South East Coast Ambulance Service NHS
NHS Foundation Trust

Council of Governors Meeting to be held in public

29 January 2018 10:00-13:00

SECAmb HQ, Nexus House, 4 Gatwick Road, Crawley RH10 9BG

Agenda

Item No.	Time	Item	Enc	Purpose	Lead
Introduction and matters arising					
96/17	10:00	Chair's Introduction	-	-	Richard Foster (Chair)
97/17	-	Apologies for Absence	-	-	RF
98/17	-	Declarations of Interest	-	-	RF
99/17	-	Minutes from the previous meeting, action log and matters arising	A A1	-	RF
Statutory duties: performance and holding to account					
100/17	10:15	Chief Executive's Report: - Integrated Performance Report - Executive Team appointments and future plans - Questions from the Council	B B1	Information and discussion	Daren Mochrie (CEO)
101/17	10:45	Trust Improvement Plan: - Outcomes delivered to date; - What progress means for the Trust; and - Key risk areas in relation to constituents, partners, and staff	C	Information and discussion re assurance	DM
11:20 Comfort break					
102/17	11:30	Workforce Directorate assurance: - Outcomes and achievements in relation to Prof Lewis' recommendations on Bullying and Harassment; - Progress on the wider cultural workstream; - The effectiveness of the new Actus appraisal system; - The timeliness of disciplinary and grievance cases in the Trust.	D1 D2 D3 D4	Information and discussion re assurance	All Non-Executive Directors present (Tim Howe, Lucy Bloem, Terry Parkin)
103/17	11:50	Quality Account overview and decision on indicator to audit	E	Information and decision	Kirsty Booth (Business Support Manager – Medical and Quality)
104/17	12:10	Board Assurance Committees' escalation reports: Audit Committee - 4 December WWC - 7 December	 F1 F2	Information and discussion	All Non-Executive Directors present (Tim Howe, Lucy Bloem, Terry Parkin)

		Finance and Investment Committee - 18 January Quality and Patient Safety - 23 January	**F3** **F4**		
Statutory duties: member and public engagement					
105/17	12:40	Membership Development Committee Report: - Membership and public/staff engagement	**G**	Information	Mike Hill (MDC Chair and Public Governor for Surrey)
Committees and reports					
106/17		Governor Development Committee report:	**H**	Information	James Crawley (Lead Governor and Public Governor Kent)
107/17		Governor Activities and Queries report	**I**	Information	James Crawley (Lead Governor and Public Governor Kent)
General					
108/17	12:50	Any Other Business (AOB)	**-**	-	RF
109/17	-	Questions from the public	**-**	Public accountability	RF
110/17	-	Areas to highlight to Non-Executive Directors	**-**	Assurance	RF
		Date of Next Meeting: Thursday 29 March	**-**	-	RF

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.

13:45-15:30
Afternoon session: Council workshop (held in private)
The Trust's new external audit providers, KPMG, will join the Council to discuss the role of the auditor, how KPMG aim to work collaboratively with the Council, and how the Council would like to work with KPMG.

If you wish to consider questions and discussion points in advance, guidance on the role of external audit in relation to the Council can be found in Chapter 7 of the statutory guide here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284473/Governors_guide_August_2013_UPDATED_NOV_13.pdf However, this is rather dry and we hope that KPMG will come prepared to make the session as interactive and engaging as possible.

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

30 November 2017

Present:

James Crawley	(JC)	Public Governor, Kent – Lead Governor (Chair)
Nick Harrison	(NH)	Staff-Elected Governor (Operational)
Alison Stebbings	(AS)	Staff-Elected Governor (Non-Operational)
Jean Gaston-Parry	(JGP)	Public Governor, Brighton and Hove
Mike Hill	(MH)	Public Governor, Surrey & N.E Hants
Felicity Dennis	(FD)	Public Governor, Surrey & N.E Hants
Matt Alsbury-Morris	(MAM)	Public Governor, West Sussex
Francis Pole	(FP)	Public Governor, West Sussex
Brian Rockell	(BR)	Public Governor, East Sussex
Marguerite Beard-Gould	(MBG)	Public Governor, Kent
David Escudier	(DE)	Public Governor, Kent
Marian Trendell	(MT)	Appointed Governor, Sussex Partnership NHS FT
Mike Hewgill	(MH)	Appointed Governor – East Kent Hospitals

In attendance:

Tim Howe	(TH)	Non-Executive Director and Senior Independent Director
Peter Lee	(PL)	Company Secretary
David Hammond	(DH)	Director of Finance and Corporate Services
Al Rymer	(AR)	NED
Angela Smith	(ASm)	NED
Jon Amos	(JA)	Director of Strategy and Business Development
Tim Fellows	(TF)	Operating Unit Manager – Specialist Operations

Minutes:

Izzy Allen	(IA)	Assistant Company Secretary

Apologies

Richard Foster	(RF)	Chair
Graham Gibbens	(GG)	Appointed Governor, Kent County Council
Nigel Coles	(NC)	Staff-Elected Governor (Operational)
Peter Gwilliam	(PG)	Public Governor, East Sussex
Stuart Dane	(SD)	Public Governor, Medway
Charlie Adler	(CA)	Staff-Elected Governor (Operational) – Deputy Lead Governor
Gary Lavan	(GL)	Public Governor, Surrey & N.E Hants
Dr Peter Beaumont	(PB)	Public Governor, Surrey& N.E Hants
Dr Terry Collingwood	(TC)	Public Governor, Kent

Declarations of interest

There were no declarations of interest.

75. Chair's Introduction

75.1. JC welcomed everyone to the meeting and explained that both RF and Daren Mochrie (CEO) were unavoidably involved in Executive Director recruitment and sent their sincere apologies.

78. Minutes and action log

78.1. The minutes of the Council meeting of 28 September were approved as an accurate record.

78.2. The action log was reviewed and updated.

78.3. IA advised that detail on action ref. 204 regarding assurance around levels of one to ones and appraisals would be provided at the next Council meeting.

78.4. FD asked whether this area was covered on quality assurance visits.

78.5. DH advised that he had done a visit recently which had included those factors, but work was ongoing to look at what the key quality indicators should be for appraisals. The data available in different areas was of patchy quality, which the visits were establishing. The new electronic system gave real-time access to the detail.

78.6. AS advised that she had received an email to ask her to do her Appraisals, which she had done, but she had not pressed the correct button and so it may not have been recorded effectively. DH acknowledged the difficulties with the data. However, he appreciated the way the system allowed managers to structure one to one meetings more effectively.

78.7. TH advised that his understanding was that Joe Garcia (Director of Operations) was developing a scorecard to go through each month with his managers, to include this type of data. NH noted that the content of appraisals was more important than the numbers. A lot of staff still felt it was a tick-box exercise and team leaders often did not have experience of doing appraisals. Also managers should act on the outcomes of the appraisal. NH noted that he had not had a formal appraisal for three years.

78.8. DH would take away the point that the process would only work if managers were able to conduct the appraisal effectively.

78.9. Annual Members Meeting minutes

78.10. The minutes of the Annual Members Meeting of 28 September were approved as an accurate record.

79. Chief Executive's Report

79.1. DH advised that Daren Mochrie (CEO) was undertaking Director of Nursing interviews along with RF.

79.2. Executive recruitment continued and the Council could expect some appointments to be announced before Christmas.

79.3. DH advised that the Care Quality Commission Quality Summit had been a very good session, with much more parity from the Trust and those in attendance than at the previous Quality Summit. It was made clear that strides forward had been made since April and Daren's appointment.

79.4. It was important to note that licence conditions in relation to medicines management and the Emergency Operations Centre (EOC) call recording had been lifted. There was much more to do to move out of special measures however.

79.5. The go-live of the Ambulance Response Programme (ARP) had meant a number of changes in EOC and across the Trust.

79.6. The electronic Patient Clinical Record (ePCR) had been paused due to some technical issues and the opportunity to enhance it was being taken.

79.7. The Trust had employed an individual to work specifically on over-coming handover delays at Accident & Emergency departments. Crucially, this was supported by NHS Improvement (NHSI) and NHS England (NHSE) with a system-wide approach being taken.

79.8. The Trust continued to work with Commissioners because we were an under-funded service. This was tough timing as the ARP had changed the way performance was measured. The demand and capacity review in the South-East continued, which would give us a baseline of resources, vehicles etc. based on real demand.

79.9. Finally, the Autumn budget allocated a pot of money to the NHS and the Trust awaited word of how this would be allocated.

79.10. FD asked how the daily operational conference call was working and for feedback on how it impacted on staff. DH advised that this was a common step at this time of year; it was good for grip and control but also helping with autonomy and empowering people to understand the bigger picture.

79.11. BR noted that handover delays had been discussed for at least ten years, but delays had always got worse. BR had been to the CQC summit last year, listening to a pledge from acute CEOs to take action. At the Board yesterday, the guidance on handover delay from Prof Keith Willetts had been referenced. It set out things that acute Trusts must do. The Council should be aware of this as a measure and ask the Trust to be robust with partners to ensure this was implemented.

79.12. DH noted that the incentives behind the requirements were not clear.

79.13. NC advised that he had been present for the go-live of the ARP. It had gone well. Recently in Surrey, quite a few vehicles had been lost over the border to Kent, which left Surrey struggling for resources. DH did not know the details and would take that away, but the idea of the daily calls was to arrange this.

ACTION: IA to ask for a response to NC's point regarding vehicles being moved from Surrey to Kent leaving Surrey short of resources.

79.14. MH asked whether the 111 contract would be included in the 999 contract negotiations.

79.15. JA advised that Swale Clinical Commissioning Group (CCG) had advised that SECAmb would likely see three 111 tenders along county lines, which the Trust did not feel was the best way to go, but it looked like this would happen.

79.16. DH noted that it seemed obvious that for call centres there were economies of scale.

79.17. JC asked the NEDs how comfortable they were with the state of contract negotiations. AS noted that debate had been tough at the Board. In general, the NEDs were not very happy about timings, while the Board was behind the decision taken to get to this point but were now disappointed with progress. The Board had initiated some work to provide an even more definitive picture of the resource requirements to meet our targets. SECAmb had done its best to work within the system collegiately. NEDs were confident that negotiations with commissioners would be concluded in the new year, soon after the resources review report was received.

79.18. FP noted that the change in the method of hospital handover meant that in his experience it was taking longer than before. JA noted that underlying the whole picture there were a couple of good news stories: good work at Royal Surrey County Hospital (RSCH) and at Ashford and St Peters. The new oversight from NHSI and the CQC around the patient risk caused by handover delays was welcome. There were a couple of beacons of good practice with Paula Head at RSCH who would be chairing a group to help challenge other CEO's and share good practice too. NC noted that Frimley Park Hospital also worked well. This learning was what the system needed to learn too.

79.19. JC noted that a strategy had been due to come to the Board about volunteering. DH would take this away.

ACTION: DH to request an update on the volunteering strategy that had been due to come to the Board in November.

80. Trust Improvement Plan

80.1. JA noted that the November performance dashboard gave data to the end of October and set out a challenging picture. On call answer time, there had been very specific challenges with abstraction for training in EOC. There had also been a challenge with staff as many had left since the move to Crawley. The numbers had picked up week by week since the end of the training showing a massive improvement in call answering time.

80.2. TF joined the meeting and advised that he was moving into an Operating Unit Manager role supporting Community First Responders (CFRs) and blue light collaboration (working with other emergency services).

80.3. DE asked about the commitments given to improve things with and for CFRs. TF thanked some of those round the table for their input and work on improving things for CFRs. TF noted that the 5-day course for CFRs was being developed as an interim solution. He was considering options for courses and keen to get training underway.

80.4. He noted that over 60 people in CFR teams were already trained to deliver training or assessments. A working group would be set up early in the new year for implementation by 1 April 2018.

80.5. On ID cards for CFRs, TF advised that there was a lot of work to be done with the Trust's security manager to make this happen.

80.6. On emails for CFRs, TF advised that the Trust had adopted a system through Microsoft to provide dedicated email addresses for SECAmb CFRs. Other volunteers might be included within this too.

80.7. CFRs now received a weekly newsletter. He was building structures to get proper engagement and feedback.

80.8. JC asked about organisational blocks regarding, for example, ID cards. He noted that the Trust had have vetted CFRs who were allowed into patients' homes but they could not get into the Trust buildings at the moment. TF advised that this was being given priority but there was a lot happening in the security part of the organisation. DH clarified that there was a lot of work to be done to scope the implications of the move to providing ID cards.

80.9. On email addresses, DH advised that giving volunteers a Microsoft 360 account would cost £1000, which is why CFRs were being given dedicated email addresses but not 360 accounts.

80.10. JC noted that he did not understand that it was taking such a long time to provide ID cards. MAM added that a commitment had been given to all CFRs to provide ID cards.

80.11. DH noted that there were complexities, but there was a core workstream and the work was being done: he apologised if it was taking longer than it should. MAM asked for a date when the decision would be made. DH would follow this up and provide a response.

ACTION: DH to provide an update on progress and timings regarding providing CFRs with swipe card access to Trust premises.

80.12. BR noted his concerns around call answer times. He had previously asked questions about it and the length of the tail. BR noted that Terry Parkin (NED) had spoken about the challenge of employing people in the Crawley area. BR had asked about the actions the Board had taken around the transfer of a large number of people and was given assurances that people had been consulted and would move: this assurance had not been as accurate as we would wish. BR asked TH how assured he was that mitigations were in place to address significant staff gaps.

80.13. TH noted that it was a complex issue with Crawley, the move had been hotly debated because it was a full employment area. The Executive had undertaken an exercise on who would move and lots of staff had but some had then found they did not like the extra travel. HR had a good pipeline of people coming in now. There was not a large staff shortage. The Crawley location was both a plus and a minus. The question was more around how the Emergency Medical Adviser (EMA) role might be adjusted to reduce turnover by making the post more attractive.

80.14. AR agreed with TH, and noted that the delayed reaction to turnover was a concern but the issues were predicted and action was being taken to get back to the right level of staffing in EOC.

80.15. In terms of Governors seeing the indicators improving, AR remembered the Council meeting where BR had raised the point about the

tail of callers, and it was something AR had also raised. This was now an indicator on the performance report, covering the 95th percentile.

80.16. DH advised that the EOC turnover rate had been way above what it should be for many years, which was not just about the move but more about the environment in which people were working, the levels of training, employee expectations and other factors. Recruitment in Crawley had started well before the move here, and relative to Banstead it was probably easier to recruit in Crawley.

80.17. FP noted there was a very low unemployment rate in Crawley and EMAs were not well paid given their responsibilities. Also, rates of pay in Gatwick were generally quite a bit higher. FP had heard that conditions in EOC were better than Banstead and Lewes but that the environment was pretty soulless, especially at night. Retention rates were also poor. DH agreed, and noted that the Trust over-recruited constantly in EOC to address the high turnover.

80.18. NH advised that the EMA role was enormously stressful, there was a draconian audit policy, and the pay was terrible. DH agreed but noted that the executives were aware of retention issues. JA noted that exit interviews were taking place, but also 25% of staff 'leaving' were leaving to go into another job within the Trust.

80.19. NH noted the unrest about Coxheath and its role, and asked when a decision would be made about the future of the building. A project was just being completed to put 50 new EOC call stations into Coxheath to provide resilience for Crawley. The Trust would be looking at the overall picture across ambulance services nationally in relation to call taking and this would conclude in the next 12 months or so. In the meantime, the Trust was investing in Coxheath.

80.20. DH noted that an HQ user group would be set up to address softer issues around the new HQ.

80.21. FP noted the need to conduct exit interviews across the Trust.

80.22. FD asked the NEDs about tackling performance times. Did they feel that the Trust was managing improvements in a robust way? JC asked FD to come back to this question in relation to the Ambulance Response Programme (ARP) session to follow.

80.23. JA provided an update on the implementation and changes brought in by the Ambulance Response Programme. JA noted it was early days but things looked promising on Category 1 and 2 calls. The issue then would be to develop capacity for the lower category calls.

80.24. FD asked whether there was sufficient focus and management capacity to deliver the various number of projects in train.

80.25. TH noted that the data on ARP showed we were in the pack on ambulance service performance. Operational focus was definitely there but the new statistics were not really comparable. JA added that the new measures were much more consistent nationally so would provide better comparable data. Weekly benchmarking data was being provided. DH noted that Joe Garcia provided an overview of weekly performance at each

Executive Team meeting. TH noted that it was a pity CA was not at the meeting as he had been mildly encouraged by the data coming through.

80.26. NC wished to highlight an issue: there were not enough call takers, and there was an escalation process that once five calls were stacking an ambulance was automatically dispatched. Call takers were spoken to dreadfully by other health professionals and the Trust had sent managers to meet with those organisations. Also, there were not enough clinicians in the room. DH recognised this latter issue and the impact it could have across the wider system.

80.27. DH advised that the new surge management plan would provide a different approach to escalation and de-escalation.

80.28. DH would feed back to the Executive about how health professionals were spoken to by other professionals, both health and including the police.

ACTION: DH to feed back to the Executive regarding the way other professionals spoke to EOC staff, including both health professionals and the police.

80.29. TF noted that the statistics were encouraging, particularly around Category 1 calls. Patient experience was also important, and category 4 patients' experience in particular. Good work had been done on frequent callers. IBIS was also able to help.

80.30. MAM observed, from call-listening in EOC, that waving a card to get a clinician's attention when needed, did not seem appropriate.

80.31. BR noted that time and evidence would show whether communities were getting the better service that our communities deserved. He hoped the ARP was not a political fudge to make services appear to be doing better than they were. He was heartened that it was possible to escalate e.g. elderly or vulnerable people if needed.

80.32. JC noted that he was pleased to see the Private Ambulance Providers (PAPs) and CFR performance contribution on the performance dashboard. JC asked the cost of CFRs to the organisation relative to PAPs and employees? DH would take this away and come back on what the percentages meant in real terms from the report.

ACTION: DH to look into relative costs of CFRs versus PAPs and employees and also what the percentages in the performance report meant in real terms.

80.33. AR noted that CFR attendance at incidents was counted in the performance statistics but this was only part of their function. JA advised that it was important to compare like with like. PAPs were regularly used for transporting, for example, rather than aiding Category 1 performance.

80.34. MT raised an issue regarding mental health section 136, which she had just mentioned to JA in the break. On 11 December the Policing and Crime Act would change the duties for section 136, a person in mental health crisis will only be able to be detained by the police for 24 hours. She was responsible for the multi-agency policy for implementation of the changes and

Daren Mochrie would be asked to sign the policy. Commissioners accepted parity of esteem to convey mental health patients in crisis by ambulance. In Sussex last year 215 people had been taken into custody and they would now go to hospital places of safety: this should be by ambulance. MT had been in discussion with the Trust about this for some months.

80.35. Currently SECAmb were finding it difficult to do the first conveyance, i.e. when the police called to say there was a patient needing conveyance. There had been 40 conveyances by SECAmb for section 136 for Sussex, when in fact there were more than 200 conveyances undertaken. This means the other patients are conveyed by the police.

80.36. What would change was that now, when people needed to go to A&E, they would need a second conveyance back to a mental health place of safety. In Sussex, SECAmb advised this was new business and the Trust could not provide this second conveyance. The police say they cannot either. She had been asked to raise this by the mental health commissioners. This was about how patients should be treated in crisis.

80.37. JA noted that this was complex. There was a disconnect in the commissioning of ambulance, A&E and mental health services. It is important for SECAmb to work regionally on this, not locally. SECAmb was commissioned to provide an ambulance response within 60 minutes, this was the initial response and was not quick enough so the police often conveyed in practice. Nationally, as part of the ARP the response became a Category 2 response, which was a better response time than that previously commissioned. There was a funding gap here but a better response time.

80.38. The next issue was the conveyance response time for civil sections to 2 and 3 which provided a bigger challenge for the system and caused long delays for the patient in crisis. The vast majority of the patients did not need a Paramedic/blue light transport, but Patient Transport Service (PTS) options were not timely enough to meet the need. Discussions were under way however it was recognised that PTS would be suitable for most while a small number would need a blue light response. Conversations were ongoing and focused in the next few days to get interim arrangements in place for the 11th December. Further questions around this had been added to the demand and capacity work being undertaken.

80.39. DH advised that this was an example of a system issue that would require someone to pick these patients up.

80.40. TH advised that the Board should be advised to clarify the risk associated with this. Might it come to the Quality and Patient Safety Committee next week? JA and DH agreed. The main risk was to patients. The initial response should be much improved, but the secondary transfer piece was more complex and had not progressed in recent days.

80.41. MT had to complete the multi-agency policy which Daren would receive this week. MT asked if she can include ARP Category 2 response time within the policy. JA and DH could not commit to this and JA committed to pick this up with MT over the next couple of days.

80.42. DH agreed that JA would pick this up as part of contract discussions, and then would come to the next Executive Team meeting to escalate to the Board if necessary.

ACTION: Provide the Council with an update on Section 136 negotiations and outcomes.

80.43. MAM noted that if requirement had only become clear on 6 November he would wish to write to his MP about the short lead in time. MT explained the process she had been through and advised that the change had been a long time coming. MAM was content to write to his MP on this. He would like details to write to his MP about the lack of timescales. MT advised that MAM should look up the crime act and provided him with details.

80.44. FD would be interested to understand the impact of the increased activity. JA agreed this would be considered, and DH noted that SECAmb should respond to demand as calculated by commissioners.

80.45. DH advised that this was an Executive management decision and would go to QPS for assurance if the Executive wished to escalate it on a risk-based basis. MH wanted to check whether the policy was for the whole of SECAmb's area. MT advised it was for Sussex only.

80.46. JC asked whether the policy for Kent would look similar to MT's policy. MT believed that it would however Surrey mental health commissioners had said that there were different ways of funding in Surrey. JA confirmed that local contract changes addressed the initial response but not the secondary response.

80.47. JC noted that the commissioning model was broken, and operating to so many masters was not helpful to provide the best service to our patients.

80.48. JC noted the use of a car funded for NW Sussex using a different street triage model. MT clarified that the ambulance street triage staff could not directly detain anyone under section 136. JC asked if there had been an impact? MT advised that it had reduced the number of people taken to A&E, it was very successful and MT hoped it would continue. JA advised that the model looked good but tweaks would be needed to re-pilot and then seek a funding stream to continue with it.

81. Electronic Patient Clinical Record

81.1. JA advised that the Board had signed off almost four years ago on bringing in personal issue iPads for frontline staff. 99.2% of frontline clinicians now had an iPad. This provided lots of opportunities. For example, IBIS and JRCALC were now accessible via iPads. ePCR itself had proved more complex to implement.

81.2. Three weeks ago the decision had been taken to pause the use of ePCR in order to implement fixes working with users in Thanet. This would be subject to testing over the next week or two and then ePCR would be rolled back out. The current contract had a break clause effective March 2018. ePCR was still really important to the Trust and wider system.

81.3. JC noted that the Trust had clearly invested so it was sensible to try to fix it. How convinced were the NEDs that this was fixable? DH advised that there was a contractual relationship with the supplier. The Board would say that the right solution would be in place going forward and that would be looked at by the right people and learning taken on board. But we were disappointed with where we were.

81.4. TH advised that DH had updated the NEDs yesterday and the NEDs were content with the way forward.

82. Finance and Investment Committee (FIC) escalation report

82.1. AS advised that there was an effective and constructive challenge process between the NEDs and Executives. The FIC had a very interesting discussion about the digital enabling strategy. The Trust was not intrinsically comfortable with ground-breaking approaches and this had been taken on board by the Executive.

82.2. NH noted that AS said she felt comfortable with tried and tested methods, yet the platform the Trust used was bespoke. AS noted that the particular proposal was informatics and data, but AS wanted to assure NH that this was being discussed and would look more towards tried and tested than bespoke systems in future.

82.3. FD asked about the Cost Improvement Programmes (CIPs) and whether AS was comfortable about the balance between recurrent savings and one off savings. AS had not been part of the Trust when the plan was put together, but it was on track to being delivered. Regarding saving money, AS felt the Trust was not as efficient as it could be. Additional resource was needed to do what we wanted to do. She was keen to ensure that money could also be saved.

83. Workforce and Wellbeing Committee (WWC) escalation report

83.1. AR noted that there had been a discussion at WWC around bank staff. The NEDs had felt the discussion was a little mechanistic and had not addressed the qualitative elements of how bank staff might be utilised in future. However overall it had been a positive discussion.

83.2. On appraisals, there was a continuing focus on getting on track and the Committee was monitoring this.

83.3. On the workforce plan, the Committee was assured that within the HR department there was an increasingly strong grip on staff numbers and tackling vacancies. There was work going on to form a future workforce strategy. The Board had taken a paper on the draft strategy yesterday, which was moving forward but had a very wide scope and covered the ground needed. There was more to do and it was dependent on the capacity review taking place.

83.4. Risk management was discussed, and the Committee was very keen that there should not be undue blockages to recruitment and moving forward.

83.5. FP asked about disciplinary and grievance timeliness. He had heard of a case which had been going on since August unresolved. There were

implications for staff and colleagues. AR advised that he didn't have the numbers at his fingertips, but he wasn't aware that timescales for completion were outwith the policy: they had certainly reduced, or there were clear reasons why certain cases took longer.

ACTION: Provide the Council with the latest figures on disciplinary and grievance processes

83.6. DH advised that the area of focus at present was on why people were in the disciplinary process in the first place, i.e. on the importance of not penalising someone for an honest mistake. TH agreed and noted that Daren had raised this specifically around defining an honest mistake clearly and trying to make things less subjective.

83.7. JA noted that there was a challenge about making some of these changes visible without highlighting individuals and individual cases. AR agreed that, and noted that the perception of a punitive culture and taking appropriate action was also highlighted in the Lewis report.

83.8. MAM noted that bullying and harassment did not appear on the agenda and requested assurance that the action plan was being developed. The report was expected to the Board in January. TH advised that Mark Power was an extra resource in HR taking this work on. DH advised that the themes coming out of the workshops were being worked through. It was difficult to show that things worked in terms of disciplinary action without identifying the individual(s).

83.9. FD noted that Governor involvement in bullying and harassment would be important. IA advised she was following this up following discussion at the Governor Development Committee (GDC).

84. Quality and Patient Safety Committee

84.1. TH advised that the quality report had now been received from Steve Lennox (Director of Quality and Patient Safety and Chief Nurse) to include rag ratings:

Safeguarding – amber (training)

Complaints – amber (backlog)

Infection control – red (hand hygiene, deep clean)

Incident reporting – amber

PCRs – amber (unreconciled PCRs against incidents on the Computer Aided Despatch system)

Medicines management - green

84.2. On medicines management, there was evidence that this was now effective and was taken by the Committee as a case study.

84.3. JC asked whether the issues with PCRs was a problem with paper or whether it was a more systematic problem. JA noted that there were complex reasons why reconciliation (of PCRs with calls taken by EOC) was

challenging. The Trust saw 11-14% of PCRs unreconciled which needed to be improved but nationally it was a challenge and other Trusts had around 9% unreconciled. The Trust was also working with commissioners on using NHS numbers to reconcile.

84.4. NC suggested that further matching could be undertaken by Operational Team Leaders when collecting PCRs. JA noted that there would not be one solution. MH noted that data quality had improved.

84.5. FD noted that she was disappointed that the patient experience group still hadn't lifted off the ground and she would like the QPS to consider whether there was an issue here.

84.6. PL had been asked to undertake a task to look at groups in the round and who was on what and what they were doing. FD noted that perhaps the new Head of Effectiveness and Engagement post would provide the opportunity to look at this in the round.

85. Membership Development Committee (MDC)

85.1. MH noted the full report and highlighted the key areas.

85.2. He advised that the feedback on the Annual Members Meeting was overwhelmingly positive and he thanked Katie Spendiff for her hard work on this.

85.3. He noted that there was concern that those originally involved in developing the Volunteer Charter ought to be involved in any review and reutilisation of the Charter.

85.4. He further noted that Investors in Volunteering aimed to improve the awareness of the Council within the Trust.

85.5. NC was now Deputy Chair of the MDC.

86. Governor Development Committee (GDC)

86.1. JC emphasised that the GDC was open to all and encouraged Governors to attend.

86.2. The GDC had discussed the Lewis Bullying and Harassment report and Governor attendance and Appointed Governor organisations. The GDC had also discussed the importance of self-assessments of Governor effectiveness.

86.3. JC noted that the next GDC was on 18 December in Crawley.

87. Governor Activities and Queries

87.1. JC thanked colleagues who do so much for the Council and the Trust, and noted the quality of the Governor queries.

88. Any Other Business

88.1. The venue for the January Council meeting was discussed. There were arguments for and against using Crawley or Polegate but the Council preferred to use Polegate for this meeting.

88.2. AR noted that average times for grievance to be heard over last 12 months were 1.9 months. 22 grievances were resolved within a month and

ten had taken up to three months, and there were a number of outliers which were group grievances. NEDs had been assured there was a focus on this.

89. Questions from the public

89.1. Frank Northcott observed that at yesterday's Board meeting there had been a lot of discussion about disciplinary and grievance proceedings and the Board had aimed for there to be no disciplinary proceedings. JA clarified that the discussion had been regarding there being no disciplinary proceedings where an honest mistake had been made.

