



Council of Governors Meeting to be held in public

1 December 2020 10:00-13:00 held online (MS Teams)

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Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
40/20	10:00	Chair's Introduction	-	-	David Astley (Chair)
41/20	-	Apologies for Absence	-	-	DA
42/20	-	Declarations of Interest	-	-	DA
43/20	-	Minutes from the previous meeting, action log and matters arising	A A1	-	DA
		Minutes of the Annual Members Meeting	A2	Decision	
Statutory duties: performance and holding to account					
44/20	10:10	Chief Executive's report: - performance challenges, EU Exit, COVID, Flu and 111 CAS	B	To receive an update from the CEO	Philip Astle (CEO)
45/20	10:45	Assurance from the Non-Executive Directors: - Integrated Performance Report (October data)	C	To take as read – queries to NEDs to be taken under escalation reports	-
Statutory duties: member and public engagement					
46/20	10:50	Membership Development Committee Report	D	Information	Brian Chester (Public Gov. for Upper West)
Committees and reports					
47/20	10:55	Governor Development Committee Report: - Governor Query Flow Chart	E F	Information Agreement	Nicki Pointer (Deputy Lead Gov. and Public Gov. for Lower East)
48/20	11:05	Governor Activities and Queries Report	G	Information	Nicki Pointer
Statutory duties: performance and holding to account					



49/20	11:10	<p>Board Assurance Committees' escalation reports to include the key achievements, risks and challenges:</p> <p>Workforce and Wellbeing Committee</p> <ul style="list-style-type: none"> - 17th September 2020 – plus Governor Observation Report - 22nd October 2020 <p>Quality and Patient Safety</p> <ul style="list-style-type: none"> - 17th September 2020 - 19th November 2020 – plus Governor Observation Report <p>Audit Committee</p> <ul style="list-style-type: none"> - 10th September 2020 <p>Finance and Investment Committee</p> <ul style="list-style-type: none"> - 10th September 2020 - 12th October 2020 - 12th November 2020 – plus Governor Observation Report 	<p>H1 H2 H3</p> <p>H4 H5 H6</p> <p>H7</p> <p>H8 H9 H10 H11</p>	Holding to account, assurance and discussion	All Non-Executive Directors present
11:45 Comfort Break					
50/20	11:55	Annual report of the Auditor to the Council	I	Assurance	Fleur Nieboer, Partner, KPMG
51/20	12:10	<p>Scrutiny – Audit and Finance and Investment Committee deep dive:</p> <ul style="list-style-type: none"> - Key areas of responsibility - Areas of focus/risk - Future plans <p>Terms of Reference and annual Cycle of Business for each attached for information.</p>	<p>J J1 K K1</p>	Information	<p>Michael Whitehouse (NED & Chair of AuC) & Howard Goodbourn (NED & Chair of FIC)</p>
General					
52/20	12:40	Any Other Business (AOB)	-	-	DA
53/20	12:50	Questions from the public	-	Accountability	DA
54/20	-	Areas to highlight to Non-Executive Directors	-	Assurance	DA
55/20	-	Review of meeting effectiveness	-	-	DA
		Date of Next Meeting: 4 March 2021	-	-	DA

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

PLEASE NOTE: This meeting of the Council is being held in public using Microsoft Teams. The meeting will be video-recorded and made available for public viewing following the meeting.

Anyone who asks a question consents to being recorded and the publication of their participation in the meeting.

There is a section of the agenda for questions from the public. During the rest of the meeting, attendees who are not members of the Council are asked to remain on mute with their video off



in order
to help

South East Coast Ambulance Service



NHS Foundation Trust

the meeting run smoothly. *This is a strict rule and anyone not following this will be removed from the meeting.*

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 4 September 2020

Present:

David Astley	(DA)	Chair
Geoff Kempster	(GK)	Public Governor, Upper West
Brian Chester	(BC)	Public Governor, Upper West
Chris Devereux	(CD)	Public Governor, Upper West
Nicki Pointer	(NP)	Public Governor, Lower East
Leigh Westwood	(LW)	Public Governor, Lower East
Marianne Phillips	(MP)	Public Governor, Lower East
David Escudier	(DE)	Public Governor, Upper East
Cara Woods	(CW)	Public Governor, Upper East
Sian Deller	(SD)	Public Governor, Upper East
Nigel Robinson	(NR)	Public Governor, Lower West
Harvey Nash	(HN)	Public Governor, Lower West
Marguerite Beard-Gould	(MBG)	Public Governor, Upper East
Amanda Cool	(AC)	Public Governor, Upper West
Marcia Moutinho	(MaM)	Staff Governor (Non-Operational)
Malcolm MacGregor	(MMc)	Staff-Elected Governor (Operational)
Was Shakir	(WS)	Staff-Elected Governor (Operational)
Chris Burton	(CB)	Staff Governor (Operational)
Graham Gibbens	(GG)	Appointed Governor – Local Authorities
Howard Pescott	(HP)	Appointed Governor – Sussex Community Trust
Sarah Swindell	(SS)	Appointed Governor – ECUHFT

In attendance:

Lucy Bloem	(LB)	Senior Independent Director & Non-Executive Director
Al Rymer	(AR)	NED and Chair of ARC
Terry Parkin	(TP)	NED
Howard Goodbourn	(HG)	NED and Chair of FIC
Laurie McMahon	(LM)	NED and Chair of WWC
Michael Whitehouse	(MW)	NED and Chair of AuC
Peter Lee	(PL)	Company Secretary
Philip Astle	(PA)	CEO

Apologies:

Vanessa Wood	(VW)	Appointed Governor – Age UK
DCC Nev Kemp	(NK)	Appointed Governor – Surrey Police

Minute taker: Isobel Allen – Assistant Company Secretary

17. Introduction

- 17.1. DA introduced the meeting and thanked everyone for attending. He set out the ground rules for the meeting and noted the questions from the public and staff would be taken at the end of the meeting.

18. Apologies

18.1. Apologies were noted as above.

19. Declarations of interest

19.1. No additional declarations of interest were made.

20. Minutes and action log:

20.1. The minutes were taken as an accurate record. The action log was reviewed and updated.

21. CEO Report

- 21.1. PA noted that regarding COVID we were in a lull in our part of the country: the disease was spreading in the community but not in a way that suggested a second surge was imminent, though this was happening in other parts of the country.
- 21.2. Nationally, the 7-day infection rate was the important thing and when it reached 15-20 per 100,000 that was when increased restrictions were considered.
- 21.3. In our area it was about 7, but London was increasing e.g. from 7-12 in the last week.
- 21.4. PA noted that risk assessments of clinically vulnerable and BAME staff had been completed, as well as for over 90% of all staff. This was positive and there were some people not able to return to their current jobs.
- 21.5. On Test and Trace, SECamb had developed a speciality testing team. This was currently our own version of the test and trace service. When one of our staff was identified as positive, they managed the impact on the rest of our staff carefully.
- 21.6. PA noted that demand had returned to pre-COVID levels, but during busy periods had been up by 15% year on year. Around 50 staff per day were off with COVID-related sickness or self-isolation for a family member. We were working hard to increase efficiency and get people back to work and were getting back towards the middle of the pack relative to other ambulance services.
- 21.7. There was a worrying increase, particularly in the Brighton area, in assaults on staff, and in other emergency services too. We were working in partnership with the police as part of Operation Cavell to try and address this. We were taking this threat to staff very seriously.
- 21.8. We had won a Gold Award from the Equalities Network.
- 21.9. PA noted he had now been with the Trust for a year and a couple of days. He was delighted to be part of the SECamb team, having learned how good most of our people were. We still had issues, and would always be able to improve, but overall, it had been a pleasure to be here.
- 21.10. PA advised that regarding clinical education, the team had been doing really good work moving everything online and new people had been recruited into the team. However, we had discovered another backlog of marking that was partially created by the on-boarding of over 100 new staff and moving things online. The quality of the marking had also not been as good as we had hoped. We were fixing this, and it was disappointing that we hadn't seen this coming.

22. CEO overview of the Trust

22.1. PA noted that the rest of the NHS was absolutely focused on the recovery of their normal operations. People were waiting long periods of time for elective surgery, cancer service etc. However, the ambulance and 111 services had carried on doing our normal work

- throughout the crisis, so we didn't have a backlog to work through: our recovery was more about learning.
- 22.2. We had learned that there were better ways of communicating. It didn't make sense to ask managers to travel from the corners of our patch for a meeting when we could do that online. That would be a permanent change, but we also recognised when face to face conversations were preferable.
- 22.3. Our attention to and understanding of logistics had been enhanced. It looked like we, along with other NHS organisations, had learned that lesson before during preparations for other crises, but we lost that learning about having high levels of PPE and on-going fit testing etc. We needed to put more effort into the logistics end of our business.
- 22.4. We had learned new ways of working for office-based staff.
- 22.5. We had also learned to work better within the wider health systems, and had been approached to deliver things across systems, which had greater awareness of what we could do. For example, Sussex were looking to us to provide transport services for very sick patients.
- 22.6. The identifying and learning of lessons would be a 6-9 month effort but it was well underway.
- 22.7. On new business, the 111 Clinical Assessment Service (CAS)'s aim was to be a one stop shop for the patient, enabling patients to tell their story once and to provide a broad clinical assessment service connected to the services required early, connecting the patient to the right care.
- 22.8. SECamb would be running it for Medway, Kent and Sussex but not Surrey, which was run by Care UK on a 5-year contract. We would be interested in taking that contract if it became available. 111CAS would go live on 1st October, and we were working through the last steps, especially around connecting systems to make this function.
- 22.9. During COVID, we had learned that controlling the flow of patients into hospitals could help provide better care to those who needed it. Nationally, investigations were underway about how we could do this triage effectively through the 111 service, before walking into A&E.
- 22.10. This was called Think 111 First, though some people were calling it Talk Before You Walk.
- 22.11. Trials were taking place in Portsmouth, London and one in the North. These were being called pilots but roll out nationally was very likely, and the NHS was trying to arrange funding because this would be additional work for 111. There was no contract to deliver this but we were in touch twice weekly to discuss. We might see Think 111 First launched in December.
- 22.12. In Sussex, we were considering whether to invest in Patient Transport Service delivery. Kent were also going to be offering their Out of Hours and home visiting service, which commissioners felt we would be good at running but we needed to make a business decision about this.
- 22.13. Looking ahead at future risks, we had a possible perfect storm. COVID was still without a vaccine, the flu season was about to start, and we had additional pressure from the EU Exit transition period potentially ending with no deal so Kent would be particularly badly affected and the rest of the system. We were planning for this now. We had started the flu vaccination programme, aiming to vaccinate everyone this year, from October onwards. The first COVID vaccines may be available around Christmas we hoped. The NHS would be at the front of the queue for vaccination but it would take time to deliver.

- 22.14. On EU Exit, things were better than this time last year as more infrastructure was in place, but the customs and border work was still very much undeveloped. We must use energy to plan for worst case scenarios.
- 22.15. HN asked about why EU Exit was missing from the documents provided for the meeting, such as not being in the Integrated Performance Report in horizon scanning. To what extent would the previous planning work be of use, or had this been overtaken and needed to be restarted? PA assured Council that EU Exit was now back front and centre, previous planning had been extremely useful but needed to be updated based on scenarios which had changed throughout the year. We needed to adjust our plans against modelling, for example around traffic impacts.
- 22.16. PA felt that even if there was a general no deal, there would be some mutually beneficial deals done.
- 22.17. NR asked whether PA was confident that there would be appropriate governance, checks and balances around 111 CAS as this evolved. PA confirmed this was absolutely in place. Everything was clinically led. There were already good systems for 111 to check, learn, etc. We were now adding things we had never provided before like prescribing, which added a completely new risk to SECamb and needed to come with clinical checks, validation, and risk assessment. All of that would be built in. We were doing this in partnership with IC24 who had experience doing this so we could learn from them.
- 22.18. CB asked about the Brexit plan as a whole. He noted that the Trust had considered keeping some of the issues confidential to a degree last time around, for example, stockpiling. PA noted that this was a public meeting and DA advised that we were an ambulance service and needed to keep in proportion the part we played. The Board had been keeping a careful eye on this, though COVID had dominated during the height of the pandemic. EU Exit was now becoming more prominent.
- 22.19. CB wished to qualify his statement by noting that patient safety was at the forefront of the things we do.
- 22.20. MBG advised that she was a Kent public Governor and had to suffer the M20 between Ashford and Maidstone with restricted traffic. There had been no way through for emergency vehicles, which was of great concern for anyone using that route. It was important for us as a Trust to work on how we would manage to get patients through that bottleneck. PA confirmed that this risk focused heavily in our planning.

23. Assurance from the NEDs – Integrated Performance Report (IPR)

- 23.1. DA explained the purpose of the IPR, which was a report to Board providing data about Trust performance. It was providing data from May due to unfortunate timings around Board and Council this time around. Governors would be able to seek assurance on more current issues during the session on Board Committees later.
- 23.2. There were no questions.

24. Membership Development Committee (MDC) Annual Report

- 24.1. BC introduced himself and the work of the Committee. He noted how pleasing it was to see so many members attending online. He highlighted key points from the report.
- 24.2. The report showed that our public member numbers had increased by 3% while staff membership had increased by 9% during the year. This was a small percentage when we looked at the population SECamb served.

- 24.3. The report included reports from the Inclusion Hub Advisory Group, Staff Engagement Advisory Group, and the Patient Experience Group.
- 24.4. The MDC worked for the Council to improve our contact with members and staff going forward. A membership engagement plan had been developed with Governors and Board input. This had two strands: to identify and support membership engagement opportunities to benefit the Trust's priorities, and ensure the Trust used these routinely. The second strand was enabling Governors to connect locally with teams on the ground and our volunteers.
- 24.5. There was a Governor election communication plan to ensure would-be Governors were aware of the requirements of the role.
- 24.6. Development of the Patient Experience Strategy had been high on the agenda.
- 24.7. He thanked all members of staff and public for their continuing support for the Trust. It had been great to see the NHS response during COVID. He thanked the IHAG and PEG for their passion and effort.
- 24.8. Whilst the report looks back to 2020, we were all well aware of the pressure on staff and he thanked the Staff Engagement Advisory Group for their hard work.
- 24.9. Finally, he encouraged people to join our Foundation Trust membership.

25. Governor Development Committee (GDC) Annual Report

- 25.1. NP noted that she had been appointed Lead Governor along with Waseem Shakir as Deputy. DA recorded his thanks.
- 25.2. NP described the purpose of the Committee. During the past year the Committee had met five times and had work on improving effectiveness, including aligning Council meetings to focus on different Committees of the Board to understand risk more effectively.
- 25.3. She thanked Governors who had left during the year, including Felicity Dennis, Frank Northcott, Pauline Flores-Moore, Roger Laxton, Marian Trendell and James Crawley.

26. Governor Activities and Queries Annual Report

- 26.1. NP noted that Governors were asked to inform the Trust of activities they have participated in over the past year. Lots of forums had been attended to try and engage with constituents.
- 26.2. She highlighted the questions Governors had put through to the Non-Executive Directors, showing that Governors were committed to the role between meetings.
- 26.3. She highlighted a couple of queries: one on serious incidents and another on clinical training. She thanked Governors for their outstanding questions and recommended that people read the full report.
- 26.4. MMc asked about the Governor queries paper and why there were no questions and answers listed since March 2020. IA advised that this was an annual report for the financial year 2019-20 and other questions would be reported as usual at the next Council.

27. Board Assurance Committees' escalation reports

- 27.1. **Workforce and Wellbeing Committee:**
- 27.2. LM noted that a lot of the issues would be covered on the WWC deep dive session later.
- 27.3. **Quality and Patient Safety:**

- 27.4. LB advised that two escalation reports had gone to the Board meeting at the end of July. QPS had met more regularly during COVID. DA advised that the Board had maintained a normal meeting agenda throughout the emergency period.
- 27.5. MMc asked about the Emergency Operations Centre clinical safety project. How assured were the NEDs that the Trust was engaging and supporting this staff group? LB advised that she had looked at this in the round as there had been a number of issues in EOC that had been discussed.
- 27.6. GK noted that he was concerned about call backs. Were we comfortable that EOC were doing timely call backs to patients where we had delayed responses? LB advised that she was not confident and this was therefore the first scrutiny item at the next QPS meeting. The Committee had asked for information about the capacity of resources to understand the demand.
- 27.7. WS noted that there had been increasing numbers of hospital divers: the report stated assurance on clinical outcomes but the IPR showed an increasing trend in call to arrival time at hospitals for stroke. LB noted that they had discussed stroke and looked at SECamb against other Trusts. LB would ensure that divers were addressed at the next QPS meeting. LB noted that the stroke service changes were no longer a surprise as we were now key partners in those discussions.
- 27.8. MMc asked about the plan to remove tympanic thermometers in favour of tempa dot thermometers which he believed was not a feasible nor safe solution, and that the driver had been financial, albeit it was now on pause. Was QPS assured that financial considerations were not overshadowing clinical considerations when decisions were made? LB advised that a Quality risk assessment should be undertaken through the organisation. On her next agenda she had added this item as an AOB, so this would be covered then. She was happy to feed this back.
- 27.9. MMc further commented that if this had been discussed with frontline staff members earlier it would have been clear to managers that this would cause significant issues. Staff engagement had not taken place. LB and DA noted this.
- 27.10. HP asked about performance improvement plan within the CEO's report, what oversight there was from QPS in relation to performance and whether there had been any clinical issues. LB advised that the plan was overseen by the Finance and Investment Committee, but QPS would look at trends from incidents and serious incidents. They had asked for information about discharge by non-clinicians to come to QPS on that basis.
- 27.11. **Audit Committee (AuC):**
- 27.12. MW drew Council's attention to the additional money we had received to respond to COVID. The priority was to spend this effectively and appropriately. AuC had taken assurance that appropriate controls were in place.
- 27.13. **Finance and Investment Committee (FIC):**
- 27.14. HG noted that operational performance was the continued focus of the Committee. During COVID, performance had been particularly good but we had struggled since, caused by some challenges post-Covid including sickness and issues with fit testing.
- 27.15. HG further noted that on 111 CAS, the Executive Team had done a good job of avoiding the risks of IT integration.

- 27.16. GG asked about 999 performance. He noted that FIC was only partially assured due to the performance deterioration. He would like some clarification about what impact the situation was having on patients and what was being done.
- 27.17. On 111 CAS he believed that 1 October was interesting timing to launch given winter and a second COVID peak were on the horizon. Were the NEDs assured this would be ok? HG noted that this specific point had been raised, and it was not an ideal time, but we were required contractually to do that. The team had worked very hard over the summer. He felt they were as well-prepared as they could be in the circumstances.
- 27.18. On 999 performance he was not aware of any clinical issues that had arisen as a result, but long waits were a customer experience issue. The Board expected resilience and capacity to deal with issues that arose.
- 27.19. LB was unaware of any trends related to incidents, but the next QPS was next week so she would know more then. DA advised that this question featured in his weekly meetings with the CEO as well.
- 27.20. MaM asked about the 999 improvement plan which had received partial assurance. Did HG believe that the Trust response was fast enough: she felt the Trust could have predicted some of these issues and should learn from them. How could the plan be sustained, if it was working?
- 27.21. HG noted that sustainability was only possible by building in resilience and over-capacity and the Committee would be challenging the Executive to aim higher on the number of hours delivered.
- 27.22. There was certainly learning in terms of speed of response and realising, which was partially a function of delayed information, but we were on top of it now. They had requested the improvement plan to deliver the frontline hours.
- 27.23. MMc noted that he was reassured to hear the push to deliver hours. There was a rumour that the Trust had cut its target hours per day from approximately 10,000 to under 9,000. Was this the case? HG was not aware of this. PA confirmed that the target varied based on time of the year and demand. It was set at the level needed to achieve performance. DA advised that on resources in general, the Trust had to work within the NHS and had been seeking for years to receive more resources to meet demand, but we must demonstrate that we used all resources effectively and so could demonstrate we would respond effectively when demand increase if we had increased resources.

27.24. Appointments and Remuneration Committee

- 27.25. HN asked about Director remuneration, showing a 12% increase during the year. The remuneration report did not address why there had been such an increase. He was aware that there had been an interim HR Director who no doubt cost more. Could someone comment on the 12% increase? AR advised that he would like to look more specifically at the issue, and would provide a full answer outside the Council, however the use of interims was probably the major contributory factor.

ACTION: Al Rymer to review the 12% remuneration increase for Directors and provide a rationale outside the Council.

- 27.26. He further noted that a thorough benchmarking exercise on Executive pay had been conducted to ensure we pitched salaries at the right level to attract, retain and motivate a

high calibre executive team, but the Board recognised that has to be proportionate and would not contribute to salary inflation in the NHS.

27.27. He noted that the Trust's annual report should in future explain any increase clearly.

27.28. Charitable Funds Committee (CFC)

27.29. MW advised that the committee met twice a year and the focus was on ensuring we had processes and controls in place that were sufficiently light touch but robust enough to ensure that those who raised money had access to it. We recognised we had a statutory duty to ensure SECamb and its charities complied with Charities Commission requirements. We had reviewed the terms of reference and were now focused on making sure the processes and controls were in place.

27.30. CFC had noted the additional money raised during COVID and took assurance that this was being used appropriately to support our people. DA thanked the wider public and anyone who donated during Covid which was well-received and welcomed by staff.

27.31. LW was a Community First Responder. He noted that issues with CFR's access to funds had been going on for a while, but teams were still finding it hard to access funds or get agreement about how much they could access.

27.32. MW would take this away and look at this and get back to LW on this.

ACTION: Michael Whitehouse would seek further information around issues with CFRs accessing funds from the charitable fund.

27.33. PA advised that he would like to recognise Katie Spendiff's role in securing COVID charitable funds for the Trust.

27.34. MBG asked all NEDs about SECamb's interesting projects in development. Were these still being captured on a register or log so they could receive proper scrutiny? LB advised that she recalled the issues in the past: there was now a quality review process and projects should all be captured, and she looked at them annually through QPS, and would make sure that it was reviewed again and some research done to ensure the right things were on there. She advised that QPS also looked at cost improvement plans which she had sent back asking for more information to provide evidence that the process had been followed.

27.35. LM noted that in terms of the learning from projects, he was unsure about where the evaluation and learning was used to develop further services in the patch. He would consider this as an item for WWC.

28. Scrutiny: WWC and ARC

28.1. AR introduced the work of ARC, and noted that the 5th March Council had included a deep dive on this. He had been pleased that the appointments made over that period had worked really well. ARC processes had been refined and improved since. ARC was responsible for Executive appraisals. The committee took an overview of succession planning and Board structure and balance, specifically considering the Director of Operations post as the incumbent had announced his retirement in Spring next year, so the Committee had been able to consider how he could be succeeded and how to get a really good search started for that successor. Steve Emerton was leaving the Executive, and ARC would be building on its discussion of Board structure and balance to advise on any changes to Executive portfolios as a result of this.

- 28.2. Since March, assurance had been received including around Fit and Proper Person checks, and the Committee had benchmarked Executive pay. ARC conducted annual reviews of salaries, which put us in a good position if responsibilities changed as a result of changes in the Trust's services.
- 28.3. LM introduced the work of the WWC. He noted that he took over as Chair of the committee in April from TP. Since he became Chair, the agenda has been focused around COVID, sickness, self-isolation, fit testing, and wellbeing. The Committee were generally really impressed by the Trust's response to the pandemic.
- 28.4. The Committee had received further assurance around HR processes, but felt the Executive were getting a grip of the basic HR functions. The improvements in the HR team itself had been the main cause of this he felt, with a good permanent substantive HR Director after a series of interims.
- 28.5. LM had been impressed by the HR team's energy and capability.
- 28.6. In the past, WWC had focused on looking back on what the Trust had done, but he felt that the circumstances in which the Trust now operated WWC needed to seek assurance more into the future, on workforce and welfare issues, to scan ahead and ensure the Trust was formulating appropriate responses.
- 28.7. System change was coming down the track, with the emergence of new pathways as well as systems and partnerships, which introduced opportunities for the Trust, but would need a flexible and motivated workforce.
- 28.8. LM would in future seek assurance that the Executive could manage the triangle of workforce planning and recruitment, training and development, and management relationships and culture. These three were intrinsically linked and needed careful development. WWC needed to be assured that the Trust understood the nature and scale of the workforce required to hit our targets on current services and to adapt as needed in the future.
- 28.9. We were seeing staff flow modelling coming through, which was positive.
- 28.10. WWC wanted to be assured that we were pursuing our values around diversity and inclusion.
- 28.11. On education, training and development there were short term issues in putting things right in clinical education, but we also needed to look for assurance that surprises would not happen again, and be thinking into the future to show that the whole area of learning and development was managed in an integrated way.
- 28.12. On improving management culture, SECamb had dabbled with this for years, but changes were already afoot. WWC had held a special meeting to consider a draft of an integrated management and leadership strategy, bringing hope that we might address issues systematically and effectively.
- 28.13. WWC would like to continue to hear voices from within the organisation rather than relying on Executives and senior managers. WWC have asked for a review of staff engagement to consider how WWC renewed its leadership visits around the Trust for soft intelligence. LM welcomed Governors raising issues and concerns with him directly.
- 28.14. TP advised that the forward agenda of the Committee had been provided in the papers. The prime focus was sorting out the systems and structures in HR that had caused so many issues for colleagues. Timely, accurate pay, for example, remained a focus. On staffing, there remained issues. On training, there were still issues to address as Council had heard. Once the basics were achieved, we could focus on other areas.

- 28.15. MP noted that she had previously asked for assurance around clinical education, and had heard that NEDs were mindful of this, but felt that the FutureQuals report would only give limited assurance, and a new backlog had been identified, which raised Governors' concerns.
- 28.16. LM noted that the escalation report showed that clinical education had been on the agenda with partial assurance. He agreed that more was required, and the focus would continue. MP asked for a timescale. LM advised it was on the agenda for the next WWC meeting and the Trust would be pushing that agenda as quickly as possible.
- 28.17. TP advised that an improvement plan had been worked though, but some of the basic things had been missed. As a consequence, four new staff had started this week to support this assessment. The Executive had addressed this urgently. The Trust had focused on the big picture but had lost focus on the basics. We may need more staff in this area.
- 28.18. WS noted improvements in culture between management and staff over the years, and asked about how the Staff Engagement Advisory Group would be engaged and staffside/unions. LM agreed that this was essential once a strategy was drafted to ensure it fitted. On culture, this was the sum of management and leadership behaviours so the development of the leadership strategy would address the cultural issue full on. WWC would look at where there were high levels of grievances, sickness etc to focus on organisational development in those areas.
- 28.19. MMc noted that colleagues were facing real difficulties in relation to clinical education such as poor communication, lack of support, lack of funding for CPD, cancelled courses and marking backlog and feeling trapped because external candidates were given priority over internal. MMc had raised all these points back in December 2019 at Council. MMc had enquired then about triangulation and whether NEDs had spoken to students and staff on the frontline. Yet he believed that we were again similarly caught unawares by similar issues. Triangulation by speaking to the students and staff involved had not taken place. Why had no-one been speaking to staff on the ground?
- 28.20. DA advised that it was not the remit of the NEDs to ask students about their experiences. They were assured by the Executive. LM noted that it raised a cultural issue, because the information from the frontline wasn't flowing up to the Committee and the Board. He felt that the new strategy would help in general and specifically around hearing the voices of staff in this. TP advised that there had been numerous reviews. He did not believe that it was necessarily the function of NEDs to go out and talk to individuals. One key issue was there was a lot that was not known, including to staff going through the system.
- 28.21. AR noted that triangulation was done by NEDs.
- 28.22. DA suggested that we took an agenda item on education and training at the next Council meeting. LM noted that staff engagement needed to be right and then we might have learned about this earlier.

ACTION: Consider Council agenda item on training and education.

- 28.23. MaM asked about new ways of working for non-operational staff. Some were content to work from home and others had decided to return to the office. Some staff had been given no choice but to return to the office, without a clear explanation. Could NEDs focus on this as we moved forward? LM advised that he had been impressed about the degree to which the Trust had focused on learning from COVID. He hadn't heard this issue before but was now interested in the plan and would seek assurance. DA agreed that we must get the benefits and learn from this.

- 28.24. GK advised that he had been in conversation with a Paramedic yesterday who had been on light duties since April this year and had spent 12 weeks trying to get back into active service but Occupational Health would not sign him off via a telephone consultation. DA asked that this be taken back through his line management. LM would help if this could not be resolved.
- 28.25. MMc noted that Paramedic Practitioners were the most senior (with CCPs) in the Trust. The role had expanded significantly over the years but we did not have enough PPs, so they were compromising at all times regarding fully delivering their role. The budget for PPs had also been cut significantly.
- 28.26. DA noted that he had asked PA to take this away and get back to him but also let WWC know whether there remained an issue.

ACTION: PA to consider the PP role and available budget and report back to DA and WWC if there was an issue.

- 28.27. On GK's point, PA noted that we would need to know the name of the person he was speaking about. MMc noted that he had received a response from NEDs saying they would look at PPs previously.

29. Questions from the public

- 29.1. Frank Northcott asked about item 14.3 of the last meeting's minutes regarding changes that had been made to the electoral boundaries. Mr Northcott had been unable to find documentation around the making of this decision. He believed the decision had not been correct constitutionally. DA advised that Peter Lee had spoken to the member concerned.
- 29.2. Mr Northcott further asked why his email about this had not been received by Governors. He wanted to have direct access email accounts for Governors. DA noted that all emails received were forwarded to Governors. He would get back to Mr Northcott outside of the meeting as this had been raised before.
- 29.3. Margaret Parker – Kent member: The Government had stated their intention to reform the way patients would access Accident and Emergency and Urgent Care in future, for example by phoning ahead via 111 and booking a slot. Had SECamb been involved in any discussions about these changes and had consideration been given to whether it will result in more patients requesting an ambulance for urgent care?
- 29.4. PA advised that this was a live consideration. The service was currently being designed and tested: we were aware of that risk and the way things were implemented should mitigate it.

30. Any other business

- 30.1. DA noted that this was a record attendance at Council – peaking at 93 people.
- 30.2. BC noted that as a Governor he was well aware of Mr Northcott's challenge and his concerns about the electoral boundary changes but was very content as Chair of MDC that the Trust had gone through the appropriate processes in making these changes.

31. Areas to highlight to the NEDs

- 31.1. DA confirmed that the key areas were around education and training, and performance monitoring and particularly the quality of our performance particularly around long waits.

32. Review of meeting effectiveness

- 32.1. DA asked for Governors to send him any comments about areas for improvement.
- 32.2. He thanked everyone for attending and looked forward to welcoming everyone to the Annual Members meeting that afternoon.

Signed:

Name and position:

Date:

Meeting Date	Agenda item	AC ref	Action Point	Owner	Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
06.06.19	8.3	263	CFC to consider impact of CFR schemes in any new charitable proposals/governance processes that are implemented.	IA	Jän.21	CoG	IP	This was highlighted to the CFC ahead of their July meeting to further discuss proposals. Governors did not feel this issue was satisfactorily addressed by NEDs at the September Council meeting and wish it to remain on the action log. Note link to action 270 - CFC next meeting 12 December. Update 26.02.20: the chairman agreed to lead a working group to ensure that the issues are considered as a whole including consequences (intended and unintended) are considered.
20.09.19	33.2	268	Arrange a workshop briefing for Council on clinical performance and understanding the integrated performance report	IA	Feb.20	CoG	IP	This remains on the suggested items list that goes to the GDC. The IPR has now been revised and a session may come to the next Council meeting if Governors would like.
20.09.19	39.10	270	How assured was the Trust that CFRs had access to the funds raised in their name, as this had been an issue in the past	IA	Sep.19	CoG	C	This action was captured again at the September meeting so this action is being closed.
03.12.19	71.6	272	Review Governor representation numbers and whether B&H should revert to having its own Governor	IA	Dez.22	CoG	IP	This to be revisited prior to next Governor elections, ie end of 2022.
04.06.20	11.3	287	QPS to consider job cycle times and the reasons for any increase pre-COVID.	LB/MMc	Dez.20	CoG	IP	LB had received some feedback on this, and data didn't show any marked increase as MMc may be looking at different data. She asked MMc to provide more information outside the meeting.
04.09.20	27.25	288	Al Rymer to review the 12% remuneration increase (2019-20) for Directors and provide a rationale outside the Council	AR	Dez.20	CoG	IP	AR believed this was likely due to having an Interim HR Director for much of that period but would check.
04.09.20	27.32	289	Michael Whitehouse would seek further information around issues with CFRs accessing funds from the charitable fund	MW	Dez.20	CoG	IP	
04.09.20	28.22	290	Consider Council agenda item on training and education	CoG	Feb.20	CoG	IP	To be considered at GDC as an option.
04.09.20	28.26	291	PA to consider the PP role and available budget and report back to DA and WWC if there was an issue	PA	Dez.20	CoG	IP	

South East Coast Ambulance Service NHS Foundation Trust

Annual Members Meeting minute

Friday 4th September 2020 15:00 – 16:15 [held online on Teams Live](#)

1. Introduction

- 1.1. David Astley SECAmb's Chair opened the meeting, welcoming members and staff and explaining how the meeting would work.
- 1.2. He advised that last year's minutes had been approved by Council during the year and were available on the website for reference.
- 1.3. He introduced a video outlining the impact of COVID on the Trust.
- 1.4. DA reflected on the part everyone had played in terms of helping the people we serve, including the way the sector was able to work together in terms of mutual support. Staff had been on an emotional journey too and we had sadly lost colleagues.

2. Chief Executives presentation

- 2.1. Philip Astle (CEO) introduced himself noting that he had been CEO now for precisely a year and two days. We had 10,000 members of the public as FT members and 500 volunteers who supported us.
- 2.2. He thanked Fionna Moore for her interim leadership as CEO for the first half of the financial year 2019-20. We welcomed Ali Mohammed during the year as substantive HR Director. Our NHS staff survey had been favourable during the year and we spent a lot of time trying to make life better for staff and improve relationships with volunteers.
- 2.3. In 999, we had been effectively on target on category 1 & 2, but further away on 3 and 4. We were improving but needed to continue to improve.
- 2.4. In 111, it had been a challenging start to the year, but things had massively improved and were better in the current year.
- 2.5. On clinical and financial performance, we were just below the national average in terms of clinical indicators, but where the data measured bundles, we can see real improvement helped by the implementation of an electronic patient care record on staff iPads. Financially, we were on target to break even.
- 2.6. Highlights of the year included a CQC inspection rated as Good overall but as Outstanding in urgent and emergency care, well deserved by our staff.
- 2.7. Several projects saw progress, a new Make Ready Centre in Brighton, improvements at Worthing and Sheppey stations, and approval for major developments at Banstead and Medway.
- 2.8. We expanded partnership working with Joint Response Units working with police colleagues.
- 2.9. The COVID pandemic had affected us in three stages: Feb-June 2020 saw incredible responsiveness, partnership working and innovations, as well as PPE, testing and ensuring robust governance was in place. In June-Aug we focused on protecting core services, supporting staff wellbeing, more on

PPE, and undertaking risk assessments with BAME and clinically vulnerable staff.

- 2.10. Aug onwards we shift to embedding learning and making changes based on that where we can, shielding is ending and we focus on staying safe and dealing with our operational challenges.
- 2.11. In the future, our immediate challenges continue to be around our 999 performance, the potential of a second spike, impact of increased demand in winter, implications of EU Exit, and the go live of our new 111 Clinical Assessment Service, and Think 111 First may be introduced which would mean 111 became the triage service for entry to A&E.
- 2.12. Further ahead, we needed to be mindful of the aftereffects of the pandemic, such as financially, and embedding our learning, engaging with the wider system and new health structures, developing and seeking opportunities to grow and expand.

3. Director of Finance and Corporate Services presentation

- 3.1. David Hammond (Director of Finance) presented an overview of our use of resources. Financial performance was important, and we needed a secure and sustainable financial base to enable improvements going forward.
- 3.2. 2019/20 was a year of significant investment and improvement. We delivered a surplus of £0.3m, which included a central allocation of £1.8m for meeting our financial targets. We run a small structural deficit of £1.5m was improved by £0.2m in the year. The cash balance increased to £28.3, an increase of £4.1m. We also delivered our cost improvement target of £7.1m.
- 3.3. Our income had increased over the past two years through new contracts and central allocations for things like pay structure and inflationary pressures. Our income was 84% from our 999 contract, 111 continued to be a growth area but provided 6% of our income last year.
- 3.4. 69% of money was spent on pay, 7% transport costs, 5% on estate.
- 3.5. Our balance sheet reflected the financial health of the organisation, which was a better position than the previous year. £3.4m had been invested in IT and infrastructure, £5.2m on estates improvements, £3.7m on 75 new ambulances.

4. Lead Governors report

- 4.1. Nicki Pointer (Lead Governor) delivered the Council's report to the meeting. The full text of the report is in our Annual Report and copied here:
- 4.2. I represent the interests of the people of Kent, Medway and the eastern parts of London (SECamb's 'upper east' constituency) on the Council of Governors. This report will focus on how the Council – a group of 24 volunteers including members of the public, staff and people from key partner organisations – has fulfilled its statutory duties in the past year.
- 4.3. Our collective duties are two-fold:
- 4.4. To represent the interests of our Foundation Trust members and the wider public; and

- 4.5. To hold the Non-Executive Directors to account for the performance of the Board.
- 4.6. I'll also touch on Council's perception of the Trust as it continues to progress with plans for significant improvements and embedding improvements already made.
- 4.7. Of course, as I write this in mid-March, the Trust is focused on coordinating the South-East-wide response to the coronavirus outbreak. It's a huge task for management, but much was learned and already in place from the contingency planning in case of a 'no deal' Brexit earlier in the year.
- 4.8. Covid-19 notwithstanding, overall, the Council has been really pleased to see the Trust making improvements. SECamb's frontline staff, providing care face to face with patients or over the phone thorough the 999 and 111 call centres, have consistently provided a caring service. This year the Trust was recognised as 'good' by the CQC, giving Governors an independent source of assurance that things are really moving in the right direction regarding the Trust's leadership, clinical governance, patient safety and quality of care.
- 4.9. Improving the Trust's leadership and governance has really made a difference this year. The Council has appointed a number of new Directors within the Trust, and been involved in the recruitment and selection of a new Chief Executive Officer, Philip Astle, after Daren Mochrie left for pastures new and closer to his Scottish home, and a new Director of HR.
- 4.10. The Council appoints independent Non-Executive Directors (NEDs) who sit on the Board alongside the Executive Directors and provide oversight and assurance that the Trust is operating effectively and for the benefit of patients. The Council has recruited and appointed one NED during the year, Howard Goodbourn, who brings vast relevant experience to the Board. We have also worked closely with all the other NEDs, who attend our four Council meetings a year where we raise issues from our own experience of interacting with the Trust: as Governors we feel we are taken seriously and our concerns are usually followed up. We have also appraised the performance of all NEDs over the year and reviewed their remuneration.
- 4.11. I'm pleased to say that issues Governors have raised were listened to. The openness between Council and Non-Executives is very welcome and their responsiveness to the issues we've raised has been, we hope, beneficial to the Trust, its staff and its patients. Having said that, often the issues we raise are already high on their agenda, which is fantastic, and of course sometimes things take longer to change than we would like. We have a good relationship with the Chair, and he makes much-appreciated time for two meetings a year with Governors from each constituency to frankly discuss how we think things are progressing.
- 4.12. Despite the ongoing improvements needed, the Council is generally content that the Board has a firm grip on the priorities for the Trust: everyone recognises there will always be improvements that can and should be made.
- 4.13. Here's a flavour of what we've focused on this year on your behalf:
- 4.14. Receiving assurance that the health and safety of our staff is being effectively protected;

- 4.15. Seeking continuous improvement to our safeguarding practices;
- 4.16. Improving the Trust's response to patients requiring transport because of mental ill health;
- 4.17. Continuously looking for better performance for our lower acuity patients (Category 3 and 4) – there is more to do at the time of writing - and seeking improvements in call answer time, which we have been pleased to see made and sustained;
- 4.18. Ensuring that the Trust's commitment to staff engagement was sustained;
- 4.19. Asking for clarity around how volunteers access charitable funds they've raised and ensuring the visibility of Community First Responders' contribution to Trust performance;
- 4.20. Raising concerns that issues around clinical education in the Trust were not seen earlier by the Board;
- 4.21. Seeking assurance about improvements needed in the HR Directorate, including improving recruitment processes and staff retention;
- 4.22. Urging the Trust to join a partnership with the police to ensure staff who are assaulted are supported by the full weight of the law;
- 4.23. Supporting the Trust's communications about the new NHS 111 clinical advice service;
- 4.24. Pushing for improvements in our clinical outcomes, particularly around strokes.
- 4.25. We held two workshops with the full Board of Directors, one to share our views about the Trust's strategic position and plans for the future, and the other to focus on what it means to be a membership organisation and how we can make better use of all the insight we can gain from our members.
- 4.26. In addition, and as usual, Governors have been out and about over the year meeting people at events and plugging ourselves into our local communities. We visited a MENCAP event for people with learning disabilities, Trans Pride in Brighton, a patient forum at Kent and Canterbury Hospital, Surrey Minority Ethnic Forum and Eastbourne 999, for example. If we met you there, we hope you've joined the membership!
- 4.27. At SECamb, we have taken part on your behalf in Quality Assurance and Patient Safety visits to Trust premises, helped review and set SECamb's quality objectives for the year and contributed to the Trust's Patient Experience Strategy. We observed Board Committees – which have been well-run with great engagement, challenge and support from all involved.
- 4.28. Our Annual Members Meeting – planned by the Council's Membership Development Committee – was a roaring success with the biggest attendance SECamb had ever seen. It was fantastic to meet so many members of the public and committed SECamb staff and volunteers: even the air ambulance graced us with a landing.
- 4.29. Elections were held in February 2020 and we were sorry to see two colleagues weren't re-elected, our then-Lead Governor, Felicity Dennis, as well as Harvey Nash. Two other Governors chose not to stand for re-election, Roger Laxton and Nick Harrison. Three Governors resigned during the year

for various reasons and I'd also like to thank them: James Crawley, Frank Northcott and Lorraine Tomassi. And finally, Marian Trendell stood down after nine years (the maximum term) as an Appointed Governor, having worked so hard to improve SECamb's response to people with mental ill health in both her professional capacity and as a Governor.

4.30. We were also very pleased to welcome seven new colleagues to the Council in March, who bring a wealth of diverse interests and experience – it's important that Governors come and go fairly regularly to bring new experience, insight and fresh eyes on SECamb to the Council.

4.31. Finally, a huge thank you to everyone on the Council for giving your time and energy freely in the service of ambulance service patients and staff, to SECamb's staff who work so hard and to the Chair and Board for engaging constructively with the Council. I do hope members feel we are adequately representing your interests and urge you to get involved - opportunities are included in your membership newsletter. We look forward to supporting more progress in the service in the coming year.

5. Question and Answer session

5.1. Joe Garcia Director of Operations introduced the Q&A panel:

5.2. David Astley (Chair), Philip Astle (CEO), Lucy Bloem (Non-Executive Director), Fionna Moore (Medical Director), David Hammond (Director of Finance).

5.3. Robin Kenworthy asked: could an update on the development of the Kent and Medway Care Record project and the impact on SECamb be given in document form please? I am unable to locate any information beyond, I quote:- We hope to be able to confirm this approval towards the end of 2019, and work with our chosen supply on developing the system to begin roll-out from April next year. The patient-accessible version of the KMCR will be delivered in 2021.

5.4. JG advised that we were actively working with Kent and Medway, so we were working on the same underlying technologies, anticipating access for our staff late this year or early 2021. DH added that the impact of COVID across the system had been felt on lots of projects, but we had continued to be involved. The documentation would be going through the usual Trust processes.

5.5. Frank Northcott asked when will Brighton Make Ready Centre come online. DH advised that the planned date was Spring 2021. We were going through some interesting negotiations with BT Open Reach about connectivity to the site. As soon as there was a firm opening date that would be published widely.

5.6. Question about the care bundles: the slide was interesting, but it would be good to know how many people each applied to. FM noted that we included all the stroke patients and the data came from the national database and it was verified in that way. She didn't know the actual numbers.

5.7. What steps had we been able to take to address the delays handing over to acute hospitals. JG advised that we had had a lot of success working in

partnership with hospitals to minimise handover delays. They were now the lowest they had been for many years. Dedicating a senior manager to work on this had had a great impact. We were spending 400 hours a week less on handover since pre-COVID times.

- 5.8. The next question was about pre-COVID response times across Kent. JG advised that there had been a focus on recruiting in Kent and putting lots of Newly Qualified Paramedics on the road, many starting in Paddock Wood and Medway areas. There also tended to be more private provider resource in that area too.
- 5.9. On training, Robin Kenworthy asked about the strains the COVID situation had put on the Trust. Were there arrears in terms of various types of training? FM advised that continuing education was a priority for the Trust, but it was a difficult balance to provide staff for operational delivery, patient safety and keep them up to date on training. Throughout the earlier part of the year we continued key skills training. This had since been paused due to operational issues, and some of the practical elements had not been possible. We had plans to address that. We now used one of the further education colleagues to deliver apprenticeship training.
- 5.10. David Romaine asked about the time taken over the resolution of patient/paramedic disputes. PA advised that he didn't know the specific case referred to, however in general our disputes were settled as quickly as the Trust could do them, but the processes could be quite complex and we needed to follow rules and take the right advice. Our legal department met most of their targets but there wasn't a specific target for these disputes because they had to be done safely. It was disappointing the amount of times these things could take as everyone was unhappy so we did them as quickly as we could.
- 5.11. On charitable funds, was there something patients could contribute to and something around investment in recruitment, retention and training.
- 5.12. DH advised that there had been a huge amount of generosity from the general public. SECAMB could draw down on funds from the NHS Together Charity. We also had a registered charity which would allow us to buy additional things that were not funded more generally. There was a Just Giving link on our website. There was a Charitable Funds Committee to oversee the way this was spent.
- 5.13. DH advised that investment in training, recruitment and retention was a priority for the Trust. A lot of work was going on in terms of staff engagement to understand what was required.
- 5.14. On abandoned 111 calls, JG advised that the abandonment rate was extremely high during COVID. We have prided ourselves by trying to reach a higher target 2% than the national 5%. He was unable to talk about the exact time but abandonments that took place after 30 seconds were counted and reported on.
- 5.15. On finance, are we funded on a per capita population basis taking account of health inequalities? DH advised that this was not the case yet.

