CONFIRMED (Disclosable)

MINUTES OF THE EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST BOARD MEETING (PUBLIC SESSION) WEDNESDAY 13 JULY 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 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
	Melissa Dowdeswell	Director of Nursing, Clinical Quality and Improvement
	Mrunal Sisodia	Non-Executive Director
	Simon Walsh	Interim Medical Director
	Tom Abell	Chief Executive Officer
	Wendy Thomas	Non-Executive Director
	Alan Jackson	Community Engagement Group Representative

PUBLIC SESSION (Disclosable)

1.0 WELCOME

1.1 *The meeting commenced at 09:00.*

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 Neville Hounsome, Non-Executive Director (NED-NH).

3.0 DECLARATIONS OF INTEREST

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

4.0 STAFF STORY

4.1 *Caroline Nwadu, Cultural Ambassador (CA) joined the meeting.*

4.2 Caroline Nwadu presented on her experiences as a cultural ambassador. She advised that she had been involved in the cultural ambassador programme since its inception in February 2020. The role was appointed with the intention of promoting fairness in formalised trust processes, with an initial focus on BAME staff. The ambassadors supported employee relations (ER) cases in which a BAME staff member was involved. Their role was not to support the individual staff member, but to apply their understanding and provide guidance in relation to cultural issues. Data

demonstrated that staff members from an ethnic minority background were disproportionately impacted in disciplinary cases. As such, in collaboration with the Royal College of Nursing equality and diversity team the cultural ambassador programme was developed. This enabled managers and staff to have a better understanding of the impacts of both conscious and unconscious bias which could influence the disciplinary process. In 2019 the relative likelihood of an ethnic minority staff member entering a formal disciplinary process compared to a white staff member was 2.39 times greater, the relative likelihood of a white individual being shortlisted compared to an ethnic minority individual was 1.59 times greater. This demonstrated the immediate requirement to address the disparity for staff of an ethnic minority background. In November 2020 15 staff were trained as the first cultural ambassadors alongside two HR representatives and one trade union representative. EEAST was the only ambulance service with a cultural ambassador programme. There were challenges associated with the initial launch of the programme, managers were concerned the programme was divisive and did not account for all protected characteristics. A commitment was therefore made to rollout the programme to all nine protected characteristics. Since this period the SOP and policies had been updated in line with this commitment alongside a data security agreement for all cultural ambassadors. Since the formal launch of the programme cultural ambassadors met regularly to share experiences and learning from cases. The programme was subsequently extended to those staff with a disability. The Trusts WDES figures stated that in 2020/2021 the relative likelihood of Non-Disabled candidates being appointed from shortlisting compared to disabled candidates was 1.31 times greater. The relative likelihood of disabled staff entering the formal disciplinary capability process compared to non-disabled staff in 2020/2021 was 2.12 times greater. In 2021/2022 the relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates was 0.95 times greater. The relative likelihood of disabled staff entering the formal disciplinary capability process compared to non-disabled staff in 2021/2022 was 2.94 times greater. As such the cultural ambassadors were provided additional training to support disability related ER hearings and interviews. The National Cultural Ambassador programme had since been rolled out to 30 Trusts and 3 ICSs. Nationally there were around 400 cultural ambassadors, from all different backgrounds and professions. Initial feedback demonstrated that the presence of an ambassador on hearings reassured the staff member that the case was supported in a fair and equitable approach. There were a number of cases in which inequitable treatment of a minority staff member in a case were raised, policy not followed, and bias associated with investigations and reporting. Since the launch of the programme, the number of ambassadors in post had reduced associated with resignations and unsupportable time commitments. Two ambassadors had refused to sign the data security agreements and capacity impacted the ability to attend the level of meetings/ interviews required. An increase in cultural ambassador capacity was required and approved of the payment of overtime to cultural ambassadors to support commitments.

4.3 Hein Scheffer, Director of Strategy, Culture and Education (DoSCE) advised that a survey was being launched to better understand individuals from an ethnic minority background to determine how the organisation could ensure it was more inclusive and representative. NHSE were also seeking to explore how the Trust could be more aware of individuals with a physical or mental health challenge, working alongside network chairs to ensure a representative and inclusive organisation. Consideration would be given to overtime payments for cultural ambassadors outside of the meeting.

