South East Coast Ambulance Service
NHS Foundation Trust

Trust Board Meeting to be held in public

05 June 2025

10.00-13.00

Trust HQ, Nexus House, Crawley

Agenda

Item No.	Time	Item	Purpose	Lead
Board Administration				
24/25	10.00	Welcome and Apologies for absence	-	MW
25/25	10.01	Declarations of interest	To Note	MW
26/25	10.02	Minutes of the previous meeting: 30 April 2025	Decision	MW
27/25	10.03	Matters arising (Action log)	Decision	PL
28/25	10.05	Chair's Report	Information	MW
29/25	10.10	Chief Executive's Report	Information	SW
Board Governance				
30/25	10.30	Board Effectiveness Annual Review	Information	PL
Strategy & Performance				
31/25	10.40	Board Story – Volunteers	-	JL
32/25	11.00	Volunteers External Review	Information	JA
	11.25	Break		
Strategic Aim: Our People Enjoy Working at SECAmb				
33/25	Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report			
34/25	11.40	People Committee Assurance Report	Assurance	MP
35/25	11.50	People Improvement Plan 2025-26	Information	SWa
36/25	12.00	Equality Diversity & Inclusion	Information	SWa
37/25	12.10	FTSUG Report	Assurance	MD
Strategic Aim: We Deliver High Quality Care				
38/25	12.25	Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report	Assurance	MD RQ JL
Strategic Aim: We are a Sustainable Partner as Part of an Integrated NHS				

39/25	Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report c) Month 1 Finance Report			
40/25	12.40	Finance & Investment Committee Report	Assurance	PB
Closing				
41/25	12.55	Any other business		MW

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

30 April 2025

Nexus House, Crawley

Minutes of the meeting, which was held in public.

Present:

Michael Whitehouse	(MW)	Chair
Simon Weldon	(SW)	Chief Executive
David Ruiz-Celada	(DR)	Chief Strategy Officer
Jacqueline Lindridge	(JL)	Chief Paramedic Officer
Howard Goodbourn	(HG)	Independent Non-Executive Director
Jen Allen	(JE)	Chief Operating Officer
Karen Norman	(KN)	Senior Independent Director
Liz Sharp	(LS)	Deputy Chair
Margaret Dalziel	(MD)	Chief Nursing Officer
Mojgan Sani	(MS)	Independent Non-Executive Director
Max Puller	(MP)	Independent Non-Executive Director
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Richard Quirk	(RQ)	Acting Chief Medical Officer
Simon Bell	(SB)	Chief Finance Officer
Sarah Wainwright	(SWa)	Chief People Officer

In attendance:

Peter Lee	(PL)	Director of Corporate Governance / Company Secretary
Stephen Bromhall	(SBr)	Chief Digital & Information Officer
Nick Roberts	NR)	Chief Digital & Information Officer
Janine Compton	(JC)	Director of Communications & Engagement

01/25 Welcome and Apologies for absence

MW welcomed members, and those in attendance and observing. In particular to NR to his first meeting and thanked SBr for his contributions over the last 12 months.

In the context of the recent decision to exit the Recovery Support Programme (RSP), MW thanked the executive and all colleagues on their efforts to ensure the demonstrable improvements over the last 2-3 years.

MW then addressed the recent Sky News coverage. He provided assurance that, without going into specific detail, both of the cases highlighted in the media coverage were properly investigated, including through external investigation where necessary and appropriate action taken in each case. MW acknowledged the work still to do to make the organisation the best it can be, but the perception given of both SECAmb as a workplace and of the care we provide to our patients, was wholly inaccurate. The leadership shown by Simon and our Executive Team during the past three years has resulted in measurable, positive change; as evidenced by the decision of NHSE to exist RSP.

MW confirmed the considerable level of support that has been shown for Simon and the leadership team this week. Collective letters of support have been shared by all members of the Senior Management Group and by the Lead and Deputy Governor, plus dozens of individual messages of support from across the organisation have been sent to Simon, the Executive team and to MW as Chair. MW particularly highlighted a heartfelt letter received yesterday from more than 20 of our operational managers, giving their wholehearted support for Simon and the very real difference he has made since joining SECAmb.

MW closed by explaining that while there is thinking needed on the next steps to be taken, he and the Board is confident that Simon and the whole leadership team will not let this detract from continuing to make the improvements we want and need to make.

The following apologies were noted:
Subo Shanmuganathan (SS) Independent Non-Executive Director

02/25 Declarations of conflicts of interest
The Trust maintains a register of directors' interests, set out in the paper. No additional declarations were made in relation to agenda items.

03/25 Minutes of the meeting held in public 06.02.2025
The minutes were approved as a true and accurate record.

04/25 Action Log [10.05-10.06]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

05/25 Chair's Report [10.06–10.10]
MW summarised his report, making three observations:

1. It is the end of April and so an opportunity to look back and also look forward to ensure confidence that we are manging risks and priorities to deliver the best patient care and environment for our people. The Board meeting is therefore framed against this context; to set out how we intend to navigate the coming year. He asked the Board throughout the meeting to seek assurance on this.
2. The really constructive meeting of COG, where Governors reinforced the need to make good progress on our strategy.
3. The importance of keeping in mind the considerable progress made and the need to build on this to ensure the improvements are sustained.

06/25 Chief Executive's Report [10.10–10.22]
SW looked back at the year just ended. A year we should be proud of. He drew out the key highlights from his report, including SECAmb being one of a few achieving the C2 mean target. Also, our cardiac arrest performance demonstrated a survival rate that is the highest recorded in England. That said, we must not be complacent and ensure we retain the aspiration of our strategy to meet patient needs. SW also drew out the positive feedback from the staff survey, noting the separate paper later on the agenda.

SW acknowledged there is more to do and to do this we need to restructure the organisation. This is why we are revising our divisional structure to ensure more local meaningful autotomy. There is also more to do in the space of EDI, something the Board itself acknowledges.

The balance between quality performance and efficiency will be challenging in the current operating environment and one thing to think about is the challenge of commissioners to go even further with our C2 mean. Sustainability also requires us to think differently, e.g. the work to collaborate with SCAS.

SW concluded by adding to MW's comments about exiting RSP; this is a mark of considerable progress in a range of domains. He acknowledged the contribution of Steve Lennox, Improvement Director, in supporting us on this improvement journey.

Finally, SW welcomed NR and thanked SBr for his work in last year with a now coherent and forward looking digital strategy. SW reflected on the appointments to the executive team in the past year, which has strengthened the team to help face in to the challenging period ahead.

MW is really pleased to see the commitment to EDI. He would like to see more women in senior positions for example, although noting the high number of women around this Board table.

MW also reflected on the strength of the executive team now in place. He and the Board expressed its confidence in the team and their leadership.

There were no questions for SW.

07/25 Audit & Risk Committee Report [10.22-10.30]
HG summarised the output of the most recent meeting. Two items under Alert are on today's agenda risk appetite and digital resilience. Also, by way of Alert, HG confirmed the assurance in place related to FOI compliance.

On the Assurance side, the Board noted the positive findings from Internal Audit. This will help inform the head of IA opinion, which is expected to be positive / above the line. But the committee is not complacent and has challenged the executive to drive toward 'substantial' assurance.

The year end process is progressing well; there are no issues to raise to the Board.

Lastly, on counter fraud, HG highlighted the curiosity of the committee to ensure the lower reporting of fraud is robust, i.e. not a reporting issue but rather due to improved controls.

MW opened to questions.

MS asked about FOI compliance and for a timeline to compliance. HG responded that the plan is to achieve mush improved compliance by the end of Q1 and the executive is in discussion with the ICO proactively, who are being supportive, acknowledging this is an issue seen elsewhere throughout the public sector.

MW referred to the control environment given the issues last year, and asked SB for his view in light of the positive IA reports to-date. SB responded that there is more to do but we are seeing good progress with reasserting our controls e.g. financial procurement etc. But we will need to become systematically good at productivity and efficiency as we will come to later on the agenda.

HG reaffirmed his confidence via KPMG that we on plan for the year end audit, report and accounts.

MW then introduced the next four agenda items which help set out our priorities for year to navigate the significant challenges. These documents have gone through considerable scrutiny by the relevant committees.

08/25 Operating Plan [10.30-10.49]

SB set out the details of the which ensures it is compliant, i.e. breakeven plan and achieves an improved C2 mean. The plan was submitted on 27 March. SB outlined some of the detail of both the financial and performance aspects confirming that the QIA is now complete and signed off.

SB expressed confidence that the plan is deliverable, but it comes with much risk, including 2 mins of the C2 improvement being reliant on system improvements; we will therefore be holding the ICB and other providers to account for delivery. It is unclear what happens to the additional funding if the system does not deliver. In the meantime, we are working through our mitigations.

Noting the Board Check and Challenge session last week, MW asked if there were any additional questions. He asked LS and MD if they are content from a quality impact perspective. LS responded that she believes we are doing as much as we reasonably can but agrees with SB related to the reliance on system improvements and is also concerned given the context of the ICB turmoil over coming months. LS is much more confident in what we can deliver, i.e. what is within our immediate control.

MD added by outlining the engagement internally and with TU colleagues, as well as externally with partners.

HG felt it is a good plan but very ambitious. Therefore, we need to acknowledge this. For example, H&T above 19% is a huge challenge from the current position - 15.5%. He asked for more comfort in ensuring the balance between virtual care and sending an ambulance when absolutely needed.

JA reassured the Board on the work to optimise our response to patients in line with the strategy. There is a robust framework for progressing virtual care and H&T. She acknowledged the need to monitor the extent to which H&T is successful, i.e. number of failed H&T, but there is no evidence currently this is an issue.

Action
Gap in Assurance: in the context of virtual care and the ambition of the operating plan this year to increase H&T to 19%, QPSC to explore how we are triaging need to ensure those patients who really need an ambulance get a timely response.

KN referred to handovers and, in context of provider collaboration and Models of Care, asked for response on where the risks might be. SW acknowledged the contribution of acute trusts for making us one of the strongest for handover delays in the country. This has been a result of much work over several years to get to this position and there is strong evidence linking handover and overall performance / patient care.

JA added in response to KN that provider collabs are critical to work on now, to ensure delivery of their part in improving performance. Discussions are live about the challenges in community pathways that link directly to solving handover issues. We will therefore be paying more of a provider coordination role in the future.

MW asked if our people would buy in to this plan. JL responded that she thinks they will, as she has heard directly from some of our people that this is well supported.

In summary, MW confirmed the Board's support. We are on record that the Government has challenged the NHS to improve productivity and improve patient care and this plan rises to that challenge. It is not without risk, and dependent on system partners who are engaged closely on our shared goals. The Board will need to monitor this closely.

09/25 Board Assurance Framework [10.49-11.03]

PL confirmed that this version of the BAF supports year 2 of the Trust Strategy. It is informed by the work on the operating plan that SB has just talked to and follows much engagement including with the wider senior leadership team, and at the joint Board COG meetings in Dec and March.

The Board noted that many of the priorities are the evolution of those from year 1, providing the continuity with the strategic aims. The structure of the BAF is well established and remains unchanged and PL highlighted slide 9 which summarises the key areas of focus; these are then set out in more detail under each of the 3 strategic aim headings.

Subject to any questions, PL asked the Board to approve the BAF, which will then guide its focus over the next 12 months.

MW confirmed that this has had much scrutiny and asked each of the committee chairs to confirm they are content.

PB, Chair of FIC is content, reflecting the really good work based on strong planning. FIC will ensure we are close to delivery and on track. SW confirmed the plan to have formal quarterly stock takes of the plan and will report progress to Board. This discipline will allow us to report progress so there is clarity on where we are with the risks.

LS, Chair of QPSC is also really supportive and this will help frame the agenda and level of assurance we require. The strategy is transforming healthcare and so we need to understand views / expectations of our patients. The Models of Care is central to this. MW asked how we get direct feedback from patients. LS explained there are some gaps in understanding about our shift in clinical model. MD added that we have increased network points to ensure more feedback and have a large staff group who also need to understand the strategic aims, which will be covered by the Board Story today.

MP. Chair of PC is supportive too and will use this to drive the focus of the committee.

KN, Chair of ARC welcomed the opportunity to refine the BAF over the last couple of months. On how we know it is working she suggested a need to keep asking how we know through evaluation. Ensuring we are measuring what matters to patients.

MW asked DR about being data led to track delivery. DR responded that we talk as an executive on a weekly basis about how we use data better. We are not currently measuring everything we need to as will come out via the Board Story re models of care; so more thinking on this is needed over the coming period.

MW confirmed that the Board approved the BAF.

10/25 Risk Appetite Framework [11.03-11.05]

PL expressed his confidence that as we start to implement this new Framework it will help us take a step change in our approach to risk management. The key benefits of this approach include ensuring a better focus and clarity on risks, e.g. those outside of appetite, to inform the amount and type of risk the Board is willing to accept to meet is aims, as set out in the BAF; support decision making; and should also encourage proactive risk seeking, especially in the context of innovation.

PL confirmed that we have engaged with others, such as NEAS, who introduced this recently and used their learning, such as phasing implementation. We are therefore starting the roll out with the Board and Executive. PL felt that almost certainly we will not get this right from the start and so will adjust over the

next period as we learn from using the Framework in practice. This is another reason to use this first phase as a Pilot.

For now, PL asked the Board to agree the Framework noting that things like the categories and appetite levels may be subject to change as we learn from the initial period of implementation.

The Board approved the Framework and asked the implementation is overseen by the Audit Committee.

11/25 Board Development Plan [11.05-11.10]
PL noted that this Plan has been reviewed by both the executive and non-executive, and he thanked Steve Lennox for his support in the thinking behind the Plan. The purpose of the Programme is to help the Board become as effective as possible, and in doing so to support its role in overseeing the delivery of the strategy as set out in the BAF. While we will utilise some external support, we will largely draw on the extensive skill and experience of board members. The Plan sets out the approach in a more strategic way, but with flex as things might emerge in year.

PL confirmed the two main drivers to inform the priorities for development, were the last well led review and the Insightful Board. The proposal is that the Board adopts the 6 areas where the Board has collective responsibility, as suggested by the Insightful Board, and that the Plan reflects the three themes from the last well led review – Governance, with a particular emphasis on risk and curiosity; Connectivity, where we will continue to invite operational leaders; and Ambition, defining what the Boards ambition is for itself.

The Board agreed the Development Plan and in doing so adopted the 6 responsibilities set out in the Insightful Board, as the Board's Purpose.

12/25 Board Story [11.08-11.55]
RQ introduced this, and his clinical colleagues who joined to talk to the slides, which outlined the different modes of care, and reinforced the alignment with our strategy and meeting the needs of the group A and B patients.

There are 11 models of care / conditions and the Board considered three and the specific plans for the year ahead to ensure we better meet needs of patients. Andy Collen, Consultant Paramedic, started by reinforcing our approach to allocating finite resources to ensure we meet needs of patients in a different way, i.e. not all need an ambulance.

<u>Falls Frailty and Older People</u>
Tom Pullen, Practice Dev Lead, provided the current position and the work in place to amend the model to respond in a more proactive system wide intervention, which recognises this group of patients have long standing and ongoing needs. This aligns with national direction of travel.

<u>End of Life</u>
Jen Scott, End of Life Care Lead, set out the approach for this patient group reinforcing that we are only part of solution so need to work with system more closely to support us and put in place new pathways.

<u>Reversible Cardiac Arrest</u>.
Dan Cody, Consultant Paramedic, highlighted how we are approaching this patient group which will fall in to the group A group. As heard earlier, we have the highest rates of survival in the country, but there is still more to do. The purpose of his model is to increase survivors and there is a clear link between the speed we get to patients and their survival. This is why our strategy is about ensuring resources are reserved for people who really need an ambulance. Dan also touched on the role of public access defibs and the link to health inequalities.

MW thanked the team for their work and bringing the strategy to life through the focus on patients.

SW commented that this is critical to our strategy. The challenge is how we measure what is different at the end of the year. Also, how we chip away at inequalities shown by the cardiac arrest slides. SW asked what support is needed from the Board.

MD commended the presentations and noted how good it is to see strategy in action. She asked about end of life, and the role of primary care who have greatest oversight of this patient group, yet primary care are often absent in provider collaboration meetings. Jen responded that it has to be part of a system solution, but all partners need to be brought together given the different roles, including charity partners. JA acknowledged primary care will be biggest challenge, especially given issues within ICBs.

MS asked about falls and partnerships with community providers. Tom outlined some of the partnerships across the region.

KN commented on falls and referred to some research concluding falls is a symptom not a condition. So challenged how we think about framing this group of patients. KN then asked what would be the one area to go at related to inequalities.

LS asked if we have IT systems to identify these patients and if we refer to alternative pathways there is a safety net to ensure they are followed up.

Tom responded that grouping falls frailty and older people needs revisiting especially as we don't code patients in this way, e.g. fallers. So, the focus is initially to ensure we better identify this patient group. NR responded to the data comments and the work we are taking re access to the national care record.

MW summarised that the Board is fully behind this programme. This helps demonstrate the shift in becoming clinically led which was the emphasis of our strategy. So it is good to see.

Break 11.55-12.05

13-14/25 We Deliver High Quality Care [12.05-12.18]
The BAF & IQR informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the Quality Committee.

Noting the areas covered already, LS summarised the outputs of the most recent meeting of Quality & Patient Safety Committee, in particular the areas of Alert, which included models of care just covered by the Board Story and Clinical Supervision which will have a significant positive impact. Focus of QPSC aligned well to the BAF and risk register. Broadly there is a good level of assurance related to quality and patient safety.

MW then turned to PB if he wanted to add anything from the FIC review of operational performance. PB did not highlight anything specific other than what was in the report.

MW then asked MD RQ and JL in particular if they wanted to highlight anything specific. MD reflected on the maturity of the committee itself and the level of support and challenge which is constructive. CQC observed the meeting and provided positive feedback.

JA bult on the issue of integration in how we work through the committees and the relationship between quality and productivity; there are some implications on the time of clinicians for things like clinical supervision. JL felt we are better at describing the input rather than output, and so as we mature this

conversation, we need to be conscious of these points given the finite resources and need to allocate carefully based on impact.

DR confirmed that we have distinguished the Plan this year between productivity and efficiency and how we close the circle between productivity and safety.

MW summarised that the Board is broadly assured with the quality of care delivered at the moment.

15-19/25 Our People Enjoy Working at SECAmb [12.18-12.55]
The BAF & IQR informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the People Committee.

MP then summarised the output of the most recent meeting of the **People Committee** some of which are on the agenda.

MW asked SWa about her confidence with staff appraisals and stat man training. SWa responded that we continue to work on the number and quality of appraisals, but there are still some issues with the quality of data. We are looking at this and in the meantime despite this we are on an improving trajectory. JL confirmed she is following up as this moves in to her portfolio.

MW asked if our management training includes support to managers undertaking quality appraisals, using this as a learning opportunity. JL responded that this is a gap and requires some further analysis.

Action
Gap in Assurance: People Committee to explore in the next 6 months how management training is preparing managers to undertake quality appraisals.

Education Quality Intervention
JL summarised the paper and our response to the recommendations. The improvement plan is in place, as reviewed at the People Committee last month; set out on the PC report. JL confirmed a further report following a conversation follow up in Feb is due soon but expects this to closely align with the previous report and our improvement plan.

KN asked about the relationship with the universities and asked for more assurance on this. JL responded that we need to improve our comms and process with universities when concerns are raised from a learner, to ensure timely action is taken. Also, how we provide broader assurance on our placements.

MW asked for assurance on how we get direct feedback from learners' experience. JL explained there is a national education survey run by NHSE, akin to the NHS Staff Survey. This gives some insight. Also, there are internal surveys and mechanisms. MW asked if this is considered sufficient by the learners. JL responded that we use more the feedback from what learners tell us from the training courses. This is used to then amend our approaches as needed.

Staff Survey
JC paid tribute to her team, some of whom were observing the meeting, for their work in our engagement initiatives over the past 12 months. The staff survey included feedback from over 3,000 staff, which demonstrates really positive progress. This compared positively with our peers and we were the top performing ambulance trust for morale. However, as reflected at the People Committee, we know the ambulance sector is relatively low compared to other parts of NHS and this feeds our aspiration to continue to do better, being realistic and balancing ambition with what is achievable. JC picked out key headline

improvements, noting that we saw small improvement related to sexual safety, but know we have much more work to do.

There were three areas of deterioration from the 100+ questions; two related to discrimination and we are reviewing the detail of this as it is not trust wide and so more targeted support is needed. This feeds into our EDI plan. The third area relates to violence from public / patients.

JC then outlined the approach being taken locally to ensure we provide information to managers to drive improvement locally. Response to this approach has been very positive as managers are owning their results. At a corporate level we are using the data to inform the EDI plan and HR plan and also triangulating the data with employee relations, complaints, and patient safety to looked in the round to identify hotspots - where support might be needed. This is about co-designing with local managers and offering support where needed.

MD drew the Board's attention to the data re violence from the public and linked this to the IQR, where the data from related incidents shows as increase in 2024 peaking with the civil unrest in the summer. However, since then and the measures put in place to support staff late last year, and IQR data is showing a gradual decrease.

SW thanked the comms team and all the good work in the past year; it has been great progress. He then reinforced the importance of saying when behaviour of the public is not acceptable. This is an issue across the sector and so more to do and not easily solved. On triangulation, culture is mostly located, and conversations are needed about how we support leaders.

MW summarised that this is a brilliant response from our people, really encouraged they took the time to respond in such big numbers. On hotspots, where behaviours not acceptable, we need to focus on this going forward.

Action
Gap in Assurance: People Committee to receive information about the outputs of the triangulation from the SS, and other sources, to identify the hot spots and how teams are being supported.

KN encouraged us to think about the message that this is all our responsibility and does not just lay at the doors of local managers.

Shadow Board
JC was excited to share this with the Board. The first induction session is planned with new shadow board. This will enable us to hear different voices and help to further build the link between the Board and the road. June Board will receive feedback from the first meeting.

MP who will chair the Shadow Board added his views on this positive initiative.

The Board welcomed this and will look forward to the feedback to inform the June meeting.

20-22/25 Sustainable Partnerships [12.55-13.08]
The BAF, IQR and M11 Finance Report informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the Finance Committee.

PB then summarised the output of the most recent meeting of the **Finance & Investment Committee**. Good assurance in the integrated operating plan and as discussed earlier will closely monitor progress given the risks. Also assured with operational performance and the approach to virtual care in line with our strategy.

HG asked about the IQR and KPI reviews. There is a good executive summary in the IQR but still some issues with not having targets which results in SPC not working, e.g. in quality of care. He accepts we won't always have targets and so wants to know why we haven't set them; assurance is needed on this as part of the IQR review.

SW responded that the UEC framework will set new metrics and we will publish this and look again at the IQR as part of the ongoing review, to ensure clarity on which are national priorities.

Digital

SBr talked to his paper summarising the progress in the digital agenda over the past 12 months including the introduction of the digital strategy.

MW thanked SBr for his leadership in taking these areas forward, ensuring good foundations are in place.

MW then noted that we never stand still with cyber and asked how the Board will keep up to speed with cyber resilience. NR responded that it is important we provide ongoing assurance and reinforced some of the current controls. NR will bring back to Board his cyber maturity assessment.

Action
Gap in Assurance: Between FIC and AUC, further assurance needed on the controls in place to manage the Cyber risk.

23/25 AOB

None.

MW reflected on a really good meeting, good challenge and demonstration of our Values. He started the meeting by saying this was the end of one year and the start of another, and so an important point in our business cycle. He is confident in what we have achieved and going forward we require continued good governance to navigate our way through the dynamic operating environment; the Board is committed to patient care, improving productivity and ensuring value for money.

There being no further business, the Chair closed the meeting at 13.10

UK then confirmed there have been no questions from the Public.

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

Date _____

South East Coast Ambulance Service NHS FT Trust Board Action Log

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP)	Comments / Update
30.04.2025	08 25	Gap in Assurance: in the context of virtual care and the ambition of the operating plan this year to increase H&T to 19%, QPSC to explore how we are triaging need to ensure those patients who really need an ambulance get a timely response.	JA	26.06.2025	QPSC	IP	Added to agenda
30.04.2025	15 25	Gap in Assurance: People Committee to explore in the next 6 months how management training is preparing managers to undertake quality appraisals.	JL	Q3 date tbc	PC	IP	Added to COB
30.04.2025	15 25	Gap in Assurance: People Committee to receive information about the outputs of the triangulation from the SS, and other sources, to identify the cultural hot spots and how teams are being supported.	SWa	31.07.2025	PC	IP	Added to agenda
30.04.2025	22 25	Gap in Assurance: Between FIC and AUC, further assurance needed on the controls in place to manage the Cyber risk.	NR	17.07.2025	AUC	IP	Added to agenda

Key

- Not yet due
- Due
- Overdue
- Closed

South East Coast Ambulance Service
NHS Foundation Trust

Item No	28-25

Name of meeting	Trust Board
Date	05.06.2025
Name of paper	Chair Board Report
Report Author	Michael Whitehouse, Chair

Introduction

We last met just four weeks ago and, in that time, we have had a really constructive Board Development Session and had the opportunity to meet with our Board colleagues at South Central Ambulance Service (SCAS)

As agreed as part of the annual Board effectiveness review, the outputs of which are set out in a separate report, the agendas of the Board will rotate between the three strategic aims; this month the focus is on Our People.

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 helps to ensure ongoing Board oversight of the delivery of our strategic priorities; in year planning commitments; and areas of compliance. It provides the Board with clarity on progress against the organisational objectives and the main risks to their achievement, thereby informing the Assurance Cycle.

The primary focus of this meeting will be on Our People, where we will be considering our response to the external review of volunteers and how this will help shape our new volunteer strategy; confirm the approach to the People Improvement Plan, which is one of our key strategic priorities; review the EDI priorities as follow up to our two most recent development sessions; and then hear from the FTSU Guardian, which will help inform our July development session on Speaking Up.

Engagements

The second Board to Board with SCAS was held on 28 May. This was a highly constructive meeting as part of our strong commitment to working more collaboratively to deliver both better value for money for taxpayers and benefits for patients. We commended the ongoing functional

collaboration efforts and look forward to a further meeting in October where we will receive the business case that sets out how we can ensure closer alignment both from a commissioning and delivery perspective.

During May I met with a number of Chairs across the system, as well those from other ambulance trusts; visited the Ashford Hub; and joined Simon at his Meet the Chief event at Chertsey. While the challenges being faced by us all are significant, there is a determination to ensure we work together to ensure the best possible care for patients.

Board Appointments

The Council of Governors has concluded its recent Non-Executive Director (NED) search, and has appointed what will become in Q4 our new Chair of Audit Committee, in addition to a new Chair of our Finance Committee:

Peter Schild (Audit Committee Chair) is the Chair of the Audit and Assurance Committee at the HSSIB and previous roles include Director of Assurance at HMRC and Finance Director at DWP.

Suzanne O'Brien (Finance Committee Chair) is currently the Finance Committee Chair at Dartford & Gravesham Trust and held previous roles at Barclays, Morgan Stanley and EY. Suzanne also has a passion for health inequalities. She is Chair of a Charity supporting adults with Learning Disabilities and has an EDI Fellowship with specialisms in Race, Culture and Leadership.

Peter and Suzanne are scheduled to join the Board later in June.

South East Coast Ambulance Service
NHS Foundation Trust

Item No	29-25

Name of meeting	Trust Board
Date	5 June 2025
Name of paper	Chief Executive's Report

1	This report provides a summary of the Trust's key activities and the local, regional, and national issues of note in relation to the Trust during April and May 2025.
	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	Key issues discussed by EMB recently have included our approach to efficiencies and productivity moving forward, close monitoring of our 'Tier 1' programmes in particular the HR Improvement Plan and the ongoing collaboration work.
4	We also continue to discuss the emerging national changes announced by the Government, regarding future changes to NHS England and ICBs, and any potential impact on SECAmb, as well as the financial requirements all Trusts will need to meet.
5	EMB also continues to hold meetings each month as a joint session with the Trust's Senior Management Group and also with a wider senior leadership group. These meetings help to ensure we are taking a consistent approach, as a senior leadership team, to addressing key issues including financial performance and the implementation of our strategy.
6	**Substantive CDIO joins SECAmb** We were pleased to be joined on 1 April 2025 by our new substantive Chief Digital Information Officer (CDIO), Nick Roberts. My thanks to Stephen Bromhall for his hard work during his secondment with us and who returned to his substantive role at East of England Ambulance Service at the end of April.
7	Nick was previously Chief Information Officer at Moorfields Eye Hospital NHS Foundation Trust and has a wide range of digital portfolio experience across several NHS Trusts.

8	Digital is one of our key strategic areas of focus and I am sure that Nick will ensure we are able to successfully implement our agreed Digital Strategy and maximise the benefits that digital can bring to our patients and our people.
9	I look forward to hearing more about this from Nick in August, when he brings his delivery plan to the Board.
10	**Successful Volunteer Conference** I was pleased to attend our second Volunteer Conference on 5 April, where we were able to celebrate the significant contribution made by our fantastic team of SECAmb volunteers.
11	We welcomed more than 200 SECAmb community first responders, chaplains, and support volunteers to the conference with topics for discussion including the national strategic direction for volunteers and the future for volunteers in SECAmb. Thank you to our external speakers for giving up their time to attend.
12	A particular thank you to Helen Vine, the Volunteering Lead from the Association of Ambulance Chief Executives (AACE), who has been supporting us during recent months as we review our approach to volunteering moving forwards and whose expertise has been invaluable. I know we will hear more about this separately on today's agenda
13	We also celebrated the very real impact that our volunteers make for our patients through the presentation of return of spontaneous circulation (ROSC) awards to 54 volunteers whose life-saving skills had directly contributed to saving the life of a patient.
14	This year's conference was extremely successful and a great way, I believe, to celebrate our incredible team of volunteers and show how deeply appreciative we are as a Trust of their commitment and dedication
15	**Engagement** During the past couple of months, I have continued to attend national, regional, and local meetings on behalf of the organisation.
16	These include the continuation of my 'Connect with the Chief' programme, with recent visits to Worthing (10 April) and Chertsey (15 May).
17	This programme sees me visit many of our sites, where colleagues can meet with me for a one-to-one session, attend informal roundtable discussions and highlight anything they would particularly like to share.
18	These are great opportunities to hear directly from colleagues on their experiences and ideas for improvement and I look forward to continuing the programme.
19	We have also continued to progress our collaboration work with colleagues at South Central Ambulance Service (SCAS), and it has been good to meet with both their Executive Team (7 May), and with the wider Board (28 May) as this work develops.

20	With lots of changes taking place nationally, I am also continuing to attend relevant national events, including the NHS Providers' Chairs and Chief Executives network, as well as NHS England Leadership events, to ensure we are as sighted as possible on the changes taking place.
21	**'Hearing Different Voices' – our first Shadow Board for SECAmb** I am very proud that our new Shadow Board programme is now underway, providing us with an exciting opportunity to engage with our people in a different way.
22	We saw fantastic interest from our people who were interested in being part of this new initiative, and, following an application and selection process, have selected 16 colleagues from right across the Trust to form our Shadow Board.
23	Ahead of each Trust Board meeting, the Shadow Board will meet to examine key documents and debate a focused 'Hot Topic,' bringing forward their views to inform Board discussions. Members will work closely with senior leaders, offering a fresh perspective on issues that matter to our people and patients.
24	Thank you to Max Puller and Karen Norman who will share chairing responsibilities; Deputy Chief Executive Margaret Dalziel is the executive sponsor, championing the initiative and ensuring a strong connection with the Trust Board.
25	To support this important role, members receive bespoke leadership development through a tailored programme. This includes training on how to interpret board papers, ask meaningful questions, and constructively challenge reports.
26	The first formal Shadow Board meeting will take place in July, although the preparation is already well underway.
27	I am excited to see this initiative progress, as part of our wider engagement framework, ensuring that, as leaders, we truly are 'hearing different voices.;'
28	**Celebrating Success Event** I was delighted to attend our latest Celebrating Success Ceremony at the Crowne Plaza Hotel in Crawley in April, where we recognised the achievements of 53 colleagues who have recently successfully gained a range of different qualifications.
29	The event brought together paramedic graduates, associate ambulance practitioners (AAPs), and emergency care support workers (ECSWs), along with their families, to honour their dedication and success.
30	Special awards were given to five individuals for outstanding and most improved learner performance, celebrating those who have gone above and beyond in their development.

31	This event is an important reminder of the strength and talent within our workforce. It reflects not only individual success but also the impact of strong partnerships and the supportive culture we are building across SECAmb.
32	I very much look forward to continuing this tradition of recognition and celebrating all our academic achievers.
33	**Opening of refurbished Medicines Distribution Centre** On 2 April, I was really pleased to co-open our newly refurbished Medicines Distribution Centre (MDC) at Paddock Wood, together with NHS England Regional Chief Pharmacist, Inderjit Sanghera.
34	The re-opening follows a significant refurbishment programme, which has completely transformed the working environment in the Centre.
35	I know that this has been long-awaited by the team based there, who were working previously in poor conditions, and it's great to see their suggestions incorporated into the improvements.
36	The MDC plays a key role in supporting our front-line clinicians, handling 50,000 medicine pouches each year, so it was great to see the great new facilities in place.
37	**SECAmb football tournament** As an avid football fan, I was disappointed to miss our first ever football tournament and fun day at Lingfield College recently, as I was away on annual leave. I understand it drew over 400 colleagues and family members for a wonderful day of sport, celebration, and community.
38	Sixteen mixed, six-a-side teams from across the Trust competed for the SECAmb Champions Cup, with Thanet MRFC emerging as champions after a thrilling final and penalty shoot-out against GCFC (Guildford & Chertsey) Utd.
39	The day also raised an impressive £1,860 for SECAmb's charity, supporting staff and volunteers across the Trust.
40	I very much look forward to meeting our champions in June when I visit Thanet for a Connect with the Chief event.
41	Reflecting on this event, it truly demonstrates team spirit, inclusivity, and organisational pride. I very much look forward to attending next year's event to see if Thanet can retain their title!
	B. Regional Issues
42	**GoodSAM** It has been heartening to hear lots of examples recently of the positive impact that the 'GoodSAM' app is having on outcomes for patients who suffer a cardiac arrest in the community.

43	The GoodSAM app is used by ambulance services to alert first-aided trained individuals to nearby cardiac arrests. It actively searches for the closest responder within a 500m radius of a potential cardiac arrest incident and allows our 999 call takers to alert these local volunteers to incidents close to them, allowing them to perform CPR and/or bring a defibrillator to the scene of an arrest and minimise the time a patient spends without receiving CPR.
44	There are currently some 850 of our people including volunteer CFRs, registered directly with SECAmb to respond via GoodSAM. As a Trust, we would also encourage members of the public with first aid training to also consider signing up to the GoodSAM app.
45	**Integrated Quality Report (IQR) refresh** I am pleased to see that for this month's Board, the Trust's Integrated Quality Report (IQR) has been refreshed this month, to align to our new Board Assurance Framework (BAF) priorities for the coming year and the new NHS performance framework. It also reflects the success of the Trust in embedding improvement in a range of areas and exiting from the Recovery Support Programme (RSP).
46	The updated IQR will enable richer discussions at our Board committees through a refined set of metrics, which are then triangulated via the Board report and commentary and committee chair reports.
47	There will be more focus on delivery of our strategic objectives, enhancing our productivity and identifying areas for further investigation and action, with the new report and process being proactively reviewed and improved through the next six months.
	C. National Issues
48	**Sad news** We were saddened to hear of the recent death of renowned cardiologist Professor Douglas Chamberlain.
49	Douglas' work in the early 1970s led to the birth of the UK paramedic profession in Brighton, as the first 'ambulance men', who had been selected for additional training by him, began to respond to patients equipped with the first ambulance defibrillators.
50	SECAmb is very proud of and is fortunate to have had an extremely close working relationship with Professor Chamberlain for many years and I know that he will be remembered extremely fondly by colleagues past and present.
51	A large portrait of Douglas takes pride of place at our Make Ready Centre in Brighton, Chamberlain House, which was opened and named in his honour in 2020.
52	I was privileged to meet Douglas shortly after I joined SECAmb and found him truly inspirational. The paramedic profession would not be what it is today without his leadership and vision, and it is clear that his legacy will continue to inspire colleagues in SECAmb and beyond.

South East Coast Ambulance Service
NHS Foundation Trust

Item No	30-25

Name of meeting	Trust Board
Date	05.06.2025
Name of paper	**Board Effectiveness Annual Review**
Executive Lead	Director of Corporate Governance

The Board's annual effectiveness review was undertaken across the two development sessions in March and May, in line with the programme of development agreed by the Board.

As well as satisfying the requirements in the Code of Governance, this annual review supported the Board's ambition to become the best Board it can be. The review was undertaken through four reflective lenses, as set out in section 4 of the report, and will be used to help triangulate with the external well-led review we plan to commission later in the year.

Overall, the Board can be assured that it already poses many of the characteristics of a strong Board. Through this review it has demonstrated insight into the areas it is less strong, and a commitment through the agreed actions; revised objectives of its committees; and the 'we will statements', to ensure further improvement in the coming year.

Recommendations, decisions or actions sought	The Board is invited to collectively accept the outcome of the effectiveness review and individuals are asked to champion the 'we will statements' so that the Trust Board can be as effective as it possibly can be.

Board Effectiveness Review 2025

1. Introduction

1.1. This paper is aligned to the Board Development Programme that was approved by the Board in April.

1.2. The Development Programme commenced with a review of Board and Committee Effectiveness and depending upon the outcome this could add further detail to the Programme.

1.3. The effectiveness review was undertaken in March & May 2025. This paper presents a summary of that review.

2. Risks

2.1. This work has no direct link to the risks contained within the BAF or any risks considered as extreme within the risk register. However, there is an indirect relationship to the risk register in that a high performing Board will have a greater impact on risk and other internal controls.

3. Compliance

3.1. Having a Board Development plan in place helps the Trust adhere to the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 and specifically the following regulatory requirements.

Regulation 17: Good Governance

Regulation 5: Fit and Proper Persons Requirement (Directors)

Regulation 19: Fit and Proper Persons Employed

Regulation 18: Staffing

Regulation G4: NHS England Guidance

3.2. Undertaking an Annual Effectiveness Review is mandated in section 4.5 of the Code of Governance for NHS provider Trusts where there is a comply or explain requirement.

3.3. It also helps to maintain the Trust's compliance with the licensing obligations.

Section 4.5 Code of Governance

4. Methodology

4.1. The 2025 effectiveness review was undertaken through four reflective lenses. Three lenses for the Trust Board and one lens for the committees.

- Lens 1- Board comparison with other Boards
- Lens 2- Board self-assessment with the NHS England Insightful Board
- Lens 3- Board self-assessment with the NHS England Leadership Competence Framework
- Lens 4 – Committee reflective discussion

5. The Trust Board

Lens 1. Benchmarking - Comparing with Others

5.1. With support from the NHS England Improvement Director, the Board undertook a benchmarking exercise with organisations within the commercial sector and NHS organisations rated as outstanding by the CQC.

5.2. The purpose was to identify if the function of the Board remained aligned with current best practice and to identify opportunities where the Board may be able to learn from others.

5.3. Overall, the benchmarking exercise suggests that the functioning of the Board is aligned to current thinking. For example, the Board has previously adopted the responsibilities outlined in the Insightful Board (2024) and is striving to spend a greater portion of Board time on strategy whilst asking the Board Committees to primarily focus on oversight and assurance.

5.4. There is recognition within the commercial sector that there is a link between successful Boards and a Board's ability to be resilient and tolerate massive fluctuations in the strategic and operational landscape. The Trust Board recognises this and remains ambitious. The Board will aim to further strengthen **resilience** in the coming year.

5.5. The Board also agrees that being the final stop before decision means a Board discussion needs to be as informed as possible. The Board is instrumental in maintaining corporate safety and it is the **discussion** through challenge that maintains effective and safe decision making. The Trust Board will make some adjustments to improve this function in the coming year.

5.6. The Board agrees that staying **relevant and connected** needed to be actively managed. It is too easy to become overwhelmed by the wide agenda and lose sight of the context and impact. The 2022 CQC report identified a gap between senior leaders and service provision and the Board will continue to make improvements in this area in the coming year.

5.7. The Board also recognises that there would be organisational benefit from strengthening the Board's leadership of **inclusivity**. The Board composition does not yet reflect the widest range of diversity. The new Shadow Board will help considerably but it is not a panacea to the issue. The Board will make improvements in this area during the coming year.

5.8. Therefore, through the reflective benchmarking exercise, the membership identified four areas where the Board will be even more curious. These improvement areas are,

- **How the Board can become more resilient**
- **How the Board uses challenge to promote the very best discussion possible**
- **How the Board becomes even more relevant/connected**
- **How the Board becomes (and leads) a more inclusive culture**

5.9. The benchmarking exercise also identified specific interventions from other NHS Providers where the Board could learn and implement.

5.10. Consequently, a set of “we-will” statements have been created for each of the four improvement areas.

5.11. These we-will statements will act as an aide-memoir and be used through the year to grow and develop. These are contained within Appendix-I.

5.12. Committee Chairs are invited to refer to the We Will statements as part of their on-going effectiveness monitoring.

Lens 2. The Insightful Board

5.13. In November 2024 NHS England published The Insightful Board (2024) to help Boards understand and strengthen its role within a provider organisation. The guidance includes questions where Boards need to be curious and promote enquiry.

5.14. The Trust incorporated these questions into a reflective self-assessment to help reveal areas where SECAmb’s Board could be strengthened.

5.15. This exercise revealed that the Board was consistent with the model outlined in the Insightful Board and could demonstrate many areas where curiosity was strongly evidenced.

5.16. There were areas which the Board could develop. For example, there is recognition that the Integrated Quality report is a valuable resource and if the narrative was enhanced then the tool could be even more powerful. Going forward the executives will each review their own contributions to the narrative.

5.17. There is also recognition that strengthening the supporting governance architecture could bring additional benefit. This includes hearing from different voices for triangulation and some functional improvements with the identification and monitoring of internal controls. This will be considered by the Director of Corporate Governance.

5.18. The section that requires the most focus was the health Inequalities and Inclusion section. This resonates with the findings of Lens 1 (Benchmarking). The Board would benefit from receiving information that could help connect population health with the strategic priorities. This has been identified within the “We-Will” statements.

5.19. The self-assessment will now act as a baseline for the coming year and repeated in the 2026 effectiveness review.

Lens 3. NHS Leadership Competency Framework for Board Members

5.20. In 2019, the Tom Kark KC review of the Fit and Proper Person Test was published. And a supporting Competency Framework was published in 2024.

5.21. The Framework considers six competencies required of all Board members regardless of their role on the Board.

- Driving high-quality and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance

- Creating a compassionate, just and positive culture
- Building a trusted relationship with partners and communities

5.22. This was completed by individual Board members to help identify personal development needs and also identify areas where the Trust could strengthen the collective competence.

5.23. The competency that was expressed the least was "*promoting equality and inclusion and reducing health and workforce inequalities*". There was little difference between the executive and the non-executive, and this is consistent with the outcome of the other two reflective lenses.

5.24. This is a competency that the Board is fully aware of and there is a very strong desire to strengthen this area. This is included extensively within the 2025/26 Board Development plan by asking for an inclusion/diversity lens to be added to every theme within the programme. This commenced with a half day in March 2025 and a further session in May 2025.

5.25. The half day in March identified four specific areas for the Board to consider. These will be overseen by the Trust's EDI lead and contained within the supporting improvement plan. The four areas are:

- Development and empowerment of staff networks
- Focus on inclusive recruitment
- Enhanced Staff Development
- Improved analytics and reporting

5.26. The self-assessment will now act as a baseline for the coming year and will also be repeated in the 2026 effectiveness review.

6. Committees of the Board

6.1. As part of the effectiveness review each Board Committee undertook a reflective discussion of its effectiveness. This was led by the Committee Chair and each Chair identified improvement areas. A summary is provided below.

Committee 1 - People Committee

6.2. The People Committee has recently appointed a new Chair who facilitated the reflective discussion. This helped identify specific committee objectives for the coming year. These are:

- Through delivery of the People Plan, ensuring confidence in the People function and its ability to enable colleagues to 'enjoy working at SECAmb'
- Ensuring the right support and workforce plan are in place to achieve both successful and sustainable corporate services reorganisation and transition to the new divisional leadership model
- Hearing different voices from across the organisation, including D&I networks, subject matter experts and other colleagues about their lived experiences

- Fostering a greater sense of curiosity to explore challenges and opportunities, sharing insights and ideas, to learn from others and inform and shape decision-making and spark innovation

Committee 2 - Quality & Patient Safety Committee

6.3. The reflective discussion revealed there was a need to strengthen the operational input and to try and include more outcome data and strengthen the link between the patient safety report and the corporate Integrated Quality Report.

6.4. The reflective discussion helped identify committee objectives for the coming year. These are:

- Ensuring clarity of the clinical triumvirate and their roles and responsibilities to each committee.
- Supporting the development of SECAmb as a learning organisation and raising the profile of our research and development team
- Strengthening the partnership and system working across all committees to identify best practice, knowledge sharing and any lessons learnt
- Agree how to cascade QPSC content and decision making to the wider organisation

Committee 3 - The Finance & Investment Committee

6.5. The Finance Committee has recently appointed a new Chair who facilitated the reflective discussion. This helped identify committee objectives for the coming year. These are:

- Review the most recent 1 page board summary sheet at each committee meeting
- Spend more time on strategy and building blocks to deliver success (e.g. cultural change, ensuring front line fully engaged and supportive, new ways of working etc)
- Build on the trust we have with executive colleagues to encourage them to describe performance, issues and proposed solutions rather than scrutinising papers
- In recognition of the valuable contribution of governors, to make time for liaison with governors before and after meetings

Committee 4 - The Audit & Risk Committee

6.6. The Audit Committee has recently appointed a new Chair who facilitated the reflective discussion. This helped identify committee objectives for the coming year. These are:

- Chairs of each committee to have a standing agenda item slot for a verbal update to Audit Committee to raise any items of concern about internal control issues
- Oversight of the PMO to be included and set out as appropriate in the cycle of business

- The cycle of business to ensure complete coverage of the organisation either by internal audit or external audit or other reviews over a 3-year period

7. Going Forward (Actions)

7.1. The outcome of the four exercises has been consistent and has suggested the Board is effective in most areas but with a need to consider how it can include a wider range of perspectives. This is strongly featured within the detail of the actions and the 2024/2025 Board Development.

7.2. There are two main drivers for the Board's development. These are the 2025/26 Board Development Programme and the "We-Will" statements.

7.3. The Board Development programme was presented to Board in April 2025. The outlined plan is consistent with the themes emerging from the effectiveness review and will remain as the template for the coming year. The Board can confidently say the 2025 plan has been developed based on need and is less reactive than previous. But it still offers some flexibility to issues that may arise in-year.

7.4. The We-Will statements will be used by the Board Committees as an evaluation/effectiveness tool.

7.5. The Committees will draw upon their objectives through the year and include in the 2025/26 effectiveness review.

7.6. Each executive will review the narrative that is contained within their section of the Integrated Quality report.

7.7. The Director of Corporate Governance will consider how to improve the inclusion of other voices for triangulation and functional improvements with the identification and monitoring of internal controls.

7.8. To repeat the Competency Assessment in the 2025/26 Effectiveness Review.

7.9. Ensure the 4 EDI improvements identified in the March 2025 workshop are incorporated within the EDI Improvement Plan.

7.10. A 2025/26 External Well-Led review will consider progress against the above actions.

8. Recommendations

8.1. The Board is invited to collectively accept the outcome of the effectiveness review and individuals are asked to champion the 'we will statements' so that the Trust Board can be as effective as it possibly can be.

9. Appendices

9.1. Appendix I -We Will Statements

Appendix I

We Will Statements

How do we become more resilient?

1. **We will ensure that 70% of the Board agenda is focussed on strategy** and 30% on other issues and that this is reversed at Committee level.
2. **We will all understand that challenge keeps the organisation safe** and regard ourselves open and accepting to rigorous challenge. But we also acknowledge we may not always be able to answer at that moment in time.
3. **We will have in place a comprehensive cycle of** business for the Board and Committees that is planned, and where non-compliance is clearly identified.
4. **We will move towards the committees becoming the engine room for assurance** and The Board maintaining a robust oversight of strategy and committee function.
5. **We will take responsibility for our own individual development plans and our role in supporting the Board Development Plan** and that these are linked to the Insightful Board and we will ensure we have identified areas where we wish to develop further strength.
6. **We will ensure we undertake an annual review of each committee** and continuously monitor committee effectiveness at the end of each meeting.

How do we use challenge to promote the very best discussion possible?

1. **We will ensure all committee papers are completed on time** unless the matter is an urgent escalation. This will allow time for colleagues to process the necessary information.
2. **We will ensure we support all members to be heard at every Board meeting** by accepting all perspectives add value to a discussion. This means there may be times when we need to step back, encourage others to express their view, and at times step forward.
3. **We will ensure all relevant papers have their associated risks clearly identified** and that the impact on those risks is clearly explained.
4. **We will ensure papers are short, focussed and succinct and that discussion points are highlighted** and invite supplementary information being supplied in appendices**.**
5. **We will announce impactful bad news prior to the Board** and delay the commencement of the meeting by an appropriate time so that members are given the time to process the news ahead of the meeting.

6. **We will adjust the running order of the agenda at each meeting** as we recognise energy can reduce towards the end of the meeting.

How do we become even more relevant/connected?

1. **We will invite the subject matter experts to be present at the board** and will support their choice to contribute to their item or to listen to the discussion.
2. **We will invite the staff networks to visibly contribute to the work of the People Committee and furnish the Board with an annual joint report** that reflects the improvements and challenges within their area of oversight.
3. **We will ask Board papers to reference staff in the most respectful language** and will ask papers to refer to staff as Colleagues. E.g. Clinical Colleagues, Management Colleagues, Make Ready Colleagues etc.
4. **We will make every effort to acknowledge and celebrate success** of our organisational colleagues by inviting success stories to be told in the Board Room or at Committee.
5. **We will review and build these we will statements annually** to help us achieve our purpose.

How do we become (and lead) a more inclusive culture?

1. **We will ensure we actively value and act on the information arising from the Shadow Board** and will invite the 2025/26 well-led assessment to take a view on this aspect.
2. **We will make every effort to hear the voice of generations not represented in the Board room** by inviting the Director of Communications and Engagement to engage with colleagues to identify a suitable mechanism for capturing their voice.
3. **We will, year on year, improve our monitoring of diversity and inclusion** within the relevant Board level metrics.
4. **We will invite the Executives to try and illustrate how they have included the wider voice of others in the development of their papers** and support them to be accompanied in the Board room by those closest to the issue being presented**.**
5. **We will continue to invite leaders at all levels into relevant Board Development sessions** to help build strong relationships where a wider voice feels able to contribute.
6. **We will lead by example and collectively ensure all board members involved in a discussion feel heard and respected** and invite the Chair to champion this within the meetings.

South East Coast Ambulance Service
NHS Foundation Trust

	Item No	31-25

Name of meeting	Trust Board
Date	5 June 2025
Name of paper	Board Story
Executive sponsor	Jaqualine Lindridge, Chief Paramedic Officer
Author name and role	Janine Compton, Director of Communications & Engagement

Recognising the contribution of our volunteers

This week (2 to 8 June 2025) is national Volunteers' Week, an opportunity to celebrate locally the significant contribution made by our team of SECAmb Volunteers.

Our Board Story this month highlights the impact made by our Community First Responders (CFRs), highlighting the real difference they make to outcomes for our patients and their vital role in the 'chain of survival'.

In the story today, we highlight the incredible work of CFR Team Leader, Lance French.

On Easter Sunday this year, Lance was dispatched and responded to an emergency involving a woman in her 70s who had collapsed while out for lunch with her family at a pub in Staplehurst in Kent.

The patient, Margaret Monks, shares her experience and highlights why having a network of trained volunteers like Lance, especially in rural communities such as Staplehurst, is so essential and deeply appreciated.

Recommendations, decisions or actions sought	The aim of the Board Story is to help frame the meeting using stories from our people and patients.

South East Coast Ambulance Service
NHS Foundation Trust

Item No	32-25

Name of meeting	**Trust Board**
Date	5 June 2025
Name of paper	Volunteering at Secamb: AACE report and response
Executive sponsor	Jen Allan, Chief Operating Officer
Author name / role	Lara Waywell, Divisional Director of Operations Danny Dixon, Head of Community Resilience

This paper presents the AACE report on Secamb's volunteering function, and the Trust's response and proposed way forward for Volunteering at SECAmb.

We would like to offer our thanks to Helen Vine (AACE) for her excellent work and to all who contributed. We would also like to thank our over 400 volunteers, who make a huge difference to our patients and staff. Last year for example, our volunteers gave over 95,000 hours of their time, and were first on scene to around 10% of our immediately life-threatening Category 1 calls. Volunteering is a key part of our strategy, and we look forward to working together with our teams and volunteers to shape this.

The Trust formally acknowledges and accepts the AACE Report and its recommendations, which have been presented to EMB in March 2025 and to our Volunteer Conference on 5 April 2025, as well as to People Committee in May 2025. The report notes that a refreshed strategy for volunteering at the Trust is needed and that this should address a mismatch between the needs and expectations of our volunteers and those of the Trust, building on the valued contribution of volunteers to date. We will be reviewing and taking forward the recommendations in the report in line with our new Volunteer strategy once developed, noting that a number of immediate improvements in our volunteering service are already in train.

Volunteer function leadership has been strengthened through interim appointments to vacancies, which supported the recent well attended and successful Volunteer conference, celebrating the contribution of our many volunteers. Action has also been taken to enhance communication with volunteers, to ensure the CFR desk is consistently staffed and dispatch support to volunteers is robust, and to submit data to track volunteering activity. The Emergency Responder (ER) pilot has been extended until 30/9/25 and a formal evaluation plan drawn up to ensure outcomes are properly understood to inform a decision on its future.

The paper further outlines our approach to developing a new Volunteer strategy for the Trust, focusing on delivering outcomes aligned with the Trust Strategy. Priorities for the strategy and for our volunteer work have been identified, including addressing health

inequalities, integrating volunteering and the GoodSam programme, enhancing support processes for volunteering and improving our data capture, analysis and benchmarking around the impact of volunteering. We also want to prioritise developing the scope of what our volunteers can do at Secamb into new areas, building on our strong chaplaincy support.

