



Council of Governors Meeting to be held in public

7 December 2021 10:00-12:30 held online (MS Teams)

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Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
47/21	10:00	Chair's Introduction	-	-	David Astley (Chair)
48/21	-	Apologies for Absence	-	-	DA
49/21	-	Declarations of Interest	-	-	DA
50/21	-	Minutes from the previous meeting, action log and matters arising Annual Members meeting minutes	A A1 A2	-	DA
Statutory duties: performance and holding to account					
51/21	10:10	Chief Executive's report	B	To receive an update from the CEO	Philip Astle (CEO)
Statutory duties: member and public engagement					
52/21	10:30	Membership Recruitment and Engagement Report	C	Information	Brian Chester (Public Gov. for Upper West)
Committees and reports					
53/21	10:35	Governor Development Committee Report:	D	Information	Harvey Nash (Public Gov. for Lower West)
54/21	10:40	Governor Activities and Queries Report	E	Information	Harvey Nash
Statutory duties: performance and holding to account					
55/21	10:45	Assurance from the Non-Executive Directors: - Integrated Performance Report (October data as presented to Board in November)	F	To take as read – queries to NEDs to be taken under escalation reports	DA



56/21	10:50	<p>Board Assurance Committees' escalation reports to include the key achievements, risks and challenges:</p> <p>Performance Committee</p> <ul style="list-style-type: none"> - 19 August 2021 - 16 November 2021 <p>Workforce and Wellbeing Committee</p> <ul style="list-style-type: none"> - 14 October 2021 <p>Quality and Patient Safety</p> <ul style="list-style-type: none"> - 16 September 2021 - 18 November 2021 <p>Finance and Investment Committee</p> <ul style="list-style-type: none"> - 9 September 2021 - 11 November 2021 - FIC Governor observation report <p>Audit Committee</p> <ul style="list-style-type: none"> - 23 September 2021 - Audit Governor observation report 	<p>G1</p> <p>G2</p> <p>G3</p> <p>G4</p> <p>G5</p> <p>G6</p> <p>G7</p> <p>G8</p> <p>G9</p> <p>G10</p>	Holding to account, assurance and discussion	All Non-Executive Directors present
11:15 Comfort Break					
57/21	11:20	Presentation of the KPMG annual audit report of the Trust	H	Assurance	Ben Lazarus KPMG Director Public Sector Audit
58/21	11:35	Board Committee scrutiny: Audit Committee and Finance and Investment Committee Terms of reference and agenda frameworks included with papers	I1 - I4	Information and discussion	Michael Whitehouse (Chair of AuC) & Howard Goodbourn (Chair of FIC)
General					
59/21	12:05	Any Other Business (AOB)	-	-	DA
60/21	12:15	Questions from the public	-	Accountability	DA
61/21	-	Areas to highlight to Non-Executive Directors	-	Assurance	DA
62/21	-	Review of meeting effectiveness	-	-	DA
		Date of Next Meeting: 3 March 2022	-	-	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 – 3 September 2021

Present:

David Astley	(DA)	Chair
Geoff Kempster	(GK)	Public Governor, Upper West
Brian Chester	(BC)	Public Governor, Upper West
Leigh Westwood	(LW)	Public Governor, Lower East
Nicki Pointer	(NP)	Public Governor, Lower East
David Escudier	(DE)	Public Governor, Upper East
Colin Hall	(CH)	Public Governor, Upper East
Sian Deller	(SD)	Public Governor, Upper East
Harvey Nash	(HN)	Public Governor, Lower West
Nigel Robinson	(NR)	Public Governor, Lower West
Marcia Moutinho	(MM)	Staff Governor (Non-Operational)
Chris Burton	(CB)	Staff Governor (Operational)
Sarah Swindell	(SS)	Appointed Governor – EKHFT
Howard Pescott	(HP)	Appointed Governor – Sussex Community Trust
Vanessa Wood	(VW)	Appointed Governor – Age UK

In attendance:

Philip Astle	(PA)	CEO
Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee
Laurie McMahon	(LM)	NED and Chair of Workforce and Wellbeing Committee
Subo Shanmuganathan	(SS)	NED
Paul Brocklehurst	(PB)	NED
Michael Whitehouse	(MW)	NED and Chair of Audit Committee and Senior Independent Director
Peter Lee	(PL)	Company Secretary
Chris Gonde	(CG)	NExT Director
David Hammond	(DH)	Deputy CEO and Chief Operating Officer
Ali Mohammed	(AM)	Director of HR & OD
Fionna Moore	(FM)	Medical Director

Apologies:

Chris Devereux	(CD)	Public Governor, Upper West
Was Shakir	(WS)	Staff-Elected Governor (Operational)
Amanda Cool	(AC)	Public Governor, Upper West
Nigel Wilmont-Coles	(NC)	Staff-Elected Governor (Operational)
DCC Nev Kemp	(NK)	Appointed Governor – Surrey Police

Minute taker: Isobel Allen – Assistant Company Secretary

31. Introduction

- 31.1. DA welcomed everyone to the meeting.
- 31.2. He outlined the agenda for the day and set out the ground rules for the meeting.

32. Apologies

32.1. Apologies were noted as above.

33. Declarations of interest

33.1. No additional declarations of interest were made.

34. Minutes and action log:

34.1. The minutes were taken as an accurate record.

34.2. The action log was reviewed and updated.

35. Membership recruitment and engagement annual report

35.1. BC introduced himself. He described the role and responsibilities of the Membership Development Committee (MDC) in respect of membership communication, engagement and recruitment.

35.2. He noted that COVID had impacted our ability to get in touch with members directly during the year.

35.3. Membership numbers for the past year had risen slightly and the paper contained a detailed analysis of the composition of the membership.

35.4. The MDC had assisted in planning the Annual Members Meeting and he asked members to attend this afternoon's meeting.

35.5. He gave an overview of the MDC's activities during the year. He noted the focus on increasing representation from people with disabilities, and asking Governors to utilise Patient Participation Groups to encourage more people to join the Trust and connect with local communities. He advised that Governors were members of the Inclusion Hub Advisory Group (IHAG) which was a group comprising public FT which advised SECamb in its work.

35.6. He noted that the Staff Engagement Advisory Group (SEAG) had Staff Governors on their standing agenda to share what was happening at Council and canvas views. The SEAG was also looking at new ways of working and improving management and leadership training.

35.7. The Patient Experience Group had two Governors on their group to help move things forward.

35.8. BC thanked all members, staff and public, for their continuing support for the Trust.

35.9. He encouraged people to join the Foundation Trust membership and consider standing as a Governor in the upcoming elections.

36. Governor Development Committee (GDC) Annual Report

36.1. NP introduced herself and her report and outlined the role and responsibilities of the GDC to advise and inform Council agendas, discuss Governor training needs, and recommend improvements to the way the Trust supports Governors to fulfil their role.

36.2. She outlined key achievements around improving the effectiveness of the Council. A three-year cycle of Governor elections had been introduced to smooth transition year on year, evening out the number of Governors standing for election in any single year.

36.3. She outlined the areas where the Governors had sought assurance during the year. These included staff wellbeing, performance challenges, and implementation of the patient experience strategy. She thanked all members of the GDC over the year and thanked Governors who had left the Trust.

- 36.4. IA advised that the Council had conducted its annual self-assessment of its own effectiveness, which was good practice for all Councils. The assessment also asked key stakeholders for their views on how the Council was working. Finally, an assessment of the effectiveness of the Lead Governor role was included. She thanked everyone who had input to the assessment.
- 36.5. The report set out the feedback and this had been discussed in some detail at the recent Governor Development Committee.
- 36.6. Overall, the Council was felt to be working well however there had been a marked decline in people feeling entirely content with some aspects of the way the Council operated - there were a lot more 'not sure' responses than last year, some of which may be due to the remote ways of working over the past 18 months. Some Governors elected in 2020 had not had time to find their feet before COVID changed the way we worked.
- 36.7. The GDC made a series of recommendations following its discussion, as set out in the paper, namely:
- 36.7.1. Recirculate role of the Lead Governor to the Council for information.
 - 36.7.2. Work with the GDC to prepare a rolling training plan for Governors over the year.
 - 36.7.3. Feed back to the Chair on the importance of early notification of significant incidents in the Trust or affecting the Trust to Governors and staff members.
- 36.8. The paper asked Governors to review the data and bring any comments on the results to this meeting, as well as consider the recommendations of the GDC and bring any additional suggestions.
- 36.9. There was no additional feedback on the annual self-assessment.

37. Nominations Committee (NomCom) Annual Report

- 37.1. DA gave an overview of the role, responsibilities, and activities of the NomCom. He thanked the committee members for their diligence and commitment in securing NED colleagues for the Trust Board.
- 37.2. He noted the sad loss of NED Tricia MacGregor back in June 2020 and advised that an annual award would be put in place in her honour.
- 37.3. He further thanked Lucy Bloem and Terry Parkin who stood down from the Board at the end of August, and Al Rymer who had stood down earlier in the year.
- 37.4. He noted the goal around the Board setting the direction by improving its diversity and advised that some progress had been made in terms of representation on the Board. In addition, the Trust had joined the NExT Director scheme to bring on the next generation of NEDs of black and minority ethnicity, offering 12 month placements and exposure of the NExT Directors to the Board and its committees, and aiding the Trust by gaining the views of additional individuals with relevant skills and experience.

38. Governor Activities and Queries Report

- 38.1. NP noted what the report covered, advising that it had been difficult for Governors to get out and about this year, as noted above. She ran through the activities that Governors had managed to undertake.
- 38.2. She outlined some of the Governor queries submitted over the year, and highlighted the queries about student Paramedics being supported and provided with appropriate clinical support and wellbeing supervision as they would be vulnerable. A detailed response had

been received at the time. She noted that Governors received timely responses, and were able to request extra assurance as required.

38.3. DA thanked NP for all her hard work. He noted how active Governors had been and thanked them.

39. Assurance from the Non-Executive Directors – Integrated Performance Report

39.1. DA noted that comments and queries would be taken under the escalation reports in the next item.

40. Board assurance Committee's escalation reports

40.1. Workforce and Wellbeing Committee (WWC)

- 40.1.1. LM introduced the report. He noted that because of operational and staffing pressures the August meeting of the WWC was cancelled. Many of the assurances called for in the report were still due at the next meeting.
- 40.1.2. He noted that WWC had previously focused on getting the basics right around Trust HR processes. The WWC was confident that considerable improvements had been made and continued to be made.
- 40.1.3. The WWC could now focus on more future-orientated risks. Clinical education was well-covered in the report. In general, the WWC were reassured that the new team were bringing things into order. He suggested a meeting with NP given her mention of clinical education in the previous item.
- 40.1.4. LM noted that on recruitment and our obligation to all the communities we work with, WWC had asked for assurance around what SECamb was doing to make SECamb a great place to work for everyone.
- 40.1.5. LM was pleased as Chair of WWC to move from looking at past performance to consider more fundamental and future risks. He paid tribute to Terry Parkin who began this work.
- 40.1.6. Workforce planning and recruitment was an area of focus, and there was a need for a shift in gear here. It was important to ensure we were realistic about the recruitment market and paid heed to the new models of care being introduced.
- 40.1.7. He highlighted the issue of the recruitment of Paramedics by GP practices. This had huge consequences about our ability to deliver to patients and our communities. WWC was assured that all was being done to limit that abstraction by GPs through discussion with the four Integrated Care Systems and potentially developing a rotational model.
- 40.1.8. Training and development for staff was vital and postponing this would have an effect on our ability to deliver our services. WWC would be looking at this closely.
- 40.1.9. LM asked TQ whether he wanted to say anything about staff wellbeing or clinical education. TQ noted that he was the Wellbeing Guardian, a new Board level role, however staff wellbeing was everyone's responsibility. TQ was working with the HR Director and regional and national colleagues on how we support staff. A lot of work was going on behind the scenes to ensure that the Board understood the wellbeing of our staff: there was a new wellbeing reporting framework that would be announced by NHS England early in the new year. NEDs were seeking assurance to ensure we were trying to do everything we could to support staff through difficult times now and in future. The focus on getting meal breaks and ending shifts on time was important, but he also

wanted to understand the qualitative feedback and get back out to listen to people. He had spent time at EOC the previous week and welcomed talking to colleagues.

- 40.1.10. On clinical education, TQ and LM had met with staff governors to discuss a range of concerns, they were engaging on the draft Clinical Education strategy, and were triangulating with the Universities we worked with to provide Paramedic education and training to understand their views.
- 40.1.11. LM welcomed SS to the WWC too. He noted that it was great to involve Governors in WWC meetings. He found engagement with Governors at WWC was very useful.
- 40.1.12. GK noted that we were running at below 90% capacity in terms of the hours supplied on the road. He was concerned to see that a high level of the illness was down to mental health issues and asked what was being done to address these issues.
- 40.1.13. TQ advised that he was meeting monthly with the Head of Wellbeing and the Deputy Director of HR to keep up to date. He noted that all NHS organisations were seeing a similar picture because of the unrelenting pressure. Nationally we were thinking about what could be done. Strategically, ultimately we needed to reduce demand. He had also had a discussion about how to support frontline managers to support their team members, to reduce the escalation of mental health issues.
- 40.1.14. He advised that issues around releasing people for that kind of mental health first aid training had already been covered, but he felt we needed to release our frontline leaders to address some of this. He further noted how challenging it was and that no-one had found a solution to this. The Trust was doing everything it can, in the circumstances in which it found itself.
- 40.1.15. MW wanted to support TQ. He had visited Brighton Make Ready Centre and spoken to a staff member there and he felt assured about the level of support provided if people had mental health issues. NEDs were focused on this.
- 40.1.16. MM welcomed the training for our leaders. She noted that we needed to encourage staff to seek support, although the Wellbeing Hub was very good.
- 40.1.17. She asked about the increase in incidences of violence against our staff. The papers didn't seem to say NEDs were fully assured that everything was being done around this. What did the NEDs expect in order to feel assured?
- 40.1.18. LM agreed and noted that WWC had received an initial response on this and would be following up at the next meeting. The body worn cameras were only part of the solution as there wasn't a lot of evidence they reduced the level of violence. NEDs would want to understand staff experience of them.
- 40.1.19. DA commented that the continual challenges of performance remained but the issue of staff wellbeing also remained front and centre.
- 40.1.20. LM noted the need to focus on immediate performance and how we 'afforded' the abstraction to support and develop staff, and protect performance in the longer term. The balance needed to be right. There was a limit to how long we could continue to chase the hours and performance targets.
- 40.1.21. HN noted that in the IPR on p.18 he wanted to confirm that we didn't have 733 incidents in a month – should that be 73? Over the two months reported there had been 150 assaults on our people. He asked whether SEC Amb actively seek a prosecution in every case where an actual assault occurs?
- 40.1.22. PA noted that in every case that the staff member makes a report a prosecution is sought: sometimes colleagues won't press charges as they feel sorry for the aggressor.

HN asked whether the staff were aware that courts would take into account where there were mental health issues that affected an assailant. The important thing was assaults were taken suitably seriously.

- 40.1.23. HN asked about the Patient Experience Group (PEG) and noted that over the last ten months he had participated in meetings and felt we hadn't really advanced in terms of achieving anything tangible for patients, nor using the information in a meaningful way to give patients a better experience. He felt we needed to start using the information we had.
- 40.1.24. LM noted how important this was, which also linked in with how we engaged and used the intelligence gathered. The WWC had taken an interest in engagement more generally so might pick this up. He noted that the Board had decided to think about the scope of the WWC and how it might best handle issues wider than HR but linked to workforce and wellbeing.
- 40.1.25. TQ noted that the PEG fall within the remit of the Quality and Patient Safety Committee, but we needed to work as a Board across Committees to triangulate information. Patient experience had now gone up his radar.
- 40.1.26. HP was pleased to hear TQ was the Wellbeing Guardian at the Board. How were NEDs assured around the implementation of a Just Culture, because the Freedom to Speak Up index had shown we were 12th from the bottom across the country. While the ambulance average was lower than other Trusts' averages, SECamb still performed poorly.
- 40.1.27. SS thanked HP for the question. She had just taken on the role of Freedom to Speak Up Guardian. She had been having a conversation about learning from incidents and preventing occurrences, and would seek to understand the scale and types of issues and how we learn from the themes. She would also keep the Board informed and hoped to give more of an in-depth response shortly.
- 40.1.28. PL advised that the F2SU Guardian gave a Board report twice a year, and the next was in September and would include reference to the index.
- 40.1.29. DA further noted that management issues were coming through the F2SU route which would be dealt with better in other ways, which the Board was sighted on in terms of the cultural changes needed.
- 40.1.30. DE asked about the metrics in the IPR. Up to 59% of complaints relate to crews' attitude. How assured were the NEDs that we got to the root cause of complaints? There was no data around the root cause of these.
- 40.1.31. TQ noted that he couldn't answer this specific question and would come back to DE about crew attitude and what that was telling us. LM advised he would add this to the next WWC agenda.

ACTION: TQ and LM, through their respective committees as appropriate, to consider the data around the root cause of complaints related to crew attitude, which was up to 59% of complaints, as detailed in the June IPR.

40.2. **Quality and Patient Safety (QPS)**

- 40.2.1. TQ introduced the report. In July, the Committee's focus had been on serious incidents and looking at the shift in activity from Category 3 patients to Cat2 patients. The quality team had been looking thematically at incidents, most of which were about delay, which went back to the issues of rising demand and the need to match our resources to these

very sick patients, which as discussed had been challenging for the Trust. Cat3 patients were still important.

- 40.2.2. QPS continued to seek assurance around undertaking the actions in response to the learning from incidents. Fewer incidents were being reported by staff. QPS had noted the need for staff to continue to submit incident reports.
- 40.2.3. The Committee had covered patient safety during this REAP4 escalation to optimise staffing, incentivising shifts and the risks of that, and using clinicians effectively in the control rooms to aid decision-making and communication with patients, as well ensuring the increased focus on Cat2 patients meant we weren't missing other delayed patients who may have escalating need. Supporting staff back from sickness and self-isolation would help us help patients too.
- 40.2.4. Bariatric care had been considered, training, and policies and procedures requiring update, and medicines management had been reviewed too. Audits showed good levels of compliance around medicines management and our processes were safe albeit time-consuming. They had received a paper on clinical outcomes by the grade of staff member responding to the patient. The paper had been very frank, and there had been gaps in assurance so QPS had asked for further information. It seemed that the decision not to convey a patient should be made by a registered clinician and if they were absent, those colleagues on scene should seek advice before leaving the patient, and this wasn't consistently happening so more work needed to be done on this.
- 40.2.5. Clinical audit had been reviewed and again assurance had been sought around the actions coming out of the learning.
- 40.2.6. MM asked how assured the NEDs were that the Trust was taking all possible actions to maintain clinical safety. TQ advised that he believed the Trust was doing everything it can in the circumstances. He personally was assured. DA noted that the Board had looked at this in detail at their last meeting and the Board had felt that there was little else that we could do – the issue was the calls coming through. He commended staff in these difficult circumstances.
- 40.2.7. TQ noted the risk of moral injury for staff who come to work to do their best for patients: across the NHS it was not currently possible to do everything to the standard people wanted which was causing stress and anxiety.

40.3. **Finance and Investment Committee (FIC):**

- 40.3.1. HG noted that the committee had been considering the operating model SECamb used and the transformation programme to do things more effectively and efficiently, for example through virtual technology. An advisory group had been set up for this 'Better By Design' programme.
- 40.3.2. This was a longer-term programme but did provide NEDs with some assurance around the strategic focus on changing things to meet our targets. This adaptation of the operating model was very positive and important.
- 40.3.3. Performance operationally at present was very challenged as Council had heard. The June statistics had showed that we were doing better than the England average on C2, but nationally the whole position was challenged, with C1 about 20 secs behind the England average, and then towards the bottom of the pack on C3 and C4. However, C2 represented about 60% of incidents.

- 40.3.4. HG advised that the Finance Committee was being split up into two elements. There would be a separate Operational Performance Committee going forward.
- 40.3.5. HG was reasonably assured we were on target to meet the financial plan for the first half of the year, which was a deficit of £5 million. That had been agreed within the Integrated Care System (ICS) in which we operated. We did not have the funding position for Half 2 (H2) but were assuming it would be roughly the same as H1.
- 40.3.6. COVID funding was continuing, which was good, to enable us to meet the plan so far.
- 40.3.7. He noted we might end the year with a £10m deficit which was not insignificant but was in line with the ICS' plans. We should continue to challenge within the ICS that we had an unacceptable deficit of that size.
- 40.3.8. HN noted the announcement of additional funds from Government for ambulance services. He was interested in how this would be spent and impact on performance. PA noted that he would cover this in his forthcoming report.

40.4. **Audit Committee (AuC)**

- 40.4.1. MW had no substantive issues around assurance that he wanted to draw the Council's attention to. The AuC was key in giving assurance that the Trust had controls in place and delivered value for money, including patient care.
- 40.4.2. At July's meeting, the Committee did not have many substantive items to consider. Going forward he wanted to assure Council of the programme of internal audit work that would cover many issues discussed during today's meeting. He noted the pressures and resource constraints, and the importance of maintaining appropriate controls.
- 40.4.3. AuC looked at the risk register to be confident that the Trust focused on the appropriate risks. He gave that assurance. AuC were focused on ensuring we had a clear timetable for resolving risks that can be resolved and could see the action being taken.
- 40.4.4. There were no questions from the Council.

40.5. **Charitable Funds Committee (CFC)**

- 40.5.1. MW noted the CFC met twice a year and were mindful of the work done by Community First Responders (CFRs) to raise money to support SECAMB and the communities we serve.
- 40.5.2. The Trust had raised substantial funds during COVID. The committee had challenged the Executive to ensure that CFRs were supported to use their funds in the interests of SECAMB and the patients we serve.
- 40.5.3. The Committee considered the controls around the money that were in place, striking the right balance between control and bureaucracy. The Trust was aiming to recruit by Christmas an expert in charitable activities to support fundraising.
- 40.5.4. Our community strategy was also discussed and how money was used to support volunteering activities. The strategy would be reviewed and enhanced after this recruitment exercise.
- 40.5.5. He thanked HN for his feedback on the Committee following his attendance.

41. **Chief Executive's Report**

- 41.1. PA took the report as read. He noted that the subsequent agenda item would cover performance in detail.

- 41.2. He advised regarding COVID that we were in wave 3. Most pandemics have about 5 waves and then drift into life as normal. It was still having a considerable effect on staff, with between 150-250 staff off with COVID-related illness, and worryingly 36 had long COVID, and some for a year and a half now. There was a national issue with long COVID.
- 41.3. There was also an increased level of normal sickness, including stress and anxiety, back problems and other musculoskeletal injuries and issues. The stress and anxiety levels were high.
- 41.4. There was a lot in the press about whether more vaccinations were required. We were prepared to start a booster programme for staff imminently, but national guidance would not come out until next week. We had a provisional start day of Monday week but awaited the Joint Committee on Vaccination and Immunisation (JCVI) guidance.
- 41.5. It would be a six-week programme to revaccinate all staff, in most cases with a different jab than last time. This would be done coincidentally with the flu jab.
- 41.6. He further highlighted Board level changes, echoing thanks to LB and TP on leaving and he recognised their contribution. He welcomed PB and SS who had joined the Board as NEDs.
- 41.7. At the Executive level, David Ruiz-Celada would be joining the Board as Planning and Business Development Director. This was a vital role for the Trust. He would be supported by a Performance Cell which would provide better data to aid planning.
- 41.8. Bethan Eaton-Haskins was leaving and her current deputy would act up in the interim. He was delighted that the Queen's Ambulance Medal Award had been awarded to Dr Fionna Moore, the Trust's Medical Director.
- 41.9. The estates plan was moving ahead and we had enough capital to continue the programme.
- 41.10. On SECamb's share of the £55m additional Government funding, this was about £4.3m and was non-recurrent meaning we couldn't 'buy' additional frontline staff with it. We could use it to fund private provision but not permanent staff. Call taking would benefit hugely from additional staff however so we would be using the money for additional people there and clinicians to sit in call centres and increase our capability – this was possible with non-recurrent funds due to the staff turnover in our call centres.
- 41.11. NR asked about staff who had declined to be vaccinated. Was this a concern and how might this affect the Trust's resilience?
- 41.12. PA confirmed there were some people ineligible, such as pregnant staff, but there were a small number who had declined. The number was so small it wouldn't have a significant effect on us or patients. Thought was going on about whether it was ethical for a member of the NHS to be treating people without having had a vaccination. At the moment, vaccination remained voluntary.
- 41.13. CH noted the number of staff off with stress, and had held conversations with Ashford staff about the office move to Medway. He noted that in excess of 200 members of staff would have to drive past the complex at Medway and park offsite, and asked whether this might increase stress.
- 41.14. PA advised that the Programme Board that was running the Medway move had been modelling movements and holding meetings with Union representatives. Staff car parking was a concern but there were more spaces at the new station than at the old stations put together, so car parking was being increased by the move. As we got closer to the move the turnover of staff in 111 was such that by the time we moved most staff would have been

recruited in the knowledge they would be based in Medway not Ashford. It was an issue that was being worked on. A park and ride service would also be provided free of charge for some staff for the first three months to see if that was useful.

42. Scrutiny item: Operational Performance in 999 and 111

- 42.1. DH gave a presentation about the level of pressure the Trust was facing in 111 and 999. He showed Council the current pressures and set out the Trust's understanding of the causes. He noted the health system-wide pressures that the Trust was experiencing.
- 42.2. He highlighted the issues around handover times at certain hospitals in the patch, notably the Royal Sussex County in Brighton. The system had started to notice the risks involved in holding ambulances at hospital.
- 42.3. He showed graphs demonstrating volatility around call answer times and also call activity and showed our performance against each of our response time targets compared to other ambulance trusts.
- 42.4. He noted our focus on responding to the most poorly patients, and advised that our assets were running out to respond to Category 3 patients, as demonstrated by our poor performance at C3. We hoped to increase hear and treat responses to treat these less-serious patients by directing people to alternative appropriate services.
- 42.5. In 111, he noted the impact of Think 111 First was challenging, particularly without commensurate funding coming through.
- 42.6. He outlined the actions being taken to improve things: these included a performance improvement plan, weekly scrutiny at Executive level, establishment of a Performance Cell, the setting up of the new scrutiny Committee of the Board focused on Performance, and then strategically reviewing our operational model in the longer term to best align ourselves to deliver for our patients.
- 42.7. CB noted that there were two ambulance Trusts not in REAP4. What were they doing well? DH advised that he was unsure why they weren't in REAP4. He would take this away and see if there was anything more to learn.

ACTION: DH to check what the two ambulance Trusts in REAP3 might be doing that we weren't, in case there was any learning to gain.

- 42.8. Nationally, PA advised that nine out of ten services had been in REAP4 through most of the Summer. National discussions had been held about all sorts of possible solutions. There appeared to be no golden bullet.
- 42.9. CB noted that South Central were consistently higher than SECamb in Cat2 and 3 and wondered if we could investigate what they were doing better. He would like more information. He didn't accept annual leave was an excuse for poor ambulance provision.
- 42.10. DH advised that West Mids and South Central had fared best for lots of reasons and we were learning from them, for example the Performance Cell approach: they could respond to volatility far better than we could at present. They had been really helpful to us by enabling us to borrow learning from them. The service models were also different across the country.
- 42.11. DH noted that on annual leave, he didn't mean this was an excuse but it was a statement of fact that we had far more annual leave in the system to use following the roll over of 20 days from last year due to COVID and the Trust was trying to be pragmatic in allowing that to be used and recognising staff needed a break. This was a fine balance.

- 42.12. BC noted, as an Upper West Governor covering Surrey, that 111 services for Surrey were not provided by SECamb. He asked whether this impacted on our own efficiency as the services were not so integrated in Surrey.
- 42.13. DH agreed: we provided the services for Sussex and Kent. Not providing 111 in Surrey did impact our ability to use our economy of scale and scope. The integration we had was of benefit for the patients. He would not comment on the service PPG (111 provider in Surrey) provided but we didn't see particular implications and had a good relationship with Surrey commissioners should there be strategic issues.
- 42.14. HN noted that in July we said we had sought Military Aid and he saw that on 20th August it was being provided to four other ambulance services. He had been advised that we had been offered military assistance but only during August. Was this the case, as if so, it was appalling that this was the only resource available for a short amount of time and he asked whether we could publicise that decision?
- 42.15. PA advised that the military could give us 6 weeks of cover, with the first part being training. That was the smallest number of weeks we could agree to in order to get a return on the investment in the training. When the decision to provide the support went into the political arena, their availability was 4 weeks only, which made it untenable to train them to make it worthwhile. HN noted that this wasn't in the public arena and the public had a right to know that part of the problem was the lack of support we were initially promised.
- 42.16. PA would not criticise a department of state as he was not privy to the decisions and rationale there. DA noted that the issue would remain on the table for requesting support when required.
- 42.17. HN asked whether the other trusts were getting assistance into September. PA noted they were only receiving it until the end of August too.
- 42.18. CG noted the call abandonment rates of 15% in August in 111. Was this reflective of usual abandonment rates? DH advised that this followed the volatility due to excess demand or lack of resource to answer the calls quickly enough. Nationally, we did ok on most of the 111 metrics. Our original contract was for 1 million calls a year and at present we were receiving 1.6 million.
- 42.19. GK noted that at the beginning of the pandemic a large number of CFRs were assessed to be C1 drivers for Double Crewed Ambulances (DCAs) but they had never been used. Why was this?
- 42.20. DH would take this away as he didn't know the detail. An answer would be provided outside the meeting.

ACTION: DH to follow up as to why CFRs who had C1 licences were not being used on DCAs.

- 42.21. DA thanked DH for his comprehensive report. He noted the full support of the Board and that Board members would continue to challenge constructively, thinking about the medium to long term.

43. Any Other Business

- 43.1. There was none.

44. Questions from the public

- 44.1. Lisa James, who worked in the legal team at SECAMB advised that SECAMB had a wonderful responsive Wellbeing Hub. She asked how staff working at home would be supported. It was hard to spot problems with staff when working remotely.
- 44.2. DH noted that there was a “new ways of working” workstream underway but we were waiting for some national guidance to be issued. DA noted the importance of increasing the visibility of this work.
- 44.3. LJ further noted that on serious incidents, we were looking more at clusters, and asked how this would be aligned with the expectations of Coroners and patients, who wanted individual information. The clusters were getting bigger.
- 44.4. DA asked TQ to take this away and follow up outside the meeting.

ACTION: TQ to explore (through QPS Committee) how the Trust would satisfy Coroners’ and family’s requirements for detail following an SI, given the current policy of investigating some SIs in clusters.

- 44.5. Suzanne Stronge asked about evidence that people were leaving SECAMB. She was overwhelmed by the dedication of SECAMB staff, having been at the sharp end for so long. She thanked everyone and also the families of everyone working for SECAMB.
- 44.6. Robin Whitwell asked about Medway parking arrangements: was there any assurance that road crew would be given priority for the parking on site. He further noted that demand had been very high and he knew that mental health and wellbeing was a real issue for staff. Had we considered mental health first aid courses for all staff?
- 44.7. DH advised we were looking at the Medway site holistically as it was a multi-functional site. Late night finishers would be prioritised. He took the point clearly and we would do our best.
- 44.8. On mental health first aid, there was some central funding available and our Consultant Mental Health Nurse was working with the system on this type of training as well as other things to support colleagues. More information would be available in due course. Robin noted the train the trainer courses available.
- 44.9. Diana Parisi asked about clinical education: courses that were already running and people were part way through had been postponed due to the pandemic. In some respects this was having an impact on staff being able to progress in their job. When would the courses be back up and running? She further noted that in EOC staff were lacking. Having undertaken welfare shifts herself, could we use student Paramedics and give them the opportunity to be able to train to work within EOC and become dual role?
- 44.10. LM noted that these were the kinds of conversations LM and TQ would be having with ClinEd colleagues around the balance to be struck. PA advised there was some restriction around the hours needed to keep up to date on EOC to ensure people were compliant with their Pathways licence.

45. Areas to highlight to the NEDs

- 45.1. DA summarised that he believed the areas to highlight to NEDs were around:
 - 45.1.1. Performance, its challenges and the need to improve into the future.
 - 45.1.2. Staff welfare and particularly the mental health of our staff.
 - 45.1.3. The cumulative effect of the 18 months of working under pandemic conditions.
 - 45.1.4. Finances and a number of future risks.
 - 45.1.5. The balance around staff training and patient care.

46. Review of meeting effectiveness

46.1. DA asked for Governors to comment about areas for improvement. The meeting was deemed to have been effective. He thanked all participants and observers.

Signed:

Name and position: David Astley, Chair

Date:

Meeting Date	Agenda item	AC ref	Action Point	Owner	Completion Date	Report to:	Status: (C, IP, R)	Comments / Update
20.09.19	33.2	268	Arrange a workshop briefing for Council on clinical performance and understanding the integrated performance report	IA	Mär.22	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.
04.09.20	28.22	290	Consider Council agenda item on training and education	CoG	Mär.22	CoG	IP	Was considered by GDC as an option, remains on potential agenda items list. Due to new person in post, suggest possible item for September or subsequent CoG meeting
01.12.20	49.18	292	DA to keep Governors informed about progress in Clinical Education, particularly around levels of assurance.	DA	Sep.21	CoG	C	TP gave an update regarding assurance around clinical education: more was to be done before they could be assured. A new Head of Clinical Education had been appointed and TP had met with them on 8 February and had left the meeting confident that the issues were known and appropriate systems were in place but more to be done before assurance was provided. Further oversight would be provided through Quality and Patient Safety Committee escalation reports to the Council.
04.03.21	76.16	295	Implement proposed changes to election timings and Governor numbers via Board, updating the Constitution and for elections in 2022	IA	Sep.21	CoG	C	Complete and elections commenced in September with announcement date in November.
03.06.21	16.3	301	KS to recirculate the Governor event feedback form	KS	Sep.21	CoG	C	Has been sent to Governors.
03.09.21	40.1.31	303	TQ and LM, through their respective committees as appropriate, to consider the data around the root cause of complaints related to crew attitude, which was up to 59% of complaints, as detailed in the June IPR	TQ/LM	Dez.21	CoG	IP	Response on this due 07.12.21 meeting
09.11.17	123 (GDC)	304	Council to receive update on a review of the effectiveness of the Trust's internal and external communications by the end of 17/18 financial year.	PA	Dez.21	CoG	IP	This action was moved from the GDC action log to the Council action log for oversight on the 21.10.21 The WWC is working with the Executive on a review of the wider 'corporate affairs' function in the Trust. IA to seek timeline for completion from the Chief Exec. Update 19.08.21 If Governors have concerns then they can clarify what that is and test at COG through the NEDs to establish a) the extent to which this is a concern of the Board and b) its priority and therefore c) timeline for taking action. This action and it's origin date will be moved to the Council Action Log.
03.09.21	42.7	305	DH to check what the two ambulance Trusts in REAP3 might be doing that we weren't, in case there was any learning to gain.	DH	Dez.21	CoG	C	All Trusts went to REAP 4 shortly after that meeting and have remained there since. As a Trust we are all networked via the Association of Chief Executives, the National Medical Directors Group, National Operations Director Group and Director of Quality and Nursing groups. These meet frequently and exist to ensure that all learnings are shared across the sector
03.09.21	42.20	306	DH to follow up as to why CFRs who had C1 licences were not being used on DCAs.	DH	Dez.21	CoG	C	CFRs have been invited to undertake training to enable them to support on ambulances.
03.09.21	44.4	307	TQ to explore (through QPS Committee) how the Trust would satisfy Coroners' and family's requirements for detail following an SI, given the current policy of investigating some SIs in clusters.	TQ	Dez.21	CoG	C	TQ: I can confirm I did raise the issue of meeting Coroners and family's requirements regarding dealing with SIs/ cluster SIs at subsequent QPS and other fora. I note that in the IPR for tomorrow's Part 1 Board the issue of being behind with Duty of Candour is highlighted too.

South East Coast Ambulance Service NHS Foundation Trust

Annual Members Meeting minutes

Friday 3rd 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. This meeting was a two-way conversation with members and there was a good amount of time allocated for a Q&A session with members at the end of the event.
- 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. DA noted the pandemic had been hard for everyone, he thanked colleagues, volunteers, and the public, for their support during this difficult period.
- 1.4. DA noted the sad passing of some Trust colleagues during the year and that our condolences were with their families.

2. Chief Executives presentation

- 2.1. Philip Astle (CEO) introduced himself. He shared a slide on the Trusts response to the pandemic to date, giving an overview of demand and the challenges faced.
- 2.2. PA noted the Trust's entire support staff had been asked to work from home at the beginning of the pandemic and had adapted to this change really well.
- 2.3. PA noted the NHS 111 service experienced increased demand at the beginning of the pandemic with people seeking assistance and answers to questions on testing and symptoms.
- 2.4. The Trust expanded its community support to support London Ambulance Service at the peak of the pandemic as the demand in London outweighed resources. The Trust was planning for the EU Exit at this time as well.
- 2.5. PA noted that there were fast paced reactive changes in line with the 4pm Prime Minister briefings that took place in the first few months of the pandemic.
- 2.6. PA noted that 18 colleagues had died over the period of the pandemic, and that was 18 families who were missing those people. PA noted there were seven cases of long covid in Trust staff presently.
- 2.7. PA noted close working with the military and fire service to support the Trusts response to increased demand.
- 2.8. Roll out of the vaccination programme was successful for staff, volunteers, and vulnerable household members.
- 2.9. April 2021 onwards the focus shifted to learning and embedding change where needed. Society started to open up. Preparation for future waves of the pandemic were in place.
- 2.10. PA noted the huge contribution of our volunteers during this time. From welfare vehicles, to delivering test samples to a lab, there was no hesitation to provide help.

- 2.11. PA noted the Trusts clinicians had consistently focussed on good delivery of care on top of the pandemic pressures.
- 2.12. The Trust was preparing for the roll out of Booster vaccinations once agreed by government.
- 2.13. Looking forward, the Trust needed to improve performance and undertake a review of lessons learnt in the last 18months. The Trust also need to focus on supporting colleagues post pandemic. Optimising workforce numbers would be a key area.

3. Director of Finance and Corporate Services presentation

- 3.1. David Hammond (Chief Operating Officer and Exec Director of Finance) presented an overview of our use of resources. Noted the Trust's Annual Report and Accounts were due to go to parliament later in September and a draft version of the document was available for members on the Trust's website.
- 3.2. 2020/21 was an unprecedented year. Focussed on maintaining good governance throughout the pandemic especially on the Trust finances. Lots of necessary transactions took place in a short period of time at the beginning of the pandemic, such as laptops for all support staff to be able to work from home, significant volume of Personal Protective Equipment for colleagues, changes to estates to accommodate social distancing requirements, and launching an updated 111 service in the middle of the pandemic. The focus was on colleagues having what they needed to deliver the best patient care possible.
- 3.3. The Trust reported a deficit of £6.7m, this included a £6.6m price change impairment. With this removed the £0.1m deficit was an improvement on the original plans of £6.4m. This improvement was due to further non recurrent central funding being made available as the pandemic progressed. The cash balance at year end was £40.2m.
- 3.4. Cost improvements of £5m were delivered and reinvested in frontline services.
- 3.5. Capital investments of £19.5m were made in the year, investing in the infrastructure and tools staff need to undertake their roles.
- 3.6. Income for 2020/21 £298.8m up from £252.4m last year. The majority of our money comes from our 999 service (73%).
- 3.7. Main expenditure is on pay (65%), followed by transport, estates, and clinical supplies.
- 3.8. DH asked members and the Council of Governors to receive the Annual Report and Accounts 2020/21.

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 East Sussex and Brighton and Hove (SECAmb's 'Lower 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 as a Council are two-fold:

To represent the interests of our Foundation Trust members and the wider public; and

To hold the Non-Executive Directors to account for the performance of the Board.

4.4. We also have some very specific powers and I'll outline where we have used those during the year.

4.5. But first I should start by reflecting on this extraordinary year: COVID-19 has impacted so heavily on most people in some way and of course the ambulance service has been quite literally on the frontline providing care throughout the year. As Governors, we have tried to support the service as it acted to flex as needed to keep providing the best possible service to patients while balancing the safety of SECAMB's staff and volunteers. I'd like to thank everyone working at SECAMB for their incredible efforts to date. At the time of writing (April 2021) lockdown restrictions are beginning to be eased and patient demand is returning to usual levels. We all hope there is no return to the transmission rates, hospitalisations, sickness, and mortality rates seen during the past year.

4.6. SECAMB has sadly lost a number of staff members to the virus, as outlined elsewhere in this report. Council has been focused throughout the year on helping ensure that the Trust was doing its best to protect its staff and volunteers, while recognising that at times demand for its services was incredibly high and the number of Covid patients meant it was inevitable that crews would find themselves at the sharp end of the virus. The challenges with PPE early in the pandemic are well-documented but as availability improved, PPE has become part of day-to-day life for our crews. The hard work and stress levels of the crews and call-centre staff during the height of the various waves cannot be underestimated.

4.7. Many of our Community First Responders, including some Governors who volunteer in that role, were unable to respond to patients due to lack of safety equipment and so took to the road (when lockdown rules allowed) to provide welfare support to the frontline staff instead. This was particularly valuable when hospitals were at their busiest during the first and second waves, and crews and patients were spending a long time waiting to hand patients over to Emergency Departments. The 'welfare vans' provided much-needed refreshments and a friendly (if masked!) face during long shifts. Council adds its thanks to all the incredible volunteers who have and continue to support the Trust.

4.8. The Trust has been the grateful recipient of charitable funding which has helped stock the welfare vans but also provided some cheer on our stations and for our hardworking back-office teams – from coffee machines and water bottles to a table tennis table, the funds have been put to good use for the benefit of staff. If you have donated to NHS Charities Together during the year – thank you.

