CONFIRMED (Disclosable)

MINUTES OF THE EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST BOARD MEETING (PUBLIC SESSION) WEDNESDAY 9 MARCH 2022 AT 09:00
VIRTUAL MEETING

Present:	Nicola Scrivings	Trust Chair
	Alison Wigg	Non-Executive Director
	Carolan Davidge	Non-Executive Director
	Emma De Carteret	Director of Corporate Affairs and Performance
	Esther Kingsmill	Deputy Head of Corporate Governance
	Julie Hollings	Director of Communications and Engagement
	Julie Thallon	Associate Non-Executive Director
	Kate Hall	Improvement Director
	Kate Vaughton	Director of Integration
	Kevin Smith	Director of Finance and Commissioning
	Linda Gove	Head of Corporate Governance
	Marcus Bailey	Chief Operating Officer
	Marika Stephenson	Director of People Services
	Mrunal Sisodia	Non-Executive Director
	Neville Hounsome	Non-Executive Director
	Paul Gates	Deputy Clinical Director
	Tom Abell	Chief Executive Officer
	Tom Burton	Strategic Planning Director
	Wendy Thomas	Non-Executive Director
	Members of the Public	

PUBLIC SESSION (Disclosable)

1.0 WELCOME

1.1 *The meeting commenced at 09:02.*

1.2 Nicola Scrivings, Trust Chair (TC) welcomed those present to the public board meeting.

2.0 APOLOGIES FOR ABSENCE

2.1 Apologies were received from Juliet Beal, Interim Director of Nursing, Clinical Quality and Improvement (DoNCQI).

3.0 DECLARATIONS OF INTEREST

3.1 There were no declarations of interest related to matters on the agenda.

4.0 PATIENT STORY

4.1 Paul Gates, Deputy Clinical Director (DCD-PG) introduced the patient story from a patient who had experienced multiple fractures and had a significant wait for an ambulance. The patient reflected on the improvements which could be made when communicating with patients in challenging and distressing situations.

4.2 Non-Executive Director, Alison Wigg (NED-AW) sought assurance on the actions which had been taken to improve communication with patients in the circumstances outlined. DCD-PG confirmed

there was activity to improve communications with patients over the phone, which was particularly focussed on stressful situations in which patients potentially experienced long delays. The education packages for call handlers were regularly reviewed to incorporate feedback from patients.

4.3 Marcus Bailey, Chief Operating Officer (COO) reflected on the psychological impact for patients who experienced delays and were in pain. Numbers of call handlers were being increased to enable them to have welfare discussions with patients. The clinical presence in the control room was being increased to enable personalised advice beyond the scripted triaging undertaken. A review was also underway of the models of care to identify whether alternative responses could be pursued which were more appropriate.

5.0 TRUST CHAIR REPORT

5.1 The TC presented the report. She reflected on the patient story and how despite the pressures being experienced, which were consistently challenging, the role of the Trust Board was to drive progress towards the vision to be an ambulance service which provides 'outstanding care, exceptional people, every hour of every day'. The reports demonstrated good progress in planning, integration and clarity, with better connections between workstreams and connections from committee to Trust Board. It was critical to drive an improvement in the experience for staff and patients, delivering change which was embedded and not a short-term requirement.

6.0 CEO REPORT

6.1 Tom Abell, Chief Executive Officer (CEO) reflected on the activity which had been undertaken since he commenced in post six months ago. He suggested positive progress had been made although there was a wealth of improvement activity still required. He further outlined the work to improve engagement across the region with both external stakeholders and partners in healthcare. The key challenge moving into 2022/23 was how the switch from planning to delivery was achieved. By improving culture and planning this would support the drive towards the ambition to deliver exceptional care. Work continued with the Equality and Human Rights Commission (EHRC) as part of their monitoring arrangement for the undertakings. Work also continued to establish the exit criteria from SOF4 with NHSE/I which would underpin the plans and outcomes to secure. It was important to ensure there was a single plan, set of measures and outcomes to deliver against the objectives. A substantive executive team had been appointed and would be commencing in post over the coming months.

6.2 Non-Executive Director, Neville Hounsome (NED-NH) welcomed Kate Vaughton who had commenced as Director of Integration (DoI). The appointment was timely as the organisation responded to the progression of Integrated Care Boards (ICBs) which would have statutory responsibilities for financial and workforce planning. He enquired whether there were any concerns on how the ambulance service would be incorporated within ICBs. The CEO advised that arrangements for regional services, such as ambulance services lacked clarity. In 2022/23 the Trust would continue with the consortia agreement through Suffolk and North-East Essex CCG for commissioning. There was the opportunity to shape the agreement for ICBs in partnership with systems which provided the opportunity for resilience, mutual support and scale benefits. Consideration would be given to where it made sense to localise the way services were delivered such as alternative pathways of care. The DoI would help drive the future of the business and partnership function towards a partnership network approach. NED-NH was keen to understand how these changes would affect operationally, financially and from a workforce planning and engagement perspective. It was agreed an update would report in May.