4.4 Non-Executive Director, Mrunal Sisodia (NED-MS) commended the programme which provided a compelling case for the benefits of ambassadors. He enquired whether the Trusts ambition was to have a cultural ambassador represented in all key processes, and the scale of this requirement. It was vital this was prioritised as the current workforce was not reflective of the ethnic diversity of the population. The DoSCE advised that recruitment was underway for a Head of Culture and Inclusivity who would be responsible for supporting a more inclusive organisation. He recognised the benefits of involving cultural ambassadors at all levels of the organisation to ensure fair

processes and to support the re-education of staff as part of the cultural journey. The ambition for cultural diversity and inclusion was being developed.

4.5 The TC enquired whether there was a link to the raising concerns forum. The Chief Executive Officer, Tom Abell (CEO) advised that the latest raising concerns forum had considered the race standards and had committed to working alongside network leads to support a more representative and equitable workforce. A survey had been launched to understand the diversity needs of the organisation, a system of support would then be required to improve equality and diversity, support wellbeing and facilitate cultural change which would be informed by the survey, focus groups and the network involvement.

4.6 The CA concluded the presentation by highlighting that the organisation was on a cultural journey, staff were aware that it would take time to change but were keen to see work being progressed to support these improvements and organisation support of the journey which was now apparent.

4.7 *The CA left the meeting.*

5.0 TRUST CHAIR REPORT

5.1 The TC recognised the commitment of staff to caring for patients and communities during what had been a high-pressure period. There had been clear improvements recognised by the CQC following the latest inspection, which was the first stage in ensuring improvements were embedded and sustained. The Trust had been recognising the contribution of staff through the long service awards, the queens medal and platinum jubilee. She had met with other organisations who had transitioned out of special measures to understand the common themes, which included the right leadership to deliver changes, a shared vision and clear communication of the change programme. The Trust Board had been working on the strategy and development of the urgent and emergency care clinical model which would inform the workforce model. A revised corporate strategy would also be developed by April 2023 reflecting the ambitions for system working.

6.0 CEO REPORT

6.1 The CEO was pleased to highlight the celebratory activity associated with the jubilee and long service awards. There had also been further activity to develop a clinical strategy. He focussed on the whole NHS which was under extreme pressures associated with the compounding impacts of the heatwave and rising COVID cases both in the population and amongst staff. Actions were being taken to increase resource availability and respond to heatwave pressures working alongside the broader NHS to support. Additional infection prevention measures were taken to minimise the risk of COVID transmission in the workplace which would continue to be reviewed to ensure patients and staff were as safe as possible. A draft code of governance had been issued by NHS providers, a briefing for which had been circulated. As an NHS trust under direction from NHSE there was not any significant impact to the Trust arising from this. An area to consider was the alignment to the Trusts objectives, and systems as they formed. The clinical strategy had been driven by the urgent and emergency care priorities of local systems and would also be aligned with provider objectives.

7.0 MINUTES FROM THE PREVIOUS MEETING

7.1 The minutes from the meeting on 11.05.2022 were approved.

8.0 MATTERS ARISING AND ACTION LOG

8.1 09.03.22/6.2: The TC suggested the action remain open until there was mapping of the relationships within the draft working arrangements.

8.2 09.03.22/10.2: The Trust Board ratified the decision to invite the CEG chair to attend the People Committee and Quality Governance Committee. The action was closed.

8.3 09.03.22/12.14: The action was agreed as closed.

9.0 FIT FOR THE FUTURE UPDATE

9.1 The CEO presented the update on the fit for the future programme and confirmed there had been positive progress to support delivery across all of the key workstreams. The programme was underpinning the cultural and leadership activity within the well led framework. Further work was required against the culture workstream to enable delivery. Performance metrics were being established for the programme to align with the committees and IPR. Further work was also underway to support the development of the IPR into sector-based reporting by Autumn. Moving forward there would be a wider programme for quality and safety as part of a continuous improvement approach.

9.2 The Director of Corporate Affairs and Performance, Emma De Carteret (DoCAP) highlighted two areas associated with engagement with staff and stakeholders within the programme. It was recognised further work was required to support staff to understand the programme and become involved to ensure the activity taking place met expectations and requirements. As part of the culture workstreams there was work underway on the communications and engagement strategy to ensure this supported, enabled and involved staff in changes within the organisation. It was proposed future reporting of the programme be through the Transformation Committee and escalated to Trust Board through the chairs escalation report.

9.3 Non-Executive Director, Alison Wigg (NED-AW) iterated concerns associated with the cultural activity – the metrics were demonstrating a deteriorating position, and actions lacked clear targets. She was concerned the amber status was not accurate. The CEO highlighted that both mandatory training had increased to 76.36% and appraisal compliance had increased to 44% although the overall appraisal process required consideration. It was widely understood the causes behind the increase in ER cases, with actions put in place to mitigate the position. There were clear plans in place which it was anticipated would deliver tangible improvements at pace.

