CONFIRMED (Disclosable)

MINUTES OF THE EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST BOARD MEETING (PUBLIC SESSION) WEDNESDAY 11 MAY 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
	Hein Scheffer	Director of Strategy, Culture and Education
	Julie Hollings	Director of Communications and Engagement
	Julie Thallon	Associate Non-Executive 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
	Melissa Dowdeswell	Director of Nursing, Clinical Quality and Improvement
	Mrunal Sisodia	Non-Executive Director
	Neville Hounsome	Non-Executive Director
	Simon Walsh	Interim Medical Director
	Tom Abell	Chief Executive Officer
	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 Kate Hall, Improvement Director (ID-KH) and Wendy Thomas, Non-Executive Director (NED-WT).

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 The Director of Nursing, Clinical Quality and Improvement, Melissa Dowdeswell (DoNCQI) presented the patient story, which outlined the experiences of a relative of a patient who had experienced a fall at home. She was pleased to see how crews had supported the individual alongside their family members at the scene, working alongside system partners to optimise care.

4.2 Kate Vaughton, Director of Integration (DoI) reflected on how the patient story effectively encapsulated the activity EEAST undertook with system partners to support patients. There were

ongoing discussions with key partners including primary care networks, the GP federation and practices to explore how provider collaboration could be enhanced to better support patients.

4.3 Hein Scheffer, Director of Strategy, Culture and Education (DoSCE) was pleased to hear directly from a service user on their positive experience. He recognised there remained further work required to ensure the Trust was consistently delivering the best care possible but was pleased to celebrate what had been a generally positive experience.

5.0 TRUST CHAIR REPORT

5.1 The TC reflected on what continued to be a challenging period for the Trust and extended her thanks to staff who continued to provide the best care possible to patients and the public, supporting the delivery of urgent care to those in the communities. She had met with two community first responders over the preceding period and joined perfect day modelling to identify areas in which improved system working could support the provision of an improved service for patients. She was pleased to work alongside staff to understand the challenges they continued to experience. It was important to highlight the improved Integrated Performance Reporting (IPR) which was being progressed to provide more intelligent analysis of the position. This IPR would be key to supporting decision making and assurance. Once rollout of the IPR had been finalised this would be amended to support the sub-committee and accountability structures to ensure a single source of data for holding the organisation to account for progress.

6.0 CEO REPORT

6.1 The Chief Executive Officer, Tom Abell (CEO) presented the CEO report and advised that the initial feedback following the CQC core services and well led inspection had been received. There were a number of areas of concern highlighted through the core services inspection which the Trust was working to improve. Elements of these concerns related to staff morale, which was a recognised issue and impacts of the operational pressures which had necessitated the prioritisation of the frontline response above staff training requirements. REAP four pressures had meant patients awaiting a response in the communities had increasing delays. There had been queries on whether the rollout of REAP four escalation measures were appropriate for utilisation on an ongoing basis given the continued pressures being experienced. The CQC had also identified further work requirements to support the control centres, there had been significant recruitment in these areas to support call handling. In addition specific estates issues were identified in the Chelmsford control centre. Concerns were raised in relation to medicines management, and whether EEAST was consistently delivering best practice, as well as incidents associated with adherence to PPE requirements. Initial feedback from the most recent well led inspection had been received. It recognised the level of investment in the development of the Trust Board and specifically the executive team, however given this was a new team there was further work required to develop and ensure clarity on portfolios and the capacity to deliver required improvements. The second area of focus was on how activity was prioritised and how staff were engaged in relation to these priorities. The exit criteria had been finalised with NHSE/I, the Trust would be considering how patients were informed and engaged within this. There was a recognition of the significant work to strengthen governance systems and structures but further work was required to ensure these were embedded and working effectively at all levels. There was also activity required to strengthen the Trust Board reporting in both the quality of reporting and data analysis. The draft report was anticipated in June 2022 and would be supported by an action plan in response to the findings.

6.2 The DoNCQI advised that the CQC had highlighted that the Trust did not have any methods for monitoring temperature in medicines storage rooms. Although the Trust did not stock any medications which required temperature management, it was good practice to monitor the temperature in these areas. As such, thermometers had been rolled out in all medicines storage

areas at pace and were reviewed as part of the twice daily controlled drugs check. An escalation process was required where temperatures exceeded the expected range, the policies had been amended to highlight this escalation process where temperatures either exceeded 25 or dropped below 8 degrees Celsius. She was assured there was clear guidance on the access permissions for controlled drug storage which would be more clearly articulated in the policies with reminders circulated in relation to tailgating.