Options for the Volunteer strategy in future include one or more of the following:

- Stabilising the function through substantiating leadership and making operational improvements to volunteer management and contributing to the falls pathway;
- Extending volunteer roles and numbers significantly to support much greater input to patient care, and wider opportunities for volunteers across the Trust, requiring commensurate leadership and supporting resource;
- Focusing on community engagement, including proactive education and Good Sam recruitment particularly in under-represented areas, and building blue light partner collaboration.

The approach to developing the strategy, particularly to ensure a focus on clinical outcomes, alignment with Trust strategy, national volunteering approaches and our collaboration with SCAS, is outlined. There will be a consultative process through the year to engage stakeholders, including volunteers, front line staff and leaders, to develop the strategy, and a business case for any required investment will be drawn up.

The Board is asked to:

- Formally receive and accept the AACE report on SECAmb Volunteering
- Review and comment on the approach to developing a new Volunteering strategy aligned to Trust strategy and outcomes, and a supporting business case.
- Note that the report and this paper has been proactively shared with our current Volunteers and their input will be sought into the strategy development process

The strategy and business case are anticipated to be developed by the end of 2025. We plan to update Board on progress during the coming months and hope to present the new strategy and business case to the People Committee and Board in December.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Bringing together skills, expertise and shared knowledge in UK ambulance services

Strategic Review of Volunteering at SECAmb

Helen Vine

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Terms of reference:

- Leadership infrastructure
- Funding and finance
- Data and evidence base
- Volunteer experience and expectations
- Opportunities for the future of volunteering at SECAmb linked to the SECAmb strategy and NHS 10-year plan

Methodology:

- 7 focus groups
- 15 staff interviews
- 80+ direct contacts from volunteers
- Submission of documentation and data from the trust

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Key Findings:

- There is a tension between what volunteers expect and what the trust needs.
- Previously evolution of volunteering rather than strategic development.
- Current leadership infrastructure does not provide the stability and capacity required for current or future potential volunteering activity.
- Existing funding and finance models could be perpetuating health inequalities for patients and communities.
- It is essential to agree, collect and share robust metrics which evidence the impact of volunteering and support the business case for investment.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

- An effective communications strategy within an overall volunteering strategy will support the trust to address the tensions that exist.
- This is a great opportunity to:
  - get the basics right
  - integrate volunteers and the community resilience function into the new divisional structure
  - provide enabling support from wider trust functions
  - reduce the siloed nature of volunteering
- Volunteers can offer non-clinical and clinical activity and there are opportunities to lift and shift successful roles from other ambulance trusts into SECAmb.
- With a sustainably funded leadership infrastructure, the development of a volunteer and community resilience strategy and a robust evidence base, volunteering will support implementation of the trust's strategy, Saving Lives and Supporting Our Communities 2024-2029

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

The review makes 62 recommendations for the short, medium and long term .

Early priorities:

1. Review and rationalisation of the various communication platforms and development of a **communication strategy** for volunteers to ensure everyone is clear about the role and impact of volunteers.
2. Collection of **robust data** in respect of the trust's strategic aims to demonstrate volunteering is aligned with strategic intent and impacting positively for patients and communities.
3. A **funding** settlement for volunteering which covers at least the duration of the trust strategy.
4. Introduction of a volunteer and community resilience hub providing **strategic volunteering leadership** with collaboration across the SECAmb divisional structure and support functions.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Opportunities

Volunteer experience is generally positive, however, there are opportunities to improve with some quick wins.

- National AACE packages available for swift implementation:
  - AACE volunteering policy guidelines
  - AACE volunteering reward and recognition framework
  - AACE national volunteering dashboard
  - AACE volunteer EPRR framework

- Support offer from the AACE national volunteering lead – Joe Crook

- Support offer from National Ambulance Service Responder Managers' Group

- Lifting and shifting the best of volunteering to SECAmb volunteering – Community Ambassador volunteers NEAS, Community Welfare Support volunteers WAST etc.
- Clear lines of sight between trust strategic objectives and the volunteer offer – increase OHCA survival rates by 5%, reduction in avoidable conveyance to 39%, increasing outreach to marginalised and underserved communities etc.

ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Bringing together skills, expertise and shared knowledge in UK ambulance services

Helen Vine

Email: helen.vine@aace.org.uk

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Next steps – actions and response

Strategic Review of Volunteering in SECAmb

Danny Dixon, Head of Community Resilience

v0.1 24 April 2025

V0.2 May 2025 for EMB PC

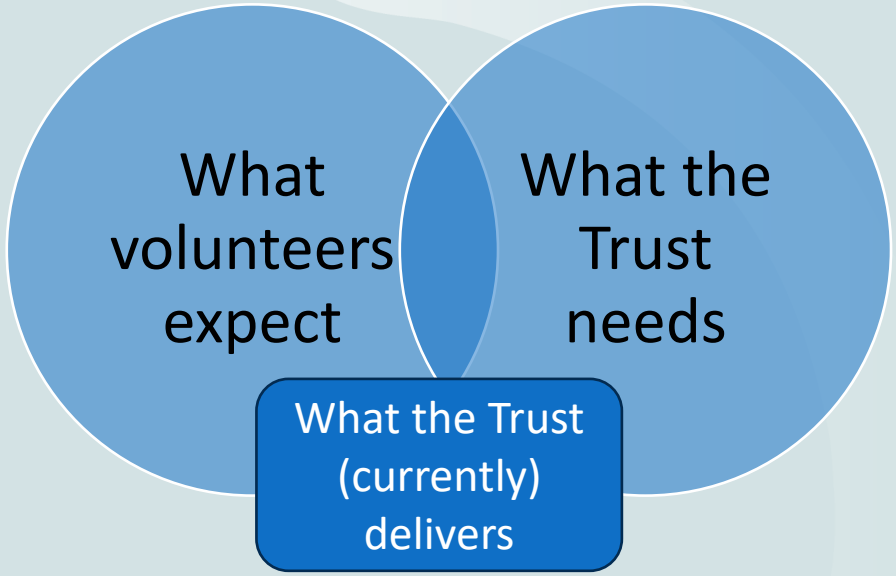
V2 May 2025 for Board

Background

- SECAmb, along with the wider NHS, has a long history of volunteer activity.
- There is a strong focus on clinical volunteering (Community First Responders, Emergency Responders), although other volunteering opportunities exist (Chaplains, Support volunteers).
- There are also other unpaid roles in the Trust which are not traditionally badged as volunteer roles and many paid staff intermittently choose to undertake additional unpaid community support work.
- Support for volunteers is primarily led by the Community Resilience Team.
- Volunteers contribute significantly to various priority areas of Trust activity, including cardiac arrest survival outcomes, patient experience and satisfaction, and staff welfare and morale.
- Despite all this positive acivity and support there is a lack of clear direction of the expectation of volunteers in the Trust and minimal reporting on the impact of volunteering activity.
- This is partly due to how volunteering has evolved, rather than being developed in line with a strategy, Executive oversight, appropriate governacne and silo working.

Strategic review

- In 2024, the Association of Ambulance Chief Executives (AACE) were commissioned to undertake a strategic review of ambulance volunteering within SECAmb.
- This was completed by Helen Vine between October 2024 and February 2025, and identified discrepancies in perceptions and expectations:



- The report presents 62 recommendations, with suggested timescales, covering the following themes:
  - Leadership and infrastructure
  - Funding and finance
  - Data and evidence base
  - Volunteer experience
  - Future opportunities

The Trust is grateful to Helen for her time, expertise and experience in completing the report

Progress to date

- A number of the recommendations are accepted to be fundamental to the future of Volunteering in SECAmb, and as such are already either completed or in progress:

DATA	Submitting data returns to NHS England mandatory volunteering data set and AACE ambulance volunteering dashboard. BI team developing mechanism for automated submission to ensure ongoing compliance, due by August 2025.
COLLABOR	Engaging with AACE, the national volunteering lead, and the National Ambulance Service Responder Managers Group. Interaction via email, FutureNHS Collaboration platform, and quarterly meetings ongoing.
COMMUN	Increase internal and external communications relating to the impact of volunteers. Work ongoing, with significant plan in place for Volunteers Week 2nd – 8th June.
DISPATCH	Ensuring CFR Response Desk is consistently staffed and that EOC have access to relevant information to 'think CFR' when dispatching. Monthly meetings in place to review issues and facilitate improvements.
FEEDBAC	Ensuring the 'volunteer voice' is heard through regular engagement and participation in the annual AACE national volunteering survey. Survey completed in March 2025 – to participate in 2026 survey to evidence improvements.
LEADERS	Provide stabilisation for the leadership of volunteers through the Community Resilience Team interim appointments. Further work to design a clear structure aligning to the Trust's new Clinical Operating Model and a funding settlement to support discussed within this report.
HIP	

Volunteer Emergency Responder Scheme trial

South East Coast Ambulance Service NHS Foundation Trust

Apr '23 Launched in 2023 as two-year pilot using charitable funding.

Mar '25 Funding exhausted in March 2025, formal evaluation not yet completed.

Apr '25 EMB agreed 6-month extension with express purpose of completing formal evaluation.

Oct '25 Trial now due to end in October 2025.

- Scheme divisive, with strong polarised views both in favour and against.
- Internal review in 2024 identified challenges with data collection and concluded limited benefits, but review methodology and content challenged.
- Some 'mission creep' evident since original inception (additional volunteers, locations, deployment).
- Independent external evaluation currently being commissioned to evalute benefits, alternatives, risks and recommend whether to adopt, adapt or abandon the scheme.
- Aim to embed learning from evaluation into volunteering strategy including CFR deployment methodology.

Volunteers Conference 2025

- Took place on Saturday 5th April 2025
- An opportunity for volunteers from across the Trust to come together to network, learn and celebrate achievements.
- Over 220 volunteers (including CFRs, ERs, Support volunteers, Chaplains) in attendance.

- A particular highlight included the ROSC awards, where the contributions of volunteers at cardiac arrest calls were recognized:
  - 307 lives saved following CFR input.
  - CFR present at 8% of cardiac arrest calls.
  - First on scene in nearly half of these.

Strategic response

- The report highlights the need for a clear strategic direction for volunteering in SECAmb, and supports this through several key recommendations:

> Produce a SECAmb Volunteering Strategy, underpinned by the SECAmb Trust strategy, applicable to a full range of clinical and non-clinical volunteering opportunities and aligned with the AACE direction for ambulance volunteering.

This MUST:

- Save lives
- Serve the community
- Be sustainable

Recommendations summary

N.B. 55 removed (duplicate of 47).
60 removed (captured within 54).

[1] Funding for CRT roles to meet current and future capacity requirements.	[11] Introduce and recruit to volunteer forum.	[21] Ensure data collection linked to strategic intent and positive impact.	[31] Publish annual training plan to include CPD opportunities.	[41] Ensure CFR response desk is consistently staffed.	[51] Include introduction to ambulance volunteers on all staff inductions.
[2] Consider renaming team.	[12] Ensure enabling support from Trust functions (HR, Clin Ed, BI)	[22] Report metrics and trends to Board on twice-yearly basis.	[32] Review requirements for CFR availability in CFR Policy.	[42] Ensure EOC aware of volunteer skillsets and 'think volunteer'.	[52] Review and update all volunteer policies, ensure AACE compliance.
[3] Review JDs and areas of responsibility.	[13] Review volunteer expenses policy and process.	[23] Develop comms plan to share volunteer impact internally and externally.	[33] Review options for booking on (particularly C1 vs C1/C2 vs all calls).	[43] Ensure 24/7 access to escalate or for decision-making support.	[53] Participate in AACE national ambulance volunteering survey.
[4] Adopt hub and spoke model.	[14] Agree funding settlement for volunteering function.	[24] Review published evaluations of projects and pilots to consider adopting.	[34] Quantify expectations of chaplains and record activity and impact.	[44] Refresh process for referrals to chaplains and communicate.	[54] Produce a SECAmb volunteering strategy in line with Trust strategy.
[5] Move clinical volunteers under local OU operational leadership.	[15] Implement AACE funding and finance paper of October 2023.	[25] Complete end-to-end review of volunteer recruitment.	[35] Consider CFR lone working position with option for dual responses.	[45] Maximise impact of volunteers / communities on OHCA survival (^5%).	[56] Consider volunteer role to support lower acuity calls / avoid S&T.
[6] Other volunteers under local leadership or central teams appropriate to role.	[16] Review current model of charity-based schemes.	[26] Develop recruitment strategy which ensures diverse representation.	[36] Review comms platforms and apps in use with view to rationalising.	[46] Review ER pilot to determine future actions (adopt, adapt, abandon).	[57] Implement AACE OHCA health inequality report recommendations.
[7] Introduce meetings framework for effective information dissemination.	[17] Ensure new Trust charity lead links directly to volunteering leadership.	[27] Ensure volunteer and staff capacity to support / mentor new volunteers.	[37] Complete post implementation review of NMA.	[47] Review opportunity to introduce analgesia to volunteers.	[58] Review volunteer models in other UK ambulance Trusts.
[8] Connect to and engage with national work via AACE and NASMRG.	[18] Submission of data to NHSE mandatory volunteering dataset.	[28] Introduce volunteer to career pathway.	[38] Review current volunteer PCR.	[48] Review scope of practice for clinical volunteers, consider tiers.	[59] Review and introduce AACE EPRR framework.
[9] Review AACE leadership maturity matrix and adopt findings.	[19] Submission of data to AACE national volunteering dashboard.	[29] Review all volunteer training packages.	[39] Review PCR collection and storage mechanism.	[49] Review equipment provided to volunteers and ensure suitability.	[61] Deliver internal comms campaign about volunteer roles.
[10] Provide CPD programme for CRT Leadership team.	[20] Establish a dataset for internal reporting.	[30] Review statutory and mandatory training provision.	[40] Agree appropriate and consistent uniform for each volunteer role.	[50] Ensure reward and recognition processes in place (AACE framework).	[62] Strengthen blue light / charity sector collaboration opportunities.

Recommendations heatmap – complete / in progress

[1] Funding for CRT roles to meet current and future capacity requirements.	[11] Introduce and recruit to volunteer forum.	[21] Ensure data collection linked to strategic intent and positive impact.	[31] Publish annual training plan to include CPD opportunities.	[41] Ensure CFR response desk is consistently staffed.	[51] Include introduction to ambulance volunteers on all staff inductions.
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Developing the strategy and business case using the recommendations and broader collaboration

South East Coast Ambulance Service NHS Foundation Trust

Develop future Volunteering and Community Resilience Strategy

Volunteer role

- [45] Maximise impact of volunteers / communities on OHCA survival (^5%).
- [46] Review ER pilot to determine future actions (adopt, adapt, abandon).
- [48] Review scope of practice for clinical volunteers, consider tiers.
- [62] Strengthen blue light / charity sector collaboration opportunities.
- [56] Consider volunteer role to support lower acuity calls / avoid S&T.
- GoodSAM
- Chaplaincy
- Blue light collaboration
- Support volunteers

Team structure

- [2] Consider renaming team.
- [4] Adopt hub and spoke model.
- [3] Review JDs and areas of responsibility.
- [5] Move clinical volunteers under local OU operational leadership.

Leadership and governance

- [58] Review volunteer models in other UK ambulance Trusts.
- [21] Ensure data collection linked to strategic intent and positive impact.
- [59] Review and introduce AACE EPRR framework.
- [9] Review AACE leadership maturity matrix and adopt findings.

Team development

- [26] Develop recruitment strategy which ensures diverse representation.
- [52] Review and update all volunteer policies, ensure AACE compliance.
- [50] Ensure reward and recognition processes in place (AACE framework).

Business Case to deliver strategy

- [1] Funding for CRT roles to meet current and future capacity requirements.
- [14] Agree funding settlement for volunteering function.
- [15] Implement AACE funding and finance paper of October 2023.
- [27] Ensure volunteer and staff capacity to support / mentor new volunteers.
- [16] Review current model of charity-based schemes.

Strategic priorities

NHS South East Coast Ambulance Service NHS Foundation Trust

- The following priority areas have been identified for review and development regardless of the future direction, which align with the Trust's clinically led strategy and supports our patients, people and partners:

SAFEGUARDING	Ensure a robust method for ensuring the safeguarding of both individual volunteers and volunteer activity, in line with Trust policy, and ensuring that appropriate professional supervision is in place. Include consideration of EDI / representation.
RECRUITMENT	The recruitment of volunteers is often their first experience of the Trust, and therefore needs to be a positive experience, administratively accurate, timely, and follow the Trust's safer recruitment processes.
CHARITY	Integration with the Trust's charitable work, and collaboration with the new Head of Charity, to ensure the two functions align to deliver in line with the strategy.
IMPACT	Ensuring that the impact of volunteer activity is recorded, understood and evaluated, with a view to basing decisions on the data in order to reduce healthcare inequalities, increase community engagement and address challenges with rurality.
RISKS	Clear articulation of the potential risks and issues present, with appropriate short-term mitigations and long-term resolutions planned or in place, and adequate oversight from the relevant Trust governance groups.
GOODSAM	Full alignment of GoodSAM into the volunteer strategy and support function, allowing for development of a GoodSAM Responder volunteer role to sit between current CFR and ungoverned external GoodSAM system users.

High level options for the strategy

Overall, the strategy must focus on improving clinical outcomes for our patients.
The extent to which we will adopt the recommendations in the report will be linked to the strategy option chosen.

Current position (as reviewed) unsustainable: insufficient funding to maintain core activity and number of volunteers.

Option one - Stabilisation:
- Structure and governance improvements in line with recommendations
- Business case for leadership resource to support ongoing CFR, chaplain and welfare offer
- Consideration of Falls scope of practice / pathway

Option two - Volunteer expansion:
- Increase volunteer numbers and activity leading to subsequent cost efficiencies but requiring increased core funding.
- Review and enhance scope of practice and explore new pathways / offers from volunteers in new areas
- Expand welfare support offer / chaplaincy
- Articulate future structure and governance for expanded volunteer offer

Option three - Community focus:
- Stabilisation for our existing CFR cohort, with focus on falls pathway
- Expand significantly the community engagement around OHCA incl. education and Good Sam with a focus on under-represented areas, connected and led within the volunteer function
- Ensure the progression of blue light collaboration and response
- Engagement with VCSE Sector

Option four – Aggregate and/or Regional option:
- Options 2 and 3 together could represent a significant shift in the volunteer offer
- Consideration of how elements best align with a broader SE region volunteer approach

"Our volunteers will be an integral part of our delivery model"
– SECAmb Strategy 2024 – 2029

Approach to Strategy development and appraisal

NHS South East Coast Ambulance Service NHS Foundation Trust

- Options for the Volunteering and Community resilience strategy will be developed through a consultative engagement process with stakeholders.
- This will include our current volunteers, front line colleagues and leaders, appreciating all views but recognising as per the AACE report that there may be tension between the priorities for volunteers and for delivery of our strategy
- The strategy will focus on improving clinical and people outcomes; optimising opportunities for engagement and volunteering in under-represented communities; and understanding the value of investment to be made, in line with our strategy
- The role of charitable support to volunteering, and the breadth of volunteering opportunities, will be a focus for the strategy in collaboration with the new Head of Charity
- In particular, differentiate between infrastructure costs (staffing, equipment, vehicles) which will require a consistent funding stream to ensure stability, and project delivery costs which can be charitably funded, allowing for flexibility in delivery and balance of charitable input versus output.
- The strategy will look to align with national volunteering strategy and will be considered alongside our collaboration with SCAS and their volunteering approach
- During the development period, we will also progress priorities for our current volunteering offer, including the falls pathway, and alignment with GoodSam response.

Quality patient care	Our people	Sustainable partner
• OHCA and Falls outcomes • Addressing health inequalities	• Staff support offer and experience • Integrated opportunities to volunteer	• Stability for delivery • Alignment with national and regional partners

Next Steps

June

01

Board view

Steer on approach and options to define scope of strategy.

July–Sep

02

Strategy development

Consultative engagement to develop our volunteering and community resilience strategy.

Oct–Dec

03

Business case

Define costs, benefits and business case to support strategy delivery.

2026

04

Commence delivery

Plan implementation and delivery of the future of Volunteering in SECAmb

We will update People Committee and Board on the development process 6 monthly, and plan to present the draft strategy in December

NHS
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NHS Foundation Trust

Integrated Quality Report

Trust Board June 2025

Data up to and including April 2025

April 2025 data – presented June 2025

What

The IQR has been refreshed this month to align to our 2025/26 Board Assurance Framework priorities and to refine the focus of metrics for Board committees enabling oversight and triangulation through the Board discussion. The refreshed report and process will be reviewed and improved through the next 6 months.

The Trust finished 2024/25 with strong operational, clinical and financial performance, and remains in a robust position through April. Changes to dispatch through the Local Community Dispatch Model have supported improved incident cycle time and staff experience, and a C2 mean of 25:02 was achieved, supported by relatively strong resourcing and stable demand in April. Handover times are in seasonal variation and call answering has exceeded target at 1second with a good staffing position in call handling. Achieving our H&T trajectory remains challenging as the rate is increasing but not on target; an increase in S&C rate alongside the greater H&T rate has been observed. This is expected, but will be reviewed to ensure appropriate, as the use of alternatives to ED is still limited. We continue to deliver improving cardiac outcomes and good patient safety and Health & Safety indicators, with the first PSIRF reviews completed this month. There is an improvement in MAST and Appraisal driven by focus from HR and managers, while turnover continues in improving trend and our employee relations position is stable.

So What

Although performance was good, the spring and summer period needs greater focus on responsiveness to enable a 25min average C2 mean across the year to be achieved. Clinical training of B6 paramedics to contribute to H&T rate, greater clinical call handling productivity, and further work with system partners on alternative pathways and handovers is also in train and will be needed to impact on the overall position.

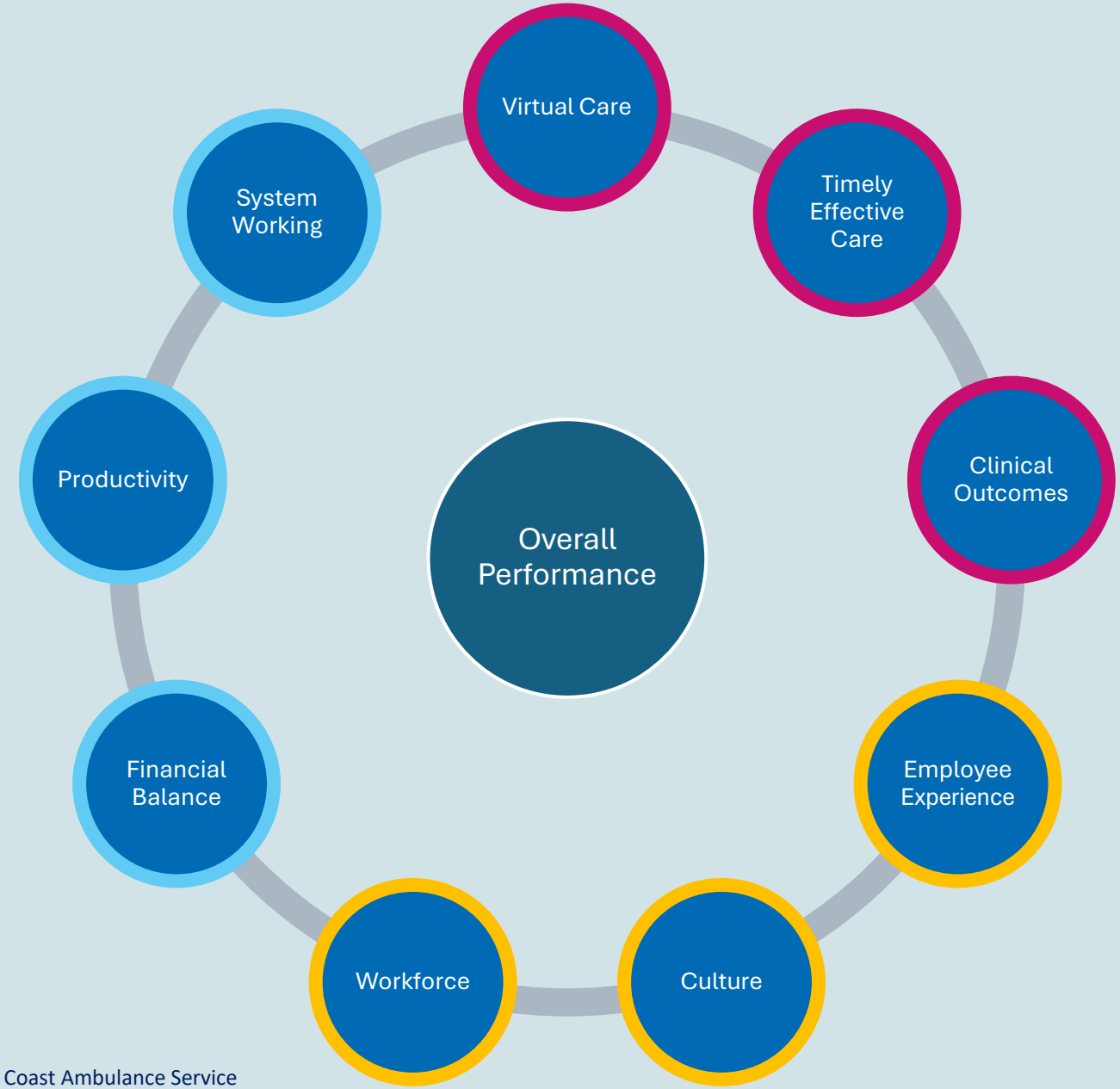
Clinical indicators are strong and will be enhanced by our focus on three particular models of care, including Falls which is now being monitored as a Board metric. We will continue to embed PSIRF to support a learning culture and to use QI to make improvements, and embed enhanced quality governance from floor to Board, as well as working through our aligned Virtual Care and Models of Care programmes.

The divisional clinical operating model is now being implemented supporting local autonomy and focus and enhancing integration of clinical, operational and corporate leadership teams. Following our improved Staff survey results, local processes to continue to embed change and target hotspot areas have been put in place, while SMG is undertaking work on sickness rates and abstractions. The corporate restructure is moving towards completion and will offer greater resource for employee relations support, which is needed to address case numbers, length of time to resolve cases, and continued high levels of suspension days in the Trust.

What Next

Further focus on our productivity programme will be needed to ensure that the planned improvements to care delivery are made as soon as possible so the impact on performance, particularly the C2 mean, is achieved. Similarly, the efficiency programme will be a key area to ensure that we meet our financial plan throughout the year. We will review delivery of efficiency and productivity on a quarterly basis with the next Executive check and challenge in July 2025.

Our ongoing work to improve employee experience and culture will continue through collaboration with staff, unions and the corporate restructure, and with the integrated divisional leadership teams supporting improvement in appraisal, clinical supervision, Speaking Up and MAST. We will also be developing more resilience metrics incl. EPRR and Cyber elements and moving forward looking to bring an organisational resilience framing to our understanding of performance.



BAF outcomes 25/26

- Category 2 Mean <25 minutes average for the full year
- Call Answer 5 seconds average for the full year
- Hear & Treat 18% average for 25/26 / 19.7% by the end of Q4
- Cardiac Arrest outcomes: Improve survival to 11.5%
- Internal productivity:
  - Reduce the volume of unnecessary calls from our highest calling Nursing/Residential Homes
  - Job cycle time (JCT)
  - Responses per incident (RPI)

- Improve staff reporting they feel safer in speaking up: statistically improved from 54% (23/24 survey)
- Our staff recommend SECAmb as a place to work: statistically improved from 44% (23/24 survey)
- 85% appraisal completion rate
- Reduce sickness absence to 5.8%
- Resolve ER cases more quickly to reduce the formal caseload over time, even as new cases are opened

- Deliver a financial plan
- Handover delay mean of 18 minutes
- Increase Urgent Community Response (UCR) acceptance rate of 60-80%
- Reduce Vehicle Off Road rate (VOR): 11-12%
- Achieve over 90% compliance for Make Ready

What we will deliver in 2025/26

We deliver high quality patient care

- Deliver an average Cat 2 mean response time of 25 mins and 999 call-answer of 5 secs
- Increase clinical triage of Cat 2-5 calls, delivering Hear & Treat of 19.7% by Mar 26
- 3 Focus Models of Care:
  - Palliative and EOL Care
  - Reversible Cardiac Arrest – increase survival to 11.5%
  - Falls, frailty and older people – reduce vehicle dispatch to fallers by 10% using more CFRs
- Deliver improved clinical productivity using QI (Eq. to 4mins C2 mean)
- Overhaul our oversight framework for quality of care aligned to our new divisional model, including station accreditation programme

Our people enjoy working at SECAmb

- Completion of our organisational re-design to deliver empowered Divisions
- Improve our People Services enabling effective support for our staff and enhanced ER resolution timelines
- Publication of our workforce plan in alignment with our clinical models of care
- Implement Wellbeing Strategy
- Launch of our first ever Shadow Board
- Expansion of the role of our volunteers

We are a sustainable partner as part of an integrated NHS

- Safely deliver our financial breakeven plan, including our efficiencies of £10m
- Work in partnership with the systems to deliver productivity improvements (Eq. to 2mins C2 mean)
- Develop a Business Case and roadmap for collaborating more closely with SCAS
- Publish a strategic estates plan that supports our development for the next 5 years
- Improve the quality and integration of our data systems to improve efficiency, productivity and outcomes
- Deliver vehicle replacement, >90 new MAN DCAs to be deliver in-year

Icon Descriptions

Integrated Quality Report

	P	?	F	
	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently **HIT OR MISS** the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
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				Special cause variation where **UP** is neither improvement nor concern.
				Special cause variation where **DOWN** is neither improvement nor concern.
				Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

South East Coast Ambulance Service
NHS Foundation Trust

People

Workforce trends remain steady, with continued improvement in retention across key areas and a focus on embedding local initiatives to sustain progress. Organisational change activity is ongoing across both corporate and operational areas with the introduction of a new divisional operating model. Formal consultation across 3 corporate areas has now closed, with a second phase being planned in other directorates for completion by the end of the year. We are progressing efficiencies with workforce planning and vacancy controls in place to support financial and service alignment.

There continues to be a focus on strengthening assurance around appraisal and statutory training compliance. Appraisal compliance has improved by 8.1% since the last IQR and is now being driven through directorate-level accountability for compliance, with a revised cycle launched in April 2025. Work continues to improve the quality of appraisals alongside this. Statutory and mandatory training compliance is progressing towards the 85% target, with the 2025/26 programme now underway with good learner feedback. Data cleansing is underway to ensure accurate reporting, with CSTF compliance now at 83.23%.

Employee relations activity continues to be closely monitored, with enhanced triage processes supporting earlier resolution and a reduction in formal cases. Work is underway to build a learning culture through a new community of practice, aligned to the 2025/26 People Improvement Plan. The organisational change aims to create more focussed ER capacity and support for divisional teams locally to deal with cases in a more timely fashion.

Following the publication of the 2024 NHS Staff Survey results in March, the first 'check in' with managers will take place in June to check on progress made in using their local results to frame discussions with their teams and drive improvements.

Our first Shadow Board will take place in July 2024, with preparation work well underway.

Our people enjoy working at SECAmb

1 Tier 1 | 2 Tier 2 | QI | Directorate objective

2024-2029 Strategy Outcomes

- Deliver 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
- Reduce staff turnover to 10%
- Our Trust is an open and inclusive place to work - demonstrate improvements in workforce race and disability standards indicators

2025/26 – Strategic Transformation Plan

- **Organisational Operating Model Programme** 1
  - Implement corporate restructure (including Hybrid Working Practices) going live **by end Q3**
  - Transition to Clinical Divisions **by end Q2** and undertake Clinical Operating Model design by end of Q4
- **People Services Improvement Programme** 1
  - Embed People Services new structures to enable effective support, with 90% staff in post by end of Q2
  - Develop Case for Change for optimising Recruitment and Service Centre by end of Q3
  - Enhance ER processes to ensure fair, timely case resolutions with strengthened staff confidence in ER services by end of Q4
  - Develop capability and professional practice of People Services
- **Long-term Workforce Plan Definition**
  - Scope to be developed by Q3 following the development of Models of Care

2025/26 - Outcomes

- Improve staff reporting they feel safer in speaking up – statistically improved from 54% (23/24 survey)
- Our staff recommend SECAmb as place to work – statistically improved from 44% (23/24 survey)
- 85% appraisal completion rate
- Reduce sickness absence to 5.8%
- Resolve ER cases more quickly to reduce the formal caseload over time, even as new cases are opened.

2025/26 – Operating Plan

- Full implementation of Resilience (Wellbeing) Strategy **by Q4**
- Implement Shadow Board **in Q1**
- Embed Trust Values & associated Behaviour Framework **by Q4**
- Refresh of the professional standards function by **end of Q2**
- Development of Integrated Education Strategy, informed by the EQI **by end of Q3**
- Establish the approach to volunteers

Compliance

- Equality Act / Integrated EDI Improvement Plan
- Sexual Safety Charter Commitments
- Education
- Statutory & Mandatory Training & Appraisals

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.
- **People Function:** There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy.
- **Workforce capacity & capability:** There is a risk that the Trust does not have a sustainable workforce model, supported by a 2025/26 workforce plan with a clearly identified clinical skill mix, due to competing strategic and operational priorities, resulting in an inability to transition from physical to virtual care long-term.
- **Organisational Change:** There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised.

Variation

Special Cause Improvement			Common Cause		Special Cause Concern			
10%	15%		65%		5%	0%		
2	3		13		1	0		

Assurance

Pass	Hit and Miss	Fail	No Target
5%	45%	30%	20%
1	9	6	4

Culture

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Collective Grievances Open	Apr-25	3	1	1.3		
Board	Count of Grievances Closed	Apr-25	12	3	14.8		
Board	Count of Sexual Safety / Sexual Misconduct Cases	Apr-25	3	3	3.7		
Board	Individual Grievances Open	Apr-25	8	5	14.6		F
Supporting	Bullying & Harrassment Internal	Apr-25	1	2	1.7		
Supporting	Disciplinary Cases	Apr-25	9	3	10		
Supporting	Mean Suspension Duration (Days)	Apr-25	215	70	128.7	H	F
Supporting	Freedom to Speak up: Cases Opened in Month	Apr-25	15	3	10		
Supporting	Freedom to Speak Up: Total Open Cases	Apr-25	22		23.5		

Workforce

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Annual Rolling Turnover Rate	Apr-25	15.1%	15%	16.9%	L	F
Board	Sickness Absence %	Apr-25	5.8%	5%	6.6%		F
Board	Turnover Rate %	Apr-25	1%	0.8%	1.3%		
Supporting	Number of Staff WTE (Excl bank and agency)	Apr-25	4594	4579.26	4481.9	H	F
Supporting	Vacancy Rate %	Apr-25	0.1%	5%	1.9%	L	P
Supporting	CFR Attendances	Apr-25	1634		1529		

Employee Experience

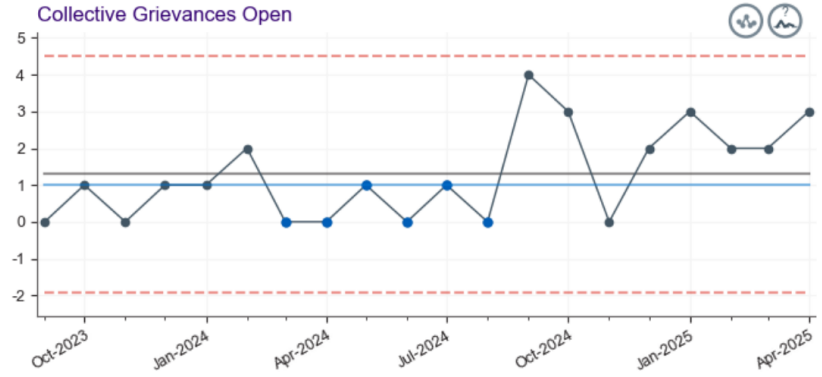
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	% of Meal Breaks Outside of Window	Apr-25	40.6%		50.3%	L	
Supporting	% of Meal Breaks Taken	Apr-25	98.6%	98%	98.3%		
Supporting	999 Frontline Late Finishes/Over-Runs %	Apr-25	40.7%	45%	44.1%		

Pending metric: WRES/WDES - Needs to be defined

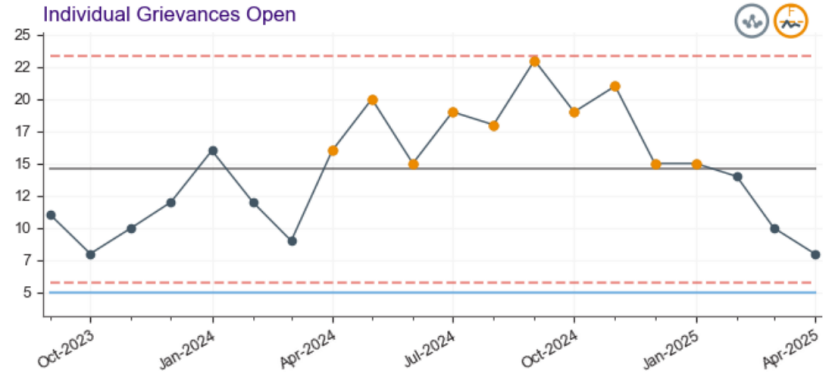
Employee Development

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Appraisals Rolling Year %	Apr-25	71.1%	85%	62.2%	H	F
Board	Statutory & Mandatory Training CSTF Rolling Year %	Apr-25	81.7%		81%		

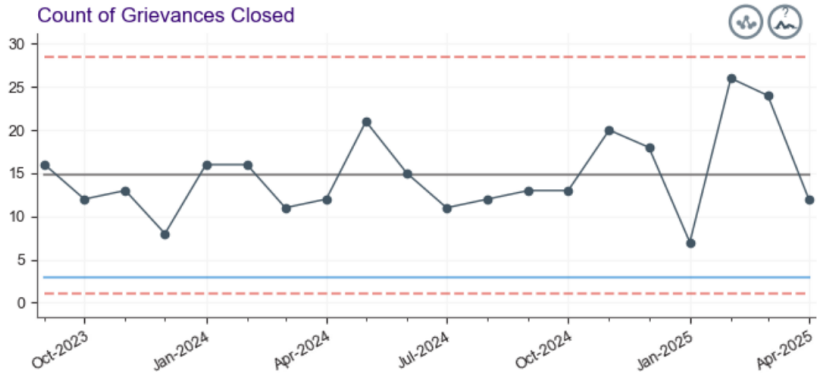
Pending metric: Education - Needs to be defined



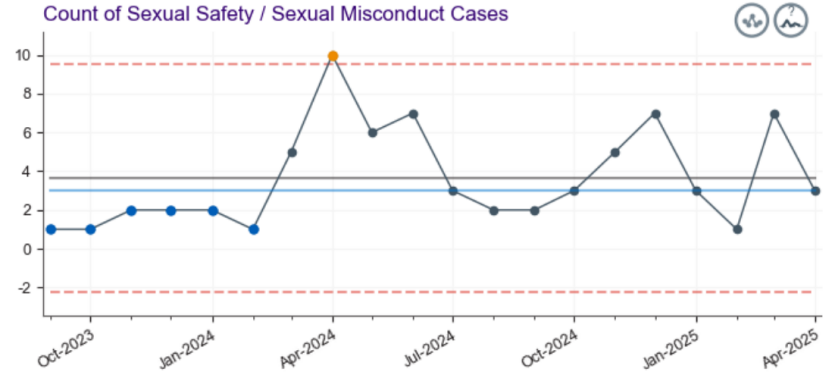
WF-11
Dept: Workforce HR
Metric Type: Board
Latest: 3
Target: 1
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-10
Dept: Workforce HR
Metric Type: Board
Latest: 8
Target: 5
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-42
Dept: Workforce HR
Metric Type: Board
Latest: 12
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

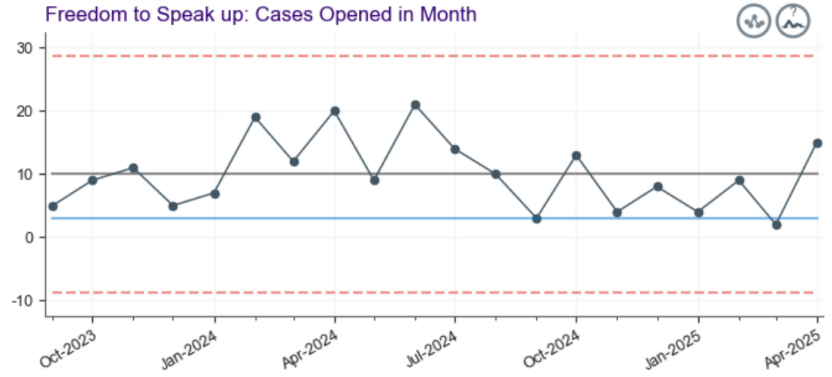


WF-41
Dept: Workforce HR
Metric Type: Board
Latest: 3
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

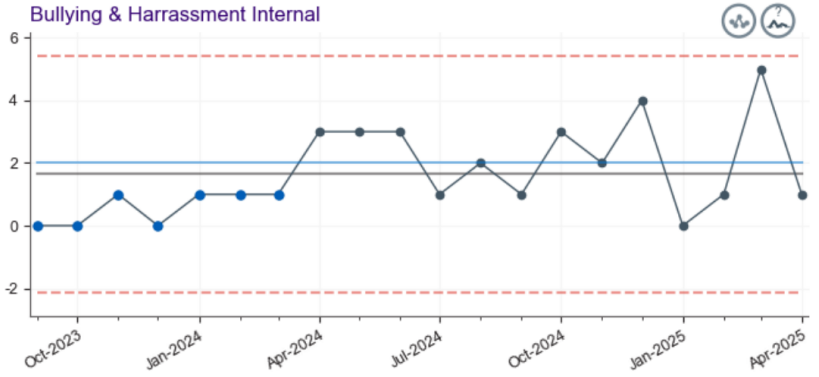
Grievances
12 grievances have been closed and 8 grievances opened during this month. The introduction of an enhanced triage processes has helped to reduce the number of grievances by 12 cases since February. The introduction of this triage has resulted in cases being assessed with improved rigour, so that some cases have been redirected to line managers, policy applied more appropriately, or redirection to an alternative approach such as mediation. Without the triage process in place, we would have reported 19 new grievances opened during this month as opposed to 8.

Grievances
There are a number of multiple cases (n19) from one individual which are near to conclusion, and this will improve the closure rate next month. However there has been a reduction in individual cases open from previous months. Whilst it is noted that the 'target' has been set at 5 cases, it is challenging to reduce grievances, and the current method has been the introduction of triage and training line managers to reduce the need for staff to raise formal complaints because their claims are being managed informally by their line manager wherever possible.

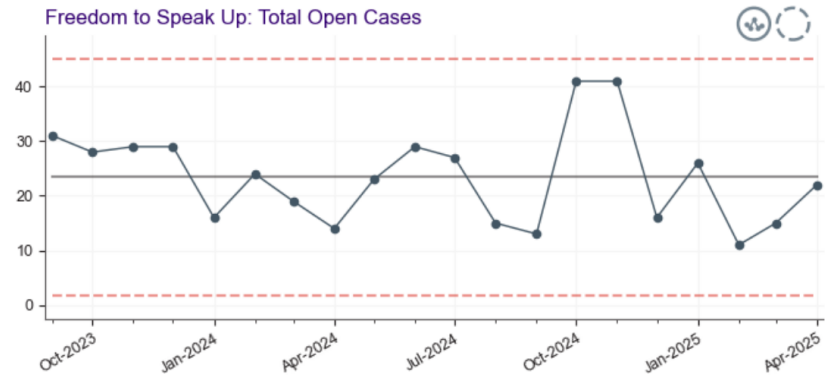
Sexual Safety
An external review of MDT process has been completed and the redesign of the format and make-up of this process is currently being undertaken.



QS-27
Dept: Quality & Safety
Metric Type: Supporting
Latest: 15
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

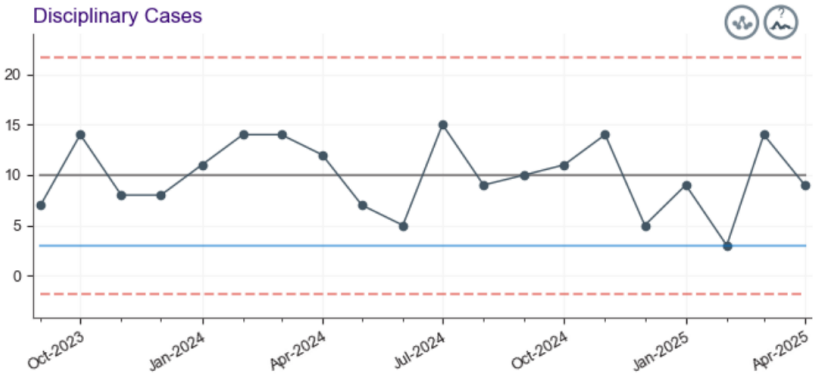


WF-12
Dept: Workforce HR
Metric Type: Supporting
Latest: 1
Target: 2
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-27
Dept: Quality & Safety
Metric Type: Supporting
Latest: 22

Common cause variation, no significant change.



WF-9
Dept: Workforce HR
Metric Type: Supporting
Latest: 9
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

FTSU: open cases opened in month

Remains within normal variation on SPC chart. During March and April 2025;

- 38 concerns were raised to the FTSU team. 26% were submitted anonymously and 3% included detriment.
- 10 concerns arose from EOC, 7 from Field Operations, and 4 from Digital.
- Worker safety & wellbeing remained a key theme
- The trend in the number of concerns being closed with a satisfactory outcome continues to improve.
- Additional to the cases mapped here, there has been an increase in staff seeking advice and guidance, many of whom are now feeling confident to address concerns locally themselves.

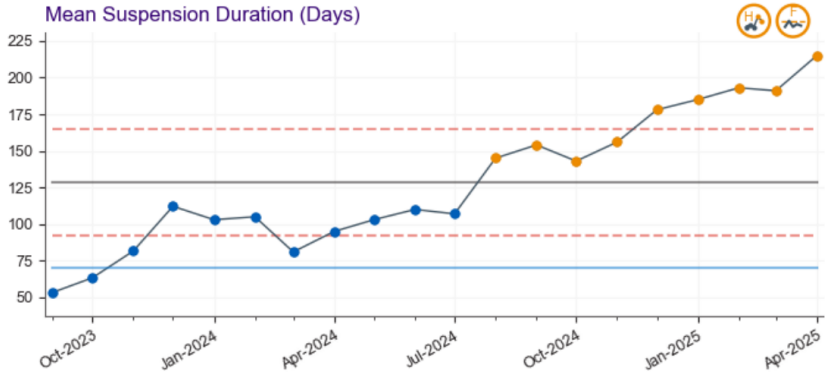
In response to the rise in anonymous reporting, leadership speak up workshops are being planned at both a local and senior level to strengthen confidence in open conversations.

Bullying and Harassment

The number of B and H cases remains low with one recorded this month. We continue to monitor this closely in line with the reported bullying and harassment through the national staff survey.

Disciplinary

In March we had the highest number of cases closed in 12 months, 24 cases (average number being 13 over a 12 month period). The current MDT approach provides clarity on next steps or alternative action such as informal processes. This approach aims to help to reduce the number of cases received. Focus attention on legacy cases continues with regular case reviews, to monitor progress.

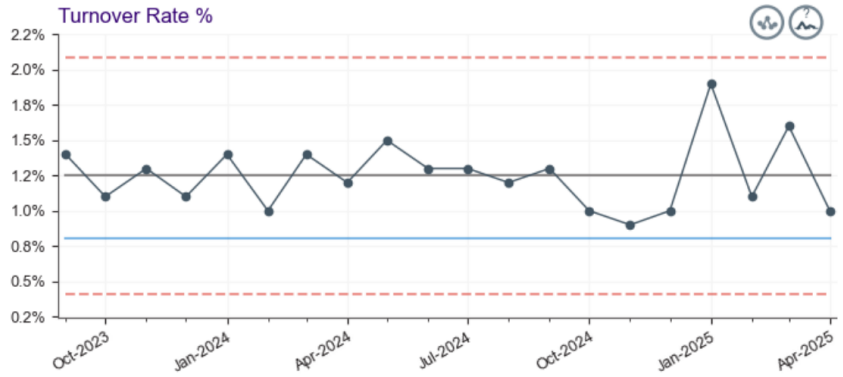


WF-47
Dept: Workforce HR
Metric Type: Supporting
Latest: 215
Target: 70
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

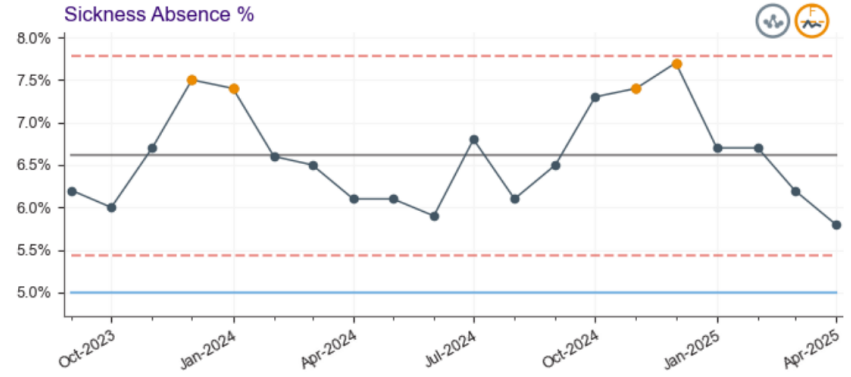
Suspensions

To note that this chart represents the number of days not number of suspensions. For context, as at 28.05.25 we currently have 20 staff suspended.

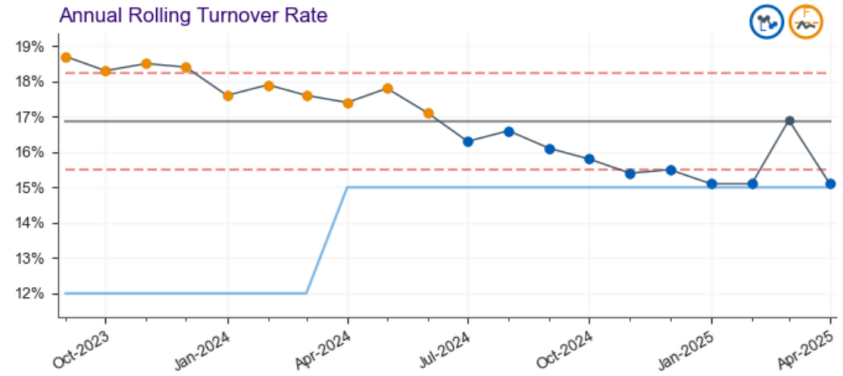
Each new potential suspension is reviewed and risk assessed by Execs prior to suspension being actioned. The suspensions currently live are reviewed by Execs on a weekly basis. The common cause for suspensions having longer length of days has been the involvement of an external agency and which has meant that in some cases SECAMB is not able to proceed to take action and this can take a long time to conclude.



WF-48
Dept: Workforce HR
Metric Type: Board
Latest: 1%
Target: 0.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-49
Dept: Workforce HR
Metric Type: Board
Latest: 5.8%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-7
Dept: Workforce HR
Metric Type: Board
Latest: 15.1%
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.

Turnover

Our retention activities are focusing on local initiatives to support Trust Wide retention. We continue to focus on Culture, Gender Pay Gap, Do No Harm, and Sexual Safety as our key drivers as we strive to make SECAmb a great place to work.

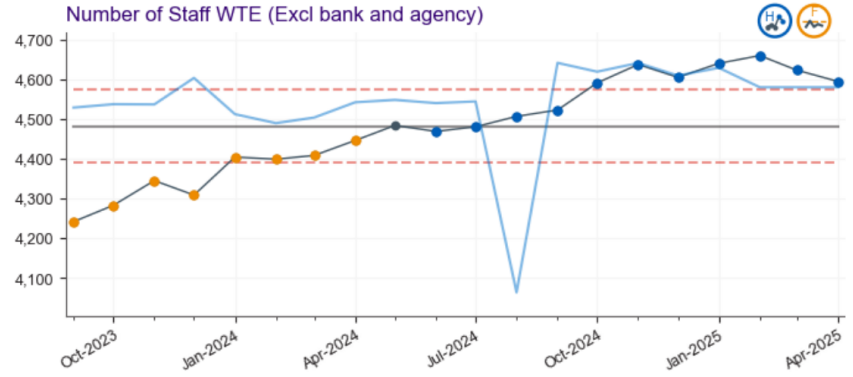
Working with the Quality Improvement Team, 111 has implemented retention initiatives during the past six months, using the Trust's continuous improvement methodology. As a result, 111 has seen turnover fall from 54.94% to 38.85%. This has had a positive impact on Trust wide turnover. A similar approach in EOC has seen their turnover fall from 44.46% to 34.34%.

There are restructures going on across Corporate Services, and between June and September we may see some variation in turnover figures as change is embedded, and the impact is fully realised.

Sickness Absence

Rolling Sickness absence is within normal variation. Our focus on long term sickness absence produced a 0.2% improvement over the last six months, however short term sickness absence increased.

SMG have commissioned a deep dive into sickness absence, focusing on cause and processing in order to improve how absence is managed. There is also a link to the employee relations cases which is being considered as part of the triage of cases to support resolution that may allow people to return to work, and to avoid harm that may cause the absence.



WF-1

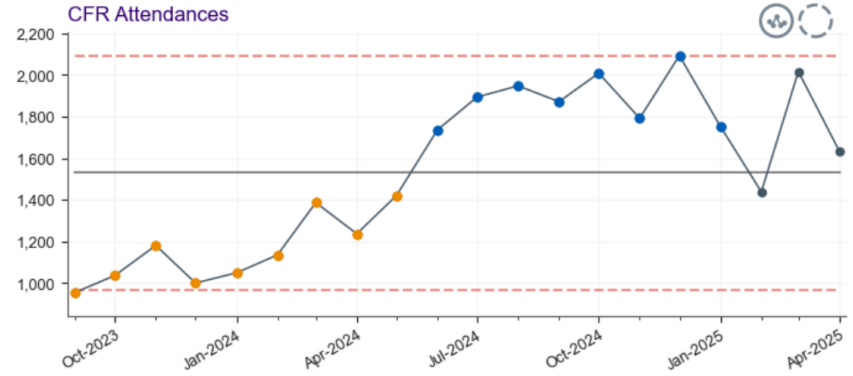
Dept: Workforce HR

Metric Type: Supporting

Latest: 4594

Target: 4579.26

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.