9.4 The CEO confirmed activity had been undertaken to ensure executive team meetings were more focussed on each of the strategic goals which provided an opportunity to review progress to deliver against the goals, risks and actions.

9.5 Non-Executive Director, Wendy Thomas (NED-WT) noted the deadline for time to lead was April 2023. This was a key objective to ensure managers had the capacity to support staff, which would be key to delivering cultural change. She requested a timescale and trajectory for the changes within this workstream. The CEO advised that the first proposals for frontline management would be September and would be focussed on ensuring the correct leadership was in post by Winter. This would progress in a staged approach commencing with band 7 frontline management teams and working to other areas of leadership within the organisation. It was vital this programme was phased, with a focus on avoiding significant organisation change and instability during the high-pressure winter period. Dedicated programme leadership had been agreed.

9.6 Non-Executive Director, Carolan Davidge (NED-CD) noted that system partnerships would be key moving forward, it was vital the organisation was present and engaged in the initial phase as integrated care systems were formed. She enquired whether there were any areas within the system partnership workstream which were a concern. Kate Vaughton, Director of Integration

(DoI) advised that one area was amber/ green due to consideration of whether the actions identified were sufficient to fulfil the requirement and to identify key milestones for delivery. Work was underway with systems to agree the regional headline priorities. She assured the Trust Board there was sufficient momentum and activity to determine how EEAST could support urgent and emergency care systems.

9.7 The CEO confirmed programme activity had been prioritised and presented to the Transformation Committee, resources had been realigned to support with a particular focus on time to lead and the development of a clinical strategy.

10.0 CQC UPDATE

10.1 The CEO provided the CQC update and confirmed the CQC report had been published on 13.07.2022. The overall rating for the trust had remained as 'requires improvement' with some movement at domain and service level. The overall well led domain rating had improved from 'inadequate' to 'requires improvement'. There was a decline in the responsive rating to 'requires improvement' which aligned with operational pressures. The caring rating had reduced from 'outstanding' to 'good' although the CQC recognised the fantastic care provided, they had been unable to go out on ambulances due to COVID restrictions to witness this, therefore there was not sufficient evidence. This was not unique to EEAST and had been reflected in other organisations. The recommendation from the CQC was for the organisation remain in SOF4 for continued support. At local service level there had also been movement, in urgent and emergency care there were impacts on caring and responsive, and significant movements within the EOC related to some of the challenges which had been well articulated. A key focus in urgent and emergency care was around training and appraisals and ensuring sufficient staff to meet the increased demand on the service. In terms of the AOC, areas of focus related to call answering and resource levels to ensure calls were answered in a timely fashion. It was also vital to maintain the cultural change within the organisation, there had been fewer incidents of staff reporting bullying and harassment, but one incident was too many and as such this focus should be maintained. Within fit for the future it was vital there was clear engagement with staff to ensure they understood the activity and there were policies in place for those returning from maternity leave. Significant work had been undertaken to support an increase in training compliance in the 'unbundling' of training modules and the conversion of training to e-learning. In terms of staffing there had been significant call handler recruitment and the commitment to additional frontline staff to support PFSH. Recruitment were working to improve recruitment processes to ensure the Trust was an attractive place to work. There had been some improvement in appraisals although the end-to-end process was being reviewed to ensure this was valuable for staff whilst being manageable for those delivering the appraisal process. There had been significant people engagement activity alongside wellbeing activity. In terms of the wider improving response times there was activity required both internally and with wider systems to address handover delays and the availability of alternative pathways of care. In terms of 'should do' actions, the approach for communications in relation to the fit for the future programme was being reinvigorated and the maternity policy updated. The cultural workstream within fit for the future remained a focus for cultural change.

10.2 The DoCAP highlighted the progression from the 'must do' actions identified in the 2019 inspection and the 2020 concerns. There had been positive feedback in the way governance and risk processes had become embedded throughout the organisation. The CQC had identified incidences in which risk was not acted upon. Positive feedback was received in relation to medicines management and safeguarding concerns which were 'must do' areas in 2019 and identified in 2020. This was phase one of a three to five-year plan, which would require continual focus, in particular the management of the culture programme to enable leaders and managers to have the tools and skills to be equipped to deal with this behaviour, as well as recognising the link between the leadership piece, urgent and emergency care and control room inspection. How

staff were supported and managed to deliver effective patient care and manage operational demand to deliver sustainable improvement was vital. Lots of work was already underway.

