Bundle Public Board of Directors 25 July 2024

0 Agenda
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1 Chair's Welcome and Apologies for Absence - Sumit Biswas - Verbal/ For Noting

2 Declarations – Directors' Interests and Fit and Proper Persons Test - Sumit Biswas - Verbal For Noting
- 2.0 Board Members Register of interests_July 2024

3 Minutes from the meeting held on 30 May 2024 - Sumit Biswas -For Approval
- 03.0 Draft SCAS Public Board Minutes 30.05.24 v1.1 BS

4 Board Actions Log - Sumit Biswas -For Approval
- 04.0 Public Board Action Log 30.05.24

5 Chair's Report - Sumit Biswas -For Noting
- 05.0 Chair's report cover sheet July 24
- 05.1 Chair Report July 24

6 Chief Executive Officer's Report - David Eltringham -For Noting/ Information
- 06.0 CEO report July 2024 with cover sheet

7 Update to the previous Private Board meeting held on 27 June 2024 - Sumit Biswas -For Noting
- 07.0 Private Board update to public board

8 Staff Story - Natasha Dymond - SR1 12 - For Information
- 08.0 Report Cover Sheet Staff Story 25.07.24
- 08.1 Roy's story - A TUPE experience from the NHS to a PP and return to the NHS

9 Integrated Performance Report - Stuart Rees & Executive Director Leads -For Assurance
- 09.0 IPR Summary Sheet Cover Sheet
- 09.1 IPR FINAL

10 Quality and Patient Safety Report - Helen Young - SR1 12- For Assurance
- 10.0 Quality and Safety Board paper Cover Sheet- Final
- 10.1 Quality and Safety Board Paper JULY Final

11 Chief Medical Officer's Report - John Black - SR1 12- For Noting
- 11.0 Chief Medical Officer Report Cover Sheet - July 2024 - Draft
- 11.1 Chief Medical Officer's Board Report - July 2024 - draft

12 Assurance Report Quality and Safety Committee, 17 July 2024 - Dhammika Perera -SR1 12- For Assurance
- 12.0 Upward Report QS - 17 July 2024 - Amended Final

13 Finance Report Month 3 Update - Stuart Rees- SR5 16- For Assurance
- 13.0 Month 3 Finance Report TB July 2024 - Cover Sheet
- 13.1 Month 3 Finance Report TB July 2024

14 Assurance Report Finance and Performance Committee, 18 July 2024 - Les Broude - SR5 16- For Assurance

15 Assurance Report Charitable Funds Committee, 10 July 2024 - Nigel Chapman - SR5 16- For Assurance
- 15.0 Upward Report - July 2024 CFC

16 Assurance Report Audit Committee, 11 July 2024 - Mike McEnaney -SR5 16 - For Assurance
- 16.0 i AC upward report to Board i - 24-07-25
- 16.0 ii AC upward report to Board ii - 24-07-25
- 16.0 iii AC upward report to Board iii - 24-07-25

17 Questions submitted by Board Members on agenda items: 14, 15 & 16

18 Assurance Report People and Culture Committee, 17 July 2024 - Ian Green - SR7 12- For Assurance
- 18.0 PACC Upward Report Meeting Template Accessible - Copy

19 Communications Update - Gillian Hodgetts -For Noting

19.0 Communications Marketing and Engagement Summary sheet SCAS Public Board - 25 July 2024 final

19.1 Communications Marketing and Engagement Public Board Paper - 25 July 2024 final

20 Questions submitted by Board Members on agenda items: 18 & 19

21 Chief Digital Officer Report - Craig Ellis - SR8 15 SR10 20- For Noting

21.0 Report Cover Sheet - July 24 Board Update (Chief Digital Officer)

21.1 Meeting Report - Digital Board Update July (Chief Digital Officer)

22 Assurance Report Improvement Programme Oversight Board Update 10 July - Caroline Morris -For Assurance

22.0 July Board - Cover Sheet Improvement Programme Update

22.1 20240710-Report_Pack-IPOB-v1.0-FINAL

23 Any Other Business -Verbal For Noting

24 Questions from observers (items on the agenda) - Sumit Biswas -Verbal For Noting

25 Review of Meeting Non-Executive Director: Ian Green Executive Director: Helen Young-Verbal For Noting

26 Date, Time and Venue of Next Meeting in Public Thursday 26 September 2024 at 9.30am Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN -Verbal For Noting

27 End of pack/

27.0 end of Board pack

27.1 NHS Acronyms 270723

Agenda

Public Trust Board

Date: Thursday 25 July 2024
Time: 9.30 – 12.30
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members:	
Sumit Biswas	Deputy Trust Chair, Non-Executive Director
David Eltringham	Chief Executive Officer
Les Broude	Non-Executive Director
Nigel Chapman	Non-Executive Director
Ian Green OBE	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Dr Dhammika Perera	Non-Executive Director
Dr John Black	Chief Medical Officer
Jamie O'Callaghan	Interim Chief Governance Officer
Helen Young	Chief Nurse Officer
In attendance:	
Kofo Abayomi	Head of Corporate Governance & Compliance
Mark Ainsworth	Director of Operations
Craig Ellis	Chief Digital Officer
Kate Hall	Intensive Support Director, NHSE/I
Gillian Hodgetts	Director of Communications, Marketing and Engagement
Nicola Howells	Assistant Director Organisational Development
Caroline Morris	Transformation Programme Director
Jack Phillips-Lord	Chief of Staff
Stuart Rees	Interim Director of Finance
Ann Utley	Associate of NHS Providers
Susan Wall	Corporate Governance & Compliance Manager
Apologies:	
Natasha Dymond	Assistant Director HR Operations
Paul Kempster	Chief Transformation Officer
Melanie Saunders	Chief People Officer
Professor Sir Keith Willett CBE	Chair

Questions received in advance from Board Members for those items marked as 'For Noting' 12, 14, 15, 16, 18, & 19 will be received under agenda item 17 and 20.

Item		BAF	Action	Time
	OPENING BUSINESS			
1	**Chair's Welcome and Apologies for Absence** Sumit Biswas	-	**Verbal For Noting**	09.30
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Sumit Biswas	-	**Verbal For Noting**	
3	**Minutes from the meeting held on 30 May 2024** Sumit Biswas	-	**For Approval**	
4	**Board Actions Log** Sumit Biswas	-	**For Approval**	09.35
5	**Chair's Report** Sumit Biswas	-	**For Noting**	09.40
6	**Chief Executive Officer's Report** David Eltringham	-	**For Noting/ Information**	09.45
7	**Update to the previous Private Board meeting held on 27 June 2024** Sumit Biswas	-	**For Noting**	-
8	**Staff Story** Nicola Howells	**SR1 12**	**For Information**	09.50
9	**Integrated Performance Report** Stuart Rees & Executive Director Leads	-	**For Assurance**	10.05
	High quality care and patient experience - We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.			
10	**Quality and Patient Safety Report** Helen Young	**SR1 12**	**For Assurance**	10.45
11	**Chief Medical Officer's Report** John Black	**SR1 12**	**For Noting**	-
12	**Assurance Report** Quality and Safety Committee, 17 July 2024 Dhammika Perera	**SR1 12**	**For Assurance**	10.55
	5 MINUTES COMFORT BREAK 11.00			
	Finance & Sustainability – We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partner.			
13	**Finance Report Month 3 Update** Stuart Rees	**SR5 16**	**For Assurance**	11.05
14	**Assurance Report**	**SR5**		11.15

Item		BAF	Action	Time
	Finance and Performance Committee, 18 July 2024 Les Broude	16	Verbal For Assurance	
15	**Assurance Report** Charitable Funds Committee, 10 July 2024 Nigel Chapman	SR5 16	For Assurance	11.20
16	**Assurance Report** Audit Committee, 11 July 2024 Mike McEnaney	SR5 16	For Assurance	11.25
17	**Questions submitted by Board Members on agenda items: 14, 15 & 16**	-	-	11.30
	People & Organisation – We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			
18	**Assurance Report** People and Culture Committee, 17 July 2024 Ian Green	SR7 12	For Assurance	11.35
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
19	**Communications Update** Gillian Hodgetts	-	For Noting	-
20	**Questions submitted by Board Members on agenda items: 18 &19**	-		11.40
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
21	**Chief Digital Officer Report** Craig Ellis	SR8 15 SR10 20	For Noting	-
	Well Led – We will become an organisation that is well led and achieves all of its regulatory requirements by being rated Good or Outstanding and being at least NOF2.			
22	**Assurance Report** **Improvement Programme Oversight Board Update 10 July** Caroline Morris	-	For Assurance	11.45
	CLOSING BUSINESS			
23	**Any Other Business**	-	Verbal For Noting	
24	**Questions from observers (items on the agenda)** Sumit Biswas	-	Verbal For Noting	11.50
25	**Review of Meeting** Non-Executive Director: Ian Green Executive Director: Helen Young	-	Verbal For Noting	11.55
26	**Date, Time and Venue of Next Meeting in Public** Thursday 26 September 2024 at 9.30am	-	Verbal For Noting	-

Item		BAF	Action	Time
	Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN			

South Central Ambulance Service
NHS Foundation Trust

BOARD MEMBERS REGISTER OF INTERESTS

South Central Ambulance Service NHS Foundation Trust
Unit 7 & 8, Talisman Business Centre, Talisman Road,
Bicester, Oxfordshire, OX26 6HR

INTRODUCTION & BACKGROUND

The following is the current register of declared interests for the Board of Directors of the South Central Ambulance Service NHS Foundation Trust.

Note: All Board Members are a Trustee of the South Central Ambulance Charity

DOCUMENT INFORMATION

Date of issue: 18 July 2024

Produced by: The Governance Directorate

PROFESSOR SIR KEITH WILLETT CBE, TRUST CHAIR

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Professor of Trauma Surgery, University of Oxford
2. Chair of the Chair' Group and Council of the Association of Ambulance Chief Executives (AACE)
3. Retained with NHS England and NHS Improvement to support COVID-19 public inquiry

Current 'Other' Interests

4. Honorary Air Commodore to 4626 Squadron, RAuxAF

Interests that ended in the last six months

5. None

SUMIT BISWAS, NON-EXECUTIVE DIRECTOR / DEPUTY CHAIR

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. Director Zascar Ltd (trading as Zascar Consulting)
3. Part owner of Zascar Ltd.

Interests that ended in the last six months

4. None

LES BROUDE, NON-EXECUTIVE DIRECTOR / SENIOR INDEPENDENT DIRECTOR

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. Independent member of the Buckinghamshire Healthcare NHS Trust Charitable Funds Committee

   Interests that ended in the last six months

3. None

NIGEL CHAPMAN, NON-EXECUTIVE DIRECTOR

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. Labour City Councillor for Headington Hill and Northway, Oxford City Council.
3. Oxford City Council – Cabinet Member for Citizen Focused Services & Council Companies, Member of Oxford City Council Planning Committee
4. Vice Chair of Care International UK
5. Director of Farrar Chapman Ltd*
6. Director Empowering Leadership Ltd

7. Community Governor, New Marston Primary School, Oxford (part of the River Learning Trust).

**Farrar Chapman Ltd is an Educational Consultancy business that has no dealings with the NHS.*

Interests that ended in the last six months

8. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Chair of Salisbury NHS Foundation Trust

Current 'Other' Interests

2. Chair of Estuary Housing Association
3. Member of Advisory Group, NHS Patient Safety Commissioner
4. Strategic Advisor, Prevention Access Campaign (US based charity)

Interests that ended in the last six months

5. Member of Welsh Governments Expert Advisory Group on banning LGBTQ+ Conversion Practices

MIKE McENANEY

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Non-executive director and chair of Audit & Risk Committee – Royal Berkshire NHS Foundation Trust
2. Director of South Central Fleet Services Ltd.
3. Member of NHS Providers Finance & General Purposes Committee
4. Chair of FTN Limited (Trading subsidiary of NHS Providers charity)

Current 'Other' Interests

5. Member of Oxford Brookes University Audit Committee
6. Governor at Newbury Academy Trust (primary and secondary education)

Interests that ended in the last six months

7. None

Dr DHAMMIKA PERERA

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. Global Med Director of MSI Reproductive Choices
3. Member of the Clinical Committees on Safe Abortion Care at the WHO and at the International Federation of Obstetricians and Gynecologists (FIGO)

Interests that ended in the last six months

4. None

KATIE KAPERNAROS

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Non-Executive Director, Manx Care.
2. Non-Executive Director, The Pensions Regulator.
3. Non-Executive Director, Oxford University Hospitals NHS Foundation Trust.
4. Non-Executive Director, The Property Ombudsman.

Current 'Other' Interests

5. Trustee (Company Director, Voluntary) - Wallingford Rowing Club

Interests that ended in the last six months

6. None

DAVID ELTRINGHAM, CHIEF EXECUTIVE OFFICER

Current NHS Interests (related to Integrated Care Systems and System Working)

7. None

Current 'Other' Interests

8. Married to Deputy Chief Nurse, Birmingham Women's and Children's Hospital NHS Foundation Trust

Interests that ended in the last six months

9. None

PAUL KEMPSTER, CHIEF OPERATING OFFICER

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

JOHN BLACK, CHIEF MEDICAL OFFICER

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Emergency Medicine Consultant, Oxford University Hospitals NHS Foundation Trust
2. Honorary Consultant Civilian Adviser in Pre-hospital Emergency Care to the Army
3. Member National Ambulance Medical Directors Group (NASMeD)
4. Investor Oxford Medical Products Ltd*

**Oxford Medical Products Ltd presents no clinical or commercial conflict of interest with SCAS*

Current 'Other' Interests

5. None

Interests that ended in the last six months

6. None

PROFESSOR HELEN YOUNG, DIRECTOR OF PATIENT CARE AND SERVICE TRANSFORMATION

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Chief Nurse and Trustee for ACROSS (a medical charity taking terminal and very sick travellers on respite breaks travelling on a Jumbulance)
2. Chief Nurse and Trustee for HCPT (a medical charity taking terminal and very sick children and young people on respite breaks to Lourdes)
3. Clinical Advisor for Dorothy House Hospice Care
4. Chair of Soroptimist International (Bath Club) (a charitable organisation that works to empower, educate and enable women and young girls in UK and internationally).

Current 'Other' Interests

5. None

Interests that have ended in the last six months

6. SRO for NHS 111 Covid Response Services (March 2023)

DARYL LUTCHMAYA, CHIEF GOVERNANCE OFFICER

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

MELANIE SAUNDERS, CHIEF PEOPLE OFFICER

Current NHS Interests (related to Integrated Care Systems and System Working)

1. Employers representative on the national NHS Employers Staff Partnership Forum

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

Stuart Rees, Interim Director of Finance

Current NHS Interests (related to Integrated Care Systems and System Working)

1. SCFS Ltd Managing Director as of December 2023

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

Craig Ellis, Chief Digital Officer

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. I am a Non-Executive Director for the London Cyber Resiliency Centre. I undertook this in Nov-2022 and continue in the role which was declared when undertaking my application.

Interests that ended in the last six months

3. None

Mark Ainsworth, Director of Operations

Current NHS Interests (related to Integrated Care Systems and System Working)

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

END

Minutes
Public Trust Board Meeting

Date: 30 May 2024
Time: 9.30 – 12.30
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members Present:

Professor Sir Keith Willett CBE	Chair
David Eltringham	Chief Executive Officer
Sumit Biswas	Non-Executive Director
Les Broude	Non-Executive Director
Nigel Chapman	Non-Executive Director
Ian Green	Non-Executive Director
Paul Kempster	Chief Transformation Officer
Professor Helen Young	Chief Nurse Officer
Dr John Black	Chief Medical Officer
Craig Ellis	Chief Digital Officer

In Attendance:

Stuart Rees	Interim Director of Finance
Gillian Hodgetts	Director of Communications, Marketing & Engagement
Mark Ainsworth	Director of Operations
Natasha Dymond	Asst Director HR Operations
Caroline Morris	Transformation Programme Director
Kate Hall	Intensive Support Director, NHSE
Kofo Abayomi	Head of Corporate Governance & Compliance
Susan Wall	Corporate Governance & Compliance Officer
Jack Lord-Phillips	Chief of Staff to Chief Executive Officer
Caroline Whitworth	Head of Patient Experience (Item 9 Only)
Emma Hunt	SCAS Paramedic/Patient relative (Item 9 Only)
Mark Ainsworth-Smith	Consultant PHCP (Item 9 Only)

Apologies:

Daryl Lutchmaya	Chief Governance Officer
Melanie Saunders	Chief People Officer
Mike Murphy	Chief Strategy Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	Keith Willett (Chair) welcomed everyone to the meeting. Apologies were noted as above.

1.2	The Chair informed explained that the organisation being a public body and an NHS Trust was constrained by pre-election rules, termed purdah which commenced on 25 May 2024. The Board were advised that a decision on the Trust's approach to engaging with members of political parties during the election period.
1.3	The Board discussed Fit for the Future programme agenda item in light of purdah and agreed that this item was not impacted by purdah because the item was an update on operational progress and discussion will be restricted to cover this area only.
2	**Declarations of Interests**
2.1	There were no new declarations of interests at this meeting.
3	**Minutes from the meeting held on 28 March 2024**
3.1	The minutes were agreed as an accurate record of the meeting, subject to the following: • Item 10.2, 2nd sentence to be changed to "Helen Young explained that there is ongoing end mapping of each process to identify safeguarding risks with oversight by the Task and Finish Group. DocWorks have also taken over posting safeguarding incidents to ensure effective safeguarding referrals. • Nigel Chapman to be added to the attendance list • Mike Ainsworth to be corrected to Mark Ainsworth
4	**Matters Arising and Action Log**
4.1	The action log was reviewed, and the following action was agreed to be closed: • Action 3 (30/11/23) – EDI Board Seminar session to be arranged to identify the metrics that are specific to SCAS and develop a health and inequality statement that is relevant to the organisation. • Action 2 (28/03/24) - To review risks/prioritisation of dropping safeguarding training check for honorary contracts. The Board noted that checks are carried out to ensure that statutory and mandatory training are carried, these checks are confirmed with the host organisation with evidence of completion provided. There are also audits at recruitment to ensure that trainings are completed. The Board were also assured that bank and agency staff are not given shift work without evidence of statutory and mandatory training. • Action 5 (28/03/24): Risk review and mitigation for transition to PSIRF was requested by the Board. The Board noted that the PSIRF policy and Implementation plan were approved by the Quality and Safety Committee and the ICS. The Trust has also transitioned from serious incidents to PSIRF. • Action 6 (28/03/24): Report to Board activity in alternative pathways as identified by SCAS Connect. • Action 8 (28/03/24): Lost hours due to vehicles off the road to be added to the operations report. The Board noted that there is a reporting system in place and agreed to close the action.
5	**Chairs Report**
5.1	The Chair summarised the upcoming elections and the need for the Board to agree the Trust's approach to political parties.
5.2	The Chair noted that there continued to be pressure and increasing demand on services resulting in fluctuations in performance.

5.3	The Board were informed that there have been conversations regarding the NHS Oversight Framework and the Recovery Support Programme between the Trust and NHS England National Team which will be covered in detail in the Chief Executive Officer's report.
5.4	The Board was asked to note the Chair's site visits and stakeholder engagements detailed in his written report.
5.5	The Board **noted** the Chairs Report.
6	**Chief Executive Officer's Report**
6.1	David Eltringham presented key highlights from his Chief Executive Officer's report and asked the Board to note content of the report.
6.2	Nigel Chapman commented on the duty of candour in relation to the blood inquiry report and stated that the Trust is light on the duty of candour and resourcing of the Trust's Freedom to Speak Up, furthermore, there were leadership issues around freedom to speak up and sought assurance that the Trust had the right level of leadership in place. It was noted that there will be no reduction to the Freedom to Speak up team, recruitment to backfill the vacant post is in progress. Ian Green informed the Board that this issue and risk was discussed at the People and Culture Committee and the Committee was comfortable with the level of assurance provided around resourcing of the Freedom to Speak up team. Helen Young summarised the Trust's Duty of Candour arrangements and professional engagement with families of patients.
6.3	Nigel Chapman referred to resource allocation withing the national UEC plan and inquired about the impact rostering systems in addressing the Trust's long term issues. In response, Mark Ainsworth summarised actions in place for rostering. **Action: The Board noted actions in place for rostering systems and requested that a report on impact, effectiveness and efficiencies is reported to the Finance and Performance Committee in a few months**.
6.4	**The Board noted the Chief Executive Officer Report.**
7	**Executive Management Committee Terms of Reference**
7.1	The Board received the Executive Management Committee Terms of Reference for approval.
7.2	Dhammika Perera advised that paragraphs 4.1.1 and 4.1.12 should include accountability of the Committee.
7.3	Sumit Biswas reiterated the request from Non-Executive Directors that decisions made by this Committee is given high visibility at Board level. The summary notes circulated by the Chief of Staff was welcomed and it was agreed that this will continue to be circulated after each Committee meeting.
7.4	Ian Green suggested that an upward report from the Executive Management Committee should be reported to the Board to align with other Committees of the Board. It was noted that items discussed at the Executive Management Committee go through various Committees of the Board and reported to the Board via assurance upward reports. Consideration was given to whether the summary notes circulated to Non-Executive Directors should form the basis of an upward report to the Board.
7.5	The Chair advised that paragraph 4.1.12 should be given primacy in terms of order as it relates to the Trust values, staff and patients.

7.6	Craig Ellis noted that the Director of Communications appeared twice within the membership of the Committee.
7.7	**The Board Approved the Executive Committee Terms of Reference**.
8	**Update to the Public Board on the previous Private Board meeting held on 28 March, 26 April and 1 May 2024**
8.1	The Board **noted** the update to the Public Board on the previous Private Board meeting held on 28 March, 26 April and 1 May 2024.
9	**Patient Story**
9.1	The Board received a patient story, presented by Emma Hunt, the sister in law of the patient and Paramedic for SCAS. She told the story of her sister-in-law's interactions with SCAS before she very sadly died. The Board noted that significant learning came out of this sad case and in summary included new work on reviewing the current Falls training package to give crews clearer indication about red flags for all patients, not just those over 65 years old; work on improving Falls guidance across SCAS and revised Sudden Death Policy (not strictly linked to this case but this is relevant).
9.2	Ian Green asked whether proactive feedback are given to the ambulance crews in such instances and further inquired about the Trust's approach to responding. It was noted that real time feedback and educative learnings are provided. Crew members are also supported in open and transparent ways to understand where there are faults in areas of mis practice. Mark Ainsworth-Smith, Consultant Practitioner summarised the Trust's approach including bespoke training for student paramedics and changes made to the Trust's policies.
9.3	Les Broude asked how the fundamental issues would have been picked up if Emma Hunt was not a SCAS paramedic. Mark Ainsworth-Smith explained that he compiled a list of top 22 conditions with recommended observations to be done on patients, the Trust now have a matrix in place used by majority of staff. He admitted that some cases will fall under the radar if not raised. He further explained that there is a robust system and review process in place when issues are raised. Helen Young added that daily risk assessments are carried out and a random audit process is utilised which selects a number of cases which are then checked against Trust policies. Les Broude queried why the matrix was not being used by all staff. Mark Ainsworth-Smith explained that these tend to be used by junior staff, it was noted that the more senior staff are clinicians and are autonomous practitioners who will use guidelines only if they choose to. He explained that they are experienced and capable individuals.
9.4	The Board thanked Emma Hunt for her courageousness in sharing her sister in law's story and Mark Ainsworth-Smith for his contribution to the Board discussion.
9.5	**The Board noted the Patient Story**.
10	**Integrated Performance Report (IPR)**
10.1	Stuart Rees provided the overview of the IPR. The Board was asked to note the error on vehicles off the road, this was 36% not 0.36% vehicles are off the road. the Integrated Performance Report.
10.2	**Finance** The Board noted that the Trust's financial position at month 1 (April) was £1.9 million deficit which is £0.7 million adverse to plan. The Trust has a financial plan for 202425 year of £11.2 million. The Trust's Financial Recovery Plan includes a net savings target of £27.7 million.

10.3	**Operational Performance** Mark Ainsworth summarised operational performance for April. The Board were informed that there is an ongoing pilot "drop and go" for patients who are unable to get themselves to hospital for Emergency Department attention at the Queen Alexandra Hospital, Portsmouth University NHS Trust and Milton Keynes University Hospital with good impact and significant savings achieved particularly at the Queen Alexandra Hospital. These pilot has now been rolled out in all provider hospitals.
10.4	The Board received a verbal update on May performance which showed deterioration at the start of the month with 1000 hours lost due to handover delays.
10.5	In response to Ian Green's query about how April performance can be sustained, Mark Ainsworth explained that that operational hours in the operating plan needs to be delivered. He highlighted that the Trust was short of operational hours including private provider and SCAS hours in May. Mark Ainsworth summarised that a balance is required around these factors to sustain improved performance i.e. hours need to get back to plan and handover delays mitigated. Ian Green also expressed concern about the issue of vehicles off the road and enquired whether further to the deep dive by the Finance and Performance Committee there were actions in place to overcome this challenge. Stuart Rees reported that the new fleet were delayed due to mechanical issues with the new fleet, this issue has now been resolved and vehicles fit for purpose with delivery scheduled to commence weekly in June and next delivery in December. This will ease the pressure and allow the older fleet undergo maintenance.
10.6	Further to Nigel Chapman's comment on mitigating the issue of private provider hours and additional measures to ensure that contractual obligations are met, Mark Ainsworth explained that some contracts are now finalised and penalties for failure to deliver full hours are included in the contracts with additional penalty to reduce or re-tender the hours.
10.7	Sumit Biswas noted that a member of staff circulated an email around challenges with vehicles and sought assurance that communication was issued to staff with detailed plans. Mark Ainsworth confirmed reasons for the delay and refreshed timelines were issued to staff with relevant information on the Trust Hub. Gillian Hodgetts also confirmed that there were webinars on this with opportunities for Q&As. Sumit Biswas also sought clarity on 111 call back target and inquired whether the Trust was delivering the 111 model set out by the Trust. Mark Ainsworth explained that the 95% target is a national target and providers are failing to achieve this target. He described the benchmarking target and how the trust clinicians are utilised to be able to deliver the target. The Board noted that the Trust is in the process of increasing clinicians. Sumit Biswas sought clarity on the issue of cultural response impacting decision making. Mark Ainsworth explained that this issue relates to failure of some staff in using the SCAS connect, particularly staff who have been with SCAS for longer period . There is targeted work to ensure that staff use SCAS connect every time they are with patients to be able to triangulate data to the urgent care response team.
10.8	Dhammika Perera inquired whether the discrepancy in data reporting from the BI system and other areas have now been resolved. Helen Young provided clarity on this issue and explained that the discrepancy relates to the safeguarding training (95% target) data reported in the current IPR which the Trust was transitioning from, and the data agreed with the Commissioners (90% target), and this was yet to reflect on the BI system.
10.9	Les Broude queried why the drop and go pilot did not deliver benefits in May. Mark Ainsworth responded that the highest benefit was delivered in Q1 particularly at the Queen Alexandra Hospital however there was an overall deterioration in May.

10.10	**Quality and Patient Safety** Helen Young provided key highlights within the Integrated Performance Report. The Board noted that in the reporting period, the Trust transitioned to PSIRF on 22 April with three Serious Incidents (SIs) declared within the month, there will be dual reporting until the SIs are closed.
10.11	Helen Young reported limited assurance in the following areas: • Themes from incident reporting (serious incidents and safety incidents) mainly attendance delays caused by both internal (meal break and shift policies, roster reviews and workforce plan) and system wide issues. Helen Young summarised mitigations in place to address internal issues. • The Trust achieved 87% against the 90% set against level 3 Safeguarding training compliance. Additional training sessions will be organised to close the gap. • Quality Assurance Framework pertaining to safeguarding application. Whilst significant progress has been made with areas hosted by DocWorks there are still interface issues with the application to address. This issue is being managed by the Task and Finish Group and monitored by the Executive Management Committee. • Infection Prevention Control: The Board were informed that there are concerns around inadequate auditing of operational vehicles from an IPC perspective, this is due to the demand on the vehicles preventing deep cleaning of vehicles.
10.12	The Board were informed that the Trust declared a Never Event due to administration of intravenous medicine in the wrong route.
10.13	The Chair provided feedback from his site visits that crew members spoke to him about cancellation of previously approved overtime options and queried whether this was due to availability of vehicles. In response, Mark Ainsworth explained that previously approved overtime options were being cancelled to allow the vehicles undergo maintenance.
10.14	Further to Nigel Chapman's query on the differences between reporting serious incidents previously and under the new framework, Helen Young summarised the differences and noted that in relation to the serious incident framework, there is a set of criteria against which we judge whether the incident met the criteria for declaration and level of harm attributed to that incident, in PSIRF this is about proportionality which is considered by a Safety Review Panel and actions undertaken would therefore not necessitate the launch of a full scale investigation. Nigel Chapman pointed out the risk of reducing public transparency under PSIRF. Helen Young stated that this risk is mitigated by the learning from experience report. Mike McEnaney noted that lack of clarity in the differences have been highlighted at some Trust Boards, his concern was the Board losing sight of number of incidents as they occur. Helen Young assured that KPIs will be visible to the Quality and Safety Committee to mitigate this risk.
10.15	**Workforce** The Board received the workforce section of the IPR. Sumit Biswas noted that the metrics were being reviewed and asked whether the scope of the review included targets. He had previously raised a query whether one of the targets was fit for purpose. Stuart Rees assured the Board that the review would cover SCAS internal metrics and targets alongside national targets.
10.16	The Board **noted** the Integrated Performance Report.
11	**Quality and Patient Safety Report** The Board received the Quality and Safety Report.
11.1	The Board discussed the confirmation from BMLK ICB that mental health response vehicles will not be funded and noted that confirmation from BOB ICB was still awaited. The Board

	discussed this, and the Chair agreed to raise this issue with Chair colleagues of BMLK and BOB ICBs. David Eltringham informed the Board that this linked in with his action to follow up with the Chief Executive of BOB ICB. The Board agreed to take a firm stand and request justification for the decision by BMLK ICB not to provide funding.
11.2	Dhammika Perera inquired about plans for the Board and all staff in regard to CQC inspection preparedness i.e. shared message around progress and improvements since the last inspection. The Board discussed this and agreed that improvements and progress are cascaded to all staff. Helen Young summarised ongoing work on CQC preparedness and assured that the Executive Management Committee has oversight of this piece of work.
11.3	The Board **noted** the Quality and Patient Safety Report.
12	**Medical Director's Report**
12.1	The Chair noted that mental health was not listed under alternative pathways. He questioned what the next steps were now that data is now available on SCAS connect and advised that the Executive Management Committee consider how to use this data for patient benefit, influence commissioning and wider system response. John Black advised that the SCAS connect dashboard is shared with ICB Chief Medical Officers, this also used to drive conversations with individual acute providers about existing pathways.
12.2	The Board noted that SCAS national clinical performance for December 2023 benchmarked well in comparison to England's other Regional Ambulance Services. The Board congratulated John Black and his team for this achievement.
12.3	**The Board noted the Medical Director's Report.**
13	**Fit for the Future – Operations Modernisation Programme**
13.1	The Board received the Fit for the Future – Operations Modernisation Programme report. Paul Kempster reported that the proof of concept piece of work continued together with communication and engagement across the organisation. The Chair confirmed attendance of the last programme webinar and congratulated Paul Kempster and his team for a successful and well organised event.
13.2	**The Board noted the programme update.**
14	**Quality and Safety Committee Terms of Reference**
14.1	The Board received the Quality and Safety Committee Terms of Reference for approval. Helen Young informed the Board that the responsibility for Health and Safety had moved from the Committee. She assured that the Committee will continue to have oversight of health and safety from a quality perspective and there is a shared responsibility between the People and Culture Committee and the Risk Assurance and Compliance sub-committee (reporting into the Executive Management Committee) for the health and safety of staff.
14.2	Mark Ainsworth noted that Chief Operating Officer in the attendee list should be amended to Executive Director of Operations.
14.3	The Chair noted that there was provisions for the Chair to attend Committee meetings once a year however he has been attending meetings from time to time, he requested to be included in Board Committee circulation list. **Action: Governance Team to ensure that the Trust Chair is included in Board Committees circulation list**.

14.4	**The Board approved the Quality and Safety Committee Terms of Reference**.
15	**Assurance Report** **Quality and Safety Committee 22 May 2024**
15.1	**The Board noted the Quality and Safety Committee Assurance Report.**
16	**Finance Update- Month 1**
16.1	The Board received the month 1 report and noted that the financial environment remained extremely challenging and therefore plans were yet to be finalised. The Hampshire and Isle of Wight system had recently established its control total and system partners are current working through the component elements. Currently, this will require the Trust to improve its efficiencies/savings by a range of £0.4m to £1.1m in-year.
16.2	Mike McEnaney sought assurance on controls in place to monitor PTS provider expenditure. Les Broude informed the Board that concerns were raised by the Finance and Performance Committee. It was the responsibility of the Financial Recovery Group (FRG) to have oversight of expenditure. Les Broude highlighted that the expectation was for the Finance and Performance Committee to monitor PTS expenditure and other areas drifting off plan monthly, currently oversight was still on FRG level. Stuart Rees explained the process put in place which included daily monitoring updates by Executives, weekly reports to the FRG as part of the grip and control measures. David Eltringham summarized additional measures in place to address issues identified from the PTS challenges, this included a reset of the FRG and a review of the governance channels.
16.3	**The Board noted the Finance Month 1 Update**.
17	**Finance and Performance Committee Terms of Reference**
17.1	**The Board approved the Finance and Performance Committee Terms of Reference.**
18	**Assurance Report** Finance and Performance Assurance Committee 22 May 2024.
18.1	Les Broude informed the Board that the feedback from the Committee was that business approvals presented to the Committee still lacked robustness in helping the Committee make required decisions. The Committee have concerns over the Financial Recovery Group and responsibilities of Executive Director colleagues on savings and performance improvements.
18.2	The Board discussed the issues of the timeliness and quality of business cases. Stuart Rees explained that the backlog will even out in a few months and the robust process will be become evident. Craig Ellis noted that there are tight procurement timeline in place which needs to be reviewed. David Eltringham highlighted that the Trust currently has in place cumbersome processes for business case approvals which have caused significant delays. He assured the Board that a simplified planning and governance process was being developed by Caroline Morris.
18.3	**The Board noted the Finance and Performance Assurance Committee Report.**
19	**Annual Report of the Charitable Funds Committee**

19.1	Nigel Chapman presented the report. He informed the Board that there was an error with the agenda item, the report to the Board relates to the annual report of the Charitable Funds Committee and not the annual report and year-end financial position of SCAS Charity.
19.2	The Board was asked to note the verbal amendment to the agenda item.
19.3	**The Board noted the Annual Report of the Charitable Funds Committee.**
20	**Charitable Funds Committee Terms of Reference**
20.1	**The Board approved the Charitable Funds Committee Terms of Reference.**
21	**Assurance Report** Charitable Funds Committee, 12 April 2024
21.1	Nigel Chapman summarised items considered at the meeting held on 12 April 2024. The Board were informed that Craig Ellis agreed to be a regular attendee of the Committee due to the increasing digital work being undertaken by the Charity.
21.2	**The Board noted the Charitable Funds Committee assurance report.**
22	**Audit Committee Terms of Reference**
22.1	The Board discussed attendance of the Chair and it was agreed that attendance was required at least once a year and for this to be reflected in the terms of reference.
22.2	**The Board approved the Audit Committee Terms of Reference.**
23	**Questions submitted by Board Members on "For Noting" agenda items:8, 12, 16, 19 & 22** No questions received.
24	**People and Culture Committee Terms of Reference**
24.1	Natasha Dymond advised that the sub-committee Joint National Consultative Committee should read Joint Negotiation and Consultative Committee within the committee structure.
24.2	Mike McEnaney raised concerns that there was no reference to Health and Safety and there is a risk that oversight will be lost. He advised that oversight should sit with People and Culture Committee on the basis that it relates to staff and employment and not patients. Mike McEnaney also pointed out that there was no mention of a health and safety sub-committee and requested that the health and safety management structure and monitoring should be evidenced. David Eltringham confirmed that there is a Health and Safety Group in compliance with Health and Safety legislation. **Action: Executive Management Group to plot Health and Safety line of sight and advise the Board**.
24.3	Les Broude raised a query on quorum stated in paragraph 5.2 and there was a discussion whether any other Executive Director instead of a deputy should count towards quorum. **Action: The Head of Governance was asked to check whether there is consistency across all terms of reference on quorum.**
24.4	**The Board approved the People and Culture Committee Terms of Reference subject to the above actions**.

25	**Remuneration Committee Terms of Reference**
25.1	Sumit Biswas described the purpose of the Committee and additional areas added to the terms of reference including the annual invitation extended to all Non-Executive Directors to the Committee meeting and visibility of Committee business to Non-Executive Directors.
25.2	**The Board approved the Remuneration Committee Terms of Reference subject to adding Very Senior Managers (VSM) to paragraph 2.1 and Foundation to paragraph 1.1.**
26	**Assurance Report** People and Culture Committee 16 May 2024
26.1	Ian Green presented the assurance report and informed the Board that the Committee had an informative deep dive into the Personal Development Review (PDR) including actions to drive improvements.
26.2	The Committee also considered the ongoing corporate review and queried the governance and line of sight.
26.3	**The Board noted the People and Culture Committee Assurance Report.**
27	**Communications Update**
27.1	**The Board noted the Communications Update.**
28	**Questions submitted by Board Members on agenda items 24, 27 & 28** No questions received.
29	**Board Assurance Framework**
29.1	The Board received the closing position for 2023/24 and noted that there is an ongoing refresh for the current financial year. A Board workshop session was held in April to ensure that the BAF aligns with the annual plan and strategic objectives. Output from the workshop is now with the Executive Team for finalisation and will then go through the governance channel i.e. Executive Management Team and Board for approval.
29.2	**The Board noted the Board Assurance Framework Update.**
30	**Self-Certification – Licence Conditions**
30.1	Kofo Abayomi presented the self-certification, licence conditions to the Board for approval.
30.2	Mike McEnaney pointed out that condition 7 – Availability of Resources was not completed out and advised that based on the discussion around the Trust financial position, section 3b should be completed and an agreed narrative added to the statement section.
30.3	**Action: The Board delegated approval of the narrative of condition 7 – G6 (Systems for compliance with License Conditions and related obligations) to the Chair of the Finance and Performance Committee. Interim Director of Finance to provide narrative.**
30.4	**The Board approved the Self-Certification – License Conditions subject to the above action**.

31	**Improvement Programme Oversight Board Update 10 January 2024** Caroline Morris
31.1	**The Board noted the Improvement Programme Oversight Board Update - 1 May 2024.**
32	**Any Other Business**
32.1	**SCAS approach to Political Parties during election period** Further to the Chair's introductory briefing on this matter, the Board discussed the approach and agreed that the Trust's focus remained SCAS patients and that the Trust will not engage with political parties during the election period. It was agreed that this information will be cascaded to all staff through the Communications and Engagement Team.
33	**Questions from observers** There were no questions from observers at this meeting.
34	**Non-Executive Director Review of the meeting** Les Broude reflected that: • Board papers were issued at the appropriate time with only one version circulated • Robust and clear discussion on finance, patient safety and performance • Executive to Executive and Executive to NED challenge still lacking **Executive Director Review of the meeting:** John Black reflected that: • Thanked the governance team for their work coordinating the board meeting • Challenging still lacking • Good progress made with discussion, but this was still focussed on operations • Good venue and location
35	**Date, Time and Venue of Next Meeting in Public** Thursday 25 July 2024 - Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN.

Board Meeting in Public 27 July 2024

Key for Status

	Open		Propose to Close

Action No.	Date of Meeting	Agenda Item & No.	Detail of Action	Action Owner	Due Date	Status	Progress Update
6	30/05/24	6. Chief Executive Officer Report	The Board noted actions in place for rostering systems and requested that a report on impact, effectiveness and efficiencies is reported to the Finance and Performance Committee in a few months	Executive Director of Operations	July 24	Propose to Close	The agreed review timeframe for the assessment of the new rotas is 6 months after implementation. Update on Hampshire is scheduled for Finance and Performance Committee in December and update for the North is scheduled for March 2025. This will be added to the Finance and Performance Forward Planner.
7	30/05/24	14. Quality and Safety Committee Terms of Reference	Governance Team to ensure that the Trust Chair is included in Board Committees circulation list.	Head of Corporate Governance	July 24	Propose to Close	Actioned. Trust Chair now receiving Board Committee papers.
8	30/05/24	18. People and Culture Committee Terms of Reference	Executive Management Committee to plot Health and Safety line of sight and advise the Board.	Chief Governance Officer/EMC	September 24	Open	Interim Chief Governance Officer now in post and will be reviewing the Governance Structure.

9	30/05/24	18. People and Culture Committee Terms of Reference	The Head of Governance was asked to check whether there is consistency across all terms of reference on quorum.	Head of Corporate Governance	July 24	Propose to Close	Consistency confirmed.
10	30/05/24	30. Self-Certification – Licence Conditions	The Board delegated approval of the narrative of condition 7 – G6 (Systems for compliance with License Conditions and related obligations) to the Chair of the Finance and Performance Committee. Interim Director of Finance to provide narrative.	Interim Director of Finance	July 24	Propose to Close	Action Completed. Narrative provided by Interim Finance Director and confirmation of Finance and Performance Committee Chair provided in email dated 31 May 2024.
1	28/03/24	8	To review 'disability adjustments' process to allow more local discretion by the Executive Management Committee and outcomes reported to Board.	Chief People Officer	July 24	Propose to Close	27 July meeting update Disability and Neurodiversity Policy was approved by the People and Culture Committee. In addition, the People Redeployment Guidance and Procedure covers reasonable adjustments and has been drafted by HR and EDI and will be considered at the August meeting of the People Policy Review Group. 30 May meeting update The Board noted that significant amount of work has been done to review disability adjustments. There is a draft guidance document relating to disability and neurodiversity awaiting approval through the Trust governance channels. Further updates will be provided to the Board.