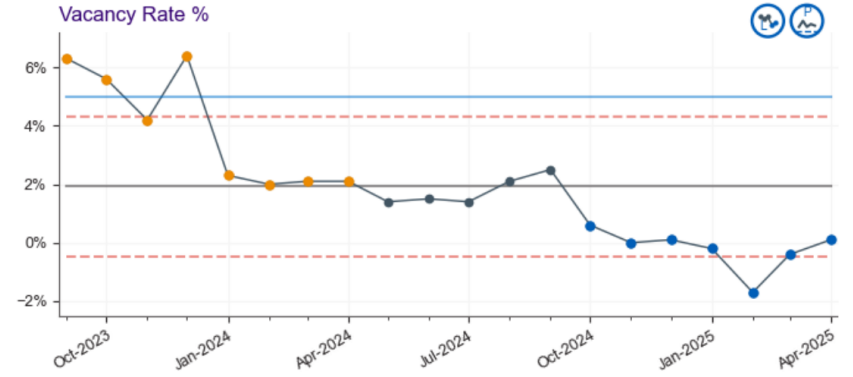
999-10

Dept: Operations 999

Metric Type: Supporting

Latest: 1634

Common cause variation, no significant change.



WF-4

Dept: Workforce HR

Metric Type: Supporting

Latest: 0.1%

Target: 5%

Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

Number of Staff WTE

The workforce and establishment shows special cause variation, with the Trust currently operating above its established staffing levels. This over-establishment is linked to legacy workforce planning decisions and the pipeline from training and development programmes. While anticipated, this position is being monitored to ensure alignment with future workforce needs and financial sustainability.

The Trust has a long-established Workforce Planning Group that currently focuses on short-term (12-month) planning. A new strategic workforce group is being developed to extend this horizon, enabling more robust 3–5 year planning aligned with service transformation and financial strategy.

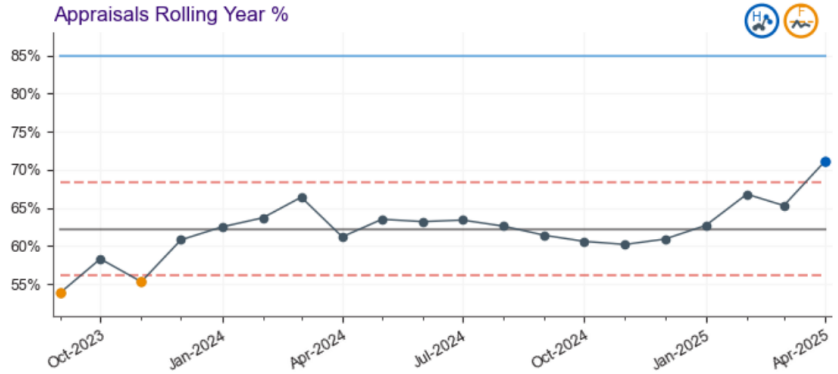
Number of Staff WTE

The current climate where the Trust is over-established, there are financial pressures resulting in vacancy controls and the Trust is part-way through large scale restructures, it is expected that vacancy rate will be low.

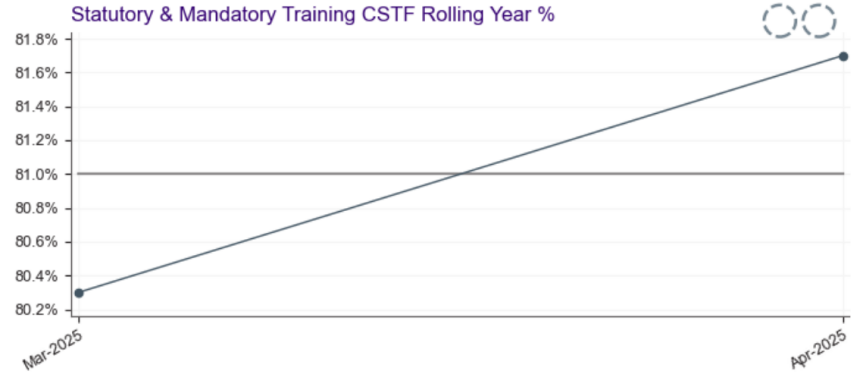
This position will continue to be reviewed through established workforce planning and governance processes, ensuring that any adjustments to staffing levels are aligned with service redesign, financial constraints, and longer-term workforce strategy.

People: Employee Development | Board Metrics

Integrated Quality Report



WF-40
Dept: Workforce HR
Metric Type: Board
Latest: 71.1%
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.



WF-6
Dept: Workforce HR
Metric Type: Board
Latest: 81.7%

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

At last review appraisal compliance was 63% (June 2024), this has significantly increased to 71.1% **(+8.1%).**

The actions specified in the 2024 IQR are still pending after the recent restructure of education. However, will be part of the objectives for the Learning and Development within education to achieve within this current year.

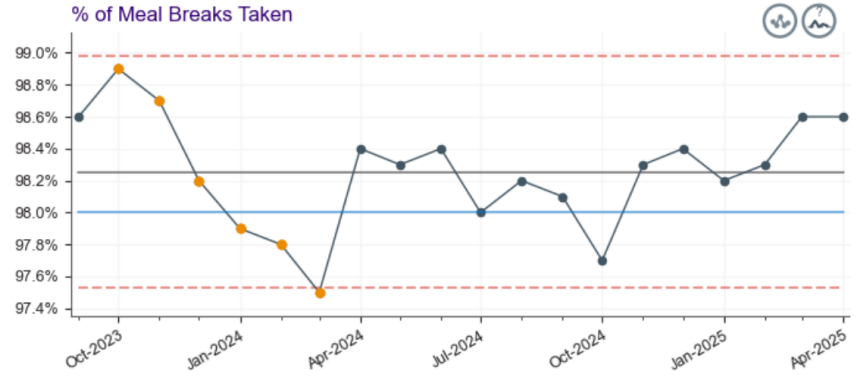
The focus of the coming year will be to ensure that individual directorates comply with the completion of appraisals in a timely manner, to ensure the upward trend of completion rates continues to improve by 10% within the next reporting year and thus achieve target.

To note, the appraisal start date has been amended with all appraisals to commence from the April 2025.

This report provides an overview of the current compliance percentage for Statutory training across the organisation. There has been an increase in compliance data in the training subjects required to meet the NHSE Core Skills Training Framework **(83.23%)**.

Resuscitation Level 2 and 3 is currently in delivery as part of the key skills programme and will ensure the overall training target of 85% target is achieved and recorded by quarter two. Resilience and Specialist Operations eLearning module has been changed from an eLearning module for all clinicians to classroom delivery in quarter four for frontline staff and the e-learning module will be completed by all new starters further improving training compliance data. The Rolling Year % totals shown in the above graph includes Resilience and Specialist Operations.

The focus for data training compliance improvement is now on the recording and reporting of other mandated courses identified in the trust training needs analysis, 2024. This includes the new e-learning modules Sexual Safety at Work, training subjects required under the EPRR Core Standards, the Health and Safety at Work Act and the centralise recording of Safeguarding Level 3.



999-27

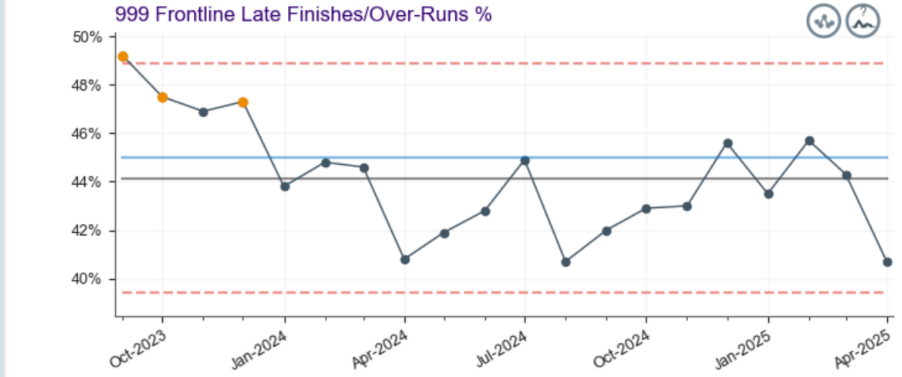
Dept: Operations 999

Metric Type: Supporting

Latest: 98.6%

Target: 98%

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



999-15

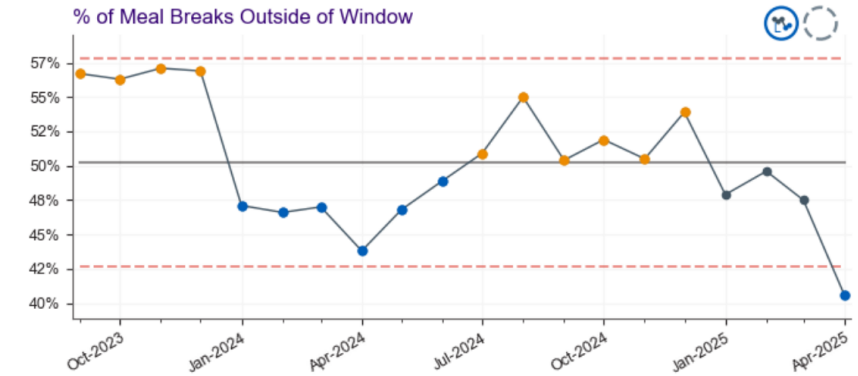
Dept: Operations 999

Metric Type: Supporting

Latest: 40.7%

Target: 45%

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



999-28

Dept: Operations 999

Metric Type: Supporting

Latest: 40.6%

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

- Further benefits from the LCDM are demonstrated above which is beneficial
- meal breaks within windows increased
- reduction in claims for meal breaks out of area
- less over-runs fand late finishes for staff
- Increased availability of ambulances for patients

Appendix 1: Glossary

Integrated Quality Report

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Board Assurance Framework

2025/2026

June v1.0

Contents:

South East Coast Ambulance Service NHS Foundation Trust

- Our Strategy 2024 – 2029
- How our Board Assurance Framework Works
- Delivering High Quality Patient Care
  - Executive Assurance Summary
  - BAF Objectives in line with Strategy Plan
  - Progress Highlight Reports on Key Programmes
  - BAF Risks
- Our People Enjoy Working at SECAmb
  - Executive Assurance Summary
  - BAF Objectives in line with Strategy Plan
  - Progress Highlight Reports on Key Programmes
  - BAF Risks
- We are a Sustainable Partner
  - Executive Assurance Summary
  - BAF Objectives in line with Strategy Plan
  - Progress Highlight Reports on Programmes
  - BAF Risks

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:**

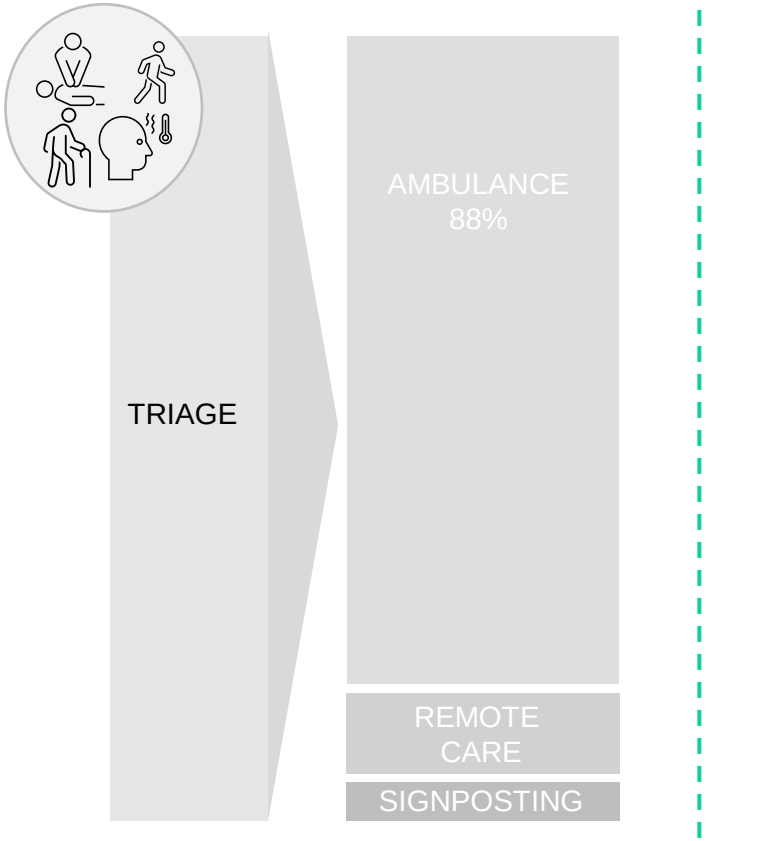
Saving Lives,

Serving Our Communities

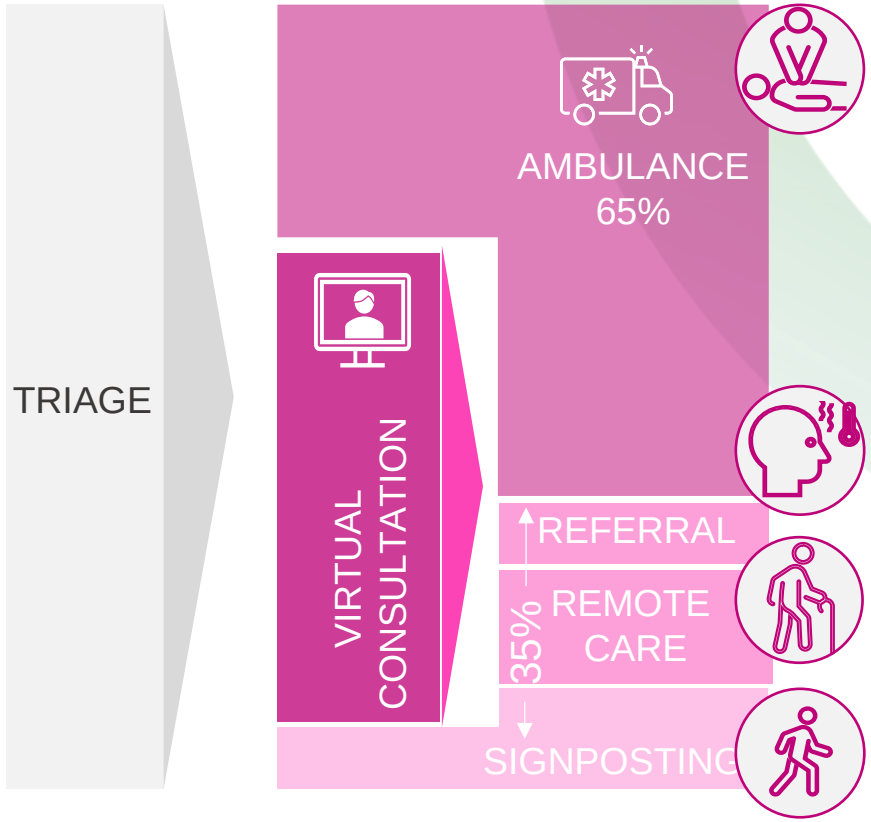
Our Strategy 2024-2029

NHS 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:

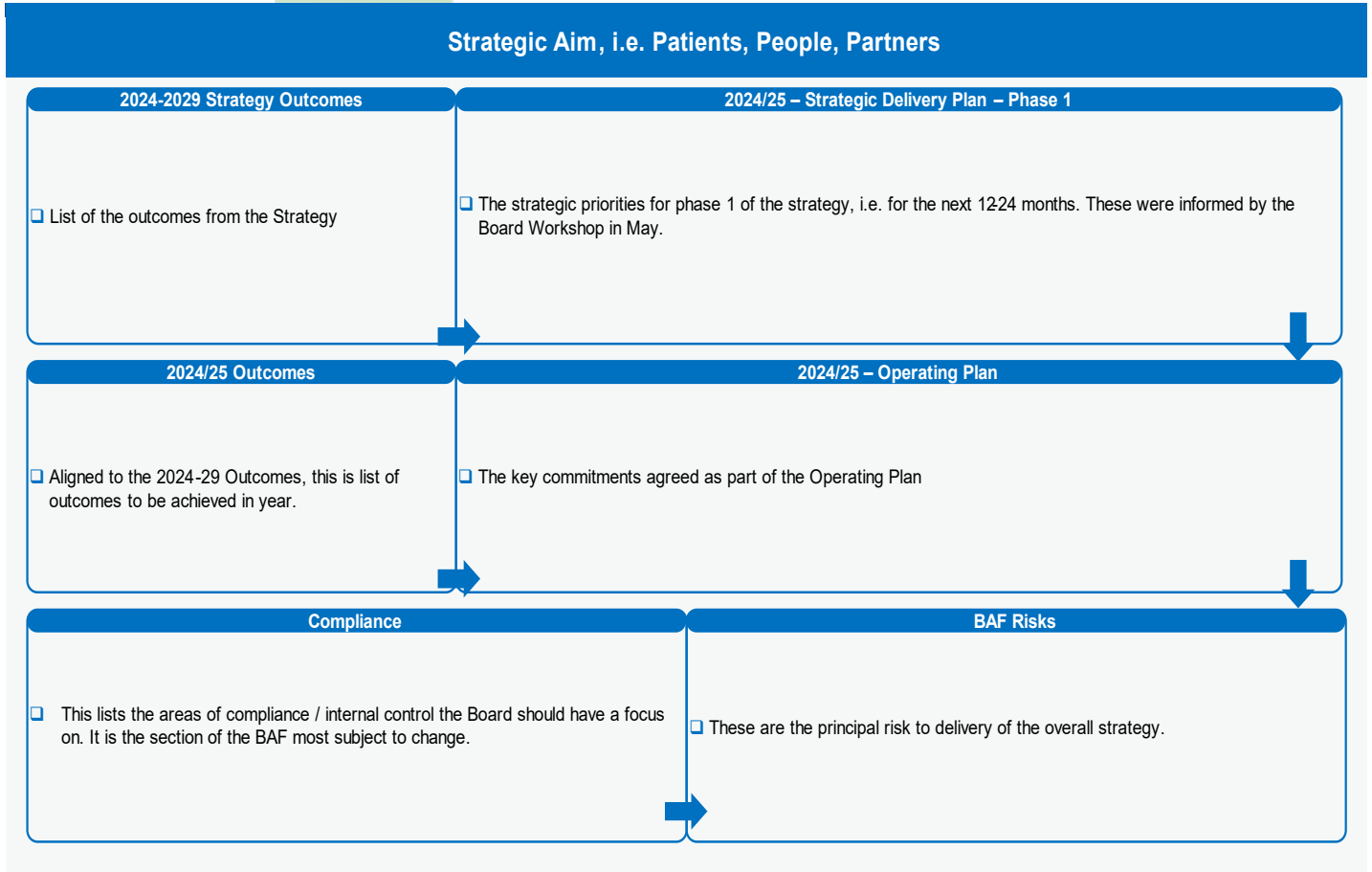
If, once assessed, the patient's needs do not require a SECAmb response, they will be signposted to an appropriate agency or service.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

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.

Reporting Templates

South East Coast Ambulance Service NHS Foundation Trust

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 –

Progress Report Against Milestones:	SRO / Executive Lead:	Previous RAG	Current RAG
Key achievements against milestone			
Upcoming activities and milestones	Risks & Issues:	Score	Mitigation
Escalation to Board of Directors			

Q1 (Apr-Jun 24)	Q2 (Jul-Sep 24)	Q3 (Oct-Dec 24)	Q4 (Jan-Mar 25)
◆ ◆	◆ ◆ ◆	◆ ◆	◆

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

South East Coast Ambulance Service NHS Foundation Trust

Our People Enjoy Working at SECAmb

Our People enjoy working at SECAmb Executive Summary

- As we move beyond the foundations that were built during Phase 1, we recognise there is more to do embed the People Services function to deliver a more **efficient, responsive, and supportive service** to staff across the Trust.
- We are benefitting from milestones achieved in Phase 1, such as the launch of the mediation programme and the Employee Relations Investigation training delivered to our managers and ER team, and we continue to focus on programmes to change our culture and address our case management.
- The objectives for the People Services for next Financial Year have been confirmed and we are finalising the mandate and action plan, mapping dependencies across all Tier 1 programs, for which there are many.
- We recognise the year ahead will be another year of transition, supporting a restructure and further improvement across both the department and the organisation. The focus will remain on resolving the root cause of the issues to ensure a sustained position into Year 3 and beyond.

Our people enjoy working at SECAmb

1	Tier 1
2	Tier 2
QI	QI
Directorate objective	Directorate objective

2024-2029 Strategy Outcomes

- Deliver 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
- Reduce staff turnover to 10%
- Our Trust is an open and inclusive place to work - demonstrate improvements in workforce race and disability standards indicators

2025/26 – Strategic Transformation Plan

- **Organisational Operating Model Programme** 1
  - Implement corporate restructure (including Hybrid Working Practices) going live **by end Q3**
  - Transition to Clinical Divisions **by end Q2** and undertake Clinical Operating Model design by end of Q4
- **People Services Improvement Programme** 1
  - Embed People Services new structures to enable effective support, with 90% staff in post by end of Q2
  - Develop Case for Change for optimising Recruitment and Service Centre by end of Q3
  - Enhance ER processes to ensure fair, timely case resolutions with strengthened staff confidence in ER services by end of Q4
  - Develop capability and professional practice of People Services
- **Long-term Workforce Plan Definition**
  - Scope to be developed by Q3 following the development of Models of Care

2025/26 - Outcomes

- Improve staff reporting they feel safer in speaking up – statistically improved from 54% (23/24 survey)
- Our staff recommend SECAmb as place to work – statistically improved from 44% (23/24 survey)
- 85% appraisal completion rate
- Reduce sickness absence to 5.8%
- Resolve ER cases more quickly to reduce the formal caseload over time, even as new cases are opened.

2025/26 – Operating Plan

- Full implementation of Resilience (Wellbeing) Strategy **by Q4**
- Implement Shadow Board **in Q1**
- Embed Trust Values & associated Behaviour Framework **by Q4**
- Refresh of the professional standards function by **end of Q2**
- Development of Integrated Education Strategy, informed by the EQI **by end of Q3**
- Establish the approach to volunteers

Compliance

- Equality Act / Integrated EDI Improvement Plan
- Sexual Safety Charter Commitments
- Education
- Statutory & Mandatory Training & Appraisals

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.
- **People Function:** There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy.
- **Workforce capacity & capability:** There is a risk that the Trust will be unable to transition from physical to virtual care long-term, due to the absence of a sustainable workforce model with a clearly identified clinical skills mix.
- **Organisational Change:** There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised.

Our people enjoy working at SECAmb

2025/26 – Strategic Transformation Plan

Programme	Milestone	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Organisational Operating Model	Implement corporate restructure (including Hybrid Working Practices)	Q3			EMB	Yes	Chief People Officer	People Committee
	Implement transition to first phase of Clinical Divisional Model	Q2			EMB	Yes	Chief Operating Officer	People Committee
	Complete design of second phase of Clinical Divisional Model	Q4						
People Services Improvement	Embed People Services new structures to enable effective support	Q3	Q3	Roxana Oldershaw	EMB	Yes	Chief People Officer	People Committee
	Develop Case for Change for optimising Recruitment and Service Centre	Q4	Q4					
	Enhance ER processes to ensure fair, timely case resolutions	Q4	Q4					
	Develop Capability and Professional Practice of People Services	Q4	Q4					
Workforce Plan	Scope to be developed following the development of Models of Care	Q3			EMB		Chief People Officer	People

2025/26 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date last reviewed @ Committee
Full implementation of Wellbeing Strategy				Chief Nursing Officer	EMB		People Committee	
Implement Shadow Board				Director of Communications/ Chief People Officer	EMB	No	People Committee	
Launch new Values & Behaviours Framework				Chief People Officer	EMB		People Committee	
Refresh of Professional Standards Function				Chief Paramedic Officer	SMG	No	Quality Committee	
Development of Integrated Education Strategy				Chief Paramedic Officer	EMB	No	People/ Quality Committee	

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Culture and Staff welfare: There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy.	16	08	CPeO
People Function: There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy.	12	08	CPeO
Workforce capacity & capability: There is a risk that the Trust will be unable to transition from physical to virtual care long-term, due to the absence of a sustainable workforce model with a clearly identified clinical skills mix.	20	08	CPeO
Organisational Change: There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised	16	08	CPeO

Board Highlight Report – People Services Improvement Programme

SRO / Executive Lead: Sarah Wainwright

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones

Key achievements against milestones

- **Phase 1 Completion**: successfully delivered the first phase of the HR Improvement Plan
- **MARS Programme**: 29 colleagues exited the Trust
- **Suspension Review & Grievance Triage implementation:** greater oversight and consistency **Mediation Launch:** 30 trained mediators; sample average resolution time reduced from 209 to 21 days
- **ER Casework Improvements**: ongoing progress with further developments planned
- **ER Training**: well-received, with staff welcomed upskilling and development opportunities; ER Investigations: 49 attendees (Operational Managers, Senior Managers, and HR); CPD: 21 attendees (HR Team); Sexual Safety: 60 attendees (Investigators & Commissioning Managers)
- **Phase 2 Planning:** scope, objectives, and milestones confirmed; Steering Group and Delivery Group Terms of Reference agreed and meetings reinstated
- **Recruitment Collaboration**: discussions underway with Royal Free, SCAS & EEAST
- **ER Team Stabilisation**: additional resources identified, including Power BI Analytics Lead (ER data and reporting), ER Case Management Consultant (data compliance) and Head of ER (programme delivery)

Upcoming activities and milestones

- **Senior Leadership Engagement**: wider engagement sessions planned for programme updates
- **People Services Consultation**: process completed, feedback collated to inform updates to ER job descriptions; consideration meetings scheduled with outcomes document due 04 Jun
- **Payroll Contract:** review underway in collaboration with SCAS
- **Policy Review**: prioritise policy updates for better clarity and understanding
- **Data compliance audit:** external review of current MI and case management system for ER

Escalation to Board of Directors

- None

Previous RAG	Current RAG	RAG Summary
N/A		The first phase of the HR Improvement Plan, running from Oct 24 to Mar 25 has now been completed. Phase 2 has been rebranded as the **People Services Improvement Programme**, with a new scope and set of objectives, currently on track

Risks & Issues	April	May	Mitigation
Risk PSIP5: People Services Restructure | There is a risk that the programme deliverables may be delayed due to the ongoing restructure (consultation outcomes, role realignment, recruitment timelines, and staff transitions) as current engagement and resources are impacted, particularly in the ER department	N/A →	16	• Rephase programme deliverables to align with realistic staff onboarding timelines • Maintain close engagement with key stakeholders to monitor dependencies • Monitor weekly through risk reviews and escalate concerns early

Q1 (Apr-June 25)

- Consultation completed
- Data compliance audit completed
- ER Process Mapping framework reviewed
- Payroll contract reviewed

Q2 (Jul-Sep 25)

- New structures in place
- Grievance Panel & MDT Frameworks reviewed
- ER Community of Practice launched
- CIPD Mapping Phase 1 assessments completed

Q3 (Oct-Dec 25)

- Business Partner teams in post
- Recruitment & Service Centre Business Case Approved
- New ER ways of working embedded
- Mediation Programme review completed
- SCAS & People Services tender specification confirmed

Q4 (Jan-Mar 26)

- Recruitment & Service Centre consultation launched
- NHS Fair Recruitment Framework implemented
- CIPD Mapping Phase 2 assessments completed
- Divisional BI Dashboard released

Outcomes

- Embed People Services new structures to enable effective support
- Develop Case for Change for optimising Recruitment and Service Centre functions
- Enhance ER processes to ensure fair, timely case resolutions with strengthened staff confidence in ER services
- Develop capability and professional practice of People Services

Board Highlight Report – Organisational Operating Model

SRO / Executive Lead: Sarah Wainwright

Key
Completed
On Track
At Risk
Delayed

Progress Report Against Milestones:

The Organisational Operating Model group aims to enhance oversight, risk management and delivery of our future model by **bringing the Clinical Operating Model, Corporate Operating Model and Organisational Development & Culture programmes of work under one strategic framework**. This integrated approach will ensure that corporate functions and clinical operations are optimally structured and supported, improving collaboration, decision-making and overall service delivery. Each of the programmes is complex and affects staff across the organisation. The oversight group believes it more effective to run each programme separately rather than to incorporate into one as was original suggested. Each group will report separately into the agreed governance forum (EMB or SMG).

The Organisational Operating Model Oversight Group will focus on delivering a strategically aligned structure across all three programmes:

Clinical Operating Model
- Develop a more effective clinical operating model through the Divisions, ensuring streamlined structures, clear accountabilities and improved service delivery.
- Enhance governance and leadership, enabling greater autonomy, faster decision-making and better patient care.
- Strengthen operational processes and make best use of clinical resources to support delivery of the Trust's strategic priorities.

Corporate Operating Model
- Phase 1: Restructure HR, Quality & Nursing and Strategy & Transformation to align with the new divisional model, ensuring better integration and support for frontline services.
- Phase 2: To be confirmed (possibly Digital, Paramedical and Finance)

OD and Culture
- Implement a holistic OD plan to support implementation of new clinical and corporate operating models, development of divisional teams and associated activity with partners and wider stakeholders.
- Embed 'hybrid working' programme activity into wider OD plan and capture other complementary work currently underway such as Leadership development framework, Values and Behaviours and new Engagement Framework.
- *Workstreams to be scoped*

Previous RAG	Current RAG	RAG Summary
N/A		

Risks & Issues:	Score		Mitigation
The volume of organisational change will negatively impact on service delivery [covered in BAF risk 649]			Phasing Corporate and Divisional structure changes to enable focus on each in turn
Competing priorities within the Clinical operating model Design workstreams will be unable to be resolved, resulting in unsatisfactory outcomes or staff disengagement			Robust engagement to seek all views but manage expectations Clear objectives against which options can be evaluated
Contrasts between SECAmb and SCAS models will be unable to be resolved due to lack of organisational buy in or clinical risk associated with leaner structures			Early engagement and insight to SCAS models and ability to codesign a best of breed solution

Key Priorities (to be confirmed)

Clinical Operating Model

Transition
- Divisional Directors appointed
- Divisional Leadership Teams developed and embedded
- Divisional Governance & Processes implemented, aligned to Trust Governance

Design
- Operating Configuration – including first line management & MRC model
  - Develop aims of and options for the future wider Divisional structures
- Specialist Teams – including Volunteers, APPs, CCPs, HART, SORT teams
  - Consider optimal roles, function and leadership structures to support integrated working and delivery of the strategy

Corporate Operating Model

- Phase 1 Corporate Structures (x4) implemented
- Development of Divisional senior leaders/ways of working
- Phase 2 Corporate Structures design and implementation

OD & Culture

- 'Ways of Working' incl. Hybrid working, values and behaviours – scoping and engagement
- Individual, team and divisional OD interventions for senior divisional teams
- Leadership and management development scoped

Board Highlight Report – Clinical Operating Model

SRO / Executive Lead: Jen Allan

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

KEY ACHIEVEMENTS AGAINST MILESTONES

Transition Workstream
- 3 x Divisional Directors (Field Ops) appointed
- Divisional governance and reporting developed and implemented for field operations
- Transition initiated with divisional model in place from 1 June

Design – Operating Configuration Workstream
- Engagement approach and timeline for design and implementation of clinical operating model (field ops) developed
- Core design team for clinical operating model established
- Operating Model design expert consulted
- Initial engagement session conducted (Joint Teams B) around intention and high-level timelines
- SCAS collaboration discussions continued for identification of alignment opportunities within operating model design
- Operating Model parameters and aims drafted
- Programme governance groups established

Design – Specialist Teams Workstream
- Scope agreed

UPCOMING ACTIVITIES & KEY MILESTONES
- Development and agreement of Specialist Ops / Resilience model design plan to consider optimal roles, function and leadership structures to support integrated working and delivery of the strategy
- IC & Field Operations Job Description validation exercise group sessions undertaken (June 2025)
- Launch of divisional governance meetings (field ops) / Divisional leadership teams embedded
- Completion of divisional leadership responsibilities workshops and RACI matrix agreed

Previous RAG	Current RAG	RAG Summary
N/A		Programme currently on track to deliver against key milestones.

Risks & Issues:	April	May	Mitigation
Failure to effectively manage engagement process in Clinical Operating Model design workstreams could result in unsatisfactory outcomes and reduced staff engagement.	N/A	12	Robust engagement plan to seek all views but manage expectations. Clear objectives identified against which options can be evaluated.
Unresolved contrasts between the SECAmb and SCAS models due to limited buy-in or clinical risk concerns, could delay delivery or affect outcomes	N/A	8	Early engagement with SCAS to understand their model and collaboratively co-design an optimal, integrated solution. Recognition there will not be perfect / immediate alignment
Requirement of key staff in delivering change while maintaining critical services could place pressure on BAU operations and risk service disruption if not carefully managed.	12 →	12	COO as SRO well placed to ensure im changes are operationally safe. Engagement is currently good and with a robust plan to support transition and design process.

Q1 (Apr-Jun 25)
- 3 x Div Directors appointed
- Clear engagement approach defined and implemented
- Operating Model Design expert consulted & recommendations made
- Core Div Leadership Team Responsibilities drafted
- Div Governance and reporting developed and implemented
- IC Div Leadership team structure drafted
- Current op model review completed
- IC & Field Ops JD validation exercise completed for affected roles

Q2 (Jul-Sep 25)
- Div Director for Kent in Post
- Div Governance review undertaken and adjusted as required
- IC Div Leadership team structure approved
- Core Div Leadership Team Roles and Responsibilities agreed (RACI Matrix)
- Engagement period for design completed
- Business case/op model proposal EMB sign-off

Q3 (Oct-Dec 25)
- Operating Model transition for wider support functions
- Fornal consultation period completed
- Evolve definition and design of broader integrated divisional operating model

Q4 (Jan-Mar 26)
- New field ops/IC clinical operating model implemented
- Clearly defined specialist ops/resilience model embedded across front-line ops

Outcomes
- Alignment of SECAmb organisational structure to ICB boundaries
- Improved relationships and integrated working practices with ICBs & system partners
- Provide more integrated patient pathways and service delivery in each ICS to enable our strategic ambitions

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

Contributory factors, causes and dependencies: Scale of organisational change, continuing into 25/26; ER Casework backlog still high; legacy of inconsistent ER case management; varied leadership behaviours, and a slow rollout of cultural improvement initiatives

Accountable Director	**Chief People Office**
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 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Mediation Programme launched, with a six-month review scheduled for Oct 2025; ER training delivered on investigations, CPD, and Sexual Safety; further training scheduled for 2025/26, including management training in key people policies. Ongoing enhancement of ER processes and governance, including integration of absence monitoring with ER data to support early intervention and safe staffing. ER mapping framework design in progress to support appropriate decision-making at each stage. Establish an ER Community of Practice to support consistency and capability. Enhanced ER triage process. Wellbeing Strategy refresh scheduled for 25/26. Project Management expertise from external consultants in place to support strategic delivery and implementation of Project Management Office. Adoption of NHS Fair recruitment framework to improve internal shortlisting and selection experience. EDI Plan implementation. OD interventions underway to support divisional leadership teams.

Gaps in control: Inconsistencies in approach to ER casework. Inconsistent decision-making across the organisation impacting staff experience. The OD interventions underway but not yet imbedded.

Positive sources of assurance:. Staff survey results show improved morale. Suspension Review and Grievance Triage Panel forums in place, with standardised triage practices reducing unnecessary escalations. Positive results from Mediation Programme to date. External providers commissioned to support complex investigations and reduce case backlog. Realignment of L&D and Wellbeing under appropriate leadership for better integration.

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: Limited evidence of sustained improvements across all directorates. Ongoing staff feedback indicates variable experience of ER processes and inconsistent support.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Delivery of management ER training	Chief People Officer	Q2 25/26	Delivery of this training begun in Q4 2024/25
Embed Trust Values & Behaviour Framework	Director of Comms	Q3 25/26	
Refresh Wellbeing Strategy implementation plan	Chief Quality & Nursing	Q4 25/26	The Wellbeing Strategy proposal has been developed and is awaiting discussion/approval at the People Committee alongside an analysis outlining the options for the future Wellbeing model by the end of July 2025..

BAF Risk 603 – People Function

There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy

Contributory factors, causes and dependencies: Scale of organisational change, continuing into 25/26; ER Casework backlog still high.

Accountable Director	**Chief People Officer**
Committee	**People Committee**
Initial risk score	**Consequence 4 X Likelihood 5 = 20**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12**
Target risk score	**Consequence 4 X Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Phase 1 of the HR Improvement Plan showed positive outcomes; now transitioning into the rebranded People Services Improvement Programme (Tier 1). Transitional resource plan approved by EMB (Oct 2024) and refreshed May 2025 to provide capacity during the restructure. Interim senior HR team in place to provide stability following MARS. New People Services operating model designed to support both centralised and decentralised working. New structures approved, with implementation planned by September 2025. Phase 2 restructure to focus on optimising Recruitment and the Service Centre. CIPD mapping to be rolled out across all People Services staff. Opportunities for collaboration with SCAS. Whole Trust restructure coordinated to align corporate functions with divisional model for improved local support.

Gaps in control: Two-phase restructure is ongoing and in early stages of implementation, with most functions yet to transition to the new model.

Positive sources of assurance: Tier 1 programme progress continues to be tracked across various governance forums including Steering Group and Executive Check & Challenge meetings, People Committee forum, EMB and Trust Board through RAG. SMG similarly monitors Tier Two projects. Whole Trust restructure planned so that corporate departments are managed concurrently.

Negative sources of assurance: Review by Hunter Healthcare stated that there was a need for immediate improvement in the function and identified some high-risk areas. Concerns raised around ER process consistency and staff confidence in outcomes. Delays in case resolution until new structures embedded and teams are fully staffed.

Gaps in assurance: None identified

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Delivery of People Services Improvement Programme	Chief People Officer	Q4 2025/26	Mandate for Year 2 program set and workstreams underway
People Services Restructure	Chief People Officer	Q2 2025/26	Restructure underway, Consultation now complete and under review, outcome to be shared with impacted divisions in June 2025.
NHS Fair Recruitment framework implemented	Chief People Officer	Q3 2025/26	Scoping work being undertaken as part of the collaboration opportunities.

BAF Risk 648 - Workforce capacity & capability

There is a risk that the Trust will be unable to transition from physical to virtual care long-term, due to the absence of a sustainable workforce model with a clearly identified clinical skills mix.

Contributory factors, causes and dependencies:

Accountable Director	**Chief People Officer**
Committee	**People Committee**
Initial risk score	**Consequence 4 X Likelihood 5 = 20**
Current Risk Score	**Consequence 4 X Likelihood 5 = 20**
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q4 2026/27**

Controls, assurance and gaps

Controls: virtual care programme monitored as part of BAF. Collaboration with partners could increase workforce capacity.

Gaps in control: current gaps in both capacity and capability have a likely impact on both productivity and delivery. No defined workforce model, in-year plan or clinical skill mix yet identified.

Positive sources of assurance: Virtual care programme monitored through BAF with clearly identified in-year and multi-year deliverables.

Negative sources of assurance:

Gaps in assurance:

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Development of a 2025/26 workforce plan	Chief People Officer	Q1 2025/26	Not yet started.
Development of a long-term sustainable workforce model	Chief People Officer	Q4 2025/26	Not yet started.

BAF Risk 649 – Organisational Change

There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised

Contributory factors, causes and dependencies: Scale of organisational change across two phases; change fatigue and uncertainty.

Controls, assurance and gaps

Controls: Tier 1 Programmes in place to manage change, bringing the Clinical Operating Model, Corporate Operating Model and Organisational Development & Culture programmes of work under one strategic umbrella. Divisional Directors appointed and Leadership Teams in place by Q2. Hybrid Working practices scoping and embedding. OD Plan under review. Regular staff briefings, pulse surveys and feedback mechanisms to monitor understanding and sentiment. CSU support in place. Divisional leadership development support underway.

Gaps in control: Line management roles and new structures not fully stabilised. Lack of stability in certain functions while structures embed. Embedding of new model not due until Sep at the earlies. Staggered approach to divisional restructures is delaying full implementation of change.

Positive sources of assurance: Phase 1 Corporate Structures in delivery stage, consultation processes is complete for key areas (May 25). Regular staff engagement through consultation processes.. Impact Assessments undertaken as part of restructure process. Established governance structures with clear programme milestones and delivery plans.

Negative sources of assurance: Staff feedback indicating change fatigue and lack of clarity on future roles. Uncertainty around hybrid working requirements and timelines.

Gaps in assurance: N/A

Accountable Director	**Chief People Officer**
Committee	**People Committee**
Initial risk score	**Consequence 4 Likelihood 4 = 16**
Current Risk Score	**Consequence 4 Likelihood 4 = 16**
Target risk score	**Consequence 4 Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Delivery of restructure has clear plan and end date	Chief People Officer	Q4 2025/26	Implementation of planned restructure underway. Alignment of timing of organisational restructures to reduce loss of staff.
Ongoing communications plan in relation to organisational changes	Director of Strategy and Communications	Q4 2025/26	Implementation of plan underway.

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	34-25

Name of meeting	Trust Board
Date	5 June 2025
Name of paper	People Committee Assurance Report – 15 May 2025
Author	Max Puller, Independent Non-Executive Director – Committee Chair

INTRODUCTION

The People 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 meeting on 15 May, which was a shorter meeting to follow up on three specific issues. It is set out in the following way:

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

ALERT

Volunteers

This is an area of focus at the Board meeting in June. In its May meeting, the committee received the response to the external review and explored the actions being taken as part of the development of a new volunteer strategy.

There are a range of options that will need to be explored through the engagement on the strategy, which the committee agreed needs to be extensive. This impacts both people and quality, so there will be a role also for the Quality & Patient Safety Committee as the detail of the strategy starts to emerge. In the meantime, the committee reinforced the following points:

- More emphasis is needed on risks e.g. safeguarding
- Need to explore how we might properly utilise (and generate) charity monies to support volunteering
- Importance of engaging the charity and social enterprise sector
- Using this as a further opportunity to address some of the health inequalities through improving spread of volunteers / public access defibs etc.

NHSE Education Quality Review
This relates to Risk 602 - *non-compliance with regulatory requirements.* The formation of the action plan within the associated oversight framework reduces the risk of non-compliance in relation to placement provision for undergraduate and apprentice paramedic learners.

As reported to the Board on 1 May, NHS England Workforce, Training and Education quality team arranged a Senior Leadership Conversation in February, which followed the report published in December 2024. The committee considered the output of this, which aligns fully with the action plan already in place.

The requirements relate to the provision of documentary evidence of learner feedback, communication, the management of learner concerns, and implementation of the Safe Learning Environment Charter. The NHSE team concluded that the Trust has the appropriate level of oversight to ensure the issues of concern are addressed. They acknowledged the comprehensive improvement plan in place and recognised the considerable amount of work that has been undertaken to improve the quality of our placements for undergraduate learners.

The committee agreed that the NHSE findings were fair and pragmatic and is assured with the level of grip demonstrated by the executive. It explored the level of confidence in being able to provide the necessary evidence by the October deadline, and the committee will scrutinise this evidence at its meeting in September.

ASSURE

N/A

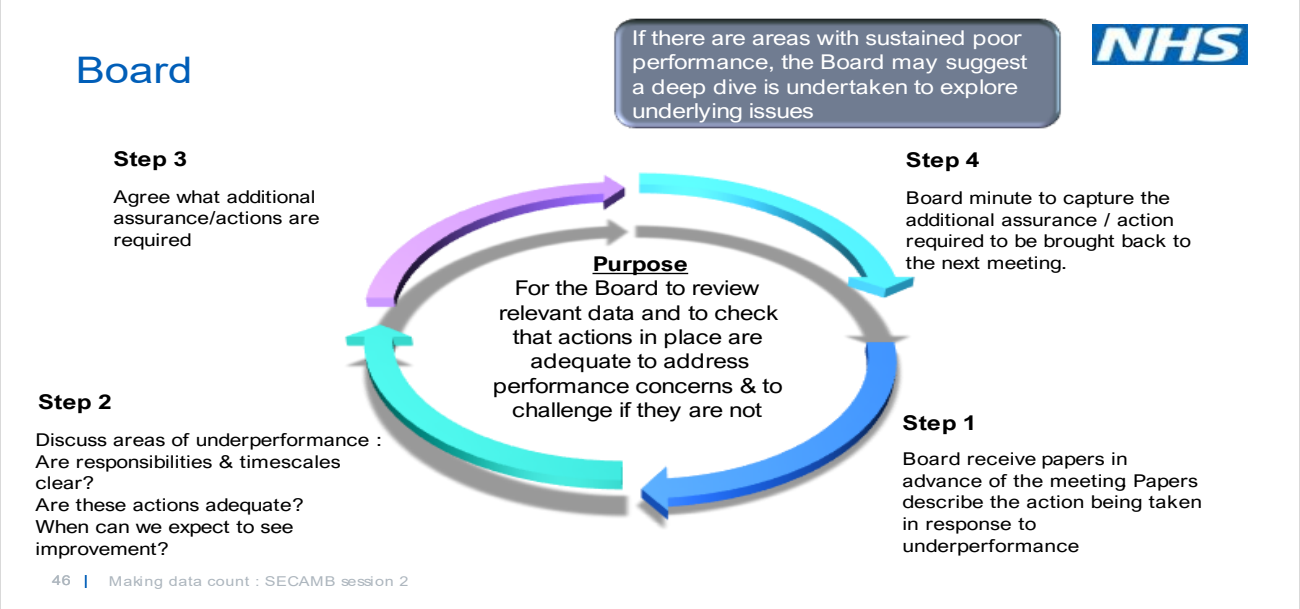
ADVISE

Sexual Safety Charter
Ahead of the full paper due to be received by the committee in July, there was a good discussion about the progress to-date against the Charter. While there is more work to do across the specific areas within the Charter – policy; training; data; comms; and process, overall, there is good evidence through our speaking up mechanisms that there is good awareness, and that people are speaking up. Linked to the Education Quality Intervention, the committee is assured that there is a specific focus too with students.

The committee will report its level of assurance following the paper due in July and, in the meantime, the next Board development session in July will be on speaking up, and so aspects of this will be covered then too.

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

Item No	35-25

Name of meeting	Trust Board
Date	05.06.2025
Name of paper	**People Improvement Plan**
Executive Lead	Chief People Officer

The Mandate sets out the aims for year 2 of the people services improvement programme, which were agreed as part of the development of the Board Assurance Framework for 2025-26. This is a key strategic priority for the Board and progress is closely monitored by the People Committee.

The Programme aims to enhance the effectiveness of the people services function, providing a more efficient, responsive, and supportive service to staff across the Trust. The Mandate sets out the key areas of focus which include embedding the new operating model, streamlining recruitment and service centre operations, improving employee relations processes, and strengthening the capability and professional practice within People Services.

Recommendations, decisions or actions sought	For Assurance

NHS
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People Services Improvement Programme
Programme Mandate

SRO: Sarah Wainwright

Programme Manager: Roxana Oldershaw

Version 4.0

Last updated: 28 May 2025

Journey since Apr 2024

Aim: 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

Engagement & Discovery	Data-driven insights	Benchmarking	Operating model review	Integrated People Improvement Plan
Engaged HR staff, managers, EMB/SMG, and Trade Unions to understand key risks and challenges Commissioned an independent deep dive into ER to uncover systemic issues	Analysed data from staff surveys, internal audits, QI reports, appraisals, CQC (2022), Grant Review (2023), and NHS Long Term Workforce Plan	Explored best practices from other NHS Trusts (LAS, EofE), CIPD and ACAS guidance, and the Future of NHS HR & OD report	Reviewed all HR services against new leadership structure to inform our new operating model	Developed and delivered Year 1 of the Integrated People Improvement Plan, aligned with Trust Strategy, to drive cultural change, embed Trust values, and pinpoint resource needs

STAKEHOLDER ENGAGEMENT | TRUST VALUES | EVIDENCE-BASED

The People Improvement Plan centred on four priority areas: Operating Model, ER Casework, ER Training, and Trade Union relationships. Each was informed by robust stakeholder engagement and evidence drawn from internal data and national workforce strategy.

Y1 | Achievements

Safe staff = Safe patients

South East Coast Ambulance Service NHS Foundation Trust

Safe

We focused programme on areas to ensure a safe working environment for staff, directly translating to patient safety

We implemented the Sexual Safety Multi-Disciplinary Team (MDT) to strengthen safeguarding

We delivered ER training with strong feedback and engagement

We transitioned L&D to Chief Paramedic for better clinical and governance alignment

Effective

We improved ER case management, reducing delays and improving consistency

We used data and national benchmarks to inform priorities

We strengthened manager support for health, attendance, and local resolution

We tracked progress across governance forums including Steering Group and Executive Check & Challenge meetings, People Committee forum, EMB and Trust Board through RAG

Caring

We took a values-based approach to wellbeing and organisational culture

We designed structures around trust, inclusion and accountability

We introduced a Mediation Programme to address workplace conflicts informally and encourage informal resolution

We offered a MARS scheme to support individuals to make decisions about their own future

Responsive

We launched the Grievance Triage Panel to act quickly on staff concerns

We focused on faster resolution times and removing ER legacy cases

We aligned restructures to the divisional model to provide better localised support and to reflect service provision at place

Well-Led

We stabilised senior HR leadership to support delivery and continuity

We embedded new values and design principles

We utilised executive expertise as part of our Lean-in programme to address risks

We realigned L&D and Wellbeing functions under appropriate leadership for better integration

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Programme Summary

The People Services Improvement Programme aims to **enhance the effectiveness of the People Services function**, providing a more **efficient**, **responsive**, and **supportive service to staff across the Trust**. Key areas of focus include embedding the **new operating model and structures**, **streamlining recruitment and service centre operations**, improving **employee relations processes**, and strengthening the **capability and professional practice within People Services.**

Key Objectives

1. Enhance responsiveness | We will ensure People Services delivers timely & effective support

- Stronger presence in local units, leading to improved divisional support and positive feedback from operational teams
- Reduction in average case resolution time, demonstrating continuous service improvements

2. Drive efficiency | We will improve processes & systems for a more streamlined and productive service

- A more efficient payroll service, demonstrated by reduction of overpayments/underpayments
- Workforce stability demonstrated by improved recruitment and onboarding candidate experience

3. Strengthen People Services support | We will build trust & confidence in the People Services functions

- Reduced variation in ER advice, evidenced by positive feedback from Community of Practice members
- Reduced discontent among employees and managers, with surveyed staff confident in the ER process lifecycle
- Accurate data reporting, with OUMs/Divisional Directors confirming clear understanding of ER cases in their area

4. Elevate professional standards | We will invest in the development of the People Services teams

- All People Services staff requiring CIPD qualification registered or working towards registration
- All People Service staff have up-to-date appraisals and development plans

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Balance Scorecard

Perspective	Objective	KPI	Target	Initiative / Action Plan
Financial	Drive efficiency	Payroll processing accuracy	= 95%	Review payroll processes and provide line manager upskilling training
Customer	Enhance responsiveness	Informal case resolution (grievances resolved via mediation)	= 50%	Accessible and visible teams on site, aligned to Divisional model
		Average case resolution time decrease (from 209 to 90 days)	< 68%	Streamline ER case management; improve governance;
	Strengthen People Services support	Community of Practice member survey	> 80%	Launch and embed ER Community of Practice
		Onboarding experience survey	> 85%	Undertake QI initiative for onboarding process
Internal processes	Embed People Services Operating Model	Posts filled by Sep 25	= 90%	Complete consultation, recruitment, selection, and induction
Learning & Growth	Elevate professional standards	CIPD qualified staff (registered or working towards)	= 100%	Complete CIPD Professional Mapping

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Link To Strategic Commitments

- **(4) We will create an inclusive and compassionate environment where our people are happy:** Shift towards a resolution culture and proactive case management to reduce formal ER cases and improve employee experience
- **(5) We will invest in our people's careers to better meet patient needs**: Invest in line managers' capability to handle difficult conversations, apply policies effectively, and lead with confidence
- **(6) We will become a sustainable and productive organisation**: Optimise People processes to increase productivity & identify efficiencies

Programme Dependencies

- **Divisional Model/Corporate Restructure**: Alignment of organisational change approach and timelines is essential for HR transformation
- **Digital Systems Support**: Alignment of HR digital system improvements with the digital strategy
- **BI Support:** Collaboration on the design and implementation of ER dashboards to improve case tracking and reporting
- **SCAS (Potential Partnership):** Identify opportunities to explore efficiencies e.g. Occupational Health, Recruitment, Payroll

Programme Budget

- Operating Model (Phase 1 Restructure) - £500k transition cost approved by EMB for 25-26 for embedding the approved structure
- ER Case Investigations - £200k + Training (specialist training ie AACE)

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Key Deliverables

WORKSTREAM 1 | Embed People Services Operating Model / Restructures

- Ensure **full implementation of the People Services structures** consultation process, recruitment, selection, induction) by Sep 25
- Submit **Business Case for Phase 2 organisational change**, including redesign of Recruitment and Service Centre functions by Feb 26

WORKSTREAM 2 | Optimise Recruitment and Service Centre functions (Case for Change)

- Review **Payroll contract**
- Align **collaboration opportunities with the SCAS programme Functional Collaboration workstreams** by Dec 25
- Review **recruitment processes and ways of working** to optimise resources by Dec 25
- Evaluate system efficiencies to ensure **alignment with the Trust's digital strategy** by Dec 25
- Demonstrate **alignment with the NHS Fair Recruitment** framework

WORKSTREAM 3 | Foster a culture of resolution – Enhance ER processes

- Embed **new ways of working within newly appointed ER teams**, aligned with the divisional model
- Launch an **ER Community of Practice forum** as a Quality Assurance function to ensure consistent HR advice across the Trust by Sep 25
- Implement an **ER process mapping framework** to streamline case management and enable decision-making at the appropriate level and stage by Oct 25
- Review the **efficiency of the Grievance Panel, MDT** and other ER governance processes to ensure stronger coordination of ER cases and reduce resolution time by Oct 25
- Update key ER policies to ensure fit-for-purpose and shared understanding by Mar 26
- Enhance **Quality Management Information** (QMI) and data reporting to improve oversight of ER case volumes and complexity by Mar 26

WORKSTREAM 4 | Develop capability and professional practice of People Services

- Complete CIPD Professional Mapping for People Services Teams by Dec 25

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Key Milestones

Apr 25 – June 25

- Phase 1 consultation completed
- Consultation outcomes published – new structures approved
- Data compliance audit completed
- Payroll contract reviewed

Jul 25 – Sep 25

- People Services staff in post
- Grievance Panel & MDT frameworks reviewed
- ER process mapping framework reviewed
- CIPD Mapping Phase 1 assessments completed

Oct 25 – Dec 25

- New ways of working embedded within newly appointed ER teams
- SCAS & People Services tender specification confirmed
- Recruitment & Service Centre business case approved
- Mediation Programme six-month review completed

Jan – March 26

- Recruitment & Service Centre consultation launched
- NHS Fair Recruitment framework implemented
- Divisional dashboards released
- CIPD Mapping Phase 2 assessments completed (new starters)

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Key Risks

ID	Description	Current RAG	Target RAG	Mitigation
PSIP 4	**Industrial Relations Disruption** | There is a risk that unresolved industrial relations issues may escalate or persist, which could impact business-as-usual activity, divert leadership attention, delay programme milestones, and affect staff morale and engagement.	12	6	• Maintain regular engagement through agreed forums to support open communication and de-escalation • Align and coordinate messaging to reduce uncertainty and limit misinformation
PSIP 5	**People Services Restructure |** There is a risk that the programme deliverables may be delayed due to the ongoing restructure (consultation outcomes, role realignment, recruitment timelines, and staff transitions) as current engagement and resources are impacted, particularly in the ER department	16	8	• Rephase programme deliverables to reflect realistic onboarding timelines • Maintain close engagement with key stakeholders to monitor dependencies • Monitor weekly through risk reviews and escalate emerging issues early
PSIP 6	**Workstream Resourcing and Delivery Momentum |** There is a risk that insufficient dedicated delivery resource per workstream could undermine milestone delivery and hinder the programme's ability to rebuild trust in People Services	9	6	• Identify and secure delivery resources for each workstream • Review delivery capacity weekly and escalate resourcing risks • Use fixed term support or adjust scope where capacity is limited
PSIP 9	**Service Centre Restructure and Payroll Contract |** There is a risk that concurrent delivery of the Service Centre restructure and payroll contract renewal may disrupt payroll operations	6	4	• Map critical timelines and complete impact analysis to minimise disruption • Develop and test contingency plans to ensure payroll continuity

Y2 | People Services Improvement Programme

Striving to be a trusted and valued People Services function

South East Coast Ambulance Service NHS Foundation Trust

Programme Structure & Governance Forums

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

ESCALATION

Role | Oversee and make recommendations for the direction of the People Services Improvement Programme; report into EMB

Documentation/Reporting
- Programme RAID log

Frequency | Monthly

SCAS COLLABORATION PROGRAMME

PEOPLE SERVICES IMPROVEMENT PROGRAMME STEERING GROUP

SRO/Chair: Sarah Wainwright
Programme Lead: Roxana Oldershaw
Membership:
- Jaqueline Skeel - Deputy Chief People Officer
- Vicki Doody - Deputy Chief People Officer
- Tina Ivanov - Programme Director
- Kevan Burns - Finance BP
- Janine Compton - Director of Comms & Eng
- Lara Waywell - Deputy Director of Ops
- Jo Crerar - Field Operations OUM
- Simon Clarke - Head of Ops for Integrated Care
- Philip Tremewan - Assoc Director for Quality and Safeguarding
- TBC - Digital

DELIVERY

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

Documentation/Reporting
- Action Plan
- Programme RAID log

Frequency | Weekly

SERVICE CENTRE & RECRUITMENT OPTIMISATION WORKING GROUP

Lead: Tina Ivanov
Membership:
- TBC

EMPLOYEE RELATIONS WORKING GROUP

Lead: Victoria Doody
Membership:
- TBC

OPERATING MODEL WORKING GROUP

Monitored under wider Corporate Operating Model programme

Agenda No	36-25

Name of meeting	Public Board
Date	5th June 2025
Name of paper	EDI Progress Update for Public Board
Executive sponsor	Sarah Wainwright – Chief People Officer
Author(s) names and roles	Caroleanne L'etendrine – EDI Manager (Programme Lead) Dawn Chilcott – interim Assistant Director of OD and Culture Jacqui Skeel – Deputy Director of People and OD

Executive Summary

Our dedicated Board Development days have provided a vital platform to focus on Equality, Diversity and Inclusion (EDI). These sessions brought together over 50 Executive and Non-Executive Directors, Senior Leadership Groups, Operational Leaders, Staff Network Leads, and HR colleagues to deepen our shared understanding—rooted in powerful lived experiences and external insights. The session in May, supported by the NHS Race and Health Observatory, further challenged the Board to reflect on its role in creating a meaningful and lasting legacy for EDI.

