South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting to be held in public.

26 March 2020
10.00-12.30

Crawley HQ

Agenda

Item No.	Time	Item	Encl	Purpose	Lead
Introduction					
101/19	10.00	Apologies for absence	**-**	-	Chair
102/19	10.01	Declarations of interest	**-**	-	Chair
103/19	10.02	Minutes of the previous meeting: 30 January 2020	**Y**	Decision	Chair
104/19	10.03	Matters arising (Action log)	**Y**	Decision	PL
105/19	10.05	Chief Executive's report	**Y**	Information	PA
106/19	10.15	Response to COVID-19	**Verbal**	Assurance	PA
Strategy					
107/19	11.00	Delivery Plan	**Y**	Information	SE
108/19	11.20	Patient Experience Strategy	**Y**	Decision	BH
Break					
Quality & Performance					
109/19	11.40	Integrated Performance Report / Committee Escalation	**Y**	Assurance	SE
Governance & Risk					
110/19	12.15	Audit & Risk Committee Escalation Report	**Y**	Information	MW
111/19	12.20	Board Committee TOR / Annual Planning	**Y**	Decision	PL
Closing					
112/19	12.25	Any other business	**-**	Discussion	Chair
113/19	-	Review of meeting effectiveness	**-**	Discussion	ALL

Close of meeting
After the meeting is closed questions will be invited from members of the public

Date of next Board meeting: 28 May 2020

South East Coast Ambulance Service NHS
NHS Foundation Trust

Item No	105-19

Name of meeting	Trust Board
Date	26.03.2020
Name of paper	Chief Executive's Report
Executive sponsor	Chief Executive
Author name and role	Philip Astle
Synopsis	The Chief Executive's Report provides an overview of the key local, regional and national issues involving and impacting on the Trust and the wider ambulance sector.
Recommendations, decisions or actions sought	The Board is asked to note the content of the Report.

Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

CHIEF EXECUTIVE'S REPORT TO THE TRUST BOARD

1. Introduction

1.1 This report seeks to provide a summary of the Trust's key activities and the local, regional and national issues of note in relation to the Trust during February and March 2020 to date.

2. Local issues

2.1 Operational Performance

2.1.1 The Trust's Senior Operational Leadership Team is continuing to ensure there is close monitoring of our 999 and 111 performance and that we are making the most efficient use of the resources we have available.

2.1.2 Delivery against some measures of performance has been particularly challenging in recent weeks due to the significant impact of COVID-19 on the Trust. Further details on our response to COVID-19 is detailed in the national issues section below.

2.1.3 In light of this, operational teams are continuing to ensure that overtime is focussed on the front line, in EOC and 111. This includes re-introducing targeted incentives for key shifts.

2.1.4 February and March 2020 have continued to see the Trust experience periods of significantly high demand, primarily due to the impact of COVID-19. This increase in demand has been particularly felt in NHS 111 but demand is also up in 999 and will increase further as the level of infection increases.

2.1.5 Apart from the Category 1 Transport target, we are not currently meeting the national standards for any of the other response categories, however the Category 1 and Category 2 response times were proportionately better than those for the lower categories.

2.1.6 We continue to perform well nationally in the area of 999 call answer in the latest national figures for February released by NHS England on 12 March 2020. Despite recent challenges, I am pleased that we continue to be among the best in the country for this measure.

2.2 Executive Management Board (EMB)

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

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

2.2.3 During recent weeks, the EMB has focussed on a number of key issues, including those below. However, the main focus has been on the impact of COVID-19, the rapidly-changing national picture and the impact on the Trust.

2.2.4 Other issues covered include:

- Refreshing the approach to how we lead the system with 'hospital handover delays/appropriate conveyances
- Exploring our approach to shared paramedic workforce across the system
- Approving a number of business cases, including one for the new Brighon Make Ready Centre

2.3 Development of Trust Strategy

2.3.1 During recent weeks and following extensive engagement with a range of internal and external stakeholders, the Board has spent time agreeing the Trust's future direction of travel and finalising the new Trust Strategy.

2.3.2 Following this work, we had hoped to launch the new Strategy internally and externally this month, however, due to the current national situation, we have decided to postpone the launch until later in the year. Internally we will be working to the revised strategy from 1 April 2020.

2.4 Changes to Trust Board

2.4.1 Further to updates provided previously on Non-Executive Director (NED) recruitment, I am pleased that a recommendation was made to the Council of Governors to appoint to the financial NED role. Howard Goodbourn has now joined the Trust in this role and I know that his extensive experience will be a valuable addition to the Trust Board.

2.4.2 Unfortunately, an appointment was not made during this recruitment round to the second NED role. The Council of Governors, through its Nominations Committee, will discuss the next steps at its meeting in April 2020.

2.5 Local visits

2.5.1 During recent weeks, I have spent time meeting key external partners, as well visiting Trust locations and spending time with staff.

2.5.2 On 2 March 2020 I held an introductory meeting with Miles Scott, the Chief Executive Officer of Maidstone & Tunbridge Wells NHS Trust and his senior team, who operate two hospitals in our area. It was an extremely useful meeting, where we were able to discuss how we work together and how we can make improvements.

2.5.3 On 2 March, I was also very pleased to attend the retirement presentation for Paramedic and Operational Manager, Anne Copson at Dartford Ambulance Station, where her colleagues celebrated her 43 year ambulance service career.

2.5.4 On a sad note, on 12 March 2020 I had the privilege of attending the funeral of paramedic James McKeough, who tragically died in a road accident in February. It was a really emotional occasion but I was very pleased to see it so well attended by many of Jim's colleagues and friends.

2.5.5 I have spent time recently with some of our newest EOC staff at both Crawley and Coxheath when I have spent time with Emergency Medical Advisors and Clinicians during their training. This included presenting some with certificates for successfully completing their training. I am sure they, along with all of their new colleagues, have promising careers with SECAmb ahead of them.

2.5.6 I have also enjoyed spending time at Ashford 111 recently and, despite the significant pressures they have been under, it has been very impressive to see the excellent team spirit amongst all members of the team.

2.6 Governor elections

2.6.1 Thank you to all our members who voted or stood in the recent round of Governor elections.

2.6.2 I am pleased to see that the following members were elected for a three-year term of office from 1 March 2020 until 28 February 2023:

- Christopher Burton: Operational Staff Governor and Paramedic Practitioner
- Leigh Westwood: Lower East SECAmb Public Governor (East Sussex and Brighton)
- Nigel Robinson: Lower West SECAmb Public Governor (West Sussex)
- Sian Deller: Upper East SECAmb Public Governor (Medway/ Kent/ East London)
- David Escudier: Upper East SECAmb Public Governor (Medway/ Kent/ East London)
- Marguerite Beard-Gould: Upper East SECAmb Public Governor (Medway/ Kent/ East London)
- Amanda Cool: Upper West SECAmb Public Governor (Surrey/ Hants/ West London)

2.6.3 The following members were also elected, for a two-year term of office as follows from 1 March 2020 until 28 February 2022:

- Marcia Moutinho Non-Operational Staff Governor and Patient Experience Officer
- Cara Woods Upper East SECAmb Public Governor (Medway/ Kent/ East London)

2.6.4 I would like to thank those Governors whose terms had come to an end and chose not to re-stand or were not re-elected this time. Their hard work and commitment over their term of office is truly appreciated. Thank you to Felicity Dennis, who leaves us from the position of Lead Governor, Nick Harrison, Roger Laxton, Harvey Nash and Marian Trendell.

2.7 Staff Award Ceremonies

2.7.1 On 27 February 2020 I had the absolute pleasure of hosting the first of this year's Staff Award Ceremonies, held in Kent. During the evening we recognised the many years of service given by our staff and volunteers, as well as those who had gone 'above and beyond' and had been awarded the Chief Executive's Commendations.

2.7.2 During the ceremony the long service of staff was recognised with the presentation of long service awards, and 13 worthy recipients were awarded the Queen's Medal for Long Service & Good Conduct by the Deputy Lieutenant of Kent, Dr Bhargawa Vasudaven on behalf of HM The Queen.

2.7.3 I was really pleased that we also recognised a number of our volunteer Community First Responders (CFRs) for their long service and the time they have given up to support their local communities. I was also very proud to see three of our great team of chaplains recognised for the support that have provided to staff during the past 20 years.

2.7.4 In the second part of the ceremony, I was privileged to present a number of Chief Executive's Commendations, with every one of the award winners clearly demonstrating the values of the Trust and demonstrating real commitment to our patients and to their colleagues. Congratulations and well done to every single winner.

2.7.5 Unfortunately, due to the COVID-19 situation, we took the difficult decision to cancel the remaining two Staff Awards Ceremonies planned to take place shortly afterwards. I know that this was really disappointing for all those due to attend and we will do our very best to re-arrange these as soon as we are able to.

2.8 CQC update

2.8.1 On 20 February 2020, we held our annual review meeting with the CQC to discuss the areas that we had been asked to focus on previously. It was a really positive meeting and the CQC were pleased with progress we're making in many areas.

2.8.2 We know that there is more that we need to do but this was a good indication that things are continuing to go in the right direction. Thank you to Bethan and her team for leading on our relationship with the CQC and everyone involved in continuing to improve the quality of everything we do

3. Regional Issues

3.1 Delay to implementation of new NHS111/CAS contract

3.1.1 In the light of rising pressure on the Trust due to COVID-19 and in particular on the NHS 111 service, discussions took place with our commissioners and a system-wide decision was taken to postpone the launch of the new NHS 111/CAS contract planned for 1 April 2020.

3.1.2 We will continue to review the situation during the weeks ahead with our partners and refine the implementation plans. We expect to launch the new service before the winter, however, in the meantime, the current NHS 111 service continues as normal.

3.1.3 I would like to thank everyone both at SECAmb and our future partners at IC24 for their hard work on progressing this project in recent weeks, despite the obvious challenges.

4. National issues

4.1 COVID-19 outbreak

4.1.1 As mentioned above, SECAmb has been and continues to be significantly impacted by the current COVID-19 outbreak.

4.1.2 We are working closely with Public Health England, NHS England, NHS Improvement and the National Ambulance Resilience Unit (NARU) to ensure we are utilising the most up to date guidance available and doing everything possible to keep our staff and our patients safe.

4.1.3 During this period, we have seen a significant impact on both our NHS 111 and 999 services. In common with other NHS 111 providers nationally, we have received increased numbers of calls during this period from patients who meet the criteria for testing, as well as from the 'worried well'. In our area, we also saw the particular impact on NHS 111 of the temporary closure of a number of GP surgeries in late February 2020.

4.1.3 We have also seen an impact on our 999 service. Initially, front-line 999 crews were responsible for collecting patients from their home address, transporting them to an appropriate facility for testing and then returning them home. This had a real impact on the availability of resources due to the requirements for appropriate precautions to be taken by staff and the need for deep cleaning of the vehicles used afterwards.

4.1.4 More recently, the testing approach has moved towards community testing and we have worked with acute and community providers to undertake testing of suspected patients in their homes, without the need for transporting to hospital. This has included providing the regional co-ordination service for testing on behalf of the system.

4.1.5 A key focus during the past week has been on ensuring that we keep pace with the changing national guidance around self-isolation and monitor and manage the very real impact that this will have on our workforce.

4.1.6 EMB has spent a considerable amount of time focussed on our response to the COVID-19 pandemic. Key decisions taken have included:

- Declaring a Business Continuity Incident (BCI)
- Reviewing the Trust's REAP Level and what actions to take in order to increase resource availability

- Establishing a COVID-19 Co-ordination Cell
- Establishing a governance approach including the Covid Business Continuity Group (CBCG) led by the Executive Directors
- Reviewing all on-call arrangements and increasing these where needed
- Pausing delivery of Key Skills refresher training
- Standing down student paramedics from on-road time and exploring alternative roles where they can be deployed

4.1.7 I am very proud of the hard work and effort that has been put in by staff across the Trust to responding to this situation. It has been challenging due to the speed at which the situation has developed, however there has been real focus on the safety of staff and patients which has been great to see.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	107-19

Name of meeting	Trust Board
Date	26 March 2020
Name of paper	Delivery Plan Progress Update
Responsible Executive	Steve Emerton, Director of Strategy and Business Development
Author	Eileen Sanderson, Head of PMO
Synopsis	The report sets out the progress against the projects within the delivery Plan, and is supported by the following appendices; • Appendix A – CQC Tracker • Appendix B – Portfolio Timeline • Appendix C – Quality and Compliance Dashboard • Appendix D – Transforming Clinical Education Dashboard • Appendix E - CIP Pipeline Tracker • Appendix F – CIP Delivery
Recommendations, decisions or actions sought	For information

Does this paper, or the subject of this paper, require an equality analysis record ('EAR')? (EARs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

Executive Summary

The Board should be specifically drawn to the following since the last reporting period:

1. HR Transformation Programme:

    - The Fundamentals Leadership Programme was launched in Ashford on 3rd March 2020 with three further cohorts planned from now till end of May 2020.

2. Transforming Clinical Education (TCE) Programme:

    - TCE is currently transitioning to business as usual (BAU) with a target handover date of 31st March 2020. Of the 7 remaining workstreams, 3 have completed their objectives within agreed timescales.
    - A Self-Assessment Review (SAR) was submitted to Ofsted on the 14th February 2020 and work is ongoing to update the Quality Improvement Plan (QIP). A weekly Task and Finish group has been set up to monitor the Ofsted plan and to prepare the Trust for a Future Quals review due 1st May 2020.

3. Estates Programme:

    - Epsom Relocation: A contract extension of 12 months has been granted by the landlords to remain at Epsom Ambulance Station until 30th June 2021.
    - Worthing Re-Development: Phase 2 is delayed awaiting recruitment of a project management resource. Also, clarification is required on the type of security fencing needed. A site risk assessment has been conducted and a written report is due to be shared shortly, where further information can then be provided on requirements.

4. Quality and Compliance:

    - Following a period of consistency, the EOC Call Answer Performance action plan successfully transitioned to BAU on 30th January 2020.
    - Work has started on transitioning Improving Operational Performance in 111 and Clinical Recruitment action plans to BAU by 31st March 2020.
    - A discussion has been held around moving forward with the Datix Cloud Migration. It has been agreed that a Project Mandate will be created for two modules (Learning from Deaths (LFD) & Safety Alerts). It is expected that formal reporting of the project will commence in the next reporting period.

5. KMS 111 IUC Mobilisation Programme:

    - Covid-19 presents a significant challenge to the Trust in terms of capacity and has already impacted on both current 111 services and the delivery teams.
    - A delay in key IT work stream elements i.e. in particular Testing, Telephony Integration, Cleo/Cleric interface, Direct Appointment Booking due to the team focusing on BAU activity.
    - SECAmb have highlighted risks and concerns to commissioners to ensure that any potential delay to the CAS Mobilisation does not create any additional risk to patients as SEC 111 IUC service is already delivering an interim Clinical Advice Service (CAS) and as a result, a number of the NHS England IUC pillars are in place, and the IC24 service is providing a CAS element as part of its 111 service.

6. The 2019 CQC Must & Should Do Tracker and Portfolio Timeline have been updated and can be found in Appendices A & B.

7. The following change requests have been approved:

    - E-Timesheets (CR058): Descoped E-Timesheet policy and procedure and Pay principles policy. Timeline changes related to the completion of several objectives.
    - Transforming Clinical Education (CR059): Timeline changes related to the completion of several objectives. Scope addition relating to the mentoring qualification and a change to the numbers in the KPI relating to upskilling Band 5 paramedics.

8. The following Post Project Implementation Reviews (PPIR) have been approved for:

    - Service Transformation and Delivery Programme: Following the review, although some activities have been completed after the programme transitioned into business as usual, there are still some post project activities that have not been completed. A further PPIR will be conducted in six months' time to review progress.

    - EOC Clinical Safety & Performance: Since the project transitioned into business as usual, full establishment of resource dispatchers has been achieved, new dispatch desk rota patterns has been implemented and the CAD Interoperability Tool Kit (ITK) is now live which allows the transfer of calls between 999 and 111. There are still some post project activities that have not been completed so a further PPIR will be conducted in six months' time.

1.0 Introduction

1.1 This paper provides a summary of the progress for the Trust's Delivery Plan. The plan includes an update on the following:

- Estates Programme
- Financial Sustainability
- Quality & Compliance
- HR Transformation
- KMS 111 IUC Mobilisation

1.2 In this reporting period, there is a Dashboard for:

- Quality & Compliance (see Appendix C)
- Transforming Clinical Education (See Appendix D)

1.3 The Dashboards provide high level commentary and key points to note for this reporting period. As projects come to completion the reader should note that project closure processes will be enacted to ensure that continued and sustained delivery moves into BAU. Performance will be managed/reported within existing organisational governance and within the Trust's Integrated Performance Report (IPR) where appropriate.

1.4 A summary of overall progress and whether the projects are on track to deliver within the expected completion dates and/or risks of failing can be found in the detail of this report.

1.5 All projects are given RAG ratings using the following definitions:

Red: Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints; requires escalation.
Amber: Significant risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints.
Green: On track and scheduled to deliver business case/ mandate objectives within agreed constraints.
Grey: The project is on-hold.
Blue: The project has been completed.

2.0 Estates Programme

2.1 **Brighton Make Ready Centre –** The project RAG is rated Green. The project plan has been baselined following refinements from the meetings held with key stakeholders. The Room Data Sheets (RDS) have been approved and a design freeze has been agreed at the Brighton Management meeting on 12th February 2020.

A process for any future changes to RDS has now been established to ensure any requests/additional requirements follow a process and the impact of time, cost and scope are considered. Furniture requirements are currently being mapped to enable quotes to be obtained and reviewed against budget. HR are currently calculating relocation payments to provide the budget for the 4-year payment period.

2.2 **Sheppey Ambulance Re-Development –** This is the first reporting period. The project is RAG rated Green. The project mandate has been approved and the project is on track to deliver by end August 2020.

A Letter of Intent was issued to the contractor on 8th February 2020 and a project kick-off meeting was held on 24th February 2020 with key stakeholders. A baselined project plan is in progress awaiting receipt of the construction plan from the contractor.

Fortnightly project boards have been established to enable progress of the project to be tracked.

3.0 Digital Programme

3.1 **ePCR –** Formal closure was approved at the Sustainability Steering Group (11th February 2020). Since closure, ePCR use by area has been increasing week by week, with an average of 80% of incidents with an ePCR (as of 9th March 2020).

4.0 Financial Sustainability

4.1 **CIP –** The Cost Improvement Programme RAG remains Amber as at month 11, February 2020. £7.2m of schemes have been fully validated and transferred to the CIP Delivery Tracker, an improvement of £0.8m compared to last month. The full year risk-adjusted forecast of £6.9m is £1.7m below the planned £8.6m. Recurrent schemes represent 63% of the total.

The current pipeline scheme value of £9.0m includes £30k of validated and £0.2m of scoped schemes, which are pending Executive Sponsor and QIA approval prior to moving to delivery. Engagement with budget leads is focused on the development of further schemes required to achieve the remaining £1.7m proposed value on the Pipeline tracker and to mitigate the slippage in the forecast.

CIP achievement for the eleven months, at £6.3m, is £1.6m below plan. The shortfall is largely due to the difficulties in delivering the planned improvements in operational efficiencies, notably task cycle time and sickness levels being higher than planned. Finance is working collaboratively with operations budget leads to scope alternative schemes to compensate for the year to date underachievement. The full year projected savings target of £8.6m is expected to be met, although this continues to be challenging. The CIP Pipeline and Delivery Tracker (Appendices E & F) provides more detail on the progress of the Programme.

5.0 Quality & Compliance

5.1 **Clinical Recruitment (Action Plan) –** The action plan remains Amber due to an ongoing issue relating to the recruitment of 14 Clinical Safety Navigator's (CSN's) by 31st August 2020 (currently 7 WTE). Internal shadowing opportunities are being offered to clinical supervisors to help manage the gap.

Recruitment of Clinical Supervisors to 43 WTE is also at risk (currently 27.5 WTE) with 14 WTE at various stages in training. These figures are lower than previously reported (35 WTE) as clinicians in training were previously counted in the numbers and part-time individuals were counted as full time. Adverts are currently published to recruit more Clinical Supervisors with 6 candidates shortlisted for interview.

The international recruitment process is still ongoing, and it is likely the Trust will be employing 8 recruits from this recruitment drive due to several candidates dropping out of the process due to failing courses or candidates not being suitable.

5.2 **NHS Pathways Audit (Action Plan) –** The action plan remains Red due to the outstanding grievance. The grievance investigation is in its final stages and a report is expected week commencing 9th March 2020.

Recruitment is ongoing to fill temporary roles focusing on the 2019 backlog; 8 quality coaches are in place with 3 more clinical auditor posts expected to be filled by 31st March 2020.

There is a slight improvement to non-clinical and clinical audit compliance and this is expected to improve further with the introduction of the temporary staff. Following the national levelling session delivered by NHS Pathways, the Trust now delivers monthly local levelling as BAU to improve and maintain consistency of audits.

5.3 **Improve Operational Performance in 111 (Action Plan) –** The action plan RAG remains Amber as call volumes continue to increase due to external factors, mainly related to Covid-19. However, it should be noted that performance throughout January 2020 was good with the service outperforming the national average, and the average handling time target was met with a monthly average of 546 seconds. A letter of correspondence was received from the Commissioners in February 2020 to say they were really pleased with the high performance in the 111 service in recent months and to commend the service on their hard work to get the service to such a strong level.

The activities within the action plan is now in the process of transitioning into BAU by 31st March 2020 in-line with the action plan completion date. The transition will be made against the PMO BAU transition process which will provide the assurance that all aspects of the plan have BAU owners as applicable and governance is in place to ensure monitoring of the performance is maintained. QCSG will continue to have oversight of performance data.

5.4 **EOC Call Answer Performance –** The Quality and Compliance Steering Group (QCSG) approved transition to BAU on 17th December 2019 as a period of consistency in call answer improvement has been evident. The project transitioned on 30th January 2020.

5.5 **Safe Staffing (Rota Compliance) –** It was agreed at the Quality & Compliance Steering Group (17th December 2019) to place the project on hold until the end of March 2020 except for training and the implementation of the planning Workforce tool 'Injixo'.

