**Council of Governors Meeting to be held in public**

**30 March 2017 10:00-12:30**

**Ashford 111 Centre Moat Way, Willesborough, Ashford, Kent TN24 0TL**

**Agenda**

| Item No. | Time | Item | Enc | Purpose | Lead |
|---|---|---|---|---|---|
| **Introduction and matters arising** | | | | | |
| 95/16 | 10:00 | Chair's Introduction | - | - | Peter Dixon (Chair) |
| 96/16 | - | Apologies for Absence | - | - | PD |
| 97/16 | - | Declarations of Interest | - | - | PD |
| 98/16 | - | Minutes from the previous meeting, action log and matters arising | A A1 | - | PD |
| **Statutory duties: performance and holding to account** | | | | | |
| 99/16 | 10:30 | Chief Executive's Report and performance dashboard:<br>- Progress against the recovery plan and CQC must dos<br>- Questions from the Council | B B1 | Information and discussion | David Hammond (Acting Chief Executive) |
| 100/16 | 10:55 | Board Assurance Committees' escalation reports:<br>- Audit Committee 1 March<br>- Finance and Investment Committee 14 March<br>- Workforce and Wellbeing Committee 16 March<br>- Quality and Patient Safety Committee 17 March<br>- Questions from the Council | C1 C2 C3 C4 | Information and discussion | All Non-Executive Directors present |
| **11:20 Comfort break** | | | | | |
| 101/16 | 11:30 | Risk management and (patient/staff) impact assessments:<br>- To provide assurance that risks inherent in improvement and sustainability changes are being identified and effectively managed | D D1 | Information and discussion | Lucy Bloem (Non-Executive Director), David Hammond (Acting CEO) |
| 102/16 | 12:00 | Proposed induction for the Chair | - | Information and discussion | Peter Lee (Company Secretary) |
| **Statutory duties: member and public engagement** | | | | | |
| 102/16 | 12:10 | Membership Development Committee report:<br>- Membership and public engagement | E | Information | Mike Hill (MDC Chair and Public Governor for Surrey) |
| **Committees and reports** | | | | | |
| 103/16 | - | Governor Development Committee report:<br>- Process for elections to Lead/Deputy Lead Governor posts | F F1 | Information | Brian Rockell (Lead Governor and Public Governor for East Sussex) |
| 104/16 | - | Nominations Committee | - | Information | PD |

| 105/16 | - | Governor Activities and Queries report | G | Information | BR |
|--------|---|------------------------------------------|---|-------------|----|
| **General** | | | | | |
| 106/16 | 12:30 | Any Other Business (AOB) | - | - | PD |
| 107/16 | - | Questions from the public | - | Public accountability | PD |
| 108/16 | - | Areas to highlight to Non-Executive Directors | - | Assurance | PD |
| | | Date of Next Meeting: 2 June 2017, venue to be confirmed | - | - | PD |

**Observers who ask questions at this meeting will have their name and a summary of their question and the response included in the minutes of the meeting.**

**PLEASE NOTE: Meetings of the Council held in public are audio-recorded and published on our website.**

**13:15-15:15**

**Afternoon workshop (not open to the public):**

**Final Draft Strategy presentation and discussion**
Led by Jayne Phoenix (Associate Director working with the Director of Strategy and Business Development), Governors and NEDs will receive an update on our plans and comment on them, to enable the Trust to understand and take into account the views of the Council. This session builds on sessions held in November and January.

**South East Coast Ambulance Service NHS Foundation Trust**

**Council of Governors**

**Meeting held in public**

**31 January 2017**

**Present:**

| | | |
|---|---|---|
| Peter Dixon | (PD) | Chair |
| Charlie Adler | (CA) | Staff-Elected Governor (Operational) |
| Nigel Cole | (NC) | Staff-Elected Governor (Operational) |
| Alison Stebbings | (AS) | Staff-Elected Governor (Non-Operational) |
| Chris Devereux | (CD) | Public Governor, Surrey |
| Mike Hill | (MH) | Public Governor, Surrey |
| Dr Peter Beaumont | (PB) | Public Governor, Surrey |
| Jean Gaston-Parry | (JGP) | Public Governor, Brighton and Hove |
| Brian Rockell | (BR) | Public Governor, East Sussex – Lead Governor |
| Geoff Lovell | (GL) | Public Governor, West Sussex |
| James Crawley | (JC) | Public Governor, Kent |
| Michael Whitcombe | (MW) | Public Governor, Kent (on the phone) |
| Maggie Fenton | (MF) | Public Governor, Kent |
| Marguerite Beard-Gould | (MBG) | Public Governor, Kent |
| Marian Trendell | (MT) | Appointed Governor, Sussex Partnership NHS FT |
| Dom Ford | (DF) | Appointed Governor, BSUH |
| Graham Gibbens | (GG) | Appointed Governor, Kent County Council |

**In attendance:**

| | | |
|---|---|---|
| Peter Lee | (PL) | Company Secretary |
| Al Rymer | (AR) | NED |
| Lucy Bloem | (LB) | NED |
| Tim Howe | (TH) | NED and Senior Independent Director |

**Minutes:**

| | | |
|---|---|---|
| Izzy Allen | (IA) | Assistant Company Secretary |

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**80. Chair's Introduction**

80.1.    PD welcomed Governors and observers to the meeting. He noted that a number of Governors were standing for re-election, and while it was pleasing for the Trust that competition for vacancies was strong, this meant that some Governors may not be re-elected.

80.2.    The Trust and Council wished to record thanks We would record thanks to them should they not be re-elected.

80.3.    Maggie Fenton would not be standing again and PD wished to thank her for her hard work and patience. PD thanked MF for her work on staff welfare and Paddock Wood.

80.4.    MF advised that it had been a pleasure to work with the Council, Board and the NEDs.

## 81. Apologies

Peter Gwilliam        (PG)   Public Governor, East Sussex
Di Roskilly             (DR)   Appointed Governor, Sussex Police
Jane Watson           (JW)   Public Governor, Surrey

## 82. Declarations of Interest
82.1.       There were no declarations of interest.

## 83. Minutes from the previous meeting
83.1.       PB advised that section 54.13 did not fully capture the discussion around CCPs and PPs and potential changes to their role. IA would update the minutes. GD advised that the aim of considering Critical Care Paramedics' (CCP) and Paramedic Practitioners' (PP) role within the Trust strategy was to maximise the response of staff to our patients, given the current pressures. Historically, CCPs and PPs had not been appropriately tasked. In conversation with Joe Garcia (Director of Operations), a tasking desk would be put in place to ensure that PPs and CCPs would be tasked appropriately, within the SECAmb 'plan'. GD and JG had met with CCPs and PPs to discuss this, and a number now understood the purpose of the changes.

83.2.       PB asked whether training would be started again. GD advised that training had not been suspended: the 2017 cohort of CCP and PP intake had been suspended. CCPs would be provided with a days' training.

83.3.       JC asked whether the opportunity cost in terms of talent attraction had been analysed. GD advised that SECAmb's intake was full to August 2017 and there was a waiting list. The Trust needed to respond to a population of 4.7m people. This was the focus, and this was what SECAmb was were funded to do. The commissioners did not fund the Trust for CCPs and PPs.

## 84. CEO's report
84.1.       GD noted that the report highlighted the major operational performance challenge the Trust had over the festive period. Demand had exceeded commissioned levels. The whole of the NHS was experiencing similar demand issues. Handover delays were severely higher than anticipated. The Trust had agreed funding to respond to 3,400 patients per month with Commissioners and saw around 7000/month, affecting the Trust's ability to respond. London Ambulance Service's Computer Aided Dispatch system (CAD) had also broken down and SECAmb had supported them, which had resulted in a Business Continuity Issue (BCI) for SECAmb.

84.2.       Despite this the Trust was endeavouring to meet patient demand. This fed into the decision around suspending the new intake of PPs and CCPs as already discussed.

84.3.       The Trust was not commissioned to meet national standards this year so would focus on achieving agreed trajectories.

84.4.       GD personally wished to thank staff, and noted that despite the pressures frontline staff had continued to provide the best possible service to

patients. However, the Trust needed to reflect alongside the wider system on how other services 'falling over' impacted on the ambulance service.

84.5.     NHS Improvement has sent a firm letter to the CE's of the three southern ambulance trusts, and trusts are expected to escalate every handover delay over an hour. This would create an enormous amount of bureaucracy and noise. However, it was important to ensure that the system, including commissioners, was sighted on the issues.

84.6.     PD agreed, and noted this was relevant in terms of the development of the Trust's strategy, to enable a response to the wider system context. System changes were underway in the acute sector too.

84.7.     GD advised that Daren Mochrie would start with the Trust as substantive CEO on the 3 April, and GD would hand over to him then. DM was spending some time with the Trust in the interim.

84.8.     Dr Rory McRae had resigned in early January. Dr Andy Carson was due to replace Rory, however his illness had returned. A potential replacement had been identified and should be appointed for 6-12 months in the next week or so. Recruitment would commence for a substantive Medical Director soon.

84.9.     The organisation was still reflecting on the CQC report, particularly around clinical leadership. In light of this, a consultation was underway about whether the three clinical director positions should continue. Prof Andy Newton decided to step down from his Director duties in light of these conversations.

84.10.    Operations had been considering the functionality and stability of the CAD system. Nearly 50 staff members had been involved in reviewing prospective suppliers and one had been selected, with the aim of having this in place by the time SECAmb moved Lewes and Banstead Emergency Operations Centres (EOCs) to Crawley.

84.11.    The Operational restructure continued, with a delay in relation to Make Ready Centre (MRC) staff.

84.12.    Contract negotiations were underway – there were pressures to finalise these. The commissioners had agreed an additional £4m funding and also agreed to another capacity review to be concluded by 31 March 2017. This would seek to resolve the £26m shortfall the Trust believed existed between what was needed to run a safe service and what the trust was paid.

84.13.    Financially SECAmb was challenged. Measures were being taken to reduce spends to ensure the Trust did not exceed the projected £7.1m deficit. PD advised that as part of this, Council of Governors' meetings would be moved to Trust premises and today would be the last relatively sumptuous lunch. It was important to give the right messages to people.

84.14.    On performance, JC noted how welcome it was to see the CFR figures in the dashboard. Was it possible to include Private Ambulance Services' contribution in the figures?

84.15.    CA noted that SECAmb was on the cusp of changing to electronic records. Was it now possible to use data from the Electronic Patient Care Records to log and show the handover issues?

84.16.    GD advised that, on handover delays, the issue was not SECAmb staff but the ability of hospitals to accept patients. Medway hospital had chosen to take seriously the delays and would not tolerate them, and this was reflected in reduced handover times there. Other hospitals had not taken this approach. ePCR should help the Trust show when staff 'go green' and prove the issue is with the hospitals. CA noted that from a staff perspective, Ashford and St Peters hospital should also be recognised for enabling handover. GD advised that this was also due to the CEO's prioritisation of the issue.

84.17.    MBG noted that in relation to having CoG meetings on Trust premises, one of the problems was to make sure that the public meetings were accessible across the Trust. Two Board meetings in the last three were at Tangmere, which was inaccessible to people from Kent. A balance to enable the public to attend needed to be struck. She worried that Trust venues would not be accessible. PD advised that venues were being researched to try and ensure that the Council and Board could move around. Once the Trust moved to Crawley, this venue would likely be used when possible. There had been a lot of public members at Tangmere however.

84.18.    MW wished to understand how the Trust was clear that the CAD would be fit for purpose. He had spent time in EOC recently, and staff had expressed concerns. GD advised that the existing CAD was a bespoke CAD, based in the US. This meant that it had been challenging to use and update. The new system would be an off the shelf system that was deemed fit for purpose by three other ambulance trusts. 50 staff were involved in the selection process which provided additional assurance. During implementation SECAmb would continue to test and consult with staff, while the current system was still up and before switch over.

84.19.    LB had participated in the selection process, which involved users and had been robust. There was a monthly project board, with good individuals involved and input from EOC. The functional design was being worked on and was essential to get right. Change management aspects would be the bigger challenge most likely. LB was as assured as she could be and would continue to be involved.

84.20.    MH asked which system LAS used, given it failed in December. They used a different system.

84.21.    LB advised that this was a big project in a tight timescale. MW noted that it would be important to communicate at all levels in EOCs. GD would take this away to ensure this happened.

**ACTION: GD to ensure relevant communication about the new CAD across all EOCs**

84.22.    CD advised that public transport accessibility should also be considered regarding CoG venues.

84.23.    MF noted that Green 2 calls were not currently in the performance report. GD advised that the Executive Team would be discussing what was reported, where and when. It would be important to show how the Ambulance

Response Programme impacted on the Trust too. MF wished to see the G2 calls and had been asking for a long time. GD advised that the tail was also vitally important.

84.24. BR advised that he had taken an interest in call answering times. He hoped that the call answering time tail was also under scrutiny.

84.25. GG noted the preponderance of red items on the performance dashboard. He wished to see an improvement plan. GD advised that there was a £26m funding gap, and therefore a major challenge to get into the green on all targets. PD advised that the recovery plan sought to address these items. There was a trajectory within the recovery plan, however the funding gap should not be used as an excuse.

84.26. MW asked whether a review of the impact of new initiatives 'nature of call' and 'dispatch on disposition' had been undertaken. GD advised that this was closely monitored.

84.27. The Trust had discussed with the CQC yesterday the action plan and must dos. 106 actions had been completed, 163 were on target and 28 were at risk.

84.28. The key risk area was around medicines management in the Trust. This would be the focus for the remainder of the financial year. The CQC would be re-inspecting the Trust in the early first quarter of the financial year. A lot of work had been done on safeguarding by Emma Wadey, and the CQC were assured of this plan and implementation.

84.29. On infection control, a lot of work had been done to change the policy and improve training, and the CQC were assured that plans were in place.

84.30. Finally, the culture of the Trust and allegations of bullying and harassment was a key issue. The HR directorate had ensured policies and procedures were up to date and implemented. The systems now needed to be put into place to support these policies. The Operations review should provide frontline managers with the time to manage effectively which should help address some of the cultural issues. New Speaking Out and whistleblowing processes had been introduced and were being well-used.

84.31. The Executive Team were seeking to spend more time in other areas of the Trust.

84.32. PD advised that the number of 'reds' on the dashboard was in one sense a good thing: previously the Trust had said it was on track when it wasn't on track. There was more to do than address the areas identified by the CQC. Other areas such as medicines management had been identified as needing improvement. It was positive that challenges were being identified.

84.33. JC asked about medicines management and whether the Trust had employed a permanent Pharmacist. GD advised that someone would start in April, however an interim would be appointed to help deliver in the meantime. The Trust needed support with external scrutiny of medicines management.

84.34. SECAmb used more drugs than other ambulance services and it was important to justify their use and that there was effective governance. Drugs would need to be withdrawn if this was not in place.

84.35.   JC asked whether the lack of move towards more MRCs had prevented good medicines management. GD advised that this was not the issue: rather the issue was whether there was basic compliance in place for all drug usage.

84.36.   MT asked whether the process, storage, administration and recording of drugs was safe, and therefore the public were safe. GD advised that SECAmb was an outlier in terms of the range of drugs used due to pushing the boundaries. The Omnicell system provided excellent, auditable security for drug dispensing. There was a high level of breakages in the organisation. A challenge was to ensure there were safe processes in place where Omnicell was not yet used.

84.37.   LB advised that there were numerous issues, from dissemination of drug alerts, effective temperature controls though to central dissemination. More work was being done and LB would continue to monitor.

## 85. Board Committee Escalation Reports

**85.1.   Audit Committee:**

85.2.   The chair of the Committee had recently left the organisation so PD advised that the risk register was not yet ready for the Board but it was moving forward. Internal audit reviews were not providing assurance, but previously had provided inaccurate assurance, so internal audit may be working better than it had previously.

**85.3.   Quality and Patient Safety:**

85.4.   LB advised that the Committee had been meeting monthly, which was necessary due to the size of the agenda. The scrutiny item format was working well and had highlighted the medicines issue. Use of Private Ambulance Services would be considered in one of the future meetings. LB advised that there was risk in the length of the tail and this would be considered.

85.5.   MW asked whether there had been progress on the defibrillator review. LB advised that there would imminently be a final report from NHSI which would come to QPS.

**85.6.   FIC:**

85.7.   The report was taken as read and there were no questions.

**85.8.   WWC:**

85.9.   TH noted that due to commissioning discussions it was not possible to set out a clear workforce plan, however HR were recruiting to the maximum possible. GG asked about mandatory training compliance, which was behind trajectory, as were appraisals, even in comparison to last year. TH advised that on training, he was reasonably assured that mandatory training would be complete by the end of the year. On appraisals, this would not be the case. The appraisals system was being reviewed. Once the operational units were in place and unit managers had time to manage, this should improve.

85.10.   GD advised that mandatory training was being monitored and there was a plan in place to meet the target. PD noted that it may be that the decision was made to tolerate these levels of compliance in order to protect

performance. BR noted that this issue had been raised in subsequent years and the Council were told each time there was a plan in place, which then failed to deliver. He was not assured this year.

85.11.      PB advised that the mandatory training figures were on par with other NHS Trusts, and asked whether staff might complete online training while waiting at hospitals. TH was content that the training was now being tracked accurately, and accurate figures would be available soon.

85.12.      PB asked whether the workforce plan assumed any changes to the skill mix of frontline staff. TH noted that this should be discussed as part of the wider strategy discussion. GD advised that it was as yet unclear whether the Trust would bridge the funding gap of £26m. The service model should maximise patient care/responsiveness in the context of the available funding. For example, the Band 6 Paramedics would be funded centrally this year but not in future years.

85.13.      MF asked whether there was assurance that the impact of decisions on staff and patients are being considered. Were staff impact assessments being undertaken? PD advised that there was a quality impact assessment undertaken on any change of substance. TH advised that the Programme Management Office had been invited to the next WWC to provide that assurance. LB advised that at QPS they had been through the quality impact assessment process, and QPS had requested evidence that it was being used.

85.14.      JC noted that the capability of leadership and management had the biggest impact on staff. What steps were being taken to reduce the number of interims? PD advised that the new CEO would start 3 April and other posts would be advertised from then. PD envisaged substantive Directors would be recruited over the next 6-9 months.

## 86. Progress on performance

86.1.      On 111, GD advised that the Integrated Performance Report reported on the four key indicators that the Trust was commissioned to deliver. The first three should be delivered, however none of the providers were commissioned to deliver on the fourth combined target. Targets for 111 were on trajectory. However, the financial implications of 111 could lead to a cost pressure of £0.5m and conversations were under way with commissioners. The commissioners wished to extend the contract for another year, and the Trust sought to increase the cost it was paid per call.

86.2.      On 999, the key issue was to maximise available resources to respond to patients, by maximising core staffing and responses from Private providers, CFRs and fire co-responders. The improvement trajectory agreed with commissioners was not being reached at present.

86.3.      CFRs were being embedded within local operational teams, and dedicated, integrated dispatch desks were being developed. Joe Garcia (Director of Operations) was looking at how the Trust communicated appropriately in real time with CFRs to improve their contribution to patients.

86.4.    Co-responder schemes saw an improving response, and the Trust sought to extend the schemes within Sussex.

86.5.    PD advised that there were some positive variances of note too: call answering performance and Hear & Treat were ahead of trajectory, as was the contribution of CFRs and co-responders. This was positive and the Trust should build on it and reinforce it.

## 87. Quality Account (QA)

87.1.    Dan Hale (Associate Director – Governance) presented an overview of the QA measures from 2016-17.

87.2.    The first domain was around increasing PP referrals. He noted that changes brought in with the Ambulance Response Programme had affected the ability of the Trust to accurately report against the PP referral rate. GC asked why the referral rate was lower than previously. DH advised had only recently taken responsibility for the Quality Account and more work would be done to analyse the available data.

87.3.    The second domain was around frequent caller identification. Frequent callers had reduced and H&T episodes were up on previous months. Clear metrics had not been set around H&T nor the roll-out of frequent callers' activity.

87.4.    On 111 clinical advisers advancing their skills, a number of education programmes had been put into place. 111 was compliant with clinical audits. Again, there were limited metrics which DH's team was seeking to remedy.

87.5.    The final quality domain was around using IBIS in end of life care. There were clear metrics and clear improvements here. The number of plans on IBIS continued to grow.

87.6.    On the 999 call community first responder survey, the response rate had improved, and the responses from patients were positive.

87.7.    DH asked which area the Governors would wish to audit. The Trust normally recommended an area, and in this case were recommending that an audit consider the end of life care process as the Trust wished to continue to work on this.

87.8.    Three QA measures for 2017-18 had been agreed at a workshop and by the Exec:

87.9.    Improving outcomes from Out of Hours cardiac arrest;

87.10.    Duty of Candour reporting and compliance; and

87.11.    Learning from incidents and improving patient safety.

87.12.    PD invited questions. He believed that clear metrics were essential, and the results on PP referrals were concerning.

87.13.    CA advised that on end of life care, he was pleased to hear that there had been a qualitative intervention process, allowing clinicians to recognise that a preferred place of death set early on might change for the patient given the circumstances at the time of near death.

87.14.    PB advised that in terms of being a learning organisation, he had struggled to provide SECAmb crews with either positive or negative feedback

in his role as a clinician at an acute hospital. It had taken 2-3 weeks to receive a reply. Two-way communication could be improved.

87.15.     JC advised that he would prefer the clinical effectiveness of 111 to be the area to audit, given that end of life care seems to be working well. DH advised that the CQC had provided a good report on this aspect which might be regarded as assurance.

87.16.     JC advised that qualitative work could check whether 111 call takers were compassionate, caring and clinically effective etc. GD advised that it may be helpful for the CoG to hear from 111 managers about what was audited in 111 as a matter of course.

87.17.     DH further advised that the 111 licence provided for a certain number and standard of audits. LB advised that auditing (in terms of the number of audits undertaken) had not been compliant in 111 and 999 but the Trust had made progress.

87.18.     MT asked whether improving outcomes from cardiac arrest might be audited, since survival could depend on which hospital patients were taken to. DH advised that this was reported nationally, including how the hospitals were doing. This might be something that could be included within the internal audit programme.

87.19.     BR advised that end of life care remained important for the public, and perhaps not something that ambulance services had always considered.

87.20.     CA advised that from a crew perspective frequent callers were a constant frustration, which linked into improving the staff perception of the effectiveness of IBIS. CA was convinced IBIS was an essential tool, and already felt that end of life was already done well. CA felt that looking again at frequent callers might make more sense, in order to inform best practice with IBIS across the patch.

87.21.     It was agreed that the Governor's QA audit area would be the identification and management of frequent callers.

## 88. CoG self-assessment

88.1.     BR advised that there had been an improvement in survey responses this year.

88.2.     The GDC had reviewed the data and wanted to enable the Council to review the suggested analysis and suggest any potential actions for the GDC to consider to make improvements.

88.3.     JC wished to clarify in relation to 5.6, mentioning the number of CFRs on the Council, what the issue was. BR advised that the constituencies would be reconsidered in 2017 and this could be considered as part of that wider discussion.

88.4.     MF felt that it was irrelevant whether someone was a CFR or not, however in elections there was a block vote for CFRs which gave CFRs the advantage. It might be better to have a Governor representing volunteers. JC agreed that this should be considered in the round.

88.5.     JGP advised that she felt that the Council had not had enough information to hold the NEDs to account in the past year. BR advised that this

had been reflected in the results. The next stage would be to consider actions at the GDC.

88.6.      PD advised that it would be helpful for the Council to be specific about information it felt it had not received. It was also important to get information at the right level. BR advised that there was a training session on February 14th to cover holding to account, which would include this discussion. BR noted that there were other ways of holding to account aside from receiving information, such as being at Board meetings or listening to the recordings.

88.7.      MBG advised that the Board meetings and Council meetings should be held across the patch so they were accessible to all. PD believed that meetings could be live-streamed in the future and JC noted that Facebook streaming was a good service which could be explored.

## 89. Membership Development Committee (MDC)

89.1.      MH highlighted a proposal to streamline the next Annual Members Meeting. A venue was being pursued in Kent for 28 September. The MDC report included the Inclusion Hub Advisory Group and Staff Engagement Forum minutes. The results of the annual members survey would be discussed at the MDC on Thursday, and all Governors were welcome to attend.

89.2.      MH thanked MF for her help as part of the MDC, and for actively signing up new members.

## 90. Governor Development Committee (GDC)

90.1.      BR invited questions and there were none. He reminded Governors that the GDC was open to all.

## 91. Governor Activities and Queries

91.1.      BR thanked Governors for taking part in the selection day for the CEO position. BR also thanked JC for his contribution to the CFR Project Board. It was pleasing to see the CFR contribution improving.

91.2.      PD noted that there was a query outstanding on the mealbreak policy. GD advised that a response would be provided once negotiations with staff side had been concluded.

## 92. AOB

92.1.      JC advised that he had met with Joe Garcia regarding meal-breaks, and he was keen that Governors were sighted and would like to report back to the Council on this.

92.2.      MH asked about the roll out of the electronic Patient Clinical Record (ePCR). LB advised that it would be carefully rolled out for conveyed patients after non-conveyed patients. EPCR would not be used for cardiac arrests, and there would be some anomalies. There were benefits in frontline staff having iPads in addition to the use of ePCR. It should improve staff communications dramatically. JC asked whether there were processes in place for handovers between clinicians and private crews, CFRs etc.

92.3.    LB advised that where a paper form was started, the form would be continued on paper after handover. LB advised that there had been strong information governance in relation to the project.

92.4.    MBG noted that she had raised the issue of handover from paper a number of months ago. LB advised that she had asked for a review of PCRs as there seemed to be some issues with the paper version, regardless of the electronic record. The QPS Committee was going to consider this.

92.5.    CA advised that ePCR should be an improvement on the paper form, however he had experienced delays using it, and it should pre-populate: there were clear functionality improvements which would help transform usage.

## 93. Questions from the public
93.1.    There were no questions.

## 94. Areas to highlight to Non-Executives
94.1.    LB advised that she would take the ePCR issue forward at the QPS Committee.

94.2.    PD thanked the Council and closed the meeting.

**SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST**
**Trust Council of Governors Action Log 2016-17**

| Meeting Date | Agenda item | AC ref | Action Point | Owner | Completion Date | Report to: | Status: (C, IP, R) | Comments / Update |
|---|---|---|---|---|---|---|---|---|
| 28.07.16 | 19,10 | 174 | Timeline regarding information from the CQC and what was shared when to be sent to the Council | GD | 27.09.16 | CoG | S | Given the CQC are due to revisit the Trust shortly, it is proposed that the CoG consider inviting them to a meeting following their re-inspection. |
| 28.07.16 | 19,31 | 178 | GD to communicate with staff regarding not seeing lengthy waits at A&E as business as usual | GD | 27.09.16 | CoG | IP | The Trust's incident reporting process is being reviewed as part of the Trust's rectification/unified recovery plan. The revised policy is currently out to consultation with staff across the Trust. Once the review is complete, communications to all staff will make clear where incidents should be reported, including in relation to delays at A&E. |
| 27.09.16 | 37,4 | 182 | IA to provide DD with a response regarding G2 reporting to the Board. DD's concern is that there are a lot of G2 patients and no Board oversight of them because there is no reporting target. | IA/DD | 29.11.16 | DD | IP | This is being considered as part of a review of the Integrated Performance Report taking place in the next quarter. |
| 31.01.17 | 84,21 | 188 | GD to ensure relevant communication about the new CAD across all EOCs | GD | 30.03.17 | CoG | C | There has been an extensive programme of engagement across all EOCs about the new CAD and the move to Crawley |
| | | | | | | | | |

**SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST**

**B - CHIEF EXECUTIVE'S REPORT**

**March 2017**

## 1. Introduction

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the Trust.

## 2. Local issues

### 2.1 Changes at Director/Senior Management level

2.1.1. Following a robust recruitment and selection process and appointment by the Council of Governors, Richard Foster was confirmed on 14th March 2017 as the new Trust Chairman.

2.1.2 Richard has held senior positions in the public and voluntary sectors and his career has seen him serve as Chair, CEO, Trustee, Executive Director and Non-Executive Director of a variety of large, complex, public, voluntary and private sector bodies. He will start with the Trust on 31st March 2017.

2.1.3 On 6th March 2017, Dr Fionna Moore joined the Trust as Medical Director, following the departure of the previous Interim, Dr Andy Carson, on ill-health grounds.

2.1.4 On 9th March 2017, Geraint Davies announced his decision to bring forward his leaving date from 31st March to 9th March 2017. David Hammond is currently Acting Chief Executive, ahead of Daren Mochrie joining the Trust on 1st April 2017.

2.1.5 On 24th March 2017, Director of Nursing & Urgent Care/Chief Nurse, Professor Kath Start, also confirmed that she will be leaving the Trust in April to pursue other interests.

### 2.2 Revised Executive portfolios

2.2.1 As reported previously, in order to clarify clinical responsibilities and otherwise address issues identified by various external reviews of the Trust, a review of Executive Director portfolios has recently concluded.

2.2.2 Following consultation, there will be changes made to the number of Executive Directors on the Trust Board and to their portfolios. The new Director roles will be:

- Chief Executive
- Executive Director of Finance & Corporate services
- Executive Director of Quality & Patient Safety/Chief Nurse
- Executive Medical Director
- Executive Director of Operations

- Executive Director of Strategy
- Director of HR

## 2.3 Care Quality Commission (CQC) inspection

2.3.1 As reported previously, the Trust has received confirmation that the CQC will be re-visiting the Trust between 15th & 18th May 2017. Requests for information in preparation for this inspection are already coming into the organisation.

2.3.2 The Trust is continuing to deliver the CQC action plan as part of the Trust's broader Recovery Plan, focussing on the 'should dos' and 'must dos' identified by the CQC during their inspection last year.

## 2.4 Staff Award ceremonies

2.4.1 On 23rd February and 9th March 2017, I was very proud to join more than 300 members of staff and their guests at our two Staff Awards Ceremonies, held in Maidstone and Cobham. At each event, we celebrated both the long service and the outstanding commitment of our staff and volunteers and were very pleased to be joined by the Deputy Lord Lieutenants of Kent and Surrey respectively, to present Queens Medals to those staff who had completed twenty years' front-line service.

2.4.2 During what are difficult times for the Trust, it was extremely heartening to be part of such positive events and hear the fantastic stories of our staff and volunteers who have 'gone the extra mile' to support their patients and colleagues.

## 2.5. NHS Staff Survey

2.5.1 On 7th March 2017, the results of the latest Staff Survey results were published for al NHS organisations.

2.5.2 The results for SECAmb are extremely disappointing but reflect, to a great extent, the challenges that the Trust has faced during the last year and the impact that these have had on staff.

