South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors Meeting to be held in public

2 September 2022 10:00-13:00 held in person

Lingfield Park, Racecourse Road, Lingfield, Surrey, RH7 6PQ
Lingfield Park Resort

Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
101/22	10:00	Chair's Introduction	-	-	David Astley (Chair)
102/22	-	Apologies for Absence	-	-	DA
103/22	-	Declarations of Interest	-	-	DA
104/22	-	Minutes from the previous meeting, action log and matters arising	Y	-	DA
Statutory duties: performance and holding to account					
105/22	10:10	Chair and Chief Executive's report	Y	To receive an update from the CEO	David Astley (Chair) Siobhan Melia (Interim CEO)
Statutory duties: member and public engagement					
106/22	10:30	Membership Development Committee Report	Y	Information	Brian Chester
Committees and reports					
107/22	10:35	Nomination Committee Report	Y	Information	DA
108/22	10:40	Governor Development Committee Report	Y	Information	Kirsty Booth
109/22	10:45	Governor Activities and Queries Report	Y	Information	Leigh Westwood
Statutory duties: performance and holding to account					
110/22	10:50	Assurance from the Non-Executive Directors: - Integrated Quality Report	**Y – to follow**	Overview of the new methods and report presentation	David RC

111/22	11:20	Board Assurance Committees' escalation reports to include the key achievements, risks and challenges: Performance Committee - 23 July 2022 Workforce and Wellbeing Committee Quality and Patient Safety - 21 July 2022 Finance and Investment Committee - 30 May 2022 Audit Committee - 14 July 2022		Holding to account, assurance and discussion	All Non-Executive Directors present
11:35	**Comfort Break**				
112/22	11:45	Improvement Journey	**Y**	Update	Siobhan Melia / David RC
113/22	12:15	Board Committee scrutiny: Performance Committee			Howard Goodbourn
114/22	12:30	Update on National ambulance specification		Information and discussion	David RC
General					
115/22	12:40	Any Other Business (AOB)	**-**	-	DA
116/22	12:45	Questions from the public	**-**	Accountability	DA
117/22	-	Areas to highlight to Non-Executive Directors	**-**	Assurance	DA
118/22	-	Review of meeting effectiveness	**-**	-	DA
		Date of Next Meeting: **Joint meeting – 3 November 2022** **Formal CoG - 5 December 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 gives consent 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 the meeting run smoothly. *This is a strict rule and anyone not following this will be removed from the meeting.*

**this meeting is followed by the Annual Members Meeting & Exhibition 1315-1630hrs*

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

Meeting held in public – 6 June 2022

Present:

David Astley	(DA)	Chair
Michael Tebbutt	(MT)	Public Governor, Upper East
Leigh Westwood	(LW)	Public Governor, Lower East
Chris Burton	(CB)	Staff Governor (operational)
Vanessa Wood	(VW)	Appointed Governor – Age UK
Martin Brand	(MB)	Public Governor, Upper West
Andrew Latham	(AL)	Public Governor, Lower West
Linda Caine	(LC)	Public Governor, Upper East
Nicholas Harrison	(NH)	Staff Governor (operational)
Nigel Robinson	(NR)	Public Governor, Lower West
Colin Hall	(CH)	
Patricia Delaney	(PD)	Public Governor, Lower East
David Romaine	(DR)	Public Governor, Lower East
Stuart Dane	(SD)	Staff Governor (operational)
Howard Pescott	(HP)	Appointed Governor – Sussex Community Trust
Ann Osler	(AO)	Appointed Governor – Upper West

In attendance:

Fiona Moore	(FM)	Interim CEO
Subo Shanmuganathan	(SS)	NED
Liz Sharp	(LS)	NED
Paul Brocklehurst	(PB)	NED

Apologies:

Howard Goodbourn	(HG)	NED and Chair of Finance and Investment Committee, Chair of Operational Performance Committee
Peter Lee	(PL)	Company Secretary
Kirsty Booth	(KB)	Staff Governor (non-operational)
Tom Quinn	(TQ)	
Amanda Cool	(AC)	
Michael Whitehouse	(MW)	
Brian Chester	(BC)	Public Governor, Upper West

Absent:

Matt Alsbury-Morris	(MM)	Public Governor – Lower West
ACC Lisa Bell	(LB)	Appointed Governor – Police Services

Minute taker: Julie Harris – Assistant Company Secretary

Item No.	Introduction and matters arising
80/22	**Introduction**

	DA welcomed all and announced our new Lead/Deputy Lead Governors.
81/22	**Apologies for Absence** As above
82/22	**Declarations of Interest** No declared interests
83/22	**Minutes from the previous meeting, action log and matters arising** The minutes were taken as an accurate record of the meeting. The action log was reviewed and updated.
	Statutory duties: performance and holding to account
84/22	**Chief Executive's report** Report to be taken as read. DA provided a summary of the Chief Executive's Report including Covid performance, the staff survey and the CQC report. DA further noted a shift towards in-person meetings, providing a better communications environment. DA thanked the previous CEO for his role in keeping our staff safe through covid – the most challenging time in the history of the NHS. FM shared the Chair's comments on the previous CEO and noted that the CQC report should be expected the week of 13 June. FM added her thoughts on the outcomes of the staff survey and preliminary CQC report, noting that in some areas the golden thread of quality was missing. FM explained that the IPR is being refreshed to ensure that data is more efficiently managed. FM was proud to be involved in Jubilee Medal/Covid coin presentations, noting her displeasure that the EOC staff weren't eligible for the Jubilee medal. DA noted that one of the things that we need to tackle in the organisation is inappropriate leadership styles, bullying, sexualised behaviours, etc. MB questioned the medal eligibility and associated flaws. LC confirmed that the staff do not feel they are being heard and is looking forward to how the leadership will be engaging with them in the future. NH questioned the lack of engagement throughout the organisation (especially in terms of new initiatives). FM confirmed there is a framework to work on along with a feedback mechanism (QR code). NH further questioned how staff is becoming aware of this. DA confirmed that we do not currently develop and coach our leadership to be equipped in communicating with staff and this forms part of our priorities. NR confirmed that this is a fine opportunity for ensuring that staff are being heard, representation from all levels of the trust in order to place the building blocks for the future – we must be transparent in this engagement – staff need to feel like they are part of the solution, satisfying the needs of the staff.

	HP questioned the use of freedom to speak up. SS confirmed that they are looking at guardians/resourcing as the current guardian is quite overwhelmed and that staff feel that the routes through their leadership/management is not effective. AL questioned whether we have a clear internal communications plan surrounding the potential contentiousness of the CQC report. FM confirmed that the CQC was not comprehensive and therefore the rating is unlikely to be changed, but that the well-led review is unlikely to be positive and the communications will be around that. MB questioned the potential of using external facilitation.
	Statutory duties: member and public engagement
85/22	**Membership Recruitment and Engagement Report** Report to be taken as read. JH noted that the next MDC meeting is on 20 June 2022 and will focus on plans for the Trust's Annual Membership Meeting and opportunities to take part in member recruitment and engagement at public events.
	Committees and reports
86/22	**Nomination Committee Report** Report was taken as read.
87/22	**Governor Development Committee Report** Report was taken as read.
88/22	**Governor Activities and Queries Report** Report was taken as read.
	Statutory duties: performance and holding to account
89/22	**Assurance from the Non-Executive Directors:** **- Integrated Performance Report (Nov/Dec data as presented to Board in May)** Report was taken as read. FM confirmed that we are in the process of refreshing the way the data is being used and reported. MB questioned the lack of trend graphs (especially in terms of the 111s). FM noted the financial deficit as the current funding does not match the demand and it is projected that demand will increase 20 percent within the next year, but we do not have assurance of funding. FM confirmed that the demand may be due to GPs not being able to service their own demand and are referring the 111. DA noted that our record in comparison with other ambulance services is very good – our performance is better. FM also noted the lack of services (such as mental health) lends to an increase in 111/999 demand. NR questioned how we can bridge the gap (ICS) in terms of finance deficits. FM confirmed that there has been additional funding available for all ambulance services (inflation) but that is still a work in progress. DA confirmed that our working relationship with our ICS is very good and the challenge a wider issue (meeting demand).

	NH questioned the funding breakdown. FM HP questioned how strong a voice does SECAmb have on system calls and challenged that SECAmb does not. FM confirmed that it would depend on the level of the system call, that operationally we have a very strong voice, but that in the higher leadership system calls our voice is still evolving. DA confirmed that how we equip our staff to contribute to those calls is imperative to ensure a louder voice. CB noted that there are patients that fall through the net (primary care, mental health) have helped us improve end-of-life care, GP/surgery relationships, and is looking for auditable evidence of jobs that could defer funding that would improve our service. MB questioned the availability of mental health nurses in EOC. FM confirmed that the EOC and 111s do have mental health nurses but there aren't enough of them to provide a 24/7 service.
90/22	**Board Assurance Committees' escalation reports to include the key achievements, risks and challenges:** **Performance Committee** **- 21 April 2022** **- Governor observation report** Report was taken as read. GB sent a message advising that comprehensive answers to the questions asked during the Governor's pre-meeting will be provided shortly via email. **Workforce and Wellbeing Committee** **- 17 February 2022** **- 25 February 2022 (extra-ordinary)** **- 12 May 2022** **- Governor observation report** Report was taken as read. SD and LC (observing Governors) noted that the meeting was well structured and well organised. **Quality and Patient Safety** **- 17 March 2022** **- 19 May 2022** Report was taken as read. **Finance and Investment Committee** **- 22 March 2022** Report was taken as read. **Audit Committee** **- 10 March 2022**

	Report was taken as read. JH summarised the questions provided from the Governor's pre-meeting. **Appraisals (SS confirmed that these questions will be address in the deep-dive presentation on Workforce and Wellbeing Committee)** 1. The Council consider that the Trust's target of 80% appraisal to be completed by March 2023 is unacceptable and the aspiration should be increased to 100%. Appraisals are a fundamental building block of good people management. It is however accepted that due to a limited number of special circumstances, for example long term sickness, this may not be completely achievable. The Council seek assurance that this target will be reviewed and delivered by the end of March 2023. 2. The Council seeks assurance that the Trust has sufficient plans and resources to train and develop existing and recently promoted managers to enable them to be effective in their role and deliver excellence in leadership and management of their teams in the expectation that this will assist in improving staff morale and reducing leavers genuinely making SECAmb "the best place to work". **Culture (SS confirmed that these questions will be address in the deep-dive presentation on Workforce and Wellbeing Committee)** 3. Can we be assured that the culture change program that has been in effect in our contact centres is appropriate and effective. 4. Given the results of the staff survey have we considered a root cause analysis of the breakdown within the employee/management/leadership relationship, is this possible without involving staff feedback to somebody external to the hierarchy? 5. Can we be assured that exit interviews are being done, and that someone is reviewing the results? Are there any thematic reasons for employee departures? **Finance (JH confirmed that comprehensive answers to these questions will be provided via email)** 6. Is there an end-date for the decision from the Commissioners surrounding the resolution of financial deficit? Email response from HG - I am not aware of a formal end date but I believe 20 June is the date for revised submissions of 22/23 plans so this is the next key milestone. 7. There is a mention of a draft engagement plan presented to the Board in April, did this occur and is more information forthcoming? Email response from HG - Yes, this was discussed and is a subject that the NED's have jointly and constantly sought assurance on - particularly with regard to the improvement plans. There is methodology that will be introduced by Ali to ensure full employee engagement. 8. In terms of the 5-year replacement cycle for vehicles, do we have funding in place and what is this funding based on? Email response from DRC/HG - There is no formal funding in place to allow this 5 year replacement cycle to happen. It is thus rather a statement of intent. There is sufficient funding for the first year allowed for in our plan for 22/23 (which also includes a rollover from 21/22) particularly now that there is additional funding coming from NHS.

The five-year plan was submitted, however, only ratified from a finance point of view for one year. Is it worth mentioning the NHSE/I financial support that has been offered on a one for one basis.

As part of this, we are pleased to confirm that £8,700,000 has been allocated to South East Coast Ambulance Service with the following profile:

22/23	23/24	24/25	Total
3,000,000	2,880,000	2,820,000	8,700,00

It is intended that, in addition to the purchase of national specification DCAs via the national procurement, this investment will be utilized to begin the roll out of zero emission DCAs. The allocation above has been split as per the table below:

22/23		23/24		24/25		Total	
Diesel	Zero	Diesel	Zero	Diesel	Zero	Diesel	Zero
3,000,000	0	2,880,000	0	2,220,000	600,000	8,100,000	600,00

It is envisaged that the funding above will be used to purchase the following DCAs:

22/23		23/24		24/25		Total		
Diesel	Zero	Diesel	Zero	Diesel	Zero	Diesel	Zero	Total
33	0	33	0	25	3	91	3	9

9. Do you have assurance that the efficiency savings won't come from non-recurrent funding in the context of a projected c£31m deficit under the most likely scenario including very stretching targets hence risk and a reserve of £53.9m?
10. The final account figure for the Gillingham MRC as published in Your Call shows an increase of £5.5m over the original £19.5m as published in The Outline Business Case, where will this additional expenditure be found? And what is the projected final account expected to be?

Fleet

11. We are seeking assurance on the engagement of the implementation of the Lord Carter review (which could change the ambulance service as a whole).

Email response from DRC/HG - The Lord Carter review covered several different areas. In particular, for Fleet, we will be receiving the first Carter-Specification Fiat Ducatos this year. We are aware of the feedback from colleagues on the older models we had purchased, however those were not national specification. We recently sent a group of 13 road colleagues with the fleet team to conduct a full equipment fit to a full-specification DCA, and the feedback has been positive. We have started in January 2022 a User Driver Group which is monitoring feedback from colleagues on any fleet-related issues, and there are several known issues which the Fleet team are working to resolve. In addition, we are reviewing our Fleet Strategy in line with the feedback from this group, to ensure we can positively challenge any issues with the new vehicles and implement learnings into future models.

	12. Requesting an updated from the Chair (action from the last meeting) on the LAS decision to use /not use Fiats. Email response from DRC/HG - As we understand it, LAS had a dispensation which was time-limited, and they have Fiat Ducatos in their plans for this year. Recent (over the last 4 weeks) issues relating to the weight of the Fiat against a 95% load vs GVW specification means that both SECAmb and LAS are the 2 remaining Ambulance Services which are yet to accept the new specification on the basis that it breaches the contracted specification. We are pending further internal safety-based evidence to decide for ourselves on a way forward, which could involve asking Fiat to increase the GVW (the same model has a GVW of 5,000kg in other markets), re-plate the vehicles to a higher GVW (this is a process we have done previously), ensuring that we maintain vehicles always under 100% load against GVW. 13. If 10% of our front-line staff are unable to physically fit inside the crew cab or rear of the Fiat vehicles what happens to those staff when our fleet moves to 100% Fiats? Email response from DRC/HG - The statement of "10% of our front-line staff are unable to physically fit inside the crew cab or rear of the Fiat vehicles" is not correct. Our independent high-court automobile forensic investigator which has been commissioned by Stellantis for SECAmb and NHSEI has confirmed that the vehicles are safe for use and compliant with all regulations. In regard to the positioning of the seatbelt, we are implementing a step-wise approach training that will be delivered by the Driver Standards Manager to all staff who have raised issues. This step-wise approach will work for 90% of staff. This does not mean that the remaining 10% are not safe, it means that their physiognomy is outside of the 90% population design most automobile designers use. Those colleagues are still safe in the vehicles, and therefore they will follow the step-wise approach to seat fitting and then they can adjust further if they have any issues (an example we've seen is knees hitting the dash). By adjusting the seat back to avoid this, that colleague could have the seatbelt fall under the shoulder. This does not mean the vehicle is un-safe and that colleague will be expected to drive the vehicle. Colleagues who refuse to drive the vehicle, or are unable to, will be taken through the appropriate HR route **CEO recruitment** 14. Looking for an explanation surrounding the strategy and recruitment process for the Interim CEO and why Interim rather than a wholetime substantive post? NR noted that communications/key messages is the fundamental crux of the issues at hand. DA agreed that engagement is key to overcome current and future challenges. SS confirmed that the engagement issue is something that the board is aware of, diverse workforce, expectations, modernisation, dialogue, how we engage and communicate, tech-savvy, patient safety/quality, etc.
	Comfort Break
91/22	**Trust Priorities and Engagement** Papers taken as read. FM provided an overview of the delivery plan, highlighting People

	and Culture acceptable behaviours. MB questioned whether the new CEO would have to sign up to the architecture already in place. DA confirmed that this a process of negotiations, that the objective is to get someone already experienced in this area that will be able to build on the work that Fiona is currently doing, reshape and communicate the strategy. DA advised that we needed to be united in that voice. AL questioned the status of Better by Design. FM confirmed that we failed to communicate the Better by Design strategy and noted that the concept and framework of BBD is integral for the strategy going forward (HR project, Clinical Education) and the new plan is our improvement journey. HP advised that we need to be careful how we communicate the strategy across, language is key – patient care at the same level as staff engagement, outcome focused statements, what is it going to look/feel like, etc. NR noted that for example our complaints procedure may be due for a review, to be action/data focused – analytical raw-data that could underpin what we need to move forward. LS confirmed that we relaunched the patient experience strategy, revisiting pre-covid process, listening, attending Healthwatch committees, accessing different health needs for different groups, feedback to patients on the complaints, duty of candour. MB questioned what engagement and communications actually means. VW added issues surrounding delays in safeguarding communications. XY also noted that a large percentage of calls into the call centres could be dealt with by the GP but cannot get through and that the whole system needs to be looked at and we need to work collaboratively to reach the same goal. LS confirmed that we are the only ambulance service in the country with a 24-hour safeguarding lead/team.
92/22	**Board Committee scrutiny:** **Workforce and Wellbeing Committee, including an update on Agile Working** SS provided an overview of the Workforce and Wellbeing Committee, including membership and participation, annual cycle of business, scheduled meetings, extraordinary/scrutiny meetings, outcomes and assurances, scrutiny items mapped to CQC key lines of enquiry: • HR performance improvements • Workforce planning and recruitment • Clinical education plan • People plan • Agile working • Retention • Paramedics and PCNs • Sickness Management • Recruitment of EMAs/Clinicians • Approach to diversity/inclusion • FTSU • Appraisals • Employee relations update • Ops sickness management

	• Abstraction: Trust learning and development plan ops 2022-2025 • Incidents and violence and aggression • Clinical education strategy • HR graduate feedback • Improving staff experience • Until it stops briefing • Clinical education delivery plan • Gender pay gap • Management training rollout SS confirmed that as an organisation we are transitioning in terms of appraisals systems and that we should aim for 100 percent, but currently due to organisational challenges is not feasible. Also, there is an importance for high-quality appraisals whilst hitting 80 percent rather than a tick-box 100 percent. SS confirmed that there are external people engaged focused solely on dispatch. SS provided an update on Agile Working. In terms of Freedom to Speak Up, SS noted that a deep dive in the increase of HR-type reports coming in through Freedom to Speak Up and advised that more work is required to determine what learnings we can take from that. DR questioned the risk of losing momentum with all these actions. SS confirmed that prioritising is key to ensuring the momentum is not lost. AL questioned the consideration of volunteers. SS confirmed that volunteer force falls within the WWC terms of reference. DA confirmed that integrating the volunteer workforce is key to organisational efficiency going forward. NR questioned the emergent trend of scrutiny – rota-ing staff to attend command training – cost vs staff vs availability vs flexibility. SS confirmed that the WWC probed the capacity of ensuring training does occur and assurance has been given that it has been rota-ed in. FM explained the issues surrounding abstraction and that there are moves to ensure that training is rostered into the rotas directly. FM confirmed that training facilities have been integrated at all new MRCs. DA advised that we needed to be funded appropriately for the abstraction rate. CB noted the mandatory training is being done by frontline staff on their own time/overtime, we already have a tired workforce, and questioned how it was to be addressed. SD questioned the number of exit interviews occurring prior to departure. SS confirmed that the information will be collected and shared with the Governors. SD further questioned the support given to staff following a difficult case (paediatric death). LS confirmed that the safeguarding team is there for the staff as well. MB questioned whether there were measures in place to indicate milestones have been reached. SS confirmed that surveys will be more frequent, EDRC, audit process for

	appraisals, feedback from training, etc. MB further questioned how front-line staff meet the criteria/soft-skills needed to engage in appraisals (management). SS confirmed that when looking at recruitment, retention and promotion, we need to appreciate that there is a culture here of being promoted due to time served, but this is changing, and is in transition to move towards a different ethos to find people more suitable to management roles.
General	
93/22	**Any other business** None
94/22	**Questions from the public** None
95/22	**Areas to highlight to Non-Executive Directors** - Engagement, engagement, engagement - Difficult messages - Financial challenges - Staff development and training
96/22	**Review of meeting effectiveness**
	Date of next meeting: **Formal CoG & AMM – 2 September 2022** **Joint Meeting – 3 November 2022** **Formal CoG – 5 December 2022**

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	42-22

Name of meeting	Trust Board
Date	25.08.2022
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 July and August 2022 to date. Section 4 identifies management issues I would like to specifically highlight to the Board.

A. Local Issues

2 **Executive Management Board**
The Trust's Executive Management Board (EMB), which meets weekly, is a key part of the Trust's decision-making and governance processes.

3 As part of its weekly meeting, the EMB regularly considers quality, operations (999 and 111) and financial performance. It also regularly reviews the Trust's top strategic risks.

4 The key issues for EMB during this period have remained operational performance (including patient safety and the impact on staff) and progress of our Improvement Journey, however other issues covered include:

- Receiving updates on Emergency Preparedness, Resilience & Response (EPRR) standards and seeking further assurance ahead of the annual assessment due later in the year
- Reviewing and then recommending to the Board the NHS Culture & Leadership Programme
- Agreeing the establishment of and Terms of Reference for a new Clinical Advisory Group, recognising the need to strengthen the clinical voice' within the Trust. Once established, this group will provide an important forum to review and test ideas, as well as making recommendations of areas for action or development

5 EMB continues to hold two meetings each month as joint sessions with the Trust's Senior Management Group to oversee the delivery of the Improvement Journey and the approach to and feedback from the on-going programme of leadership visits.

6 At a recent meeting, EMB and SMG jointly considered the current financial challenges facing the Trust, including how we assess the question of affordability in light of the cost pressures and investments needed, as well as work on developing a

framework for a multi-year Integrated Plan.

7 During this period, EMB have also agreed a number of key investment decisions including:

- Extension to the lease of the Clinical Education Centre at Haywards Heath College
- Creation of a new senior role – Deputy Director for Quality Improvement - to drive our organic approach to quality improvement

Engagement

8 I continue to enjoy spending time out and about around the Trust, meeting and listening to staff. During the past couple of weeks, I have spent time at Worthing, Brighton, Paddock Wood and Hastings, as well as with the Clinical Education team at Haywards Heath.

9 On 18th August, I met with Daniel Elkeles, Chief Executive of London Ambulance Service at our new Make Ready Centre at Banstead. It was pleasure, together with the local operational managers, to show Daniel around the great facilities there but also to have the opportunity to discuss the very real challenges facing ambulance services across the country at present.

10 I continue to be impressed with the commitment shown by our teams but recognise that we need to continue to do more to listen to their concerns and their ideas on how we can accelerate our improvement journey.

Welcome to our new international recruits

11 On 16th August, I was very pleased to welcome our six new international paramedic colleagues to SECAmb at a special reception held at HQ, ahead of them joining their operational teams later that week.

12 Our new colleagues – from Nigeria, the USA, India and Australia - will be with us for a minimum of three years and are the first of more than 30 international paramedics due to join us over coming months, as part of our wider recruitment plan to recruit to all clinical grades and increase our front-line capacity.

13 It was great to meet our new colleagues and with growing national and international demand for paramedics, I'm absolutely delighted that they've chosen to continue their careers in the UK with SECAmb.

Medical Director to step down

14 On 9th August, we announced that Dr Fionna Moore had decided to stand down as Executive Medical Director in January 2023, after an impressive 50 years' NHS service.

15 Fionna has enjoyed a distinguished and lengthy career in the ambulance service spanning more than 20 years and has played an important role at SECAmb since joining in March 2017.
I know that Fionna is held in the highest regard by our staff and the wider ambulance service, both nationally and internationally and so am very pleased that she and I are

16	in discussion about various options for alternative roles with SECAmb once she steps down.
17	**Clinical Education Centre to remain at Haywards Heath** Having seen first-hand the excellent facilities enjoyed by students and the Clinical Education team at Haywards Heath College, I'm very pleased that the Leadership Team have approved the investment required to extend the current lease for a further three years. It is imperative for us to invest, as an organisation, in learning and development for all staff and having access to great facilities such as these is a key part of this.
18	
	B. Regional Issues
19	**Initial feedback following CQC visit** On 26th July, the Care Quality Commission (CQC) undertook an unannounced inspection of our Urgent & Emergency Care and Resilience services, following their inspection earlier in the year into Well Led, our Emergency Operations Centres and 111. As part of their inspection, the CQC team visited a number of Make Ready Centres across our patch, as well as observing crews at A&E departments.
20	We are awaiting the detailed report following their inspection, however we have received initial feedback from the inspection team. This feedback is in line with the CQC's report published on 22nd June 2022, with key issues highlighted including communication and engagement with staff, leadership visibility and risk management processes.
21	This feedback aligns with the plans we have developed as part of our Improvement Journey but we will ensure that, once the full report is received, all issues are properly addressed in our plans.
22	**Brighton Pride returns** On 6th August, I was pleased to join more than 80 colleagues taking part in Brighton Pride after an absence of two years due to the pandemic. It was fantastic to see the great reception the team received from the local community and see, so obviously, how much everyone enjoyed taking part.
23	With thousands of additional visitors to Brighton during Pride, I know it's also a very busy weekend operationally, so thank you to all those involved in planning for and responding to such a popular and high profile event.
	C. National Issues
24	**Extreme weather** We have continued to experience periods of extremely hot weather during recent weeks, which continue to put both our services and those in primary and secondary care under considerable pressure, which in turn has a knock-on impact on demand for both 999 and 111 services.
25	The hard work and effort put in by staff across the Trust continues to be outstanding and I'm pleased to see our staff welfare vehicles out and about, providing refreshments for staff where possible. Thank you to the team of volunteers for giving up their time to support colleagues – it is very much appreciated.