From these engagements, the Trust has identified four priority areas that now shape the focus of our integrated EDI delivery plan for the next 12 months:

1. Development and empowerment of staff networks
2. Ensuring our recruitment processes are inclusive
3. Enhanced staff development
4. Improved analytics and reporting

Following feedback from both development sessions, we recognise the need to codify accountability and embed consistent governance to sustain delivery, this includes:-

- EDI plan:
  - Integration of the four focus areas into our Trust-wide EDI Plan, with clear objectives, timelines and accountability.
- Governance and assurance:
  - Oversight through our People and Culture Committee, with quarterly assurance reporting.
  - Use of data to track progress and measure success, supporting learning and course correction if appropriate.
- Continuous Board development:
  - Further Board EDI Development Days to review progress and shape our new Inclusion Strategy, due to launch in November 2025.
- Implementation of our new organisational operating model.
  - Shifting from a centralised model of EDI delivery to one that is embedded and owned locally within strategic divisional teams.
  - Developing a distributed and accountable approach, to build a legacy that does not rely on individual champions, but on a system-wide commitment to inclusion, fairness, and belonging.

The slides provide a summary of the proposed approach to implementation of our EDI plan focusing on the 4 key areas outlined, including key themes and strategies identified for improvement and outlines how these priorities are being embedded across the organisation with steps we are taking to ensure measurable and impactful progress over the next 12 months.		
Recommendations, decisions or actions sought	For Information	
Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).		**No**

NHS
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Equality Diversity and Inclusion Progress Update for Public Board

Date: 5th June 2025

Contents

South East Coast Ambulance Service NHS Foundation Trust

- Executive Summary
- Outcomes from EDI Board Development sessions held in March and May
- Summary of the Trust's 4 EDI focus areas and activity for the next 12 months
- Governance
- Next steps

Executive Summary

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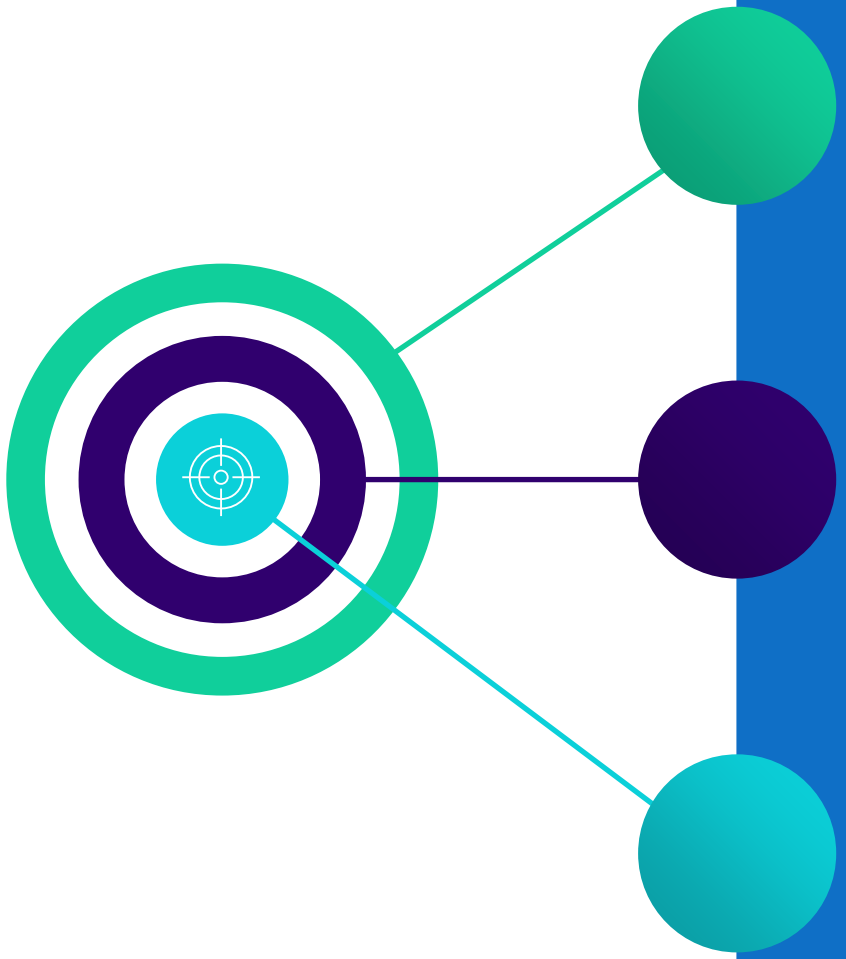
Board Development Session 1: 6 March 2025



54 senior leaders attended, including Non-Executive Directors, Operational Unit Managers, Staff Network Leads, HR Business Partners, and our Executive Team.

The **aim** of the day was to encourage curiosity and openness around Equality, Diversity and Inclusion (EDI). We heard powerful lived experiences from our Staff Network Leads and an Operating Unit Manager, helping us to better understand the real impact of EDI in the workplace.

We explored what our leaders must do to drive meaningful change, which included showing visible commitment, engaging in continuous learning, holingd themselves and others accountable, empowering staff networks, and embedding EDI in all decisions and strategies.

Guest speakers from **Yorkshire Ambulance Service** and **Surrey County Council**, who shared insights from their own EDI journeys.experiences of implementing EDI initiatives at their respective organisations and the challenges that were faced.

Explored findings from the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), gender pay gap reports, and staff surveys to highlight systemic barriers.

Engaged with personal stories shared by employees to amplify lived experiences.

Session 1:
Key themes from discussions

Systemic barriers

Lack of representation for women and underrepresented groups in leadership positions.

Quality of data

Some questions raised around the quality of data, as some suggested it did not reflect their lived experience.

Disability and religion

Debias disciplinary processes, especially for disabled colleagues and provide more support to handle conversations around religion.

Cultural intelligence

Match cultural understanding and emotional intelligence at leadership levels and beyond.

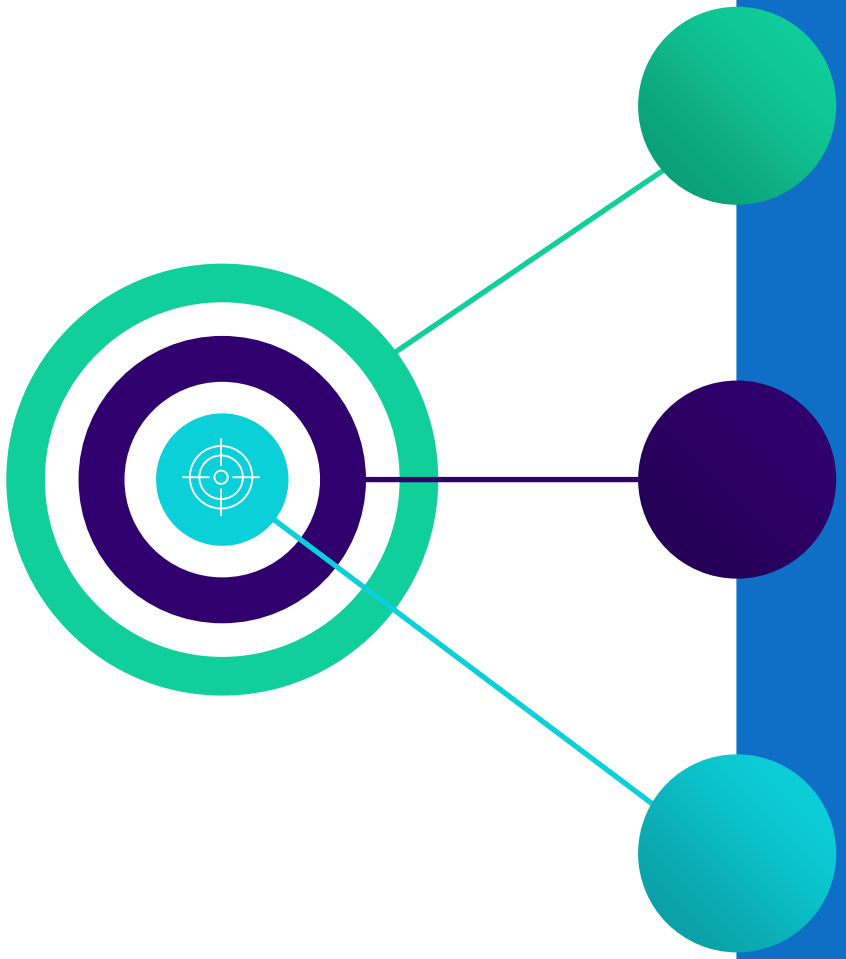
Empowering staff networks

Staff network leads expressed a clear desire for greater visibility, structure and influence.

Leadership accountability

Embed inclusion in strategic planning and performance metrics.

Board Development Session 2:
1 May 2025 - Facilitated by NHS Race and Health Observatory



Session Focus:

- Exploring how the Board can enhance its competence, curiosity, and confidence in leading on EDI.

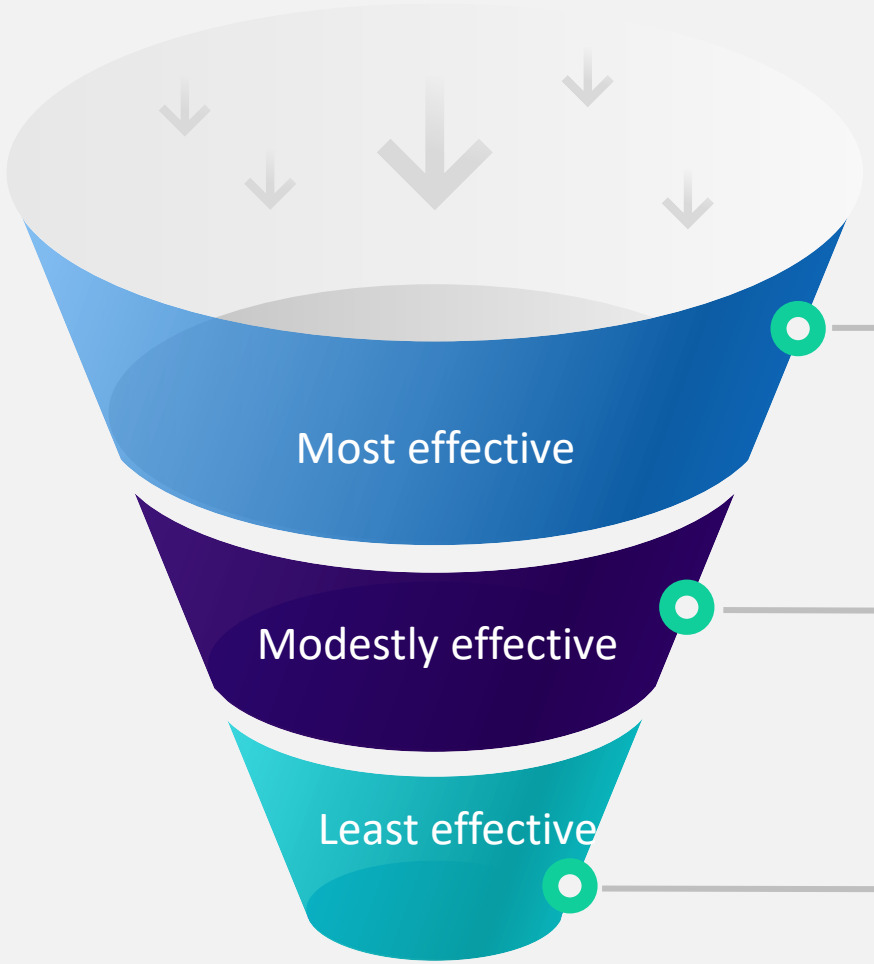
Session Goals:

- **Stimulate thought** – Challenge assumptions and inspire new ways of thinking.
- **Learn from others** – Highlight success stories from partner organisations.
- **Plan forward** – Define practical next steps to improve Board leadership on EDI.

Approach:

- Encourage questions and curiosity.
- Share insights into the kinds of data and information the Board should seek out.
- Reinforce that inclusive leadership is active, visible, and accountable.

Session 2:
Strategies identified for improvement



Mandatory programs, or programs with explicit authority, accountability, support from the leadership, developing psychologically safe spaces and monitoring interventions

Mentoring and networking (including reverse mentoring)

Reducing managerial bias through education (e.g. diversity training, unconscious bias training) and feedback (diversity evaluations)

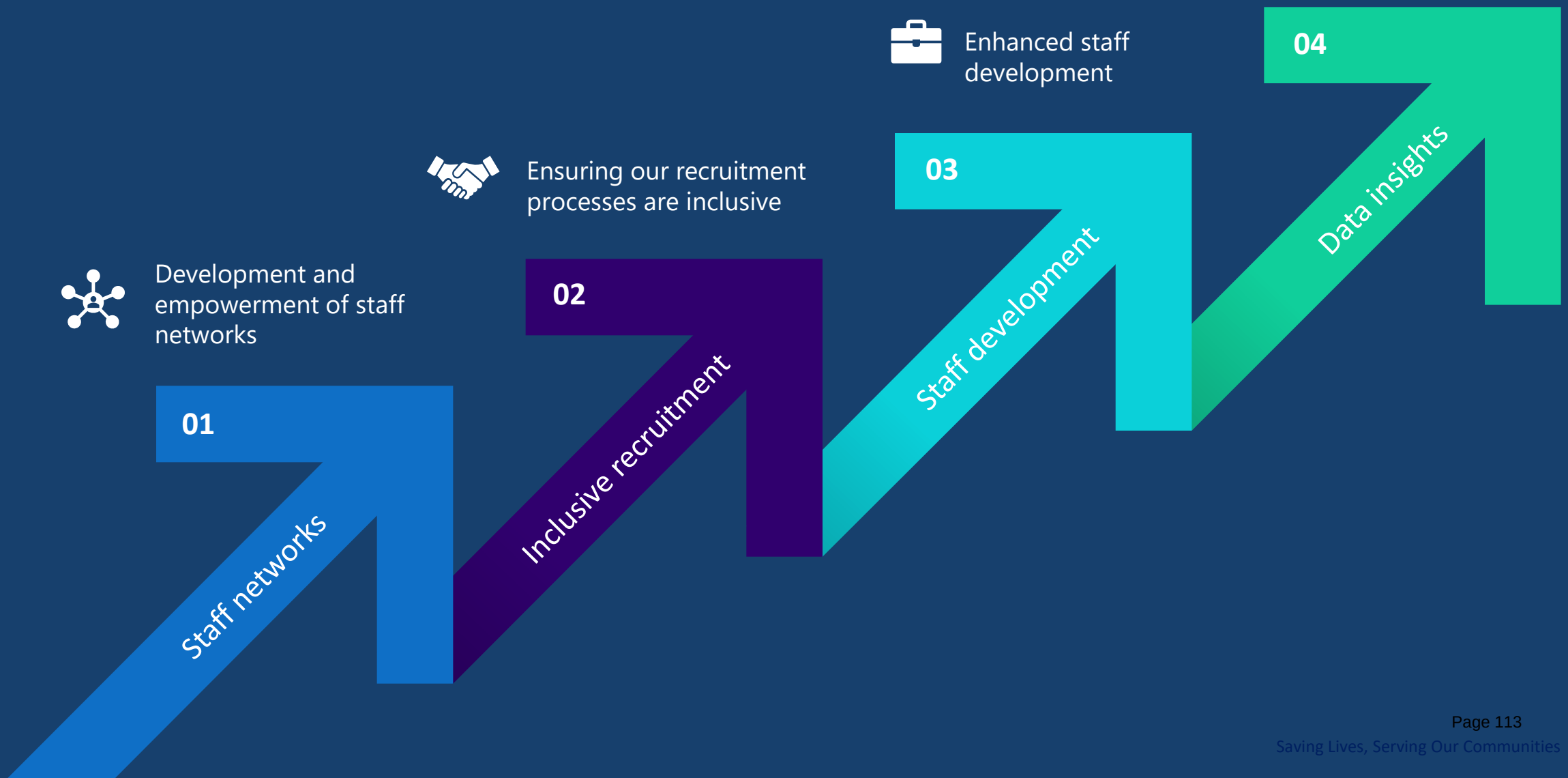
4 Focus areas for next 12 months

Development and empowerment of staff networks

Ensuring our recruitment processes are inclusive

Enhanced staff development

Improved analytics and reporting



Focus area 1: Staff networks

Development and empowerment of staff networks

How will we achieve this?

- **Recruitment and support:** We will prioritise the growth and sustainability of staff networks, ensuring they have the necessary resources and leadership sponsorship to thrive.
- **Influencing policy and strategy:** Staff networks will be invited to play a more integral role in organisational decision-making. Their input will help shape new policies, strategic initiatives, and workplace practices.
- **Platform for voices:** Opportunities will be created for staff network leads to speak directly with executive teams and senior leaders, embedding lived experience into our organisational learning and decision-making.

Activity already underway:

1. **UK Supreme Court ruling:** Worked closely with Pride network leads and National lead for Trans staff to support staff in response to UK Supreme Court ruling through listening events, signposting, policy and facilities review and support with Equality and Human rights council consultation.
2. **Sponsor for each staff network:** Each Network now has both an **Executive and Non-Executive Sponsor**, and the feedback from leads has been very positive about this support.
3. **Accredited staff network lead development programme:** Staff network leads are enrolled to attend an external **accredited development programme for Network leads** starting this June.

Focus area 2: Inclusive recruitment

Ensuring our recruitment processes are inclusive

How will we achieve this?

- **Inclusive recruitment training:** A dedicated programme for hiring managers will be rolled out to ensure inclusive approaches are embedded in all recruitment processes.
- **Internal recruitment surveys:** We will pilot a feedback mechanism for colleagues who have experienced internal recruitment, helping us benchmark our progress and identify areas for improvement.
- **Targeted outreach:** Recruitment strategies will continue to focus on engaging underrepresented communities, with targeted drives in geographical areas with high BME populations.

Activity already underway:

1. **Inclusion ambassadors programme:** Process being finalised for the launch of the programme in July. This programme will provide assurance that our recruitment episodes are equitable for all candidates.
2. **Disability confident accreditation:** The Trust currently holds the Level 1 accreditation and a review is underway to align our organisation with Disability confident Level 2.

Focus area 3: Staff development

Enhanced staff development

How will we achieve this?

- **Expansion of EDI learning opportunities:** We will broaden access to EDI training for all staff, with a particular focus on:
  - Embedding EDI principles into all leadership development programmes.
  - Creating learning content in the form of webinars and workshops that goes beyond recognition and celebration and instead supports deeper understanding and behavioural change.
- **Reverse mentoring:** We will expand our reverse mentoring programme to connect senior leaders with staff from diverse backgrounds, fostering awareness, empathy, and inclusive leadership.
- **Development of business partners:** Following the redesign of the People Service Directorate, we will be aligning our team to divisions and developing our Business Partners to support with the delivery of the EDI plan at a local / service level. This will be significantly different to the centralised EDI delivery model currently in place.

Activity already underway:

1. **Reverse mentoring:** Cohort 1 has concluded. Cohort 2 will launch in November.
2. **Beyond bias workshops: '**Deep Insight' were commissioned to deliver beyond bias workshops to the Senior leadership teams of two directorates. We will continue working with them to deliver more sessions across more directorates.

Focus area 4: Data insights

Improved analytics and reporting

How will we achieve this?

- **Strengthening data-driven decision-making:**
  - We will improve the integration and analysis of EDI-related data (e.g., disciplinary actions, career progression, pay gaps, recruitment outcomes) to identify trends and inform targeted interventions.
  - Better use of intersectional data will help us understand overlapping inequalities and tailor support more effectively.
- **Quarterly progress updates:** Progress against EDI objectives will be reported quarterly. We are exploring routes for these updates to be reviewed by a Joint Leadership Forum, Executive Management Board (EMB), Senior Management Board (SMB), and the People Committee to ensure visibility and accountability.

Activity already underway:

1. **EDI data dashboard:** A first draft of the EDI data dashboard has been created with a final version planned for August.

Governance structure

South East Coast Ambulance Service NHS Foundation Trust

ASSURANCE

Role | Ensure that the Intergrated EDI Plan priorities are on track to deliver the intended benefits and outcomes.

Documentation/Reporting
- Intergrated EDI Plan

Frequency:
- **Executive Management Board (EMB)|** monthly
- **Trust Board |** as requested

Executive Management Board and Senior Management Group

Trust Board / People Committee

ESCALATION

Role | Oversee and make recommendations for the direction of the Intergrated EDI Plan ; report into EMB

Documentation/Reporting
- Intergrated EDI Plan
- Trust Inclusion Strategy (from December 2025 onwards)

Frequency | Monthly updates to EMB

Inclusion Programme Group

Lead: Chief People Officer
- Assistant Director of OD and Culture
- EDI Manager

DELIVERY

Role | Monitor Intergrated EDI Plan, risks, dependencies, change requests and escalate issues to EMB

Documentation/Reporting
- Trust Intergrated EDI Plan
- Trust Inclusion Strategy (from December 2025 onwards)

Frequency | Monthly/Quarterly

NETWORK Leads Meeting

Lead: EDI Manager
Membership:
Network Leads

People Directorate Meeting

Lead: Deputy Director of People
Membership:
HRBP's

Next steps

South East Coast Ambulance Service NHS Foundation Trust

- Integration of the 4 focus areas into our Trust-wide EDI Plan, with clear lines of accountability, objectives and a 12-month delivery timeline.
- Oversight through our People and Culture Committee, with quarterly assurance reporting.
- Implementation of new People Services structure and comprehensive development of Divisional Business Partners to ensure support and delivery of EDI plan at a local/service level.
- Use of data to track progress and measure success, supporting learning and course correction if appropriate.
- Further Board Level EDI Development Days – next session July 2025.
- Development of new Inclusion Strategy, due to launch in November 2025.

South East Coast Ambulance Service
NHS Foundation Trust

Item No	37-25

Name of meeting	Trust Board
Date	5th June 2025
Name of paper	Freedom to Speak Up Report from the FTSU Guardian
Executive sponsor	Margaret Dalziel – Chief Nursing Officer/Dep CEO
Author name and role	Kim Blakeburn, Freedom to Speak up Guardian
Executive Summary	The purpose of this paper is to provide the Trust Board with an overview of the progress and development of the FTSU service since the last board paper in November 24. The paper also includes insights, hotspots and themes arising from the cases received by the Freedom to Speak Up Guardian (FTSUG) from 1st April 2024 to 31st March 2025. Finally, the paper highlights key risks and actions planned for the coming year. **Key highlights from the paper are follows:** - Detriment numbers reducing - Increase in concerns closed with satisfactory outcome - Increase in anonymous reporting
Recommendations, decisions or actions sought	**The Board is asked to:** • Continue in their support of speaking up at SECAmb and encouraging action and learning from concerns. • Encourage senior leadership to view speaking up not as a challenge, but as an opportunity for learning and improvement,

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

Freedom to Speak Up Guardians Board Report

1. Introduction and Background

Freedom to Speak Up (FTSU) is about creating a workplace where everyone feels safe, supported, and able to speak up about anything that's getting in the way of doing our jobs well, whether that's about patient safety, working conditions, or anything else that matters to our teams. At SECAmb, we know that listening to staff and acting on their concerns is vital for both staff wellbeing and the quality of care we provide.

Since the National Guardian's Office was set up in 2016, all NHS organisations, including ambulance services, have been required to have a Freedom to Speak Up Guardian. The Guardian's role is to make sure there's someone staff can turn to when they're not sure where else to go, or when other routes haven't worked. Here at SECAmb, I'm proud to be part a team that helps to ensure speaking up is encouraged, taken seriously, and followed up in the right way.

Our staff can raise concerns in lots of ways, through their manager, HR, union reps, Datix, the whistleblowing hotline, or directly with the FTSU team. Speaking up isn't just about flagging problems; it's also about sharing ideas and making suggestions for how we can do better together.

The support from our Chief Nursing Officer, our Chief People Officer, the NED for FTSU and regular access to the Chief Executive continues to make a big difference. Their involvement helps ensure that FTSU stays visible and taken seriously at all levels of the organisation.

I also co-chair the National Ambulance Network for FTSU, which gives us opportunities to learn from others, share what's working, and tackle some of the challenges we're all facing together.

This report highlights what's been happening with FTSU at SECAmb over the past year—including what's going well, where we're seeing changes, and the areas we still need to work on.

2. Summary of updates from the FTSU Service

a. Significant reduction in reported detriment

The number of cases where staff have reported experiencing detriment as a result of speaking up has reduced by 70% year on year. This marked decrease is a strong indicator of the positive cultural shift taking place across SECAmb. It may suggest that more staff feel safe and supported when raising concerns and that the Trust's response to speaking up has become more effective and empathetic.

This reduction also reflects the impact of our continued focus on early intervention, proactive safeguarding against detriment at the first point of contact, and improved awareness among leaders of their responsibilities when responding to concerns. The decline in detriment cases is a key measure of our success in building a psychologically safe environment and reinforces our commitment to fostering a culture where every voice can be heard without fear of reprisal.

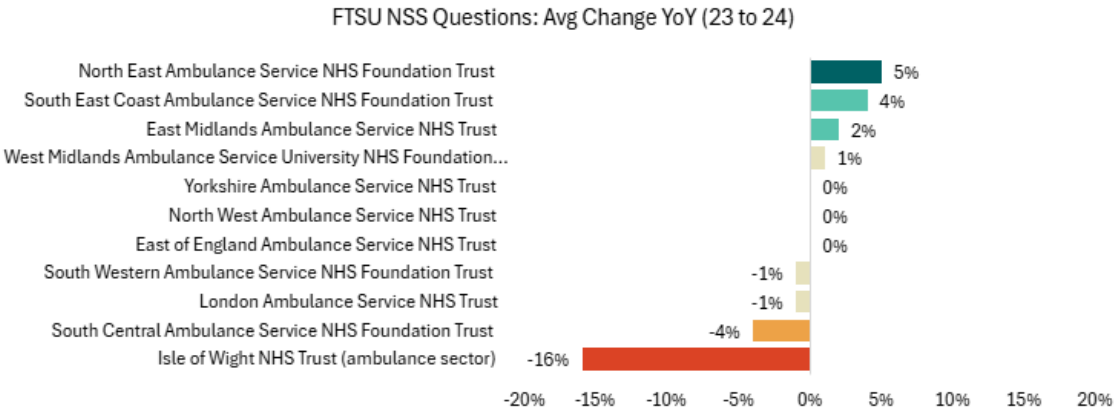
b. Continued progress in Staff Survey results for speaking up

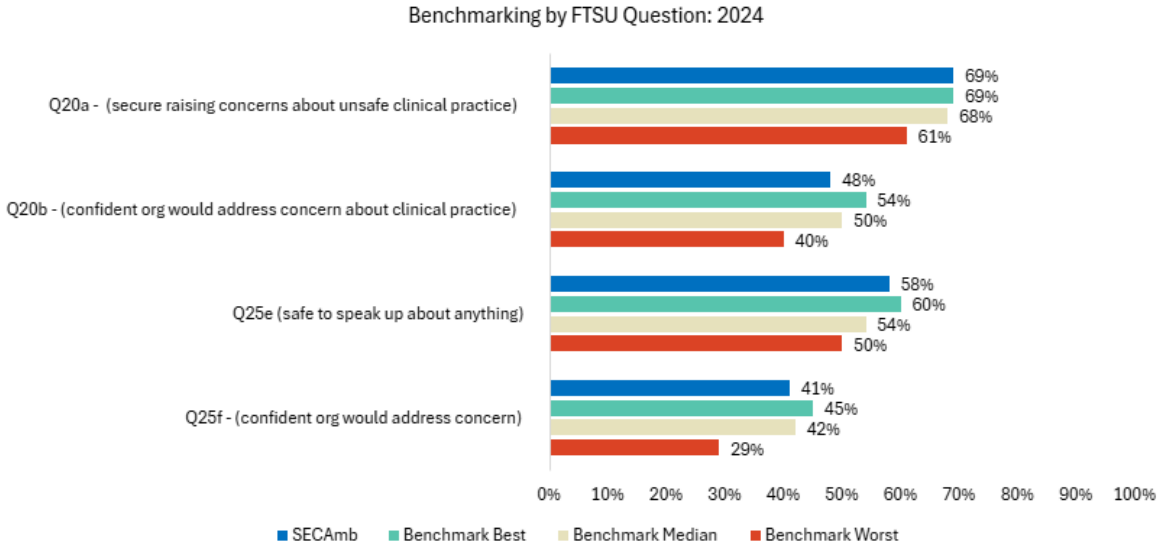
Following recognition by the National FTSUG Office of the 2023 NHS Staff Survey results placing SECAMB as the most improved ambulance Trust nationally for Freedom to Speak Up indicators, we are pleased to report a continuation of this positive trajectory in the latest results published in April 2025. SECAmb has sustained encouraging performance across key FTSU-related questions, demonstrating a growing confidence among our workforce in raising concerns.

This year, we ranked second out of all ambulance trusts for year-on-year improvement in FTSU scores, with a 4% overall increase—just behind North East Ambulance Service NHS Foundation Trust, which achieved a 5% rise. Furthermore, SECAmb remains above the benchmark median for key measures such as feeling safe to speak up about anything (58% vs. a 54% median) and security in raising concerns about unsafe clinical practice (69%, equal to the benchmark best).

We are currently placed mid-table for overall positive responses to FTSU questions, with 54% of our staff answering favourably. This consolidates our position among the better-performing trusts and reflects steady gains in fostering a culture where staff feel both able and supported to speak up.

These results are a testament to the continued efforts of our leadership, FTSU team, and frontline managers to embed openness and psychological safety into everyday practice. We will use this data, alongside our ongoing engagement work, to further strengthen the speaking-up culture across the organisation.



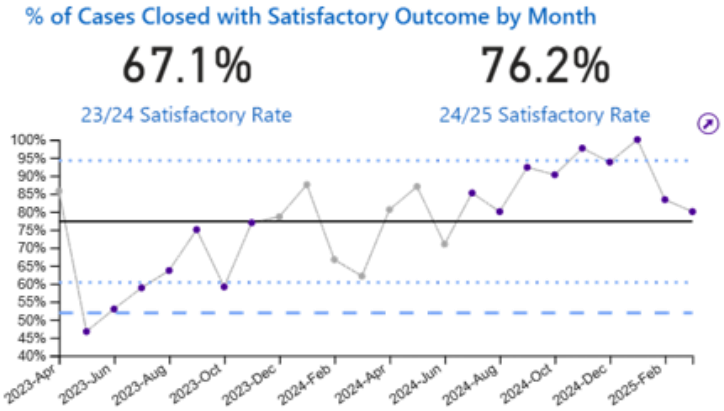


c. Concerns closed with satisfactory outcome increased by 9.1% year on year

One of the most encouraging developments this year has been the increase in the proportion of concerns closed with a satisfactory outcome, which has risen by 9.1% year on year. This improvement reflects the growing confidence of our staff have not only in raising concerns, but also in our ability to respond meaningfully and constructively.

A key contributor to this progress has been the use of learning and listening reviews. These sessions have enabled a more compassionate and reflective approach to resolving concerns, one that places value on listening, learning, and restoring trust. Staff have fed back that this approach has helped to ensure their concerns are not dismissed or treated as futile but instead recognised as opportunities for growth and change.

As we continue to embed a culture of openness and learning, this trend gives us assurance that our efforts are making a meaningful difference.



d. University student workshops

Since the last report, the FTSU team has visited all partnership universities, continuing to deliver and update workshops to ensure content remains current and relevant. Student feedback has remained very positive, reflecting the ongoing value of these sessions in building awareness and confidence around speaking up.

We are particularly pleased to share that Surrey University has invited the FTSU team to contribute to their learning simulation programme. This innovative initiative integrates 'speak up' scenarios into real-life clinical simulations, with students being assessed not only on their clinical skills but also on their responses to raising concerns. This collaboration represents an important step forward in embedding a speak-up culture early in paramedic training.

The team is excited to be part of this pioneering work and looks forward to reporting on its impact and further developments in future updates. This continued partnership strengthens our commitment to supporting the next generation of paramedics in fostering a safe and positive workplace culture through early and effective speaking up.

3. Future plans

a. Responding to an increase in Anonymous concerns

Since the last update, we have observed an 88% increase in anonymous reporting. This initially appears contradictory to the positive trend identified in the recent staff survey, which indicates a greater proportion of staff feel safe to raise concerns openly.

On closer examination, data from October reveals a significant spike, with 19 anonymous concerns raised—approximately five times the monthly average. This peak coincides with Speak Up Month, when staff are actively encouraged to voice concerns. Notably, 10 of these reports related to the Emergency Operations Centre (EOC).

In response to the concerns raised within the EOC, a listening event was promptly organised. The recommendations arising from this event have been integrated into a Quality Improvement (QI) initiative currently underway in this area. Delivery of these actions will be overseen by the EOC/111 senior leadership team, and supported by the Deputy Chief Nurse, ensuring strong accountability and focus.

An issue with anonymous reporting is we are unable to feedback actions and changes made as a result of the concerns being raised. Looking ahead, we propose to explore technology platforms currently used by other blue light services and NHS organisations that enable anonymous reporting while allowing concerns to be allocated to the appropriate managers. Crucially, these systems maintain the reporter's anonymity but facilitate direct two-way communication, enabling managers to seek further information and provide tailored responses.

We anticipate that, although the introduction of such a system may initially lead to an increase in anonymous reports, over time it will build trust through the evidence of effective local management responses. This, in turn, will help create an environment where staff feel more confident to raise concerns openly.

4. Speak Up - Statutory & Mandatory training

Module	Staff grade/level	Time allocated	Frequency	Completed	Required	%
Speak Up	All Staff	1.5hrs	Occurring every 2 years	3872	4934	78.48%

Speak Up training continues to form an important element of our statutory and mandatory training requirements for all staff at SECAmb. The training content, developed in partnership with the National Guardian's Office and Health Education England, underpins our commitment to fostering a positive speak-up culture that promotes both patient and workforce safety. Monitoring compliance levels helps to ensure our teams are equipped with the skills and confidence to raise concerns effectively.

As of this reporting period, we have achieved a 78.48% compliance rate for the Speak Up training module, with 3872 staff having completed the training out of 4934 required. This represents an improvement from the previous figure of 74.28%.

We have been unable to obtain updated compliance figures for the Listen Up and Follow Up modules. The Listen Up training remains key, as it is aimed at equipping our managers with the foundational skills to respond appropriately when concerns are raised.

As highlighted previously, we continue to see some examples where colleagues initially raise concerns through the Freedom to Speak Up process, only to move into formal procedures such as grievances when they do not receive a satisfactory response. This reinforces the importance of ensuring our managers are confident and capable in handling concerns at a local level, and of managing expectations. The Listen Up module plays a vital role in this, and the absence of current data means that we are unable to provide assurance to the Board on progress in this area.

We will continue to work with relevant departments to resolve the data access issues and ensure a full picture is presented in future updates. In the meantime, we urge continued prioritisation of Speak Up and Listen Up training across all levels of the organisation as a means of improving our culture and safeguarding both staff wellbeing and patient care.

5. FTSU data

FTSU Numbers – 23/24 – 24/25

	23-24 Total	23-24 - Anon	23-24-Detriment	24-25 Total	24-25 - Anon	24-25-Detriment
Apr	14	5	5	36	6	5
May	15	4	7	23	3	2
Jun	17	2	8	31	3	3
Jul	17	3	10	27	4	2
Aug	22	2	11	15	3	3
Sep	12	1	3	13	4	0
Oct	22	5	4	41	19	1
Nov	26	3	11	42	5	2
Dec	14	1	6	16	4	1
Jan	16	2	0	26	3	2
Feb	24	4	7	12	5	2
Mar	29	1	8	15	3	1
Total	228	33 (14.47%)	80 (35%)	297	62 (20.88%)	24 (8%)

In the financial year 2023/24, a total of 228 concerns were raised through the FTSU service. This increased to 297 concerns in 2024/25. This upward trend may be interpreted as a positive indicator that staff feel increasingly empowered to speak up, and a growing belief that speaking up leads to positive change. It reflects the ongoing efforts to promote the FTSU agenda and improve the visibility, credibility, and accessibility of the FTSU Guardian roles. It may also indicate the increased confidence of the expanded team, as two full time Deputy FTSU Guardians were appointed on a year fixed term contract in Oct/Nov 2022, made substantive in Oct/Nov 2023.

While the significant reduction in reported detriment – from 80 cases in 2023/24 to 24 in 2024/25 – is an encouraging indicator of progress, it is important to view this trend within a broader context. During the same period, there has been a marked increase in anonymous reporting, rising from 33 to 62 cases. This shift suggests that more staff may be choosing to speak up anonymously to protect their identity, potentially due to ongoing concerns about repercussions. Naturally, where concerns are raised anonymously, the likelihood of detriment being reported also decreases, as staff are less easily identifiable.

Therefore, while the fall in detriment is welcome, we must remain cautious in interpreting this solely as a sign of cultural improvement. It remains essential to continue fostering a psychologically safe environment where staff feel confident to raise concerns openly, knowing they will be supported and protected from any form of discrimination.

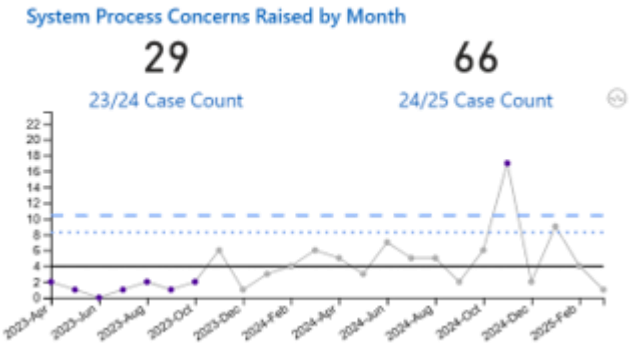
6. Most commonly occurring themes, national classifications & trends 24/25:

- Worker safety wellbeing
- System process
- Relationship & Behaviours

Worker safety and wellbeing concerns increased by 37.5% during 24/25. This may highlight a growing focus from staff on their physical, psychological, and emotional safety at work, but may also signal that more colleagues are experiencing challenges in this area that they feel require attention.

The upward trend reinforces the critical importance of establishing a wellbeing strategy that is grounded in lived experience, supports self-care and is attuned to the nature of our service. As pressures across the service continue, it is vital that we maintain accessible support pathways, actively listen to staff concerns, and ensure that wellbeing remains a visible and embedded component of our organisational culture. Addressing these concerns proactively also supports our broader ambition of becoming an employer of choice, where people feel safe, valued, and supported.

In the 24/25 data, concerns raised relating to **System Process** doubled from the previous year. These are concerns raised that relate specifically to staff experience with Employee Relations (HR) and formal processes, some examples of these may include difficulty accessing support, timely responses and perceived bias.



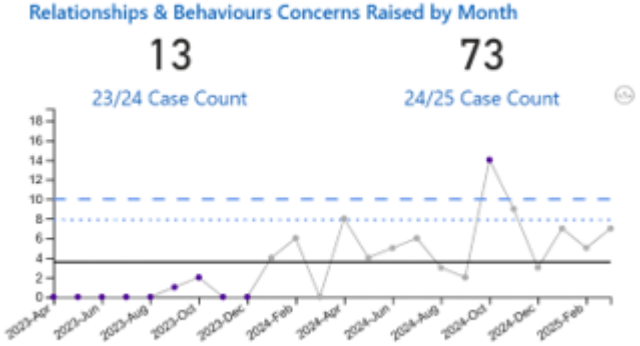
Improvements required in this area are reflected in the People Directorate Improvement Pan, and the proposed changes to the structures and teams within HR focused on divisional roles enabling greater local expertise, support, visibility and accountability.

The theme of **Relationship and Behaviours** has seen a notable increase in 2024/25, rising from 13 cases in the previous year to 73 cases, an increase of 460%. This significant shift indicates a growing number of staff are experiencing challenges in interpersonal dynamics, including issues such as communication breakdowns, inappropriate behaviours, incivility, bullying, or perceived lack of respect and professionalism in the workplace.

Such concerns are often among the most personally impactful for staff and can have implications for team cohesion, psychological safety, and overall organisational culture. This rise may reflect both an increase in these behaviours and a greater willingness among staff to come forward, possibly due to improved visibility of the Safe in the Back, Sexual Safety and Driving Standards speaking up campaigns, and the Freedom to Speak Up function reinforcing that concerns will be and are being taken seriously.

Nevertheless, this trend highlights a need for organisational reflection and action. Tackling issues related to behaviours requires sustained commitment to fostering respectful, inclusive, and values-driven workplace cultures which is something that SECAMB is committed to improving. It is crucial that leaders at all levels are supported and accountable for setting the tone, modelling appropriate behaviour, and addressing issues promptly when they arise.

As part of our response, the FTSU team will continue to engage with leadership, HR, and OD colleagues to ensure that behavioural concerns are explored and that staff feel safe and supported when raising such issues.



7. Areas of note

Emergency operations Centre

Of the 297 concerns raised this year, 71 (23.91%) have been raised about Emergency Operations Centre (EOC). Notably, 19 (26.76%) of these were raised anonymously. To put this into proportion and offer a fair comparison between departments of different sizes, we have calculated a standardised concern rate (per 100 staff). This allows us to assess whether higher number of concerns in areas are proportionate to workforce size.

The general number of concerns raised across all of SECAmb is 6.46 per 100 staff, in the EOC this increases to 11.31 per 100 staff.

The main themes emerging from these concerns include Relationships and behaviours, System process, and worker safety/wellbeing. This feedback points to a clear need for ongoing efforts to address these issues and create a safer, more inclusive environment where EOC staff feel empowered to speak up without fear of reprisal. Strengthening our support for EOC teams has been a priority as we work to improve the overall speaking-up culture in this critical part of our organisation.

Operations

33 (11.11%) of the 297 concerns this year have been raised specifically by staff with concerns related to Operations, focusing primarily on the leadership within this area rather than on issues within individual Operating Units. Six (18.18%) of these were raised anonymously. Encouraging senior leadership within Operations to view speaking up not as a challenge, but as an opportunity for learning, improvement, and team development remains a key priority. It is essential that concerns raised by staff are seen as valuable insights that can inform positive change and strengthen trust in leadership.

To support this, the Freedom to Speak Up team is actively working with the newly appointed Divisional Directors to establish quarterly meetings as an opportunity to share regional data, explore emerging themes and key issues, and foster open, curious conversations around any barriers to speaking up. We are currently liaising with the Directors to schedule these meetings, with the aim of embedding a more reflective, proactive, and supportive approach to concerns raised within Operations.

8. FTSU Service User Feedback Summary

We have received 60 responses to our anonymous Freedom to Speak Up service user feedback form. Overall, feedback has been predominantly positive with 47 individuals **(78%)** reported being **very satisfied** with the support they received, and a further 6 **(10%)** indicating they were **satisfied**. Two respondents **(3%)** were **neither satisfied nor dissatisfied**, while 3 **(5%)** reported being **dissatisfied**, 1 **(2%) very dissatisfied**, and 1 selected other.

Some comments taken from responses to '**How satisfied were you with the Freedom to Speak Up Service?'**

> "I had a prompt response to my initial enquiry and meetings were arranged when convenient for me. I was kept informed of any updates after others had been spoken to and feedback was given. Although on this occasion my concern has not been fully resolved I have been

assured that processes are in place to deal with the matter and that I can reopen my concern if I feel nothing has been done in a few months time."

"My issue was dealt with promptly and in a professional manner. I feel I confide in this service again if I need to."

"Worsening the situation"

"I found the whole process to be very professional, reassuring and made me feel comfortable with having the courage to speak up. I cannot thank the team enough."

When asked whether, given their experience, they would speak up again, **90%** of respondents said **yes**, with only **5%** indicating **no**, and **5%** selecting **prefer not to say**.

Some examples responses taken from response to **'Given your experience, would you speak up again?'**

"Given me confidence to be open with in the work place and talk out about inappropriate behaviours"

"I felt heard, understood and generally having someone to talk through it helped a lot."

"Positive experience - although overall may not get desired outcome from concern raised, FTSU did everything they could and support throughout."

"I would probably go to unions first FTSU made me feel listened to but only superficially."

In response to whether their concern was satisfactorily resolved, **65%** of respondents said **yes**. However, **12%** felt their concern had **not been satisfactorily resolved**, and **15%** respondents chose **prefer not to say.**

Some examples responses taken from response to **'Do you feel like your concern was satisfactorily resolved?'**

"Not resolved but processes are being put into place to resolve the issues trust wide , which is all I wanted . Rome wasn't built in a day"

"Although my issue wasn't resolved, that was not because of FTSU"

"I received a reply from HR within 24hrs when I have been waiting over 6 months from my personal enquiry"

"Yes I felt that the outcome was acceptable."

Demographic Insights – Potential Barriers to Speaking Up

The demographic data from our recent FTSU user feedback provides a valuable lens through which to examine who is engaging with the service – and, importantly, who may not be. While the overall profile suggests positive engagement across a range of roles and backgrounds, some patterns indicate areas where further reflection or action may be required to ensure equity of access and support.

The gender split among respondents (58% female, 37% male) appears broadly representative of the workforce profile in many NHS services. Only one respondent selected "other" and two preferred not to say, which may suggest that colleagues with gender identities outside the binary may not feel fully comfortable or visible in raising concerns. While this number is small, it points to the importance of maintaining inclusive language and visible allyship within the FTSU function.

Approximately 35% of respondents reported that their day-to-day activities are limited due to a long-term health condition or disability, with 9 indicating they are affected "a lot". This is a significant proportion and may suggest that colleagues living with health challenges are more likely to experience workplace issues that lead them to speak up. It also raises questions around whether those with more significant health-related barriers find it more necessary, or potentially more difficult – to access support, highlighting the need for accessible, flexible speaking up channels.

The vast majority of respondents identified as White British (80%). While this may reflect the wider demographic of the workforce, it may also indicate that colleagues from minority ethnic backgrounds are underrepresented among those using the FTSU service. This warrants consideration, as national evidence has shown that staff from ethnically diverse backgrounds may face greater barriers to speaking up due to fear of victimisation, lack of confidence in outcomes, or previous negative experiences.

Although 47 respondents identified as heterosexual, 7 individuals identified as lesbian, gay, bisexual, or another minority sexual orientation, with a further 6 choosing not to disclose. While this indicates some level of trust and openness, the relatively high "prefer not to say" response suggests ongoing concerns around privacy and psychological safety for LGBTQ+ staff. Visibility and reassurance around confidentiality and support remain essential.

Responses were received from a broad age range, with a strong representation from those aged 35–54. However, relatively few responses came from those aged under 25 or over 65. This may suggest either lower awareness or a different level of perceived risk or confidence in speaking up among younger and older staff groups. Tailored messaging or outreach may be beneficial to ensure those at both ends of the age spectrum feel equally empowered to raise concerns.

9. Conclusion

The reduction in detriment cases, rise in satisfactorily resolved concerns, and sustained improvement in FTSU-related Staff Survey results all point to a positive cultural shift underpinned by trust, psychological safety, and early intervention.

Whilst acknowledging these encouraging developments, we recognise that challenges remain. The marked increase in anonymous reporting and the rise in concerns relating to behaviours, interpersonal dynamics, and wellbeing, particularly within the Emergency Operations Centre and Operations, highlight areas where further targeted effort is required. These themes reinforce the importance of sustained investment in local level listening and response mechanisms.

As we continue to embed the principles of openness and learning across the organisation, initiatives such as listening events, learning reviews, and planned engagement sessions with Divisional teams are key. These steps, along with the exploration of new technologies to

support safe and effective anonymous reporting, and a continued focus on detriment will help to strengthen our collective response and ensure all staff feel heard and valued.

The increase in case numbers, along with growing staff confidence, suggests we are building a culture where speaking up is increasingly seen as a route to positive change.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board June 2025

Data up to and including April 2025

April 2025 data – presented June 2025

What

The IQR has been refreshed this month to align to our 2025/26 Board Assurance Framework priorities and to refine the focus of metrics for Board committees enabling oversight and triangulation through the Board discussion. The refreshed report and process will be reviewed and improved through the next 6 months.

The Trust finished 2024/25 with strong operational, clinical and financial performance, and remains in a robust position through April. Changes to dispatch through the Local Community Dispatch Model have supported improved incident cycle time and staff experience, and a C2 mean of 25:02 was achieved, supported by relatively strong resourcing and stable demand in April. Handover times are in seasonal variation and call answering has exceeded target at 1second with a good staffing position in call handling. Achieving our H&T trajectory remains challenging as the rate is increasing but not on target; an increase in S&C rate alongside the greater H&T rate has been observed. This is expected, but will be reviewed to ensure appropriate, as the use of alternatives to ED is still limited. We continue to deliver improving cardiac outcomes and good patient safety and Health & Safety indicators, with the first PSIRF reviews completed this month. There is an improvement in MAST and Appraisal driven by focus from HR and managers, while turnover continues in improving trend and our employee relations position is stable.

So What

Although performance was good, the spring and summer period needs greater focus on responsiveness to enable a 25min average C2 mean across the year to be achieved. Clinical training of B6 paramedics to contribute to H&T rate, greater clinical call handling productivity, and further work with system partners on alternative pathways and handovers is also in train and will be needed to impact on the overall position.

