91.6%
Target: 100%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.



MM-9

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

Summary

MM-8: PGD compliance is trending upwards and is a reflection of everyone's hard work to get the PGDs reviewed and reauthorisation complete. Communicaton cascades are being used to ensure teams are aware of updates.

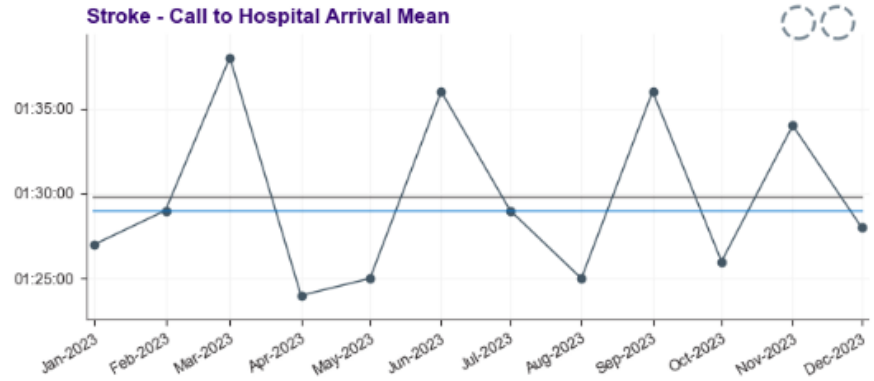
MM-9: Resilience stock at the MDC has been intentionally increased in preparation for the refurbishment and potential disruption to packing activity. Stock will run-down post-refurbishment to acceptable levels.

What actions are we taking?

MM-9: Once the refurbishment is complete, work will be undertaken to re-establish a sensible level of resilience stock to hold.

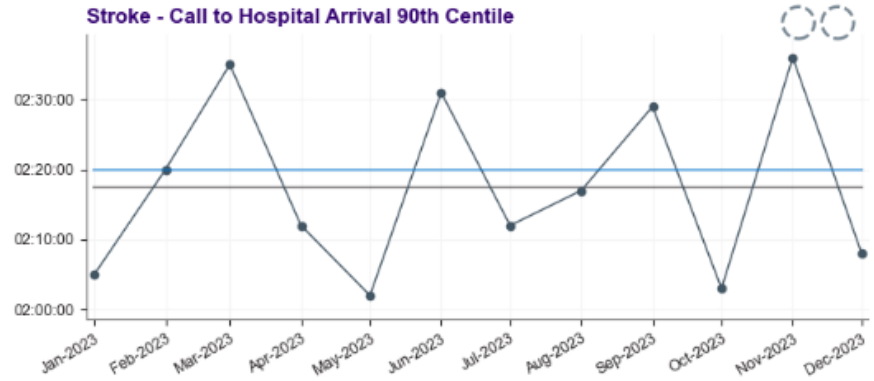
QUALITY OF CARE

Impact on Patient Care – Stroke



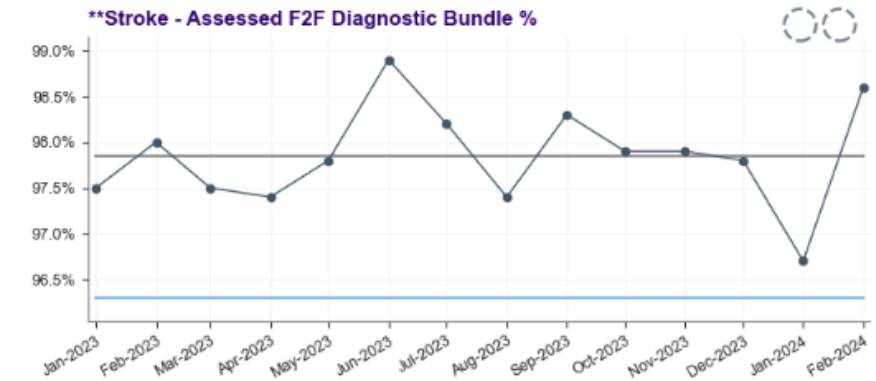
M-8

Dept: Medical
IP: Quality Improvement
Latest: 01:28:00
Target: 01:29:00
Special cause or common cause cannot be given as there are an insufficient number of points.



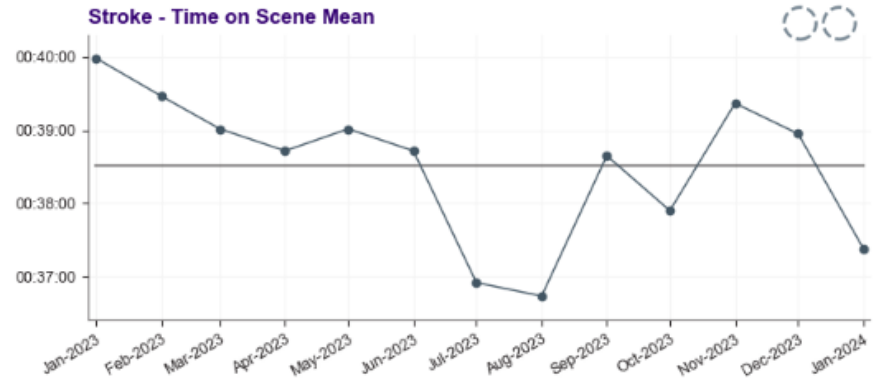
M-9

Dept: Medical
IP: Quality Improvement
Latest: 02:08:00
Target: 02:20:00
Special cause or common cause cannot be given as there are an insufficient number of points.



M-10

Dept: Medical
IP: Quality Improvement
Latest: 98.6%
Target: 96.3%
Special cause or common cause cannot be given as there are an insufficient number of points.



M-28

Dept: Medical
IP: Quality Improvement
Latest: 00:37:23

Special cause or common cause cannot be given as there are an insufficient number of points.

Summary

Stroke – Call to hospital Arrival mean. – continues to show common cause variation with SECAmb hovering around 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..

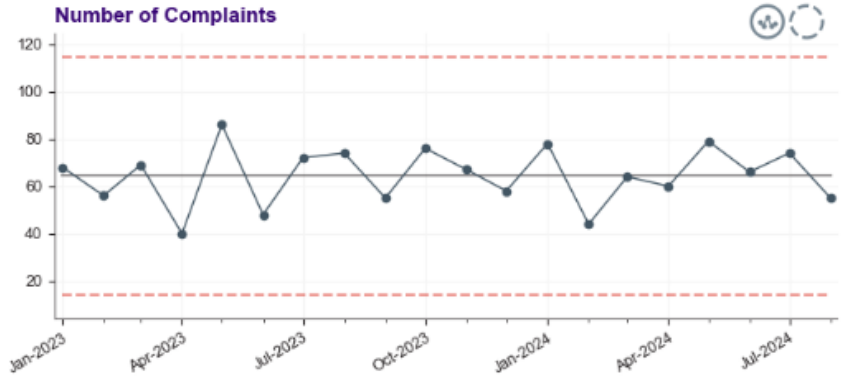
Stroke Time on scene mean. Common Cause variation but with an improving trend, though the nationally mandated move to Telemedicine in all areas will continue to challenge this.

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 OF CARE

Patient Experience



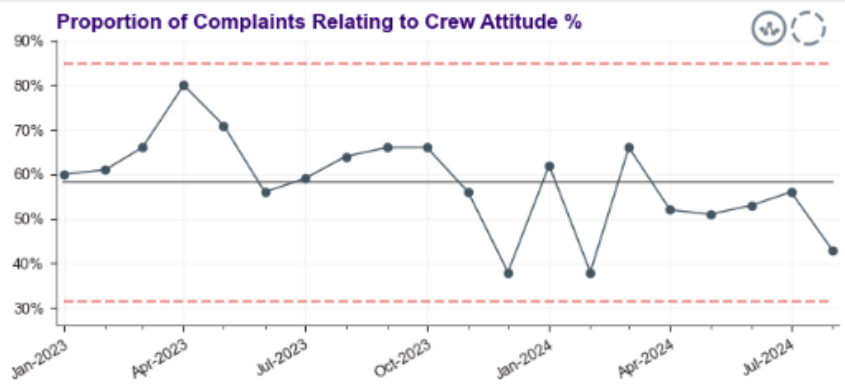
QS-5

Dept: Quality & Safety
IP: Quality Improvement
Latest: 55

Common cause variation, no significant change.

QS-4

Dept: Quality & Safety
IP: Quality Improvement
Latest: 96%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-10

Dept: Quality & Safety
IP: Quality Improvement
Latest: 43%

Common cause variation, no significant change.

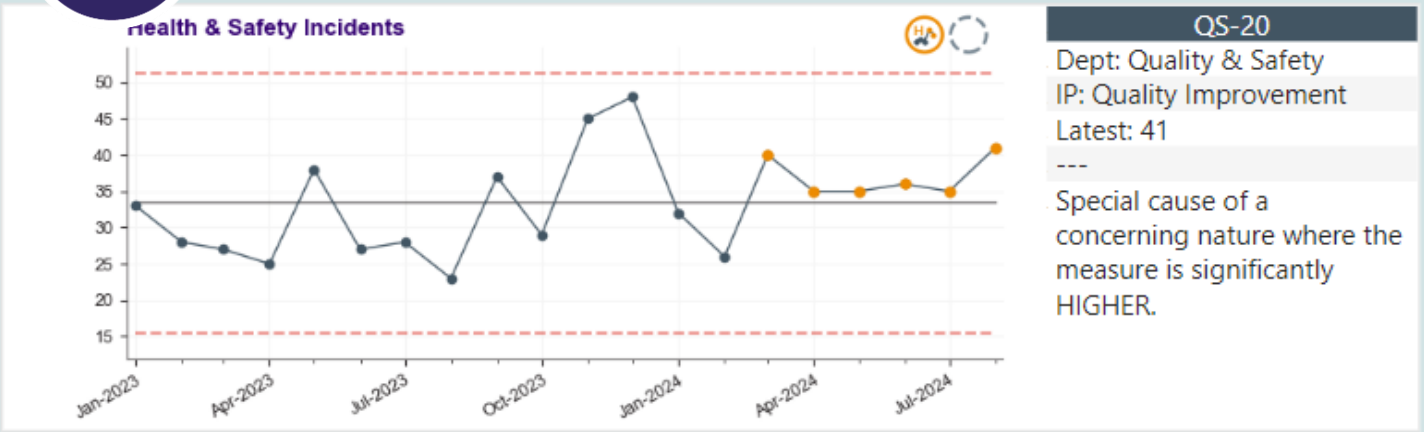
Summary

- With the support of operational, 111 and 999 colleagues the 95% timeliness target continues to be met.
- Concerns relating to crews' attitude is showing normal variation and it is hoped numbers will continue to reduce because of the learning identified in relation to this following the deep dive undertaken earlier this year.
- The number of complaints received is showing normal variation.

What actions are we taking?

- Complaint training for new OTL's has taken place in June and July with further dates in July, August and September. The PALS manager is also attending Teams C meetings to raise awareness of the high number of compliments operational staff receive compared to complaints. 5.66 compliments were received for every complaint over previous 6 months. The opportunity is also being you to raise the profile of learning from investigations.
- A deep dive into complaints relating to care, residential, nursing homes and hospices is nearing completion and will be finalised by the end of October 2024.
- Since raising the profile of identifying and recording learning in investigations we have identified learning from 50% of complaint investigations over the previous six months. Work is continuing in this area.

QUALITY OF CARE Safety in the Workplace (1 of 3)



Health & Safety Incidents

There were 35 Health & Safety incidents reported during July and 41 in August. During the same period last year 51 incidents were reported combined for both months. Some pest infestations (ants) led to a smaller increase in reporting during the summer months. Paramedics remained the highest reporters of incidents during July and August.

Highest reported categories

- Cuts and Abrasions
- Environmental issues
- Slips, trips and falls

What are we doing

- On-line Health and Safety Risk assessment training to be implemented in October 2024.
- Health & Safety internal reviews went live in June2024 with 10 reviews completed to date. The Programme will run until December 2024 and 21 sites in total will be reviewed.
- The team undertake regular visits to local Operating Units to support, review and complete annual audits to identify opportunities for improvement.
- The regional and Trust-wide Health & Safety groups will continue monitoring incident trends.

Manual Handling Incidents

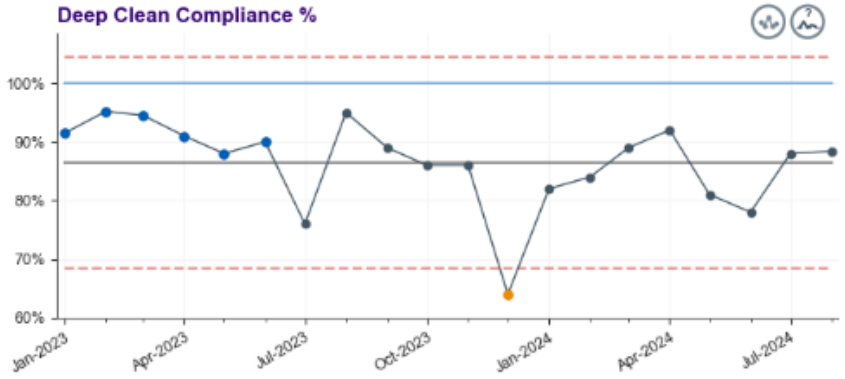
The data for manual handling incidents is showing normal variation with no significant change. There were 29 reported incidents during July and 22 in August. During the same period last year 57 incidents were reported.

What are we doing

- Task & Finish group to be created in Q3 2024 to identify ways to reduce Manual Handling injuries and RIDDOR incidents.
- Annual Health and Safety audits and reviews.
- The H&S team are working with Clinical Education and the EDTG to ensure inclusion of face-to-face manual handling training for all frontline staff in key skills from April 2025.

QUALITY OF CARE

Safety in the Workplace (2 of 3)



QS-19
Dept: Quality & Safety
IP: Quality Improvement
Latest: 88.4%
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: 77%
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. Current Deep Clean % for Q1 is an average of 82% Vs a Target of 100%. July Deep Clean figures were 88% & August Deep Cleans was 85% Vs a Target of 100%.

Other key indicators include the % of vehicles Made Ready which stands at 79% for Q1 24/25 up to and including June 2024, This is the figure of vehicles that have been Made Ready Vs Vehicle Shift Starts, however the current contract agreement with Churchill is that 95% of 90% vehicle shifts start is the target and therefore the % for Q1 24/25 April - June is 88%.

Update: Make Ready Throughput based on contracted 95% of 90% for July =84% and August = 89%.

The shortfalls are largely driven by the hours provided by the contractor against the contract, the average hours provided are 78% of what is agreed in contract.

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 deliver Make Ready), and workforce challenges. Current Churchill MRO Vacancy rate = 19.5% August 2024

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 20%. 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 82% compliance score of their internal audits Updated August 2024 - we are aiming to increase the joint Audit frequencies.

Churchill Recruitment: We have agreed that Churchill can advertise on our Vacancy bulletins to try and reach a further audience. This has see an improvement in applicants that are in the process of being shortlisted.

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 for 1 year 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.

Hand Hygiene Compliance

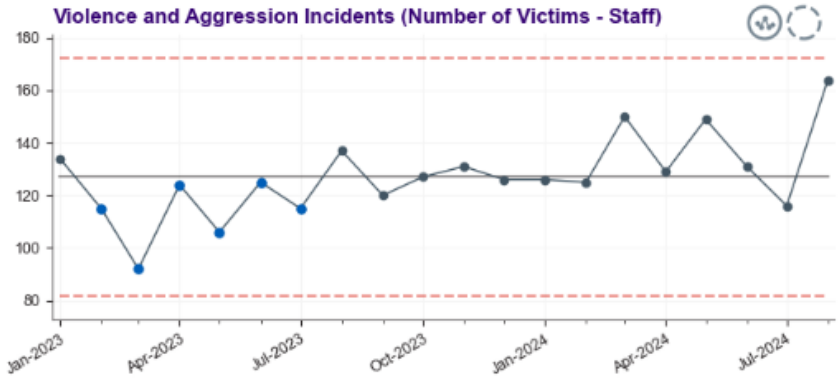
The data is showing normal variation although there has been a decline in compliance for August (77%). A deep dive of the data has been reviewed at the September IPC Subgroup and actions for improvement discussed.

What Actions are we taking?

- IPC Team to visit local areas to discuss the findings of the practice reviews with their leadership teams.
- Ongoing discussions to take place at the monthly System Governance Groups to share data and identify opportunities for improvement.
- Full review of the new practice review process to take place at the end of Q2 with a focus on hand hygiene compliance.

QUALITY OF CARE

Safety in the Workplace (3 of 3)



QS-13
Dept: Quality & Safety
IP: Quality Improvement
Latest: 164

Common cause variation, no significant change.

Violence & Abuse

There continues to be an increase in the number of violence and abuse incidents reported by staff. This should be considered a positive increase in reporting culture following the work of the team to raise the profile of violence and aggression and support staff who have been affected.

Staff reported 116 violence and aggression related incidents in July 2024. 22% of these incidents were categorised as assaults.

Staff reported 164 violence and aggression related incidents in August 2024. 18% of these incidents were categorised as assaults.

Most incidents continue to be verbal aggression directed at our staff working within our contact centres.

An increase in reported incidents in August correlates with the civil unrest being seen nationally. However, only one incident was identified as being a direct consequence of this. The team saw an increase in Body Worn Camera usage at this time indicating that staff may not have felt safe.

What actions are we taking?

- Face to Face Conflict Resolution Training (CRT) for front-line staff.
- 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.
- We are now able to identify the protected characteristics of staff reporting incidents of violence of aggressions. This will enable us to identify any groups or characteristics of staff that may mean they are disproportionately affected.

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.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

System Integration

SYSTEM INTEGRATION Summary

August 2024

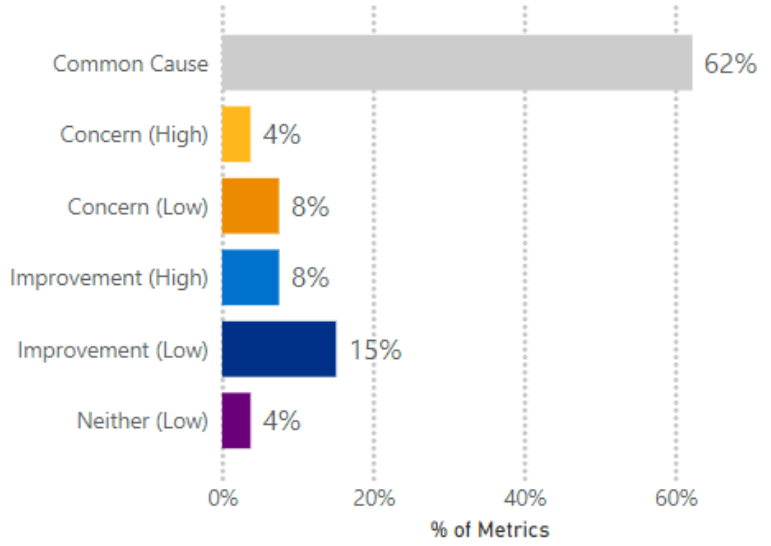
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	111 to 999 Referrals (Calls Triaged) %	999 Call Answer Mean 999 Call Answer 90th Centile	Hear & Treat % See & Convey % Average Wrap Up Time 111 Calls Answered in 60 Seconds % 111 Calls Abandoned - (Offered) %	JCT Allocation to Clear at Scene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

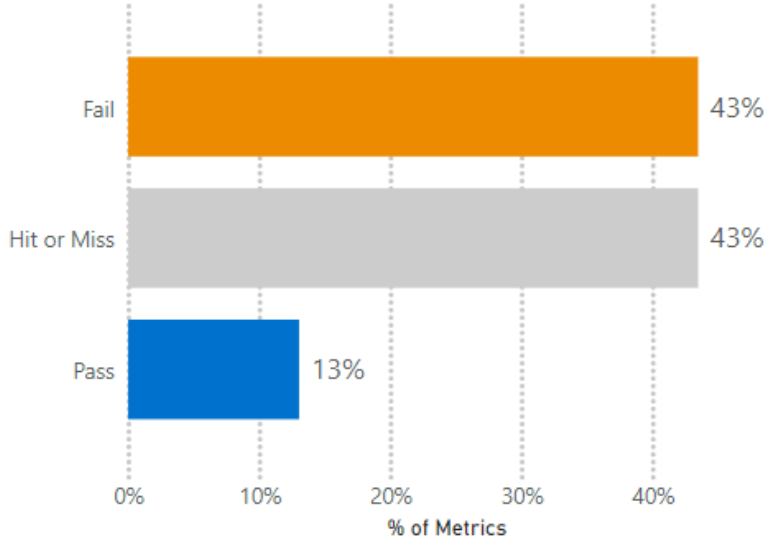
SYSTEM INTEGRATION

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	Aug-2024			01:22:01		02:11:56		
Section 136 Mean Response Time	Responsive Care	Aug-2024	00:25:17		00:14:00	00:24:45	00:35:31		
Cat 1 Mean	Responsive Care	Aug-2024	00:08:18	00:07:00	00:07:31	00:08:32	00:09:34		
Cat 1 90th Centile	Responsive Care	Aug-2024	00:15:30	00:15:00	00:13:55	00:15:37	00:17:20		
Cat 1T Mean	Responsive Care	Aug-2024	00:09:41	00:19:00	00:08:41	00:09:59	00:11:17		
Cat 1T 90th Centile	Responsive Care	Aug-2024	00:17:55	00:30:00	00:15:59	00:18:26	00:20:53		
Cat 2 Mean	Responsive Care	Aug-2024	00:26:37	00:30:00	00:19:11	00:28:04	00:36:58		
Cat 2 90th Centile	Responsive Care	Aug-2024	00:55:16	00:40:00	00:37:45	00:57:16	01:16:47		
Cat 3 90th Centile	Responsive Care	Aug-2024	04:50:06	02:00:00	02:28:03	04:51:33	07:15:03		
Cat 4 90th Centile	Responsive Care	Aug-2024	05:07:12	03:00:00	02:28:11	06:12:12	09:56:14		
HCP 3 Mean	Responsive Care	Aug-2024	01:51:04		01:03:00	02:04:11	03:05:22		
HCP 3 90th Centile	Responsive Care	Aug-2024	04:30:23		01:56:24	04:37:56	07:19:29		
HCP 4 Mean	Responsive Care	Aug-2024	02:18:30		01:13:58	02:39:20	04:04:42		
HCP 4 90th Centile	Responsive Care	Aug-2024	05:54:08		02:41:35	06:15:43	09:49:52		

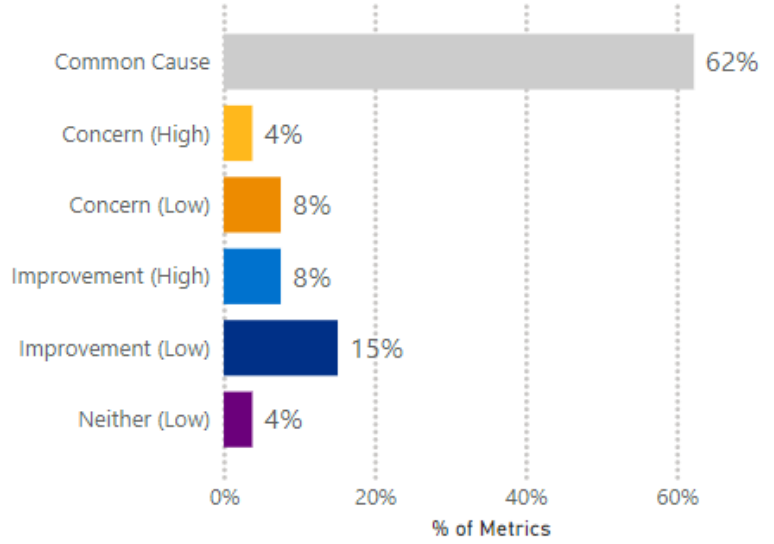
Emergency Operations Centres (EOC)

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Duplicate Calls %	Responsive Care	Aug-2024	23.5%		19.7%	23.1%	26.5%		
999 Calls Answered	Responsive Care	Aug-2024	71052		55682.99	70786.75	85890.51		
999 Call Answer Mean	Responsive Care	Aug-2024	00:00:07	00:00:05	00:00:05	00:00:18	00:00:41		
999 Call Answer 90th Centile	Responsive Care	Aug-2024	00:00:07	00:00:10	00:00:23	00:01:02	00:02:27		

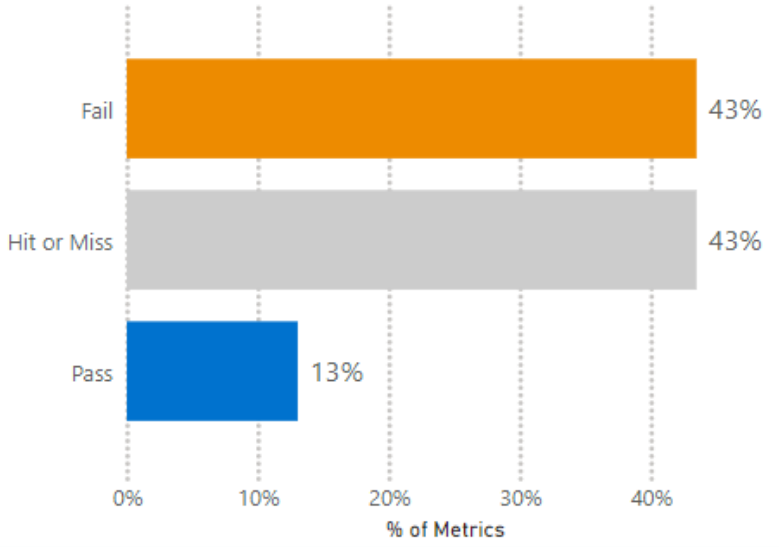
SYSTEM INTEGRATION

Overview (2 of 3)

Variation Icon Summary



Assurance Icon Summary



Utilisation

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Hours Provided %	Responsive Care	Aug-2024	86.9%	100%	86.73%	98.86%	110.98%		
Provided Bank Hours %	Responsive Care	Aug-2024	0%		0.36%	0.66%	0.96%		
Provided Overtime Hours %	Responsive Care	Aug-2024	3.6%		3.17%	6.59%	10.02%		
Provided PAP Hours %	Responsive Care	Aug-2024	0%		2.47%	3.61%	4.74%		
999 Operational Abstraction Rate %	Responsive Care	Aug-2024	25.4%	28%		26.52%			
999 Remaining Annual Leave FY	Responsive Care	Aug-2024	30.2%		12.89%	29.11%	45.34%		
Vehicles Off Road (VOR) %	Responsive Care	Aug-2024	14.6%	10%	10.42%	13.84%	17.26%		
% of DCA vehicles off road (VOR)	Responsive Care	Aug-2024	16.2%		11.58%	14.78%	17.97%		
% of SRV vehicles off road (VOR)	Responsive Care	Aug-2024	1.9%		-15.93%	7.28%	30.49%		
Critical Vehicle Failure Rate (CVFR)	Responsive Care	Aug-2024	80		51.87	110.95	170.03		
Number of RTCs per 10k miles travelled	Responsive Care	Aug-2024	0.51		0.3	0.74	1.18		
% of planned vehicle services completed	Responsive Care	Aug-2024	74%		58.81%	71.17%	83.53%		
% of statutory estates compliance (gas, water, electrical, asbestos, fire, LOLER)	Responsive Care	Aug-2024	95%	95%		93.55%			
Incidents Cat 2 Proportion (Cat 1-4)	Responsive Care	Aug-2024	63.9%		60.74%	63.69%	66.64%		
111 to 999 Referrals (Calls Triaged) %	Responsive Care	Aug-2024	6.2%	13%	5.68%	6.44%	7.2%		
Incidents	Responsive Care	Aug-2024	61597		55008.8	62443.5	69878.2		

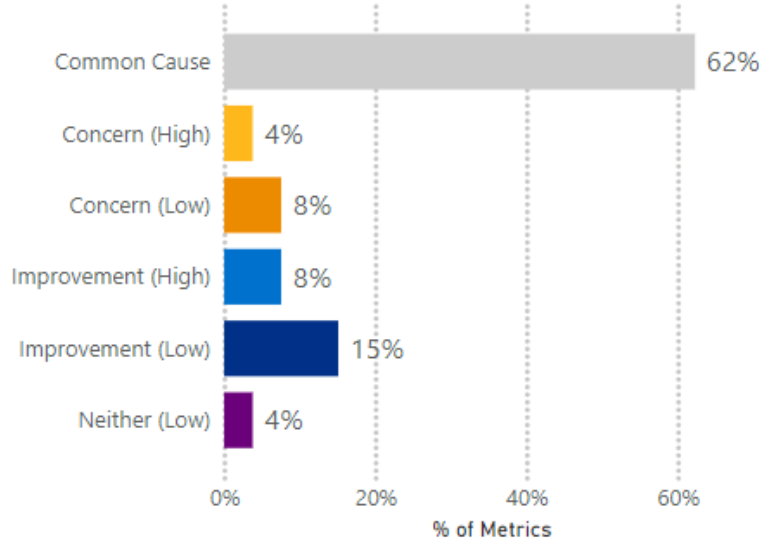
111

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
111 Calls Offered	Responsive Care	Aug-2024	78837		76476.45	95607.45	114738.45		
111 Calls Answered in 60 Seconds %	Responsive Care	Aug-2024	81.1%	95%	29.49%	46.42%	63.34%		
111 Calls Abandoned - (Offered) %	Responsive Care	Aug-2024	3.3%	5%	5.74%	12.8%	19.85%		
999 Referrals	Responsive Care	Aug-2024	4517		3875.74	4880.8	5885.86		

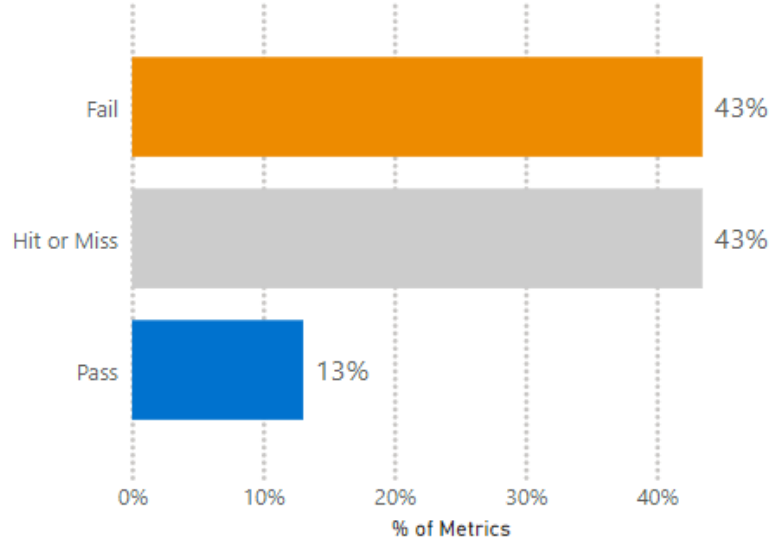
SYSTEM INTEGRATION

Overview (3 of 3)

Variation Icon Summary



Assurance Icon Summary



999 Frontline

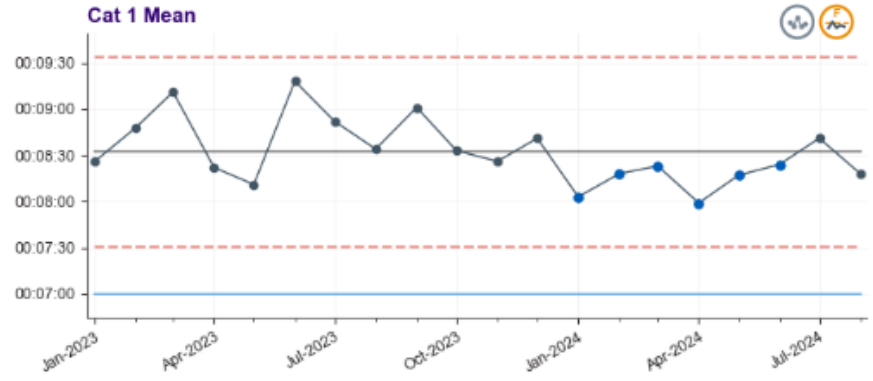
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
JCT Allocation to Clear at Scene Mean	Responsive Care	Aug-2024	01:14:50		01:15:12	01:17:04	01:18:55		
JCT Allocation to Clear at Hospital Mean	Responsive Care	Aug-2024	01:50:19		01:49:34	01:52:04	01:54:33		
Responses Per Incident	Responsive Care	Aug-2024	1.1	1.09	1.09	1.09	1.1		
CFR Attendances	Responsive Care	Aug-2024	1948		732.07	1218.85	1705.63		
FFR Attendances	Responsive Care	Aug-2024	43		35.79	118.25	200.71		
ECAL Mean Response Time	Responsive Care	Aug-2024	00:27:09		00:22:41	00:24:50	00:26:59		

111/999 System Impacts

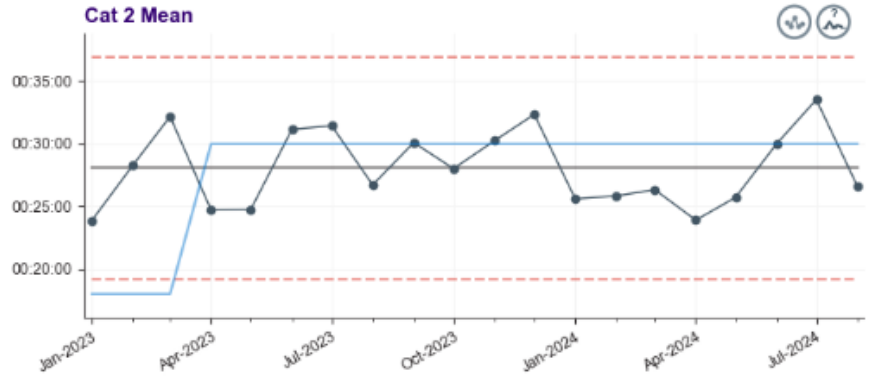
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Hear & Treat %	Responsive Care	Aug-2024	13.6%	14%	10.45%	12.2%	13.95%		
See & Treat %	Responsive Care	Aug-2024	30.9%	35%	29.81%	30.94%	32.07%		
See & Convey %	Responsive Care	Aug-2024	55.3%	55%	55.29%	56.72%	58.14%		
Hours Lost at Handover as a Proportion of Provided Hours %	Responsive Care	Aug-2024	1%		0.7%	0.97%	1.23%		
Number of Hours Lost at Hospital Handover	Responsive Care	Aug-2024	2676.85		2071.55	2962.7	3853.86		
Average Wrap Up Time	Responsive Care	Aug-2024	00:16:23	00:15:00	00:16:29	00:16:58	00:17:27		
Proportion of Wrap Up Times > 15 minutes	Responsive Care	Aug-2024	43.7%		42.37%	44.92%	47.47%		
A&E Dispositions %	Responsive Care	Aug-2024	7.7%	9%	6.85%	8.1%	9.35%		
A&E Dispositions	Responsive Care	Aug-2024	5603		4537.71	6149.95	7762.19		
Clinical Contact %	Responsive Care	Aug-2024	45.5%	50%	45.1%	48.65%	52.19%		
Ambulance Validation %	Responsive Care	Aug-2024	49.5%	85%	55.2%	66.77%	78.33%		

SYSTEM INTEGRATION

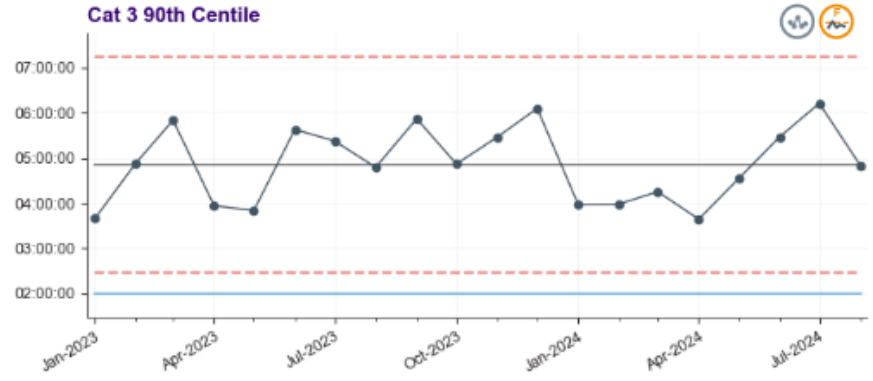
Response Times



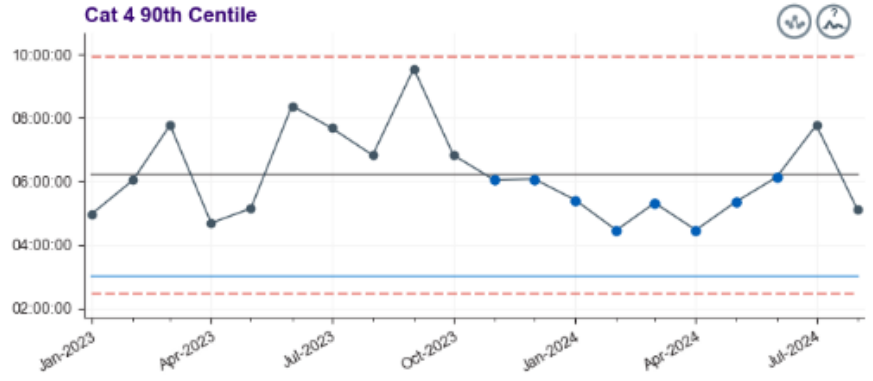
999-2
Dept: Operations 999
IP: Responsive Care
Latest: 00:08:18
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
IP: Responsive Care
Latest: 00:26:37
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: 04:50:06
Target: 02:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-6
Dept: Operations 999
IP: Responsive Care
Latest: 05:07:12
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

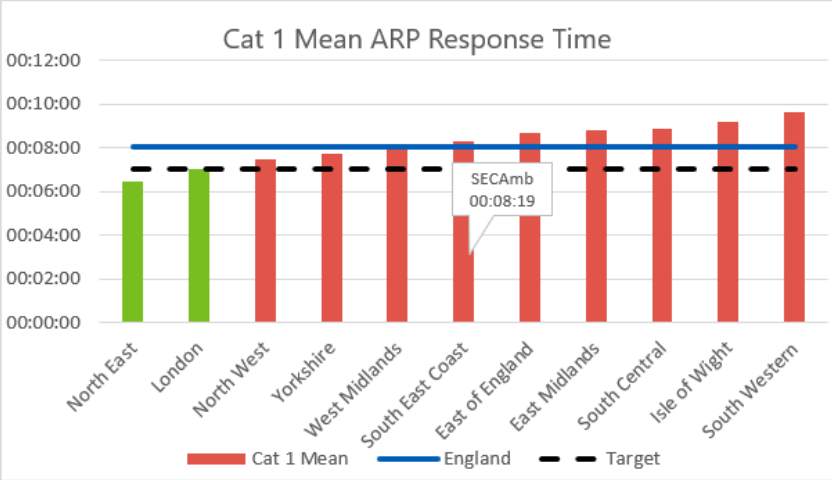
- As can be seen from the charts above, the Trust is failing to meet the ***national ARP standards*** for all categories of call and has been in this position reasonably consistently over the past 2 years.
- The key metric for the financial year, being C2 mean, remains in a positive position against the delivery plan – in August 2024, performance was 26min 38sec, against a national average of 27min 25sec.

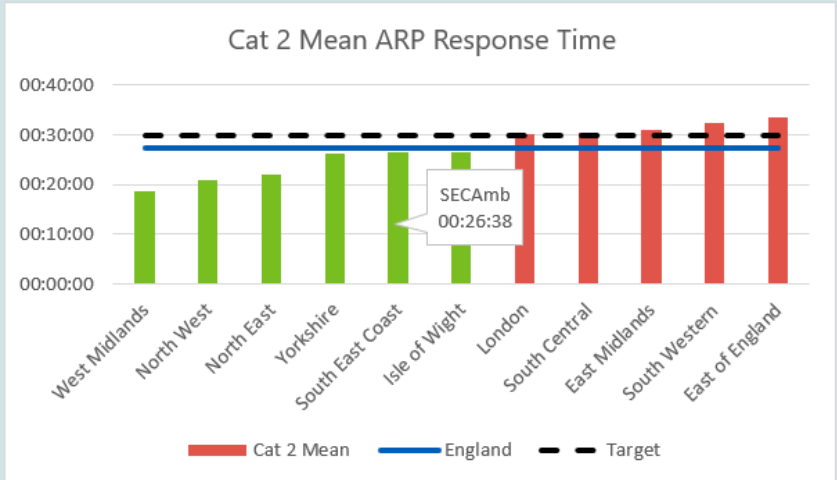
What actions are we taking?

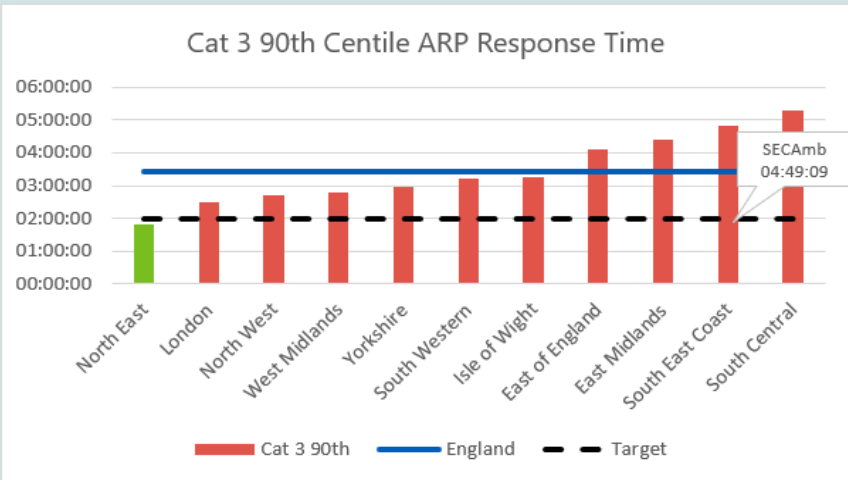
- Ongoing Expansion of NHS PaCCS across Field Ops to support clinical assessment and to explore appropriate alternative pathways for C3 & C4 patients.
- Continued focus on recruitment for clinical staffing in EOC to maintain patient safety and support ambulance dispatch, with the final cohort of overseas nurses now live.
- Focused attention on abstraction management for sickness management & training planning with updated policy to simplify.
- NQP new starters between now and January, 158 new frontline staff.
- Work is on track to establish 5 Unscheduled Care Navigation Hubs
- Specific work at Royal Sussex University Hospital ongoing between Brighton OU team, Sussex ICB & Hospital clinical leaders with external NHS E support.
- Update to divert process started.