- 4.9. A notable success this year has been the Trust's extensive vaccination programme, which was able to extend to volunteers, including Governors once priority frontline staff were vaccinated. As I write the Trust has started to roll out second jabs to eligible staff and volunteers.
- 4.10. The way the Council has worked alongside the Board during the pandemic has of necessity moved online, with Council meetings and committees continuing virtually. This has had some benefits, enabling more members of the public and staff to join the meetings, but I think it's fair to say that Governors have missed the contact with the Board, and particularly the informal catchups that are possible when meeting face to face. Governors have continued to observe Board meetings and Board committees, which have also moved online, and have provided Council with assurance that Board scrutiny and oversight has continued despite the many challenges.
- 4.11. At the time of writing, discussions are ongoing about how we maximise the benefits of enabling online access to future meetings while planning for meeting face to face when it is possible to do so safely.
- 4.12. Naturally, Foundation Trust membership engagement and recruitment external events have had to be stopped during the year, though we have held several sessions online to try and reach out to members, with limited success. Communication via our membership newsletter, Your Call, has continued and our membership numbers remain strong despite Governors' lack of physical presence out and about around the South East. Our Annual Members Meeting online was a huge success, with good feedback from the more than 200 attendees who joined us in September to hear about the Trust's pandemic response and other areas of work.
- 4.13. It is fair to say that for Council as well as for the Board and Trust more widely, the focus has, of necessity, been squarely on responding effectively to the unprecedented challenges posed by the virus. However, Council have continued to seek improvements in other areas of the Trust where reasonable during the year. We do this through questions submitted between formal meetings as well as by holding the Non-Executive Directors to account at our Council meetings.
- 4.14. Areas of focus for Council have included:
Use of patient experience feedback and learning;
Improved staff engagement and communication;
The Trust's evolving strategy and the impact of ongoing changes in the wider health system; and Staff wellbeing.
- 4.15. Council has a rolling agenda of scrutiny items covering the remits of each of the Board committees, and these have continued through the year.
- 4.16. Governor questions to the Non-Executives between meetings have included the following topics, some Covid-related but not all:
Assurance around plans to create a new Make Ready Centre in Medway;
Clarity around staff annual leave entitlements;
Concern at delays at some Kent hospitals;
Progress on a project to improve responses to falls;
PPE provision and 'fit testing';

Monitoring of contracted private ambulance providers, including around PPE;
Arrangements for staff working from home;
Finding for the Trust's Paramedic Practitioner programme;
Streamlining the process for CFRs to access funds they have raised;
Traffic management in Kent in the run up to EU Exit;
Accessibility of the service to hearing-impaired patients;
Environmental considerations at new buildings; and
Improvements in the Trust's provision of clinical education.

- 4.17. In terms of our statutory powers, the Council has made several Non-Executive Director appointments and reappointments this year. NED remuneration has remained static.
- 4.18. The Chair, David Astley, was reappointed for second three-year term of office at our meeting in early March 2021, Lucy Bloem was reappointed for a final year in August 2020, and Laurie McMahon reappointed for a second three-year term from February 2021. Council appointed two new NEDs during the year: Prof. Tom Quinn joined the Trust in October 2020 and Dr Subo Shanmuganathan in March 2021, both recruited by the Nominations Committee of the Council (working in tandem with BAME Recruitment agency).
- 4.19. In January, Council said a fond farewell to Al Rymer who concluded his second three-year term as a NED at SECamb. On behalf of the Council, I would like to thank him for his diligent service and wish him well for the future.
- 4.20. Council were very sad at the passing of NED Tricia MacGregor in June 2020. Tricia had developed a good relationship with the Council and her patient focus was hugely appreciated. She is missed.
- 4.21. No Council elections were held this year, but we have seen a few changes among Governors, with three Governors stepping down for various personal reasons: Pauline Flores-Moore in May 2020 after a little over a year with us; Malcolm Macgregor in December 2020 after 18 months as a Staff Governor; and Marguerite Beard-Gould in October 2020 after more than 6 years' service. Marguerite had been particularly consistent in her contribution to the Nominations Committee. I thank them all on behalf of the Council and am only sorry we couldn't meet up to thank them in person.
- 4.22. Subsequently, we welcomed Colin Hall back to the Council representing Kent and Medway (Upper East SECamb), Harvey Nash representing West Sussex (Lower West), and Nigel Wilmont-Coles as a Staff Governor (Operational).
- 4.23. Finally, as we begin to emerge from what we hope are the worst of the impacts of the pandemic, I must express again on behalf of my Governor colleagues our admiration and respect for everyone working for or with SECamb and across the wider health and social care system during the past year. Governors must continue to hold the Non-Executive Directors to account for the performance of the Board, in the interests of our members and the wider public, particularly during times of additional pressure and

stress. We do this with the utmost respect for the pressures everyone has been under and look forward to working together and meeting in person again in the coming year. NP handed back to DA.

4.24. DA advised that although we have been working through a pandemic, the Trust has continued to invest in our frontline service and new technology because that is what's going to help our patients the most. A film from earlier in the year was played, which illustrated how investing in and using technology helps us to provide even better care to our patients, enabling them to quickly access specialist care & avoiding delays. A [video](#) on technology improvements for stroke patients was played for members.

5. Question and Answer session

5.1. DA introduced the Q&A panel:

5.2. Philip Astle (Chief Executive Officer), Nicki Pointer (Lead Governor), Fiona Moore (Medical Director), Emma Williams (Director of Operations), Michael Whitehouse (Senior Independent Non-Executive Director) & David Hammond (Deputy Chief Executive & Chief Operating Officer).

5.3. Questions received as follows:

5.4. **Q: Tim Williams – What do Make Ready Centres (MRCs) do?**

A: EW noted MRCs were where our frontline colleagues start and finish their shifts and also where admin support is based for their Operating Unit. There was space for training as well at these multi-functional sites. Make Ready Operatives who maintain stock and standards of vehicles and items on them also work out of the MRCs. New iterations will include 111 and 999 services in the East at the new planned Medway MRC build.

5.5. **Q: Lyn Gallimore – Has any interest been shown from Kent about the use of technology to Face Time a consultant in case of suspected stroke?**

A: FM noted that the Kent hospitals embraced the idea for telemedicine first so that was where the pilot for it was launched. This pilot had been extremely effective, and the Trust would be keen to undertake this in other areas.

5.6. **Q: Daniel Gregory - What do red epaulettes represent?**

A: FM noted that red epaulettes are worn by the Trusts specialist clinicians such as Critical Care Paramedics, Paramedic Practitioners, and the small cohort of doctors who work directly for SECamb.

5.7. **Q: Izzy Allen - If there was one thing you would want members of the public to understand about how to help the NHS with its current pressures, what would it be?**

A: PA noted that it would be good for more public messaging on the broad range of services available to them within the NHS, so they request the right service at the right time. PA noted the Trust was a 24/7 service and would be there if you needed help, however he felt it was useful for people to understand what's available locally such as urgent treatment centres. EW noted the reality was the whole of the NHS was under significant

pressure, and as individuals we need to take some responsibility for our own health including being mindful that the virus is still out there. EW noted positive impact of pharmacists as a local point of health information and advice. We will always be here; it is about using the NHS as smartly as you can. Walk in centres and Urgent treatment centres are readily available. FM noted we were not through COVID yet and infection prevention guidelines were important. FM noted during the beginning of the pandemic there was an outpouring of support for the NHS, but conversely that meant that some patients didn't feel they should contact us for help when they really should. If you have a real emergency, you should not hesitate to call 999. If it's not an emergency, the 111 online service is really easy to use and takes the pressure off our call centres.

5.8. Q: Robin Whitwell - Any plans for increasing the numbers of SECamb crewed ambulances to assist with the increased demand whilst allowing potential for staff decompression time after trying incidents or series of incidents. I appreciate the pressure on crews but was surprised recently that 2 ambulances were diverted and then no ETA could be provided when taken ill at Gatwick.

A: EW noted that the challenge we are all facing at the moment is tough. We are trying to support patients to the best of our ability with the resourcing levels we have. We are running under optimal levels for staffing and staff have taken paid time off, quite rightly, to decompress and relax. We have increased our private provider hours. Our focus is on getting as many hours out as we can, but there is a balance as overtime is undertaken during time off, so we need to consider welfare of colleagues as well. Ambulance diversions take place when there is a higher acuity call in the same area that is prioritised. In order to add to our capacity we need more staff not vehicles, we are recruiting but there are limited resources outside of this. We have worked with the fire service and military for support. We continue to work with St John. All ambulance Trusts are in a similar position and fishing from a small pool of qualified paramedics. MW noted the Trust was focussed on making the best use of the people and resources we have and that we support colleagues welfare. The Board want to take a longer-term view in terms of resilience and building capacity. There is a new project on this, so it is very much in the Board's sight.

5.9. Q: Daniel Gregory. What is the difference between paramedics in urgent care and the paramedics in critical care?

A: FM noted both groups are specialist paramedics who have undertaken additional training. Paramedic Practitioners specialise in urgent care including wound care and carry additional drugs to treat people in the home. Our Critical Care Paramedics are trained to attend our most serious incidents such as serious road traffic accidents, cardiac arrest and both sets of clinicians are trained to masters level.

5.10. Q: Andrew Latham. When will the Trust actually start the Community Falls Team responding to fallers at home?

A: FM noted community resilience team have been quite stretched, getting

the system up and running and the right governance in place has taken time. It needs to be rolled out in a supported and effective fashion and is in the works. DA noted the positive impact this pilot would have on falls patients and that the Board were supportive of this workstream taking place.

5.11. Q: Elaine Taylor. Do the Council of Governors feel that their work with the Trust is worthwhile?

A: NP noted she felt as a Council we provide a valuable wealth of experience which is used to hold the NEDs to account for the performance of the Board. NP noted she was a nurse in the NHS and that members of the Council came from all walks of life and were ably supported by the Trust Chair to represent members views. NP encouraged members to stand in the Governor elections to be more involved in their local ambulance service. DA confirmed the council were very effective in their duties and provided a much-needed sense check at times which kept the Board grounded.

5.12. Q: Michael Miller - With the development of the move to ICS's will SECAMB be using SNOMED CT subset as the clinical oncology and if so, when? When and which ePCR will you be using and will there be a project to implement "Lab in a Bag" such that crews can carry our limited Lab Tests.

5.13. A: *Provided post event.* SNOWMED and the Ambulance Data Sets (ADS) is a grouped piece of work that is currently at a national level. Historically, Ambulance Trusts have been reliant on nonspecific data sets and there is no current ambulance subset for SNOWMED that I have been able to find. Nationally SNOWMED and ADS is being developed and tested prior to full national implementation. As a Trust we are currently mapping our systems to ensure we are currently gathering the SNOWMED, and ADS datasets set nationally. This is a data set that is focussed on Ambulance setting and includes SNOWMED subsets that relate directly to the ADS codes, effectively making an Ambulance SNOWMED CT Subset. The Cleric Electronic Patient Care Record (ePCR) has already had initial developments in line with the ADS and further national level developments are in discussions between Trusts using this product to ensure compliance with the ADS and SNOWMED CT subsets. As the ADS is not yet finalised this is an evolving work piece. Once a full data set has been signed off nationally and Cleric development in line with the Cleric ePCR national user group requirements has been completed this will then be fully implemented. Whilst there was an ISN in 2015 to ensure that all Trusts are using SNOWMED CT and as there is some 10+ Thousand codes, and no specific Ambulance subset agreed, there is then always improvement that can be implemented until the national ADS work is rolled out.

5.14. Q: Robert Richardson - The video shown at the end of the presentation was very impressive and a great story to tell for SECAMB. I can see that the technology that frontline currently use is iPad and facetime. I wondered if the Trust would be interested in testing a solution that we offer called Airlink which would provide a direct link to

the end user and more functionality than Face Time also removing the need for any Face Time app.

5.15. A: *Provided post event.* From a systems view, we would always be happy to look at new technology and how we can implement that into how the Trust does its business so thank you for highlighting. We are already working with the GoodSam app and on a development of the ePCR Cleric solution. Thank you for highlighting, we will be in touch should we wish to pursue looking into the services you offer.

5.16. **Q: Robin Whitwell – Has SECAMB considered working with other ambulance Trusts in the development of a standardised grade not requiring a paramedic science degree – for example Technician roles.**

A: PA noted that the Trusts Advanced Ambulance Practitioner role had similarity's to the previous Technician role. EW noted she started as a trainee Technician. The challenge is that nationally the paramedic role was clinical standard for ambulance services in terms of a registered professional. We do have staff who work alongside our paramedics who are trained but are non-registered clinicians – Emergency Care Support Workers. There is a pathway for progression from this role. No conversations on a separate role to date. ECSW is the current model for non-registered clinicians.

6. Chair's closing comment.

6.1. DA thanked everyone who took part in the meeting. We really appreciate your questions and interest in our service. We will share the recording of this meeting more widely on social media and on our website so please do pass it on to anyone in your networks. We will also include a write up of the meeting in our member newsletter.

6.2. Thank you all for attending, and for your continued support of South East Coast Ambulance Service NHS Foundation Trust.

Minutes written by Katie Spendiff – Corporate Governance and Membership Manager

Item No	47-21
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Name of meeting	Trust Board
Date	19.11.2021
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 2021 to date. Section 4 identifies management issues I would like to specifically highlight to the Board.
2	Recognising the current operational pressure the Trust is under, this Report will reflect only the key issues affecting us at present.
A. Local Issues	
3	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.
4	As part of its weekly meeting, the EMB regularly considers quality, operations (999 and 111) and financial performance. It also regularly reviews the Trust's top strategic risks. In addition to the main weekly meeting, we also hold regular Executive 'huddles' to ensure that there is a frequent opportunity for issues to be raised and discussed and action taken.
5	The key issues for EMB during this period have been operational performance and patient safety, however, other issues overseen include: <ul style="list-style-type: none"> • Sickness Management • Progress with the capital developments at Banstead & Medway • Development of non-medical prescribing in 111 CAS • Our on-going workforce pipeline • Work underway to improve staff experience
6	Decisions have also been taken by EMB on: <ul style="list-style-type: none"> • The delivery of Key Skills Training • The national H2 Financial Plan
7	EMB have also agreed the following investment decisions: <ul style="list-style-type: none"> • Automating Driving License Checks

- Investment of national funding received to support staff wellbeing

8 Engagement with stakeholders and staff

During November the Chair and I have met virtually with small groups of our regional MPs. These meetings have been useful opportunities to provide them with an update on the challenges we are facing currently, including the on-going impact of the COVID pandemic, as well as for them to provide feedback on our services on behalf of their constituents.

9 On 19th October 2021, I attended the Chaplains' Plenary Meeting to meet with the majority of our Trust Chaplains. It was a good opportunity to spend time with them discussing their role, as well as to thank them for the on-going support they provide to our staff.

10 On 18th November 2021, the Chair and I met with Sir Andrew Morris, previously the Chief Executive of Frimley Health NHS Foundation Trust and now a senior Non-Executive Director. We had a very useful exchange of ideas about how to improve things for the Ambulance sector. These ideas were backed up by the opinions of staff as we visited various teams in Crawley.

11 Launch of new Wellbeing Volunteers team

On 16th November 2021, I was delighted to attend the launch for our new team of Wellbeing Volunteers. More than 50 volunteers have been recruited so far, including CFRs, staff and members of the public, to support us in providing welfare vehicles and trolleys to our staff.

12 The team are now up and running and are aiming to provide five welfare vehicles based at Brighton, Chertsey, Polegate, Sittingbourne and Thanet which will visit local hospital sites in the region with hot drinks and treats for staff. They will also provide welfare trollies in our EOCs and 111 centres at Crawley, Coxheath and Ashford.

13 It was a real pleasure to meet the team– their enthusiasm and willingness to support us during these challenging times was overwhelming – and I'm equally pleased that we now have welfare vehicles and trollies back out supporting our staff.

14 Staff Award Ceremonies

During October, I was extremely proud to host our three Staff Award Ceremonies, together with the Chair and present Chief Executive's Commendations to a number of extremely worthy winners who had all truly gone 'above and beyond'.

15 At each event, we were joined by either the Lord Lieutenant or Deputy Lieutenant who presented Medals for Long Service & Good Conduct on behalf of HM The Queen to eligible frontline staff and the Chair presented a number of staff and volunteers with long service awards marking 20, 30 and 40 years' service.

16 To allow the events to proceed safely, we held each as a combined in-person and virtual event; this allowed more than 300 guests to participate across the three events and there was a great atmosphere between those guests who were 'in the room' and those who had joined on-line.

17	Although it was disappointing that we weren't able to all be able to be together in person, they were all great evenings and it was fantastic, particularly after the challenges of the past 18 months, to be able to celebrate the long service and outstanding achievements of so many colleagues.
B. Regional Issues	
18	New Executive Director of Quality and Nursing Following Bethan Eaton Haskins' decision to stand down from her role at Christmas, I am pleased to share that following a rigorous recruitment and interview process, we have a preferred candidate to take on the role of Executive Director of Quality and Nursing.
19	At the time of writing, I am not able to give any further details but look forward to making an announcement in the very near future.
20	Poppy Ambulances I am pleased that, once again, we have shown our support for the Royal British Legion's Poppy Appeal as a Trust, by featuring a special design on the side of some of our ambulances.
21	Vehicles across our fleet carried poppy stickers with an additional 12 ambulances, spread across the region, carrying a larger remembrance design on their sides.
22	As an organisation, we have strong links with the armed forces with many staff having had previous careers in the forces or continuing to serve as reservists and I am glad that our Poppy-wrapped ambulances once again served as a visual sign of our remembrance.
23	Critical Incident At 8.30am on 17 th November 2021, a Critical Incident was declared by the on-duty Strategic Commander following a significant IT issue which affected a number of our systems, including the Computer Aided Dispatch (CAD) and our telephony systems.
24	As a result, local and national contingency plans were put into place as work was underway to identify the issues and undertake the work necessary to bring all systems back online. This happened during the evening and the Critical Incident was stood down at 11.30pm.
25	I would like to thank our staff who responded magnificently to what was an extremely challenging day, as well as our fellow ambulance trusts and local NHS partners who were extremely supportive.
26	We have now begun the technical, resilience and patient safety reviews into the incident and will ensure that any learning arising from these is acted upon moving forwards.
C. National Issues	
27	COVID-19 outbreak As the pandemic progresses, we are continuing to monitor the situation closely: <u>Governance:</u> The COVID Management Group (CMG), chaired by Bethan Eaton-Haskins, our Lead Director for COVID-19, continues to meet, ensuring that all decisions and actions

related to COVID are considered appropriately.

Impact on staff numbers: We are continuing to see the impact of the pandemic on our staffing levels in a number of different ways, including staff needing to self-isolate, staff with COVID symptoms or confirmed COVID and the on-going impact on staff of long COVID.

COVID booster vaccine: On 4th October 2021, we went live with our Autumn Vaccination Programme, which allows us to deliver the flu vaccine and COVID booster vaccine to our staff via an in-house programme. We are one of the only ambulance Trusts in the country to go through the rigorous process to allow us to deliver this in-house.

The programme delivers the vaccines from clinics at Crawley HQ and Coxheath and staff can opt to have either both vaccines during the same clinic visit or either vaccine individually. In phase two of the Programme, we will also be providing the flu vaccine at local sites, to increase accessibility for staff.

To date, 53% of staff have had their COVID booster and 32% of staff have had their flu vaccination. We will continue to work hard to encourage as many staff as possible to have their vaccinations.

Following the Government's announcement on 10th November 2021 that COVID vaccines will become mandatory for frontline NHS staff from April 2022, we're awaiting further information about how this will work in practice. Once we have further details, we will put in place a supportive process and work with those staff who may have concerns.

AACE report on hospital handover delays published

On 15th November 2021, the Association of Ambulance Chief Executives (AACE) published a report titled *Delayed hospital handovers: Impact assessment of patient harm*.

The report looks in some detail at the impact on ambulance staff and patients of delayed hospital handover. It uses specific data from 4th January 2021 and examples provided by all ten English ambulance services; in terms of context, 4th January was one of the most challenging days we have seen during the pandemic, when many of our local hospitals were under extreme pressure.

We all know that it is vital that patients are handed over to the care of hospital teams efficiently, both for the safety of these patients and for those awaiting an ambulance response in the community.

We will continue to work closely with our hospital colleagues, as they face increased demand, to monitor levels of activity at A&E and to ensure patients are seen as quickly as possible.

We know that there aren't quick or easy solutions to the issues of bed capacity in hospitals but we also know from good progress made by some hospitals in our region, that

37	improvements can be made, even within the constraints that exist.
	NHS Staff Survey
38	The NHS Staff Survey launched this year on 22 nd September 2021 and closes on 26 th November 2021.
39	The Survey has been re-designed nationally this year to measure the progress being made by Trusts in delivering the NHS People Promise – the promise all staff must make to work together to improve the experience of working in the NHS.
40	We have worked hard this year to encourage as many staff as possible to complete the survey, as it is more important than ever that we hear their views following the challenges of the past 18 months.
41	At the time of writing, 2,472 staff have completed the survey – a Trust-wide response rate of 58% and we will continue to work hard until the survey closes to encourage as many responses as possible.

D. Escalation to the Board

42	Operational Performance Demand for our 999 and 111 services remains higher than we would expect to see at this time of the year for a variety of reasons.
43	This increased demand is occurring at a time when our staff are extremely fatigued and the resources we have available to respond to patients, both on the road and in our control centres, is significantly impacted by the numbers of staff affected by various COVID-related issues and high sickness levels.
44	The combination of increasing demand and pressure on our operational resources is leading to an extremely challenged operational situation for us, where we are seeing some patients wait a long time for a response. Although we have seen some improvement in recent weeks as new staff come on-line, I am also concerned that there are times when our 999 call answer performance is significantly impacted.
45	As was evident from the national ambulance response time data published recently for October 2021, all ambulance services nationally remain under considerable pressure as is the wider NHS system. This has generated significant national media coverage in recent weeks.
46	As a result of the on-going challenging situation, we remain at REAP Level 4 and with a declared Business Continuing Incident (BCI) in place. Both are reviewed regularly and are in place to ensure that we are able to take all possible steps to maximise our operational performance as far as possible in these challenging times.
47	Emma Williams, our Executive Director of Operations, continues to lead on the on-going delivery of an over-arching plan to improve our operational performance, supported by

<p>David Hammond as Chief Operating Officer. Through our quality and safety governance framework, we also continue to closely monitor the impact of any delays on our patients and ensure we are taking all steps possible to maintain safety.</p>
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B - 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 where available.

2. MDC Meeting summary

- 2.1. The MDC met in June and November 2021. The key areas of focus were:
- 2.2. Planning, delivering and then reviewing the Annual Members Meeting which took place online this year on the 3rd of September 2021. More on this below in the member engagement summary.
- 2.3. Sharing updates from the various member groups that feed back via the MDC to the Council including the IHAG, Patient experience Group, Staff Engagement Advisory Group, and an update on the work of the Community Resilience Team. These updates are detailed further on in this paper.
- 2.4. The MDC received an update on the current position with public communications from the Head of Communications. This generated quite a bit of discussion and members were keen for the organisation to be as transparent as possible regarding current challenges being faced by the Trust.
- 2.5. The remaining items on the Membership Action Plan were transferred to the action log for completion by year end. These include:
- 2.6. - Connecting Governors to local Make Ready Centres (MRC) and Community First Responder (CFR) Teams by dividing Governors out by location to key MRCs and CFR teams in their patch. Coordinate introduction meetings online and pave the way for more regular communication.
- 2.7. - Promote the engagement toolkit to colleagues from frontline to Exec level to explain the value of engagement and highlight work streams where it becomes a 'must do'. The Engagement Toolkit designed by our Staff Engagement Leads with contributions from the Membership Office, Inclusion Lead and members is on pause for now. The new Head of Learning and Organisational Development was unable to attend the November MDC but will attend the February meeting to give a direction of travel for this piece of work, staff engagement and the OD strategy in general.
- 2.8. The next MDC meeting is on the 21st of February 2022.

2.9. Membership update

The total staff membership as of 31.10.21 was 4,365 which is up 0.27% since the last report.

Current public membership by constituency (at 08.11.2021) is 9,679 broken down as follows. This is down 1.8% since the last report.

Constituency	Members	Population exc London	% of eligible population
Lower East SECamb (East Sussex and Brighton)	1,950	848,414	0.24
Lower West SECamb (West Sussex)	1,494	866,131	0.18
Upper East SECamb (Medway/ Kent/ East London)	3,471	1,850,857	0.19
Upper West SECamb (Surrey/ Hants/ West London)	2,360	1,386,062	0.17
Out of Trust Area	404	-	-
Total number of members	9,679		

3. Membership engagement summary

3.1. Membership recruitment

3.2. Membership numbers have dipped in the last year due to our inability to recruit members in the traditional way. Some activity has taken place in the last year to try to mitigate this with varied success, including online member drop-in sessions with Governors and online member recruitment via social media platforms. We look forward to being able to hopefully plan a year of attendance at events in 2022 to boost our member numbers in underrepresented areas, gain some fresh perspectives from members, and, give Governors the opportunity to engage with their constituents.

3.3. Original areas of focus for membership recruitment were agreed as follows.

3.4. - To attend one membership event in each constituency area to enable Governors to meet and sign up new members within their area.

3.5. - Attend an additional large-scale event in West Sussex to develop membership numbers to bring them more in line with East Sussex figures as the populations are similar.

3.6. - Attend an additional patient/disability event to build patient membership numbers as these have been on a declining trend over the past few years. This can tie into the patient strategy plans for engagement.

3.7. - Governors to utilise local patient participation groups to advertise membership to build up patient representation and the Governor Toolkit to undertake attendance at small events themselves.

- 3.8. Further online membership recruitment via social media could take place this year relating to wider health campaigns such as carers week as there is more capacity within the membership office now.
- 3.9. Suggestions on creative membership engagement in the interim are welcomed.
- 3.10. Annual Members Meeting
- 3.11. 100 people attended the meeting on the day, 145 registered to attend in advance. The make up of attendance was predominantly staff which is different to the type of attendance we see at inperson events (public members). The feedback we received noted that that the content of the event was 'very interesting' and that it was simple to register and attend.
- 3.12. 2 people emailed having issues joining (1 public and 1 staff member) but they managed to resolve there issues and join.
- 3.13. There were some technical challenges on the day. The webinar settings were for all attendees cameras and mics to be off as default, and that we would be able to enable them for the Q&A when people raised their hand. This did not work on the day which was disappointing as it had worked in the practice event. Similar challenges occurred for playing the video, presentation and fully using the chat function. These issues got resolved and again this had worked in the rehearsal which took place 30 minutes before the live event.
- 3.14. The event ran to time and despite technical difficulties we still managed to have an active Q&A with questions being posted in the chat once it re-appeared!
- 3.15. The Council are encouraged to provide any additional feedback on the days event.
- 3.16. Additional technical support and different online or hybrid platforms would be looked at for future events.
- 3.17. Governor elections
Governor elections took place in November. Thanks to those members that showed an interest and stood for election. They have proved popular this year with a contested election in all constituencies, and a good overall level of interest from staff and public members.
- 3.18. There are 13 seats in the Council of Governors elections, and we have seen significant change upon receiving the results. A number of Governors have had to step down from the role for various reasons over this particularly challenging year. Some chose not to re-stand for another term and these seats were accounted for in this election. Thanks to all Governors for their support over the last few years, sorry to see some faces go, and good luck and wlecome to those starting their Governor journey with us.
- 3.19. We have adapted the election schedule this year to enable newly elected Governors to start their induction to the Trust earlier so they can observe the existing Council in action (meeting on 7 December) before commencing their term of office and prior to attending their first formal Council meeting as a Governor (in March 2022).
- 3.20. Election results were announced on 19th November. This timetable will also allow newly elected 'shadow' Governors to meet with the new Governors and share their experiences. The ability now to meet virtually should enable this to happen more easily, however Governors may prefer to meet face to face or combine the meetings with a visit to Trust premises (COVID-allowing).

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

3.22. 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.

3.23. 43 members (70 registered) joined to observe the Council meeting in September which was a good opportunity for members to see and understand the work of the Council.

3.24. We will continue to make these meetings available to be viewed online in real time and advertise them to members. Recordings of the meetings are available on our [website](#).

3.25. Member Newsletter

3.26. The next edition is due out in Spring 2022 and will focus on our response to the pandemic amongst other items.

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. There had been a reduction in attendance at meetings recently, members had been lost as some wanted to return to face to face meetings, but others' lives and capacity to volunteer had changed because of the pandemic.

4.4. A survey went out to all members of the IHAG asking about how to move forward with IHAG membership and what gaps they should fill.

4.5. Yvette Bryan Head of Organisational Development and Learning would shortly take over as Chair of IHAG.

4.6. IHAG had heard from colleagues about the changes around the Integrated Care Systems/partnerships etc, and the End-of-Life Care lead had joined the recent meeting to describe her work, and she sought members of the IHAG to join her stakeholder group.

4.7. The IHAG had also been asked about doing a Christmas event and they were very keen to hold an event with Governors and invite the new Governors as an informal networking opportunity. This has since been circulated to the Council and IHAG and is planned for the 22nd December and will be online.

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. The MDC were advised that the Staff Engagement Advisory Group (SEAG), hadn't been accomplishing what was needed, with low engagement in the group and a small proportion of staff attending. A new Head of Learning & Organisational Development had started, she had brought a different perspective and helped solidify views around staff engagement and how to best achieve this going forward.
- 5.4. It would remain important to involve staff in decisions that affected them, but more work would be done to help raise levels of engagement, as it was obvious from staff survey scores and feedback that engagement was not working.
- 5.5. SEAG meetings were therefore paused for now. There was a Town Hall Q&A which people could attend and offered good engagement with senior leaders in Operations.
- 5.6. The MDC noted the lack of engagement with corporate staff. The Town Halls were focused on operational colleagues. This was taken as an action to look into.
- 5.7. The engagement toolkit launch would be part of the staff survey outcomes launch. The new strategy should likely launch Q4 or Q1 when hopefully we would be in a better place to progress this.

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 appointed Governor representatives on this group.
- 6.2. Representation was sought from the Patient Experience team to join the MDC to provide updates on work at the PEG but unfortunately no one was available to join the November meeting. Future meeting dates have been sent on to Graham Parrish Patient Experience Manager for attendance.
- 6.3. PEG meeting due on 18/11/21 was postponed until 16/12/21 so no new input for CoG on 7/12.

7. Update from the Community Resilience Department

- 7.1. Sue Orchard Community Resilience Manager is part of the MDC as a representative from the Community Resilience Department.
- 7.2. SO noted that since March they had recruited 100 new Community First Responders (CFRs) into the Trust, and they had been trained. A new recruitment plan started in April for another 100, targeting where they would make most difference in terms of improving our rural responses. There was a trial for the Isle of Sheppey to try and recruit a whole team there.
- 7.3. New CFR recruits now got a Future QUALS level 3 qualification.
- 7.4. Restart a Heart programme had been undertaken: 50% online and 50% at schools, the team were also working on mutual aid participation for the CFRs, and Public Access Defibrillator (PAD) sites had been audited to ensure they were all rescue ready on the Trusts Computer Aided Dispatch (CAD) system. A known issue was that there were 3,500 privately owned PAD sites on the CAD that we had no idea about. The Trust is working with the British Heart Foundation (BHF) to see if we could integrate them into the BHF circuit programme to pick up the responsibility for this.
- 7.5. The Community Resilience Team had all undertaken a level 3 City and Guilds course on teaching and the whole team would now be able to help with the training of CFRs and more courses could be put on.

7.6. They had also just purchased a [JRCALC](#) app which included appropriate clinical guidelines for CFRs to access.

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. Consider how best to encourage Governors to make use of such information, and to make use of the IHAG appropriately to help understand the perspective of public Foundation Trust members.
- 8.4. Encourage those they meet to become members of our Trust (it's free) at: 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 B1 MDC minutes June & November

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Membership Development Committee Minutes

22 June 2021 11:30 – 13:30 on Teams

Present:

Katie Spendiff	(KS)	Corporate Governance and Membership Manager
Brian Chester	(BC)	Upper West SECAMB Public Governor (MDC Chair)
Asmina Islam Chowdhury	(AIC)	Inclusion Manager
Rob Groves	(RG)	Organisational Development & Engagement Advisor
Colin Hall	(CH)	Upper East SECAMB Public Governor
Geoff Kempster	(GK)	Upper West SECAMB Public Governor
Sian Deller	(SD)	Upper East SECAMB Public Governor
Emma Saunders	(ES)	Organisational Development & Engagement Advisor
Elaine Taylor	(ET)	Corporate Governance Officer

Minutes: Isobel Allen (IA) Assistant Company Secretary

Apologies:

Harvey Nash (HN)	Lower West SECAMB Public Governor
Chris Burton (CB)	Staff Governor (Operational)
Marcia Moutinho (MMo)	Staff Governor
Nigel Robinson (NR)	Public Governor
Leigh Westwood (LW)	Public Governor
Sue Orchard (SO)	Community Resilience Manager

David Escudier (DE)
Amada Cool (AC)
Waseem Shakir (WS)

Upper East SECAMB Public Governor
Upper West SECAMB Public Governor
Staff Governor

1. Welcome and introductions

1.1. BC welcomed members to the meeting and welcomed KS back to the Trust.

2. Apologies for absence

2.1. As recorded above.

3. Declarations of interest

3.1. None were received.

4. Minutes of the last meeting and matters arising and the action log.

4.1. The minutes were noted to be an accurate record of the previous meeting.

4.2. The action log was reviewed.

4.3. KS advised that the action log included actions from the previous meeting and KS had been off sick since then. The Communications Strategy should have been covered at this meeting but wasn't on the agenda as it was not ready.

4.4. BC noted that after the previous meeting, the MDC had held a conversation with Laurie McMahan, Chair of the Workforce and Wellbeing Committee to discuss communications. BC felt that the discussion with Laurie had not moved things forward. KS advised that she had not followed up with the Communications Team however IA noted that she believed the Comms Strategy would now come under the banner of 'Corporate Affairs' which was being considered more widely across the Trust. This had been in part inspired, she believed, by Governors' meeting with Laurie, but explained why the Communications Strategy was not forthcoming at this time.

4.5. KS thanked everyone for their attendance at the recent meeting with Laurie.

4.6. Sue Orchard had completed action 515 around CFRs. GK noted his comment at the Board regarding CFRs not being able to respond in care homes. This was being taken forward as a Governor query.

4.7. AIC noted that Communications Strategy development was also on the agenda for the Inclusion Working Group, which had received an update on the Corporate Affairs piece from Janine Compton suggesting she was still moving forward with the strategy with a deadline of March 2022.

4.8. Two in progress, around Governors reaching out to Patient Participation Groups online which would remain open, and around plugging staff governors into the Operations Town Hall meetings.

4.9. ES noted that the Town Hall meetings were still going ahead. The team were trying to step back and allow local operational managers to lead on those conversations. She felt there was more work to do on promoting them further.

4.10. ES and RG received anonymous emails from people who didn't feel confident enough to speak up in that environment, which was usually a reflection on them not feeling as safe in their local teams, not on attitudes towards the senior managers. The key to staff engagement was local engagement. ES noted that the

Town Halls incorporated answers and actions being reported back on which was what made them so effective.

- 4.11. KS asked whether the informal catch ups for Governors had gone well and whether more were needed. KS noted that we could leave it through the Summer and then come back to them perhaps in September if required. This was agreed.
- 4.12. On GP surgeries, BC noted that the delay wasn't of much consequence as they have only recently opened up again. BC noted his local surgery had been bombarded because the central NHS had asked people to get BP checks. They were starting to meet people face to face again.

5. FT Membership update plus IHAG, SEF, PEG, and voluntary services

- 5.1. KS gave an update on the Trust's membership. The narrative detailed under-represented areas in our membership. We would talk about this in more detail in the item looking at our membership priorities.
- 5.2. ES noted that Staff Engagement Advisory Group was meeting monthly during COVID which had worked well to begin with, but fatigue set in and therefore the meetings were back to quarterly with the next meeting at the end of July. The team were in discussion with the new Head of Learning and Organisational Development who was putting together a staff engagement strategy for the Trust.
- 5.3. ES noted that the staff engagement toolkit was on the agenda for later.
- 5.4. Work was ongoing around developing a restorative just culture, which would create a psychologically safe environment for staff and positively impact on staff engagement.
- 5.5. The Trust would be using a quarterly survey of the staff engagement indicators from the annual staff survey to give a timelier indication of staff perspectives.
- 5.6. The NHS Staff Survey would be coming out soon.
- 5.7. GK asked whether there were Town Hall meetings for admin and road staff. RG noted that the town halls were for all operational staff: all frontline, EOC and 111 were all included. There were plans for expanding more of the senior leadership availability, spotlight sessions around topics, etc. This would help make the meetings about the entire Trust.
- 5.8. Ownership by senior leaders was what made the Town Halls work and popular. GK was concerned that corporate staff may feel left out. ES noted that it was intentional that there was a focus on Operations. SEAG enabled corporate staff to raise issues.
- 5.9. GK suggested that SEAG be added to the corporate calendar.
- 5.10. AIC noted that SEAG used to add value when senior leaders brought projects to the group to get views from a wide range of staff. This part of the Inclusion Strategy was now not being delivered. RG agreed and noted that it needed embedding and to become a must-do not a nice to do.
- 5.11. KS advised that everything discussed was in the membership action plan, the aim of which was helping people understand why it's important to listen to and engage with staff. She noted that the engagement toolkit had been developed to aid people and would work with RG and ES about embedding this.

- 5.12. AIC noted that the Inclusion Hub Advisory Group had not met since the previous meeting. IHAG members were finding the virtual environment hard to navigate. Engagement in this way was simply not the norm at the moment.
- 5.13. The Staff Equality Networks had been a huge engagement tool over the last year and had been well-attended.
- 5.14. On Patient Experience Group, BC noted the challenge that not a lot had been happening prior to COVID nor since. There had not been a lot of feedback from the last meeting. He would like the MDC to continue to focus on patient engagement.

6. Membership Action Plan

- 6.1. KS noted the paper included was from the last meeting and she would continue working with RG and ES on the plan. In addition, the action to connect Governors with local CFRs and MRCs could be moved forward.
- 6.2. BC advised that it would be helpful to see the latest version of the toolkit for engagement. ES noted that a lot of feedback had been received and incorporated, and the toolkit was ready from their perspectives. She noted that the Head of L&OD would need to see the toolkit and ensure it fitted with her emerging strategy before launch.
- 6.3. BC would like this to be shared with Council more widely.
- 6.4. GK asked about the connections between MRC and CFRs: this had been made easier with the recent reorganisation of the CFR Teams, with a senior team leader connected to each MRC. This would be a simple contact point for KS to follow up.

7. Annual Members Meeting planning

- 7.1. KS advised that her inclination would be to hold another online event for the AMM, given where we were in the course of the pandemic. She asked for ideas for content and format.
- 7.2. The MDC agreed that they were supportive of an online event.
- 7.3. BC noted the benefits of the video last year, which had been very well-received by participants, and that we could reflect some of the pressures over the year and how we had responded.
- 7.4. KS noted that she would follow up with the Communications Team – but we had some excellent patient stories too as a fall-back position.
- 7.5. AIC noted that another Trust had used their AMM to do some training for everyone around dementia and becoming a Dementia Friendly organisation. A learning piece could be really good.
- 7.6. SD felt that highlighting partnership working across the pandemic would bring positivity and a lot of people from other organisations had attended last year. KS agreed and noted it would be great interview our partners about their experience.
- 7.7. RG advised that the 111 Clinical Assessment Service launch and new ways of working would be really relevant to people.
- 7.8. GK noted that the joint police/ambulance unit would be great to feature.
- 7.9. The MDC felt that the patient needed to be featured whatever else we did. KS would create a draft agenda and circulate to Chair, CEO and MDC shortly.

ACTION: KS to circulate draft AMM agenda to Chair, CEO and MDC.

8. Governor – Membership engagement and recruitment

- 8.1. KS advised that we needed to reach out to patients, carers, LGBTQ, and ethnically diverse members. She felt that a balance between specific events to reach out in every patch, plus a widescale event for doing mass recruitment would work well.
- 8.2. AIC noted that we were also concerned to make the ambulance service an attractive career pathway and get young people involved in the service too. Was there something that we could do to support that?
- 8.3. KS noted that we had tried to recruit younger members previously but the age limit for membership/voting was 16.
- 8.4. BC noted that finding a way of reaching out to people by offering real experiences with the service would be really good. AIC agreed that young person's or youth membership might be good. KS liked the idea; it was a question of who would do this work. We didn't have any funding for public education and did nothing on this. KS was happy to be in the loop with conversations already underway.

ACTION: AIC to invite KS and GK to be involved in work around engaging with young people.

- 8.5. BC noted the value of work experience. AIC advised that Restart a Heart Day was poorly done within SECamb. In other trusts, all corporate staff were out and engaging on that day to help be part of that initiative. This would drive engagement, membership sign ups etc.
- 8.6. GK noted that Restart a Heart Day tended to be coordinated by an ECSW and there was little investment.
- 8.7. ES noted that on youth engagement, last Summer Surrey Fire moved away from doing this ad hoc and introduced a Youth Engagement manager approach, with specific activities and courses. It was unlikely this would happen unless there were specific responsibilities.
- 8.8. AIC would invite KS and GK to be involved in the discussions around schools and youth engagement.

9. Any other business

- 9.1. No other business was raised.

10. Meeting effectiveness

- 10.1. The meeting was deemed to have been effective.
- 10.2. BC noted that running the MDC on the same day as GDC hadn't improved the turnout particularly. BC would like to leave the next meeting on 2nd November, but maybe next year we should seek to run them concurrently. The MDC agreed this was a good idea.
- 10.3. SD noted that we would see increased benefits to same day meetings once we met face to face again.

ACTION: Incorporate GDC and MDC meetings on the same day into Council meeting agenda plans.

Date of next meeting: 2nd November 2021

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Membership Development Committee Minutes

02 November 2021 11:30 – 13:30 on Teams

Present:

Katie Spendiff	(KS)	Corporate Governance and Membership Manager
Brian Chester	(BC)	Upper West SECAMB Public Governor (MDC Chair)
Asmina Islam Chowdhury	(AIC)	Inclusion Manager
Geoff Kempster	(GK)	Upper West SECAMB Public Governor
Emma Saunders	(ES)	Organisational Development & Engagement Advisor
Sue Orchard	(SO)	Community Resilience Manager
Harvey Nash	(HN)	Lower West SECAMB Public Governor
Marcia Moutinho	(MM)	Staff Governor (Non-Ops)

Minutes: Isobel Allen (IA) Assistant Company Secretary

Apologies:

Chris Burton	(CB)	Staff Governor (Operational)
Nigel Robinson	(NR)	Public Governor
Leigh Westwood	(LW)	Public Governor
Vanessa Wood	(VW)	Appointed Governor

11. Welcome and introductions

11.1. BC welcomed members to the meeting. KS advised that she had asked the Patient Experience Group to send a management representative, but they had been unable to put someone forward in the absence of Graham Parrish. KS would follow this up to request future attendance.

ACTION: KS to seek a PEG management representative at MDC in future.