2.5.3 We are committed to responding to the results and will take a full diagnostic of the survey outcomes to the Executive Team for discussion. We will then agree with the whole Board the key areas we will be focussing on addressing.

2.5.4 Much has already been done to address some of the issues the survey highlights but we still have a long way to go.

## 2.6 Paramedic banding

2.6.1 The national development of the Band 6 paramedic profile has now been finalised and, in adherence to the national agreement, we are getting ready to move eligible paramedics across to Band 6.

2.6.2 As per the national agreement, those paramedics who were trained, registered and in paramedic roles before 1st September 2016 are eligible to have their role matched to the new profile. Those joining on or after 1st September 2016 will remain on Band 5 as a newly qualified paramedic (NQP) and will enter a 24-month preceptorship programme.

2.6.3 Local panels, consisting of representatives from both management and staff-side, have successfully job matched and consistency checked the job description against the profile. Our first focus is on transitioning those who joined prior to 1st September 2016 and whose roles match to the new Band 6 profile, across to the higher pay band. Any changes that need to be made will be back-dated to take effect from 31st December 2016.

## 2.7 New HQ/EOC up-date

2.7.1 As the fit out of the new building at Crawley nears completion, final details of the move are being worked through and shared with those staff affected. Details around the process for moving and familiarisation and induction for staff are being developed.

2.7.2 Dates for the move have been finalised and shared with staff as follows:

- 1st May to 19th May 2017 – re-location of Lewes corporate staff to Crawley
- 22nd May to 12th June 2017 – re-location of Banstead and Lewes EOC staff to Crawley
- By 30th June 2017 – re-location of remaining corporate staff completed and de-commissioning of Lewes site completed

# 3. Regional Issues

## 3.1 Contract negotiations

3.1.1 The Trust, working in partnership with CCGs has agreed terms for an independent review of the structural gap and the internal and system actions needed to address this in the short and longer term. The review is expected to report by the end of April 2017.

## 3.2 Potential changes to acute provision at Kent & Canterbury Hospital

3.2.1 On 20th March 2016 we were informed by East Kent Hospitals University NHS Foundation Trust that, following a visit to the Kent & Canterbury Hospital site by Health Education Kent Surrey and Sussex to assess junior doctor training, changes may need to be made to the provision of acute services at the Kent & Canterbury site.

3.2.2 No decisions have been made as yet but we will ensure that we work closely with the hospitals Trust and the CCG to ensure that the impact on SECAmb of any changes made is fully understood and accounted for.

# 4. National Issues

## 4.1 Implementation of Ambulance Response Programme (ARP)

4.1.1 Evidence to the Public Account Committee on 20th March 2017 has confirmed that a final national report on the Ambulance Response Programme is expected in April.

4.1.2 Separately, a letter from the Chief Executives of NHS England and NHS Improvement has confirmed the plan to implement this nationally by October 2017.

**4.2 National Audit Office (NAO) report into ambulance services**

4.2.1 Following publication of the NAO report earlier this year, the Trust has now received the Trust-specific follow-up report.

4.2.2 A comprehensive report will be taken to the Audit Committee in due course, addressing both the public report and this supplementary information but key highlights relating to SECAmb from the follow-up report include (information related to 2015/16 data):

- Incidents per head of population are high (second highest nationally)
- Private provider costs are high but most other non-pay costs benchmark well
- Handover delays have grown, whilst crew clear delays have decreased
- We perform well on see and treat but less well on hear and treat
- Despite high see and treat rate, re-contact rates are low

## 5. Recommendation

5.1 The Board is asked to note the contents of this Report.


**David Hammond, Acting Chief Executive**

**21st March 2017**

| Item No | 211/16 |
|---|---|

| Name of meeting | Board Meeting |
|---|---|
| Date | 28th March 2017 |
| Name of paper | Integrated Performance Dashboard |
| Executive sponsor | David Hammond |
| Author name and role | Executive Team |
| Synopsis (up to 120 words) | The monthly Integrated Performance Dashboard gives the board oversight of the key performance indicators for the Trust, together with explanatory commentary to give suitable context and what actions are being taken to address any shortfalls.<br><br>The dashboard includes score cards for each area (Workforce, Performance, Clinical Effectiveness, Quality & Patient Safety and Finance), suitable supporting commentary and charts with historic performance for trending purposes.<br><br>The Integrated Performance Dashboard is an evolving item and is expected to undergo continuous improvement and change going forward. |
| Recommendations, decisions or actions sought | For Discussion |
| Why must this meeting deal with this item? (max 15 words) | Overview of the Trusts key performance indicators including patient outcome KPIs, AQI and associated performance KPIs, finance KPIs, and workforce KPIs. |
| Which strategic objective does this paper link to? | All |

| Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases). | Yes / **No**<br>If yes and approval or ratification is required, a completed EA Record must be attached. |
|---|---|

**Executive Summary**

SECAmb's 999 response time performance was under the trajectories for Red 1, Red 2 and Red 19 for February. The 999 improvement plan, with the exception of the hospital turnaround performance remains on track. Hospital handover delays continue to affect job cycle time and remain higher than expected. The Trust lost 12% more hours (5,464) in February compared to 4,891 hours compared to the same period last year. This was despite transporting 16% fewer patients to hospital. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital.

Demand was circa 2.6% lower than that agreed with commissioners for the month but still 3.75% above last year's YTD position. SECAmb has increased its call answer performance in February to the highest position in over 12 months.

KMSS 111 achieved its best monthly operational performance of 2016-17, in returning an "Answered in 60" Service Level Agreement (SLA) KPI of 92.5% in February.

The Surrey PTS contract is transferred to South Coastal Ambulance Service (SCAS) at the beginning of the new financial year. The service has and will continue to deliver performance, at or above the levels attained in the previous year.

For the Clinical Outcome Indicators, the Trust's performance for October 2016 was better than the national average for four of the eight Indicators including ROSC, ROSC Utstein, STEMI 150 and Stroke 60, three of which were are in the top three performing Trusts nationally. The poorest performance was for STEMI 150 with a 15.6% negative variance. Survival to Discharge Utstein also had a 10.3% negative variance against the national average. The other two indicators below the national average were Survival to Discharge and Stroke Care Bundle.

Short term sickness levels have decreased from 3.2% to 2.7% following the negative variance attributable to seasonal illnesses in December and January long term sickness absence remains stable at 2.5%. Appraisals remain below target and Mandatory training has seen an increase but is still below target, however it is expected that Mandatory training compliance will deliver on target.

Complaints have demonstrated an improvement in response rates, the top three most recurrent themes for complaints have remained the same for two months. Incident reporting remains constant with an increase in overall reporting. The DATIX rebuild has remained on track to deliver the new and revised modules which will ensure the system is user friendly to encourage reporting and support better thematic analysis. Serious incident reporting remains consistent, themes for this month, possible incorrect patient pathways. Safeguarding training has shown an improvement in month for level 1 and level 2 training but remains off trajectory for the quarter. The pilots complete in March for level 3 training currently at 64% for February aiming to be 82% in March.

The Trust's financial performance for month 11 reflects a deficit of £0.4m which is in line with the forecast. This takes the YTD deficit to £6.7m compared with the £0.7m surplus position assumed in the plan. The expected outturn at the end of the year is £7.1M as has been forecast since Q1.

## 1. SECAMB Regulation Statistics

| ID | KPI | Value |
|---|---|---|
| R1(b) | Use of Resources Metric (Financial Risk Rating) | 4 (Red) |
| R2 | Governance Risk Rating | Red |
| R3 | CQC Compliance Status | Trust: Inadequate (Special Measures) 111 service: Requires improvement |
| R5 | IG Toolkit Assessment | Level 2 - Satisfactory |
| R6 | REAP Level | 3 |

## 2. Workforce

### 2.1. Workforce Summary

2.1.1.  Short term sickness levels have decreased from 3.2% to 2.7% following the negative variance attributable to seasonal illnesses in December and January Long term sickness absence remains stable at 2.5%.

2.1.2.  Appraisals remain below target and Mandatory training has seen an increase but is still below target, however it is expected that Mandatory training compliance will deliver on target.

## 2.2. Workforce Balanced Scorecard

| | **Workforce Commentary :- Data from Feb 2017 and Jan 2017** | | | | | | |
|---|---|---|---|---|---|---|---|
| ID | KPI | Current Month (Plan) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan) | YTD (Actual) | YTD (Prev. Yr.) |
| Wf-1A | Short Term Sickness - Rate | | **2.7%** | 2.5% | | **2.7%** | 2.5% |
| Wf-1B | Long Term Sickness - Rate | | **2.5%** | 3.5% | | **2.5%** | 3.5% |
| Wf-2 | Staff Appraisals | 83% | **49.6%** | 63.0% | | | |
| Wf-3 | Mandatory Training Compliance (All Courses) | 95% | **81.9%** | 89.9% | | | |
| Wf-4 | Total injuries | | **66** | 56 | | **681** | 688 |
| Wf-5 | Total physical assaults | | **14** | 12 | | **194** | 175 |
| Wf-6 | Vacancies (Total WTE) | | **286.8** | | | Not Relevant | |
| Wf-7 | Annual Rolling Staff Turnover | | **16.6%** | 14.3% | | | |
| Wf-8 | Reported Bullying & Harassment Cases | | **0** | | | **14** | |
| Wf-9 | Cases of Whistle Blowing | | **0** | | | **3** | |

## 2.3. Workforce Commentary

2.3.1.  The work of the HR Advisor team has seen short term sickness absence figures drop from 3.2% to 2.7% following the negative variance attributable to seasonal illnesses in December and January Long term sickness absence remains stable at 2.5% again managed via the HR Advisor team.

2.3.2.  The improvement in the accuracy of establishment figures continues to support better recruitment activity with a further reduction in the vacancy numbers from 323 WTE to 287 WTE and an overall vacancy rate of 8.2% down from 9.3% in January and 9.4% in December. The resourcing are working to clearly defined establishment figures recognised by the managers which has greatly increased the efficiency of the team.

2.3.3.  There has been a slight improvement in the turnover rate from the previous month. This figure is likely to remain constant over the next few months until the increased staff engagement activities take effect.

2.3.4.  As expected appraisals remain below target. The roll out of the online appraisal system, Actus, will start from April which will support the delivery of the declared target by March 2018.

2.3.5. Mandatory training has seen an increase but is still below target. There is a strong push to get all mandatory training completed by the end of March, with an expectation this will be delivered.

2.3.6. There have been no new formal Whistleblowing or Bullying and Harassment cases. The lack of formal bullying and harassment cases is in contrast to the staff survey figures which shows significant issues in this area. The survey currently underway and facilitated by Duncan Lewis will help us assess the true situation.

2.3.7. SECAmb do not report an agency worker metric but it may be worth bringing to the Board's attention the work in this area. In January the Trust engaged 170 agency workers, this has dropped to 99 at the time of writing and is expected to be below 60 by the end of April. This increased control and rigour has been a joint working effort between the HR and Finance teams.
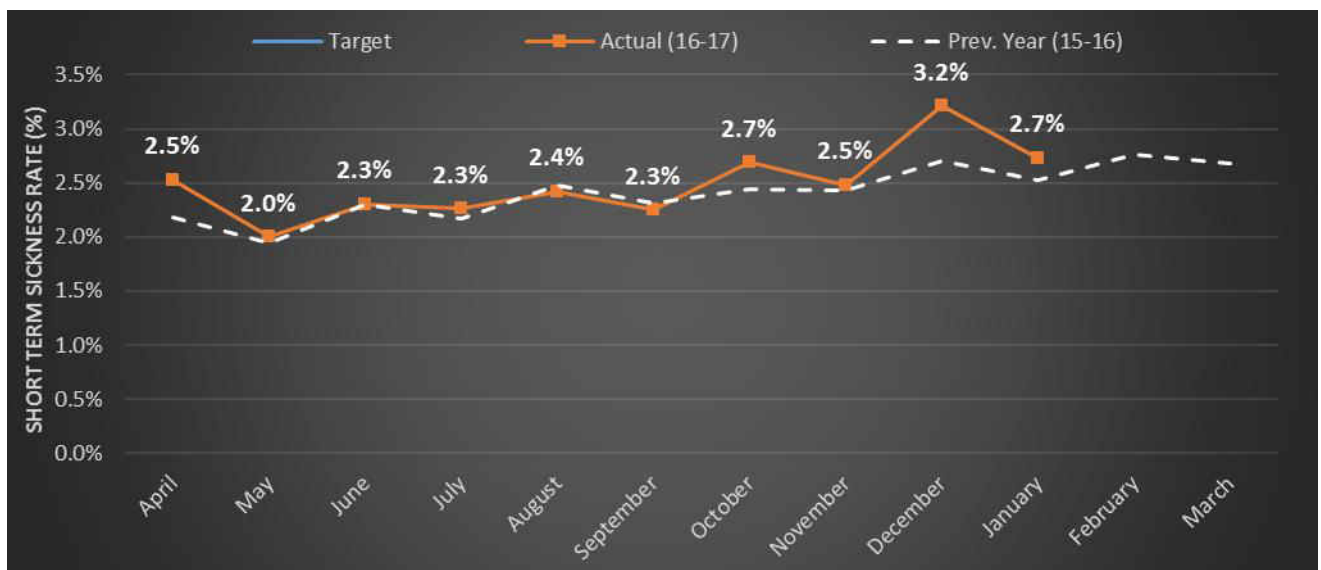
## 2.4. Workforce Charts
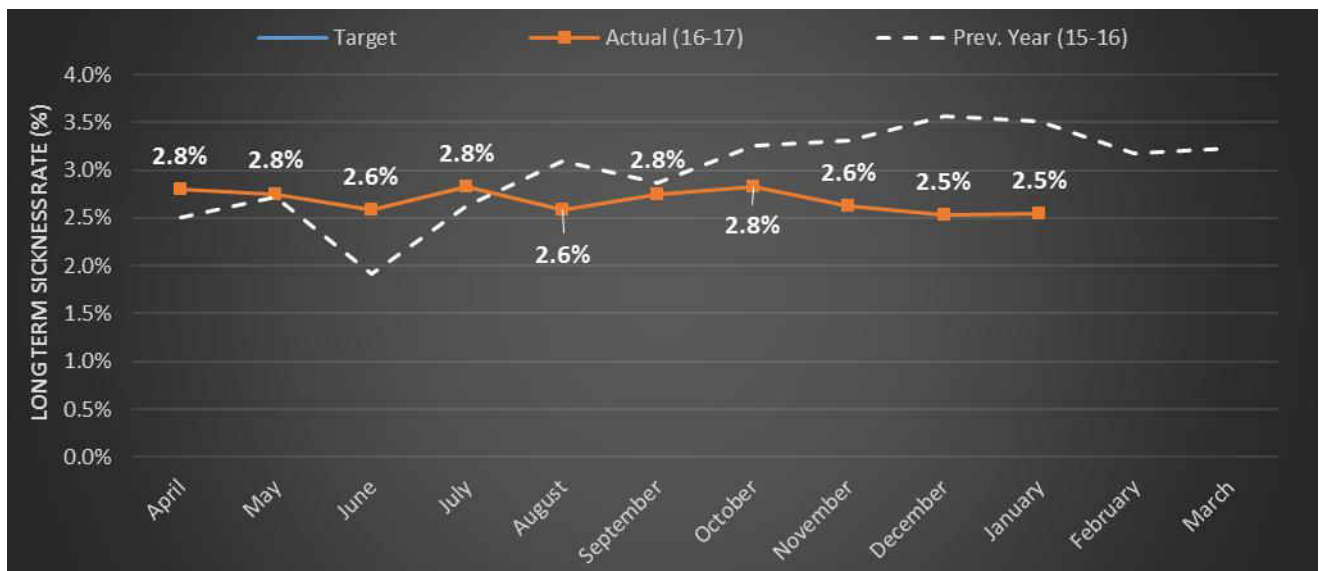


Figure Wf-1A - Short Term Sickness Rate



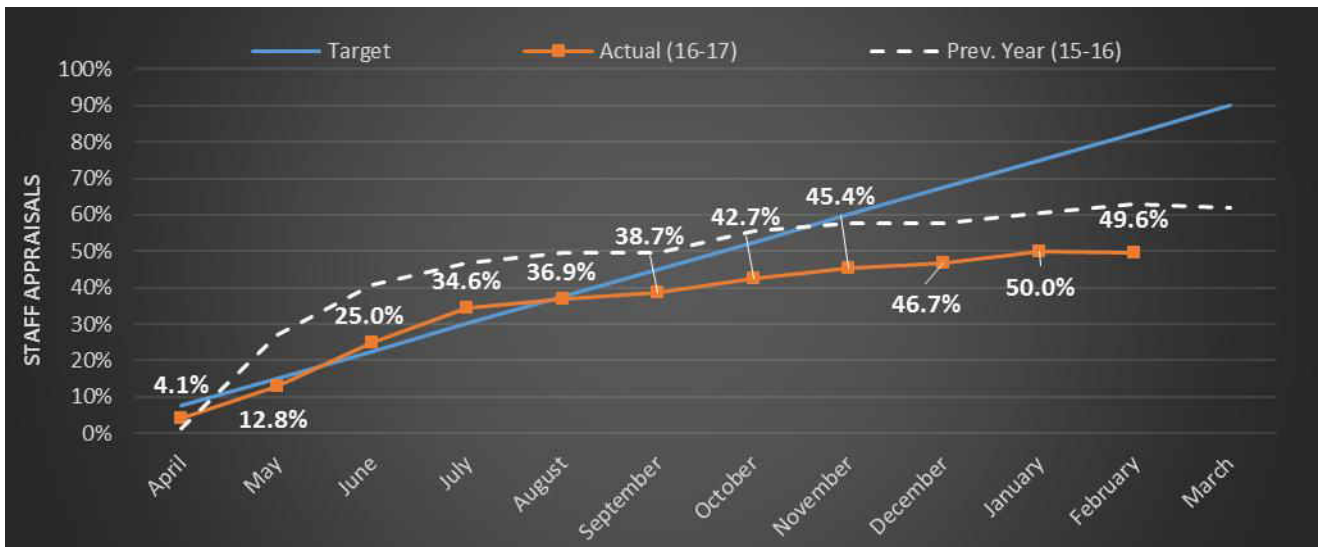Figure Wf-1B -  Long Term Sickness – Rate
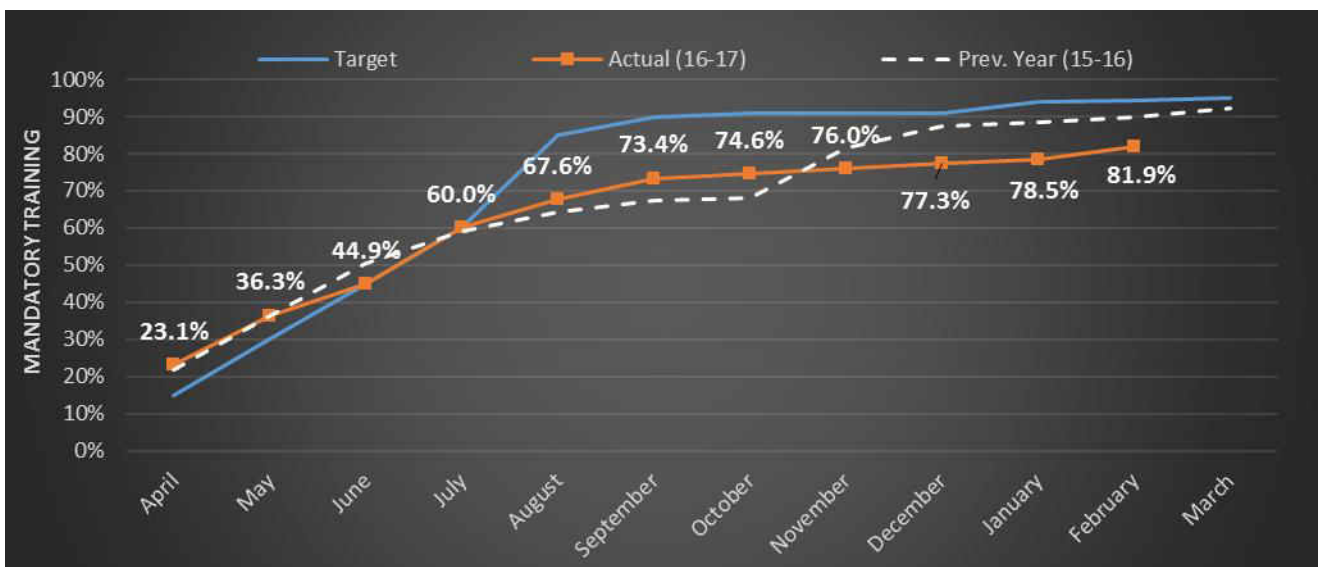
*Figure Wf-2 - Staff Appraisals*



*Figure Wf-3 - Mandatory Training Compliance (All Courses)*
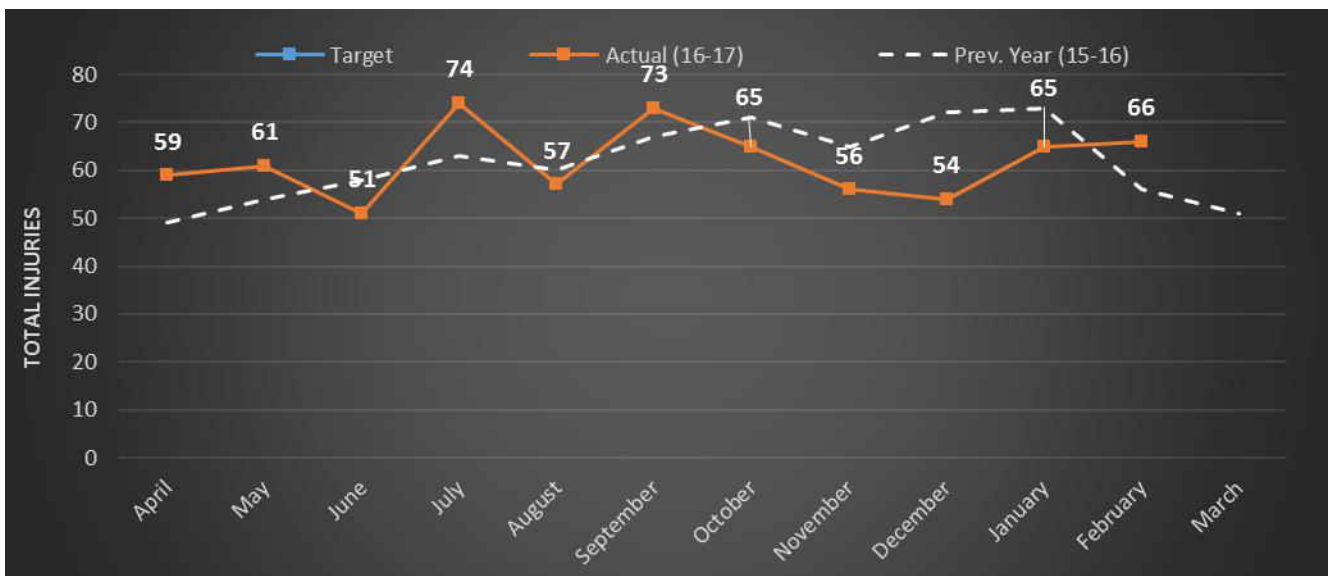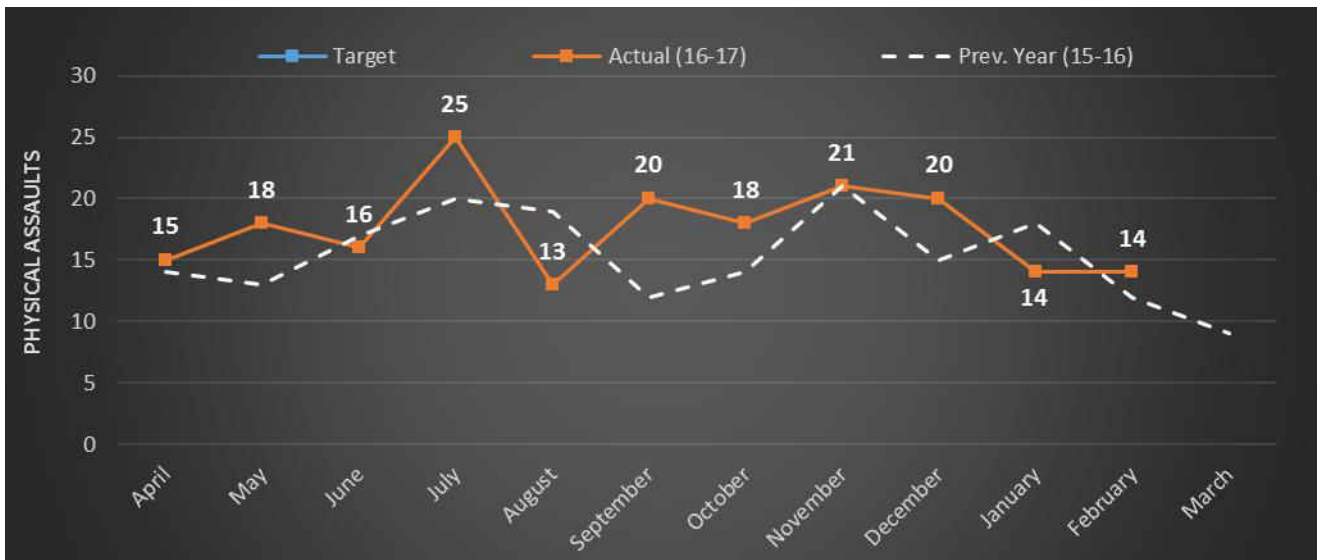


*Figure Wf-4 - Total injuries.*

*Figure Wf-5 - Total physical assaults.*
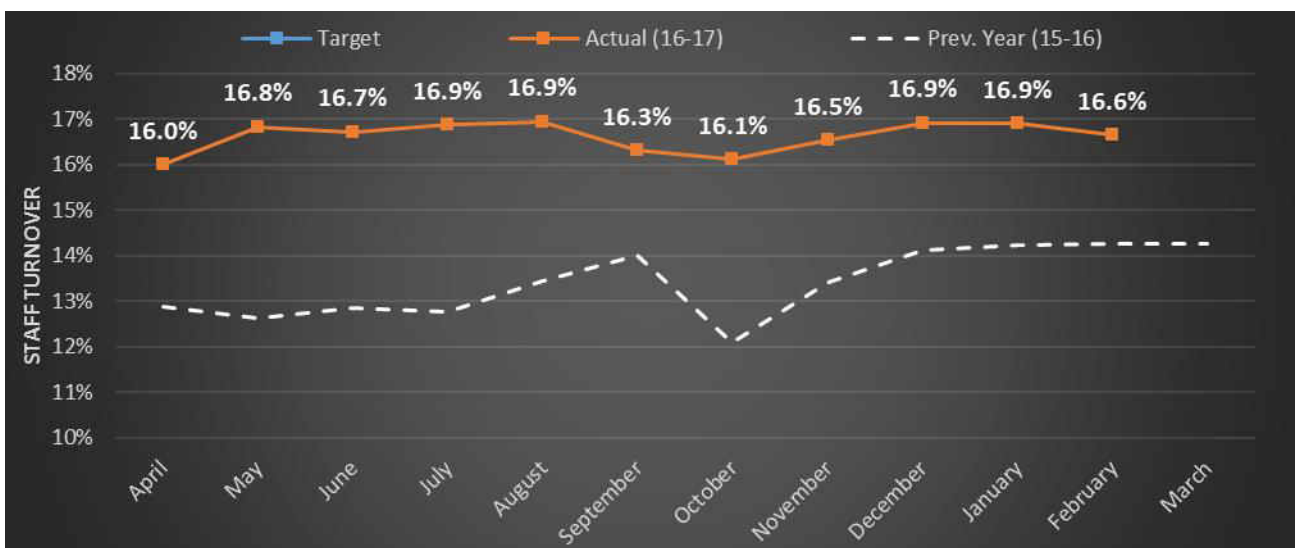


*Figure Wf-6 - Vacancies (Total WTE)*
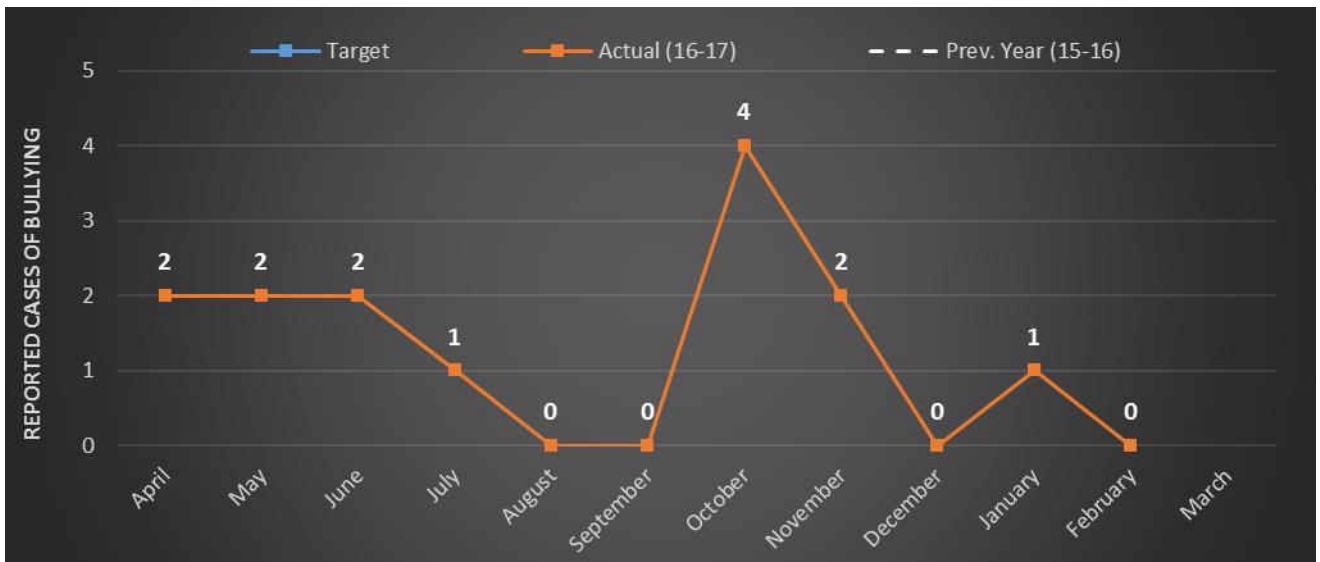


*Figure Wf-7 - Annual Rolling Staff Turnover*
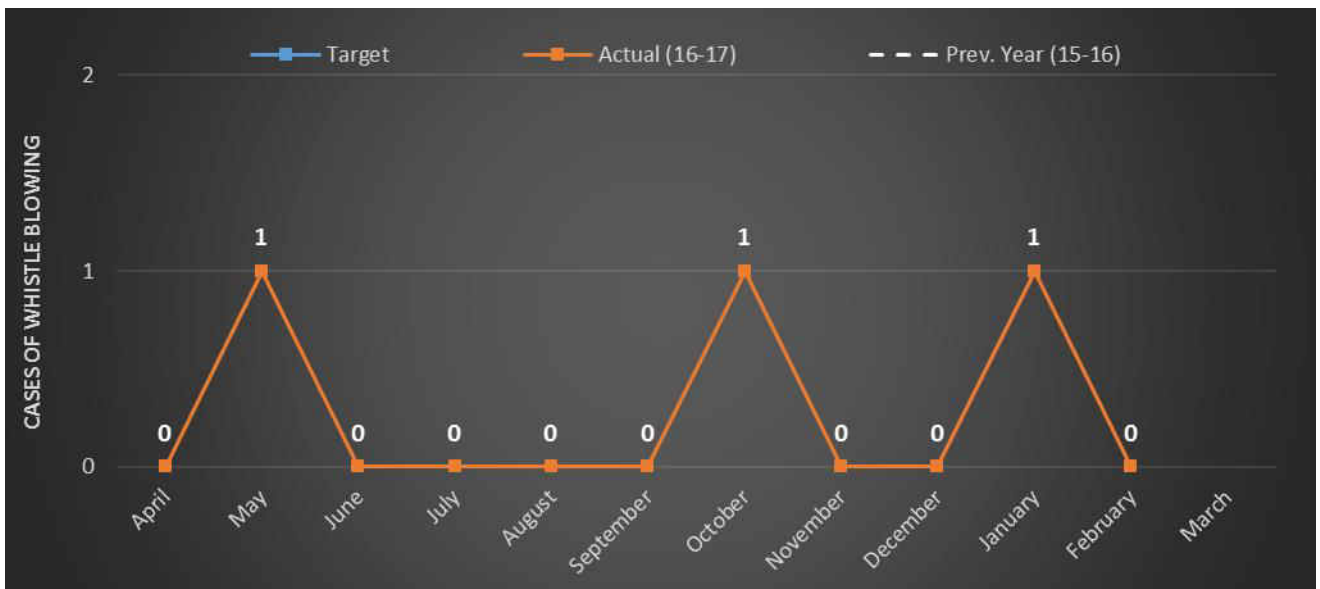
*Figure Wf-8 - Reported Bullying & Harassment Cases*



*Figure Wf-9 - Cases of Whistle Blowing*

## 3. Operational Performance

### 3.1. Operational Performance Summary

3.1.1. SECAmb's 999 response time performance was under the national targets and SECAmb did not achieve the new trajectories for Red 1, Red 2 and Red 19 for February.