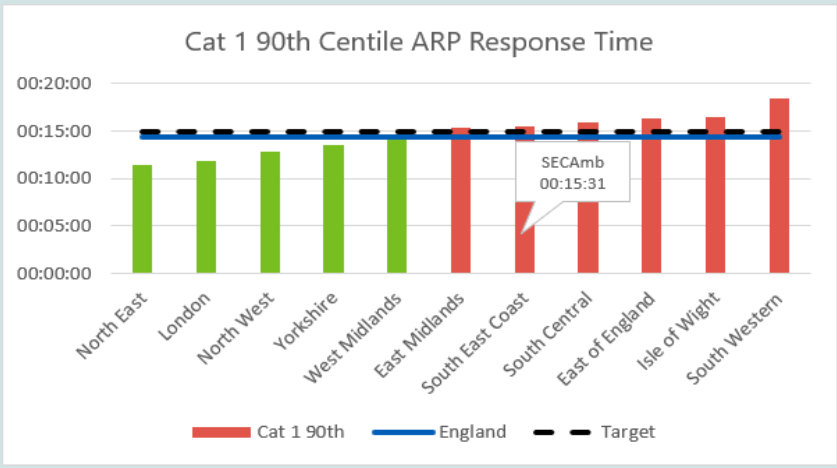
SYSTEM INTEGRATION

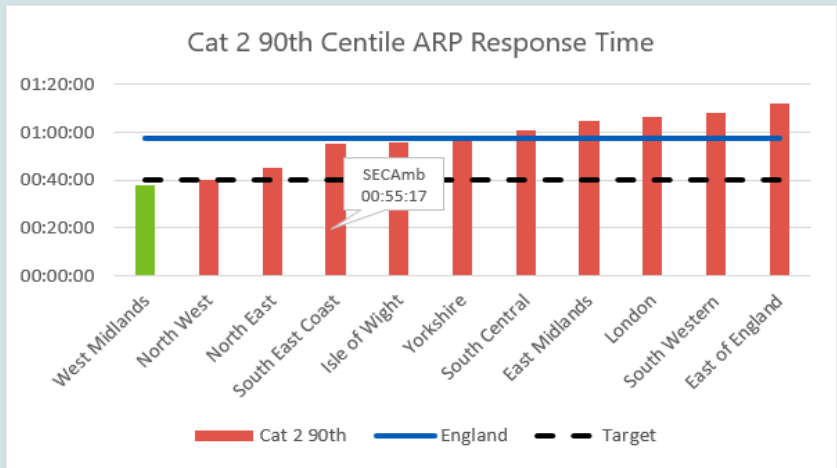
ARP Response Time Benchmarking (data provided for June 2024)

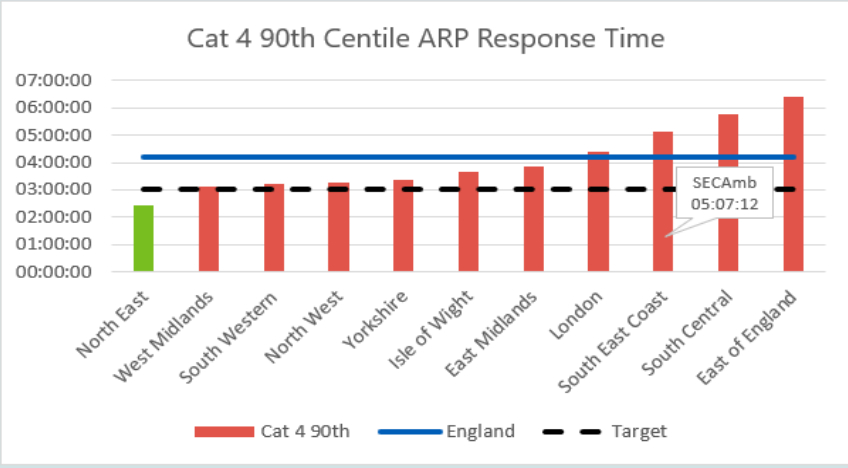








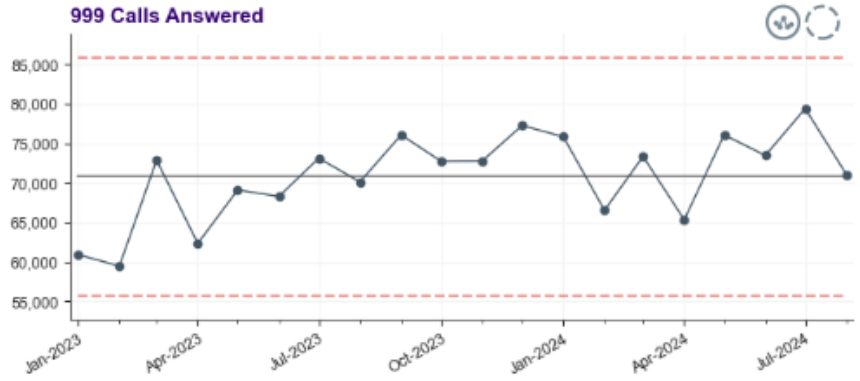




Summary

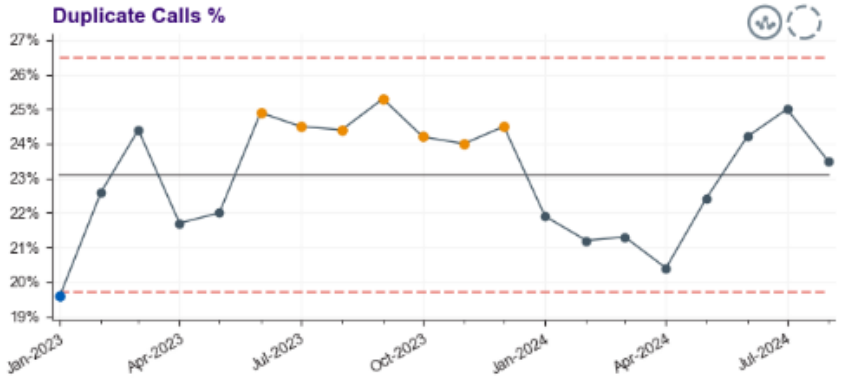
- C2 mean is only slight behind our expected position year to date with this quarter at 29:55.
- A focus on Hear and Treat mitigating the risk of delays in dispatch.

SYSTEM INTEGRATION EOC Emergency Medical Advisors



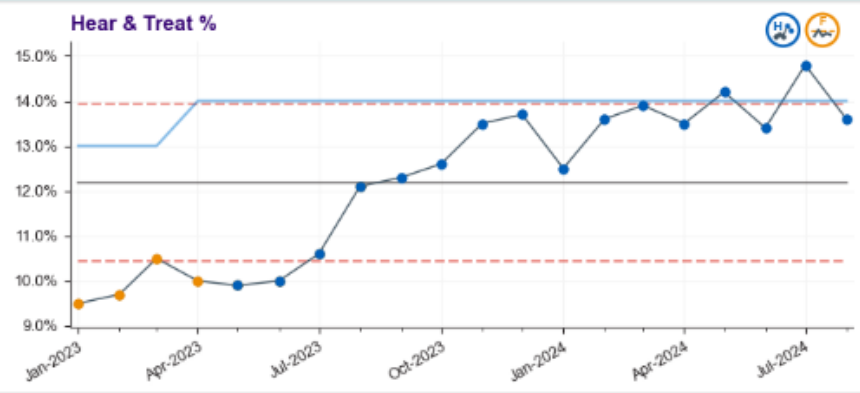
999-10
Dept: Operations 999
IP: Responsive Care
Latest: 71052

Common cause variation, no significant change.

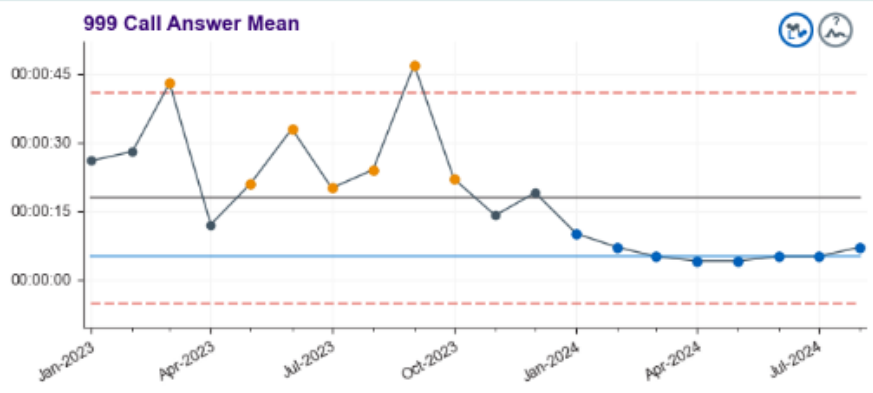


999-33
Dept: Operations 999
IP: Responsive Care
Latest: 23.5%

Common cause variation, no significant change.



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



999-1
Dept: Operations 999
IP: Responsive Care
Latest: 00:00:07
Target: 00:00:05
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Summary

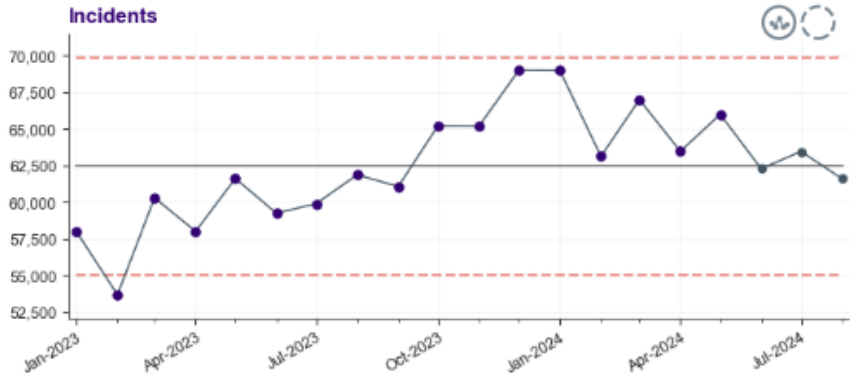
- In this financial year, call answer mean time has been in line with national AQI targets which is a significant improvement on 2023/24; However, August saw the 999 call answering mean marginally above the 5 seconds target. This was attributable to a variety of factors including day-to-day fluctuation in call demand and profiles, some incidences of high short-term sickness and the reduction in Call handling overtime. The service is now fully staffed for its Emergency Medical Advisors (EMAs) and to remain within budget, the service has had to restrict overtime.
- EMA recruitment and the staff retention remain service focusses, in addition to improving productivity and the quality of 999 call handling performance.
- The underlying trend for Hear & Treat is still upwards but the dip in performance is attributable to multiple factors including a significant numbers of new overseas clinicians still in training and requiring mentoring and support, and the Trust still not making progress in being able to deploy additional clinicians to undertake H&T beyond that which was in place at the end of 23/24. As a result, the service is not able to populate the rotas consistently at the 100% required to achieve the Trust Hear & Treat target.

What actions are we taking?

- EMA establishment is above plan for the funded establishment of 265WTEs. Despite the ongoing challenge presented by recruitment in the Gatwick area, recruitment in Medway following the move in 2023 progresses well. The current position being 274 WTEs of which 252 WTE are live and 22 WTE in training and/or mentoring.
- The 999 Call Answering project phase 2 has started, with a focus on the quality of call handlers and their productivity. The EOC operations rota review has gone smoothly, with positive collaboration between the service and our unions, and is now complete, The new rotas are due to go-live in October 2024.
- The C3 & C4 clinical validation model and C2 segmentation continues, with modifications to the C2 Segmentation operating model going to SMG for approval in September.
- The Hear and Treat trajectory is for 16% by the 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 23 WTEs expected to be fully operational by the end of October 2024. 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.

SYSTEM INTEGRATION

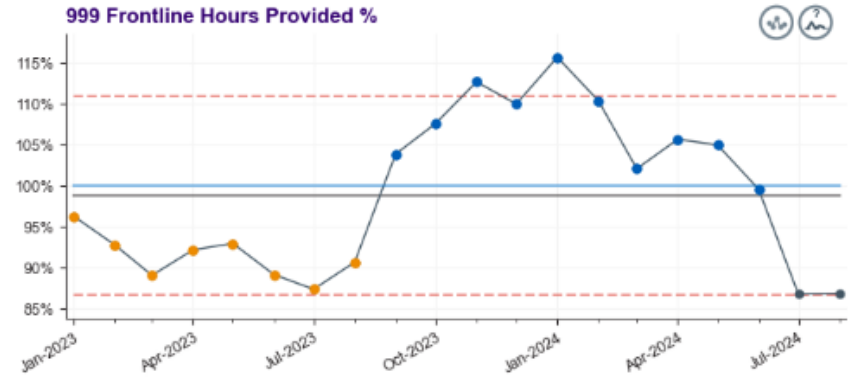
Utilisation



999-10

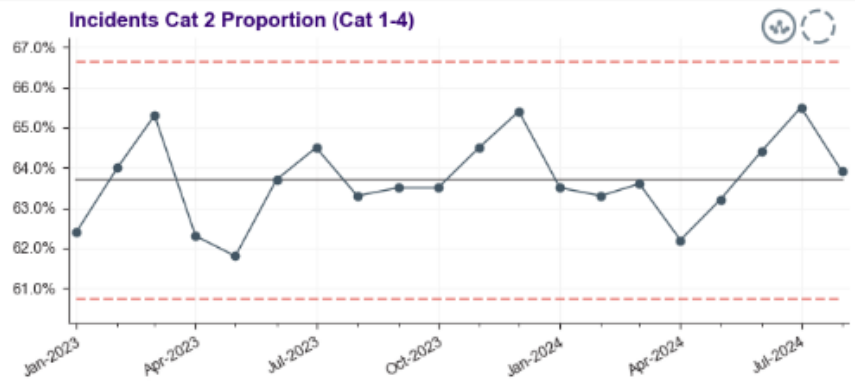
Dept: Operations 999
IP: Responsive Care
Latest: 61597

Common cause variation, no significant change.



999-12

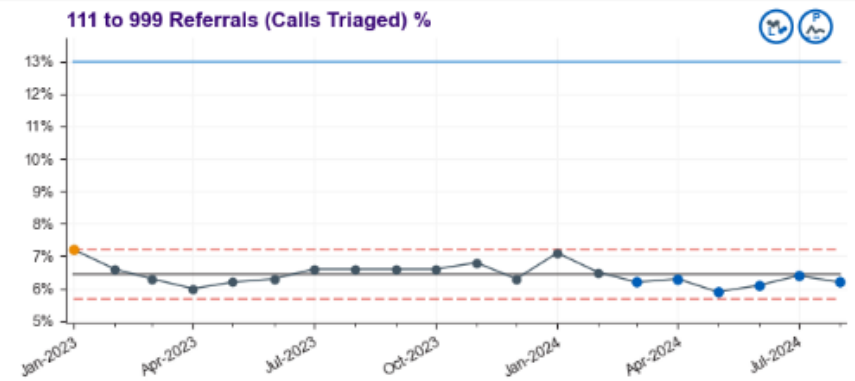
Dept: Operations 999
IP: Responsive Care
Latest: 86.9%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-32

Dept: Operations 999
IP: Responsive Care
Latest: 63.9%

Common cause variation, no significant change.



111-4

Dept: Operations 111
IP: Responsive Care
Latest: 6.2%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Summary

- A focus on the quality of NHS Pathways triage and clinical validation of ambulance referrals in 111 has resulted in a national best in class, low ambulance referral rate from 111 to 999 in Kent and Sussex.
- The Trust also continues to deliver exceptional Direct Appointment Booking (DAB) in its 111 service, supported by consistently good ED validation as per the NHS E 111 First criteria. This has enabled 111 to protect the wider healthcare economy and facilitate patient flow to the appropriate downstream services.
- 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.
- End of PAP provision affected Paddock Wood the most. Use of overtime has mitigated this until the OU is at full staffing levels.

What actions are we taking?

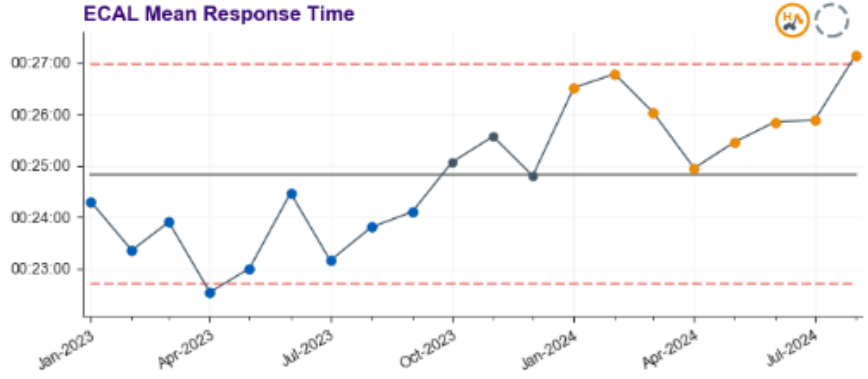
- Greater flexibility between the Trust's 111 and 999 services to flex clinicians to maintain C3/C4 validation at a high level, prior to ambulance dispatch. This also applies to specialist clinicians like Mental Health Practitioners and Paediatric Nurses.
- Continued focus on optimising resources through abstraction management and targeted overtime to provide additional hours – continued management of sickness and reduction in annual leave levels has improved resourcing.
- Ongoing focus on optimising clinical validation in EOC in real-time, coordinated by Clinical Safety Navigators and overseen by the Trust's Operations Managers Clinical (OMC) to mitigate risk and improve clinical effectiveness across 999.
- Urgent Community Response (UCR) Portal is fully live for Sussex and Surrey. The service is still having to undertake MS Teams calls daily for UCR providers across Kent. Looking ahead, the focus is on extending the roll-out of the UCR Portal across Kent and implementing a fully digital solution.
- Work is ongoing after the launch of Tiresias 2 to ensure that all hours are correctly calculated.

SYSTEM INTEGRATION

999 Frontline

999-17

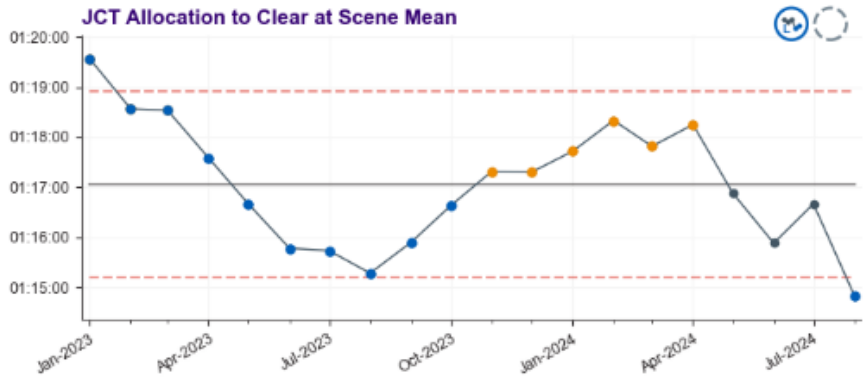
Dept: Operations 999
IP: Responsive Care
Latest: 1.1
Target: 1.09
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-13

Dept: Operations 999
IP: Responsive Care
Latest: 00:27:09

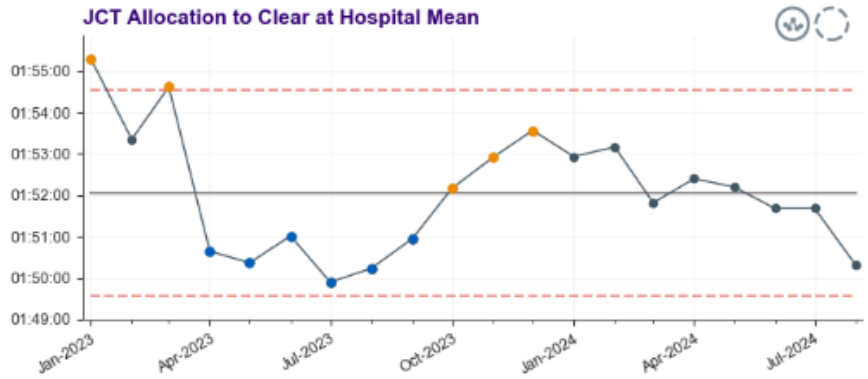
Special cause of a concerning nature where the measure is significantly HIGHER.



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:14:50

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



999-11

Dept: Operations 999
IP: Responsive Care
Latest: 01:50:19

Common cause variation, no significant change.

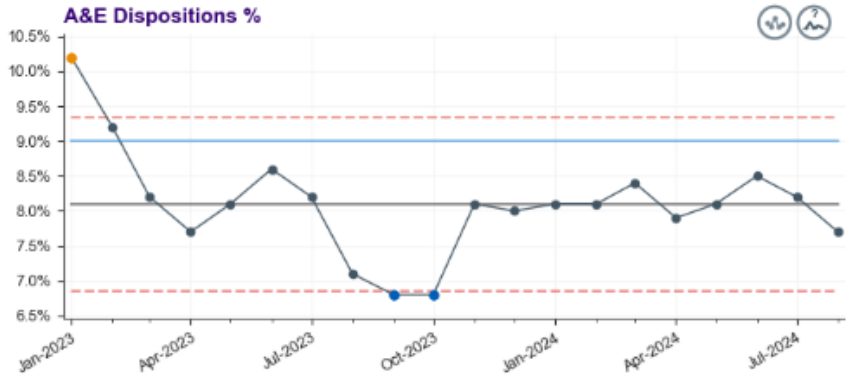
Summary

- 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 or on 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?

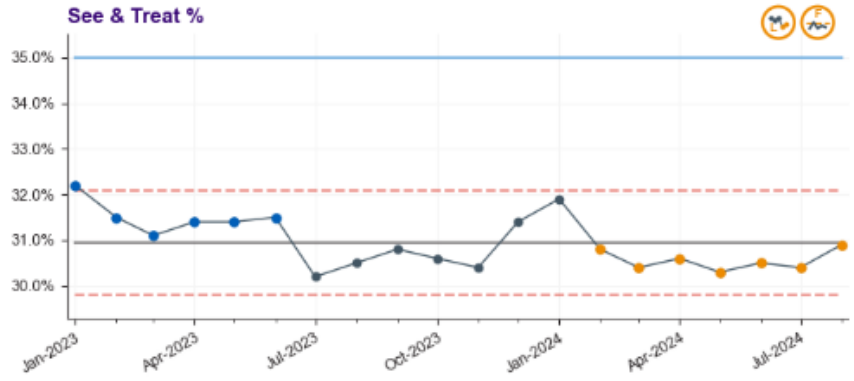
- The Trust commissioned an external AACE review of the Dispatch function, and the recommendations are currently being addressed as part of the Responsive Care Group plan. Phase 1 of this plan was completed at the end of October 2023 – phase 2 has commenced in Q1 of 2024-25 and is ongoing.
- Continued focus on delivery of *Advanced Paramedic Practitioner Hubs* to ensure optimal response to ECALs from crews to assist with on-scene decision making and signposting to clinical pathways. The Unscheduled Care Navigation Hubs project is on track to be delivered in October.
- Specific work has been undertaken in local dispatch desk areas focusing on hospital handover and on-scene times. Hospital Handovers have shown an improvement and are under the 18-minute mean set by the Trust at 17minutes and 17 Secs for August. As system pressures increase, as do hospital handover time across multiple acute trust sites – this is expected over the winter period.

SYSTEM INTEGRATION 111/999 System Impacts



111-5

Dept: Operations 111
IP: Responsive Care
Latest: 7.7%
Target: 9%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



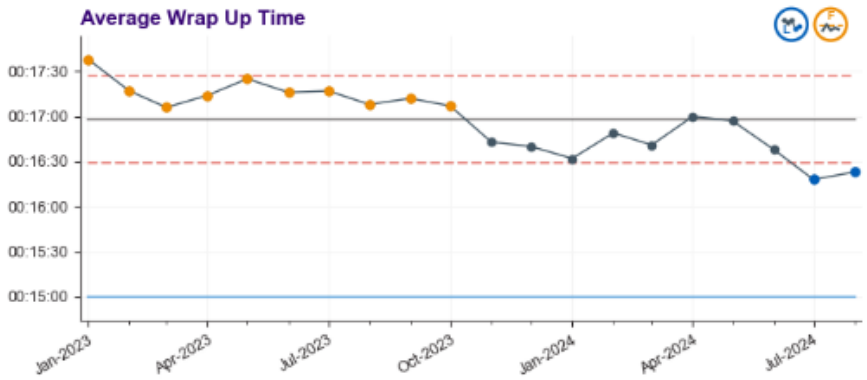
999-9

Dept: Operations 999
IP: Responsive Care
Latest: 30.9%
Target: 35%
Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.

999-24

Dept: Operations 999
IP: Responsive Care
Latest: 2676.85

Common cause variation, no significant change.



999-31

Dept: Operations 999
IP: Responsive Care
Latest: 00:16:23
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.

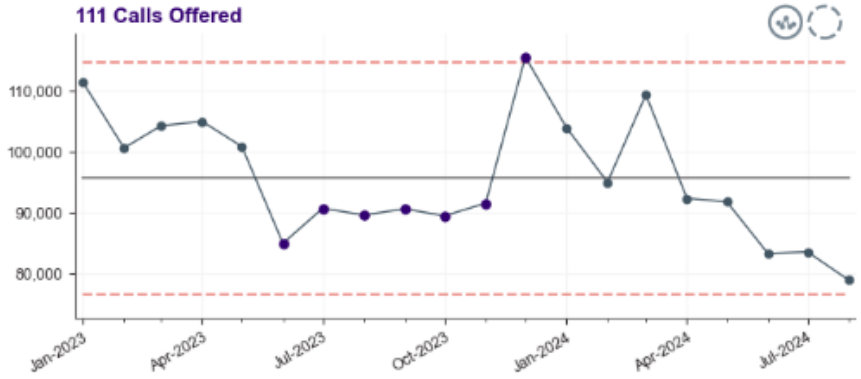
Summary

- The 111 to ED disposition rate has been maintained at a very low level since the introduction of "111 First", Direct Appointment Booking (DAB) and ED validation. The Trust's 111 service is consistently effective at DAB and ED validation, resulting in an ED referral rate significantly better than the NHS E 111 national average and benchmark leading DAB.
- The Trust See and Treat rate has improved to a level of 30.8%, 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 with average wrap up times across the Trust.

What actions are we taking?

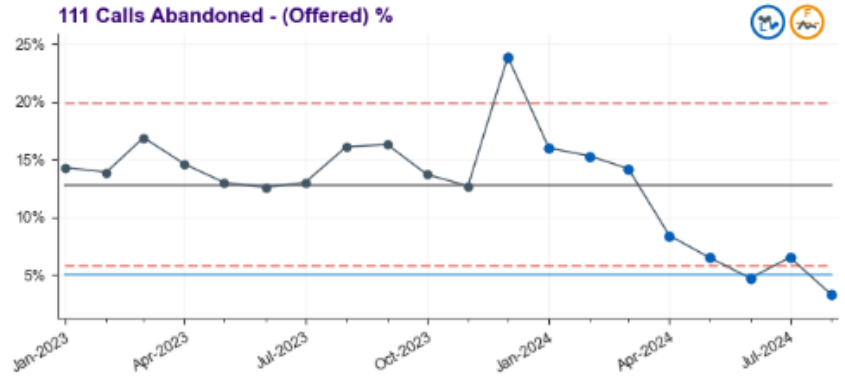
- The Trust has embarked on a programme to lead collaboration with local teams regarding the engagement with local systems and utilisation of community pathways of care i.e., Urgent Community Response (UCR) and other services. The Trust was nominated for two HSJ awards for this collaborative work.
- The UCR portal is now active across Sussex and Surrey, with a plan to implement across Kent before the end of October 2024. In the meantime, daily UCR calls are held with the respective downstream UCR service providers.
- 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.
- Overall, Trust level performance is just above the 18 min target at 18.28. Wrap up times are at 16:22. A target of 15 mins is set as a KPI for operational teams with weekly review meeting held by ADOs and OUMs

SYSTEM INTEGRATION 111

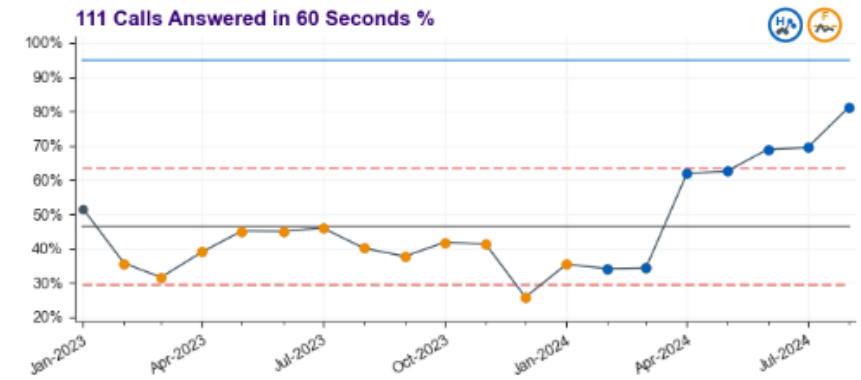


111-1
Dept: Operations 111
IP: Responsive Care
Latest: 78837

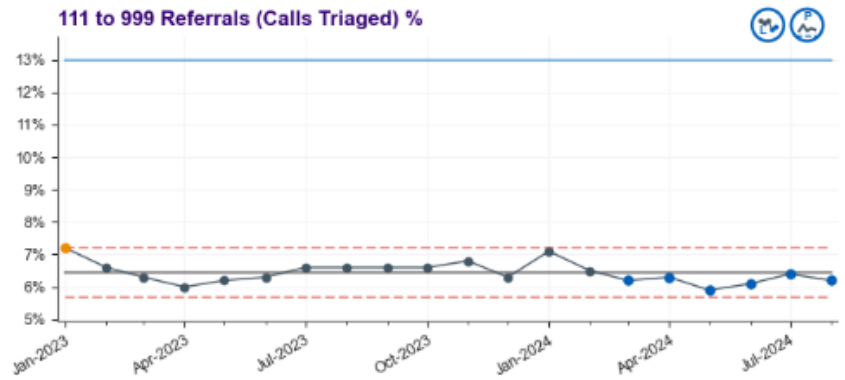
Common cause variation, no significant change.



111-3
Dept: Operations 111
IP: Responsive Care
Latest: 3.3%
Target: 5%
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



111-2
Dept: Operations 111
IP: Responsive Care
Latest: 81.1%
Target: 95%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.



111-4
Dept: Operations 111
IP: Responsive Care
Latest: 6.2%
Target: 13%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Summary

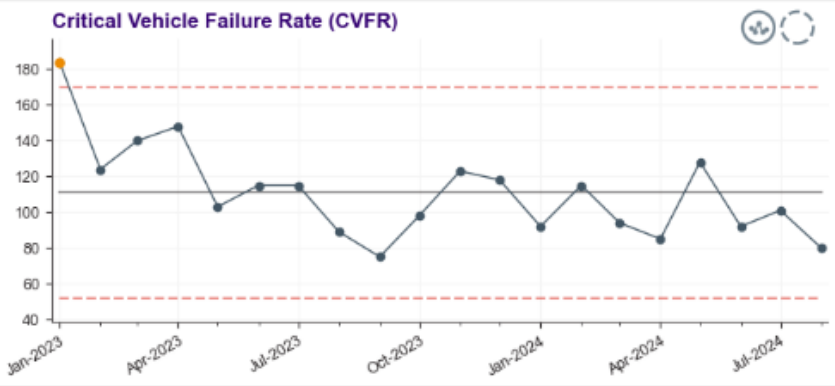
- Although the 111 call volume year to date has decreased, the actual calls answered has increased because of greater staff availability and better productivity.
- The service's operational responsiveness has noticeably improved in Q1 of 2024/25, as reflected in the reduced Average Speed to Answer (ASA) and lower rate of abandoned calls.
- The improved operational performance of the service is directly related to the increased Health Advisor numbers, due to lower attrition and good recruitment numbers.
- The clinical outcomes remain strong, and the service leads the country in terms of ETC1 (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 Direct Appointment Booking (DAB) significantly above the NHS E national average, whilst maintaining a stable clinical contact rate for the service.

What actions are we taking?

- The service continues to protect the wider healthcare economy by being a benchmark IUC provider nationally for 999 and ED validation, in addition to Direct Appointment Booking (DAB).
- The Trust has recently been successful in working with NHS E and has secured additional support from an established 3rd party 111 provider, to support operational performance delivery until February 2025.
- The Trust continues to work with its 111 sub-contractor to improve rota fill and performance across key metrics, operationally and clinically.
- The service has worked hard on improving culture and on staff retention, aided by now having more than 120 "Agile" workers, having the flexibility to answer calls from home.
- The service has addressed its previous staff shortfall prior to moving to Medway. The funded Health Advisor call handler target of 252.6 WTE, has been surpassed with a current established staffing of 275 WTE, including 11.5 WTE in training.

SYSTEM INTEGRATION

Support Services
Fleet and Private Ambulance Providers

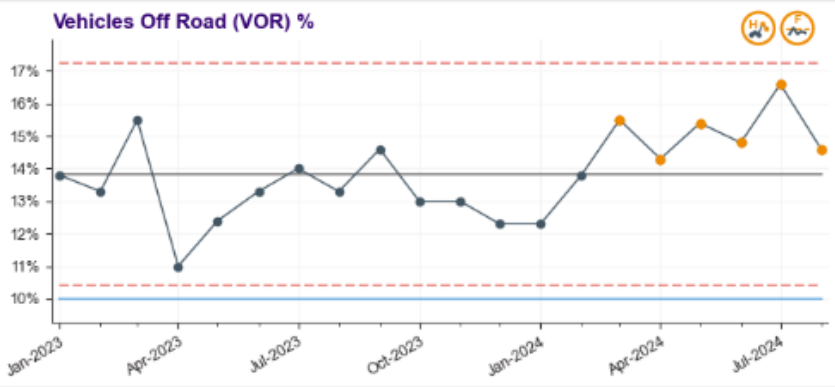


FL-12
Dept: Fleet
IP: Responsive Care
Latest: 80

Common cause variation, no significant change.

FL-3
Dept: Fleet
IP: Responsive Care
Latest: 74%

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



FL-13
Dept: Fleet
IP: Responsive Care
Latest: 14.6%
Target: 10%
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

Summary and Action Plans

Critical Vehicle Failure Rate and VOR Currently 16% 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 and reliability of 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 are down from c. 10% to 4%). We currently have 4 vacancies as of September 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 is currently at 74% for September. This is due to current Fleet staff vacancies and staff abstraction, dedicated agency workers for this work and increased staff overtime is being used where possible to improve our performance in this area. There is a requirement to increase our VMT workforce to increase available workshop hours to meet the required demand of hours required to complete planned vehicle maintenance for our fleet size and a business improvement template has been drafted for submission in October 2024.

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

A business improvement template has been submitted to secure capital investment funding for this replacement vehicle investment that will bring in a different make of DCA.

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Appendix

Appendix 1: Glossary

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

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Agenda No	59-24

Name of meeting	Trust Board
Date	October 3, 2024
Name of paper	Winter Plan Exec Summary
Responsible Manager	Margaret Dalziel Interim (Accountable Emergency Officer)
Author	Lucas Hawkes-Frost, Associate Director of Resilience Lara Waywell, Deputy Director of Operations
Recommendations, decisions or actions sought	Review of overarching priority areas and intentions of plan. NB: Detailed program / OU level detail to follow. The Trust Board is asked to review, with particular focus on the strategic intentions of the plan and the key action areas, including: • Unscheduled care hubs • Trust Operations Cell • Focus on Welfare and Wellbeing • Vaccination The Trust Board is also asked to note that the plan focuses on utilising existing leadership, command, and communication structures wherever possible, and to note that the plan emphasises the absence of additional winter pressures funding, therefore requiring operating units and other Trust departments to review assumptions in Business Continuity planning, ie recourse to overtime, etc. Drafting of this document is overseen by SMG.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	Yes (Partially completed)

SECAmb Winter Planning Update
September, 2024

The SECAmb winter plan is an extension of year-wide planning around escalation and business continuity. Therefore, the plan should be viewed through the lens of an iterative and changeable context. The production of the SECAmb winter plan has included review of modelling data, system engagement, and collective review and analysis at an Operating Unit and program level internally.

Regional and Trust Context: This year's winter plan has been structured to include additional considerations, including recognition that the NHS is undergoing a period of constrained funding with little prospect of additional uplift and continuing significant patient flow issues across the wider South-East region health economy.

Strategic intentions of the winter plan centre around maintenance of a clinically safe and effective service that meets the clinical needs of all our patients and the maintenance of accurate situational awareness of systems pressures across the integrated care system.

The Trust will run a winter table-top exercise on October 24, 2024, to test the plan, with particular focus on operational and support elements and to identify gaps at local or regional levels.

Priority areas of organisational focus are:

- Unscheduled Care Navigation Hubs, which are intended to provide patients with access to care suitable for their individual condition when an emergency response is not required.
- SECAmb will be establishing a Trust Operations Cell (TOC) on November 4, 2024. This aligns with national and local recommendations and emerging best practice around providing systems management oversight.
- Welfare (community resilience) Support, and staff Wellbeing.
- The Trust vaccination program is underway with the intention to maximise the uptake of vaccinations across the Trust.
- Focus on defining and describing organisational management priorities for leaders across SECAmb.

Development and Adoption:

The organisation will continue to refine the plan, particularly around OU-specific actions and mitigations and will share and develop the plan with liaison with external stakeholders and local resilience forums (week of 7 October) following approval through SMG and EMB. A draft version of the plan has been tabled for the October 2 SMG and EMB sessions with an emphasis on iterative improvement prior to external publication. The final version of the plan will go to Trust Board in December, 2024.

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Agenda No	/24

Name of meeting	Trust Board
Date	3 October 2024
Name of paper	People Committee Assurance Report – 12 September 2024
Author	Subo Shanmuganathan Independent Non-Executive Director – Committee Chair

INTRODUCTION

The People Committee is guided by a cycle of business that algins with the Board Assurance Framework – strategic priorities; operating plan commitments; compliance; and risk. This assurance report provides an overview of the most recent meeting on 12 September 2024. Acknowledging that committees are an extension of the Board, this report is one of the key sources that the Board relies on to inform its level of assurance. It is set out in the following way:

- **Assure**: where the committee is assured
- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Advise**: items for the Board's information

At this meeting there was lots of constructive challenge, done in the right spirit. Including executive to executive. Notwithstanding the challenges, there is good progress in a number of areas, and the committee believes it is important to recognise this. The discussion across a range of subjects is starting to feel more joined up and more cohesive too. Overall, it was a positive meeting.

ASSURE

HR Improvement Plan

The committee reviewed the plan following the Board session in early September, with a focus on the areas requiring priority, such as the HR model, employee relations and internal recruitment. The committee is assured with the way this plan is being developed. In particular, with the openness and transparency shown by the HR Director, her team and the wider executive, demonstrated by the level of engagement there has been.

At this meeting the committee tested the view of each of the executive team in terms of their confidence in achieving the plan; their specific role given the plan requires cross-directorate support; and how they will judge over time that the plan is on track. Immediately noticeable from this was how together the executive is, all clearly behind the plan and accepting their roles in it. There was slight variance in the levels of confidence, but this was itself assuring as it demonstrates honesty, especially given the recent history of HR at SECAmb. All agreed that it feels different this time, with it being seen as a shared problem / solution. Once the plan is finalised and approved by the Board, the committee will review progress at each if its meetings.

EOC Culture
Noting the work still needed, the committee is increasingly assured by the impact of the actions taken locally to address some of the longstanding cultural issues, supported by some of the ER metrics moving in the right direction and some of the softer intelligence from recent leadership visits. This includes feedback suggesting a more positive working environment.

Workforce Plan Delivery 2024-25
The trust is on track to deliver the plan and is currently over-established. This is really positive and there is a focus on how to most effectively deploy these resources. The committee supports the need to ensure continued vigilance in the plan and to keep recruitment under review in line with attrition, and the different model as per the strategic direction. The planning for next year is started and there will be a draft plan by Christmas.

ALERT

Career Pathways & Talent Management
The Board should note that there is still much work needed to be put in place first, before the trust is in a position to take this priority forward in any meaningful way. This is an area central to the role of the new Chief Paramedic Officer, who joins in October, and includes areas such as portfolio careers which requires engagement with system partners. While the pathways for clinicians is relatively well defined, there is more thinking needed for support staff, and there is of course a direct link to retention.

Incidents of Violence & Aggression to Staff
The executive undertook some analysis following the data in the IQR showing Special Cause Concern. The increase in reporting (primarily related to non-physical aggression) can be seen positively, as it helps demonstrate a good culture of reporting. However, the impact on our people is a concern. The conflict resolution training is now in place and on track to deliver to patient facing staff within the two year period agreed. To date just under 800 staff have received this and the hotspots shown by the data are being prioritised.

There was no specific increase in incidents directly related to the recent civil unrest, and the data is not showing any obvious issue related to race. But more analysis against all the protected characteristics is being undertaken, noting that reported incidents and experience might be different for some groups of staff. In this context the committee will be exploring in the near future how the trust can become an anti-racist organisation, like some others have done.

ADVISE

MARS Scheme
This national scheme that is open to all non-patient facing roles launches at the end of September and is supported by the committee.

Culture Dashboard

This new dashboard is developing well, linked to the key questions from the staff and pulse surveys. The meeting is November will receive the final version which will then be used by the committee as a way of tracking the impact of the different actions in place to improve the trust's culture.

Trust Values

The launch of the new values followed the August Board meeting, and the committee then spent some time exploring the initial implementation plan and how the tools will be used to help support staff embed the values. It is reassuring that staff are already suggesting different ways on how they might be embedded and so while there is a need to drive some things centrally, the committee supported a more organic and therefore sustainable approach.

Retention Plan

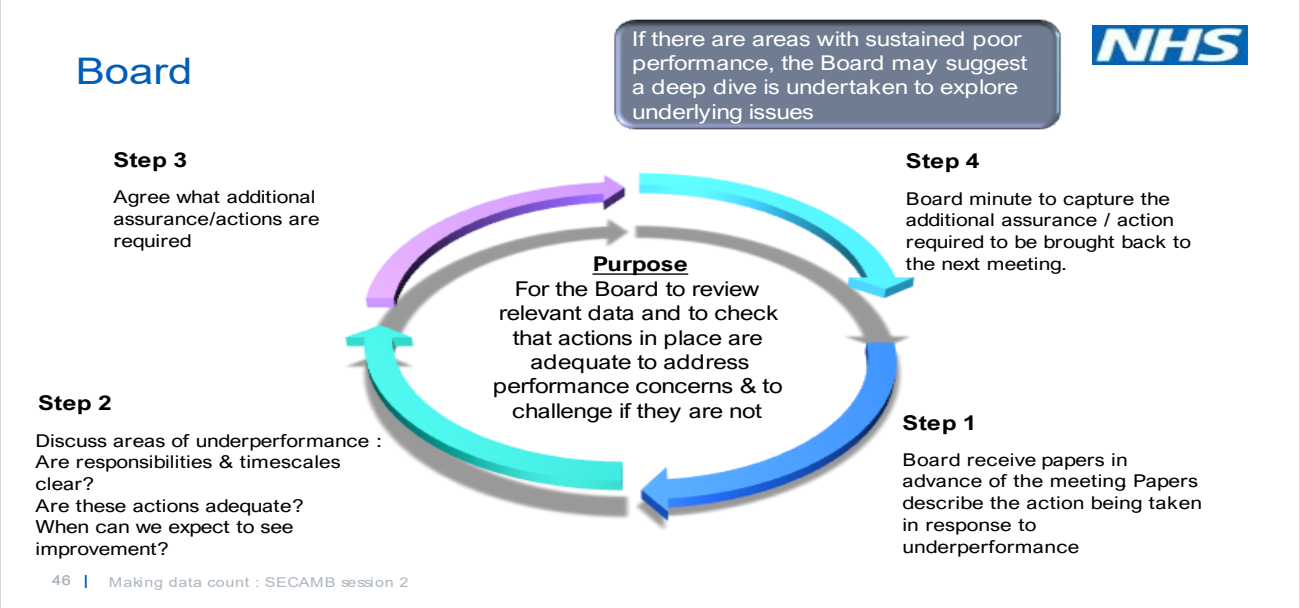
The executive will consider in the context of the HR improvement plan, the approach to the retention plan and will bring a proposal back in due course. In the meantime, the committee is assured by the actions in place to support the related strategic aim and notes the data showing recent improvements in retention.

Equality Diversity & Inclusion

The committee led an interim conversation while it awaits the detailed EDI plan in November, where it will seek assurance that the executive is committed to the plan and that it links to the strategy.

Recommendation

The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle



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Board Assurance Framework

15 July 2024

Our People Enjoy Working at SECAmb

Our People enjoy working at SECAmb Executive Summary

South East Coast Ambulance Service NHS Foundation Trust

- The Integrated People Improvement Plan, developed in response to the diagnostic work, was reviewed by the Board and People Committee and the Senior NHS South-East Regional team. A consistent theme of feedback was that the plan is ambitious and may be trying to achieve too much. In September the HR Improvement Plan was agreed by EMB to include a set of four in-year priorities. This reprioritisation aligns with the feedback. (see substantive item on Agenda)
- The Trust has launched its MARS scheme to run through to 20 October 2024.
- With the executive leadership team appointments now in post, the Leadership Restructure programme is now focussed on the next stages of developing and implementing the regional ('divisional') operating model. This will begin with the appointment of three Divisional Quality Leads in November 2024, and three Divisional Directors by FY24/25 end.
- The People QI priority focused on EOC Audits (slide 21) has been postponed as BDO are currently undertaking an audit across both East & West EOC focused on the robustness and effectiveness of the current process, that will inform the QI project and act as a benchmark for change.

