Bundle Public Board of Directors 26 September 2024

0 Agenda
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- 0.0 Public Board Agenda 26 Sept 2024 final

1 Chair's Welcome and Apologies for Absence Professor Sir Keith Willett CBE -Verbal For Noting

2 Declarations – Directors' Interests and Fit and Proper Persons Test Professor Sir Keith Willett CBE -Verbal For Noting
- 02.0 Board Members Register of interests as at 20.09.24

3 Minutes from the meeting held on 25 July 2024 Professor Sir Keith Willett CBE -For Approval
- 03.0 Draft SCAS Public Board Minutes 27 July 2024 v1.0

4 Board Actions Log Professor Sir Keith Willett CBE -For Approval
- 04.0 Public Board Action Log 25.07.24 JOC updated

5 Chair's Report Professor Sir Keith Willett CBE -For Noting
- 05.0 Chair's report cover sheet Sept 24
- 05.1 Chair Report Sep 24

6 Chief Executive Officer's Report David Eltringham -For Noting/ Information
- 06.0 CEO Report Sept 24

7 Hampshire and Isle of Wight ICS Finance Report David Eltringham -For Information
- 07.0 24-25 M5 ICS PUBLIC BOARD Finance Report Final

8 Update to the previous Private Board meeting held on 22 August 2024 Professor Sir Keith Willett CBE -For Noting
- 08.0 Private Board update to public board

9 Patient Story Helen Young For Information
- 09.0 Public Board paper Cover Sheet- September 2024

10 Integrated Performance Report Stuart Rees & Executive Director Leads -For Assurance
- 10.0 IPR Summary Cover Sheet Sept 24 Board
- 10.1 IQPR 13.09.2024 FINAL

11 Quality and Patient Safety Report Helen Young SR1 12For Assurance
- 11.0 Report Cover Sheet - Quality Paper - Final
- 11.1 Quality and Safety Board Paper September 2024 - Final

12 Chief Medical Officer's Report John Black SR1 12For Noting
- 12.0 Chief Medical Officer Report Cover Sheet - September - Draft
- 12.1 Chief Medical Officer's Board Report - September - draft

13 Annual Patient Experience Report Helen Young SR1 12For Noting
- 13.0 Cover Sheet PE Annual Report 2024 - Final
- 13.1 PE Annual report July 2024 v4 trust board

14 Annual Safeguarding Report Helen Young SR1 12For Noting
- 14.0 Cover Sheet - Safeguarding Annual Report 2023-24 - Final
- 14.1 SCAS Safeguarding Annual Report 202324 Version 4

15 Annual Infection Prevention & Control Report Helen Young SR1 12For Noting
- 15.0 Cover Sheet - IPC Annual Report - Final
- 15.1 DIPC Annual Report 2023-2024 V9 trust board

16 Assurance Upward Report Quality and Safety Committee, 17 July 2024 Dhammika Perera SR1 12For Noting/ Assurance
- 16.0 Upward Report Q&S - 18 Sept 2024

17 Finance Report Month 5 Update Stuart ReesSR5 16 For Assurance
- 17.0 Month 5 Finance Report Sept 2024 - Cover Sheet
- 17.1 Month 5 Finance Report September 2024

18 Assurance Upward Report Finance and Performance Committee, 19 August and 19 September 2024 Les Broude SR5 16 For Noting/ Assurance

18.0 Upward Reporting Fin Perf Committee Aug 24 and Sept 24 Final

19 Assurance Upward Report Audit Committee, 18 September 2024 Mike McEnaney SR5 16For Noting/ Assurance

19.0 AC upward report to Board i - 24-09-18

20 Questions submitted by Board Members on agenda items: 12 & 18 --

21 Assurance Upward Report People and Culture Committee, 9 September 2024 Ian Green SR7 12 For Noting/ Assurance

21.0 PACC Upward Assurance Report September

22 The Southern Ambulance Service Collaborative (SASC) 2024/25 Manifesto and 2024/25 Budget David Eltringham/Gillian HodgettsSR14 8 For Approval

22.0 Public Board report cover sheet - Southern Ambulance Services Collaborative (SASC)

22.1 SASC- Part-A

22.2 DOCUMENT 1 - manifesto poster vfinal

23 Communications Update Gillian Hodgetts -For Noting

23.0 Communications Marketing and Engagement Summary sheet SCAS Public Board - 26 September 2024

23.1 Communications Marketing and Engagement Public Board Paper - 26 September 2024

24 Questions submitted by Board Members on agenda items: 20 & 22 -

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

25.0 Cover Sheet - August 24 Board Update (Chief Digital Officer)

25.1 Meeting Report - Digital Board Update September (Chief Digital Officer)

26 Performance and Accountability Framework Stuart ReesFor Approval

26.0 Report Cover Sheet PMAF Board

26.1 DRAFT Performance Management and Accountability Framework V1.3

27 Board Assurance Framework Jamie O'CallaghanFor Approval

27.0 Board Assurance Framework cover sheet

27.1 SCAS BAF - 24-25 September

28 Assurance Report Improvement Programme Oversight Board Update 04 September 2024 Caroline Morris -For Assurance

28.0 September Board - Cover Sheet Improvement Programme Update

28.1 20240904-Report Pack-IPOB-v1.0-DRAFT

29 Any Other Business -Verbal For Noting

30 Questions from observers (items on the agenda) Professor Sir Keith Willett CBE -Verbal For Noting

31 Review of Meeting Non-Executive Director: Mike McEnaney Executive Director: John Black-Verbal For Noting

32 Date, Time and Venue of Next Meeting in Public Thursday 31 October 2024 at 9.30am Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN -Verbal For Noting

Our Values

Caring:

Compassion for our patients, ourselves and our partners

Professionalism

Setting high standards and delivering what we promise

Innovation

Continuously striving to create improved outcomes for all

Teamwork

Delivering high performance through an inclusive and collaborative approach

Agenda

Public Trust Board

Date: Thursday 26 September 2024
Time: 9.45 – 12.45
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members:

Professor Sir Keith Willett CBE	Chair
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
Craig Ellis	Chief Digital Officer
Stuart Rees	Interim Director of Finance
Duncan Robertson	Chief Paramedic Officer

In attendance:

Natasha Dymond	Interim Director of People
Phil Browne	Programme Turnaround Director
Kofo Abayomi	Head of Corporate Governance & Compliance
Mark Ainsworth	Executive Director of Operations
Kate Hall	Intensive Support Director, NHSE/I
Gillian Hodgetts	Director of Communications, Marketing and Engagement
Caroline Morris	Transformation Programme Director
Jack Phillips-Lord	Chief of Staff
Ann Utley	Associate of NHS Providers
Susan Wall	Corporate Governance & Compliance Manager

Apologies:

Paul Kempster	Chief Transformation Officer
Melanie Saunders	Chief People Officer

Questions received in advance from Board Members for those items marked as 'For Noting' 12, 13,14, 15, 16,18,20 & 22 will be received under agenda item 20 and 24.

Item		BAF	Action	Time
	OPENING BUSINESS			
1	**Chair's Welcome and Apologies for Absence** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	09.45
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	
3	**Minutes from the meeting held on 25 July 2024** Professor Sir Keith Willett CBE	-	**For Approval**	
4	**Board Actions Log** Professor Sir Keith Willett CBE	-	**For Approval**	09.50
5	**Chair's Report** Professor Sir Keith Willett CBE	-	**For Noting**	09.55
6	**Chief Executive Officer's Report** David Eltringham	-	**For Noting/ Information**	09.45
7	**Hampshire and Isle of Wight ICS Finance Report** David Eltringham	-	**For Information**	09.55
8	**Update to the previous Private Board meeting held on 22 August 2024** Professor Sir Keith Willett CBE	-	**For Noting**	-
9	**Patient Story** Helen Young		**For Information**	10.05
10	**Integrated Performance Report** Stuart Rees & Executive Director Leads	-	**For Assurance**	10.20
	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.			
11	**Quality and Patient Safety Report** Helen Young	**SR1 12**	**For Assurance**	10.50
12	**Chief Medical Officer's Report** John Black	**SR1 12**	**For Noting**	-
13	**Annual Patient Experience Report** Helen Young	**SR1 12**	**For Noting**	-
14	**Annual Safeguarding Report** Helen Young	**SR1 12**	**For Noting**	-

Item		BAF	Action	Time
15	**Annual Infection Prevention & Control Report** Helen Young	SR1 12	**For Noting**	-
16	**Assurance Upward Report** Quality and Safety Committee, 17 July 2024 Dhammika Perera	SR1 12	**For Noting/ Assurance**	-
	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.			
17	**Finance Report Month 5 Update** Stuart Rees	SR5 16	**For Assurance**	11.05
18	**Assurance Upward Report** Finance and Performance Committee, 19 August and 19 September 2024 Les Broude	SR5 16	**For Noting/ Assurance**	11.20
19	**Assurance Upward Report** Audit Committee, 18 September 2024 Mike McEnaney	SR5 16	**For Noting/ Assurance**	11.25
20	**Questions submitted by Board Members on agenda items: 12,13,14,15,16 & 18**	-	-	
	People & Organisation – We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			
21	**Assurance Upward Report** People and Culture Committee, 9 September 2024 Ian Green	SR7 12	**For Noting/ Assurance**	-
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
22	**The Southern Ambulance Service Collaborative (SASC) 2024/25 Manifesto and 2024/25 Budget** David Eltringham/Gillian Hodgetts	SR14 8	**For Approval**	11.30
23	**Communications Update** Gillian Hodgetts	-	**For Noting**	-
24	**Questions submitted by Board Members on agenda items: 20 & 22**	-	-	
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
25	**Chief Digital Officer Report** Craig Ellis	SR8 15 SR10 20	**For Noting**	-

Item		BAF	Action	Time
	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.			
26	**Performance and Accountability Framework** Stuart Rees		**For Approval**	11.40
27	**Board Assurance Framework** Jamie O'Callaghan		**For Approval**	11.50
28	**Assurance Report** **Improvement Programme Oversight Board Update 04 September 2024** Caroline Morris	-	**For Assurance**	12.00
	CLOSING BUSINESS			
29	**Any Other Business**	-	**Verbal For Noting**	12.10
30	**Questions from observers (items on the agenda)** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	12.15
31	**Review of Meeting** Non-Executive Director: Mike McEnaney Executive Director: John Black	-	**Verbal For Noting**	12.20
32	**Date, Time and Venue of Next Meeting in Public** Thursday 31 October 2024 at 9.30am Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN	-	**Verbal For Noting**	-

NHS
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: 20 September 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
3. Director of Welcombe Ltd

Interests that ended in the last six months

4. 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. Director Empowering Leadership Ltd
5. Chair Elmore Community Services, Oxford

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

Interests that ended in the last six months

7. Director of Farrar Chapman Ltd*

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

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

Jamie O'Callaghan, Interim Chief Governance Officer

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

4. None

Current 'Other' Interests

5. None

Interests that ended in the last six months

6. None

END

NHS
South Central Ambulance Service
NHS Foundation Trust

Minutes
Public Trust Board Meeting

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

Members Present:

Sumit Biswas	Deputy Chair, Non-Executive Director (Chairing)
Professor Sir Keith Willett CBE	Trust Chair
David Eltringham	Chief Executive Officer
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
Stuart Rees	Interim Director of Finance
Jamie O'Callaghan	Interim Chief People Officer

In Attendance:

Nicola Howells	
Gillian Hodgetts	Director of Communications, Marketing & Engagement
Mark Ainsworth	Director of 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

Apologies:

Katie Kapernaros	Non-Executive Director
Daryl Lutchmaya	Chief Governance Officer
Melanie Saunders	Chief People Officer
Paul Kempster	Chief Transformation Officer
Natasha Dymond	Asst Director HR Operations

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	Sumit Biswas chaired the meeting. Members and attendees were welcomed to the meeting. Apologies were noted as above.
1.2	Sumit Biswas welcomed Jamie O'Callaghan, Interim Chief Governance Officer to the Trust Board.
2	**Declarations of Interests**
2.1	There were no new declarations of interests at this meeting. Nigel Chapman pointed out the Register of Interests did not reflect changes to his interests. It was agreed that the register will be amended to reflect up to date Board member declarations.
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 minor amendments.
4	**Matters Arising and Action Log**
4.1	The action log was reviewed, and the following action was agreed to be closed: • Action 6: 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. • Action 7: Governance Team to ensure that the Trust Chair is included in Board Committees circulation list • Action 9: The Head of Governance was asked to check whether there is consistency across all terms of reference on quorum. • Action 10: 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. • Action 3: 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 The Board discussed the following actions: Action 1 (28/03/24): To review 'disability adjustments' process to allow more local discretion by the Executive Management Committee and outcomes reported to Board. Sumit Biswas queried the governance route of the policy and did not recall this had been to the People and

	Culture Committee. **Action: Jamie O'Callaghan was asked to track the governance journey of the policy.** It was also highlighted that the origin of the action was about what the Trust is doing to support staff by making necessary changes. It was also advised that the People and Culture Committee to provide assurance to the Board that the policy is achieving the desired flexibility. Action 4 (28/03/24): QI programme Methodology to be reported to Board for understanding the implementation. Further to the verbal update provided by Caroline Morris, the Board requested that the this is given a higher priority on the board development planner.
5	**Chairs Report**
5.1	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	The Board were informed that Duncan Robinson was appointed as the Trust's Chief Paramedic Officer, he will be in post by 16 September on a 12 month secondment. Duncan Robinson is currently the Deputy Chief Paramedic of Welsh Ambulance Service. David Eltringham stated that this will be a key step forward for the Trust in terms of professional leadership for paramedics in the organisation and will address some of the bandwidth issues in the executive team.
6.3	Gillian Hodgetts informed the Board that the Trust have started to receive requests from new MPs and there are planned visits to the CCC and other parts of the services. The Board noted that the Trust had now moved from the decision to restrict political engagement taken during Purdah.
6.4	Further to the comment by Les Broude that additional funding to the NHS would only be beneficial if the Trust already has improved processes in place, David Eltringham explained expected measures that should already be in place to qualify for the funding, and these included smarter and more efficient ways of working. Furthermore, the Trust will be reviewing efficiency and productivity, refining policies, processes and procedures to mitigate over reliance on additional funding going forward.
6.5	Nigel Chapman inquired about the impact of the recent IT outage on SCAS services and queried how the COVID-19 data will be safely transferred to the Department of Health and Social Care. Craig Ellis assured the Board that the IT outage was now resolved and SCAS was not primarily affected however a large number of third parties and hospitals were affected by the outage. During this period, operational colleagues were managing business continuity and demand. Craig Ellis was on calls with the National Chief Information Officer (CIO) and CIOs countrywide during this period. There will be a follow up plan around business continuity and resilience across the system. He explained that this was less of technical IT issues and informed the Board that an update will be provided at the next Board meeting. In response to the query on data repatriation, an interim consultant is now in post, Anita Lines is experienced in data repatriation, she is currently developing the timelines to repatriate the data between now and end of the year, a programme plan, strategy and proposal is being built around this, a briefing will be provided to the Board at the next

	meeting. Craig Ellis and Helen Young are fully engaged and will be producing a document on management of data end of life.
6.6	Les Broude advised that based on recent business continuity issues, the Trust business continuity plan is presented to the Finance and Performance Committee for assurance. Craig Ellis added that there is a planned ongoing internal audit on business continuity function , he advised that this should be linked with the paper to the Committee to demonstrate oversight and assurance. Mike McEnaney highlighted that this was an Audit Committee function and suggested a discussion with Les Broude, Chair of the Finance and Performance Committee. Mark Ainsworth confirmed that the internal audit on business continuity and added that the is an EPRR assurance across the NHS for the current year with focus on cybersecurity. The Trust will be internal work and working with the ICBs. It was agreed that the EPRR assurance and business continuity plan will be taken together.
6.7	Helen Young informed the Board that the Trust will be seeking to recover the cost of data held above and beyond the end of the contract and this is significantly difficult and complex, nonetheless attempt to recover the cost is ongoing.
6.8	**The Board noted the Chief Executive Officer Report.**
7	**Update to the Public Board on the previous Private Board meeting held on 27 June 2024**
7.1	The Board **noted** the update to the Public Board on the previous Private Board meeting held on 27 June 2024.
8	**Staff Story**
8.1	The Board received a staff story from Roy Wilshere, relating to a TUPE experience from the NHS to a private provider company. The Story outlined the positive experience of Roy Wilshere, a member of staff who shared his good news story on becoming a SCAS employee and joining the NHS. The story also highlighted the importance of treating people with compassion, as individuals and doing the right thing for them.
8.2	In response to Mark Ainsworth's question on whether Roy Wilshere and colleagues felt adequately supported by the Trust with the ongoing transition, Roy Wilshere stated that more support can be provided as staff have limited knowledge of the private provider company and relevant information was not coming through.
8.3	Mike McEnaney acknowledged that TUPE processes are always anxious times for staff and advised that engagement with the procuring organisation on the welfare of staff should be prioritised and also raised with the ICB.
8.4	Nigel Chapman thanked Roy Wilshere for a very powerful and relevant and stated that it was uplifting to hear about the care provided by Natasha Dymond and the HR team who went beyond the call of duty and looked after Roy and colleagues. He noted that for the current TUPE, there is a vacuum of information and lack of visibility and engagement, Nigel Chapman urged the Executive Team to visit sites for two way engagement with PTS staff.
8.5	David Eltringham noted points raised by Non-Executive Director colleagues about visibility to

	PTS staff and summarised ongoing and planned engagement. Sumit Biswas requested that Non-Executive Directors are provided with relevant communications for site visits. Gillian Hodgetts confirmed that the Communications team are developing FAQs and developing responses to more specific questions to support the engagement process and will be shared in due course.
8.6	Further to Les Broude's point on direct discussions with the private provider company to be able to provide assurance to SCAS staff, Stuart Rees confirmed that SCAS is already in discussions with the company and David Eltringham is also in discussion with the Chief Executive Officer.
8.7	Ian Green highlighted the importance of adhering to the statutory process for TUPE and sometimes this was not particularly empathetic and felt that this could be personalised for staff by ensuring a good relationship with the provider company and robust engagement with staff prior to the transfer obligations.
8.8	John Black suggested that with Roy Wilshere's consent, the story should be shared with the private provider company as part of the engagement process.
8.9	**Action: The Board requested an update on the contract and transfer of PTS staff to the private provider company is reported to the People and Culture Committee.**
8.10	**The Board noted the Staff Story**.
9	**Integrated Performance Report (IPR)**
9.1	Stuart Rees provided the overview of the IPR. The Board was asked to note that the percentage of Vehicles off Road is 39.1% instead of 0.39% reported in the IPR. This was a system error and work is ongoing to resolve this issue.
9.2	There was a discussion on the IPR with detailed explanation from Stuart Rees and David Eltringham on plans to improve IPR reporting. Non-Executive Directors felt that the IPR process was still not joined up and still lacked robustness and accuracy. Currently, more time is spent discussing the process rather than assurance on performance
9.3	**Operational Performance** Mark Ainsworth summarised operational performance for the reporting period. The following points and queries were raised by Board members: • Assurance was sought on how challenges around international recruitment are being managed. The Board noted that assurance around international recruitment is varied, the Trust is behind plan in international recruitment due to internal (culture challenges and adjusting to the new environment particularly those recruited from African countries) and external (delays in HTPC registration). To mitigate these issues, Mark Ainsworth is in discussion with the education team for international paramedics on how to resolve these issues as quickly as possible and taking learnings from these challenges. • There was a query on fleet management, specifically around how to manage the

	trajectory of vehicles off the road. Stuart Rees assured the Board that the Trust continued to take delivery of the new fleet as planned, vehicles of the road were due to the aging fleet, the plan to mitigate this issue is additional workshops in the north and south which will improve capacity. The Board were also informed of operational plans in place for the fleets to increase performance. • A query was raised around how private provider hours target is being managed by the Executive Management Team. Mark Ainsworth explained the performance variability within private provider hours and agreed targets set in the trust financial plan. The Board were assured that the performance and financials were being monitored closely but this remained challenging due to financial restriction however in Q3, it is expected that private provider hours will increase to 51,000 hours per week with improvements in Category 2 performance. David Eltringham assured the Board that this was a big focus for the Executive Team with proactive planning and engagement with the Integrated Care Systems (ICS) and regulators. • It was highlighted that there were significant targets to achieve, some of which were impacted by systemwide issues. It was noted that an improvement in turnaround time at the Queen Alexander Hospital was necessary, an update on plans to improve this area was requested. The Board noted that David Eltringham attended a national meeting which focussed on London Ambulance model (W-45) safely leave patients within 45minutes in the Emergency Department, this model is being discussed with the Trust ICBs with an agreed way forward with Hampshire and Isle of Wight ICB. This was not an immediate fix and required buy in by the medical and clinical teams. There is acknowledgement from the ICBs that careful management of this issue is required in preparation for winter months.
9.4	**Quality and Patient Safety** Helen Young and John Black summarised key highlights within the Integrated Performance Report. • Safeguarding Level 3 training, safeguarding overall and Infection Prevention Control within the Trust have been moved into defined improvement programme with trajectories. Oversight and scrutiny to be provided by the Quality and Safety Committee. • Places on safeguarding level 3 training have now been increased to 50 from 30 for each training session. • Staff who are coming to the end of their safeguarding training are particularly targeted to mitigate deterioration of the compliance rate. • Infection Prevention and Control has been challenging, within this are the audit of vehicles which has been unsustainable, and the quality of audits are not of the required standard. Improvement plan around audits includes a clear tracking system of vehicles requiring audits and deep cleaning. Education in this area has also been a focus, with work ongoing to improve E-Learning and face to face education on Infection Prevention and Control for shared understanding of risks faced if we do not have clean and fit for purpose spaces to work. IPC Champions are also doing targeted work in the Trust locations, service areas and buildings. • The improvement plan will be monitored by the Task and Finish Group, the Executive Management Committee and the Quality and Safety Committee.
9.5	**Workforce** Nicola Howells summarised the workforce section of the IPR, with key focus on retention

	plans; freedom to speak up with an upward trend. There is a Freedom to Speak up Guardian coming into post on 12 August 2024. The Board noted the update on appraisals including the error in the IPR which should read the team are focussed on maintaining 100% compliance. Nicola Howells informed the Board that there was still no target for PDRs, but the team continue to work on the trajectory for improvement. Consideration will be given to the need for an improvement trajectory on the PDR rates rather than a set target piece. Sumit Biswas agreed that this was a good approach for a month on month trajectory to be reported.
9.6	Mike McEnaney commented on the upward trend of speaking up and advised that as a Board, attention should be given to these trends. Nicola Howell advised that there is an increase in bullying and harassment and also sexual harassment since the Trust campaign.
9.7	Keith Willett stated that although the Freedom to Speak up data have increased, more work needs to be done with teams to understand issues and the need to engage with interpretation of issues raised and appreciation of the support offered by the Freedom to Speak up team. He encouraged Executive Director colleagues to explain the importance to their teams.
9.8	Further to the point raised by Mike McEnaney, it was highlighted that where improvement plans are in place, this should be clearly highlighted in the IPR to manage Board expectation and discuss contingency plans. David Eltringham agreed and stated this had recently been discussed by the Executive Management Team.
9.9	**Finance** The Board noted the finance section of the IPR.
9.10	The Board **noted** the Integrated Performance Report.
10	**Quality and Patient Safety Report** The Board received the Quality and Safety Report.
10.1	Nigel Chapman noted that the safeguarding risks remained high and there have been no recent Board level discussion around the robustness of mitigations. Helen Young explained that around 60,000 safeguarding referrals are made by the Trust yearly with majority of the referrals done effectively and audited however there are a small number (circa 20 monthly) there have been delays due to human error or failure to follow processing practices. The most difficult referrals are those with technical or interface issues affecting the referrals going through as planned. The Board were informed that a Task and Finish Group was commissioned by the Executive Management Committee jointly led by the Chief Nurse and Chief Digital Officer to address referrals with technical/interface issues. Helen Young summarised areas and risks that were being focused on by the Craig Ellis and the new form for safeguarding referrals to simplify the process to make it more effective and resilient. It is anticipated that the Task and Finish Group will be working through September to resolve issues. Helen Young confirmed that this was on track and evidenced by the reconciliation reports received by the group which shows weekly reduction in delayed referrals.
10.2	The Board **noted** the Quality and Patient Safety Report.
11	**Chief Medical Director's Report**
11.1	**The Board noted the Medical Director's Report.**

12	**Assurance Report** **Quality and Safety Committee 17 July 2024**
12.1	**The Board noted the Quality and Safety Committee Assurance Report.**
13	**Finance Report Month 3 Update**
13.1	Stuart Rees presented the report and asked the Board to note that in month 3, the Trust's Income and Expenditure (I&E) position showed an in-month deficit of £0.9m which was £0.4m ahead of plan and an improvement on month 2 of £0.7m. This resulted in a Year-to-date (YTD) deficit of £4.7m against a planned deficit of £5.1m. The month position against the original plan before rephasing was a favorable variance of £0.2m and a YTD adverse variance of £0.9m. Regarding the financial recovery plan, the month 3 to date savings stand at £3.2m against a plan of £4.5m with recovery actions being implemented.
13.2	David Eltringham informed the Board that there are concerns around savings and the Cost Improvement Programme. This has been subject to thorough review by the Executive team and scrutinized by the Financial Recovery Group. The Board were also informed of planned pieces of work to come to grip with savings, recovery, and risk mitigations to be able to provide assurance to the Board through the Finance and Performance Committee.
13.3	**The Board noted the Finance Month 3 Update**.
14	**Assurance Report** Finance and Performance Committee 18 July 2024.
14.1	**The Board noted the Finance and Performance Assurance Committee Report.**
15	**Assurance Report** Charitable Funds Committee, 10 July 2024
15.1	**The Board noted the Charitable Funds Committee assurance report.**
16	**Assurance Report** Audit Committee, 11 July 2024.
16.1	**The Board noted the Audit Committee assurance report.**
17	**Questions submitted by Board Members on "For Noting" agenda items:14, 15 & 16**
17.1	No questions received.
18	**Assurance Report** People and Culture Committee 17 July 2024.
18.2	**The Board noted the People and Culture Committee Assurance Report.**
19	**Communications Update**

19.1	Dhammika Perera's observation from his engagement with teams within the Trust was that there is a disconnect in matters communicated to staff and advised that consideration should be given to more effective all staff communication.
19.2	David Eltringham explained that the culture diagnostic piece provides an opportunity to address this issue, this will be discussed as part of the Board seminar. Gillian Hodgetts also explained that the Trust Communication strategy would be revised, and the team are looking at different ways of enhancing communication to staff.
19.3	**The Board noted the Communications Update.**
20	**Questions submitted by Board Members on agenda items 18 & 19** No questions received.
21	**Chief Digital Officer Report** **The Board noted the Chief Digital Officer report.**
22	**Improvement Programme Oversight Board Update 10 July 2024**
22.1	Les Broude raised concern around lack of resources was highlighted in all the workstreams reporting into the Improvement Programme Oversight Board. He stated that there have been several Board discussion on this issue and attention should be given to this issue. Caroline Morris explained that there is an ongoing piece of work across the improvement programme on how best to use available resources.
22.2	**The Board noted the Improvement Programme Oversight Board Update.**
23	**Any Other Business**
23.1	No other business was discussed at this meeting.
24	**Questions from observers**
24.1	There were no questions from observers at this meeting.
25	**Non-Executive Director Review of the meeting**
25.1	Ian Green reflected that: • Quality of papers continues to improve however executive summary in reports still needs improvement • Would like to see board pack issued only once • Concerned about the staff story and level of support to be provided but the conversation flow improved as the discussion progressed • IPR is still challenging, data and information contained in the IPR needs to improve to help board discussion

25.2	**Executive Director Review of the meeting:** Helen Young reflected that: • Pros and Cons on timing and direction through the agenda, summaries were clear and opportunities to ask questions were given however there was not enough time provided for dialogue • Challenge was light from Executive colleagues • There were a lot of detail and information in the reports and Executive colleagues highlighted key issues which should have helped the NEDs • Different style of the meeting in chairing and discussions
25.3	Kate Hall added that there is a balance to be had and there is an ongoing process. She noted that this was an excellent meeting and one of the best observed. The questions were challenging and clear and answers provided very good. Overall, it was a good meeting.
26	**Date, Time and Venue of Next Meeting in Public** Thursday 26 September 2024 - Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN.