A 12-month training plan has been agreed and will be taken to the next EOC Governance meeting on 19th March 2020 for approval. The mapping of shifts from GRS to Injixo is now underway and it is anticipated that Injixo will go live shortly.

5.6 **Transforming Clinical Education –** The programme RAG has moved from Amber to Green following the completion of 3 workstreams within the mandated timescales. Activities are now progressing at a steady pace and this programme is transitioning to business as usual by 31st March 2020.

Backlog Marking – Following the agreed marking trajectory and the onboarding of Emstar and Chichester College Group, there has been a reduction in the number of assessments in the backlog. As of 6th March 2020, 297 were outstanding with 15 over 30 days. Personal development plans have been put in place to manage the 37 learners identified in the initial backlog with outstanding assignments.

Clinical Education Courses – All activities in this workstream are now complete with the 2019/20 and 2020/21 training plan mapped onto the accredited template.

Ofsted Compliance – The FutureQuals Report has now been received and checked for factual accuracy, with the Trust scoring a 2/5 'good'. A Self-Assessment Review was submitted to Ofsted on 14th February 2020 and work is ongoing to update the Quality Improvement Plan. Weekly review meetings have now been established to prepare the Trust for the FutureQuals review on 1st May 2020.

Work is continuing to address the 11 issues identified in the Ofsted monitoring inspection report, with 7 of the issues due to be completed by 30th March 2020.

Co-delivery of Apprenticeships – All activities on this workstream have been successfully delivered. Following the approval of a co-delivery model with the Chichester College Group, the delivery of the first Associate Ambulance Practitioner (AAP) Programme with 23 students commenced on the 20th January 2020; with a signed contract now in place with the College. Mapping of tutors against courses to identify gaps or overlaps was carried out and the conflicts identified are now mitigated. The College has recruited a Programme Lead and interviews are scheduled for Tutors from 9th March 2020.

Functional Skills – All activities for this workstream are now complete, with the ProTrain contract for the delivery of the Level 2 Maths and English to the 48 existing students now approved. A tracker is in place to monitor enrolment and completion; this will be overseen by the Apprenticeship Working Group. All students are expected to complete the classroom courses by 29th May 2020.

Level 6 Paramedic Programmes – The outline business case was approved in principle at the Business Case Review Group on 4th February 2020 and approved by the Executive Management Board on 19th February 2020.

The University of Cumbria (identified to co-deliver the programme) met with the Trust on 6th February 2020 and defined/agreed programme activities; conversations are ongoing to determine staffing requirements, following which a full business case will be submitted for approval to the business case review group, Executive Management Board and the Trust Board. The Health and Care Professions Council programme approval visit to Newbury for the co-delivery programme is scheduled for the 2nd/3rd June 2020.

Workforce Education Development Review - Following the confirmation of the number of Paramedics requiring an uplift, a plan has been defined and work is underway to ensure the staff identified have been successfully enrolled on the necessary modules for face-to-face training by 31st March 2020.

Dates have been booked for Paramedics to complete their mentorship qualification from 1st April 2020. NHS England have been informed of the Trust's delivery method of this programme.

6.0 HR Transformation

6.1 **E-Expenses –** The project RAG has moved from Green to Amber as it is unlikely to meet the business case / mandate objectives due to the delay in the roll out of the final phase to operational staff. The planned go-live has moved from 1st March 2020 to 30th June 2020 to allow all potential issues and legacy discrepancies to be fully explored and to ensure all guidance is clear before implementation for all staff working across the Trust.

6.2 **E-Timesheets –** The project RAG remains Amber as it is unlikely to meet the business case / mandate objectives. The timeline for the phased roll out will now move from April 2020 to June 2020 as there is a need to bolster delivery capacity and check that the implementation is correct as it rolls out. This will include, for example, consideration of how a parallel run of existing and new systems will occur to ensure accurate calculations for hours and pay.

6.3 **Culture Change –** The project RAG remains Amber as it is unlikely to meet the business case / mandate objectives. The new Head of Learning and Organisational Development has recently taken up post and is now reviewing the Learning and Organisational Development Strategy which will build on the activities from the culture mandate.

Progress to date; series of videos have now been produced by the Learning and Organisation and Development team to develop positive behaviours at work which will form part of the train the trainers programme for the delivery of Key Skills Programme. The NHS Healthcare Leadership 360 tool will be rolled out to the Executive Team next month with future roll out of the tool to managers shortly as part of the Learning and Organisational Development strategy.

6.4 **HR Structure –** The action plan was formally approved for closure at the HR Transformation Steering Group on 27th January 2020. All senior management roles have now been appointed. Further reporting on this will now cease.

7.0 KMS 111 IUC Mobilisation

7.1 **NHS 111 Mobilisation –** The Programme RAG is Red. Several workstreams are progressing well with NHS England Checkpoints, these include workforce, communications and governance however, the programme will remain Red until the external factors, in particular, Covid-19 and the IT interface testing between Cleric/Cleo can be completed successfully.

The Trust has established a central Covid-19 coordinating team to manage the evolving demands on our services however Covid-19 represents a specific issue to the KMS 111 CAS mobilisation in respect to the capacity of workstreams.

Workforce – Recruitment is progressing well with many roles are now almost at establishment and the related training is planned. However, the Urgent Care Practitioner (UCP) role has proven more challenging to fill internally due to contractual differences (NHS Agenda for Change) for Paramedic Practitioners (PP's) transitioning to the new UCP role. We are looking at alternative sources for this workforce, including agency staff and continue to recruit in partnership with our delivery partners IC24.

Clinical Quality – This workstream has made significant progress with teams from both organisations working closely to finalise joint processes to maintain and enhance patient safety. These processes however are also dependent on the technical processes being available in the test environment in order to ensure that processes are effective and safe.

Digital Workstream – The delay of the interface between Cleo/Cleric integration testing means that this workstream is impacting on others in terms of the completion of policy and training on any changes being made subsequent to the new system. We have a dedicated Digital Project Manager in place who coordinates daily between our suppliers and IC24 in order to resolve this delay.

Information Governance (IG) – IG processes and agreements have been finalised but is dependent on the digital testing plan.

Due to the wider changes occurring to downstream services, for example, Urgent Treatment Centres and face to face primary care provisions, there are multiple dependencies that need to be understood and agreed in order to facilitate effective referral from the CAS. Whilst outside of SECAmb's immediate control, these inter-dependencies are being worked through with commissioners and providers to ensure a safe phasing of service transition.

Appendix A - Care Quality Commission 2019 'Must and Should Do' Oversight and Assurance Report
March 2020
Last Updated 16/03/2020, v0.1

South East Coast Ambulance Service NHS Foundation Trust

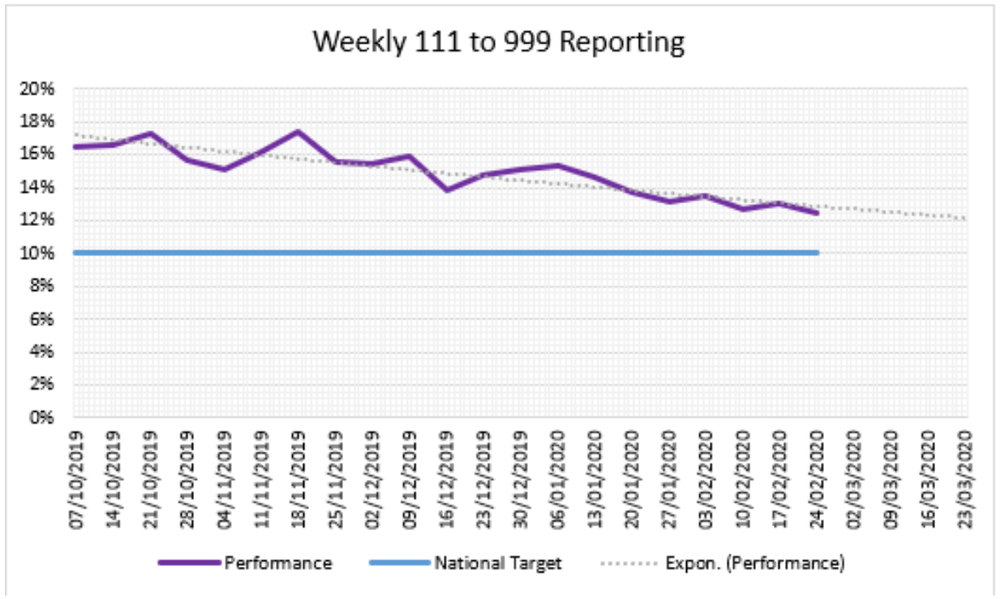
Domain	CQC Findings ('Must or Should Do')	Metrics	RAG rating

111 - The Trust must ensure care and treatment is provided in a safe way to patients.

To meet contractual performance key indicators for 95% calls answered in 60 seconds/sustained abandoned calls <5% and ambulance transfer rates <13% by 31 March 2020

1. Daily 111 to 999 Reporting

The SEC 111 AMB rate continues to fall, it is now below the 13% target and the service aims to sustain the rate below this level. Further actions to improve further upon this include additional activities to raise call handler awareness and the development of a Live Clinical Support Procedure to enable clinical support and scrutiny to call handler cases in real time.

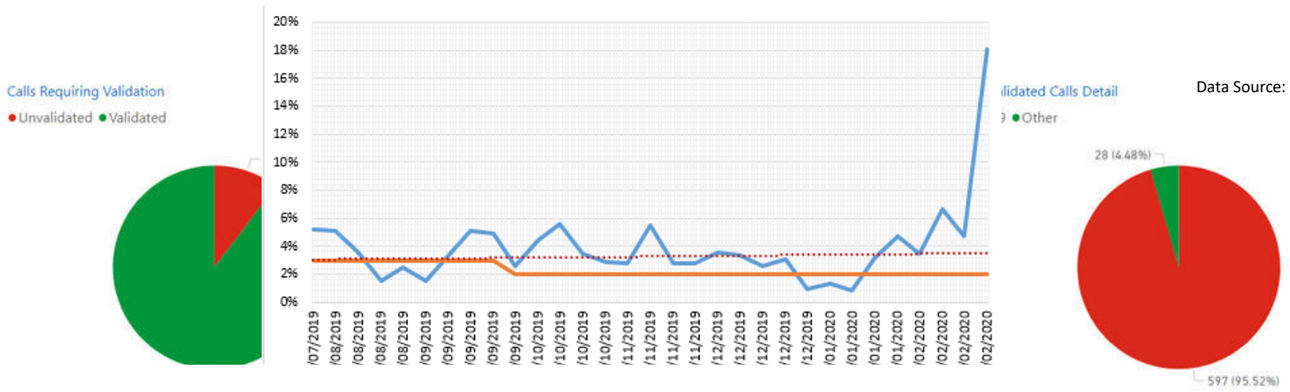


Data Source: Power BI

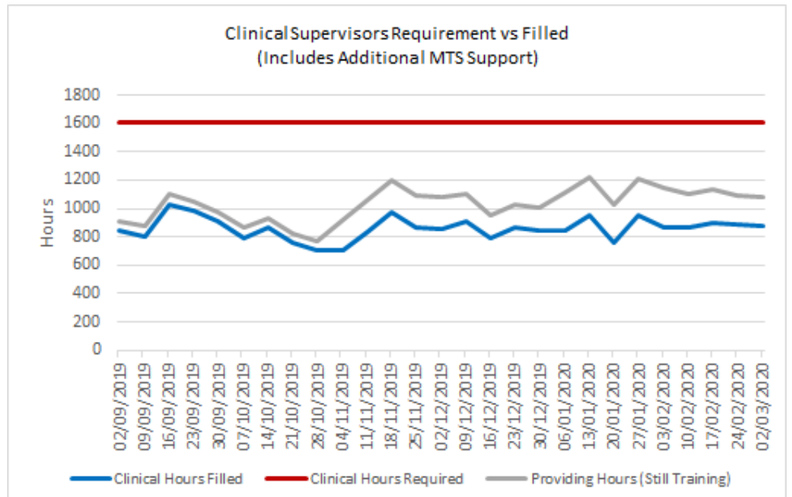
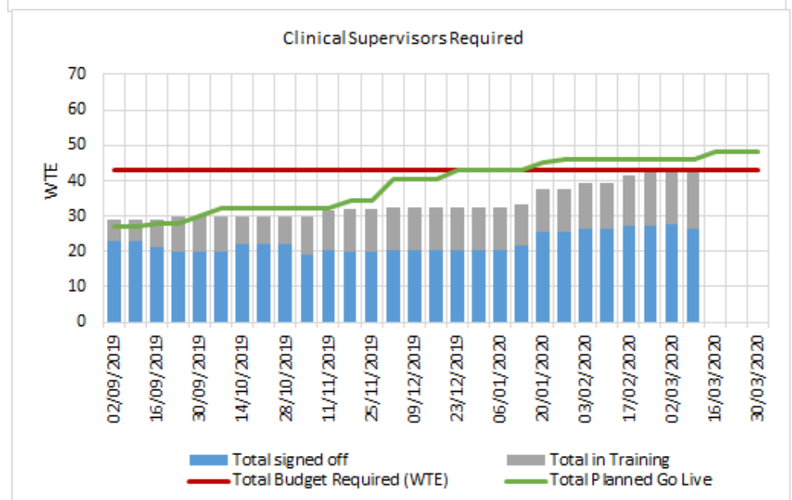
2. Ambulance Validation

111 Calls Validation Data

Category 3 and 4 validation continue to be highly effective throughout January 2020. 94.17% of interim C3 / C4 dispositions were validated, of which 65.12% were downgraded to a non-AMB disposition. The validation rate fell to 89.64% in February 2020 due to CoVID pressure on our clinical cohort, but downgrades are still acheved at a similar rate.

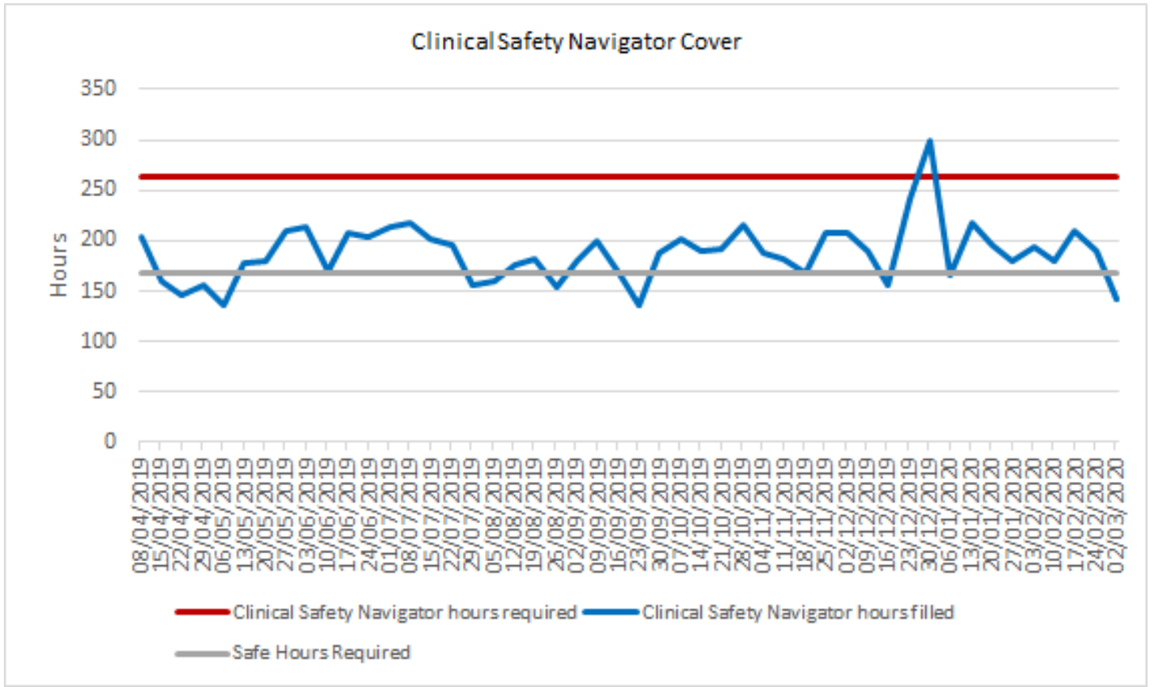


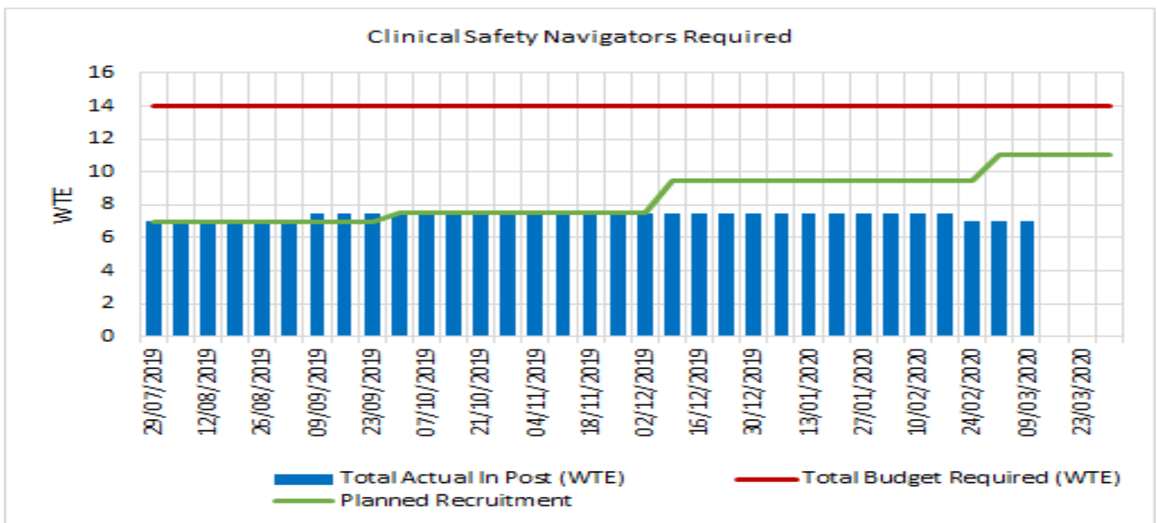
Data Source: Power BI – February 2020 Data

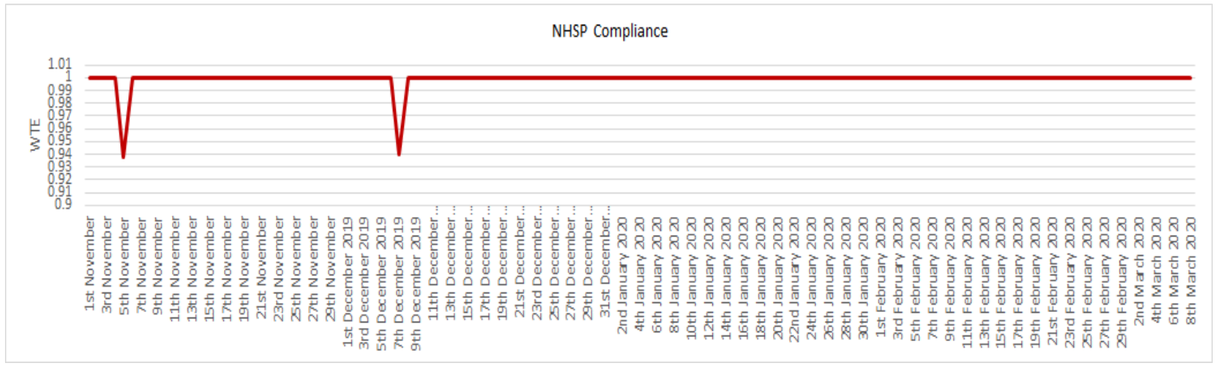
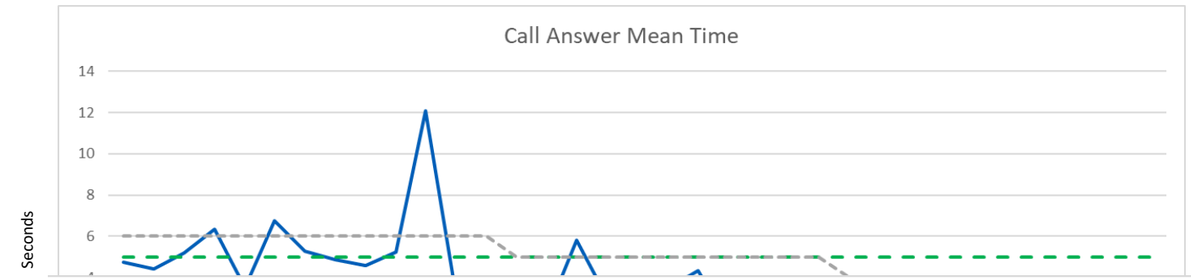
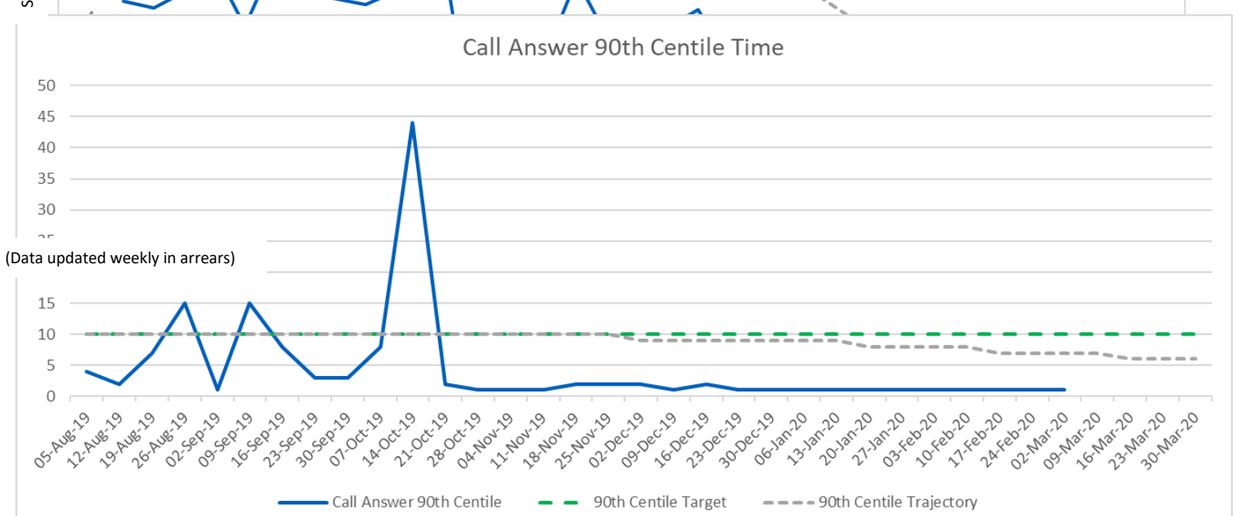
Safe	111 - The Trust should take action to ensure patient feedback mechanisms are fully established.	The SEC 111 IUC Service has an agreement in place with a suitable provider to commence the use of a texting service to evaluate patient feedback (mirroring the process in place previously for the KMSS 111 contract) via a Patient Satisfaction Survey. The Trust's Information Governance team have approved the Data Protection Impact Assessment (DPIA) review of the survey, and the survey has had Quality Impact Assessment (QIA) approval. The Trusts IT/Systems have been contacted with the Patient Survey Proposal and approved DPIA as part of the use case for the process. Currently awaiting feedback and requirements in order to establish work requirements and capacity in order to establish a delivery date.	
Safe	The Trust should take action to ensure there are a sufficient number of clinical staff in each emergency operations centres at all times.	**Clinical Supervisors (CS)** Since January 2019, the Trust has continued to focus on improving recruitment within the operation centres. The Trust is no longer on trajectory to be at full establishment for the recruitment into the Clinical Supervisors roles, however it is anticipated that the 43 WTE will be achieved by the end of May 2020. *Note – Due to clinicians in training being included in previous numbers, the number of WTE was inaccurate in the last report.   	