3.1.1. The 999 Improvement Plan, with the exception of the Hospital Turnaround performance remains on track. Hospital delays in February were better compared with the circa 7700 hours in December and 7950 in January, which were over double the maximum level agreed with commissioners. SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital.

3.1.2. Demand was circa 2.6% lower than that agreed with commissioners for the month but still 3.75% above last year's YTD position. SECAmb has increased its call answer performance in February to the highest position in over 12 months.

3.1.3. KMSS 111 achieved its best monthly operational performance of 2016-17, in returning an "Answered in 60" Service Level Agreement (SLA) KPI of 92.5% in February. Despite the underlying reduction in like-for-like call volumes compared to the winter surge that was prevalent in February 2016, other NHS 111 service providers have been unable to sustain a similar level of resilience and operational performance, as seen by the NHS England SLA average for February of 89.4%.

3.1.4. The Surrey PTS contract is transferred to South Coastal Ambulance Service (SCAS) at the beginning of the new financial year. The service has and will continue to deliver performance, at or above the levels attained in the previous year.

## 3.2. Operational Performance Scorecard

### Operational Performance Scorecard:- Data From February 2017

| ID | KPI | Current Month (Plan*) | Current Month (Actual) | Current Month (Prev. | YTD (Plan*) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| 999-1 | Red 1 response <8 min | 68% | 65.7% | 65.4% | | 64.6% | 72.6% |
| 999-2 | Red 2 response <8 min | 57% | 49.8% | 57.7% | | 52.7% | 69.1% |
| 999-3 | Red 19 Transport <19 min | 91% | 87.6% | 91.3% | | 89.1% | 94.5% |
| 999-4 | Activity: Actual vs Commissioned | 63759 | 62138 | 66093 | 723775 | 750927 | 719170 |
| 999-5 | Hospital Turn-around Delays (Hrs lost >30 min.) | 2627 | 5464 | 5123 | 26510 | 62977.6 | 41355.3 |
| 999-6 | Call Pick up within 5 Seconds | 92% | 90.8% | 82.0% | | 76.6% | 87.2% |
| 999-7 | CFR Red 1 Unique Performance Contribution | 1.5% | 2.2% | | | | |
| 999-8 | CFR Red 2 Unique Performance Contribution | 1.2% | 1.5% | | | | |
| 111-1 | Total Number of calls offered | | 79876 | 102628 | | 1042491 | 1078300 |
| 111-2 | % answered calls within 60 seconds | 85% | 92.5% | 65.0% | 85% | 79.0% | 82.5% |
| 111-4 | Abandoned calls as % of offered after 30 secs | 5.0% | 0.7% | 9.3% | 5.0% | 4.2% | 3.3% |
| 111-5 | Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician) | 77% | 73.6% | 73.8% | | 74.6% | 86.5% |
| PTS-1 | PTS Activity (Surrey) | 11180 | 8578 | 12055 | 129632 | 114188 | 161233 |
| PTS-2 | Arrival - % patients to arrive <= 15 min after appt. time. | 95% | 87.2% | 88.8% | 95% | 86.5% | 84.1% |
| PTS-3 | Departure - % patients collected <= 60 min of planned collection time (Surrey) | 95% | 84.3% | 90.5% | 95% | 86.1% | 84.7% |
| PTS-4 | Discharge - % patients collected <= 120 min of booked time to travel (Surrey) | 95% | 76.7% | 77.2% | 95% | 79.9% | 76.2% |

*For the following KPI's, the "Plan" in the table above is the Unified Recovery Plan (URP) target agreed with commissioners. The URP targets and the standard national targets are both shown in the Charts on the following few pages. KPIs affected: 999-1 to 999-3; 999-6; 111-2, 111-4 and 111-5.*

### 3.3. Operational Performance Commentary

3.3.1.  The Red 1 position was improved on the January position but less than the revised February target. The slight improvement in Red 2 performance compared to January is much lower than anticipated given the significant reduction in activity compared to January. Hospital Turnaround delay would have impacted on this but further investigation is ongoing as to what is generating such a low level of performance.

3.3.2.  Demand was circa 2.6% below the plan agreed with commissioners for the month but Year to Date (YTD) was still 3.75% above last year's position. Both activity and performance continues to show a slow but steady improvement based on the March performance to date.

3.3.3.  SECAmb has successfully implemented Nature of Call and Dispatch on Disposition as planned on the 18th October as part of the national pilot for the Ambulance Response Programme.  No serious clinical incidents have been reported since go live, we have improved to circa 60% plus of Red 1's are being identified during the Nature of Call process, compared to the national assumption of 75%, whilst not realising the national assumption this is still in line with other Ambulance Services.

3.3.4.  The Trust has implemented plans to increase contribution from community first responders (CFRs). This entails improving technical links with CFRs, new processes in EOC to mobilise the CFRs and an extensive engagement campaign with the CFRs themselves. Benefits are being realised in February are above the planned trajectories for this group of responders.

3.3.5.  SECAmb has maintained its Hear and Treat performance for February.  There is already an encouraging improvement in the Hear and Treat ratios and further recruitment of clinicians continues, SECAmb has 40 WTE in post and are aiming for a total 45 WTE to support the NHS Pathways activity. The concept of an additional pool of clinicians to undertake a dedicated Clinical Assessment Team for the 2017/2018 year is being put together, this will prepare SECAmb for its phase 2 of the Ambulance Response Programme changes to incident categorisation.

3.3.6.  Call answer performance improved from last month's performance despite the February activity and SECAmb achieved 90.8% in 5 seconds compared to a revised trajectory plan of 92%. Despite not meeting the revised target this is the best performance for call answering in over 12 months.

3.3.7.  SECAmb has been working with both commissioners and acute hospitals to strengthen its hospital handover procedures and reduce delays at hospital.  These improvements are built into the improvement trajectories. Hospital delays in February were better compared with the circa 7950 hours in January which was over double the maximum level agreed with commissioners.  February still saw 5464 lost hours which was the single biggest impact on our performance trajectory for February. Hospital Turnaround delay is the single most external factor which impacts SECAmb performance and we have least control.  A recent instruction from NHSI to increase the prompts to Acute Hospital Directors On-Call for every patient delay over 1 hour is being developed into a robust Operational Plan to ensure consistency across the region.

3.3.8.  KMSS 111 achieved its best monthly operational performance of 2016-17, in returning an "Answered in 60" Service Level Agreement (SLA) KPI of 92.5% in February.  Despite the underlying reduction in like-for-like call volumes compared to the winter surge that was prevalent in February 2016, other NHS 111 service providers

have been unable to sustain a similar level of resilience and operational performance, as seen by the NHS E SLA average for February of 89.4%.

3.3.9.  The service continued to achieve the 95% target during weekdays on a routine basis. Although weekends continue to be more challenging, the service only reported six "red" days for the month. The Call Abandonment rate dropped to below 1%, compared to a national benchmark of 2.2% and the formal contractual target of 2%.

3.3.10. Whilst improving and embedding the service's operational performance, KMSS 111 continues to exceed the national average for the Combined Clinical KPI of immediate warm transfer or a clinician call-back within ten minutes. The service year to date for 2016/17 has achieved a Combined Clinical KPI of 74.6%.  This has been delivered despite clinical resource being redirected to mobilise the Clinical In-line Support (CIS) function, provided by specifically planned "floor-walking" clinicians which has helped increase KMSS 111's overall clinician contact for its cases (29% for January 2017) and more importantly, has enabled the service to continue returning an Emergency Department referral rate (6.9%), lower than the NHS E average (7.3%).

3.3.11. The Ambulance referral rate was higher than the NHS E average for this month however the service continues to refine its ambulance validation processes and is currently undertaking call profiling modelling work to ensure that KMSS 111 maximises the impact of its CIS when our 999 colleagues (and patients) most need this clinical intervention and support.

3.3.12. The overarching trends for both of these referral rates is downward. Despite its operational improvement, the ED and 999 referrals remain key areas of focus, in line with the recent communication from NHS E relating to "Managing A&E Demand". As agreed with Commissioners, there is also now a greater representation of the KMSS 111 Senior Management Team (SMT) at A&E Delivery Boards and other external forums. The service is developing proposals to mitigate referrals and conveyances to Emergency Departments, especially in relation to how call handlers can maximise their utilisation of services presented on the Directory of Services (DoS). KMSS 111 is also planning to capture an accurate and automatically generated measurement of our clinical contact for cases, which is currently under-reported due to system limitations. An IT solution is due to be implemented in March 2017 that should permit this key (non-contractual) NHS E data-set to be captured and reported on more easily and accurately. This will aid our progress towards realising Simon Stevens' NHS England objective that "the number of 111 calls receiving clinical assessment increases by a third before March 2018." These proposals also form an integral part of ongoing discussions with Commissioners relating to the KMSS 111 Contract Phased Migration, incorporating potential collaboration with other service providers on Integrated Urgent Care pilots and proofs of concept.

3.3.13. KMSS 111 is anticipating a strong finish to the 2016-17 reporting year, representing a successful journey from a very difficult and uncertain operational environment twelve months ago towards now achieving full service stability.

3.3.14. Beyond March, KMSS 111 is planning for Quarter 1 of the new financial year and in particular, the Easter weekend and following Public Holidays in May. Currently there are three large cohorts of Health Advisors in training across both Contact Centres and this new HA resource has predominantly been recruited on a weekend shift basis.  The service has acted flexibly and creatively in scheduling and accelerating the training programmes to allow new HA's to achieve full proficiency in time for the pressures and increased call activity of the Easter weekend. With the addition of ongoing clinical

recruitment, we are confident of commencing 2017-18 as one of the highest-performing and innovative NHS 111 services nationally.

## 3.4. Operational Performance Charts
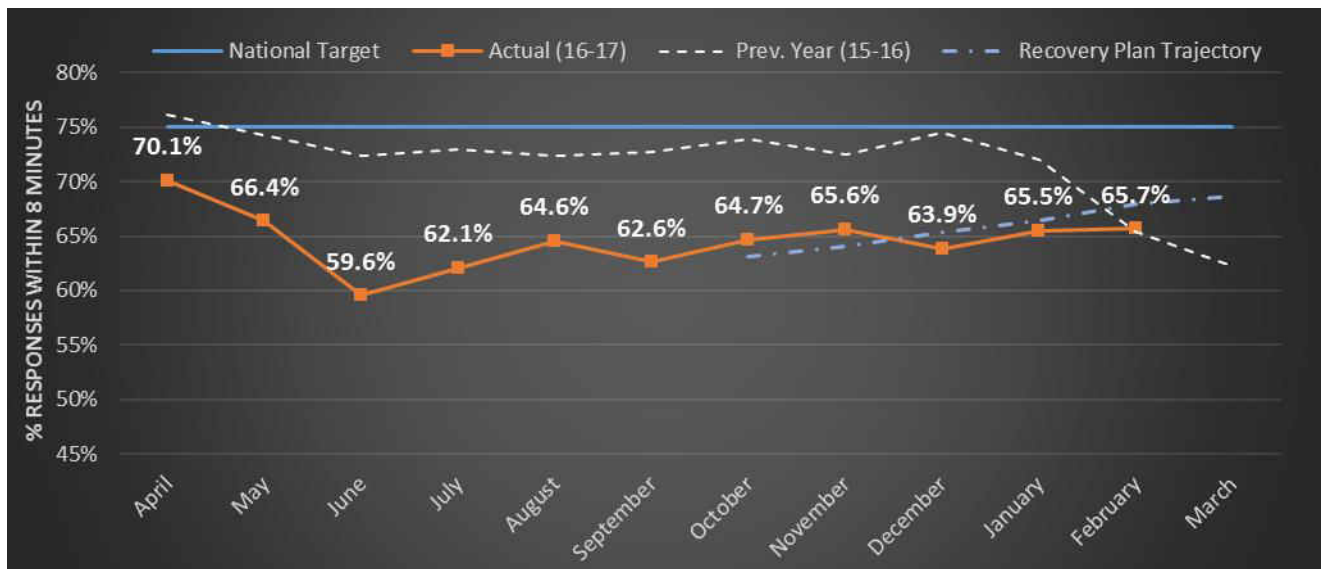


Figure.999-1 - Red 1 response <8 min



Figure.999-2 - Red 2 response <8 min

*Figure.999-3 - Red 19 Transport <19 min*
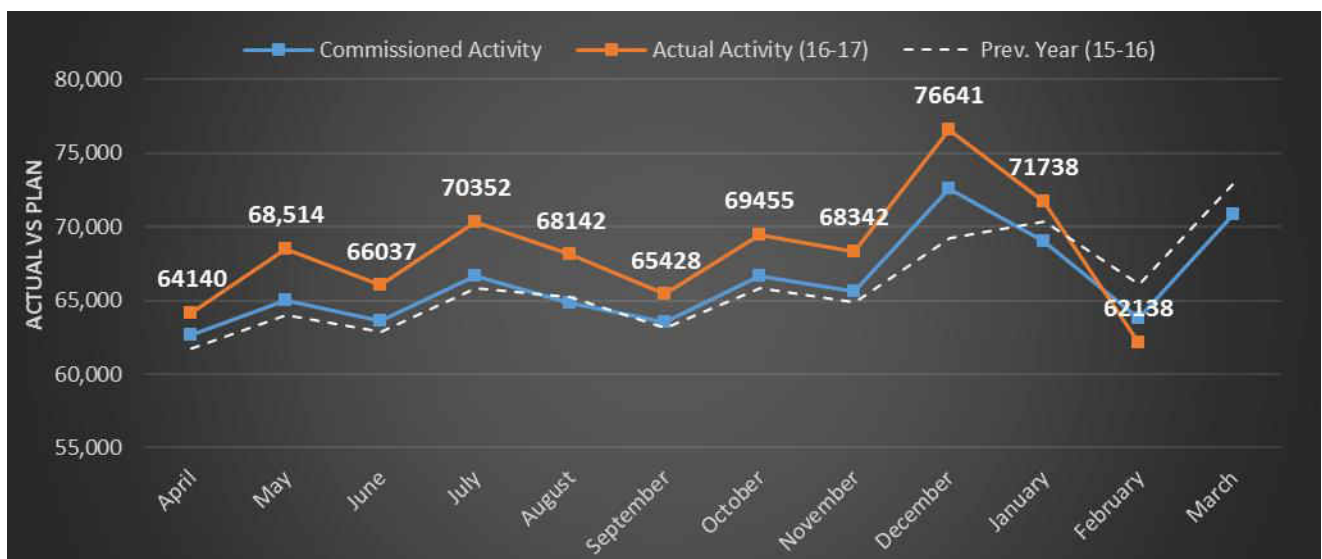


*Figure.999-4 - Activity: Actual vs Commissioned*
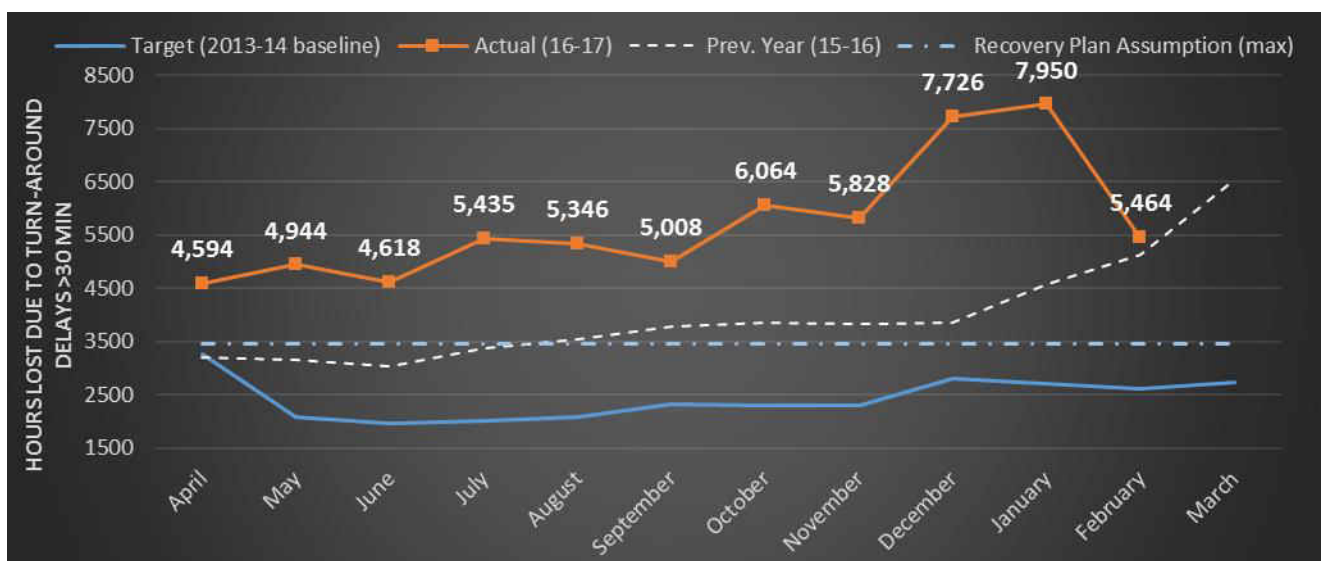


*Figure.999-5 - Hospital Turn-around Delays (Hrs lost >30 min.)*
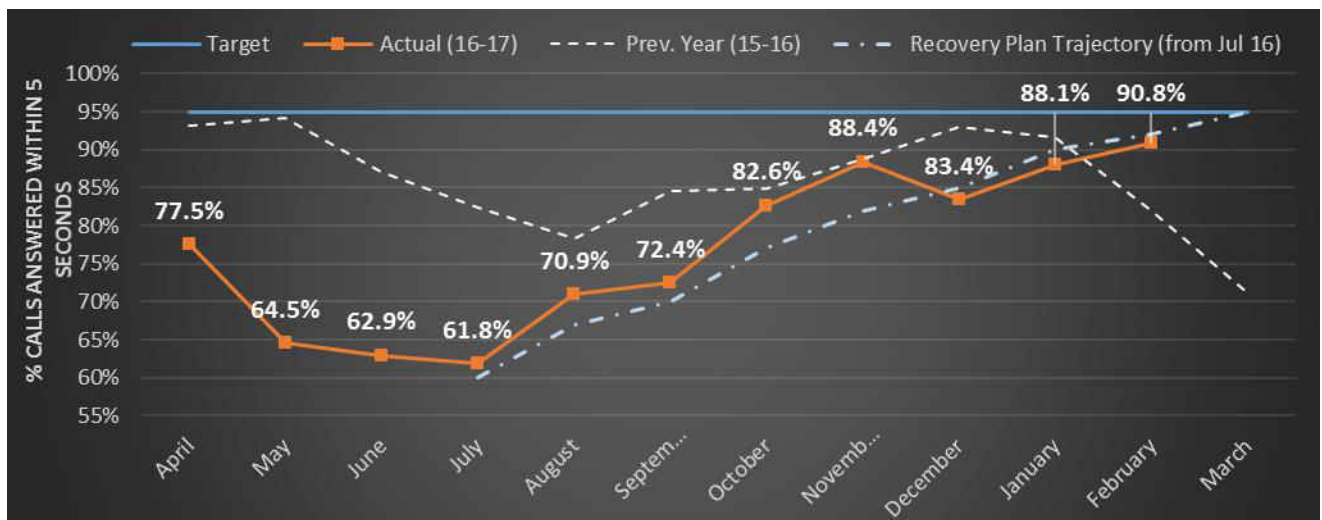
*Figure.999-6 - Call Pick up within 5 Seconds*
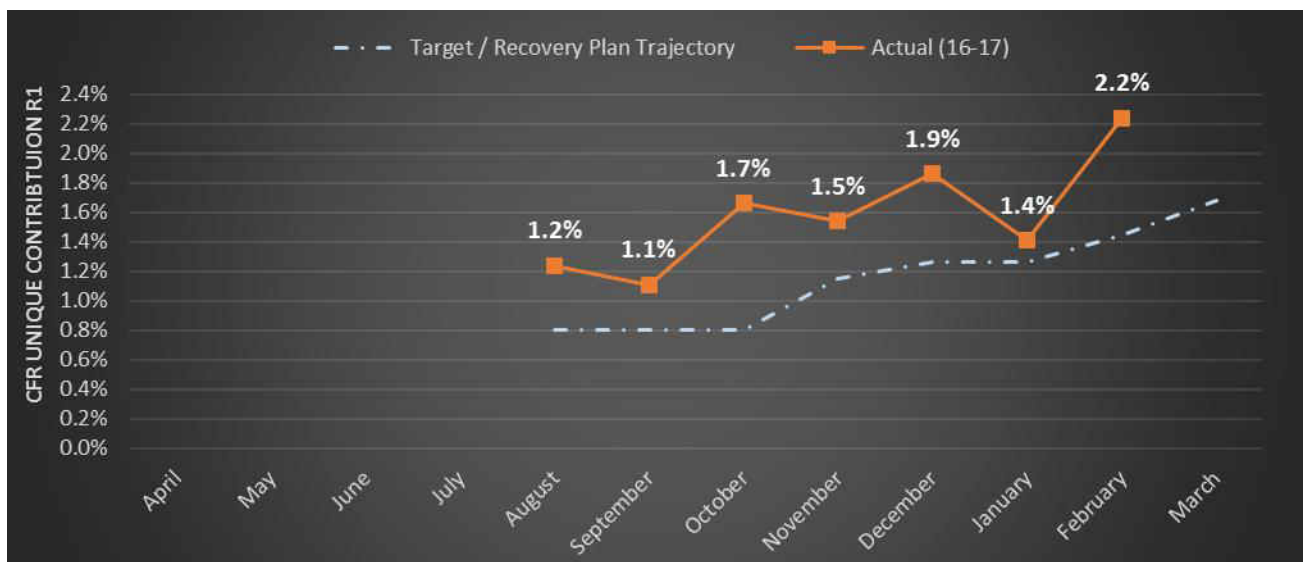


*Figure.999-7 - CFR Red 1 Unique Performance Contribution*
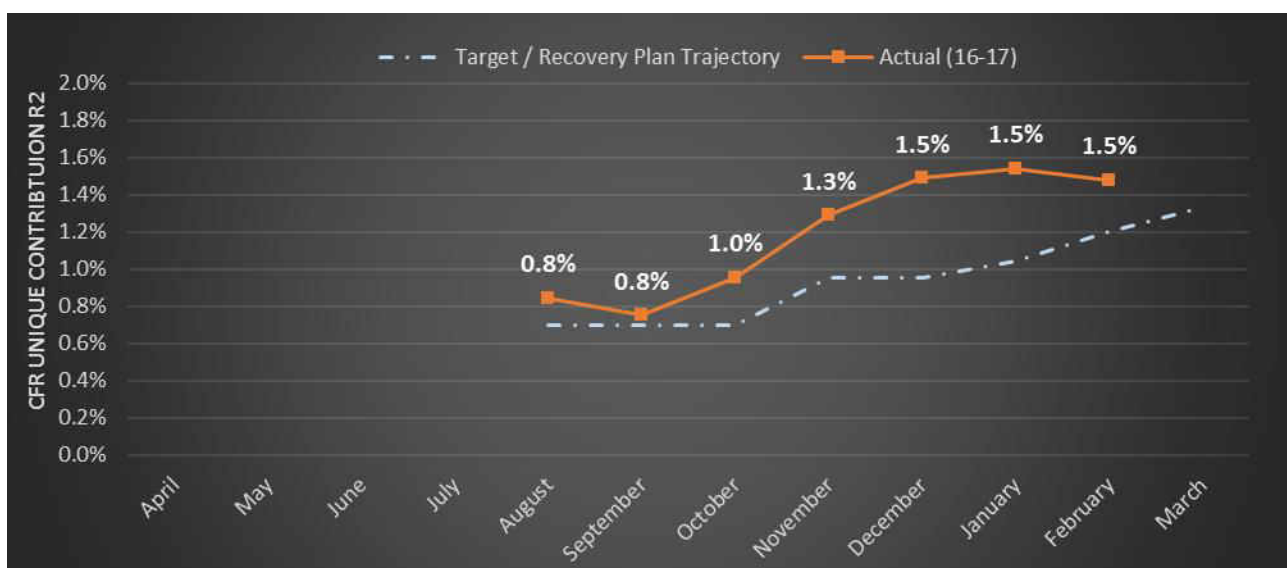


*Figure.999-8 - CFR Red 2 Unique Performance Contribution*

17
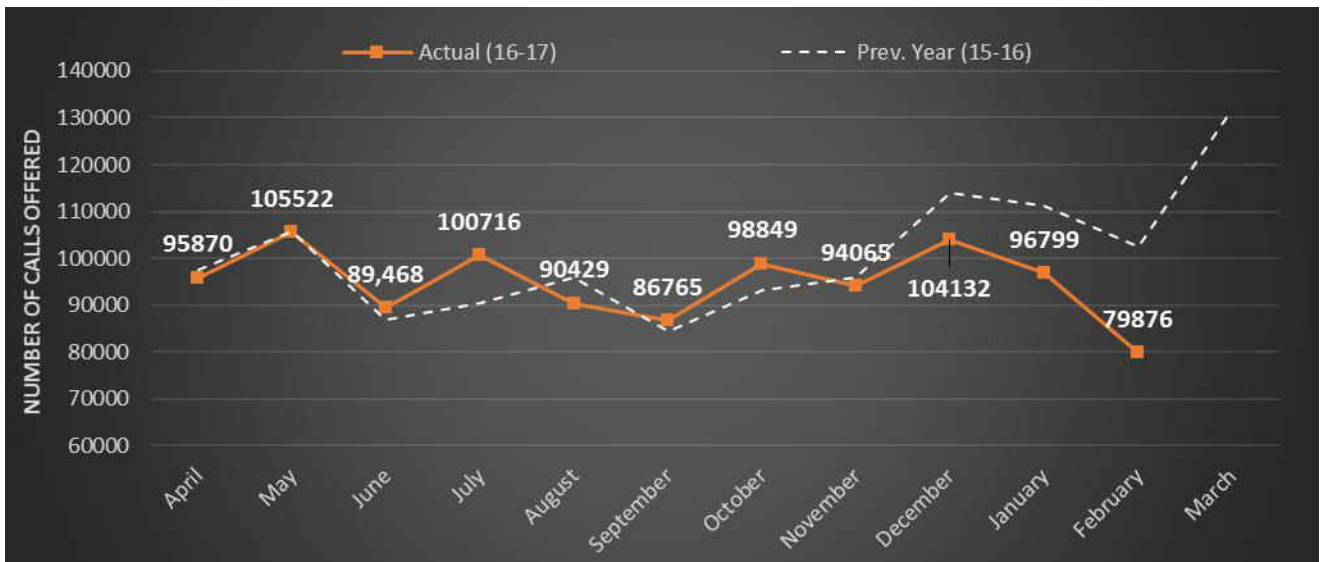
*Figure.111-1 - Total Number of calls offered*
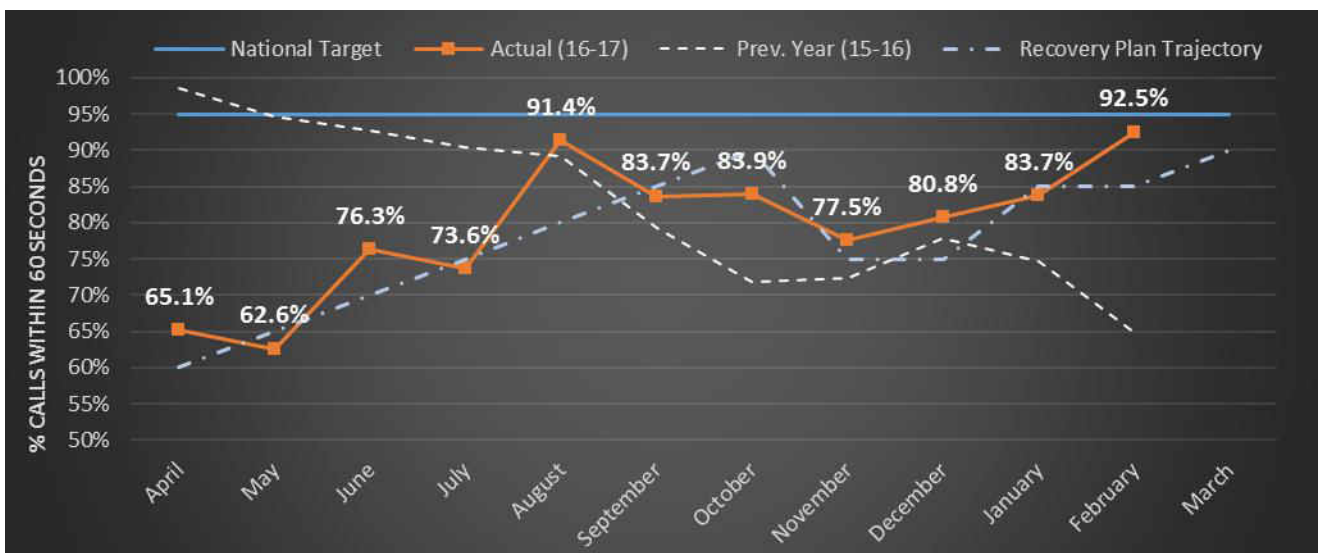