6.3 The Chief Operating Officer, Marcus Bailey (COO) advised there had been immediate activity within Chelmsford AOC with a focus on estates and logistics including lighting and desk configuration. This had been accelerated as part of a 12-week plan to understand and address the specific concerns highlighted by the CQC alongside a remedial cosmetic review. It was important in the longer term to establish a long-term model which was aligned with the models of care. This included how staff were supported in both their leadership development and the establishment of additional posts as needed.

6.4 The TC noted a full action plan would be published and enquired when this would be released. The CEO confirmed the initial findings had been published with actions from these findings progressed and monitored. Following receipt of the draft report, an extended action plan would be developed to encompass all areas within the report. As part of this process consideration was also being given to the conditions arising from previous inspections. An assessment would be undertaken to determine whether concerns had been sufficiently addressed to apply for closure of the conditions. There was a significant programme required to address well led and the organisation culture which would be mapped to existing workstreams where appropriate to ensure there was not duplication.

6.5 Non-Executive Director, Carolan Davidge (NED-CD) noted the statements outlined on p13 in relation to the measures of success and enquired how these statements aligned with the values of the organisation. She also enquired how teams would be involved in contributing to the success of the statements, and how the statements translated into measurable outcomes which both patients and staff would be able to see the difference. The CEO confirmed the statements did not supersede the Trust values. The Trust values outlined the foundational behaviours for both individuals and the collective organisation. There was a mid- and long-term aspiration outlined in the corporate strategy, the aspirations were key to establishing the measures which would demonstrate success, providing a qualitative assessment of progress. There was lots of work underway to co-produce strategies and plans for delivery. However, EEAST was not clearly articulating how this connected to the wider delivery of cultural change, service change and service improvement. To support this infographic tools and resources were being developed to more clearly outline how this transactional change correlated with tangible outcomes. NED-CD therefore enquired whether these changes were expected to be seen to be making a difference. The CEO advised that the exit criteria had quarterly trajectories for improvement which would be key to demonstrating the transition. As part of this, it was vital to be clear on what EEAST could do themselves and how the wider system could be influenced to improve overall service delivery for patients.

6.6 Non-Executive Director, Neville Hounsome (NED-NH) enquired when a further update would be provided on progress against the targets for the sustainability agenda. The CEO confirmed a full report would be provided against the sustainability agenda in July and would include a progress update.

ACTION: provide progress update on delivery against the sustainability agenda to the public board meeting in July.
Lead: CEO

7.0 MINUTES FROM THE PREVIOUS MEETING

7.1 The minutes from the meeting on 09.03.22 were approved.

8.0 MATTERS ARISING AND ACTION LOG

8.1 09.03.22/8.2: The CEO advised that discussions remained underway with NHSE/I to agree a financial plan for the organisation. Once concluded a finalised business plan would be reported in July.

8.2 09.03.22/12.12: The DoNCQI confirmed that an incorrect data set had been provided which accounted for the misalignment between complaints data reported to the Quality Governance Committee (QGC) and complaints data reported within the IPR. This had since been resolved and it was confirmed the data sets aligned at both board and committee level.

8.3 Mrunal Sisodia, Non-Executive Director (NED-MS) noted recurrent issues in relation to the data sets reported at board and committee level. There was further activity required to support data integrity, which was key to the assurance that could be provided against key metrics. Given the level of concern associated, the Audit Committee (AC) had requested a deep dive of a case study of both complaints data and appraisals to understand the causes for the discrepancies and lessons arising from this. An internal audit review had also been requested of the IPR with mapping of data blocks to the governance structures to ensure clarity on the ownership of data sources.

8.4 The Director of Corporate Affairs and Performance, Emma De Carteret (DoCAP) advised that the internal audit opening meeting had been scheduled. She recognised the need to ensure that the data being reported was the same data sets that leaders and managers were utilising to drive delivery. The informatics team were supporting a review of sector level data sets to ensure these aligned with data sets at board and managerial level.

8.5 The action was closed.

8.6 09.03.22/12.14: financial impacts from operational areas of challenge would be addressed through the establishment of a financial and operating plan linked with the Quality Cost Improvement Plan. This would report to PAF as the financial plan was developed and Transformation Committee in relation to the QCIP. As part of the exit criteria the Trust was required to establish a financial model by year end which was aligned with the ORH report.