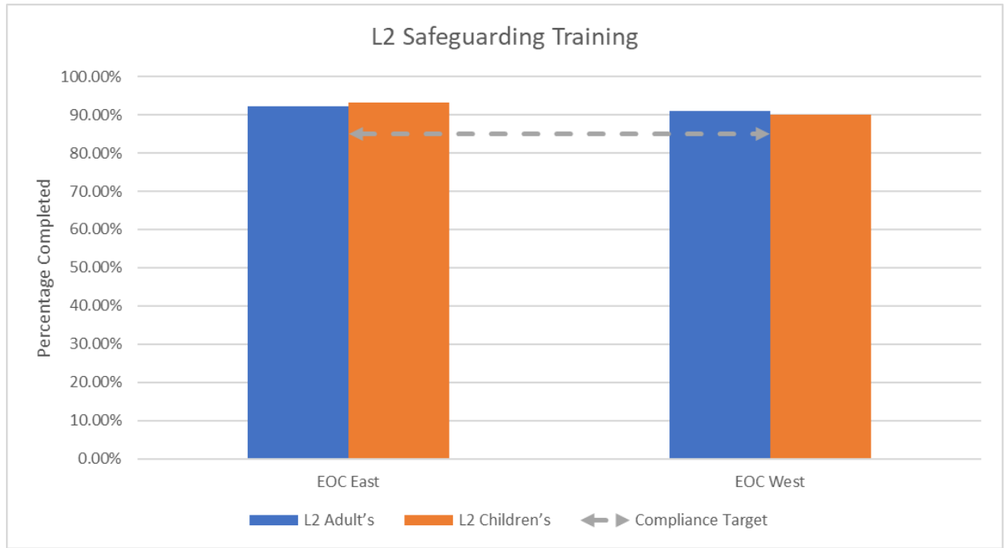
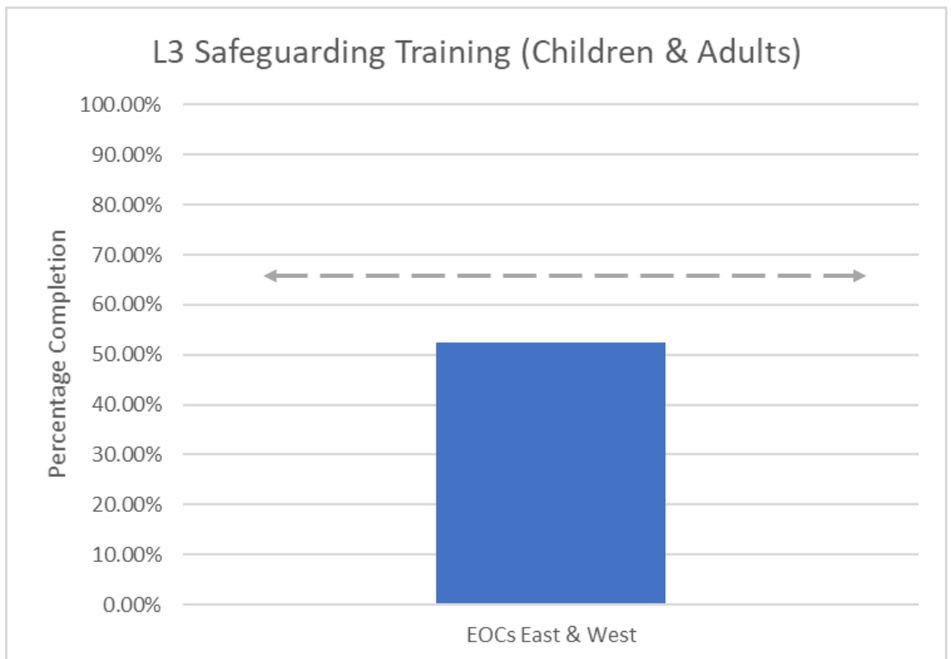
Clinical Safety Navigators

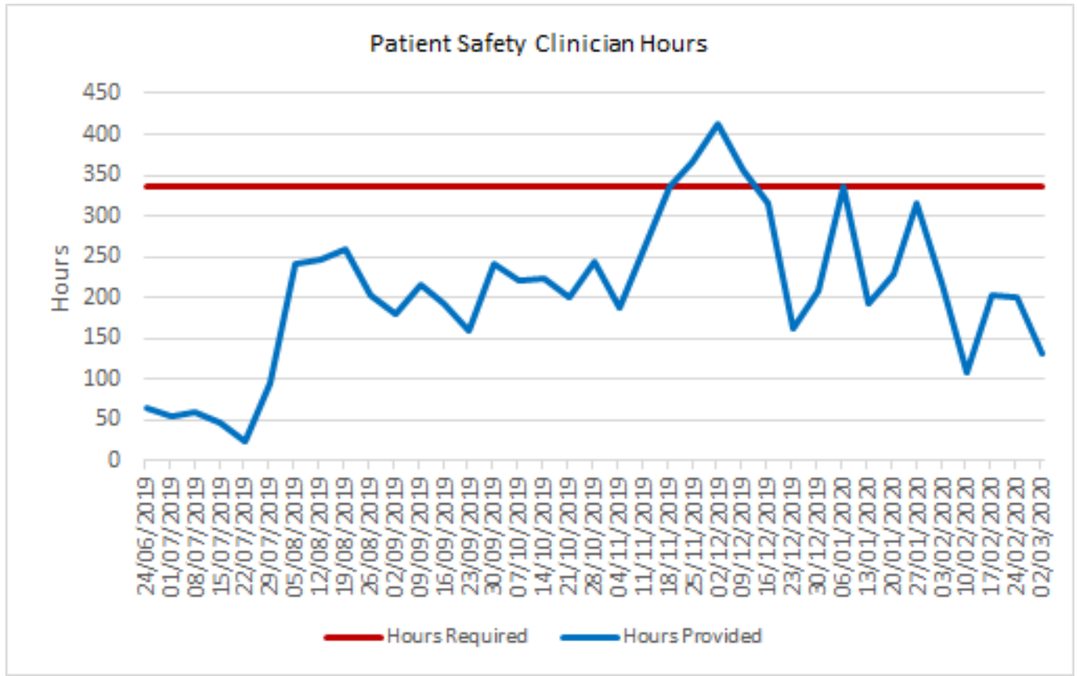
The recruitment of Clinical Safety Navigators has been challenging due to the telephone triage experience required. Although Clinical Supervisors are currently being recruited and will be eligible to apply for the Clinical Safety Navigator role after 6 months in post; there is no guarantee that they will be interested in this role. Therefore, the Clinical Supervisor role is being over recruited to in order to try and mitigate this.



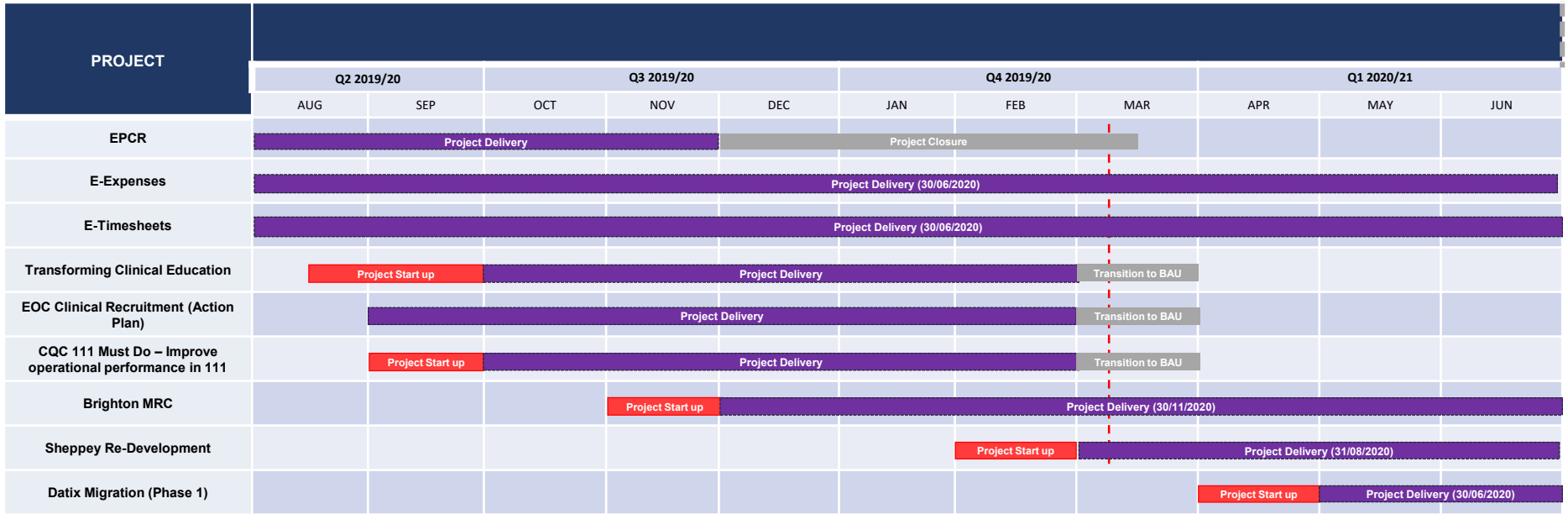


		NHS Pathways Compliance  Whilst recruitment is ongoing, agency staff and the management team are providing clinical hours to maintain our NHS Pathways (NHSP) compliance.	
Effective	The Trust should take action to meet the national performance target relating to call answering times.	The call answer performance target has been achieved since 25 November 2019.  	

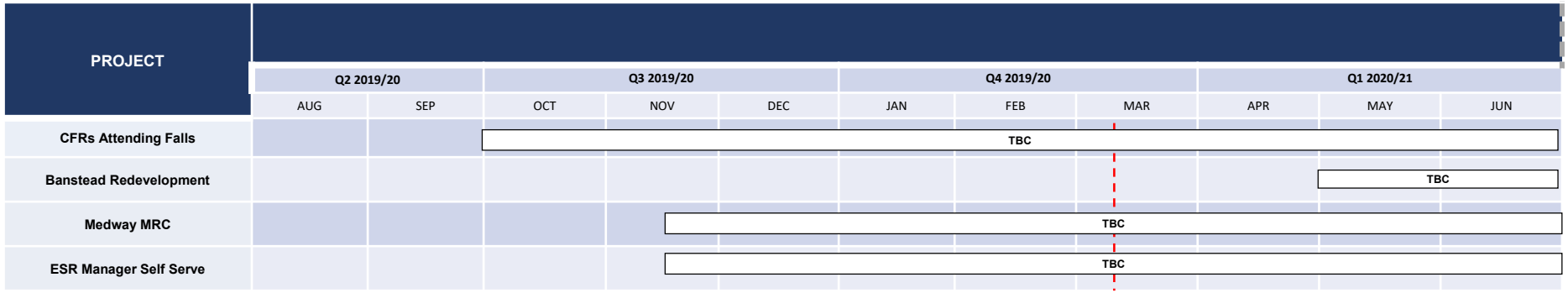
		(Data updated weekly in arrears)	
Safe	The Trust should take action to ensure all staff have completed the level two adult and children safeguarding and all relevant staff have completed level three adult and children's safeguarding.	 	

		 Work continues to ensure that the training records held on locally training logs is aligned to ESR. The Quality and Compliance Steering Group are actively monitoring progress.	
Safe	The Trust should take action to ensure the clinical welfare calls are completed within the targeted timeframes.	The Trust has recognised the need to keep patients safe whilst they are waiting for a response to attend their location. To address this, the Patient Safety Clinician role has been introduced. This is a Band 5 nurse role which is currently being resourced by agency staff along with SECAmb staff who are currently on alternative duties. The graph below shows the current requirement of 336 hours against actual numbers. 	

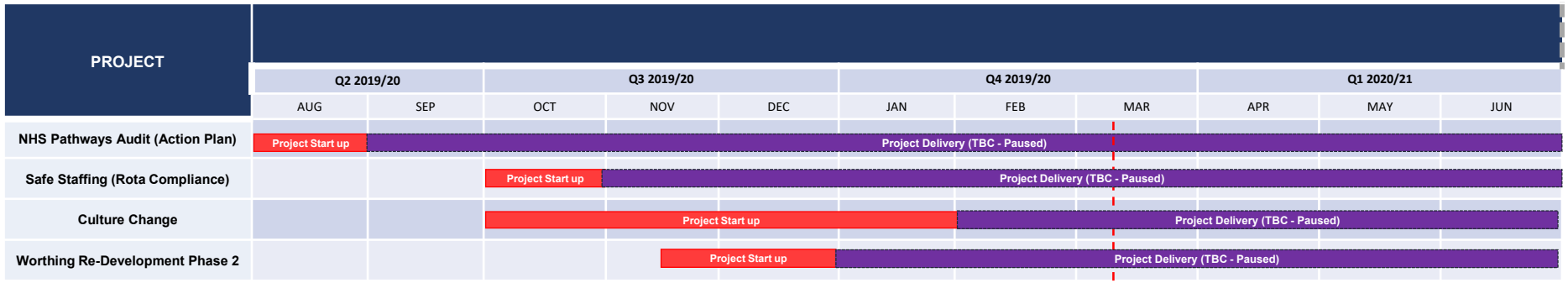
PMO Portfolio Timeline – Live Projects (Last updated: 10 March 2020)



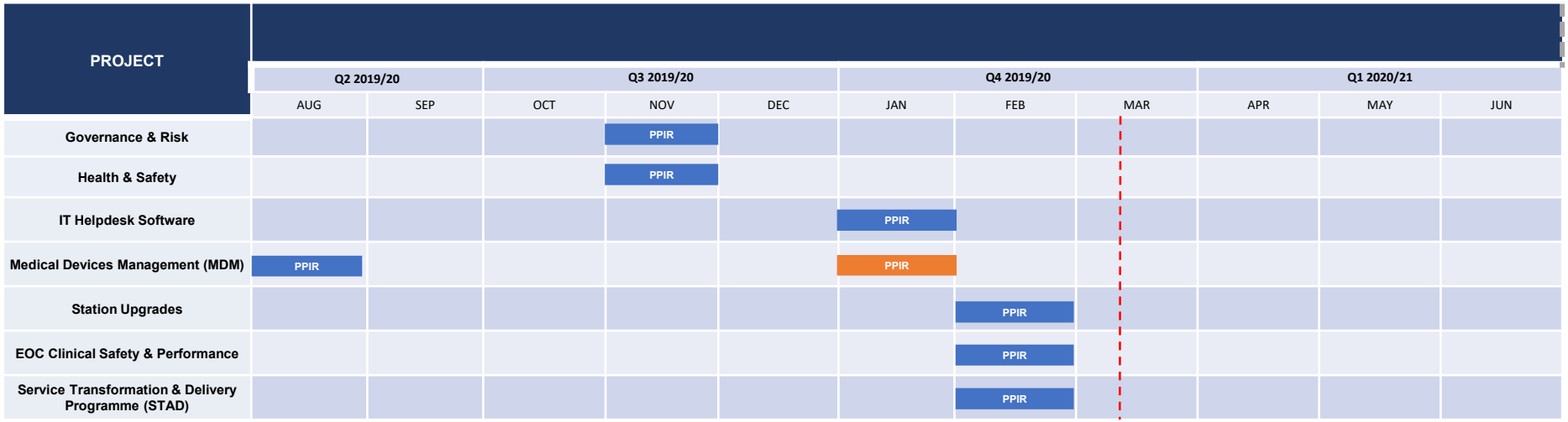
PMO Portfolio Timeline – Pipeline Projects (Last updated: 10 March 2020)



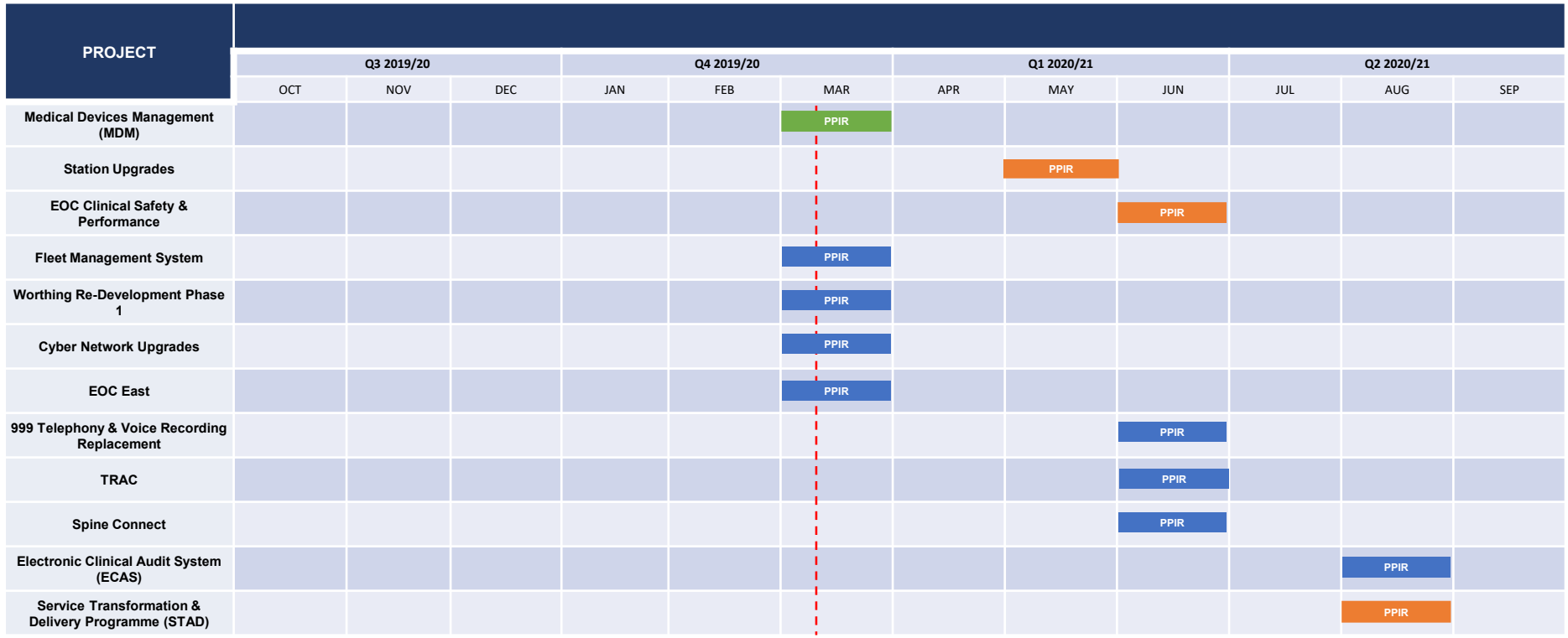
PMO Portfolio Timeline – Paused Projects (Last updated: 10 March 2020)



PMO Portfolio Timeline – PPIRs Completed (Last updated: 10 March 2020)



PMO Portfolio Timeline – PPIRs Due (Last updated: 10 March 2020)



Quality & Compliance Steering Group Dashboard

Reporting Period: 17/01/2020 – 13/03/2020

RAG Key:

Red	Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints; requires escalation.
Amber	Significant risk that project may not deliver to business case/ mandate objectives within agreed constraints.
Green	On track and scheduled to deliver business case/ mandate objectives within agreed constraints.
Blue	Completed.
Grey	On hold.