12. Apologies for absence and Declarations of Interest

12.1. As recorded above.

13. Current position with public communications

13.1. The Trust's Head of Communications provided an update on external communications from the Trust and nationally. During COVID, national protocols had been introduced by NHSE/I to manage the flow of information effectively. These protocols remained in place and affected the level of detail the Trust was expected to share about current pressures in the Trust and wider system. NHSE/I was approving Trust communications prior to issue. This included NHSE/I reviewing and in some cases recasting responses to journalists.

13.2. The Communications Team recognised the importance of being seen to reflect the authentic experience of SECAMB colleagues and volunteers in their external communications. They were concerned that this was not always possible with the current protocols in place.

13.3. The Communications Team were keen to issue proactive communications over winter and would focus on doing so from 1 December to the middle of January. As well as the usual data related activity, they would focus on providing preventative and health advice information for the categories of call The Trust received most of over the winter. Secondly, they would be seeking to promote the top five things the public could do to help SECamb.

13.4. She would share a copy of the detailed communications plan if the MDC wanted to see it.

ACTION: JC to share copy of the winter communications plan.

13.5. Nationally there were no plans for big communications campaigns, however 111 online would receive a big push, particularly for younger age groups.

13.6. Members noted that devolved nations seemed more able to share information about the current pressures in the system. Members further discussed when SECamb may wish to declare a critical incident, given the challenges being experienced by SECamb and the system as a whole. Another ambulance service had done this which had enabled them to draw attention to its challenges but also they should have had to trigger the criteria for a critical incident. Members were not clear that this Trust was in any more challenging a period than SECamb.

13.7. The Head of Communications was clear that NHSE/I approved releases could be shared with journalists and the Team made it clear that this was the case when issuing those communications. Governors noted that Board and Council meetings published detailed papers with data about performance, and these were accessible to the public. SECamb was able to be quite active on social media highlighting the pressures.

13.8. The Association of Ambulance Chief Executives (AACE) was able to speak out on behalf of the sector and had been doing so. Senior leaders were also part of constructive discussions regionally and at national level. The health system overall was aware of the issues and supportive of the Trust's continued attempts to sustain adequate performance: this was not the case in any part of the health system at present.

13.9. SO asked about the unions asking ambulance colleagues to send them photos of the queues of ambulances. The Head of Communications advised this was for national GMB work, but it was not appropriate for them to use our internal Facebook page to do that. They were welcome to use their own channels. She could not allow this to be done on an internal Trust site. She was also concerned at the approach to hospital colleagues. The problems were systemic, and we must not blame each other.

13.10. HN wondered to what extent our local unions were able to play a role, but what he'd heard was the confusion with the national pay award issues. Locally though, did we have a union structure that was active? JC advised that GMB were a small player NHS wide but big in the ambulance service, while Unison was smaller locally but bigger nationally. She noted the potential of unions speaking with one voice to describe the issues faced.

13.11. KS asked whether JC could share the information from NHSE/I about the communication restrictions? JC advised that it wasn't written down as such but was

due to the national pandemic level we were in which she would share, this was then translated by communications people down the line to her and her team.

ACTION: JC to share the communications requirements set out by NHSE/ regarding pandemic comms.

- 13.12. JC's internet connection broke.
- 13.13. BC advised that the MDC had heard it was a systemic problem and agreed it was not worth setting parts of the system against each other. It was important to recognise that individuals who are members of staff may feel reluctant to speak out – but Governors were able to speak and in fact had a duty to do so.
- 13.14. BC wanted to discuss this further: how Governors should raise this going forwards, such as raising it at Council. GK agreed that it was important.
- 13.15. BC noted there was also a Facebook community for Governors that might be used.
- 13.16. IA agreed that it would be worth raising this with fellow Governors to see whether they had similar concerns.
- 13.17. IA suggested also having a conversation with NEDs when they were undertaking shared visits on Thursday as she was aware that the NEDs had previously discussed feeling challenged about not speaking out.
- 13.18. MM noted that we were currently investigating issues around serious incidents and the fact this had not yet triggered the Trust to declare a critical incident was surprising.
- 13.19. BC and MM agreed and noted that she was personally concerned about the lack of capacity of the service to attend to patients in need.
- 13.20. HN noted that a question should be put to Governors at the Council about whether the CoG should write to the press themselves stating the current situation factually and noting that we cannot accept the risk to patients. He felt this needed to be openly discussed at that Council meeting. That was not until December though and so the onus was on Governors perhaps to liaise before that. HN felt that the communications surrounding the Trust should not be limited.
- 13.21. AIC wondered how much the Trust was concerned about the reputational harm of declaring a critical incident.

ACTION: IA would email the critical incident criteria to Governors on the call.

- 13.22. BC wondered what new Governors who have been elected would think: incumbent Governors could see the how COVID had stopped development post CQC inspection in its tracks.
- 13.23. AIC noted that leadership had not had time to embed good practice before COVID hit. She was concerned that there was an element of trepidation to communicate what we needed. She also felt that behaviours were deteriorating due to the pressures.
- 13.24. SO noted from the operational point of view, she was on call regularly and we had been in a BCI for months, which had a set of actions to be taken, plus our Surge Management Plan which again has actions to take to manage demand, and they had discussed what we would gain from declaring a critical incident. She noted that the escalating actions became worse and worse for patients as we got busier. Declaring a critical incident wouldn't help our patients. Something more

fundamental had to change. We had been asked to look at fire, army, and CFR aid. We needed more people out on ambulances. But hospitals were also unable to cope, and we were losing so many hours at hospitals. Staff were asking about going back into special measures and suggesting that would be preferable and safer than where we were now: someone needed to listen to that.

13.25. HN noted the challenges and the need to better serve the public. HN asked whether the Council might ask the CQC to carry out an early inspection. He further noted the external auditors were at the next Council meeting: could we ask them to note the issues we were raising. BC advised that the audit had already been undertaken to a specific point in time and IA agreed external audit was not the place to raise these issues.

13.26. HN noted the importance of communicating openly about the way the pressures were being experienced.

13.27. BC summarised and felt that a discussion with the Chair might be a good starting point. David was a bit more aware of the situation and we should check what he felt and understood. IA advised that it may make sense to ask for a meeting with both the Chair and Senior Independent Director, who was the Council's confidante. BC agreed that this was a good course of action, to be taken after the NED/Governor visits later that week.

13.28. IA and KS thanked the Governors and everyone for speaking up.

ACTION: BC to request meeting with Chair and SID to discuss the concerns raised at MDC about the Trust talking open and honestly about performance issues.

14. Minutes of the last meeting and matters arising and the action log.

14.1. The minutes were noted to be an accurate record of the previous meeting.

14.2. KS advised that this year it had been hard to move things forward.

14.3. Regarding the text to promote the virtual EA group: AIC advised that it was probably worth closing this and coming back to it in future. AIC needed to recruit to the group. The EIA had been improved and would be launched and the group would need training in the new process. Following this it would make sense to promote it. KS would close the action and AIC bring back to MDC when it was ready to promote.

14.4. AIC further advised that Inclusion no longer sat under Angela Rayner but under the Learning and Organisational Development team.

14.5. Membership satisfaction survey: newsletter to be done March/April and would cover this there. The February MDC would discuss the content, but she asked for any ideas for the newsletter in advance.

14.6. Governor toolkit: on hold until we could get out and about to external events. KS would update the action log to show amber based on the revised dates for completion.

14.7. KS would follow up on the amber membership items before the next meeting.

14.8. AIC advised no engagement with young people had occurred because of capacity/ability to go out. She noted that IHAG members were being asked their views at present about what they could do better, and this may present some opportunities. KS would update the completion date to year end. KS wished to move the remaining actions from the membership strategy to the MDC action log.

BC advised that it had been frustrating due to COVID as we had hoped we were going to be getting out to meet the public a month or so ago and this hasn't happened. His PPG was still not holding meetings.

- 14.9. KS would like to do a more engaging event online if we couldn't get out and about. She would like to make a Plan A and B in February.

15. FT Membership update plus IHAG, SEF, PEG, and voluntary services

- 15.1. ES noted in relation to the Staff Engagement Advisory Group (SEAG), that they hadn't seen it accomplishing what was needed, with low engagement in the group and a small proportion of staff attending. A new Head of L&OD had started, she had brought a different perspective and helped solidify their views around staff engagement and how to best achieve this going ahead.
- 15.2. The SEAG was no longer the way to engage, as it was more important to understand the level of engagement staff feel rather than necessarily providing forums for specific staff to engage. It would remain important to involve staff in decisions that affected them, but more work would be done to help raise levels of engagement, as it was obvious from staff survey scores and feedback that engagement was not working.
- 15.3. SEAG meetings were therefore paused for now. There was also a Town Hall which people could attend and offered good engagement with senior leaders in Operations.
- 15.4. The staff engagement toolkit was still going to be part of the plan, but would be far more engaging itself and focus on improving staff engagement rather than engaging staff per se.
- 15.5. MM noted the lack of engagement with corporate staff. The Town Halls were focused on operational colleagues. She had been approached by colleagues who felt forgotten by the Trust. MM was concerned about the wellbeing of her colleagues.
- 15.6. ES agreed and noted that this was why it was important to review the way things were done to improve them. Line managers should be enabling effective engagement and the focus should be on developing them to engage their staff.
- 15.7. HN asked whether there was a timescale for this work. ES noted that on Thursday there was a strategy meeting, and they would then understand more about the timescales for delivery.
- 15.8. The engagement toolkit launch would be part of the staff survey outcomes launch. The new strategy should likely launch Q4 or Q1 when hopefully we would be in a better place to accept changes.
- 15.9. HN further asked about how this fitted into the bigger picture. He would like to understand how this fitted into the other issues around overall communications, stance, morale etc so that this all worked together.
- 15.10. ES advised that this had been discussed at the Board Development Day last week, where the Board had been clear that staff engagement and management training were business critical, and if so, we needed to decide how to make them happen.
- 15.11. KS noted that the Staff Governor role was vital because they acted as an early warning system. We should listen to MM's polite comments. Was it worth

holding a one-off Town Hall for support staff? ES advised that this would need to be led by the Senior Leaders in corporate teams. She would raise it on Thursday as it was a good idea.

ACTION: ES to raise with her team whether a corporate Town Hall meeting for engagement would be a good idea.

- 15.12. GK also had concerns that corporate staff were having little interpersonal contact with other staff. ES agreed. But again noted that she felt that effective management was the way to address this eventually.
- 15.13. BC noted that on Thursday the NEDs and Governors would be getting out to visit each other and go to Trust premises. Was more damage being done by not taking the risk of COVID than risking it and having some face-to-face meetings, given our vaccination status.
- 15.14. IA noted that the messaging around hot desking at HQ was that hot desks were available, but no-one was using them – ES would raise this at agile working meeting she was about to go to as we may need to communicate more effectively around this.
- 15.15. MM felt that managers were not consistent in their messaging around agile working. She acknowledged that it was complex, and the Trust wouldn't be able to please everyone. But, we had been saying the same thing for the past year and there was a lack of clarity still.
- 15.16. KS shared the membership report with the MDC, noting that figures had reduced as active recruitment was required. She had been doing what she could in terms of membership communication and engagement. A plan would come to the MDC in February.
- 15.17. AIC reflected on the IHAG meeting recently and noted that members had been lost as some wanted to return to face to face meetings, but others' lives had changed because of COVID.
- 15.18. Her survey to all members of the IHAG was asking about how to move forward with IHAG membership and what gaps they should fill.
- 15.19. AIC noted Yvette Bryan would shortly take over as Chair of IHAG.
- 15.20. IHAG had heard from colleagues about the changes around the ICS/partnerships etc, and the End-of-Life Care lead had joined the meeting to describe her work, and she sought members of the IHAG to join her groups. The IHAG had also been asked about doing an Xmas event and they were very keen to hold an event with Governors and invite the new Governors as an informal networking opportunity.
- 15.21. BC agreed this sounded productive and asked for a date to be set quickly.
- 15.22. SO noted that since March they had recruited 100 new CFRs into the Trust and they had been trained. A new recruitment plan started in April for another 100, targeting where they would make most difference in terms of improving our rural responses. There was a trial for the Isle of Sheppey to try and recruit a whole team there.
- 15.23. New CFR recruits now got a Future QUALS level 3 qualification.
- 15.24. Restart a Heart programme had been undertaken: 50% online and 50% at schools, the team were also working on mutual aid for the CFRs, and PAD sites

had been audited to ensure they were all rescue ready on the CAD. The issue was there were 3500 privately owned PAD sites on the CAD that we had no idea about. We were working with the BHF to see if we could integrate them into the BHF circuit to pick up the responsibility for this.

15.25. The Community Resilience Team had all undertaken a level 3 City and Guilds course on teaching and the whole team would now be able to help with the training of CFRs and more courses could be put on.

15.26. They had also just purchased a JRCALC app for CFRs to access all their guidelines.

16. Annual Members Meeting Review

16.1. KS introduced the paper. The overview was that the Council seemed to go well, and people found it easy to register and access the AMM on the day. There had only been a small sample of respondents to the evaluation request. She would like to look at other platforms. She wanted the Communications Team to be more involved and take more responsibility in the future.

16.2. People said they enjoyed it but obviously the technical problems were an issue.

16.3. MM noted that our AMM had been far better than others she had gone to. She further noted that she was surprised that the Communications Team were not more involved. KS explained the background that the corporate team managed the AMM when it was held face to face, and the Comms Team had cited capacity issues this year.

16.4. AIC noted that the money saved in not hiring a venue can be put to use getting a very good platform provider, as the Comms Team did not have that expertise. She recommended this. A hybrid approach would be brilliant.

16.5. AIC noted that the meeting had predominately been attended by staff. KS agreed and AIC noted that digital exclusion was a real issue.

16.6. HN noted that the hybrid option was far more complicated. He was concerned that high staff attendance showed they were not getting information through other sources. He congratulated KS on how it went.

16.7. BC noted that when we look at communications, there was a need for support and technical knowhow, and BC would like to feed back that proper 'nerd' knowhow was required for this type of event.

16.8. BC believed it was likely a bandwidth issue which had caused the technical issues.

16.9. GK noted that using Teams may have put off members of the public who used Zoom not Teams. KS agreed about the need to remove any barriers.

16.10. BC advised that we should seek other platforms with funding for appropriate support.

16.11. IA noted that it was important to recognise the tiny sample size responding to the evaluation after the AMM and suggested asking questions about preferred platforms as part of the planned membership survey.

ACTION: KS to include a question about preferred online platforms in the next membership survey.

17. Membership Action Plan

- 17.1. KS noted that she proposed moving the open actions to the action log. This was agreed.

18. Any other business

- 18.1. HN noted there had been a number of ambulance road traffic incidents recently, and he was concerned about whether the Governors got to hear the outcome of these cases. They might be end of shift times, people who are tired etc. Governors would like to know what happened as an outcome.
- 18.2. IA suggested that Governors would not receive communications unless there was a press release about it. Governors could ask questions however at any time, and she advised that it might be worth Governors receiving the summaries of SIs that were sent out widely to senior managers, as part of their request for assurance?

ACTION: Seek an update on outcomes of RTAs and establish whether Governors might receive the regular SI summaries as part of their assurance around patient experience.

- 18.3. BC summarised the need to give serious thought to how Governors responded to the issues they had identified, and MM agreed that meeting with DA and MW was a good step.
- 18.4. MM further noted that finding solutions to these problems was really difficult, but it was good to try and had been good to share experiences and worries.

19. Meeting effectiveness

- 19.1. The meeting was deemed to have been effective.

Date of next meeting: 21st February 2022

Post meeting Note: A meeting took Place on 23 November between the Chair, SID, BC and HN. Since the MDC meeting, significant coverage in the National Media had covered the concerns which had been raised on the 03 November and following detailed discussions HN/BC were assured that the issues had been adequately covered at a Senior level within SECAMB.

Appendix B2 IHAG minutes July

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

Notes of a meeting held on 28th July 2021
held virtually on Microsoft Teams: 10:00 to 12:20 hours

Attendees:

Angela Rayner	(AR)	Katie Spendiff	(KS)	Dave Atkins	(DA)
Asmina Islam	(AIC)	John Rivers	(JRi)	Simon Hughes	(SH)
Chowdhury					
Penny Blackburn	(PB)	Sarah Pickard	(SP)	Geoff Kempster	(GK)
Gary Davies	(GD)	Emma Saunders	(ES)	Rob Groves	(RG)
Waseem Shakir	(WS)	Monica Vidal	(MV)		

Secretariats:

Sophie Emery (SE)

Apologies:

Jane Watson	(JW)	Michael Tebbutt	(MT)	Phillip Watts	(PWa)
Jim Reece	(JR)	Patrick Wolter	(PW)	Tim Merrill	(TM)
Jane Watson	(JA)	Paula Dooley	(PD)		

1 Welcome and introductions

- 1.1 AR opened the meeting, welcoming members, and guests.
- 1.2 AR tabled apologies as given above.

2 Minutes of the previous meeting and IHAG Action Log Review



IHAG Minutes
25.01.2021 v0.1.docx

- 2.1 The notes of the last meeting were reviewed and confirmed as an accurate record.

Action log



IHAG Action Log
25.01.21.xlsx

- 2.2 AIC presented the Action Log
 - 2.2.1 Action 286.1 – Nathan Daxner, Frequent Caller Lead was unable to attend July's meeting. He has been invited to October's meeting instead.
 - 2.2.2 Action 286.4 – This was to invite a member from the strategy team to talk about the Trusts new commissioning environment. They will instead attend October's meeting.
- 2.3 AR acknowledged that the current pressures within the Trust have made attendance at meetings difficult at this time.

3 Review of IHAG activities since last meeting

3.1 Members updated the group on the activities since the last meeting, and these included attendance and participation in the following:

- JRi updated that yesterday he was involved in the interview process for the next Non-Executive Director. Fed back that this was positive and that suitable candidates were found.
- PB updated that she has been attending the falls group. Advised meetings are now bi-weekly. The current plan is to introduce a pilot in Kent using both CFR's and Kent Fire and Rescue around October, this pilot is currently in its training phase. This is progressing well.
- PB attended the Sussex Care and User Patient Experience Group. Their first meeting was two weeks ago. Advised it was a positive meeting and will be a good thing to remain involved in.
- AIC updated that there has been a request from the history marking team to have someone the meetings until the usual participants are able to attend again.

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ACTION: AIC to send out an email to IHAG members advising how those interested in participating in the history marking team meetings can express their interest.

ting patient mental health

4.1 GD updated that his team engage with Kent, Surrey, and Sussex police regularly about mental health issues. There is an ongoing piece of working around the use of the Mental Capacity Act. This work is focused on the increased number of cases where the police have declined to assist crews when an individual is deemed to lack capacity.

4.2 GD acknowledged that although the team is patient facing, there has been an increased demand to support our staff during the current climate. This support has been offered alongside the support that is available from the wellbeing hub.

4.3 There is ongoing training being offered around mental health although GD acknowledged that current pressures have made it difficult to get staff into classrooms to undertake this training.

Current training packages being offered include:

- Zero Suicide Alliance training which has been done within SECAmb key skills.
- Trauma Informed care training

GD is now focused on providing a mental health first aid training package. This is almost ready to go. The team are trying to take an innovative approach and develop online training that staff may be able to access more easily.

4.4 The Trust have a mental health car in Crawley. This model will be trialled in Brighton during August to see if there is further need for a vehicle within this area. This is following new commissioning guidance that details how we should minimise police conveyance, minimise conveyance to emergency departments and to seek mental health support on scene. Since implementation of the Policing and Crime Act 2017, the number of individuals being conveyed to police custody using a section 136 has

decreased significantly. The Mental Health team continue to work to Police around section 136 to significantly improve outcomes.

- 4.5 KS requested more information on the nature of the mental health care that will be trialled within Brighton. GD advised that the current car is staffed by a SECAmb paramedic and a mental health professional from Crawley crisis team. This will run between the hours of 12:00 and 22:00, seven days a week. Data analysed showed that this resource is being underused. This led them to look at the areas of higher acuity, identifying Brighton.
- 4.6 GD advised that colleagues from Sussex Partnership Foundation Trust (a mental health trust) on the car can refer and link individuals to ensure that care is continued and/or aftercare is provided. There are also mental health havens being developed across all counties. Crews can refer and convey individuals to these havens where they will be assessed by mental health professionals and if required, further care is provided.
- 4.7 It was noted that there has been an increase in young suicides being attended by our staff and the concerns raised about the impact this may have on them. GD confirmed that the training packages all aim to assist in supporting our staff. AR thanked GD for his attendance and update.

5 Update from Staff Engagement Advisory Group

- 5.1 RG updated that SEAG had been meeting monthly, however in April, due to operational pressures this moved back to quarterly meetings. The next meeting is due this Friday, but this has not yet been confirmed due to REAP 4.
- 5.2 It was noted that staff engagement within the Trust is not as effective as it should be. This is currently being reviewed to look at how it can be restructured in order to encourage engagement. ES attended a conference run by NHS England about staff engagement, staff survey and the people pulse. There were several trusts that had increased their staff engagement scores. They did talks on the various methods used; ES has fed these back in the hope they can be incorporated into what we do within our Trust. One of the key points was getting management to understand why staff engagement is so important.
- 5.3 KS expressed concerns about losing SEAG altogether. ES advised that staff engagement is important, and they are looking at ways to get the most engagement as it is not working in its current format.

6 Update from Membership Development Committee (MDC)

- 6.1 The AMM is taking place on Friday 3rd September online from 14:30 – 16:00. Invitations have been circulated to members by email, and the event is being publicised via all our communication platforms internally and externally
- 6.2 The **communication toolkit**, which was previously reviewed by IHAG, highlighting the available avenues for engagement within the Trust to our colleagues has been refined based on feedback received. It is currently on pause for the roll out as the new Head of HR and OD, Yvette Bryan, will be developing a staff engagement strategy that will more than likely include the use of a toolkit for managers etc. Yvette

has been invited to the November MDC to work on next steps and will be picking up other elements of the membership action plan in the meantime.

6.3 Governor elections are coming up in September and all members will be informed and have the opportunity to stand or vote in relevant constituencies. They will be notified via a hard or digital postcard regarding getting involved and ballot papers will be sent in due course. The timeline is earlier this year from September to November 2021 to allow for some overlap with existing Governors during which newly appointed Governors can receive training before commencing term in March 2022. This election will see increased representation in West Sussex to bring it in line with East Sussex.

6.4 Our next member newsletter will be in December 2021 and proposals for member events will be discussed at the next MDC for 2022/23. It has been a while since we have done any specific member information events other than the AMM and Governor drop-in sessions. Dependent on Government guidance we may attend some external public events this winter to undertake membership recruitment and give Governors' opportunity to speak with members. Looking at membership data, there is a need to continue to reach patients, carers, LGBTQ and members with disabilities and long-term health conditions to enhance representation. This will be combined with a presence at larger 999 events to boost member numbers will likely be the approach adopted when we can get out and about.

6.5 We will also be seeking a representative from the Patient Experience Group to join the **MDC** to close the gap on triangulating engagement work within the Trust. We have Governors who are on the PEG but felt it would be useful to have a member of the Trust's PEG management team to attend.

7 Horizon Scanning and future agenda items

7.1 PB asked if Andy could attend the next meeting to update on the falls workstream.

7.2 The equality objective is due for review. AIC is currently looking at workforce data and suggested bringing back recommendations to this group and developing a subgroup to look at objectives.

7.3 A

ACTION: AIC and AR to ask for expressions of interest to develop a small subgroup to further explore next steps on objectives.

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a membership review. Advised sending a small survey to ask individuals if they are still interested and wish to be involved and to also ask for key interests from those that do wish to be involved. SH requested to ask individuals how they feel meetings should be formatted going forward: face to face or virtually. This is to ensure that people are not being isolated from participation due to technology. KS highlighted that even though individuals may not attend meetings they may still engage with emails and messages including the sharing of any ideas they have.

8 Any
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ACTION: AIC and AR to develop and send out a small survey to ask members if they are still interested and if so, what their key interests are.

SS

8.1 PB highlighted that the meeting was due to be held during a half term, previous discussions had decided that meetings would try to be avoided during half terms and holidays. AR confirmed that this would be reviewed.

9 Review of meeting effectiveness

9.1 It was agreed that the meeting was positive with good participation and engagement.

10 Date of next meeting

The next meeting to is scheduled to take place virtually via Microsoft Teams on **21 October 2021**, 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 8 August 2021 and 21 October 2021. 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 meeting.
- 1.7. The GDC meeting in August covered: feedback from the previous CoG, the agenda for the September CoG meeting, constitutional changes on Governor numbers and elections (including a proposal to update constituency boundaries to match OU boundaries), Board Committee observation and feedback proposals, Council annual self-assessment of effectiveness, Governor training and development requirements, and a review of Governor attendance at Council.
- 1.8. The GDC meeting in November covered: the agenda for the December CoG meeting, consideration to return to face-to-face or hybrid meetings, new Governor induction proposals, Governor training and development requirements, and a review of 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.
- 2.2. The GDC noted the importance of the continuation of training after induction and supported a Lead Governor role – with an objective to be the bridge between Council and NEDS rather than to lead the Governors.

- 2.3. The GDC felt constituency representation was currently working well so saw no need to change this but were supportive of the work stream of embedding Governors into their local OU and Community First Responder teams.
- 2.4. Following a discussion on whether to return to face-to-face meetings, it was determined that the GDC is not in a position to currently go back to face-to-face meetings but will continue to re-evaluate.
- 2.5. The GDC agreed to include a new shadowing period for new Governors to get to grips with the role. The importance of a face-to-face induction was also discussed and deemed crucial.

3. Recommendations:

- 3.1. The Council is asked to:
 - 3.1.1. Note this report; and
 - 3.1.2. Read the minutes provided.
- 3.2. All Governors are invited to join the next meeting of the Committee on **10 February 2022 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 – 19th August 2021

Present:

Geoff Kempster	(GK)	Upper West SECAMB Public Governor
Isobel Allen	(IA)	Assistant Company Secretary
Chris Burton	(CB)	Staff Elected Governor
Brian Chester	(BC)	Upper West SECAMB Public Governor
Marica Moutinho	(MM)	Non-Operational Staff Governor
Colin Hall	(CH)	Upper East SECAMB Public Governor
Harvey Nash	(HN)	Lower West SECAMB Public Governor
Nicki Pointer	(NP)	Lower East SECAMB Public Governor
Amanda Cool	(AC)	Upper West SECAMB Public Governor
Leigh Westwood	(LW)	Lower East SECAMB Public Governor
Nigel Robinson	(NR)	Lower West SECAMB Public Governor

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 David Astley, Vanessa Wood, Waseem Shakir, Howard Pescott and Sian Deller.

3. Declarations of interest

3.1 There were no new declarations of interest.

4. Minutes, action log and matters arising

4.1 The minutes were reviewed and taken as an accurate record.

4.2 The action log was reviewed. NP noted in respect of the Governor website bios and links action, if Governors would be interested in a dedicated Governor account on social media pushing out key messages via the comms team. This could be considered at the next MDC.

4.3 GK noted the first action on the list was on hold, regarding Trust communications review. GK noted it had been four years since this action was raised. IA gave an overview of what had happened on this previously under a different CEO and advised it was currently sitting as a corporate communications affairs review which was yet to progress. HN noted the next scheduled Workforce and Wellbeing Committee (WWC)

meeting was not until December and that he felt the WWC committee should review this piece of work prior to that date.

- 4.4 Governors noted their frustrations on a lack of progress in this area. NP was keen to understand who the Exec Lead was on this piece of work.
- 4.5 IA noted leadership so far within the meetings held for it had been the CEO, Head of Comms and the Company Secretary. It was agreed that the action should be highlighted as overdue in red on the log. IA noted the last update she had heard was that the work was being scoped out. IA would follow up. IA noted need for target completion date from Chief Executive.

ACTION: IA to follow up on internal comms work action and to seek deadline for completion of this piece of work.

5. Draft Council of Governors agenda for 03.09.2021

- 5.1 NP asked for views on the proposed agenda.
- 5.2 GK noted he would like to see something around absenteeism, not just in respect of covid, and that the Trusts non covid related absentee was at 9% currently which presented a challenge on the hours the Trust was able to put out for patient care. IA noted it was a 28% abstraction rate currently, a lot of this would be in respect of colleagues taking annual leave. IA noted main challenge Trust faced was the output of hours over the actual demand so it should be picked up within the performance report.
- 5.3 NR noted he had heard comments around the Trust stopping all training for frontline staff. NP raised concerns over how staff could maintain competency and clinical skills without access to training. NP noted he would be keen to hear about how this would be addressed going forward. IA noted the plan at the moment was for operational colleagues to undertake training in September and October. IA noted it was a fine balance between making training available and maintaining patient care due to hours needed on the road and in our Emergency Operations Centres.
- 5.4 CB noted that there were delays with training, but there were plans in place to reinstate it. He was assured it would come soon based on what he was hearing in East Kent. NP noted that most NHS Trusts had suspended training, not just SECamb, and that Trusts were trickling mandatory training back in.
- 5.5 MM noted that having only 30 minutes for performance on the upcoming agenda did not sit well with her. It was the largest challenge the Trust faced. IA noted CEO report could focus on anything other than performance and then extend the actual performance section to cover this in more detail from David Hammond.
- 5.6 HN keen to understand what the Trust were doing to address burn out within staff. HN noted slight concern over asking the CEO to not cover performance. HN suggested CEO covered performance headlines and this segued into the performance report.
- 5.7 IA noted putting the performance report next to the CEO report on the agenda to combine the time available and ensure appropriate flow of content. IA noted she was keen to hear how well we were serving our patients in terms of quality of care, alongside target reports.
- 5.8 CH noted that the new Medway building would be coming in a years' time and the parking provision was under what he would have expected. CH noted concern around the impact of operation stack, alongside parking provision for staff coming and going. IA noted she had seen a project report that looked to address the parking issues so welcomed this challenge from CH.

Action: Seek an update on the Trusts plans for delivering training to staff over the coming months.

6. Board decision regarding constitutional changes on Governor numbers and elections

6.1 IA noted the constitutional changes had been approved by Council and the Board. The changes centred on increasing representation in West Sussex and amending the timeline. IA had checked with NHSP and a vote on the changes was not required at the Annual Members Meeting.

6.2 The GDC were content with this.

7. Board Committee observation and feedback proposals

7.1 IA noted previous feedback had been taken onboard and a revision to the template had been circulated. Governors felt it would be useful to be able to feedback on NED performance and content of the meeting as an aid memoir for appraisals and to ensure any issues were actively addressed by the Chair. The structure of the report was that part A formed a report for public domain, and that part B would be private and sent to the Chair and Council only to cover these two aspects.

7.2 IA noted the Chair had shared these forms with the Senior Independent Director Michael Whitehouse for feedback. IA noted they were content with part A, but on the part B they noted that although it was valid and useful for Governors to have a repository of their views on NEDs performance, there was already a process in place for raising concerns on NEDS. IA was keen for Governors views on the usefulness of the part B report.

7.3 HN noted he had found the record of Governor thoughts useful as a reference when it came to the appraisals. HN noted there was a difference between having a concern and noting an observation on performance. If there was an immediate concern on performance HN noted it should be flagged, via the existing structure. HN felt the part B report did not duplicate the existing process as that focussed on concerns rather than observations.

7.4 IA noted their concerns over the part B report being shared with the entire Council. The GDC agreed to proceed with part A & B reports and for the Trust to keep a repository of the reports and for part B reports to only be shared with the Chair and Michael Whitehouse. When it came to appraisals, the Trust could supply the reports to the Governors who attended the meeting as an aide.

7.5 HN was keen for the report to continue to be collaborative as it currently was and for the reports to be agreed by all Governors in attendance at the meeting observation before being submitted. HN noted Governors should not be keeping files on individuals, the Trust would hold the records and circulate as needed.

7.6 IA confirmed the report templates would be issued to Governors observing the next NED committee. IA noted the Trust would keep the process under review to see how it went.

8. Council annual self-assessment of effectiveness

8.1 IA noted that every year the Council was asked to appraise its own effectiveness. The colleagues Council works with closely were also asked for their views. IA noted it had been a challenging 18 months and the remote working was particularly difficult in respect of some aspects of the Governor role.

- 8.2 IA noted that the pre-meets and support of the Lead Governor were well received.
- 8.3 IA noted there was not a large response to training needs, but a continuation of training after induction was the takeaway point as this had not been as effective as we would have liked over the last year.
- 8.4 NP noted that whoever took on the Lead Governor role was the bridge between Council and NEDs and not to Lead the Governors. NP noted it might be a slightly misleading title and wanted to clarify what the role actually looked like.
- 8.5 NR noted that after starting this role in Feb 2020, it had been good to take part in the NHS Providers training on starting the role. NP was keen to get further training on the Governor role so that the Trust was getting the best out of the Governors and vice versa. NR noted training was still happening more widely and the Trust had perhaps dropped the ball on this in terms of Governor development. NR noted he hadn't fully understood the Lead Governors role until NPs explanation in the meeting and was keen to understand how Governors developed their knowledge of this. NP keen to understand Trust expectations of Governors.
- 8.6 NP noted with the Teams mechanism in place there was a platform to undertake training.
- 8.7 KS noted previous afternoon sessions at Council were a useful training opportunity and it was something that should be re-visited. The GDC agreed.
- 8.8 BC noted element of parallels in new elections for mentoring and training to improve the experience of the next Council of Governors.
- 8.9 HN asked NP what she liked about the Lead Governor role and vice versa and if anything could be learnt from that. NP noted more emphasis on her role would be valuable in terms of the wider Council understanding it. NP noted that she was sighted on Governor queries and the responses. NP noted the Lead Governor chaired the GDC and got to be part of other meetings within the Trust. NP noted she was currently based out of A&E so also had some interaction with frontline colleagues. NP encouraged Governors to reach out to her with any issues or areas they could use more support in.
- 8.10 IA noted the title was perhaps misleading, and that in previous times this had provided challenges within the Trust. IA noted that talking to the Lead Governor did not mitigate talking to the Council. IA welcomed any views on a revision to the title.
- 8.11 IA noted that the stakeholder feedback was welcome and showed the Board had good relations with the Council.
- 8.12 IA asked if there was anything information wise that Governors felt they should receive that they weren't currently.
- 8.13 MM noted that it was disappointing to see the lack of communication internally between management and staff when something significant happened in the Trust. MM struggled with the Trusts reluctance to speak to staff in an honest and timely fashion. MM noted that the recent accident with an ambulance and pedestrian had not been spoken of on the 4pm call the following day. MM would have liked to have heard how the affected staff member was being supported. The GDC were disappointed in how the information relating to the accident was not shared with Governors or colleagues in a timely fashion.
- 8.14 More broadly NR noted that internal comms needed to reflect the accuracy of the situation the Trust was in.
- 8.15 IA noted that more widely there were lots of controls in place by NHSE/I on what messaging went out publicly during a pandemic.
- 8.16 BC noted that the support that Governors received from IA & KS was of very good quality and somewhat superior to communications and processes elsewhere in the Trust.

8.17 HN endorsed BCs views and said the support and information Governors received was very good and should not be underestimated.

Action – Recirculate role of the Lead Governor to the Council for information.

Action: IA and KS to prepare rolling training plan for Governors over the year.

Action: Feed back to the Chair on Governor and Staff early notification of significant incidents.

9. Consideration of whether it might make sense to update constituency boundaries to match Operating Unit (OU) boundaries in some way

9.1 IA gave an overview of the paper and noted there was a plan to embed Governors in local OUs and CFR teams in their locality as part of the Membership Development Committee work.

9.2 NP noted her closest OU was Paddock Wood, but she represented East Sussex and was located on the border which was tricky.

9.3 HN noted that if operational boundaries were ever shifted then constituencies would need to be shifted and this would be relatively complex to manage. HN noted the need as Public Governors to represent public as opposed to staff and that by aligning constituencies to OUs he felt this somewhat diminished the public representation element.

9.4 NP noted it would be useful for the closest located Governor to an OU to be on hierarchal info posters.

9.5 GK noted from a relationship point of view embedding Governors in OUs would be positive, but not from a constituency perspective in terms of alignment as operational domains change.

9.6 The GDC felt constituency representation was currently working well so saw no need to change this but were supportive of the work stream of embedding Governors into their local OU and Community First Responder teams.

10. Governor training and development requirements:

10.1 IA noted this had been discussed earlier in the meeting and that a proposal would come to Council for a rolling plan of training.

10.2 Governor attendance. IA noted there was no paper as the Council haven't met since the last GDC meeting. NP was keen to see a mandate on Governors attending committee meetings. IA noted the statutory role was to attend Council meeting. The Trust could ask but not demand that Governors attended committee meetings. IA noted need to focus on holding meetings that were worth Governors time and energy to encourage attendance.

11. Any other business

11.1 CB noted there was an emergency services show in Birmingham EEC in September and that it was a good opportunity to get a national perspective of emergency services. NP encouraged attendance as it had been a worthwhile experience when she had attended.

11.2 BC noted he was keen for an update on the election timeline. KS to circulate info to the Council on this. IA encouraged Governors to sign up friends and family as members

so they were eligible to vote in elections. KS would share the election posters with Governors to put up in their areas and send out membership forms as needed.

12. Review of meeting effectiveness

12.1 The meeting was deemed to have been effective.

The next GDC meeting takes place on 21 October 2021 2-4pm venue TBC

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Microsoft Teams – 21st October 2021

Present:

Isobel Allen	(IA)	Assistant Company Secretary
Brian Chester	(BC)	Upper West SECAMB Public Governor
Marica Moutinho	(MM)	Non-Operational Staff Governor
Colin Hall	(CH)	Upper East SECAMB Public Governor
Harvey Nash	(HN)	Lower West SECAMB Public Governor
Leigh Westwood	(LW)	Lower East SECAMB Public Governor
Nigel Robinson	(NR)	Lower West SECAMB Public Governor
Chris Burton	(CB)	Operational Staff Governor

Minute taker:

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

- 1.2. HN welcomed Governors to the meeting and noted he had offered to Chair the meeting in Nicki and Was's absence.

14. Apologies

- 14.1 Apologies were received from Geoff Kempster, Waseem Shakir and Nicki Pointer.

15. Declarations of interest

- 15.1 There were no new declarations of interest.

16. Minutes, action log and matters arising

- 16.1 The minutes were reviewed and taken as an accurate record. HN noted there was a 'd' missing from opposed in point 9.3.
- 16.2 HN noted the recent Trust awards given to Leigh Westwood and Geoff Kempster and commended their commitment to supporting the Trust. He noted Sian Deller was leaving the Council but staying within the wider NHS family in her new role. It was IA's last GDC and wanted to take a moment to thank IA for her magnificent approach to supporting Governors and the Council and wished her well in her endeavours.
- 16.3 The action log was reviewed.
- 16.4 Action 123: Council to receive update on a review of the effectiveness of the Trust's internal and external communications by the end of 17/18 financial year. IA advised this had been escalated to the Chair on numerous occasions who had sought updates from the two different CEOs the Trust had has in this time on this. Current suggestion is that this action should be moved from the GDC action log and onto the Council log so assurances can be sought from NEDs at Council. Close it on the GDC log. BC noted need to capture the original date when the action was moved over.
- 16.5 Action 151: IPR interpretation workshop for Governors. IA noted this would be picked up within the agenda item on training and this could be covered in an afternoon session

at the Council. BC noted this could be post-election to help the new Governors understand the report.

- 16.6 Action 188: Ask if Governors are able to observe yet with crews. This is still on hold, however site visits to Operating Units will go ahead as part of the Joint Council and Board session.
- 16.7 Action 201: recirculate role of the Lead Governor to the Council for information. This was sent out recently as a reminder of the role and the process for election to it.
- 16.8 Action 203: feed back to the Chair on Governor and Staff early notification of significant incidents. This has been shared and can now be closed. The Governor support team are proactively trying to address this.
- 16.9 NR noted lack of progression with the Patient Experience Group (PEG) of which he was a rep. NR noted he felt under utilised in the PEG and was unsure that there was any intention from management to progress and achieve key workstreams. NR had raised this with Judith Ward who acknowledged the challenges but in his view didn't offer any solutions.
- 16.10 BR noted encouragement for NR to stay on as a representative and keep asking the questions and pushing for progress.
- 16.11 IA noted this has been raised via the MDC as well. Work streams were delayed due to Covid. IA asked for a specific example to escalate upward.
- 16.12 HP noted one of the questions we could be asking is how assured the NEDs are that the PEG's work compares to the NHS framework for improving patient experience. This could be audited as well to provide a steer.
- 16.13 MM noted that the patient experience of our service was poor at the moment and the team who managed complaints were under significant pressure. MM noted purpose of the PEG should be re-clarified as it was not clear.
- 16.14 HN noted he attended September PEG and there had not been a lot of progress as staff had been diverted to operational work and the quality account. HN asked if it would be better to pause the groups work for 6 months. HN advised that Tammy Moorcroft did not want to pause it which actually was a good sign.
- 16.15 KS noted representation at MDC from the management of PEG had been requested for the next meeting.
- 16.16 NR noted lack of focus on benchmarking scores and root cause analysis at the PEG.
- 16.17 NR noted there was no perceived buy in at a senior level to the importance of listening to patient experience and learning from serious incidents. IA noted this should be escalated again to the NEDs via the Council meeting.

ACTION –Seek assurance from the NEDs at the December meeting that the PEG's work supports the NHS framework for improving patient experience.

17. Feedback from September's Council meeting

- 17.1 BC noted technical issues at the Council and Annual Members Meeting, and this would be reviewed at the MDC in more detail.
- 17.2 IA noted the Council had asked some exceptional questions on the day and really come together as a team in seeking assurance from the NEDs.

18. Draft Council of Governors agenda for 7th December's meeting

- 18.1 HN noted the comms action discussed earlier would need to be raised at the meeting. IA noted the CEO could be given a heads up on this to cover it within his paper.