*Figure.111-2 - % answered calls within 60 seconds*
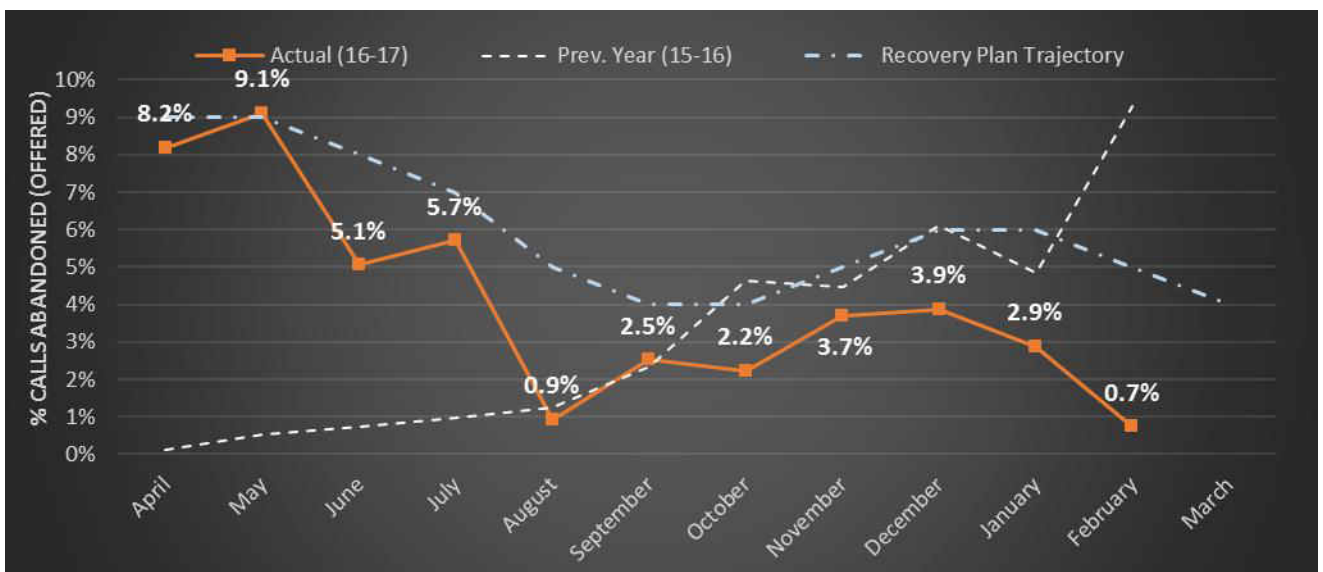


*Figure.111-4 - Abandoned calls as % of offered after 30 secs*
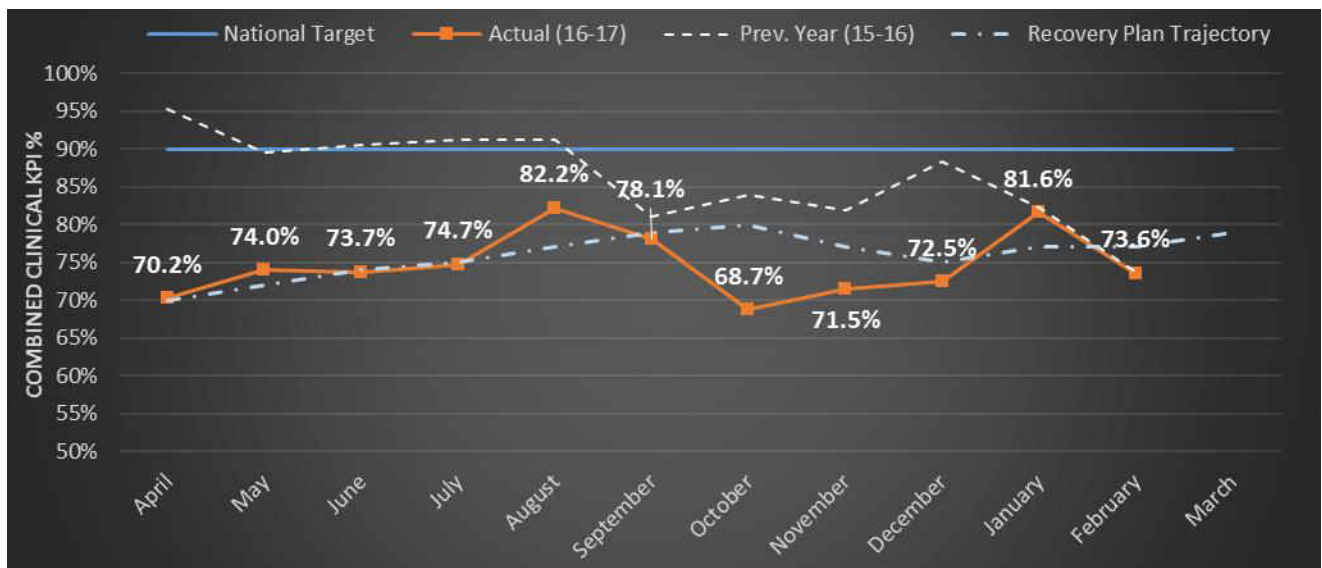
*Figure.111-5 - Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician)*



*Figure.PTS-1- PTS Activity (Surrey)*

*Figure.PTS-2 - Arrival - % patients to arrive <= 15 min after appt. time. (Surrey)*



*Figure.PTS-3 - Departure - % patients collected <= 60 min of planned collection time (Surrey)*
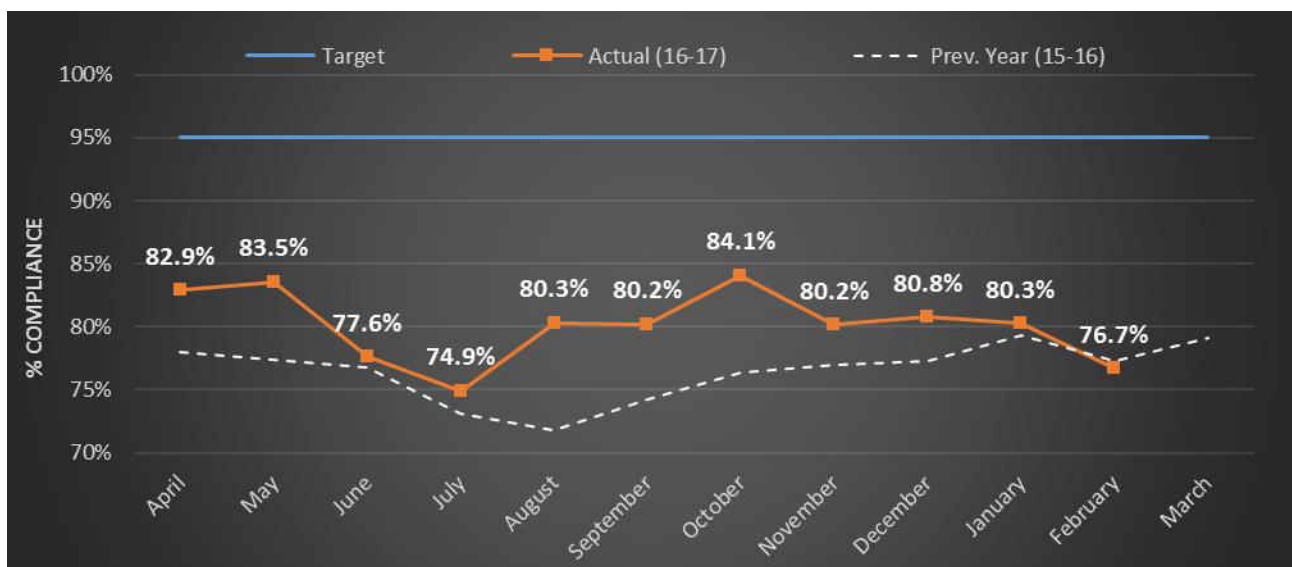


*Figure.PTS-4 - Discharge - % patients collected <= 120 min of booked time to travel (Surrey)*

## 4. Clinical Effectiveness

### 4.1. Clinical Effectiveness Summary

4.1.1. This report describes Trust performance reported against eight Clinical Outcome Ambulance Quality Indicator (AQIs) to NHS England for Month 7 (October 2016).  The data continues to show variable standards in delivering patient outcomes.

### 4.2. Clinical Effectiveness KPI Scorecard

| ID | KPI | Current Month (Nat. Av.*) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Nat. Av.*) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| CE-1 | Cardiac arrest - ROSC on arrival at hospital  (Utstein) | 47.6% | **48.1%** | 54.5% | 51.8% | **53.6%** | 48.8% |
| CE-2 | Cardiac arrest - Return of spontaneous circulation on arrival at hospital  (All) | 26.6% | **27.8%** | 28.4% | 28.6% | **27.9%** | 27.3% |
| CE-3 | Cardiac arrest -Survival to discharge - Utstein | 25.7% | **15.4%** | 22.2% | 26.9% | **27.0%** | 23.8% |
| CE-4 | Cardiac arrest -Survival to discharge - All | 7.8% | **4.3%** | 8.0% | 8.8% | **7.9%** | 8.5% |
| CE-5 | Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle) | 78.7% | **63.1%** | 77.4% | 79.5% | **68.3%** | 68.3% |
| CE-6 | Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes | 86.4% | **96.9%** | 92.7% | 86.3% | **91.8%** | 93.4% |
| CE-7 | % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes | 51.7% | **62.6%** | 67.0% | 54.4% | **66.5%** | 65.5% |
| CE-8 | % of suspected stroke patients assessed face to face who received an appropriate care bundle | 97.6% | **95.4%** | 97.4% | 97.6% | **95.9%** | 96.4% |

### 4.3. Clinical Effectiveness

4.3.1. In October the Trust's performance was better than the national average for four of the eight Clinical Outcome Indicators; ROSC, ROSC Utstein, STEMI 150 and Stroke 60, three of which were are in the top three performing Trust.

4.3.2. The poorest performance was for STEMI 150 with a 15.6% negative variance and Survival to Discharge Utstein with a 10.3% negative variance against the national average. The other two indicators below the national average are, Survival to Discharge and Stroke Care Bundle.

In more detail:

4.3.3. **ROSC (All)** – In October 2016, performance improved to 27.8% with a 2.5% positive variance from the previous month.  This has placed the trust in a 3$^{rd}$ position nationally, highest ranking for over 3 years, however, this should be treated with caution as overall the national average ~~performance~~ dipped in October.

4.3.4. **ROSC (Utstein)** – In October performance improved to 48.1%, a 4% positive variance on September's performance, taking the trust above the national average for the first time since July-17.  Performance is comfortably within the national control limits of 2 s.d.

4.3.4.1. It must be noted that performance in the Utstein cohort often fluctuates, this is due to the small number on incidents that meet the Utstein inclusion criteria.

4.3.5. **Survival to Discharge (StD) –** October performance figures for All and Utstein must be treated with caution.  Whilst it appears that performance has significantly deteriorated (Std: Sept 9.4%, Oct 4.3%; StD Utstein Sept 30.0%, Oct 15.4%), these figures are skewed as a result of data being extracted from the national spine.  Please note, that following the implementation of the new process (national spine), a significant proportion of October survival data is still outstanding from hospitals.  An improvement will be evident once all data has been received.

4.3.6. **STEMI 150** – In October performance has significantly improved from 86.7% to 96.9%. This has placed the Trust at the top of the national rank.

4.3.7. **STEMI Care Bundle** –   The delivery of the care bundle continues to be a challenge with performance dipping to 63.1%, a 13.5% negative variance on the previous month.   The delivery of this outcome indicator continues to be compromised by the failure to record two pain scores.

4.3.8. **Stroke 60** –  In October 2016, 52% of FAST positive patients in England, assessed face to face, and potentially eligible for stroke thrombolysis arrived at hospitals with a hyperacute stroke unit within 60 minutes of an emergency call connecting to the ambulance service. The largest proportion for October 2016 was 63% for South East Coast.

4.3.9. **Stroke Care Bundle** - In October, performance has remained stable at 95.4%, however, nationally South East Coast have been in the worst three performing trust for the last four consecutive months.   Recording of blood glucose is the element of the care bundle that compromises overall Trust performance.

## 4.4. Clinical Effectiveness Charts
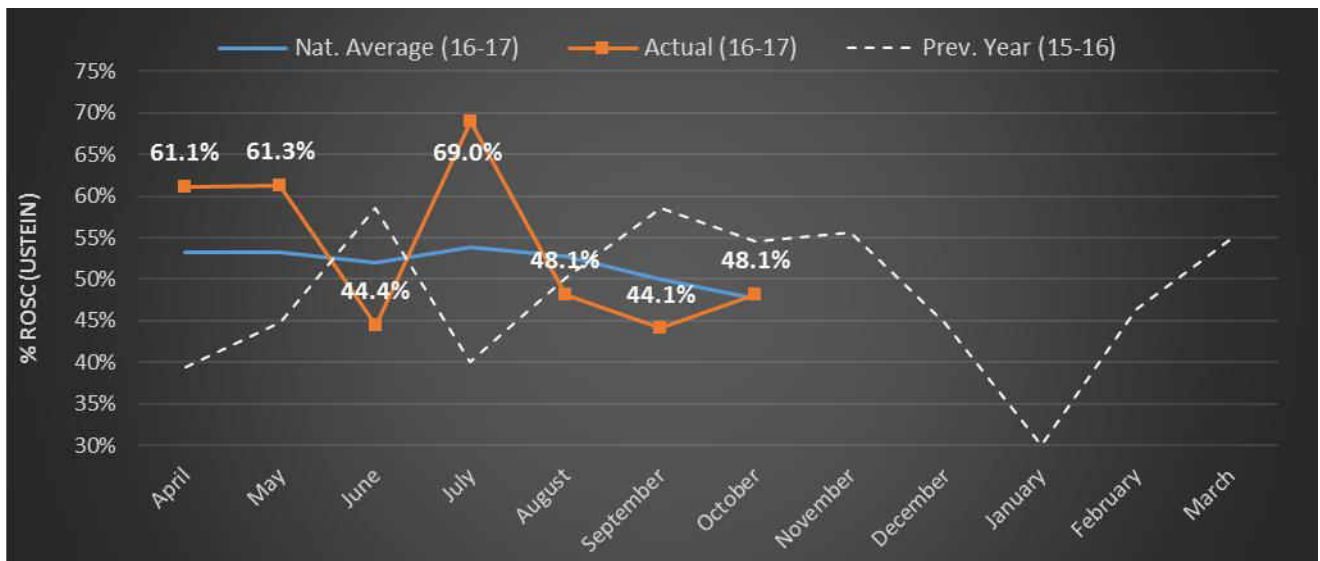


Figure.CE-1 - Cardiac arrest - ROSC on arrival at hospital (Utstein)
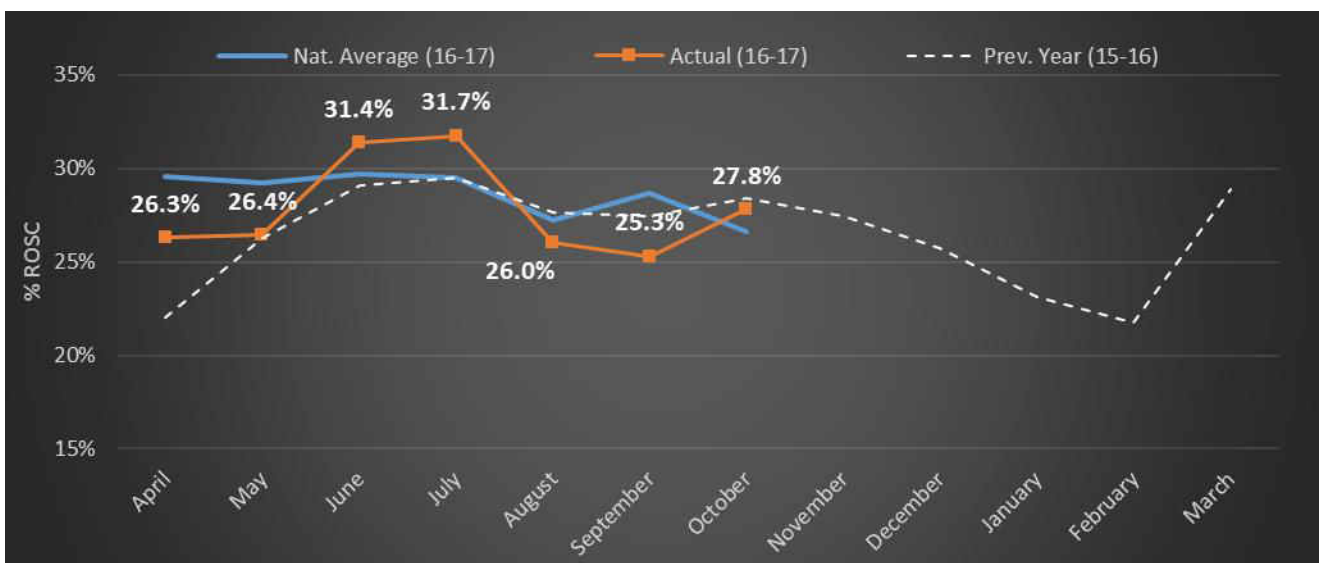


Figure.CE-2 - Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All)

*Figure.CE-3 - Cardiac arrest -Survival to discharge - Utstein*



*Figure.CE-4 - Cardiac arrest -Survival to discharge – All*



*Figure.CE-5 - Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle)*

*Figure.CE-6 - Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes*
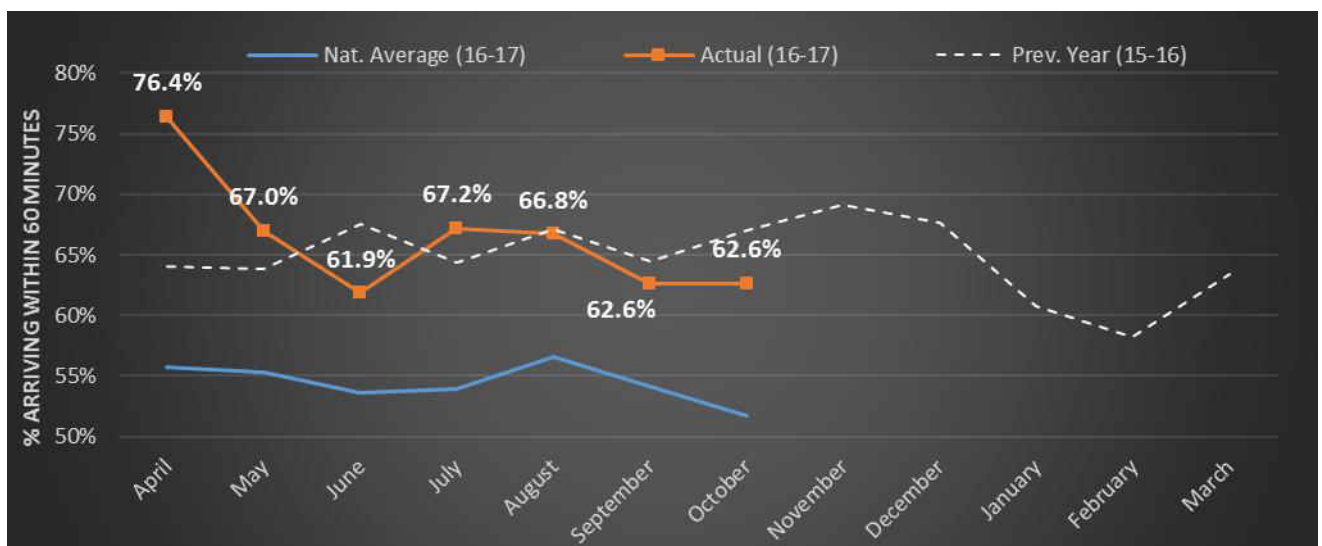


*Figure.CE-7 - % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes*

*Figure.CE-8 - % of suspected stroke patients assessed face to face who received an appropriate care bundle*

# 5. Quality & Patient Safety

## 5.1. Quality & Patient Safety Summary

5.1.1. Complaints have demonstrated an improvement in response rates, the top three most recurrent themes for complaints have remained the same for two months, timeliness of emergency response, staff conduct and attitude and pathways. PALS (issues with no clinical concerns or staff identified) remain predominantly driving incidents/ concerns and generic poor staff attitude. Incident reporting remains constant with an increase in overall reporting. Recurrent themes this month have been safeguarding referrals as the highest incident reported, concerns raised by staff attending patients no incidents have been raised this month regarding staff, equipment failures are where the kit fails at point of contact, again there have been no specific kit identified, and patient care primarily delays in arrival at scene times. The DATIX rebuild has remained on track to deliver the new and revised modules which will ensure the system is user friendly to encourage reporting and support better thematic analysis.

5.1.2. Serious incident reporting remains consistent, themes for this month, possible incorrect patient pathways and CAD failure. We continue to have late submissions of Serious incident reviews to the CCG, the longest delay 224 days (hospital delayed handover) families are routinely offered to be engaged in the serious incident process, it is envisaged with the introduction of the new investigation template the timeless will improve.

5.1.3. Safeguarding training has shown an improvement in month for level 1 and level 2 training but remains off trajectory for the quarter. The pilots complete in March for level 3 training currently at 64% for February aiming to be 82% in March

## 5.2. Quality & Safety KPI Scorecard

### Quality & Safety KPI Scorecard:- Data From February 2017

| ID | KPI | Current Month (Target) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Target) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| QS1a | SI Reporting timeliness (72hrs) | 100% | **100.0%** | | 100% | **34.9%** | |
| QS1b | SI Investigation timeliness (60 days) | 100% | **0.0%** | 100.0% | 100% | **60.0%** | 100.0% |
| QS1c | Number of Incidents reported | | **465** | **390** | | **5553** | 4820 |
| QS1d | Number of Incidents reported that were SI's | | **5** | **4** | | **25** | 25 |
| QS1e | Duty of Candour Compliance | 100% | Data not available | Data not available | 0% | Data not available | Data not available |
| QS2a | Number of Complaints | | **96** | 133 | | **96** | 133 |
| QS2b | Complaints reporting timeliness (All Complaints) | 95% | **93.8%** | 69.0% | 95% | **66.8%** | 61.1% |
| QS3a | Number of Safeguarding Referrals | | **770** | 766 | | **9587** | 9534 |
| QS3b | Safeguarding Referrals relating to SECAmb staff or services | | **0** | 0 | | **4** | 4 |
| QS3c | Safeguarding Training Completed (Adult) Level 1 | 92% | **70.6%** | | 92% | **70.6%** | |
| QS3d | Safeguarding Training Completed (Children) Level 1 | 92% | **71.4%** | | 92% | **71.4%** | |
| QS3e | Safeguarding Training Completed (Adult) Level 2 | 92% | **89.1%** | | 92% | **89.1%** | |
| QS3f | Safeguarding Training Completed (Children) Level 2 | 92% | **89.8%** | | 92% | **89.8%** | |

### 5.3. Quality & Patient Safety Commentary

#### 5.3.1. Complaints

5.3.1.1.	Following the reintroduction of the 25-day complainant reporting target there is an improvement in the percentage closed within timescale due to improved return rate of reports by operational teams, improved communication with complainants and renegotiation of timescales. The full capability of Datix is being utilised to report consistently on our performance. 62 of the complaints were at least partly upheld – 64.5%. This is consistent with January's figure of 64.8% being at least partly upheld. The year to date (YTD) outcomes (01.04.16 to 28.02.17) 60.8% are at least partially upheld. The past two months have been in excess of 64% showing that there is an upward trend in concerns being upheld.

5.3.1.2.	The top three subjects are (same as in January):
- Timeliness of Emergency resources – 29 (30.2%)
- Staff Conduct/attitude – 22 (22.9%)
- Pathways – 15 (15.6%)

5.3.1.3.	The YTD subjects are:
- Staff Conduct – 21.4%
- Pathways 17.1%
- Timeliness 14.4%

5.3.1.4.	The call back initiative commenced in January continues to receive positive feedback from complainants as issues can be resolved earlier.

#### 5.3.2. Incident reporting

5.3.2.1.	Following on from previous months work the reporting system has an additional / enhanced module:

#### 5.3.3. Live modules:
- Risk Register
- Claims
- Complaints (updated)
- Safety Alerts

5.3.3.1.	The Incident module goes live on April 1st.

#### 5.3.4. Incidents module

5.3.4.1.	Schedule of work:

| 15 March | SECAmb / Datix review of feedback from test site pilot |
|---|---|
| 20 March | New SECAmb organisational structure due to be announced – this needs to be built in to the Datix hierarchy (discussed with Peter Lee) |
| 22 March | Datix to continue to apply changes obtained from feedback |
| 27 March | Transfer of Hierarchy, Locations and Categories to live site (remote work by Datix) |
| 28 March | Request to NRLS to sign-off mapping (already contacted NRLS to pre-empt this date) |
| 29 March | Datix to provide RR demo to Board (discussed with Peter Lee) |

| 31 March | Switch on all changes to live site ready for 01 April |
| 10 April | SECAmb / Datix post implementation review |

5.3.4.2. Training is booked for Heads of service booked for the 20th and 21st March at Paddock Wood. With a further 3 days training to be accessed as part of the rebuild to include the safety alert module, reporting functions and super user training.

5.3.4.3. Specific work being carried out includes improvements such as:
- History marking – addition of a tick box and built-in template / data options to capture everything currently recorded manually when a marker is required; auto-notifications will be issued to the existing history.marking@secamb.nhs.uk email for all incidents that have a tick in this box
- Enquiries – restricted access to the Complaints module will be provided to those who are responsible for handling incident, claims and safeguarding enquiries so that these can be logged and tracked in Datix. This is best practice across the NHS.
- Acronyms – all terms will be spelt in full alongside the acronym
- Reporter feedback will be automatic going forward to allow the reporter to see feedback and actions taken
- Student – will be added to the incident type alongside 'visitor, contractor, member of the public'
- Initial risk grading – will be added to the IWR-1 / the current risk grading will be in the IWR-2 once the investigation has begun – these fields are searchable to help with early identification of any potential Sis.
- SI tick box – once selected this will issue an automated notification to the Head of Risk, Chief Nurse and Deputy Chief Nurse.
- Clinical Education – clinical development / education incidents will be flagged to the Clinical Education team via an automated notification

5.3.4.4. Below are the top five categories

| Rank | Category | 2015-16 | 2016-17 | Monthly variance Lowest to highest month |
|------|----------|---------|---------|------------------------------------------|
| 1 | Safeguarding (formerly Vulnerable Persons) | 9195 | 9162 | 690-886 |
| 2 | Equipment | 1320 | 1674 | 74- 208 |
| 3 | Patient Care | 818 | 951 | 56-95 |
| 4 | Assaults / Aggression | 550 | 640 | 36-36 |
| 5 | Accidents | 500 | 494 | 34-47 |

5.3.4.5. Staffing within the Datix investigation team has been challenging over the last 2 months with long term sickness and vacancies. Sickness has improved but the vacancy position remains challenging with the withdrawal of the candidate for the Incident Manager post for the third time ,the advert has been reinstated and advert reviewed.

**5.3.5. Serious Incidents**

5.3.5.1.　　The National SI Framework identifies the timescales for completing investigations and final reporting to the Clinical Commissioning Group. The Trust breached the Commissioning submission deadlines for 7 incidents in quarter 3 and two were not breached. Of the 7, 1 has been submitted to the commissioners and the remaining 6 have been completed and are progressing through the internal review stages in preparation for submission to the CCGs.

5.3.5.2.　　There are 49 listed SIs 7 have missed the CCG deadline (5 x A&E, 1 x EOC, 1 x PTS)

| Directorate | No. SIs | Stage 1 | Stage 2 | Stage 3 | Ongoing (with IM) | Complete (pending closure) | Closed |
|---|---|---|---|---|---|---|---|
| NHS 111 | 5 | - | - | - | 2 | - | 3 |
| Ops – A&E | 26 | 1 | 3 | 1 | 9 | 6 | 6 |
| Ops – EOC | 13 | 2 | - | - | 8 | 3 | - |
| Ops – PTS | 2 | - | - | - | - | 2 | - |
| Not stated | 3 | - | - | - | 3 | - | - |

5.3.5.3.　　The new template for serious incident reporting is being used for all incidents in the system currently, following the serious incident and human factors training in February, staff are being supported to complete the documentation from the compliance lead, the feedback for using the standard template has been positive and focuses the investigator on the root causes and recommendations.

5.3.5.4.　　The Duty of Candour section remains unpopulated until the Datix rebuild is live

5.3.5.5.　　In Quarter 3, 8 SIs were reported and 13 investigations were submitted to the commissioners. At this time 33 incidents remain open. Of the 33, 18 are ongoing investigations which are either newly reported, or have not yet breached their submission deadlines. Of the remaining 15 which have breached, the reports are either progressing through the review and internal sign off stages or are due to be completed imminently.