3	28/03/24	10	Further to discussions, it was agreed that David Eltringham will speak to BOB ICB Chief Executive about the provision of mental health vehicles in the North for resolution	Chief Executive Officer	July 24	Propose to Close	27 July meeting update This matter has been raised with commissioners and is the subject of ongoing commissioning discussions. 30 May meeting update Action reworded and relates to the north. Agreed that this will be kept open until Chief Executive has an update on the resolution of the action. David Eltringham has discussed the action with Nick Broughton, who agreed to review the situation. This action was followed up on 22 May with a response that this is still being followed up and a definitive answer will be provided.
4	28/03/24	10	QI programme Methodology to be reported to Board for understanding the implementation.	Transformation Programme Director / Chief Nurse	July 24	Open	27 July meeting update Verbal update to be provided at meeting. 30 May meeting Update Mike Murphy has taken over executive ownership of the QI methodology piece of work. Date of the Board Seminar to be agreed with the Governance Team.
7	28/03/24	12	Annual Assurance of SCAS EPRR functions to be presented to the Board.	Executive Director of Operations	August 24	Open	28 July 2024 Report scheduled for August Trust Board meeting.

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Report Cover Sheet

Report Title:	Chair's Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	5
Executive Summary:	The purpose of the Chair's report is to keep the Board updated of stakeholder engagement and site visits since the Board held in May 2024.
Recommendations:	The Trust Board is asked to note the report.
Accountable Director:	Not Applicable
Author:	Keith Willett, Chair
Previously considered at:	Not applicable
Purpose of Report:	The Board is asked to note the stakeholder engagements and site visits update.
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Not applicable

List of Appendices	Not applicable

Meeting Report

Name of Meeting	Board of Directors in Public Meeting
Title	Chair's update
Authors	
Accountable Director	Keith Willett, Chair
Date	25th July 2024

1. Purpose

The purpose of this Chair Report is to inform the Board of stakeholder engagement and site visits since the Board held in May 2024.

Since the last Public Board meeting, I have undertaken the following visits and stakeholder meetings:

June 2024

- Southern Ambulance Services Collaborative (SASC) Workshop
- BLMK Research and Innovation Network Meeting
- All SCAS Webinar
- RAuxAF 100 / D Day 80 Commemorative Event
- Leadership visit to Oxford City
- ICS Monthly Chairs Meeting
- GGI Meeting
- Capability Demonstration Event, RAF Brize Norton
- SCAS Nomination Committee

July 2024

- SASC Chairs meeting
- SCAS Leader Webinar
- FTSU Keep In Touch meeting
- Ambulance Report Review meeting
- SCAS/SECAMB Chairs and CEOs catch-up
- SCAS HWBE Forum Group
- Leadership visit to Bicester 111 CCC
- AACE Board
- AACE Chairs

Other

- Monthly: SE Senior Leaders Briefings (Anne Eden)
- Lead Governor meetings
- NED 1:1 meetings

Recommendation

The Board is invited to **note this report.**

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Report Cover Sheet

Report Title:	CEO Briefing
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	6
Executive Summary:	The CEO Report includes the following: • A tribute to colleagues. • Operational challenges and staff recognition. • Southern Ambulance Service Collaboration (SASC) launch and progress. • Government changes and the Urgent and Emergency Care (UEC) review. • COVID-19 Enquiry. • Importance of system working and HIOW collaboration. • Recovery Support Programme (RSP) update.
Recommendations:	The Trust Board is asked to: Note
Accountable Director:	David Eltringham – Chief Executive Officer
Author:	David Eltringham – Chief Executive Officer
Previously considered at:	N/A
Purpose of Report:	Note
Paper Status:	Public

Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	Not Applicable
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Not Applicable
List of Appendices	Not Applicable

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Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Chief Executive Officer's Update
Author	David Eltringham, Chief Executive Officer
Accountable Director	David Eltringham, Chief Executive Officer
Date	25/07/2024

1. Purpose

The purpose of this CEO Report is to keep the Board abreast of key issues and developments since its last meeting in public held in May 2024.

2. Background and links to previous papers

This update is based on information relating to May to July 2024.

3. Executive summary

This report provides an update on key areas at SCAS, including:

- A tribute to colleagues.
- Operational challenges and staff recognition.
- Southern Ambulance Service Collaboration (SASC) launch and progress.
- Government changes and the Urgent and Emergency Care (UEC) review.
- COVID-19 Enquiry.
- Importance of system working and HIOW collaboration.
- Recovery Support Programme (RSP) update.

A tribute

Firstly, it is with deep sadness that I take this opportunity and acknowledge the recent passing of three of our colleagues: Karen Hardie, Kieran Short, and Chris Pothecary.

Their dedication over the years to the NHS and being part of the SCAS family will be deeply missed. Our thoughts and condolences remain with their families during this difficult time. We offer our sincere gratitude for their service to SCAS and the communities we serve. Loosing colleagues will bring different levels of emotions, and we have encouraged anyone who requires support to reach out through the various options we have to support staff wellbeing.

Operational challenges and staff recognition

As you know, we continue to face significant operational pressures. Balancing quality and safety with performance targets, staff wellbeing, and financial constraints remains a constant focus. It's a complex ask, and I want to express my sincere gratitude to each member of the SCAS team for their dedication and commitment. Their unwavering service ensures we continue to deliver high quality care to our patients.

I’m pleased to report, following months of delays, the new batch of double crewed ambulances have started to arrive with the first few out on shifts. This is an excellent milestone following months of delays which have been outside of our control. These new ambulances will increase our total fleet numbers. While it will take time to receive the full order, we should start seeing improvements in our fleet numbers week on week.

Southern Ambulance Service Collaboration launch, conference, and projects

The collaboration launched in May, with five ambulance services joining forces in a collaboration with the aim to improve patient care and service delivery across the south of England. Following the launch, the first collaborative workshop was held on the 7 June and hosted by SCAS in Reading. This day saw approximately 90 senior members from all five organisations come together face to face.

The morning session was an introduction to the collaboration and the potential benefits of working together with a question and answer session lead by myself and the other trust's CEO's, followed by a talk from Sir Julian Hartly, CEO at NHS Providers.

In the afternoon attendees worked in breakout groups to discuss:

- HR services
- Fleet and Procurement
- CAD & Triage
- Digital & AI
- Clinical Operating Model

I'm pleased to share I have taken the CEO lead within the fleet and procurement group. We had a positive session at the workshop on potential ideas for the scope of work and the benefit we could create by working together in this space.

Activity has been ongoing since the workshop around reviewing the discussions held in all five groups and developing the year one manifesto, which will be published in due course. The launch, the workshop, and the ongoing projects, represent positive progress for the collaboration. This initiative holds promise for improving several factors, both within SCAS and for patients across the south of England.

New Government and Urgent and Emergency Care review

The recent change in government will likely bring a new agenda and potentially new priorities. We'll continue to closely monitor developments, particularly those related to the upcoming Urgent and Emergency Care (UEC) review. We will continue to focus on quality and safety, operational delivery and our current finance plans as the government sets out its policies.

COVID-19 Inquiry

The UK Covid-19 Inquiry continues to progress through to module three, which relates to the impact on the healthcare systems throughout the UK. As part of the inquiry, I had to submit evidence on behalf of SCAS. I have received notification that

the inquiry will not be calling myself to give evidence in person at the hearing. We will continue to watch with interest and produce actions from any lessons identified as the inquiry progresses.

Importance of system working and HIOW collaboration

For the UEC review, and beyond, a strong, collaborative approach across the entire healthcare system is crucial. I continue to actively work with Hampshire and Isle of Wight ICS (HIOW) to ensure SCAS plays a key role in the future of UEC services. Having a system-wide view on UEC across 111, community, 999 A&E, and patient transport services is crucial to ensure the patient pathways are aligned and operating smoothly in order for the system as a whole to deliver high quality patient care, enhance efficiency and reduce unnecessary wastage, alongside supporting staff wellbeing.

Recovery support programme letter and exit criteria review

Finally, I'm pleased to report that at the private board in June we received the latest letter in respect of our recovery support programme. We're currently participating in the review of exit criteria and timelines. I will keep the Board updated on further developments.

Thank you,

David Eltringham

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Report Cover Sheet

Report Title:	Update to the Public Board on the previous Private Board meeting held on 27 June 2024
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	7
Executive Summary:	The report details agenda items that were received by the Private Trust Board, decisions made, and items noted at the meetings held on 27 June 2024.
Recommendations:	The Board is asked to note the update.
Accountable Director:	David Eltringham, Chief Executive Officer
Author:	Kofo Abayomi, Head of Corporate Governance
Previously considered at:	n/a
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Not applicable
List of Appendices	Not applicable

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Update to the Public Board on the previous Private Board meeting held on 27 June 2024
Author	Kofo Abayomi, Head of Corporate Governance and Compliance
Accountable Director	David Eltringham, Chief Executive Officer
Date	25 July 2024

Private Trust Board 27 June 2024

Confidential Report from the Chief Executive Officer & Recovery Support Programme (RSP) Review meeting: South Central Ambulance Service NHS Foundation Trust (SCAS)

The Board received an update from the Chief Executive Officer and Recovery Support Programme (RSP) review meeting with SCAS.

Integrated Performance Report

The Board received the Integrated Performance Report (IPR).

Fit for the Future – Operations Modernisation

The Board received the Fit for the Future – Operations Modernisation update.

Improvement Programme Oversight Board Update

The Board received the Improvement Programme Oversight Board update.

Quality Priorities

The Board received and approved the Trust Quality Priorities and noted an update on the Quality Accounts as part of the discussion.

Finance Month Update 2

The Board received the Month 2 report.

SCAS Non-Emergency Patient Transport Services (NEPTS) Contracts: Hampshire and Isle of Wight ICB (HIOW) 2024 / 26 Lot 1 Call Handling, Co-ordination & Management Service and Lot 2 NEPTS Contracts (Direct Award)

The Board approved the direct award.

SCAS - HSH IUC Variations to ongoing contract for 24 / 25 and final funding for Paediatrics Desk 23 / 24

The Board approved the contract variation.

Annual Report and Accounts

The Board approved the Annual Report and Accounts for year ended 31 March 2024 subject to their being no significant aspects in the areas still to be finalised.

999 CAD Replacement Project – Tender Update & Options Paper

The Board received an update on the tender and approved the preferred option proposed to the Board.

Digital Business Case Approvals

The Board approved the following digital business cases:

a) Hexagon CAD Contract Addendum Renewal
b) Annual Microsoft Server Licensing
c) WAN/LAN Contract Renewal
d) Telephony Circuits – funding and contractual options

Chief Digital Officer Report & NIS Information Request Notification

The Board received the Chief Digital Officer report and noted the update on the NIS information request notification.

Board Assurance Framework 2024/25

The Board approved the Board Assurance Framework 2024/25.

Legal claims and Inquest 6 Months Update

The Board received a 6 month update on the Trust's legal claims and Inquest.

Board Site Visits 2024-25

The Board **noted** the Board (Executive and Non-Executive Director) Site Visits 2024-25.

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Report Cover Sheet

Report Title:	Staff Story
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	8
Executive Summary:	The Story outlines the positive experience of Roy Wilshere, a member of staff who shares his good news story on becoming a SCAS employee and joining the NHS. The story also highlights the importance of treating people with compassion, as individuals and doing the right thing for them.
Recommendations:	The Trust Board is asked to: Note
Accountable Director:	Melanie Saunders, Chief People Officer
Author:	Jacqueline Thomas, Senior Operations Manager - Sussex Patient Transport Service
Previously considered at:	N/A
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** • **Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	N/A
Strategic Objective(s):	People & Organisational

Links to BAF Risks or Significant Risk Register:	SR7 - Staff Feeling Unsafe, Undervalued and Unsupported
Quality Domain(s)	Not applicable
Next Steps:	N/A
List of Appendices	N/A

Roy's story – A TUPE experience from the NHS to a Private Provider Company

I worked for years in South East Coast Ambulance Service NHS Foundation Trust, starting my career in 2002 and was proud of the working for the NHS and my Organisation.

Sadly in 2016, when the NEPTS Sussex contract went out to tender, SECAMB lost the contract and we found ourselves in the worrying and confusing situation of facing a TUPE.

It was a stressful time, my colleagues and I were sad, anxious, and very concerned for our futures. Many staff left.

During the TUPE process, the incoming Private Provider company were not forthcoming, they hardly engaged with us, so the fear of the unknown became worse as time went on.

The time came for us to be transferred out of the NHS and into a private company, we said our goodbyes to working for the NHS, to our organisation who we had served and had been dedicated to for so long, we said goodbye to the way things were, to our remaining friends and Paramedic colleagues that we had worked alongside and shared a base station with.

We found ourselves plunged in another world, with no processes or policies in place, the framework of all we had known had vanished. Our uniform was poor, vehicles inferior and were in a shocking state, some were untaxed, broken seats, cracked windows, mould growing on the interior surfaces.

There was no HR support, Health and Well-being Team or any other NHS networks that we had previously know which had been of huge support and re-assurance to all employees.

Working for VM Langfords was hard, it was depressing and demoralising, in all honesty, I felt compelled to carry on because of the love that I have for serving the community and providing our patients with the best quality care. I felt constantly torn, my emotions trying to figure out how this could have happened, how was it possible to be working in such an unprofessional way.

All my colleagues who had previously worked for the NHS felt as though they did not want to abandon their patients and diligently carried on providing a service despite the appalling conditions, we had to work in.

In October 2016, my life was to about to take another turn, when I had discovered a lump and went for tests. When I was told it was cancer, my whole life was catapulted into the unknown, myself and family fearful and devastated.

I was unable to work and had to book absent, prior to this my attendance record was excellent. The Private Provider company did not acknowledge me, nor provide any welfare or support, I felt abandoned and lonely, scared because I had to pay my mortgage and provide security for my wife and son. Not knowing if the company would sack me.

My fellow colleagues were kind and caring, and really it was their care that made a palpable difference. I realise that these NHS core values were still intact with my colleagues, and this was demonstrated, it was in their fabric, they had worked with these ethics for many years within SECAMB, it was never lost.

However, the Private Provider management team did not have the same set of ethics or core values, I felt like a number and not a person.

During these months my health declined, the cancer treatment took its toll and I grew weaker and weaker. My colleagues did what they could to keep my spirits up.

I did not know if I would make it. At no point did the company VM Langfords provide any pastoral care or meet with me to discuss the future and provide guidance and support about my wages and financial status. To make matters worse and more stressful, the company stopped paying our wages, all of us were left not knowing from month to month if we were going to receive our money. It was a horrendous period of strain and uncertainty and in my fragility, I was struggling on all levels.

As I am a member of the Union, I was able to gain some help from the GMB, this was a great help.

When the Private Provider company collapsed due to the catastrophic failure of delivering the NEPTS contract, we heard the news that the contract would be taken back into the arms of the NHS. We were all in disbelief, a mixture of great relief and jubilance.

For me, I was fighting for my life, but knowing this news was a dream come true, and I felt that despite not knowing if I would survive, in my heart I felt a sense of great peace and happiness to know that the NEPTS contract would be back with the NHS, where it belongs.

Early 2017, we began to engage with South Central Ambulance Service NHS Foundation Trust, we met with Paul Stevens the Assistant Director of Commercial Services and the HR Executive Team.

We all felt in safe hands, and meetings were held in which we could ask questions, meet the team and get measured up for uniforms and be introduced to the Organisations vision.

Unfortunately, I was too ill to be able to go to the meetings, but all the information was cascaded to me by my regular welfare contact from my Team Leader who had previously worked with me in South East Coast Ambulance Service NHS Trust.

The help, support, and treatment I received from South Central Ambulance Service was amazing. They engaged with me from the beginning, ensuring that I had Employee Assist support and for the first time since I became unwell, I was referred to Occupational Health.

With remarkable good fortune, I began to get stronger but was not quite out of the woods.

When I had some strength, I met with Natasha Dymond Assistant Director of HR Operations, my Team Leader accompanied me. Natasha was kind and sympathetic, offering a listening ear, and providing great support, and even gave me her mobile number if ever I needed to ask a question. I will never forget her kindness and compassion.

SCAS offered to continue to pay my salary and indicated that they would continue to pay it at the full time rate. There would be no financial impact of having to go to reduced pay.

Having Agenda for Change Terms and Conditions is something not to be taken for granted.

This came as such a huge relief to my family and me. I vividly recall the tears streaming down my face when Natasha told me that I would stay on with SCAS.

As I progressed and was given the miraculous news that I was all clear, South Central Ambulance Service continued to provide the best support in arranging my return to work.

I had my formal sickness review meetings with HR Manager Phil Smith, who provided me with great welfare support, and I was able to update him on my status.

Phil was always considerate and helpful, he offered me reassurance and clear guidance on what my eventual return to work would look like.

This gave me hope, the meetings provided me with something to look forward to, it allowed me to dare to dream of a future where I would be back doing the job I love within the NHS.

As an employee, I was treated with dignity, respect and felt valued. It felt as though I had been thrown a lifeline, and believe it was part of the reason I got better. The process gave me hope. I always remember Phil with fondness and will never forget his compassionate nature.

I am forever thankful to South Central Ambulance Service NHS Foundation Trust.

I hold huge gratitude towards the Organisation, how they stay true to their core values.

7 years later, I am pleased to say that I am still working for SCAS which is a pleasure, I did recently retire but did not want to leave! Here I am, still out and about, caring for patients, providing them with the highest level of care, my Organisation supporting me to be my best.

SCAS gave me all that I needed to get through the worst times. It made a positive difference; I always recommend them as a quality professional employer.

Going through the TUPE process is tough, it feels as though you are being cast out to a distant planet. It involves a group of employees who are all humans, individuals, with differing situations. Being considered as an individual and managed with dignity, with recognition of the emotional factors should always be at the forefront of the process. Sadly, we find ourselves back at the doomful door of yet another TUPE.

To this day, I am so proud to wear my uniform and work for the NHS. I am thankful for being given the opportunity to work for South Central Ambulance Service.

With best regards

Roy Wilshere.

NEPTS ACA

Sussex

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Report Cover Sheet

Report Title:	Integrated Performance Report (IPR)
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	9
Executive Summary:	This report high-level Integrated Performance Report (IPR) serves to provide an Executive Summary for the Board and give organisational oversight of all key areas across the Trust. Bringing together the areas of Quality, Operations, Workforce and Finance. The IPR consists of core metrics to monitor the performance across all main functions of the organisation in the pursuit of achievement of our strategic goals. Each of the relevant Executive Directors will provide a short overview of the key critical areas outlined in the section below and in the executive summary page of the IPR document. The June document highlights the following points: Operational Performance • Category 1 performance was 9 minutes 6 seconds (deterioration of 9 seconds from May), • Category 2 performance was 29:50 (improvement of 4:07 from May), • Category 3 was 5:05:32 (improvement of 1h 23) • Category 4 was 6:33:53 (improvement of 1h 50). • Our 999 mean call answer time improved by 3 seconds to 13 seconds and 12 seconds for Q1 against the 10 second target, • Hear and treat fell by 0.22% compared to May, however, remains above the 13% target at 13.09% and was 12.9% for Q1, • See and treat rates increased by 0.4% in June in part due to the drop in H&T, • 111 call answer improved by 3.6% with us answering 89.6% of calls within 120 seconds. Finance • The Trust's financial position at month 3 (June) is £0.9m deficit which is a £0.4m better than the budget. • Cash balance at the end of June stood at £17.5m. • The June month end over 90-day debt has increased this month and now stands at £178k (up from £100k in May). The 90-day category debt has decreased to 8.67% of the total sales debt (down from 11.12% in May).

	• The Trust's capital spend in the month is £1.5m which is £6.2m behind plan due to the delays receiving ambulances. Workforce • Change programmes, a focus on retention and robust control of vacancies, is clearly having an impact on turnover and numbers of staff in post, with numbers reducing for the third month running. • Recruitment continues to focus on our newly qualified paramedic cohorts along with reviewing our PTS workforce plans due to the transfer of 2 contracts in April 2025. • FTSU shows an upwards trajectory, this should be seen as a positive increase, which reflects that our staff are becoming confident to raise concerns and more confident that their concerns will be dealt with appropriately. • Although still under trajectory, PDR compliance is slowly improving, despite continuing pressures in operational areas. Quality • Work progresses to improve IPC and specifically to increase the number of vehicles we can audit, as this is below target and obviously is of concern due to potential risk to patient care. • PSIRF continues to progress to plan. • Safeguarding Level 3 training has been focussed on this month and work to ensure education dashboards and BI reporting into the IPR aligns has been completed. We are sitting at 84.1% against a target of 90% with focus on additional sessions for staff and targeting those staff who are approaching the end of their cycle of compliance.
Recommendations:	The Trust Board is asked to: The Board is asked to: • note the Integrated Performance Report and receive it for information, assurance and discussion.
Accountable Director:	Stuart Rees
Author:	Various
Previously considered at:	
Purpose of Report:	Note and approve.
Paper Status:	Internal
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable

Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	N/A
List of Appendices	IPR Report

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Integrated Quality and Performance Report: Jun-24

Executive Summary

Operational Performance

- 999 Operations
- CCC (EOC and 111)
- PTS

Safety and Quality

People

Finance

Executive Commentary :

Category 2 response times improved in June from the challenges we had in May, linked to improved operational hours and reduced demand. 999 incident demand was 2% lower than planned levels with us responding to 45,937incidents. Category 1 performance was 9 minutes 6 seconds (deterioration of 9 seconds from May), Category 2 performance was 29:50 (improvement of 4:07 from May), Category 3 was 5:05:32 (improvement of 1h 23) and category 4 was 6:33:53 (improvement of 1h 50).

Our category 2 target for June was 30:46 and we were 56 seconds below this target. The lower demand level had a positive effect on our cat 2 performance of 2 minutes 39. Our Operational hours were 0.6% below planned levels (-1,180 hours) negatively impacting cat 2 by 34 seconds. The hours deficit was due to private provider hours which were 3,039 hours below contracted levels. We offset this deficit through higher SCAS staff hours which were 1,859 hours above planned levels.

June saw handover delays being above plan and these increased delays negatively impacted cat 2 by 5 minutes 9 seconds. Handover delays were higher in BOB and Frimley ICB by 41 seconds, and in Hampshire delays were 8 minutes 30 higher (QAH 18:29higher). The total hours lost to handover delays reduced in June by 1,471 hours (from May) with us losing a total of 4,877 hours. There is however a significant increase at QAH compared to June 23, with us losing 4 times the level of hours compared to June 23 with an increase of 1,494 hours in the month. We are continuing to share the monthly handover times reports and targets with each acute trusts, however only 4 out of 10 acute trusts met their handover target in June. We have also seen an increase in SCAS clear up times for the 5th consecutive month increasing by 17 seconds, and this is being picked up through the task time reduction work to reduce overall task time.

Our 999 mean call answer time improved by 3 seconds to 13 seconds and 12 seconds for Q1 against the 10 second target. The improved performance was through reduced abstractions and reduced average handling time in the month. Hear and treat fell by 0.22% compared to May, however remains above the 13% target at 13.09% and was 12.9% for Q1. See and treat rates increased by 0.4% in June in part due to the drop in H&T. The focus remains in reducing ST&C to ED and this was at 49.2% which is 0.2% above the target. We are working with NHS HIOW to develop a Single Point of Access pilot which will provide improved access to non ED pathways for SCAS crews and support non ED conveyance.

111 call answer improved by 3.6% with us answering 89.6% of calls within 120 seconds. This has been achieved through our average handling time remaining below the mean for the last 2 months combined with a decrease in demand of 111 calls with us answering 133,119 calls, a reduction of 12,000 from May. Abandonment rate remains below the national target at 1.5%. We have received the proposed funding offer from BOB ICB, however this remains significantly below the existing gap in funding. We are in on-going communications with the ICB and will be providing them with options to reduce our costs with the associated impact through reduced performance and higher ED attendance as we will cease completing ED validation calls.

Key actions for July are to continue to monitor operational hours to ensure we deliver the planned hours in line with budget; assess the private provider bids when the tender closes at the end of July; continued focus on delivering the call answer and hear and treat action plans in EOC.

Executive Commentary (continued) :

The Trust's financial position at month 3 (June) is £1.0m deficit which is a £0.4m better than the budget.

The Trust's cash balance at the end of June stood at £17.5m. There was a net cash outflow in month 3 of £4.1m due mostly to the payments to suppliers of £12.5m and £1.5m block income shortfall against budget.

The June month end over 90-day debt has increased this month and now stands at £178k (up from £100k in May). The 90-day category debt has decreased to 8.67% of the total sales debt (down from 11.12% in May).

The Trust's capital spend in the month is £1.5m which is £6.2m behind plan due to the delays receiving ambulances.

Change programmes, a focus on retention and robust control of vacancies, is clearly having an impact on turnover and numbers of staff in post, with numbers reducing for the third month running. Turnover is expected to rise due to these change programmes and therefore our People Promise Manager is reviewing and redeveloping our engagement (previously referred to as retention) along with directorate management teams. Recruitment continues to focus on our newly qualified paramedic cohorts along with reviewing our PTS workforce plans due to the transfer of 2 contracts in April 2025.

We continue to be on an upwards trajectory for reported FTSU cases. This should be seen as a positive increase, which reflects that our staff are becoming confident to raise concerns and more confident that their concerns will be dealt with appropriately. However, we still have work to do to improve this, in particular with ensuring leaders are confident in the FTSU process.

Although still under trajectory, PDR compliance is slowly improving, despite continuing pressures in operational areas. An improvement plan is in place to improve the PDR process, and in turn improve compliance.

Executive Commentary (continued) :

Work progresses to improve IPC and specifically to increase the number of vehicles we can audit, as this is below target and obviously is of concern due to potential risk to pt care. We continue to see high use of our vehicles, which has contributed to why we are not at the required number we are able to audit. However, we are increasing the number of vehicles we audit, but need to ensure we see corresponding compliance of those audits to assure those vehicles are clean and fit for use. The number of buildings we audit are above target but not all of those audits were deemed as compliant, which we are discussing and performance managing with our cleaning providers.

PSIRF continues to progress to plan and we are also seeing good progress in closing actions from our previously logged serious incidents, which allows us to evidence we have not only taken action but started to embed some of the learning.

We have appointed our AD for Pt Safety and are delighted to report she will commence with us from August 5th. As an internal appointment, she will also bring her direct experience of the operations directorate to pt safety directorate. We are also working to fill gaps created by a vacancy of a pt safety manager, using the opportunity to gain maternity specialist knowledge into the team.

Alignment of Safeguarding Level 3 training reporting has been focussed on this month and work to ensure education dashboards and BI reporting into the IPR aligns has been completed. We are sitting at 84.1% against a target of 90% with focus on additional sessions for staff and targeting those staff who are approaching the end of their cycle of compliance.

Lastly, under the area of senior leadership, governance and “grip”, we have some key staff retirements over July, August and September with planned retirements of ADs in Pt Safety, Pt Experience, Safeguarding and the Deputy Chief Nurse.
I am pleased to report we have risk assessed the gaps and already appointed into the AD for Pt Safety. We interview for Head of Safeguarding on 24th July and we are currently recruiting for replacement of the Deputy Chief Nurse.
Some of the senior staff who are retiring have agreed to come back on reduced hours to support key work and we have reached out to ICB and partner providers to seek interim support whilst we recruit. Should these requests not yield any support, we will approach agency, as these are key roles for pt safety and quality.

Statistical Process Control:

An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data. To help you interpret the data a number of rules can be applied.

The rules:

1) Any single point outside the process limits.

2) Two out of three points within 1 sigma of the upper or lower control limit.

3) A run of 6 points above or below the mean (a shift) .

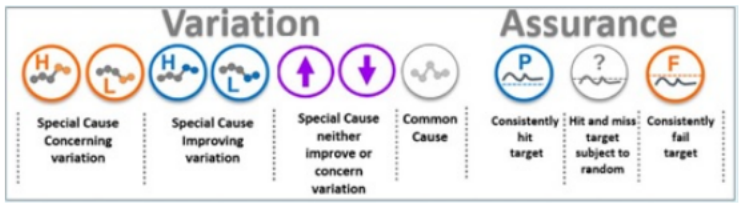
4) A run of 6 consecutive ascending or descending values (a trend).

All these rules are aids to interpretation but still require intelligent examination of the data.

This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration.

If you change in your process and observe a persistent shift in your data, it may be appropriate to change the process limits. A process limit change can be added if the observed change is sustained for a longer period not just 6 points. You should try and find out the cause of the process change before recalculating the limits and annotate this on the chart. Be very cautious if you do not know what changed the process.

Icon Key



NHS Icon Descriptions

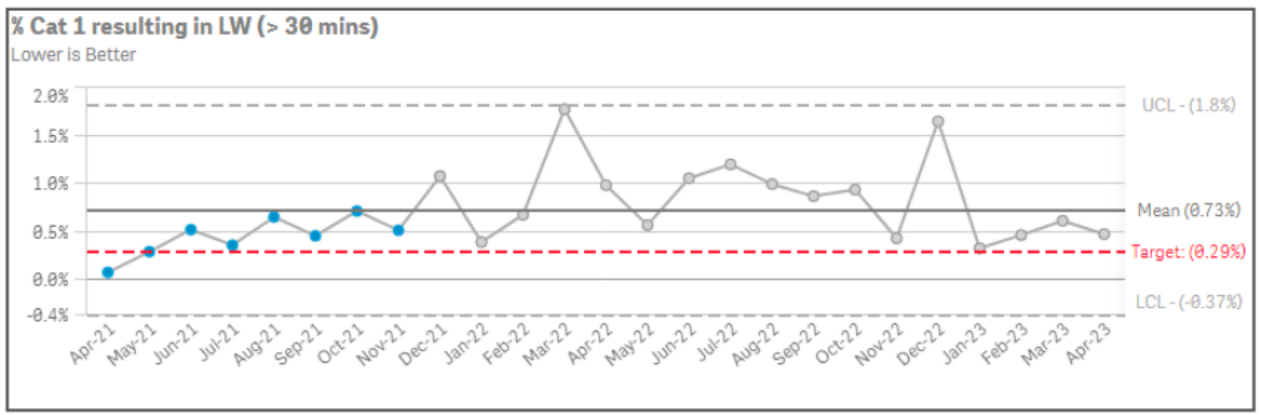
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.
	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly LOWER. This process is will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.
	Common cause variation , no significant change. This process is capable and will consistently PASS the target	Common cause variation , no significant change. This process will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Common cause variation , no significant change. This process is not capable. It will FAIL the target without process redesign.	Common cause variation , no significant change. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measurs is significantly HIGHER.The process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measurs is significantly HIGHER.This process will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Special cause of a concerning nature where the measurs is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measurs is significantly HIGHER.Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly LOWER.This process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measure is significantly LOWER.This process will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.

				Special cause variation where UP is neither improvement nor concern.
				Special cause variation where DOWN is neither improvement nor concern
n/a				Special cause or common cause cannot be fiven as there are insufficent number of points. Assurance cannot be given as a target has not been provided.

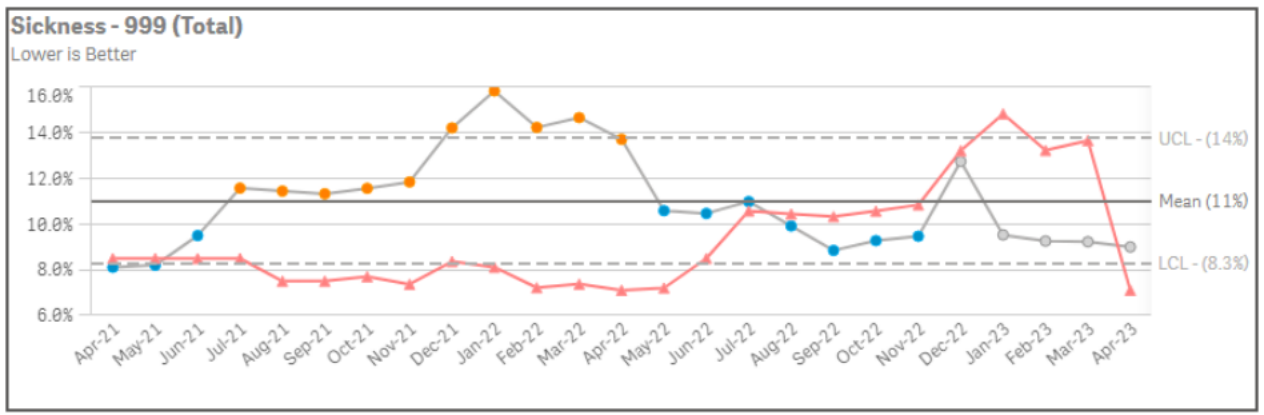
Assumptions:

The below SPC chart shows an example of the metric values per month.
The points on the line are coloured orange, grey, or blue in accordance with the SPC guidelines.
A dashed red line shows the target for the metric if there is one present.
A red line with triangle markers shows the plan projected for the metric if one is present.
The plan is different to a target, as the target is static; the plan can vary each month.
No Assurance Icon will be produced for the metric if no target value is available.
Quarterly Metrics and Metrics without data pre April 2022 will be visualised in a line chart and not an SPC Chart.

Example of Target Line Chart



Example of Plan Line Chart



UCL & LCL:

When the variance in the values is normal within the process (common cause varition) all the points will fall above or below them mean, but within the upper and lower control limits as represented by the lines on the chart.

If values(s) fall above the UCL or below the LCL, then they are statistically not expected, special cause variation.

However, it is important to realise that even if all the points fall within the control limit lines it does not mean the process is in control. Ideally a process should have no variation, the values should all be the same. So it is important to understand what is causing the common cause variation. The wider the gap between the mean line and the control limits, the larger the variance

NHS Overall Summary

June-24 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		Clear up Delays - SCAS VOR - Total		1
L	Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds	Patients Collected within time S&T - SCAS		
	Appraisals - Trust Average Hospital Handover Time - SCAS Cat 1 Mean SCAS	17	Over-runs >30 mins - SCAS	15
L		111 Calls abandoned after 30 secs % 999 Calls abandoned % 999 Mean Call Answer Time ST&C (ED 1&2) - SCAS		3
H	111 Call back < 20 min 111 call answer in 120 Secs % Safeguarding Level 3	H&T - SCAS		5
↗				1
↘		PTS Call Volume PTS Volume - No. of Journeys		4

Metrics:

Hit and Miss Common Cause Metrics:
Building cleanliness completed audits ; Cardiac Arrest Survival, Utstein ; Cat 1 90th %ile SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 3 90th %ile SCAS ; Cat 4 90th %ile SCAS ; Debtors > 90 days> 5% total balance ; Patients Arrived within time ; Percentage of compliant Building cleanliness audits ; Percentage of compliant Vehicle cleanliness audits ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Vehicle cleanliness completed audits

NHS

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Operational Performance

NHS Operational Performance Overview

June-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		Clear up Delays - SCAS VOR - Total		
L	PTS - Calls answered in 60 seconds	Patients Collected within time S&T - SCAS		
	Average Hospital Handover Time - SCAS Cat 1 Mean SCAS	Cat 1 90th %ile SCAS Cat 2 90th %ile SCAS Cat 2 Mean SCAS Cat 3 90th %ile SCAS Cat 4 90th %ile SCAS Patients Arrived within time		1
L		111 Calls abandoned after 30 secs % 999 Calls abandoned % 999 Mean Call Answer Time ST&C (ED 1&2) - SCAS		
H	111 Call back < 20 min 111 call answer in 120 Secs %	H&T - SCAS		
↗				
↘		PTS Call Volume PTS Volume - No. of Journeys		1

Operations - Response Times/Utilisation/Operations Centre

*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Jun-24	00:09:06	00:07:00		F	00:09:04	00:07:23	00:10:45
Cat 1 90th %ile	Jun-24	00:16:44	00:15:00		?	00:16:20	00:13:22	00:19:19
Cat 2 Mean	Jun-24	00:29:50	00:30:00		?	00:33:39	00:14:16	00:53:02
Cat 2 90th %ile	Jun-24	00:58:28	00:40:00		?	01:07:40	00:25:28	01:49:52
Cat 3 90th %ile	Jun-24	05:05:32	02:00:00		?	05:21:22	00:44:27	09:58:18
Cat 4 90th %ile	Jun-24	06:33:53	03:00:00		?	06:50:39	00:55:44	12:45:34
% Vehicles off the road	Jun-24	0.39%	23%	H	?	0.3%	0.2%	0.3%
Ave Handover	Jun-24	00:22:25	00:15:00		F	00:25:10	00:16:41	00:33:39
Handover > 15mins	Jun-24	47%	0.48%		n/a	44.9%	35.4%	54.4%
Clear up Delays	Jun-24	00:15:54	00:15:00	H	?	00:15:02	00:14:21	00:15:44
% See and treat	Jun-24	33%	35%	L	?	34.1%	32.8%	35.5%
% ST&C to ED	Jun-24	49%	47%	L	?	49.6%	47.1%	52.0%
999 Call Answer	Jun-24	14%	10%	L	?	35.8%	-19.8%	91.4%
999 Ab. Rate	Jun-24	2.8%	2%	L	?	6.3%	-1.2%	13.7%
% Hear and treat	Jun-24	13%	13%	H	?	11.9%	9.5%	14.3%
111 Call Answer	Jun-24	90%	95%	H	F	60.4%	27.8%	93.0%
111 Ab. Rate	Jun-24	1.5%	3%	L	?	8.6%	-4.3%	21.6%
111 Call backs	Jun-24	34%	95%	H	F	22.7%	12.0%	33.5%

Operations - PTS Calls and Outcomes

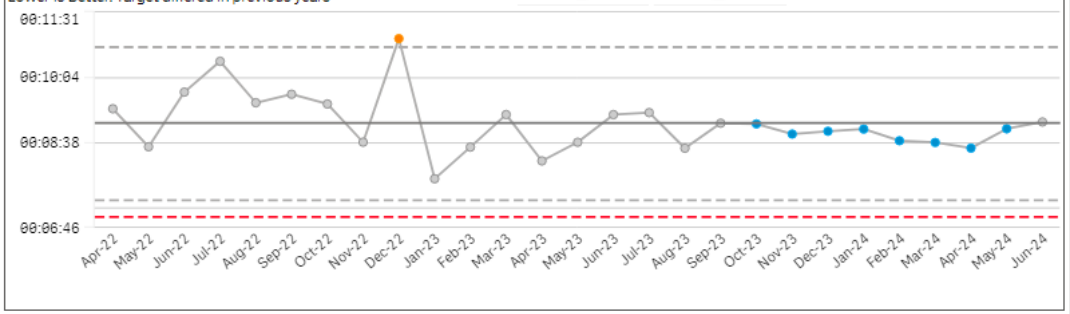
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Calls Answered (PTS)	Jun-24	61%	90%			64.5%	48.5%	80.5%
Number of calls (PTS)	Jun-24	29,957	37,333			33,336.6	25,647	41,026.1
% Patients arrived in time	Jun-24	85%	87%			86.9%	84.1%	89.6%
% Patients collected in time	Jun-24	86%	87%			88.8%	87.2%	90.4%
PTS Volume - No. of Journeys	Jun-24	66,362	79,359			78,266.5	67,430.8	89,102.2
Number of Patients Transported	Jun-24	18,505			n/a	22,133	19,285.7	24,980.2

Operations - Response Times

Cat 1 Mean

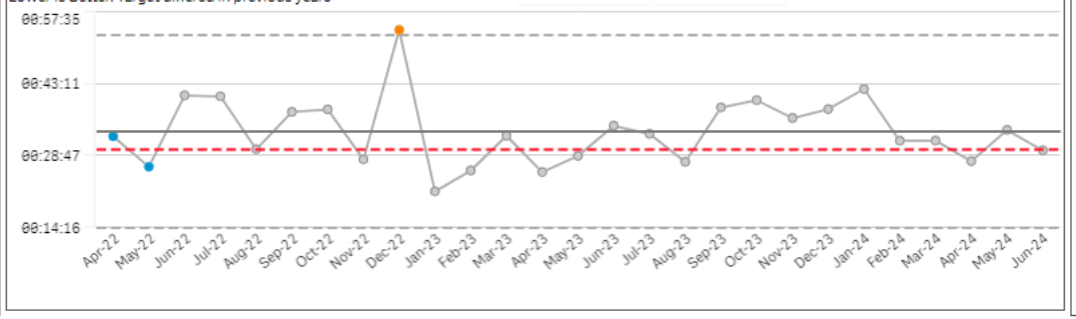
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	00:07:00	00:09:06

Cat 2 Mean

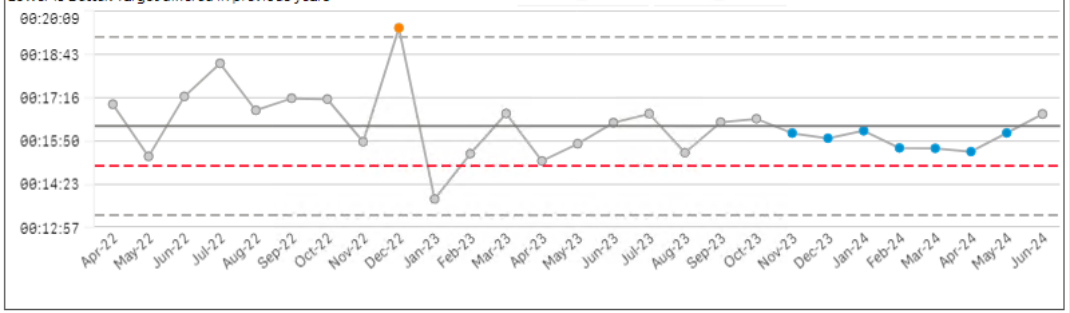
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:30:00	00:29:50

Cat 1 90th %ile

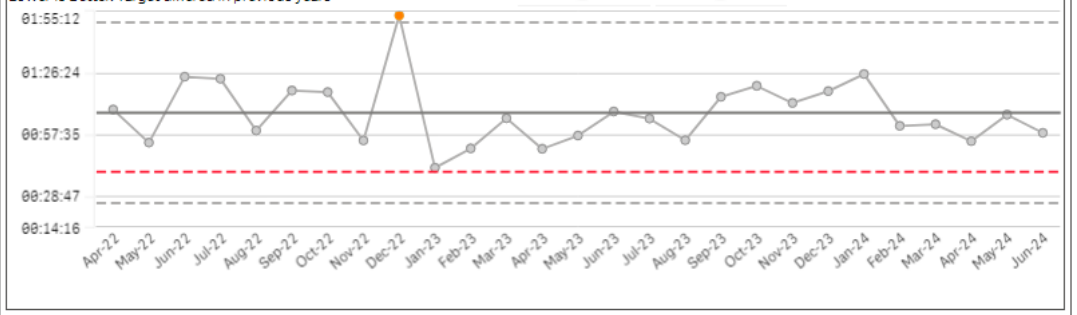
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:15:00	00:16:44

Cat 2 90th %ile

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:40:00	00:58:28

Understanding the Performance:

The Trend in decline of Cat one performance continued into June, ending at 09:06. This is a 9 seconds increase on May and rose above the mean for the first time since October 23. Cat two Performance improved fallen below the mean and the target at 29:50, an improvement of 04:07. This was driven by improved operational hours from both PP and SCAS and hospital handovers across the month.