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**
  - Define the operating model for Ops Directorate – structure under exec / regional model **by Q3**
- Definition of workforce plan from 2025
  - Scope to be developed by Q3 following the development of our Clinical Models of Care
- People Improvement Plan
  - Deliver People Improvement Plan to increase capacity & capability by Q4
  - Improve response to ER casework and reduce backlog by Q4
  - Agreed cohorts of managers trained in ER by Q4
  - Improved relationships with Trade Unions

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)**
- 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 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

- **Culture and Staff welfare:** There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy without continued effective trade union engagement.
- **Staff Morale:** There is a risk that the failure to correct the historic pay issues (in relation to ECSW pay and section two concerns) could have a significant impact on morale.

Our people enjoy working at SECAmb

2024/25 – Strategic Transformation Plan – Phase 1

Project	Milestone	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Restructure	Appoint required Executive Directors & Director of Governance	Q2	Complete	Eileen Sanderson	EMB	No	CEO	People
	Define the new 'regional' operating model for the Operations Directorate	Q3	Q3	Rosie Bucknall	EMB	Yes	Director of Operations	Finance & Investment
	Appoint & onboard 3 Divisional Directors	Q4	Q4				CEO	People
	Define the scope and delivery plan for next phase of regional operating model delivery (Phase 2+ : FY25/26)	Q4	Q4				Director of Operations	Finance & Investment
People Improvement Plan	**HR Operating Model** | Defining service and Phase 1 HR structures	Q4	Q4	Roxana Oldershaw	EMB	Yes	Director of HR & OD	People
	ER Casework | Improve response to ER casework and reduce backlog	Quarterly	Quarterly					
	ER Training | Managers trained to lead with confidence	Q4	Q4					
	Partnerships | Effective partnership working with Trade Unions	Q4	Q4					
Workforce Plan from 2025	Scope to be developed following development of Clinical Models of Care	Q3						People

2024/25 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Programme Manager	EMB / SMG	PMO	Oversight Committee	Date last reviewed at Committee
Deliver 24/25 education, training and development plan				Tara Burn	SMG	No	People Committee	Due 30.01.2025
80% rollout clinical supervision		TBC	TBC	Andy Collen	SMG	No	QPSC	Due 17.10.2024
Deliver workforce plan including sickness, retention and recruitment trajectories				TBC	SMG	No	People Committee	12.09.2024
Deliver 1 People QI priority	EOC Clinical Audit Process	NA Paused	N/A	Amy Igweonu	SMG	No	QPSC	Due 09.01.2025

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Culture & Staff Welfare: There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy without continued effective trade union engagement.	16	08	HR &OD
Staff Morale: There is a risk that the failure to correct the historic pay issues (in relation to ECSW, TAAPs pay and section 2) could have a significant impact on morale.	15	04	CFO

Board Highlight Report – Leadership Restructure

Progress Report Against Milestones:

Key achievements against milestones

- Executive leadership team appointed and in post
- Programme scope for remainder of FY24/25 agreed (Phase 1: appointment of Divisional Directors) and programme resource in place
- Initial strawman drafted for organisation design of the target regional ('divisional') model, pending initial feedback from EMB (mid Oct)
- Scoping exercise for Phase 2+ (FY25/26+ delivery) underway

Upcoming activities and milestones

- Mid Oct – Senior Leadership initial design presentation to EMB
- End Oct – Formation of Programme Board subject to EMB approval
- Completion of JDs for Divisional Director roles
- Completion of programme scoping & detailed planning exercise

Escalation to Board of Directors

- None during this reporting period

SRO / Executive Lead:	Previous RAG	Current RAG
Simon Weldon / Eileen Sanderson		

Risks & Issues:	Score	Mitigation
Issue: It has been identified that SECAmb does not have sufficient HR & change management expertise in key areas to support the change process towards the target operating model	12	Develop a resource plan working closely with HR & Transformation colleagues to address the gaps identified
Scale and complexity of the longer term restructure and regional operating model programme (i.e. beyond Phase 1: Divisional Director appointment) is significant. Inherent execution, comms, capability and service continuity risks that need to be managed as part of planning.	12	Complete risk profiling exercise as part of planning. Assess programme and change capability and capacity requirements in readiness for Phase 2 delivery (FY25/26).
Clarity on who and how many individuals will be negatively affected by the restructure and overall change to a regional model is currently unknown. Risk of organisational destabilisation in the absence of a comms plan informed by this analysis.	9	Complete initial impact assessment to identify & quantify individuals likely to be the most significantly impacted

Q1 2024/25 (Apr-Jun 24)	Q2 2024/25 (Jul-Sep 24)	Q3 2024/25 (Oct-Dec 24)	Q4 2024/25 (Jan-Mar 25)
• Appointment of Executive Directors as per the Executive Leadership Structure for 2024/25	• Identification and appointment of leads for individual work packages • Governance structure agreed and full resource plan appointed to oversee the Programme of works	• Complete programme plan for Senior Leadership Restructure Phase 1 (FY24/25 scope) & Phase 2+ (FY25/26+ scope) • Phase 1 (FY24/25): 3x Divisional Directors appointed (offers accepted to allow for likely 3 month notice period)	• Phase 1 (FY24/25): 3x Divisional Directors in post

Board Highlight Report – People Improvement Plan

Progress Report Against Milestones:

Key achievements against milestone

- Feedback gathered from Board (Board Development Day conducted), People Committee and NHS SE Regional Team resulting in revised plan identifying four key priorities for FY 24/25 agreed at EMB (People Operating Model, ER Casework, ER Training, Trade Unions)
- Assessment of current HR structure conducted – Service Specification (current state) produced
- External ER casework providers procured – a number of legacy and complex casework outsourced
- MARS Scheme launched

Upcoming activities and milestones

- Operating Model Phase 1 designed
- MARS outcomes confirmed
- Reconfiguration of ER system (Selenity) and design of ER training package
- JPF ToR review underway

Escalation to Board of Directors

Action sought: The Board is asked to support the four priorities within the HR Improvement plan, and the overall approach.

For noting: Decision at EMB for Individual Directorates will be accountable for tracking retention within their teams and therefore no longer a specific priority within the HR Improvement Plan

For noting: a Lean-in plan has been developed to provide additional leadership support and capacity agreed through EMB.

SRO / Executive Lead:	Previous RAG	Current RAG
Sarah Wainwright		

Risks & Issues:	Score	Mitigation
There is a risk that performance/morale will be impacted during the HR operating model change process, which may delay both the delivery of the improvement plan and HR supported activities in other departments		Full resource requirements to be confirmed and planned against all activities, before final approval of programmes of work. Ensuring an effective comms and engagement plan to support the process.
There is a risk that the HR Improvement Plan won't be delivered due to insufficient leadership capacity/capability.		Resource plan for additional transitional support is in development and discussion for funding approval.

Q1	Q2	Q3	Q4
N/A	N/A	❑ **Operating Model** | People Operating Model Phase 1 (ER/Wellbeing/Retention/L&D/OD) design and integration aligned with Trust Operating Model (central vs regional services). Operating Model Business Case approved. Pre consultation engagement.	❑ **Operating Model** | People Operating Model Phase 1 consultation and implementation.
		❑ **ER Casework |** ER System (Selenity) reconfigured, KPIs & target defined, users trained and dashboard released. Approach to Mediation launched, agreed and published. Formal and legacy casework undertaken by external investigators. Mediation training delivered (Cohort 2).	❑ **ER Casework** | Updated Selenity reporting implemented. Mediation service launched. ER Investigations operating procedure agreed.
		❑ **ER Training I** ER training package designed and socialised with TUs. Training KPIs agreed in collaboration with external company (Hunters). Training cohorts identified and abstraction plan agreed with Ops. Cohort 1 & Cohort 2 training delivered and feedback gathered/reviewed. Plan developed for quarterly Action Learning Sets.	❑ **ER Training I** Cohort 3 Training delivered. Training performance review undertaken (target vs realised benefits/KPIs). Action Learning Set conducted.
		❑ **Trade Unions** |Monthly meetings undertaken with JPF to review ToR.	❑ **Trade Unions**| Revised JPF ToR approved and implemented. Review of JPF effectiveness undertaken following ToR implementation.

BAF Risk 539 – Culture and Staff Welfare

There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy without continued effective trade union engagement.

Controls, assurance and gaps

Controls: JPF meetings re-established. Programme to define the future work programme of JPF. Working in partnership with union colleagues into internal improvement programmes (e.g. employment relations, fair recruitment). Successful partnership working such as the agreement on the re-banding of ECSWs – see risk 540. Work in partnership to improve the approach to employee relations (ER) , which forms part of the wider HR plan to develop a proposal for training co-design and delivery of some sessions with Trade Unions in ER training. Additional HR support for complex case resolution.

Gaps in control: Inconsistencies in approach to ER casework within HR function which is impacting Trade Union relationships. Training for managers in key people-related policies. Updated Terms of Reference for JPF required.

Positive sources of assurance: Positive engagement with TU colleagues around ECSW rebanding and Section 2. Improvement in the management of polices with more best practice examples co-developed with TUs and fewer out of date.

Negative sources of assurance: Grant Reviews (2022 and 2023) and Hunter Healthcare diagnostics report (2024) both identified risks in relation to SECAmb's management of ER cases. The number of formal cases remains high, and the root causes have not yet been resolved.

Gaps in assurance: We have yet to agree a joint-forward workplan with Union colleagues.

Accountable Director	**Human Resources and Organisational Development**
Committee	**People Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 4 X Likelihood 4 = 16**
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Agree joint-forward workplan.	HR & OD	Q3 2024	Rescheduled meetings for Oct, Nov and Dec to agree workplan and ToR.
Co-design and delivery of management ER training with TU partners	HR & OD	Q3 2024	Contractors appointed and suppliers are being on-boarded.
Procurement of specialist investigation support	HR & OD	Q3 2024	Contractors appointed and suppliers are being on-boarded.
Establishing a new process of Bulletins	Corporate Governance	Q3 2024	Completed - revised bulletin governance agreed. Launching 1 Oct 24.
HR improvement Plan	HR & OD	Q3 2024	Board dev session in Sep incorporated feedback. Board sign off Oct 24.

BAF Risk 540 – Staff Morale

There is a risk that the failure to correct the historic pay issues (in relation to ECSW pay and section 2 concerns) could have a significant impact on morale.

Controls, assurance and gaps

Controls: Employment of an experienced consultant who will by the end of June 2024: describe the issue in relation to the deployment of ECSW into band 4 roles, identify the extent of the section 2 errors in application, provide an estimate of the financial exposure to the Trust of rectifying errors and propose a recommended set of actions and timescales to mitigate the risk to the Trust of TU or legal challenge. There is evidence of positive working with Trade Union through the working group and a strong partnership framework to allow constructive and honest working to resolve historical issues. An initial provision has been made for the 2024/25 budget.

Gaps in control: Evidence- based estimate of the financial exposure and therefore the current provision may need revising with a resultant impact on budget. Clear and agreed process for rectification of past error including any time limitations. Revised Partnership Framework for Trade Union engagement.

Positive sources of assurance: Board and EMB sighted on the issues underlying the risk. Working group established and reporting to JPF to agree implementation of approach. ECSW re-banding for 24/25 in Aug, backdated to Jan.

Negative sources of assurance: none yet identified.

Gaps in assurance: Rectification programme with time limits and no estimate of financial exposure.

Accountable Director	**Chief Finance Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 5 X Likelihood 3 = 15**
Current Risk Score	**Consequence 5 X Likelihood 3 = 15**
Target risk score	**Consequence 4 X Likelihood 1 = 04**
Risk treatment	**Treat**
Target date	**Q4 2024/25**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Funding estimates will be confirmed	CFO	Q2 2024	
Paper to EMB for ESCW rectification	HR & OD	Q2 2024	ECSW re-banding for 24/25 in Aug, backdated to Jan.
Paper to EMB for section two rectification	HR & OD	Q3 2024	

BRAGG Scoring Criteria

	Project, **Milestone** or **Criteria** has been achieved and embedded **Risks** have been fully mitigated
	Project, **Milestone** or **Criteria** is at high risk of not being met or already off-track **Risks** have significant impact on project outcomes and/or timeline
	Project, **Milestone** or **Criteria** is at some risk of not being completed **Risks** have moderate impact on project outcomes and/or timeline
	Project, **Milestone** or **Criteria** is on track to be completed in time **Risks** have low impact on the delivery of the project
	Project, **Milestone** or **Criteria** has just started being worked on, resources have not been deployed, and it's too early to tell

Version	Noted Changes	Date
V.1.0	First Submission of BAF	Aug-24
V.1.1	Review & Update of first submission Changes: - Virtual Care Hubs Executive Lead updated (DoO to DoQ/CN) - Strategic Transformation Plan Overview updated to reflect decision of 4 key priorities under people improvement and removal of "Getting Things Right for Our People" objectives - Highlight report – Getting things right for our people removed as all elements now out of scope except ER which has been added to People Improvement Plan	Sep-24

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Integrated Quality Report

Trust Board – October 2024

Reporting Period: July & August 2024

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.

Our Objectives for 24/25

South East Coast Ambulance Service NHS Foundation Trust

We deliver high quality patient care

- Delivery of Performance Targets
- Increase our volunteer workforce by 150
- Improve Cardiac Arrest outcomes and Stroke outcomes
- Implement 5 unscheduled care navigation hubs
- Rollout of Clinical Supervision
- Quality Account and Patient Safety Framework
- Quality Improvement

Our people enjoy working at SECAmb

- Leadership Re-structure
- Leadership Development
- Review our HR and OD Model
- New engagement framework
- Culture Improvement
- Honour the forward liabilities for legacy pay issues

We are a sustainable partner as part of an integrated NHS

- Improve our internal controls and deliver our deficit plan
- Develop an agreed multi-year plan to break-even
- Progress collaboration opportunities with partners
- Refresh our strategic commissioning framework supported by our new models of care
- Develop and begin to deliver on a digital strategy

Our people enjoy working at SECAmb

South East Coast Ambulance Service NHS Foundation Trust

People

PEOPLE

Summary

August 2024

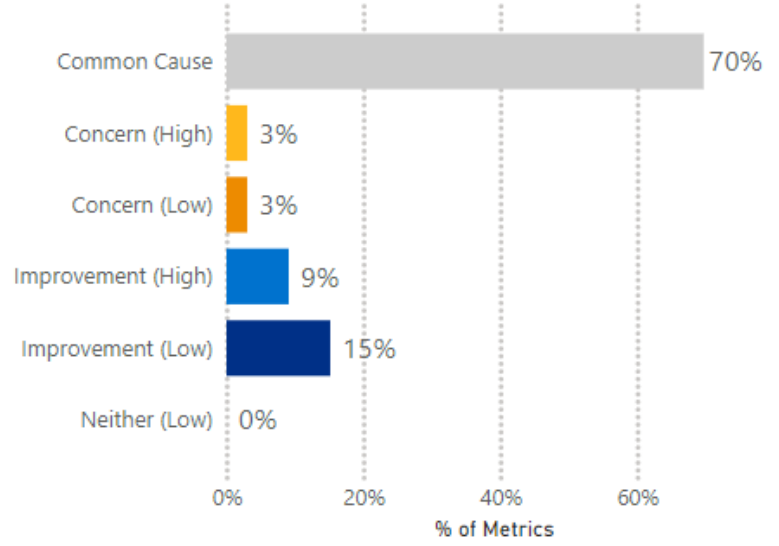
	Pass	Hit and Miss	Fail	No Target
Special Cause Improvement	Number of Staff WTE (Excl bank and agency)	Vacancy Rate % 999 Frontline Late Finishes/Over-Runs %	Annual Rolling Turnover Rate Sickness Absence % Appraisals Rolling Year % Grievances Mean Case Length (Days)	Fundamentals Training Completion %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

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.

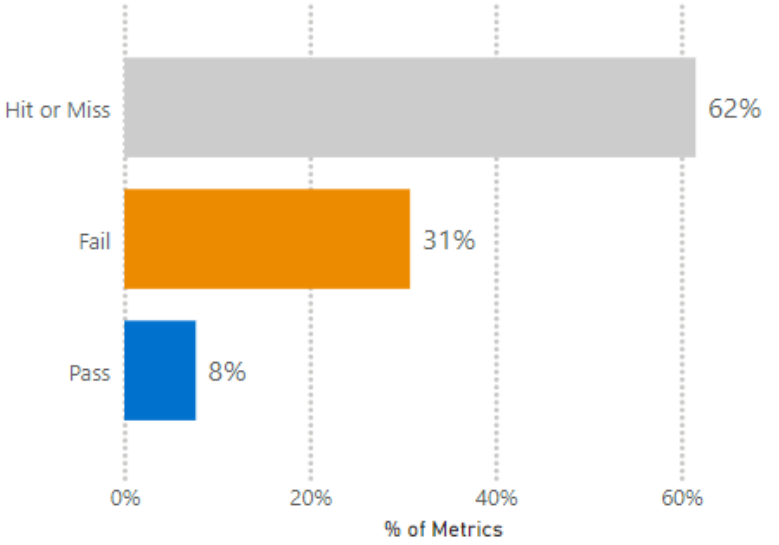
PEOPLE

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	Aug-2024	4506.12	4063.62	4194.02	4280.39	4366.77		
Vacancy Rate %	People & Culture	Aug-2024	2.1%	5%	-0.22%	4.92%	10.05%		
Turnover Rate %	People & Culture	Aug-2024	1.2%	0.8%	0.55%	1.38%	2.2%		
Annual Rolling Turnover Rate	People & Culture	Aug-2024	16.6%	15%	17%	17.94%	18.88%		
Sickness Absence %	People & Culture	Aug-2024	6.1%	5%	5.39%	6.87%	8.35%		
DBS Compliance %	People & Culture	Aug-2024	94%	90%	90.94%	97.58%	104.21%		
Current licence details held for Operational Staff %	People & Culture	Aug-2024	96.8%	100%	96.79%	98.03%	99.26%		
Time to Hire - Volume (Days)	People & Culture	Aug-2024	194	60	64.78	141.5	218.22		
Time to Hire - Individual Recruitment (Days)	People & Culture	Aug-2024	66	60	31.91	71.25	110.59		

Employee Development

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Statutory & Mandatory Training Rolling Year %	People & Culture	Aug-2024	76.7%	85%	67.61%	76.04%	84.46%		
Appraisals Rolling Year %	People & Culture	Aug-2024	62.6%	85%	54.04%	60.71%	67.37%		

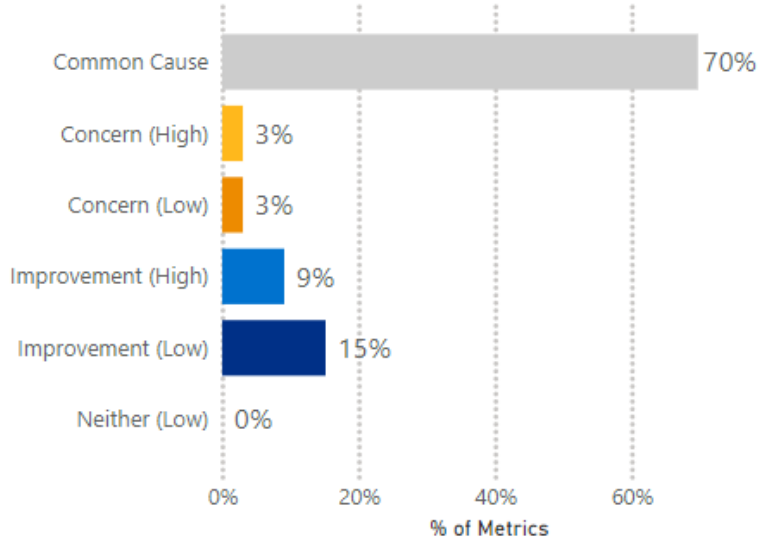
Employee Experience

Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
999 Frontline Late Finishes/Over-Runs %	People & Culture	Aug-2024	40.7%	45%	40.89%	45.48%	50.07%		
Average Late Finish/Over-Run Time	People & Culture	Aug-2024	00:38:00		00:36:09	00:37:33	00:38:57		
% of Meal Breaks Taken	People & Culture	Aug-2024	98.2%	98%	97.57%	98.36%	99.14%		
% of Meal Breaks Outside of Window	People & Culture	Aug-2024	55%		44.26%	51.43%	58.59%		

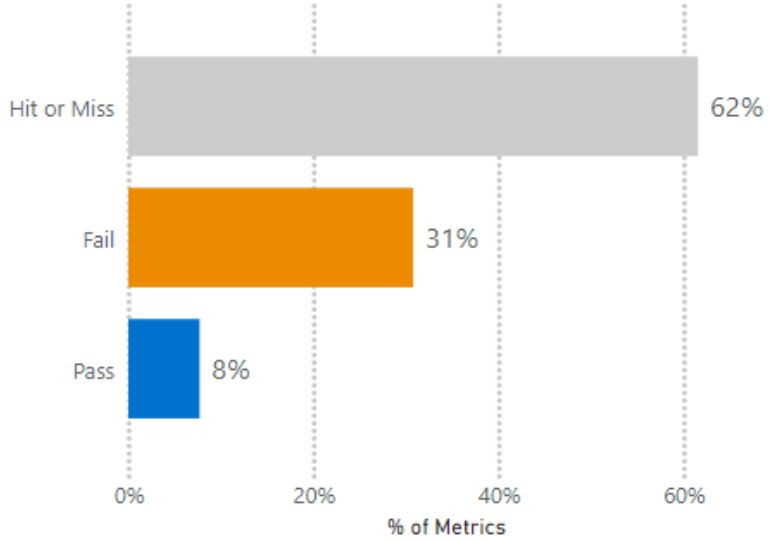
PEOPLE

Overview (2 of 2)

Variation Icon Summary



Assurance Icon Summary



Culture

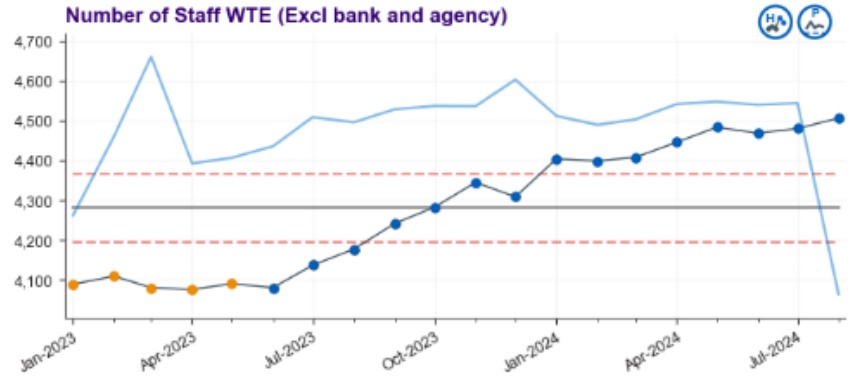
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Individual Grievances Open	People & Culture	Aug-2024	18	5	2.42	13.2	23.98		
Collective Grievances Open	People & Culture	Aug-2024	0	1	-1.86	0.8	3.46		
Count of Grievances Closed	People & Culture	Aug-2024	12	3	2.74	13.8	24.86		
Grievances Mean Case Length (Days)	People & Culture	Aug-2024	114	93	115.96	151.59	187.21		
Bullying & Harrassment Internal	People & Culture	Aug-2024	2	2	-1.32	1.2	3.72		
Disciplinary Cases	People & Culture	Aug-2024	9	3	-1.8	7.3	16.4		
Freedom to Speak Up: Total Open Cases	People & Culture	Aug-2024	15		8.88	24.7	40.52		
Freedom to Speak up: Cases Opened in Month	People & Culture	Aug-2024	10	3	-2.97	9.35	21.67		
Freedom to Speak up: Cases Closed in Month	People & Culture	Aug-2024	5		-1.63	10.55	22.73		
Count of Until it Stops Cases	People & Culture	Aug-2024	2	3	-3.52	3.2	9.92		

Health & Wellbeing

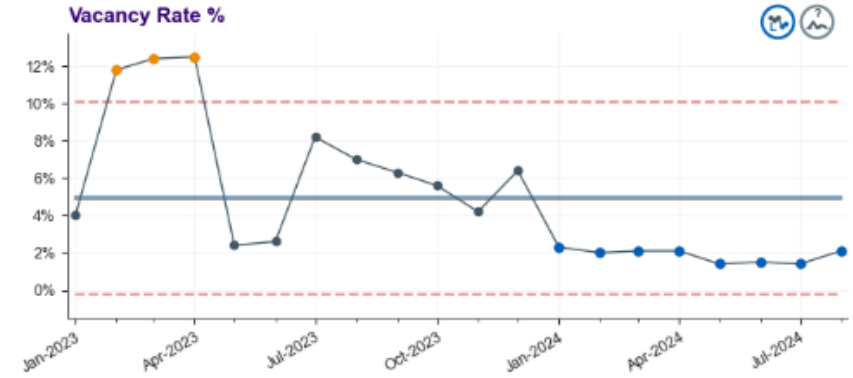
Metric	Improvement Programme	Latest Date	Value	Target	-3σ	Mean	+3σ	Variation	Assurance
Number of Wellbeing Hub Referrals	People & Culture	Aug-2024	145	86	76.49	119.05	161.61		

PEOPLE

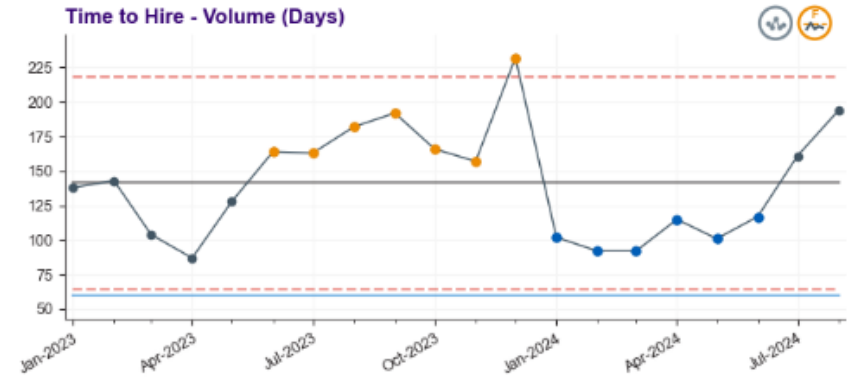
Workforce (1 of 3)



WF-1
Dept: Workforce HR
IP: People & Culture
Latest: 4506.12
Target: 4063.62
Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target



WF-4
Dept: Workforce HR
IP: People & Culture
Latest: 2.1%
Target: 5%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-43
Dept: Workforce HR
IP: People & Culture
Latest: 194
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: 66
Target: 60
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

The vacancy rates for the new financial year have now been calculated with the updated establishment. This shows a small rise which is partly due to the rise in establishment for July (59.92FTE) and an increase in leavers from the previous month.

Time to Hire (TTH) for volume recruitment has increased slightly from the previous month as we move further into the NQP recruitment cycle for this year. This is an anticipated rise and not due to any processes failing* TTH should reduce as cohorts that have been recruited from universities join the Trust throughout the next few months.

TTH reporting is now available for both working and calendar days. This allows us to benchmark appropriately with other Trusts, as there is an inconsistency with what is used and disparity for comparison. August TTH (working days) for volume was 130*, and individual recruitment was 50.

**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.*

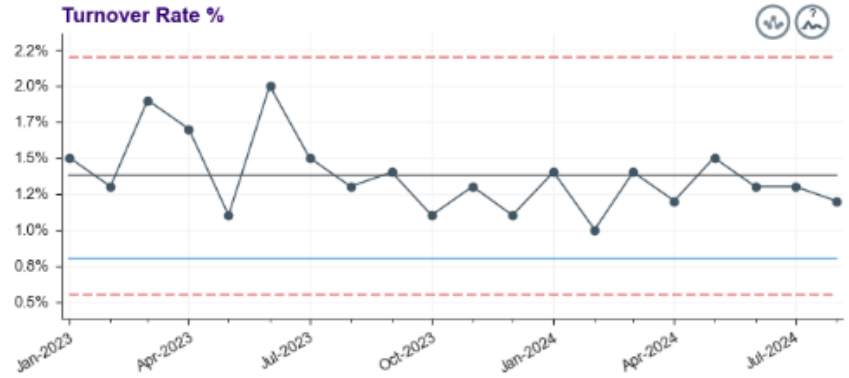
What actions are we taking?

The Trust will continue to have a target of fill courses to capacity and ensure alignment with the trajectories in the workforce plan. The Recruitment Team continue to focus on ensuring vacancies are filled with good quality candidates.

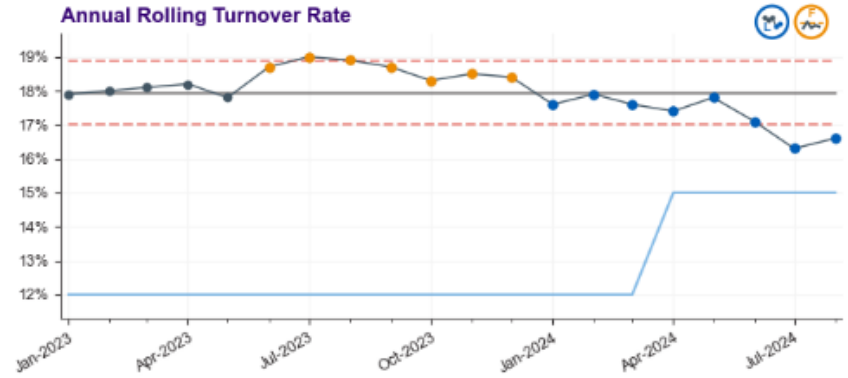
A review of the five stages of recruitment is underway and focus is on;
Enhancing Attraction
Effective Shortlisting
Selection
Pre-Employment Checks
Onboarding

PEOPLE

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: 16.6%
Target: 15%
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:

Turnover currently stands at 16.16%. This compares to 18.94% for the same period in 2023. Turnover I down almost a whole percentage point from the July IQR.

Today (16th September 2024) saw the communication of the Trusts Mutually Agreeable Resignation Scheme which goes live in two weeks' time. This will inevitably have a negative impact on turnover figures in future reports.

The Trust continues to focus on leadership development and culture, both of which are having positive impacts on attrition.

Sickness absence continues on a downward trend towards the 5% target which is positive The current position is at 6.59%. This is in part due to some high long terms sickness absence rates dropping off our rolling 12-month figure.

What actions are we taking?

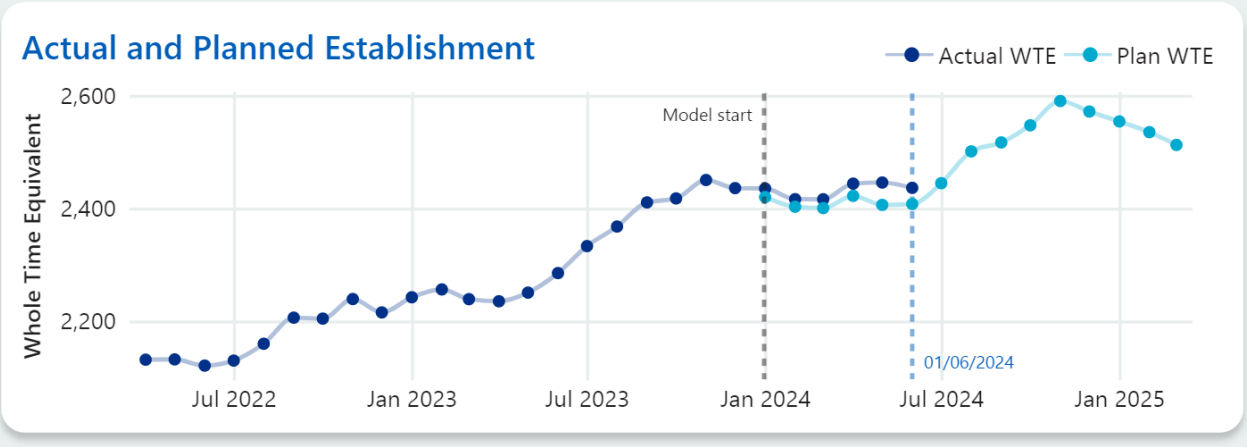
Work continues with the Trade Unions to address two long standing terms and conditions issues. These are about the application of Section 2 of Agenda for Change and the ECSW re-grading from Band 3 to Band 4. ECSW re-grading has been completed and we are now negotiating on the back pay element.

Our review and refresh of the Retention Plan to enable a more focused and segmented approach to our biggest retention challenges is progressing well. Our plan remains to relaunch the refreshed and more targeted approach during Q2. We have two pieces of work relating to retention, one being the above mentioned overarching Trust plan, and the second being a focused plan for 111 EOC and Thanet.

PEOPLE

Workforce (3 of 3)

(999 Frontline)

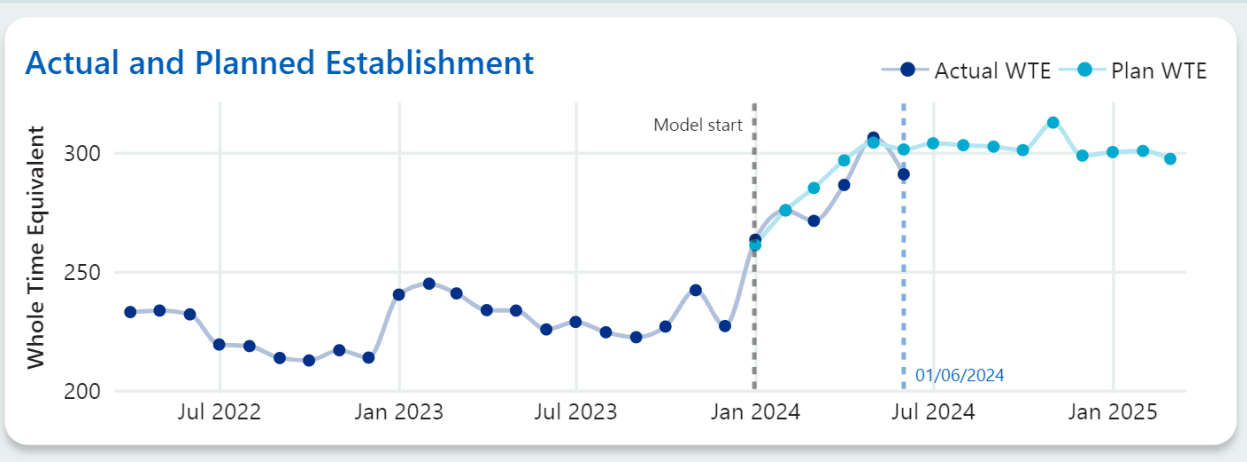


Summary – 999 Frontline
Total budget for field ops is 2407.9 for 2024/25. August's data shows a decrease in WTE against the workforce plan (52.0WTE).
For AAP/Technicians, we saw new starters with 0WTE in July and 26.0WTE in August. In both July and August, we saw less actual leavers against the planned (total of 1.12WTE retained).
For ECSWs, we saw new starters with 5.65WTE in July and 3.80WTE in August. In July we saw the actual leavers less than the planned leavers, and in August we saw less leavers than planned (overall for both months total -5.95WTE against planned –6.68WTE).

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)



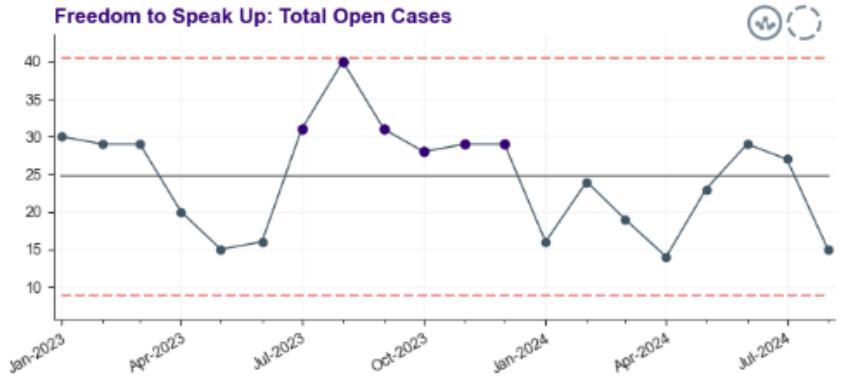
Summary – EOC EMA
EMA establishment in August saw a small reduction in WTE from being above planned to below, with a difference of –4.6WTE (-1.6%). July and August saw 34 new starters (against planned of 36), we saw more leavers than planned with 34.8WTE leaving against planned 28.30WTE.

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.

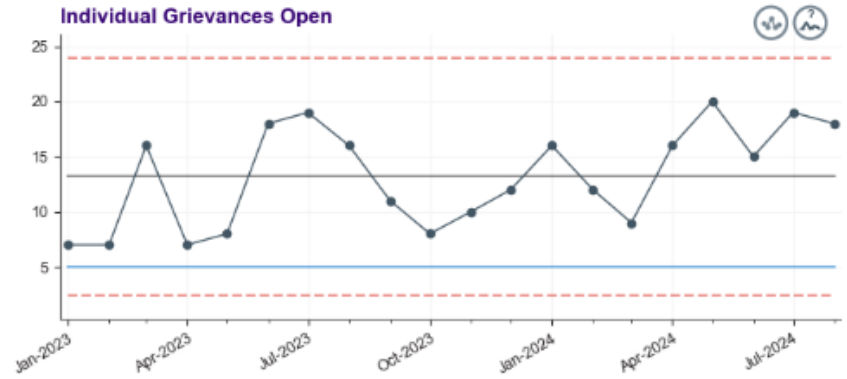
PEOPLE

Culture (1 of 2)

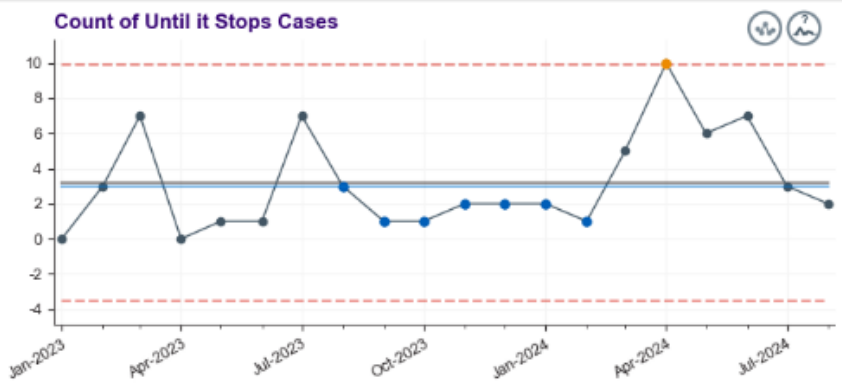


QS-27
Dept: Quality & Safety
IP: People & Culture
Latest: 15

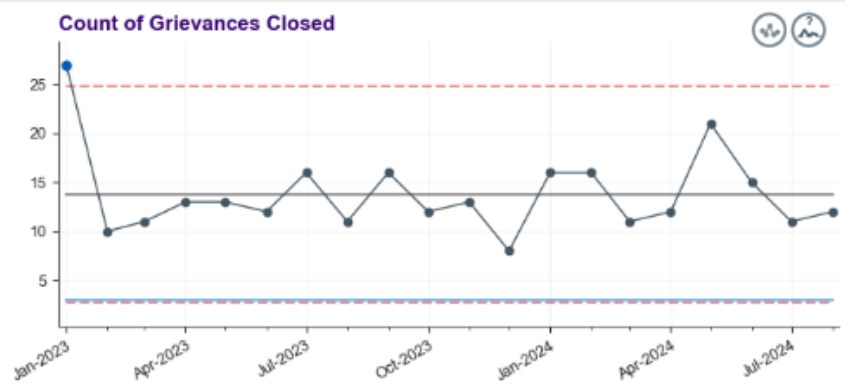
Common cause variation, no significant change.



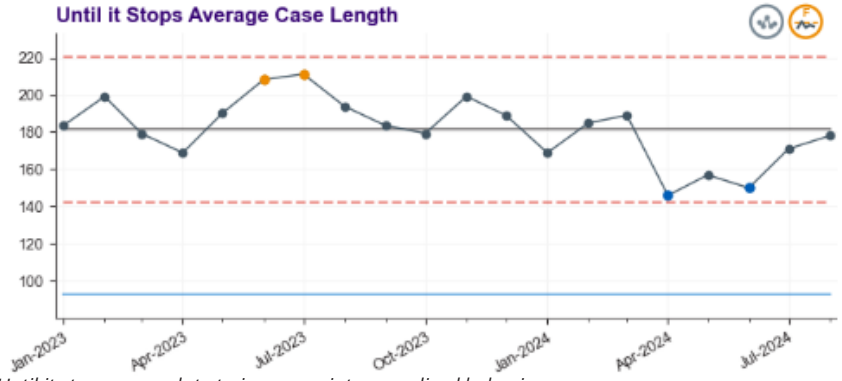
WF-10
Dept: Workforce HR
IP: People & Culture
Latest: 18
Target: 5
Common cause variation, no significant change. This process will not consistently hit or miss the target.



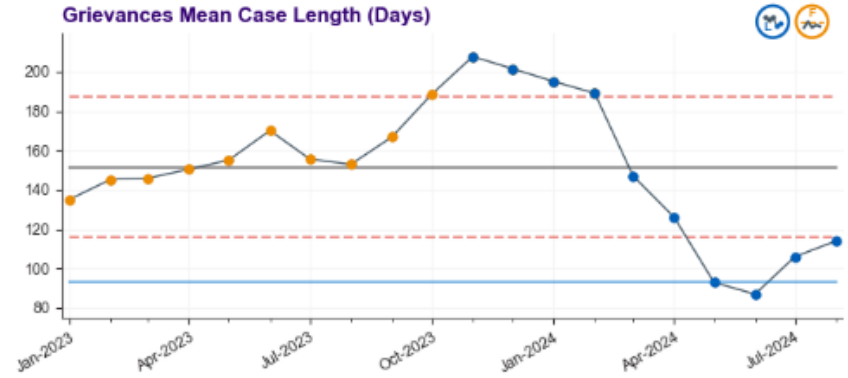
WF-41
Dept: Workforce HR
IP: People & Culture
Latest: 2
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.



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.



WF-50
Dept: Workforce HR
IP: People & Culture
Latest: 178
Target: 93
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-44
Dept: Workforce HR
IP: People & Culture
Latest: 114
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.

Note: Until it stop cases relate to inappropriate sexualised behaviours

PEOPLE

Culture (2 of 2)

Summary

Grievances

We have 80 current open grievances. A focus on informal resolution is being progressed and there are plans to train managers to improve this competence.

FTSU

During July and August, 42 concerns were raised to the FTSU team. This represents an increase from the 39 concerns raised during the same period last year.
Of the 42 concerns raised, approximately 19% were submitted anonymously. This marks an increase compared to last year, when 12% of concerns were raised anonymously for the same period. Overall, comparing the percentage for the years so far, the number of anon reporting has reassuringly improved, however it's important that we monitor this increase.
In terms of detriment, 12% of individuals who raised concerns during July and August reported experiencing detriment as a result of speaking up. This is a significant improvement compared to last year, where 54% of individuals reported detriment for the same period.

What actions are we taking?

Grievances

To reduce the number of formal grievances there is a focus is on informal resolution within the Trust and we have recently trained two cohorts of mediators so we can provide a mediation service for cases that could be appropriately managed by agreement in this way.

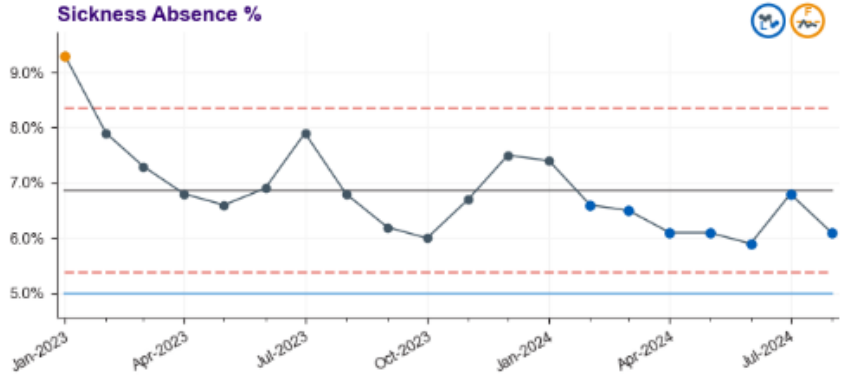
A Resolution pre-assessment and Triage process is being progressed to assess whether early resolution, informal resolution, or formal investigation is appropriate. MDT & Triage working party established and Grievance Culture and Employee Harm meeting initiated.