10.3 The CEO acknowledged this was the first phase in a larger journey for the organisation, it was vital to progress to a place in which EEAST was the employer of choice and delivering outstanding care. The report had been shared with staff, and question and answer sessions scheduled. The action plan was being developed and was linked to the continuous assurance framework for discussion at QGC in July ahead of submission to the CQC. A review was underway of the s29a and s31 conditions as it was considered the findings within the report provided a basis for the application for removal of these conditions. The proposal was that delivery of these actions would be monitored through the QGC. Engagement work continued alongside triangulation between assurance mechanisms and activity at ground level.

10.4 NED-JT extended her thanks to everybody who had contributed to the improved position but was disappointed to see the rating for caring had reduced to 'good'. She suggested where the CQC were unable to assess, they would ordinarily provide a statement that they were unable to rate. This would be disappointing for staff who had been working in challenging situations. As such she enquired how staff were being supported to understand why this rating had reduced. The CEO advised that managers had received a pre-brief alongside deep dives in areas of specific concern such as the AOC to ensure managers were sufficiently briefed to speak with local teams about the context and what this meant for them. Given the operational challenges the ability to provide outstanding care had been impacted, however it was vital this did not impact staff motivation.

10.5 NED-MS commended the progress made based on the current circumstances but highlighted the key message that recovery was only commencing, and this focus and drive would need to be maintained without complacency. He was particularly pleased to note the CQC report had not identified any previously unknown areas - the issues cited had been well articulated and discussed previously. The reports provided external validation of this focus, but momentum needed to be maintained.

10.6 The DoCAP emphasised the importance of ensuring these conversations were a key element in all activity and momentum was maintained to progress to a position in which staff were able to clearly see the difference every day. The overall plan to progress from the position in 2020 to everything being in place, embedded and functioning was a three-five year programme.

11.0 INTEGRATED PERFORMANCE REPORT

11.1 The DoCAP advised that following the movement to demonstrate the measures as driven by the goals there had been concerns this may results in areas of missed oversight due to the overlap between portfolios. As such the reports had been updated to provide enhanced oversight.

11.2 The Director of People Services, Marika Stephenson (DoPS) advised that staff turnover remained high at 11.73%, a deep dive had been conducted which reported into People Committee. Next steps had been determined including the establishment of a task and finish group to consider the data. ER cases were increasing, this had been on an improving trajectory but an influx of cases related to the social media cases of May 2022 had since been processed. Timeframes for case closure were improving alongside a reduction in the average duration of suspensions. Sickness absences were also demonstrating an improvement, although an increase in cases was expected from May 2022 in line with the increasing COVID cases.

11.3 The DoSCE confirmed an improvement in mandatory training compliance following the 'unbundling' of modules.

11.4 The Chief Operating Officer, Marcus Bailey (COO) noted that performance had been clearly identified within the CQC report and was a theme also reflected within the IPR for C1, C2 and call pick up responses. To ensure the workforce was being maximised it was vital to ensure all eligible staff were able to complete their C1 licenses and blue light training to become fully workforce effective. Staff absences had reverted to heightened levels. As such supportive IPC measures had been considered to maintain safety. The organisation was operating at a high level of surge demand management within REAP four and was enacting the heatwave plan. These challenges were being mitigated through increasing the level of PFSH and reassigning clinical staff to support frontline care delivery alongside enactment of the local resilience infrastructure. Moving into August and September the focus would be on maximising capacity to realise improvements and drive efficiencies. Teams were working closely to minimise patient wait times which had been further supported by the volunteer response. These pressures were impacting the capacity to deliver long term changes. No send and cancelled at point of call continued to be utilised alongside hear and treat as part of the surge response.

11.5 NED-JT enquired when a trajectory would be available for abstractions. She noted the previous meeting the AACE review of C1 had been discussed and enquired whether the outcomes from this review had been included in the IPR. The COO noted that the most significant impact to C1/ C2 responses was the level of PFSH, which was key to activity. The AACE review of C1 was scheduled to report to PAF in September and would consider national benchmarking and the areas in which the biggest improvements could be realised. Emergency medical dispatchers were key to effectively prioritising C1 calls.

ACTION: AACE Review of C1 calls to report to PAF
Lead: DoN

11.6 The TC enquired when there would be a plan and trajectory to deliver operational performance. The COO confirmed this was scheduled to report from Performance and Finance Committee and into Trust Board in September.

