South East Coast Ambulance Service NHS Foundation Trust

Trust Board Meeting, 27 January 2022

Via Video Conference
Minutes of the meeting, which was held in public.

Present:

David Astley	(DA)	Chairman
Philip Astle	(PA)	Chief Executive
Ali Mohammed	(AM)	Executive Director of HR & OD
Judith Ward	(JW)	Interim Executive Director of Quality & Nursing
David Ruiz-Celada	(DR)	Executive Director of Planning & Business Development
Emma Williams	(EW)	Executive Director of Operations
Fionna Moore	(FM)	Executive Medical Director
Howard Goodbourn	(HG)	Independent Non-Executive Director
Liz Sharp	(LS)	Independent Non-Executive Director
Michael Whitehouse	(MW)	Senior Independent Director / Deputy Chair
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Tom Quinn	(TQ)	Independent Non-Executive Director

In attendance:

Christopher Gonde	(CG)	Associate NED
Janine Compton	(JC)	Head of Communications
Peter Lee	(PL)	Company Secretary
Phil Astell	(PAs)	Deputy Director of Finance

Tribute to Alice Clark

Before the meeting started DA paid tribute to Alice Clark. On 5 January there was an RTC involving an ambulance; three staff were on board, two were injured and Alice died at scene. PA then said a few brief words about Alice and the incident that led to her untimely death. There was then a minute's silence.

DA sent condolences to Alice's friends and family and all those affected by this tragedy.

Chairman's introductions

DA welcomed members, those in attendance and those observing.

55/21 Apologies for absence

David Hammond	(DH)	Chief Operating Officer and Executive Director of Finance
Laurie McMahon	(LM)	Independent Non-Executive Director

56/21 Declarations of conflicts of interest

The Trust maintains a register of directors' interests. No additional declarations were made in relation to agenda items.

57/21 Minutes of the meeting held in public 25.11.2021

Correcting the date (to November, from September) the minutes were approved as a true and accurate record.

58/21 Action Log [10.05-10.06]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

59/21 Chair's Report [10.06–10.10]
DA summarised the key issues from his report in order to set the context for this meeting, which he explained is longer than normal given the business needing to be transacted. He reinforced the need to keep a focus on the here and now, while also looking forward to ensure we are well placed to meet future challenges. This is demonstrated by the work on strategy that is on today's agenda; Better by Design looks to the future operating model, although it is in the early stages of development.

60/21 BAF Risk Report [10.10–10.21]
PL confirmed the format of this report, which the Board is now familiar with. He reflected that in many ways, section 3 is the most important part of the report as this illustrates the extent to which there is oversight of the BAF risks through the Board, either directly or via one of its established committees. He will continue to work with the committee chairs to help ensure the right focus.

The aim of the report is to provide assurance to the Board that the principal risks are firstly identified and then that they are being managed. In this version, one risk has been removed, related to system engagement. PL explained that this is not to say it is no longer a risk, but the executive feels it is not a BAF risk. Instead, it will be managed in the usual way as part of the risk register.

Two risks have also been added. Firstly, Compulsory COVID vaccinations, following the legislation passed earlier this month. The Board noted that there is a separate item on this later on the agenda. The second risk relates to the 111 single virtual contact centre. EW outlined the context of this emerging risk, where NHSE are looking at integrating call handling / clinical queues to manage workload better. The expectation was that it will be implemented in the coming months, but some concerns have been expressed by providers about clinical risk and the impact on 1s and 9s integration. Clinical and IT colleagues are working together on this and this is much work still to do.

DA suggested that, given the importance of this in terms of assurance, the Performance Committee will consider in greater detail the implications and a paper will come to the Board in due course.

Action
The performance committee to explore the risk related to the 111 single virtual contact centre, and a paper will come back to the Board in due course.

In the context of the virtual contact centre MW asked about the digital IT platform and our level of confidence that we are doing all we can within our control to make this integration work. EW explained that there has been much investment in the 111 CAS IT platforms and so can give good assurance on this. The NHSE IT team are looking at a cloud solution, so existing systems will be retained. However, the key commissioning intention has been to create integration between 1s and 9s, e.g. dual trained staff and single CAD system, which bring efficiencies and are effective, so we would be against rowing back from this to create a separate 111 and 999 system.

PB felt that the devil will be in the detail here, so we must understand precisely what is needed so we can test it, but suggested we are not at that stage yet.

With regards the BAF risk, the Board is assured we have the right risks recorded with good visibility on their management.