26	**Go-live of documentary following the Joint Response Unit** On 17th August, the first episode was screened of Channel 5's '999 Emergency Call Out', which follows the work of the Joint Response Unit (JRU), run jointly with Kent Police. Filming has been underway for the past few months and the 10-part series will cover the wide variety of calls that the JRU are dispatched to.
27	It was great to see the team in action and I'm really proud that we're able to showcase not only the work of the JRU but also of the wider SECAmb team.
	D. Escalation to the Board
28	**Improvement Journey** Our Improvement Journey is covered elsewhere on the agenda, however I wanted to highlight here the emphasis that we are placing on delivering our Improvement Plan, which focusses on our key priorities for the year and which takes account of the key CQC requirements, especially the Warning Notices and 'must do' actions.
30	**Operational Performance** As is evident from the national ambulance response time data, all ambulance services remain under considerable pressure as does the wider NHS system. These pressures have been increased recently by the extreme weather conditions.
31	We are continuing to work hard to ensure that we provide as responsive a service as possible to our patients with the resources available to us, although we recognise that some patients, especially those in Categories 3 and 4, are waiting longer at times than they should. We have raised this with system colleagues to ensure that alternative pathways are developed for some of these patients ahead of winter.
32	We continue to closely monitor the impact of these delays and ensure we are taking all steps possible keep patients safe when there are longer response times, although this remains a challenge.
33	We also know that 999 call answer times remain longer than we would like at times, due to the availability of staff in our Emergency Operations Centres. This is a problem for many ambulance services nationally and is an area that we will continue to monitor closely.
34	Our REAP Level is regularly reviewed and at present, we remain at REAP Level 4, the highest level of escalation. We have, however, taken the decision not to suspend essential training for operational staff, recognising the importance of ensuring staff are supported in their clinical practice.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	28-22

Name of meeting	Trust Board
Date	25.05.2022
Name of paper	Chair Board Report
Report Author	David Astley, Chairman

This is one of the additional Board meetings we introduced following the CQC report in June, with a narrower focus on progress against the Improvement Journey, which includes our response to the CQC findings.

On the agenda we have the draft Board Assurance Framework Risk Report, which is being redeveloped to take account of both the Board's feedback and that of CQC. The finalised version will be received in September and then at every other Board meeting, along with the Improvement Journey and the new Integrated Quality Report; these will be main reports the Board receives at each of its 'full' meetings to help enable triangulation of risks and issues. In the intervening months, the focus will be more narrowly on progress with the Improvement Journey.

As the Board noted last month, in light of the depth of the Improvement Journey, the Executive has re-prioritised the workstreams to ensure sufficient attention to the areas most closely linked to the Warning Notice and Must Dos. There is also now alignment to the five main Board committees, which will allow the committees to test the evidence and impact of the actions more deeply, providing assurance to the Board.

One Board committee has met since the last Board meeting on 28 July. The Performance Committee's usual report will be received next month. In the meantime, there is one escalation to the Board related to the integrated plan and, specifically, the risk that the recruitment plan to increase our clinical workforce will be undermined by high attrition. The committee challenged the Executive about the extent to which our retention strategy is effective and also whether we are managing sickness effectively; sickness and attrition the main drivers for our inability to provide sufficient hours. This is an area within the Responsive Care Programme of the Improvement Journey and at the meeting I will be asking the Executive to respond to this gap in assurance highlighted by the committee.

At the last Board meeting we received a paper on Board development, which is also an area within the Improvement Journey. I am looking forward the development session after the Board meeting, where we will have scheduled time to continue our review of the IQR, supported by the NHSE Making Data Count team, and also on preparation for the Board engagement with the NHSE Culture and Leadership Programme.

As part of the programme of leadership visits, non-executive colleagues continue to be out and about meeting and talking to our people in operating units and support services. I visited Polegate Make Ready Centre on 2nd August and held a number of informal meetings with staff. That morning I met with the Chair of the Royal Sussex University Hospitals Trust, at their Royal Sussex County site. I was introduced to their A&E team and given a tour of their Emergency Department. I was briefed on the steps they had

taken to reduce ambulance handover delays. SECAmb staff I spoke to confirmed that was the case. The conditions for patients and staff in the A&E Department were challenging. However, the commitment to safe patient care was evident. They reported there was good working relations with the SECAmb team.

The NHS locally is facing many challenges. However, in spite of that, the commitment of staff is exemplary with many examples of selfless care to patients and families. As we discuss our agenda items today, I ask Board colleagues to be particularly mindful of how difficult it is for the people needing our services and the pressures on our staff, their moral and what we as a Board are going to do to sustain our workforce to ensure safe services through the challenging period ahead.

South East Coast Ambulance Service NHS Foundation Trust

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 on 20 June 2022 and focused on plans for the Trusts Annual Membership Meeting and opportunities to take part in member recruitment and engagement at public events.

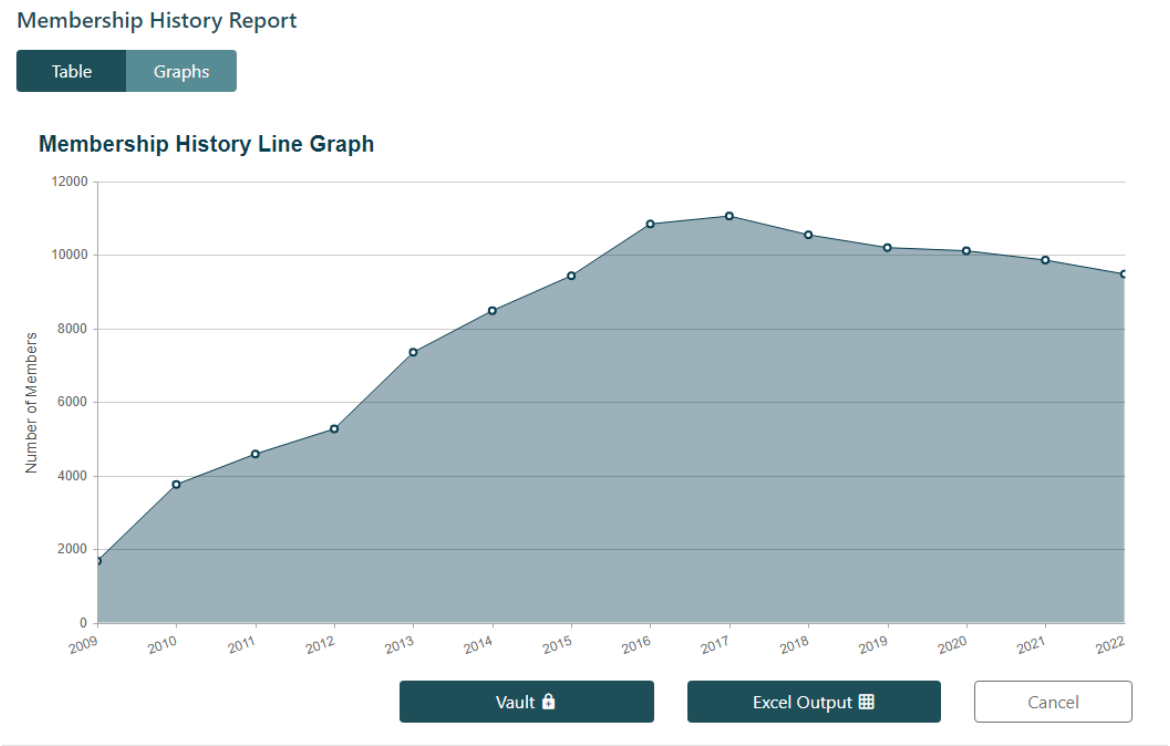
2.2. The next MDC meeting is on 7 November 2022 and will continue to focus on opportunities to take part in member recruitment and engagement at public events.

3. Membership update

3.1. The total staff membership including bank members as of 25 August 2022 is 4678.

3.2. Current public membership by constituency (at 25.08.22) is 9,366. Break down data provided as follows.

Constituency	Members	Population exc London	% of eligible population
Lower East SECAmb (East Sussex and Brighton)	1,864	848,414	0.22
Lower West SECAmb (West Sussex)	1,439	866,131	0.17
Upper East SECAmb (Medway/ Kent/ East London)	3,361	1,850,857	0.18
Upper West SECAmb (Surrey/ Hants/ West London)	2,245	1,386,062	0.16
Out of Trust Area	457	-	-
Total number of members	9,366		



3.3 Membership history report

This graph above shows membership stats from period of inception of Trust Foundation Trust status to date. Our inability to do wide scale member recruitment in its traditional format in 2020/21 as well as 2021/22 has had an impact and we will look to rectify this as soon as we can. We maintain active contact with our current membership and have had good engagement on the recent election communications.

3.4 Membership recruitment update

3.5 We have always sought to maintain the membership numbers rather than dramatically increase them overall. Our approach for 2022 was proposed and agreed at the recent MDC meeting as follows:

- To attend one membership event in each constituency area to enable Governors to meet and sign-up new members within their area.
- 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.
- 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 any patient strategy plans for engagement.
- Consider developing youth membership representation by attending specific events and/or trialling participation in different types of events to the ‘usual’.

Further online membership recruitment via social media will take place this year relating to wider health campaigns such as carers week as there is more capacity within the membership office now.

3.6 Membership Engagement Update

3.7 Our recent member newsletter went out in July 2022 and focused on performance, a focus on a critical care paramedic, the Annual Members Meeting, staying safe in the sun, as well as our Community first responders.

3.8 Our next member newsletter is due out in December and suggestions for content for future editions are welcomed. Our membership survey will be refreshed with input from the MDC and issued in the latter part of 2022.

3.9 We have moved back to in person formal Council meetings which are held in public at venues located around the areas we serve. The public, members and staff members are welcome to join to observe these meetings and ask questions at the end.

3.10 Thanks to those Governors who observed the recent Board meetings.

3.11 We will continue to advertise these meetings to members. Recordings of the meetings are availiable on our website.

4. Public Members' Views

4.1. The Inclusion Hub Advisory Group (IHAG) is a diverse group of our public Foundation Trust members who bring a wide range of views and perspectives from across the South East Coast area. SECAmb staff brief the group on plans and service changes and seek the group's advice on whether wider community engagement is necessary or simply gather the views of the IHAG to inform the Trusts' plans. This group are also able to feed information on issues of importance to them into the Trust.

4.2. **IHAG meeting summary:**

4.3. The IHAG held a shortened subgroup meeting on 5th April 2022 to review the Equality Diversity and Inclusion policy and to begin discussing the review of the Trust equality objectives. The results of the IHAG member survey were reviewed and a recommendation for consideration by the IWG was put forward.

4.4. The next IHAG meeting is on 4 October 2022.

5. Staff Members' Views

5.1. Organisation Development and Engagement Advisors (Emma Saunders) attend the MDC to provide an update on their work.

5.2. The Staff Engagement Advisory Group (SEAG) was the Trust's staff forum, which met quarterly. This has been on hold for a significant period of time whilst they review the purpose and aims of this group and direction of travel for this going forward. SEAG itself is paused whilst we finalise the Employee Engagement Plan to strengthen local listening, owned by managers and leaders.

5.3. The toolkit on employee experience and engagement has been launched to all managers and continues to be promoted through the Fundamentals! programme, the Zone, with Staff Survey promo etc.

5.4. The Involvement toolkit has now been unpublished and has been updated to be called the Listening Toolkit. This aims to support our Listening Framework and will guide managers in delivering effective local listening across the Trust.

6. Patient Members' Views

6.1. The Patient Experience Group (PEG) is a group of public, patient and staff representatives. Nigel Robinson and Anne Osler are the Governor representatives on this group.

6.2. PEG met on 5 July 2022 and the next meeting is scheduled for 27 September 2022. The Patient Experience Team (PET) are currently liaising with NHS partners and the National Ambulance Service Patient Experience Group with a view to improving attendance and improving the feedback PEG can provide. PET will be reporting back to PEG in the September meeting.

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. An update on this area of our service was provided at the MDC and a full report will be provided at the December CoG.

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 1

Membership Development Committee Meeting Minutes

20.06.22 Microsoft Teams – 10:00 – 12:00

Papers on Teams

Present:

Katie Spendiff (KS)	Corporate Governance and Membership Manager
Brian Chester (BC)	Upper West SECAmb Public Governor (MDC Chair)
Nigel Robinson (NR)	Public Governor
Leigh Westwood (LW)	Public Governor
Emma Saunders (ES)	OD & Engagement Lead
Colin Hall (CH)	Public Governor
Martin Brand (MB)	Public Governor
Patricia Delaney (PD)	Public Governor
Kirsty Booth (KB)	Non-Ops Staff Governor
David Romaine (DR)	Public Governor
Linda Caine (LC)	Public Governor
Nick Harrison (NH)	Public Governor

Minutes: Julie Harris (JH) Assistant Company Secretary

Apologies:
Asmina Islam Chowdhury (AIC) Inclusion Manager
Sue Orchard (SO) Community Resilience Manager
Victoria Baldock (VB) Patient Experience Group Management Representative
Graham Parish (GP) Patient Experience Manager

Item No.	Item
01/22	**Welcome and introductions** Attendees were welcomed to the meeting.
02/22	**Apologies for Absence / Declarations of Interest / AOB** Apologies were received from Asmina Islam Chowdhury, Sue Orchard, Graham Parrish, Victoria Baldock. No declared interests.
03/22	Minutes of the last meeting and matters arising. The minutes were taken as an accurate record of the meeting. Action log KS noted that there was one action still outstanding, which was connecting governors to make ready centres and connecting in with their local community first responder teams. KS prioritised getting governors into EOC and 999 and 111 and out on the road first to get that side of the experience within our organisation so that that will be the second step. There is a list of governors and mapped against who their local community first responder teams are and we will look to connect Governors to their local operating unit as well. BC noted that many of the staff and public engagement activities that had been put on hold due to Covid had possibly done us a disservice in terms of the CQC and staff survey results. ES provided an update on the staff engagement advisory group, including a history of SIAG, current use of town halls (noting that town halls are a more effective way of the actual managers engaging with their staff). ES confirmed we have a long journey ahead of us to involve managers managing in

	an engaging way and that moving forward we have the staff survey once a year, national quarterly pulse survey, and now a quarterly addition from the NHS (every three months all staff members in the NHS are able to provide feedback to the leaders in their organisation and we're able to get a staff engagement score from that as well). ES shared a slide surrounding the six building blocks of employee engagement from NHS England where the key point was building a culture where engagement is a joint responsibility. More thought was being given as to what this would look like across our Trust. KB noted that town halls were good for Ops and EOC and questioned what we were doing for the corporate teams? ES explained her vision of the proper employee experience in terms of organisational conversations and agreed that the townhall needs to be mimicked in corporate. KB asked whether staff engagement was included in the quality improvement program. ES confirmed that employee engagement should be built into any quality improvement projects that involves a decision, a change, an improvement, an innovation, that affects either staff or patients. BC commented that in terms of the documents provided to accompany the update they describe what should really be second nature to anybody who has been put in a management role. ES confirmed that for the last five years not one single manager has had any management or leadership development (for a variety of reasons), therefore there is no real guidance around how to be a manager and how to look after your teams and to do the holistic stuff. MB questioned the reasons for the lack of leadership training. ES confirmed that due to operational pressures, abstractions, and the pandemic it has been impossible to deliver the training. ES confirmed that a Fundamentals of Management Leadership course is due to roll out in July for all first-line managers, so this was a solid first step in bringing about positive change. KB noted that Governors could seek an update on the roll out of the training. KB noted the Trust had been autocratic for a number of years and needed to move towards being more democratic and involving and empowering staff to make change. ACTION: BC suggested that a meeting with Subo (Chair of WWC) with Martin, Kirsty, Brian and Emma to seek assurance on the roll out of first line manager training prior to the AMM.
04/22	**FT Membership update plus Inclusion Hub Advisory Group, Staff Engagement Advisory Group, Patient Experience Group and the Community Resilience team - key updates from respective members to encourage cross-pollination between these groups, wider reporting and profile raising.** The SEAG update was taken under the previous agenda item. KS provided an updated on IHAG, offering many thanks to Asmina Islam Choudhury for her years of service as she was due to leave the Trust and had provided so much wisdom and support for membership engagement via her role as Inclusion Lead. KS noted that Yvette Bryan (Head of L&OD) would be taking patient and public engagement through IHAG forward. KS noted it would be useful to have an update on the progress with this at the November MDC. KS noted the new Inclusion lead would be invited to be a part of the MDC so hoped an introduction could be made in the coming months. KS provided a summary of the PEG report provided, noting that there was a patient experience report in development, including themes on compliments and complaints – which will be coming to the patient experience group for scrutiny. NR noted the frustration due to the lack of strategic direction, that although a great deal of time and hard work was put in to produce the document, there didn't seem to be the people and commitment to drive it forward strategically. KS encouraged Governors to attend the PEG. Martin Brand was keen to

	attend and KS would connect him with the Patient Experience Manager to enable this. MB questioned the number of governors on the PEG. BC confirmed that there were two (Nigel and Ann). MB noted his interest. NR confirmed that the next PEG is 5 July 2022. KB suggested that this could be an offline conversation with Tom Quinn regarding the scrutiny of the work of the PEG and their strategic direction. KS confirmed that this had been escalated before from Council to Tom Quinn but I don't think we received the evidence we wanted that this was being addressed. KS noted Head of Quality and Patient Safety - Rob Nicholls was taking the lead with the PEG and it would be good for Governors to see him lead his first PEG and then provide feedback and arrange a meeting with Tom Quinn if required re seeking further assurance. **ACTION – Governors to provide independent feedback on the next PEG meeting on 5th July to determine whether a further meeting with Tom Quinn is required for assurance on the progress of work in this area.** DW provided an update on the community resilience team (community first responders (CFRs) and chaplain contingent). • 323 current CFRs in the Trust. • Benefits (CFR attendance first on scene for 111x C1 calls, 748x C2 calls, 97xC3 calls – 4000+ volunteer hours in the month of May). • 100% compliance on statutory and mandatory training. • Falls team update (Gatwick/Crawley & Polegate/Hastings) – 70 calls responded to so far after the last three months – plan to roll this out across the organisation. • Challenge of effective engagement and management of our CFRs – applied for national funding through NHS charities for a team uplift (3 extra staff & 24x emergency responder vehicles) = £500,000 over 2 years which was awarded. • Looking to recruit an extra 300 CFRs over the next two years. KS implored governors to support DW and seek assurance that the Trust was investing in our volunteers. BC agreed. MB noted the importance of reinforcing sustainability, taking attrition in consideration. MB keen to see the future funding and investment in this area. DW noted the progress made over the past two years to embed volunteers within the organisation but noted that there was much more that we need to do as an organisation to bring ourselves up to a level on a par with our ambulance counterparts.
05/22	**Engagement** **- Employee experience toolkit // Involvement toolkit // civility toolkit** **- Wider 4 pillars programme underway** ES provided an overview about the four pillars programme being rolled out in the Trust which was about cascading the Trust's priorities and developing a way for staff to give their feedback around the new priorities. The priorities were developed off the back of the CQC report and staff survey. Other aims included supporting the leadership team in raising their visibility and supporting them to engage with staff – including the improvement journey toolkit. An overview of this toolkit was given. KS noted the contribution of ES to this work piece and that it was good to see work happening in this area. KS noted the need to resource this appropriately to see long term meaningful change in the Trust in the area of employee engagement and communications. ES stressed the importance of the quarterly pulse survey in providing a temperature check on colleagues feelings on engagement and priorities in the organisation.
06/22	**Annual Members Meeting** **- Firm up agenda**

	- Creative ideas for content **- Hybrid approach query** KS noted that generally the AMM is an in-person event with an exhibition of stands, an opportunity for our public members and our staff members to come and find out more about our services and questioned if there are any ideas for this year's event. Discussion points would be hybrid vs in-person event style and stakeholders that we want to reach out to and involve. KB noted that we shouldn't deviate from the standard agenda, but that we need to consider including research (programmes on delivering on patient care) very heavily this time around. SECAmb is leading quite a lot of national research programmes and it would be good to profile this. KS noted she would pick this up as part of the exhibition. MB noted that an educational video about what happens behind the scenes (video) when you call 999. MB was keen for an overview of the Council to be given as part of the lead governor report. KS advised that the Lead Governor presentation was a look back on what Governors have been focused don in the last year as per the statement in the annual report. KS noted that Trust priorities were raised as an area of fucus for this meeting by a number of people. KB agreed that this should be about our improvement journey and the Trust priorities. ES suggested that we engage some of the more disenfranchised members of staff (dispatchers, 111, 999, etc) in the event. ES was keen to see a 'I am a dispatcher ask me anything' type session or similar at a future event. BC and MB questioned whether we have a hybrid event or not. KS confirmed that we have always livestreamed the event but that the question is how to deal with the Q&A session and the interactive session. BC noted members would be invited to the event in the July newsletter and was keen to see a hybrid approach to the event. KS noted there was a trade off in doing a hybrid event, a lot of people may not turn up in person and just watch online and this would change the experience for attendees on the day. MB noted the benefit of access with holding a online event. MB keen to see online interactivity facilitated. KS keen to see an external company manage the online participation and engagement such as online Q&A participation. KB keen for the tone to be set for the meeting by the Chair early on and for everything to relate back to our improvement journey. KS noted need to be honest and upfront about the challenges the Trust faces. CH voiced his concern about the reduction of public engagement over the last two years. KS confirmed that there will be a Governor stand at the AMM to help support new membership sign ups. KS noted that prior to the pandemic, member engagement events were a regular occurrence, and she would provide more detail on this in the next section. KS noted it had been an extraordinary two years and was keen to demonstrate what public and member engagement had looked like before and could look like going forward.
07/22	**Membership Engagement and Recruitment for 2022** KS noted the hiatus over the past two years of traditional face-to-face membership events due to the pandemic. Over the past two years online campaigns, newsletters, social media, drop in events with Governors on Teams, we have continued to try to maintain a sense of membership engagement whilst traditional methods were unavailable. KS gave an overview of what membership engagement had looked like prior to 2020 and this included in person 'do you know your ambulance service' type events across the areas we serve for the public to learn more about our services and meet their local governors. KS noted challenges of getting members along to events that were just for meeting your governor, they were more well attended when combined with an info session from colleagues in green. DR noted the need for more public membership sign ups, perhaps by attending events with a lot of

	footfalls. KS noted that there is a governor toolkit that can be available to Governors to attend small local events themselves – although this needed updating. KS noted that as part of the toolkit there was an existing document that detailed local organisations Governors could plug themselves in to to hear local views on the service. KS noted that Andrew Latham had recently collected some membership forms and goodies to talk about membership at an event he was attending. KS noted that there was an upcoming 999 show in Eastbourne that she could plug Governor into. KS confirmed that we have always prioritised quality vs quantity in terms of membership numbers and recruitment. KS noted that what she was hearing was that Governors could make good use of the Governor Toolkit and that they would like it to be refreshed and re-issued. KS noted she would send this out a started for ten for Governors to review and provide feedback on. KS noted th commitment of the membership office to attend 1 large scale event in each area, but also empowering Governors to be able to go out and do membership recruitment themselves at smaller local events if they so wished. KS noted events were just starting to come along over the last few weeks. KS noted a plan for attendance at events was usually presented at the February meeting, so we are slightly on the backfoot with this but trying to catch up. BC noted Governors could do some local research on events and compile information on this to share with the Membership Office for a central record on events. KS noted the usual approach was to look at the membership data to see what areas we should be focussed on in developing a representative membership and mapping that to the events available. MB and BC were keen to attend the Brooklands 999 show. KB noted that the EPRR team would have a list of large-scale events the Membership Office could take part in. **ACTION – Update the Governor Toolkit and reissue/ publicise to the Council. Consider where it will be stored for easy access by Governors.** **ACTION - KS send out toolkit and crib sheet for feedback from Council for updating and upcoming event dates to governors to get involved with.** **ACTION – All Governors to research their area for events that could support membership recruitment next year, with the required set of information required (footfall, costs, stand requirements). Feed this back to the membership office to build a record of possible yearly events.**
08/22	**Areas of focus for Member newsletter** **- Please bring article suggestions for future editions.** KS provided an overview of the July newsletter and asked if other subject matter should be included. MB noted that there should be feedback mechanism where the constituency have the opportunity to contact the governors directly – perhaps with a SECAmb email address. KS confirmed that there is Governor area SECAmb email addresses on our website and way's to contact the Governors are publicised in every edition of the newsletter. KS noted she did get emails to Governors from members and shared these with the relevant people. KS was happy to facilitate conversations or Governor blogs to be shared with members. KS noted there was an article in this edition on the role of the Council, and how to be more involved as a member, encouraging members to attend the CoG and Board and reach out to Governors.
09/22	**Deputy MDC Chair** **- We welcome any interest in this position to be raised at the meeting** None were received in advance. BC would take this up outside of the meeting

10/22	**Any Other Business from members** None was raised.
11/22	**Review of Meeting Effectiveness:** BC apologised that he was late in attendance. BC commended the discussion that had taken place at the meeting and thanked all for taking part in some rich and useful discussion.
Date of Next Meeting: 7 November 2022	

SOUTH EAST COAST AMBULANCE NHS FOUNDATION TRUST

Council of Governors

Nominations Committee Report

1. Introduction

1.1. The Nominations Committee (NomCom) is a Committee of the Council that makes recommendations to the Council on the appointment and remuneration of Non-Executive Directors (NEDs) and considers NEDs' appraisals, including the appraisal of the Chair.

1.2. This report provides an overview of the activities of the NomCom for the Council.

2. NED recruitment

2.1. The NomCom is currently focused on making one appointment, with required experience and expertise currently being defined and developed.

2.2. BAME, a consultancy agency has been appointed to support this recruitment and initial development of the recruitment campaign is in progress.

2.3. It is planned that the NomCom is aiming to interviewing and recommend candidates for appointment to the Council circa September/October timeframe. Additional Governors should be able to be involved so do hold the date if you are interested.

3. NED Appraisals

3.1. NomCom has formally reviewed the NED appraisal process and contributed to the NED appraisals. NED appraisals were reviewed during the last meeting including the Chair's appraisal and objectives.

4. Recommendation

4.1. Council is asked to note this report and the NomCom are happy to take questions or comments.

David Astley, Chair (on behalf of the Nominations Committee)

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

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 18 August 2022. 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 Council meeting and AMM, observation opportunities, CoG self-assessment to begin in January 2023, Governor training and development requirements, including a future financial development session.