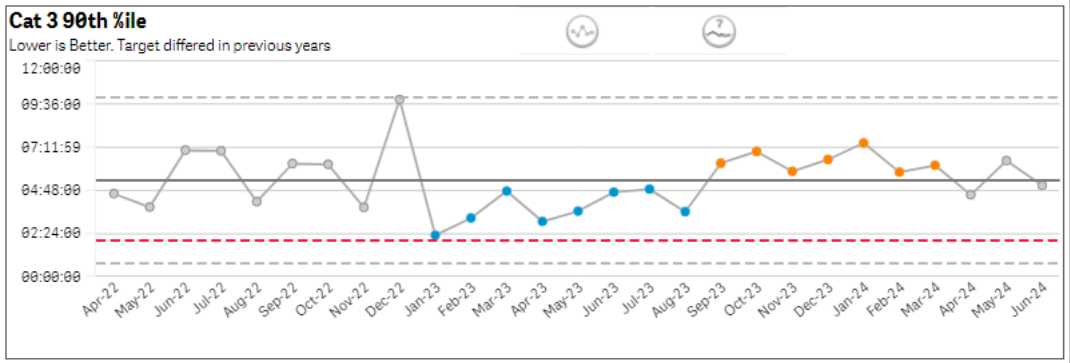
Actions (SMART):

Hours continue to be monitored to meet plan and stay within budget. Additional hours added at risk to PP tender to allow for additional 2 million.

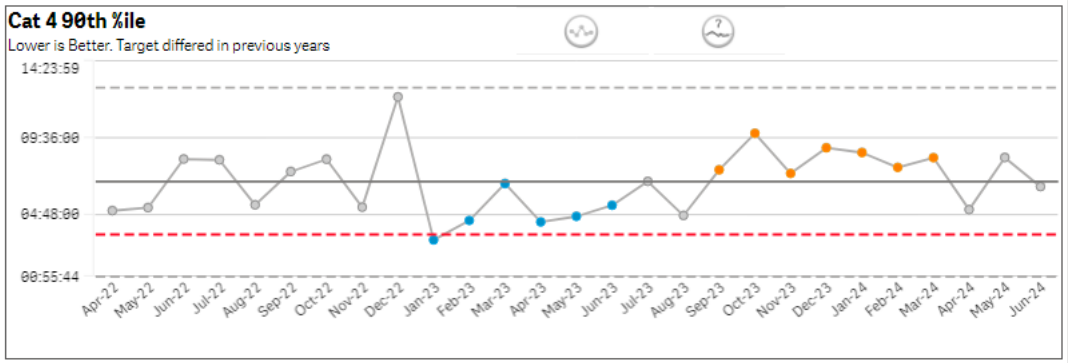
Risks:

International recruitment trajectory and delivery of new PP tender from 1st October.

Operations - Response Times



Variation	Expected
Assurance	Random
Target	02:00:00
Latest	05:05:32



Variation	Expected
Assurance	Random
Target	03:00:00
Latest	06:33:53

Understanding the Performance:

Cat 3 and Cat 4 performance improved in June with both ending below their mean for the second time since last August. Cat 3 ended at 5:05, an improvement of 01:23 on May and Cat 4 ended at 06:34, an improvement of 01:50. This was driven by improved operational hours and hospital handovers across the month.

Actions (SMART):

Continued monitoring of hours to best match plan within budget.

Risks:

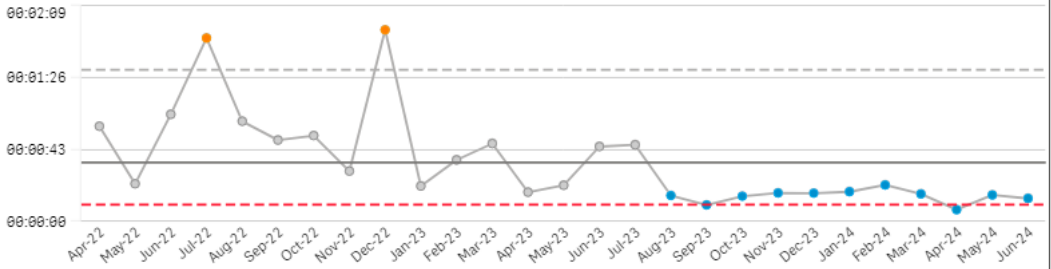
International Recruitment plan and October delivery of PP Tender.

NHS

Operations - Operations Centre

999 Call Answer

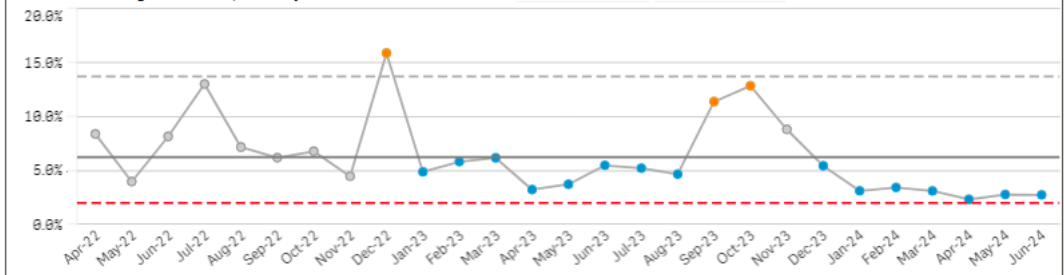
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	00:00:10	00:00:13

999 Ab. Rate

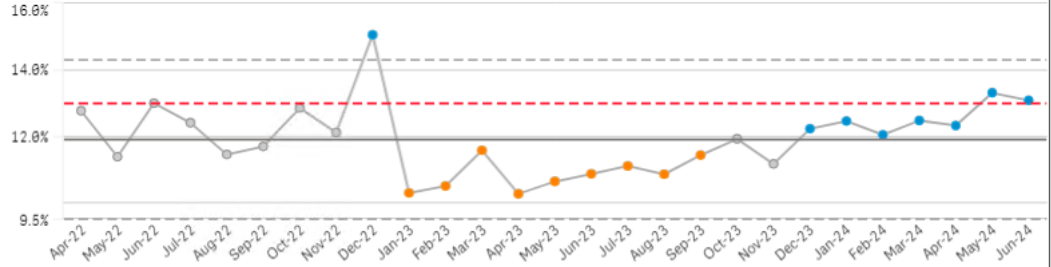
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	2%	2.8%

% Hear and treat

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	13%	13.1%

Understanding the Performance:

Mean call answer at 13 seconds remains outside but close to national target, below the mean. Correspondingly abandonment rate at 2.76% remains below the mean and close to target. Hear and treat at 13.09% has achieved internal target sitting above the mean. Calls offered in June rose above planned levels driven in part by the heat towards the end of June, with duplicate calls as a result of delays also playing a part. Logged in hours through June have dropped as abstractions have risen, whilst work effective ECT figures remain stable (163 WTE), overall establishment levels have dropped. Currently in post 184.07 WTE ECTs. WMAS support was paused on 21st June for 2 weeks at the request of WMAS.

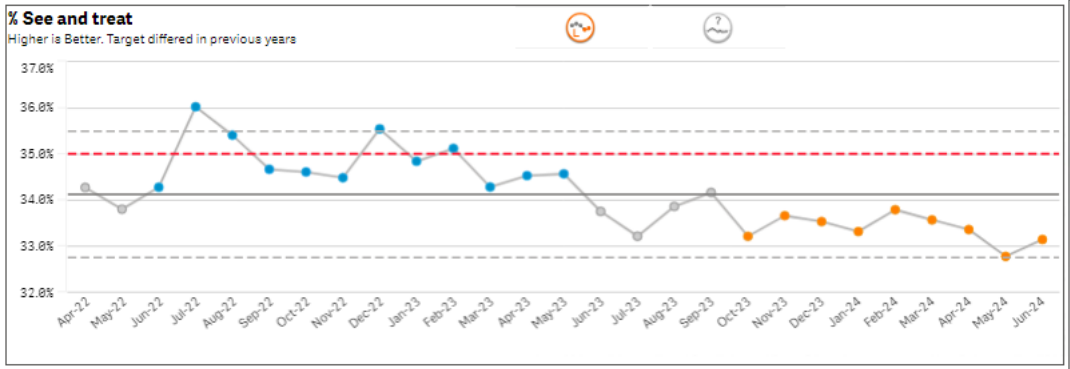
Actions (SMART):

The team continue with the actions laid out in the call answer and hear and treat improvement plans. The ECT roster consultation has finished and the team are on track for roster build in July, go live remains September. Positive impact on AHT for those ECT attending probing and call control workshops - we continue roll out of workshops. AACE workshop arranged for early August due to leave within team. Visit from Cat 2 Segmentation Clinical Ambassador arranged for July. Dual skilling pilot has kicked off and the identified 111 HA will start training in August.

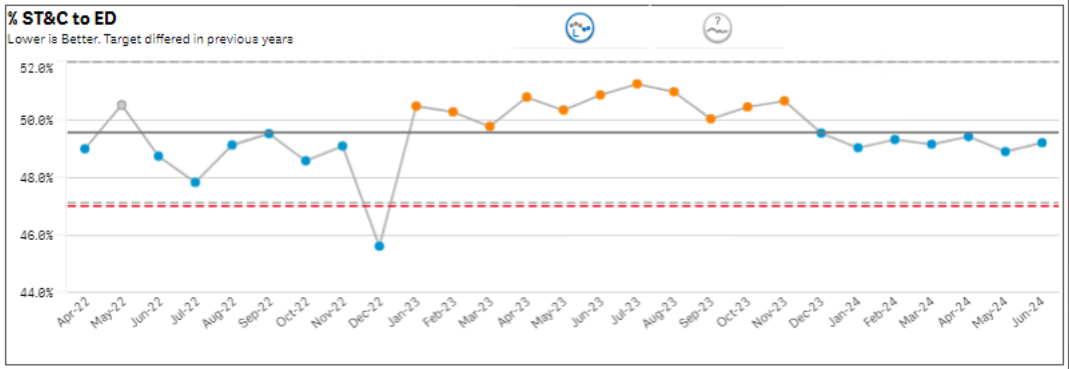
Risks:

Demand above planned levels will outstrip capacity and impact call answer performance. Lack of call centre workforce management system limits ability to flex hours to meet demand, current financial challenges mean ability to offer overtime is limited. Any delay in rota build and roll out will result in continued challenges to meet demand in certain hours/days. WMAS may not continue support resulting in longer call waits at certain times of day/night. Capacity and skill of the team may impact delivery of improvements as laid out in AACE review, call answer and hear and treat improvement plans.

Operations - Utilisation



Variation	Assurance	Target	Latest
Declined	Random	35%	33.1%



Variation	Assurance	Target	Latest
Improving	Random	47%	49.2%

Understanding the Performance:

June saw a small increase in S&T with an increase of 0.25%. S&T should always be looked at alongside H&T as the relationship between the two is intrinsically linked. The rise in S&T corresponds to the decline in H&T through June. ST&C to ED increased in June to just below the mean value but this has been the case for the past 7 months. As previously described ST&C to ED is often lower when we are seeing higher handover delays and for the first 3 weeks of June we had much reduced delays at acutes which would explain the rise in ST&C to ED.

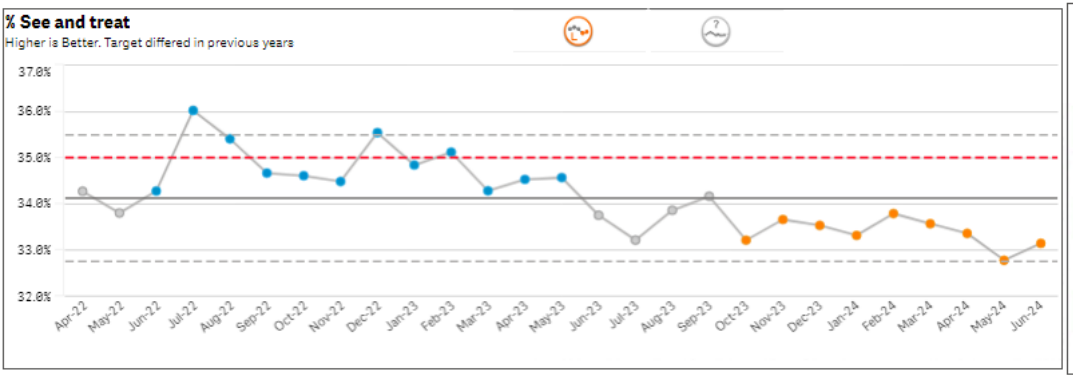
Actions (SMART):

Acuity was slightly lower than May and with the decrease in handover delays through the first 3 weeks of June would account for the increase in ED conveyance and the link between H&T and S&T shows us again when one is higher it translates to the other being a lower value.

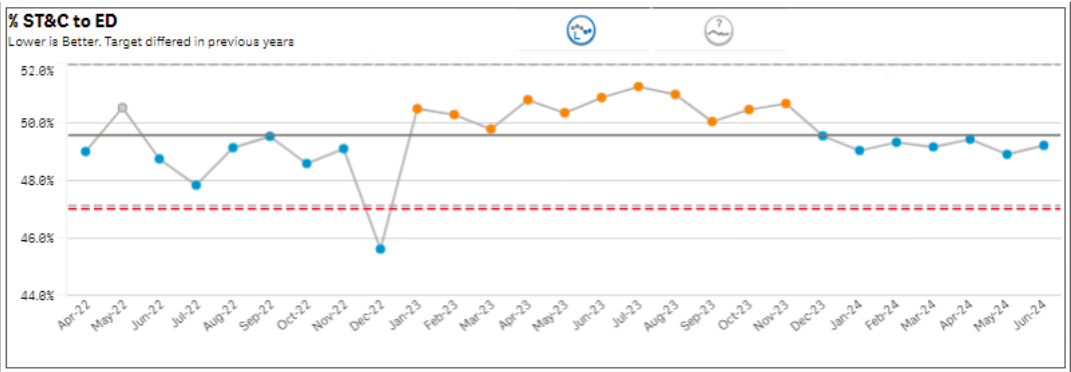
Risks:

S&T, and H&T and activity must all be looked at as a collective as variations in each of those measures will affect the whole. Understanding the human factors in dispatch habits when demand is lower and how staff might act when we are seeing high delays compared to actions when we are having better flow at hospitals. The system/providers not able to provide the pathways that are needed to improve patient experience and the knock on performance gains.

Operations - Utilisation



Variation	Assurance	Target	Latest
Declined	Random	35%	33.1%



Variation	Assurance	Target	Latest
Improving	Random	47%	49.2%

Understanding the Performance:
June saw a small increase in S&T with an increase of 0.25%. S&T should always be looked at alongside H&T as the relationship between the two is intrinsically linked. The rise in S&T corresponds to the decline in H&T through June. ST&C to ED increased in June to just below the mean value but this has been the case for the past 7 months. As previously described ST&C to ED is often lower when we are seeing higher handover delays and for the first 3 weeks of June we had much reduced delays at acutes which would explain the rise in ST&C to ED.

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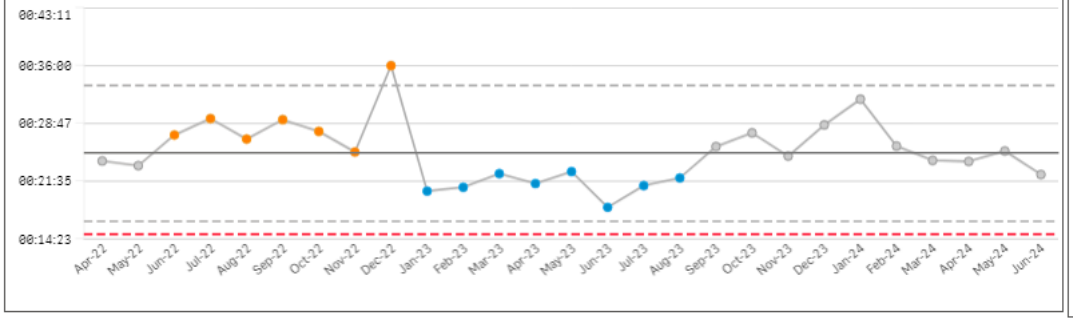
S&T, and H&T and activity must all be looked at as a collective as variations in each of those measures will affect the whole. Understanding the human factors in dispatch habits when demand is lower and how staff might act when we are seeing high delays compared to actions when we are having better flow at hospitals. The system/providers not able to provide the pathways that are needed to improve patient experience and the knock on performance gains.

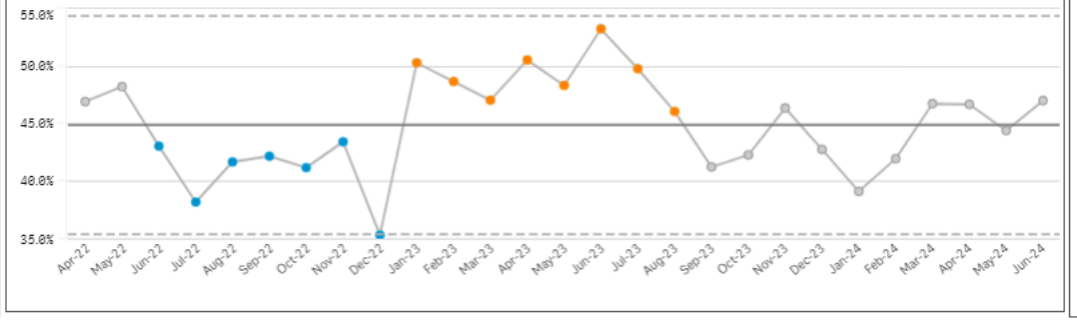
Operations - Utilisation

Ave Handover
Lower is Better. Target differed in previous years



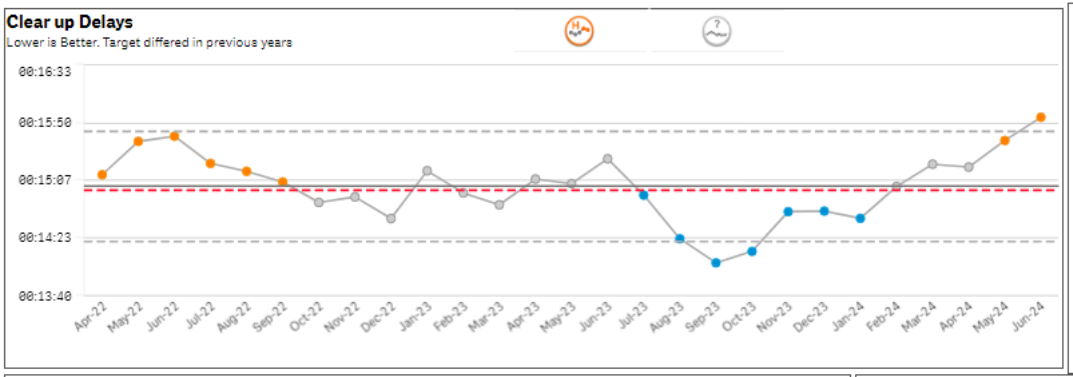
Variation	Assurance	Target	Latest
Expected	Fail	00:15:00	00:22:25

Handover > 15mins
Lower is Better. Target differed in previous years



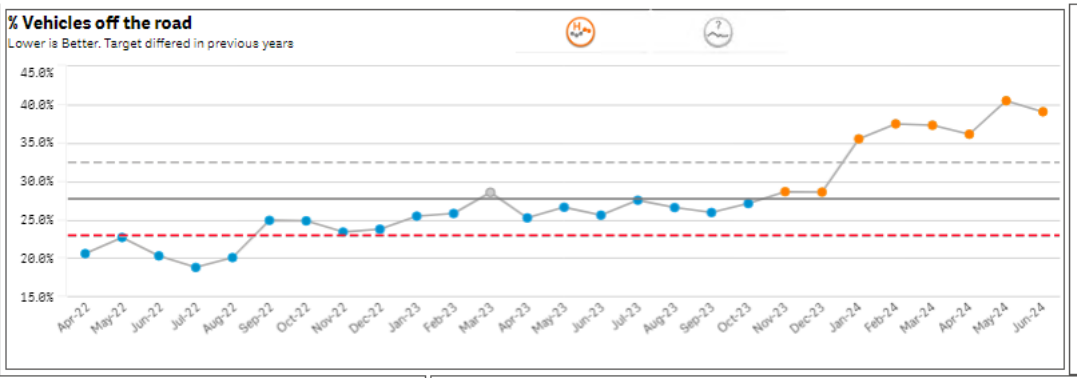
Variation	Assurance	Target	Latest
Expected	-	0.48%	47.0%

Clear up Delays
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Random	00:15:00	00:15:54

% Vehicles off the road
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Random	23%	39.1%

Understanding the Performance:
Handovers remain an ongoing concern, however currently showing common cause variation with no significant change for the past 4 months. Clear up delays continue to show a deteriorating picture on a concerning nature - in terms of average time, although total time lost has reduced slightly since May.

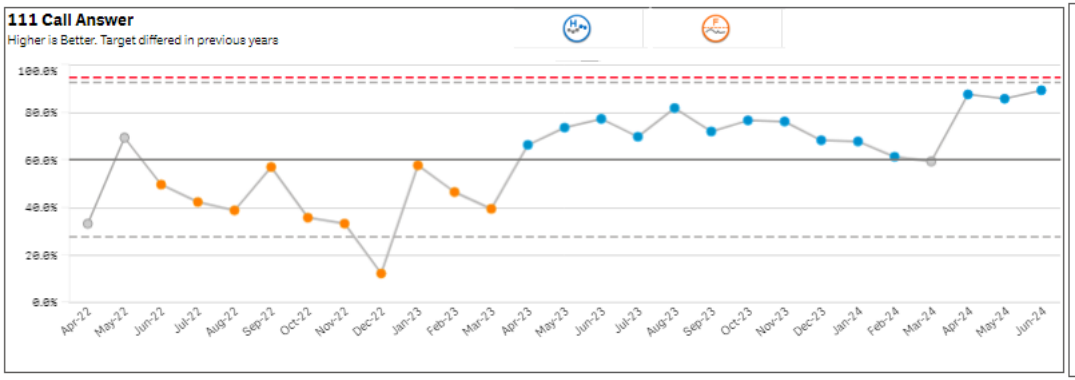
Actions (SMART):
Handovers remain a key area of focus for the local Ops teams who continue to work with Acutes and ICBs. The senior ops team are engaged and monitoring progress. With clear up delays there is variation between areas and work is ongoing to share good practice and ensure correct use of IPT to ensure robust capture of accurate data

Risks:
Whilst handover delays remains within common cause variation, there is still a significant risk that the position will deteriorate impacting on SCAS ability to respond to patients. Fleet availability continues to be a risk to service delivery.

NHS

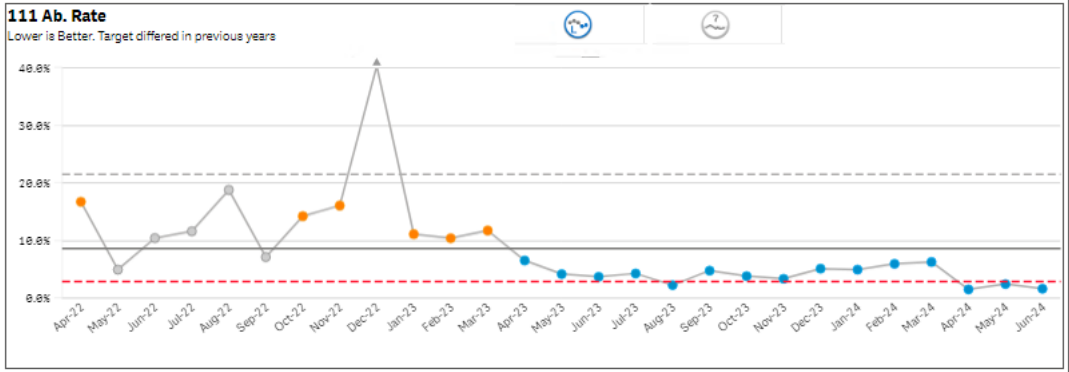
Operations - Operations Centre

111 Call Answer
Higher is Better. Target differed in previous years



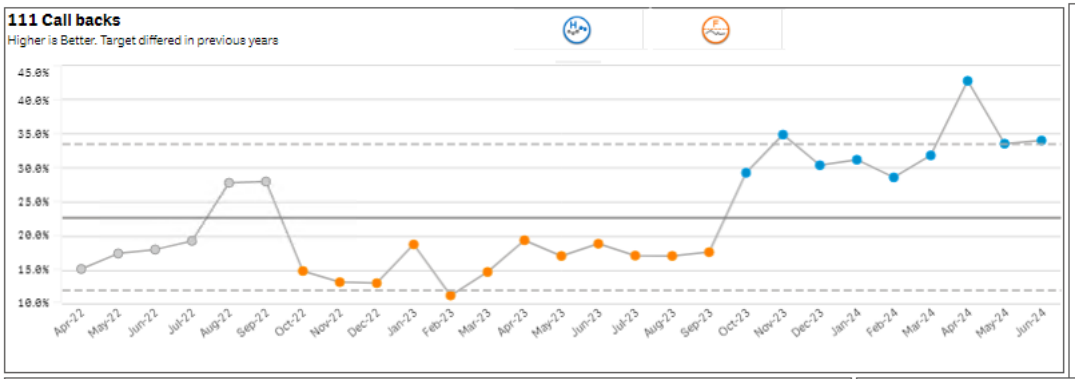
Variation	Improving
Assurance	Fail
Target	95%
Latest	89.6%

111 Ab. Rate
Lower is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	3%
Latest	1.5%

111 Call backs
Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Fail
Target	95%
Latest	34.0%

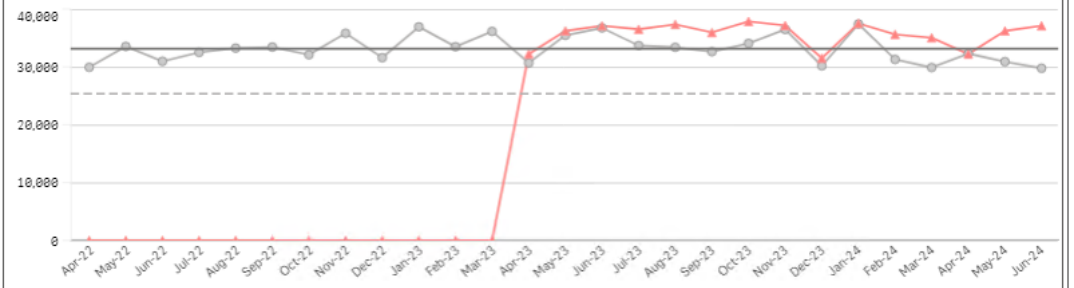
Understanding the Performance:
Calls answered in 120 seconds reached highest levels since new telephony platform, but remains outside of national target, at 89.63% above the mean and towards the upper control limit. Abandonment rate at 1.55% did achieve national target and remains consistently below the mean and at the lower control limit. Clinical call backs in 20 minutes sit above the upper control limit but outside of national target at 34.02%. All these metrics show improvement as a result of staffing levels being closer to plan, with improvements in retention and abstractions. Currently in post 245.27 WTE of Health Advisors (under plan by 19 WTE) and 84.23 WTE Clinical Advisors (1.73 WTE above plan).

Actions (SMART):
The team continue to focus on releasing efficiencies through further reductions in average handling time as well as the support for staff to maintain and improve on our current position. We are working closely via IWP meetings to maintain planned establishment levels, recruiting into specific rota gaps and also updating our retention plan.

Risks:
Challenges around funding may result in over resourcing, an assessment of cost reduction and impact is being undertaken to further inform conversations with ICB. Significant changes in demand may still outstrip capacity as with current fixed rolling rotas and no call centre workforce management tool there remains the inability to flex rapidly to change.

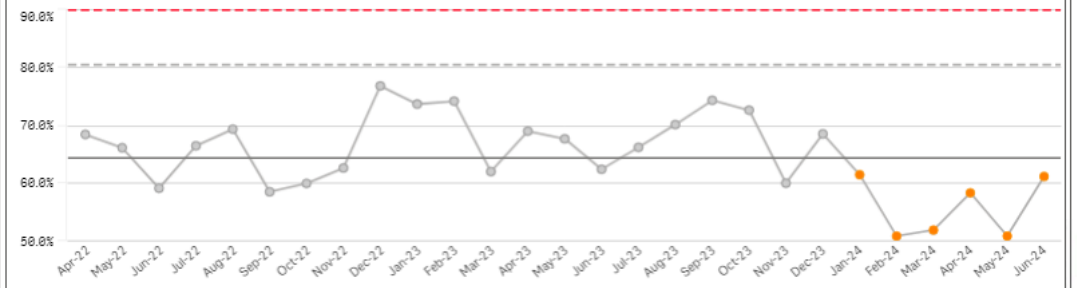
Operations - PTS - Calls and Outcomes

PTS Call Volume
N/A. Target differed in previous years



Variation	Assurance	Target	Latest
Improved	Random	37,333	29,957

PTS - Calls answered in 60 seconds
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Fail	90%	61.1%

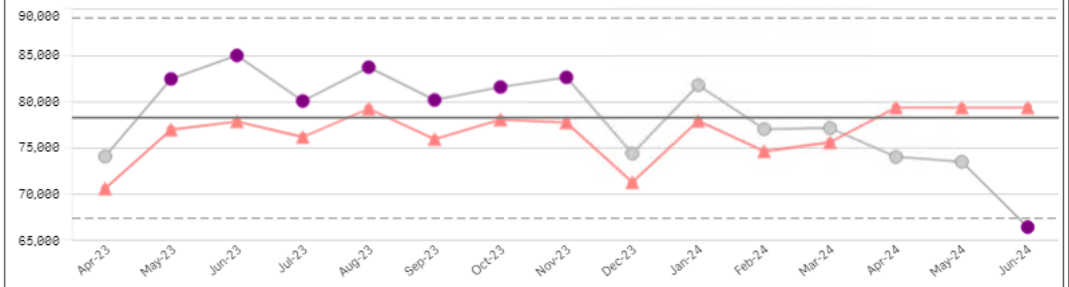
Understanding the Performance:
- Call Answer performance continues to be a challenge, but there has been an improvement from Mays previous reduced level however only returning towards the mean performance over the last 2 years.
- Sickness has improved but still have 4 remaining off sick.
- Call volumes have slightly declined from May in June; this is likely due to the ongoing work around pushing online bookings to reduce the pressures within the contact centre which will be the main driver for improved performance as the hours remain fairly static but with less calls performance will improve.

Actions (SMART):
- Need to review what the Call Handler budget calculates to in terms of wte to understand how that compares to 23/24 with the expectation the overall performance target will reduce from 90% to 63%, therefore the performance being reported is far nearer to budgeted expectations but will not achieve contractual targets.
- Continue to manage sickness robustly

Risks:
- Continued uncertainty for many staff, may increase sickness and/or attrition further impacting performance as well as known unfortunate outcome for both Sussex & BOB/Frimley contract
- Not budgeted to hit contractual Call Answer Performance, risk of performance management or increased challenges and pressures

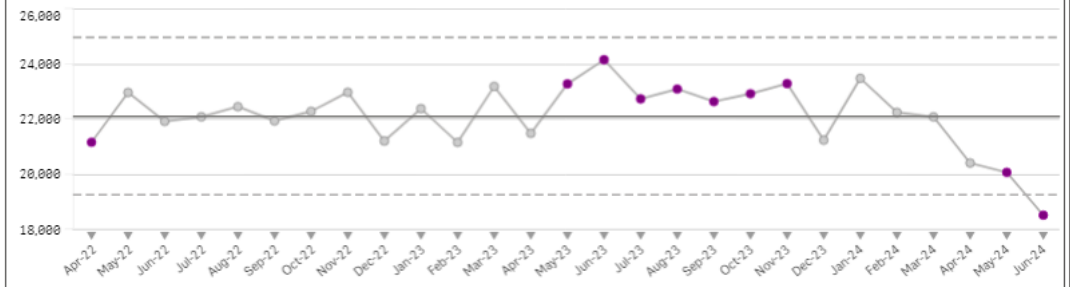
Operations - PTS - Calls and Outcomes

PTS Volume - No. of Journeys
N/A. Target differed in previous years



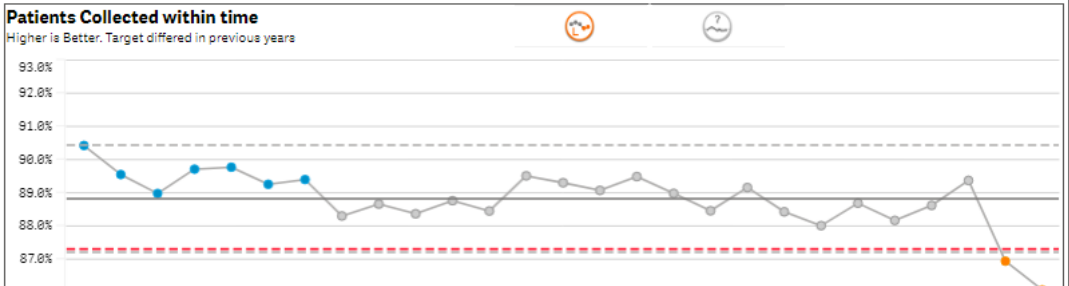
Variation	Assurance	Target	Latest
Improved	Random	79,359	66,362

Number of Patients Transported
N/A. Target differed in previous years



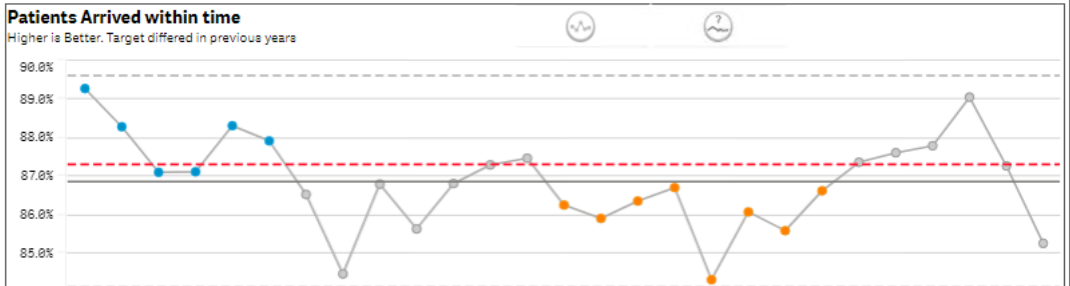
Variation	Assurance	Target	Latest
Improved	-	0	18,505

Patients Collected within time
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Random	87%	86.1%

Patients Arrived within time
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	87%	85.3%

Understanding the Performance:

-Demand has seen a significant decline in June, this is due to the introduction of the demand cap 10 June which has helped to bring the activity back to the IAP levels provided by Finance and used for budgeting purposes.

-Due to the introduction of the demand cap, there was a crossover in the demand and hours process which has resulted in slightly lower hours used initially for the level of demand already booked when the cap was introduced, as a result there was an impact to performance. However, year to date the overall performance is in line with 23/24 full year %.

Actions (SMART):

-Continue to monitor demand, hours and performance as a result of the introduction of the demand cap. Ensure we balance hours and performance. Continued detailed analysis to establish how certain changes in terms of acuity may affect the average efficiency measure which may result in slightly increased hours required due to high acuity patients requiring more hours to load and unload.

-Close monitoring and reporting of hours, demand and cost introduced through a range of reports being shared internally with a request from ICBs for some reporting to be shared, this is being reviewed.

-Review of future resource requirements and review Integrated Workforce Plan aligned to IAP and budget. Alongside reviewing assumptions for one contract since the news of not retaining it post March 2025.

Risks:

- Overspends being reported monthly due to broadly flat phased draft budgets and as such demand showing as flat phased not considering any profiling
- 1 contract remains unsigned due to be resolved through NHS E arbitration route, 1 contract signed off for 2 years with significant risk and a 12 month notice period agreed to if needing to be exercised. 2 other contracts for 24/25 not signed off but exiting end of 24/25 loss equates to circa 500 staff
- IAP figures provided and implemented within the demand cap process being queried by ICB for one contract, huge risk that incorrect figures which would result in demand cap being increased and as such additional hours being required which would increase/undo the cost reductions seen from 10 June to date

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

June-24 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
High				
Low				
		Building Audits Building Audits % CA Survival Utstein STEMI 90th STEMI Mean Stroke 90th Stroke Mean Stroke Median Vehicle Audits Vehicle Audits %		5
Low				
High	Safeguarding Level 3			
↗				1
↘				2

Metrics:

NHS Quality Safety– Core Measures Icon Summary

*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PSI Low/no harm inc.	Jun-24	519			n/a	493	400	586
Monthly PSII	Jun-24	2			n/a	2.67	-2.65	7.99
Monthly PSILR	Jun-24	5			n/a	6.33	-12.3	25
PSII Cases > 6 mths	Jun-24	0			n/a	0	0	0
Datix incidents	Jun-24				n/a	218	-	-
Duty of Candour	Jun-24	0.0%			n/a	0.00333	-0.0233	0.0299
Level 3 Safeguarding	Jun-24	84.1%	90%			53.9%	40.6%	67.3%
Complaints	Jun-24	44			n/a	44	44	44
Complaints in time	Jun-24	97.0%			n/a	0.965	0.938	0.992
Building Audits	Jun-24	38	21			32.3	0.748	63.8
Building Audits %	Jun-24	65.8%	80%			82.0%	49.7%	114.3%
Vehicle Audits	Jun-24	74	167			104	18.7	190
Vehicle Audits %	Jun-24	85.1%	90%			94.2%	79.8%	108.7%

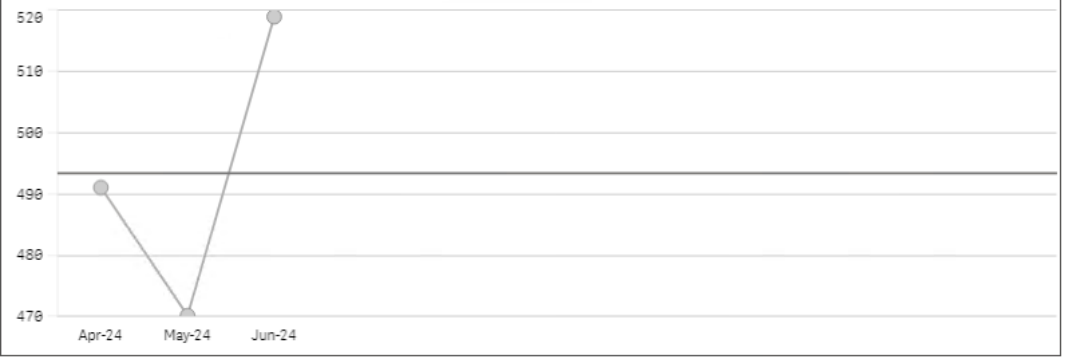
NHS Quality Safety– Ambulance Quality Indicators (AQIs)

*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Mean	Jun-24	02:23	-			02:16	01:47	02:45
STEMI 90th	Jun-24	03:33	-			03:14	01:47	04:41
Stroke Mean	Jun-24	01:34	-			01:38	01:09	02:07
Stroke Median	Jun-24	01:23	-			01:22	01:06	01:39
Stroke 90th	Jun-24	02:15	-			02:36	01:33	03:38
ROSC All	Jun-24	28.3%	-	-	n/a	24.9%	20.4%	29.3%
ROSC Utstein	Jun-24	52.4%	-	-	n/a	55.0%	41.4%	68.6%
CA Survival All	Jun-24	10.8%	-	-	n/a	8.6%	2.8%	14.4%
CA Survival Utstein	Jun-24	35.0%	-			30.4%	3.5%	57.2%

Quality & Safety – PSIRF

PSI Low/no harm inc.
Higher is Better. Target differed in previous years

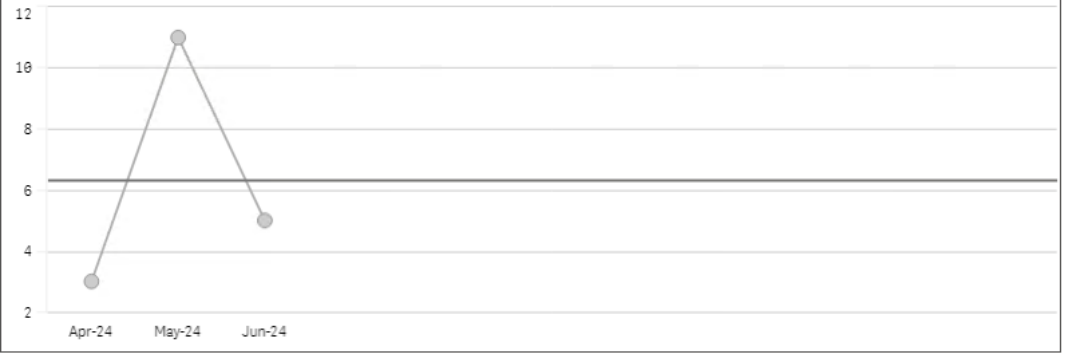


Variation	Assurance	Target	Latest
Expected	-	-	519

Monthly PSII
N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Improved	-	-	2

Monthly PSILR
N/A. Target differed in previous years



Variation	Assurance	Target	Latest
Improved	-	-	5

PSII Cases > 6 mths
. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	0

Understanding the Performance:
SRP reviewed 38 incidents in June of which 2 were declared PSIIs and a further 5 were assigned a learning response under PSIRF. the main theme continues to be delay. A PSII was declared in relation to delayed sending of referrals (TIA, Falls & Safeguarding). incidents being reported in relation to Mental health care continues to be monitored and are being added as a local priority for PSII on the Trusts PSIRP

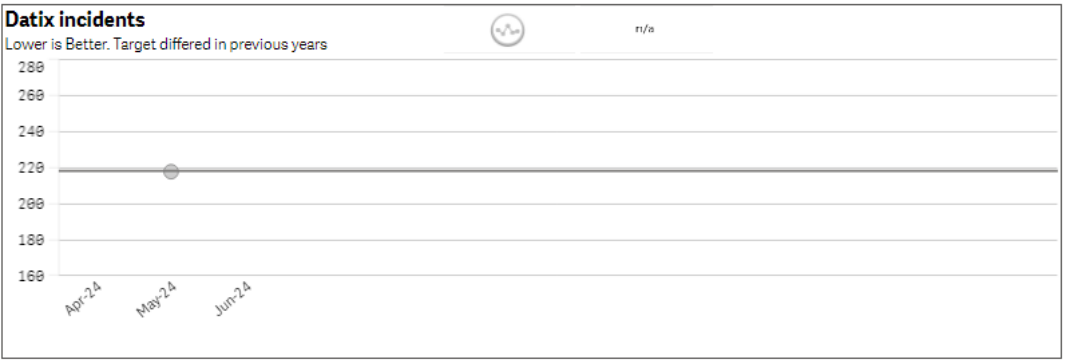
Actions (SMART):
PSIRF Lead in post. TNA nearing completion. PSP policy completed and submitted for approval. The trust has 2 SIs ongoing 1 stop the clock applied the other has the stop the clock removed and is now in progress. there are no other current open SIs for the Trust. the Trust continues to see timeliness of reviewing incidents at SRP with majority of incidents reviewed within 1 week of reporting. overdue actions from completed SIs are being tracked closely we have seen a 56% reduction of number overdue in month of June.