11.7 NED-WT advised that as part of the Mid and South Essex improvement week she had gone on a rapid response vehicle in the area. Of the calls they received there were a number which did not warrant an ambulance response and would be better suited to primary or social care. It was clear there was further work EEAST could be doing to maximise efficiency and response, but there was a further element associated with the triage of calls. As such, consideration was required of the internal triaging systems and how the Trust responded to calls which did not require paramedic intervention. The COO advised that there were two triaging calls approved for use in the UK – NHS pathways and MPDS, EEAST currently utilised MPDS. Work was ongoing to determine whether the NHS pathways tool offered a different profiling of patients. There were opportunities to signpost C2 calls differently, as well as further activity on resilience, escalation and emergency preparedness. Further exploration was required of which organisation was responsible for managing the risk within the community associated with elongated response times and the complexity of issues which fell outside of the ambulance service remit and skills. There was a significant performance gap compared to national standards, such that a shared response would be key to supporting the closure of this gap. The utilisation of patient data to support non conveyance would also be considered.

11.8 NED-MS requested clarity on the difference between ‘no send’, ‘cancelled at point of call’ and ‘hear and treat’ activity, and how the risks associated with these responses were managed. The COO confirmed ‘hear and treat’ was based on a control room clinician response, ‘no send’ was based on a scripted patient code and condition response, and ‘cancelled at point of call’ was utilised for patients categorised between C2 and C5 based on clinical review, with the decision made as calls came in. The level of assessment and approach was dependent on the level of surge.

11.9 Melissa Dowdeswell, Director of Nursing, Clinical Quality and Improvement (DoNCQI) advised that clinical quality targets had been impacted by response times, in particular the level of harm associated with delays. The improvement week for mid and south Essex would also be rolled out across other systems, this provided an opportunity for clinical improvements required as well as how the call stack could be better managed from a quality and safety perspective. The requirement for mandatory mask wearing had previously been ceased, however following the dramatic increase nationally in COVID cases this was reintroduced to safeguard patients, staff and communities. There had been an overall increase in SIs associated with delays, an action plan had been established to learn from these incidents.

11.10 NED-AW iterated concerns associated with safeguarding level one and level two training, although this had incrementally improved it remained off target. As such she enquired what plans were in place to improve compliance. The DoNCQI advised that compliance with safeguarding training was being reviewed to determine hotspot areas. Clinical supervision discussions both formally and informally had improved and supported the competency assessment. The evidence demonstrated that referrals to hospitals and social services were of an improving quality and standard despite the low compliance with mandatory safeguarding training. This demonstrated the discussions with individuals on patient safety were ensuring patient safety was maintained. To support compliance with mandatory training, modules had been reviewed to ensure they were simple for staff to complete, information was correct and the requirements were succinct.

11.11 NED-MS noted that operational pressures and more complex calls would further impact the clinical quality response, he enquired whether there was sufficient capacity to manage these concerns, such as increasing complaints, concerns and SI levels. The DoNCQI acknowledged that capacity was finite and would need to be managed. As part of the urgent and emergency care strategy consideration would be given to alternative ways of working which could better manage the resources available to deliver operational and clinical requirements. This would include clinical supervision, advanced practice and potentially new roles to support quality and safety. SIs associated with delays were being managed as a system issue. Resources were being redirected to areas of priority. Consideration was also being given to maximising process efficiency – for instance, complaints had also been managed against a standard timeframe of 25 days whilst the national standard was six months. As such the timeframe would be considered to ensure a timely but reasonable response time within the context of the organisation pressures.

11.12 The DoFC noted there had been a lack of clarity associated with the financial position for 2022/23 due to the extended planning round. The final planning round had since concluded and would be reflected in reports from May onwards. There had been overspends in areas such as emergency operations to mitigate some of the operational pressures, as well as consideration of short-term incentives. The biggest risk to the financial plan was how operational pressures would impact the ability to deliver an ambitious QCIP. There would be scrutiny and oversight to drive forward this QCIP with senior leadership appointed to ensure this focus was maintained. The financial plan would be impacted by inflationary impacts which was a trend reflected nationally.

11.13 Alan Jackson, Community Engagement Group Representative (CEG-R) enquired whether consideration had been given to financial support for the mileage of CFRs when responding to patients, CFRs had historically paid for this themselves however due to increasing fuel prices this was becoming unsustainable. The DoFC confirmed this was being considered by the executive leadership team. There was appetite to support the proposal but further work was required to define how this looked logistically and operationally.