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 discussed the possibility of receiving a financial update during the professional development session in December.

2.3. That an agenda Item for GDC and CoG should be added to discuss raising the profile for the CoG

2.4. Formal and informal development opportunities for Governors were presented and that plans were underway for observation opportunities with 111/999/Field ops. The next learning and development session will be on the financial position of the Trust.

2.5. TORs for all CoG committees to be reviewed by 13 October 2022.

2.6. It was suggested that January 2023 would be a good time to launch the Council of Governor Self-Assessment to complete within the 30-day launch.

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 **20 October 2022, 2-4pm venue TBC.**

Julie Harris (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 – 18th August 2022

Present:

Kirsty Booth	(KB) Non-Operational Staff Governor (Chair)
Linda Caine	(LC) Upper East Public Governor
Patricia Delaney	(PD) Lower East SECAmb Public Governor
David Romaine	(DR) Lower East SECAmb Public Governor
Andrew Latham	(AL) Lower West Public Governor
Mark Rist	(MR) Appointed Governor
Christopher Burton	(CB) Operational Staff Governor
Angela Glynn	(AG) Appointed Governor
Julie Harris	(JH) Assistant Company Secretary

Apologies

Leigh Westwood	(LW) Lower East SECAmb Public Governor & Lead Governor

Minute taker (from recording):

Leigh Herbasz	(LH) Corporate Governance Officer

Item No.	Item
Introduction and matters arising	
79/22	**Welcome and introductions** KB welcomed everyone to the meeting and asked everyone to introduce themselves to Mark Rist and Angela Glynn, who are new Appointed Governors.
80/22	**Apologies for Absence** Leigh Westwood (LW) Lower East SECAmb Public Governor & Lead Governor
81/22	**Declarations of interests** No declared interests. **ACTION: Revisit and share declarations at next meeting**

82/22	**Minutes of the Meeting 16.06.22** AL advised he had sent his apologies and they may have been missed. Minutes from 16 June approved.
82b/22	**Action Log and EMB Escalation Log updates** The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed. **ACTION: Agenda Item for GDC and CoG to raise the profile for the CoG**
Main business	
83/22	**Draft Council of Governors agenda for September's meeting** KB asked if everyone is happy with the agenda – Approved KB sought assurance from NEDs for board committees and the IQR, David Ruiz-Celada has been asked to do a presentation on IQR in its current format and the process it has been through from IPR. JH noted issues with the IPR and mentioned that the IQR will answer questions. DR talked about the National Ambulance specification review – on a personal note; has spoken to his local MP, who has undertaken to asking a parliamentary question, regarding the lack of consultation with the workforce before the specification was drawn up.
84/22	**CoG Self-Assessment – content / timings & review of committee ToRs** JH asked when this should be launched and if we want to keep questions the same, if kept the same then we can measure like from like. AL thought the questions were thorough, due to many of the CoG members being new this year, it has been suggested that next year would be a good time to launch to complete (January 2023) – 30-day launch. All agreed. JH asked for TOR to be reviewed for the MDC, GDC and CoG, in the next couple of months, all agreed. AL talked about the Nominations committee and asked if JH could check details regarding appointment of the CEO, as he thought it should be part of TOR but couldn't see it on there, same for Chairman and Execs. **ACTION: TOR – All to read and send comments by 13th October**
Standing agenda items	
85/22	**Governor training and development requirements:** - For discussion regarding priorities - Training and development opportunities for discussion

	- Observation opportunities with 111/999/Field Ops Observing and reporting on NED committee meetings KB asked what priorities, training – KB suggested for everyone to think about this before the next meeting, development, assessments are of interest. JH spoke about the number of CoG attending committee meetings will change and there will be more opportunities to engage. AL talked about the Trust Financial position and how it works – Debt forecasting £40m+, asking where sources of income, come from. Would like someone from Finance to explain this. JH has suggested we talk about ICS's at the December GDC JH talked about the training that is available and is always included in the Friday emails, in particular NHS Pathways and GovernWell, courses such as effective questioning, challenging and engagement, all are encouraged to sign up. KB mentioned that field ops, 999/111 and reminded everyone that restrictions have now been lifted. CB has reminded everyone that they are always welcome to join him on a shift. AO mentioned that she joined a crew on the ambulance and asked if there was anything that could be done for them with regards to traffic announcements. DR would like to know how we can triage 111/999, he also mentioned about google maps being delayed when there are traffic announcements, unfortunately there is always a delay. He has done the assessment to third man on an ambulance. PD had an opportunity to sit with 111 for a day and felt there should be a filter system to address social issues that emerge with mental health issue and there is an overlap with straight forward medical issues. PD also mentioned that she has hearing difficulties and doesn't think she would be suitable to go on third manning on an Ambulance. AG is interested in going on third manning. KB asked if anyone was interested in going to Clinical Education Centre at Haywards Heath and asked if JH could look into this. AG, MR and MR are interested in being included in Clinical Education Centre visit. KB has mentioned about CoG observing NED led committees and as soon as opportunities are available this will be announced. **ACTION: Arrange Financial development session to integrate external sources/ICS's at the December GDC – try to encourage as much attendance as possible.** **ACTION: JH to arrange with Clinical Education visit.**
PART 2 – Other business	
86/22	**Any other business** JH Elections – 7 Seats for the CoG, she has asked everyone to re-enlist if possible as we

	haven't worked together long enough. KB – CoG to be more flexible and dynamic to support the NEDs and more challenging for them and how can we engage more to serve the public. JH Asking for volunteers to help at the AMM on reception and represent the Governors stand, there is a 999 event at Brooklands Museum in Woking. DR has expressed his interest with helping. We will pre-prepare for the next season. AG brought up the concern regarding people in full-time work that may be excluding that group of people. JH agreed with AG and confirmed this is why we are trying to maximise the seats for the Governors and therefore all should maximise engagement opportunities within our own areas.
87/22	**Review of meeting effectiveness** The meeting was deemed to have been effective. **The next GDC meeting takes place on 20 October from 2-4pm on Teams.**

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

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.

Date	Activity	Governor
15.03.2022	Inhouse NHS Providers training for Governors	Kirsty Booth Nick Harrison Linda Caine Ann Osler Mike Tebbutt Stuart Dane David Romaine Martin Brand Colin Hall Alison Fisher Andrew Latham Howard Pescott Matt Morris Patricia Delaney
22.03.22	Attended a training course - Governwell: NHS Finance and Business Course	Chris Burton
01.04.22	I have been spending time talking to crews about how they are feeling and how they are finding/ coping with the current pressures the Trust is under as I come across them as a CFR and as a St. John Ambulance volunteer in Brighton at the ED at RSCH where I have been both waiting to unload	Andrew Latham

	patients we have been deployed to by SECAmb and also volunteering in the ED directly for the Hospital.	
11.04.22	Attended the NHS Provider Governor Focus Conference	Stuart Dane Trish Delaney Martin Brand
May 2022	Governors provided feedback on the Quality Account draft	Sent to all Governors.
May 2022	Site visits available to NHS 111 service in Ashford to learn about the service. Tour of the site and an introduction to staff members handling calls. Observe and engage with staff members including call handlers and clinical support roles, spending time with each discussing their roles and contribution to the organisation.	Linda Caine Colin Hall Patricia Delaney Leigh Westwood
May 2022	Governor site visits to EOC East and West 999 centres. Tour of the site and an introduction to staff members handling calls. Observe and engage with staff members including call handlers and clinical support roles, spending time with each discussing their roles and contribution to the organisation.	Vanessa Wood Linda Caine Colin Hall Patricia Delaney Nigel Robinson ACC Lisa Bell David Romaine Anne Osler
May 2022	Governors observed NED committees and reported back to Council on this.	Stuart Dane Kirsty Booth Chris Burton Linda Caine Andrew Latham David Romaine Leigh Westwood Patricia Delaney
20.05.22	Gave a talk to local group about CFR'ing, SECAmb and falls and encouraged them to sign up as members of the Trust. Various informal chats to front line staff about their motivations and concerns about the Trust.	Andrew Latham

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.

07.03.2022 – Patricia Delaney

Question: Reading the bulletin, I noticed how much the assaults on staff had escalated during the pandemic, and that there is now a campaign "Work without Fear" commencing soon.

Alongside this, I noted that the JRU's were being set up. I wonder what the composition of the JRU team would be? and if a mental health worker was included, especially if aggravating factors included drug/alcohol/ and mental ill health ? If so, it would be interesting to see if the number of assaults reduced., and if it correlated with the composition of the JRU. And also that how the addition of an extra worker would physically fit inside the ambulance without inhibiting patient care.

Response (Alexander Wilson) 08.03.22: The JRU comprises of a police officer and paramedic. The idea being. We self-allocate to either police incidents or ambulance generated calls that require both services. We do not have any specialist mental health worker, and we are very clear that we are not a mental health resource. By the very nature of mental health, sometimes needing police assistance, we do attend mental health jobs. I think there is a massive need for a mental heath car with a paramedic and mental health specialist, but we have tried before but getting funding from the mental health teams has proved hard.

I would be very against sending a police officer to every mental health presentation as they are not required and mental health is a health issue, not a policing problem. It's a normal SRV, attempting to minimise the need for multiple ambulance or police resources. If needing conveyance, we can convey in care if clinically appropriate or yes we request a DCA.

We attend incidents that require both services ranging from , but not exclusive to assaults, sudden deaths, mental health (only when need for police) RTC, concern for welfare, domestics, jobs in public places, crew request for police assistance, mental capacity assessment support. We want to provide a quicker response for when ambulance need police, or vis versa. We also want to speed up response times to these categories of calls, and aim to close them down a lot quicker.

So we are not a project as such any more... in Kent we have been set up for over 3 years now, and the unit is very well embedded into operations.

08.03.2022 – Kirsty Booth

Question: I would like to seek assurance that any changes to the Paddock Wood estate prior to the changes in guidance for COVID have been thought out and discussed in consultation with the teams that use those sites. I visited Paddock Wood last week and there are some changes being made to the offices where Procurement used to work, this has become a hot desk area for quite a few teams, the office in that room used to be used for 121s etc has now been locked with swipe card access only. If the space is being re-purposed can you seek assurance that affected staff have been consulted with?

Response (Gio) 08.03.22: Background on the change of room use –

The procurement office is managed by Paul Ranson, head of procurement. Paul kindly gave staff at PW the use of the office as a 'hot desk' room, whilst his staff were working from home during the pandemic. The small private office was Paul Ranson's office and was always locked prior to Paul changing his base due to the pandemic. Paul Ranson and Mark Eley have discussed the use of the office and have agreed Mark will use this as a local base to work from. The swipe access has been changed as you will appreciate that as deputy director of operations Mark keeps a lot of confidential papers in the office. The use of the main Procurement office has not changed and is accessible by all and is still available as a hot desk room.

10.03.22 – Nigel Robinson

Question: As some of the burden of COVID eases and business returns to a new normal there may be an issue about which your reassurance would be beneficial please.

The trust continues to publicise how busy it is daily, whilst also having to defend incidence of delayed attendance at emergencies of various categorisations or at hospital ED's.

Yet in amongst this heightened level of public and media awareness and scrutiny, the trust continues to support public entertainment events by providing SECAMB officers, vehicles, and crews for those events.

1. Does the trust continue to have an appetite and resources for providing this service?

2. What statutory legislation is there that requires the trust take on these roles and thereby maintain its legislative compliance?

3. Is this type of commitment morally defendable whilst facing such high call volumes and seemingly a shortage of vehicles and crews in the event there were to be a challenge from public, media or other another body?

Response (Emma Williams) 23.03.22: 1. The Trust has a requirement to be involved in public events in terms of planning and in some situations, attendance via a command/operational response (see the answer to question 2). In addition to this statutory position, several very large events require additional medical cover and SECAmb have had been contracted to deliver this service. More recently the Trust has declined to undertake this additional work, however there are a small number of historic contracts that are being reconsidered at this time.

2. The Trust has a statutory requirement to engage with partners across the region with regards to event planning and delivery – details of these requirements can be found in two industry standard guides:

- Green Guide: Guide to Safety at Sports Grounds, compiled by the Sports Grounds Safety Authority (SGSA), a non-departmental public body in the United Kingdom funded by the Department for Culture, Media and Sport (DCMS).

- The Purple Guide to Health, Safety and Welfare at Music and Other Events, written by The Events Industry Forum in consultation with the events industry and the Health & Safety

Executive. 3. We are reviewing SECAmb attendance at all events from both the statutory and contractual basis, particularly considering the current challenges to resourcing and performance. Where we have committed contractually to provide additional services this position is being re-evaluated in terms of the medium and longer term planning. Nigel met with Dir of operations 21.04.22 to talk through this.

24.03.22 – Colin Hall

Question: I have seen other ambulance services sending equipment to Ukraine. How is the Trust providing meaningful aid towards what is happening in Ukraine?

Response (John O'Sullivan / John Griffiths): SECAmb has engaged in the following:

- Two decommissioned/de-branded Mercedes vehicles are being made available to go to Ukraine with all emergency systems still intact and kitted out with patient carrying devices (as per normal).

- We have identified a charity (TBD) that can get them out to Poland and into the Ukraine and the checks for this to happen are still ongoing.

- We are in the process of Identifying all consumables that are running out of date in the next couple of months with the aim of sending them out to the Ukraine either on the back of the ambulances or separately, depending on timings.

24.03.22 – Query from Council meeting

Question: Can we have an update on the review of the Fiat vehicle concerns raised by some colleagues regarding seatbelt placement.

Response (John O'Sullivan / John Griffiths): On 30 March a forensic engineer will be visiting SECAmb (commissioned by Stellantis – the parent body of FIAT) having done a full review of all vehicles, will present a report which will provide the scientific approach to how to position yourself in the vehicle (utilising all adjustment on seat and steering wheel). This report will form the basis of a personal risk assessment for all the staff that have self-declared under op instruction 465. On 30th March the forensic engineer will be presenting these findings as well as take people through the step-wise approach on the FIAT itself.

13.04.22 – Matt Alsbury-Morris

Question: Want to raise what I consider to be an urgent Quality & Patient Safety issue... according to the email below, signed by Fionna Moore, the SECAMB Public Access Defibrillator database has been turned off. To my knowledge, it's replacement doesn't have any of the data in. The email below claims 'Data Protection' limitations on giving details to the British Heart Foundation. This law doesn't apply to the 30+ sites our charity provided as a charity doesn't have data protection rights... but that's a different issue.

To my knowledge the database held the location & access details to 3,000+ Public Access Defibrillators (at least in 2017/18 it did) that the public were directed to in the case of a 999 cardiac call.

The Circuit, which they have advised is the replacement, is not stocked with the relevant data... I know this as the site is live at https://www.defibfinder.uk/ and this doesn't show our Responder Charity sites...

Every Responder group & charity I'm aware of is in uproar this evening on social media given the last minute ask to now put that data in manually - and wait 2 days whilst the BHF setup our organisational accounts etc. Which creates a great patient risk in my view... for data SECAMB already had.

Can we please urgently seek clarity from the Non-Execs what assurance they have that the board is managing the patient risk from the removal of over 3,000 public access defibrillators from SECAMB's Computer Aided Dispatch systems?

It would be good to have some assurance that this is not causing patient harm.

Response (Tom Quinn): For your information, the Trust's management plan for PADs was considered by the Quality & Patient Safety (QPS) Committee at its meetings of 18th March 2021. It was clear that while the BHF Circuit aimed to catalogue all PADs and who was responsible for their maintenance, SECAmb was responsible primarily for the maintenance of the PADs that were owned by the Trust (Phase 1). Management of the wider pool of PADs not owned by the Trust (Phase 2) was not something SECAmb were commissioned to undertake.

QPS received an update at the 18 November meeting. Phase 1 was complete, with confirmation that all Trust owned PADs had been identified and confirmed as 'rescue ready'. It was confirmed that, in terms of patient safety, there had been no reported incidents related to PADs not working.

Dr Fionna Moore's 11 April 2022 communication to all (known) PAD guardians across the Trust footprint asking them to register their PAD with The Circuit, stated that the Trust's local database is no longer active. I have confirmed with Emma Williams, Executive Director of Operations, that this database is no longer being updated, and therefore the 'rescue readiness' of any PAD not owned by the Trust, if not already registered on The Circuit, cannot be verified. The responsibility for registration of non-Trust PADs is the responsibility of the owners. BUT this does not mean that PADs previously registered with the Trust have all been erased from the CAD, merely that their status cannot be verified until they are registered with The Circuit.

The Trust works closely with The Circuit to ensure that owners are communicated with, that permission is given to register on The Circuit, and that sites where there is no response from the PAD owner, or maintenance of rescue readiness remains unclear over a period of time, such PADs are removed from the CAD.

On the basis of the above, I confirm I am assured that:

- SECAmb owned PADs are rescue ready, and
- The Trust is working with The Circuit through an agreed process to ascertain the state of readiness and maintenance of all the other (non-Trust owned) PADs that were previously registered on the local database.

10.05.22 – Chris Burton

Question: There is an Operational Team Leaders position (Band 7) vacant at Haywards Heath. It is believed that SECAMB will only offer this position with staff that are willing to work full time (1.0WTE) or part time (0.5WTE). This would hinder members of staff who for example have the right qualifications but cannot commit , due for instance, to child care issues? I question whether this would unfairly discriminate against women getting management positions? I suspect the reasoning behind this would be that one day here or there may not be enough to commit to the role of bronze command and inhibit the amount of contact the staff in the OTL`s team would have with the OTL

It is of concern, if the Chair of WWC has agreed to this?

I would be grateful if we could receive some assurance in this matter.

Response (AIC): Sent to AIC for fact checking first. Having checked with recruitment team they have confirmed that OTL positions are primarily advertised as full time only or part time (18.75hrs) when this is requested to back fill a vacancy left by a colleague who previously had part time hours. Having been made aware of a recent communication regarding ops positions overall being a minimum of 18.75hrs a week we have asked for a equality impact analysis to be undertaken on this.

17.06.22 – Nigel Robinson

Question: I feel compelled to write to you direct and copy in colleagues such is the continuance of real concerns over the suitability of the Fiat as a DCA. The Fiat may well be a most suitable vehicle and well designed and equipped. However such are the comments all around this particular chassis, if that is the case, then a reassurance programme is urgently required.

I risk stating the obvious here and I sincerely apologise as I know you are very knowledgeable but this matter appears to be gathering momentum and is just not going away. Now whilst it is accepted that this boarders on an operational matter, one also feels compelled to consider the overall governance of the equipment and vehicle provision. A provision that is part of the core day to day business and one which impacts across the trust and the public we serve. This is especially so if the trust may not be getting this matter quite right.

I understand the whole subject of vehicle provision is now an emotive and subjective issue, but the ongoing comments, apparent issues for staff and colleagues is simply just not going away and that worries me.

Senior staff reassurance may be missing the issues at the heart of this matter or not listening?

I have captured a few comments below from colleagues, staff, associates in other trusts, hearsay and reports. These and the private e mails I have been sent, leave me and a number of colleagues worried things are not as they should be – hence this e mail to you for your consideration please.

Some comments;

1. It is difficult to perform CPR in the back of the vehicle

2. The driver's seat cannot be properly adjusted

3. The seat belts cannot be worn safely

4. Consideration is being given to cutting holes in the dash so that people at 6'+ can sit in the driver's seat

5. If I do not drive the vehicle I will be put on other duties

6. If I do not drive the vehicle I will be dismissed

7. The equipment cupboards and essential kit in the back is in the wrong place

8. The equipment stowed within the cab is unsecure and may cause injury if we are involved in an RTC

9. I should bring a cushion to work so I can reach the vehicles control pedals

10. Clearly the writers of final reports have never experienced patient care duties in the back of a Fiat DCA

11. The Lord Rogers report was flawed, the outcome fell short

12. Depending on the weight of the crew / patient the vehicle may exceed its SWL

These points are not all of those travelling around the trust and the UK. They are certainly not here for a blow by blow analysis, they are merely examples of some issues being raised and heard of. Were 50% dismissed as grumbling and rhetoric there are still enough remaining for concerns to be raised. One wonders if this matter should be scrutinised by the NED's corroborated by comments from the front line, vehicle maintenance and do a real 'deep dive' into a matter that is truly bothering the trusts most valuable assets – its staff.

I feel I should almost apologise for adding to the rumour mill by sending this email to you but truly David this is a worrying matter and even if the comments are all proven to be unfounded, not factual etc then lets see the staff be told that by officers acting as ambassadors for the trust, in as many an open forum situation as possible. That may be an opportunity to build on officer v staff morale as well!

23.06.22 – Colin Hall

Question: I wonder if someone can clarify if the article in Health Service Journal (https://www.hsj.co.uk/workforce/trust-rows-back-on-too-tall-or-too-short-dismissal-threat/7032631.article) is the Trusts management of this issue… are Execs actually proposing to sack workforce due to a fleet issue? Rather than resolve what is potentially an issue with the van (a quick Google will show you that people have had similar issues with camper van conversions of the same chassis for years… so not limited to ambulances!)

Can we please raise a formal governors question on what the NEDs are cited on regarding the mitigating actions being taken? Is this limited to what we've seen, or have they been given further assurances? Also, have the NEDs had the impact to workforce & service delivery (and

therefore patient quality / safety) quantified as to the impact on an already under resourced & stretched workforce as a direct impact of these fleet issues?

Response (David Ruiz-Celada): Response from Director of Planning - David Ruiz-Celada:

1. It is difficult to perform CPR in the back of the vehicle

[A] The Trust moved away from carrying our CPR in a moving vehicle a long time ago. The model is to complete a resus through to completion on scene and only transport patients post Return of Spontaneous Circulation (ROSC) and then the norm is for a Lucas device to be fitted to the patient which can be used during transportation. Evidence shows that manual CPR in a moving vehicle is practically ineffective.

2. The driver's seat cannot be properly adjusted

[A] The independent high-court expert witness (automobile forensic investigator and engineer) confirmed the vehicle is compliant, meets all safety standards and adjustability requirements for UK and European legislation. There most-likely is a training gap in the full range of adjustability of the seat which is part of the individual assessments we will be rolling out.

3. The seat belts cannot be worn safely

[A] Part of the above report clarifies that the seatbelt will fit on the shoulder for 90% of the population, but that does not mean that 10% are un-safe if the seatbelt goes under the shoulder, as the seatbelt is there to protect life and will be effective in any position. The pyrotechnics within the seatbelt mechanism would trigger in the event of collision, pulling back from any position. We reviewed this evidence during a demonstration day with our union colleagues who also raised this as a concern and they have accepted the report and the safety of the seatbelt. What we have identified as a next step is a risk-assessment / training package to be delivered individually to colleagues who have raised concerns with the seatbelt (around 10% of our driving workforce), so that they can find the best fit for them in the cabin. We have been given a step-by-step approach by the independent expert on how this is achieved. We recognise there may be a handful of colleagues who after this process, will still have issues like knees hitting the dashboard, or not reaching the pedals. This can be because of a range of reasons, and likely to be very specifically due to their body-type and the van cabin, and see below on 5 and 6 on the current process we are going through to support colleagues who end up finding themselves in this position. It's important to stress that we have no way of guaranteeing any other vehicle would not have similar issues, maybe for a different cohort of staff, however the Fiat Ducato is very widely driven and the most popular van in Europe, therefore we expect this to be a situation that impacts a very small minority of colleagues. Any process we follow will be in accordance with the Equalities Act 2010 to ensure protected characteristics and vulnerable groups are not discriminated because of our choice of fleet.

4. Consideration is being given to cutting holes in the dash so that people at 6'+ can sit in the driver's seat

[A] We will not consider making modifications to a safety-approved cabin that are not approved by the manufacturer and the relevant regulator.

5. If I do not drive the vehicle I will be put on other duties

[A] This may be an outcome, however as per the recent discussions with Union colleagues at JPF, we are pending a full Equality Impact Assessment to be completed which will identify the appropriate mitigations, and reasonable adjustments, which may be applicable for colleagues who either refuse to drive, or can't drive, any one of our vehicles, as this process needs to be built around any fleet vehicle. An EIA panel which includes union colleagues and the EIA team are developing this together on Wednesday 22/06/22, and we are seeking comparable situations from other industries (aviation, bus operators) as well as external EIA support from our lead commissioner, to ensure robustness of the approach. The process extends and must be consistent with reviewed a reviewed recruitment approach.

6. If I do not drive the vehicle I will be dismissed

[A] As above.

7. The equipment cupboards and essential kit in the back is in the wrong place

[A] We are reviewing the layout of the clinical setting in the back following a visit by the Driver User Group to Stafford to review the new full-specification DCA from WMAS. This is a continuous improvement process and future fleet design is influenced by the feedback we are receiving. The membership of the Driver User Group is as follows:

- Head of Fleet & Logistics (Chair)
- Fleet Services Manager
- Fleet Commissioning Manager
- Fleet Administrator
- Driver Training Manager
- Clinical Education Manager
- Operational Unit Manager West
- Operational Unit Manager East
- Risk and Incident Lead
- Health and Safety Manager
- Union JPF members
- Make Ready Centre Manager East
- Make Ready Centre Manager West

8. The equipment stowed within the cab is unsecure and may cause injury if we are involved in an RTC

[A] We know there are items which need securing following receipt of the report from the expert; primarily, the fridge and torches. Fleet are working on a solution and will ensure new builds are ok and a retrospective modification programme is being worked up which may see an alternative torch fitted on existing vehicles. The extinguisher securing is going to be moved through 180 degrees which will prevent the catching on trousers. Again this will happen for both new builds and in-house modification.

9. I should bring a cushion to work so I can reach the vehicles control pedals

[A] Individuals will need to go through a personal assessment to ensure a safe driving position is achieved and achievable. OH are involved in this process and recommendations for individuals may vary, i.e. use of a lumbar support cushion may be a recommendation for colleagues who require additional support due to lower back conditions.

10. Clearly the writers of final reports have never experienced patient care duties in the back of a Fiat DCA

[A] The expert is a forensic vehicle engineer with significant experience in vehicles and working with a range of emergency services. The SME input was achieved through two days of working with staff-side colleagues, discussions with staff at the station that housed the visit, H&S colleagues, the Driver Standards Manager, the Driver Training Manager (clinician), Fleet representatives with years of experience in designing from scratch and the Head of Fleet and Logistics (who is a current and practicing Paramedic). We did not engage the expert to advise on the merits of the van conversion as a clinical setting but advise on the safety of the vehicle and specifically to advise in regard to the issues raised with the seatbelt. Please refer back to the Driver User Group as the forum where we are seeking to get feedback from colleagues on challenges around the vehicles, and how they are addressed now and in future builds.