ACTION: Provide an update on how the transition to integrated care boards would affect EEAST financially, operationally, in workforce planning and engagement.

Lead: CEO/ DoI

6.3 Non-Executive Director, Carolan Davidge (NED-CD) enquired what support was available for staff affected by the Ukraine/ Russia conflict. The CEO confirmed there were staff who were both directly and indirectly affected by the war in Ukraine. There were also those staff who had families in the military who were affected by the deployment of troops. Work had been undertaken to ensure wellbeing officers and psychological support was available and promoted to those staff affected. Requests had been received from community groups and staff members on the supply of equipment. The NHS response to Ukraine was being co-ordinated nationally, working alongside the Ukrainian government to co-ordinate the supply of goods and services. This was initially met through national supplies with requests to individual organisations where specific equipment was required. To date, the NHS had supplied over 500,000 items of equipment to Ukraine to support the medical response.

6.4 NED-AW was pleased to see the progress made over the preceding six months and enquired what additional areas the CEO was seeking to progress over the following six months, and the barriers for this. The CEO advised that he would have preferred greater pace of change. He highlighted that the significant operational pressures had been challenging and were adversely impacting both staff and patients. The patient story had demonstrated the impacts of demand on the service which was further compounded by hospital handover delays which increased pressures and stress on staff, contributed to operational pressures and was adversely driving increased staff sickness. Until demand was progressed to a more sustainable position operational pressures would continue to be a challenge to realising improvement. The quality of activity for EEAST was positive, but the ability to prioritise these plans and deliver against them with these challenges was the test moving into 2022/23.

7.0 MINUTES FROM PREVIOUS MEETING

7.1 The minutes from the meeting on 12.01.2022 were approved subject to clarification at 20.6 on the variation between how EEAST was supporting CFRs and how the charity was supporting CFRs.

8.0 FIT FOR THE FUTURE UPDATE

8.1 The CEO confirmed positive progress had been made to establish the programme plans and metrics including the development of a dashboard to assess delivery against the agreed metrics. Work also continued to establish a leadership development framework which had concluded consultation. CQC QIP delivery had improved to 90% of actions complete. Work was underway to assure that actions were completed, embedded and sustained. Focus was shifting from the establishment of processes and towards delivery against each of the programmes of work, as well as how the standard could shift beyond compliance and towards delivery of the ambitions. There was a requirement to increase communications and engagement with staff to ensure they were aware of the changes taking place and how they could be involved.

8.2 Mrunal Sisodia, Non-Executive Director (NED-MS) noted that good progress had been made to establish the processes for delivery, but delivery impacts and outcomes were not yet being realised. He was concerned frontline staff were not seeing these changes, and it was not realising an improvement in patient welfare and care. He suggested the report required updating to reflect what had changed tangibly since the previous report, and what would be different by the next report. Without staff being able to see these changes there was a risk the goodwill of these staff would be lost. The CEO accepted the challenge to move towards more robust outcome and impact reporting actions including reporting of the impacts on patients and staff. In some areas it was accepted there would be a delay between delivery of the action, and when benefits were realised. The first focus of the programme had been agreement of the SOF4 exit criteria and ensuring this was reflected in the business plan, individual and collective objectives. Following

approval of the business plan this would provide a single focus for delivery. It was important to recognise there would be unforeseen challenges arising which may impact the business plan, the Trust would need to stay focussed on delivering against the agreed prioritises regardless of any new risks materialising. From May 2022 there would be a clear plan for delivery, outcomes and measures to demonstrate impacts for patients and people.

ACTION: Prioritised business plan aligned to Trust metrics to report to Public Board in May 2022.
Lead: CEO

8.3 NED-WT sought to clarify timescales for delivery and outcomes from interventions. She also sought an update on progress to complete essential care skills (ECS) training. The CEO confirmed timeframes would be included within the highlight report and dashboard and would include the delivery requirements. There was a plan to ensure all those staff requiring ECS training had received this by August 2022, which would be monitored at site level.

8.4 The TC noted a key requirement to delivery of the programme was active collaboration and engagement between the NED and ED on each of the workstreams. She also noted that it was important the executive and NED were fully compliant against the areas that staff were being held to account for, and role modelling these behaviours and requirements.