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Board Meeting in Public September 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
1.	25/07/24	Declarations-Directors' Interests	2024/25 Register of Interests to be amended to reflect Nigel Chapman's interests and ensure all Directors' Interests are up to date.	Corporate Governance Team	August 24	Propose to Close	Completed and noted at August Private Board meeting.
2.	25/07/24	Staff Story	The Board requested an update on the contract and transfer of PTS staff to the private provider company is reported to the People and Culture Committee	Natasha Dymond	September 24	Propose to close	Ongoing report to the private People and Culture Committee. Updates will continue until transfer or longer if required.
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	Propose to close	26 September meeting update Health and Safety Group feeds into EMC. Health and Safety relating to Patients to QSC/ Staff to PPC
1	28/03/24	8	To review 'disability adjustments' process to	Chief People Officer/ Chief	July 24	Propose to Close	26 September meeting update

			allow more local discretion by the Executive Management Committee and outcomes reported to Board. July update/action Jamie O'Callaghan was asked to track the governance journey of the policy.	Governance Officer			A 'Disability in Employment policy' is due to be considered by the People Policy Refresh Group on 8 October, should this be approved, the policy will then be distributed for staff consultation. Following this, any changes will be made and formal ratification will be had at JNCC. JNCC reports to People & Culture Committee.
4	28/03/24	10	QI programme Methodology to be reported to Board for understanding the implementation. Action: 25 July meeting: Board Development and Seminar forward planner to be reviewed to ensure that QI programme methodology is prioritised.	~~Transformation Programme Director / Chief Nurse~~ Chief Governance Officer	July 24	Proposed to Close	Scheduled for October Board Seminar ~~27 July meeting update~~ ~~Further to the verbal update provided it was requested that this is higher priority on the board development planner.~~ ~~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~~ November 24	Open	28 July 2024 ~~Report scheduled for August Trust Board meeting.~~ Deferred to November Board meeting – report to include updates to SCAS EPRR function and annual assurance.

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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, 26 September 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 meeting held in July 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

NHS
South Central Ambulance Service
NHS Foundation Trust

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Chair's update
Authors	
Accountable Director	Keith Willett, Chair
Date	26th September 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 July 2024.

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

August 2024

- SCAS Long Service Awards
- BLMK Research and Innovation Network Meeting
- NHS England Chair's Advisory Group
- SECAMB/SCAS CEO & Chair catch-up
- Royal Edinburgh Military Tattoo 2024
- SASC Chairs & CEOS meeting
- Chief Governance Officer interviews
- Leadership Walkaround: Lymington
- Leadership Walkaround: Ringwood
- All SCAS Webinar: Corporate Services Review
- BOB Chairs catch-up

September 2024

- HIOW Trust Chairs group
- Leadership walkaround: Andover
- Leadership walkaround: Alton
- Thames Valley System Leaders' Summit
- BLMK ICS Research and Innovation Network Meeting
- National Ambulance Memorial Service
- NHS Confed Chairs Group
- BOB Chairs catch-up
- SCAS RemCom Meeting
- NHS England Chair's Advisory Group

Other

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

Recommendation

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

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	CEO Briefing
Name of Meeting	Board of Directors in Public Meeting
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	6
Executive Summary:	The CEO Report includes the following: • Operational challenges and staff recognition • Corporate review • New 'Team Brief Live' process introduced • Southern Ambulance Services Collaboration (SASC) • Recovery support programme, transformation and collaboration
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

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	26/09/2024

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 July 2024.

2. Background and links to previous papers

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

3. Executive summary

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

- Operational challenges and staff recognition
- Corporate review
- New 'Team Brief Live' process introduced
- Southern Ambulance Services Collaboration (SASC)
- Recovery support programme, transformation and collaboration

Operational challenges and staff recognition

As you know, the operating environment continues to be tough. The periods of extreme heat, whilst few this summer, still put extra pressure on our services as well as increased demand over the bank holiday periods. Our focus remains around balancing patient safety, performance and staff wellbeing whilst working within the financial constraints. We are also working with system partners on improvements, in particular handover delays in Portsmouth and South-East Hampshire. I want to thank each member of the SCAS team for their dedication and ongoing commitment in helping us deliver high quality care to our patients.

On the 30 July we held the SCAS Long Service awards at Farnham Castle on the Surrey/Hampshire borders. Over 100 attendees enjoyed the event with staff and their guests representing all services and being recognised for their outstanding long service of more than 20 years. More detail may be found in the Communications Board paper.

Corporate review

The corporate services review launched on Tuesday 20 August, with the consultation due to close at midnight on 11 October. The review is an essential part of helping us return to financial sustainability and is part of making our organisation fit for the future.

Over a number of years, the Trust's corporate costs have increased as we have taken on staff to support the delivery of new contracts. Now that some of those contracts have ended, our corporate workforce is significantly larger, proportionally, than national benchmarks. We need to bring corporate services back in line, which will in turn help to address the deficit and ensure we are fit for the future. The proposals to restructure corporate services are a core part of our financial recovery plan and aim to reduce costs by £7.1m.

We have also been running two sessions weekly, one for staff affected and one for line managers to answer any queries and to give support outside of their direct line management.

The consultation is not something the Trust leadership has entered into lightly. We understand that the proposals will have a significant impact on all staff in our corporate services and we are committed to supporting colleagues who are affected.

New ‘Team Brief Live’ process introduced

To improve the cascade of communications within the Trust, and in response to feedback we have heard from staff, we have developed a new monthly drum beat of communications messaging. From previous surveys that the Communications team have undertaken, it is evident that many staff prefer face to face communication and particularly value this at a local level with their direct line managers.

Following the month end SCAS Board meetings, on the first Tuesday of every month, I now lead, with the support of the Executive team, ‘Team Brief Live’, held on TEAMS. I present key operational performance and top line issues from areas including quality and patient safety and financial performance. This is followed by me presenting updates on three key areas of work across the Trust.

All SCAS leaders with managerial responsibilities are required to attend the TEAMS briefing. Following the session, managers are asked to cascade the information that has been shared, with their teams and to gather any questions/comments that may result. They are also emailed a written version of the Team Brief as a crib sheet that allows them to not only brief consistently but to tailor the messages to their own specific areas. We are cognisant that we have many challenges with reaching staff, geographically, with rosters and in specific areas such as call centres that require staff to be taking calls continually with little time to receive briefings.

In the third week of every month, again Tuesdays 9-10am, I lead a follow up feedback session with the same group of leaders, where they are requested to feedback comments, thoughts/questions from their teams, following the briefing that they were given. These sessions are designed to listen and hear staff feedback, to take away themes that we can address going forward and to use it to inform future staff communications.

I hosted the first ‘Team Brief Live’ early in September with the first feedback session last week, hosted by Stuart Rees in my absence. Valuable feedback resulted and we are already using this to prepare for the next ‘Team Brief Live’ in early October.

Southern Ambulance Services Collaboration (SASC)

SASC is a Collaboration of five ambulance services, East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) . The founding goals of the collaboration are to support the delivery of consistently high-quality frontline care, enhance the wellbeing of our staff, manage financial constraints and develop a culture of ‘stealing with pride’. After a workshop involving over 100 staff from across the five partner Trusts in early June, a manifesto has now been developed outlining three key priorities for the first year to improve the services we deliver to our people, patients and communities.

The three priorities are Shared Procurement, Artificial Intelligence in Emergency Operations Centres and developing a model for ambulance resources.

All five Trusts are being asked to approve the manifesto at their trust boards this month.

Recovery support programme, transformation and collaboration

I mentioned in the July report that we were participating in the review of exit criteria in respect of our recovery support programme. The transition criteria was approved at the private Board meeting in August and we are making good progress in adapting our programme governance to deliver the necessary improvements.

Winter is always an important time for the NHS. The second half of the year is the time when we test and deliver on the work we have planned for in the first half of the year. Our focus is on delivering improvements to elective waiting times, ambulance handovers and response times, and the overall recovery of urgent and emergency care services. The system knows that a lot of our collective effort is on tackling access challenges and improving our collective financial performance, so we can exit from the recovery support programme.

To further strengthen system development, the NHS Chief Executives came together last month to discuss what more we need to do to deliver our transformation programmes this year, and we held a wider development day with NHS Chairs. We have taken the learning from this year's planning process and are now starting the process earlier, to ensure we are in a strong position going into next year.

Thank you,

David Eltringham

NHS
Hampshire and Isle of Wight

Integrated Care Board

Board Meeting in Public

Title of paper	ICS Public Board Finance Report		
Agenda item		**Date of meeting**	Click or tap to enter a date.
Lead	Martin Sheldon	**Clinical Sponsor**	(if applicable)
Author	Graham Groves		
Purpose	For Information		

Executive Summary	
The purpose of the Month 5 (M5) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the financial position and system recovery plan for the ICS as at the end of August 2024. At M5 the Hampshire and Isle of Wight system in-month position is a deficit of £11.9m compared to a planned deficit of £9.7m so an adverse variance to plan of £2.2m The ICS is reporting a year-to-date deficit of £78.9m at the end of August 2024, compared to a planned year-to-date deficit of £63.3m, so an adverse variance to plan of £15.5m. The ICS continues to forecast achievement of its combined £70.0m deficit plan for 2024/25.	
Recommendations	1 Each Board needs assurance that their organisation is going to deliver on their operating plan, and that appropriate mitigations and recovery plans are in place where required. 2 Each Board needs assurance from their executives on their organisation's contribution to each system transformation programme, and that the programme(s) that their executives are leading on will deliver the planned outcomes and cost improvements, with an appropriate plan in place for any shortfalls.

Strategic objectives
1. To make best use of our resources, living within our means
Risks to the strategic objectives
(which of the organisational risks does this relate to (link to BAF) or does it create any new

risks)
Regulatory and legal implications (e.g., NHS England/Improvement ratings, Care Quality Commission essential standards, competition law etc)
The system remains in System Oversight Framework (SOF) 4 as a result of our financial and operational performance
Financial implications / impact (e.g., cost improvement programmes, revenue/capital, year-end forecast)
As described in the executive summary and paper
Specific communications and stakeholder/staff engagement implications
Patient / staff implications (e.g., linked to NHS Constitution, equality and diversity)
All decisions arising from our financial recovery process will be subject to assessment of their impact on quality across the system and appropriate organisational and system governance.
Equality and quality impact assessment
As above
Data protection impact assessment
None
Previous considerations by the Board
Background papers / supporting information

NHS
Hampshire and Isle of Wight

Integrated Care Board
Finance Report for
Hampshire and Isle of Wight Integrated Care System
August (Month 5) 2024/25

Table of Contents

1. Purpose

1.1 The purpose of the Month 5 (M5) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide an overview of the financial position and system recovery plan for NHS organisations within the Hampshire and Isle of Wight ICS as at the end of August 2024.

1.2 This report has been shared with all NHS organisations in the system, to ensure Boards are able to gain assurance and hold their organisation(s) to account for delivery of their operating plan as well as their contribution to recovery of the whole system.

1.3 This Month 5 report is an interim format, in order to provide timely input into Board meetings in September. The final version of this report will be completed by the end of September, to feed into October Board meetings.

2. Background

2.1 The final agreed system plan for 2024/25 is a £70m deficit, consisting of a £9.6m surplus plan for NHS Hampshire and Isle of Wight (the Integrated Care Board), and a combined provider deficit plan of £79.6m.

2.2 The whole system continues to be in the NHS England (NHS E) Financial Recovery programme. This requires additional assurance and reporting requirements to NHSE as well as controls around decision making.

3. Discussion

3.1 Integrated Care System Financial Overview

Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	(£9,665)	(£11,854)	(£2,189)	(£63,338)	(£78,881)	(£15,543)	(£69,998)	(£69,998)	£0

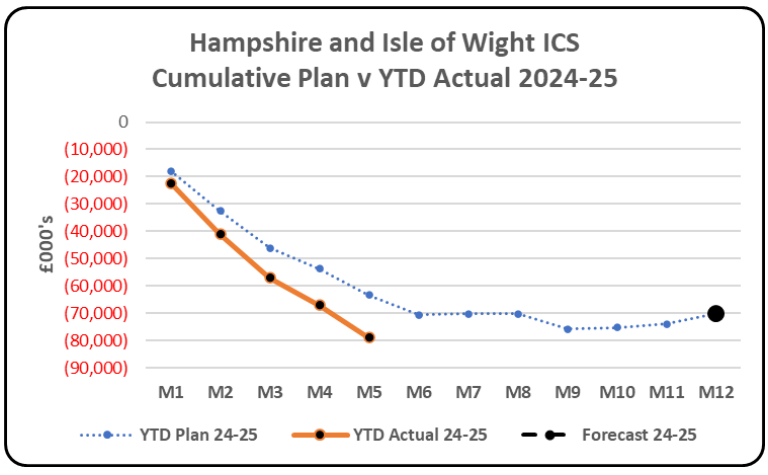
3.1.1 The above table summarises the ICS financial position reported at month 5 (August 2024). In August itself, the ICS reported a deficit of £11.9m against a planned deficit of £9.7m, so an adverse variance to plan of £2.2m.

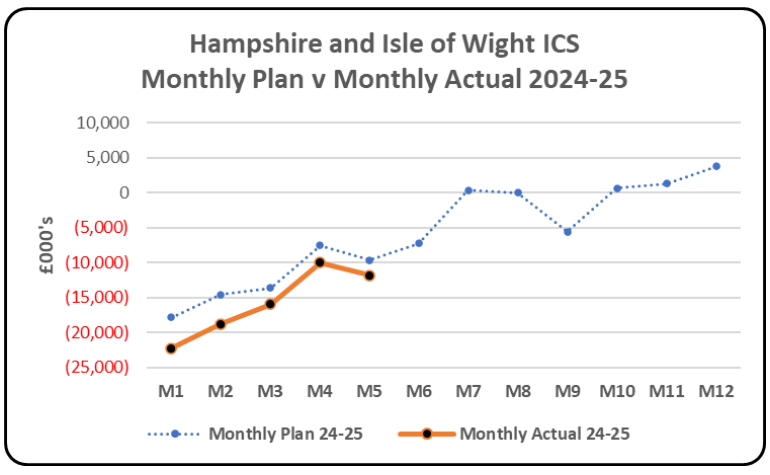
3.1.2 The system is currently reporting a year-to-date deficit of £78.9m at month 5 compared to a planned £63.3m deficit, therefore a £15.5m adverse variance to plan.

3.1.3 The ICS is forecasting to achieve its current plan of a £70m deficit by financial year end.

3.1.4 The ICS will continue to prioritise the implementation of the agreed system plan and transformation programmes to support achievement of our financial plan in financial year 2024/25.

3.1.5 The graphs below summarise the ICS position reported at month 5:





3.1.6 Industrial action in June and July has caused increased costs and reduced income e.g. due to cancelled elective activity. Some organisations have also reported under-delivery of cost improvement plans and other pressures. The ICB is working with providers who are off-plan to put in place additional support. All providers continue to forecast achievement of their plans by year-end.

3.1.7 The ICS and all its constituent NHS organisations must continue to prioritise the implementation of the agreed system plan and transformation programmes to support achievement of each organisation's financial plan in financial year 2024/25. All system transformation savings are embedded within the financial plans of Hampshire and Isle of Wight organisations, so system success is reliant upon every organisation delivering on their commitments.

3.2 System Actions to Support Financial Recovery

3.2.1 In 2023/24, additional controls were required by NHS England as a consequence of our deficit plan. Individual providers may also have had enhanced conditions as described in undertakings letters and where revenue or capital cash support was required, additional conditions will apply, including assessment of affordability of capital plans. All our existing system business rules, conditions and controls remain extant in 2024/25.

3.2.2 System financial recovery and delivery of our system transformation programmes is overseen by a monthly System Recovery and Transformation Board, which is attended by all Provider Chief Executives and chaired by the ICB Chief Finance Officer and Deputy CEO.

3.2.3 System leaders have agreed additional steps in 2024/25 to strengthen our delivery of plans, including:

- A system vacancy control panel, to review any proposed external recruitment and identify opportunities to resource from within the existing NHS workforce
- Chief executive-level leadership for each system transformation programme
- Organisation and system-level delivery units focused on our system transformation programmes, coordinated by a system Programme Management Office (PMO).

3.2.4 Additional external support has been commissioned for some system organisations, either to support continued delivery of their 2024/25 plan, or to support recovery where organisations are already materially off-plan.

3.3 System Transformation Programmes

3.3.1 Our system plan for 2024/25 is intended to address the challenges impacting our financial position which required a system response. Together we identified six key programmes for corrective action to reduce our system deficit in 2024/25 and enable delivery of each organisation's operating plan. Our system transformation programmes are:

Programme	Lead Chief Executive	Lead ICB Executive
Discharge	Penny Emerit	Caroline Morison
Local Care	Alex Whitfield	Lara Alloway
Urgent and Emergency Care	David Eltringham	Nicky Lucey
Mental Health	Ron Shields	Nicky Lucey
Planned Care	David French	Lara Alloway
Workforce (including Corporate Right-Sizing)	David French	Danny Hariram

3.3.2 Each transformation programme reports on progress and key metrics into the monthly System Transformation and Recovery Board, which is attended by all Provider Chief Executives. Reporting is supported by a system Programme Management Office.

3.4 Elective Recovery Fund

3.4.1 The Elective Recovery Fund (ERF) aims to increase elective activity in the NHS by providing additional funding to Integrated Care Boards (ICBs). The funding is uncapped meaning that additional funding can be given to ICBs and NHS Providers that exceed their individual targets.

3.4.2 Each organisation has a specific target level of activity growth (compared to 2019/20) above which additional income is earned. For Hampshire and Isle of Wight as a whole, our target level is 108.7% of 2019/20 activity, but our operating plans for 2024/25 were based on achieving 119.9%. At Month 5, initial data shows achievement of 118%.

3.4.3 It is important to note that as at M5, NHS Hampshire and Isle of Wight has not received any national data from NHS England to confirm the year-to-date activity being reported by our providers, or the final ERF performance targets for 2024-25.

3.5 Provider Productivity

3.5.1 The latest available productivity data (for M3) shows that Hampshire and the Isle of Wight providers' productivity remains 9.1% worse than the same period in 2019/20. This is a loss of productivity, but compares favourably with the

averages for the South East (12.1% worse than 2019/20) and England (14% worse than 2019/20).

M3 2024/25 against M3 2019/20			
	Real terms cost growth	Cost-weighted activity growth	Implied productivity growth
Hampshire and Isle of Wight	26.3%	14.9%	-9.1%
South East	25.2%	9.2%	-12.1%
England	23.1%	5.9%	-14.0%

3.5.2 Hampshire and the Isle of Wight providers have increased their productivity by 5.1% compared to the same period in 2023/24, the highest rate of improvement in the South East region and considerably higher than the England average of 2%. All Hampshire and Isle of Wight acute providers are more productive than 2023/24.

M3 2024/25 against M3 2023/24			
	Real terms cost growth	Cost-weighted activity growth	Implied productivity growth
Hampshire and Isle of Wight	-0.5%	4.6%	5.1%
South East	3.3%	4.5%	1.2%
England	3.9%	6.0%	2.0%

4. Recommendations

4.1 Each Board needs assurance that their organisation is going to deliver on their operating plan, and that appropriate mitigations and recovery plans are in place where required.

4.2 Each Board needs assurance from their executives on their organisation's contribution to each system transformation programme, and that the programme(s) that their executives are leading on will deliver the planned outcomes and cost improvements, with an appropriate plan in place for any shortfalls.

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Report Cover Sheet

Report Title:	Update to the Public Board on the previous Private Board meeting held on 22 August 2024
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 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 22 August 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 22 August 2024
Author	Kofo Abayomi, Head of Corporate Governance and Compliance
Accountable Director	David Eltringham, Chief Executive Officer
Date	26 September 2024

Private Trust Board 27 June 2024

Confidential Report from the Chief Executive Officer

The Board received an update from the Chief Executive Officer.

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.

Finance Month 4 Update

The Board received the Finance Month 4 report.

Financial Recovery Plan

The Board received the Financial Recovery Plan.

Oxford University Hospitals NHS Foundation Trust (OUH) Logistics and Shuttle Bus Services Contract

The Board approved the contract.

SCAS Non-Emergency Patient Transport Services (NEPTS) Contract – BMLK ICB NEPTS CONTRACT 2024/26

The Board approved the contract.

SCAS Non-Emergency Patient Transport Services (NEPTS) Contract – Sussex ICB NEPTS Contract Variation for 2024/25

The Board approved the contract variation.

QLIK Contract Renewal

The Board approved the contract renewal.

Recovery Support Programme – Revised Transition Criteria

The Board approved the Recovery Support Programme – Revised Transition Criteria.

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Report Cover Sheet

Report Title:	Patient story
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	9
Executive Summary:	This patient story is to be presented to the Board of Directors by Caroline Whitworth, Head of Patient Experience, Clare Walters, Integrated Urgent Care (IUC) Compliance Quality Lead and the patient, Mrs Lorraine Smith. • Patient had calf pain worried about a DVT. • Patient phoned 111, told pharmacist would ring back, no call received. The call has been found to be non-compliant and not handled in accordance with expected protocols. • Patient call their GP on the Monday and was prescribed anticoagulants and was diagnosed with a DVT. Learning has come from this case, and this is explained in detail as part of the slides and the story. In summary they are; • As a result of these findings, the Health advisor has received feedback regarding this incident, completed a call review, completed a reflective practice, received coaching session and the learning from the patient experience has been shared with the 111 clinicians so that they can support Health advisors with identifying complex calls and risk factors. • Changes made to NHS Pathways on the lower limb pathway to include questions relating to DVT symptoms this was not part of this actions from this case.
Recommendations:	The Trust Board is asked to: Note the story, actions and learning that has come about as a result of this complaint.
Accountable Director:	Professor Helen Young, Chief Nursing Officer
Author:	Caroline Whitworth, Head of Patient Experience
Previously considered at:	Nil
Purpose of Report:	Note

Paper Status:	Internal
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:** Significant
Justification of Assurance Rating:	Not Applicable
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	Not Applicable
Next Steps:	Nil
List of Appendices	Nil

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Report Cover Sheet

Report Title:	Integrated Performance Report (IPR)
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	10
Executive Summary:	This report high-level Integrated Performance Report 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. This IPR covers the performance period of August 2024, the fifth month of the financial and operational year. The August document highlights the following points, the performance challenges:

Special Cause Variation – Deterioration		**Target**	**Measure**
	Meal Breaks Compliance	70%	45%
	PTS Calls answered in 60 seconds	90%	61%
	VOR Total	23%	42%
	Clear up Delays	00:15:00	00:15:31
	Patients Collected with time	87%	86%
	See & Treat	33%	32%
Common Cause Variation and Missed Target			
	Average Hospital Handover Time	00:15:00	00:23:22
	Cat 1 Mean	00:07:00	00:08:54
	Cat 1 90th percentile	00:15:00	00:15:57
	Cat 2 90th percentile	00:40:00	01:00:51
	Cat 2 Mean	00:30:00	00:30:35
	Cat 3 90th percentile	02:00:00	05:17:22
	Cat 4 90th percentile	03:00:00	05:45:14
	Patients Arrived within Time	87%	87%
	ST&C (ED 1&2)	49%	51%
	Building Audits	21	10
	Building Audits %	80%	70%
	Vehicle Audits	167	130
	Vehicle Audits %	90%	80%
	Over-runs > 30 mins	25%	16%
Special Cause Variation – Improving			
	111 Call back < 20 min	95%	48%
	111Call answer in 120 Secs %	95%	96%
	Appraisals	95%	87%
	Safeguard Level 3	90%	87%
	111 Calls abandoned after 30 secs %	3%	1%
	999 Calls abandoned %	2%	2%
	999 Mean Call Answer Time	10%	11%
	Debtors > 90 days > 5% Total Balance	5%	4%
	H&T	13%	13%

Further information is provided within the report for each indicator identified for assurance reporting.

Recommendations:	The 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, Interim Director of Finance
Author:	Various
Previously considered at:	Board Committees.
Purpose of Report:	Note and approve.
Paper Status:	Internal

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:	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:	(What actions will be taken following agreement of the recommendations) Please see action plan.
List of Appendices	(Please list any supporting information accompanying this Summary Sheet and Meeting Report) IPR Report

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Integrated Quality and Performance Report: Aug-24

Executive Summary

Operational Performance

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

Safety and Quality

People

Finance

Executive Commentary :

Operations Commentary -999 response times improved across all measures in Aug and are predominantly linked to improved handover delays and fleet availability vs staff hours than was seen in August.

- Category 1 response times decreased by 33 seconds to 8:54
- Category 2 response times decreased by 9mins and 25 secs to 30:35
- Category 3 response times decreased by 2hrs and 45min to 5hrs and 17mins
- Category 4 response times decreased by 4hrs and 32mins to 5:45

Our category 2 target for August was 33:44 and we were 9secs below this at 30:35. Our response demand was 5.7% below planned levels with us responding to 44 537 incidents and this lower level of demand would have a positive impact on cat 2 of 5 minutes 19. Our operational hours were 1.56% above planned levels with us delivering 206 820 hours and this marginal increase would have a positive impact on cat 2 of 1min and 56 seconds. This level of hours was achieved through increasing SCAS hours to offset the private provider shortfall of 5355 hours in the month. The main factor affecting our performance was handover delays. The BOB/Frimley acute trusts were 2.4% better target which had a positive impact on cat 2 of 51 seconds. The HIOW acute trusts were 24.2% above target impacting by 08:28 with the QAH being 55.2% above target impacting by 07:52. Total hours lost at QAH was 2,866, an increase of 793 from June and 1,011 higher than July 23. Work has begun to flow toward the W45 principle around handover (the London model) with a CEO to CEO conversation begun with further work underway to understand how to deliver this and triggers for escalation.

PTS and Calls and Outcomes

Broadly in line with expectations, given the holiday period in August, PTS 'call volume' decreased considerably below the mean, down to 28,177. The degree to which this decreased was amplified by the ongoing availability of online booking via the Cleric system, however, call volumes are expected to increase back towards the mean next month. It should, however, be noted that the increased utilisation of the online system will continue to impact the quantum of calls, with values not expected to increase back to previous forecast volumes. Calls answered within 60 seconds improved slightly in month to 61.5%, slightly below the agreed, (re-aligned to budget), performance target of 63.7%.

The number of patients transported decreased again in month, again in line with expectations, owing to ongoing impact of the introduction of new eligibility criteria in February and more recently the delivery limited to commissioned contract values (from June).

86.9% of patients arrived within time, slightly above mean performance and only marginally below the 87% target. This demonstrated a significant improvement from both June and July's performance. As highlighted above, demand management in relation to agreed contract volumes, resulted in the number of journeys remaining well below the mean at was well below the mean, and the Indicative Activity Plan of 79,359. It should be noted that this pattern is expected to continue and contribute to PTS reaching its financial targets. However, the percentage of patients collected within time reduced again in month as a result of a reduction in low acuity patient journeys, resulting from the reduced number of non-essential journeys resulting from implementation of strict contract and demand management in place. Detailed analysis, (underway), is required to ensure services match and balance the tensions between hours, unpredictable demand and performance, to maximise financial efficiency. Daily monitoring of hours, demand and costs to continue to ensure management oversight and control.

Executive Commentary (continued) :

111 calls offered fell 10% from July to August, returning to levels closer to those seen in August 2023. Call handler logged in time also dropped but in line with the drop in demand. As a result of this ratio of resource against demand, combined with the efforts around AHT, Aug 24 saw the highest performing month on our new telephony achieving national target on both call answer and abandonment rate. 96.3% calls answered in 120 seconds and 0.55% abandonment. Clinical call backs in 20 minutes also stepped up well above mean to 48%, although still outside of national target.

All actions to support a reduction in AHT continue with monitoring of these at operational departmental level, weekly operational AHT monitoring and monthly DOPR. Challenges around funding continue, QIA has been jointly developed with ICB and is stepping through process in relation to rightsizing workforce, with risks to overall service performance. The current contract position has meant that the pharmacist and TVIUC GP hours have been lost, this may increase workload for clinical team potentially impacting the ability to call patients back in a timely fashion, with performance affected, if demand outstrips capacity.
999 Call demand fell by 14.6% in August compared to July, returning to a level more comparable to that seen in April, and sat below forecasted demand. This was driven in part by a substantial reduction (22%) in duplicate calls. By comparison logged in hours increased in August in comparison to July. There was also a marked improvement in average handling time this month with both call center's delivering below 9 minutes for the month. As a result there was an improvement in mean call answer, remaining below the mean, close to target at 11 seconds. Similarly abandonment rate improved siting at 2.13%. As response and wait times improved, hear and treat dropped towards mean, marginally below target at 12.67%. This flux will be seen until improvements in deployment model are undertaken.