8.7 09.03.22/16.3: The DoNCQI advised that although safety and security incidents in Norfolk and Waveney were higher than other areas this did not significantly deviate from the expected level based on the ratio of calls and staff. The action was closed.

8.8 09.03.22/10.2: The DoCAP advised that she had attended the latest meeting of the Community Engagement Group. Following the decommissioning of the People Engagement Committee and realignment of patient involvement into the QGC and volunteer engagement into the People Committee further consideration would be given to how the stakeholder voice was best represented. A board workshop was scheduled for 08.06.2022 at which further consideration would be given to the agenda plan and flow for each of the committees, and how stakeholders were represented.

9.0 FIT FOR THE FUTURE UPDATE

9.1 The CEO advised that the fit for the future dashboard had been updated to reflect the core measures to judge successful delivery of the programme. Significant progress had been made since the previous meeting. The overall assessment rating had moved from green to amber, the initial focus was on establishing the programme and ensuring the right documentation and

individuals to support delivery. This phase had been concluded and the programme had shifted to demonstrating delivery and the impact from the programme, which required further work to establish the measures and demonstrate consistency and delivery at pace. Due to duplication between workstreams, the capability and capacity workstream had been merged with existing workstreams. There was a risk associated with the level of engagement on fit for the future and how this would impact individuals, including how activity was prioritised against business as usual requirements.

9.2 NED-AW sought clarity on what the ambition was, and how the measures would support delivery of this. She noted some actions were green but had not yet commenced. The CEO confirmed a clear narrative was being developed on how the programme would deliver tangible changes against the goals and aspirations. The DoCAP advised the RAG rating provided assurance on the preparedness of each work stream. The overarching rating for the programme had shifted to amber in recognition of the shift from assessing preparedness of the programme to the impact workstreams were having. NED-AW therefore enquired when the long-term plan and progress against this would be reported. The DoCAP confirmed there would be a report at Trust Board in July 2022. Progress would also be assessed based on the exit criteria. The overall objectives had been reviewed to better define how these changes would look and feel for staff and stakeholders.

9.3 Associate Non-Executive Director, Julie Thallon (NED-JT) noted that staff understanding and knowledge of fit for the future had been raised by the CQC and enquired where plans to increase this awareness were reflected in the reporting. The CEO confirmed there was already activity underway to publicise the programme, including blogs, executive Q&A sessions, leadership messages and key messages from monthly programme board meetings. However these were not clearly articulating what this meant for patients and staff which required greater focus.

9.4 The TC suggested greater oversight was required of the programme and recommended consideration be given to Transformation Committee reporting. The CEO advised that as the programme was designed to address every aspect of well led and the cultural issues within the organisation, collective ownership was required from the Trust Board. However reporting could be taken to the Transformation Committee to oversee the programme delivery infrastructure to support delivery. The DoCAP supported the requirement for the board to maintain oversight of the programme, which was critical to addressing the root cause of issues to support sustainable change. However she also recognised the benefits from dual reporting to Transformation Committee to oversee the programme structure.

9.5 NED-MS noted that there was further work required to translate the programme benefits to staff – the programme had delivered significant policy changes, but had not clearly articulated the reasons for these changes linked to the cultural change programme.

10.0 BOARD EFFECTIVENESS REVIEW

10.1 The DoCAP presented the detailed outcomes of the effectiveness review of the Trust Board. There had been a positive improvement in the agenda prioritisation, the skills, knowledge and experience to progress workstreams and how individuals demonstrated the values and behaviours of the organisation. There was a clear requirement to consider the quality of the information provided to ensure this enabled effective discussion. Within the effectiveness review for the board and committees there was a key theme arising related to the quality of reporting, which had also been discussed in Performance and Finance Committee and Quality Governance Committee. Moving forward, the focus would be on building the phase two board development programme following conclusion of 360-degree board observation and feedback, and ensuring report quality, accuracy and timeliness. A training session had been agreed for the executive directors and report authors to support reporting quality.

10.2 The TC noted that a strategy away day had not been scheduled in the agenda plan. The DoCAP advised that a strategy away day was included in the board development plan.