Risks:
Current limited capacity in the Patient safety team current 1 WTE PSM vacancy, interviews postponed no update if / when these can commence. No current senior leadership, gap at AD level, role recruited to unknown start date, interim role on hold no update. TNA is nearing completion currently PSMs leading on all PSIRs. PSS continues level 3&4 course with protected study time and is due 4 further in-person days at various locations.

Quality & Safety – PSIRF

Datix incidents

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	-	-	

Duty of Candour

Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	0.0%

Understanding the Performance:

5 Incidents reviewed in June had a statutory DoC applied to them. all those with a statutory DoC were within Regulation 20 time frame

Actions (SMART):

Reconfiguration of Datix has been carried out to enable accurate reporting of statutory / professional DoC. where Statutory DoC is applied to an incident this will be documented and evidenced within the datix with copies of follow up letters being uploaded to the datix. Any breaches in regulation 20 can also now be reported within the datix

Risks:

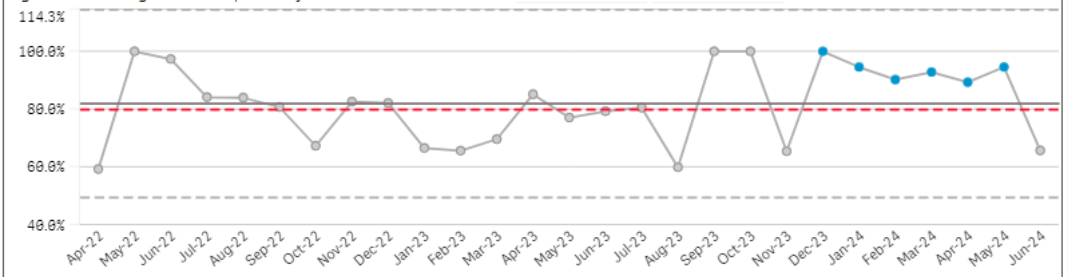
DoC policy is due for review and update in September, however NHSE are due to publish their up to date guidance until this is published the SCAS Policy update is on hold.

NHS

Quality & Safety - Audits

Building Audits %

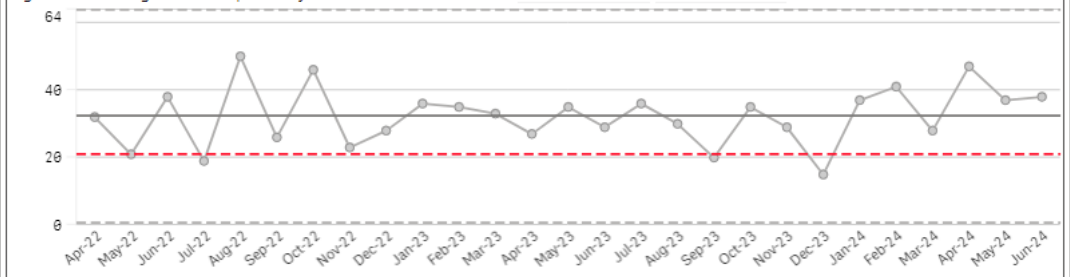
Higher is Better. Target differed in previous years



Variation
Expected
Assurance
Random
Target
80%
Latest
65.8%

Building Audits

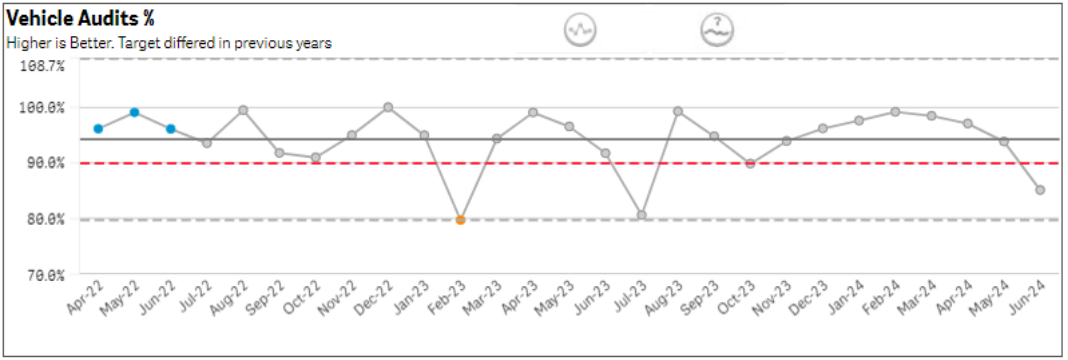
Higher is Better. Target differed in previous years



Variation
Expected
Assurance
Random
Target
21
Latest
38

Vehicle Audits %

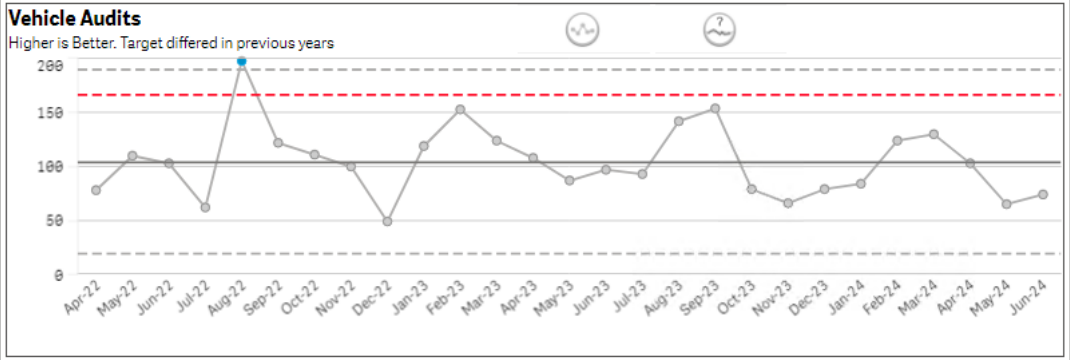
Higher is Better. Target differed in previous years



Variation
Expected
Assurance
Random
Target
90%
Latest
85.1%

Vehicle Audits

Higher is Better. Target differed in previous years



Variation
Expected
Assurance
Random
Target
167
Latest
74

Understanding the Performance:

Increased completion within building and vehicle audit rates. Building and vehicle compliance is below target. The ammended audit schedule commenced from May, therefore more audits completed also containing level 3 asurance audits which has ability to affect overall compliance, still within normal deviation.

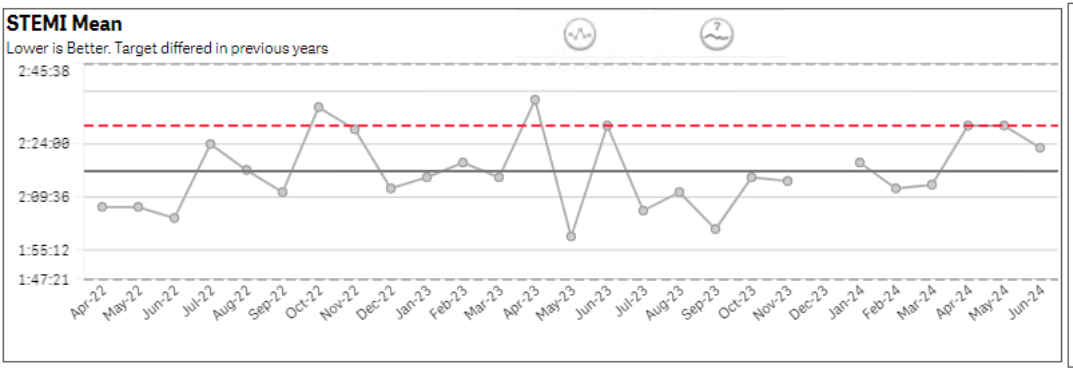
Actions (SMART):

IPC working closely with Quality Compliance Lead to support Operations embed and complete improvement action plans. IPC lead working with, monitoring quality within contracts meetings for make ready/cleaning contract with documented+ actions and monitored through IPC Commitee.

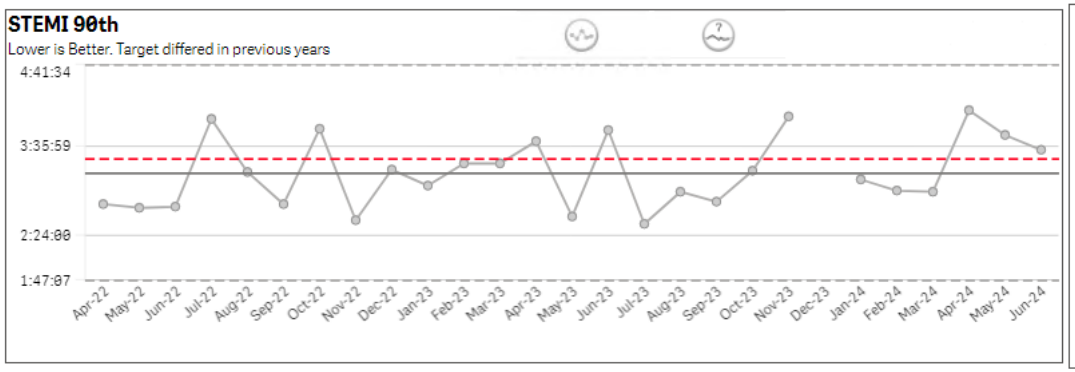
Risks:

If cleaning standards fall below Lower Conrol Limits this has the potential to affect patient care and safety due to increase in environemntal contamination leading to transmission, and increased rik of illness or infection to patients and staff.

Quality & Safety – AQIs – STEMI



Variation
Expected
Assurance
Random
Target
02:29
Latest
02:23



Variation
Expected
Assurance
Random
Target
01:35
Latest
01:37

Understanding the Performance:
within expected variation - February 2024 cases

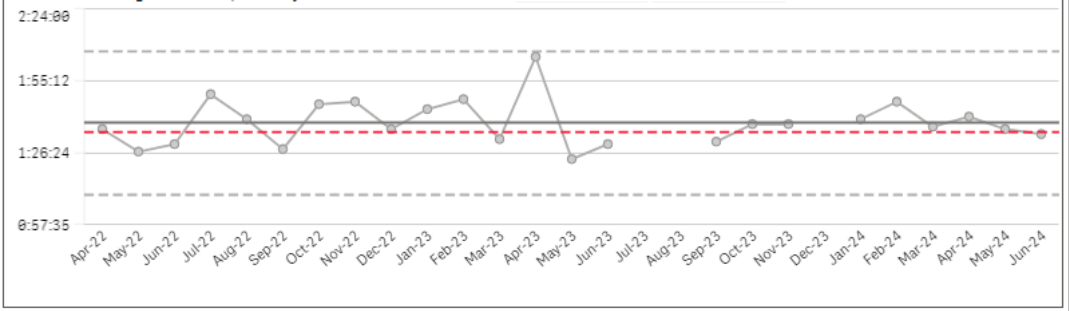
Actions (SMART):
Mean SCAS 2:23 (England 2:29) 90th Centile 3:33 (England 3:26) Cat 2 improvement plan in place

Risks:
Patient outcome if delays in care

Quality & Safety – AQIs – Stroke

Stroke Mean

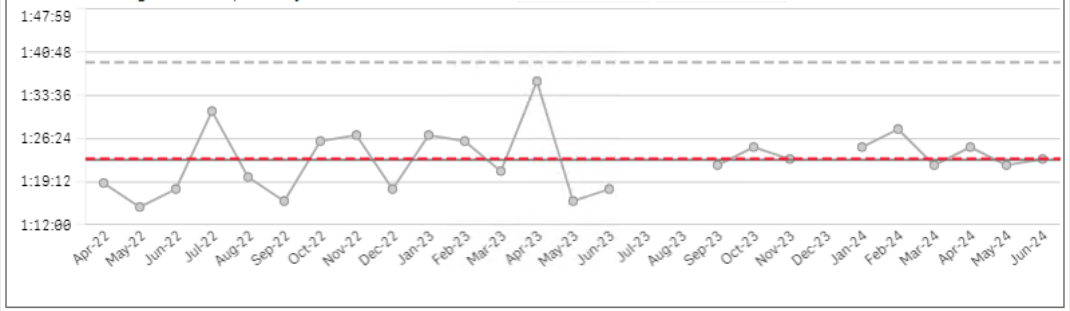
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	01:35
Latest	01:37

Stroke Median

Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	01:23
Latest	01:23

Stroke 90th

Lower is Better. Target differed in previous years

Variation	Expected
Assurance	Random
Target	02:28
Latest	02:39

Understanding the Performance:

within expected variation - February cases

Actions (SMART):

Mean SCAS 1:34 (England 1:35) 90th SCAS 2:15 (England 2:28) Cat 2 improvement plan in place

Risks:

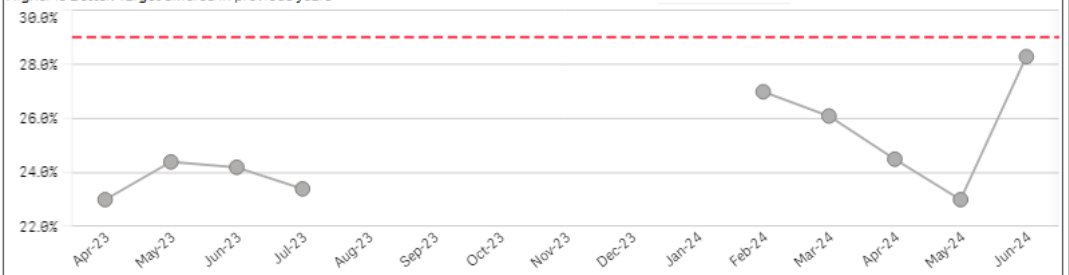
Time critical care

NHS

Quality & Safety – AQIs – Cardiac

ROSC All

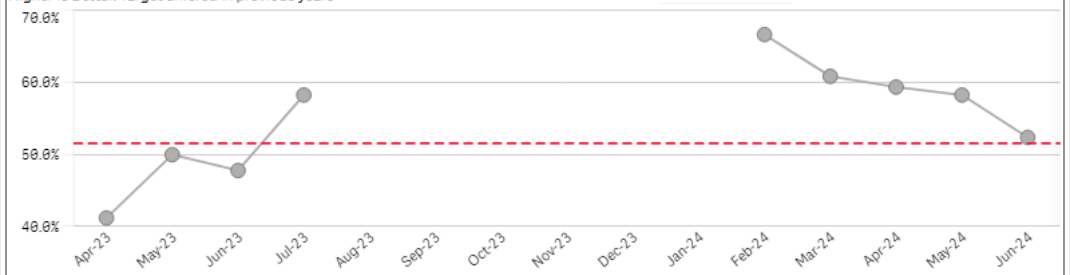
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	-	29.0%	28%

ROSC Utstein

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	-	51.5%	52%

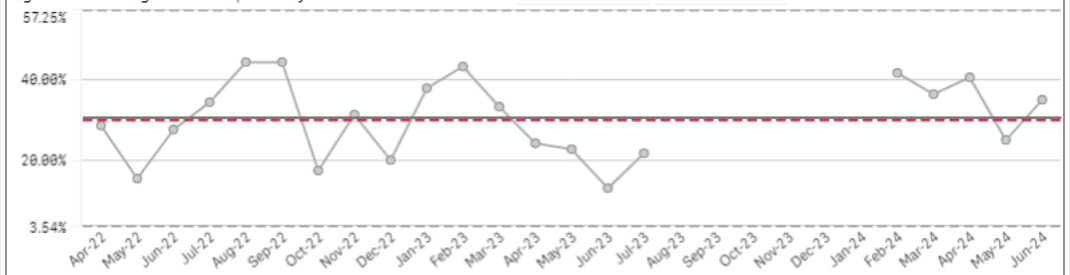
CA Survival All

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
	-	9.6%	11%

CA Survival Utstein

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	29.9%	0.35%

Understanding the Performance:

Within normal variation - February 2024 cases

Actions (SMART):

Survival at 30 days Utstein group 35% (England average 29.9%) ROSC Utstein SCAS 52.4% (England average 51.5%) Cat 2 improvement plan in place

Risks:

Patient care and survival

Quality & Safety – Safeguarding and Patient Experience

Complaints

N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	44

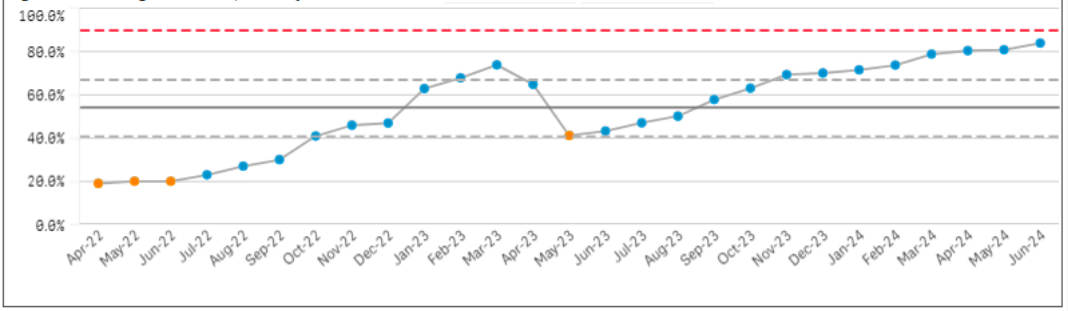
Complaints in time

N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Improved	-	-	97.0%

Level 3 Safeguarding

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	90%	84%

Understanding the Performance:

Actions (SMART):

Risks:

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

NHS People Overview

June-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L	Meal Break Compliance - SCAS			
	Appraisals - Trust		Over-runs >30 mins - SCAS	8
L				1
H				2
↗				
↘				

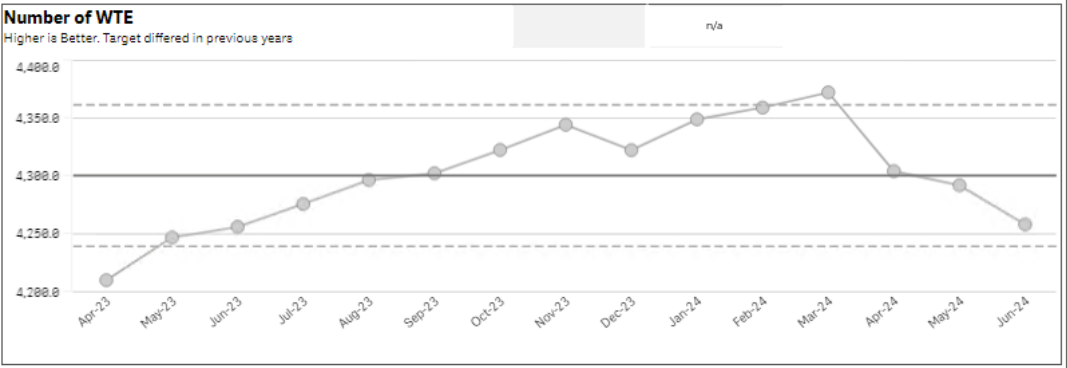
People - Workforce, Culture & Employee development, Employee experience

*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Jun-24	4,258			n/a	4301.0	4239.7	4362.2
% Trust staff who are BAME	Jun-24	7.0%	6.3%	H	n/a	5.7%	5.2%	6.3%
% Trust staff who are declared disabled	Jun-24	8.4%	8.6%	H	n/a	6.9%	5.8%	8.1%
% DBS Compliance	Jun-24	97.2%	95%		n/a	97.2%	-	-
% Turnover	Jun-24	16.4%		L	n/a	18.2%	16.6%	19.8%
% Vacancy	Jun-24	11.7%			n/a	10.4%	9.0%	11.7%
% Sickness in month	Jun-24	6.2%			n/a	6.5%	5.4%	7.6%
% Long term sickness	Jun-24	3.7%			n/a	3.8%	3.5%	4.0%
Appraisals - Trust	Jun-24	82.6%	95%		F	77.6%	70.3%	84.9%
% Stat and Mand Training	Jun-24				n/a	78.6%	-	-
Staff Engagement Score	Jun-24	5			n/a	5.0	-	-
FTSU Cases	Jun-24	19			n/a	11.4	-1.3	24.1
Meal Break Compliance - SCAS	Jun-24	45.1%	70%	L	F	51.6%	34.3%	68.9%
Over-runs >30 mins - SCAS	Jun-24	18.5%	25%		P	17.6%	15.1%	20.1%
Time to hire	Jun-24	118			n/a	102.5	-	-

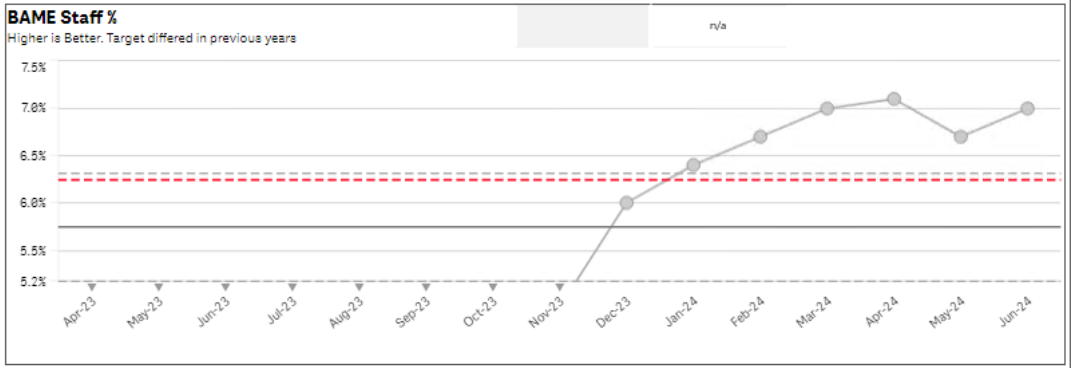
People - Workforce

Number of WTE
Higher is Better. Target differed in previous years



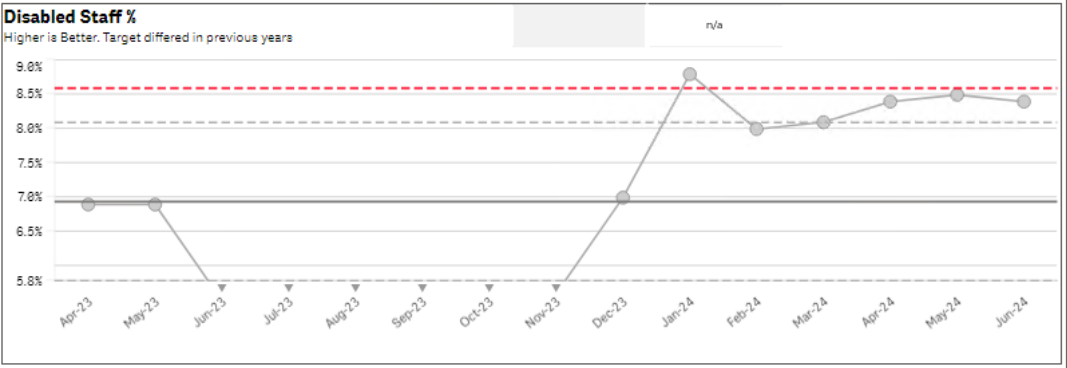
Variation	-
Assurance	-
Target	-
Latest	4258.1

BAME Staff %
Higher is Better. Target differed in previous years



Variation	-
Assurance	-
Target	6.3%
Latest	7.0%

Disabled Staff %
Higher is Better. Target differed in previous years



Variation	-
Assurance	-
Target	8.6%
Latest	8.4%

DBS Compliance
Higher is Better. Target differed in previous years

Variation	-
Assurance	-
Target	95%
Latest	97.2%

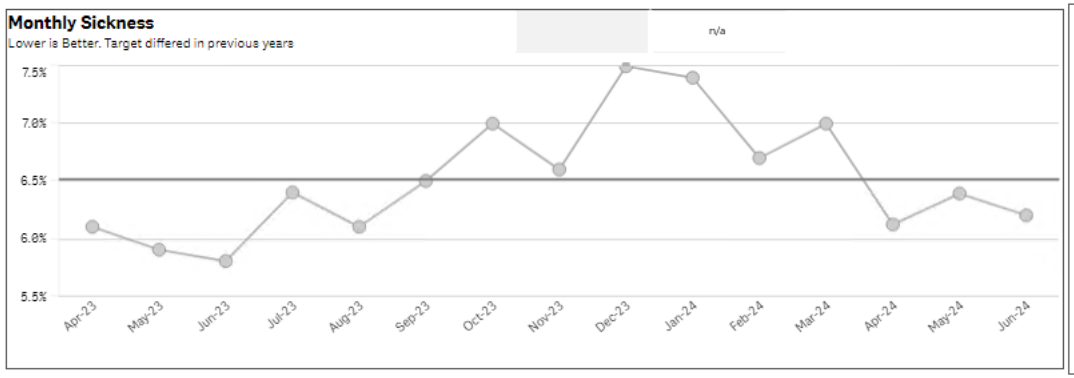
Understanding the Performance:
We have seen more leavers than joiners in June, but that is not unexpected as we have reduced our recruitment in CCC and many of the frontline operations start dates are in Q2. PTS recruitment has been challenging this month and the announcements about changes to contracts will clearly impact on retention moving forward.

Actions (SMART):
We have good fill rates for our NQP start dates in Q2. We need to re-work our PTS workforce plans for Q2 onwards.

Risks:

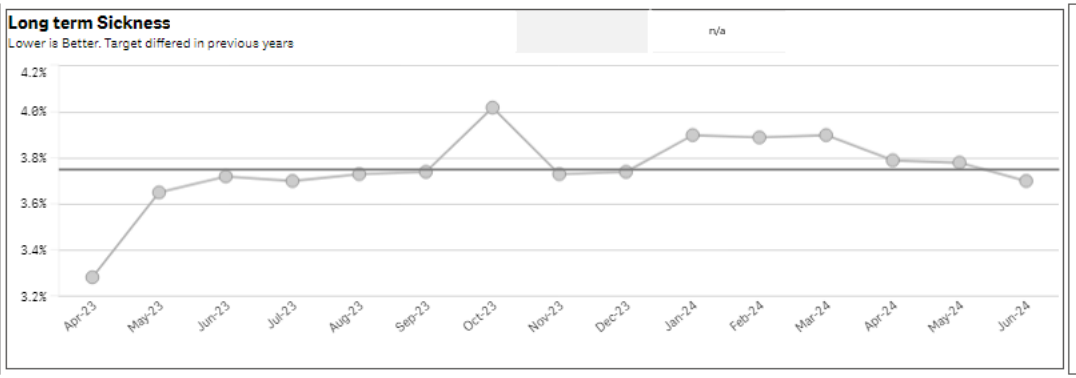
People - Workforce

Monthly Sickness
Lower is Better. Target differed in previous years



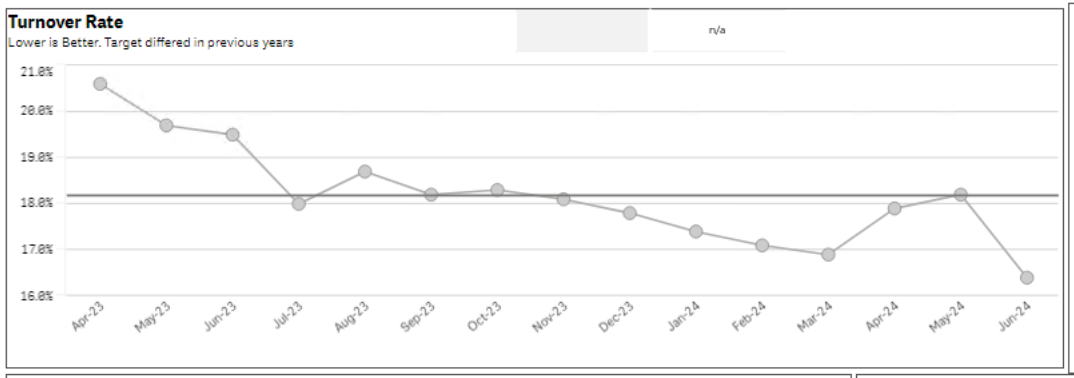
Variation
-
Assurance
-
Target
-
Latest
6.2%

Long term Sickness
Lower is Better. Target differed in previous years



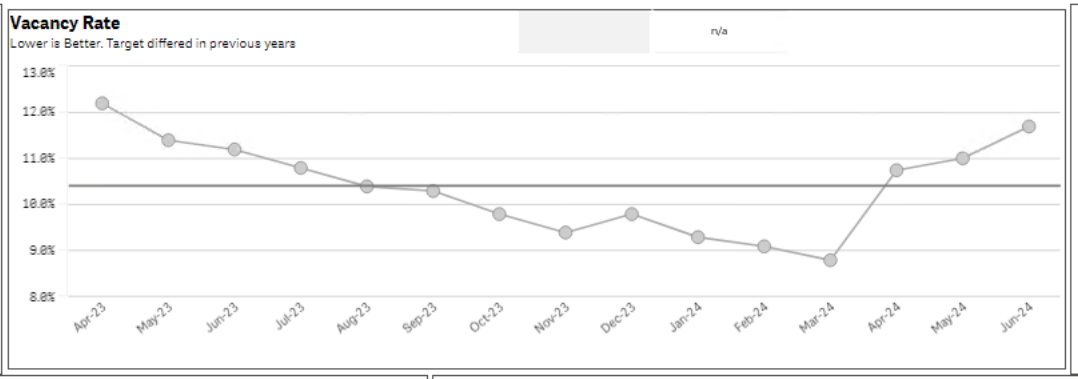
Variation
-
Assurance
-
Target
-
Latest
3.7%

Turnover Rate
Lower is Better. Target differed in previous years



Variation
-
Assurance
-
Target
-
Latest
16.4%

Vacancy Rate
Lower is Better. Target differed in previous years



Variation
-
Assurance
-
Target
-
Latest
11.7%

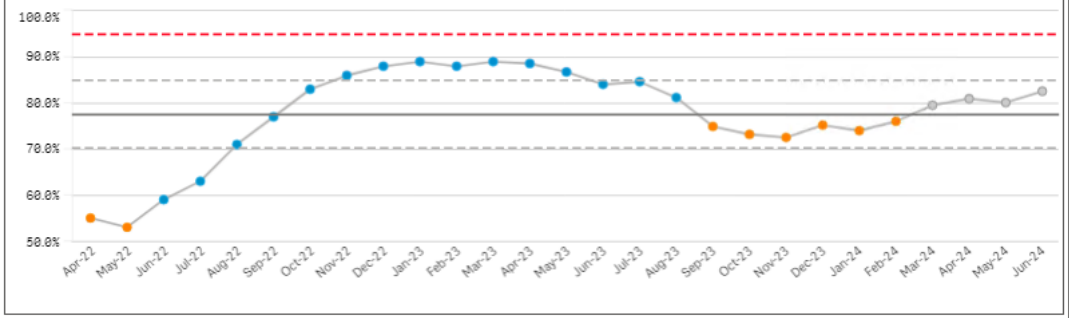
Understanding the Performance:
We have seen a reduction in turnover which may be a reflection of the reinvigoration of the retention and engagement plans within the Trust.

Actions (SMART):
Further plans are currently being developed with local leads to reflect local priorities and needs with support from our People Promise Manager and HR.

Risks:
As we go through a re-structure, this can be unsettling and we may see turnover increase outside of the planned reductions.

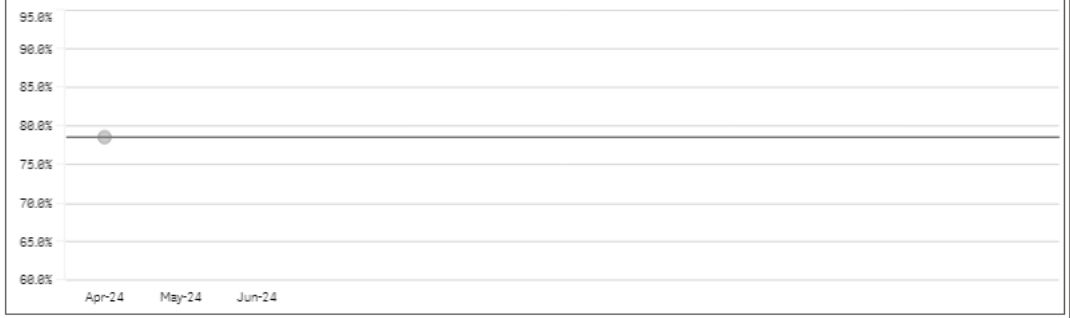
People – Culture & employee development

Appraisals
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	95.0%	82.6%

Stat and Mand Training
Higher is Better. Target differed in previous years

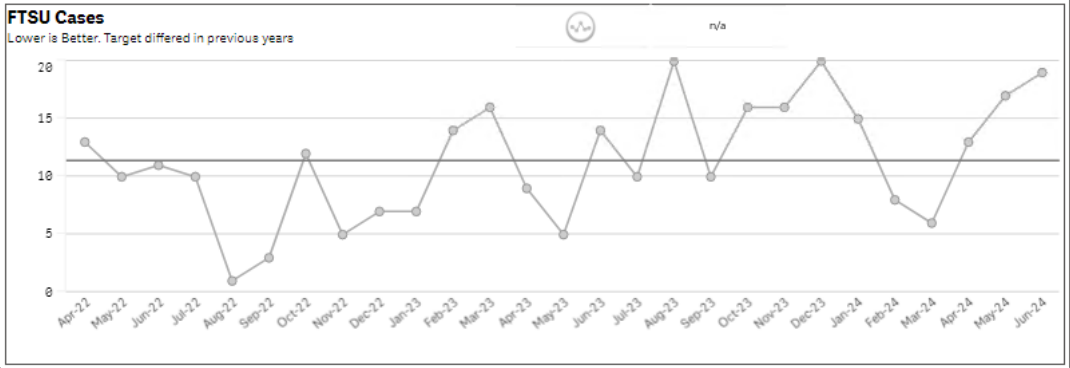


Variation	Assurance	Target	Latest
Expected	-	-	

Staff Engagement Score
Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	4.96

FTSU Cases
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	-	-	19

Understanding the Performance:
19 cases of which only 5 were 'open' continuing with the Fear and Futility theme where people are not feeling safe to speak up to Managers. Bullying & Harrasment, Sexual Safety and system/process are the higher concerns received.

Staff engagement scores is a quarterly figure from the national people pulse survey (April , July and January).

Between May 2024 and June 2024, there was a positive percentage change of 3.07% in PDR completion rate. Noting that 111 D and EOC C both maintained 100% increase from last month. OPS Support and Finance department continue to have challenges.

Actions (SMART):
FTSU newsletter circulated, sharing learning, themes and work completed by the Team. Manager drop-in sessions well attended providing support and safe space to discuss topics such as Sexual Safety. BME Conference attended. Reasonable adjustments work on-going with LD & EDI Lead. Interviews completed for Deputy Guardian; External FTSU Audit in progress.

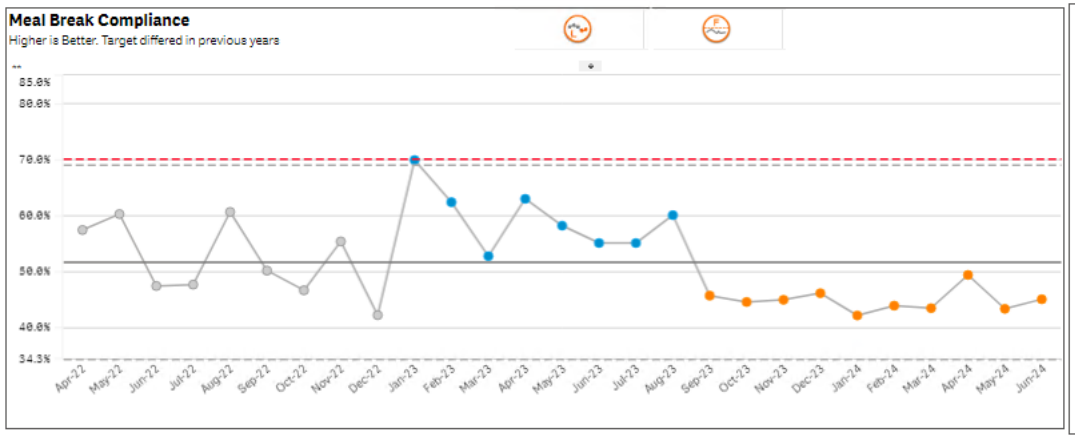
New template well received, progression made towards digital PDR solution.

Risks:
Increased case numbers and feeling of fear and futility. Defensiveness & lack of engaging/embedding/understanding of FTSU.

NHS

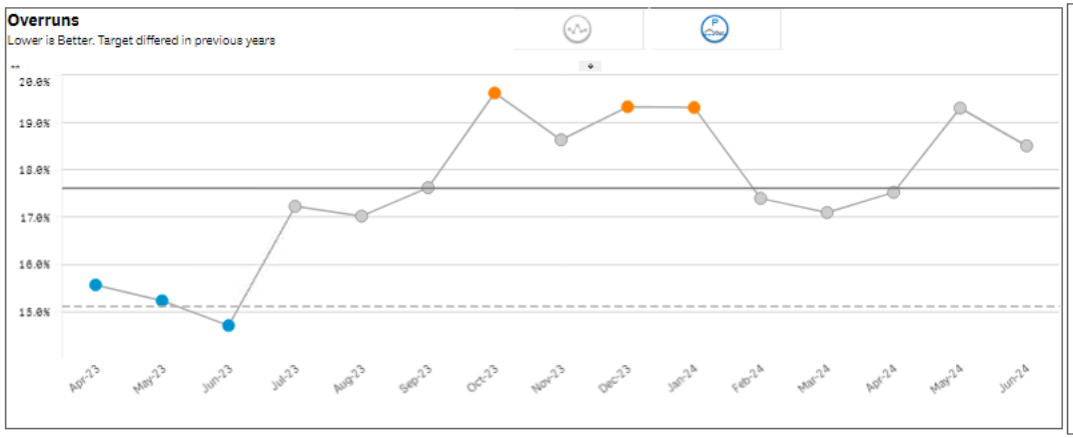
Workforce - Employee Experience

Meal Break Compliance
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Fail	70%	45.1%

Overruns
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	25%	18.5%

Time to Hire
Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	118

Understanding the Performance:
Meal breaks continue to fail and as such is a focus still, June saw a 1.6% improvement from may, this was partly attributed to the lower C2 demand in the first half of the month as well as the QA handover delays and movement of vehicles south to support the South East demand. Also in the month the overruns decreased compared to the previous months again attributable to demand and reduced delays.

Time to hire for June is higher than previous months. This is partly due to lower numbers recruited in June with a small number of candidates with external factors delaying start dates affecting the overall average.

Actions (SMART):
The unions have a greed a draft paper which now needs to be agreed at exec then two QIA's need to be completed to allow the trial to progress.