This seemed to be the direction of the NHS ten-year plan. At present, we were commissioned on a regional basis across our three counties.

- 5.16. JG advised there had been several questions about fleet: why do we use so many third-party ambulance providers? JG advised that we would like our own staff to do more, but as our growth rate increases, we always require some additional support to target it in the areas that need it most. Private providers only contribute about 6% of daily response hours.
- 5.17. JG advised that there were several questions around fleet, and double crewed ambulances. The choice of ambulance services was removed once the Carter review work was undertaken to try and standardise the vehicle used and make efficiency savings. Fiat were the only manufacturer that makes a chassis that meets the requirements. We anticipated that other vehicle manufacturers would adapt to make a similar chassis. So, this wasn't a choice undertaken by SECamb.
- 5.18. JG noted that someone had thanked the Trust for the video representing every corner of our Trust. This represented the team spirit and ethos. We had been functioning as a well-oiled team during COVID. The whole leadership team were grateful and proud of the contribution everyone had made.
- 5.19. JG advised that any named questions would receive a response outside the meeting. JG closed the Q&A.

6. Chair's closing comment.

- 6.1. DA wanted to thank all our staff for their contribution in a challenging year. He also recognised the memory of valued colleagues lost during the year, including Tricia McGregor.
- 6.2. He hoped the event had been well-received and helped to improve people's understanding of SECamb. The video would be shared, and he asked people to recommend the video to friends. The Q&A box would remain open for any feedback for the next 15 minutes or so.
- 6.3. He thanked everyone for their contribution and those behind the scenes.

Minutes taken by Isobel Allen – Assistant Company Secretary

		Item No	
Name of meeting	Council of Governors		
Date	24 November 2020		
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 October and November 2020. Section 4 identifies management issues I would like to specifically highlight to the Council of Governors.		
	A. Local Issues		
2	Executive Management Board The Trust’s Executive Management Board (EMB), which meets weekly, is a key part of the Trust’s decision-making and governance processes.		
3	As part of its weekly meeting, the EMB regularly considers quality, operational (999 and 111) and financial performance. It also regularly reviews the Trust’s top strategic risks.		
4	As the pandemic continues, EMB is continuing to focus and monitor the impact of COVID-19 on the Trust. In addition to the main weekly meeting, we hold short daily Executive ‘huddles’ to ensure that there is a frequent opportunity for issues to be raised and discussed and action taken. Specific COVID-related issues discussed recently have included: on-going risk assessments for staff, the impact on the Trust of the national move to a ‘tier’ system and preparation for staff testing and vaccination.		
5	Other issues covered by EMB during this period include: <ul style="list-style-type: none">• Focus on 999 improvement plan; COVID response; Winter/EU transition planning; Flu vaccinations.• Approach to agile working• Development of an interim model for adult critical care transfers across the region• Agreement to a new neurodiversity charter (see below)• Financial planning for rest of year		
6	EMB have also continued to monitor improvements in clinical education and how we mitigate and respond to assaults on staff.		
7	The following investment decisions have also been agreed by the EMB during this period:		

	<ul style="list-style-type: none"> • New 'all seasons' coats for frontline staff • New post to support Chief Pharmacist • Driving instructors – revised JD and pay band to improve quality and recruitment. • Critical systems support (people)
8	<p>Engagement with stakeholders and staff</p> <p>During recent weeks, I have continued my on-going programme of meeting with local stakeholders and spending time at our Trust locations, although this has been more limited than usual. Specific locations visited have included our sites at Hastings, Chertsey, Coxheath, Tongham and Tangmere as well as frequent drop in opportunities to the 111 operation and the EOC at Nexus House.</p>
9	<p>On 12th November, I visited the ambulance station on the Isle of Sheppey, which has recently been subject to an extensive re-development programme. I was very impressed with the developments made and delighted to hear first-hand how well the improvements have been received by local staff.</p>
10	<p>On 11th November, the Chair, David Astley and I also hosted a virtual visit from NHS Providers, the membership organisation for NHS trusts in England, regarding the impact that the COVID pandemic has had and continues to have on SECamb and the challenges we anticipate facing moving forwards.</p>
11	<p>This was an extremely constructive meeting and we were pleased to have the opportunity to discuss the challenges we have faced during the past nine months, as well as how best NHS Providers can support us moving forwards.</p>
12	<p>Progression of key estates developments</p> <p>During recent weeks, we have continued to see good progress being made on our key estate developments.</p>
13	<p><u>Medway:</u> Planning permission for the Bredgar Road development in Gillingham was granted in August, to house a combined Medway MRC & East EOC/111 Contact Centre. Works are due to commence in the Spring of 2021, subject to approval of the business case by the Trust Board and the Department of Health and Social Care.</p>
14	<p><u>Banstead:</u> Following approval of both the planning permission and the business case in September, the existing Banstead site will be fully vacated by 20th November 2020 in preparation for works to commence. As a result of this, our Clinical Education team have moved to the Crawley College site at Haywards Heath, and colleagues from Fleet, Medical Equipment and Stores & Logistics have moved to alternatives sites in Crawley and Paddock Wood.</p>
15	<p><u>Brighton:</u> Significant progress has been made in recent weeks and preparation is being made for staff from Brighton, Lewes and Hove Ambulance stations to start reporting from the new Make Ready site from 30th November 2020, and for the site to be fully operational by 6th December. This represents the Trust's ninth Make Ready Centre.</p>

16	<p>OFSTED Monitoring Visit</p> <p>On 28th and 29th October, we received an OFSTED monitoring visit looking at our provision as an apprenticeship provider.</p>
17	<p>We have now received the formal report following their visit, reporting that as a Trust we had made 'reasonable progress' since their last visit in the three areas inspected - leadership and management, quality of training/education and Safeguarding.</p>
18	<p>We know that we still have a long way to go to continue the improvements that need to be made in our approach to education and training but this is a big step in the right direction. Well done to the Clinical Education team for their hard work both ahead of and during the visit.</p>
19	<p>Poppy Ambulances</p> <p>I was very proud to see front-line vehicles across the SECamb fleet, once again, carry poppy stickers this year to publicly show our support for the national Poppy Appeal. This included twelve ambulances which were 'wrapped' with a large remembrance design.</p>
20	<p>Well done to Rob Martin and the Fleet Team for arranging this great tribute, especially at a time when there are many conflicting demands on their time. The response to the 'poppy ambulances' from staff and members of the public has been extremely positive.</p>
21	<p>Neurodiversity Charter</p> <p>On 27th October, SECamb became the first NHS Ambulance Trust in the country to sign a charter to support greater awareness and support for Neurodiversity in the workplace.</p>
22	<p>The GMB national congress recently passed a motion for an awareness campaign titled 'Thinking Differently at work' focussing on Neurodiversity – a wide range of neurological differences, such as autism, ADHD, dyslexia, dyspraxia, dyscalculia and specific language impairment - in the workplace.</p>
23	<p>The focus of the motion is around hidden disabilities, providing practical support, and developing advice and learning materials on Neurodiversity in the workplace and the SECamb GMB branch was chosen to lead this campaign as a national first.</p>
24	<p>As part of our commitment to the charter, we will be pulling together a multi-disciplinary team, including our other SECamb trade unions, to produce a strategy to ensure we are best placed to support our Neurodivergent colleagues.</p>
B. Regional Issues	
25	<p>Flu vaccination programme for staff</p> <p>Our flu vaccination programme began at the start of October, with an ambitious target of having all of our staff vaccinated this year. Due to the way our vaccines were delivered this year, we focused our campaign firstly on patient-facing staff, followed by EOC, 111 and CFRs</p>

	in late October. We then began offering support staff the flu vaccine from early November.
26	We began our programme with a good uptake amongst our patient-facing staff and in the first two weeks of the programme, 1,508 patient-facing staff had the vaccine compared to 789 of all our staff during the same period in last year's programme. As of 23 rd November, 72.4% of our patient-facing staff have now had their flu vaccine, with an overall Trust-wide figure of 59.5%.
27	We are continuing to work hard to encourage staff to have their vaccine with regular communications through various mechanisms as well as targeted work with the areas that have a lower uptake. Communications activity has included sharing a very poignant case study from one of our CFRs, Fergus Chalmers, who passed on flu to his father Keith, who subsequently became very unwell and nearly died as a result of developing sepsis. You can watch the video here .
28	Update on 111 & the Clinical Assessment Service As shared previously and six months later than planned, due to the impact of the coronavirus pandemic on our existing 111 service, an enhanced Clinical Assessment Service (CAS) went live on 1 October 2020, as part of a new five-year contract for Kent, Medway and Sussex led by SECamb working in conjunction with not-for-profit social enterprise Integrated Care 24 (IC24).
29	The CAS now means that when you call 111 (free from mobiles or landlines 24/7) - or access the service via www.111.nhs.uk - you can speak to a wider range of healthcare professionals, including GPs, paramedics, nurses, midwives, mental health professionals, dental nurses and pharmacists who will be able to assess symptoms over the phone, issue prescriptions and directly book onward care appointments if needed.
30	The mobilisation has been a success, despite having to manage a sustained increase in call volumes with in excess of 3,000 calls on weekdays, and approaching 5,000 calls per day at weekends. There has been a reduction in the rate of abandoned calls after more than 30 seconds, which is on target at just over 5% and better than the NHS England national average. The introduction of the full CAS means that the new service, with its multi-disciplinary clinical team is already close to the national target of 50% of triaged cases in 111 having some form of clinical contact within the Integrated Urgent and Emergency Care system. There is work to do, however, around the percentage of patients we advise to attend A&E and the number of calls we transfer to 999.
31	We have already seen a noticeable uplift in pharmacy, dental and mental health cases coming through the CAS which helps alleviate pressure on other parts of the health system and over the coming months, NHS111 will integrate more closely with our 999 service and existing out-of-hours care, including providing access to evening and weekend GP appointments, home visiting services, minor injury units, urgent treatment centres and Accident & Emergency departments. The Trust continues to work collaboratively with commissioners and other providers to implement the national 111 First initiative across the region, following the successful

32	mobilisation of the first three pilots.
C. National Issues	
33	<p>COVID-19 outbreak</p> <p>I remain extremely proud of the way that the Trust has remained focussed on delivering the best service possible, despite the changing circumstances and the on-going impacts of the pandemic.</p>
34	<p>As we continue to see the pandemic continuing unabated, we need to recognise that, as an organisation, we have had to operate in a very different way for the past nine months in order to respond to the pandemic, as well as delivering our 'business as usual' services. We must acknowledge the impact of this on our staff, not just at work but also at home and the unseen impact on people whether it be emotional, financial or physical. We need to ensure that, more than ever, we focus on supporting our staff through a wide variety of mechanisms.</p>
35	<p><u>Governance:</u> The Operational Response Management Group (ORMG) continues to meet regularly during the week and at weekends, ensuring that all decisions and actions related to COVID are considered appropriately. ORMG now also oversees workstreams covering 999 performance, EU Transition planning and our flu vaccination programme, given the inter-dependencies with the COVID workstreams.</p>
36	<p><u>National Lockdown/Tier system:</u> Following the initial national move to a 'tier' system in terms of restrictions and the subsequent move to a second national four-week lockdown period on 5th November, we have worked hard to understand the implications of these on our staff, especially those who are considered clinically vulnerable or clinically extremely vulnerable.</p>
37	<p>We also continue to review our COVID Risk Assessment processes, to ensure that we identify any staff members who are at greater risk due to COVID and take appropriate actions.</p>
38	<p>On 23rd November, the Prime Minister announced that there will be a return to the tier system of restrictions, following the end of the lockdown period on 2nd December. We are working through the implications of this for us, given the possibility of different areas within our region being at different tier levels.</p>
39	<p><u>Lateral Flow Device (LFD) testing:</u> On 20th November and in line with national requirements, we launched our internal Lateral Flow Device testing programme to ensure patient-facing staff, EOC, 111 and those in critical functions can undertake a regular test for COVID, one of the first ambulance trusts nationally to go live with the testing programme. The testing is not mandatory, however we are strongly encouraging all eligible staff to participate in the testing programme.</p>
40	<p>This has seen testing kits distributed to staff to enable self-testing to take place on a twice-weekly basis for an initial three-month period. Staff are asked to report the results of each test to our internal Test and Trace Cell and, if any staff members receive a positive LFD test,</p>

	they will then require a further PCR/swab test to be taken.
41	As of 23 rd November, 950 of those staff eligible had already registered for the testing programme confirming they had received the testing kits and were beginning the programme.
42	<u>COVID Vaccination programme:</u> We have also worked hard to prepare for the potential introduction in coming weeks of a COVID-vaccination programme for NHS staff. We are still awaiting confirmation of the detailed approach but it is likely to see us responsible for vaccinating our own staff who are eligible, rather than our staff being vaccinated by another provider.
43	<u>Test & Trace:</u> In line with the national model, our internal COVID Test and Trace Cell is continuing to undertake the contact tracing of SECamb employees, collation of information on Covid-19 positive staff and communication with line managers to establish contacts of the Covid-19 positive staff member. The Test and Trace Cell are also responsible for the declaration and investigation of any internal outbreaks, involving two staff members or more.
44	NHS Staff Survey We launched the annual NHS Staff Survey 2020 in SECamb on 21 st September, with all eligible staff receiving an email directly from our chosen survey provider, Quality Health. Recognising the on-going pandemic, this year survey is a little different to previous years and includes a new section specifically about the COVID pandemic, designed to help understand the impact of the pandemic on staff.
45	The survey period closes on 27 th November but I am delighted that, as I write, we have reached our target of a 60% return rate across the Trust, our highest return rate ever! This means that we will be hearing a more representative view from our staff when the results are published.
46	Thank you to our Staff Engagement Team for their hard work in encouraging this improved response rate and to all those who took the time to complete the survey. I look forward to receiving the results, when these are published in the Spring of next year and, most importantly, ensuring that we take real action in response to the results.
47	Black History Month I was very pleased to see SECamb join in celebrating Black History Month during October, with a range of specially-arranged events for staff to participate in and the creation of a Black History Month 'microsite' on The Zone, containing lots of background information on BHM, as well as links to relevant and interesting music, films and books. It was also great to see colleagues sharing a wide range of personal experiences during the month. Well done and thank you to Asmina Islam Chowdhury, our Inclusion Manager and members of our re-named staff network, Inspire, for all of their work and enthusiasm in planning for Black History Month.
	D. Escalation to the Board

48	<p>999 Operational Performance</p> <p>Response time performance during October and November to date remains challenged and variable, although our performance is not out of line with many of our colleagues nationally. We have not consistently met either the Category 1 or Category 2 standards during this period, which is of concern, given that these are most seriously ill and injured patients, although our Category 2 performance has been stronger overall. Our performance against the Category 3 and 4 standards continues to also be challenged and on occasion we are still seeing unacceptably long waits to a small number of calls in these categories.</p>
49	<p>Our 999 call answer performance continues to remain strong, despite peaks in 999 demand. This has enabled us to provide virtual call-taking support to colleagues nationally on occasion, including Yorkshire Ambulance Service.</p>
50	<p>As we see the impact of the ‘second wave’ of the pandemic begin to have an impact in our region in terms of increasing numbers of COVID cases, we are starting to see this impact on the regional NHS system. This is resulting in periods where we are seeing lengthy handover delays at some of our local hospitals. We are continuing to work with the wider NHS system to address these. The Integrated Care Systems are working to co-ordinate the response across all providers with the local health economies and SECamb continue to be an active participant in those conversations. The Trust continues to ensure that the system is aware of the risk to our patients left in the community whilst Ambulances are delayed at hospitals.</p>
51	<p>The delivery of the 999 Performance Improvement Plan and the impact of the actions being taken is closely monitored by the Operational Response Management Group and by the Executive Management Board. Through the Plan, there continues to be close focus on maximising the resources available on the road and in our EOCs to respond to patients, including planning ahead as far as possible and practicable. This remains a key area of concern, as we continue to see the availability of resources significantly impacted by abstractions, including the numbers of staff in self-isolation.</p>
52	<p>EU Transition Planning</p> <p>With uncertainties over the impact and structure of EU Transition we have established a governance structure to support our planning. SECamb’s response is being overseen via Programme Board with a number of supporting workstreams covering command and control, the operational model, scheduling, production, fleet and logistics, EOC & 111 and a corporate workstream. This then reports into ORMG, then through the EMB to the Trust Board.</p>
53	<p>Despite a number of uncertainties, we are continuing to develop plans as best we can, and we are working closely with local and national resilience leads. The key objective of this work is to ensure the resilience of our response to patients, despite any challenges that may arise as a result of the UK’s Transition from the EU.</p>



South East Coast
Ambulance Service
NHS Foundation Trust



Integrated Performance Report

Trust Board
November 2020

Data up to and including October 2020

Best placed to care, the best place to work



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CQC Rating and Oversight Framework

NHSI Oversight Framework*	2	▲
CQC Rating **	GOOD	●
Information Governance Toolkit Assessment ***	Level 2 Satisfactory	●
REAP Level ****	3	●

* NHSI segments Trusts (1-4) according to the level of support each Trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability, with level 4 requiring the most support (Trusts in special measures).

** Our rating following the most recent CQC inspection. These can help patients to compare services and make choices about care. There are four ratings that are given to health and social care services: outstanding, good, requires improvement and inadequate. **GOOD:** We are performing well and meeting CQC expectations.

*** The Information Governance Toolkit is a system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit Assessments. Levels range from 0 to 3; 3 being the highest.

**** Resourcing Escalatory Action Plan (REAP) is a framework designed to maintain an effective and safe operational and clinical response for patients and is the highest escalation alert level for ambulance trusts. Level 3: Major pressure (September 2020)

Symbol Key

▲ Improving performance	▼ Deteriorating performance	— Data not provided
● No change	■ Aspirational metric	PD Performance direction

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How to use this report

A New Format & Reporting Aspirations

- The aim is to present a more holistic overview of Trust performance, under CQC domains, which brings together the most helpful indicators to allow the Board to better understand performance across the totality of the Trust.
- There is much more to do, but in building this new IPR within the Trust's Business Intelligence Power BI Platform, we have put in place the foundations for much-improved performance management across the Trust using accessible data that can be drilled down into as required, and datasets selected and exported according to the user's needs.
- We have begun to provide reporting a month in arrears, where this is possible.

Performance Dashboards

- The Board is presented with additional data sets this month. The Board will note that for some of these, we have been unable to provide historic data, however the data sets will grow in coming months to give a better sense of trends etc.
- As an indication of the types of metrics we will seek to report on in the coming months, 'aspirational' metrics are included (with no data attached). Where there is no data this does not mean the Trust does not monitor these areas of performance, merely that those metrics are not routinely presented to the Board and work is still to be done to provide them in this format.
- The vision for the IPR is that it is dynamically generated, with RAG ratings and performance direction automatically populated, giving us the ability to maintain a core set of metrics but also to select those most relevant for the Board in order to tell our story more fully.
- More work is to be done to include all targets and to distinguish internal targets from national ones.

Performance Charts

- In the future, we intend to include trend lines on charts, where it will help the viewer understand the data better, and where possible targets too. We also aspire to include forecasting and performance versus forecast wherever possible.
- **Please note** that the SPC charts are no longer functioning as a licence has lapsed, according to the BI Team. The Team are working on replacing this functionality.

A Focus on CQC Domains

- Our suite of 'aspirational' metrics includes numerous across all domains, and when populated will provide a far more rounded snapshot of performance to the Board.

Reporting Performance Highlights & Exceptions

- Rather than provide commentary against all metrics, which was often repetitive or uninformative, we are keen to focus the Board's attention on what is going well, and what requires improvement.
- In order to sharpen this focus, exception reporting has not been provided for every instance of performance deterioration – rather only where the deterioration is sustained or outside acceptable tolerances.



Chief Executive Overview

This is the third time the Board has received this new version of the IPR and, as set out on page 3, there have been some additions since September and further developments in progress.

The aim of this integrated report is to show the key performance indicators and highlight to the Board through the exception reports where the executive is most concerned. Directors will talk to these areas at the meeting, but I just wanted to specifically draw the Board's attention to the following:

Oversight Framework

As the Chairman has confirmed in his report, we are now placed in segment two of the NHS Oversight Framework. This recognises the sustained improvements the Trust has made.

NHS Pathways Licence

I am really pleased to be able to report that the focus we have given to EMA and clinical supervisor audits has resulted in us continuing to achieve the levels set by NHS Pathways. This is a really important measure as we use audit in this way as a tool to support continual improvement.

Incidents of violence and aggression

I continue to be concerned about the number of incidents of violence and aggression towards our staff. As this report shows, the number of incidents in the reporting period has increased and this is an area me and my executive team are keeping under close review. Bethan Eaton-Haskins, Executive Director of Nursing & Quality will update the Board on this and the steps we are taking.

999 Performance / Front Line Hours

I updated the Board in September about how we are approaching the issue of front line hours as a separate improvement plan. The Executive Management Board has established an Organisational Response Management Group, which dedicates one of its three main weekly meetings to the plan. We have seen some marked improvement in recent weeks, which has resulted in performance against the ARP standards stabilise. However, I am acutely aware of the risks we face over the next period related to COVID; sickness and self-isolation; testing; and the vaccination programme, which will all adversely impact on abstraction. Emma Williams, Deputy Director of Operations, who will be standing in for Joe Garcia this month while Joe recovers from surgery, will provide a fuller update on the improvement plan and the steps we are taking to help mitigate the current risks.



Philip Astle
Chief Executive



Trust Overview: Strategy, Values & Ambition

Our Purpose

As a regional provider of urgent and emergency care, our prime purpose is to respond to the immediate needs of our patients and to improve the health of the communities we serve – using all the intellectual and physical resources at our disposal.

Our Strategy

SECamb will provide high quality, safe services that are right for patients, improve population health and provide excellent long-term value for money by working with Integrated Care Systems and Partnerships and Primary Care Networks to deliver extended urgent and emergency care pathways.

Our Priorities

- *Delivering modern healthcare for our patients* – a continued focus on our core services of 999 and 111 CAS;
- *A focus on people* – they are listened to, respected and well supported;
- *Delivering quality* – we listen, learn and improve;
- *System partnership* – we contribute to sustainable and collective solutions and provide leadership in developing integrated solutions in Urgent & Emergency Care

Our Values

Our values of *Demonstrating Compassion and Respect, Acting with Integrity, Assuming Responsibility, Striving for Continuous Improvement* and *Taking Pride* will underpin what we do today and in the future.



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



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Trust Overview:

Domain Overview Dashboard (November 2020)

Key indicators at a glance for October 2020 (unless otherwise indicated)

Safe			Effective			Caring			Responsive			Well-Led		
Metric	Oct-20	PD	Metric	Oct-20	PD	Metric	Oct-20	PD	Metric	Oct-20	PD	Metric	Oct-20	PD
999 Frontline Hours Provided %	94.60%	▲	**Cardiac ROSC Utstein %	45.00%	▼	Proportion of Complaints Relating to Crew Attitude %	23.00%	▲	Cat 1 Mean	00:07:33	▲	Cost Improvement Plan (CIP) (£000s) Month	£71.00	▼
Number of Incidents Reported as SIs	4	▼	**Stroke - Assessed F2F Diagnostic Bundle %	97.00%	▼	End of Life Care Performance		■	Cat 1 90th Centile	00:13:59	▲	Surplus/Deficit (£000s) Month	£-590.10	▼
Hand Hygiene Compliance %	99.00%	▲	**Sepsis Care Bundle %	87.00%	▼	Falls Performance		■	Cat 2 Mean	00:18:20	▲	Disciplinary Cases	3	▲
Physical Assaults (Number of Victims - Staff)	18	●	**Acute STEMI Care Bundle Outcome %	67.00%	▼	Proportion of Complaints Relating to Dignity and Respect %		■	Cat 2 90th Centile	00:33:41	▲	Collective Grievances	0	▲
Medicines Management % of Audits Completed	98.00%	●	ECAL Mean Response Time	00:23:41	▲	Dementia Performance		■	Cat 3 90th Centile	03:06:47	▲	Bullying & Harassment Internal	3	●
DBS Compliance %	100.00%	●	999 Operational Abstraction Rate %	38.30%	▲				Cat 4 90th Centile	04:28:26	▲	Annual Rolling Turnover Rate	11.70%	▲
Number of RIDDOR Reports	16	▼	Statutory & Mandatory Training Compliance %	75.00%	▼				999 Call Answer Mean	00:00:02	▲	Annual Rolling Sickness Absence	6.20%	▼
									111 Calls Answered in 60 Seconds %	66.60%	▲	Absence Relating to Mental Health %	10.80%	▼
									111 Calls Abandoned - (Offered) %	5.40%	▲	Absence Relating to MSK %	4.20%	▼
									111 to 999 Referrals (Answered Calls) %	11.80%	▼	999 Frontline Late Finishes/Over-Runs %	50.60%	●
									Complaints Reporting Timeliness %	88.00%	▲	Staff Successfully FIT-Tested %	90.50%	—
			**Latest data: Sep-20											

Symbol Key

▲ Improving performance	▼ Deteriorating performance	— Data not provided
● No change	■ Aspirational metric	PD Performance direction



Current Operational Performance

999 Emergency Ambulance Service (as of 17/11/20)

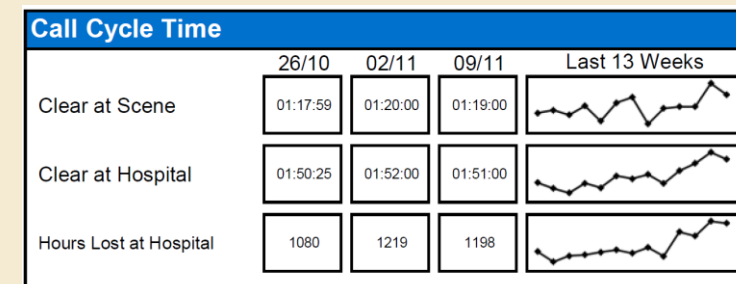
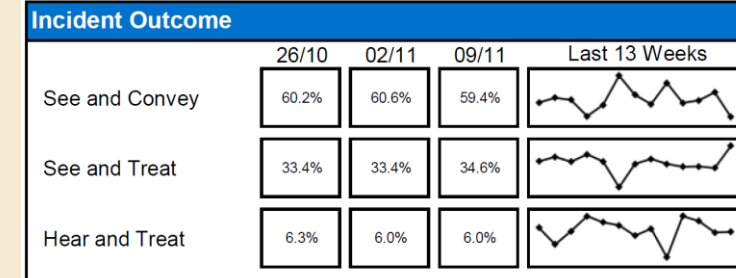
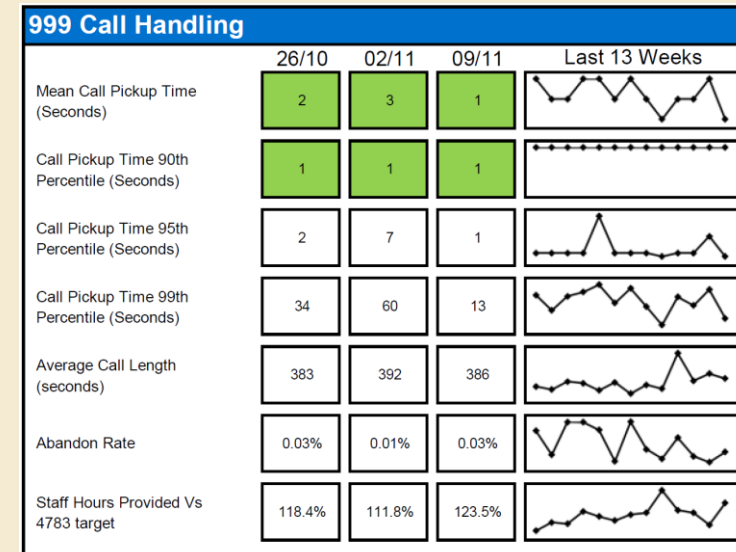
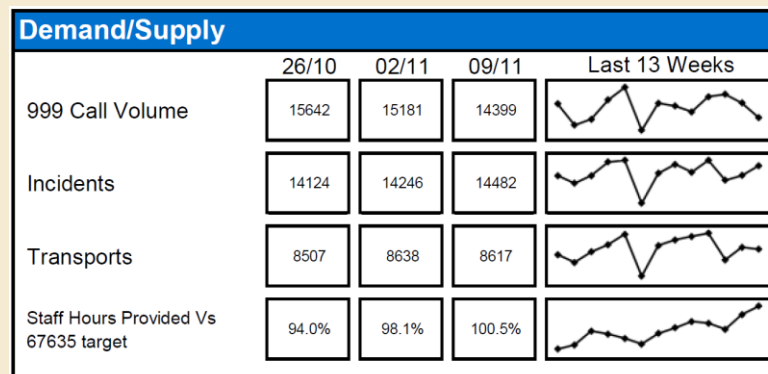
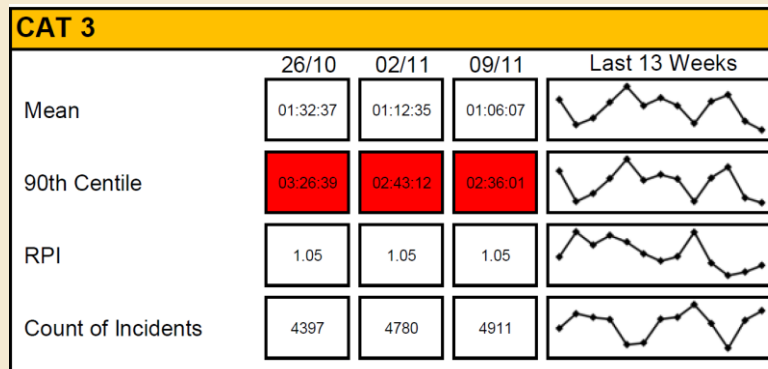
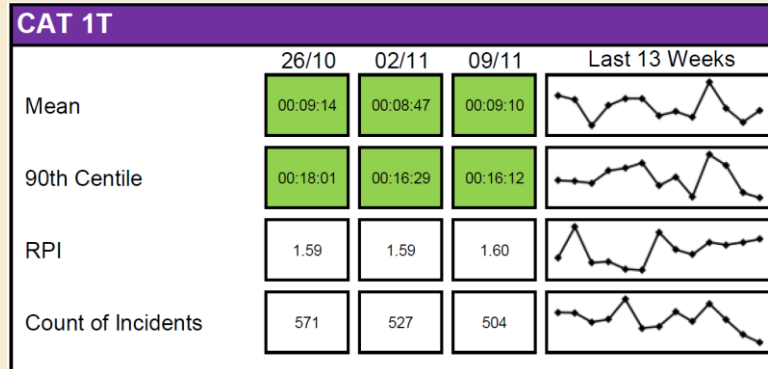
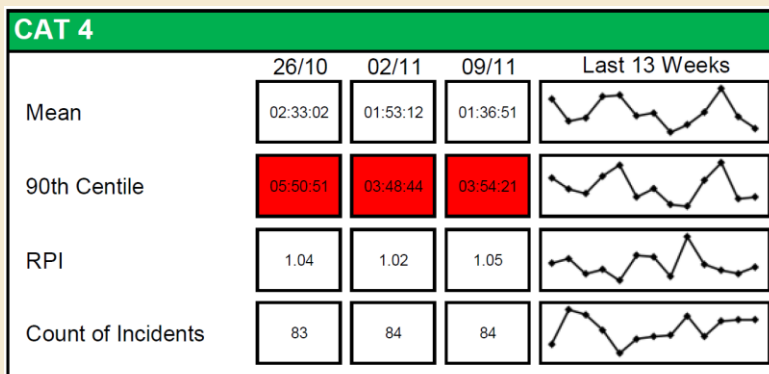
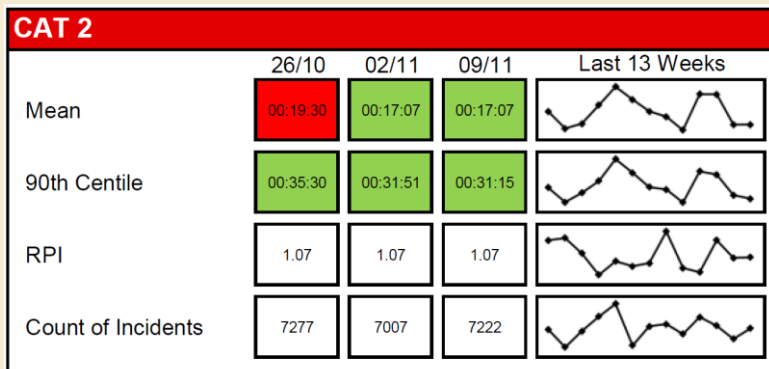
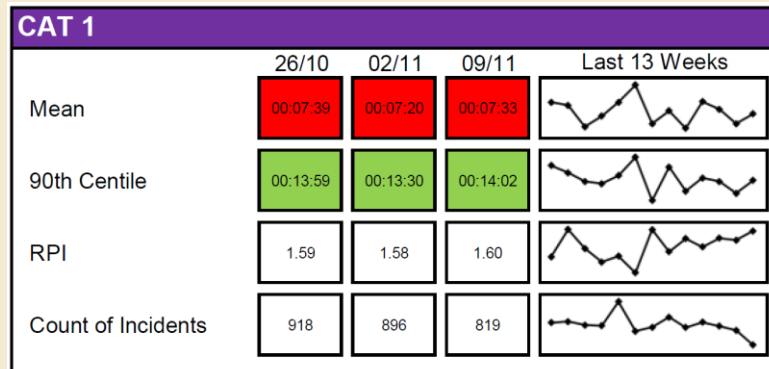
	Target		Month to Date			Quarter to Date		
Category	Mean	90th Centile	Incidents	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	2064	00:07:30	00:13:47	6124	00:07:34	00:13:56
C1T	00:19:00	00:30:00	1242	00:09:09	00:16:59	3814	00:09:17	00:17:25
C2	00:18:00	00:40:00	16727	00:17:31	00:32:17	48936	00:18:05	00:33:15
C3		02:00:00	11165	01:12:36	02:47:48	32116	01:20:11	03:01:05
C4		03:00:00	203	01:50:56	04:10:15	549	01:54:05	04:33:19
HCP 3			644	01:59:07	03:52:39	1726	01:58:10	03:53:01
HCP 4			465	02:47:29	05:04:19	1186	02:51:18	05:16:30
IFT 3			280	01:51:35	03:40:26	797	01:52:40	03:52:12
IFT 4			67	02:22:37	05:15:17	151	02:25:14	05:16:36
ST			11484	34.20%		32665	33.57%	
SC			20045	59.70%		58487	60.11%	
HT			2048	6.10%		6148	6.32%	
Count of Incidents			33577			97300		
Count of Incidents with a Response			31529			91152		
999 Mean	Call Answer Target 00:05		34776	00:02		101980	00:02	
999 90th	Call Answer Target 00:10			00:01			00:01	
Trust EOC 999 Abandoned Calls			8	0.0%		45	0.0%	
A0	EOC All Calls		41897			123642		

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Current Operational Performance

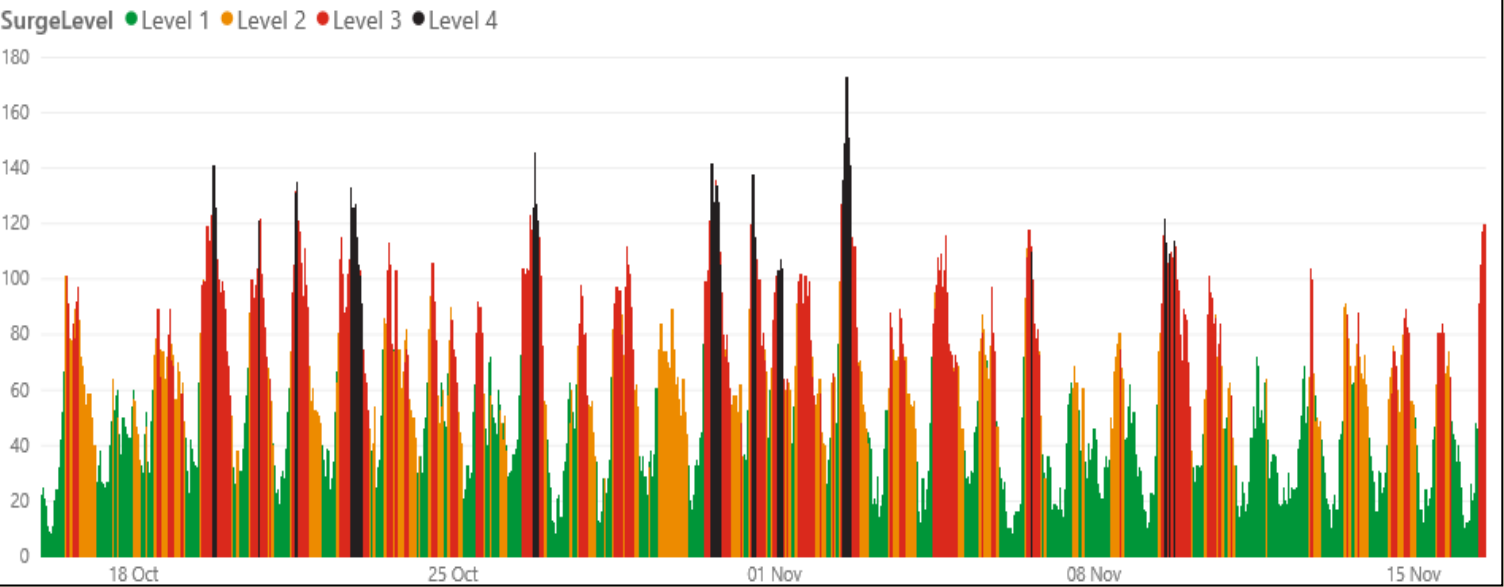
999 Emergency Ambulance Service (16/10/20– 15/11/20)



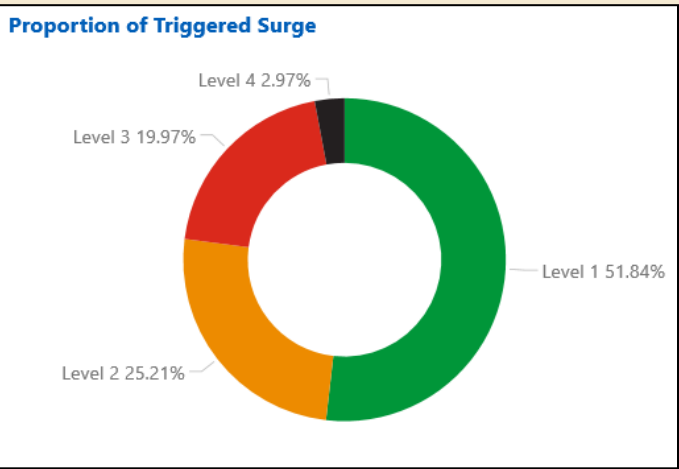
Current Operational Performance

999 Emergency Ambulance Service (16/10/20 – 16/11/20)

Total Calls Outstanding by Triggered Surge Level



Proportion of Triggered Surge



Surge Management Plan Triggers

Level 1

Business as Usual (BAU)
Ability to dispatch and respond to meet patient needs as identified within Ambulance Response Programme (ARP) metrics

Level 2

- Any of the triggers below:
- 2x Category 1 unassigned for >7 Minutes **or**
 - 8x Category 2 unassigned for >9 Minutes **or**
 - 20x Category 3 unassigned for >60 Minutes **or**
 - 20x Category 4 unassigned for >120 Minutes **or**
 - 20x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or**
 - **A combined total of 30 from any of the above triggers**

Level 3

- Any of the triggers below:
- 5x Category 1 unassigned for >7 Minutes **or**
 - 15x Category 2 unassigned for >9 Minutes **or**
 - 35 x Category 3 unassigned for >60 Minutes **or**
 - 35 x Category 4 unassigned for >120 Minutes **or**
 - 35x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or**
 - **A combined total of 45 from any of the above triggers**

Level 4

- Any of the triggers below:
- 10x Category 1 unassigned for >7 Minutes **or**
 - 30x Category 2 unassigned for >9 Minutes **or**
 - 60 x Category 3 unassigned for >60 Minutes **or**
 - 60 x Category 4 unassigned for >120 Minutes **or**
 - 60x HCP 1/2/4 unassigned for (>45/>60/>180 Minutes) **or**
 - **A combined total of 80 from any of the above triggers**



Trust Overview:
Summary of Performance Highlights

Domain	ID	Performance Highlight
Safe	Required NHS Pathways Audits Completed	Despite staffing challenges in EOC audit, the proportion of EMA and Clinical Supervisor audits completed continues to meet the level set by NHS Pathways
Effective	n/a	Nothing new to report
Caring	n/a	Nothing new to report
Responsive	n/a	Nothing new to report
Well-led	n/a	Nothing new to report



Trust Overview: Summary of Exceptions

Domain	ID	Exception
Safe	Datix incidents	The number of incidents recorded on Datix during October increased to 1342 from 952 during September, which although is quite a large increase is as a direct result of the KMS 111 CAS Service going live on 1 October 2020. This new service generated new types of incidents and has inevitably resulted in an increase of concerns and incidents being raised by external organisations, which are captured on the system. These are being investigated as per the usual process. However, Datix is used as a monitoring system during mobilisation and the EOC/111 have undertaken the usual one-hour, one-day, one-week, one-month reviews to ensure safety during any major change.
Safe	Violence and aggression	During the month of October, our staff reported 124 violence and aggression related incidents. This was the highest number of monthly incidents reported for this category. Staff reported 18 physical assaults, 56 verbal abuse incidents, 35 anti-social behaviour incidents and 15 attempted physical assaults. 43 of the verbal abuse incidents were reported from our EOC. A large proportion of the EOC incidents were attributable to one-patient calling on a considerable number of occasions.
Safe	RIDDOR	During the month of October, 16 RIDDOR incidents were reported to the Health and Safety Executive. 13 incidents were reported on time to the HSE and the 3 late reports were due to late incident reporting internally. The highest sub-category linked to the RIDDOR incidents were manual handling related.
Safe	Outstanding actions relating to SIs outside of timescales	The overall number of open actions has reduced significantly, as has the breach total. However, this is not reflected when shown as % compliance. By way of explanation of the previous statement, the following numbers evidence the significant improvement that has been made in reducing the outstanding SI actions. During April 2020, the overall number of open actions was 509, with 500 of them overdue (98%); whereas the 87.3% in September reflects 197 overall actions with 172 overdue; and the 87.2% in October equates to 181 open actions with 158 of them overdue. This metric evidenced as a number does show the reduction better than a % figure.
Safe	Frontline hours (999)	The total 999 frontline hours provided remain under plan, however we have seen improvements as the Performance Improvement Plan is implemented.
Effective	STEMI care bundle	Although the Trust has seen improvements in delivery of the STEM Care Bundle, performance remains below the national average.
Effective	Frontline workforce skills mix	The Demand & Capacity Review 2017/18 set out a requirement for the frontline workforce to grow, and for its skills mix to be made up of: 16% ECSWs, 17% AAP/Techs and 67% registered paramedics (NQP+P+CCP+PP).
Responsive	Complaints reporting timeliness	The timeliness of complaints reporting has deteriorated due to operational units failing to return reports within the required timescales as a result of Covid-19 operational pressures. Regrettably, this has affected some joint complaints with EOC/Ops. There was also an increase in the number of complaints received during September. On average the Trust receives an average of 14 complaints per week,. This rose to 17.75 in September. However, in October the average returned to within the normal range of 14.25.



Trust Overview: Summary of Exceptions

Domain	ID	Exception
Responsive	999 Operational Performance	Ongoing poor performance against Cat 3 and 4 90 th percentile is being addressed through a Performance Improvement Plan. There were improvements in August - October. Mitigations are also in place to improve Hear & Treat, See & Treat, and therefore reduce See & Convey where appropriate.
Responsive	111 Operational Performance	The new 111 IUC CAS (Clinical Assessment Service) went live on the 1 October 2020. Although the service is appropriately staffed current activity is significantly higher and different in nature to that which was commissioned. As a result, the service is currently performing below some of its contractual targets and this is most obvious with the service's operational metrics of calls answered in 60 seconds, and the abandonment rate. However, the Trust is using the additional funding that has been provided to support the delivery of the NHS E 111 First national initiative, to ensure that the KMS 111 CAS remains safe and effective in protecting the wider healthcare system.
Well-led	Policies and procedures outstanding review	During Covid, the regular three-year review of policies and procedures was paused to enable focus on operational response. This has created a backlog and we are seeing the percentage of documents overdue review creeping up. In addition, a similar number of documents will be due for review over the coming winter/EU transition/second wave period. A risk-assessment has been undertaken at senior level and document review dates extended (up to 12 months) where it is safer to continue using the current document than shifting management focus from operational delivery.
Well-led	Gender pay gap	The Trust reports against the metrics of the Gender Pay Gap annually, and this is published each year in arrears. SECamb has reported a worsening gender pay gap in both 2019 and 2020. Although, Agenda for Change (AfC) ensures that we are proving equal pay for equal work, we can see discrepancies in the ratio of males to females within pay bands. The latest figures reflect improvements at pay band 8C and above for those reported in the 2020 Gender Pay Audit, as well as increasing number of females in the overall workforce. The data also shows that women continue to be over-represented in the lower pay bands, and there is a marked difference for band 6 - band 8b in particular.
Well-led	Disability monitoring	The Trust is contractually required to report workforce disability data annually as part of the Workforce Disability Equality Standard, which includes declaration rates. In 2020, the Trust reported a 3.5% disability declaration on ESR against an NHS average of 3%. However, this is in contrast to a Trust declaration of 27% (564 responses) on the 2019 NHS staff survey. Reasons for non-declaration are numerous, including lack of understanding for disclosure; an individual's perception of their disability, access to systems to update, lack of trust / fear that declarations would be accessed inappropriately. The level of positive disability declaration via ESR continues to decline, and we continue to see increases in the number of staff whose disability declaration is required as unspecified.
Well-led	Workforce ethnicity monitoring	The Trust is contractually required to report workforce ethnicity data annually as part of the Workforce Race Equality Standard, which includes declaration rates by pay band. In 2020, the Trust reported 5% of its workforce were from Black, Asian and minority ethnic backgrounds, and this figure has increased (now at 5.32%). The NHS People Plan and Long Term Plan set out that organisations should be representative of the population they serve and this should be reflected throughout all levels of the organisation.