89.2. Mr Northcott believed the ACAS target was 28 days for a disciplinary hearing. This should be adhered to. The difference between Serious Incident investigations and grievances needed to be clear and the prosecuting officer and investigating officer should not be the same person.

89.3. TH noted that a review of the Disciplinary Policy was underway and TH would not wish to pre-empt that. In addition, sometimes there were good reasons why things should take longer, and certainly there needed to be more separation between the investigator and prosecutor.

89.4. JA would feed this back to those involved.

ACTION: Feed back the concerns raised around timeliness of grievances and the separation of prosecuting and investigating officer within disciplinary processes.

90. Areas to highlight to the NEDs from today's meeting

90.1. There were no areas to highlight.

The next meeting of the Council is 29 January 2018 at Polegate

Status Key Code: C- Complete, IP - In progress, S - Superseded

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
02.06.17	20.2	201	RF to write to the charities who had advised of PAD sites (to thank them) and check that the PAD reporting system was in working order	RF	28.09.17	CoG	IP	The PAD team are now up to date on putting details of PAD sites we have been notified about onto the CAD. Information about two of the three sites that Peter Gwilliam advised us about have not been found and the team are writing to the organisations that informed us in order to apologise and request that they send the details in again. The third is now on the CAD and details will be provided to the Chair for all three in roder to write to them and thank them and apologise for the delay. Improving PAD processes is on tim Fellows' to do list as part of his responsibility for CFRs etc. and he says: The registering of PAD sites was reported as up-to-date at our Team C meeting on 4th January 2018. There is a challenge if a call is diverted to another Trust as can happen at times of pressure. We are looking to see how we can migrate the data to applications such as The Good Sam App as long as we can satisfy the governance issues.
27.07.17	26.4	204	IA to liaise with HR to secure data regarding which areas of the Trust were failing to carry out appraisals.	IA/HR	29.01.18	CoG	IP	Assurance to be provided regarding level of one to ones and appraisals for the January 2018 meeting.
27.07.17	27.30	206	DM to provide update on CFR training compliance and record keeping at September meeting of the Council.	DM	28.09.17	CoG	C	An update was provided at the Council meeting in November 2017.
30.11.17	79.13	209	IA to ask for a response to NC's point regarding vehicles being moved from Surrey to Kent leaving Surrey short of resources.	IA	29.01.18	CoG	C	James Pavey advises that SECAmb operates across county borders and does not separate out Surrey and Kent in the way suggested by the query. However, at times of high demand or depending on the specialist servcies provided at hospitals in Surrey or Kent, more vehicles may be pulled into Surrey from Kent and vice versa. James believed that the issue was more likely that vehicles were moving from Kent to Surrey due to specialist units at hospitals, if anything. He was happy to look into this more deeply if date(s) could be provided, but it wasn't an issue he had come across.
30.11.17	79.19	210	DH to request an update on the volunteering strategy that had been due to come to the Board in November.	DH	29.01.18	CoG	IP	Initial scoping work on the Volunteer Strategy has been undertaken, and Tim Fellows came to the Inclusion Hub in January to present and take feedback on the ideas thus far. The IHAG were clear that an inclusiive process was needed to collaboratively produce a Volunteer Strategy and Angela Rayner and Izzy Allen have volunteered to work with the Team to set up a process for its development that includes all key stakeholders, not least volunteers. The timings are likely to be extended to accommodate meaningful consultation and so it's likely that we will aim to launch the Strategy at a Volunteer event in Autumn.
30.11.17	80.11	211	DH to provide an update on progress and timings regarding providing CFRs with swipe card access to Trust premises.	DH	29.01.18	CoG	C	Agreement has been secured from the Trust's Security Manager, who has contributed to a Procedure which is currently in draft and moving through the approval process, in consultation with staffside. This will take 1-3 months depending on how smoothly it moves through the approval process. We have noted that it would be important to communicate with CFRs about the timings.
30.11.17	80.28	212	DH to feed back to the Executive regarding the way other professionals spoke to EOC staff, including both health professionals and the police.	DH	29.01.18	CoG	C	DH has fed this back to the Executive Team at their meeting on 10.01.18
30.11.17	80.32	213	DH to look into relative costs of CFRs versus PAPs and employees and also what the percentages in the performance report meant in real terms.	DH	29.01.18	CoG	C	This action is not felt to be a useful exercise as, per discussion noted in the minutes subsequent to the action, it would not be comparing like with like.
30.11.17	80.42	214	Provide the Council with an update on Section 136 negotiations and outcomes.	MT	29.01.18	CoG	IP	Marian Trendell will provide a verbal update at the January Council meeting.
30.11.17	83.50	215	Provide the Council with the latest figures on disciplinary and grievance processes	Workforce Directorate	29.01.18	CoG	IP	Paper and discussion with NEDs around assurance on timeliness of these processes coming to January Council meeting.
30.11.17	89.40	216	Feed back the concerns raised around timeliness of grievances and the separation of prosecuting and investigating officer within disciplinary processes.	JA	29.01.18	CoG	C	Steve Graham advised and asked to ensure the relevant people were aware.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

B - CHIEF EXECUTIVE'S REPORT

Covering December 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 during December 2017.

2. Local issues

2.1 Recruitment to the Executive Team

2.1.1 Following the recent recruitment and interview process for the Director of Nursing & Quality, I am pleased to confirm that we have now made an offer to an excellent candidate. I will be able to confirm further details and start date shortly.

2.2 999 performance over the Christmas/New Year period

2.2.1 Led by our Operational Management Team, staff from many areas of the Trust put a great deal of planning into preparing for the Christmas/New Year period, with the aim of providing as responsive a service as possible to our patients during this busy time.

2.2.2 The approach we took in our planning for the Christmas and New Year period was based on our normal demand planning methodology but with additional focus on specific expected activity patterns. Underpinning our planning assumptions was a substantial drive, in the weeks leading up to the festive period, to maximise field operational and control room staffing - filling all available shifts and making this a priority for the leadership team at all levels.

2.2.3 This year we also ensured that, in addition to the support provided by senior clinical and operational managers during this period (which was available 24/7 at a tactical, strategic and executive level), during periods of specific escalation we also introduced two-hourly conference calls involving all on-call managers, as well as representatives from each operational area and control room. This level of senior oversight and management allowed rapid escalation and de-escalation as needed, as well the opportunity to identify emerging issues and take action to address.

2.2.4 As anticipated, SECAmb experienced sustained and significant pressure across the festive period. There were several days when this additional workload was particularly severe, notably 26th December, 27th December, 1st January and 2nd January. As a consequence of this pressure, we escalated through our Demand Management Plan (DMP), up to level 6 on occasion and declared a Business Continuity Incident on Boxing Day.

2.2.5 However, it is also worth emphasising that Christmas Eve, Christmas Day, New Year's Eve and overnight into New Year's Day were managed well in terms of our responsiveness to the more seriously ill patients, although our response to lower acuity patients was challenged.

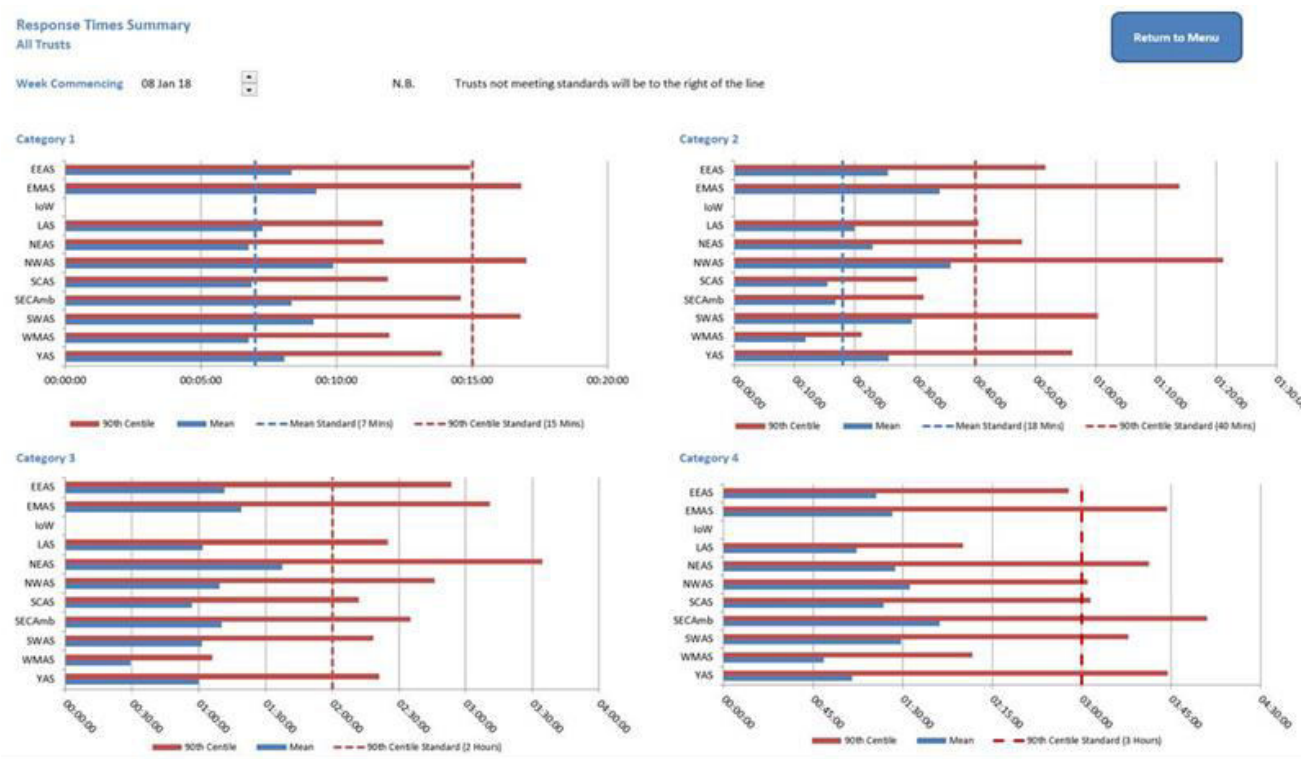
2.2.6 Handover delays at hospitals were also a substantial challenge for SECAmb during this period, not only in terms of lost hours but also because of the amount of management time and additional SECAmb clinicians sent to hospital sites. We lost in excess of 3,200 operational ambulance hours to handover delays over 30 minutes during this period – an increase of 18% over the same period last year. It is also worth noting we transported approximately 5% fewer patients to hospital than the same period last year.

2.2.7 I would like to thank all of our staff and volunteers for their significant efforts and commitment to patient care during this extremely busy period. Despite the high levels of demand and pressures in the system, our staff worked extremely hard and with good humour to ensure we provided as responsive a service as possible to our patients.

2.3 Performance against Ambulance Response Programme (ARP) standards

2.3.1 December 2017 saw the first month of all English ambulance services reporting against the new Ambulance Response Programme (ARP) response standards. As a reminder, SECAmb moved to ARP on 22nd November 2017.

2.3.2 More details on our performance during December 2017 can be found in the IPR. However, it is worth noting our performance for December in comparison with other Trusts, as below:



2.4 Launch of Wellbeing Hub

2.4.1 In early January, we saw the launch of the Trust's new Wellbeing Hub. The Hub, part of the Trust's Wellbeing Strategy which was launched last year, brings together a range of previously separate services under one umbrella, meaning an array of support is available via just one email or phone call.

2.4.2 The Hub includes access to mental and emotional wellbeing support, physical health including physiotherapy referrals and Trauma Risk Management (TRiM) – a system that provides access to speak and meet with colleagues who have undergone specialist training in the management of people who have experienced traumatic incidents. The confidential service can also provide access to support for other matters including relationships, finances, drugs and alcohol, sleep, nutrition and fitness and access to the dedicated team of Trust chaplains. It will also co-ordinate a wide range of workshops, specialist training and events to meet the needs of all our staff and volunteers.

2.4.3 I'm really proud that the new Wellbeing Hub is now operational, as it brings together a number of areas which, taken together, all impact on the wellbeing of staff but which previously had not always been very accessible, in a single place. Staff wellbeing is an integral part of our strategy and I see this launch as a real step forward in demonstrating our commitment to make things better for all staff and volunteers.

2.5 Engagement with local stakeholders

2.5.1 During December 2017, I have continued to meet with a range of key internal and external stakeholders. I met with Caroline Lucas MP for Hove on 8th December 2017 and had a meeting with our regional Chief Constables and Police & Crime Commissioners on 14th December 2017. I also met with Sam Allen, Chief Executive of Sussex Partnership NHS Foundation Trust to discuss how we can collaborate more closely to improve the care provided to mental health patients.

2.5.2 Internally, I continued my programme of station visits, with visits to Tangmere Make Ready Centre and Littlehampton, Worthing and Shoreham Ambulance Stations on 11th December 2017. I also undertook an operational shift out of Godalming Ambulance Station on 19th December 2017. The programme of station visits will continue in January with visits to Caterham, Godstone, Dartford and Thameside planned.

2.5.3 On New Year's Eve I spent time with staff in both of our EOCs, at Ashford 111 and in the A&E Department at the William Harvey Hospital Ashford.

3. Regional issues

3.1 Flu

3.1.1 As reported in local and national media, hospital admissions and GP visits for influenza have seen a sharp rise going into 2018, especially in the South East region.

3.1.2 We are continuing to work hard to encourage as many of our staff as possible to have their flu jabs. As at 12th January 2018, just under 63% of our staff have received their flu jabs so far.

4. National issues

4.1 During December, as part of the Association of Ambulance Chief Executives (AACE), we participated in close national working with NHS Improvement and NHS England, to ensure we were as prepared as possible for winter.

4.2 This work will continue through coming weeks, including look-backs over Christmas and the New Year, to influence winter planning for next year.

5. Recommendation

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

Daren Mochrie QAM, Chief Executive

16th January 2018

South East Coast Ambulance Service
NHS Foundation Trust

Integrated Performance Report

January 2018 Board Meeting

SECAmb Integrated Performance Report

Contents

SECAmb Regulation Statistics

Use of Resources Metric (Financial Risk Rating)	3
CQC Compliance Status	Trust: Inadequate (Special Measures) 111 Service: Good
IG Toolkit Assessment	Level 2 - Satisfactory
REAP Level	3

Data Notes

It should be noted that clinical data is to August 2017. This is due to national timelines for clinical data submission and associated benchmarking with other Ambulance Trusts. Such benchmarking data follows a 3 month cycle and as such is not contemporary

Due to the recent introduction of ARP AQIs the ability to conduct trend analysis is currently limited. Whilst the Trust has sought to deliver stability in a highly volatile environment some performance measures reflect this volatility.

Chart Key:

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

SECAmb Executive Summary

This Integrated Performance Report follows on from recent review and feedback given at Trust Board held on 11th January 2018.
SECAmb has continued to operate in a volatile environment whereby performance is affected by system pressures and demand across the South East Health Economy.

Clinical Safety

Performance across the Trust's operations to August 2017 (Earlier data due to availability of National peer to peer benchmarks) is above or at National average. Concern remains as to the use of Care Bundles in Cardiac cases and is being addressed through various training tools. The Trust remains alert to Stroke conveyance performance and continues to monitor this is in tandem with overall performance against new ARP AQI indicators.

Clinical Quality

Performance now includes a detailed initial report of Health and Safety matters with supporting narrative. The Trust is increasing its reporting / detection of incidents and explanatory notes are included within this section covering incidents, those reported as serious, Duty of Candour requirements and complaints in the reporting period. On the latter it should be noted that with additional and targeted hours within EoC and for crews complaints have fallen with respect to Ambulance Delays. Hand Hygiene will be addressed through continued education and engagement with Operational Units.

Operational Performance

Trust operations have continued to be affected by wider system pressures although the Trust is taking specific and targeted action within the Emergency Operations Centre (EoC) to support call handling response time. SECAmb continues to implement the Ambulance Response Programme (ARP) Ambulance Quality Indicators (AQI) and is currently 00:01:31 over the target mean and 00:00:16 away from reaching our 90th Centile target for Category 1 calls. Category 2 performance for December was 00:00:41 away from reaching our target. Performance for the 90th centile was 00:05:42 under target. Handover delays are of concern although significant work across the system is being conducted to address this long term issue. SECAmb will continue to work with Commissioners and Regulators to understand and improve performance in Category 3 and 4 calls. Whilst performance has improved this should not detract from the required scrutiny by the Trust to ensure that clinical risk is managed accordingly.

Workforce

Vacancy rates have increased in the reporting period, the Trust, however, pipeline vacancy rates have increased going into 2018 across EoC and Operations, due to acceptance of offers and an increase in assessment days.

Finance

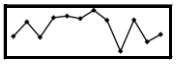
Finance is reporting at month 9 that the Trust will achieve its control total of £1.0m deficit.

SECAmb Clinical Safety Scorecard

Cardiac Return of Spontaneous Circulation (ROSC) - Utstein (a set of guidelines for uniform reporting of cardiac arrest)

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	44.8%	37.9%	54.5%	
Previous Year %	44.4%	69.0%	48.1%	
National Average %	52.4%	53.4%	53.8%	

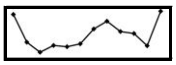
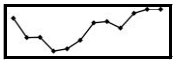
Cardiac ROSC - ALL

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	28.1%	24.4%	25.6%	
Previous Year %	31.4%	31.7%	26.0%	
National Average %	31.2%	30.9%	30.8%	

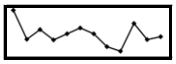
Cardiac Survival - Utstein

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	17.9%	17.2%	40.6%	
Previous Year %	22.6%	28.6%	34.8%	
National Average %	28.4%	28.7%	28.8%	

Cardiac Survival - All

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	5.9%	3.6%	10.0%	
Previous Year %	7.9%	10.4%	8.9%	
National Average %	9.7%	10.0%	10.0%	

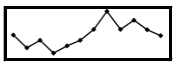
Acute ST-Elevation Myocardial Infarction (STEMI) Care Bundle Outcome

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	70.5%	62.9%	64.4%	
Previous Year %	65.3%	64.7%	72.7%	
National Average %	76.6%	76.3%	73.8%	

Acute STEMI receiving primary angioplasty within 150 minutes

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	88.2%	85.9%	86.5%	
Previous Year %	91.0%	95.2%	89.9%	
National Average %	85.5%	82.6%	86.7%	

FAST Identified Stroke - arriving at a hyper acute stroke unit within 60 minutes

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	62.7%	57.5%	57.5%	
Previous Year %	61.9%	67.2%	66.8%	
National Average %	57.0%	55.2%	54.0%	

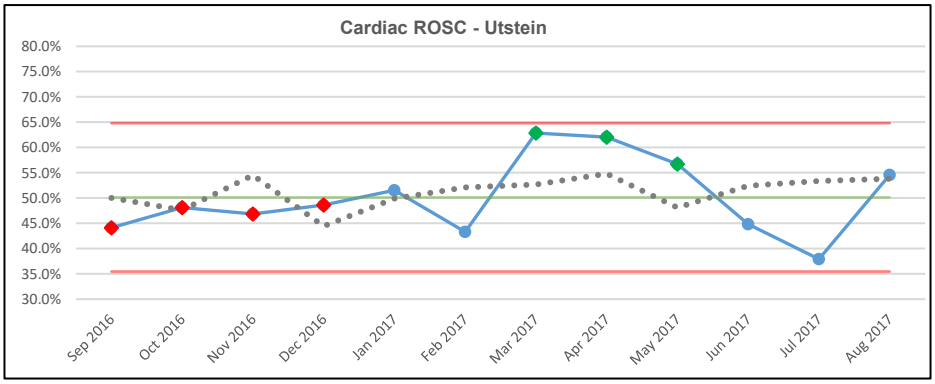
Stroke - assessed F2F receiving care bundle

	Jun-17	Jul-17	Aug-17	12 Month's
Actual %	94.4%	95.2%	95.6%	
Previous Year %	98.2%	96.5%	94.2%	
National Average %	97.4%	97.2%	97.5%	

Medicines Management

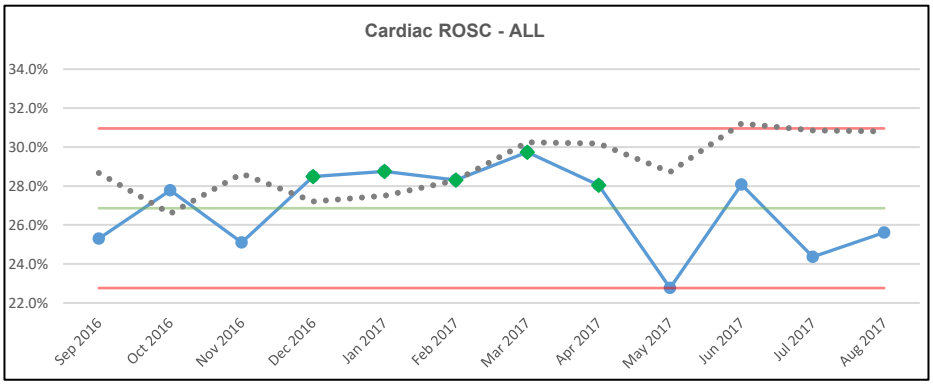
	Oct-17	Nov-17	Dec-17	12 Month's
Actual	Dev	97.10%	96.70%	NA
Number of audits	Dev	136	218	

SECAmb Clinical Safety Scorecard



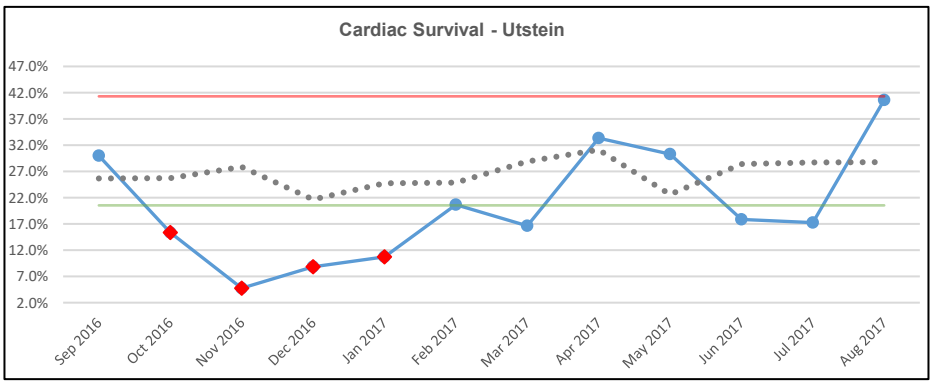
Performance for the cardiac arrest ROSC indicator for the Utstein group for August 2017 is above average and in line with the national average.

The medical directorate continue to explore potential quality improvement opportunities, including the development of a cardiac arrest registry and increased roll-out of mechanical Cardio Pulmonary Resuscitation (CPR) devices.



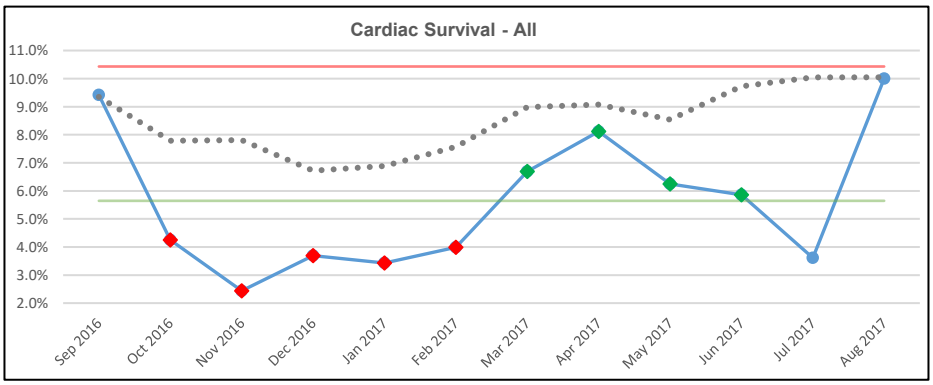
In August 2017, we saw a slight increase in performance against this indicator, this is consistent with the patterns of variation seen previously.

The medical directorate continue to explore the quality of data and quality improvement opportunities.



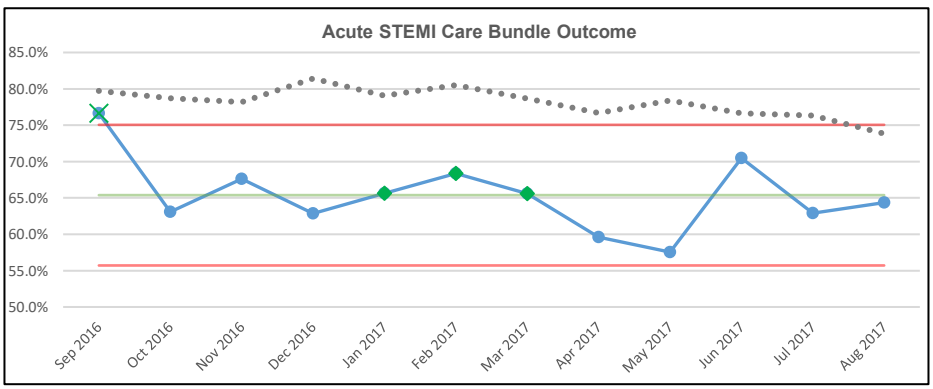
In August 2017, survival to discharge for the Utstein group was above our own mean and the national average.

This may be normal variation in the data, however we will explore activity for August to see whether there were any changes that led to this improvement. This learning could inform quality improvement in this area.



In August 2017, our cardiac survival for all cardiac arrest patients was above our average and in-line with the national average.

We will investigate this data to identify any learning opportunities.

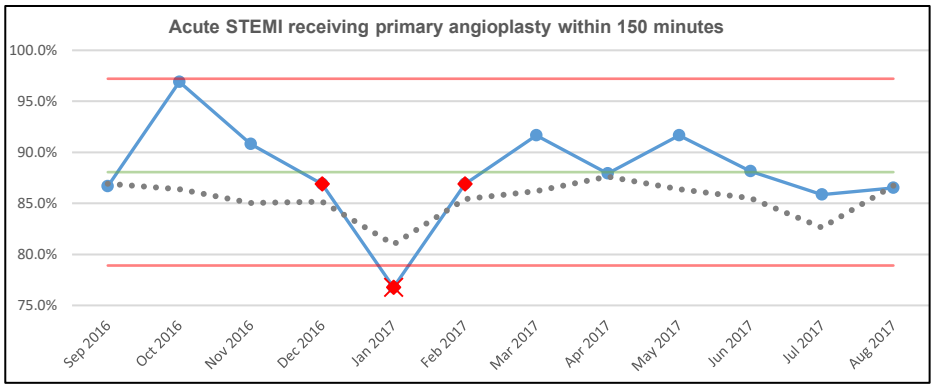


Performance for August 2017 increased to 65%.

Dashboards showing local performance levels have now been shared with Operating Units (OUs) to facilitate focussed quality improvement.

We plan written (and are considering video) communications with clinical staff to emphasise the importance of care bundle (the components of treatment that should be given) completion and clear documentation of any deviation from care bundles.

SECAmb Clinical Safety Additional Information



August 2017 saw a slight increase on the previous month's performance against this indicator. We are still below the Trust's mean performance, but remain in line with the national average.

Our below average performance against this indicator is associated with lower than average performance in the red call category.

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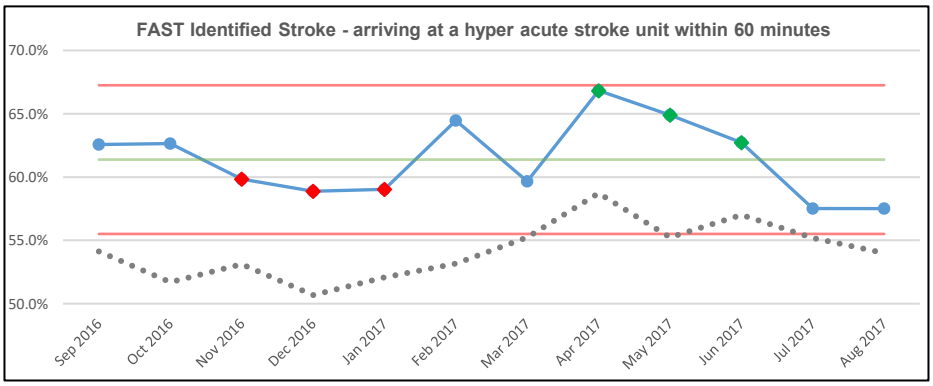
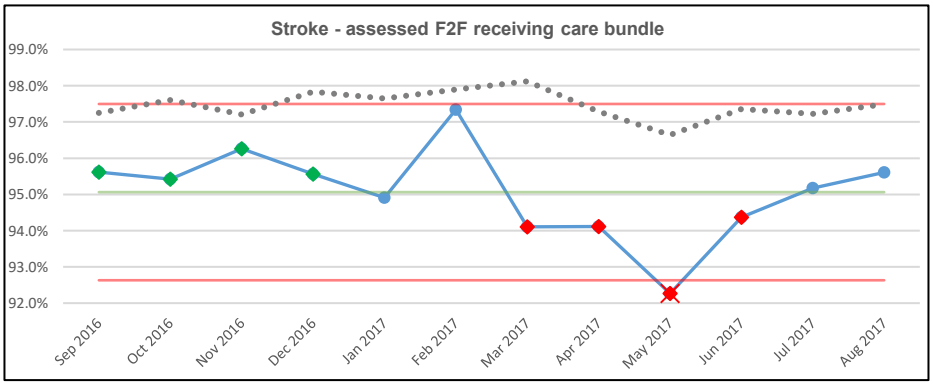


For August 2017 performance for FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit (HASU) within 60 minutes was 3% above the national average. However, remains below the trust mean.