A further workshop was held with AACE to review/agree clinical deployment model with clear actions set, a project manager has been assigned to support the program of change, key resource has been identified from operations and has been released to support delivery of the actions. Initial project group meeting to be held 26th September, with monthly meetings thereafter to monitor progress.

Finance

The plan for the month was a deficit of £1.0m and was exceeded by £0.2m, the year to date financial position at month 5 (August) is £6.0m deficit which is £0.6m better than the budget. With the year end control total of £10.1m there will need to be an improvement in the run rate as the deficit of £6.0m represents 59% of this after 5 months.

The Trust's cash balance at the end of August stood at £20.9m. There was a net cash inflow in month 5 of £4.4m, due in the main to block income catch up and sale and leaseback arrangement.

The August month end over 90-day debt has decreased this month and now stands at £76k (down from £158k in July). The 90-day category debt has increased to 4.26% of the total sales debt (up from 9.78% in July).

The Trust's capital spend to August was £3.7m with £6.8m of vehicle sale and leaseback sales producing a net income of £3.1m. The Trust is underspent against its year-to-date capital budget by £9.4m, this is made up of digital and estates being £4.5m behind plan and the International Financial Reporting Standard IFRS 16 costs of £2.7m related to leaseback arrangements not being in place until September.

The final plan submission for the Trust was to deliver a £10.1m deficit. In order to achieve this, the financial recovery plan requirements must be met. With the CIPs year to date position now £6.7m against a plan of £8.2m, there is a weekly focus on recovery actions at the Financial Recovery Group and recovery plans continue to be developed.

Executive Commentary (continued) :

People

PDR completion has increased by almost 4% in the month of August, which is reflective of the ongoing strategy to improve the quality and quantity of PDR conversations. However, continued momentum needs to be had as we move towards winter months and the People directorate are working with local managers to ensure that they feel equipped to efficiently carry out these important conversations.

DBS compliance has reduced by 1%, due to the full review the requirement for roles to have a DBS check, which identified new roles which historically had not required the checks. The compliance levels should increase again once the checks have been completed and should not be a cause for alarm at the current time.

The WTE across the Trust has reduced as attrition has increased. This is to be expected due to uncertainty across, particularly PTS and corporate teams, alongside planned reductions in workforce. A deep dive on turnover planned for Q3 will also be used, alongside local intelligence, to review the directorate retention plans to ensure that they are current and reflecting the important work required particularly now, to ensure that staff feel supported and engaged. It is expected that turnover will continue to increase due to the level of organisational change the Trust is experiencing.

Average time to hire has increased over the last 2 months, mainly due to the long lead time in recruitment of NQPs. However, it is important to note that time to hire differs depending upon roles and can range from 50 days to 200 days.

Sickness absence has remained below our mean; however, we do anticipate an increase, again due to the organisational change and as we enter winter months. The People team continue to identify and support individuals who are absent with timely interventions.

Executive Commentary (continued) :

IPR Exec Summary for quality and pt safety

This month we have continued to see our progress towards the 90% target for Level 3 SG. Although not at the required target yet, we have seen the plan to reach this within 8 weeks progress each week. We are continuing to identify and target staff who require this training and the number of spaces on each session has been increased to accommodate additional staff required to reach our target.

IPC has also completed all the infrastructure improvements identified in the improvement plan, including a live tracker of vehicles, and data on compliance now available at node, station level and team level. We saw compliance and improvement in all IPC KPIs last month, but this month we have simply not audited enough vehicles and buildings. This is partially due to service demand, which operational teams need to address, but the standard of cleaning of some of our vehicles and buildings is also not at the required standard and requires management through the contract and performance management meetings with Make Ready and the cleaning companies, which is being done.

We have been participating in a ICS wide review of PISRF implementation led by HIOW and noted a variance in the number of PSIIs we are declaring compared to other providers, i.e. we are declaring higher number of PSIIs whereas other providers are using higher numbers of PSLRs to address the incidents being reported by staff. We will monitor this and benchmark against other ambulance services during the coming 3 months.

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) .

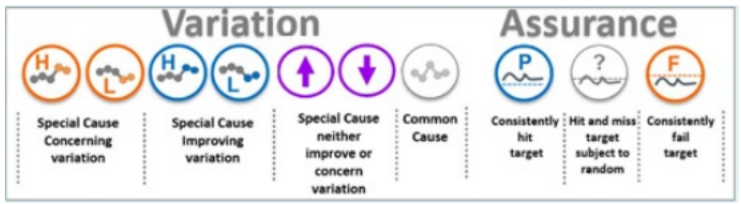
4) A run of 6 consecutive ascending or descending values (a trend).

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

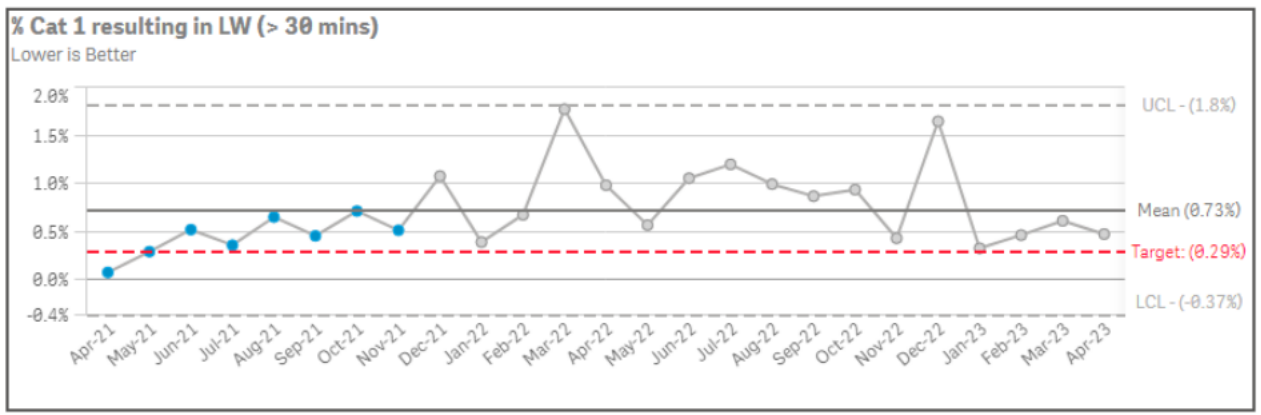
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS 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.

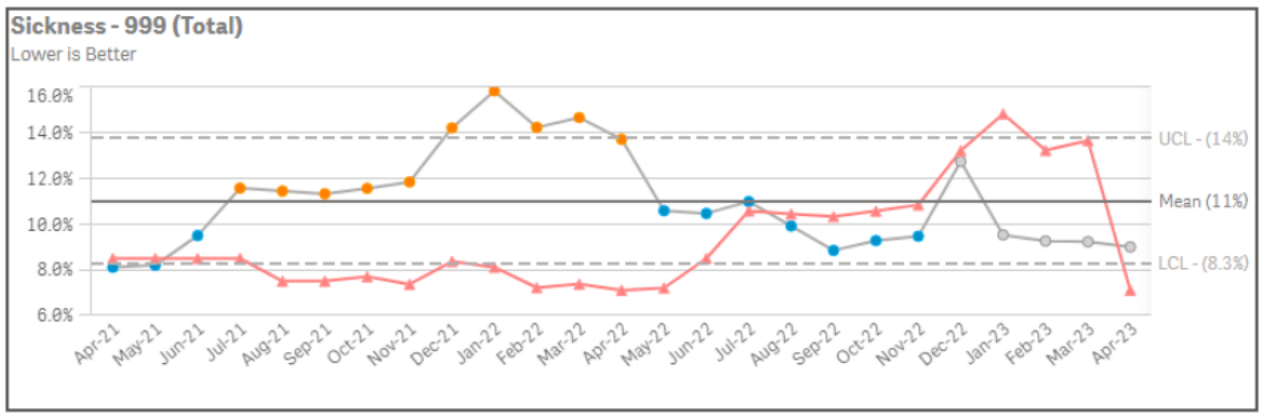
Assumptions:

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

August-24 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H	VOR - Total	Clear up Delays - SCAS		2
L	Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds	Patients Collected within time S&T - SCAS		2
	Average Hospital Handover Time - SCAS Cat 1 Mean SCAS Stroke - Call to Hospital arrival Median	16	Over-runs >30 mins - SCAS	10
L		111 Calls abandoned after 30 secs % 999 Calls abandoned % 999 Mean Call Answer Time Debtors > 90 days> 5% total balance		4
H	111 Call back < 20 min 111 call answer in 120 Secs % Appraisals - Trust Safeguarding Level 3	H&T - SCAS		5
↗				3
↘		PTS Call Volume PTS Volume - No. of Journeys		3

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 ; Patients Arrived within time ; Percentage of compliant Building cleanliness audits ; Percentage of compliant Vehicle cleanliness audits ; ST&C (ED 1&2) - SCAS ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke Call to Hospital arrival - Mean ; Vehicle cleanliness completed audits

NHS

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Operational Performance

NHS Operational Performance Overview

August-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H	VOR - Total	Clear up Delays - SCAS		
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 ST&C (ED 1&2) - SCAS		1
L		111 Calls abandoned after 30 secs % 999 Calls abandoned % 999 Mean Call Answer Time		
H	111 Call back < 20 min 111 call answer in 120 Secs %	H&T - SCAS		
↗				
↘		PTS Call Volume PTS Volume - No. of Journeys		1

NHS 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	Aug-24	00:08:54	00:07:00		F	00:09:04	00:07:25	00:10:43
Cat 1 90th %ile	Aug-24	00:15:57	00:15:00		?	00:16:21	00:13:27	00:19:15
Cat 2 Mean	Aug-24	00:30:35	00:30:00		?	00:33:46	00:13:54	00:53:38
Cat 2 90th %ile	Aug-24	01:00:51	00:40:00		?	01:07:49	00:24:58	01:50:40
Cat 3 90th %ile	Aug-24	05:17:22	02:00:00		?	05:27:30	00:33:54	10:21:06
Cat 4 90th %ile	Aug-24	05:45:14	03:00:00		?	06:55:12	00:40:36	13:09:49
% Vehicles off the road	Aug-24	42%	23%	H	F	28.8%	23.8%	33.7%
Ave Handover	Aug-24	00:23:22	00:15:00		F	00:25:05	00:16:53	00:33:17
Handover > 15mins	Aug-24	46%	0.48%		n/a	44.9%	35.8%	54.1%
Clear up Delays	Aug-24	00:15:31	00:15:00	H	?	00:15:04	00:14:24	00:15:45
% See and treat	Aug-24	32%	33%	L	?	34.0%	32.7%	35.4%
% ST&C to ED	Aug-24	51%	49%		?	49.6%	47.2%	52.1%
999 Call Answer	Aug-24	11%	10%	L	?	34.7%	-20.0%	89.4%
999 Ab. Rate	Aug-24	2.1%	2%	L	?	6.0%	-1.0%	13.1%
% Hear and treat	Aug-24	13%	13%	H	?	12.0%	9.5%	14.5%
111 Call Answer	Aug-24	96%	95%	H	F	62.6%	31.4%	93.9%
111 Ab. Rate	Aug-24	0.55%	3%	L	?	8.1%	-4.2%	20.4%
111 Call backs	Aug-24	48%	95%	H	F	24.1%	12.8%	35.4%

Operations - PTS Calls and Outcomes

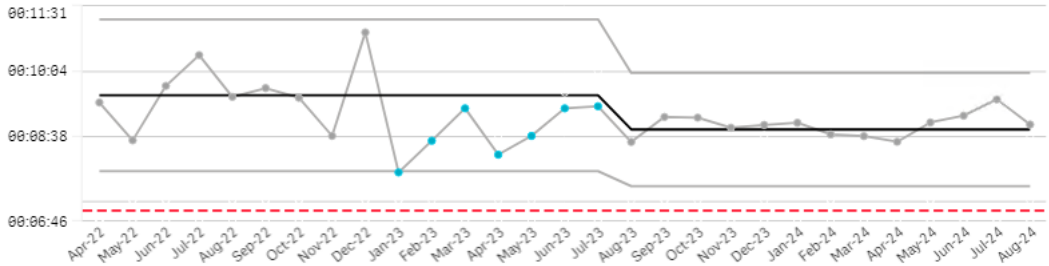
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Calls Answered (PTS)	Aug-24	61%	90%			64.3%	49.2%	79.3%
Number of calls (PTS)	Aug-24	28,177	37,575			33,170.9	25,152	41,189.7
% Patients arrived in time	Aug-24	87%	87%			86.8%	84.0%	89.6%
% Patients collected in time	Aug-24	86%	87%			88.6%	87.1%	90.2%
PTS Volume - No. of Journeys	Aug-24	67,064	79,359			77,185.1	66,250.5	88,119.7
Number of Patients Transported	Aug-24	17,722			n/a	21,873.5	19,057.7	24,689.3

Operations - Response Times

Cat 1 Mean

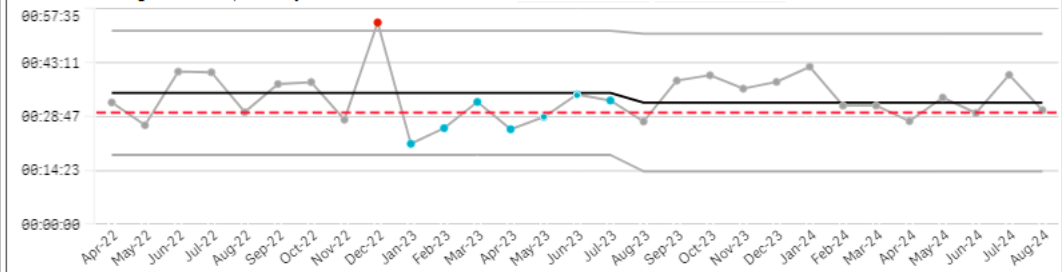
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	00:07:00	00:08:54

Cat 2 Mean

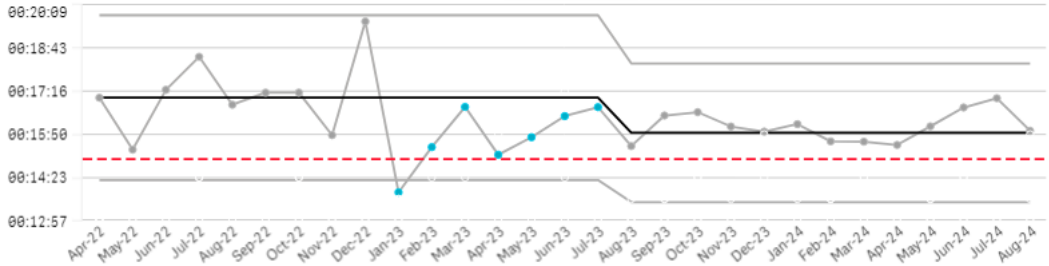
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:30:00	00:30:35

Cat 1 90th %ile

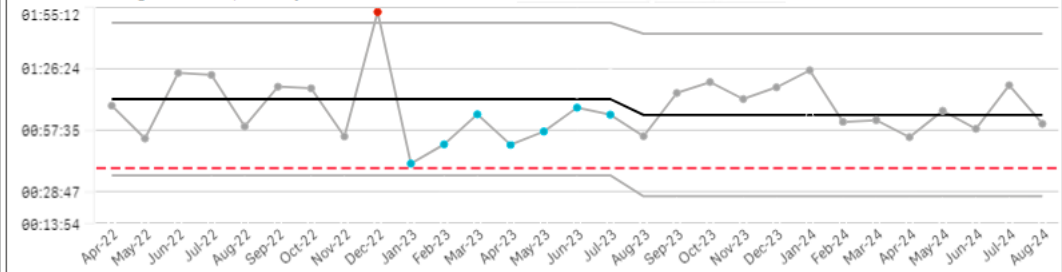
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:15:00	00:15:57

Cat 2 90th %ile

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:40:00	01:00:51

Understanding the Performance:

For the first time since May Cat 1 performance fell below the mean ending on 08:54 an improvement of 0:33 seconds on July, remaining over target. Cat 2 fell below the mean to 30:35 remaining above target but below plan for the month by 9 seconds. This performance was driven by lower than expected demand, 5.7% (2690 incidents) below plan and hours 1.56% (3186 hours) above plan. This improved performance is despite hospital delays in Hampshire added 08:09 minutes to Augusts cat 2 performance with the QA being responsible for 07:52 minutes. QA performance was 55.2% worse than planned at an average of 01:04:10 against a plan of 00:41:21.

Actions (SMART):

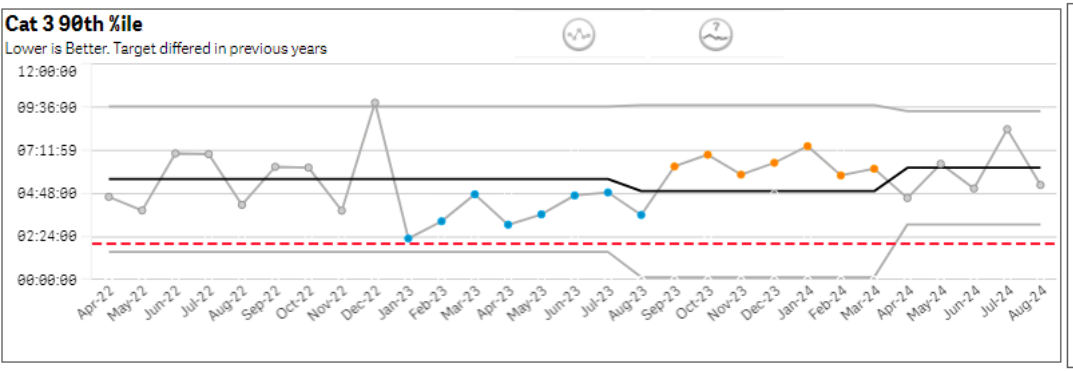
Delivery of PP hours against core contracts improving for from regional providers. QA improvement essential if SCAS is to deliver cat 2 following the £3 million reduction is resource hours. Operations continues to work closely with QA at all levels and ICB. SCAS and PP hours Hours continued to be monitored and managed.

Risks:

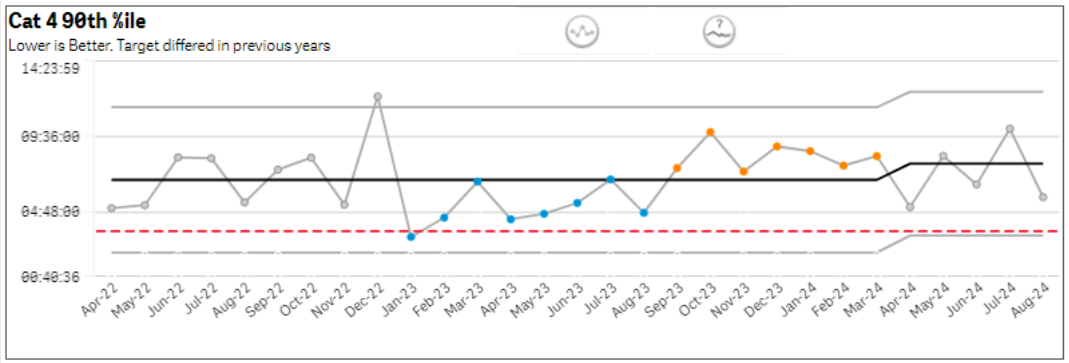
The continued failure of the QA to meet its handover trajectory remains a significant risk. Should their performance continue on its current trajectory our ability to deliver a 28:24 Cat 2 performance will become untenable. PP delivery of core contract hours for capacity fill providers remains a challenge as tenders reach conclusion and new tender award delayed - options being considered to protect the hours until new tender is awarded and mobilised.

NHS

Operations - Response Times



Variation	Assurance	Target	Latest
Expected	Random	02:00:00	05:17:22



Variation	Assurance	Target	Latest
Expected	Random	03:00:00	05:45:14

Understanding the Performance:
Improved Cat 3 performance ending below the mean by 5 seconds at 05:22:17 an improvement on July of 03:06. Cat 4 also fell below the mean to 05:45:14 and improvement of 04:22 on July. For both categories this is only the 3rd time in 12 months that performance has been below the mean. Driven by lower than planned demand and higher than planned hours.

Actions (SMART):
As with Cat 1 and 2 - Improved QA performance essential. SCAS and PP hours continue to be monitored and managed. Delivery of core contracted hours from regional providers improved.

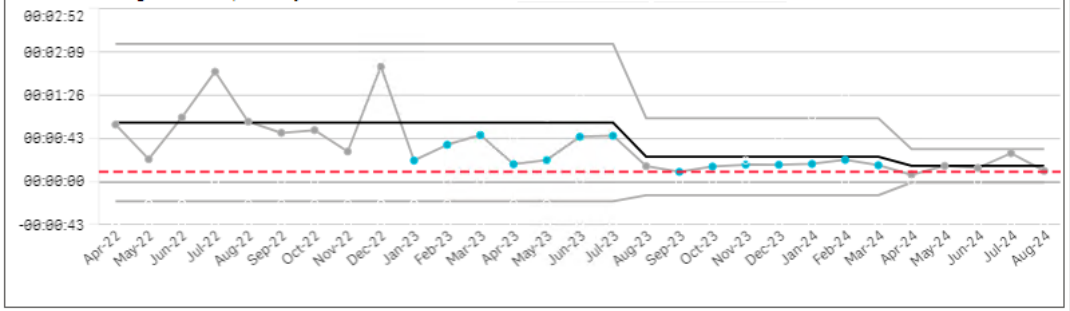
Risks:
As with Cat 1 and 2 - QA delivery against budgeted hours significant risk to SCAS performance. Delay in award of H2 capacity fill PP contracts - options for mitigation under consideration.

NHS

Operations - Operations Centre

999 Call Answer

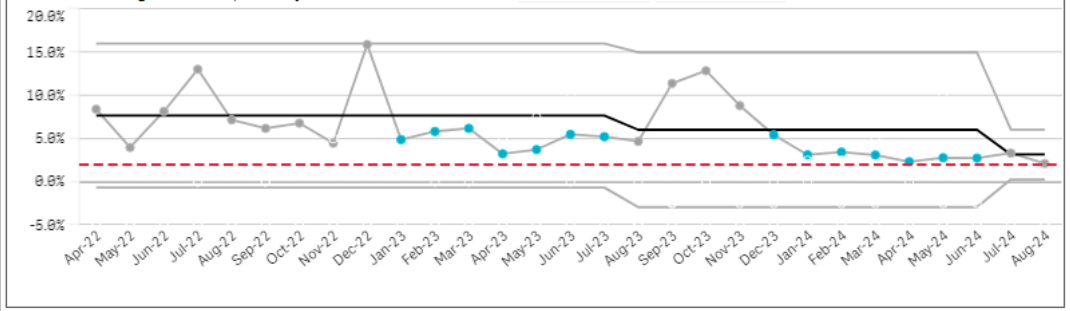
Lower is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	00:00:10
Latest	00:00:11

999 Ab. Rate

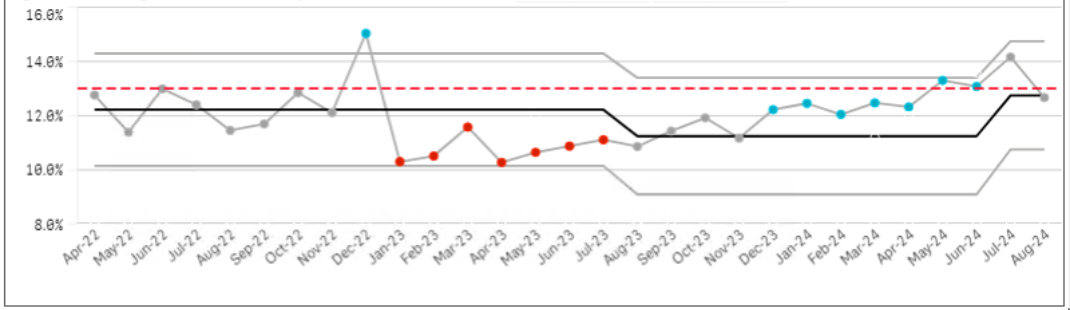
Lower is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	2%
Latest	2.1%

% Hear and treat

Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	13%
Latest	12.7%

Understanding the Performance:

Call demand fell by 14.6% in August compared to July, returning to a level more comparable to that seen in April, and sat below forecasted demand. This was driven in part by a substantial reduction (22%) in duplicate calls. By comparison logged in hours increased in August in comparison to July. There was also a marked improvement in average handling time this month with both call centres delivering below 9 minutes for the month. As a result there was an improvement in mean call answer, remaining below the mean, close to target at 11 seconds. Similarly abandonment rate improved siting at 2.13%.

As response and wait times improved, hear and treat dropped towards mean, marginally below target at 12.67%. This flux will be seen until improvements in deployment model are undertaken.

Actions (SMART):

In post 173.69 WTE ECT, 16.2 WTE training/coaching, leaving gap of 18 WTE against budget. 9 WTE start on 6th Sep. Team continue to work closely with recruitment to ensure strong pipeline and course fill, monitored monthly at IWP. Focus remains on the call answer improvement actions, with a number of process changes to be implemented this month. Rosters on track for implementation in Sept.

A further workshop was held with AACE to review/agree clinical deployment model with clear actions set, a project manager has been assigned to support the programme of change, key resource has been identified from operations and has been released to support delivery of the actions. Initial project group meeting to be held 26th September, with monthly meetings thereafter to monitor progress.

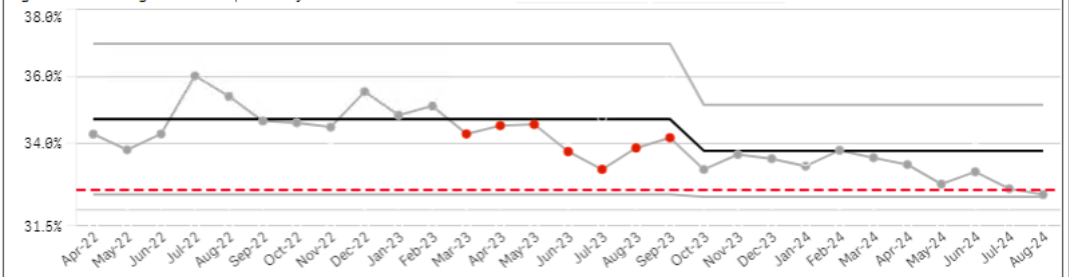
Risks:

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.
Capacity and skill of the team may impact delivery of improvements on both call answer but also clinical deployment model action.
Capacity within BI team to supply the data required to monitor improvement actions.

Operations - Utilisation

% See and treat

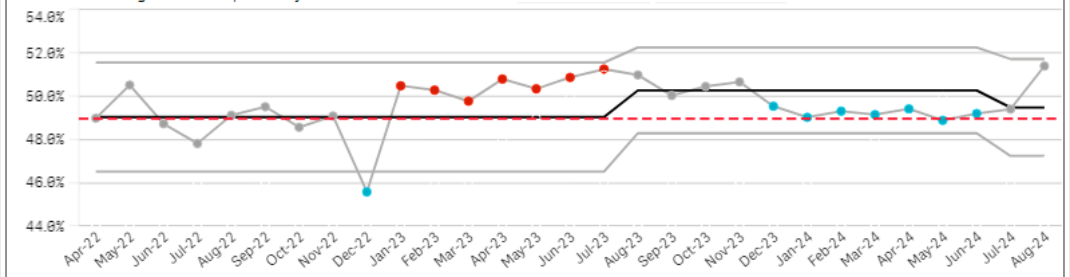
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Random	33%	32.5%

% ST&C to ED

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	49%	51.4%

Understanding the Performance:

See and Treat has decreased slightly by 0.2 % over the month of August which is a slight change in pattern when linked with the decrease in Hear and Treat. The usual correlation of the 2 measures would suggest S&T increasing with H&T decreasing so further analysis is being undertaken as it may well be linked to other data capture issues we are investigating . See , Treat and Convey to ED has seen a significant jump (near 2%) from tracking against the target for the past 8 months to above the upper control limit for August. We have seen, but don't report on anymore, a significant drop in convey to Non ED locations during the same period which has been noted and we are investing a possible issue with data collection following the introduction of NMA through July and August.