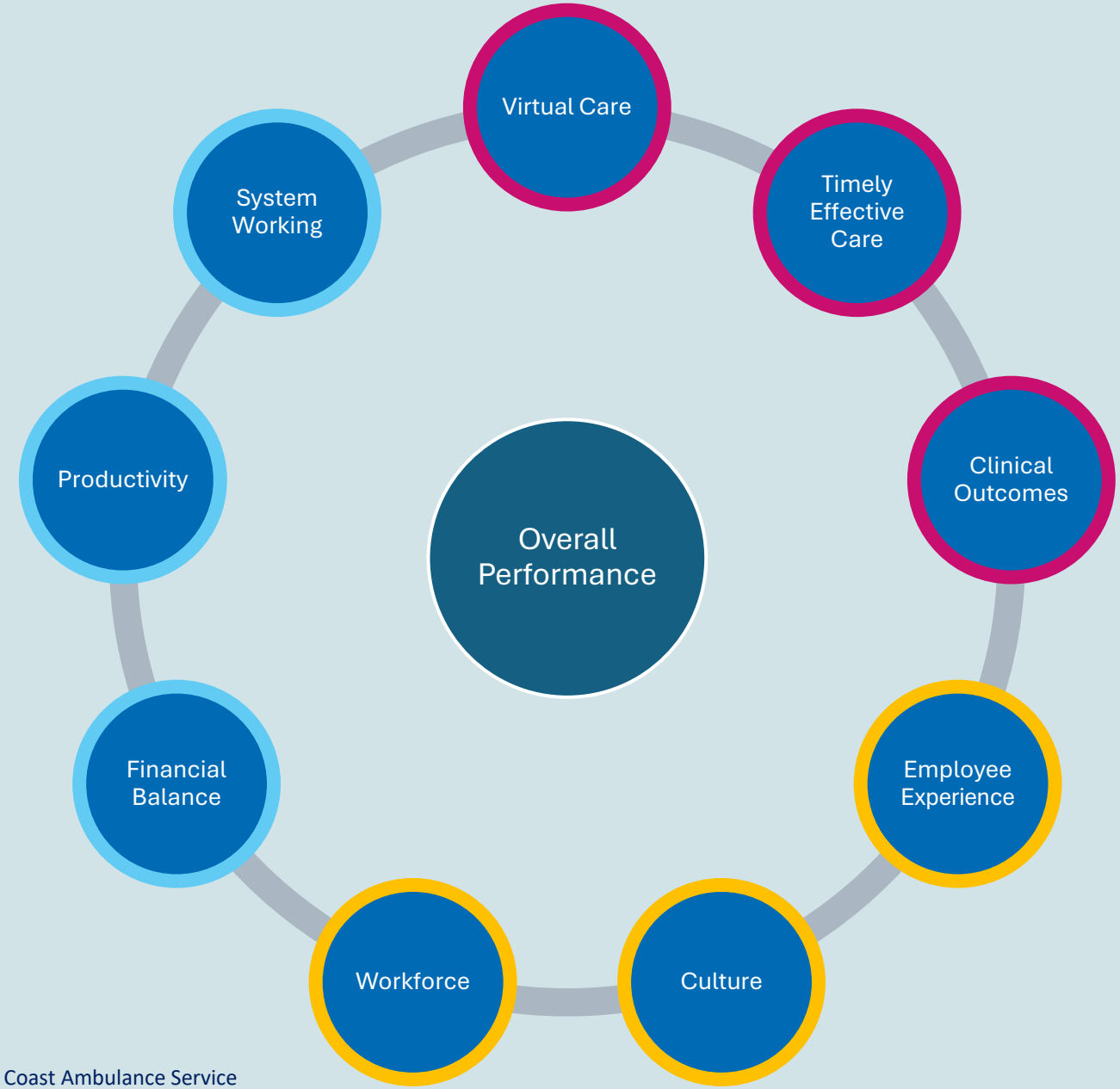
Clinical indicators are strong and will be enhanced by our focus on three particular models of care, including Falls which is now being monitored as a Board metric. We will continue to embed PSIRF to support a learning culture and to use QI to make improvements, and embed enhanced quality governance from floor to Board, as well as working through our aligned Virtual Care and Models of Care programmes.

The divisional clinical operating model is now being implemented supporting local autonomy and focus and enhancing integration of clinical, operational and corporate leadership teams. Following our improved Staff survey results, local processes to continue to embed change and target hotspot areas have been put in place, while SMG is undertaking work on sickness rates and abstractions. The corporate restructure is moving towards completion and will offer greater resource for employee relations support, which is needed to address case numbers, length of time to resolve cases, and continued high levels of suspension days in the Trust.

What Next

Further focus on our productivity programme will be needed to ensure that the planned improvements to care delivery are made as soon as possible so the impact on performance, particularly the C2 mean, is achieved. Similarly, the efficiency programme will be a key area to ensure that we meet our financial plan throughout the year. We will review delivery of efficiency and productivity on a quarterly basis with the next Executive check and challenge in July 2025.

Our ongoing work to improve employee experience and culture will continue through collaboration with staff, unions and the corporate restructure, and with the integrated divisional leadership teams supporting improvement in appraisal, clinical supervision, Speaking Up and MAST. We will also be developing more resilience metrics incl. EPRR and Cyber elements and moving forward looking to bring an organisational resilience framing to our understanding of performance.



BAF outcomes 25/26

- Category 2 Mean <25 minutes average for the full year
- Call Answer 5 seconds average for the full year
- Hear & Treat 18% average for 25/26 / 19.7% by the end of Q4
- Cardiac Arrest outcomes: Improve survival to 11.5%
- Internal productivity:
  - Reduce the volume of unnecessary calls from our highest calling Nursing/Residential Homes
  - Job cycle time (JCT)
  - Responses per incident (RPI)

- Improve staff reporting they feel safer in speaking up: statistically improved from 54% (23/24 survey)
- Our staff recommend SECAmb as a place to work: statistically improved from 44% (23/24 survey)
- 85% appraisal completion rate
- Reduce sickness absence to 5.8%
- Resolve ER cases more quickly to reduce the formal caseload over time, even as new cases are opened

- Deliver a financial plan
- Handover delay mean of 18 minutes
- Increase Urgent Community Response (UCR) acceptance rate of 60-80%
- Reduce Vehicle Off Road rate (VOR): 11-12%
- Achieve over 90% compliance for Make Ready

What we will deliver in 2025/26

We deliver high quality patient care

- Deliver an average Cat 2 mean response time of 25 mins and 999 call-answer of 5 secs
- Increase clinical triage of Cat 2-5 calls, delivering Hear & Treat of 19.7% by Mar 26
- 3 Focus Models of Care:
  - Palliative and EOL Care
  - Reversible Cardiac Arrest – increase survival to 11.5%
  - Falls, frailty and older people – reduce vehicle dispatch to fallers by 10% using more CFRs
- Deliver improved clinical productivity using QI (Eq. to 4mins C2 mean)
- Overhaul our oversight framework for quality of care aligned to our new divisional model, including station accreditation programme

Our people enjoy working at SECAmb

- Completion of our organisational re-design to deliver empowered Divisions
- Improve our People Services enabling effective support for our staff and enhanced ER resolution timelines
- Publication of our workforce plan in alignment with our clinical models of care
- Implement Wellbeing Strategy
- Launch of our first ever Shadow Board
- Expansion of the role of our volunteers

We are a sustainable partner as part of an integrated NHS

- Safely deliver our financial breakeven plan, including our efficiencies of £10m
- Work in partnership with the systems to deliver productivity improvements (Eq. to 2mins C2 mean)
- Develop a Business Case and roadmap for collaborating more closely with SCAS
- Publish a strategic estates plan that supports our development for the next 5 years
- Improve the quality and integration of our data systems to improve efficiency, productivity and outcomes
- Deliver vehicle replacement, >90 new MAN DCAs to be deliver in-year

Icon Descriptions

Integrated Quality Report

	P	?	F	
	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.

South East Coast Ambulance Service
NHS Foundation Trust

Quality Patient Care

The Trust's Quality Patient Care Board and supporting metrics demonstrate overall stability and consistency, with most indicators showing normal variation, though a consistent decline in NHS Pathways clinical audit compliance has been noted over recent months. There are numerous activities in place to both understand and address this as outlined on slide 14.

28 patients survived an out of hospital cardiac arrest in December 2024. All cause survival of out of hospital cardiac arrest is reported at 10% for the month of January, which is broadly consistent with the autumn and winter period. This is below our target level, and the Cardiac Arrest Outcome Improvement Group are reviewing data to identify actionable improvement opportunities. Return of spontaneous circulation rates remain strong and stable, as does our Utstein survival rate at 36.4%. In other areas of cardiac care, STEMI care bundle delivery has improved significantly to 86.4%, supporting improved outcomes and reduced mortality in this patient group.

Our PGD training compliance is at 96.1% and beginning to achieve stability at this high level of compliance.

The Trust has recently changed its approach to vehicle deep cleaning to streamline the Make Ready process following a QIA, aligned to and in discussion with AACE and the national IPC teams, and has included Specialist operations teams in medications auditing, necessitating a change to reporting.

We deliver high quality patient care

1	Tier 1
2	Tier 2
	QI
	Directorate objective

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

2025/26 – Strategic Transformation Plan

- ❑ Models of Care 1
  - 3 Focus Models of Care (Reversible Cardiac Arrest, Palliative and End of Life Care, Falls, Frailty and Older People) to be delivered within 25/26
  - Produce a three-year delivery plan for the 11 Models of Care
- ❑ Delivering Improved Virtual Care / Integration 1
  - Evaluation to inform future scope of virtual care commences April 2025
  - Design future model to inform Virtual Care, including integration of 111/PC
  - Establish commissioning implications of evaluation outcomes and inform multi-year commissioning framework

2025/26 Outcomes

- ❑ C2 Mean <25 mins average for the full year
- ❑ Call Answer 5 secs average for the full year
- ❑ H&T Average for 25/26 of 18% / 19.4% by end of Q4
- ❑ Cardiac Arrest outcomes – improve survival to 11.5%
- ❑ Internal productivity
  - ❑ Reduce the volume of unnecessary calls from our highest calling Nursing/Residential Homes by 1%
  - ❑ Job Cycle Time (JCT)
  - ❑ Resources Per Incident (RPI)

2025/26 – Operating Plan

- ❑ Operational Performance Plan – continuous monitoring through the IQR
- ❑ Set out Health Inequalities objectives for 2025-2027 by Q3
- ❑ Develop Quality Assurance Blueprint, including design of station accreditation complete by Q4
- ❑ Deliver our three Quality Account priorities by Q4
- ❑ Patient Monitoring replacement scheme by Q4 & design future model for replacements 2
- ❑ Deliver improved clinical productivity through our QI priorities by Q4
  - IFTs
  - EOC Clinical Audit

Compliance

- ❑ EPRR assurance
- ❑ Medicines Management & Controlled Drugs
- ❑ PSIRF Compliance to standards

BAF Risks

- ❑ **Delivery of our Trust Strategy:** There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.
- ❑ **Internal Productivity Improvements:** There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability.

NHS South East Coast Ambulance Service NHS Foundation Trust

Quality Patient Care Overview

Integrated Quality Report

Variation

Special Cause Improvement			Common Cause		Special Cause Concern			
11%	9%		72%		2%	2%		
5	4		34		1	1		

Assurance

Pass	Hit and Miss	Fail	No Target
2%	32%	21%	45%
1	15	10	21

Clinical Effectiveness & Patient Outcomes

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	**Acute STEMI Care Bundle Outcome %	Jan-25	86.4%	64.7%	68%		
Board	**Cardiac Arrest - Post ROSC %	Jan-25	74.1%	76.8%	76.1%		
Board	**Cardiac ROSC ALL %	Jan-25	25.6%	23.8%	27.9%		
Board	**Cardiac ROSC Utstein %	Jan-25	58.8%	45.1%	52.9%		
Board	**Cardiac Survival ALL %	Jan-25	10%	9.6%	11%		
Board	**Cardiac Survival Utstein %	Jan-25	36.4%	25.6%	33.2%		
Board	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	Dec-23	02:41:00	02:22:00	02:33:30		
Board	Hear & Treat %	Apr-25	15.4%	16.5%	14%		
Board	See & Convey %	Apr-25	55.1%	55%	55.3%		
Board	See & Treat %	Apr-25	29.4%	35%	30.6%		
Supporting	Compliant NHS Pathways Audits (Clinical) %	Apr-25	88.2%	100%	82.9%		
Supporting	Compliant NHS Pathways Audits (EMA) %	Apr-25	80.5%	100%	81.3%		
Supporting	Required NHS Pathways Audits Completed (Clinical) %	Apr-25	101.6%	100%	102.1%		
Supporting	Required NHS Pathways Audits Completed (EMA) %	Apr-25	102.9%		102.9%		
Supporting	A&E Dispositions %	Apr-25	7.4%	9%	7.6%		
Supporting	PGD Compliance %	Apr-25	96.1%	95%	88.1%		

Response Times

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	111 Calls Answered in 60 Seconds %	Apr-25	73.7%	95%	59.3%		
Board	999 Call Answer Mean	Apr-25	00:00:02	00:00:05	00:00:10		
Board	999 Call Answer 90th Centile	Apr-25	00:00:01	00:00:10	00:00:27		
Board	Cat 1 Mean	Apr-25	00:07:56	00:07:00	00:08:24		
Board	Cat 1 90th Centile	Apr-25	00:14:38	00:15:00	00:15:26		
Board	Cat 2 Mean	Apr-25	00:25:01	00:30:00	00:28:26		
Board	Cat 2 90th Centile	Apr-25	00:50:31	00:40:00	00:57:53		
Supporting	Cat 3 90th Centile	Apr-25	03:27:31	02:00:00	04:59:32		
Supporting	Cat 4 90th Centile	Apr-25	03:29:09	03:00:00	05:32:31		
Supporting	HCP 3 90th Centile	Apr-25	03:28:38		04:40:24		
Supporting	HCP 3 Mean	Apr-25	01:32:04		02:05:04		
Supporting	HCP 4 90th Centile	Apr-25	05:15:05		06:32:33		
Supporting	HCP 4 Mean	Apr-25	02:01:40		02:44:47		
Supporting	Section 136 Mean Response Time	Apr-25	00:16:40		00:24:24		

Models of Care

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Falls Care Bundle Compliance %	Dec-24	44.2%		39.3%		
Board	% of 999 Calls from Nursing Homes	Apr-25	6.3%		6%		

Pending metric: EOLC - Needs to be defined

NHS South East Coast Ambulance Service NHS Foundation Trust

Quality Patient Care Overview

Integrated Quality Report

Variation

Special Cause Improvement			Common Cause		Special Cause Concern			
11%	9%		72%		2%	2%		
5	4		34		1	1		

Assurance

Pass	Hit and Miss	Fail	No Target
2%	32%	21%	45%
1	15	10	21

Productivity

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of 999 Calls Receiving Validation	Apr-25	21.1%		18.5%		
Board	CFR Backup Time (CFR First on Scene) Mean	Apr-25	00:16:20		00:19:10		
Board	Responses Per Incident	Apr-25	1.1	1.09	1.1		
Board	JCT Allocation to Clear at Hospital Mean	Apr-25	01:49:08		01:52:23		
Board	JCT Allocation to Clear at Scene Mean	Apr-25	01:16:51		01:17:26		
Board	JCT Allocation to Clear All Mean	Apr-25	01:35:31		01:37:32		

Demand

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	111 Calls Offered	Apr-25	98084		92484.6		
Supporting	999 Calls Answered	Apr-25	68673		74010.5		
Supporting	Incidents	Apr-25	64323		65053.1		

Patient Safety

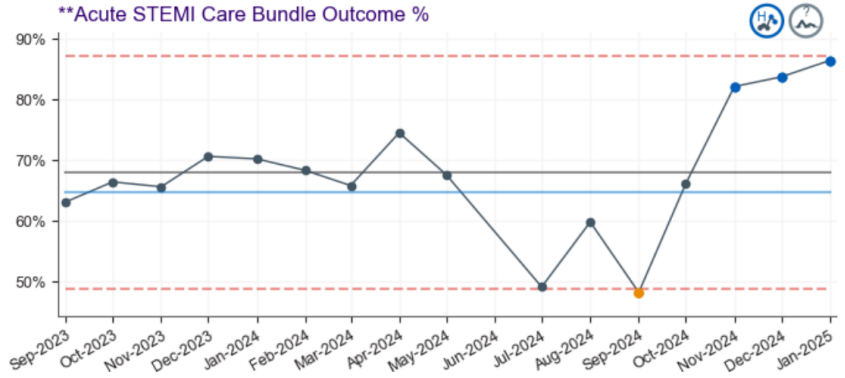
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	Duty of Candour Compliance %	Apr-25	66.6%	100%	90%		
Supporting	Harm Incidents per 1000 Incidents	Feb-25	3		3		
Supporting	Outstanding Actions Relating to SIs, Outside of Timescales	Apr-25	9		7.3		
Supporting	Number of Medicines Incidents	Apr-25	183		170.8		

Patient Experience

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	Complaints Reporting Timeliness %	Apr-25	88%	95%	93.6%		
Supporting	Number of Complaints	Apr-25	59		66.7		

Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Board Metrics

Integrated Quality Report



M-5

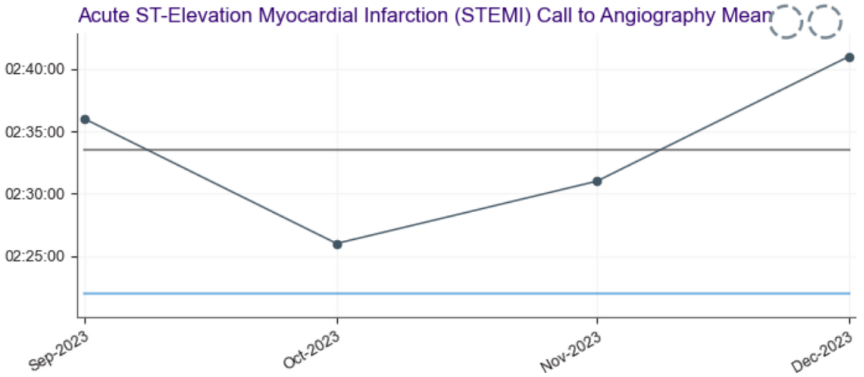
Dept: Medical

Metric Type: Board

Latest: 86.4%

Target: 64.7%

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



M-6

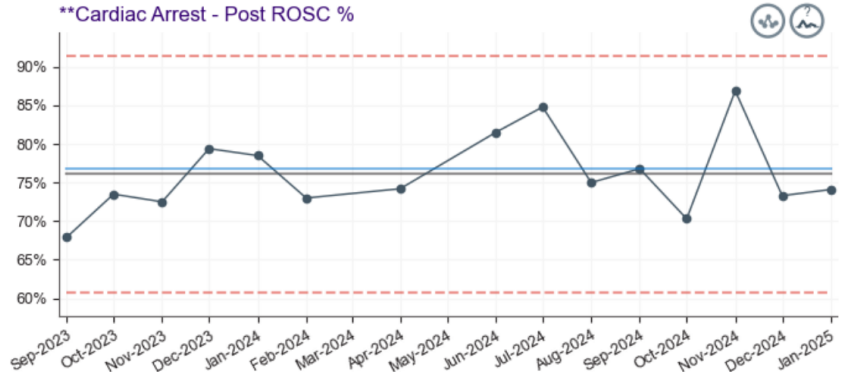
Dept: Medical

Metric Type: Board

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-11

Dept: Medical

Metric Type: Board

Latest: 74.1%

Target: 76.8%

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

Recent data shows a **significant improvement in Acute STEMI Care Bundle compliance**, now at **86.4%**, significantly above the **64.7%** target. This likely reflects strengthened processes around early ECG acquisition, prompt recognition of STEMI, and consistent delivery of pre-hospital interventions such as aspirin administration and direct conveyance to PCI centres. Clinically, this improvement supports better myocardial preservation and reduced mortality.

The **mean call-to-angiography time has risen to 2:41:00**, exceeding the **target of 2:22:00**. Though trend data is limited, potential contributing factors include delays in inter-hospital transfer, variable lab availability, or handover inefficiencies. These delays could negatively impact patient outcomes by prolonging ischaemic time. Addressing this will require closer coordination with receiving centres, review of bypass protocols, and real-time feedback mechanisms to crews on timeliness metrics. Increased dispatch of senior clinicians, such as Critical care paramedics (CCP), to active STEMI may also assist with reduced scene time.

Sustaining bundle compliance while reducing angiography delays should be a dual focus, as both are essential to achieving optimal STEMI outcomes.

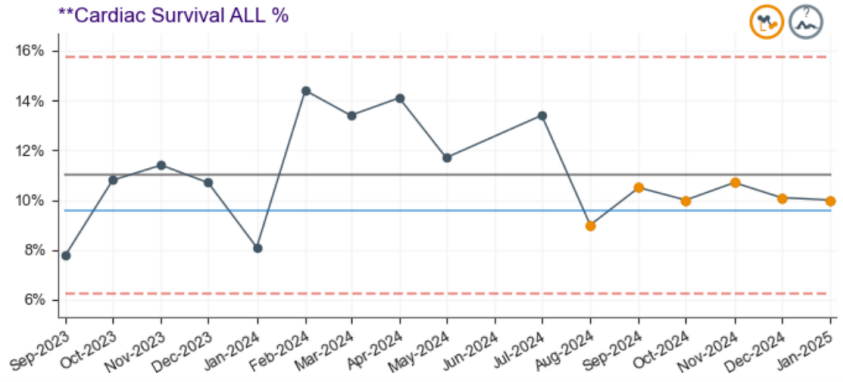
Current compliance with the Post-ROSC care bundle stands at **74.1%**, slightly below the **76.8%** target, with no significant trend of improvement over time. The bundle includes interventions such as 12-lead ECG, blood glucose monitoring, temperature management, and timely conveyance to specialist care.

It is important to note that **there is limited evidence to directly link compliance with this bundle to improved patient outcomes**. However, these elements align with recognised post-resuscitation care priorities, and consistent delivery may support neurological recovery and survival.

Internal data indicates that **bundle compliance is notably higher when a Critical Care Paramedic (CCP) is present on scene**, suggesting that senior clinical leadership can positively influence care delivery in complex, high-pressure scenarios. To improve performance, the service may benefit from enhanced training, simplification of documentation, and structured team debriefs following resuscitations.

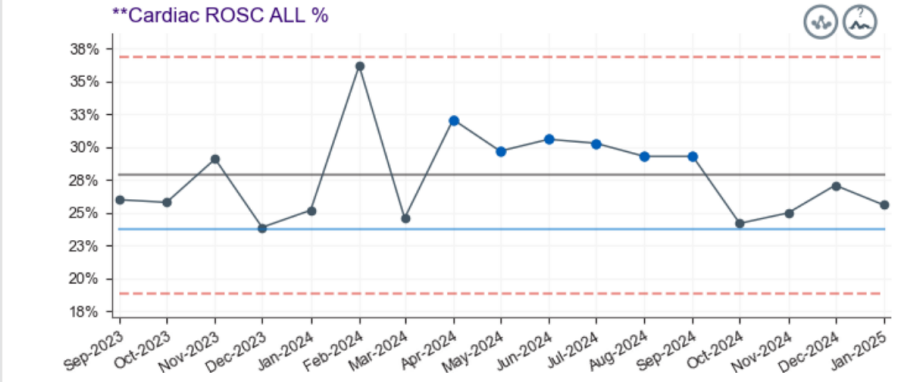
Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Board Metrics

Integrated Quality Report



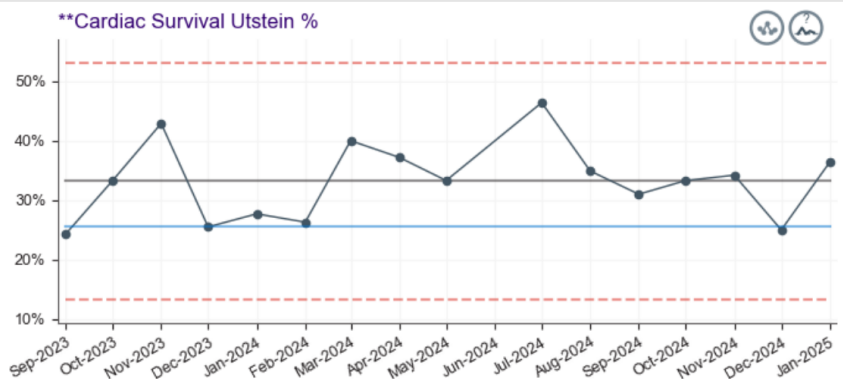
M-4

Dept: Medical
Metric Type: Board
Latest: 10%
Target: 9.6%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



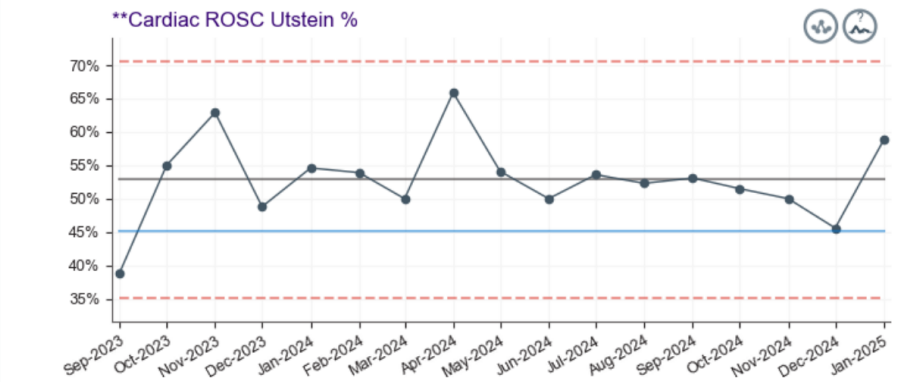
M-2

Dept: Medical
Metric Type: Board
Latest: 25.6%
Target: 23.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-3

Dept: Medical
Metric Type: Board
Latest: 36.4%
Target: 25.6%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-1

Dept: Medical
Metric Type: Board
Latest: 58.8%
Target: 45.1%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

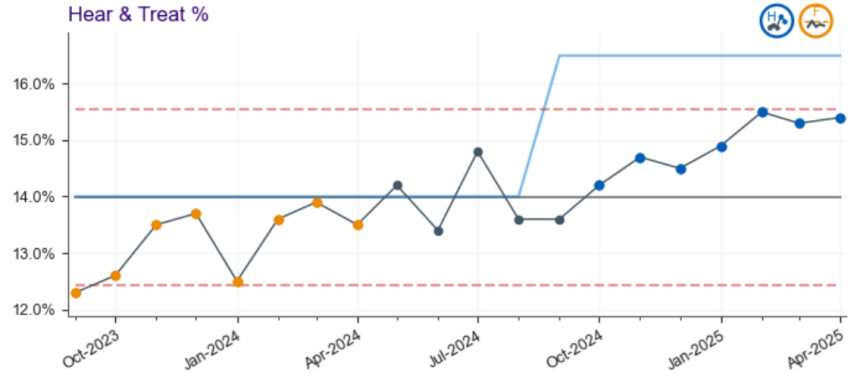
Return of Spontaneous Circulation (ROSC):
ROSC rates remain consistent. Overall ROSC (M-2) is 25.6%, just above the national average of **23.8%**, while Utstein ROSC (M-1) is **58.8%**, comfortably exceeding the national benchmark of **45.1%**. Both measures display **common cause variation**, indicating no significant change over time. These results suggest that pre-hospital resuscitation is being delivered effectively and in line with national performance, particularly for the Utstein group—typically those with the best chance of survival.

Survival to Discharge:
Overall survival from cardiac arrest (M-4) is reported at 10%, marginally above the national average of **9.8%** (Apr-Dec 24). However, the recent run of data points **consistently below the Trust's own average** suggests a **special cause concern** and a potential downward trend. This may reflect clinical or system factors occurring post-ROSC—such as variability in hospital-based care, delays in definitive interventions, or changes in patient acuity.
Utstein Survival (M-3) is **36.4%**, well above the **national average of 25.6%**, but shows no consistent upward or downward trend. This metric remains a reliable indicator of system performance in high-potential cases and underscores the continued value of early defibrillation and bystander CPR.

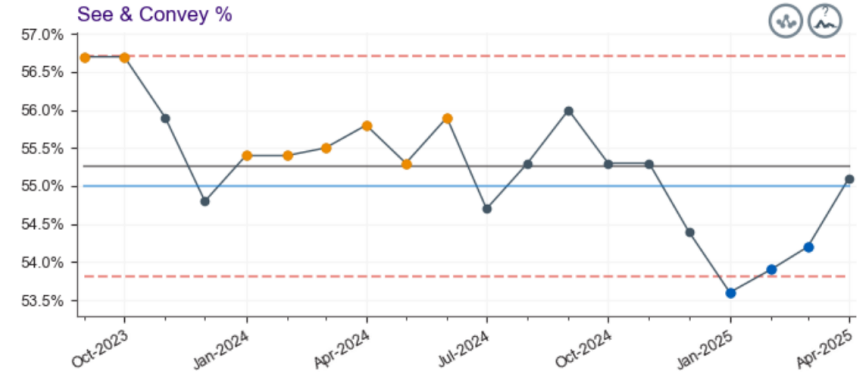
- The **disconnect between stable ROSC rates and a potential decline in survival** warrants further investigation. While hospital care is outside the Trust's direct control, there may be upstream factors—such as scene times, decision-making post-ROSC, or variation in handover quality—that can be optimised.
- The **Cardiac Arrest Outcome Improvement Group** will be pivotal in interpreting these trends, identifying contributory factors, and coordinating any pre-hospital changes that could positively influence patient outcomes.
- The continued strength in **Utstein survival** highlights effective recognition and response in high-potential arrests. Further focus on bystander engagement, rapid defibrillation, and reducing time to first shock will support sustained performance.

Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Board Metrics

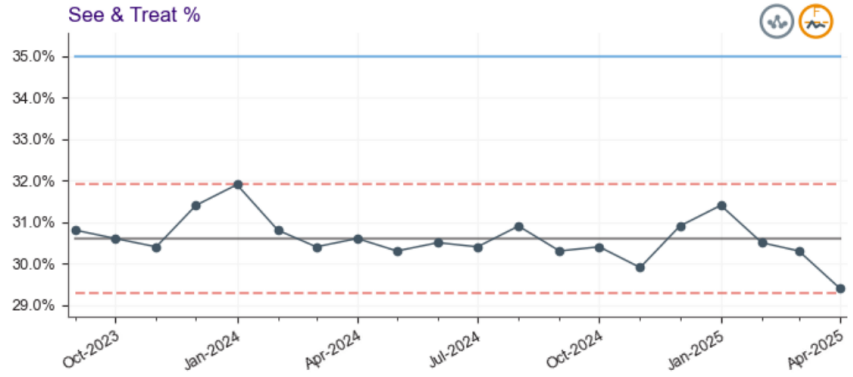
Integrated Quality Report



999-9
Dept: Operations 999
Metric Type: Board
Latest: 15.4%
Target: 16.5%
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.



999-9
Dept: Operations 999
Metric Type: Board
Latest: 55.1%
Target: 55%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-9
Dept: Operations 999
Metric Type: Board
Latest: 29.4%
Target: 35%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Although there is an underlying trend upwards with regards to the Trust's Hear & Treat, it is still behind the target trajectory for Q1 of 25/26. The Trust continues to use NHS E guidance to focus on key elements of virtual care, such as C3/C4 validation and C2 segmentation. There is real variability in Hear & Treat rates each day, ranging from 13.58% to 17.98% across April. Each day can have a different contributing factor to the higher levels such as case acuity, overall, Trust demand, virtual care clinician capacity etc. which adversely impacts the ability to deliver the target levels consistently.

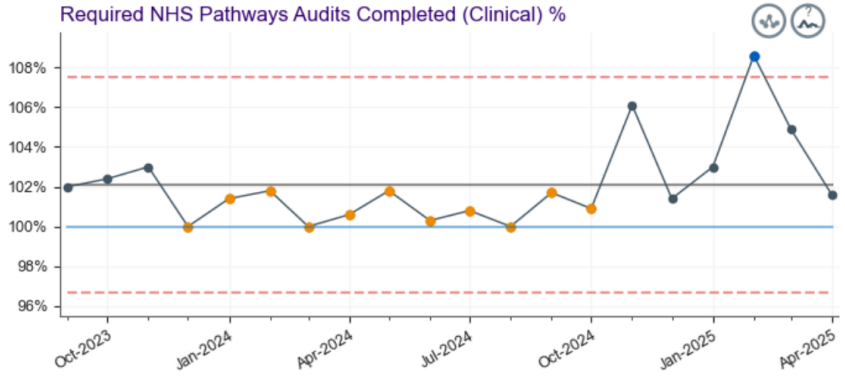
Current EOC substantive clinical staffing sits at 61% to achieve the 100% C3/C4 clinical validation. This reaffirms the importance of the next phase of training for the band 6 dual role Paramedics, which commenced with 13 of the 72 awaiting staff already trained and ready to start on the rota on 16th July 2025 (further 8 currently in training). With the pending start of the dual role working for our operational paramedics, a review of the daily operating model for this group of staff is urgently required which should then allow a timelier flow of patients through the system as efficiency is improved.

Following a declining picture of audit compliance in addition to issues with the audit process, the team are working closely with the EOC Practice Development team to review and change the dynamic including creating a new clinical audit tool for NHS Pathways (NHS P) auditing, following support from NHS E. This collaborative piece of work is supported by the QI team and is vital to ensure service safety and clinical effectiveness. The Virtual Care programme is the key vehicle for the Trust to ensure grip with regards to its key strategic goal of facilitating more virtual care and reducing See & Treat. A key component of this programme is focused on optimising alternative care pathways.

A recent UCNH review day brought together Urgent Care Response (UCR) teams from Kent localities where the opportunity was taken to push the UCR portal, which is vital to completing the full deployment of the UCR portal across the SECAmb areas and should see the first of the Kent providers live on the portal in Q1 of 25/26.

Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Supporting Metrics

Integrated Quality Report



M-23

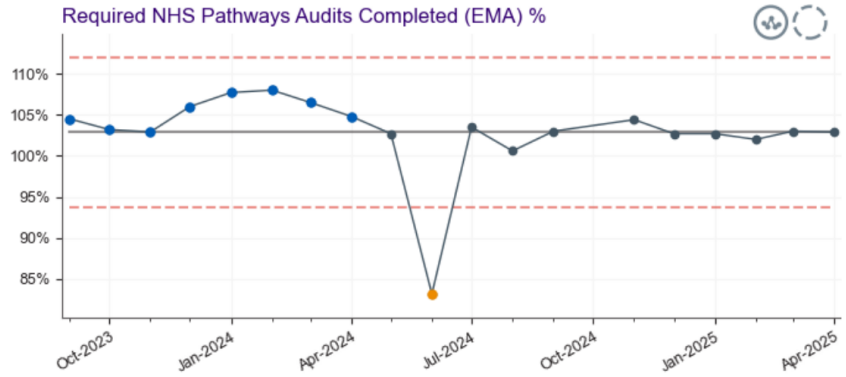
Dept: Medical

Metric Type: Supporting

Latest: 101.6%

Target: 100%

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



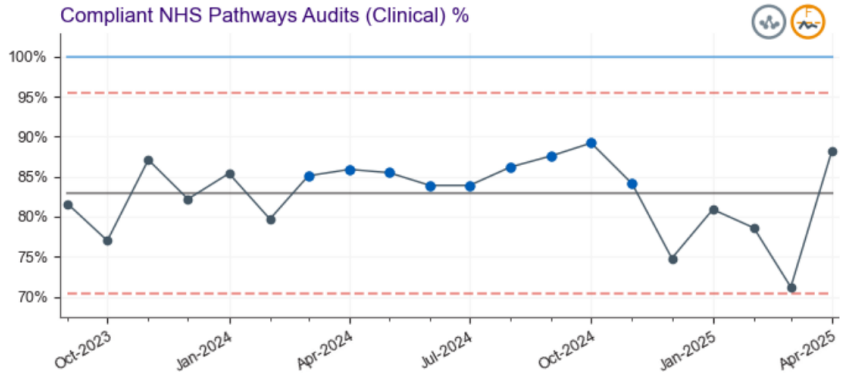
M-21

Dept: Medical

Metric Type: Supporting

Latest: 102.9%

Common cause variation, no significant change.



M-20

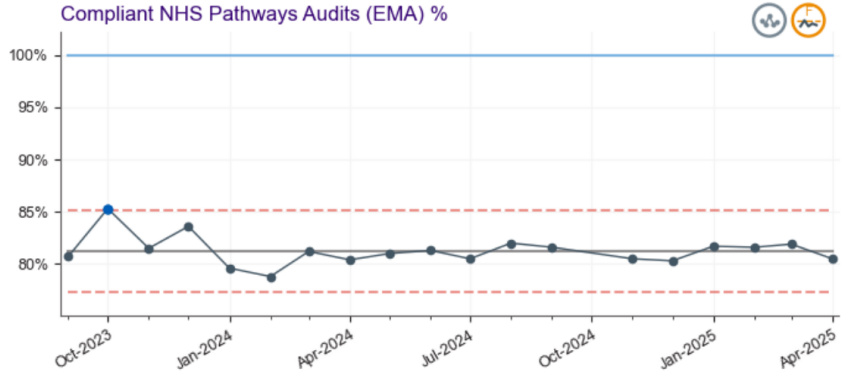
Dept: Medical

Metric Type: Supporting

Latest: 88.2%

Target: 100%

Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



M-22

Dept: Medical

Metric Type: Supporting

Latest: 80.5%

Target: 100%

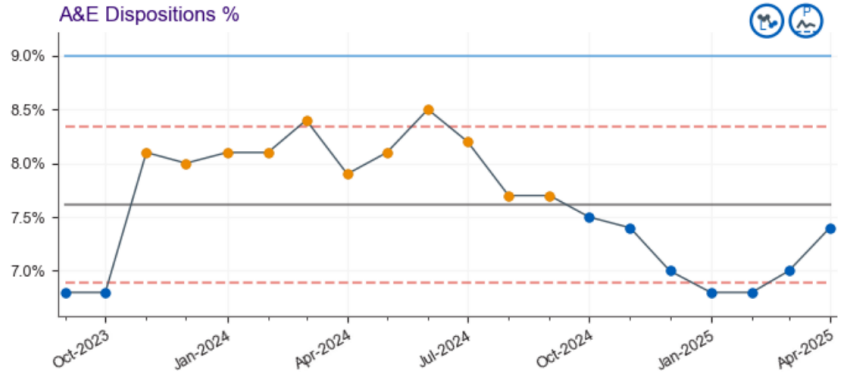
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Summary:

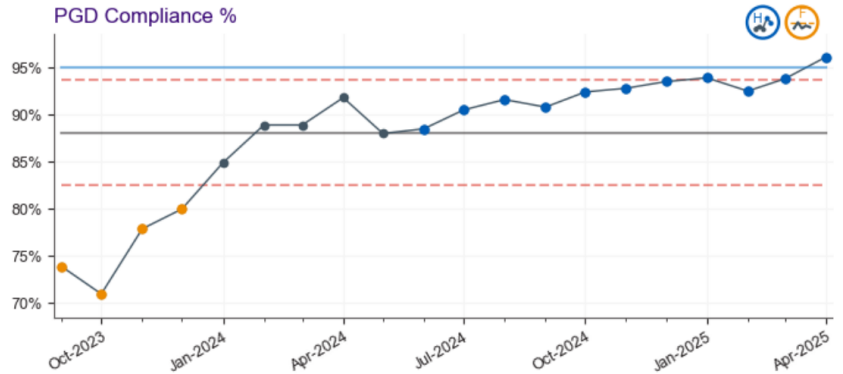
- NHSP 999 (clinical) audit activity continues as per plan with the target for 100% of audits each month being consistently achieved. Performance is within normal variation.
- This is replicated for EMA audit activity with activity also showing normal variation and the target of 100% being consistently achieved
- Any above target activity is as a result of additional audits retrospectively completed for investigation purposes.

Actions:

- An internal OD review has been undertaken to identify any human factor impacts adversely impacting compliancy and gaps identified.
- A culture review has also commenced.
- A collaborative piece of work is currently underway jointly with the EOC and EOC Practice Development management teams to review and revise the NHS Pathways Audit Tool for a trial period
- A QI Project to address the identified gaps/actions has commenced May 2025
- Training for EOC colleagues on 'how to give' and 'how to receive feedback' is underway
- Levelling training is continuing to be rolled out to EOC colleagues and a new tracker developed
- Dashboards in development to closely monitor teams' performance at staff level as well as teams' level



111-5
Dept: Operations 111
Metric Type: Supporting
Latest: 7.4%
Target: 9%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.



MM-8
Dept: Medicines Management
Metric Type: Supporting
Latest: 96.1%
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 Clinical Performance

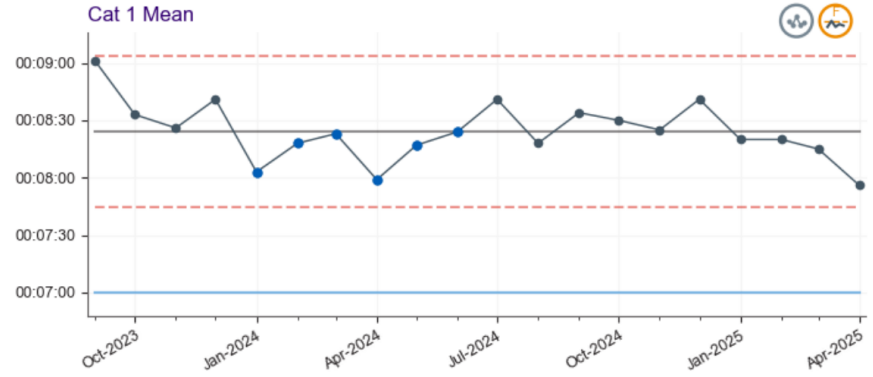
During April 2025, KMS 111 had an ambulance referral rate of 5.95% (4,863 ambulances sent of 81,669 triaged cases) and this was supported by a C3/C4 ambulance validation rate of 46.00%, with the service contracted to validate 50% of this activity.

Clinical assessment in the Clinical Assessment Service (CAS) of ED dispositions remains a key focus of the Trust. In April, 44.75% of all calls triaged were assessed by a clinician, in line with the NHS E national average.

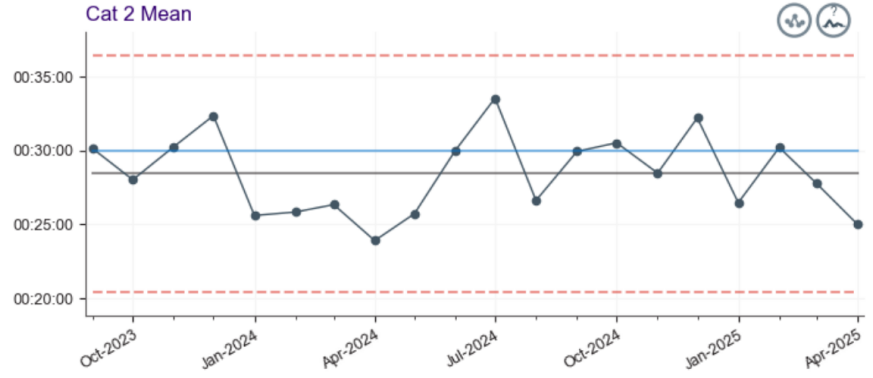
The proportion of total calls initially given an ED disposition that received remote clinical intervention was 44.01%, an increase from March and indicative of sustained clinical capacity. In addition, the proportion of cases identified by NHS E requiring clinical assessment via 111 First was 5,500, with 4,640 (84.4%) receiving a clinical intervention. These clinical interventions are vital in reducing unheralded demand to EDs and protecting the wider healthcare economy. Again, the Trust's 111 service delivered exceptional performance with regards to its ED referral rate, achieving 7.5% vs a target of 9%.

PGD compliance (MM-8)

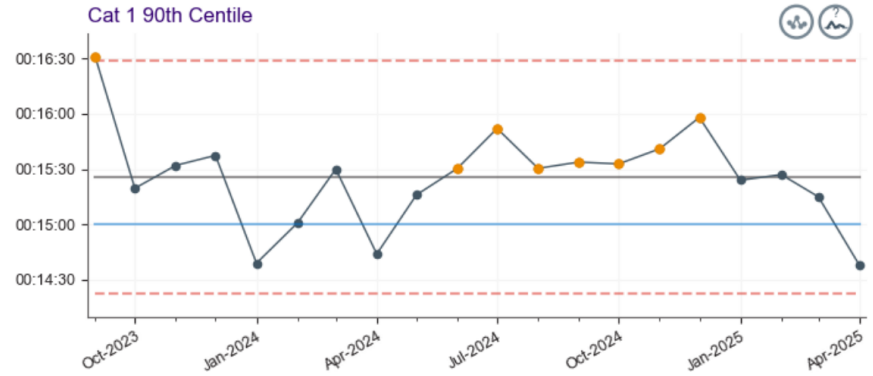
Significant work has been undertaken to understand staff roles and rationalise the groups of staff expected to undertake PGD competency assessments. This is reflected in the current compliance of 96.1% and is above target. Progress is expected to be maintained.



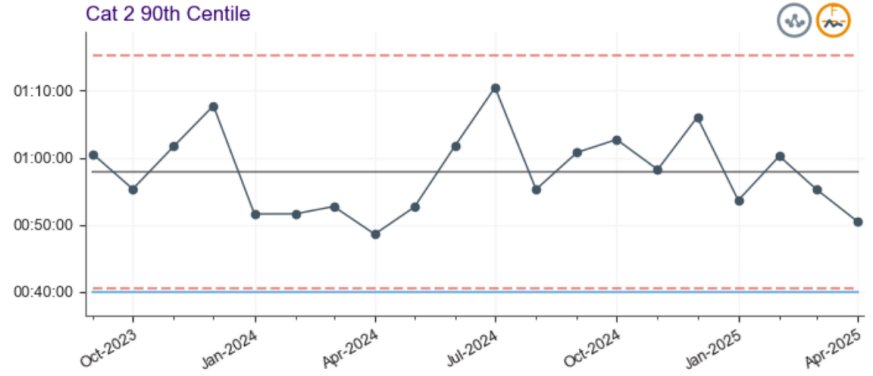
999-2
Dept: Operations 999
Metric Type: Board
Latest: 00:07:56
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
Metric Type: Board
Latest: 00:25:01
Target: 00:30:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-2
Dept: Operations 999
Metric Type: Board
Latest: 00:14:38
Target: 00:15:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-4
Dept: Operations 999
Metric Type: Board
Latest: 00:50:31
Target: 00:40:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

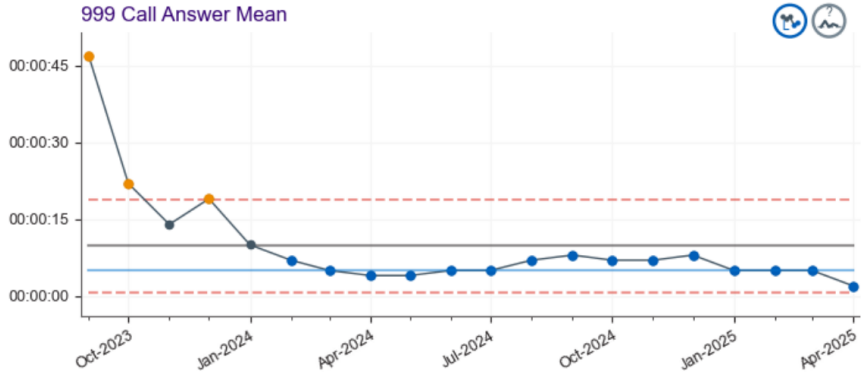
Cat 1 Performance

- For the year 2024/5 C1 performance was 8.24 seconds against an ARP target of 7 minutes

- C1 performance has continued to improve in 2025 and was 7.55 in April 2025
- Improved focus by CCD on C1 dispatch is showing improvement to RPI and no patient detriment.

Cat 2 Performance

- In February the C2 mean was 30.12 seconds due to demand, however, in March it was below the 30 minutes national target at 27:48 which was better than the NHSE average of 28:34 and the Trust was mid table in the national AQI benchmarking table.
- For the year 24/25, SECAmb achieved a C2 mean of 28:51min.
- In April performance continued to improve and the C2 mean was 25.02 seconds, this was achieved by providing the required hours on the road and a reduction in demand.
- We continue to focus on delivery of the C2 mean with all OUM's across Operations. with regular prospective reviews of hours available on the road, monitoring abstractions and improving sickness rates (both long and short term)



999-1

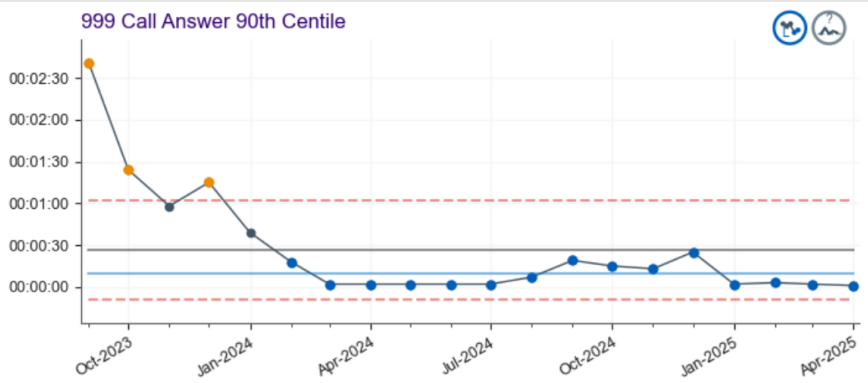
Dept: Operations 999

Metric Type: Board

Latest: 00:00:02

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.



999-1

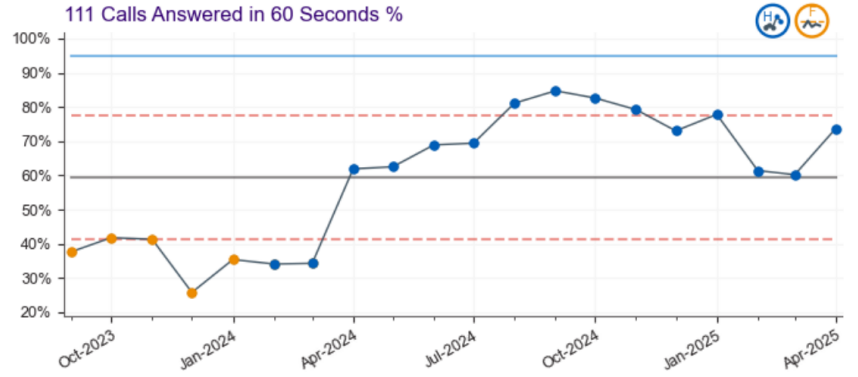
Dept: Operations 999

Metric Type: Board

Latest: 00:00:01

Target: 00:00:10

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



111-2

Dept: Operations 111

Metric Type: Board

Latest: 73.7%

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.

999 Call Handling Performance

Performance in April saw the Trust comfortably meet the AQI target of 5 secs, for the fourth consecutive month, with a mean call answer time of 2 secs.

Activity – Daily activity was down 4.7% vs. March, with an average 18.8K calls per week.

Despite some 999 still services struggling, Intelligent Routing Platform (IRP) call overflow across most ambulance services remains low, with few long waits necessitating calls diverting via IRP and the Trust accepting more calls to support other services, than "flowed out". NHS E has agreed to extend IRP until the end of Q1 25/26, and ambulance trusts are in dialogue with NHS E regarding IRP, via AACE.

Current staffing position - service currently has 278 WTE call handlers (inc. Diamond Pods) live on the phones vs. a budget of 265 WTE, with 15 further in training or mentoring. This training should offset staff turnover in Q1 and ensure good service performance is maintained.

Sickness in April remained stable at 8.5%, with abstractions overall at 27.2%, due to lower uptake of annual leave.

Looking ahead - the service experienced a fall in attrition last month and overtime will be reviewed and targeted where needed. The ongoing impact of the re-banding of ECSWs is being monitored; consequently, Emergency Medical Advisor (EMA) recruitment continues to be reviewed to align with current trends in attrition. The EOC operations rota review is now in place with further reviews ongoing. An updated EMA rota will be in place in May, with a dispatch relief rota pilot taking effect in June.

111 Call Handling Performance

Recruitment remains positive, with staffing levels now stable resulting in the number of NHS Pathways (NHS P) courses per month being reduced.

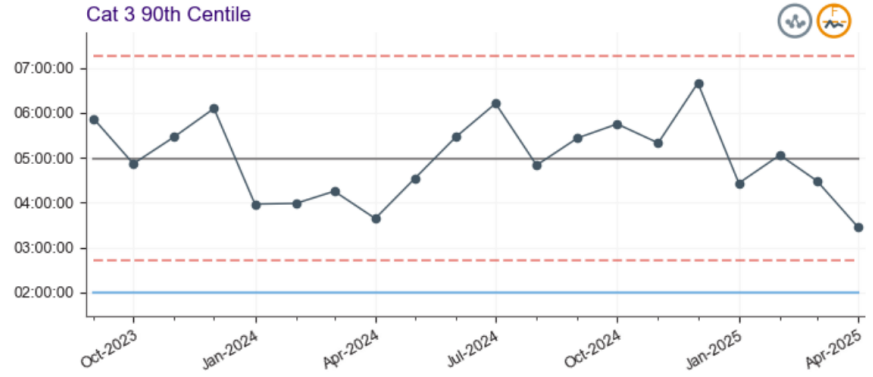
April total call handling staffing was 282 WTEs including 8 WTEs in training.

Recruitment remains strong, with improved retention linked to increased "Hybrid" flexible working. Currently more than 130 operations colleagues have a Hybrid 'kit'. A review of hybrid working and potentially extending this will take place in Q1 25/26, following the changes in operating model in May.