A contributing factor to our decline in performance in arrival at a HASU within 60min may be a reduction in performance against the red 2 call category.



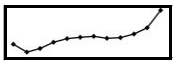
Performance in completing the stroke care bundle has improved for a third month. We are above our mean level of performance. This may relate to written communications sent to staff regarding to completion of the stroke care bundle.

Dashboards showing local performance levels have now been shared with OUs facilitate focussed quality improvement.

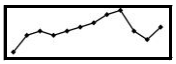
Further work is planned to facilitate quality improvement in this area.

SECAmb Clinical Quality Scorecard

Number of Incidents Reported

	Oct-17	Nov-17	Dec-17	12 Month's
Actual	615	665	811	
Previous Year	512	580	512	

Number of Incidents Reported that were SI's

	Oct-17	Nov-17	Dec-17	12 Month's
Actual	6	4	7	
Previous Year	1	1	2	

Duty of Candour Compliance (SIs)

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	83%	75%	80%	
Target	100%	100%	100%	

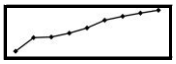
Number of Complaints

	Oct-17	Nov-17	Dec-17	12 Month's
Actual	129	107	93	
Previous Year	98	111	114	
Complaints Timeliness (All Complaints)	40.1%	35.5%	44.0%	
Timeliness Target	95%	95%	95%	

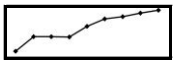
Compliments

	Oct-17	Nov-17	Dec-17	12 Month's
Actual	NA	NA	121	To follow

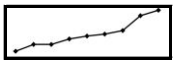
Safeguarding Training Completed (Adult) Level 2

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	50.82%	55.55%	59.65%	
Previous Year %	Dev	Dev	Dev	
Target	58%	67%	75%	

Safeguarding Training Completed (Children) Level 2

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	50.00%	54.70%	59.07%	
Previous Year %	Dev	Dev	Dev	
Target	58%	67%	75%	

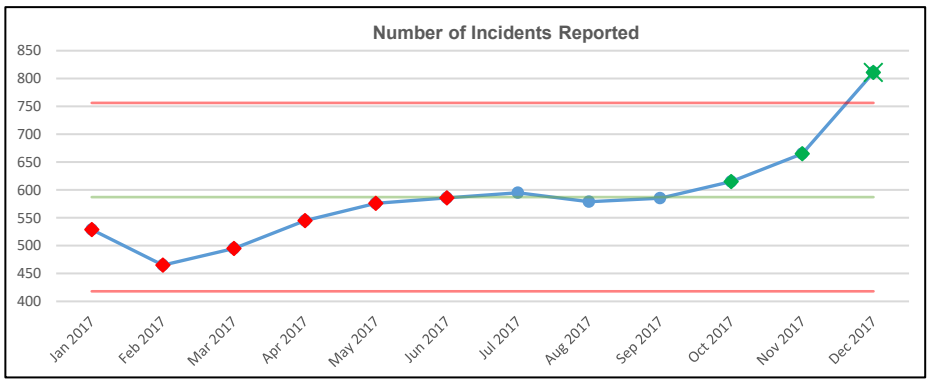
Safeguarding Training Level 3 (Adult/Child)

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	30.52%	48.10%	54.41%	

Hand Hygiene

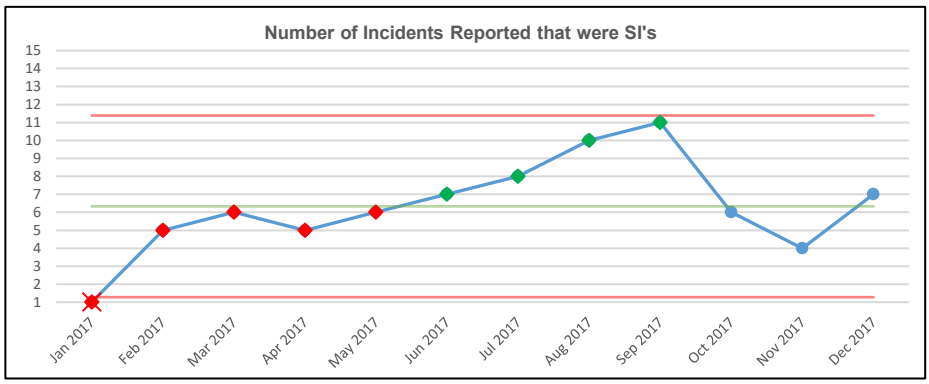
	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	78%	89%	83%	
Target	90%	90%	90%	

SECAmb Clinical Quality Scorecard



Incident reporting rates are continuing to rise across the organisation to 811 incidents being reported in December 17. This increase is as a result of raised awareness across the organisation of incident reporting together with training from the Datix manager on how to report an incident.

Demands placed upon the service (whether directly or as an impact of lost resource due to delays in handover) during recent months has had the commensurate effect on the ability to respond. The Board will be aware of extensive work being undertaken at system level to address issues of delay

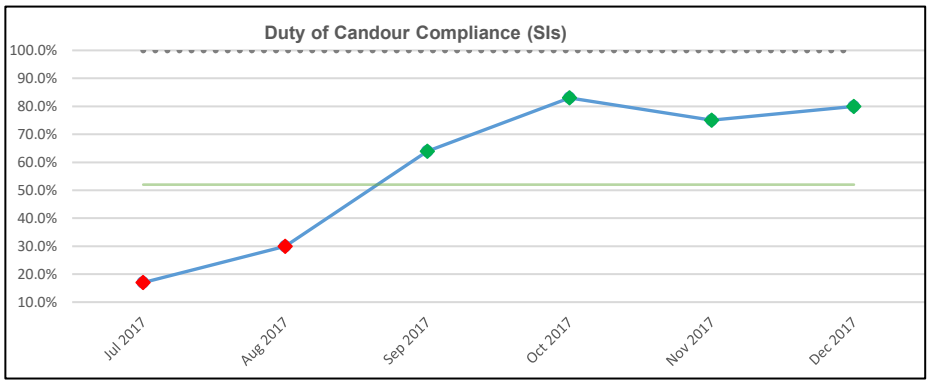


Seven Serious Incidents (SIs) were declared in December 2017. 2 were not directly patient-related; of these 1 was a CAD outage of 15 minutes and the other was relating to the voice recorder not recording due to licence issues.

There were 3 delayed attendance incidents, 1 each in Kent, Surrey and Sussex areas.

1 incident was an Information Governance issue around complaints details sent in error to a CCG.

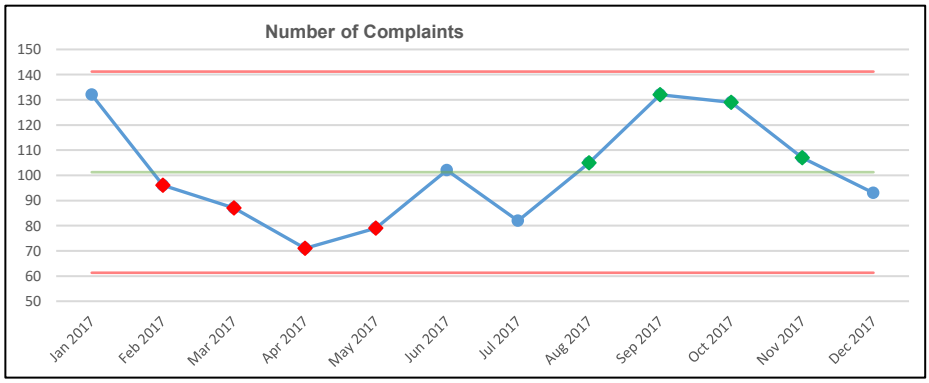
A patient care incident was reported about transportation of a post cardiac arrest patient.



Of seven incidents reported two were not applicable for Duty of Candour; one was a BCI declared following network disconnection of the CAD and another was related to the voice recorder licence.

Of the 5 that required Duty of Candour, 4 were made (one was attempted but unknown patient outcome hampered efforts).

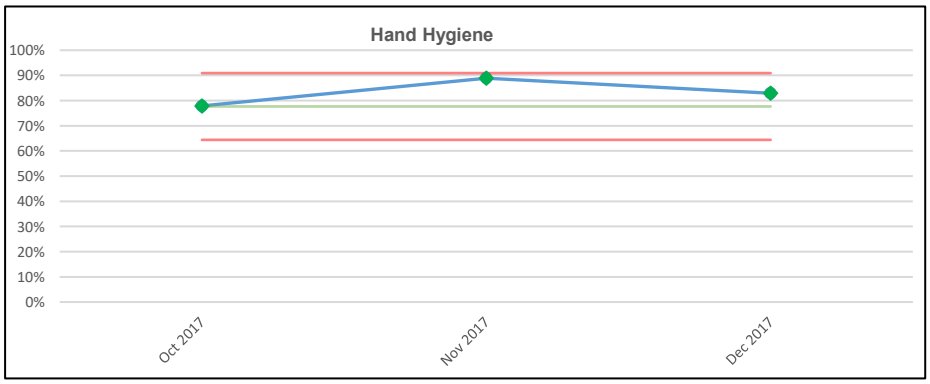
To ensure that Duty of Candour is being completed, the SI Team have agreed that initial contact will be made by them until we are sure that allocation and action by Investigating Managers is robust.



The number of complaints received in December has decreased again against November and is at the lowest level since July.

This reduction is largely due to a specific reduction in the number of complaints about ambulance delays, which has reduced from 63 in October, to 41 in November, to 32 in December.

It should be noted that complaints about staff are also back to their lowest level this calendar year, with just 21 (the same as in September).



Hand Hygiene compliance will form one of the key elements in the IPC Improvement Plan. December's compliance total has dropped, but this may well be due to the change from ten audits a month to ten a week for each OU.

We will be introducing an IPC Dashboard so that OU's can check on their progress and are holding the second IPC Champion training day where we intend to discuss the audit programme and seek views on compliance rates.

We will also be introducing hand hygiene training at a local level with the use of UV training kits and evidence based explanations to staff about the importance of compliance whilst delivering direct

SECAmb Health and Safety Reporting

Health and Safety (H&S)

Introduction
The Trust is introducing a range of H&S metrics to the Integrated Performance Report.

It has been established, by benchmarking other ambulance trusts, that our current H&S structure needs strengthening. Therefore, a business case has been produced to seek investment into the team and introduce a new Head of Health & Safety role. This will allow greater monitoring and practical support to our OUs, EoCs and support services. In addition, the Trust is commissioning an external review of Health & Safety so that an objective baseline assessment can inform a new service improvement plan.

However, there is active improvement work within Health & Safety and the Central Health & Safety Working Group has oversight of this work. This work includes,
• A review of training and risk assessments is underway along with the development of an individual risk assessment tool that can be used during the ACTUS appraisal process.
• A new Moving and handling policy has been written and is currently going through the consultation process.
• A new overarching Health and Safety policy has been drafted.
• We have reintroduced the monthly H&S inspections which will improve our assurance that our buildings are safe and enable identification of common themes.
• To enable increased visibility of safety issues at board level we are also proposing a program of Director led patient and staff safety walk rounds.

Violence and Aggression Incidents - See Figure 1 below

The number of reported incidents of violence and aggression toward our people continues to show a slow downward trend with 476 reported to 31/12/17 compared to 554 at the same time last year.

These incidents range from verbal abuse to actual physical assault. Our Security manager continues to pursue sanctions through partnership working with local police forces. The risk from lone working has been reduced by the move to ARP, we need to further strengthen our lone worker policy and procedure to ensure avoidable risks are highlighted at the earliest opportunity, ideally before dispatch.

Manual handling Incidents - See Figure 2 below

The manual handling incidents are predominantly associated with moving patients using equipment and are not always avoidable. It is anticipated that the new revised moving and handling policy, the relaunched training (planned for 2018/19) and the revised risk assessments will help to improve awareness and reduce incidents.

In addition, nine members of the clinical education team have been trained to L3 manual handling which will ensure the quality of future training of our people. Since April 2017 the Trust has had 142 new staff. This includes 112 paramedics, 22 Emergency Care Support Workers and 8 Associate Practitioners. These have received manual handling training.

H&S incidents - See Figure 3 below

An upward trend is seen in the reporting of H&S incidents which is in line with the Trust's intention to increase the number of low/no harm incident reports. This is an indication of greater awareness of potential risks and therefore a safer working environment.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)) - See Figure 4 below

The majority of our RIDDORs are associated with over 7 day absences caused by lifting and handling injuries with use of the carry chair being reported by staff on Datix as the most common often cause.

We have 15 days to report these to RIDDOR under the regulations. Training is planned for managers to improve our compliance with this reporting target and to improve the quality of the investigations and therefore shared learning opportunities.

We need to reduce our Muscular Skeletal Disorder, which includes the lifting and handling injuries, but also disorders associated with workstation set up, repetitive strain etc. The Health & Safety team will consider a realistic target and develop subsequent actions. The majority of our occupational health referrals shows the main injury region as the lower back. These numbers are subject to change as there a number of needle stick and contamination incidents where blood test results are awaited.

Figure 1

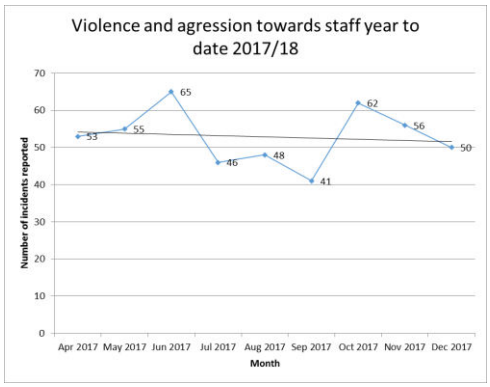


Figure 2

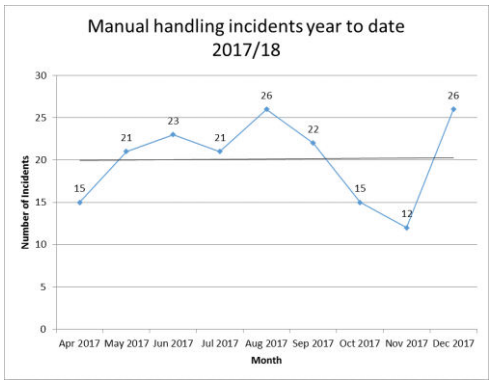


Figure 3

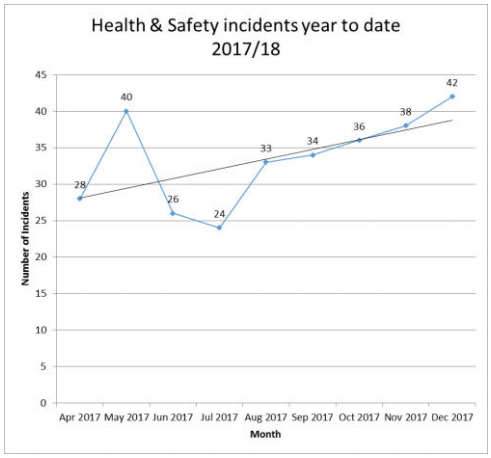
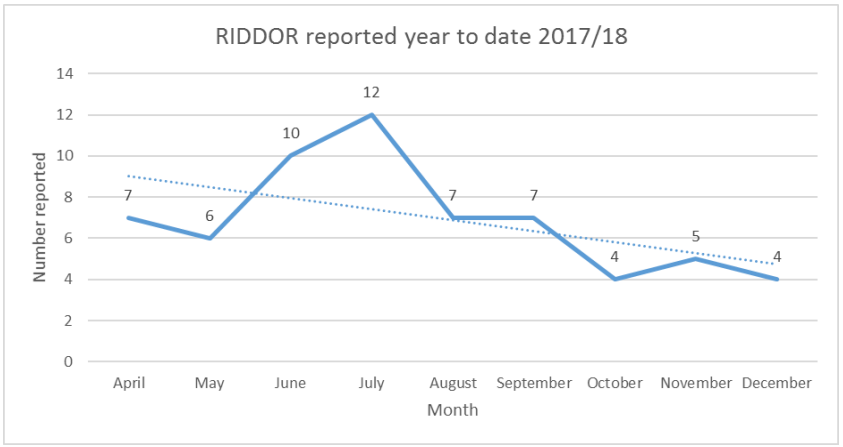
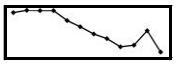


Figure 4



SECAmb 999 Operations Performance Scorecard

Call Handling

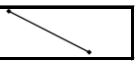
	Oct-17	Nov-17	Dec-17	12 Month's
5 Sec EOC Performance	50.7%	67.4%	42.7%	
Average Call Pick Up Time (secs)	17.6	12.7	21.5	
Call Pick Up Time 95th Percentile (Secs)	230	124	220	

Dispatch

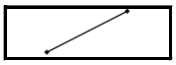
	Oct-17	Nov-17	Dec-17	12 Month's
Average Allocation Time - Cat 1 (Secs)	NA	NA	NA	NA
Allocation Ratio	1.67	1.68	1.68	
Response Ratio	1.13	1.13	1.11	

November's performance data only refers to the 22nd - 30th (Post-ARP)

Cat 1 Performance

	Oct-17	Nov-17	Dec-17	12 Month's
Mean (00:07:00)	NA	00:08:35	00:08:31	
90th Percentile (00:15:00)	NA	00:14:59	00:15:16	

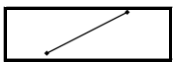
Cat 1T Performance

	Oct-17	Nov-17	Dec-17	12 Month's
Mean (00:19:00)	NA	00:11:23	00:11:50	
90th Percentile (00:30:00)	NA	00:20:34	00:21:01	

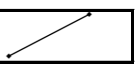
Cat 2 Performance

	Oct-17	Nov-17	Dec-17	12 Month's
Mean (00:18:00)	NA	00:16:42	00:18:41	
90th Percentile (00:40:00)	NA	00:30:43	00:34:58	

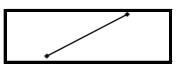
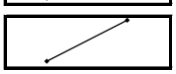
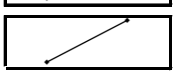
Cat 3 Performance

	Oct-17	Nov-17	Dec-17	12 Month's
Mean	NA	01:10:05	01:39:34	
90th Percentile (02:00:00)	NA	02:40:41	03:47:52	

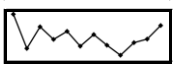
Cat 4 Performance

	Oct-17	Nov-17	Dec-17	12 Month's
Mean	NA	01:26:38	02:30:33	
90th Percentile (03:00:00)	NA	03:15:10	05:54:29	

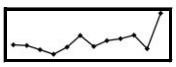
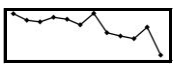
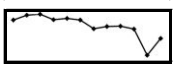
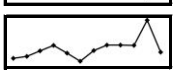
HCP

	Oct-17	Nov-17	Dec-17	12 Month's
HCP 60 (75%)	NA	23.1%	33.5%	
HCP 120 (75%)	NA	18.4%	42.4%	
HCP 240 (75%)	NA	23.4%	51.7%	

Demand/Supply

	Oct-17	Nov-17	Dec-17	12 Month's
Call Volume	86300	85379	98429	
Incidents	59901	60565	63336	
Transports	33342	33858	35704	

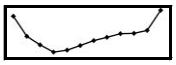
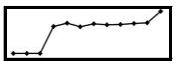
Incident Outcome (Contract)

	Oct-17	Nov-17	Dec-17	12 Month's
Hear & Treat	14.3%	12.0%	18.0%	
See & Treat	31.5%	32.7%	29.7%	
S&C HCP	8.8%	6.1%	7.8%	
S&C 999	45.4%	49.2%	44.4%	

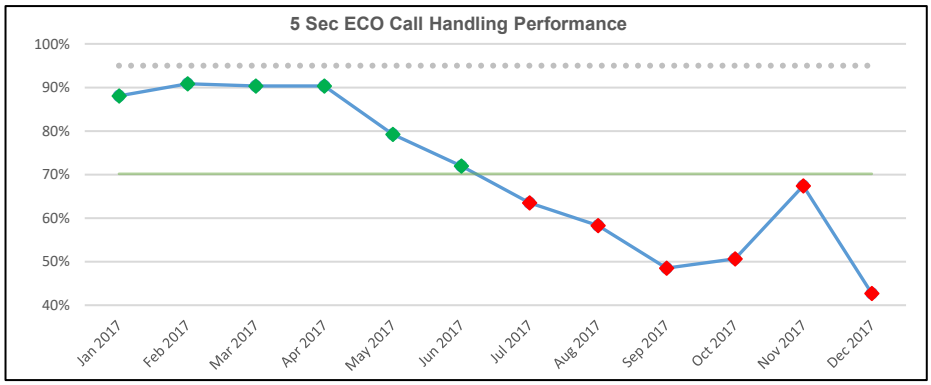
Community First Responders

	Oct-17	Nov-17	Dec-17	12 Month's
Volume of incidents Attended	1246	1324	1518	
Cat 1 Attendances	tbc	tbc	tbc	tbc
Hours Provided	20543	14130	16216	

Call Cycle Time

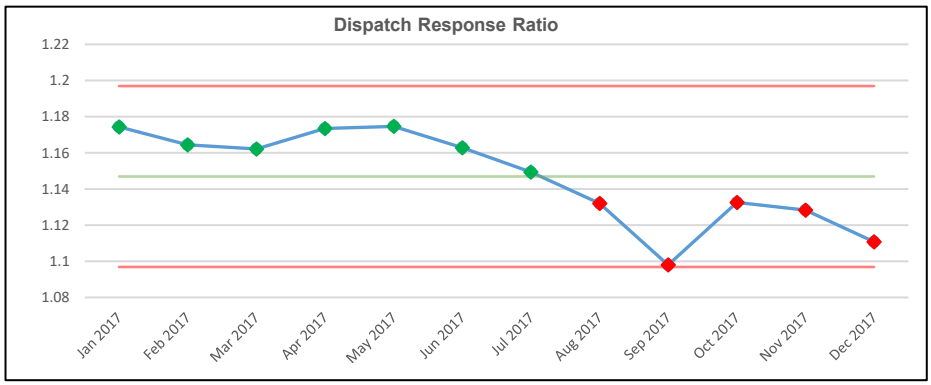
	Oct-17	Nov-17	Dec-17	12 Month's
Clear at Scene (mins)	74.58	74.59	75.84	
Clear at Hospital (mins)	105.9	106.5	110.3	
Handover Hrs Lost at Hospital (over 30mins)	5457	5522	7636	
Number of Handovers >60mins	661	596	1433	

SECAmb 999 Operations Performance Scorecard

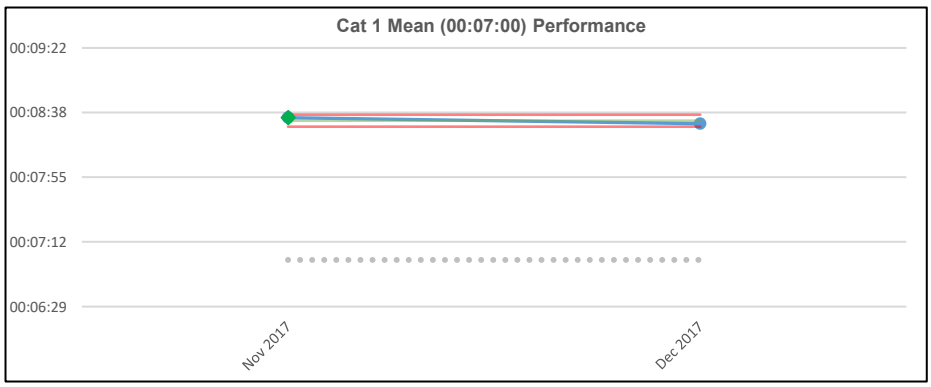


Call handling performance for December has decreased significantly reaching its lowest point this calendar year and comparing to this time last year which was 83.4%. Correlated to this there was a significant increase in call volume along side significant operational pressures which increased the length of each call.

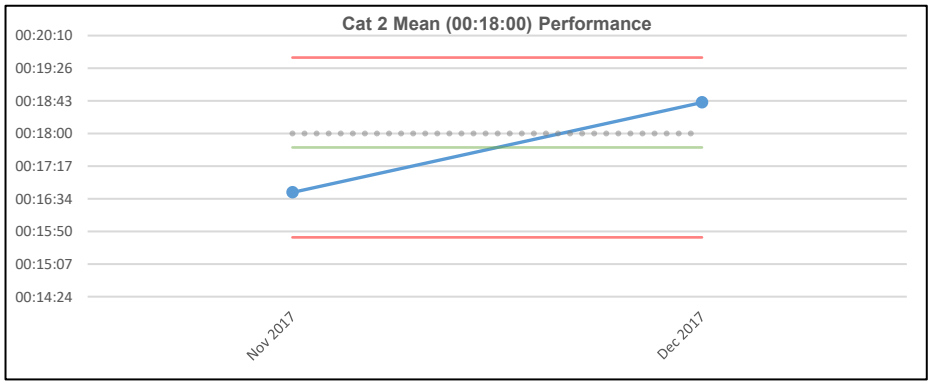
Call pick up performance is now included in the EoC action plan to address the CQC requirement of improving AQI, recruitment and staff retention. Significant scrutiny is still being placed on call handling performance with all efforts being made to improve this. There has been an additional cohort of call takers recruited, that can take routine calls, to improve the efficiency of the emergency medical



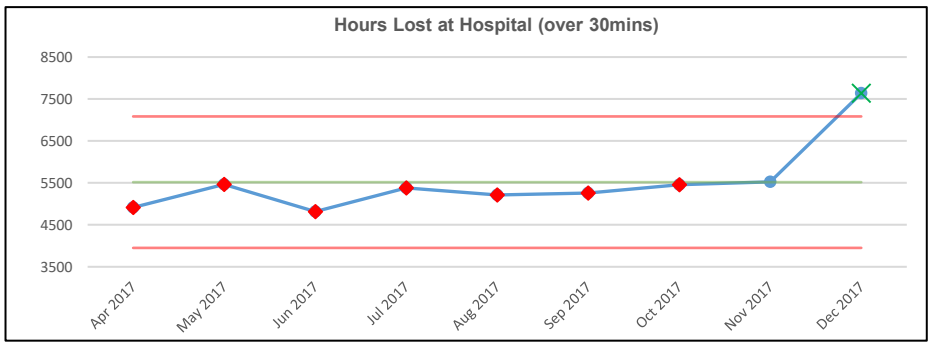
Response ratio has decreased in comparison to last month. This metric will be referred to as Responses per Incident going forward as it comes under greater scrutiny with the ARP



Following the change to reporting categories with ARP we now have a full month's worth of data for December. The Trust is currently 00:01:31 over the target mean and 00:00:16 away from reaching our 90th Centile target. This delay in average response time is likely due to poor call answer performance and is being addressed through the measures included above under call handling performance



Cat 2 performance for December was 00:00:41 away from reaching our target. We had excellent performance for our 90th centile with 00:05:42 under target.



Handover delays increased in December and continue to create significant pressure for SECAmb. More than 7636 hours lost through handover delays. As the graph show December was outside of the control limits. This was a decrease of 65hrs compared to December 2016.

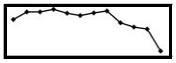
This has an impact on both patient safety and experience. The delays also means that SECAmb are unable to respond to public 999 calls.
To address this system wide issue, SECAmb and NHSI have appointed a dedicated Programme Director for 6 months to provide additional leadership and focus. A system wide Task and Finish group is in place together with two (East and West) operational groups who are responsible for delivering the changes needed to ensure improvement.