FTSU

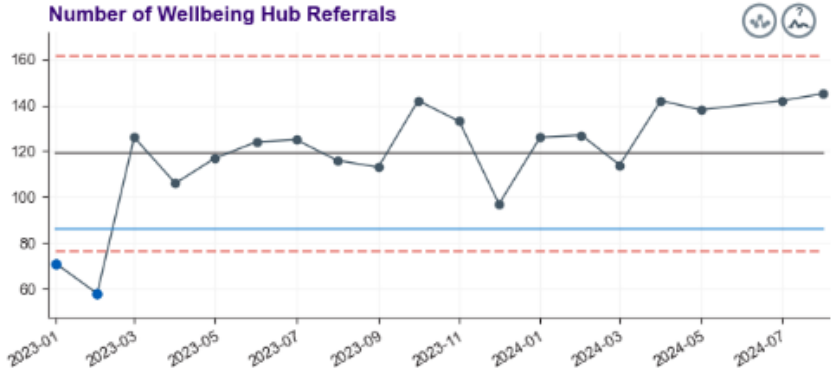
The FTSU team is actively preparing for Speak Up Month in October. This year's theme, *Listen Up*, provides us an opportunity to focus on engaging with managers to better understand their fears and barriers around responding to concerns. The aim is to support managers in viewing speaking up as a learning opportunity, rather than a challenge, and to foster an open and supportive culture.

PEOPLE

Employee Sickness



WF-49
Dept: Workforce HR
IP: People & Culture
Latest: 6.1%
Target: 5%
Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



WF-25
Dept: Workforce Wellbeing
IP: People & Culture
Latest: 145
Target: 86
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

Sickness absence continues on a downward trajectory which is positive, and all indicators point towards us achieving or exceeding our target of 5% by the end of Q4 as long as we remain focused.

Compared to the same period last year, a downward trend continues. For August 2023 sickness levels were 7.98%, and in August 2024 they are 6.59%.

We continue to explore approaches to managing long term sickness, as this accounts for 3.35% of total absence. This is an improvement again against the last IQR of 0.09%

What actions are we taking?

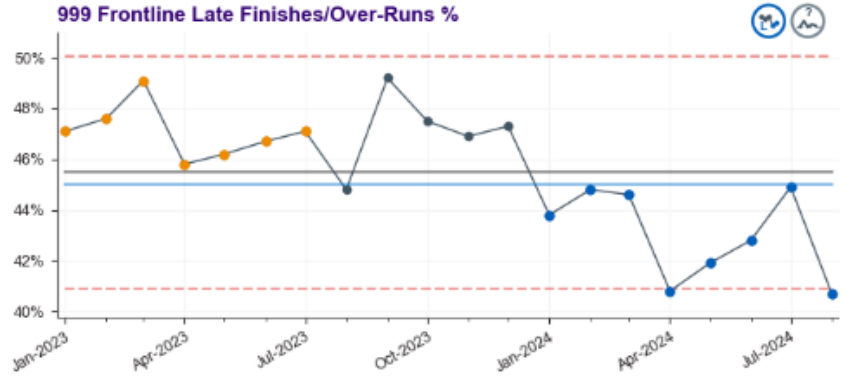
We are currently exploring approaches to managing long term sickness as this accounts for 3.35% of the total absence. To support this, we have two task and finish groups in place, one addressing the mandated improvement in sickness absence by NHSE, and the other looking at improvements in process for alternative duties.

The Wellbeing Hub is continuing with its QI review and looking at implementing changes where identified. This piece of work should conclude by Christmas 24.

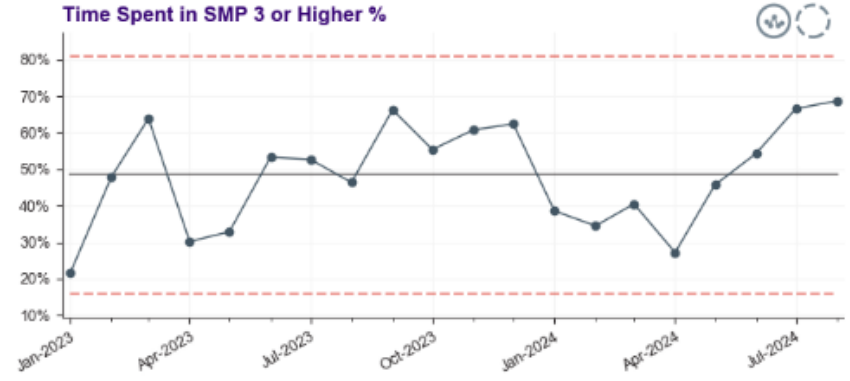
A separate piece of work is also under way to review the function and its operating model, with a focus on Clinical Supervision.

PEOPLE

Employee Experience

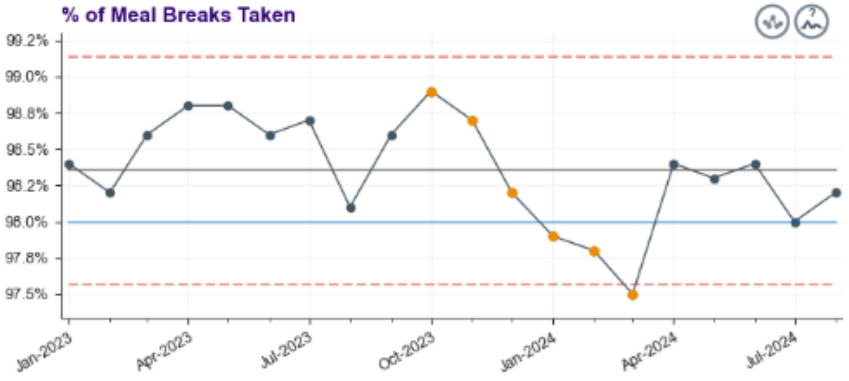


999-15
Dept: Operations 999
IP: People & Culture
Latest: 40.7%
Target: 45%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-14
Dept: Operations 999
IP: Quality Improvement
Latest: 68.7%

Common cause variation, no significant change.



999-27
Dept: Operations 999
IP: People & Culture
Latest: 98.2%
Target: 98%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Summary

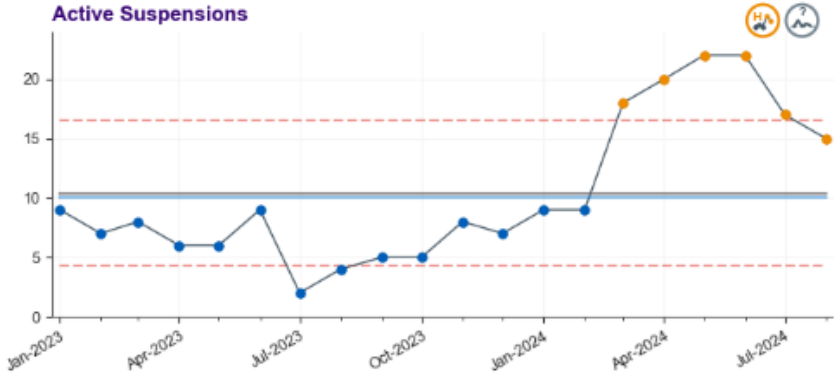
- This compilation of charts has been designed to provide a view of the key metrics that are directly related to the factors staff report as important to them.
- While the late finishes and meal break metrics directly affect field operations, the time spent at higher levels of SMP significantly impacts EOC staff, especially dispatchers and clinicians managing response and flow.

What actions are we taking?

- **Meal Break Policy**: The policy is currently under review and being updated to better meet staff needs, aiming to enhance well-being and operational efficiency.
- **Ready to Respond' Programme**: Implemented to ensure all front-line staff have the necessary PPE, uniforms, and equipment to perform their roles safely and effectively.
- **Placed-Based Educators Pilot**: This new initiative, which delivers an enhanced key skills programme, has been well received.
- **Focus Groups by OUMs**: Operational Unit Managers have established focus groups to address concerns raised by staff, fostering open communication and collaborative problem-solving.

PEOPLE

Employee Suspensions



WF-46

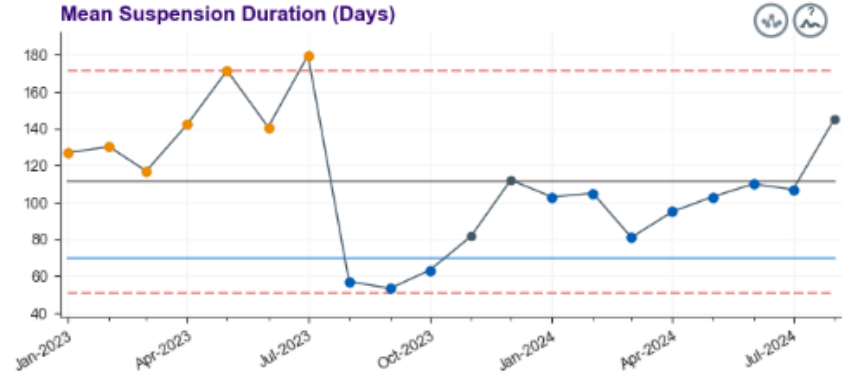
Dept: Workforce HR

IP: People & Culture

Latest: 15

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

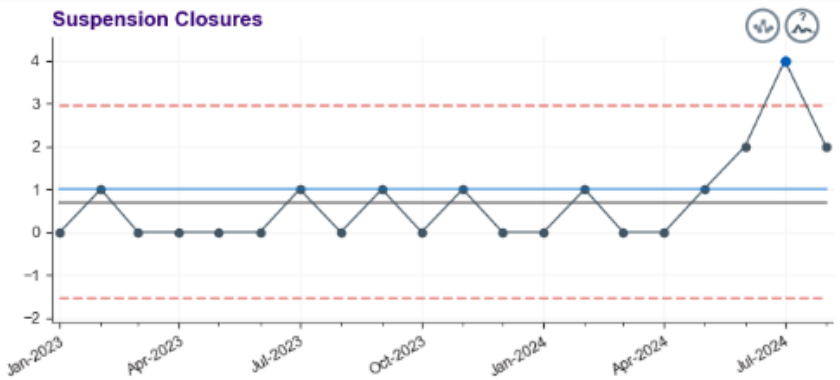
Dept: Workforce HR

IP: People & Culture

Latest: 145

Target: 70

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



WF-45

Dept: Workforce HR

IP: People & Culture

Latest: 2

Target: 1

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

Summary

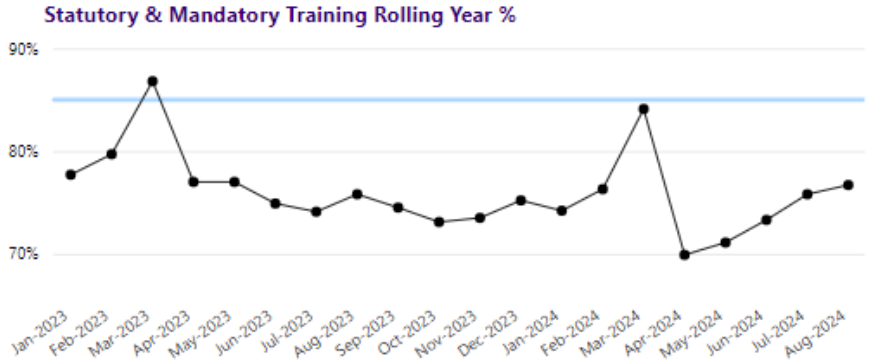
There are currently 13 active suspensions of which (>5 and under 10) cannot be progressed due to involvement of external agencies. This small number of cases are where delays can be significant and this impacts the mean suspension duration as a result.

What actions are we taking?

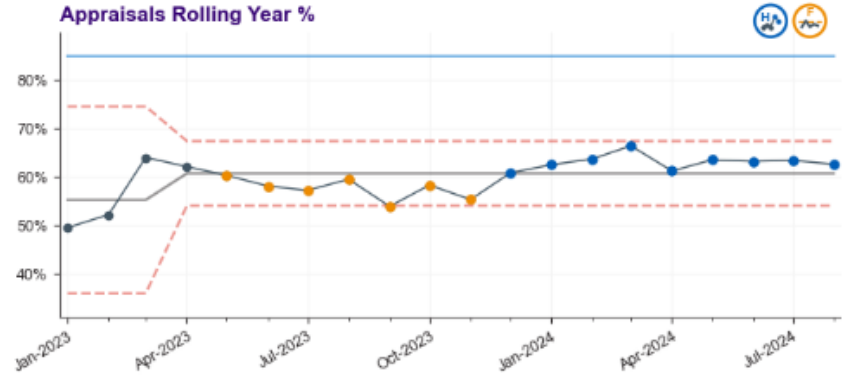
Full risk assessments are completed before any suspensions are authorised. Weekly reviews take place to ensure that individual cases are continually monitored. A further review is undertaken every fortnight, which involves two Executive Directors, to provide appropriate checks and challenge, as well as ensuring cases are progressing take place.

PEOPLE

Employee Development



WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 76.7%
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: 62.6%
Target: 85%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

Summary
Statutory & Mandatory training and Appraisals continue to under-perform against the Trust's target of 85%.

Statutory & Mandatory Training - As of September 2024, the rolling overall compliance rate for statutory and mandatory training stands at 76.67%, which is comparable with the previous month. Compliance has been on an upward trend since April, which was at 69.93%.

The Trust acknowledges the importance of achieving 85% compliance and report all eleven Core Skills Training Framework (CSTF) subject areas, plus additional Trust mandatory training subjects. These include Safeguarding Adults Levels 1 & 2 at 90.23% compliance and Resilience and Specialist Operations at 25.41%, the face-to-face elements of which are scheduled for Q4 operations 'Key Skills' delivery. The current compliance percentage for CSTF subjects is 82.07%.

Appraisals - As of September 2024, appraisal compliance stands at 61.95%. While this reflects a minor decrease from the 63% compliance recorded in July 2024, it remains a substantial improvement from the 40% achieved in June 2022. Despite this progress, compliance continues to fall short of the Trust's 85% target, highlighting the ongoing need for further efforts to meet and exceed the benchmark.

In response to the findings from the recent RSM audit report, the Trust has established a cross-organisational Appraisals Working Group. This dedicated team is actively working to address the ten management actions identified in the audit. The current ESR Appraisal system has been flagged as user-unfriendly, causing engagement challenges. To resolve this, the HR&OD directorate is conducting research to explore potential alternatives for the system. In the interim, the existing ESR appraisal form is being updated to reflect the new Trust Values.

What actions are we taking?

Statutory and mandatory training

1. Socialising the new Power BI Dashboard continues: 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

The Learning and OD Team continues to make progress on improving the completion and quality of appraisals across the Trust. In line with the 10 management actions identified in the internal audit, we are implementing several ongoing initiatives:

- The cross-organisational working group, involving key stakeholders, has been established to drive an improvement plan that addresses the management actions. Leadership engagement and buy-in remain central.
- We are actively collaborating with the HR Business Partnering team to progress management action 7(b), supporting a cultural shift that enhances the overall quality of appraisals.
- Development of an internal appraisal moderation process is well underway, ensuring consistency and fairness in the appraisal outcomes.

Additionally, the appraisal form is currently being updated to align with the newly defined Trust Values, ensuring that the appraisal process reflects the organisation's core principles.

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Appendix

Appendix 1: Glossary

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

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Board Assurance Framework

15 July 2024

NHS
South East Coast Ambulance Service
NHS Foundation Trust

We Are a Sustainable Partner

We are a sustainable partner
Executive Summary

- Control total compliant deficit plan of £10.5million agreed with NHSE and year to date and forecast are in line with the plan and reported accordingly to Board and NHSE. This includes CIP plans.
- A review of internal controls has been undertaken by CFO and improvements reported to and agreed by EMB. Implementation and monitoring will be managed by EMB.
- Recovery plan first draft process and principles agreed with ICBs. First draft three-year recovery plan presented. to EMB by 28th August. Process and three year trajectory presented to SCG and SAM.
- Year to date and forecast position at month 5 on track
- Digital Strategy is in draft and presented to the Board on 3 October.
- We are working collaboratively with partners to progress our strategy. Through Q1 we have developed a specification and evaluation framework with Kent, Surrey, Sussex and Frimley ICBs for our Unscheduled Care Navigation Hubs, and we have progressed one new Hub in West Kent.

We are a sustainable partner as part of an integrated NHS

2024-2029 Strategy Outcomes

- ❑ Breakeven / 8% reduction in cost base: £26m annually. Avoid 100m additional expenditure / 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 a £16.5m deficit 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 of £23.9m
  - 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

- ❑ **System Collaboration:** There is a risk that the Board is unable to collaborate effectively with ICBS, due to the regional footprint and capacity to engage.
- ❑ **Sustainable Financial Plan:** 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.
- ❑ **Internal Financial Control:** There is a risk our internal financial controls are not robust enough to ensure we are managing within our budget.
- ❑ **Cyber-attack:** 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.

We are a sustainable partner as part of an integrated NHS

2024/25 – Strategic Transformation Plan – Phase 1

Project	Status	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Develop multi-year plan	Approach agreed internally and with ICBs. Baseline three-year plan to EMB end August	Q3		Alex Croft	EMB	Yes	CFO	Finance & Investment
Refresh strategic commission framework to support sustainability plan	Programme being scoped as part of the response to SE Ambulance Review	Q3		Claire Webster	EMB	Yes	SP&T	Finance & Investment
Develop enabling Digital Strategy	Strategy due at August FIC	Q3		TBC	EMB	No	CDIO	Finance & Investment
Engage in productivity collaboration opportunities	Collaborative work with SCAS led by SP&T. Southern Ambulance Collaborative launched. Collaboration plan to be shared with Board in November 2024.	Q4		Claire Webster	EMB	Yes	SP&T	Finance & Investment
Refresh core enabling strategies	Draft Procurement Strategy produced, Estates strategy being refreshed	Q4		Claire Webster	EMB	No	CFO	Finance & Investment

2024/25 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Programme Manager	EMB / SMG	PMO	Oversight Committee	Date Last reviewed by Committee
Deliver financial plan	Meet CIP plan of £23.9m			Judit Freidl	SMG	No	FIC	August 24
	Deliver logistics waste reduction (QI)			Amy Igweonu	SMG	No	FIC	*TBD*
Review service delivery model for Make Ready				Rosie Bucknall	SMG	No	FIC	*TBD*
Deliver 6 priority green initiatives	The introduction/trial of an electric DCA			Rob Martin	SMG	No	FIC	*TBD*
	The removal of single use cups			Lee-Ann Witney	SMG	No	FIC	
	The introduction of 3 Evitos on the PP rota			Rob Martin	SMG	No	FIC	
	Amending the Lease car and support vehicle policy to mandate the use of hybrid/electric			Judit Freidl	SMG	No	FIC	
	The potential reduction of CO^2 Emissions from vehicles due to the intended target of increasing Hear and Treat from 11% to 16+%pa			Lee-Ann Witney	SMG	No	QPSC	
	A trial to determine the benefits of Eco run			Lee-Ann	SMG	No	FIC	

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
System Collaboration: There is a risk that the Board is unable to collaborate effectively with ICBs, due to the regional footprint and capacity to engage.	12	04	SP&T
Sustainable Financial Plan: There is a risk that due to uncertainty over medium to long term funding (3-5 years), the Trust is unable to agree with Commissioners a sustainable financial plan which delivers safe and effective services and improves value for money.	16	12	CFO
Internal Financial Control: There is a risk our internal financial controls are not robust enough to ensure we are managing within our budget.	12	04	CFO
Cyber Attack: 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.	12	08	CDIO

Board Highlight Report – Multi-Year Plan Development

Progress Report Against Milestones:

Key achievements against milestone

- Produce and agree with ICBs plan and timeline
- A draft baseline 25/26 position has been developed, including draft workforce plan to initiate recruitment cycle with universities in 25/26
- EMB have reviewed the initial scenarios in August 2024
- ICBs have provided us with a consolidated income position for 24/25 a key control function lacking during planning for 24/25

Upcoming activities and milestones

- The Trust will run a consolidated business case process where all investment for 25/26 will be considered in November to be included in the plan. No other cases will be considered in-year during October/November

Escalation to Board of Directors

- None – normal reporting cycle to EMB

SRO / Executive Lead:	Previous RAG	Current RAG
Simon Bell		

Risks & Issues:	Score	Mitigation
Capacity of Finance Team to produce and maintain a 3 year finance plan	12	▪ Review of capacity in hand
Commissioners unable to commit to multi-year plan as one year funding settlement for 25/26 likely	9	▪ Known issue. Working with ICBs & NHSE to gain agreement in principle through Finance Committees
Lack of financial clarity from ICBs means Trust income is unclear	9	▪ Confirmed senior ICB finance resource into the SCG to co-ordinate contract negotiations

Q1	Q2	Q3	Q4
◆ Agree 24/25 deficit plan with NHSE in line with supportable control total	◆ Produce first draft baseline plan (assuming 0% uplift in funding and 27/28 break-even trajectory) by end August 24	◆ All business cases (workforce, capital, and revenue) aligned and prioritised against strategic objectives by end October. ◆ Comprehensive version of recovery plan shared with ICBs and NHSE by End of November ◆ RSP Exit Criteria Assessment	◆ Ongoing iterative development of plan in line with planning guidance and commissioning intentions

Board Highlight Report – Digital Strategy

Progress Report Against Milestones:

Key achievements against milestone

- Draft Strategy completed and went through board development session in July
- Joint SMG and EMG approved the principles of the strategy subject to some minimal changes and approved as an emerging strategy
- Lead NED providing check and challenge
- Emerging strategy to be approved by Board on 3rd October
- Draft enabling plan completed and presented at FIC 26th October

Upcoming activities and milestones

- Costing (revenue and capital) identification of investment opportunities to drive the strategy to be developed post strategy approval, as part of the centralised business case process

Escalation to Board of Directors

- None

SRO / Executive Lead:	Previous RAG	Current RAG
Stephen Bromhall		

Risks & Issues:	Score	Mitigation
Revenue and Capital Funding will be required in Future years	6	▪ Build into future budget cycles
Cyber	12	• Strategy to provide remediation options aligned to Audit Committee recommendations

Q1	Q2	Q3	Q4
◆ Develop Digital Strategy	◆ Board Development Session ◆ Digital & Data Strategy Approved	◆ Approval of Cyber Future Model	◆ Creation of Next Generation funding business cases

Board Highlight Report – Productivity and Collaboration

Progress Report Against Milestones:

Key achievements against milestone

- Monthly Sustainability collaboration meetings in place to share best practice, joint problem solving and identify future opportunities.
- Opportunity scoping meetings held for Digital & Data, Fleet Procurement and Medicines Procurement T&F groups.
- Quality Improvement collaboration opportunity identified, sharing best practice, expertise and SECAmb's implementation journey.

Upcoming activities and milestones

- Transformation steering group (03/10).
- Workforce collaboration scoping workshop (10/10).
- Continue feasibility studies to understand high level cost and benefits of each opportunities, with the output of a summary report of recommendations for EMB review and agreement to take forward.

Escalation to Board of Directors

- Minimal cost saving opportunities for in-year recommendations.
- Resource support is required to take opportunities forward to feasibility (regional & national request).

SRO / Executive Lead:	Previous RAG	Current RAG
David Ruiz-Celada		

Risks & Issues:	Score	Mitigation
Capacity to deliver collaboration workstreams on top of core delivery of our strategy	12	Additional support is being sourced from regional teams and SCAS/SECAmb have allocated additional programme support. Each feasibility study has its own resource requirement identified so work can be progressed across discrete areas

Q1	Q2	Q3	Q4
◆ Mobilisation group meetings establish ◆ Review and planning of T&F groups	◆ Design workshop with SCAS ◆ Plan & refinement of opportunities ◆ Steering Group: T&F group feasibility workplan and resource requirements	◆ Feasibility studies to analyse the high-level cost/benefits ◆ Implement of in-year benefits ◆ Response report to be presented to Boards	◆ Planning and preparation for opportunities to be realised in 25/26

BAF risk 541 – System Collaboration

There is a risk that the Board is unable to collaborate effectively with ICBs, due to the regional footprint and capacity to engage.

Controls, assurance and gaps

Controls: A roadmap and blueprint for change has been produced and agreed by EMB, including establishment of a Leadership and Operating Model Programme (the 'Programme') for the work required in 2024/25. Funding has been identified in the 2024/25 budget, subject to ratification. The appointment of a Programme Director (and resource) has been agreed and is underway. Financial control of the Programme established via the Recruitment Panel System. Partnerships team and Executive Lead for each ICB.

Gaps in control: Programme Director not yet appointed. Gap between the work of the Executive Structure Project Group and handover to the Programme (with HR Consultant leaving at end of June 2024). Revised Partnership Framework for Trade Union engagement. The funding for the appointment of Regional Directors is currently uncertain. Without these roles, the Board will struggle to have sufficient capacity for effective collaboration. The Board does not have full visibility of all the ICB meetings and the expectations for their involvement. No clear process to ensure that the board can attend and engage with the ICBs. The scheduling of the ICB meetings is not well coordinated and there is no mechanism for delegating attendance.

Positive sources of assurance: Report from Recruitment Panel on meeting financial commitments. Reports to EMB setting out position of Programme and identifying risks. Ad-hoc invitations to and attendance at Senior system meetings (Sussex Committee in common). 2023/24 External Well-Led Review provided confidence that organisation had made good progress.

Negative sources of assurance: Executives cannot always attend Senior meetings and rely upon more junior staff members.

Gaps in assurance: Programme not yet established, therefore no oversight or additional governance to gain visibility of emerging issues. Board members do not have system engagement in objectives. No board-level partnership management strategy.

Accountable Director	**Strategic Planning and Transformation**
Committee	**Trust Board**
Initial risk score	**Consequence 4 X Likelihood 3 = 12**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12**
Target risk score	**Consequence 4 X Likelihood 1 = 04**
Risk treatment	**Treat**
Target date	**Q4 2024/25**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Board level partnership management strategy	SP&T	Q2 2024	EMB are reviewing the partnership strategy approach for 2024/25.
Board members have objectives relating to system engagement and collaboration	SP&T	Q3 2024	Not yet started
Appointment of Regional Directors	SP&T	Q3 2024	Regional model design on-track.
Appointment of Programme Director, project manager and HRBP	SP&T, HR, Chief of Staff	Q2 2024	Complete, full resource requirement for the re-structure plan included in the people plan presented at Board 3/10
Execution of MARS	HR & OD	Q2 2024	MARS comms completed and applications opened 30/9

BAF Risk 542 – Sustainable Financial Plan

There is a risk that due to uncertainty over medium to long term funding (3-5 years), the Trust is unable to agree with Commissioners a sustainable financial plan which delivers safe and effective services and provides value for money.

Controls, assurance and gaps

Controls: The Trust is in dialogue with the national and regional team about the medium-term financial settlement. SECAmb will draft a recovery plan, which will include additional cost savings within two years.

Gaps in control: Allocated funding largely outside of SECAmb control.

Positive sources of assurance: Trust strategy in place and communicated to ICBs and NHSE region. Monthly updates provided to Finance and Investment Committee and Trust Board.

Negative sources of assurance: None yet identified.

Gaps in assurance: Annual planning cycle in NHS and likely CSR will impact commissioner and NHSE ability to confirm longer term funding. SECAmb still in RSP due to lack of sustainable financial plan. SAM and SCG asked to provide confirmation of how ICBs /NHSE will provide agreement to a 3 year recovery plan in the context of a single year settlement for the NHS in 25/26 which has yet to be confirmed.

Accountable Director	**Chief Finance Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 4 X Likelihood 4 = 16**
Target risk score	**Consequence 4 X Likelihood 3 = 12**
Risk treatment	**Treat**
Target date	**Q4 2024/25**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Continue to engage positively with ICB, regional and national colleagues particularly through SAM (strategic assurance meeting) in relation to additional income.	CEO, CFO, SP&T	Ongoing	
Extension of RSP for up to twelve months. Sustainable financial plan to be drafted within that timeframe.	CFO	Q3 2024	
SAM and SCG asked to provide confirmation of how ICBs /NHSE will provide agreement to a 3 year recovery plan in the context of a single year settlement for the NHS in 25/26.	CFO	Q3 2024	Yet to be confirmed.

BAF Risk 543 – Internal Financial Control

There is a risk our internal financial controls are not robust enough to ensure we are managing within our budget.

Controls, assurance and gaps

Controls: EMB are reviewing and revising financial controls in June 2024. Proposals include:
- A recruitment panel managing corporate vacancies and the Executive Restructure.
- Moving to an annualised financial planning cycle where business cases are assessed annually and incorporated into financial plans according to priority.

SMG have ownership of CIP which will be enhanced to include recurring cost savings. SECAmb will draft a recovery plan, to include cost savings likely within two years. Continued conversations with national and regional colleagues about additional monies.

Gaps in control: controls listed above not currently "live".

Positive sources of assurance: Recent internal audit gave reasonable assurance on financial controls. 23/24 financial year ended in line with financial plan. Monthly reporting to FIC and Board. SMG looking at CIP monthly. Monthly meeting with Directorates to consider CIP.

Negative sources of assurance: Underlying deficit.

Gaps in assurance: Proposals due to go to EMB in June 2024 and are therefore yet to be agreed. Reporting mechanisms for some elements of the plan are not in place (for example, around contract reporting.)

Accountable Director	**Chief Finance Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 4 X Likelihood 3 = 12**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12**
Target risk score	**Consequence 4 X Likelihood 1 = 04**
Risk treatment	**Treat**
Target date	**Q4 2024/25**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Paper on financial controls to EMB	CFO	Q1 2024	
CIPs reported on a bi-monthly basis to EMB	CFO	Ongoing	
£8.6 million outstanding in additional funding bids	CFO	Q4 2024/ 25	

BAF Risk 544 – Cyber Attack

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.

Controls, assurance and gaps

Controls: SECAmb: Firewalls around network perimeter; Permissions based privileges; Anti-virus/ anti-malware software on all devices which are regularly patched; Trust and CAD vendor alerted to specific risks by NHS digital; In and out of hours responses to disable impacted devices; NHS secure boundary and Imperva; Penetration testing and social engineering testing; Remote monitoring of end points by Sophos. Supply chain: NHSE mandate that supply chain risks considered as part of the procurement process.

Gaps in control: SECAmb: some servers not immediately patched; No standardised action card re: handling cyber-security events; No security on-call team; Trust not fully compliant with DPST re: frequency of penetration testing; No business continuity plan for cyber-attack; No programme of training or awareness focussing on cyber-security; No ID verification for in-person or telephone users approaching IT for support; Multiple network providers in place – increased complexity and chance of a breach. Controls around social engineering for staff are not sufficiently robust. Robustness of leavers process. No XDR technology in place to mitigate risk. Supply chain: NHSE mandate not in place for products which have been procured historically

Positive sources of assurance: SECAmb asked to do cyber-preparedness review for all Ambulance Trusts. Will be an external review covering BCP, preparedness plans. A national review is ongoing and SECAmb will be reviewed Sept 24 which will determine funding.

Negative sources of assurance: None yet identified.

Gaps in assurance: Cyber-preparedness review scheduled for July 2024 – learning from the review not yet identified.

Accountable Director	**Chief Digital and Information Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 5 X Likelihood 4 = 20**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12**
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q1 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Automation of leavers process to reduce risk	CDIO, HR&OD	Q1 2025/26	NHS wide HR future strategy working group have identified this as a risk. The inaugural meeting was 14 June 2024.
Increasing penetration testing	CDIO	Q3 2024	Digital Strategy due to be signed off at Board August 2024.
Procurement of social engineering tool to expose vulnerabilities.	CDIO	Q1 2025/26	Digital Strategy due to be signed off at Board August 2024.
Privilege access management (PAM) starting with suppliers and then internal stakeholders.	CDIO	Q2 2025/26	Subject to funding following the National Ambulance Cyber Security review finalising in Q3 2024.

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Compliance: RSP Review

July 2024

(No changes to BRAGG ratings since August Board)

Progress Against Exit Criteria

South East Coast Ambulance Service NHS Foundation Trust

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-D1	Interim CEO appointed and the Trust's Board-level leadership seen as stable by the Trust Chair, Surrey Heartlands ICB and NHS England.	**Achieved**: • A substantive CEO is currently in place. • A new Chair has been appointed as of December 2023 and will assume the role in May 2024. • An Executive and Senior Leadership Development Programme was initiated in September 2023. • 2 appointments to clinical NED positions have been completed. • An Executive structure review commenced in Q3 23/24 to support the strategy implementation. • Appointments to substantive Director of Quality & Nursing, Chief Paramedic, Director of Operations and interim CDIO, completed in Q1 24/25 **Plan to Exit**: • An interim Executive structure will be maintained throughout 2024/2025, with interim positions for CFO and Director of HR and OD. • A Chief Paramedic Officer role will be established as part of the clinical leadership team, along with a new DOO. • Embedding of the clinical triumvirate model from Q3 24/25 once new Executive appointments in place. **Evidence Required**: • Leadership stability measured through re-benchmarking Organisational and Leadership Trust Index (as done by the Executive Development Programme)		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-D3	There is sustained improvements in executive cohesion and collaboration as measured through the well-led review.	**Achieved**: • There are sustained improvements in executive cohesion and collaboration as measured through the well-led review. • An Executive Development Plan was initiated at the end of September 2023. • Informal executive meetings have been taking place, encouraging proactive engagement. • Cross-referencing is evident through board papers and during the execution of the Quality Summit. • A Well-Led report was undertaken in February 2024. **Plan to Exit**: • The Trust Index, as measured by the development programme, will show improvement. • The development plan for the executive team will clearly outline how it will support cohesion of the executive team structure resulting from the structure review. • The stability of the leadership, as perceived by NHS England, will be clearly demonstrated. • Outputs of the development plan for year 2 will be developed in collaboration with the CEO and ID. • Strengthening of deputy layer of the organisation (Senior Manager Group) with clear accountabilities in delivery of the annual plan and strategic plan in line with the Board BAF, ensuring year workplan maintains a golden thread throughout the organisation. **Risk:** • The successful implementation of the new executive team structure is crucial for the long-term sustainability of the leadership team. **Evidence Required**: • Board and new Chair working as a stable and cohesive team to collectively manage risk and issues as seen by NHSE, ICB and Improvement Director • Succession plans in place for executive board roles		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-C3	The Trust has a vision for clinical leadership that is supported by a Board approved clinical education strategy.	**Achieved**: • New Head of Clinical Education appointed and due to start in September 2024. (Phase 2 of strategy). • Phase 2 of strategy in planning (local Education Leads in each Operating Unit). • The Clinical Education Strategy has been presented to and approved by the Board, providing necessary support for the investment in the Clinical Education team. • ADD System-level governance forums **Plan to Exit**: • Phase 2 of the clinical education strategy investment is expected to align with the workforce plan, which will be developed by Q4 as part of the Trust-wide strategy and subject to approval by ICBs and Commissioners. • Implementation of the Clinical Triumvirate, including Clinical Quality Leads and a reshaped Clinical Leadership structure. • Setting out of a clinical leadership development model from the Clinical Triumvirate. • Clarification of roles and responsibilities within the Clinical Leadership team and target operating models that will support a new operating regional delivery model. • The triumvirate in each Region to be developed in line with the operational restructure. **Evidence Required**: • Key appointments in place to strengthen clinical governance, setting of clinical standards and delivery of the clinical and non-clinical education portfolios.		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-G1	Clear lines of responsibility and accountability for individual executives.	**Achieved**: • Clear lines of responsibility and accountability for individual executives are established. • An Executive structure review began in Q3 23/24 and is completed to align with the new strategy. • The Executive Development Plan for 2023/2024 has completed and the phase 1 executive structure for 24/25 is completed with individual roles and accountabilities clearly mapped out. **Plan to Exit**: • The executive structure needs to embed with key new appointments in place for Chief Paramedic, CDIO and director of operations. • Re-structuring of portfolios due to happened through Q2 and Q3 24/25. **Evidence Required**: • In line with updated leadership structure, updated corporate governance developed and reflecting of new operating models for the new portfolio which clearly defines accountability and responsibility matrixes for each executive		

Progress Against Exit Criteria

South East Coast Ambulance Service NHS Foundation Trust

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-G2	Trust Board sighted on all key risks through an effective Board Assurance Framework and improved quality reporting aligned to the BAF and the comprehensive improvement plans.	**Achieved**: • An updated BAF is in place. Our annual plan and objectives feature clear SMART objectives and milestone deliverables, integrated into the new BAF, driving the Board's business cycle. • Subcommittees are showing improvements in discussions related to risk and assurance, with positive progress in implementation. Subcommittee Chairs report better insights. • The new BAF 24/25 has been signed off with in-year objectives, operating plans, and strategic programmes aligned with the strategy. • This was approved at the last public board meeting in June, and progress will be reported starting from the August 8th Board meeting. There is an agreement to recalibrate BAF risks to align with the strategy and reflect them in the Risk Register. **Plan to Exit**: • Further work is needed to fully embed strategic risks emerging from the strategic planning process in Q3/Q4, and to provide evidence that the Board is dynamically managing these risks. • Appointment of a Head of Compliance is scheduled to be completed in August 2024. **Evidence Required**: • Key changes to strengthen board assurance and governance in line with the new approved strategy and executive are implemented within what is affordable, including appointment to a Head of Compliance, re-aligning the governance to a fit-for-purpose executive structure and updating BAF objectives and risks in light of the new structure • Evidence that business discussion and Board and Committee agendas are driven by the most significant risks on the BAF		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-G3	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	**Achieved**: • In Q4 2022/23, a review of Board effectiveness and Well-Led was conducted by an NHSE Improvement Director. • All recommended actions have been adopted and are actively monitored by the relevant committees and the Board. These actions are now integral to the Board Development Plan for 2023/24. • Valuable input has been received from frontline colleagues and Operational Unit Managers (OUMs), who shared their experiences working for SECAmb during Board development sessions. Our leadership development plan is designed to support our Executives based on this feedback. **Plan to Exit**: • There will be a continued focus on Board engagement with OUMs to ensure the embedding of meaningful autonomy. • Continuation of the Board-approved development plan for 24/25 **Evidence Required**: • WLR recommendations taken into a comprehensive 2024/25 Board development plan that links to the trust's strategy		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit

RSP-G6	Comprehensive financial sustainability plan in place supported by diagnostic of deficit drivers, Quality Impact Assessment, robust efficiency plans and agreed levels of ICS investment.	**Achieved**:
		• An external review has been completed, with most actions and recommendations implemented. (22/23)
		• The Trust has broken even in 2023/24. This plan has been agreed upon and signed off by commissioners and scrutinised by NHSE, with trajectories met for the last two quarters.
		• Implementation of an internal financial recovery plan. Actions taken approved by executive management board in July including additional controls e.g. recruitment panel.
		
		Plan to Exit:
		• Development of a multi-year plan will require joint approach with commissioners and region to agree activity, commissioning and model assumptions.
		• The Trust is developing this multi-year plan in the context of the SE Ambulance Commissioning review, including maximising opportunities for collaboration with SCAS.
		
		Evidence Required:
		• Long-term roadmap identified with system partners to achieve financial sustainability through the lens of the new strategy, including a multi-year plan developed and signed off by Trust Board and ICBs with activity, income investment, workforce and clinical outcome assumptions.
		• The financial recovery plan needs to achieve:
		  • The plan sets a trajectory to recurrent financial balance and has been stress-tested to ensure timescales for this are optimised.
		  • It enables the Trust to make progress with implementation of its refreshed strategy to deliver better care and financial sustainability in a way that is financially affordable to the Trust and ICBs.
		  • The plan will incorporate the opportunities from the SE-wide ambulance review as these are worked up through the new steering group.		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-G7	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.	**Achieved**: • An external review has been completed, with most actions and recommendations implemented. (22/23) • The Trust has broken even in 2023/24. This plan has been agreed upon and signed off by commissioners and scrutinised by NHSE, with trajectories met for the last two quarters. • Implementation of an internal financial recovery plan. Actions taken approved by executive management board in July including additional controls e.g. recruitment panel. **Plan to Exit**: • In developing our strategy, the Trust will agree on a cost model to support its proposed operating model with system leads. • The Trust is developing this multi-year plan in the context of the SE Ambulance Commissioning review, including maximising opportunities for collaboration with SCAS. **Evidence Required**: • Agreement with system partners what is the multi-year plan approach to support implementation of the trust strategy		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-HR3	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	**Achieved**: • HR reporting has improved, providing a clear understanding of ER caseload and challenges. • New HRD appointed in Q1 of 24/25 – diagnostics has been completed and shared, including of previous external review of HR (SG report) • Re-started JPF following ACAS mediation with Unions • HR Improvement Plan at Board Development in September 24. **Plan to Exit**: • Re-structuring of HR team to increase capacity and capability across specific functions (ER, HRBP, Wellbeing, L&OD) • Agreeing new TOR for JPF and re-starting ACAS mediation discussions to develop 12 month joint forward plan • Solution requirements are being captured for Learning Management and Digital Appraisal products, capable of linking to ESR to support Employee, Supervisor and Manager Self Service. Once the requirements are captured, these will be signed of by the Exec Team (Board) and procurement will commence. **Evidence Required**: • Conclusion of ACAS mediation and evidence of a functioning JPF for 12 months, including approval of a new recognition agreement, agreed updated JPF TOR and a 12-month joint forward plan • Evidence of implemented changes in line with an agreed recovery plan by interim HRD		

Progress Against Exit Criteria

RSP ref.	Requirement Description The Trust must:	Position Statement	Progress	Risk to Exit
RSP-Co2	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	**Achieved**: • There has been a significant increase in leadership visibility and Pulse Survey responses, which improved from 812 (April 2023) to 901 (July 2023). This positive change spans various areas, including employee engagement, advocacy, involvement, motivation, colleague mood, support from team members, being well informed about changes, and proactive support in health and wellbeing. • The Staff Survey was completed by over 60% of respondents. • National Quarterly Pulse Survey (NQPS) Engagement Scores improved from 4.3 to 5.3 between July 2022 and July 2023. • Staff Survey Results Engagement Scores improved from 5.4 to 5.9 between autumn 2022 and autumn 2023. • Completion of year 1 of the People and Culture implementation plan, addressing approximately 40 issues identified by colleagues. • Star of the month, recognition platform **Plan to Exit**: • Integrated people plan for year 2 is under development in line with the strategy. Focus on retention, EDI, and wellbeing. • Re-structure of HR directorate includes creation of a “Communications and Engagement” team – historically, separate teams. This will be followed by a new engagement framework. **Evidence Required**: • Evidence of the engagement plan implemented • Continued improvement in survey results		

BRAGG Scoring Criteria

	Project, **Milestone** or **Criteria** has been achieved and embedded **Risks** have been fully mitigated
	Project, **Milestone** or **Criteria** is at high risk of not being met or already off-track **Risks** have significant impact on project outcomes and/or timeline
	Project, **Milestone** or **Criteria** is at some risk of not being completed **Risks** have moderate impact on project outcomes and/or timeline
	Project, **Milestone** or **Criteria** is on track to be completed in time **Risks** have low impact on the delivery of the project
	Project, **Milestone** or **Criteria** has just started being worked on, resources have not been deployed, and it's too early to tell

Version	Noted Changes	Date
V.1.0	First Submission of BAF	Aug-24
V.1.1	Review & Update of first submission Changes: - Virtual Care Hubs Executive Lead updated (DoO to DoQ/CN) - Strategic Transformation Plan Overview updated to reflect decision of 4 key priorities under people improvement and removal of "Getting Things Right for Our People" objectives - Highlight report – Getting things right for our people removed as all elements now out of scope except ER which has been added to People Improvement Plan	Sep-24

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Integrated Quality Report

Trust Board – October 2024

Reporting Period: July & August 2024

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.