61/21 Chief Executive Report [10.21–10.39]

PA started with COVID and planning for the Omicron spike, which seems now to have passed. The main impact on us is staff sickness. which will be covered later on the agenda. At its worst we had over 400 staff away from work with COVID related sickness. Long COVID is continuing to increase, with currently over 40 staff affected by this, some of whom have not been able to work since January 2020. There is continued focus on supporting this group of staff.

Hospitals are also under significant pressure. We have been at the highest REAP level (4) since July 2021 and systems have been in Opel 4 on and off for the last few months. The biggest issue is patient flow, linked to social care capacity. Despite this, PA reflected that our performance has improved, such that we took the decision yesterday to come out of the BCI and move to REAP 3. Other ambulance services are deescalating in a similar way, but we will watch carefully and respond accordingly. One issue coming up could be effect of mandated vaccines. There is a separate agenda item on this.

PA went on to explain that we continue to make good progress on our estate developments, including the major Banstead and Medway projects. We are pushing forward on our strategic agenda, including within our planning capability that DR will cover shortly.

Lastly, in terms of people, PA confirmed that Rob Nicholls will be joining next month as Executive Director of Quality and Nursing, and thanked JW who has been covering. PA also confirmed that we say goodbye to Francis Pole who has been a great servant as head of chaplains.

DA thanked PA for his summary and opened up for questions.

HG asked about the impact of flu, noting that vaccinations are only at 58%. PA acknowledged that take up from staff has been slower than previous years, in part due to linking the vaccine with the COVID booster. However, we do now have a mobile facility that is pushing up the numbers. JW added that we are in alignment with other Trusts and are following up with staff as some will have had it elsewhere, and just not yet informed us.

SS noted that there was 61% completion of the staff survey and asked how this compares to previous years. PA confirmed it is lower than last year by 1% which was our highest ever. AM added that the average across England is under 50%, with other ambulance trusts at that sort of level. He agreed with PA that we are likely to receive difficult feedback.

DA reinforced the importance of working with staff on their feedback to make improvements once results are known.

62/21 Trust Strategy – Better by Design [10.39–11.06]

PA explained that Better by Design (BBD) is how we will deliver our strategy. It will be a series of programmes that the BBD Board will ensure are aligned. The really exciting part will be the refinement of the care delivery model that EW is executive lead for; this will build on the learning from the past two years to develop a more virtual response, using the skills we have and will bring into our control rooms. We think that this will be the best way to use resources most efficiently and help flow of patients through the system. It effectively enables us to do more with less and those needing a physical response will get better and more timely care, as we will better balance supply with demand.

We intend to provide more details by March when there will be a variety of communications, including how to get involved. Then the specific programme plans led by an executive director will be developed. Once this is all in place we will agree how to report regularly to the Board.

DA agreed that this is a critical programme for the Trust, and one the Board will need to closely scrutinise. He then opened up for questions.

MW supports this but felt there are some risks we need to manage. For example, the language we include in the draft document on engagement is not good enough yet. MW asked to hear from more junior staff about what BBD feels for them. Unless you can demonstrate this engagement, it won't be successful. He then referred to the ambition of SECAmb to be a system leader to help address some of the issues in emergency care and public health and suggested in order to do this we need to be out there talking about BBD to get real engagement with the system so there is understanding and buy-in for what we are doing. MW summarised his position, which is that there is still some work to do before he is fully assured.

PB added that we must be able to explain how we pull all the other strategies together and use plain English, and some indication on timetable.

CG asked how much engagement there has been. PA responded that there is the design of the care delivery model and everything else supports this. We haven't yet set out what this should look like, we have simply set a direction that we need do more virtual / from the control room. The next step will be to start the engagement with our workforce and other stakeholders. EW added that while we have not engaged formally under the banner of BBD, we have been talking with people and testing ideas staff have about how better to provide services. PA reflected the driver for this comes from staff feedback, for example about them often attending people they shouldn't. This is the driver for the virtual model and so connects directly to what staff have been consistently telling us.

HG did not agree with framing the BBD document (shared with the Board in draft) as a blueprint, as this usually indicates an answer. Instead, this is a blueprint of the process not the end result. PA agreed and acknowledged that there is a risk of giving the impression we have come up with answers; we have not.

HG reminded the Board that we are not starting here from scratch, as for example the performance cell (one of the programmes) is already well advanced. This reinforces BBD is just the way we overlay what we are doing as part of strategic delivery; BBD's main aim is therefore alignment.