Last Updated 12/03/2020 v1.0

Key Points

Project	Brief Summary
Clinical Recruitment (Action Plan)	The action plan remains Amber due to an ongoing issue relating to the recruitment of 14 Clinical Safety Navigator's (CSN's) by 31st August 2020 (currently 7 WTE). Internal shadowing opportunities are being offered to clinical supervisors to help manage the gap. Recruitment of Clinical Supervisors to 43 WTE is also at risk (currently 27.5 WTE) with 14 WTE at various stages in training. These figures are lower than previously reported (35 WTE) as clinicians in training were previously counted in the numbers and part-time individuals were counted as full time. Adverts are currently published to recruit more Clinical Supervisors with 6 candidates shortlisted for interview. The international recruitment process is still ongoing, and it is likely the Trust will be employing 8 recruits from this recruitment due to several candidates dropping out of the process due to failing courses or are unsuitable.
NHS Pathways Audit (Action Plan)	The action plan remains Red due to the outstanding grievance. The grievance investigation is in its final stages and a report is expected week commencing 9th March 2020. Recruitment is ongoing to fill temporary roles focusing on the 2019 backlog; 8 quality coaches are in place with 3 more clinical auditor posts expected to be filled by 31st March 2020. There is a slight improvement to non-clinical and clinical audit compliance, this is expected to improve further with the introduction of the temporary staff. Following the national levelling session delivered by NHS Pathways, the Trust now delivers monthly local levelling as BAU to improve and maintain consistency of audits.
Improving Operational Performance in 111 (Action Plan)	Performance throughout January 2020 was good with the service outperforming the national average, and the average handling time target was met with a monthly average of 546 seconds. A letter of correspondence was received from the Commissioners in February 2020 to say they were really pleased with the high performance in the 111 service in recent months and to commend the service on their hard work to get the service to such a strong level. The action plan is now in the process of transitioning into business as usual by 31st March 2020 in-line with the action plan completion date. The transition will be made against the PMO BAU transition process which will provide the assurance that all aspects of the plan have BAU owners as applicable and governance is in place. QCSG will continue to have oversight of performance data.
EOC Call Answer Performance (Action Plan)	The Quality and Compliance Steering Group (QCSG) approved transition to BAU on 17th December 2019 as a period of consistency in call answer improvement has been evident. The project transitioned on 30th January 2020.
Safe Staffing (Rota Compliance) Action Plan	It was agreed at the Quality & Compliance Steering Group (17th December 2019) to place the project on hold until the end of March 2020 except for training and the implementation of the planning Workforce tool 'Injixo'. A 12-month training plan has been agreed and will be taken to the next EOC Governance meeting on 19th March 2020 for approval. The mapping of shifts from GRS to Injixo is now underway and it is anticipated that Injixo will go live during March 2020.
Transforming Clinical Education	The programme RAG has moved from Amber to Green following the completion of 3 workstreams within the mandated timescales. Activities are now progressing at a steady pace and this programme is transitioning to BAU by 31st March 2020. For further information on individual workstreams, please see separate Dashboard, Appendix D.

Key Issues

Project	Brief Summary	Score
NHS Pathways Audit Action Plan	Compliance for clinical audit remains poor. The consultation period for the proposed new staffing model to address this has been delayed due to an outstanding grievance. Mitigations are in place to provide temporary cover for audit.	Issue: High
EOC Clinical Recruitment Action Plan	The trajectory to recruit CSN's has not been met. Although Clinicians are currently being recruited, they will not be eligible to apply for the CSN role until after 6 months in post. This is being mitigated by the 4 Operational Managers Clinical covering shifts as required and development of shadowing opportunities and part-time roles.	Issue: Medium
Improving Operational Performance in 111 (Action Plan)	Call volumes have increased steeply from external factors and winter pressure which has hit the 111 service earlier and at higher volumes than this time last year, impacting on the performance SLA's.	Issue: High
Improving Operational Performance in 111 (Action Plan)	Evaluation of the pilot dual skilling group cannot be undertaken as true dual skill call taking has not be able to take place due to a configuration issue with the CallVision Centricity system	Issue: High

Project	Expected End date	Current RAG	Previous RAG
Clinical Recruitment (Action Plan)	31/08/2020		
NHS Pathways Audit (Action Plan)	30/04/2020		
Improving Operational Performance in 111 (Action Plan)	31/03/2020		
EOC Call Answer Performance (Action Plan)	30/06/2020		
Safe Staffing (Rota Compliance) Action Plan	TBC	On hold	
Transforming Clinical Education	31/10/2020		

Achievements this period

- EOC Call Answer Performance- action plan transitioned to BAU following a period of consistency in call answer performance.
  Improving Operational Performance in 111 – Achievement and Closure of Milestone 1
- Improving Operational Performance in 111 – Commissioners letter received for high performance and commended for hard work undertaken

Transforming Clinical Education Programme Board Dashboard

Reporting Period: 17/01/2020 – 13/03/2020

RAG Key:

Red	Serious risk that the project is unlikely to meet business case/ mandate objectives within agreed time constraints; requires escalation.
Amber	Significant risk that project may not deliver to business case/ mandate objectives within agreed constraints,
Green	On track and scheduled to deliver business case/ mandate objectives within agreed constraints
Blue	Completed

Last Updated 10/03/2020 v1.0

Key Points

Project	Brief Summary
Backlog Marking	Following the agreed marking trajectory and the onboarding of Emstar and Chichester College Group, there has been a reduction in the number of assessments in the backlog. As of 6th March 2020, 297 were outstanding with 15 over 30 days. Personal development plans have been put in place to manage the 37 learners identified in the initial backlog with outstanding assignments.
Clinical Education Courses	All activities in this workstream are now complete with the 2019/20 and 2020/21 training plan mapped onto the accredited template.
Ofsted Compliance	The FutureQuals Report has now been received and checked for factual accuracy, with the Trust scoring a 2/5 'good'. Work is ongoing to update the Quality Improvement Plan. Weekly review meetings have now been established to prepare the Trust for the FutureQuals review on 1st May 2020. 7 of the 11 issues identified in the Ofsted monitoring inspection report have been addressed, this is on track to be completed by 30th March 2020.
Co-delivery of Apprenticeships	All activities on this workstream have been successfully delivered. Following the approval of a co-delivery model with the Chichester College Group, the delivery of the first Associate Ambulance Practitioner (AAP) Programme with 23 students commenced on the 20th January 2020; with a signed contract now in place with the College. Mapping of tutors against courses to identify gaps or overlaps was carried out and the conflicts identified are now mitigated. The College has recruited a Programme Lead and interviews are scheduled for Tutors from 9th March 2020.
Functional Skills	All activities for this workstream are now complete, with the ProTrain contract for the delivery of the Level 2 Maths and English to the 48 existing students now approved. A tracker is in place to monitor enrolment and completion; this will be overseen by the Apprenticeship Working Group. All students are expected to complete the classroom courses by 29th May 2020.
Level 6 Paramedic Programmes	The outline business case was approved by the Executive Management Board on 19th February 2020. The University of Cumbria (identified to co-deliver the programme) met with the Trust on 6th February 2020 and defined/agreed programme activities; conversations are ongoing to determine staffing requirements, following which a full business case will be submitted for approval to the business case review group, Executive Management Board and the Trust Board. The Health and Care Professions Council programme approval visit to Newbury for the co-delivery programme is scheduled for the 2nd/3rd June 2020.
Workforce Education Development Review	Following the confirmation of the number of Paramedics requiring an uplift, a plan has been defined and work is underway to ensure the staff identified have been successfully enrolled on the necessary modules for face-to-face training by 31st March 2020. Dates have been booked for Paramedics to complete their mentorship qualification from 1st April 2020). NHS England have been informed of the Trust's delivery method of this programme.

Key Risks

Brief Summary	Score
The Business case for the Level 6 Paramedic Programme is yet to be approved by the business case review group, EMB and Trust Board. Therefore, there is no contract in place with a preferred supplier, this may cause a delay in the outsourcing of the apprenticeship programme. To mitigate, conversations are ongoing with the preferred supplier to agree on requirements for the co-delivery. The business case is due to be presented at EMB and Trust Board at the next available meetings.	Risk:6
There is a risk that the Trust will fail to meet the minimum assessment requirements of the Osfted Inspection visit, as a result of an inability to manage the identified gaps and ensure rectification measures are in place, fit for purpose and embedded. To mitigate, gaps identified by Future Quals have been incorporated into the Ofsted improvement plan and monitored through weekly task and finish groups	Risk:6

Project	Expected End date	Current RAG	Previous RAG
Objective 1 - Backlog Marking	31/05/2020		
Objective 2 - Clinical Education Courses	28/02/2020		
Objective 4 - Ofsted Compliance	30/06/2020		
Objective 5 - Co-delivery of Apprenticeships	28/02/2020		
Objective 6 - Functional Skills	28/02/2020		
Objective 7 - Level 6 Paramedic Programmes	01/09/2020		
Objective 10 - Workforce Education Development Review	31/03/2020		

Achievements this period

- Self Assessment review was submitted to Ofsted on the 14th February 2020
- The backlog marking trajectory has been met continuously for 5 consecutive weeks.
- The key skills plan was approved for 2020/2021 by Executive Management Board on the 19th February 2020

Programme for 2019/20 to deliver a minimum of £8.6m savings to achieve the planned £0.1m control total deficit.

Financial Reporting Period: Month 11 - February 2020

Programme Summary:

1. Current Pipeline schemes of £9.0m exceeds the savings target of £8.6m.

2. Following a rebasing of schemes in line with Demand and Capacity the value of Fully validated CIP schemes of £7.2m have been moved to the Delivery Tracker after QIA approval.

3. £0.0m Validated schemes are currently awaiting sign off and £0.2m Scoped schemes are undergoing development. Proposed schemes of £1.7m remain to be scoped at the end of eleven months ending February 2020.

4. Positive engagement continues with Executives Directors and CIP Project Leads. The CIP Programme governance framework and processes remains functional in the Trust.

5. Further CIP schemes anticipated for development include benefit realisations that might arise from i) opportunities identified across Integrated Care Systems (ICS) with which the Trust is engaged ii) the Carter Recommendation for Ambulance Trusts iii) operations efficiencies iv) Model Hospital and Corporate Services benchmarking.

6. The Cost Improvement Programme risk remains Amber.

CIP Opportunity Classification - KEY

Opportunity Status	Description	Key
Fully Validated	Scheme with confirmed savings calculation prior to delivery tracking	
Validated	Scheme with identified benefits under development	
Scoped	Scheme to be scoped for further development	
Proposed	Proposed CIP idea in analysis	

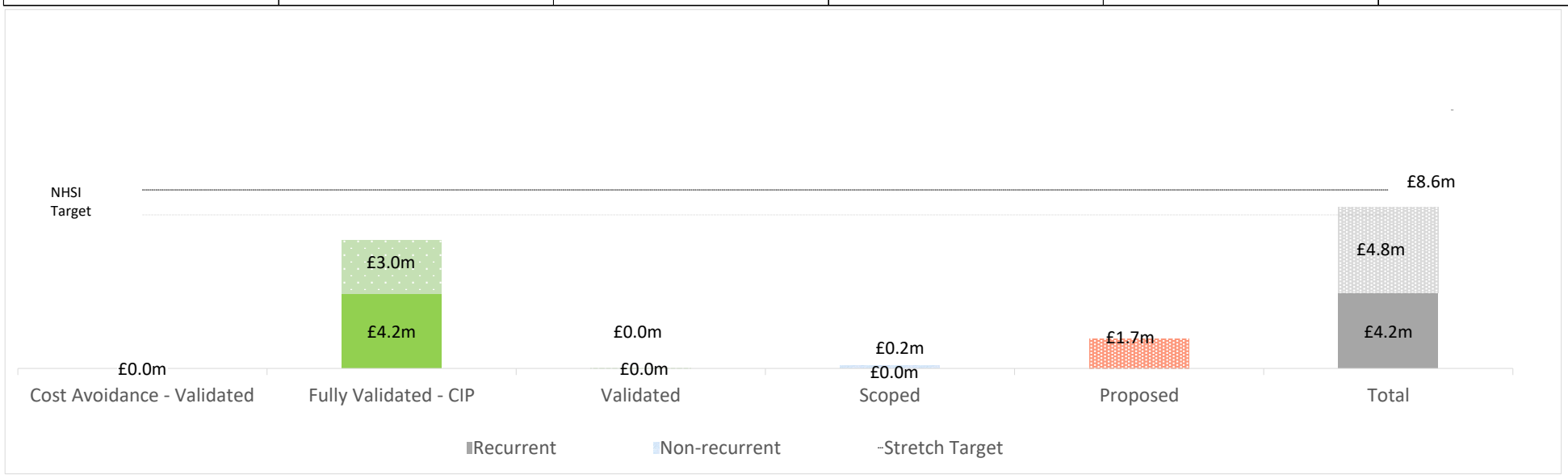
CIP Pipeline and Delivery: Risks and Issues

	Risk	Mitigating action	Owner	Current RAG	Previous RAG	Date to be resolved by
1	Risk that the 2019/20 CIPs target of £8.6m will not be fully delivered due to uncertainties within the Operations Directorate.	The savings target of £8.6m has been allocated to Directorates based on their individual pro rata share of operating expenses to total Trust operating expenses. Monthly meetings with Budget Holders and the Senior Operations Team in progress. Performance against target communicated regularly and support	Phil Astell	Amber	Amber	31-Mar-20

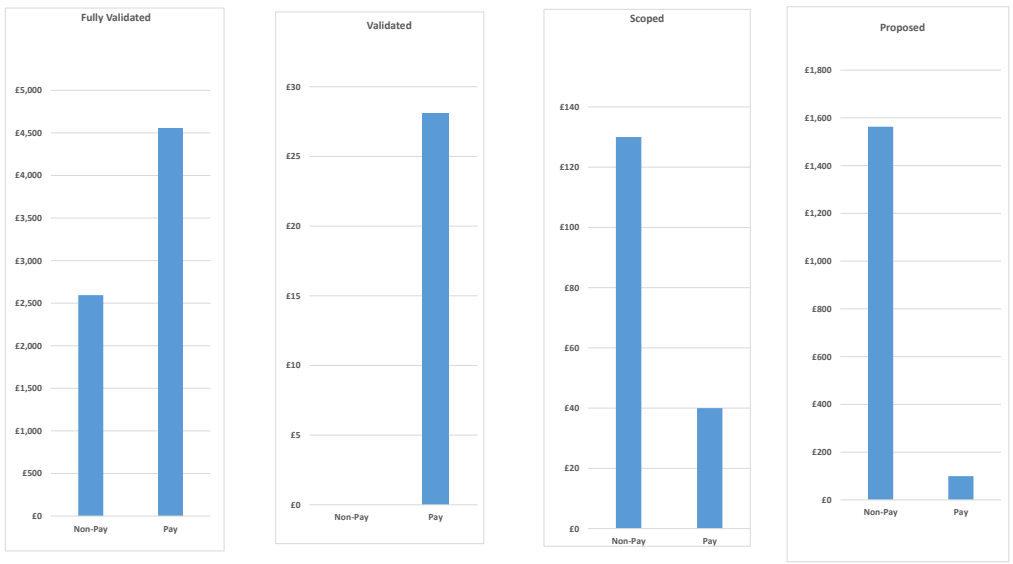
	Issues to be resolved	Mitigating action	Owner	Current RAG	Previous RAG
1	New Lease Cars policy to be agreed.	New club car scheme was launched in January 19 - pilot data provided and being evaluated. Governance process being reviewed and made more robust.	Ian Shaw/Ali Mohammed	Amber	Amber
2	E-Expenses - potential savings from automation.	E-Expenses system in progress and expected to be delivered as part of the HR Transformation.	Ali Mohammed	Amber	Amber
3	Agency Staff - Potential cost avoidance CIP	Development of savings plan in progress.	Charlie Griggs	Amber	Amber
4	Develop further Operations CIP schemes.	Regular liaison with Exec Sponsor and Operations Leads to identify and scope	Priscilla A-Sarpy/Finance Business Partners	Amber	Amber
5	Devise a mechanism for recoveries of historic salary overpayments	Ongoing discussions with Payroll Manager/HR Director.	Phil Astell/Ali Mohammed	Amber	Amber

CIP Pipeline Summary

Cost Avoidance	Fully Validated	Validated	Scoped	Proposed	Grand Total
£0	£7,166	£28	£170	£1,672	£9,036



Pay / Non-Pay / Income Breakdown and scheme summary



Scheme Category	Fully Validated	Validated	Scoped	Proposed	Total
Accounting efficiencies	961	-	-	12	973
Budget Allocation	-	-	-	45	46
Discretionary Non Pay	23	-	110	50	183
Estates and Facilities management	-	-	-	63	63
External Consultancy	24	-	-	-	24
External consultancy & contractors	30	-	20	953	1,003
Fleet - Equipment	42	-	-	-	42
Fleet Veh Run Costs - Fuel	200	-	-	-	200
Fleet vehicle costs	100	-	-	-	100
IT Productivity and Phones	178	-	-	-	178
Lease costs - ambulances	120	-	-	-	120
Legal/Professional Fees	29	-	-	-	29
Meal Break Costs	-	-	-	-	0
Medicine Management - Equipment	100	-	-	-	100
Medicines Management - Consumables	208	-	-	-	208
Medicines Management - Equipment	100	-	-	-	100
Operations efficiencies	4,580	28	-	539	5,147
Public Relations Expenses	12	-	-	-	12
Recruitment delays & recharges - clinical	-	-	-	-	0
Recruitment delays & recharges - non clinical	26	-	40	-	66
Training courses & accommodation	219	-	-	11	230
Travel & Subsistence	215	-	-	-	215
Grand Total	7,166	28	170	1,672	9,036

South East Coast Ambulance Service: CIP Workstream

CIP Delivery Dashboard

Reporting Month Feb-20

Programme for 2019/20 to deliver a minimum of £8.6m savings to achieve the planned control total surplus of £0.1m.

Programme Summary: (See Pipeline Tracker for Risks and Issues)

1. The rebasing of schemes in line with Demand and Capacity last month means CIP achievement for the eleven month to February 2020 is £6.3m. This is £1.6m adverse to NHSI plan target.

2. £7.2m of fully validated savings have been transferred to the Delivery Tracker year to date month 11. The risk adjusted forecast of £6.9m is £1.7m below the target savings of £8.6m. The recurrent element represents 63.9% of the total, YTD: 63.5%.

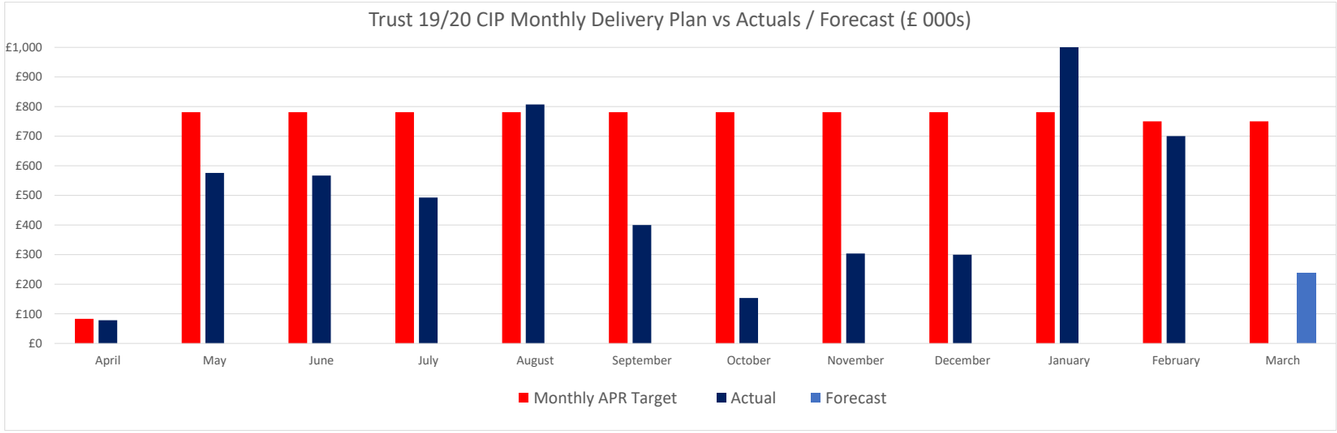
3. Review meetings with Budget Leads and Finance Business Partners continue to focus on identifying new schemes to build a sustainable pipeline of recurrent schemes for 2019/20 and the future years.

4. The CIPs schemes under development include savings arising from i) opportunities identified across Integrated Care Systems (ICS) with which the Trust is engaged ii) the Carter Recommendation for Ambulance Trusts iii) operations efficiencies iv) Model Hospital and Corporate Services.

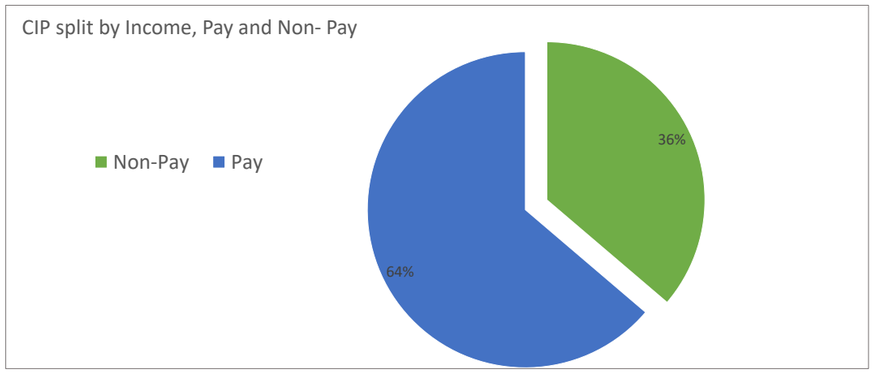
5. Delivery of £1.4m savings expected in the last month of financial year 2019/20 remains challenging. The CIP risk is rated Amber.