- 18.2 IA noted the external auditors would be in attendance to present at the meeting and the new Governors would be in attendance shadowing. Scrutiny piece is on audit and finance committee.
- 18.3 Progress and governance of operational review programme 'better by design' was added as an item of interest as the Council were rightly focussed on performance and support for staff at this time. IA noted it would be good to seek assurance on progress.
- 18.4 HP noted the most important element of any organisation is it's staff. SECAmb's Freedom To Speak Up (FTSU) index is right at the bottom for the whole of the NHS. In terms of staff wellbeing and the current staff survey, had the previous year's results come to Council in a 'you said, we did' format and if not where would be the encouragement to complete the staff survey this year?
- 18.5 MM noted she would like to know how well colleagues were actually being supported outside of the wellbeing hub services. Keen to understand how managers are supporting colleagues directly and how much take up there was of the support options offered by the hub. IA noted the Board meeting contained a FTSU report and there was robust challenge on Trust culture by the NEDs and lack of action off the back of the staff survey. There is a Board Development Day focussing on this.
- 18.6 IA noted it would be useful for an update from the Chair on the Board Development session on this at this meeting. The GDC agreed.
- 18.7 HN noted he had seen the discussion at the Board and sent some thoughts to the Chair on practical ways of addressing the concerns as his background was in organisational development.
- 18.8 HP noted he would want to see a commitment re the implementation of 'Just Culture' programme work that was being done nationally. HP noted the focus was how we support people when something goes wrong.
- 18.9 MM was concerned there was a lack of support for staff when addressing complaints.
- 18.10 NR noted the significance of the 'Just culture' programme and was keen to understand if the Trust was adopting this approach. NR keen to seek assurance on the Trust's commitment to this.
- 18.11 HN noted need for a learning culture not a blame culture.
- 18.12 NR noted he had observed the Board and there was almost an acceptance of culture issues in the Trust. The constant state of emergency in the Trust being at REAP4 for such a long period was having significant impact on people's wellbeing and their ability to keep up skills via training, when lots of initiatives are put on hold to address operational demand.
- 18.13 IA noted there were options within the Chair's update and CEO presentation to address these concerns. IA noted there could be a Council development session to help support the Board in the development of a plan to address these concerns.
- 18.14 HN noted the 'better by design' section could address some of these concerns on staff wellbeing and culture and colleagues' ability to look out for and after each other. IA noted this would be a good starting point for the Council in seeking assurance in this area. The GDC agreed and were keen for regular updates on this to come to Council.
- 18.15 IA noted HR colleagues had been charged with introducing the 'just and restorative culture' piece. NR was keen to see a specific team put in place to support this large-scale piece of work.

19. Should Council return to face-to-face or hybrid meetings?

- 19.1 IA noted Covid cases were increasing, and new protective guidance was being issued by the Trust in spite of recent Government statements. IA noted a proposal to

alternate f2f and online meetings for the Board. IA noted though not in a position currently to go back to face to face meeting. Propose this item stays on the agenda for the next GDC meeting.

19.2 NR asked if the site visit on the 4th November were going ahead. IA advised that we had made the case that these were essential in the Council and NEDs being able to undertake its duties and this kind of engagement had been on hold for 18 months.

20. New Governor induction proposals

20.1 IA gave an overview of the paper and noted the new shadowing period for new Governors to get to grips with the role.

20.2 IA noted the usual tour of HQ and EOC may likely need to be put on hold.

20.3 IA noted that in previous years we had buddied up Governors in the same constituency for support.

20.4 BC noted that if there was a large change on the Council, people seeing how 999 works and meeting in person was really important and a case could be made for the value of this.

20.5 MM noted she would be happy to meet with the new staff Governors before the Council meeting to share her experience and what to expect.

20.6 IA noted we could do the introduction for new Public Governors so Governors could reach out. We could also facilitate an online relaxed 'get to know each other' session as we had done earlier in the year.

20.7 NR noted that the induction was crucial and stated the value in doing this face to face. Opportunity to lay out reality of the role verses ambitions of those standing for election. A follow up virtual hang out session a few weeks after the induction with operational colleagues with an overview of the service in more depth would be useful. NR was keen to see more in-depth information on the service within the induction.

20.8 HN welcomed the Senior Independent Director being part of his induction and would recommend a session with him outlining what the NEDs want from Governors.

20.9 IA noted she heard the importance of face to face visits and inductions and would look to incorporate the hang outs.

20.10 IA noted we would do constituency introductions and leave it to people to make contact their preferred way.

20.11 BC noted that if a new Governor is replacing a sitting Governor some thought would need to take place on buddying.

20.12 IA noted current Governors are the elected representative until the end of February, regardless of the election results but she appreciated his point entirely.

21. Governor training and development requirements

21.1 HN noted the value of good training and preparations to undertake the role.

21.2 IA advised there was a range of formal and informal opportunities for Governors to use while with the Trust as detailed in the paper.

21.3 IA noted there was a suggestion to bring NHS Providers trainers inhouse where a number of people want to attend the same course.

21.4 IA noted the proposal to have afternoon sessions after the Council and use this time for development and learning and encouraged Governors to block out an entire day for Council meetings.

21.5 IA asked if the GDC were content for this paper to go to the Council. The GDC were.

21.6 NR noted Tuesdays were challenging for him to attend training on, could this be considered.

21.7 HN asked for a line in the PEG section saying about nominated Governors who attend it – HN and NR.

21.8 HN noted previous Quality and Safety site visits had been useful.

21.9 HN asked if external events should feature in this paper – a line on encouraging people to attend once they are agreed at the MDC would be included.

22. Review of Governor attendance at Council

22.1 IA noted that CD was not re-standing in the election and his absence had been explained to date.

22.2 IA noted that Nev Kemp Appointed Governor from the Police was understandably struggling to attend meetings at the moment with the change in his role and the pandemic, and that the Council may wish to monitor this.

22.3 NR noted there were often valid reasons why people couldn't attend, and this should be considered. IA noted this was the purpose of the agenda item and that the challenge would only come forward if we were not informed why they did not attend.

23. Any other business

23.1 Corporate Governance Team to look at planning for future meetings and find out people's commitments in advance. For example NR had prior commitments on a Tuesday.

23.2 HN asked about the new operational performance committee and when there would be an opportunity to observe and when the Council would start to see escalation reports. IA noted this was a timing issue and was underway.

24. Review of meeting effectiveness

24.1 The meeting was deemed to have been effective.

The next GDC meeting takes place on 10 February 2022 2-4pm venue TBC

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=UeDqcq7pE0mFIJzyYfBhGFHlnsSYmzxOp1c2Ro-88d1URE1MVDQ1NVVINEQ2N1dDR05OSDg1VUxWVC4u>

Date	Activity	Governor
30.06.21	Agile Working Sub Group meeting	Marcia Moutinho
08.07.21	Governor Focus Conference 2021	Marcia Moutinho
13.07.21	Effective questioning and challenge training	Colin Hall
24.07.21	Extra meeting with NED's re Clinical Education & Mental Health Wellbeing	Chris Burton & Waseem Shakir
10.11.21	NHS Providers Governor event	Harvey Nash

2. Governor Enquiries and Information Requests

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

10.06.21 Harvey Nash

Q: Philip mentions the Body Worn Camera trial, which is welcomed, and very much focuses on reducing / prosecuting assaults which would be equally welcomed. However, will the trial also look for any other aspects, positive or negative of such equipment. I guess

this has been considered but I cannot recall seeing anything. If I have missed it could I have a copy, if not could this be raised as a Governor question, please.

A: It's very reassuring the support we are seeing across the whole Trust for this trial. Below are the monthly metrics we will report back to NHS England on and also how we will use data to inform us of other areas than solely successful prosecutions:

NHS England

SECAMB METRICS

In addition to recording the impact on successful prosecutions our incident management system has been amended for the purpose of the BWV trial to capture the following information:

1. Did the wearing of BWV escalate or deescalate the situation
2. Did the warning of activating of BWV escalate or deescalate the situation
3. Did the activation of BWV escalate or deescalate the situation
4. Justification for each activation of BWV

11.06.21 Harvey Nash

Q: It looks from this that the BWV trial is purely about reducing 'assaults'. However, would you ask if any consideration has been given to other uses of BWV please. I am thinking of it assisting in non-assault incidents, complaints, or bouquets, learning from dealing with unusual situations etc.

It appears from the info given that crews decide when to activate BWV and part of the trial is to assess whether activation calms or exacerbates a situation. What have crew been told about when / when not to use BWV and when / how to activate it?

A: We are working within the scope of a national funded trial that aims to look at the impact of reducing violent and aggressive behaviours towards our staff and where they do occur and staff wish to formalise proceedings, to provide BWV footage as evidence leading to improved instances of the CPS proceeding with prosecution and the use of first evidence of BWV in securing successful prosecutions for our staff.

Clearly if we decided that we wished to continue with BWV post trial then the scope of BWV would need to be discussed.

A communication is about to go out to staff that are involved in the trial that will include FAQ. Additionally before a staff member can use the BWV they will have to complete an online training course on Discover that will be recorded on the ESR platform that will include:

BWV Training video

Short BWV user guide

Policy and Procedure

Action card 1 – Cleaning of equipment

Action card 2 – Recording of BWV activation on Datix our incident management system

28.06.21 Was Shakir

Q: Our Service has seen immense pressures with the current Pandemic causing additional

stresses on staff at home and at work. It is clear that sickness levels have risen with increasing numbers of staff reporting Mental Health issues, I am grateful for the staff in destigmatising this subject.

I am aware that a First Aid for Mental Health Course which is Nationally Accredited and designed to improve resilience has been externally funded is ready to be rolled out to staff but now has stalled prior to delivery as “we are unable to abstract staff”.

Please can you provide assurance that Mental Health Resilience is an area which will be invested, and if you are able to provide where we are in relation to delivering training in this area?

A: Meeting arranged to address concerns between Workforce and Wellbeing Chair and Staff Governors. Questions about the mental health training courses and about the governance of Clinical Education in general were on the agenda for next WWC. Staff Governors were also invited to observe the WWC meeting.

25.06.2021 Nigel Willmont-Coles

Q: Can we receive assurance that the Trust has oversight and records of all SECAmb Public Access Defibrillator sites in the region.

A: Historically there had been a lack of focus and oversight in this area. Within the last two months the following has been underway to address the risks.

- A PAD database has been developed
- An alternative duties person has been assigned to take responsibility to audit and population of the new database for SECAmb owned PAD sites only at this stage (At the time of starting the process we had 603 sites we owned). The other 3500 sites are public / privately owned.
- Both alternative duties staff and CFRs are being tasked across the geographical area of the trust to check the PAD sites for us and update the database (This process is being overseen and coordinated by the alternative duties person).
- Currently there is no one dedicated person who maintains or has responsibility for SECAmb owned PAD sites.
- Those sites where it is unclear on ownership, these are being removed from the CAD.

22.07.2021 Harvey Nash

Q: The 999 pickup and response times, especially the 90%ile are very worrying and worsening. I know that a BCI has been declared and that enables some additional focus and do hope that assists. I also note that the overall absence rate is now in single figures, which is helpful but may be storing up issues as our people push themselves even harder to meet rapidly growing patient demand. I am also aware that HMG has now promised some additional funding for ambulance services, though unclear whether this will be sustained or how, even in the short term, this will have any meaningful effect.

The problem is matching resource with demand, and we cannot magic much more resource from already stretched people, so there must be effort to reduce demand. In this vein I am concerned at the minimal publicity being given. I have seen no press coverage of SECAmb's BCI, there is nothing about it on our own website. The most recent news there is from 16th but focuses on heat wave precautions, not the BCI, not our over-stretched resources. If the public (and our members) are not aware of issues they cannot take them

into account. So my question for our NEDs is how assured are they that SECamb is effectively informing the public in order to minimise ambulance demand?

NB. When checking the website today I also looked at 'Stakeholder news' in case that gave a fuller picture. Far from such, the last item was back in 2019! Hardly reassuring.

A: I have spoken to the Head of Comms, and she has noted they are doing all that they can within the constraints of working within pandemic communication guidelines and having to have everything signed off by NHSEI around messaging. For example Fionna Moore was on BBC Sussex the other day speaking about the impact of the hot weather, and a lot of general messaging has been going out on our social media platforms. I have actually sent information to our public membership today on alternative NHS treatment routes alongside the Annual Members meeting invite etc.

29.07.21 Harvey Nash

Q: Hi David (Peter copied in), I have two queries which I refrained from raising in the public session (given that neither required full Board involvement today and time was against us) but would appreciate answers on.

Thanks for posing the question I had raised re Self-Isolation exemptions. Philip's response and the other inputs indicate that there is no practical difference between the rules for the Police and Fire and those for our frontline crews, and that patient vulnerability was a factor. My concern is that this is not clear publicly - the BBC website clearly indicates different schemes and in particular the rules for Police, Fire (and countless others) allow exemption regardless of vaccination status, whereas the NHS rules require double vaccination and case by case consideration. I can understand that when all factors are considered there may be little if any difference in numbers exempted, but do our frontline colleagues understand this, do the public? How well are we communicating this internally (do our crews feel they are being seen as less necessary, trusted?) and externally (ambulance people are less pressured or they would be given wider exemption)?

My other query relates to press coverage. Yes, we are being active in appealing to people's better nature and asking them to only seek an ambulance / 999 in a real emergency.

However, the public get a similar message from virtually every organisation - please use / see our website, rather than phoning, we are very busy due to Covid... - but we are not mentioning let alone highlighting the real consequences. The time to answer and time to respond figures are clear and worsening, demand is way up and still rising, resources are reduced and further stretched by handover delays, and this is everywhere - the potential consequences for some patients can be dire. Those affected could be anyone's friends or family. I am not seeking scare tactics but some upfront clarity on why people really need to think before calling 999. Is this being considered?

A: From Company Secretary:

Like you, I read the headlines thinking this would be a real positive step in response to our challenges with staff self-isolation. But then I saw the guidance and what stuck out for me was notwithstanding all the exclusions, it was voluntary. So staff could choose whether they wanted to take advantage of the guidance or remain in self isolation.

The guidance is generic, and so does not take account of the different healthcare settings. One of the main exclusions is that related staff cannot attend extremely clinically vulnerable patients. For other settings where this is known it is easier to allocate staff accordingly. For

us, it is often the case we won't know 'til we get to the patient. This is why ambulance services are trying to develop the guidance to take account of the issues within our sector. In the meantime, we have agreed locally, in conjunction with unions, to apply the guidance to EOC/111 only. Until the national AACE guidance is established.

But even here there are some queries, and the devil as always is in the detail. For example, staff are asking if in coming to work they can stop and the petrol station or get to the food van during a shift. The guidance is silent on this.

Of the x number of staff who are self-isolating (it is a high number, but I don't have it to hand) those that qualify in light of the guidance is a single digit number. Moreover, of this small number, each member of staff has chosen to continue too self-isolate.

To your point about what the public understand, I am not sure. Certainly from our contacts in other parts of the NHS, none are reporting any significant numbers of staff returning following this guidance.

And of course it will be a moot point in 3 weeks when the self-isolation guidance changes. Harvey, on the really good point about comms, this is definitely being considered and as I think Janine mentioned earlier, there is always a fine balance with this as this can be counterproductive (I am told) where such comms increases demand on our services.

I can't recall whether it was in part 1 or part 2 but the challenge of the Board is to influence nationally to get some concerted comms on this very point across the country.

From NED: I am assured but Harvey makes a good point about how we seek to influence public opinion which was discussed at the Board on Thursday. I think it might be good if we continue to get on going feedback at the Board and that we continue to make representations up the NHS system. This is very likely to become a bigger issue over the winter and worth raising at Council.

06.08.2021 Geoff Kempster

Q: Can you please ask the appropriate NED if they are assured that the Trust is really dealing with the current pressures in the best possible way? I am seeing things that do not appear to make sense. There are NQPs that want to work Bank, but are being declined the opportunity, and we have now apparently changed the rules relating to bank staff requiring a minimum number of hours, resulting in a number of bank staff potentially leaving. These are all people that could contribute man hours to the Trust to help alleviate the pressures. We also have a large number of CFRs who hold C1 licenses, and around 30 have also been assessed and approved to drive Trust vehicles, that would probably be more than willing to assist. They are already trained in the basics required to assist a technician or Paramedic, and most are familiar with the layout and most of the equipment in the vehicles. Some CFRs are also ex Police or Fire and are Blue Light trained. So we have a ready and willing group of people that would happily step in to assist, but they are not being utilised. I appreciate that it is useful to have them on call to respond locally, but in many cases there are teams covering the area, so they can be available. I find it strange that the Trust seems to be unwilling to make use of the resources at its disposal but would rather call on the Army to provide drivers who are unable to drive on Blue Lights and require training to provide basic life support and familiarisation with the vehicles.

A: From Company Secretary. Geoff, notwithstanding the specifics, you might find it helpful to review the recording of the last Board meeting a couple of week ago. This meeting was focussed on your very point and there was a circa 60min presentation from the executive

setting out the challenges and key actions being taken, including the safety measures all the while we aren't getting to patients quickly enough. The summary of this in terms of assurance was I think that the Board was not assured by current performance (we are far from the ARP quality standards) but was assured that we are doing everything we reasonably can. In other words, the Board could not find anything else that isn't being taken forward. The Board ack. that despite all the efforts it is having relatively minimal impact, but such are the uniqueness of the challenges, which are being seen across all amb services. There aren't any easy short-term solutions. We did also have a session with CQC (last week) who wanted to seek assurance given the challenges, and they expressed significant assurance (across 1s and 9s) in how well understood the issues are and the steps we are taking, both in relation to what is within our gift and the wider system issues. This will no doubt be a key focus of the COG meeting in Sept.

06.08.21 Nigel Robinson

Q: I want to express my frustration and disappointment that yesterday via social media I was informed of the dreadful accident involving a SECAMB ambulance in which a member of the public died. I find the total lack of communication very disappointing. Such is our position within the trust and specifically the area in which I was voted to serve the public - the expectation is so at odds to the reality. On 3 occasions since 09.30 hrs yesterday – I had nothing I could say.

I understand the constraints of sub judice, investigations and sensitivity that surrounds such events I have indeed been closely involved in such situations during my time in uniform, but David, where was / is the official statement on this dreadful event? Someone should at least give us a corporate statement. If something has been issued – I did not get it.

I think we as a collective should have been told at least by close of play yesterday.

A: Company Secretary: I think what this has highlighted is a potential gap in how we trigger the need for internal comms with the COG, following such incidents.

I will talk to Janine and colleagues about this. An update on this incident was shared with the Council.

20.08.21 Harvey Nash

Q: I have just seen on the BBC website that the military have been deployed to assist four ambulance services (inc SCAS) but no mention of SECAMB. I had understood that MACA assistance for us had been requested and certainly recent performance numbers and discussions at GDC yesterday highlight the need. I would like to know, urgently, why MACA assistance is being given elsewhere but not to SECAMB. And what our NEDs are doing to ensure our executives are addressing this effectively and promptly!

A: Mutual Aid requests were arranged nationally with the army. Initial spec was to receive support from the army until the end of September. SECAMB were advised that the MACA offer of support closed on 31st August which was an issue as it was support in September for cover that was required. Decision made to cease bringing them in as a limited return on investment after the training period required to get them up and running.

27.08.21 Geoff Kempster

Q: I am concerned to see that the operational front-line hours have now dropped below 90%. I appreciate, but am also concerned, that the absentee rate is double the expected

norm, but I do not believe that accounts for all of the drop-in operational hours. I am hearing reports of a number of staff leaving due to the pressures they are experiencing and also due to relocation of their operating base.

I feel the council need to have some feedback from the Trust regarding this serious drop in operational hours and the actions they are taking to address this. The less operational hours we achieve results in increased pressure on the remaining staff, with the knock-on effect that more are likely to leave for less stressful environments, such as GP practices.

A:

Resource provision has been increasingly challenging since mid-May this has been due to a range of issues:

- Increasing annual leave – with the lifting of lockdown, large numbers of staff are taking their leave with July and August seeing the highest levels of leave for the year – and greater than during 2020.
- Sickness is at high levels – in some areas the level is twice the ideal level. The themes within the sickness have been:
 - o increasing Covid-related sickness that has now somewhat stabilised
 - o increasing levels of sickness related to mental health conditions related to stress, anxiety, and depression
 - o other areas of sickness are still present (e.g. musculoskeletal injuries, general sickness etc)
- We have been working hard to offset these losses via a number of key actions:
 - o looking to bring in additional private ambulance providers, however this has not realised additional resource as they are facing the same challenges as we are
 - o incentivised overtime – over the past few months, it has been seen that there has been a lower uptake (approx. 40% less) in overtime than experienced at the start of the year
 - o additional efficiencies through ensuring managers undertake clinical shifts, working with the hospitals to manage handover times etc
- Staff turnover last year was less than seen previously as opportunities across the wider market were lower, however we have seen this pick up more recently in a couple of main areas:
 - o as the airline and other service industries re-open, staff who wish to return to their careers that were put on pause, are now doing so – this has impacted EOC & 111 to a greater extent
 - o We have been in discussions with system partners for over 18months regarding the increased demand for Paramedics within primary care in particular. Working in other areas of health is no less stressful but having a ‘portfolio’ career is a more attractive option for a greater proportion of staff – this is something that we are considering how we can support and engage with going forward
- With regards to relocation – we are continuing to rollout the organisational strategy to provide the best estate we can for all staff. In order to do this we are investing in new buildings, learning all the time from the various iterations of Make Ready Centres as they are completed. When such work is undertaken, often staff have to relocate which may impact some staff more than others. With regards to Banstead and Medway MRC constructions, we have a programme of consultation with all staff affected to work through

any concerns on an individual level.

09.09.21 Marcia Moutinho

Q: You may recall that during the Council of Governors in June, I sought assurance around the PADs (public access defibrillators) management process. I believe that David mentioned at the time that this is a process being managed by the Executive Team. Is this something that QPS committee is still overseeing and seeking assurances on?

A: The public access defibrillator issue is on the agenda for tomorrow's QPS, where we will have a management response from Emma Williams following the full paper discussed by the Committee a couple of months ago.

15.09.21 Colin Hall

Q: Re Pulse Survey results - I would be interested to know how the trust will use this information. Also it would be useful if the responses were shown in their respective groups for example how the staff from EOC, Corporate and Ops etc. responded, rather than having all the 718 responses as a whole this would give a truer an indication of how the different sections of staff view the trust. Over time the trust will have a more accurate indication of whatever initiatives they employ are working.

A: Regarding how the Trust will be using the data, the EMB/SMG plan is that the National Quarterly Pulse Survey results, along with the NHS Staff Survey results will be used to feed into a rolling strategic action plan that may change as new results come in, thus possibly changing which actions are required. There is currently a paper put forward by Ali Mohammed, called Improving Staff Experience, which sets out the strategies and actions that will take place to address a number of issues that have been raised through previous surveys and other data. Regarding the results, the initial overall results have been shared Trust wide, as you know. The breakdown of results has been shared with EMB. The plan will be to develop a space on the Zone in which the results will be updated each quarter the survey runs, which would then show the break downs. As this survey has only just launched, and does not run again until January, we have not yet had time to prioritise sharing the break down, but we will endeavour to get this done as soon as we have capacity to. If the governor has any further questions about actions taken from the results, we advise contacting EMB directly, as any resulting action plans would not fall within our remit.

30.09.21 Geoff Kempster

Q: On the subject of MACA, I am still surprised that the Trust is ignoring the 30+ CFRs who have C1 licenses and have been assessed to drive DCAs. I have raised this a number of times with Community Resilience and am told it is with Operations or somewhere, but the somewhere seems to be a black hole.

A: The Executive have discussed the C1/CFR issue and Philip was grateful that you had brought this to his attention. An options paper is in progress and scheduled to be considered by EMB on 20 October and we will let you know the outcome. I think it was accepted that this has been a long time coming and there are different reasons for this, but

Philip has asked that we now get to an agreed position ASAP. We've made a note to send you another update after the Executive have considered the best way forward.

03.10.21 Colin Hall

Q: This is a follow-on question previously. In the attachment I have highlighted concerns I have over the documents listed below.

Car Parking Tabletop Exercise 10/08/2021 (D1), Travel Plan for Bredgar Road Version 0.5 (D2) Medway MRC – East EOC/111 – Car Parking Tabletop – 10 August 2021 (D3)

Medway MRC – East EOC/111 – Parking – July 2021 (D4) If you could forward it onto the relevant NED's for their comments I would be grateful.

A: From the Chair: You were in correspondence with Isobel Allen towards the end of September this year asking further detailed questions about the parking and transport arrangements for the new Medway Make Ready Centre (MRC) and Emergency Operations Centre.

My Non-Executive colleagues and I have taken a keen interest in the planning of the Medway development. On receipt of your further questions I asked the Chief Executive to review the parking and transport arrangements. I asked for an assurance that everything possible within existing Planning regulations had been done to provide practical solutions to this important issue. He is the Accountable Officer, and he has given me that assurance.

From a Non-Executive perspective we cannot do anymore at this stage. I am though asking that the Workforce and Well-being Committee to monitor the arrangements for car parking at Medway MRC when it is operational and ensure if required the Chief Executive and his team give it appropriate attention.

27.10.21 Geoff Kempster

Q: I am seeing a rather concerning post in the SECAMB Community regarding toilet breaks in the WEST EOC that implies that if a member of staff needs to go to the toilet, the time taken is removed from their break period. Likewise if they wish to get a drink, the time taken is removed from their break period. If this is the case, I find it a very archaic and demoralising way of working. Can one of you please get clarification on this and ascertain if this really is the case. If it is, then I am sure the governors will want to raise this with the NEDs.

A: Response from Chris Mather - Thank you for your email. I will start by saying that it has never been the case that EMAs are required to take a token to go to the toilet or to make a drink. That is categorically not true and in my opinion, is inflammatory on behalf of GMB. It paints West EOC in a poor way and raises concerns like the below unnecessarily. EMAs are required to wait for a token when they are going for a screen break or their 30-minute unpaid break to ensure that we do not have an exodus of EMAs at any one time. This ensures that we maintain a safe level of staffing to allow us to answer 999 calls in a timely manner. The number of tokens available flexes with the number of EMAs on duty to ensure that all are able to take a break in a timely manner.

28.10.21 Nigel Robinson

Q: 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.

A: 01/11/2021 - Response from Ali Mohamed -

a) We did consider whether additional financial support could be provided for 'running costs' but decided in the end (Executive Management Board decision) not to do so because there is that trade-off between savings on travel etc however we did make provision for staff to be able to claim reimbursement for home equipment purchased to support home working i.e. equipment not supplied by the Trust such as laptops, etc and staff have been accessing this. No reasonable claim has been refused.

b) We have carried out quite extensive surveys and of those currently remote working, c.87% wished to continue or come in occasionally to the office so this obviously has a massive consideration in terms of account of our colleagues views from an engagement perspective.

c) It's also worth flagging that of the c.450 staff working remotely, only about 5 said that they really needed to work from the office due to unsuitable facilities etc at home.

d) Just in response to the New Ways of Working Group question, this group (which I chaired) has now been superseded this year by an Agile Working Programme Board, which I also chair which reports directly to EMB and is leading our work in this area.

29.10.21 Nigel Robinson

Q: It has been discussed within the Patient Experience Group that an updated Datix system was previously budgeted for, proposed, and prepared then understandably placed on hold upon the outbreak of COVID.

1. Are NEDs fully assured that the continued delay in actioning this work is justified and in SECAMB's best interests? If the NEDs are assured, then is their equal assurance, that this work will be commenced at the earliest practicable time? If not, is the continued delay justified and when will this work resume?

2. How assured are the NED's that with due consideration to the extreme workloads currently being experienced across the trust, that any identified learning outcomes following a complaint or significant incident is being appropriately disseminated across the Trust?

3. To that end how confident are the NEDs that the new Datix system will have provision for, and the organisational appetite exists for meaningful learning outcomes from complaints and SI's to be (i) meaningfully investigated and any learning outcomes harvested and collated within the new system or (ii) even declared?

The recently issued NARU Duty of Care Briefing Note April 2021 (Page 3 & 5) certainly impacts upon this whole matter. This whole issue may provide the trust with an element of safeguarding if it is ever challenged either internally or externally.

Item 3 above may significantly improve the trusts' ability to identify the root cause of complaint/s and become one of the key drivers to affirm all is well or underpin the need for improvements in so many areas of trust work streams e.g., Training need analysis, Staff counselling, Improvement to Equipment or Transport, Procedural and / or policy changes/ reviews and many more key functions of the trust.

After some cursory exploration it appears that the outcomes from the current system may simply be a numeric exercise. It appears there is little or no meaningful data analysis and integration from which to confirm all is well or examine, initiate change or improvement in corporate and institutional key areas?

A: From Director of nursing:

1. This work is on track against a revised timetable agreed by the Executive team (small delay agreed due to the pandemic and REAP 4) and elements have already gone live with the new datix cloud system. It will be fully operational early in 2022.

2. Harm reviews are undertaken on a daily basis and learning from these and from serious incidents are embedded through existing processes, if urgent issues are identified these are picked up through daily calls with the strategic commanders. The NEDs and the quality and patient safety committee are fully sighted on this.

3. SECAMB are required to adhere to the national framework in relation to these areas and are currently revising processes to ensure we embed the new framework effectively and extract learning to embed changes into practice. The quality and patient safety committee will be scrutinising this over the coming months.

NED reply: Having considered Bethan's response to each question, I am happy to confirm assurance from my perspective that all items raised in the questions are being addressed, and can give partial assurance to item 3 given that the processes are underway to embed the new framework effectively, and will provide further assurance once QPS has the opportunity to scrutinise at a future meeting.

03.11.21 Marcia Moutinho

Q: I would like to ask a question about the Agile Working Programme Board, please. I expect and understand that progress has been slow with this, however is it possible to find out whether staff is getting an update any time soon from this group? Even if just to

reassure people that this matter has not been forgotten. It seems like a long time has passed since the last update. My other question would be for the NEDs, and the WWC in particular, regarding their level of assurance about the work being done around this programme and the level of engagement with staff throughout this process.

A: The Agile Working Programme Board met last week to review the current progress on each of the workstreams which are related to this work. Progress has slowed over the past few months due to REAP 4. During this time the Agile Working Policy and its accompanying guidance has been developed and will go out to all staff consultation via the bulletin this week. Alongside these proposals for how Crawley HQ is going to be laid out, to accommodate both those corporate staff who may be returning or coming into work on occasion and the expanded EOC & 111 staff, are being considered and once a finalized plan has been agreed and costed the work on this will begin. This will inform the total number of desks, hot desks, and meetings rooms available to corporate staff.

In the meantime staff are still able to work out of Crawley HQ on the desks we already have set up for corporate staff there, they will just need to pass this up through their line manager for approval. Wider comms will be going out to the Trust in the coming weeks to provide an update on this work once more confirmed timelines are available.

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



South East Coast
Ambulance Service
NHS Foundation Trust



Integrated Performance Report

Trust Board
November 2021

Data up to and including October 2021

Best placed to care, the best place to work



Contents		Page
How to use this report		3
Chief Executive Overview		4
Trust Overview	Strategy, Values & Ambition	5
	Domain Overview Dashboard	6
	Current Operational Performance	7
	Summary of Performance Highlights	13
	Summary of Exceptions	14
	Exception Reports by Domain	16
Performance Dashboards	Safe	27
	Effective	29
	Caring	31
	Responsive	32
	Well-Led	34
National Benchmarking	999 Emergency Ambulance Service	39
	999 Clinical Outcomes	40
Appendix 1	Performance Charts	41
Appendix 2	Glossary & Metrics Library	56
Appendix 3	Symbol & Chart Keys	58

CQC Rating and Oversight Framework

NHSI Oversight Framework*	2	●
CQC Rating **	GOOD	●
Information Governance Toolkit Assessment ***	Level 2 Satisfactory	●
REAP Level ****	4	●





* 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



How to use this report

Format & Reporting Aspirations

- The aim is to present a 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 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 are now reporting a month in arrears, where this is possible.

Performance Dashboards

- The Board will note that some newer data sets do not have historic data provided, 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.

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.
- Work is ongoing in the Quality and Nursing Directorate to develop indicators which will enable us to flesh out the Caring domain.

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.



The IPR continues to develop each month as we improve and add to the metrics. The aim of the report is to provide the key performance data and indicators which highlight to the Board, through the exception reports, the areas where the executive is most concerned. These are summarised on pages 14 and 15.

Operational performance and patient safety remain significant issues. We have seen some small improvement and we have certainly fared better than some other Ambulance services this month. Whilst this is welcome our time based performance is still far from that to which we aspire; the pressure on our performance is reflected across all sectors of the regional and national health economy.

Alongside providing services to patients we continue to also focus on how we can improve the welfare of our staff as the pandemic goes into its second winter. This IPR includes over twenty metrics which we use to measure this important area. This should be a primary focus of the Board as we review this document.



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***



Trust Overview:

Domain Overview Dashboard (November 2021)

Key indicators at a glance for October 2021 (unless otherwise indicated)

Safe			Effective			Caring			Responsive			Well-Led		
Metric	Oct-21	PD	Metric	Oct-21	PD	Metric	Oct-21	PD	Metric	Oct-21	PD	Metric	Oct-21	PD
999 Frontline Hours Provided %	89.50%	▲	**Cardiac ROSC Utstein %	48.70%	▼	Proportion of Complaints Relating to Crew Attitude %	30.00%	▼	Cat 1 Mean	00:09:08	▼	Disciplinary Cases	1	▲
Number of Incidents Reported as SIs	7	▼	**Stroke - Assessed F2F Diagnostic Bundle %	97.10%	▲	End of Life Care Performance		■	Cat 1 90th Centile	00:16:19	▲	Collective Grievances	0	▲
Hand Hygiene Compliance %	86.00%	▼	**Sepsis Care Bundle %	86.20%	▲	Falls Performance		■	Cat 2 Mean	00:34:55	▼	Bullying & Harrassment Internal	3	●
Violence and Aggression Incidents (Number of Victims - Staff)	110	▼	**Acute STEMI Care Bundle Outcome %	62.70%	▲	Complaints relating to privacy and respect %	0.00%	●	Cat 2 90th Centile	01:10:47	▼	Annual Rolling Turnover Rate	14.50%	▼
Medicines Management % of Audits Completed	91.90%	▼	ECAL Mean Response Time	00:24:22	▼	Dementia Performance		■	Cat 3 90th Centile	08:06:05	▼	Annual Rolling Sickness Absence	8.30%	▼
DBS Compliance %	100.00%	●	999 Operational Abstraction Rate %	32.90%	▲				Cat 4 90th Centile	09:53:30	▼	Absence Relating to Mental Health %	5.90%	▲
Number of RIDDOR Reports	14	▼	Statutory & Mandatory Training Rolling Year %	66.30%	▲				999 Call Answer Mean	00:00:44	▲	Absence Relating to MSK %	5.70%	▼
									111 Calls Answered in 60 Seconds %	16.30%	▼	999 Frontline Late Finishes/Over-Runs %	53.30%	▼
									111 Calls Abandoned - (Offered) %	30.20%	▼			
									111 to 999 Referrals (Answered Calls) %	8.90%	▲			
									Complaints Reporting Timeliness %	71.00%	▼			

** August 2021 data

Symbol Key

- ▲ Improving performance
- ▼ Deteriorating performance
- No change
- Aspirational metric
- Data not provided
- PD Performance direction



Current Operational Performance

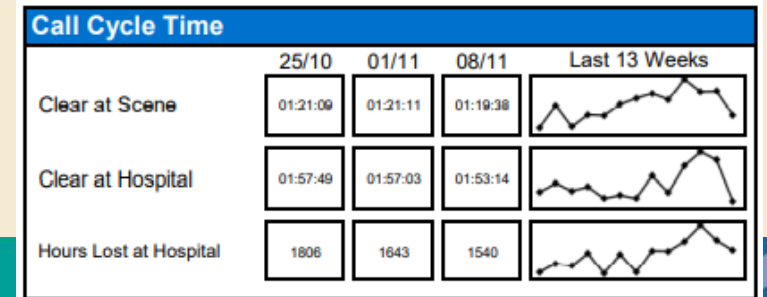
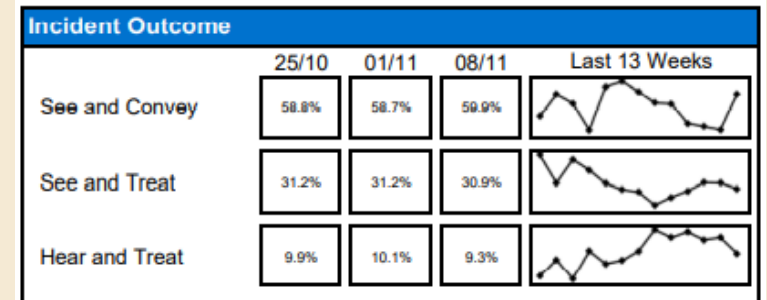
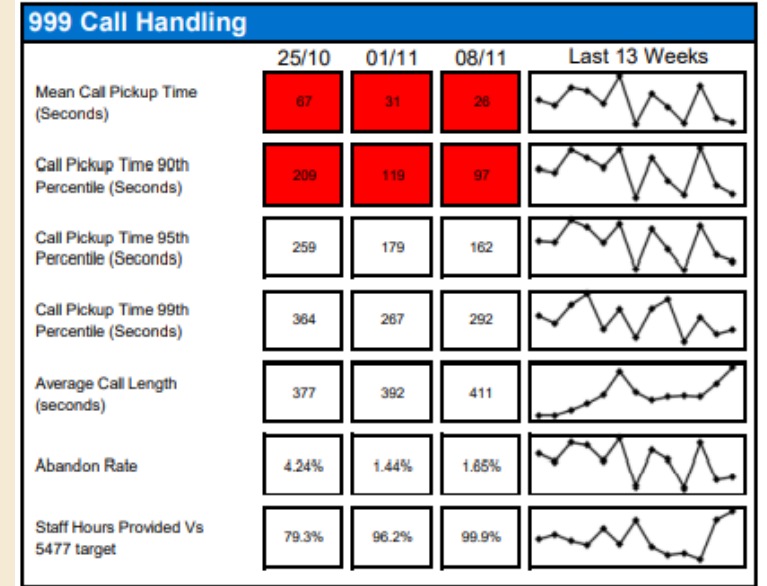
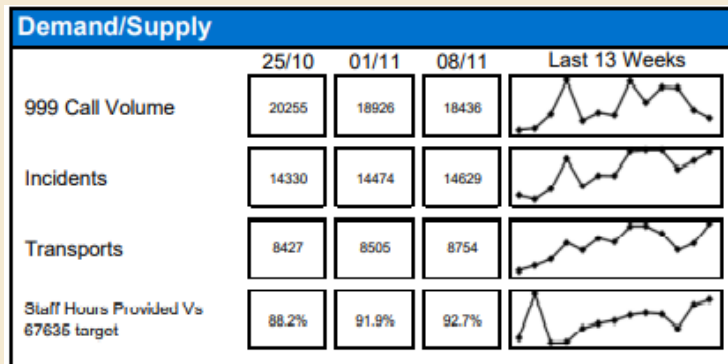
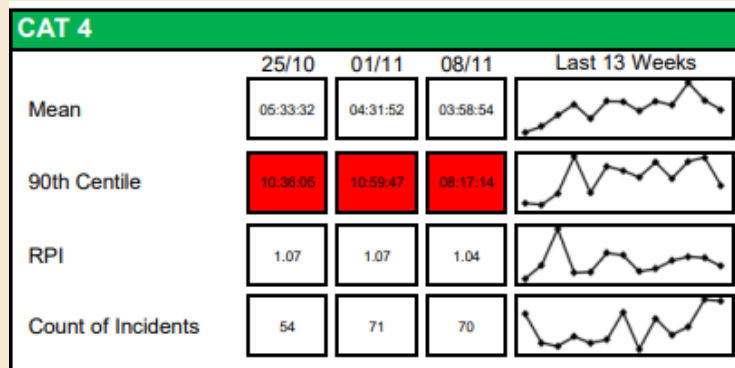
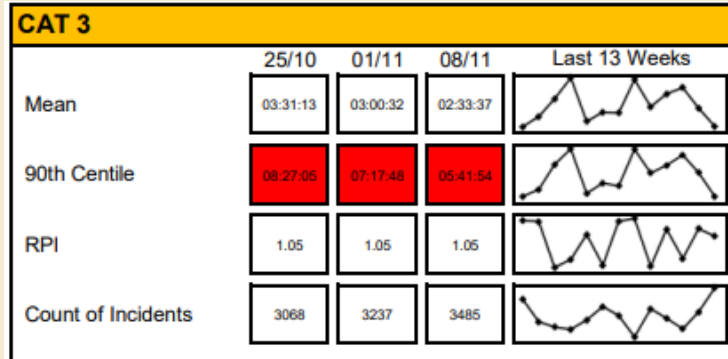
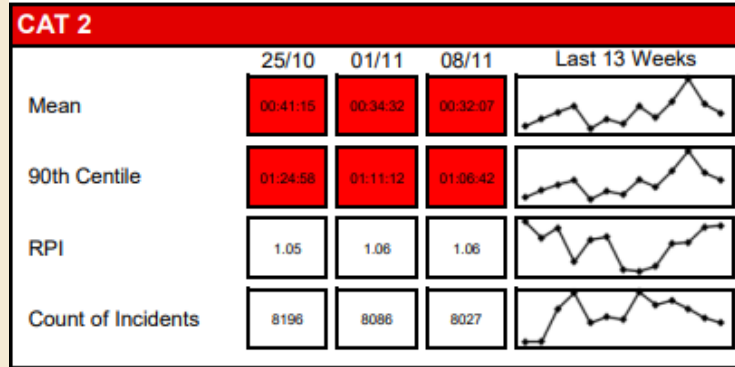
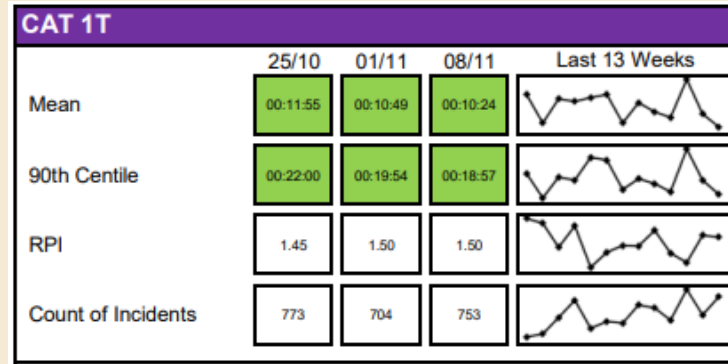
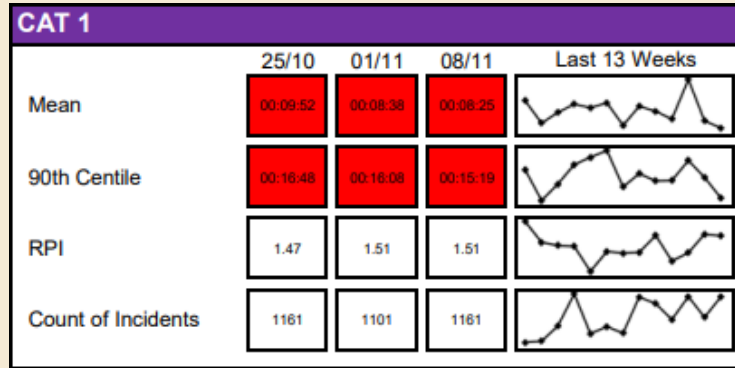
999 Emergency Ambulance Service (as of 15/11/21)

Category	Target		Month to Date			Quarter to Date		
	Mean	90th Centile	Incidents	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	2339	00:08:30	00:15:38	7349	00:08:56	00:16:08
C1T	00:19:00	00:30:00	1505	00:10:39	00:19:28	4747	00:11:04	00:20:04
C2	00:18:00	00:40:00	16714	00:33:12	01:08:53	53414	00:34:24	01:10:09
C3		02:00:00	6928	02:44:31	06:17:47	20710	03:11:05	07:35:44
C4		03:00:00	158	03:57:55	09:43:56	448	03:52:08	09:50:31
HCP 3			453	03:28:19	07:49:09	1356	04:01:40	09:32:26
HCP 4			400	03:51:39	08:19:26	1159	04:51:29	11:12:54
IFT 3			237	03:37:41	08:07:18	667	04:12:42	09:29:10
IFT 4			45	04:57:32	11:24:48	154	05:21:02	12:45:07
ST			9406	31.16%		29139	30.74%	
SC			17850	59.13%		56034	59.11%	
HT			2930	9.71%		9629	10.16%	
Count of Incidents			30186			94802		
Count of Incidents with a Response			27256			85173		
999 Mean	Call Answer Target 00:05		38876	00:28		128215	00:41	
999 90th	Call Answer Target 00:10			01:47			02:25	
Trust EOC 999 Abandoned Calls			593	1.5%		3228	2.5%	
A0	EOC All Calls		37220			118711		



Current Operational Performance

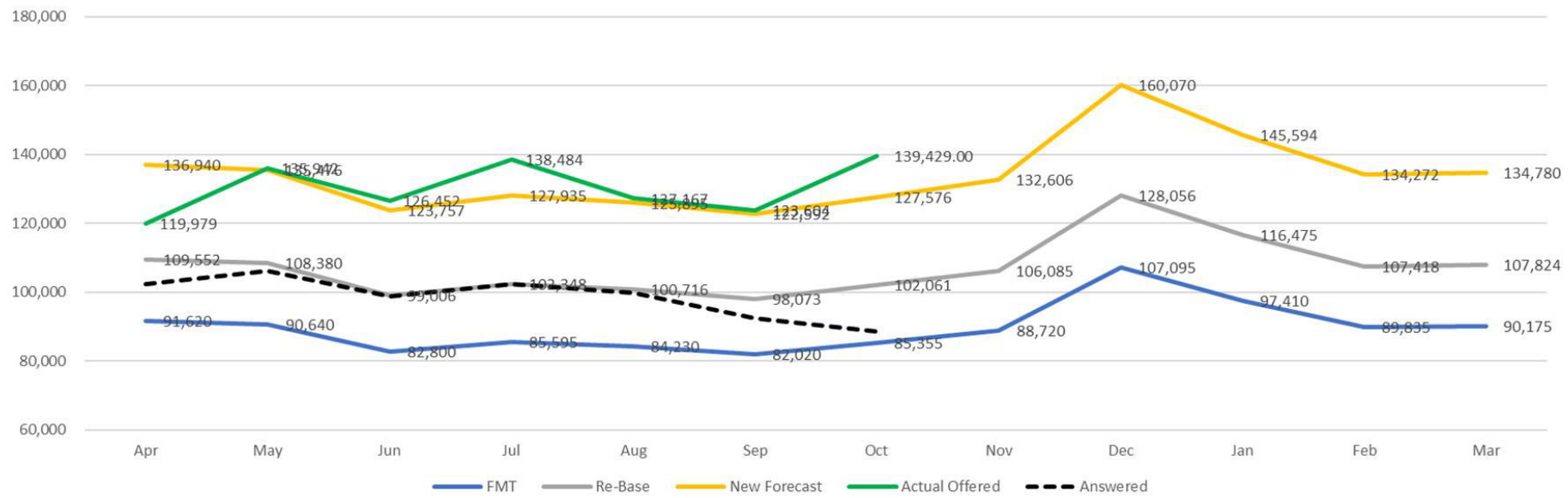
999 Emergency Ambulance Service (25/10/21 – 14/11/21)



Current Operational Performance

NHS 111 CAS Service – 111 Activity

Activity & Forecast vs FMT vs Re-Base



Current situation

- October offered activity up 37% on proposed re-base and 63% on FMT.
- YTD activity up 27% on re-base and 51% on FMT.
- Expected revised yearly activity c.1.61 million (c.1.54m if churn removed)
- Answered activity and HA WTE in line with proposed 21/22 re-base.
- 34 HA's dual trained to take 999 calls

Key

- FMT – Financial Modelling Template (original demand profile)
- Re-base – Demand re-profiling undertaken and verbally agreed with commissioners in March 2021

Yearly Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
FMT	1,075,495	91,620	90,640	82,800	85,595	84,230	82,020	85,355	88,720	107,095	97,410	89,835	90,175
Re-Base	1,285,995	109,552	108,380	99,006	102,348	100,716	98,073	102,061	106,085	128,056	116,475	107,418	107,824
New Forecast	1,607,494	136,940	135,476	123,757	127,935	125,895	122,592	127,576	132,606	160,070	145,594	134,272	134,780
Actual Offered	911,057	119,979	135,942	126,452	138,484	127,167	123,604	139,429.00					
Answered	689,821	102198	106161	98748	102283	99,720	92,271	88,440.00					



Health Advisors

Current situation

- Current 236 WTE HAs (Health Advisors) – in line with re-based requirements
- 80% pass rate for all NHS Pathways courses.
- HA hours taking calls has not increased in line with WTE.