SECAmb 111 Operations Performance Scorecard

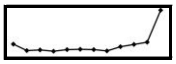
Calls Offered

	Oct-17	Nov-17	Dec-17	12 Month's
Actual	84639	82468	124624	
Previous Year	98849	94065	104132	

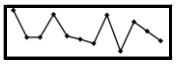
Calls answered in 60 Seconds

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	75.3%	72.9%	47.9%	
Previous Year %	83.9%	77.5%	80.8%	
Target %	95%	95%	95%	

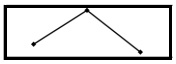
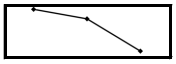
Calls abandoned - (Offered) after 30secs

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	2.8%	3.6%	14.3%	
Previous Year %	2.2%	3.7%	3.9%	
Target %	2%	2%	2%	

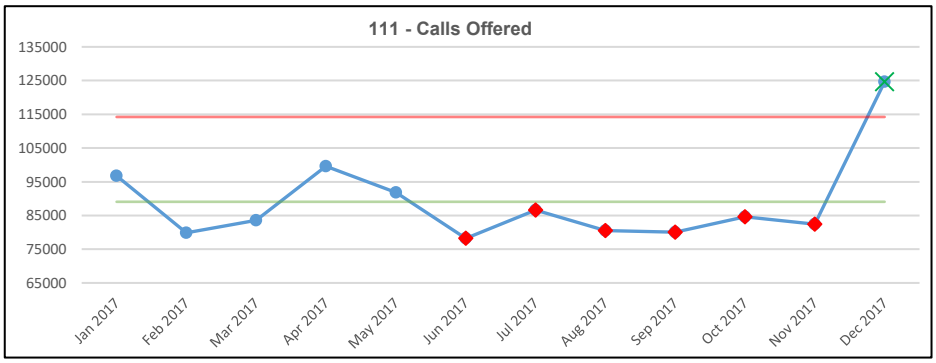
Combined Clinical KPI

	Oct-17	Nov-17	Dec-17	12 Month's
Actual %	78.2%	75.3%	72.5%	
Previous Year %	68.7%	71.5%	72.5%	
Target %	90%	90%	90%	

Outcomes

	Oct-17	Nov-17	Dec-17	12 Month's
999 Referrals % (Answered Calls)	11.1%	12.4%	10.8%	
999 Referrals (Actual)	8993	9687	10954	
A&E Dispositions % (Answered Calls)	7.7%	7.4%	6.4%	
A&E Dispositions (Actual)	6238	5809	6540	
Home Management %	6.2%	6.4%	5.8%	

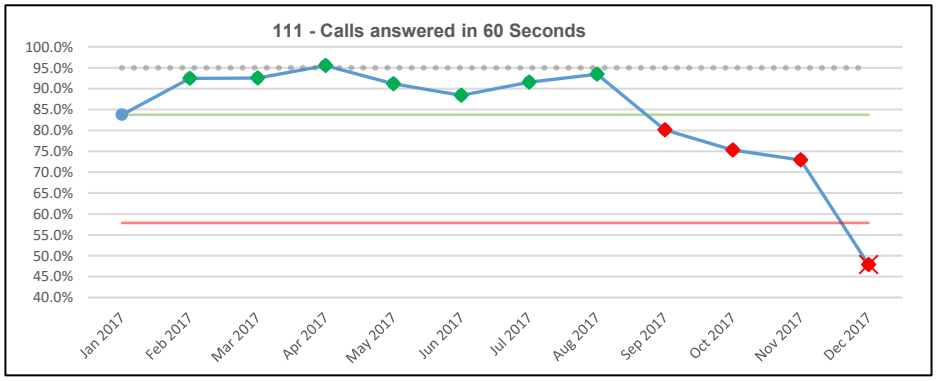
SECAmb 111 Operations Performance Scorecard



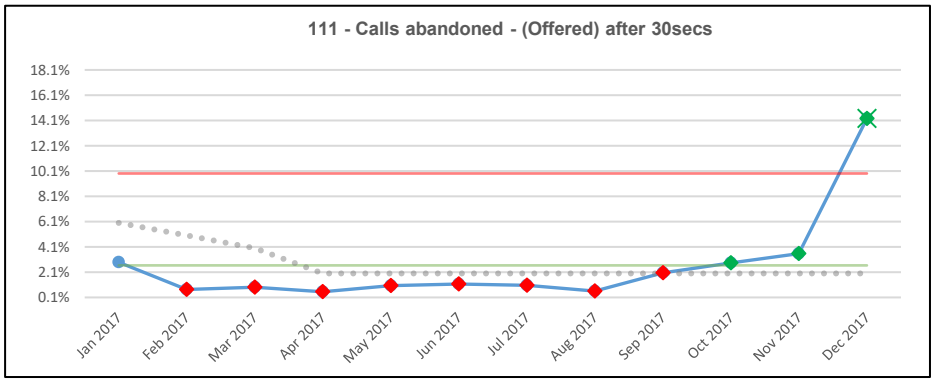
Exceptional call volumes with 125,000 Calls Offered in December 2017.

This resulted in the busiest month for the service in its five-year history.

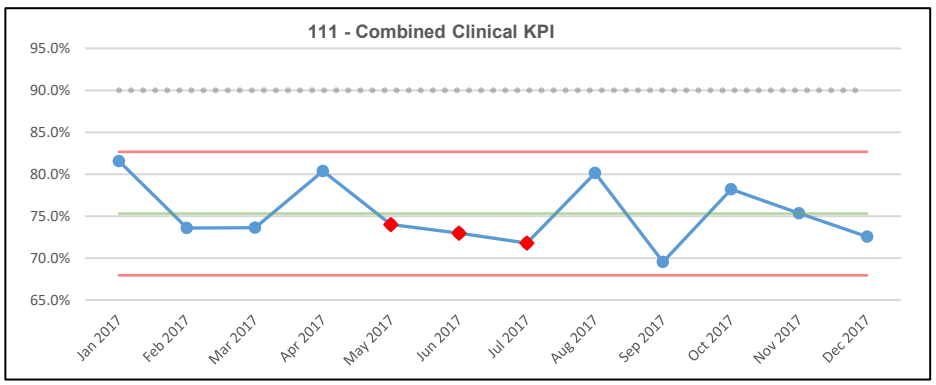
The Christmas period saw a 13% year-on-year increase in activity.



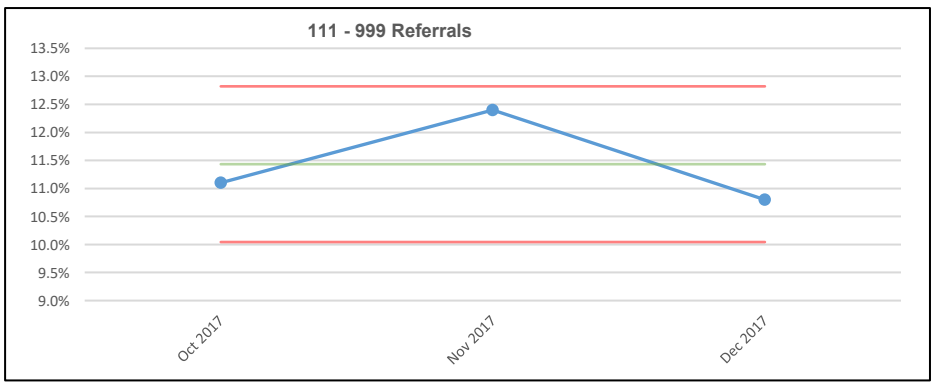
The "Answered in 60" KPI dropped to 47.9% as a result of the exceptional volumes. However we answered 86% of calls.



Abandonment rate up to 14.25% but the measure is undergoing validation as this may be related to the high volumes of calls as shown above.



Clinical performance at 72.53%, this is 10% better than the national 111 clinical performance. Limited capacity for Warm Transfers but excellent Queue management resulted in good patient experience for clinical contact.

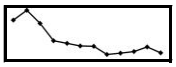
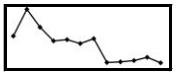
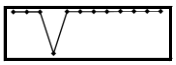
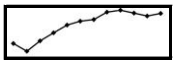
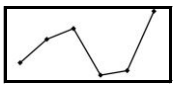


The KMSS 111 Ambulance referral rate fell to 10.79%, this is slightly lower than the national average. The service was successful in protecting SECAmb during DMP6, by mitigating C3 / C4 referrals throughout the Christmas period.

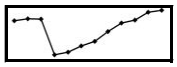
Intentionally Blank

SECAmb Workforce Scorecard

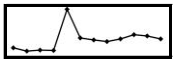
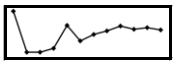
Workforce Capacity

	Oct-17	Nov-17	Dec-17	12 Month's
Number of Staff WTE (Excl bank & agency)	3043.3	3061.2	3039.0	
Number of Staff Headcount (Excl bank and agency)	3318	3333	3308	
Finance Establishment (WTE)	3525.24	3524.74	3526.29	
Vacancy Rate	13.51%	13.09%	13.46%	
Vacancy Rate Previous Year	9.15%	8.22%	9.35%	
Adjusted Vacancy Rate + Pipeline recruitment %	7.70%	7.90%	10.53%	

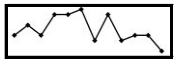
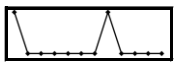
Workforce Compliance

	Oct-17	Nov-17	Dec-17	12 Month's
Objectives & Career Conversations %	50.66%	62.13%	65.08%	
Statutory & Mandatory Training Compliance %	76.06%	71.06%	73.61%	
Previous Year %	74.60%	76.02%	77.30%	

Workforce Costs

	Oct-17	Nov-17	Dec-17	12 Month's
Annual Rolling Turnover Rate %	18.17%	18.05%	17.77%	
Previous Year %	16.10%	16.50%	16.90%	
Annual Rolling Sickness Absence %	4.93%	4.96%	4.92%	

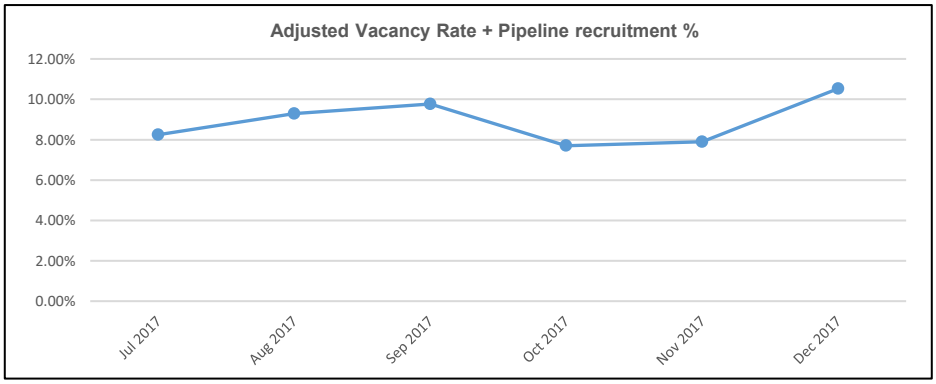
Employee Relations Cases

	Oct-17	Nov-17	Dec-17	12 Month's
Disciplinary Cases	5	5	2	
Individual Grievances	6	5	5	
Collective Grievances	0	1	0	
Bullying & Harassment	2	2	2	
Bullying & Harassment Prev Yr	4	2	0	
Whistleblowing	0	0	0	
Whistleblowing Previous Year	1	0	0	

Physical Assaults (Number of victims)

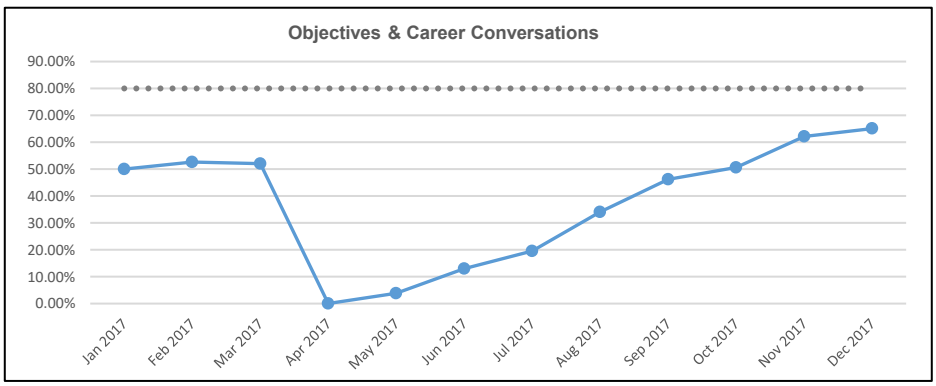
	Oct-17	Nov-17	Dec-17	12 Month's
Actual	17	20	17	
Previous Year	18	20	19	
Sanctions	0	2	1	

SECAmb Workforce Scorecard



New starters reduced in December due to the Christmas period. Pipeline vacancy rates have increased going into 2018 across EoC and Operations, due to acceptance of offers and an increase in assessment days.

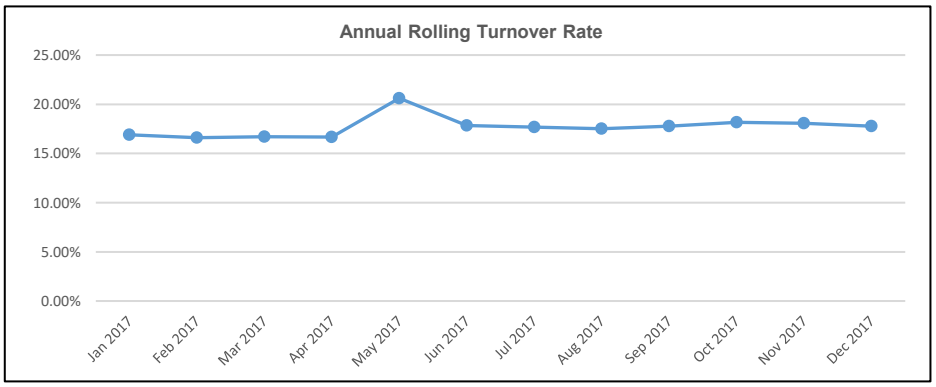
We are continuing weekly assessments across January 2018 and aim to have a healthy talent pool moving into the year ahead. We have new team members within the resourcing function to cope with demand. We are aligning with the East / West operating model and will work closely with HR colleagues to look at retention and resilience at interview stage to bridge the gap in requirements versus leavers.



Meetings have been taking place with Operational Managers with two key objectives

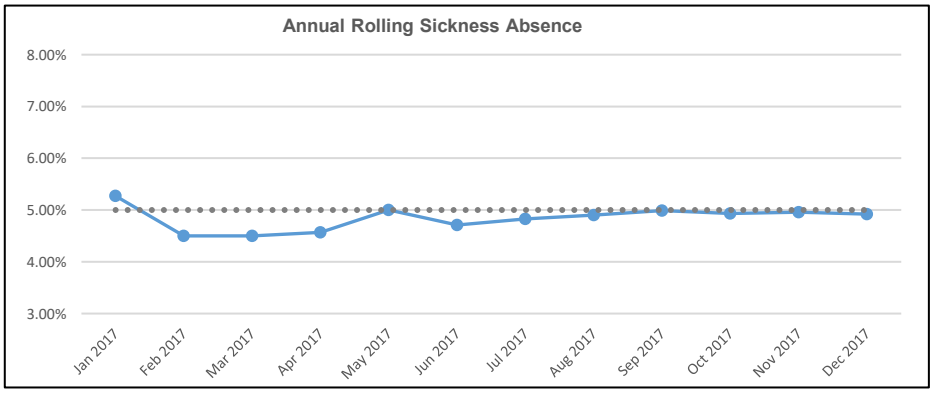
1) Re-validating the data held in Actus
2) Agreeing on plans to achieve 80% compliance by 31st March 2018.

Managers will be supported to deliver on objectives and will understand their accountability in this regard via area Governance



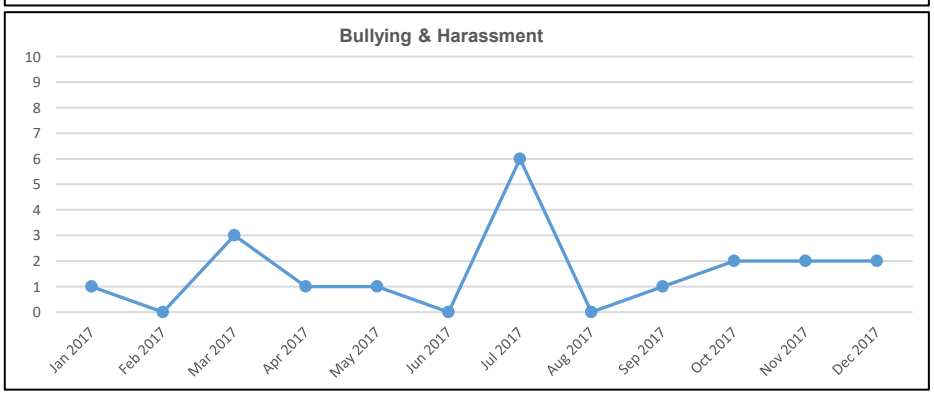
The Trust turnover rate remains constant although a high turnover rate in EoC should be noted. This is being addressed via the EoC Task and Finish Group. In addition, there are 2 dedicated EoC HR Advisors who are working in the EoC to support the management team.

Benchmarking data below at Fig 5 (Leaver Rate) shows the turnover rate across all ambulance trusts. In response to this SECAmb is in contact with Trusts where turnover is low to seek examples of best practice and emulate this within SECAmb and be used to create and deliver retention activities.



The trusts sickness rate is consistent and the focus remains on the EoC staff where there is a higher level of sickness. This is being addressed with 2 dedicated HR Advisors who are based in each EoC who are working with the Managers to support in sickness rates and to clear the backlog of sickness hearings to bring matters to a conclusion

The aim is to bring staff back to work and with the support of the wellbeing hub the promotion of alternative duties. The benchmarking data below at Figure 6 - Absence rate shows the sickness absence data across ambulance Trusts.



October, November and December, Bullying and Harassment (B&H) cases remain unchanged but do represent an increase when compared to August. As mentioned previously, some of this is attributed to the ongoing Trust B&H initiatives and the subsequent awareness of how to raise concerns and what is acceptable and unacceptable behaviour.

External training to deliver investigation skills training to line managers, and therefore increase the number of available investigators, speeding up case management has been approved with the first cohort attending training on 2nd February 2018.

SECAmb Workforce Additional Information

Benchmarking - The graphs below show the benchmarking of SECAmb against other ambulance Trusts.

Figure 5

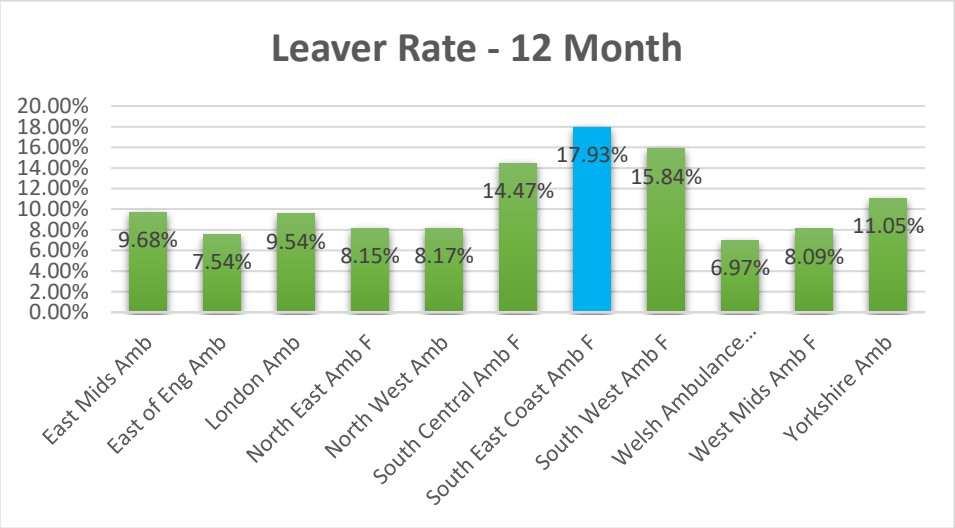
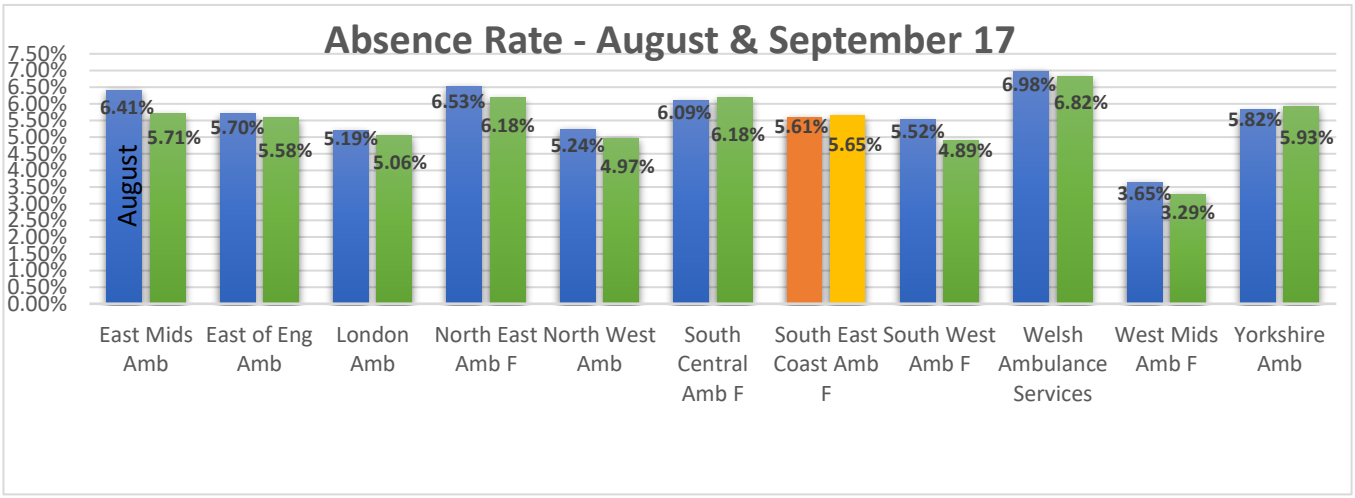


Figure 6



Statutory and Mandatory Training

Overall Completion % by Directorate	SaM
Chief Executive	**34.78%**
Finance & Corporate	**83.33%**
Human Resources	**68.32%**
Quality & Safety	**31.42%**
Strategy & Business	**56.25%**
Medical	**49.31%**
Operations	**72.14%**

Overall Completion % by Directorate	SaM
Ashford OU	**95.38%**
Brighton OU*	**54.25%**
Chertsey OU*	**66.66%**
Dartford & Medway OU	**88.41%**
Gatwick & Redhill OU	**89.32%**
Guildford OU	**62.76%**
HART	**93.60%**
Paddock Wood OU	**84.78%**
Polegate & Hastings OU*	**52.16%**
Tangmere & Worthing OU	**60.82%**
Thanet OU	**82.44%**
OU Admin & Management - Kent	**77.90%**
OU Admin & Management - Surrey	**73.77%**
OU Admin & Management - Susse	**48.96%**
EOC*	**58.16%**
111*	**53.22%**

* There is a lag in reporting centrally for these OU's

Meetings are being held with Operational Unit Managers to agree plans to achieve Statutory and Mandatory Training Compliance

SECAmb Finance Performance Scorecard

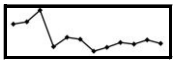
Income

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	£ 16,329	£ 16,490	£ 18,210	
Previous Year £	£ 16,370	£ 16,489	£ 17,536	
Plan £	£ 18,621	£ 18,826	£ 20,620	

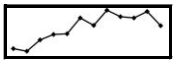
Expenditure

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	£ 16,625	£ 16,498	£ 17,406	
Previous Year £	£ 17,655	£ 17,985	£ 17,446	
Plan £	£ 18,932	£ 18,849	£ 19,830	

Capital Expenditure

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	£ 376	£ 554	£ 406	
Previous Year £	£ 701	£ 1,629	£ 752	
Plan £	£ 1,865	£ 856	£ 856	
Actual Cumulative £	£ 2,639	£ 3,194	£ 3,600	
Plan Cumulative £	£ 11,556	£ 12,412	£ 13,268	

Cost Improvement Programme (CIP)

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	£ 1,304	£ 1,459	£ 1,114	
Previous Year £	£ 558	£ 500	£ 1,114	
Plan £	£ 1,332	£ 1,349	£ 1,399	
Actual Cumulative £	£ 8,356	£ 9,815	£ 10,929	
Plan Cumulative £	£ 8,164	£ 9,513	£ 10,912	

CQUIN (Quarterly)

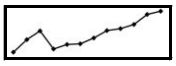
	Q2 17/18	Q3 17/18	Q4 17/18
Actual £	£ 846	£ 847	NA*
Previous Year £	£ 952	£ 1,019	£ 716
Plan £	£ 848	£ 848	£ 848

*The Trust anticipates that it will achieve the planned level of CQUIN

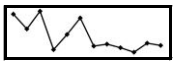
Surplus/(Deficit)

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	-£ 296	-£ 8	£ 804	
Actual YTD £	-£ 3,979	-£ 3,987	-£ 3,183	
Plan £	-£ 311	-£ 23	£ 790	
Plan YTD £	-£ 4,019	-£ 4,043	-£ 3,253	

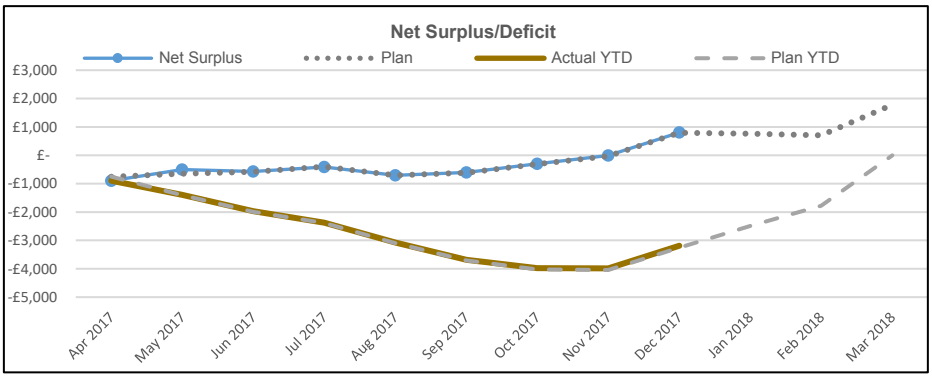
Cash Position

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	£ 14,327	£ 16,344	£ 17,024	
Minimum £	£ 10,000	£ 10,000	£ 10,000	
Plan £	£ 5,219	£ 7,317	£ 6,088	

Agency Spend

	Oct-17	Nov-17	Dec-17	12 Month's
Actual £	£ 121	£ 240	£ 212	
Plan £	£ 334	£ 333	£ 331	

SECAmb Finance Performance Scorecard

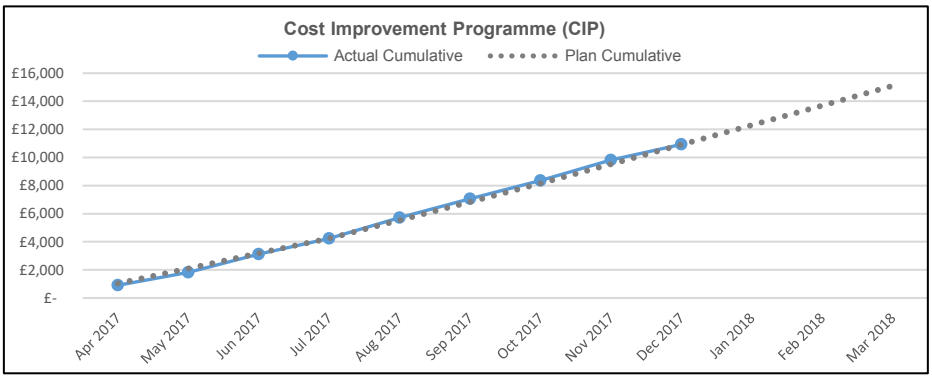


At month 9 it is projected that the Trust will achieve its control total of £1.0m deficit.

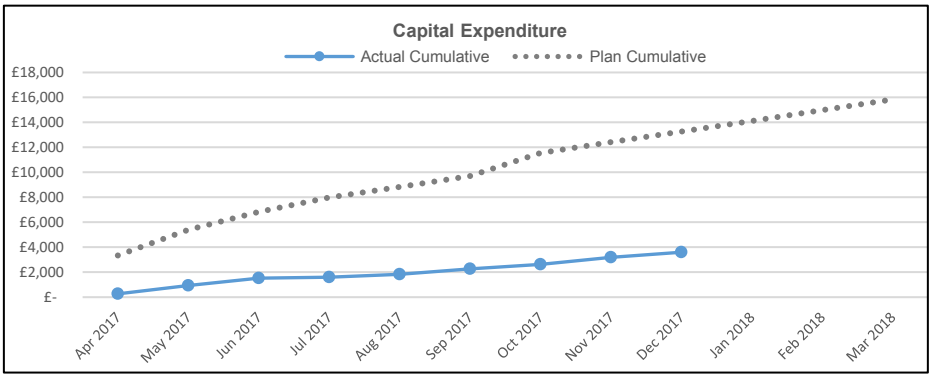
The Trust made a surplus of £0.8m in the month, slightly better than plan. This reduced the cumulative deficit to £3.2m, which is £0.1m better than plan.