Our Objectives for 24/25

South East Coast Ambulance Service NHS Foundation Trust

We deliver high quality patient care

- Delivery of Performance Targets
- Increase our volunteer workforce by 150
- Improve Cardiac Arrest outcomes and Stroke outcomes
- Implement 5 unscheduled care navigation hubs
- Rollout of Clinical Supervision
- Quality Account and Patient Safety Framework
- Quality Improvement

Our people enjoy working at SECAmb

- Leadership Re-structure
- Leadership Development
- Review our HR and OD Model
- New engagement framework
- Culture Improvement
- Honour the forward liabilities for legacy pay issues

We are a sustainable partner as part of an integrated NHS

- Improve our internal controls and deliver our deficit plan
- Develop an agreed multi-year plan to break-even
- Progress collaboration opportunities with partners
- Refresh our strategic commissioning framework supported by our new models of care
- Develop and begin to deliver on a digital strategy

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Sustainability & Finance

SUSTAINABILITY & FINANCE

Delivery Against Plan

	August 2024 In the month			April 2024 to August 2024 Year to date			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income	26,924	28,292	1,369	134,618	137,357	2,739	328,886	333,198	4,313
Operating Expenditure	(27,487)	(28,854)	(1,367)	(138,779)	(139,515)	(735)	(339,381)	(341,696)	(2,316)
Trust Surplus/(Deficit)	***(563)***	***(562)***	***1***	***(4,161)***	***(2,158)***	***2,003***	***(10,495)***	***(8,498)***	***1,997***
Reporting adjustments:									
Remove Impact of Donated Assets	*0*	*0*	*0*	*1*	*1*	*0*	*2*	*2*	*0*
Remove Impact of Impairments	*0*	*0*	*0*	*0*	*(1,997)*	*1,997*	*0*	*(1,997)*	*1,997*
Reported Surplus/(Deficit)	**(563)**	**(562)**	**1**	**(4,160)**	**(4,154)**	**6**	**(10,493)**	**(10,493)**	**0**

Cash	31,571	28,095	(3,476)	31,571	28,095	(3,476)	29,249	29,249	0
Capital Expenditure	653	443	210	2,918	4,158	(1,240)	22,338	22,338	0
Efficiency Target	1,441	1,166	(275)	8,803	7,266	(1,537)	23,926	23,926	0

*values subject to rounding

Summary

1. The Trust is monitored according to it's 'control total' by NHS England, thus the difference between the Trust's position and the reported position removes the value of impairments or its reversal for assets because of valuations as well as donated assets. The commentary reflects this reported position. The Trust's agreed deficit plan is £10,493k.

2. For the year up to the end of August 2024, the Trust's financial performance was £6k better than planned. This is driven by lower than planned profits on disposal because of delays in selling Trust assets offset by income for the new Adult Critical Care Service and underspend across the Trust because of vacant positions within support and Corporate functions, favourable fuel rates, and reduced clinical supplies due to lower activity levels. The additional non-recurrent income to maintain the C2 performance level that were offset by associated cost.

3. The efficiency programme is £1,537k behind plan, partly due to the delays in the planned sale of Trust assets.

4. In M05 cash receipts exceeded payments by £3,071k which has improved the cash balance by that amount compared to M04. The Trust's cash position was £28,095k that is £3,476k lower than plan. This is due to earlier than planned capital investments and other timing differences, which are expected to reverse during the financial year.

5. Capital expenditure of £4,158k is £1,240k above plan year to date. This is due to the timing in receiving DCA (Double Crewed Ambulances) which have been received earlier than planned.

What actions are we taking?

1. Finance continues to work with budget holders to ensure that Trust delivers its plan for future years.

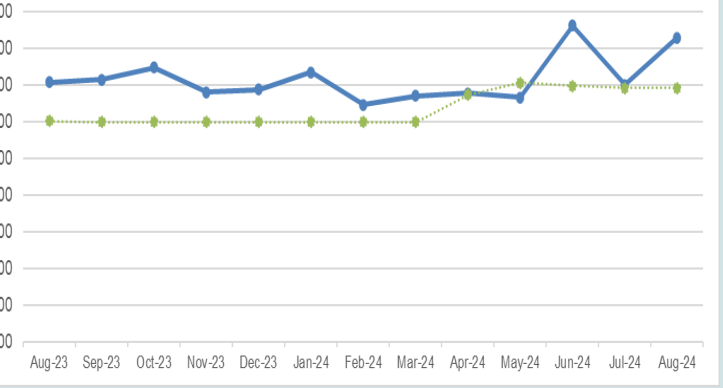
2. Regular updates are being provided to the Joint Leadership Team meetings, Senior Management Group meetings and Finance and Investment Committee on financial performance, including delivery of the efficiency plans.

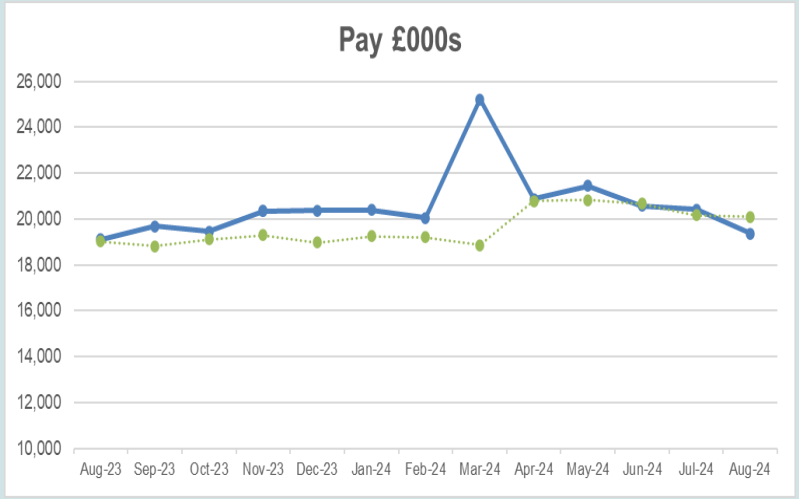
3. Monthly budget holder financial performance meetings are continuing to take place to ensure that each directorate delivers their element of the financial plan e.g., budget and efficiency target.

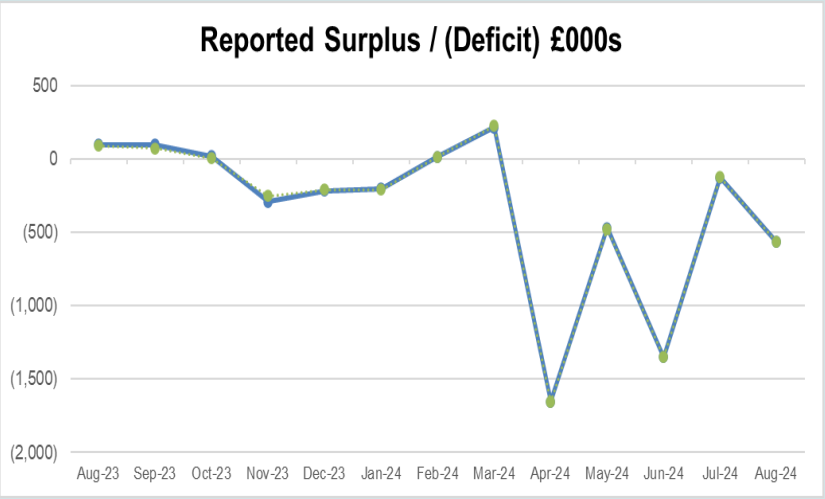
4. The Trust has developed its 2024/25 operating plan that aligns with strategy and partnership working.

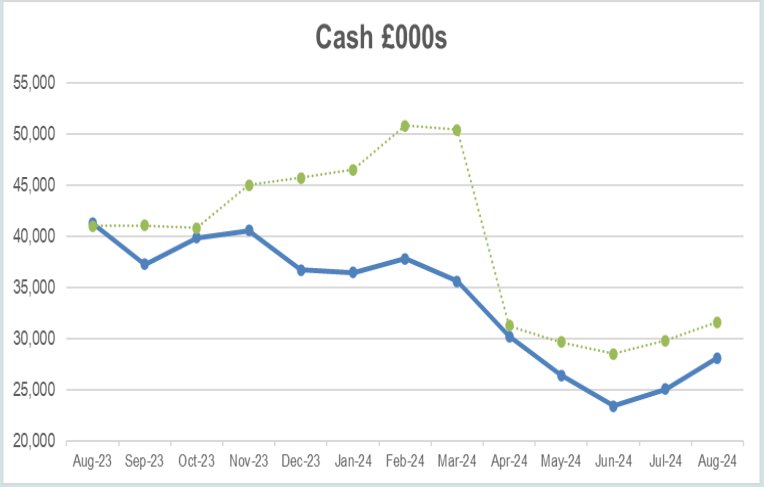
SUSTAINABILITY & FINANCE

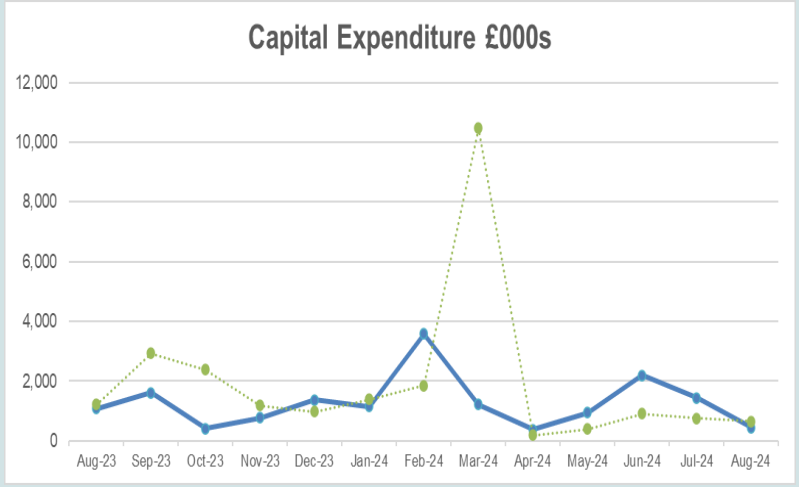
Delivery Against Plan











Summary

- The Trust's financial performance was £6k better than planned for 5 months to August 2024 when compared to the plan.
- The financial performance in all our key business areas were on track. However, this is largely due to the transfer of operations costs to the £2.5m additional non recurrent fund. Effective controls and mitigations are in place to ensure the subsequent run rate of spend for the rest of the financial year remains in line with the expected assumptions to facilitate the delivery of the planned £10.5m deficit.
- The main areas to highlight from the graphs are the surge in August 2024 relating to pay for the historic application of Section 2 of Agenda for Change and the ECSW re-grading from Band 3 to Band 4, when payments were made to staff. Capital expenditure was behind plan in March due to delays in receiving DCA vehicles.

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Appendix

Appendix 1: Glossary

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

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	61/24

Name of meeting	Trust Board
Date	3 October 2024
Name of paper	Finance & Investment Committee Assurance Report – 26 September 2024
Author	Howard Goodbourn Independent Non-Executive Director – Committee Chair

INTRODUCTION

The Finance & Investment Committee is guided by a cycle of business that aligns with the Board Assurance Framework – strategic priorities; operating plan commitments; compliance; and risk. This assurance report provides an overview of the most recent meeting on 26 September 2024 and is one of the key sources that the Board relies on to inform its level of assurance. It is set out in the following way:

- **Assure**: where the committee is assured
- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Advise**: items for the Board's information

ASSURE

Financial Performance / Efficiencies 2024-25

The trust is on target to meet its financial plan for the year and the committee is confident this will be delivered. The efficiency programme at month 5 is £1.5m adverse to the plan, but with over half of this due to the timing of an anticipated property disposal. The remainder is spread across several cash releasing schemes and there are mitigations in place with good assurance this will deliver.

The process this year for the efficiency programme was commended by the committee, with close oversight by the Senior Management Group. This has ensured cross directorate ownership with good levels of engagement that the committee heard has helped empower budget holders.

Financial Controls

The committee is assured with the progress in strengthening the financial controls, including the work to update the standing financial instructions that were reviewed by the Audit & Risk Committee and procurement (see section below).

Operational Performance

There continues to be a good level of assurance with the effective management of operational performance; the C2 mean is being met and call handling is in line with ARP. Hear & Treat is central to the clinical strategy and is slightly below the trajectory, although there is a reasonable level of confidence in delivering the 17% target by year end. The committee will review this at the next meeting to better understand the impacts of the different levers.

The trust is doing all it can, in line with its commitments, to ensure implementation of the Unscheduled Care Navigation Hubs. This relies also on our system partners and discussions are ongoing about the findings risk linked to provision of clinicians by the other providers.

ALERT

Financial Sustainability Plan

This is one of the BAF risks and in terms of actions within our control, the committee is assured that the executive is doing all it can. As part of the new financial controls there is now a more robust annual planning cycle; this will help ensure early (by the end of Q3) clarity on where we need to invest and allocate resources to help deliver against our strategic aims. The early planning assumptions / principles that we have shared with commissioners, will likely provide for a plan that is in deficit up to 2027/28. This will require ongoing dialogue with our partners to inform what we can reasonably take forward and where risks will need to be managed. It will be a key feature of the Board's ongoing planning discussions and, acknowledging the many interdependencies, the committee has asked for these to be mapped out to inform the decisions the Board will need to make over the coming months.

Digital Strategy

The strategy was reviewed, and the committee recommends its approval by the Board. The decision on resources will be taken as part of the planning cycle, but the committee believes this strategy offers significant opportunities and is a key enabler of the trust's strategic aims.

Procurement

The committee is increasingly assured with the controls being put in place to ensure more robust procurement and contract management. It reviewed the strategy and recommends its approval by the Board.

At this most recent meeting the Head of Procurement provided an update on our readiness for the new Procurement Regulations, which are now slightly delayed and will come in to force from 24 February 2025. The strategy and related actions are helping to support our readiness for these new regulations.

ADVISE

Fleet Performance

The vehicle off road (VOR) rate recently reported to the Board has since improved from 16% to 14%. This risk, which is caused by the profile of the fleet and challenges with recruitment of technicians, is being actively managed with a key control being the fleet replacement plan. The analysis of the risk demonstrated that the likelihood of crews being prevented from going on the road is low. A related risk (planned safety inspections) is also being well managed, and while compliance needs to improve, this is not having an adverse impact on fleet availability.

Estates Performance

Statutory Compliance Controls & Planning: performance against the Service Level Agreement criteria is at a satisfactory level 99%. For context the trust spends £200k and completes one thousand planned

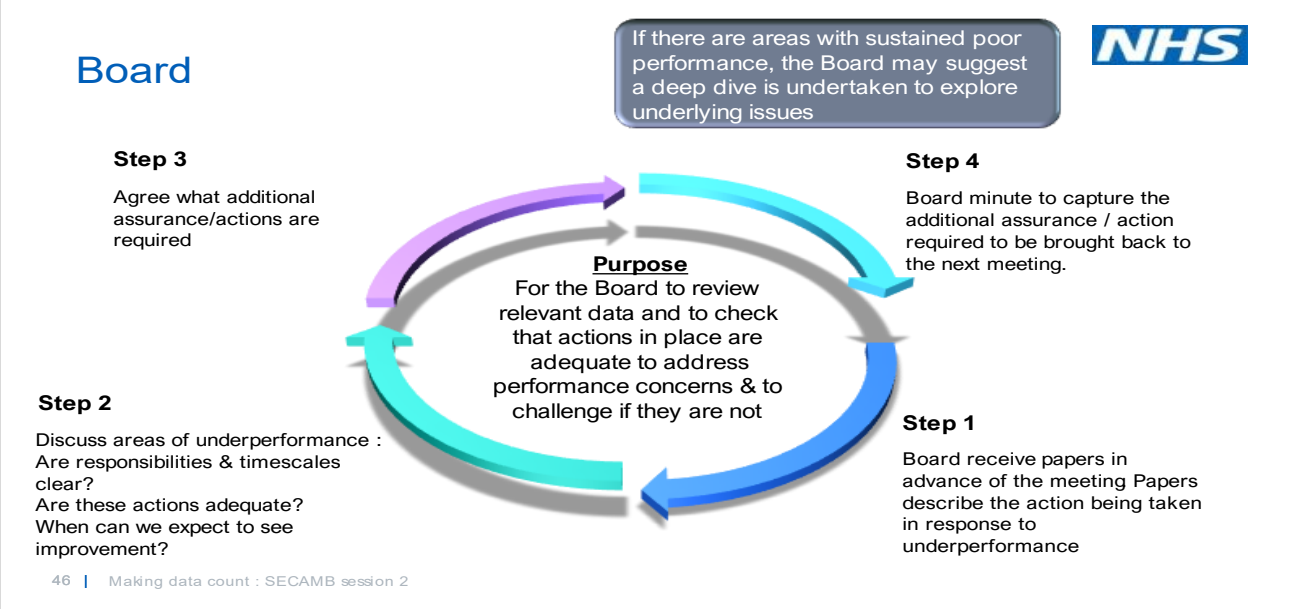
maintenance and re-active repairs every month. Particular attention is being focussed on our Fire Risk Assessment remedial work, with priority being on fire doors. The Strategic Estates Management Group has a high level of confidence in the assurance concerning our statutory compliance, and the recent changes to improve local reporting and follow ups. Work is underway to refresh the estates strategy, which the committee will review in early 2025-26.

Patient Level Information & Costing System

The trust's submission shows a 2.0% increase in cost per incident compared to 2022/23. This is a combination of a 2.5% increase in activity, and 4.6% increase in cost quantum, mostly driven by the pay award. Once we are satisfied that the information is robust and comparable between ambulance trusts, the plan is to use it to enhance our reporting at business sector level, inform contract discussions, add financial values to productivity metrics and undertake benchmarking exercises. In the meantime, the committee felt that it could be used to help assess the impact of the Hubs on the system level costs.

Recommendation

The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle



South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	61-24

Name of meeting	Trust Board
Date	3 October 2024
Name of paper	M05 (August 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 £6k favourable variance against its planned deficit of (£4,160k) for the year to August 2024 (YTD). This includes an additional anticipated £2,217k of funding, supporting C2 mean improvement in line with the NHS England approved bid matched by cost of the additional resources provided by Operations. The planned efficiency programme was £1,537k adverse to the plan. £843k of the shortfall is due to the timing of the anticipated Crawley sale. The remainder £694k underachievement is spread across several cash releasing schemes. The Trust has mitigations in place and is on track to deliver its agreed financial deficit plan of (£10,493k) for the year ending 31 March 2025. In M05 cash receipts exceeded payments by £3,071k which has improved the cash balance by that amount compared to M04. The M05 closing cash was £3,476k lower than planned due to earlier than planned capital investments and other timing differences, which are expected to reverse during the financial year.
Recommendations, decisions, or actions sought	The Board is asked to note financial performance for the year to August 2024 (M05) of the 2024/25 financial year

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

South East Coast Ambulance Service NHS
NHS Foundation Trust

2024/25
Finance Report to the Board of Directors
5 Months to 31 August 2024

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Executive Summary

The Trust reported a £4,154k deficit for the year to (YTD) August 2024 in line with plan. The Trust's forecast deficit remains a deficit of £10,493k.

	Year to August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	134,618	137,357	2,739	328,886	333,198	4,313
Expenditure	(140,117)	(140,037)	81	(341,103)	(343,445)	(2,343)
Planned Profit on Sale of Assets	1,338	522	(816)	1,722	1,749	27
Trust Surplus / (Deficit)	**(4,161)**	**(2,158)**	**2,003**	**(10,495)**	**(8,498)**	**1,997**
Reporting adjustments:						
Remove Impact of Donated Assets	1	1	0	2	2	0
Remove Impact of Impairments	0	(1,997)	(1,997)	0	(1,997)	(1,997)
Reported Surplus / (Deficit)*	**(4,160)**	**(4,154)**	**6**	**(10,493)**	**(10,493)**	**0**

Efficiency Programme	8,803	7,266	(1,537)	23,926	23,926	0
Cash	31,571	28,095	(3,476)	29,249	29,249	0
Capital Expenditure	2,918	4,158	(1,240)	22,338	22,338	0

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

Year to August 2024 (YTD)

- For August 2024, the Trust's financial position is in line with the plan. However, there are both adverse and favourable variances in the overall financial performance. The adverse variance is mainly due to increased operational costs, driven by the additional pay resources of £2,232k to maintain the C2 performance, which is funded from the £2,500k non-recurrent income. The expected profit on disposal is also below plan by £816k due to delays in the sale of properties. This is partly mitigated by favourable variances in other directorates, particularly in Strategic Partnership & Transformation (SP&T) and Medical, which are further detailed below.

- The Trust's deficit plan of £10,493k is based on the delivery of £23,926k of efficiencies, which is 6.6% of the Trust's planned operating expenditure.
    - Plans have been identified for 96.9% of the £23,926k target, which includes the entire non-cash releasing element valued at £19,176k recognised during the planning process.
    - Cash-releasing schemes worth £4,001k have been developed YTD. £2,759k of these schemes have been fully validated and transferred to the delivery phase, which is an improvement of £1,067 since last month. This leaves 1,242k schemes that require Executive Director and/or QIA approval before moving to delivery.
    - For YTD, August 2024, the Trust has delivered £7,266k efficiencies that is £1,537k below the target. 83.4% of the savings were generated on a recurrent basis with 16.6% non-recurrently.
    - Of the £7,266k savings, £6,904k are non-cash releasing, against the plan of £7,747k. The shortfall remains £843k adverse to plan due to a delay in the planned property sales.

  - Cash-releasing savings of £362k are £694k below the plan because of the delays in realising expected process improvements, operational efficiencies, and contract reviews.
- The overall efficiency program is currently rated as amber risk. However, further work is continuing with the Senior Management Group (SMG) to develop sustainable plans to achieve the 2024/25 target.

- The closing M05 YTD actual cash position of £28,095k is a £3,071k higher compared to last month, however it is £3,4760k less than planned. The shortfall against plan is a timing difference which is expected to reverse during the financial year. During M05 receipts, which included predominantly payment from Commissioners for core services (96%) were £3,071k higher than payments made to staff and suppliers. However, year-to-date cash expenditure was higher than planned in the early part of the financial year, mainly due to timing of capital spend and payment of backdated banding uplift to ECWS earlier than anticipated within the plans. The forecast closing cash balance is £29,249k.

- Capital expenditure of £4,158k is £1,240k above plan.

- The reversal of £1,997k impairment is based on asset revaluation. The reversal of the impairment had a positive impact on the Trust's position, however this benefit from revaluation is removed and adjusts the reported position to (£4,154k) deficit in line with plan. An impairment and its reversal are adjusted for in the financial position and is treated as an allowable adverse or favourable movement against assets value which has also been agreed with auditors.

Full Year Forecast

- For the year ending March 2024, the Trust is projecting to meet the agreed planned deficit of £10,493k.

- The following provides further detail of the elements of the financial position.

1. Income

	Year to August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	120,872	123,089	2,217	290,092	292,844	2,752
111 Income	11,568	11,527	(41)	27,763	27,730	(33)
HEE Income	1,119	1,002	(117)	2,605	2,896	291
Other Income	1,059	1,739	680	8,426	9,728	1,303
Total Income	**134,618**	**137,357**	**2,739**	**328,886**	**333,198**	**4,313**

- 999 income is £2,217k greater than plan, this is from the anticipated additional income (£2,500k) from NHS England to support funding the additional resources required to improve C2 mean performance.

- 111 income is £41k below plan, this is due to the reduction in the cost of prescription fees, that is recharged to commissioners and subsequently is offset by the decrease in expenditure.

- HEE (Health Education England) income is £117k below plan. This reflects the most recent funding schedules received for 2024/25 and the reduced planned expenditure for some the ongoing projects (mainly for the advance clinical paramedic (PP)) and is a timing issue matched to the actual expenditure.

- Other income is £680k above plan, mainly through additional income from the new Adult Critical Care Service (£326k) and the sale of obsolete equipment.

2. Expenditure

The below table shows the 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 August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(1,809)	(1,899)	(90)	(4,175)	(4,858)	(683)
Finance	(6,515)	(6,620)	(105)	(15,780)	(16,685)	(905)
Quality and Safety	(1,440)	(1,486)	(46)	(3,440)	(3,469)	(29)
Medical	(8,055)	(7,512)	543	(19,645)	(19,592)	53
Operations	(78,580)	(80,426)	(1,846)	(189,899)	(190,118)	(219)
Operations - 111	(11,753)	(11,413)	340	(28,163)	(28,269)	(106)
Strategic Planning & Transformation	(12,571)	(11,828)	743	(29,966)	(29,340)	626
Human Resources	(2,315)	(2,476)	(161)	(5,528)	(5,913)	(385)
Total Directorate Expenditure	**(123,038)**	**(123,660)**	**(622)**	**(296,596)**	**(298,244)**	**(1,648)**
Depreciation	(7,162)	(7,477)	(315)	(19,196)	(19,872)	(676)
Financing Costs	(356)	(253)	103	(854)	(752)	102
Corporate Expenditure	(5,130)	(6,395)	(1,265)	(13,840)	(15,831)	(1,991)
Total Expenditure	**(140,117)**	**(140,037)**	**81**	**(341,103)**	**(343,445)**	**(2,343)**
Planned Profit on Sale of Assets	1,338	522	(816)	1,722	1,749	27
Total Trust Expenditure	**(138,779)**	**(139,515)**	**(735)**	**(339,381)**	**(341,696)**	**(2,316)**

*Excludes Income

Year to Date performance against plan

- Total expenditure at year to August 2024 was £139,515k, and £735k worse than plan (please note £1k difference on "variance" is due to rounding).

- The net overspend is a combination of adverse variances in Operations of £1,846k. This is largely due to the additional capacity resources of £2,232k costs matched by £2,217k worth of income and favourable variances across other directorates as explained below.

- The YTD Operations spend, excluding the additional capacity cost of £2,232k, is £387k below budget. This is largely driven by the following factors:
    - A favourable variance of £354k in Specialist Operations due to the timing of various planned spend, notably underspent on protective clothing of £103k and vehicle expenses.
    - Although there are current pressures in EOC amounting to £183k, this is expected to align with the plan following the review of clinicians working dualling across the cost centres costs requiring transfer to NHS 111. The international clinicians become operational in September, and the need for agency support at a premium and overtime in Quarter 1 reduces.
    - The Field Operations spend is £266k below plan despite the over-establishment of staff. This is mainly due to reduced overtime, time off in lieu (TOIL) payments, and timing of new recruits' resulting in an underspend of £448k. Additionally, a decrease of 27.1% in the provision of hours by Private Ambulance Providers in Quarter 1 led to an underspend of £355k. However, these are offset by the YTD bank staff costs of £508k.

- The financial performance of our NHS 111 service shows a favourable variance of £340k compared to the plan. £289k of this is due to lower spending on clinician pay, which is currently being charged to EOC and will be adjusted after the staffing review. The

remaining underspend of £51k is spread across several expense categories, particularly in the timing of uniforms, training, and travel, which is helping to offset higher costs of £73k in our sub-contract charges with IC24.

- There were favourable variances across other directorates, including vacancies in support and back-office functions of £525k due to the timing of recruitment, particularly within Medical and the Contracting team within Finance. In addition, non-pay costs in SP&T were £743k lower than expected, largely due to the reduced fleet costs of £467k because the lower fuel rate of £1.47 per litre compared to the planned £1.60 resulted in £399k underspend and lease costs were £68k below plan due to timing. Logistics also underspent by £251k, largely due to reduced clinical equipment costs. These are partly offsetting the overspending of £161k in HR, due to the additional senior management and employee relations positions to improve service delivery and are expected to contribute to planned efficiency schemes.

- Finance costs is contributing an additional £102k 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) (please note £1k difference on "variance" is due to rounding).

NHSE Categories	Year to August 2024			Forecast to March 2024		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Pay/Staff Costs	(101,034)	(101,517)	(483)	(247,753)	(251,980)	(4,227)
Depreciation	(7,162)	(7,477)	(315)	(19,197)	(19,871)	(674)
Premises Costs	(8,922)	(8,657)	265	(21,698)	(21,755)	(57)
Transport Costs	(7,492)	(6,700)	792	(18,036)	(17,248)	788
Purchase of Healthcare (PAPs;IC24;HEMS)	(5,301)	(5,015)	286	(10,582)	(10,296)	286
Supplies and Services	(4,211)	(3,896)	315	(10,277)	(10,093)	184
Establishment	(2,347)	(2,247)	100	(5,623)	(6,040)	(417)
Education Costs	(850)	(766)	84	(2,199)	(2,494)	(295)
Operating Lease Expenditure	(845)	(619)	226	(2,028)	(1,768)	260
Finance Costs	(356)	1,745	2,101	(855)	1,246	2,101
Clinical Negligence (CNST)	(820)	(852)	(32)	(1,967)	(2,000)	(33)
Other	(777)	(4,036)	(3,258)	(887)	(1,146)	(259)
Total Expenditure	**(140,117)**	**(140,037)**	**81**	**(341,102)**	**(343,445)**	**(2,342)**
Planned Profit on Sale of Assets	1,338	522	(816)	1,722	1,749	27
Total Trust Expenditure	**(138,779)**	**(139,515)**	**(735)**	**(339,380)**	**(341,696)**	**(2,315)**

Full year performance against plan

- As of August 2024, the Trust is forecasting achievement of plan.

- Additional costs in pay are offset by the additional expected funding to support C2 mean performance and underspend in other directorates.

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 August 2024			Month of August 2024			Vacancies* - August 2024		
	Jul-24	Aug-24	Movt	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	50.8	48.5	(2.3)	50.8	48.5	2.3	50.8	48.5	2.3
Finance	44.4	40.4	(4.0)	44.3	40.4	3.9	44.3	39.3	5.0
Quality and Safety	53.7	53.4	(0.3)	53.7	53.4	0.3	53.7	59.1	(5.4)
Medical	224.0	200.9	(23.2)	224.0	200.9	23.2	224.0	195.8	28.2
Operations	3,726.4	3,623.8	(102.6)	3,730.3	3,623.8	106.4	3,730.3	3,461.3	269.0
Operations - 111	428.3	404.9	(23.4)	428.3	404.9	23.4	428.3	384.9	43.4
Strategic Planning & Transformation	139.0	141.6	2.6	139.0	141.6	(2.6)	139.0	138.4	0.6
Human Resources	72.6	74.1	1.5	72.6	74.1	(1.5)	72.6	73.1	(0.5)
Digital	54.0	56.5	2.5	54.0	56.5	(2.5)	54.0	54.0	0.0
Total Whole Time Equivalent (WTE)	**4,793.3**	**4,644.1**	**(149.2)**	**4,797.0**	**4,644.1**	**152.9**	**4,797.0**	**4,454.4**	**342.6**

*Excludes 3rd Party Providers (PAPs)

*Net Funded WTE less Contracted (ESR) WTE

- 149.2WTE less was provided in August compared to last month, mainly in Operations and 111 as resources were reduced following review of rotas and reflects seasonality.

- The Trust is 152.9WTE below plan for August, this is mainly seen in Operations, as noted above, 111 and Medical, linked to current vacancies. Operational vacancies are supported by overtime and bank.

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 August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	134,618	137,357	2,739	328,886	333,198	4,313
Expenditure	(138,779)	(139,515)	(735)	(339,381)	(341,696)	(2,316)
Surplus / (Deficit)	**(4,161)**	**(2,158)**	**2,003**	**(10,495)**	**(8,498)**	**1,997**

999 (Emergency Services)	Year to August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	121,679	124,038	2,359	297,832	300,897	3,066
Expenditure	(125,439)	(126,940)	(1,502)	(307,289)	(308,657)	(1,368)
Surplus / (Deficit)	**(3,759)**	**(2,902)**	**857**	**(9,458)**	**(7,760)**	**1,698**

111 (KMS)	Year to August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	11,568	11,527	(41)	27,763	27,730	(33)
Expenditure	(11,753)	(11,413)	340	(28,162)	(28,268)	(106)
Surplus / (Deficit)	**(185)**	**114**	**299**	**(399)**	**(538)**	**(139)**

Other	Year to August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	1,371	1,792	421	3,291	4,570	1,280
Expenditure	(1,587)	(1,161)	426	(3,929)	(4,771)	(842)
Surplus / (Deficit)	**(216)**	**630**	**847**	**(638)**	**(200)**	**438**

- 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, Adult Critical Care Transfer Service, Gatwick Airport, 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 £857k better than plan for the YTD, mainly driven by the reversal of the impairment (£1,997k).

- 111 is £299k better than plan, as noted above.

- Other is £847k better than plan from reduced planned expenditure within the HEE education projects, mainly through timing, the Adult Critical Care Transfer Service is contributing £240k.

5. Efficiency Programme

- The Trust's agreed financial plan deficit of £10,493k for 2024/25 is predicated on the delivery of a £23,926k efficiency target, which represents 6.6% of operating the expenditure.

Pipeline Tracker - Cash Releasing and Non-Cash Releasing Efficiencies

Scheme Category	Fully Validated	Validated	Scoped	Total Schemes	Proposed	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Digital Productivity	167	-	-	167	-	167
Discretionary Non Pay	73	-	-	73	-	73
External consultancy & contractors	-	-	51	51	-	51
Fleet - Other Efficiencies	100	-	-	100	-	100
Hear and Treat improvement	1,629	-	-	1,629	-	1,629
Income generation	1,722	-	-	1,722	-	1,722
Medicines Management - Drugs	93	-	-	93	-	93
Medicines Management - Equipment	44	-	-	44	-	44
Operations Efficiencies	1,307	-	-	1,307	-	1,307
Optimisation in establishment - clinical	2,350	-	-	2,350	-	2,350
Optimisation in establishment - non clinical	3,023	-	23	3,046	-	3,046
Policy & Process review	521	-	-	521	-	521
Policy, Process &Service reviews & re design	9,871	-	-	9,871	-	9,871
Procurement contracts review	-	-	168	168	299	467
Recruitment & Retention optimisation	-	-	1,000	1,000	-	1,000
Reduction in Sickness Absence	620	-	-	620	-	620
Savings following sale of property	267	-	-	267	-	267
Service Improvement SCAS Collaboration	-	-	-	-	450	450
Supply Chain review	148	-	-	148	-	148
Grand Total	21,935	0	1,242	23,177	749	23,926

- As shown in the table above, we have developed efficiency plans totalling £23,177k, which is 96.9% of our target of £23,926k. This comprises 35 fully validated schemes worth £21,935k that have been moved to the delivery phase. Out of this, the total non-cash releasing target of £19,176k has been established from the 16 schemes identified during the planning stage.

- 27 cash-releasing schemes have been developed YTD, which represents 84.2% of the £4,750 cash-releasing target. This includes the £450k expected from the SCAS collaboration.
    - 19 schemes equalling £2,759k have been transferred to the delivery phase. This is an improvement of 4 schemes valued at £1,067k that moved from "validated" to delivery since last month.
    - There are 8 schemes amounting to £1,242k that have been scoped and are pending executive directors' approval before undergoing QIA review.
- 16 schemes have been identified and are under development to bridge the current gap of £749k including the anticipated SCAS collaboration savings.

Summary of YTD Efficiency Delivery - Cash-releasing and Non-Cash releasing

2024-25 M5 Efficiencies Status	Plan YTD M05			Actuals YTD M05				Full Year Plan			Full Year Forecast Fully Validated Schemes			
	Recurrent	Non Recurrent	Total	Recurrent	Non Recurrent	Total	Variance	Recurrent	Non Recurrent	Total	Recurrent	Non Recurrent	Total	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cash Releasing Efficiencies	1,056	0	1,056	322	40	362	(694)	4,750	0	4,750	2,123	636	2,759	(1,991)
Non-Cash Releasing Efficiencies	5,957	1,790	7,747	5,740	1,164	6,904	(843)	16,373	2,803	19,176	16,373	2,803	19,176	0
Total Efficiencies	**7,013**	**1,790**	**8,803**	**6,062**	**1,204**	**7,266**	**(1,537)**	**21,123**	**2,803**	**23,926**	**18,496**	**3,439**	**21,935**	**(1,991)**
Recurrent /Non recurrent percentage	*79.7%*	*20.3%*		*83.4%*	*16.6%*			*88.3%*	*11.7%*		*84.3%*	*15.7%*		

- Delivery of £7,266k efficiency savings YTD August 2024, is £1,537k below plan.
- Recurrent savings represent 83.4% of the total savings compared to the plan of 79.7%. While 16.6% of the schemes were generated non recurrently.
- 95.0% of the £7,266k savings relate to non-cash releasing schemes. This is however £843k below plan due to the delays in the planned sale of properties.
- The YTD cash-releasing efficiency of £362k is 65.7% worse than the plan. The shortfall of £694k is due to several factors, including underachievement in planned efficiencies across Operations (£264k), timing of expected service and process improvements (£170k), procurement contract review in Finance and HR (£160k), and delays in service productivity (£100k), as detailed in the directorate summary below.

Summary of YTD Efficiency Delivery - Cash releasing by Directorate

Directorate / Business Areas	YTD M05 Plan	YTD M05 Actuals	Variance		Full Year (FY) Plan	FY Forecast Fully Validated	Variance	
	£000	£000	£000		£000	£000	£000	
Chief Executive Office	9	18	8	✓	42	42	0	✓
Finance & Corporate Services	237	0	(237)	✗	1,061	267	(794)	✗
HR	222	0	(222)	✗	1,000	0	(1,000)	✗
Medical	89	73	(16)	✗	399	399	0	✓
Operations	314	50	(264)	✗	1,414	1,414	0	✓
Quality & Nursing	7	3	(4)	✗	31	205	174	✓
Strategic Planning & Transformation	58	142	84	✓	261	340	79	✓
Digital and Information	20	77	56	✓	92	92	0	✓
Trust wide	100	0	(100)	✗	450	0	(450)	✗
1,057	**362**	**(695)**		**4,750**	**2,759**	**(1,991)**	

- We are currently forecasting to deliver the underlying planned 2024/25 efficiency target. However, the efficiency program is currently risk-rated “amber” due to dependencies affecting the savings realisation of multiple large value schemes.
- In addition, most of the cash-releasing efficiencies are expected to be realised in the second half of the year, which may prove challenging due to winter pressures on operations faced by the Trust during that time.

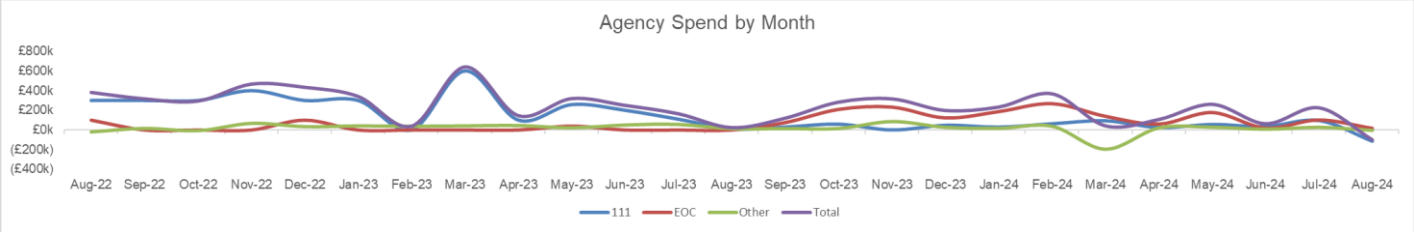
- SMG leads are working with their Finance Business Partners (FBPs) to:
    - develop identified initiatives and progress them through the Executive Director/QIA and delivery phase to reduce the current cash-releasing forecast variance of £1,991k.
    - drive the development of sustainable schemes and explore new opportunities to mitigate potential risks to ensure the delivery of their directorate's allocated cash-releasing target.
- Regular updates are provided to SMG, the Joint Leadership Team, and the Finance and Investment Committee.

6. Agency

	Year to August 2024			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Agency Expenditure	(805)	(538)	267	(1,932)	(1,932)	0

- Overall spend with agencies is £267k less than planned. A review of agency costs was undertaken in August, resulting in a reduction in agency spend in NHS 111.

- Majority of the agency spend for the year to date was in EOC (£286k) and NHS 111 (£97k).



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	98,624	(1,407)	97,217	97,966
Intangible Assets	1,593	256	1,849	2,131
Trade and Other Receivables	0	0	0	0
Total Non-Current Assets	**100,217**	**(1,151)**	**99,066**	**100,097**
CURRENT ASSETS				
Inventories	2,791	119	2,910	2,684
Trade and Other Receivables	14,617	(841)	13,776	6,739
Asset Held for Sale	1,373	0	1,373	1,953
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	25,024	3,071	28,095	35,568
Total Current Assets	**43,805**	**2,349**	**46,154**	**46,944**
CURRENT LIABILITIES				
Trade and Other Payables	(32,837)	(3,036)	(35,873)	(34,236)
Provisions for Liabilities and Charges	(15,683)	1,622	(14,061)	(13,881)
Borrowings	930	(6,587)	(5,657)	(5,245)
Total Current Liabilities	**(47,590)**	**(8,001)**	**(55,591)**	**(53,362)**
Total Assets Less Current Liabilities	**96,432**	**(6,803)**	**89,629**	**93,679**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(10,757)	0	(10,757)	(10,757)
Borrowings	(24,836)	6,241	(18,595)	(19,513)
Total Non-Current Liabilities	**(35,593)**	**6,241**	**(29,352)**	**(30,270)**
TOTAL ASSETS EMPLOYED	**60,839**	**(562)**	**60,277**	**63,409**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,537	0	109,537	109,537
Revaluation reserve	5,897	0	5,897	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(52,999)	0	(52,999)	(52,999)
Income and expenditure reserve - current year	(1,596)	(562)	(2,158)	0
TOTAL TAX PAYERS' EQUITY	**60,839**	**(562)**	**60,277**	**63,409**

- Non-Current Assets decreased by £1,151k in the month arising from £443k monthly additions and £27k net impact of disposals offset by monthly depreciation of £1,567k.

- M05 movement within Trade and other receivables is a net decrease of £841k and the closing balance is £1,732k higher than plan YTD plan. In M05 the decrease is driven by a £10k decrease in the value of invoices, accrued income reducing by £1,053k as invoices

were settled which were offset by an increase of £222k in prepayments. Over future periods there will be a decrease in accrued income, in line with forecast.

- The closing August 2024 cash position of £28,095k is £3,476k less than planned. This shortfall is a timing difference which is expected to reverse during the financial year. Cash expenditure was higher than planned in the early part of the financial year due to earlier than planned capital investments, and some prepayments to suppliers in line with contract. The forecast closing cash balance is £29,249k.

- Trade and other payables increased by £3,036k which is made up of £1,020k increase in the value of invoices (trade payables) and £2,016k increase in accruals. The latter includes a £1,283k adjustment for the Annual Leave Accrual, previously shown under provisions, £290k increase in accruals for tax, national insurance and pension £800k increase in non-NHS accruals for invoices yet to be received offset by £348k deferred income and £9k decrease in payroll accruals.

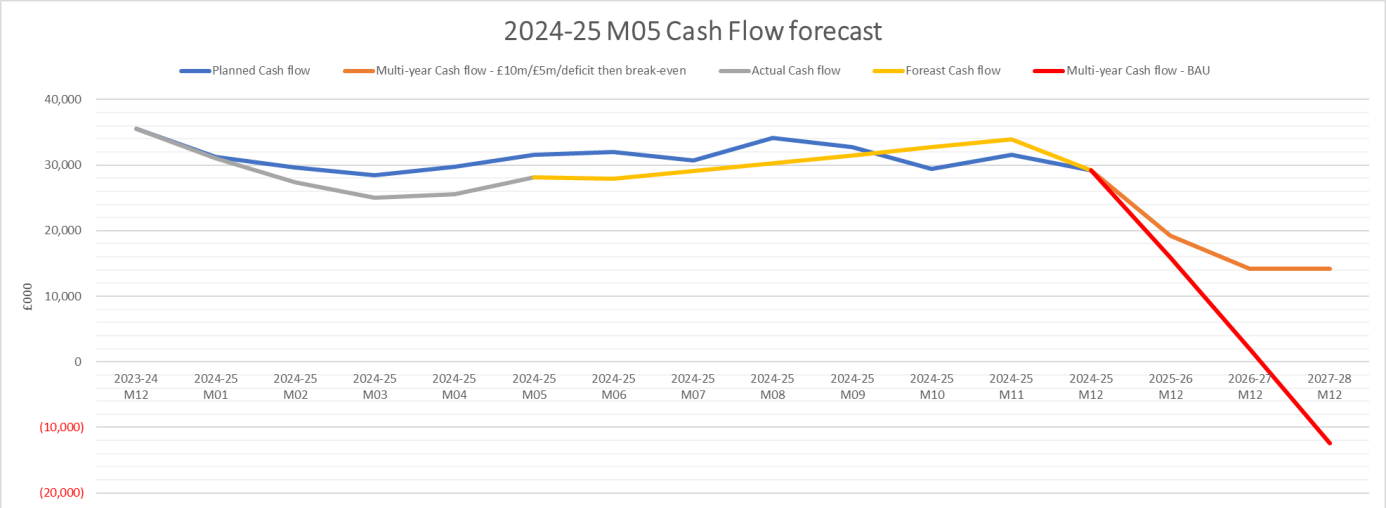
- The provision balances decreased by £1,622k during the month and relate to £1,283k moved to trade and other payables, and £268k released to offset the ECSW re-banding costs applicable to 2023/24 (19 January 2024 to 31 March 2024).