5.3.5.6.　　Learning from closed serious incidents examples:

| Initial Grade of harm: Moderate Harm | |
|---|---|
| **Initial Information – pre-investigation:** The Trust's Patient Experience Team has received a complaint from the father of a child who was scalded.  The complainant says that the crew who attended applied a tea tree bandage and wrapped the patient in cling film. Their advice was to keep the cling film on for 20-30 minutes, to keep the wound open and aired, for the patient to carry out normal activities, and to go home. Four days later the wounds blistered and were weeping. The patient's mother took the patient to A&E, where he was treated and referred to the Burns Unit. He now has to have dressings changed every 3 to 4 days. The complainant says that consultants at both locations advised that the treatment by the crew was wrong and the patient should have been referred to A&E, and they will be submitting complaints too. | |

| Immediate Action Taken: | The Paramedic involved was been placed on restricted duties and additional training provided. The HCPC informed of his restriction. |
|---|---|

| | | | | |
|---|---|---|---|---|
| Initial Grade of harm: Unknown Harm | | | | |

**Initial Information – pre-investigation:**

The Trust has received a complaint from a member of the public who is also a registered nurse. The nurse was witness to an accident involving a 4x4 and a motorcyclist. She was first on scene and was able to administer first aid and make an initial assessment of the motorcyclist. Due to the symptoms and signs - back pain and a thready pulse she was concerned about possible internal bleeding and possible damage to the spine, therefore she immobilised him as best she could and waited for the ambulance. When the crew arrived she explained who she was and gave a basic handover of his condition. The nurse states that following a brief assessment by the crew, they asked him to stand up and get on the stretcher, they then proceeded to move the patient onto the vehicle the wrong way round, and then had to take him off and move him again the right way. She has listed various other points of concerns relating to their general assessment and treatment of him. The nurse states that the patient was taken to hospital where he was found to have numerous serious injuries including damage to his spine and a ruptured spleen. The patient is currently in a neck and back brace awaiting further treatment.

| Immediate Action Taken: | The investigating manager will take restriction/suspension orders out to protect staff/patients if serious concerns are identified from initial review of actions on scene and PCR. |
|---|---|

| | | | | |
|---|---|---|---|---|
| Initial Grade of harm: Moderate Harm | | | | |

**Initial Information – pre-investigation:**

A Technician driving a Single Response Vehicle, was en route to a Red 2 incident when they collided with a car. The driver and passenger of the car were trapped inside it due to the collision causing the car to spin and impact with traffic lights. Both patients were extricated and taken to hospital. The Technician, at this time, is thought to have sustained minor injuries not requiring further treatment.

| Immediate Action Taken: | SECAmb driver removed from driving following the incident and stood down. Consideration will be given to suitability of the SECAmb driver to return to full driving duties on his return to work, this will be conducted by his line manager and he will only return to driving duties if it is found to be appropriate. Welfare support is ongoing with the staff member. |
|---|---|

### 5.4. Safeguarding

5.4.1.1.   Level 1 training figures have improved in month following a targeted campaign on non-compliant individuals and line managers.  Both level 1 and level 2 training are below the trajectory agreed.  E-mail correspondence has been circulated with a highlight report attached to remind teams to undertake the on line training.

5.4.1.2.   Level 3 training package has been approved externally and the final pilot takes place at the end of March.  Dates for 2017/18 have been circulated to allow for abstraction throughout the year.

5.4.1.3.   A draft training strategy have been developed and will be presented at the March Safeguarding Group for approval.  Proactive senior presence at the various safeguarding boards in all of the counties over the last six weeks has been maintained, to share the safeguarding improvement plan and methodology for the quality assurance visits where safeguarding forms part of the key line of enquiry, many of the board members are keen to become observers of the quality assurance visits and have reported positively to the engagement.

## 5.5. Quality & Safety Charts
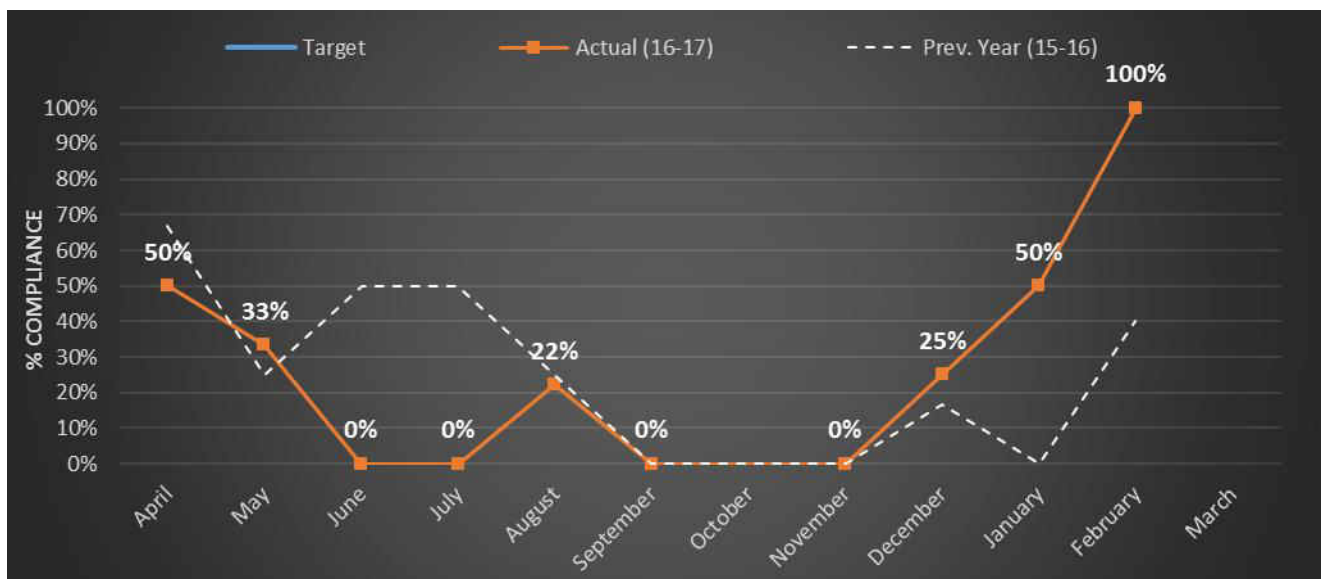


*Figure.QS1a - SI Reporting timeliness (72hrs)*
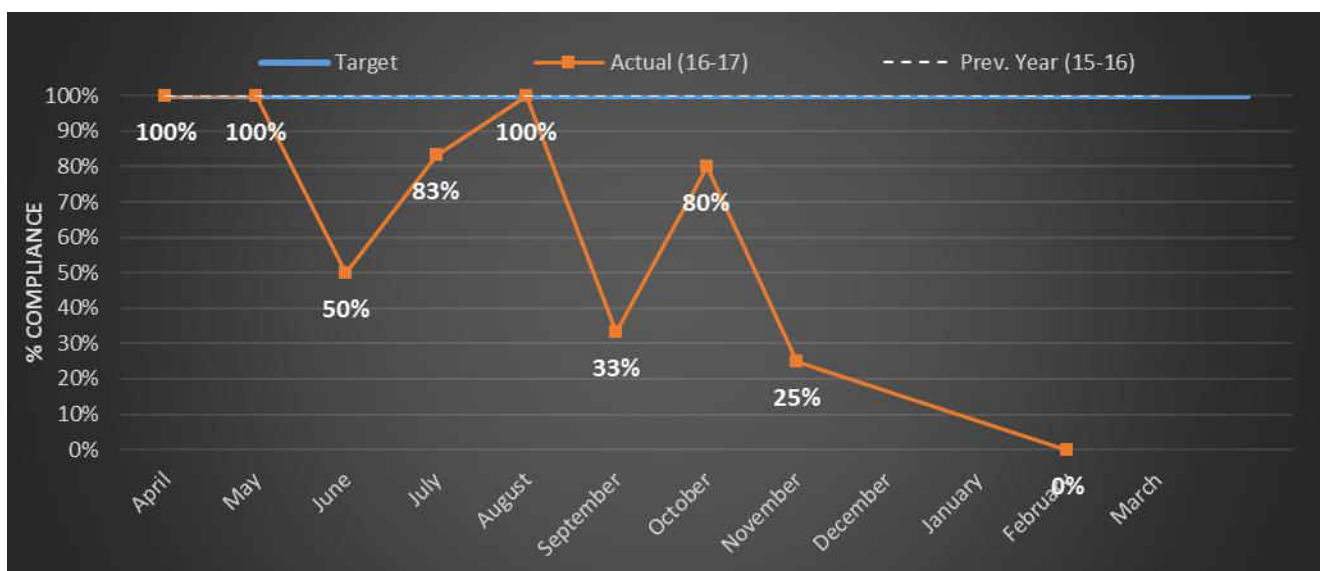


*Figure.QS1b - Serious Incident (SI) Investigation timeliness (60 days). Please note that no SI's were due for completion for last month (no data points will be shown)*
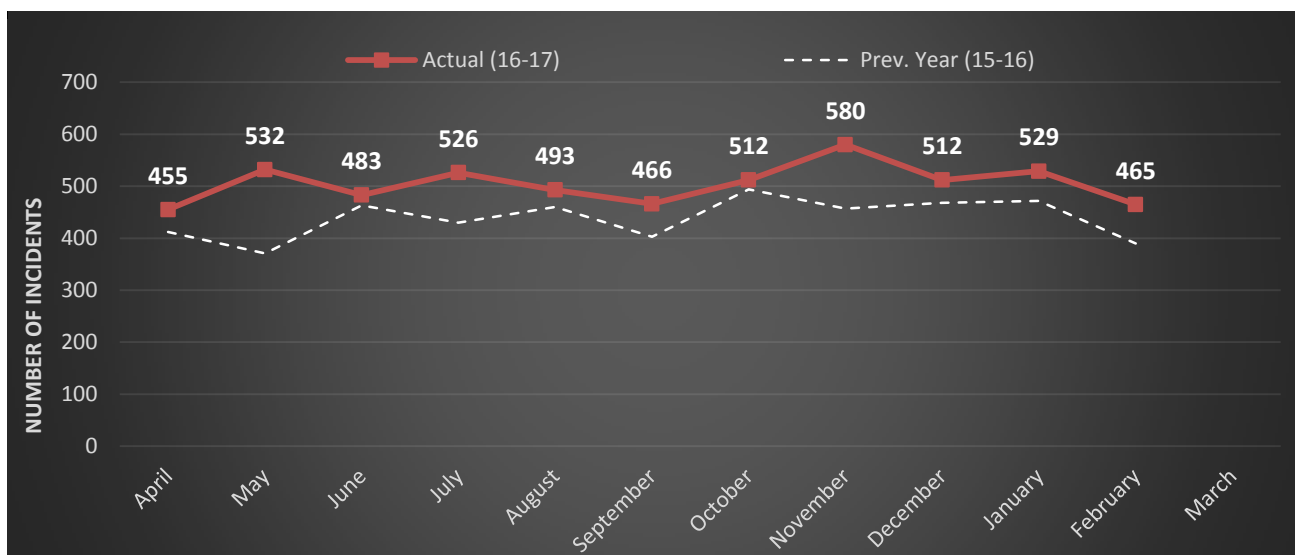
*Figure.QS1c - Number of Incidents reported*



*Figure.QS1d - Incidents reported that were SI's*

Data not available.

*Figure.QS1e - Duty of Candour Compliance*

*Figure.QS2a - Number of Complaints*
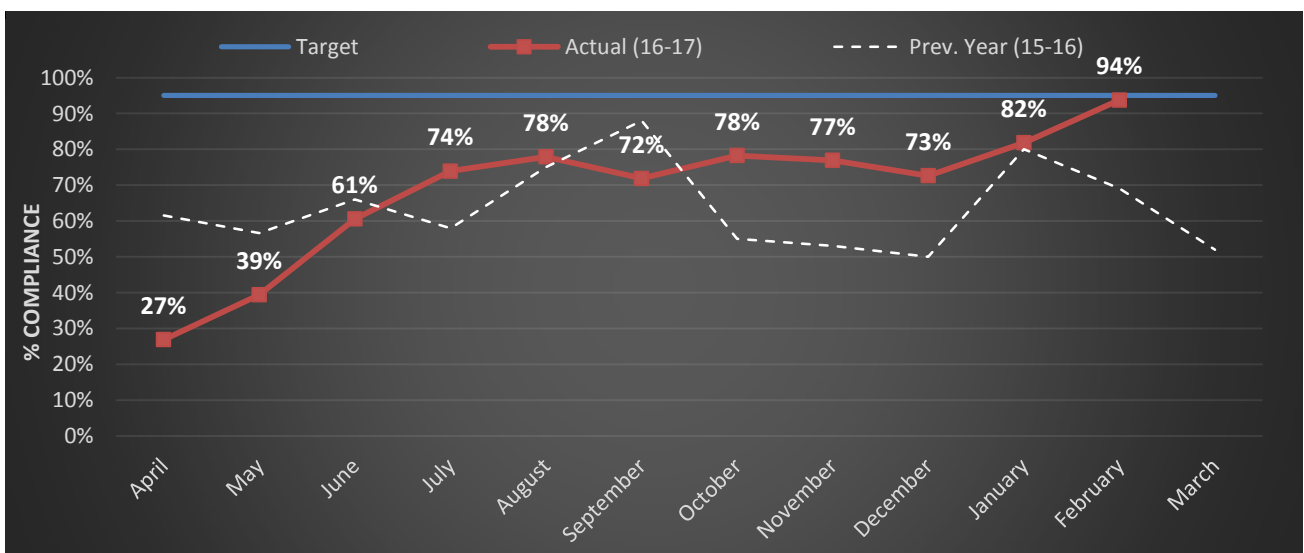


*Figure.QS2b - Complaints reporting timeliness (All Complaints)*



*Figure.QS3a - Safeguarding Referrals*
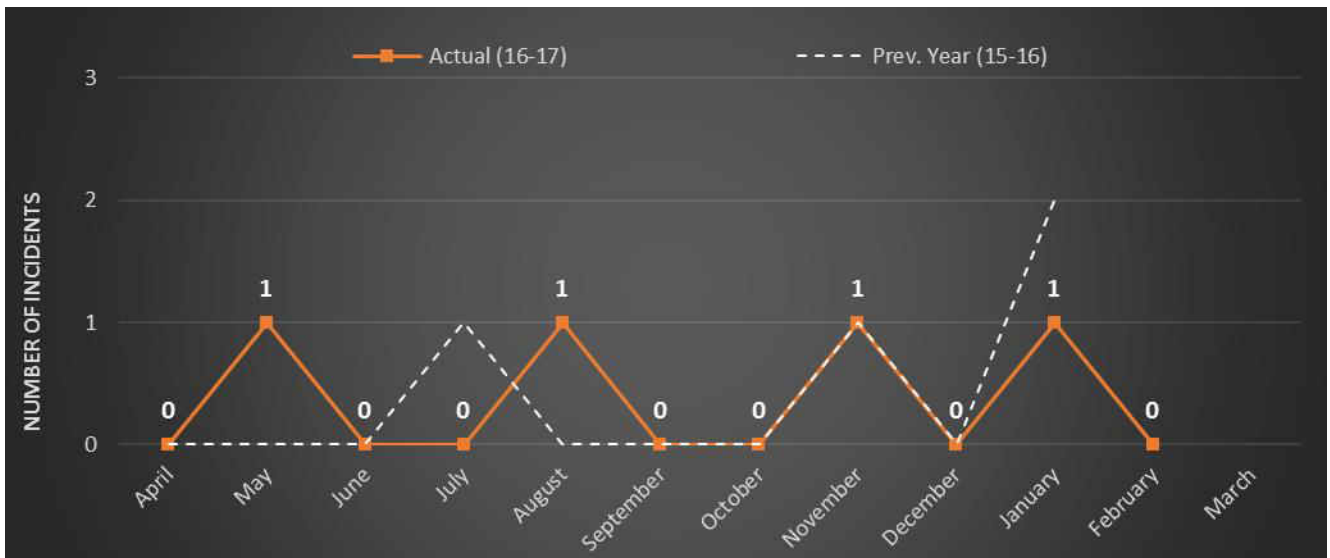
*Figure.QS3b - Safeguarding Referrals relating to SECAmb staff or services*
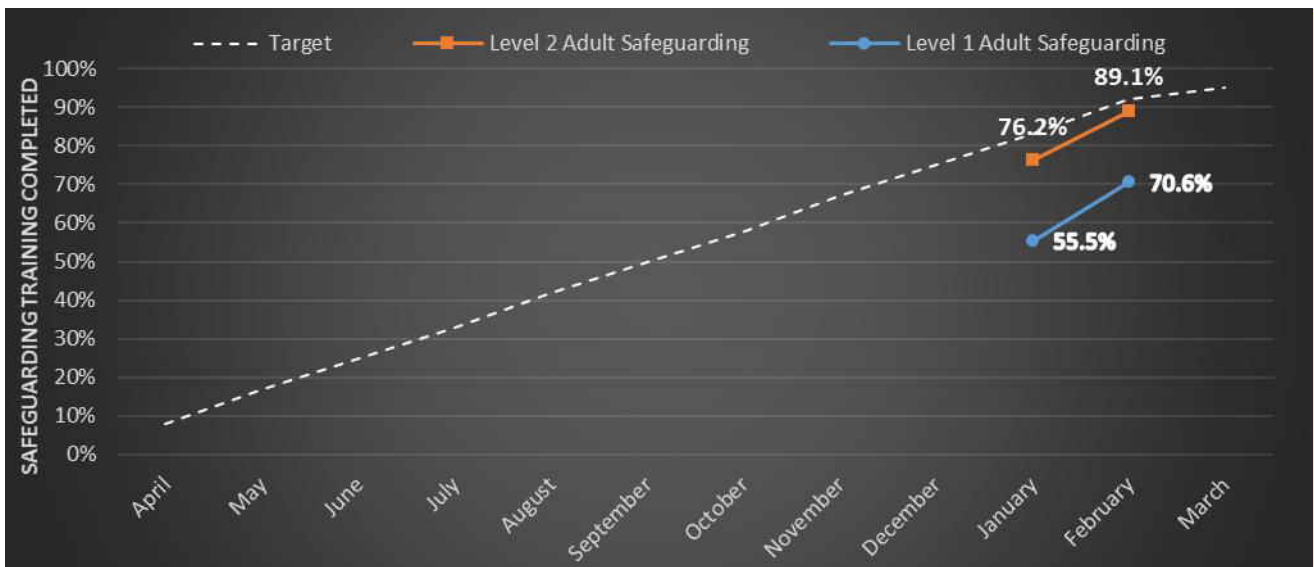


*Figure.QS3c and QS3e - Safeguarding Training Completed Adult, Level 1 and 2*
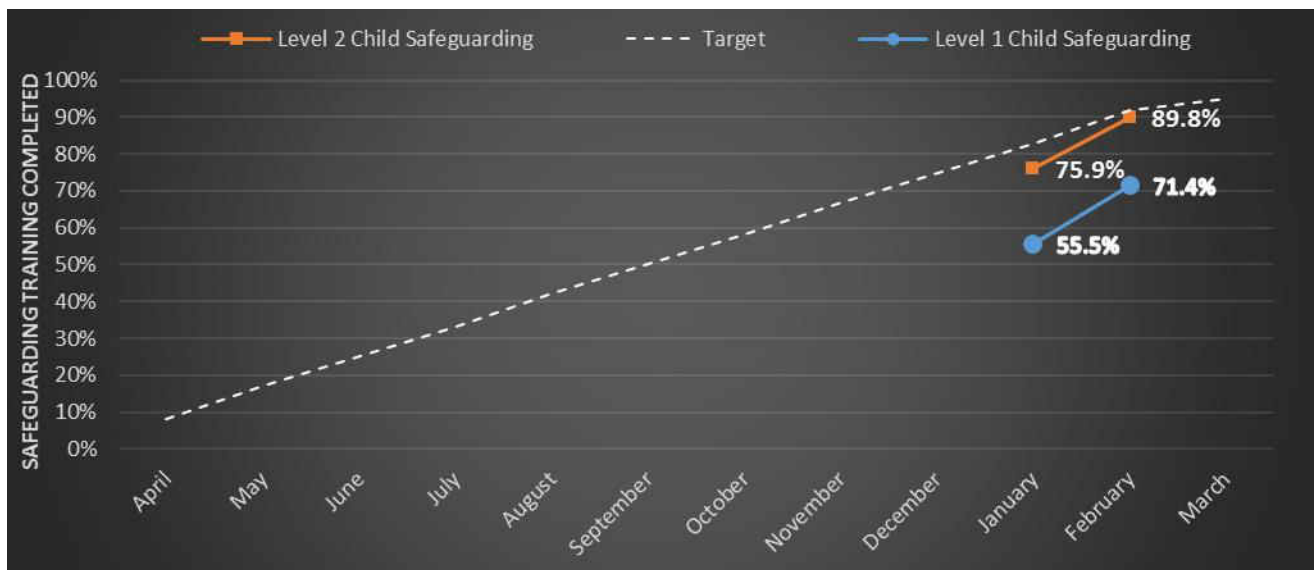
*Figure.QS3d and QS3f - Safeguarding Training Completed Children, Level 1 and 2*

## 6. Finance

### 6.1. Finance Summary

6.1.1.  The Trust's financial performance for month 11 reflects a deficit of £0.4m which is in line with the forecast. This takes the YTD deficit to £6.7m compared with the £0.7m surplus position assumed in the plan.

6.1.2.  The position includes £0.4m of costs relating to the Paramedic re-banding from 5 to 6 as directed by NHSI. The Trust has now received confirmation from NHS England that there will be additional funding in this financial year to offset these costs; the re-banding will therefore be cost neutral.

6.1.3.  The 16/17 FOT deficit has been returned to £7.1m, which the Trust is confident will be achieved. This is supported by the improved outlook on meal break costs, agency spend and non-essential expenditure in the last quarter.

6.1.4.  The Trust continues to be at level 4 using the new NHSI Use of Resources Rating (UOR), which potentially triggers financial special measures. The drivers behind the adverse rating, have been the variance against APR largely as a result of agency expenditure. The Trust has tightened up the temporary agency controls by implementing a more robust recruitment and approval process. As a result, the number of agency staff has fallen sharply from 170.0wte to 71.0 wte as of March 2017, saving the Trust £0.3m in this quarter. The FOT on agency spend indicates a lower UOR by 31 March 2017. In addition, controls around discretionary spend have been tightened and there is greater scrutiny on all purchase orders, which now require senior manager approval. Other areas being looked at include legal costs, medicines management and training costs.

6.1.5.  The demand in A&E activity continues to track above plan for the year to date, but below plan in month. The activity in February is 1.8% lower than APR (YTD: 2.2% above plan) and 2.5% below the commissioned level (YTD: 3.8% above).  Clinical performance remains below the recovery plan trajectory and national targets. The Red 1 performance in February improved slightly compared to January. In February the Trust delivered Red 1 performance of 65.5% (YTD: 64.6%) but Red 2 performance of 48.8% (YTD: 52.8%) against the 75% national targets.  The Trust has delivered its YTD CIP target of £6.6m.

### 6.1. Finance Scorecard

| ID** | KPI | Current Month (Plan) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan) | YTD (Actual) | YTD (Prev. Yr.) |
|------|-----|------|------|------|------|------|------|
| F-1 | Income (£'000) | £ 15,977 | £ 17,179 | £ 17,086 | £177,463 | £ 181,539 | £185,387 |
| F-2 | Expenditure (£'000) | £ 16,140 | £ 17,576 | £ 17,229 | £176,755 | £ 188,246 | £185,845 |
| F-6 | Surplus/(Deficit) | -£ 163 | £ 397 | -£ 143 | £ 708 | £ 6,707 | -£ 458 |
|  |  |  |  |  |  |  |  |

| ID** | KPI | Current Quarter (Plan) | Current Quarter (Actual)* | Current Quarter (Prev. Yr.) | YTD (Plan) | YTD (Actual)* | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| F-5 | CQUIN - Quarterly (£'000)* | £ 1,038 | | £ 1,013 | £ 3,724 | | £ 3,688 |

| ID** | KPI | Current Month (Plan) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| F-3 | Capital Expenditure (£'000) | £ 1,282 | £ 1,367 | £ 2,140 | £ 19,810 | £ 14,988 | £ 18,244 |
| F-7 | Cash Position (£'000) | £ 12,353 | £ 11,262 | £ 18,353 | £ 12,353 | £ 11,262 | £ 18,353 |
| F-4 | Cost Improv. Prog. (CIP) (£'000) | £ 596 | £ 488 | £ 1,124 | £ 6,608 | £ 6,640 | £ 9,354 |
| F-8 | Agency Spend (£'000) | £ 339 | £ 434 | £ 273 | £ 3,691 | £ 6,108 | £ 5,935 |

*Each Quarter's data will not be available until the completion of the Quarter (e.g. Q1 will be available in July)*

*** KPI's have been re-ordered (Sep '16) however each KPI's ID has remained the same for consistency (hence the ID ordering is out of sync).*

## 6.2. Finance Commentary

6.2.1.  The YTD adverse variance of £7.4m against the APR is across all service lines.  The financial performance in 999 is £6.5m worse than the APR.

6.2.2.  The key drivers are the price of hours with costs being higher than planned as the recruitment is lower than the original workforce plan resulting in a higher reliance on PAPS.  Hospital handover delays continue to affect job cycle time and remain higher than expected. The Trust lost 12% more hours (5,464) in February compared to 4,891 hours compared to the same period last year.  This was despite transporting 16% fewer patients to hospital.

6.2.3.  In EOC, the management have made some changes in the way in which meal breaks are disturbed which has resulted in a large reduction in the number of claims made from January. The changes are in line with the current policy.

6.2.4.  Fleet is overspent by £0.3m YTD mainly on fuel costs. The vehicle maintenance regime has been revised to reduce costs whilst ensuring safe levels are maintained.

6.2.5.  PTS performance was a deficit of £0.1m in February due to an excess of costs over income. The YTD position is £0.8m adverse against plan. Activity is 22% below expectations YTD resulting in a 15.0% variance on income, which is the main reason for the adverse variance. The reduction in hours to match this lower activity has not been delivered.

6.2.6. The financial performance in KMSS111 continues to be positive, and February reported a break even position. The YTD position is an adverse variance of £0.1m and it is expected that performance in March will improve the year end position. The improvement in the last quarter is attributable to additional income from the East Kent contract extension and reduction in expenditure. There has been a reduction in agency spend which is attributable to switching agency staff to permanent contracts and strict adherence to agency cap rates.

6.2.7. The YTD capital expenditure of £14.3m.

6.2.8. The Trust's YTD cash balance of £11.2m is £1.2m lower than the original plan. This has improved from last month's position due to the draw-down of £4.6m of the working capital facility. The Trust has secured a total working capital facility of £15m from DoH.