The following is a summary bridge between the original and normalised plans (£m): -

Original planned deficit (NHSI plan)	(1.0)
Structural deficit income excluded	(24.8)
Frontline hours excluded	18.9
Reserves and other budgeted costs to support delivery	5.9
'Normalised'/Commissioned plan	(1.0)

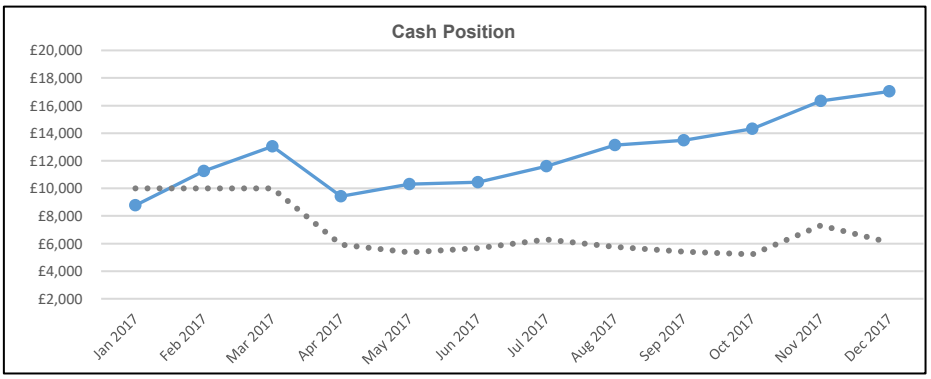


CIP schemes to the value of £17.3m have now been identified, exceeding the £15.1m target. The projected achievement is currently at £15.3m, despite the withdrawal of the Task Cycle Time CIP for operational reasons and delays in the delivery of agency savings. The PMO is continuing to seek additional opportunities for savings to mitigate the risk of non-delivery of the target. 56 per cent of the projected savings relate to recurrent schemes.



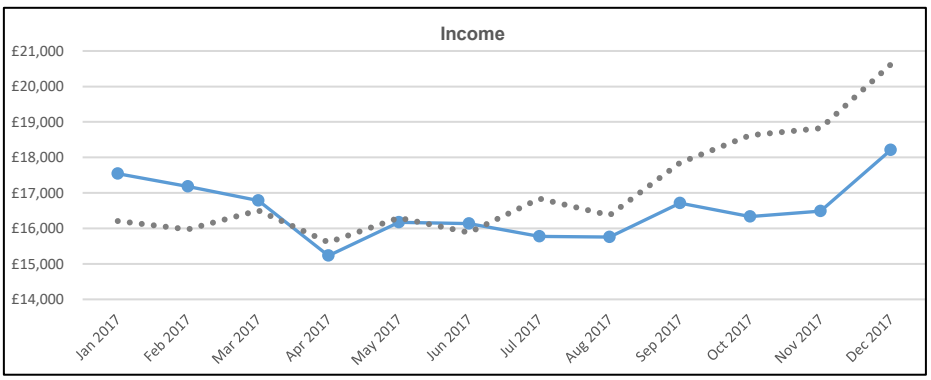
Spend on capital for the year to date is £3.6m against a plan of £13.3m. The full year forecast is £7.6m against a plan of £15.8m. The projected underspend of £8.2m is entirely the result of accounting for planned vehicle replacement via operating leases, rather than finance leases. The lease costs have therefore been moved to revenue, with some offset from the associated reduction in capital charges (depreciation and PDC dividend).

The projected spend for the year includes schemes that have been re-prioritised, notably the purchase of 16 ambulances at a cost of £2.3m and a new Informatics system at £0.2m. Both schemes have been approved by the Board.



The cash balance at the end of December increased again to £17.0m. The latest cash flow forecast has incorporated all known issues, including an element of catch up on capital spend, and reveals no liquidity concerns. The situation remains under regular review.

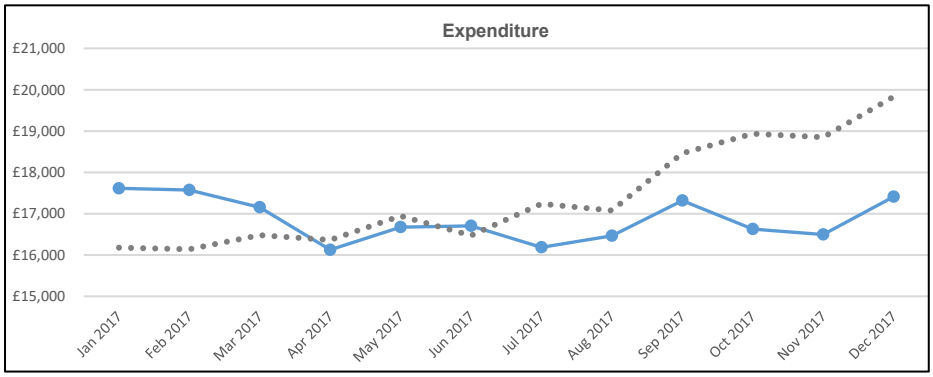
A working capital facility of £15.0m is available until January 2022, but there are currently no plans to make a further drawdown against this facility and the working capital loan balance of £3.2m is likely to be repaid in the current year.



A&E contract income is £5.1m below plan for the year to date due to lower than planned activity. After taking account of other, favourable income variances, the overall adverse income variance falls to £2.1m. The estimate of activity growth in the current year to date is zero per cent, compared to the planned 4.7%.

The way the new Computer Aided Dispatch System (CAD) counts multiple responses to a single incident has exacerbated the income and activity shortfall in the year to date. However, it has been assumed that this shortfall, being technical in nature, will be funded by commissioners within the full year settlement.

SECAmb Finance Performance Additional Information



Favourable expenditure variances, on both pay and non-pay, largely offset the adverse position on income. The favourable variances are mainly attributable to the service's ability to flex operational hours downwards to reflect commissioned levels of activity.

SECAmb Risk Narrative

SECAmb is working to improve its approach to risk management and has undertaken the following actions to improve the Trust's approach and capability in this important area:

Revalidation - Consistency of all Risks
1:1's scheduled with each of the Principle Risk Leads to review all the risks on Datix with a status of Open and Proposed for Closure.
Governance
This has included clarification of roles and responsibilities within Datix:
Principle Risk Lead – person who has the authority to progress the action(s).
Forum – Each forum will scrutinise progress of action(s) and manage controls assurance.
Accountable Executive - Responsibility for final sign off of risks.
For continuity, standardised narrative describing risk management responsibility and reporting criteria has been drafted for each operational Forum TOR i.e. Safeguarding, Infection Control, Medicines Governance etc. and this will be forwarded to each of the forum chairs during January 2018.
Audit
Audit programme will be developed and implemented, to provide assurance each Forum is undertaking its risk management responsibility and outcomes will be reported to the appropriate oversight; Group, Committee etc. in accordance with their terms of reference.
Assurance Only Authorised Frameworks Operating in SECAmb (Datix)
Scoping exercise completed to ensure the previous organisational risks recorded on SharePoint have been transferred onto Datix.
All Directorates and Operating Units (OUs) Reviewed for existence of local Risk Registers.
Education Programme
This is included within the improvement plan and will be delivered during 2018.
Risk Awareness poster being distributed to all operating units in January 2018.
Procedural Documentation
Review and development of procedural documentation described within improvement plan.

The Trust Risk Register and supporting action plans are being improved in the light of above and Risks identified / managed include the following themes:

- Performance
- Responding to procurement opportunities
- Estates and Infrastructure
- Incidents
- Training and clinical / work practice
- Health & Safety at Work Regulations
- Financial and sustainability
- Recruitment
- Continuity with Trust Executive
- Commercial
- Contracting
- Public Health
- Digital including informatics and information availability
- Data protection
- External operational issues

C - Delivery Plan Progress

1.0 Introduction

1.1 This paper provides a summary of the progress in the Delivery Plan. The Dashboard captures the high level commentary and associated Key Performance Indicators (KPIs) for this reporting period where appropriate.

1.2 Steady progress is being made to the CQC 'Must Do's' and issues are actively managed through the Compliance Steering Group. Further work is required to ensure that we have the appropriate data to ensure delivery for each of the projects.

1.3 The Project Plans will continue to be developed to provide assurance to the Executives that there is pace and grip of the projects and they continue to deliver the expected outcomes.

1.4 This report highlights the exceptions with more detail on progress detailed within the Delivery Plan Dashboard (Appendix A)

2.0 Service Transformation

2.1 Challenges remain with delivery of the Hear and Treat project, in particular the recruitment of sufficient clinicians. There are delays in implementing system changes to support non NHS Pathways triage by experienced clinicians, hence the project in this reporting period is RAG rated Red.

2.2 The Demand and Capacity Review is progressing well, with the reporting scheduled for late February 2018. The scope of this work has now been extended to include EOC which will extend the final reporting date. Phase 2 of the Ambulance Response Programme has been successfully implemented with a further phase expected to commence following completion of the Demand and Capacity Review.

2.3 Over the coming weeks a Service Transformation and Delivery Steering Group will be established to oversee the delivery of the projects and provide strategic direction to ensure the projects delivery to scope, time and quality.

3.0 Sustainability

3.1 Delivery of EPCR remains delayed, though a new version of the software has been released and successfully tested. This will be evaluated in Thanet OU before further decisions are made on progressing roll-out. The project RAG remains at Red for this reason. CIP plans are on track with this project, see Appendix B for further detail.

4.0 Compliance

4.1 Implementation of actions within Improvement Action Plans for all CQC projects is ongoing with provision of data to measure progress against outcomes and to ensure focus on quality.

4.2 Risk Management and Governance, Health Records and Clinical Audit CQC deep dive sessions are due to be held on Friday 19th January 2018.

5.0 Key messages on CQC Projects

5.1 Incident Management project is RAG rated Amber this reporting period due to the challenge the Trust is having to complete SI investigations within 60 days. To mitigate this risk, there is now a renewed focus on STEIS reporting which should see a significant improvement in next months' reporting period.

5.2 Safeguarding project is RAG rated Amber due to the e-learning training target below trajectory. Over the coming weeks, focus will be given to those Operating Units where training is below the trajectory to increase compliance rates.

5.3 Risk Management is RAG rated Amber due to the number of individual risks reviewed on Datix with Principle Leads is below trajectory and this is being closely monitored via the weekly Task and Finish Group. The Trust is also unable to evidence equipment servicing during this reporting period however there are planned actions within the project plan to address this and data will be available which will demonstrate progress for next reporting period.

5.4 For Governance and Health Records, the Project is RAG rated Amber due to the risk of the Trust failing to meet the target of all complaints being concluded within the Trust's target of 25 working days. A complaints review is currently being commissioned to help to mitigate this.

5.5 For EOC, the project is RAG rated Red due to the insufficient recruitment of staff which has led to calls not being answered and audited within the appropriate timescales. Additional resources within EOC has now been identified which should see an upward trend with call answer and audit in the next reporting period. In addition, some staff in EOC have been refocussed to support the audit process. External funding has also been secured to target EOC which should see a positive impact on call handling performance. During this reporting period, we currently do not have data for the number of audits to support 100% compliance.

5.6 Medicines Governance is RAG rated Amber due to there been no significant impact made with the number of key losses after the introduction of sign in and sign out of keys process. The project will be going into Intensive Support next week for a period of 4 weeks to identify further areas of support that may be required from Operations.

5.7 Infection Prevention and Control project is RAG rated Red due to the project currently being re-scoped. A revised project plan is required to be developed over the coming weeks to focus on the required behaviour change to ensure that the Trust is compliant.

5.8 Risk and Issue logs are continuing to be actively managed within Task and Finish Groups. Where it is deemed the group cannot meet a resolution, the risk/issue is escalated to Compliance Steering Group, Turnaround Executive and, where appropriate, intensive support.

5.9 Work is taking place to identify dependencies and interdependencies within projects and the impact of these on teams within the organisation.

Delivery Plan Dashboard

Reporting period from 12th January 2018 to Friday 19th January 2018

RAG Key:

Red	At significant risk of failure due to circumstances which can only be resolved with additional support
Amber	A risk of failure but mitigating actions are in place and these can be managed and delivered within current capacity
Green	On track and scheduled to deliver on time and with intended benefits
Blue	Completed

South East Coast Ambulance Service NHS
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Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Service Transformation & Delivery Steering Group	Increased Hear and Treat Project	Red	Red	Scott Thowney	Joe Garcia	n/a	25.07.2018	The objective of the project is to ensure ambulance dispatch rates by appropriately and safely increasing the percentage of Hear and Treat cases from 6% to 10% from emergency call volume. The project is on trajectory to establish baseline demand in order to model Hear and Treat. Clinical Navigation roles are now in place within EOC to ensure appropriate call/patient management. The project is above trajectory to integrate 999 with 111.	45 clinical supervisors in post in EOC	32	45	45	Project RAG remains Red. This is as a result of the continued difficulty in recruiting appropriate clinicians into the role. A paper has been presented that addresses one element as a potential option around the change to remuneration but it was felt that the primary reasons for staff leaving the role were not necessarily focused around pay. Therefore, the Executive have encouraged the team to look at other aspects of change that will improve the working shift patterns, educational development, use of decision support software, potential rotations through EOC into the other clinical roles and the enhancement of the clinical navigator position. The risks related to the delivery of the project are under review to ascertain whether any actions can be taken to mitigate risk.
									Hear and Treat Performance	6.0%	10%	10%	
	Demand and Capacity review	Amber	Green	Jon Amos	Steve Emerton	n/a	13.04.2018	It should be noted that with the additional scope of the EoC the final report for this programme of work will be April 2018 with regular interim reports provided up to this deadline (including February 2018). The overall intention of this review is to evaluate and assess differing models of operational delivery taking into account current service configuration and then developing a clear cost base for such. This will then be factored into current and future contract placement with Commissioners. The outputs will include: - Review of historic demand and development of a future capacity plan aligned to the ARP standards to include rota profiles and vehicle mix. - Case for Change to seek support from the wider system. - New contract process and payment model to support compliance with the new ARP standards. - Timeline and transition plan to move from current state to the new rota profile, fleet mix etc.	Creation of fit for purpose, agreed operational model and service level options, together with evidenced costs and aligned resource, for agreement with commissioners				The completion date has moved from 1 March 2018 to 13 April 2018 and this is due to the scope of the project now including EOC. This was signed off at the Demand and Capacity Review Oversight Group. The impact this also had is that there is an increase in project budget. In addition to this, discussion are taking place vis-a-vis contractual arrangements beyond 31 March 2018 such that the Trust and Commissioners continue within an agreed (Contract Plan) financial envelope. For this reason, and pending the completion of this transaction, the status of this project is shifted to Amber.
	Ambulance Response Programme - Phase 2	Complete	Amber	Sue Barlow	Joe Garcia	n/a	22.11.2017	ARP went live as planned on 22 November 2017. Phase 2 is therefore complete. Phase 3 is currently being agreed in terms of scope, timescales, budget etc.					No reported risks during this period.
Sustainability Steering Group	HQ PHASE 2	Amber	Red	Paul Ranson	David Hammond	n/a	01.09.2018	Coxheath EOC expansion (Phase 1) is now complete. 32 EOC positions have been implemented. Decision made at HQ Phase 2 Project Board on 14th December 2017 to close the Document Disposal work stream. This work will be captured under a new project.	32 new EOC positions are sufficiently equipped and ready to be used by an EOC member of staff to answer a 999 emergency call.	100%	100%	100%	Project RAG is Amber due to the risk that Clinical Education and Fleet, Logistics and Production may not have vacated Banstead by 31st March 2018. The favoured option for Clinical Education was Wray Park, however this may not be available anymore. Other options will now be considered. Fleet, Logistics and Production - options have been appraised, however a recommended option is yet to be agreed.
	Electronic Patient Clinical Records ("EPCR").	Red	Amber	Steve Topley	Jon Amos	n/a	29.03.2018	Temporary withdrawal of ePCR software to enable stability upgrades. Testing of software is now completed and will be trialled in Thanet following completion of a new QIA					Project RAG remains at Red due to ePCR being paused although it is intended to garner learning from the pilot and start creating project collateral and goverance. This will support the Trust's ability to deliver the project once learning is available from the pilot in Thanet.
	Financial Sustainability	Green	Green	Kevin Hervey	David Hammond	n/a	31.03.2018	On track to deliver. Some CIP schemes under-delivering. Additional CIP schemes under development.	£17.3 million current schemes fully validated	15.3m	£15.1m	£15.1m	Risk is assessed as being low (specifically the likelihood of non achievement of our aims) in this work area due to progress being made as planned, CIP targets being delivered. As with all projects, risk will be continually monitored.
									£1.0 million of financial deficit forecast	£1.0m	£1.0m	£1.0m	
	Incident Management	Amber	Amber	Samantha Gradwell	Steve Lennox	08.Nov.17	01.08.2018	The Trust Incident Management process has been a reactive process used to identify harm and it was frequently perceived as a vehicle to punish staff when they were seen as causing the identified harm. The aim of this project is to ensure the Trust has an effective incident management system that clearly identifies learning and that learning is valued and shared widely across the Trust to continually drive improvements in safety.	20% increase in overall incident reporting (Monthly)	751	556	556	This area has been RAG rated Amber due to the combination of positive and negative test measures. Incident Management is progressing to plan whilst Serious Incident management is not to plan.There has been a renewed focus and changes to Duty of Candour which should give 100% next month and renewed focus on STEIS reporting.This should significantly improve the KPIs. The principle risk is the challenge the Trust is having to complete SI investigations within 60 days.
									>75% of incidents closed within time target [SECAmb Target]	79.0%	59.0%	75.0%	
									90% of Serious Incident investigations will be completed within 60 working days.	20.0%	74.0%	90.0%	
									Serious Incidents Investigations submitted to CCG.	15	20	20	
									100% of Serious Incidents compliant with 72 hour STEIS reporting	40.0%	50.0%	100.0%	
									96% of incidents graded as near miss, no harm or low harm	94.0%	90.0%	96.0%	
									80% of incidents where feedback has been provided	5%	50%	80%	
									100% compliance with Duty of Candour for SIs	80%	90%	100%	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
Compliance Steering Group	Safeguarding	Amber	Green	Philip Tremewan	Steve Lennox	01.Dez.17	31.08.2018	The Trust did not fully appreciate its safeguarding obligations or understand the wider aspects of safeguarding. The development of the Safeguarding CQC Improvement Action Plan has allowed greater focus on the Trust-wide approach to Level 3 Safeguarding Children training, both face to face and e-learning. The Action Plan is divided into 6 key objectives aimed at addressing the concerns raised following the most recent CQC inspection and the Prof Duncan Lewis report into a culture of bullying and harassment at SECAmb. Weekly Task & Finish Group meetings scrutinise the Action Plan with assurances gained that positive progress is being made across each objective.	The number of staff trained to level 3 Safeguarding	58.0%	68.0%	85.0%	Project RAG is Amber from Green. Although we are above trajectory to deliver face to face training by 31st March 2018, the e-learning element is below trajectory. The uptake for e-learning has been discussed at Operational teams to develop a plan to deliver training to Operating Units that are falling below trajectory. In further mitigation, greater focus by the Project Delivery Lead will support those Operating Units falling below trajectory. There is a risk that unless a focus is placed on the e-learning module, we could the compliance standard after the planned date.
									90% of staff, when asked on audit, feel adequately prepared to identify safeguarding concerns and know how to obtain assistance. This will be measured through quality assurance visits and fed back through appraisal bulletins, local governance groups. No data as yet TBC.	94.0%	n/a	90.0%	
	Risk Management	Amber	Green	Samantha Gradwell	Steve Lennox	19.Jän.18	31.08.2018	Risk Management governance and systems were ineffective and roles and responsibilities were unclear. The Trust had an IT system that was not fit for purpose to manage the recording of the servicing data of medical devices. This caused input issues which were further aggravated by a lack of any real audit process being in place. The aim of the project is to ensure that the Trust will have effective risk management governance and systems, with clear roles and responsibilities identified. Learning is valued and shared widely across the Trust to continually drive improvements in safety. All Medical devices will be serviced, maintained and available to all operational members of staff in accordance with the Medical Devices Management Policy, and security of all Trust operational premises and ambulance vehicles will be upheld. The project is currently receiving additional support from other key teams in preparation for the CQC Deep Dive (19th January 2018) which is helping to support the issues around data.	Individual Risks Reviewed on Datix With Principle Risk Lead (includes training & awareness)	72	80	140	Project RAG is Amber from Green due to the number of individual risks reviewed on Datix, with Principle Risk Lead below trajectory; we should be at 80 and currently reporting 72. This will be monitored weekly via the Task and Finish Groups. We have no current data for the auditing of Medical Devices to enable the monitoring of progress, however the data should be available for next reporting period. The project is above trajectory on 2 measures - achieving individual risks reviewed that are not on Datix and identifying the number of Risk Registers that may be held locally. The main risk within this workstream is our ability to evidence equipment servicing requirements, but the improvement team are confident that the planned actions will deliver to plan.
									Operational sites & Directorate Risk Registers Identified Other than Datix	29	25	29	
	Governance, Records & Clinical Audit	Amber	Green	Fiona Wray	Fionna Moore	19.Jän.18	31.03.2018	The Trust did not complete Patient Clinical Records accurately, there was a lack of identified training opportunities for staff and there were delays and inefficiencies in processes involving the recovery and scrutiny of health records. The overall aim of the project is to increase the quality and efficiency of the Trust's completion, storage and audit of health records. The Patient Clinical Record form (PCR) is to be redesigned to increase ease and efficiency of completion, and therefore elicit greater compliance and quality. The current PCR audit system is a check of completeness of the form against the requirements of the Minimum Data Set. A process for scrutinising the quality of the data entered is in development.	Patient Records will be completed accurately and stored securely	94.7%	N/A	100.0%	Project RAG is Amber from Green. There is a risk relating to the capacity of the health records team's ability to meet the demand for the scanning and validating of PCRs. Staffing levels are in the process of being increased through the use of temporary staff and exploring the use of an external company to scan those forms not compatible with Formic. Consideration is also being given to obtaining additional scanners or industrial scanners, and shift working.The risk around the agreement of a Quality Improvement methodology remains in place. Although the Trust has now agreed a methodology, the practical details and plan for implementation are yet to be defined.
									Incidents will have Patient Clinical Record linked	86.2%	N/A	90.0%	
	Complaints	Amber	Green	Louise Hutchinson	Steve Lennox	14.Mär.18	31.03.2018	There was a lack of attention paid to complaints and the value of learning from them. Sufficient priority had not been afforded to these processes throughout the organisation. The aim of the project is to restore complainant/patient confidence in our service; to generate improvements in the treatment and service provided to patients and their carers as a result of learning from complaints; and to reduce the likelihood of problems recurring, and raise awareness among staff of the value of complaints as a tool for improvement by sharing the learning from complaints widely. Overall improvement has not been as rapid as expected owing to an issue with recruiting to a dedicated post, hosted by EOC, to investigate low-level complaints about EOC and ambulance delays; a person was due to start in post on 8 November 2017 but withdrew their candidacy that day, however another person has now been recruited and started on 2 January 2018. The impact this has had on the project is that there were capacity issues which caused many EOC complaints received in September 2017 and October 2017 to breach. Performance for NHS111 is consistently high, with between 88% and 100% of complaints completed within timescale across the last three months. A&E performance has also improved, from 36% in October, to 62% in November, to 63% in December 2017.	Complaints will be concluded within the Trust's target of 25 working days.	42.0%	n/a	80.0%	One of the risks associated with the achievement of the complaints response timescale is "The Potential for REAP level eroding protected admin time dedicated to complaints investigation". During December and early January, the Trust experienced extremely high levels of demand, resulting in the declaration of BCIs on 26 December, 27 December and another from 30 December – 2 January. As a result, Operations Managers were tasked with providing support in the control room hub, which depleted the admin time available to them to complete complaints investigations. In addition, the Christmas and New year period always sees a high level of annual leave, and this year many staff succumbed to sickness of one form or another, the Patient Experience Team included, all of which has had an impact on staff's ability to keep track of complaints deadlines and complete complaints within timescale. There is a risk that we may not be sufficiently compliant with our 25 day standard trajectory without a review of complaints. The review of complaints is currently being commissioned.
									Evidence of learning from at least 95% of complaints that are upheld in any way.	Data not due till 31st Jan 2018	n/a	95.0%	
									100% of Area Governance Meetings, Clinical Evaluation & Effectiveness Sub-Group meetings will have shared learning from complaints.	Data not available	n/a	100.0%	
	EOC	Red	Green	Sue Barlow	Joe Garcia	18.Apr.18	31.08.2018	The Trust had not invested sufficiently in recruitment and retention within the EOC. Moving EOC West to Crawley has also had an impact on recruitment. Staffing and supervision levels are impacting significantly on the Trust's ability to meet the requirements for clinical supervision, call answering and call auditing set out in NHS Pathways. The aim of this project is to recruit, train, retain and appropriately deploy sufficient levels of staff in all EOC roles to achieve the target for call answering, clinical supervision and call auditing. Clinical Supervisor Recruitment and Retention is progressing which has an interdependency with the Hear and Treat Project. Call audit figures remain significantly adrift of the trajectory that would meet the requirement of approx. 1300 by April 2018. Staffing capacity is an issue. Outsourcing the function is being considered but has so far not developed into a sustainable plan/model. To help to mitigate this, the EOC Audit User Group is now established and is working with the 111 to develop the auditing and tracking tools and to establish a dedicated team who will complete future auditing. Call answer is adrift and impacts heavily by the EMA recruitment issues. EMA recruitment levels are now rising with January seeing 23 new recruits. Plans are also now in place to begin reviewing EMA rotas with interviews arranged for EMAs.	Clinical supervisors in post in EOC	32	45	45	Project RAG is Red from Green due to the recruitment of staff which has led to calls not being answered and audited within the appropriate timescales. The recent issue concerning the inability to retrieve calls for 3 weeks in December 2017 has now created a backlog. To mitigate this, resource in 111 and EOC is now refocused to carry out audits. Discussion with Commissioners have previously agreed additional funding from November 2017 to target EOC staff to support call handling performance.
									The audits will take place on a monthly basis via an audit function on the info system which was created by SECAmb	Not available	Not available	100.0%	
									95% of calls answered within 5 seconds.	38.0%	80.0%	95.0%	
									FTE EMAs in post within EOC	154	164	171	
	Performance Targets and AQI's	Amber	Green	Chris Stamp	Joe Garcia	31.Aug.18	30.09.2018	The Trust has consistently performed poorly against some of the national performance indicators. The objective of this project is to improve compliance with national clinical and response time ambulance quality indicators. The project remains on trajectory to meet response time standards. (Category 1, Category 1T, and Category 2.) As of August 2017 50% of clinical AQI targets have been achieved with significant improvement to the remaining trajectories. Static planned targets have been included for baseline reference. However, we aim to meet or exceed national averages, which will change monthly.	Category 1 (90th centile) mm:ss	15.13	15.00	15.00	Project RAG is changed to Amber as the project plan is below trajectory to deliver the required performance. Further detail is set out in the supporting Integrated Performance Report. Several dependency workstream feed into this project. These remain on trajectory and are anticipated to further improve the primary KPI outcomes and remaining CQC should dos by their target dates. Internal and External/System risks and issues (for example Hand Over Delays and Staff Retention) will continue to have an impact on performance but are managed via detailed disussion at weekly Task and Finsih group.
									Category 1T (90th centile) mm:ss	21.28	30.00	30.00	
									Category 2 (90th centile) mm:ss	38.50	40.00	40.00	
									STEMI (care bundle)	64.40%	81%	73.80%	
									Stroke (care bundle)	95.60%	98%	97.50%	
									Cardiac Arrest Survival (Combined)	25%	20.50%	19%	
									ROSC (Combined)	40.50%	41.50%	42.30%	
	Medicines Governance	Amber	Green	Carol-Anne Davies-Jones	Fionna Moore	19.Feb.18	31.03.2018	The Trust did not have insufficient resource and inadequate governance and oversight of medicines. The aim of this project is to identify improvements that need to be made with regards to structures, systems and training. This will guide medicines optimisation within Trust to ensure it is integrated into our systems, work practices and culture at all levels from individual practitioner to Board. Progress continues on the surrounding of safe, secure storage of medicines and the culture change around medicines, including further strengthening governance process, pathways, legislation and on-going education/training as well as implementation of NICE good practice guidance. To measure progress we now have data on CD Breakages, Drugs Cabinet Key Losses, Compliance % per OU and Medicines Quiz Passes.	Medical Quiz Passes	470	575	2425	Project RAG is Amber from Green as we have not yet seen an impact on key losses with the introduction of the sign in/sign out of keys. This will continue to be monitored through the Task and Finish Group.
									Compliance per Operating Unit	93.30%	96.50%	100%	
									Drug cabinet key losses	21	0	0	
									CD Breakages	20	0	0	