10.3 The TC was concerned regarding the low number of respondents to the assessment. She was also concerned regarding report quality and timeliness and enquired how assurance on this could be gained. The DoCAP advised that metrics had been established to monitor the timeliness of reports, where these were late individuals could then be held to account. To ensure the effectiveness of the meetings, board and committee observations were being scheduled with a focus on the exit criteria and report quality. The utilisation of external observation to support quality improvement would be key to providing independent assurance. She also suggested the TC should be taking a qualitative view in the Trust Chair report.

10.4 The DoI reflected on the high level of report requirements and suggested a greater focus was required on ensuring absolute clarity on the purpose of reports and what they were aiming to achieve.

11.0 CONDITION G6 AND FT4 SELF CERTIFICATION

11.1 The DoCAP presented the report, she confirmed the Trust was not compliant with the condition FT4 self-certification against two assertions. This related to the organisations failure to deliver against national ambulance targets and concerns arising from the CQC report and SOF4 which impacted the Trusts duty to operate efficiently, economically and effectively (FT4(5)(a) and a failure to ensure compliance with healthcare standards binding on the Trust (FT4(5)(c). Given the move to special measures, development of exit criteria and legal undertakings associated with SOF4 there was clarity on how this impacted the license, until there was evidence from the CQC that there had been sufficient improvement against the conditions the Trust was reporting as non-compliant. Alignment with the exit criteria and legal undertakings would be key in sighting areas of lack of focus. She was confident that the actions to be delivered as part of the undertakings and exit criteria would support the transition to 'confirmed' against these two assertions once evidenced.

12.0 INTEGRATED PERFORMANCE REPORT

12.1 The COO advised that the Trust continued to be affected by the pandemic de-escalation to a level three emergency and the REAP 4 position which were driving system pressures and adversely affecting response times, performance and standards. The C1-C4 response rate continued to report outside of national targets due to the inability to generate sufficient patient facing staff hours (PFSH) to meet demand, hospital handover delays and other key pressure points. Due to the reactive nature of the Trusts operations, this had necessitated significant mitigating actions which were incorporated within the exit criteria. This included a pause on appraisals and statutory/ mandatory training to maximise capacity to respond to pressures. Within the long term financial and operating model there would be areas outlined for delivery which were within the ability of EEAST to deliver and should drive an improving position. The clinical risk debate then came into force for SR1 'failure to deliver a timely service to our patients in line with commissioned national standards, to ensure a safe level of service' in terms of how these actions were supporting the delivery of contractual standards.

12.2 The DoNCQI advised that Infection Prevention and Control (IPC) compliance rates had shown an incremental deterioration, although they continued to meet national standards. There had been high sickness absence rates in March 2022 which had resulted in a reduction in vehicle cleaning compliance. Although Trust uniform compliance continued to report positively, there were recurrent themes arising associated with bare below the elbows – the policy was being reviewed to ensure absolute clarity on this requirement. The complaints policy had also been amended and was being embedded.

12.3 The DoI advised that reporting would be updated to incorporate metrics associated with the system partnership survey and co-response to calls. The key impacting factor across the system was hospital handover delays, which were concentrated in Cambridge and Peterborough, Norfolk and Waveney and Herts and West Essex. Handover recovery plans were being reviewed, with work underway as a system to check and challenge the finalisation of these plans and key milestones for monitoring. A workshop was being arranged for the three sectors with significant handover delays to progress action plans. There had been an agreement to consider how co-response could be pursued for C4 and C5 patients – priorities for each system would be agreed in June/ July and should enable a consistent approach across systems with minor nuances associated.

12.4 The DoNCQI confirmed there was a decline in STEMI, stroke and sepsis care bundle compliance although this remained above the national average position. This decline was attributed to delays.

12.5 NED-CD observed that the Trust was delivering hear and treat rates of 9% with a target to deliver 10% for the rest of 2022/23. At the previous PAF meeting it had been demonstrated in the perfect day scenario that up to 15% hear and treat could be delivered – as such she suggested the target could be more ambitious. The COO advised that a more ambitious stretch target for hear and treat could be set, but there was a risk that by stretching this target it would reduce the focus on other core areas of compliance. Perfect day modelling also required validation to ensure the outcomes could be consistently applied and embedded. The modelling had enabled the transition of patients to alternative care pathways – business cases would be developed on these findings by the end of June 2022. There was the potential that hear and treat rates were adversely impacted by surge actions such as 'no send' and 'cancelled at the point of call', which would mean the business case would not necessarily drive an improvement in C1/ C2 performance.