11. The Lord Rogers report was flawed; the outcome fell short

[A] The Lord Carter report in 2016 looking at unwarranted variation in ambulance services built on his previous report looking at the same types of issues in acute trusts. There was extensive engagement with key parties in relation to the report (and recommendations) including AACE and trade unions. For further assurance, we have requested evidence from the National Team who led on this of clinician input into the Lord Carter report as well as considerations for accessibility and EIA which would have supported the definition of the National Specification.

12. Depending on the weight of the crew / patient the vehicle may exceed its SWL

[A] The work is currently ongoing to understand what capacity is available post conversion for the new-builds. Carter specification stated that this should not exceed 95% of the Gross Vehicle Weight (GVW) of the plated vehicle (currently 4250kg) for a van conversion in its base specification. This allows for 5% of GVW to be managed by Trusts. We will not accept vehicles that are not compliant with the carter spec. Some of our internal options add weight and some remove weight, and the 95% calculation already includes 6 passengers and equipment, fully topped fluids, etc. The margin of 212.5kg is there to ensure that variations in weight by passengers, and other variations inclusive of safety features we have decided to include in our options as an example, never take the vehicle over 100%. We are building a one off full-spec vehicle to test out build before committing to further purchases, and we are seeking legal

contractual advice on our position if the vehicles exceed 95% from convertor, as we may be able to refuse the vehicles, however we would not be allowed under the NHS Contract to procure other vehicles without dispensation (we are pending the legal view on this point)

23.06.22 – Colin Hall

Question: I note although I was assured the ongoing problems with the Fiat Ambulances would be an agenda item, it has failed to appear on the agenda. Is there a reason for this? As this is a problem which may have a detrimental effect on the service provided by the trust may I request it is included on the agenda for the meeting on June 6.

Response (Julie Harris): Discussion surrounding the Fiat Ambulances will occur during the QPS NED report. You will note the following that was included on their March report to the board. If the Council have any questions on this matter, it would be appropriate to engage during the NED QPS report.

11.07.22 – Colin Hall

Question: The outstanding questions are: -

1 How many staff are at this time not driving the Fiat ambulances?

2 How many paramedics are required by the trust in order to have the optimum number?

3 Are you still waiting for a copy of the report that I requested a copy of.

Response (John Griffiths/Andy Rowe): We should have 70% registrant of 2555 so current vacancies = 356 but 150 are filled by pap so 206, however we should have 1788 registrants for 70% but these are filled by lower grade clinicians.

Regarding the RTC on the 5th January 2022 I can confirm that I continue to be the link between the Kent Police investigation and SECAmb. I have had 2 meetings in person with the Senior Investigating Officer, one in January and one a couple of weeks ago. I have provided the SIO with the information he requested since the RTC and our colleagues in IT and Driver Training Manager, have assisted with a reconstruction several months ago.

Their investigation is progressing, and they are now at the stage of writing their detailed forensic collision investigation report which will form part of the overall investigation. This part will always take a lengthy amount of time and I do not envisage getting any update from them before the end of this year.

Kent Police are unable to update me on anything further and all information they have requested from us, remains confidential as part of their investigation.

No internal investigation will take place until after the Police investigation is complete.

The number of staff currently not driving the Fiats is circa 360.

11.08.22 – Chris Burton

Question: I hope I am correct in addressing this e-mail to you, in hope that you may be able to disseminate some information to the appropriate NEDs.

I have recently been lucky to visit many of the stations across the whole of SECAmb.

During my travels and chats with crews, some general items have consistently been foremost.

1.One item that is common over all counties is some inconsistencies with equipment and uniform etc arriving on stations for new front-line staff to start their duties.

Some equipment / uniform has been late / not sent out to appropriate stations, sent to the wrong stations and staff iPads not sent out with the software for EPCR, loaded .

2.Operational team leaders (OTLs) are saying they are not trained in tech' to load the new iPads correctly. I wonder if we could ensure the all the soft tech is loaded properly by tech support, prior to issue.

Additionally, I would also like receive assurance that OTLS and Operational Managers secamb-wide have joined up thinking regarding local and corporate induction of new recruits.

Lastly, I was fortunate to see Chertsey Make Ready Station in post flood condition. It was a sad sight. Can the NEDs please receive assurance that all appropriate actions are taken to ensure Chertsey Station is refurbished in a timely manner (including newly painted floors). It is imperative this station is returned to service again quickly , because it causes unnecessary pressure to surrounding stations. (i.e extra staff personal cars and equipment on stations with limited capacity.).

Although these could be deemed as operational issues, I feel that assurance from the NEDs would be appropriate.

I would address this to the Welfare and workforce committee.

Response (Andy Rowe): This a known and shared frustration and to improve this we are writing a business case and change template for a one stop shop at Telford place.

We are meeting this week to merge onboarding and corporate induction into one.

With regards to Chertsey - we are hoping to move back into a better upgrade faculty business case depending.

Recommendations

2.2. The Council is asked to note this report.
2.3. 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. The new form will be circulated in due course.

Julie Harris
Assistant Company Secretary
(In the absence of a Lead Governor)

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report
Councill of Governors – September 2022

Best placed to care, the best place to work

Executive Summary

- The Integrated Performance Report is a key mechanism for providing assurance and monitoring of all aspects of the delivery of safe and effective patient care.
- CQC highlighted to the Trust that the quality of information presented to the Board and was insufficient, and that there was a lack of professional curiosity and triangulation of workforce, finance and quality data to make decisions and mitigate risk.
- The Trust has worked closely with NHSE to adopt the "Make Data Count" framework.
- The July Board saw the first iteration of the newly branded "Integrated Quality Report".
- Initial feedback from NHSE has been very positive – and we have now full alignment in our reporting and our "Improvement Journey", enabling the Board to monitor the delivery against it's strategic objectives and key risks in a more effective way.

- The development of the IQR is on-going:
  - Meaningful targets are required for effective assurance.
  - Development of this framework has highlighted that 75% of all data points are not available.
  - A roadmap for development is being developed to ensure we further strengthen the IQR and we align it to
  - Addition of an overall Balanced Scorecard, definition for all metrics, and B&H and ER detail will be added in September 2022 as a minimum

Before

- Report structured around CQC domains – poor link between actual CQC KLOE and metrics
- Data available driving reporting – rather than Trust priorities and strategic objectives
- Too much information – RAG – no consistency
- Weak link between report – trust strategic objectives – and improvement mechanism

Trust Overview: Summary of Performance Highlights

IPRID	Department	Metric
QS-1	Quality & Safety	Number of Datix Incidents
QS-13	Quality & Safety	Violence and Aggression Incid of Victims - Staff)
MM-1	Medicines Management	Number of Medicines Incident
MM-5	Medicines Management	Number of CD Breakages
QS-17	Quality & Safety	Outstanding Actions Relating t of Timescales
QS-19	Quality & Safety	Deep Clean Compliance %
QS-20	Quality & Safety	Health & Safety Incidents

IPRID	Department	Metric	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Target	Vs Target	Sparkline
QS-1	Quality & Safety	Number of Datix Incidents	1070	1149	1051	1175	1253	1493	1397	1149	1070	1398	1652	1706	1532	N/A	N/A	
QS-2	Quality & Safety	Number of Incidents Reported as SIs	7	1	7	3	6	11	5	1	7	6	5	5	5	N/A	N/A	
999-12	Operations 999	999 Frontline Hours Provided %	103.20%	96.90%	99.10%	99.30%	94.30%	90.10%	86.90%	88.00%	89.50%	92.60%	91.60%	92.74%	88.96%	100.00%	-	
QS-3	Quality & Safety	Duty of Candour Compliance %	100.00%	75.00%	100.00%	67.00%	100.00%	100.00%	100.00%	75.00%	100.00%	80.00%	100.00%	100.00%	100.00%	100.00%	=	
QS-7	Quality & Safety	Hand Hygiene Compliance %	93.00%	95.00%	94.00%	95.00%	95.00%	92.00%	90.00%	95.00%	93.00%	84.00%	81.00%	87.00%	78.00%	90.00%	-	
QS-8	Quality & Safety	Safeguarding Training Completed (Children) Level 2 %	82.00%	90.40%	88.70%	87.00%	87.30%	86.00%	86.20%	90.40%	82.00%	84.00%	84.20%	83.30%	83.61%	85.00%	-	
QS-13	Quality & Safety	Violence and Aggression Incidents (Number of Victims - Staff)	60	60	65	73	87	91	99	60	60	76	117	108	88	N/A	N/A	
MM-1	Medicines Management	Number of Medicines Incidents	142	173	152	171	118	156	141	157	165	146	153	107	89	N/A	N/A	
MM-3	Medicines Management	Single Witness Signature Use CDs Omnicell	9	4	3	2	3	6	7	14	5	13	23	38				
MM-4	Medicines Management	Single Witness Signature Use CDs Non-Omnicell	1	1	0	0	0	1	0	0	1	1	0	170				
MM-5	Medicines Management	Number of CD Breakages	10	27	16	16	19	10	17	9	29	20	16	22				
MM-7	Medicines Management	Medicines Management % of Audits Completed	88.00%	95.00%	95.00%	98.40%	98.70%	98.10%	97.90%	94.10%	91.90%	98.40%	98.50%	87.30%				
WF-1	Workforce HR	Number of Staff WTE (Excl bank and agency)	3968	3974	3945	3952	3957	3936	3939	3949	3965	3957	3934	3944				
WF-2	Workforce HR	Number of Staff Headcount (Exc bank and agency)	4358	4367	4335	4342	4350	4327	4336	4344	4365	4350	4337	4351				
WF-3	Workforce HR	Finance Establishment (WTE)	3956	3946	3946	3946	3946	4070	4060	4040	4033	3946	3996	3976				
WF-4	Workforce HR	Vacancy Rate %	-0.30%	-0.70%	0.10%	-0.10%	-0.20%	3.30%	3.00%	2.20%	1.70%	-0.20%	1.50%	0.80%				
QS-9	Quality & Safety	Number of RIDDOR Reports	12	8	10	11	14	17	14	8	12	15	11	7				
WF-16	Workforce HR	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%				
M-20	Medical	Compliant NHS Pathways Audits (Clinical) %	90.00%	93.00%	92.00%	92.00%	87.00%	97.00%	94.00%	95.00%	96.00%	96.00%	93.00%	82.00%				

111 Demand/Supply

	28/02	07/03	14/03	Last 13 Weeks
111 Call Volume	23750	26356	26720	
Calls Answered	18703	19051	18552	
Calls Answered % of Volume	78.7%	72.3%	69.4%	
% Calls Answered in 60 seconds (> 95%)	37.1%	24.0%	15.3%	
% Calls abandoned after 30 seconds(< 5%)	15.9%	21.7%	24.6%	

Note – Contracted volume is 24,730/week

CAT 1

	27/12	03/01	10/01	Last 13 Weeks
Mean	00:08:25	00:08:24	00:08:13	
90th Centile	00:15:37	00:15:16	00:15:09	
RPI	1.53	1.60	1.56	
Count of Incidents	1179	1000	968	

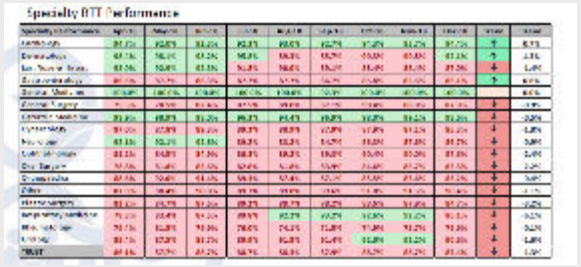
CAT 1T

	27/12	03/01	10/01	Last 13 Weeks
Mean	00:10:35	00:09:56	00:09:58	
90th Centile	00:19:48	00:18:29	00:18:45	
RPI	1.54	1.63	1.53	
Count of Incidents	722	635	591	

WN2 – Quality of Information and Board Assurance

CQC requirement	CQC Finding	Action type
The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge.	*The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge. A read of the executive board and sub board committee papers showed limited triangulation of information for example; quality, workforce and finance, to assist effective understanding and mitigation of risk. There was limited evidence of effective and timely actions being taken when risks had been identified or holding to account for such actions.*	***Warning notice (Section 29A) WN2*** 

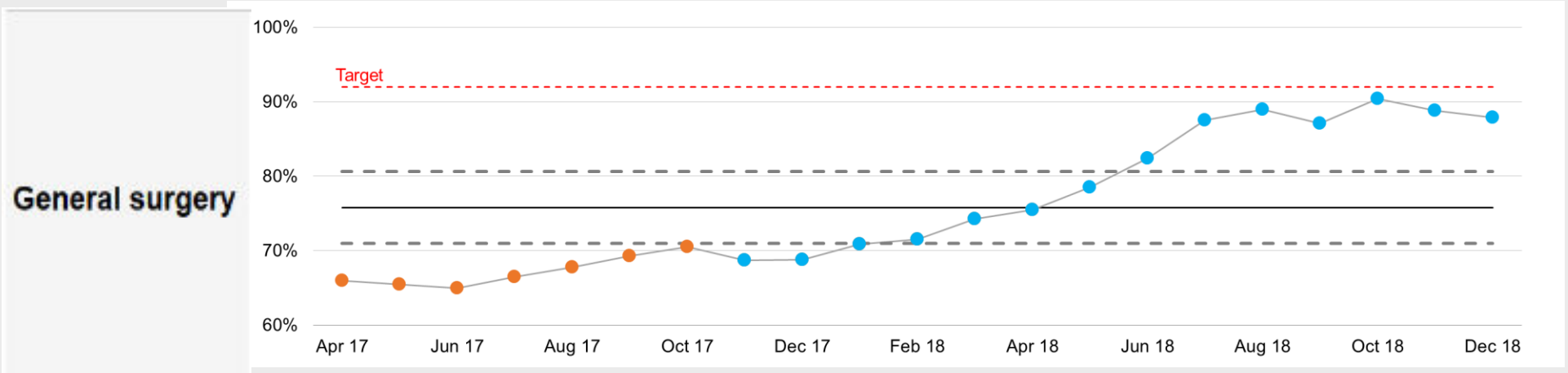
Making Data Count



General Surgery

General Surgery	75.5%	78.5%	82.4%	87.5%	89.0%	87.1%	90.4%	88.8%	87.9%	↓	-0.9%

Decline & Failing?



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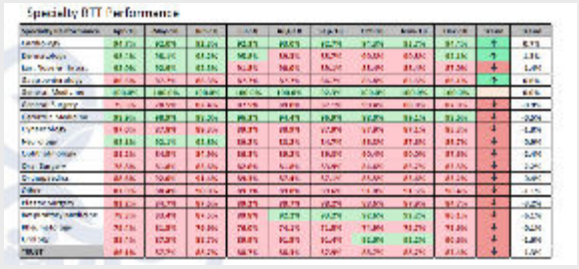


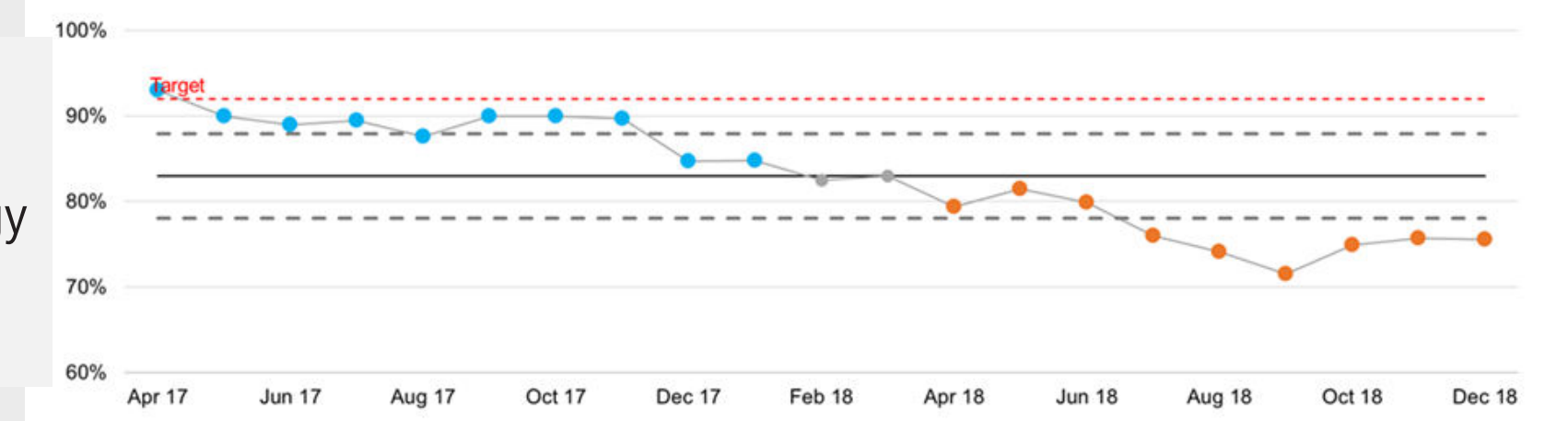
Rheumatology

Rheumatology	79.4%	81.5%	79.9%	76.0%	74.1%	71.5%	74.9%	75.7%	75.6%	↓	-0.1%

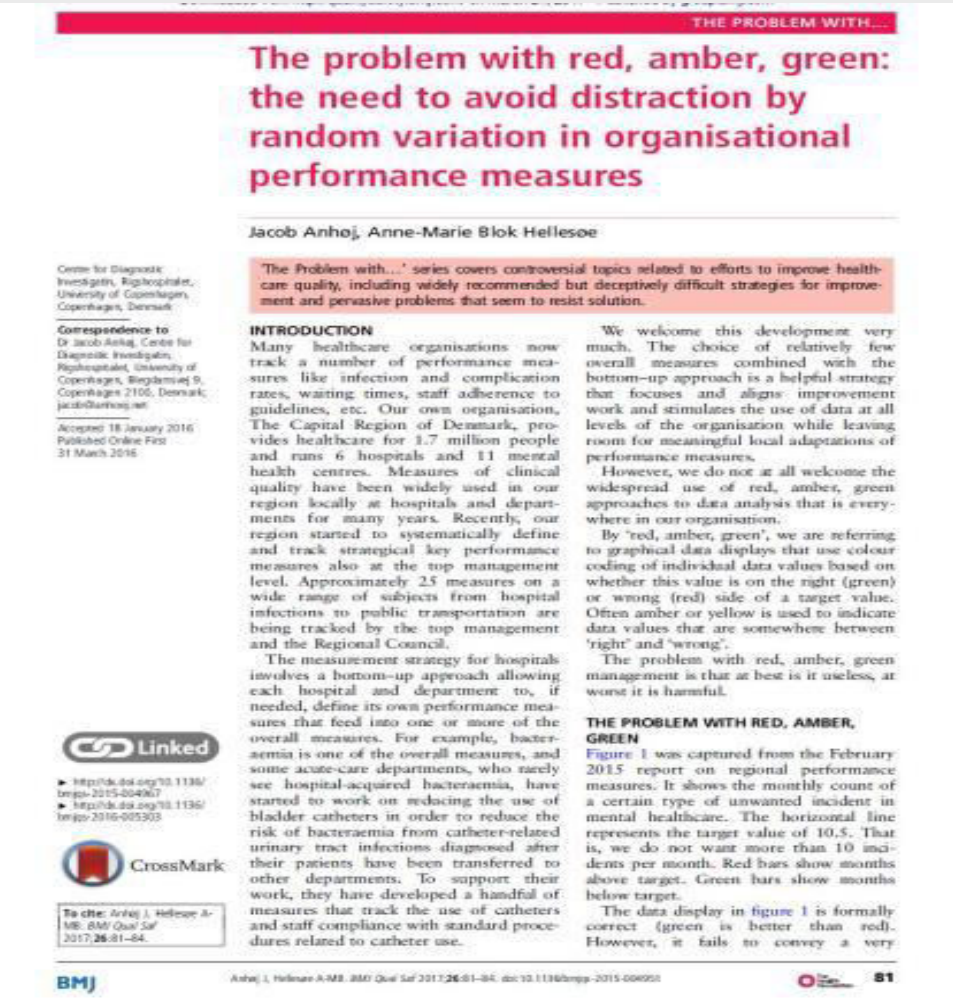
↓

Same misinterpretation as before?

Rheumatology



Strong Evidence Base



THE PROBLEM WITH...

The problem with red, amber, green: the need to avoid distraction by random variation in organisational performance measures

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'The Problem with...' series covers controversial topics related to efforts to improve healthcare quality, including widely recommended but deceptively difficult strategies for improvement and pervasive problems that seem to resist solution.

INTRODUCTION

Many healthcare organisations now track a number of performance measures like infection and complication rates, waiting times, staff adherence to guidelines, etc. Our own organisation, The Capital Region of Denmark, provides healthcare for 1.7 million people and runs 6 hospitals and 11 mental health centres. Measures of clinical quality have been widely used in our region locally at hospitals and departments for many years. Recently, our region started to systematically define and track strategical key performance measures also at the top management level. Approximately 25 measures on a wide range of subjects from hospital infections to public transportation are being tracked by the top management and the Regional Council.

The measurement strategy for hospitals involves a bottom-up approach allowing each hospital and department to, if needed, define its own performance measures that feed into one or more of the overall measures. For example, bacteraemia is one of the overall measures, and some acute-care departments, who rarely see hospital-acquired bacteraemia, have started to work on reducing the use of bladder catheters in order to reduce the risk of bacteraemia from catheter-related urinary tract infections diagnosed after their patients have been transferred to other departments. To support their work, they have developed a handful of measures that track the use of catheters and staff compliance with standard procedures related to catheter use.

We welcome this development very much. The choice of relatively few overall measures combined with the bottom-up approach is a helpful strategy that focuses and aligns improvement work and stimulates the use of data at all levels of the organisation while leaving room for meaningful local adaptations of performance measures.

However, we do not at all welcome the widespread use of red, amber, green approaches to data analysis that is everywhere in our organisation.

By 'red, amber, green', we are referring to graphical data displays that use colour coding of individual data values based on whether this value is on the right (green) or wrong (red) side of a target value. Often amber or yellow is used to indicate data values that are somewhere between 'right' and 'wrong'.

The problem with red, amber, green management is that at best is it useless, at worst it is harmful.

THE PROBLEM WITH RED, AMBER, GREEN

Figure 1 was captured from the February 2015 report on regional performance measures. It shows the monthly count of a certain type of unwanted incident in mental healthcare. The horizontal line represents the target value of 10.5. That is, we do not want more than 10 incidents per month. Red bars show months above target. Green bars show months below target.

The data display in figure 1 is formally correct (green is better than red). However, it fails to convey a very

Linked

► http://dx.doi.org/10.1136/bmjqs-2015-004067
► http://dx.doi.org/10.1136/bmjqs-2016-005303

CrossMark

To cite: Anhøj J, Hellesøe A-MB. *BMJ Qual Saf* 2017;**26**:81–84.

EDITORIAL

From stoplight reports to time series: equipping boards and leadership teams to drive better decisions

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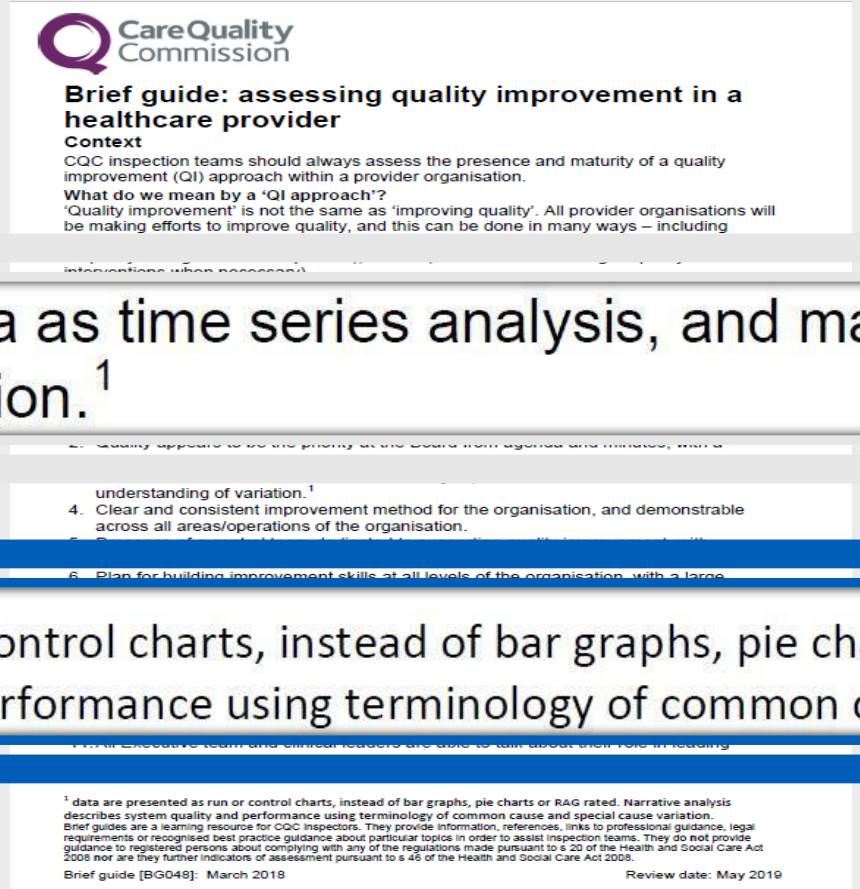
One of us was shown a letter received by a hospital infection control leader from the CEO congratulating her on an excellent monthly performance—for the previous month MRSA infections had decreased from 4 to 2 cases. A couple of months later the same CEO sent a letter expressing serious concern, asking for an explanation of why the monthly MRSA cases had doubled from 2 to 4. Implicit in the CEO's letter is an all too common misunderstanding when using point-to-point data comparisons that every data point is a signal of meaningful change. Absent any information about or understanding of the nature and extent of the underlying variation of the process or event type being analysed, in point-to-point comparisons the only thing one can be sure of is that the second data point will likely be either higher or lower than the preceding data point.