9.0 GOVERNANCE DOCUMENTATION REVIEW

9.1 The Director of Corporate Affairs and Performance, Emma De Carteret (DoCAP) presented the activity to ensure all framework, documentation and ToR were aligned to reflect the way in which business activity was undertaken. The amendments had all been reported to Audit Committee (AC) and were recommended to Trust Board for approval. The focus was on ensuring all documentation was reflective of the executive restructure which had been undertaken including clarification of the remit and leadership. A ToR had been created for the Trust Board to ensure clarity on roles and responsibilities of members. It was recommended the People Engagement Committee (PEC) be decommissioned, the committee had supported the increased focus on engagement with patients, the public and staff but there was a risk of duplication identified and a siloed engagement approach which was not in line with the other committee functions. The work of the PEC had been realigned into the remaining committees. The AC were assured of the changes and recommended for approval subject to the caveat that the committees should review all ToR to ensure they were clear and consistent with their duties. A board development workshop would also be scheduled to ensure clarity on the areas of focus. On an ongoing basis reports required check and challenge to support the quality of reporting and triangulation between forums. Within the Standing Orders the addition of Associate Non-Executive Directors would be made to ensure clarity on their function, role and delegated authority to Board. Approval was requested of the documentation, on the basis that a workshop would be scheduled in Q1 to assess the effectiveness of the revised structure following implementation. Following approval, the Board Governance and Assurance Framework would be updated to reflect the changes made.

9.2 NED-MS advised that a governance review had been undertaken which provided clarity on the concerns the Trust had already identified. As a result, a wealth of actions were being progressed including a review of the committee structure. Additionally, a new executive leadership team was coming into post. He was assured that the framework outlined met the requirements, however greater assurance would be provided by the rollout of the framework, allowing this to function ahead of reconsidering the position to ensure it continued to meet requirements and there were no gaps or duplication. He requested assurance on the line of sight for volunteers. The DoCAP confirmed volunteers would align with the People Committee which aligned with the people plan

and strategy, and how the workforce was trained and supported regardless of whether they were a volunteer, staff member or student/ apprentice.

9.3 Subject to the above caveats, the governance documentation was approved, including the decommissioning of the PEC.

10.0 BOARD AND COMMITTEE EFFECTIVENESS REVIEW

10.1 The DoCAP presented the annual effectiveness review, which was a requirement for the Trust Board and sub committees to complete each year. There had been a transition to improve the quality of reporting at Trust Board and Sub-committee level to support increased triangulation, data quality and oversight. The effectiveness review provided an assessment of the effectiveness, leadership and infrastructure and support at each of the meetings. Despite the pandemic and other operational challenges and abstractions each meeting maintained full quoracy and oversight and assurance throughout the pressures. There was a broad recognition of the improvement with greater dedicated focus to integrated communication. The leadership were increasingly triangulating between forums and escalating assurance in committee escalation reports both to Trust Board and in risk reports to Audit Committee. Actions to address concerns raised were aligned with the findings from the governance review and would be monitored through this programme. A key enabler moving into 2022/23 was on Integrated Performance Reporting to ensure meaningful data which was statistically relevant. Assurance in the data presented would enable the focus to shift from the data towards what was being done about the findings from the data. There had been a deterioration in a number of areas. It was anticipated that the deteriorating position in some of the core measures could be attributed to increasing awareness of the expectations. Each committee would receive a summary report of findings from their effectiveness review to determine further actions required. Assurance would report through the committee escalation report. Either through Board development or at the next Board meeting the Board will also reflect on its summary report and agree further areas for improvements.

10.2 NED-CD supported the decommissioning of the PEC but was keen to ensure the stakeholder voice was adequately represented at sub-committee level.

ACTION: Consider how stakeholder voice would be represented at committee level.
Lead: DoCAP

10.3 The TC escalated concerns regarding the quality of information, which had shown a deterioration in the effectiveness review. Underpinning this position was the review of the IPR; assurance was required that the establishment of a robust IPR would deliver the required quality of reporting, or whether further action was required. Additionally, the establishment of metrics for fit for the future would further support the quality of reporting. The DoCAP confirmed the deterioration in quality reporting related to the establishment of a revised IPR which had initially been frustrating. It was important to note that rollout of a completely aligned and effective IPR however would not necessarily result in a full improvement, the quality of the narrative and check and challenge was also vital from authors. The next phase of the demonstrating impact stream would be focussing on how the IPR was broken down at board and into committee level to enable a focus on those areas requiring specific attention. Consistency in the data presented at board and committee level was pivotal to gain assurance on the issues and areas of focus as well as celebrating improvements where they occurred.

11.0 DECLARATION OF INTEREST AND REGISTER OF SEALS

11.1 The DoCAP requested approval of the register of interests, which would be published on the website as required. The corporate seal had been attested on two occasions in 2021/22 to date.