12.6 NED-JT noted that although activity levels were largely consistent there had been an increase in C1 calls, C2 calls remained stable and C3/C4 calls reduced. She enquired whether calls were audited to determine acuity and whether the call categorisation was accurate. She was also concerned that hospital handover delays were increasing despite the local and regional actions agreed to address these delays. She enquired at what stage improvements were expected given the level of concern associated. The COO advised that a review had been undertaken by AACE on C1 performance, the outcomes from this review were being assessed. This had indicated the disparity between the coding for MPDS call handlers vs emergency call handlers who tended to be risk averse and over categorise C1 calls. Module modification had been undertaken which supported a slight reduction in categorisation as a result of training. All call handlers would receive full training by the end of July, and only fully trained MPDS call handlers would be recruited moving forward. Auditing of calls was required on a monthly basis, with 1% of calls reviewed each month. Simon Walsh, Interim Medical Director (MD) recognised concerns related to handover delays which were adversely driving SIs associated with delayed responses. There was harm for those patients in handover queues as well as the patients waiting in the community. Additionally, crew wellbeing was affected. He represented EEAST on national forums – the root cause of handover delays was attributed to capacity constraints in hospitals and an inability to discharge patients to social care. These delays were not within EEASTs ability to influence alone. At the national forums he had been emphasising the concerns and impacts of these delays and was assured they were being considered at the highest level of both the NHS and government. Integrated care systems had been asked to develop an improvement plan for each system. It was hoped this system approach would support movement to address underlying causes.

12.7 The DoPS confirmed that employee relations case volumes remained high, which was as expected, although anecdotally there appeared to be a positive shift in the willingness of staff to share their experiences. To address the increasing case volume the potential for the secondment of senior leaders to work as case chairs had been progressed with significant interest received. She was confident an appointment would be made which would support more swift case

resolution. An additional two investigators had also commenced with the Trust, and active recruitment was underway for case managers and business partners which would enable a focus on case closure in line with required timeframes. The number of suspensions was decreasing alongside the average duration of suspensions which was reducing in line with legacy case closure. Secondment numbers continued to increase with a task and finish group established to consider the policy and procedure for these to ensure equity in secondments as well as ensuring the secondments were justifiable or could be more effectively progressed as a substantive appointment.

12.8 The DoSCE advised that mandatory training had been broken down into its individual elements to provide enhanced reporting against each module. Work was underway to link ESR with OLM which would enable reporting by directorate and profession. The first report would be received in July and would support reporting against healthcare and non-healthcare professionals. He was intending to review the appraisal process to ensure a focus on planning and personal development requirements in a structured approach. Appraisals for the executive team had been concluded and defined objectives agreed.

12.9 NED-NH requested clarity on the compounding issues which had driven a deterioration in mandatory training and appraisal performance. He acknowledged REAP four could be contributing to operational staff compliance challenges, but was concerned this did not account for those non-operational areas which were statistically in the same position. The CEO confirmed work would be undertaken with each corporate areas to understand the reasons for the decline in compliance and to progress statutory and mandatory training. The essential care skills (ECS) training days would support frontline staff to undertake mandatory training. NED-NH therefore enquired the level of confidence that Q1 targets for mandatory training and appraisal completion would be met. The DoSCE confirmed he was confident the targets for mandatory training would be met in Q1. There was data cleansing required, based on this he was confident actual compliance was higher than the level being reported. Additional resource was being recruited to support appraisals. The DoCAP acknowledged the centralised activity to support training and education, but emphasised the importance for the executive directors responsible to take action in their areas to support local compliance. The executive had undertaken their appraisals and objective setting, which would be cascaded through the management structure by the end of June 2022.

12.10 The DoFC confirmed he was assured the revised forecast outturn of £10m deficit had been delivered subject to external audit confirmation. Despite the challenged position quality cost improvements of £3.95m had been achieved which exceeded the target. The capital resource limit of £10.6m had been utilised and had enabled the delivery of a number of improvements. The cash balance position remained in a good position moving into 2022/23 despite the forecast deficit. There remained uncertainty around the financial position for the NHS as a whole. There had been guidance to set the plan for 2022/23 which had progressed, the draft submission of £12m had been reforecast to reflect inflation and COVID impacts, and revised upwards to £19m subject to regulatory review.

12.11 NED-MS advised that there was a cumulative break even duty over the life of an NHS organisation which EEAST was now in breach of. It was anticipated there would be further Trusts to breach this position in year, but this came with internal financial planning implications alongside regulatory impacts.