1. Monthly CIP Trust Profile - as at 29 February 2020

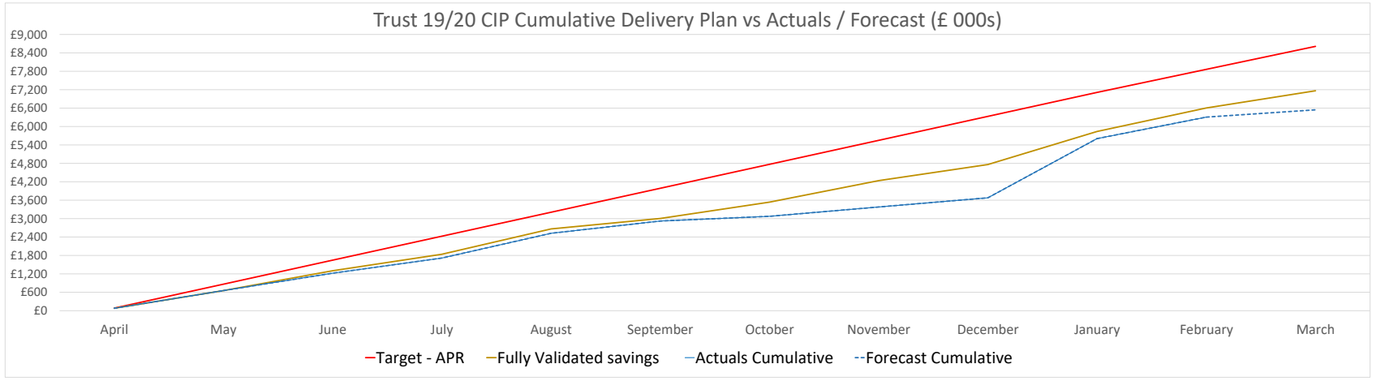
CIP Target for 19/20 £000's	Total planned savings on delivery tracker £000's - as at 29 February 2020	Total forecast savings on delivery tracker £000's - as at 29 February 2020	YTD February 2020 - Target Savings £000's	YTD February 2020 - Actual Savings £000's	YTD February 2020 - variance £000's
8,612	7,165	6,544	7,862	6,306	(£1,556)



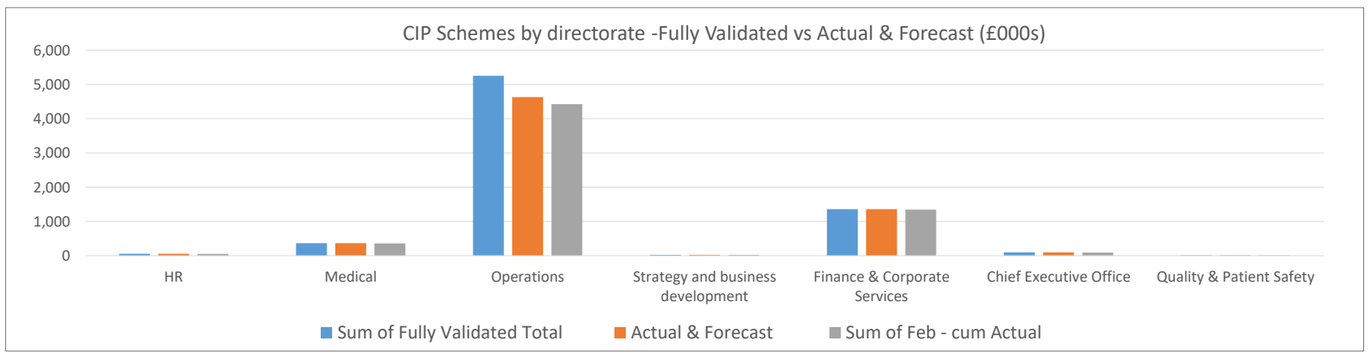
2. CIP - Planned savings split by income, pay and non-pay: as at 29 February 2020



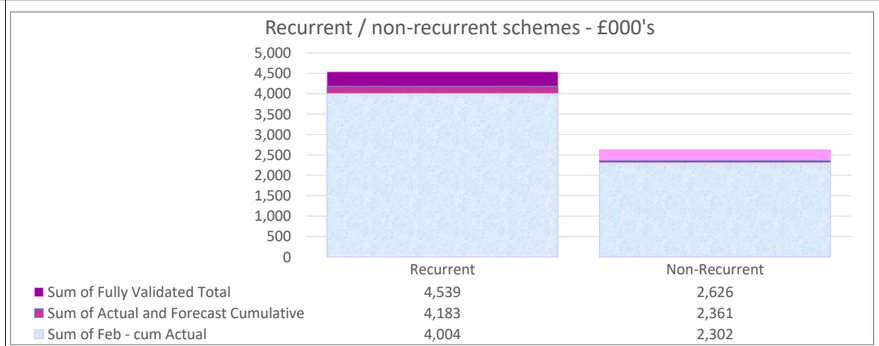
3. Cumulative CIPs - Target Plan & Actual / Forecast savings 2019/20



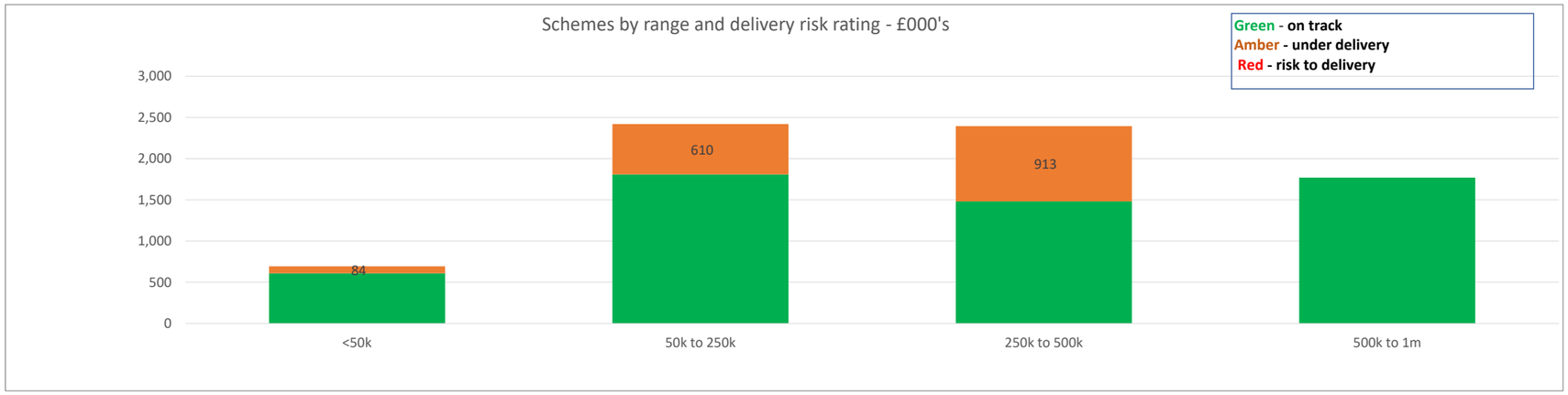
4. CIP schemes by directorate - Fully Validated vs Actual & Forecast 2019/20



5. Value of forecast recurrent and non-recurrent savings - 29 February 2020



6. Planned savings by scheme size and delivery risk rating £000's



7. YTD Identified CIPs to Date and Savings - November Reporting Period

Scheme Category	2019/20 Value of Fully Validated Schemes - £000	2019/20 Forecast Value £000	Full Year Variance £000	2019/20 Forecast Value Risk Adjusted £000	Full Year Forecast Risk Adjusted Variance £000	YTD Planned (Month 11): £000	YTD Actuals (Month 11): £000	YTD Variance £000	Comments (+/- £20k variance)
External consultancy & contractors	171	171	0	171	0	165	165	0	-
Stationery	5	5	0	5	0	5	5	0	-
Travel & Subsistence	215	215	0	215	0	198	198	0	
Medicines Management - Equipment	322	322	0	322	0	307	307	0	
Medicines Management - Consumables	48	48	0	48	0	44	44	0	-
IT Productivity and Phones	178	178	0	178	0	172	173	1	
Discretionary Non Pay	28	28	0	28	0	26	26	0	-
Training courses & accommodation	239	239	0	239	0	234	234	0	-
Medicines Management - Drugs	230	230	0	230	0	225	225	0	-
Operations Efficiencies	3,376	3,020	(356)	3,349	(27)	2,907	2,873	(34)	Underachievement largely due to lower than expected improvement in Task Cycle time and sickness
Recruitment delays & recharges - clinical	0	0	0	0	0	0	0	0	-
Recruitment delays & recharges - non clinical	0	0	0	0	0	0	0	0	-
Accounting efficiencies	980	980	0	980	(0)	976	976	0	-
Lease costs - ambulances	120	120	0	120	0	115	115	0	-
Legal/Professional Fees	29	29	0	29	0	26	26	0	-
Public Relations Expenses	12	12	0	12	0	11	11	0	-
Fleet Veh Run Costs - Fuel	200	200	0	200	0	180	180	0	-
PAPs/ OT price differential	913	648	(265)	648	(265)	913	648	(265)	YTD underachievement - alternative schemes being sought
Fleet vehicle costs	100	100	0	100	100	100	100	0	-
Total Fully Validated Schemes	**7,165**	**6,544**	**(621)**	**6,873**	**(292)**	**6,604**	**6,306**	**(298)**	
Variance to Savings Target	(1,447)	(2,068)	(£621)	(1,739)	(£292)	(1,258)		(£1,258)	Variance between Fully Validated Schemes and Control Total Target
Total Savings Target	**8,612**	**8,612**	**0**	**8,612**	**0**	**7,862**	**6,306**	**(1,556)**	

South East Coast Ambulance Service
NHS Foundation Trust

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	108/19

Name of meeting	Trust Board
Date	26th March 2020
Name of paper	Patient and Family/ Carer Experience Strategy
Responsible Executive	Bethan Eaton-Haskins– Executive Director of
Author	Judith Ward– Deputy Director of Nursing and Quality
Synopsis	This paper supports the attached Patient and Family / Carer Experience Strategy. The strategy has been co-developed with key partners including patients, carers, our staff, the Inclusion Hub Advisory Group, Council of Governors, Clinical Commissioning Groups and Health Watch. The methodology is set out in the strategy. The strategy sets out a 5-year strategy and plan which is based on the NHS Improvement (NHSI) Patient Experience Improvement Framework. NHSI have supported the development.
Recommendations, decisions or actions sought	The Board are requested to approve the attached strategy.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**Yes QIA and EIA completed.**

Patient and Family/Carer Experience Strategy 2020 - 2025

South East Coast Ambulance Service
NHS Foundation Trust

Living our Values:

Our values are the standards which everyone working at our Trust is expected to live up to. They help us to make the right decisions and guide how we treat our colleagues, our patients and their family and friends.

Demonstrating Compassion and Respect
Supporting our colleagues, and those we serve, with kindness and understanding.

Acting with Integrity
Being honest and motivated by the best interests of those we serve

Striving for Continuous Improvement
Seeking and acting upon opportunities to do things better.

Taking Pride
Being advocates of our organisation and recognising the important contribution we make to its success.

Assuming Responsibility
Having ownership of our actions and a willingness to confront difficult situations.

Contents

Introduction

Director of Nursing & Quality

I am very pleased to introduce the first Patient and Family / Carer Experience Strategy for South East Coast Ambulance NHS Foundation Trust. The experience of our patients is central to providing high quality care. Our patients clearly told us that the experience of their families / carers is also central to patient experience and, therefore, this strategy takes a more holistic approach to experience.

I would like to thank all those who have been involved in the development of this strategy As a Trust we have been delighted with the engagement of our patients, their families and carers, our staff, and external partners, including Health Watch across the region, to co-develop this strategy. Our vision is that this strategy will be co-delivered with our partners and anticipate that over the next 5 years we will see an increasing influence from patients and their families / carers in the care that we provide. We are also grateful to the support from NHS I/E to develop this strategy.

The development of our strategy has helped us to identify areas that we currently do well in addition to those where we need to change how we do things. We will build on our existing good practice. We recognise that we need to be ambitious in order to truly improve the experience of our patients and their families / carers. We will take a Trust wide approach to examining our culture, leadership, patient and staff engagement and how we measure experience

The format of this full strategy document is not helpful to patients who want a quick and easy reference. We have had to obtain a balance between governance requirements of the Trust and information which is accessible to patients. Therefore, following endorsement by our Board, we will develop a shorter one page more accessible format which clearly defines the elements of our strategy. This will also be made readily available throughout our Trust.

Bethan Eaton-Haskins, Executive Director of Nursing & Quality

About this Strategy

Patient experience, on the face of it, can seem quite simple, however, we all experience things slightly differently and each experience is itself made up of a number of experiences or 'moments' that are all measured against our original expectations. Patient Experience is what the process of receiving care feels like for the patient, their family and their Carers. It is a key element of quality alongside clinical excellence and safer care. Patient experience has many facets including, how a telephone call is answered, to the way the patient is examined or treated, to how our staff explain what is happening to our patients.

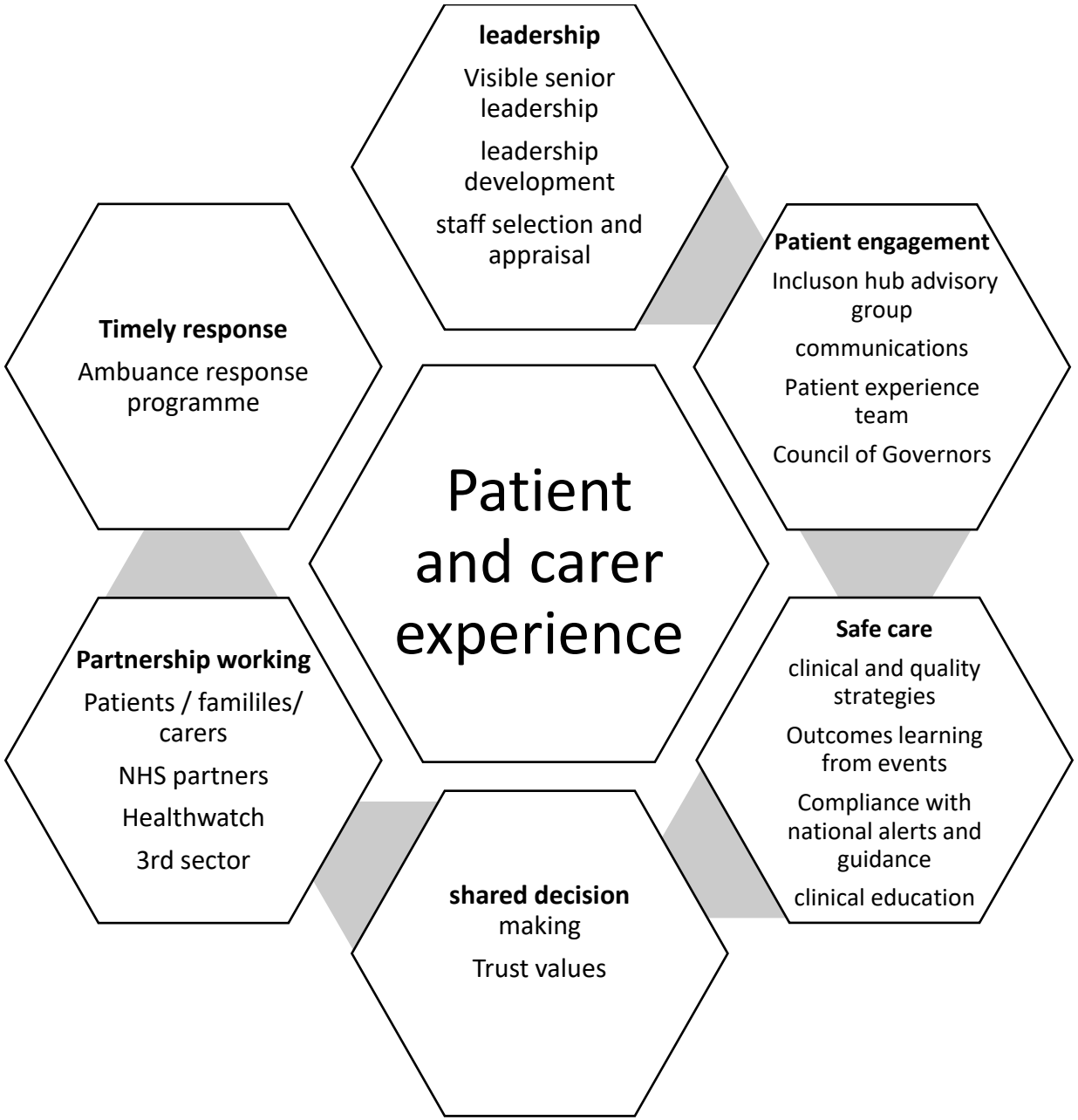
Understanding and improving patient experience is not simple. As well as effective leadership and a receptive culture, a whole- systems approach is required to collecting, analysing, using and learning from patient feedback for quality improvement. Without such an approach it is almost impossible to track, measure and drive quality improvement[1]. This strategy will guide the organisation's development in terms of patient experience, ensuring that our approach is pro-active, in partnership with our patients and their Carers, and meets the Trust's statutory responsibilities.

This Strategy has been developed in collaboration with our patients, their Carers and other key stakeholders including members of our Council of Governors, Our Inclusion Hub Advisory Group, our commissioners, local Health Watch and our staff.

An initial scoping exercise was undertaken in 2019 with a smaller group of stakeholders which identified many varying expectations. In order to, manage the wide-ranging expectations and attempt to offer as many stakeholders as possible the opportunity to contribute, an online survey, followed by three wider face to face stakeholder events where held during July and August 2019 in Kent, Surrey and Sussex. Both focussed on the question "what matters most to our patients". 282 responses were received to the online survey. Whilst rudimentary, this supported us to obtain views across the wide geography covered by the Trust. In addition, patients and families / carers provided feedback about the service we currently provide. As appropriate, key learning has been embedded into this strategy and other work within the Trust. We are grateful to our partners in Clinical Commissioning Groups and Health Watch who were pro-active in advertising and supporting our work. The online survey also enabled a greater number of our operational staff to contribute.

A positive patient experience cannot be achieved by one workstream within an organisation. It requires a Trust wide approach. The following diagram represents many of the co-relationships.

[1] Patient Experience Improvement Framework. NHS Improvement June 2018


leadership
Visible senior leadership
leadership development
staff selection and appraisal
Patient engagement
Incluson hub advisory group
communications
Patient experience team
Council of Governors
Timely response
Ambuance response programme
Patient and carer experience
Partnership working
Patients / famililes/ carers
NHS partners
Healthwatch
3rd sector
Safe care
clinical and quality strategies
Outcomes learning from events
Compliance with national alerts and guidance
clinical education
shared decision making
Trust values

Background and policy context

There is a strong body of evidence which demonstrates benefits in improving patient experience, including better outcomes for patients[2], improved service delivery and more efficient services, organisational reputation, and staff development and satisfaction.

In 2008, the work of Lord Darzi[3] signalled a need to consider patient experience alongside safety and quality. In addition, the Francis Report[4] highlighted the importance of culture and leadership in terms of patient experience.

In 2013 NHS Constitution was strengthened in terms of patient experience[5]

The NHS Outcomes Framework[6] includes measures across the NHS to measure patient experience. The Friends and Family Test (FFT)[7] is a requirement for all providers that hold an NHS Standard Contract. It is a national feedback tool which supports the principle that people who use the NHS should have the opportunity to provide feedback on their experience. From April 2020, the national FFT (patients) guidance allows ambulance services to consider whether they will continue with the Friends and Family Test but are required to run a co-produced patient experience project on an annual basis. The NHS Staff Friends and Family Test will continue. The Trust NHS 111 service plans to use a text messaging service to access patient experience, which will be developed during mobilisation of the service prior to April 2020. Past evidence suggests this is a successful methodology for this service.

In 2019, The Care Quality Commission report on South East Coast Ambulance Service NHS foundation Trust noted that the Trust had systems in place to learn from complaints. In addition, "Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated people. People reported that staff go the extra mile and their care and support exceeds their expectations. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. People's emotional and social needs were seen as being as important as their physical needs. Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment". This strategy will continue to support the high-quality care already provided by our staff.

[2] Feeling better? Improving Patient Experience in hospital
[3] High Quality Care for all : NHS Next Stage Review Final report. 2008
[4] Report of the Mid Staffordshire NHS Foundation Trust Inquiry, 2013
[5] Updated NHS Constitution NHS England 2013.
[6] NHS Outcomes Framework NHS digital
[7] Friends and Family Test NHS England 2019.

Background and policy context

The Patient Improvement Framework supports NHS trusts and Foundation Trusts to achieve good and outstanding ratings in their Care Quality Commission (CQC) inspections.

The framework enables organisations to carry out an organisational diagnostic to establish how far patient experience is embedded in its leadership, culture and operational processes. The framework integrates policy guidance with the most frequent reasons CQC gives for rating acute trusts 'outstanding', as identified in the NHSI review of CQC reports in January 2018. South East Coast Ambulance Service NHS Foundation Trust is working towards for a CQC registration graded as outstanding by 2022.

The Framework focuses on key areas which will form the basis of this strategy:

- Leadership
- Organisational culture
- Collecting feedback: capacity and capability to effectively collect feedback
- Analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other quality measures
- Reporting and publication: patient feedback to drive quality improvement and learning: the ability to use feedback effectively and systematically for quality improvement and organisational learning.

A gap analysis aligned to the framework identified that the organisation has many of the required elements in place (some of which need strengthening) and some gaps. This has been used to identify the direction of this strategy.

The work of South East Coast Ambulance Service NHS Foundation Trust

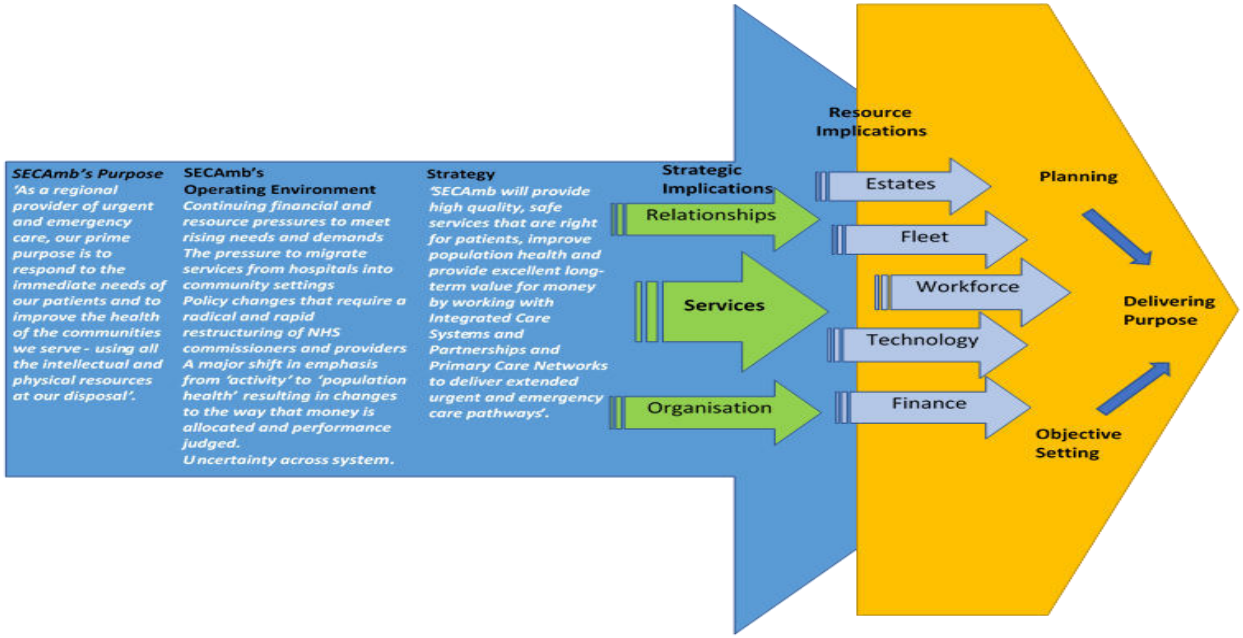
The Trust provides services to a diverse catchment of 4.7 million people. The area that we cover is 9,400 square kilometres and includes Kent, Surrey, Sussex and North East Hampshire.