## 6.3. Finance Charts



*Figure.F-1 - Income (£'000)*



*Figure.F-2 - Expenditure (£'000)*

*Figure.F-6 - Surplus/(Deficit) (Year To Date)*



*Figure.F-5 – CQUIN - Quarterly (£'000)\**



*Figure.F-8 – Agency Spend (£'000)*

*Figure.F-3 – Capital Expenditure (£'000)*



*Figure.F-7 – Cash Position (£'000)*

*Figure.F-4 - Cost Improv. Prog. (CIP) (£'000)*

## Integrated Performance Dashboard Balanced Scorecard for the March 2017 Board Meeting

### Workforce Commentary :- Data from Feb 2017 and Jan 2017

| ID | KPI | Current Month (Plan) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| Wf-1A | Short Term Sickness - Rate | | 2.7% | 2.5% | | 2.7% | |
| Wf-1B | Long Term Sickness - Rate | | 2.5% | 3.5% | | 2.5% | |
| Wf-2 | Staff Appraisals | 82.5% | 49.6% | 63.0% | | | |
| Wf-3 | Mandatory Training Compliance (All Courses) | 94.5% | 81.9% | 89.9% | | | |
| Wf-4 | Total injuries | | 66 | 56 | | 681 | 688 |
| Wf-5 | Total physical assaults | | 14 | 12 | | 194 | 175 |
| Wf-6 | Vacancies (Total WTE) | | 287 | | | | |
| Wf-7 | Annual Rolling Staff Turnover | | 16.6% | 14.3% | | | |
| Wf-8 | Reported Bullying & Harassment Cases | | 0 | | | 14 | |
| Wf-9 | Cases of Whistle Blowing | | 0 | | | 3 | |

### Clinical Effectiveness KPI Scorecard:- Data From October 2016

| ID | KPI | Current Month (Nat. Av.*) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Nat. Av.*) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| CE-1 | Cardiac arrest - ROSC on arrival at hospital (Utstein) | 47.6% | 48.1% | 54.5% | 51.8% | 53.6% | 48.8% |
| CE-2 | Cardiac arrest - Return of spontaneous circulation on arrival at hospital (All) | 26.6% | 27.8% | 28.4% | 28.6% | 27.9% | 27.3% |
| CE-3 | Cardiac arrest -Survival to discharge - Utstein | 25.7% | 15.4% | 22.2% | 26.9% | 27.0% | 23.8% |
| CE-4 | Cardiac arrest -Survival to discharge - All | 7.8% | 4.3% | 8.0% | 8.8% | 7.9% | 8.5% |
| CE-5 | Acute ST-elevation myocardial infarction - Outcome from STEMI (Care bundle) | 78.7% | 63.1% | 77.4% | 79.5% | 68.3% | 68.3% |
| CE-6 | Acute ST-elevation myocardial infarction - Proportion receiving primary angioplasty within 150 minutes | 86.4% | 96.9% | 92.7% | 86.3% | 91.8% | 93.4% |
| CE-7 | % of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes | 51.7% | 62.6% | 67.0% | 54.4% | 66.5% | 65.5% |
| CE-8 | % of suspected stroke patients assessed face to face who received an appropriate care bundle | 97.6% | 95.4% | 97.4% | 97.6% | 95.9% | 96.4% |

*\* The Clinical AQIs (CE-1 to 8) do not have a target, and so are benchmarked against the national average.*

### Operational Performance Scorecard:- Data From February 2017

| ID | KPI | Current Month (Plan*) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan*) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| 999-1 | Red 1 response <8 min | 67.9% | 65.7% | 65.4% | | 64.6% | 72.6% |
| 999-2 | Red 2 response <8 min | 57.0% | 49.8% | 57.7% | | 52.7% | 69.1% |
| 999-3 | Red 19 Transport <19 min | 90.7% | 87.6% | 91.3% | | 89.1% | 94.5% |
| 999-4 | Activity: Actual vs Commissioned | 63759 | 62138 | 66093 | 723775 | 750927 | 719170 |
| 999-5 | Hospital Turn-around Delays (Hrs lost >30 min.) | 2627 | 5464 | 5123 | 26510 | 62978 | 41355 |
| 999-6 | Call Pick up within 5 Seconds | 92% | 90.8% | 82.0% | | 76.6% | 87.2% |
| 999-7 | CFR Red 1 Unique Performance Contribution | 1% | 2.2% | 0.0% | | 0.0% | 0.0% |
| 999-8 | CFR Red 2 Unique Performance Contribution | 1% | 1.5% | 0.0% | | 0.0% | 0.0% |
| 111-1 | Total Number of calls offered | | 79876 | 102628 | | 1042491 | 1078300 |
| 111-2 | % answered calls within 60 seconds | 85% | 92.5% | 65.0% | 85.0% | 79.0% | 82.5% |
| 111-4 | Abandoned calls as % of offered after 30 secs | 5.0% | 0.7% | 9.3% | 5.0% | 4.2% | 3.3% |
| 111-5 | Combined Clinical KPI (% of Call Back >10mins & % of all 111 calls warm referred to a Clinician) | 77% | 73.6% | 73.8% | | 74.6% | 86.5% |
| PTS-1 | PTS Activity (Surrey) | 11180 | 8578 | 12055 | 129632 | 114188 | 161233 |
| PTS-2 | Arrival - % patients to arrive <= 15 min after appt. time. (Surrey) | 95% | 87.2% | 88.8% | 95% | 86.5% | 84.1% |
| PTS-3 | Departure - % patients collected <= 60 min of planned collection time (Surrey) | 95% | 84.3% | 90.5% | 95% | 86.1% | 84.7% |
| PTS-4 | Discharge - % patients collected <= 120 min of booked time to travel (Surrey) | 95% | 76.7% | 77.2% | 95% | 79.9% | 76.2% |

*\* For the following KPI's, the "Plan" in the table above is the Unified Recovery Plan (URP) target agreed with commissioners. The URP targets and the standard national targets are both shown in the Charts on the following few pages. KPIs affected: 999-1 to 999-3; 999-6; 111-2, 111-4 and 111-5.*

### Finance Scorecard:- : Data from February 2017

| ID** | KPI | Current Month (Plan) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| F-1 | Income (£'000) | £15,977.0 | £17,179.0 | £17,085.6 | £177,462.5 | £181,539.3 | £185,387.2 |
| F-2 | Expenditure (£'000) | £16,140.0 | £17,576.0 | £17,228.5 | £176,754.5 | £188,246.0 | £185,845.0 |
| F-6 | Surplus/(Deficit) | -£163.0 | £397.0 | -£143.0 | £708.0 | £6,706.7 | -£457.9 |

| ID** | KPI | Current Quarter (Plan) | Current Quarter (Actual)* | Current Quarter (Prev. Yr.) | YTD (Plan) | YTD (Actual)* | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| F-5 | CQUIN - Quarterly (£'000)* | £1,038.0 | | £1,013.0 | £3,724.0 | | £3,688.0 |

| ID** | KPI | Current Month (Plan) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Plan) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| F-3 | Capital Expenditure (£'000) | £1,282.0 | £1,367.3 | £2,140.0 | £19,810.0 | £14,988.3 | £18,244.0 |
| F-7 | Cash Position (£'000) | £12,353.0 | £11,262.0 | £18,353.0 | £12,353.0 | £11,262.0 | £18,353.0 |
| F-4 | Cost Improv. Prog. (CIP) (£'000) | £596.0 | £488.0 | £1,123.7 | £6,608.0 | £6,640.0 | £9,354.3 |
| F-8 | Agency Spend (£'000) | £338.6 | £434.0 | £273.3 | £3,691.4 | £6,107.7 | £5,935.4 |

*\* Each Quarter's data will not be available until the completion of the Quarter (e.g. Q1 will be available in July)*
*\*\* KPI's have been re-ordered (Sep '16) however each KPI's ID has remained the same for consistency (hence the ID ordering is out of sync).*

### Quality & Safety KPI Scorecard:- Data From February 2017

| ID | KPI | Current Month (Target) | Current Month (Actual) | Current Month (Prev. Yr.) | YTD (Target) | YTD (Actual) | YTD (Prev. Yr.) |
|---|---|---|---|---|---|---|---|
| QS1a | SI Reporting timeliness (72hrs) | 100.0% | 100.0% | | | | |
| QS1b | SI Investigation timeliness (60 days) | 100.0% | 0.0% | 100.0% | 100.0% | 60.0% | 100.0% |
| QS1c | Number of Incidents reported | | 465 | 390 | | 5553 | 4820 |
| QS1d | Number of Incidents reported that were SI's | | 5 | 4 | | 25 | 25 |
| QS1e | Duty of Candour Compliance | 100.0% | | | | | |
| QS2a | Number of Complaints | | 96 | 133 | | 96 | 133 |
| QS2b | Complaints reporting timeliness (All Complaints) | 95.0% | 93.8% | 69.0% | 95.0% | 66.8% | 61.1% |
| QS3a | Number of Safeguarding Referrals | | 770 | 766 | | 9587 | 9534 |
| QS3b | Safeguarding Referrals relating to SECAmb staff or services | | 0 | 0 | | 4 | 4 |
| QS3c | Safeguarding Training Completed (Adult) Level 1 | 92.0% | 70.6% | | | | |
| QS3d | Safeguarding Training Completed (Children) Level 1 | 92.0% | 71.4% | | | | |
| QS3e | Safeguarding Training Completed (Adult) Level 2 | 92.0% | 89.1% | | | | |
| QS3f | Safeguarding Training Completed (Children) Level 2 | 92.0% | 89.8% | | | | |

### SECAMB Regulation Statistics

| ID | KPI | Value |
|---|---|---|
| R1(b) | **Use of Resources Metric (Financial Risk Rating)** | 4 (Red) |
| R2 | **Governance Risk Rating** | Red |
| R3 | **CQC Compliance Status** | Trust: Inadequate (Special Measures) 111 service: Requires improvement |
| R5 | **IG Toolkit Assessment** | Level 2 - Satisfactory |
| R6 | **REAP Level** | 3 |

**Appendix 2: Notes on Data Supplied in this Report**

**7.1. Preamble:**
    7.1.1. This Appendix serves to inform the reader of any significant changes to measurement or data provided in the Integrated Performance Dashboard.
    7.1.2. Two months history are kept for easy reference and to cover when there is a month with no board meeting.

**7.2. Executive Summary:**
    7.2.1. No changes of note.

**7.3. Workforce Section:**
    7.3.1. Some of the data in the workforce section is one month in arrears.

**7.4. Operational Performance Section:**

    7.4.1. February Board Changes:
        ➤ The KPI the "Calls Abandoned - Intro Message" is no longer a key performance measure so the data has been omitted.

**7.5. Quality and Outcome Section: Now 'Clinical Effectiveness (Dec 2016)**
    7.5.1. The Clinical Outcome data (now CE-1 to 8) are all reported a number of months in arrears as per the titles of the sections.

**7.6. Quality and Patient Safety Section:  Added Dec. 2016**
    7.6.1. March Board Changes:
        ➤ Duty of Candour KPI is still under development.
        ➤ Safeguarding training is now available as a percentage (rather than number of staff trained).

**7.7. Finance Section:**
    7.7.1. February Board Changes:
        ➤ The CIP figure for December has been corrected to match December's finance pack, the variation was due to an input error.
    7.7.2. No other changes of note for finance.

**SECAMB Board**

**Summary Report on the Audit Committee Meeting of 1<sup>st</sup> March 2017**

| | |
|---|---|
| **Date of meeting** | **1 March 2017** |
| **Overview of issues/areas covered at the meeting:** | The meeting considered papers covering Financial Reporting, Internal Audit, External Audit Risk Management/Governance and Contra-Fraud items.   In summary, key matters were as follows<br>• The committee noted that good progress was being made in Risk Management / Governance matters, albeit that further development was urgent.<br>• The committee approved the preparation of the 2016/2017 accounts on a going concern basis but felt that it was premature to consider the relevant wording to be set out in the accounts at this time.<br>• The committee noted, with surprise, the relatively positive assessment of Internal Controls in the draft head of Internal Audit Opinion for the 2016/2017; however, the Internal Audit team may yet revise this. |
| **Reports *not* received as per the annual work plan and action required** | An updated Risk Register was included in the Committee papers at a late stage.  Whilst the committee commended the work done, the committee felt that it had insufficient notice to consider the Risk Register properly at this meeting |
| **Changes to significant risk profile of the trust identified and actions required** | none |
| **Weaknesses in the design or effectiveness of the system of internal control identified and action required** | In view of the number of disappointing Internal Audit Reviews undertaken during 2016/2017, and other well documented shortfalls, the Audit Committee was surprised by the relatively positive draft overall Internal opinion presented to the meeting.  Internal Audit explained that their program for 2016/2017 was not yet fully completed and, therefore, that their final opinion may change.   The committee emphasised to Internal Audit that it was seeking a proper, fair and, above all independent view of SECAmb's systems of control in order to help the organisation better focus it resources and priorities |
| **Any other matters the Committee wishes to escalate to the Board** | **Board Assurance Framework** - the BAF led to significant discussion at the committee.  The focus on key "Strategic" risks was supported although there was some doubt as to whether, in practice, the approach proposed would prove sufficient to give the Board definitive confidence in the overall effectiveness of the risk management / controls / governance environment.  The committee finally decided to support the proposed approach subject to a review in around 6 months' time |

| | |
|---|---|
| | **Risk Management Strategy & Policy** - the Committee noted substantial development in this area but was not persuaded that the proposal was sufficiently customised to South East ambulance at this stage.  The executive undertook to revise the paper considering points made and to consult with the Audit Chair in view of her particular risk management expertise. |

**South East Coast Ambulance Service NHS Foundation Trust**

**SECAMB Board**

**Escalation report to the Board from the Finance & Investment Committee**

| | |
|---|---|
| **Date of meeting** | 14 March 2017 |
| **Overview of issues/areas covered at the meeting:** | This meeting was an exceptional FIC held by conference call to cover the following items:<br><br>• Progress on PID and 2017/19 Contract following mediation in December 2016 – update to be provide at Board following further meetings with CCG's during March 2017<br>• Update on potential contract extension for 111 – to be further discussed at part 2 of Board due to commercial sensitivity<br>• Approval of lease for property in Gatwick to house major incident vehicles – to be further discussed at part 2 of Board due to commercial sensitivity |
| **Reports *not* received as per the annual work plan and action required** | All reports received as requested |
| **Changes to significant risk profile of the trust identified and actions required** | Risks remain as previously identified |
| **Weaknesses in the design or effectiveness of the system of internal control identified and action required** | None identified at this meeting |
| **Any other matters the Committee wishes to escalate to the Board** | Approval of lease on property in Gatwick as requires Board approval per SFI's. |

**SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST**

**COUNCIL OF GOVERNORS**

**D - Quality Impact Assessment Process**

## 1. Introduction

1.1. This paper provides a summary of the QIA process which has been developed to provide assurance to the Executive team that changes resulting from projects within the recovery programme will not impact on quality or patient safety.

## 2. QIA Process

2.1. If the requirement for a QIA is identified during one of the three Steering Groups (Financial Sustainability, Organisational Recovery or Quality) the project team or initiative owner will be required to complete a Summary QIA.

2.2. The Summary QIA template considers the impact of the project / initiative in respect to five categories:

- Patient safety
- Clinical effectiveness
- Patient experience
- Staff experience
- Other

2.3. Risks in respect to the above five areas are required to be rated in terms of likelihood of the risk occurring (1 to 5) and impact if the risk were to occur (1 to 5), therefore providing a rating of 1 to 25 for each area.

2.4. If the average rating is equal to or above 9, or the patient safety rating is equal to or above 9, a full QIA is required.

2.5. The Deputy Chief Nurse, Sarah Songhurst, will review all completed Summary QIAs to ensure she is comfortable with the risk ratings applied to the project / initiative. The Deputy Chief Nurse will either approve the project / initiative, request further information or request a Full QIA if there are possible quality or patient safety risks.

2.6. If a Full QIA is required, this will be completed by the project leads / initiative owners. The Full QIA focuses on a more thorough review of risks, mitigating actions required and benefits under eight categories:

- Clinical effectiveness

- Patient experience
- Patient safety
- Staff experience
- Staff health and safety
- External provider impact
- Targets / performance
- CQC fundamental standards

2.7. Completed Full QIAs are currently required to be reviewed and signed off by the Executive Team at the Turnaround Executive. Once a Medical Director is in post, QIAs can be reviewed and approved outside of the Turnaround Executive jointly by the Chief Nurse and Medical Director.

2.8. The QIA form is attached to this paper for information.

| Project Reference | *From Project Mandate* |
|---|---|
| Project Title | *From Project Mandate* |

# Appendix B: Quality Impact Assessment

**ACCOUNTABILITY**

| Directorate | *Directorate where project / initiative sits e.g. Operations, Medicine* |
|---|---|
| Exec Sponsor | *Executive responsible for delivery* |
| Project Lead | *Person responsible for driving delivery (non-Exec)* |
| Project Manager | *Project Manager responsible for driving delivery* |

**QIA REQUEST**

| SG in which QIA requirement raised | |
|---|---|
| Individual completing assessment | |
| Date of assessment | |

**PROJECT / SCHEME / INITIATIVE DETAIL**

| Project Title | **From Project Mandate** |
|---|---|
| Scheme / Initiative | |
| Objectives | |

**SUMMARY QIA**

| Patient Safety | Details | Likelihood *(1 - 5)* | Impact *(1 - 5)* | Score |
|---|---|---|---|---|
| | *Consider the following:*<br>*- What is the impact on partner organisations and any aspect of shared risk?*<br>*- Will this impact on the organisations duty to protect children, young people and adults?*<br>*- Impact on patient safety?*<br>*- Impact on preventable harm?*<br>*- Will is affect the reliability of safety systems?*<br>*- How will it impact on systems and a process for ensuring that the risk of healthcare acquired infections to patients is reduced?*<br>*- What is the impact on clinical workforce capability care and skills?* | | | |

| Clinical Effectiveness | Details | Likelihood *(1 - 5)* | Impact *(1 - 5)* | Score |
|---|---|---|---|---|
| | *Consider the following:*<br>*- How does it impact on implementation of evidence based practice?*<br>*- How will it impact on clinical leadership?*<br>*- Does it reduce / impact on variation in care provision?*<br>*- Does it impact on ensuring that care is delivered in most clinically and cost effective setting?*<br>*- Does it eliminate inefficiency and waste by design?*<br>*- Does it lead to improvements in care pathway?* | | | |

| Patient Experience | Details | Likelihood *(1 - 5)* | Impact *(1 - 5)* | Score |
|---|---|---|---|---|
| | *Consider the following:*<br>*- What is the impact on race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience?*<br>*- What impact is it likely to have on self reported experience of patients and service uses? (response to national / local surveys / complaints / PALS / incidents)*<br>*- How will it impact on the choice agenda?*<br>*- How will it impact on the compassionate and personalised care agenda?* | | | |

| Staff Experience | Details | Likelihood *(1 - 5)* | Impact *(1 - 5)* | Score |
|---|---|---|---|---|
| | *Consider the following:*<br>*- Staff satisfaction*<br>*- Staff turnover / obsentee rate*<br>*- Bank and agency staff level* | | | |

| Other | Details | Likelihood *(1 - 5)* | Impact *(1 - 5)* | Score |
|---|---|---|---|---|
| | | | | |

| Mitigations | Details |
|---|---|
| | *Actions put in place / to put in place to ensure that potential risks are managed or monitored to ensure appropriate action is efficiently taken* |

| | OVERALL SCORE *(average)* | 0 |
|---|---|---|

**APPROVALS**

**Automatic requirement for a full QIA if:**
   **a) Average score from summary QIA is 9 or above; OR**
   **b) Patient safety score is 9 or above**

| Deputy Chief Nurse approval | Name | | Signature | |
|---|---|---|---|---|
| | Role | | Date | |
| | **Comments from Deputy Chief Nurse** | *Include reasons for full QIA requirement* | | |
| | **Full QIA required?** | | | |

**FULL QIA**

**Risks**

| | Description of Risk | Likelihood | Impact | Risk Rating | Mitigating Actions/controls | Residual Risk Rating | Indicators | Baseline | Target | Trigger for escalation | Responsible person |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Effectiveness | | | | | | | | | | | |
| Patient Experience | | | | | | | | | | | |
| Patient Safety | | | | | | | | | | | |
| Staff Experience | | | | | | | | | | | |
| Staff Health & Safety | | | | | | | | | | | |
| External Provider impact | | | | | | | | | | | |
| Targets/ Performance | | | | | | | | | | | |
| CQC fundamental standards | | | | | | | | | | | |

**Benefits**

| | Description of Benefit | Measurement | Baseline | Target | Responsible person |
|---|---|---|---|---|---|
| Clinical Effectiveness | | | | | |
| Patient Experience | | | | | |
| Patient Safety | | | | | |
| Staff Experience | | | | | |
| Staff Health & Safety | | | | | |
| External Provider impact | | | | | |
| Targets/ Performance | | | | | |
| CQC fundamental standards | | | | | |

**APPROVALS**

<span style="color:red">Upon approving this document, I give formal consent that the project / initiative / scheme may go ahead with the agreed mitigations in place</span>

**Clinical approval**

| Decision | |
|---|---|
| Name | |
| Role | Chief Nurse |
| Signature | |
| Date | |
| Comments from Chief Nurse | *Include reasons for requiring Executive Team sign-off* *Include any ongoing requirements to ensure quality is maintained* |

| Decision | |
|---|---|
| Name | |
| Role | Medical Director |
| Signature | |
| Date | |
| Comments from Medical Director | *Include reasons for requiring Executive Team sign-off* *Include any ongoing requirements to ensure quality is maintained* |

| Executive Team sign-off required? | |
|---|---|

| Executive Team sign-off required? | |
|---|---|

**Executive Team approval**

| Decision | | | |
|---|---|---|---|
| Executive Meeting Chair | | Signature | |
| Role | | Date of approval meeting | |
| Comments Executive Meeting | | | |

**South East Coast Ambulance Service NHS Foundation Trust**

**Council of Governors**

**E – Membership Development Committee Report**

1. **Introduction**

   1.1. The Membership Development Committee 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 duties of the MDC are to:
      - Advise on and develop strategies for recruiting and retaining members to ensure Trust membership is made up of a good cross-section of the population;
      - Plan and deliver the Trust's Annual Members Meeting;
      - Advise on and develop strategies for effective membership involvement and communications;
      - To contribute to the realisation of the Trust's vision to put the patient at the heart of everything we do.

   1.2. 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.

   1.3. The Membership Development Committee (MDC) met on the 02 February 2017. The draft minutes of this meeting (Appendix 1) and a meeting summary are detailed in the membership update below. The MDC next meets on 10 May 2017.

   1.4. This paper comes to every Council meeting and covers:
      - Discussion at and recommendations from the most recent MDC meeting (if one has taken place since the previous Council meeting),
      - Reports on membership engagement at the Inclusion Hub Advisory Group (public FT members) and Staff Engagement Forum (staff FT members),
      - Reports on other public and membership engagement and involvement,
      - A summary of our current public membership numbers and geographical representation to inform Public Governors' membership recruitment,
      - Anything else relevant to the Council regarding membership and engagement.

   1.5. The MDC wishes Governors to form a view on recommendations coming from the Committee so there is ownership and understanding from the wider Council. Governors are asked to bring their views on the recommendations to the Council meeting.

2. **Membership Update and MDC meeting summary**
   2.1. The current (16.03.17) public membership stands as follows, by constituency:

| Public constituency | No. of members | % of eligible population |
|---|---|---|
| Brighton & Hove | 524 | 0.19 |
| East Sussex | 1793 | 0.34 |
| Kent | 3120 | 0.23 |
| Medway | 641 | 0.25 |
| Surrey | 2381 | 0.18 |
| West Sussex | 1618 | 0.20 |
| **TOTAL PUBLIC** | **10,078** | **0.22%** |

2.2. The Trust has a total of 13,941 members, of which 10,078 are public members and 3,863 staff members.

2.3. The MDC last met on the 02 February 2017 and the draft minutes are included as Appendix 1. At this meeting the MDC discussed the results of the annual membership survey, planning for upcoming member events, proposal for a change to the large scale member recruitment events the membership office usually attends, and suggestions for newsletter content and focus were received.

3. **Membership recruitment and engagement**

3.1. The Trust has a healthy membership of just over 10,000 public members. The MDC had agreed that it was more important to support an engaged, representative membership than to seek to increase membership numbers greatly. It was proposed and accepted at the MDC to have a year's break from large scale membership recruitment in line with cost saving exercises the Trust is currently undertaking and the timing of the relocation of the Membership Office to the new HQ. The whereabouts of the storage of the large amount of event kit is still to be confirmed by the team responsible for the move. This will also have an effect on attendance at events over the summer until it is all settled and arranged.

3.2. Engagement opportunities that will be provided by the Trust will centre on existing agreed internal events such as the 'Your Call' member events and the Annual Members Meeting (28 September – Kent – venue tbc).

3.3. The MDC noted they could provide support for the new Governors and indeed all Governors to meet with local groups such as Public Participation

Groups, local HealthWatch and Clinical Commissioning Groups, or local fetes etc. using the Trust Governor toolkit which would continue to be available.

3.4. Governors will have access to the regional Governor toolkits with display boards, pop up banners, member forms and giveaways should they wish to attend any small local events to carry out member recruitment. Please contact katie.spendiff@secamb.nhs.uk to arrange to access these. Thanks to Mike Hill and former Governor for Surrey, Chris Devereux, who attended a Charity Special Tattenhams Market at St Marks Church in Epsom where they recruited 25 new foundation trust members using the Governor Toolkit.

3.5. Permission to hold two member events was received from the Company Secretary on the basis that they would be held in-house at a Trust property where possible, or at a village hall or community space for a small fee if there was no suitable Trust space in the area. The events are confirmed as follows:

**West Sussex event**
**16<sup>th</sup> May from 4pm - 6pm**
Venue: South East Coast Ambulance Service Tangmere Make Ready Centre, Unit 7 Chichester Business Park, City Fields Way, Tangmere, West Sussex, PO20 2FT.

**Surrey event**
**17<sup>th</sup> May from 2.30pm - 4.30pm**
Venue: Box Hill Village Hall, Boxhill Road, Tadworth, Surrey, KT20 7JT.

**Programme (TBC):**
Introduction from the Chairman (5mins)
Governors' welcome message (15mins)
Presentations from staff and local Community First Responders (50mins)
Your questions and comments to Governors and staff, followed by request to complete evaluation. (35mins)
Members welcome to look inside/ quick guide to vehicles present outside. (15mins)

Governors are sought to participate in the events by being part of a Governor welcome message providing a brief intro as to who you are and why you stood in the elections, so members can get to know you. Please let Katie know if you are free to be a part of the events. It only involves speaking (from a seated position) for a few minutes, and is also a good way to find out more about our services.

3.6. The membership newsletter 'Your Call' is due to be sent to members in early April. This edition includes information on the appointment of the new Chair and Chief Exec, and the results of the Governor elections. There is also an

update on the improvement works taking place as part of the Care Quality Commission inspection outcomes and improvements required by our regulator NHS Improvement. The newsletter features an interview with a Community First Responder, staff interviews, the outcomes from the member survey, and the promotion of the member events in West Sussex and Surrey.

3.7. The results of the 2016 member survey were reviewed by the MDC. The majority of members agreed that overall their membership with SECAmb was giving them the opportunity to be involved as they would like. Two new questions were asked this year as a kind of temperature check on our membership. The first asked if members felt they had been kept informed on the Trust's plans to improve. The majority of members agreed that they felt they had, some members noted interest in details of the specific actions the Trust had taken. An update was provided in the 4th article on this subject in the latest newsletter.

Given the challenging year the Trust has experienced we thought it may be interesting to see how members felt about their membership. Members were provided with a selection of words describing positive and negative feelings about their membership. It was reassuring to see that the most frequently selected words in answer to the question were 'Interested', 'Informed', 'Content' and 'Proud'. However, there were some members who felt the opposite. Staff members were sent the newsletter and survey link by email and I think some of the free text comments have come from staff i.e. "Have gone from feeling proud of my uniform to slightly embarrassed due to bad press". In the free text comments where members could list words that were not featured; 'Frustrated' and 'Let down' were mentioned a couple of times. The full results and data from the survey were reviewed and discussed by MDC members with outcomes from the survey being actioned by the Membership Office. I will be recommending that staff and the public are surveyed separately next year.

3.8. Thanks to the 35 members who put themselves forward in the recent elections, and thanks to members who voted in them. Congratulations to all the newly appointed and re-appointed Governors as follows:

Public (West Sussex) – Matt Morris
Public (East Sussex) – Brian Rockell (re-elected)
Public (Surrey and North East Hampshire) – Felicity Dennis
Public (Surrey and North East Hampshire) – Gary Lavan
Public (Kent) – Terry Collingwood
Public (Kent) – Marguerite Beard-Gould (re-elected)
Public (Kent) –  David Escudier
Public (Medway) – Stuart Dane
Staff (Operational) – Nick Harrison

3.9. The MDC would like to thank the previous Governors who did not get re-elected or chose not to re-stand as follows: Paul Chaplin, David Davis, Chris Devereux, Maggie Fenton, Jane Watson, Michael Whitcombe.

## 4. Staff Engagement Forum report

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

4.2. The SEF held a meeting on the 13th February. The meeting focussed on collecting staff views to contribute to the new health and well-being strategy, and an overview of the paramedic pay banding changes. The minutes of this meeting are currently unavailable. They will be included in the next MDC report to the Council. The November SEF meeting minutes are now available and shared below as Appendix 2.

4.3. Management of the SEF has recently changed within the Trust (from the Membership Office to the Inclusion Team, and now finally to the Workforce Directorate), and interim management is in place. Responsibility will be transferred to Steve Singer in the Workforce Directorate by the end of March.

4.4. The SEF's 2017/18 meeting dates are yet to be confirmed by the HR team who facilitate and minute the meetings. Dates will be circulated to Staff Governors for attendance as soon as they are available, however the provisional date for the next meeting is 12 June.

## 5. Inclusion Hub Advisory Group report

5.1. Since the last report the Inclusion Hub Advisory Group of public members met on 25th January 2017. Marguerite Beard-Gould and Chris Devereux were the representatives from the Council at IHAG meetings. Chris Devereux was not re-elected so in theory there is a Governor vacancy on the IHAG. The MDC is awaiting further instruction from Angela Rayner (Inclusion Manager) on how she wishes to proceed.

5.2. Agenda items included:

- Presentation on the development of the Risk Management Strategy and Incident Management Policy where members received information and provided feedback to contribute views and inform the development of the policies and undertake Equality Analysis.

- Presentation from the Head of Communications – Janine Compton on developing key messages for public communication around Trust recovery

plans with the assistance of the IHAG.

- Tour round the new HQ & EOC for IHAG members and Governors. IHAG members reviewed the accessibility of the new site and fed back their views to the project manager John Flowers.

5.3. The full minutes of the January meeting are included as Appendix 3.

5.4. IHAG members noted the following was to be included in their highlight report to the Inclusion Working Group:

- The group welcomed the proposed changes that would be brought in by the revised Risk Management Strategy, and Incident Management and Reporting Policy. However, they felt there was clear need for increased patient and public participation in the Serious Incident process, but it was yet to be agreed at what stage this should be.

- Members of the group who attended the new HQ site raised concerns regarding the accessibility around a number of areas of the new building including the reception, kitchens, placement of automatic door buttons and toilet facilities.

5.5. All Governors are reminded that they are welcome to attend meetings of the IHAG from time to time, in order to hear the views of and work alongside a diverse group of public FT members. Please advise Asmina Chowdury (Asmina.IChowdury@secamb.nhs.uk) if you plan to attend so she can check availability of spaces.

5.6. The next IHAG meeting takes place on the 12th April 2017.

## 6. Recommendations
6.1. The Council of Governors is asked to:
Note this report; and review the attached minutes for more detail.


**Mike Hill, Public Governor for Surrey & N.E. Hants & MDC Chair**

**Appendix 1**

## SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

### Council of Governors

### Membership Development Committee

### 2 February 2017 – 10.30 – 14:00

**Present:**

| | | |
|---|---|---|
| Mike Hill | (MH) | Public Governor, Surrey/NE Hants (Chair) |
| Katie Spendiff | (KS) | Membership Coordinator |
| Chris Devereux | (CD) | Public Governor, Surrey/NE Hants |
| Jean Gaston-Parry | (JGP) | Public Governor, Brighton and Hove |
| Alison Stebbings | (AS) | Staff Governor, Non-Operational |
| Izzy Allen | (IA) | Assistant Company Secretary, and Secretariat |

### 23. Welcome

23.1.   MH welcomed members to the meeting. MH formally thanked MF on behalf of the MDC for all her hard work on the Committee and in relation to membership recruitment and engagement.

### 24. Apologies

24.1.   Apologies were received from:

| | | |
|---|---|---|
| Maggie Fenton | (MF) | Public Governor, Kent |
| Brian Rockell | (BR) | Public Governor, East Sussex and Lead Governor |
| Jane Watson | (JW) | Public Governor, Surrey/NE Hants |
| Marguerite Beard-Gould | (MBG) | Public Governor, Kent |
| Nigel Coles | (NC) | Staff Governor, Operational |

### 25. Declarations of interest

25.1.   There were no declarations of interest.

### 26. Minutes, matters arising and action log

26.1.   The minutes of the previous meeting were taken as an accurate record. KS apologised that the previous MDC had taken place following the Extraordinary

CoG meeting which had been fractious and so the MDC had not been as focused as usual.

26.2.   The action log was reviewed and updated. The action to review the Constitution and as part of this the name of the Surrey constituency to include NE Hants would take place in Q1 of the new financial year.

26.3.   KS advised that the constituency name had been updated on the website and badges etc. CD asked whether there was a candidate from NE Hants. KS would check and let the MDC know.


**ACTION: KS to check whether any of the candidates standing for election were from NE Hants.**

**27. Membership update**

27.1.      IA advised that the Staff Engagement Forum (SEF) had met in November to support the Trust with a staff engagement plan around the CQC and NHSI Recovery Plan. MDC members wished to see the engagement plan.

**ACTION: IA to follow up with Janine Compton and circulate the staff engagement plan**

27.2.      The IHAG had visited the new HQ in Crawley. CD advised that Patrick Walter from the Mary Francis Trust at Leatherhead had joined the IHAG to represent mental health.

27.3.      The site visited had identified accessibility issues including badly positioned door openers, toilets without access from one side for wheelchair users, and inaccessible kitchen areas. It was noted that Surrey County Council (SCC) were responsible for the central column shared areas.