Actions (SMART):

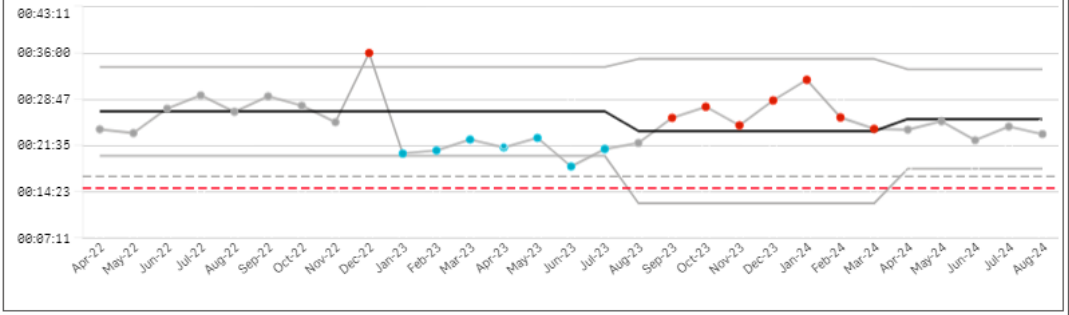
We have commissioned a review of the data being captured as one of the potential factors causing those step changes is an increase in OTHER as a final destination which creates ED as a default final location and what is reported on. There are other possible reasons such as input error and there is no suggestion that the platform is not doing what it should.

Risks:

Data commentary not reflective of the true picture.

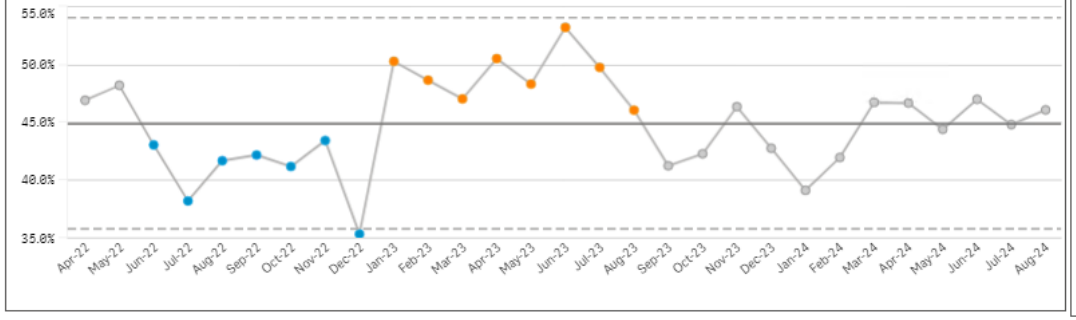
Operations - Utilisation

Ave Handover
Lower is Better. Target differed in previous years



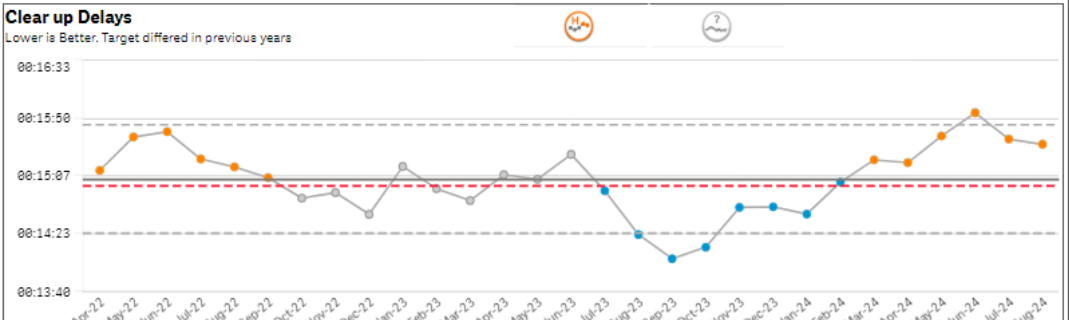
Variation	Expected
Assurance	Fail
Target	00:15:00
Latest	00:23:22

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



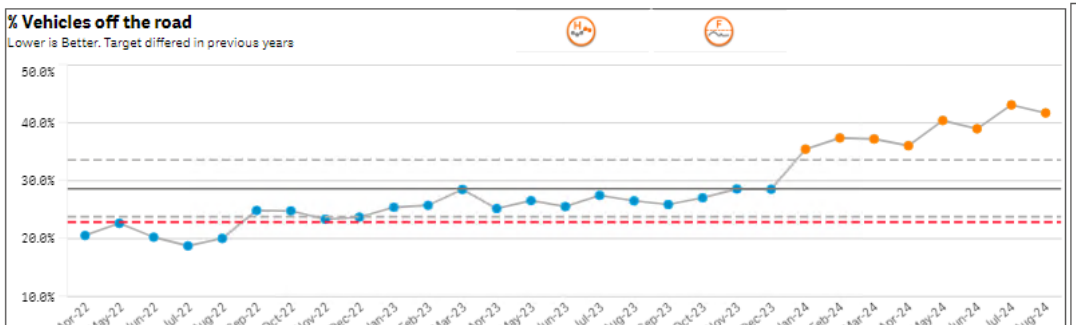
Variation	Expected
Assurance	-
Target	0.48%
Latest	46.1%

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



Variation	Declined
Assurance	Random
Target	00:15:00
Latest	00:15:31

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



Variation	Declined
Assurance	Fail
Target	23%
Latest	41.9%

Understanding the Performance:
Handovers in 15mins has decreased slightly in August but is largely tracking against the mean. Handover delays against trajectory in BOB/Frimley ahead of plan giving 28secs to C2 performance against HIOW being in a negative position against plan impacting 8mins and 28secs to C2 performance and QAH was also behind plan adding a further 7min and 52secs to C2. Clear up delays improved slightly in August showing local actions are starting to take effect
Overall VOR has improved month on month, but remains above KPI. Main drivers continue to be mechanical defect relating to age and high utilisation of fleet. Slow progress made on reducing overall VOR but volume of defects being created is exceeding current workshop capacity. Outsourcing remains a key element of the overall VOR reduction plan

Actions (SMART):
Handovers -W45 (LAS handover model) has been socialized with CEO to CEO discussions and work is being progressed on operationalizing this a handover standard. Continuing to focus on local owned actions to improve turnaround/clear up compliance.
VOR - Business Case for a new workshop has gone through EMC and is due at F&P, This will build capacity for the workshops and allow SCAS to reduce VOR in line with KPI targets. New fleet continues to come into SCAS with over 27 uplift DCA's now in operational use

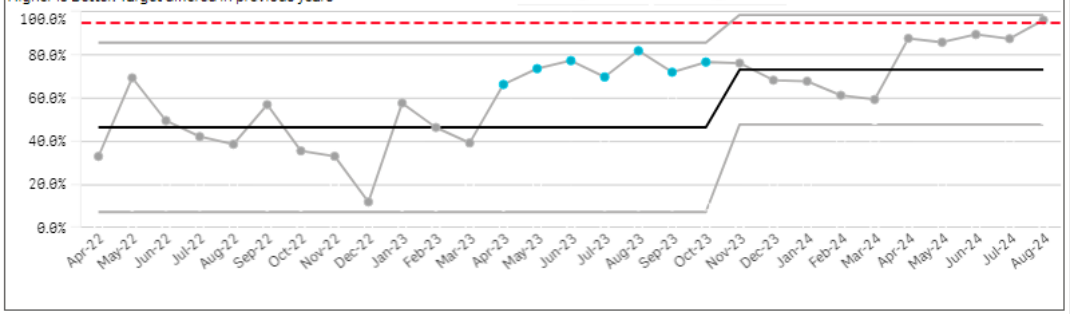
Risks:
Handovers - Delays remain a key focus as although handover within 15mins is tracking around the mean individual acutes show significant variances impacting on service delivery.
VOR -SCAS not having a workshop capacity to control its VOR remains a clear risk as sudden increases in VOR rates will limit how many DCA's SCAS has available for operational use and will limit its ability to serve the public.

NHS

Operations - Operations Centre

111 Call Answer

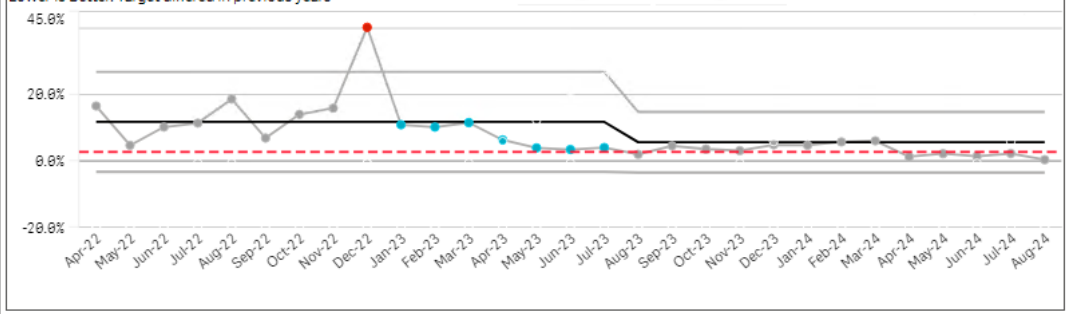
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	95%	96.3%

111 Ab. Rate

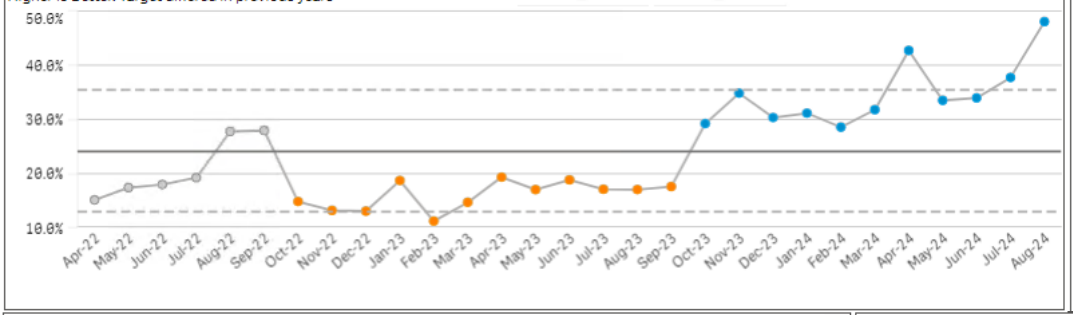
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	3%	0.5%

111 Call backs

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	95%	48.2%

Understanding the Performance:

Calls offered (reporting impacted by data outage) were 4.5% down against July, returning to levels closer to those seen last summer although 3.4% up on Aug 2023. Call handler logged in time also dropped but in line with the drop in demand. As a result of this ratio of resource against demand, combined with the efforts around AHT, Aug 24 saw the highest performing month on our new telephony achieving national target on both call answer and abandonment rate. 96.3% calls answered in 120 seconds, above the mean and at the upper control limits and 0.55% abandonment, below the mean and at the lower end of control limits. Clinical call backs in 20 minutes also stepped up well above mean to 48%, although still outside of national target.

Actions (SMART):

Majority of actions remain similar to last month, close monitoring of workforce in partnership with recruitment/HR to ensure stability in work effective numbers for both HA and CA, with weekly and monthly IWP meetings continuing. In post 226 WTE HA with recruitment onto specific rota patterns, 81.49 WTE CA sitting at budgeted levels. All actions to support a reduction in AHT continue with monitoring of these at operational departmental level, weekly operational AHT monitoring and monthly DOPR.

Risks:

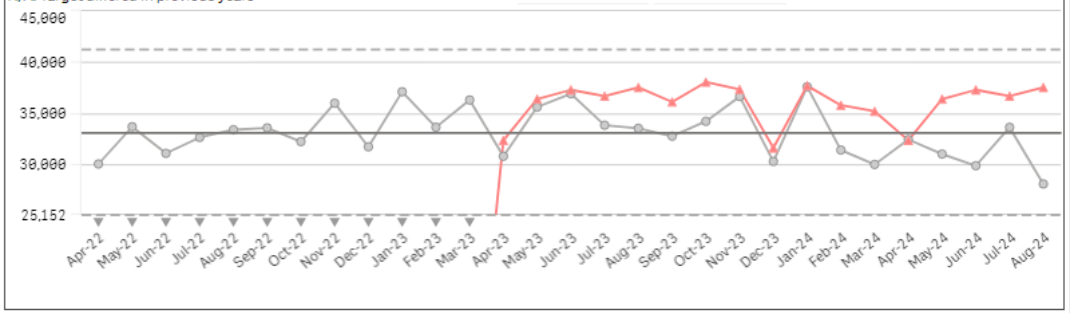
Challenges around funding continue, QIA has been jointly developed with ICB and is stepping through process in relation to rightsizing workforce, with risks to overall service performance. The current contract position has meant that the pharmacist and TVIUC GP hours have been lost, this may increase workload for clinical team potentially impacting the ability to call patients back in a timely fashion, with performance affected, if demand outstrips capacity.

Any unexpected increase in demand could potentially affect our overall performance.

Operations - PTS - Calls and Outcomes

PTS Call Volume

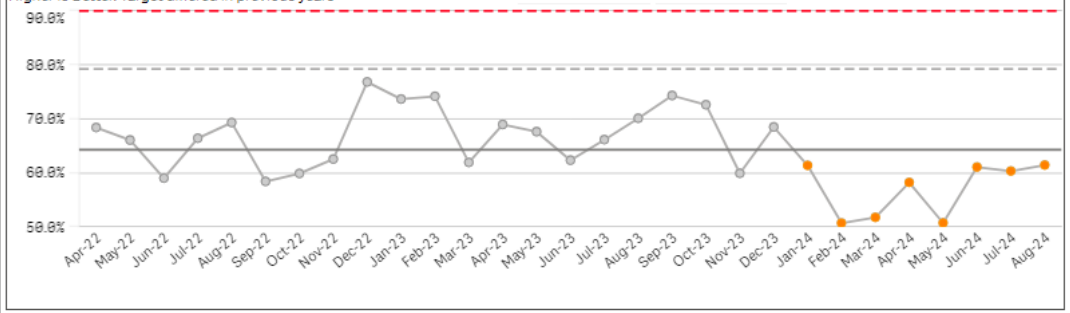
N/A. Target differed in previous years



Variation	Improved
Assurance	Random
Target	37,575
Latest	28,177

PTS - Calls answered in 60 seconds

Higher is Better. Target differed in previous years



Variation	Declined
Assurance	Fail
Target	90%
Latest	61.5%

Understanding the Performance:

- Call Answer performance continued to be a challenge, broadly consistent with previous two months, but there has been an improvement returning closer to the mean performance over the last 2 years.
- Sickness increased compared with prior month.
- Call volumes have decreased to below the mean as expected due to August being summer holidays. The introduction of the Cleric Demand cap online which results in any essential bookings wanted to be placed online must be phoned through to the Contact Centre with the ongoing challenge of not being able to re-activate the online accounts for HCPs due to ICB service change implemented. Call Volumes are expected to increase next month back towards the mean.

Actions (SMART):

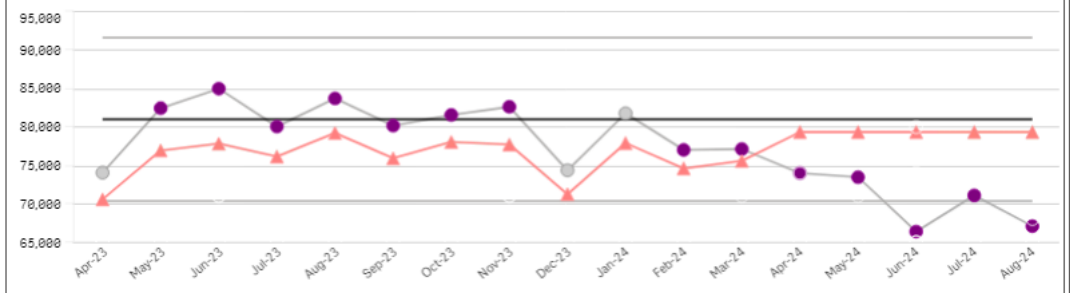
- Budget now been confirmed with performance target agreed of 63.7%, therefore the mean performance over the last 2 years is broadly aligned to the reduced budget seen in 24/25 for call handlers.
- Request to be raised to ICB to allow HCP accounts to be reactivated to enable the push for online bookings to return and reduce call volumes into the contact centre thus expecting an improvement in performance.
- Proposal raised with ICB to reduce contact centre operating hours and condense team members shifts enabling an increase in performance.

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

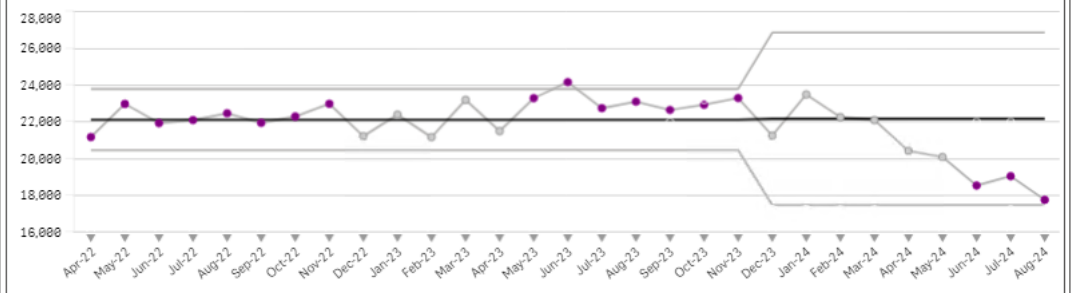
Operations - PTS - Calls and Outcomes

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



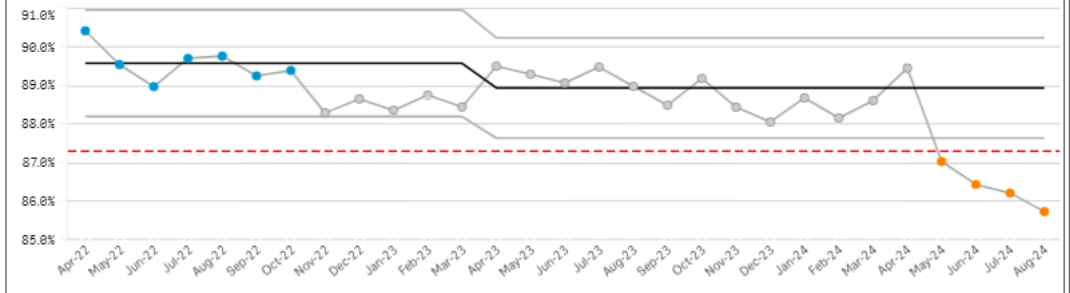
Variation	Assurance	Target	Latest
Improved	Random	79,359	67,064

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



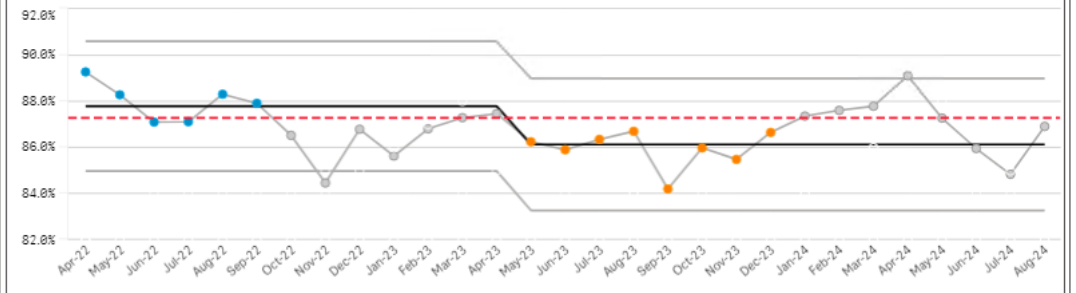
Variation	Assurance	Target	Latest
Improved	-	0	17,722

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



Variation	Assurance	Target	Latest
Declined	Random	87%	85.7%

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



Variation	Assurance	Target	Latest
Expected	Random	87%	86.9%

Understanding the Performance:
Demand has seen a decrease in August, this is as expected due to being a summer holiday month and a month containing a bank holiday, in addition August contained higher weekend days consisting of 9. The Demand Management process remains in place, therefore showing reduced demand compared to prior years.
- Activity is lower than the demand cap in 2 out of 4 contracts which is making it difficult to forecast the demand and hours required and as such costs will fluctuate and been challenging against budget.

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.
- Monitoring and reporting of hours, demand against costs through daily review call. External reporting shared with ICBs weekly.
-Review of resources required at a contractual level rather than aggregated level due to differing challenges across areas.

Risks:
- Overspends compared to the flat phased budget, pivots not yet received to enable review.
- 1 contract remains unsigned with a joint investigation process commencing
- 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
- If recruitment decreases and attrition increases there is a risk that the resourcing cost across Thames Valley will be higher than budget due to the resourcing mix.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

August-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L				
	Stroke - Call to Hospital arrival Median	Building Audits Building Audits % CA Survival Utstein STEMI 90th STEMI Mean Stroke 90th Stroke Mean Vehicle Audits Vehicle Audits %		3
L				1
H	Safeguarding Level 3			
↗				3
↘				1

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.	Aug-24	450			n/a	484	391	576
Monthly PSII	Aug-24	7			n/a	4	-1.99	9.99
Monthly PSILR	Aug-24	8			n/a	6.2	-6.44	18.8
PSII Cases > 6 mths	Aug-24	0			n/a	0	0	0
Datix incidents	Aug-24	44		L	n/a	101	93	109
Duty of Candour	Aug-24	0.0%			n/a	0.002	-0.0113	0.0153
Level 3 Safeguarding	Aug-24	87.1%	90%	H	F	56.2%	43.5%	68.9%
Complaints	Aug-24	42			n/a	45.8	28	63.5
Complaints in time	Aug-24	100.0%			n/a	0.963	0.838	1.09
Building Audits	Aug-24	10	21		?	31.1	-0.851	63
Building Audits %	Aug-24	70.0%	80%		?	82.1%	46.9%	117.2%
Vehicle Audits	Aug-24	130	167		?	107	15.4	199
Vehicle Audits %	Aug-24	80.0%	90%		?	93.9%	77.6%	110.2%

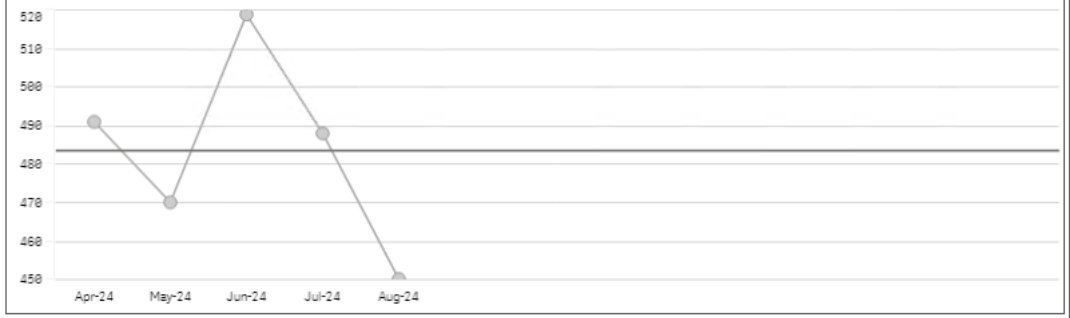
Quality Safety– Ambulance Quality Indicators (AQIs)

*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	Aug-24	02:10	-			02:16	01:47	02:45
STEMI 90th	Aug-24	03:07	-			03:13	01:50	04:36
Stroke Mean	Aug-24	01:29	-			01:38	01:10	02:05
Stroke Median	Aug-24	01:19	-			01:22	01:07	01:37
Stroke 90th	Aug-24	02:24	-			02:35	01:36	03:33
ROSC All	Aug-24	23.1%	-	-	n/a	25.0%	20.0%	30.0%
ROSC Utstein	Aug-24	45.0%	-	-	n/a	54.0%	40.5%	67.4%
CA Survival All	Aug-24	9.1%	-	-	n/a	8.6%	3.2%	14.1%
CA Survival Utstein	Aug-24	30.0%	-			30.5%	5.5%	55.4%

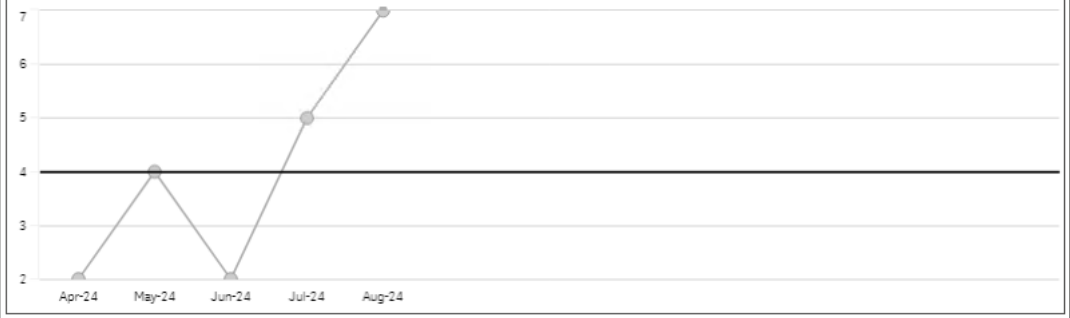
Quality & Safety – PSIRF

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



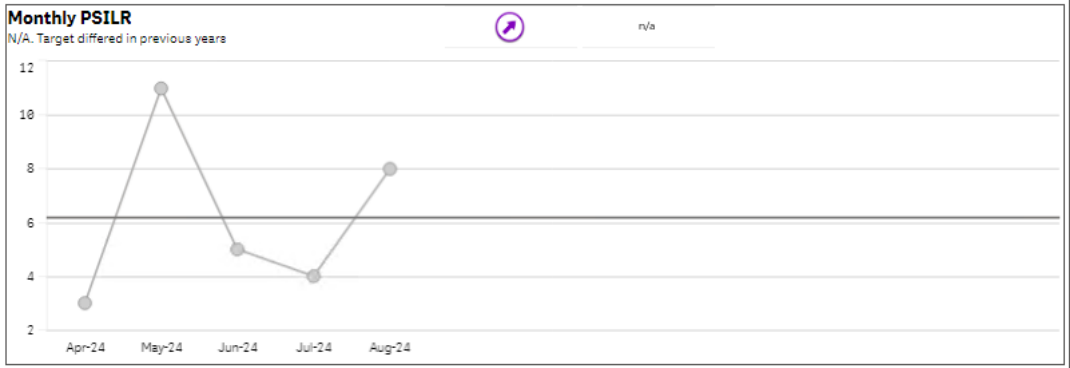
Variation	Assurance	Target	Latest
Expected	-	-	450

Monthly PSII
N/A. Target differed in previous years



Variation	Assurance	Target	Latest
Improved	-	-	7

Monthly PSILR
N/A. Target differed in previous years



Variation	Assurance	Target	Latest
Improved	-	-	8

PSII Cases > 6 mths
. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	0

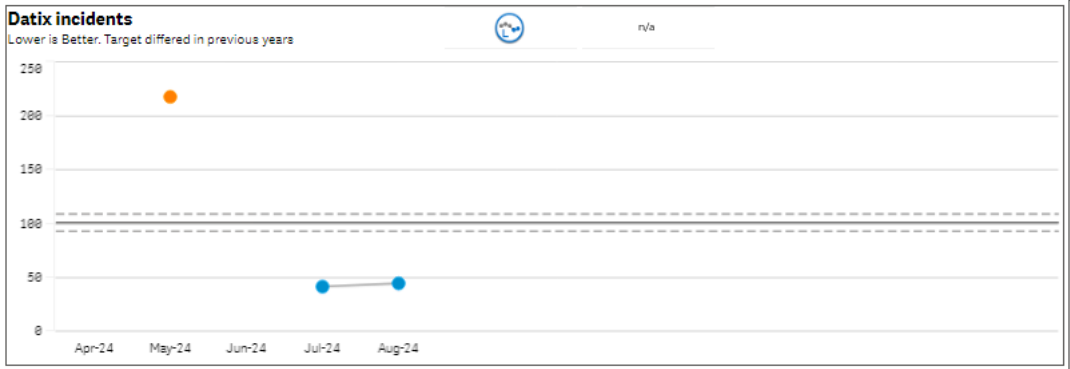
Understanding the Performance:
new themes are driving the increase outside of delay including clinical decision making.

Actions (SMART):
PSIRF plan under review to ensure local priorities are still relevant and to offer more guidance on process. Divisional Clinical governance groups reviewing reports and actions for local ownership. Engagement in BOB & HIOWA system led peer review groups.