Risks:
The negative impact currently on staff and patients with the MB and EOS policies.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Finance

NHS Finance Overview

June-24 Summary

Metrics:

Assurance → F | ? | P

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				1
L				
		Debtors > 98 days> 5% total balance		
L				1
H				
↗				
↘				

*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Debtors > 90 days> 5% total balance	Jun-24	8.7%	5%			16.8%	-2.3%	36.0%
Agency Spend	Jun-24	155	363		n/a	327.778	106.282	549.274
Overall SOF Segment	Jun-24	4			n/a	3.55556	3.35094	3.76017
CIP's Total	Jun-24	2,608	3,173	-	-	855.933	-1,440.79	3,152.65
Pay Spend	Jun-24	17,500	17,704	-	-	17,749.1	13,019.7	22,478.6

Finance - Finance 2

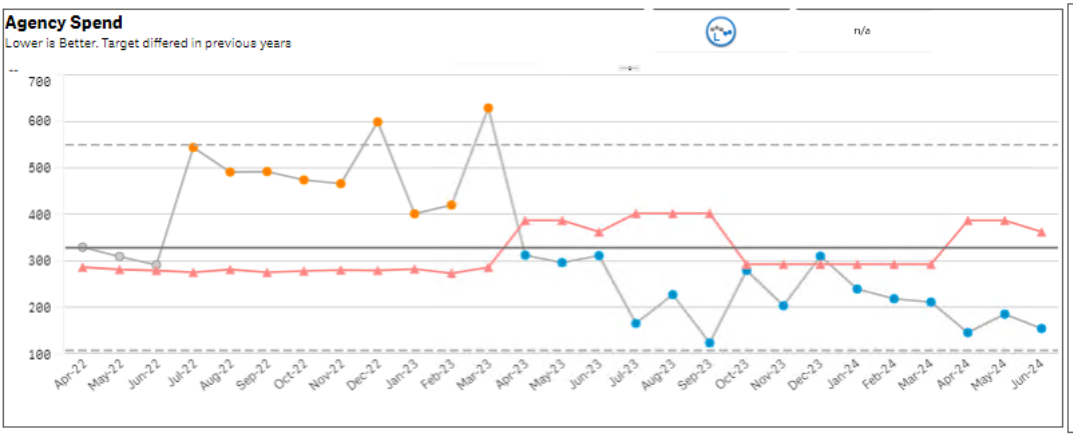
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Overall SOF Segment	Apr-24	4			n/a	3.556	3.351	3.76

Understanding the Performance:	Actions (SMART):	Risks:

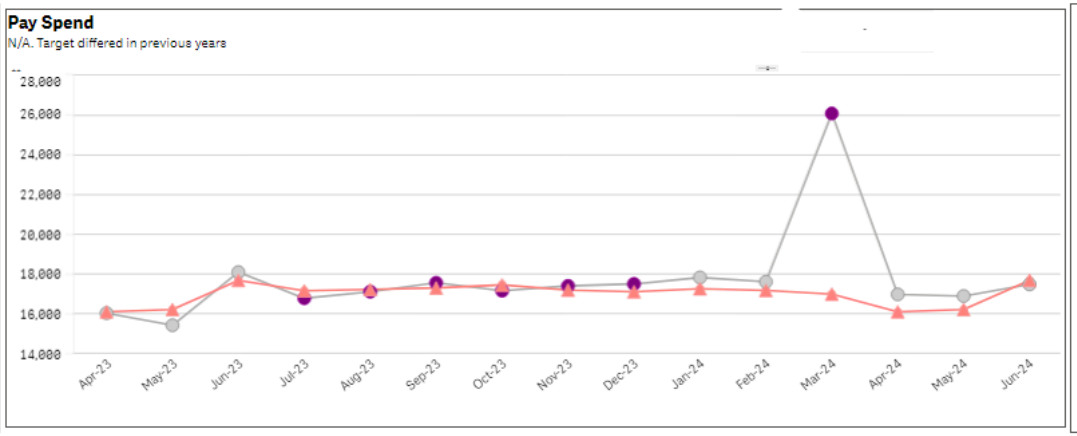
Finance - Finance 1

Agency Spend
Lower is Better. Target differed in previous years



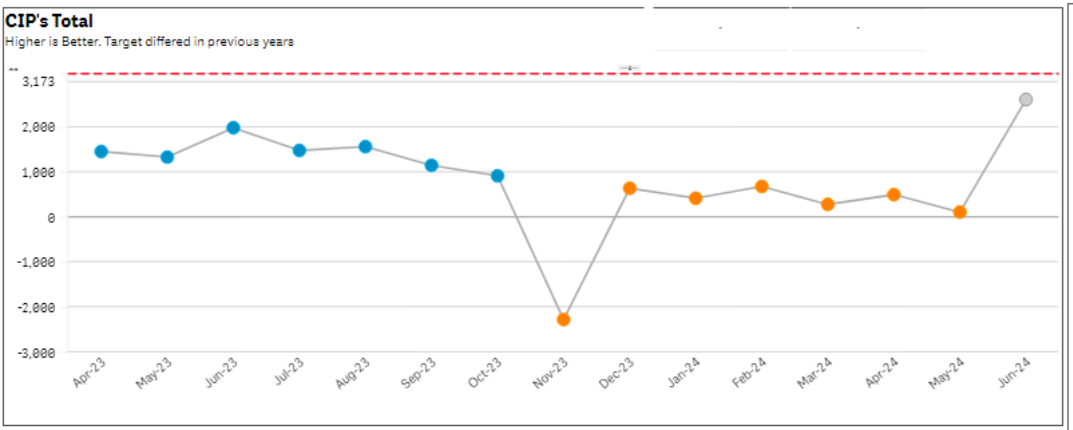
Variation	Assurance	Target	Latest
Improving	-	363	155

Pay Spend
N/A. Target differed in previous years



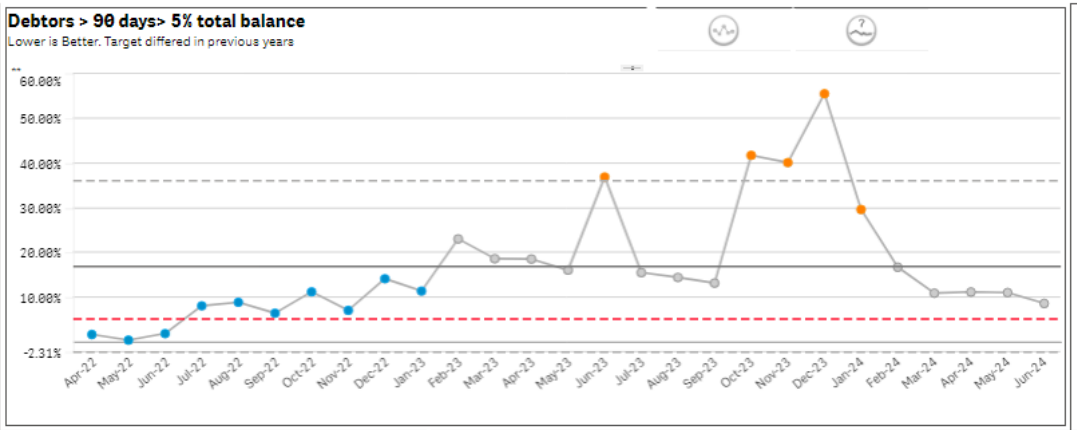
Variation	Assurance	Target	Latest
	-	17,704	17,500

CIP's Total
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	Fail	3,173	2,608

Debtors > 90 days> 5% total balance
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	5%	8.7%

Understanding the Performance:

Agency continues to reduce as the Trust replaces agency nurses in the 111 services with substantive staff.

This couple with the increase in frontline staff has lead to increase in the pay run rate.

The aged debt position for the month was £178k which was 8.67% of over all debt. This has increased by £78k since May and there is a focus on reduce this back below the 5% target.

There was a YTD catch up in CIPs with the year to date position now £3.2m against a plan of £4.5m.

Actions (SMART):

There is a weekly focus on the cost savings performance within the Financial Recovery Group and key areas such as PTS have specific recovery actions in place. We are starting to see the impact of this focus specifically within PTS.

Risks:

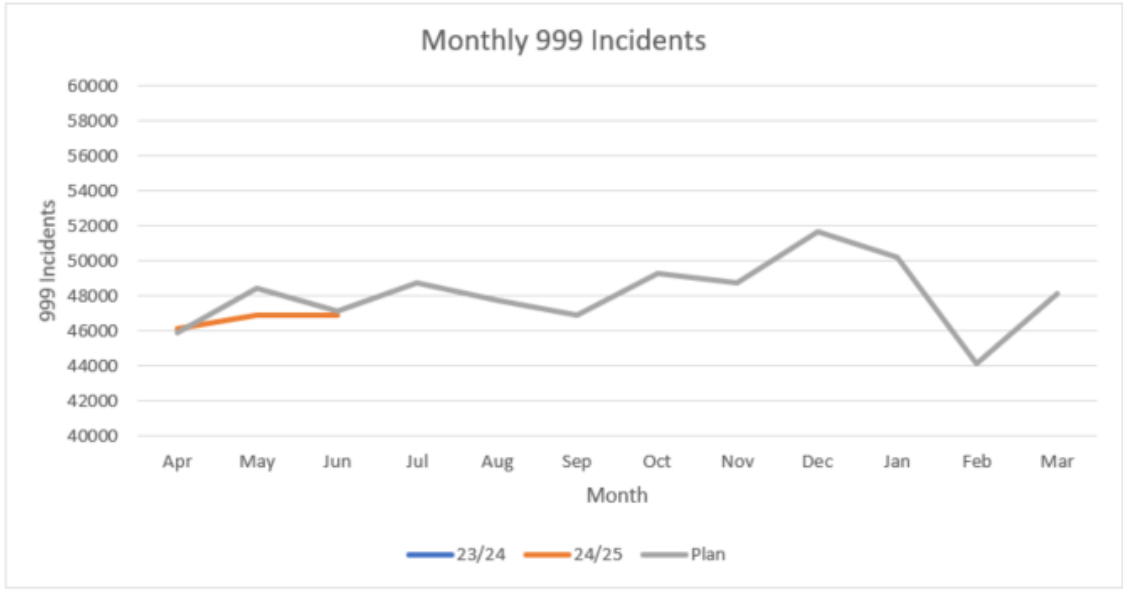
There is a risk that the loss the Thames Valley and Sussex PTS contracts may impact the Trusts' ability to reduce costs in line with the Financial Recovery Plan as the focus turns to the exit plan.

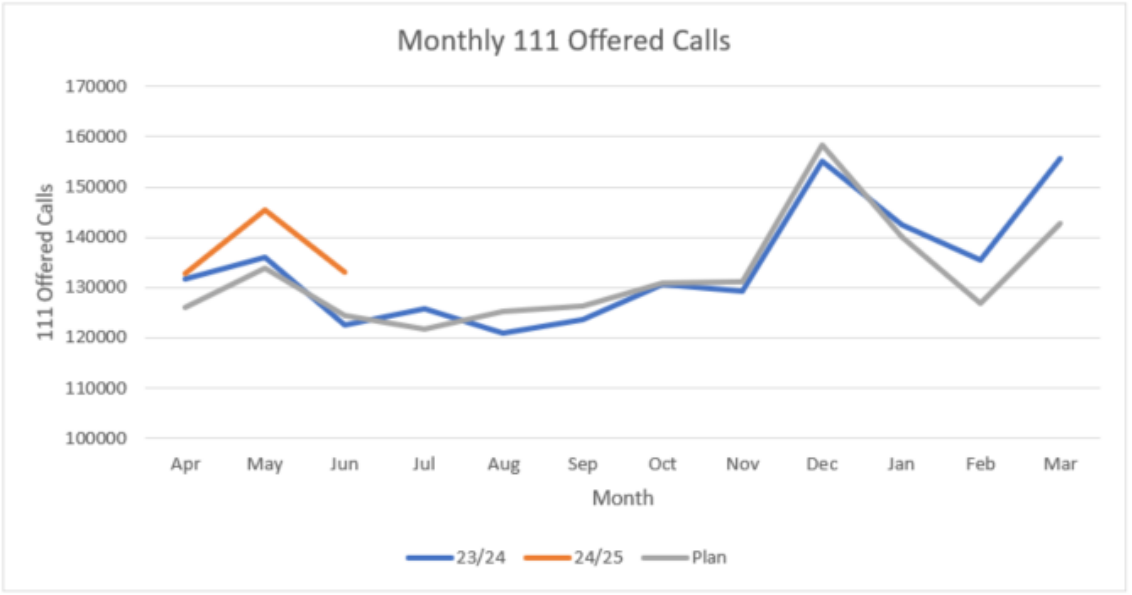
Other risks are the ability to achieve the financial improvement in the 999 service as the Trust focuses on meeting the national expectations around Category 2 response times.

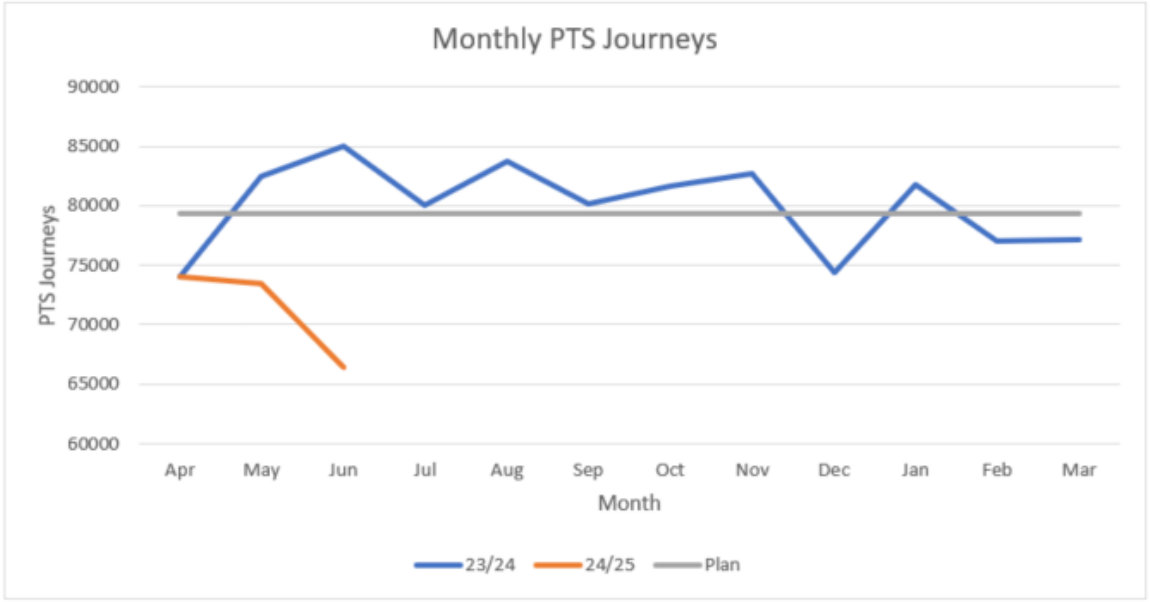
Data Quality Reference

Inaccuracies in Data Quality = Data is aggregated on a monthly average and therefore not accurate

	Accurate Data Quality	Inaccuracies in Data Quality
YTD	21	45
12 Months	21	45


Monthly 999 Incidents
999 Incidents
60000
58000
56000
54000
52000
50000
48000
46000
44000
42000
40000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Month
23/24
24/25
Plan


Monthly 111 Offered Calls
111 Offered Calls
170000
160000
150000
140000
130000
120000
110000
100000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Month
23/24
24/25
Plan


Monthly PTS Journeys
PTS Journeys
90000
85000
80000
75000
70000
65000
60000
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Month
23/24
24/25
Plan

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Report Cover Sheet

Report Title:	Quality and Patient Safety Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	10
Executive Summary:	Progress continues to be made against the objectives outlined in The *Patient Safety Improvement Plan.* There has been a review of RAG rating and several amendments made to the sustainability section taking them to amber from green, this includes: ○ IPC Audits, ○ Safeguarding (SAFF) and Level 3 training. ○ Mental capacity Act- embedding of knowledge. ○ Storage of medications **The top risks for the Trust** continue to be Handover Delays at the Queen Alexandra Hospital (25), Handover Delays at other hospitals (25) and Safeguarding System Outage (20). Progress against actions is monitored through local governance meetings and the committee structure. **Compliance.** Evidence gathered from compliance visits is being mapped to the quality statements and shared with EMC fortnightly. The management teams are working on communicating key messages and improving practice to embed correct compliance and practice. A monthly dashboard of audits is shared with the directorate leads so that local management team actions can be reviewed and tracked. A digital action tracker has been built and a guide is being developed. This will enable visibility and tracking of actions in a central location. **Infection Prevention and Control (IPC)** Vehicle audit compliance (deep cleans) remains a challenge and reporting remain the same as previous reports. E&UC have completed 183 audits, although below trajectory compliance within these remains at (93) %. NEPTS overall 53 audits completed with compliance of (95) %. Total Trust wide 236 audits completed with overall compliance of (93) %. Compliance action tracker is now available and will form the basis of the overarching improvement plan., **Pharmacy**

	Medicines Security – Track and Trace business case has been presented to ETB and soft market testing is now in progress. This will improve traceability. There has been a small increase in the numbers of CDs losses recorded this month, but investigations are ongoing and the main reasons for loss mitigated against. The Trust has applied for the Controlled Drug License and is awaiting contact from the Home Office. The pharmacy team are working to ensure all procedures and processes are ready for this inspection. **Medical Devices** All of SCAS's most critical clinical equipment listed on a BI dashboard which shov compliance status and performance data. **Safeguarding** Level 3 face to face Safeguarding training is currently reporting (85) % against a (90) %target. The discrepancy between business intelligence and education data is now resolved. This will ensure consistent reporting. Additional training sessions have been arranged. **The highest Safeguarding risk remains the ongoing technical interface issues, impacting on reporting, and non-compliance of staff in completing the SG referral process correctly.** A systematic end to end review of the system and associated processes is in progress by a Task and Finish group has mitigated many of the issues and is working to resolve them by September 2024. **Mental Health** Mental health response vehicle deployment in North remains on hold. Three vehicles are available but due to ICB funding concerns a new option needs to be considered. **Clinical / Non- Clinical Incidents** During the reporting period the Trust has noted a marginal increase overall in the number of reported patient safety incidents. This reflects the increasing service demand. Delay continues to be the main reporting theme but has reduced since the previous reporting period. **PSIRF / Serious Incidents** **Current PSIRP cumulative year to date activity, (8) PSIIs** have been declared with (2) requiring downgrading after scoping of the investigation found **no new organisational learning** in **relation to delay.** Currently **6 open PSIIs and 3 open Sis.** 1 Never Event (wrong route administration of medication- private provider) was reported on 22 May 2024. Investigation commenced. On review it was found that the PSIRF Policy was not explicit regarding the process. This has since been amended and a SOP developed. The patient was assessed in hospital and no adverse effects were found following the incident. The investigation report will be provided to EMC in due course. **Safety Review Panel (SRP) Activity**

	During this reporting period SRP had reviewed 41 incidents. There have been 2 After Action Reviews completed and 10 incidents benchmarked against the *Delays Thematic Review Actions* *Mental Health Care* related incidents added to the *Local Priorities* for PSII due to the continued need for monitoring of this theme of incident. **Duty of Candour** **(**1**)** incident breached DoC in May due to a miscommunication between providers**.** There is now a process in place to avoid any further future breaches. **Patient Experience (PE) and Engagement** All complaints responded to within agreed timescales achieving (95) % target. **PHSO** There is currently one case being reviewed by the PHSO. **Compliments** The trust received (217) compliments for the care and services delivered by our staff.
Recommendations:	The Trust Board is asked to: Receive the paper and note the key quality and patient safety issues and indicators.
Accountable Director:	Professor Helen Young, Chief Nursing Officer
Author:	Sue Heyes, Deputy Chief Nursing Officer / Director of Nursing and Quality
Previously considered at:	Patient Safety and Experience Committee Quality and Safety Committee
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable - Overall Partial - Safeguarding Referral System
Justification of Assurance Rating:	Internal and external process of scrutiny against improvements plans (Patient Safety Delivery Group, IPOB, TPAM) External peer reviews (ICS) and system partners
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	All Quality Domains
Next Steps:	Safeguarding System Review has commenced and subsequent actions and recommendations to be managed at Patient Safety and Experience Committee and upwardly reported to Quality and Safety Committee.
List of Appendices	

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PUBLIC TRUST BOARD PAPER

Title	Quality & Patient Safety Report
Author	Sue Heyes, Deputy Chief Nursing Officer
Responsible Director	Professor Helen Young, Chief Nursing Officer
Date	July 2024

1. Purpose

1.1 The purpose of the paper is to provide the Board with a summary against the statutory quality and safety processes necessary to ensure the delivery of safe, effective clinical care to our patients and our people.

1.2 The report presents the data relating to the period **May - June 2024** (unless otherwise stated), and will highlight risks, issues and mitigations which are reflected in the Corporate Risk Register (CRR), Integrated Performance Report (IPR) and Board Assurance Framework (BAF). The information provided within the paper demonstrates evidence of compliance against Care Quality Commission (CQC) regulations where appropriate.

2. Executive Summary

2.1 The Patient Safety Improvement Plan consists of specific workstreams which include, Safeguarding, Patient Safety and Experience, Management of Medical Devices and Equipment, Medicines Management and Infection Prevention and Control (IPC). The actions are managed and monitored through the Patient Safety Improvement Plan which reports and provides assurance to the Patient Safety Delivery Group (PSDG) and the Integrated and Oversight Board.

2.2 A review of the projects sustainability RAG rating has resulted in an amber (from green) position for four areas, this includes, IPC Audits, Safeguarding (*SAFF, Level 3 Training, Mental Capacity Act- embedding of knowledge and the Storage of Medications*). This is being managed through PSDG and relevant committee structure.

2.3 Safeguarding Level 3 face to face training compliance is currently (85) % against a (90) % target.

2.4 The top risks for the Trust continue to be handover delays at the Queen Alexandra Hospital (25), Handover delays at other hospitals (25) and Safeguarding system outages (25). All risks are reviewed through the relevant committee structures.

2.5 During the reporting period compliance visits have continued to be increased across the Trust. Evidence is being mapped to the quality statements by the compliance team. This will increase visibility of the evidence sources and identify any associated gaps.

2.6 A regular oversight report is provided to Executive Management Committee.

2.7 Since the introduction of PSIRF (April 2024) there have been (8) PSII declared. with (2) requiring downgrading after scoping of the investigation found **no new organisational learning** in **relation to delay** and therefore were referred for benchmarking against the *Delay Thematic Review Recommendations.* There are currently (6) open PSIIs.

A decision has been made to add *Mental Health Care* related incidents to the *Trusts. Local Priorities* for PSII due to the continued need for monitoring of this theme of incident.

3. Main Report and Service Updates

3.1 Compliance

Since the last board update webinars to both senior leadership group and all SCAS have been completed. The aim of the meetings was to share information with staff across the trust regarding CQC assessment methodology.

Evidence is being mapped to the quality statements by the compliance team. This will increase visibility of the evidence sources and identify any associated gaps. The associated driver diagrams are presented at EMC and shared with the Senior Leadership Group for discussion. They will also be the focus of the discussion at the quality statement self-assessment group.

The management teams are working on consistency in terms of communication and practice. A monthly dashboard of audits is shared with the directorate leads so that local management team actions can be reviewed and tracked.

A digital action tracker has been built and a guide is being developed. This will enable visibility and tracking of actions in a central location.

3.2 Infection, Prevention and Control (IPC)

IPC Level 2 training compliance has demonstrated a marginal increase to (88) % during the reporting period. Bespoke training and support continues to be provided to improve the overall audit compliance position. There have been **no reported IPC harm related incidents** during the reporting period.

Vehicle Audits overall have remained static. E&UC have completed 183 audits, although below trajectory compliance within these remains at (93) %. NEPTS overall 53 audits completed with compliance of (95) %. Total Trust wide 236 audits completed with overall compliance of (93) %. **IPC have commenced Level 3 Assurance Audit Programme, and a specific IPC Improvement Plan is now being managed through the IPC Committee to address the on specific challenges.**

Compliance action tracker built, access now developed for individuals to access to update actions from IPC Audit, and feed into stations overall improvement plans. A “how to” guide is under development to support the role out of the compliance action tracker. Actions open, in progress and completed will be reported through IPC Committee

3.3 Pharmacy

Medicines Security – Track and Trace business proposal has been presented to ETB and soft market testing is now in progress. This will improve traceability. The safe and secure handling of medicines gap analysis completed in 2021 is being reviewed with a view to progress improvements and consider introduction of electronic cabinetry.

Pharmacist capacity remains a concern currently there is only 1.2WTE Pharmacists working within the trust due to maternity and vacancy so interim support requested.

The project board has been established for in house medicines bag packing and workstreams are underway.

The Trust has applied for the Controlled Drug License and is awaiting contact from the Home Office. The pharmacy team are working to ensure all procedures and processes are ready for this inspection.

There has been a small increase in the numbers of CDs losses recorded this month, but investigations are ongoing and the main reasons for loss mitigated against.

3.4 Management of Medical Devices

SCAS Clinical Equipment department is currently undergoing significant change as the Equipment Manager has left SCAS and recruitment activities are underway to recruit a new Clinical Asset Manager to take the department forwards.

The future department will be integrated into the wider central logistics team to facilitate a smoother working relationship between the departments and very positive progress has already been made.

The team now have all SCAS's most critical clinical equipment listed on a BI dashboard showing the very latest compliance and performance data to allow SCAS to have a significantly improved governance mechanism in place.

The Asset Management System project has commenced after having to overcome some procurement and IT governance challenges. This will start to be operationalised over the coming months with further board updates to be provided in future reports.

3.5 Safeguarding

Level 3 face to face Safeguarding training is currently reporting (85) % against a (90) %target.
The discrepancy between business intelligence and education data is now resolved to ensure consistent reporting. Additional training sessions have been arranged.

An incident in May 2024, resulted in 109 being delayed referrals requiring risk assessment and processing. Although this demonstrated that the governance system in place to detect delays worked, it showed some of the Trust processes and interfaces are not fully effective. The exec led Task and Finish Group is addressing this and has mitigated the issues identified.

All the referrals from this incident have been assessed and processed through to Local Authorities. Many were found to be duplicated (i.e., already processed). One referral has been rag rated red (as risk of harm). This is being assessed with system partners.

3.6 Mental Health

Mental health response vehicle deployment in North remains on hold. Three vehicles are available but due to ICB funding concerns a new option needs to be considered.

3.7 Clinical Incidents

During the reporting period there were (81) patient safety incidents reported in EOC, which accounts for 75% of all incidents reported by this service line. This is an increase in patient safety incident reporting when compared to March and April when 53 were reported. This reflects the increasing service demand, evidenced by a return to REAP 3 on the 14 May 2024 and EPSP activations on the 26 & 27 June 2024.

The top three reported patient safety incident categories across both EOCs during the reporting period continue to be, Delay, Patient Treatment / Care, and Non-attendance.

3.7.1 999/E&UC

During the reporting period there were (760) patient safety incidents reported. an increase of 38% from the previous reporting period. The severity of cases remaining low with (694) incidents being logged as low or no harm.

The top three reported categories were Patient Treatment / Care (265), Clinical Equipment (157) and Medicines (129).

3.7.2 NEPTS

During the reporting period there were (117) patient safety incidents reported, remaining within normal variation. Most incidents are graded as no or low harm. The top 3 categories continue to be slip, trip and fall, patient treatment / care, and ill health.

3.7.3 NHS 111

During the reporting period there were (96) patient safety incidents reported. There has been a decline in reporting notably since LFPSE was implemented in April 2024. This is being closely monitored by governance team. The two most prevalent categories continue to be Delay and Patient treatment / Care.

The main themes for SCAS 111 relate to potential inappropriate dispositions, not logging out of phone, delays caused by cases in case tracking queue and Category 2 ambulance responses being placed into the validation queue.

The main theme for Primary Care continues to relate to callers being sent to 111 for appointments which we are not able to access. Pharmacies are also redirecting callers back to 111 instead of directly referring themselves. These have both reduced since the last reporting period and the ongoing communication with the services continues.

There has been one (111) PSII declared in June relating to multiple missed opportunities for a quicker response.

3.8 Patient Safety Incident Response Framework (PSIRF)

Current PSIRP cumulative year to date activity, (8) PSIIs have been declared with (2) requiring downgrading after scoping of the investigation found **no new organisational learning** in **relation to delay** and therefore were referred for benchmarking against the Delay Thematic Review Recommendations

There are currently (6) open PSIIs.

A decision has been made to add Mental Health Care related incidents to the Trusts.
Local Priorities for PSII due to the continued need for monitoring of this theme of incident.

The Patient Safety Partners Policy has been drafted and will be submitted for approval at PSEC in August.

Sustained Safety Improvements: Delay in treatment incidents: Although showing a notable decline during this reporting period of incidents of this category requiring a learning response the Trust still sees this being the main theme of PSI being reported. However, the harm attributable to Delay in the majority of the reported incidents is no / low harm.

There has been no **new learning** from the incidents reviewed in relation to delay in this reporting period however (3) have required benchmarking against the Delays Thematic Analysis.

Duty of Candour: (1) incident breached DoC in May due to a miscommunication between providers. There is now a process in place to avoid any further future breaches.

Duty of Candour Policy is due for review and updating in September 2024, initial review has commenced however NHS England haven to yet published the updated guidance in relation to PSIRF.

3.9 Patient Safety Incidents

Year to date the Trust has identified (3) Sis and (8) PSIIs.

1 Never Event (wrong route administration of medication- private provider) was reported on 22 May 2024. Investigation commenced. On review it was found that the PSIRF Policy was not explicit regarding the process. This has since been amended and a SOP developed. The patient was assessed in hospital and no adverse effects were found following the incident. The investigation report will be provided to EMC in due course.

3.10 Safety Review Panel (SRP) Activity

During this reporting period (at time of writing this report) SRP had reviewed (41) incidents

- 5 Patient Safety Incident Investigations
- 2 After Action Reviews
- 10 incidents bench marked against the Delays Thematic Review Recommendations
- 6 incidents required learning responses.
- 18 incidents referred for local management of incident with no learning response required under PSIRF.

3.11 Patient Experience (PE) and Engagement

The data presented in the IPR show no significant change (common cause variation) in the number of PE cases received during the reporting period.

The Trust received 566 PE contacts during the reporting period;

- Formal Complaint – 88
- Concern – 162
- HCP Feedback - 316

There is currently (1) case being reviewed by the PHSO. The Trust has received provisional views for one case in the NW 999/HEMS which was not upheld and a NHS111 Thames Valley case which was upheld, and a £5000 remedy payment has been requested.

Themes of Patient Experience cases remain; inappropriate disposition (NHS111), CPR protocol when a patient has died (EOC), delay in/no attendance of frontline 999 and PTS vehicles and safeguarding referrals that have not been explained to callers/patients properly.

The Trust have now held several Patient Panel meetings. The meetings were productive and workstreams for improvement through patient engagement were scoped with the panel members.

All complaints responded to within agreed timescales achieving (95) % target.

3.12 Compliments

During the reporting period the Trust received (217) compliments for the care and service delivered by our staff.

4. Recommendations

4.1 The Board is invited to note the content of the report.

Sue Heyes, Deputy Chief Nursing officer

Date: 17 July 2024

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Report Cover Sheet

Report Title:	Chief Medical Officer's Report
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	25 July 2024
Agenda Item:	11
Executive Summary:	The purpose of the paper is to update the Board on key clinical issues relating to: 1. SCAS Clinical Research 2. Ambulance Clinical Quality Indicators (ACQI) Exception Report 3. Roll out of access to Thames Valley Integrated Health Record for frontline clinicians from 17th July 2024
Recommendations:	The Trust Board is asked to **note** the contents of the Chief Medical Officer's report.
Accountable Director:	John Black Chief Medical Officer
Authors:	Martina Brown Research Steering Group Jane Campbell Assistant Director of Quality John Black Chief Medical Officer
Previously considered at:	N/A
Purpose of Report:	Note
Paper Status:	Public

Assurance Level:	**Assurance Level Rating Options** • **Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	N/A
Strategic Objective(s):	High Quality Care & Patient Experience
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	Clinical Effectiveness
Next Steps:	• Continue to expand SCAS Clinical Research Portfolio • Monitor frontline utilisation of Shared Care Records to support clinical decision making /care navigation and to extend access throughout SCAS. • Roll out of GoodSam App to mobilise SCAS volunteer staff responders, Co-responders and CFRs to further improve Cat 1 response times and outcomes for patients suffering Out-of - hospital cardiac arrest
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Public Board Meeting Report

Name of Meeting	Board of Directors in Public Meeting
Title	Chief Medical Officer's Update
Author	John Black Martina Brown Jane Campbell
Accountable Director	John Black
Date	July 2024

1. Purpose

The purpose of the paper is to update the Board on key Clinical Issues relating to:

- SCAS Clinical Research
- Ambulance Clinical Quality Indicators (ACQI)
- Roll out of access to Thames Valley Integrated Health Record for frontline clinicians 17th July 2024.

2. Executive Summary

2.1 Clinical Research Update

Table 1 below shows the participant's recruitment into the currently opened to recruitment research projects in the trust.

Study title/acronym/IRAS number	**Current recruitment/ Participants type** ***[updated to 16 July 2024]***	**NIHR endorsement**
Randomised controlled trial of the clinical and cost-effectiveness of cervical spine immobilisation following blunt trauma (SIS Trial); IRAS 316755	125 patients	• Non-commercial • NIHR portfolio • Interventional • Pre-hospital speciality

Early surveillance for autoimmune diabetes (ELSA); IRAS 309252	462 patients online	• Non-commercial • NIHR portfolio • Interventional • Primary care/community speciality
Intramuscular tranexamic acid for the treatment of symptomatic mild traumatic brain injury in older adults: a randomised, double-blind, placebo-controlled trial (CRASH4); IRAS 283157	372/patients	• Non-commercial • NIHR portfolio • IMP (drug) trial • Pre-hospital speciality
Pre-hospital randomised trial of medication route in out-of-hospital cardiac arrest (PARAMEDIC3); IRAS 298182	748 patients	• Non-commercial • NIHR portfolio • Interventional • Pre-hospital speciality • **Trial completed its patient recruitment stage on 1 July 2024** • **SCAS is the second best among the eleven recruiting ambulance services.**
Cardiac arrest 'Bundle of Care' trial (CABARET) (IRAS329970)	5 patients	• Non-commercial • Interventional • 'Home-grown' project, in collaboration with HIOWAA
A Phase IIIb randomized open label study of nirsevimab (versus no intervention) in preventing hospitalizations due to respiratory syncytial virus in infants (HARMONIE) IRAS 1005180)	70 patients (main phase) 46 patients (2nd year follow up phase)	• Commercial • NIHR portfolio • IMP (drug) trial • Community/Acute speciality
Protocol Title: Specialist Pre-Hospital Redirection for Ischaemic stroke thrombectomy: a cluster randomised controlled trial with included health economic and process evaluations (SPEEDY)	KPI screening only	• Non-commercial • NIHR portfolio • Interventional/observational • Pre-hospital speciality

(IRAS: 312053)		
Protocol Title: Randomised trial of clinical and cost effectiveness of Administration of Prehospital Fascia Iliaca compartment block for emergency hip fracture care Delivery (RAPID 2) (IRAS: 291853)	Staff undertaking specialised training to deliver the project on scene	• Non-commercial • NIHR portfolio • Interventional/observational • Pre-hospital speciality

The **Emergency Research Dispatcher/Research Assistant**, a newly introduced and innovative role (externally funded) within the research team, is with collaboration with the research team members effectively meeting its objectives of increasing access to clinical research opportunities for our patients. This role plays a crucial part in alerting frontline clinicians to potential research enrolment opportunities, thereby enhancing patient participation in research studies.

The SCAS research team is organizing extended opportunities for University of Southampton (UoS) medical students to clinically shadow and gain observation experience in the Southern House 999 / 111 Clinical Coordination Centers.

The SCAS research team have been invited by the Wessex CRN partners to contribute to the NIHR bid for the Commercial Research Delivery Centers (submitted on 3 July 2024). If successful, this bid will secure continuous funding for our pharmacy, finance, and research teams for the next seven years. However, these operations must be tied to commercial projects delivered through the partnership network. These operations will be capable of generating capacity funding.

SCAS researchers have been invited to speak at a number of scientific events, including the 999 Emergency Medical Services Conference (September), the First Responder Conference (October), and the Wessex CRN Conference (October). Additionally, SCAS research delivery model has been nominated for a Parliamentary award, although the shortlisting process has been postponed due to governmental elections. Two abstracts (Stalled; Posed) co-authored by the SCAS research team members were selected for poster presentation at the national key conference 999 EMS this year. As these abstracts were accepted through the peer review process, they will be also eligible for publication in an online conference supplement of the Emergency Medicine Journal.

Helen Pocock, Senior SCAS Research Paramedic, has been awarded her NIHR Doctorate on a Feasibility to assess Prehospital Optimal Shock Energy for Defibrillation (POSED) – the first research paramedic at SCAS to achieve this

prestigious milestone. Dr Pocock's project was chosen for a poster presentation at the 999 EMS conference in September 2024.

Success story: The NIHR Clinical Research Network' **final issue of VISION magazine** (e-link VISION Magazine: Summer 2024 by nihr.crnwessex - Issuu) on pages 44-47 celebrates the collaboration between SCAS research team and UHS Southampton clinical team.

2.2 Ambulance Clinical Quality Indicators (ACQI) Exception Report

The audit team are working to ensure that the trust submits the national data on time for current audits and continuing the catch-up plan for the submissions that were not possible during the EPR outage.

The tables below shows benchmarked data for the national clinical indicators for January 2024.

ACQIs - Jan '24 - Against Average

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Difference	Greater or lower than Average	Comments
% Cardiac Arrest ROSC At Hosp	14.29%	30.02%	15.73%	24.31%	23.02%	-1.29%	↓	% of Cardiac Arrest patients who ROSC'd at hospital handover
% Cardiac Arrest Ustein ROSC	0.00%	60.47%	60.47%	46.50%	58.33%	11.83%	↑	% of Ustein patients who ROSC'd at hospital handover
% Cardiac Arrest Survive At 30 Days	0.00%	10.60%	10.60%	7.37%	8.80%	1.43%	↑	% of Cardiac Arrest patients who survive to 30 days
% Cardiac Arrest Utstein Survive At 30 Days	0.00%	34.00%	34.00%	21.11%	25.00%	3.89%	↑	% of Utstein patients who survive to 30 days
% Cardiac Arrest Resus Care Bundle Achieved	56.18%	100.00%	43.82%	78.20%	56.18%	-22.02%	↓	% of Cardiac Arrest patients that received the care bundle
% STEMI Care Bundle	42.86%	94.74%	51.88%	76.19%	58.21%	-17.98%	↓	% of patients that received the care bundle
% Stroke Care Bundle Achieved	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		% of patients that received the care bundle
STEMI PPCI Mean Time CTN	136	172	36	153	149	- 3.58	↓	CTN= call to needle (minutes). Lower is better
STEMI PPCI 90Centile CTN	164	242	78	210	225	14.75	↑	Lower is better
Stroke Mean Time CTD	01:22:30	01:54:54	00:32:24	01:37:03	01:36:18	-00:00:45	↓	CTD = Call to door (time). Lower is better
Stroke 50Centile CTD	01:12:00	01:37:00	00:25:00	01:23:22	01:22:00	-00:01:22	↓	Lower is better
Stroke 90Centile CTD	02:08:00	03:08:00	01:00:00	02:32:35	02:22:00	-00:10:35	↓	Lower is better
% Sepsis Care Bundle Received	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		% of patients that received the care bundle

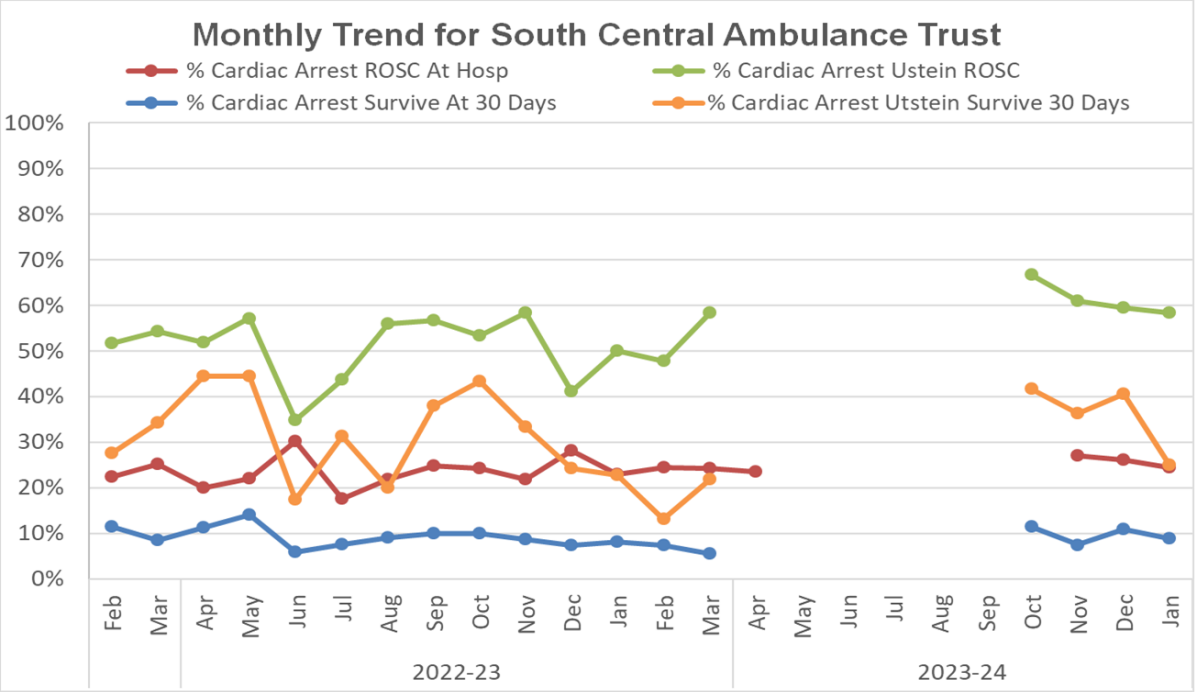
ACQIs - Jan '24

Clinical Quality Indicator	IOW	London	North East	North West	Yorkshire	East Mids	West Mids	East of England	South East	South Central	South West
% Cardiac Arrest ROSC At Hosp	14.29%	30.02%	22.45%	29.02%	23.29%	24.91%	18.84%	27.62%	25.08%	23.02%	28.82%
% Cardiac Arrest Ustein ROSC	0.00%	51.92%	60.00%	51.16%	42.22%	60.47%	34.62%	49.02%	54.55%	58.33%	49.23%
% Cardiac Arrest Survive At 30 Days	0.00%	10.60%	7.29%	9.83%	9.46%	6.14%	4.09%	7.84%	8.06%	8.80%	8.96%
% Cardiac Arrest Utstein Survive At 30 Days	0.00%	34.00%	24.14%	20.93%	20.93%	18.60%	11.54%	26.53%	28.26%	25.00%	22.22%
% Cardiac Arrest Resus Care Bundle Achieved	100.00%	88.64%	82.35%	73.85%	60.55%	90.82%	69.12%	95.45%	78.46%	56.18%	64.80%
% STEMI Care Bundle	42.86%	80.16%	78.21%	88.83%	69.63%	80.77%	94.01%	94.74%	69.78%	58.21%	80.92%
% Stroke Care Bundle Achieved	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
STEMI PPCI Mean Time CTN	161	154	136	156	144	149	152	172	147	149	161
STEMI PPCI 90Centile CTN	171	196	164	202	214	226	220	233	219	225	242
Stroke Mean Time CTD	1:26:06	1:32:48	1:29:42	1:31:48	1:33:48	1:52:54	1:42:18	1:44:24	1:22:30	1:36:18	1:54:54
Stroke 50Centile CTD	1:18:00	1:19:00	1:21:00	1:19:00	1:21:00	1:34:00	1:24:00	1:30:00	1:12:00	1:22:00	1:37:00
Stroke 90Centile CTD	2:20:00	2:28:00	2:14:30	2:21:00	2:31:00	3:08:00	2:43:00	2:45:00	2:08:00	2:22:00	2:58:00
% Sepsis Care Bundle Received	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Rag key	1st	2nd	3rd	4th	If highlighted represents within upper quartile						

This latest report shows that SCAS Cardiac Arrest Utstein ROSC is third nationally at 58.33%. SCAS Cardiac Arrest Utstein STD 30 days places fourth nationally at 25%.

Quality improvement project underway regarding pain scores continues to address STEMI care bundle compliance.

This month's data is within expected range on the SPC chart s in the IPR.



The monthly trend chart shows the SCAS data since February 2022. The gaps in the data relate to the EPR outage and are the audits that the team are completing.

2.3 Roll out of access to Thames Valley Integrated Health Record for frontline clinicians from 17th July 2024.

The Thames Valley Shared Care Record (TVS) will allow ambulance clinicians to access much more granular clinical information about the patients they attend to help support decision making than currently exists in the national Summary Care Records. The aim of the project is to unite data feeds from GP practices, acute hospital trusts, community providers, mental health trusts, social care trusts and ambulance services. South Central Ambulance Service (SCAS) are integrating the TVS into their Ortivus EPR record.

This will include, for example, access to care plans and hospital discharge summaries, clinical investigation results (e.g. blood tests, x-ray reports and ECGs), previous medical records relevant to emergency and urgent care, across the Health and Care System.