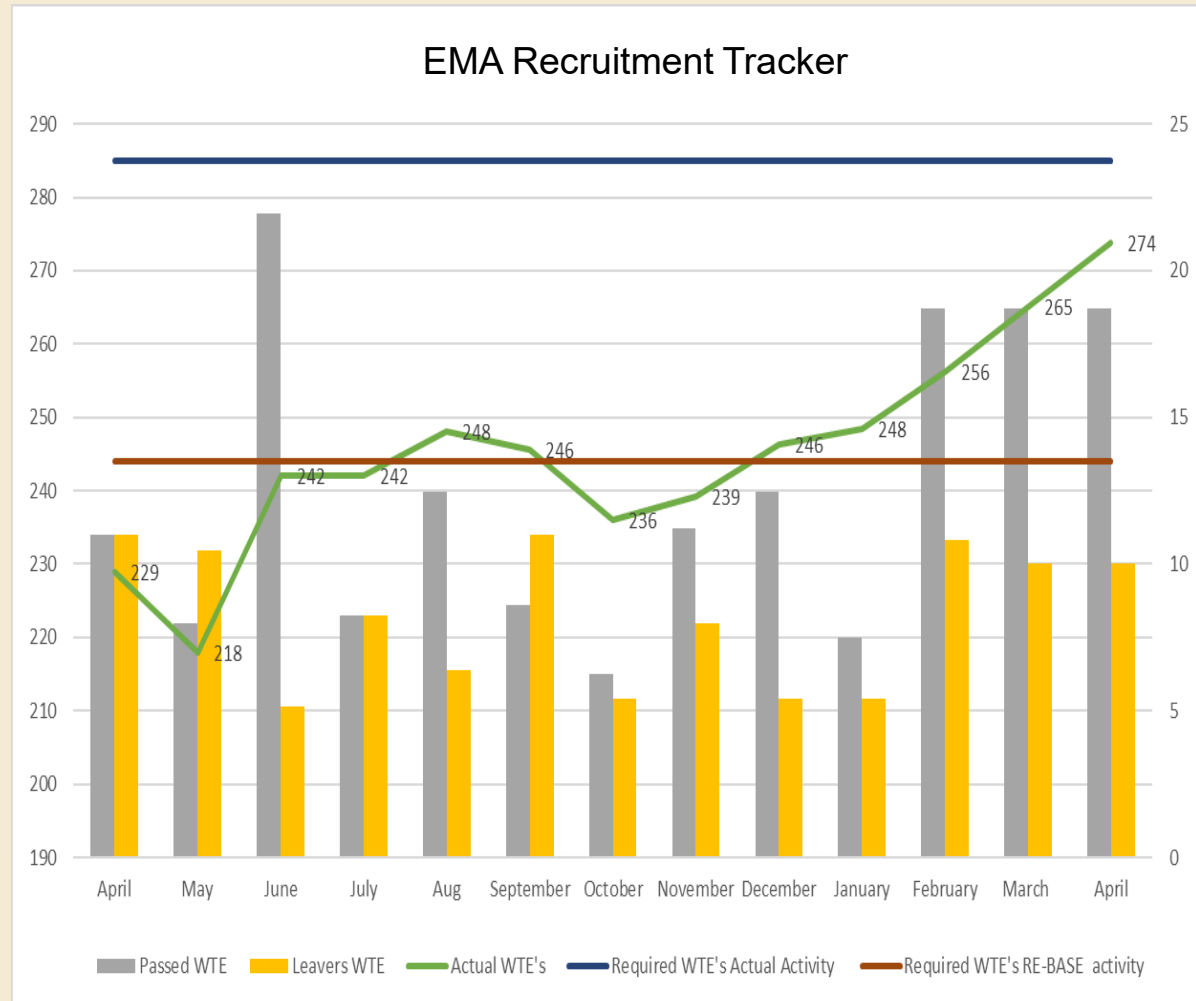
Causes

- "No shows" on Day 1 of each course recently.
- 34 HAs assisting 999 but no dual trained EMAs supporting 111.
- PSCs (Patient Safety Callers) moved to support clinical queue.

Actions

- Additional courses planned through to March '22
- Use of agency resource being explored.
- Over subscribing training courses to allow for no shows.
- Training new NHS Pathways trainers in September.

NB future months are extrapolated from previous months' data.



Clinicians

Current situation

- Substantive CAS Clinical Staffing - increased July to 89.5% of total requirement against re-based activity.
- Attrition in CAS Clinical continues to be minimal, when it has occurred, predominantly 'positive attrition' in role succession to CCN role.
- Recruitment for core Clinical Advisor role key challenge and are using agency on boarding for winter pressures
- Clinical staffing to meet CAS forecast activity for W/C 08/11 - 71%
- Key roles filled:
 - GP = 99% rota fill
 - Clinical Advisor = 65% rota fill
- All CCN hours filled with current 10 WTE against required 14 WTE.

Amb. referral rate

Current situation

- Ambulance referral rates saw an increase from 9.15% to 9.07%
- Revalidation rate has averaged in excess of 95% consistently for the 10 weeks to end Oct

Causes

- National data for comparison has not been received weekly national since w/c 11/10

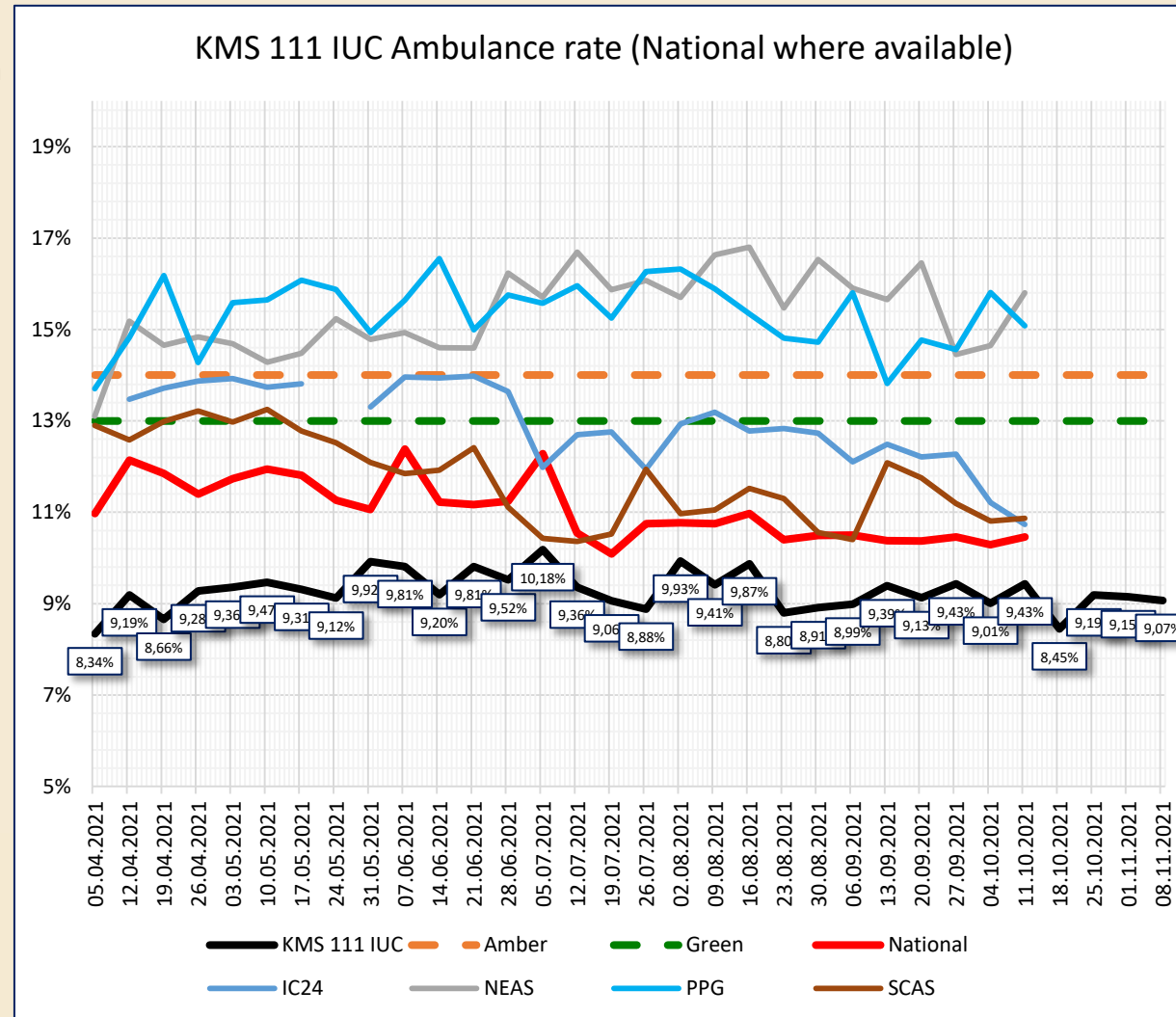
Actions

- Ongoing clinical queue management and prioritisation of highest acuity / validation cases
- Implemented daily CAS Breach reports to focus 100% on delayed validations

Key

Minimum standard for KPI (14%) — Amber

KPI target – 13% — Green



Clinical contact rate

Current situation

- Latest week Clinical Contact Rate 48.93% (target 50%) stable and above the national position of 40.04%

Causes

- National performance comparatives - historical NHS E National Average c.40% but have not received weekly national since w/c 27/09
- Identified key providers with 50% (or more) also deliver face to face services, increasing metric numerator. These are not included within KMS 111 reporting.

Actions

- Liaison with commissioners weekly, updating on current position and included in POP meetings.
- From 03/08/21 introduced ED validation through online which is increasing clinical contact rate.
- Implementation of automated Clinical Productivity management changes due in Nov 2021

Key

Minimum standard for KPI (45%) — Amber

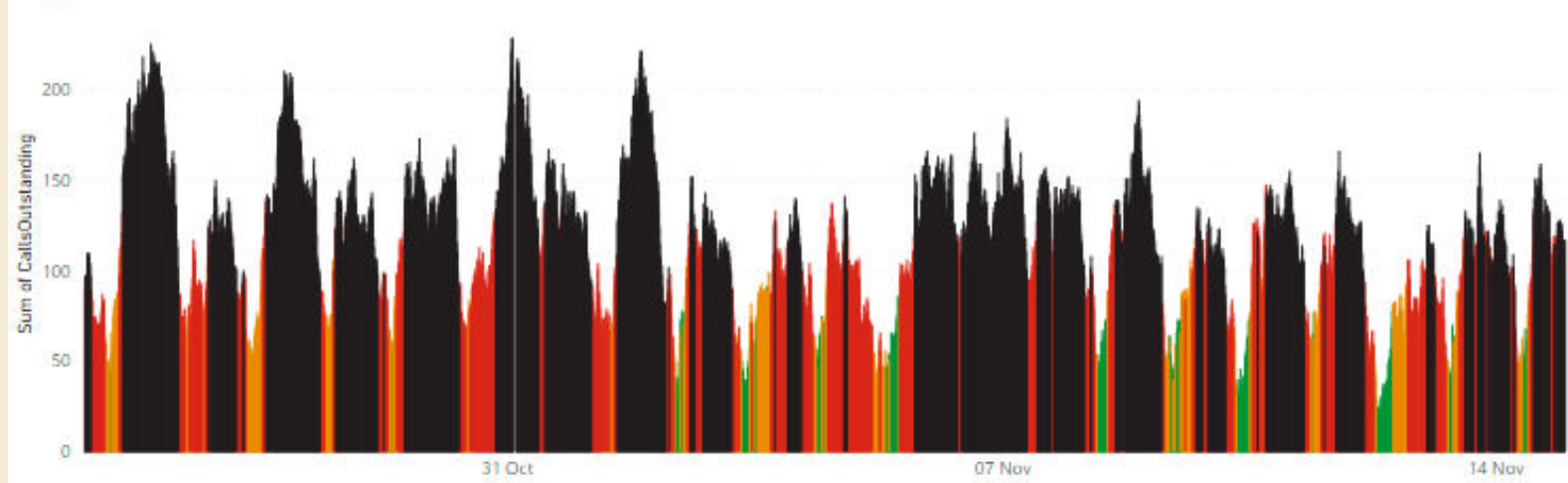
KPI target – 50% — Green

Current Operational Performance

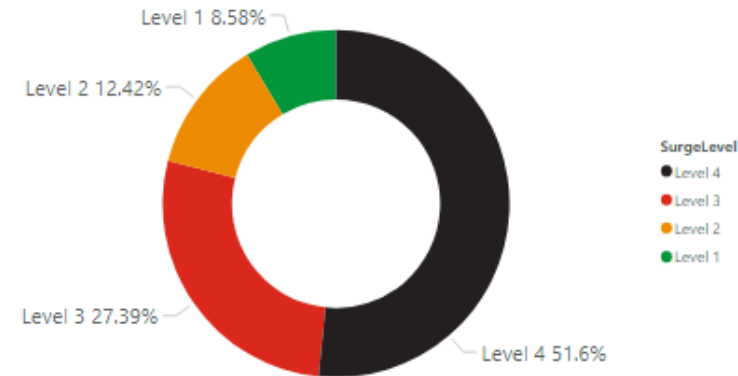
999 Emergency Ambulance Service (25/10/21 – 14/11/21)

Total Calls Outstanding by Triggered Surge Level

SurgeLevel ● Level 1 ● Level 2 ● Level 3 ● Level 4



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	Highlights
Safe		Nothing new to report.
Effective		Nothing new to report.
Caring		Nothing new to report.
Responsive	Hear & Treat (999-9)	Hear & Treat in the EOC has steadily increased and improved since Q1 as a result of a concerted focus on improving this AQI, thereby mitigating the risk of the Trust having long dispatch queues, with insufficient resource to dispatch. The foundation of this improvement is centred around the implementation of the NHS E 999 CAT 3 & 4 validation pilot, which facilitated a step change in the Trust's Hear and Treat performance. The Trust plans to build upon this success and further improve its Hear and Treat in H2 of the financial year.
Well-led		Nothing new to report.



Trust Overview: Summary of Exceptions

Domain	ID	Exceptions
Safe	Hand hygiene compliance (QS-7)	In September and October, the Trust dropped below the lower limit for hand hygiene compliance. One of the areas that has been highlighted via the observational audits is staff not carrying hand gel with them at all times, so unable to perform hand hygiene at the point of patient care.
Safe	Duty of Candour compliance (QS-3)	Compliance with Duty of Candour has dropped during the past two months, which is mainly due to the challenge in securing investigating managers in a timely way and the SI Team's attention being primarily given to undertaking daily harm reviews.
Safe	Flu Vaccine compliance (QS-25)	The Trust's joint COVID-19 booster and flu vaccination programme started on the 4 October 2021, which is slightly later than the normal flu programme.
Safe	Controlled drug breakages and single witness signatures (MM-3 & MM-5)	There was an increase in breakages in October and in single witnessed signatures authorising removal of controlled drugs from Omnicell storage in September. Reasons for both are being investigated by the Medicines Team.
Safe	999 Frontline hours provided (999-12)	The availability of staff continues to be negatively influenced by covid-related absence, higher levels of leave being taken, and increases in sickness absence. In addition there has been reduced take up of overtime and some instability in delivery of PAP delivery for the same reasons.
Effective	Statutory & Mandatory Training YTD and annual rolling (%); Appraisals YTD and annual rolling (%) (WF-20, WF-6, WF-5, & WF-40)	As the Board is aware, completion of training and appraisals have been a victim of the Trust's activity and REAP level over the last year.
Caring		Nothing new to report.
Responsive	999 Operational Performance (999-1 to 999-9)	Sustained deterioration in performance against all ARP metrics. This is primarily as a result of reduced resource hours within the Emergency Operations Centres and Field Operations due to high abstraction rates as described in the previous exception report relating to resource hours.

Trust Overview: Summary of Exceptions

Domain	ID	Exceptions
Responsive	Time spent in SMP 3 or higher % (999-14)	Due to the ongoing imbalance between demand and resourcing, the Trust is spending significant amounts of time in escalated surge levels. During the month of October, the Trust was in SMP1 for only 3.88% of the month with in excess of 60% of the time in SMP4.
Responsive	111 Call Answer & Abandonment Rate (111-2 & 111-3)	The 111 call-answering performance has gradually deteriorated throughout the financial year, resulting in a high rate of abandoned calls and a decreasing average speed to answer 111 calls.
Well-led	Annual Rolling Sickness (WF-8)	The current high levels of sickness absence are being addressed by a 23 point action plan shared between Operations and HR and OD that looks at interventions along the entire sickness absence pathway.
Well-led	Time from referral to being offered a wellbeing appointment (days) (WF-30)	Referral numbers were exceptionally high in September at a time when there was high annual leave affecting team capacity. This has resulted in a backlog.



Performance by Domain Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-7	<p>Standards: Hand Hygiene Compliance %</p> <p>Definition:</p>	In September and October, the Trust dropped below the lower limit for hand hygiene compliance. One of the areas that has been highlighted via the observational audits is staff not carrying hand gel with them at all times, so unable to perform hand hygiene at the point of patient care.

Action Plan

Actions being taken to mitigate issues:

The Head of IPC will ask the IPC Sub Group to consider a change to policy and add in that all patient facing staff have to carry hand gel with them at all times.

Accountable Executive

Named person:

Executive Director for Nursing & Quality

Complete by date:

IPC Sub Group is scheduled for 9/11/21 for initial discussion on a change to policy



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-3	<p>Standards: Duty of Candour Compliance %</p> <p>Definition:</p>	<p>Compliance with Duty of Candour (DoC) has dropped during the past two months, which is mainly due to the challenge in securing investigating managers in a timely way and the SI Team's attention being primarily given to undertaking daily harm reviews. Whilst the reported compliance seems low at 50% and 80% respectively for September and October the denominator is low to begin with leaving the impact seemingly worse. For context - September four cases required DoC and two missed the deadline, one of which has since been completed and the other is outstanding an update from the investigator. October five cases required DoC and one missed the deadline, an update is still being chased from the investigator.</p>

Action Plan

Actions being taken to mitigate issues:

Whilst DoC is monitored weekly by the Serious Incident Group (SIG) the recent challenges had not been escalated; again this is as a result of attentions being diverted to the daily harm reviews. The SIG will continue to closely monitor compliance and where potential delays arise will agree who from within the group will undertake the DoC for each case. This should work to prevent future missed deadlines.

Accountable Executive

Named person:

Executive Director for Nursing & Quality

Complete by date:

Ongoing monitoring



Performance by Domain Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
QS-25	<p>Standards: Flu Vaccine Compliance %</p> <p>Definition:</p>	The Trusts joint COVID-19 booster and flu vaccination programme started on the 4 October 2021, which is slightly later than the normal flu programme.

Action Plan

Actions being taken to mitigate issues:

The uptake for the flu vaccine is less than the COVID-19 booster and plans are being developed to provide some mobile clinics across the Trust so that staff can access the flu vaccine locally.

Accountable Executive

Named person:

Executive Director for Nursing & Quality

Complete by date:

March 2022



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
MM-3 & MM-5	<p>Standards: Single Witness Signature Use CDs Omnicell and Number of CD Breakages</p> <p>Definition: Number of times controlled drugs are extracted from Omnicell storage with only one authorising signature; Number of times a controlled drug vessel is reported to have been broken (wastage)</p>	<p>The Medicines Governance Group regularly reviews this data and undertakes further investigation into issues as they arise.</p> <p>The Datix reports for breakages is discussed two months following the recognition of an issue that requires investigation, to allow time for Operational Team Leaders to investigate the rationale for the anomalies. There is no further information to provide an evidenced update to the Board as yet regarding the increase in breakages in October (though see further info below). Should the trend continue a further report will come to the Board.</p> <p>In relation to single witness signatures, the Medicines Team are aware that Critical Care Paramedics are singly signing out drugs at Burgess Hill – this has been discussed with the Critical Care Paramedic for CCPs but the Team hasn't yet identified a solution.</p>

Action Plan

Actions being taken to mitigate issues:

From previous investigations and deep dives, we know that any batch issues leading to breakages are very difficult to address as crews do not report batch numbers on Datix. This can be due to time restraints completing the Datix or not knowing that this information is needed, or because the vial is smashed and they do not know the batch number without handling broken glass.

There are more detailed reports available that have been presented to the Medicines Governance Group, which escalates to Clinical Governance Group and reports through to the Quality and Patient Safety Committee of the Board.

Accountable Executive

Named person:

Medical Director

Complete by date:

February 2022



Performance by Domain

Safe: Exception Report

We protect our patients and staff from abuse and avoidable harm

ID	Standard	Background
999-12	<p>Standards: 999 Frontline Hours Provided %</p> <p>Definition:</p>	<p>The availability of staff continues to be negatively influenced by covid-related absence, higher levels of leave being taken, and increases in sickness absence. In addition there has been reduced take up of overtime and some instability in delivery of PAP delivery for the same reasons.</p>

Action Plan	Accountable Executive
<p>Actions being taken to mitigate issues: Hours provided within frontline operations continue to be reviewed weekly at regional Teams B meetings. A review takes place of planned hours for the current week projected to week 5. Shortfalls are highlighted and remedial actions identified. The review includes staff abstractions against [1] maximum annual leave allowances, [2] short notice leave (requested within 28 days), [3] sickness absence and absence management measures, and [4] training and skills assurance, which are confirmed or cancelled with redeployment to operational duties if required. Overtime and incentives continue to be offered where appropriate.</p> <p>Daily monitoring of covid-related sickness absence including reactions to booster vaccines.</p>	<p>Named person: Executive Director for Operations</p> <p>Complete by date: 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
WF-20 & WF-6 WF-5 & WF-40	<p>Standards: Statutory & Mandatory Training YTD and annual rolling (%); Appraisals YTD and annual rolling (%)</p> <p>Definition: As above</p>	As the Board is aware, completion of training and appraisals have been a victim of the Trust's activity and REAP level over the last year.

Action Plan	Accountable Executive
<p>Actions being taken to mitigate issues: We know that low levels of completion are not sustainable for a well led nor rewarding employee experience.</p> <p>A plan for sustainable delivery of Stat & Man and development training is being developed by Clinical Education and Learning and Development & Organisational Development to bring forward to the Senior Management Group and Executive Management Board.</p> <p>A new appraisal policy and set of forms was agreed at the Joint Partnership Forum in November and will be rolled out from November onwards. It will start in HR and OD and onward through corporate services, with any necessary refinements before moving in to Operations. The intention is to complete the roll-out over 6 to 12 months depending on system pressures.</p>	<p>Named person: Executive Director for HR & Organisational Development</p> <p>Complete by date: Training plan – to WWC in December</p> <p>Appraisals Policy for approval 11/11/21 and roll out to follow</p>

Performance by Domain

Responsive: Exception Report

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

ID	Standard	Background
999-1 to 999-9	<p>Standards: 999 Operational Performance (All metrics)</p> <p>Definition:</p>	Sustained deterioration in performance against all ARP metrics. This is primarily as a result of reduced resource hours within the Emergency Operations Centres and Field Operations due to high abstraction rates as described in the previous exception report relating to resource hours.

Action Plan

Actions being taken to mitigate issues:

Continued recruitment of Emergency Medical Advisors (EMAs) supported by additional winter monies.

- Development of a tool to support risk stratification in the C2 queue during high demand to quantify the risk in the C2 stack and make sound clinical judgement on prioritisation of care – building on learning from other ambulance services who have implemented this already.
- Falls programme – looking at utilising CFRs to respond to falls where the patient is still on the floor/ground. If successful this should assist in reducing long lying waits and may reduce conveyance with early intervention.

Accountable Executive

Named person

Executive Director of Operations

Complete by date:

Ongoing



Performance by Domain Responsive: Exception Report

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

ID	Standard	Background
999-14	<p>Standards: Time spent in SMP 3 or higher %</p> <p>Definition:</p>	Due to the ongoing imbalance between demand and resourcing, the Trust is spending significant amounts of time in escalated surge levels. During the month of October, the Trust was in SMP1 for only 3.88% of the month with in excess of 60% of the time in SMP4.

Action Plan

Actions being taken to mitigate issues:

Performance, activity and demand continues to be closely monitored with weekly performance reviews shared with the Executive Management Board.

Accountable Executive

Named person

Executive Director of Operations

Complete by date:

Ongoing



Performance by Domain

Responsive: Exception Report

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

ID	Standard	Background
111-2 & 111-3	<p>Standards: 111 Call Answer & Abandonment Rate</p> <p>Definition:</p>	The 111 call-answering performance has gradually deteriorated throughout the financial year, resulting in a high rate of abandoned calls and a decreasing average speed to answer 111 calls.

Action Plan

Actions being taken to mitigate issues:

The root cause for this is two-fold:

1. Current demand (calls offered) is tracking consistently at more than 25% above the re-base activity agreed for 2021/22 with commissioners in March 2021.
2. There is an ongoing funding inequality resulting in a significant funding deficit for the 111 service. Although current staffing levels reflect those agreed as part of the re-base, significant additional recruitment is required to bridge the staffing shortfall to address the current performance shortfall.

It is important to note that the additional 111 activity levels are being seen nationally, with a comparable adverse impact on all 111 providers in terms of their call handling performance

Accountable Executive

Named person

Executive Director of Operations

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
WF-8	<p>Standards: Annual Rolling Sickness Absence (%)</p> <p>Definition: As above</p>	Annual rolling sickness absence has been trending higher since October 2020, rising from 6.20% then to 8.14% in September 2021.

Action Plan

Actions being taken to mitigate issues:

The current level of sickness absence is being addressed by a 23 point action plan shared between Operations and HR and OD that looks at interventions along the entire sickness absence pathway, from notification, through return to work, welfare, case management within Policy and Procedure, OH referrals and data reporting.

Critical to managing sickness absence are return to work interviews that are consistent in application and quality and support and coaching to managers by the HR Business Partnering. Work is ongoing with Planning on the forms in GRS for RTW interviews and coaching of managers and OTL's in their application.

The Operations Directorate is the focus as all other directorate sickness absence is at or within the Trust target of 5%, and they employ ~80% of the Trust workforce. The action plan supports the Field Operations and Contact Centres to address system wide and specific issues for each 'sector'.

Accountable Executive

Named person:

Executive Director for HR & Organisational Development

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
WF-30	<p>Standard: Time from Referral to Offered Wellbeing Appointment (days)</p> <p>Definition: Covering all wellbeing referrals, the number of days from referral to being offered an appointment.</p>	Increase in time for first offered appointment relates only to wellbeing referrals - physio is still under 2 weeks. Wellbeing referrals number were exceptionally high in September, paired with annual leave in the team, has resulted in backlog of referrals and therefore an increase in wait times.

Action Plan

Actions being taken to mitigate issues:

Where possible, service users are being signposted to external resilience hub, Sussex Staff in Mind (SSIM). SSIM offer assessment and intervention such as fast track access to Improving Access to Psychological Therapies (IAPT services) for those with GPs registered within Sussex. This is hoped to reduce impact on internal Practitioner wait times.

Furthermore, NHS England/Improvement have offered NHS Trusts financial grants for wellbeing services. The bid will propose two new practitioners for high demand areas for 16 months. If approved, this will further reduce impact on internal wait times.

Accountable Executive

Named person:

Executive Director for HR & Organisational Development

Complete by date:

Ongoing monitoring



Performance by Domain

Safe: Performance Dashboard

We protect our patients and staff from abuse and avoidable harm

ID	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
QS-1	Number of Datix Incidents	1342	1470	1751	1595	1070	1149	1051	1175	1253	1493	1397	1278	1459					▼
QS-2	Number of Incidents Reported as SIs	4	9	8	6	7	1	7	3	6	11	5	3	7					▼
999-12	999 Frontline Hours Provided %	94.60%	99.40%	95.10%	96.10%	103.20%	96.90%	99.10%	99.30%	94.30%	90.10%	86.90%	88.00%	89.50%	100.00%		-		▲
QS-3	Duty of Candour Compliance %	100.00%	84.00%	80.00%	67.00%	100.00%	75.00%	100.00%	67.00%	100.00%	100.00%	100.00%	50.00%	80.00%	100.00%		-		▲
QS-7	Hand Hygiene Compliance %	99.00%	95.00%	96.00%	94.00%	93.00%	95.00%	94.00%	95.00%	95.00%	92.00%	90.00%	88.00%	86.00%	95.00%		-		▼
QS-8	Safeguarding Training Completed (Children) Level 2 %	74.90%	74.90%	78.20%	79.40%	82.00%	90.40%	88.70%	87.00%	87.30%	86.00%	86.20%	84.20%	84.50%	95.00%		-		▲
QS-13	Violence and Aggression Incidents (Number of Victims - Staff)	124	74	70	53	60	60	65	73	87	91	99	90	110					▼
MM-1	Number of Medicines Incidents	162	141	125	125	142	173	152	171	118	156	141	157	165					▼
MM-3	Single Witness Signature Use CDs Omnicell	3	0	6	5	9	4	3	2	3	6	7	14	5	0		-		▲
MM-4	Single Witness Signature Use CDs Non-Omnicell	0	0	3	1	1	1	0	0	0	1	0	0	1	0		-		▼
MM-5	Number of CD Breakages	17	9	25	21	10	27	16	16	19	10	17	9	29					▼
MM-7	Medicines Management % of Audits Completed	98.00%	94.00%	94.00%	93.00%	88.00%	95.00%	95.00%	98.40%	98.70%	98.10%	97.90%	94.10%	91.90%	100.00%		-		▼
WF-1	Number of Staff WTE (Excl bank and agency)	3888	3967	3956	3959	3968	3974	3945	3952	3957	3936	3939	3949	3965					▲
WF-2	Number of Staff Headcount (Exc bank and agency)	4271	4354	4345	4353	4358	4367	4335	4342	4350	4327	4336	4344	4365					▲
WF-3	Finance Establishment (WTE)	3880	3925	3950	3951	3956	3946	3946	3946	3946	4070	4060	4040	4033					▼
WF-4	Vacancy Rate %	-0.20%	-1.10%	-0.20%	-0.20%	-0.30%	-0.70%	0.10%	-0.10%	-0.20%	3.30%	3.00%	2.20%	1.70%					▲
QS-9	Number of RIDDOR Reports	16	5	9	9	12	8	10	11	14	17	14	12	14					▼
WF-16	DBS Compliance %	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		=		●
M-20	Compliant NHS Pathways Audits (Clinical) %	96.00%	94.00%	92.00%	93.00%	90.00%	93.00%	92.00%	92.00%	87.00%	97.00%	94.00%	95.00%	96.00%					▲
M-21	Required NHS Pathways Audits Completed (EMA) %	100.00%	100.00%	100.00%	98.00%	49.00%	96.00%	103.00%	105.00%	83.00%	53.00%	70.00%	78.00%	102.00%					▲

- ▲ 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-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
M-22	Compliant NHS Pathways Audits (EMA) %	100.00%	94.00%	92.00%	82.00%	83.00%	85.00%	83.00%	84.00%	84.00%	90.00%	82.00%	84.00%	84.00%	100.00%		-		●
M-23	Required NHS Pathways Audits Completed (Clinical) %	85.00%	94.00%	100.00%	100.00%	97.00%	100.00%	102.00%	102.00%	102.00%	102.00%	101.00%	76.00%	99.00%					▲
QS-17	Outstanding Actions Relating to SIs, Outside of Timescales	158	127	111	126	112	117	141	114	112	116	117	118	123					▼
QS-19	Deep Clean Compliance %	95.00%	86.50%	82.50%	72.80%		94.90%	95.00%	85.00%	82.00%	73.00%	41.50%	69.00%	64.00%					▼
QS-20	Health & Safety Incidents	37	35	22	35	33	31	29	59	47	39	30	41	32					▲
WF-24	Current licence details held for Operational Staff %	88.50%	88.10%	86.40%	89.50%	90.40%	92.40%	96.10%	96.10%	96.00%	93.80%	92.60%	91.10%	91.50%	100.00%		-		▲
QS-22	Manual Handling Incidents	29	26	24	29	32	22	17	43	28	35	33	36	29					▲
QS-25	Flu Vaccine Compliance	58.00%		78.80%		79.80%	80.10%							24.00%	90.00%		-		—

- ▲ 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

** August 2021 data

ID	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-11	JCT Allocation to Clear at Scene Mean	01:16:39	01:18:48	01:20:16	01:22:00	01:19:51	01:19:00	01:18:57	01:14:38	01:17:12	01:16:00	01:16:34	01:16:44	01:17:56					▼
999-11	JCT Allocation to Clear at Hospital Mean	01:49:01	01:51:39	01:57:53	01:57:24	01:51:48	01:49:29	01:49:30	01:50:58	01:49:19	01:52:57	01:53:43	01:54:04	01:55:44					▼
M-1	**Cardiac ROSC Utstein %	44.00%	47.70%	40.90%	40.00%	48.50%	40.00%	41.00%	40.00%	40.80%	54.20%	48.70%							▼
M-2	Cardiac ROSC ALL %	27.00%	21.50%	15.70%	16.30%	23.70%	22.00%	23.00%	22.30%	22.70%	31.00%	24.80%							▼
M-12	**Sepsis Care Bundle %	85.00%	85.40%	87.00%	84.20%	86.30%	85.00%	85.00%	84.60%	84.90%	81.30%	86.20%		100.00%			-		▲
M-3	Cardiac Survival Utstein %	20.00%	23.80%	15.90%	26.70%	33.30%	18.00%	28.00%	17.80%		31.30%								▬
M-4	Cardiac Survival ALL %	12.00%	7.60%	4.20%	5.10%	9.10%	8.00%	13.70%	8.40%		14.00%								▬
M-11	Cardiac Arrest - Post ROSC %	72.00%	79.70%	85.50%	75.30%	61.60%	78.00%	81.00%	78.10%	81.40%	75.80%	68.00%							▼
M-5	**Acute STEMI Care Bundle Outcome %	64.00%	62.20%	65.60%	64.10%	63.90%	74.00%	69.00%	73.50%	68.50%	60.60%	62.70%							▲
M-6	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography Mean	02:15:00	02:15:00	02:30:00	02:33:00	02:14:00	02:20:00	02:20:00	02:19:00										▬
M-7	Acute ST-Elevation Myocardial Infarction (STEMI) Call to Angiography 90th Centile	03:04:00	03:02:00	03:33:00	03:26:00	03:02:00	03:15:00	03:02:00	03:17:00										▬
M-8	Stroke - Call to Hospital Arrival Mean	01:22:00	01:30:00	01:43:00	01:46:00	01:24:00	01:27:00	01:28:00	01:26:00										▬
M-9	Stroke - Call to Hospital Arrival 90th Centile	02:12:00	02:19:00	02:42:00	02:57:00	02:15:00	02:22:00	02:07:00											▬
M-10	**Stroke - Assessed F2F Diagnostic Bundle %	98.00%	97.00%	96.60%	96.90%	95.80%	95.00%	96.00%	95.30%	95.50%	94.10%	97.10%		100.00%			-		▲
M-13	Sensitivity of Cardiac Arrest Detection During Telephone Triage %	91.00%	94.30%	93.30%	87.00%	93.40%	82.00%	82.00%	81.60%	81.60%	91.20%	95.50%							▲
M-14	Proportion of Non-EMS Witnessed Cardiac Arrests with Bystander CPR %	81.00%	75.10%	73.80%	74.30%	79.30%	79.00%	78.00%	78.50%	77.50%	79.40%	80.30%							▲
M-15	Time to Commence Telephone-Guided CPR Mean																		■
M-16	Proportion of Non-EMS Witnessed Cardiac Arrests with PAD Applied to Patient %	8.00%	7.50%	6.30%	5.70%	4.90%			8.90%	4.00%	12.10%	6.40%							▼

- ▲ Improving performance
- ▼ Deteriorating performance
- No change
- Aspirational metric
- + Outperformed target
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- 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