The Board then explored the potential speed of change and need to ensure we don't promise things we can't deliver in the timeframe expected. The comms strategy throughout and at all levels must therefore be clear and consistent, to manage expectations.

DA summarised that this is a very exciting and important programme and goes directly to the quality of care and staff experience. The Board has not received any final documents to review today due to operational challenges and staff illness of key personnel and will receive this in February. It's challenge to the executive is that we must have good engagement of staff and other stakeholders to make this work.

63/21 Clinical Education Strategy [11.06–11.28]

FM introduced Ashley Richardson Head of Clinical Education. Ashely outlined the approach to the development of this enabling strategy, which aims to ensure we have an industry standard education department to support operational delivery. The intent is to use BBD as the vehicle to implement this and drive through the changes. A delivery plan is being developed which will deliver over a 3-year period using the current governance framework to assure delivery. The aim is to create a positive learning environment to enable staff to reach their potential.

DA clarified that this has been scrutinised by the workforce and wellbeing committee (WWC). SS confirmed the committee has seen two drafts and had opportunity to talk to Ashley and visited the Clinical Education Centre in Haywards Heath. She added that this is critical to the talent pipeline and an important strand of transformation work under BBD which links to the workforce plan that is starting to come together. The challenge from WWC is where this will sit within the broader education training and development strategy across the whole workforce; this is not just clinical but about management and leadership too. So the committee wants to see it sit as one coherent whole.

DR is really supportive and this increases our ability to retain talent. His challenge is to ensure this sits hand in hand with the workforce needs. This increases capacity to ensure we meet the target workforce, as it might change over time.

MW asked about integration. PAs clarified that funding is a combination of what we receive from HEE and what we invest in infrastructure, therefore a mixed model of funding. There is a devolved budget for clinical education managed in the medical directorate and any additional funding goes through a business case process. MW challenged that we need assurance when we look at budgets that we have the right resources in clinical education.

Action
WWC and/or FIC to test that we have allocated adequate resources to ensure education training and development to meet the needs of our workforce.

EW added that WWC looked at all courses run at the Trust to meet the various requirements for key skills / management training framework. Planning from next year will look over a longer term (3-5 years) and will be role based, to ensure it is more targeted. Assurance will therefore come through WWC and through FIC related to abstraction and then the Performance Committee related to the impact on provision of hours / performance.

TQ is supportive of the strategy and asked about the different health professionals and whether the continued professional development is in scope. Ashley confirmed it is and will cover all disciplines. TQ is assured by this.

AM felt that this is a big step forward. We have committed to training plans for the new financial year. There are also other dependencies such as estates and IT and as we get the Education Board up and running, we will have a more comprehensive answer to the challenge on integration.

FM thanked everyone for their support and agreed to consider all the feedback. This now empowers Ashely and his team to take forward the next steps to develop business case for the investment needed to deliver.

DA summarised that this enables our strategy relating to integration. The Board supports it and looks forward to reports on progress.

64/21 Green Strategy [11.28–11.41]
DR introduced this next item as the first step on our journey to become environmentally sustainable. He noted for context that the aviation industry accounts for 3% of worldwide emissions; in the UK NHS accounts for 6%. We have a long way to go to resource this strategy to deliver the target in reducing carbon emissions. It is a huge undertaking given the majority of our emissions come from ambulances. DR confirmed that this strategy sets the framework within the overall NHS green plan, but is just a first step and the delivery plan will be more specific about how we achieve the targets.

In the meantime we are talking to external stakeholders to ensure we get the right expertise to help deliver as we don't have this yet. Lastly, DR confirmed the pilot of electric ambulances, agreed just this week.

DA reinforced the need for a delivery plan with objectives and timeframes but felt that this strategy will help change our mentality in relation to the environmental impacts of everything we do. It aligns with our values and beliefs.

PB reflected that there is lots of work here and asked for assurance on how we will resource this. DR confirmed we have a long way to go. Most trusts have a waste and energy managers; we don't and so there are some specific gaps. At the same time, this is about a multi-million pounds programme of investment to get us where we need by 2028. We don't have the technical capability to understand what we actually need to do, therefore are securing the external support to help us quantify this.

DA summarised that the Board is pleased to endorse this strategy and there is general enthusiasm and interest to all of us being greener. It is an important topic and will keep regular oversight via FIC in particular.

[Break 11.41-11.50]

65/21 Patient Safety Strategy [11.50–12.20]
JW explained that this sets a direction from the national patient strategy required of all providers. Our Head of Patient Safety is the named 'Patient Safety Specialist' (PSS), but due to illness could not attend today. This has been under development for some time and JW took members through the slides that set out the strategy which links to our approach to just culture. The Board noted the next steps is to develop a delivery plan.