Work stream	Project Name	Project RAG Current Period	Project RAG Previous Period	Project Lead	Executive lead	CQC Deep Dive (where applicable)	Project Completion Date	High-level Commentary	KPI / Outcome	Actual	Planned	End Target	Risks and Issues to Project Delivery
	999 Call Recording	Green	Green	Barry Thurston	David Hammond	n/a	30.03.2018	The voice recording system has failed to record all 999 calls since January 2017. The aim of this project is to ensure that we have a robust voice recording system and the Trust will keep 100% of completed and accurate recordings of 999 calls. 24 calls have been audited throughout November 2017 and no issues found with call recording. 24 hour audits suspended in December 2017 due to winter pressures but auditing has started again from 05 January 2018. Daily testing of calls continue and if they are any issues found, this will be escalated to the Compliance Steering Group. A business case was approved at Trust Board (11th January 2018) to replace both the voice recording and telephone system. A project mandate and QIA will be produced shortly with a new project plan developed.	100% of all 999 calls recorded Auditing of calls take place on a weekly basis from 05 January 2018 (circa 2500 calls) Approx. 15 sample calls carried out				No reported incidents during this period and proposal to replace Telephony and Voice Recording system has been approved and project mandate QIA to be developed in the coming weeks.
	Infection Prevention and Control	Red	Green	Adrian Hogan	Steve Lennox	n/a	TBC	Since November 2010 the Trust has had one person delivering the IPC programme on a day to day basis and this has led to a disconnect in the knowledge and awareness that staff delivering patient care require to ensure that no avoidable healthcare associated infections (HCAI) occur. The last two CQC inspections have highlighted the lack of resources within the IPC Team and have also evidenced poor IPC practices from staff including, hand hygiene, compliance to Bare Below the Elbows (BBE), lack of actions shown following IPC audits and cleanliness standards in vehicles and the environment. The aim of this project is to help support the engagement of staff and embedding of IPC practices across the Trust and will focus on compliance to hand hygiene procedures, compliance to BBE, cleanliness standards for the vehicles and the environment, ensure there are audit tools to provide assurances, support staff following an untoward incident and embedding IPC into practice across all structures of the Trust and most importantly to the staff. A workshop was held on 11 January 2018 to determine the scope of the project and a Project Mandate and QIA is currently being developed.	KPIs and Outcome measures unconfirmed within this reporting period				Project RAG is Red from Green. A Project Mandate and QIA have not been signed off. A workshop was recently held to identify the scope of the project and an update will be provided in the next report. The principal risk is that hand hygiene compliance will not be within trajectory. However a revised improvement plan will focus on the required behaviour change.
Culture and Organisational Development Steering Group	Culture Change	Green	Green	Mark Power	Steve Graham	n/a	31.07.2018	The culture of SECAmb has been poor with lack of accountability, lack of support, openness and honesty, acceptance of poor practices and behaviours, including bullying and harassment. Communication has also been poor between senior leadership and the wider workforce and there has been poor awareness and understanding of the Trust's vision, strategic objectives, core values and behaviours. The aim of this project is to to make substantial improvements to SECAmb's culture, working environment, and people management and leadership, through the involvement, engagement and recognition of staff, across all levels and all roles. Whilst a significant element of this Action Plan is focused on establishing, promoting and embedding agreed core values/behaviours which will underpin organisational culture change, it also reflects the broader span of OD activity led by the HR Directorate. The combined delivery of the objectives and actions included within the Improvement Action Plan will make a substantial contribution to enhancing the working lives of SECAmb's multi-disciplinary staff, increasing productivity and performance, and improving the quality of care provided to patients and Service users. A survey has been conducted with staff on behaviours with a view to bringing proposals to Executives and then the Board over the next month, a document outlining our approach to OD and Culture has been drafted and will be shared with Executives and the Board. The appraisal rate is on track, and plans are in place to develop trajectories with each OUM to ensure the target is met. Milestones within reporting period have been delivered. Our embargoed survey results have been received and work is underway to develop the response plan engaging with staff. The review of the enabling infrastructure has taken place.	Appraisal completion rate (completion by 30th April 2018)	65.0%	53.0%	80.0%	No reported issues in this period. There are reported risks in relation to resources within the Trust to deliver the plan. There is lack of awareness of the Culture and OD across the organisation. Both risks have adequate controls in place so hence the project RAG for this reporting period remains Green.
									Staff Survey completion rates	39.6%	N/A	40.0%	
Strategy	Enabling Strategy	Amber	First reporting period so no previous RAG	Jayne Phoenix	Steve Emerton	n/a	31.03.2018	22 enabling strategies, of which 4 are complete, 5 are overdue but there is remedial action taking place now to get them on track. The remainder are work in progress.	All strategies completed by agreed timescales.				This project is RAG rated Amber due to the 5 currently delayed strategies however, we need to recgonise some of these are interdependent on each other
	Annual Planning	Amber	First reporting period so no previous RAG	Jayne Phoenix Philip Astell	Steve Emerton	n/a	To be confirmed	There is a Strategy meeting on Monday 22nd January 2018 of the Lead with the Chief Executive. The overarching strategy will be reviewed throughout February. In the light of findings of the Demand and Capacity Review. Further review in May 2018. Note that EOC is now added to the Demand and Capacity Review. Business Planning is underway but in the absence of National Guidance at present, this will also be influenced by the outcome of the Demand and Capacity Review.	Completion of budget planning, CIP planning, strategy review, workforce planning and operating plan - date to be confirmed				This project is RAG rated Amber due to the lack of National Planning Guidance and the outcome of the Demand and Capacity Review
	Quality Improvement	Amber	First reporting period so no previous RAG	TBC	Steve Emerton	n/a	To be confirmed	Adoption of the quality improvement methodology from IHI is currently under discussion and review with the Executive.	An approved quality improvement methodology is agreed				This project is RAG rated Amber due to a methodology not yet approved.
	Commissioner and Stakeholder Alignment	Amber	First reporting period so no previous RAG	TBC	Steve Emerton	n/a	To be confirmed	Commissoning and Engagement strategy will include plans to focus engagement immediately on STP Leads/CEOs/Accountable Officers. The initial focus will on the outputs of the Demand and Capacity Review.	Alignment of commissioner and stakeholder expectations with delivery and operating plans for 2018/19				This project is RAG rated Amber due to the dependency on the Demand and Capacity review timetable.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Meeting of the Council of Governors
29 January 2018

Held in public

10:00

Nexus House, 4 Gatwick Road, Crawley RH10 9BG

Your service, your call

D1 - Review of Outcomes and Achievements in relation to the Duncan Lewis Bullying and Harassment Report

January 2018

Author: Ian Jeffreys

1. Overview

Following on from receipt of the Professor Duncan Lewis Bullying and Harassment report commissioned by the Trust, several actions have taken place to engage with staff to determine how they felt and what we could do better. This report aims to provide an update as to where we are and what we have achieved to date.

2. Focus Groups

Throughout August and September 2017 a series of focus groups were run across the trust with the findings shared with the Executive Team via a very comprehensive paper written by Steve Singer (Head of Learning and Organisational Development).

The report made many recommendations including:

- Defining Bullying and Harassment
- Taking action against known bullies
- Ensuring that policy is applied fairly
- Training managers
- Improving induction
- Engaging the workforce
- Introduction of a Wellbeing Hub
- Review of policies
- Local action plans

The paper culminated in the development of the Culture and OD Steering Group to take forward these actions via an Executive lead approach.

3. Culture and OD Steering Group

The Culture and OD Steering Group is chaired by Steve Lennox (Executive Director of Quality and Nursing) and lead by Mark Power (HR Consultant) with support across a number of functions.

The group has 3 main objectives:

1 (Staff Engagement): By 31 March 2018, achieve substantial, measurable and sustainable improvements in: the proportion of staff participating in regular appraisal; the effectiveness of communications with staff; addressing bullying and harassment in the workplace, and responding to feedback received via the annual Staff Survey.

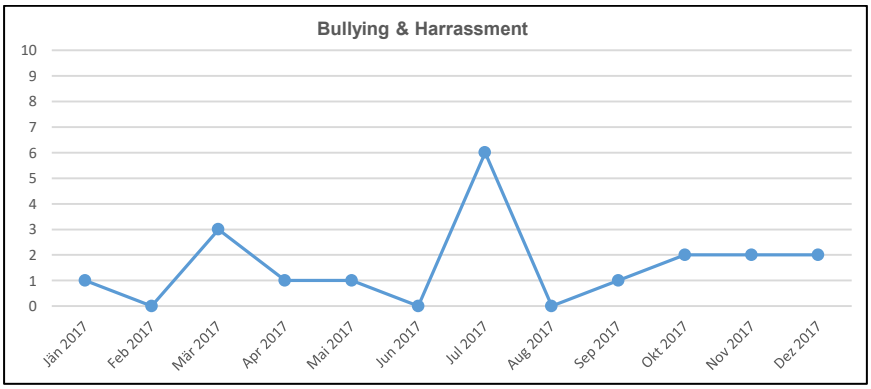
2 (Culture Change): By 31 January 2018, deliver Phase One (methodology and principles; high level plan; review of enabling infrastructure) of a Two-Phase programme of sustainable Culture change that has a measurable and positive impact in improving the working environment, staff experience, and service performance.

3 (Culture Change): By 31 July 2018, implement Phase Two of a two-phase programme which will lead to a sustainable Culture change that has a measurable and positive impact in improving the working environment, staff experience, and service performance.

4. Progress to date

B&H focus group findings report reviewed by Executive
B&H focus group findings report published
B&H action plan developed and branded as Cultural Development
Staff engagement champions recruited
IGNITE supported Cultural Development via a complete review of HR policies
Plan in place for all policies updated by March 2018
Quarterly Pulse Survey implemented
Operations Directorate restructured
Values refresh under way
Implementation of ACTUS appraisal system
ACTUS 360-degree feedback in development
Assessment Centre approach to all recruitment implemented
Investigations skills training for managers scheduled for February 2018
Wellbeing Hub implemented
ASK HR roadshow established

5. Facts and Figures



19 reported cases of B&H over the last 12 months

0.65% of workforce

South East Coast Ambulance Service
NHS Foundation Trust

Supporting Our Improvement Journey

SECAmb's Approach to Culture and Organisational Development: 2017-2020

SECAmb's Vision and Mission

Our Vision

To support our staff to provide a caring, high quality and efficient urgent and emergency care service to our communities

Our Mission

To deliver our aspiration to be better today and even better tomorrow for our people and our patients

Realising our **Vision** and **Mission** will underpin the achievement of our **Five-year Strategy**

Introduction

by the Chief Executive

The Trust's Five-year Strategy and current Delivery Plan aim to respond to a number of organisational challenges facing SECAmb. Many of these challenges are historical, and effectively addressing their root causes is recognised as being a critical factor in achieving future high performance.

Earlier this year many colleagues took the opportunity to share with the Board, through focus groups, their thoughts on what it is like to work for SECAmb, what they thought of our culture and what behaviours they would like to see demonstrated by everyone who works for our Trust - regardless of their role or seniority.

These views, along with the Care Quality Commission (CQC) findings and the Lewis report into perceptions of bullying in the Trust, helped us to frame a new Vision and Mission for SECAmb. To ensure these are more than just statements of intent, we have set in motion an ambitious Culture and Organisational Development (OD) programme of work.

The purpose of this document is to summarise why this programme is important and explain the approach being taken in its delivery.

Ultimately, we aim to promote an inclusive, supportive and respectful culture based on collective achievement of shared goals, through aligned values and behaviours. Establishing and maintaining such a culture will ensure we all share in a successful future that benefits all of our staff, our patients, our service users, and our partner organisations.

Daren Mochrie QAM
Chief Executive Officer

Context

Why we are concerned with culture and OD

Culture is an important consideration for any organisation, and is largely defined by the behaviours, beliefs and attitudes of employees - how they interact with and treat each other and how they are perceived by the people they serve. An organisation's culture, whether healthy or otherwise, is largely determined by its senior leaders, who 'set the tone' for everyone else.

A formal inspection of the Trust, conducted by the Care Quality Commission (CQC) in May 2017, reported issues of concern associated with both the 'Effective' and 'Well-led' domains. These and other concerns spanning all domains served to highlight, within SECAmb, an organisational culture characterised, in general, by: low levels of staff engagement and satisfaction; decision-making and influence vested in the few; an unwillingness by some to take responsibility and accountability for their actions; and insufficient understanding of the organisation's vision and strategic objectives. This prevailing culture led, in some areas, to an acceptance of under-performance, at individual and team levels, and a reluctance to address poor practice and behaviour. The conclusions of the later Lewis Report into perceived bullying and harassment in the workplace further highlighted some shortcomings relating to staff behaviours and attitude.

The perpetuation of such a culture would almost certainly guarantee that we will fail to meet our statutory duties and obligations as a Foundation Trust, and also fail our staff, patients and service users. The present Trust Board is not tolerant of such failings and is fully committed to leading positive and sustainable change.

In promoting proactive and progressive OD interventions and culture change initiatives, the following are recognised as being key drivers:

- There is a clear link between a motivated, committed and well-informed workforce, and quality of care provided to service users.
- Successful change requires the application of empowered, supportive and intelligent leadership, at all levels, which has service quality, patient-centred care and efficiency at its heart.
- Staff must be appropriately informed of, and effectively engaged in, supporting the delivery of SECAmb's Five-year Strategy, whilst also being involved in determining, and subsequently applying, the Trust's 'signature' behaviours.
- There is widespread acknowledgement of the direct link between leadership capability and sustained high performance (the contribution and motivation of our staff are key to our collective achievements).
- There is increasing evidence that where health professionals are provided with clear information relating to the resources associated with their services, together with the authority and accountability to make improvements and efficiencies, then improved quality and better care results.
- The NHS Constitution pledges to "engage staff in decisions that affect them and the service they provide. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families" (Section 4a).
- Where staff are encouraged and supported to work to the top of their potential, it follows that all areas of the organisation will work more effectively: efficiency will improve; waste will be reduced, and overall performance will be enhanced.

Our approach

How we are responding to past failings and their root causes

The consequences of accepting poor practices and behaviour are only too evident from contemporary reports of organisational failures, both within and outside of healthcare. Where such acceptance is widespread, managers, clinical leaders and staff are disempowered and inhibited from making decisions or suggestions for improvement, and even from owning up to mistakes.

Ultimately, a culture that fails to promote engagement, inclusion and distributed responsibility, accountability and decision-making, is likely to focus on 'doing the system's business, rather than the patients'.

We recognise that the principal root causes of our recent organisational failings include:

- lack of accountability, performance management and assurance;
- inconsistent change management procedures;
- lack of support, openness and honesty;
- acceptance of poor practices and behaviours, including bullying and harassment;
- poor people management practices;
- ineffective communication between senior leadership and the wider workforce;

  and

- lack of awareness and understanding of the Trust's vision, strategic objectives, core values, and expected behaviours.

SECAmb's Board is committed to building upon current progress, strengths and opportunities to create the right environment in which to achieve a sustained and successful Service. Our approach in doing so aims to promote and maintain a 'healthy organisation' that:

- promotes trust, openness and engagement;
- engenders a 'can do' and flexible approach by all staff, encouraged by supportive working processes;
- fosters competent, confident and authentic leadership that inspires high performance, and encourages and supports personal and professional development;
- builds effective partnership working, both within SECAmb and with our partner organisations, and expects personal responsibility and accountability at all levels;

  and

- achieves high levels of staff motivation, satisfaction and wellbeing.

Through this approach we are determined to put right the failures of our past and ensure that SECAmb is recognised as an attractive organisation in which people are proud to work and contribute, and are able to fulfil their ambitions.

Our culture and OD priorities and commitments

Our priorities are focused on five key interdependent themes:

By focusing on these five themes we aim to fulfil the following principal commitments:

- **Culture Change**
  With the support and engagement of staff and volunteers, refresh the Trust values and behaviours.

- **Effective Leadership and Management**
  Develop leadership and management competence at all levels, through our new selection and assessment processes, and development programmes.

- **Staff Engagement**
  Ensure all staff and volunteers have clear objectives, which align with SECAmb's Strategy, and a plan for their personal and professional progression, set through regular appraisal, and performance and development conversations.

- **Inclusion and Wellbeing**
  Make further improvements to the way in which we support the physical and mental health and wellbeing of our staff and volunteers.

- **Clinical Education**
  Improve our working with education and partner organisations to develop and implement career pathways and educational interventions that support effective clinician decision-making and practice.

An important consideration in achieving our objectives is to ensure that we have an effective **infrastructure** (i.e. working practices; clear lines of accountability and responsibility; policies and procedures) that enables the necessary improvements to be made and sustained.

Our focus on shared values and behaviours as a key enabler

A central plank of our Culture and OD approach is the identification of the shared values and behaviours we all expect to see demonstrated by everyone who works for SECAmb, regardless of their role. In taking full account of the views of staff, we are agreeing a set of values and behaviours that we believe will:

- help improve the way we all work together;
- enhance our environments;

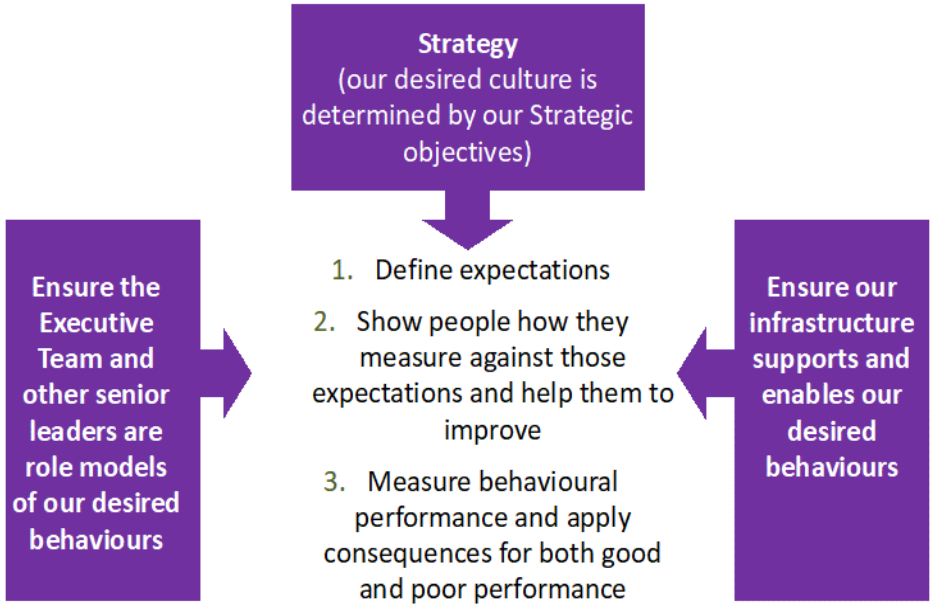
and

- have a positive impact on the care we provide to our patients and service users.

Through a rolling series of interactive development sessions, we will work with staff at all levels (including the Executive Team, and senior managers) to ensure they are equipped with the skills they need to adopt and apply our desired behaviours, and support others in doing so.

Again, we will also take appropriate measures to ensure that our organisational policies and procedures, and operating systems and processes align with our values and desired behaviours.

A summary of our culture change methodology



How we will deliver

A summary of our intentions

Commitment	Intended Outcomes	Key Enabling Actions
With the support and engagement of staff and volunteers, refresh the Trust values and behaviours.	• The consistent demonstration of our shared values and behaviours, by all staff, will positively impact all areas of our organisational performance. • Improved staff satisfaction and experience. • Improved patient satisfaction and experience. • Better clinical outcomes. • Substantial reductions in reported inappropriate behaviour.	• Reviewing, revising and agreeing our desired values and behaviours. • Equipping staff with the skills and understanding needed to adopt and demonstrate our desired behaviours, and to support others in doing so. • Being clear about the consequences of both good and poor behaviour, and being consistent in the application of those consequences.
Develop leadership and management competence at all levels, through our new selection and assessment processes, and development programmes.	• Leaders and managers have clear lines of responsibility and accountability. • Consistently high levels of leadership and management competence and confidence. • Leaders and managers are role models of SECAmb's values and behaviours. • Talent and potential, at all levels, is recognised and developed.	• Reviewing and improving the effectiveness of our leadership and management development interventions to ensure they are aligned with our Strategic objectives, and our values and behaviours. • Developing and implementing a 'staff lifecycle management' framework. • Capitalising on the opportunities provided by national leadership development programmes. • Developing and implementing a talent management and succession planning framework.

Commitment	Intended Outcomes	Key Enabling Actions
Ensure all staff and volunteers have clear objectives, which align with SECAmb's strategy, and a plan for their personal and professional progression, set through regular appraisal, and performance and development conversations.	• Improved organisational, team and individual performance. • Increased job satisfaction and better staff experience. • Reduced staff turnover. • SECAmb recognised as an attractive place to work. • Improved patient experience and clinical outcomes.	• Implementing ACTUS - an online appraisal and Personal Development Record. • Developing a tool to monitor and manage SECAmb-wide adoption and application of desired behaviours aligned to performance management processes. • Enabling staff self-service: e-staff record, e-expenses, e-procurement.
Make further improvements to the way in which we support the physical and mental health and wellbeing of our staff and volunteers.	• Improved staff health and wellbeing. • Bullying and harassment close to zero - if it is found to exist it is not tolerated. • Improved recruitment and staff retention. • SECAmb recognised as an attractive place to work.	• Incorporating a focus on improving wellbeing, and addressing bullying and harassment, into all culture change activities. • Fully implementing our agreed approach to health and wellbeing. • Fully establishing our wellbeing 'hub'. • Developing and implementing progressive supporting Policies.
Improve our working with education and partner organisations to develop and implement career pathways and educational interventions that support effective clinician decision-making and practice.	• Staff, patients and partner organisations fully involved in the design and delivery of clinical education curricula. • Improved evidence-based practice. • Education curricula are effectively governed, quality assured and evaluated, and are responsive to Ambulance Quality Indicators.	• Developing career pathways and interventions that support staff with clinical decision-making. • Developing and implementing a comprehensive and inclusive clinical education programme. • Developing and implementing personalised learning packages. • Developing and implementing comprehensive quality assurance and evaluation standards. • Ensuring that access to learning is fare and inclusive.

Leadership

Chief Executive

Responsibility: Sponsor
Tel: 01737 364401
Email: daren.mochrie@secamb.nhs.uk

Director of Human Resources

Responsibility: Accountable Executive Lead
Tel: 07773 361903
Email: steve.graham@secamb.nhs.uk

Head of Learning and OD

Responsibility: Delivery Lead
Tel: 07825 100647
Email: steve.singer@secamb.nhs.uk

South East Coast Ambulance Service NHS
NHS Foundation Trust

D3 - Effectiveness of the Appraisal System

Overview

It is well recognised that staff with clear objectives and feed back on their performance deliver better outcomes.

SECAmb has traditionally used a paper based appraisal system to provide this feed back to staff. This has limited success in relation to quantity of appraisal carried out and quality of the interaction with only 48% of having an appraisal in the year 2016/17.

In late 2016 the OD team identified an online system (Actus) that provides a much more structured approach to these key conversations and also provides reporting of the numbers.

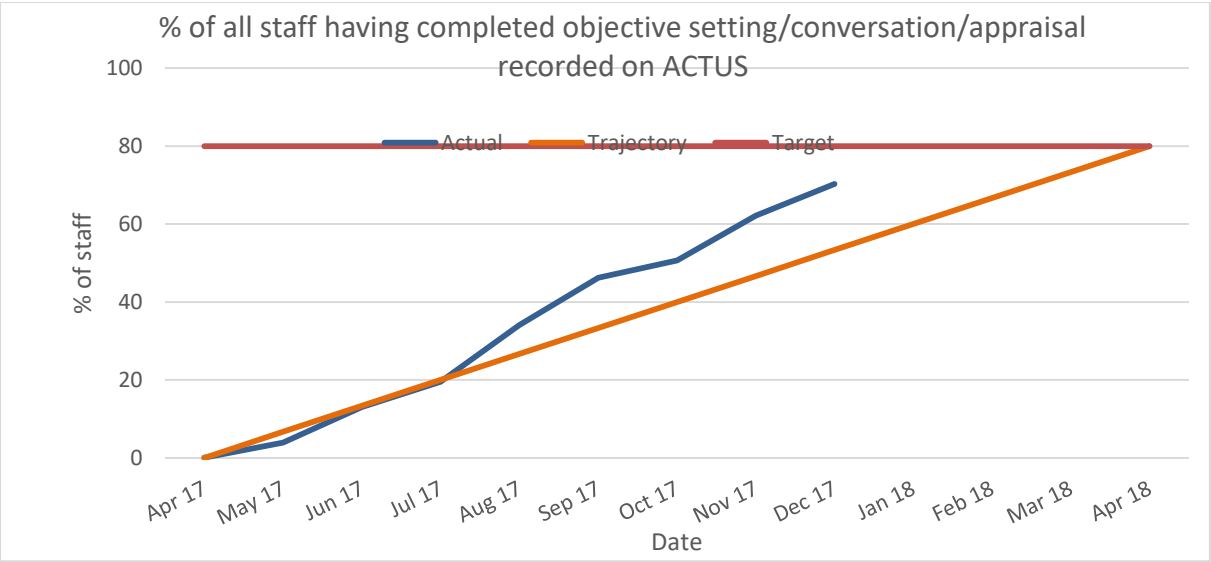
This system was procured and during January 2017 – March 2017 a programme of training and awareness raising was undertaken prior to launch.

In April 2017 the Trust launched Actus and has started recording the career conversations between managers and employees, these can take the form of objective setting or appraisal conversations.

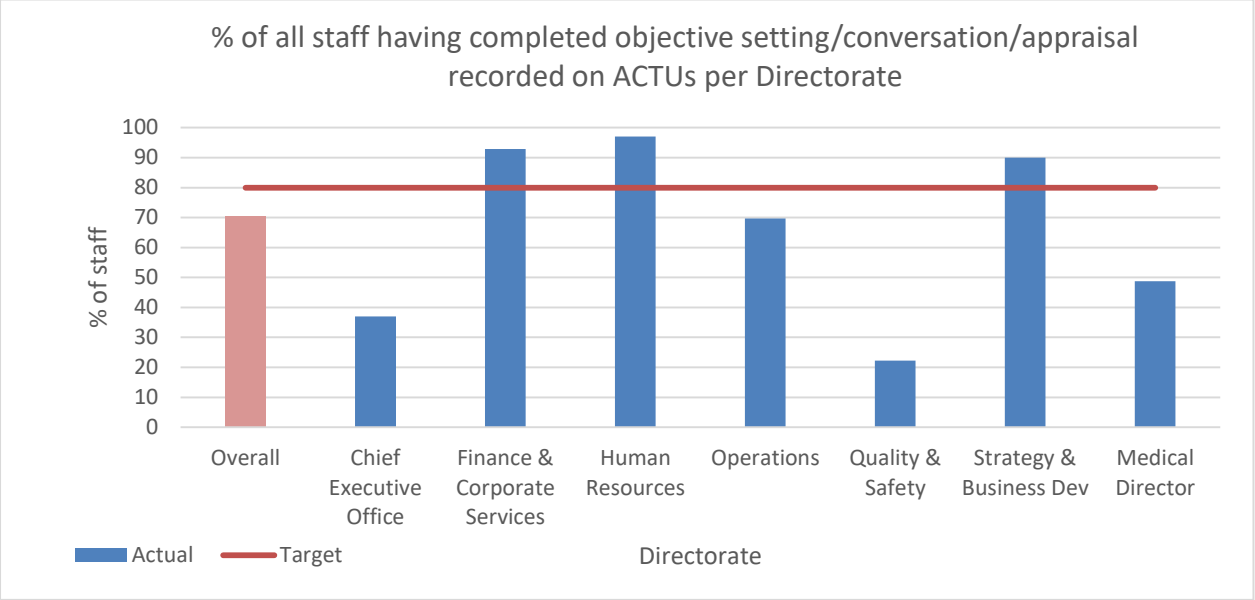
Update on Progress

The graph below shows the current progress against our target of 80% of staff having a completed career conversation recorded on Actus.

The council will see that we are above the trajectory for delivery of the target.



This is also monitored by Directorate as shown below



We also monitor progress by Operating Unit

	Appraisal			
	Headcount		Percentage	
	Completed	Not Completed	Completed	Not Completed
Ashford OU	80	41	66.12%	33.88%
Brighton OU	98	80	55.06%	44.94%
Chertsey OU	100	25	80.00%	20.00%
Dartford & Medway OU	86	125	40.76%	59.24%
Gatwick & Redhill OU	147	93	61.25%	38.75%
Guildford OU	111	34	76.55%	23.45%
HART	63	21	75.00%	25.00%
Paddock Wood OU	65	50	56.03%	43.48%
Polegate & Hastings OU	106	120	46.90%	53.10%
Tangmere & Worthing OU	179	22	89.05%	10.95%
Thanet OU	149	4	97.39%	2.61%
OU Admin & Management - Kent	55	21	72.37%	27.63%
OU Admin & Management - Surrey	55	6	90.16%	9.84%
OU Admin & Management - Sussex	53	16	76.81%	23.19%
EOC	292	53	84.64%	15.36%
111	112	7	94.12%	5.88%

Conclusion

The introduction of the online system has proved effective in providing managers and staff with an effective way of recording their conversations in relation to appraisal and objective setting.

The Trust is well on its way of meeting the target for this year.

The OD team meet with OU managers on a regular basis to ensure they have a planned trajectory to meet the target and provide support where necessary to ensure dleivery

D4 - Review of Grievance Timelines

January 2018

Author: Ian Jeffreys

1. Overview

As a part of our regular internal review processes we carried out a check in October 2017 into the numbers of and average timings for hearing and processing Grievances and Disciplinaries.

Both Grievance and Disciplinary numbers are down from last year. This could be down to either fewer incidents occurring, or fewer incidents being reported.

We are currently unable to report on the timings of disciplinary investigation but there does appear to be a drop in the length of time taken to resolve grievances.

We have invested in an Employee Relations Tracker which will provide more comprehensive data for both grievance and disciplinary investigations including length of time to conclude.

2. Disciplinary Cases

There were 74 new cases received over the previous 12 months (September 2016 – September 2017), 34 of which have been closed.

Compared to the same period (September 2015 – September 2016) new cases are down 14%, and down 15% compared to the period (September 2014 – September 2015).

40 cases remain open, 20 of which have been open for a period of three months or more.