11.2 Subject to minor amendments to the declaration of interests, they were approved for publication. The seal attestation was noted.

12.0 INTEGRATED PERFORMANCE REPORT

12.1 The DoCAP advised that the metrics had been aligned with each of the four organisation goals which supported the focus on areas of positive improvement and areas of concern. This had been triangulated with the Board Assurance Framework to provide an overarching perspective on the position and assurance within EEAST. There had been an improvement in the levels of staff declaring their ethnicity or disability status which demonstrated improved confidence in reporting. Level three safeguarding training had improved but was not yet compliant with requirements. Concerns related to ER live cases and allegations which were showing common cause variation, with no significant change. As these were key areas of focus, this required careful monitoring and the development of supplementary measures to assess progress. Actions aligned with goal two also aligned with the core strategic risks SR1 and SR4. There had been an improvement in the timeliness of response for C1 and C4 responses although this was not compliant with national standards. Delivery of the sepsis care bundle was consistently high and supported quality care provision. There had also been an improvement in the levels of drug errors reported which reflected the significant work underway to more effectively manage medicines over the preceding year. There continued to be concerns for operational delivery, overall sickness levels which adversely impacted the operational response, statutory training and how the system functioned and worked together effectively. Although vehicle IPC interim cleans met the target this was showing a sustained decline depicted through special cause variation. Efficiency gains from a financial and efficiency perspective had exceeded the year-to-date target despite the challenges associated with operational pressures. The organisation cash position was stable, with an improvement in supporting procurement in a timely manner. The main area of concern related to the financial deficit position and how the balance between operational delivery, quality of care and the financial position was managed.

12.2 The COO reminded the committee that hospital handover delays had been a recurrent focus at board and committee level and adversely impacted the ability of EEAST to respond to demand. Ten of the most challenged hospitals for handover delays were within the footprint of EEAST. Although EEAST could support cohorting and intelligent conveyance to mitigate some of the pressures this came with associated risks to patients and staff and did not address the root cause. As such, system wide address was required, with management of the risks across the system supported by regulators. The Trust was progressing actions within its remit including alternative pathways to mitigate some of the pressures presented by handover delays. A rapid release trial had been progressed which provided a risk share approach for handover delays. In addition alternative models of care, and expert advice would support the redirection of patients from emergency departments where appropriate.

12.3 NED-AW enquired whether there were any national targets to realise an improvement in hospital handover delays. The COO confirmed national handover standards were within the contract specification. Hospitals were being asked to submit a trajectory to return to standards. He was pleased to note the national recognition of the risk presented to patients from handover delays.

12.4 NED-CD noted the continued unprecedented levels of SI's which were being discussed nationally, she enquired whether there was an update from these discussions. The MD advised that the severity of the problem was understood nationally. Similar changes were reflected across all ambulance trusts including handover delays which in turn delayed response times to 999 calls. NHSE/I had commenced an exercise to identify the harm caused by delays for patients. The root cause of the issue was generally capacity constraints at acute trusts. Processes for investigating serious incidents in which moderate or severe harm has been caused to a patient were being reviewed, with a particular focus on harm to the patients which was not immediately apparent.

An audit of the preceding months would be undertaken to determine whether there was any harm being realised later in the patients care from delays.

12.5 NED-JT noted that the risks for all goals were predominantly red and enquired when the impact from activity was expected to realise an improvement. The CEO confirmed internal assurance was required for activity including optimising dispatch, optimising resourcing, optimising how people were supported to reduce sickness absence, addressing alternative working duties and third manning. These would all be reflected in the business plan and supported the operational response, cultural response and the business delivered. The second set of activities was the system and partnership working being progressed, including how the Trust supported systems to progress to a more sustainable position for how the urgent and emergency care system was operating for both handover delays and making best use of alternative care pathways where appropriate. Kate Vaughton, Director of Integration (DoI) recognised that the role EEAST played in each system could support the system review of the overall offer to communities and patients as a regional service provider. These included opportunities for co-response, understanding how existing schemes were working including the impact and understanding inequities. The level of positive response, community and contact had been positive with system partners keen to engage.

12.6 The TC was concerned there was not sufficient board visibility of the activity within each system including delivery against each initiative. The DoI agreed to consider how board visibility would be provided on the activity and initiatives at system level.