12.0 RISK MANAGEMENT STRATEGY AND POLICY

12.1 The DoCAP advised that the key strategic risks which aligned with patient safety and delivery - SR1- '*failure to deliver a timely response to our patients'* and 'SR2- '*failure to achieve continuous*

improvements and high-quality care delivery' remained at an escalated score of 20 due to the ongoing challenges associated with operational pressures. Following the CQC report, SR3- '*failure to embed a culture focused on staff safety and wellbeing*' and SR7 – '*failure to ensure a well governed and accountable Trust'* which scored 20 and 16 respectively would be reviewed to determine whether the risk score could reduce in light of the findings. The PAF had undertaken a deep dive of the long term financial model and sustainability which aligned with SR4 – '*failure to deliver an efficient, effective and economic service'*. Work was underway to establish a long-term financial model which aligned with the legal undertakings and requirements of the s30 cumulative deficit position. There were escalated risks associated with the pandemic and hospital handover delays.

12.2 The DoI confirmed SR5 – 'ability to embed EEASTs place within the system to support delivery of the NHS Long Term Plan' would be linked with the FFF programme with the metrics and milestones aligned to the plan being finalised. It was anticipated that once tracking was in place and milestones agreed with each system there would be a positive improvement in the risk.

13.0 BUSINESS PLAN

13.1 The CEO advised that discussions around the financial position and prioritisation remained underway. The assumptions for activity, workforce and growth had been submitted to NHSE via the ICS lead arrangements. The organisation had committed to the development of a business plan as part of the exit criteria, including a medium-term plan for service delivery and to support financial stability. There remained pressures and risk associated with demand, COVID impacts and the workforce impacts associated with the OFSTED inspection. Investments were being made to support the cultural and service improvements with reprioritisation of other areas to focus resource.

13.2 The TC sought assurance the plan was based on rational assumptions which was confirmed.

13.3 NED-MS highlighted that there remained a cost challenge associated with the plan which would be monitored. The urgent and emergency care strategy would be a key element which would drive workforce, system engagement and financial modelling.

14.0 PEOPLE SERVICES REVIEW

14.1 The DoPS advised that the focus had been on job evaluations, employment tribunals, turnover and retentions alongside course fill rates to ensure the organisation skill mix met the requirements to deliver a robust patient response. A revised structure and funding to support these improvement requirements had previously been approved. A consultation had commenced to ensure the structure was fit for purpose, with recruitment underway to business partner roles and a focus on processes to streamline requirements, improve leadership training and capability and identify technical solutions. The People Strategy had been drafted and incorporated the principles of the NHS People Promise Pillars. A three-year action plan had been included within the strategy categorised into the eight individual pillars. Focus groups addressing each pillar and associated action plan were nearing completion, with a thematic review scheduled to be presented to ELT in mid-July. ER case volumes had increased in Q1 associated primarily with the social media cases. A deep dive had been undertaken of bullying and harassment cases to identify peak areas to focus capacity. Positive progress had been made to close cases within agreed timescales, with circa 54% of cases closed within the recommended timescale. Staff turnover was increasing at 11.73%, it was vital to recognise that employees were transitioning from EEAST as a pipeline to support the wider healthcare system. Sickness absences accounted for 9.32% of staff, this was expected to further increase associated with the rise in COVID related cases. There was a backlog in job evaluations which was causing delays in the progression of roles. As such, generic templates were being secured which could be amended to support roles. There had been a decline in frontline course applications with more innovative approaches pursued to attract people

to the ambulance service as an employer of choice. This included agreement to the funding of travel expenses for individuals on training courses. To support employee wellbeing approval had been provided for deployment of the headspace app which would support mental wellbeing, with KPI's confirmed which would be tracked against an agreed trajectory. The wellbeing team had been fully recruited to, with feedback received from staff on how wellbeing could be better integrated and how the HALO role could be better utilised to support employee wellbeing.

14.2 NED-CD noted there had been a shift in the leading causes for sickness absences from physical injuries to mental health related causes. She sought assurance the Trust had sufficient support in place for employees mental health. The DoPS confirmed further work was required to maximise the mental health offer. The use of HALOs to support wellbeing would be key alongside the deployment of wellbeing vans which focussed on individuals needs working alongside the organisation chaplains. Leadership development was being reviewed to better support staff with a focus on individuals with specific needs. She considered the activity underway would start to demonstrate a tangible improvement within 12-18 months. The organisation had also rolled out a wellbeing garden which had been well received amongst staff as an opportunity for recuperation.