[12.03 DA left due to fire alarm. MW took over as deputy chair]

MW asked about the timeline for the actions required. JW explained that by the end of March we should complete the next steps listed in the slides. But it will take two years or so to really embed, as was seen in some of the pilot sites.

MW reinforced the importance of investing the right time and energy in this. JW responded that we are doing the gap analysis and developing the plan which will determine the resource needed.

[12.10 DA returned]

TQ welcome this and confirmed this is not starting from a standing start. He contacted the PSS about her formal role and how we develop the relationship. TQ then asked about the implications for the medical examiner role. FM explained this is for acutes as we don't have a medical examiner, but it gives us the opportunity to work with acutes on data sharing as discussed in previous meetings and touched on in the learning from deaths report where we look only at deaths we are aware of, not for example those that happen within 8 hours of admission to hospital.

PL added that while it is not explicit in the next steps, this strategy does include an ambition for quality / patient safety committees to include Patient Safety Partners by June 2022. He confirmed that through our quality committee we will establish how we might achieve this.

SS clarified the role of FTSU as an early warning and JW agreed this is really important to the strategy when looking at themes and trends.

DA summarised that this is an excellent strategy, which QPS will oversee in terms of delivery, and in terms of 'just culture' this needs to be role modelled.

66/21 Operation CARP [12.20–12.37]

FM confirmed that the SI investigation is ongoing, but in the meantime provided the Board with an update. Firstly for context, this relates to two ex-employees who were arrested last August and subsequently pleaded guilty for distraction burglary; they received custodial sentences. They identified end of life patients and stole their related drugs posing as district nurses. The paper lists the initial actions we took. The CCP had been suspended in March 2021 and was awaiting a hearing for gross misconduct. We are looking at security of controlled drugs and use of the CAD; to date we have strengthened our policy on the latter so staff are clear what constitutes appropriate access; audits will then pick this up. Regarding the controlled drugs, the offences occurred in an area we have Omnicell, which makes it easier for audit. The review of these two employee's uses of drugs did not show any excess or outliers. We have found no evidence our drugs were diverted, but we have found that there is work to improve wastage processes. A trial is scheduled shortly.

DA reflected that his is a very serious and regrettable matter and asked if the Board is satisfied with the actions taken to date.

CG asked what more could have been done to check the activities of these staff e.g. audits. FM explained that we do regular audits but there is more we could do re random audits of controlled drugs. She added that people who divert drugs are pretty clever and will only be able to when they are very determined so we need to ensure systems are as tight as they can be. With our Omnicell and the planned upgrade of software this will enable better audits. Non Omnicell relies on paper records which makes it more time consuming.

HG expressed concern about the learning related to the employees living together and asked how we mitigate conflicts e.g. counter signing drugs. FM responded that we are looking at the policy for this; the way ambulance staff work historically is that you tend to have a regular crew mate that can lead to similar issues, e.g. too close to challenge, which may be more relevant than living together. These two employees however were in different roles and so did not routinely work together; one was CCP and one a trainee, so had access to different drugs. But we are looking at the principle.

PB asked if previous audits picked up anything untoward. FM confirmed the controlled drugs audits happen daily and weekly and we report all lost drugs. FM is assured this audit process is strong. Drugs misappropriated in this instance weren't from SECAmb, but the CCP was suspended due to concern about one drug incident. This followed a member of staff alerting us to potential concern, which PA noted was a positive sign. PA then added that this has appalled a huge amount of our workforce and so expressed regret for them who would never abuse the trust they are given to care for patients.

DA summarised that it is important we learn and have an investigation underway. He thanked the executive for its openness and transparency.

67/21 Vaccination a Condition of Deployment [12.37–12.59]

AM explained this is a fast-moving situation and updated from the paper that we had a webinar last week and it is clear we are required to implement the legislation but in a way that supports staff as best we can. The legislation was passed on 6 January and we have a 12-week grace period, leading to enforcement from 1 April 2022. The 3 February is therefore the deadline for staff providing evidence of a first vaccination or exemption. There are multi streams of work in place. In terms of numbers, the current position is that roles in scope are more straight forward for us compared with acute trusts, and we did this in conjunction with unions; we agreed what are in and out of scope. There are 3325 staff in scope. We are having conversations to ascertain their status.