ACTION: Consider how Board visibility of activity at system partnership level could be gained including the delivery of key initiatives.
Lead: DoI

12.7 Operations: The COO reminded the Trust Board that despite the reduction in COVID restrictions, COVID continued to represent a significant challenge, with high portions of staff absent for COVID related causes affecting the number of ambulances which could be deployed to patients. When triangulated with hospital handovers it contributed significantly to the ongoing pressures being experienced. In undertaking surge demand management actions including no-send and cancelled appointment call, this supported delivery operationally in a risk-assessed approach. In terms of improving cardiac arrest and return to spontaneous circulation the expansion of CFR activity and public defibrillators supported this timeliness of response. Despite these pressures it was important to recommence ECS training and other key learning elements which would both support staff and support the clinical response. The phase one recruitment plan had been approved to quickly commence urgent recruitment. Approval had also been provided on the commissioning of private ambulance services for a two-year period which provided both consistency and stability of resourcing. These would be weighted towards areas which were under sustained and significant pressure.

12.8 People Services: The DoPS advised that staff turnover was reporting at 9.89% which was of concern, this was a trend reflected across the ambulance sector. Actions were in place including the establishment of task and finish groups focussed on retention and leaver questionnaires to determine causes for attrition. There had been an increasing number of requests for flexibility which would support the work/life balance. Employee relations (ER) cases remained at a high level with a slight reduction in January 2022. It was anticipated ER volumes would remain at a high level, as such the Trust had committed to additional investigators and hearing chairs to support these cases. There had been both external and internal interventions on some cases to determine learning which could be shared with teams and to test the risk appetite in relation to some of the outcomes. Sickness absences remained high at 12.01% which was being investigated and analysed to determine actions required to realise an improvement.

12.9 NED-WT was pleased to note the increase in staff declaring their disability status and ethnicity. She noted that secondments provided an opportunity for individuals to learn, develop, grow and progress within the organisation however some long-term secondments had adverse impacts. She enquired how reporting would be clear on both the positive secondments and those which the Trust should be moving away from. She was further concerned regarding the levels of staff experiencing verbal and physical abuse and enquired how body worn cameras would support this. The DoPS confirmed the Trust had a high level of secondments which would be reviewed to determine where they were considered positive, but also to outline those cases in which individuals were seconded to unsubstantiated roles which would be considered in workforce planning. This formed one of the joint KPIs with operations to determine causes for secondment and where appropriate/ inappropriate. It was confirmed the outcomes from the body worn cameras pilot would report to QGC in Q1.

ACTION: Confirm outcomes of body worn cameras pilot at QGC.
Lead: COO

12.10 The DoI noted the loss of paramedics to primary care networks (PCNs) and the impact on EEAST. Where decisions had been made previously on the financial viability of rotational schemes to PCNs she suggested it would be helpful to look at the overarching financial and workforce impact to EEAST to consider what the model was for these staff.

12.11 Clinical: DCD-PG advised that in January, 72% of serious incidents were delay related and were representative of the operational performance challenges and handover delays. He was pleased the Trust was reporting above the national average for delivery of the sepsis, stroke and STEMI care bundles. Return of Spontaneous Circulation (ROSC) was showing a deterioration which was linked to C1 performance. ECS training focussed on resuscitation skills alongside the review and update of the cardiac arrest checklist to ensure the delivery of high-quality CPR. There had been a reduction in complaints in January 2022 which related to a change in the way complaints were reported. Compliments reported positively, with eight compliments received for every complaint. Complaint themes predominantly focussed on attitude, communication and delays. Given the recent rollout of SPC for clinical data reporting, consideration was being given to how this was reported at sub-committee level in an aligned approach.

12.12 NED-WT iterated concerns that the data reported at QGC and the data reported to Trust Board did not allign. Specifically this related to closed complaints within agreed timescales which showed a significant variation in the reporting. One of the leading factors in complaints, communication and call handling, was of significant concern and adversely impacted the patient experience, as outlined in the patient story. The DCD-PG agreed to work with the clinical team to determine the causes for data variation and to ensure this was aligned.

ACTION: Confirm causes for variation in complaints data between QGC and the IPR and align this data.
Lead: DCD-PG/ DoCAP

12.13 Finance: The DoFC confirmed the YTD deficit position was £8.5m which was predominantly driven by increasing expenditure on frontline resource and PTS/ control room resources as well as additional fleet to support the frontline response. This was a reduced deficit from the plan as the additional resources sought in planning had not been secured. As such, the year-end forecast was being revised and would propose a reduction from the forecast £13.2m deficit. QCIP delivery was anticipated above target although this was predominantly driven by non-recurrent savings. There would remain a challenging QCIP for 2022/23. The capital programme was on track for delivery, £2m of which was on new defibrillators. Anticipated COVID expenditure in 2021/22 was £35m, the allocation for 2022/23 COVID related expenditure was a significant reduction on this level and would be a challenge.