12.12 The DOFC highlighted that during peak COVID pressures there had been a reducing focus on the financial regime, this was now shifting back towards finances as a key element of the overall risk profile. There was a challenging QCIP in 2022/23 of £13.2m, within the gateway process for these QCIPs there was an impact assessment with a focus on quality improvement and safety. Nationally there was a challenge on the funding availability and expectations of the service. The

ambulance service varied in that elective recovery did not impact ambulance services in the same way. Most other ambulance trusts were also reporting a deficit position for 2021/22.

12.13 The DoI recognised the potential as a system risk to progress innovation such as joint posts.

13.0 BOARD ASSURANCE FRAMEWORK

13.1 The DoCAP confirmed that the seven strategic risk scores remained unchanged, reporting at escalated scores of 16 and 20. In relation to SR3 '*failure to embed a culture focused on staff safety and wellbeing'* and SR7 '*failure to ensure a well governed and accountable Trust*' the outcomes from the latest CQC inspection would be key to assessing the current position, particularly when triangulated with the staff survey and harassment survey results. Following receipt of the draft report the risks would be reviewed. The risk associated with workforce planning 'ability to deliver an effective workforce plan that enables safe staffing to deliver quality care' had a residual score of 12. An update had been received on the work commissioned and supported by Carnal Farrer to assess the next steps and timeline.

13.2 NED-AW was concerned there had been no change to the highest scoring risks and enquired whether the actions identified were delivering the required improvements, or whether further action was required to effectively mitigate these risks. The DOCAP confirmed reporting at committee level enabled a greater focus on individual risk actions, concerns could then be escalated for discussion at Trust Board.

14.0 STAFF SURVEY

14.1 The CEO presented the results from the 2021/22 NHS staff survey from November 2021. The findings provided a poor indication of EEASTs performance during the period, which was reflective of the cultural issues and other challenges prevalent. Staff engagement reported lower than the sector average and NHS. There had been some positive improvement in staff who felt able to report bullying and harassment, a reduction in people experiencing bullying and harassment and increasing confidence in those who felt able to speak up. The focus was on improving staff access to learning and development, career progression and recognition and reward which was a key source of discontent. The executive directors had also committed to the development of bespoke improvement plans for their directorate.

14.2 NED-MS accepted the focus on learning as a priority area but suggested greater focus was also required on staff engagement and how staff felt listened to. The DoCAP advised that engagement was a core driver within the fit for the future programme and engagement task and finish group. The survey results were supported by free text fields which provided a more accurate indication of what staff were seeking – namely increased recognition, compassionate care, supportive leaders and career development, alongside the primary concern of ensuring staff were working in a safe environment.

14.3 NED-NH highlighted that although the results were disappointing, EEAST was also the most improved ambulance service in the domains.

14.4 The TC enquired how the central actions agreed met staff expectations of priority areas. The CEO advised that staff experience would be greatly improved by addressing the core causes of concern and dissatisfaction such as ensuring staff were paid on time, finishing shifts on time and working manageable hours. A people strategy was being developed through co-production with staff. This strategy would focus on the period up to 2030 with priorities based directly on staff feedback. Focus groups had commenced in week and had received significant interest. These groups would be scheduled quarterly to ensure the priorities remained were still appropriate and to discuss progress in each of the domains.

15.0 PEOPLE COMMITTEE REPORT TO BOARD

15.1 NED-NH presented the people committee report, and confirmed that attrition rates were increasing within EEAST, which was a trend reflective across the NHS as a whole. A deep dive had been requested on staff leaver reasons and where they were leaving for. A deep dive was also undertaken of sexual harassment and misconduct cases to identify lessons learnt. The DoPS advised that Browne Jacobson had provided a training session with HR and local teams involved in cases to ensure learning and insight from cases. They were also scheduled to attend the senior leadership away day to share this learning. Legal training for all leaders would commence from 16.05.2022 and would help to understand legislative requirements for the Trust to support employees.