27.4.      The MDC were keen to know that the views of the IHAG had been fed back to SCC.

**ACTION: IA to check with Angela Rayner and John Flowers whether the views had been passed on.**

27.5.      IHAG also looked at the Risk Management Strategy and Incident Management Policy and conducted Equality Analyses on both documents.

27.6.      MH wished to note that the joint IHAG/Governor Christmas lunch had been a success.


**28. Annual Members Satisfaction Survey 2016-17**

28.1.      KS advised that she wished the MDC to consider the responses to the new questions added to the survey this year, which were designed to check whether members felt they had received information about the changes in the Trust and the Recovery Plan.

28.2.      The last three issues of the Membership newsletter had focused on changes and issues at the Trust. The survey tested whether members felt informed from this.

28.3.    Nearly three-quarters of respondents felt they had received relevant information.

28.4.    CD advised that some members he had spoken to had found emails from the Trust in spam, or had not received information.

28.5.    KS advised that there had been an issue with NHS mail and it may be that the recent edition did not reach everyone.

28.6.    AS asked whether letters had gone out to everyone at any stage; KS advised that following R3 a letter had been sent to all public members. Otherwise, information was included within the newsletter.

28.7.    KS advised that the Trust needed to use an email system that would manage bounce-backs. Capita, the Trust's membership services provider, was ceasing to provide membership services, which would offer the opportunity to move to another provider where emails can be managed more effectively.

28.8.    KS further advised that it might be possible to send simpler emails with links to news on the internet, rather than attach the newsletter. This was agreed.

28.9.    AS asked whether members received other communications from the Trust. KS advised that the main communication was the newsletter, and we were conscious that our budget did not allow us to regularly contact members by post. We had decided not to simply send information to those on email.

28.10.    JGP noted that older people were often more interested in the ambulance service, but were less likely to be on email.

28.11.    KS advised that if the Trust went into financial special measures then the print newsletter may need to stop. She noted that, in the survey, members had asked for more information about the recovery plan and actions being taken. This information had been in each newsletter. The MDC discussed whether members were reading the newsletter.

28.12.    KS advised that she would like to trial not attaching the newsletter PDF to the email but rather linking through to the Trust website. This was agreed for the next edition.

28.13.    KS would like to create a branded SECAmb template to professionalise the email.

28.14.    MH asked whether there were opportunities on social media. KS advised that the link to the newsletter could be tweeted from SECAmb's account. Staff now received it by email, and it was more accessible now they had iPads.

28.15.    KS was interested in members' views about other information Governors felt she might send out by email.

28.16.    CD asked whether membership forms could be promoted more online. KS advised that we might run a membership week of online recruitment.

28.17.    Another new question in the survey was around selecting words to describe how members felt about their membership. This was intended as a

temperature check, given the challenging year. There was more positivity than negativity in the responses.

28.18.    MH and JGP advised that they felt the results were better than expected.

28.19.    KS advised that the newsletter had gone out to staff, and the comments in free text made it clear that a lot of staff were responding: this would likely have affected the outcome of the mood check. Next year, it would be better to provide staff members with a separate link.

28.20.    KS advised that a number of free text comments were about issues with PTS. The MDC noted that the public were not clear that SECAmb was not responsible for PTS across the patch. KS also received queries regarding PTS on the membership phone line. KS would like to promote the correct contact numbers, including HealthWatch, for people to talk to within the newsletter.

28.21.    KS would continue to keep simple messages within the newsletter, and would use the IHAG's suggestions around public messaging to inform the detail of the next article about Trust improvement plans.

28.22.    MH noted that the survey should include a follow-up question asking people to explain the reason for their answer, in relation to the mood word choices. This was agreed.

**ACTION: Next membership survey to include a follow-up question after the mood words question to enable participants to explain why they answered the way they did.**

28.23.    AS advised that the NEDs have said they have assurance that the recovery plan is going well and the new HQ is going well, but she wished to have more granular detail about what was going well. AS had been unable to understand the recovery plan. She felt that staff would benefit from hearing more about the progress being made. For example, AS had been part of a team putting new signage on/storage for medical gases. This area could be mentioned.

28.24.    IA advised that there should be a list of the 160+ actions that had been undertaken already, and she would share this to inform Governors about the areas where progress had been made. It would also be useful for staff to see what had been done.

**ACTION: IA to provide Governors with a list of actions taken to date.**

**ACTION: IA to advise SECAmb Communications that all staff might benefit from more about what progress had been made, as a good news story, including the must dos and should dos**

28.25.    MH advised that although there were reports to the Board about the improvements, it was not easy to see at a glance what had been done.

28.26.    Returning to the membership survey, the MDC noted that in general, the member survey showed a fairly positive response to membership, with a number of members wishing to get more involved with the Trust.

28.27.    The number of candidates standing in the elections showed clear interest.

28.28.    KS advised that a Patient Experience Group would be set up and she had offered to contact the membership who had told us they were patients.

28.29.    AS advised that the average person outside and within SECAmb did not know what the Board did, what the Council did, and generally how things worked.

28.30.    KS noted that it was clear that frontline staff did not regularly access email so there should be other ways to communicate.

28.31.    MH was concerned that the lack of overtime funding for ePCR training risked the Trust not realising the benefit of the iPads. He wished to ask a question of the NEDs in this regard.

28.32.    MH was also concerned that the number of acronyms at Board meetings was increasing, and also in Board papers.

**ACTION: IA to contact Lucy Bloem and Tim Howe to request assurance re iPad roll-out and training**

**ACTION: IA to ask the Company Secretary to remind Board members not to use acronyms in public meetings nor papers for those meetings.**

28.33.    CD noted that the membership was still not ethnically representative of SECAmb's patch. KS noted that work had been done in the previous year, however more could be done, including potentially conducting an online campaign to make connections between local groups/organisations and Governors.

**ACTION: KS would consider planning an online campaign to connect with ethnically diverse local groups, promote membership and connect Governors with the groups as relevant**

29. **Membership Engagement and Recruitment for the coming year**
    29.1.    KS noted that membership recruitment and engagement usually took place during the Summer months. Different approaches had been taken in previous years in terms of the types of events the Trust went to. The new HQ move in June was in the lead up to the majority of events, and the team had a potential issue around storage of the publicity materials at the new HQ.

    29.2.    KS did not wish to commit to attend an event and then let someone down. The proposal was to take a year off large scale events, unless once moved into the new HQ it was possible to get into an event at the last minute.

    29.3.    It was noted that lots of Governors attended local groups, and this could be the focus for the year. The MDC could provide support for the new Governors and indeed all Governors to meet with local groups such as Public Participation Groups, local HealthWatch and Clinical Commissioning Groups,

or local fetes etc. using the Trust membership toolkit which would continue to be available.

29.4.    MH advised that the Weybridge Museum 999 event the previous year had been excellent, and MH was content to attend events like this without SECAmb staff.

29.5.    CD advised that there was an emergency services day 24-25 June at the Amberley Museum. All emergency services were welcome.

29.6.    MH noted that 999 events were great for recruiting members. The MDC discussed whether it would be possible to do these big events, without kit available. Also at least four volunteers would be needed to staff stalls at these big events, due to the volume of traffic to the stall.

29.7.    KS advised she would prefer to do such events the following year with CFRs, more support, vehicles etc. if the Trust was in a position to do so.

29.8.    CD was going to a little event in March and would take the toolkit from Jane Watson.

29.9.    It was agreed that the MDC would not plan events, however if any Governor wished to attend an event they should contact KS. If, once the move to Crawley was completed, things were straightforward, some events might then be booked.

29.10.    KS asked whether there were other avenues Governors could suggest to promote Governors and membership.

29.11.    The MDC discussed posters in GP surgeries, and text on GP screens.

29.12.    A crib sheet for Governors could be produced to include Black and Minority Ethnic organisations and carers' organisations locally. KS suggested that Governors might buddy new Governors, and include the details on the crib sheet so local Governors could take part in things together.

**ACTION: KS would bring membership forms to the next MDC and the recruitment toolkit to the new Governor induction**

**ACTION: KS to produce a crib sheet for Governors with local organisations, including BME and carers' organisations, that Governors might make links with**

## 30. Your Call Member events 2017

30.1.    KS advised that Your Call membership events arose from previous member feedback, and enabled members to hear from local staff, CFRs and Governors around the patch. One had been trialled in Kent, which had been very well-received, and then two further were held in East Sussex and NE Hants. 80 people and 30 people respectively attended the events.

30.2.    Feedback from attendees had been fantastic. The MDC had agreed to hold a West Sussex event and a Surrey event. It was possible that Trust property might need to use, or failing that to use local venues which would perhaps cost slightly less than e.g. hotels.

30.3.     Tangmere was a possible venue for an event in West Sussex, however the event numbers would need to be capped. Banstead was a possible venue for Surrey however given parking issues this might not be ideal. The Banstead Centre was relatively cheap. KS would investigate venues and discuss approval with the Company Secretary.

30.4.     Surrey suggestions: Letherhead Institute in Leatherhead, St Martin's Church Hall, Dorking. West Sussex suggestions: St Richard's Church Hall in Goring, Billingshurst Community Centre, Billingshurst.

30.5.     The MDC felt that May was a good time to hold the events. AS would volunteer for the West Sussex event. CD and MH would participate in the Surrey one. KS would seek additional Governor volunteers once a date and location had been finalised.

30.6.     KS advised that at previous events, Mark Pantony had attended and provided AV kit, including microphones and PA system. The bigger the audience the more mics would be needed. Events had previously been recorded and shared online. The MDC felt that either the events should be fully supported, or should revert to very small scale events in local venues. It would not be appropriate to involve volunteers and staff and not enable people to hear them properly.

30.7.     The MDC discussed the purpose of the events. MH suggested that they could focus on improvements in mental health work. The MDC discussed how vehicles were popular with the public and IA advised that staff participating in the events sometimes brought a vehicle if any were available on the day, but the Trust could not promise a vehicle in attendance as patient care had to take priority.

30.8.     KS would consult with the Company Secretary on costings and advise the MDC asap.

30.9.     JGP noted that County Councils tended to have a list of free venues. CCGs might also have a list of places where they hold meetings.

**ACTION: KS to research venues and dates in West Sussex and Surrey for Your Call events**

**ACTION: KS to consult with the Company Secretary on approval for any costs associated with the events**

## 31. Items for the next newsletter

31.1.     The next newsletter would come out end of March/beginning of April and would include:

31.1.1.     Introduction to the new Governors

31.1.2.     Advertising Your Call events

31.1.3.     More on the Trust's recovery

31.1.4.     Overview of member survey outcomes

31.1.5.     CoG blog, as per usual

31.1.6.     Chair, CEO and new NED recruitment update

31.2.     KS asked whether Governors had any information for the CoG blog, and if so to please send it through to her.

31.3.     MH noted that the membership feedback was good overall and KS advised that it was useful for her to understand news from around the Trust.

**ACTION: MDC members to send KS copy for the CoG Blog – this could be simple updates about their work as a Governor**

## 32. Any other business

32.1.     IA advised that Louise Hutchinson would be setting up a Patient Experience Group in March and would send through a description of the purpose of the group once available. IA would share this with the MDC in order to discuss the process for deciding who should represent the Council on the group.

32.2.     KS suggested that the MDC should receive formal feedback from the participant at each meeting and then report back to the CoG through the MDC report. The PEG participant should be part of the MDC in order to report. IA advised that it would make sense to have a deputy in case the lead participant was unavailable.

32.3.     KS wished to be clear that the FT members should be invited to participate, as the membership contained a lot of patients.

32.4.     MH wished to emphasise that all Governors were welcome to attend MDC meetings. KS was grateful to those who had attended, given the uncertainty around the elections.

**ACTION: IA to circulate the description of the purpose of the Patient Experience Group once available**

**ACTION: IA to reiterate to Louise Hutchinson that public FT members included SECAmb patients and should be invited to participate in the PEG, if relevant given the purpose of the group**

## 33. Review of Meeting Effectiveness

33.1.     Members reviewed the effectiveness of the meeting, which was agreed to have been effective. IA and the MDC thanked KS for her clear papers which had made the discussion focused. MH thanked members and closed the meeting.

**The next meeting will be held on 10 May at 10:30 at Banstead HQ.**

**Appendix 2**

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**South East Coast Ambulance Service NHS FT**

**Staff Engagement Forum - 21st November 2016, 10:00 – 16:00**

**Gatwick Holiday Inn**

</div>

**Present:**

| | | |
|---|---|---|
| Angela Rayner | (AR) | Inclusion Manager, |
| Liz Spires | (LS) | Communications Manager |
| Tim Howe | (TH) | Non-Executive Director |
| Dave Atkins | (DA) | Clinical Operations Manager, Crawley |
| Karen Lavender | (KL) | HR |
| Katie Spendiff | (KS) | Membership Coordinator |
| Sally Robinson | (SR) | PA to Kath Start Director of Nursing |
| Karen Mann | (KM) | IT Development Project Manager |
| Izzy Allen | (IA) | Membership & Governor Engagement Manager |
| John Waghorn | (JW) | Paramedic |
| Roseanne Fright | (RF) | Clinical Scheduling Ashford and PW |
| Asmina Islam Chowdhury | (AIC) | Inclusion Coordinator |
| Louise Chambers | (LC) | EOC Manager, Coxheath |
| Nigel Coles | (NC) | Paramedic former Staff elected Govenor |
| Nigel Sweet | (NS) | Trade Union Representative, Technician |
| Paul Leonard | (KB) | Health Advisor, 111 |

**In attendance**

| | | |
|---|---|---|
| Claire Irvine | (CI) | Acting Resource Manager |
| Kate Mackney | (KMa) | HA 111 Dep for Paul Leonard |
| Steve Carpenter | (SC) | Contingency and Resilience |
| Peter Steventon | (PS) | Branch Secretary UNISON |
| Ariel Mammana | (AM) | Acting Branch Secretary MB (Part) |

**Presenters**

| | | |
|---|---|---|
| Andy Collen | (AC) | Consultant Paramedic |
| Ben Banfield | (BB) | Head of PMO |
| Dan Hale | (DH) | Associate Director Governance |
| Janine Compton | (JC) | Head of Communications |

**Secretariat**

| | | |
|---|---|---|
| Barbara Macanas | (BM) | Senior Policy & ER Manager |

**Apologies:**

| | | |
|---|---|---|
| Debbie Evans | (DE) | ECSW, Paddock Wood |

| Lee Warwick | (LW) | HART Paramedic, Ashford MRC/HART |
| Lee-Ann Witney | (LAW) | Fleet |
| Katy Larkin | (KL) | OD Learning and Development Lead |
| Geraint Davies | (GD) | Acting Chief Executive |
| Geoff Fitch | (GF) | CCP, Thanet |
| Danny Dixon | (DD) | Clinical Education Trainer |
| Alison Stebbings | (AS) | Staff-elected Governor, Logistics Manager |
| Steve Graham | (SR) | Acting Head of HR |
| Paul Leonard | (PL) | NHS 111 |

## 1. Welcome, introductions and apologies

1.1. KM welcomed members to this extra ordinary SEF, which has been requested to cover activities taking place to address both the consequences of the CQC inspection and messaging around the activities taking place to address this. Members were requested to listen carefully to what may be some difficult messages and feed-back constructively to assist the Trust in moving forward.

1.2. KM thanked AIC and AR for supporting the SEF and welcomed KL and HB who would be taking over that role.

## 2. Minutes

2.1. The minutes of the meeting held on 17<sup>th</sup> October 2016 were reviewed and agreed as an accurate record of the meeting, with one amendment to JW's clinical grade which should be Paramedic not ECSW.

## 3. Action log

3.1. Action 159 – Electronic Wage slips; SG advised that this was being considered as part of the move to Self-Serve in HR. Action superseded and reassigned to SG.

   **ACTION:** SG who would provide an update on timescales for this project outside of the meeting.

3.2. Action 167 – Attendance - please advise HB in future if you are unable to attend the meetings.

3.3. Action 176- Provision of a video guide to the fitness test – ongoing action owner now LS

3.4. Action 194.3 & 194.5 Communication of rationale for immediate handover policy – JC happy for SEF to be involved in developing messaging. KM and LS to liaise re Bulletin articles

3.5. Action 195.2 – Superseded by a further action – to close

3.6. Actions 197.3- Ongoing

3.7. Action 199 - carry forward as SG not in attendance

3.8. Action 200.1 – ongoing

3.9. Action 200.2 – awaiting completion of 200.1

3.10. Action 201 – carry forward

3.11. Action 202 – carry forward

3.12. Action 203.1 – The Unified Recovery Plan can be found on the intranet

3.13. Action 203.2 – The Ambulance Response Program is working well and the H&T rate has increased although there is little communication around impacts on Red 1 or staff feedback around perceived adverse incidents. TH referenced a recent report to the Trust Board - JC to provide update in line with 6-month national review

3.14. Action 204.1- Crawley move update – JC advised nothing able to confirm at present – copies of previous presentations to be recirculated – LS to progress

3.15. Action 205 – carry forward

3.16. Action 206 – has been circulated to Staff Side – to be added to Bulletin

3.17. Action 207 – Circulated with minutes of last meeting – Close

3.18. Action 208 – completed – close

3.19. New Action KM to follow up with Finance Director the position with Estates Outsourcing

## 4.     Presentation – Dan Hale

4.1. DH's Presentation on an update following the CQC report is attached.



CQC Update
Presentation 21.11.1

4.2. The key improvements required of the Trust centre around the 16 Fundamental Standards, delivering safe, effective and responsive care. All activities undertaken should link bac to these, including operational performance and financial sustainability.

4.3. As a Trust we need to manage risk effectively, developing a learning and reporting culture.

4.4. Feedback was provided directly and included.

4.5. Bulletin articles to demonstrate how the fundamental standards translate into everyday activities, improvements to the DATIX system, key engagement with CTLs, clinician reflective practice and development of a fundamental standards handbook for all staff.

4.6. DH asked that it be noted that Emma Wadey is the Trust 'Freedom to Speak Up' Guardian.

4.7.   DH may be contacted on 07884 476835 if any other groups would like this or a similar presentation to raise awareness.

4.8.   KM thanked DH for his presentation.  Any further questions or feedback would be welcomed directly to DH after the meeting.

## 5.   JC Presentation

5.1.   JC's presentation on the Unified Recovery Plan (URP) is attached.

URP - briefing
slides jc v3 21.11.16.

5.2.   The meeting then divided into groups to discuss specific elements and feed back to the whole meeting for discussion.

5.3.   These were very detailed and evidenced the complexity of managing the recovery process with numerous competing demands and controversy over the perceived effectiveness of certain innovations.

5.4.   All feedback will be targeted to the teams involved, led by the PMO (Program Management Office) who would welcome continued comment and suggestions.

5.5.   KM thanked JC who had found the session very useful in providing recommendations for structuring messaging for the wider Trust.

## 6.   AC Presentation

6.1.   AC's presentation on the Task Cycle Tine (TCT) project is attached.

TCT Project SEF -
21st Nov16 - AC v1 0

6.2.   This prompted considerable and animated group discussion which was wide ranging and detailed.
6.3.   AC took away all comments which will be included with the outcome of the Tangmere trial and further updates will be provided via both the Bulletin and Staff magazine.

## 7.   Speak in Confidence launched.

7.1.   Group members were requested to take a leaflet and promote this initiative in their areas and departments.

## 8.   AOB

8.1. The impact of STPs on the Trust was queried. The Trust is engaged in the process at senior level and will provide information as and when it is available. SECAmb encompasses four STP areas so engagement in all the workstreams is challenging.

## 9. Review of meeting effectiveness

9.1. Members agreed that it the meeting had been informative and valuable.

9.2. Additional comments should please be sent to HB.

9.3. KM thanked the members for their support as this was a short notice additional commitment.

**Date for next meeting:  13<sup>th</sup> February 2017 at Tangmere MRC**

**Appendix 3**

**South East Coast Ambulance Service NHS Foundation Trust**

**Inclusion Hub Advisory Group (IHAG)**

Notes of a meeting held on 25<sup>th</sup> January 2017
At Stanhill Court Hotel, Charlwood, Surrey: 09:30 to 16:00 hours

**Attendees:**

| | | | | | |
|---|---|---|---|---|---|
| Angela Rayner | (AR) | Jim Reece | (JR) | Mo Reece | (MR) |
| Ann Osler | (AO) | John Rivers | (JRi) | Patrick Wolter | (PW) |
| Ann Wilson | (AW) | Karen Mann | (KM) | Penny Blackbourn | (PB) |
| Chris Devereux | (CD) | Katie Spendiff | (KS) | Sarah Pickard | (SP) |
| David Atkins | (DA) | Leslie Bulman | (LBu) | Stephen Merriman | (SM) |
| Hilda Brazil | (HB) | Marguerite Beard-Gould | (MBG) | Terry Steeples | (TS) |

**Presenters & Guests:**

| | | | | | |
|---|---|---|---|---|---|
| Alison Stebbings | (AS) | Dan Hale | (DH) | Janine Compton | (JC) |
| Jean Gaston-Parry | (JGP) | John Flower | (JF) | John Gooderham | (JG) |

**Secretariat:**

| | |
|---|---|
| Asmina Islam Chowdhury | (AIC) |

**Apologies:**

| Lucy Bloem | (LB) | Mark Kelner | (MK) | Nick Goh | (NG) |
| Ollie Walsh | (OW) | Paula Dooley | (PD) | Simon Hughes / Deirdre O'Halloran | (SH/DO) |

- **Welcome and introductions**

o AR welcomed everyone to the meeting in particular PW, who was joining the group as the lead contact for IHAG's new partnership organisation The Mary Frances Trust. The Mary Frances Trust will be representing the needs of people with mental health needs and PW will be supported on the IHAG by Dan Cartwright who will act as his Deputy. AR also advised that Public member John Gooderham would be joining part of the meeting later to observe the role of the IHAG.

o AR tabled apologies as given above, and also gave apologies for lateness from IA, KM, & MBG, and that we would also be joined by guests Staff Elected Governor AS and Public Governor JGP later in the morning. AR noted that the format of the meeting had been adapted to allow for a tour of the new Headquarters and Emergency Operating Centre during the afternoon session.

- **Minutes of the previous meeting**

o The notes of the meeting held on 13th October 2016 were reviewed for accuracy. AR proposed that the minutes of the last meeting be taken as an accurate record. LB seconded and the agreement was carried.

- **Matters arising & IHAG Action Log Review**

o Action 188.3 – Patient Experience: Dan Hale (DH) advised that this work was beginning to take shape within the Quality and Safety Directorate, and they were currently reviewing outcomes from Healthwatch. They were also looking at the establishment of a Patient Experience Group (PEG) and were in the process of developing the Terms of Reference to support this. DH advised that a review was under way to the current format of responding to complaints, which would include the development of a patient information leaflet regarding the role of the ambulance service.

IHAG members expressed their interest in being involved in the design of the leaflet. DH agreed it would be essential to have IHAG members on the PEG.

o Action 198.3 – Draft meeting etiquette: IA updated that although this was still a need, it was not a priority at the present time. The group agreed that they were happy for this to remain on the action log but would not expect any progress at present. Action carried forward.

o    Action 198.3 – Trust Governance update: IA provided an update that a review of the effectiveness of the "Policy on Policies" was currently underway. Action carried forward.

o    Action 201.2 – IHAG recruitment: AR advised that this was ongoing and progress had been made with the recruitment of the Mary Frances Trust.  AR noted that we were really struggling with both BME patient / public member recruitment and an organisation to represent the needs of young people on the IHAG, and requested assistance from the group. Action carried forward.

o    Action 202.3 – IHAG webpage update: AIC advised that this was ongoing, with updates from two members so far. Action carried forward.

o    Action 203 – IHAG feedback: JRi had raised the IHAG feedback at the last IWG and this had been well received by the group, with matters being escalated where there had been a need. The MDC would be receiving the first of feedback reports at the February meeting. This action will now be built into IHAG meeting business and therefore the action was closed.

o    Action 206 – NHS Sustainable Transformation Plans (STPs): DH advised that SECAmb faced challenges with the proposed plans as we were covered by four STP's across the area we cover, but Jayne Phoenix, Interim Associate Director of Strategy and Business Development was involved in this work stream for SECAmb. It was agreed that this action should be closed and that Jayne Phoenix should be invited to the April meeting to provide further information on how the STP's would affect SECAmb.

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**Action:  AIC to invite Jayne Phoenix to present at April IHAG**

**Date:    February 2017**

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o    It was **agreed** to close all other actions which had been noted as completed in the Action Log since the last meeting:  195.1, 199.4, 200.1, 204 and 205.


•    **Review of activities undertaken by members**

o    Members updated the group on the activities since the last meeting and these included: Attendance at the Staff Engagement Forum, participating in the visit to Gatwick Make Ready Centre; Representing the IHAG at the Inclusion Working Group. Members also attended the Quality Account; Safeguarding Policy and Equality Analysis Consultation; Clinical Risk Sub-Group; Interviewing of the Deputy Chief Nurse; The Joint IHAG and Governors Christmas event and Sussex Patient Transport Service Patient Forum, Ashford CCG Rural Committee meeting and PTS Sussex Transition Board meetings

o    JR advised that he continued to attend meetings of the History Marking Sub Group and advised that the review of the policy was ongoing, with concerns regarding reporting of the group having been raised and escalated at the December IWG.

- o PB and LB provided an update following the recent Clinical Risk Sub-group raising the following concerns

    - Lack of feedback on risks identified and submitted by the group
    - Length of agenda is prohibitive due to insufficient time to cover all items.

    DH advised that with the changes being made to the reporting systems (DATIX) would allow for improved electronic feedback mechanisms.

- o AR thanked members for their continued support by attending such a wide range of events and contributing into groups across the Trust.

- **Development of the Risk Management Strategy and Incident Management Policy**

- o AR introduced Dan Hale (DH), Interim Associate Director of Governance. DH advised that in response to the CQC report in September 2016 and the Red 3 report published in March, the Trust had a number of actions to review the way that Risks were managed within the organisation.

- o DH outlined a number of actions which were being undertaken, which included;

    - Review of Risk Register

    - Recruitment of a Datix Manager, this is a new position within the Trust. The post holder would be responsible for the administration of the system.

    - Changes to the Datix system which will see a web based form for use by crews; immediate availability of data available to the central team.

    - Improved reporting mechanisms which will allow the following to be recorded centrally; patient (safeguarding) and staff safety; claims handling; incident and complaints reporting, as well as incorporate the risk register.

- o DH also discussed plans to integrate the Trust Computer Aided Dispatch (CAD) system, with the incident reporting provided via Datix systems and the electronic Patient Clinical Record (ePCR) which is being rolled out via an IPad application. Work is also being undertaken in conjunction with Communications and Clinical Education Teams to develop a Training Needs Analysis to roll out training to all staff on the changes being made.

- o Issues of poor data quality had also been identified as a result of the current systems and processes. This has led to over reporting of incidents nationally by the Trust, as we are unable to distinguish between patient and staff related incidents at present. DH advised that the directorate was also looking into the procurement and development of a Datix team to support the above, as well as to development of an app for real time reporting.

o   DH outlined the Trust strategic objectives which were driving the development of the Risk Strategy as well as a need to use the risk register to;
   - identify issues which had issues
   - identify potential risks
   - drive business improvement using the Risk Register

o   DH provided a breakdown of how the risks will be managed under the new strategy with increased accountability at local level for low risk clear escalation and assurance routes which will be supported by the introduction of a key performance indicator to challenge lack of progress.  There will also be an audit of all risks 12 months after closing.

o   DH also provided an overview of the draft Incident Management and Reporting Policy and Procedure which had been shared with the group prior to the meeting. DH advised that the policy was being reviewed to ensure the Trust was meeting national reporting guidelines and reduce variation in the management and response rates to incidents.

o   Members provided a feedback on the policy, which included;

   - a need to either reference or link the policy to the Disciplinary Policy.

   - Clarification of the availability of staff welfare for staff members affected by the report of an incident and the timescale within which the review is completed.

   - a requirement to improve training so managers are able to understand and identify what constitutes a serious incident (SI).

o   DH also advised that the policy and procedure would be implemented and monitored by a Serious Incident Review Group and this would report into a Serious Incident Assurance Group. The group discussed the need for patient representation within this process and it was agreed that DH and AR would discuss this further outside of the meeting.

> **Action:  DH to consider how best to ensure adequate patient/public involvement in the new process and to discuss with AR.**
>
> **Date:    February / March 2017**

o   Having reviewed the Incident Management and Reporting Policy and Procedure  and the Risk Management Strategy, members were satisfied that no negative impacts  were identified. However, they felt that it was important to note that there could be a potential impact on the mental health of staff and patients involved in a review and that care was taken to ensure they were supported throughout the process.

o   DH advised the group that the plan was that the Strategy would be going to the Board on 26th January for approval and the policy would be discussed at the Senior Management Team Meeting in early February.  AR thanked DH for coming to speak to the group.

- **Public communication around Trust recovery plans**

o   AR welcomed JC, Head of Communications to the meeting.

o   JC provided a short presentation, providing an overview of the current situation within the Trust, and advised that in the wake of recent publicity, the Communications Team had been responding to enquiries on an ad-hoc basis and there was a need to develop more consistent messaging whilst understanding that some of this may be unpalatable. In addition to this JC noted that the NHS as a whole was under a high level of scrutiny, and that there was an unprecedented level of sustained and detailed enquiries coming from the media due to the Trust's current situation.

o   The group discussed the key themes that had been identified for development of messages and a short workshop session was held to identify the key messages around;

- Our response to patients – response times, types of response
- Regulatory measures – CQC, Special Measures
- Finance

o   JC thanked members for their input into the development of the messages which she felt reinforced those that had been identified.  AR thanked JC for engaging with the IHAG. A copy of JC's presentation can be found below;



IHAG presentation
25.01.17.pdf


- **Staff Engagement Forum (SEF) update**

o   KM noted that there had been two meetings of the SEF since the last IHAG, the planned meeting in October and an extraordinary meeting which had been held in November to enable timely engagement with staff around actions that were being undertaken in response to the CQC report.  This had included a session from the Programme Management Office who were coordinating the Trust's recovery plan.  It was felt this had helped staff to understand how ownership could be taken at all levels of the organisation.

o   KM also advised that she was shortly due to take up a 12-month secondment at the Department of Health and therefore IA would be taking up the role of SEF chair in her absence, as the deputy.