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
Datix Incidents	<div><div>Standard:</div><div>Datix incidents</div><div>Definition:</div><div>No. of Datix incidents</div></div>	<p>The number of incidents recorded on Datix during October increased to 1342 from 952 during September, which although is quite a large increase is as a direct result of the KMS 111 CAS Service going live on 1 October 2020. This new service generated new types of incidents and has inevitably resulted in an increase of concerns and incidents being raised by external organisations, which are captured on the system. These are being investigated as per the usual process. However, Datix is used as a monitoring system during mobilisation and the EOC/111 have undertaken the usual one-hour, one-day, one-week, one-month reviews to ensure safety during any major change. The Trust has been working towards increased reporting with lower or no levels of harm. This is supported by this trend.</p>

Action Plan	Accountable Executive
<div><div>Actions being taken to mitigate issues:</div><div>The incidents will continue to be recorded and investigated in the usual way, and any themes identified and explored further for learning purposes.</div></div>	<div><div>Named person:</div><div>Executive Director for Nursing & Quality</div><div>Complete by date:</div><div>Ongoing</div></div>



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
Violence & Aggression	<div><div>Standard:</div><div>Violence and aggression towards our staff</div><div>Definition:</div><div>No. of physical assaults</div><div>No. of attempted physical assaults</div><div>No. of direct verbal abuse incidents</div><div>No. of antisocial behaviour incidents</div></div>	During the month of October, our staff reported 124 violence and aggression related incidents. This was the highest number of monthly incidents reported for this category. Staff reported 18 physical assaults, 56 verbal abuse incidents, 35 anti-social behaviour incidents and 15 attempted physical assaults. 43 of the verbal abuse incidents were reported from our Emergency Operation Centres. A large proportion of the EOC incidents were attributable to one-patient calling on a considerable number of occasions.

Action Plan	Accountable Executive
<div><div>Actions being taken to mitigate issues:</div><div>The Trust is monitoring the number of incidents on a weekly basis to identify early key trends and provide additional support and guidance to our staff. Significant progress has been made with Sussex Police to implement Operation Cavell. The same process will be repeated with Kent and Surrey police forces to ensure a Trust wide implementation of Operation Cavell.</div></div>	<div><div>Named person:</div><div>Executive Director for Nursing & Quality</div><div>Complete by date:</div><div>Ongoing</div></div>



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
RIDDOR	<div><div>Standard:</div><div>RIDDOR</div><div>Manual handling incidents</div></div> <div><div>Definition:</div><div>No. of RIDDOR report submitted</div><div>No. of manual handling incidents reported</div></div>	During the month of October, 16 RIDDOR incidents were reported to the Health and Safety Executive. 13 incidents were reported on time to the HSE and the 3 late reports were due to late incident reporting internally. The highest sub-category linked to the RIDDOR incidents were manual handling related.

Action Plan	Accountable Executive
<div><div>Actions being taken to mitigate issues:</div><div>Ongoing monitoring by the Health and Safety Management Team</div></div>	<div><div>Named person:</div><div>Executive Director for Nursing & Quality</div></div> <div><div>Complete by date:</div><div>Ongoing</div></div>



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
SIs	<div><div>Standard:</div><div>Outstanding actions relating to SIs outside of timescales</div><div>Definition:</div><div>% of outstanding actions relating to SIs outside of timescales</div></div>	<p>The overall number of open actions has reduced significantly, as has the breach total. However, this is not reflected when shown as % compliance. By way of explanation of the previous statement, the following numbers evidence the significant improvement that has been made in reducing the outstanding SI actions. During April 2020, the overall number of open actions was 509, with 500 of them overdue (98%); whereas the 87.3% in September reflects 197 overall actions with 172 overdue; and the 87.2% in October equates to 181 open actions with 158 of them overdue. This metric evidenced as a number does show the reduction better than a % figure.</p>

Action Plan	Accountable Executive
<div><div>Actions being taken to mitigate issues:</div><div>Targeted work to reduce the breach rate is ongoing and proving to be effective.</div></div>	<div><div>Named person:</div><div>Executive Director for Nursing & Quality</div><div>Complete by date:</div><div>Ongoing</div></div>



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
999 hours	<div>Standard: 999 frontline hours provided</div> <div>Definition: % of 999 frontline hours provided against plan</div>	The performance improvement plan (PIP) has specifically been focused on actions to increase the total number of hours available for front-line response - the trend during Oct has been improvement although overall hours remains under plan.

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <div>All actions within the PIP are reported on weekly to the Executive Team & the Organisational Response Management Group.</div>	<div>Named person:</div> <div>Executive Director of Operations</div> <div>Complete by date:</div> <div>Ongoing</div>



Performance by Domain

Effective: Exception Report

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

ID	Standard	Background
STEMI Care Bundle	<div>Standard: STEMI Care Bundle</div> <div>Definition: STEMI Care Bundle delivery</div>	Although the Trust has seen improvements in delivery of the STEMI Care Bundle, performance remains below the national average.

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <p>The Trust is working with the National Ambulance Service Clinical Quality Group to support a review and potential redesign of all care bundles to ensure that are fit for purpose. The Trust's Quality Improvement Lead is also leading a programme of work to improve the quality of feedback delivered to clinicians in relation to clinical outcome indicators.</p>	<div>Named person:</div> <p>Medical Director</p> <div>Complete by date:</div> <p>Ongoing</p>



Performance by Domain

Effective: Exception Report

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

ID	Standard	Background
Frontline workforce skill mix	<div>Standard: Frontline workforce skill mix</div> <div>Definition: % of ECSWs against plan % of AAP/Techs against plan % of Registered Paramedics against plan</div>	The Demand & Capacity Review 2017/18 set out a requirement for the frontline workforce to grow, and for its skills mix to be made up of: 16% ECSWs, 17% AAP/Techs and 67% registered paramedics (NQP+P+CCP+PP).

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <div>The proportion of registered paramedics is being improved through: 1) maximum recruitment of NQPs each year; and 2) enabling as many AAP/Techs as Ops is able to abstract to enter into in-service Paramedic training.</div>	<div>Named person:</div> <div>Executive Director of Operations</div> <div>Complete by date:</div> <div>Ongoing</div>



Performance by Domain

Responsive: Exception Report

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

ID	Standard	Background
Complaints Reporting	<div>Standard: Complaints reporting timeliness</div> <div>Definition: Complaints reporting timeliness %</div>	The timeliness of complaints reporting has deteriorated due to operational units failing to return reports within the required timescales as a result of Covid-19 operational pressures. Regrettably, this has affected some joint complaints with EOC/Ops. There was also an increase in the number of complaints received during September. On average the Trust receives an average of 14 complaints per week,. This rose to 17.75 in September. However, in October the average returned to within the normal range of 14.25.

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <p>During this period of additional pressure a collaborative approach to assist Operations with patient safety investigations is being taken; a plan is being developed to form a central team of staff made up of operational staff on alternative duties that will lead on investigations full time, this will significantly reduce the pressure on the operational areas, and the patient safety teams.</p>	<div>Named person:</div> <p>Executive Director of Nursing & Quality</p> <div>Complete by date:</div> <p>Ongoing</p>



Performance by Domain

Responsive: Exception Report

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

ID	Standard	Background
999	<p>Standard:</p> <p>999 Operational Performance</p> <p>Definition:</p> <p>Cat 3 & Cat 4 90th centile performance, Hear & Treat %, See & Treat v See & Convey %</p>	<p>Cat 3 & Cat 4 90th centile performance: Ongoing poor performance against these metrics, however with improvements noted during August - October. This improvement is primarily driven by the Performance Improvement Plan and associated actions.</p> <p>Hear & Treat %: Deteriorating position across August - October. Overall unclear on rationale as clinical staffing in EOC is strong, however work to baseline this activity within a specific workstream reporting into Covid Recovery, Learning and Improvement Group (CRLIG) is identifying significant process and structural issues contributing to this overall poor performance.</p> <p>See & Treat v See & Convey %: Marginally off target - these two metrics are mutually exclusive of each other. It is expected as we progress into winter that the See & Convey rate would increase due to the overall increase in acuity of patients at this time of year. The See & Treat rate is being actively supported by Paramedic Practitioner hubs.</p>

Action Plan	Accountable Executive
<p>Actions being taken to mitigate issues:</p> <p>Performance Improvement Plan actions are reported weekly at to the Executive Team and Organisational Response Management Group.</p> <p>Actions around Hear & Treat are managed under the Operations CRLIG workstream, monitored bi-weekly at programme boards.</p> <p>On See & Treat v See & Convey, no active actions beyond Paramedic Practitioner Hub support for local decision-making. Crews are also cognisant of the impact of conveyances to ED and the impact on those services so will, where appropriate and possible, use alternate pathways.</p>	<p>Named person:</p> <p>Executive Director of Operations</p> <p>Complete by date:</p> <p>Ongoing</p>



Performance by Domain

Responsive: Exception Report

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

ID	Standard	Background
111	<p>Standard:</p> <p>111 Operational Performance</p> <p>Definition:</p> <p>111 calls answered in 60 seconds</p> <p>111 calls abandoned</p> <p>111 referrals to 999</p> <p>A&E dispositions</p>	<p>The new 111 IUC CAS (Clinical Assessment Service) went live on the 1 October 2020. Although this has been a very challenging and complex service mobilisation, not least because it has been undertaken with the back-drop of the COVID-19 pandemic, the service has gone live as planned and is already making a positive difference and protecting the wider healthcare system, as referenced in feedback from Commissioners and other downstream providers. This is achieved by being a first point of contact within the urgent and emergency care system, helping to avoid inappropriate referrals to 999, EDs and to Primary Care. However, the challenge presented to the KMS 111 CAS is huge, with a significantly elevated call volume associated with winter pressures, COVID-19 and the NHS E national initiative of 111 First.</p> <p>Although the service is appropriately staffed and profiled to meet the original forecasted demand, current activity is significantly higher and different in nature to that which was commissioned almost two years ago. As a result, the service is currently performing below its contractual targets and this is most obvious with the service's operational metrics of calls answered in 60 seconds, and the abandonment rate. In addition, the way that the CAS disposition outcomes are measured has also changed because the new CAS uses the NHS E Aggregated Data Set (ADS) guidance and as such, this has increased the actual % 999 and ED referral rates in the short term.</p> <p>NHS E is also launching its 111 First initiative nationally from the 1 December (KMS 111 CAS already has three pilots which have gone live across Kent, Medway and Sussex). This will increase (and already has) incoming call activity, as the public will be encouraged to access EDs by calling 111 First.</p> <p>KMS 111 CAS also has to operate currently with an interim Electronic Prescribing Service (EPS) solution, which necessitates the use of two systems and is inefficient. The delay for the new solo CAD solution with SECamb, and IC24 as our sub-contractor both using Cleric with a permanent EPS solution is as a result of NHS Digital not yet accrediting our EPS solution.</p> <p>Continues overleaf ...</p>



Performance by Domain

Responsive: Exception Report

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

ID	Standard	Background
111	<div>Standard: 111 Operational Performance</div> <div>Definition: Calls answered in 60 seconds 111 referrals to 999 A&E dispositions</div>	Continued ...

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <p>The service is mitigating the risk to its current performance by:</p> <ul style="list-style-type: none">• Converting NHS Pathways trained bank staff to substantive contracts to ensure more appropriate rota fill• Recruiting additional clinicians via agencies and training them to support the management of the CAS• Training the existing Trust Video Consultation GPs to support 111 First if required• Continuing the dual-skilling of the Trust's 999 EMAs to support the handling of 111 calls, when safe and appropriate, and without adversely impacting 999 call handling which remains very good• Extension of agile working to more 111 and 999 clinicians, providing greater flexibility and availability of clinicians when required• Undertaking a comprehensive review of rota planning and rotas, amending to reflect the new call profiles and demands experienced in 111 since the onset of COVID-19• Escalating the ongoing delays with the accreditation of the Trust's permanent EPS solution to NHS E's executive team• Meeting with Commissioners to discuss and agree the way to calculate and present the contractual KPIs, as per the NHS E ADS requirements• Maintaining the current degree of scrutiny and focus internally via the SLT and CAS Program Board meetings, whilst also ensuring that both SECamb and IC24 has daily contact at an operational/clinical level to address issues as and when they arise• Continuing to have daily performance meetings with Commissioners and monthly Joint Assurance Committee meetings with Commissioners, NHS E and other stakeholders to enable the Trust to continue to operate in a transparent and collaborative manner.	<div>Named person: Executive Director of Operations</div> <div>Complete by date: Ongoing</div>



Performance by Domain

Well-Led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
Policies	<div>Standard: Policies & Procedures Outstanding Review</div> <div>Definition: No. of Policies & Procedures Outstanding (3-Year Review)</div>	During Covid, the regular three-year review of policies and procedures was paused to enable focus on operational response. This has created a backlog and we are seeing the percentage of documents overdue review creeping up. In addition, a similar number of documents will be due for review over the coming winter/EU transition/second wave period.

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <p>The documents already overdue review and those due for review by the end of March 2021, have been risk assessed by both SLT and then the Joint Partnership Policy Forum (involving Union colleagues) to consider formally extending the review dates of some of these documents. The risk assessment considered the risk to our patients, staff and the Trust of an extended review date for existing policies and procedures (i.e. currently in good use by the Trust) versus the risk of undertaking rushed or lightly resourced reviews, drawing resources away from other urgent areas of Trust focus. The risk assessment identified a small number of documents which would present unacceptable risk if not reviewed. The remainder will have their review date extended by 6-12 months to enable us to plan to reduce the backlog, and allocate appropriate resources.</p>	<div>Named person:</div> <p>Company Secretary</p> <div>Complete by date:</div> <p>Ongoing</p>



Performance by Domain

Well-Led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
Diversity & Inclusion	<p>Standard:</p> <p>Gender Pay Gap</p> <p>Definition:</p> <p>Gender pay gap by pay band (by month)</p>	<p>The Trust reports against the metrics of the Gender Pay Gap annually, and this is published each year in arrears. SECAMB has reported a worsening gender pay gap in both 2019 and 2020. Although, Agenda for Change (AfC) ensures that we are proving equal pay for equal work, we can see discrepancies in the ratio of males to females within pay bands. The latest figures reflect improvements at pay band 8C and above for those reported in the 2020 Gender Pay Audit, as well as increasing number of females in the overall workforce. The data also shows that women continue to be over-represented in the lower pay bands, and there is a marked difference for band 6 - band 8b in particular.</p>

Action Plan

Actions being taken to mitigate issues:

The Trust was due to launch a Gender Equality Staff Network in March 2020, which was delayed due to the Covid-19 pandemic. This launch is now scheduled for January 2021. The network will help shape the priorities for the next 12 months. The Trust approved a pilot cohort of the Springboard Women's Development Programme, which is planned for Q4 2020/21. The Trust has committed to continue to explore opportunities for more flexible or alternative shift working across the organisation, including how this could be introduced into a wider range of roles. The Trust has committed to ensuring that gender diverse interview panels are in place for all roles at band 8 and above. This is being delivered as part of the Integrated Equality Plan.

Accountable Executive

Named person:

Executive Director for HR & OD

Complete by date:

Ongoing



Performance by Domain

Well-Led: Exception Report

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
Diversity & Inclusion	<div>Standard: Disability monitoring</div> <div>Definition: Workforce disability monitoring</div>	The Trust is contractually required to report workforce disability data annually as part of the Workforce Disability Equality Standard, which includes declaration rates. In 2020, the Trust reported a 3.5% disability declaration on ESR against an NHS average of 3%. However, this is in contrast to a Trust declaration of 27% (564 responses) on the 2019 NHS staff survey. Reasons for non-declaration are numerous, including lack of understanding for disclosure; an individual's perception of their disability, access to systems to update, lack of trust / fear that declarations would be accessed inappropriately. The level of positive disability declaration via ESR continues to decline, and we continue to see increases in the number of staff whose disability declaration is required as unspecified.

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <p>The Workforce & Planning Team are undertaking a data cleanse following identification of an issue within ESR and will provide us with a better understanding of non disclosure rates. This data will be reported in the next quarter. However, the large discrepancy between positive declaration rates on ESR and in the NHS staff survey highlights that we need to continue to promote awareness of the importance of declaration to help us to meet the needs of staff. The Trust is currently working towards the launch of a Neurodiversity Charter, and further promotion of why we should declare will be included as part of the messaging to launch this. A declaration section of ESR has been repositioned to make this more prominent on login.</p>	<div>Named person:</div> <p>Executive Director for HR & OD</p> <div>Complete by date:</div> <p>Ongoing</p>



Performance by Domain

Well-Led: Exception Report

Our leadership, management and governance of the organisation make sure it’s providing high-quality care that’s based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Standard	Background
Diversity & Inclusion	<div>Standard: Workforce ethnicity monitoring</div> <div>Definition: Workforce ethnicity monitoring</div>	The Trust is contractually required to report workforce ethnicity data annually as part of the Workforce Race Equality Standard, which includes declaration rates by pay band. In 2020, the Trust reported 5% of it's workforce were from Black, Asian and minority ethnic backgrounds, and this figure has increased (now at 5.32%). The NHS People Plan and Long Term Plan set out that organisations should be representative of the population they serve and this should be reflected throughout all levels of the organisation.

Action Plan	Accountable Executive
<div>Actions being taken to mitigate issues:</div> <div>The Trust has an integrated Equality Objective Plan to deliver further improvements in the ethnicity of its workforce. The HRWG will be looking to make a recommendation regarding targets for improvement.</div>	<div>Named person:</div> <div>Executive Director for HR & OD</div> <div>Complete by date:</div> <div>Ongoing</div>



Performance by Domain

Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-1	Number of Datix Incidents	868	1024	1042	1019	1043	1028	834	973	905	940	861	952	1342					▼
QS-2	Number of Incidents Reported as SIs	8	9	12	7	9	2	5	7	9	10	5	2	4					▼
999-12	999 Frontline Hours Provided %	86.80%	89.20%	92.70%	94.80%	90.70%	87.50%	97.30%	99.10%	93.80%	89.30%	92.50%	91.20%	94.60%	100.00%		—		▲
QS-3	Duty of Candour Compliance %	100.00%	90.00%	91.00%	100.00%	90.00%	100.00%	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		=		●
QS-7	Hand Hygiene Compliance %	89.00%	89.00%	92.00%	90.00%	93.00%	92.00%	95.00%	95.00%	92.00%	82.00%	97.00%	93.00%	99.00%	95.00%		+		▲
QS-8	Safeguarding Training Completed (Children) Level 2 %	62.20%	65.80%	66.30%	69.80%	72.30%	86.90%	12.30%	35.60%	60.20%	67.10%	69.90%	72.70%	74.90%	95.00%		—		▲
QS-13	Physical Assaults (Number of Victims - Staff)	2	2	4	10	3	5	3	18	22	16	29	18	18					●
MM-1	Number of Medicines Incidents	111	162	139	149	165	135	112	168	111	146	103	89	162					▼
MM-3	Single Witness Signature Use CDs Omnicell	4	9	4	6	4	5	4	2	0	0	14	0	3	0		—		▼
MM-4	Single Witness Signature Use CDs Non-Omnicell	0	3	3	3	3	4	0	1	0	0	0	0	0	0		=		●
MM-5	Number of CD Breakages	14	18	19	21	21	11	20	17	17	16	14	14	17					▼
MM-7	Medicines Management % of Audits Completed	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	100.00%	99.00%	99.00%	99.00%	98.00%	98.00%	100.00%		—		●
WF-1	Number of Staff WTE (Excl bank and agency)	3624	3710	3689	3685	3667	3667	3734	3768	3784	3793	3806	3859	3888					▲
WF-2	Number of Staff Headcount (Exc bank and agency)	3940	4034	4016	4020	4001	4005	4075	4120	4141	4154	4173	4231	4271					▲
WF-3	Finance Establishment (WTE)	3811	3860	3940	3920	3924	3905	3905	3905	3905	3800	3816	3818	3880					▲
WF-4	Vacancy Rate %	4.90%	3.90%	6.40%	6.00%	6.50%	6.10%	4.40%	3.50%	3.10%	0.20%	2.60%	-1.10%	-0.20%					▼
QS-9	Number of RIDDOR Reports	8	5	4	2	6	12	2	8	6	11	8	7	16					▼
WF-16	DBS Compliance %									100.00%	98.00%	100.00%	100.00%	100.00%	100.00%		=		●
M-20	Compliant NHS Pathways Audits (Clinical) %	84.00%	80.00%	83.00%	79.00%	80.00%	74.00%	77.00%	80.00%	84.00%	95.00%	95.00%	83.00%	96.00%					▲
M-21	Required NHS Pathways Audits Completed (EMA) %									82.00%	102.00%	102.00%	100.00%	100.00%					●

- ▲ Improving performance

▼ Deteriorating performance

● No change

■ Aspirational metric
- + Outperformed target

- Underperformed target

= On target

- Data not provided



Performance by Domain

Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
M-22	Compliant NHS Pathways Audits (EMA) %									84.00%	84.00%	84.00%	90.00%	100.00%	100.00%		=		▲
M-23	Required NHS Pathways Audits Completed (Clinical) %												85.00%	85.00%					●
QS-17	Outstanding Actions Relating to SIs, Outside of Timescales %											97.20%	87.30%	87.20%	0.00%		-		▲
QS-19	Deep Clean Compliance %							77.00%	107.00%	105.00%	103.00%		92.00%	95.00%					▲
QS-20	Health & Safety Incidents									43	42	35	42	37					▲
WF-24	Current licence details held for Operational Staff %											79.30%	88.80%	88.50%	100.00%		-		▼
QS-22	Manual Handling Incidents									22	46	30	26	29					▼
QS-23	Direct Verbal Abuse Incidents									5	15	16	23	56					▼
QS-25	Flu Vaccine Compliance (Winter 2020-21)													58.00%	45.00%		+		—

Performance by Domain

Effective: Performance Dashboard

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

** Latest data: Sep-20																			
ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-11	JCT Allocation to Clear at Scene Mean	01:16:58	01:18:03	01:14:23	01:15:07	01:15:55	01:19:00	01:22:33	01:19:55	01:19:20	01:16:03	01:14:37	01:15:23	01:16:39					▼
999-11	JCT Allocation to Clear at Hospital Mean	01:49:14	01:50:19	01:50:13	01:50:34	01:50:08	01:51:21	01:50:08	01:47:51	01:46:43	01:46:34	01:47:37	01:47:30	01:49:01					▼
M-1	**Cardiac ROSC Utstein %	54.00%	52.00%	50.00%	55.00%	22.00%	42.00%	33.00%	43.00%	45.00%	32.00%	46.00%	45.00%						▼
M-2	Cardiac ROSC ALL %	25.00%	27.00%	23.00%	28.00%	25.00%	18.00%	24.00%	22.00%	24.00%	15.00%	24.00%	29.00%						▲
M-12	**Sepsis Care Bundle %	61.00%	86.00%	87.00%	87.00%	87.00%	87.00%	88.00%	84.00%	81.00%	87.00%	88.00%	87.00%						▼
M-3	Cardiac Survival Utstein %	31.00%	22.00%	29.00%	33.00%	9.00%	31.00%	14.00%	24.00%	31.00%	8.00%	19.00%							—
M-4	Cardiac Survival ALL %	11.00%	5.00%	8.00%	10.00%	7.00%	7.00%	9.00%	11.00%	9.00%	4.00%	7.00%							—
M-11	Cardiac Arrest - Post ROSC %	78.00%	82.00%	75.00%	80.00%	77.00%	78.00%	81.00%	62.00%	74.00%	80.00%	79.00%	78.00%						▼
M-5	**Acute STEMI Care Bundle Outcome %	56.00%	63.00%	65.00%	71.00%	69.00%	73.00%	71.00%	73.00%	64.00%	64.00%	68.00%	67.00%						▼
M-6	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	02:07:00	02:14:00																—
M-7	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	02:37:00	03:09:00																—
M-8	Stroke - Call to Hospital Arrival Mean	01:26:00	01:30:00																—
M-9	Stroke - Call to Hospital Arrival 90th Centile	02:25:00	02:24:00																—
M-10	**Stroke - Assessed F2F Diagnostic Bundle %	92.00%	94.00%	96.00%	97.00%	99.00%	97.00%	98.00%	98.00%	97.00%	98.00%	98.00%	97.00%						▼
M-13	Sensitivity of Cardiac Arrest Detection During Telephone Triage %												96.00%						—
M-14	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %												79.00%						—
M-15	Time to Commence Telephone-Guided CPR Mean																■	■	■
M-16	Proportion of Non-EMS Witnessed Cardiac Arrests with PAD Applied to Patient %												6.00%						—

- ▲ Improving performance

▼ Deteriorating performance

● No change

■ Aspirational metric
- + Outperformed target

- Underperformed target

= On target

- Data not provided



Performance by Domain

Effective: Performance Dashboard

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

** Latest data: Sep-20

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-13	ECAL Mean Response Time	00:28:27	00:27:42	00:25:55	00:27:03	00:27:49	00:26:21	00:23:15	00:23:51	00:24:00	00:25:49	00:23:34	00:24:10	00:23:41					▲
999-12	999 Operational Abstraction Rate %									32.50%	32.50%	32.60%	38.40%	38.30%	28.00%		—		▲
WF-6	Statutory & Mandatory Training Compliance %	68.80%	70.20%	70.60%	73.60%	76.60%	83.70%	68.60%	70.80%	75.10%	76.10%	75.90%	75.40%	75.00%	100.00%		—		▼
999-17	Responses Per Incident	1.10	1.11	1.10	1.11	1.10	1.08	1.08	1.09	1.10	1.12	1.12	1.08	1.08	1.09		+		●
999-18	Section 136 Mean Response Time									00:19:17	00:17:16	00:16:57	00:18:30	00:16:38					▲
999-19	Section 135 Mean Response Time									00:22:07	04:44:00	00:54:56	00:05:19	00:03:44					▲
999-20	ePCR Usage									94.70%	93.80%	95.30%	93.70%	94.80%	95.00%		—		▲
999-24	Number of Hours Lost at Hospital Handover	3929	4022	4428	4268	3753	3192	2289	2046	1916	3610	4202	3958	4435					▼
999-25	Hours Lost at Handover as a Proportion of Provided Hours %	1.40%	1.40%	1.50%	1.40%	1.40%	1.10%	0.80%	0.70%	0.70%	0.20%	1.50%	1.40%	1.60%					▼
WF-23	Recruitment: Advert to Start Date														100.00%		■	■	■
WF-31	ClinEd: Course capacity utilisation %																■	■	■
WF-32	ClinEd: Qualification obtained when expected %																■	■	■
WF-33	ClinEd: Course satisfaction score																■	■	■
WF-34	Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	30.00%	30.20%	30.80%	30.90%	31.00%	31.10%	31.10%	31.30%	31.50%	31.90%	31.40%	30.80%	30.50%	29.00%				
WF-35	Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	22.30%	22.30%	22.10%	22.10%	22.10%	22.00%	22.30%	22.10%	22.70%	22.80%	20.50%	20.20%	20.00%	23.00%				
WF-36	Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	47.70%	47.50%	47.10%	47.10%	46.80%	46.90%	46.60%	46.60%	45.80%	45.30%	48.10%	49.00%	48.40%	48.00%				

Performance by Domain

Caring: Performance Dashboard

Our staff involve and treat our patients with compassion, kindness, dignity and respect

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-12	Proportion of Complaints Relating to Dignity and Respect %																■	■	■
QS-10	Proportion of Complaints Relating to Crew Attitude %									48.00%	42.00%	40.00%	37.00%	23.00%					▲
M-17	Dementia Performance																■	■	■
M-18	End of Life Care Performance																■	■	■
M-19	Falls Performance																■	■	■
111-6	111 SMS Feedback																■	■	■
QS-11	Patient Experience																■	■	■

- ▲ Improving performance

▼ Deteriorating performance

● No change

■ Aspirational metric
- + Outperformed target

- Underperformed target

= On target

- Data not provided



Performance by Domain

Responsive: Performance Dashboard

Our services are organised so that they meet our patient's needs

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
111-1	111 Calls Offered	72487	78017	92173	75904	85080	162194	89757	81333	70230	71925	85338	90438	104059					—
111-2	111 Calls Answered in 60 Seconds %	78.30%	77.50%	78.20%	86.30%	61.50%	16.50%	48.70%	87.90%	93.50%	91.20%	84.00%	60.10%	66.60%	95.00%		—		▲
111-3	111 Calls Abandoned - (Offered) %	3.80%	3.60%	3.00%	1.90%	8.00%	50.20%	18.60%	1.40%	0.60%	1.00%	2.00%	9.70%	5.40%	6.00%		+		▲
111-4	111 to 999 Referrals (Answered Calls) %	16.90%	15.80%	15.10%	14.50%	12.70%	9.80%	11.90%	13.00%	13.80%	13.60%	12.40%	11.60%	11.80%					▼
111-4	999 Referrals	9454	9638	10672	8726	7960	5443	6734	8768	8443	8407	8864	7943	11110					▼
111-5	A&E Dispositions %	10.20%	9.70%	9.50%	10.70%	9.70%	6.00%	9.20%	11.60%	13.40%	13.80%	12.70%	12.10%	12.00%					▲
111-5	A&E Dispositions	5697	5903	6676	6443	6047	3316	5235	7795	8161	8544	9102	8320	11350					▼
QS-15	Complaints per 1000 999 Calls Answered									1.00	1.16	0.79	1.28	0.97					▲
QS-16	Compliments per 1000 999 Calls Answered									3.26	3.66	2.75	3.25	2.49					▼
999-10	999 Calls Answered	69301	68437	73898	65125	63620	77690	56319	54224	55915	62772	69541	64025	67031					—
999-10	Incidents	64407	64620	68798	65363	61110	64209	58064	60484	58653	61196	64489	61313	63644					—
999-1	999 Call Answer Mean	00:00:06	00:00:03	00:00:03	00:00:02	00:00:02	00:00:07	00:00:01	00:00:01	00:00:02	00:00:02	00:00:03	00:00:03	00:00:02	00:00:05		+		▲
999-1	999 Call Answer 90th Centile	00:00:11	00:00:01	00:00:01	00:00:01	00:00:01	00:00:12	00:00:01	00:00:01	00:00:01	00:00:01	00:00:02	00:00:01	00:00:01	00:00:10		+		●
999-2	Cat 1 Mean	00:07:43	00:07:39	00:07:55	00:07:36	00:07:43	00:07:52	00:07:05	00:07:00	00:07:31	00:07:38	00:07:53	00:07:42	00:07:33	00:07:00		—		▲
999-2	Cat 1 90th Centile	00:14:37	00:14:39	00:14:46	00:13:59	00:14:30	00:14:55	00:13:32	00:12:10	00:14:01	00:14:34	00:14:50	00:14:22	00:13:59	00:15:00		+		▲
999-3	Cat 1T Mean	00:09:31	00:09:26	00:09:49	00:09:22	00:09:26	00:09:25	00:08:28	00:07:59	00:08:59	00:09:18	00:09:43	00:09:20	00:09:20	00:19:00		+		●
999-3	Cat 1T 90th Centile	00:17:59	00:18:09	00:18:19	00:17:14	00:17:44	00:17:32	00:15:38	00:14:31	00:16:40	00:17:51	00:17:38	00:17:40	00:17:41	00:30:00		+		▼
999-4	Cat 2 Mean	00:20:06	00:20:54	00:21:42	00:18:06	00:19:15	00:21:26	00:14:50	00:14:28	00:16:43	00:18:31	00:18:57	00:18:55	00:18:20	00:18:00		—		▲
999-4	Cat 2 90th Centile	00:38:01	00:39:48	00:41:32	00:34:10	00:36:29	00:41:02	00:27:32	00:26:58	00:31:02	00:34:56	00:34:57	00:35:28	00:33:41	00:40:00		+		▲
999-5	Cat 3 90th Centile	03:52:51	04:03:22	04:11:54	02:50:33	03:25:09	04:00:52	01:54:57	01:40:20	02:38:05	03:19:04	03:31:37	03:15:36	03:06:47	02:00:00		—		▲
999-6	Cat 4 90th Centile	05:34:12	04:46:20	05:21:05	03:33:38	04:46:32	04:56:30	02:42:46	02:14:44	03:30:44	04:40:05	05:01:24	04:50:26	04:28:26	03:00:00		—		▲
999-7	HCP 3 Mean	02:20:25	02:05:07	02:25:37	01:50:21	02:00:42	02:18:26	01:11:25	01:11:14	01:41:16	02:06:57	02:20:06	01:51:46	01:56:51					▼
999-7	HCP 3 90th Centile	05:03:44	04:46:42	05:34:57	03:53:48	04:09:57	04:59:29	02:43:28	02:40:50	03:39:26	04:20:06	05:01:43	04:10:32	03:52:35					▲
999-7	HCP 4 Mean	03:25:25	03:17:34	02:59:04	02:32:29	02:49:16	03:08:44	01:32:09	01:34:23	02:28:17	02:53:34	03:09:26	02:21:41	02:52:18					▼

Performance by Domain

Responsive: Performance Dashboard

Our services are organised so that they meet our patient's needs

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-7	HCP 4 90th Centile	06:51:36	06:43:46	05:43:16	05:44:15	05:44:04	07:17:56	03:50:42	04:00:58	05:23:41	06:15:50	06:29:29	05:33:15	05:23:36					▲
999-9	Hear & Treat %	5.80%	6.20%	6.70%	5.60%	6.50%	8.40%	6.70%	5.90%	6.30%	6.60%	7.20%	6.40%	6.20%	7.80%		▬		▼
999-9	See & Treat %	31.30%	30.80%	31.70%	31.50%	31.80%	37.10%	42.40%	37.10%	34.60%	33.60%	33.80%	33.30%	33.40%	35.00%		▬		▲
999-9	See & Convey %	62.90%	63.00%	61.60%	62.90%	61.70%	54.40%	50.90%	57.00%	59.10%	59.80%	59.00%	60.40%	60.40%	57.20%		▬		●
999-10	CFR Attendances	1340	1242	1321	1185	1051	785	0	0	75	152	520	614	673					▲
999-10	FFR Attendances	221	338	398	427	261	243	144	180	192	171	201	171	190					▲
QS-4	Complaints Reporting Timeliness %	55.00%	55.00%	73.00%	72.00%	78.00%	90.00%	92.00%	86.00%	95.00%	95.00%	96.00%	83.00%	88.00%	95.00%		▬		▲
QS-5	Number of Complaints	111	91	68	79	66	56	43	48	56	73	55	82	65					▲
QS-6	Number of Compliments	147	231	148	213	187	197	169	168	191	224	177	208	167					▬
QS-14	Learning from deaths: Number of Structured Judgment Reviews				20	20	20	20	20	20	20	20	20	20	20		=		●
QS-26	Learning from deaths: Number of SJRs showing harm																■	■	■
999-14	Time Spent in SMP 3 or Higher %	42.10%	45.40%	49.90%	15.00%	31.70%	43.90%	3.90%	0.60%	13.70%	29.10%	38.10%	27.90%	25.90%					▲
C-2	Number of BCIs									2	2	3	1	2	0		▬		▼

Performance by Domain

Well-Led: Performance Dashboard

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Metric	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Plan	Vs Plan	Full Year Forecast	Full Year Forecast vs. Plan	Perf Direction
F-1	Income (£000s) (Month)	20,390	22,456	21,049	19,410	23,189	21,877	22,787	22,394	22,042	22,557	22,397	22,430	22,521	(91)			+
New	Income (£000s) (Year to date)						21,877	44,665	67,058	89,100	111,658	134,054	156,484	152,752	3,733	276,908	14,984	+
F-2	Operating Expenditure (£000s) (Month)	20,024	20,877	20,227	19,428	22,281	21,877	22,787	22,394	22,052	22,559	22,399	23,020	22,521	499			-
New	Operating Expenditure (£000s) (Year to date)						21,877	44,665	67,058	89,110	111,669	134,069	157,089	152,752	4,337	283,161	(21,238)	-
F-6	Surplus/Deficit (£000s) (Month)	367	1,579	822	(18)	908	0	0	(0)	(10)	(2)	(3)	(590)	0	(590)			-
New	Surplus/Deficit (£000s) (Year to date)						0	0	0	(10)	(12)	(15)	(605)	0	(605)	(6,253)	(6,253)	-
F-4	Cost improvement plans (CIPS) (£000s) (Month)	337	627	575	700	776	0	0	1,022	252	148	681	71	508	(437)			+
New	Cost improvement plan (CIPS) (£000s) (Year to date)						0	0	1,022	1,274	1,422	2,103	2,174	2,974	(800)	5,515	0	-
F-3	Capital expenditure (£000s) (Month)	845	1,022	851	1,012	1,860	1,262	254	862	687	1,196	1,237	834	2,437	(1,603)			+
New	Capital expenditure (£000s) (Year to date)						1,262	1,516	2,378	3,064	4,260	5,497	6,332	9,532	(3,200)	18,499	(11)	-
F-7	Cash position (£000s) (Month)	24,966	26,136	25,758	26,577	28,326	48,150	44,676	43,742	46,283	46,647	46,862	48,231	27,175	21,056	16,877	(5,258)	-
F-7	Agency Spend (£000s) (Month)	364	432	356	(145)	146	232	69	285	211	175	259	85	355	(270)			+
New	Agency Spend (£000s) (Year to date)						232	301	586	797	972	1,231	1,316	2,610	(1,294)	3,438	860	+

- ▲ Improving performance

▼ Deteriorating performance

● No change

■ Aspirational metric
- + Outperformed target

- Underperformed target

= On target

- Data not provided



Performance by Domain

Well-Led: Performance Dashboard

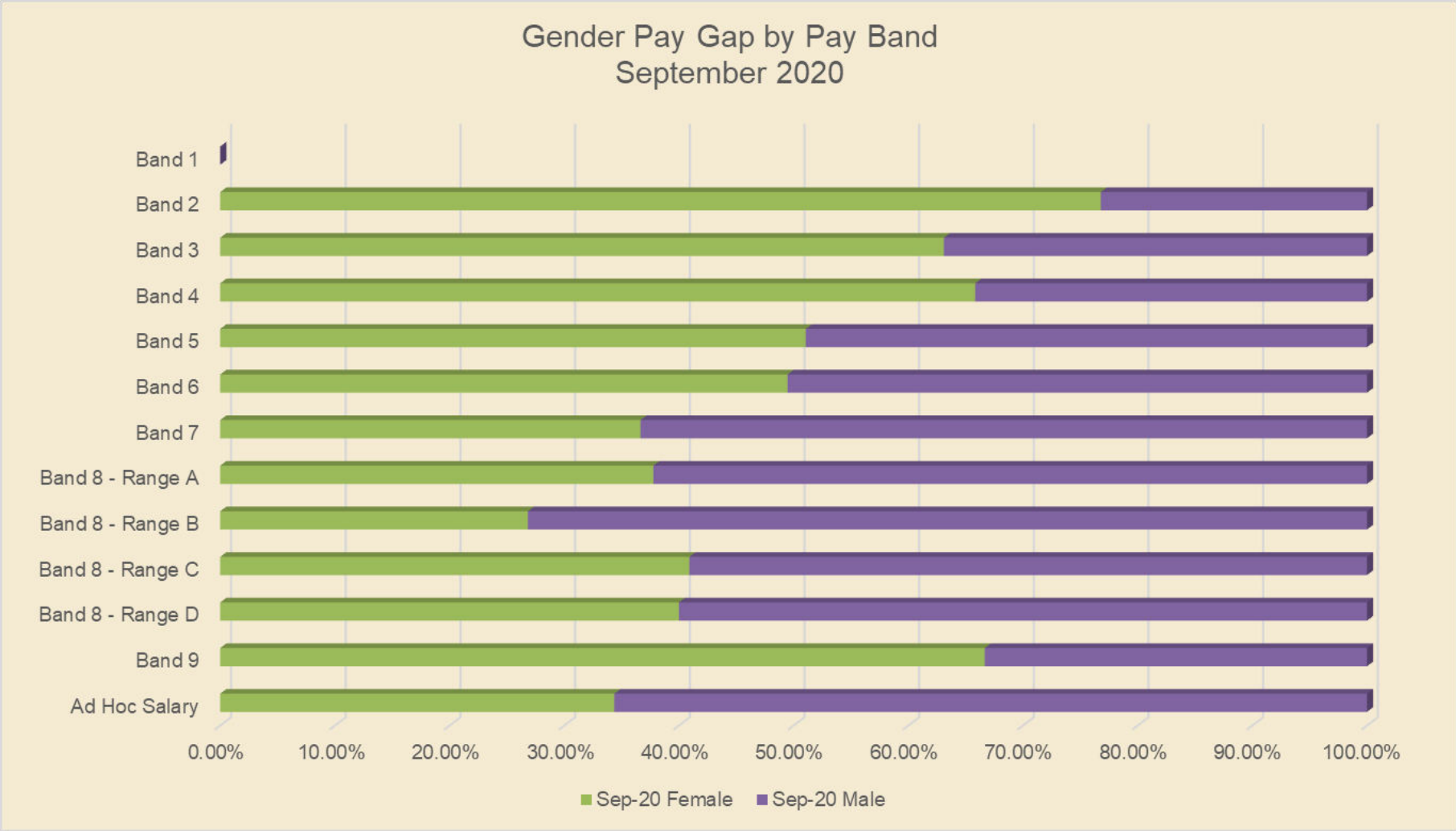
Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture

ID	Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-24	Organisational Risks Outstanding Review %											14.00%	10.00%	18.00%	0.00%		-		▼
WF-5	Objectives & Career Conversation	42.60%	45.60%	49.60%	56.20%	61.30%	71.70%	5.40%	16.50%	22.90%	28.20%	31.70%	34.10%	36.70%	80.00%		-		▲
WF-7	Annual Rolling Turnover Rate	15.90%	15.40%	14.90%	15.60%	15.90%	15.80%	15.60%	14.80%	13.90%	13.40%	12.60%	11.90%	11.70%					▲
WF-8	Annual Rolling Sickness Absence	5.40%	5.60%	6.00%	5.70%	5.70%	5.80%	6.10%	6.00%	6.00%	5.90%	6.00%	6.10%	6.20%	5.00%		-		▼
WF-9	Disciplinary Cases	1	4	8	6	5	2	6	4	9	6	4	4	3					▲
WF-10	Individual Grievances	7	10	7	8	8	6	4	4	8	7	5	10	11					▼
WF-11	Collective Grievances	5	1	0	1	2	1	1	0	1	0	0	2	0					▲
WF-12	Bullying & Harrassment Internal	5	0	4	2	1	2	2	1	2	2	5	3	3	0		-		●
WF-13	Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0	0					●
WF-26	Vacancy Rate for Leadership Roles %																■	■	■
WF-28	Staff Affected by Restructures %																■	■	■
WF-29	Staff Acting Up/Secondments %												3.30%	2.50%					▼
WF-37	Diversity: Disability - declared %												3.40%	3.40%					●
WF-38	Diversity: Disability - declined to declare %												46.30%	46.30%	0.00%		-		●
WF-39	Diversity: Ethnicity - BAME %												5.30%	5.30%					●
WF-27	First Line Managers who have had Leadership Training (Fundamentals) %									0.00%	0.00%	0.00%	0.00%	0.00%	100.00%		-		●
WF-18	Absence Relating to Mental Health %									12.10%	12.00%	12.10%	9.90%	10.80%					▼
WF-19	Absence Relating to MSK %									4.60%	2.80%	3.60%	3.60%	4.20%					▼
WF-25	Number of Wellbeing Hub Referrals										112	104	112	124					▬
WF-30	Time from referral to offered wellbeing appointment (days)													14					▬
FL-1	Vehicles Older Than Target Age %									55.00%	55.00%	55.00%	35.00%	35.00%	0.00%		-		●
999-15	999 Frontline Late Finishes/Over-Runs %									47.60%	51.10%	52.20%	50.60%	50.60%					●

Performance by Domain

Well-Led: Gender Pay Gap by Pay Band – September 2020

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture



National Benchmarking

999 Emergency Ambulance Service (October 2020)

Key indicators at a glance for October 2020

Primary Triage Software		SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS	
		NHS Pathways	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	NHS Pathways	AMPDS	
999 Call Answer		ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Call Answer Time	00:00:17	00:00:01	00:00:04	00:00:15	00:00:14	00:00:01	00:00:27	00:00:39	00:00:04	00:00:03	00:00:01	00:01:55	
Calls Answered	742617	67031	70950	77401	1441	116556	35221	124987	41587	82243	82720	42480	
Mean Call Answer Time	00:00:07	00:00:02	00:00:02	00:00:08	00:00:10	00:00:02	00:00:12	00:00:13	00:00:06	00:00:04	00:00:01	00:00:37	
Incident Proportions (Over All Incidents)		ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	745327	63696	77709	67909	2203	104710	36786	97839	51288	76648	95468	71071	
C1 Incidents %	8.14%	6.42%	8.10%	9.88%	5.22%	7.01%	6.98%	9.57%	7.10%	10.57%	7.05%	8.10%	
C2 Incidents %	52.73%	50.60%	55.23%	58.49%	42.81%	55.70%	56.51%	53.22%	43.36%	52.87%	45.08%	56.54%	
C3 Incidents %	22.70%	32.90%	17.10%	17.15%	33.68%	22.66%	18.20%	15.48%	32.84%	20.25%	34.71%	16.19%	
C4 Incidents %	1.23%	0.53%	0.51%	0.24%	2.13%	1.48%	1.13%	2.56%	2.11%	0.68%	1.88%	0.50%	
Incident Outcomes		ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	7.88%	6.24%	8.98%	8.91%	7.31%	7.99%	9.58%	10.61%	8.94%	5.30%	4.45%	9.03%	
See & Convey %	54.03%	58.66%	56.20%	53.70%	57.60%	55.59%	54.58%	52.60%	50.71%	52.32%	52.14%	53.89%	
See & Treat %	32.67%	33.40%	32.21%	31.19%	33.86%	31.01%	27.57%	29.83%	34.11%	37.99%	37.69%	29.37%	
Response Performance		ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:13:11	00:13:59	00:13:13	00:13:52	00:16:09	00:10:35	00:11:25	00:13:22	00:11:43	00:14:46	00:12:31	00:15:00	
90th Centile Response Time: C2	00:52:06	00:33:41	00:48:43	01:03:15	00:46:05	00:29:13	01:05:29	01:40:28	00:29:54	00:55:02	00:24:43	01:01:55	
90th Centile Response Time: C3	02:47:38	03:06:47	02:32:25	04:02:08	02:47:17	01:31:38	04:53:30	05:36:30	01:45:17	03:14:49	01:33:39	03:23:52	
90th Centile Response Time: C4	03:52:00	04:28:26	03:19:22	04:23:32	02:55:15	02:52:32	03:56:46	05:57:11	02:37:28	04:16:45	02:22:11	04:00:47	
Mean Response Time: C1	00:07:29	00:07:33	00:07:07	00:07:47	00:09:10	00:06:21	00:06:40	00:08:03	00:06:23	00:07:56	00:07:11	00:08:42	
Mean Response Time: C2	00:25:21	00:18:20	00:23:45	00:30:11	00:22:31	00:15:13	00:32:20	00:45:40	00:15:27	00:27:08	00:13:23	00:29:13	

Best placed to care, the best place to work



National Benchmarking 999 Emergency Ambulance Service Clinical Outcomes (October 2020)

Key indicators at a glance for October 2020

Cardiac Arrest ▲	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Proportion of cardiac arrests discharged alive %	8.02%	8.99%	10.19%	4.50%	0.00%	6.18%	4.17%	5.38%	12.22%	8.94%	12.07%	6.67%
Proportion of cardiac arrests discharged alive utstein %	25.48%	30.77%	38.10%	18.18%	0.00%	19.35%	22.22%	25.00%	31.82%	15.00%	28.95%	20.69%
Proportion who had ROSC on arrival at hospital %	27.64%	24.74%	30.00%	16.18%	11.11%	31.10%	28.30%	28.38%	25.56%	29.20%	34.44%	25.00%
Proportion who had ROSC on arrival at hospital utstein %	50.59%	45.24%	62.79%	39.13%	100.00%	56.10%	40.91%	51.61%	54.55%	46.34%	57.50%	41.18%

National Benchmarking NHS 111 Service (October 2020)

Key indicators at a glance for October 2020

Metric ▼	SECAmb	Care UK	Devon Doctors	DHC	DHU	HUC	IC24	IOW	Kernow Health	LAS	LCW	Medvivo	NEAS	NWAS	SCAS	Vocare	WMAS	YAS
Calls Answered in 60 secs %	57.59%	87.17%	68.53%	43.87%	84.12%	78.85%	91.71%	84.65%	76.76%	94.81%	95.63%	71.40%	30.91%	13.50%	59.42%	71.89%	83.18%	69.75%
Abandoned Calls %	5.38%	1.32%	9.28%	12.19%	0.51%	1.36%	0.33%	3.12%	2.70%	0.26%	0.43%	3.94%	19.93%	28.80%	7.43%	4.12%	1.00%	1.80%
111 to A&E Transfer %	12.61%	10.59%	8.01%	10.88%	5.02%	5.67%	11.44%	14.73%	2.49%	12.06%	13.61%	8.94%	10.05%	9.94%	8.04%	8.75%	9.34%	11.45%
111 to 999 Transfer %	12.35%	12.89%	15.06%	13.04%	11.48%	8.35%	13.02%	13.38%	8.05%	8.25%	9.31%	11.33%	14.15%	11.91%	10.44%	10.68%	11.84%	10.69%

Best placed to care, the best place to work



Appendix 1

Performance Charts

Best placed to care, the best place to work

An abstract graphic design featuring several overlapping, curved, ribbon-like shapes in vibrant colors: green, magenta, teal, and blue. These shapes are layered to create a sense of depth and movement. The background is a solid light beige. At the bottom, there is a dark blue horizontal band that serves as a base for the text.