We receive and respond to 999 calls from the public and health care professionals; receive and respond to 111 calls; and provide the regional Hazardous Area Response Team (HART) which responds to specialist emergency challenges.

To ensure we can deliver our services we employ over 3,500 staff, 85 % of whom are directly involved in patient care.

As a Trust we are committed to learning from our patients and our staff and to embed Trust wide change as a result of this learning.

The diagram below demonstrates how our organisational strategy supports our purpose.



This Patient and family / carer experience strategy supports the organisational strategy and outlines our approach to patient experience for the next 5 years. In developing this strategy, we have considered our responsibilities under the NHS Constitution and our commitment to work in partnership with our patients, their families and their carers.

Our vision and values for patient experience

Our Vision South East Coast Ambulance Service is taking a whole organisation approach to patient experience. By applying the term 'patient experience' we refer to the patient, their family and their carer.

Patient experience will have a focus in all departments within the Trust and at all levels of the organisation. This will be underpinned by robust governance arrangements which will help us to understand what it is like to be a patient or carer.

Our values as an organisation we continue to learn and develop. Feedback from our patients, their families and their carers is central to understanding the care we deliver and continually working towards improvement.

Our patient experience strategic themes

Our strategic themes for patient experience focus on the themes within the Patient Experience Framework outlined earlier in this document.

Our objectives

This strategy has several objectives, which will be underpinned by a development plan. The overarching development plan will be monitored by our Patient Experience Group.

Leadership

- We will strengthen our governance arrangements in terms of relationship between the patient and experience group and the wider arrangements within the Trust to ensure that themes and risks are identified early and that staff at all levels of the organisation understand what it feels like to be a patient or carer.
- Our patient and Carer strategy will be driven and overseen by our Patient Experience Group. The Terms of Reference and Membership will be reviewed to ensure that the group is supported to challenge effectively and contribute to some of the workstreams to deliver this strategy.
- Senior clinicians within the Trust will be involved in decision making which may impact on patients, and patient experience will continue to be an integral element of this assessment.
- We will provide an Annual Patient and Carer Experience Report to Board which will be developed over the next 5 years to ensure that is easily understood. This will be co-produced with our Patient experience group.
- We will increase the visibility of our senior leadership team, including to patients and their Carers.
- We will develop strong leadership within the Trust. Patient and Career experience will be central to this and will include the involvement of patients in key staff selection and recruitment; feedback from patients and carers in regular management of staff; and leadership training.

Organisational culture

- We will continue to develop a listening culture which engages with and listens to our patients and their families/ carers.
- The Trust will continue to embed a safety culture which learns from patient feedback and can demonstrate effective change as a result.
- The Board will continue to value and celebrate innovation by frontline staff to improve the experience of patients and specifically staff who demonstrate they consistently exceed patient expectation, and always deliver individualised care. Whenever possible patients and carers will be involved in selection of the winners of the Annual Trust Awards.
- We will continue to celebrate our organisational values, and these will be incorporated into complaints investigation, recruitment and management oversight of staff.
- The Trust will continue to express its commitment to patients through all its communications by ensuring that information provided to patients is easily accessible and easy to understand (without jargon).
- The Trust will continue to support staff to share decision making about care and treatment with patients, and actively support staff to involve carers. Staff will be trained to understand the fundamentals of shared decision making.

- We will continue to offer our staff a wellbeing and a Chaplaincy service in order to support their wellbeing and spiritual needs, thereby supporting our patients and their carers

Collecting feedback: capacity and capability to effectively collect feedback

- We will explore and develop innovative ways in which we can engage with our patients and their families/ carers to obtain feedback. This will include collaboration with external partners such as Health Watch.
- The Trust will assess its mechanisms for collecting patient and carer feedback on an annual basis and make improvements year on year. Patients will be offered a range of ways in which they can feedback.
- The Trust will have a patient friendly complaints process which adheres to national guidelines. This will be accessed within 2 clicks on our website.
- We will audit our complaints process on an annual basis in terms of adherence to national guidelines, including the quality of our investigations and our response.
- The Trust will participate in all mandated patient / carer surveys and will publish learning in an easy to read format.
- The Trust will monitor key elements of the NHS Staff survey which provides insight into patient experience and will strive for year on year improvement.

Analysis and triangulation: the use of quality intelligence systems to make sense of feedback and to triangulate it with other measures

- The Trust will continue to develop effective mechanisms for analysing and triangulating feedback from patients and carers and will review this on an annual basis. The Patient Experience Group will receive regular reports identifying themes and risks.
- The Trust will use patient and carer feedback to inform a dashBoard which demonstrates an early warning of deteriorating care.
- The Trust will use quality improvement methods and tools to try to continuously improve quality of experience of care and outcomes for patients.
- We will use analysis of patient and carer feedback as an integral element of any service change or redesign. We will involve patients or carers directly in this decision making whenever possible.

Reporting and publication: patient feedback to drive quality improvement and learning; the ability to use feedback effectively and systematically for quality improvement and organisational learning

- The Trust will routinely publish transparent and publicly accessible information about the feedback patients have provided, and our response to feedback and will ensure this information is available through multiple routes).
- The Patient Experience Group will develop a supporting process to disseminate information to patients and carers in collaboration with our communications department.
- The Trust will support a model of co-production. In particular, the Trust will move to co-produce the Annual Patient and Carer Experience Report.

Our Development Plan for Patient Experience

The Trust development journey in terms of patient and carer experience will be monitored by our Patient Experience Group and will develop throughout the period of this strategy.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
Leadership				
The Board has a strategy to deliver improved patient experience and regularly engages with groups of patients and other key stakeholders. The organisation uses the output from such engagement to inform its plans to deliver the strategy.	The organisation has a patient experience strategy coproduced with patients and frontline staff, consulted upon, and signed off by the Board.	(Strategy to be developed with key stake holders signed off by Board March 2020).	We will start to review our strategy in year 4 in readiness to publish a reviewed strategy in year 5.	Publish revised strategy end of year 5.
	The trust also has a delivery plan, impact measures and review timetable and carries out an annual review of progress towards achieving the strategy.	Development plan to be agreed and monitored by patient experience group.	Annual review of Development plan.	Annual review of Development plan.
Patient experience is embedded in all trust leadership development work (including that undertaken by operational managers and clinical staff).	Leadership training will include and support patient experience.	We will embed 'Always Events' within our leadership training.		
		We will undertake a training needs analysis for all levels of the organisation which will include (but not exclusive to), investigation training, report writing to a standard patients understand, difficult	We will embed the findings of our training needs analysis into training throughout the year at all levels of the organisation.	We will continue to embed the findings of our training needs analysis into training throughout the year at all levels of the organisation.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
		conversations, understanding of NHs constitutional requirements, impact of our behaviour and comments on patients and their carers.	Training will include vignettes based on feedback from patients and / their carers.	Training will include vignettes based on feedback from patients and / their carers.
		Our Board development sessions will include a focus on patient and carer experience.		
		Staff working exclusively within, or oversight of, services directly related to patient experience (e.g. patient experience, incidents and serious incidents) will receive dedicated training to support their roles.	Training will continue.	
		We will continue to significantly strengthen the relationship between our patient experience group and key partners within the Trust to engage with patients and capture a holistic view of what it feels like to be a patient / carer. This will include incidents and serious incident processes; communications team, inclusion hub advisory group.		
	Patients are involved in assessment and appraisal processes for staff. (for example, patient feedback data or other forms of involvement		Appraisals and one to one meetings will look at compliments, complaints and testimonials.	

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	including complements, complaints, testimonials).			
			We will explore and start to include patients and carers in recruitment interviews.	
There is visibility of the senior leadership team with an identified executive lead accountable for leading quality improvements in patient experience, who routinely presents reports and leads discussion with Board colleagues on patient experience.	The executive lead for patient experience routinely provides the Board with reports and proactively leads this area of work within the organisation. Patient stories are routinely used at Board meetings and other trust settings.	We will continue to provide an annual patient experience report to Board which will be easy to understand. This will be published on our website.	We will explore how our senior leadership team engages directly with patients.	
		We will continue to show patient stories at Board meetings. In addition, we will use patient stories at internal governance meetings and team meetings.		
	The senior leadership team is accessible and visible in the organisation and routinely engages with patients and frontline staff.	We will continue to ensure that our senior team has opportunities such as quality assurance visits and A & E visits to engage with our front-line staff.		
There is clear clinical leadership from the medical director and director of nursing and engagement of clinicians in the	All clinicians are engaged and provide input into the development of services and efficiency changes and how	We will continue to undertake a quality impact assessment, an equality impact assessment and a data privacy impact		

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
development of the quality strategy and clinical strategy which provides momentum in terms of quality, patient experience and safety.	change impacts on patients and front-line staff.	assessment on all service changes to understand the impact on patients. These will be signed off by senior clinicians or subject matter experts. In addition, clinicians and patients will be involved in the design of service changes which may impact on patients.		
	There is clear medical engagement in patient experience as an equal facet of the quality agenda alongside patient safety and clinical effectiveness.	We will review the terms of reference for our patient experience group to ensure equitable medical engagement alongside Nursing & Quality.		
Organisational Culture				
The Board values and celebrates innovation by frontline staff to improve the experience of patients and specifically staff who demonstrate they consistently exceed patient expectation, and always deliver individualised care.	Staff are supported to listen and act locally as a response to patient feedback and the organisation routinely captures analyses and reports on the outcomes from this.	We will review our operational governance structures to ensure that patient feedback is reported and discussed at all levels of the organisation. The structures will facilitate early discussion of risks and themes emerging relating to patient and career experience at all levels in the organisation and facilitate staff on the ground to escalate thematic concerns easily.		
	There is a process in place to identify and celebrate achievements of staff who consistently exceed patient expectations and the Board is	Our annual staff awards will continue to recognise and celebrate staff who exceed patient's expectations.	We will include patients and their carers in our decision-making group for the staff awards.	

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	engaged and fully involved in the process.			
		The patient experience team will start to collate information on potential nominees for the staff awards. Our patient experience group will nominate staff for our annual awards ceremony.		
	Staff are engaged in the process of setting staffing levels and in developing their own workforce.	We will undertake a gap analysis against the NHSI/E safer staffing guidance when published and implement necessary changes.		
	Staffing level escalation processes are well defined and embedded throughout the organisation to ensure safe staffing.			
	Staff give care that is compassionate, involves patients in decision-making and provides good emotional, spiritual and religious support to patients.	We will continue to provide a wellbeing service to support our staff which has a clear remit. In addition, we will continue to offer a Chaplaincy service to our staff.	We will provide training to ensure that our staff understand specific spiritual and religious requirements.	
Staff are proud to work for the organisation and speak highly of the culture. Staff throughout the organisation feel able to raise concern and believe they will be listened to and supported.	The organisation has developed, with patients and staff, a set of values, articulated NHS Constitution. The organisation has a process for ensuring values are owned by staff through all corporate documents.	We will continue to embed and celebrate our organisational values and embed our values into complaints investigations.		
	The organisation has in place a	We will embed our values-based		

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	values-based recruitment and appraisal system.	recruitment into practice.		
The organisation expresses its commitment to patients through all its communications, and routinely offers to provide copies of clinical correspondence.	The organisation's website and other externally facing communications are accessible and clear and patients would judge them 'patient friendly'. They also articulate commitment to patients.	Our organisation website will have information on how to provide patient feedback within two clicks. We will work with external partners such as Healthwatch to ensure that our communication is accessible and clear.	Review of website and engagement exercise re usefulness of site	
	The trust has a process of testing its communications to patients with patients, prior to publication	We will review our communications oversight process to ensure that crucial patient facing information is tested with patients prior to publication.	Review of communications strategy in relation to patient experience and engagement	
	Patients are routinely offered copies of correspondence about them in an accessible format (Accessible Information Standard)	We will work with key stake holders including our patient experience group and Healthwatch to review our correspondence including responses to complaints and serious incident reports to ensure that they are clear and understandable for patients.		
Collecting feedback				
The organisation participates in all mandated surveys (including where applicable the National Patient Survey Programme, the Friends and Family Test and systematic local surveys) and works with commissioners to	Full compliance with all mandated surveys, and a comprehensive programme of seeking rapid, real or near real time from patients using the most up to date technology available to them.	Our 999 service will run an annual co-produced patient experience project on an annual basis. This will be reported at Board level, published on our website and included in our annual quality account.	Our 999 service will run an annual co-produced patient experience project on an annual basis. This will be reported at Board level, published	Our 999 service will run an annual co-produced patient experience project on an annual basis. This will be reported at Board level, published

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
develop and implement rapid/real, or near real-time patient feedback.		In addition, our 111 service will use technology to gather and understand the experience of patients. We will also review our staff, friends and family survey on an annual basis to understand the impact of our care on patients.	on our website and included in our annual quality account.	on our website and included in our annual quality account.
The trust has a patient friendly complaints process, which complies with national guidance.	The organisation has an accessible user-friendly complaints process.	We will review our information on the complaints process to ensure that it is user friendly.	We will review our information on the complaints process to ensure that it is user friendly.	We will review our information on the complaints process to ensure that it is user friendly.
	Complaints information is clearly displayed on the Trust's website and available within two clicks.	We are developing our organisation website. This will include information on how to provide patient feedback within two clicks.		
	Complainants are offered a face-to-face meeting, supported throughout the process and their feedback sought on completion of dealing with the complaint.	We will continue to offer complainants a face to face meeting and will aim to increase the number of face to face meetings for level three complaints year on year. In addition, we will agree a process for feedback following completion of a complaint. Feedback will be reported to our patient experience group.		
	Feedback about how the complaint was handled is routinely gathered.	We will undertake an annual audit cycle of our complaints process which looks at:	Continue annual audit and embed learning.	Continue annual audit and embed learning.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
		▪ Timeliness of response ▪ Quality of investigation ▪ Quality of response This audit will be undertaken with key stakeholders including Healthwatch and our patient experience group. This will be reported to our patient experience group.		
	There is evidence that practice has changed following complaints and improvements have been sustained.	We will review our processes for sharing learning on an organisational wide basis and will strengthen our governance processes to ensure that learning is embedded.		
Frontline staff take ownership of, and deal with, issues raised by patients, and only where necessary refer on to others. When patients express a wish to complain clear information is provided and support given. The Duty of Candour is followed.	Frontline staff are supported by managers and their teams to address concerns raised by patients, and there is a process for teams to share and learn from this.	One to one's will include a review of patient feedback. All team meetings will include a review of patient feedback.		
	Duty of Candour regulations are well understood and embedded. The organisation's processes are clear and transparent.	We will review the quality of our current training to ensure that the principles are understood by all staff, and managers are supported to have difficult conversations.		
	The importance of patient	Our annual training programme	Our annual training	Our annual training

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	feedback is embedded in the organisation's approach to staff training.	will continue to be informed by themes arising from patient feedback and incidents affecting patients.	programme will continue to be informed by themes arising from patient feedback and incidents affecting patients.	programme will continue to be informed by themes arising from patient feedback and incidents affecting patients.
Patients are given information about the range of ways they can provide feedback (which might include paper-based surveys, comment cards, web, text, devices, kiosks, and apps) and are supported by staff to use these. Approaches offered take account of the needs of patients who are less able or less willing to feedback.	The organisation employs a range of methods to collect patient feedback, based on patient need and preference. Staff are familiar with these and encourage and support patients.	We will review the methods we use to collect patient feedback directly. In addition, we will work with external partners to understand how we can engage with processes for system wide learning and initiatives such as citizen advocates. This will include feedback from carers.	We will review the effectiveness of our feedback mechanisms and embed any required changes.	We will review the effectiveness of our feedback mechanisms and embed any required changes.
Analysis and triangulation				
The organisation has a systematic way of analysing patient feedback in all its forms, including complaints. The organisation also has dedicated analytics and intelligence support for its patient experience data, which produces clear helpful reports.	The organisation routinely and systematically analyses feedback, brings together all strands and identifies themes which it acts on.	We will continue to include patient and carer feedback within our monthly thematic analysis which also included incidents and serious incidents. We will also include litigation and coronial findings.	We will continue to include patient and carer feedback within our monthly thematic analysis which also included incidents and serious incidents. We will also include litigation and coronial findings.	We will continue to include patient and carer feedback within our monthly thematic analysis which also included incidents and serious incidents. We will also include litigation and coronial findings.
		When themes are identified we will continue to investigate using appropriate methodology.		
		We will develop systems which inform local understanding of		

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
		themes. These will be developed in collaboration with operational managers.		
The organisation produces reports that demonstrate the correlation between improving patient outcomes, patient safety and patient experience. This is also routinely triangulated with staff and the staff survey.	Reports highlight themes where patient experience correlates with other quality measures (for example patient safety and clinical outcomes) and Board reports clearly articulate the relationships and the quality improvement actions arising.	The Terms of Reference for the patient experience group will be reviewed and strengthened to ensure oversight of patient and carer experience alongside clinical outcomes and patient safety.	We will review Terms of Reference for patient experience group on annual basis.	We will review Terms of Reference for patient experience group on annual basis.
The organisation is able to use patient experience data effectively to identify and locate deteriorating performance, and to enable quick action to address the causes.	The organisation effectively uses patient experience data to provide an early warning system for deteriorating standards of care that enables leaders at a range of levels to spot when there are concerns, using quality improvement approaches.	We will start to develop a dashboard to reflect deteriorating performance which is impacting on patient and carer experience.	We will review our dashboard and amend as appropriate.	We will review our dashboard and amend as appropriate.
The organisation uses quality improvement methods and tools to try to continuously improve quality of experience of care and outcomes for patients.	The organisation is using data related to patient experience to understand variation. Patient experience is both fully aligned with and integral to quality improvement.	Patient and carer experience data will inform quality improvement initiatives. We will use quality improvement methodology to support changes which positively impact on patient and carer experience.	Patient and carer experience data will inform quality improvement initiatives. We will use quality improvement methodology to support changes which positively impact on patient and carer experience.	Patient and carer experience data will inform quality improvement initiatives. We will use quality improvement methodology to support changes which positively impact on patient and carer experience.
	The organisation performs	Our performance monitoring	Our performance	Our performance

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
	above peer in the NHS Mandate goal to 'improve the percentage of NHS staff who report that patient and service user feedback is used to make informed improvement decisions.	will include key questions within the NHS Staff survey.	monitoring will include key questions within the NHS Staff survey.	monitoring will include key questions within the NHS Staff survey.
The organisation supports staff to share decision making about care and treatment with patients, and actively supports staff to involve patients in their care.	Staff demonstrate a good understanding of the theory and practice of shared decision making, its principles are underpinned through training programmes.	We will review our training and develop a plan.	We will review our training plan	
	Patients and their families are involved in their care and understood what is expected in relation to their care.	We will develop ways of collecting and analysing patient feedback in relation to this.	We will continue to collect and analyse patient feedback.	We will review our collection methodology and continue to collect and analyse patient feedback.
	The organisation performs above peer in the NHS mandated national survey questions asking if patients felt involved in decisions about care and treatment.	We will review our results and implement learning.	We will review our results and implement learning.	We will review our results and implement learning.
The organisation uses staff appraisal to identify training needs and based on need, implements training for staff so they able and confident to use feedback to improve services using quality improvement methods and tools.	The organisation has a systematic approach to identifying staff training needs related to using patient feedback to improve services.	We will continue to include themes arising from patient and carer experience within our annual 'key skills' mandatory training	We will continue to include themes arising from patient and carer experience within our annual 'key skills' mandatory training.	We will continue to include themes arising from patient and carer experience within our annual 'key skills' mandatory training.

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
All proposals for service change, project initiation document and business cases are accompanied by evidence of their potential impact on the experience of patients.	Patients and service users have been involved in the design stage of any service change. There is evidence of coproduction.	We will explore how we can involve patients and their carers in service design or change when appropriate.	We will use patients and carers to support pathway development.	
Reporting and Publication				
The organisation routinely publishes transparent and publicly accessible information about the feedback patients have provided, and its response to feedback (and ensures this information is available through multiple routes).	Information is available and accessible to patients and the public.	We will explore the use of "you said – we did" methodologies to publicise our responses and learning arising from patient and carer feedback.		
		We will work with external stakeholders to evaluate our organisation against the accessible information standard and implement changes.		
		We will publish the progress of our patient and carer experience strategy and associated improvement plan within our Annual Quality Report and Account.	We will publish the progress of our patient and carer experience strategy and associated improvement plan within our Annual Quality Report and Account.	We will publish the progress of our patient and carer experience strategy and associated improvement plan within our Annual Quality Report and Account.
		We will use thematic analysis and patient stories to support system wide decision making relating to services. This will include Integrated Urgent Care Clinical Governance meetings	We will use thematic analysis and patient stories to support system wide decision making relating to services. This will include Integrated	We will use thematic analysis and patient stories to support system wide decision making relating to services. This will include Integrated

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
			Urgent Care Clinical Governance meetings.	Urgent Care Clinical Governance meetings.
	We will provide an annual Patient Experience Report to Board	We will continue to provide an annual patient experience report to Board on an annual basis.	We will co-produce our Annual Patient Experience report with our patient experience Group. This report will accurately reflect what it is like to be a patient or carer. The Annual Report will be written in an easy to understand format.	We will review the format of our report and the engagement of our patient experience group in the process and implement learning.
			Our Annual patient experience report and Annual Quality Report and Account will describe the progress of our 999 patient experience improvement project.	
The organisation supports a model of co-production and supports patients and staff to deliver this approach.	Co-production is widely used, and the organisation can cite examples of co-production, including the use of specific improvement methodologies, where staff have worked in partnership with patients to improve services.	The delivery of this strategy will be delivered in partnership with our patient experience group and our inclusion hub advisory group. We will make a sincere commitment to designing changes to our service which impact on patients in partnership with patients and carers.	The delivery of this strategy will be delivered in partnership with our patient experience group and our inclusion hub advisory group. We will make a sincere commitment to designing changes to our service which impact on patients in	The delivery of this strategy will be delivered in partnership with our patient experience group and our inclusion hub advisory group. We will make a sincere commitment to designing changes to our service which impact on patients in

Aim	Objective	Years 1 and 2	Years 3 and 4	Year 5
			partnership with patients and carers.	partnership with patients and carers.