- **Open session, horizon scanning and future agenda items**

o   AR advised that in response to the financial pressures, the Trust had cancelled all external meeting venues and that the IHAG meeting had been given an exemption for this meeting as it wasn't possible to find a central, accessible Trust venue.  AR asked the group for their views on venue costs and it was proposed that accessible, central low cost venues such as church halls or

community centres should be utilised with a basic lunch provided if Trust premises were not available.

o   LB noted that he had been involved with four NHS Trusts and SECAmb was by far the most supportive he had come across.

o   The group also noted that the new Chief Executive Daren Mochrie, was due to take up his post on 3<sup>rd</sup> April 2017 and the IHAG agreed that he should be invited to attend a meeting at the earliest opportunity.

| |
|---|
| **Action:  AR to invite Daren Mochrie to either the July or October IHAG meeting.**<br><br>**Date:    April 2017** |

o   AR invited members to express their interest in being part of a subgroup to plan this year's approach to the equality objective review.  AR also requested feedback from members on their views of the approach which had been taken in 2016.

o   It was noted that there had been a poor uptake to the request for volunteers to be involved in the upcoming chairman selection, and both IA and AR reminded members about the opportunity and process for getting involved.

o   LB shared figures following a recent Freedom of Information request regarding rural response time in Kent and raised concerns regarding the disparity between rural and urban response times. It was agreed that AR would invite Chris Stamp, Regional Operations Manager to attend the next meeting.

| |
|---|
| **Action:  AR to invite Chris Stamp to present on rural response times at the April IHAG**<br><br>**Date:    February 2017** |

o   JRi raised a query regarding the review of the volunteer charter. AR agreed to follow up when the Charter was due for review. A copy of the Volunteer Charier will also be circulated again to all members.

| |
|---|
| **Action:  AR to check if there is a review date for the Volunteer Charter, and circulate a copy to all members**.<br><br>**Date:    February / March 2017** |

•   **Crawley Headquarters and EOC Tour.**

o   Members of the IHAG and Governors travelled to the new headquarters and were provided with a tour of the building facilities by John Flower. The group raised a number of points for consideration regarding accessibility of the headquarters facilities and provided feedback on site.

- **IHAG feedback report**

o The group agreed the following to be reported in their highlight report to the IWG:

   1. The group welcomed the proposed changes that would be brought in by the revised Risk Management Strategy, and Incident Management and Reporting Policy. However, they felt there was clear need for increased patient and public participation in the Serious Incident process, but it was yet to be agreed at what stage this should be.

   2. Members of the group who attended the new site raised concerns regarding the accessibility around a number of areas of the new building including the reception, kitchens, placement of automatic door buttons and toilet facilities.

- **Meeting effectiveness**

o Members felt that it had been a good meeting with a realistic agenda.

- **AOB**

o None raised.

- **Date of next meeting**

o The next meeting will be held on **12th April 2017,** 09:30 to 16:00 hours.

**SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST**

**Council of Governors**

**F – 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 on 27 February 2017. The full minutes are provided for the Council as an appendix to this paper.

   1.6. The GDC meeting focused on: feedback from the previous Council meeting; the way the Council wished to work with the new Chair and the Trust moving forwards; and setting the agenda for the next Council meeting. The full minutes are included in the Council pack and Governors are encouraged to read them.

2. **Feedback from the previous CoG**
   2.1. The GDC noted that responses to some questions at the meeting had not been adequate. In particular, the GDC wished to record that the impact on recruitment and retention of any pause/halt in training specialist Paramedics must be monitored in the longer term: it was not sufficient to say that recruitment continued on track at present, since any adverse effect would be down the line.

   2.2. Tim Howe (Non-Executive Director and Chair of the Board's Workforce and Wellbeing Committee offered to bring the workforce plan to the Council in March – however TH was unavailable to come to the meeting due to participating in an appeal hearing. This could be deferred to the June Council meeting.

3. **Working with the new Chair**
   3.1. The GDC noted the opportunity presented to develop a relationship with the new Chair based on mutual understanding and agreement of the most effective ways of working together.

   3.2. The GDC noted that the key areas for improvement highlighted in the self-assessment were:

- timeliness and appropriateness of information provided outside the meeting;
- interactions with the Chair;
- and interaction with the wider Trust.

3.3. The GDC discussed a number of issues and ideas for improvement under these headings, which are set out in full in the minutes appended to this report.

3.4. The GDC considered establishing a task and finish group to consider these areas and make proposals to the Council and the new Chair.

3.5. The Council is asked whether it believes this would be a useful way forward, and if so, for Governors to express their interest in participating in such a group.

## 4. Agenda setting

4.1. Members reviewed a number of items which included items mandated by the Council Agenda Framework, from the Council Action Log, and other timely items. A draft agenda was agreed.

4.2. Members had concerns about the risk management process around changes being made within the Trust to respond to the CQC's findings and to make financial savings. This was agreed to be the main agenda item.

4.3. In addition, the Council needed to review the CoG's self-assessment and receive a report on the Quality Account, including selecting an area of the Account to audit.

4.4. The afternoon session would be further work on the developing 5-year strategy, which would be more interactive than the November session.

## 5. Recommendations:

5.1. The Council is asked to note this report and advise the GDC on:

5.1.1. Whether a task and finish group to discuss Council information needs is required and, if so;

5.1.2. Governors are asked to volunteer to participate in this group.

Brian Rockell, Lead Governor (On behalf of the GDC)

*See over for the minutes of the GDC meeting*

**South East Coast Ambulance Service NHS Foundation Trust**

**Minutes of the Governor Development Committee**

**Lewes Office – 27ᵗʰ February 2017**

**Present:**

| | | |
|---|---|---|
| Peter Dixon | (PD) | Chairman |
| Izzy Allen | (IA) | Assistant Company Secretary |
| Marian Trendell | (MT) | Appointed Governor |
| Brian Rockell | (BR) | Lead Governor & Public Governor for East Sussex |
| Alison Stebbings | (AS) | Staff Elected Governor – Non Ops |
| Mike Hill | (MH) | Public Governor for Surrey and NE Hants |
| Jane Watson | (JW) | Public Governor for Surrey and NE Hants |
| Jean Gaston-Parry | (JGP) | Public Governor for Brighton |
| Chris Devereux | (CD) | Public Governor for Surrey and NE Hants |
| Tim Howe | (TH) | Senior Independent Director & NED |
| James Crawley | (JC) | Public Governor for Kent |

**Apologies:** Maggie Fenton, Marguerite Beard-Gould

**Minute taker:** Katie Spendiff

1. **Welcome, declarations of interest, minutes an action log:**
   1.1. BR welcomed members to the meeting. BR noted that he was up for re-election and hoped to see the GDC at their next meeting pending the result. BR noted that MF had chosen not to stand for a third term and thanked MF for her participation in GDC meetings. In turn BR noted that there would be new colleagues at the next Council meeting with election results being announced on the 1ˢᵗ March.
   1.2. BR noted that the Council and its committees had been exceptionally busy and that the support received from IA & KS, had been "first class". The GDC agreed with BR and thanked IA & KS.
   1.3. No declarations of interest were received.
   1.4. The minutes of the previous meeting were reviewed and taken as an accurate record of the meeting.
   1.5. The action log was reviewed. Action 86 - IA noted that she was almost in a position to circulate Board committee dates for observation to the Council.  IA advised that it would likely be shared post- election, and that new Governors could receive these dates at their induction and they could then be circulated to the wider Council.
   1.6. Action 99 – 'IA to follow up with Project Management Office (PMO) about management of the Trust's project list'. IA noted she had circulated a response from Jon Amos which provided reassurance that the projects list had been reviewed by the PMO, and either taken up by PMO as a 'live' project or closed down if necessary.

1.7. BR sought assurance that the projects that were closed down had been appropriately notified and that work had ceased. BR also sought clarification that projects were not still taking place outside of the PMO. TH noted that any 'live' projects throughout the Trust now have to go through the PMO. TH noted that there were no 'live' projects taking place outside of the PMO to his knowledge. IA noted possible communication improvements about the work of the PMO and the process. IA noted that she had not received information/ a directive on project work and the process and queried if all staff were aware of the procedure for new projects. IA noted that current 'live' projects were well supported by the PMO.

2. **Discussion of any feedback from the previous Council meeting:**

2.1. BR noted the inclusion of the agenda from the meeting on the 31 January in the papers for reference.
2.2. JC noted his personal opinion that the Council had been misinformed in an answer to a question he had asked on medicines management at the Council that was answered by the acting Chief Executive. BR noted the upcoming change in the organisation and the need for patience and perspective.
2.3. PD noted that what the CQC had found on this subject was of concern but they had not highlighted all the issues now known regarding medicines management. The more serious issues had been highlighted by the Quality and Patient Safety Committee. PD noted that if the Chief Executive's answer had been related to the CQC report, then it could be considered accurate. JC noted it was a stylistic point and hoped for improvement in the future. MT noted importance of issues of the past being left behind with the opportunity to work with new CEO and new Chair. MT noted that now would be the time for Governors to receive any outstanding reassurance that is required, so a line could be drawn and Governors could move forward without bringing up historical events.
2.4. JC noted he had sought reassurance around changes in recruitment and the monitoring of this at the previous meeting. JC felt he had not received a complete answer to this question. JC noted it was the long term effect on recruitment and retention of changes to the Paramedic Practitioner and Critical Care Paramedic programme that he sought reassurance on. JC noted that the Trust would possibly not see effects of this change until the longer term: the statement that the change had "not had an impact" was invalid. JC noted his hope for improved communication style at future meetings.
2.5. TH noted that the Workforce and Wellbeing Committee was focusing on a workforce plan and that he was content to pick up on this and present at the March Council meeting.

**ACTION:**
**TH to present at March Council meeting on the Trust's workforce plan.**

3. **Working with the new Chair:**

3.1. IA noted that with the appointment of a new Chair comes the opportunity to reflect on how the Council would like to work with them.
3.2. IA noted that in the paper it reported on outcomes from the Governor self-assessment survey, and the evaluation and key points of recent in-house Governwell training on effective questioning and holding to account. IA noted it was important that the GDC had read the paper to make informed suggestions.
3.3. IA noted that the Governwell training had been a day long course with focus on holding to account and asking effective questions. GDC members who had attended noted that the

effective questioning had been of particular interest and benefit. BR noted that the encouragement and exercises in lifting up question style instead of drilling down in to detail had been incredibly useful. IA noted a recommendation that new Governors attend the Core Skills courses provided by Governwell, as the accountability and effective questioning courses were used to create this in-house training for Governors.

3.4. JW noted that she had found the in-house training far more beneficial, as it was focussed on SECAmb. JW noted that external Governwell courses had attendees from different Trust's so the practical examples were more general. GDC members who had attended agreed with JW. KS noted it would be worth comparing cost of in-house training vs travel and individual course fees if we had a number of new Governors interested in the course - budget permitting.

3.5. IA asked at what point in a Governor's term the GDC thought the training became of most value. The GDC agreed that towards the end of the first year of a Governors term would be the best time for training.

**ACTION:**
**KS to price up in-house training for Governors in February 2018 on accountability and effective questioning vs Core Skills (in-house - £1500 cost in 2017 for 10 pax).**

3.6. IA noted that at the training there had been discussion around usefulness of pre-meets prior to public Council meetings. The purpose suggested by the trainers was to discuss and agree the Council's focus for the meeting and questions Governors had planned to raise. The GDC were asked to consider this. JC queried whether a post-Council meeting may be more suitable to discuss what the Council had heard and are focussed on, and provide direction for follow up at the next meeting. IA reminded the GDC of the Council's statutory duty to members and the public to hold NEDs to account for performance of the Board, which was perhaps best done in a *public* meeting. She noted that the advantage of a pre-meet was to enable the Council to agree their own areas of interest ready to raise at the meeting. If the interests were shared at a pre meet, interests could be triangulated, and then Governors could support each other in further lines of questioning if a satisfactory answer was not received.

3.7. IA noted there had also been a suggestion of a task and finish group to help examine whether the information Governors receive is fit for purpose in both content and style of presentation. IA sought the GDC's view on this. BR noted that on the training course they had received examples of different reporting styles, and these would be important to consider and review at a task and finish group if formed. IA noted that the Governor dashboard created by previous Company Secretary Andy Chittenden could be reviewed by this group and considered as to whether it would be useful.

3.8. IA noted that the key areas for improvement highlighted in the self-assessment were:
- timeliness and appropriateness of information provided outside the meeting;  - interactions with the Chair;
- and interaction with the wider Trust.

3.9. The GDC had a break out session to consider the key points, outcomes have been captured as follows:

3.10. *Information provided outside of formal meetings*
- Focus on current issues not historical.
- Management of email chains and reply all culture.

- Knowledge on area of expertise of NEDs - IA noted this could be shared. TH noted the NED role was quite broad, and they should have an overview of all key issues in the Trust.
- BR noted facility to channel questions through Izzy, for monitoring and forwarding.
- Remember Governor remit in context of information requesting.
- WhatsApp Governor Group.
- Timeliness around sharing negative articles that may appear in the press.

3.11. IA noted that it was useful for the Trust to brief staff and Governors when they could prior to a story breaking in the press. IA noted that the reasoning for this is so Governors were aware if pubic members mentioned it to them. JC noted Governors could set up their own google alerts for SECAmb stories, but this would only cover stories that were already in the press.

3.12. ***Interaction with the wider Trust***
- Focus on a collective view, not a focus on individual crusades on matters outside the Council meetings.
- Focus on all NEDs attending Council meetings.
- Important to share the benefit of attending the Board to observe work of the NEDs and Board and their interaction across tables.
- Observing committee meetings.
- WhatsApp Governor Group.

3.13. MT noted that SECAmb used to hold Board and Council meetings on the same day, with the Council having opportunity to observe Board in the morning and form questions after this. MT noted benefits in the reduction of travel and printing. IA noted there were pros and cons of this format that had been reviewed a number of times, but that perhaps in light of the new CEO and Chair starting it could be timely to review again. IA noted that the main con was that the afternoon sessions at Board and Council would have to be carried out on another day.

3.14. PD noted that the Council focused on a broader agenda, and that he felt it would be a shame to just focus on what happened at the Board meeting. PD noted that his preference would be for the Council meetings to be more thematic – focus on patients, focus on stakeholder engagement and have sub groups for further exploratory work such as a patient experience group. IA noted that the Trust does not presently have a patient experience group, but that she understands that the terms of reference for a group like this are under review and she will share with Governors when available. IA noted that Governors would be a part of any patient experience group in line with the inclusion strategy. JC noted that a patient group could choose the patient story for Board meetings.

3.15. JC noted given his work commitments he would appreciate more access to Board meetings if done in the way MT suggested. PD noted that all day meetings can be tiring, and focus may lessen for participants that were there all day. TH echoed PD's sentiments around tiredness and its effect on questioning.

3.16. AS noted operational staff governors had trouble getting time off to attend meetings, and queried support for time off by relevant managers. The GDC discussed attendance at Council meetings by Governors. The GDC requested that attendance at Council meetings should continue to be monitored and reported back to the GDC. The GDC agreed the data could be reviewed every 6 months at the GDC to monitor attendance and support attendance of Governors where needed. MH encouraged Governor's to attend meetings outside of the formal meeting if possible, i.e. Council committees.

3.17.     TH noted that in line with the new Chair, it may be timely to review the continued suitability of the Trust's Appointed Governors/organisations, with a focus on if the partner organisations were still relevant and prominent to the Trusts working relationships. IA noted that the Trust's constitution was due to be reviewed in the next 6 months and that this could form part of the review.

3.18.     BR emphasised Governors' ability to understand their remit, and that the constitution and Monitor guidance should be familiar to Governors.

3.19.     TH supported a Governor WhatsApp group, and noted need for concise messaging.

3.20.     TH noted Governors should be welcome to observe 111 and 999 centres, especially as meetings now took place on Trust premises. IA noted that this would be arranged as part of the induction for new Governors.


**ACTION:**
**GDC to review attendance of Governors at Council meetings every 6 months.**


3.21.     ***Relationship with chair***
   - Relationship should be firm but fair with the Chair having an appreciation and knowledge of what the Council does, and the Council having knowledge and appreciation of the Chair's role.
   - Contact and information flows. Formal and informal.
   - Informal: once a year Chair should have informal conversation with individual Governors (a general get to know you chat).
   - Formal: being impartial, maintaining balance of time and focus between Board and Council.
   - Respect views of others and respectful tone when communicating with volunteer Governors on and offline.
   - Honest and impartial chairing style.

3.22.     BR noted that previous constituency meetings with the Chair had worked well. BR welcomed the suggestion of the return of these as they provided the option to raise things formally and informally with the Chair.

3.23.     IA noted that Staff Governors used to have quarterly meeting with the Chair and Chief Executive, and that previous staff Governors had valued this. IA noted it presented a good opportunity for myth busting/ early warning system for any issues arising. AS noted she would strongly welcome this opportunity.

3.24.     TH noted he sought Governor assistance in objective setting for the new Chair. TH noted a sub-committee could be formed to review and propose ideas. BR noted his conversations with a few Governors on this subject already, and advised TH that he could make suggestions re participants for the sub group. TH welcomed this suggestion.

3.25.     AS noted the first few public Council meetings she had attended were quite fractious, in terms of the way both Governors and the newly appointed Chair at the time spoke to each other. AS noted timing of new Chair, Chief Exec and Governors and that it would be important to set the tone of meetings moving forwards. IA noted that there was no fixed meeting etiquette but that Governors should abide by the Trust's Code of Conduct and Nolan Principles. IA noted that some kind of meeting etiquette guidance for all Trust meetings would be useful but timing would be important. IA suggested it could be of benefit for the meeting space at the new HQ. IA noted that meeting etiquette guidance could be rolled out to the Council for trial.

3.26.    IA noted that a summary of the GDC's discussions on working with the new Chair would be produced and shared with the Council, and then with the new Chair and Chief Exec when appropriate.

**ACTION:**
**Consider task and finish group to review Governor information needs and the presentation style of reports and if needed feed back/ seek volunteers.**

**Share summary of 'working with new Chair' discussions with the Council and then Chair/CE.**

**BR to put forward participants for a sub group to discuss the Chair's objectives.**

4. **Council assurance requirements:**
   4.1. IA advised that Governors had raised concerns over certain changes taking place in the Trust in line with improvement and financial plans. IA noted that Governors sought assurance that NEDs were assured that risk reviews and quality impact assessments had been completed in line with those changes.
   4.2. IA proposed the question was brought to the Council meeting. The GDC agreed.

**ACTION:**
**Council to seek assurance from the NEDs around change management in the Trust, focussing on assurance of risk review and quality impact assessments on the change.**

5. **Agenda items for the Council meeting of 30 March:**
   5.1. IA asked the GDC if the paper could be taken as read, supplemented by the following suggestions. GDC agreed.
   5.2. IA noted that suggested agenda items on the Chair and Quality Account could now be removed as these items had been covered.
   5.3. IA noted that the suggested item on the New HQ/EOC be given priority due to timeliness of the move and seeking assurance. IA noted key area of risks around change with the New HQ were a priority. IA noted that the Council agenda framework item would need to need to come to the next meeting.
   5.4. TH queried the fact that the new Chief Exec would not be at the next Council meeting as start date was April. BR noted assurance is sought from NEDs not Chief Exec so did not view this as a concern for the meeting.
   5.5. IA asked the GDC if there were any additional subjects for consideration. MH noted interest in receiving an update on the Operating Unit restructure and the roll out of the ePCR. TH noted that an update on the ePCR would be good to hear on as OU's were in progress and May time would be more appropriate for an update on them. BR noted interest in the Council receiving top level statistics on the roll out of the ePCR i.e. number of users/ areas of roll out. IA noted she thought this information had gone to the Board recently, and that this could be circulated outside of the Council meeting. The GDC agreed.

**ACTION:**
**IA to circulate top level update on the roll out of the ePCR to the Council.**

6. **Any other Business:**
   6.1. AS noted she had arranged a meeting with Andy Collen about the Ambulance Response Programme to take key points and feed back to the wider Council. AS noted that the programme was about allowing up to 2 minutes to further assess a patient over the phone if not deemed critically ill, and arranging the right response. AS noted she would be happy to feed back to the Council on this.
   6.2. IA noted that for a number of years Governors had asked for Green 2 performance details to be included on the performance dashboard. IA noted that she had asked Emma Wadey to consider this as part of her wider review into information included in the dashboard. JC noted he would be interested in seeing the private ambulance provider unique contribution reported in the dashboard.
   6.3. TH noted that he felt the Council should be focussed on the NHS Sustainable Transformation Plans and the effect they will have. TH suggested an agenda item come to a future Council meeting. TH also suggested Governors may be interested to receive an update on the current 999 and 111 contract negotiations. The GDC agreed they would like updates on these items at future meetings.

7. **Review of meeting effectiveness:**
   7.1. The meeting was deemed to have been effective.

   **The next GDC meeting takes place on 2nd May in the Boardroom at Banstead HQ.**

Signed:

Name and position:

Date:

**South East Coast Ambulance Service NHS Foundation Trust**

**Council of Governors**

**Lead Governor/Deputy Lead Governor Elections Process**

## 1. Overview

1.1. This paper sets out the process by which Lead and deputy Lead Governor elections are held, provides an overview of the roles, and informs Governors about when the election will take place.

1.2. The Lead Governor at present is Brian Rockell (Public Governor for East Sussex). There is no Deputy Lead Governor in post since the resignation of David Davis (Staff Governor – Operational) from the Council, as he ceased working for the Trust.

1.3. The paper is a template paper and so it includes '**XXX**' and highlighted areas where names/dates etc. will be added once Governors have been asked to submit expressions of interest. This paper is for information about the process only at this stage.

1.4. The election will be held at the meeting of June 2 2017 in a Part Two meeting (held in private).

1.5. Governors will be asked to submit expressions of interest by Friday 19 May 2017 and will be reminded by email closer to the deadline.

1.6. Governors who wish to find out more about the elections or the role are encouraged to contact Izzy Allen.

**TEMPLATE**

## 1. Introduction

1.1. The Constitution sets out the requirement for the Council of Governors to appoint a Lead Governor and the option to appoint a Deputy Lead Governor. The Council has previously agreed to appoint a Deputy Lead Governor to undertake the role in the Lead Governor's absence.

1.2. This paper sets out the election process agreed by the Council at its meeting of January 2014 and updated by the Governor Development Committee at its meeting of April 2015 and notifies of candidate names.

## 2. Candidates:

2.1. There are **XXX** candidates for the role of Lead Governor and so an election will be held. The candidates are, in alphabetical order by surname, **XXX**

2.2. The candidate who secures the most votes shall become Lead Governor.

2.3. A second and separate election will then be held for the role of Deputy Lead Governor.

## 3. The role of Lead Governor/Deputy Lead Governor

3.1.	The Constitution states that the Lead Governor shall:

- Chair meetings of, or parts of meetings, of the Council of Governors in accordance with Annex 6; and
- Communicate directly with Monitor in circumstances where it would not be appropriate for the Chairman of the Board of Directors to contact Monitor directly, or vice versa.

3.2.	The Deputy Lead Governor shall perform these duties in the absence of the Lead Governor.

3.3.	In addition, the Council has previously agreed that the Lead Governor and Deputy Lead Governor should be responsible, with the Chairman, for agreeing Council of Governor meeting agendas.

3.4.	The Lead Governor Chairs the Governor Development Committee, or the Deputy Lead in the Lead Governor's absence.

3.5.	The CoG may also request that the Lead and/or Deputy Lead Governors undertake other duties if agreed by the CoG at a future meeting.

## 4.	The nominations process

4.1.	Governors were asked to express an interest in standing for election as Lead Governor by **XXX**. Those wishing to stand for election were asked to include a statement of up to one side of A4 setting out their reasons for standing to be received by the same date.

4.2.	Candidates' statements are attached as Appendix A. Governors are asked to read the statements prior to the meeting on **XXX**.

## 5.	Voting

5.1.	Voting will be undertaken during a confidential session of the formal meeting of the Council of Governors on **XXX**.

5.2.	The Council has selected a voting system where one election is held for Lead Governor and the person who receives the most votes becomes Lead Governor.

5.3.	A second, separate election should then be held for the post of Deputy Lead Governor, with the successful Lead Governor removed from the ballot paper.

5.4.	In both elections the vote will be first past the post in a single anonymous ballot.

5.5.	Ballot papers will be provided to the Council on **XXX**.

5.6.	The vote shall take place anonymously, and each member of the Council shall have one vote.

5.7.	It should be noted that the Chair, as a member of the Council, has a vote. As per the constitution (Annex 6), in the case of a tied vote the Chair has a second and casting vote.

5.8.	There is no provision for proxy voting if a Governor is unable to be present at the meeting. Only those governors present at the meeting will be entitled to vote.

5.9.   The Company Secretary will count the votes and announce the outcome.

6.   **Qualification to Vote**

6.1.   The constitution (Annex 6) states the following: A Governor may not vote at a meeting of the Council of Governors unless he has made a declaration on a form provided by the Secretary stating the Constituency of which he is a Member and that he is not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 of the 2006 Act or otherwise under this Constitution and that he will at all times abide by any code of conduct that may be adopted by the Trust from time to time (such code (as amended) to be notified to Governors as soon as reasonably practicable).

6.2.   Governors will be provided with a form on **XXX** on which to make such a declaration prior to voting.

7.   **Term of office**

6.1    The term of office of the Lead Governor and Deputy Lead Governor is one year or until their term of office on the Council comes to an end, whichever is the sooner. The Lead Governor and Deputy Lead Governor may stand for re-election for as long as they are members of the Council.

8.   **Recommendations**

8.1.   The Council of Governors is asked to:

   8.1.1.  Read the candidates' statements at Appendix A.
   8.1.2.  Participate in the elections if present at the meeting on **XXX**.


**Appendix A**

**Candidates' statements for the role of Lead Governor**

**South East Coast Ambulance Service NHS Foundation Trust**

**Council of Governors**

**G – Governor Activities and Queries**

## 1. Governor activities

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

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

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

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

www.surveymonkey.com/s/governorfeedback

| Date | Activity | Governor(s) |
|---|---|---|
| 14.0217 | NHS Providers training in accountability and effective questioning – learned new skills | Brian Rockell, Jean Gaston-Parry, Alison Stebbings, Chris Devereux, Peter Gwilliam, Jane Watson, Mike Hill |
| 04.03.17 | Charity Special Tattenhams Market at St Marks Church in Epsom - recruited 25 new foundation trust members using the Governor Toolkit. | Mike Hill, Chris Devereux |
| 17.03.17 | New Governor induction – learned about SECAmb, spoke with other Governors, discussed the role of the Council | Stuart Dane, Nick Harrison, James Crawley, Mike Hill |

1.5 For the benefit of new Governors, I am including a snapshot from last year (below) to show other types of things Governors have been up to and which are recorded using the form (link above).

| | | |
|---|---|---|
| 02.05.16 | 999 Event, Brooklands – spoke to people about SECAmb informally, recruited members | Mike Hill |
| 23.05.16 | East Surrey CCG Patient Reference Group, Nutfield – spoke to people about SECAmb informally, contributed to discussion | Mike Hill |
| 02.06.16 | Seaford Chamber of Commerce – spoke to people | Peter Gwilliam |

| | | |
|---|---|---|
| | about SECAmb informally, recruited members | |
| 30.06.16 | Borough Green Village Fete – spoke to people about SECAmb informally, recruited members | Peter Gwilliam |
| 02.07.16 | Capel Fete – spoke to people about SECAmb informally, recruited members | Maggie Fenton |
| 02.07.16 | Eastbourne 999 Day – spoke to people about SECAmb informally, recruited members | Michael Whitcombe |
| 03.07.16 | Kent Police Open Day – spoke to people about SECAmb informally, recruited over 300 members!! | Michael Whitcombe (KS, JL) |
| 29.07.16 | Seaford Women's Institute – Gave a talk about SECAmb. Peter noted: By far the greatest majority of people are unaware of the current issues within SECAMB and are not in the least concerned. | Peter Gwilliam |
| 05.08.16 | LGBT conference AMEX Brighton – spoke to people about SECAmb informally | Alison Stebbings |
| 12.08.16 | Experts by Experience training in Crawley – learned new skills | Alison Stebbings |
| 15.08.16 | Spent the day with call takers and despatchers | Alison Stebbings |
| 13.09.16 | Care for carers group – Gave a talk about SECAmb. Peter says: The talk was to a group of individuals who are mostly full time carers for a close relative or spouse. The individuals find great comfort and support from each other in what is generally an unrecognised but essential role they undertake. They come into contact with SECAMB regularly via the 999 system and were full of praise for attending crews | Peter Gwilliam |
| 18.09.16 | Riverhead Carnival – spoke to people about SECAmb informally | James Crawley |
| 20.09.16 | Recruiting NEDs training – London – learned new skills | Jean Gaston-Parry, Alison Stebbings |
| 25.09.16 | SECAmb Survivors event – represented the Council | James Crawley |
| 14.10.16 | Restart A Heart - Allington Primary School – Gave a talk about SECAmb | James Crawley |
| 16.11.16 | Participated in selection day for the CEO position – represented the Council on a focus group | Peter Gwilliam, Jean Gaston-Parry, Charlie Adler, Marguerite Beard-Gould, Brian Rockell and Alison Stebbings |

## 2. Governor Enquiries and Information Requests

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

| Feb 17 | A series of questions around the decision to change the way mealbreaks are implemented and the categorisation of calls: Q1. If only about half of cardiac arrests, let alone other critical patient presentations that might be even more difficult to detect through the triage process are categorised as R1, (Acknowledging NHS Pathways only picks up 50% of cardiac arrests as R1) surely the other half of patients that should be R1, but are put into R2 will have a higher risk of a slower response, leading to death and disability? Q2. How has the potential impact been assessed by senior Trust clinicians and through want governance process has it been agreed? Q3. What is the position of the commissioners regarding this change, and when did they agree it? Q4. If implemented, how will the impact be evaluated in terms of patient impact, in terms of mortality and morbidity? Q5. What additional training and support in patient assessment and patient support will be provided to CFRs who will inevitably have to cover the gaps in service delivery that will be created by this change? Pain management would be an example here, training in NEWS scores etc. Q6. What has been the crew/trade union and other input to this change? | Query sent to relevant NEDs and Executives. Item to be part of wider discussion about risk identification, mitigation and impact assessments as part of the Council agenda on 30.03.17 |
| --- | --- | --- |
| Feb 17 | Query regarding medicines management and how decisions were made to stop clinicians using certain drugs | Query was discussed at the Governor Development Committee and forms part of the wider discussion about risk as noted above. |

## 3. Recommendations

3.1. The Council is asked to note this report.

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

**Brian Rockell**
**Lead Governor & Public Governor for East Sussex**