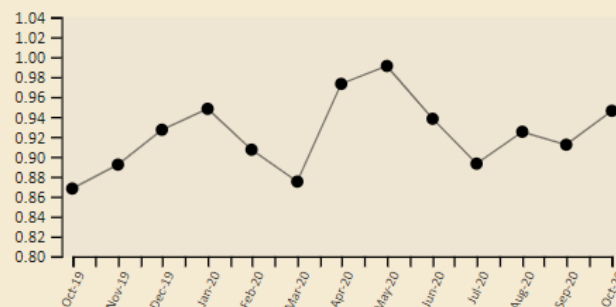
Performance by Domain

Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

999-12

999 Frontline Hours Provided %



October 2020

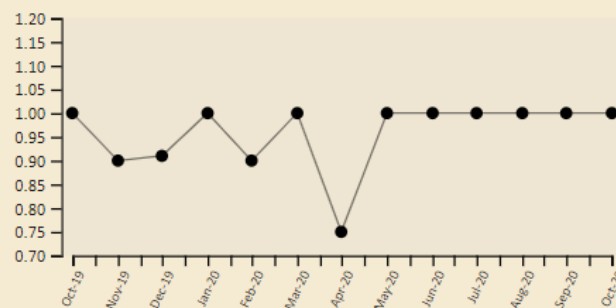
94.60%

Target

100.00%

QS-3

Duty of Candour Compliance %



October 2020

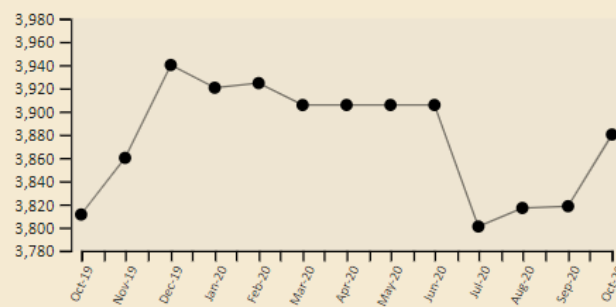
100.00%

Target

100.00%

WF-3

Finance Establishment (WTE)



October 2020

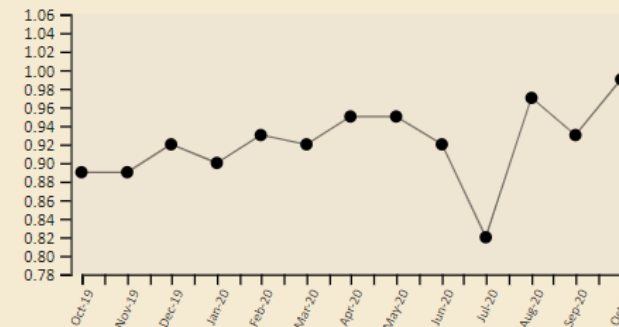
3880

Target

N/A

QS-7

Hand Hygiene Compliance %



October 2020

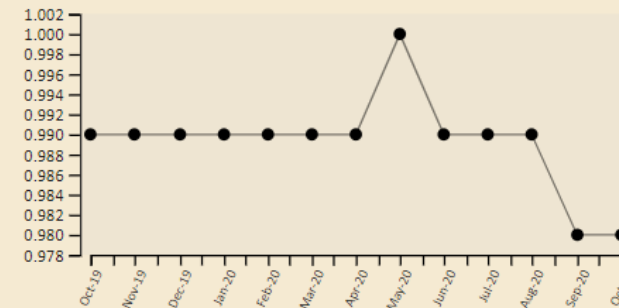
99.00%

Target

95.00%

MM-7

Medicines Management % of Audits Completed



October 2020

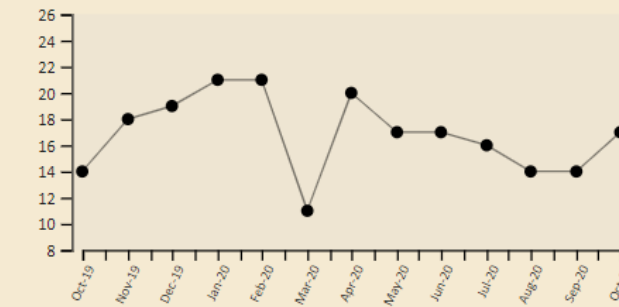
98.00%

Target

100.00%

MM-5

Number of CD Breakages



October 2020

17

Target

N/A

Best placed to care, the best place to work



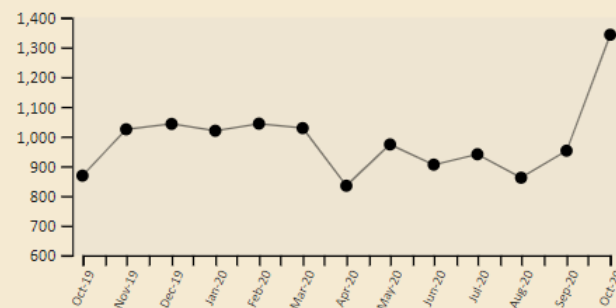
Performance by Domain

Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

QS-1

Number of Datix Incidents



October 2020

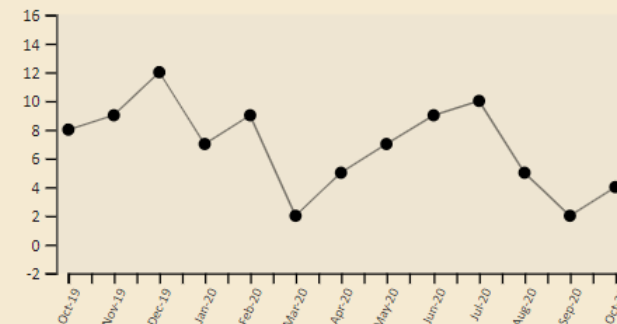
1342

Target

N/A

QS-2

Number of Incidents Reported as SIs



October 2020

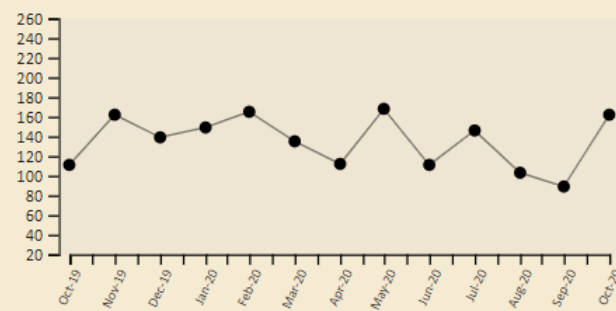
4

Target

N/A

MM-1

Number of Medicines Incidents



October 2020

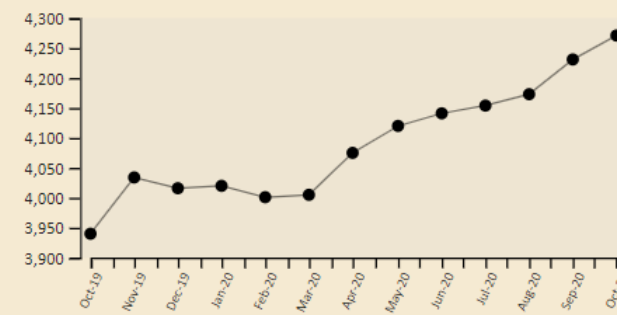
162

Target

N/A

WF-2

Number of Staff Headcount (Excl bank and agency)



October 2020

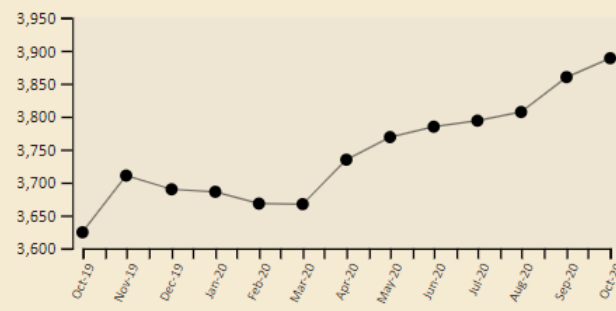
4271

Target

N/A

WF-1

Number of Staff WTE (Excl bank and agency)



October 2020

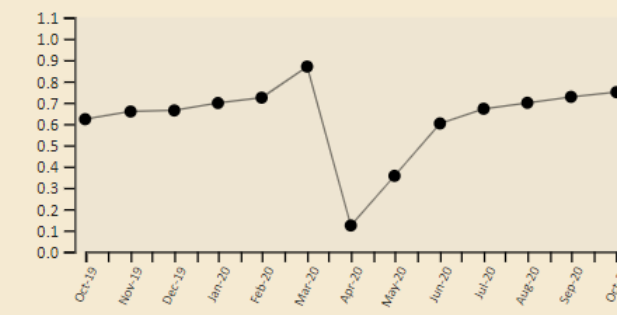
3888

Target

N/A

QS-8

Safeguarding Training Completed (Children) Level 2 %



October 2020

74.90%

Target

95.00%

Best placed to care, the best place to work

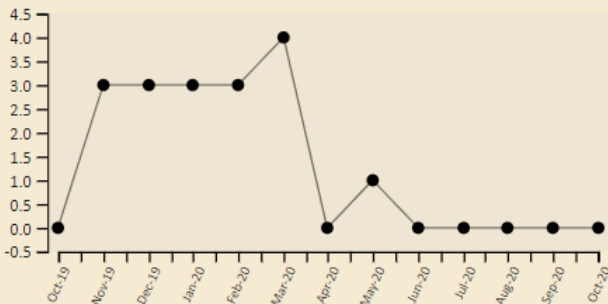


Performance by Domain

Safe: Performance Charts

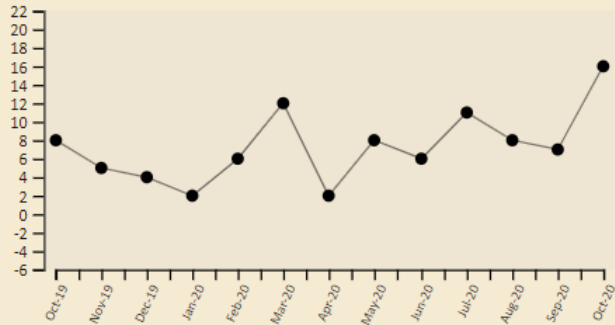
We protect our patients and staff from abuse and avoidable harm

MM-4
Single
Witness
Signature
Use CDs
Non-Omicell



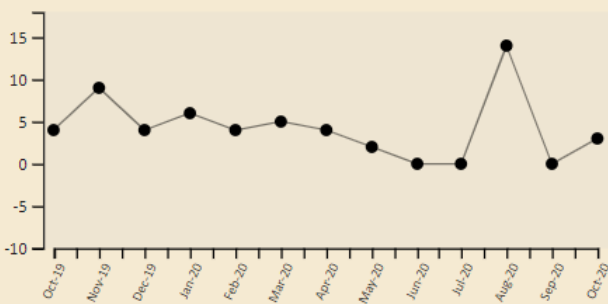
October 2020
0
Target
N/A

QS-9
Number of
RIDDOR
Reports



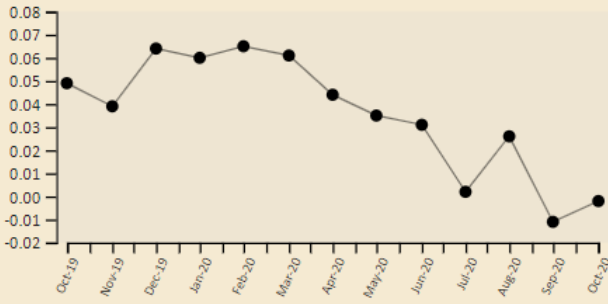
October 2020
16
Target
N/A

MM-3
Single
Witness
Signature
Use CDs
Omicell



October 2020
3
Target
N/A

WF-4
Vacancy Rate
%



October 2020
-0.20%
Target
N/A

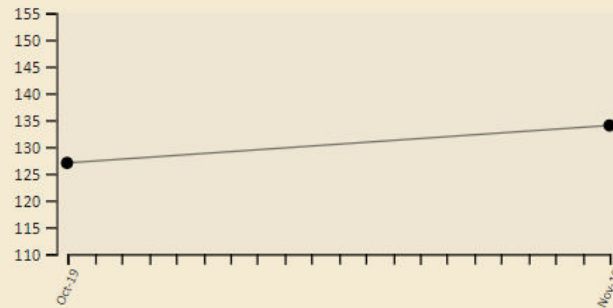


Performance by Domain

Effective: Performance Charts

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

M-6
Acute
ST-Elevation
Myocardial
Infarction
(STEMI) Call
to
Angiography
Mean



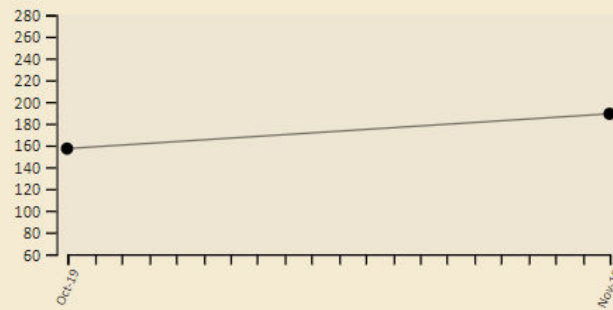
Nov-19

02:14:00

Target

N/A

M-7
Acute
ST-Elevation
Myocardial
Infarction
(STEMI) Call
to
Angiography
90th Centile



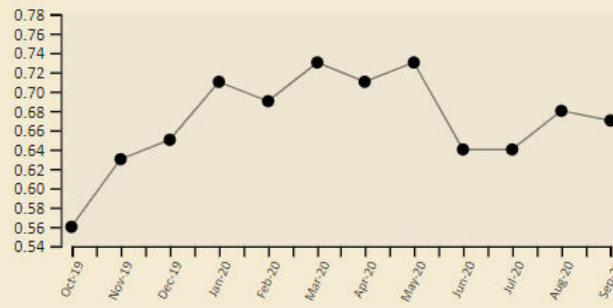
Nov-19

03:09:00

Target

N/A

M-5
**Acute
STEMI Care
Bundle
Outcome %



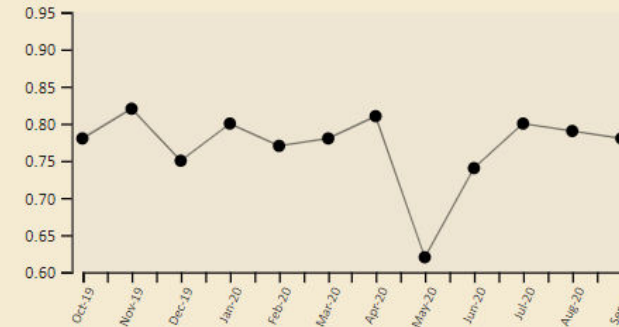
Sep-20

67.00%

Target

N/A

M-11
Cardiac Arrest
- Post
ROSC %



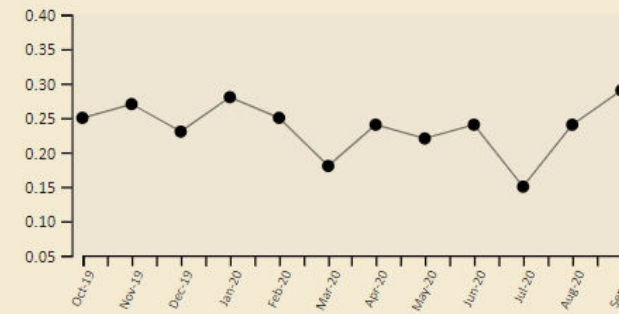
Sep-20

78.00%

Target

N/A

M-2
Cardiac
ROSC ALL %



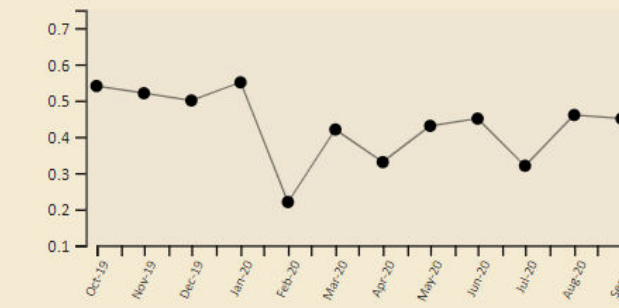
Sep-20

29.00%

Target

N/A

M-1
**Cardiac
ROSC Utstein
%



Sep-20

45.00%

Target

N/A

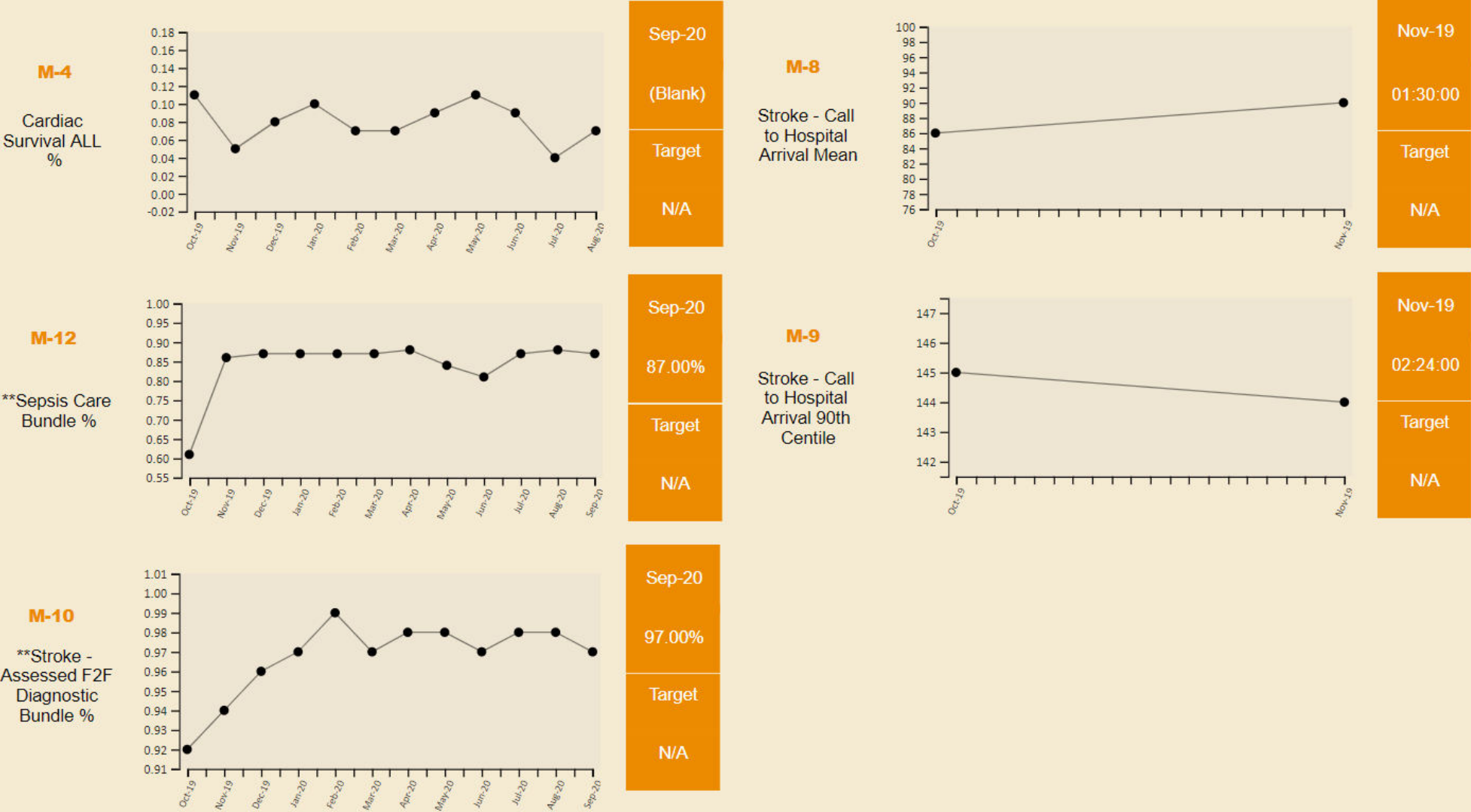
Best placed to care, the best place to work



Performance by Domain

Effective: Performance Charts

Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence



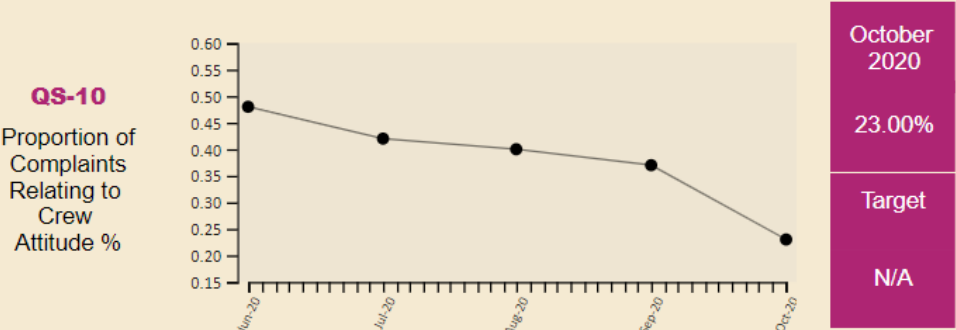
Best placed to care, the best place to work



Performance by Domain

Caring: Performance Charts

Our staff involve and treat our patients with compassion, kindness, dignity and respect

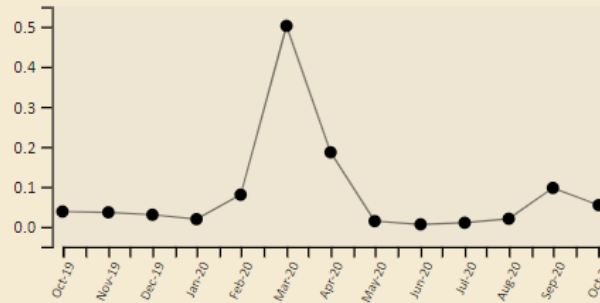


Performance by Domain

Responsive: Performance Charts

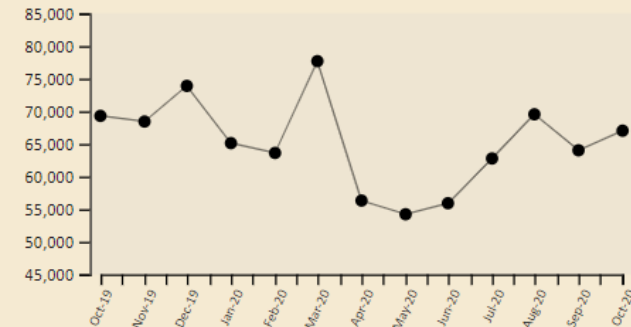
Our services are organised so that they meet our patient's needs

111-3
111 Calls
Abandoned -
(Offered)
After 30
Seconds %



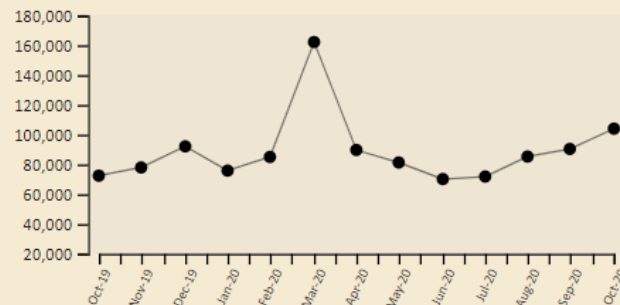
October
2020
5.40%
Target
6.00%

999-10
999 Calls
Answered



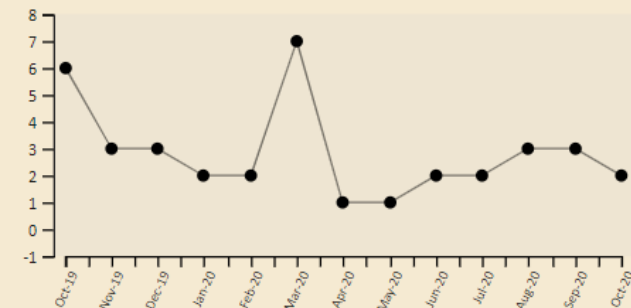
October
2020
67031
Target
N/A

111-1
111 Calls
Offered
Actual



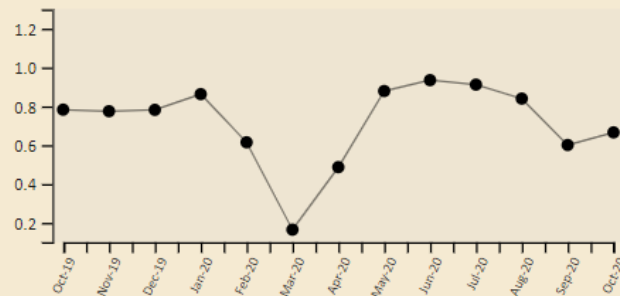
October
2020
104059
Target
N/A

999-1
999 Call
Answer Mean



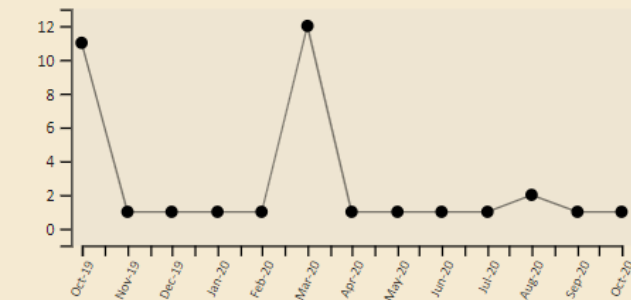
October
2020
00:00:02
Target
00:00:05

111-1
111 Calls
Answered in
60 Seconds
%



October
2020
66.60%
Target
95.00%

999-1
999 Call
Answer 90th
Centile



October
2020
00:00:01
Target
00:00:10

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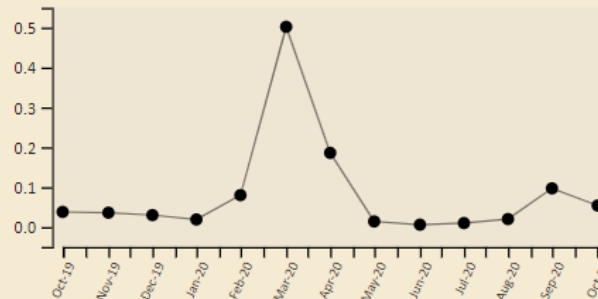


Performance by Domain

Responsive: Performance Charts

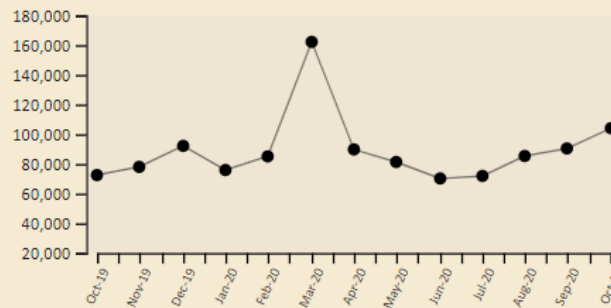
Our services are organised so that they meet our patient's needs

111-3
111 Calls
Abandoned -
(Offered)
After 30
Seconds %



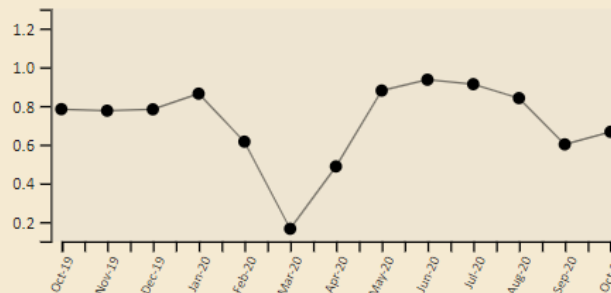
October
2020
5.40%
Target
6.00%

111-1
111 Calls
Offered
Actual



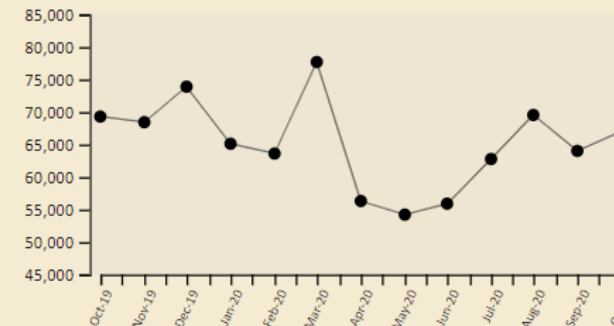
October
2020
104059
Target
N/A

111-1
111 Calls
Answered in
60 Seconds
%



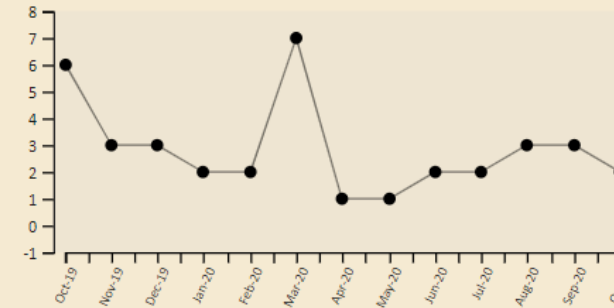
October
2020
66.60%
Target
95.00%

999-10
999 Calls
Answered



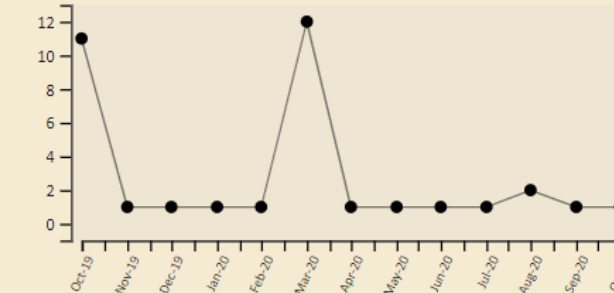
October
2020
67031
Target
N/A

999-1
999 Call
Answer Mean



October
2020
00:00:02
Target
00:00:05

999-1
999 Call
Answer 90th
Centile



October
2020
00:00:01
Target
00:00:10

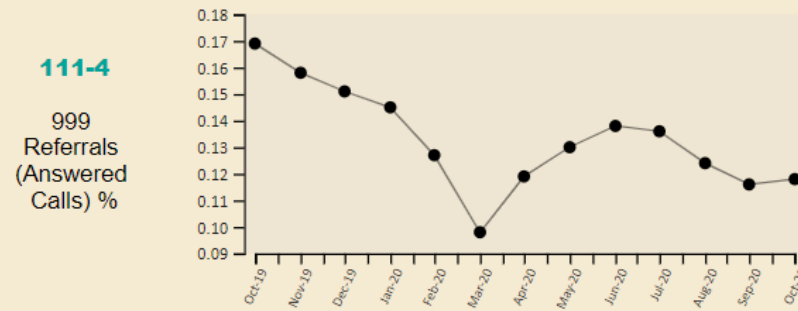
Best placed to care, the best place to work



Performance by Domain

Responsive: Performance Charts

Our services are organised so that they meet our patient's needs

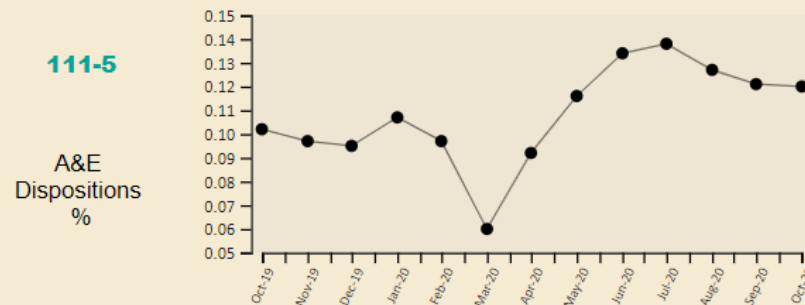


October 2020

11.80%

Target

N/A

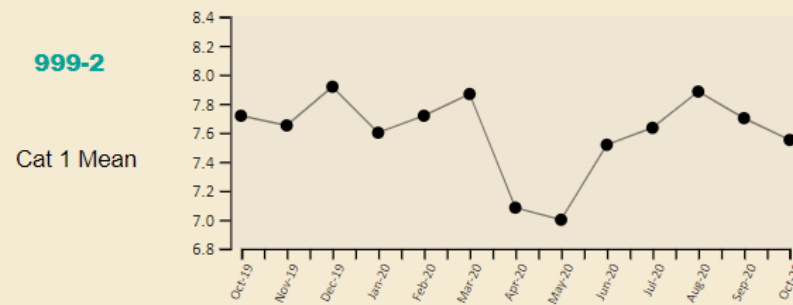


October 2020

12.00%

Target

N/A

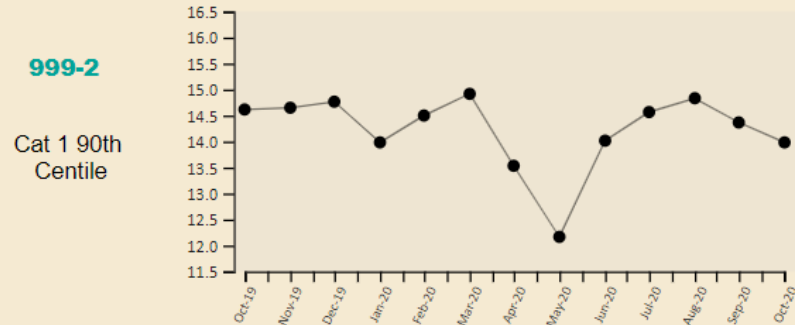


October 2020

00:07:33

Target

00:07:00

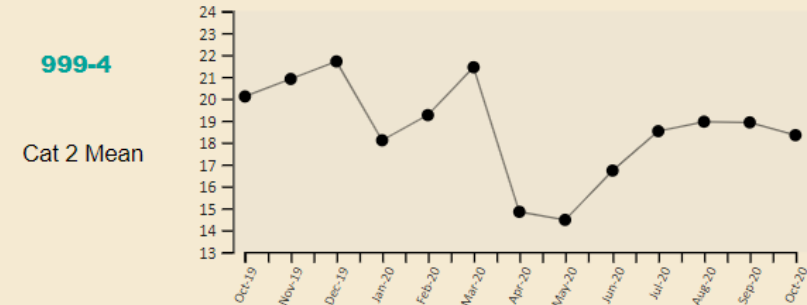


October 2020

00:13:59

Target

00:15:00

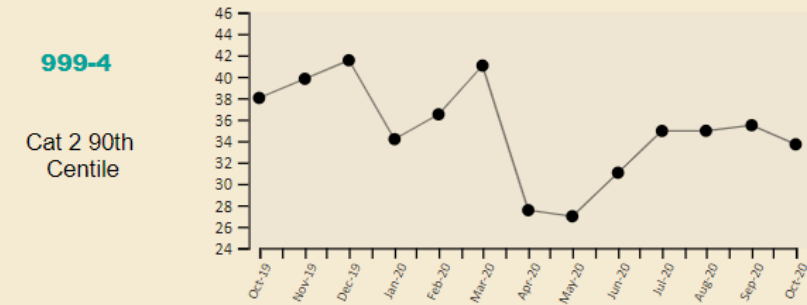


October 2020

00:18:20

Target

00:18:00



October 2020

00:33:41

Target

00:40:00

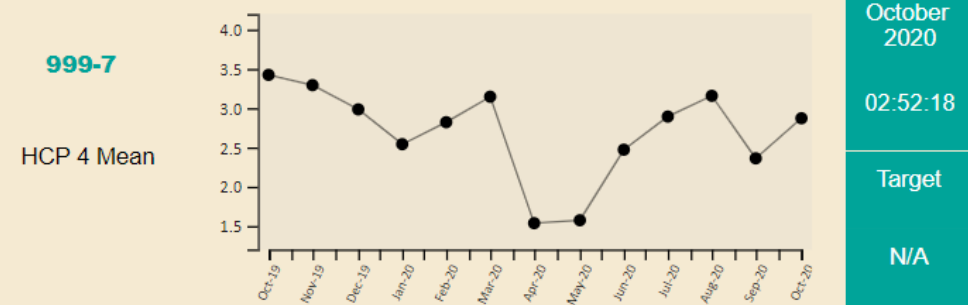
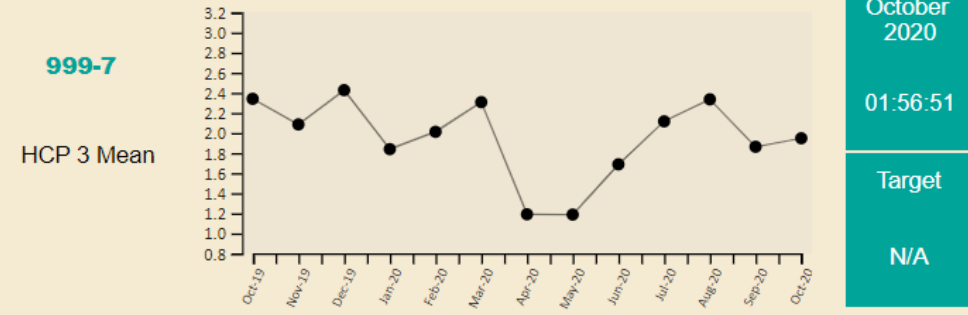
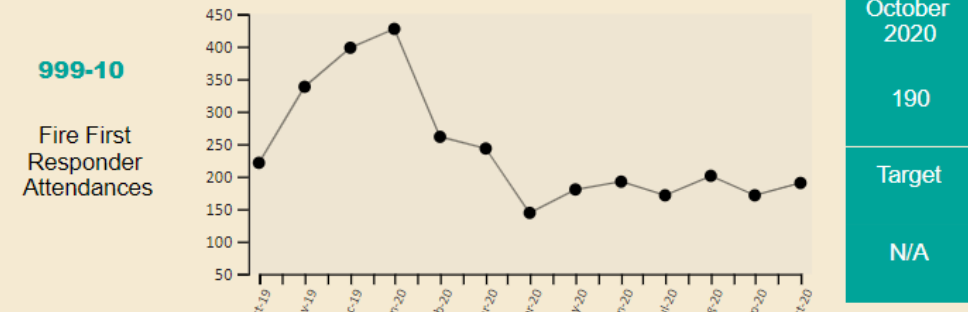
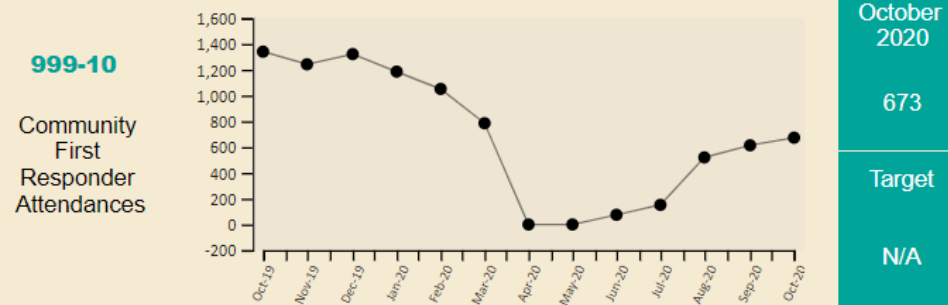
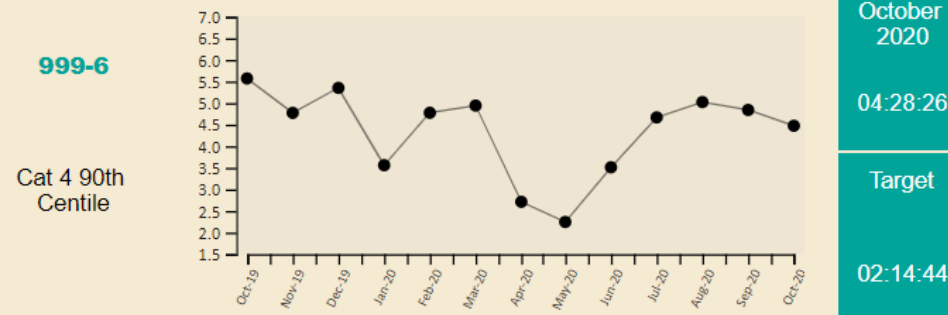
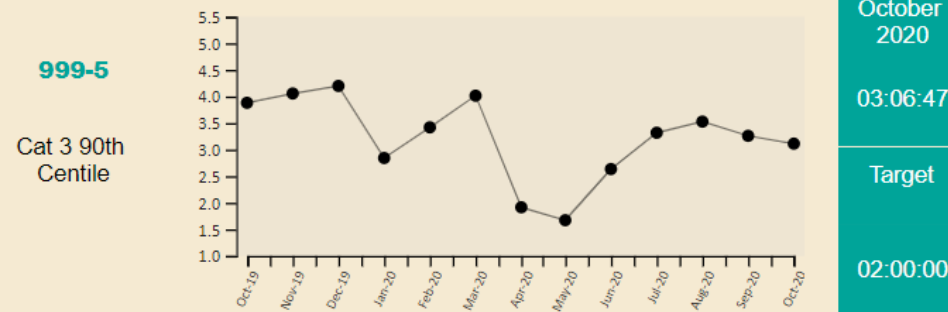
Best placed to care, the best place to work