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SECAMB Board

QPS Committee Escalation report to the Board

Date of meetings	09 March 2020
Overview of key issues/areas covered at the meeting:	The committee was attended by both the Chair and the Chief Executive. This meeting first considered several ***Management Responses*** (*responses to previous items scrutinised by the committee)*, including: **SI Actions Not Assured** An update was provided on the high number of open actions. The committee acknowledged a good majority of these, especially those prior to 2019, will have been superseded, and supported management in its efforts to close these as soon as reasonably possible. The committee will continue to monitor this, both in terms of progress with the backlog and most importantly to ensure the controls in place support timely responses to the more current actions. **Hand Hygiene Not Assured** Although the committee is confident in the range of immediate actions being taken to ensure good hand hygiene, it was disappointed to note the drop in compliance seen in Q3. The training and awareness is deemed sufficient to ensure staff know what should be happening and so the committee explored the measures being taken to ensure there is a consistent approach to holding staff to account when practice is not as it should be, given how critical this. This is being taken forward by OU / team and the committee is expecting to see significant improvement when it reviews this at its next meeting in May. The meeting also considered several ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **CFRs – Administration of Salbutamol Assured** Following its decision to allow CFRs to use salbutamol, subject to training and audit, the Board asked for a 6-month review. The committee reviewed the position at three months and the audit aimed to identify whether: • this medication is administered in accordance with the medicine administration protocol • circumstances arising and resulting from administration of medication are adequately documented The sample was small, but it demonstrated 100% compliance. The sample-size at 6-months will be significantly bigger and will include qualitative feedback. **Co-Responders Assured** This reviewed the overall support and management that is in place, plus the activity which demonstrates good use of co-responders. The committee was assured with the governance and support in place.

	EOC Clinical Safety **Partially Assured** The focus at this meeting was on welfare calls. This remains an area of non-compliance, primarily due to the recruitment gap. The committee explored with management whether the bar at SECamb has been set too high with regards the frequency of calls and who makes them. Some benchmarking is ongoing, and this will help inform a new procedure that best supports this function. **111 CAS Mobilisation** **Partially Assured** A review of the current position was undertaken, and the committee noted the issues both internal and external, which put at risk the safe mobilisation of this new service from 1 April 2020. A risk assessment has been shared with commissioners to take account of the current pressures, including those arising from COVID-19. Since the committee meeting on 9 March this has developed much further and there has since been agreement by the system to postpone the mobilisation. The Board will receive a separate update on this. **Management of COVID-19** **Assured** The committee was assured that we are doing all we can to respond to the ever-changing position with COVID-19. An update was received on the actions taken and their impact. This included the MOU agreed by the ICSs for the Trust to provide a central function in running a command hub. The Board will be receiving a detailed update on the current position. The committee also received reports under its section on *Monitoring Performance*, including: **EOC Clinical Audit Review** The committee expressed concern that the restructure agreed by the Board as part of the business case approved last May, is still to be implemented due to an ongoing grievance. In the meantime, some posts have been filled on an interim basis, but the Trust remains non-compliant. The restructure is expected to proceed in March and the committee will confirm this at its next meeting. **Quality Account** The committee reviewed progress with development of the 2019/20 annual report and supported the suggested priorities for 2020/21. This will come to the Board as part of the Annual Report and Accounts in May.
Any other matters the Committee wishes to escalate to the Board	The **Patient Experience Strategy** was reviewed. The committee provided some feedback and explored whether we are getting to carer groups. It also asked for management to test whether this can be resourced sufficiently to deliver. Subject to this, the committee recommends it to the Board for approval (agenda item 108-19). A verbal update was provided on delivery of **Key Skills**; there is some variance by OU, but the majority of training has been delivered. The biggest gaps appear to be related to the online training.

South East Coast Ambulance Service NHS Foundation Trust

SECAMB Board

Escalation report to the Board from the Workforce and Wellbeing Committee

Date of meeting	**12th March 2020**
Overview of issues/areas covered at the meeting:	Attendance by staff was appropriate and papers of a good standard. The meeting was quorate. Staff were able to dial-in and agenda slots were timed to allow staff to attend for their slot only. The usual starting point with staff presenting their responses to the staff survey was cancelled to ensure operational staff were not taken from their core duties. We continued the scrutiny of the HR transformation programme noting that again the workforce dashboard is yet to be developed. This is linked to an agreement on the updated demand and capacity review and any updating necessary for the refreshed workforce plan for 2020-2021. WWC was clear that this must be available for the next meeting, and based on organisational needs, including any gaps with commissioned activity. The meeting considered a number of ***Scrutiny Items*** *(where the committee scrutinises that the design and effectiveness of the Trust's system of internal control for different areas),* including; **Covid-19 issues** WWC discussed the issues around returning negative results to patients. Case for funding the additional work this is bringing is to go to Board with the support of WWC. Some staff working in EOC are not registered clinicians but are working on patient data and so may need to have some retrospective authorisation. WWC was assured that clinical oversight in the Hub was appropriate. Staff who are self-isolating are being supported with around two dozen in that position with around 450 hours lost. This has led to a number of pay and related queries and WWC was assured that staff in this position were supported both medically and financially. FAQs being prepared so that staff have access to information: this is a particular issue for part time staff and those on draw-down contracts. Corporate teams have identified staff who can work shifts in the Hub and WWC would want staff taking-on these additional responsibilities properly recognised. WWC was concerned that the resilience of our PAPs may not be as rigorous as our internal systems and Exec has identified this issue and it is currently being tested. Similarly, issues might arise with volunteers (CFRs). It was also reported that IT relies on significant numbers of agency staff and Executive will want to assure itself that areas of business

heavily reliant on agency staff are resilient.

HR Transformation Programme
Recognised that capacity has been lacking in this area since the project manager left. WWC was assured overall that the new Executive Director was refocussing work on the Transformation Programme was internally consistent and reflects better our principle of working closely with staff on developing new ways of working.

It was generally accepted that response to Corvid-19 may delay completion further.

E-Expenses Partially Assured
WWC heard that this has been rolled-out to most staff but unions were originally not convinced of its appropriateness, and some are advising staff to use former systems. This has led to a review of how we engage with Unions so that relationships are able to continue to improve. Revised timeline is to complete by end of June 2020.

Driving License Checks Partially Assured
These have been separated from the e-expenses system work as it was felt that conflating the two was not helpful. Previous systems did not allow simple verification of compliance by senior staff and so were not fit for purpose. Around one-third of staff have been checked but no issues found. A question arose that staff 'volunteered' their licenses and so further assurances were sought concerning those not providing licenses. Revised timeline is to complete by end of June 2020.

Personnel Files Partially Assured
Found to be in similar position to E-expenses and so project plan being revised as quality of materials collated was not adequate. Revised plan using central staff so that quality can be better controlled. Supported by staff side. Revised timeline is to complete by end of June 2020.

E Timesheets Partially Assured
Revising roll-out in response to pressures on organisation and recognised that resources available to the project were insufficient. Implementation plan shared and WWC was confident that it was sound.

DBS Checks Assured
Being considered separately to allow WWC to be assured it is working but a refresh of the policy is underway. Agreed to bring any revised proposals to Full Board.

Retention Strategy Partially Assured
A very strong paper was received and supported: the feeling from WWC was that targets needed to be more ambitious this reflected EMB's view The paper identified the key issues around the retention of all grades and was a significant concern to WWC. As well as data quality, issues were identified around role expectations and the feeling from the Committee was that this was more of a recovery plan than a strategy but valuable in that

	context. **Staff Survey Engagement Plan Assured** An update on results and some planned actions were covered. WWC was pleased that OU level and team responses had been sent to managers allowing local identification and addressing of issues. A good plan for the support of teams in taking a lead on their own improvement was shared returning responsibility to staff themselves. A useful discussion was held in relation to the significant number of staff comments and the Committee was assured that HR were intending to analyse these in some depth and look how to respond. **Ethnicity and Gender Pay Gap Assured** Two high quality papers were received to note. Recommendations were supported. WWC noted once again the poor levels of representation of BME communities in the organisation which distorts any analysis of ethnicity pay gaps and would challenge the organisation to understand this and address it. Similarly, issues need better understanding with regard to gender. It was the view of WWC that working towards better representation of the communities we serve should be a key part of our recruitment and retention processes moving forward, and this should include supporting people moving into new roles. There was also a review of the plan to refresh the **Wellbeing Strategy which** was supported.
Reports *not* received as per the annual work plan and action required	None. The pre-agenda meeting continues to work effectively to ensure required Reports are developed in a timely manner.
Changes to significant risk profile of the trust identified and actions required	WWC is confident that the major risks are captured and considered by the Executive. The HR dashboard remains under development and needs to form a better link between the integrated performance report, the risk register and the committee dashboard. This in the intended direction of travel and was supported by WWC
Weaknesses in the design or effectiveness of the system of	None

internal control identified and action required	
Any other matters the Committee wishes to escalate to the Board	WWC would want the Board to be aware of the work on the integrated performance report and the implications that that will have for various dashboards informing committee work, and their link into the organisational risk register.

South East Coast Ambulance Service NHS
NHS Foundation Trust

Agenda No	111-19

Name of meeting	Board of Directors
Date	26 March 2020
Name of paper	Board Committee Annual Review / TOR
Author	Peter Lee, Company Secretary
Synopsis	This is the annual review of the Board Committees' plans for 2020/21 and their Terms of Reference (Appendices 1-10). The annual plans have been considered jointly by each of the committees and will be appropriately dynamic to reflect any need to change focus. On behalf of the Board, the Audit & Risk Committee will undertake a formal review of the plans mid-year. The amendments to the terms of reference are indicated in the version control schedules at the end of each document.
Recommendations, decisions or actions sought	The Board is asked to confirm that it is satisfied with the plans for each of the four main committees and to agree the revised terms of reference / membership. The change in committee Chairs (WWC and FIC) will take effect following a handover in Q1.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	**No**

SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Appointments and Remuneration Committee (ARC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Appointments and Remuneration Committee (ARC).

2. Purpose

2.1. The Committee is responsible for identifying and appointing candidates to fill all the executive director positions on the Board and for determining their remuneration and other conditions of service.

2.2. The Committee is also responsible for determining the remuneration and terms of service for any other senior employee appointed on terms outside of the Agenda for Change framework, i.e. where their remuneration exceeds Band 9.

2. Membership

3.1. The Committee shall be composed of all the independent non-executive directors. However, when appointing or removing executive directors (other than the Chief Executive) the Chief Executive will be a member, as described in Schedule 7, 17 (3) of the NHS Act 2006, as amended by the Health & Social Care Act 2012.

3.2. The Trust Chair will determine who should be Chair of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be three members.

5. Attendance

5.1. Only members of the committee have the right to attend committee meetings.

5.2. The trust secretary shall be secretary to the committee.

5.3. At the invitation of the committee, meetings shall normally be attended by the director of human resources.

5.4. Other persons may be invited by the committee to attend a meeting so as to assist in deliberations.

5.5. Any non-member, including the secretary to the committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

6. Frequency

6.1. Meetings shall be called as required, but at least twice in each financial year.

7. Authority

7.1. The Committee is constituted as a standing committee of the trust's board of directors (the board). Its constitution and terms of reference are as set out in these terms of reference, which are subject to amendment at future board meetings.

7.2. The Committee is authorised by the board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the committee

7.3. The Committee is authorised by the board to instruct professional advisors and request the attendance of individuals and authorities from outside the trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

7.4. The committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

8. Duties

8.1. Appointments – the committee will;

i. regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, and nomination committee of the council of governors, with regard to any changes;

ii. give full consideration to and make plans for succession planning for the chief executive and other executive board directors taking into account the challenges and opportunities facing the trust and the skills and expertise needed on the board in the future;

iii. keep the leadership needs of the trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy;

iv. be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise;

v. when a vacancy is identified, evaluate the balance of skills, knowledge and experience on the board, and its diversity, and in the light of this evaluation,

prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria;

vi. ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation;

vii. ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise;

viii. ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

ix. carefully consider what compensation commitments (including pension contributions) the directors' terms of appointment would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw back provisions should be considered in case of a director returning to the NHS within the period of any putative notice;

x. consider any matter relating to the continuation in office of any board executive director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract

8.2. Remuneration – the committee will

i. establish and keep under review a remuneration policy in respect of executive board directors [and senior managers on locally-determined pay];

ii. consult the chairperson and/or chief executive about proposals relating to the remuneration of the other executive directors.

iii. In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors [and senior managers on locally-determined pay], including:

- salary, including any performance-related pay or bonus;
- provisions for other benefits, including pensions and cars;

- allowances;
- payable expenses;
- compensation payments.

In adhering to all relevant laws, regulations and trust policies:

iv. establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the trust;

v. decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

vi. make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the foundation trust, and take as a baseline for performance any competencies required and specified within the job description for the post;

vii. consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements;

viii. use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors [and senior managers on locally-determined pay], while ensuring that increases are not made where trust or individual performance do not justify them;

ix. be sensitive to pay and employment conditions elsewhere in the trust, especially when determining annual salary increases;

x. monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels;

xi. monitor procedures to ensure that existing directors are and remain 'fit and proper' persons as defined in law and regulation.

8.7 In accordance with the Standing Financial Instructions, the Committee will consider and approve individual redundancy payments that fall outside of the employees' contract / standard AfC terms and conditions

8.8 The Committee will also consider and approve large scale redundancies, e.g. as a result of re-organisation.

8.9 The Committee will consider any other workforce issue referred to it by either the Chief Executive, the Chairman or a Committee member, where the nature of the discussion is considered to be sensitive and not appropriate for more general discussion at one of the other Board Committees.

9. Reporting

9.1. Formal minutes shall be taken of all committee meetings

9.2. The Chair of the Committee shall report a summary of the proceedings of each meeting to the Board and draw to the attention of the Board any significant issues that require disclosure.

10. Support

10.1. The secretary to the committee shall support the committee by:

- Agreeing meeting agendas with the Chair of the Committee;
- Providing timely notice of meetings and forwarding details including the agenda and supporting papers to members and attendees in advance of the meetings;
- Recording formal minutes of meetings and keeping a record of matters arising and issues to be carried forward.
- Advising the Chair and the Committee about fulfilment of the Committee's Terms of Reference and related governance matters.

11. Review

11.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

11.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

11.3. These Terms of Reference shall be approved by the Board and formally reviewed at intervals not exceeding two years.

Approved by: Trust Board
Approved date:
Review Date:

ARC ANNUAL CYCLE OF BUSINESS 2020-21

Appointments & Remuneration Committee	Executive Lead	25 June 2020	24 Sept 2020	21 January 2020			
ADMINISTRATION							
Apologies	Chair	√	√	√			
Declarations of Interests	Chair	√	√	√			
Minutes	Chair	√	√	√			
Action Log	Chair	√	√	√			
Next Meeting Agenda / Forward Look	Chair	√	√	√			
APPOINTMENTS / GOVERNANCE							
Executive Succession Planning / Skills Gap Analysis / Diversity	Chief Executive	√					
Annual Review of structure, size and composition of the Board	Trust Chair	√					
Fit and Proper Persons Test Annual Review	Company Secretary	√					
Committee Annual Review / TOR	Company Secretary			√			
REMUNERATION / APPRAISALS							
Executive Director Remuneration Framework	Chief Executive		√				
Annual Review of Executive Remuneration	Chief Executive		√				
Chief Executive Appraisal / Objectives Incl. 'Earn Back' Review	Chair	√ **A**	√ **EB**				
Executive Director of HR & OD Probation Outcome	Chief Executive	√					
Executive Director Appraisals	Chief Executive	√					
*Staff Remuneration Outside of AfC / Interims & Consultants to be Approved	Chief Executive						
*Redundancy / Exit Packages to be Approved	Chief Executive						

*AS REQUIRED

South East Coast Ambulance Service NHS Foundation Trust

Audit & Risk Committee (AuC)

Terms of Reference

1. Constitution

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Audit & Risk Committee (AuC), referred to in this document as 'The Committee'.

2. Purpose

2.1. The purpose of the Committee is to provide the Trust with a means of independent and objective review of internal control over the following key areas:

- Financial systems
- The information used by the Trust
- Assurance Framework systems
- Performance and Risk Management systems
- Compliance with law, guidance and codes of conduct

2.2. In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

3. Membership

3.1. The Committee shall have at least three members, to include the Chairs of the other Board committees appointed by the Board from amongst the independent Non-Executive Directors of the Trust.

3.2. The Chairman of the Trust shall not be a member.

3.3. One of the members with recent and relevant financial experience shall be appointed Chair of the Committee by the Board.

3.4. Current members**:**

- Michael Whitehouse, Independent Non-Executive Director (Chair)
- Al Rymer, Independent Non-Executive Director - ARC
- Howard Goodbourn, Independent Non-Executive Director - FIC
- Laurie McMahon, Independent Non-Executive Director - WWC
- Tricia McGregor, Independent Non-Executive Director - QPS

In addition, each Independent Non-Executive Director (save the Chairman) will be an ex-officio member of the committee.

4. Quorum

4.1. The quorum necessary for formal transaction of business by the Committee shall be two Independent Non-Executive Directors.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Executive Director of Finance & Corporate Services
- Executive Director of Nursing & Quality
- Company Secretary
- Internal Auditor
- External Auditor
- Counter Fraud

5.2. The Chairman and organisational managers and officers may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed.

5.3. Officers unable to attend a meeting are required to send a fully briefed deputy or provide a written update to the Committee members at least two working days beforehand.

5.4. The Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should non-attendance jeopardise the functioning of the Committee the Chair will discuss the matter with the members and if necessary seek a substitute or replacement.

5.5. Attendance at Committee meetings will be disclosed in the Trust's Annual Report and Accounts.

6. Frequency

6.1. The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least four times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

6.2. At least once a year the Committee shall meet privately with the External and Internal Auditors. The External Auditor or the Internal Auditor may request a private meeting if they consider this to be necessary.

6.3. Meeting dates will be diarised on a yearly basis.

7. Telephone Conference

7.1. With leave of the Chair of the Committee, any member or attendee of the Committee may participate in a meeting of the Committee by means of a teleconference/videoconference where circumstances require it or similar communications equipment whereby all persons participating in the meeting can hear each other and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

8. Authority

8.1. The Committee has no executive powers. It is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8.2. The Committee is authorised by the Board to investigate any action within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

8.3. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers necessary. It may challenge the reports and duties of other Committees to ensure due and robust business processes are in place.

9. Duties

9.1. The subject matter for meetings will be wide-ranging and varied but in particular it will cover the following:

9.2. Governance, Risk Management and Internal Control

9.2.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives.

9.2.2. In carrying out this work, the Committee shall primarily utilise the work of Internal Audit, External Audit and other assurance functions, but shall not be limited to these audit functions. It may seek reports and assurances from directors and managers as appropriate. The Committee may also take assurances from work undertaken by other established committees of the Trust Board.

9.2.3. Reviews by the Committee shall concentrate on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This shall be evidenced through the Committee's use of an effective Assurance Framework to guide its work and the work of the audit and assurance functions that report to it. In particular, the Committee shall review the adequacy of:

i. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, External Auditor's opinion or other appropriate independent assurances, prior to endorsement by the Board;

ii. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks (including through review of the Risk Register and Board Assurance Framework) and the appropriateness of the above disclosure statements;

iii. The processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements;

iv. The policies and procedures for all work related to fraud, corruption and security management as set out in the NHS Standard Contract which requires providers to put in place appropriate arrangements for counter fraud and as required by NHS Protect;

v. The Trust's whistleblowing policy(s) so test that arrangements are in place for proportionate and appropriate investigation;

vi. The Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

9.3. Internal Audit

9.3.1. The Committee shall ensure that there is an effective Internal Audit function established by management that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive and Board. This shall be achieved by:

vii. Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal;

viii. Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework;

ix. Consideration of the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources;

x. Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;

xi. Annual review of the effectiveness of Internal Audit.

9.4. External Audit

9.4.1. The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This shall be achieved by:

xii. Consideration of the appointment and performance of the External Auditor in so far as compliance with governance codes permits;

xiii. Making a recommendation to the Council of Governors on the appointment, reappointment or removal of the External Auditor; and if the Council of Governors does not accept the Committee's recommendation, ensuring that the Board includes in the annual report a statement from the Committee explaining its recommendation and setting out reasons why the position of the Council of Governors was different;

xiv. Discussion and agreement with the External Auditor, before audits commence, about the nature and scope of the audit ensuring coordination, as appropriate, with other External Auditors in the local health economy;

xv. Discussion with the External Auditor concerning assessment of the Trust with regard to locally evaluated risks, and the associated impact on the audit fee;

xvi. Reviewing all External Audit reports, including agreement of the ISA 260 before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

9.5. Financial Reporting

9.5.1. The Committee shall ensure that systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

9.5.2. The Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

xvii. The wording of the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

xviii. Changes in, and compliance with, accounting policies and practices;

xix. Unadjusted mis-statements in the Financial Statements;

xx. Major judgemental areas;

xxi. Significant adjustments resulting from audit.

9.6. Other Assurance Functions

9.6.1. The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider any implications for the governance of the organisation.

9.6.2. These shall include, but shall not be limited to, consideration of any reviews by Department of Health arms length bodies, regulators or inspectors (e.g. NHSI, Care Quality Commission, NHS Resolution etc.), or professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

9.6.3. In addition, the Committee shall review the output of other committees established by the Board, whose work can provide relevant assurance to the Committee's own scope of work.