- Borrowings increased by £436k overall (recurrent and non-recurrently) that arise from an increase in leased asset obligations.

- The movement on the I&E reserve represents the Trust's reported deficit for the month and the Full Year.

The below graph shows the 2024-25 planned (blue line), actual (grey line) and forecast (yellow line) cash balance and what the closing balance would be in future years assuming no change in business activities (red line - business as usual) and assuming a £10m and £5m deficit for 2025-26 and 2026-27 respectively then a breakeven for 2027-28 (orange line).

The Trust is forecasting a £29.2m closing cash balance for 2024-25. Should the Trust carry on business as usual then cash will be used up by M02 in 2027-28 and the Trust would need to seek cash support from DHSC and HMT which would be interest bearing, based on the then published rates. This would further increase the deficit as finance cost would increase. If the Trust reduces its deficit in the next couple years and achieve break-even by the end of 2027-28 then the Trust would have £14.2m cash at bank that would cover approximately two weeks' worth of pay and non-pay expenditure.



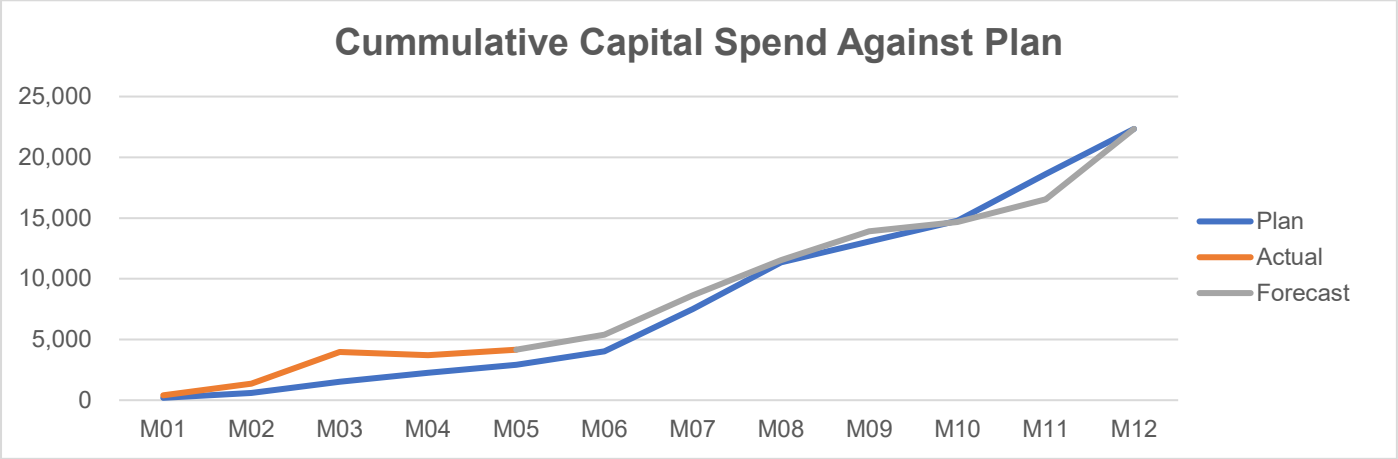
8. Capital

The in-month capital spend is £443k. The in-month actual is £210k lower compared to the plan of £653k.

The Trust has overspent on the YTD capital plan of £2,918k by £1,240k, which is due to slippage from 2023/24, the early delivery of 16 Double Crewed Ambulances (DCAs) and will be offset by future underspends.

	In Month August 2024			Year to August 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	311	224	87	1,320	962	358	4,501	4,994	(493)
Strategic Estates	0	39	(39)	0	163	(163)	0	163	(163)
IT	42	65	(23)	164	453	(289)	3,907	3,907	0
Fleet	212	98	114	460	553	(93)	3,058	3,058	0
Medical	0	0	0	45	0	45	45	45	0
Total Original Plan	**565**	**426**	**139**	**1,989**	**2,131**	**(142)**	**11,511**	**12,167**	**(656)**
Extra Allocation*									
Total Extra Allocation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
CDEL Credit**									
Total Sales Income	0	0	0	0	(656)	656	(1,903)	(656)	(1,247)
Total Spend	0	0	0	0	0	0	1,903	0	1,903
Total CDEL Credit	**0**	**0**	**0**	**0**	**(656)**	**656**	**0**	**(656)**	**656**
PDC									
Total PDC	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Purchased Assets	**565**	**426**	**139**	**1,989**	**1,475**	**514**	**11,511**	**11,511**	**(0)**
Leased Assets									
Estates	40	(23)	63	168	730	(562)	674	1,143	(469)
Fleet	48	39	9	240	1,953	(1,713)	7,825	7,162	663
Specialist Ops	0	0	0	228	0	228	2,328	2,522	(194)
Total Leased Assets	**88**	**17**	**71**	**636**	**2,683**	**(2,047)**	**10,827**	**10,827**	**0**
Total Capital Plan	**653**	**443**	**210**	**2,625**	**4,158**	**(1,533)**	**22,338**	**22,338**	**(0)**

The Trust is forecasting to meet its capital plan of £22,338k by year end.



9. Risks and Opportunities

Risk Title	Impact	Likelihood	Rating	Target Rating
New Procurement Regulations (Procurement Act 2023)	3	4	12	8
Outdated Standing Financial Instructions, Standing Orders and Scheme of Delegation	3	4	12	6
Procurement Contract Management	3	4	12	8
Capacity of the Procurement Team	2	2	4	3
e-Procurement Platform	3	1	3	3
Financial Sustainability - Capital Programme 24/25	3	4	12	6
Financial Sustainability - Fraud	3	3	9	6
BAF Risk - Historical Pay Issues	5	3	15	4
BAF Risk - Sustainable Financial Plan	4	4	16	12
BAF Risk - Internal Financial Control	4	3	12	4

- The table above shows those risks to achieving the finance department's objective that are linked to the organisation's ability to achieve its financial target.

- Potential opportunities for the year have been incorporated into the Trust's plan which mitigate risks identified.

South East Coast Ambulance Service
NHS Foundation Trust

	Item No	62-24
Name of meeting	Trust Board	
Date	03.10.2024	
Name of paper	SFIs – Annual Review	
Author name and role	Simon Bell, CFO	
As part of the enhanced financial controls, the SFIs are updated (having been overdue review) to reflect the current financial environment. A process has been put in place to ensure annual review. The changes are summarised below and enclosed is the full version with track changes. The Audit & Risk Committee support this review and recommend their approval by the Board.		
Recommendations, decisions or actions sought	For approval.	

Updated Standing Financial Instructions, FP1, FP3, and Scheme of Delegation.

Version: Second Draft, September 2024 (First draft, August 2024 approved by EMB 14/08/24 with one amendment noted below)

Based on final Board approved SFIs in issue version 3 September 2019, published on the Foundation Trust's intranet and the amendments made by the Scheme of Delegation version 3 September 2019

Updated by: Chief Finance Officer

Track changes from version 3 September 2019 included for reference.

Summary of changes to SFIs & FP1:

Naming conventions updated: e.g. Trust is Foundation Trust, NHSI replaced with NHS England (NHSE), Scheme of Delegation abbreviated to SD changed to SoD, job title changes to reflect current structure, committee names per current ToRs, etc.

Annual planning: amended to strengthen the annual planning process in line with financial control improvements agreed by EMB around a single point of business case sign off for all revenue and capital business cases and the production of a recovery plan where the FT is in deficit.

Staff appointments and remuneration: further restrictions on process introduced where the FT is in deficit.

Treasury management: amended to reduce flexibility around investing surplus cash to high security non-clearing bank institutions and limit investments to £0.5m per institution in such cases.

Appendix 1: substantially amended to update tendering and requisitioning to reflect PCR and current regulation. Single tender waiver use clarified and restricted. Mandates the compliance role of Procurement in managing the process. Reference to EU removed.

Capital spending: decreasing the authority of the CFO in funding decisions on capital investments.

Appendix 2: FP1, authority to commit expenditure, updated to change operation in the event the FT is in deficit.

Summary of changes to FP3:

Naming conventions updated: e.g. Trust is Foundation Trust, CFO, etc.

Simplification of process: Process aligned with annual planning cycle. Reducing complexity by relying on the process set out in FP1

Templates: NOT UPDATED, but will need to be ahead of Board approval in October.

Summary of changes to SoD:

As SoD is essentially a subset of SFIs and says nothing additional to SFIs. Once Audit Committee has reviewed SFIs SoD will be updated accordingly and presented to October Board for approval.

EMB Approval

EMB reviewed and approved the revised SFIs and Financial Procedures 1 and 3 (FP1 & FP3) with one amendment

South East Coast Ambulance Service NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Version: 1
Issued Date: August 2024 DRAFT
Review Date: Sept 2025

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1. INTRODUCTION

1.1. General

1.1.1. The Standing Financial Instructions (SFI) have effect as if incorporated in the Standing Orders (SO) of the ~~Trust~~Foundation Trust. SOs are set out in the Constitution of the Foundation Trust.

1.1.2. The SFIs detail the financial responsibilities, policies and procedures to be adopted by the ~~Trust~~Foundation Trust. They are designed to ensure that financial transactions are made~~carried out~~ in accordance with the law, ~~and~~ government policy, and the purposes for which public funding is allocated ~~in order to~~to exercise full corporate governance. They should be used in conjunction with the Scheme of Delegation (S~~o~~D) adopted by the ~~Trust~~Foundation Trust.

1.1.3. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer~~Executive Director of Finance and Corporate Services~~ (~~DoF~~CFO) must be sought before any actions are taken.

1.1.4. Failure to comply with SFIs and SOs is a disciplinary matter. If considered gross misconduct it could result in dismissal. It is every member of staff~~,~~s responsibility to ensure they have read and comply with this document. Budget holders will be required to sign ~~off~~ to confirm ~~that~~ they have read and understood them. They are published on the ~~Trust~~Foundation Trust's Intranet and public website.~~.~~

1.2. Terminology

1.2.1. Any expression to which a meaning is given in relevant Acts of Parliament or in the Regulations or Orders made under those Acts shall have the same meaning in this document.

1.2.2. Terms defined in section 2 of the SOs apply equally to the SFIs. Additional terms are set out below.

1.2.2.1. "Business Plan" (Plan) means the plan prepared by the ~~Trust~~Foundation Trust which outlines the ~~Trust~~Foundation Trust's financial, operational and clinical plans and budgets for a financial year. Plans are submitted to NHS England ~~Improvement~~ (~~NHSI~~NHSE).

1.2.2.2. "Audit and Risk Committee" (AR~~u~~C) is the committee as defined in the Constitution and SFIs.

1.2.2.3. "Budget" means a resource, expressed in financial terms, approved by the Board of Directors (Board) for the purpose of carrying out, for a specific

period, any or all of the functions of the ~~Trust~~Foundation Trust under delegated authority to Budget Holders.

1.2.2.4. "Budget Holder" (BH) means the director or employee with delegated authority to manage finances (income, expenditure and/or assets) for a specific area of the organisation.

1.2.2.5. "Finance and Investment Committee" (FIC) means the committee of the Board set up to provide scrutiny of the operational and financial performance of the ~~Trust~~Foundation Trust and to provide scrutiny of financial investments or commercial contracts entered into by the ~~Trust~~Foundation Trust.

1.2.2.6. "Legal Adviser" means the properly qualified person appointed by the ~~Trust~~Foundation Trust to provide legal advice.

1.2.2.7. "Local Counter Fraud Specialist" (LCFS) means the contractor or person responsible to the ~~DoF~~CFO and ~~AuC~~ARC for the ~~Trust~~Foundation Trust's anti-fraud and bribery activities.

1.2.3. Wherever the term 'employee' is used, it shall be deemed to include employees of third parties contracted to the ~~Trust~~Foundation Trust when acting on behalf of the ~~Trust~~Foundation Trust.

1.2.4. Unless stated otherwise these SFIs apply equally to funds held in trust (charitable funds).

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control by:

1.3.1.1. formulating the financial strategy;

1.3.1.2. requiring the submission of, and approving, budgets;

1.3.1.3. defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

1.3.1.4. defining specific responsibilities and accountability placed on directors and employees as indicated in the ~~SD~~SoD.

1.3.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal sessions. These are set out in the ~~SD~~SoD.

1.3.3. The Board will delegate responsibility for the performance of its functions in accordance with the ~~SD~~SoD adopted by the ~~Trust~~Foundation Trust.

1.3.4. Within the SFIs, it is acknowledged that the Chief Executive (~~CE~~CEO) is ultimately accountable to the Board and, as the ~~Trust~~Foundation Trust's accountable officer, to NHS England~~Improvement,~~ for ensuring that the ~~Trust~~Foundation Trust meets its obligation to perform its functions within the available financial resources. The ~~CE~~CEO has overall executive responsibility for the ~~Trust~~Foundation Trust's activities and is accountable to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the ~~Trust~~Foundation Trust's system of internal control.

1.3.5. Whilst the ~~CE~~CEO and ~~DoF~~CFO will, as far as possible, delegate their detailed responsibilities, they remain accountable for financial control.

1.3.6. It is a duty of the ~~CE~~CEO to ensure that existing directors and employees and all new appointees are notified of, and understand, their responsibilities within these SFIs.

1.3.7. The ~~DoF~~CFO is responsible for:

1.3.7.1. implementing the ~~Trust~~Foundation Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

1.3.7.2. maintaining an effective system of internal financial control including ensuring that detailed financial procedures, processes and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

1.3.7.3. ensuring sufficient records are maintained to show and explain the ~~Trust~~Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the ~~Trust~~Foundation Trust at any time.

1.3.8. Without prejudice to any other functions of directors and employees to the ~~Trust~~Foundation Trust, the duties of the ~~DoF~~CFO include:

1.3.8.1. the provision of financial advice to the ~~Trust~~Foundation Trust, its directors and employees;

1.3.8.2. the design, implementation and supervision of systems of financial control; and

1.3.8.3. the preparation and maintenance of such accounts, certificates, estimates, records and reports as the ~~Trust~~Foundation Trust may require for the purpose of carrying out its statutory duties.

1.3.9. All directors and employees, severally and collectively, are responsible for:

1.3.9.1. the security of ~~Trust~~Foundation Trust property;

1.3.9.2. avoiding loss;

1.3.9.3. exercising economy and efficiency in the use of resources; and

1.3.9.4. conforming to the requirements of SOs, SFIs and the ~~SD~~SoD.

1.3.10. For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the ~~DoF~~CFO.

2. AUDIT

2.1. Audit and Risk Committee (~~AuC~~ARC)

2.1.1. In accordance with the Constitution, the Board shall formally establish an ~~AuC~~ARC. The purpose of the committee is to provide an overview of internal controls and of significant financial risks facing the ~~Trust~~Foundation Trust. In meeting these objectives the committee shall:

2.1.1.1. oversee internal and external audit services;

2.1.1.2. review significant risk areas and financial systems;

2.1.1.3. monitor compliance with SOs and SFIs; and

2.1.1.4. review losses, write-offs and significant financial judgements.

2.1.2. Where the ~~AuC~~ARC feel there is evidence of *ultra vires* transactions or evidence of improper acts, or if there are other important matters that the ~~AuC~~ARC wish to raise, the chairman of the ~~AuC~~ARC should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to ~~NHSI~~NHSE.

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2.1.3. It is the responsibility of the ~~DoF~~CFO to ensure an adequate internal audit service is provided and the ~~AuC~~ARC shall be involved in the selection process when an internal audit service provider is changed.

2.2. Chief Finance Officer~~Executive Director of Finance and Corporate Services~~ (~~DoF~~CFO)

2.2.1. The ~~DoF~~CFO is responsible for:

2.2.1.1. ensuring that there are arrangements in place to review, evaluate and report on the effectiveness of internal financial controls by the establishment of an internal audit function;

2.2.1.2. ensuring that internal audit is adequately resourced and managed and meets the NHS mandatory audit standards;

2.2.1.3. deciding at what stage to involve the ~~p~~Police in cases of misappropriation and other irregularities; and

2.2.1.4. ensuring that an annual audit report is prepared for the consideration of the ~~AuC~~ARC and the Board, which must include:

2.2.1.4.1. a clear statement on the effectiveness of internal control;

2.2.1.4.2. major internal financial control weaknesses identified;

2.2.1.4.3. progress on the implementation of internal audit recommendations;

2.2.1.4.4. progress achieved against the internal audit plan over the previous year;

2.2.1.4.5. a strategic internal audit plan covering the coming three years; and

2.2.1.4.6. a detailed internal audit plan for the coming year.

2.2.2. The ~~DoF~~CFO, designated auditors and LCFS are entitled, without necessarily giving prior notice, to require and receive:

2.2.2.1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

2.2.2.2. access at all reasonable times to any land, premises or employee of the ~~Trust~~Foundation Trust;

2.2.2.3. the production of any cash, stores or other property of the ~~Trust~~Foundation Trust under an employee's control; or

2.2.2.4. explanations concerning any matter under investigation.

2.3. Role of Internal Audit

2.3.1. Internal Audit will review:

2.3.1.1. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

2.3.1.2. the adequacy and application of financial and other related management controls;

2.3.1.3. the suitability of financial and other related management data;

2.3.1.4. the extent to which the ~~Trust~~Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

2.3.1.4.1. fraud, bribery and other offences;

2.3.1.4.2. waste, extravagance and inefficient administration;

2.3.1.4.3. poor value for money;

2.3.1.4.4. report upon the adequacy of follow-up action on audit reports; and

2.3.1.4.5. carry out investigative/project work as agreed with and under such Terms of Reference as may be laid down by the ~~DoF~~CFO.

2.3.2. Internal Audit shall independently assess processes in place to ensure that the ~~Trust~~Foundation Trust's assurance frameworks are in accordance with current guidance from the CQC, ~~NHSI~~NHSE and other regulatory bodies or requirements.

2.3.3. The head of Internal Audit (HoIA) will prepare an annual work plan which takes a risk-based approach to controls and value for money audits. This plan will be reviewed by the ~~DoF~~CFO and approved by the ~~AuC~~ARC.

2.3.4. The HoIA is required to provide an opinion to the external auditors annually, which forms a part of the Annual Report for the ~~Trust~~Foundation Trust.

2.3.5. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, Internal Audit shall notify the ~~DoF~~CFO immediately.

2.3.6. The HoIA has a right of access to all ~~AuC~~ARC members, the Chair and the ~~CE~~CEOO of the ~~Trust~~Foundation Trust.

2.3.7. The HoIA shall be accountable to the ~~DoF~~CFO. The reporting system for internal audit shall be agreed between the ~~DoF~~CFO, the ~~AuC~~ARC and the HoIA. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual.

2.4. External Audit

2.4.1. The ~~Trust~~Foundation Trust's external auditor is appointed by the Council of Governors (CoG).

2.4.1.1. The ~~AuC~~ARC must ensure that the external auditor appointed by the CoG meets the criteria required by ~~NHSI~~NHSE within the Audit Code for NHS Foundation ~~Trust~~Foundation Trusts, at the date of appointment and on an on-going basis throughout the term of their appointment. External audit has a responsibility (in compliance with the requirements of ~~NHSI~~NHSE) to provide:

2.4.1.2. an audit opinion on the Annual Report and Accounts in accordance with current guidance;

2.4.1.3. an audit opinion on the Quality Account in accordance with current guidance;

2.4.1.4. a Value for Money opinion in accordance with current guidance;

2.4.1.5. an audit opinion on the accounts of Charitable Funds held in trust; and

2.4.1.6. such other opinions as may be required from time to time.

2.5. Fraud, Bribery and Corruption

2.5.1. The ~~Trust~~Foundation Trust's ~~CE~~CEO and ~~DoF~~CFO shall monitor and ensure compliance with Health Service directions on fraud, bribery and corruption. The ~~AuC~~ARC will provide oversight on behalf of the Board.

2.5.2. The ~~Trust~~Foundation Trust shall nominate a suitable person, employee or contractor, to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud Manual and Guidance.

2.5.2.1. The contact details for the LCFS should be held with the ~~AuC~~ARC records and should be published on the ~~Trust~~Foundation Trust intranet so that it is easily available to all staff.

2.5.3. The LCFS will provide a written report to the ~~AuC~~ARC, at least annually, on counter fraud work within the ~~Trust~~Foundation Trust.

2.5.4. The LCFS shall report to the ~~DoF~~CFO and shall liaise with staff in the NHS Counter Fraud Authority (CFA).

2.5.5. The ~~Trust~~Foundation Trust shall have policies covering fraud, corruption and bribery, which are available to all staff. It is the responsibility of the ~~DoF~~CFO to ensure that the ~~Trust~~Foundation Trust maintains these policies. It is also the responsibility of the ~~DoF~~CFO to ensure that reasonable effort is taken to mitigate the risk of fraud, bribery and corruption though effective internal control and education and to ensure that allegations of fraud, corruption or bribery are investigated properly and sensitively.

2.5.6. It is the duty of all employees to meet the minimum legal standards of conduct with respect to fraud, corruption and bribery as well as to comply with ~~Trust~~Foundation Trust policies in these areas. Failure to do so can result in disciplinary action and criminal prosecution.

2.5.7. The legal framework relating to bribery is provided by the Bribery Act 2010, which makes it an offence to give or receive a bribe. A bribe is an inducement for an action, which is illegal unethical or a breach of trust. Inducements can take the form of gifts loans, fees rewards or other privileges.

2.5.8. The legal framework relating to fraud is provided by the Fraud Act 2006. This identifies a number of ways of committing a fraud. Further details can be found in the ~~Trust~~Foundation Trust's Anti-Fraud and Bribery Policy or

via the following link to the legislation: https://www.legislation.gov.uk/ukpga/2006/35/contents

2.5.9. It is the responsibility of all staff to avoid committing acts which could be fraudulent or corrupt and to report potential fraud or bribery to the ~~DoF~~CFO or to the LCFS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1. The Business Plan (Plan) and the annual planning cycle

3.1.1. The ~~Trust~~Foundation Trust will complete an annual planning exercise in line with NHSE Planning Guidance and timeframes; this would usually be expected to allow the Foundation Trust's Board to approve an annual plan in March and ahead of the start of the new financial year. Where this is not possible because of NHSE changes to timeframes the Board will still be required to approve the plan ahead of final submission. ~~.~~

3.1.2. The Plan will set out the detailed spending plans by Directorate, including capital expenditure and investments for a minimum of one year. It is expected that all capital and revenue investments above baseline, other than inflationary adjustments prescribed by annual NHSE Planning Guidance, will be subject to a summary business case for inclusion into the annual plan in October. Once approved for inclusion in the annual plan, further development of the business case for investment ahead of final approval will be required.

~~3.1.3. The Plan will require Board approval.~~

3.1.3. Normally it is expected that this requirement will form a part of the annual planning and strategy refresh required by ~~NHSI~~NHSE.

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3.1.4. Where the Foundation Trust is in deficit a recovery plan will additionally be required which describes the recovery of the deficit position to a minimum break-even position with a timeframe which is acceptable to the Foundation Trust's Board and to NHSE.

3.2. Detailed Plan development

3.2.1. The ~~CE~~CEO is responsible for submission of the Plan to the Board.

3.2.2. The Executive Director ~~of~~for Strategic Planning and Transformation ~~Strategy & Business Development~~ (~~DSBD~~DSPT ~~), who is also the Senior Information Risk Owner (SIRO))~~ is responsible for agreeing ~~establishing the planned levels of income from the~~ commissioned and contracted services taking account of demand and capacity~~activity~~ changes, ~~pricing or~~ service changes, and the financial position of the Foundation Trust. P~~The p~~lanned capacity ~~activity~~ should as far as possible ~~ideally~~ be aligned with the C~~c~~ommissioners demand and expendiuture plans' ~~expectations~~. Where this is not possible, e.g. unplanned demand growth, the implications of this should be clearly laid out to the Board and to Commissioners. The DSPT is

responsible for reviewing, ensuring, and improving the productivity of the Foundation Trust in line with agreed plans.

3.2.3. The Executive Director of Operations ~~Executive Director of Operations (~~DoO~~DoO~~) is responsible for developing a detailed operational plan including staff and other resource requirements for all service lines in line with the ~~activity~~planning assumptions agreed ~~with~~by the ~~DSBD~~DSPT.

3.2.4. The Executive Director of Human Resources (HRD) is responsible for ensuring that there is a workforce plan, which reflects the anticipated demand and capacity~~activity~~, the unit hour plan and other proposed investments.

3.2.5. The ~~DoF~~CFO is responsible for ensuring that a detailed Plan is produced covering all expenditures in each directorate of the ~~Trust~~Foundation Trust. This detailed Plan must be consistent with the planned income levels, unit hour plan and workforce plan. This Plan must also deliver the overall financial objectives of the ~~Trust~~Foundation Trust.

3.2.6. The Plan must reflect the necessary level of cost improvements to ensure that the ~~Trust~~Foundation Trust can continue to meet its strategic and operational objectives.

3.2.7. The ~~DoF~~CFO is responsible for managing the overall Cost Improvement Programme (CIP) and ensuring that the program measures and delivers genuine year over year increases in productivity.

3.2.8. Each CIP will have a responsible Executive Director (ED) who must ensure that the CIP has a credible action plan and an effective set of measurements and/or metrics.

3.3. Board Approval

3.3.1. The ~~DoF~~CFO will be responsible for presenting the Plan to the Board. This presentation must, at a minimum, cover:

3.3.1.1. the significant assumptions on which the plan is based;

3.3.1.2. the planned income showing changes in services, activity or price;

3.3.1.3. the planned expenditure showing significant investments, cost changes, salary increases and cost pressures;

3.3.1.4. the planned expenditure broken down by directorate and showing the extent of uncommitted expenditure ('reserves');

3.3.1.5. capital expenditure plans;

3.3.1.6. CIP plans which must be backed by credible actions and meaningful metrics;

3.3.1.7. a projected balance sheet; and

3.3.1.8. a projected cash flow.

3.3.2. The ~~CE~~CEO will prepare a summary of the principal goals and objectives of the ~~Trust~~Foundation Trust including the key areas for operational delivery, investment, clinical innovation, people development strategic developments and financial performance.

3.3.3. The Board will be asked to approve the Plan.

3.3.4. Once approved, the ~~DoF~~CFO can confirm budgetary allocations for each directorate with the responsible director in line with the Plan.

3.3.5. Subject to 3.3.6 below, the approval of the Plan by the Board will allow each directorate's responsible ED the authority to execute the current year planned expenditure provided that the directorate remains within its overall financial envelope and that the expenditure is in line with the goals and objectives outlined by the ~~CE~~CEO.

3.3.6. Any proposed increase in budget baselines, other than those arising from nationally funded cost pressures (e.g. national pay awards) are subject to approval in accordance with the ~~Trust~~Foundation Trust's published Business Case Process (FP3).

3.3.7. Subject to requirements of the Virement Process an ED may reassign resources within their directorate provided this remains within the total approved spend from the Plan. Assurance is required that the overall goals and objectives of the ~~Trust~~Foundation Trust will be met and that the overall expenditure will remain within the agreed limits.

3.3.8. An ED is accountable to the Board for the financial and operational performance laid out in the Plan.

3.4. Annual Plan submission to ~~NHSI~~NHS England (NHSE)

3.4.1. The Plan approved by the Board will form the basis of the Plan submission to ~~NHSI~~NHSE.

3.4.2. The ~~DoF~~CFO is responsible for ensuring that the figures submitted to ~~NHSI~~NHSE agree with the Plan approved by the Board.

3.4.3. Individual EDs are responsible for ensuring that the commentary in the Plan submission is correct and consistent with the Plan goals and with their plans.

3.4.4. The Board will review and approve the final submission to ~~NHSI~~NHSE.

3.5. Budgetary Control and Reporting

3.5.1. The ~~DoF~~CFO will deliver monthly financial reports to the Board containing:

3.5.1.1. income and expenditure to date, showing trends and forecast year-end position;

3.5.1.2. explanations of any material variances from plan; and

3.5.1.3. details of any corrective action where necessary and the ~~CE~~CEO's and/or DOF's view as to whether such actions are sufficient to correct the situation.

3.5.2. The ~~DoF~~CFO will deliver monthly financial reports to the FIC containing:

3.5.2.1. a detailed analysis of the current financial position including such commentary as is needed to understand that position;

3.5.2.2. cash position versus plan;

3.5.2.3. capital spend and projected outturn against plan; and

3.5.2.4. CIP versus plan.

3.5.3. The ~~DoF~~CFO will be responsible for the provision of timely, accurate and clear financial reports to each BH, covering the areas for which they are responsible.

3.5.4. The ~~CE~~CEO is responsible for delegating responsibility to each BH within the overall Plan approved by the Board.

3.5.5. Each BH is responsible for ensuring that they achieve their delegated service objectives within their approved budget. This will include ensuring that:

3.5.5.1. any likely overspending or reduction of income is not incurred without prior approval in accordance with the Business Case Process or Virement Process to gain additional budgetary resources; and

3.5.5.2. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised.

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3.5.5.3. no permanent employees are appointed without the approval of the ~~DoF~~CFO other than those provided for in the budgeted establishment as approved by the Board or supplemented through the Business Case Process.

3.5.6. The Chief Medical Officer ~~Executive Medical Director~~ (~~MD~~CMO) and Executive Director of Quality and Nursing (DoQN) are jointly~~is~~ responsible for ensuring that all CIP schemes and Business Cases are assessed for their impact on quality of care via completion and authorisation of a Quality Impact Assessment (QIA) document.

3.5.7. The Equality Assessment Checkpoint (Information Working Group (IWG) representative) for each relevant directorate is responsible for ensuring that all CIP schemes and Business Cases are assessed for Equality Impact, as evidenced via an Equality Assessment Report (EAR).

3.5.8. The ~~DSBD~~DSPT is responsible for ensuring that planned i~~I~~ncome ~~Generation~~ activities are delivered in line with the Plan.

3.5.9. The ~~DoF~~CFO is responsible for ensuring that all items in the CIP are delivered in line with the Plan.

3.6. Capital Expenditure and Financing

3.6.1. The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.6.2. The ~~DoF~~CFO is responsible for ensuring that the ~~Trust~~Foundation Trust has adequate and appropriate financing for capital and other expenditure. Where funding does not exist, the ~~DoF~~CFO is responsible for informing the ~~Trust~~Foundation Trust and adjusting capital expenditure plans accordingly.

3.7. Monitoring Returns

3.7.1. The ~~DoF~~CFO is responsible for ensuring that the appropriate financial monitoring forms are submitted to the relevant monitoring organisations. The ~~CE~~CEO is responsible for ensuring that the appropriate governance returns are submitted to the relevant monitoring organisation.

4. ANNUAL ACCOUNTS AND REPORTS

4.1. Financial Returns

4.1.1. The ~~DoF~~CFO will:

4.1.1.1. prepare and submit financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care, ~~the~~His Majesty's Treasury, ~~NHSI~~NHSE, the ~~Trust~~Foundation Trust's accounting policies, and the Government's Financial Reporting Manual (FRem)~~d generally accepted accounting practice~~; and

4.1.1.2. prepare and submit financial reports to ~~NHSI~~NHSE in accordance with current guidelines.

4.2. Annual Report

4.2.1. The ~~CE~~CEO on behalf of the ~~Trust~~Foundation Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it at the Annual Members' Meeting.

4.2.2. The document will comply with ~~NHSI~~the Government's ~~'s~~ Financial Reporting Manual (FReM).

4.2.3. The Annual Report will follow the relevant regulatory requirements and will include the following elements:

4.2.3.1. Strategic Report;

4.2.3.2. Directors' Report;

4.2.3.3. Remuneration Report

4.2.3.4. Quality Account;

4.2.3.5. Annual Governance Statement; and

4.2.3.6. External Audit Opinion.

5. TREASURY MANAGEMENT AND BANK ACCOUNTS

5.1. General

5.1.1. The ~~Trust~~Foundation Trust will follow the principles set out in the ~~NHS~~ Monitor document "Managing Operating Cash in NHS Foundation ~~Trust~~ Trusts" (NHS foundation trusts: managing operating cash - GOV.UK (www.gov.uk)).

~~5.1.1.~~

5.1.2. The ~~DoF~~CFO is responsible for managing the ~~Trust~~Foundation Trust's Treasury Management arrangements and for advising the ~~Trust~~Foundation Trust on the provision of banking services and operation of accounts.

5.1.3. The ~~Trust~~Foundation Trust shall have in place a Treasury Management Process for the management of cash, liquidity and investment requirements. Restrictions on the investment of surplus funds are outlined in section 10.2.

5.1.4. The banking regulations apply to both commercial bank accounts and to Government Banking Service accounts.

5.1.5. The FIC will review the Treasury Management arrangements of the ~~Trust~~Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the ~~Trust~~Foundation Trust's banking business.

5.2. Bank

5.2.1. The ~~DoF~~CFO is responsible for:

5.2.1.1. proper management of all ~~Trust~~Foundation Trust bank accounts;

5.2.1.2. reporting to the FIC all arrangements made with the ~~Trust~~Foundation Trust's bankers for accounts to be overdrawn;

5.2.1.3. ensuring that payments made from bank accounts do not exceed the amount credited to the account, except where appropriate overdraft arrangements have been made; and

5.2.1.4. establishing separate bank accounts for the ~~Trust~~Foundation Trust's non-exchequer funds.

5.3. Banking Procedures

5.3.1. The ~~DoF~~CFO will prepare detailed instructions on the operation of bank accounts which must include:

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5.3.1.1. those authorised to sign cheques or other orders drawn on the ~~Trust~~Foundation Trust's accounts;

5.3.1.2. the limit to be applied to any overdraft (in the event that this should be required); and

5.3.1.3. the conditions under which each bank account is to be operated (other than the conditions imposed by the Government Banking Service and the Treasury).

5.4. Investment of Surplus Funds

5.4.1 Arrangement for, and restrictions on, the investment of surplus funds are detailed in section 10.2.

6. CASH RE~~CE~~CEIPTS AND PAYMENTS

6.1. Income Systems

6.1.1. The ~~DoF~~CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

6.1.2. The ~~DoF~~CFO is responsible for the prompt banking of all monies received.

6.2. Fees and Charges

6.2.1. The ~~DoF~~CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by statute.

6.2.2. All employees must inform the ~~DoF~~CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3. Debt Recovery

6.3.1. The ~~DoF~~CFO is responsible for initiating and managing appropriate recovery action on all outstanding debts.

6.3.2. Overpayments should be detected (or preferably prevented) and recovery initiated.

6.3.3. Income not received should be dealt with in accordance with losses and compensations procedures.

6.4. Security of Cash, Cheques and Other Negotiable Instruments

6.4.1. The ~~DoF~~CFO shall be responsible for:

6.4.1.1. ensuring there are effective systems and appropriate controls over electronic payment methods including CHAPs and BACs;

6.4.1.2. approving all methods for recording monies received or receivable;

6.4.1.3. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, and the procedures for keys;

6.4.1.4. prescribing systems and procedures for handling cash, cheques, credit cards, purchasing cards, and other alternatives to cash on behalf of the ~~Trust~~Foundation Trust; and

6.4.1.5. ensuring there are effective systems and procedures for handling electronic banking transactions.

6.4.2. The ~~Trust~~Foundation Trust's liquid funds shall not, under any circumstances, be used for the encashment of private cheques.

6.4.3. The holders of safe keys shall not accept unofficial funds for depositing in their safes.

6.5. Duty to comply with procedures to inform the ~~DoF~~CFO of monies

6.5.1. All employees have a duty to:

6.5.1.1. Ensure that they are authorised under these SFIs to initiate or deal with transactions which result in payment before committing to those transactions; and

6.5.1.2. To ensure that the ~~DoF~~CFO is made aware of monies due by complying with these SFIs and with other financial procedures.

7. CONTRACTS FOR PROVISION OF SERVI~~CE~~CES

7.1. Commissioning

7.1.1. The ~~DSBD~~CFO is responsible for commissioning NHS service agreements for the provision of services to patients. Prior to any binding commitment, the ~~DSBD~~CFO should report to the Board. The report will need to address the following:

7.1.1.1. costing and pricing of services;

7.1.1.2. activity assumptions;

7.1.1.3. the expected income for the ~~Trust~~Foundation Trust;

7.1.1.4. actions which will be needed to deliver on ~~CQUIN or other~~ conditional income, including the expected cost and the risk to delivery;

7.1.1.5. payment terms and conditions; and

7.1.1.6. amendments to NHS contracts terms and conditions.

7.1.2. The Board must agree any new contract for services, with delegation to the FIC documented in the ~~SD~~SoD.

7.1.3. The ~~DSBD~~CFO is responsible to making the Board aware of any Commissioner Requested Services as identified by the NHS Provider Licence.

7.1.4. The ~~DSBD~~CFO is responsible for ensuring that the contracting arrangements for multiple ~~CCG~~Commissioners are properly defined.

7.2. Other contracts for the provision of services

7.2.1. The ~~DSBD~~CFO is responsible for other sales or service provision contracts.

7.2.2. Prior to any binding agreement, the ~~DSBD~~CFO should report to the Board with a report as outlined in section 7.1.

7.2.3. Prior to any negotiations the ~~DSBD~~CFO should seek direction from the Board as to the desirability of entering any contracts, and any conditions that the Board will expect to see reflected in a final agreement.

8. REMUNERATION AND TERMS OF SERVI~~CE~~CE

8.1. Remuneration and Terms of Service for the Chairman and Non-Executive Directors (NED)

8.1.1. In accordance with the Constitution the ~~Trust~~Foundation Trust shall establish a Nominations Committee.

8.1.2. The committee will recommend appropriate remuneration and terms of service for the Chair and NEDs for approval by the CoG.

8.2. Remuneration and Terms of Service for Chief Executive, Executive Directors and other designated senior staff

8.2.1. In accordance with SOs, the Board shall establish an Appointments and Remuneration Committee (ARC), whose terms of reference shall specify which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.2.2. ARC is responsible for the appointment and removal of the ~~CE~~CEO and EDs of the ~~Trust~~Foundation Trust.

8.2.3. ARC is responsible for deciding and reporting to the board about appropriate remuneration and terms of service for the ~~CE~~CEO and EDs and any senior employee above band 9~~8~~ who is not covered by Agenda for Change (AfC) Terms and Conditions, having proper regard to the ~~Trust~~Foundation Trust's circumstances and performance and to the provisions of any national arrangements where appropriate.

8.2.4. ARC also decides and reports to the Board for all employees on any bonus or incentive scheme proposed by the Executive and any non-contractual payments either in employment or on termination that have to be reported to ~~NHSI~~NHSE.

8.3. Terms and Conditions for all staff

8.3.1. Changes to standard terms and conditions should be approved by the Board.

8.4. Funded Establishment

8.4.1. The manpower plans incorporated within the annual budget will form the funded establishment.

8.4.2. The funded establishment of any department may not be increased, unless funding is available in current budgets or approved through the Business Case Process or through the Virement Process.

8.5. Staff Appointments

8.5.1. No director or employee may engage employees, either of a permanent or temporary nature, or hire agency staff, outside of the approved and delegated annual budget with the exception of approved~~without approval through the Staff Requisition Process, which requires confirmation of available budgetary funding from the Finance Department. Funding may be available within the baseline budget, from~~ an approved virement or an approved business case. ~~or business brief~~.

8.5.2. No director or employee may re-grade existing employees or alter any aspect of remuneration of an existing employee without approval through the Staff Recruitment & Remuneration~~quisition~~ Process (Recruitment Panel), which requires confirmation of available budgetary funding from the Finance Department. Funding may be available within the baseline budget, from an approved virement or an approved business case. ~~or business brief~~.

~~8.5.2.~~8.5.3. Where the Foundation Trust is in deficit or operating in a recovery plan situation additional staff controls covering appointments and amendments to remuneration will be introduced to further restrict the processes outlined otherwise in section 8.5.

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8.6. Processing of Payroll

8.6.1. The HRD is responsible for:

8.6.1.1. specifying timetables for submission of properly authorised time records and other notifications;

8.6.1.2. the final determination of pay;

8.6.1.3. making payment on agreed dates; and

8.6.1.4. agreeing method of payment.

8.6.2. The HRD will issue instructions regarding:

8.6.2.1. verification and documentation of data;

8.6.2.2. the timetable for receipt and preparation of payroll data and the payment of employees;

8.6.2.3. security and confidentiality of payroll information;

8.6.2.4. checks to be applied to completed payroll before and after payment;

8.6.2.5. authority to release payroll data under the provisions of the General Data Protection Regulation / Data Protection Act 2018;

8.6.2.6. methods of payment available to various categories of employee;

8.6.2.7. procedures for payment by cheque, bank credit or cash to employees;

8.6.2.8. procedures for the recall of cheques and bank credits;

8.6.2.9. pay advances and their recovery;

8.6.2.10. a system to ensure the recovery from leavers of sums of money and property due by them to the ~~Trust~~Foundation Trust.

8.6.3. Appropriately nominated managers have delegated responsibility for:

8.6.3.1. submitting time records, and other notifications in accordance with agreed timetables;

8.6.3.2. completing time records and other notifications in accordance with the HRD's instructions and in the form prescribed by the HRD;

8.6.3.3. submitting termination forms in the prescribed form immediately upon knowing the effective date of any employee's resignation, termination or retirement; and

8.6.3.4. where an employee fails to report for duty in circumstances that suggest they have left without notice, informing the ~~DoF~~CFO immediately.

8.6.4. The HRD will issue instructions regarding:

8.6.4.1. maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;

8.6.4.2. maintenance of regular and independent reconciliation of pay control accounts;

8.6.4.3. separation of duties for preparing records and handling cash; and

8.6.5. Regardless of the arrangements made for providing the payroll service, the ~~DoF~~CFO shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.7. Timely and accurate records

8.7.1. All line managers and those in the chain of management up to Director are required to ensure that time records, and other change forms which impact payroll, are submitted in line with the timetable set by the HRD.

8.8. Contracts of Employment

8.8.1. The Board shall delegate responsibility for:

8.8.1.1. ensuring that all employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation;

8.8.1.2. dealing with variations to, or termination of, contracts of employment;

8.8.1.3. dealing with claims, settlements, compensation, tribunals and disputes generally arising from employment, subject to ARC approvals.

9. NON-PAY EXPENDITURE

9.1. Delegation of Authority

9.1.1. The Board will approve the level of non-pay expenditure on an annual basis.

9.1.2. The ~~DoF~~CFO, in consultation with the ~~CE~~CEO, will provide for managers, in an appendix to these SFIs, guidance on the following matters (see Appendix 2):

9.1.2.1. the grade of managers who are authorised to place requisitions/orders for the supply of goods and services;

9.1.2.2. the maximum financial level for each requisition/order and the system for authorisation above that level; and

9.1.3. The ~~DoF~~CFO is responsible for maintaining a list of authorised signatories held and maintained within the Finance Department.

9.1.4. The ~~DoF~~CFO shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1. The requisitioner, in choosing the item to be supplied (or the service to be performed), shall always obtain the best value for money for the ~~Trust~~Foundation Trust. In so doing, the advice of the ~~Trust~~Foundation Trust's Associate ~~Head of Procurement~~Associate Director of Procurement (~~HoP~~ADoP) shall be sought. ~~Where this advice is not acceptable to the requisitioner, the DoF (and/or the CE) shall be consulted and decide upon an appropriate course of action.~~ Standing Financial Instructions (SFI) Waivers should be the exception and apply if the procurement thresholds cannot be observed for one or more of the following three reasons:

- Sole supplier (service only available from one supplier)
- Extension of similar existing competitively tendered contract
- Unforeseen urgency (failure to plan effectively does not meet the grounds of unforeseen urgency)

Waivers will require the approval of the ADoP and the CFO/CEO.

~~9.2.1.~~

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9.2.2. The ~~DoF~~CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms or otherwise in accordance with national guidance.