** August 2021 data

ID	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-13	ECAL Mean Response Time	00:23:41	00:24:03	00:24:23	00:23:54	00:23:36	00:24:20	00:23:43	00:23:31	00:22:56	00:22:57	00:24:18	00:24:03	00:24:22					▼
999-12	999 Operational Abstraction Rate %	38.30%	32.70%	35.30%	36.00%	32.50%	33.30%	25.20%	25.80%	31.00%	33.10%	27.10%	34.70%	32.90%	28.00%		-		▲
WF-6	Statutory & Mandatory Training Rolling Year %	75.00%	74.30%	76.10%	75.60%	76.20%	78.70%	67.10%	60.70%	63.30%	67.00%	66.60%	65.90%	66.30%	100.00%		-		▲
999-17	Responses Per Incident	1.08	1.08	1.08	1.08	1.09	1.00	1.01	0.99	1.01	1.09	1.09	1.08	1.09	1.09		+		▼
999-18	Section 136 Mean Response Time	00:16:38	00:20:49	00:25:04	00:24:02	00:16:07	00:17:36	00:23:22	00:18:10		00:33:15	00:23:37	00:33:17	00:29:58					▲
999-19	Section 135 Mean Response Time	00:03:44	00:14:55			00:06:04	01:43:52	03:48:17	00:22:29	00:23:57			00:35:04						=
999-20	ePCR Usage	94.80%	96.10%	96.40%	96.20%	96.10%	96.70%	97.00%	91.00%	95.70%	93.10%	96.20%	96.70%	96.70%	95.00%		+		●
999-24	Number of Hours Lost at Hospital Handover	4435	3358	5426	4583	2296	2237	2271	3249	2614	3698	3568	3638	4547					▼
999-25	Hours Lost at Handover as a Proportion of Provided Hours %	1.60%	1.20%	1.90%	1.60%	0.80%	0.80%	0.80%	1.00%	0.90%	1.40%	1.40%	1.50%	1.60%					▼
WF-23	Recruitment: Advert to Start Date														100.00%		■	■	■
M-24	ClinEd: Course Capacity Utilisation Associate Ambulance Practitioner %			96.00%	93.00%	93.00%	93.00%	93.00%	93.00%	92.00%	92.00%	92.00%	92.00%	91.00%					▼
M-24	ClinEd: Course Capacity Utilisation Transition to Practice %			65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	75.00%	74.00%	75.00%	73.00%					▼
M-25	ClinEd: Students at Risk of Not Obtaining Qualification %			40.00%		39.00%	44.00%	46.00%	45.00%	39.00%	29.00%	25.00%	23.00%	19.00%					▲
M-26	ClinEd: Course satisfaction score																■	■	■
WF-34	Frontline Workforce Skillmix: ECSWs vs plan (Trust average)	30.80%	31.30%	31.40%	31.20%	31.60%	31.40%	31.40%	31.30%	31.60%	32.50%	31.60%	30.30%	29.40%	29.70%		-		▼
WF-35	Frontline Workforce Skillmix: AAP/Techs vs plan (Trust average)	19.10%	18.60%	18.60%	18.90%	18.80%	19.00%	19.00%	19.00%	18.80%	18.40%	18.00%	17.80%	17.50%	19.30%		-		▼
WF-36	Frontline Workforce Skillmix: Registered clinicians vs plan (Trust average)	50.10%	50.10%	50.00%	49.90%	49.60%	49.60%	49.60%	49.60%	49.50%	49.30%	50.40%	51.90%	53.10%	51.00%		-		▼

- ▲ Improving performance
- ▼ Deteriorating performance
- No change
- Aspirational metric
- + Outperformed target
- Underperformed target
- = On target
- Data not provided



Performance by Domain

Caring: Performance Dashboard

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

ID	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction	
QS-12	Complaints relating to privacy and respect %								0.00%	0.00%	0.00%	0.20%	0.00%	0.00%						●
QS-10	Proportion of Complaints Relating to Crew Attitude %	23.00%	59.00%	37.00%	38.00%	50.00%	56.00%	31.00%	33.00%	31.00%	18.00%	25.00%	19.00%	30.00%						▼
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
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Performance by Domain

Responsive: Performance Dashboard

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

ID	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
111-1	111 Calls Offered	104059	111727	115809	93018	87249	110294	119979	135942	126452	138484	127167	123804	139429					==
111-2	111 Calls Answered in 80 Seconds %	66.60%	59.80%	55.40%	62.90%	74.00%	73.10%	53.40%	36.50%	33.90%	29.10%	33.70%	27.10%	16.30%	95.00%		-		▼
111-3	111 Calls Abandoned - (Offered) %	5.40%	6.30%	8.20%	6.10%	3.00%	3.50%	7.70%	14.80%	15.90%	19.70%	15.50%	19.00%	30.20%	6.00%		-		▼
111-4	111 to 999 Referrals (Answered Calls) %	11.80%	14.10%	13.90%	14.90%	15.00%	13.40%	8.70%	9.10%	9.70%	9.30%	9.30%	9.10%	8.90%	13.00%		+		▲
111-4	999 Referrals	11110	12276	12384	11903	11064	12058	8188	8901	8805	8675	8585	7961	7648					▲
111-5	A&E Dispositions %	12.00%	13.40%	14.60%	14.70%	15.40%	15.60%	15.20%	14.90%	16.00%	9.10%	8.10%	8.90%	8.30%	9.00%		+		▲
111-5	A&E Dispositions	11350	11718	12925	11683	11349	14047	14261	14571	14472	8501	7534	7790	7153					▲
111-7	Clinical Contact %						48.10%	48.20%	45.20%	44.90%	46.00%	46.00%	46.20%	48.00%	50.00%		-		▲
111-8	Ambulance Validation %						95.40%	95.30%	95.10%	90.60%	95.20%	93.60%	95.90%	95.80%	85.00%		+		▼
999-10	999 Calls Answered	67031	62456	76806	70262	50316	60200	61386	77074	71529	85769	77173	81649	86089					==
999-10	Incidents	63644	62332	66615	65239	56470	62648	62845	65474	67474	65161	62343	60808	64510					==
999-1	999 Call Answer Mean	00:00:02	00:00:04	00:00:07	00:00:15	00:00:02	00:00:04	00:00:05	00:00:22	00:00:08	00:00:48	00:00:42	00:00:58	00:00:44	00:00:05		-		▲
999-1	999 Call Answer 90th Centile	00:00:01	00:00:01	00:00:01	00:00:54	00:00:01	00:00:02	00:00:02	00:01:19	00:00:22	00:02:34	00:02:22	00:03:03	00:02:29	00:00:10		-		▲
999-2	Cat 1 Mean	00:07:33	00:07:35	00:08:23	00:08:25	00:07:33	00:07:37	00:07:32	00:08:18	00:07:57	00:08:49	00:08:45	00:09:00	00:09:08	00:07:00		-		▼
999-2	Cat 1 90th Centile	00:13:59	00:13:49	00:15:07	00:15:16	00:13:53	00:14:14	00:13:56	00:15:08	00:14:54	00:16:19	00:16:03	00:16:25	00:16:19	00:15:00		-		▲
999-3	Cat 1T Mean	00:09:20	00:09:06	00:10:16	00:10:17	00:09:01	00:09:02	00:09:20	00:10:24	00:09:36	00:10:54	00:10:51	00:11:07	00:11:15	00:19:00		+		▼
999-3	Cat 1T 90th Centile	00:17:41	00:16:48	00:18:48	00:18:43	00:16:36	00:16:46	00:17:13	00:19:13	00:17:38	00:20:14	00:20:03	00:20:19	00:20:21	00:30:00		+		▼
999-4	Cat 2 Mean	00:18:20	00:17:34	00:26:49	00:25:52	00:16:48	00:18:37	00:18:54	00:26:11	00:21:28	00:30:37	00:29:42	00:30:58	00:34:55	00:18:00		-		▼
999-4	Cat 2 90th Centile	00:33:41	00:32:19	00:51:55	00:51:18	00:31:09	00:34:46	00:34:58	00:50:55	00:40:51	01:00:47	00:58:53	01:00:37	01:10:47	00:40:00		-		▼
999-5	Cat 3 90th Centile	03:06:47	02:52:45	05:51:35	05:38:23	02:01:52	02:49:03	02:58:41	05:40:07	03:51:24	07:21:23	06:17:02	07:12:42	08:06:05	02:00:00		-		▼
999-6	Cat 4 90th Centile	04:28:26	03:56:04	07:42:55	08:27:07	02:44:51	03:29:30	04:28:40	07:21:59	04:39:46	06:51:57	05:29:55	08:43:12	09:53:30	03:00:00		-		▼
999-7	HCP 3 Mean	01:56:51	01:57:59	03:16:55	03:01:30	01:25:11	01:39:18	02:02:40	03:25:11	02:32:00	04:06:19	03:32:39	03:46:37	04:18:12					▼
999-7	HCP 3 90th Centile	03:52:35	03:52:54	06:45:20	06:30:54	02:55:47	03:23:05	04:00:25	06:56:27	05:08:05	08:36:33	08:28:04	08:37:59	10:01:35					▼
999-7	HCP 4 Mean	02:52:18	02:50:22	04:18:54	03:45:45	01:49:46	02:01:07	02:44:10	04:22:49	03:20:43	04:56:09	04:46:11	04:47:22	05:23:02					▼
999-7	HCP 4 90th Centile	05:23:36	05:19:06	07:46:24	07:26:58	04:10:26	04:28:16	05:11:59	08:01:14	06:21:05	09:20:02	10:41:54	10:28:52	12:48:15					▼
999-9	Hear & Treat %	6.20%	6.60%	8.60%	8.00%	6.00%	6.90%	6.90%	9.30%	7.90%	9.60%	9.00%	8.80%	10.30%	10.00%		+		▲

- ▲ Improving performance
- ▼ Deteriorating performance
- No change
- Aspirational metric
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Performance by Domain

Responsive: Performance Dashboard

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

ID	Metric	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction
999-9	See & Treat %	33.40%	33.70%	36.30%	37.40%	35.20%	32.60%	32.10%	31.20%	31.60%	32.00%	32.10%	31.30%	30.50%	35.00%		-		▼
999-9	See & Convey %	60.40%	59.70%	55.10%	54.60%	58.80%	60.50%	61.00%	59.40%	60.50%	58.40%	59.00%	59.80%	59.10%	55.00%		-		▲
999-10	CFR Attendances	673	800	648	749	580	1034	1089	1337	1219	1592	1354	1290	1467					▲
999-10	FFR Attendances	190	224	175	205	142	318	260	364	241	425	383	339	353					▲
QS-4	Complaints Reporting Timeliness %	88.00%	95.00%	69.00%	95.00%	64.50%	88.00%		98.00%	96.00%	87.00%	81.00%	90.00%	71.00%	95.00%		-		▼
QS-5	Number of Complaints	65	69	61	69	48	64	68	72	116	106	114	85	91					▬
QS-6	Number of Compliments	167	182	140	173	191	187	208	159	162	171	177	110	175					▬
QS-15	Complaints per 1000 999 Calls Answered	0.97	1.11	0.79	0.98	0.95	1.06	1.11	0.09	0.16	0.13	0.14	0.96	1.28					▼
QS-16	Compliments per 1000 999 Calls Answered	2.49	2.91	1.82	2.46	3.80	3.91	3.69	0.21	0.23	0.21	0.22	0.97	1.88					▲
QS-14	Learning from deaths: Number of Structured Judgment Reviews	20	20	20	20	20	20								20				▬
QS-26	Learning from deaths: Number of SJRs showing harm	0	0	0	0	0	0								0				▬
999-14	Time Spent in SMP 3 or Higher %	25.90%	20.50%	75.00%	60.70%	1.30%	12.10%	15.40%	36.00%	68.90%	83.00%	70.70%	82.50%	86.20%					▼
C-2	Number of BCIs	2	1	7	3	2	0	0	1	2	1	1	1	1	0		-		●

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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-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction	
WF-6	Appraisals YTD	36.70%	39.70%	41.60%	43.20%	45.70%	52.20%	3.40%	7.00%	9.10%	10.70%	11.30%	12.60%	13.90%						▲
WF-40	Appraisals Rolling Year %						52.20%	48.90%	40.80%	38.80%	34.10%	31.60%	30.30%	28.70%	80.00%		-			▼
WF-7	Annual Rolling Turnover Rate	11.70%	11.10%	11.20%	10.90%	10.50%	10.30%	10.80%	11.40%	12.10%	12.90%	13.60%	13.90%	14.50%						▼
WF-8	Annual Rolling Sickness Absence	6.20%	6.30%	7.40%	7.10%	7.30%	7.10%	7.10%	7.30%	7.50%	7.70%	7.90%	8.10%	8.30%	5.00%		-			▼
WF-9	Disciplinary Cases	3	3	2	1	1	4	9	8	2	6	1	4	1						▲
WF-10	Individual Grievances	11	8	9	8	5	8	10	8	8	5	9	8	10						▼
WF-11	Collective Grievances	0	0	0	0	1	0	1	1	1	1	0	2	0						▲
WF-12	Bullying & Harrassment Internal	3	5	1	1	1	6	5	4	1	0	4	3	3	0		-			●
WF-13	Whistleblowing	0	0	0	0	0	0	0	0	0	3	0	0	0						●
QS-27	Freedom to Speak Up: Total Open Cases							31	33	38	45	20	7	28						▬
QS-27	Freedom to Speak up: Open cases re possible patient safety issues								3	3	2	2		4						▬
QS-27	Freedom to Speak up: Cases Closed in Month With Resolution							0	0	1	0	0	4	1						▬
QS-27	Freedom to Speak up: Cases Closed in Month Without Resolution							2	2	1	25	0	12	1						▬
WF-26	Vacancy Rate for Leadership Roles %																			■
WF-28	Staff Affected by Restructures %																			■
WF-29	Staff Acting Up/Secondments %	2.50%			2.70%	2.60%	3.10%	2.90%	2.90%	2.70%	2.30%	2.20%	2.50%	2.50%						●
WF-37	Diversity: Disability - declared %	3.40%	3.40%	4.00%	4.00%	4.00%	4.20%	4.20%	4.20%	4.30%	4.30%	4.30%	4.80%	4.80%						●
WF-38	Diversity: Disability - declined to declare %	46.30%	47.90%	10.00%	10.00%	10.00%	7.80%	7.80%	7.80%	7.50%	7.50%	7.50%	7.00%	7.00%	0.00%		-			●
WF-39	Diversity: Ethnicity - BAME %	5.30%	5.30%	5.50%	5.50%	5.50%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%	5.60%						●
WF-27	First Line Managers who have had Leadership Training (Fundamentals) %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%		-			●
WF-18	Absence Relating to Mental Health %	10.80%	7.60%	5.30%	4.70%	8.10%	6.70%	6.70%	8.40%	8.90%	11.50%	8.20%	9.80%	5.90%						▲
WF-19	Absence Relating to MSK %	4.20%	3.60%	3.10%	2.80%	8.10%	4.50%	8.30%	6.20%	5.70%	5.60%	6.10%	5.60%	5.70%						▼

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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-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Target	National Avg	Vs Target	Vs National Avg	Perf Direction	
WF-25	Number of Wellbeing Hub Referrals	124	98	112	95	98	115	111	138	125	111	93	142	79						▲
WF-30	Time from referral to offered wellbeing appointment (days)	14	14	14	14	14	14	14	14	14	14	14	21	28	14		-			▼
999-27	% of Meal Breaks Taken						99.20%	91.00%	98.40%	98.80%	98.30%	98.40%	98.40%	98.00%						▼
999-28	% of Meal Breaks Outside of Window						49.90%	51.10%	54.80%	59.30%	59.10%	58.70%	58.80%	60.70%						▼
999-15	999 Frontline Late Finishes/Over-Runs %	50.60%	50.10%	61.10%	59.50%	51.00%	52.40%	51.90%	60.20%	53.40%	50.80%	49.20%	51.90%	53.30%						▼
999-15	Average Late Finish/Over-Run Time	00:40:46	00:44:20	00:54:50	00:53:25	00:40:19	00:40:17	00:44:03	00:47:33	00:43:27	00:41:00	00:41:00	00:41:00	00:41:59						▼
999-21	Provided Bank Hours %	2.80%	2.30%	5.60%	2.30%	0.30%	0.30%	0.40%	0.60%	0.60%	0.70%	1.70%	0.00%	0.90%						▬
999-21	Provided Overtime Hours %	9.10%	10.40%	9.10%	11.50%	15.40%	14.60%	9.10%	8.60%	10.40%	10.50%	9.30%	11.40%	12.00%						▬
999-21	Provided PAP Hours %	6.40%	6.40%	5.80%	5.90%	6.10%	6.30%	4.30%	4.80%	4.50%	4.80%	5.30%	6.80%	6.90%						▬
999-22	999 Remaining Annual Leave FY	50.70%	48.00%	45.00%	33.00%	27.00%	20.00%	53.00%		84.00%		34.60%	62.50%	55.70%	41.70%		-			▲
FL-1	Vehicles Older Than Target Age %	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	35.00%	36.00%	36.00%	36.00%	36.00%	0.00%		-			●
C-1	Policies & Procedures Outstanding Review %	13.20%	10.80%	11.80%	11.80%	11.00%	11.30%	15.80%	17.40%	29.00%	32.00%	37.00%	36.50%	37.20%	0.00%		-			▼
QS-24	Organisational Risks Outstanding Review %	18.00%	21.00%	14.00%	59.00%	57.00%	52.00%	59.00%	81.00%	73.00%		40.40%	48.00%	43.00%	0.00%		-			▲
IT-1	CAD System Uptime %								98.900%	85.960%	100.000%	99.900%	100.000%	100.000%						●
IT-2	Telephony System Uptime %								85.690%	100.000%	100.000%	100.000%	100.000%	100.000%						●
IT-3	ePCR System Uptime %								84.390%	100.000%	97.900%	100.000%	100.000%	100.000%						●
IT-4	Number of Calls to IT Service Desk	1310	1537	916	279	1436	1924	1324	1442	1214	1214	1187	1372	1090						▲
IT-5	Marval IT Requests Raised - IT Service Desk	1807	1870	1359	1561	1559	1847	1638	1705	1503	1288	1168	1477	1414						▲
IT-5	Marval IT Requests Raised - Critical Systems Team	668	523	480	539	694	724	728	757	765	775	664	611	592						▲
IT-6	Missed Calls to IT Service Desk	433	410	201	95	460	624	586	456	378	382	447	441	377						▲

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Performance by Domain

Well-Led: Finance Dashboard (October 2021)

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-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Plan	Vs Plan	Full Year Forecast	Full Year Forecast Vs Plan
F-1	Income (£000s) Month	£22430.00	£22133.40	£23376.80	£23858.00	£28134.50	£36076.00	£23241.00	£23340.80	£23325.10	£23415.40	£23521.20	£29157.60	£23450.50	£22170.00	£1280.50		
F-9	Income (£000s) YTD	£156484.00	£178617.40	£201994.00	£225852.00	£251986.50	£287063.00	£23241.00	£46582.10	£69907.20	£93332.60	£116853.80	£146011.40	£169461.90	£164313.00	£5148.90	£297125.10	£132812.10
F-2	Operating Expenditure (£000s) Month	£23020.10	£23093.50	£24451.80	£25312.10	£24952.70	£38485.00	£23947.00	£24554.20	£24345.40	£24929.90	£25040.50	£27981.60	£24300.60	£23104.68	£1195.92		
F-10	Operating Expenditure (£000s) YTD	£157088.60	£180182.10	£204633.90	£230346.00	£255298.70	£293784.00	£23947.00	£48503.60	£72849.00	£97787.90	£122828.40	£150810.00	£175110.60	£170288.83	£4821.77	£306496.30	£136207.47
F-3	Capital Expenditure (£000s) Month	£834.38	£2343.59	£1080.59	£4378.10	£1223.15	£4138.00	£1618.00	£987.96	£983.67	£1252.68	£412.32	£655.48	£395.11	£2112.00	£-1716.89		
F-14	Capital Expenditure (£000s) YTD	£6331.68	£8875.27	£9755.85	£14138.03	£15361.18	£19499.00	£1618.00	£2605.91	£3589.58	£4842.26	£5254.58	£5910.07	£6305.18	£9897.00	£-3591.82	£25487.92	£15590.92
F-4	Cost Improvement Plan (CIP) (£000s) Month	£71.00	£673.00	£8.00	£522.00	£478.00	£709.00	£0.00	£0.00	£150.00	£430.00	£250.00	£238.00	£161.00	£493.00	£-332.00		
F-13	Cost Improvement Plans (CIPS) (£000s) YTD	£2174.00	£2847.00	£2855.00	£3790.00	£4268.00	£4977.00	£0.00	£0.00	£150.00	£580.00	£830.00	£1068.00	£1229.00	£3364.00	£-2135.00	£5872.00	£2508.00
F-6	Surplus/Deficit (£000s) Month	£-590.10	£-960.10	£-1075.20	£-1454.10	£1181.80	£-3409.00	£-706.00	£-1213.40	£-1020.30	£-1514.50	£-1519.30	£1176.00	£-850.10	£-934.68	£84.58		
F-7	Cash Position (£000s) Month	£48231.00	£46275.00	£46819.00	£41747.00	£51441.00	£40152.00	£36526.00	£36448.00	£35923.00	£36684.00	£38289.00	£40507.00	£46592.00	£19757.52	£26834.48	£19757.52	£0.00
F-8	Agency Spend (£000s) Month	£84.98	£81.95	£205.95	£106.34	£-80.27	£155.00	£169.00	£250.04	£107.24	£347.61	£234.08	£168.06	£154.98	£273.00	£-118.02		
F-16	Agency Spend (£000s) YTD	£1315.79	£1398.74	£1803.88	£1710.00	£1830.00	£1784.00	£169.00	£418.90	£526.14	£873.76	£1107.84	£1275.89	£1430.87	£2004.00	£-573.13	£2638.40	£634.40

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Performance by Domain

Well-Led: Performance Dashboard

Key Performance Indicators

Month					
% PY Var	£000 Prior Year	£000 Plan	£000 Actual	£000 Variance	% Variance

4.5%	22,430	22,169	23,451	1,282	5.8%
(1.1)%	16,297	16,776	16,471	305	1.8%
82.4%	44,195	6,183	7,783	(1,600)	(25.9)%
59.9%	60,492	22,959	24,254	(1,295)	(5.6)%
(97.9)%	(38,062)	(790)	(803)	(13)	1.6%
68.5%	149	146	47	99	67.7%
97.8%	(38,211)	(936)	(850)	86	9.2%
0.0%	2	1	(98)	(99)	(9900.0)%
97.5%	(38,212)	(935)	(948)	(13)	(1.4)%

% PY Var	Incidents Prior Year	Incidents Plan	Incidents Actual	Incidents Variance	% Variance
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1.2%	63,743	66,587	64,489	(2,098)	(3.2)%
✓	3	3	3		✓
	Prior Year	Plan	Actual	Variance	
✓	71	493	161	(332)	✗
✗	834	2,112	395	(1,717)	✗
✓	48,231	19,758	46,592	26,834	✓
✗	4,371	4,407	4,337	70	✗
✓	1,058	35	982	(947)	✓

% PY Var	£000 Prior Year	£000 Plan	£000 Actual	£000 Variance	% Variance
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(82.4)%	85	273	155	118	43.2%
(473.5)%	148	0	849	(849)	0.0%
(160.9)%	475	591	1,239	(649)	(109.8)%
(235.1)%	623	591	2,088	(1,498)	(253.5)%

Year To Date					
£000 Plan	£000 Actual	£000 Variance	% Variance	£000 Prior Year	% PY Var

164,313	169,462	5,149	3.1%	156,484	8.3%
122,718	129,531	(6,873)	(5.6)%	117,626	(10.2)%
46,554	44,785	1,769	3.8%	38,803	(15.4)%
169,272	174,376	(5,104)	(3.0)%	156,430	(11.5)%
(4,959)	(4,914)	45	(0.9)%	55	(9116.3)%
1,019	735	284	27.9%	659	(11.5)%
(5,978)	(5,649)	329	5.5%	(605)	(833.7)%
26	(266)	(292)	(11)	14	1966.9%
(5,952)	(5,915)	37	0.6%	(530)	(901.9)%

Incidents Plan	Incidents Actual	Incidents Variance	% Variance	Incidents Prior Year	% PY Var
----------------	------------------	--------------------	------------	----------------------	----------

463,398	448,452	(14,946)	(3.2)%	428,239	4.7%
3	3		✓	2	✗
Plan	Actual	Variance		Prior Year	
3,364	1,229	(2,135)	✗	2,174	✗
9,897	6,305	(3,592)	✗	6,332	✓
19,758	46,592	26,834	✓	48,231	✓
4,386	4,381	5	✗	4,444	✓
6,635	6,824	(189)	✗	10,027	✗

£000 Plan	£000 Actual	£000 Variance	% Variance	£000 Prior Year	% PY Var
-----------	-------------	---------------	------------	-----------------	----------

2,004	1,431	573	28.6%	1,316	(8.7)%
1,020	1,163	(143)	(14.1)%	1,347	13.6%
3,481	2,517	964	27.7%	4,434	43.2%
4,501	3,680	821	18.2%	5,781	36.3%

Full Year					
£000 Plan	£000 Forecast	£000 Variance	% Variance	£000 Prior Year	% PY Var

275,157	297,125	21,968	8.0%	287,063	3.5%
205,855	226,073	(20,218)	(9.8)%	203,049	(11.3)%
78,156	78,964	(808)	(1.0)%	90,533	12.8%
284,010	305,037	(21,026)	(7.4)%	293,581	(3.9)%
(8,853)	(7,911)	942	(10.6)%	(6,519)	21.4%
1,745	1,460	285	16.3%	203	(619.1)%
(10,598)	(9,371)	1,227	11.6%	(6,722)	(39.4)%
31	(261)	(292)	(941.9)%	57	557.9%
(10,567)	(9,632)	935	8.8%	(77)	(12474.7)%

Incidents Plan	Incidents Forecast	Incidents Variance	% Variance	Incidents Prior Year	% PY Var
----------------	--------------------	--------------------	------------	----------------------	----------

806,987	761,194	(45,793)	(5.7)%	741,767	2.6%
3	3		✓	1	✓
Plan	Forecast	Variance		Prior Year	
5,872	5,872	0	✓	4,977	✓
25,491	25,488	(3)	✓	19,499	✓
24,360	45,334	20,974	✓	40,152	✓
4,350	4,347	3	✗	4,452	✗
7,095	14,229	(7,134)	✓	19,556	✗

£000 Plan	£000 Forecast	£000 Variance	% Variance	£000 Prior Year	% PY Var
-----------	---------------	---------------	------------	-----------------	----------

3,298	2,638	660	20.0%	1,784	(47.9)%
1,020	2,013	(993)	(97.4)%	2,451	17.9%
2,890	5,094	(2,204)	(76.3)%	6,281	18.9%
3,910	7,107	(3,197)	(81.8)%	8,732	18.6%

- ▲ Improving performance
- ▼ Deteriorating performance
- No change
- Aspirational metric
- + Outperformed target
- Underperformed target
- = On target
- Data not provided

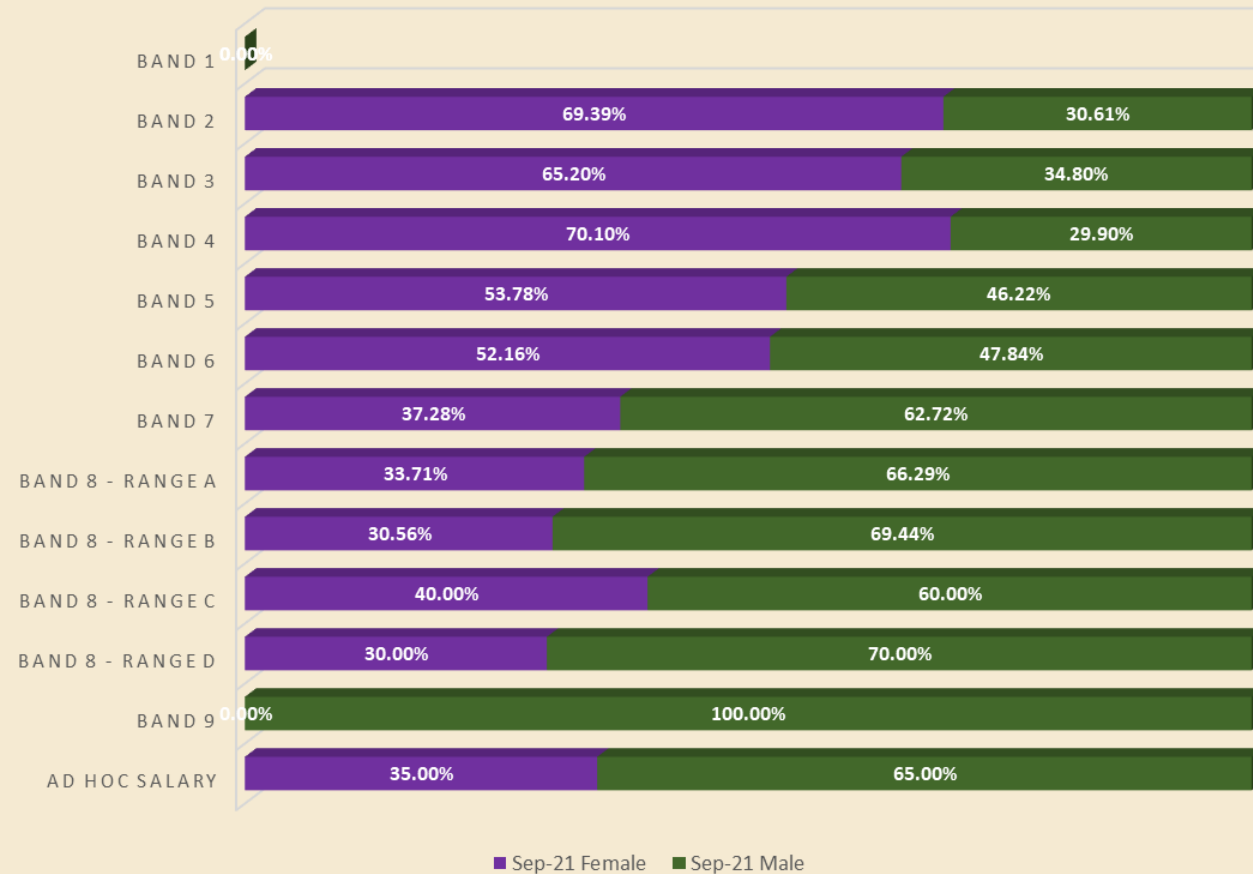


Performance by Domain

Well-Led: Gender Composition by Pay Band (September 2021)

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

GENDER COMPOSITION BY PAY BAND (SEPTEMBER 2021)



National Benchmarking 999 Emergency Ambulance Service (October 2021)

Key indicators at a glance for October 2021

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	00:02:37	00:02:38	00:02:39	00:01:50	00:01:35	00:01:36	00:02:50	00:01:45	00:03:19	00:05:07	00:00:19	00:06:45
Calls Answered	1012143	89087	101377	93765	2179	158184	46649	141567	64712	111104	128039	75480
Mean Call Answer Time	00:00:56	00:00:47	00:00:53	00:00:32	00:00:30	00:00:25	00:01:06	00:00:34	00:01:07	00:02:13	00:00:06	00:02:46
Incident Proportions (Over All Incidents)	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
All Incidents	747472	64490	74283	67230	2585	109450	36428	92879	57062	74837	97610	70618
C1 Incidents %	10.99%	7.77%	11.43%	12.88%	6.62%	9.96%	9.58%	15.60%	7.09%	12.05%	10.56%	10.71%
C2 Incidents %	56.53%	56.90%	60.12%	60.91%	46.11%	55.25%	56.59%	55.05%	48.92%	60.47%	53.61%	58.57%
C3 Incidents %	14.81%	21.35%	13.11%	11.00%	26.54%	13.88%	13.02%	12.31%	24.92%	14.03%	13.88%	13.37%
C4 Incidents %	0.51%	0.35%	0.38%	0.14%	2.01%	1.01%	1.04%	0.00%	1.41%	0.13%	0.62%	0.21%
Incident Outcomes	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Hear & Treat %	12.31%	10.39%	9.87%	10.80%	12.38%	16.34%	13.26%	8.85%	13.73%	10.65%	17.51%	9.31%
See & Convey %	51.36%	57.65%	54.28%	50.99%	56.09%	50.35%	51.99%	52.53%	48.28%	47.40%	47.08%	55.08%
See & Treat %	31.52%	30.56%	32.89%	32.88%	30.91%	29.73%	25.74%	31.74%	33.61%	38.24%	29.92%	28.57%
Response Performance	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
90th Centile Response Time: C1	00:16:23	00:16:18	00:19:19	00:17:01	00:17:39	00:12:00	00:12:54	00:15:33	00:16:31	00:21:12	00:14:26	00:18:44
90th Centile Response Time: C2	01:56:13	01:10:46	02:00:02	02:07:06	01:06:11	01:47:09	01:35:36	02:28:44	01:13:15	03:04:58	01:46:25	01:32:33
90th Centile Response Time: C3	07:47:15	08:06:11	07:34:54	09:43:04	03:54:13	05:10:16	07:01:33	10:27:54	05:04:29	10:33:45	09:57:02	05:33:17
90th Centile Response Time: C4	08:01:16	10:28:49	09:04:33	06:06:09	04:46:27	08:07:47	04:21:48	00:00:00	06:29:48	13:29:55	10:28:05	07:52:54
Mean Response Time: C1	00:09:20	00:09:08	00:10:37	00:09:29	00:09:55	00:07:02	00:07:14	00:09:14	00:09:11	00:11:48	00:08:12	00:11:04
Mean Response Time: C2	00:53:54	00:34:56	00:56:01	00:59:05	00:32:07	00:49:57	00:48:17	01:07:42	00:35:38	01:24:25	00:46:34	00:43:40

National Benchmarking 999 Emergency Ambulance Service Clinical Outcomes (June 2021)

Key indicators at a glance for June 2021

Cardiac Arrest	ENG	SECAmb	EEAS	EMAS	IOW	LAS	NEAS	NWAS	SCAS	SWAS	WMAS	YAS
Proportion who had ROSC on arrival at hospital %	25.67%	28.27%	26.35%	28.14%	33.33%	25.84%	26.47%	26.56%	22.95%	22.81%	21.84%	27.67%
Proportion who had ROSC on arrival at hospital utstein %	46.00%	48.65%	41.86%	48.78%		44.44%	54.55%	58.06%	39.29%	38.18%	43.48%	48.15%

NB: NHSE's most recent publication of national clinical outcomes no longer includes 'proportion of cardiac arrests discharged live' metrics.





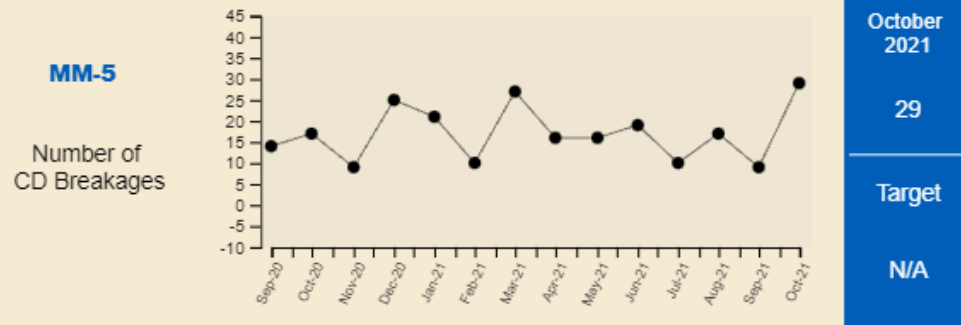
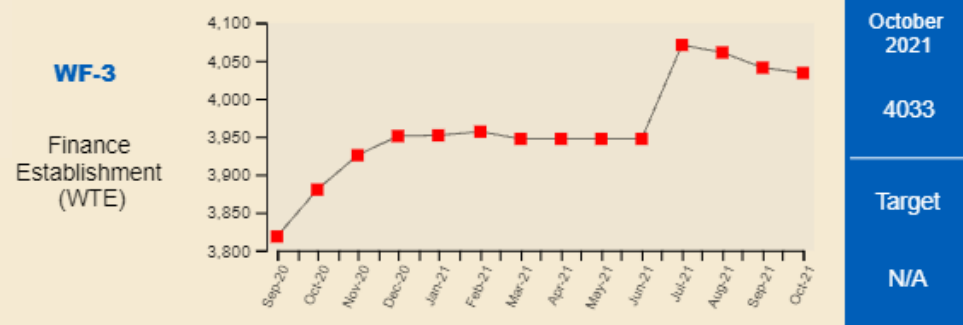
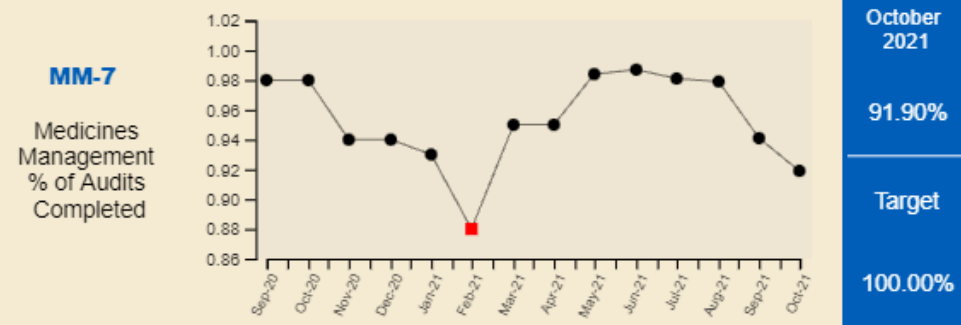
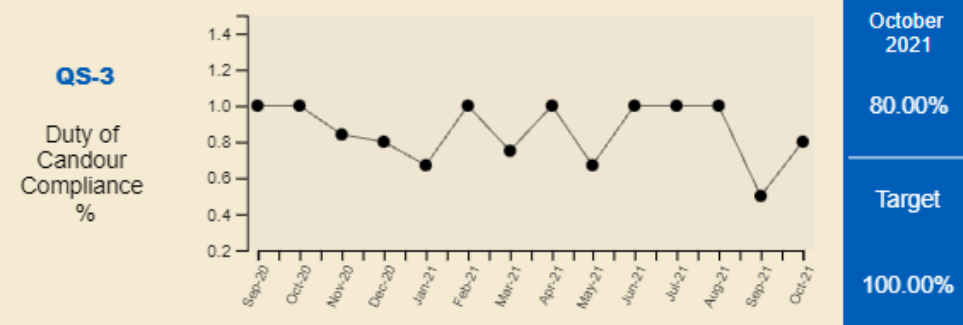
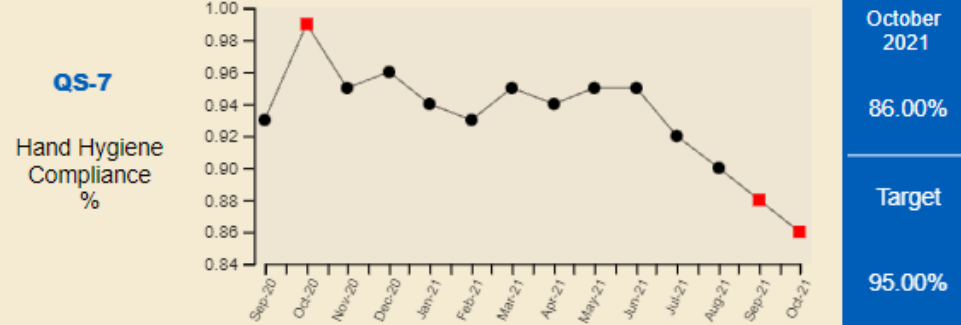
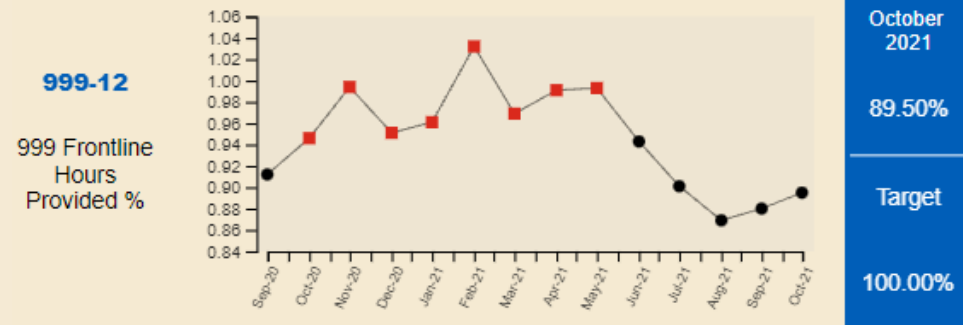
Appendix 1