12.14 NED-MS enquired whether the Trust was able to quantify the impact of internal challenges such as hear and treat reduction and changes in on scene times, with system challenges and the financial impact. The DoFC confirmed the Trust would be working with commissioners to determine the funding for 2022/23 which would provide a contractual position for the period. This included the request for additional funding, although it was likely the Trust would be challenged on its inefficiencies which were behind the average in a number of areas based on benchmarking. Further activity could be undertaken internally between sectors to share best practice. Handover delays were the key focus for system help, however the Trust struggled to quantify the financial impact as this was broadly focussed on the day on patients and operational performance. Consideration was given to how this could more accurately be presented to demonstrate the financial impact. NED-MS requested a further report at committee level on the financial impacts from key system and operational challenges. The DoFC advised that within the baseline funding before COVID there was a provision for hospital handover delays, however these were being realised in excess of the level accounted for.

ACTION: Confirm reporting forum and timeframe to report back on financial impacts from key operational areas of challenge.
Lead: DoFC

12.15 NED-CD noted the IPR was reporting on financial sustainability but did not yet reflect environmental sustainability, she enquired when this would be reported at Trust Board level. The DoCAP confirmed the next phase of the IPR would provide the committee with data in the same format to enable tracking and increased oversight/ assurance. The second element would be looking at the information in the underpinning strategies to determine how these key indicators should be reflected at IPR level, the sustainability strategy would be key to this. The other key measures in improvement work also required consistent reporting until there was confidence in delivery. The second phase of the IPR would be developed over a six-month period, with escalations ahead of this period where possible.

13.0 FTSU QUARTERLY REPORT

13.1 *Janice Scott, FTSU Guardian (FTSUG) joined the meeting.*

13.2 The FTSUG confirmed 98 cases had been raised in Q3 and 68 closed in the period. It was anticipated this would be the quarter with the highest caseloads as a result of national FTSU month. 19 staff had previously raised a concern in the preceding 6 months. There were 64 new cases since January. Case themes focussed on bullying and harassment and systems and processes as the predominant concern including the application of systems and processes. There were increasing concerns related to flexible working for those with a disability and with families. The most notable change was the number of concerns raised about managers, which had increased from previous months. Staff were increasingly open to speaking about specific management concerns rather than broader concerns. From April 2020-March 2021 there remained 12 open legacy cases, although these were open to the staff member they were not being actively managed. There were 138 cases still open, 35% approaching resolution, 40% with the staff member being supported and 25% which were largely new cases with further meetings required to gain clarity. The general feel across all areas and levels was that this was a deteriorating position, but when this was further broken down there was a recognition of the positive changes being made, with the poor position reflective of habitual negativity. There was also an increase in those being held to account for their actions, whilst in operations concerns focussed on late finishes, hospital delays and rest breaks. This was exacerbated by miscommunication and a lack of response to issues raised. Staff also reported frustrations at the level of demand. Positively, the FTSU team had been contacted by teams previously closed off to undertake targeted FTSU activity, more managers were contacting the team to improve

engagement with staff and there was a shift in the mentality of staff with greater acceptance that the cultural change was permanent and every individual had a role to play.

13.3 NED-MS was keen to see how the pulse survey would reflect staffs sense of the routes to raise concerns, and whether they were comfortable reporting concerns around bullying, harassment and clinical practice which he was keen to see improving. It was important the intelligence gathered through FTSU and other sources was translated into tangible actions. The EDI groups would be key to driving this, with increasing recognition of the challenging conversations within these groups. The raising concerns forum should be actively responding to concerns. At the last raising concerns forum there had been rich discussion on disability discrimination which led to genuine outputs. System and process concerns related to staff feeling they were treated inequitably when it came to promotions, secondments and training opportunities. Increasingly staff were conflating culture with operational issues, it was important to address these operational issues to make progress in the cultural areas.

13.4 NED-NH noted a high number of concerns related to flexible working and enquired how this could be addressed. There was no age-related equality network, as such how would the themes of these concerns be progressed with a realistic plan to deliver an improvement. The FTSUG noted the flexible working policy generally applied to disability, family, and carer nuances. Consideration would be required of whether this should be developed whilst recognising that as a 24/7 service not all requests may be able to be supported. It was important to recognise that if the Trust was unable to respond to flexible working requests there was the potential these staff would leave. NED-NH noted there were policies in place which were compliant with the law, he was keen to understand what staff were actually experiencing when these issues were raised. The CEO noted the issue did not relate to the policy, but consistent application of the policy and procedure across the organisation. Initial discussions had been held through the disability network to understand their experiences and to centralise and standardise the processes for reasonable adjustments. Initial work would be focussed on disability before broadening this towards flexible working and reasonable adjustments. The lack of flexible working would generally disadvantage women over men therefore the All Women EEAST network would also be engaged in this process. NED-NH supported the focus on disability and gender but emphasised the importance of also focussing on age. He welcomed further reporting to the Workforce Committee on this issue.