AM reflected that the critical part of this relates to tone, and we are finalising the formal letters that are needed adapted from national templates, in agreement with unions. We have also identified a need additional resource and NHSE have provided two HR staff to support us and we are using the head of the COVID management team and a project manager from HR working full time on this.

Lastly, a sector wide Equality Impact Assessment has been completed; this has identified some negative impacts that we are working through, but the overriding justification is through the legislation.

DA thanked AM for this detailed update on a very important issue.

The Board challenged the executive to ensure clarity on everyone within scope as quickly as possible and how we support BAME staff who we know are generally more hesitate on vaccination.

DA summarised that the Board welcomes the update and endorses the approach the executive is taking to manage this with compassion. Despite what our individual beliefs may be, we have no choice but to enforce this legislation.

[Lunch 12.59-13.30]

68/21 IPR /Committee Reports (13.30–15.05)

PA introduced the IPR report explaining the new items that have been included this month; reflecting that it is becoming an increasingly useful report. He highlighted that given the current pressures, we need to keep looking at all the metrics, so nothing is missed and the IPR helps enable this. He then handed over to EW.

<u>Operational Performance / Performance Committee</u>

Operations

EW summarised the exception reports, focussing firstly on the positives. 111 CAS performance at call answer is still challenging but all the way through we have demonstrated good outcomes, this means patients a getting appropriate outcomes. Revalidation rate is above 95% for 111>999 and we have a low referral rate to emergency departments.

EW referred next to call handling in EOC, explaining that additional funding has helped more EMA and resultant improvement in performance against ARP. Call handling 90th centile improved and relative to other ambulance trusts we are 4th as we are when comparing C1 mean and 90th; we are 3rd for C2. This is an important message as helps demonstrate safety during a challenging period.

EW then set out the issues with abstraction, due to annual leave, COVID and other sickness. All of which is higher than is optimal, but we are clear staff must take leave. We are continuing with training, stat man and also key skills focussed on those staff that have not had key skills within the past 18 months.

Lastly, job cycle time is increasing and there are number of factors for this, such as traveling further / hospital handovers due to emergency department pressures. Lost hours at hospital remains a challenge although in the Southeast it is better when compared with our neighbours. Engagement between local operations teams and emergency departments has been really positive, including the use of HALOs. We recognise the challenges at acute hospitals.

The Board noted that meal breaks is above 98% but this is not always in the right window/time so more work is needed to achieve this. It is slowly improving. Late sign off is higher than would like, but overall the staff welfare metrics are improving.

DR then picked up the approach to executive performance assurance weekly meetings alternating between the improvement plan and the look ahead. The Christmas incentives appeared to have a positive impact; initially we saw a 30-40% reduction of on shift absences we think related to incentives. But this cost circa £800k as set out in the FIC report.

DR outlined progress with the integrated workforce plan using the assumptions including a need for operational efficiencies, such as job cycle time that EW mentioned. This links to care delivery model in BBD.

DR also confirmed the new fleet metrics in the IPR (page 36-38) linked to the improvement work aligned with the Internal Audit review concluded recently.

Before opening up to questions DA asked HG to summarise his report from the Performance Committee.

Performance Committee
HG outlined the outcome from the recent meeting, including the areas of assurance and where there are gaps, as set out in the report. DA is pleased there is better assurance on performance including in our ability to predict and plan. He then opened to questions.

MW commended the quality of information and asked firstly if EW is confident that staffing in EOC is more resilient and then DR what we need to do to ensure sustainability, e.g. what is the timeline to make the changes we have identified as needed. In response, EW confirmed she is more confident especially with call handlers, although challenged more on clinical staff given competition for these roles. We have taken on more and continue to increase further. On the things we need to do and milestones, related to our integrated planning, DR explained that we can't just tell people to reduce job cycle time by a certain percent. Instead, we need to engage and capture ideas from staff about what will work better to ensure more timely responsive care. This is a significant workstream and will require much work to make happen, but we must make it happen in the right way if we want to be sustainable.

PB asked about violence and aggression incidents and the Board noted the data when compared with incidents is very small. JW outlined the work we are taking with Police to ensure zero tolerance and the body worn camera trial that is ongoing.

DA summarised by thanking staff for their efforts in ensuring improvements during such a challenging period. The financial challenges ahead are significant and the executive are taking this forward. Abstraction is critical but we need training and staff must take annual leave so we need to find a sustainable solution.