Performance by Domain

Responsive: Performance Charts

Our services are organised so that they meet our patient's needs



Best placed to care, the best place to work



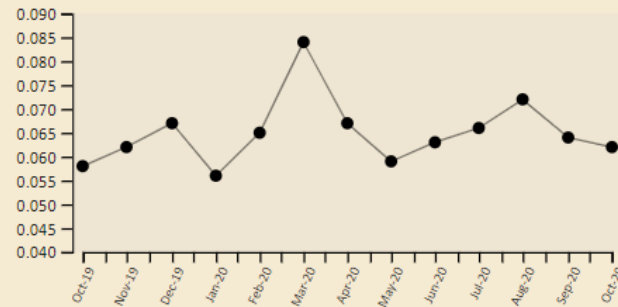
Performance by Domain

Responsive: Performance Charts

Our services are organised so that they meet our patient's needs

999-9

Incident Outcome Hear & Treat %



October 2020

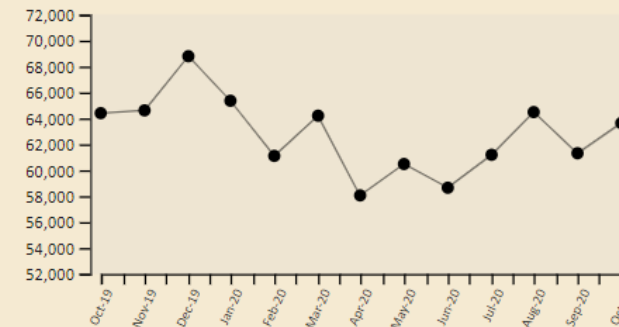
6.20%

Target

N/A

999-10

Incidents A7



October 2020

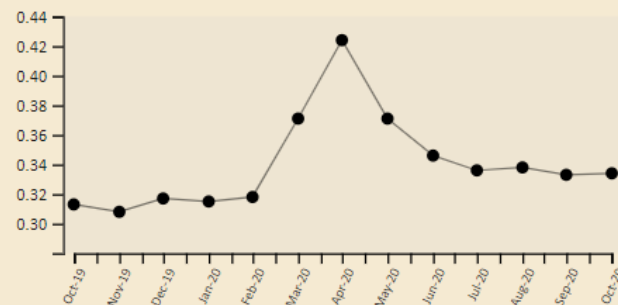
63644

Target

N/A

999-9

Incident Outcome See & Treat %



October 2020

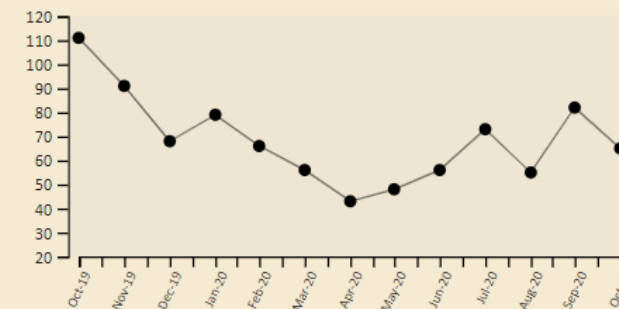
33.40%

Target

N/A

QS-5

Number of Complaints



October 2020

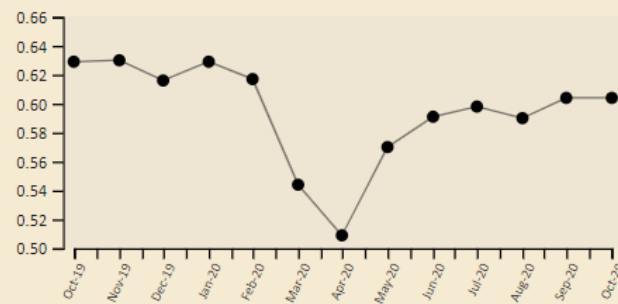
65

Target

N/A

999-9

Incident Outcome See & Convey %



October 2020

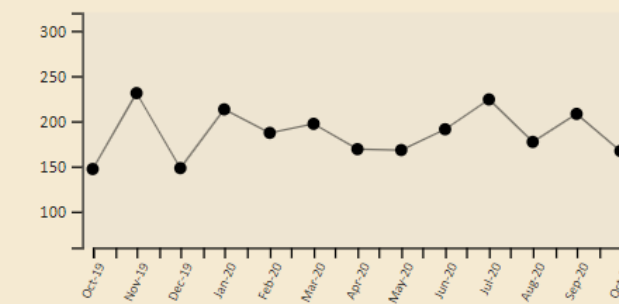
60.40%

Target

N/A

QS-6

Number of Compliments



October 2020

167

Target

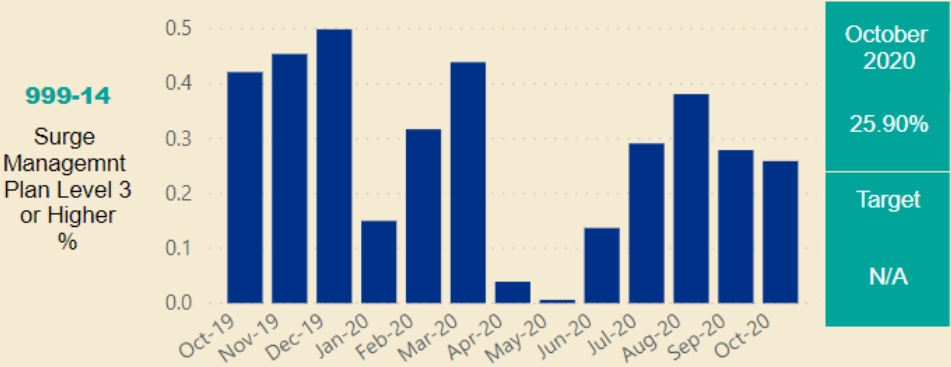
N/A

Best placed to care, the best place to work



Performance by Domain
Responsive: Performance Charts

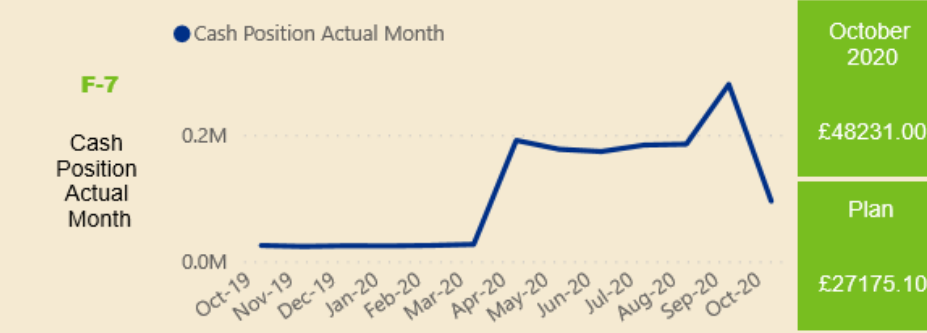
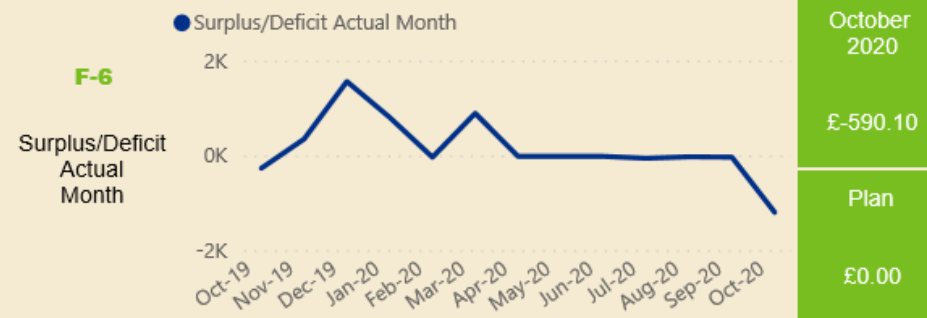
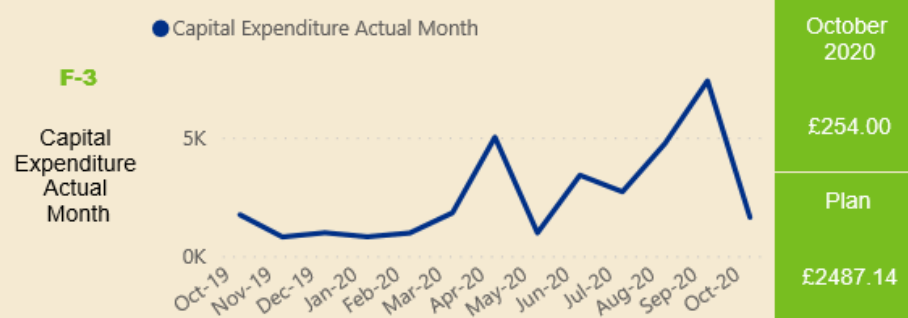
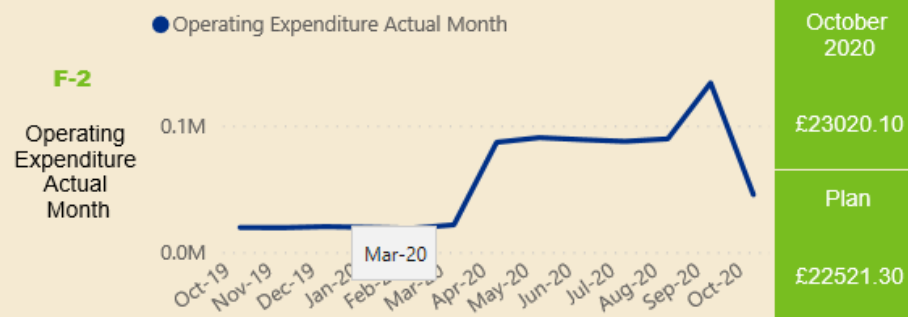
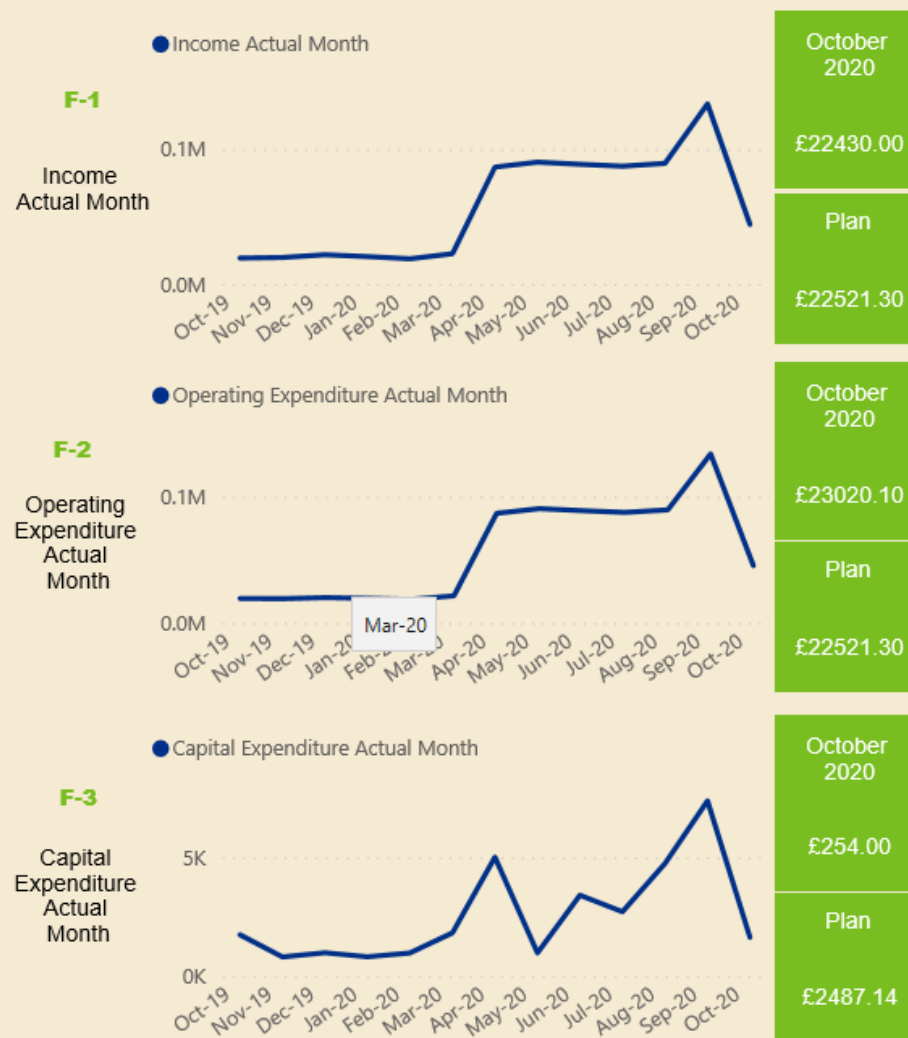
Our services are organised so that they meet our patient's needs



Performance by Domain

Well-Led: Performance Charts

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture



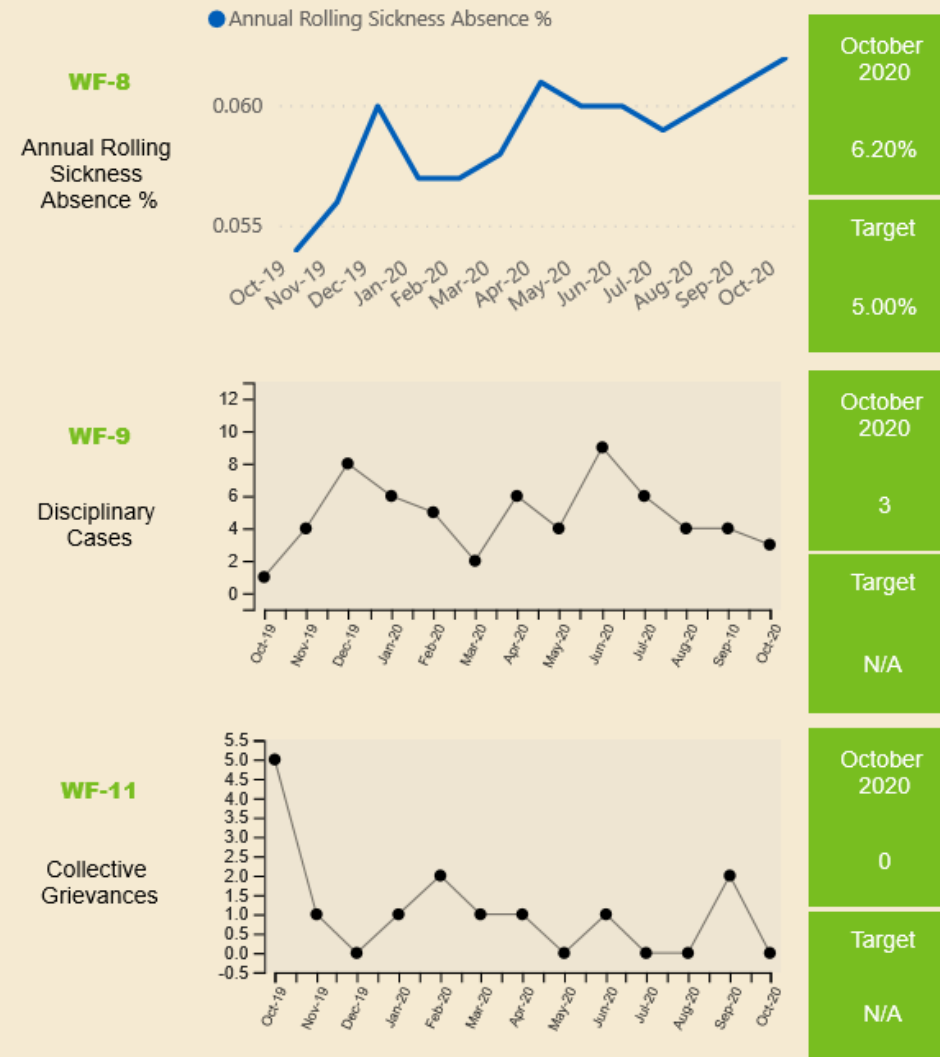
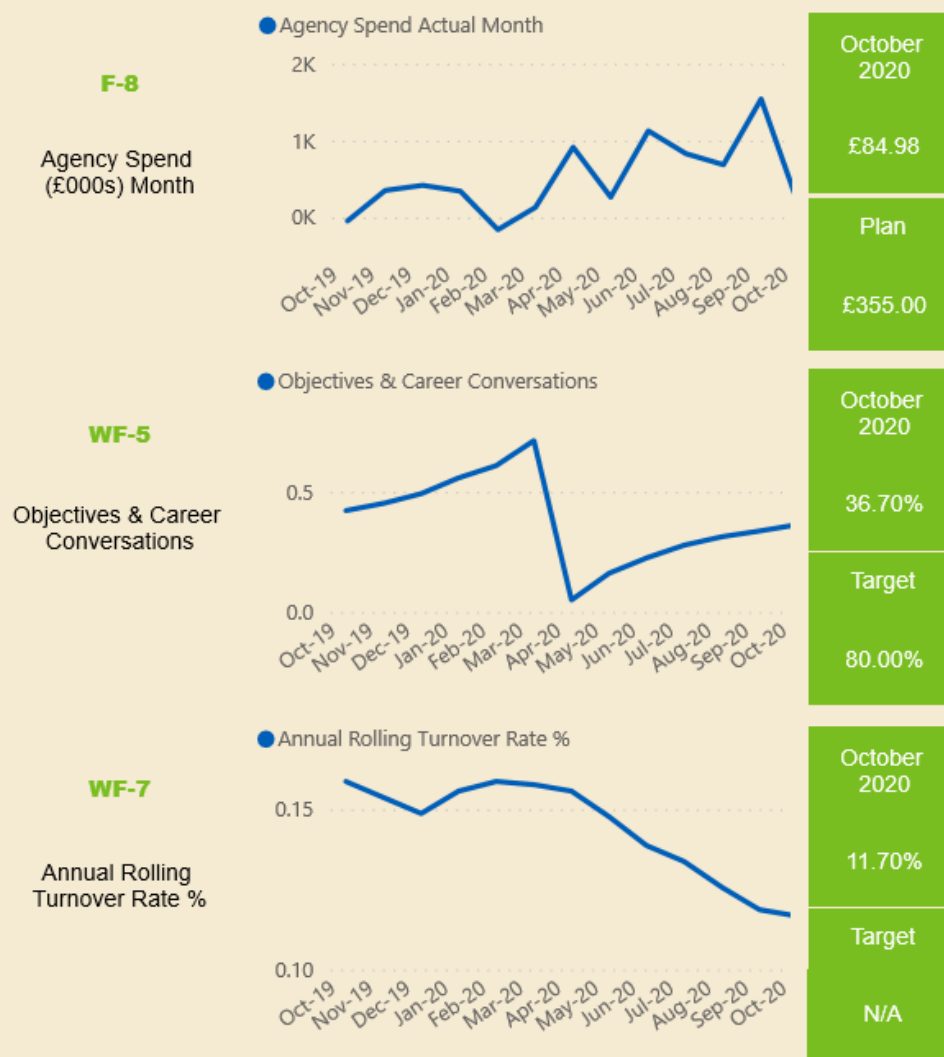
Best placed to care, the best place to work



Performance by Domain

Well-Led: Performance Charts

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture



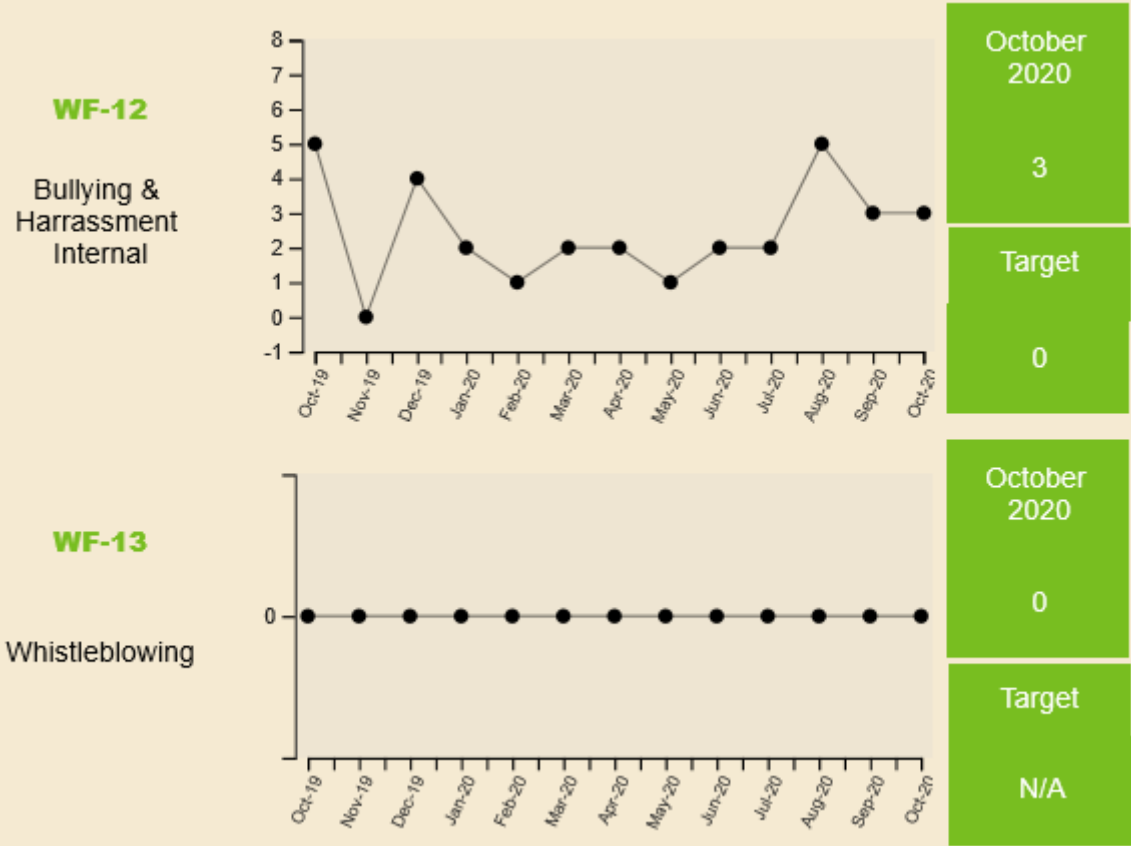
Best placed to care, the best place to work



Performance by Domain

Well-Led: Performance Charts

Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture



Appendix 2

Glossary




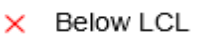
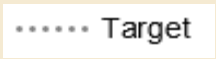
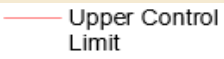
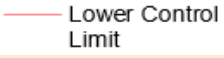
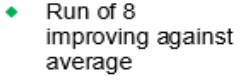
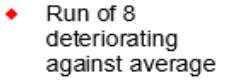
A&E	Accident & Emergency Department	F2F	Face to Face	Transports	AQI (A53 + A54)
AQI	Ambulance Quality Indicator	FFR	Fire First Responder	ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
Cat	Category (999 call acuity 1-4)	HCP	Healthcare Professional	TIA	Transient Ischaemic Attack (mini-stroke)
CAS	Clinical Assessment Service	ICS	Integrated Care System	WTE	Whole Time Equivalent (staff members)
CD	Controlled Drug	Incidents	AQI (A7)		
CFR	Community First Responder	JCT	Job Cycle Time		
CPR	Cardiopulmonary resuscitation	MSK	Musculoskeletal conditions		
CQC	Care Quality Commission	NHSE/I	NHS England/Improvement		
CQUIN	Commissioning for Quality & Innovation	Omnicell	Secure storage facility for medicines		
Datix	Our incident and risk reporting software	PAD	Public Access Defibrillator		
DBS	Disclosure and Barring Service	RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations		
DNACPR	Do Not Attempt CPR	ROSC	Return of spontaneous circulation		
ECAL	Emergency Clinical Advice Line	SI	Serious Incident		
ED	Emergency Department	STEMI	ST-Elevation Myocardial Infarction		



Appendix 3

Symbol Key			
PD	Performance Direction		
▲	Improving performance	+	Outperformed target
▼	Deteriorating performance	-	Underperformed target
●	No change	=	On target
■	Aspirational metric	-	Data not provided

Chart Key

 Data Point	This represents the value being measured on the chart.	 AVG	This line represents the average of all values within the chart.	 Above UCL  Below LCL	When a value point falls above or below the control limits, it is seen as a point of statistical significance and should be investigated for a root cause.
 Target	The target is either an internal or National target to be met.	 Upper Control Limit  Lower Control Limit	These lines are set two standard deviations above and below the average.	 Run of 8 improving against average  Run of 8 deteriorating against average	These points will show on a chart when the value is above or below the average for 8 consecutive points. This is seen as statistically significant and an area that should be reviewed.



D - Membership Development Committee Report

1. Introduction

- 1.1. The Membership Development Committee (MDC) is a committee of the Council that advises the Trust on its communications and engagement with members (including staff) and the public and on recruiting more members to the Trust. The MDC meets three times a year. All Governors are entitled to join the Committee, since it is an area of interest to all Governors.
- 1.2. In this report, we focus on membership updates and summaries of the top items from the MDC meetings and those that report into the MDC (Staff Engagement Advisory Group, Inclusion Hub Advisory Group, Patient Experience Group and Voluntary Services). For a full picture of the important items discussed at these meetings and how staff and members are feeding in their views to the Trust, I recommend that you read the full minutes appended to this report.

2. MDC Meeting summary

- 2.1. The MDC met in July and November. The key areas of focus were:
- 2.2. The finalised proposal of a membership engagement action plan which had been developed with Board, Council & membership input. This is in addition to the mechanisms in place for smaller scale membership engagement which is covered within our Inclusion Strategy. It focusses on proportional membership engagement with our wider membership (c3,500 staff and 10,000 public members) looking at the wider priorities of the Trust over a 12-month period, and then considering which of these priorities needs wider engagement.
- 2.3. Planning the delivery of the Annual Members Meeting and reviewing it at the November meeting. More on this below.
- 2.4. Discussing and planning membership engagement opportunities and ways for Governors to reach out to members and the public at this time via virtual methods. More on this below.
- 2.5. Made recommendations for Governor representation on the Patient Experience Group.
- 2.6. The minutes of the July & November MDC meetings are available as appendix 1 & 2. The next MDC meeting is on the 02 Feb 2021 10am – 12noon on Teams

Membership update

- 2.7. The total staff membership as of 30.09.20 was 4,231 which is up 2.7% since the last report.
- 2.8. Current public membership by constituency (at 20.10.2020) is 9,962 broken down as follows. This is down 1% since the last report.

Constituency	Members	Population exc London	% of eligible population
Lower East SECamb (East Sussex and Brighton)	2,031	848,414	0.24
Lower West	1,542	866,131	0.18

SECamb (West Sussex)			
Upper East SECamb (Medway/ Kent/ East London)	3,580	1,850,857	0.19
Upper West SECamb (Surrey/ Hants/ West London)	2,404	1,386,062	0.17
Out of Trust Area	405	-	-
Total number of members	9,962		

3. Membership engagement summary

3.1. Online virtual constituency member meetings with Governors

3.2. At the MDC we agreed to trial Staff and West Sussex Governor online member constituency meetings. Governors were keen to hear members views on how things were going in relation to the ambulance service in their areas. The events took place on 25th November and will be reviewed in full by the MDC at the meeting in February where any further events for other areas will be agreed pending success.

3.3. Annual Members Meeting

3.4. The Annual Members Meeting (AMM) took place on the 4th September 2020 online via a Microsoft Teams Live event. The event was recorded for sharing afterwards. We peaked at 165 live attendees on the day. This is the first purely online event the Trust has held for all members.



3.5. Attendees included public FT members/ members of the public and staff FT members. We also saw a number of attendees from London Ambulance Service attend, Care Quality Commission, Healthwatch and Clinical Commissioning Group attendees.

3.6. The attendance data can be split out as 35 external attendees and 130 staff members attendees. This is interesting because in previous years the participation type has been the opposite of the above with more public attendees.

3.7. The event was widely well received by both internal and external participants and will be reviewed in full later on at this

meeting.

3.8. Suggestions were gratefully received at July MDC meeting to help shape the content of the event. The suggestion from Asmina Chowdhury and staff networks on the development of a film looking at staff experience during the pandemic was particularly welcomed and delivered at the event to high acclaim from those that saw

it.

3.9. Live stream and access to observe Board and Council meetings

- 3.10. As of September 2020, we were able to make our Council and Board meetings held in public accessible in real time via Microsoft Teams. The public, members and staff members are welcome to join events and watch live and ask questions at the end.
- 3.11. Observer numbers for the Council meeting peaked at 93 which is the most we've had...ever! Staff Governors received some nice feedback from colleagues who had watched their performance at the meeting, as did the Chair. I am hopeful this will raise the profile and known value of what the Council of Governors bring to the Trust, and how they represent our members.
- 3.12. We will continue to make these meetings available to be viewed online in real time and advertise them to members. We record them for viewing later as well.



Member newsletter

- 3.13. Our summer member newsletter went out in July to all members both staff (c4000) and public (c10,000) and to our volunteers (c500). This edition included an invite to our Annual Members Meeting, an update on our performance and response to the pandemic and a 24 hours in EOC article from two 999 emergency medical advisors.
- 3.14. The next edition was sent out in late November and will focus on our response to the pandemic, 111 CAS, estate updates, thanking staff and info on charitable fund donations, shift diary from a Dispatch Team Leader and a spotlight interview of a paramedic practitioner.

4. Public Members' Views

- 4.1. The Inclusion Hub Advisory Group (IHAG) is a diverse group of our public



Foundation Trust members who bring a wide range of views and perspectives from across the South East Coast area. SECamb staff brief the group on plans and service changes and seek the group's advice on whether wider community engagement is necessary or simply gather the

views of the IHAG to inform the Trusts' plans. This group are also able to feed information on issues of importance to them into the Trust.

4.2. IHAG meeting summary:

- 4.3. The IHAG met in July and October. Governors Was Shakir and Geoff Kempster are the Council's representatives at IHAG meetings. Any Governors in attendance may wish to add their own comments. All Governors are welcome to request to observe

the IHAG from time to time. The minutes of the July meeting are included as appendix 3. The key areas of discussion at the meetings included:

- 4.4. Being presented a new model of care for falls. The aspiration is to get to fallers within 20 minutes after the initial fall, as after this point complications and other risks begin to build up. The IHAG acknowledged the patient benefit from this proposed model and highlighted areas to be looked into regarding supporting Community First Responder in the roll out.
- 4.5. Reviewing a Quality Improvement Methodology and highlighting need for ensuring staff understand the reason for the change via clear communication. Engagement needs to be built in and clarity for staff on how to progress a good idea
- 4.6. Patient Experience Strategy – Five Year Plan 2020-2025. How to embed equality & diversity, putting the patient at the heart of inclusion. The HAG provided feedback on identified priorities for the next six months.

5. Staff Members' Views

- 5.1. The Staff Engagement Advisory Group (SEAG) is the Trust's staff forum, which meets quarterly. It consists of a cross-section of staff members with different roles and from different parts of the Trust and enables the Trust to gather views and test ideas. The Staff-Elected Governors are permanent members of the SEAG, and it provides them with a forum to hear the views of their members and share their learning from the SEAG.

5.2. SEAG meeting summary:

- 5.3. Since the last report the SEAG met on 11th August and 21st November. Any staff Governors in attendance may wish to add their own comments.
- 5.4. Key items from the SEAG meetings:
- 5.5. Staff Governors now have a slot on the agenda at every meeting to provide an update on their areas of focus and to canvas views.
- 5.6. New Ways of Working: developing a process and toolkit for local senior managers to be having the conversations and making the decisions on what their areas should like look and how they should work going forwards (agile etc), including operational staff
- 5.7. Management & Leadership Feedback: SEAG asked to complete a survey that looked at ways to improve our Management and Leadership training.
- 5.8. Staff Survey: SEAG were asked to engage with wider temas on completing the survey and given an overview on the value of doing this.
- 5.9. Trust Strategy: opportunity to understand Trust priorities and what the strategy means in real terms.
- 5.10. Staff Governors are asked to prioritise attendance at these meetings: 29th January 10am – 12noon on teams. Public Governors can request to observe the meetings from time to time.

6. Patient Members' Views

- 6.1. The Patient Experience Group (PEG) is a group of public, patient and staff representatives. Nigel Robinson and Harvey Nash are the newly appointed Governor representatives on this group.
- 6.2. The first meeting of the refreshed group took place on 23rd November. Harvey and Nigel may wish to provide a verbal update on this at the Council meeting.

7. Update from the Voluntary Services Department

- 7.1. Greg Smith Voluntary Services Manager for Community Resilience has started a new role as an Operating Unit Manager in Kent. We will seek representation from this team at future MDC meetings.

8. Recommendations

- 8.1. The Council of Governors is asked to:
- 8.2. Note this report; and review any attached minutes for more detail.
- 8.3. Provide any additional feedback on the Annual Members Meeting.
- 8.4. Consider how best to encourage Governors to make use of such information, and to make use of the IHAG and SEAG appropriately to help understand the perspective of public Foundation Trust members.
- 8.5. Encourage those they meet to become members of our Trust (it's free) at:
<https://www.secamb.nhs.uk/join-us/become-a-member/> Members receive our newsletter, 'Your Call', three times a year to keep them up to date with the Trust's activities. Members can vote or even stand in public & staff Governor Elections to the Council.

Brian Chester
Upper West SECamb Public Governor &
Membership Development Committee Chair

Appendix 1 July MDC minutes

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Membership Development Committee

6 July 2020 – MS Teams 10:00-12:00

Minutes

Present:

Katie Spendiff	(KS)	Corporate Governance and Membership Manager
Brian Chester	(BC)	Upper West SECamb Public Governor (MDC Chair)
Harvey Nash	(HN)	Lower West SECamb Public Governor
Geoff Kempster	(GK)	Upper West SECamb Public Governor
Nigel Robinson	(NR)	Lower West SECamb Public Governor
Asmina Islam Chowdhury	(AIC)	Inclusion Manager
Rob Groves	(RG)	Organisational Development & Engagement Advisor
Emma Saunders	(ES)	Organisational Development & Engagement Advisor

Minutes: Izzy Allen (IA) Assistant Company Secretary

Apologies:

Greg Smith (GS) Voluntary Service Manager

1. Welcome and introductions

1.1. BC welcomed members, particularly welcoming HN back to the meeting.

2. Apologies for Absence

2.1. As noted above.

3. Declarations of Interest

3.1. None were received.

4. Minutes of the last meeting and matters arising

4.1. BC noted that the minutes had been comprehensive. At 7.15 HN became NH – IA would revise.

4.2. With that correction the minutes were approved as an accurate record of the meeting.

4.3. The action log was reviewed and updated:

4.4. On 6.11 – BC would like to re-engage regarding contacting members.

4.5. On 10.1 – BC noted that co-option to elected bodies was a possibility in other organisations. KS advised that the Trust's constitution had no provision for co-option. HN had not been co-opted but rather had been approached as he was second in the election for that post. If he had declined, the person next in line in terms of number of votes would have been approached. If no-one had been willing to take the position, it would have been held open until the next elections took place (up to 12 months).

4.6. BC would like to revisit the constitution around these rules in due course.

5. FT Membership update

5.1. KS noted the key issues from the paper:

5.1.1. Demographic breakdown data was included along with index ratings;

5.1.2. The focus had been on developing BME and LGBTQ membership, which was improved but there was more to do;

5.1.3. The membership recruitment plan had not been enacted due to Covid-19.

This had included plans to attend an event in each constituency and focus on West Sussex recruitment to bring it up to East Sussex levels;

5.1.4. KS was keen to improve patient numbers among our membership;

5.1.5. Online/social media recruitment had been taking place.

5.2. The plan was still appropriate and would be enacted when it was possible.

5.3. A communications plan had been put in place for the NHS' 72nd birthday this weekend.

5.4. She asked for any suggestions for creative membership engagement.

5.5. BC noted the poor level of membership in the now-extended areas of Upper SECamb. He advised that it was important to expand the membership to increase the pool of possible Governors and voters.

5.6. NR asked whether the current circumstances were a good time to seek some engagement with local radio stations. BC advised that this had been discussed in February: he was a big believer in using local radio and local newspapers.

5.7. IA advised that it would be worth disaggregating the London numbers so the Committee could compare like with like on the membership figures.

5.8. HN noted that he agreed and advised that the membership numbers/representation would also be misleading if we include London. IA agreed and KS would work out how to display this.

ACTION: KS to display representation among membership excluding London members to enable focus and prioritisation.

- 5.9. HN asked whether the Worthing event that had been cancelled would occur soon: KS would confirm.
- 5.10. KS asked colleagues to give an update on their areas of work.
- 5.11. AIC noted that the IHAG had been cancelled for the first time in 8 years, in May. They planned to meet virtually in July to look at the Trust's Quality Improvement Strategy, inclusion in Serious Incidents and other work. Engagement had reduced during COVID.
- 5.12. AIC advised the Committee of various priorities for inclusion and engagement work in the coming months. Membership was always promoted at engagement events – however all had been cancelled and would be considered again moving forward.
- 5.13. AIC was pleased to report better engagement with staff through the staff networks during COVID. This was really positive. The networks had been a key source of support for staff.
- 5.14. NR noted that he was wholly supportive of the improved engagement with staff. But he observed that the primary points of public membership engagement were not happening, and the potential for media and radio promotion previously discussed should be capitalised on.
- 5.15. KS noted that KS, AIC and RG/ES had a big presence on social media. AIC detailed some of the work undertaken and highlighted the value of this engagement.
- 5.16. MDC discussed how to enable a focus on media for the 'less modern' amongst the public. GK felt that the follow-up from radio would actually be minimal, while social media was more effective through providing links to click on. Our focus should be on recruiting younger people, not expending efforts on channels more aimed at older people.
- 5.17. KS advised that we could make a video on membership/engagement/annual members meeting and share through social media.
- 5.18. ES advised that staff engagement activity had similarly moved online but had continued to meet regularly. This was preferred by some colleagues as it avoided travel and gave people more access. Meetings had moved from quarterly to monthly.
- 5.19. The current staff membership was not representative, and a recruitment drive was underway to improve representation from across the Trust.
- 5.20. ES had been involved in the Trust's Covid Recovery Learning and Improvement Group (CRLIG) to try to ensure staff were engaged in the Trust's response.
- 5.21. KS noted that the CRLIG slotted in clearly to her plans to engage members in our recovery and would pick this up with ES/RG outside the meeting.

ACTION: KS, RG and ES to meet and ensure engagement with SECamb's recovery was joined up as part of the plan to engage members in relevant parts of SECamb.

- 5.22. KS noted that we used to have good engagement across the Trust in the staff engagement group. ES noted that there were now more than 50 people on the group, but we wanted to grow it further.
- 5.23. AIC advised that staff networks had been involved in the Staff Engagement Advisory Group for some time, and it may be worth checking the diversity of the Staff Engagement Representatives to monitor who was involved. ES/RG agreed. This would enable targeting of individual networks to ensure diverse views were represented.

- 5.24. AIC received feedback from the staff networks regarding the representatives doing the work to seek the views of staff in their own area. ES agreed and noted that a new role brief had been distributed to emphasise this element of the role. More support would be put in place to help representatives gather structured feedback.
- 5.25. KS further advised that where something was very important the Trust should be providing opportunities for all staff to engage.
- 5.26. ES advised that NHS People Pulse was a tool that was being provided twice a month to check how staff were feeling about anything, for free from the NHS.
- 5.27. BC noted that social media could be more targeted on younger people, but numbers and the profile of people listening to commercial/local radio was not as homogenous as being all older people. Messaging using local radio should be based on understanding the demographics of listeners and who was listening to what.
- 5.28. IA noted that joined-up messaging needed to be done and AIC noted that we also needed to tailor messages and focus on specific audiences.
- 5.29. RG noted that the Director of HR had introduced a focus on the staff networks and there was a meeting with him on 14th July to 'supercharge' the networks. KS asked to be involved further down the line once the ideas were scoped by the staff network lead.

6. Membership action plan

- 6.1. KS noted that the action plan had been refined over the past year. This was to use the Trust's wider membership more effectively and consistently. Membership survey results always told us that members wanted to more involved.
- 6.2. It would be important to use the SEAG and IHAG to recommend wider engagement which could be facilitated via the Membership Office as required.
- 6.3. KS was keen to make engagement with the wider membership a 'must do'.
- 6.4. AIC noted that one of the issues over the past year was that people were coming to present at meetings too late for members to be able to engage in development properly.
- 6.5. This went back to making engagement a must do, and demonstrating the benefits of engaging early and well. ES advised that NHS Horizons were engaging with people early on and we should be taking this approach: where early effective engagement took place and interested stakeholders set the agenda themselves rather than being talked to.
- 6.6. KS was very keen to try and join the dots and ensure that the Trust engaged at the right time.
- 6.7. RG noted that on the staff side one of the things that can be done is to link into the weekly webinars, which should focus more on the CRLIG work to engage more effectively.
- 6.8. KS would like to promote wider engagement and the different channels through the webinar.
- 6.9. GK noted that we needed to talk about the public membership as well. KS advised that membership covered both staff and public.
- 6.10. IA agreed but noted that our colleagues needed to understand the benefits of engagement in order to seek to engage with the public membership at the right time.
- 6.11. KS introduced strand two of the membership plan, around embedding Governors into localities to provide a local connection and improve staff understanding of the Governor role too.
- 6.12. BC noted that he had visited a local station recently and wondered whether we could start to move forward with linking Governors with localities. KS advised

that this would not yet be possible, but could be done virtually and introductions made.

- 6.13. KS noted the further strand in relation to Staff Governors who should proactively attend the SEAG meetings to fully understand each others' roles and how to use the SEAG to gather information and share their activities.
- 6.14. GK noted that welfare vans were out and about and Governors could join CFRs and meet staff at the same time.
- 6.15. NR noted that he agreed with this direction of travel. But he noted that if not carefully managed this would become more detailed and needed to be managed to avoid getting into too much detail while Governors should be concerned with the governance of the Trust.
- 6.16. KS would arrange a meeting with AIC, RG and ES to agree a direction of travel for public and staff engagement.

ACTION: KS would arrange a meeting with AIC, RG and ES to agree a direction of travel for public and staff engagement

- 6.17. NR asked whether he was able to have detailed breakdown of facts and figures in relation to SECamb's activity in his county. IA advised that this was probably a level of detail too far but if there were questions around whether there were sufficient resources in his areas, sufficient staff of the right clinical level etc. then he should by all means direct them to the Team for a response.
- 6.18. BC noted that it would be helpful to try and increase support for the MDC from Governors as the number of people attending was very limited.

7. Annual Members Meeting

- 7.1. KS introduced the paper, noting the legal requirement to present the annual report and accounts at the meeting.
- 7.2. KS noted that one exciting thing about the previous year had been giving free reign (within reason) to colleagues to present their area of work in innovative ways.
- 7.3. ES asked what platform would be used for the meeting and advised that MS Teams would not be the best for doing this online. Other large events used Zoom or WebEx because of additional functionality.
- 7.4. The MDC felt that it was important to get the functionality right.
- 7.5. AIC noted that she had been putting together a video on the experience of staff during COVID-19 which might prove useful for the AMM. This would be broadly showing how the organisation had responded to COVID. This could be launched at the AMM.
- 7.6. GK asked whether we know of other Trusts that have tried to run this type of event virtually, and what sort of attendance they have had. He wanted to put proportionate effort in.
- 7.7. KS noted that she had a network of counterparts across the NHS, most AMMs were taking place in September but there was one happening on Tuesday next week and she would be attending to get ideas and see how it went. She noted that the interest was not at all bad: we had between 300-500 views of each AMM recording over the past few years.
- 7.8. KS noted that she believed we would be looking at an hour-long event maximum so as to sustain interest and engagement.
- 7.9. KS further noted her view that the AMM could comprise the presentation of the Annual Report, a summary of the work of the Council, as well as AIC's video, and an introduction from the CEO and then a really interactive session.
- 7.10. HN asked whether 4th September was set in stone and KS confirmed that it was.

- 7.11. HN felt that David Hammond had done well on the finances. We should take account that the event will be rewatched more than watched live and should take that into account when planning. The public would be very much focused on COVID and what we had learned and would be doing in the future, rather than the history of the Trust's previous year. We should make it as forward looking as possible.
- 7.12. HN suggested doing online snap polls to engage people.
- 7.13. AIC noted that the audience would be different online to the usual attendance in person – the older cohort of our members may wish to participate and we would not want to make it too difficult for them.
- 7.14. BC asked whether we needed an extraordinary MDC to review the firmer plans so that the Governors were involved further and understood the delivery plans.
- 7.15. KS advised that she draft an agenda, circulate for comment to the MDC and then circulate a draft to the CEO and Chair for final agreement.
- 7.16. On timings, the MDC felt that between 6 and 8pm were the best timings to enable wide participation.

8. Member communications

- 8.1. KS advised that she had stayed in touch with members whose email addresses we had every month during Covid.
- 8.2. The newsletter had not been sent due to the focus being on the NHS delivering care and focusing on the frontline.
- 8.3. KS wondered whether a postal mailing should be sent out to advise members about the AMM for example.
- 8.4. BC was inclined to do a final mailing in advance of the AMM and share that it would be online and give a final opportunity to members to send their email addresses.
- 8.5. IA agreed but noted she felt that it would not be right to cut older members off and AIC advised that we should check who we didn't have email addresses for and see whether it truly was among the elderly.
- 8.6. HN noted that COVID-19 had been a period where many things had changed, and post in particular posed a threat of infection so now might be an appropriate time to change our communication methods to online only.
- 8.7. It was agreed that members would be given another chance to give us their email addresses.

ACTION: KS to send communication by post to members without email address again asking them to update their records.

9. Any other business from members?

- 9.1. There was no other business.

10. Review of Meeting Effectiveness

- 10.1. The meeting had been effective.

Date of Next Meeting: 3 November 2020

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Membership Development Committee

3 November 2020 – MS Teams 10:00-12:00

Minutes

Present:

Katie Spendiff	(KS)	Corporate Governance and Membership Manager
Brian Chester	(BC)	Upper West SECamb Public Governor (MDC Chair)
Harvey Nash	(HN)	Lower West SECamb Public Governor
Waseem Shakir	(WS)	Staff Governor (Operational)
Chris Burton	(CB)	Staff Governor (Operational)
Malcolm Macgregor	(MM)	Staff Governor (Operational)
Asmina Islam Chowdhury	(AIC)	Inclusion Manager
Graham Gibbens	(GG)	Appointed Governor
Vanessa Wood	(VW)	Appointed Governor

Minutes: Izzy Allen (IA) Assistant Company Secretary

Apologies:

Rob Groves	(RG)	Organisational Development & Engagement Advisor
Emma Saunders	(ES)	Organisational Development & Engagement Advisor
Nigel Robinson	(NR)	Public Governor
Leigh Westwood	(LW)	Public Governor
Greg Smith	(GS)	Voluntary Service Manager
Marcia Moutinho	(MMo)	Staff Governor

11. Welcome and introductions

- 11.1. BC welcomed members, he noted that numbers were a little depleted. AIC would join us in half an hour.
- 11.2. KS noted that CD was struggling with his internet connection for these meetings. There were few options to support CD with this. CD was Deputy Chair of the Group.

12. Apologies for Absence

- 12.1. As noted above.

13. Declarations of Interest

- 13.1. None were received.

14. Minutes of the last meeting and matters arising

- 14.1. The minutes were noted as an accurate record.
- 14.2. BC advised that under 17.4, it talked about people presenting at meetings too late to engage effectively. IA clarified that it was about consulting early on to shape plans at the right time.
- 14.3. On the action log, this hadn't reproduced fully in the circulated papers. She shared her screen. A lot of the actions were on hold.
- 14.4. The EA Group sat with AIC and it was unclear what her plans were for that but KS would revisit this with AIC.
- 14.5. On the membership satisfaction survey, this went out every year. We were aiming to get it out in May pre-pandemic, but the membership newsletter didn't go

out. The year had been a bit of an anomaly, so she proposed to send it out in May 2021 as very little had been able to take place with the members before then. The MDC agreed.