ACTION: Report to WFC on how assurance would be gained on the effectiveness of the application of the flexible working policy.
Lead: DoPS

13.5 NED-AW enquired whether the FTSUG was receiving sufficient support in her role or whether further support was required. The FTSUG confirmed ambassadors had been effectively recruited alongside the extension of team capacity. She was receiving sufficient support at executive level, the main frustration related to the lengthening of processes and times for response.

14.0 BOARD ASSURANCE FRAMEWORK

14.1 The DoCAP presented the report and highlighted the high-risk profile across all the strategic risks including operational performance, quality of care, culture and wellbeing of staff, including how these impacted financially. Within each strategic risk was an anticipated mitigation date, some of these had shifted to align to collective timeframes. Once the exit criteria had been finalised a roadmap would be established to review the strategic risks and define when a movement was expected in the risk scores. There was triangulation across all committees of the risks, with audit committee viewing the assurance lines from each committee and assured in the management of risk.

14.2 The TC reflected on the emerging ambition to be a learning organisation with a focus on transforming the environment to support staff to embrace learning opportunities which was underpinned by development. She noted this was not referenced in the BAF and was a key enabler and enquired how this would be reported. The DoCAP advised that there was an escalated risk for students to ensure an effective learning environment. Moving into 2022/23 in the annual risk workshop it was incumbent to consider the progress made in the people plan and strategy which underpinned SR3, with consideration of whether this overarching risk provided the required oversight, or whether a standalone risk was required in relation to how the Trust identified, delivered and tracked both statutory and mandatory training and developmental training, and the positive impact this should have moving forward. The SPD advised that the original BAF risk had focussed on the OFSTED response, consideration was required of the current training offer and how the Trust considered its ambitions and wider approach to learning.

15.0 PEOPLE ENGAGEMENT COMMITTEE REPORT TO BOARD

15.1 NED-CD presented the PEC report to Board and highlighted the discussion on equality, diversity and inclusion with a focus on the EDI strategy which the committee considered lacked both ambition and focus. It was also noted at the PEC there had been a lack of progress on implementing action plans for the WRES and WDES. Given this lack of progress, the committee had escalated this for discussion at the private board, with a recommendation this be considered at a future public board meeting.

16.0 WFC REPORT TO BOARD

16.1 NED-NH presented the report and confirmed a transition from discovery to delivery. The committee were concerned around areas in which the Trust was consistently behind usual practice including employee wellbeing and safety, appraisals, mandatory training leadership training, managing ER cases and managing job evaluations. In many of these areas there was improved analysis of the underlying problems and what was required, but few had robust improvement plans with robust trajectories which could be tracked. There was a growing concern training needs were being identified but this was not co-ordinated with the budgets and necessary abstractions.

16.2 The DoPS confirmed work had been undertaken to assess and establish the baseline position and had identified the core KPI's for a number of areas, with the focus now shifting to delivery and accountability for all key areas raised. It was recognised there would be a lead time required to gain traction.

16.3 NED-JT noted the health, safety and security annual report and reflected that Norfolk and Waveney were generally an outlier reporting at slightly or significantly worse than most other areas. She enquired whether this related to the number of staff in each area, or whether this represented specific concerns in Norfolk and Waveney.

ACTION: Confirm why Norfolk and Waveney generally reported higher health, safety and security incidents than other sectors.
Lead: DoNCQI

17.0 QGC REPORT TO BOARD

17.1 NED-WT presented the report and confirmed concerns related to the number of serious incidents, with 66 of the 94 serious incidents relating to delays in the system. Complaint response times were a concern, with further work required to align this reporting with the IPR. The committee also sought greater clarity on the routes of closure for FTSU cases. SR2 remained at the highest risk score due to pressures within the system. The committee received the safeguarding annual report which was reporting to public board for approval. An internal audit report was received on

safeguarding which provided reasonable assurance, this audit had focussed on the 12 actions identified by the CQC. Staff sickness rates were increasing, with three COVID outbreaks reported in which COVID secure measures were not followed. Vaccination as a condition of deployment had been considered and mitigating actions put in place, the government had since ceased this approach. An internal audit report of medicines management was also received which provided reasonable assurance, a significant improvement from the previous year. There was a lack of assurance in the clinical audit plan, at the time of reporting 50% of the audit cycle had been delivered, there was a drive to achieve 65% by year end. It had previously been agreed that audits would be focussed on the national performance indicators, but it was noted that the use of EPCR would support these audits.

17.2 NED-AW highlighted the variation in each area in utilising EPCR, she was pleased to note this would be tracked. She enquired whether this could be tracked through the accountability reviews with a focus on increasing usage which was agreed.