This digitally enabling project, as part of Fit for the Future improvement programme, is closely aligned with the SCAS Clinical Strategy of delivering the ‘right care, first time

every time'. This will also support NHS England's objective of the delivery of urgent and emergency care in an appropriate care setting as close to home as possible via appropriate care navigation.

3. Recommendations

The Board is invited to **note** this report.

John JM Black
Chief Medical Officer
17 July 2024

NHS
South Central
Ambulance Service
NHS Foundation Trust

Upward Report of the Quality and Safety Committee

Date Meeting met **17 July 2024**
Chair of Meeting **Dhammika Perrera, Non Executive Director (NED)**
Reporting to **SCAS Board**

Items	Issue	Action Owner	Action
Areas of concern and / or Risks			
Vacancy situation in Patient Care	A number of planned retirements in the Senior Patient Care Team and vacancies in the pharmacy team may mean a risk for patient safety.	Chief Nursing Officer	Provide progress update on recruitment to September Q&S
Areas still working on improvement.	Resuscitation eLearning and practical compliance levels below target.	Chief People Officer / Chief Medical Officer	Provide update on plan for reaching mandatory completion rates and an update at September Q&S
Risk relating to IPR	Whilst mitigations are in place, timeliness are not meeting Q&S meeting. Narratives still require improvement.	Chief Finance Officer	Provide a timely IPR with narratives that explore what is seen, not just repeat what data shows.
Items for information and / or awareness			
End of WMAS support	As per Operations update, due to impact.	Chief Operating Officer	Provide update on impact and mitigation measures at next Q&S.

Hospital Handover Delays	As per Operations update, actions and meetings have not delivered tangible results, although aware of ongoing work, this still presents highest risk to quality and patients.	Chief Operating Officer	Provide account of what has not worked and why at next Q&S.
Safeguarding	Some of the Safeguarding system interfaces and some of the Safeguarding referral pathways are not fully effective and present a risk to pt safety.	Chief Nursing Officer	Provide assurance that referral pathways are effective, and risks mitigated through the SG Committee and EMC.
		Chief Digital Officer	Provide overview of Clinical System risks and plan to address these including those specifically related to safeguarding to September Q&S.
Preparedness and Assurance	SCAS preparedness for CQC inspection and compliance against the single assessment framework, including the ability of front-line staff to recognise and articulate the changes made since last CQC visit, was discussed. A concern that staff may not be able to articulate the changes and innovation sufficiently.	Chief Nursing Officer	Provide further and ongoing update on CQC preparedness and compliance.
		Head of Comms	Present Comms plan to support CQC preparedness
Policies approved*			
Mental Health Policy	Policies approved by Q&S, but several policies presented with DRAFT watermarks and comments.	Chief Governance	Policies' content approved under the condition that all versions formatted as FINAL polices.
Learning Disability and Neurodiversity Policy			
Clinical Service Policy			
Resuscitation Policy			

Patient Clinical Record Policy		Officer / Executive Assistant	
Restrictive Interventions Policy			

Author: Dhammika Perera

Title: Non-Executive Director

Date: 17 July 2024

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	M3 Finance Report
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	13
Executive Summary:	This report provides the year to date (YTD) and full year forecast (FY) financial performance of the Trust. The Trust's Month 3 (June) reported position (before technical adjustments e.g., peppercorn rent, etc) is:

Key Performance Indicators				
		Plan	Actual / Forecast	Variance
1	Surplus / (Deficit) Year to date	(4.9)	(4.5)	0.4
2	Surplus / (Deficit) In-month	(1.3)	(0.9)	0.4
3	Surplus / (Deficit) FOT	(10.1)	(10.1)	0.0
4	Capital Spend YTD	7.7	1.5	(6.2)
5	Capital FOT	41.5	41.5	0.0
6	Cash - Year to date	14.7	17.5	(2.8)
7	Cash - Year In-month	(1.8)	(4.1)	0.0
8	BPPC - YTD - Value	95.0%	99.5%	4.5%
9	BPPC - YTD - Number	95.0%	89.3%	(5.7%)

I&E Position

The Trust recorded an in-month deficit of £0.9m in M3, a favourable variance of £0.4m against its planned deficit of £1.3m. The underlying factors driving the deficit remain unchanged however NEPTS performed better in the month whilst the 111 service had a shortfall of

	£0.3m due in part to the Thames Valley 111 contract income not being agreed. The Trust's deficit of £10.1m is based on the delivery of £31.9m in-year Financial Recovery Plan (FRP), which is 9.3% of the Trust's operating expenditure. <u>Capital</u> The Trust's capital spend to June was £1.5m. The plan to June was £7.7m. The underspend was due to the 2022/23 cohorts of Double Crewed Ambulances (DCAs) being further delayed, as a majority of the cost was expected in May. Better Payment Practice Code (BPPC) in the month showed a deterioration on the number metric as there were six invoices totalling £3k that have been delayed due to queries on the spend.
Recommendations:	The Board is asked to note the report.
Accountable Director:	Stuart Rees, Interim Director of Finance
Author:	Alan Monks, Deputy Chief Finance Officer
Previously considered at:	Finance and Performance Committee.
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Partial
Justification of Assurance Rating:	The financial position is currently behind the original plan and there is a recovery plan in place to meet the year end control total.
Strategic Objective(s):	Finance & Sustainability
Links to BAF Risks or Significant Risk Register:	SR5 - Increasing Cost to Deliver Services
Quality Domain(s)	All Quality Domains

Next Steps:	N/A
List of Appendices	N/A

Meeting Report

Name of Meeting	Board of Directors in Public Meeting
Title	M3 Finance Report
Author	Alan Monks, Deputy Chief Finance Officer
Accountable Director	Stuart Rees, Interim Director of Finance
Date	25th July 2024

1. Purpose

This report is produced monthly to update the Board on the latest financial position and any risks to the achievement of financial objectives.

2. Executive Summary

Income and Expenditure

In month 3, the Trust's Income and Expenditure (I&E) position shows an in-month deficit of £0.9m which is £0.4m ahead of plan and an improvement on month 2 of £0.7m. This results in a Year-to-date (YTD) deficit of £4.7m against a planned deficit of £5.1m.

£m	M1	M2	M3	YTD
Plan	(1.9)	(1.7)	(1.3)	(4.9)
Actual	(1.9)	(1.7)	(0.9)	(4.5)
Variance to Plan	**(0.0)**	**(0.0)**	**0.4**	**0.4**

The month position against the original plan before rephasing was a favorable variance of £0.2m and a YTD adverse variance of £0.9m.

£m	M1	M2	M3	YTD
Original Plan	(1.2)	(1.4)	(1.1)	(3.6)
Actual	(1.9)	(1.7)	(0.9)	(4.5)
Variance to Plan	**(0.7)**	**(0.3)**	**0.2**	**(0.9)**

Financial Position

The Month showed an improvement on the first two months of the year, with the main areas of improvement being non-emergency patient transport services (NEPTS) and Corporate.

The NEPTS service shows a favorable variance of £0.1m in the month, which is offset by the adverse contribution of £0.3m in the 111 service while the 999-service performance was on plan in the month. This resulted in the operations total contribution being £0.2m adverse to plan. Corporate areas were underspent by £0.6m.

		Month 3			Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
999	Income	19.3	19.0	0.2	57.0	56.7	0.3	226.1	226.1	0.0
	Expenditure	(16.1)	(15.9)	(0.2)	(47.5)	(47.2)	(0.2)	(183.7)	(183.7)	0.0
	Contribution	**3.2**	**3.2**	**0.0**	**9.5**	**9.4**	**0.1**	**42.5**	**42.5**	**0.0**
	%	**16.5%**	**16.7%**		**16.7%**	**16.6%**		**18.8%**	**18.8%**	
111	Income	3.3	3.5	(0.1)	10.0	10.1	(0.1)	41.4	41.4	0.0
	Expenditure	(3.2)	(3.0)	(0.2)	(9.3)	(9.2)	(0.2)	(36.5)	(36.5)	0.0
	Contribution	**0.2**	**0.5**	**(0.3)**	**0.6**	**0.9**	**(0.3)**	**4.9**	**4.9**	**0.0**
	%	**5.1%**	**13.7%**		**6.4%**	**9.4%**		**11.9%**	**11.9%**	
PTS	Income	5.4	5.4	(0.0)	16.1	16.1	(0.0)	63.2	63.2	0.0
	Expenditure	(4.8)	(4.9)	0.1	(15.6)	(15.7)	0.1	(56.0)	(56.0)	0.0
	Contribution	**0.6**	**0.4**	**0.1**	**0.5**	**0.4**	**0.1**	**7.2**	**7.2**	**0.0**
	%	**10.5%**	**8.3%**		**3.3%**	**2.5%**		**11.4%**	**11.4%**	
Operations Total Contribution		**3.9**	**4.1**	**(0.2)**	**10.7**	**10.8**	**(0.1)**	**54.6**	**54.6**	**0.0**
%		**14.0%**	**14.7%**		**12.9%**	**13.0%**		**16.5%**	**16.5%**	
Corporate		(4.9)	(5.5)	0.6	(15.4)	(15.9)	0.5	(65.5)	(65.5)	0.0
Surplus/(Deficit)		**(1.0)**	**(1.4)**	**0.4**	**(4.7)**	**(5.1)**	**0.4**	**(10.9)**	**(10.9)**	**0.0**
Reporting Adjustments		0.1	0.1	0.0	0.2	0.2	0.0	0.8	0.8	0.0
Reportable Surplus/(Deficit)		**(0.9)**	**(1.3)**	**0.4**	**(4.5)**	**(4.9)**	**0.4**	**(10.1)**	**(10.1)**	**0.0**

The main points to note for Month 3 performance are:

- Within the 111 service, additional income was included within the Financial Recovery Plan (FRP) relating to funding the Thames Valley contract to the appropriate level. The Trust has now received a formal contract offer from Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB) however as this is below the Trusts' expectation it is yet to be accounted for. Resource costs in the month were £92k higher than budget and cost savings of circa £100k were not achieved.

- Overall, NEPTS resource costs are down against plan for the month related to lower activity resulting from the demand management. This fall in costs is visible across all commissioners except HIOW which remains high, driven by the reliance on private providers and taxis as well as the pace of recruitment within the service which remains behind schedule.

- In the 999 service, the total expenditure for the month was £0.2m above budget offset by additional income of £0.2m. There were higher costs in the month related to Emergency Operations Centre (EOC) spend £0.1m and frontline resource of £0.1m.

Financial Recovery Plan (FRP)

The Trust's deficit of £10.1m is based on the delivery of £31.9m in-year FRP, which is 9.3% of the Trust's operating expenditure.

The Trust's initial FRP includes a net savings target of £28.8m for the year includes a total unidentified savings of £1.7m.

Including savings required in the budget and further savings required to offset approved business cases the overall cost savings plan now stands at £31.9m.

The month 3 to date savings stand at £3.2m against a plan of £4.5m. With recovery actions be implemented.

Capital

The Trust's capital spend to June was £1.5m. The Trust underspent against its Month 1 to 3 capital budget by £6.2m, this was mostly due to slippage in delivery of the 2022/23 DCA cohort from Venari. The receipt of the 2022/23 cohort (53 double-crewed ambulances (DCA's)) vehicles from Venari are now being received, however, they are requiring some remedial work prior to being ready for use. There was no expected spend in June for International Financial Reporting Standard 16 Leases (IFRS 16) capital departmental expenditure limit (CDEL), the first expected IFRS16 CDEL spend is in August with the expected sale/leaseback of the 53 2022/23 DCA cohort for which the sale cash income is expected to be received in August.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	0.0	1.6	(1.6)	9.4	9.4	0.0
	IFRS16	0.0	0.0	0.0	2.7	2.7	0.0
	Total	**0.0**	**1.6**	**(1.6)**	**12.0**	**12.0**	**0.0**
Digital	Internal CDEL	0.1	1.9	(1.8)	4.3	4.3	0.0
	PDC	0.0	0.0	0.0	1.1	1.1	0.0
	PDC Income	0.0	0.0	0.0	(1.1)	(1.1)	0.0
	Total	**0.1**	**1.9**	**(1.8)**	**4.3**	**4.3**	**0.0**
Fleet (22/23 DCA Cohort)	Internal CDEL	1.3	3.6	(2.3)	(1.8)	(1.8)	0.0
	IFRS16	0.0	0.0	0.0	5.4	5.4	0.0
	Total	**1.3**	**3.6**	**(2.3)**	**3.6**	**3.6**	**0.0**
Fleet (23/24 DCA Cohort)	Internal CDEL	0.0	0.0	0.0	(2.8)	(2.8)	0.0
	IFRS16	0.0	0.0	0.0	7.3	7.3	0.0
	Total	**0.0**	**0.0**	**0.0**	**4.5**	**4.5**	**0.0**
Fleet (24/25 DCA Cohort)	Internal CDEL	0.0	0.0	0.0	2.2	2.2	0.0
	IFRS16	0.0	0.0	0.0	10.2	10.2	0.0
	Total	**0.0**	**0.0**	**0.0**	**12.3**	**12.3**	**0.0**
Fleet (Non-DCA)	Internal CDEL	0.0	0.6	(0.6)	1.6	1.6	0.0
	IFRS16	0.0	0.0	0.0	3.1	3.1	0.0
	Total	**0.0**	**0.6**	**(0.6)**	**4.7**	**4.7**	**0.0**
Internal CDEL Total		1.5	7.7	(6.2)	12.9	12.9	0.0
IFRS16 Total		0.0	0.0	0.0	28.6	28.6	0.0
PDC Total	Expenditure	0.0	0.0	0.0	1.1	1.1	0.0
	Income	0.0	0.0	0.0	(1.1)	(1.1)	0.0
Total		**1.5**	**7.7**	**(6.2)**	**41.5**	**41.5**	**0.0**

Key drivers of the current capital position are:

- Delivery of the 2022/23 and 2023/24 DCA cohorts which have been significantly delayed due to supply chain issues affecting the conversion of the chassis into DCAs. The first delivery from the 2022/23 cohort arrived in February, with one vehicle delivered by the end of the 2022/23 financial year. Thirty-three vehicles from the 2023/24 cohort were delivered in the first quarter. Three have been received in July, however, there are further delays to the remaining seventeen vehicles which may create further slippage into August.

- The delay in delivery of the DCAs means that these vehicles cannot be sold and leased back to SCAS within the months planned, the sale/leaseback transaction for the 53 is now expected in August. This means that costs incurred to date are allocated against internal capital departmental expenditure limit (CDEL) and will be transferred to IFRS16 CDEL upon completion of the sale/leaseback transactions.

Cash

The Trust's cash balance at the end of June stood at £17.5m. There was a net cash outflow in month 3 of £4.1m due mostly to the payments to suppliers of £12.5m and £1.5m block income shortfall against budget. The shortfall in block payments is expected to be received in month 5 following the completion of contract agreements.

There is still an expected deterioration in cash balance in the early part of the year driven by the underlying financial pressures. If there are any delays to, or non-delivery of, the financial recovery plan this could worsen the cash position and potentially reduce interest receivable or result in costs associated with cash support, further worsening the overall financial position.

2024/25	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	32.8	26.9	27.3	28.2	33.0	34.6	27.7	32.5	34.3	27.6	27.6	41.3
Expenditure £m	(30.6)	(32.5)	(31.4)	(31.5)	(31.2)	(34.0)	(32.0)	(32.2)	(30.9)	(32.3)	(30.0)	(38.8)
Net Inflow/(Outflow) £m	2.2	(5.6)	(4.1)	(3.3)	1.8	0.6	(4.3)	0.4	3.4	(4.7)	(2.5)	2.6
Cash Balance £m	**27.2**	**21.6**	**17.5**	**14.3**	**16.1**	**16.7**	**12.4**	**12.8**	**16.2**	**11.4**	**9.0**	**11.5**

Moving into 2024/25 additional cash monitoring will be applied and early warning systems maintained in order to assess the ongoing viability of the capital programme and also to ensure the NHSE cash support process is ready if and when required.

The 90-day debtor total increase to £0.2m in June (£0.1m in May).

3. Risk Score

The risk of not delivering financial targets is monitored as part of the Board Assurance Framework. The score for this risk has reduced in 2024/25 from 20 down to 16 as the Trust now has a control total which is in line with the planned deficit.

4. Areas of Risk

- Financial implications of the loss of the NEPTS contracts for Thames Valley and Sussex
- Financial implications of needing to use additional frontline resources to achieve national expectations around category 2 response times.
- There could be unforeseen consequences on the organisation of remaining within control total.
- If the Trust needs to utilise
- NHSE cash support, there will be additional costs that impact the financial position.
- If the cash position deteriorates then it will impact the Trusts ability to fulfil its capital plan.

5. Recommendations

The Board is asked to note the finance position.

Upward Report of the Charitable Funds Committee

Date Meeting met **10 July 2024**
Chair of Meeting **Nigel Chapman, NED**
Reporting to **Board of Directors in Public Meeting**

Items	Issue	Action Owner	Action
Points for escalation			
Volunteer Manager	The Volunteer Manager role has grown since it was introduced two years ago. The implementation of the Volunteer Strategy, designed to increase cohorts of volunteers across SCAS, by working with other departments who see the value of volunteering, now takes up significant time. Working with AACE gives us an important platform to influence and support the development of volunteering nationally. As part of our strategy, we want to work towards Investor in Volunteering (IiV). All of these priorities are becoming difficult to manager as a one-person team. To significantly grow and develop volunteering across SCAS more resources are required. The importance of this role has been proven over the last two years and we now	**Charity CEO**	Business Case to be prepared for the introduction of an administrative support role to enable volunteering to grow across SCAS

	need to look at some administrative support for the Volunteer Manager, so her time, knowledge and expertise can be used to best effect.		
Key issues and / or Business matters to raise			
Volunteer Development	We had 50 new volunteer starters in the last quarter. 32 of these were CFRs; 12 VCDs, 5 Patient Panel members and 1 Charity Volunteer. Volunteer eLearning is still in discussion with SCAS Education. It currently sits at over 20 hours with some elements doubling up with CFR initial training and requalification.	**Volunteer Manager**	
Volunteer Awards	Volunteer Awards – two nominations have been shortlisted in the BBC Make A Difference Awards: • Volunteer of the Year, BBC Oxford – James Clark, CFR Hook Norton • Volunteer of the Year, BBC Surrey – Pip Brookes, VCD Surrey (now Hampshire)	**Volunteer Manager / SCAS Education**	Discussion to continue with a clear steer from Education on essential eLearning and cutting down on duplication.
AACE National Volunteer Strategy	The refreshed AACE National Volunteer Strategy has three new strategic aims: • Health, Inequalities & Diversity • Leadership, Data & Impact • Policy & Governance Sarah Callaghan will Co-Chair the Policy & Governance Aim focusing on policies, toolkits	**Volunteer Manager**	.

	and guidance to support ambulance services with recruitment and onboarding.		
Corporate Fundraising	We are now making real progress with developing corporate partnerships. There are currently three potential partnerships moving forward towards agreement. • **APCOA** – now looking to create the final presentation to APCOA to fund a new SCAS/Charity film to promote CPR & defib familiarisation. Following the face-to-face session, we offer corporates this APCOA branded film will enable the company to reach their national offices and partners. The film will be funded and branded by APCOA and the partnership will also provide additional income to the Charity with a cause related marketing opportunity from car park ticket sales • **CARTER JONAS –** currently working with one of their Partners & Head of Sustainability alongside our SCAS Sustainability Manager to support the development of two key EV charging hubs at North Harbour and WERC as well as a feasibility report to create EV charging hubs that can be scaled across SCAS. We will be presenting to the Social Impact Coordinators on 22 August and hope to then have agreement to create a formal partnership.	**Charity CEO**	

	• **LORNE STEWART** – The facilities team are our new SCAS contractors and approached us wanting to look at how they can support the improvement of one or two sites to create better staff facilities. We will also be discussing business life saver training which we can deliver to their teams In addition, the CPR-A-Thon last held in 2022 will again take place in Berkshire in October. Corporate teams will take part in a 24-hour marathon to raise money for the Charity. In 2022 £12,000 was raised and the team are hoping to exceed that this year.		
Revised Budget 2024-2025	The annual budget for the current year was agreed. Success will be dependent on achieving ambitious income targets. The budget is inline with the Charity strategy and includes £100k expenditure for internal grants. The end of year deficit reflects funds received last year that are being spent this year. Management accounts and reforecasts are reviewed at each CFC meeting.	**CFC**	Charity CEO/Finance Manager to manage expenditure and to present a month 6 plan and reforecast at the next meeting in October 2024.
Internal Grants Programme	Last year's legacy bequest has enabled a new internal grants programme to be created. The first round of grants saw £46,000 of grants approved. 15 applications were received – 8 for small grants (less than £5k) and 7 for major grants (over £5k). 7 small grants were approved in full or part and 3 major grants. The next round will open on 1 September.	**Charity CEO**	

Microsoft Licensing for Volunteers	The Microsoft philanthropy grant providing free Charity licenses will come to an end next month after 8 years. We have explored options to purchase the necessary licenses and also ensure our volunteers have full access to the Hub, education opportunities and eLearning. EMC have agreed volunteers should have access to information via the Hub and also to reviewing licensing arrangements from next year with a view to the cost being included within SCAS ICT budget. The CFC has approved the cost of the licenses for the next twelve months and this is in the agreed budget for the year. This will now proceed with the Charity funding the next 12 months and the two Microsoft tenants being joined to enable those with a sca-charity.org.uk email address to have the same access to the hub as those with a SCAS.nhs.uk email address.	**Charity CEO Chief Digital Officer**	Purchase the new licenses for September 2024 and work together to provide access for volunteers.
Areas of concern and / or Risks			
Charity Risk Register	The Risk Register is reviewed at each meeting and a number of risks around income generation remain high. The risk around Financial governance has been reduced and will be removed from the register following the Charity audit report if there are no significant issues raised by the the auditors. We have worked with the SCAS Risk team and are revising our risk template to follow the new approach SCAS is now using,	**Charity CEO**	

Items for information and / or awareness			
External Grants	The Charity wasn't successful in its application to NHS Charities Together & CW+ for the Volunteering in Health grant. The NHSCT Community Resilience grants opens in the Autumn. Each ambulance charity has an even allocation of grant set aside from the Omaze campaign but applications will need to be submitted and approved to access these funds	**Charity CEO**	Application for the Community Resilience grant to be submitted in the Autumn.
Best Practice and / or Excellence			
Compliance with Terms of Reference			
	Fully compliant with CFC Terms of Reference		
Policies approved*			
	All policies reviewed as per the cycle of review and were signed off at the CFC meeting in April.		

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Vanessa Casey

Title: Charity CEO

Date: 11 July 2024

Upward Report of the – Audit Committee

Date Meeting met **03/05/24**
Chair of Meeting **Mike McEnaney, NED**
Reporting to **SCAS Public Board meeting**

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
23/24 Annual Report	Good work had been done, a detailed schedule of work had been produced and areas for improvement from last year had been addressed. Due to resource availability and the lead for this piece of work passing to Stuart Rees, progress was behind schedule but delivery of the draft to the auditors was expected to be on time.	Stuart Rees	All executives to ensure their contributions are produced to deadlines.
23/24 Annual Accounts	Draft accounts were submitted to NHSE within the deadline. The committee reviewed the accounts in detail and found them to be well developed.		

Areas of concern and / or Risks			
Items for information and / or awareness			
Best Practice and / or Excellence			
Compliance with Terms of Reference			
Committee Terms of Reference	An updated draft was reviewed and further amendments were requested.	Kofo Abayomi	Update and circulate
Policies approved*			

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Mike McEnaney

Title: Chair of Audit Committee

Date: 17/07/24

Upward Report of the – Audit Committee

Date Meeting met **20/06/24**
Chair of Meeting **Mike McEnaney, NED**
Reporting to **SCAS Public Board meeting**

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
23/24 Accounts External Audit	Good progress is being made. Ther were areas of concern around property valuations in terms of timeliness of information and accuracy. Although a number of issues had been found there was no indication that the accounts would be qualified although some adjustments would be necessary.	Stuart Rees	Work with the auditors to finalise the accounts to schedule.
Head of Internal Audit Opinion Statement	"Overall, we are able to provide Moderate Assurance that there is a sound system of internal controls, designed to meet the Trust's objectives, that controls are being applied consistently across various services." This		

	represents an improvement over the previous year in that the statement is more robust.		
Areas of concern and / or Risks			
Internal Audit – management responsiveness	BDO noted a delay in the progress of internal audits due to a lack of engagement of management due to workload prioritisation or staff having left. The DSP toolkit audit was incomplete due to a lack of data provision and the report on the Payroll system was "Moderate" and issues arose around the provision of timely data.	Stuart Rees/David Eltringham	The executive team to review the status monthly and BDO to escalate to Stuart Rees in the first instance then directly to DE where any significant problems arose.
Items for information and / or awareness			
BAF	The BAF was reviewed and the latest changes noted. The committee received assurance that risks were being reviewed and updated.	Kofo Abayomi	Remind Board Committees that their BAF risks need regular review and such considerations be reported to the Board in their upwards reports.
Best Practice and / or Excellence			
Procurement Compliance	There have been a number of significant changes made to the regulations that determine the rules for public sector and NHS procurement as a result of Brexit and the development of the ICSs together with the requirement for greater control. A report on these changes, how they affect SCAS and the implications for future procurement was reviewed. A key impact is the requirement to		

	retrain all staff involved in the procurement process. The committee noted the new requirements and the risks associated with them.		
Compliance with Terms of Reference			
Governance Manuals	Updated draft Scheme of Delegation and standing Financia Instructions were provided to the committee. Further review and discussion was required due to these being completely rewritten. A draft Performance management and Accountability Framework was presented for the first time.		
Policies approved*			

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Mike McEnaney

Title: Chair of Audit Committee

Date: 17/07/24

Upward Report of the – Audit Committee

Date Meeting met **11/07/24**
Chair of Meeting **Mike McEnaney, NED**
Reporting to **SCAS Public Board meeting**

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
Year End	It was confirmed that the year end was now complete in terms of the external audit, annual accounts and the annual report. The committee thanked both the audit team and the finance and governance teams for their hard work. There were a number of areas that could have gone better and an improvement plan, agreed by Finance and Azets will be reviewed at the September meeting.	Stuart Rees	Year end improvement plan to the September committee.
Areas of concern and / or Risks			

Items for information and / or awareness			
Counter Fraud (LCFS) Annual Report	The committee received the annual report which included the annual Counter Fraud Functional Standard Return (a regulatory requirement) which resulted in an overall rating of Green, meaning that overall SCAS is fully compliant with the counter fraud activities and able to evidence it. The only area highlighted for improvement is the number of staff attending the counter fraud training and information events. The Fraud Risk Register was reviewed. A counter fraud benchmarking report was reviewed comparing SCAS with 60 healthcare providers and showing SCAS is placed around the average in terms of incidents.	Stuart Rees	Raise the level of attendance at the counter fraud training events.
Best Practice and / or Excellence			
Risk Deep Dives	A proposal was presented and agreed for carrying out deep dives on key risks for review at the Committee.		
Compliance with Terms of Reference			
Policy Register	The policy register was reviewed and good progress was noted with the overall control, however, 35 policies remain out of date. Policies are being reviewed but the pace is not sufficient	Kofo Abayomi/ Stuart Rees	To ensure the Executive Management Team review the status and progress monthly.

	to exceed the rate at which they are going out of date.		
Governance Manuals	The Standing Financial Instructions were approved subject to the application of a number of minor amendments. The Scheme of Delegation was to be reviewed separately with members of the Committee and Stuart Rees due to the number of queries and changes proposed.	Stuart Rees	Scheme of Delegation reviews to be set up.
Policies approved*			

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Mike McEnaney

Title: Chair

Date: 19/07/24

Upward Report of the – People and Culture Committee

Date Meeting met **17th July 2024**
Chair of Meeting **Ian Green, Chair**
Reporting to **Board**

Items	Issue	Action Owner	Action
Points for escalation			
PDR Action Plan	Following the recent deep dive the Committee received the action plan setting out the trajectory to deliver the PDR target. Whilst this gave a degree of assurance the Committee noted that collective corporate leadership was required to deliver against the plan. It was agreed that this should come back to the next committee with an update. outlining what could be achieved and what "good" would look like with a successful PDR system for SCAS.	NH	Further update to September meeting
Corporate Review	Received an update report on Corporate Review. Key risk identified as bandwidth with executive colleagues to champion the review on their divisions and lack of capacity for effectively communicate the reason for the review. Positive to hear that comms support was now identified but this had been slow in coming.	CPO	

Culture Review	The committee received and reviewed the report commissioned looking at the Culture within SCAS. The report identified some areas where things were improving but the overall picture identified further areas for improve. It was acknowledged that this was not something that could be achieved overnight but does require focussed action. Additional resource was now available to assist with this and an urgent presentation should be made to the Board in August.	CPO	Discussion at a Board workshop
Key issues and / or Business matters to raise			
Areas of concern and / or Risks			
Corporate Risk Register/BAF	Updated BAF and risk register reviewed. Timeliness of reviews/mitigating actions remains a concern, but this was already coming back to the September meeting	CPO	Consideration at September PCC
Items for information and / or awareness			
2023/24 Metrics	Data was reviewed – split between clinical and non-clinical staff was presented for the first time leading to assurance being sought of international recruitment. Historical data would come back to September committee	CPO	September
Best Practice and / or Excellence			

Compliance with Terms of Reference			
Policies approved*			

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Ian Green

Title: Chair

Date:20th July 2024

Report Cover Sheet

Report Title:	Communications, Marketing and Engagement Update
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	19
Executive Summary:	**SCAS Branding** Much work is underway to ensure that we maximise the power and influence of the SCAS brand, supporting health education messaging and thereby promoting better engagement with our communities. **Modernising SCAS – 'Fit for the Future' (FFF)** A comprehensive communications and engagement plan has now been developed to support the delivery of this programme and the team have been hosting webinars and publishing material on the Hub to help inform and engage staff **SCAS Website development** Work is ongoing on our site to improve its resilience to potential cyber attacks and to ensure that we are using the site to positively influence how our services are accessed and used
Recommendations:	The Board of Directors is asked to: Note the contents of this report.
Accountable Director:	Gillian Hodgetts
Author:	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Previously considered at:	
Purpose of Report:	Note
Paper Status:	Public

Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Significant
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	
Quality Domain(s)	Not Applicable
Next Steps:	N/A
List of Appendices	N/A

Meeting Report

Name of Meeting	Board of Directors in Public Meeting
Title	Communications, Marketing and Engagement Update
Author	Gillian Hodgetts
Accountable Director	Gillian Hodgetts
Date	25 July 2024

1. Purpose

The purpose of this information paper is to update the Board as to the activities undertaken by the Communications, Marketing and Engagement team and where appropriate to highlight any challenges, special achievements or matters worthy of public interest.

2. Background and Links to Previous Papers

This Board Paper is an update on the Communication, Marketing and Engagement Paper that is presented Bi-Monthly to the Board of Directors Meeting in Public.

3. Executive Summary

SCAS Branding

Utilising vehicle livery to inform and educate

SCAS Branding is an important strand of work that flows from our team objective to educate and inform the public. Working closely with our SCAS fleet department, we have continued to support the display of various campaigns on our vehicles. Thus far we have featured campaigns including those for sepsis and the act F.A.S.T campaign for strokes and are looking to have many more in the future, working in partnership with Public Heath England. These campaigns can be particularly effective in reaching specific communities, especially in remote areas where healthcare information might be less accessible.

By promoting healthy behaviours through preventative measures, these campaigns can reduce the incidence of certain conditions, and thus lessen demand for our emergency services. Information shared on ambulances may well be perceived as more trustworthy and credible, leading to higher engagement and support from the

public. This can also reinforce the public health campaigns, making them more memorable and effective.

Overall, leveraging ambulances for health campaigns integrates healthcare education into everyday environments, making it a practical and impactful strategy for public health promotion.

Creating graphics for demand management

Templates and various graphics have been created for our social media channels, as well as using NHS public health campaigns. Social media posts such as knowing when to call an ambulance can help save lives and identify what constitutes a medical emergency. We have utilised educational infographics to help members of the public to recognise a medical emergency #EmergencyCare #staysafe.

There is a significant need for information identifying possible alternative services for non-emergencies, such as urgent care clinics, 111 online and calling 111 helplines. Self-care tips feature in many of our messages and provide helpful information on managing minor illnesses at home.

Job role adverts template for social media channels

Another area of work has been the creation of various templates for different job roles to ensure all job adverts are consistent with the SCAS branding. Over time this has helped create a recognisable and professional image.

This ensures that all job postings convey the same tone and style in their advertising on social media, maintaining brand consistency and saving time. The communications team support departments across the Trust through its Brand Guardian role and offers advice and practical support.

Brand update with The King's Royal Cypher

Updating the King's Royal Cypher across the brand for all digital, print and livery is still very much in development. Much of the digital applications have had the new logo updated and the next batch of vehicles will be updated with the new cypher too. This reinforces the ambulance service's connection to the Royal family, symbolizing respect for tradition and the official endorsement. keeping the branding current and relevant and aligning the service with a new era of the monarchy.

4. Fit For the Future Programme (FFFP)

SCAS has set up an operational modernisation programme in response to the ongoing challenges faced by the organisation and to make SCAS fit for the future. This is now known as the **Fit for the Future Programme**.

We need to:

- Look after, build, develop and sustain the workforce
- Improve the delivery of high-quality, safe services
- Improve operational performance
- Deliver a financial recovery plan

In order to do this, some significant changes need to be delivered, and soon. The programme will deliver large-scale organisational change that has not been seen in SCAS since its inception in 2006. This is something we are not taking lightly and one that must be delivered to ensure the delivery of our mission to deliver the Right Care, First Time, Every Time.

The programme consists of a number of different workstreams in order to deliver its aims, including redesigning the operating models for our patient facing services, redesigning our built environment and fleet model, ensuring that our digital systems are future fit and lastly, making sure that our corporate support services design is patient centred.

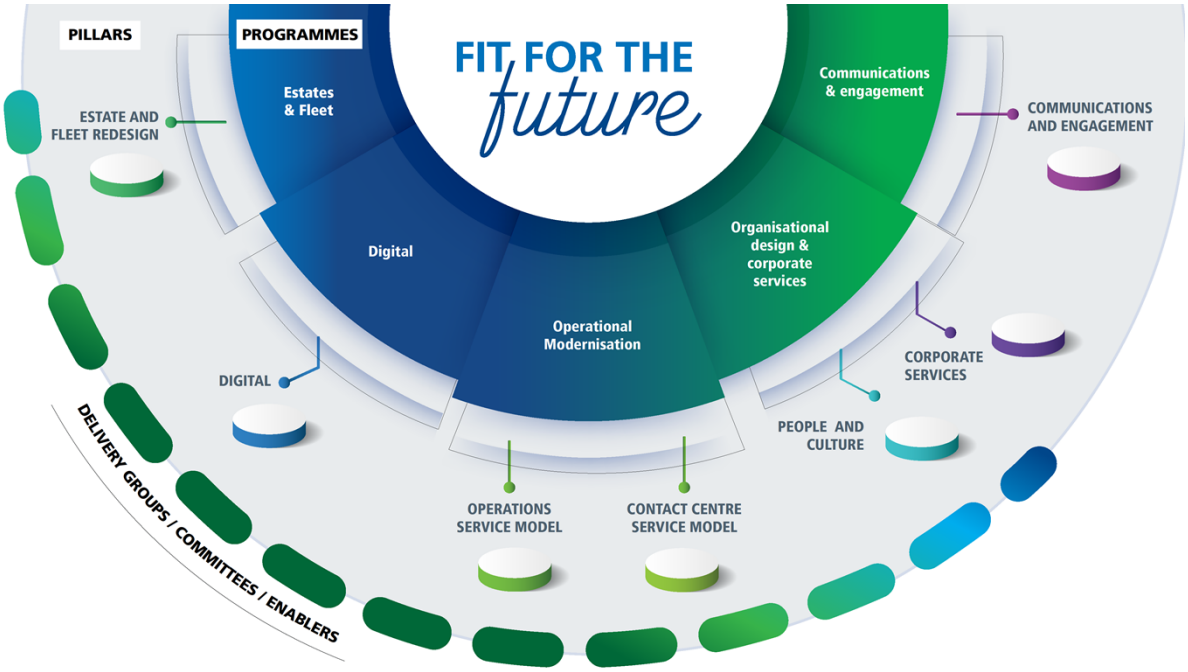
Communications support

The communications team has been heavily involved in supporting the FFTF team. As the programme moves forward the need for comprehensive communications support is becoming even more critical in ensuring its successful delivery.

It has now been agreed that “Fit for the Future” is the vehicle for the delivery of the SCAS strategy and that the Operations Modernisation Programme (OMP) will deliver the first two workstreams: the Operations Service Model and Contact Centre Service Model.

Next year, **2025/26**, we will focus on delivering the transformation of the Trust against the backdrop of a clean balance sheet budget, with our expenditure and income balanced.

So far, we have focussed on delivery of the Operations Modernisation Programme, which covers two of the seven FFFP workstreams. We have developed proofs of concepts to be tested in the Clinical Contact Centres and North Harbour in the SE node from October 2024.



At the same time, we have been working hard to make the Trust financially sustainable, and we have to make savings this year of £35m to make sure that from April 2025 our income matches what we spend.

We had planned to announce the proposed hub locations by the end of June but for the time being we will instead be focussing on the proof-of-concept sites and testing improved processes and ways of working that can be rolled out to existing sites to address long-standing staff concerns.

Staff engagement

Involving staff in this programme is critical and there have been many visits by programme team members to Resource Centres to attend team meetings, as well as other 999 and 111 contact centres.

The Senior Leadership forum contributed to a workshop specifically focused on the OMP, together with an all-Trust webinar. The SCAS Hub site has a dedicated area about the FFTF programme and is the main repository for information about the programme. The Communications team are working to keep this continually refreshed and updated as well as to organise and host the staff webinars. Stakeholders are being updated through SCAS stakeholder newsletters and a workshop was held together with the Association of Ambulance Chief Executives.

A comprehensive communications and engagement plan has been drafted and further detailed plans to communicate the progress within individual workstreams are planned.

5. Website development

A significant part of our Communications, Marketing and Engagement Strategy relies heavily on our ability to develop new digital technologies to support and deliver effective communications.

The following developments have been made to the SCAS website:

- Care and attention is taken to monitoring the SCAS website to keep it up to date with the latest corporate information, board papers, personnel changes, medical research, directors expenses and financial spending reports
- The latest version of WordPress is always maintained to try and reduce the chances of the website being targeted through cyber attacks
- Two factor authentication has been installed to make the site more secure
- All of the Policies have been removed and are now available on request
- The team who upload the Policies and Board Papers have been fully trained to work autonomously to do this

Public awareness

SCAS' social media channels are used for a variety of reasons, celebrating positive achievements, talking about our SCAS news and are utilised for public awareness.

Our public awareness work on those social media channels not only utilises national content, strengthening the messages and using familiar content which can be seen on mediums/channels across the country, but also local content, supporting those national messages using our own and familiar people and places, creating content which is then supported and shared by public and staff alike.

Over the last month we have been creating support and awareness on topics such as:

- Covid 19 vaccination
- Loneliness
- Blood donation
- Violence towards staff
- Disability
- Armed Forces
- Industrial action
- Utilising our services wisely

Some of these topics are also supported by some of our other social media accounts run by other teams, further strengthening our work across SCAS as an employer and provider of choice.

6. Responsibility

The responsibility for this Board Paper is Gillian Hodgetts, Director of Communications, Marketing and Engagement.

7. Recommendations

The Board is asked to note the contents of this report.

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Report Cover Sheet

Report Title:	Chief Digital Officer Report
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 25 July 2024
Agenda Item:	21
Executive Summary:	To provide an update to the SCAS board of directors and executives on key issues, achievements, and upcoming plans within the Digital Function.
Recommendations:	Note
Accountable Director:	Craig Ellis, Chief Digital Officer
Author:	Craig Ellis, Chief Digital Officer
Previously considered at:	N/A
Purpose of Report:	Note
Paper Status:	Private
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	Technology Transformation
Links to BAF Risks or Significant Risk Register:	SR8 - Ability to Deliver the Digital Strategy
Quality Domain(s)	Not applicable

Next Steps:	Note
List of Appendices	N/A

Meeting Report

Name of Meeting	SCAS Board (July 2024)
Title	Digital Update
Author	Craig Ellis, Chief Digital Officer
Accountable Director	Craig Ellis, Chief Digital Officer
Date	July 2024

1. Purpose

The report is to provide a high-level overview of the Digital Function (IT, Business Information and Cyber Security), and to call out key achievements, issues and noted concerns.

2. Background and Links to Previous Papers

N/A

3. Rationale for Private Paper

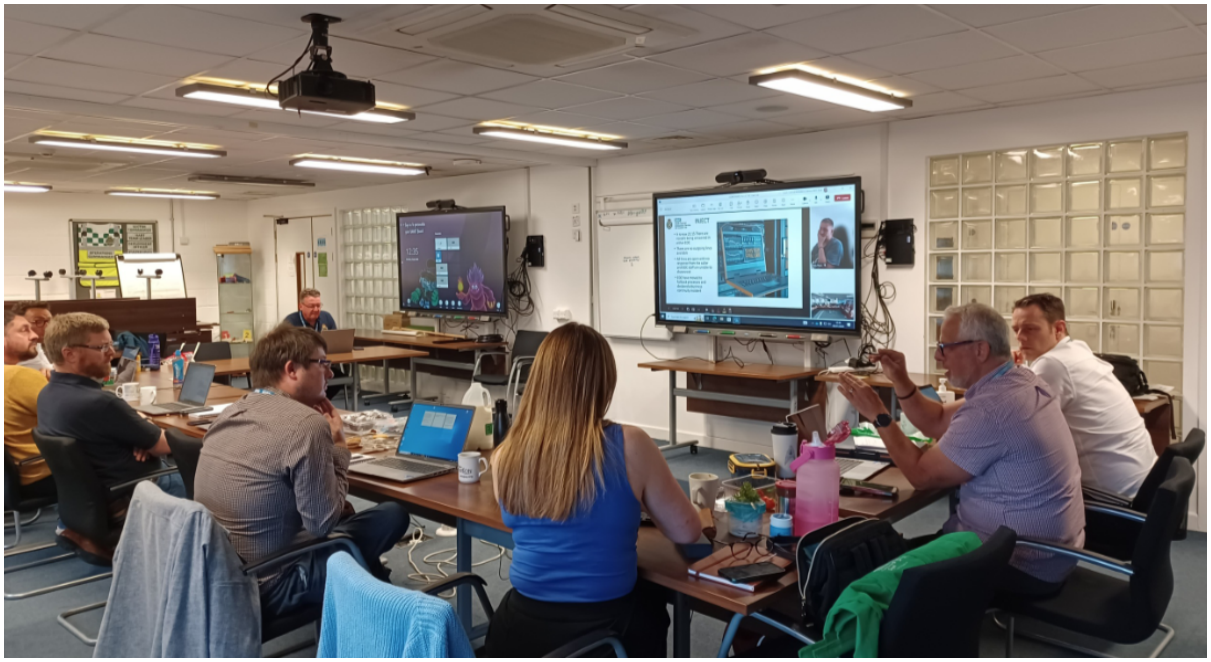
N/A

4. Executive Summary

A stable month again, with only one major outage affecting smart card access for our call-centre agents due to a human error by a team leader (detailed below). During the month, the team has spent time finalising our 2024/25 programme plan which is aligned to our capital allocation for 24/25 and our “Fit For The Future” strategy. In addition, the CAD tender was brought to a close as per the June board discussion, with all required parties notified and the tender formally cancelled. During July we have begun the lessons learnt review and we are now assessing as an executive team how best to structure the programme to move forward taking the learning from the situation which occurred.