Risks:
Limited organisational learning

Quality & Safety – PSIRF

Datix incidents
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	-	-	44

Duty of Candour
Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	0.0%

Understanding the Performance:
positive impact from overdue Datix lists reported in service line clinical governance meetings

Actions (SMART):
Moderate harm and higher incidents are reviewed at SRP to ensure compliance with statutory DoC. Continue with overdue Datix reporting

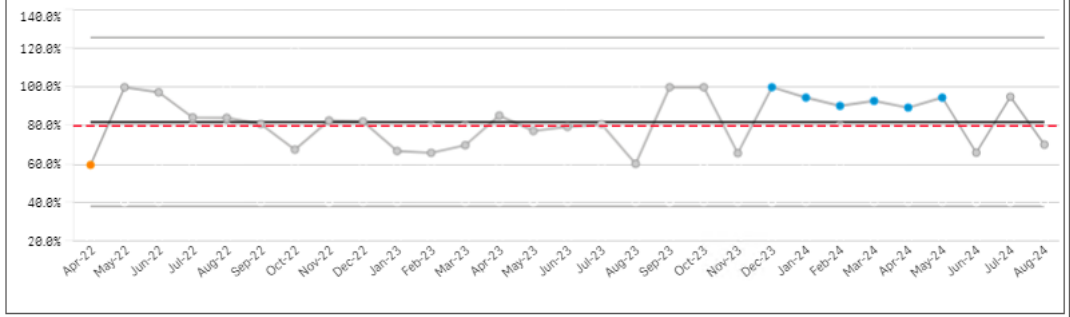
Risks:
risk of not investigating in a timely manner and opportunity for learning. DoC not meeting regulatory standard if breached

NHS

Quality & Safety - Audits

Building Audits %

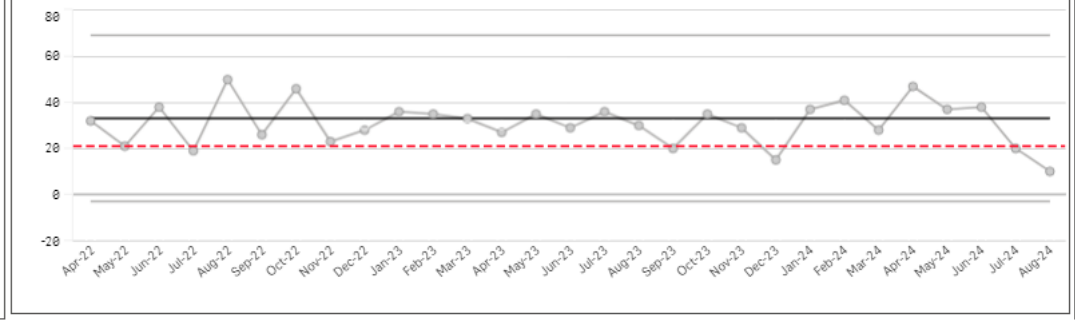
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	80%	70.0%

Building Audits

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	21	10

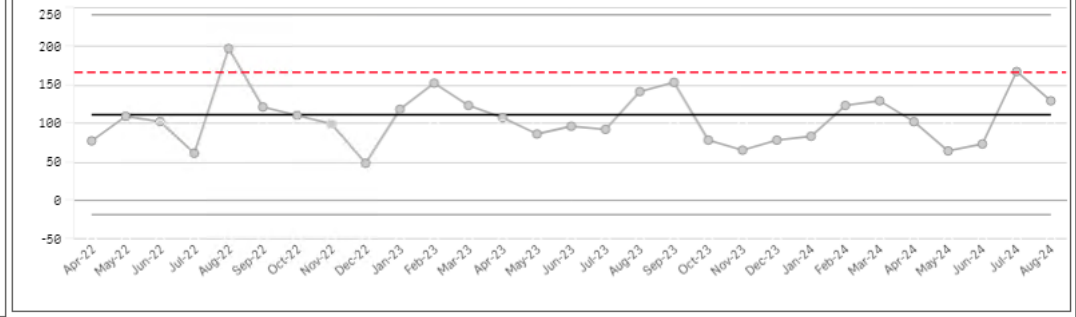
Vehicle Audits %

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	Random	90%	80.0%

Vehicle Audits

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	167	130

Understanding the Performance:

Level 3 audit schedule commenced. Embedding of audit schedule. Data collated manually to improve accuracy and reliability.

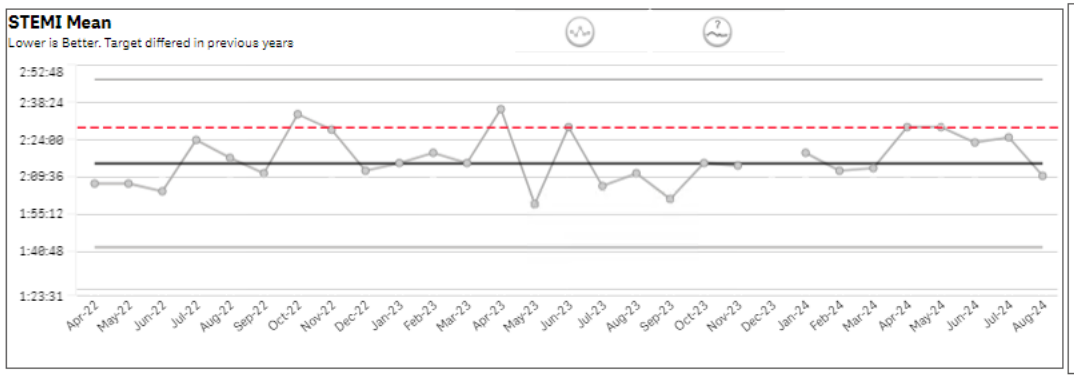
Actions (SMART):

Bespoke local actions plans in place to increase compliance. Weekly communication from IPC on the trajectory of completion. IPC working alongside fleet to increase standards of cleanliness achieved through contract KPI's.

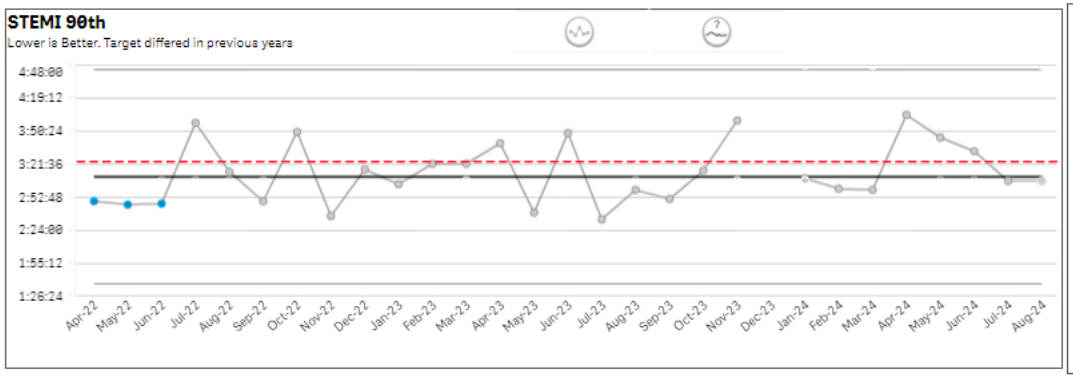
Risks:

cleaning below standards has the potential to affect patient care and patient safety

Quality & Safety – AQIs – STEMI



Variation	Assurance	Target	Latest
Expected	Random	02:29	02:10



Variation	Assurance	Target	Latest
Expected	Random	01:30	01:35

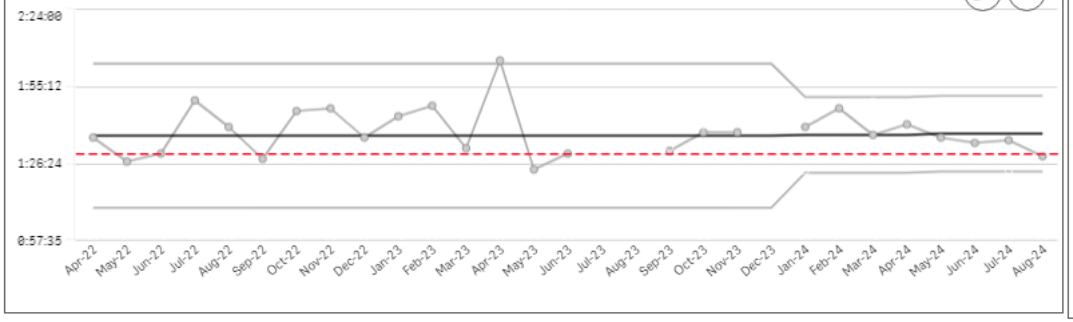
Understanding the Performance:
April 24 cases

Actions (SMART):
Mean SCAS 2:10 (England 2:29) 90th Centile 3:07 (England 3:24) cat2 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

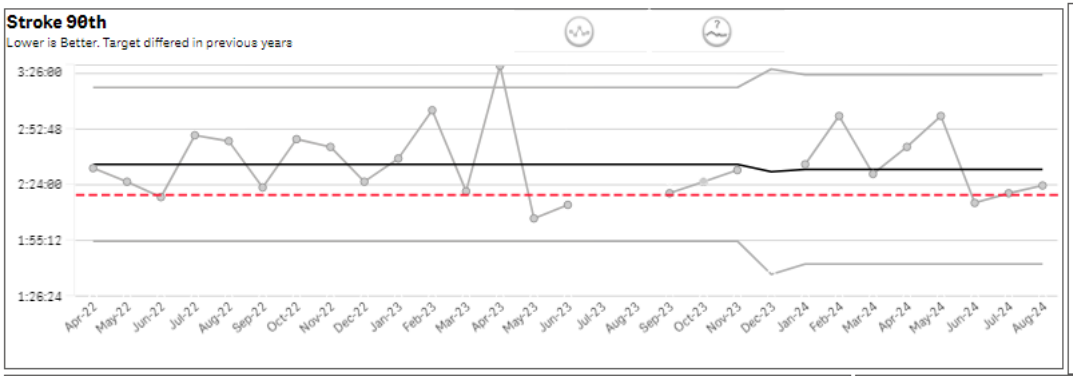


Variation	Expected
Assurance	Random
Target	01:30
Latest	01:35

Stroke Median
Lower is Better. Target differed in previous years

Variation	Expected
Assurance	Fail
Target	01:20
Latest	01:22

Stroke 90th
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	02:19
Latest	02:32

Understanding the Performance:
April 24 cases

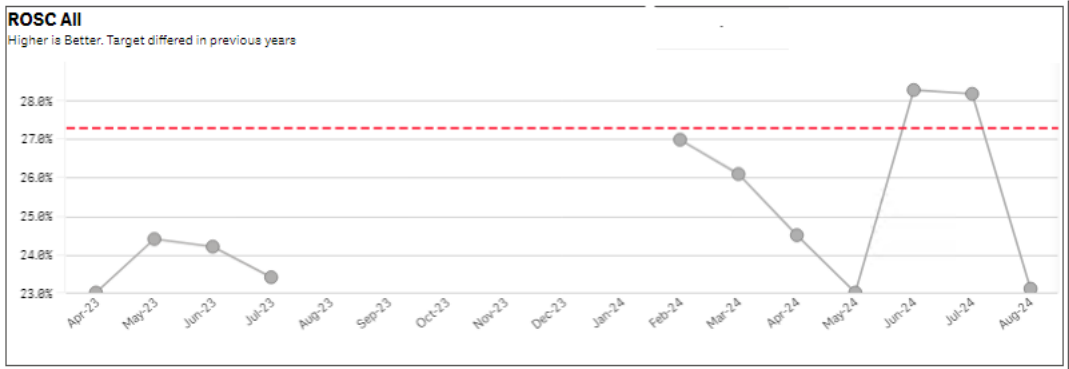
Actions (SMART):
Mean SCAS 1:29 (England 1:30) 90th Centile 2:24 (England 2:19) Cat2 improvement plan in place

Risks:
Time critical care - patient outcome

Quality & Safety – AQIs – Cardiac

ROSC All

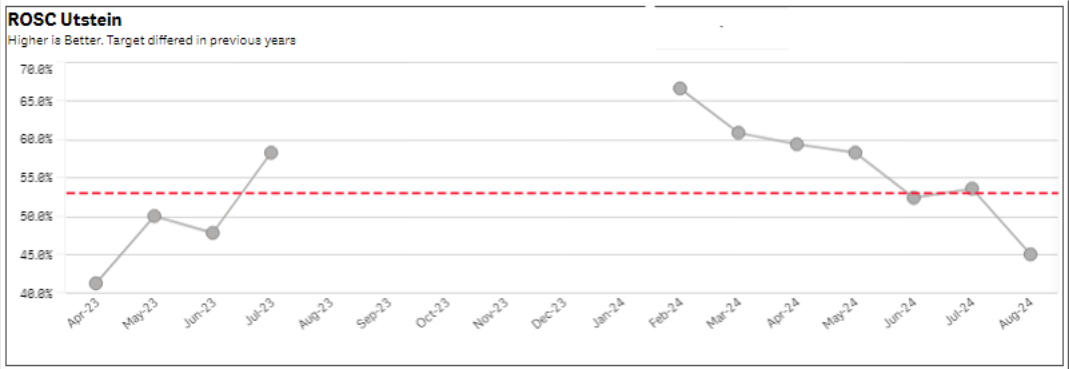
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	-	27.3%	23%

ROSC Utstein

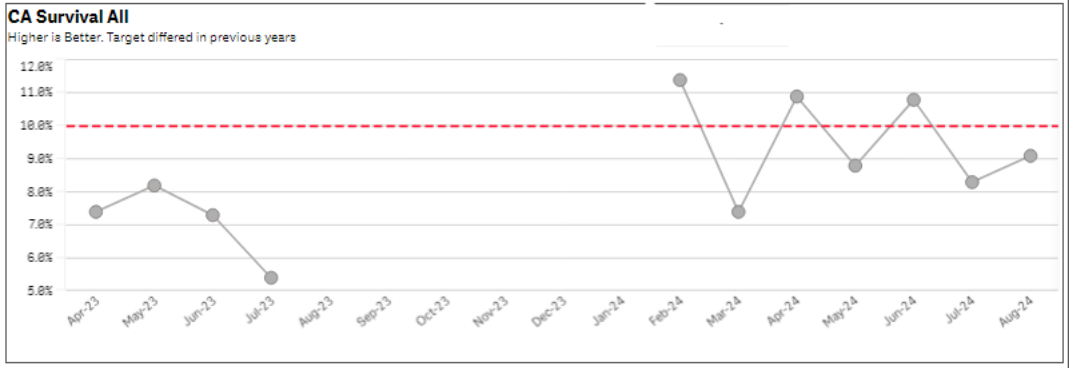
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	-	53.0%	45%

CA Survival All

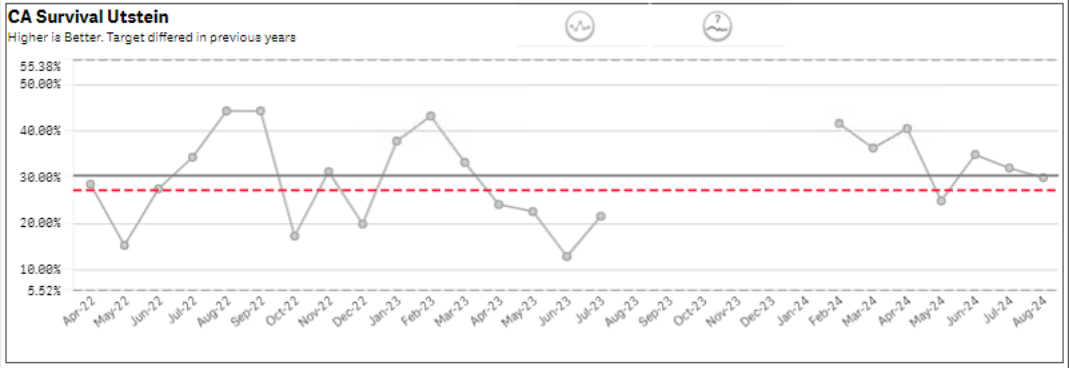
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	-	10%	9.1%

CA Survival Utstein

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	27.3%	0.3%

Understanding the Performance:

April 24 cases

Actions (SMART):

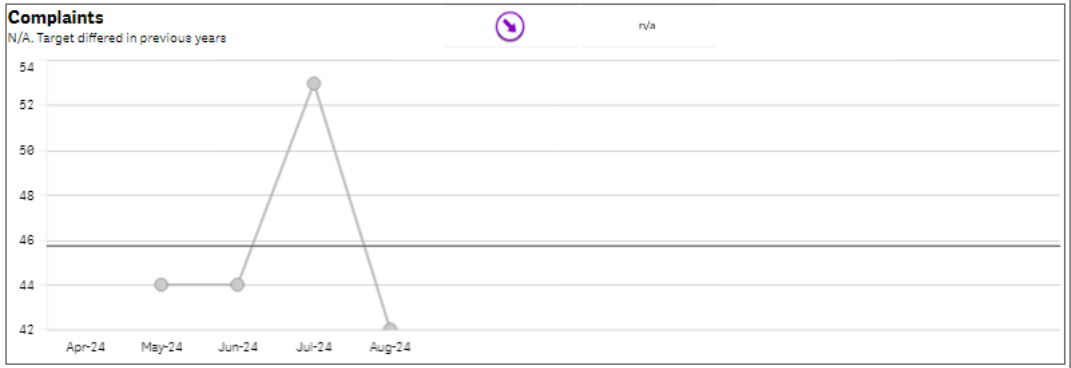
Survival at 30 days Utstein group 30% (England 32.4%) ROSC Utstein 45 (England 53%) Category 2 improvement plan and resus training in place

Risks:

Patient care and survival

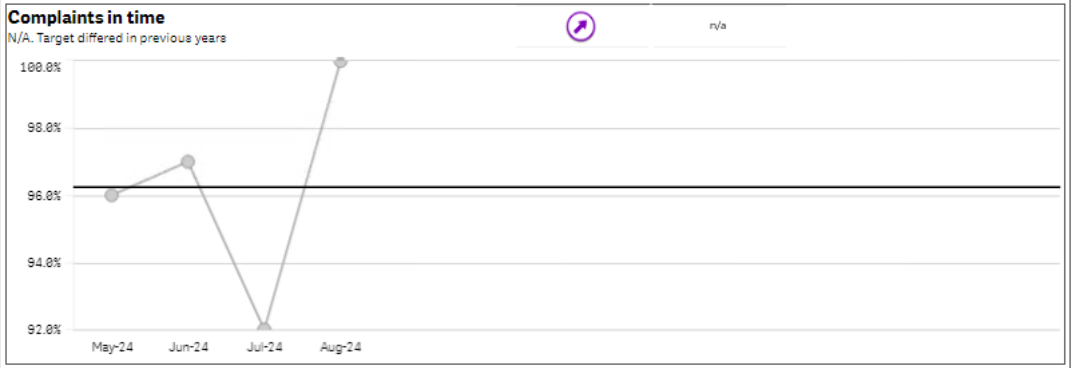
Quality & Safety – Safeguarding and Patient Experience

Complaints
N/A. Target differed in previous years



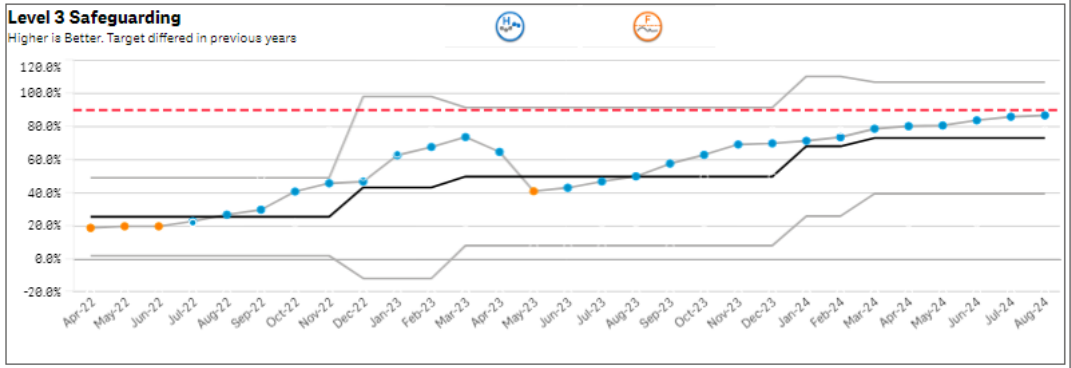
Variation	Assurance	Target	Latest
Improved	-	-	42

Complaints in time
N/A. Target differed in previous years



Variation	Assurance	Target	Latest
Improved	-	-	100.0%

Level 3 Safeguarding
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	90%	87%

Understanding the Performance:
Safeguarding training consistent improvement in line with improvement plan.

Actions (SMART):
Ongoing work to improve real time monitoring of timeframes within Datix, improved PE process to escalate early when timeframes may not be met. Regular case reviews with operational leads to increase local oversight.

Risks:
safeguarding - staff non compliant could impact patient care. Complaints - non compliance statutory standard and poor experience

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

August-24 Summary

Metrics:

Assurance →

Variance ↓

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

People - Workforce, Culture & Employee development, Employee experience

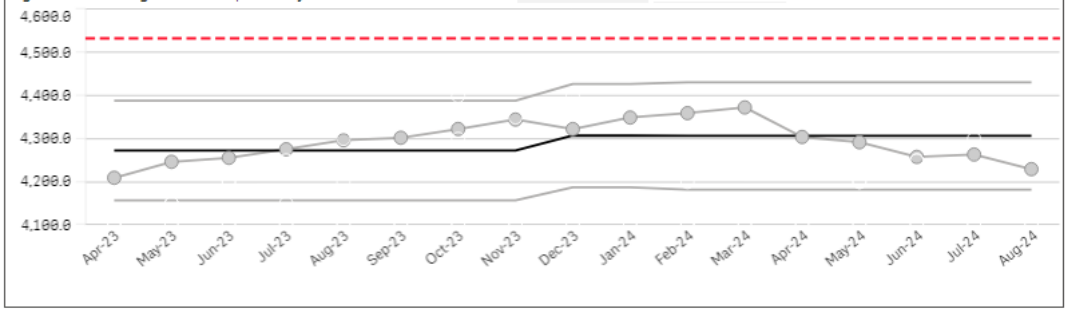
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Aug-24	4,230	4,532	L	n/a	4294.6	4234.4	4354.7
% Trust staff who are BAME	Aug-24	7.4%	6.3%	H	n/a	6.0%	5.3%	6.7%
% Trust staff who are declared disabled	Aug-24	8.7%	8.6%	H	n/a	7.1%	6.1%	8.2%
% DBS Compliance	Aug-24	97.8%	95%		n/a	97.6%	-	-
% Turnover	Aug-24	16.8%		L	n/a	18.0%	16.6%	19.5%
% Vacancy	Aug-24	11.9%		H	n/a	10.5%	9.2%	11.7%
% Sickness in month	Aug-24	6.3%	5.4%		n/a	6.5%	5.4%	7.6%
% Long term sickness	Aug-24	3.7%	3.7%		n/a	3.7%	3.3%	4.1%
Appraisals - Trust	Aug-24	87.0%	95%	H	F	78.1%	70.9%	85.3%
% Stat and Mand Training	Aug-24	37.4%			n/a	37.3%	-	-
Staff Engagement Score	Aug-24			L	n/a	5.0	-	-
FTSU Cases	Aug-24	12			n/a	11.7	-0.8	24.1
Meal Break Compliance - SCAS	Aug-24	45.3%	70%	L	F	50.9%	33.1%	68.7%
Over-runs >30 mins - SCAS	Aug-24	16.4%	25%		P	17.6%	15.1%	20.1%
Time to hire	Aug-24	137			n/a	116.9	-	-

People - Workforce

Number of WTE

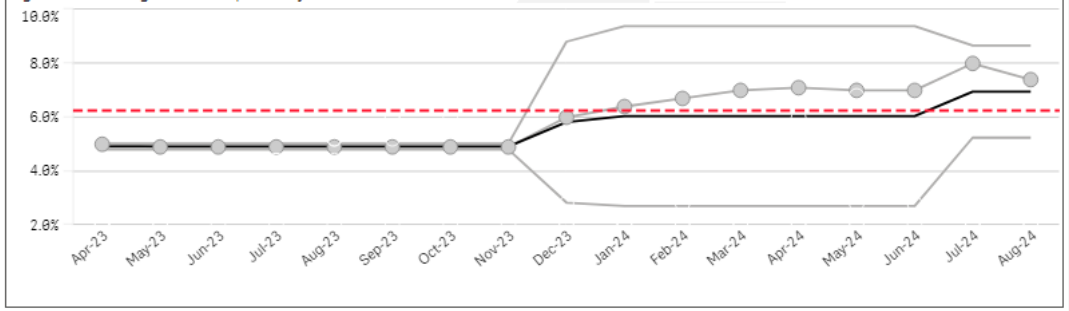
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	4,531.9	4229.7

BAME Staff %

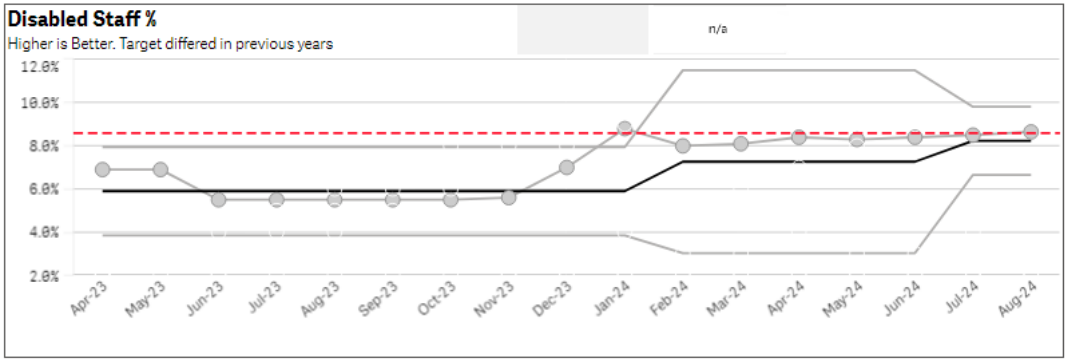
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	6.3%	7.4%

Disabled Staff %

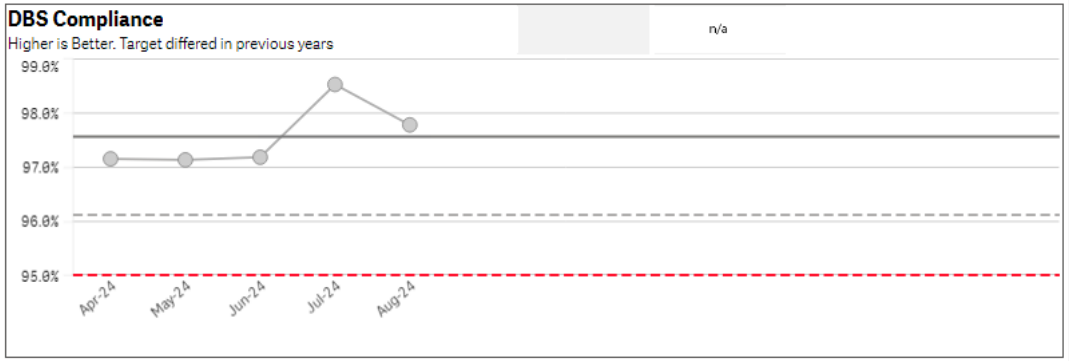
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	8.6%	8.7%

DBS Compliance

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	95%	97.8%

Understanding the Performance:

WTE in post has dropped slightly as turnover has risen, this has impacted BAME figures slightly, although the change from last month is minimal. DBS compliance has reduced by 1%, this is because we have done a full review of all our DBS checks across roles and are updating and re-checking positions where required. The target for DBS compliance is 95% so we remain above this target. Whilst the WTE has reduced, we do have plans in some areas of the Trust for this to happen, e.g. ECTs within EOC. We are also seeing attrition at expected levels. August is always a month where we lose more people than we recruit.

Actions (SMART):

We continue to book to courses to increase numbers as needed. We are preparing a deep dive into reasons for turnover and the retention workstreams are being reinvigorated. We are not seeing the attrition rates increase significantly within the service lines. We normally see WTE reduce in August as this is a month where we don't have a lot of new starters, but we do continue to have leavers. We are starting the process of reviewing and updating each IWP area's plan for H2 to work through the service line changes for the rest of the year. Any role that has been newly identified as needing a DBS check has had it applied for already and we are updating ESR records as and when these are received back from the DBS.