The top four recorded allegations over the last 12 months:

1. Breach of Policy
2. Conduct
3. Breach of Social Media Policy
4. Safeguarding

The new Employee Relations tracker has now gone live, and Hazel Brown will be working to get the previous 12-months data on to the system. This will take a little while but the system will then allow us to better manage/report cases, with the aim of reducing the amount of time it takes to resolve cases.

A joined up approach to safeguarding allegations has now been initiated to include safeguarding, professional standards, HR and the Trusts Speak in Confidence Guardian and others as necessary.

To ensure consistency in the sanctions issued, the HR Business Partners will hold regular reviews of the hearing outcomes and discuss reasoning and rationale

Outcome of Gross Misconduct hearings are determined by a panel, which will be made up of Band 8 and above. Lower level hearing outcomes will be determined by the appropriate level of panel.

3. **Grievances**

There were 59 new cases received over the previous 12 months (September 2016 – September 2017), 29 of which have been closed.

Compared to the same period (September 2015 – September 2016) new cases are down 59%, but up 40% compared to the period (September 2014 – September 2015).

There is no obvious explanation for the huge variations, however improved reporting is likely to play a key role.

Start to completion average for grievances over previous 12 months (September 2016 – September 2017) is 1.9 months compared to 2.2 months for the period (September 2015 – September 2016).

The longest start to completion for a single grievance over the previous year is eight months.

The longest current grievance is a collective grievance that has been running since late February regarding organisational restructure/relocation.

Ten grievances over the previous 12 months have remained open for three months or more.

Over the previous 12 months 22 grievance have been resolved within one month of being raised.

The shortest grievance was raised and resolved within three weeks.

The top three recorded reasons for grievances over the last 12 months:

1. Unfair/ poor treatment
2. Application of Policy/ Procedure
3. Reorganisation/ restructure

There are no grievances outstanding from 2016.

4. Conclusion

Once we have the new Employee Relations tracker up-to-date with all of the historical cases input for the past 2 years, we should have a clearer view as to what the trends are and where further improvement needs to be made, this will include monitoring the timeliness of disciplinary cases.

The HR Team are currently reviewing certain processes around Grievances and Disciplinary's in hopes that we will soon be able to turn both around in a much shorter space of time.

E - Quality Account Measure for Internal Audit 2017/18

1. Introduction

1.1. This report provides the Council of Governors with an update on the current measures in the Quality Account.

2. Learn from Incidents and improve patient safety

2.1. The initiatives for this measure are:

2.1.1. Improved user experience in reporting incidents via the Datix system with an enhanced/streamlined IRWI form.

2.1.2. Introduction of staff feedback loop following incident reporting and lessons identified.

2.1.3. Improve local oversight of reporting metrics across Operating Units.

2.2. The goals for this measure are:

2.2.1. 10% increase (with previous year comparison) in near miss reporting by Q4.

2.2.2. 10% increase (with previous year comparison) in low harm reporting by Q4.

2.2.3. Compliance with CQC fundamental standards.

2.3. Work is progressing well with this measure, with face-to-face training being rolled out throughout the organisation and changes to the Datix system still in progress. This work forms part of one of the Integrated Action Plans (IAP) and is monitored weekly by the Compliance Steering Group.

2.4. Below is an update for Quarter 3 from the Quality & Patient Safety Committee on the number of incidents being reported by staff:

All Incidents Reported	
Q1	1722
Q2	1765
Q3	2086
Near Miss Incidents	
Q1	190
Q2	201

Q3	232
No Harm Incidents	
Q1	1240
Q2	1180
Q3	1481
Low Harm Incidents	
Q1 2017	205
Q2 2017	249
Q3 2017	241

3. Patient & Family Involvement in investigating incidents

3.1. The initiative for this measure is:

3.1.1. Improved management and reporting of incidents within Datix, enabling the identification of incidents meeting Duty of Candour requirements

3.2. The goals for this measure are:

3.2.1. Introduction of a process to monitor and report the number of incidents meeting the Duty of Candour requirements

3.2.2. Upward trajectory of compliance to the Duty of Candour requirements across the year, particularly with regard to timescales for informing patients that we have caused harm

3.3. This work also forms part of one of the IAPs and is monitored weekly by the Compliance Steering Group.

3.4. The Interim Head of Risk has introduced Root Cause Analysis training for all staff, this two-day programme is providing a consistent approach to all investigations and has received positive feedback form those staff that have completed this training. Further courses are planned for Q4.

	Q1	Q2	Q3

3.5.

SIs reported	18	31	19
Those where DOC applicable	14	27	15
DOC made/attempted within deadline	5 (35.7%)	11 (40.7%) *7 are since 1st September	7 (46.6%)
DOC not made within deadline	9 (64.3%)	16 (59.3%) **	8 (53.3%)

** *Incident data shows that there were 65 incidents identified by the reporter or manager as needing Duty of Candour. All 65 have confirmed via the Datix system that the patient has been informed of the incident. Further work is required to demonstrate all other aspects of the Duty of Candour requirement*

iance with Duty of Candour reporting is improving, with changes to the initial contact being made by the Risk team from January 2018.

4. Improving Outcomes from Out of Hospital Cardiac Arrest (OHCA)

4.1. The initiative for this measure is:

4.1.1. Develop and implement a trust-wide Cardiac Arrest Strategy

4.1.2. Develop and implement a 'PITSTOP' model

4.1.3. Implement a clinical partnership model, working locally with the Operating Units to improve health outcomes for patients

4.2. The goals for this measure are:

4.2.1. Analysis of StD data through the national COI data

4.2.2. Early recognition of cardiac arrest by implementing Nature of Call (NOC) and the Ambulance Response Programme.

4.3. A full review of how we manage and respond to cardiac arrest calls within the Trust was undertaken by Mark Whitbread (Consultant Paramedic) and was presented to the EMB in August 2017. The review is now in an action plan with key deliverables for each section.

4.4. A cardiac arrest registry is in development and will be managed within the Clinical Audit team.

4.5. Improved reporting of our cardiac arrest activity, which allows the EMB and Trust Board to understand the data more easily.

4.6. New Resuscitation guidelines were introduced on 14 November 2017 in line with national guidance from the Resuscitation Council UK.

4.7. A programme of local roadshows targeted at Operational Team Leaders (OTLs), led by Mark Whitbread, commenced during Q3. The roadshows, part of the Cardiac Arrest Strategy, focus on ECG interpretation, the Trust's new Resuscitation Guidelines and best practice in treating cardiac arrest patients.

4.8. Working with Clinical Audit, an OU dashboard has been developed; this will be delivered during Q4, which will allow reporting of OOHCA data by specific area. This will allow lower-performing areas to be identified and action taken where necessary, as well as identify areas of best practice

5. Summary

5.1. Work is still progressing on the measures. The Quality & Patient Safety Committee reviews updates on each measure quarterly.

6. Recommendation

6.1. The measure we recommend for internal audit is **Learn from Incidents and improve patient safety**.

6.2. The CoG is asked to note this paper and support the recommendation in 6.1.

SECAMB Board

F1 - Audit Committee Escalation Report

Date of meeting	**4 December 2017**
Overview of issues/areas covered at the meeting:	**Quality and timeliness of papers** Papers were sent out in good time for the first time this year. This was much appreciated by the Committee. The quality of papers is improving (The Strategic Risks paper being excellent in structure) but further improvement would be useful - Papers should have a clear purpose and articulation of executive opinion/actions proposed/intended together with sufficient evidence for the Committee to add constructive challenge and support. The committee emphasised again that in normal circumstances, all papers submitted should have the support of the Chief Executive **The agenda** The meeting discussed papers covering Internal Audit, losses to be written offer, counter fraud, policy management, Strategic Risks, Board Reporting and points raised at the Council of Governors. **Internal Audit** Audit Committee extended the contract of RSM (our outsourced Internal Audit team) for 12 month Based on discussion at the meeting the committee determined that it needed to be assured that staff records were being properly recorded and managed and authorised an additional audit to be funded and carried out before the end of the financial year. The Audit is to cover staff records management with the terms of reference being agreed between RSM and the Executive team in the usual way. **Other matters** The remaining sections of this briefing note set out conclusions in respect of other areas discussed at the meeting
Reports *not* received as per the annual work plan and action required	Whilst a Strategic Risks Report was presented to Audit Committee on this occasion, there was no paper based on the risk profile of the trust. Audit Committee expects to see a Risk Management paper presented at every ordinary meeting of the committee

Changes to significant risk profile of the trust identified and actions required	Audit Committee commended the work done so far to develop a risk management process but recognises that further development is needed; the committee made a number of detailed suggestions. Audit Committee noted that there were lots of red rated risks and was concerned that this was becoming normalised. Audit Committee suggested that three common themes ran through **all** risks listed in the Strategic Risks Report. Whilst there is no perfect way of reporting on risks across any organisation, the committee was concerned that a focus on these themes might get lost. The three common themes were thought to be - Weak management processes - Limited Capacity / Resources - Continuation of a blame rather than support and development culture
Other Matters	Audit Committee discussed a concern that had been highlighted at the last CoG - there were allegations that EMA staff had been subjected to abuse on the telephone by other healthcare professionals who were displaying aggressive and unprofessional behaviour. Audit Committee was of the view that if true, it was difficult to see the matter as being anything other than unacceptable (and might be a significant factor in the current high level of EOC staff turnover). Audit Committee asked the Executive and Workforce Committee to look into the matter and report back.
Policy Management	Audit Committee proposed, for discussion at other Board Committees, the following overall policy management guidance and expectations as follows: Policies should be subject to periodic review Acceptable policies should: o Be clear in scope o As short as is practicable referencing other documents / standards and using appendices as needed to assist clarity o Contain a clear and testable set of standards to be achieved and/or actions to be taken as a result of the policy (in addition, it is acceptable for policies to contain introductory matters and/or overall principles intended to assist relevant individuals, teams and/or oversight mechanisms in situations not covered by the testable requirements) o Contain standards and/or actions that reflect the latest relevant legislative and/or regulatory guidance and (additionally) are proposed in the context of an understanding of good NHS ambulance service practice o Identify relevant individuals, teams and/or oversight mechanisms

	on a “RACI” basis ensuring that all tasks set out are relevant to spheres of interest, job descriptions, powers etc., etc. o Identify and contain a mechanism for reviewing compliance on a periodic basis It will be for each Board Committee to establish periodicity and the comprehensiveness of policy coverage in relation to their terms of reference; however, Audit Committee guidance and expectations would be: - All areas of critical trust performance/controls to be covered by policy - More important policies to be reviewed as to content/appropriateness and as to compliance at least once a year and all other policies not less than bi-annually.
Board Reporting	Audit Committee proposed, for discussion at other Board Committees, the following overall Board Reporting guidance and expectations as follows: 1- A relative short KPI dashboard that will be updated in each report 2- A written section from the Exec setting out areas of importance and emphasis aimed at directing the attention of the reader 3- A small section of Key statistics aligned to the aegis of each Board Committee 4- Detailed information available only on request (and ultimately online) 5- Reports to each Board Committee that mirror the structure of the overall Board report but which are focussed on their respective terms of reference 6- Changes to the structure of reports to be approved by Board Committees/Audit Committee Audit Committee recommended that reporting continue in its current format for the time being and a project undertaken to produce something along the lines of the approach outlined above.

South East Coast Ambulance Service NHS Foundation Trust

F2 - Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	07 December 2017
Overview of issues/areas covered at the meeting:	The committee scrutinised the following areas: **Workforce Plan** The committee acknowledged the impact of the demand and capacity review on the workforce plan, and agreed with management that the plan would need to take account of the outcome of this review. However, as management is currently, through the business planning for 2018/19, working through what the establishment needs to be, the draft workforce plan will be considered at the committee meeting in February. In the meantime, the committee was **assured** that despite it not seeing a written workforce plan for 2017/18, the Trust has been working to the agreed funded establishment. **Suspension Protocol** The committee supported this amended protocol, which supports the existing policy, and was **assured** that it clarified responsibilities. **IR35 – Off Payroll Information** The committee was **partially assured** about the process currently in place, given the complexity and uncertainty about the guidance to support organisations to determine whether IR35 applies. The committee asked for further clarity about how this is being managed going forward. **Workforce Race Equality Standards** The committee reviewed the progress against the action plan, following the WRES submission the Trust Board considered at its meeting in July. The committee was **assured** that the Trust is doing the right things to ensure appropriate diversity when recruiting to new posts. It agreed with management that a coordinated effort continued to be needed to help ensure the workforce was more representative, for example, using the community developer worker to encourage BME people in to the paramedic profession. The committee was encouraged by the range of initiatives and acknowledged the challenges. The committee also considered the **Workforce Dashboard.** It felt that the dashboard was showing improved data, and asked management to include better narrative to describe what the data was demonstrating, including how we benchmark against others. It noted the good progress on career conversations (appraisals) and shared the confidence of management that we are on track to meet the target. The Q2 review of the wellbeing strategy was noted and the committee asked that management quantify the impact of the strategy.
Reports *not* received as per the annual work plan and action	None

required	
Changes to significant risk profile of the trust identified and actions required	None – the committee reviewed the workforce risks on the risk register and was confident that they reflected the current issues.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	As the committee noted in its last escalation report, while it felt the main risks are reflective, it needed to have better visibility of the mitigations so that it would judge whether they are effective.
Any other matters the Committee wishes to escalate to the Board	The committee discussed concern about how staff files are managed and this led to a broader discussion about corporate records. It has asked that the Audit Committee pick this up to seek assurance that we have a robust and effective corporate records policy.

South East Coast Ambulance Service NHS Foundation Trust

F3 - Escalation report to the Board from the Finance & Investment Committee

Date of meeting	18th January 2018
Overview of issues/areas covered at the meeting:	This meeting considered a number of Management Responses (responses to previous items scrutinised by the Committee) **Fleet (not assured)** The Trust have invested in vehicle telematics. The Committee was not assured that management has sufficiently evaluated the impact of this investment and is awaiting development of the Fleet Strategy. **Planning of Hours (assured)** The Committee was assured that there is good correlation between the planning for hours, the delivery of hours and the cost of hours. **CAD Implementation (assured)** The project to implement the new CAD has been successful and has now been closed. This meeting also considered a number of Scrutiny Items (where the Committee scrutinises the design and effectiveness of the Trust's system of internal control for different areas) **Q3 Financial Performance (assured)** The Committee noted the ongoing with discussions with Commissioners. On the basis of well thought through assumptions the committee was assured that the Control Total for 2017/18 and performance trajectory were on track. **Business planning (partial assurance)** The Committee noted the planning process the Trust was to follow. However, having a robust business plan is dependent on the outcome of the capacity review, now not expected until the new financial year. **Estates (not assured)** The committee expects to receive an updated Estates Strategy in April 2018. It was assured that once health and safety issues are identified they are addressed despite the significant maintenance backlog. **Learning from the exit of PTS (not assured)** The committee noted that the exit from the Surrey PTS contract had occurred at a difficult time for the Trust. It was not assured that the wider learnings (i.e. for Commissioners and suppliers, as well as individuals) had been sufficiently considered. It is important that any wider learner is taken into the re-contracting process for 111. **ARP** The Committee reviewed recent performance and the continuation of the trends

	since implementation in November 2017. **EPCR and IPADS (not assured)** Further work is required to develop a way forward. **Cyber Security (assured)** The Committee was assured that the Trust has a good work plan in place.
Reports *not* received as per the annual work plan and action required	None
Changes to significant risk profile of the trust identified and actions required	Slippage in the timetable for delivering the capacity review output which would affect the ability to produce a robust Business Plan.
Weaknesses in the design or effectiveness of the system of internal control identified and action required	none
Any other matters the Committee wishes to escalate to the Board	1. Way forward for EPCR and iPads. 2. PTS learning to be taken into 111 re-contracting.

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

G - 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.

1.2. 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.

1.3. 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.

1.4. 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)**, **Staff Engagement Forum (staff FT members)** and **Patient Experience Group (patient 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. Please do take the time to read at least the summary reports of these items and also the full minutes (if possible). This is our opportunity to triangulate the areas of focus in the Trust from the point of view of different stakeholders. It provides a really good overview of possible areas that Governors may want to seek assurance or further information on.

1.6. **MDC meeting summary:**

1.7. The Membership Development Committee (MDC) met on the 20 November 2017 and a summary of the meeting and draft minutes were included in the November report to the Council. The next MDC meeting is on 15th Feb at Crawley HQ from 10.30am – 3pm. We will be welcoming a Governor from Kent Community Health NHS FT who will be presenting on member engagement to the committee. We will also be reviewing the member survey outcomes and planning our recruitment and engagement strategy for 2018.

2. **Membership Update**

2.1. Current public membership by constituency (at 02.01.18):

Constituency	No. of members	Member numbers percentage increase or decrease compared to previous report	Proportion of the population who are members
Brighton & Hove	517	**same**	0.20
East Sussex	1712	**1.15%**	0.35
Kent	3048	**1.07%**	0.24
Medway	642	**0.31%**	0.25
Surrey	2304	**1.36%**	0.19
West Sussex	1591	**0.37%**	0.21
Total	**9,814**	**0.71%**	**0.23**

Decreases in all areas are due to data cleanses that take place prior to the newsletter going out which check our member data for deceased members and possible 'Gone-Aways' and remove the records as necessary. We also get return to sender newsletters that are returned to us when people have moved and not notified us.

We do not actively do any member recruitment from a Trust perspective in winter outside of the Annual Members Meeting, as this usually takes place over the summer months at 999 events etc. The focus has always been on quality rather than quantity. However, this does not stop Governors from carrying out membership recruitment locally if they wish to bump their numbers up! Please contact the membership office if you would like member forms and promotional materials.

2.2. The total staff membership as of 31.12.17 is 3,308.

3. **Membership engagement summary**

3.1. The next member newsletter is due out in March/April time. Subjects covered in that issue will include information on the Sustainability and Transformation

Partnerships, a Council of Governors Blog and outcomes from the membership survey.

3.2. The annual membership survey accompanied the December newsletter and the results of this will be reviewed at the MDC meeting on the 15th February. The results contribute to the formulation of the annual membership engagement plan which is reviewed by the MDC. It also provides a temperature check on how members feel about their membership and highlights what we are doing well and what can be improved with membership. We have had another challenging year in the Trust so one of the questions in the survey is if members feel they have been kept up to date on our improvement plans. So far we have received 230 responses.

3.3. The Council of Governors and Inclusion Hub Advisory Group members were invited to a festive thank you lunch for their work over the year which included an information event on the Ambulance Response Programme (ARP) in December. The event was well attended by Governors, IHAG members, NEDs, Exec and the Chair. Attendees were given a presentation on the Ambulance Response Programme from Janette Turner, Reader in Emergency & Urgent Care Research & Director of Health Services Research at CURE - Centre for Urgent & Emergency Care Research.

3.4. They took part in a piece of work on the 999 'holding message' that is played in times of high demand and provided feedback to the Head of Emergency Operations Centre Systems on this around content, prioritising the message content and tone.

3.5. Attendees also took part in a Q&A session on the ARP with Janette and members of SECAmb's operational team where assurance was sought by Governors around the implementation within SECAmb and the impact on patients and staff.

4. Public Members' Views

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

4.2. **IHAG meeting summary:**

4.3. Since the last report the Inclusion Hub Advisory Group of public members met on 18th January 2018. Felicity Dennis, Brian Rockell & Marguerite Beard-Gould are the Council's representatives at IHAG meetings. Representatives

may wish to provide a verbal report at the meeting as the meeting summary and minutes will be included in March's MDC report to the CoG.

4.4. The IHAG October meeting minutes are now available and attached as Appendix 1. Octobers meeting focussed on:

An update on patient experience and plans for the patient experience group. Louise Hutchinson (patient experience lead) advised that it was due to start up again in November and a date would be circulated soon. It was confirmed that Felicity Dennis would be the Governor representation with Gary Lavan in her absence, and that Penny Blackbourne and Ann Osler would be the IHAG reps. The IHAG were keen to receive detail on the aims of the group from Louise as this was not yet available.

Introduction to Chief Executive Officer, Daren Mochrie. The role of the IHAG within SECAmb.

IHAGs feedback was sort on new branding for the Trust and also views and feedback on the strategy delivery plan.

4.5. 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.

4.6. The next IHAG meeting takes place on the 10th April 2018.

5. **Staff Members' Views**

5.1. 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.

5.2. **SEF meeting summary:**
The SEF have not met since the last Council meeting. October and July's meeting summaries were included in the last report to the Council.

5.3. 2018 SEF meeting dates are as follows and they take place at Crawley HQ. Staff Elected Governors should make every effort to attend these meetings:
12th February 2018
15th May 2018
4th September 2018
16th November 2018

6. Patient Members' Views

6.1. The **Patient Experience Group (PEG)** were due to meet on the 14th December but this meeting was postponed. They were next due to meet on 22nd January and feedback on the activities of the Patient Experience Group will be reported back on at MDC meetings and a summary included in this report to the wider Council. Felicity Dennis & Gary Lavan are the Governor representatives on this group and may provide a verbal update if the meeting took place.

7. Recommendations

7.1. The Council of Governors is asked to:

7.2. Note this report; and review any attached minutes for more detail.

7.3. Consider how best to encourage Governors to make use of such information, and also to make use of the IHAG appropriately to help understand the perspective of public Foundation Trust members.

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

Appendix 1

South East Coast Ambulance Service NHS Foundation Trust

Inclusion Hub Advisory Group (IHAG)

Notes of a meeting held on 19th October 2017
At Nexus House, Gatwick Road, Crawley: 09:30 to 16:00 hours

Attendees:

Angela Rayner	(AR)	Penny Blackbourn	(PB)	Suzanne Akram	(SA)
John Rivers	(JRi)	Paula Dooley	(PD)	Sarah Pickard	(SP)
Leslie Bulman	(LBu)	Patrick Wolter	(PW)	Ollie Walsh	(OW)

Presenters & Guests:

Aide Hogan	(AH)	Daren Mochrie	(DM)	Jen Ratcliffe	(JR)
Alison Stebbings	(AS)	Graham Parrish	(GP)	Jean Gaston-Parry	(JGP)

Brian Cumming	(BC)	Louise Hutchinson	(LH)	Peter Cripps	(PC)
Charlie Adler	(CA)	Janine Compton	(JC)		

Secretariat:

Asmina Islam Chowdhury	(AIC)

Apologies:

Ann Osler	(AO)	Jim Reece)	(JR)	Simon Hughes	(SH)
Ann Wilson	(AW)	Karen Mann	(KM)	Stephen Merriman	(SM)
Dave Atkins	(DA)	Katie Spendiff	(KS)	Terry Steeples	(TS)
Hilda Brazil	(HB)	Mark Kelner	(MK)		
Jane Watson	(JW)	Mo Reece	(MR)		

1 Welcome and introductions

1.1 AR opened the meeting welcoming all present

1.2 Round table introductions were made, and AR welcomed guests, and advised that Trust Chief Executive Officer, Daren Mochrie would be joining us later. AR welcomed Brian Cumming, Communications Officer and Peter Cripps who were attending to inform an article on the IHAG in the Trust magazine, SECAmb News.

1.3 AR also welcomed Staff Elected Governor AS and Public Governor JGP who would be feeding back to the Membership Development Committee (MDC) in the absence of MBG, as well as Staff Elected Governor CA. AR advised that further representation from the MDC for the IHAG would be confirmed at their November meeting.

1.4 AR tabled apologies as given above. Apologies from AW and HB were received part way into the meeting due to a medical emergency whist en-route.

2 Minutes of the previous meeting

2.1 The notes of the meeting held on 13th July 2017 were reviewed for accuracy.

2.2 SA motioned that the notes be accepted as an accurate record and PD seconded and the agreement was carried.

3 Matters arising & IHAG Action Log Review

3.1 Action 198.3 – Draft meeting etiquette: Group agreed that the delivery date for this should be amended to reflect that this was a low priority.

3.2 Action 199.2 – Trust Governance update: As per 198.3

3.3 Action 207.1 – Serious Incident Review Process: AR advised that this will be picked up with the Risk Manager once they are in post.

3.4 Action 211 – Q-Volunteering Workshop: Update received from Karen Ramnauth that we are at present, still awaiting sign off on the job description, and further information will be provided in readiness for the January 2018 meeting.

3.5 Action 212 – Non-Executive Director membership of IHAG. At the time of the meeting, this was on the agenda for discussion at the NED meeting scheduled for November 2017.

3.6 Actions 213.1- Patient Experience: Action update from LH was reviewed and it was agreed that the action could now be closed.

3.7 Action 213.3 - Patient Experience Group: Action carried forward as group has been unable to meet since the last meeting.

3.8 Action 215.1 – IHAG feedback and promotion: Planning of SECAmb News article is currently in progress, action carried forward.

3.9 Action 215.3 – IHAG feedback: AIC provided an update that this was currently under review and a further update would be sought before the next meeting.

3.10 It was **agreed** to close all other actions which had been noted as completed in the Action Log since the last meeting: 207.2, 209, 213.2213.4,214, 215.2, and 215.4.

3.11 Members also requested assurance how the work of the Clinical Risk Sub-group had been integrated in other Trust work streams.

Action:	**AIC to seek assurance from Andy Collen on how the work of the CRSG had been integrated into other work-streams and committees and report back to the group.**
Date:	**Jan 2018**

4 Review of activities undertaken by members

4.1 Members updated the group on the activities since the last meeting and these included: History marking sub-Group, Inclusion Working Group; Annual Members meeting, Executive recruitment stakeholder groups; National Ambulance LGBT Network Conference, Sussex PTS Patient Forum; Kent Association of Local Councils (KALC) Clerks' Conference; Investing in Volunteers stakeholder group; Trans Pride engagement event; and CQC Stakeholder event.

4.2 PD had attended the Employers Network for Equality and Inclusion's (enei) parliamentary reception and noted that it had been a good opportunity to reflect on all strands of equality and diversity. AR noted that SECAmb had recently cancelled their Stonewall Diversity Champion membership as we needed to focus on intersectionality rather than on any one characteristic disproportionately.

4.3 AR also gave thanks to AO for covering the stand at the Annul Members Meeting at short notice.

4.4 It was agreed that the notes of the CQC stakeholder event would be circulated to IHAG members.

Action:	AIC to circulate notes from CQC stakeholder event in October to IHAG members.
Date:	Dec 2017

4.5 LB advised that he was working closely with South East Coastal CCG and continued to publicise the work of SECAmb and the IHAG at this forum.

4.6 AIC shared concerns raised by JR following the most recent meeting of the History Marking Sub-Group, regarding the groups record keeping, and lack of minute taking and reporting mechanisms for governance. It was agreed that this feedback would be forwarded onto both Izzy Allen, and raised at the next Inclusion Working Group Meeting.

Action:	AIC to circulate notes from CQC stakeholder event in October to IHAG members.
Date:	Dec 2017

5 Staff Engagement Forum (SEF)

5.1 AR passed apologies from Lucy Greaves and Kim Blakeburn, who had been unable to attend the meeting to provide the update on (SEF), and tabled an update from the meeting held on 13th October 2017. A copy of the update has been included below.

Update from Staff Engagement Forum m

5.2 AR advised that we would be looking at the feasibility of having SECAmb email addresses for IHAG members once these had been rolled out for the CFR's and tested for any issues.

6 Patient Experience Update

6.1 AR welcomed Louise Hutchinson (LH), Patient Experience Lead and Graham Parrish (GP), who had recently joined the Trust as Complaints Manager to the meeting. LH provided an update on Patient Experience building on information shared at the meeting on 13th July.

6.2 LH identified the three top themes for complaints being patient care, staff attitude and response timeliness.

6.3 Complaints regarding staff attitude have seen a decline, which LH attributed to the inclusion of patient experience training within staff key skills, improved training at university, and improvements in recruitment.

6.4 The Trust had over 50 complaints around timeliness of response, an increase from the usual 20, however it was noted that none of the ambulance trusts were currently able to meet response time targets. At the time of the meeting, the Trust was due to implement the Ambulance Response Programme (ARP) the following month. The group discussed the implications of ARP and LH anticipated that although ARP would help with added time to triage calls and potentially increased time to respond, there would also be an expected increase in the number of complaints. LH also outlined actions being undertaken to improve timeliness.

6.5 An update was provided on actions being taken as a response to the Care Quality Commission's (CQC) feedback around sharing the learning from complaints. LH advised that she was also working with the Project Management Office on how to take this work forward and what the measurable targets should be. The IHAG made a recommendation that the Staff Engagement Forum look at the current Reflections bulletin to ensure that this is the correct mechanism and had the right tone for sharing and disseminating learning.

6.6 Members discussed the need for the Patient Experience Group (PEG) to be able to evidence outputs, and LH advised that the PEG would be developing the Patient Experience leaflet and looked to hold a meeting before the end of 2018 to progress this.

6.7 LH discussed that she had recently raised a need for patient experience reporting to go the Board, and would be implementing this in the coming months. In addition, the team is looking at improving reports so they can be broken down by EOC/ and Operating Unit (OU) area to increase accountability and competition.

6.8 AR thanked LH for the update and LH advised that she would be happy to provide the group with an update against the improvement plan at a future meeting.