- 14.6. Governor engagement meetings and Governor toolkit items were on hold but could be considered later on the agenda.
- 14.7. HN asked about the Governor toolkit, and whether it could be provided for the Council. This would help with external conversations Governors were having or wishing to have.
- 14.8. KS confirmed that the current version was in use as recently as last Summer. Everything was moving so quickly, so the best source of information for Governors were the daily COP updates. The Toolkit did have a list of local Patient groups etc and ideas for reaching out during the pandemic which would be useful to circulate.
- 14.9. On reporting membership figures, these were now skewed because we had extended the boundaries into London, which made us look particularly unrepresentative in London areas. KS had manually adjusted the figures but wanted to talk through the challenges when we got to the membership report.
- 14.10. The membership action plan was on the agenda today. This would continue to be on the agenda for oversight.
- 14.11. HN asked about the impact of using the Newsletter to ask members for their email addresses. KS advised that she didn't have the exact figure, but we had had a little flurry of people asking for their communication method to be changed.
- 14.12. BC noted that the Governors had a toolkit to engage with groups. BC had used this with his surgery effectively. KS noted that it was for Governors to take advantage of online engagement events to engage during the pandemic. KS would circulate the engagement suggestions from the toolkit as a reminder to Governors.
- 14.13. BC reminded Governors to update the Governor activities log.

ACTION: KS to circulate the section of the Governor Engagement Toolkit containing suggestions for external engagement.

15.FT Membership update

- 15.1. KS noted the key issues from the paper:
- 15.2. KS had done work to review representation prior to the boundary changes, but there was no way to go back in time and view the representation in terms of diversity: we couldn't change the base figures because of the boundary change.
- 15.3. We could still draw conclusions from the figures and take action, however. We had consistently focused on improving representation and this remained important.
- 15.4. HN asked about our diversity statistics, noting that now it included parts of London which were outside of SECamb's operational area, it was unlikely to be easy to engage with those more remote areas outside our patch. We should not be swayed by representation in SE London, for example, but focus on our core patch.
- 15.5. IA agreed and noted we should use Kent, Surrey, and Sussex representation/seldom heard data to focus our continued efforts to diversify.
- 15.6. BC noted that maintenance of the membership numbers was adequate given the lack of face to face engagement.
- 15.7. KS noted that her counterparts across the area were holding Governor elections and were finding a lot of interest and increasing support due to interest in the NHS through Covid.
- 15.8. KS highlighted the Trust's new website which was not effective as yet. The majority of the information was not there at present. We had been assured that the old pages were being transferred. KS asked members to look at the public website and she would welcome any support in moving this forward.

- 15.9. BC was happy to support that. He still believed that communications continued to remain an issue. KS agreed and noted that she was unclear why the site had been launched without being ready, at a time when there was considerable interest in the NHS.
- 15.10. AIC joined the meeting. She noted that the website had been launched urgently because the Banstead server was being switched off. The Communications Team were due to attend the IHAG in January to discuss the website and Trust Communications Strategy. Governors were welcome.
- 15.11. KS would take an action from the group to pursue Communications to prioritise the membership areas of the Trust. IA advised that having a quick link on the home page would be simple and useful.
- 15.12. The IHAG was on 25 January.

ACTION: KS to continue to pursue the Communications Team for both the full membership content on to the website and in the short term a quick link to join us as a member.

- 15.13. KS noted that GK had sent a critical email about the new website which had been sent to the Communications Team. She had received a reply about the servers and that they were working their way through updating the content.
- 15.14. HN believed that the website as the public face of SECamb should be updated within the next few weeks. We were losing members.
- 15.15. The MDC sought to seek reassurance from the Chair that work was being effectively undertaken and prioritised.

ACTION: IA to escalate concerns about the website to the Chair.

- 15.16. IA advised that we didn't have a communications strategy, so it was hard to judge whether we had the correct resources within the Communications Team. BC noted that he had been raising the issue of communications for two years. He had been told it was not high on the CEO's priority list, which he had raised consistently with the Chair. Operationally there was a lot of pressure, but we couldn't continue to say this was an issue that cannot be fixed.
- 15.17. AIC noted that not having a Communications Strategy impacted the Trust in numerous ways. Another issue was around accessibility and how we market ourselves outside the organisation. The Board had now signed off the commitment to having a Communications Strategy by 2021 to meet our race equality objectives.
- 15.18. Communication with the public during this pandemic was key, HN felt.
- 15.19. KS advised that the MDC might revisit progress at its next meeting.

ACTION: KS to include Communications Strategy and Website on the next MDC agenda.

- 15.20. AIC noted that the comms strategy came under the Inclusion Working Group (IWG) too and Laurie McMahon was the key NED for that.
- 15.21. KS noted that we had 93 people observing the Council meeting in September online, which was phenomenal. We had good feedback from participants about the quality of the meeting.
- 15.22. Marcia Moutinho had received positive messages about how the Chair had handled the meeting. It was also a really good PR exercise for us.
- 15.23. It would be interesting to see what turnout for December's meeting was.
- 15.24. The Summer newsletter had gone out in July and the next one would go out in the first week of December.

- 15.25. AIC provided an update on the IHAG, which had met in July and October, after a hiatus from January.
- 15.26. Outstanding issues around national Patient Experience reporting had been considered. The patient experience strategy had been signed off and there was now more engagement regionally and nationally. They were developing a plain English format version of the strategy to aid communication about it.
- 15.27. The Quality Account (QA) priority setting had been discussed, and Governors and IHAG had both been involved. The IHAG had discussed the importance of supporting how project leaders during the year to deliver their priorities.
- 15.28. The QA process was being finalised and they had heard the feedback and were looking for additional support for project leads. Once the one-page version of the strategy was released, the main focus for year one was on patients with dementia, seeking a Dementia Lead and developing a dementia strategy, which she hoped IHAG would get involved in. VW offered to support this work if that would help.
- 15.29. The new Quality Assurance Framework had been discussed at IHAG. Governors had attended in previous years to attend stations to do mini-CQC inspections with NEDs, to identify what was working well, less well etc.
- 15.30. The QAF was an attempt to bring together the measurement of what's working and what's not, pulling staff engagement, health and safety, culture etc together.
- 15.31. Ali Mohammed came to meet the IHAG to speak about his priorities to look after our staff to look after our patients.
- 15.32. There had also been an update from the staff engagement group.
- 15.33. In January, the IHAG had the Communications Strategy and large-scale estates changes on the agenda, plus a discussion about the quality improvement programme and how we moved this through all our work.
- 15.34. KS noted that she had been asked to put an article in the membership newsletter about large estates changes and she hoped that staff had been advised prior to this going out. IA believed we had engaged more effectively with those affected by upcoming moves in relation to working arrangements and terms and conditions, but we still seemed to fall down in terms of consulting around the working environment, design and accessibility.
- 15.35. A staff engagement advisory group meeting had taken place last week.
- 15.36. This had discussed increasing representation on the staff engagement group, reward and recognition, a staff lottery, plus agile working moving forward. The group had discussed the lack of capacity and time for people to engage.
- 15.37. There was concern that conversations were cyclical and that the Staff Engagement group should be a key resource right now.
- 15.38. BC noted that at the first meeting RG and ES had joined the MDC, the MDC had offered to give them support.
- 15.39. WS noted that staff motivation had been discussed too. KS advised that there were a lot of demands put on everyone to be involved in different things.
- 15.40. GG left the meeting.
- 15.41. CB advised that we needed a clear plan to think about how we hold events in the future. Once we were able to conduct meetings face to face, we should have a plan ready to go for public engagement in 2021.
- 15.42. WS advised that the last staff engagement meeting had been really positive with staff from across the Trust. We had considered how staff governors might engage better with our staff members.
- 15.43. IT was not good within SECamb, and our recruitment of a NED with IT experience may help with this. IA advised that it was important to distinguish our

technical IT capability – which was good e.g. launching 111CAS – from the communications aspects, such as the website, which were less good.

15.44. The MDC offered continued support for staff engagement.

16. Membership action plan

16.1. KS provided an update on strand 1 regarding membership engagement opportunities. KS would work with AIC, RG and ES, to ensure engagement at the right time and highlighting engagement opportunities to the right people.

16.2. KS noted that the distribution of the branded face masks was an example of where there had been something distributed with no consultation nor clarity about purpose. Ideas should be sense-checked.

16.3. Strand 2 was around Staff Governors. The connection with the Staff Engagement Advisory Group had been made. They were seeking to develop representation perhaps by representatives being given capacity to join meetings.

16.4. Finally, strand 3 was around connecting local Governors and their OUs/CFR teams. This aimed to divide up and allocate Governors to make better connections with their local OUs. Winter might not be the optimum time. We needed to give thought to how this was messaged and the purpose of it.

16.5. BC noted that the Committee would support KS to get on with implementing the plan. He thanked KS for all that she did do. The charitable work and AMM had been fantastic.

16.6. KS sought to roll out the membership plan by March 2021.

17. Annual Members Meeting

17.1. 165 people observed or attended on the day. It was a good mix of people, including LAS, CCGs, Healthwatch etc. as well as staff and the public.

17.2. The staff networks had suggested the idea for the film, about life during the pandemic. It landed really well.

17.3. The Q&A had really good questions and people were engaged with the subject matter. We didn't ask people to register so we weren't able to contact them to ask them for evaluation remarks. This would be built in in future.

17.4. Teams Live may not have been the best platform.

17.5. BC noted that while KS' report was balanced, in fact the achievements far outweighed the few small negatives she had identified.

17.6. BC advised that we should start planning now, as next year we would likely still be looking at an online meeting.

17.7. KS advised that platforms others had used had been researched. IT had not been able to support KS' suggestions without licensing, but with a year to do this we could be doing this more interactively. KS would like to research the cost.

17.8. AIC noted that feedback had been that virtual platforms can be quite prohibitive, something more blended might be effective if physical proximity was possible. A hybrid approach going forward would be ideal.

17.9. IA noted that other parts of the Trust might be able to make use of more effective engagement technical solutions so it would be worth broadening out to help the Trust select one platform going forwards. She advised that a case would clearly need to be made about what a new platform could bring that Teams could not.

17.10. HN agreed that a hybrid event would be best, which allowed informal contact too. Also, on getting the budget, we would highlight the fact that we had a poor turn out of our public, only 35 people.

17.11. BC noted that we needed a meaningful AMM and to make it accessible to the public. Software might have chat rooms that we could open to all.

- 17.12. VW noted that Teams meeting are not accessible if you have hearing/sight impairments or other health conditions.

18. Patient Experience Group and IHAG

- 18.1. NR had offered to join whatever was required. HN had also volunteered and was interested in IHAG or PEG or both.
- 18.2. KS wished to provide a summary of the purpose of each group, take expressions of interest and then go to the wider Council
- 18.3. AIC advised that the IHAG was like our own patient participation group, made up of diverse representation. We expressly selected representation from groups not always included, where they had specific health inequalities, such as Trans and gypsy/traveller groups.
- 18.4. The primary role was to ensure the patients' needs are always taken into account in decision-making.
- 18.5. The group met quarterly, pre-Covid, for a whole day, plus an annual Equality Delivery System grading event over two days.
- 18.6. IHAG was currently meeting virtually quarterly for 3 hours. There were opportunities to get involved in other workstreams depending on interests.
- 18.7. We had three slots for MDC members to join the IHAG, to include two public members and a staff elected Governor. WS and GK were already on the IHAG.
- 18.8. KS noted that it was important that the rep on the IHAG also attended the MDC. This would be a key criterion for the representative.
- 18.9. The IHAG reported into the Inclusion Working Group, chaired by the CEO.
- 18.10. The PEG also had a vacancy for a Governor. This group oversaw the development and implementation of our Patient Experience Strategy. The group meets first on 23 November and there were six meetings per year.
- 18.11. There was a real opportunity to listen to our patients and act on feedback. It had never quite got off the ground to date.
- 18.12. HN would be happy to do either role, NR had also volunteered. Consistent representation was key.
- 18.13. AIC noted that the IHAG representative from PEG had stepped down so they would be seeking a new volunteer. KS noted that she had offered to go out to the wider membership for expressions of interest and received no response from those managing the PEG as yet.
- 18.14. HN further noted that when he went to the IHAG he had simply observed. Could Governors still observe IHAG meetings. This was confirmed. HN asked if this was also true of the PEG. KS would ask. Would it be possible to have a deputy for the PEG representative. KS had asked whether we could have two representatives for that very reason and she would follow this up.

ACTION: KS would ask for further interest from the full Council and select volunteers for PEG and IHAG based on regularity of attendance at the MDC.

19. Constituency meetings/online Governor meetings

- 19.1. This issue had been raised at Constituency meetings with the Chair. KS was happy to set up Governor constituency meetings and invite them to attend.
- 19.2. She wanted to understand what the purpose of the meetings would be and what Governors wanted to get from these meetings.
- 19.3. MM advised that he would really like this to happen, ideally a recurring meeting 3 times a year. He felt it was fine to enable people to raise concerns, which Governors might then reflect back through other channels.
- 19.4. For Public Governors, it could be broken down by Kent/Surrey/Sussex or East and West.

- 19.5. We expected the NEDs to be doing this too so we needed to do it ourselves.
- 19.6. HN agreed that there were likely to be complaints raised, but this would be an enormously positive thing. This conduit would be to make a note of what was said and ensure issues were passed into the organisation.
- 19.7. This could be the equivalent of an MPs surgery: just make Governors available to discuss whatever they want.
- 19.8. KS noted that previous events had focused in on whoever in green had turned up, and we never got questions for Governors.
- 19.9. IA advised that it might be possible to do something along with our Complaints team as part of the PEG work.
- 19.10. WS noted that for staff governors, they should try and use an existing forum where possible.
- 19.11. AIC noted that it may help to have someone who facilitated the session and took questions, signposting to the respondents.
- 19.12. BC noted that he was in favour in theory but was concerned about how it would work in practice. Would Governors have the skill set to deal with more thorny questions, for example?
- 19.13. IA suggested we might be able to bring NEDs into this. BC suggested that we might be able to run a trial session for Governors who wanted to do this.
- 19.14. IA noted that the staff governor session was clearly different, and using the SEAG was sensible.
- 19.15. HN noted the difference between staff and public governors in this. Would it be worthwhile one of the Public Governors joining the staff Governors?
- 19.16. He felt that for Public Governors, it would work better on a constituency basis.
- 19.17. In terms of people making complaints, we needed to be very careful as it was a public forum, and so personal complaints with personal information was not appropriate.
- 19.18. KS agreed that we needed to be clear what the aim was for public Governors.
- 19.19. West Sussex could be a good area to do a test event as HN and NR were particularly keen to do this.
- 19.20. On the staff Governor version, MM felt that it could be arranged in the lead up to Council meetings once the agenda was known, and use that as an informal agenda for the constituency meetings. Also, important to sell it clearly by saying we cannot fix things ourselves but want to understand the issues and feed them in in a broad way through the Council meeting. IA suggested doing the same with the Public trial meeting with key messaging around not bringing specific issues but broad feedback and questions.
- 19.21. KS asked what time would work for staff? WS advised that late evening might be best. We could also ask for questions in advance.
- 19.22. HN advised that for Public Governors we could trial one mid-late afternoon and one early evening to see what worked better.
- 19.23. These could be reviewed at February's MDC to see if they had been effective.

ACTION: KS to follow up regarding setting up Staff and Public Governor meetings prior to the December Council meeting, and bring evaluation back to February's MDC.

20. Any other business from members?

- 20.1. There was no other business.

21. Review of Meeting Effectiveness

- 21.1. The meeting had been effective. We would like to see more participants at the meeting.

Date of Next Meeting: 2 February 2020

Appendix 3

South East Coast Ambulance Service NHS Foundation Trust Inclusion Hub Advisory Group (IHAG)

Notes of a meeting held on 27th July 2020
held virtually on Microsoft Teams: 09:30 to 16:00 hours

Attendees:

Adele McCutchen	(AM)	Leslie Bulman	(LB)	Phillip Watts	(PWa)
Christopher Burton	(CB)	Marguerite Beard-Gould	(MBG)	Robert Groves	(RG)
Dave Atkins	(DA)	Malcolm McGregor	(MM)	Sarah Pickard	(SP)
Francis Pole	(FP)	Ollie Walsh	(OW)	Suzanne Akram	(SA)
Geoff Kempster	(GK)	Patrick Wolter	(PW)	Terry Steeples	(TS)
John Rivers	(JRI)	Penny Blackbourn	(PB)	Waseem Shakir	(WS)

Guests:

Andy Collen	(AC)	Rachel Turner	(RT)
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Secretariats:

Asmina Islam	(AIC)	Joanna Wood	(JWo)
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Chowdhury

Apologies:

Angela Rayner	(AR)	Katie Spendiff	(KS)	Simon Hughes	(SH)
Ann Osler	(AO)	Paula Dooley	(PD)	Felicity Dennis	(FD)

- **Welcome and introductions**
 - JRi opened the meeting, welcoming members, and guests. Round 'table' introductions were made.
 - AIC and JWo tabled apologies as given above.

- **Minutes of the previous meeting and IHAG Action Log Review**



02 IHAG Minutes
12.02.2020 v0.3.docx

- The notes of the meeting held on 12th February 2020 were reviewed and approved.

Action log



- Action 250.1. Patient Experience Group: Further to the Patient Experience Strategy approval, the first Patient Experience Group (PEG) meeting was last Friday 24th July.). PWA was in attendance and confirmed that process is going well but group will need to be expanded. There is also a need to put the strategy into plain and PWA will be supporting this. **Action carried forward.**
- Action 261.1. Template for FOI requests: On hold due to covid-19. New team members, who suggest that a template does not give enough flexibility. AIC to push back and suggest further consideration. **Action carried forward.**
- Action 271.1. Draft Patient and Carers Experience Strategy feedback: Strategy now approved. **Action closed.**
- Actions 272.1, 272.3. Falls Project Development: First meeting had just been held when Covid-19 struck, so whole workstream was placed on hold. AIC will seek updates now that everything is being started up again. **Action carried forward.**
- Actions 273.1. New 111 System: Communications to be developed for Foundation Trust Members. April launch was delayed due to Covid-19. AIC heard last week that a new launch is being planned, but messaging will need to be adapted following the pandemic. AIC to seek further feedback. **Action carried forward.**
- Action 275.1: Survey Monkey Questionnaire for Christmas Event: AIC apologised as she hasn't done this. Needs to think about learning from last year, as well as what the event will look like this year if there are still ongoing restrictions etc. AIC to send out questionnaire. **Action carried forward.**
- Action 276.1: Quality Account Process: Awaiting update from Judith Ward. Still unsure what support is provided to project leads identified by the Quality Account. **Action carried forward.**
- Members agreed to close all other actions that had been noted as completed in the Action Log since the July meeting including: 270.1, 272.2, 274.1, 276.1.
- AIC confirmed she will provide updates on as many of the open actions as possible in her email updates to IHAG members.

Matters arising

- No matters arising.
- **Review of activities undertaken by members**
- Members updated the group on the activities since the last meeting, and these included attendance and participation in the following:
 - Inclusion Working Group
 - Patient Experience Group

- AIC thanked everyone for quick virtual feedback provided by the group on recent projects including the frequent callers workstream.
- JRi confirmed that during the latest IWG meeting there was thanks and praise for the IHAG – much appreciation for the IHAG's input into various projects etc.

- **Integrated Falls Model of Care for SECamb (AC)**



Falls MOC IHAG 27th
July 2020.pptx

- JRi welcomed AC back to the IHAG (and back to SECamb). AC presented the model of care for Falls that SECamb are taking forward. Please see the attached presentation slides for an overview of the project.
- AC discussed the risks associated with falls which make up a large number of the calls to SECamb. However, our triage system can present challenges as the system looks for threats to life threats and falls are not often immediately life threatening. AC gave an overview of risks associated with falls and risks that create further risks. He confirmed that SECamb's response is contributing to that risk, hence the needs for a new model which makes the necessary changes for the benefit of the patients.

Falls are the second biggest accidental injury killer worldwide. Around half of those who break a hip will not regain independence, and half of these will die within the first year. It is important they are triaged correctly. Need to ensure those that are not injured from initial fall are not then left waiting which can cause serious complications. We know from data that vast majority of such patients are uninjured, but they wait a long time.

- AC presented a new model of care for falls. Our aspiration is to get to fallers within 20 minutes after the initial fall, as after this point complications and other risks begin to build up. This includes three types of responses with the introduction of an additional primary response.

- Primary response includes a rapid response by a Community First Responder (CFR) or colleague from the Fire Rescue Service. This response would also provide a visual assessment of whether they are injured informing whether additional resources are required. The main purpose of this response is to get the patient off the floor (injuries allowing).

There is a current workstream looking at CFR's attending non-injury fallers. AC acknowledged previous concerns and advised this had been assessed by the Clinical Governance Group, where it was agreed there was greater risks from disease as a result of a 'long lie' than the possibility of exacerbating an injury by lifting a patient from the floor.

- Secondary response would be to get a clinician to the patient's side within the normal response standard. If the patient does not require hospital admission, they will send a detailed response to the tertiary response as per current processes.
- The tertiary response involves referral to a community team (falls team etc). There may be additional opportunities in the future to host the tertiary response team.

○ IHAG members provided the following feedback on the proposals.

- As a CFR Team Leader himself, JRi noted that CFR response to falls had been debated a number of times, and this appears to be best model presented thus far. He is glad to see more utilisation of CFR's as part of the model as this will raise morale. He also noted progress in the roll out of the CFR app and it would be good to identify any opportunities this may also provide.
- LB stated that there had been discussion of a dedicated falls vehicle, previously. AC confirmed the insights from this project had been considered and the dedicated vehicle was a large resource for the activity we actually had. The proposed model will allow the tertiary response team to see many more people.
- Concerns were raised about a potential gap between CFR arriving on scene and further vehicle/ support arriving. AC confirmed that once patient's risks have been resolved i.e. they were off the floor/comfortable, the CFR can request family/ friends/ neighbours to sit with them. This enables the CFR to be released from scene to respond to other patients. The current grading process for back up is also under review and is being led by the Operational Response Management Group.
- AC confirmed that of a CFR makes a response there still needs to be a medical assessment. We will not allow discharge from scene without this and therefore will always send clinical response to follow in from the CFR. This will also inform the first year's data collection.
- AC confirmed the Trust will not be implementing a pilot but will move towards a full implementation and audit. There isn't currently a Project Manager assigned but hoping to have one in place ahead of winter pressures.
- It was raised that some areas may not have CFR teams and how would patients in these areas be impacted. AC acknowledged that at present we were at risk of losing CFRs due to engagement/ lack of morale. AC confirmed that Kent, Surrey,

Sussex have 20% of all care homes in the UK where there are large numbers of falls but acknowledged that Deputy Director of Operations is undertaking a mapping exercise looking at age, deprivation etc of local areas.

- AC told members that success would be measured on the following.
 - o timely response for CFRs to patient
 - o how quickly they get the right secondary response
 - o quantitative and qualitative data including from DATIX's (untoward incidents, episodes of harm).

PB felt a tertiary response would count more as a success from a patient point of view. AC confirmed this would be considered by the Strategy team in development of relationships and multi-disciplinary working.

- TS felt model focused on sensory reasons for falls, but has personally had a number of falls outside due to uneven pavements etc. AC agreed there should be a better system for reporting these and AC would feedback to the working group to identify possible ways for linking with local authorities.

- o AC said he felt reassured that IHAG colleagues feel this model would be beneficial for colleagues, patients and the organisation.

- **Quality Improvement Strategy (RT)**



SECAmb Quality
Improvement Strategy

- o JRi welcomed to RT, who joined SECAmb in Jan 2020 as Quality Improvement Lead, with a history in musculoskeletal physiotherapy. RT presented an overview of Quality Improvement (QI). Please see the above slides for an overview of the presentation.
- o RT confirmed initial cohort of Quality Improvement Foundation Course was set up prior to Covid-19 but had to be continued virtually. RT confirmed two open feedback sessions around QI strategy ideas were held on 1st July, which has helped to shape where the strategy is now. This work is ongoing and will keep developing.
- o RT gave an overview of the model/ methodology ideally used for quality improvement. She reiterated the need for everyone to approach any type of improvement work in the same way and stated the need for any improvement/ change to be embedded within the organisation. RT advised that combining QI approaches is ideal as it allows you to pick from what works well across multiple projects, so although you follow the same method, you can use more than one QI approach.
- o IHAG members provided their feedback on the proposed methodology, highlighting:
 - Importance of using the SMART (Specific, Measurable, Assignable, Relevant and Time-based) principles - RT confirmed that SMART principles were being used, but it was not always possible to embed this at the start, so regular reviews are built in.
 - Ensuring staff understand the reason for the change via clear communication. Engagement needs to be built in, otherwise you risk spending a lot of time trying to persuade people.

- There needs to be clarity for staff on how to progress a good idea (process/ who to go to etc). MM stated his attempts at doing a QI project at SECamb have been very difficult and fallen by the wayside because of this.
 - RG wanted to highlight that the L&OD team are working on similar project to the current QI one and that there is a large overlap between QI and L&OD. Identified a need for greater clarity between the remits of the two teams.
 - JRi stated that in the past there have been many personnel changes, lots of 'acting roles' – SECamb not got a good track record and this has affected development and QI greatly.
- RT shared the QI teams' priorities and plan for the next few years including the main areas of focus (see presentation). Feedback on these included:
 - IHAG to be added to the list of stakeholders as a recognised team.
 - There needed to be more emphasis on patients. They should be at the centre of the diagram, but patients and the community should also be an influencer providing a two-way communication loop. RT agreed
 - RG wanted to highlight the need for L&OD team and QI team to be working together closely as HR Director has already taken similar projects to the Executive Board and it was important that we worked to reduce duplication. RT confirmed they haven't yet worked on the structure; they are currently just collating feedback on what people are saying is needed. RG confirmed that the L&OD team has found that working with multiple directorates on a shared project has been far more effective.
 - JRi thanked RT and asked if it would it be possible for RT to come back in 6 months' time with an update.

Action:	AIC/JW to invite RT to return in six months to provide an update on progress.
Date:	February 2021

- **Staff Engagement Forum**

- RG provided a brief update on how the Staff Engagement Group has adapted during Covid-19 and adjusted their engagement processes. He confirmed they previously met every quarter for a whole day meeting, and these were paused due to the pandemic. However, it was identified that staff feedback and engagement was essential during a time of crisis to learning from what has happened and improvements going forward.

As a result, the group now meets monthly for two hours. There was initially a positive feedback about positive communication, but now creeping back towards low morale and more of the business as usual (excessive workload/ not as many vehicles etc).

- **Horizon scanning**

- SA stated that Covid-19 has highlighted a disparity and health inequalities experienced by those from a Black, Asian, and Minority Ethnic backgrounds. The Surrey Minority and Ethnic Forum are working more with Surrey Heartlands identifying what further support is required for communities. In addition, the Black Lives Matter movement has global event have made many uncomfortable with inequity that still exists, but a lot of organisations have shown support. SA wanted to share that a lot of good work has come out around race equality and hopes that this momentum continues within communities and workforce.

- LB suggested the group would be interested in focusing on interagency working and how we can use resources in a more efficient way.
 - AIC confirmed we are working closely alongside with the Integrated cares Systems in our area as well as Public Health England, with more work is interagency and working with regional colleagues. She highlighted that it was important when considering engagement, we also consider the needs of under-represented groups in our messaging.
- AIC advised that since the last meeting Ali Mohammed had joined the Trust as a substantive Director of HR and Organisation Development. AIC to invite HR Director to future meeting for an introductory meeting.

Action:	AIC/JW to invite HR Director to October 2020 meeting.
Date:	October 2020

- OW confirmed that partner had risk assessment through work due to the disproportionate impact of COVID on those from ethnic minority groups. OW asked whether it was a general risk assessment or whether individual Trusts have their own assessments. AIC confirmed that these risk assessments were largely designed by individual Trusts, and at present 97% of our staff from these groups had been risk assessed.
- **AOB**
- PB asked whether others had contacted Jack Barrett who is doing a research study on head injuries. AIC confirmed Jack is still looking for patient participants for the study, so if anyone can contribute to this project, please do let AIC or Jack know. PB confirmed he would also like people without any previous knowledge/ experience of head injuries to feedback into his study.

Action:	Members to advise AIC if they wish to be part of the research study on head injuries.
Date:	August 2020

- **Meeting Effectiveness**

- SA felt that this was a good meeting and thanked JR for chairing and AIC for papers etc. LB stated that it was a good meeting but difficult to see/ hear people due to everyone using different technology.
- Thanks to all from AIC, who recognises challenges of holding the meeting virtually. She asked IHAG members to share what would make it easier for them to be engaged and feed into workstreams during this time.

Action:	Individuals to email AIC with thoughts around how to keep IHAG engaged/ supported during this time.
Date:	August 2020

- The next meeting to is scheduled to take place on **Friday 16th October 2020**, time TBC.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

E – Governor Development Committee

1. Introduction

- 1.1. The Governor Development Committee is a Committee of the Council that advises the Trust on its interaction with the Council of Governors, and Governors' information, training and development needs.
- 1.2. The duties of the GDC are to:
 - Advise on and develop strategies for ensuring Governors have the information and expertise needed to fulfil their role;
 - Advise on the content of development sessions of the Council;
 - Advise on and develop strategies for effective interaction between governors and Trust staff;
 - Propose agenda items for Council meetings.
- 1.3. The Lead Governor Chairs the Committee and both the Lead and Deputy Lead Governor attend meetings.
- 1.4. All Governors are entitled to join the Committee, since it is an area of interest to all Governors. The Chair of the Trust is invited to attend all meetings.
- 1.5. The GDC met online on 23 June, 20 August and 8 October 2020. The minutes of these meetings are provided for the Council as an appendix to this paper.
- 1.6. Governors are strongly encouraged to read the full minutes from the GDC meetings.
- 1.7. The GDC meeting in June covered: feedback from the previous CoG, the format of online meetings, election of a Lead and deputy Lead Governor, Governor training and induction feedback.
- 1.8. In August it covered: reviewing the draft Quality Account, feedback on the 'get to know you' session for Governors, agenda setting for the September CoG, establishing an escalation process if responses were not received from Governor queries, and a preliminary discussion around election timings.
- 1.9. In October the meeting covered: reviewing the September CoG and AMM, agenda setting for the December CoG, approving the Governor Query Flowchart to come to full Council (enclosed for Council approval), agreeing proposals around changes to election timings to come to full Council (in February 2021), and reviewing Governor attendance at Council.

2. Items of note

- 2.1. The full minutes are provided and Governors are strongly encouraged to read them in full. Given the volume of meetings and activity since the GDC reported to Council, this paper only highlights key recommendations made by the Committee:
 - 2.1.1. Council pre-meets to be re-established to enable Governors to collect their thoughts and focus lines of enquiry before Council meetings;
 - 2.1.2. Recommendations were made around including a COVID update on each Council meeting agenda, and holding a 'get to know you' session of the Council;

- 2.1.3. Online training was offered to Governors during the pandemic;
- 2.1.4. The GDC offered early detailed feedback on the Trust's Quality Account draft – all Governors have since been given the chance to provide feedback;
- 2.1.5. Agreed to scope out the possibility of a Council Christmas get together;
- 2.1.6. Set out requirements for a flow chart showing agreed timescales for obtaining responses to Governor queries and a clear escalation route where responses were not received. This is before Council today for comment and approval; and
- 2.1.7. Recommendations have been made to standardise Governor election timings so they take place every year, rather than two years out of three, also bringing one election for a Lower East SECamb public Governor in line with other elections. A full proposal will come to Council's next formal meeting for approval.

3. Recommendations:

3.1. The Council is asked to:

- 3.1.1. Note this report;
- 3.1.2. Read the minutes provided; and
- 3.1.3. Review, comment on and hopefully approve the Governor Query Flow Chart provided to Council as Paper F.

3.2. All Governors are invited to join the next meeting of the Committee on **11 February 2021 2-4pm via Teams.**

Nicki Pointer, Deputy Lead Governor (On behalf of the GDC)

See below for the minutes of the GDC meetings

Appendix GDC Minutes

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 23 June 2020

Present:

Nicki Pointer	(NP)	Upper East Public Governor, Deputy Lead of CoG
Brian Chester	(BC)	Upper West SECAMB Public Governor
Geoff Kempster	(GK)	Upper West SECAMB Public Governor
David Astley	(DA)	Chair of the Board/Council
Marcia Moutinho	(MMO)	Staff Governor (Non-Operational)
Marguerite Beard-Gould	(MBG)	Upper East SECAMB Public Governor
Harvey Nash	(HN)	Lower West SECAMB Public Governor
Isobel Allen	(IA)	Assistant Company Secretary
Sian Deller	(SD)	Upper East SECAMB Public Governor
Amanda Cool	(AC)	Upper West SECAMB Public Governor
Chris Burton	(CB)	Operational Staff Elected Governor
Malcolm MacGregor	(MM)	Operational Staff Elected Governor

Minute taker:

Katie Spendiff	(KS)	Corporate Governance & Membership Manager
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Welcome and introductions

NP welcomed Governors to the meeting.

Apologies

Apologies were received from Marianne Philips, Nigel Robinson and Vanessa Wood.

Declarations of interest

There were no new declarations of interest.

Minutes, action log and matters arising

The minutes were reviewed and agreed as an accurate record.

There were no questions in relation to the action log. The volunteer strategy was still awaiting Board approval. Action 180 NP to advise Greg Smith (CFR Team) regarding perceived lack of communication in the utilisation of CFRs. NP advised that regular comms were now going out to CFRs and that they had been re-deployed. This action could be marked as complete.

Feedback on the previous Council meeting

IA noted that in a previous Part Two at Council, Governors had not felt they had enough information about the decisions they were being asked to take. The most recent part 2 private

meeting had passed without much comment from Governors and IA wanted to check whether the information provided had been sufficient.

BC noted he felt the right information was available within the papers but was keen to hear from colleagues who weren't on the nomination committee on this. NP noted that the silence was generally acceptance of the content of the papers.

IA asked if everyone felt able to contribute at the meeting. BC queried whether the Council should have a pre-meet online as per previous in person Council meetings. BC noted it helped frame the meeting, gave an opportunity to get to know each other and direct questions so everyone gets a chance to participate. GDC agreed this would be useful.

ACTION: Pre-meets to be scheduled into upcoming Council meetings.

IA sought a view on NED attendance at the last meeting and the interaction. Previously, deep dives on specific committees were taken at Council meetings so this was a slightly different approach.

BC noted that having a lot of NEDs at the last meeting was appropriate given the circumstances and the assurance that was sought.

MBG noted that previously NEDs gave an overview of how they came to work for SECAMB and their experience to date and that this had been very useful. MBG noted new Governors would find value in this as she has.

DA noted it would be useful for Governors to do this too to provide insight into their own experience and would support colleagues getting to know each other.

NP noted some Trusts undertook a programme called the 'Exec Factor' which is where Execs and NEDs write a skit to showcase themselves.

HN was inclined to look at bigger picture rather than deep dives on specific committees. HN noted that Governors should be keen to hear about the Trust's recovery plan and feed in to this where possible.

DA was keen to combine deep dives with a 'state of the nation' overview of where the Trust was in its response to the pandemic.

ACTION: Consider blending NED committee deep dives at Council meeting with a getting to know you section.

Format of Council meetings

BC noted differences in interaction from online meetings verses meeting in person. BC queried effectiveness of the Council long term when only utilising online platforms.

MBG noted challenge of undertaking Teams meeting on tablets as she found it restrictive compared to Zoom.

SD noted that as a new Governor it had been difficult to get to know Council colleagues virtually, however the online platform had meant she had been able to participate whereas she likely

wouldn't if she had had to commute to Crawley during this time. SD noted that online meetings did not facilitate a deeper level of conversation that would be needed at these kinds of meetings going forward.

DA noted the immediate future of Trust meetings would likely be a hybrid approach. DA noted that training in person was more useful and helpful in building relationships.

NP noted she felt the main Council meetings were better face to face and that smaller committee meetings could be undertaken online.

IA proposed September Council meeting be online, and consideration for December Council to be in person if possible.

IA sought feedback on monthly webinars with the Chief Executive and the Chair and future frequency of those. It had been necessary at the beginning with the pace of change to have them monthly. Second spike permitting, IA proposed building a Covid update into Council meetings from management on a quarterly basis. IA noted that the weekly webinars were being shared with the Council so that would be your 'go to' place for current information. GDC accepted this proposal.

ACTION: Regular overview of the Trust's response to the pandemic at each Council meeting from an Executive going forward.

Electing a Lead Governor

IA thanked NP for stepping into the role of Lead Governor and noted her thanks for all the support NP had provided over the last few months. IA noted she would request expressions of interest to the Lead Governor role before the September Council meeting and the election would take place within the meeting. Consideration around how votes would be captured was required. IA advised that the Lead Governor does not lead the Council, they are on an equal footing with other Governors. The Lead Governor Chairs GDC meetings and has some other formal responsibilities that IA would share in her email on this. IA noted that other Governors are not excluded from decision making and that talking to the Lead Governor did not mean you had spoken to the Council. IA advised voting was first past the post, and that second place would be allocated the Deputy Lead role if content to accept.

Governor Induction feedback

IA thanked all new Governors who provided feedback on their induction. It was good to see Governors felt very welcome at their first Council meeting and the induction itself.

A who's who of Board and Council would have been useful and timings between induction and council meetings were tight this year. Consider election timeline to support Governors being in post for a little while before the first Council meeting.

SD noted she was looking forward to developing relationships with colleagues in person. AC noted that online meetings had made the Governor role more accessible for her during this time. MMO noted the volume of the paperwork for the first Council meeting was a little daunting. MMO noted she felt it a bit intimidating to ask questions in online meetings as the Governors do not know each other well yet.

KS suggested a getting to know you session online on the dates of the July and August webinars

as she was aware there has not been any informal meetings to do this since the role commenced. IA suggested a socially distanced meet up in a park. This would be considered.

ACTION: Plan a 'get to know you session' with the Council either online or socially distanced gathering.

Governor Training

IA gave an overview of what had previously been undertaken and what was currently available remotely in respect of Governor training. Unfortunately face to face training was yet to be available.

NP noted for new Governors it would be useful to get this training in sooner rather than later via online and for other Governors to have some refresher training later in the year. The GDC agreed. KS would look to get this in place prior to the September Council meeting.

ACTION: Online Governor training to be organised for new Governors.

CB keen on effective questioning training. CB is keen to understand when we could be meeting in person with timelines. GK noted the meeting space at the HQ had been re-purposed so it would not be a quick snap back to business as usual.

Any other business

NP noted she had received a query from a FT member on the constitution boundaries. NP advised that the Trust had followed the appropriate protocols within the constitution. BC noted that these suggestions were fully reviewed and supported by Council.

NP noted the passing of NED Tricia McGregor and that she would be sorely missed. IA noted that she had sent on the Council's kind comments on her passing to Tricia's husband.

GK noted the welfare van for crews was currently out and about – this would be open to Governors to take part in. Governors to get in touch with KS and IA if interested. This would go out in the weekly email to all Governors.

BC noted his thanks to Pauline Flores Moore for her contribution as a Governor before stepping down. BC thanked the Trust for the offer of antibody testing for Governors.

Review of meeting effectiveness

The meeting was deemed to have been effective and NP's chairing excellent. DA noted a flexible approach to meetings had transformed the Trust's ways of working, saving not only on miles travelled, but time and improving efficiency. It would be important not to lose sight of this.

The next meeting of the GDC will take place on:
20 August 2020 2-4pm via Teams

Signed:
Nicki Pointer
Deputy Lead Governor

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 20 August 2020

Present:

Nicki Pointer	(NP)	Lower East Public Governor, Deputy Lead Governor
Brian Chester	(BC)	Upper West SECAMB Public Governor
Geoff Kempster	(GK)	Upper West SECAMB Public Governor
Marcia Moutinho	(MMO)	Staff Governor (Non-Operational)

Harvey Nash	(HN)	Lower West SECAMB Public Governor
Isobel Allen	(IA)	Assistant Company Secretary
Sian Deller	(SD)	Upper East SECAMB Public Governor
Waseem Shakir	(WS)	Operational Staff Elected Governor
Leigh Westwood	(LW)	Lower East Public Governor
Graham Gibbens	(GG)	Appointed Governor
David Astley	(DA)	Chair

Guests: Judith Ward (JW) Deputy Director of Nursing and Leane Stephens Head of Quality Assurance.

Minute taker:

Katie Spendiff	(KS)	Corporate Governance & Membership Manager
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1. Welcome and introductions

1.1. NP welcomed Governors to the meeting.

2. Apologies

2.1 Apologies were received from Marguerite Beard-Gould, Malcolm MacGregor.

3. Declarations of interest

3.1 There were no new declarations of interest.

4. Reviewing the draft Quality Account

4.1 Judith Ward and Leanne Stephens joined the meeting. JW gave an overview of the Quality Account and its statutory purpose. JW noted the draft was provided for initial input from Governors. The document would likely be finalised in December and she sought input from Governors at this draft stage.

4.2 MM noted one of the priorities in the document was to improve the Trust's response to long waiting falls calls. MM was keen to understand if the EOC falls flow chart had been implemented in care homes to support the Trust's efforts. MM asked what plans were in place to address welfare compliance.

4.3 JW noted the flowchart was used in EOC to review the risk on long wait fall patients. Work to embed this document continues. JW noted that the work on falls is still in

progress. The Trust had been working with care homes with Clinical Commissioning Group support in West Kent and noted this probably needed to be highlighted in the report. There was an appetite to roll this work out into the Surrey area and the Trust would likely look to highlight the work undertaken with care homes in next years' Quality Account Report.

4.4 WS noted it was a comprehensive document. He was mindful of the Trust's care bundles and what happens when we aren't treating patients appropriately in terms of auditing. WS highlighted opportunities to use audit outcomes locally to coach and improve his team's practice, but advised that the detail was not available to Team Leaders. He felt this was a missed opportunity and something teams would be interested in. JW noted she would pick this up outside of the meeting with WS.

4.5 BC noted page 20 and the reference to s136 transports (mental health) and the disparity of figures between SECamb and Sussex Police. BC noted this was a well-known challenge and asked if the Trust were able to resolve it prior to publication.

4.6 JW advised that the Trust would know where the discrepancies were when Sussex Police introduce the same criteria for data collection as Surrey Police. Once that is in place, the Trust will be able to make accurate comparisons. BC noted the paragraph on this in the document looked out of place and that indications towards a timeline to rectify the challenges would be welcomed. JW advised that the Trust was reliant on Sussex Police arranging the appropriate data terminals first. In terms of a workaround in the meantime, there are data protection measures that prevent comparing data in detail between the Police and the Trust. JW noted the Trust was proactive in seeking updates on the data terminal implementation.

4.7 GK noted that the falls projects being run by Andy Collen would be worth including in the Quality Account.

4.8 GK highlighted the graphs on complaint response times on page 66. The graph shows a sharp drop to 35% response rate in April, prior to this it was consistently around 90%. GK noted narrative supporting the graph would be useful for the reader to understand why.

4.9 JW agreed and advised that Emergency Operations complaints were being handled by colleagues on alternative duties and they had returned to their regular duties around that time, so compliance dropped. This had highlighted a lack of process following in EOC and work was undertaken to train staff in how to agree the level of complaint and investigation required which released more resource. It also highlighted there was no business continuity for sickness in this area, and the complaints team now managed their own processes far more effectively.

5. Minutes, action log and matters arising

5.1 The minutes were reviewed and agreed as an accurate record. The action log was reviewed.

5.2 IA advised that the 29th September date was locked in for NHS Provider training for new Governors. IA thanked all Governors for finding the time to attend this important training.

6. Discussion of any feedback from the CoG 'get to know you' catch-up meeting in July

6.1 MM had really enjoyed the session and thanked IA & KS for making it interesting and fun. BC also really enjoyed it and would have liked it to have lasted a bit longer as the poll activity was entertaining.

6.2 BC noted it was a shame more Governors could not attend as it worked really well. BC asked if Governor attendance at meetings was reviewed? IA noted this was reviewed twice yearly and this could be scheduled for a future GDC.

ACTION: Governor meeting attendance to be reviewed at a future GDC meeting

6.3 NR noted that the getting to know you session had been very good. He advised that regarding future events Tuesdays and Wednesdays were generally challenging for him although he appreciated everyone had busy diaries.

6.4 It was suggested that a Christmas event could be arranged online with a quiz and other activities. NP suggested a date poll for a Christmas event be circulated to the Council.

6.5 IA noted the Trust normally hosted a joint event with colleagues on the Inclusion Hub Advisory Group who were also public foundation trust volunteers. IA advised some thought would need to be given as to whether it would work as a joint online event this year.

ACTION: Council Christmas get together to be arranged (likely online for now). Speak to AIC re separate or joint events this year. Date poll to be issued to Council.

7. Discussion of agenda of Council meeting 4 September 2020

7.1 IA noted the format was usually slightly different as the Council meeting took place prior to the Annual Members Meeting (AMM) so would have a good audience of public members in attendance.

7.2 IA advised that this year's AMM and Council meetings would be online and promoted to the public and colleagues. Normally annual reports on the work of Council committees are presented at this meeting. The Council usually picked an area of interest for a deep dive presentation that would be of interest to the public to cover as well.

7.3 IA noted that the new community resilience strategy could have been a good item, but the team were not planning to launch the strategy until later in the year. The community resilience team had suggested they attend the December Council meeting instead. GK noted he felt the AMM would have been a great place to launch the strategy and was disappointed that the opportunity had not been grasped by the team.

7.4 IA noted that the pandemic was of interest to all; how it's impacted the Trust, the implications moving forward and more generally the implications across the NHS. IA noted that it could segue into an update on the 111CAS service and the benefits to patients which would be of great interest to the public.

7.5 HN noted that the AMM was after the Council so the Trust would want to avoid repetition if covering Covid19 at both events. HN noted that the Trust's preparations for the EU Exit would be an area of interest to the public. IA noted that Ian Shaw would be well placed to provide an overview on all of this as a senior leader with responsibilities in both areas.