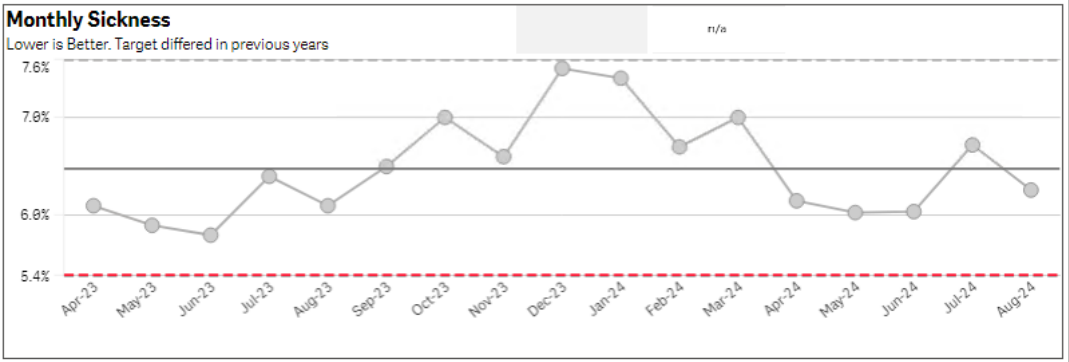
Risks:

Corporate restructure and PTS contract changes could mean that we have higher than expected volume of leavers as people "in scope" are likely to start searching for alternative employment.

People - Workforce

Monthly Sickness

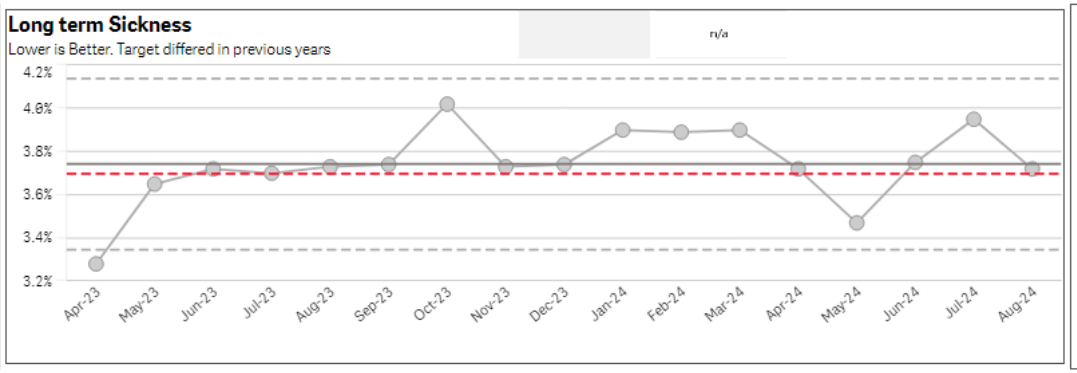
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	5.4%	6.3%

Long term Sickness

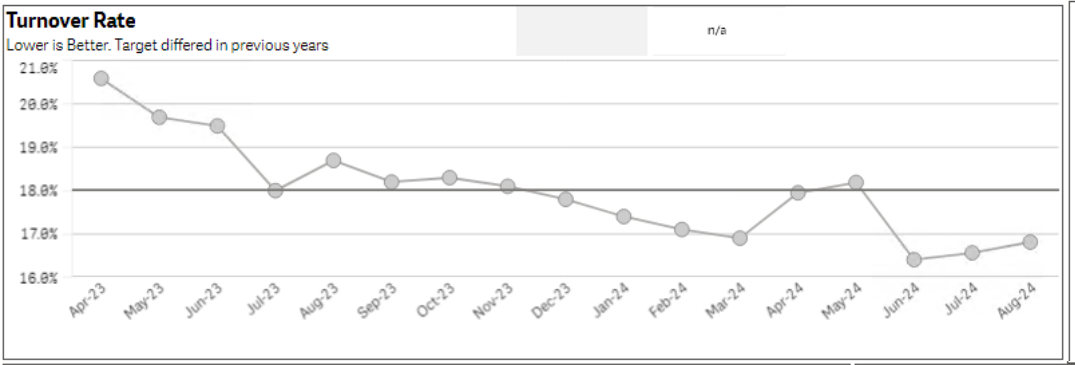
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	3.7%

Turnover Rate

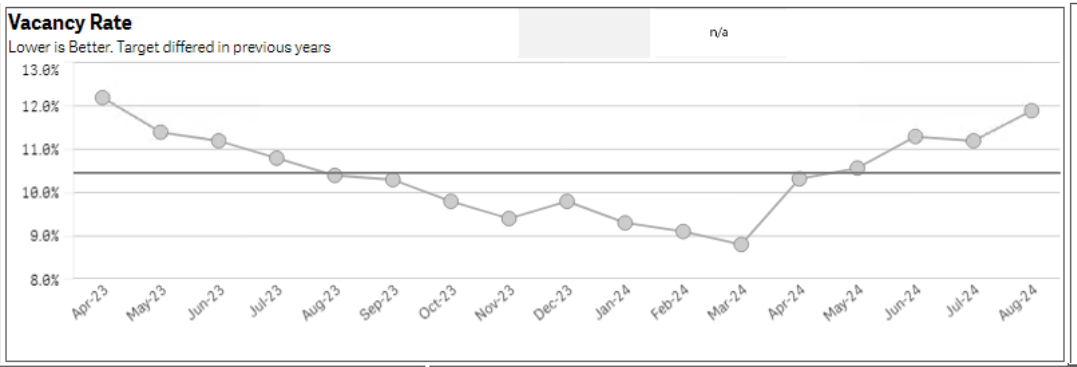
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	16.8%

Vacancy Rate

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	11.9%

Understanding the Performance:

Sickness absence has remained at our below our mean. Turnover has seen a small increase and we expected to see this increase with the recent TUPE announcements affecting PTS in TV in addition to Logistics and Sussex. We would also expect to see an increase as a result of the Corporate Restructure as some of those potentially affected will likely look for, and take, opportunities elsewhere to ensure their continued employment. As turnover has increased, so too have vacancies. Managers and HR continue to have sickness review meetings with absent staff as per policy with the aim of implementing supportive measures to return staff as soon as possible.

Actions (SMART):

Absence continues to be actively monitored with regular meetings held between HR and management teams to ensure the appropriate management of absence issues in as timely a manner as possible. Communication and engagement with the populations of staff affected by TUPE is being undertaken to provide as much assurance as possible with a view to retaining them up to the point of transfer. Engagement sessions with staff affected by the Corporate restructure are also being held to ensure staff are informed and up to date on the progress of this work to try and mitigate against staff deciding to leave. We are expecting an increased intake of new starters in Q3, which should see the vacancy rate reduce.

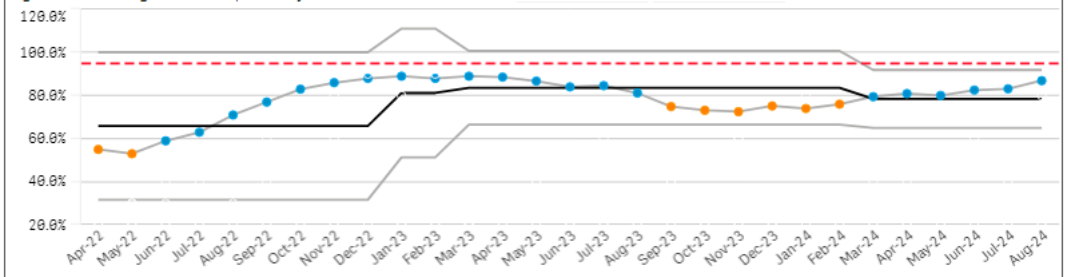
Risks:

We have seen staff in Logistics resign and take other opportunities ahead of their transfer date under TUPE so would anticipate this being replicated but with larger numbers in PTS for Sussex and TV. The work to engage early and fully with staff is intended to mitigate against this by introducing them to the new employer and becoming more familiar with them and how they work as far in advance of the transfer dates as possible. This has begun on an informal basis and the formal processes will begin at the end of September. It is likely that turnover in Corporate services will increase over coming months due to Corporate review. This may be beneficial in terms of cost savings and increasing redeployment opportunities.

People – Culture & employee development

Appraisals

Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Fail
Target	95.0%
Latest	87.0%

Stat and Mand Training

Higher is Better. Target differed in previous years

n/a

Variation	Expected
Assurance	-
Target	-
Latest	37.4%

Staff Engagement Score

Higher is Better. Target differed in previous years

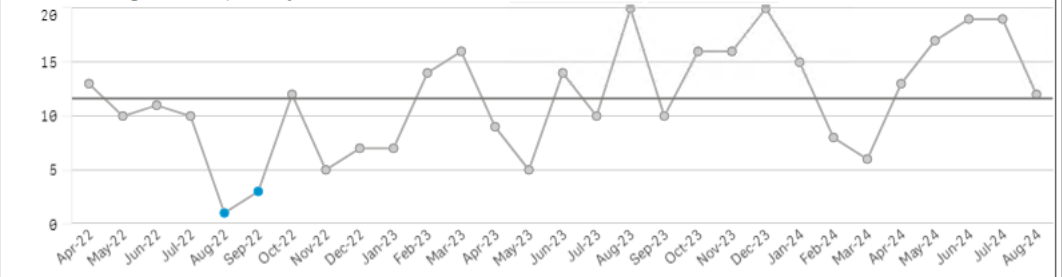
n/a

Variation	Declined
Assurance	-
Target	-
Latest	

FTSU Cases

Lower is Better. Target differed in previous years

n/a



Variation	Expected
Assurance	-
Target	-
Latest	12

Understanding the Performance:

FTSU : Anon x 2; confidential x 5; open x 5. Increase in fear of speaking up around reactions/responses and defensiveness. Requirement/desire for more data;

Appraisals - Between July and August, the PDR completion rate showcased a significat increase of 4%. This reflects a notable boost in PDR converstaions and people engagement.

Actions (SMART):

FTSU : Continue to promote FTSU through presentations and walkabouts; encourage ways for teams to link in with us and embed culture of psychological safety; New seconded guardian has commenced in role.

Appraisals: An ongoing strategy to improve both the quality and quantity of PDR conversations is being actively monitored to ensure sustained progress and continuous improvement.

Risks:

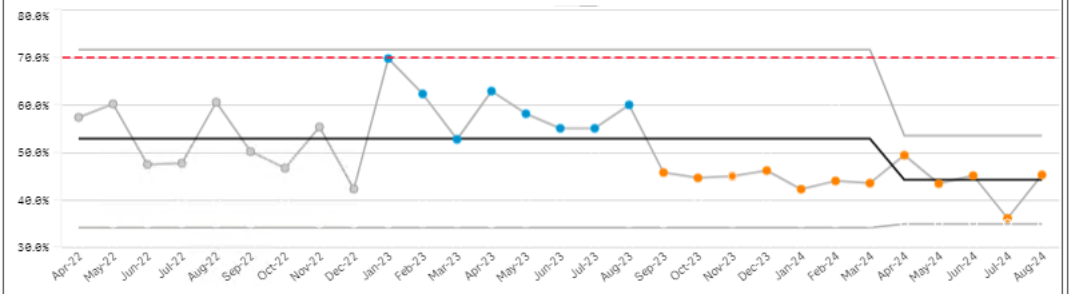
FTSU: Dashboard - will enable production of relevant data; Lack of psychological safety will increase fear & futility

NHS

Workforce - Employee Experience

Meal Break Compliance

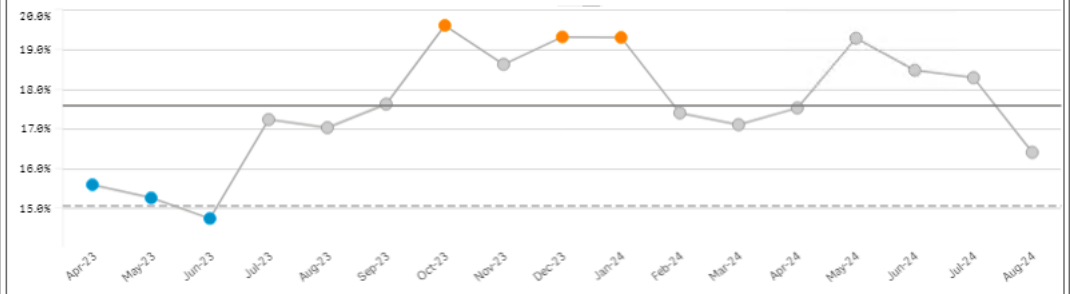
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Fail	70%	45.3%

Overruns

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	25%	16.4%

Time to Hire

Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	-	-	137

Understanding the Performance:

Time to hire has reduced slightly from July, but is still higher than ideal. This is partly due to an NQP course starting this month as the NQP onboarding process is long through necessity. We job offer the NQPs around 6 months before they start with SCAS so the standard time to hire metric for this is statistically skewed by our NQPs. This metric - taken in isolation and without context, will create concern. Time to hire ranges from c50 days for a call handler through to over 200 days for our NQPs. This month there were no call handlers to reduce the overall averages.

Actions (SMART):

We are working on a number of actions to reduce time to hire wherever possible, including reviewing delays in each part of the process to establish what is within our control to improve. We will continue to job offer both our NQPs and international paramedics several months before they can start work with us. We do this so that NQPs don't decide to go to another Trust. It may be worth considering moving this to a quarterly or half yearly metric rather than monthly. We have KPIs for each of the portfolios and these are monitored and remedial action put in place where required.

Risks:

If we delay job offering positions just to improve our time to hire figures, then we could see a reduction in clinical new starters.

NHS

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Finance

NHS Finance Overview

August-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				1
L				
L		Debtors > 90 days> 5% total balance		1
H				
↗				
↘				

NHS Finance

*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	Aug-24	4.3%	5%	L	?	16.2%	-2.3%	34.6%
Agency Spend	Aug-24	309	403	L	n/a	322.966	102.661	543.271
Overall SOF Segment	Aug-24	4		H	n/a	3.58621	3.39621	3.77621
CIP's Total	Aug-24	1,623	3,173	-	-	952.118	-1,221.27	3,125.5
Pay Spend	Aug-24	16,995	17,251	-	-	17,695.9	13,440.8	21,951.1

Finance - Finance 2

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

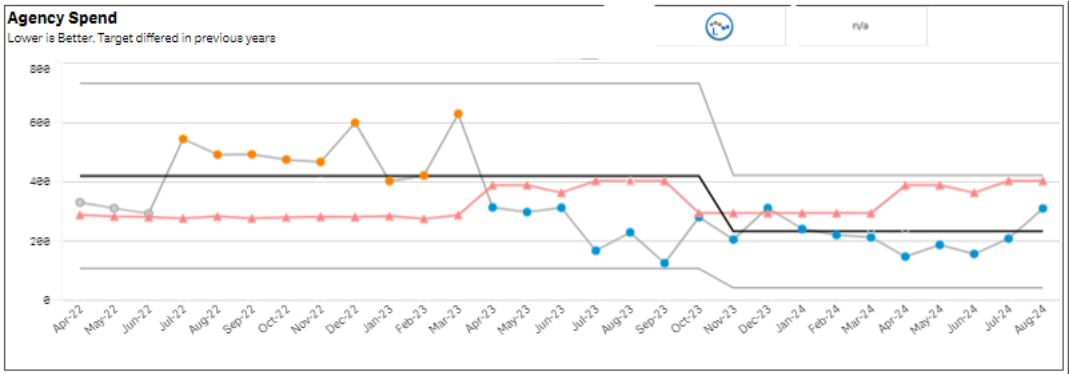
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Overall SOF Segment	Apr-24	4			n/a	3.586	3.396	3.776

Understanding the Performance:	Actions (SMART):	Risks:

NHS

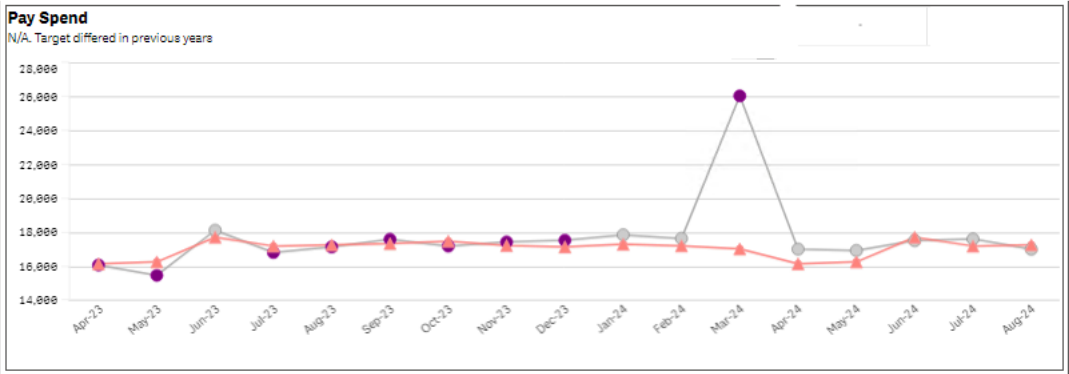
Finance - Finance 1

Agency Spend
Lower is Better. Target differed in previous years



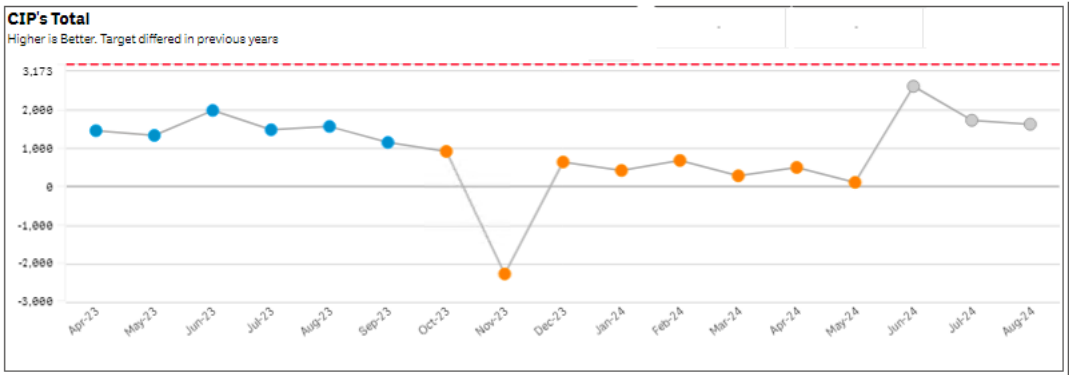
Variation	Assurance	Target	Latest
Improving	-	403	309

Pay Spend
N/A. Target differed in previous years



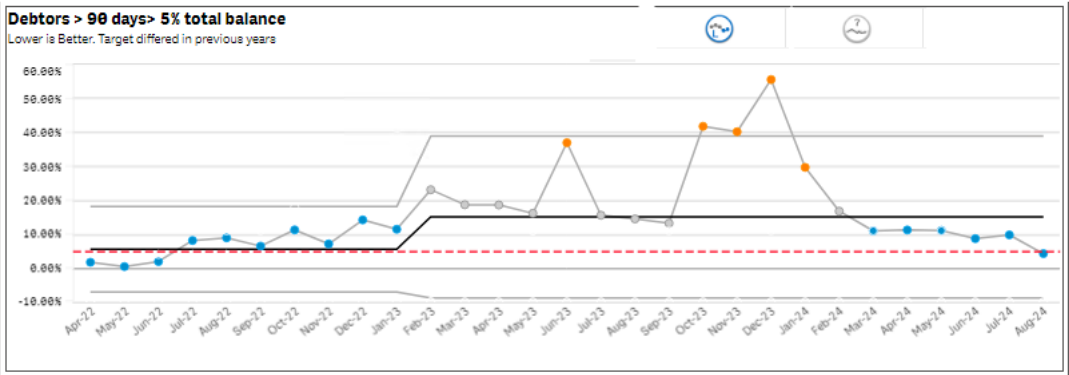
Variation	Assurance	Target	Latest
	-	17,251	16,995

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



Variation	Assurance	Target	Latest
	Fail	3,173	1,623

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



Variation	Assurance	Target	Latest
Improving	Random	5%	4.3%

Understanding the Performance:
Agency has increased in the month as the Trust has filled a number of key Corporate roles on a short term basis as part of the corporate review using agency however, the spend remains below plan.
The aged debt position has improved, with the month at £76k which was 4.26% of overall debt. The largest individual elements of debt were £40k for International Projects and £45k for University Hospitals Southampton, these were collected in August.
The CIPs year to date position now £6.7m against a plan of £8.2m.

Actions (SMART):
There is a weekly focus on the cost savings performance within the Financial Recovery Group (FRG) and key areas such as PTS have specific recovery actions in place. The PTS plan include daily monitoring of resource costs and this is reported to FRG on a weekly basis. We are starting to see the impact of this focus 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

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Report Cover Sheet

Report Title:	Quality and Safety Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	11
Executive Summary:	Work progressing against plan in all pt safety workstreams. Further improvements are required in: • Safeguarding Level 3 training currently sitting at 89% against 90% target. Target expected to be met within 4 weeks • Mental Capacity Act (MCA)Training- L1 94% & L2 93% against 95% target improving over last three months. • IPC Audits of building and vehicles – in hit and miss category. Improvement Plan in progress to improve numbers of buildings and vehicle audited. • Medicines management working towards running medicine bag packing in house by Nov 2024 as current provider will cease at that time. The PSIRF plan is undergoing its six-month review with ICB led peer reviews planed in Oct/Nov Delays in care seen as the main theme in reported patient safety incidents and declared PSII and PSLRs. Delays theme also echoed in the complaints and feedback. One complaint being reviewed by PHSO. Returns of paper-based PTS and 111 patient satisfaction surveys below required level so SMS version and digital application proposed to Transformation Board.
Recommendations:	The Trust Board is asked to note the report and data presented in the IPR and discuss.
Accountable Director:	Professor Helen Young, Chief Nursing Officer
Author:	Helen Young, Chief Nursing Officer
Previously considered at:	N/A

Purpose of Report:	Assure
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Partial
Justification of Assurance Rating:	Improvements required outlined in the paper with associated timescales
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	Not applicable
Next Steps:	Not applicable
List of Appendices	Not applicable

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PUBLIC TRUST BOARD PAPER

Title	Quality & Patient Safety Report
Author	Assistant Directors of Quality and Safety
Responsible Director	Professor Helen Young, Chief Nursing Officer
Date	September 2024

1. Purpose

The purpose of the paper is to assure and inform the Board of key issues being addressed as part of the improvement and governance of quality and safety. The Board is asked to discuss the report.

The report presents the data relating to the period July - August 2024 (unless otherwise stated), and highlights risks, issues and mitigations which are reflected in the Corporate Risk Register (CRR), Integrated Quality Performance Report (IQPR) 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

The Patient Safety Improvement workstreams include, Safeguarding, Patient Safety and Experience, Management of Medical Devices and Equipment, Medicines Management and Infection Prevention and Control (IPC). The actions overseen by the appropriate committee e.g. Patient Safety and Experience Committee (PSEC), Clinical Review Group (CRG). Safeguarding Committee and Infection Control and Prevention Committee with upward reporting to Executive Management Committee and Quality and Safety Committee.

Further improvements are required in:

- Safeguarding Level 3 training currently sitting at 89% against 90% target.
- Mental Capacity Act (MCA)Training - L1 94% & L2 93% against 95% target improving over last three months.
- IPC Audits of building and vehicles – in hit and miss category.
- Medicines management

The main **themes seen in reported patient safety incidents** in EOC (call centre), and E&UC (999) were delays. The main themes in 111 were incorrect disposition and delays, including issues with Language Line and errors in completing pt data to enable correct spine matching. The main themes in NEPTS were slips, trips, and falls and failed discharges as pts became unwell on the journey home.

The **themes of delays care were echoed in the complaints and feedback** received this month from patients and healthcare partner feedback.

The Trust is repeatedly seeing lower than required number of paper-based patient surveys for 111 and PTS being returned, and so is exploring an alternative digital option of SMS based surveys which ask patients to rate the service and experience they have received .

One case is currently being reviewed by the PHOS (Health Ombudsman).

The PSIRF plan is undergoing its six-month review with Level 3 peer review visits being organised in October and November by the ICB to assess progress and share learning.

1. Main Report

1.1 Regulatory and CQC Compliance

Pilot visits of two SCAS sites resulted in amendments being made to the Trust accreditation manual which now includes seeking staff feedback prior to a compliance visit and including an improvement tracker. The next accreditation visits are planned for October.

The Self-assessment group is a multi-disciplinary group who assess evidence gathered against the CQC quality statements. This group meets monthly providing feedback to services and EMC and identifies actions necessary to address gaps found. EMC and Q&S Committee receives a summary report on state of compliance against quality statements and more granular detail about compliance of individual services by site. EMC have confirmed whilst there still more work to do against the quality standards including well led, there is evidence of progress. Both compliance and leadership visits continue by Board (exec and NED) and our compliance team with a log of findings and actions.

1.2 Infection, Prevention and Control (IPC)

The IPC KPIs continue to be in the Hit and Miss category of the IPR as we are unable to consistently audit enough of our vehicles and buildings. This is partially due to the demand on our vehicles and their availability to be audited, but also due to some issues with the companies providing the cleaning. More vehicles have been commissioned and work to secure a second maintenance hub will improve the availability of vehicles to service the demand The contracts for cleaning and Make Ready have been reviewed and the providers are now subject to performance and monthly contract management meetings which will address failure to meet cleaning schedules.

IPC Dashboard development would assist with visibility and managing the KPI's. This has been requested and the CDO is considering the priority of this request for BI team. In the meanwhile, reports are being produced manually for services at area and node level to monitor level 1 assurance. The IPC and Compliance team are working together with operational colleagues providing level 2/peer review audit support. These visits have been increased at this time and findings shared with Head of Operations and area leads in PTS to ensure local action plans are in place.

The National Infection Prevention and Control board assurance framework (IPCBAF) is issued by NHS England for use by the organisation to enable a response utilising evidence-based approach to maintain the safety of patients, service users, staff, and

others. The framework provides an assurance for board against which the system can effectively self-assess compliance with measures set out in the National Infection Prevention and Control; Manual (NIPCM), the Health & Social Care Act 2002: code of practice on the prevention and control of infections. The current SCAS IPCBAF was presented to the IPC Committee. No areas of Non-Compliance were noted but items with partial compliance/require improvement are included in the IPC workplan.

Annual Director of Infection Prevention and Control (DIPC) report approved at IPC Committee in July 2024 and EMC in September was ratified at Quality and Safety Committee who have recommended it to September SCAS Board meeting.

1.3 Pharmacy

The Pharmacy strategy was reviewed and approved by MOGG and presented at the August Clinical Review Group. This provides detail on the ambitions of the Pharmacy service. Next step is presentation to Executive Management Committee on 24 September 2024.

Current risk in this area is ensuring that medicines bag packing service is set up in house by November 2024.The current provider has been served notice and work is underway to transfer existing staff and recruit new staff to enable this service to function effectively.

A Home Office licence is required to store and distribute Controlled Drugs. Preparation work is on track, and we await the date of visits from Home Office.

1.4 Safeguarding

Level 3 Safeguarding training compliance is now at 89 % against the 90 % target. Recovery training plan in place and we are expected to reach target within 4 weeks by training an additional 50 people. Extra training places are being made available and scheduling are cherry picking and releasing staff who currently non-compliant, to undertake the training.

User and partner testing has been completed on the revised Safeguarding referral form and we are on track to launch this by the end of September 2024. Staff members are receiving training on how to complete the form, which is expected to positively influence the quality of the forms submitted to Local Authorities enabling them to process and deal with the referrals more efficiently. The outcome of this will lead to improved safeguarding of our patients.

The Safeguarding Annual Report was approved by SG committee and EMC and then ratified at Quality and Safety Committee in September. Q&S Committee recommending it to the September SCAS Board meeting.

1.5 Mental Health and Learning Disability

The Hampshire MHRV service is being expanded from 1st October to cover 12 shifts from 10 currently, reducing the need for dispatching additional DCA. In the last month there was a 90% see, treat, and convey which is one of the highest levels seen.

The hosted MH 111 triage Service in Hampshire has a funding uplift allowing SCAS to employ more registered mental health staff to answer the phones and reduce the need to put patients back into the system.

Oliver McGowan training E-learning is 92% against a 95 %.

Learning Disability Patient Panel subgroup are currently working on easy read documents for patient information.

1.6 Clinical Incidents

a. EOC

The top three reported patient safety incident categories across both EOCs were Delay, Patient Treatment / Care, and External Feedback Request.

Governance, educational and assurance works undertaken during the reporting period includes an audit relating to the NHS England mandated Category 2 segmentation six months after the initiative was launched. No harm was found in any of the events clinically reviewed in this audit. Ongoing monitoring of incidents and Patient Experience reports which involve segmentation will continue.