Common to board members, corporate-suite executives, directors and managers is the need to rapidly interpret key data and to decide what if any actions are needed. Two papers in this edition highlight the critical need to ensure that such data presentations do not lead decision-makers astray. In the first paper by Schmidtke *et al*,[1] analysing data presented to Boards of English NHS isolation. Together these two papers are useful contributions to a literature about what forms of data decision-making groups should see in order to focus attention on the most pressing areas, to understand the causes that underpin what the data show, and determine what action should follow. The central question is: how to get data to decision-makers in a form which drives the most useful decision-making?

Anhøj *et al* make the striking claim that red, amber, green management reporting is at best useless and at worst harmful. These reports rely on the simple colour-coded heuristic of 'green is good... proceed as is', 'yellow or amber is warning...proceed with caution' and 'red is bad...stop and take action'. We think their critique is a bit too stark: there are situations when application of the stoplight type reporting may be appropriate. For example, in situations in which process reliability should be 100%—for example, as with never events—each data point can represent a meaningful signal. Likewise for well understood, tightly controlled processes with little inherent variation, stoplight reports may be of value. The primary advantage of stoplight reports is their simplicity and ease with which a large amount of information can be quickly presented.

Linked

Signs of a mature QI Approach



Care Quality Commission

Brief guide: assessing quality improvement in a healthcare provider

Context

CQC inspection teams should always assess the presence and maturity of a quality improvement (QI) approach within a provider organisation.

What do we mean by a 'QI approach'?

'Quality improvement' is not the same as 'improving quality'. All provider organisations will be making efforts to improve quality, and this can be done in many ways – including

3. The Board looks at data as time series analysis, and makes decisions based on an understanding of variation.[1]

understanding of variation.[1]

4. Clear and consistent improvement method for the organisation, and demonstrable across all areas/operations of the organisation.

[1] data are presented as run or control charts, instead of bar graphs, pie charts or RAG rated. Narrative analysis describes system quality and performance using terminology of common cause and special cause variation.

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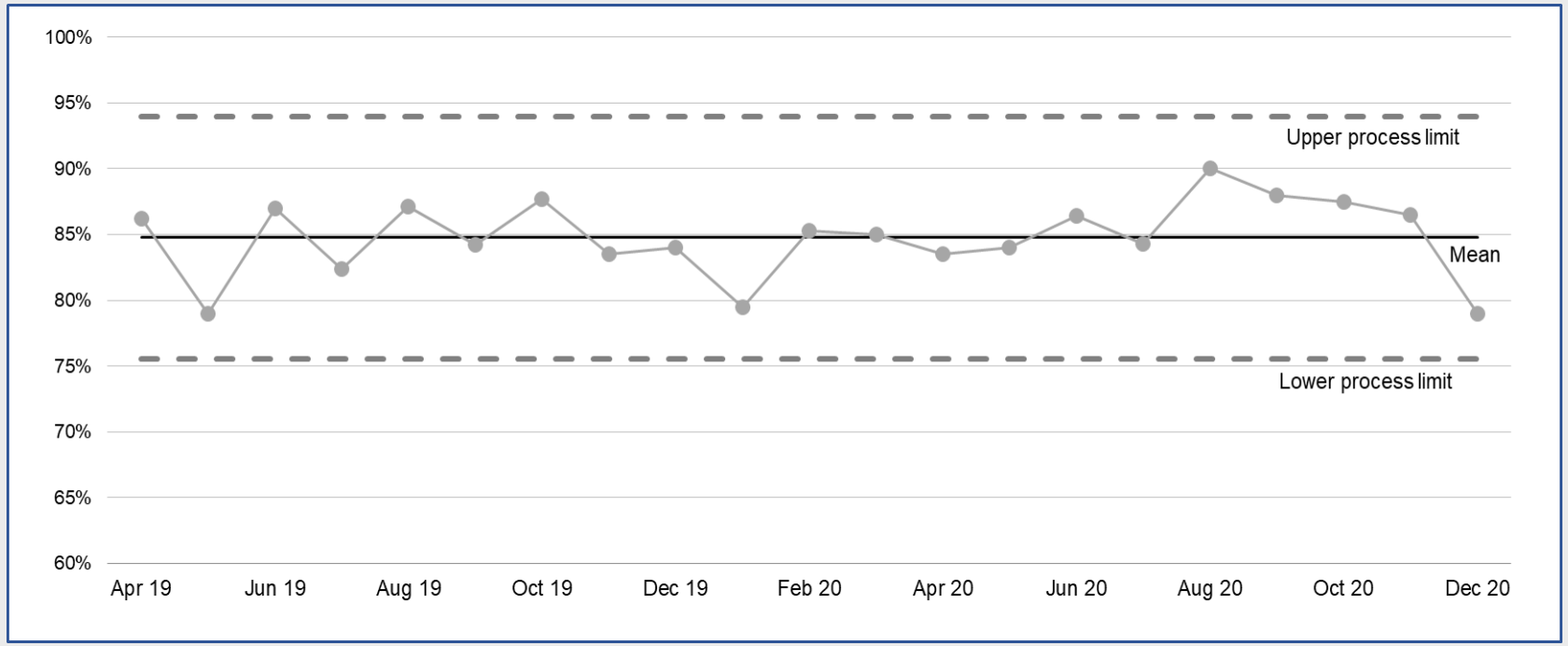
Brief guides are a learning resource for CQC inspectors. They provide information, references, links to professional guidance, legal requirements or recognised best practice guidance about particular topics in order to assist inspection teams. They do **not** provide guidance to registered persons about complying with any of the regulations made pursuant to s 20 of the Health and Social Care Act 2008 nor are they further indicators of assessment pursuant to s 46 of the Health and Social Care Act 2008.

Brief guide [BG048]: March 2018 Review date: May 2019

https://www.cqc.org.uk/sites/default/files/9001395_Brief_guide_Assessing_quality_improvement_in_a_healthcare_provider.pdf

Anatomy of an SPC Chart

Time series line chart with 3 reference lines

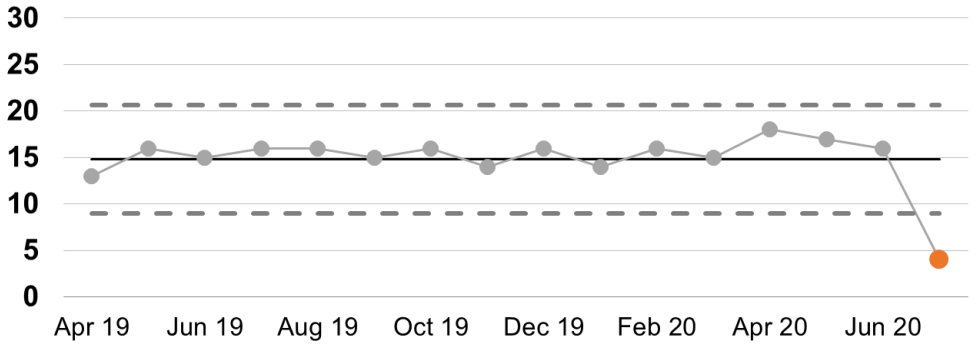


≈ 99% of data

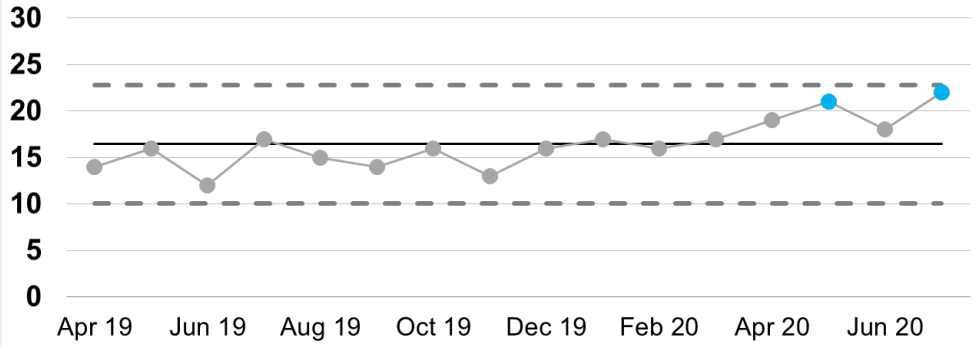
15+ data points for a robust analysis

Special cause variation – something to talk about

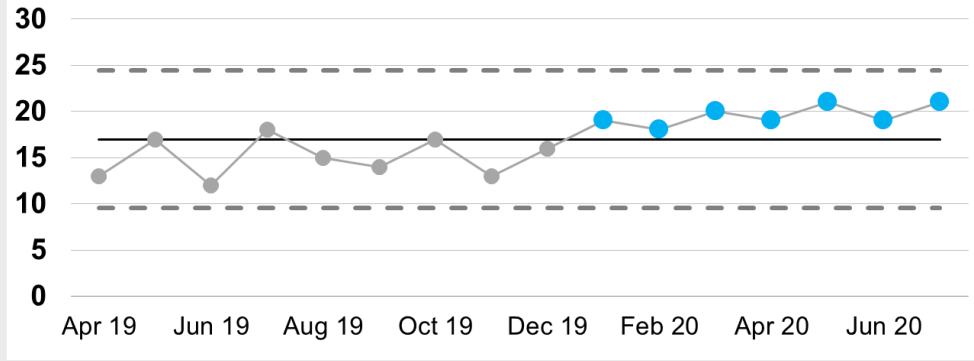
A single point outside the process limits



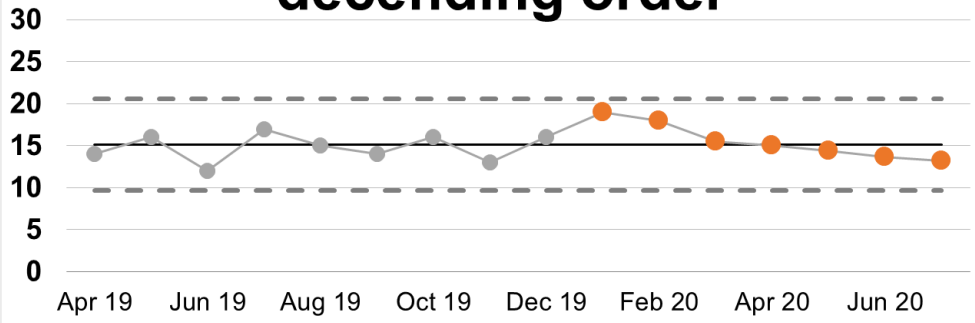
Two out of three points close to a process limit



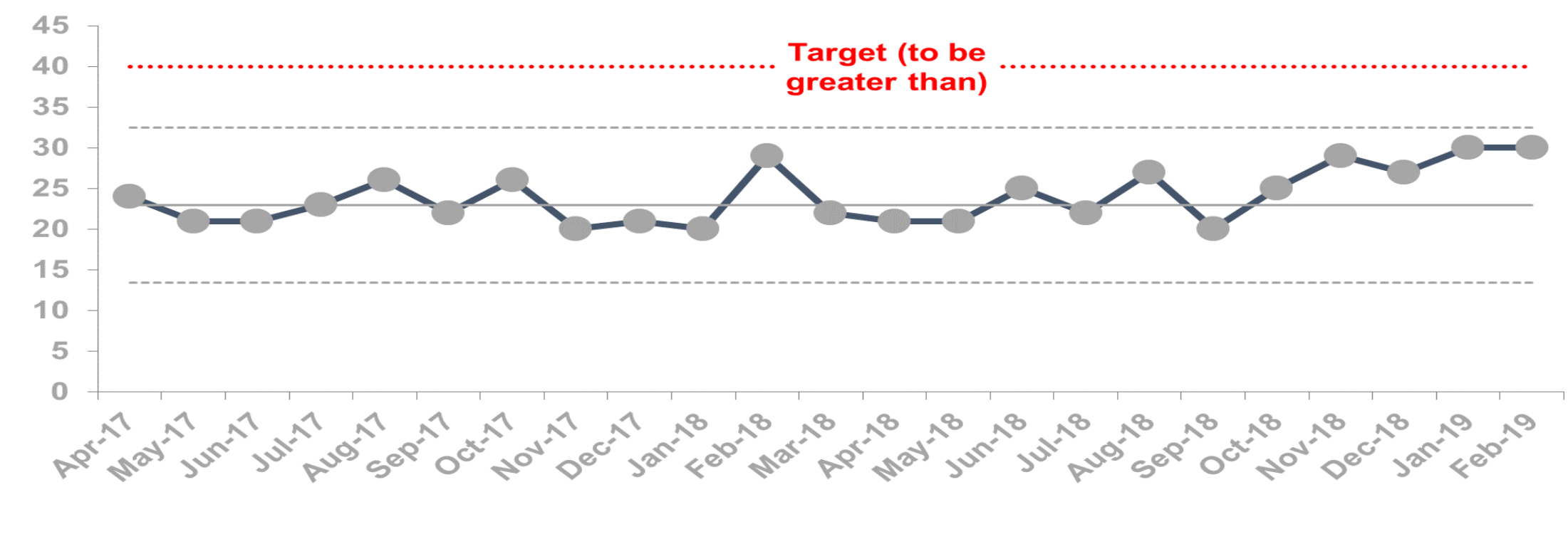
A shift of points above / below the mean



A run of points in consecutive ascending or decending order

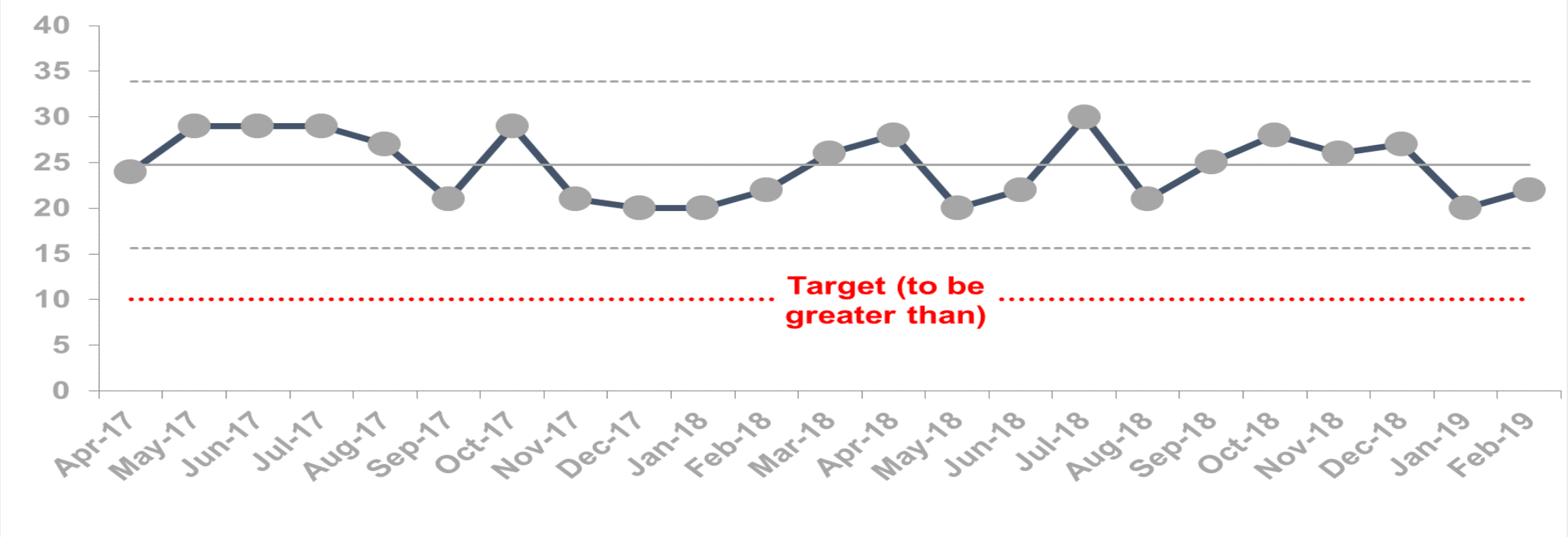


No rules triggered = common cause



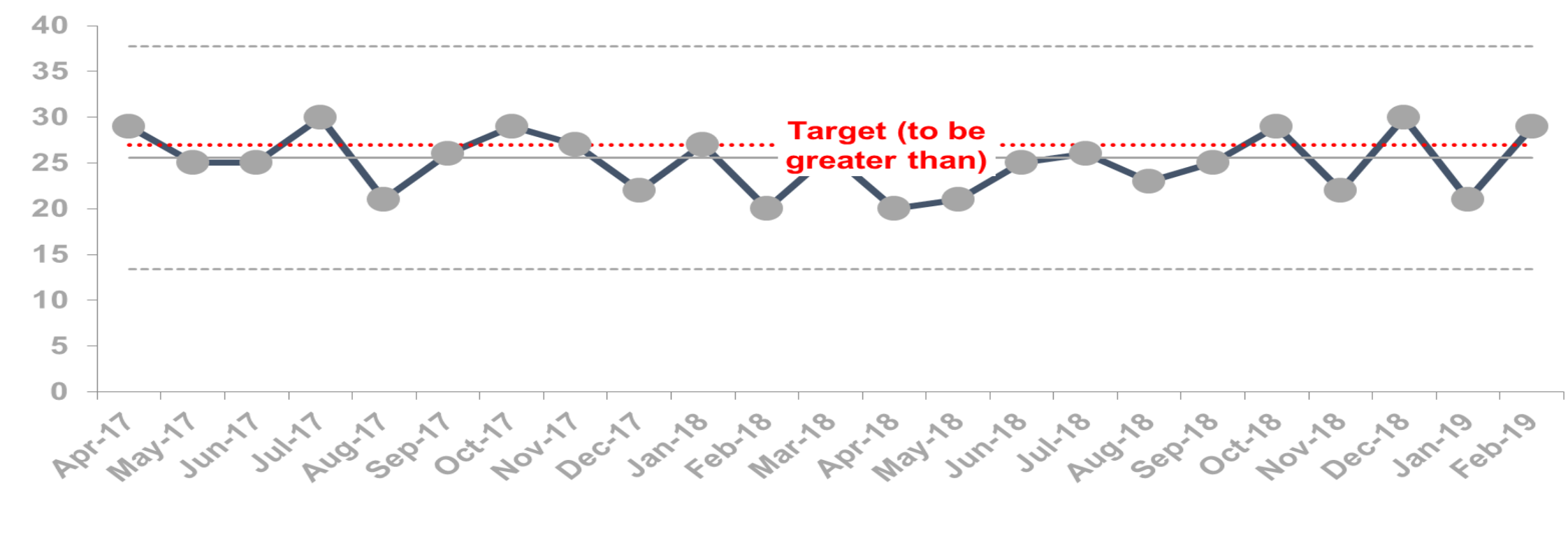
Redesign the system

SPC for assurance



Capable system

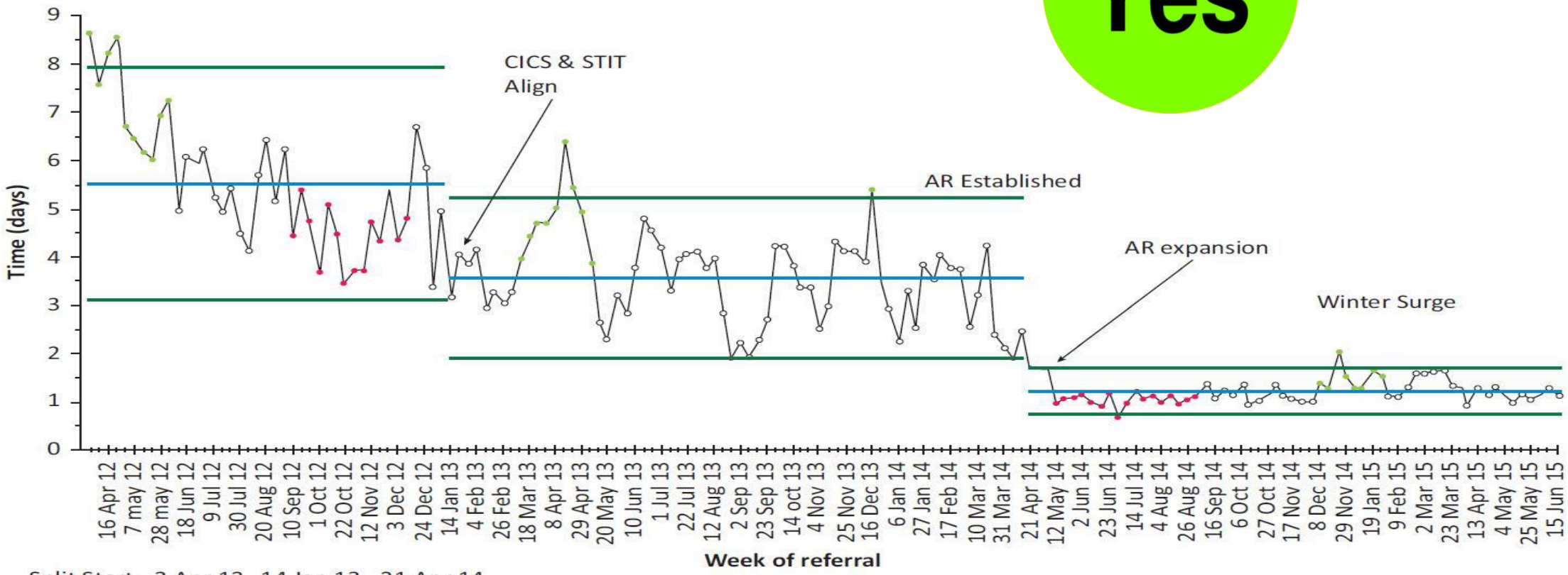
SPC for assurance



Will not reliably hit the target

Did our changes work?

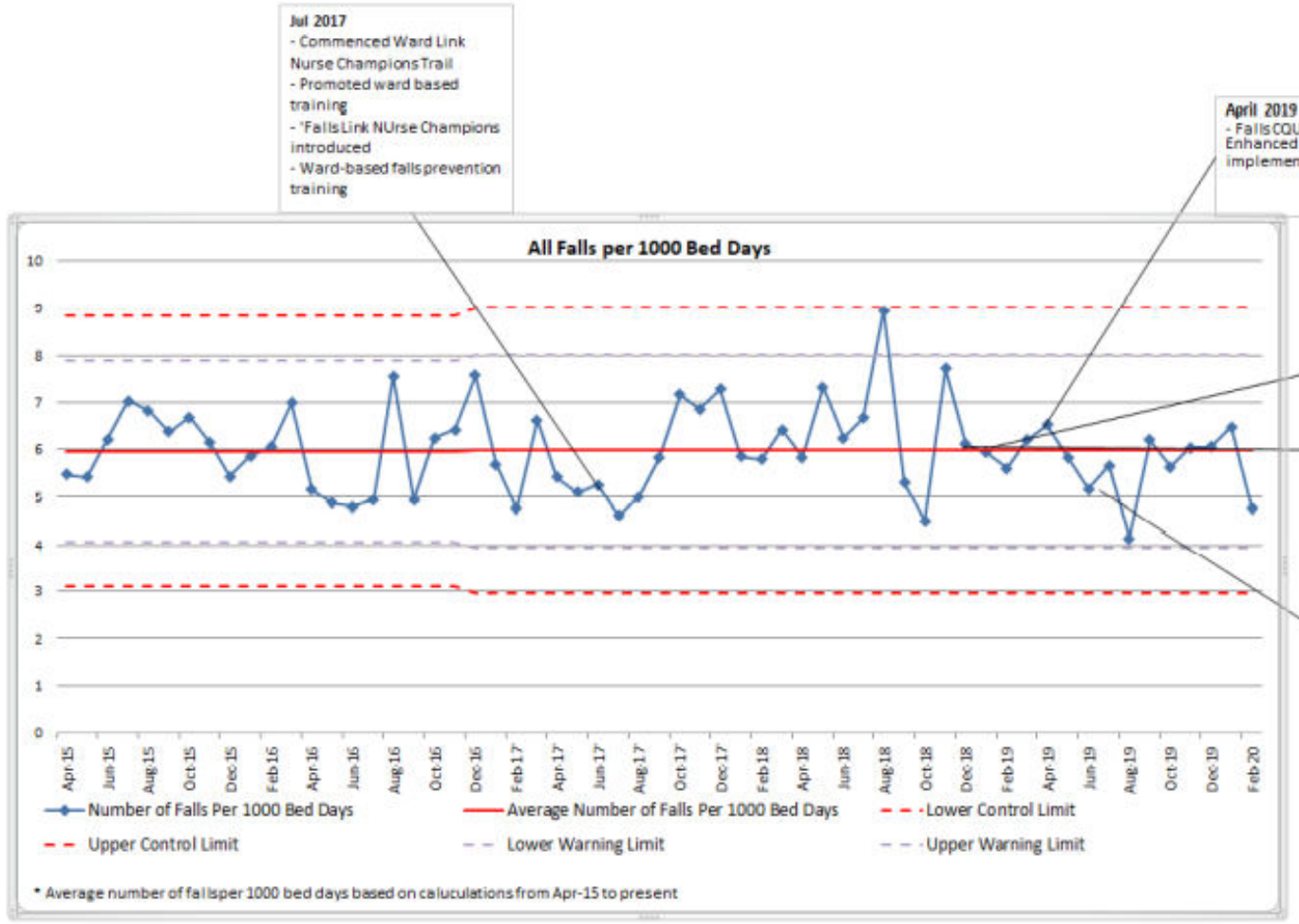
Yes



Split Start	2 Apr 12	14 Jan 13	21 Apr 14
U.C.L.	−7.9	5.2	1.7
Mean	−5.5	6.6	1.2

Fig 2. Reducing patient wait for active recovery from a hospital bed. AR = Active Recovery; CICS = Community Intermediate Care Service; STIT = Short Term Intervention Team

Did our changes work?



Were these the correct interventions?

Did we implement them properly?

Are there other factors we should consider?