<u>Quality and Patient Safety / QPS Committee</u>
FM started by highlighting the good practice before the exception reports. The NHS Pathways audit team is now stable and when EOC is busy they help call taking, while still ensuring 96% of audits. In terms of exceptions, FM highlighted the single sign out at Omnicell sites (not counter signed). The number has increased in December, and the reason is that OTLs need to validate, but no one else is on station to counter sign. OTLs have been doing more shifts in December. FM clarified that there is no evidence of any missing controlled drugs.

There is a deep dive planned to help better understand the reasons why STEMI care bundle still scoring lo, we will look at how other report to ensure it is like for like.

JW noted the duty of candour improvement and provided the Board with the context that at ambulance trusts it can be problematic as we don't always have details of patients / carers. It is however always completed, just not always within the timeframe. JW then highlighted the complaints response time data (decreasing) and assured the Board that we are still taking this seriously, but struggle with timeliness due to

an increase in numbers and our ability to keep up with demand. Also, there are pressures on the front line and their ability to provide information quickly.

On Hand hygiene, JW explained that we would expect fluctuation and this is a sign of rigorous audits; nevertheless it is lower than is optimal. A plan is in place to address it but again issues with capacity given all the operational challenges.

Lastly, in relation to the number of SI actions overdue, JW confirmed this related to us not having the evidence, but we are systematically working through each one.

QPS Committee
TQ took the Board through the report including where there were gaps in assurance. The meeting was last week and some of the issues been covered by JW above. The committee is assured with the focus on duty of candour but we need more information in due course on how we prepare managers for having really difficult conversations. After TQ went through the areas covered by the committee DA opened to questions.

CG asked if there is more violence against BAME staff. JW explained we are doing some work to better identify this through our reporting processes; we need to add a field collecting this data.

Workforce and Wellbeing
AM referred to sickness already covered, but specifically the 23-point action plan. The IPR mentions the revised guidance on COVID sickness management, which is different to other sickness. AM confirmed there is no sign of this changing yet but it may over the next period. In the meantime we working to national guidance. The three main reasons for sickness are COVID, mental health and MSK. The action plan is overseen by the senior management group on a weekly basis and WWC receives regular updates too.

AM then referred to turnover rates that are higher than in the recent past. Some of this relates to pressures and the three common reasons are work life balance, wellbeing, and hours.

DA thanked AM for the update and handed to SS, in LM's absence, to summarise the work of the workforce and wellbeing committee.

WWC
SS summarised the outputs of the most recent meeting explaining the constant conundrum between abstraction and training. The committee is supportive of the work to look at this more holistically as EW mentioned earlier. On appraisals, the committee has noted the actions and an update will come to the next meeting in a couple of weeks.

Finance /FIC
PAs gave the headlines on the financial position and outlook; we are on track to achieve our financial targets and the risk is very low. Although this is a deficit plan, so we need to think about how we get back into surplus in future years. The position includes some non-recurrent funding as touched on earlier, e.g. 111 First and COVID funding that is to be reduced by 57%. There are also a number of other underlying pressures. The planning guidance suggests contracting as pre COVID, but the detail is to be worked through.

PA added that we need to trey and ensure we are funded to meet performance targets and also need a revised approach to efficiencies, where the ask is likely to be significant.

FIC
HG summarised the areas covered at the most recent meeting. Financial planning is a significant issue for the Board as we cannot afford to roll over the deficit which to a large extent was a quirk of the block contract; also the non-recurrent funding in 111. BBD will be key to delivering efficiencies but we are not in a position to translate this into what a budget will look like to ensure we have resources to deliver.

EW does not underestimate the challenge with commissioners this year. Her concern is that historically handover was 15 minutes, but the new guidance says 65% within 15 minutes and the remainder not more than 60 minutes. This has a potential impact on handover time in light of discussion earlier on job cycle time and the need for efficiencies. DR added that the assumption is 70 WTE from what EW has just described. DA noted that this is a real quality issue we must put forward.

DA summarised that as we prepare for the next contract round, we need to be clear about the challenges to get to an informed negotiating position. He asked FIC to support this to confirm the parameters and triggers for Board escalation.

Audit Committee
MW summarised the headlines within the report, giving assurance that we have robust plan for the production of the annual report and accounts. In terms of Internal Audit, in response to some concerns earlier in the year related to the development of BBD, we asked for an initial review of governance, which we touched on earlier. One concern related to the role of the Chief Operating Officer and a potential conflict with the role of finance director. We asked Internal Audit if this was unusual; in the public sector it is not uncommon to combine these roles especially given the finite resources. Their advice is it is fine so long as we have clear division of responsibilities, which we do.