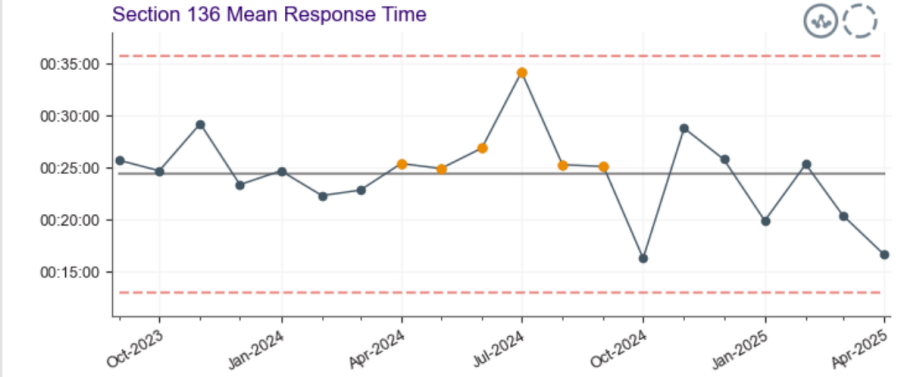
Following the successful embedding of psychometric testing, this is now being used in conjunction with newly designed face-to-face interviews to improve the calibre of NHS P trainees.

A risk remains with staff in training and requiring mentoring and coaching, this will adversely impact service delivery short term and potentially increase sickness and attrition. However, performance is on an improving trajectory and has been sustained throughout 24/25 and continues in quarter 1 of 25/26.

The service continues over-staffing its 111 call handlers, above that which it is funded for following the significant reduction in commissioner funding for 23/24, continuing into 24/25. The Trust will endeavour to address the funding shortfall though dialogue with commissioners when extending the current service, and through the Trust's efficiency programme and digital innovation.

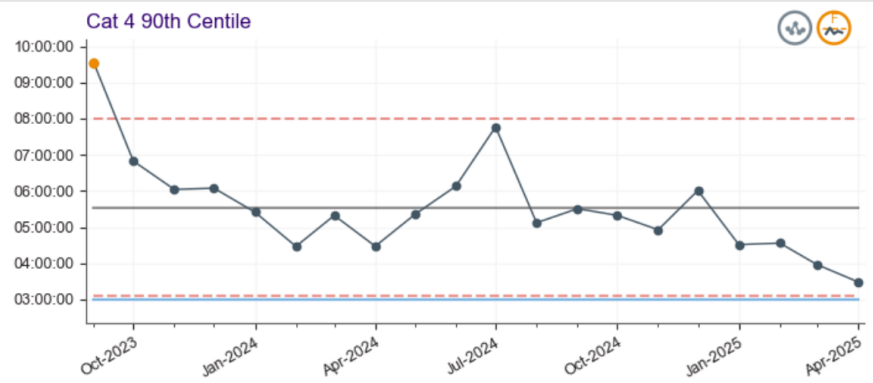


999-5
Dept: Operations 999
Metric Type: Supporting
Latest: 03:27:31
Target: 02:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-18
Dept: Operations 999
Metric Type: Supporting
Latest: 00:16:40

Common cause variation, no significant change.

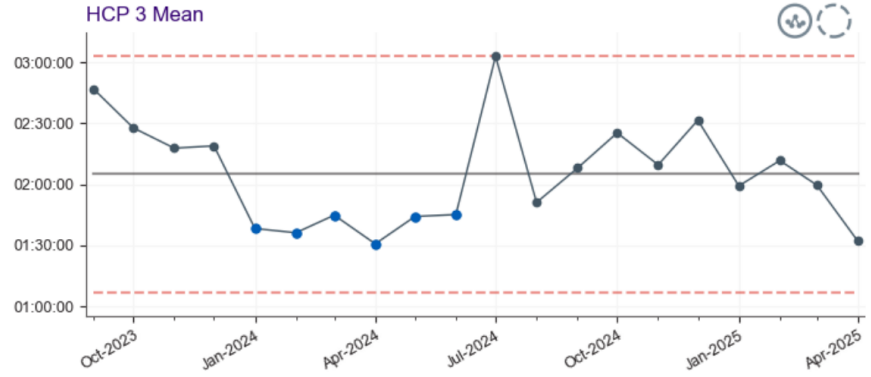


999-6
Dept: Operations 999
Metric Type: Supporting
Latest: 03:29:09
Target: 03:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

C3 response times continue to improve with the embedding of staff numbers and the local community dispatch model – there is still a long way to go to meet the national AQI standard and there are known dispatch delays due to all c3 and c4s going into validation, This can create increased response times, however the correlation and conversion to hear and treat from C3 and C4 is reliant on validation in a timely manner which collectively contact centres and field operations are working to improve process and timeliness.

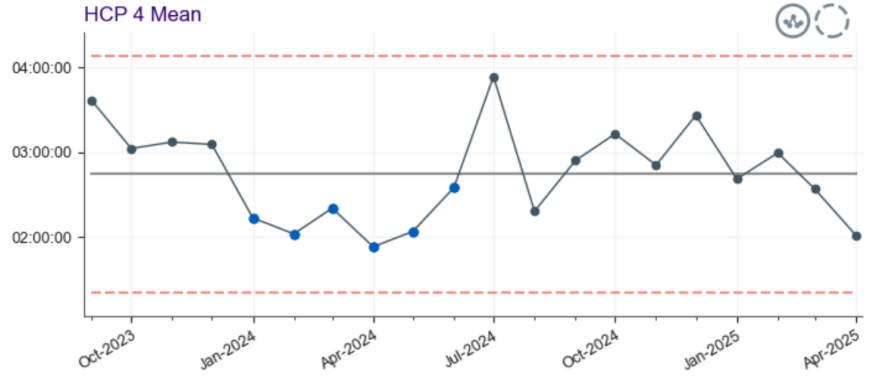
C4 response times (very low numbers of activity) remain challenged due to volume of C2 and C3s which are dispatched ahead of this call type. The risk to patients is low as categorised as non emergency response.

136 mean response time – shows no significant change – numbers are low and working in partnership with police to address nature of incident is ongoing through Right person right care programmes.



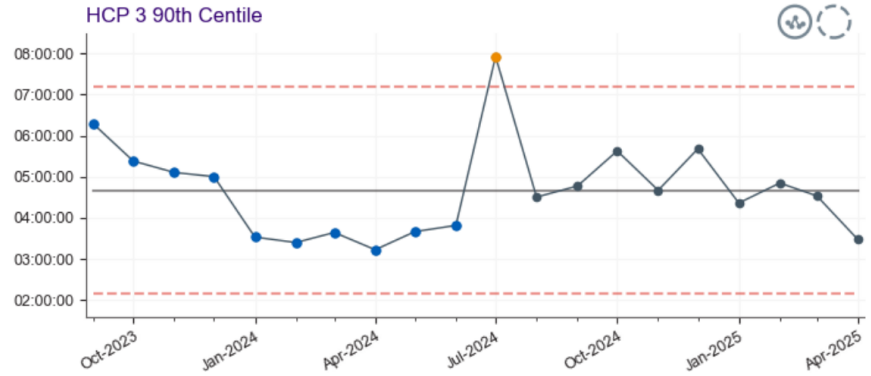
999-7
Dept: Operations 999
Metric Type: Supporting
Latest: 01:32:04

Common cause variation, no significant change.



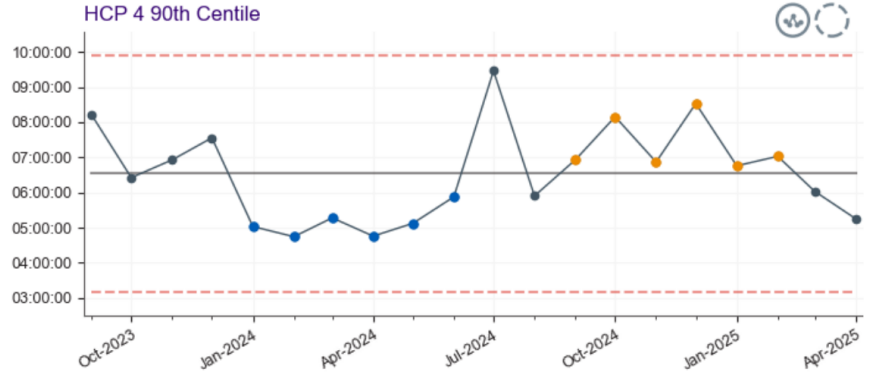
999-7
Dept: Operations 999
Metric Type: Supporting
Latest: 02:01:40

Common cause variation, no significant change.



999-7
Dept: Operations 999
Metric Type: Supporting
Latest: 03:28:38

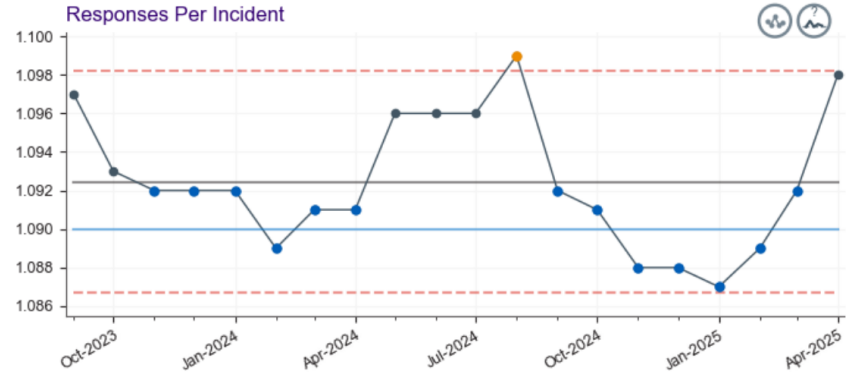
Common cause variation, no significant change.



999-7
Dept: Operations 999
Metric Type: Supporting
Latest: 05:15:05

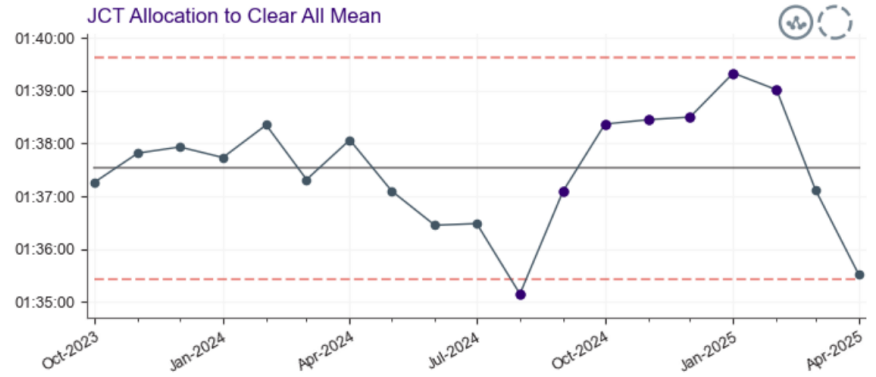
Common cause variation, no significant change.

HCP response times correlate to the provision of Urgent Transport vehicle (UTV) provision and the mean is within expected ranges. The 90th centile demonstrates that when unable to dispatch a UTV the work is dispatched on numerous times by 999 ambulances which get diverted to high acuity work. Recent changes to policy and focus on IFTs continues to keep focus and provide a downward trajectory.



999-17

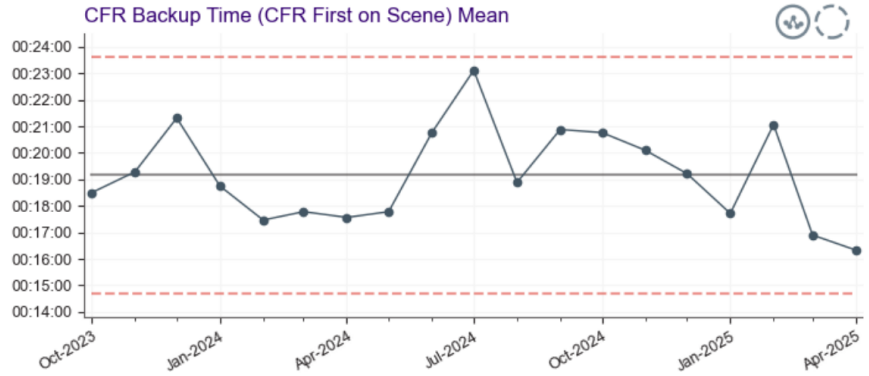
Dept: Operations 999
Metric Type: Board
Latest: 1.1
Target: 1.09
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-44

Dept: Operations 999
Metric Type: Board
Latest: 01:35:31

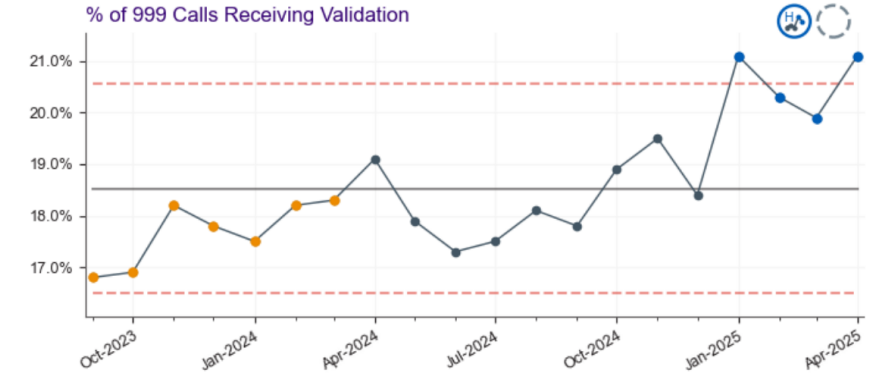
Common cause variation, no significant change.



999-36

Dept: Operations 999
Metric Type: Board
Latest: 00:16:20

Common cause variation, no significant change.



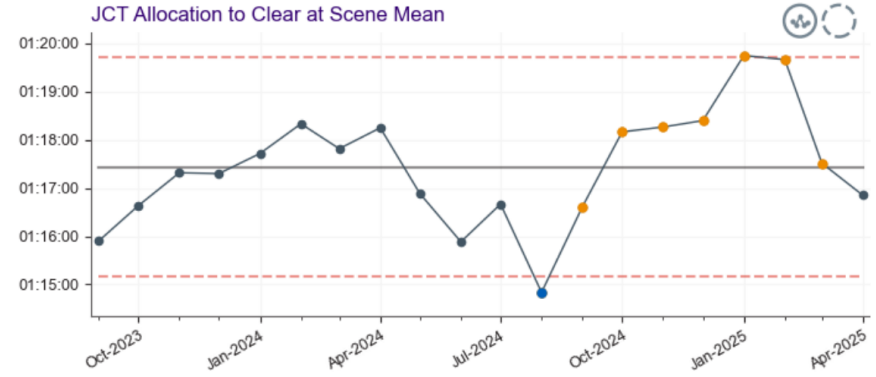
999-34

Dept: Operations 999
Metric Type: Board
Latest: 21.1%

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

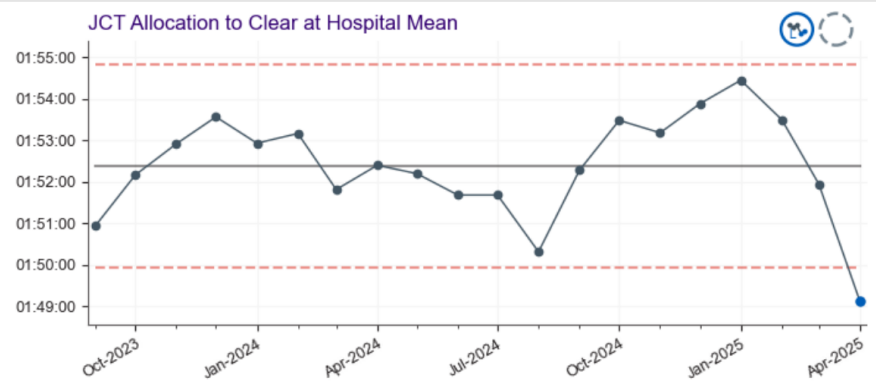
RPI – @

JCT shows normal variation for time of year
Local Community Dispatch Model 9LCDM) has been piloted and demonstrates improvements to overall JCT due to lower travel time and mileage. A robust evaluation will be completed at the end of May 2025.



999-11
Dept: Operations 999
Metric Type: Board
Latest: 01:16:51

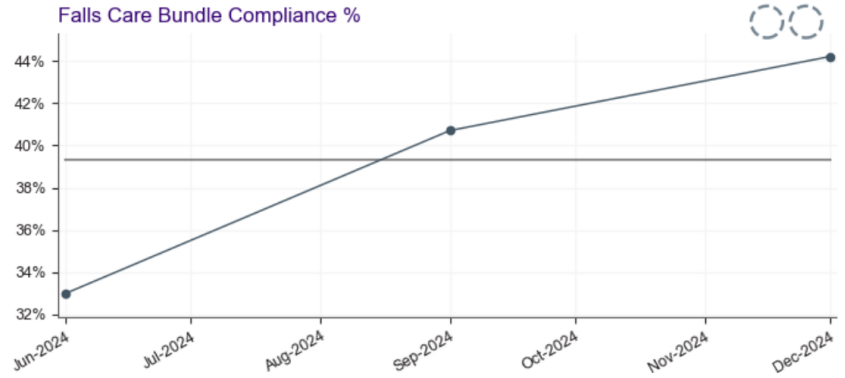
Common cause variation, no significant change.



999-11
Dept: Operations 999
Metric Type: Board
Latest: 01:49:08

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

JCT – allocation to clear at scene – correlation to LCDM and expected reductions is demonstrated from March through to the end of April – and is seen to be having a great variance when we convey the patients to hospital – the benefits of local crews who know local pathways has always showed shorter job cycle times although should be noted it is only JCT to clear at hospital that current has seen a year-on-year improvement for April verus April.



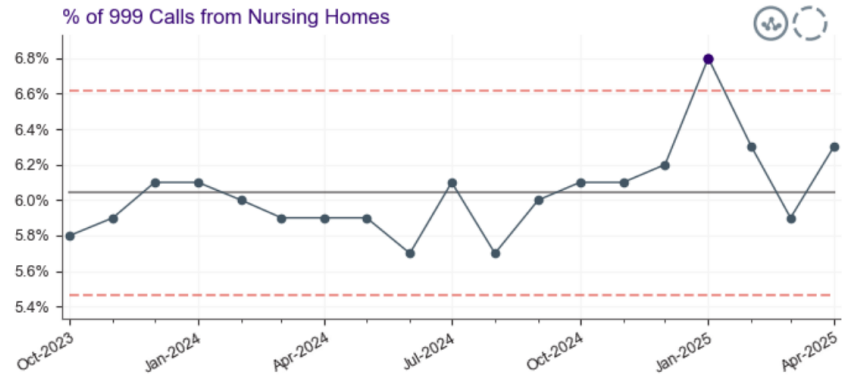
M-29

Dept: Medical

Metric Type: Board

Latest: 44.2%

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



999-35

Dept: Operations 999

Metric Type: Board

Latest: 6.3%

Common cause variation, no significant change.

Summary:

- Falls audit data is monitored quarterly as per the national audit requirements.
- Current compliance remains below target but shows a clear positive trend
- Insufficient data currently exists to identify trends or commonality with confidence.
- However, the upward trajectory in compliance is encouraging.

Since November 2024, Health Informatics Leads have:

- Provided regular feedback to Operating Units on audit results, highlighting both positive findings and areas for improvement.
- Distributed targeted resources to support areas with lower compliance.

Which has contributed to the positive increase in compliance.

Actions:

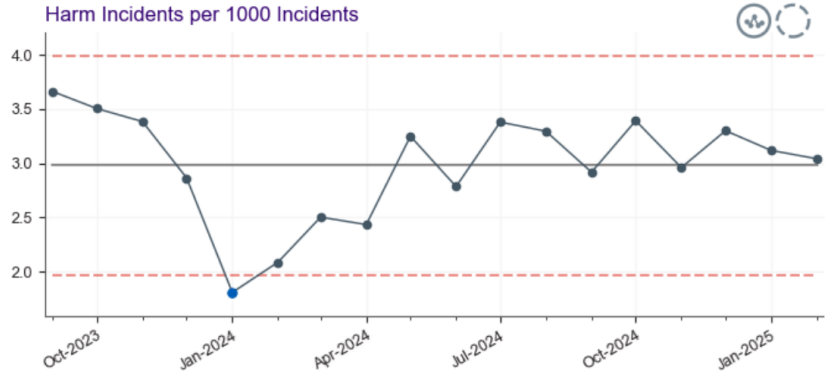
- Health Informatics Leads are visiting Operating Units to provide targeted compliance feedback.
- Dashboards are being developed to support appraisals by displaying individual compliance data for road staff.
- Resources have been distributed to stations focused on key low compliance areas, including examples of intrinsic vs. extrinsic falls.
- A revised approach to collecting and analysing falls data is in development to ensure proportional representation of Operating Unit data. This change is based on feedback from the Brighton System Governance Group and continues to follow NHSE guidance for this audit.

Summary

This is new measure for this year as part of our productivity plans and follows a presentation that an Advanced Paramedic Practitioner gave to the Trust Board about a project they had led to educate care home staff on how to manage patients who deteriorated without the need to always call an ambulance.

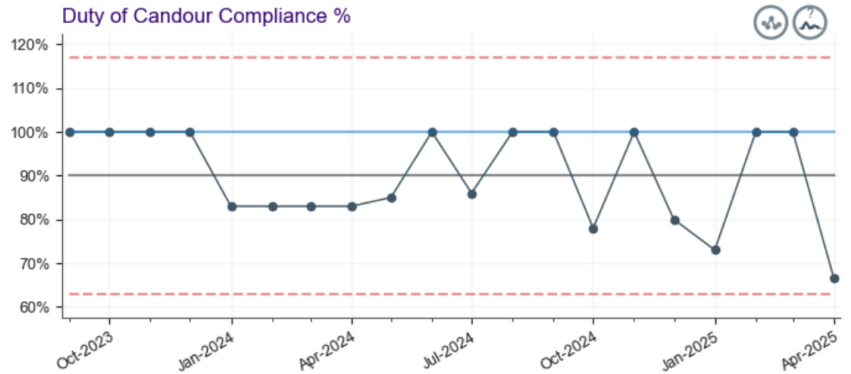
This APP has been commissioned to lead a project, Trust-wide, to work with the care homes who call 999 most frequently to support and educate them on what to call for help and when to manage the situation within the care facility.

We aim to reduce unnecessary calls from care homes by 1% over this year.

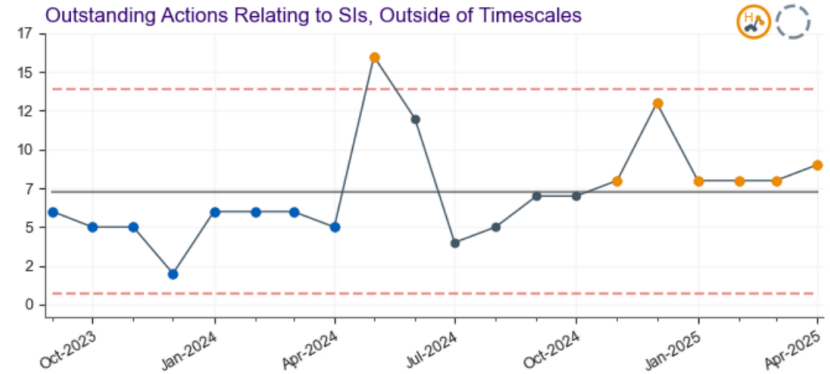


QS-29
Dept: Quality & Safety
Metric Type: Supporting
Latest: 3

Common cause variation, no significant change.



QS-3
Dept: Quality & Safety
Metric Type: Supporting
Latest: 66.6%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-17
Dept: Quality & Safety
Metric Type: Supporting
Latest: 9

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

MM-1
Dept: Medicines Management
Metric Type: Supporting
Latest: 183

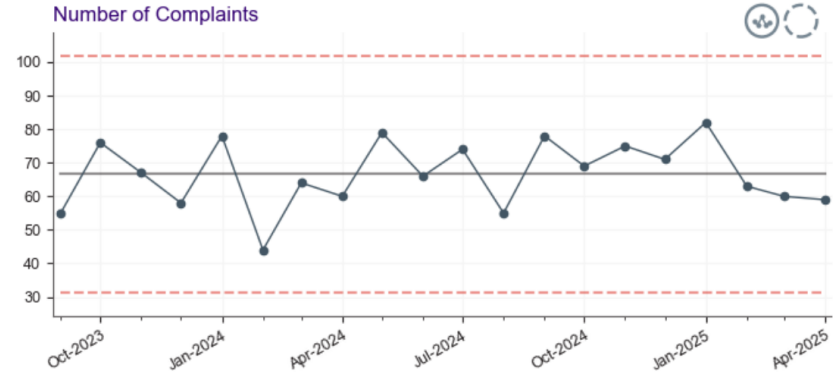
Common cause variation, no significant change.

Harm per 1000 incidents we attend shows, common cause variation and no significant change. System Governance Groups are reviewing variation amongst OUs to ensure consistent cross organisation reporting.

Outstanding actions relating to Serious Incidents (Sis), outside of timescales The Trust have closed their final Serious Incident (SI) case and work is underway to close all remaining SI actions. Outstanding actions have been divided between systems with a focus on the quality and effectiveness of the actions.

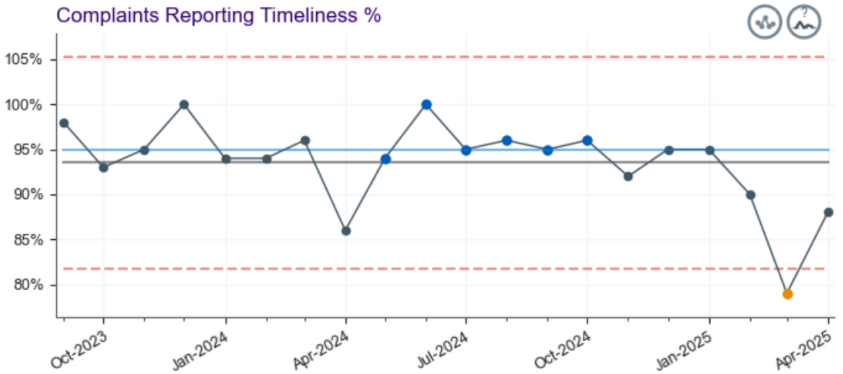
Duty of candour compliance. Common cause variation seen. Four of six incidents requiring duty of candour were completed on time. The Trust had challenges identifying next of kin and/or contacting those involved for the remaining two. However, every effort was made within the 10-day period.

Number of Medicines Incidents (MM-1)
Reporting of medicines-related incidents continues to be encouraged. There is no increase in harms associated with medicines use.



QS-5
Dept: Quality & Safety
Metric Type: Supporting
Latest: 59

Common cause variation, no significant change.



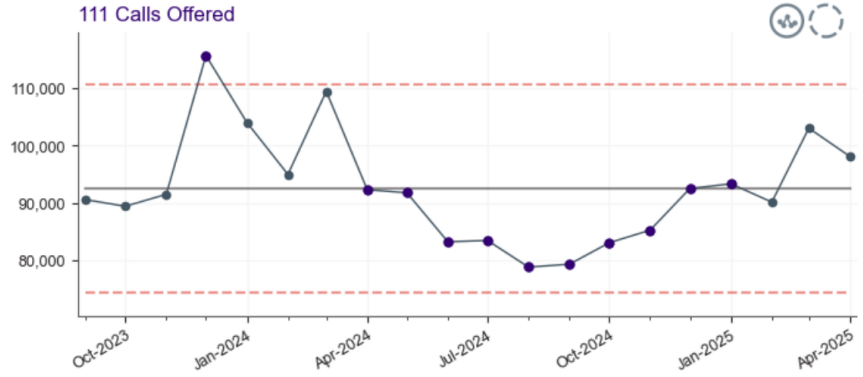
QS-4
Dept: Quality & Safety
Metric Type: Supporting
Latest: 88%
Target: 95%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Complaints
Number of complaints remains consistent and within normal variation on SPC chart.

Complaints reporting timeliness
April has seen a return of timely responses following a dip below normal variation in March. This was due to sickness across the teams, and a loss in capacity to process responses accordingly.

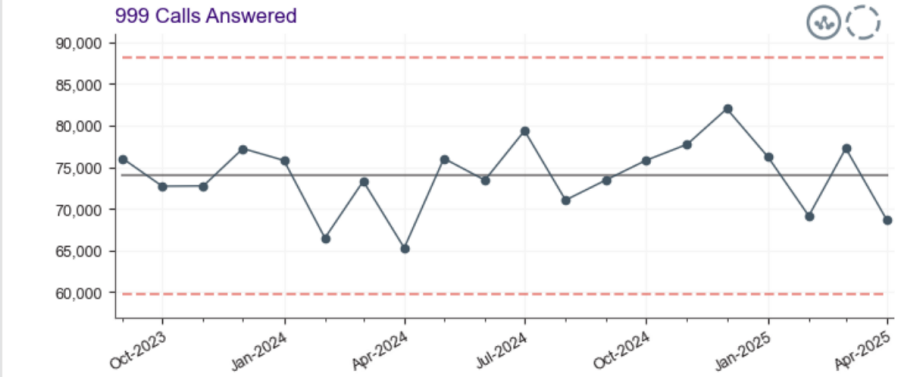
Under the current organisational change process underway, the PALS teams will be moving into Divisional based patient safety and experience teams, that will enhance the ability to identify, analyse and address underlying issues affecting local populations resulting in complaints being raised.

It will also provide greater grip on timeliness and oversight of complaints, enabling the teams to consistently reach and maintain the 95% as per national target.



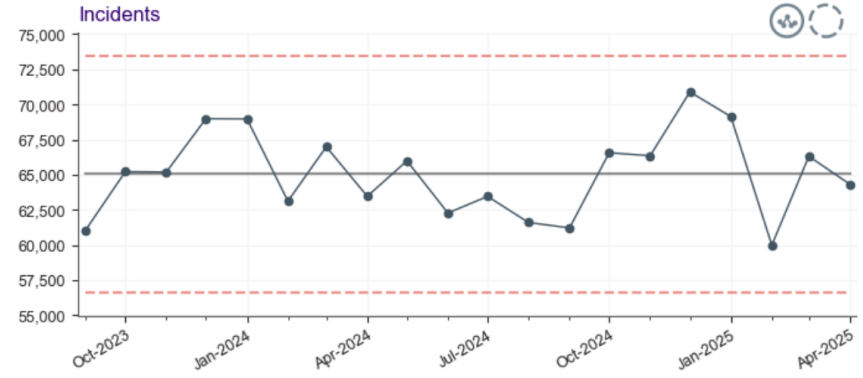
111-1
Dept: Operations 111
Metric Type: Supporting
Latest: 98084

Common cause variation, no significant change.



999-10
Dept: Operations 999
Metric Type: Supporting
Latest: 68673

Common cause variation, no significant change.



999-10
Dept: Operations 999
Metric Type: Supporting
Latest: 64323

Common cause variation, no significant change.

111 Calls
The number of 111 calls offered continues to trend upwards however, the volume of calls answered by the service, and the average speed to answer is also on an improving trajectory.
The service continues to record an abandoned call rate below the contractual target of 5%.

999 Calls
The number of 999 calls answered remains broadly consistent however, the actual call handling performance and % of calls abandoned has significantly improved, with the Trust having achieved its 999 call answering mean and 90th centile targets every month so far this calendar year.

Incidents
The volume of incidents that the Trust has responded to has remained broadly level across the past 15 months. This has helped the Trust with regards to its planning, and scheduling appropriate resource to respond to patient demand, be that in contact centres or in field operations.

Appendix 1: Glossary

Integrated Quality Report

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Board Assurance Framework

2025/2026

June v1.0

Delivering High Quality Patient Care

Delivering High Quality Patient Care Executive Summary

The embedding of PSIRF continues to develop with the first two completed Patient Safety Incident investigations presented to the oversight group leading to structural changes, such as within JRCALC and the Trust guidelines in relation to medication administered to patients who are fitting.

We deliver high quality patient care

1	Tier 1
2	Tier 2
	QI
	Directorate objective

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

2025/26 – Strategic Transformation Plan

- ❑ Models of Care 1
  - 3 Focus Models of Care (Reversible Cardiac Arrest, Palliative and End of Life Care, Falls, Frailty and Older People) to be delivered within 25/26
  - Produce a three-year delivery plan for the 11 Models of Care
- ❑ Delivering Improved Virtual Care / Integration 1
  - Evaluation to inform future scope of virtual care commences April 2025
  - Design future model to inform Virtual Care, including integration of 111/PC
  - Establish commissioning implications of evaluation outcomes and inform multi-year commissioning framework

2025/26 Outcomes

- ❑ C2 Mean <25 mins average for the full year
- ❑ Call Answer 5 secs average for the full year
- ❑ H&T Average for 25/26 of 18% / 19.4% by end of Q4
- ❑ Cardiac Arrest outcomes – improve survival to 11.5%
- ❑ Internal productivity
  - ❑ Reduce the volume of unnecessary calls from our highest calling Nursing/Residential Homes by 1%
  - ❑ Job Cycle Time (JCT)
  - ❑ Resources Per Incident (RPI)

2025/26 – Operating Plan

- ❑ Operational Performance Plan – continuous monitoring through the IQR
- ❑ Set out Health Inequalities objectives for 2025-2027 by Q3
- ❑ Develop Quality Assurance Blueprint, including design of station accreditation complete by Q4
- ❑ Deliver our three Quality Account priorities by Q4
- ❑ Patient Monitoring replacement scheme by Q4 & design future model for replacements 2
- ❑ Deliver improved clinical productivity through our QI priorities by Q4
  - IFTs
  - EOC Clinical Audit

Compliance

- ❑ EPRR assurance
- ❑ Medicines Management & Controlled Drugs
- ❑ PSIRF Compliance to standards

BAF Risks

- ❑ **Delivery of our Trust Strategy:** There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.
- ❑ **Internal Productivity Improvements:** There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability.

We deliver high quality patient care

2025/26– Strategic Transformation Plan

Programme	Milestone	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Virtual Care Programme	Evaluation to inform future scope of virtual care	Q1	Q1	Kate Mackney	EMB for Reporting SMG for Delivery	Yes	Chief Operating Officer	Quality & Patient Safety
	Design future model to inform Virtual Care, including integration of 111/PC	Q3	Q3					
	Establish commissioning implications of evaluation outcomes and inform multi-year commissioning framework	Q4	Q4					
Models of Care	Design 3 year delivery plan for MoC and obtain agreement with system partners	Q1	Q1	Katie Spendiff	EMB	Yes	Chief Medical Officer	Quality & Patient Safety
	Deliver 3 Focus Models of Care (Reversable Cardiac Arrest, Palliative and End of Life Care, Falls & Frailty and Older People) within 25/26	Q4	Q4					

2025/26 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date Last Reviewed @ Committee
Operational Performance Plan				Chief Operating Officer	SMG	No	FIC	
Set out Health Inequalities objectives for 25-27			N/A	Chief Medical Officer	SMG	No	QPSC	
Develop Quality Assurance Blueprint			N/A	Chief Nursing Officer	SMG	No	QPSC	
Deliver the three Quality Account Priorities	Health Inequalities Year 2: 1) Maternity 2) MH			Chief Nursing Officer	SMG	No	QPSC	10/04/2025
	ePCR			Chief Nursing Officer	SMG	No	QPSC	10/04/2025
	Framework for patients with Suicidal ideations/intent		N/A	Chief Nursing Officer	SMG	No	QPSC	N/A
Patient Monitoring Replacement	Commence the replacement scheme by Q4		N/A	Chief Medical Officer	SMG	Yes	QPSC	N/A
	Design future replacement programme by Q4		N/A				QPSC	N/A
Develop a Trust-wide patient safety improvement plan				Chief Nursing Officer	SMG	No	QPSC	
Deliver improved clinical productivity through our QI priorities	IFTs			Chief Nursing Officer	SMG	No	QPSC	
	EOC Clinical Audit		N/A	Chief Nursing Officer	SMG	No	QPSC	N/A

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Delivery of our Trust Strategy: There is a risk that we are unable to deliver our trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.	12	08	CSO
Internal Productivity Improvements: There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability.	12	08	COO

Board Highlight Report – Virtual Care

SRO/Delivery Lead

Jen Allen – Chief Operating Officer

Key
Completed
On Track
At Risk
Delayed

Progress Report Against Milestones:

Key achievements against milestones

- **Programme Governance Realignment:** Programme governance structure re-aligned to ensure consistency with the wider Model of Care Programme. The new Steering Group is set to launch in June 2025.
- **UCNH Evaluation Paper:** Evaluation completed and currently under review. Ready for socialisation at relevant committees and governance meetings alongside Virtual Care Committee reports.
- **Kent Hub Review** Completed: In collaboration with the ICB and system partners, the Kent Hub Review was completed with several actionable outcomes:
  - UCR Portal installed in North and West Kent
  - UCR Portal pathway to be established for East Kent
  - Joint ICB-led UCNH Dashboard developed
  - Improved connection between EOC and UCNHs
- **Launch of Workstream 5: Clinical Productivity:** Focused on increasing Hear & Treat activity. Productivity outcomes are now being integrated into the wider Virtual Care Programme for enhanced delivery.
- **Transition of Workstreams:** Workstream 1 (Performance & Evaluation) and Workstream 2 (Clinical Governance) proposed for closure. Deliverables to be transitioned into business-as-usual (BAU), other programmes, or presented at governance forums (e.g., Evaluation & Audit Framework).

Upcoming activities and milestones

- **Governance Engagement**: Socialisation of the UCNH Evaluation Paper and Virtual Care Committee Report across relevant governance groups to demonstrate progress and impact.
- **Clinical Productivity Workstream Progress:** Draft Standard Operating Procedure (SOP) for Virtual Consultations, Baseline Key Performance Indicators (KPIs) identified and under review, Draft governance and accountability structures developed

Escalation to Board of Directors

Previous RAG	Current RAG	RAG Summary
		The programme is rated **Amber** as governance alignment, workstream transitions, and key deliverables (SOPs, KPIs, evaluation) are still in progress; to reach **Green**, these elements must be finalised and embedded, and the pace and progress of clinical productivity schemes must accelerate to demonstrate measurable impact

Risks	April	May	Mitigation
Risk: Local ICB-level funding and commissioning timelines for the current financial year remain uncertain. This creates immediate risk to the continuity and consistency of MDT staffing in UCNHs, which are important to the Virtual Care model. Without clear commissioning agreements and confirmed funding, there is a risk of gaps in staffing, inconsistent service provision, and reduced clinical oversight.	12	12	• Development and submission of robust Business Cases to ICBs to secure short-term funding. • Ongoing engagement with ICB leads to align UCNH priorities with local operational plans. • Contingency planning for temporary workforce models if funding is delayed.
Risk: There is a risk that the Virtual Care Programme will be unable to deliver planned clinical productivity improvements while maintaining safe and effective patient outcomes. This may result from insufficient design, inconsistent implementation, or a lack of accountability around standardised service delivery processes and productivity expectations across different teams or settings. If unresolved, this could lead to unrealised operational efficiencies, reduced programme impact, and challenges to financial sustainability	N/A	16	• Define and agree a clear clinical productivity framework with aligned KPIs • Implement standard operating procedures across virtual care settings • Embed performance reporting and feedback loops into routine governance • Provide clinical leadership development and change management support • Pilot new approaches before wider rollout to ensure feasibility and safety

Q1 (Apr-June 25)	Q2 (Jul-Sep 25)	Q3 (Oct-Dec 25)	Q4 (Jan-Mar 26)	Outcomes
VC Dashboard & Performance Framework Evaluation of the UCNHs UCR Portal Launch - Kent Overnight Operations: Confirm Mandate from NHS E, Assess Risks & Process Requirements C2 Seg: Maximise Agency Resources C2 Seg: Integrate BI Tools for Decision Making 111 Efficiencies: Review DoS, Optimise H&T Pathways	C3/4 Validations: Design & Implement KPIs for Clinical Productivity	C2 Seg: Achieve 125 Daily Segmentations C3/4 Validations: Reduce the number of deployments from 60% to 45% ECALs: Implement a Structured Approach to ECALs Triage & Navigation	Training Education: Establish Joint Shadowing with Partners ECALs: Optimise UCNHs to Support ECALs Assess UTV Resourcing & Contract Opportunities	• Optimise usage of alternative pathways for clinically appropriate patients • Enhance patient centered care • Effective Care Planning and better utilisation of emergency responses • Increase hear and treat • Ensure 55% of patients to receive a virtual response • Trusted assessor

KS0

Board Highlight Report – Models of Care

SRO/Delivery Lead

Richard Quirk / Andy Collen

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Key achievements against milestones

- Governance structure reviewed while mapping alignment between VC and MOC programmes to avoid duplication and streamline the governance on the relevant workstreams. Joint Ops/Medical/EOC/Quality/Paramedic oversight by unified programme board commencing June 2025 under the programme title 'We provide High Quality Care'.
- Year 1 delivery aims for all 11 MoCs agreed by clinical leads and moved into individual quarterly milestone plans for FY 25/26. Overarching programme in place to monitor progress on deliverables.
- Mapped interdependencies with other Trust programmes to ensure alignment.
- Baseline data process through one-to-one sessions between the clinical lead and BI analyst completed and Level 1 & 2 metric data now shared with authors.
- Indicative target metrics for the Models of Care established, with a five-year trajectory outlined in the mandate.
- Session with Executives to align VC and MOC programmes and outline future pathways and a high-level model undertaken.

Upcoming activities and milestones

- Develop an internal and external engagement and communications plan, with an emphasis on PPIE.
- Define and scope workforce planning requirements for years 1 and 2 across all 11 MOC.
- Map out the goals of the Clinical Reference Groups, their chosen system-wide pathways, and how these intersect with the relevant MoCs.

Escalation to Board of Directors

- None at this stage.

Previous RAG	Current RAG	RAG Summary
		Models of Care – broadly on track to meet Q1 25/26 milestone deadlines. Workforce planning to commence at pace. Pathways of Care - Focus is on head injuries and falls regionally. MOC falls lead to join the CRG working group for alignment & oversight.

Risks	April	May	Mitigation
Risk: Transition to new pathways of care. There is a risk that the transition to stop Seg/Validation and move to Virtual Care will have a significant impact on clinical roles and settings. This could impact operational performance during transition and a reduction in staff satisfaction organisational change. KS2	6	4	**Develop clear and consistent communications** to articulate the differences between service models, including internal and external education requirements. Support the organisational change needed to implement these models and ensure alignment of goals and expectations from the Board through to steering and working groups and mapping VC deliverables to MOC and joint oversight via refreshed governance model. Comms plan in development and joint governance model in place.
Risk: The long-term **financial viability of the Models of Care Programme** could be at risk due to inadequate or changes in funding, resource allocation, or unforeseen costs. This could result in delays, reduced scope, or failure to deliver the programme's intended outcomes.	6	6	**Develop detailed budgets**, contingency plans, and cost control measures. Advocate for sustained funding with evidence of programme benefits. Regularly review financial health and address emerging risks promptly. Periodic review and adjustment of programme scope in line with available resources. Watch and wait re this risk and changing landscape of commissioning.
Risk: Gap in workforce planning expertise in the Trust. There is a risk that a lack of workforce planning expertise being made available to the programme will have a significant impact on our ability to deliver the MOC outcomes required as workforce planning and changes are a core component of the succesful delivery of the models.	9	9	**Acquire resource.** TI has been allocated from HR to work on this and there has been potential resource identified in NHS England that could be used at no cost to support this. Initial scoping for this is being undertaken via the SCAS/SECAmb collab work with mapping against proposed operational models. Score maintained until the broader MOC workforce planning scoping commences in late May 2025 now resource is identified.
Risk: Delay in CRG system recommendation for a pathway of care. There is a risk that the delay to the agreement of the regional focus on a particular pathway of Care may affect the speed of the delivery of a Models of Care that relates to this.	12	9	**Monitor CRG progress.** Focus is on head injuries and falls regionally. MOC falls lead to join the CRG working group for alignment and oversight. Work closely with the CRG to monitor progress and encourage timely agreement on the regional pathway focus. Maintain regular communication with stakeholders to ensure alignment and readiness for implementation.

Q1 (Apr-June 25)

- MOC Steering and Working Groups fully operational, to drive delivery.
- Year 1 MoC delivery aims translated into actionable, cross-referenced milestone plans aligned with VC, SCAS & Digital deliverables.
- Scope workforce planning needs for year 1 & 2

Q2 (Jul-Sep 25)

- Design MoC dashboard for delivery tracking
- Draft programme EIA, QIA & DPIA's & send for review
- Submit resource cases, ensure a mid-year strategy review by the Board to ensure priorities are aligned with SCAS collaboration outcomes and financial planning.
- Year 2 delivery aims are drafted for all 11 MoCs, incorporating insights from the strategy check and challenge process
- Evaluation framework drafted & initiate the PDSA cycles
- Scope any resource cases for the financial planning cycle

Q3 (Oct-Dec 25)

- Submit EIA, QIA & DPIA's
- MoC Dashboard fully operational
- Approved programme EIA, QIA & DPIA's to meet legal, quality & inclusion standards
- Year 2 delivery aims are finalised and underpinned by updated maturity matrices across all MoCs, aligning future delivery with strategic growth
- Outcome of financial planning cycle confirms resource allocations to support Year 2 MoC implementation

Q4 (Jan-Mar 26)

- Year 1 Evaluation Completed

Outcomes

- Ensure patients receive a timely response, either physical or virtual depending on outcome of triaging, to meet their ongoing needs

BAF Risk 537 – Delivery of our Trust Strategy

There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.

Contributory factors, causes and dependencies: Reliance on engagement with commissioners and partners to support strategic delivery, against a backdrop of considerable financial pressure.

Accountable Director	**Acting Chief Medical Officer**
Committee	**Quality and Patient Safety Committee**
Initial risk score	**Consequence 5 X Likelihood 5 = 25**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12**
Target risk score	**Consequence 4 X Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Vision and strategy agreed at Board. Agreed organisational financial plan which prioritises strategic delivery. Multi-year plan developed as part of exit criteria for Recovery Support Programme. A fully functioning programme board providing leadership and governance. A workforce committed to the improvements needed. Learning from the virtual care provided by the navigation hubs. Clinical leads appointed to each of the 11 models of care workstreams. A full time programme manager overseeing delivery. Business Intelligence support has been secured.

Gaps in control: Supporting workforce plans to build capability not yet live. Some loss of organisational capability and memory through ongoing organisational restructure and MARS scheme.

Positive sources of assurance: Robust monitoring of both strategic delivery and patient outcomes through BAF. Consultant Paramedic overseeing the clinical leadership of the 11 models of care. Programme board membership from each directorate overseeing delivery. Models of care debated within the Professional Practice group (PPG). External scrutiny via the Clinical Reference Group (CRG) at NHS England region.

Negative sources of assurance: Previous CQC inspection report describing sub standard care and the need to change. Past inclusion in the RSP programme due to past failings in the delivery of care need to influence future models. Patient feedback (particularly about long waits) need to be considered.

Gaps in assurance: Presentation of the three year delivery plan is yet to be presented to Board (planned for Q1 25/26). Operational planning is still required to ensure that clinical plans are deliverable. The joint clinical model with SCAS is yet to be developed.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Evaluation to inform future scope of virtual care	Acting Chief Medical Officer	Q1 2025/26	This will conclude in April 2025.
Workforce Planning Lead to appointed to programme.	Chief People Officer	Q1 2025/26	Nominated individual assigned.
Business Intelligence Analyst to be assigned to Trust Strategy/Models of Care to support development of plan.	Chief Digital Officer	Q1 2025/26	Nominated individual assigned.

BAF Risk 646 – Internal Productivity Improvements

There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability

Contributory factors, causes and dependencies:
Organisational culture and employee relations situation limiting ability to make change
Risk averse in regards to clinical practice meaning low appetite to make productivity changes without significant assurance on safety, reducing potential pace of delivery

Accountable Director	**Chief Operating Officer**
Committee	**Finance and Investment 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 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Ongoing process to enhance ER processes and renegotiate policies prioritised within People BAF; Specific schemes and robust oversight of productivity scheme delivery through SMG; detailed planning and QIA process to assure safe delivery. Quarterly review process for productivity and efficiency schemes.

Gaps in control: Ongoing process of Clinical Operating Model Design creating possible gaps in leadership or governance structures.

Positive sources of assurance: Robust monitoring of both strategic delivery and outcomes through SMG, EMB and BAF. IQR reporting. Operational reporting. Finance reporting

Negative sources of assurance:

Gaps in assurance: Limited analytical and finance capability/capacity to understand impact of productivity changes and ensure embedded / benefits realised.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Design and delivery of three priority models of care	Chief Medical Officer	Q4 2025/26	This will commence in April 2025.
Ongoing work with SCAS and SASC to enhance productivity and efficiencies	Chief Strategy Officer	Q4 2025/26	CSO now joint strategic advisor for SCAS and SECAmb.
Support team incl senior coordinating role, finance and BI input for productivity and efficiency being put in place	Chief Finance Officer	Q1 2025/26	Under discussion

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Integrated Quality Report

Trust Board June 2025

Data up to and including April 2025

April 2025 data – presented June 2025

What

The IQR has been refreshed this month to align to our 2025/26 Board Assurance Framework priorities and to refine the focus of metrics for Board committees enabling oversight and triangulation through the Board discussion. The refreshed report and process will be reviewed and improved through the next 6 months.

The Trust finished 2024/25 with strong operational, clinical and financial performance, and remains in a robust position through April. Changes to dispatch through the Local Community Dispatch Model have supported improved incident cycle time and staff experience, and a C2 mean of 25:02 was achieved, supported by relatively strong resourcing and stable demand in April. Handover times are in seasonal variation and call answering has exceeded target at 1second with a good staffing position in call handling. Achieving our H&T trajectory remains challenging as the rate is increasing but not on target; an increase in S&C rate alongside the greater H&T rate has been observed. This is expected, but will be reviewed to ensure appropriate, as the use of alternatives to ED is still limited. We continue to deliver improving cardiac outcomes and good patient safety and Health & Safety indicators, with the first PSIRF reviews completed this month. There is an improvement in MAST and Appraisal driven by focus from HR and managers, while turnover continues in improving trend and our employee relations position is stable.

So What

Although performance was good, the spring and summer period needs greater focus on responsiveness to enable a 25min average C2 mean across the year to be achieved. Clinical training of B6 paramedics to contribute to H&T rate, greater clinical call handling productivity, and further work with system partners on alternative pathways and handovers is also in train and will be needed to impact on the overall position.

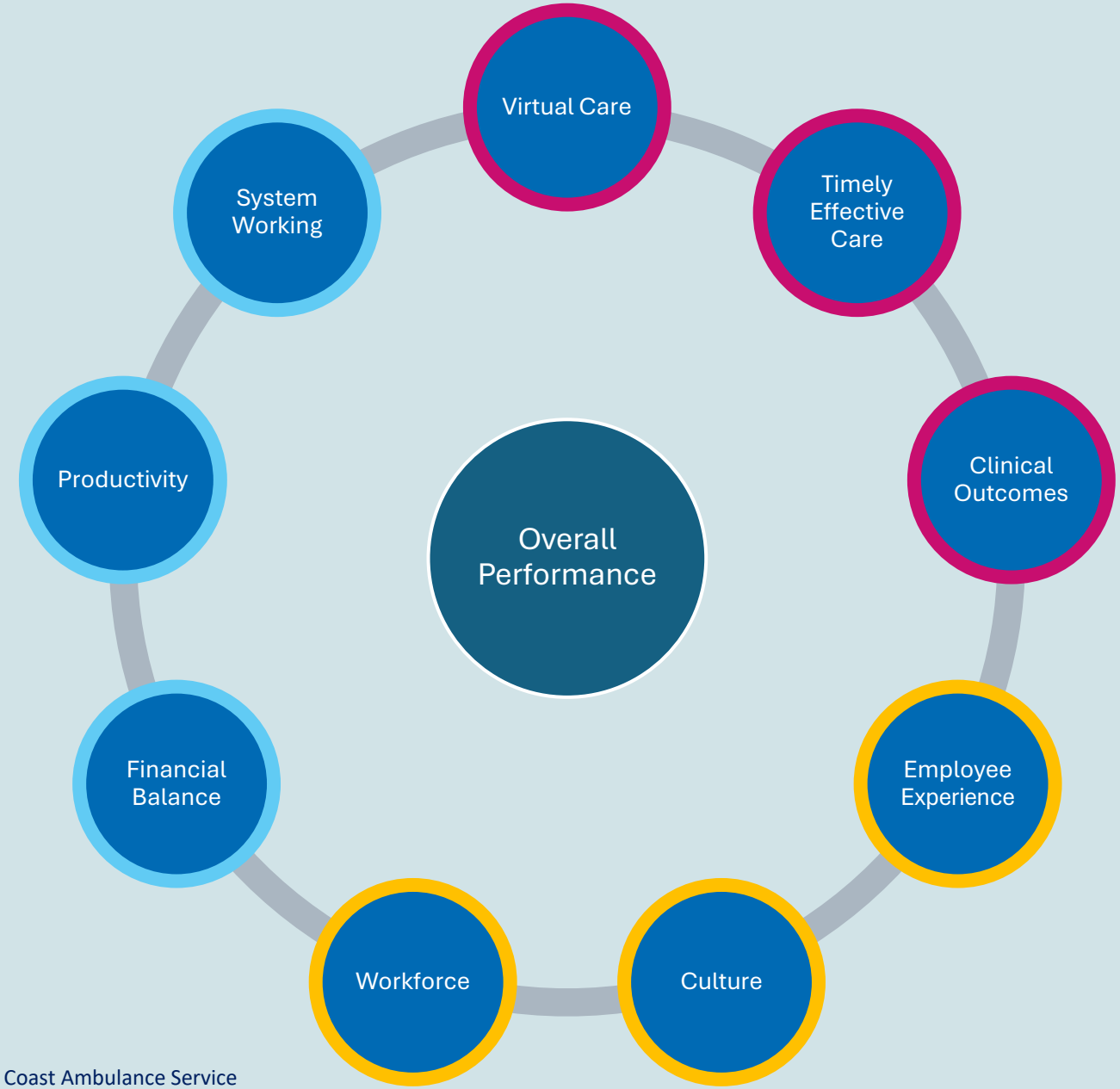
Clinical indicators are strong and will be enhanced by our focus on three particular models of care, including Falls which is now being monitored as a Board metric. We will continue to embed PSIRF to support a learning culture and to use QI to make improvements, and embed enhanced quality governance from floor to Board, as well as working through our aligned Virtual Care and Models of Care programmes.