EOC educational releases during the reporting period included the following topics - Accurate Documentation, How to complete a Safeguarding referral - Top Tips, and Quick Quiz Spotlight on Remote Observer Calls

b. E&UC

The top three reported categories were Patient Treatment / Care, Delay and External Feedback Request.
Delays relate to staff reporting when they have experienced a handover delay at Acute trusts when it is identified that there is queueing at Emergency Departments due to capacity issues.

c. NEPTS

The top 3 categories were Slip, trip and fall, Patient treatment/care, and Ill Health.
All reported incidents in the Slip Trip and Fall category were low/no harm. All Patient treatment/care incidents were reported as no harm. 33% of incidents were failed discharges due to patients becoming unwell during conveyance. The Data is used to inform training on moving and handling and failed discharges are reviewed with commissioners and provider partners to ensure learning is shared re assessment of patient's suitability for PTS.

d. 111

The two prevalent categories remain Patient treatment/care and Delay. Within patient treatment the main theme reported was potentially incorrect dispositions selected, which can mean patients are incorrectly assessed or delayed in getting the right care. Within the category of delay, issues with language line and errors within the patient spine matching/demographic process were identified.

A thematic review of language line incidents is being undertaken by the Patient Safety Team with recommendations taken to the CCC Clinical Governance Group. The thematic review will include potential learning for call handlers on how to work with callers for whom English is not their first language. All incidents that have been reported are of no/low harm.

1.6 Patient Safety

The six-month review of the current PSIRF plan is being undertaken by the Pt Safety team and ICB peer visits are planned in October and November.

The Patient Safety Partners Policy was approved at PSEC in August. Terms of reference for PSIRF panels were also approved and have been submitted to service line meetings for implementation.

Delay in treatment is the main theme seen in reported incidents and the main reason for most of the Patient Safety Incident Investigations and Patient Safety Learning Responses. However, the harm attributable to delay, in most 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, (6) have required benchmarking against the Delays Thematic Analysis.

1.7 Patient Experience (PE) and Engagement

The Trust received 618 PE contacts between 1st July & 31st August 2024:

- Formal Complaint – 93
- Concern – 153
- HCP Feedback - 372

Themes of Patient Experience cases remain; inappropriate disposition (NHS111), delay in/no attendance of frontline 999 and PTS vehicles.

One case is being reviewed by the PHSO. Following a challenge the PHSO decided not to uphold the complaint, but this is being re-challenged by the family. We await further update.

The trust received 249 compliments for the care and service delivered by our staff across between July & August 2024. Compliments are shared with the staff concerned and their line managers and the Head of PE is continuing work on a QI project regarding the way we record & disseminate compliments throughout the Trust.

An ongoing risk is the fluctuation in survey response rates for our NHS111 and PTS surveys. The Trust is currently non-compliant with contract target because of low response rates we have using the paper surveys. There is no financial penalty, but an improvement plan has been implemented. The PE team have presented a proposal and a business case to the Trust Transformation Board to change to SMS based surveys for NHS111 and a digital app to be used by PTS, which will increase response rates. Currently a MS Forms survey has been agreed by the Information Governance team for use.

2. Recommendations

The Board is invited to note the content of the report and discuss assurance offered.

Date: September 2024

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Report Cover Sheet

Report Title:	Chief Medical Officer's Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	26 September 2024
Agenda Item:	12
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) Report
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:	Not Applicable
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:	Not Applicable
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:	Deep dive into post ROSC Care bundle to be reviewed at CRG in October.
List of Appendices	Not Applicable

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Public Board Meeting Report

Name of Meeting	SCAS Public Board
Title	Chief Medical Officer's Update
Author	John Black Martina Brown Jane Campbell John Black
Accountable Director	John Black
Date	September 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)

2. Executive Summary

2.1. Clinical Research Update

a. Recruitment to open studies (data cut 30 August 2024): 404 *new patients have been enrolled in research studies since the last report submitted in May 2024.*

- Spinal Immobilisation Study (**SIS**): 143 patients;
- Early surveillance for type 1 diabetes in children (**ELSA**): 606 patients;
- Tranexamic acid for mild head injury in older adults (**CRASH4**): 394 patients;
- Medication route in cardiac arrest (**PARAMEDIC3**): 735 patients;
- Redirection to major stroke centre for thrombectomy treatment (**SPEEDY**): 10 patients

b. The PARAMEDIC3 trial ended the participant recruitment on 31 July 2024. It is noteworthy that the academic paper (in writing) features 4 SCAS staff as Authors and 12 as collaborators.

c. The research team has secured funding from the SCAS Charity for the acquisition of two LUCAS3 chest compression devices and supplementary batteries. These advanced resuscitation devices will be instrumental in conducting the CABARET research study and other research portfolio, enhancing our capabilities in emergency cardiac care.

d. Since the last report, SCAS staff have co-authored 2 academic articles published in peer-reviewed journals:

- Development of a centralised national AED (automated external defibrillator) network across all ambulance services in the United Kingdom
  - https://doi.org/10.1016/j.resplu.2024.100729

- Introduction of a section for recording dementia improves data capture on the ambulance electronic patient record: evidence from a regional quality improvement project.
  - https://doi.org/10.29045/14784726.2024.9.9.2.29

e. In response to the lower-than-expected flu vaccination uptake among SCAS staff during the 2023/24 campaign, which reached only 39% coverage, the research team has proposed an innovative dual-purpose messaging strategy. The proposed strategy involves implementing a combined messaging campaign that invites staff to participate in both the annual flu vaccination program and carefully selected research screening trials, offered at F2F vaccination clinics across SCAS locations. This approach aims to address two key objectives simultaneously:

- Integrated health promotion (support flu vaccination & research recruitment)
- Efficient utilization of waiting times in the vaccination ‘queue’.

This strategy seeks to maximize engagement opportunities and improve overall health outcomes for our staff while supporting valuable clinical research efforts.

f. SCAS staff made a significant impact at this year's 999 Emergency Medical Services (EMS) conference in Cambridge, featuring a key speaker on the topic of Research Rapid Response Vehicles. Additionally, two research projects led by SCAS staff have been selected for poster presentations, meeting the objectives in the Research strategy 2024-27 as highlighting our commitment to advancing knowledge and innovation in emergency medical services.

SCAS Research team will host the next year’s 999 EMS conference.

g. Two Research Steering Group members (Prof Deakin and Dr Pocock) represent SCAS at the International Liaison Committee on Resuscitation (ILCOR). Their participation contributes to ILCOR's ongoing work in various aspects of resuscitation, including Basic Life Support, Advanced Life Support, Paediatric Life Support, Neonatal Life Support, Education, Implementation and Teams and First Aid.

The upcoming ILCOR meeting in October 2024 is set to finalise the Consensus on Science and Treatment Recommendations (COSTRs) for the new global resuscitation guidelines, due for publication in 2025. This presents a valuable opportunity for SCAS to contribute to and influence international resuscitation practices. Additionally, it allows SCAS to expedite the preparation and implementation of these forthcoming changes into resuscitation practice.

2.2. Ambulance Clinical Quality Indicators (ACQI) Exception Report

The tables below show the national clinical indicators for February 2024.

ACQIs - Feb '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%	41.90%	27.61%	28.12%	28.33%	0.21%	↑	% of Cardiac Arrest patients who ROSC'd at hospital handover
% Cardiac Arrest Ustein ROSC	41.03%	75.00%	33.97%	52.47%	52.38%	-0.09%	↑	% of Utstein patients who ROSC'd at hospital handover
% Cardiac Arrest Survive At 30 Days	6.67%	14.47%	7.80%	10.25%	10.80%	0.55%	↑	% of Cardiac Arrest patients who survive to 30 days
% Cardiac Arrest Utstein Survive At 30 Days	22.92%	38.89%	15.97%	30.74%	35.00%	4.26%	↑	% of Utstein patients who survive to 30 days
% Cardiac Arrest Resus Care Bundle Achieved	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		% of Cardiac Arrest patients that received the care bundle
% STEMI Care Bundle	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		% of patients that received the care bundle
% Stroke Care Bundle Achieved	92.82%	99.61%	6.79%	97.67%	97.97%	0.30%		% of patients that received the care bundle
STEMI PPCI Mean Time CTN	139	162	23	149	144	- 5.58	↓	CTN= call to needle (minutes). Lower is better
STEMI PPCI 90Centile CTN	178	240	62	206	214	8.04	↑	Lower is better
Stroke Mean Time CTD	01:04:24	01:52:36	00:48:12	01:32:31	01:34:54	00:02:23	↑	CTD = Call to door (time). Lower is better
Stroke 50Centile CTD	01:04:00	01:35:00	00:31:00	01:21:22	01:23:00	00:01:38	↑	Lower is better
Stroke 90Centile CTD	02:04:00	02:59:00	00:55:00	02:25:11	02:15:00	00:10:11	↓	Lower is better

The chart below shows the national benchmark for the clinical indicators in February 2024.

ACQIs - Feb '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%	33.24%	41.90%	28.81%	21.51%	29.05%	24.39%	24.74%	36.17%	28.33%	26.89%
% Cardiac Arrest Ustein ROSC		58.54%	75.00%	47.92%	52.78%	50.00%	41.03%	46.15%	53.85%	52.38%	47.06%
% Cardiac Arrest Survive At 30 Days	14.29%	10.80%	12.72%	7.94%	9.06%	9.17%	7.65%	6.67%	14.47%	10.80%	9.16%
% Cardiac Arrest Utstein Survive At 30 Days		26.32%	37.50%	22.92%	38.89%	26.09%	33.33%	30.77%	26.32%	35.00%	30.30%
% Stroke Care Bundle Achieved	98.21%	96.35%	98.57%	97.92%	92.82%	97.41%	99.49%	99.61%	98.64%	97.97%	97.34%
STEMI PPCI Mean Time CTN		150	147	154	140	157	139	158	143	144	162
STEMI PPCI 90Centile CTN		203	178	208	188	240	189	228	187	214	223
Stroke Mean Time CTD	1:04:24	1:30:18	1:31:36	1:21:36	1:24:42	1:50:18	1:37:30	1:39:42	1:30:06	1:34:54	1:52:36
Stroke 50Centile CTD	1:04:00	1:21:00	1:20:00	1:15:00	1:15:00	1:35:00	1:23:00	1:26:00	1:18:00	1:23:00	1:35:00
Stroke 90Centile CTD	2:05:00	2:20:00	2:17:00	2:04:00	2:14:00	2:54:00	2:35:00	2:35:00	2:19:00	2:15:00	2:59:00
% Sepsis Care Bundle Received											
Rag key	1st	2nd	3rd	4th	If highlighted represents within upper quartile						

SCAS are third nationally for cardiac arrest Utstein survival at 30 days and fourth for cardiac arrest survival at 30 days, PPCI mean time call to needle, and stroke 90% call to door.

A deep dive is being undertaken into post-ROSC care bundle. The report will be discussed at Clinical Review Group in October.

2.3 National Quality Group updates

Updates to the ACQI technical guidance have been released. The main changes are:

- Update on the post-ROSC care bundle change with an exception added to each of the care bundle elements: 'HEMS managed onward care'. This should only be applied where clinical justification for omitting that specific care bundle element is documented within the record. This change will go live from our May 2024 care bundle data.
- The Falls care bundle has now gone live as a full ACQI. The first cycle will use June 2024 data.
- The Stroke care bundle ACQI has been retired (last data collection month was February 2024) and is to be replaced with the National Recontacts Audit.
- As a result, the ACQI submission schedule has changed.

3. Recommendations

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

John JM Black
Chief Medical Officer
September 2024

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Report Cover Sheet

Report Title:	Patient Experience Annual Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	13
Executive Summary:	The report is the Patient Experience Annual report for 2023/24 The report includes performance data from all service areas, numbers of complaints, compliments, concerns and feedback, engagement updates, patient panel, quality accounts, surveys and PHSO cases. The Board is asked to note: 1. A 6% increase in complaints, concerns and healthcare professional feedback received during 2023-24. 2. The number of complaints, concerns and HCP feedback remained less than 1 tenth of a percent (0.07%) when compared with our total service demand. 3. SCAS received four Parliamentary and Health Service Ombudsman requests for a review in 2023/24. 4. The Trust received 1493 Compliments for our staff an volunteers which were shared with them and their leadership teams. 5. The top two subject categories are Delay in arrival of PTS Vehicle and Inappropriate Care Pathway (111 & 999). **Notable practice:** 1. 98% rate of response to our contacts within the required timeframes. 2. Patient Panel has been set up and meetings are continuing monthly. 3. Only 4 cases reviewed by PHSO in 2023/24 – testament to the thorough investigations completed. **Next steps:** 1. Further increase in communication with Complainants to keep them updated with the progress of their investigation. 2. Continued monitoring of patient experience issues, themes and learning through Patient Safety & Experience Committee.

Recommendations:	**The Board are asked to note the annual report**
Accountable Director:	Professor Helen Young, Chief Nursing Officer
Author:	Caroline Whitworth, Head of Patient Experience
Previously considered at:	Patient Safety and Experience Committee Quality and Safety Committee
Purpose of Report:	Note
Paper Status:	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)	All Quality Domains
Next Steps:	Not Applicable
List of Appendices	Nil

South Central Ambulance Service
NHS Foundation Trust

Patient Experience Annual Report

1st April 2023 - 31st March 2024

Author: Caroline Whitworth, Head of Patient Experience

Date: July 2024

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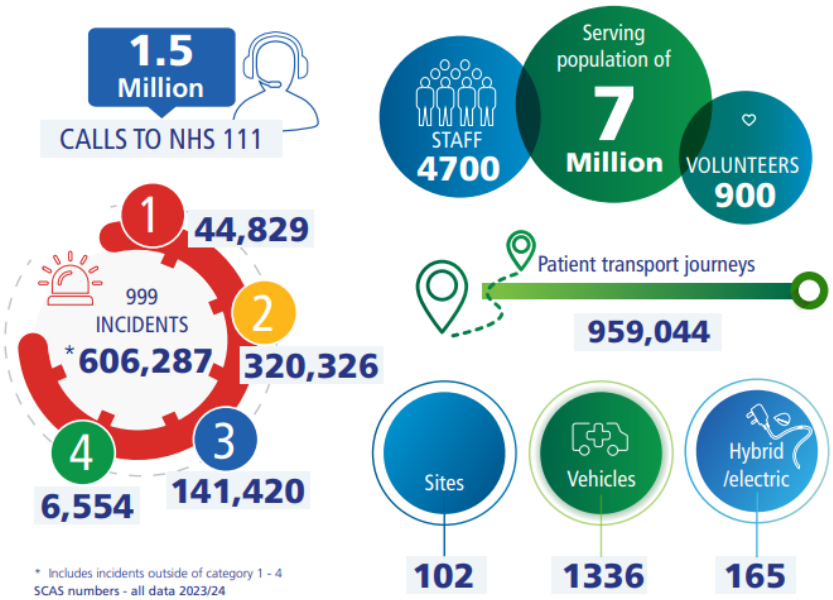
Contents

Introduction

South Central Ambulance Service NHS Foundation Trust was formed on 1 July 2006. We employ 4,700 staff who, together with over 900 volunteers, enable us to operate 24 hours a day, seven days a week.

What we do:
• Receive and respond to 999 calls using resources including: community first and co-responders, rapid response vehicles, ambulances, and air ambulances
• Provide the NHS 111 services for the Thames Valley and for Hampshire
• Provide non-emergency Patient Transport Services across six counties including Surrey and Sussex
• Provide a logistics service for NHS partners across Oxfordshire SCAS is the monopoly provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas). All other services the Trust delivers are tendered for on a competitive basis.



Executive Summary

At South Central Ambulance Service NHS Foundation Trust (SCAS) we welcome feedback from our patients, their families and representatives and healthcare professional colleagues.

The Trust reports an increase in the number of complaints, concerns and healthcare professional (HCP) feedback received during 2023-24, up 6% from those raised during the previous year. Demand pressures remained high throughout the year, as was the case across all areas of the NHS. The number of complaints, concerns and HCP feedback remained less than 1 tenth of a percent (0.07%) when compared with our total service demand.

SCAS received four Parliamentary and Health Service Ombudsman requests for a review in 2023/24. This demonstrates the diligent work of our investigators, report writers and Patient Experience Team to ensure anyone sharing feedback receives a comprehensive, open and honest response to the issues raised.

Engagement and survey work continued throughout the year with many opportunities for our team to engage with communities in person.

This year we achieved a 98% rate of response to our contacts within the required timeframes.

The collaborative approach between the Patient Experience Team and colleagues within SCAS to complaints, clinical incidents, safeguarding referrals, coroners' cases, and legal claims, continued to develop and mature to ensure that the patient voice is represented, and engagement with service users and their families is central to Trust processes.

The Head of Patient Experience and the Patient Experience Team continued to drive further improvement in complaints performance with close ongoing management of cases and improved communication, support, and delivery of patient experience investigations training across all service areas of the Trust. This improvement work, which places patient experience at the center of our processes and decision making, will continue in 2024/25.

Patient Experience Cases received.

SCAS has a commitment and statutory requirement to respond to the Complaints, Concerns and Healthcare Professional Feedback it receives, from any source, seriously and in a timely way, in line with NHS Complaints policy and Trust Patient Experience Policy.

The number of Patient Experience issues raised when compared with service activity across the Trust remains at less than a tenth of 1% of contacts. SCAS welcomes this feedback and we continue to work in partnership with our patients, their representatives, the public and healthcare professionals to learn from their experiences. Patient feedback is used to inform our improvement activities and examples are included in the learning section.

PE Contacts received 2034/2024

Complaints, Concerns and Healthcare Professional (HCP) feedback	**3929**
Compliments	**1493**
Total PE Contacts received	**5422**

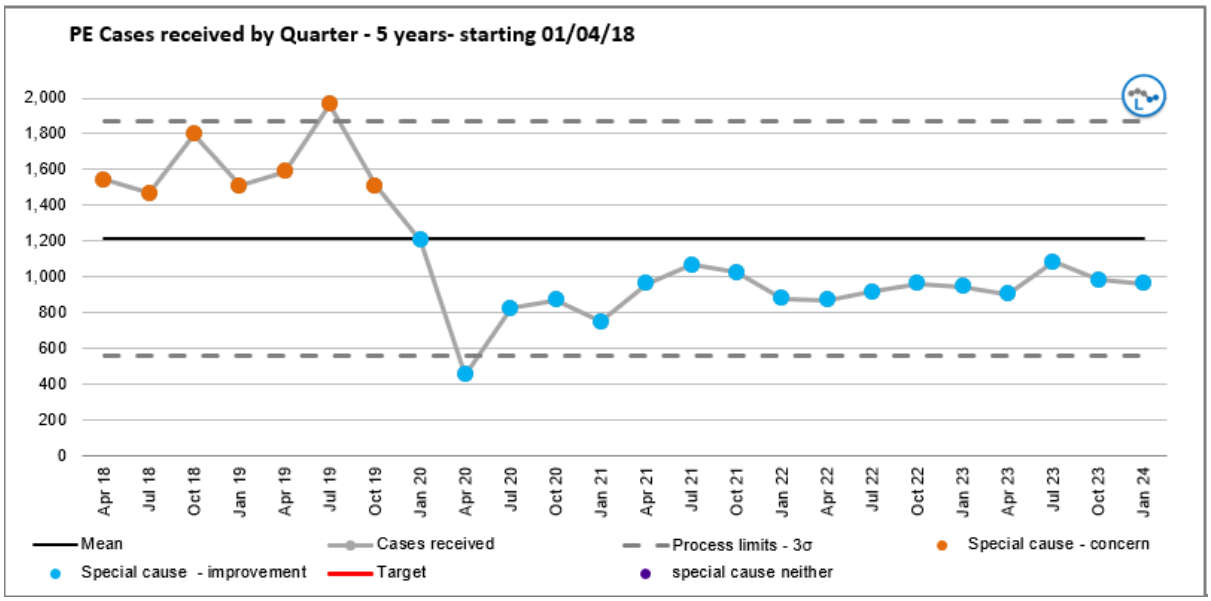
PE Contacts received 2023/2024 by Service Area

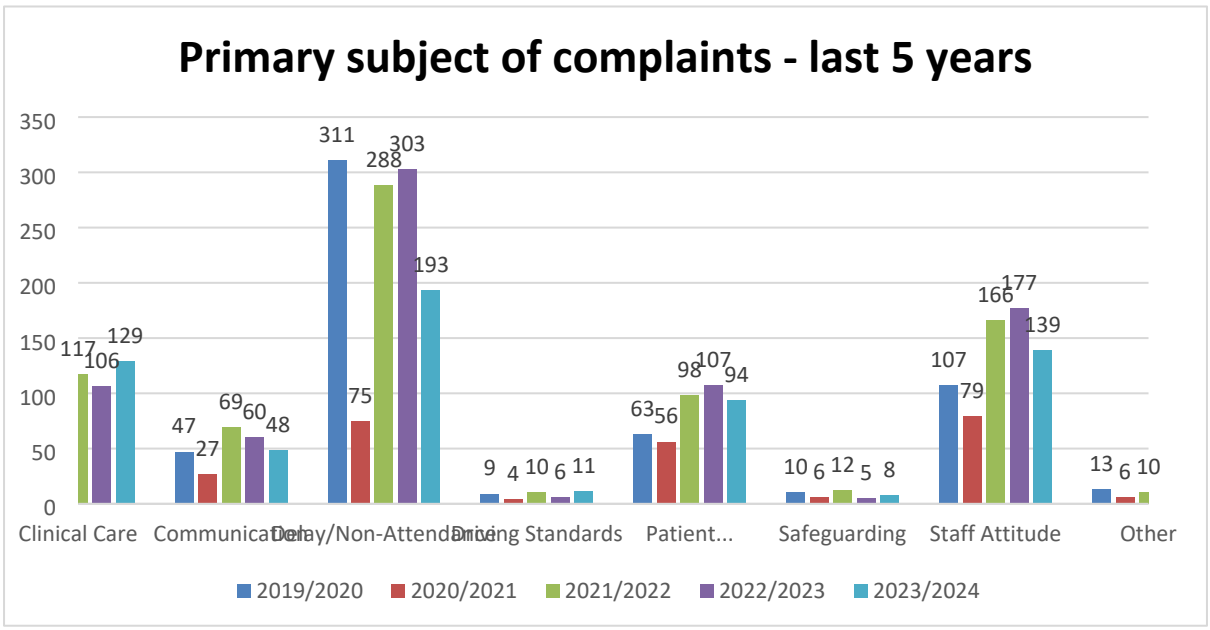
2023-2024	Complaints	Concerns	HCP	PE Total	Demand	%*
NHS111*	100	127	511	738	1,330,861	0.04%
999 Operations	196	160	353	709	556,761	0.14%
EOC*	97	102	171	370	1,035,389	0.03%
Other/Admin	0	2	10	12	n/a	n/a
NEPTS	241	566	1293	2100	588,795	0.15%
Trust Total	634	957	2338	3929	4,700,535	0.07%

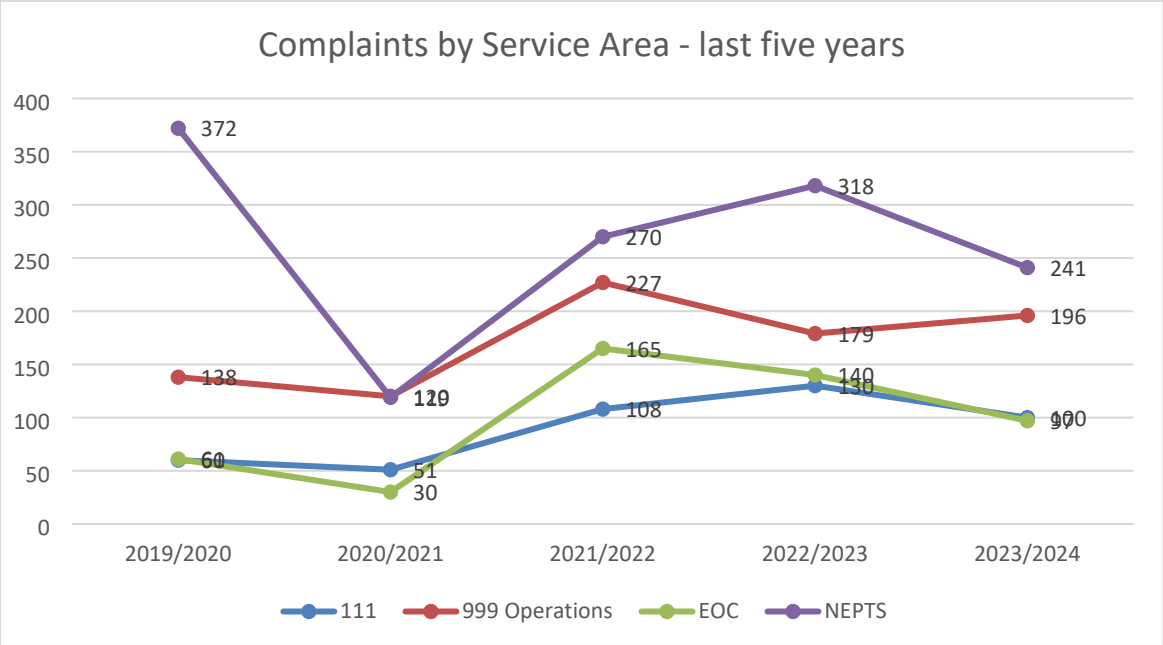
*NHS111 includes the Mental Health Triage Service

Patient Experience Cases received – Last 5 years.

The chart below shows special cause improving variation. The number of cases we received dipped significantly during the pandemic and although there has been an increase, we have not reached pre-pandemic levels.

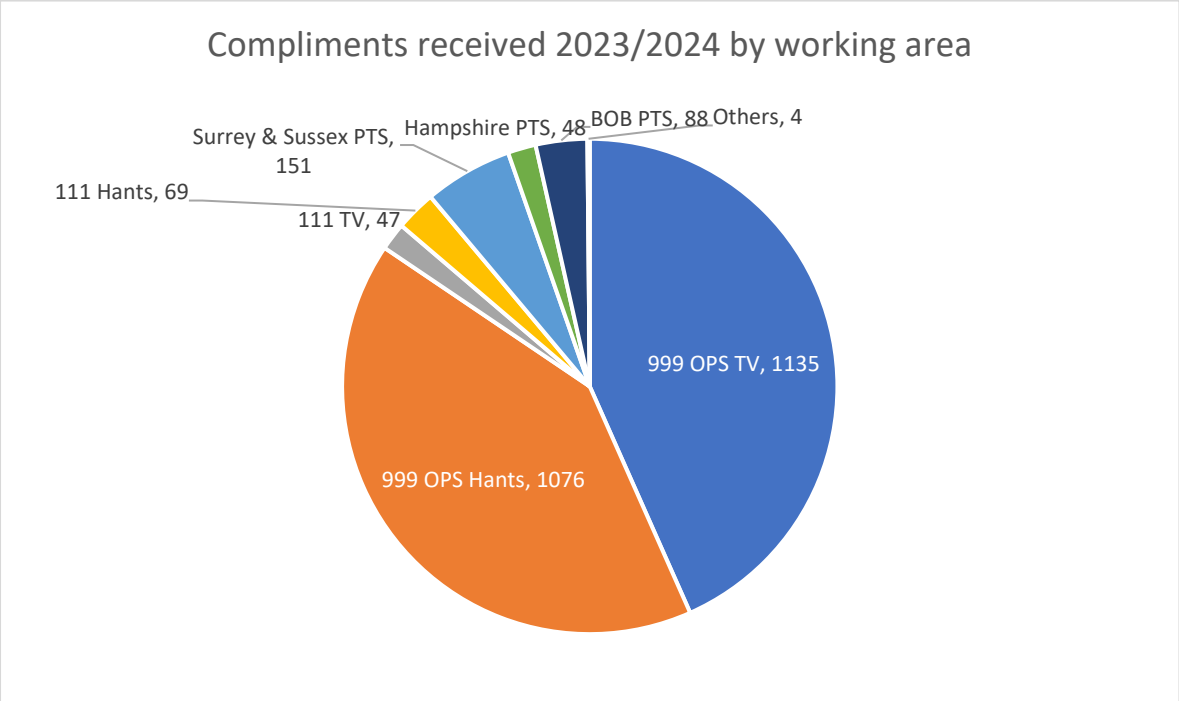






Compliments

In 2023/24 the Trust received 1493 compliments for our staff and volunteers. Below is a chart to show the number by division and area. Please note the 999 OPS includes CFR's/HART/ Basics.