7 Introduction to Chief Executive Officer, Daren Mochrie. The role of the IHAG within SECAmb.

7.1 AR opened the item, welcoming Daren and outlining that this was an opportunity for the IHAG to talk about their work and provide examples of where SECAmb staff had benefitted from advice and appropriate engagement in their projects.

7.2 The purpose of the IHAG is also to advise and make recommendations to the Trust, and report to the Inclusion Working Group about:

7.2.1 Implementing and measuring the success of the Trust's Inclusion Strategy.

7.2.2 Embedding the principles and practice of involvement and engagement in the Trust.

7.2.3 Working with stakeholders in an effective, integrated way.

7.2.4 How and when stakeholder involvement is beneficial and necessary.

7.2.5 Involving relevant stakeholders at the appropriate time and in appropriate ways.

7.2.6 Participating in the Equality Delivery System 2 process, by acting as the Trust's 'Community of Interest'

7.2.7 Providing appropriate feedback to those the Trust has engaged and involved.

7.2.8 Providing advice to staff on appropriate engagement regarding their current work streams.

7.3 Members of the IHAG provided an overview of work streams they had been involved in, including; How the IHAG operates as a subgroup of the IWG, with a two-way interaction that ensures Patient and Public Engagement is appropriately considered in work streams and projects within the trust, and the benefits of this (JR), progress the Trust has made in raising Trans awareness, the re-development of the policies and the development of the statutory mandatory E&D training, (PD), contributions that the IHAG makes to the EDS2, and the equality analyses used in the development of Trust policies and procedures, and the work in helping to develop the Patient Experience Group, and Exec recruitment stakeholder group (PB). LB spoke about the role of the IHAG on the various Trust groups that members sit on, e.g. 111 IHAG liaison.

7.4 LB also advised that members of the IHAG often held roles on a number of other groups and were keen to see SECAmb better represented across the patch. He noted a lack of SECAmb presence at a number of Sustainable Transformation Partnership (STP's) events. DM noted the difficulty that the Trust had due to the size of its operating area. However, he had invited the Chief Operating Officers of all four of STP's to meet with himself and Jayne Phoenix, Associate Director of Business Strategy. An action was taken to put LB in touch with Jayne Phoenix, Associate Director of Strategy.

Action: AIC to circulate notes from CQC stakeholder event in October to IHAG members and liaise with Jayne Phoenix to contact LB

Date: Dec 2017

7.5 DM thanked members of the IHAG for their commitment to the group and the Trust and that he looked forward to working in partnership with the group. He shared a presentation with members on feedback from the CQC following the re-inspection and recent unannounced visits a few days before the quality summit.

7.6 DM advised that the Trust had been issued two notices of proposal on Medicines Management and EOC call handling. However, following the recent the unannounced visit, the CQC had noted the significant improvement in medicines management and as a result the notice of proposal for this area would be lifted. With regards to EOC 999 call handling, significant compatibility issues between the telephony and recording systems had been identified and were being addressed.

7.7 In additional a total of 17 'must do' areas had been identified and 11 task and finish groups set up to address these, replicating the quality and methodology used to address the medicines management issues. The work had been split into phases to ensure that the focus was spread across both the 'must do's' and 'should do's'.

7.8 DM also highlighted that with regards to safeguarding, we needed to address safeguarding issues, both externally (patient focussed) and internally in light of the Duncan Lewis report. The report had highlighted issues around the Trust culture and appropriate behaviour. DM acknowledged that this was significant area of work for the Trust, and noted that staff had already seen a significant amount of change and different staff were on different points of the change journey, and as a result had different needs. An action plan was being developed to address the issues that had been raised using feedback from staff. For external safeguarding the Trust was working on rolling out Level 3 safeguarding training and the task and finish group would be looking at further actions.

7.9 DM also provided an update on system challenges that SECAmb faced including high on scene and hospital waiting times. An average of 2000 jobs a day and a job cycle time of 1 hour to 1hour 47 minutes. DM also noted the impact of handover delays on resources and how this meant that this could mean availability of 20 fewer ambulances on some days. DM advised that he was keen to work with HOSC's and other stakeholder groups as part of SECAmb's improvement journey and asked members to consider how they could assist in this area.

7.10 AR thanked DM for his update and invited him to attend a future meeting and provide an annual update.

Action: AIC to share invitation for DM to attend future meeting.

Date: Dec 2017

8 Infection Prevention and Control (IPC)– Mystery Shopper

8.1 AR welcomed Aide Hogan, Infection Prevention & Control Lead to the meeting. AH outlined that "bare below the elbow (BBE)" guidance had come in as AH started in post as part of Department of Health guidance, and meant that staff could only wear one plain band ring. AH outlined that as members were aware, IPC compliance was still an issue, and one of the 'must do's' and requested the support of IHAG members in identifying regional issues where compliance may be an issue via "mystery shopper" style audits.

8.2 AH shared the form that would be used for this and discussed what should and shouldn't be included However he noted that they would not be asking collectors to note employee names, but just where they had noticed the incident. IHAG members noted the size of the patch and limited opportunities to undertake this work, and agreed that it may be better to send out to the wider Trust membership or Healthwatch for their involvement.

8.3 IHAG members advised that there would be a requirement to finalise guidance for volunteers undertaking this work and a covering letter for volunteers sitting in hospitals to complete the observations. IHAG members also raised concerns about the impact on staff morale and their view of the audit, which could be viewed as detrimental to the staff engagement work that the Trust was undertaking. AH clarified that the process would be looking at both compliance and non-compliance.

Action: AH to develop a covering letter for presentation to the ED matron for use by those completing audits at hospital.
Date: Dec 2017

8.4 Members also sought clarity around provision of alcohol hand gel (paid for by Trust) and fob watches (individual purchase), and AH took an action to find out if the fob watches were tax deductible as a part of uniform requirement.

8.5 It was agreed that a subgroup meeting should take place to look at how this work can be taken forward.

Action: AH to investigate whether fob watches can be counted as tax deductible for clinical staff.
Date: Dec 2017
Action: AIC to discuss promoting this initiative to Foundation Trust members
Date: Dec 17
Action: Subgroup to meet to look at how this work stream is progressed with AH, AIC, PD, PB, and OW.
Date: Jan 18
Action: AH to discuss initiative with LH and Healthwatch members.
Date: Dec / Jan 18

9 SECAmb Strategy Delivery plan

9.1 AR gave apologies for Eileen Sanderson who had been due to attend and present on the Strategy Delivery Plan, but had been called away unexpectedly. This will be rescheduled for a future meeting.

10 SECAmb branding

10.1 AR welcomed JC, Head of Communications to the meeting. JC advised that the current SECAmb branding had been in use since the Trust became a Foundation Trust in 2011, and following a launch of the new strategy, the Trust were looking at refreshing the branding.

10.2 JC shared five potential designs and it was agreed that these plus the current branding would be circulated via an electronic poll to capture feedback from all members.

Action: AIC to circulate a link to an electronic poll on designs for review of SECAmb branding **Date:** Dec 2017

11 Open session, horizon scanning and future agenda items

11.1 Bereavement leaflet – AR shared a leaflet that a member of staff had developed to leave with patients following the death of a loved one, to offer guidance on next steps and support. AR asked for members to identify whether the Trust should formally develop a leaflet.

11.2 CA advised that the Trust only recognised life extinct, and do not certify death, and as a result it may not be appropriate for the Trust to develop on our own. However, the Police do act as the coroner's representative therefore it may be suitable for a collaborative piece of work between SECAmb and our Police partners.

Action: AR to raise with Matt England to take forward with Police and Shirmilla Datta, End of Life lead. **Date:** Dec 2017 **Action**: AR to provide feedback to the staff member who had developed the leaflet. **Date**: Dec 2017

11.3 CQC Quality Summit: LB and PB shared feedback from the event held on 5th October. The session was hosted by the Trust but had been run by the CQC. It was reported that there was a feeling the event had little value, although it had given SECAmb the opportunity to demonstrate the milestones achieved since the inspection in May.

11.4 SECAmb East and West: Members acknowledged the change in language at today's meeting which showed that the Trust was moving from a county split to an East and West split. It was agreed that a map of the borders and OU areas would be shared with all members.

Action: AIC to share updated map of area covered by the Trust split into East and West.

Date: Dec 2017

11.5 Safeguarding: IHAG members referenced the safeguarding update provided by DM earlier in meeting which had advised that an 8B post had been recruited in to help drive the necessary improvements. Members requested an update on the consultation work which they had taken part in during November 2016 to support the development of a new policy and procedure.

Action: AIC to request an update on development of a safeguarding policy and procedure from the safeguarding lead.
Date: Dec 2017

11.6 JR had recently attended a community safety partnership meeting, where there had been representation from all emergency services, except SECAmb. AR advised that we could feed this back to James Pavey, Regional Operations Manager. However, due to the size of the area served by SECAmb, it was often difficult to ensure the most an appropriate representative was able to attend all meetings.

Action: AIC to share contact details for James Pavey with John Rivers
Date: Dec 2017

11.7 PD queried whether the training needs session completed by the IHAG in November 2015 continued to inform the threading through of diversity and inclusion in clinical education. It was agreed that assurance would be sought from members of the Clinical Education Team and a survey would be developed for the first quarter of 2018/19 to monitor attitudes toward diversity and inclusion.

Action: AIC to share contact details for James Pavey with John Rivers
Date: Dec 2017
Action: AIC to develop an E&D survey for circulation to all staff in Q1 of 2018/19
Date: March/ April 2018

Horizon Scanning

11.8 AR asked members to hold the 8th and 15th December for a joint IHAG and Governors Christmas meeting, advising that dates would be confirmed once a keynote speaker was confirmed.

12 Meeting effectiveness

12.1 Members felt that it had been a good meeting. It was noted that presenters may need better guidance on the accessibility of information being presented on slides, and also around the acoustic implications of a large room.

13 AOB

13.1 AIC provided an update on the Sexual Orientation Monitoring Information Standard (SOM) requirement that had been released by NHS England on 5th October. Under the requirements of the SOM the Trust would be required to ask the following on every patient face to face contact; "Which of the following options best describes how you think of yourself?

1. Heterosexual or Straight
2. Gay or Lesbian
3. Bisexual
4. Other sexual orientation not listed
5. Person asked and does not know or is not sure
6. Not stated (person asked but declined to provide a response)
7. Not known (not recorded)"

13.2 IHAG members were asked for their feedback and they agreed unanimously that they did not feel that this would affect patient care or was suited to the ambulance service. It was agreed that this feedback would be shared with the National Ambulance Diversity Forum at their next meeting.

13.3 Further details on the SOM can be found below https://www.england.nhs.uk/about/equality/equality-hub/sexual-orientation-monitoring-information-standard/

14 Date of next meeting

14.1 The next meeting will be held on **17th January 2018,** 09:30 to 16:00 hours.

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Council of Governors

H – 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 18 December 2017 to plan this Council meeting. The minutes are provided for the Council as an appendix to this paper.

1.6. The GDC meeting covered: feedback from the previous Council meeting and setting the agenda for the next Council meeting.

2. Feedback from the previous CoG

2.1. The GDC noted that in the past it had been hugely exceptional for the Chair not to chair a Council meeting, however it noted the urgency around Executive recruitment which had led to Richard missing the November Council meeting. It also acknowledged that Richard had been clear that he was unavailable on Mondays and Tuesdays in the medium term and in hindsight alternative arrangements might have been made for January's meeting (it has since been confirmed that Richard is able to attend to Chair the January Council). While understanding, the GDC were very keen to see improved attendance in future and it was noted that things should improve from March 2018.

2.2. The GDC reflected on what it saw as an increased tendency for some Governors to seek more detail than strictly necessary at Council meetings. It was noted that this was sometimes understandable when Council had been regularly asking for information on the same issue and it was not forthcoming.

3. Agenda setting

3.1. The GDC prioritised seeking assurance around the Trust's improvement plans and specific progress, actions taken and the benefits for patients. In addition, the GDC wished to understand how the Trust was addressing workforce issues, including bullying and harassment.

3.2. The Trust's new external audit team would be invited to the January afternoon session to discuss their role and ways of working with the Council.

4. **Staff engagement**

4.1. The GDC were joined by the Trust's Staff Engagement Advisers, who provided an overview of their work and areas of current focus. Following the discussion, the GDC were keen to invite the Advisers to the full council in March to update everyone on their work and take questions.

4.2. The GDC was pleased to hear that the Advisers were keen to support better engagement with volunteers and that there was buy-in from the Director of Operations and monitoring to ensure Operating Unit Managers enabled operational staff to get involved and promote staff engagement.

4.3. The Advisers were also working to support more effective engagement between the Executive and the rest of Trust staff, and were recruiting Staff Engagement Champions who would support staff engagement in their parts of the Trust.

4.4. The discussion was lengthy and Governors are encouraged to read the full minutes if they are interested in this area of work.

5. Queries arising from meetings with the Chair

5.1. The GDC reviewed responses to the queries and comments raised by governors during the recent constituency meetings between Governors and Richard. More information was sought in relation to fundraising and CFRs, though it was noted that any CFR scheme that is a registered charity has its fundraising regulated by the Charities Commission and SECAmb would not need to duplicate this oversight.

6. Other business

6.1. There was no other business.

7. Recommendations:

7.1. The Council is asked to note this report.

7.2. Governors are invited to join the next meeting of the Committee on 28 February, 14:00-16:00 at Crawley HQ.

James Crawley, Lead Governor (On behalf of the GDC)

See over for the minutes of the GDC meetings

South East Coast Ambulance Service NHS Foundation Trust

Minutes of the Governor Development Committee

Crawley HQ – 18th December 2017

Attendees:

James Crawley	(JC)	Lead Governor & Public Governor for Kent
Brian Rockell	(BR)	Public Governor for East Sussex
Felicity Dennis	(FD)	Public Governor for Surrey & N.E Hampshire
Jean Gaston Parry	(JGP)	Public Governor for Brighton & Hove
Alison Stebbings	(AS)	Staff Elected Governor – Non Ops
Marguerite Beard-Gould	(MBG)	Public Governor for Kent
Peter Lee	(PL)	Company Secretary

Apologies: Matt Alsbury-Morris, Francis Pole, Marian Trendell, Mike Hill

Presenting: Lucy Greaves & Kim Blakeburn – Staff Engagement Advisor

Minute taker: Katie Spendiff

1. **Welcome, apologies for absence and declarations of interest**
   1.1. JC welcomed members to the meeting. Apologies for absence were received as follows: Matt Alsbury-Morris, Francis Pole, Marian Trendell, Mike Hill.
2. **Minutes from the previous meeting, action log & matters arising**
   2.1. The previous meetings minutes were taken as an accurate record.
   The action log was reviewed as follows.
   109 'timetable for full review of constitution' PL noted that the current constitution limits the number of directors on the Board as 7 NEDs & 7 Execs. Pending the recent work of the NomCom and chosen appointments and the crossover with Tim Howe's term of office the Trust is looking to amend the constitution on this point. The Trust would look to put forward an amendment to change it to not limit the number of NEDs or look to not have no more than 2 extra NEDs compared to number of Exec. PL noted that a paper on this was due to the Board in January, and then to January CoG. BR noted line of approval as Board, CoG & then NHSI approval needed. PL noted the need for NHSI approval had been removed. AS queried increase in Exec as well to match NED number? PL advised the Exec number would remain the same and it would stipulate there would be no more than 2 higher in Number of NEDs compared to Exec. GDC confirmed they were happy with the proposed timeline.
   2.2. 116 on Council's review of Appointed Governors' discussion would be going to the January Board meeting where the Board would decide on representation.
   2.3. 119 – KPMG to be invited to PM session of January CoG to discuss ways of working with the Council. KS advised she would follow up and issue the invitation.

2.4. 120 – Include call tail information in performance report. This is now included in the Board integrated performance report.

3. **Staff engagement**

3.1. The GDC welcomed the Trust's Staff Engagement Advisors Kim Blakeburn and Lucy Greaves to the meeting. Introductions were made. Kim & Lucy advised that their remit was quite broad. They noted that one of their key projects was to set-up Staff Engagement Champions (SECs) across the patch. They advised that the CQC outcomes supported the need for engagement with staff and had increased momentum of the work. SECs establish local forums within their areas and by the end of January all areas (split out by Operating Unit) will have had their first local staff engagement meeting with the support of a local manager. The meetings aim to empower local decision making and staff engagement. SECs also attend a quarterly Staff Engagement Forum (SEF) meeting to ensure views from across the patch are centralised and that good practice can be shared. They noted there was also Exec support and attendance at the SEF to enable any trends or areas for escalation to be fed back. Lucy advised that the push for local engagement accountability was necessary as with 3,500 staff and volunteers and only two staff engagement advisors, buy in was needed from managers to implement their own staff engagement. Responsibilities of the role were formalised and there is training in January to support SEC's to carry out their role in each area.

3.2. They advised they had developed a staff engagement toolkit to support local managers to embed engagement in their area and to provide consistency across the Trust. An engagement audit took place at the beginning to see what was currently in place and who was doing what/well etc. This audit showed huge differences across the patch – the toolkit supports a consistent approach to staff engagement.

3.3. They advised that dedicated staff engagement is new to the Trust. Staff engagement had previously been an add on to existing roles. Dedicated posts provide the focus and capacity to deliver effective staff engagement.

3.4. Lucy noted that other staff engagement projects included pulse surveys which provided a temperature check on the work taking place to make improvements around staff survey outcomes, this also incorporated the Friends & Family test. Noted B&H results – interim checks on work around this. Kim advised that this year they would be overseeing the annual staff survey – promotion etc. and review of results. Kim advised results would be issued by locality to empower local managers to provide a response specific to their area, alongside the Trust wide response which includes the development of an action plan.

3.5. Kim advised that they currently look after the corporate induction and have focussed on making changes to the format and content to make it more engaging for new starters.

3.6. Kim advised she was working with Karen Ramnauth to improve engagement for Community First Responders (CFRs). Kim had noted that she had invited CFRs to the inductions and that videos were made to showcase their work. Kim advised that EOC inductions for CFRs to understand how jobs are allocated etc. were in the works. There had also been a Volunteer pulse survey.

3.7. Lucy advised that Bullying & Harassment (B&H) sessions had taken place which were arranged by the staff engagement advisors. Kim advised that B&H sessions for volunteers were due to be organised with the backing of the Chief Exec due to volunteers asking for them. Kim advised they were currently working on setting up emails for CFRs and that SEC's had been asked to invite all CFRs to their local OU engagement session.

3.8. Kim advised that they were also working on Exec Team engagement – breaking down the "us and them" perception and building staff understanding of roles through newsletters,

social media, and local event attendance. This work had been paused whist the final substantive positions on the Board were recruited to.

3.9. Lucy and Kim advised of current projects in the pipeline for the future which included looking in to a praise and recognition scheme and consistency in the staff suggestion scheme. Lucy advised that an external company; Ignite, are working on a culture piece on the Trust's staff values and in the new year there will be a piece of engagement work on behaviours and embedding them.

3.10. BR noted that he would welcome a wider focus on all the volunteers within the Trust and not just CFRs. Kim advised that pending success of initial work, it would be considered regarding opening the engagement work to the wider volunteer sector in the new year.

3.11. JC noted he was very pleased to hear their views on volunteers and the inclusive language that was used by them both. JC queried the rate of up take for SECs? Lucy advised that the initial interest was high – as the role developed – responsibility had grown and some people had backed down from the role. Lucy advised that some managers had reached out to staff members to encourage participation. JC queried genuine vs un-genuine motives for being a SEC. Kim advised that evidence was required of work being carried out in their area. Kim advised there was 6 hours paid overtime to carry out the role each month. Kim noted that they were struggling for SEC representation in support services but that it was a different setting and environment so perhaps a different level of approach was required.

3.12. JC queried where the oversight of the staff engagement work sat. Kim & Lucy advised that they are monitoring staff engagement plans locally. Lucy meets Daren quarterly to check in on what the Execs are doing to propel staff engagement locally. There is regular contact with Operating Unit Managers (OUMs). In respect of reporting back on their work – this was fed in to the compliance and culture steering groups who have oversight of staff engagement.

3.13. JGP queried OUM support of the idea. Lucy advised that it was inconsistent in terms of levels of enthusiasm, but that there was a mechanism for monitoring the work and participation of all OUMs on engagement and that it was fed back to Joe Garcia.

3.14. FD queried process for agenda setting for local engagement meetings. Lucy noted local accountability around agenda setting and that the first meetings would kick off with the local staff survey results, the hope being that agenda items will then self-generate moving forward. FD queried availability of staff to attend and having to do this in their own time. Kim advised that it was important to push on with staff engagement regardless of numbers attending, it would grow organically when people saw results from the meeting, and even if it was just the SECs and local managers initially you had to start somewhere. Local staff engagement should become business as usual but it would take time and is part of the wider cultural change that is necessary.

3.15. JC noted that their positivity was refreshing and was keen to see deliverables and buy in from the Exec and timeliness around actions. Kim & Lucy noted there were evidenced case studies within the NHS around the positive impact of quality staff engagement.

3.16. KS noted she felt positive that the outcomes of the staff survey were being dealt with differently this year with more local accountability.

3.17. GDC thanked them for their presentation and noted the importance of staff engagement advisors coming to the full Council to present on their work, ideally at the March meeting.

Action: Staff Engagement Advisors to be invited to present on their work at a future Council meeting.

4. **Discussion of any feedback from the previous CoG meeting**
   4.1. BR noted that up until this point it had been wholly exceptional for the Chair to be unable to chair a CoG meeting, with this happening only once before. BR voiced concern that by the end of March it will have been 6 months since the Chair chaired a CoG meeting. BR sought assurance from that point forward on the Chair's engagement with the CoG and commitment to Chair meetings. JC noted that in November the Chair and Daren didn't attend due to Exec appointment recruitment and that the GDC had unanimously agreed to keep the date and carry on with the meeting in their absence. JC queried that the Chair had stated he could not do Monday/Tuesdays at the beginning of this role and that in hindsight the January Council meeting date should have perhaps been revised in advance. JGP queried the role of the Deputy Chair of the Trust. JC advised that the Deputy Chair was of the Trust and not Deputy Chair of the CoG as detailed in the constitution.
   4.2. JC noted that the Chair's attendance at Council and GDC meetings had been expressed as being essential in his appraisal. PL noted it was not unusual for a Chair to not be able to attend every meeting. PL noted that with the usual caveats the Chair should be able to attend meetings from March onwards.
   4.3. In relation to the previous meeting, BR noted an abundance of "digging down" in to operational detail, digressing away from the Council working as a whole, in particular the subject of ID cards etc. at the last meeting. PL noted that effective holding to account comes with experience of working together as a Council. MBG noted her personal view that people frequently overstepped the mark in terms of requesting detail simply because of frustration.

5. **Agenda items for the Council meeting of 29 January 2018**
   5.1. Agenda items for the next Council meeting were discussed. The GDC agreed that they would be keen for KPMG to attend the PM session of the January meeting.
   5.2. The agenda item 3 'patient experience' was suggested to be delayed until March.
   5.3. Governors were keen for a combination of items 4 & 6 to be covered at the next CoG. Governors were keen to hear from Daren on the Improvement plan, specifically assurance on outcomes from the action plan for improvement – more detail on actual progress and what that means for Trust as oppose the completion
   Governors were keen for Steve Graham and relevant NED to come to the Council to provide overview of B&H outcomes and improvements and how/if the Council can support the work that needs to be undertaken. There was appetite for this item to also cover where we are with appraisals numbers wise and assurances on the quality of appraisals being carried out. Finally, an overview of grievance and disciplinary stats regarding timeliness. PL advised that there had been a recent Board assurance report on this from the WWC.
   5.4. For part 2, Governors discussed the need to include the constitution review – detailing changes.
   5.5. JC noted he would like an attendance review at the next CoG as the last one had happened 6 months ago and the GDC had made a commitment to review this twice yearly. Governor attendance would be reviewed and any relevant Governors would be contacted in interim to provide explanation for absence. This data could then be brought to the CoG for review in the part 2 meeting.
   5.6. MBG noted she would like to hear from the Chief Exec & Chair at the March Council meeting for an informal discussion on their 1st year in position. PL noted 6 month look back

and 6-12mth look forward on this would be coming to the January Board. The GDC noted that if KPMG were unable to attend the PM session then this could be a backup item for January PM session, but ideally would take place at the March meeting. The GDC re-iterated the need for the session to be an informal afternoon session.

6. **Responses to Governor queries in constituency meetings**
   6.1. KS introduced the paper and asked Governors if they were content with the responses and whether it highlighted any possible future agenda items for the Council.
   6.2. The GDC queried the response around establishing a charity as part of the Trust and sought further clarity on if the Trust has an appetite to establish a charity. MBG queried concern over CFRs fundraising independently of the Trust and potential lack of oversight and/or any reputational damage that could occur through failure to comply with any regulation around fundraising. It was noted that the majority of CFR fundraising was carried out appropriately. Governors discussed the idea of centralising fundraising activities and making it part of the volunteer strategy. MBG noted the Chair constituency meetings raised items for Governor focus when the Trust's initial key priorities were taken care of. Governors were keen for their concerns to be logged with the Directors in charge of creating the volunteer strategy and policies that supported it.

   Action: CFR fundraising oversight to be raised with those creating the volunteer strategy and policies that underpin it.

7. **Any other business**
   7.1. There was no other business.

8. **Review of meeting effectiveness**
   8.1. The meeting was deemed to have been very effective.

Signed:

Name & Position: James Crawley – Lead Governor & GDC Chair

Date:

South East Coast Ambulance Service NHS Foundation Trust

Council of Governors

I – 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

November 17	Investing in Volunteers follow up meeting – Contributed to a discussion. James says: As part of the Trust's attempts to gain Investing in Volunteers status, stakeholder groups from all parts of the Trust's volunteers are being consulted on current volunteering. I attended along with Katie to represent the Governors.	James Crawley (Katie Spendiff)
23.11.17	NED recruitment process participation: Focus group member for applicants prior to interview. Contributed views. Felicity notes that she highly recommends Governor participation in the NED recruitment process. NB Nominations Committee members are automatically involved but Felicity volunteered in addition.	Felicity Dennis
24.11.17	Interview presentations for applicants for the post of Director of HR. Felicity says: I really welcomed the opportunity to be a member of this staff focus group as part of the recruitment selection process for the HR Director. Meeting the candidates and hearing the staff discussion was most enlightening	Felicity Dennis
27.11.17	Quality Account Forum - developing the Trust quality account measures for 2018-19. Felicity notes: Very useful to be involved in the decision making process for the Trust quality measures for 2018/19. These will be given additional focus for delivery during the coming year and should contribute to improved care for patients and improved working environment for staff. I welcomed the opportunity to speak to staff members on a range of issues and to understand	Felicity Dennis

	the key focus areas for quality improvement going forward. Highly recommend future COG engagement at every opportunity .	

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.

02.01.18	When using the website 'What Do They Know' which collates information about Freedom of Information requests, I noted that SECAmb has at least 11 FOI requests that are showing as unresolved & overdue. The oldest of which is from 2015. Well beyond the time period allowed for providing a response to the questions asked, or a legal reason why this isn't supplied. I'd therefore like to ask what assurances the board has that all Freedom of Information Act requests are being handled in compliance with the legal duties placed on the authority. I'd also like to understand what the risk of financial penalty from the ICO is for outstanding requests which are overdue. I'm concerned about what I've discovered in a public forum. It is a bit of a reputation issue.	The Trust previously had an experienced longstanding FOI coordinator in situ who resigned at the end of April 2017. Whilst this position was temporarily filled until the middle of May 2017 there was then a period where the process was completely unattended due to lack of resource. This was then recorded as a risk on the Corporate Risk register. However, following a successful recruitment campaign the Information Governance Lead successfully appointed a substantive member of staff who joined the Trust on the 12 June 2017. The new FOI coordinator 'inherited' a significant backlog and has worked hard alongside the Information Governance Lead to manage the backlog, review and address breaches and streamline the process. There have been two complaints received by the Information Commissioner's Office (ICO) in relation to the Trust breaching the 20-day statutory timeframe. In each instance, the Information Governance Lead has provided a full letter of explanation and apology to the requestor. Open dialog has also taken place with the ICO and in the spirit of remaining 'open and transparent' a formal letter has been sent on behalf of the Trust by the FOI Lead. This notification confirmed the Trust's current position (at this time) regarding the historic backlog whilst providing assurance that it has recently invested in additional resource to support this process. The ICO have confirmed that they have noted the Trust's position and no further action has been taken. The Trust is fully aware of its responsibilities to comply with this statutory process and to date there are approximately 46 requests outstanding with 18 breaches. An internal review of requests is

		undertaken on a regular basis and a weekly report is forwarded to the Trust SIRO – this process has been in place since September 2017. The Trust now has a fully operational IG Working Group which meets bi-monthly, is chaired by the SIRO and attended by the Caldicott Guardian. FOI's are a standing agenda item for these meetings and an update report is presented within the meetings remit. The website in question has requests marked as 'Long overdue' or 'Awaiting classification' even if we have contacted the requestor asking for further information/clarification and are awaiting a response from them, and in some cases even where we have sent a response.

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.

James Crawley
Lead Governor & Public Governor for Kent