Performance Charts

Performance by Domain

Safe: Performance Charts

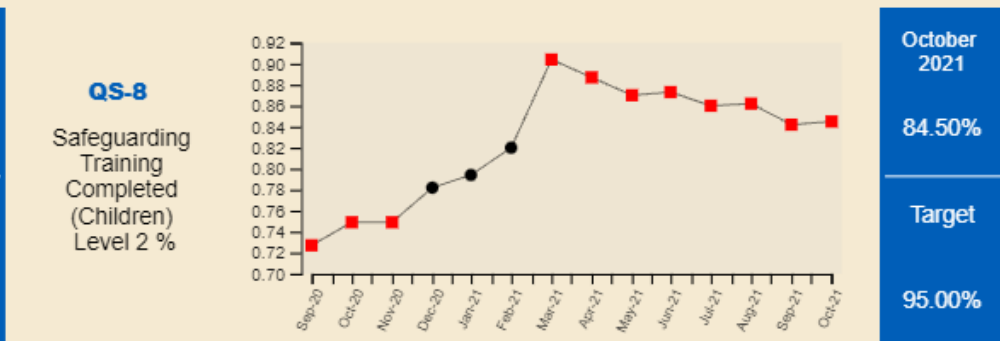
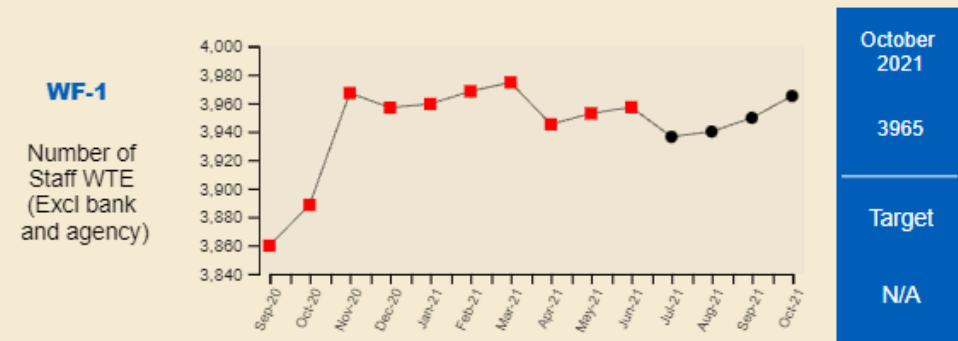
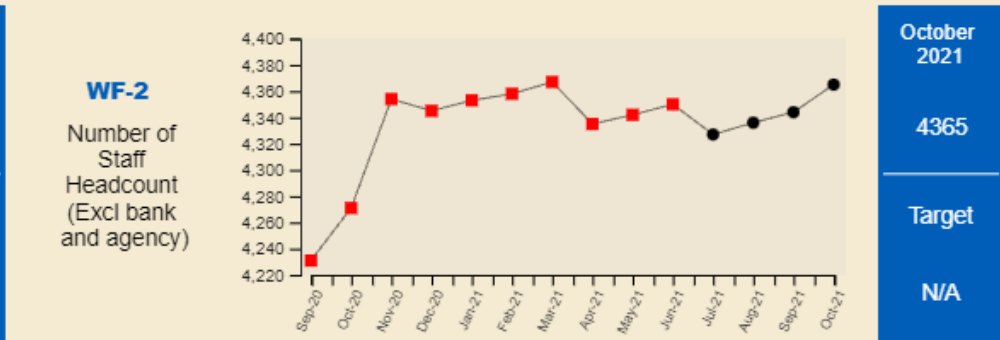
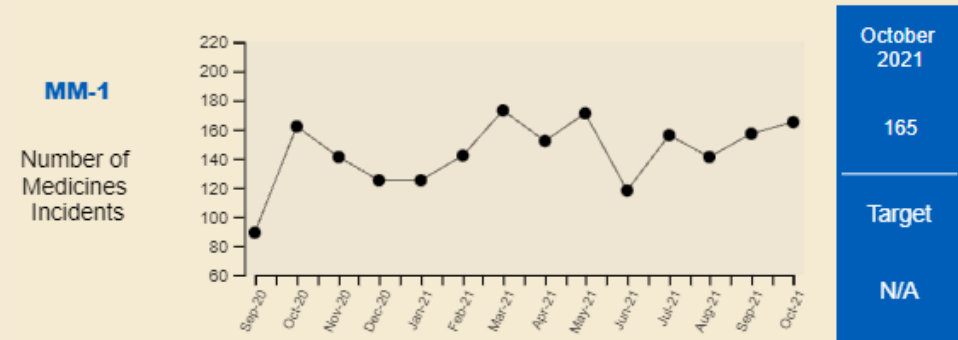
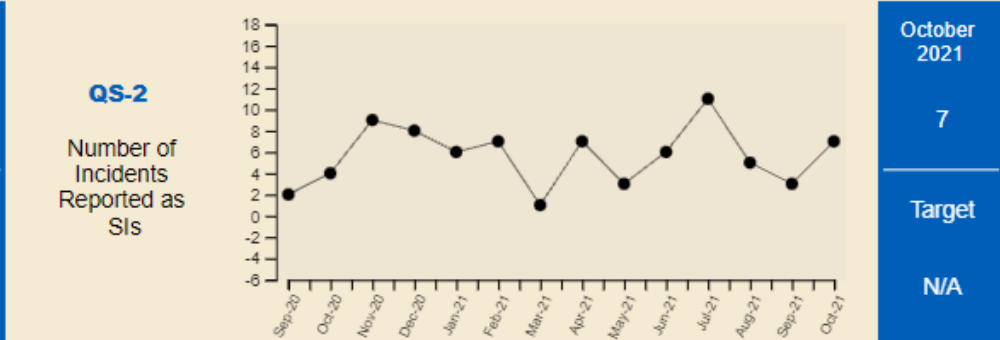
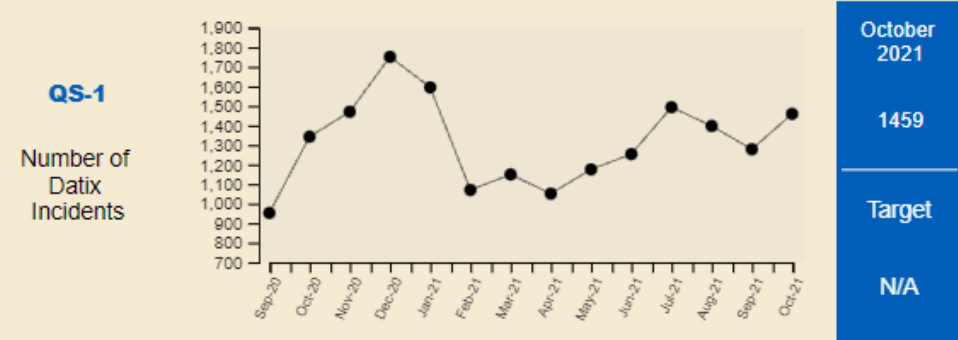
We protect our patients and staff from abuse and avoidable harm



Performance by Domain

Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm



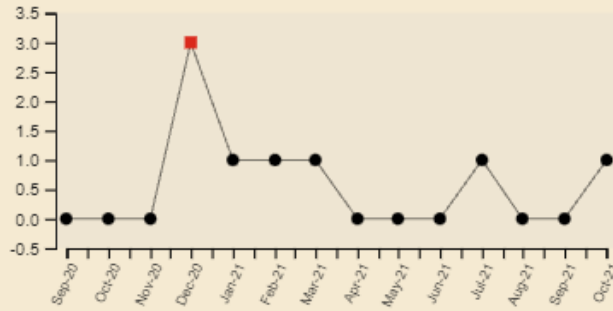
Performance by Domain

Safe: Performance Charts

We protect our patients and staff from abuse and avoidable harm

MM-4

Single Witness
Signature
Use CDs
Non-Omniceil



October 2021

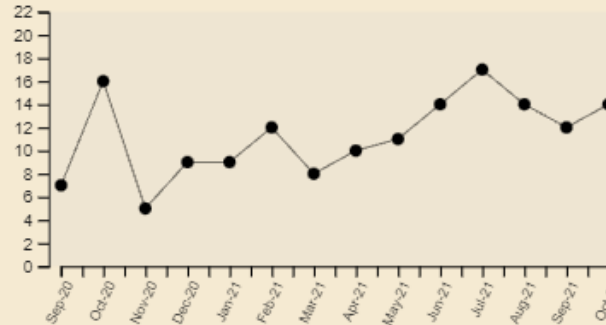
1

Target

N/A

QS-9

Number of RIDDOR Reports



October 2021

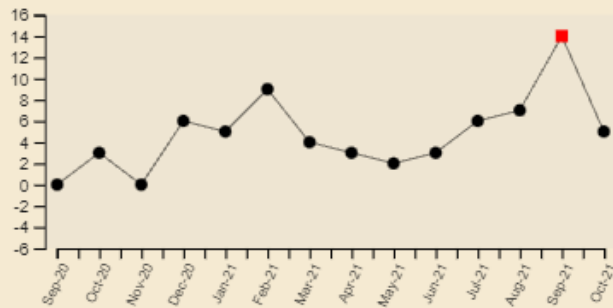
14

Target

N/A

MM-3

Single Witness
Signature
Use CDs
Omniceil



October 2021

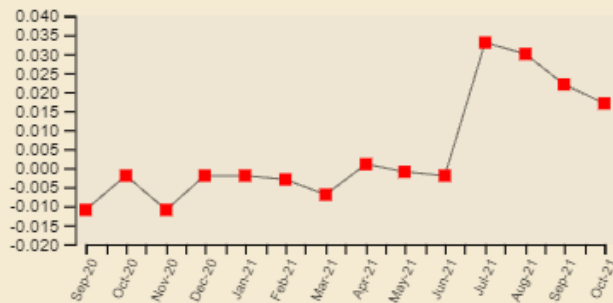
5

Target

N/A

WF-4

Vacancy Rate %



October 2021

1.70%

Target

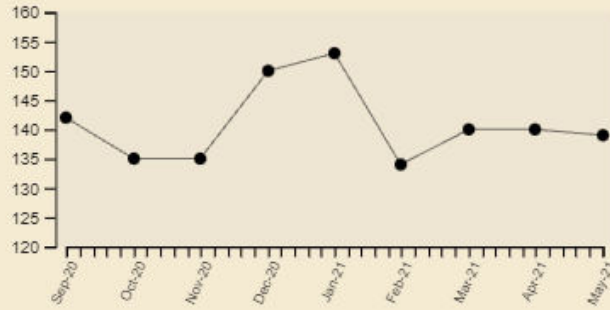
N/A

Performance by Domain

Effective: Performance Charts

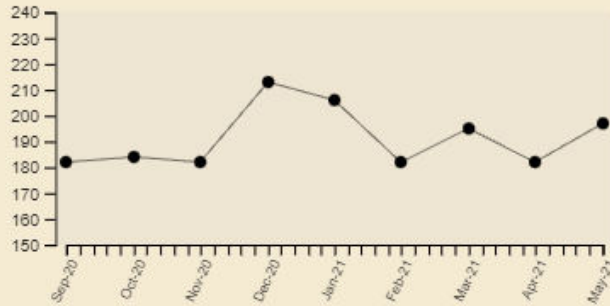
Our care, treatment and support achieves good outcomes, helps our patients to maintain quality of life and is based on the best available evidence

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



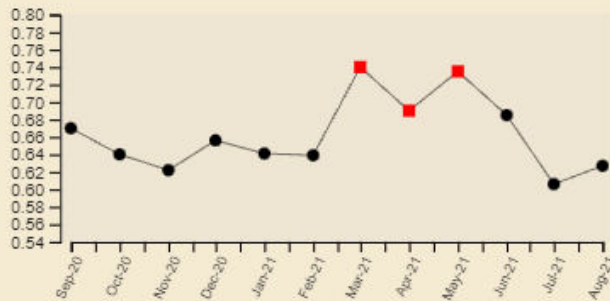
May 2021
02:19:00
Target
N/A

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



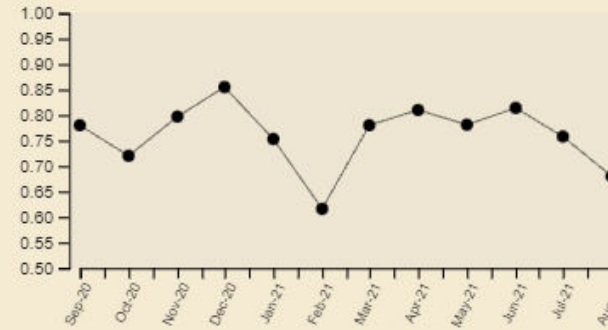
May 2021
03:17:00
Target
N/A

M-5
**Acute STEMI Care Bundle Outcome %



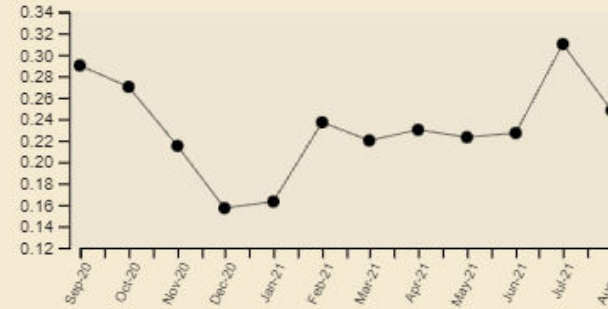
August 2021
62.70%
Target
N/A

M-11
Cardiac Arrest - Post ROSC %



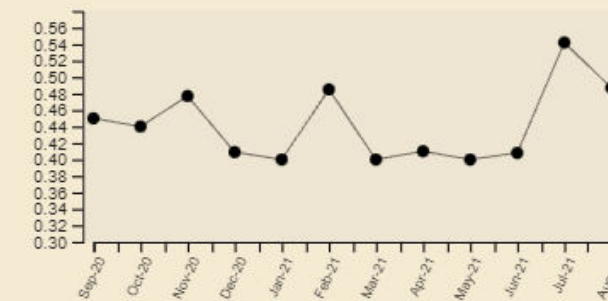
August 2021
68.00%
Target
N/A

M-2
Cardiac ROSC ALL %



August 2021
24.80%
Target
N/A

M-1
**Cardiac ROSC Utstein %



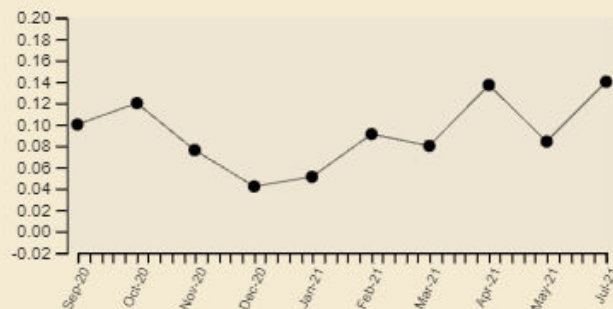
August 2021
48.70%
Target
N/A

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-4
Cardiac Survival ALL %



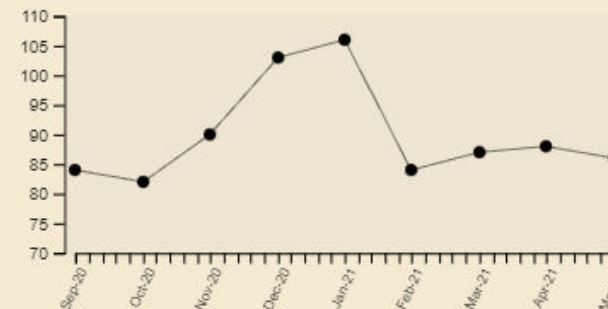
July 2021

14.00%

Target

N/A

M-8
Stroke - Call to Hospital Arrival Mean



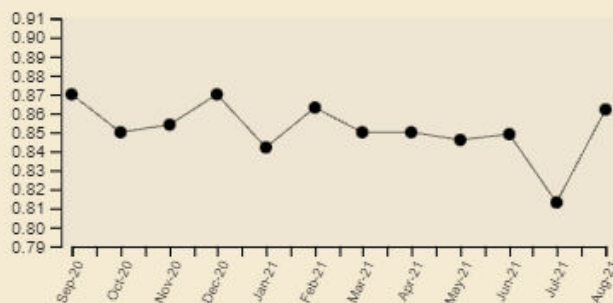
May 2021

01:26:00

Target

N/A

M-12
**Sepsis Care Bundle %



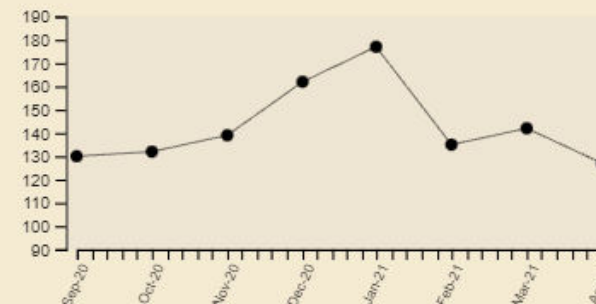
August 2021

86.20%

Target

N/A

M-9
Stroke - Call to Hospital Arrival 90th Centile



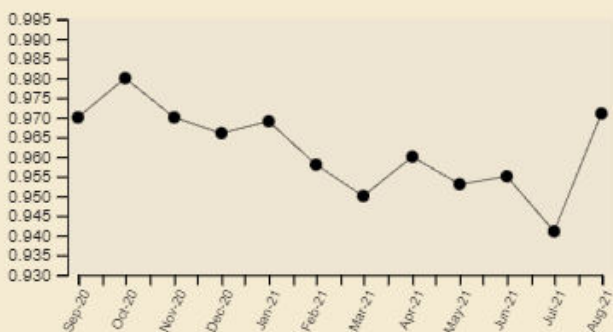
April 2021

02:07:00

Target

N/A

M-10
**Stroke - Assessed F2F Diagnostic Bundle %



August 2021

97.10%

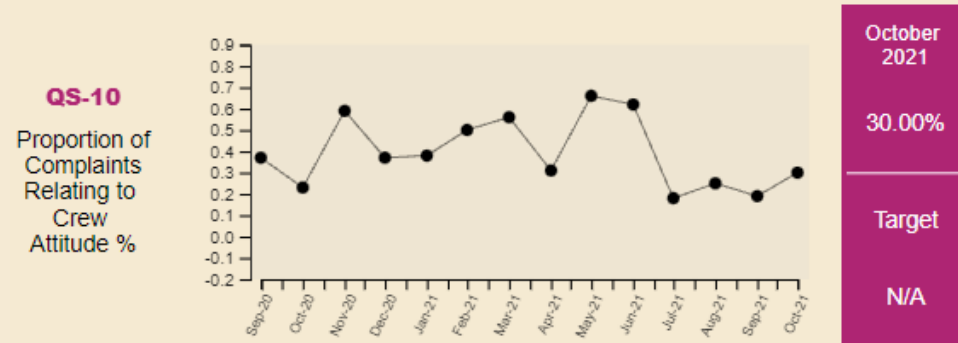
Target

N/A

Performance by Domain

Caring: Performance Charts

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

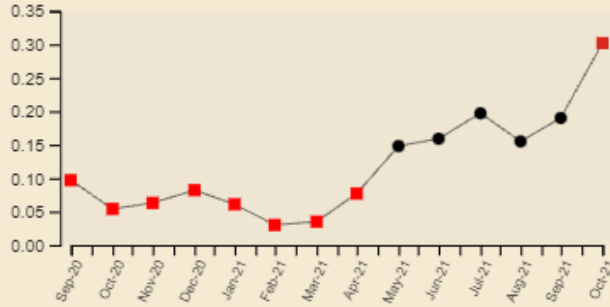


Performance by Domain

Responsive: Performance Charts

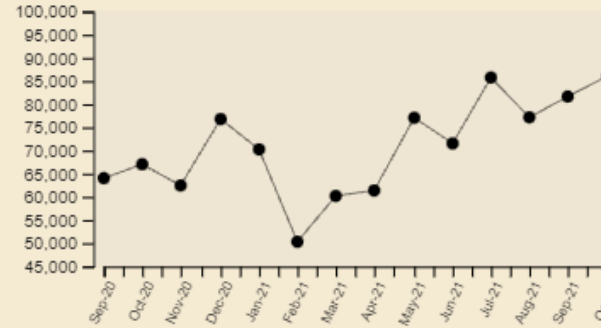
Our services are organised so that they meet our patient's needs

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



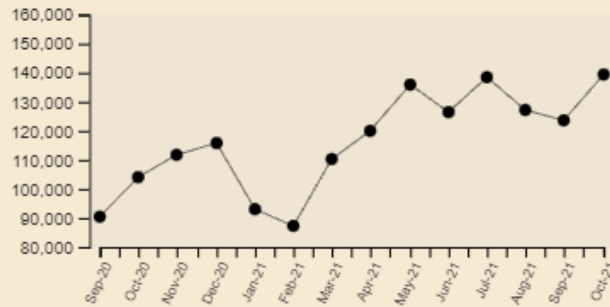
October 2021
30.20%
Target
6.00%

999-10
999 Calls Answered



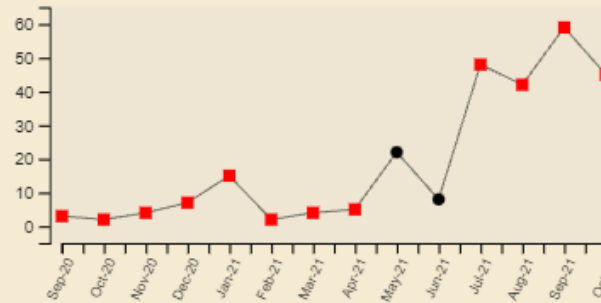
October 2021
86089
Target
N/A

111-1
111 Calls Offered Actual



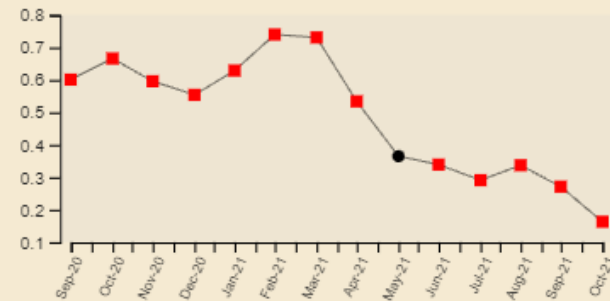
October 2021
104059
Target
N/A

999-1
999 Call Answer Mean



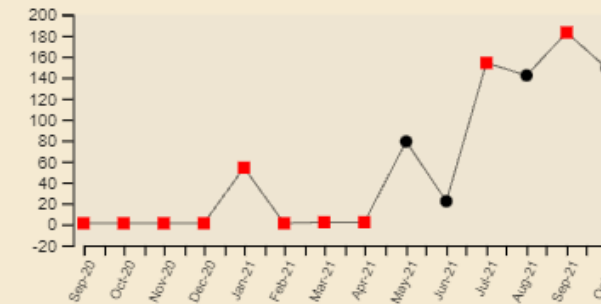
October 2021
00:00:44
Target
00:00:05

111-1
111 Calls Answered in 60 Seconds %



October 2021
16.30%
Target
95.00%

999-1
999 Call Answer 90th Centile



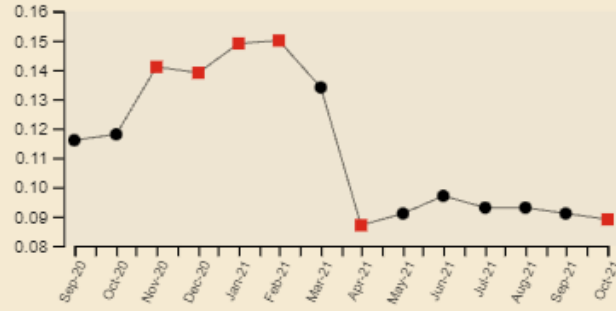
October 2021
00:02:29
Target
00:00:10

Performance by Domain

Responsive: Performance Charts

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

111-4
999 Referrals (Answered Calls) %

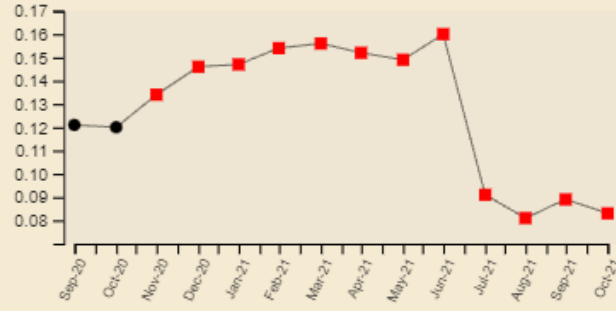


October 2021
8.90%

Target

N/A

111-5
A&E Dispositions %

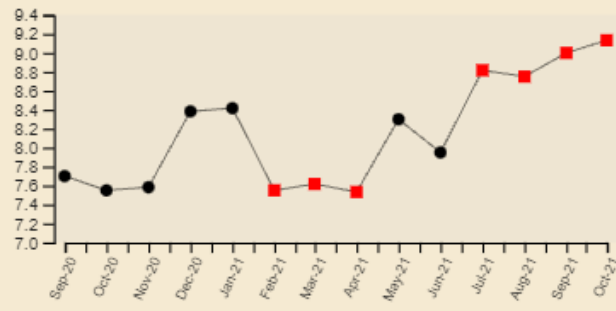


October 2021
8.30%

Target

N/A

999-2
Cat 1 Mean

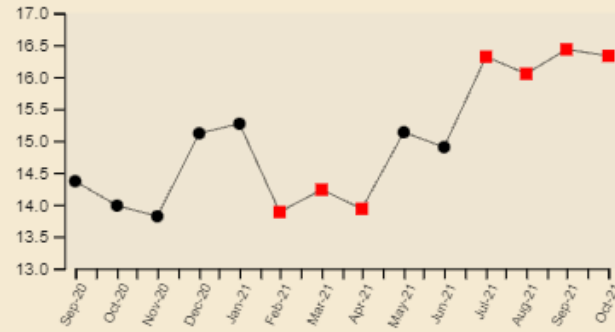


October 2021
00:09:08

Target

00:07:00

999-2
Cat 1 90th Centile

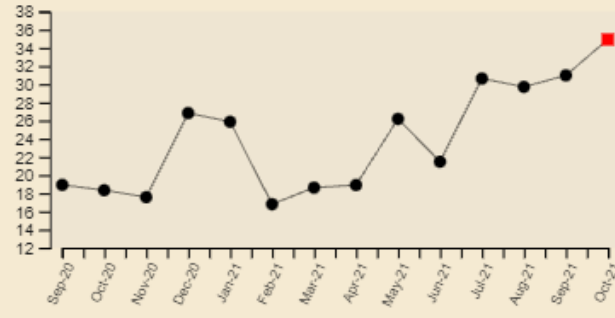


October 2021
00:16:19

Target

00:15:00

999-4
Cat 2 Mean

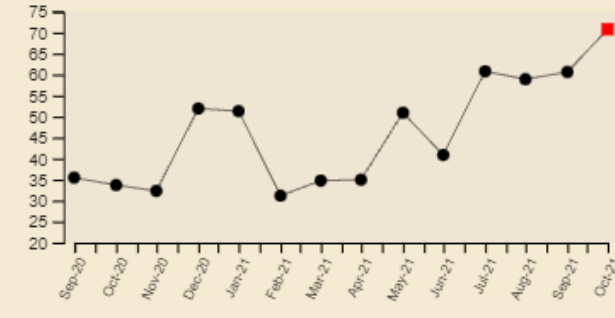


October 2021
00:34:55

Target

00:18:00

999-4
Cat 2 90th Centile



October 2021
01:10:47

Target

00:40:00

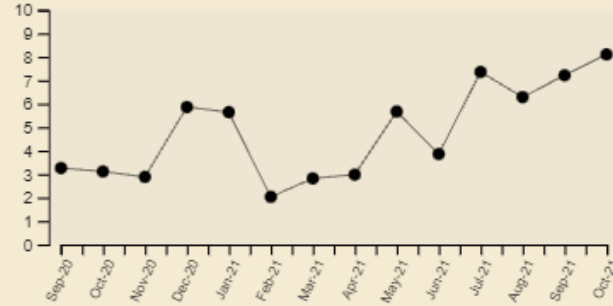
Performance by Domain

Responsive: Performance Charts

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

999-5

Cat 3 90th Centile



October 2021

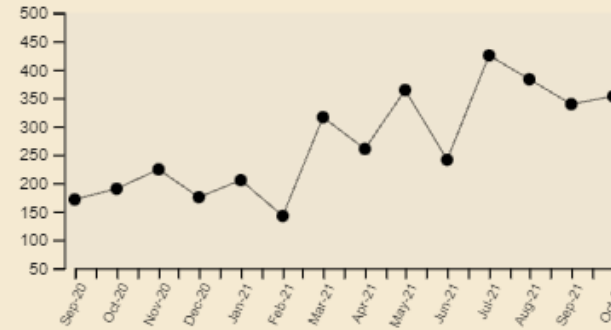
08:06:05

Target

02:00:00

999-10

Fire First Responder Attendances



October 2021

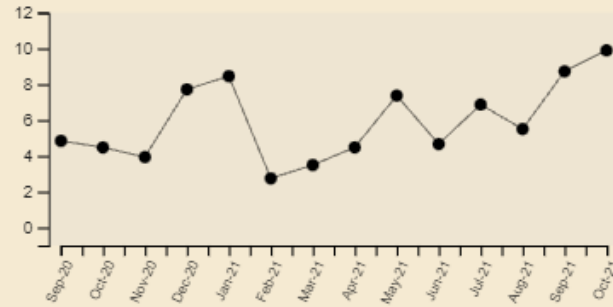
353

Target

N/A

999-6

Cat 4 90th Centile



October 2021

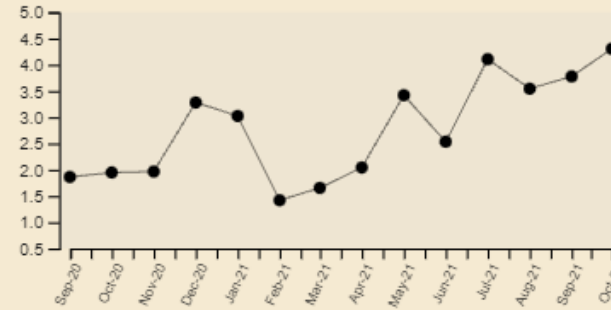
09:53:30

Target

02:44:51

999-7

HCP 3 Mean



October 2021

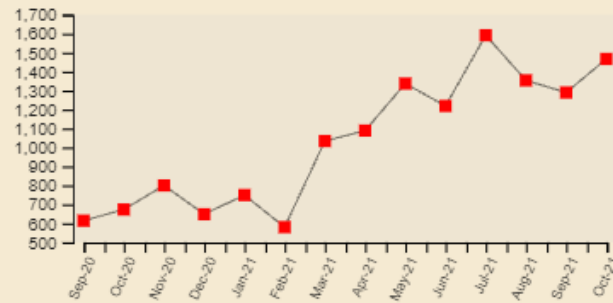
04:18:12

Target

N/A

999-10

Community First Responder Attendances



October 2021

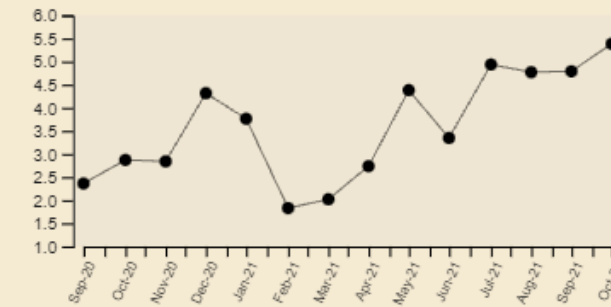
1467

Target

N/A

999-7

HCP 4 Mean



October 2021

05:23:02

Target

N/A



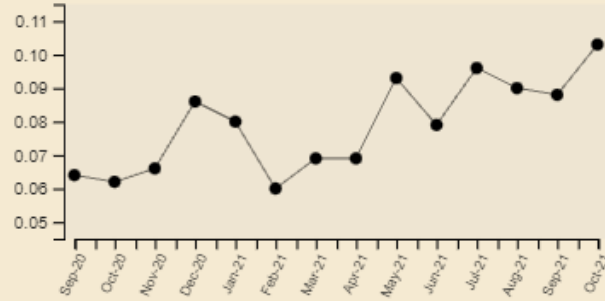
Performance by Domain

Responsive: Performance Charts

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

999-9

Incident Outcome Hear & Treat %



October 2021

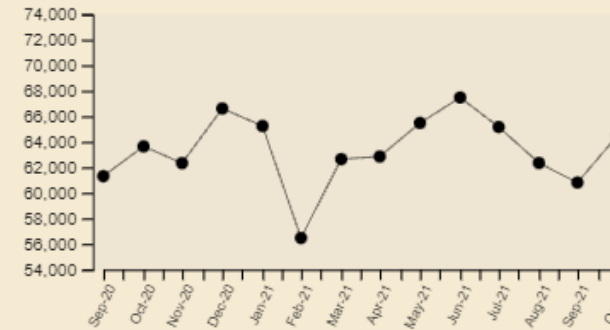
10.30%

Target

N/A

999-10

Incidents A7



October 2021

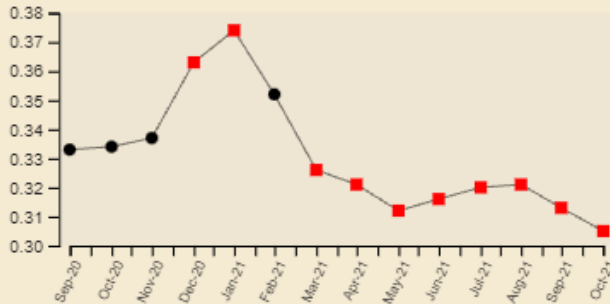
64510

Target

N/A

999-9

Incident Outcome See & Treat %



October 2021

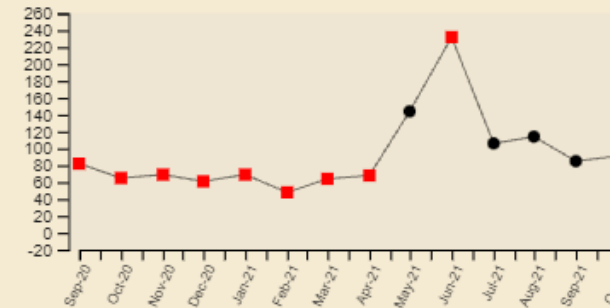
30.50%

Target

N/A

QS-5

Number of Complaints



October 2021

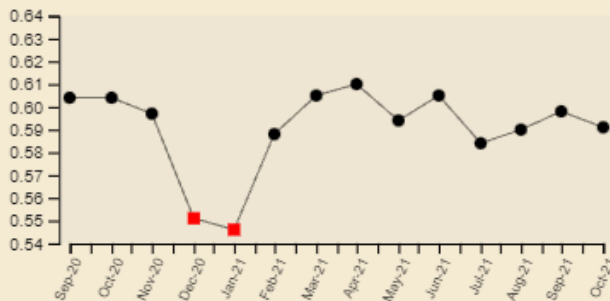
91

Target

N/A

999-9

Incident Outcome See & Convey %



October 2021

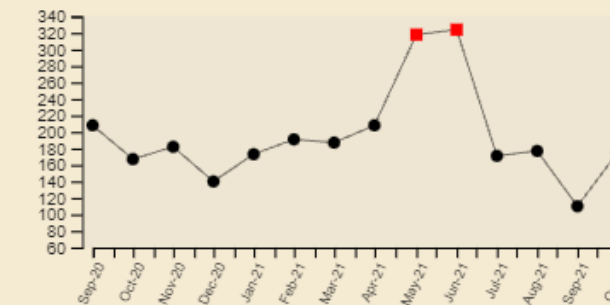
59.10%

Target

N/A

QS-6

Number of Compliments



October 2021

175

Target

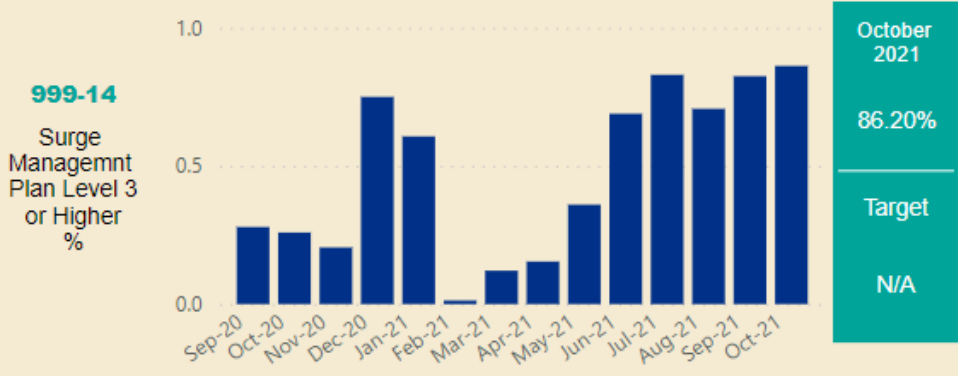
N/A



Performance by Domain

Responsive: Performance Charts

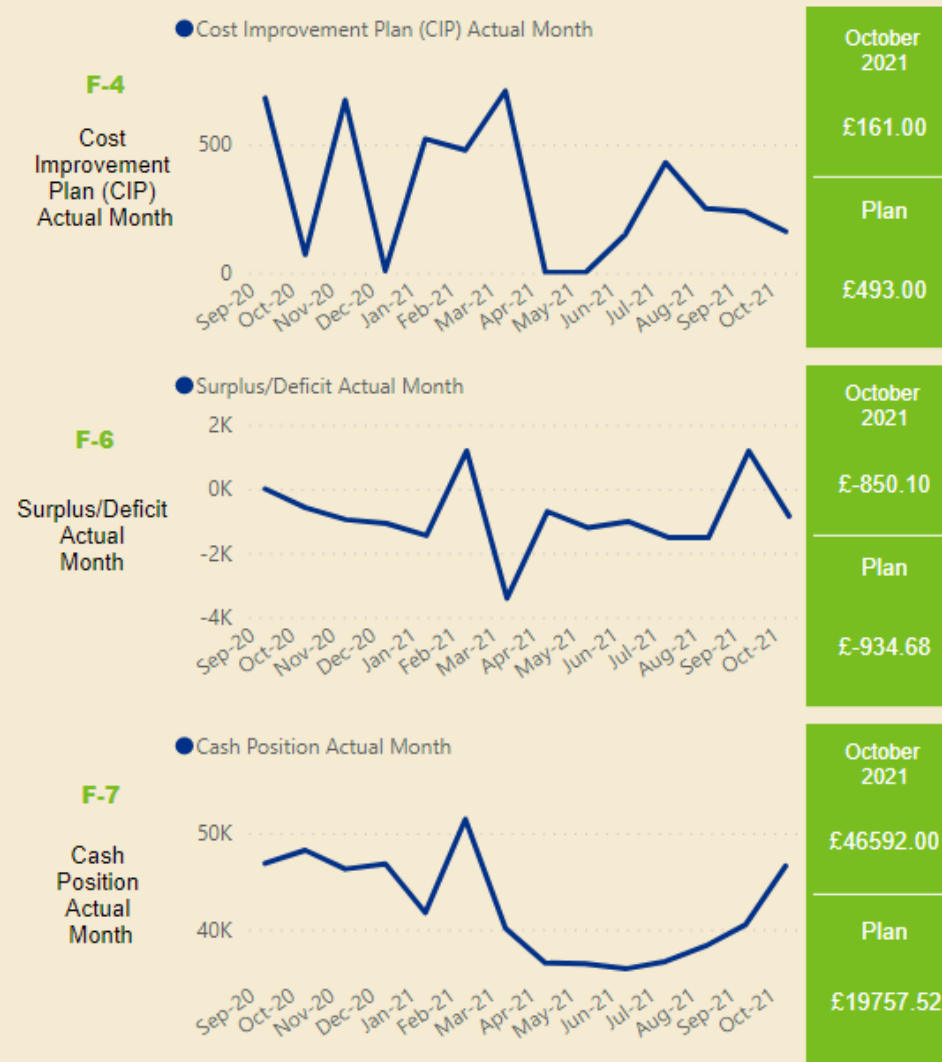
Our services are organised so that they meet our patient's needs



Performance by Domain

Well-Led: Performance Charts

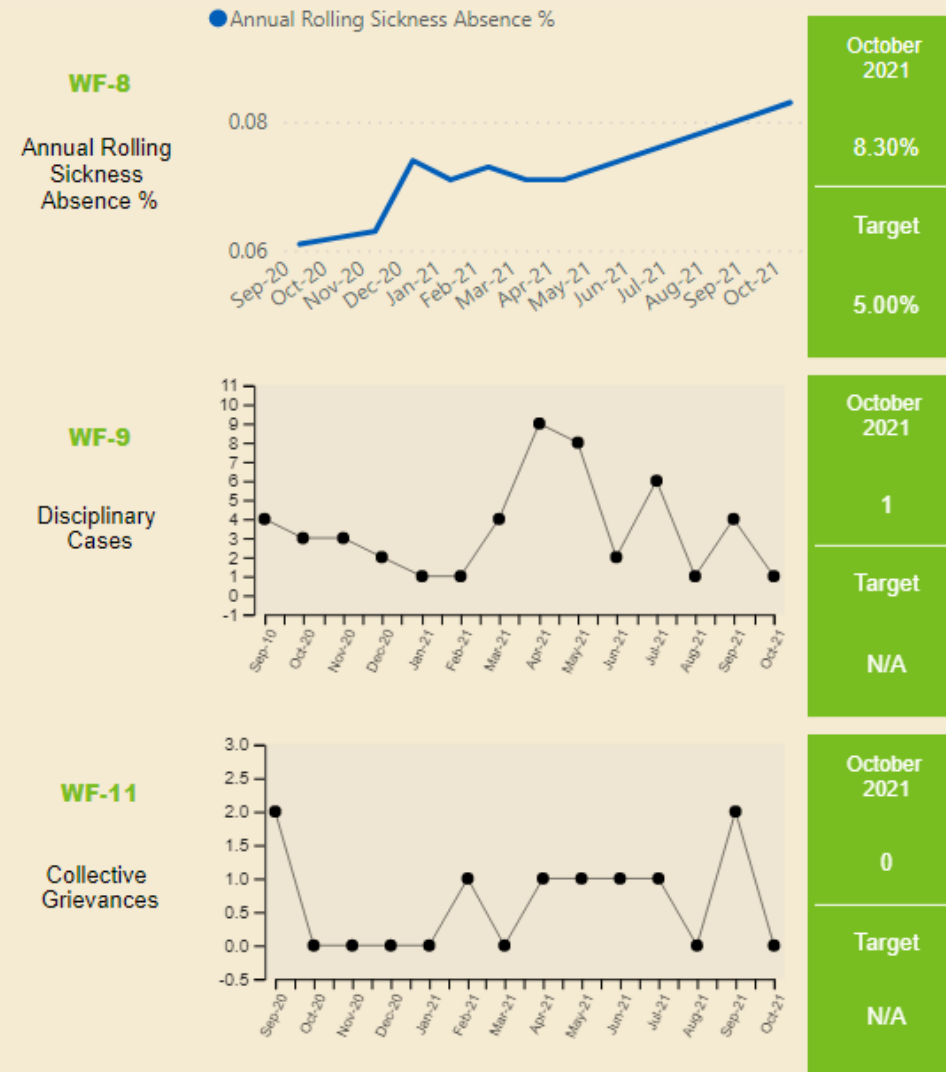
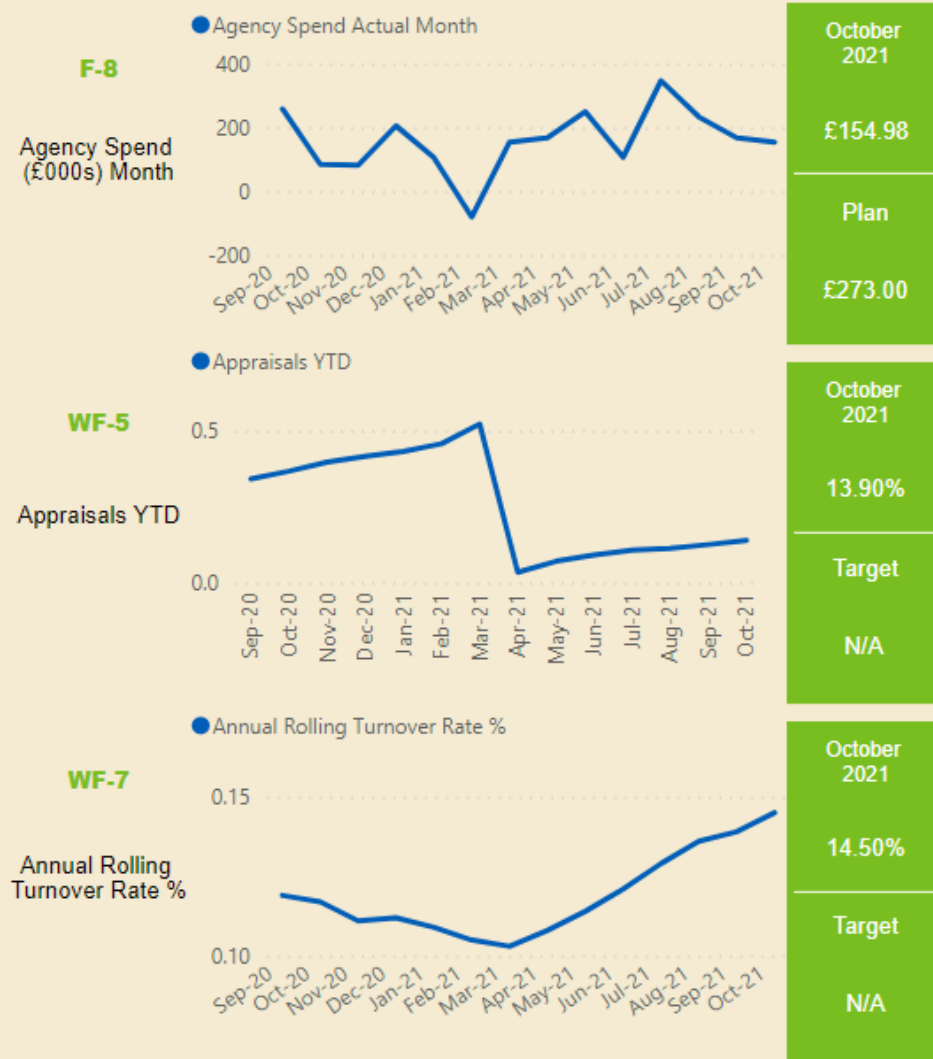
Our leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs. It encourages learning and innovation and that it promotes an open and fair culture



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



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 & Metrics Library

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

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



Appendix 2

Glossary & Metrics Library

RAG	Red – Amber – Green
REAP	Resource Escalatory Plan
RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations
ROSC	Return of spontaneous circulation
SCAS	South Central Ambulance Service
SI	Serious Incident
SIG	Serous Incident Group
STEMI	ST-Elevation Myocardial Infarction
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
TIA	Transient Ischaemic Attack (mini-stroke)
Transports	See AQI A53 + A54
UCL	Upper Control Limit
WTE	Whole Time Equivalent (staff members)
YTD	Year to Date



Appendix 3 Symbols & Chart Keys

Symbol Key

PD	Performance Direction		
	Improving performance	+	Outperformed target
	Deteriorating performance	-	Underperformed target
	No change	=	On target
	Aspirational metric	-	Data not provided

Ambulance Call Categories (Ambulance Response Programme)

Category	
Cat 1	Calls from people with life-threatening illnesses or injuries – such as cardiac arrest
Cat 2	Emergency calls – serious conditions such as stroke or chest pain
Cat 3	Urgent calls – conditions which require treatment and transport to hospital
Cat 4	Less urgent calls – stable cases which require transport to hospital or a clinic

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.