7.6 KS thanked HN for highlighting possible duplication regarding presentations. KS noted that the AMM would be headlines on the pandemic and the Council would be more in depth.

7.7 IA noted the Lead Governor election would take place at the September Council meeting, and that there would be a pre-meet at 9.30am as requested by Governors at a previous meeting. IA advised that there may be a part 2 recommendation for a clinical NED appointment.

8. Timeliness of Governor query responses and escalation process if responses not received

8.1 IA noted there had been a quite a few queries coming through from Governors throughout the pandemic which was welcome as it showed Governors were still able to undertake their duties in representing members and seeking assurance on their behalf.

8.2 Prior to Covid the corporate governance team had been receiving timely responses to Governor questions and this had seemed to slip a bit recently. HN noted he was surprised at how long it took for a response to his question (a month) and was concerned as to what had changed as this had not been his experience to date.

8.3 HN noted he didn't see any NED assurance initially as the focus was on an operational response first. HN was unsure why the team didn't seek a NED response initially to see if the item had been discussed at committee. NP noted that NEDs could be copied into the initial acknowledgement reply that is sent to Governors, so it is put onto their radar. The GDC wanted to see a clear timeline given for expected response.

8.4 IA noted that the level of detail in Governor questions was often granular and would need a management response first. When the question was purely assurance based, they were sent directly to NEDs.

8.5 The GDC agreed that the process could benefit from being mapped out and circulated to Governors for clarity.

ACTION: IA to map out the Governor query process and circulate to the Council.

9. Standardising election timings

9.1 KS advised that one Governor's term of office was coming to an end next year and that it was not particularly cost effective to hold an election for one seat now the constituency boundaries had been extended for that area (Brighton and Hove had joined East Sussex to form Lower East SECamb).

9.2 KS had thought out two options on the advice of the elections agency but sought input from the GDC on any further ideas.

9.3 One option was to keep the seat vacant for a year to bring it in line with the other seats that were up for election in 2021.

9.4 The second option, as per an existing GDC action, was to extend the representation in West Sussex to provide an additional seat in that constituency and hold an election with the East Sussex seat vacancy next year.

9.5 KS was keen to minimise the number of Governors potentially leaving in one go to retain some experience on the Council so was leaning towards suggestion 2. KS opened it up to the GDC for discussion.

9.6 BC noted that rotation of a third of the Council each year would be optimal if it could be achieved. BC asked if there was any opportunity for crossover of terms – a month for existing governors and new governors to handover. The GDC agreed that overlap would be beneficial. BC noted co-opting Governors could be looked in to and have a limit set at 1 or 2 seats to ensure that this was only done in specific circumstances and the Council remained elected on the whole so as to ensure representation through election.

9.7 HN noted that Appointed Governors were in effect co-opted. He felt it was important to focus on continuity going forward but also not to lose sight of additional representation in West Sussex on the Council.

9.8 IA advised that any changes to the constitution needed to go for approval to both Board and Council members. Any changes to the role or responsibilities of the Council within the constitution would need to go to the AMM for approval. It was felt this would not be a change in the role and responsibilities of the Council.

ACTION: IA to review options for election timings and bring a proposal to the October GDC meeting.

10. Any other business

10.1 KS noted there was a Council meeting on 1st December 2020 venue/format TBC, and that there was a GDC booked in for 8th October 2-4pm on Teams. NP noted she might not be attending as her due date was 4th Oct.

11. Review of meeting effectiveness

11.1 The meeting was deemed to have been effective.

The next GDC meeting takes place on 8th October 2-4pm on Teams.

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 08 October 2020

Present:

Geoff Kempster	(GK)	Upper West SECAMB Public Governor
Marcia Moutinho	(MMO)	Staff Governor (Non-Operational)
Harvey Nash	(HN)	Lower West SECAMB Public Governor
Isobel Allen	(IA)	Assistant Company Secretary
Malcolm MacGregor	(MM)	Staff Elected Governor
Waseem Shakir	(WS)	Staff Elected Governor & Deputy Lead Governor
Leigh Westwood	(LW)	Lower East Public Governor
Graham Gibbens	(GG)	Appointed Governor
Nigel Robinson	(NR)	Lower West SECAMB Public Governor
Chris Burton	(CB)	Staff Elected Governor

Minute taker (from recording):

Katie Spendiff	(KS)	Corporate Governance & Membership Manager
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12. Welcome and introductions

- 1.1. WS welcomed Governors to the meeting.

13. Apologies

- 13.1 Apologies were received from David Astley, Sian Deller, Katie Spendiff, Nicki Pointer, David Escudier, Marianne Philips,

14. Declarations of interest

- 14.1 There were no new declarations of interest.

15. Minutes, action log and matters arising

- 15.1 The minutes were reviewed, MM & NR attended the last meeting and the minutes needed updating to reflect this. The action log was reviewed.

- 15.2 Regarding the IPR action and Governors understanding of the report. A new version of the IPR went to the July Board. An agenda item on this could be for consideration for the Council agenda in December or the joint session with the Board in November.

16. Discussion of any feedback from Council and Annual Members Meetings in September

- 16.1 MM noted he felt overall it went well and the Council functioned effectively and discharged their duties in holding the NEDs to account. MM noted that the second part of the meeting had felt a bit rushed.
- 16.2 GK noted that public attendance at the online meeting was very welcome. IA noted there was a large portion of staff that had joined to learn more. NR noted there was a wide spectrum of people observing the meeting which was positive. IA noted that

promotion of the meetings had been very effective, and thanks were recorded for KS's work on this.

- 16.3 WS noted the Chair had been particularly effective at the meeting in managing and responding to questions from the public.
- 16.4 WS noted that it felt like a long meeting and was quite a full agenda. IA noted the meeting time was similar to the usual face to face length, but online meetings were a different dynamic and attention span needed to be considered.
- 16.5 HN noted difficulty in sensing colleagues' reactions when presenting reports and there was a possible inclination to talk more than was needed to overcompensate for this. Tendency to overly lean on use of PowerPoint was highlighted.
- 16.6 MM welcomed more time to challenge NEDs on their reports. MM noted the second part was more focussed and was where the Council held NEDs to account.
- 16.7 IA gave an overview of the current format of the agenda and the rationale behind it. IA sought any alternative views on this. GDC agreed the rationale was sound.
- 16.8 MM noted that in the Part 2 he had asked a question regarding clinical education to the NEDs on the Workforce and Wellbeing Committee and that he felt the Chair had jumped in first and steered the answer before passing it back to them. MM felt on two occasions in the meeting that he did not get satisfactory responses to the important points he was raising. WS noted he felt MM had been closed down on one of his points. IA noted this would be fed back to the Chair. IA noted that it was partly due to timing in that one of MM's points was raised towards the end of the meeting and the Chair was under pressure to get to the public's questions.
- 16.9 IA noted Part 2 focussed on a NED appointment and the Chair's objectives. CB was keen to meet the new NED and see him in action, CB noted concern over the new NEDs clinical experience being up to date. GK noted the newly appointed NED reviewed a paper as part of the recruitment exercise and the candidate excelled at scrutinising it, which is a key part of the NED role. GG noted he was quizzed on his current level of clinical expertise within the interview.
- 16.10 IA noted that Howard Pescott's observations were helpful regarding the wording of the Chairs objectives.
- 16.11 Regarding the Annual Members Meeting, WS noted he missed the interaction with the public that a live event provides.
- 16.12 IA noted the event would be reviewed in full at the MDC. HN noted that for a member's event it went extremely well and everyone that spoke got their points across effectively. The event flowed well and had a good audience.
- 16.13 GK noted he also missed the face to face interaction but under the circumstances understood. GK advised that Clinical Education were not featured in the film that was shown and they had taken it personally. IA hoped they could understand that it was not that they were purposefully omitted it was that not all departments could be represented in a 12-minute film.
- 16.14 LW noted that a hybrid event in the future would reach a wider audience.

17. Discussion of agenda of Council meeting 1 December 2020

- 17.1 IA gave an overview of the paper and that there would likely need to be a Part 2 for a review of a NED appointment with a focus on HR and Organisation Development. IA noted it was scheduled for an Audit and Finance and Investment Committee deep dive to take place alongside a report from auditors KPMG.
- 17.2 IA advised any changes to the election process would need to come to Part 1 as well.

- 17.3 IA noted 111CAS was the biggest area of public interest now, alongside performance. GK noted that both items would be important to prioritise on the agenda as they had patient impact and interest.
- 17.4 HN noted EU Exit impact summary would be welcomed as the meeting was in December. IA noted the CEO could cover these three areas and draw on other colleagues to support if required.
- 17.5 NR noted the Trust's management of COVID incidents, winter resilience and flu, how the Trust will support staff to continue to do their work. NR noted that a personal sentiment on those areas from the CEO would be more welcomed, with less of a political angle.
- 17.6 MM noted re ePCR, it had become integral to frontline roles but there were known issues. MM noted the Council had previously heard from Ryan Bird on ePCR, and he would be keen to hear whether the predicted benefits had materialised.
- 17.7 WS noted 111 had an impact on 999 workload and the Trust was under scrutiny for its performance. A steer on this would be welcomed alongside EU Exit and flu preparations.
- 17.8 IA advised that there was a joint Board and Council session in November. IA suggested the IPR item went to this meeting as part of performance scrutiny and ePCR might fit within this session as it was about data, how it's used and what is learnt from it. HN was keen for any early warning private discussion on planning around EU Exit, flu, and pandemic to come to the November meeting as well.
- 17.9 IA proposed that the formal Council focussed on performance challenges, EU Exit, COVID, Flu and 111 CAS as part of the CEO report. This was supported by the GDC.
- 17.10 MM noted that an area of interest for future discussion would be that there in his view there was an over reliance on black and white data when Exec and NEDs were making decisions and that there was a lack of triangulation. MM noted context and qualitative data from the people involved was often overlooked from his observations and observations from colleagues. IA noted this sat firmly within the IPR focus and would be a good conversation starter for the joint meeting.
- 17.11 HN noted the pause of observing, public events, and quality walkarounds which was making it hard for Governors to gain soft intelligence on what it was like on the frontline and the public's current perception and experience of the Trust's services. HN noted hesitancy to rely totally on numbers and was concerned and in agreement as per MM's point.
- 17.12 IA suggested engagement opportunities could be discussed at the MDC. For Public Governors IA noted that local forums were useful such as patient participation groups and that for staff intel, the Council was reliant on staff Governors feeding views back in. The GDC noted possible online constituent events for discussion at the MDC to bridge the gap.
- 17.13 GK noted observing had re-opened to CFRs and student paramedics and the question could be asked regarding Governors observing.

ACTION: Ask if Governors can observe on shifts.

18. Governor query flowchart – for comment and recommendation to Council for approval

- 18.1 IA noted there had been a quite a few queries coming through from Governors throughout the pandemic and that there had occasionally been a delay in the time it took to receive responses from colleagues. The flowchart aimed to set out the process and timeline for receiving and responding to Governor queries and the escalation process.

- 18.2 IA noted that when a Governor was seeking assurance only, it goes straight to the NEDs. The proposal is if there is no response within 2 weeks, it would be escalated to the Chair.
- 18.3 IA advised that if the query was very detailed and required a management response to understand it initially, it would be sent to management and the response from management is then shared with the NEDs and Governors for triangulation. An escalation process was detailed for this as well.
- 18.4 HN noted he felt there was a further distinction where Governors were just making a simple enquiry which was usually handled by IA & KS. HN noted if it was a concern that was being raised then could the NED be copied in when it was sent to management in the first instance to cover all bases. HN raised concern over potentially waiting 4 weeks for a response.
- 18.5 IA noted agreement re caveat of serious concerns meaning cc'ing NEDs when the query was sent to management.
- 18.6 The flowchart was agreed.

19. Election proposal for discussion

- 19.1 The paper covered a proposal to even out the number of vacancies at elections.
- 19.2 The former Brighton and Hove seat was the only seat that took place outside of the other two bulk sets of elections. The seat comes to an end in 2021 and the Governor in post had advised she did not plan to re-stand. This provides an opportunity to hold that post open for nine months to bring it inline with the next bulk set of elections in 2022.
- 19.3 WS noted that constituents could still reach out to the other two representatives over the nine months where the seat was held vacant. The GDC agreed it would be better value for money to roll it over to the 2022 elections. HN noted that it would be positive for members to be involved in the elections every year. IA noted this proposal would come to the December Council for approval.
- 19.4 Discussions had taken place about increasing representation in West Sussex to bring it in line with East Sussex. The GDC were widely in support of this and agreed it should go to Board and Council as per governance relating to changes to the constitution.
- 19.5 The GDC had previously talked about starting the elections earlier to provide crossover between those leaving and those starting a post.
- 19.6 To achieve this, the elections process would need to start in October for announcement in December.
- 19.7 IA noted the only risk identified so far would be that a Governor would know if they had been re-elected or not three months before their term was due to end, so would commitment to the role be impacted for those last few months.
- 19.8 IA noted that if the Council wanted to get a third of Governors elected on rotation, the Trust would need to manoeuvre election terms, so some were for three years and some for two years. Consideration over which Governors got which length of term could be based on the number of votes, the highest getting the longer term. IA sought views on the proposal.
- 19.9 WS noted he was not necessarily in favour of these changes. He felt the process worked as it was.
- 19.10 GK noted he had about two weeks before his first Council meeting when he had first started and that he found it quite challenging.
- 19.11 MM noted that he would be in favour of keeping the existing process. He noted that he may be less inclined to attend meetings if he knew he wasn't going to be re-elected.

- 19.12 HN noted that he felt Governors would see their terms through to the end. HN queried the extension of the timeline of the election and the vote taking place in January.
- 19.13 NR noted that a handover from previous Governors would be very welcomed. It would increase effectiveness and confidence in the role.
- 19.14 MMO noted the time for her between being elected and the first Council meeting was far too short, and it had been overwhelming and confusing for her as a new Governor in post. MM noted the benefit would outweigh the risk.
- 19.15 IA noted the elections to be held with an end date for mid-December and a welcome and induction come January.
- 19.16 NR suggested allocating mentors to new Governors. IA noted that each existing Governor in a constituency could take new Governors under their wing.
- 19.17 HN queried the number of maximum terms served available to Governors and if the change to two/three-year terms would have an impact on this (nine years being maximum term). IA noted this was a very valid point and that she would seek advice on this as it could be the number of terms took a Governor over the maximum of nine years and three terms. Clarity on this would need to be included in the proposal taken to Council.
- 19.18 The GDC agreed the proposal on one third rotation could go to the Council and Board for review.

20. Review of Governor attendance at Council

- 20.1 IA noted that the Council's strength lay in attendance at the formal meetings.
- 20.2 IA advised that twice yearly attendance was reviewed to enable monitoring of this.
- 20.3 IA noted that Howard Pescott who is an Appointed Governor had triggered the attendance marker by failing to attend three meetings in a row. He had since attended the September Council meeting. IA asked the GDC to advise how to proceed. IA noted that the Trust he represented had a CQC inspection around the time of the meetings he missed.
- 20.4 This was discussed and the GDC decided not to escalate this to the Council. Attendance would be monitored at the next reporting interval.
- 20.5 WS noted he would prefer to address matters straight after they had happened. IA noted this would mean reviewing the data more often. IA noted the spreadsheet could be updated after each Council meeting to enable this.

ACTION: Governor attendance spreadsheet to be updated and monitored after each Council meeting.

21. Any other business

- 21.1 IA noted that NHS Providers have a Governor Advisory Committee (GAC) which is made up of Governors from a variety of Trusts. The GAC are there as an independent advisory capacity for any Councils experiencing difficulties with their Trusts which are unable to be resolved through existing established channels. IA would circulate details to the full Council on the position available. The elections take place on 2nd November.

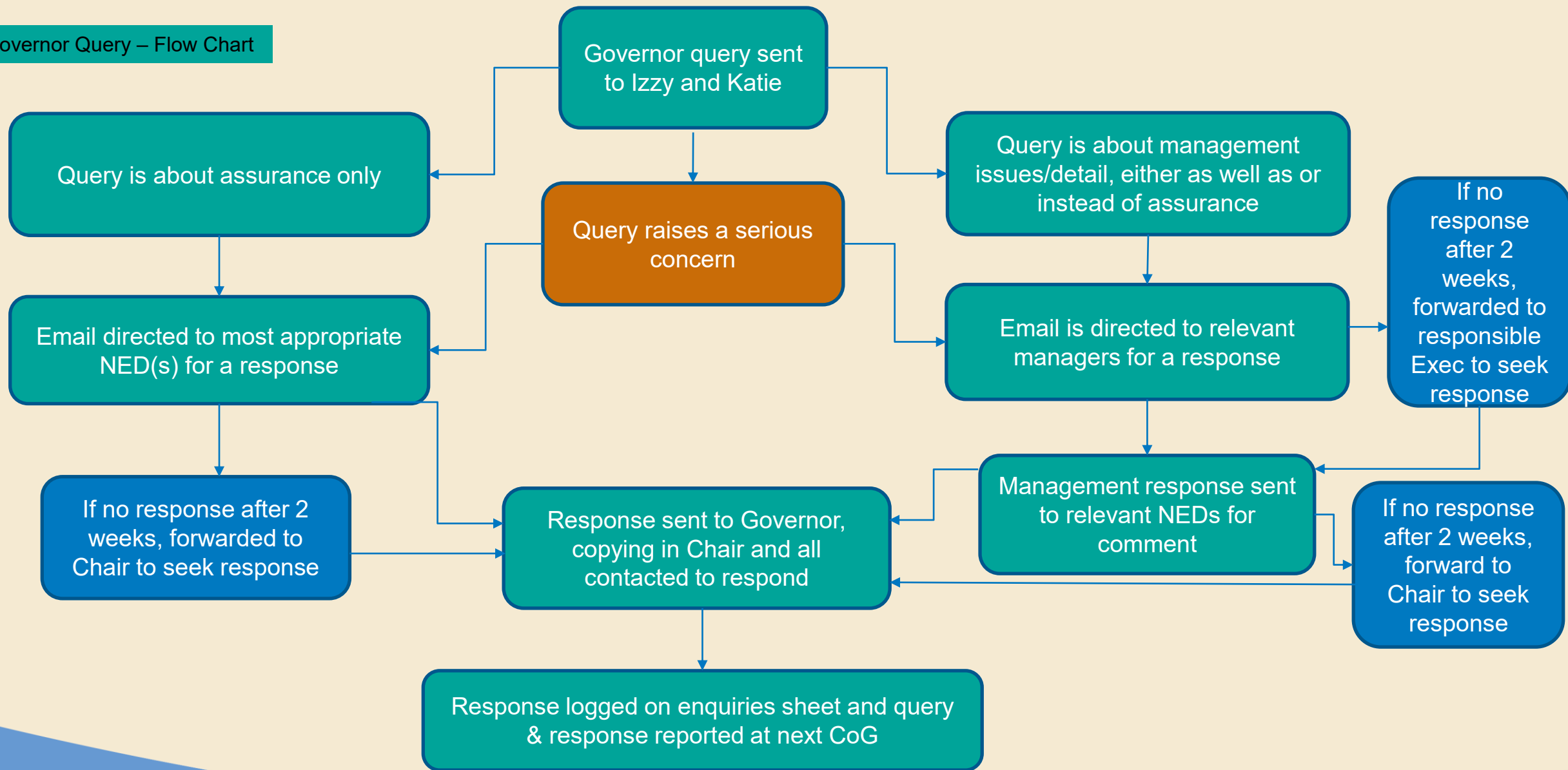
ACTION: IA to circulate details on position on NHS Providers Governor Advisory Committee to full Council

22. Review of meeting effectiveness

22.1 The meeting was deemed to have been effective and WS was commended on his Chairing skills.

The next GDC meeting takes place on 11 February 2021 2-4pm via Teams.

Governor Query – Flow Chart



South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

E - Governor Activities and Queries

1. Governor activities

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

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

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

1.4 **Governors are asked to please remember to update the online form after participating in any such activity:**

1.5 <https://forms.office.com/Pages/ResponsePage.aspx?id=UeDqcg7pE0mFIJzyYfBhGFHlnsSYmzxOp1c2Ro-88d1URE1MVDQ1NVVINEQ2N1dDR05OSDg1VUxWVC4u>

Date	Activity	Governor
Sept 2020	Inhouse Governor training on effective questioning and core duties	Nigel Robinson, Vanessa Woods, Leigh Westwood, Chris Burton, Sian Deller, Marcia Moutinho, Cara Woods, Amanda Cool
Nov 2020	Governor Focus conference	Sian Deller David Escudier

2. Governor Enquiries and Information Requests

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

15.06.20

Letter outlining continued concerns over PPE provision and fit testing from all three Operational Staff Governors sent to the Chair and WWC Chair for review. Scrutiny into the decision-making process surrounding the general issue of PPE remains a significant concern for the staff operational governors.

Chair advised it would be reviewed at QPS and a response prepared.

02.07.2020

In today's COP the number of staff 'unfit' due to FFP3 is shown as 58, whereas yesterday it was 49. Is this increase because some fitting kit has now failed or.....? If these numbers are merely the number of staff who would have been on frontline per rota then they do not tell us much about progress, which I had thought they were showing.

The Governor is seeking some assurance around: the non-fitting FFP3 masks data reliability. What is the purpose of the stats on this in the COP - is it operational or organisational, tactical (next day impact) or strategic (progress to solving issue)? I would thus like assurance that NEDs are fully aware and monitoring this with the Exec Board and are:

(a) satisfied that SECamb knows the numbers, and names, of all our people affected, knows exactly what is being done / planned to fix (inc timescales) and are being regularly updated with progress.

and (b) satisfied that the Board knows the impact on daily operations.

Whether that needs to be in each COP is for the Exec Board and NEDs to decide, but what is shown at present does not, for me, provide any reassurance.

Answer from Emma Williams Deputy Director of Operations:

The number of staff 'unit' due to FFP3 does relate to the number of staff unavailable that day to undertake front-line duties. It is to give an indication of the potential impact on the service for the day.

The data regarding which individuals have or do not have an FFP3 solution is accurately captured and recorded within the PowerBI system. This system has been in place for a few months and has been demonstrated as providing the level of assurance required to both the Executive Team and the Trust Board. A report on the journey relating to fit-testing across the Trust in relation to the COVID was delivered to the Quality & Patient Safety Committee in July, within it was a section relating to data reporting, recording and assurance.

At the time of writing (05.08.2020), the Trust has now received enough stock of reusable masks/hoods to support all staff needing these items for them to return to front-line duties. The COVID Management Group monitors the current situation relating to both current PPE issues as well as reviewing performance including reviewing the REAP (Resource Escalation Action Plan) position. Escalations are taken to the Executive Management Board and on to Trust Board as appropriate.

08.07.2020

My concern on the changes to shielding is that the original HMG notices talked of those (c2M) at especial risk who should fully shield, would get food deliveries etc and those at 'increased' risk - 70+ and those with a variety of medical conditions (but essentially those that GPs would invite for flu jabs), who would be contacted by GPs and should take particular care to obey social distancing etc. In virtually everything since the references have been to those shielding and occasionally to 70+ (as in Bethan's note), but no mention of those under 70 at increased risk (but not classed as shielding). Is 70+ used as shorthand to include such, or has there been a change that makes these people less at risk or? I suspect SECamb will have far more of the latter than 70+. Is anything being done specifically to assist them?

Sent to Dawn Chilcott 04.08.2020 Answer from Dawn Chilcott Head of HR Business Partners on Bethan's behalf:

Those classed as shielding include lots of people under 70 – anyone who received a letter from the Government, has a GP note, or a long-term condition the Trust is aware of have been included in the first tranche of clinically vulnerable and shielding risk assessments that are nearly completed now.

The next phase is to risk assess all staff to capture anyone missed during this process. There has been a huge amount of communications about requesting a risk assessment from your line manager if you were not approached by the manager in previous weeks.

The risk assessments identify those at low/medium risk and that initiates a discussion with line managers about appropriate mitigations of risk e.g. PPE, COVID-secure workplaces and with those in place the colleague can come back to work.

Colleagues found to be at high risk are advised to continue shielding or redeployed to a non-patient-facing role.

It's been a learning curve for managers and colleagues as managers are not used to having so much discretion to effectively negotiate whether their team members feel able to come to work, but we hope we are striking the right balance between protecting staff and keeping people on the road to provide the care our patients need.

14.07.2020

There is new guidance from NHSE/I to implement SDEC pathways to all disciplines not exclusive ED or frailty. Are we assured that NHS 111 Are ready to implement these new

pathways and dispositions by the October deadline.

Sent to Sean Daisy on 20.07.2020? Chased for clarity on initial response below re timeline and acronyms on 04.08.2020: Response from John O'Sullivan Associate Director for contact Centres 111 & 999: I can confirm that this sits within the work for CAS mobilisation which has an October deadline for deployment. In terms of specifics, SECamb have been provided with a Digital Roadmap from Kent, Medway, and Sussex commissioners which our IT, Systems, and Performance & Information team are reviewing and discussing to establish what is feasible within the timescales.

Progress against the evolving commissioning requirements to facilitate Direct Appointment Booking (DAB) from 111 into SDEC is being tracked through the Trust's KMS 111 Mobilisation Programme Board. As a Trust, SECamb is working with system partners in Medway on a 'proof of concept' regarding DAB from 111 into Emergency Departments. Currently, this is the only pilot across Kent and Sussex where SECamb is undertaking this NHS E initiative. We are also working with other systems and providers to support the implementation of the Commissioner-led digital roadmap across the region, developing electronic interoperability/email referral notification whilst enabling services to directly contact the patient to arrange an appointment.

24.07.20

With recent and ongoing increases in mental ill health among ambulance staff (preceding but exacerbated by the COVID pandemic), are you confident that the trust has sufficient skills and capacity to support staff? This inquiry is in light of comments brought to my attention by front-line colleagues that our wellbeing hub seems to be struggling under workload and therefore unable to provide useful or timely support.

GED says: My team has supported the Hub by providing a MH drop in service for EOC/111 during lockdown, and we have frequently provided support to OUs on request. We are about to begin attending OUs to support staff in anxiety management. In addition to this we often support the Hub when request to advise on specific cases. Scott says: The Wellbeing Hub is currently experiencing an elevated number of referrals for psychological support/assessment, as recently highlighted in the weekly comms bulletin dated 23rd July 2020. Where we have a self-imposed 2 week wait limit for assessment, due to both demand, and capacity, we are currently in a position where we may not be able to meet this. This is the case across the Hub generally... We anticipate the referral numbers to increase over coming months, and we are continually assessing the level of referrals against capacity, and continually striving to meet this deadline. The skill set of staff can be assured in relation to their specific roles, however additional capacity may be required...

Prior to the onset Covid-19, the Hub/Trust had committed to a Strategy Review of the Hub, which was set to commence in April 2020, however this has been delayed until either a suitable time, or method for carrying it out is established. It is anticipated that this method will aim to utilise Microsoft Office technology to assist in this... It is anticipated that the outcome of this review and support from the Trust may provide an updated model for the Hub, and help alleviate the current capacity pressure...

27.07.2020

At the IHAG meeting today Andy Collen briefed the IHAG on the progress being made in the falls project. This appears to be an excellent project which will have a positive impact on our patients and potentially improve the outcome for many them. When he was asked when this would start, he explained that it was waiting for a project manager to be assigned to the project to start the process moving forward. He was therefore unable to give any indication of the timescales. The IHAG has therefore asked the Council of Governors to get assurance from the NEDs that allocating a project manager to this project will be given the highest possible priority in order to ensure that we are providing this support to our patients as soon as possible.

We have Peter Goodbody, the Medical Consultant Admin, supporting the project currently. He has a project/programme management background and is kindly and competently assisting until such time as either the new Medical PM starts or the falls project is embedded into the Medical CRLIG, in which case would fall under PMO resourcing. This will be discussed today coincidentally.

It should be stressed that this is not delaying the project in any way and we are making progress against our action plan/log etc. If any stakeholders would like further scrutiny or assurance, I would be happy to meet but at this stage we have no identified resource or delivery risks.

Oct 2020 - I am pleased to say that Naomi Green, the new Medical Directorate project manager, is now the PM for the falls project manager. She has attended several meetings and is organised the project into its individual workstreams and is working with each workstream lead on the delivery plans. She is providing effective project oversight and governance and is working closely with me to manage any risks, issues, escalations, and approvals.

29.07.20

What assurance do you have that our paramedic practitioner management team have the necessary financial support/budget to deliver key objectives and to allow the paramedic practitioners to undertake the full range of their duties?

The issues you have raised have been escalated to Executive colleagues, and there is a growing understanding and acceptance that the situation requires urgent resolution. The way of working for PPs has been formally agreed and the current level of posts significantly limits the delivery of the core aspects of the role in the OUs, as per the OU Toolkit specification.

It appears that the ECAL/hubs element of the role was omitted from the initial Demand and Capacity review, and discussion are taking place to substantiate this and to resolve ahead of the next phase of the demand and capacity review. As you correctly point out, there are many elements of a fully established PP programme that provide benefits to patients, staff and the wider trust and this has been included in the COVID recovery and learning programmes in both the Operations and Medical directorates.

We very much hope to be able to fully staff PP rotas in all OUs in order to realise the additional benefits that a fully established PP programme can deliver to patients and staff.

03.08.20

I was wondering if I could ask clarification about something. I have been made aware through my work within PET that our service seems to be unable to contact deaf patients. I have copied below an extract of the email I received which hopefully will explain my query.

'After speaking to OUM call handling and several EMATLs, it seems that we are unable to call people using Relay UK, and if we are no one knows how to use it. The only time we can speak to a deaf patient is if they instigate the 999-call using relay UK or a text relay service. However, as soon as this call has been terminated it appears we have no special way of contacting them, which causes undue distress to the deaf caller, however, it also poses a significant safety risk to our patients, i.e. if the address is wrong. It would be good to find out what the trust systems for dealing with this situation is, as no one in EOC, even senior management can advise a system for contacting deaf or hard of hearing callers. If a caller is hard of hearing and no text relay is available, all they do in EOC is 'early exit' – 'triage not possible' and reach a C3 disposition'.

I find it concerning that this may be the case and hopefully someone will be able to assure me that there is in fact a system in place which then needs to be better publicised as nobody seems to be aware of it.

With the service constantly experiencing high demand and relying on welfare calls to manage the risk when leaving patients waiting for hours for an ambulance, I find it hard to believe that we are unable to carry out welfare calls to deaf patients.

There has been a lot of recent talk on inclusion and we will all agree that communicating effectively with all our patients is a key element of an inclusive service.

The information I have regarding text relay in EOC is attached but you are correct, I don't see a way to go back to the patient with a hearing impairment other than to send them a text message. This is something that was highlighted to me within the pandemic and we do need to look at accessibility for our hearing-impaired patients both face to face and in EOC. I've had initial discussions with Judith and will be having further discussion with the new Head of Patient safety when they start.

13.08.20

The increased phone response times for 999 are significant - 18 secs for the 90%ile means some are waiting for what will seem like ages. On the other hand, 111 calls seem to be holding up better (do check my understanding on that!). Are we clear on why the bigger impact is at the front end - lots of heat stroke...? Is there any opportunity to shift 111 phone resources to 999?

The assessment from the governor is correct that 999 have been under significantly more pressure, although 111 is now experiencing increases in demand, and this has been consistent with previous shifts in demand linked to weather which impacts 999 immediately and then

impacts 111 gradually. This is being experienced nationally. 111/999 trained clinical resources and 111/999 dual-skilled call handlers can and have been shifted to 999 to support the increased pressure. The Trust is looking to expand that resilience with dual skilling.

Penny Green regarding cause of impact on 999: I would echo Sean 's thoughts around the impact weather has on the 9's in a shorter time frame. Those with long term health conditions are more adversely effected by the heat and can be push into having a health crisis by the extremes of weather we saw last week, for example long term heart conditions the impact of heat means individuals bodies are working harder therefore more susceptible to emergency situations they would feel most appropriately assisted by the 9's rather than the 1's.

Re performance, in summary, we resourced to meet the activity forecasted but the demand for our service was much higher than forecasted. Work had started to develop the cross training of our staff when the pandemic hit. This work had to be paused to meet the new challenges we faced but it is now again being prioritised but still faces challenges as the training capacity needs to be planned into business as usual as well as planning normal training pipelines.

25.08.20

Clinical Education:

What efforts have been made to triangulate the assurances you have received from management colleagues by speaking to those who deliver and receive education "on the ground"?

How will you be assured that the serious and ongoing issues will be addressed?

Do you remain assured that the trust has the capability to successfully deliver nurse conversion courses and internal paramedic training courses?

From the Chair: I have discussed this issue with colleagues and I would like to address your specific questions now, and then some of the broader concerns will be picked up at the COG meeting tomorrow. Firstly, in terms of triangulation, the Board has relied on different sources of assurance, for example, the feedback from Ofsted and most recently Future Quals. In terms of your direct question, I am not aware any NEDs have spoken directly with those delivering or receiving education. You ask how assurance will be sought that these issues will be addressed. The workforce and wellbeing committee will continue to have clinical education as one of its priority areas of focus. The current issues have only recently emerged and as a Board we are reflecting on how this took us by surprise. The committee was updated last week verbally and will be seeking assurances at its next scheduled meeting on 17 September. It will then report to the Board in the usual way. Considering these recent issues, the Trust Board will also be asking for specific assurances when it meets at the end of the month.

The general answer to your final question is that prior to the current issues there was already significant concern about clinical education, notwithstanding some of the improvements that had been reported and independently validated. It remains one of our BAF risks.

More specifically, I am told that the nurse conversion courses have already been put on hold as there are other priorities. We are progressing the employment of nurses in 111, mental health etc, but a conversion course to put nurses with no current prehospital experience on an ambulance is something to be progressed in the future. The Board is not aware of any specific issues with the internal Paramedic courses; we are working with the University of Cumbria to progress this with the first intake next year and understand this is currently all going to plan.

I hope this helps to address your specific questions. The recent issues are very disappointing and, as I say, we are as Board reflecting on how this came about in the way it did.

05.09.20

*During the CoG yesterday, I was very pleased to hear you state, unprompted, that you and the NED team will be challenging the Exec to plan for surplus in terms of front-line hours, rather than running the minimal number of hours simply in order to meet demand. However, not five minutes later in response to my question, the CEO stated very clearly that this demand-driven approach is *exactly* what is being done currently, and this certainly correlates with what I hear from other sources.*

Could you please assure me that it is indeed your goal to continue to challenge the exec on this point and highlight the benefits that such an approach is likely to bring.

Thanks for your email. I have spoken with Philip Astle today and plan to speak to David Hammond tomorrow. I have made the point that that either we need to target more than 100% of expected demand (or alternatively, as Philip mentioned to me, make less aggressive assumptions on 'abstractions' in the planning - which would have exactly the same effect of increasing the required base level of hours) as we continue to undershoot the frontline hours supplied.

We are all trying to do the right thing with the same objective and as always (as I'm sure you know) the problem is more complex than meets the eye (e.g. the type / mix of hours and their geographical distribution) but I do think that increasing the base level of hours and being less reliant on overtime and PAPs to meet regular demand is the right approach. This raises the question of financing the higher base level of hours which is why I need to discuss it with David and FIC members and ensure we are all agreed on a way forward but I am optimistic there will be a way through which achieves this maybe with an offsetting lower cost by reduced use of PAPs. I am also aware this is not necessarily a quick solution as it involves additional recruitment.

09.09.20

I am currently working with the Clinical Education team fit testing the student paramedics, so they are ready for their placements. During my time with them, I was concerned to hear of the very low morale within the department, and the high turnover of senior managers in the department. The morale issue was highlighted by the video shown at the AGM, which appeared to cover all departments except for Clinical Education, despite the large amount of effort they have had to put on to reorganise all of the courses to be online rather than in the classroom.

Can we please get assurance from the relevant NEDs that they are aware of the low morale within this department, and that the executive team are ensuring that their concerns are being recognised and addressed going forwards. We are aware there have been some issues within some parts of the department, but the whole department feels it has been tarred with this brush and that they are getting a lot of stick for things that are outside of their control.

Response from Michael Bradfield

- There

have been significant challenges that we are still working through post COVID, including the issues around OFSTED, FutureQuals staffing and the move to a new location

- The senior leadership team is listening to the concerns of staff, including the WWC scrutiny and the assurance reports you have requested from us (the HEI report for this week's meeting from Neil Monery has some good detail on the excellent work done by that team, as well as the challenges being faced)
- I feel we are not good as a team in sharing our successes so cannot expect others to know what we do, we are trying to address this but the recent environment has not been conducive to 'marketing' our work and those of the learners. I believe most people would not be able to say all the work that Clinical Education does.
- Staffing has now increased considerably with 3 new Practice Education Leads and 3 new Clinical Education Leads joining the team since March 2020
- When I started we did have one Senior Education Manager on secondment to an HEI, and then one to the COVID command hub for a few months, but we now have all three substantive Senior Education Managers back in post, so that tier of leadership is steady
- The head of department staff turnover point is harder to challenge, as we have had multiple people in "head of" positions in the past 12 months. I have been in post since February 2020 but am leaving the Trust in November, so that may be what has prompted that comment. Fionna and Richard will be best placed to comment on the senior leadership recruitment plan, but once I have been replaced, there will only be a couple of vacancies due to progression or end of secondments within the team and we easily recruited last time around.

14.09.20

For estates: Q: How are you considering environmental and sustainability factors in new builds and how are you engaging with colleagues on this and the proposed builds?

All new build designs include considerations relating to Building Research Establishments Environmental Assessment Method (BREEAM). Through compliance to these standards, the proposed designs will meet a 'very good' rating. By achieving this rating, the Trust will be ensuring a significant reduction in our estate's carbon footprint and will develop an exemplar building that operates to a very high standard of resource efficiency and sustainability.

The requirements to meet this rating of 'very good' are outlined in the building designs which are reviewed and approved as part of the planning process with delegated leads from each of the relevant workstreams.

Project Boards have been established for each of the projects to ensure senior managers in relevant departments are sighted on all aspects of the design and allow collaborative decision making.

23.09.20

Yesterday I attended an exercise to look at the traffic management plans for Kent following the UK's exit from the EU on 31st December 2020. Key organisations were involved as well as Government departments. SECamb took part both in person and virtually.

Much of the traffic management plan remains the same as last year but there are also significant changes that will potentially have an even greater impact on SECamb especially around Junction 10a of the M20 (coastbound), which will be used as a border readiness checkpoint for outbound freight and the potential use of the Waterbrook site formally Truckstop 24 for inbound CT checks. The use of these sites would have a major impact on SECAMB as well as the East Kent Hospitals in particular WWH. There are a number of challenges that SECamb face once these traffic management plans are implemented in Kent, although designed to keep the freight moving, the full impact is still an unknown quantity and all risks need to be assessed and where possible contingencies are put in place.

I would like to seek assurance from the NED's that all the risks and impacts have been taken into account, and that the SECamb plans align with what is being proposed by the Op Fennel traffic management plan. Much of the plan is still dependent on information from the Government but with only 100 days remaining, I'm keen to ensure that SECamb is in the best position possible to continue providing a service.

The MOD were also at the meeting, they are keen to work with organisations to develop plans that consider how military assistance could be utilised. I know the military are already working with SCAS and would be keen to work with SECamb in a similar way.

Yes we are actively engaged in the planning and preparation for the EU-Transition and have a number of working groups established within the Trust already to look at this. Indeed, we have an Information and Analytical cell, an Operating model cell and linked in with our Operating Unit Managers for the three counties as we can see the effect of this could be wider than just Kent. We have reviewed the risk assessments from the last period and updated these on Datix and have been updating and reviewing all the plans in place for this period that were in place for the last period of EU Exit. As noted in the question the majority of the information is still awaited so the Trust is working to the Reasonable Worst Case Scenarios that have been issued and with our partner agencies within the Kent Resilience Forum and the Kent Resilience Team.

In addition, our Associate Director of Resilience has been in contact with our MOD liaison officers to establish connections should we require the assistance of the MOD. This follows the established process to request any support from the military in our region. The winter period as a whole falls under the Organisational Response Management Group, a cross organisation group, established to provide oversight and coordination during this period.

18.09.20

I would like to inquire as to whether or not you have received sufficient assurances that our Paramedic Practitioner programme will be sufficiently funded in order to carry out all aspects of the role as expected by the trust.

The consultant paramedics have been working with colleagues from the Operations Directorate to review the current position of the PP programme. The levels of staffing and funding are currently out of kilter with the model of care outlined in the OU support documents. Essentially, we were short of establishment, not necessarily funding, because as we lost PPs into other

roles within the NHS and primary care, their posts were converted into alternative clinician establishment numbers. We are now starting to rectify this and have a 3-year plan to increase our establishment and are in discussion with HEEKSS around re-establishing the funding for the education of this group of staff.

In terms of increasing numbers, 22 Student PPs qualify this month (cohort 24). Cohort 25 have a start date of late January / early February 2021 and places have been offered to 24 students.

We now have Practice Development leads in 5 OUs with the aspiration to increase this to cover all our OUs. The PPs remain within operations and therefore line management falls under the operational management structure.

The PP establishment has increased to 131 WTEs from April 2021.

28.09.20

At the AMM I sought further information/assurances about the ongoing difficulties of CFR teams being able to easily access funds from the SECamb charitable account.

I have had a few TLs contact me across the Trust, reporting they still have issues and asking for support, but I have not overall received anything back from Michael Whitehouse who advised he would look into and come back to me.

From MW - At the Council meeting in September you raised with me as Chair of Secamb's Charitable Funds Committee the time it was taking in Brighton to access charitable funds. My apologies for not getting back to you sooner but both David Astley and I wanted to look at this in some depth to understand the issue you raised and how it might be successfully resolved. Firstly, I want to emphasise the great appreciation which the Board and Secamb more widely has for the work and time which Community First Responders and their supporters contribute to both patient care and in raising funds.

It is paramount that those who devote their time and energy to raising money can be confident that this results in real tangible benefits for those whom we serve and the wellbeing of Secamb's people. At the same time however, as I know you appreciate, as a charity we need to ensure that we operate appropriate governance which meets the requirements of the Charity Commission and commands public trust. Inevitably an appropriate balance is needed so that we have reliable controls but ones which are not unnecessarily onerous. It is this which we want to ensure and to help achieve it. David Astley has suggested having a larger meeting of Community First Responders when we can both to thank them for their considerable contribution and achievements and also to explain and consult with them on the overall governance needed so that we get the right balance. This meeting will be arranged shortly. May I finish by thanking you for raising this important issue.

01.10.20

I have had some concerns raised to me regarding the Trusts move from Timpanic Thermometers to the 3M Tempa Dot disposable thermometers.

Could you please ask the NEDs on the Patient Safety Committee for assurance that the switch to these has been thoroughly investigated.

The reservations that have been voiced to me are regarding the time take to get a temperature (compared to the Timpanic Thermometers) and how they are to be used on an unconscious patient.

I have had a conversation regarding this with Andy Collen, and can confirm that I am assured that the move to tempa dot will not have a negative impact on patient care or the staff's ability to ascertain the patients temperature.

02.10.20

Re new website not properly being tested, no mention of membership and how to become a member, links don't work.

After discussion at the MDC the comms team quickly rectified the issues with the membership and Council pages.

07.10.20

I want to know more about SECAMB in detail.

Currently my initial quest is for the following.

- 1. How many ambulance stations and where are they*
- 2. How many vehicles and what type?*
- 3. How many staff in what roles – Paramedics, CFR's, Technicians, PTS staff, EOC staff, Workshop staff, Admin, and support staff and so on*
- 4. Overall cost to run the trust – surplus or deficiency?*
- 5. Staff training strategy?*

Annual Report sent by IA. Our "Staff training Strategy" is still work in progress, as it's been signed off by the Exec, but we are still working on the Business Case

Please find the slide attached which illustrates where we are currently, and if you need any further information, feel free to contact me.

09.10.20

Staff workplace location – potential for remuneration. For some time SECAMB staff have been assisting the trust to reduce the risk from COVID by working from home. This has a beneficial impact upon staff and the trust. However, whilst it may be argued they are saving on travel costs they may also be exposed to a somewhat punitive financial impact and may be facing additional costs albeit hidden in the main.

Question

How confident is the board that due consideration is being taken on behalf of the staff to ensure that;

1. *any staff who are being asked to work from home or are asking to work from home should not be incurring additional costs? Any such arrangements or impositions must not be seen as a benefit nor liability to the trust?*
2. *Is it appropriate for the trust to consider a financial pro rata contribution toward the cost of homeworkers e.g. extra use of utilities - electricity, gas, internet provision, workplace facilities – be that a room or carpet as simple examples? Even down to and including extra water being drawn off on the meter for toilet, tea, hand wash etc? Frankly the consideration list is endless.*

Both questions have been discussed at the New Ways of Working group and with a wider engagement group of managers to develop a plan moving forward for how agile/home working will function, including financial support, arrangements for additional cost in bills etc.

A framework and a project plan for how to get us there dealing both with the intermediate plan and long-term plan has been written up as a paper to the board which was considered yesterday afternoon. Once we have heard back with regards to decisions on this we can provide further detail, this will also be going out to the Trust through wider communications shortly.

09.10.20

Much has been discussed around the suitability of face masks, fit testing, and facial hair. The type of masks has been examined and re-examined. When staff are patient facing the requirement to wear masks and the duration of each wear, appears quite definitive. During other duties staff have been told when /where to wear masks – office, EOC, rest areas, make ready locations and so on. Staff should also be fully aware of any limitations of the masks, the potential limiting factors upon the duration time of any wear, when and how should masks be disposed of? Current guidance should be adequately definitive for all those other non-patient wear times when all staff are repetitively/continuously wearing the masks.

Question.

How confident is the board, if challenged as a consequence of any incident occurring which may be attributable to the methodology of mask wearing and associated guidance that;

1. *the welfare of all staff, the practical application of PPE & RPE regulations and guidance is fully understood and can be adhered to?*
2. *all current guidance provides adequate information to all staff around the wearing time and disposal of masks, including any potential limiting factors upon this type of RPE?*

From Aide Hogan - 1. staff understand the practical application of PPE & RPE regulations and that guidance is fully understood and is be adhered to? - staff undertake IPC training on an annual basis which includes PPE & RPE instruction and we have also kept staff informed of changes due to Covid-19 guidance all the way through the pandemic.