16.0 QUALITY GOVERNANCE COMMITTEE REPORT TO BOARD

16.1 NED-MS advised that the increasing levels of serious incidents continued to be a key focus for the committee, with 139 incidents reports at the last committee meeting predominantly driven by system concerns. There had been some challenge on how harm was classified within Sis, to provide further assurance an external peer review had been agreed of cases to ensure they were being managed consistently. The utilisation of 'no send' and 'cancelled at point of call' responses was increasing in line with pressures. The impact of C1 delays on cardiac patients had been considered, with triangulation between delays ad response times and ACQIs, complaints and Sis. An initial review had been undertaken of the Kerslake report into the Manchester arena bombing which would be investigated in greater detail at the next meeting of the QGC. The DoNCQI advised that consideration had been given to how harm was managed and recorded, this varied significantly across ambulance services which means reporting was impacted by these inconsistencies. It had been agreed a full review would be undertaken into Ockendon following release of the Kirkup report.

16.2 NED-JT enquired why there was partial assurance on 'no send' and 'cancelled at point of call' activity. NED-MS advised that this was due to the need to consider the relationship between these responses and any impacts on hear and treat rates.

17.0 SYSTEM INTEGRATION AND PARTNERSHIPS UPDATE

17.1 The DoI advised that systems were in the process of agreeing membership on integrated care boards as part of a nomination and voting process. The business and partnerships team were reviewing the information to determine EEASTs position within these systems. The Trust Board would need to consider whether EEAST sought to nominate itself on these system boards. From 01.07.2022 there would be a significant change in the NHS governance model with the formalisation of integrated care systems. Her recommendation was that EEAST did not seek a position on Integrated Care Boards (ICB) due to the capacity this would absorb, with the exception of SNEE as lead commissioner.

17.2 NED-AW agreed with the recommendation EEAST pursue a position on the ICB for SNEE as lead commissioner. She suggested greater use could be made as NEDs on chairs groups to ensure maximum benefit from these forums.

17.3 The MD acknowledged EEAST should support a position on SNEE ICB. He noted EEAST was the only provider covering the whole region geographically and there were challenges associated throughout the region in relation to hospital handover delays. There was a pressing need to address these delays which should be a focus across systems.

17.4 The DoNCQI acknowledged the need for EEAST representation as a provider who served the whole region, who needed to understand the wider implications of initiatives and how these would impact patients and communities.

17.5 NED-CD noted that EEAST was building relationships across the system and had representation on a number of forums including chairs groups which would support this agenda.

17.6 The DoI highlighted the talented workforce and need to ensure they were being developed and supported in the right way which opened up the opportunity for system positions. There were active recruitment campaigns underway for primary care paramedics but this was likely to also extend to urgent care. There had previously been discussion on the potential for rotational posts with a focus on advanced practice which had not progressed. This process had been reopened and significant interest received. Systems had all expressed interest in a rotational model.

18.0 AUDIT COMMITTEE REPORT TO BOARD

18.1 NED-MS advised that the committee had received oversight of the new risk management framework which was being embedded. There had been an increase in compliance associated with the new process however this was not yet consistent. A deep dive was undertaken of policies to ensure they were kept up to date, how they were rolled out and compliance with these policies. The committee had considered the new governance arrangements and integration of the new executive team. They were broadly content with the position, as the new roles became embedded this would provide greater insight into how governance was working in practice, and any revisions required. The internal audit plan had been received for 2022/23 and was clearly mapped to the corporate risks. The committee had approved amended standing orders to reflect the role of associate NEDs as committee chairs, and the appointment to senior independent director. These revisions were presented to Trust Board for approval. Data quality had been a recurrent issue which would be a focus at future committee meetings.

18.2 The Trust Board approved the revised standing orders.

19.0 PERFORMANCE AND FINANCE COMMITTEE REPORT TO BOARD

19.1 NED-JT presented the report and confirmed the most recent focus had been on the quality and timeliness of reporting at committee level. Due to the nature of reporting, an interim meeting had been agreed. There had been concern related to the scale of the QCIP for 2022/23 in particular, the large number of backloaded efficiencies. There was an agreement that oversight of QCIP processes would be transferred to the Transformation Committee, PAF would maintain oversight of the financial delivery and risks associated with this.

20.0 REFLECTIONS ON THE MEETING

20.1 The CEO provided the reflection on the meeting. He reflected on the fair level of challenge and open discussions. He was pleased with the triangulation across portfolios in discussions and improving data quality which had supported these discussions. A key theme continued to be how patients and staff were refocused as the integral element of all decisions, and how actions were impacting patients and people. There was positive participation, although he reflected that reporting required enhancing to support clear communication

21.0 QUESTIONS FROM THE PUBLIC

21.1 There were no questions from the public.

22.0 ANY OTHER BUSINESS

22.1 There was no other business and the meeting closed at 12:58.