WN2 - Board Reporting Alignment and IQR

Improvement Journey

Quality Improvement	Responsive Care	People and Culture	Sustainability
Embedding quality amongst everything we do	*Improving operational performance and patient care*	*Improving our culture, engage our people, and support development of our teams*	*Ensuring long-term sustainability*
Patients	***Service***	***People***	***Sustainable***
- *Incident Management* - *Medicines Management* - *Patient Experience* - *Safeguarding* - *Safety in the workplace* - *Impact on Patient Care*	- *Ambulance Quality Indicators* - *Call Handling* - *Utilisation* - *999 Frontline Efficiency* - *Supporting the system* - *111 Operation*	- *Employee Experience* - *Workforce* - *Wellbeing*	- *Delivery against Plan*

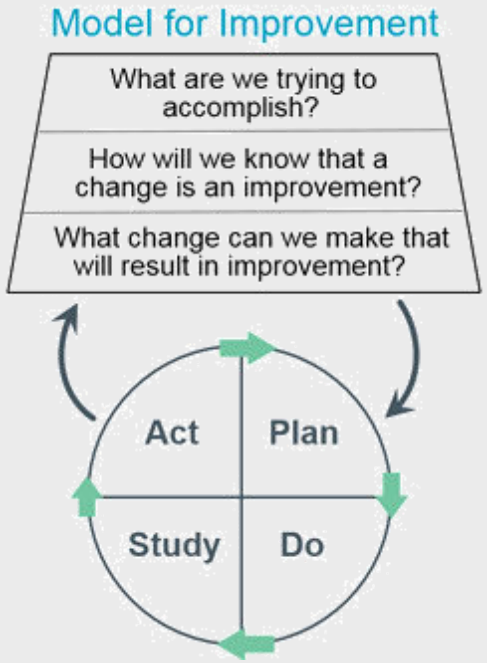
IQR Themes

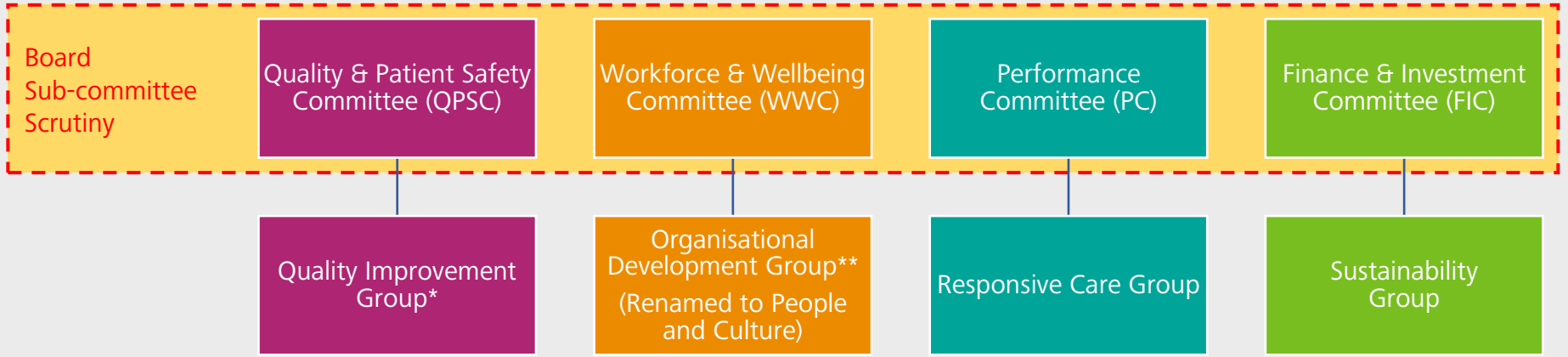
Key Messages:

1. Significantly improved Quality of information enabling triangulation of workforce, finance, culture, performance data
2. Positive feedback received from NHS MDC Team – further development planned in August and September with targeted Board Development from MDC
3. Focus now to develop a framework that expands beyond Board and to all levels of the organisation

WN2 - Integrated Quality Report

WN2 - Board sub-committee alignment and assurance





Key Messages:

1. Alignment of the Sub-committees of the Board, with the Improvement Journey "pillars", Trust Priorities, and the IQR, enables for the first time a structure that allows full line of sight of the effectiveness of the plans in place to deliver improvements
2. Sub-committees to conduct 2x targeted deep dives per session going forward in alignment with Improvement journey plan

SECAMB Board

Performance Committee Escalation Report to the Board

Date of meeting	23 June 2022
Overview of key issues/areas covered at the meeting:	Under **escalation**, an update was given on the work on the *improvement journey*, in particular the Responsive Care priority. The Director of Operations took the committee through the highlight (flash) report, setting out the structure and aim. Progress to-date was noted including the risks and issues. The committee reinforced the need for the golden thread to patient care and challenged the executive to refrain from describing aims in managerial speak, for example the objective related to rotas is really about being able to provide more timely quality care and supporting the workforce. There was also challenged about the comms plan that sits alongside the improvement journey; this must be more strategic to ensure coherent top line messages that has the golden thread of people and quality. And ensuring we engage continually to ensure we continue to focus on the right things. The committee noted the capacity risks to deliver this and asked the executive to ensure it is really open with Board on what the support gaps are. The first part of the meeting focussed on **planning and forecasting**. **Integrated Plan: 2022 – 2023** This looked at the workforce plan at month 2. The Trust is aiming to deliver a total frontline workforce of at least 2555 WTE, comprising a combination of substantive staff, overtime, and private ambulance providers. The substantive staff was planned to be 2228 WTE as of May 2022. However, the Trust is currently 78 WTE below this target position, at 2150 WTE. The executive confirmed that to mitigate this, additional courses have been created later in the year to catch up to the original recruitment plan, which sees the Trust back on track by August 2022. By August therefore, if the plan is not back on track, we will know whether the mitigating plans are working. The committee requires a greater level of assurance about the balance between road staff and staff in the EOC, i.e. the nature of our operating model. This remains the longer-term plan. Initial workstreams within the Responsive priority of the improvement plan helps to establish the baseline and then the evidence we need to inform a new operating model. There was also a helpful discussion about this one-year plan being heavily focussed on the supply-side. The strategic solution will be to drive demand issues and how we reduce / redirect system demand. Unless this is done as a system trying to meet demand (patient need) will be a constant challenge. **12-week look ahead** The committee noted in March we exceeded the projected performance levels but this would be unlikely to continue; the projections for C2 mean is around the 35min

	range. The meeting then reviewed **current performance** levels. In May ARP improved and we compare well relative to other ambulance services. ARP though in past few weeks has seen a noticeable deterioration linked to staffing issues. 111 performance challenges continue also. The **performance improvement plan** was reviewed using SPC charts (linked to the work on the IPR) to show true trends and variation. This helped to identify a number of gaps in assurance and specific hotpots. The committee noted a number of areas failing, requiring process redesign. While the committee needs greater assurance with the actions being taken it is assured there is executive focus. In future it has asked for clearer timelines for resolution along with more specific plans, which will be provided via the Improvement Journey. **Performance & Patient Harm / Colleague Wellbeing Correlation Analysis** Analysis was completed to help support discussions with commissioners related to funding and link between resources and performance (quality and safety). ▪ Using Category 2 Mean as a proxy for overall performance – we can describe with some certainty the relationship between delayed responses and patient harm. ▪ Where we have seen C2 Mean exceed 30 minutes, we see between a 2.5x and a 3x in verified patient harm, taking us to the region between 15 and 18 reported incidents of harm every 5 days. ▪ In addition, overall incident reporting has doubled in volume in Q4 of 21/22 versus the 2019 baseline. This is putting a significant strain on our ability to process incidents, in turn creating significant backlogs in our investigation processes and is an indication of the level of strain and moral injury staff who report the incidents are under. Weekly reported incidents involving a patient death has increased by 10. This reinforces that ARP standards directly links to patient quality and safety.
Any other matters the Committee wishes to escalate to the Board	In terms of overall assurance, there is more assurance on the Integrated Plan (to reach the commissioned 2555 WTE) but this position will be clearer in August. The committee welcomes the increasing ability to forecast and plan, but even the best-case improvement trajectory (linked to the 2555 WTE) still falls short of achieving the ARP standards.

SECAmb Board

QPS Committee Escalation Report to the Board

Date of meeting	Thursday 21 July 2022
Overview of key issues/areas covered at the meeting:	The Committee received three executive escalations: 1. **Extreme heat – impact on patients and staff** Through NASMed the medical director linked with British Columbia, Canada to learn from their experiences through extreme heat. This provided some insight in to where to direct our areas of concern. Patients with Schizophrenia and mental health problems were seen to be more at risk, this information was passed to our Mental Health team for their awareness. Air pollution would be poor, this may lead to an increase in stroke and STEMI patients going forward. The Trust used both internal messaging and Public Health messages. In terms of staff support we mandated the second refreshment break, and as temperatures increased a 10-minute timeout was introduced, where staff could go to a place that was known to have aircon to cool down. NHSP guidance was recirculated every 24 hours on keeping rehydrated. Hospital handovers were good in general and adhered to the 30-minute mandate. A post heatwave review to be completed and lessons to be learnt and cascaded. 2. **COVID management** – clarification required on current Trust Covid management and PPE. It was confirmed that universal mask wearing for all patient contact is still in place along with dynamic risk assessments for staff to decide the level of PPE they will wear. 3. **Serious Incident Management (demand & capacity)** – Challenging period over the last two weeks due to delayed hospital handovers and increased response times to patients. Level of harm incidents has increased from 22 to 46 within a week. Additional review meetings are being undertaken but this is labour intensive and stretching existing resource. Root cause is a system wide demand and capacity misalignment. The Trust plans to work with our system partners and Commissioners and hold a round table approach to complete the reviews and agree solutions together. There was one *Management Response* (related to gaps in assurance from previous meetings): **NHS Pathways audits** The committee asked for this management response to cover more detail on how we are using the learning from audit to improve practice, where there are gaps and any actions being taken to address these. There was some challenge on timescales and whether an interim plan could be looked at. This is ongoing to support with one to ones and appraisals. There was discussion on how the Trust feeds back to NHS Pathways, the EOC team are in contact with NHSP weekly to escalate any issues. The main changes expected may be local and related to how we managed defibrillation and cardiac arrest calls. The main *scrutiny items* were as follows: **Specialist Care Scope of Practice – CCP** The committee received the paper which included how the scope of practice is set for Critical Care Paramedics (CCPs), how we ensure this continues to be accurate and in line with best practice guidance and current evidence, and the processes taken to ensure compliance and safe clinical practice.

The committee noted that this group of staff sit under a regional management structure working locally at Operating Units and have a high retention in comparison to other areas of the Trust.

The CCP team undertake remote clinical supervision, but the Committee asked how the wider clinical supervision work is progressing. The committee challenged on when they would likely see a timeframe for the introduction of the clinical supervision framework.

The Committee supported the career framework of clinical progression and how staff can progress.

Integrated Learning
An update was given on the Integrated Dashboard development, the first development draft will be ready w/c 25 July. This is part of the Making Data Count workstream. The committee will review the new Quality Dashboard in September.

Safeguarding
The Committee received the Safeguarding Annual report showing that there is a good level of Safeguarding reporting throughout the Trust and that staff are aware of their responsibilities in this. This year we will move to quarterly reporting.

Concerns were raised by the CQC about the low percentage of level 3 training completed by registered staff. This will recommence in September, with a target of 85% completion by the end January 2022/23.

The introduction of a Safeguarding out of hours on-call function during the pandemic has demonstrated a benefit to both patients and staff.

The committee explored whether there are areas of the safeguarding agenda that the Trust needs to improve on, linking in with the FTSU highlights. The team acknowledge that they have not shared where the team have impacted patient safety and will look at how they can do this going forward.

The team are reviewing how they manage allegations made against staff and further development is needed to link with the Trust culture change programme.

Medicines Governance
The Committee received the paper that focussed on the Medicines Distribution Centre, prescribing in the 111 service, anti-microbial stewardship and the medicines management review commissioned by the Executive Director of Quality & Nursing.

The committee noted that of the 17 medicines risks, eight have non-effective controls. It asked for clarity on the timelines for the actions being taken.

Serious Incidents/ Harm Reviews - Partial Assurance
The Committee received the new style of report, which is still in development, that gives the Committee assurance rather than reassurance.

The Committee noted that poor patient experience is increasing, the team are actively working on this, but this is linked to the demand being placed upon the Trust.

The Committee asked that external best practice be integrated into the Quality Improvement programme to assist in formulating our next steps. The priority for the QI programme will be improving patient safety through learning from incidents.

The committee asked for assurance on the capacity of the team to manage the demand.

The Committee thanked the team for the work that has been done so far on reducing the

	significant backlog of incidents. **End of Life Care** The committee noted the concerns around how end of life care calls are coded and how we can develop a dashboard that links with the regional teams, and it welcomed the move to developing an End-of-Life Care Strategy. The Committee have asked for a Board Seminar on how the Trust manages End of Life Care and how we can work across our region with our ICB to develop this area. **Learning from Deaths Q3 Report** The Committee received the Q3 report and noted that a significant number of incidents that the Trust attends have either a ReSPECT or DNACPR order in place. This report has identified areas of poor or adequate care using the Structured Judgemental Reviews (SJR) this is linked to delayed response to C1 calls. This does not translate to avoidable deaths, which is good. The level of compassion shown by our staff to relatives of patients that have died remains high. The reviews are a statutory requirement, but the team are looking at other potential learning that can be gained by adapting the reviews.
Any other matters the Committee wishes to escalate to the Board	It was a constructive meeting. The papers presented at this meeting were well written and presented in a good way. The Committee noted that there are gaps in capacity in the portfolios that reported today, the Executive have been asked what the risks are associated with these gaps and how can the Trust address them.

SECAMB Board

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

Date of meeting	30 May 2022
Overview of key issues/areas covered at the meeting:	**End of year Financial Summary 2021/22** There was a detailed review of the end of year accounts which show a deficit of £4.9m, which include a £1.5m gain on property disposals and a £1.2m impairment reversal as a result of a revaluation. Therefore, after excluding these items the deficit for the year was £7.6m, which was £2.0m better than the planned deficit of £9.6m. An external Audit of the financial accounts is presently underway by KPMG. The cash balance at year end was £62.6m, significantly above plan due to property sales and a large value of capital accruals. The Committee requested this needs to be articulated clearly in the financial reporting, noting that although this is a timing issue, it impacts hugely on the cash position and could result in a perception that cash is not being effectively managed. CIPS were £4.7m against a target of £5.9m (27% of these savings delivered were non-recurrent). **Month 1 – Financial Performance** There was a detailed review of month 1 performance summary: - Month 1 is reporting a deficit of £2.6m in line with plan - both income and expenditure are in line to plan - Planned hours in the month were 7% below the planned trajectory towards 2670 WTE – overtime represented 10.5% of the total hours provided. - Cash fell from £62.6m to £52.9m due partly to the deficit and partly to due to the settlement of capital creditors. - Capital spend in the month was £1.1m against a plan of £1.9m The initial five-year Capital Plan was submitted to NHSE&I on 17 March 2022, a final submission is due on 20 June. Members agreed the Capital Plan remains at risk with proposed changes in the financial regime meaning that limits on ICS capital spending could be enforced on Foundation Trusts. The plan will need to be closely monitored and expenditure appropriately prioritised. More work is required to align the Vehicle Fleet spend. **Financial Planning and Commissioned Contracts** A long stop has been agreed with Commissioners until funding discussions are completed, this includes certain specifics still being worked on such as service specification, data quality impacts and the service development improvement plan. Results have been compared to the latest submitted plan, with a deficit of £39m, although a further planning submission is due on 20 June 2022. No account has yet been taken in the plan of the recently announced funding boost which is estimated to reduce the planned deficit in 999 by c£14m. Discussions continue with Commissioners and NHSE/I on drivers and potential funding of the remaining gap. Concern was raised around the 111-funding gap, currently 7% below trajectory, which unless urgently addressed will continue to rollover and increase. Mitigations are being developed in discussions with the ICS to scrutinize on a more granular level. The proposal will be to negotiate further income for 111 or not to resource up to the planned level unless the additional funding is received. It is anticipated there will be a 20% rise in 111 calls for the next

	year, which technically the Trust will be unable to respond to. There is a considerable risk to not only finances but patient safety and quality. The committee is partially assured with the approach and process of planning until we are clearer about outcomes, and particularly in relation to Capital funding. A verbal update was received around the Trust's NHS commissioned contracts, it was noted that the Paediatric Transfer initiative ceased on 31 March, along with the Adult Critical Care Contract. CQUIN funding will commence again this year (this equates to 1.25% of the 999-contract figure). Requests for the Trust to support individual events are being reviewed on a case-by-case basis to ensure they align with Trust Strategy and do not divert resources away. **Private Ambulance Providers (PAP's)** The Committee received a helpful paper containing the current contractual arrangements for PAP's which included legacy background, current contract status/plans for 2022/23 and PAP governance arrangements. It was noted that for the past two years PAP DCA's have accounted for approximately 5% of total operational resource. PAP provision is contracted to 31 March 2023, and the current PAP Procurement Framework expires on 31 August 2022. The Committee were assured by the management of the contract and steps being taken to enhance and extend the PAP contract, and aligning it to the longer workforce strategic plan, noting it needs to be a five-year outlook with some assurance of funding longer term. **Fleet Strategy** Members were pleased to receive a progress report on the Fleet Strategy refresh, and noted the positive steps being made to understand and align the different elements involved in refreshing the Strategy to ensure it is more future proof and data driven. Detailed discussion took place around the FIAT issues, and the Committee were assured that everything that could be done was being done to ensure resolution safely and at pace, including the support of an external forensic engineer, and including Union, HR and Legal colleagues. It was clear that more work is need around understanding the fleet requirement, and in particular the DCA requirements and how they align to the Capital Plan. The Committee requested more detailed work around this to establish any gaps in lease costs against potential capital costs, particularly in light of some additional DCA funding available centrally (although match funded). **Green Strategy** Members noted that the Business Case to commission an external company to help implement the Green Strategy is due to be reviewed at the Business Case Group Meeting in mid-June. FIC will continue to track progress, as work is expected to be completed on the Delivery Plan by Q4.
Any other matters the Committee wishes to escalate to the Board	This was another good meeting with constructive debate and exploration of important issues. On reviewing the effectiveness of the meeting members discussed the thread of Quality evidenced throughout and agreed that all future FIC papers and slides will include a statement around their impact on quality and patient care. Whilst aspects of Quality were being captured verbally, this needed to be evidenced robustly in written papers.

SECamb Board

Summary Report on the Audit & Risk Committee

Date of meeting	**14 July 2022**
Overview of issues/areas covered at the meeting:	
Internal Audit	Two **Internal Audit Reviews** were considered at this meeting. Reasonable Assurance was provided for Community Resilience and Financial Services. There was also a review of the Data Security Protection Toolkit which provided Moderate Assurance. In the review of the annual audit plan, the committee explored the increasing concern about HR and management issues. It asked for an independent view of these issues and the Chief Executive will discuss with Internal Audit how this can be sought. Linked to this was concern about a management action arising from a HR IA review last year, which has been pushed back by 12 months. The committee did not accept this and asked the Chief Executive to pick this up and report back next time.
Counter Fraud	The committee continues to be assured we are in a strong position and the annual assessment does not identify any significant gaps. However, concern was expressed about the extent to which we are tolerating the high number of incidents where staff are found to be working while on sick leave. It challenged the executive to ensure we apply policy consistently and fairly.
IPR	There was a review of the development of the IPR – now framed as an Integrated *Quality* Report. The committee supports the good progress that has been made and discussed how the Board could better use this report, reflecting that in the past it has been too formulaic, rather than using it as a tool to inform how the Board seeks assurance / makes decisions.
Risk Management	This is an area of focus within the Improvement Journey. While the committee is assured that the new policy will help support effective risk management, it asked for clarity on how the executive will be testing its implementation. The committee suggested holding an externally facilitated risk seminar with the full Board early next year.
Serious Incident	The committee received the outcome of a SI concerning the internal controls relating to areas such as information governance and medicines management. It noted the recommendations that have been taken forward.

Preamble. Observation of the Audit Committee

I have included this preamble to the observation report as I feel that it is important make a few reference points before compiling n the actual report.

As this is the first observation report from me there was no pre-meeting preparation to establish any desired outcomes with the Chair of the committee.

Microsoft Teams. Due to the nature of Teams with respect to the Hands-Up signals, it limits the quality of interaction and monitoring/control that can be exerted by the Chair. It also tends to extend the meeting length.

Observations on individual NEDs are based on their attitude, contribution, and general input to the Committee agenda. My observations are not intended to be judgemental.

For future reference I would like to discuss aspects of the committee agenda/process assurance expectations with the chair before the meeting so that the Chair can then review how effective the meeting had been against their expectations.

Only one governor (David Romaine) observed the meeting. Therefore, there are no collaborative observations.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

Part A Governor's Report on the AUDIT 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: 14/07/2022

Governors present: David Romaine

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

1. Prior to the meeting: Nothing to report. See preamble above

2. Introductions: None made other than general greetings.

3. Attendance:

Michael Whitehouse, Howard Goodbourn, Tom Quinn, Subo Shanmuganathan, David Astley, Peter Lee, Julie Harris, David Hammond, David Ruiz-Celada and CEO S Melia (part time). Several others observed but did not directly contribute to the meeting.

4. Agenda: The meeting followed the agenda with some reconfiguring of the order to suit individual time constraints.

5. Observations on individual NEDs:

Michael Whitehouse. Well controlled approach, courteous in dealing with committee members. Analytical and summaries discussed agenda items well. Enthusiastic and diplomatic. Used his extensive experience to help discussion and meeting progress. Due to the nature of Teams (as discussed in the preamble) some of the NEDS did not have the opportunity to contribute more and it is thought that it would be desirable if the Chair could monitor this aspect and try to override the 'Hands' signals to ensure that all NEDS get to fully contribute. This is a suggestion and not a criticism. Made a strong contribution to the meeting.

Howard Goodbourn. Monitors the meeting items and progress very attentively. He challenged many aspects of the meeting's discussion. Makes his points in a clear and positive fashion. Seeks assurance wherever possible. Sought answers wherever possible. Made a strong contribution to the meeting.

Professor Tom Quinn. Made challenges and sought assurance on staff wellbeing in terms of financial investments and relevance of data/information. Referred to his previous challenges in this respect. Made a good contribution to the meeting

Liz Sharp. Asked good questions in respect of the currency of data and made relevant input where appropriate. Made a good contribution to the meeting.

N.B. Both Tom and Liz were 'victims' of the Teams 'Hands Up' system with a high volume of other 'Hands Up' taking up meeting time.

Subo Shanmuganathan. Always a smiling face. Raised several concerns and asked good questions. Made strong concerns on HR processes. Courteous in approach and summaries her thoughts out loud before asking exacting questions. Made a strong contribution to the meeting.

7. De-brief: Spoke with the Chair in respect of trying to ensure that all NEDS get an equal opportunity to contribute to the meeting (despite the effect of the Microsoft 'Hands Up' facility).

8. Conclusion: A long, intense meeting with a packed agenda. Overall, the meeting was well managed by all concerned. The meeting concluded on time**.** The CEO had to leave early for another appointment**.**

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Improvement Journey Update

Board Paper – 25th August 2022

Best placed to care, the best place to work

Executive Summary – Progress since last update

- The Trust approved the critical delivery resource required on 13/07/22
- We have struggled to recruit to key posts during the Summer
- As a result and despite significant internal movements – we have not met the quality of reporting or required assurance by evidence we expected by August
- Second CQC inspection and further information requests in late July and early August have created additional capacity bottlenecks
- However – noticeable progress has been achieved in:
  - Key staff engagement areas, both in change areas, and increased leadership visibility
  - Reduction of outstanding investigations and strengthening of incident and harm process
  - Development of a new IQR, replacing the old IPR, alongside a developing Data Strategy

- Key areas of focus over the next month:
  - Fully resource project delivery team and complete re-baselining of programme.
  - Deliberate focus on outcomes required to satisfy "significant improvement" against WNs 1-4 by 1st November 2022 – inclusive of Board sub-committee alignment
  - Strengthen internal engagement and communications around the CQC action plan in preparedness for review date of November.

Support Offer – critical resources required to enable programme

Portfolio	
Associate Director / Portfolio Lead (B8d)	Matt Webb in post
Improvement Director (NHSEI)	Steve Lennox in post
Portfolio Delivery Manager (B8a)	Claire Webster in post
Quality Improvement	
Programme Delivery Lead (B7)	Nicola Brooks providing interim support
Interim Deputy Director – QI (B8d)	Recruitment ongoing. Post offered - planned start date 10/2022.
Medicines Project Manager (B8a)	Katie Spendiff in post
Responsive Care	
Strategic Operations Programme Director (B8d)	Eileen Sanderson in post
Programme Delivery Lead (2xB7)	Recruitment ongoing
Operations Support Delivery Manager (B8a)	Recruitment ongoing
Administrative Support (B4)	Recruitment ongoing
Organisational Development	
Programme Delivery Lead (PM) (B7)	Post vacant – interim support provided by Claire Webster and NHSE/I x2 days per week
Financial Sustainability	
Improvement Director (External review)	Finance ID in post
Programme Delivery Lead (B7) - unfunded	Post vacant

Key Messages:

1. Programme significantly at risk of not being able to evidence progress adequately or provide necessary assurance and scrutiny over issues due to lack of project resource
2. **Escalation to SAM:** System support required to identify skilled project management resources who can support in particular on Quality Improvement and People and Culture

Internal Audit recommendations – linked IJ programmes

ID	RSM consideration	Linked IJ programme	Current Status (16.08.22)
RSM1	Ensure there is an easy way to slice the reporting so that if required it can easily report back against the specific actions stipulated by the CQC without having to extract these individually from the Improvement Journey workstreams	Portfolio	Tracker produced
RSM2	Consider giving higher profile to help show more clearly the role of the secondary director and to help evidence this joined-up approach, e.g., within associated governance documents and reporting	Portfolio	QIG revised. Will also clarify in supporting documentation
RSM3	It will be important to identify an assigned action owner for the actions within QIG8 where the action owner is currently shown as "to be recruited".	Quality Improvement	Will resolve end of October
RSM4	Ongoing review of the individual action owners and associated progress towards delivery should be undertaken to ensure that where there are leavers or known changes of responsibility that these can quickly be reflected in the plan and, if necessary, formal handover to the new action owner undertaken in a timely manner.	Portfolio	Plan is to change names to roles
RSM5	It will be important to determine whether the specified resource funding is available, as well as the source of the funding, and to progress towards appointing to the "critically" identified posts to help prevent a loss of momentum or delay in delivery of the action plan.	Portfolio	Critical resourcing is identified
RSM6	We understand that in some instances funding for critical posts may only be available non-recurrently, up to for instance 31 March 2023. In such instances it will be important to understand the requirements of the Trust and the Improvement Journey beyond that point in time and whether there will be a need for ongoing resource or an opportunity to absorb within existing funded structures	Financial Sustainability	Also dependent on RSP status
RSM7	A walk through of the specific CQC actions should be conducted to ensure that all of these can be accurately reconciled to clear outcomes. Embedding the actions within the Improvement Journey workstreams is good but it is important there are no gaps in confirming that CQC actions are being met and that the Trust knows and can evidence when this has taken place.	Portfolio	Metrics identified
RSM8	It is good that it has been recognised that there may not yet be a suitable form of measurement in all instances and that this remains to be defined but it will be important that these measurements are developed and then built into the reports so that improvement or successful achievement of actions can be demonstrated.	Portfolio	Metrics identified
RSM9	Review how the existing sub-committees, Executive team and Board can link into the governance arrangements as set out for the Improvement Journey. Consider whether the sub-committees of the Trust Board could be used to deep-dive into specific actions and to focus on the assurance around the outcomes, for instance on key workstreams. Consider how the Board agenda is set out to link business as usual with the oversight required of the Improvement Journey	Portfolio	Currently being mapped
RSM10	As work is undertaken to develop, refresh and engage on the Trust's strategy it will be important to sense-check back against the Improvement Journey to ensure that actions being implemented are geared towards a sustainable and medium to long term future.	Financial Sustainability	Not yet required
RSM11	Whilst recognising that the time of Non-Executives is comparatively limited it would be good to ensure some of that time is allocated to active engagement through visits and listening and observation exercises. It may be beneficial to review Non-Executive portfolios so that a suitable balance of time can be shared between engagement, governance and leadership tasks	Organisational Development	Visits being planned. Non exec champion being considered

Key Messages:

1. SECAmb Board commissioned Internal Audit to conduct a review of the Improvement Journey Framework.
2. Majority of considerations incorporated - expectation that all will be incorporated by October

Assurance Against Warning Notices

WN1 – Board disconnect

CQC requirement	CQC Finding	Action type
There was a disconnect between the board and the wider organisation and the board was not working effectively together to achieve its full potential.	*There was a disconnect between the board and the wider organisation. We were told there was not collective leadership at executive board level and that there were poor relationships between certain members of the board and that there was separation between the board and the core services. Staff told us there was lack of visibility of senior leaders in clinical areas.*	***Warning notice (Section 29A) WN1***

SECAmb Planned Outcome by November
Effective Board in operation as measured by the "Healthy NHS Board" framework and CQC Well-led. The Board will be following a programme of development that is informed by a training needs analysis, supported by CQC, Staff and NHSEI feedback. The Board meetings are regularly being conducted and checked in alignment to the Trust's values. The Board and senior leadership team have a programme of structured leadership visits and effective mechanisms to review trends of feedback and close the loop where issues, concerns, or ideas for improvement are identified.