SECAMB Board

Performance Committee

Date of meeting	19 August 2021
Overview of key issues/areas covered at the meeting:	<p>TOR and Cycle of Business</p> <p>Members scrutinised the TOR and cycle of business, for this new Committee which would take place bi-monthly and agreed the TOR needed to indicate some cross referencing to other Committees as some items would naturally overlap. It is envisaged the Performance Committee will become more sophisticated around understanding performance within localities and drilling into granular levels.</p> <p>Performance Management Overview</p> <p>Detailed slides were shared to provide an overview of scrutiny into the different performance components being managed. The Trust remains extremely challenged with the biggest issue continuing to be extractions. Detailed discussion took place around areas to address this, and the outcome of the previous MACA requests, which suggested these needed a clearer understanding of regional conversations and processes should this be revisited again in the future.</p> <p>SMP related to in hour on day escalations and de-escalations according to the number of calls being held, and members were assured of the dynamic actions being taken in response to this. REAP levels were continuing to be reviewed weekly, noting the actions are not as dynamic. The performance plan will be ongoing with different phases looking at different areas.</p> <p>Focus is on demand management, and members discussed the recent surge in calls, which is down to not having enough resources to answer calls, currently 28% are duplicate calls, where people are chasing. Response needs to be within the supply side, with more clinical staff in the control room triaging, although welfare calling and welfare texting is assisting in managing some public expectations.</p> <p>Members were advised of a £4.3m bid submitted by the Trust to obtain extra clinical resourcing in the call centres, and also to release Ops staff from admin back to front line.</p> <p>Members noted the plans to review rotas over the next 12 months, which in turn will align to demand profiles, and address seasonal patterns which are not always flat.</p> <p>Discussion took place around job cycle, wrap up times and CFR utilisation, noting there had been an improvement in job cycle times since January, however this is not mirrored in respect of clearance times at Hospitals which remains challenging.</p> <p>Weekly Review</p> <p>The weekly data review of performance was shared, and an overview given of how this is presented at weekly EMB meetings and with Senior Ops Managers. The data included a wide understanding of how all services are positioned, with trend patterns and breakdown of proportionality against 999, and how this links to current surge levels, workforce, wellbeing and including the totality of CFR contribution. Members welcomed the ability to be able to forecast more around structure and demand over the next 3 – 6 months.</p>

National Ambulance Quality Indicators (AQI) Position

The monthly AQI position was shared, which showed a continued pattern of red across the Ambulance Trusts, and this continues to increase. The Trust remains strong in the C2 category, but other metrics are less strong with call answering significantly deteriorating in the last four months. Trends within SECamb appear mirrored to national trends. Detailed discussion took place around how commissioning is managed regionally, with no dedicated resource per area, and how going forward this is revisited.

Summary

In summary, there had been high quality debate and discussion and the Committee were assured that as much as possible is being done to address performance levels across the Trust. Whilst not expecting a massive surge on demand over the next two months, immediate focus will be on addressing the workforce issues, noting that A/L will decrease and noting various management initiatives to return staff from sickness absence, whilst also noting that COVID sickness had crept up. The levels of absences seen across all areas of the business remain of concern.

Members welcomed the opportunity to scrutinise the performance data at a more localised level at the next meeting, and whether for example it is geographical or workforce related, by each location.

Members were also keen to see the maturity of BI information evolve, and encouraged the Executive to develop this, so that each level of performance can be drilled down from the top, the performance cell will help to propel this.

Whilst Winter Planning had historically been reviewed at FIC, the Performance Committee moving forward would cover all 'Seasonal' planning and this would be captured in the cycle of business.

Any other matters the Committee wishes to escalate to the Board

SECAMB Board

Performance Committee Escalation Report to the Board

Date of meeting	16 November 2021
Overview of key issues/areas covered at the meeting:	<p>Management Governance and Assurance Arrangements Assured</p> <p>The committee reviewed the new performance assurance framework that the executive is putting into place. The aim of the Performance Assurance Meetings is to ensure a more consistent understanding of the key issues among senior management, based on the improvement plan and the look forward trajectory. The committee was particularly supportive of the focus on both glancing backwards for assurance against the plans and looking forward to assure we are preparing ourselves as well as possible to meet future demand.</p> <p>The committee will receive a summary of the trends identified through these assurance meetings, highlighting:</p> <ul style="list-style-type: none">▪ Key areas of progress achieved▪ Key areas where progress has stalled, and why▪ Look forward projections at key risks within a 12-week outlook▪ Escalation as appropriate to the Board <p>The committee acknowledged how this approach will also help to distinguish between management and structural issues.</p> <p>Integrated Planning Assured</p> <p>The executive has responded to recent challenge from the Board about the need for a plan that looks forward, specifically on having a strong and consistent baseline plan as well as scenarios around this baseline for constraints such as finance. The committee received a presentation outlining a proposal for how we implement an integrated planning process starting in 2022/23, with the view to utilising this as a precursor to the 2-5 year strategic planning and operating model design that will then be undertaken as part of supporting Better by Design. Some of the tools required to fully embed this process are being delivered over the next six months, in line with the Performance Cell Business Case the Board recently approved. The committee noted that this process has started and will enable a blueprint for the approach to integrated planning, which will be overlaid with more accurate and sophisticated tools as they become available. The objective of the proposal considered by the committee is to achieve a first draft of the plan before Christmas with the final plan coming to the Trust Board at its meeting in January 2022.</p> <p>Overall, the committee is assured with the progress being made. While this will become more mature over time it is a good set of tools to ensure more informed decision making. It also helps us better understand our cost base. The committee reinforced with the executive the need to ensure that we bring internal and external stakeholders with us.</p> <p>12-week look ahead incl. Christmas Not Assured</p> <p>A helpful paper was received providing a look forward over the next 12 weeks, identifying the key areas of risk to service delivery, using projections and</p>

	<p>assumptions. Firstly, the committee is assured that management is considering the mid-term horizon risks so that it can more effectively mitigate the risks, and therefore reduce the impact on patient safety. The identified risks include a high level of projected absences, including sickness (significant reduction in hours), and a higher than usual activity in January. The mitigating actions include targeted incentivisation of shifts and maximising availability and use of Private Ambulance Providers (PAPs). On the latter, the more recent increase in PAP provision was noted.</p> <p>Although the committee is assured by the process of planning for the different scenarios, it is not assured that the actions will close the forecasted gaps significantly enough, particularly in the provision of hours to meet demand. This is not a criticism of management but a reflection of the very difficult challenges that currently exist. The committee acknowledged the national and local communications aimed at ensuring people only use services when they are really needed.</p> <p>Current Performance Not Assured</p> <p>On 111 CAS, the committee acknowledged the difference between assessing performance against what we are commissioned, and what additional demand is being seen through 'Think 111 First'. As the Board will note from the IPR, performance levels in 111 continue to be challenging.</p> <p>As does performance in 999, although there are small improvements in some areas, including in call answer performance which has been an area of significant concern in recent months. Our position against ARP in comparison to our peers has also improved, but this is more a reflection of how all ambulance services are struggling.</p> <p>Against this background, the committee explored staff welfare, and noted that there is a high percentage (circa 98%) getting meal breaks, but not always within the expected window. Shift overruns are high. Hospital handover delays are increasing in both the East and West. There is much work ongoing with the most challenged hospitals and the committee noted how this requires complex dynamic management.</p> <p>The committee also asked about the triggers for MACA, noting that this comes at a very high cost, and in any event is not a silver bullet, and so other options are more viable currently, such as incentives/over time/PAPs etc. However, assurance was provided that no reasonable option is being completely discounted.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>The committee acknowledges how hard everyone is working in really difficult circumstances. It will continue to support and challenge the executive to do what is reasonably possible to ensure performance levels are maintained through the next period, which will likely be as difficult as recent months, if not more so.</p>

SECamb Board

WWC Escalation Report to the Board

Date of meeting	14 October 2021
Overview of issues/areas covered at the meeting:	<p>This meeting was attended by the Chair and Chief Executive.</p> <p>Executive Escalation</p> <p>At each Board committee, this standing agenda item has been added to provide for the executive to escalate or raise any specific issues the committee ought to be aware of.</p> <p>The director of operations used this opportunity to outline the steps being taken to ensure a more holistic approach to staff training and development. A Task & Finish Group has been set up and the Learning and OD team are reviewing every role in Trust to establish the training needs over a 1–3-year cycle, taking account of abstraction. This will allow us to take a risk-based approach to what can be achieved. The first phase of this work is due to be reviewed by the committee in December.</p> <p>There were then a number of scrutiny items.</p> <p>HR Process Performance Update/IA Actions update Assured</p> <p><u>E-Expenses</u> – This project is coming to a close. The committee noted that despite some concerns from unions related to insurance and financial detriment to individuals, no issues have been flagged. This project has been well implemented.</p> <p><u>P-Files</u> – The committee noted the quarterly audit of 100 random files has been set up, with any issues being reported to the Executive Management Board (EMB). No issues identified to-date.</p> <p><u>Driving Licences</u> – The numbers outstanding within operations fluctuates due to turnover and expiry of licences; at the time there were 243 outstanding. The committee explored the risk and the probability that these would have been checked and just not recorded on GRS. It therefore agreed with the executive that the risk is low. Longer term, however, it would be more efficient to have in place automated checks to mitigate the heavy admin burden. The committee noted that a related business case was being developed.</p> <p><u>Payroll Provider</u> – The new provider is now in place. A pre-retirement seminar and a 1 to 1 consultation day is also planned. The committee was assured to hear about the early positive feedback about the new provider.</p> <p>The committee explored hot spots; where specific areas are being highlighted across a range of indicators, such as sickness, driving license, ER issues etc. The executive</p>

South East Coast Ambulance Service NHS Foundation Trust

explained that we need better analytics, because while there are some clusters, other areas have cluster events, where the issues are different (nuanced) despite the symptoms appearing similar. The deeper analysis will help to identify the action needed to support these areas, e.g. OD /action learning, focussed on teams and functions. The committee acknowledged this is work in progress.

Sickness Management – Action Plan Partial Assurance

The Trust has a target of 5% sickness absence with abstraction from field operations and the contact centres calculated on this basis. The sickness absence management pathway starts with notification of sickness, through welfare and support, to management of absence that exceeds triggers set out in the policy. The rolling twelve-month sickness is significantly above this target, and in-month (August) within operations the target was exceeded by 100%. The main reasons excluding Covid is ‘anxiety/stress/depression’.

The committee supported the challenge set by EMB to bring the current levels at or below the Trust target. A 20-point action plan has been developed to support managers and its aim is to make improvements in the short-term and also bring long-term sustainable improvements in the sickness absence management pathway, while ensuring that staff are provided with the level of welfare and support needed.

The committee will continue to monitor progress against the plan.

Improving Workforce Diversity Partial Assurance

The committee followed up the discussion at the Board meeting in September where there was constructive challenge about whether we are ambitious enough with the targets being set. It noted that the six national actions to improve recruitment, talent management, and retention have been built into the plan, but we have also widened these to cover our three areas of focus, ethnicity, gender, and disability.

One of the challenges from the Board was about having a recruitment strategy, to set out how we are going to make improvements in this area, including interview training. The committee was pleased to see this covered in the six-point plan. However, it noted that one of the main challenges of the plan is to find space to have conversations about race and how we integrate this into our wider learning; exploring with other organisations how best to take this forward productively.

The committee explored some of underlying issues possibly requiring a more targeted response. It supported the need for targets that are achievable but pressed the executive to ensure we get there and as quickly as possible. For example, does every executive director have an objective / target and are they held to account through appraisal? This is something that is being considered.

Appraisal update Not Assured

A really helpful paper was received about the implementation of the ESR appraisal system and the link to pay progression. The committee reviewed the suggested approach and sought assurance on the quality and moderation process for making judgments on ratings linked to pay progression. It also wanted further assurance that we have a robust plan to support the completion of appraisals. The executive confirmed that in the context of the current performance challenges assurance could not be provided that all appraisals will be completed this year.

Employee Relations Partial Assurance

The committee considered the current position where the open caseload of ER cases is currently 54. This is much lower compared to recent months. The majority relate to two EOCs and there is only one case related to performance/capability, which is surprising. It seems to be that these are dealt with more under a disciplinary process, which the executive is picking up to inform how it structures the strategy to this. The committee agreed that this is symptomatic of the broader discussion during the meeting about how we manage our people.

The final section of the meeting was the Forward Look / Horizon Scan.

Draft Clinical Education Strategy

The committee welcomed sight of the early draft of the strategy, noting the overall aim to align to the HEI quality framework. The committee reinforced the need for this strategy to break down silos to ensure clinical education is fully integrated with other directorates / functions in the delivery of services and is responsive to organisational need. It challenged the extent to which this fits within wider education training and development (ETD) of the Trust and the risk of having clinical education standing alone with its own strategy. Other feedback from the committee included being clear on accountabilities, and how this fits in the wider strategy of the Trust, given what this does with clinicians is hugely important to deliver the strategy.

The executive was able to provide some assurance on the wider ETD point that a governance group will bring learning and OD and clinical education together. This is under active discussion between the medical and HR directors to establish a clear oversight framework.

The committee was supportive and acknowledging there is much to do asked the executive how the immediate priorities will be determined. Noting that first priority is to establish the structure of clinical education, as otherwise it can't deliver the support our learners need, the priorities will be agreed in due course by EMB, via the delivery plan. The committee will review the next version of the strategy and the draft delivery plan at its next meeting.

South East Coast Ambulance Service NHS Foundation Trust

<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>The committee is concerned by the concerns coming through Freedom to Speak Up (FTSU) related to workforce / employee relations. Following the Board discussion about this, the committee has asked for some analysis of the issues and some assurance on the extent to which management is working effectively, including any hot spots. This will be picked up at the meeting in December.</p> <p>At the December meeting there will be focus on ETD Abstraction (BAF Risk) and specifically how we plan more effectively for the betterment of the Trust.</p>
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SECamb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 16 September 2021
Overview of key issues/areas covered at the meeting:	<p>Further to the review of the Board and its committees at the Board development session in August, the committee adapted its approach, ensuring a more focussed agenda that provides time for deeper review of the key issues within its purview.</p> <p>The feedback after the meeting was that this evolution in approach is a positive step forward. We will continue to make these adjustments over the next period.</p> <p>One of the changes is to include a committee dashboard, taken from the KPIs within the Integrated Performance Report. A draft version was reviewed and this will now be received at each meeting to enable the committee to ensure it is focussed on the right issues.</p> <p>Another change was the introduction of space for executive escalation, to be used as and when required. At this meeting the committee noted an emerging change in risk profile related to delays in call answer for category 1 calls. The committee is assured that the executive is taking corrective action and it will look at this more closely at the next meeting.</p> <p>The main scrutiny item included the following and the statement of assurance provided below relates to the extent to which the committee is assured by the actions that the executive can reasonably be expected to take. While the committee continues to have significant concern about the impact of delays on quality, safety, and patient (and staff) experience, it recognises the unique challenges currently facing the Trust and the wider healthcare system.</p> <p>EOC /111 Clinical Safety - Partial Assurance</p> <p>This is currently a standing agenda item although with different areas of focus. This meeting focused on how the executive is utilising clinicians in the control room(s) and the implementation of the new NHS Pathways Clinical Consultation Support (PaCCS). This is a clinical decision support solution that provides greater flexibility to support more remote assessments. The committee noted some of the limitations of roll out related to training and mentorship but really welcomes this as a different and potentially more effective way to manage demand and improve quality and patient outcomes. It has asked for a trajectory and will monitor progress.</p> <p>Harm Reviews - Assured</p> <p>This committee is impressed by the efforts being made to ensure we identify when harm occurs as a consequence of our inability to get to patients quickly.</p> <p>At the end of July, the criteria for these reviews changed to include 50% of the C2 double breaches and 10% of all triple breaches for other categories. The burden on the team undertaking these reviews was noted both in terms of time and wellbeing. As mentioned earlier, given the more recent shift in risk profile, the criteria were changed again to focus on C1 call answer delays and 10% of C2 delayed attendances. To give an idea of the scope of this, in the period to 6th August 3,149 incidents have been reviewed. The committee explored some of the outcomes and grades of harm. In the week before the meeting approximately 80 harm reviews were undertaken with one case identified as moderate harm; the others were either low or no harm. Although the trend seems to be showing fewer incidences of harm the committee were mindful of the impact of delays on patient experience and this would be a focus of future meetings.</p>

	<p>Serious Incidents – Partial Assurance</p> <p>The usual report was received summarising the serious incidents reported since the last meeting and the outcomes of the investigations that have been completed. This is extremely helpful in giving the committee a good insight into the issues and learning. The main theme continues to be delays.</p> <p>The committee is assured by the robust and well-established process for SIs but noted that the timeliness of investigation is understandably being impacted by the reallocation of resources in undertaking the harm reviews. The executive is mindful of this and provided good assurance by the mechanisms in place to ensure immediate learning is identified.</p> <p>The committee then spent some time under the new heading of Horizon Scan, to discuss two issues. Firstly, the issue of completing Key Skills which links to one of our BAF risks. The committee accepts that as we are in REAP 4 all training should be paused. However, there are consequences to this and a possibility, or even probability, that we will be in Reap 4 for much of Winter. There was therefore a good discussion about this difficult conundrum and the challenges in balancing the risks. No solutions were found, but the committee did ask that in its considerations, the executive think carefully about when the time might come that continuing to pause key skills outweighs the risk of abstraction.</p> <p>More reassuringly, the committee noted we did just over 50% of key skills last year and said then that the aim this year would be to complete the other 50%. This equates to 2677 sessions and of this number 1000 were completed in April and May.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>The committee received a verbal update on the work being undertaken on Public Access Defibrillators (PAD). This is a complex area that is a national issue. Phase 1 (review of Trust owned sites) is in final stages, and this is to ensure each PAD is functional. A paper will come to the committee in November which will include how the executive intends to take forward phase 2, which is about the other circa 3,500 sites that are privately owned.</p>

SECamb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 18 November 2021
Overview of key issues/areas covered at the meeting:	<p>In review of the committee dashboard, which is taken from the KPIs within the Integrated Performance Report, concern was raised about compliance with duty of candour and hand hygiene. The committee has asked for separate papers on the corrective action being taken which will come to the next meeting in January.</p> <p>Under executive escalation, an update was provided on the recent issue with the CAD that led to the Critical Incident. It is too early to identify if there was any harm as a result, and this will be a consideration as part of the well-established harm review process. The incident met the criteria for an SI and the committee will receive the outcome of this in due course.</p> <p>The committee also received an update on the flu and COVID Booster vaccination programmes. Acknowledging some of the reasons, such as locations of the vaccination centres, it was surprised and concerned to learn that take up is not higher – 31.2% Flu and 50.9% Booster.</p> <p>There were four Management Responses:</p> <p>Impact of Clinical Audit Actions Partial Assurance It was reassuring to hear that the 2021/22 plan is now back on track and that there are just 48 open actions on the tracker, which is a significant improvement from earlier in the year.</p> <p>The Committee had previously asked for a report on the impact of clinical audit actions on patient outcomes. It noted that being able to report against this is challenging as the team do not always have patient outcome data available for analysis. However, a comparison of the 2020/21 clinical audits with previous audit findings has enabled the identification of any notable changes with compliance. The assumption is that the higher the compliance, the more likely that patients will have a better outcome. Of the seven audits, four were RAG-rated Green showing improvement. Three were Amber, which shows some compliance levels have worsened or shown minimal improvement, suggesting not all audit actions have had a successful positive impact.</p> <p>The committee clarified that all actions have owners and timeframes, with clear governance in place to track progress. Overall, it had better assurance with the <i>impact</i> of clinical audits.</p> <p>Birthing Centre Transfers Assured This arose from previous concern about C1 calls from birthing units not actually requiring a C1 response. The executive has since taken positive action to ensure a more appropriate use of our services, which has seen a significant reduction in C1 calls.</p> <p>Public Access Defibs (PAD) Assured The committee received assurance that Phase 1 of the project is complete which has ensured all Trust-owned PAD sites are now rescue ready. Further assurance was received confirming there have been no incidents related to PADs not working when needed. The committee noted the process in place to maintain our PAD sites, and the decision that will be needed longer term, e.g. replacement programme. For those PADs owned by others, some progress is being made on the British Heart Foundation Circuit.</p>

Key Skills Assured

As reported to the Board in September, the committee noted that we completed just over 50% of key skills in 2020/21 and said then that the aim this year would be to complete the other 50%. This equates to 2677 sessions and of this number 1000 were completed in April and May. The committee supported the decision of the executive in taking a risk-based approach to the delivery of key skills for the remainder of this year, noting that the assessment of risk confirmed there have been no patient safety incidents directly related to the omission of training. The plan agreed is to provide a single day for the 881 staff that has not received key skills training in the past 18 months; if possible, it will then be opened up to more. This will start from 15 November. In addition, statutory and mandatory training will continue for everyone; Practice Placement Education training will continue for all appropriate staff in order to ensure sufficient mentoring capacity for staff in training; Safeguarding level 3 training will only be delivered for individuals as identified/required; and management training will go ahead for non-operational/corporate staff.

The main scrutiny items were as follows:

EOC Patient Safety – Mental Health Partial Assurance

A verbal update was provided relating to the provision of clinical support for patients with potential overdose or suicidal. A national directive was provided to update Cleric and this was delayed by about three months. The paper that will follow will set out the reasons and impact. In the meantime, the committee is assured that this has now been done and is effectively the automated solution that upgrades potential suicidal patients from a category 3 to a category 2.

111 Electronic Prescribing Assured

A verbal update was provided following on from the meeting in May when the committee reviewed the roll out plan for the electronic prescribing service (EPS) in the 111 clinical assessment service (CAS). Assurance was received that there have been no adverse incidents from prescribing. Currently only GPs use the EPS, but most CAS have non-medical prescribers (NMP). The next phase therefore is to develop a NMP policy and the aim to start this shortly. This will be the last element before we become a fully functioning CAS.

The committee was assured by the way EPS has been implemented and is supportive of the next phase for NMP. It reinforced the scope of practice requirements to ensure NMP is always within scope. Positive assurance was also received by confirmation that no clinician working in the CAS does so without a clinical decision tool.

Harm Reviews – Embedding the Learning Assured

Firstly, in light of the harm review report from AACE that has been recently published, the committee reflected on the oversight it has had for a number of years now on harm reviews, including those related to hospital handover delays.

This meeting's focus was on how we embed the learning from this now well-established process. A really informative paper was considered providing analysis relating to the operating units / areas most impacted, the criteria used for the reviews and the initial levels of harm being identified. The paper also provided intelligence relating to the wider impact on patient and staff experience and gave examples of how findings have been utilised to inform broader conversations across the Trust to aid decision-making.

The committee agreed that the findings from the harm reviews have been invaluable and provided enormous intelligence. They have aided conversations amongst senior management and influenced decisions, such as the Trust's REAP level and they have led to actions to manage the safety of the clinical queues in the EOC.

The committee noted that from the thousands of harm reviews completed very few

	<p>identify harm, but much more adversely impact patient experience, which is also very important.</p> <p>The Accountable Officer for Controlled Drugs Annual Report was received. Unfortunately, the medical director, who is the accountable officer, was unable to attend the meeting and so will speak to this report at the Board meeting on 25 November. While the committee accepted the broad assurance provided by the report, it noted the need for continual improvement and also more consistent compliance with processes.</p> <p>The meeting concluded with two items under the forward look section. Firstly, the committee discussed the soon to be published new Working Safely Guidance. Few changes are expected and the executive plan to use this as an opportunity to reinforce the measures we need to continue to take.</p> <p>There was also a discussion about Respirator Hoods – Fit Testing in the context of national guidance that is expected to require all providers to have a secondary option for RPE. It is unclear whether this will be extended to ambulance providers, but if so, there will be implications for fit testing and the investment the Board made in 2020 for powered hoods, on the basis that fit testing would not be needed.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>Two assurance papers were not received as scheduled, although helpful verbal updates were provided. The papers will follow in January. Otherwise, the papers received were of good quality that aided effective and succinct discussion.</p>

SECAMB Board

Finance and Investment Committee (FIC) Escalation report to the Board

Date of meeting	9 September 2021
Overview of key issues/areas covered at the meeting:	<p>This was the first meeting since the new Performance Committee was established, which has enabled greater focus on financial performance and longer-term financial planning.</p> <p>ICS Financial Position</p> <p>To put the Trust’s position into context, the committee began the meeting looking at the ICS financial position, which is currently forecast to be breakeven. There is increasing focus on the outturns at ICS-level rather than by organisation. This is something the Board will need to consider over the coming months as it raises interesting issues.</p> <p>The committee explored the variance between the organisations and the potential consequences of the Trust planning a not insignificant deficit, largely due to a shortfall of the block contract that was introduced as a consequence of the pandemic. The expectation is that this gap will be closed with non-recurrent funding, like last year, but this is by no means certain. Constructive conversations with commissioners are ongoing about this and how we deal with the shortfall from 2022-23.</p> <p>In the meantime, the committee reinforced the need for the executive to ensure we continue to drive all the internal efficiencies.</p> <p>Financial Performance – Partial Assurance</p> <p>The committee is assured that we are managing our money well and are on track to meet our planned targets. However, this means a circa £10m deficit (caveat is the expectation this will be closed by commissioners as stated above) and in the context of the uncertainty for the second half of the year. At the time of the meeting there was still no confirmation from commissioners / NHSE about this.</p> <p>The funding gap in 111 CAS was explored and while discussions at that time were positive there was potential for us running a commercially let contract at financial risk. The committee asked that there is update on this at the Board meeting. This will be in Part 2 due to the commercial sensitivities.</p> <p>Finally on current performance, the committee noted the gap in our cost improvement programme. While the executive reassured the committee that there are a number of initiatives to improve efficiencies, this is a concern and something that will be monitored closely.</p> <p>Financial Planning – Not Assured</p> <p>The statement about not being assured is not a reflection on the executive management team, but rather to reflect the uncertainty that remains from the centre about funding for the second half of the year and beyond. The consequence is that we are not able to effectively plan for the long term, which is one of our BAF risks.</p>

	<p>Digital Strategy</p> <p>A first draft of the strategy was considered. There are three aspects to this, IT; Clinical Information; and Performance Information. The committee supported the approach reinforcing that this is about how we use modern technology to improve patient care / experience.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>The committee also received a helpful report on commissioned contracts and is assured that we have effective contract management in place. There was also a report for information on estates disposals and acquisitions and the committee will receive this bi-annually.</p>

SECAMB Board

Finance and Investment Committee (FIC) Escalation report to the Board

Date of meeting	11 November 2021
Overview of key issues/areas covered at the meeting:	<p>Financial Performance – Partial Assurance</p> <p>The committee reviewed the month 6 position where the planned £1.1m surplus in month and £5m deficit for the first 6 months was met.</p> <p>There was also positive news about the commissioners providing the funding for 111 to reflect the current in-year demand, driven mainly by ‘111 First’. The committee is assured this will meet all the costs currently being incurred to ensure a breakeven position. There is however some uncertainty about the longer-term position from 2022/23.</p> <p>Despite the funding gap between the original bid and current demand having been closed, the committee noted that activity continues to increase with this predicted to continue. The challenge is being able to accurately forecast this demand and how it will be profiled. There are ongoing discussions with commissioners and NHS England about the impact of this on funding, which links into the national direction for the promotion of 111. The committee suggests there is some time planned in the New Year for a Board discussion about the strategic positioning of the 111 CAS service.</p> <p>The ‘Flowers’ settlement (legal case affecting all ambulance services) has been funded but there is an ongoing £2.6m p.a. cost pressure for this as there will be no ongoing funding. We are challenging this decision as a sector.</p> <p>The cost improvement plan (CIP) is significantly below target at month 6. The executive outlined a plan to take a new approach to cost improvement, to shift the overall culture from 2022 /23. In the meantime, the risk of this shortfall to the final position is not considered to be significant with some of the gap offset by Underspends in other areas (that would in previous years have been badged as CIPs).</p> <p>The main risk to the underlying financial position is the uncertainty about non-recurrent funding sources.</p> <p>The committee explored the allocation of resources related to staff welfare, especially in the context of the ongoing pressures. Some areas are not easy to directly quantify, such as the additional hours provided to help mitigate long shift overruns and meal breaks etc. Assurance was received that there are no funding constraints, despite the deficit position. The committee encouraged the executive to review how we communicate some of what we are doing to raise awareness.</p> <p>Year to date there is an underspend on Private Ambulance Providers (PAPs) which the committee challenged. It noted that PAPs are experiencing the same issues as we are in terms of delivering hours. That said, in month the provision has significantly increased, and the committee reinforced the need to look strategically at how we use PAPs given the assumptions we will be applying in our operating model going forward. It will schedule some time on this in early 2022.</p>

Financial Planning 2021/22 – Partial Assurance

The Board is aware of the unique position this year due to the pandemic where nationally funding for services was only confirmed for the first 6 months. The uncertainty this creates is one of our BAF risks. The committee reviewed the revised plan for the second half of 2021/22 (also on the Board agenda), which needs to be submitted on 25 November, and the headlines are as follows:

- In May 2021 we submitted a £5.0m deficit plan for H1 with an indicative full-year deficit of £10.6m
- Current high-level planning for H2 indicates a deficit of £9.6m for the full year
- The ICS will be required to break even and it is not yet known what the expectation will be from individual trusts
- The intelligence is that other trusts are also projecting deficits; the host CCG will have reserves that can be allocated to individual trusts as full or partial offset
- If initial submissions indicate an overall system deficit, there will be discussions at CEO/CFO level to consider how the gap can be closed

The committee explored the difference between the hours we are paying for and the hours we are actually able to provide to meet demand. The gap being abstraction, which must be reduced. Our inherent assumptions about the short to medium term indicates much risk and this is why the review of our operating model is so crucial, to ensure we are more resilient.

Update on Capital Programme Plan Partial Assurance

The slippage to the plan, including with the Medway development was noted. The committee expressed concern about the risk of this in relation to the central 'wave 4' funding, as the final £9.4m is due this year and therefore some might be lost. The committee will continue to monitor this and at its next meeting has asked for an assurance paper on the steps being taken to deliver the plan on time.

Additional Winter Monies – Update on spend/delivery Partial Assurance

Additional funding has been agreed centrally for all English ambulance services and allocated proportionally to the Trust according to current budget value in relation to other Trusts. The intention for this money is to build capacity and tangibly improve performance during Q3 and Q4 2021/22. The total value for the additional monies for SECAMB is £4.3m. The committee reviewed the five programmes as per the original plan:

1. Additional EMA recruitment	On plan and trajectory for call answer is improving.
2. Additional EOC Clinician recruitment	Issues with attracting clinicians that has led to a review of the plan
3. Increased use of PAPs	Increased provision at month 6, but risks given the issues PAPs are also facing.
4. Increased use of HALOs to support hospital handover times, particularly at the	On track

	<p>most challenged hospitals</p>	
	<p>5. Implementation of the use of taxis to convey appropriate patients</p>	<p>Plan in development.</p>
<p>Any other matters the Committee wishes to escalate to the Board</p>	<p>NHS Greener Update A verbal update was provided on our compliance with the NHS Greener Plan. The committee supported the approach being taken by the executive to ensure this becomes a greater priority. For example, there is a plan to provide some Board training and awareness and a Green Impact Assessment is being introduced in the same way quality and equality impact assessments inform decisions. A gap analysis will come to the Board in January 2022.</p> <p>The committee received an update on the Medway Travel Plan, given some concerns about the parking there. The executive set out the steps being taken to establish the extent to which parking will be a significant issue and some of the possible solutions. This discussion reinforced the need for a Trust wide sustainable travel plan, which is being picked up under NHS Greener.</p> <p>There was also a good update that provided assurance on how we are managing our Commissioning Contracts and a separate paper for information on the new National Ambulance Vehicle Conversion Framework.</p> <p>Finally, there was a detailed review of the current Fleet Activity and the ongoing work towards department KPIs. The updated Fleet management system has vastly reduced paperwork generated by the vehicle maintenance technicians; they are all now able to update maintenance records as they carry out their work via touchscreen tablets or PCs. This provides for more timely information to support more efficient processes.</p> <p>Looking ahead, and linked to NHS Greener, one of the key objectives will be how we introduce more environmentally friendly vehicles onto the Fleet such as Electric Vehicles, Hybrids and vehicles that run on Hydrogen. We are on a waiting list to trial the new electric Fiat Ducato and in the process of trialling an electric Mercedes Sprinter van.</p> <p>The committee took much assurance from all of this activity and challenged the executive to have greater clarity on the total cost of (fleet) ownership. More work is needed on this to help inform the unit cost of running fleet dept.</p>	

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Finance and Investment Committee

The aim of the observation is for Governors to see and understand the assurance NEDs seek in action. The Trust is keen for NEDs to undertake their business as they would if Governors were or were not at the meeting.

Part A should be used for general observations about the functioning of the Committee. Please keep your observations brief and do not detail any confidential information leading to redaction.

If Governors have any individual concerns on NEDs performance or style, they can speak to the Chair directly ([David Astley](#)) or the Senior Independent Advisor and Deputy Chair ([Michael Whitehouse](#)).

Date of meeting: 11 November 2021

Governors present: Harvey Nash

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

1. Prior to the meeting: Received papers and confirmation expected to observe (with another Governor). No pre-briefing. On day could not find link to join meeting and took 45 minutes to get access so missed initial items.

2. Introductions: Missed the agenda session but was welcomed by Chair (HG) at the earliest break in discussions when I did join. I knew all attendees from previous observations etc.

3. Attendance:

NEDs

Howard Goodbourn – Chair

Michael Whitehouse

Paul Brocklehurst

Execs

David Hammond

David Ruiz-Celada

Peter Lee

Plus: Philip Astell (Asst Dir F) and Justine Buckingham (notes)

4. Agenda:

Standard items with Scrutiny across Financial Performance and Planning, Capital Program, Contracts and Medway Travel and Parking plus monitoring of Fleet including Vehicle conversion and NHS Greener.

5. Discussion during meeting:

Discussions were full and informed with all NEDs involved and asking appropriate questions and seeking assurances. Items included separation of 111 and 999 costs, use and recent changes to PAPs, use of resources, vacancy actions in light of no 'full-year' plan as such, ICS set-up progress, communicating risks to public without alarming them, becoming more data-savvy (strong NED support for DRC's work in this area) and the impact of electric vehicles on make-ready (e.g. current 45 mins target turn-round).

6. Chair:

Sound control of meeting and discussions, ensured agenda covered, all had full chance to input and that topics amply discussed. Meeting was agreed as effective.

7. De-brief:

None. Second Governor did not join meeting so no off-line discussion.

8. Conclusion:

Some topics inevitably somewhat dry and specialised, but demonstrated awareness and acumen from NEDs (and often from Execs in response) provided a good level of assurance. Issues are around current unknowns – notably impact of pandemic focus on longer term resilience and of ICSs on funding and priorities.

SECAMB Board

Summary Report on the Audit & Risk Committee

Date of meeting	23 September 2021
Overview of issues/areas covered at the meeting:	
Internal Audit	<p>Three reviews were considered.</p> <p>Freedom to Speak Up – Partial Assurance Firstly, the committee acknowledged that a number of issues raised through FTSU probably should be dealt with via the usual line management process. This links to the ongoing discussion about the need for management training and development. There was then a detailed discussion about the benchmarking data that shows we have a higher number of complaints especially related to behaviours such as bullying and harassment. The committee asked the executive to ensure the root causes of this are established so that we can take corrective action.</p> <p>The committee also explored the risk that with so many ‘management’ issues taken through FTSU we might miss significant patient safety concerns, given that patient safety was the driver for FTSU. The conclusion was that this was likely to be a small risk and mitigated by the robust incident management processes. Nonetheless, work is needed to ensure FTSU is always used appropriately.</p> <p>The committee asked that, through the Chief Executive, a single member of the executive team takes ownership of implementing the recommendations. Currently, different directors have tasks assigned to them so we have the risk that while the sum of the parts will be implemented it might not secure the overall improvement needed.</p> <p>111 Performance & Data Quality – Reasonable Assurance The committee was assured by the outcome of this review, noting that no specific actions were recommended as the issues identified are being picked up by the existing 111 optimisation plan.</p> <p>Incidents Management – Reasonable Assurance There was also good assurance from this review, especially that our processes continued to be robust through the pandemic.</p>
Counter Fraud Assured	The committee received very good reports on progress against the annual plan, and fraud risk assessment. The committee is assured that we have a really good counter fraud culture with strong controls.
Information Governance Assured	<p>A very good annual report was received setting out the controls we have in place to manage information in a way that is safe and compliant with the law, while ensuring the sharing of information to support good patient care.</p> <p>The committee has asked for a session in the coming months to explore whether the opportunities to use information in a way that really supports the delivery of our strategy.</p>

<p>Business Continuity Partial Assurance</p>	<p>It is clear that there are good business continuity plans in place and with the way we have learnt to work (remotely) during the pandemic this has had the effect of mitigating some of the risks from a business continuity incident. However, the executive reported that due to recent pressures not all the plans have been tested as would usually be the case. In addition, the EPRR self-assessment that is currently being completed identifies areas of partial compliance. Management is clear about the improvements needed and the completed annual EPRR assessment will come to the Board in November.</p> <p>The committee noted our involvement in the inquiry into the bombings in Manchester and the likely recommendations arising from this relating to all ambulance services. It also noted the upcoming national COVID inquiry and asked for assurance in December that we are well prepared for this.</p> <p>It also suggested some time is given at a Board development session, to ensure the Board is up to date with its responsibilities related to business continuity and emergency planning etc.</p>
<p>Environmental Sustainability Partial Assurance</p>	<p>There was a good discussion about this and the committee noted the work being undertaken by the executive including in developing a Green Plan. There was an acknowledgement that this needed to be higher on the Board’s agenda over the coming months.</p>
<p>Other matters</p>	<p>The committee received a helpful report on Estates Valuations and good assurance on the effectiveness of our policy on declaration of interests, gifts and hospitality.</p> <p>The usual review of the BAF risks was undertaken and the committee is assured these reflect the key risks too achieving the strategic objectives, and that there is good focus on their management at Board and committee level.</p>

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the Audit Committee

Date of meeting: 23 September 2021 – virtual format

Governors present: Harvey Nash, David Escudier

The following report is from the Governors, noting their observations.

1. Prior to the meeting: Received link in good time, had to request pre-briefing and meeting papers. Good pre-brief with Michael Whitehouse (MW) the AC Chair and agreed brief post-meeting discussion. MW outlined three aspects he was particularly keen to ensure were covered – FTSU, Better by Design and Medicines Management

2. Introductions: Straight into business, given size of agenda – knew all the regular attenders. Governor role mentioned when MW asked for input on FTSU and Management Development.

3. Attendance: NEDs: Michael Whitehouse, David Astley, Tom Quinn and Laurie McMahon present and Howard Goodbourn had sent comments and questions with his apologies. Board: David Hammond (for CEO), Peter Lee and Emma Williams with apologies from Philip Astle and Bethan. Inputs from two members of the Internal Audit team.

4. Agenda: received just as meeting commenced, wide-ranging and covered previous minutes, actions, updates, plans etc and linked with papers available during the meeting

5. Discussion during meeting: constructive questions and inputs from all attendees. NEDs sought clarity and reassurance on a broad range of issues and risks, with discussions spanning staff morale and investment, management training, resourcing operations while balancing short and longer term aspects, culture, communications, business learning, links with other services, ICS challenges and many more. Good reassurance on links and plans for Winter and agreement on a Board session on this.

6. Chair: Focussed, involving approach ensuring all had multiple opportunities to speak and respond. MW gave succinct summaries of agreed actions with a good regard for timely progress and clarity. Effective chairing ensuring the agenda was covered and items needing discussion afforded time.

7. De-brief: Chair asked for immediate feedback and any issues. We had a short positive discussion and ideas / thoughts offered were welcomed.

8. Conclusion: Very good well-run meeting with good contributions from all attending and very clear questioning, action orientation and challenges from NEDs.