MW also highlighted the partial assurance review of EPRR and the importance if focussing our improvement in this area. The committee will keep this under close review.

Overall, MW confirmed the work of committee continues to provide good levels of assurance on the overall governance within the Trust.

69/21 Learning from Deaths Q4 Report [15.05-15.17]
FM highlighted the key findings that have already been presented to QPS as per its report earlier on the agenda. DA thanked FM for this very informative report and the assurance that we are looking in good detail at these cases to ensure learning from both good and suboptimal care.

MW asked about the resus issue identified. FM explained this was about how staff record the decision not to start resus. This is an area of focus for the end-of-life care team.

The Board agreed there is a robust learning from death process in place to adhere to the related policy.

70/21 Patient Experience Annual Report 2020/21 [15.17-15.20]
JW explained that this includes the key work in year to help embed the patient experience strategy in addition to the complaints' themes and learning. The Board noted the report which has been reviewed by QPS. TQ added that patient experience will continue to be a focus of the committee.

71/21 Incidents and SI Annual Report 2020/21 [15.20-15.24]
JW confirmed that she has touched on much of this under the patient safety strategy item earlier. She summarised the report confirming that it demonstrates reporting increases with moderate and decreasing higher harm, which is positive. Also, the harm reviews have been really positive to ensure we identify where harm occurs so that learning can inform our approach, especially during the pandemic.

The Board noted the report.

72/21 Business Cases [15.24-15.28]

a) COVID EOC
b) COVID 111
c) 111 First Activity

EW summarised these three which are how we use the funding that has been received. The business cases capture all the costs. The Board agreed that this demonstrates good financial practice and approved each one.

d) MS Licensing

PAs explained that this related to the accreditation of secure email accounts, which requires two additional licenses. This is a not insignificant cost, hence the trigger Board consideration. The Board accepted the need for this and approved the business case.

73/21 AOB

None

74/21 Review of meeting effectiveness

DA felt the meeting was effective and hoped everyone had the opportunity to contribute, balancing governance, scrutiny and patient safety.

There being no further business, the Chair closed the meeting at 15.29

DA then asked if there were any questions from the public in attendance, related to today's agenda.

Linda Caine asked DR about the Green Strategy in terms of transition to electric vehicles, and whether we are linked to other providers. DR responded that we are seeking to engage stakeholders to better understand how to best approach. In terms of vehicles, they are standard specs for electric vehicles, but how we utilise charging for example at hospitals will be part of what we need to consider. He is not aware of any grants but DR is happy to receive information if Linda or anyone has it.

Signed as a true and accurate record by the Chair: _____

Date _____

SECAMB Board

Performance Committee Escalation Report to the Board

Date of meeting	01 March 2022
Overview of key issues/areas covered at the meeting:	The Committee began by reflecting on a point of content from the January meeting that Hear and Treat reduces when there are more resources available to dispatch because culturally there is a natural inclination to send the resource, however the decision to dispatch should be based on clinical assessment. **Assurance Process and Escalation Assured** Detail was provided on the mechanics of the performance assurance process; each Friday afternoon the data is reviewed, and highlights identified. These reviews alternate between looking back by a week and looking ahead to the next week. This is then presented to the Executive team and to the senior management team the following week. Since the January 2022 Performance Committee meeting, seven such Friday sessions have taken place. Challenges remain in introducing efficiencies into areas such as job cycle time and reducing on-scene times, due to both annual leave and sickness abstractions in the short term, and in the medium term, due to an insufficient resourcing and training pipeline. The committee is assured by the approach being taken by the executive. Having a defined and working assurance process gives the wider senior management access to the same performance data set and aids in sharing the visibility of issues, concerns, and areas of interest across the organisation. **Integrated Plan: 2022 – 2023 Partial Assurance** This paper had also been presented to the most recent Workforce and Wellbeing Committee meeting, to which members of the Performance Committee had been invited. The Committee recognised that Commissioners might have a different perspective to the executive. As an example, whilst increasing Hear and Treat is positive and in fact desirable, this can correlate to an increase in complaints from patients and their relatives that no ambulance was sent. The Committee reinforced the importance of sharing the overarching picture to Commissioners to afford them a fuller understanding of the business. The baseline of 2,413 has not changed for 3 years and was the result of a 2017 analysis. The work done by the Performance Cell and monitored through the Annual Planning Working Group confirmed based on 2021/22 assumptions, that 3021 WTE would be required in field operations to deliver performance, highlighting the gap between required and available resources today. Even if this 3021 resource level was affordable the recruitment pipeline could not support this goal. A structural change is required to encompass rota change, determine when and where resources are allocated, identify the optimal skill mix, reduce the need for and reliance on incentivisation, and introduce efficiencies. The integrated planning work seeks to