14.3 The TC noted that there had been challenges associated with the skill mix of staff which had been impacted by challenges obtaining employee C1 licenses. The DoNCQI advised that the staff skill mix was generally defined by the safer nursing care tool in acute trusts, but this was not utilised in ambulance services. Carnal Farrer were supporting modelling of the specific needs but the skill mix would be dependent on the clinical model and variation in resources. This would be visible, flexible and adaptable to support each community.

15.0 MODERN SLAVERY STATEMENT

15.1 The DoPS reminded the Trust Board that the organisation was required to update its modern slavery statement on an annual basis as outlined in the modern slavery act, the legislation addressed slavery, servitude, forced or compulsory Labour and human trafficking and links to the transparency of supply chains.

15.2 The Trust Board approved the Modern Slavery Statement for 2022/23.

16.0 PEOPLE COMMITTEE REPORT TO BOARD

16.1 NED-WT presented the people committee report to board, she advised that at its last meeting the committee had undertaken a deep dive of turnover causes and had recognised the importance of the ambulance service operating as part of the pipeline for the wider NHS. It was evident that key causes for females leaving employment related to a lack of flexibility. There were also a high level of individuals leaving the organisation within 18 months of commencing, reporting at 54% of new starters. It was vital the organisation transitioned to become an attractive employer of choice for staff staying in post and joining the organisation. The first draft wellbeing strategy had been received with the recommendation this be a five-year plan as the organisation was starting from a low base level. A presentation was received from the chair of the multi faith network, this was the least developed of the staff networks with further support required to ensure momentum. The WRES and WDES findings had been received and were recommended to Trust Board for publication. The committee had recognised further activity was required to expand ambitions in this area. Partial assurance was provided in relation to the EHRC progress report, due to the requirements for 300 managers to complete all passport training by 31.07.2022, at the time of the committee only 21% of managers had completed this training. The committee had considered concerns associated with the ability for learners to achieve their C1 license which related to national delays. An alternative facility had been agreed provided by the police which provided increased capacity with lower cost associations.

16.2 The committee approved the WRES and WDES for publication.

17.0 QGC REPORT TO BOARD

17.1 The TC provided the QGC report to board and confirmed concerns associated with the NARU audit in relation to the organisations ability to respond to a terrorist attack had previously been escalated. There was assurance the action plan would be progressed to support delivery. The quality account was discussed and was considered a high quality report.

17.2 The clinical audit and legal services annual reports were approved.

18.0 SYSTEM INTEGRATION UPDATE

18.1 The DoI provided the update and confirmed there was a strong working relationship with mid and South Essex CCG who had supported the commissioning of schemes aimed at supporting alternative pathways to conveyance to ED within a variety of vulnerable cohorts. The data demonstrated a high success rate for avoiding conveyance and enhancing patient outcomes where schemes were in place, through targeted support at the communities in which it was most required. This data would help to inform the clinical strategy. An engagement programme was being developed. The focus had been on supporting access to the EEAST stack in the wider healthcare sector to enable partners to support the response. There had been some positive progress in the agreement of advanced practice support and rotational paramedic posts.

18.2 NED-JT noted a wide level of variation in both the activity being undertaken and the level of engagement provided. She was keen to understand why there was such a significant level of variance and any good practice which could be reflected between areas.

19.0 TRANSFORMATION COMMITTEE REPORT TO BOARD

19.1 NED-AW presented the committee report and confirmed there had been a discussion of the risks associated with delivery of the QCIP. It had been agreed the overall QCIP would report into PAF to ensure oversight of both the financial risk associated and delivery of this, and to minimise duplication between forums. The Transformation Committee were focussed on ensuring the key transformation programmes would help to drive delivery against the key corporate goals. A prioritisation exercise had been undertaken to map the priorities to resources. The next stage would be mapping the two-to-three-year plan for programmes to demonstrate how they would support the goals and provide a clear trajectory for holding to account. An update had been received on the fleet with specific focus on accessibility issues, work was underway nationally to determine flexibility against the national standards to mitigate the access issues employees were experiencing. The Transformation ToR were approved.

20.0 PERFORMANCE AND FINANCE COMMITTEE REPORT TO BOARD

20.1 NED-JT provided an update on the previous two meetings of the committee. She advised that discussion had focussed on the financial challenge and changes to the planning guidance which would impact the organisation. The committee had escalated concerns associated with the ability to deliver against the QCIP. Sector level reporting would be improved from September in line with the IPR update schedule. The ToR for the committee had been approved.