On Monday 8th July, the Digital Team undertook a “desktop” business continuity exercise with our colleagues in emergency planning James and Hollie. The event was a real-life scenario exercise where we replicated losing core IT systems, and how we undertake business continuity in such situations. It was a rewarding day, albeit it did highlight a large number of gaps and areas to address in both Digital Business Continuity and SCAS Business Continuity processes as an organisation in relation to IT outages, however this is a positive in a strange way as it means the

remit of the day was achieve and learning and actions underway (Viva Engage Post).



I have personally spent time in July undertaking the risk-assessment of the 16 Core IT risks highlighted in May. This has been a challenging exercise due to a lack of quantitative data to help drive the residual risk scores, however overall, I am happy with the assessment which is attached for board viewing and was recently reviewed by the EMC and F&P with positive feedback, and approval to move forward with the Risk Mitigation plans for the five top risks highlighted.

Lastly, we completed our DSPT 23/24 assessment on time (End of June) and for the first year we have "met standard" with a number of risks accepted by the SIRO with actions in place over the next 6-months which will be assured at the Audit Committee. This is a positive as for the last two years we have been "reaching standard" and so it's a step forward in how we are managing complex cyber and IT risks and assurance, and that we are slowly maturing in some areas which is recognised.

Key Achievements

- DSPT Approval met with a "reaching standard" measurement, and a number of actions to be completed by Dec 2024
- Desktop Business Continuity Exercise held with good learning and actions noted.

Key IT Issues

- RA Smart-Card issue in July due to a human error by a call-centre team leader accidently deleting a "profile" not an account which

resulted in over 200 accounts requiring rebuild. Lessons Learnt to be undertaking to negate via access management the noted issue.

5. Areas of Risk

The Digital department and associated remit bring associated risk across all the below key areas within SCAS. Each of the below risk areas are relevant for IT and are managed accordingly within our IT risk-management framework.

- Clinical/Quality
- Financial*
- Business
- Reputational
- Performance

6. Link to Trust Objectives and Corporate/Board Assurance Framework Risks

SR8 - Ability to Deliver the Digital Strategy

7. Governance

N/A

8. Responsibility

Chief Digital Officer

7. Recommendations

To Note

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Report Cover Sheet

Report Title:	Improvement Programme Oversight Board Update - July 2024
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Wednesday, 31 July 2024
Agenda Item:	22
Executive Summary:	This paper covers the Improvement Programme Highlight Report for July 2024. • **Overarching Programme Update:** ○ The RAG ratings on the sustainability of the patient safety programme have moved down from green to amber this month based on reducing confidence in the sustainability of our improvements across safeguarding, mental capacity and medicines management. This means that that a detailed recovery plan is required alongside a summary of the key risks and mitigations in place at the next IPOB meeting. ○ Work to review metrics and develop driver diagrams is ongoing. This is highlighting where work programmes need further refinement to ensure that the actions we are taking are delivering the outcomes expected in a measurable way. ○ NHS England and the ICB together with SCAS senior leaders are working on revising the RSP exit criteria, which will be presented to the Board for agreement in August. • **Key risk to highlight:** ○ Capacity to support the delivery of the improvement plan priorities has remains a growing risk across all workstreams as the corporate review is delivered and a number of senior leaders depart the organisation • **Individual Programme Updates:** <u>Culture and staff wellbeing</u> ○ Fixed term support (Louise McKenzie) to develop the SCAS response and planning from the culture review has started ○ Sexual Safety Campaign continues including development of Upstander toolkit and manager training

- Root cause analysis of the barriers to better use of Personal Development Plans has been concluded and team is now exploring the potential to digitise the process to make it simpler to undertake and complete.

Governance

- The main risks to the programme which focused on the absence of an executive workforce lead has been resolved.
- The Governance Assurance and Accountability framework is being reviewed prior to publication by the new Interim Chief Governance Officer with a view to simplifying the document, reducing duplication with other policies and procedures.
- Further work to ensure that the recommendations of the Independent Governance Review continues to be enacted.

Performance

- Changes to the Care Pathway Policy has led to significant behaviour changes encouraging better decision making and onward referrals supporting Hear and Treat levels.
- The team has visited SECAmb to share learning, a range of ideas are in development where there are opportunities for SCAS to rapidly implement proven ways of working.
- The EOC roster consultation has been completed and new ways of working are scheduled to go live in September.
- As part of the Fit for the Future Business Case, AACE has completed an evaluation of 999 clinical deployment model. Implementation may be affected by constraints in clinical capacity and leadership.

Patient Safety

- The Safeguarding Task and Finish Group continues to work through a detailed action plan designed to strengthen and streamline the safeguarding referral process. A further detailed report is due to EMC in September. Until this issue is resolved SAAF compliance will not be achieved and therefore the rag rating against safeguarding must and should dos have been reduced to amber.
- Confidence in the sustainability of the improvements made to medicines management, and in particular the management of controlled drugs requires an action plan to bring the organisation in line with national guidance. Staff capacity has become a key constraint.
- While the Mental Capacity Act Policy is in place, concerns have been raised regarding the correct application of the policy leading to the downgrading of the sustainability of improvement to amber.

	○ A risk concerning the capacity of the team at senior level has been recorded. Capacity constraints are leading to delays in commencing some must do activities arising from internal audit and MaPSaF.
Recommendations:	The Trust Board is asked to: Note this paper
Accountable Director:	Caroline Morris, Transformation Programme Director (Acting up for Paul Kempster, Chief Transformation Officer)
Author:	Caroline Morris, Transformation Programme Director
Previously considered at:	Improvement Programme Oversight Board (IPOB)
Purpose of Report:	Assure
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** • **Significant** – High level of confidence in delivery of existing mechanisms/objectives • **Acceptable** – General confidence in delivery of existing mechanisms/objectives • **Partial** – Some confidence in delivery of existing mechanisms/objectives • **No Assurance** – No confidence in delivery **Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR9 - Delivery of the Trust Improvement Programme
Quality Domain(s)	All Quality Domains
Next Steps:	Not Applicable
List of Appendices	IPOB Update report pack July 2024

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Improvement Programme Oversight Board (IPOB)

Report Pack

10th July 2024

Contents

RAG Definitions

	Definition	Actions Required
Red	**One or more of the following:** A. Initiative requirements have not been clearly defined/accepted. B. Implementation is highly problematic - for instance actions no longer deliverable, delay exceeds agreed risk tolerance level. C. Failure is highly likely and/or intervention has not had desired effect. D. Resolution is not within team control and requires escalation. E. Anticipated change has become demonstrably unsustainable.	• Detailed Recovery Plan to be agreed by appropriate governance forum, breaking down actions into timed, risk assessed interventions
Amber	**One or more of the following:** For new initiatives: A. Requirements are not well defined with limited/no arrangements for delivery and reporting in place. For established initiatives: A. Implementation is problematic - for instance time slippage / resource issues / material change of specification. B. Unforeseen circumstances have arisen, or requirements have changed, but is recoverable with the right level of resources. C. Area of concern is not necessarily within the improvement team control and others need to be aware of the difficulties. D. Concerns about the sustainability of the change are beginning to emerge, for instance through use of QI tools	• Project initiation to be reviewed, gaps identified and reworked or • Detailed Recovery Plan to be agreed by relevant delivery group and summary of key risks and mitigations to appropriate governance forum
Green	**All of the following that apply:** For new initiatives: A. Requirements are well defined with evidenced arrangements for delivery and reporting in place. For established initiatives: A. Implementation is on track as per agreed plan. B. Implementation is aligned to agreed business case. C. Evidence to support change is being gathered.	• Ensure project/initiative plan is maintained and • Ensure systematic approach to evidencing change is in place
Blue	Expected change has been delivered and is evidenced as sustained >6 months	• Ensure BAU reporting in place.

Improvement Programme Summary

Including Progress & Sustainability Updates

Improvement Programme Summary: June 2024

	Progress	Sustainability		Progress	Sustainability
Governance & Well Led:	⇨	⇨	**Culture & Staff Wellbeing:**	⇨	⇨
Performance Improvement:	⇨	⇨	**Patient Safety:**	⇨	⇩

Key Progress:

- Review of the GAAF in progress and socialising with stakeholders in July ahead of publication.
- Annual mandatory submissions of Fit & Proper Persons (FPP) checks successfully submitted to NHSE Regional colleagues on 26 June 2024.
- Culture - three month RSP-funded resource from w/c 08/07/24 to review all available evidence, gather themes and set out priorities for culture and leadership development
- PDR and Talent/Succession – immediate PDR fixes underway; all cohort 1 Talent briefings completed
- June saw an improvement against plan with 29.50 delivered against the plan of 30.46 which left the Q1 position down against plan of 30.31 vs plan of 30.08. Hospital handover delays impacted Cat 2 by 4 minutes 40, with 2 minutes 37 seconds coming from QAH, North handover were 13 seconds above with South Handover 7 minutes 49 seconds above plan, with QA handover 13 minutes 24 seconds above plan. Reduced staff hours (due to a return of face-to-face training) impacted in the same period causing a further circa 4min impact on Cat 2.
- AACE evaluation of the 999 Clinical Deployment model is complete with suggestions for refining both the SCAS Clinical Deployment model and the EOC Structure. Assessment of these to align with current budgets and determine which adjustments are feasible immediately is underway, with a workshop, facilitated by AACE, arranged for 8th August.
- Task/Finish for SG Referrals continues with oversight at strategic level (led by CNO) with delivery at the operational level. Interim report to EMC showing on track to conclude by Sep 24.
- PSIRF Implementation Lead has been in post since 1 June 2024. Appointed the AD PS via an internal candidate start date to be agreed. Head of SG role advertised and closed 3rd July

Key Risks/Issues:

- Significant pressure on staff resources across all workstreams due to BAU pressures, live issues (e.g. SG referrals), absence and vacant positions. Situation being actively managed at a senior level with escalation to EMC as required
- Patient Safety vacancies – DCNO, AD SG soon to be vacant, AD PS and AD PE now vacant. Compounded by system controls and SCAS Corporate Review. Capacity for strategic/tactical decision-making impacted with an element of uncertainty being felt across the directorate. Recruitment activity ongoing for AD PS (offer accepted) and head of SG role (shortlisting).
- Work is being undertaken to review the capacity and resourcing risk across the workstreams and review how the programme can highlight this to create an informed overall picture with what actions are being taken.

RAG Assessment:

With the exception of Patient Safety, RAGs for all other workstreams remain the same. Changes to 4 of the Patient Safety RAG ratings, moving from green to amber for sustainability and the overall RAG for sustainability drops to amber. Remediation actions are ongoing to address these areas and bring them back on track.

Further work is being undertaken to re-analyse requirements against Must, Should and Exit Criteria. This review, led by the Transformation Programme Director, will include the creation of driver diagrams to ensure not only progress but also sustainability of activity undertaken against the revised timeline for exit from NOF4 by the end of Mar 25.

SCAS Improvement Programme: Progress & Sustainability Update

June 2024

Governance & Well Led [Daryl Lutchmaya]: *Substantive improvement in governance and leadership with evidence of improved assurance and accountability*		**Progress**	**Sustainability**
Exit	Improved board effectiveness; use of Board Assurance Framework and significant progress in embedding recommendations from the governance review	⇨	⇨
Exit	Improved assurance through effective corporate governance structures and information flows between committees and board	⇨	⇨
Exit	Board development programme in place including senior leadership review completed with plan signed off and progressing	⇨	⇨
Exit	Evidence of strengthened partnership working	⇨	⇨
Must	*The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)*	⇨	⇨
Should	*The trust should consider how to improve communication and relationships between staff and senior leaders*	⇨	⇨
Should	*The trust should review methods of communication between senior executives and call takers in the EOC to ensure important information is received and understood*	⇨	⇨
Should	*The trust should consider asking staff and patients with less positive experiences to present to the board to allow more opportunities for learning*	⇨	⇨

Culture & Staff Wellbeing [Melanie Saunders]: *Board approved culture improvement programme in place, with evidence of improved engagement and experience from all staff including volunteers*		**Progress**	**Sustainability**
Exit	Revised and approved People and OD Strategy to ensure SCAS has the necessary infrastructure to meet future need	⇨	⇨
Exit	Culture Improvement Programme in place, including evidence of improved engagement	⇨	⇨
Exit	Clear recruitment and retention plan, with agreed timeline and evidence of delivery to support the revised operating model (see below)	⇨	⇨
Exit	Approved FTSU plan (strategy, process and function) with evidence of delivery against plan and impact	⇨	⇨
Must	*The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. This to include where staff have raised concerns relating to bullying, harassment and sexually inappropriate behaviours. Regulation 17 (2) (b)*	⇨	⇨
Must	*The trust must ensure that it listens and responds to staff who raise concerns in line with their own policy and the Public Interest Disclosure Act (1998)*	⇨	⇨
Should	*The trust should ensure it provides appraisals and continuous professional development to all staff*	⇨	⇨
Should	*The trust should ensure that staff complete mandatory training appropriate to their roles and responsibilities*	⇨	⇨
Should	*The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale*	⇨	⇨
Should	*The trust should ensure all staff receive a timely appraisal to assure leaders that competency is maintained*	⇨	⇨
Should	*The trust should review the arrangements for the role of the Freedom to Speak Up Guardian to improve the speak up culture*	⇨	⇨

SCAS Improvement Programme: Progress & Sustainability Update

June 2024

	Performance Improvement [Mark Ainsworth]: *Board approved plan for performance recovery and future operating model*	Progress	Sustainability
Exit	A clear plan for performance recovery which includes representation from quality, finance, contracting and human resources / workforce	⇨	⇨
Exit	Demonstration of improvement against performance recovery plans	⇨	⇨
Exit	Demonstration of continued and sustained improvement in operational performance to be in line with the agreed trajectories in hear & treat and see & treat rates	⇨	⇨
Should	*The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times*	⇨	⇨
Should	*The trust should consider ways to monitor outcomes for patients who are not transferred to hospital to ensure the pathways are used effectively and that decisions are made in the patients' best interest*	⇨	⇨
Should	*The trust should consider revising their diversion policy to ensure they are transferred to hospital care in a timely way*	⇨	⇨
Should	*The trust should ensure ambulances are staffed by appropriately skilled crews*	⇨	⇨
Should	*The trust should ensure that staff have enough time to report adverse incidents*	⇨	⇨
Should	*The trust should ensure that staff, particularly newly qualified staff, receive appropriate clinical support and supervision to enable them to provide safe patient care*	⇨	⇨
Should	*The trust should continue to identify ways to recruit staff according to their current strategy in order to improve the call handling times*	⇨	⇨
Should	*The trust should improve response times in line with the Ambulance Response Programme*	⇨	⇨
Should	*The trust should act to ensure the clinical welfare calls are completed within the targeted timeframes*	⇨	⇨
Should	*The trust should optimise information systems to make less labour intensive for staff and improve efficiency in reporting*	⇨	⇨

SCAS Improvement Programme: Progress & Sustainability Update

June 2024

Patient Safety [Helen Young]: *Improvements in patient safety and experience, with evidence of effective systems and process in place around safeguarding and adverse incidents*		Progress	Sustainability
Exit	Embedded section 4.2.1 and the 11 core arrangements within the Safeguarding Accountability and Assurance Framework	⇨	⇩
Exit	PSIRF plan developed, approved and published in partnership with the ICB with evidence of delivery against plan	⇨	⇨
Exit	Evidence of improvement in Patient Safety and Just Culture	⇨	⇨
Exit	Demonstrable improvement in learning from SIs (individual, organisation and system wide)	⇨	⇨
Exit	Evidenced improved management of SIs	⇨	⇨
Must	*The trust must ensure all staff complete safeguarding training at the role appropriate level and any additional role specific training in line with the trust target. Regulation 18 (2) (a)*	⇨	⇩
Must	*The trust must ensure that incidents are identified, reported and investigated in line with the NHS Serious Incident Reporting Framework, that action is taken to mitigate risks and that learning is shared across the organisation. Regulation 17 (2) (b) (e)*	⇨	⇨
Must	*The board must be sighted on accurate information about serious incidents occurring at the trust to enable strategic oversight and planning. Regulation 17 (2) (b) (e)*	⇨	⇨
Must	*The trust must ensure that where trends in adverse incidents are known that these are fully investigated, and action is taken to reduce future risks. 17 (2) (b) (e)*	⇨	⇨
Must	*The trust must ensure that it meets the statutory requirements of the duty of candour. Regulation 20*	⇨	⇨
Must	*The trust must provide a separate Mental Capacity Act (2005) Policy and ensure that staff understand the principles and application of the Mental Capacity Act (2005) Regulation 17 (1)*	⇨	⇩
Must	*The trust must ensure medicines are managed in accordance with the national guidance and that only authorised persons have access to controlled drugs. Regulation 12 (2) (7)*	⇨	⇩
Must	*The provider must ensure that systems and processes for managing safeguarding within the trust are adequately resourced, effective and monitored by the board. Regulation 13 (1) (2) (3)*	⇨	⇨
Should	*The trust should ensure that medicines are always kept safely, whether in stations or on vehicles*	⇨	⇨
Should	*The trust should ensure that any shortfalls in infection prevention and control are reviewed, and action taken where needed*	⇨	⇨

Governance & Well-led

Governance & Well-led

Executive Lead:	Daryl Lutchmaya
Senior Responsible Officer:	Kofo Abayomi

Workstream Aims

To ensure robust internal assurance and leadership is in place through:

- Improved governance processes and procedures enabling effective passage of information from Point of Care to Trust Board, to inform better strategic decision-making
- Clear accountability structures throughout the organisation to ensure effective performance management
- A culture of governance and the associated behaviours are in evidence throughout the organisation

Expected Outcomes

- Effective Board Assurance Framework (BAF) in place with regular Board review and scrutiny
- All Board and Executive members attend development programme
- Regular Executive & NED assurance visits conducted
- All governance recommendations embedded into BAU
- Improving Partnership and Provider Survey results (engagement and feedback)
- Revised IPR in place

• Key Risks	• Issues
• Prolonged absence of Workstream Executive Lead and continued limited capacity in the governance team may impact workstream delivery • Volume of BAU and improvement mean capacity to deliver is limited	• Resource and changing personnel impact on improvement delivery • On-going concern around effectiveness of internal governance through key assurance meetings (TPAM / RSP)

Key Milestones

2024 / 2025	**Q1**	• Incorporate feedback received from Board Committees into the Governance Assurance & Accountability Framework (GAAF) (*Complete*) • Board approval of Board Committees ToRs *(Complete*) • Audit of Board Committees agenda and papers pack to determine progress of recommendations from the independent governance review (*Complete*) • Track Progress against implementation of recommendations from the Independent Governance Review
	Q2	• Implementation and Socialising GAAF with relevant stakeholders • Report output of audit (Board Committees agenda & Papers pack) highlighting improvement/areas of weakness and cascade recommendations to relevant stakeholders • Governance and Compliance team to collaborate on finalising Board site visit - taking into account Board feedback to improve process, reporting and follow up of issues raised. • Review and refine ongoing plan of improvement activity through the Governance and Well-Led Delivery Group • Audit the Board effectiveness feedback reviews (for last financial year) to identify progress made and identify weakness
	Q3	• Audit of Operational groups/ task and finish groups ToRs across the Trust to ensure no duplication • Ensure standard nomenclature of meetings as part of audit above
	Q4	• Progress Check with RSP colleagues to track workstream progress to ensure that must/should do and exit criteria are achieved and governance recommendations embedded into BAU

Highlight Report: Governance and Well-Led	June 2024	RAG:	Progress	Sustainability

Executive Lead: Daryl Lutchmaya ***Senior Responsible Officer: Kofo Abayomi***

Workstream Summary (Incl. RAG Assessment):

Whilst workstream resources have been a challenge over this period, a long-awaited review of metrics and deliverables has begun with the support of NHSE RSP colleagues. Work is ongoing in providing triangulated assurance of progress-to-date and develop planning for delivery of NOF 4 Exit Criteria by Sep 2024. Workstream planning is expected to go beyond this date, to provide embedded and sustainable change with evident measures of an improving culture of governance.

Progress Against Key Outcomes / Success Criteria:

- Final review of the GAAF and socialising with stakeholders prior to publication.
- Fit & Proper Persons (FPP) mandatory annual submission completed.

Key Activity, Month Ahead:

- There will be necessary focus on reviewing the Independent Governance Review recommendations to track progress on implementation, adjustment of timelines where there have been slippage.
- SRO, Improvement Programme Lead and Transformation Programme Director will continue to work with NHSE and ICB colleagues to reprioritise workstream activity, contributing to Must/Should Do and Exit Criteria delivery
- Ongoing review of Independent Governance Review actions with a focus on collation of assurance/evidence of progress

What's Gone Well:

- Work in progress with NHSE RSP colleagues to reset workstream planning and delivery, with renewed focus on achieving Exit Criteria for NOF 4 by Sep 2024.
- Additional work to be undertaken to revise workstream metrics to provide better insight into progress, and provide triangulated evidence of delivery on a whole-Trust basis
- Review of workstreams aims and outcomes by the Governance Team have provided clarity on workstream deliverables
- Grip of Independent Governance review with clarity of completed actions and outstanding actions.
- Corporate Governance & Compliance Manager vacancy now filled and will be in post from 1 July.
- Interim Chief Governance Officer will be in post from 2 July.

What's Not Gone So Well:

- Absence of CGO and vacancy withing the Governance team has required reprioritisation of workloads amongst Governance team members. Support from NHSE RSP colleagues is in place and additional PMO resource is being provided to ease admin burden

Workstream Key Risks:

- Lack of admin support within the team due to the Corporate Governance & Compliance Officer vacancy. Governance Team currently relying on Executive Assistant support across the Trust. The workstream will continue to be provided with PMO support in the short term to maintain progress

Issues for Escalation (Incl. Scope / Milestone Change Requests):

SCAS Improvement Plan Scorecard: Governance & Well Led — June 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Average timeliness of papers received by the Board and Committees per month (5 working days before meeting)	50% Q4 22/23	90% Q1 24/23	*Aim*	*N/A*	*N/A*	*50%*	*80%*	*80%*	*80%*	*90%*	*100%*	Data collected from QR code feedback and details provided from EA's. January: Board (8 responses, 5 NED, 2 ED) – 88% PACC (1 response) – 100% F&P (1 response) – 0% Q&S (3 responses) – 100% Audit (1 response) - 0% Rem Com (1 response) – 100% This question has now been removed from the QR code survey and will be solely based on EA feedback to remove any ambiguity. EA feedback for January is 33%.
				Actual	N/A	N/A	50%	55%	78%	33%			
2	Quality of papers for Board and Committees (as above) ('P' – Poor; 'A' – Average; 'G' – Good; 'E' – Excellent)	Average Q4 22/23	Excellent Q2 24/25	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Data collected from QR code feedback January: Board (8 responses, 5 NED, 2 ED) – G PACC (1 response) – G F&P (1 response) – E Q&S (3 responses) – G Audit (1 response) - G Rem Com (1 response) - G
				Actual	N/A	N/A	-	G	G	G			
3	Board Effectiveness review by survey Quality of papers for Board and Committees (as above) ('P' – Poor; 'A' – Average; 'G' – Good; 'E' – Excellent)	Average Q4 22/23	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*E*	*N/A*	*N/A*	*N/A*	Well-led review in Q3 - Focus: Strengths of the board/ Composition of the Board/Ability to resolve conflicts/ Regular reviews and reflections/vision, goals and focus of the Board/ Clear definition of roles & responsibilities / Level of constructive challenge.
				Actual	30%	64%	N/A	N/A	N/A	N/A			
4	Partners' satisfaction with joint working from SCAS (from 6 monthly survey) (Dissatisfied – 'D', Satisfied – 'S', Very Satisfied – 'V')	Satisfied Q4 22/23	Very Satisfied Q3 23/24	*Aim*	*N/A*	*N/A*	*S*	*N/A*	*VS*	*N/A*	*VS*	*N/A*	This metric will be reviewed following the decision on the approach the Trust will take to measure partnership working. Initial plans are currently being reviewed.
				Actual		3%	-	-	-	-			
5	Internal audit activities are being completed to plan No (<50%) Minimal (50% - 74%) Partial (75% -89%) Substantial (90% - 99%) Yes (100%)	Minimal Q3 22/23	Yes	*Aim*	*N/A*	*N/A*	*95%*	*95%*	*95%*	*95%*	*100%*	*100%*	For January 1 action was due and evidence for closure has been provided to Internal Audit.
				Actual	Minimal	Minimal	Partial 76%	No 8%	No 0%	Yes 100%			

SCAS Improvement Plan Scorecard:	Governance & Well Led	June 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
6	Effectiveness of committees ('P' -Poor, 'A' - Average, 'G' -Good or 'E' - Excellent)	Average Q4 22/23	Excellent	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Data collected from QR code feedback January: Board (8 responses, 5 NED, 2 ED) – G PACC (1 response) – E F&P (1 response) – G Q&S (3 responses) – A/G Audit (1 response) - E Rem Com (1 response) - E
				Actual	N/A	N/A	-	G/E	G	G/E			
7	Effective accountability structures through organisation (link to performance improvement) ('P' -Poor, 'A' - Average, 'G' -Good or 'E' - Excellent)	Poor Q4 22/23	Excellent Q2 24/25	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Chief Governance Officer's view based on progression of Governance Framework implementation. January - A The GAAF was presented and approved at EMC and Board week of the 11th December. It is now under review with Board Committees and will be updated when feedback is received. The document will then be published with associated comms.
				Actual	N/A	N/A	P	P	P/A	A			
8	Governance modules completed as part of leadership development	40% Q4 22/23	95% Q1 24/25	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*100%*	There is appetite for some Governance modules to be added to various development courses. These are not likely to be put into place until next year.
				Actual	N/A	N/A	-	-	-	-			
9	Monthly updating of the BAF ensuring links to extreme risks ('Y' -Yes, 'N' - No)	Yes Q1 23/24	Yes Q3 23/24	*Aim*	*N/A*	*N/A*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	Monthly updating of the BAF has been completed, with an additional BAF risk created in relation to the overall Improvement Programme. The Board agenda is prioritised in alignment to BAF risks.
				Actual	N/A	N/A	Y	Y	Y	Y			
10	Board development attendance	60% Q4 22/23	85% Q1 23/24	*Aim*	*N/A*	*N/A*	*100%*	*100%*	*100%*	*85%*	*85%*	*85%*	Percentage of eligible colleagues that attend Board Development sessions. January - 15 of 18 attendees present.
				Actual	N/A	N/A	71%	94%	89%	83%			

SCAS Improvement Plan Scorecard:				Governance & Well Led									June 2024
No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
11	Number of attendees at Leadership Development sessions?	80% Q4 22/23	95%	*Aim*	*N/A*	*N/A*	*60%*	*75%*	*75%*	*75%*	*95%*	*95%*	Percentage of eligible colleagues that have completed or are in the process of completing/booked on SCAS Leader and ESPM. SCAS Leader is only measurable quarterly due to the time it takes to complete the course. Reduction in completion is due to a change in reporting which has made the data gathering more accurate.
				Actual – SCAS Leader	N/A	N/A	47%	48.5%	58%	N/A			
				Actual - ESPM	N/A	N/A	61%	85%	88%	86%			
12	Feedback from Leadership Development sessions (Feedback score marked out of 5)	Average Q4 22/23	Excellent Q1 24/25	*Aim*	*N/A*	*N/A*	*3*	*3*	*4*	*4*	*5*	*5*	Data provided is feedback from ESPM only. It is currently being reviewed how feedback from both SCAS Leader and ESPM can be collated collectively, and this will be added when available. November saw a reduction in the score from October. Some of the feedback suggests that actions within the Trust do not reflect what is being taught in the modules and this is reflective in the feedback.
				Actual	N/A	N/A	-	4.64	4.26	4.41			
13	Numbers of Executive visits to sites/ride outs per month (expectation is one visit per month by each) (9 Executives)	50% Q4 22/23	95% Q1 24/25	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*100%*	Tracked through completion of online forms and EAs calendar feedback. January - 100% 9 out of 9 expected visits were completed.
				Actual	N/A	N/A	63%	85%	93%	100%			
14	Number of NED visits to sites/ride outs (8 NEDs – expectation is one visit per month by each)	Poor Q1 23/24	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*95%*	Tracked through reports provided to Marie Gittings. January - 50% 4 out of 8 expected visits were completed.
				Actual	N/A	N/A	42%	13%	29%	50%			

Culture & Staff Wellbeing

Culture & Staff Wellbeing

Executive Lead:	Melanie Saunders
Senior Responsible Officer:	Nicola Howells

Workstream Aims

To develop a culture of engagement, inclusivity and safety within the organisation by:

- Improved focus on staff engagement and feedback from the board and wider teams to the frontline
- Focus on appropriate / acceptable behaviours and evidence of addressing issues in a timely way
- The development of both accountability and support through appraisals, PDR and development opportunities
- Improved culture being part of everyone's roles, every day
- Development of Trust wide and localised Recruitment plans and Retention schemes

Expected Outcomes

- Culture improvement programme in place with clear methodology to improve trust-wide engagement and board ownership
- Completion of organisational-wide review of operating model, including benchmarking
- Clear recruitment plan and retention scheme and recruitment timelines
- FTSU policy, function & process approved by board and firmly embedded
- Sexual safety campaign

Key Risks

- Volume of improvements mean capacity to focus on improvements required is impacted.
- Financial constraints may impact delivery of some improvements (resources).
- Upcoming change in the organisation may affect staff morale / wellbeing / engagement impacting culture change benefits.

Issues

- Capacity and existing infrastructure of the People Services Directorate not able to manage the scope of improvement required

Key Milestones

2024 / 2025	**Q1**	• Culture Diagnostic by Real World HR complete and output report. (*Complete*) • Reset of culture improvement plan & culture journey. • Leadership development, through pathway of development of leaders and talent management. • Sexual Safety Reverse Mentoring Programme begins. • Launch of Sexual Safety Allyship training to 999 Ops and CCC. • Stabilising the resources in the FTSU team • Appointment of People Promise Manager (*Complete*) • Development of People Promise action plan and review of existing retention plans
	Q2	• Tender process for new paramedic apprenticeship providers begins. • Implement ESR Manager Self Service. • Sexual Safety Allyship training extends to line managers and Leaders. • Finalise FTSU Dashboard • Relaunch of Trust retention plan and directorate retention plan. • Talent Succession panel for business-critical executive roles.
	Q3	• Implement the blended apprenticeship programme (AAP and paramedic) • Present 5yr plan for Ops to Trust Board. • Implement reviewed PDR process. • CPD funding secured. • Good Start programme moved into BAU.
	Q4	• Implement changes to ECA apprenticeship (removal of PTS placements & shorten course). • People Voice process & flow fully established, feeding back to staff. • Evaluation of success of retention plans.

Highlight Report: Culture & Staff Wellbeing | June 2024 | RAG: Progress | Sustainability

Executive Lead: Melanie Saunders ***Senior Responsible Officer: Nicola Howells***

Workstream Summary (Incl. RAG Assessment):

Progress continues across all areas of the workstream. In-depth root cause analysis taking place on PDR with further development of the plan and identifying early improvement actions. Reviewing how to better allocate funding for personal development in a more equitable way. A refresh of retention is underway with a review of the local plans and drive from the People Promise Manager, also a successful launch of the new Paramedic Pathway Programme. The RealWorldHR culture review shared with the Board and dedicated resource to develop next steps in place w/c 8/6. Workstream remains amber for sustainability as key areas continue to be embedded and three exit criteria remain outstanding for completion.

Progress Against Key Outcomes / Success Criteria:

- Sexual Safety campaign continues including development of Upstander Toolkit & manager training
- 13 attendees at BAME conference meeting to share & cascade learning
- Supporting BAME network meeting to plan a new event in September
- Total of 39 FTSU peer champions (managers & non-managers)
- Overarching EDI plan against High Impact Actions to EMC 2 July

- PDR improvement - root cause analysis done. Stakeholders identified. Exploring potential for digitalisation

- Continuing engagement with Australian universities - monthly live events and linking with Student Unions on career workshops. 90+ students accepted offers to start in 2025.

Key Activity, Month Ahead:

- Test, finalise and publish Upstander toolkit
- Train the trainer for manager sexual safety training
- Finalise compassionate workplace module for A Good Start programme
- Proposal to move the People Pulse to National Quarterly Pulse (NQPS) - EMC to approve
- Further development of speaking up newsletter as part of People Voice

- Local retention leaders to be re-identified - plans to be updated incl new initiatives
- PDR – link & learn from SASC Trusts. Identify further immediate actions eg. ESR recording

- Scoping South Africa & Canada for International Recruitment
- Establish demographic monitoring for CPD funding allocations

What's Gone Well:

- FTSU newsletter launched sharing extensive 'you said, we did' feedback
- Trainee Paramedic Pathway Programme launched - online events resulted in 80 applications
- PDR documentation repaired, improved, uploaded and shared with all managers as a quick win
- PDR quality feedback channel added to the documentation

What's Not Gone So Well:

- Redeployment of resource used for the sexual safety campaign which has impacted on the launch of manager training. This has been mitigated in the short term by adding some immediate content to SCAS Leader and re-directing other short term resource to oversee all the campaign workstreams.

Workstream Key Risks:

If Call Centre attrition is higher than planned, we may struggle to recruit swiftly enough to maintain sufficient work effective staff. M1 & M2 higher than plan but attributable to known causes – trend monitoring in place

Thames Valley PTS contract not extended - retention & morale likely to be impacted

SRO / Assistant Director of OD leaving SCAS in September – interim plans for cover being considered

Issues for Escalation (Incl. Scope / Milestone Change Requests):

- NHSE CPD funding limited to registrants. No funding currently identified for non-registrants.
- FTSU capacity under pressure whilst re-recruiting third guardian. Interviews 05/07/24. All activity reduced to managing cases.

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — June 2024

No	Metric/s	Baseline (30/08/22)	End Target	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Reported cases of bullying and harassment	1	2	*Aim*	*N/A*	*N/A*	*3*	*3*	*3*	*3*	*2*	*2*	Q4. We continue to place emphasis on mediation (where appropriate) and there were 5 new mediation cases recorded in Q4.
				Actual	3	2	1	3	1	4			
2	Reported cases of sexual harassment	5	2	*Aim*	*N/A*	*N/A*	*5*	*7*	*8*	*8*	*7*	*7*	Q4. No new formal sexual harassment cases reported in the quarter which, in addition to no cases in Q3, was significantly below what we were expecting to see in light of the sexual safety campaign.
				Actual	4	4	4	3	0	0			
3	Casework (investigation) completion timeline completion against policy	35	35	*Aim*	*N/A*	*N/A*	*60*	*58*	*50*	*45*	*40*	*35*	Q4 Not including cases with police involvement. We were anticipating an increase in Sexual Harassment cases which involve outside agencies & take longer but this has not occurred.
				Actual	41	31	63	43	37	34			
4	FTSU: case numbers (overall and across service areas)	36	N/A	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	Q4 drop back to more average level of cases after the increase in volume from Speak up month in Oct / Nov pushing up Q3 figures.
				Actual	29	38	27	34	54	29			
5	FTSU: Freedom to Speak Up Sub Score	5.9 (Oct 22)	6.4	*Aim*	*N/A*	*N/A*	*N/A*	*5.9*	*5.9*	*6.0*	*6.0*	*6.1*	Q4 Limited opportunities to complete questionaries F2F during Q4, the walk about Wednesday questions were updated in Q4 (to v4.1) now reflects the new NSS 17 a&b questions , in the limited opportunities for F2F we received 33 responses but non for the sub score question set- seems to be human error. Figures in Q3 has been updated with the recently released NSS results, showing our sub-score increased to 6.1 this puts us above the ambulance benchmark of 5.96, on a par with best in sector (6.1) and ahead of trajectory. Baseline is NSS from Oct 22 (5.9). Forecast Q2 24/25 (6.1) is best in sector, end target (6.4) is national average. We are already ahead of sector average (5.8).
				Actual	N/A	N/A	N/A	5.2	6.1				

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — June 2024

No	Metric/s	Baseline (30/08/22)	End Target	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
6	FTSU: audit of time taken to complete initial investigation (% within guidelines)	93 (Q1 23 figures)	93	*Aim*	*N/A*	*N/A*	*N/A*	*93*	*86*	*86*	*93*	*93*	Q4 manual metric gathering is becoming increasingly challenging and as such no figures are available for this quarter. It is now dependent on the new automated Dashboard which is in the final stages of build specification with BI and 3rd party. Continue to engage for updates and an eta delivery date.
				Actual	N/A	N/A	93	80	78	not avail			
7	Appraisal with PDR: completion (%)	89	95	*Aim*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	Q4 – decrease overall and below trajectory for the quarter however M12 figures show a slight increase which may indicate the trend turning and improvements anticipated to continue.
				Actual	88	89	84	75	75	80			
8	Q21c – would recommend the organisation as a place to work (%)	36.5 (July 22)	59.4	*Aim*	*37*	*38*	39	40	41	42	43	44	Q4 - There has been an increase in engagement (advocacy) scores . The NSS (2023) sector average on this is 47.08%, SCAS scored 47.08% and is ahead of trajectory. Our aim is to keep improving above our sector average . The best in sector was 67.50%.
				Actual	46	36	41	35	47	47			
9	Staff feeling able to make suggestions to improve the work of their team/department (%)	47.7 (July 22)	61.7	*Aim*	*48*	*48*	*50*	*50*	*50*	*52*	*52*	*54*	Q4 - We have an increase in staff engagement (involvement) scores from the NSS survey. SCAS Scored 52.17% which is above the sector average sitting at 50.50% and is on trajectory. The best in sector is 75.11%.
				Actual	53	44	46	46	52	52			
10	Retention / Stability Index Rate (%)	82	82	*Aim*	*82*	*82*	*82*	*82*	*83*	*83*	*84*	*84*	Q4 – maintaining from Q3
				Actual	82	82	84	85	85	87			
11	Vacancy Rate (%)	15	10	*Aim*	*13*	*14*	*14*	*13.5*	*12*	*11*	*10*	*10*	Q4 – on track with workforce plan
				Actual	13	13	11	10	10	9			

Performance Improvement

Performance Improvement

Executive Lead:	Mark Ainsworth
Senior Responsible Officer:	Ruth Page / Dan Holliday

Workstream Aims

To strengthen the operational performance of the trust through:

- An agreed operational improvement recovery plan, including benchmarking delivery and resource with others
- An operational improvement development programme to include care pathways, infrastructure and support to be scoped and delivered.
- Improve Ambulance Clinical Quality Indicators (ACQI) compliance therefore improving quality of patient care.

Expected Outcomes

- Deliverable plans in place for performance improvement meeting timelines and targets
- Improved staff satisfaction and engagement (sickness and retention)
- Improved accountability and performance, using agreed trajectories to deliver performance
- Right care, right person approach to delivery of care.
- Reduced handover times through partnership working with acute trusts, releasing time to care.
- Improved ACQI metrics.

Key Risks

- Financial sustainability
- Failure to recruit to workforce plan
- Fleet availability
- Capacity within the wider team to deliver
- High dependency on interim leadership positions.
- Attrition rate increases
- MB/EOS Policy
- Political and economic position

Issues

- Changing demand within the system might create additional pressure
- Handover delays
- Financial position

Key Milestones

2024 / 2025	**Q1**	• South's roster fully implemented. • Rapid drop and go implemented across all acutes. • Immediate handover policy agreed by all sites. • AACE review of dispatch processes.
	Q2	• North's roster fully implemented. • Review and update daily shift working policy. • Performance cell implemented. • Implement recommended changes from AACE Dispatch report. • EOC rosters fully implemented.
	Q3	• H&T increase to 14%. • Implementation of new BOB 111/IUC contract • MB/EOS Policy trial in place
	Q4	• Training and familiarisation of new CAD system. • 111 Dual skill pilot complete.

Plan on a Page 2024 / 2025

Highlight Report: Performance Improvement | June 2024 | RAG: Progress | Sustainability

Executive Lead: Mark Ainsworth ***Senior Responsible Officers: Ruth Page, Dan Holliday***

Workstream Summary (Incl. RAG Assessment):

Cat 2 performance in May was 33.57 which was above the plan of 31.28. June saw an improvement against plan with 29.50 delivered against the plan of 30.46 which left the Q1 position down against plan of 30.31 vs plan of 30.08. Hospital handover delays impacted category 2 by 4 minutes 40 with 2 minutes 37 seconds coming from QAH, North handover were 13 seconds above with South Handover 7 minutes and 49 seconds above plan, with QA handover being 13 minutes 24 seconds above plan. It is also worth noting the impact of staff hours being down impacted in the same period causing a further circa 4min impact on Cat 2 mean. The reduction in hours was driven by the return of face to face training and a reduction of PP hours.

Delays at QA also increased from 2313hrs in April to 3312hrs in May but reduced in June to 2073 hrs with an average handover of 59mins and 51secs (target for QAH average HO in June was 23:05). The % of hours lost against hours at all other hospitals has increased by 14% from 41%.to 55% (3312vs 6033). This is included as a separate data set due to the financial savings based on improved performance at QA.

Call answer performance remains above trajectory, although June providing some challenges and bringing us closer to being outside trajectory. June call answer 13 sec and YTD 12 sec.

Progress Against Key Outcomes / Success Criteria: QTR 4/1

- Focus continues to be on Cat 2 response and EOC call answer:
  - Cat 2 Mean – May 33.57, June 29.50 QTD: 30.31
  - Call Answer Mean – 16 seconds for May. June 13 secs, QTD 12 seconds.
  - H&T 13.1% for June on trajectory for the quarter.