2. all current guidance provides adequate information to all staff around the wearing time and disposal of masks, including any potential limiting factors upon this type of RPE? – all guidance is up to date and follows the national guidance and we escalate any non-compliance through to their local management teams for actioning.

13.10.20

During East Governor Constituency Meeting HP asked about staff wellbeing and what support

had been put in place during COVID.

Throughout the COVID period so far, the following has been implemented with the aim of sustaining and improving the health and wellbeing of our SECamb colleagues:

- Changes to the existing wellbeing pathway was made to give colleagues who had been affected by COVID fast track access to mental health assessments. Appointments were guaranteed to be within 24 hours vs the usual two-week timeframe.
- The Physio's were unable to provide hands on physio however, we adapted our process to allow virtual physio sessions, enabling injured colleagues to receive fast and effective advice from qualified physiotherapists. Exercises would be provided, and the physio would follow up a week later to check progress.
- In addition to virtual physio, the physiotherapist would provide live stretch sessions three times a week to help our colleagues working from home (and anybody else who wished to attend).
- The following webpage was created, highlighting many external support options for a wide range of topics/issues, including depression, sleep, mindfulness, bereavement, and information for managers: Your Wellbeing During COVID Webpage
- A separate webpage was created, dedicated solely to the benefits that NHS workers could access during lockdown, for example food and drink discounts
- We promoted the Headspace app that was providing free full memberships to their app till December 2020. Headspace provides meditation and mindfulness support.
- Wellbeing bulletins were created that provided activities for children and home-schooling support. It also provided useful links to indoor exercise providers, i.e. Joe wicks.
- All colleagues could access the trauma risk management (Trim) pathway as usual.
- The COVID reassignment pathway was created with the aim to provide shielders with meaningful work to replace their front line duties whilst they were at high risk. This enabled colleagues to maintain routine, social skills and stability. It also provided vital support to various areas across the Trust.
- We advertised the use of break out rooms. These were safe spaces for ambulance personnel across the country to meet virtually to discuss their experiences with likeminded people. (This was not organised by SECamb- we simply advertised)

15.10.20

How we are assured that PAPs comply to our PPE guidance and if they are trained in JESIP standards as, as a Trust we have committed to this but I'm not sure if it extends to expectations of PAPs?

As per the standard NHS contract & framework the PAPs must comply to all trust guidance and policies stipulating PPE guidance. In terms of JESIPs principles we have never stipulated this however this can be checked and reviewed upon request.

15.10.20

At the constituency meeting I asked about the effect of COVID testing problems on Secamb and we had a clear reassurance from David that this had been effectively tackled - including via the use of mobile testing units. However, today's Daily update indicates it is affecting front-line performance!

Thank you for asking about access to COVID tests referred to in the daily Common Operating Procedure Report (COP).

My understanding is the situation regarding access to tests and obtaining results is as I reported when we met. There has been a general improvement, but some days are better than others, as our Head of COVID-19 Management Team says below.

When reports have several standardised paragraphs the variability of performance is not always communicated well. I would not expect to know or be advised of small variations in performance in any case.

My understanding is that we have mitigations in place to speed up the taking and analysis of samples for COVID when other available systems cannot do so. I would expect to know if there was a systemic failure and to date, I have not been advised of that. However, I will double check with the CEO when I meet him on Thursday.

3. Recommendations

3.1. The Council is asked to note this report.

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

Nicki Pointer

Lead Governor & Public Governor for Lower East

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	17 September 2020
Overview of issues/areas covered at the meeting:	<p>This meeting was observed by three member of the Council of Governors and had three primary focusses with each one linking directly to the three BAF risks aligned to the committee:</p> <ul style="list-style-type: none">▪ HR Workstreams – BAF Risk 362▪ Workforce Planning and Delivery – BAF Risk 111▪ Clinical Education – BAF Risk 1300 <p>HR Workstreams Update Partial Assurance</p> <p><u>E Time Sheets:</u></p> <p>The committee received the internal audit management letter confirming assurance that we are on course to implement the E-Timesheets project successfully. Specifically, that the intended aims for the project have been clearly outlined and are aligned to wider Trust strategic objectives, and that there is evidence of appropriate stakeholder engagement and project management support, with extensive trials underway to test the robustness of the new system and accuracy of data recorded.</p> <p>Phase 2 of RSM's review will be scheduled to coincide with the completion of the initial trials in order to assess the first roll-out of the e-timesheet system in an operational unit.</p> <p>The committee then heard from management who confirmed the project RAG has moved from Green to Amber, as the pilot for E-timesheet trials has identified a number of risks requiring resolution ahead of go-live. The Executive will hold the Go/No Go meeting, scheduled for the end of October 2020.</p> <p><u>E Expenses:</u></p> <p>The RAG for this project is Amber. From management's perspective this is now ready to be rolled out to operational staff; it is already in use for support services, EOC and 111 staff. There is a meeting planned with staff side to seek their support and then this will happen.</p> <p><u>P Files:</u></p> <p>The RAG for this project is also Amber. The target date for completion remain December 2020 and the committee explored progress to date, and the key issues and risks. It acknowledged the call on staff at present and the many competing priorities and reinforced the importance that we can be assured in the completion of every personnel file.</p>

There have been a verity of approaches and a further change has begun made possible by the new TrustID system; this provides direct document transfer (no need for scanning) and allows staff to send their documents from home, rather than having to bring them in to work. The committee noted that the issue is predominantly about the eligibility of documents, rather than them being missing and/or lost.

An update will be provided to the committee next time on the overall number of files outstanding and the trajectory to December, including driving licenses which is a separate workstream.

Workforce Resourcing & Delivery Partial Assurance

A detailed review was undertaken of this years' workforce plan and the approach going forward to ensure we are fully established. In-year we are circa 40 short against plan. This is impacting the ability to ensure sufficient hours and the underspend against budget (see finance committee report), although the committee did acknowledge the improvement this demonstrates from recent years where the gap was in the hundreds.

A comprehensive paper was also received setting out the different approaches for the rest of this year and in to 2021 and beyond. The committee supported the executive to effectively over-recruit, with the aim of getting nearer the budgeted establishment. It is mindful of the financial risk of this approach and concluded that if it is well planned and targeted to anticipate need, this risk could be managed. This is also acknowledging that currently the gaps are being filled with more expensive resource e.g. PAPs.

Overall WWC supported the approach and thanked the executive for a good set of papers that both described the issues and the solutions.

Clinical Education Not Assured

Firstly, and in the context of the earlier workforce discussion, the committee noted the proposal clinical education is exploring to accelerate the workforce plan.

There was then a wide ranging discussion about clinical education, in terms of the improvement plan, the training plan for the year, and key skills. With regards key skills we are just 5% behind plan which is good given the impact of COVID. There are many elements to the improvement plan, one of which being the actions arising from the Future Quals review. There is good confidence in the actions taken to date, but these are quite narrow in scope. The committee remains much less assured with the overall improvements in the delivery of clinical education, reinforced by the recent issues that emerged that require management review; this is subject to a root cause analysis. The papers did not clearly enough define the issues, the actions taken and then specifically how these actions have changed things such that the shortcomings identified will not recur. Management accepted this and at the extraordinary meeting next month an assurance paper will be received, setting this out.

That said, the committee did acknowledge all the efforts of the clinical education team.

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	<p>The committee explored how staff are feeling and heard that morale is in some areas still quite low, but the management team is doing much to ensure greater awareness of the issues and what needs to be fixed through regular engagement with the staff.</p> <p>There was also a paper updating the committee on the status of the Higher Education Institute (HEI) partnerships and education programmes with which SECAMB is involved and that are managed by Clinical Education.</p> <p>The committee heard that partnerships with HEIs and with HEE remain good despite a very challenging environment over the last 12 months. Changes to senior roles and reporting structures within Clinical Education, the requirements of the Transforming Clinical Education Project Board, the need to suspend SECAMB's placement provision during the first wave of COVID and issues with the in-service recruitment to SGUL have required considerable focus and effort to overcome. Improved staffing within the Higher Education Team provides an opportunity to restore workstreams that have had to be delayed and to improve wellbeing.</p> <p>There was then a discussion about how we might wish to restructure and simplify the relationships we have with the various HEIs, to ultimately assure the committee that we manage education training and development in the most cost effective way.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>Due to the delay the Diversity and Inclusion – Workforce Race and Disability Equality Standard Report could only really be noted by the committee. It is annexed to this report for the Board's considered review.</p> <p>The Board should also note the ongoing Payroll tender; a Contract Board is established, and the committee will receive regular updates.</p>

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor's Report on the Workforce and Wellbeing Committee

Date of meeting: 17/09/2020

Governors present: Marcia Moutinho, Geoff Kempster, Harvey Nash

The following report is from the Governor/s, noting their observations.

1. Prior to the meeting:

The governors attending held an informal meeting with Laurie McMahon prior to the WWC meeting where he explained his desire for the WWC to become more involved in steering the trust and input to strategy rather than simply providing assurance regarding WW activities.

He also went through our role, checked for queries and invited us to review the meeting with him in private once it concluded.

Laurie was very welcoming and his brief explanation of what to expect was very useful.

2. Introductions:

WWC members all knew each other and there were no introductions as such. Laurie advised them that three Governors were observing and named us. He also advised that Al Rymer would have to leave early but that he had already provided Laurie with questions for the latter part of the meeting. Additional speakers / presenters were briefly introduced by name, rather than role title (these were on the agenda). Geoff noted that it was regrettable that those persons involved in the meeting were not introduced to the governors, so that we were clear about their roles in the organisation.

3. Attendance

There were a number of attendees at the meeting. Representing the NEDs were Laurie McMahon, Terry Parking and Al Rymer. There were two Executive Directors: Ali Mohammed and Joe Garcia and the company secretary Peter Lee. There were 9 other SECamb managers attending for all or specific sections of this meeting.

4. Agenda

There was a full agenda and a great amount of reports, plans and other papers provided. It was reassuring to hear the extent of familiarity of both NEDs and EDs with the various documents and it was clear that the NEDs had well assimilated and considered the contents in advance.

The agenda and papers provided prior to the meeting were very detailed and if they were to be studied fully would require a considerable amount of time. Fortunately, they were given to us a few days before the meeting.

It was good to see some of the things that are currently concerning staff being discussed in this meeting.

5. Discussion during meeting

During the meeting the NEDs all challenged the information being presented in a positive and meaningful way. In discussions around Clinical Education, the questioning style, whilst robust, was constructive and engendered a full informative and constructive response.

Discussions throughout were focussed and well-structured. Presentations were clear and all three NEDs asked consistently relevant questions, probing details and challenging thinking and progress on a wide range of issues. The NEDs readily recognised and commended achievements and were consistently constructive when challenging or suggesting alternative or additional actions, covering not just what but why and how SECamb would benefit.

NEDs mentioned Secamb staff various times during the meeting which shows that they have a grasp of what staff normally feel within Secamb.

The use of power point was useful.

6. Chair

Laurie chaired the meeting well, and although some sections, in particular Clinical Education, did over run, the meeting did eventually finish to schedule.

He managed the meeting effectively using a light touch where appropriate, adapting the Agenda order and allowing added time on some items having checked others did not need the full forecast time.

Laurie also allowed people to participate in an organised way without losing the flow of the meeting. He provided pertinent summaries after different presentations which prompted relevant questions and brought different issues to a coherent close.

7. De-brief:

The three Governors and Laurie had a 15-minute discussion where our views on the meeting and topics were welcomed. Laurie made clear that he would value future Governor observations of the WWC and he would welcome any direct Governor ideas or comments on WWC relevant matters via Izzy or Katie.

This discussion was very open and honest and it was evident that Laurie was interested in our views.

8. Conclusion:

The meeting was well run, and the NEDs performed their role in challenging the executive on their actions and decisions without becoming involved in the details.

The current NEDs on the WWC are fully capable and active in holding EDs to account on relevant matters and are doing so in a way that positively contributes to SECAMB performance and future capabilities. As Governors we felt welcomed, involved and valued.

It was clear throughout the meeting that the NEDs want the best for staff and the patients we serve.

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	22 October 2020
Overview of issues/areas covered at the meeting:	<p>This meeting was one of the additional meetings scheduled this year and focussed on BAF Risk 1300 – Clinical Education (partial assurance). The Board will recall that in September the committee confirmed that the paper received then was not able to provide assurance, as it did not clearly enough define the issues, the actions taken and then specifically how these actions have ensured sustained improvement. The assurance paper received this time was really strong.</p> <p>As the Board will know, the issues are complex, but broadly speaking they relate to the management and governance of the education process, rather than the education itself. The committee received a good level of assurance by the progress the team has made in making good the deficiencies. The shift to online is exemplar.</p> <p>The committee tested the depth of understanding by management of what went wrong and why. Fundamentally, there was a lack of understanding of the requirements. This and the action taken to address this was clearly set out in the paper. There is greater expertise in the team now, and while there are still some gaps, there are clear actions in place to ensure every member of staff in the team is sufficiently well qualified for purposes of clinical education.</p> <p>There was a good discussion about the very ambitious recruitment targets and the resources available to deliver, in the context of high levels of sickness and stress within the team. The executive is more confident now the team is almost at establishment, although it is deemed unlikely this will be sufficient to deliver everything. The management team are therefore exploring how they work differently, for example, having more education staff in the Trust, which aren't necessarily clinical education.</p> <p>The committee was really positive about the recent additions to the team and the excellent leadership from Michael Bradfield and Nicola Brooks, in particular. In the past we hadn't really had a good understanding of what is required to run an apprenticeship scheme, this is why we have now outsourced to Chichester College to deliver as they have the skills and experience needed.</p> <p>The committee then explored education more broadly. It noted the various education and training that happens within HART and for our specialist paramedics, some of which is bespoke and not all is managed under clinical education. There are also potential gaps identified, e.g. EOC. The committee wondered whether all education and training should come under one remit, including clinical education. It also explored how management assesses the impact of education and how this flows through the executive to Board. It</p>

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	<p>concluded that we have education across the Trust probably at different standards and using different systems, and so there is likely to be a lack of consistency in education and training. The aim therefore must be to ensure an approach that provides consistency and feels the same wherever it is provided.</p> <p>In summary, the committee received good assurance that the issues from the recent past have been well understood and therefore confidence the improvement will be sustained. However, it is not assured we have a clear strategy for education training and development (ETD), although it did note that the Chief Executive has asked the Executive Director of HR & OD to review this. The committee therefore requested that there is a discussion at the Board meeting in November about the guiding principles for developing an ETD strategy.</p> <p>The committee also reviewed the current position with employee relations (partial assurance). The problem statement is that we have had a culture enshrined in formal processes rather than engagement, understanding, and learning. This is demonstrated by the number of formal grievances we have had.</p> <p>Management confirmed there is still too much formal activity; under development of managers / lack of training; and under investment in professional development of HR staff. The committee explored the new approaches being considered to better manage ER issues, which includes the need to maintain a matrix approach and support to OUs/support services. The vision is that the Trust would like to develop a multidisciplinary forum early resolution model, including a resolution policy and integration plan, to align our core values and strategic principles with our HR processes, management systems and leadership behaviours. The aim of this will be to see an 80% reduction in ER cases across the Trust within a period of 6 months.</p> <p>The committee acknowledged that the ER climate has improved over the last 18 months, evidenced by a reduction in number of compared to 2018. Also, more recently cases are being better monitored through Selenity. However, the pace of change has overall been too slow. It also explored the balance of training need between good investigations and supporting managers to avoid things escalating in the first place.</p> <p>In summary the committee thanked management for the clarity provided of the issues and what has been put in place to-date and the initial thinking of the next steps. The committee will review this again as the proposals are more developed.</p>
Any other matters the Committee wishes to escalate to the Board	None

SECamb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 17 September 2020
	The committee was attended by the Chairman and several additional attendees to present specific agenda items.
Overview of key issues/areas covered at the meeting:	<p>The five remaining management responses were presented, and the Committee were assured that all five papers had provided a satisfactory response to the initial request.</p> <ul style="list-style-type: none"> • Vehicle Strategy (Decision making process inc. Datix incidents analysis)- assured that the Trust is taking account of incidents to inform and change vehicle specifications to address issues whilst conforming to the Carter specification. Evidence of changes to be reviewed in 6 months. • Vehicle Cleanliness. Acknowledging issues in Mar-May evidence that deep cleaning now on target and ATP swab testing show that Trust is meeting vehicle cleanliness standards • Medicines – Analysis of incidents and any emerging issues. Assured that incidents are being analysed and acted upon. Note issue with pouch tagging, which is on the risk register and requested an update from November. • Birthing Centre Transfer Rates – Assured action has been taken on issues identified and a plan put in place. • Quality Impact Assessments of Cost Improvement Plans – Evidence presented of QIA process undertaken. <p>-Discharge by Non-Registered Clinicians was deferred to November's QPS meeting.</p> <p>The meeting considered several Scrutiny Items (<i>where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas</i>), including;</p> <p>EOC Clinical Safety: Welfare Calls Deep-Dive Assured (on progress made) but not on the specific issues of welfare call-back compliance, and clinical tail audits.</p> <p>The QPS noted that work had been done to ensure clinical safety and this had improved over time. Despite progress in appointment to vacant positions there was concern regarding establishment figures but cover for the vacancies had been put in place where possible with an aim to reach full establishment.</p> <p>There was also a concern around secondments; the committee asked Executives identify the mission critical roles to help prioritise where resources are needed the most.</p> <p>Welfare call-back compliance and clinical tail audits continue not to meet the required levels. The committee was briefed on the updated Welfare Procedure that is out for review. It includes a supporting escalation process for clinical intervention when required to maintain patient safety and comply with relevant legislation, regulation and guidance.</p> <p>Review of the 111/CAS Clinical Model - Assured</p> <p>The Committee noted that a temporary electronic prescribing system (EPS) was required and all risks surrounding the solution had been noted and full governance had been adhered to.</p> <p>It was acknowledged that patient experience would be impacted by the temporary EPS it</p>

	<p>will require more than one hand-off so the Trust will seek to develop a transition plan over the initial period for a more streamlined process.</p> <p>The timing of the launch coincides with the Covid-19 pandemic and the national message for people to call 111 before attending A&E. This will add pressure to the system.</p> <p>Clinical Outcomes: Frequent Callers - Assured</p> <p>This was a very good paper demonstrating committee was assured that there is a skilled team in place to manage Frequent Calls to the 999 service, which will be aligned to 111; issue of staffing escalated to the Executive. There is a patient first approach which balances needs of the patients with resources constraints of the Trust. Frequent callers represent a significant cost to the Trust</p> <p>There was a clear patient approach, and the impact of Covid-19 on Frequent Caller contacts was noted.</p> <p>Specialist Paramedics: CCPs – Requested updated paper for November meeting</p> <p>The paper did not provide the assurance and evidence expected so an outline of the content requirements would be shared with the CCP Lead and an update presented at November's QPS meeting.</p> <p>The Committee was able to review the Governance Report from the last quarter and receive verbal assurance that services are compliant with legal requirements and are safe. Governance processes are embedded for example, Patient Group Directives (PGDs), policies and procedures and clinical management plans. The Chairman suggested sharing CCP specific patient stories, and other themed experiences, for Trust Board meetings.</p> <p>Safety of Discharge – Partially Assured</p> <p>The clinical audit for Safety of Discharge was reviewed and the committee was partially assured as the Trust target is not being met. It noted that this area of work was referenced in the Quality Account 2019/20 and would be the first Quality Improvement (QI) project following a QI methodology. It was agreed that messaging around compliance / non-compliance required a refresh to provide some clarity of meaning.</p> <p>A recommendation was made to reconsider the safe discharge target rate of 100%.</p>
	<p>There were four items for review under Monitoring Performance.</p> <p>All three annual reports were discussed and commended to the Board subject to updates in parenthesis below.</p> <ul style="list-style-type: none"> • Incident/Serious Incident Annual Report [<i>include aged SI work, clarify Duty of Candour for moderate harm, include plan to make SI's more visible at Board level</i>]- noted change in incidents sub-categories from 18/19 to 19/20, more low acuity incidents being reported, delays accounting for over half of SI's and that 44.3% breached the submission deadline which whilst not satisfactory improves greatly on 81% the previous year. • Controlled Drugs Accountable Officer (CDAO) Annual Report – noted that Trust has met legal and statutory requirements, good level of incident reporting and that the CD licence was issued in August (delayed due to COVID and Home Office visit that is still outstanding). The committee noted challenges with the Omnicell software being fit for purpose and paper-based sites needing to move to a more technical solution.

	<ul style="list-style-type: none"> • Complaints (Patient Experience) Annual Report - noted this was supported by the patient experience internal audit report (Data Quality & Complaints). The Committee noted the Data Quality and Complaints Internal Audit Report July 2020 as independent validation, there were 2 compliments for every complaint in 19/20; that there was an issue with timeliness of response in 19/20 of 63% on time but received assurance that this is now at the 90% level. <p>In addition, an update on the Quality Account 2019/20 was received and this will be submitted to November Board for approval.</p> <p><i>Governance and Risk Management:</i></p> <p>Bi-Annual Review of High/Extreme Risks</p> <p>A full review of risks aligned to QPS was postponed and a new date is to be confirmed. In the meantime, the committee considered the key quality and patient safety risks, and asked the executive to review the risk on the risk register relating to 111/CAS to check the rating and to ensure it considers EPS as well as review the Welfare Call-backs/tail audits risk.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>There were three items under AOB:</p> <ol style="list-style-type: none"> 1. PPE/FIT testing – an update was received on the current position and a business case is due to be presented to the Trust Board 2. Thermometers – the committee was briefed on the governance process followed to consider withdrawing personal issue tympanic thermometers (due to anticipated supply chain issues) and replacing them with Tempadots and how patient safety issues raised by staff have been considered. The committee was satisfied that the correct process had been followed and that the subsequent patient safety concerns had been taken into account. 3. The need to discuss options that may need to be considered to provide additional resource to improve performance in the near future were flagged to the committee.
<p>Effectiveness</p>	<p>Members noted that the quality of papers had been good.</p> <p>There was a recommendation for authors to consider the potential external audience when writing their papers.</p>

SECamb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 19 November 2020
	This meeting was observed by members of the Council of Governors.
Overview of key issues/areas covered at the meeting:	<p>There was one management response, which the committee had requested following a report in September on safety of discharge (paternal assurance). It was specifically concerned with the arrangements for discharge by non-registered clinicians. The paper demonstrated there has been a good examination of the issues raised by the committee, and there was good evidence related to recontacts and discharges at scene where shared decision making is required. However, the committee was concerned with compliance against standard 6 (shared decision with an experienced paramedic or ECAL clinician will take place). The data shows that there were a number of incidents where shared decision making did not take place. A re-audit is due in the summer 2021 and the committee has asked the medical director if this could be brought forward.</p> <p>The meeting considered several scrutiny items (where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas), including;</p> <p>Section 136 Transfers Assured</p> <p>The committee was pleased to note the significant progress that has been made in ensuring people detained under section 136 of the Mental Health Act who require an ambulance, receive a timely response. Acknowledging the historical issues, particularly in Sussex, a good update was provided to clarify the reasons for this and how the approach to data collection is expected to help ensure resolution. Finally, the committee really welcomed the steps we are taking in support of our blue-light partners to reduce the overall incidences of section 136.</p> <p>EOC Clinical Safety Assured</p> <p>Although they are linked, three separate papers were received to help draw out the specific issues:</p> <p>1. Application of the surge management plan</p> <p>The committee explored the actions the Trust takes during periods of high demand and the reviews undertaken following these periods to understand any clinical harm which may have occurred.</p> <p>Firstly, the committee received good assurance by the well thought through surge management plan. Management has set clear criteria and decision making processes, with good communication, as there is a need to move through the different levels of the plan. It is a well-established and governed process.</p> <p>It is also reassuring that we have routine harm reviews and the committee noted that no harm has been identified.</p> <p>Overall, the committee is assured that plans are in place and enacted when we are unable to meet demand, and this helps to ensure patients with greater need are prioritised. There is a clear decision making process, with triggers on a real time basis. In addition, no send and clinical tail audits are up to date which is important to ensure we learn lessons.</p>

2. EOC clinical recruitment

We now have greater clinical capacity and support in the EOC than at any time in the past. The committee received a good paper that gave assurance that this is areas with real focus. The improvement is also down to the really good partnership working between operations and HR. . The committee questioned the risk on the low staffing levels for midwives and mental health practitioners, and received assurance that these were mitigated due to the integrated nature of 999 with 111, whereby these practitioners could be accessed if needed.

3. EOC welfare call compliance

The committee has kept welfare call compliance under close review over the past 12-24 months and, linked to the improved clinical support in the EOC, is really pleased to see the improvement over the past couple of months, specifically in terms of compliance with the standards we have set.

At this meeting it explored not just levels of compliance but the impact on patients, e.g. to what extent does compliance result in better patient outcomes and experience. While the data is showing that we are currently demonstrating full compliance, the committee noted some caution; both in terms of ensuring the quality of the data and the risks we have upcoming with the usual and exceptional winter pressures. It has therefore requested the following:

- That there is some independent validation of the data
- That the revision of the welfare call policy comes to the committee to ensure any changes (specifically to reducing frequency) have clear clinical rationale and governance.

Review of the 111/CAS Clinical Model **Assured**

The committee asked for this update to specifically test whether the introduction of this new modified service has been mobilised safely. It requested for example data on any rise in incidents or complaints.

As the Board knows, the service was mobilised from 1 October, with an interim solution to electronic prescribing. As expected, this has resulted in some inefficiency, which mostly impacts the patient experience, due to additional touchpoints. Work is progressing to address this through delivery of the scheduled permanent solution.

Since 1 October there has been one serious incident, but this is not related to the introduction of the new service. Reported incidents were initially high, due to the need to capture all the issues, but now the service is mobilised, we are seeing similar patient care-related incidents as before. In terms of patient feedback, the committee noted that we have received much positive feedback through patient surveys and there has been no relative increase in complaints.

Overall, the committee is assured that the mobilisation of this new service has gone as well as we could have expected. However, call answer performance is not where we want it to be, and the electronic prescribing service is still outstanding, as this hasn't been signed off by NHS Digital, and the work-around takes additional time and effort. This is particularly frustrating as there will also be increasing pressure on the service through December, which is also when Think 111 First is rolled out across the country.

HART: Governance **Assured**

There was a thorough review of the HART team, which demonstrated good adherence to the mandated standards, full establishment and up to date training. The committee noted that the annual NARU audit is deferred to 2021, due to COVID. There was also a sense that HART is increasingly productive and more integrated, which is really positive.

	<p>Critical Care Paramedics (CCPs) – Scope of Practice Partially Assured</p> <p>The committee explored the CCP role, structure and governance processes in place for CCPs. It noted that CCPs have access to 24/7 consultant physician support ('top cover') and that there is a good training programme, full establishment, good peer support and welfare arrangements. However, it was only partially assured as the paper did not fully set out the design and effectiveness of the governance processes and the committee also wanted to see the outcomes of the audits. It has asked for this to come back as a management response.</p> <p>Paramedic Practitioners (PPs) – Scope of Practice Partially Assured</p> <p>There was a detailed review of the governance processes that enable safe patient centred care by the Paramedic Practitioner's (PPs), including the status of the PP programme, the risks, issues, development goals and overarching safety and effectiveness profile.</p> <p>The committee received some good assurance about the reporting lines, clinical governance arrangements and scope of practice. However, it asked for a management response to respond to a number of questions posed by committee members, relating to areas such as non-medical prescribing; training needs (see the section on 'other matters' below); use of medicines; and how we are engaged with COVID virtual wards.</p>
	<p>There was just one item under monitoring performance, and this was the 2019/20 Quality Account. As the Board knows, publication of all NHS Quality Accounts was deferred to December 2020 due to COVID. Noting that this year there is no external audit review, the committee acknowledged the good engagement there has been with internal and external stakeholders in the development of the Account. It provided some specific feedback but otherwise recommends this to the Board for publication next month.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>Under any other business the committee considered the planning for the transferring of critical care patients between hospitals. An update was received on the plans that had been put in place to support this activity which involves transportation only; patient care which will be provided by the hospital.</p> <p>Emerging from the items considered at this meeting was the need for (clinical) education and training, reinforcing the need to have a single education offering. The committee notes this is an issues also identified by the workforce and wellbeing committee.</p>

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor's Report on the QPS Committee

Date of meeting: 19 November 2020

Governors present: Harvey Nash, Marcia Moutinho, Chris Burton & Amanda Cool

The following report is from the Governor/s, noting their observations.

1. Prior to the meeting:

We were provided with all relevant papers in advance and given the number of changes to the agenda Leane provided an updated agenda and zip file with all documents in agenda order the day before. Lucy Bloem (QPS Chair) invited us to an on-line briefing two days before. This was very helpful in our understanding the purposes and remit of QPS and the main topics for the coming meeting.

2. Introductions:

The Chairman said that a number of Governors would be observing and invited us to introduce ourselves briefly. Marcia, Chris and Harvey did so. Aside from that plus apologies and where someone was covering for a full member, there was not a 'round the table' introduction (NB there were 25+ expected participants) – rather the Chair introduced the speakers for each topic.

3. Attendance:

Exec Dirs: Bethan Eaton-Haskins, Emma Williams (vice Joe Garcia), Fiona Moore, Ali Mohammed, Peter Lee and David Hammond.

NEDs: David Astley, Lucy Bloem (QPS Chair), Terry Parkin and Tom Quinn

4. Agenda:

Seen in advance and provided with an updated version prior to the meeting. Very full.

5. Discussion during meeting:

Inputs from Execs and others introducing items were clear and focussed. The NEDs participated well asking relevant questions and probing issues. Particular points noted were:

- Those with most experience on the Committee were the most involved at this meeting. Well informed on agenda topics, asking pertinent questions, seeking assurance, raising concerns and seeking actions consistently well. Useful business-wide observations and views from outside the organisation were put forward. Inputs were pertinent, focussed and delivered with conviction.
- For one NED it was their first QPS meeting and while they made relatively few inputs in the first part of the meeting, largely seeking clarity, they were much more engaged and probing on latter matters especially around HART and Paramedics where they had informed experience and knowledge, as well as on welfare and well-being issues.

6. Chair:

The Chair was excellent, controlled and moved the meeting on as necessary with an involving style, ready praise for good work and some humour. Clearly understands QPS and well at home with relevant activities / projects / reports. Ensured topics fully explored and appropriate colleagues involved, with actions assigned and reporting back clear. Summarised topics, at their conclusion, very effectively. Clear succinct questioner, able to cut to the chase when appropriate.

7. De-brief:

This was readily offered by the QPS Chair during the pre-brief. It was impractical at the end of the meeting as there was an entirely justified 15 minute overrun. Having reflected on the meeting and compiled this report we are satisfied that a de-brief is unnecessary on this occasion.

8. Conclusion:

We were fully satisfied that the NEDs are effective in questioning, influencing and getting assurance on QPS matters. The meeting was very well run and effective.

SECAMB Board

Summary Report on the Audit & Risk Committee

Date of meeting	10 September 2020
Overview of issues/areas covered at the meeting:	<p>The key areas covered in this meeting were</p> <ul style="list-style-type: none"> ▪ Progress with the Internal Audit Plan ▪ The Trust's response to COVID-19 ▪ Business Continuity Planning Incl. EU Transition ▪ Governance of 111 CAS ▪ Declarations of Interests (DOI)
Internal Audit Plan	<p>The Internal Audit reports continue to provide good assurance, specifically in this reporting period for the following areas:</p> <ul style="list-style-type: none"> ▪ Complaints / Data Quality – the Board will see from the Patient Experience Annual Report that while there have been challenges with timeliness, this has improved since the end of 2019/20. ▪ Governance & Risk Management – the committee is really pleased with the improvements in this area and supports the executive's plan to develop our approach to risk management further. ▪ Financial Governance & Sustainability during COVID – this review concluded substantial assurance with how decisions have been made during the crisis. <p>There was also a positive advisory review related to the planning for the E-Time Sheets project. This is covered in the report from the Workforce & Wellbeing Committee.</p>
COVID-19	<p>The committee noted that the governance for the response to COVID continues to be strong, as reported to the committee and Board previously. The management group has however broadened its scope to ensure we respond effectively to the winter pressures, which this year includes COVID and a potential second wave, and EU transition.</p> <p>There was an update on the new COVID Recovery Learning and Improvement Group, which is described as a think tank aimed at helping to develop workstreams which will then follow usual governance and ensure good alignment with the Trust's strategic direction. The committee reinforced that it exists to promote good governance as an enabler of innovation, so the outputs of this Group is really important.</p>
Business Continuity Planning / EU Transition	<p>The committee sought assurance that we have the right business continuity processes in place. It is confident with the overall planning and confirmed there are the range of BC plans in place. In terms of the risks to service deliver arising from the end of the EU transition period in January, these are well rehearsed from the planning last year and system planning is starting to ramp up.</p> <p>The committee asked that an update be provided on this to the Trust Board, to include winter planning more broadly, given the number of issues that are likely to make winter really</p>

	challenging.
111 CAS	This is also an agenda item for the Trust Board, and what the committee specifically explored was the governance arrangements with the sub-contractor. As some of this is commercially sensitive a separate update will be provided in part 2.
DOI	The paper provided good assurance that we are doing all we should be with regards the management of interest. This was supported by the view of Internal Audit who through Counter Fraud helped to design our policy.
Risk Management / BAF	<p>The committee supported the approach to risk management as outlined above and reviewed some of the specific risks aligned to the committee.</p> <p>As confirmed to the Board in July, the committee is assured there is a good risk management process in place.</p>

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	10 September 2020
Overview of key issues/areas covered at the meeting:	<p>The meeting considered several Scrutiny Items (where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas), including;</p> <p>999 Operational Performance Partial Assurance</p> <p>There was a detailed review of the improvement plan, in particular the abstraction assumptions, the related actions and the reasons why the expected impact has not materialised. The committee accepts that many of the assumptions were reasonable, but despite this there has been more sickness, annual leave, some shielding staff that have moved to alternative duties, in addition to staff being taken off the road following a COVID risk assessment. Sickness is a really difficult issue in the circumstances, compounded by national policy due to COVID resulting in management being unable to manage individual sickness as they ordinarily would do. There is an expectation that this will be rescinded by the end of September when usual sickness management policy can be re-enacted. The committee noted this is an issue for all Trusts, not just SECAMB.</p> <p>For those staff on alternative duties, due to risk assessment and/or personal anxiety, the introduction of personal issue powered hoods should remedy this. The committee received a business case for this which it recommends to the Board.</p> <p>The executive are rightly focussed on the immediacy of improving hours from existing resources, and the committee asked that the current improvement plan be updated to focus on the key actions that will deliver most benefit, and then to update the trajectory as the current trajectory is unachievable.</p> <p>However, taking a broader view of the challenge to ensure sufficient hours, the committee acknowledged that we do not have enough people, reinforcing the short term nature of the improvement plan. To ensure we are more resilient in the longer term we need to address the structural gaps; this relates to things like our operating model and how our rotas work. The committee noted the steps being taken to examine the structural issues, and challenged the executive to develop a robust plan, with timeframes. The committee is concerned that until this is in place, we will continue to recruit to a sub optimal system.</p> <p>Finally, the committee reviewed the current performance compared with other ambulance trusts and noted that we are not an outlier.</p> <p>In terms of assurance, the committee is confident the executive is giving this the right level of focus, but there is much work to do to improve our performance against the ARP standards.</p>

111 / CAS Mobilisation Assured

A good update was provided on the progress to mobilisation of this new service on 1 October 2020, including the Go / No Go Plan. The main issue was electronic prescribing and specifically getting Cleric accredited by NHS Digital in time. Plan B is to use IC24's system, but at the time of the meeting there was confidence in getting the accreditation. (Subsequently this has moved on and the Board will receive a separate update about this at the meeting).

There was then a discussion about 'Think 111 First' which systems are starting to roll out now, with a long stop date of 1 December 2020. The committee noted the governance in place to ensure this is done safely, via NHSE, and explored some of the risks.

In part 2 the Board will be asked to consider the Go / No Go Plan, and the financial plan.

Winter Planning Assured

A comprehensive paper was received setting out the plan. The committee was confident the plan is comprehensive, noting that there are separate plans relating to EU transition, which will be reviewed at the Audit & Risk Committee.

PMO Partial Assurance

The committee received an update on work and structure of the PMO and how it supports the organisation.

An action was agreed to provide assurance that PMO supports *all* projects (save for projects where specific expertise is procured, e.g. 111 CAS) and that staff follow the related governance process. Until then the committee could only be partially assured.

The committee also received reports under its section on *Monitoring Performance*, including:

Financial Performance M4/Forecast

There is good confidence in the current financial performance. M5 is similar to M4 in that we are on plan for a breakeven position.

Key issues include an underspend in the operations pay budget, for the reasons set out earlier, linked to provision of hours, and a gap in the cost improvement programme.

The main financial risk relates to the Trust's underlying position.

Business Cases

The powered hoods business case has been mentioned above, and the committee recommends this to the Board. This will significantly mitigate the staff safety and abstraction issues (fit testing) seen during COVID. The committee noted that since 11 February we have completed over 14,000 fit tests.

A second business case was considered, relating to the Banstead MRC. This aligns with the estates strategy and capital programme and is recommended to the Board.

	Both business cases will be received by the Board in part 2, due to commercial sensitivities.
Any other matters the Committee wishes to escalate to the Board	<p>It is suggested that some time is set aside at the Board development session in October, to explore the 999 structural issues that require a transformational approach.</p> <p>The Board should also note the significant challenges expected this winter, with a potential second wave and EU transition overlaying the usual winter pressures.</p>

SECAMB Board

Finance and Investment Committee Escalation report to the Board

Date of meetings	12 October and 12 November 2020
	<p>Since the last Board meeting the committee has met twice. The meeting in October was an extraordinary meeting, which was also attended by the Chair and the Chief Executive. It was scheduled to focus on the 999 improvement plan, and also received two business cases. These required 'urgent decisions' provided by the Standing Orders and are included in Part 2 for ratification.</p>
Overview of key issues/areas covered at the meeting:	<p>At the meeting in October the committee explored the steps being taken to improve the provision of front line hours, as part of the specific 999 improvement plan. This included a trajectory, which demonstrated a concerning loss of on-day planned hours, e.g. self-isolation and short term sickness.</p> <p>The committee focussed on the key actions within the plan, and specifically what impact they have had and expected to have during the next period. It was assured by the increasing level of understanding there is about the issues and how best to address them, although there are few simple fixes.</p> <p>One of the most challenging issues the executive has considered is the position with key skills and whether to pause or even cancel this for the remainder of the year. The committee recognised the difficult balance of risk and supported the decision that was taken to continue with this.</p> <p>The range of actions in the plan include supporting clinical staff not in patient facing roles to take some shifts, which includes two of the executive board members, and increasing the provision of private providers; itself not as simple as it might appear due to the limited resources available in the region.</p> <p>The committee also explored the longer term strategy and actions, such as a rota review, and challenged the executive to ensure this receives the right level of focus and priority. It will support management to develop a longer term plan during Q4. The committee reinforced that the earlier the planning can be undertaken the greater the ability to test planning assumptions and ensure that all impacts are considered.</p> <p>In summary, the committee is assured that the measures are helping to maintain performance but acknowledges how fragile this is in terms of any changes in demand.</p> <p>The planned meeting in November considered several <i>Scrutiny Items</i> (where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas), including;</p> <p>999 Operational Performance Partial Assurance</p> <p>Following on from the meeting in October the committee tested the key actions within the plan and was as assured by the grip and focus being given. It acknowledged the strong performance within the EOC, in particular with call answer performance</p>

standards being met (one of the best performing compared with other ambulance trusts), which is all the more impressive given we were providing mutual aid support to Yorkshire Ambulance Service.

The committee noted that the provision of hours and related performance had improved over recent weeks and explored the reasons, which included better management of absences and annual leave. Performance has improved in comparison with our peers, save for in Cat 4.

There was also an exploration of the principal risks over the next period, both internal and external, e.g. COVID impact, EU Transition and staff fatigue in front line and support / management services. The committee specifically challenged management to ensure it distinguishes between the actions that are short term (not sustainable) and longer term (sustainable), in the context that we are not holding anything in reserves.

The committee is assured that management is doing all it reasonably can to maintain performance. The committee acknowledges that the structural changes need to ensure sustained improvement over time will take time and so over the next few months it is unlikely performance will improve. Therefore, all the effort will be in ensuring as safe a service as possible during what will be an uncertain and challenging period.

111 / CAS Mobilisation Assured

A review was undertaken by management to learn lessons from the mobilisation and the committee noted that there were no major issues to escalate. Some of the learning included to ensure the right level of resource at beginning to ensure greater understanding of the likely risks and issues, in addition to the commercial considerations.

The executive will use these lessons in its consideration of future (new) services, the first of which is potentially PTS, which the Board will consider following the market event in December 2020.

The committee congratulated the executive and everyone else who was involved in the mobilisation of the new clinical assessment service for delivering this so well especially during the Pandemic.

Capital Programme Plan – Development & Delivery Assured

The Committee noted the status of the Capital Programme and the changes required as part of the Five-Year Plan that is currently being developed. It is a substantial capital programme, which unsurprisingly identifies a funding gap over the five years, in particular years 3-5. The committee confirmed that it is quite normal to have an indicative plan for years 3-5 with related decisions to be taken at the time.

Fleet Strategy Delivery Plan Partial Assurance

There was a review of the fleet delivery plan, including the factors that influence the Vehicle Relief Rate (VRR) as a core indication of fleet system efficiency, and the planned activity.

	<p>While the paper was helpful it did not quite set out the levers that need to change to improve the VRR, which is currently quite far adrift of the target. The committee acknowledged that the new fleet management system is now starting to provide the information needed to assess vehicle usage (ideally we require at least 12 months to ensure the data is reliable enough to make well-informed decisions) and management confirmed that there are processes in place to ensure efficient deployment, although full assurance could not be given that this is always the case.</p> <p>The committee was partially assured. This is an area the Trust hasn't focussed on for a long time so what we are seeing is better awareness and the next step is to resource correctly to ensure the right actions can be taken.</p> <p>There was just one item under monitoring performance, and this was a review of the finances at month 6 and the financial planning for the remainder of the year.</p> <p>Month 6 is in line with the previous five months and we are on plan to achieve a breakeven position. There is at month 6 a net underlying underspend in the operations budget, due to hours being below the planned levels, and this partly offset by more expensive resource, e.g. PAPs.</p> <p>A verbal update was provided on the Month 7 position, which was being finalised at the time of the meeting. The underlying themes are the same as previous months. The main difference is that as we move in to the second half of the year, the 'top up' funding ceases; we will now fall within the ICS. The agreed fixed level of funding matches our projected spend with a reserve held at ICS, which we expect will cover reasonable COVID spend, although this is not certain. The plan we have submitted for the second half of the year shows a provisional gap (related to issues like COVID) and the committee explored these items noting the related risks. It will continue to keep a close eye on this over the coming weeks and months.</p> <p>There was a separate paper on COVID spend and the committee acknowledged the substantial assurance provided by Internal Audit, which demonstrated appropriate spend (see Appendix A). The committee noted that the paper referenced some of the business cases now require revising, as when they were approved, they were for a specific period of time due to the uncertainty over how long the pandemic would last. The executive assured the committee that this is in progress.</p> <p>The committee also consider the Medway MRC Full Business Case. This is recommended for approval by the Board, following the outline case the Board approved earlier in the year. This is in part 2 due to commercial sensitivity.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>The committee received a new commissioning contract report, which will become a regular report to update the committee on the Trust's NHS commissioned contracts and services and any ongoing discussions or escalations with providers and/or commissioners. Its aim is to provide assurance of effective contract management, and to provide an alert function of early awareness of potential issues or decisions that may arise. This will link to the horizon scanning report the Board will receive from November, in part 2.</p>

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Governor's Report on the FIC Committee

Date of meeting: 12 November 2020

Governors present: Harvey Nash & Brian Chester

The following report is from the Governor/s, noting their observations.

1. Prior to the meeting:

While there was only 3 days notice of our observation, attempts were made to provide the plethora of papers the FIC was to consider. Unfortunately many were for the September meeting and others arrived very late. There was no contact before the meeting from the FIC Chairman.

2. Introductions:

The Chairman said that Brian and I would be observing. Aside from that there was little introduction – participants knew each other and generally used first names.

3. Attendance:

Exec Dirs: Philip Astle, Emma Williams (vice Joe Garcia), Peter Lee and David Hammond.

Supported by: Linda Unwin, Richard Quirk, Philip Astell, Justine Buckingham plus others

NEDs: David Astley, Howard Goodbourn (FIC Chair), Michael Whitehouse and Lucy Bloem

4. Agenda:

Harvey Nash never saw the agenda for this meeting, though a copy did reach Brian Chester late on. It was however clear that the agenda was very full.

5. Discussion during meeting:

Inputs from Execs introducing items were clear and focussed and all the NEDs participated fully asking relevant questions and probing issues. Particular points noted were:

- Good clear relevant measured interventions and questions. Balanced views on options showing political as well as business awareness. Made useful practical suggestions (e.g. on briefings)
- Clear questions, able to cut to the chase when appropriate.
- Provided useful practical overviews, linking topics and setting direction where appropriate.

6. Chair:

The FIC Chair also asked informed pertinent questions and facilitated effective NED questioning and responses, pushing for fuller replies where needed (all the NEDs did this at times). He managed the meeting to time, closing items promptly without detracting from coverage – meeting finished on time despite

the vast number and complexity of items covered. It was a pity that throughout the meeting Howard was not on video (as were a number of other participants from time to time). We also had input from Ian from a moving taxi and then station forecourt, without video and with a lot of interference and cut-out on audio. This all made it more difficult for us to identify who was speaking especially during quick exchanges. There was an undertaking from Execs to try and avoid having inputs from taxis in future!

7. De-brief:

None.

8. Conclusion:

We were well satisfied that the NEDs are effective in questioning, influencing and getting assurance on FIC matters. The meeting was well run and effective.

The short notice for our attendance perhaps explains the issues with our getting papers, agenda, etc, certainly all the NEDs had received and familiarised themselves with these. That said it was unsatisfactory. More so, for us as observers, was the absence of any pre or post meeting contact with the Chairman, together with his, and others' audio-only presence. A pity given how well the meeting ran.