9.2.3. Appendix 1~~The SD will~~ sets out the thresholds above which quotations or formal tenders must be obtained. The ~~DoF~~CFO shall be responsible for designing and maintaining a system of verification recording and payment of all amounts payable. The system shall include:

9.2.3.1. a list of directors/employees authorised to certify invoices;

9.2.3.2. a process for certifying that:

9.2.3.2.1. goods have been duly received, examined and are in accordance with specification and that the prices are correct;

9.2.3.2.2. work done or services rendered have been satisfactorily carried out in accordance with the order and, where applicable, the materials used are of the requisite standard and the charges are correct;

9.2.3.2.3. in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the timesheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

9.2.3.2.4. where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

9.2.3.2.5. the account is arithmetically correct; and

9.2.3.2.6. the account is in order for payment.

9.2.4. Prepayments are only permitted where exceptional circumstances apply. The ~~DoF~~CFO or Deputy CFO is required to approve any prepayments.

9.2.5. Official orders must:

9.2.5.1. be in a form approved by the ~~DoF~~CFO;

9.2.5.2. state the ~~Trust~~Foundation Trust's terms and conditions of trade;

9.2.5.3. be held securely, issued to and used only by those duly authorised under the ~~SD~~SoD;

9.2.5.4. be authorised by an Officer of the ~~Trust~~Foundation Trust in line with the ~~SD~~SoD; and

9.2.5.5. be priced (firm or estimate).

9.2.6. Managers must ensure that they comply fully with the guidance and limits specified by the ~~DoF~~CFO and that:

~~9.2.6.1. all contracts (other than for a simple purchase permitted within the SD or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the DoF in advance of any commitment being made;~~

~~9.2.6.2.~~9.2.6.1. all transactions which qualify as significant or material transactions are reported in the appropriate manner to ~~NHSI~~NHSE;

~~9.2.6.3.~~9.2.6.2. contracts above specified thresholds are advertised and/or awarded in accordance with extant ~~OJEU~~ regulations covering ~~rules on~~ public procurement;

~~9.2.6.4.~~9.2.6.3. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees in breach of ~~Trust~~Foundation Trust policy;

~~9.2.6.5.~~9.2.6.4. where the ~~Trust~~Foundation Trust employs specialist expertise the appropriate head of department is consulted prior to purchase. Examples would include but not be limited to IT, Fleet, Estates, or Learning and Development;

~~9.2.6.6.~~9.2.6.5. no requisition/order is placed for any item or items for which there is no budget provision unless approved in line with the Business Case or Virement Process; and

~~9.2.6.7.~~9.2.6.6. all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract or purchases from petty cash.

~~9.2.6.8.~~9.2.6.7. Any orders made for goods/services from companies owned or controlled by current or former employees should require the approval of the company secretary to ensure no conflict of interest occurs in the requisition.

9.2.7. Verbal orders must only be issued very exceptionally, by an employee designated by the ~~CE~~CEO and only in cases of emergency or urgent necessity. These must be confirmed within one working day by an official order which is clearly marked “Confirmation Order”;

9.2.7.1. orders must not split or be otherwise placed in a manner devised so as to avoid the financial thresholds;

9.2.7.2. goods must not be taken on trial or loan in circumstances that could commit the ~~Trust~~Foundation Trust to a future uncompetitive purchase;

9.2.7.3. changes to the list of directors/employees authorised to certify invoices must be notified to the ~~DoF~~CFO.

9.2.8. The ~~DoF~~CFO will ensure that there are controls over additions and deletions to the ~~Trust~~Foundation Trust's list of approved contractors and suppliers.

9.2.9. The ~~CE~~CEO shall ensure that lists of all contractors are maintained in an up-to-date condition and ensure that systems are in place to deal with applications, resignations, inspection of premises etc. within the contract.

9.2.10. The ~~DoF~~CFO shall ensure that:

9.2.10.1. only contractors who are included on the ~~Trust~~Foundation Trust's approved lists receive payments;

9.2.10.2. regular independent verification of claims is undertaken; and

9.2.10.3. arrangements are in place to identify contractors receiving exceptionally high, low or no payments and these are followed through for further investigation.

9.2.11. The process and authority limits for tendering are outlined in Appendix 1 of this document.

10. EXTERNAL BORROWING AND INVESTMENTS

10.1. External Borrowing

10.1.1. The ~~DoF~~CFO will advise the Board concerning the ~~Trust~~Foundation Trust's ability to pay interest on, and repay, any proposed borrowing. The ~~DoF~~CFO is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

10.1.2. Any application for a loan or overdraft will only be made by the ~~DoF~~CFO or by an employee so delegated by him/her with Board approval following a recommendation by FIC.

10.1.3. All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement ~~in excess of~~of more than one month must be authorised by the ~~DoF~~CFO.

10.1.4. All long-term borrowing must be consistent with the plans outlined in the current Plan.

10.2. Investments

10.2.1. All surplus cash balances shall remain in liquid form~~s~~ and any investments of surplus funds shall be realisable as required and have a maturity not exceeding three months.

Surplus ~~C~~cash deposits shall only be placed with banks in line with deposit limits set out below and based on the ratings from one of the top three ratings agencies, such as Moody's Investor Services Ltd.

10.2.2. Temporary cash surpluses must be held only in such public or private sector investments as comply with the following limits:-

- Government Banking Service (GBS) is unlimited
- UK Clearing banks have a limit of £10.0m for any one institution
- If not a UK clearing bank but the parent is domiciled in the UK then:-
  - Banks rated Aaa to A1 by Moody's have a limit of £~~5.0~~0.5m per institution
  - ~~Banks rated Aa1 by Moody's have a limit of £5.0m~~
  - ~~Banks rated Aa2 and Aa3 by Moody's have a limit of £2.0m~~
  - ~~Banks rated A1 have a limit of £1.0m~~
  - ~~Banks rated A2 and A3 have a limit of £1.0m~~
  - Banks rated below this have a NIL limit

~~10.2.3.~~ The Head of Financial Account~~ing and Compliance (HFAC)~~s (HFA or equivalent) will identify the most appropriate way to invest surplus funds with the permitted institutions above. ~~The HFAC will also obtain due~~

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~~authorisation of the proposed investment in accordance with the below limits for any investment period from overnight to threex months:~~

~~10.2.3. Approval via the Finance & Investment Committee~~

10.2.4. The ~~DoF~~CFO is responsible for implementing a Treasury Management Process, which will include arrangements for investing surplus funds.

10.2.5. The ~~DoF~~CFO is responsible for advising the FIC on investment performance.

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11. CAPITAL INVESTMENT, FINANCING and ASSET MANAGEMENT

11.1. Capital Investment

11.1.1. The ~~DoF~~CFO shall:

11.1.1.1. ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Plan; and

11.1.1.2. be responsible for the oversight of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

11.1.2. The ~~DoF~~CFO has authority to determine the arrangements for funding capital expenditure. The possible sources of funding include borrowing, capital receipts, revenue contributions, leasing, or existing cash reserves. The ~~DoF~~CFO shall determine the most suitable based on the overall cash position of the ~~Trust~~Foundation Trust and the specific nature of the asset being acquired.

11.1.3. The capital plan, including financing options set out in 11.1.2 , will be approved annually by the Trust's Board per section 3.~~The DoF shall report his decision as to the funding of capital expenditure, with reasons, to either the Audit Committee or FIC if requested to do so.~~

11.1.4. For every capital expenditure proposal the ~~DoF~~CFO shall ensure that a Business Case ~~or Business Brief~~ is produced in accordance with section 3 ~~the Business Case Process~~, setting out:

11.1.4.1. a clear statement of the purpose of the proposed expenditure;

11.1.4.2. a suitable financial analysis detailed enough to allow an assessment of the payback or Net Present Value of the proposed expenditure and appropriate to the size, complexity and timeframe of the proposal;

11.1.4.3. an appraisal of other options considered which clearly lays out the reasons for the proposed decision; and

11.1.4.4. appropriate project management and control arrangements, including post project appraisal of benefits

11.1.5. For capital schemes where the contracts stipulate stage payments, the ~~DoF~~CFO will issue procedures for their management.

11.1.6. The ~~DoF~~CFO shall issue processes for the regular reporting of expenditure and commitment against authorised expenditure. This is covered in the Business Case Process.

11.1.7. The approval of a capital programme and inclusion in the annual plan as set out in section 3 shall not constitute approval for expenditure on any scheme. Following ~~Business Case~~ approval in accordance with the Business Case Process, the ~~DoF~~CFO shall confirm to the manager responsible for any scheme:

11.1.7.1. specific authority to commit expenditure;

11.1.7.2. authority to proceed to tender; and

11.1.7.3. approval to accept a successful tender.

11.1.8. The ~~DoF~~CFO shall issue guidance governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2. Estates Transactions

11.2.1. The Board must approve any decision to purchase or dispose of land or estates property. This can be part of the Board's approval of the annual plan.

11.2.2. The Board must approve any decision to enter into leases for land or estates property. This can be part of the Board's approval of the annual plan.

11.2.3. The Board is not required to approve leases for property where the inclusive annual rental is less than £5,000 and the lease term less than 10 years.

11.3. Private Finance

11.3.1. The Board must approve any decision to use private finance.

11.4. Asset Registers

11.4.1. The ~~Trust~~Foundation Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in guidance issued by ~~NHSI~~NHSE.

11.4.2. The ~~DoF~~CFO is responsible for the maintenance of registers of assets and arranging for a physical check of assets against the asset register to be conducted at least once a year.

11.4.3. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

11.4.3.1. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties; or

11.4.3.2. stores, requisitions and wages records for own materials and labour including appropriate overheads; or

11.4.3.3. lease agreements in respect of assets held under a finance lease and capitalised.

11.4.4. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to a signed disposal form and invoices.

11.4.5. The ~~DoF~~CFO shall approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers.

11.4.6. The valuation and depreciation of fixed assets is set ~~governed by generally accepted accounting practice. As it applies to Foundation Trusts this is~~ laid out in the Government FReM~~FT Annual Reporting Manual (ARM)~~.

11.5. Security of Assets

11.5.1. The overall control of fixed assets is the responsibility of the ~~CE~~CEO.

11.5.2. Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be approved by the ~~DoF~~CFO. These procedures shall make provision for:

11.5.2.1. recording managerial responsibility for each asset;

11.5.2.2. identification of additions and disposals;

11.5.2.3. identification of all repairs and maintenance expenses;

11.5.2.4. physical security of assets;

11.5.2.5. periodic verification of the existence of, condition of and title to assets recorded;

11.5.2.6. identification and reporting of all costs associated with the retention of an asset; and

11.5.2.7. reporting, recording and safekeeping of cash, cheques and negotiable instruments.

11.5.3. All discrepancies revealed by the physical verification of assets to the fixed asset register shall be notified to the ~~DoF~~CFO and reported to the ~~AuC~~ARC.

11.5.4. Any damage to the ~~Trust~~Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12. STORES AND RE~~CE~~CEIPT OF GOODS

12.1. General

12.1.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

12.1.1.1. kept to an operationally efficient minimum;

12.1.1.2. subjected to regular stock take, either perpetual and/or annual;

12.1.1.3. valued at the lower of cost or net realisable value; and

12.1.1.4. be kept as secure as practically possible.

12.2. Control

12.2.1. Subject to the responsibility of the ~~DoF~~CFO for maintaining effective systems of control, overall responsibility for the control of stores shall be delegated to an employee by the ~~CE~~CEO. Day to day responsibility may be delegated to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the ~~DoF~~CFO. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of fuel oil shall be the responsibility of the Head of Estates; and the control of vehicle fuel shall be the responsibility of the Head of Fleet.

12.2.2. Responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer.

12.2.3. The Chief Pharmacist is responsible to the ~~MD~~CMO and the Controlled Drugs Accountable Officer for the specific storage, distribution and record keeping obligations that are required for pharmaceuticals including controlled drugs.

12.2.4. The ~~DoF~~CFO shall set out procedures and systems to regulate stores including records for receipt of goods, issues, returns to stores and losses.

12.2.5. Stocktaking arrangements shall be agreed with the ~~DoF~~CFO. The relevant Heads of Department (where stock is held) shall ensure that a physical check covering all items in store is carried out at least once a year.

12.2.6. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the ~~DoF~~CFO.

12.2.7. The designated manager/pharmaceutical officer shall be responsible for a system approved by the ~~DoF~~CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the ~~DoF~~CFO any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13. DISPOSALS, LOSSES AND SPECIAL PAYMENTS

13.1. Disposals

13.1.1. The ~~DoF~~CFO shall prepare a detailed Asset Disposal Process, including condemnations, and ensure that this is notified to managers.

13.1.2. When it is decided to dispose of a ~~Trust~~Foundation Trust asset, the relevant head of department or authorised deputy will determine and advise the ~~DoF~~CFO of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3. All unserviceable articles shall be:

13.1.3.1. condemned or otherwise disposed of by an employee authorised for that purpose by the ~~DoF~~CFO;

13.1.3.2. recorded in a form approved by the ~~DoF~~CFO, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the condemning manager and countersigned by the ~~DoF~~CFO in the circumstances outlined in the Asset Disposal Process.

13.1.4. The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the ~~DoF~~CFO who will take the appropriate action.

13.2. Losses and Special Payments

13.2.1. The ~~DoF~~CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The ~~DoF~~CFO must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

13.2.2. Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must immediately inform the ~~CE~~CEO and the ~~DoF~~CFO or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the ~~DoF~~CFO and/or ~~CE~~CEO.

13.2.3. In cases of fraud, bribery and corruption or of anomalies that may indicate such offences, the ~~DoF~~CFO will instruct the LCFS to carry out an investigation.

13.2.4. The ~~DoF~~CFO must notify the LCFS and the External Auditor of all suspected cases of fraud and bribery.

13.2.5. For material losses apparently caused by theft, arson, neglect of duty or gross carelessness the ~~DoF~~CFO must immediately notify:

13.2.5.1. ~~AuC~~ARC, and

13.2.5.2. the External Auditor.

13.2.6. In accordance with the ~~SD~~SoD, the ~~DoF~~CFO shall approve the writing off of losses. It should be noted that the decision to write off assets or losses is an accounting judgement and is not, therefore, subject to ~~AuC~~ARC approval. The ~~AuC~~ARC should be informed of any decision and may request review by external auditors or independent specialists.

13.2.7. The ~~DoF~~CFO shall be authorised to take any necessary steps to safeguard the ~~Trust~~Foundation Trust's interests in personal and company insolvencies.

13.2.8. For any loss, the ~~DoF~~CFO should consider whether this is covered by an insurance policy and if so whether any insurance claim can be made to recover the losses incurred by the ~~Trust~~Foundation Trust.

13.2.9. The ~~DoF~~CFO shall maintain a record of Losses and Special Payments, in which write off action is recorded and this shall be reported to ~~AuC~~ARC annually.

14. INFORMATION TECHNOLOGY

14.1. Controls

14.1.1. The ~~DoF~~Chief Digital and Information Officer (CDIO), ~~who~~ is responsible for the accuracy and security of the digital ~~computerised~~ data of the ~~Trust~~Foundation Trust and is also ~~in conjunction with~~ the Senior Information Risk Owner (SIRO) for the Foundation Trust and shall:-

14.1.1.1. devise and implement procedures and systems to ensure adequate protection of the ~~Trust~~Foundation Trust's digital and other data and information, and its digital assets.~~programs and computer hardware~~ Including, but not limited to, ~~from~~ accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard to Data Protection legislation;

14.1.1.2. ensure that adequate controls exist and the ~~Trust~~Foundation Trust remains compliant with data protection legislation regarding data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of data, as well as the efficient and effective operation of systems;

14.1.1.3. ensure that, where cloud-based systems are used, or otherwise data is held offsite that the reliability and security of those ~~and in~~ third party systems is appropriate and secure;

14.1.1.4. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out; and

14.1.1.5. prepare and maintain a digital ~~an IT~~ strategy for regular approval by the ~~Trust~~Foundation Trust Board.

14.2. System Development

14.2.1. The ~~DoF~~CDIO shall ensure that new digital~~IT~~ systems and amendments to current systems are developed and documented in such a manner that the ~~Trust~~Foundation Trust are adequately supported either through robust third party contracts or internally through the Digital~~IT~~ function. Where this is undertaken by another organisation, appropriate UAT (user acceptance testing) and SAT (Systems acceptance testing) will be carried out by them prior to implementation.

14.2.2. Ensure that a Data Privacy Impact Assessment is completed in instances where new ~~IT~~digital systems are being developed or there is an amendment or update to a current system.

14.3. Data Security and Integrity

14.3.1. The ~~DoF~~DCIO shall ensure that contracts for ~~IT~~digital services shall clearly define service availability and that the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage is clearly defined. The contract shall also ensure the ~~Trust~~Foundation Trust has rights of access for audit purposes and confirm compliance with Data Protection Legislation.

14.3.2. Where another agency provides a digital ~~computer~~ service for financial applications, the ~~DoF~~CFO shall ~~periodically~~ seek annual assurances that adequate controls are in operation.

14.3.3. Where computer systems have an impact on corporate financial systems the ~~DoF~~CFO shall ensure that:

14.3.3.1. systems acquisition, development and maintenance are in line with corporate policies, data protection legislation, and the Information Technology Strategy;

14.3.3.2. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists; and

14.3.3.3. appropriate and effective ~~IT~~ audit reviews are carried out.

14.4. Information Governance

14.4.1. The ~~DSBD~~CDIO as SIRO shall publish and maintain standards for Information Governance.

14.5. Freedom of Information

14.5.1. The ~~DSBD~~DSPT shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner, providing a complete guide to the information routinely published by the ~~Trust~~Foundation Trust and describing the classes and types of information available.

14.6. Resilience and Disaster Recovery

14.6.1. The ~~DoF~~CDIO shall ensure that risks to the ~~Trust~~Foundation Trust from the use of ~~IT~~digital assets are identified and are considered in the development of disaster recovery plans and resilience. Disaster Recovery Plans will support each department's business continuity arrangements.

15. CHARITABLE FUNDS

15.1. Introduction

15.1.1. The SOs identify the ~~Trust~~Foundation Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and defines how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the ~~Trust~~Foundation Trust, the trustee responsibilities must be discharged separately and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on trust, and to ~~NHSI~~NHSE for all funds held under the NHS Provider Licence.

15.1.2. The ~~DoF~~CFO is responsible for establishing a procedure or process to cover the management of charitable funds. This will need to document areas where the internal controls over charitable funds differ from the standard internal controls adopted by the ~~Trust~~Foundation Trust.

15.1.3. The Charitable Funds Committee (CFC) is responsible for the oversight of matters relating to charitable funds, in line with the procedure/process on use of Charitable Funds approved by the board and detailed below.

15.2. Existing Charitable Funds

15.2.1. Charitable Funds will be used only where there is a clear charitable purpose.

15.2.2. Decisions must be made in the interest of the charity to further its charitable objects of:

15.2.2.1. the relief of those in need by reason of old age, health disability or financial hardship;

15.2.2.2. the advancement of health or the saving of lives; or

15.2.2.3. the promotion of the effective operation of the ambulance and emergency healthcare services.

15.2.3. There must be a clear open and independent process of decision making by the ~~Trust~~Foundation Trustees to support any decision.

15.2.4. The ~~DoF~~CFO shall arrange for the administration of all charitable funds and ensure that a governing document exists. Detailed processes covering every aspect of the financial management of charitable funds must be produced for the guidance of directors and employees.

15.2.5. The ~~DoF~~CFO shall periodically review the funds in existence and shall make recommendations to the CFC regarding the potential for rationalisation of such funds within statutory guidelines.

15.2.6. The ~~DoF~~CFO may recommend an increase in the number of funds where this is consistent with the ~~Trust~~Foundation Trust's approach to ensuring the safe and appropriate management of restricted funds.

15.3. New Funds

15.3.1. The ~~DoF~~CFO shall arrange for the creation of a new trust where funds, or other assets, received in accordance with the ~~Trust~~Foundation Trust's policies, cannot adequately be managed as part of existing charitable fund arrangements.

15.3.2. Governing documents for any new funds shall be presented to the CFC for approval.

15.3.3. The ~~DoF~~CFO shall give consideration to the appropriateness of any new funds. Where the purpose of new funds offered may run counter to the effective running of the ~~Trust~~Foundation Trust for its primary purpose the ~~DoF~~CFO may recommend to the CFC that new funds are declined. The CFC will make this decision in the best interests of the whole public served by the ~~Trust~~Foundation Trust.

15.4. Source of New Funds

15.4.1. In respect of donations the ~~DoF~~CFO shall provide guidance as to how to proceed when offered funds, including:

15.4.1.1. the identification of the donor's intentions;

15.4.1.2. the avoidance of new funds where possible; and

15.4.1.3. the avoidance of impossible, undesirable or administratively difficult objectives.

15.4.2. In respect of legacies and bequests, the ~~DoF~~CFO shall:

15.4.2.1. provide guidelines to officers of the ~~Trust~~Foundation Trust covering any approach regarding:

15.4.2.1.1. the wording of wills;

15.4.2.1.2. the receipt of funds/assets from executors;

15.4.2.2. if necessary, obtain grant of representation where the ~~Trust~~Foundation Trust has an interest;

15.4.2.3. be empowered, on behalf of the ~~Trust~~Foundation Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

15.4.2.4. be empowered, subject to receiving and acting upon appropriate legal advice, to enter into any agreement with the personal representative of the estate relating to the treatment of legacies and bequests.

15.4.3. In respect of fundraising, the ~~CE~~CEO and CFO are ~~shall be the only officer~~ empowered to give approval for such fund raising subject to the overriding direction of the Board and shall:

15.4.3.1. manage all arrangements for fundraising by and/or on behalf of the ~~Trust~~Foundation Trust and ensure compliance with all statutes and regulations;

15.4.3.2. liaise with other organisations/persons raising funds for the ~~Trust~~Foundation Trust and provide them with an adequate discharge; and

15.4.3.3. be responsible for alerting the Board to any irregularities regarding the use of the ~~Trust~~Foundation Trust's name or its registration number.

15.4.4. In respect of investment income, the ~~DoF~~CFO shall be responsible for the appropriate treatment and recording of all dividends, interest and other receipts.

15.5. Investment Management

15.5.1. The ~~DoF~~CFO shall be responsible for all aspects of the management of the investment of charitable funds and is required to advise the CFC on the following issues:

15.5.1.1. the formulation of an investment policy, within the legal powers of the ~~Trust~~Foundation Trust, to meet requirements with regard to income generation and the enhancement of capital value;

15.5.1.2. the appointment of advisers, brokers, and fund managers, including the terms of such appointments, subject to written agreements being signed by the ~~CE~~CEO;

15.5.1.3. pooling of investment resources and the preparation of a submission to the Charity Commission for them to authorise a scheme;

15.5.1.4. the participation by the ~~Trust~~Foundation Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

15.5.1.5. ensuring that the use of charitable assets shall be appropriately authorised in writing and changes raised within procedural guidelines;

15.5.1.6. the review of the performance of brokers and fund managers; and

15.5.1.7. the reporting of investment performance.

15.6. Disposition Management

15.6.1. The exercise of the investment disposals shall be managed by the ~~DoF~~CFO in conjunction with the CFC. In so doing the ~~DoF~~CFO shall be aware of the following:

15.6.1.1. the objects of various funds and the designated objectives;

15.6.1.2. the availability of liquid funds within each charitable fund;

15.6.1.3. the powers of delegation available to commit resources;

15.6.1.4. the avoidance of the use of exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by charitable funds at the earliest possible time;

15.6.1.5. that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the ~~Trust~~Foundation Trust; and

15.6.1.6. the definitions of "charitable purposes" as agreed by the NHS with the Charity Commission.

15.7. Banking Services

15.7.1. The ~~DoF~~CFO shall advise the CFC and, with its approval, shall ensure that appropriate banking services are available to the ~~Trust~~Foundation Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

15.8. Asset Management

15.8.1. Assets in the ownership of or used by the ~~Trust~~Foundation Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the ~~Trust~~Foundation Trust. The ~~DoF~~CFO shall ensure that:

15.8.1.1. appropriate records of all assets owned by the ~~Trust~~Foundation Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account; and

15.8.1.2. appropriate measures are taken to protect and/or to replace assets, to include the taking of decisions regarding insurance, inventory control, and the reporting of losses.

15.9. Reporting

15.9.1. The ~~DoF~~CFO shall ensure that regular reports are made to the CFC on the receipt of funds, investments and the disposition of resources.

15.9.2. The ~~DoF~~CFO shall prepare annual accounts in the required manner, which shall be submitted, to the CFC within agreed timescales.

15.9.3. The ~~DoF~~CFO shall prepare an annual trustees' report and the required returns to ~~NHSI~~NHSE and to the Charity Commission for adoption by the Board.

15.10. Accounting and Audit

15.10.1. The ~~DoF~~CFO shall maintain all financial records to enable the production of reports as above and to the satisfaction of Internal and External Audit.

15.10.2. The ~~DoF~~CFO shall ensure that the records, accounts and returns receive adequate scrutiny by Internal Audit during the year and~~. He~~ will liaise with External Audit and provide such ~~them with all necessary~~ information as required to fulfil the audit.

15.10.3. ~~AuC~~ARC will recommend the appropriate level of external audit to be adopted by the ~~Trust~~Foundation Trust within the regulations set down by the Charity Commission.

15.10.4. The Board shall be advised by the ~~DoF~~CFO on the outcome of the annual audit by ensuring that the audited accounts for the charitable funds are approved by ~~AuC~~ARC and subsequently by the Board.

15.11. Administration Costs

15.11.1. The ~~DoF~~CFO shall identify all costs directly incurred in the administration of funds held on trust and shall charge such costs to the appropriate charitable funds.

16. RETENTION OF DOCUMENTS

16.1. Archives

16.1.1. The ~~CE~~CEO shall be responsible for maintaining archives for all documents required to be retained.

16.1.2. The ~~CE~~CEO shall authorise requests to retrieve documents from archive. This power may be delegated to a nominated representative in each directorate.

16.1.3. The ~~DSBD~~DCIO is responsible for designating a document retention lead who is responsible for ensuring that documents are retained in accordance with NHS document retention guidance.

16.1.4. In the event that a document should be retained indefinitely, a corporate document register should be created. It should be noted that very few documents require indefinite retention.

17. RISK MANAGEMENT AND INSURAN~~CE~~CE

17.1. Risk Management Programme

17.1.1. The ~~CE~~CEO shall ensure that the ~~Trust~~Foundation Trust has a programme of risk management, in accordance with the requirements of the NHS Audit Committee Handbook, Care Quality Commission and ~~NHSI~~NHSE, which will be approved and monitored by the Board. The agreed arrangements can be found within the ~~Trust~~Foundation Trust's Risk Management Policy.

17.1.2. The Board is responsible for ensuring that there is an effective programme of risk management, which shall include:

17.1.2.1. a process for identifying and quantifying risks and potential liabilities;

17.1.2.2. engendering among all levels of staff a positive attitude towards the reporting and control of risk;

17.1.2.3. management processes to ensure that all significant risks and potential liabilities are addressed, including effective systems of internal control, decisions on the acceptable level of retained risk, and ~~cost-effective~~cost-effective insurance cover;

17.1.2.4. contingency plans and business continuity planning to offset the impact of adverse events;

17.1.2.5. effective audit arrangements, including internal audit, clinical audit, and health and safety review; and

17.1.2.6. arrangements to review the risk indices, programmes and procedures.

17.1.3. The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal financial control within the Annual Report and Accounts.

17.1.4. The ~~DoF~~CFO shall ensure that insurance arrangements are in place that reflect the requirements of the risk management programme.

18. ACCECEPTANCECE OF GIFTS/HOSPITALITY/SPONSORSHIP

18.1. The acceptance of gifts and hospitality represents a risk of bribery and a risk of the perception of corruption. The CECEO is responsible for ensuring that there is a clear policy in place, which complies with legislation in respect of fraud, corruption and bribery, including the offer and/or acceptance of gifts, hospitality, and sponsorship. All staff are responsible for adhering to this policy.

Appendix 1

TENDERING PROCECECEDURE

1. INVITATION TO TENDER

1.1. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted:

1.1.1. electronically using the TrustFoundation Trust's e-Tendering Toolplatform, with tenders being locked down until the return date and time; or

1.1.1.1. in a plain, sealed package bearing a pre-printed label supplied by the TrustFoundation Trust or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender.

1.2. The tender envelopes/packages shall not bear any names or marks indicating the sender.

1.3.1.2. Every tender for goods, materials, services, (including consultancy services) or disposals shall embody all NHS Standard Terms and Condition of Contract that are applicable unless a framework is being used and in these instances the framework call-off terms will apply. Every tender must have given or give a written undertaking not to engage in collusive tendering or other restrictive practices.

2. RECECEIPT, SAFE CUSTODY AND RECORD OF FORMAL TENDERS

2.1. The Head of ProcurementAssociate Director of Procurement (HoPADoP) shall authorise a procurement representative to oversee each tender.

2.2. For electronic tenders:

2.2.1. formal tenders will be submitted using the TrustFoundation Trust's e-Tendering tool platform and will be unlocked automatically on the set return date and time; and

2.2.2. the authorised procurement representative will be responsible for the maintenance of all records.

2.3. For paper based tenders:

2.3.1. formal competitive tenders shall be addressed to the TrustFoundation Trust Secretary;

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2.3.2. the date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package; and

2.3.3. the TrustFoundation Trust Secretary or DoFCFO shall receive tenders, and be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.5.

3. OPENING FORMAL TENDERS

3.1. For electronic tenders:

3.1.1. all tenders will be accepted by the unlocking of the e-Tendering toolplatform; and

3.1.2. all changes will be fully auditable within the e-Tendering toolplatform.

3.2. In the case of paper-based tenders:

3.2.1. as soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in accordance with the Scheme of Delegation (SDSoD) or Standing Orders (SO); and

3.2.2. every tender received shall be stamped with the date of opening and initialled by two TrustFoundation Trust directors, in line with the SDSoD, present at the opening.

3.2.3. A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

3.2.3.1. the names of firms/individuals invited to tender;

3.2.3.2. the names of and the number of firms/individuals from which tenders have been received;

3.2.3.3. the total price(s) tendered;

3.2.3.4. closing date and time;

3.2.3.5. date and time of opening;

3.2.3.6. and the record shall be signed by the directors present at the opening.

3.3. A record shall be maintained of all price alterations on tenders, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialled by two of those present at the opening.

~~3.4. A report shall be made in the record if price alterations are so numerous as to render this procedure unreasonable.~~

4. ADMISSIBILITY AND AC~~C~~ECEPTAN~~C~~ECE OF FORMAL TENDERS

4.1. In considering which tender to accept, if any, the designated officers shall have regard to whether best value will be obtained by the ~~Trust~~Foundation Trust and whether the number of tenders received provides adequate competition. In cases of doubt, they shall consult the ADoP or~~DoF~~CFO. The Procurement Act 2023 changes the award criteria to 'most advantageous tender' so as to ensure all qualitative elements are considered alongside cost and value for money.

4.2. Tenders received after the due time and date may be considered only if the ~~DoF~~CFO~~C~~ADoP decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the veracity of the tenderers concerned. The ~~HoP~~ADoP shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted, the late arrival of the tender should be reported in the Tender Evaluation Report and also to ~~Au~~ARC at its next meeting.

~~4.3. Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) may at the discretion of the DoFCFO be regarded as having arrived in due time.~~

~~4.4.~~4.3. Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2.

~~4.5.~~4.4. Where examination of tenders reveals errors which would affect the tender values, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing its offer.

~~4.6.~~4.5. Necessary discussions with a tenderer of the contents of its tender, in order to elucidate technical points before the award of a contract, do not disqualify the tender.

~~4.7.~~4.6. While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept ~~in safekeeping~~securely by an officer designated by the ~~HoP~~ADoP.

4.8.4.7. Where only one tender/quotation is received, the ~~DoF~~CFO or ~~HoP~~ADoP shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.9. ~~A tender other than the lowest (if payment is to be made by the Trust~~Foundation Trust~~), or other than the highest (if payment is to be received by the Trust~~Foundation Trust~~) shall not be accepted unless for good and sufficient reason the DoF~~CFO decides otherwise and reports the fact and the implications of making that decision to AuC~~ARC~~.~~

4.10.4.8. Where the form of contract includes a fluctuation clause, all applications for price variations must be submitted in writing by the tenderer and shall be approved by the ~~DoF~~CFO or ~~HoP~~ADoP.

4.11.4.9. All tenders must be treated as confidential and must be retained for a period of at least 6 years for unsuccessful tenders, or 6 years beyond the life of the successful tendered contract.

4.12.4.10. Post-tender negotiation is ~~not~~ permitted if the competitive flexible procedure has been used for the procurement.~~: clarification is permitted but price negotiation is not.~~

5. MONITORING POTENTIAL AND CURRENT SUPPLIERS

5.1. The ~~HoP~~ADoP, or a nominated specialist, shall ensure that appropriate checks are carried out as to the technical and financial capability of firms invited to tender or quote. This will usually be via a ~~Pre-Qualification Questionnaire (PQQ).~~Selection Questionnaire.

5.2. In the case of major or significant building, engineering and maintenance works, the ~~HoP~~ADoP, in conjunction with the ~~DoF~~CFO, must be satisfied on their capacity and the ~~DoF~~CFO must be satisfied that their financial standing is adequate.

5.3. In the case of the supply of goods, materials and related services, and management consultancy services, the ~~HoP~~ADoP or the nominated specialist must be satisfied as to their technical competence and the ~~DoF~~CFO must be satisfied that their financial standing is adequate.

5.4. In the case of the provision of healthcare services to the ~~Trust~~Foundation Trust by a private sector provider, the ~~DoF~~CFO must be satisfied as to their financial standing and the ~~MD~~CMO/~~DoO~~COO must be satisfied as to their technical/medical competence.

5.5. If the value of the contract exceeds, or is anticipated to exceed, the formal tender ~~EU~~ thresholds then this should be referred to the ~~HoP~~ADoP for due process.

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5.6. The ~~HoP~~ADoP will monitor the level of business transacted with suppliers by the ~~Trust~~Foundation Trust in relation to the total annual turnover of the supplier. Where it is expected or anticipated that the ~~Trust~~Foundation Trust business represents 50% or more of a supplier's total annual turnover the ~~DoF~~CFO will review the extent that this represents a risk to the ~~Trust~~Foundation Trust and agree any necessary action to remove or mitigate this risk.

6. Signing Contracts

6.1. Contracts, which have followed due process, may be signed by the ~~HoP~~ADoP or the DSPT on behalf of the ~~Trust~~Foundation Trust if the annual value is less than £250k (ex VAT). Contracts with an annual value greater than £250k (ex VAT) must be signed by the ~~DoF~~CFO or ~~CE~~CEO.

7. Value for Money Assessment

7.1. The ~~Trust~~Foundation Trust recognises that the best value for the ~~Trust~~Foundation Trust is not always delivered by the lowest cost procurement. Value will be assessed on the Most ~~Economically~~ Advantageous Terms (M~~E~~AT).

Schedule to Appendix 1

Competitive Tendering Requirements

Quotation Thresholds (ex VAT):

Up to £10K – 1 quote

£10K to £50K – 2 quotes

£50K to £116.4K – 3 quotes

Tender Threshold:

£116.4K* (ex VAT) – formal tender or further competition (or exceptionally, direct award) from a PSBO framework

PSBO's include NHS Supply Chain, CCS, ESPO, CPC, etc.

[*The PCR threshold is £139,688 incl VAT]

When requisitions are raised it is imperative that supporting documentation such as multiple quotations or evidence of a contract/agreement is uploaded with the requisition or else retained such that the Procurement Team can review it.

When intended expenditure (as raised in the form of a requisition which is then converted to a Purchase Order) is reviewed against the thresholds it must not only account for the immediate purchase value (comparing this with the thresholds) but also the value of the intended purchase with the aggregated expenditure to that particular supplier (otherwise there is a risk of challenge for deliberately disaggregating requirements in order to circumvent the Public Contract Regulations (PCR)). Procurement will review the Foundation Trust's contract register to check if a compliant and 'live' contract or agreement is in place to cover the expenditure value.

The Procurement Team will ensure compliance with our SFIs and the PCR including reviewing POs prior to 'release'.

Additionally, as a publicly funded body the Foundation Trust will comply with **transparency obligations of the Procurement Act** in relation to publishing ~~contract award~~ notices, for instance, award notices for contracts or call-off agreements in excess of £30K (incl VAT).

If POs are being presented for 'release' and there is not a compliant and 'live' contract or framework call-off agreement which covers the expenditure, and the business has not been able to evidence that the SFI's procurement thresholds are met then a **SFI Waiver** will be required prior to expenditure being committed.

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Standing Financial Instructions (SFI) Waivers should be the exception and apply if the procurement thresholds cannot be observed for one or more of the following three reasons:

- Sole supplier (service only available from one supplier)
- Extension of similar existing competitively tendered contract
- Unforeseen urgency (failure to plan effectively does not meet the grounds of unforeseen urgency)

Waivers must be endorsed by the Associate Director of Procurement and then can only be approved by the CFO or CEO.

Waivers will be routinely reported to the Audit and Risk Committee and as such full justification for their use must be evident. The Audit and Risk Committee may require further explanation for failure to comply with PCR and extant regulation covering public sector procurement regulations.

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Quotation and Tendering Requirements	
Revenue, Management Consultancy and Non-Works Capital Expenditure	
Up to £10,000	1 written quote
£10,001 to £50,000	2 written quotes
£50,001 to £180,000	3 written quotes
Over £180,000	EU Directive Requirements
Works Capital Expenditure	
£10,001 to £50,000	2 written quotes
£50,001 to £100,000	3 written quotes
£100,001 to £500,000	3 tenders
£500,001 to £4,800,000	4 tenders
Over £4,800,000	EU Directive Requirements

1. Notes :

i. It is good practice to ensure written confirmation of price/quotation is obtained for all orders of any value to help ensure value for money and to avoid future disputes with suppliers. Where there is any doubt, advice on obtaining quotations and achieving value for money should be obtained through the Procurement Department.

ii. EU Directive requirement thresholds are shown excluding VAT, and are subject to amendment by the EU biennially and to revision due to exchange rate fluctuation on an ad-hoc basis.

iii. Existing procurement frameworks can be used as an alternative to formal tendering with prior written approval from the Head of Procurement (HoP). The call-off terms of the Framework must be followed concerning the requirement for undertaking a Direct Award or Further Mini Competitions

iv. All works tenders greater than £50,000 must be reviewed with the HoP before documents are published.

2. For the purposes of compliance against tendering limits, management consultants are defined as meeting the following criteria:

2.1. provides a human resource;

2.2. primarily of an administrative, managerial or research nature;

2.3. would, if performed in-house, be undertaken by relatively senior employees;

2.4. involves a high level of delegation;

2.5. has defined deliverables; and

2.6. has defined timescales.

3. Typically, the appointment would be for a defined period of time to deliver a product, review, or implementation to a pre-set specification within a defined cost.

4. This excludes the temporary filling of vacant senior positions, and the use of retained professional services such as architects and lawyers (which will have been appointed following a Trust-wide market testing exercise).

Finance Process 1 – Authority to Incur Expenditure

FP1 - Authority to incur expenditure v9.c

South East Coast Ambulance Service NHS
NHS Foundation Trust

FINANCE PROCESS

AUTHORITY TO INCUR EXPENDITURE (FP1)

This document should be made available to all staff employed by the South East Coast Ambulance Service NHS Foundation Trust. It sets out the guidance for all staff on the subject of authority to incur expenditure and related financial matters.

This document is an appendix to the Trust's Standing Financial Instructions and Scheme of Delegation.

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Version	1~~9~~
Issued Date	: August 2024~~Feb 2019~~
Review Date	: September 2025~~Feb 2020~~

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4. Revenue Expenditure (Within Budget)……4
5. Capital and Non-Budgeted Expenditure……..5

1. INTRODUCTION

1.1 The Trust's procedures for incurring expenditure are contained within Standing Orders (SO) and Standing Financial Instructions (SFI). Copies of these policies are available on the Trust's intranet.

1.2 This process provides specific advice on the level of financial authority delegated to managers and other staff by the Chief Executive ~~or~~and ~~Director of Finance~~Chief Finance Officer, to enable staff to discharge their duties.

1.3 Managers should contact their Finance Business Partner or the ~~Associate~~Deputy ~~Director of Finance~~Chief Finance Officer for advice on any matter relating to this Process. Any decision on interpretation shall be made by the ~~Director of Finance~~Chief Finance Officer.

1.4 Any changes to the approved budget (virements) must be approved in accordance with the Budget Virement Process (FP 2), a copy of which can be found on the Trust intranet.

2. LEVEL OF AUTHORITY

2.1 Authority to incur expenditure is set at levels considered appropriate to the responsibilities of the relevant budget holder, group or committee in light of the potential impact of decisions on the financial standing of the trust.

2.2 This Process and the associated authority limits should be reviewed annually in line with the requirement to review SFIs and Scheme of Delegation.

3. GENERAL PRINCIPLES

3.1 In allocating financial authority to individual staff the following general principles should be followed:

a) The ~~line~~ relevant executive director~~/or budget holder~~ has primary responsibility for nominating managers to be budget managers in assisting the executive director ~~m~~ to manage their budgets effectively.

b) The responsibility for financial management and control should be clearly covered in personal development reviews and objectives of budget holders/budget managers.

c) All staff are required to uphold the principles & policies stated in the Trust's SFI's, SOs and associated financial proceduresesses.

d) When requested, managers must provide an explanation for incurring expenditure and provide any supporting documents.

e) A manager may not authorise any expenditure where he/she is a beneficiary. All such expenditure needs to be authorised byreferred ato his/her line more senior manager or director. for authorisation.

f) The Director of FinanceChief Finance Officer will oversee the effective operation of budgetary delegation and where concerned that SFIs are breached or at risk of breach may suspend or revise such delegations until concerns are addressed.may object, with written justification, to the appointment or continuation of a specific individual as a budget manager or may attach further conditions to the discharge of an individual's financial authority.

4. REVENUE EXPENDITURE (WITHIN BUDGET)

4.1 Any expenditure covered in this section must be within the framework of an approved budget. It is the responsibility of the budget holder/budget manager to ensure that there is sufficient budget to cover the value of the goods or services being ordered.

4.2 Approval for the purchase of goods & services within an approved budget shall be subject to the following limits.

	Value in £
Budget Holder/ Manager Band 8B and 8C	Up to £250,000
Budget Holder/Manager Band 8D	Up to £5025,000
DeputyAssociate Director of FinanceChief Finance Officer	Up to £2550,000
Executive Director	Up to £2550,000
Chief Executive or Director of FinanceChief Finance Officer	Over £2550,000

4.3 These limits are prescribed within, and automatically applied by, the SBS system, which is the primary tool for authorising expenditure.

4.4 These limits relate to the whole life cost (WLC) (see 5.2 below).

4.5 These limits exclude VAT, reflecting the way requisitions in SBS are raised.

4.6 These limits will be monitored and may be reviewed as required.

4.7 The thresholds for quotes and tenders must be complied with; these limits are detailed in appendix 1 of the Trust's Standing Financial Instructions (SFIs)

4.8 Budget holders/budget managers should seek advice from to the Associate Director ~~Head~~ of Procurement if in doubt.

4.9 In exercising this authority, the budget holder~~/manager~~ is expected to authorise the Purchase Order Request. This should be raised through the SBS system.

5. CAPITAL AND NON-BUDGETED REVENUE EXPENDITURE

5.1 All ~~unplanned~~ capital expenditure where the Foundation Trust is operating with available capital resource and all unplanned~~non-budgeted~~ revenue expenditure where the Trust is operating with sufficient revenue surplus forecast in year must be supported by an approved Business Case ~~(or Business Brief with WLC of less than £100k).~~ The table below shows the approval limits for business cases. Refer to the Business Cases – Submission and Approval Process (FP 3) for further information.

	Approval Value	Notes
~~Associate~~Deputy ~~Director of Finance~~Chief Finance Officer	Up to £10k~~,000~~	~~New Limit, managed through Budget Virement Process~~
Senior Management Group~~Business Case Group (BCG)~~	~~Up to £100,000~~Up to £100k	~~New Limit~~

Executive Management Board (EMB)	Up to £1.5million~~,500,000~~ WLC or £750k~~,000~~ in any one year.	~~Increased from £300,000~~
~~Trust~~ Board	Over £1.~~,~~5million~~00,000~~ WLC or £750k~~,000~~ in any one year.	~~Increased from £300,000~~
In exceptional circumstances by ~~Trust Board~~ Chair's Action and Two Executive Directors (one of whom must be either the CEO or CFO)	Over £1.~~,~~5million~~00,000~~ WLC or £750k~~,000~~ in any one year.	With two Directors and Chair, notify to the Board at next available meeting.