21.0 KEY MESSAGES/ RISKS

21.1 The TC noted assurance on the plans and recognised an improvement in integrated planning.

22.0 REFLECTION ON THE MEETING

22.1 The DoSCE provided the reflection on the meeting and highlighted the showcase of the cultural ambassador which demonstrated EEASTs commitment to cultural change and the organisations leading role as part of the cultural ambassador programme. He noted that the length of the meeting had been inordinate, but that the level of debate and discussion was strong despite this. There were clear timelines agreed for assurance.

22.2 The CEO also highlighted the level of discussion but emphasised the importance of maintaining a focus on the assurance and actions arising from agenda items to determine gaps and further activity requirements. There was a balance between the strategic activity and the business as usual delivery. It was vital an improved quality of reporting was supported to ensure reports were concise and clearly identified the highlights for discussion.

23.0 QUESTIONS FROM THE PUBLIC

23.1 Q: In the CQC report the EOC decline din all except one area. What are the reasons for this decline?

The CEO advised that 999 calls had doubled over a short period with the level of recruitment not sufficient to respond to this rapid increase in demand. Although recruitment continued, the appointment of new staff had exposed weaknesses in management and the ability for managers to train new staff. There were also issues associated specifically with the Estate, work had been planned but was delayed due to COVID. This was being progressed as a priority. Concerns were associated not with the quality of care provided but a range of issues which created a potential risk to patient safety.

23.2 Q: The latest CQC report shows that welcome progress is being made. Many thanks for the efforts you are making. When do you expect that EEAST will achieve the CQC rating 'Good' and when is your target to become 'Outstanding'?

We are pleased that we have moved from ‘Inadequate’ to ‘Requires Improvement’ in this inspection round but recognise we have much more work to do. Our improvement programme is a 3-5 year plan that will allow us to embed and sustain the good work to date, and then continue to move us forwards. It is our goal to be able to move from special measures (SOF4) and remove a number of the CQC condition notices in the next 12 months, and then progress to Good and beyond over the course of the improvement programme.

23.3 Q: When do you expect South Woodham Ferrers, Essex, Community First Responders Group (EZ13) to return to provide the 24/7 coverage for our Town and surrounds for which it was famous for more than its first ten years of service?

During the COVID pandemic, many of our CFRs throughout the region have had to stand down due to underlying conditions. We are now at a stage where we are beginning to safely bring people back with appropriate Risk Assessments. We have also increased our training for new recruits. From application, it takes about 6 weeks to get someone appropriately recruited and ready for training. Due to people having full time jobs it can sometimes be difficult for them to get time off to complete the 5 day course.

We know that volunteers fit in volunteering with their work/life and therefore we know that we need a higher number of volunteers to achieve 24/7 cover than we used to in the past. The role of the volunteer has also become busier over the years, and where volunteers could be available for long periods of time before they had a call within their community, we are seeing an increase

in the work of the volunteers, meaning it is not always feasible for volunteers to be available overnight as it impacts on their day employment.

We are always looking for new volunteers to support our communities, so if you know anyone who would be willing to give up a minimum of 10 hours per month, then please do follow the link to fill in the application form below:
Interested in becoming a CFR? (eastamb.nhs.uk)

We currently have five volunteers within the community, who are responding to patients within their local community, and will continue to support local communities in increasing their resilience through the volunteers, and the placement of public access AEDs, expectations of volunteer roles, and demand changes the ability to delivery 24/7 cover through volunteers has reduced.

23.4 Q: Trauma East Voices, the patient & public engagement group for the East of England Major Trauma Network, was very grateful for a presentation on 30.03.2022 on the excellent pre-hospital response and care being provided by EEAST to major trauma patients and the introduction of the silver trauma screening tool for patients over 65yrs old which may be something to promote to the rest of the country.

Thank you for your kind words, we are pleased that the work being undertaken to improve the quality of care to these patient groups has been recognised. Our work on the Urgent and Emergency Care Strategy over coming months will support how we look to enhance our clinical offer across our systems and there will be engagement on this through the summer and into autumn. Furthermore, we would like to assure you that we are active in the national ambulance forums where we share best practice.

23.5 Q: Glad progress is being made on patient & public engagement. But not being experienced at community level. Please can we discuss?

Thank you for highlighting that progress has been made, I am sorry to hear you feel it is not experienced at a community level. We will agree a meeting to consider how we can maximise what is being delivered at community level.

24.0 ANY OTHER BUSINESS

24.1 There was no other business and the meeting closed at 13:01.