	achieve a balance between contracted activity/demand, resources, and performance / patient outcomes. There was an acknowledgement that there is a risk of insufficient capacity to lead the operational efficiency targets required for 22/23 within the existing operational management team to make this work. Whilst the plan on paper balances all components of planning for next year, the stretch nature of the targets across recruitment and training, operational efficiency targets, and potential non-operational cash efficiencies, makes the plan very challenging to deliver. This was acknowledged by the committee and recognised that a longer-term solution is required deliverable beyond 12 months. The committee challenged the executive team on how the plan will be delivered and monitored. The longer-term solution for the structural issues sits under the umbrella of Better By Design with threads being fed in from multiple directions. The Committee acknowledged that this was the first time that meaningful future focussed planning was taking place outside of the pandemic scenario since the Demand and Capacity Review. In summary, the committee felt positive about the direction of travel, but acknowledged how critical it would be to obtain support from Commissioners. Clear and consistent messaging setting out the benefits was imperative in all aspects of our communication with them. **12-week look ahead Assured** Assumptions have been made about hospitals, leave abstractions and sickness absence over the next 12 weeks. Annual leave will increase towards the end of the financial year. Shortly after this, training will resume in April. Attrition is ongoing but will be partly offset in June 2022 with the addition of new staff resources. The committee then considered the challenge of balancing performance needs with annual leave requests, against a cultural background where leave requests are almost always acquiesced to. The maximum annual leave taken in an area should not exceed 15% which averaged out across all areas is being met, but 'Leave' also covers parental leave, carers' leave, and short notice leave. Other leave could constitute an additional 3% of abstraction. The solution is multi-faceted and includes a change in policy and a better reporting system than GRS. Culturally, staff should be enabled to book and take leave at relatively short notice when resources are sufficient to meet demand. In this way leave allocations would be more evenly spread throughout the year and not concentrated in quarter 4. The committee noted the increase in sickness absence related to mental health and stress and to musculoskeletal injuries. The number of staff experiencing stress is consistent with other Trusts. The committee acknowledged the extent of this Trust's wellbeing offer relative to other Trusts and that long term sickness had recently reduced from 7% to 4%. Recognising that effective annual leave management is a longer-term objective, the committee were assured that the 12-week look ahead was well founded.

	Performance Management Overview **Partial Assurance** This section of the meeting was focussed on the immediate actions being taken. Hospital handover times are not improving, and delays at emergency departments are beginning to be accepted as part of business as usual. There needs to be more recognition within the system that delays hamper the ability to reach more patients in the community, so this is in fact, a community problem. Coupled with this, sickness absences remain high. The positives were that health advisor hours were stronger and wrap up times in the east were improving and Community First Responders were being encouraged to book on. The committee then discussed late sign offs which was recorded at 50%. Make Ready Centres were in the best place for their function but in many instances, they have replaced community ambulance stations which were co-located with local hospitals. The business model means there is a greater distance to travel to base to start or finish a shift. Once back at the Make Ready Centre, the vehicle is handed to the Make Ready Crew and medicines are signed back in. Coupled with frequent cross-border working, late sign offs are increasing. The committee noted that the Performance Improvement Plan is not having any significant impact on performance, reinforcing the structural changes that are needed that are being taken forward under Better by Design. **Performance Cell – Highlight Report** **Assured** With the conclusion of the consultation, the feedback is being incorporated into the design for the new team, thus some recruitment can begin. Once staff are substantiated into roles there will be some continuity. Additional analyst capacity will be bolstered through external recruitment. Implementation will begin from mid-March 2022. Anaplan is at user acceptance testing stage. Once the integrated plan is finalised Anaplan will be used for forecasting, tracking, and planning. A delivery manager has been recruited for this work. Optima is still on-track from the end of July. The committee commended the progress made. **Additional Funding - progress against delivery** **Assured** The committee endorsed the view that a two-pronged approach was in play. In the short term, the operational performance improvement plan and the winter monies were utilised, and in the longer term Better by Design would create a lasting solution.
Any other matters the Committee wishes to escalate to the Board	It was a good meeting with strong discussion. As a relatively new Committee which is still evolving, the discussions are positively shaping a shared understanding of performance and its affiliated influencers.