5.2 These limits relate to the 'Whole Life Costs' (WLCs), including non-recoverable VAT, of the proposal. WLC is equal to the total capital spend plus unbudgeted operating costs and savings over the life of the project (notionally five years where costs are recurrent)

5.3 All capital expenditure that is financed by leasing (excluding staff lease cars) must be supported by a business case and submitted to the SMG~~BCG~~ and EMB for approval.

5.4 In urgent circumstances, the ~~Director of Finance~~Chief Finance Officer may authorise capital expenditure up to a value of £250k~~100,000~~ but this must be reported to the next meeting of the ~~BCG~~EMB for ratification.

5.6 Following approval of capital expenditure, expenditure is monitored by the the Finance Team~~Project Accountant~~ and if the WLC is anticipated to be 10% or £100k over the approved amount, further approval must be sought from the BCG and EMB via the submission of a revised business case.

5.7 Where the Foundation Trust is operating in a forecast revenue deficit position in-year and/or is operating within a recovery plan, no unplanned revenue expenditure for the year will be permitted except where this is expected to be lower than or equal to any year to date positive variance to the deficit plan and then shall be subject to the limits and requirements set out above.

South East Coast Ambulance Service NHS
NHS Foundation Trust

FINANCE PROCESS FP3

Business Cases – Submission and Approval Process

This document should be made available to all staff employed by the South East Coast Ambulance Service NHS Foundation Trust. It sets out the guidance for all staff on the approval process for Business Cases. Further guidance and advice on the application of this procedure should be sought from the Associate Director of Finance or Project Accountant.

This document is supplemental and subordinate to the South East Coast Ambulance Service NHS Foundation Trust Standing Orders and Standing Financial Instructions and does not override the governance provided by them either in part or in whole. This document should be read in conjunction with Financial Policy FP1 - Authority to incur expenditure.

Version:	1
Issued Date:	August 2024
Review Date:	September 2025

1. Introduction

1.1 The purpose of this paper is to outline the processes that must be followed for the approval of all Business Cases~~/Briefs~~. A flow chart of the process is included at Appendix A.

1.2 In preparing a business case due regard must be given to the requirements of Financial Process 1: Authority to Incur Expenditure and to the prevailing strategy and priorities of the Foundation Trust.~~A Business Change Template must be agreed by the Senior Leadership Team (SLT), prior to a Business Case/Brief being prepared. Please refer to section 3 below. This part of the process must also be completed prior to any funding bids being submitted.~~

~~2. When should the Business Case process be followed?~~

~~2.1 The Business Case Process **doesn't** need to be followed if one or more of the following criteria apply:~~

- ~~Where increased costs are incurred due to maternity or long-term sick leave, these budget changes are covered in FP2 - Budget Virement Process.~~
- ~~National cost pressures, such as pay awards~~
- ~~Contractual price increases.~~
- ~~Severance payments are not covered as part of this process.~~

~~2.2 The Business Case Process **does** need to be followed if one or more of the following criteria apply:~~

- ~~Proposed Capital[1] and/or Revenue expenditure is outside of approved delegated budgets This includes:~~
  - ~~Revenue expenditure identified at budget setting but not approved for inclusion in budgets under the criteria outlined above (funding, savings should be investigated to fund the proposal, if no other source of funding is found a budget would need to be transferred from Trust reserves in accordance with FP2 - Budget Virement Process).~~
  - ~~Unforeseen revenue expenditure or capital investments not identified at budget setting.~~
  - ~~Increased budgetary requirement arising from a change in Trust policy or procedure. Such requirements must be considered, and Business Case/Brief approval sought, prior to the policy or procedure being approved at JPPF.~~
  - ~~Any resource requirement identified as part of the development of Trust strategy.~~
  - ~~Expenditure relating to a new service, contract variation or other new funding source.~~

- ~~Any HR change that is required to follow the HR Organisational Change Policy.~~
- ~~Any implementation of a new IT system.~~
- ~~A proposed change that will have material resource implications for other departments.~~
- ~~If the proposal is to remove any resource either by ceasing to provide a service (disinvestment) or significantly changing the method or location in which a service is provided. This could include the sale of a building or other asset (see Financial Process FP4 – Disposal of Trust Assets).~~

[1] Any individual item above £5k or collection of items above £5k and more than £250 each that are functionally interdependent and have a useful life of more than one year.

~~3.~~2. Business Case Template~~Change Template (replacement for the cost pressure template)~~

~~3.1~~2.1 Before commencing with a Business Case (BCT)~~/Brief~~, it will be important to have read and understood the need for a business case in the context of FP1 and also the coherence of any proposal with the Foundation Trust's prevailing str\ategy and priorities. ~~the author must have first sought, and been granted, agreement from SLT for the proposal via a Business Change Template (BCT).~~ This is required to ensure that the proposal is in line with Trust priorities, and to avoid unnecessary work on Business Cases~~/Briefs~~ that do not meet those priorities. ~~This part of the process must be completed prior to any funding bid being submitted to ensure that the proposal is within the Trust's strategy and is a priority.~~

~~3.2~~2.2 BCTs will be collected through the annual budget setting process by Finance Business Partners (FBPs) in discussion with the budget holders. FBPs are responsible for reviewing BCTs before they are submitted for agreement. A BCT must be completed (see appendix B) and signed off by the sponsoring Executive Director. The BCT will then be added to the annual Business Change Tracker by the FBP and the reference will be added to the template.

~~3.3~~2.3 The Business Change Tracker and the BCT will ~~-~~be presented to SMG as part of the annual planning process and in line with set timescales~~LT~~ to decide the next step, by reference to agreed prioritisation criteria extant at the time. ~~BCTs that refer to a funding bid must be presented along with the draft funding bid~~. SMG~~SL~~T may also provide guidance on key elements to be included in any Business Case~~/Brief~~ to assist in the development of the BCT and ahead of formal timescales. Proposals will be considered under the categories listed below.

- Approve as a routine budgetary adjustment
- Manage within existing budget
- Proceed to prioritise the ~~a~~ Business Case within the Foundation Trust's annual plan~~/Brief in current financial year~~

- Defer
- Decline

~~3.4~~2.4 The outcome will be fed back to the relevant Budget Holders by the relevant FBP.

~~3.5 The same process will be followed in year for any emerging proposals. SLT meetings are every Tuesday, any completed and signed off BCTs received by the FBP teams on a Thursday, will be presented to the following Tuesday's SLT meeting.~~

~~4. Business Case/Brief Templates~~

~~4.1 Proposals can progress to the Business Case/Brief stage only once a BCT has been agreed by SLT. In the case of urgent funding bids, the bid can be submitted prior to a Business Case/Brief being approved, but one must be progressed alongside the bid and approved as soon as possible after the bid is submitted.~~

~~4.2 A Business Case is required if the total capital spend is above £100k or the total operating expenditure is above £100k, including, where relevant, non-recoverable VAT (advice will be provided by Finance). Costs must be included covering the whole life of the proposal (notionally five years where costs are recurrent). A Business Case is also required if the proposal is deemed to have a material impact on the organisation or multiple departments, even if the value of the case is below the Business Case threshold. This judgement will be made by SLT as part of the prioritisation of proposals.~~

~~4.3 A Business Brief can be used if the total capital spend is below or equal to £100k and the total operating expenditure is below or equal to £100k. Please confirm this with the Project Accountant or Associate Director of Finance prior to commencing your Business Brief to ensure that all costs have been included and the correct template is being completed.~~

~~4.4 Proposals with a total whole life operating expenditure of less than or equal to £10k can be approved by the Associate Director of Finance via the Budget Virement Process (FP2).~~

~~4.5 The Business Case template is embedded in Appendix C and the Business Brief Template in Appendix D. All sections of these templates must be completed before submission for approval.~~

~~4.6 The proposal will be added to the Business Case Tracker by the project accountant once a draft BC has been distributed to them and after a Proposal Initiation Template has been agreed. The Tracker is distributed to BCG and SLT+ monthly; the tracker will be updated as the proposal progresses through the drafting, review, and approval process.~~

~~4.7 The Project Accountant will provide any advice required on completion of the templates.~~

~~4.8 The Project Accountant will undertake a first review of the whole Business Case/Brief to ensure that all sections have been properly completed. At least a week should be allocated for this step as part of the timetable for developing the proposal.~~

~~4.9 The Business Case/Brief must be reviewed and explicitly supported by the managers of all affected departments. This should be done by submitting the case to the relevant programme boards,(e.g. Estates Programme Board), where relevant. If there is no relevant programme board then an email should be forwarded to the Project Accountant stating the review and support by the relevant managers. This support should be recorded within the document control section of the case. A checklist of possible affected departments and related steering groups is included at the end of the Business Case/Brief templates.~~

~~4.10 The Business Case/Brief must be reviewed and explicitly supported by the Executive Sponsor and Service Lead and confirmed as ready for submission to the Business Case Group by the Associate Director of Finance. At least a week should also be allowed for this step as part of the timetable for developing the proposal.~~

~~4.11 It is essential that the Business Case/Brief template is completed fully so that members of the approving committees have the necessary information to decide on the proposal. This will help to avoid delays.~~

~~4.12~~2.5 Title Page

~~4.13~~2.6 Inset title and date of the current version of the case, name of the author and all cases must have an Executive Sponsor. The version number must be updated following each significant reiteration and the QIA approval date must also be shown for a Business Case.

~~4.14~~2.7 Document Control

~~4.15~~2.8 All the sections, version control and the review and approvals log must be kept up to date.

~~4.16~~2.9 The following sections apply to the Business Case Template and not the Business Brief template.

~~4.17~~2.10 Proposal Overview

~~4.18~~2.11 This section should be a summary of the whole case, to include the background of the relevant department, the proposal aim, the current state, the issue or opportunity that is being addressed, all the options considered and why they have been discounted, the preferred option and the Whole

Life Cost of the preferred option. It should be clear from this section why the proposal has arisen, the nature of the proposed spend and the preferred option for addressing the issue.

~~4.19~~2.12 Strategic Case

~~4.20~~2.13 This covers how the proposal fits with the Trust's Strategy. The case must describe any significant risk or implication of the proposal not being implemented. It should indicate whether it is in response to a regulatory requirement and/or a solution to a risk on the Trust risk register.

~~4.21~~2.14 Economic Case

~~4.22~~2.15 Section a - the options that have been considered should be listed, including a 'do nothing/minimum' option. A brief description of each option should be given together with the benefits *to patients /staff / and wider NHS?* and risks of each option.

~~4.23~~2.16 Section b - this table financially compares the different options over the life of the proposal. The Trust's Project Accountant will complete the finance sections within the template, including all tables with the assistance of Proposal Lead and Finance Business Partners, as relevant. Costs should be included at current prices across the whole life, no inflation or price rises should be considered. Contractual price increases are covered as part of budget setting.

~~4.24~~2.17 **Preferred Option**

~~4.25~~2.18 In Section a, the preferred option should be stated with reasons by reference to strategic fit, deliverability and ease of implementation. The resources required must be stated and the extent to which the proposal will affect other Departments. Review the impact on the environment and sustainability. affects frontline operations. The reasons for excluding other options should be made clear.

~~4.26~~2.19 In section b the benefits of the preferred option should be listed, and the table of benefits completed, ensuring that the benefits can be tracked and quantified following implementation.

~~4.27~~2.20 Section c must include the post implementation timeframe for completing a benefits realisation review for presentation to BCG.

~~4.28~~2.21 Financial Case - Analysis and Affordability

~~4.29~~2.22 This section covers the whole life costs of the preferred option, including any capital spend, any increase required to current budgets and any reduction in budget due to agreed savings. The Project Accountant will complete the finance sections within the template with the assistance of the Proposal Lead and Finance Business Partner, as relevant.

~~4.30~~2.23 This section also includes the details of the funding required and its source, whether internal or external.

~~4.31~~2.24 Proposed increases in budget for the coming year should be identified at budget setting as a cost pressure, if they meet the criteria stated in section 2. These cost pressures will then require a Business Case to be approved before the budget is approved and uploaded. Business cases for cost pressures that have not been included in the annual planning round will only be considered if a strong case for prioritisation can be argued.

~~4.32~~2.25 Quality Impact Assessment (QIA) and Equality Analysis (EAR)

~~4.33~~2.26 These two documents must be completed and signed by the relevant staff and embedded into the Business Case before it can be sent for approval. The BCG will not except BCs unless they have at least a draft version with evidence of submission to the relevant signatories.

~~4.34~~2.27 **Risk Assessment**

~~4.35~~2.28 The top 5 risks of implementing the proposal need to be listed in this section, with appropriate mitigations and scoring.

~~4.36~~2.29 Commercial Case

~~4.37~~2.30 This covers the procurement of the proposal, how it will be carried out, whether a tender process was undertaken, or quotes were acquired. Who is the preferred supplier and how was this decision reached?

~~4.38~~2.31 **Management Case**

~~4.39~~2.32 Section a covers how the implementation will be tracked, what governance group the proposal will report to and what reports will be produced.

~~4.40~~2.33 Section b covers a high-level plan for the proposal with key dates.

~~4.41~~2.34 Stakeholder engagement/consultation

~~4.42~~2.35 State if any stakeholder engagement and consultation is required and if so, include details. Also state how affected staff groups have been engaged and how has their feedback been incorporated into the proposal.

~~5.~~3. Approval of Business Cases~~/Briefs~~

~~5.1~~3.1 Larger Business Cases, that require a tender process, such as large build projects, will need to go through a two-stage approval process. Firstly, an Outline Business Case (OBC) including estimates for pre-procurement with a second case to include firm costs based on tenders received. An OBC would be completed on the main BC template, same as for the FBC.

5.23.2 Prior to submission for approval Business Cases/Briefs must be reviewed and supported by all relevant impacted department managers.

5.33.3 All Business Case/Brief templates, once complete, will be submitted by the Project Accountant or Associate Director of Finance to SMGthe Business Case Group (BCG) for review/approval (depending on the value of the scheme). This group is chaired by the Associate Director of Finance. Terms of reference for this group, including the names of the group members can be obtained from the Project Accountant or Associate Director of Finance.

5.4 All Business Briefs, can be approved by the Executive Director of Finance and Corporate Services, based on the recommendation of BCG.

3.4 Business Cases, supported by SMGBCG for inclusion in the Foundation Trust's annual plan will then , need to go for further approval. The Deputy Chief Finance OfficerProject Accountant or Associate Director of Finance will forward cases supported by SMGBCG to the Executive Management Board (EMB) for approval and as part of the draft annual plan. Final approval of the annual plan will be subject to agreement by the Foundation Trust's Board.

5.5 FP1 section 5 sets out the limits for authority to approve unbudgeted revenue and capital spending. Such cases will be submitted along with a BCG report summarising the case and why it recommends approval. EMB can give final approval as per the limits in the table below. If the Business Case costs are above these limits the case will need to go to the Finance and Investment Committee (FIC) and the Trust Board for final approval. In exceptional circumstances, usually reserved for great urgency, cases over that need Board approval can be approved via a 'Chairs Action'. This involves authorisation to proceed from the Board Chair in conjunction with two Executive Directors. These cases will then be notified to the Board at the next available meeting. The approval levels stated above and, in the table, below are as per FP1 – Authority to incur expenditure and the Trust's Scheme of Delegation (SoD).

3.5

	Total Capital Approval Value	Total Unbudgeted Operating Expenses Approval Value	Notes
Associate Director of Finance	Up to £10,000	Up to £10,000	New Limit, managed through Budget Virement Process
Executive Director of Finance and Corporate Services	Up to £100,000	Up to £100,000	New Limit
CEO (authority exercised through	Up to £1,500,000	Up to £750,000	Increased from £300,000

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~~Executive Management Board (EMB)) *~~			
~~Trust Board~~	~~Over £1,500,000~~	~~Over £750,000~~	~~Increased from £300,000~~
~~In exceptional circumstances by Trust Board Chair's Action and Two Executive Directors~~	~~Over £1,500,000~~	~~Over £750,000~~	~~With two Directors and Chair, notify to the Board at next available meeting.~~

*Acting CEO will assume role during CEO absence.

~~5.6 BCG meets monthly and the Project Accountant or Associate Director of Finance can provide the dates of these meetings. The Proposal Lead will be asked to attend the BCG to present the Business Case/Brief and answer any questions.~~

~~5.7 In exceptional circumstances, if a Business Case/Brief is shown to be urgent it will be 'fast-tracked' by using an online voting system to determine BCG support or approval. The Executive Sponsor for the proposal will need to make the case for fast tracking.~~

~~5.8 If there is a requirement to approve a Business Case/Brief in an emergency, the CEO and DOF can approve the spend by email. This approval needs to be followed up with a Business Case/Brief being presented and reviewed at the next available BCG meeting.~~

~~5.9 Business cases/Briefs will not be considered if the BC process has not been followed and if the template is not fully completed, including a signed QIA and EAR in the case of a Business Case. The BCG will accept BCs with draft QIAs and EAs, with evidence of submission, if the author has not managed to get them approved on time. The signed versions will need to be in the BC when it is formally approved.~~

~~5.10 If the Business Case/Brief is given final approval, the Proposal Lead will be notified by the Project Accountant and implementation can commence as planned. The relevant Finance Business Partner will process the transfer of revenue budgets as appropriate, as per the Budget Virement Process (FP2), a copy of which can be found on the Trust intranet. All Purchase Orders must be processed through the SBS system and the Project Accountant will provide a financial code for the orders.~~

~~5.11 Normal requirements in the Standing Financial Instructions and Standing Orders will apply and the tendering and/or quotations process must be followed.~~

~~5.12 Purchase orders should always be annotated with the proposal name so that they can be properly accounted for against the appropriate proposal.~~

~~6.~~4. Business Case Monitoring

~~6.1~~4.1 Monthly monitoring will form part of the normal monthly reporting process of the Foundation Trust and will review~~reports will be produced and distributed on~~ actual spend to date and budget versus forecast outturn for each area~~scheme.~~.

6.2 It is the responsibility of the Proposal Lead to inform the Project Accountant or Associate Director of Finance promptly of any major changes to forecast spend so that the Capital Plan Report is reflective of the most up to date position.

6.3 Where the projected capital costs for any approved scheme are estimated after approval to be in excess of 10% or £100k higher than the original amount approved, then a revised Business Case~~/Brief~~ document will need to be submitted to the ultimate approving committee for the additional value to be approved. ~~If a scheme that was previously approved via a Business Brief breaches those approval values, the updated Business Brief document will need to go to EMB for approval.~~

~~6.4 The recurring operating budgets will be monitored by the FBPs and budget holders. If any overspend in the approved budget is forecast, this will be managed in accordance with the usual process.~~

~~7.~~5. Capital Proposal Completion

~~7.1~~5.1 When the proposal is complete, the Proposal Lead should notify the Project Accountant of the date of completion.

~~7.2~~5.2 At completion it is the Proposal Lead's responsibility to inform the Finance Team~~Project Accountant~~ of any outstanding liabilities relating to the scheme. For example, retention may still be outstanding on any building scheme. If outstanding liabilities are not identified at this stage, there is no guarantee that there will be enough capital resource available at a future date to fund these commitments.

~~7.3~~5.3 For capital proposals an operational date is needed so that the depreciation charge relating to the asset is accurately calculated and the asset can be included in the capital replacement programme.

~~8.~~6. Benefits Realisation Review

~~8.1~~6.1 For Business Cases that have been implemented, a benefits realisation review must be completed and presented to ~~the~~ SMG~~BCG~~. A proforma for this purpose is included at Appendix E. Benefits realisation relies on clear, measurable criteria having been included in the original Business Case, to provide an objective assessment of the success of the initiative. It should

articulate benefits to patients, the Trust and staff and the wider NHS if applicable.

~~8.2~~6.2 It is stated in the Business Case when the benefits realisation will be completed, this should be no later than a year after the approval of the case, unless there are extenuating circumstances.

~~8.3~~6.3 The author must present the review to the SMG~~BCG~~ and questions will be asked and any learning regarding the BC process will be taken.

~~8.4 For Business Briefs, an email update is required from authors following implementation, which will just be circulated to the BCG for information.~~

Appendix	Name of Document	Document
A	Business Case~~/Brief~~ Process Flow Chart	Business Case Approval Flow Chart v.
B	Business Change Template	Business Change Template.xlsx
C	Business Case Template	SECAmb Businesss Proposal Template v0.
D	Business Brief Template	SECAmb Businesss Brief Template v0.5.do
E	Benefits Realisation Pro Forma	Beneftis Realisation Pro forma v5.docx

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	63-24

Name of meeting	Trust Board
Date	3rd October 2024
Name of paper	Procurement Strategy
Executive Sponsor	Simon Bell, Chief Finance Officer
Author	Geoff Hopper, Associate Director of Procurement

This Procurement Strategy aims to assist with enabling the three key elements of the organisation's strategy, i.e. to deliver outstanding patient care, enhance the experience of our people and to build a more sustainable organisation. The organisation has seven strategic objectives - the one directly applicable to the Procurement Team, and which this Strategy is particularly focused on contributing to becoming a sustainable and efficient organisation.

This document has been through internal governance as detailed on the cover page of the Strategy document.

Trust Board approval is now sought.

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

Procurement Strategy 2024-27

Key document details			
Author:	Geoff Hopper, FCIPS	**Approver:**	CFO
Owner:	Associate Director of Procurement	**Version no.:**	2.0
Draft Date:	Sept 2024	**Next review:**	Sept 2027
Ratified:	The Strategy has been tabled at Senior Management Group and Audit & Risk Committee and endorsed by Strategy Transformation Group. Ratified by Finance & Investment Committee and approved by Executive Management Board. To Trust Board for final approval.		

Procurement Strategy

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1. Context

1.1 South East Coast Ambulance Service NHS Foundation Trust (SECAmb or Trust) is currently finalising its strategy for 2024-29 with an overall vision of saving lives and serving our communities. This Procurement Strategy aims to assist with enabling the three key elements of the organisation's strategy, i.e. to deliver outstanding patient care, enhance the experience of our people and to build a more sustainable organisation. The organisation has seven strategic objectives - the one directly applicable to the Procurement Team, and which this Strategy is particularly focused on contributing to becoming a sustainable and efficient organisation.

1.2 The Procurement Team will seek to be a pragmatic enabler and forthright driver for cost effectiveness and the achievement of best value for money (VFM) in a compliant way. SECAmb must maximise its resources and make cash releasing efficiency savings while delivering against its strategic, organisational and operational plans. The Procurement Team will help directorates achieve this using best practice and compliant procurement processes. The Procurement Team currently comprises six staff: Associate Director of Procurement, a Procurement Manager, two Procurement Contract Managers and two Buyers. The team structure includes other funded posts which are vacant, and the newly appointed Associate Director will undertake a review of the roles and responsibilities of team members and assess the upcoming Procurement Pipeline to determine the optimal team structure to deliver against this Strategy.

1.3 The Team will ensure that our procurement procedures and processes adhere to the Public Contract Regulations 2015 and are therefore legally compliant as well as being compliant with our organisation's Standing Financial Instructions (SFI) and Scheme of Delegation. The Team will prepare themselves and the organisation for the implementation of the Procurement Act 2023 through the new Public Contract Regulations 2024 which will be effective from 24th February 2025.

1.4 The Team has developed a Procurement Pipeline of anticipated work including open and competitive full tenders, further competitions (against public sector buying organisations (PSBO's) frameworks[1]) and, in exceptional cases, direct awards against frameworks and SFI waivers. This Pipeline details the requirements and timescales for all procurements that the Team expect will need to be undertaken. This Pipeline will be achieved through exploiting frameworks and collaboration with other NHS bodies. The Pipeline will document the following key information:

- What the requirement is
- The Directorate which has ownership of the requirement
- Whether the requirement is a one-off (such as a building project) or a recurring need
- If the requirement is for the Trust overall or specific to one of the Trust's locations
- Timelines for scoping the work, when the procurement activity needs to be completed and when the resulting contract needs to start
- Anticipated costs for the initial contract term
- What procurement strategy will be adopted, such as formal open competitive tender, further competition against a framework, extension or variation of an existing contract
- Key stakeholders:
    - from within the Directorate which owns the requirement/budget
    - to be involved in the tender preparation, i.e. scope and timetable
    - who will form the evaluation panel

[1] PSBO Frameworks such as NHS Supply Chain, NHS Commercial Alliance, Crown Commercial Services, SBS etc

- The name of the procurement lead
- Commentary, including timeframe for stakeholder involvement

1.5 The Team will strive to contract for goods and services to meet organisational needs across the whole organisation as well as specific procurements such as one-off capital projects.

1.6 This strategy is authored and owned by the Associate Director of Procurement. The strategy will be reviewed every three years.

1.7 A Procurement Policy will be developed by 2025 and this is expected to outline the following:

- How the Team will ensure compliance with PCR
- Code of conduct
- How we will protect intellectual property, commercial information and personal data
- How we will undertake supplier sourcing, contracting and achieving VFM
- How we will ensure we maintain an accurate and up-to-date contract register
- How we will support the organisation manage contracts effectively
- How we will deliver and/or contribute to responsible procurement, for instance, in relation to:
    - compliance with the modern slavery act
    - sustainability
    - decarbonisation
    - waste management
    - minimum wage legislation
    - diversity, equality & inclusion
    - social value
    - supply chain due diligence and robustness
    - AI use in Procurement
- How we will inform, upskill, provide guidance and training internally to the Team and to the wider organisation
- Details of our procurement thresholds and the process for considering waivers
- How the Team will be performance managed.

2. Introduction

2.1 Meeting our objectives depends on how well the Team can obtain the goods and services the organisation needs. The Team anticipates needing to do this against challenging timescales and budgets. The Team strives to achieve best value for money (VFM), by buying a product or service that is fit for purpose, considering its whole life cost, which looks at all life-cycle costs (including disposal costs), minimising these where possible. VFM is not always the lowest initial price option, as we should take account of any ongoing revenue/resource costs as well as the initial capital investment.

2.2 Procurement is the process of acquiring goods and services, usually covering acquisition from third party suppliers. The process spans the whole cycle from identifying need, through to the end of a service contract or the end of the useful life of an asset. It involves looking at different options and deciding whether to buy a good or service, or whether it could be provided in-house or via a Service Level Agreement.

2.3 Getting best VFM will govern all of our procurement activities. As a spender of public funds, the Trust must spend its financial resources wisely while getting the most out of them. There is considerable scrutiny on the goods and services we spend our resources on.

2.4 VFM is not just about acquiring goods and services at the lowest price. We consider quality, timeliness and total cost of ownership. For instance, if we procured information technology equipment, we would need to consider issues such as:

- warranty protection
- ongoing maintenance
- potential for upgrading
- compatibility with existing systems
- environmental issues
- scalability
- the need for the equipment to be future proofed to account for advancing and upcoming technologies
- team skill set to manage and support the equipment.

2.5 This strategy shows the overarching aims and principles the Team apply when purchasing goods and services to fulfil our objectives.

2.6 The Team, with stakeholder input, will formulate and develop a Preferred Supplier List, and this will detail all approved third-party suppliers for the Trust. Approved in the sense that they have been endorsed by the Procurement Team after having been:

- procured via a compliant route, e.g. open competitive tender or via a PSBO framework
- benchmarked for VFM.

2.7 All procurement procedures will be detailed in a revamped Standing Operational Procedures or a Procurement Manual which is expected to be developed by the end of 2025.

2.8 The Team will develop intranet pages on the Zone to contain the following:

- an outline of our current procedures
- forms and templates
- this Strategy document
- the Procurement Pipeline
- oversight of the Procurement Act 2023

During 2025 the Team would expect to expand our intranet pages to include the following:

- Procurement Policy
- Preferred Supplier List
- Standing Operating Procedures and/or Procurement Manual

3. Strategy Aim, Procurement Objectives and Measures of Success

3.1 **This strategy's aim or goal**: To procure goods and services in a cost effective and legally compliant way to meet SECAmb's strategic, organisation and operational aims and objectives whilst exploiting opportunities to leverage spend and secure savings.

3.2 **The Procurement Team's objective is**: To procure goods and services through a fair non-discriminatory and transparent process, while conforming with, and observing, statutory and regulatory requirements, as well as considering all aspects of responsible procurement. The Team will ensure best value by getting the balance right between considering whole life cost, quality, expertise, responsibility, and timeliness.

3.3 The Procurement Team will achieve this by:

- working proactively and in a helpful manner with our internal customers to meet their business expectations and needs
- adopting best practice procedures and processes
- using appropriate terms and conditions effectively so that data protection and intellectual property rights are properly managed and to eliminate the risk of contracting on unfavourable supplier terms
- working proactively and collaboratively with other NHS bodies, particularly other ambulance trusts and PSBOs to share best practice, experience, knowledge and leverage spend
- taking account of NHS guidance
- using the Contracts Finder and Find A Tender websites (via SECAmb's eProcurement platform) to advertise our requirements thus encouraging SME participation
- making sure everything the Team does follows sustainability guidance in the Government's Buying Standards
- providing proactive contract management advice and support
- helping our colleagues to get the most out of procurement by sharing information and best practice with them; this can be via the intranet or delivering in-house training courses or awareness briefings, such as an 'Introduction to Procurement'
- facilitating access to appropriate contract management training to upskill end users who have been assigned contracts to directly manage
- exploiting frameworks wherever possible to leverage spend, maximise cost efficiency and deliver goods and services promptly with the added comfort of contracting on robust terms and conditions and achieving compliance with PCR
- working closely with Directorates and the Finance team when compiling and reviewing the procurement pipeline
- ensuring the Team have appropriate frameworks, call-off agreements or retainer arrangements in place to meet our current and future needs effectively and efficiently
- achieving cash releasing savings as a result of the Team's intervention, which should far exceed the team's running costs so adding real and tangible value to the organisation; the Procurement Team's savings target covering the financial year 2024-25 will be £720K.

3.4 The measures of success through implementation of this strategy will include:

- no challenges for breach of public procurement regulations
- a procurement service which meets internal stakeholder expectations (as measured by periodic satisfaction surveys)
- participation in collaboration opportunities and the achievement of value for money
- achievement of cashable savings and meeting the cost improvement target.

4. Requirements and Principles

4.1 To achieve this overall strategy the Procurement Team must have:

- informative guidance, clear procedures and model documentation to direct us through the procurement processes and ensure consistency of approach
- access to NHS standard commercial contract terms and conditions to support formal contracts for the supply of goods and services
- sufficiently experienced staff who are deemed competent and 'expert' in public procurement and category management, for instance, staff with qualifications/membership of the Chartered Institute of Procurement & Supply (CIPS) and/or a breadth of experience and practical knowledge
- a way to update the team in procurement best practice and changes in regulations and legislation – the Procurement Team should achieve this through regular team meetings and a review of procurement policy notes which are issued by Cabinet Office
- a way to provide other staff involved in individual procurements with guidance sufficient for their needs – e.g. presentations at Senior Management Group meetings, coaching, workshops or formal training
- appropriate Trust spend/procurement thresholds to encourage competition and ultimately get best value for money. Threshold values (see Annex A) are stipulated in the SECAmb's SFIs (and will also be stated in the Procurement Policy). The organisation should be reminded of these on a quarterly basis to help embed and enforce them thus minimising the need for SFI threshold waivers. These thresholds will dictate the procurement framework for SECAmb, for instance, by detailing the circumstances when it will be right and proper to undertake spot ordering, the seeking of quotations, undertaking a formal competitive tender process or justifying a waiver
- appropriate financial delegations, from SECAmb's Scheme of Delegation, to allow staff to manage the budget approval process, which will give the Team authority to procure or order
- appropriate procurement delegations to empower the Associate Director of Procurement to formalise, enter into and execute contracts on behalf of SECAmb
- an understanding and awareness of risk, i.e. how to identify it, manage it and escalate it where appropriate
- an awareness of risk in the supply chain particularly around resilience and business continuity arrangements.

4.2 Procurement will be successful if the following general principles are followed:

- be clear on the scope of work from the outset and communicate this to potential suppliers at an early stage, to gauge the market's ability to deliver and explore possible solutions
- be aware of external factors that will impact on the procurement need, such as any policy framework or directive
- consider using an output or outcome-based specification, to give suppliers more scope to provide innovative solutions
- consult with stakeholders what Key Performance Indicators and/or Service Level Agreement should be in place to measure supplier performance against
- follow a competitive, efficient, fair, transparent and open procurement process, ensuring potential suppliers know what the process will be and how their bids will be evaluated
- be clear about affordability considering whole-life costs, and
- encourage the establishment of good contract management processes and resources to drive excellent supplier performance throughout the contract term and hopefully derive added value too.

5. The Procurement and Contract Management Process

5.1 The SFIs require the Procurement Team to be consulted on all needs where a procurement threshold requirement cannot be met, i.e. when an SFI threshold waiver is being sought, and certainly where the total order/contract value exceeds £116.4K (excl VAT). The Procurement Team must be consulted prior to the requisition stage so that it can influence the procurement strategy and offer advice on the most effective route to market and VFM.

5.2 The Team has a mandate to put in place frameworks and call-off arrangements that the Trust can access, which either provide standardised goods or services, where there is commonality, or where bespoke needs are apparent that the agreements are flexible to meet the customers' needs.

5.3 The Team is available to the organisation to meet all guidance and advice requests as well as orchestrate any formal tendering process, unless it has been agreed that this will be outsourced for a specific project (for instance, to a public sector buying organisation or consortium or procurement consultants).

5.4 Low value spot ordering can continue to be undertaken through existing processes. The Team will gain an insight into the spend areas to determine if requirements and needs can be aggregated so that the Team can exploit our Trust status to leverage spend. The Team's Buyers have the responsibility to convert requisitions to purchase orders using NHS SBS.

5.5 The procurement manual and/or Standing Operating Procedure (when developed) will provide detailed guidance for the Procurement Team (and others if desired) and the material on our intranet page will have information suitable to inform our internal customers.

5.6 The responsibility for managing contracts should rest with the immediate customer, i.e. the contract owner, as that individual is directly receiving and/or influencing the contracted service and are therefore best placed to manage the contractual relationship. High value, high risk and/or Trust-wide contracts are expected to have Procurement Team oversight whereby a Procurement (Contract) Manager will be expected to attend regular performance review meetings.

5.7 The proposed contract management approach for newly awarded contracts is for the Procurement Team Member, who has managed the tender/award process, to provide the customer/contract owner with a structure to manage the supplier relationship. This will include the following:

- an electronic copy of the full contract
- a contract summary sheet which identifies key facts about the contract (such as value, start and end dates, options to vary/extend, special terms, supplier contact details, etc)
- a proposal about how the contract should be managed, citing any contractual service level standards and/or KPIs if relevant, frequency of review meetings, anticipated management information
- the Team's participation and attendance in contract review meetings for the high value, high risk or Trust-wide contracts.

5.8 For medium to long-term contracts, the customer and supplier should agree the following at the start of the contractual relationship:

- the baseline position, i.e. where are you starting from
- the service/outputs to be delivered
- a set of performance standards to measure performance
- how, when and by whom performance will be monitored and reported
- processes to resolve any performance issues
- escalation routes.

5.9 Once the contract has mobilised then regular reviews should be undertaken by the contract owner which will look at:

- progress against the plan, performance to date
- current issues and risks
- costs and budget and explanation for any variances
- knowledge transfer
- 'smart' actions from any of the above and these to be assigned owners.

5.10 The contract owner should ensure that a summary note of the review meeting has been completed and shared and verified with the supplier as an accurate written record of the review.

6. Supplier Sourcing

6.1 Getting best VFM is at the forefront of our procurement strategy, so it is imperative that the Team can demonstrate this. The best way to do this is through competition and thus testing the marketplace.

6.2 The procurement thresholds will dictate what level of competition is required relative to the anticipated net value of expenditure for the procurement activity. For instance, if the total anticipated value was in excess of the tender threshold, then we should aim to get at least three formal tender submissions using a sealed bid process via our eProcurement platform.

6.3 The Procurement Team can access a multitude of PSBO frameworks to meet the majority of our requirements, particularly around common goods and services such as IT hardware & software, stationery, medicines, medical equipment, etc. This is an efficient way to purchase, as providers on the frameworks have already been through a competitive and robust due diligence process to agree terms and rate cards. VFM is demonstrated by running a further competition with all capable providers within a chosen Lot on a framework. Where a requirement falls outside the scope of these frameworks the Procurement Team will go direct to the market to source the requirement and may even make the decision to tender for the creation of our own framework.

6.4 If the total value of the contract is likely to be above £116.4K (excl VAT), the Procurement Team will find suppliers in the marketplace by placing an advert for a contract opportunity via our eProcurement platform.

6.5 SECAmb, as a publicly funded organisation, can 'call-off' goods and services from PSBO frameworks as well as any framework SECAmb has put in place for itself as and when required. The Procurement Team is well versed in these frameworks and how to exploit the business benefits they can deliver.

6.6 The Procurement Policy will outline the exceptional circumstances when a 'single source', i.e. an approach to, or bid from, just one supplier, may be justified and appropriate, and, in turn, the waiver process.

6.7 The Team will review supplier spend and aim to put in place and maintain SECAmb's preferred supplier list covering a multitude of commonly bought goods and services and maintain this list on the Procurement pages of the intranet. Preferred supplier status being achieved either through competitive tendering, assignment on an approved framework or benchmarking for VFM.

6.8 The Team's Buyers are involved in the process for creating new suppliers and will exercise control and restraint where appropriate and where a suitable preferred supplier already exists. The Team will need to review what due diligence is undertaken to create new suppliers such as basic credit checks and companies house checks.

7. Procurement Considerations

7.1 In addition to the need to demonstrate VFM, it is important to recognise that as a public contracting authority, SECAmb, must adhere to the Public Contract Regulations for contracted goods and services. These regulations are very explicit and are centred on the requirements of transparency, equality, fairness and integrity. The procurement manual (when developed) will contain more guidance on these regulations.

7.2 Other procurement considerations:

- the need for a good business or improvement case (depending upon the value of the requirement). This should review what options are available and the estimated cost of the preferred option to provide a budget for the procurement action
- the environmental impact of what SECAmb procures should be determined in the scoping and tendering process
- SECAmb should, wherever possible, select products which minimise polluting discharges and emissions, exercise a preference for supplies which are from recycled or renewable sources, and take account of the process of disposal at the end of a product's life (more important for electrical equipment or those items that contain hazardous components) – see section on sustainable procurement
- encourage and help customers to properly plan for procurement activity, allowing enough time for each process, so that rash and potentially uneconomic decisions are not made in haste. SECAmb recognises that some actions are outside of our control, for instance, a business continuity emergency. In these instances, the Procurement Team should consider having relevant frameworks or call-off agreements in place to deal with any potential procurement need
- be mindful of supplier resources when tendering for our contracts by only short-listing those that can demonstrate experience and expertise in the relevant field and have the capacity to fulfil our requirements; for instance, if a manufacturer of a particular piece of IT hardware has just five resellers, then only approach those five otherwise there is a risk of buying 'grey' unregulated and unwarranted stock
- consider suppliers' commitment to being responsible and ethical employers (such as being compliant with anti-slavery) and producers, for instance, observing equality standards – this can be incorporated in the approving a new supplier process
- ensure compatibility with existing systems and infrastructure, for instance, in the case of IT equipment or furniture

- claim rebates and discounts if applicable, where and when due
- observe payment arrangements, especially if these could result in early payment discounts
- encourage small and medium-sized enterprises and local suppliers to supply us
- consider the total life cycle costs for the goods or services.

8. Sustainable Procurement

8.1 Sustainable procurement is that which avoids depletion of natural resources. The Procurement Team and stakeholders should consider environmental, social and economic factors in purchasing decisions. It is about looking at what products are made of, where they have come from, and who has made them. It is even about looking at whether the purchase needs to be made at all.

8.2 Those raising purchase orders for goods should routinely encourage suppliers to remove packaging at the point and time of delivery thus eliminating waste and allowing the supplier to re-use the packaging; this is particularly relevant for the supply of IT equipment and office furniture.

8.3 Sustainable procurement promotes procurement best practice by using the principle of whole life costing where all life-cycle costs of a product or service are assessed and minimise (including disposal costs). Another key facet of sustainable procurement is challenging the repeat purchase and examining the business process to be sure that a justified business need exists.

8.4 This sustainable element of the procurement strategy will need to sit alongside and complement sustainability targets in other areas of the organisation's functions such as Estates & FM, IT, fleet and energy management etc., if there is any likelihood of becoming carbon neutral.

9. Our work and the immediate future

9.1 For us to be an effective procurer of goods and services and achieve best VFM, the Procurement Team will embrace initiatives and ideas that are new to us, as well as build upon proven and trusted methods of supply. The Team will encourage customers to plan better, to inform the procurement pipeline and to provide stakeholders with up-to-date and accurate guidance and advice and proactive practical procurement, especially for the timely and effective delivery of the procurement pipeline. There are four main themes to take forward.

9.2 **Theme 1 – Procurement pipeline and meeting customer needs**. Working through the pipeline ensuring there is flexibility to add projects and reprioritise existing**.**

9.3 **Theme 2 - Business engagement & communication**. The Team will continue to actively engage with our customer base to populate the procurement pipeline and deliver against it. We will support directorate contract managers to effectively manage and realise the value of their contracts. We will also continue to foster good working relationships with our colleagues in all directorates given their insight, work, linkages and outreach within the organisation.

9.4 **Theme 3 – Collaboration**. The Procurement Team will continue to actively explore the opportunities and potential for collaborative working and aggregation with other ambulance trusts and notably the Southern Ambulance Services Collaboration, NHS Shared Business

Services, East of England Collaboration Procurement Hub and PSBOs, to share best practice and experiences and achieve better VFM through buyer leverage.

9.5 **Theme 4 – eProcurement.** eProcurement is the collective term for technologies that can be used to automate, by computer workflow, the processes associated with sourcing and purchasing. The Team will manage the transition from Bravo to Atamis with a view to exploit the business benefits of having most, if not all, of our procurement and contract management activities contained within one system. We would hope that Atamis will help us manage our Procurement Pipeline and provide insight on supplier spend which we should verify with Finance and stakeholders.

9.6 The Procurement Team publish contract notices that comply with PCR for advertising tendering opportunities via the Bravo Portal – this has interoperability with 'Contracts Finder' and 'Find A Tender' to advertise all contract opportunities to the open market and encourage SMEs to bid.

9.7 Our current eTendering system provides a full service offering which automates processes such as:

- advertising a contract opportunity
- receiving expressions of interest
- managing questions and clarifications from suppliers
- providing a secure ePortal for the receipt of bids and then a repository of these bids for future reference
- maintaining a supply base.

9.8 The Procurement Team will aim to encourage use of e-Catalogues, e-Purchasing, e-Marketplace; and promote the use of e-Catalogues for on-line ordering of common goods and services, and ePurchasing for specific purchases.

9.9 The Procurement Team will continue to actively engage with Finance and/or NHS SBS colleagues with a view to rationalise our supply base and reduce the number of suppliers we have.

9.10 A high-level implementation plan for this strategy can be found at Annex B.

Annex A – Procurement Thresholds

Procurement thresholds (ex VAT) as detailed in Standing Financial Instructions:

Quotation Thresholds:

Up to £10K – 1 quote

£10K to £50K – 2 quotes

£50K to £116.4K – 3 quotes

Tender Threshold:

£116.4K – formal tender or further competition (or exceptionally, direct award) from a PSBO framework

[NB the Supply & Services Contract PCR tender threshold is currently £139,688 incl VAT]

Annex B – High-Level Implementation Plan

Action	By Whom	By When
Deliver the Procurement Pipeline	Procurement Team	Ongoing
Engage in collaborative procurement activities within NHS	Associate Director of Procurement and Procurement Contract Managers	Ongoing
Enhance the procurement pages on the intranet	Procurement Manager	01/01/25
Develop a Procurement Policy	Associate Director of Procurement	01/01/25
Implement new public procurement regulations	Associate Director of Procurement	24/02/25
Achieve CIP target of £720K	Associate Director of Procurement	31/03/25
Set up official Preferred Supplier List covering key categories of third party spend	Procurement Contract Managers and overseen by the Associate Director of Procurement	01/10/25
Develop a Procurement Manual	Procurement Team collectively with one of the Procurement Contract Managers leading	01/12/25