Summary of progress since CQC inspection
✓ Between March and May, the Senior Management Group and the Executive have worked together to shape the Trust Priorities for 22/23, followed by cascade across the organisation.
✓ The senior leadership team have implemented a programme of visits focussed on listening with structured reporting, and shaping weekly feedback into core messages for internal communications.
✓ There's an acknowledgment that internal communications and engagement requires an overhaul throughout all levels of the organisation.
✓ SMG/EMB now meet fortnightly with a strong agenda based on joint ownership of the Improvement Plans and staff feedback.
✓ Board Development committed to NHSE Culture and Leadership Programme, starting in August, and building on Board Development work done in Q1 of 2022.

WN1 - Leadership visit activity

Location	*Times visited*
Banstead MRC	10
Paddock Wood MRC	8
Guildford VPP	8
Brighton MRC	8
Polegate MRC	5
Chertsey VPP	5
Gatwick MRC	4
Medway VPP	4
Crawley EOC	4
Thanet MRC	3
Tangmere MRC	3
Ashford MRC	3
Dartford VPP	3
Haywards Heath	3
Coxheath EOC	2
Other - Virtual meeting	2
Telford Place	1
Other - Clin Ed Away Day	1
Worthing MRC	1
Hastings MRC	1
Ashford HART	1
Other - Crawley	1
Other - National meeting	1
Other - NARU @ Winterbourne Gunner	1
Grand Total	**83**

What Staff are telling us:

- Improve internal communications and engagement mechanisms
- Don't understand what the plan is to fix the pressures, the model is broken
- Be more compassionate – we feel like a number and expendable, especially in high SMP, and we keep on getting sent to the "wrong" jobs (NHS pathways dispositions, impacts on working out of area, and impacts on shift overrun)
- The FIATs are not fit for purpose

What we are doing:

- Overhaul of e-bulletin, weekly CEO messages. Long-term engagement embedded into IJ, session with 50 colleagues to develop stakeholder map and make recommendations of alternative moderated social media engagement means
- SMG / EMB escalation to the Board: there's a need to review our strategy and plans, and how we engage our clinicians in the development of the future plans
- Development of managers under Made@SECAmb – review of Dispatch function completed
- Fit and Risk assessments developed for colleagues with accessibility challenges, started 15th August, 57 vehicles paused from build, 8 vehicles to be road-shown during Autumn to improve functional design of the Saloon

WN1- Engagement for Improvement

Improvement Journey Briefing to share progress in an impactful way – based on staff feedback

Meeting with staff to explore their concerns and ideas, and learning from other Trusts

NHS South East Coast Ambulance Service NHS Foundation Trust

IMPROVEMENT JOURNEY BRIEFING

Case Study
Fiat Ambulances

- Fiat Ducato ambulances first introduced to SECAmb in 2018 and now form 30% of our total fleet.
- They are van conversions, in line with the national requirements of Lord Carter's review into unwarranted variation in NHS ambulance trusts (2018).
- Vehicles imposed on us by national NHS contract.

Challenges

- Fiats unpopular with some staff since introduction.
- Issues raised regarding seatbelts, driving position, space availability and layout of patient area.
- **November 2021:** Safety concerns escalated internally and externally by unions.

It was clear that staff did not feel their concerns were being listened to.

Action

- **November 2021:** Red Bulletin issued to ensure the safety of staff while investigations took place.
- Engagement with unions and staff over next six months, including work with manufactures and specialist advisers.
- **February 2022:** Commissioned a full safety review with NHSEI and Fiat to investigate concerns raised
- **25 May 2022:** Visit by team of 12 (fleet/unions/frontline staff) to West Midlands Ambulance Service to review 'new spec' vehicles
- **10 June 2022:** Joint Partnership Forum to review work so far and discuss and agree next steps with unions BUT significant HR issue raised during meeting.

Tensions heightened following JPF meeting.

- **13 June 2022:** Exec issued an apology to all staff – 'we got it wrong' – and shared recording of JPF
- **21 June 2022:** Engagement session led by Exec with unions and staff at Gatwick MRC
- **1 July 2022:** All staff webinar - 130 staff join live/recording viewed over 100 times
- **7 July 2022:** Answers to all questions raised by staff published on Intranet – viewed 200 times

Listening

- Layout of eight trial vehicles (currently in build) amended to take on board staff feedback – Lifepak re-positioned; clear-fronted cupboards introduced.
- Roadshows planned for every MRC during October so staff can see the trial vehicles and give feedback. This will then be incorporated into future builds.

Work continues to listen to and act on the issues raised by staff and unions.

Next Steps

- Progress personal risk assessments for colleagues who've raised issues - helping us gather evidence to present to our commissioners and NHSEI.
- Delay building 57 vehicles for the year, until we have collected feedback from the eight trial vehicles.

WN2 – Quality of Information and Board Assurance

CQC requirement	CQC Finding	Action type
The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge.	*The quality of information and assurance was not effective and there was a lack of professional curiosity and challenge. A read of the executive board and sub board committee papers showed limited triangulation of information for example; quality, workforce and finance, to assist effective understanding and mitigation of risk. There was limited evidence of effective and timely actions being taken when risks had been identified or holding to account for such actions.*	***Warning notice (Section 29A) WN2***

SECAmb Planned Outcome by November

Information to Board is of high quality and presented in a standardised, consistent format trust-wide, with clear professional challenge which achieves assurance and improved decision-making, supported by the improved use of data trust-wide.

Summary of progress since CQC inspection

- ✓ The Terms of Reference and Annual Plans (Cycle of Business) for each of the five main Board committees have been updated, using the model TOR as a guide, as set out in The Foundations of Good Governance. These were approved by the Board in July 2022.
- ✓ A process has been established by each committee where the Chair, Executive Lead and Company Secretary meet in advance of every meeting to agree the agenda, using the Cycle of Business as a guide, and then establish the specific purpose and assurance questions for each item.
- ✓ This will help paper/report authors better understand what assurance the committee needs, to improve the quality of information provided, and also help the committee ensure it is focussed in its challenge and holding to account.
- ✓ Data clinics have been held to inform the development of the Integrated Quality Report (IQR); this followed a Board development session with NHSE making data count team who are returning in August / September to follow up.
- ✓ Together with a revised Board Assurance Framework Risk Report (BAF) and the Improvement Journey Report, these three main reports will help the Board to better triangulate quality, people and finance.
- ✓ To support this further, and in particular helping the Board to improve how it challenges and holds to account, a Board development session has been scheduled for October with the well-established training package run by NHS Providers – Effective Challenge.

WN2 - Board Reporting Alignment and IQR

Improvement Journey

Quality Improvement	Responsive Care	People and Culture	Sustainability
Embedding quality amongst everything we do	*Improving operational performance and patient care*	*Improving our culture, engage our people, and support development of our teams*	*Ensuring long-term sustainability*
Patients	***Service***	***People***	***Sustainable***

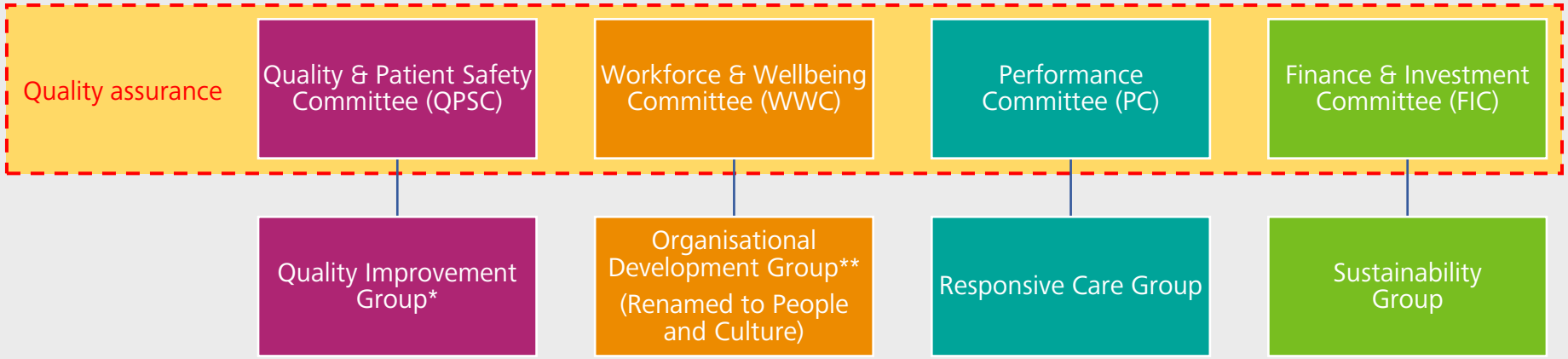
IQR Themes				
	- *Incident Management* - *Medicines Management* - *Patient Experience* - *Safeguarding* - *Safety in the workplace* - *Impact on Patient Care*	- *Ambulance Quality Indicators* - *Call Handling* - *Utilisation* - *999 Frontline Efficiency* - *Supporting the system* - *111 Operation*	- *Employee Experience* - *Workforce* - *Wellbeing*	- *Delivery against Plan*

Key Messages:

1. Significantly improved Quality of information enabling triangulation of workforce, finance, culture, performance data
2. Positive feedback received from NHS MDC Team – further development planned in August and September with targeted Board Development from MDC
3. Focus now to develop a framework that expands beyond Board and to all levels of the organisation

WN2 - Integrated Quality Report

WN2 - Board sub-committee alignment and assurance



Key Messages:

1. Alignment of the Sub-committees of the Board, with the Improvement Journey "pillars", Trust Priorities, and the IQR, enables for the first time a structure that allows full line of sight of the effectiveness of the plans in place to deliver improvements
2. Sub-committees to conduct 2x targeted deep dives per session going forward in alignment with Improvement journey plan

WN3 – Effectiveness of risk management and QI

CQC requirement	CQC Finding	Action type
Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements.	*Corporate and clinical governance were not working together to provide effective oversight of risks and issues to drive improvements in health care. We were told, as of 15th March 2022 there was a backlog of open DATIX incidents (1,500). We were told that there had been no risk stratification of these as yet to understand any risk. There was a concern that harm was not being appropriately assessed when undertaking harm, death, SIs and Datix reviews.*	***Warning notice (Section 29A) WN3***

SECAmb Planned Outcome by November

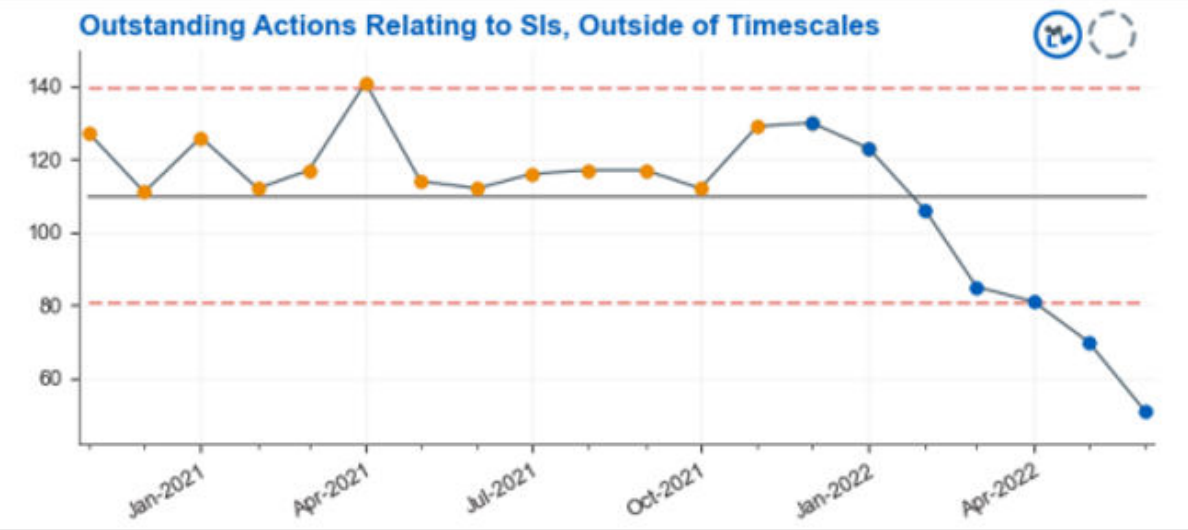
Greater oversight of clinical risks and issues through an integrated governance framework, supporting the consistent use of high-quality information and improved incident management and harm review processes, which drive improvements for patients and staff.

Summary of progress since CQC inspection

- ✓ Significant progress has been made with regards to the reduction of breached SI actions, SIs and Datix incidents.
- ✓ All trajectories to reduce overall breached numbers by 50% by end of July met, and trajectories being met to reduce to zero for SIs and SI actions, and by 90% for Datix on track.
- ✓ Workshops undertaken to map out refreshed incident management process, articulating immediate and short term actions to be undertaken by November to ensure assurance of risk stratification, quality of approach and investigations, feedback and learning is achieved.
- ✓ Operational Governance groups refreshed to provide two-way feedback of information on incidents, harm and risks to inform decisions and future models of support.
- ✓ A new model for Harm Reviews has been developed to address 5 types of harm typically encountered in pre-hospital services, and methodology to be applied to each type is now being developed.
- ✓ In the meantime, a systematic harm review was undertaken following the July Heatwave and discussed with commissioners at weekly forum.
- ✓ All SI reports submitted to Clinical Education and reformatted for use as case studies or teaching slides for dissemination to all accessing training tools and key skills curriculum.
- ✓ All policies are with appropriate Directors and plans being finalised for reviews and updates to be completed.
- ✓ Datix Cloud implementation is on track with over 80% of risk leads trained and on the system. Transfer of risks underway, updating and closing as appropriate.
- ✓ Mapping of the full patient journey has taken place (12/08/22) and 6 risk points identified.

WN3 - Achievements so far

- **Quality Improvement:**
  - Significant **reduction in outstanding incident backlog** in line with submitted trajectories.
  - Approval and appointment to **Deputy QI Director**.
  - Completed review of risk and harm governance, **migration to cloud system**.
  - Medicines management deep dive completed with system peer review. Programme fully resourced aiming for full business case in October.
  - A facilitated review of **how we keep patients safe** underway – Internal workshop in August and system review in September 2022
  - Learning from SIs



	Total open incidents	Breached	Within timeframe	Number still outstanding from original 1020
01/03/2022		1020		
23/05/2022	1427	622	805	334
14/06/2022	1404	633	771	242
21/06/2022	1459	601	858	234
29/06/2022	1304	462	842	178
04/07/2022	1262	409	853	149
12/07/2022	1328	386	942	145
19/07/2022	1265	358	907	110
26/07/2022	1218	353	865	77
02/08/2022	1194	313	881	69

WN3 - Understanding our biggest areas of risk – Patient Journey Mapping, preparation for Quality Summit

WN4 – Culture and addressing staff concerns

CQC requirement	CQC Finding	Action type
There was a culture of bullying across the organisation. There was a failure to act swiftly to address staff concerns. There was a dismissive culture where staff raising serious concerns did not have their concerns acted upon.	*There was a culture of bullying across the organisation. Our interviews with staff and CQC staff survey and number of contacts with whistle blowers indicated a culture of bullying occurring across the trust with a 'lack' of ability to hear, address or resolve incidents in a timely fashion in line with trust policies.*	***Warning notice (Section 29A) WN4***

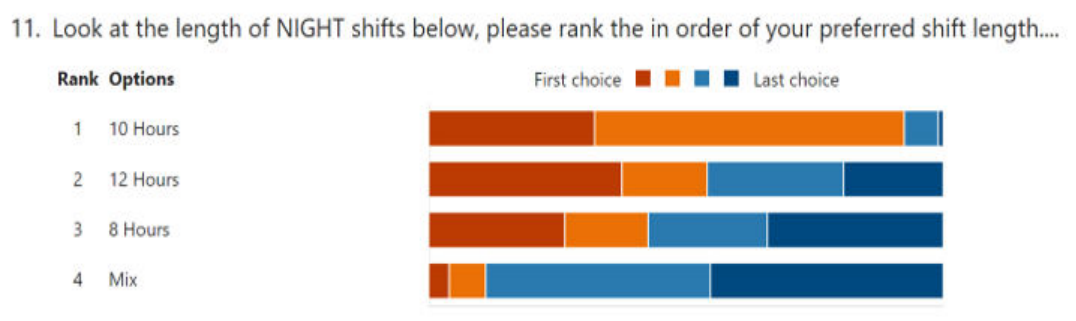
SECAmb Planned Outcome by November
Significant reduction in bullying and harassment prevalence, with staff feeling empowered and supported, through a safe mechanism, to raise concerns, promoting changes and learning as a result of speaking up in a timely manner

Summary of progress since CQC inspection
✓ An ER PowerBi Dashboards that monitors case completion has been made available to the Senior Management Group and Executive Team.
✓ This has been refreshed and re-implemented w/c August 22.
✓ Data from these dashboards shows that in August 2022, the average time to complete a grievance case was 85 days against a policy expectation of 93 days.
✓ Existing FTSU data is being be validated (quality and format) to be added to these dashboards.
✓ The new Fundamentals training programme aimed at middle managers has commenced; it is a five module programme of 24 cohorts that has specific content aimed at inclusive leadership.

WN4 - Achievements so far

- **Responsive Care:**
  - Progress towards our workforce targets for the year continues, expecting to be on target for recruitment, with attrition being the biggest risk to the plan.
  - On track for delivery of a full rota review in field operations including an engagement programme which has resulted in 978 responses to a questionnaire on rota preferences supporting improved patient response and staff welfare.
  - Completion of external dispatch review – undertaken in collaboration with AACE subject matter expert, also lessons learned from other Trusts.
  - Focus on listening to staff concerns: extensive consultation undertaken through the rota review programme for the year (over 900 responses in consultation), and development of a supportive risk-assessment process to support colleagues who have raised concerns with the FIAT DCA, supported by national NHS procurement, manufacturer, commissioners and through an independent expert. 57 FIAT DCA's build paused until new configuration engagement on-station can happen in the Autumn.

Shift length has been a key aspect of rota planning with strong links to staff welfare. We asked for staff preferences for inclusion in the rota requirements.

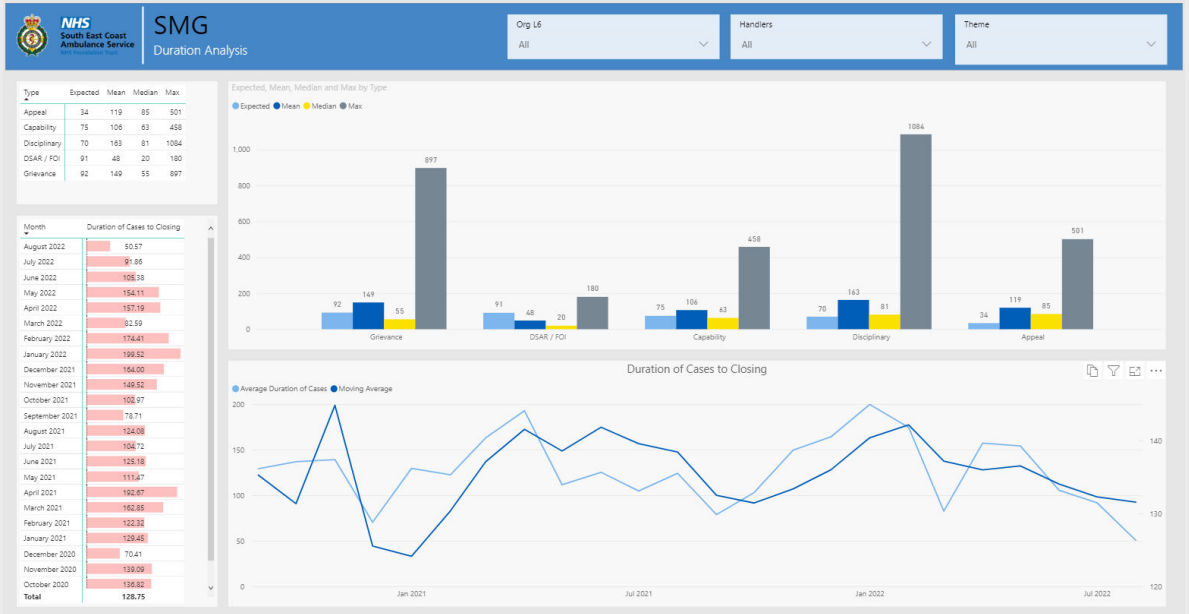


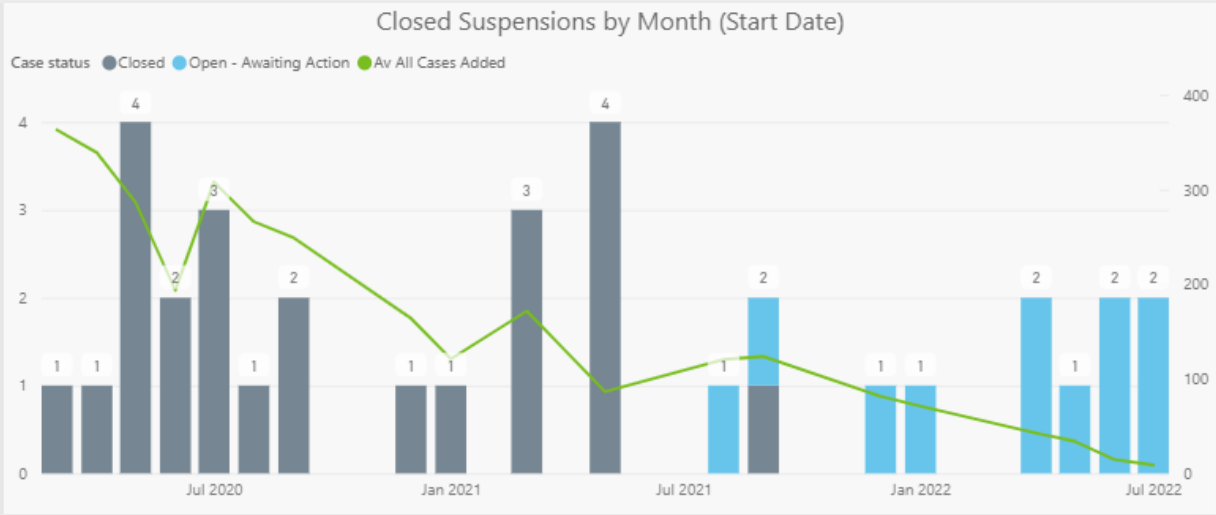
Measure	Q1 Trajectory	Q1 Actual
C1 Mean	08:30 - 09:30	08:43
C1 90th	16:00 - 17:00	15:52
C2 Mean	30:00 - 35:00	32:36
C2 90th	59:00 - 71:00	66:50

WN4 - Achievements so far

People and Culture

- Re-alignment of senior leadership behind the Trust Priorities for 22/23 and alignment to BAF, quality reporting, and Improvement and CQC Action plan. Over 200 feedback from staff sent directly to online portal with leadership personal response
- Trust has **committed to starting the NHSE Culture and Leadership Programme** and held two planning meetings. Programme formally commences on 25 August with a Board development session to affirm commitment and commence Stage 1 – Scoping.
- New **Civility and Respect Policy has completed consultation** and will now move to approval. CEO issued personal video message to all staff reinforcing message.
- **Civility and respect** programme started with the rollout of **sexual safety** workshops; four courses have been run (57 attendees) and a further four (72 attendees) are planned, with a total of **30 courses over the next two years**.
- **Leadership visibility programme** put in place with structured leadership visits on a rotational basis **– >90 visits/listening session conducted to date**
- Key additional roles to support FTSU progressed and open recruitment commenced. Improvement work **jointly approached with NGO**.
- **Made @ SECAmb management development programmes started** in line with plans – investing in leadership, and announcement of leadership conference in September – keynote speaker, Sydney Dekker, founder of Just and Restorative Culture philosophy.
- New interim CEO in place. Appointment of interim CFO awaiting HMT approval, with appointment of substantive CFO commenced.