18.0 TRANSFORMATION COMMITTEE REPORT TO BOARD

18.1 NED-AW confirmed the committee continued to develop, there was a focus on aligning the transformation programmes and ensuring prioritisation to focus capacity and oversight. Timescales and plans had been agreed for this progression. A presentation was received on data across the ambulance service to identify the opportunities to pursue different ways of working, with agreement to an engine room approach for three projects to progress through quality improvement processes. Concerns related to the potential risks related to the FIAT ambulance user issues and the mitigations which would be tested; dependent on the results further escalation may be required.

19.0 AUDIT COMMITTEE REPORT TO BOARD

19.1 NED-MS noted there was positive triangulation between the reporting at committee level and into Audit Committee. Review remained of the new risk management framework, performance had improved from the previous year and was reporting at almost double the level of compliance although this was volatile. There was a clear improvement but this evidenced it was not yet embedded and as such continued to be a focus. A review was undertaken of the KPMG governance review with a challenge from the AC on the closure of prioritisation activity, a good prioritisation framework had been created but this prioritisation process had not yet been closed and as such the action remained open. The internal audit plan for the following year had been reviewed and was mapped to risks and issues. There was positive transparency in what was being reviewed by internal audit and the recognised risks within the Trust. The committee focussed on the suitability of policies and how effectively they were rolled out which would be a focus. Data integrity would continue to be reviewed alongside the change management process.

20.0 PERFORMANCE AND FINANCE COMMITTEE REPORT TO BOARD

20.1 NED-JT presented the PAF report to board. She noted discussions on the operational service change roadmap and how impacts could be demonstrated in this area. Work was also being done to review PTS services and the appetite for this which was being considered and would report back to the committee. A benchmarking report for corporate services was received which highlighted that EEAST was an outlier in a range of areas which may impact business planning and budget setting. A referral was made to QGC to undertake a deep dive of ‘no send’ and cancelled calls which raised potential concerns.

21.0 REFLECTIONS ON THE MEETING

21.1 NED-MS provided the reflections on the meeting. He was pleased to note the level of constructive challenge within the meeting, including the transition from a process/ activity focus and driving towards outcome and impact on patients which was a necessary shift which demonstrated the progress the Trust had made and the remaining journey left. The continued improvement in the IPR was positive and had enabled a richer discussion moving from a data focus to intelligence/ analysis which had enabled exploration of underlying causes. He suggested there remained siloed working, and would support a shift towards cross working, with a focus on the financial, operational and workforce impacts in every area. It was clear underlying issues were owned by the Trust but some of these resided outside of the Trust, he was keen for the Trust Board to consider how assurance could be gained on the system owned issues and activity to support this. Assurance was required that EEAST was adequately and appropriately supporting this system working. He was keen to transition to joint presentations and KPI's for service areas.

22.0 QUESTIONS FROM THE PUBLIC

22.1 Q: Do you monitor, perhaps via a questionnaire, how crews have responded to a CFR following a call out? I am still hearing that CFR are effectively brushed aside and made to feel undervalued.

A: The COO confirmed there was a variation in feedback received, both where CFRs had reported feeling a lack of involvement, and those reporting they had been actively engaged in a call out. The PEC had supported a bespoke survey for CFRs to gain feedback and identify improvement actions specifically for this workgroup.

22.2 Q: Monday afternoon called again by people to manage an incident in a public place. Possible back, neck & head injuries, extremely cold. Appreciate priorities, but 90 minutes wait for ambulance not only poor for patient but also for EEAST's image.

A: The COO recognised the challenges being experienced which were impacting patients, which were reflective of the pressures within the Trust. A trial was underway of a dedicated falls desk to support patients who experienced a fall. It was understood from the harm analysis that for falls patients the longer a patient waited following a fall, the increased potential for harm. As such there was a rapid release pilot underway. He recognised that these instances were both disappointing and upsetting, but activity was underway to drive an improvement in the falls response. He further reflected on the individual support provided to communities from volunteers which the COO highly commended.

22.3 Q: I am hearing that your investigations of crews under investigations continue to take an excessively long time and are causing stress and concerns of skill fade during the delay. Can you please share information on the timescales for investigations and the reasons for these exceptionally long delays.

A: The COO confirmed the IPR clearly reflected the case management and timescales, which was vital for reporting in a public forum to support accountability. A significant focus was on improving this position. The DoPS confirmed metrics had been established for investigation and suspension case numbers and duration. It was key to minimise case durations with a focus on addressing those backlog cases.

23.0 ANY OTHER BUSINESS

23.1 There was no other business and the meeting closed at 12:43.