10. Reporting

10.1. The Committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Support

The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

12. Review

12.1. The Committee will undertake a self-assessment at the end of each meeting to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2. The Committee shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0		March 2016	
1.1		May 2018	1. Amend to Audit and Risk 2. Included members 3. Amended attendees 4. Quorum from 3 to 2 NEDs to reflect other committees. 5. Authority section to be consistent with other committees 6. Amended the admin support arrangements 7. Included review from every 2 years to annually to be consistent with other committees
2.1		23 May 2019	Updated membership and revised wording on frequency.
2.2			Updated membership Minor revision to section 9 – to remove the specificity of who will provide administrative support.

Audit & Risk Committee	Executive Lead	21 May 2020	16 July 2020	10 Sep 2020	03 Dec 2020	11 March 2021
ADMINISTRATION						
Apologies	Chair	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√
Minutes	Chair	√	√	√	√	√
Action Log	Chair	√	√	√	√	√
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√
FINANCIAL STATEMENTS & THE ANNUAL REPORT						
Annual Report & Accounts -External Audit Report -ISA260 Report (Audit Hilights Memo) -Management Representations Letter on the financial statements -Management Representations Letter on the quality report	Exec Director of Finance KPMG	√				
Annual Governance Statement	Company Secretary	√				√Draft
Accounting Policies	Exec Director of Finance			√		
Accounting and Reporting Systems	Exec Director of Finance					
Financial statements - integrity / judgments	Exec Director of Finance				√	
Single Tender Waivers	Exec Director of Finance		√			
Losses and Special Payments [incl. baseline numbers / % as per action 164-19 04.03.2019]	Exec Director of Finance					√
INTERNAL AUDIT						
Counter Fraud Progress Report	RSM		√	√		√
Counter Fraud Work Plan	RSM					√
Counter Fraud Annual Report incl. SRT	RSM					√
Internal Audit Progress Report	RSM		√	√	√	√
Internal Audit Annual Plan	RSM					√
Annual Report to include Internal Audit Opinion	RSM	√				√Draft
EXTERNAL AUDIT						
External Audit Finding Report	KPMG	√				
Report to Governors on Quality Report	KPMG	√				
Limited Assutance opinion on Qualiry Report Indicators	KPMG	√				
Progress Report / Technical Update	KPMG					√
Audit Plan	KPMG				√	
GOVERNANCE & RISK MANAGEMENT						
Plan for the production of the Annual Report & Accounts	Chief Executive				√	
Business Continiuty	Exec Director of Operations		√			
Data Quality	Exec Director of Strategy				√	
Whistleblowing	Exec Director of Nursing			√		
Decl. of Interests	Company Secretary			√		
Policy Matrix - Annual Review	Company Secretary					√
Assurance Map - Annual Review	Company Secretary					√
Board Assurance Framework Review	Company Secretary				√	
Risk Review, incl. BAF Risk Report	Executive Director of Nursing / Company Secretary		√	√	√	√
Risk Management System / effectivess of the policy and procedure	Exec Director of Nursing			√		√
Annual Review of SO's/SFI's	Exec Director of Finance		√			√
Annual Self Certification GC6/COS 7	Company Secretary	√				
Corporate Governance Statement	Company Secretary	√				√Draft
Integrated Performance Report Annual Review	Exec Director of Strategy		√			
Information Governance (incl. *Annual Report)	Exec Director of Nursing		√*			√
Annual Review of Cycle of Business	Company Secretary					√
Annual Self-Assessment	Company Secretary					√
Review of Terms of Reference	Company Secretary					√
Review Purview / TOR of other Board Committees	Company Secretary					√
MANAGEMENT RESPONSE (delete once received)						
Internal Audit Plan 2020 21						
BAF / Risk Management					√	
GDPR / IG						√
Financial Systems / Payroll						√

South East Coast Ambulance Service NHS Foundation Trust

Finance and Investment Committee ('FIC')

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Finance and Investment Committee ('FIC') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, corporate services and investments in future operational capability, are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute three independent Non-Executive Directors and three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Michael Whitehouse, Independent Non-Executive Director (Chair)
Howard Goodbourn, Independent Non-Executive Director
Lucy Bloem, Independent Non-Executive Director
Executive Director of Finance & Corp. Services (Executive Lead)
Executive Medical Director
Executive Director of Operations

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Executive Director of Strategy & Business Development
- Company Secretary
- Deputy Director of Finance
- A senior manager from operations

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively.

8. Purview

The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support

The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	21 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. FBDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1	19 October 17	23 October 17	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Update to membership
2.1	13 May 2019	23 May 2019	Update to membership Increased frequency from 4 to 6 meetings Revised section 7 leaving the detail of areas covered by the committee to the purview/annual plan.
2.2			Updated membership including moving the executive director of strategy to an attendee so there is equal membership between exec and non-exec. Minor revision to section 9 – to remove the specificity of who will provide administrative support.

Finance and Investment Committee	Executive Lead	14 May 2020	23 July 2020	10 September 2020	12 November 2020	14 January 2021	18 March 2021
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
SCRUTINY							
Use of operational resource / impact on performance 111 & 999	Executive Director of Operations	√		√		√	
999 Operational efficiencies, e.g. job cycle time / unit costs	Executive Director of Operations		√		√		√
Financial Planning - annual plan / budgets	Executive Director of Finance						√
Capital Programme Plan - development* and delivery**	Executive Director of Finance				√**		√*
Reference Costs / Patient Level Costing	Executive Director of Finance	√					
ERIC Return (Estates)	Executive Director of Finance		√				
Cost Improvement Programme / Overview of Schemes	Executive Director of Finance	√					
Winter Planning	Executive Director of Operations			√			
Utilisation of Technology	Executive Director of Finance		√				
Make Ready Process	Executive Director of Operations					√	
Fleet Strategy Implementation Plan	Executive Director of Operations			√			
Department Deep Dives - Procument Estates Fleet IT Finance	TBC	P	E	F	IT	F	
PMO	Executive Director of Strategy		√				
Monitoring Performance							
111 / CAS & 999 Operational Performance	Executive Director of Operations	√	√	√	√	√	√
Financial Performance (Pack) / Forecast	Executive Director of Finance	√	√	√	√		√
IT Dashboard/KPIs	Executive Director of Finance	√			√		
Estates Dashboard/KPIs	Executive Director of Finance		√				√
Business Cases							
Business Case Schedule / Tracker	Executive Director of Finance						
Business Cases for Recommendation	TBC						
Return on Investment / Benefits Realisation	TBC						
Strategies							
Digital Strategy	Executive Director of Finance						
Fleet Strategy	Executive Director of Operations						
Estates Strategy	Executive Director of Finance						
Governance & Risk							
BAF Risks	Company Secretary	√	√	√	√	√	√
Committee Annual Self-Assessment	Company Secretary					√	
Cycle of Business	Company Secretary						√
Terms of Reference	Company Secretary						√
Internal Audit Plan 2020 / 21							
Fleet Management				√			
IT					√		

Financial Planning						√	

South East Coast Ambulance Service NHS Foundation Trust

Quality and Patient Safety Committee

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Quality and Patient Safety Committee ('QPS') referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to quality governance (encompassing patient safety, clinical effectiveness and patient experience) are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three Independent Non-Executive Directors and at least three Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Tricia McGregor, Independent Non-Executive Director (Chair)
Lucy Bloem, Independent Non-Executive Director
Terry Parkin, Independent Non-Executive Director
David Astley, Chairman
Executive Director of Nursing & Quality (Executive Lead)
Executive Medical Director
Executive Director of Operations
Executive Director of HR & OD

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Chief Executive
- Company Secretary
- Deputy Medical Director
- Chief Pharmacist
- Consultant Nurse / Paramedic
- Head of IT
- Senior 999 Operations Manager
- Senior 111 Operations Manager

5.2. Other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The frequency of meetings will be agreed at the start of each financial year, ensuring the committee meets at least six times a year. Extraordinary meetings may be called by the committee chair in addition to those agreed, to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that the Trust's system of governance and internal control in relation to the areas with its purview are designed well and operating effectively to:

- Promote safety and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care
- Ensure the effective and efficient use of resources through evidenced-based clinical practice
- Protect the heath and safety of trust employee and
- Ensure compliance with legal, regulatory and other obligations

8. Purview

The purview of the committee is set out in the accompanying purview document, which is approved by the Board along with these Terms of Reference. The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk based approach to prioritisation. The committee will not review all aspects of the system of internal control identified in the purview in every year.

9. Support

The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next

meeting of the Board and draw to the attention of the Board any significant issues that require disclosure.

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	5 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. RMCGC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16.
1.1		23 October 2017	Update to membership Inclusion of additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
1.2		25 May 2018	Updated membership
2.1		23 May 2019	Updated membership Clarified that frequency of meetings is to be agreed at the start of each year
2.2			Section 7 – Addition of bullet points confirming overall role of the committee Minor revision to section 9 – to remove the specificity of who will provide administrative support.

Quality & Patient Safety Committee	Executive Lead	21 May 2020	09 July 2020	17 Sept 2020	19 Nov 2020	07 Jan 2021	18 March 2021
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	√
Declarations of Interests	Chair	√	√	√	√	√	√
Minutes	Chair	√	√	√	√	√	√
Action Log	Chair	√	√	√	√	√	√
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	√
Meeting Effectiveness	Chair	√	√	√	√	√	√
SCRUTINY							
111							
111 / CAS Clinical effectiveness	Executive Director of Operations		√			√	
EOC							
EOC clinical safety	Executive Director of Operations	√		√		√	
999							
Consent to Treatment (is it being sought in line with legislation and guidance)	Executive Medical Director	√					
Surge (application of the SMP / Clinical Harm Review)	Executive Director of Operations				√		
Bariatric Care (vehicle equipment and response) Are they located correctly, Policy, equipment, analysis of performance, tasking, training	Executive Director of Operations						
Private Ambulance Providers: to include governance, policies and procedures in place, system for planning, compliance data to include complaints, risks, issues, serious incidents. Plus clinical effectiveness	Executive Director of Operations			√			
Clinical Outcomes - deep dive in to specific areas, e.g. cardiac survival	Executive Medical Director	√	√	√	√	√	√
Medical Equipment: Full review of Medical Devices IAP including all equipment, pre implementation checks	Executive Director of Operations						
Obstetrics: effective care and treatment	Executive Medical Director	√					
RTC's - Emergency, non-emergency, Collisions not involving public, and safety. Assurance of learning from incidents	Executive Director of Operations						
Co-Responders: Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning. To include recruitment & retention. To include tasking	Executive Director of Operations						
Paediatrics: effective care and treatment	Executive Medical Director		√				
Frequent Callers - Review of Strategy/Plan and resources	Executive Medical Director						
Specialist							
HART: Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning.To include recruitment & retention. To include tasking. NARU Audit readiness assessment	Executive Director of Operations				√		
Specialist Paramedics (PP & CCP) Scope of Practice - Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning. To include recruitment & retention	Executive Medical Director		√				
Clinical Governance / Standards / Compliance							

Quality & Patient Safety Committee	Executive Lead	21 May 2020	09 July 2020	17 Sept 2020	19 Nov 2020	07 Jan 2021	18 March 2021
Non Registered Clinicians - Scope of Practice - Organisation and reporting lines, governance, assurance on skills, knowledge and experience to deliver effective care and treatment. Thematic incident analysis and learning. To include recruitment & retention	Executive Medical Director						
Medicines Governance Incl. QAVs	Executive Medical Director		√				
Infection Prevention and Control - internal controls / effectiveness	Executive Director of Nursing & Quality						
Learning from Serious Incidents, complaints, incidents.	Executive Director of Nursing & Quality						
Serious Incident Q Thematic Review / Learning from Deaths	Executive Director of Nursing & Quality / Executive Medical Director	√			√		√
Duty of Candour - compliance with legislation and staff impact	Executive Director of Nursing & Quality						
Patient Records / ECPR	Executive Director of Operations						
Complaints Management - design and effectiveness of controls	Executive Director of Nursing & Quality					√	
Safeguarding	Executive Director of Nursing & Quality						
Key Skills Annual Programme	Executive Medical Director						
CIP QIAs	Executive Director of Nursing & Quality	√					
QIA mid year review	Executive Director of Nursing & Quality						
CFR Governance & Effectiveness	Executive Director of Operations						
Clinical Supervision	Executive Medical Director						
CAS Alerts: Monitoring management and oversight of Trust policy and procedures	Executive Director of Nursing & Quality						
NHS Pathways Compliance 999 & 111	Executive Director of Operations						
Compliance with Modern Slavery Act	Executive Director of Nursing & Quality						
MONITORING PERFORMANCE & QUALITY							
Quality & Safety Dashboard / Report	Executive Director of Nursing & Quality	√	√	√	√	√	√
Safeguarding Mid-Year Review	Executive Director of Nursing & Quality						
Quality Account Development*/Sign Off**/Mid Year Review***	Executive Director of Nursing & Quality	√**			√***		√*
Incident / SI Annual Report	Executive Director of Nursing & Quality						
Infection Prevention and Control Annual Report	Executive Director of Nursing & Quality						
Clinical Audit Annual Report / Plan	Executive Medical Director	√					
Annual Safeguarding Report	Executive Director of Nursing & Quality						
Accountable Officer for Controlled Drugs Annual Report (Medicines Governance)	Executive Medical Director	√					
Cardiac Arrest Annual Report	Executive Medical Director		√				
Freedom to Speak Themes / *Annual Report	Executive Director of Nursing & Quality						
Quality Assurance Visits / Patient Safety Leadership Visit	Executive Director of Nursing & Quality						
ENABLING STRATEGIES							
Volunteers	Executive Director of Operations						
Freedom to Speak Up	Executive Director of Nursing & Quality						
Safeguarding	Executive Director of Nursing & Quality						
Patient Experience	Executive Director of Nursing & Quality						
Infection Prevention & Control	Executive Director of Nursing & Quality						
MANAGEMENT RESPONSES (delete once received)							
GOVERNANCE & RISK MANAGEMENT							
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√	√	√	√	√	√
Bi-Annual Review of High/Extreme Risks	Executive Director of Nursing & Quality						

Quality & Patient Safety Committee	Executive Lead	21 May 2020	09 July 2020	17 Sept 2020	19 Nov 2020	07 Jan 2021	18 March 2021
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary					√	
Mid-Year Review of Cycle of Business	Company Secretary				√		
Internal Audit Plan 2020/21							
Complaints (schedule as at the draft 18.02.2020)						√	
Medicines (schedule as at the draft 18.02.2020)			√				

South East Coast Ambulance Service NHS Foundation Trust

Workforce and Wellbeing Committee (WWC)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a committee of the Board to be known as the Workforce and Wellbeing Committee (WWC) referred to in this document as 'the committee'.

2. Purpose

The purpose of the committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to the workforce (encompassing resourcing, staff wellbeing and HR processes) are designed appropriately and operating effectively.

3. Membership

Appointed by the Board, the membership of the committee shall constitute at least three independent Non-Executive Directors and at least two Executive Directors. Executive Directors shall number no more than the Non-Executive Directors.

The members of the committee shall be:
Terry Parkin, Independent Non-Executive Director (Chair)
Al Rymer, Independent Non-Executive Director
Laurie McMahon, Independent Non-Executive Director (Chair from Q1)
Executive Director of HR & OD
Executive Director of Operations
Executive Director of Strategy

In addition, each Independent Non-Executive Director will be an ex-officio member of the committee.

4. Quorum

The quorum necessary for formal transaction of business by the committee shall be two Independent Non-Executive Director members and one Executive Director.

5. Attendance

5.1. In addition to the members, the following individuals shall regularly attend meetings of the Committee:

- Executive Director of Nursing & Quality
- Company Secretary
- HR Business Support Manager

5.2. At the request of a committee member, other directors, Trust leads, managers and subject matter experts shall be invited to attend or observe full meetings or specific agenda items when issues relevant to their area of responsibility are to be scrutinised.

5.3. With the agreement of the committee chair, members of the committee or other Trust managers and officers may participate in a meeting of the committee by means of a tele/video conference. In such instances, it is a requirement that all persons participating in the meeting can hear each other. Participation in the meeting in this manner shall be deemed to constitute the presence in person at such a meeting. A member of the committee joining the meeting in this way shall count towards the quorum.

6. Frequency

The committee shall meet at least six times a year and extraordinary meetings may be called by the committee chair in addition to discuss and resolve any critical issues arising.

7. Authority

The committee has no executive powers. The committee is authorised to seek and scrutinise assurances that Trust's the system of internal control is designed well and operating effectively. The committee will seek assurance from sources and systems including the frontline operations, corporate services and from external independent sources such as peer review; internal audit, local counter fraud service, external audit and others, including legal or other professional advice when required.

8. Purview

The purview of the committee is set out in the accompanying purview document and annual cycle of business, which is approved by the Board along with these Terms of Reference**.** The committee will prioritise the acquisition and scrutiny of assurances according to the Board's requirements, using a risk-based approach to prioritisation. The committee will not necessarily review all aspects of the system of internal control identified in the purview in every year.

9. Support

The Company Secretary is responsible for ensuring appropriate administrative support is provided to the committee. The support provided by the person(s) identified by the Company Secretary will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report.

10. Reporting

The committee shall be directly accountable to the Trust Board. The Chair of the Committee shall report a summary of the proceedings of each meeting at the next meeting of the Board and draw to the attention of the Board any significant issues that require disclosure

11. Review

The committee shall reflect upon the effectiveness of its meeting at the end of each meeting. The committee shall review its Terms of Reference at least once a year to ensure that they fit with the Board's overall review of the system of internal control. Any proposed changes shall be submitted to the Board for approval.

VERSION CONTROL SCHEDULE

Version no.	Date approved by committee as fit for purpose	Date ratified by the Board so that it comes into force	Main revisions from previous version.
1.0	12 July 16	26 July 16	Committee established July 16 based on principles set out in Board paper 'governance improvements' at May 16. WDC dis-established June 16. Discussed at Board June 16. Ratified 26 July 16 Board.
1.1	20 Sept 16		Minor amendment proposed at para 5.3 see italicised changes.
2.0	04 October 2017		Change in Chair and Membership Additional regular attendees Administrative support provided by the HR Business Support Manager; from the corporate governance dept.
2.1		25 May 2018	Updated membership Reduced frequency to minimum 4 times a year (from 6)
2.2		23 May 2019	Updated membership Increased frequency to minimum 6 time a year (from 4)
2.3			Change to membership – Chair will change in Q1 2020/21 Small amendment to section 9 removing the specificity of the administrative support.

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021	
ADMINISTRATION							
Apologies	Chair	√	√	√	√	√	
Declarations of Interests	Chair	√	√	√	√	√	
Minutes	Chair	√	√	√	√	√	
Action Log	Chair	√	√	√	√	√	
Next Meeting Agenda / Forward Look	Chair	√	√	√	√	√	
Meeting Effectiveness	Chair	√	√	√	√	√	
SCRUTINY							
Programmes (overview of progress against objectives)							
HR Transformation Plan	Executive Director of HR & OD	√					
Clinical Education Plan	Executive Medical Director	√	√	√			
HR Service Centre							
Payroll Discrepancy - effectiveness of policy	Executive Director of HR & OD	√					
Payroll Contract	Executive Director of HR & OD	√					
Workforce Planning							
Workforce delivery (Demand and Capacity Review Phase 1)	Executive Director of HR & OD	√	√	√	√	√	
Workforce delivery (Demand and Capacity Review Phase 2)	Executive Director of HR & OD					√	
Student Paramedics - recruitment and support	Executive Medical Director						
Workforce Governance							
Personnel Files	Executive Director of HR & OD		√				
Pre-Employment Checks	Executive Director of HR & OD		√		√		
Clinical Education							
External Compliance (Ofsted; Fquals; ESFA)	Executive Medical Director					√	
Annual Training Plan	Executive Medical Director	√		√			
Key Skills Annual Plan* / Progress**	Executive Medical Director			√**		√*	
Workforce Education Development Review (B5>6 uplift / mentorship)	Executive Medical Director						
Continuous Professional Development - clinical staff	Executive Medical Director				√		
Driving Standards	Executive Medical Director		√				
Apprenticeship Governance	Executive Medical Director					√	
Higher Education Institution - partnerships with Universities	Executive Medical Director			√			
Employee Relations							
Bullying & Harassment	Executive Director of HR & OD						
Grievances	Executive Director of HR & OD	√					
Equality, Diversity, Inclusion & Wellbeing							
Equality Delivery System - EDS2 Goals, Delivery on the WRES, DES, Equality Objectives, Gender Pay gap.	Executive Director of HR & OD						

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021	
Learning & OD							
Management Training - Fundamentals	Executive Director of HR & OD			√			
Staff Induction Programme	Executive Director of HR & OD		√				
Health & Safety							
Health & Safety Management systems	Executive Director of Nursing & Quality				√		
MONITORING PERFORMANCE & QUALITY							
Staff Survey Results / Next Steps	Executive Director of HR & OD					√	
Committee Dashboard - Power BI, incl. H&S	Executive Director of HR & OD	√	√	√	√	√	
Annual H&S Audits	Executive Director of Nursing & Quality						
Annual Wellbeing report	Executive Director of HR & OD						
Annual Inclusion report (including an overview of stat and legislative requirements: Equality Delivery System (EDS2), Delivery on the WRES, DES, Equality Objectives, Gender Pay gap, etc)	Executive Director of HR & OD						
MANAGEMENT RESPONSES (delete once received)							
STRATEGIES							
People Strategy	Executive Director of HR & OD						
Clinical Education Strategy	Executive Medical Director						
Inclusion Strategy	Executive Director of HR & OD						
Retention Strategy	Executive Director of HR & OD						
GOVERNANCE & RISK MANAGEMENT							
Board Assurance Framework / Strategic Risks relating to committee purview	Company Secretary	√	√	√	√	√	
Committee Annual Self-Assessment: Cycle of Business Terms of Reference	Company Secretary				√		
Internal Audit Plan 2020 / 21							
Recruitment Process & Governance			√				
Workforce / Resourcing				√			
Clinical Education						√	

Workforce & Wellbeing Committee	Executive Lead	14 May 2020	02 July 2020	22 October 2020	21 January 2021	11 March 2021