Sustainability

- NHSEI Finance Improvement Director **completed finance review** – report due by end of August and workstream to formally commence in September.
- **National peer-reviewed** procurement improvement programme started through the CCIAF framework – scheduled peer review starts on 1st of October.
- **Green Plan** development started with 3rd Party consultant SME, focus on 3-10 year roadmap to 80% scope 1 reduction, inclusive of De-carbonisation Board Assurance Framework with yearly milestones expected by end of Q4 22/23.
- Emerging need for the development of a refreshed **strategy** and **5-year planning** framework to address the structural issues with the current model of care, and to shape the Improvement Journey beyond 31st March 2023 – formal escalation to August Board in public

Appendix

Portfolio risks, issues and escalations

Key inherent risks (≥ 12) and issues (≥ High)						
Description	Type (R/I)	Inherent score (1-25)	Mitigations/Controls	Residual score (1-25)	Latest update	Trend
Resourcing gaps and capacity constraints identified across portfolio programmes, including the capacity of executive, SMG and delivery leads, which could impact progress and delivery.	Issue	High	Programme deputies identified with the development of a business continuity plan and weekly meetings in place to keep to deadlines. Workstreams are currently being prioritised, whilst a plan to address this is progressed.	High	Issue is now impacting assurance reporting. Application for NHSE/I funding and internal business case approved with recruitment ongoing. Interim Delivery Lead arrangements introduced for QIG and NHSE support offered for ODG.	↔
Due to operational demand or unforeseen service pressures, some delivery timeframes could be impacted.	Issue	High	Weekly programme core delivery group meetings are in place to keep to deadlines.	Medium	Demand increase is expected during the summer and reporting delays have been observed due to unforeseen operational pressures and annual leave.	↑
Due to tight timeframes for delivery, some milestones could be delayed.	Risk	16	Weekly portfolio delivery steering group meetings are in place to maintain deadlines, with business continuity plans under development.	8	Key deliverables and milestones have now been defined within the master plan for all programmes. A full review of the master plan has been completed.	↔
Additional resources may be required at short notice to aid portfolio delivery.	Risk	12	Early assessment of needs has been undertaken, with key components incorporated within NHSE/I funding request.	6	Internal business case approved, which outlines short-notice additional resource required. Recruitment activities have commenced.	↔
Additional funding is required to support key enablers, such as recruitment, the procurement of systems and training.	Issue	Medium	Early assessment of needs undertaken, with no material impacts identified presently.	Low	Programme core delivery groups are currently determining non-pay enablers that will be key to each programme's success.	↔
Proposal to close ODG/1 Immediate Communication & Engagement plan could result in potential gaps in our communication and engagement.	Risk	16	3-month communications and engagement plan/tracker developed by the Communications team. To be monitored at the portfolio level through Joint EMB/SMG meetings (standing agenda item). Communications Manager attending Portfolio Steering Group meetings.	12	The majority of the ODG/1 activities have been delivered and open employee engagement actions are being transferred to ODG/5, with communication being managed at a portfolio level. Joint EMB/SMG to agree on proposed communications and engagement plan.	↔

WN1 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion by
WN1-1	Strenghtening of SMG/EMB leadership relationships	**Descriptor:** SMG and EMB are working closer together now, with clear alignment behind direction of travel, regular joint meetings, and with a standing agenda item that is focused on engagement feedback from our staff. The SMG and EMB now have a clear DOR. **Evidence:** 1) Agenda and minutes of fortnightly Joint SMG/EMB meetings 2) Evidence of workshops conducted between EMB and SMG to define Trust priorities 3) Feedback on improved communications between SMG/EMB from core members	Gap to be covered in re-baseline	ODG	-
WN1-2	Trust priorities	**Descriptor:** SMG, EMB, Board and COG worked together through April and May to develop the Trust Priorities for the year, with a strong focus on people, engagement and leadership and built on the 200 Staff written feedback. These have supported the organisation to prepare to respond to CQC preliminary findings on a sustainable basis. The priorities have been used to engage all teams, empowering managers and local teams to develop action plans for the year in line with the Trust priorities for 22/23. **Evidence:** 1) Outcomes from facilitated workshops in April and May 2022 2) Communications plan for the Trust priorities 3) Examples of presentations where local teams have set their plans for the year in accordance with the priorities (including Teams F) 4) Examples of open feedback questions and answers (from staff to the senior leadership team)	ODG1.1	ODG	Completed
WN1-3	Leadership Engagement Plans	**Descriptor:** Rotational engagement plan for senior leadership team (SMG/EMB/NEDs/Governors) to have planned visits at stations, with structured feedback forms systematically collecting soft intelligence and feedback from staff. Leadership Engagement Coordinator recruited, ensuring even coverage of leadership visits across extensive patch, and providing summarised trend analysis on the feedback collected to the joint SMG and EMB meetings for consideration. **Evidence:** 1) Visit tracker presented, demonstrating greater leadership visibility 2) Raw and summarised leadership visit feedback forms 3) Minuted discussions and actions at SMG/EMB meetings to address issues and concerns raised 4) Adapted engagement approach with a greater social media presence demonstrated 5) Enhancements to communications with use of short videos and easily accessible updates (based on feedback received) 6) Case studies / specific evidence where the Trust has taken action based on feedback received	ODG5.1	ODG	14-Apr
WN1-4	Board reporting aligment to Trust priorities	**Descriptor:** The Board now meets monthly, with a focus on our Improvement Journey as the main conduit for measuring delivery against the Trust priorities as well as the CQC deliverables. The IQR has been re-developed with support from NHS Futures and now contains more relevant narrative focussed around each of the 4 pillars of our programme: People and Culture, Quality Care, Responsive Care and Sustainability, such to ensure there's better triangulation between the data, the discussion at the board, the improvement journey plans, and the impact it's having on patients and colleagues. **Evidence:** 1) BAF and reporting of the new IQR re-aligned to Trust priorities 2) Regular updates/reports to Board regarding the Improvement Journey 3) Board minutes	Gap to be covered in re-baseline	ODG	-
WN1-5	Board Development Plan	**Descriptor:** Our comprehensive Board development plan, and training needs analysis, identifying the needs for the Board to operate in line with NHS Leadership Academy "Healthy Board". **Evidence:** 1) Summary of all Board development sessions completed to date 2) Statement of impact from individual members of the Board 3) 12-month Board development plan - started with the work done with David Weaver from November 2021 - March 2022 4) Evidence of TNA to support development plan 5) Completion of minimum training relating to sexual misconduct and FTSU by all Board members 6) Phased plan for regular "Well-led" self-assessments in line with the KLOE as identified by CQC	ODG2	ODG	31-Mar
WN1-6	Colleague wellbeing reporting at Board	**Descriptor:** Strengthening of the people-focussed reporting and narrative at the Board and WWC sub-committee through the IQR. **Evidence:** 1) A new quality dashboard has been created to strengthen triangulation of colleague wellbeing with operational pressures and patient harm through the Integrated Quality Report (IQR) 2) Minutes of Board meetings 3) Action logs	QIG1.1 QIG1.4	QIG	20-Sep

WN2 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion
WN2-1	Re-structure of the quality governance structure	**Descriptor:** Complete overhaul of our Quality Governance Structures	QIG1.1	QIG	28-Jul
		Evidence: 1) Updated ToR and annual plans (Cycle of Business) for each of the five main Board committees			
		2) Standard templates and cover sheet for all governance groups			
		3) Example of good quality reports being presented at Board level, inc. risk summaries			
		4) Governance framework established by each Board committee outlining how the Chair, Executive Lead and Company Secretary will meet in advance of each meeting to agree agenda (using the Cycle of Business) and on specific purpose and assurance questions			
		5) Triangulation of quality, people and finance evidenced through joined up BAF, IQR and IJ reporting			
		6) Minutes which evidence how information in the IQR is being discussed			
		7) Evidence of key messages and escalations clearly being captured			
		8) Review of cycle of business and presentation of new governance approach to effectively answer the "so what" questions			
		9) Clear reporting framework that outlines how to record and report on BAF risks			
WN2-2	Closing the loop from escalations to groups and committees	**Descriptor:** Actions and escalations to committees have clear feedback look mechanisms embedded in the way they conduct business, with clearly linked actions from escalations being taken and fed back to origin (closing the loop).	QIG1.1	QIG	28-Jul
		Evidence: 1) Minutes of relevant meetings			
		2) Action logs			
		3) Examples of subsequent feedback to origination of issues			
WN2-3	Make Data Count	**Descriptor:** Re-structured approach to quality metrics reporting, following the MDC framework as supported by NHSE. This will ensure consistency and relevancy of metrics presented at the Board, supporting triangulation by design between workforce, finance, quality, and fully aligning to the Improvement Journey plans to provide assurance to Board. As part of this programme, there will be further Board Development provided by Sam Riley and her team at NHSE to ensure the Board is being professional in it's challenge based on evidence, improving quality of the narrative to the Board, and developed roadmap if there are any quality metrics missing from the current reporting systems.	QIG1.4	QIG	21-Jul
		Evidence: 1) Trust IPR converted to IQR			
		2) Board Development session on MDC and decisions (i.e. data holiday) to support development and implementation of SPC			
		3) Updated Data Strategy supporting implementation of quality metrics within the warehouse			
		4) Gap analysis undertaken linked to data strategy			
		5) Evidence of data clinics held to inform development of the Integrated Quality Report (IQR)			
WN2-4	Performance and Quality Assurance Framework	**Descriptor:** Development of a written Performance and Quality Assurance Framework that covers from Road to Board. This will include effective parameters for escalation through the operational structure and up to EMB/Board.	Gap to be covered in re-baseline	RCG / QIG	-
		Evidence: 1) Written Performance and Quality Assurance Framework			
		2) Regional (OU) and trust-wide level quality metric reports inclusive of workforce information, operational performance, quality data, and financial, as a minimum, clearly supporting written framework			
		3) Ammended TORs for a minimum of Teams B, Teams A, SMG, EMB, enabling clear escalation of issues.			
WN2-5	Promoting curiosity, constructive challenge, and holding to account	**Descriptor:** Promoting an environment of professional curiosity, with Board members and senior leaders feeling empowered to ask direct questions, check out and reflect on information received.	Gap to be covered in re-baseline	ODG	-
		Evidence: 1) Training records for committee chairs/EMB evidencing training on how to constructively challenge non-compliance			
		2) Training records for committee chairs/EMB evidencing training on how to use information within the IQR to drive challenge			
		3) Feedback from wider leadership team indicating what has changed (i.e., evidence of curiosity and challenge)			
WN1-5	Board Development Plan	Refer to WN1-5	-	ODG	-

WN3 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion
WN3-1	Key metrics: Reduction in outstanding incidents, breached SI and outstanding SI actions	**Descriptor:** Demonstrated reduction in outstanding incidents, breached SIs and outstanding SI actions in line with planned trajectories. **Evidence:** 1) Reduction in outstanding DATIX incidents to no more than 10% of overall count 2) Closure of all open SIs and associated actions 3) Planned trajectories to reduce breached SIs and to maintain this state.	QIG2.1 QIG2.3	QIG	30/12/2022
WN3-2	New incident and harm process	**Descriptor:** New process that demonstrates systematisation of the improvements achieved under WN3-1, ensuring improvements are sustained and mitigating against future backlogs. **Evidence:** 1) New policy, standardising quantification of harm across the Trust 2) Timeline of a phased approach demonstrating monitors of effectiveness 3) Evidence of learning being fed back into decision making (i.e., captured through minutes and actions of governance groups) 4) Evidence of workshop/s undertaken, outlining immediate and short-term actions to be undertaken 5) New framework for harm reviews founded on best-practice evidence 6) Evidence of ad-hoc harm reviews undertaken to respond dynamically to increased risk (i.e., heat wave) 7) Evidence of feedback to staff following incident submission 8) Evidence of triangulation between surge management/ARP and levels of harm (via Performance Cell) 9) Evidence of learning to prevent recurrence of backlog and to promote best practice - i.e., via case studies or teaching content produced by clinical education	QIG2.1	QIG	11/05/2023
WN3-3	All governance policies in date	**Descriptor:** All governance policies are in date, and there is a plan for addressing the backlog of outstanding policies and procedures which are out of date. This will ensure Trust governance is working as effectively and as up-to-date as possible. **Evidence:** 1) Risk assessment supporting prioritisation of governance policies to be updated and rationale/mitigation for those out-of-date 2) Timeline and trajectory with dates for updating all out-of-date policies (policies reviewed by accountable executive) 3) Operational governance groups refreshed to provide two-way feedback and information on incidents, harm and risks	Gap to be covered in re-baseline	QIG	-
WN3-4	Updated risk process, inc. new system	**Descriptor:** Reviewed risk management policy, reflecting changes in the TOR of meetings and clearly articulating how we manage and oversee risks at all levels of the organisation with identified accountable and appropriate owners. **Evidence:** 1) Updated risk management strategy articulating how SECAmb manages and escalates risk 2) TORs for all governance meetings where risks are discussed in line with risk management policy 3) Clear alignment of BAF risks to Improvement Journey with Board oversight 4) New Datix risk management platform in place (Datix Cloud) 5) Targets for training of risk leads, with 100% risk leads trained and target date by which >90% appropriate persons will be trained 6) Full review of all risks and evidence no risk has been "left behind" when transferring to Datix Cloud 7) Comprehensive risk report evidencing dynamic management and presenting trends, movement of ratings and stratification 8) Internal audit reports and clearly articulated process on how we are tracking recommendations and actions from internal audit.	QIG3.1 QIG3.2	QIG	10/08/2022
WN3-5	Patient journey mapping	**Descriptor:** In-depth review of the full end-to-end patient journey mapping, highlighting greatest areas of patient risk and potential harm. Learnings from this exercise will help define the Quality Summit in September, and learnings shared with key governance groups, EMB, and Board, and informing strategy going forward. **Evidence:** 1) Outcomes from patient journey mapping workshop 2) Quality Summit feedback and learning 3) Evidence of how learning has been embedded in risk and harm management processes 4) Evidence of how the outputs are used to influence future strategy.	Gap to be covered in re-baseline	QIG	-

WN4 - Evidence

ID	Evidence	What is it, and how does it impact/benefit the requirement	Link	Group	Completion
WN4-1	Key metrics: Workforce, culture and wellbeing	**Descriptor:** Key metrics that will be used to measure this requirement. **Evidence:** 1) Response time to issues raised for B&H allegations or grievances 2) Time from allegation raised to closure 3) Proportion and total amount of staff suffering from detriment when raising concerns 4) Total open grievances, and monthly new and closed 5) ER trendline of cases over time for sexualised behaviours and bullying and harassment 6) Reduction if sexualised behaviours, bullying and harassment and FTSU cases resulting in formal disciplinary action	ODG8.2	ODG	31-Mar
WN4-2	Resource plan to support caseload	**Descriptor:** A resource plan for the next 12 months to demonstrate an understanding of the requirements to adress grievances in a timely fashion and within policy timelines. **Evidence:** 1) Resource plan (e.g., FTSU) 2) Evidence to support resource plan is on track to meeting trajectory of resources required 3) Options appraisal undertaken considering longer-term resource requirements. To include Professional Standards functionality	Gap to be covered in re-baseline	ODG	-
WN4-3	Suspensions management process	**Descriptor:** Provide the evidence for safeguarding / risk assessments and weekly review of suspensions with fortnightly letters. **Evidence:** 1) Evidence of process being followed 2) Timeliness of issue identified vs outcome issued 3) Trajectory demonstrating improvement in timeliness of investigation outcomes etc.	Gap to be covered in re-baseline	ODG	-
WN4-4	Development of a "listening strategy"	**Descriptor:** A listening strategy that enable the Trust to improve it's ability to listen, hear and feedback when issues or concerns are raised. **Evidence:** 1) Written listening strategy	ODG5.1	ODG	16-Sep
WN4-5	Training and development of managers	**Descriptor:** Evidence that under the training plans for the year we are following our planned trajectories for developing leadership and managers under the Made@Secamb programme. **Evidence:** 1) Trajectories for completion of sexual safety workshops, mediation and management fundamentals courses 2) Evidence that trajectories are being met with completion summary 3) Feedback from persons who have undertaken or benefited from the training 4) Learning and outputs from the Leadership Conference	ODG6.2	ODG	03-Apr
WN4-6	Zero-tolerance stance	**Descriptor:** Visible communications from the executive and leaders across the organisation on our zero-tolerance approach to B&H and sexualised behaviours, supporting a visible zero-tolerance approach from the Trust's leadership. **Evidence:** 1) CEO weekly message reiterating Trust values and zero-tolerance stance 2) Communications plan to address a zero-tolerance stance on sexualised behaviours and B&H, including progress to date 3) Evidence of communications cascaded against plan 4) Timeline of phased approach to #UntilItStops training	Gap to be covered in re-baseline	ODG	-
WN4-7	Review of process for logging of concerns raised	**Descriptor:** Review of the process for raising concerns at SECAmb, ensuring there are effective communications and emphasis on the routes for raising concerns and supporting the FTSU function. **Evidence:** 1) External review of HR function, i.e., processes for raising and handling staff concerns 2) Full review of Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy undertaken 3) Alternative processes for raising and logging concerns mapped across the Trust, demonstrating multiple routes 4) Staff survey evidences of staff feeling heard with appropriate action undertaken and results demonstrated	ODG4.2	ODG	31-Mar
WN4-8	FTSU Board Development	**Descriptor:** Evidence that the Trust Board is supporting our FTSU function by actively engaging in Board Development based on the Board Development plan. This will increase awareness and robustness of the scrutiny at Board. **Evidence:** 1) Board Development plan with FTSU as core component 2) FTSU training undertaken led by FTSU leads 3) Feedback on impact from Board members on the Board Development	ODG4.1	ODG	08-Sep
WN4-9	Review of engagement approach through social media - in particular the FB Community Page	**Descriptor:** Feedback from colleagues is that the FB community page is not properly moderated and is systematically described as "toxic and negative". Visibly changing our approach and creating a values-based platform for social media engagement amongst colleagues. **Evidence:** 1) Options appraisal undertaken to consider staff engagement platforms 2) Where agreed, change in approach to alternative platform conducted 3) Social Media Policy reviewed and updated, with moderation process outlined	Gap to be covered in re-baseline	ODG	-

RSP exit criteria – linked IJ programmes

ID	SOF domain	Outline RSP exit criteria	Linked IJ programme	Linked IJ workstreams
L1	Leadership & capability	Interim CEO appointed and the Trust's Board-level leadership seen as stable.	Organisational Development	QIG3, ODG2
L2	Leadership & capability	Clear lines of responsibility and accountability for individual executives.	Organisational Development	QIG3, ODG2
L3	Leadership & capability	Trust Board sighted on all key risks through an effective Board Assurance Framework and improved quality reporting aligned to the BAF and the comprehensive improvement plans.	Quality Improvement	QIG1, QIG2, QIG3, QIG8, ODG2
L4	Leadership & capability	There was a culture of bullying across the organisation and a failure to act swiftly to address staff concerns. There was a dismissive culture where staff raising serious concerns did not have their concerns acted upon.	Organisational Development	QIG8, ODG2, ODG3, ODG4, ODG6, ODG8
L5	Leadership & capability	Improved communication and engagement channels between the frontline and the Board, inclusive of routes of escalation for risks and concerns.	Organisational Development	QIG1, QIG3, QIG8, ODG2, ODG5, ODG8, RCG6
L6	Leadership & capability	Evidence of improved transparency and timeliness of reporting and information sharing with ICS partners. The level of desired transparency will be agreed between the ICS partners and SECAmb as part of the improvement journey evidence framework to avoid duplication.	Quality Improvement	QIG1, QIG2, QIG3, FSG
L7	Leadership & capability	External Well-Led review co-commissioned and all key recommendations acted on effectively.	Organisational Development	QIG1, QIG3, ODG2, ODG5, ODG6, ODG8, FSG
L8	Leadership & capability	Board leadership development plan in place aligned to CQC, Staff Survey and WLR key issues.	Organisational Development	QIG1, QIG3, ODG2, ODG5, ODG8, FSG
L9	Leadership & capability	CQC reinspection has taken place and significant improvement found against all Warning Notice and Must Do findings/recommendations.	Portfolio	All
Q1	Quality, access & outcomes	Comprehensive improvement plan developed to deliver the Trust's improvement priorities including CQC's May 2022 findings and recommendations and the areas for improvement highlighted in the 2021 Staff Survey.	Portfolio	QIG1, QIG8, FSG
Q2	Quality, access & outcomes	Improved Board oversight and clarity on safety and quality metrics, ensuring there is good triangulation between demand and capacity issues driving ARP challenges, and the impact on patients and staff.	Quality Improvement	QIG1, QIG2, QIG3, QIG7, QIG8, ODG2, ODG9, RCG2, RCG3, RCG5, RCG6,
Q3	Quality, access & outcomes	Trust F2SU policy/process has received board assurance and oversight and has been appropriately resourced.	Organisational Development	ODG2, ODG4
P1	People	Improved staff engagement as measured through response levels to the Staff Survey and regular pulse checks.	Organisational Development	ODG5
P2	People	Workforce plan developed to address capacity gaps in 111 and 999 services with evidence of delivery against agreed recruitment trajectories. Subject to funding and signed contracts to support required levels of resources.	Responsive Care	ODG7, RCG5, RCG6, FSG
P3	People	Trust career development and career pathways strengthened in line with the Board-approved clinical education strategy.	Organisational Development	ODG2, ODG6
P4	People	Trust not an outlier with ambulance service peers for staff retention or sickness absence.	Organisational Development	ODG7, ODG8, ODG9, RCG6
P5	People	Strengthened HR systems and Board oversight of grievances, whistleblowing, training, staff turnover and exit interviews: themes, trends and learning.	Organisational Development	QIG1, QIG8, ODG3, ODG4, ODG6, ODG7, ODG8, RCG6
F1	Finance and use of resources	Comprehensive financial sustainability plan in place supported by diagnostic of deficit drivers, Quality Impact Assessment, robust efficiency plans and agreed levels of ICS investment.	Financial Sustainability	QIG1, FSG
F2	Finance and use of resources	Shared Trust and system understanding of risks to financial delivery with agreed mitigations in place.	Financial Sustainability	QIG1, QIG3, FSG
F3	Finance and use of resources	Trust can evidence delivery of financial trajectories for at least two most recent quarters.	Financial Sustainability	QIG1, FSG

Key Messages:

1. RSP exit criteria workshop completed on the 27th July
2. Exit criteria deliverables have been mapped and incorporated within the relevant workstreams within the Improvement Journey

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Report to the Council of Governors on the Performance Committee

September 2022

Aspiring to be ***better today*** and even ***better tomorrow***

Performance Committee

NHS
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NHS Foundation Trust

Role : to acquire and scrutinise assurance that the trust's system of internal control relating to operational performance is designed appropriately and operating effectively

Membership: Howard Goodbourn (Chair), NED's: Michael Whitehouse, Subo Shanmuganathan, Paul Brocklehurst. Executives: Emma Williams, David Ruiz-Celada, David Hammond, Ali Mohammed

Frequency: 6 meetings from September 2021 to August 2022

Way of working: Constructively challenging, strategic and systemic – thus promoting continuous improvement. Regular review of patient impact assessment of actions and performance

Key areas covered

- Operational resourcing and efficiencies
- Performance review of 111 and 999
- Development of new integrated plan
- Seasonal planning (12 week look forward)
- Performance data quality
- Responsive Care workstream as part of Improvement Journey
- Risk review

Key highlights over the year to August

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- Development of a fully integrated plan with new analytical forecasting capability and state of the art software
- Integrated Quality Report incorporating recent introduction of Statistical Process Control
- Performance improvement plan covering winter
- Strong relative performance over winter and to date
- Ongoing rota review with extensive engagement

Key lowlights over the year to August

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- Continued, relentless struggle with high abstraction levels mainly from sickness (Covid, mental health and stress)
- Recruitment plans slightly behind
- Very high attrition rate (escalated to Board)
- Still not meeting AQI's by some margin, revised targets proposed
- Long way to go to achieve hear and treat target of 14%
- Job cycle time challenges and hospital handover delays

NHS South East Coast Ambulance Service NHS Foundation Trust

IMPROVEMENT JOURNEY BRIEFING

Case Study
Fiat Ambulances

• Fiat Ducato ambulances first introduced to SECAmb in 2018 and now form 30% of our total fleet.
• They are van conversions, in line with the national requirements of Lord Carter's review into unwarranted variation in NHS ambulance trusts (2018).
• Vehicles imposed on us by national NHS contract.

Challenges

• Fiats unpopular with some staff since introduction.
• Issues raised regarding seatbelts, driving position, space availability and layout of patient area.
• **November 2021:** Safety concerns escalated internally and externally by unions.

It was clear that staff did not feel their concerns were being listened to.

Action

• **November 2021:** Red Bulletin issued to ensure the safety of staff while investigations took place.
• Engagement with unions and staff over next six months, including work with manufactures and specialist advisers.
• **February 2022:** Commissioned a full safety review with NHSEI and Fiat to investigate concerns raised
• **25 May 2022:** Visit by team of 12 (fleet/unions/frontline staff) to West Midlands Ambulance Service to review 'new spec' vehicles
• **10 June 2022:** Joint Partnership Forum to review work so far and discuss and agree next steps with unions BUT significant HR issue raised during meeting.

Tensions heightened following JPF meeting.

• **13 June 2022:** Exec issued an apology to all staff – 'we got it wrong' – and shared recording of JPF
• **21 June 2022:** Engagement session led by Exec with unions and staff at Gatwick MRC
• **1 July 2022:** All staff webinar - 130 staff join live/recording viewed over 100 times
• **7 July 2022:** Answers to all questions raised by staff published on Intranet – viewed 200 times

Listening

• Layout of eight trial vehicles (currently in build) amended to take on board staff feedback – Lifepak re-positioned; clear-fronted cupboards introduced.
• Roadshows planned for every MRC during October so staff can see the trial vehicles and give feedback. This will then be incorporated into future builds.

Work continues to listen to and act on the issues raised by staff and unions.

Next Steps

• Progress personal risk assessments for colleagues who've raised issues - helping us gather evidence to present to our commissioners and NHSEI.
• Delay building 57 vehicles for the year, until we have collected feedback from the eight trial vehicles.