The divisional clinical operating model is now being implemented supporting local autonomy and focus and enhancing integration of clinical, operational and corporate leadership teams. Following our improved Staff survey results, local processes to continue to embed change and target hotspot areas have been put in place, while SMG is undertaking work on sickness rates and abstractions. The corporate restructure is moving towards completion and will offer greater resource for employee relations support, which is needed to address case numbers, length of time to resolve cases, and continued high levels of suspension days in the Trust.

What Next

Further focus on our productivity programme will be needed to ensure that the planned improvements to care delivery are made as soon as possible so the impact on performance, particularly the C2 mean, is achieved. Similarly, the efficiency programme will be a key area to ensure that we meet our financial plan throughout the year. We will review delivery of efficiency and productivity on a quarterly basis with the next Executive check and challenge in July 2025.

Our ongoing work to improve employee experience and culture will continue through collaboration with staff, unions and the corporate restructure, and with the integrated divisional leadership teams supporting improvement in appraisal, clinical supervision, Speaking Up and MAST. We will also be developing more resilience metrics incl. EPRR and Cyber elements and moving forward looking to bring an organisational resilience framing to our understanding of performance.



BAF outcomes 25/26

- Category 2 Mean <25 minutes average for the full year
- Call Answer 5 seconds average for the full year
- Hear & Treat 18% average for 25/26 / 19.7% by the end of Q4
- Cardiac Arrest outcomes: Improve survival to 11.5%
- Internal productivity:
  - Reduce the volume of unnecessary calls from our highest calling Nursing/Residential Homes
  - Job cycle time (JCT)
  - Responses per incident (RPI)

- Improve staff reporting they feel safer in speaking up: statistically improved from 54% (23/24 survey)
- Our staff recommend SECAmb as a place to work: statistically improved from 44% (23/24 survey)
- 85% appraisal completion rate
- Reduce sickness absence to 5.8%
- Resolve ER cases more quickly to reduce the formal caseload over time, even as new cases are opened

- Deliver a financial plan
- Handover delay mean of 18 minutes
- Increase Urgent Community Response (UCR) acceptance rate of 60-80%
- Reduce Vehicle Off Road rate (VOR): 11-12%
- Achieve over 90% compliance for Make Ready

What we will deliver in 2025/26

We deliver high quality patient care

- Deliver an average Cat 2 mean response time of 25 mins and 999 call-answer of 5 secs
- Increase clinical triage of Cat 2-5 calls, delivering Hear & Treat of 19.7% by Mar 26
- 3 Focus Models of Care:
  - Palliative and EOL Care
  - Reversible Cardiac Arrest – increase survival to 11.5%
  - Falls, frailty and older people – reduce vehicle dispatch to fallers by 10% using more CFRs
- Deliver improved clinical productivity using QI (Eq. to 4mins C2 mean)
- Overhaul our oversight framework for quality of care aligned to our new divisional model, including station accreditation programme

Our people enjoy working at SECAmb

- Completion of our organisational re-design to deliver empowered Divisions
- Improve our People Services enabling effective support for our staff and enhanced ER resolution timelines
- Publication of our workforce plan in alignment with our clinical models of care
- Implement Wellbeing Strategy
- Launch of our first ever Shadow Board
- Expansion of the role of our volunteers

We are a sustainable partner as part of an integrated NHS

- Safely deliver our financial breakeven plan, including our efficiencies of £10m
- Work in partnership with the systems to deliver productivity improvements (Eq. to 2mins C2 mean)
- Develop a Business Case and roadmap for collaborating more closely with SCAS
- Publish a strategic estates plan that supports our development for the next 5 years
- Improve the quality and integration of our data systems to improve efficiency, productivity and outcomes
- Deliver vehicle replacement, >90 new MAN DCAs to be deliver in-year

Icon Descriptions

Integrated Quality Report

	P	?	F	
	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.

Sustainable Partner

The Trust's plan in 25/26 has a high reliability in our ability to work in partnership across multiple part of the system and region to help drive productivity and efficiency and deliver our strategy. Specifically, 2 minutes of our C2 Mean trajectory are attributable to improving UCR acceptance rates (to 60%) and reducing handover times (to 18 minutes on average). The Board should be alerted that those plans are still in development, creating a C2 Mean trajectory risk, and we are in the process of leveraging our newly implemented divisions working with our partnerships to develop those system-level plans directly with our partner providers in the Acutes and Community.

The Trust's month 1 year to date and forecast revenue financial position is in line with plan. This includes £5million funding for improved C2 performance already received as well as an additional £5million anticipated in September but which is contingent on successful achievement of C2 trajectories through the year. NHSE have confirmed that the funding will only be linked to productivity improvements attributable to the Trust, and therefore we would not be at financial detriment if the system productivity does not materialise, however there would be an impact on our C2 Mean trajectory.

CIP and productivity plans continue to be developed in detail and de-risked but are anticipated to be fully delivered as part of forecast reporting to Board and to NHSE.

We are a sustainable partner as part of an integrated NHS

1 Tier 1
2 Tier 2
QI
Directorate objective

2024-2029 Strategy Outcomes

- Breakeven / 8% reduction in cost base: £26m annually. Avoid 100m additional expenditure / growth
- Increase utilisation of alternatives to ED - 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%

2025/26 – Strategic Transformation Plan

- Advance **South-East Ambulance Transformation Programme** through 1
  - Progress functional priority areas (SCAS / SASC)
  - Develop Business Case (SCAS)
  - Deliver ICB-approved **multi-year plan** and refreshed **strategic commissioning framework** to support strategy delivery and sustainability, including break-even trajectory.
- Progress delivery of our **digital enablement** plans, presenting a detailed plan to the Board at the end of Q1

2025/26 Outcomes

- Deliver a financial plan
- Handover delay mean of 18 minutes
- Increase UCR acceptance rate to 60-80%
- Reduce Vehicle off Road Rate – 11-12%
- Achieve over 90% Compliance for Make Ready

2025/26 – Operating Plan

- Deliver **Financial Plan**
  - Meet CIP Plan of £23m (Efficiencies - £10m; Clinical productivity – eq. £10.5m)
- Deliver **strategic estates review** (inc. Trust HQ refurbishment - 111/999 Contact Centre & Corporate Floor) 2
- Implement H&S improvement plan to progress Trust to Level 4 of maturity by Q2 with clear milestones in place
- Complete **support services review**, including Make Ready model and vehicle provision 2
- Monitor **system-led productivity** schemes, improving alternatives to ED and reducing hospital handovers.

Compliance

- Heath & Safety
- Vehicle & Driver Safety / Driving Standards
- Data Security / Cyber Assurance Framework

BAF Risks

- **System Collaboration:** There is a risk that, due to leadership capacity, the Trust does drive collaboration, resulting in reduced strategic delivery.
- **Sustainable Financial Plan:** There is a risk that, due to significant sector uncertainty and challenging productivity plans (see separate risks), we do not deliver our financial plan for 2025/26.
- **Cyber Resilience:** There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.
- **Digital Capacity, Capability & Investment:** There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery.
- **System Productivity**: There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved.

NHS South East Coast Ambulance Service NHS Foundation Trust

Sustainable Partner Overview

Integrated Quality Report

Variation

Special Cause Improvement		Common Cause		Special Cause Concern	
0%	10%	81%		0%	5%
0	2	17		0	1

Assurance

Pass	Hit and Miss	Fail	No Target
5%	14%	5%	76%
1	3	1	16

Productivity

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of DCA vehicles off road (VOR)	Apr-25	14.5%		15.6%		
Board	Number of RTCs per 10k miles travelled	Apr-25	1		0.8		
Board	Handover Time Mean	Apr-25	00:18:32	00:18:00	00:19:15		
Board	Hear & Treat per Clinical Hour	Apr-25	0.4		0.5		
Board	See & Convey to ED %	Apr-25	52.2%		52.3%		
Board	See & Convey to Non-ED %	Apr-25	2.8%		2.9%		
Board	UCR Acceptance %	Apr-25	19.4%		20.6%		
Supporting	111 to 999 Referrals (Calls Triaged) %	Apr-25	5.9%	13%	6.5%		
Supporting	% of SRV vehicles off road (VOR)	Apr-25	1.9%		5.2%		
Supporting	Critical Vehicle Failure Rate (CVFR)	Apr-25	88		97.9		
Supporting	Vehicles Off Road (VOR) %	Apr-25	13.1%	10%	14.4%		
Supporting	999 Operational Abstraction Rate %	Apr-25	21.1%	28%	23.1%		
Supporting	Hear & Treat Recontact within 48 Hours %	Apr-25	1.9%		2%		
Supporting	Hours Lost at Handover as a Proportion of Provided Hours %	Apr-25	0.9%		1.1%		
Supporting	Number of Hours Lost at Hospital Handover	Apr-25	2928.9		3356.4		

Pending metric: Make Ready Compliance % - Data not available to BI/Not currently collected

Resilience

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance

Pending metric: Data Security / Cyber Assurance - Needs to be defined

Pending metric: EPRR Standards Compliance % - Needs to be defined

Health & Safety

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Health & Safety Incidents	Feb-25	36		36.1		
Board	Organisational Risks Outstanding Review %	Feb-25	12%	30%	30.5%		
Supporting	Number of RIDDOR Reports	Feb-25	9		9.5		
Supporting	Manual Handling Incidents	Feb-25	21		25.1		
Supporting	Violence and Aggression Incidents (Number of Victims - Staff)	Feb-25	107		127.3		

Finance

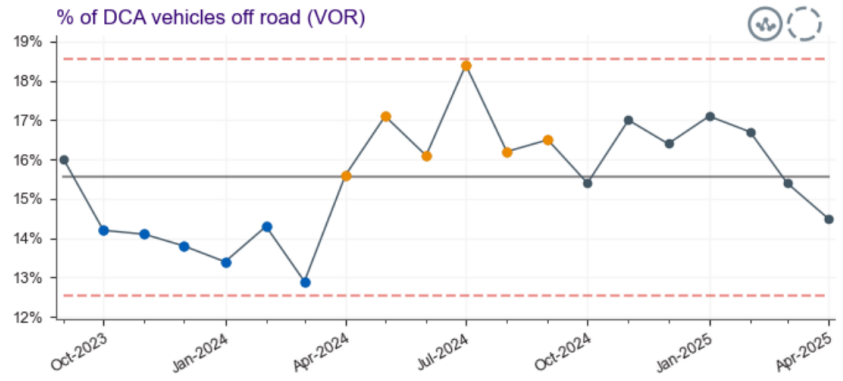
Type	Metric	Latest	Value	Target	Mean
Board	Surplus/Deficit (£000s) Month	Apr-25	-685	-135.8	58.3
Supporting	Capital Expenditure (£000s) YTD	Apr-25	1304	28259	10336.6
Supporting	Agency Spend (£000s) Month	Apr-25	-261.6	-161	-230.4

Efficiency

Type	Metric	Latest	Value	Target	Mean
Board	Cost Improvement Plan (CIP) (£000s) Month	Apr-25	0		1497.7
Board	Cost Improvement Plans (CIPS) (£000s) YTD	Apr-25	0	442.31	9778.9

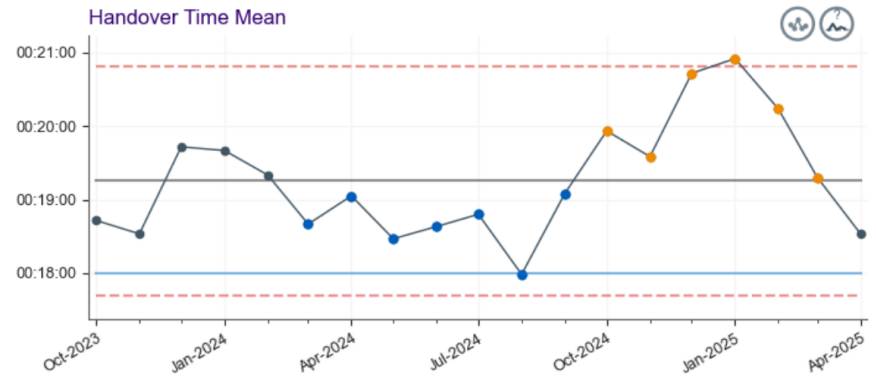
Pending metric: Cost per Call - Data not not available to BI/Not currently collected

Pending metric: Cost per Hour on the Road - Data not not available to BI/Not currently collected

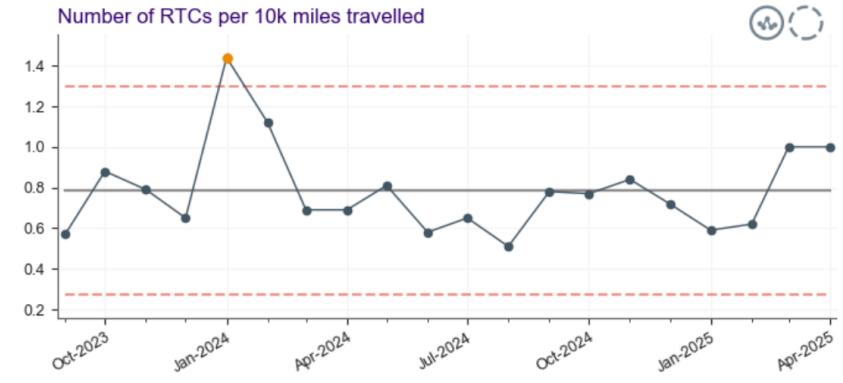


FL-4
Dept: Fleet
Metric Type: Board
Latest: 14.5%

Common cause variation, no significant change.



999-39
Dept: Operations 999
Metric Type: Board
Latest: 00:18:32
Target: 00:18:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



FL-2
Dept: Fleet
Metric Type: Board
Latest: 1

Common cause variation, no significant change.

% of DCA Vehicles off road (VOR)

Parts supply for FIAT DCA spares is still challenging with multiple parts still back ordered to Italy. This is the main driver of the increased VOR over the last 12 months. Due to the reliability of this product the Trust have now ordered 92 MAN box DCAs and 5 Electric Transit DCAs that will assist with reducing VOR Rates.
The demonstrator DCA vehicle is now built and is expected June 2025 for staff feedback with the first vehicles of our orders expected to become operational by the end of Q2 2025/26.

Number of RTCs per 10K miles travelled

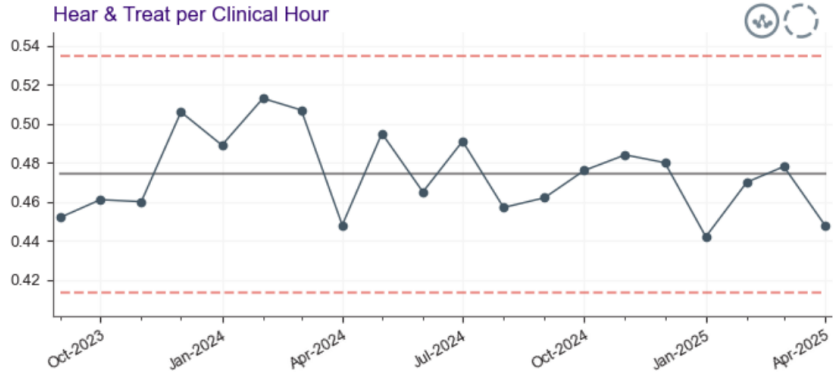
The introduction of the driving standards review panel have seen improvements in learning and education to staff post RTC which will help drive reductions in RTCs and associated vehicle downtime and costs. We are working in collaboration with SCAS to adopt a new approach to driver safety, learning from their "points system", and expect to further develop this over the summer as the functional collaboration case evolves.

Hospital Handovers continue to be an area of clinical operations focus with slight improvements across the systems

We saw seasonal variation over winter and improvements demonstrated since January 2025, however, we continue to see challenges at the Royal County and we are working with colleagues across that system following a recent CQC inspection.

Sustainable Partner: Productivity | Board Metrics

Integrated Quality Report



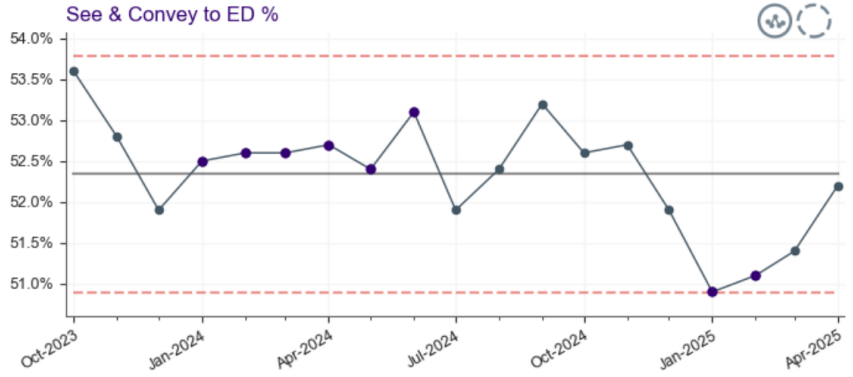
999-41

Dept: Operations 999

Metric Type: Board

Latest: 0.4

Common cause variation, no significant change.



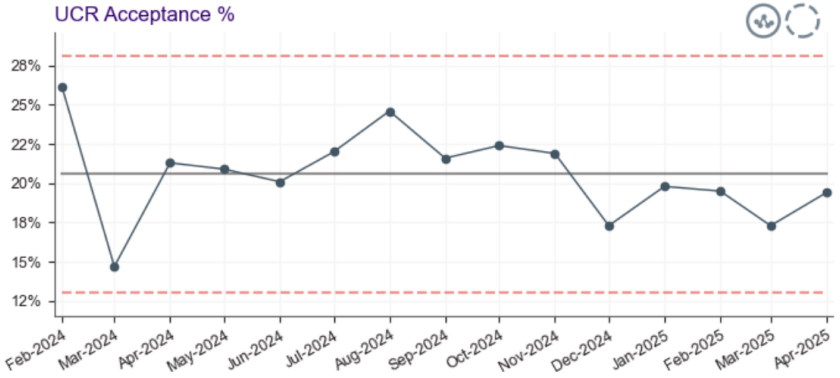
999-9

Dept: Operations 999

Metric Type: Board

Latest: 52.2%

Common cause variation, no significant change.



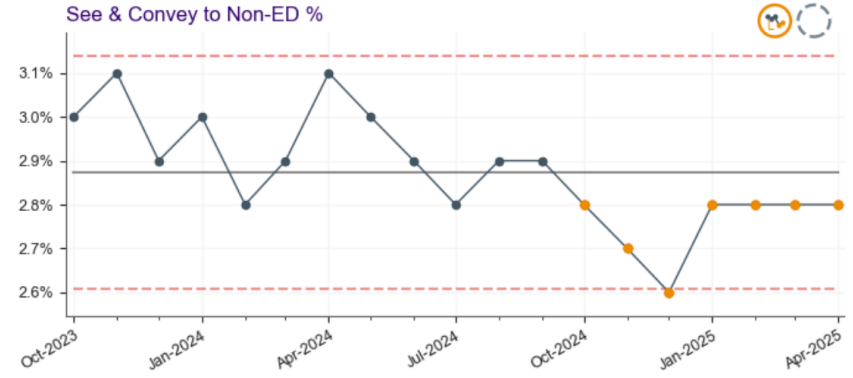
999-40

Dept: Operations 999

Metric Type: Board

Latest: 19.4%

Common cause variation, no significant change.



999-9

Dept: Operations 999

Metric Type: Board

Latest: 2.8%

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

UCR Acceptance Rate

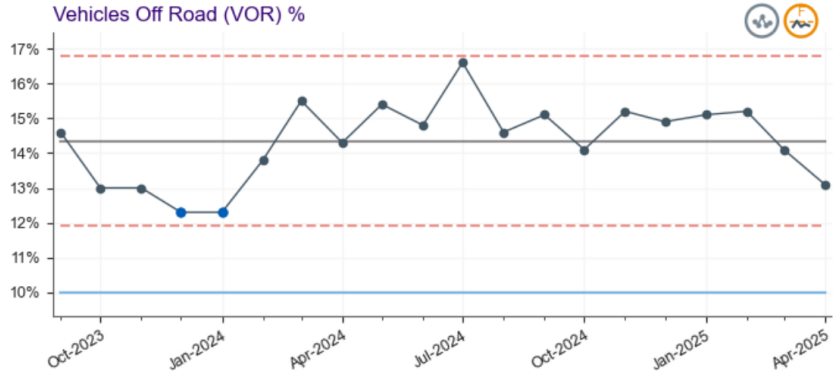
UCR Acceptance rate remains around 20%. Capacity continues to be the main reason that referrals are being declined, and as part of our system productivity plans, we are developing system-level improvement trajectories with Kent, Surrey, Sussex and Frimley, with an aim to achieve a 60% rate in 25/26.

A recent UCNH review day brought together UCR teams from Kent localities where the opportunity was taken to push the UCR portal, which is vital to completing the setup of the UCR portal across the SECAmb areas and should see the first of the Kent providers live on the portal.

Hear and Treat per Clinical Hour

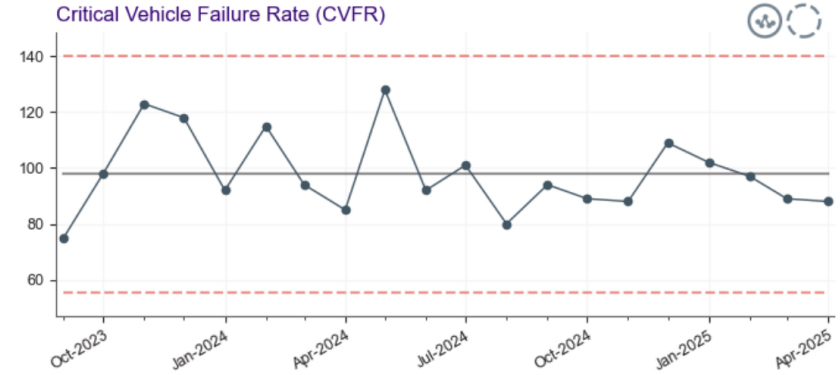
A key focus to drive internal productivity as part of the Virtual Care Tier 1 programme is improve the H&T generation per clinical hour provided, in addition to increasing the volume of H&T capacity via the dual training of paramedics to support clinical validation and assessments via C2 segmentation and Unscheduled Care Navigation Hubs.

- Hear and Treat finished at 15.4% for the month of April, with 4.19% attributable to EMA activity. Over 36% of eligible C2 incidents underwent a clinical assessment as part of C2 segmentation, with 12% downgraded to a C3/4 disposition and 30% downgraded to a non-ambulance disposition. There is real variability in Hear and Treat rates each day ranging from 13.58% to 17.98%. Each day can have a different contributing factor to the higher levels which gives a challenge to being able to deliver the target levels consistently.
- Current EOC substantive clinical staffing sits at 61% to achieve the Trust H&T target. Training for the band 6 dual role Paramedics has commenced with 13 of the 72 awaiting staff already trained and ready to start on the rota on 16th July 2025 (further 8 currently in training). With the pending start of the dual role working for our operational paramedics, a review of the daily operating model for this group of staff is urgently required which should then allow a timelier flow of patients through the system as efficiency is improved.
- The evaluation of the UCNH and review into our clinical productivity shows significant variation of calls/hr achieved, and the improvement plan this year is focussed on driving up the overall rate at Page 177 individual clinician's close cases, and the effectiveness in closing them as a H&T.



FL-13

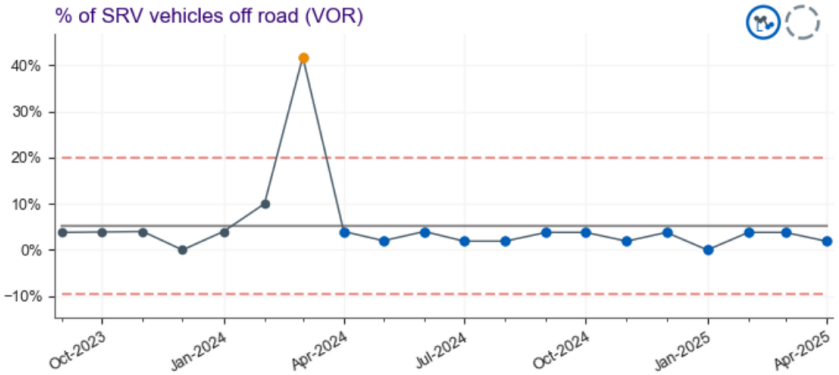
Dept: Fleet
Metric Type: Supporting
Latest: 13.1%
Target: 10%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



FL-12

Dept: Fleet
Metric Type: Supporting
Latest: 88

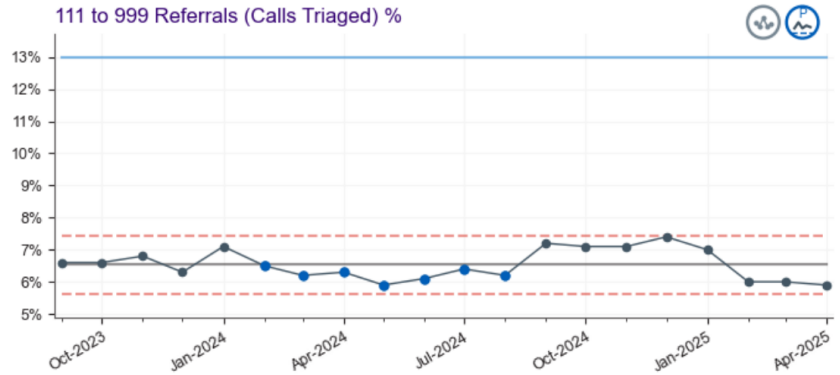
Common cause variation, no significant change.



FL-5

Dept: Fleet
Metric Type: Supporting
Latest: 1.9%

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



111-4

Dept: Operations 111
Metric Type: Supporting
Latest: 5.9%
Target: 13%
Common cause variation, no significant change. This process is capable and will consistently PASS the target.

Vehicle Off Road (VOR) %

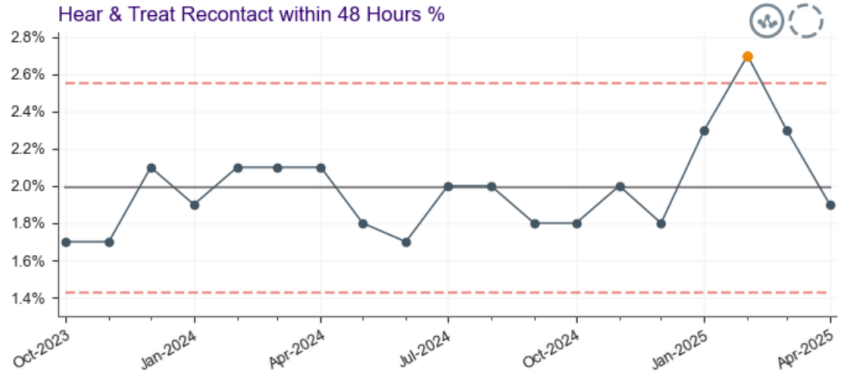
We have seen some improvements to overall VOR % against agreed target of 10%, the 97 new DCAs will offer further improvements on this once fully in service by Q3/Q4 2025/26. Along with the newer vehicles that will improve reliability and reduce average Fleet age that will bring all DCAs into their agreed replacement life cycles there is also a need to increase our Fleet maintenance staff in line with the number of vehicles we have in service.

% of SRV vehicles off road (VOR)

SRV VOR % remains stable due to all vehicle being within their greed replacement life cycle.

Critical Vehicle Failure Rate (CVFR)

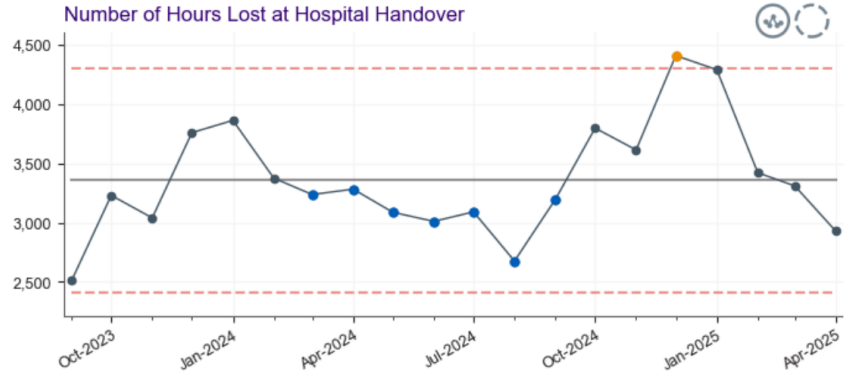
CVFR remains on a downward trajectory, The introduction of driver daily vehicle inspections (POWDERY checks) has seen improvements of vehicle serviceability before shift commencement reducing CVFR whilst in operational service.



999-42

Dept: Operations 999
Metric Type: Supporting
Latest: 1.9%

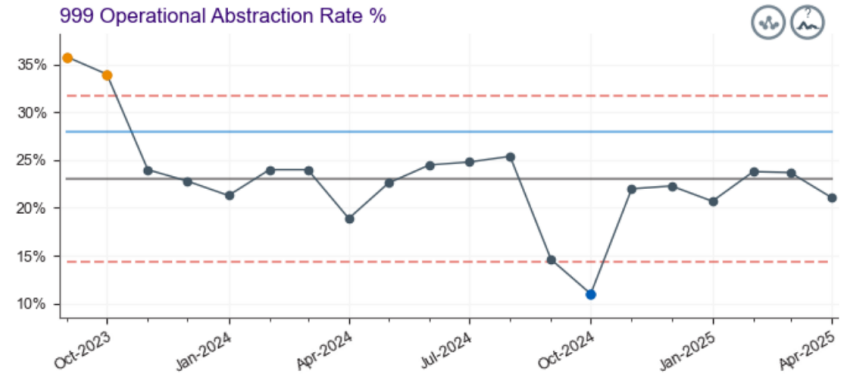
Common cause variation, no significant change.



999-24

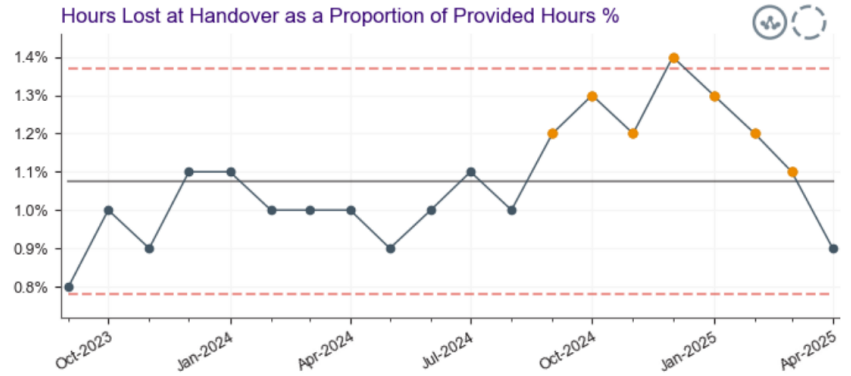
Dept: Operations 999
Metric Type: Supporting
Latest: 2928.9

Common cause variation, no significant change.



999-12

Dept: Operations 999
Metric Type: Supporting
Latest: 21.1%
Target: 28%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-25

Dept: Operations 999
Metric Type: Supporting
Latest: 0.9%

Common cause variation, no significant change.

999 Operational abstraction

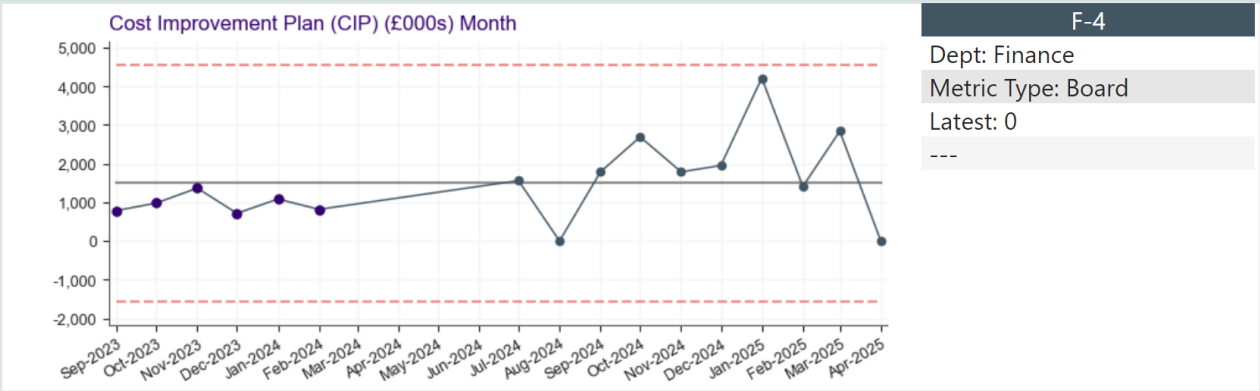
This is being reviewed following a detailed review across all Operating Units by PA consulting. Actions been agreed to address difference across the OU's and a drive to ensure all policies & procedures are followed particularly in relation to 'alternative duties, sickness management and training.

Hear & Teat Recontact

Although contact from patients who have received a Hear & Treat outcome (alternative disposition to ambulance dispatch) remains relatively low and is trending downwards, the Trust will be incorporating this in its new Virtual Care productivity dashboard, to ensure that the quality and impact of virtual care can be recorded and reviewed.

Sustainable Partner: Efficiency | Board Metrics

Integrated Quality Report

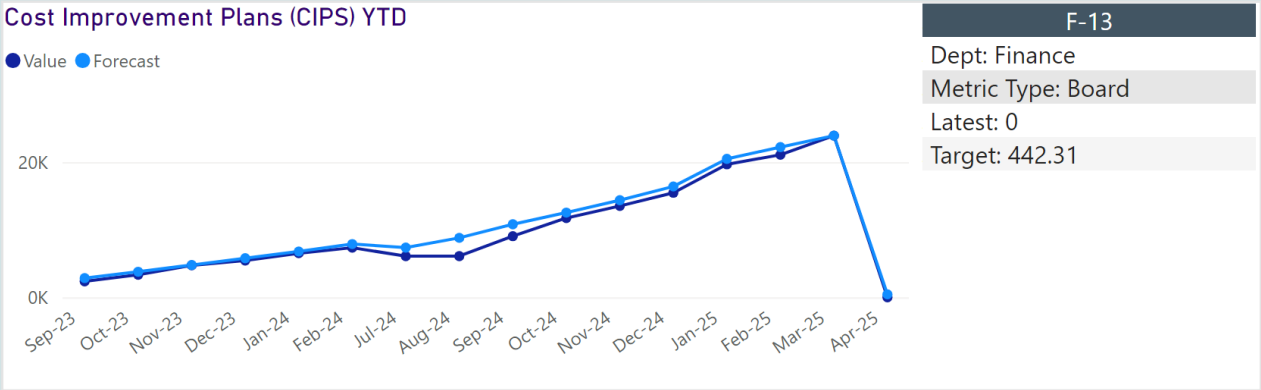


F-4

Dept: Finance

Metric Type: Board

Latest: 0



F-13

Dept: Finance

Metric Type: Board

Latest: 0

Target: 442.31

The Trust achieved its target efficiency target of £23.9m for the year to 31 March 2025.

£18.3m as achieved from productivity improvements and £5.6m from cash releasing schemes.

£17.7m of these schemes are delivered recurrently with £6.2m being delivered non recurrently (in year) to achieve the target.

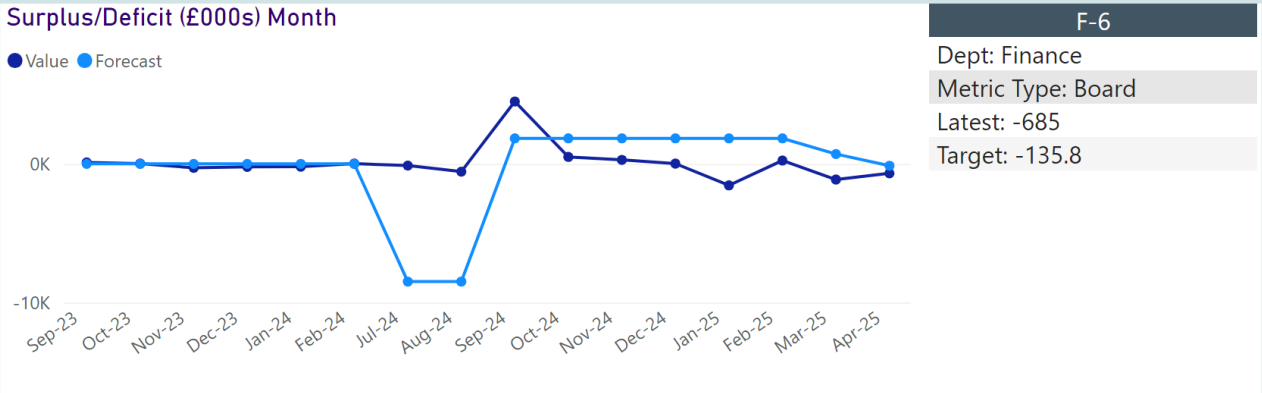
For the financial year 2025/26 the Trust has a total efficiency target of £22.6m. £12.6m from increased productivity linked to improving its C2 mean time to 25 minutes by March 2026 and a £10.0m cash releasing target (CIP).

The Trust is currently working through proposed schemes, and £8.9m cash releasing schemes have been identified.

Efficiencies are being owned and managed by the Senior Management Group that meets on a weekly basis. £0.0m of the CIP has been recognised for the year to April, as all schemes must go thorough a Quality Impact Appraisal (QIA) before it can be recognised.

Sustainable Partner: Finance | Board Metrics

Integrated Quality Report



F-6
Dept: Finance
Metric Type: Board
Latest: -685
Target: -135.8

The Trust achieved its break-even plan for the financial year 2024/25.

This was partly achieved from additional deficit support funding provided by its commissioners and additional ambulance growth funding helping the Trust to deliver an improved C2 mean performance.

For 2025/26 the Trust has again a break-even financial plan.

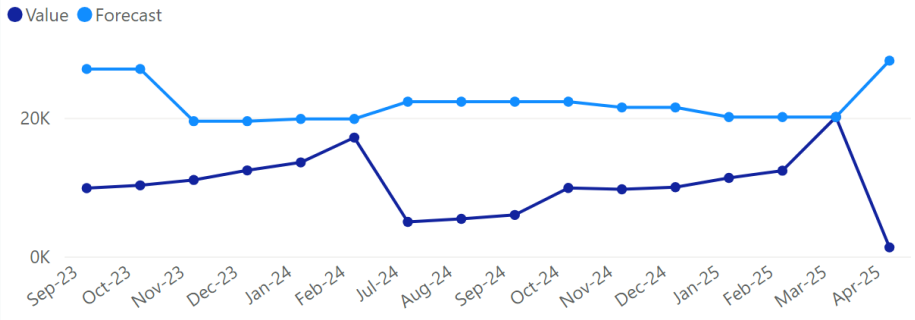
The Trust will not be receiving any deficit support funding to achieve this. However, additional ambulance growth funding has been allocated to enable the Trust to deliver a further improvement in C2 mean to 25 minutes by March 2026.

This plan is supported by the £22.6m efficiency target as mentioned above.

For the year to April 2025 (1 month), the Trust has achieved its planned deficit of £0.7m.

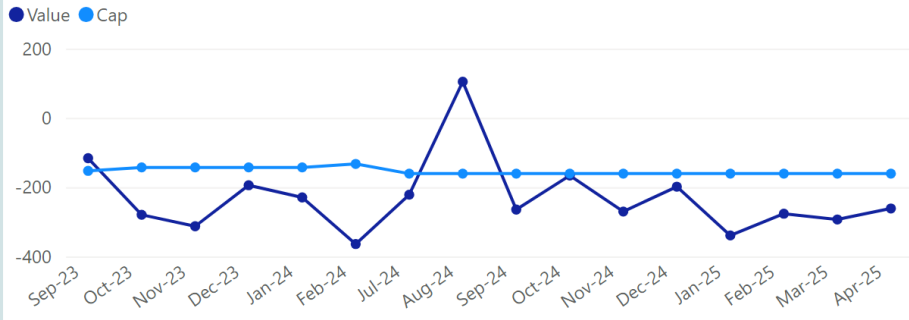
The Trusts cash position is £24.9m as at 30 April 2025.

Capital Expenditure ($000s) YTD



F-14
Dept: Finance
Metric Type: Supporting
Latest: 1304
Target: 28259

Agency Spend (£000s) Month



F-8
Dept: Finance
Metric Type: Supporting
Latest: -261.6
Target: -161

For the financial year 2024/25, the Trust incurred £20.1m of capital expenditure, this was £2.2m below plan, this underspend was agreed with its system partners.

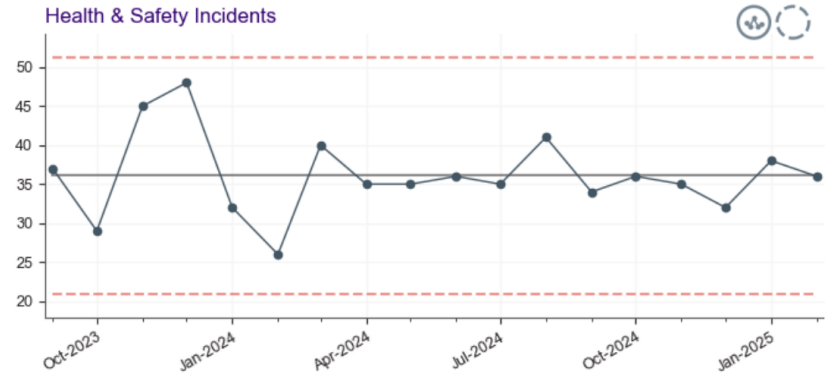
For 2025/26 the Trust has a capital plan of £28.3m, this includes £10.7m for ambulance purchases and £0.8m for Estates that is supported by national capital funding.

For the year to April 2026, the Trust has spent £1.3m, £1.2m ahead of plan, due to the timing of purchased assets.

For the financial year 2024/25 the Trust spent £2.3m on the provision of third party agency employees, this was £0.4m above plan.

This overspend was due to meet demand in both its 999 and 111 contact centres and to support productivity improvements within its 999 call centre, supporting the improvement in C2 mean and improved C2 segmentation, these improvements were supported by additional funding.

For 2025/26 in line with planning guidance, the Trust is planning to continue its reliance on agency staff by recruiting into its vacant positions.



QS-20
Dept: Quality & Safety
Metric Type: Board
Latest: 36

Common cause variation, no significant change.

QS-24
Dept: Quality & Safety
Metric Type: Board
Latest: 12%
Target: 30%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

H&S Incident Reporting

28 Health & Safety incidents were reported by staff in March 2025 and 36 incidents in April 2025. These figures are consistent with the same period in the previous year. All incidents reported during this period were classified as low harm.

Monitoring & Governance

The Trust maintains robust monitoring processes for Health & Safety incidents:

- Incident data is reviewed at both regional levels and by the Trust Health & Safety Working Group.
- Health & Safety risks are assessed monthly through the Risk Assurance Group and relevant H&S meetings.

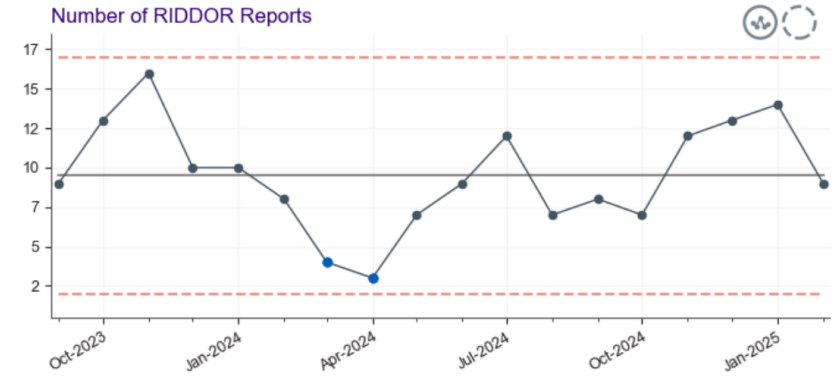
Key Health & Safety Initiatives for 2025

To support a proactive and preventative safety culture, the following initiatives are underway as reflected in the Trust wide improvement plan:

- Additional internal Health & Safety reviews
- Health & Safety culture questionnaires
- Establishment of a Musculoskeletal (MSK) Injury Reduction Working Group
- Attaining IOSH accreditation to deliver the IOSH Managing Safely course internally
- Benchmarking key metrics with other Ambulance Trusts
- Exploring learning opportunities from RIDDOR-related incidents

Sustainable Partner: Health & Safety | Supporting Metrics

Integrated Quality Report



QS-9

Dept: Quality & Safety

Metric Type: Supporting

Latest: 9

Common cause variation, no significant change.

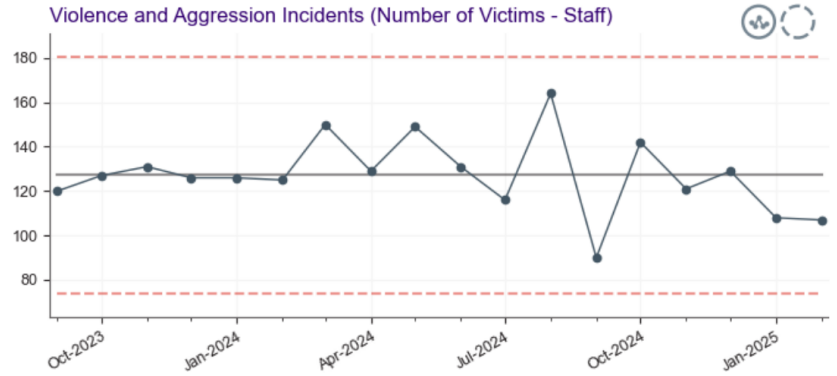
QS-22

Dept: Quality & Safety

Metric Type: Supporting

Latest: 21

Common cause variation, no significant change.



QS-13

Dept: Quality & Safety

Metric Type: Supporting

Latest: 107

Common cause variation, no significant change.

RIDDOR Incidents

During March 2025, the Trust reported 2 RIDDOR incidents to the Health and Safety Executive (HSE). This number significantly increased in April, with 13 incidents reported. This represents a notable rise compared to April 2024, when only 3 incidents were reported.

Musculoskeletal (MSK) injuries continue to be the most frequently reported category under RIDDOR. To address this, the Trust's MSK Injury Reduction Working Group is actively reviewing these incidents to identify trends and areas for improvement. Additionally, we are exploring learning opportunities from RIDDOR-related incidents to inform preventative actions and enhance staff safety going forward.

Violence & Aggression Incident Reporting

122 Violence and Abuse incidents were reported by staff in March 2025 and 127 incidents in April 2025. These figures show a decrease in comparison with the same period in the previous year. Reports have seen a reduction or no change through 8 of the last 9 months.

Monitoring & Governance

The Trust maintains robust monitoring and triage processes for violence and abuse incidents:

- Incident data is reviewed at the monthly Violence Reduction Working Group at regional levels and by the Trust Health & Safety Working Group.
- The Trust is currently 88% compliant with the new NHS Violence Reduction Standards

Key Initiatives for 2025

- Local violence risk assessment reviews
- Continued partnership working with relevant police forces.
- Hate crime focus with Kent Police
- Conflict resolution training delivery – over 2000 staff have received training.
- Continued support for body worn cameras

Manual Handling Incidents

A total of 20 Manual Handling incidents were reported by staff in March 2025, and 22 incidents in April 2025. These figures indicate a decrease of 10 incidents overall across both months for the same period last year.

Monitoring & Governance

The Trust maintains robust monitoring processes for Manual Handling incidents:

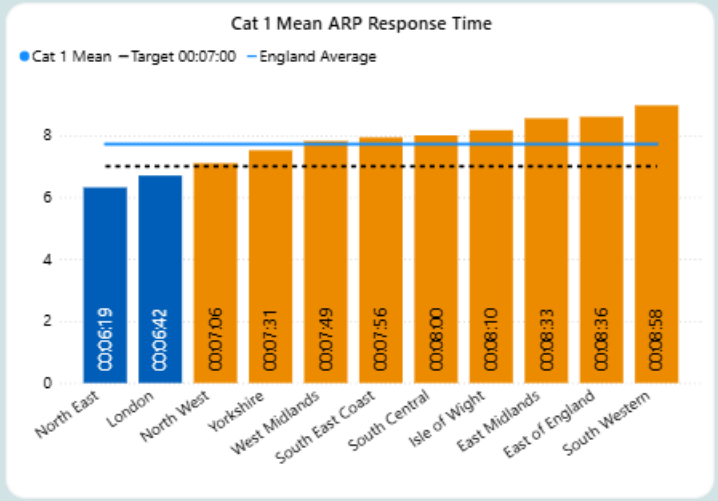
- Incident data is reviewed at both regional levels and by the Trust Health & Safety Working Group.
- Health & Safety risks are assessed monthly through the Risk Assurance Group and relevant H&S meetings.

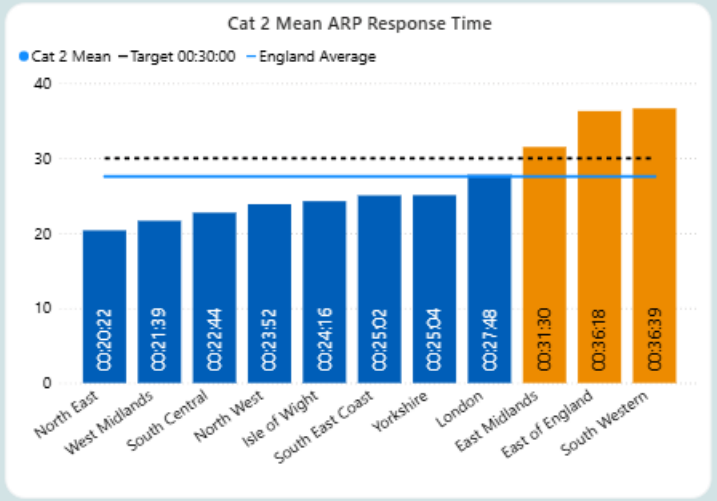
Manual Handling Initiatives for 2025

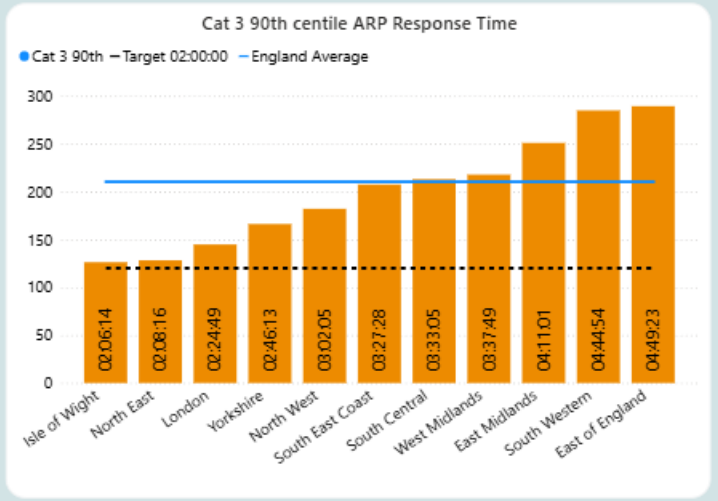
The Trust has established a Musculoskeletal (MSK) Injury Reduction Working Group to support targeted interventions and promote staff safety across all areas of the organisation.

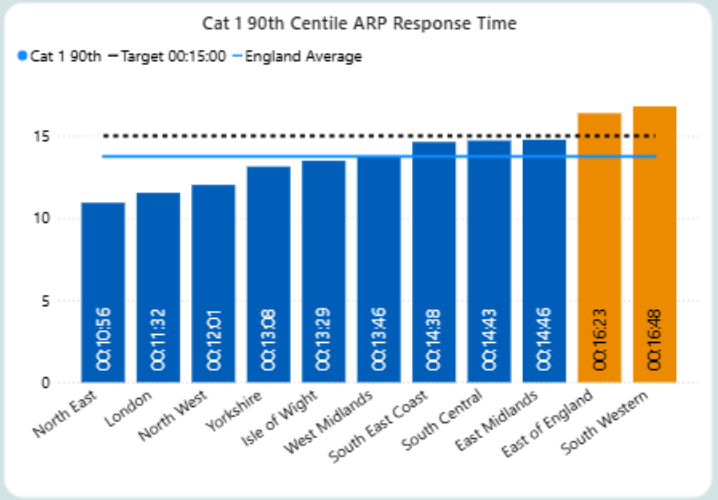
Sustainable Partner: Response Time Benchmarking April 2025

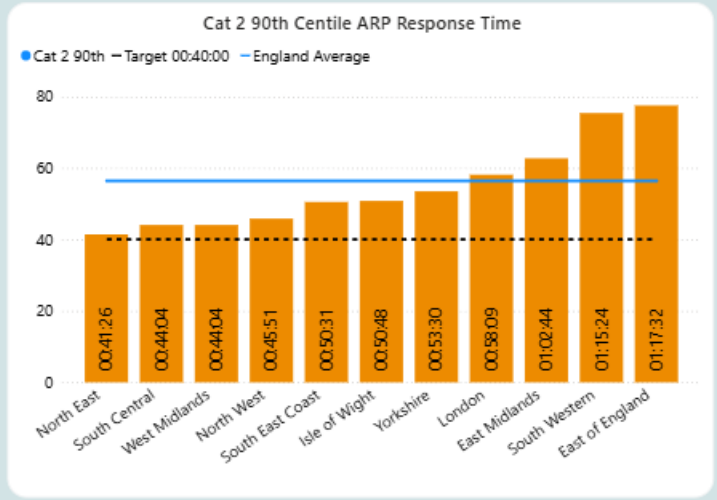
Integrated Quality Report

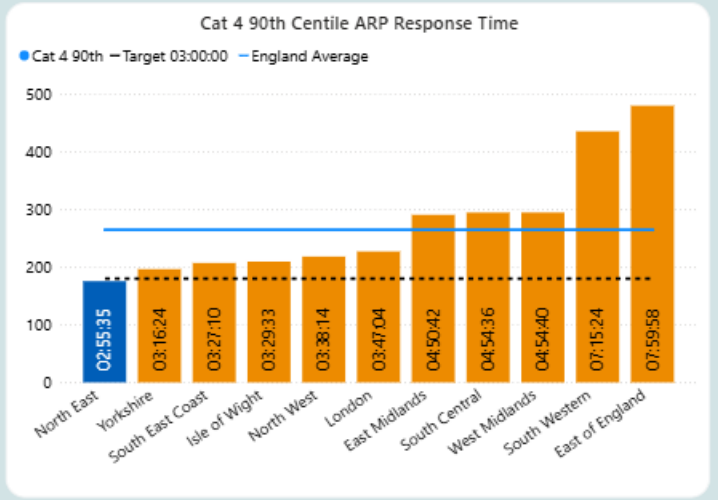












Summary:

•Secamb remain benchmarking broadly in the middle of the range of English NHS Ambulance Trusts for response times. All Trusts are being challenged to improve their C2 mean in the coming year in line with NHSE guidance.