- RSP deep dive into performance work stream

Key Activity, Month Ahead:

- Continue to deliver against "exit criteria" performance targets
- Deliver against Operations Improvement Plan
- Integrated Intermediate Care Hubs (SPoA) - NHSE / ICB focus - working with HIOW ICB in developing trial model

- Visit from Cat 2 clinical segmentation lead arranged for July.
- AACE workshop on deployment model booked for 8th August.

What's Gone Well:

- Care Pathway policy - significant changes to encourage better decision making for onward referrals
- Frontline staff survey - Pathway usage, behaviours etc. It will inform next steps for increasing S&T
- NHSE Stroke Video Triage programme - to be able to get better remote clinical advice for crews
- Visit to SECAMB and sharing of learning
- EOC roster consultation completed, and pattern agreed for build, on schedule for September go live
- Union agreement on changes to meal break policy and end of shift for a new pilot

What's Not Gone So Well:

- Handover delays – significant delays at QA and RBH
- UHS, RBH and HHFT still to agree IH

- WMAS paused support for call answer 21st June for two weeks.

Workstream Key Risks:

- Capacity within the wider team to deliver against actions in Improvement Plan
- MB/EOS policy and its impact on PT care and staff H&WB.
- Clinical capacity and leadership in EOC to deliver required change in line with AACE recommendations.
- Current CAD and procurement may limit ability to make technical changes required to deliver improvements in EOC both call answer and H&T.

Workstream Issues:

- Fleet – increasing number of significant issues with fleet. Aging fleet being stretched without the flow of replacement vehicles
- Software development in ePR to monitor F2S/RDG not live or in testing due to competing priorities.

SCAS Improvement Programme Scorecard:	Performance Improvement	June 2024

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments *(comment on performance against trajectory)*
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Improved category 2 ambulance response times	00:34:08	00:18:00	*Aim*	00:18:00	00:18:00	00:27:59	00:26:43	00:28:56	00:29:37	00:30:08	00:30:17	Cat 2 performance in Q1 above the plan of 30:08 for the quarter. April and June ahead of plan but May was below plan which was impacted by hospital delays and staff hours being below plan, impacted on overall performance.
				Actual	00:40:33	00:26:53	00:29:42	00:33:09	0:38:09	0:35:57	0:30:31		
2	Increase in Hear and Treat rates	12.20%	14%	*Aim*	13.5%	12.5%	10.5%	11.5%	12.0%	12.5%	13.0%	13.0%	June H&T 13.1%. Continue with actions in H&T plan, taking learning from SECAMB and working with providers to build effective referral pathways.
				Actual	13.4%	10.8%	10.6%	11.1%	11.8%	12.3%	12.9%		
3	Increased See and Treat rates	34.8%	35%	*Aim*	34.0%	34.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	S&T continues to be below the mean with a correlation evident with the increase in H&T
				Actual	34.9%	34.7%	34.3%	33.7%	33.5%	33.6%	33.1%		
4	Improved Mean 999 call answer time	00:00:51	00:00:10	*Aim*	00:00:10	00:00:10	00:00:24	00:00:11	00:00:20	00:00:11	00:00:10	00:00:10	Positive steps taken in maintaining requirement for work effective ECTs (162 vs 168 WTE). Team continue with actions as per improvement plan.
				Actual	00:01:06	00:00:32	00:00:25	00:00:22	00:00:17	00:00:18	00:00:11		

SCAS Improvement Programme Scorecard: Performance Improvement June 2024

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
5	Improvement in % of staff having meal breaks	54.9%	85%	*Aim*	85.0%	85.0%	63.0%	64.0%	65.0%	66.0%	75.0%	80.0%	The new rosters are now live in Hampshire and as such we are now focusing on the monitoring the number of Breaks in the window, as we have more overlaps and increased numbers of vehicles available at periods of peak demand. Unions have agree in principle a set of trial criteria which will need to be agreed at EMT.
				Actual	48.1%	61.5%	58.7%	53.8%	45.3%	42.8%	42.7%		
6	Improvement in % of staff shifts finishing no later than 30 minutes past finish time.	71.8%	90%	*Aim*	66.0%	66.0%	85.0%	85.0%	87.0%	88.0%	89%	90%	Unions have agreed in principle a set of trial criteria which will need to be agreed at EMT.
				Actual	69.0%	83.0%	84.0%	82.3%	80.5%	81.5%	81.4%		
7.	Progress against infrastructure development programme			*Aim*	N/A	N/A	Programme Brief	Programme Plan	Initial Board Approval of Plan	Final Board Approval of Plan			The fit for the future programme are continuing to develop the 'proof of concept' to be trialled a North Harbour as well as reviewing similar processes for EOC. The team are also working with the operations team on developing proposals for new operational structures
				Actual	*N/A*	*N/A*	Complete	Complete	Complete	On track			

Patient Safety

Patient Safety

Executive Lead:	Helen Young
Senior Responsible Officer:	Sue Heyes

Workstream Aims

To strengthen the oversight of Quality and Safety within the Trust by:

- Development of effective and sustainable systems, processes and governance for Patient Safety assurance (Safeguarding and Incident Management)
- Proactive safety culture and supportive learning culture development
- Effective Learning from Incidents (LfE)
- Maintaining the focus on Quality and Safety from point of care to Trust Board

Expected Outcomes

- Consistent Board-level leadership of Patient Safety, Experience & Safeguarding
- Patient Safety and Safeguarding oversight, escalation and improvement is consistently demonstrated in BAF and Corporate Risk Registers and Board papers
- Patient Safety culture maturity consistently demonstrated through internal and external audit, surveys, peer review, learning from patient events and staff engagement and feedback
- Section 4.2.1 and 11 Core Arrangements of the Safeguarding Accountability and Assurance Framework (SAAF) are embedded across the organisation
- Complete the transition to PSIRF to enable the effective management of Patient Safety Incidents
- Evidence of Just and Learning culture embedded across the Trust

Key Risks

- Recurrent impact of operational pressures on Patient Safety assurance activity
- Financial pressures may impact on capacity to fully embed and sustain Patient Safety improvements
- Imminent changes Quality and Safety leadership team disrupts improvement activity

Issues

- Reputation of SCAS (incl. Safeguarding Service) continues to be adversely affected by failures of systems and processes relating to Safeguarding referrals

Key Milestones

2024 / 2025	**Q1**	• Transition to PSIRF and Learning From Patient Safety Events (LFPSE) systems and processes • Successful resolution of Safeguarding end-to-end referral process Task and Finish Group (recommendations to be implemented Q2-4) • Introduce new IPC Audits (revised content and schedule) • Commencement of new IPC L2 (F2F) for 999/PTS operations
	Q2	• Development of Medicines tracking Business Case • Implementation of Medical Devices Asset Management system • Focus on IPC practice and procedure (e.g. Hand Hygiene/Bare Below the Elbow (BBE))
	Q3	• Evidence of continually improving patient safety culture (third MaPSaF survey to be conducted) • Joint staff engagement events to promote positive Patient Safety culture (in-line with Patient Safety Week/FTSU month) • Enhanced medicines management with potential for in-house medicines packing
	Q4	• Further demonstrable evidence of embedded and sustained improvement • Review and audit of PSIRF/LFPSE activity (12 months post-implementation)

Highlight Report: Patient Safety | June 2024 | RAG: Progress | Sustainability

Executive Lead: Helen Young ***Senior Responsible Officer: Sue Heyes***

Workstream Summary (Incl. RAG Assessment):

Progress across all workstreams continues with further work to analyse SG processes regarding referrals and improve IPC audit compliance. Complex issues continue to complicate the SG Task/Finish group but robust oversight in place, led by the Chief Nursing Officer (CNO). A significant risk will exist for a period of time (subject to ability to recruit) with the Deputy CNO and one AD retiring within a short timescale with two ADs retired in recent weeks– this will prove to be a significant challenge to capacity and decision making at a senior level.

Progress Against Key Outcomes / Success Criteria:

- Progress has continued on the historic SI open actions reducing to 23 from 29.

- SG process mapping exercise continues (referrals focussed) to ensure correct processes in place for all relevant staff groups
- Task/Finish for SG Referrals continues with oversight at strategic level (led by CNO) with delivery at the operational level.
- Interim report to EMC showing on track to conclude by Sep 24.

- Reviewed Outline Business Case (OBC) for Medicines Tracking with SCAS Digital

Key Activity, Month Ahead:

- Continue task and finish group to complete process mapping in all stages.
- To improve frequency and quality of reconciliation reports.
- SG and PE annual report.

- Prepare presentation of first multi-agency Learning Response Tool after action review (AAR), post PSIRF implementation (patient story) for PSEC in Aug.
- Completion of the TNA to support assurance of quality of learning responses within PSIRF.
- Formal Executive decision for adding a MH related theme to MH incidents to Trust Local Risk Profile.
- IPC lead working with operational team to increase the number of vehicle audits undertaken.

- To ensure alignment of the SCAS BI data and education training data.
- Present Medicines Tracking business case to Fixed Asset Management group and then to the New Business Sub Committee.

What's Gone Well:

- Appointed the AD PS, start date to be agreed. Head of SG role advertised and closed 3rd July

- 'A significant increase in the quality of SG / welfare referrals particularly around consent, the ability to contact patients and the non use of medical jargon' (report from Milton Keynes LA).
- PSIRF Implementation Lead has been in post since 1 June 2024

What's Not Gone So Well:

- Hazards identified in SG task & finish group are hindering progress against plan.

- Reduction in the number of WTE in Patient Safety Team has increased risk related to management of PSII investigations and the level of support that can be offered to staff completing other learning responses.

Workstream Key Risks:

- Full SAAF compliance will not be achieved until server referral issue is resolved. This results in a potential reputational challenge with wider SG Boards and ICB/NHSE/CQC
- WTE reduction in Patient Safety Team has increased risk related to management of PSII investigations and the level of support that can be offered to staff completing other learning responses.
- Data in different systems not aligned may lead to incorrect decisions made around training.

- Vacancies – DCNO, AD SG, soon to be vacant and AD PS, AD PE are vacant. Capacity for strategic/tactical decision-making impacted. Must do workstreams for the AD Safety have not

Workstream Issues:

- Potential emerging issue related to the number of staff required to complete a learning response v Number of available staff (NHSE have suggested Band 8A above to fulfil this task.). SCAS agreed Band 7 and above to mitigate though these are mainly operational so will have competing priorities.
- Capacity of Safeguarding Service to provide training of new form to CC Staff in July/August and the release of staff to attend (large volumes in short timeframe).

SCAS Improvement Programme Scorecard: Patient Safety June 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Increased number of Safeguarding referrals indicative of +ve reporting	12153 (30/09/22)	17956 (30/09/24)	*Aim*	*12761*	*13399*	*14069*	*14772*	*15511*	*16287*	*17101*	*17956*	5% target increase per Qtr. Q3. Data from SCAS BI/Doc-Works Q4. Data from Doc-Works
				Actual	13728	14221	16311	20458	22267	22773	TBC		
2	Compliance against trajectory of Level 3 Safeguarding training	6% (30/09/22)	90% (31/03/24)	*Aim*	*20%*	*30%*	*46%*	*60%*	*70%*	*90%*	*>90%*	*>90%*	Trust-wide compliance figure. Q4. Impacted by competence expiry/new starters.
				Actual	18%	31%	49%	60.75%	82%	82%	84%		
3	Self-assessed compliance against SAAF to safeguard children, young people & adults	20% (30/09/22)	100% (Q4 23/24)	*Aim*	*30%*	*60%*	*70%*	*80%*	*90%*	*95%*	*>70%*	*>80%*	Calculated percentage against tasks aligned to SAAF. Q4. No change
				Actual	30%	64%	94.5%	94.5%	97.8%	97.8%	97.8%		
4	Improvement in Patient Safety Culture Survey (MaPSaF) response rates	3% (28/02/23)	7.5% (30/09/24)	*Aim*	*N/A*	*3%*	*N/A*	*N/A*	*N/A*	*5%*	*N/A*	*7.5%*	Repeated every 6/12. Q4. 1008/4500 respondents. Survey closed 29/02/2024
				Actual	N/A	3%	N/A	N/A	N/A	22.4%	N/A		
5	Incident report audit using a Quality & Maturity tool to evidence Well Led and cultural change	0 (31/03/23)	40 (31/03/24)	*Aim*	*N/A*	*N/A*	*10*	*10*	*10*	*10*	*10*	*10*	Audits to assess quality of SI, DI and Low/No Harm reporting. Q4. On track
				Actual	N/A	N/A	10	10	10	10	TBC		
6	Medical Device Audit – % compliance against schedule (Zoll X-Series)	Not Known (30/09/22)	>95% (Q1 24/25)	*Aim*	*>80%*	*>90%*	*>90%*	*>90%*	*>90%*	*>90%*	*>95%*	*>95%*	Increase (to >95%) dependent on intro of new Asset Management system. Q4. Current compliance position
				Actual	80%	90%	93%	93.4%	97%	95.4%	96.3%		
7	Decrease in number of medicines unaccounted for/loss	New for 23/24 IPR	<15 (Post Q3 23/24)	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*<15*	*<15*	*<15*	*<15*	IPR compliance data (new for 23/24) Target set following Q3 data and based upon 5 or less losses/month. Q4. Data set complete
				Actual	N/A	N/A	34	82	11	15	7		
8a.	IPC audit: % compliance against buildings cleanliness target	80% (30/09/22)	95%	*Aim*	*N/A*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	IPR compliance data. Q4. Data set complete
				Actual	N/A	74%	80%	77.9%	87.3%	92.5%	91.7%		
8b.	IPC audit: % compliance against vehicles cleanliness target	91% (30/09/22)	95%	*Aim*	*N/A*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	IPR compliance data. Q4. Data set complete
				Actual	N/A	91%	96.5%	93.1%	93.3%	98.5%	95.8%		

End of Board Pack

NHS
South Central
Ambulance Service
NHS Foundation Trust

Acronyms

The following document explains some acronyms and terms which Staff and Governors may come across in their role.

A	
A&E	Accident & Emergency
AAA	Abdominal Aortic Aneurysm (a swelling) of the aorta – the main blood vessel that leads away from the heart, down through the abdomen to the rest of the body.
AACE	Association of Ambulance Chief Executives
AAP/TAAP	Associate Ambulance Practitioner /Trainee Associate Ambulance Practitioner
ABC	Airway Breathing Circulation
ACCT	Assessment, Care Custody and Teamwork
ACEs	Adverse childhood experiences
ACQI	Ambulance Clinical Quality Indicators
Acorn	Consumer classification that segments the UK population by analysing demographic data, social factors, population and consumer behaviour
ACS	Acute Coronary Syndrome (term given by doctors for various heart conditions incl. heart attacks)
ADC	Aggregate Data Collection (111 IUC ADC)
ADHD	Attention-deficit/hyperactivity disorder
AED	Automatic External Defibrillator qv FR2
AED	Adult Eating Disorders
AF/A-Fib	Atrial fibrillation (an abnormal heart rhythm characterised by rapid and irregular breathing)
AfC/A4C	Agenda for Change
AGM	Annual General Meeting
AGS	Annual Governance Statement
AHP	Allied Health Professionals
AHSC	Academic Health Science Centre
AHSN	Academic Health Science Network
AHT	Average Handling Time
AIP	Ambulance Improvement Programme

ALB(s)	Arms Length Bodies
ALF	Ambulance Leadership Forum
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMI	Acute Myocardial Unit
AMM	Annual Members Meeting
AMPDS	Advanced Medical Priority Dispatch System (ambulance triage system to decide response to calls)
AMU	Acute Medical Unit
AMU	Acute Myocardial Unit
ANPs	Advanced Nurse Practitioners
AO	Accountable Officer
APs	Approved Premises
A PAD	Ambulance Portable Access Devices
AQI	Ambulance Quality Indicator
ARC	Analgesic Review Clinics
ARC	Audit & Governance Risk Committee
ARI	Acute Respiratory Infection
ARP	Ambulance Response Programme – provides 999 response targets
ASC	Adult Social Care
ASD	Alternative Spectrum Disorder (formally Autism Spec. Disorder)
AWR	Additional Work Requests
B	
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BAU	Business as usual
BCF	Better Care Fund
BCI	Business Continuity Incident
BH	Budget Holder
BHF	British Heart Foundation
BI	Business Information
BI	Business Intelligence
BLMK	Bedfordshire, Luton & Milton Keynes
BLS	Basic Life Support
BMA	British Medical Association
BME	Black, Minority, Ethnic
BOB	Buckinghamshire, Oxfordshire and Berkshire
BoD	Board of Directors
BSM/BSO	Business Support Manager/Officer

BSI	British Standards Institution
BWVC	Body Worn Video camera
C	
CA	Clinical Advisor
CA	Coronary Artery (often seen as RCA – right coronary artery or LCA - left)
CAD	Computer Aided Dispatch System (electronic system for dispatching emergency calls used in 111/999 service centres)
Cafcass	Children and Family Court Advisory and Support Service
CALNAS	Culture and Leadership Network for Ambulance Services
CAMHS	Child and Adolescent Mental Health Services
CapEx	Capital Expenditure
CAS	Clinical Assessment Service
CAT	Category
CAT	Clinical Assessment Team
CBA	Cost Benefit Analysis
CBDT	Compact Based Drug Testing
CBRN	Chemical Biological Radiological and Nuclear
CBT	Cognitive Behavioural Therapy
CC	Care Connect – An application programming Interface being developed across the NHS
CC	Contact Centre
CCAS	Covid Clinical Assessment Service
CCC	Clinical Care Coordination
CCD	Critical Care Desk
CCG	Clinical Commissioning Group
CD	Controlled Drugs
CDA	Clinical Document Architecture
CDEL	Capital departmental expenditure limit
CDiff	Clostridium difficile
CDSS	Clinical Decision Support System (i.e. NHS Pathways)
CE / CEO	Chief Executive Officer
CES	Civica Election Services
CETV	Cash Equivalent Transfer Value
CF	Cash Flow
CFC	Counter Funds Committee
CFC	Charitable Funds Committee
CFO	Chief Financial Officer

CFR	Community First Responder
CFW	Concern For Welfare
CGG	Clinical Governance Group
CHC	Continuing Healthcare
CHD	Coronary Heart Disease
CHSWG	Central Health and Safety Working Group
CIP	Cost Improvement Plan
CMI	Chartered Management Institute
CMO	Chief Medical Officer
CMS	Capacity Management System
CNO	Chief Nursing Officer
COAD/COPD	Chronic Obstructive Airways/Pulmonary Disease
CoG	Council of Governors
COI	Clinical Outcome Indicator
COL	Conditional Offer Letter
COO	Chief Operating Officer
COP	Common Operating Picture
COPI	Control of Patient Information
COSHH	Control of Substances Hazardous to Health
COVID-19 / CV19	Coronavirus
CPD	Continuing Professional Development
CPI	Consumer Prices Index
CP-IS	Child Protection Information Sharing
CPMS	Care Plan Management System (Kent)
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CQI	Clinical Quality Indicator
CQRG	Clinical Quality Review Group
CQUIN	Commissioning for Quality and Innovation
CR	Care Record
CRASH	Clinical Randomisation of an Anti-fibrinolytic in Symptomatic mild Head injury
CRB	Criminal Records Bureau
CREWS	Caring, Responsive, Effective, Well-led, Safe (for use in CQC audits and reviews of Ambulance Trusts

CRM	Customer Relationship Management
CRN	Clinical Research Network
CRR	Corporate Risk Register
CRS	Commissioner requested services
CRS	Control Room Solution
CRS	Covid Response Service
CSD	Clinical Support Desk
CSO	Central Statistical Office
CSR	Corporate Social Responsibility
CSU	Commissioning Support Unit
CT	Computed Tomography
CTIMP	Clinical Trial of Investigational Medicinal Product
CTP	Clinical Triage Platform
CVA/CVI	Cerebrovascular Accident/Incident (Stroke)
CVD	Cardiovascular Disease
CWS	Clinical Workflow System, i.e. Clerical
CYP	Children & Young Person
CYPMH	Children & Young Person Mental Health
CYPSE	Children and Young People's Secure Estate
D	
DA	Domestic Abuse
DAB	Direct Appointment Booking
DARE	Database of Abstracts of Reviews of Effects
Datix	Incident reporting and risk management software
DBS	Disclosure and barring service
DGH	District General Hospital
DH/DoH	Department of Health
DHSC	Department of Health and Social Care
DHU	DHU Healthcare
DNA	Did Not Attend
DNAR	Do Not Attempt Resuscitation
DLG	Deputy Lead Governor
DI	Detailed Investigation
DoF	Director of Finance
dm+d	A subset of SNOMED CT. Dictionary of medicines and devices
DMP	Demand Management Plan
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DNAR	Do Not Attempt Resuscitation
DOT	Directly observed treatment

DoPHER	Database of promoting health effectiveness reviews
DPA	Data Protection Act
DPH	Director of Public Health
DPIA	Data Protection Impact Assessment
DRC	Depreciated Replacement Cost
DSAR	Data Subject Access Request
DSE	Display Screen Equipment
DTC	Diagnostic and Treatment Centre
DTOCs	Delayed Transfers of waiting Care
DTS	Data Transfer Service (replaced by MESH - see below)
DVT	Deep Vein Thrombosis
E	
EA	Equality Analysis
EA	Executive Assistant
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
ECA	Emergency Care Assistant
ECT	Emergency Care Technician
ECT	Emergency Call Taker
ECDS	Emergency Care Data Set (AKA CDS011)
ECG	Electrocardiogram (a test that measures the electric activity of the heart)
ECPAG	Emergency Call Prioritisation Advisory Group
ECR	Extra-Contractual Referral
ECSW	Emergency Care Support Worker (Ambulance Service)
ED	Emergency Department (hospital A&E)
ED(s)	Executive Directors or Emergency Department
EDD	estimated delivery date (used in Maternity terminology)
ED&I	Equality, Diversity & Inclusion
EDS2	Equality Delivery System 2
EDS	Equality Delivery System
EDS2	Equality Delivery System 2
E&UC	Emergency and Urgent Care
EEAST	
EHR	Electronic Health Record
EIA	Equality Impact Analysis
EIF	Education Inspection Framework
EMA	Emergency Medical Advisor
EMB	Executive Management Board

EMIS	Egton Medical Information Systems - electronic patient record in GP surgeries
EMSCP	Emergency Services Mobile Control Project
ENEI	Employers Network for Equality and Inclusion
ENP	Emergency Nurse Practitioner
ENT	Ear, Nose and Throat
EO	Executive Officer
EOC	Emergency Operations Centre
EOLC	End of Life Care
ePCR	electronic Patient Clinical Record or
ePCR	electronic Patient Care Record
EPLS	Emergency Paediatric Life Support
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EPS	Electronic Prescription Service
EQIA	Equality Impact Analysis
ERS	Electronic Referral System
ESC	Emergency Services Collaboration
ESFA	Education Skills Funding Agency
ESM	Executive and Senior Managers
ESMCP	Emergency Services Mobile Communications Programme
ESN	Emergency Services Network
ESPM	Essential Skills for People Managers
ESR	Electronic staff record
ETE	Education, Training and/or Employment
EU	European Union
EUC	Emergency and Urgent Care
F	
FAST	Face Arm Speech Test
FC	Foundation Council
FFT	Friends and Family Test
FHIR	Fast Healthcare Interoperability Resources specification
FIC	Finance and Investment Committee
FLSM	Front Loaded Service Model
FOI	Freedom of Information
FPPT	Fit and Proper Persons Test
FReM	Financial Reporting Manual
FRF	Financial Recovery Fund
FRICS	Fellow Royal Institution of Chartered Surveyors

FRP	Financial Recover Plan
FS	Functions Skills
FT	Foundation Trust
FTE	Full Time Equivalent
FTSU	Freedom to speak up
FTSUG	Freedom to Speak Up Guardian
G	
GAD	Government Actuary Department
GAM	Group Accounting Manual
GCS	Glasgow Coma Scale
GDC	Governor Development Committee
GDE	Global Digital Exemplar
GDP	Gross Domestic Product
GDPR	General Data Protection Regulations
GEN	Gender Equality Network
GIRFT	Getting it Right First Time
GMC	General Medical Council
GoodSAM	Good Smartphone Activated Medics
GP	General Practitioners
GP Connect	The service makes patient medical information available to all appropriate clinicians when and where they need it
GPhC	General Pharmaceutical Council
H	
H&J	Health & Justice
HART	Hazardous Area Response Team
HASC	Health & Adult Social Care Select Committee
H&T	Hear and Treat
HCA	Health Care Assistant
HCAI	Healthcare Associated Infection
HCP	Health Care Personnel/ Professional
HCPC	Health & Care Professionals Council
HCTED	High-Cost Tariff-Excluded Device
HDU	High Dependency Unit
HEAT	Healthcare Education and Training
HEE	Health Education England
HEEKSS	Health Education England across Kent, Surrey & Sussex
HEI	Higher Education Institution
HEMS	Helicopter Emergency Medical Service

HER	Health Electronic Record
HIOW	Hampshire and Isle of Wight ICB
HIS	Health Informatics Service
HJIS	Health & Justice Information Services
HJIP/HJIPs	Health & Justice Indicators of Performance
HL7	Health Level 7 (Messaging standard from NHS Digital)
HLO	Hospital Liaison Officer
HM	His Majesty's
HMIP	Her Majesty's Inspectorate of Prisons
HMPPS	Her/His Majesty's Prison and Probation Service
HMRC	His Majesty's Revenue and Customs
HO	Hand Over
HoIA	Head of Internal Audit
HORUS	Holding Obtaining Recording Using Sharing
HOSC	Health Overview and Scrutiny Committee (scrutinises and consults on local health services and changes to such)
HPC	History of Presenting Complaint
HR	Human Resources
HRA	Human Resources Advisor
HRA	Health Research Authority
HRT	Hormonal replacement therapy
HSCA 2012	Health & Social Care Act 2012
HSCIC	Health and Social Care Information Centre
HSCN	Health and Social Care Network
HSCNAs	Health & Social Care Needs Assessments
HSH	Hampshire and Surrey Heath
HSJ	Health Service Journal
HSLI	Health System Led Investment (associated with funding GDEs)
HSP	Healthcare Service Provider
HSWA	Health and Safety at Work Act
HTA	Human Tissue Authority
HWB / HWBB	Health & Wellbeing Board
I	
IA	Industrial Action
I&E	Income and Expenditure
IAM	Integrated Assurance Meeting
IAP	Improvement Action Plan

IAPT	Improving Access to Psychological Therapies
IAS	International Accounting Standard
IBIS	Intelligence Based Information System (bespoke South East Coast Ambulance (SECAmb) NHS FT - system which enables health professionals to inform the ambulance service of patients with long-term conditions).
IBP	Integrated Business Plan
IC24	Integrated Care 24 - Partner in NHS 111
ICAS	Independent Complaints and Advocacy Services
ICB	Integrated Care Board
ICCS	Integrated Communication and Control System
ICO	Information Commissioners Office
ICP	Integrated Care Pathway/Partnership
ICU or ITU	Intensive Care Unit Intensive therapy unit
ICS	Integrated Care system
ICT	Information Communications Technology
IDACI	Income Deprivation Affecting Children Index
IDAOPI	Income Deprivation Affecting Older People Index
IFRS	International Financial Reporting Standard
IFT	Inter-Facility Transfer
IG	Information Governance
IGA	Information Governance Alliance
iGAS	Invasive Group A Streptococcus
IGWG	Information Governance Working Group
IHCD	Institute of Health and Care Development (academic and vocational qualification body which provided technical courses)
IO	Intraosseously
IO	Investigating Officer
IOSH	Institution of Occupational Safety & Health
IOW	Isle of Wight
IP	Inpatient
IP/non-IP	Intellectual Property/Non- Intellectual Property
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
IPR	Intellectual Property Rights
IR1	Incident Report Form used by Ambulance Trusts
IRP	Incident Review Panel
ISDN	Integrated Stroke Development Networks

ISG	Information Sharing Gateway
ISN	Information Standard Notice
IT	Information Technology
ITK	Interoperability Tool Kit
ITT	Invitation to Tender (for contract bids etc.)
ITU	Intensive Treatment/Therapy Unit
ITV	Intermediate Tier Vehicle
IUC	Integrated Urgent Care
IV	Intravenous
IVR	Interactive Voice Recognition
IWG	Inclusion Working Group
IWP	Integrated Workforce Plan
IWRI	Incident Web Reporting Forum (online incident report form, sometimes just IR1)
J	
JESIP	Joint Emergency Services Interoperability Programme (a national programme to address recommendations and findings from Major Incident Reports)
JPF	Joint Partnership Forum (Trust's trade union and management committee)
JRCALC	Joint Royal Colleges Ambulance Liaison Committee (provides clinical practice guidelines)
JRU	Joint Response Unit
JSC	Joint Select Committee
JTAI	Joint Targeted Area Inspection
K	
KEE	Knowledge Exchange Event
KLOE	Key Lines of Enquiry
KMS	Kent, Medway and Sussex
KMCR	Kent and Medway Care Record
KPI	Key Performance Indicator
KSF	Key Skills Framework
KSS	Kent Surrey Sussex
KSSAHSN	Kent Surrey Sussex Academic Health Science Network
L	
L&D	Learning and Development
L&OD	Learning and Organisational Development

LA	Local Authority
LAEDB	Local Accident and Emergency Delivery Board
LAS	London Ambulance Service
LCFS	Local Counter Fraud Specialist
LD	Learning Disability
LDP	Local Delivery Plan
LeDeR	A service improvement programme for people with a learning disability and autistic people
LFPSE	Learn from Patient Safety Events
LFT	Lateral Flow Test
LG	Lead Governor
LGBT	Lesbian, Gay, Bisexual, and Transgender
LHCRE	Local Health and Care Record Exemplar
LMC	Local Medical Committee
LOS	Length of Stay
LOSA	Lower-layer Super Output Area
LPC	Local Pharmaceutical Committee
LRF	Local Resilience Forum
LSMS	Local Security Management Specialist
LTP	Long Term Plan
M	
M&A	Mergers & Acquisitions
MACA	Military Aid to Civil Authorities
MAIT	Multi Agency Incident Transfer
MASH	Multi-Agency Safeguarding Hub
MAU	Medical Assessment Unit
MBE	Member of the most excellent order of the British Empire
MCA	Mental Capacity Act
MDVS	Mobile Data and Voice Solution
MEA	Modern Equivalent Asset
MEAT	Most Economically Advantageous Terms
MEC	Membership and Engagement Committee
MESH	Messaging Exchange for Social Care and Health
MeSH	Medical Subject Headings
MH	Mental Health
MHCM	Mental Health Crisis Manager
MHFA	Mental Health First Aid
MHPRA	Medicines and Healthcare Products

	Regulatory Agency
MHRA	Medicines and Healthcare Products Regulatory Agency
MHSG	Mental Health Steering Group
MI	Myocardial Infarction (heart attack)
MIG	Medical Interoperability Gateway
MIU	Minor Injuries Unit
MK	Milton Keynes
MNS	Maternity and Neonatal Systems
MoJ	Ministry of Justice
MoU	Memorandum of Understanding
MR	Make Ready
MRI	Magnetic Resonance Imaging
MP	Member of Parliament
MPT	Multi Professional Team
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSA	Mixed Sex Accommodation
MSK	Musculoskeletal
MTA	Marauding Terrorist Attack
MTA	Must Travel Alone
MTFA	Marauding Terrorist Firearms Attack
MTPD	Maximum Tolerable Period of Disruption
MTS	Manchester Triage System – used in 111/999 centres
N	
NACC	National Ambulance Coordination Centre
NADS	National Ambulance Digital Strategy
NAO	National Audit Office
NARU	National Ambulance Resilience Unit
NASMed	National Ambulance Service Medical Directors Group
NASPF	National Ambulance Strategic Partnership Forum
NBV	Net Book Value
NCA	National Clinical Audit
NCDR	National Commissioning Data Repository
NCAPOP	National Clinical Audit and Patient Outcome Programme
NCPS	NHS Covid Pass Service
NDTMS	National Drug Treatment Monitoring System
NDG	National Data Guardian for Health & Care
NDOG	National Directors of Operations Group
NEAS	North East Ambulance Service

NED	Non Executive Director
NEMS	National Events Management Service
NEPTS	NHS Non-Emergency Patient Transport Services
NET	Non-Emergency Transfer (or Non-Emergency Transport vehicles)
NFPS	National Flu Pandemic Service
NHS	National Health Service
NHS111	NHS nonemergency number
NHSBSA	NHS Business Services Authority
NHSBT	NHS Blood and Transplant
NHSE/I	NHS England / Improvement
NHSI	NHS Improvement
NHSLA	NHS Leadership Academy
NHSP	NHS Professionals
NHUC	North Hampshire Urgent Care
NHSX	New Joint Organisation for Digital, Data and Technology
NICE	National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NIF	National Insurance Fund
NIHR	National Institution for Health Research
NIHCR	National Institute for Health and Care Research
NIS	National Information Systems regulations
NMA	National Mobilisation Application (ARP related)
NMC	Nursing and Midwifery Council
NPMV	Ofsted New Provider Monitoring Visit
NPSA	National Patient Safety Agency
NRLS	National Record Locator Service
NRLS	National Reporting and Learning System
NSF	National Service Framework
NUMSAS	NHS Urgent Medicines Supply Advanced Service
NVBS	National Vaccination Booking Service
O	
OBC	Outline Business Case
OCI	Other Comprehensive Income
OD	Organisational Development or Outpatients Department

ODS	Organisation Data Service
Ofsted	Office for Standards in Education
OH	Oxford Health
OH	Occupational Health
OHC	Organisational Health Check
OHCA	Out of Hospital Cardiac Arrest
OHID	Office for Health Improvement and Disparities
OHRN	Offender Health Research Network
ONS	Office for National Statistics
OOH	Out of Hours
OP	Outpatients
OPEL	Operational Pressures Escalation Levels
ORMG	Organisational Response Management Group
ORP	Operational Readiness Plan
ORSS	Oasis Restore Project Delivery Board
OSC	Overview and Scrutiny Committee
OT	Occupational Therapy
OU	Operating Unit
OUH	Oxford University Hospital
OUM	Operating Unit Manager
P	
PaCCs	Pathways Clinical Consultation Support
PACE	Promoting Access to Clinical Education
PAD	Publicly Accessible Defibrillator
PALS	Patient Advice & Liaison Service
PAP	Private Ambulance Providers
PAS	Patient Administration System
PBL	Prudential Borrowing Limit
PbR	Payment by Results or 'tariff'
PC	Provider Collaborative
PCN	Primary care network
PCT	Primary Care Trust
PDC	Public Dividend Capital
PDR	Personal Development Review
PDS	Personal Demographics Service
PDSA	Plan, do, study, act
PE	Patient Experience

PEd	Practice Education
PEG	Patient Experience Group
PEM	Post Event Message (e.g. 111 message to GP)
PETALS	Paediatric Emergency and Trauma Advanced Life Support
PFI	Private Finance Initiative
PGD	Patient Group Direction
PHE	Public Health England
PHEW	Posture Habit Exercise Warm up
PHL	Partnering Health Limited
PHPLS	Pre-Hospital Paediatric Life Support
PHQ-9	Patient Health Questionnaire (diagnostic instrument for common mental disorders, PHQ-9 is the depression module)
PHR	Personal Health Records
PHSO	Parliamentary & Health Service Ombudsman
PIAK	Personal Issue Assessment Kit
PICU	Psychiatric Intensive Care Unit or Paediatric Intensive Care Unit
PIPE	Psychologically Informed Planned Environments model
PIT	Psychodynamic Interpersonal Therapy
PLACE	Patient-Led Assessments of the Care Environment
PMH	Previous Medical History
PMM	Performance Management Matrix
PMO	Project Management Office
PO/POs	Purchase Order/Purchase Orders
POC	Point of Care Testing
POD	People and Organisational Development Committee
POSED	Prehospital Optimal Shock Energy for Defibrillation
PPCI	Primary percutaneous coronary intervention
PPE	Personal Protective Equipment
PPI	Patient and Public Involvement
PPO	Prison and Probation Ombudsman
PQQ	Pre-Qualifying Questionnaire
PRSB	Professional Record Standards Body
PSED	Public Sector Equality Duty
PSF	Provider Sustainability Funding
PSIRF	Patient Safety Incident Reporting Framework
Pt	Patient
PTS	Patient Transport Services
PTSD	Post-Traumatic Stress Disorder

Q	
QA	Quality assurance
QAH	Queen Alexandra Hospital
QAV	Quality Assurance Visit
QC	Quality Committee
QI	Quality improvement
QIA	Quality Impact Assessment
QOF	Qualities and Outcomes Framework
QPS	Quality & Patient Safety
R	
R&D	Research & Development
RAG	Red, Amber, Green (classifications)
RARs	Rehabilitation Activity Requirements – is this mentioned in any other chapter than resettlement? CHECK Substance misuse/clinical models 6
RCGP	Royal College of General Practitioners
REAP	Resource Escalation Action Plan
RECAP	Remote COVID-19 Assessment in Primary Care
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RGN	Registered General Nurse
RICS	Royal Institute of Chartered Surveyors
RIDDOR	Reporting of Injuries, Diseases, Dangerous Occurrences Regulations 2013
RMCGC	Risk Management and Clinical Governance Committee
ROCI	Read Only Clinical Information (Sussex-specific orchestration layer)
RoI	Return on Investment
ROLE	Recognition of Life Extinction (form used for confirming patient death)
ROSC	Return of Spontaneous Circulation
RPI	Retail Prices Index
RPS	Royal Pharmaceutical Society
RTA/RTC	Road Traffic Accident/Collision
RTO	Recovery Time Objective
RTT	Referral to Treatment Time

S	
S&M	Statutory and Mandatory
S&T	See and Treat
SAAF	Safeguarding Accountability Framework
SALT	Speech and Language Therapist
SAU	Surgical Assessment Unit
SAB	Safeguarding Adults Board
SBS	Shared business services
SAR	Subject Access Request
SARC	Sexual Assault Referral Centre
SCAL	Supplier Conformance Assessment List
SCAS	South Central Ambulance Service
SCBU	Special Care Baby Unit
SCOT	Senior Clinical Operations Team
SCR	Summary Care Record
SCWCSU	South Central and West Commissioning Support Unit
SD	Scheme of Delegation or Symptom discriminator
SDAT	Sustainable Development Assessment Tool
SDEC	Same Day Emergency Care
SDIP	Service Development and Improvement Plan
SDMP	Sustainable Development Management Plan
SDP	Service Delivery Plan
SEAG	Staff Engagement Advisory Group
SECAmb	South East Coast Ambulance NHS Foundation Trust
SEF	Staff Engagement Forum
SEN	Special Educational Needs
SFI	Standing Financial Instructions
SG	Symptom group
SGUL	St George's University London
SH	Southern Health
SH	Southern House
SHMI	Summary Hospital Level Mortality Indicator
SHREWD	Single Health Resilience Early Warning Database
SI	Serious Incident
SID	Senior independent Director
SIMCAS	South East Coast Immediate Care Scheme
SIRI	Serious Incident Requiring Investigation

SIRO	Senior Information Risk Officer
SITREP	Situation Report
SJA	St John's Ambulance Agreement
SJR	Structured Judgement Review
SLA	Service Level Agreement
SLC	Senior Leadership Committee
SLT	Senior Leadership Team
SMG	Senior Management Group
SMP	Surge Management Plan
SMS	Substance Misuse Services
SMT	Senior Management Team
SNOMED CT	Standard clinical terminology for the direct management of care
SO	Standing Orders
SOB	Shortness of Breath
SOC	Strategic Outline Case
SOCF	Statement of Cash Flow
SOF	System Oversight System
SOFP	Statement of Financial Position
SOG	Strategic (Single) Oversight Group
SOLT	Single Oversight Leadership Team
SOM	Senior Operation Manager (Old A&E Role)
SOP	Standard Operating Procedure
SORT	Special Operation Response
SoS	Secretary of State
SORT	Special Operations Response Team
SPC	Statistical Process Control
SPF	Strategic Partnership Forum
SPOC	Single Point of Contact
SPNs	Special Patient Notes
SPP	Strategy, Planning and Partnerships
SRO	Senior Responsible officer
SRP	State Registered Paramedic
SRV	Standalone Record Viewer
SRV/U	Single Response Vehicle/Unit
SRU	Strategic Reporting Unit
SSP	System Status Plan
SSO	Suspended Sentence Order
SSRB	Senior Salaries Review Body
S,T&C	
STaD	Service Transformation and Delivery
STaDP	Service Transformation and Delivery Programme

STEMI	Stroke and ST-Elevation Myocardial Infarction
STP	Sustainability and Transformation Partnership
SUI	Serious Untoward Incident / Serious Incident
SWAS	South West Ambulance Service
SWOT	Strengths, Weaknesses, Opportunities, Threats
T	
T&F	Task and Finish
TASC	The Ambulance Staff Charity
TBI	Traumatic Brain Injury
TC	Therapeutic Community
TDM	Targeted Dispatch Model
TIA	Transient Ischaemic Attack (mini-stroke) AKA but not to be confused w/ temporary injury allowance
TIE	Trust Integration Engine
TILEO	Task Individual Load Environment Other Factors
TOM	Target Operating Model
ToR	Terms of Reference (usually for a group or committee)
TriM	Trauma Risk Management
TPAM	Tripartite Provider Assurance Meeting
TTO	To Take Out
TV	Thames Valley
TVIUC	Thames Valley Integrated Urgent Care
U	
UCC	Urgent Care Centre
UCD	Urgent Care Desk
UEC	Urgent and Emergency Care
UHU	Unit Hour Utilisation
UK	United Kingdom
UKBSA	NHS Business Services Authority
UKHSA	UK Health Security Agency
USH	Unsocial Hours
UTC	Urgent Treatment Centre

V	
VAT	Value Added Tax
VBS	Vaccine Booking Service
VC	Video Consultation
VDRS	Vaccine Data Resolution Service
VFM	Value for Money
VOR	Vehicle Off Road
VPN	Virtual Private Network
VPP	Vehicle Preparation Point
VSM	Very Senior Managers
VTE	Venous Thromboembolism
W	
WDC	Workforce Development Committee
WDES	Workforce Disability Equality Standard
WES	Women's Estate Strategy (HMPPS)
WIC	Walk in Centre
WLF	Well Led Framework
WMAS	West Midlands Ambulance Service
WRES	Workforce Race Equality Standard
WTE	Whole-time equivalent
WWC	Workforce and Wellbeing Committee
Y	
YTD	Year to Date