Sustainable Partner: Response Time Benchmarking April 2025

Integrated Quality Report

Incident Outcomes		H&T
England		16.2%
1	London	20.5%
2	East Midlands	19.0%
3	West Midlands	18.9%
4	South Central	15.7%
5	North West	15.6%
6	South East Coast	15.4%
7	Yorkshire	14.7%
8	East of England	14.5%
9	South Western	13.8%
10	Isle of Wight	8.6%
11	North East	8.3%

Incident Outcomes		S&T
England		29.1%
1	South Western	35.8%
2	East of England	33.7%
3	Isle of Wight	33.5%
4	South Central	31.3%
5	South East Coast	29.5%
6	North East	29.4%
7	East Midlands	28.1%
8	North West	27.0%
9	West Midlands	26.6%
10	Yorkshire	26.1%
11	London	26.0%

Incident Outcomes		S&C (elsewhere)
England		4.7%
1	North East	7.3%
2	Yorkshire	6.4%
3	East Midlands	6.3%
4	West Midlands	5.9%
5	North West	5.9%
6	South Western	4.5%
7	South Central	4.1%
8	East of England	2.9%
9	London	2.8%
10	South East Coast	2.0%
11	Isle of Wight	1.2%

Incident Outcomes		S&C (to ED)
England		50.0%
1	South Western	45.9%
2	East Midlands	46.5%
3	West Midlands	48.6%
4	South Central	48.8%
5	East of England	48.9%
6	London	50.7%
7	North West	51.5%
8	Yorkshire	52.8%
9	South East Coast	53.2%
10	North East	55.1%
11	Isle of Wight	56.6%

Call Answer Times		Mean
England		2
1	North East	0
2	West Midlands	0
3	London	1
4	North West	1
5	South Western	1
6	East of England	2
7	South East Coast	2
8	East Midlands	6
9	Isle of Wight	6
10	Yorkshire	6
11	South Central	7

Call Answer Times		90th centile
England		2
1	East of England	0
2	North East	0
3	North West	0
4	West Midlands	0
5	London	1
6	South East Coast	1
7	South Western	1
8	East Midlands	3
9	Isle of Wight	5
10	South Central	5
11	Yorkshire	14

Call Answer Times		95th centile
England		10
1	North West	0
2	West Midlands	0
3	East of England	1
4	North East	1
5	South Western	1
6	London	2
7	South East Coast	2
8	East Midlands	26
9	Isle of Wight	42
10	Yorkshire	46
11	South Central	51

Call Answer Times		99th centile
England		48
1	West Midlands	7
2	South Western	8
3	North East	12
4	South East Coast	24
5	North West	31
6	London	35
7	East of England	66
8	East Midlands	102
9	Yorkshire	116
10	South Central	126
11	Isle of Wight	139

Summary:

•Secamb benchmark well on call answer times. H&T performance is in the middle of the range with room for improvement. As referenced in the report above, S&C outcomes will be reviewed.

Appendix 1: Glossary

Integrated Quality Report

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

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Board Assurance Framework

2025/2026

June v1.0

We Are a Sustainable Partner

We are a sustainable partner as part of an integrated NHS

Tier 1
Tier 2
QI
Directorate objective

2024-2029 Strategy Outcomes

- Breakeven / 8% reduction in cost base: £26m annually. Avoid 100m additional expenditure / growth
- Increase utilisation of alternatives to ED - 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%

2025/26 – Strategic Transformation Plan

- Advance **South-East Ambulance Transformation Programme** through 1
  - Progress functional priority areas (SCAS / SASC)
  - Develop Business Case (SCAS)
  - Deliver ICB-approved **multi-year plan** and refreshed **strategic commissioning framework** to support strategy delivery and sustainability, including break-even trajectory.
- Progress delivery of our **digital enablement** plans, presenting a detailed plan to the Board at the end of Q1 1

2025/26 Outcomes

- Deliver a financial plan
- Handover delay mean of 18 minutes
- Increase UCR acceptance rate to 60-80%
- Reduce Vehicle off Road Rate – 11-12%
- Achieve over 90% Compliance for Make Ready

2025/26 – Operating Plan

- Deliver **Financial Plan**
  - Meet CIP Plan of £23m (Efficiencies - £10m; Clinical productivity – eq. £10.5m)
- Deliver **strategic estates review** (inc. Trust HQ refurbishment - 111/999 Contact Centre & Corporate Floor) 2
- Implement H&S improvement plan to progress Trust to Level 4 of maturity by Q2 with clear milestones in place
- Complete **support services review**, including Make Ready model and vehicle provision 2
- Monitor **system-led productivity** schemes, improving alternatives to ED and reducing hospital handovers.
- Develop a Trust-wide Health & Safety improvement plan in Q1 for implementation by Q2

Compliance

- Heath & Safety
- Vehicle & Driver Safety / Driving Standards
- Data Security / Cyber Assurance Framework

BAF Risks

- **Collaboration:** There is a risk that the Trust does not drive collaboration, which will result in reduced strategic delivery and missed opportunities to integrate services and care pathways, reduce waste, and drive productivity to improve care.
- **Financial Plan:** There is a risk that the Trust fails to deliver a break-even finance plan, our Board, our people, our regulators and commissioners lose confidence in our organisation.
- **Cyber Resilience:** There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.
- **Digital Capacity, Capability & Investment:** There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery.
- **System Productivity**: There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved.

We are a sustainable partner as part of an integrated NHS

2025/26 – Strategic Transformation Plan

Programme	Status	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Collaboration & Partnerships	Progress functional priority areas (SCAS / SASC)			Claire Webster	EMB	Yes	Chief Strategy Officer	Finance & Investment
	Develop Business Case (SCAS)							
Multi-Year Plan	Deliver multi-year plan to support a break-even trajectory.			Jo Turl	EMB	No	Chief Finance Officer	Finance & Investment
Strategic Commissioning Framework	Work with ICB commissioning leads to deliver a refreshed strategic commissioning framework to su CW1 rategy delivery and sustainability, including break-even trajectory.			Claire Webster	EMB	No	Chief Strategy Officer	Finance & Investment
Digital Enablement	Implement priority **digital initiatives**, supporting overarching Trust Strategy			Hiran Patel	EMB	Yes	Chief Digital Information Officer	Finance & Investment

2025/26 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date Last Reviewed @ Committee
Deliver Financial Plan	Meet CIP Plan of £20.5m			Chief Finance Officer	SMG	No	FIC	
	Deliver £10m efficiencies & eq. £10.5m productivity						FIC	
Implement H&S improvement plan to progress Trust to Level 4 of maturity by Q2				Chief Nursing Officer				
Monitor System Led Productivity Schemes - improving alternatives to ED and reducing hospital handovers				Chief Operating Officer				
Deliver Strategic Estates Review	Creation of Joint 111/999 Centre			Chief Finance Officer	SMG	Yes	FIC	N/A
	Redevelopment of Corporate HQ	LM0						
	Full Trust Estate Review						FIC	
Complete Support Services Review	Make Ready Service Model			Chief Strategy Officer	SMG	Yes	FIC	
	Vehicle Provision						FIC	

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Collaboration: There is a risk that the trust does not drive collaboration, which will result in reduced strategic delivery and missed opportunities to integrate services and care pathways , reduce waste, and drive productivity to improve care.	12	04	CSO
Financial Plan: There is a risk that the Trust fails to deliver a break-even finance plan, our Board, our people, our regulators and commissioners lose confidence in our organisation.	12	06	CFO
System Productivity: There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved	12	08	CSO
Cyber Resilience: There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.	16	12	CDIO
Digital Capacity, Capability & Investment: There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery.	16	08	CDIO

Board Highlight Report – Digital Enablement

SRO / Executive Lead: Nick Roberts

Key
Completed
On Track
At Risk
Delayed

Progress Report Against Milestones:

Key achievements against milestone
After Review these Programmes have been successfully completed:

Project Name	Outcome	Completion Date
Visual IVR	✓ Improve efficiencies within EOC & 111 ✓ Align with the Digital strategy	Feb 2025
111 Recall	✓ Reduced manual data entry by 111 service ✓ Improved patient experience ✓ Efficiency in response times saving 2-3 minutes per patient call	Apr 2025
Liquid Voice<> CLERIC Integration	✓ Innovative patient solutions ✓ Improved efficiencies within EOC & 111 ✓ Align with the Digital strategy	Apr 2025
ePCR Truncate Project	✓ Introduce a new user interface designed to enhance user experience, accessibility, and overall efficiency ✓ Reduced "Automatic Case Closure Timing" (from 72 hours to 16 hours) (Approved by PPG & CST Dev. Board)	May 2025

Upcoming activities and milestones
- Re-baseline Digital Portfolio priorities for FY25_26
- Refine/Aligning Digital Directorate PMO with Corporate Governance and Reporting protocols.
- Ensure robust governance in place & all required artifacts for all in-flight projects and portfolios.
- Baseline and agree internally budget allocation for Digital spend for current financial year.

Notification to Board
- Gap Analysis Report – highlighting the current state (post PM leavers), existing gaps and future state of reporting to provide an oversight of in-flight programmes & previously agreed initiatives.
- Refine the existing Digital Demand Management process – highlight inconsistencies in existing process with no linkage to Corporate PMO and Operational teams within Digital Directorate. Aim to review the Digital Programme Key Deliverables e.g. Shared Care Records Project (reset, formerly NCRS)
- Submission of the re-baselined Digital Programmes for 25_26, aim to align with Corporate PMO with the emerging Tier 1, 2 and 3 programmes of work

Escalation to Board of Directors - None

Previous RAG	Current RAG	RAG Summary
		The overall RAG status for May 2025 remains amber due to Programme re-baseline to provide clarity on Programme vs Corporate priorities, dependencies between the Tier 1 Programmes, Finances and matched Resources agreed to deliver FY 25-26 Book of Work.

Risks & Issues:	Apr	May	Mitigation
Risk: That if the Digital Transformation Programme is not presented to Trust Board on 7 August, there may not be enough time and capacity to deliver the programme this financial year.	16	12	Resource changes applied to Digital Delivery Team and programme being developed. On track to present to Trust Board on 7 August. Further work required to produce supporting business cases.
Risk: Revenue funding to support the Digital Enablement programme is unconfirmed and capital requirements for individual projects are still undetermined. This presents a risk that available funding may not align with planning assumptions, potentially reducing the programme's scope	12		Review of current project inflight items is underway to identify the budget allocation required for the 25/26 plan. Update to be provided to Trust Board for 7 Aug 25,
Risk: There is a risk that there is insufficient capacity across the Digital Directorate to deliver both BAU & project work.	15	6	The Book of Work review has highlighted a skills and resourcing gap, currently being quantified for an interim resource request to support Tier 1 project delivery. A shortage of BAs has impacted governance, delivery, quality, and benefits realisation. The Digital PMO requires adequate resourcing to sustain delivery of ongoing and planned initiatives.
Risk: Non-delivery of the Shared Care Record solution to clinical frontline staff may inhibit the best outcomes for patients and reduce opportunities to improve C2 mean response times.	12		NCRS programme being rebased to include impact of all Health Information Exchanges to ensure fast and safe access to relevant external patient records. Consideration of impacts on response and handover performance now part of the project. Usage policies and processes being evaluated.
Risk: There is a risk that until the remediation work for Crawley and Medway infrastructure is completed, failover between EOCs may be impeded and take longer than necessary.	16		BT Report on configuration changes being implemented over multiple dates, with initial work concluding on 18 June 2025. A Phase 2 will enable full alignment of Medway and Crawley EOC configuration to enable rapid failover in event of a business continuity requirement.

Q1 (Apr-June 25)

- **Refine FY24/25 BoW**
- **Refine FY26/27 BoW**
- Define Portfolio Scope
- **Establish Digital Governance BAU & Programme**
- Business Case - Backfill Submission

Q2 (Jul-Sep 25)

- **Digital Programme Delivery Roadmap**
- **Secure Approval of Costed Prioritised BoW**
- **Define PMO framework**
- **Portfolio Scope Approved**
- Refine Digital Demand management process
- Implement Digital Demand management process
- **Implement Digital Governance BAU & Programme**
- New PID & Business Case Development
- Finalise Business Case Development– FY26/27

Q3 (Oct-Dec 25)

- **Future Business Planning – FY26/27**
- **Business Case Submissions & Approvals**

Q4 (Jan-Mar 26)

- **Transition to BAU BoW FY 25/26**
- **Deliver FY26/27 BoW**

Outcomes (for developing plan, not actual projects)

- Successful transition of Digital services to enable implementation of Digital Service and Corporate improvement programmes
- Allocate limited resources are, and demand is planned through reprioritisation exercise. A defined programme of works with costings to be developed and embedded with controls and appropriate governance.

Board Highlight Report – Collaboration & Partnerships

SRO/Delivery Lead

David Ruiz-Celada

Key
Completed
On Track
At Risk
Delayed

Progress Report Against Milestones:

Key achievements against milestone

- MoU signed off by the Chairs at each Trust – Feb 2025
- Joint Strategic Lead role commenced – Feb 2025
- Phase 1: Discovery phase completed, including analysis of strategic alignment, operational variations and identification of key business case workstreams - April 2025
- Key functional collaboration areas scoping commenced to identify what will be delivered in year, key milestones, KPI's and benefits
- Governance established with the first Joint Strategic Collaborative Committee (JSCC), held April 2025
- Joint Executive-to-Executive workshop held May 2025, which focused on three critical workstreams, aligned with the business case framework with the outputs feeding into the discussion at the joint Boards on the 28th May.

Upcoming activities and milestones

- Continued progression and monitoring of the Functional Collaboration initiatives. Focus on benefits realisation and developing joint efficiency and productivity pipeline to support 25/26 and 26/27

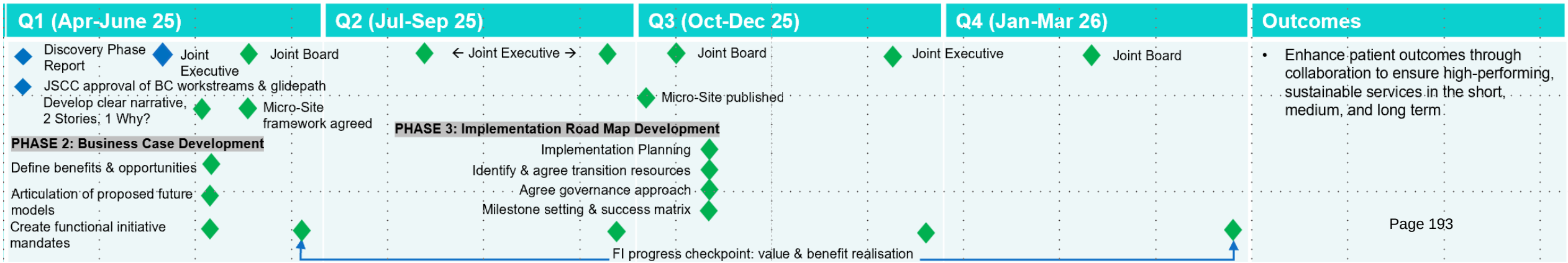
<u>Phase 2: Business Case (1 April - 28 May 2025)</u>

- Development of strategic business case for collaboration
- Articulation of proposed future models
- Development of clinical case and financial case to support 8th October joint Board milestones

Escalation to Board of Directors - None

Previous RAG	Current RAG	RAG Summary
		Programme is running on track to timeline and milestones. Governance and meeting scheduled established. Discovery phased completed and end of phase report to be presented at JSCC.

Risks & Issues:	Apr	May	Mitigation
Risk: Capacity constraints (Executive, SME and Programme)	16	12	Align joint executive objectives to collaboration priorities agreed via E2E and B2B. This will help ensure a balance of capacity and integration with the strategic direction and annual priorities. Existing programmes within each organisation are likely to align with these efforts.
Risk: Funding required to fund transitional arrangements or necessary joint investments	16	16	Transitional funding requirements to be identified as part of the financial sustainability component of the Business Case.
Risk: Alignment with strategic commissioning changes and impacts of NHSE/ICB re-configurations	16	16	Provider Executives and SHICB leads have established aligned programmes of work to co-design the changes in organisational structures and functions aligned to emerging commissioning model. However, the variability and instability in NHSE and ICB systems may strain these efforts.



BAF Risk 541 – Collaboration

There is a risk that the trust does not drive collaboration, which will result in reduced strategic delivery and missed opportunities to integrate services and care pathways , reduce waste, and drive productivity to improve care.

Contributory factors, causes and dependencies: increasing NHS financial constraints require providers to integrate and collaborate to provide consistent care, reduce waste, and drive productivity so investment can focus on front line patient care. CF Report recommended this workstream to kick off in 2024, with HIOW and SHICB working to establish single strategic commissioning function for 999/111 across Southeast. Success depends on alignment with partner organisations and ability to adapt to structural changes in regional healthcare landscape.

Controls, assurance and gaps

Controls: Sector-level engagement via Association of Ambulance Chief Executives with 2 executives chairing national groups; CEO chairs Southern Ambulance Services Collaborative Initiative; MOU with South Central Ambulance Service for collaboration business case development; joint strategic collaboration committee with SCAS; Joint Strategic Lead appointment in Chief Strategy Officer role shared with SCAS; regional steering group chaired by ICBs; divisional restructuring to align with local systems.

Gaps in control: Collaboration business case still in development; dependency on external partner commitment and ICB commissioning decisions; new divisional structure implementation ongoing.

Positive sources of assurance: Strong sector leadership positions and national influence; established governance structures with SCAS and regional partners; ICB engagement in steering group provides strategic alignment; scheduled board meetings for decision-making.

Negative sources of assurance: Complex multi-partner environment with competing priorities; financial constraints across all partners; structural changes in commissioning creating uncertainty.

Gaps in assurance: Environment of uncertainty as ICBs submit their consolidation plans; limited visibility of ICB commissioning consolidation timelines.

Accountable Director	**Chief Strategy Officer**
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 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Complete collaboration business case development with South Central Ambulance Service	Joint Strategic Lead	October 2025	Joint strategic collaboration committee overseeing development
Joint board meetings to review collaboration case and determine next steps	Joint Strategic Lead	May & October 2025	Board meetings scheduled 28th May and 8th October 2025
Complete divisional restructuring to align with local systems	Chief Operating Officer	September 2025	Restructuring in progress to support local integration
Maintain sector leadership roles and national group participation	Chief Executive Officer	Ongoing	2 executives chair national groups; CEO chairs Southern Collaborative
Establish Joint Strategic Commissioning Group	Chief Strategy Officer	July 2025	To be established to oversee strategic commissioning alignment

BAF Risk 640 – Financial Plan

There is a risk that the Trust fails to deliver a break-even finance plan, our Board, our people, our regulators and commissioners lose confidence in our organisation.

Contributory factors, causes and dependencies: Uncertainty given changes at ICB/ national level. See link to risk 647 System Productivity

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 3 X Likelihood 2 = 06**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Planning improvements: Planning for 25/26 incorporated substantial improvements over 24/25 information and controls and better integrated operational performance, ops support (fleet/make ready), workforce, and capital. Additional resource brought in to help integrate planning and, also prepare ten-year planning insight. Workforce: Omission of NQP training numbers from plan has created an affordability issue which will need further mitigation and incorporating as an improvement for 26/27 planning. Guidance clarification: NHSE has clarified guidance such that the H2 £5m performance funding is independent of the 2 minutes of C2 performance improvement dependent on system actions

Gaps in control: Training: Gap highlighted around pre-committed NQP numbers not adequately reflected in the finance element of the plan. This will require further mitigation. **System C2 Contribution:** The C2 performance element of the plan relies on 2 minutes of time being contributed by the wider system including reduced handover delays and a more consistent UEC capacity/capability. No detailed plans have been supplied at the time of final plan submission. £5m of funding linked to achieving 25 min C2 mean is therefore at risk if the additional 2 minutes is not realised in the system. **Training impacts:** Omission of NQP training numbers from plan has created an affordability issue which will need further mitigation and incorporating as an improvement for 26/27 planning.

Positive sources of assurance: Compliant plan submitted on 27th March. No negative feedback received/queries outstanding. 24/25 plan outcomes in line with plan across workforce, finance, and operational performance domains. Internal audit financial systems audit gives reasonable assurance. SECAmb and Lead ICB CEO have written to all ICB CEOs advising that if credible system plans to contribute to 2 minutes of C2 mean performance are not produced and realised then the Trust will invoice for the balance of £5m in order to offset the loss of the C" related NHSE income and breakeven. Also, that ICBs need to fund £2m of additional 111 capacity which NHSE has been funding or else accept a performance deterioration.

Negative sources of assurance:

Gaps in assurance: No detailed plans received and assured from ICBs at submission stage. No response to the CEO letter as yet received. No plans for system contribution for C2 performance yet received nor risk assessed.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress

BAF Risk 544 – Cyber Resilience

Public Version of this risk is redacted

There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.

Contributory factors, causes and dependencies:

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; Penetration testing and social engineering testing; Remote monitoring of end points; standardised action card and business continuity plan for handling cyber-security events. Network vulnerability identified, additional internal controls applied. Further analysis by 3rd party around networks and security has identified some configuration changes – currently being scoped. Supply chain: NHSE mandate that digital supply chain risks considered as part of the procurement process via AACE digital group, technology solution identified in line with NHSE guidance.

Gaps in control: SECAmb: No security on-call team; Trust submission of CAF (cyber assurance framework) compliance shows organisation is not compliant; No programme of training or awareness focussing on cyber-security; No ID verification for in-person or telephone users approaching IT for support. Controls around social engineering for staff are not sufficiently robust. Robustness of leavers process. Supply chain: NHSE mandate not in place for products which have been procured historically. Incomplete cyber policies and procedures.

Positive sources of assurance: Cyber preparedness review gave a maturity score of 65/ 100 (high amber) - this is in line with other equivalent organisations in terms of maturity. Finance and Investment Committee furnished with latest report by NHSE in January 2025. Test of cyber security arrangements conducted November 2024 – outcome identified some learning and strengths.

Negative sources of assurance: Review by an independent expert organisation has identified network misconfiguration.

Gaps in assurance: None identified

Accountable Director	**Chief Digital Information 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 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Increasing penetration testing	CDIO	Q2 2025/26	New penetration test to be undertaken due to the time elapse from the last report - due to be completed by end of Q1 2025.
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. Solution identified in Digitial Strategy and in funding round for 25/26.
"Go to green" plan from cyber preparedness review	CDIO	Q1 2025/26	Go to green plan provided to Finance and Investment Committee January 2025. Plan provides improvements to policies and procedures but must be enhanced with technical interventions. Project with business case for funding approvalrequired before implementation.

BAF Risk 650 - Digital Capacity, Capability & Investment

There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery

Contributory factors, causes and dependencies: NHS funding environment. Partner/ wider NHS focus given ongoing changes at national and regional level may make investment more challenging. Integration with national programmes (i.e.: national care records programme)

Accountable Director	**Chief Digital Information Officer (CDIO)**
Committee	**Finance and Investment**
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**

Controls, assurance and gaps

Controls: Recruitment to key senior roles in Directorate, including new CDIO and Head of Service Delivery April 2025. Digital Strategy approved by Board in Autumn 2024, outlining necessary digital development and integration – this forms part of wider strategic delivery. Business cases in relation to Digital Directorate approved as part of 2025/26 planning cycle (substantive increase in workforce of £70k and additional non-recurrent transitional costs). Opportunities for collaboration with partners in the digital space. Ongoing Digital check and challenge with Executive team.

Gaps in control: Digital restructure paused temporarily- key senior and administrative roles vacant following MARS. Business cases for Digital capital and revenue workstreams are high level and there is and therefore insufficient detail in the work programme currently to assure expenditure and delivery plans for FY25/26.

Positive sources of assurance: Strategic and operational delivery monitored through Audit and Risk Committee. Revised Digital Delivery resourcing has improved service engagement and project productivity.

Negative sources of assurance:

Gaps in assurance: Digital Transformation Programme to be presented to Trust Board on 7 August 2025.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Restructure of Digital Directorate	CDIO	Q3 2025/26	Parts of restructure completed- e.g.: Permanent CDIO in post. Restructure paused due to inconsistencies in preparation and is being reviewed for launch in Q3.
Business cases to support delivery of digital strategy			Business cases to support strategic delivery submitted comprising £4.8m capital and £1.5m revenue funding. Programme of work to Trust Board 7 August with subsequent completion of business cases to enable funding approval.

BAF Risk 647 – System Productivity

There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved

Contributory factors, causes and dependencies: National focus on improving NHS productivity following consecutive years of decline since COVID, combined with financial pressures limiting growth needed to cope with inflationary pressures. System productivity plans for 2025/26 require hospital handover times <18 minutes and urgent community response teams to accept 60% of referrals to meet C2 25 min.

Controls, assurance and gaps

Controls: Strategic commissioning group and contract review meetings with system partners; system partnership leads engaging directly with providers; operational teams restructuring to align with systems; regional teams reviewing system plans as part of new oversight framework (first meeting 24th June).

Gaps in control: System plans not yet received from 4 systems.

Positive sources of assurance: NHS England confirmed £10m funding will not be removed if targets missed due to reasons beyond our control; established governance structures and regional oversight framework.

Negative sources of assurance: System plans not yet received from 4 systems, YTD trends for UCR at M02 remain at 21% and Handover time trends remain above plan in 3 or 4 systems, with an upward trend

Gaps in assurance: n/a

Accountable Director	**Chief Strategy Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 3 X Likelihood 4 = 12** ***(Down from 16 due to reduced financial consequence)***
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
Design and delivery of three priority models of care with input from system partners	Chief Medical Officer	Q4 2025/26	This will commence in April 2025 as part of our Tier 1 programmes
Secure submission of system productivity plans from all 4 systems (Kent, Surrey, Sussex, Frimley)	Chief Strategy Officer	June 2025	System partnership leads engaging with providers directly
Establish regular monitoring of handover times and community response acceptance rates via CRM	Chief Operations Officer	June 2025	Metrics framework to be developed

Item No	39-25

Name of meeting	Trust Board
Date	5 June 2025
Name of paper	M01 (April 2025) 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)

This report provides the year-to-date (YTD) financial performance of the Trust.

The Trust reported a favourable variance of £7k compared to the planned deficit of £692k for the month ending April 2025. We are currently forecasting that we will achieve our underlying breakeven plan and expect improvements in the C2 mean performance.

However, the planned efficiency target for the month, set at £442k, has not yet been realised. This is because the identified, validated, and scoped schemes totalling £6,502k are still awaiting the Quality Impact Assessment (QIA) before they can move into the delivery phase. It is anticipated that 94% of the current total schemes will be recognised on a recurrent basis.

Capital expenditure of £1,304k is £1,167k above plan, which relates to slippage from the 2024/25 plan and will even out over the year.

In M1 cash payments exceeded receipts by £4,160k which has decreased the cash balance to £24,867k from £29,027k in the previous month. The closing balance is £7,342k below plan. The key driver for the adverse variance against plan is the Trust not receiving the first tranche, £5,100k of the £10,200k capacity support funding in line with anticipation. The remainder of the adverse variance is driven payments of £2,162k for building and customising our ambulances that was anticipated to be paid later in the year.

Note: Tables are subject to rounding differences (+/- £1k).

Recommendations, decisions, or actions sought	For Information

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

2025/26

Finance Report to the Board of Directors

1 Month to 30 April 2025

Executive Summary

The Trust reported a £685k deficit for the 1 month to April 2025 (YTD), £7k better than planned.

Note: Tables are subject to rounding differences (+/- £1k).

	Year to April 2025			Forecast to March 2026		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	29,597	29,527	(71)	354,946	354,947	0
Expenditure	(30,289)	(30,212)	78	(354,948)	(354,948)	0
Planned Profit on Sale of Assets	0	0	0	0	0	0
Trust Surplus / (Deficit)	**(692)**	**(685)**	**7**	**(2)**	**(2)**	**0**
Reporting adjustments:						
Remove Impact of Donated Assets	0	0	0	2	2	0
Remove Impact of Impairments	0	0	0	0	0	0
Reported Surplus / (Deficit)*	**(692)**	**(685)**	**7**	**0**	**0**	**0**
Efficiency Programme (cash releasing)	442	0	(442)	10,000	10,000	0
Cash	32,209	24,867	(7,342)	30,427	30,427	0
Capital Expenditure	137	1,304	(1,167)	28,259	28,259	0

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

Year to April 2025 (YTD)

- For April 2025, the Trust's financial position is £7k better than planned.
- The overall financial performance is a mix of unfavourable and favourable variances. Favourable variances in several directorates, particularly in Operations, Paramedical, and Digital, are helping to offset emerging financial pressures. These pressures include overspending in the NHS 111 service and increased depreciation costs.
- The Trust's breakeven financial plan for 2025/26 relies on achieving a £10,000k cash-releasing efficiency target, representing 2.0% of operating expenditure.
    - We have currently developed 53 out of the 82 schemes identified on the Pipeline Tracker at a value of £6,502k.
    - Out of these, 39 schemes amounting to £4,037k are pending QIA review before moving to delivery, with 14 schemes equalling £2,465 scoped and undergoing executive approval and the QIA process.
    - There are planned savings of £442k for April that are still pending due to the QIA process.
    - Of the total savings, 94% are expected to be recurrent compared to the planned figures of 70%.
    - The risk distribution for the schemes is 26% green, 48% amber, and 27% red.

  - The Trust aims to meet its efficiency target by progressing 28 proposed schemes totalling £2,424k and identifying further opportunities to achieve the underlying breakeven position.

- In M1 cash balance was £24,867k and is £7,342k below plan. The key driver for the adverse variance against plan is the Trust not receiving the first tranche, £5,100k of the £10,200k capacity support funding in line with agreement.

- Capital expenditure of £1,304k is £1,167k above plan, which relates to slippage from the 2024/25 plan and will even out over the year.

1. Income

	Year to April 2025		
	£000	£000	£000
	Plan	Actual	Variance
999 Income	26,589	26,593	4
111 Income	2,433	2,433	0
HEE Income	287	206	(81)
Other Income	288	295	6
Total Income	**29,597**	**29,527**	**(71)**

- 999 and 111 incomes are on plan (non-material variance on 999) and the Trust anticipating of receiving the full plan value.
- HEE (Health Education England) income is £81k behind plan driven by a timing difference of the learning and development funding that the Trust planned to receive in-month.
- Other income is £6k favourable compared to plan, due to research and development income received ahead of plan.

2. Expenditure

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

Expenditure By Directorate*	Year to April 2025			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(386)	(386)	0	(4,646)	(4,646)	0
Finance & Corporate Services	(1,381)	(1,386)	(5)	(17,180)	(17,180)	0
Quality and Safety	(547)	(494)	53	(6,377)	(6,377)	0
Medical	(1,095)	(1,136)	(41)	(13,575)	(13,575)	0
Operations	(17,490)	(17,266)	224	(210,631)	(210,629)	2
Operations - 111	(2,531)	(2,658)	(127)	(29,411)	(29,411)	0
Strategic Planning & Transformation	(2,429)	(2,394)	35	(29,499)	(29,499)	0
Human Resources	(463)	(438)	25	(5,413)	(5,413)	0
Digital	(1,152)	(1,053)	99	(13,886)	(13,886)	0
Paramedical	(592)	(485)	107	(7,724)	(7,724)	0
Total Directorate Expenditure	**(28,066)**	**(27,696)**	**370**	**(338,342)**	**(338,340)**	**2**
Depreciation	(1,401)	(1,567)	(166)	(19,081)	(19,083)	(2)
Impairments	0	0	0	0	0	0
Financing Costs	(89)	(122)	(33)	(1,067)	(1,067)	(1)
Corporate Expenditure	(733)	(826)	(93)	3,542	3,541	(1)
Total Expenditure	**(30,289)**	**(30,212)**	**78**	**(354,948)**	**(354,948)**	**0**
Further Trust Savings Required	0	0	0	0	0	0
Planned Profit on Sale of Assets	0	0	0	0	0	0
Total Trust Expenditure	**(30,289)**	**(30,212)**	**78**	**(354,948)**	**(354,948)**	**0**

*Excludes Income - Values subject to rounding

Year to Date performance against plan

- Total expenditure in April 2025 (month 1) was £30,212k, which is £77k below plan.

The net underspent is driven by favourable and adverse variances as follows:

- The underspend in Operations amounts to £224k, primarily due to lower-than-expected overtime costs of £136k and the timing of new recruits, which accounted for £93k in Field Operations.

- Other favourable variances include £108k in pay savings from support and back-office functions. These savings are attributed to the timing of recruitment resulting from restructuring, particularly within the Paramedical and Medical directorates.

- Additionally, there are underspends in non-pay areas across various directorates. Notably, the timing of software license renewals in Digital resulted in savings of £99k and lower subscription costs in Quality and Nursing.

- These savings help offset overspends, including financial performance in our NHS 111 service, which is tracking 5.0% worse than planned due to increased overtime and Time Off In Lieu (TOIL) needed to ensure safe service delivery during the Easter bank holiday. While the overall abstraction is at 26.2%, which is below the planned rate of 32.9%, sickness levels are high at 8.4%, compared to the target of 7.0%.

- Furthermore, depreciation has exceeded the plan by £166k due to the timing of assets going live, and finance costs have increased as well due to a higher interest payment.

3. Workforce

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

WTE* By Directorate	Month of April 2025			Vacancies* - April 2025		
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	51.8	50.2	1.7	51.8	50.3	1.5
Finance	43.8	38.3	5.5	43.8	37.9	5.9
Quality and Safety	98.0	94.0	4.0	98.0	93.2	4.8
Medical	129.2	119.2	10.0	129.2	108.1	21.1
Operations	3,777.9	3,803.8	(25.9)	3,777.9	3,593.1	184.8
Operations - 111	428.3	461.3	(33.0)	428.3	383.4	44.9
Strategic Planning & Transformation	119.4	124.4	(5.0)	119.4	115.7	3.7
Human Resources	64.5	60.9	3.7	64.5	58.5	6.0
Digital	71.0	72.8	(1.8)	71.0	67.0	4.0
Paramedical	91.5	75.9	15.6	91.5	78.0	13.5
Total Whole Time Equivalent (WTE)	**4,875.4**	**4,900.8**	**(25.4)**	**4,875.4**	**4,585.2**	**290.2**

*Net Funded WTE less Contracted (ESR) WTE

- The Trust is 25.4 WTE above plan for April that is driven by over-establishment and additional overtime provided in Operations to meet demand. These are offset by vacancies Medical and Corporate directorates.

- Vacancies in operations are supported by overtime and bank.

4. Efficiency Programme

The Trust submitted a breakeven financial plan for 2025/26 predicated on the delivery of a £10,000k cash-releasing efficiency target, which represents 2.0% of operating expenditure. In addition, there's an internal 10% contingency, which increases the target to £11,000k and does not negatively impact performance or the quality and safety for patients.

Scheme Category	Validated	Scoped	Total Schemes	Proposed	Total
	£'000	£'000	£'000	£'000	£'000
Digital Productivity	25	-	25	101	126
Discretionary Non Pay	170	104	274	246	520
Estates and Facilities optimalisation	-	96	96	100	196
Fleet - Fuel: Bunkered Fuel & Price Differential	385	-	385	-	385
Fleet - Other Efficiencies	707	-	707	-	707
Income generation	200	-	200	46	246
Medicines Management - Drugs	-	100	100	-	100
Medicines Management - Equipment	-	100	100	-	100
Operations Efficiencies	1,724	1,325	3,049	868	3,917
Optimisation in establishment - clinical	175	299	474	-	474
Optimisation in establishment - non clinical	85	-	85	450	535
Policy review	56	-	56	50	106
Process review	150	-	150	20	170
Procurement contracts review	-	402	402	328	730
Service Redesign	57	-	57	50	107
Supply Chain review	-	-	-	76	76
Travel and subsistence	196	-	196	90	286
Uniform review	107	40	147	-	147
Grand Total	**4,037**	**2,465**	**6,502**	**2,424**	**8,926**

- As outlined in the table above, by the end of April 2025 (month 01), a total of 82 efficiency schemes valued at £8,926k have been identified in the Pipeline Tracker. This amount is £1,076k (11%) below the planned target of £10,000k and £2,074k (19%) below the stretched target of £11,000k.

- Out of the 82 schemes, 53 have been developed, totalling £6,502k. Among these:

    - 39 schemes (48%) valued at £4,037k are validated and are awaiting QIA review before moving to the delivery phase.
    - 14 schemes amounting to £2,465k are currently being scoped and undergoing executive approval and the QIA process.

- Additionally, we have 28 proposed schemes equalling £2,424k that are in the process of being scoped and developed.

<u>Summary of YTD Efficiency Delivery - Recurrent and Non-Recurrent</u>

2024-25 M7 Efficiencies Status	Plan YTD M01			Actuals MTH M01				Full Year Plan			Full Year Forecast Risk Adjusted 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	223	219	442	0	0	0	(442)	6,996	3,004	10,000	536	8,390	8,926	(1,074)
Total Efficiencies	**223**	**219**	**442**	**0**	**0**	**0**	**(442)**	**6,996**	**3,004**	**10,000**	**536**	**8,390**	**8,926**	**(1,074)**
Recurrent /Non recurrent percentage	*50.5%*	*49.5%*						*70.0%*	*30.0%*		*6.0%*	*94.0%*		

- Efficiency schemes are awaiting QIA review and yet to progress to the delivery phase; therefore, we have yet to achieve the planned savings of £442k as shown in the table above.

- The recurrent savings accounted for 94.0% of the projected savings, compared to a planned figure of 70.0%. Consequently, the non-recurrent schemes make up 6.0% of total savings, instead of the planned 30.0%.

- The schemes are evaluated based on their risk levels, which consider achievability and dependencies related to policy changes, the timeliness of process adjustments, and contract reviews. The risk distribution is as follows: green - 26%, amber - 48%, and red - 27%.

- Overall, it is projected that 21.4% of the savings will be achieved in the second quarter, while 61.4% is expected in the second half of the year. However, delivering these savings in the latter half may be challenging due to operational pressures during the winter. To prevent potential under-delivery, mitigation strategies will be implemented.

- Finance Business Partners (FBPs) are working closely with the Senior Management Group (SMG) leads to:
    - Develop and expedite identified initiatives through the Executive Director/QIA and delivery phases.
    - Promote sustainable initiatives and explore new opportunities to reduce potential risks, ensuring that each directorate meets its assigned target to address the shortfall and achieve the Trust's underlying breakeven position.

- Regular updates on progress are provided to the SMG, Joint Leadership Team, and the Finance and Investment Committee.

5. Statement of Financial Position and Cash

	£000 31 March 2025	£000 Change	£000 30 April 2025	£000 31 March 2024
NON-CURRENT ASSETS				
Property, Plant and Equipment	103,275	(2,284)	100,991	97,966
Intangible Assets	1,895	(139)	1,756	2,131
Trade and Other Receivables	47	0	47	0
Total Non-Current Assets	**105,217**	**(2,423)**	**102,794**	**100,097**
CURRENT ASSETS				
Inventories	2,695	16	2,711	2,684
Trade and Other Receivables	14,578	(51)	14,527	6,739
Asset Held for Sale	1,373	0	1,373	1,953
Other Current Assets	0	0	0	0
Cash and Cash Equivalents	29,027	(4,160)	24,867	35,568
Total Current Assets	**47,673**	**(4,195)**	**43,478**	**46,944**
CURRENT LIABILITIES				
Trade and Other Payables	(37,981)	5,857	(32,124)	(34,236)
Provisions for Liabilities and Charges	(14,518)	0	(14,518)	(13,881)
Borrowings	(5,662)	(16)	(5,678)	(5,245)
Total Current Liabilities	**(58,161)**	**5,841**	**(52,320)**	**(53,362)**
Total Assets Less Current Liabilities	**94,729**	**(777)**	**93,952**	**93,679**
NON-CURRENT LIABILITIES				
Provisions for Liabilities and Charges	(12,186)	92	(12,094)	(10,757)
Borrowings	(18,798)	0	(18,798)	(19,513)
Total Non-Current Liabilities	**(30,984)**	**92**	**(30,892)**	**(30,270)**
TOTAL ASSETS EMPLOYED	**63,745**	**(685)**	**63,060**	**63,409**
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	109,889	0	109,889	109,537
Revaluation reserve	5,413	0	5,413	6,871
Donated asset reserve	0	0	0	0
Income and expenditure reserve	(51,557)	0	(51,557)	(52,999)
Income and expenditure reserve - current year	0	(685)	(685)	0
TOTAL TAX PAYERS' EQUITY	**63,745**	**(685)**	**63,060**	**63,409**

- Non-Current Assets decreased by £2,423k in the month arising mainly from £1,304k monthly additions offset by monthly depreciation of £1,568k and £2,159k of disposals.

- Movement within Trade and other receivables is a net decrease of £51k that is driven by a £470k decrease in accrual offset by a £419k increase in invoices held on the system.

- The cash balance was £24,867k and is £7,342k below plan. The key driver for the adverse variance against plan is the Trust not receiving the first tranche, £5,100k of the £10,200k capacity support funding in line with agreement. The remainder of the adverse variance is

driven payments of £2,162k for building and customising our ambulances that was anticipated to be paid later in the year.

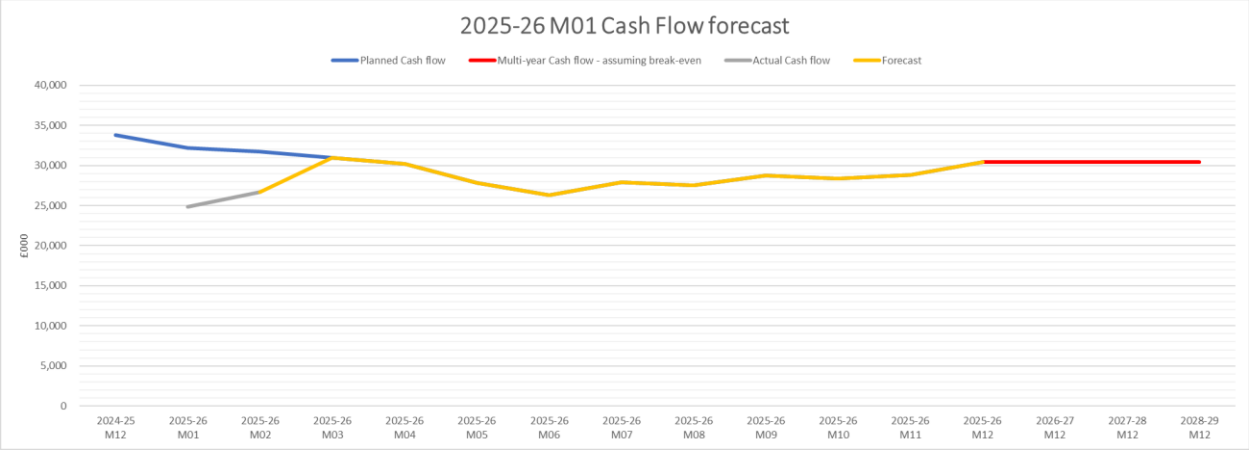
- Trade and other payables decreased by £6,237k mainly through payment of invoices, including capital payments.

- Provisions were reviewed at the end of the financial year and decreased by £92k and relating to payments for early retirement and injury benefit.

- Borrowings increased by £17k overall, arising £158k of additions, less £141k of lease payments.

- There has been no change to Public divided capital (PDC) that is used for funding non-current asset purchases.

- Revaluation Reserve did not change in month.



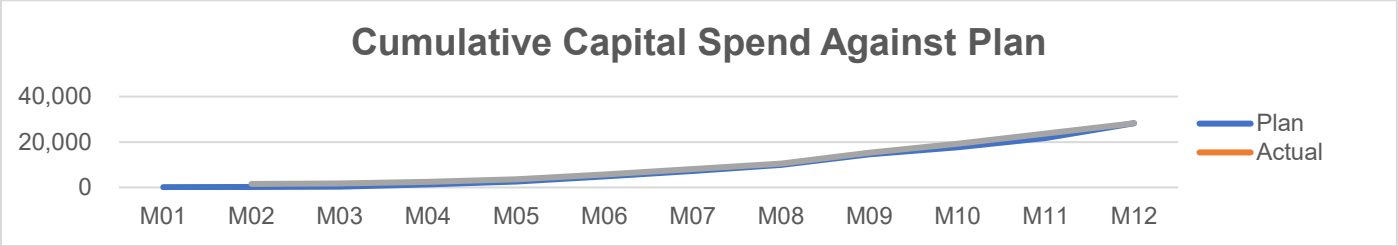
- The above graph shows the 2025-26 planned (blue line) and actual (grey line). The plan incorporates the additional £10,200k capacity funding income that was agreed during planning submission, which was supposed to be paid by Commissioners in M01 but now will be received in M03. The forecast (yellow) line captures the time delay. Assuming a breakeven from 2025-26 onwards (red line) and the statutory requirement of delivering a compliant plan in future, the Trust can retain £30.4m worth of cash that will be sufficient to meet approximately one month's worth of pay obligations. The Trust cannot afford to carry on business as usual and need to eradicate any underlying deficit as cash would be used up within the next 18 months and the Trust would need to seek cash support from DHSC and HMT that would be interest bearing, based on the then published rates. This would further increase cost and is not financially sustainable.

6. Capital

- The in-month capital spend is £1,304k. The in-month actual is £1,167k higher compared to the plan of £137k. This is due to slippage from the 2024/25 plan to ensure that was in line with the allocation.

	In Month April 2025			Year to April 2025			Actual to March 2026		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Original Plan									
Estates	20	222	(202)	20	222	(202)	3,800	3,800	0
Strategic Estates	0	0	0	0	0	0	0	0	0
IT	41	232	(191)	41	232	(191)	5,400	5,400	0
Fleet	16	12	4	16	12	4	1,500	1,500	0
Medical	0	838	(838)	0	838	(838)	374	374	0
Total Original Plan	**77**	**1,304**	**(1,227)**	**77**	**1,304**	**(1,227)**	**11,074**	**11,074**	**0**
CDEL Credit	**0**	**0**	**0**	**0**	**0**	**0**	**(1,400)**	**(1,400)**	**0**
PDC	**0**	**0**	**0**	**0**	**0**	**0**	**11,485**	**11,485**	**0**
Total Purchased Assets	**77**	**1,304**	**(1,227)**	**77**	**1,304**	**(1,227)**	**21,159**	**21,159**	**0**
Leased Assets									
Estates	20	0	20	20	0	20	900	900	0
Fleet	40	0	40	40	0	40	4,700	4,700	0
Specialist Ops	0	0	0	0	0	0	1,500	1,500	0
Total Leased Assets	**60**	**0**	**60**	**60**	**0**	**60**	**7,100**	**7,100**	**0**
Total Capital Plan	**137**	**1,304**	**(1,167)**	**137**	**1,304**	**(1,167)**	**28,259**	**28,259**	**0**

- The Trusts annual spent is forecast to be on plan of £28,259k.



7. Risks and Opportunities

Table – Risk with rating

Risk ID	Risk Status	Risk Title	Current Rating
487	Active	Compliance with Health and Safety regulations and the Equality Act 2010	12
517	Active	Compliance with Procurement Regulations	12
587	Active	Paddock Wood Medical Distribution Centre Refurbishment (leaking roof)	12
639	Active	Legacy Pay Remediation	12
640	Active	Financial Plan	12
522	Active	Capturing accurate Procurement Contract Data	9
637	Active	Under committing capital resource	9
638	Active	Fraud	9
641	Active	Internal Controls	9
642	Active	Finance Team Capacity & Capability	9
524	Active	e-Procurement Platform	6
551	Active	Electric Vehicle Infastructure	6

- 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

Agenda No	40-25

Name of meeting	Trust Board
Date	05 June 2025
Name of paper	Finance & Investment Committee Assurance Report – 29 May 2025
Author	Paul Brocklehurst 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 29 May 2025 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

Financial performance for the first month of the financial year remains broadly on plan. A minor cashflow variance has arisen due to a timing misalignment, in that the £5 million of the £10 million C2 performance funding from NHS England was initially anticipated in Q1 but is confirmed to be receivable in May. The full amount is still expected, subject to satisfactory ongoing performance.

Cost Improvement Plans (CIP) and productivity initiatives remain in development, £4 million of efficiency savings have already been validated in Month 1, 94% of which are recurrent—a positive early indicator. An additional £800k has been awarded via national health and safety funding. Efforts are underway to improve capital planning and delivery, particularly in estates and digital, following underspend issues last year.

Operational Performance

The Trust continues to maintain good call answering performance, and focus continues on improving C2 mean and hear and treat rates, and continuing collaboration with SCAS.

An opportunity to deep dive into a benchmarking report with other Ambulance Trusts allowed some informative discussion. It was agreed that this would be followed up with the BI Team, to ensure other benchmarking is reflected, although the Committee were also informed that the forthcoming Integrated Quality Report (IQR) will include a suite of detailed productivity metrics to support a more granular tracking of progress.

There has been a notable increase in the volume of Urgent Community Response (UCR) Rates, however the acceptance rate does not match this. Urgent action is required across different areas to address this, namely, auto-rejection process, clinical appropriateness and provider capacity.

ALERT

Financial Planning 2025-26

The Trust's plan has been submitted to Surrey Heartlands and rated as a Tier 1 plan — the highest assurance level, requiring minimal national intervention. This reflects strong planning but also brings a heightened expectation from NHS England around delivery assurance. Nationally, there is now a sharper focus on financial performance and compliance, reduced waiting times and improvement in urgent and emergency care access standards

System-level productivity schemes remain underdeveloped, and further progress is required to fully support the target.

In relation to the CIP target of £10m, £9m has been identified, work is ongoing to ensure schemes are fully mitigated, and a pipeline for future years is established to support long term financial sustainability. The Committee congratulated the Executive on being significantly ahead of previous years, with 90% of schemes already defined.

Within the Financial Planning slides shared around Productivity, members expressed support for the initiatives but requested clearer articulation of ambition, associated risks and tracking mechanisms to ensure meaningful progress and transparency.

Risks

There are 123 active risks on the Trust's Risk Register, and 24 of these fall under the oversight of FIC, with the majority resting with Digital and Finance. The Committee scrutinised the risks, with particular discussion around those pertaining to Estates.

The Committee encouraged more consistency of baseline assessments across directorates in respect of risks, and noted some gaps between current risk ratings and targets, thus requiring more visibility of mitigation plans and improved trajectories in further reporting.

Digital Performance

Interim changes have been made to the Digital Leadership structure to align with the required technical and engagement capabilities.

The most significant Digital risks highlighted were:

- Cybersecurity issues (e.g. firewall upgrades and network configuration) are actively being remediated.
- Data security concerns (internal controls and data sharing) are also being addressed.
- Generator and Power resilience (urgent maintenance underway and wider review of all generators)

- Completion of key infrastructure remediation milestones (firewall upgrade, BT network reconfigurations)

The Committee acknowledged the Digital agenda was heavy. Members look forward to receiving the full digital work programme and investment cases due to be presented to the Trust Board on 07 August 2025. They encouraged the Executive to continue to engage more widely to ensure frontline operational priorities inform the digital programme development. However, focus needs to remain on establishing strong foundations over rushed implementation.

ADVISE

Fleet Performance

Vehicle Maintenance Technician (VMT) recruitment remains a challenge, and although there has been improvement since the last meeting, the Committee encouraged the Fleet Team to continue to scrutinise the disparities and search for further initiatives that could be adopted around VMT recruitment.

Members were pleased to note 97 new Double Crewed Ambulances (DCA's) have been ordered, and a demonstrator vehicle has been approved and will soon be trialled across the Trust. The Trust has now transitioned to a highly regarded Polish converter with significantly better facilities and capacity (though now fully booked, and underscoring the importance of SECAmb in forward planning).

It was noted that Business Cases pertaining to fleet have been referenced in previous papers, and an update has been requested for the next meeting to understand the position of these and a timeline. The Committee credited the work of both the Fleet Teams and Driving Standards Team in the reduction of road traffic collision rates since the last meeting, and the improvement of critical vehicle failure rates. Both of these being positive outcomes following internal process enhancements and team working across the Trust.

Procurement Update

The organisation is actively responding to the Procurement Act 2023, with staff training completed and ongoing learning planned. A draft Procurement Strategy is currently under staff consultation, and the Committee look forward to reviewing this once it has completed the appropriate governance route.

Plans are underway to formalise the Procurement Pipeline, and recent activities include the successful tender of a legal services retainer and a current tender to establish a preferred supplier list for recruitment agencies, thus regulating spend and contractual terms.

It was apparent there is strong collaborative procurement with counterpart Trusts in the Southern Alliance, and the Committee noted that SECAmb were leading on Medical Equipment and Consumables. It is also exploring a joint CAD procurement with SCAS, though interdependencies and timelines require further review. Further updates on collaborative CAD procurement and strategy alignment will continue at future FIC meetings.

Commissioned Contracts

An informative update was received around all of the key commissioned contracts which included IC24, 999/111, Churchill, and Midwifery. Concern was expressed around the Midwifery Contract, and its lack of progress, and the Executive were asked to provide an update around this at the next meeting.

A delay remains in finalising the contract extension for the Kent and Sussex 111 service, and while there is agreement in principle to extend the contract, key details have yet to be confirmed.

Appreciation was expressed to the Executive Team for the improved oversight and capability in professionalising contract management, and encouraged them to explore further collaboration opportunities, particularly with SCAS.

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