The key themes that we have gathered from compliments are;

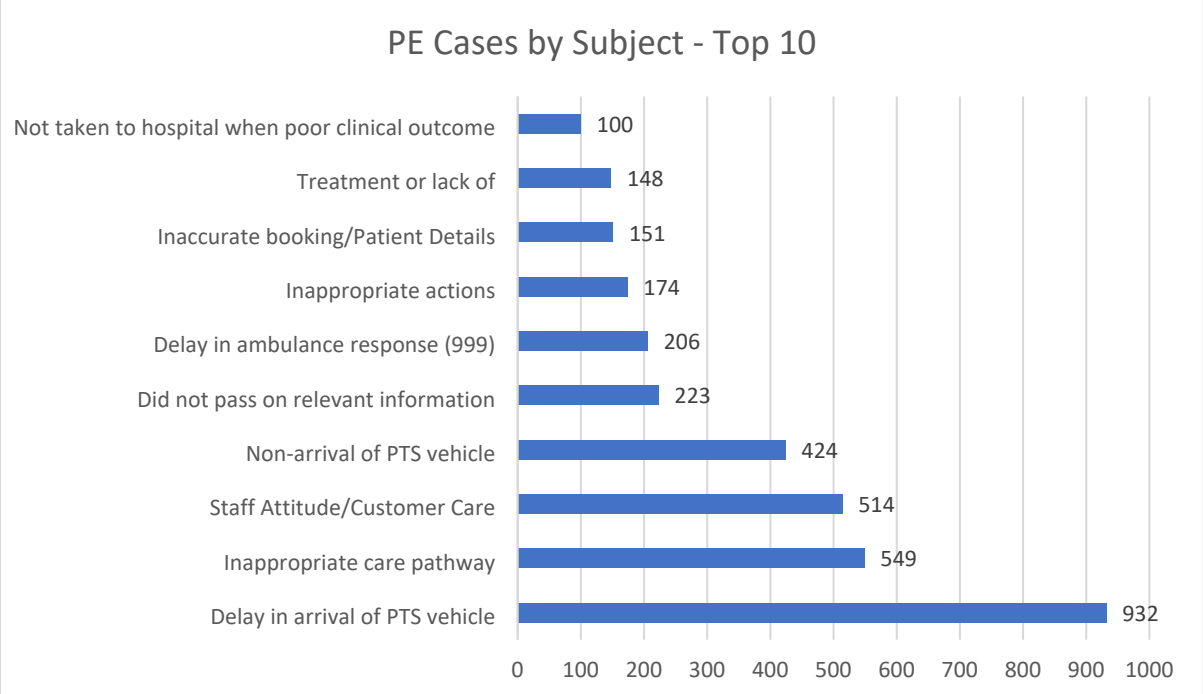
- Kind and compassionate staff who recognise that for the patient and family having an ambulance attend them is a worrying and traumatic time.
- Fast attendance when ambulance is required.
- Helpful, clear instructions and guidance from 111 & 999 call handlers
- Crew treating End of Life patients with dignity and care

Compliments sent to the Patient Experience Team are logged and disseminated to the leadership team of each working area to pass on to their staff.

Learning from Patient Experience

The Trusts mission is to deliver the right care, first time, every time. Recognising and learning from occasions where patients or members of the public may have had a poor experience is important to ensure that lessons are learned, and steps are taken to avoid a reoccurrence.

The Key themes for Patient Experience cases received in 2023/2024 were;



- Delay/ non-arrival of PTS Vehicle – This has been on the improvement work plan. It has been identified that poor or lack of communication is a large

contributing factor. A working Group has been set up to look into the root causes of this and improve this for our patients and service users.

- Inappropriate disposition (111) – The operational leads and Clinical Governance team continue to complete end to end reviews with the largest providers of HCPF regarding inappropriate referrals. These services are gaining a better understanding of NHS Pathways and the importance of their Directory of Services being appropriate and up to date. Where cases are found to have non-compliant audits, individual feedback to staff and support is provided.

- Concerns from HCP's regarding EOL transfers - One of our current themes from hospices is around SCAS's ability to meet expectations for End of Life Transfers. A meeting was between our Clinical Governance Team, BOB ICB, and the management from the Hospices to discuss these issues and to underline the services we are able to provide. In addition to this communication was sent to our external stakeholders regarding booking the appropriate level of service for each scenario.

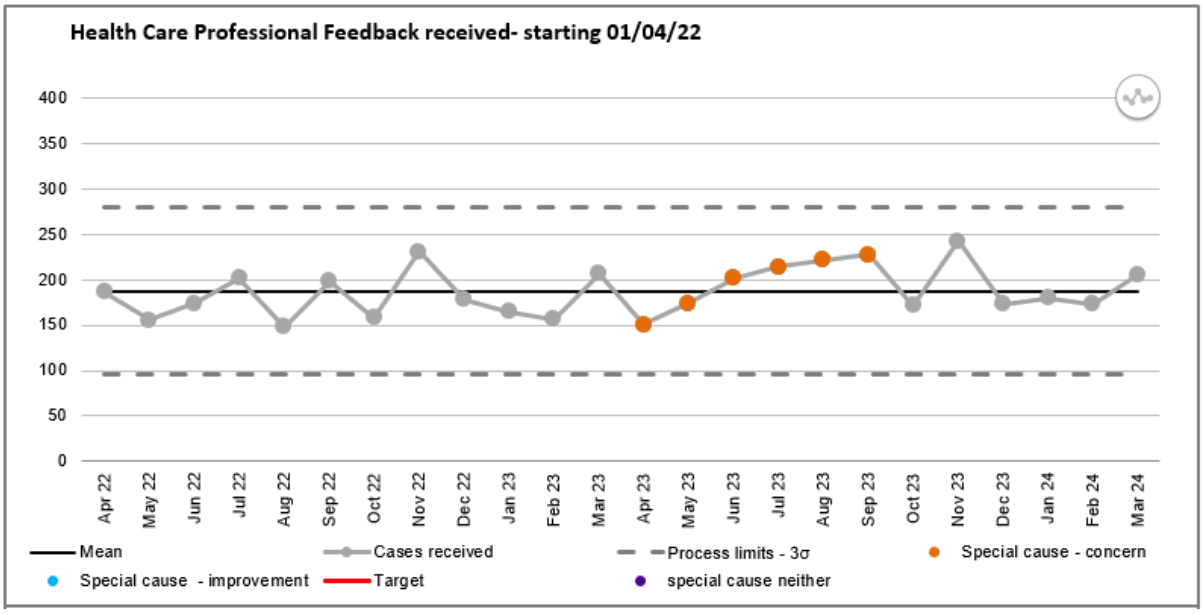
- CPR protocol when a patient has died (EOC)

Health Care Professional Feedback

The highest proportion of patient experience issues received continue to be feedback raised by healthcare professionals and remains at 59% of patient experience contacts.

The trust encourages healthcare professionals to continue raising their concerns with us, in order for any relevant learning to be implemented.

The SPC chart below demonstrates the number of Health Care professional feedback received over the last year. The chart shows common cause variation, that the numbers received were within expected limits. There was an area of special cause concern from April 2023- September 2023 where the numbers were rising.



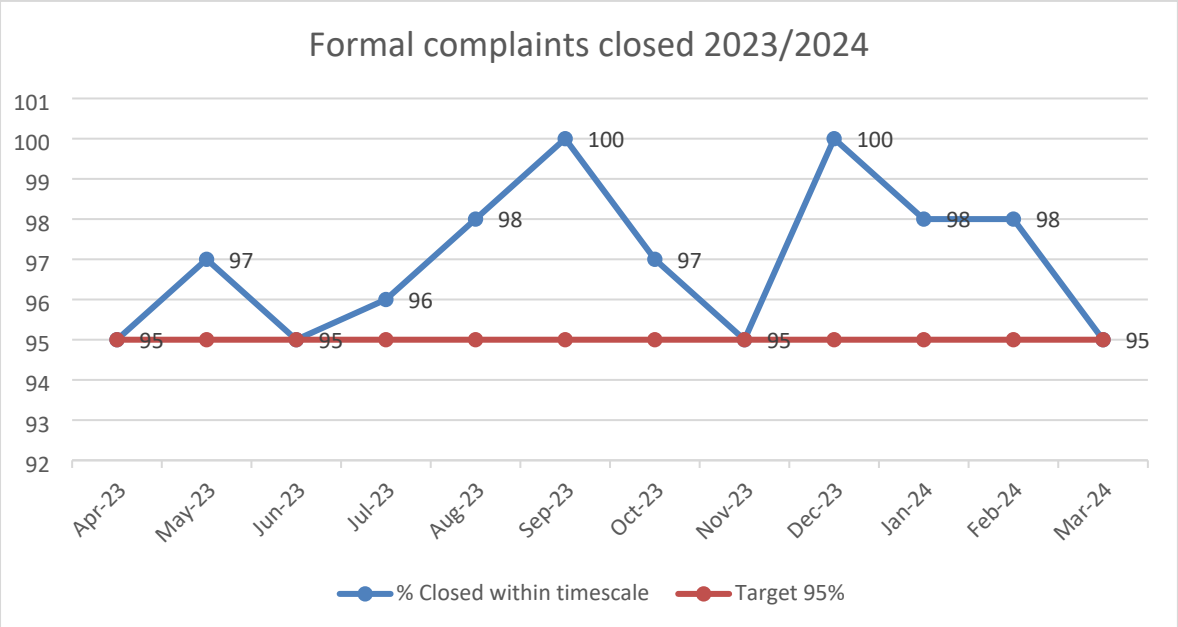
The occasional spiking of numbers of HCPF is a number of Trusts that provide the feedback in batches. This has been discussed with the Trusts and our ICB colleagues.

HCPF cases are reviewed at each service's Daily Critical Review by the Patient Safety/Clinical Governance and Patient Experience Teams. This ensures that any concerns relating to Patient Safety are explored fully and if required the case will be discussed at Safety Review Panel.

Acknowledgement & Response Performance

The Patient Experience Team achieved a performance rate of 99.2% across 2023/24, with 629 out of 734 complaints acknowledged within 3 days of receipt in accordance with the NHS regulatory timescale.

The following chart details complaints closed within 25 working days of receipt, or within an agreed extended timescale:



The target or above has been achieved for every month of the year as a result of processes designed and embedded by HoPE, good teamwork by the Patient Experience Team, additional temporary resourcing in the Patient Experience Team, along with collaborative working between the Patient Experience Team and Investigating Officers across all service areas.

Quality Accounts

The Quality Accounts priorities identified for 2023/24 for Patient Experience were:

3a.	Establish a patient panel

Please see section on Patient Panel on page 12.

3b.	Survey of NEPTS patients undergoing chemotherapy and radiotherapy – aborted journeys – impact on experience and treatment.

During Q2 and Q3 2023-24 NEPTS conducted a telephone survey of patients undergoing chemotherapy and radiotherapy who had a failed journey to look at the impact on their experience and treatment. This survey covered all NEPTS contracts excluding logistics.

142 responses were received.

1 patient reported missing their treatment due to transport not arriving.
The overall level of experience for NEPTS was good with 105 patients stating their experience being very good or good.
Of the 142 responses 89 patients travelled more than once a week.

The main themes identified were -

- Delays in collection post treatment
- Lack of this provision would mean many patients are unable to get to their treatment as the treatment centres as far away.
- High levels of satisfaction for the crews
- Negative comments around call wait times to enquire about estimated time of arrivals.

Many patients told us that we could have done better by

- Being on time.
- Improving comfort in vehicles
- Informing them if transport is going to be late.

The PTS team are replacing old fleet as many of the vehicles were from an aging fleet. Patient delays are being reviewed by the continuous improvement team. A working group has been set up to review feedback relating to delays where communication has been the biggest contributor to poor experience.

Training

The Patient Experience Team continued to review and improve patient experience processes and working practices throughout 2023/24. The Patient Experience Team worked collaboratively with all service areas to improve quality and timeliness, evidenced by the performance achieved this year.

The Patient Experience Team delivered virtual training sessions trust-wide across all service areas to approximately 95 investigating officers, to improve the quality and competency of complaint management, effective writing of complaint responses, and enhanced Datix use. The sessions were well received and help us to manage timeliness of responses to our patients. The Patient Experience Team also provided support to individuals on a 1:1 basis where required or requested. These activities were well received and will continue into 2024/25.

Patient Experience Investigation Guidance Notes for Investigating managers was widely promoted by the Patient Experience Team and is available to all Investigating managers via the Trust's intranet. The guidance includes support and advice for managing a patient experience investigation along with setting out the Trust's requirement for quality and timeliness.

Patient Engagement

Several events over the year have been held, including visits to community groups and third sector organisations and coordinated larger emergency service days. Staff volunteer to attend events and are supported by SCAS community first responders, in collaboration with SCAS charity, as well as Recruitment, Patient Experience and our Learning Disability Specialist.

A key focus of these events has been tackling health inequalities and therefore the engagement events carried out by the Patient Experience Team have focused on underserved communities.

Patient Panel

SCAS officially launched the Patient Panel with the first inaugural meeting on 21st February 2024.

The panel offers patients, family members or carers of patients who have used SCAS services the opportunity to gain insight and have a say on service developments and improvements, including across our 999 emergency services (both call centre and operationally), Non-Emergency Patient Transport Service (NEPTS) and NHS 111.

The level of participation required to be on the panel is flexible, meaning volunteers can get involved in a way that suits them to discuss issues, as well as share views on specific areas of interest, including the design, development and delivery of Trust services.

Surveys

SCAS has an annual survey plan which was reported through the Patient Experience Review Group (PERG) at the beginning of the year. NHS111 patient satisfaction surveys and Complaint Satisfaction surveys have been issued by the PE Team during 2023/24.

The plan of satisfaction surveys is updated as the year develops to ensure that new initiatives and contracts are surveyed. Outcomes of satisfaction surveys were a standing agenda item for PERG and will continue into the future at Patient Safety and Experience, offering us additional valuable insights into our patient and service user experiences.

Emergency and non-emergency survey including 111

Through the Trust's website, SCAS continues to invite service users to submit their feedback by completing our online patient feedback survey. Respondents to our online survey are encouraged to tell us about their experience of the 999 service, NHS111 and NEPTS. Feedback regarding how the call was handled, the advice and care given by ambulance staff is sort, and we invite respondents to comment on what would have made their experience better. SCAS offer free-text boxes for respondents to provide narrative comments which gives us greater insight into what has gone well and what can be improved.

NHS111 Surveys

The 2023/24 plan for NHS111 was to undertake patient surveys monthly for each contract during 2023/24. A random sample of service users were selected each month. Our aim is to issue 4800 surveys. Samples were taken from service users and included the national minimum data set of questions, asking specific questions on patient satisfaction.

The results received from NHS111 surveys are reported and shared via PERG (now PSEC) and with Commissioners and demonstrate that the vast majority of service users are very satisfied with the service and advice they received from SCAS.
In an effort to improve the response rate of our surveys we are continuing to investigate digital engagement options for survey completion, such as by text message whilst also increasing the number of surveys issued in the next year.

Friends and Family Test (FFT)

This been available to all patients to comment on their experience of care and treatment.
The FFT is made up of a single mandatory default question - *"Overall, how was your experience of our service?"*

This is followed by at least one open free-text question, so that people can tell us what they want us to know in their own words.

Since 2020/21, to report on FFT in its current format for staff and patients (in all services) and to continue to seek feedback and act on results, we have included the FFT question as the first question in NHS111 patient experience surveys, NEPTS patient satisfaction surveys, in the complaint's satisfaction survey and in our online survey. FFT response rates for NEPTS continue to be uploaded regularly to UNIFY2 and six-monthly for NHS111.

Complainant Satisfaction Survey

To help us monitor the effectiveness of our complaints process, SCAS regularly seeks feedback from complainants who have raised formal issues for investigation. This valuable feedback is used to review and improve the Trust's complaints process and evaluate if the process is meeting the needs of service users. Additionally, it is a contract requirement for the Trust to periodically seek formal feedback from complainants regarding their experience of the Trust's complaints process.

This is a Trust wide survey. The survey information is provided on bottom of the complaint response letter. This offers the complainant two ways to complete the survey; they can either complete the survey online using the weblink provided on the complaint response letter or they contact the Patient Experience Team via telephone and a member of the team will assist the complainant by completing the survey online for the complainant by noting the feedback provided by the complainant during the call.

73 surveys responses were received. Of the 73 responses received, levels of satisfaction with the complaints process has decreased.

- 58% told us they felt it was easy to raise their complaint.
- 25% told us they received contact from the Investigating Officer appointed to review their complaint (either by telephone or face to face meeting).
- 37% told us we kept them updated sufficiently regarding the process of the investigation.
- 62% told us the outcome of their complaint was explained in a way they could understand.
- 41% told us they felt that the response received addressed all of the points raised in their complaint, of which 64% told us they did inform us of the points they felt were not answered.
- 31% said they were either very satisfied or fairly satisfied with the outcome of their complaint.
- 33% told us that overall they were very satisfied or fairly satisfied with the complaints process.
- 50% told us they would be confident to raise a complaint against the Trust in the future.
- 31% answered that they had received an explanation of how their complaint would be used to improve services.
- 78% of respondents understood how to take their complaints further if they were not completely satisfied with the outcome.

We are continuing to work with our Collation of Facts Managers to explain and demonstrate the importance of early communication and explaining the outcome of their investigation to the complainant before they receive the response letter. It is clear from feedback that this is more satisfactory for the complainant and gives them a chance to discuss the outcome of the investigation and also gives the complainant an

opportunity to clarify any outcome details they may not understand with the Investigating Officer directly prior to receiving the outcome letter.

1. Parliamentary & Health Service Ombudsman (PHSO)

During 2023/24, 4 cases were referred to the Parliamentary Health Service Ombudsman (PHSO), which was a decrease on the 7 cases referred in 2022/32.

Of these 4 cases:

1) Complaint regarding clinical treatment provided to patient. The complaint file was sent but the PHSO advised they would not be investigating this complaint.

2) Historical complaint from 2021 regarding care provided to patient following an RTC. This remains under investigation by PHSO.

3) Complaint regarding concern of appropriateness of safeguarding referral completed. SCAS investigation found safeguarding referral to be appropriate. Informed by PHSO September 2023 that they will not be investigating this complaint.

4) Complaint regarding non-conveyance of patient who sadly later died. Complaint not upheld following SCAS investigation as crew assessment & clinical pathway was found to be appropriate. PHSO informed us in November 2023 that they would not be completing an investigation.

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Report Cover Sheet

Report Title:	Safeguarding Annual Report 2023/24
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	14
Executive Summary:	***To Note*** *– Some areas in the report that will have progressed or completed as the reporting period end date is 31 March 2024.* The purpose of the Annual Report is to provide safeguarding activity, risks, mitigations, achievements, and priorities for 2024/25. **Top 3 Challenges in Year** 1. Development of the Safeguarding Digital Referral System 2. Frequent outages of safeguarding referrals system for differing reasons (outlined in 6.4) 3. Improvement Journey Regulation Activity Despite the challenges described above, the Safeguarding Service has exceeded or maintained the metrics set as part of the Improvement journey. There has been a positive Peer Review in year, an increased training performance for SGL3 at year end of 84% (an increase on the previous year from 63,2%), all other safeguarding training levels are above target including PREVENT, Learning Disability and MCA Training. Prior to this year, there had been no formal safeguarding supervision programme. It is now embedded for all front-line staff and an MCA audit cycle which gives SCAS a clear description of what is required to ensure this is fully understood by our clinicians. External acknowledgement of the improvements made by positive feedback from ICB and NHSE Colleagues and latterly a marked improvement communicated by the Local Authorities on the quality of Front-Line safeguarding referrals. Quality Visits/peer reviews and audit activity triangulated the assurance. The Team was awarded a National Safeguarding Award from NHSE marking a national acknowledgment or the improvements made. Areas of improvement for the coming year:

	• The Launch of the new safeguarding referral form • The ability to sustain and improve safeguarding level 3 training • The Team itself will require a review due to the increase in activity in referrals (60% increase), the change in focus of the team (digital processes) and the increase in the level and focus on safeguarding and Prevent. • Allegation Management is an area of marked improvement but will require the same level of rigour to protect our staff and patients from risk associated with potential perpetrators.
Recommendations:	The Trust Board is asked to note the report.
Accountable Director:	Helen Young, Chief Nursing Officer Craig Ellis, Chief Digital Officer
Author:	Sarah Thompson, AD Safeguarding
Previously considered at:	Quality & Safety Committee 18.09.2024 Safeguarding Committee 8.09.2024 EMC September 2024
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**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:	N/A

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Safeguarding Annual Report 2023 / 2024

Final Version

24 July 2024

1. Introduction

1.1 South Central Ambulance Service (SCAS) within its corporate duty of care to patients has a responsibility to safeguard those who are vulnerable, based on legislation for both Children and Adults.

1.2 It is a statutory requirement to present an Annual Report to the Quality and Safety Committee and Trust Board which demonstrates how the Trust has met its safeguarding responsibilities in line with Working Together to Safeguard Children (H.M. Government 2020) as well as confirming compliance with The Children Act 2004.

1.3 In addition, The Care Act 2014 sets out statutory responsibility for the integration of care and support between Health and the Local Authority in the field of safeguarding adults.

1.4 The external strategic drivers such as CQC, policy and legal changes, government leadership and the priorities of the aligned Safeguarding Boards will always shape the direction of travel and will provide focus for the coming year. The most notable are highlighted below:

- CQC Inspection November 2021 – specific focus on Safeguarding
- CQC Inspection April/May 2022 – focus well lead inspection
- Peer Review/Quality Visits completed by representatives of Integrated Care Boards (ICB's) 5 November 2023
- Continued ICB/ NHS England/Care Quality Commission (CQC) Scrutiny Group
- Actions from Historical Serious Incidents related to Safeguarding
- Actions from Serious Case Reviews with significance to SCAS.

1.5 As well as the external drivers there have been some significant internal changes that have had an impact on the Service.

These include:

- The Improvement Workplan resulting from the CQC inspections
- The Continued challenge of the ICT Referral System and the impact this has on Business as usual for all workstreams.

1.6 The Top 3 challenges in year were:

- Development of the Safeguarding Digital Referral System
- Frequent outages of safeguarding referrals system for differing reasons
- Improvement Journey Scrutiny

1.7 The Top 3 achievements were: Top 3 Achievements in Year

- Metrics associated with Improvement Journey/Successful Peer Review
- Training compliance all areas (excluding SGL3)
- Commencement and embedding of Supervision.

1.8 The most challenging area for the coming year will be:

- The change in Leadership due to retirement of the Associate Director Safeguarding.
- The ability to continue to train staff at all levels to maintain compliance.

- The output of the Task and Finish Group to ensure the launch of the new referral form.

1.9 The ability to benchmark with the 12 other ambulance trusts this year is not possible due to the limited access to a full dataset. Data set is only available from April 1, 2023, to November 2023.

2. Safeguarding Governance/Accountability Arrangements

2.1 The Chief Nurse is the accountable Executive Director for safeguarding of vulnerable groups including children and adults at risk. This enables the Trust to fulfil its functions in partnership with others and secure effective operation of LSCP/SAB functions and ensuring the organisation is effectively engaged.

2.2 In addition, the Associate Director Safeguarding provides a safeguarding report to Quality and Safety Committee, the Safeguarding Committee, and the Trust Board. This provides safeguarding activity information to these groups, detailing progress against legislation, workstreams, safeguarding risks, good practice, and Trust safeguarding activity.

2.3 The Quality and Safety Committee, Trust Board and the Safeguarding Committee is just one vehicle to assess performance of the Safeguarding Service.

2.4 Due to the nature of the safeguarding 'business' there are many medians used to assess performance which are monitored by outside bodies such as the Care Quality Commission (CQC), the Integrated Care Boards (ICBs) and Safeguarding Boards. These bodies provide external scrutiny and governance.

2.5 All Local Safeguarding Children Boards and Safeguarding Adult Boards (LSCBs and SABs) require a yearly 'Section 11' audit or equivalent. This is an annual audit which assures the Safeguarding Boards as to whether an organisation has met its duty to safeguard.

2.6 In addition to Section 11 Audit, there have been an additional 4 audits undertaken during the year. The programme of Audit was not as anticipated due to the level of work associated with RAG rating due to safeguarding system failures. The RAG rating of cases did provide a form of audit as it provided a level of focus and quality assurance. The RAG Rating exercises are set in Bold for differentiation.

- April 2023 – review of 25 Cases related to Non-Mobile Baby Protocol led to the embedding of the Bruising Protocol for 111 and 999 Directives.
- **April 2023 (restored on 10.10.2023) Operation Avocet Cyber Attack resulting in paper referrals which were delayed leading to risk assessment by Safeguarding Service. – SI involved RAG rating of Referrals.**
- May 2023 – review of 8 Cases with Slough Safeguarding Adult Board. Led to learning with Operational Managers.
- July 2023 – Section 11 Audit HIPS via Panel. Supported Improvement Journey.
- August 2023 – Review of Adult Referrals to determine if any child/children considered as part of Domestic Abuse. CCC Safeguarding training material updated to specifically highlight to staff that two separate referrals should be made.
- **September 2023 – Backlog log scanned referrals discovered (400). RAG Rating took place.**
- **November 2022 to November 2023 – repeated outages due to unstable server**

(example - 15 outages in a 3-day period between 20.9.23 and 26.9.23)

- **30 November 2023 to 18 December 2023 – cutover to new server caused delayed referrals of 19 days. Risk Assessment by Safeguarding Service.**
- March 2024 – audit of 142 Adult Safeguarding Referrals to review appropriateness of the SCAS referral to MASH. Supported new form delivery.

The progress of these is monitored via the Safeguarding Committee and actioned in the Clinical Governance Lead meetings.

2.7 In financial year 2023-2024 there were 3 SIs declared in relation to the Safeguarding Service.

Datix 66897 StEIS - 2023/17865 – The incident occurred on 13/09/2023 declared on StEIS on 22/09/2023. In July 2023, Ortivus, the Trusts electronic patient record service provider was subject of a cyber-attack, and this resulted in a complete loss of the trust ePR system.

The loss of EPCR meant ambulance crews switched to completing manual paper referrals. This also meant the safeguarding process which was digital and had data fed into it from the ePCR had to change in the interim and a process was circulated to all staff.

The trust published an interim process which was circulated through communications and the safeguarding team contacted every single on call bronze to notify them of the change for verbal confirmation and cascade.

Despite this it became apparent that 764 referrals had not been put on the referral system by a team leader or the safeguarding team. This is believed to be because crews had been submitting them with the paperwork at the end of the shift without informing anyone and expecting them to be found, scanned, and sent.

There were 5 actions from this SI – status as below:

Actions:

2.7.1 For 'Post Boxes' to be kept in the running store area to ensure consistency of location and security.
Update - This action has been completed.

2.7.2 Effective communication with staff, via a number of portals to establish understand when EPR/critical systems become compromised and to share the learning following the recent outage.

Update – All staff were reminded about their role in completing paper referrals via the on-call bronze teams and via an Operations bulletin on April 19, 2024. This action is completed.

2.7.3 Following completion of AAR identify key learning and messages to share via an upward report to Executive team, key stakeholders, safeguarding teams, and external providers including ICB, GP and relevant community-based teams.

Update: At time of report, this remains outstanding

2.7.4 To identify a solution to allow for scanning at key resource hubs, to facilitate the ability to scan, record and store clinical records during an outage. Review if the current printer estate could be used to provide scanning as they do that, this would not require additional hardware or training. other options which could be include could be using the scanner option on iPads.
Update: Discussions have taken place regarding the Trust's printer estate, the main printers all have

the scanning option, need to test resource machines, to see if they would meet the requirements, and what costs would be if needed to upgrade them.

2.7.5 Business Continuity Manager to work with key departments to design a tabletop exercise to facilitate and establish Business Continuity Plan around EPR/critical systems outages for a protracted period, establishing effective communication with key staff.

Update – Training of all appropriately responsible staff across SCAS that require the licence to use the software to enable a business continuity plan for their area to be designed and established. This action can be closed once confirmation is received that the BC plan for ePR outages has been signed off. The Safeguarding Service has commenced documentation of the Business Continuity of Paper Referrals.

Datix 69662 StEIS 2023/22836 – 28/12/2023

The issue was identified by Safeguarding Support Officer on the afternoon of the 18.12.2023 when it became apparent there were over 1000 referrals in the 'unsent' items within the traffic light system. this was escalated to Docworks via the service desk @15.07.

It transpired that there have been no Ortivus safeguarding referrals sent since the transfer to the new server on the 29.11.2023.

The initial report from Docworks stated that there were 1377 referrals sent once the issue had been identified on 18.12.2023. of these there are 744 were duplicates, with 633 actual referrals.

This SI is not yet complete as it has a stop the clock due to a police investigation in relation to a potential DV Homicide

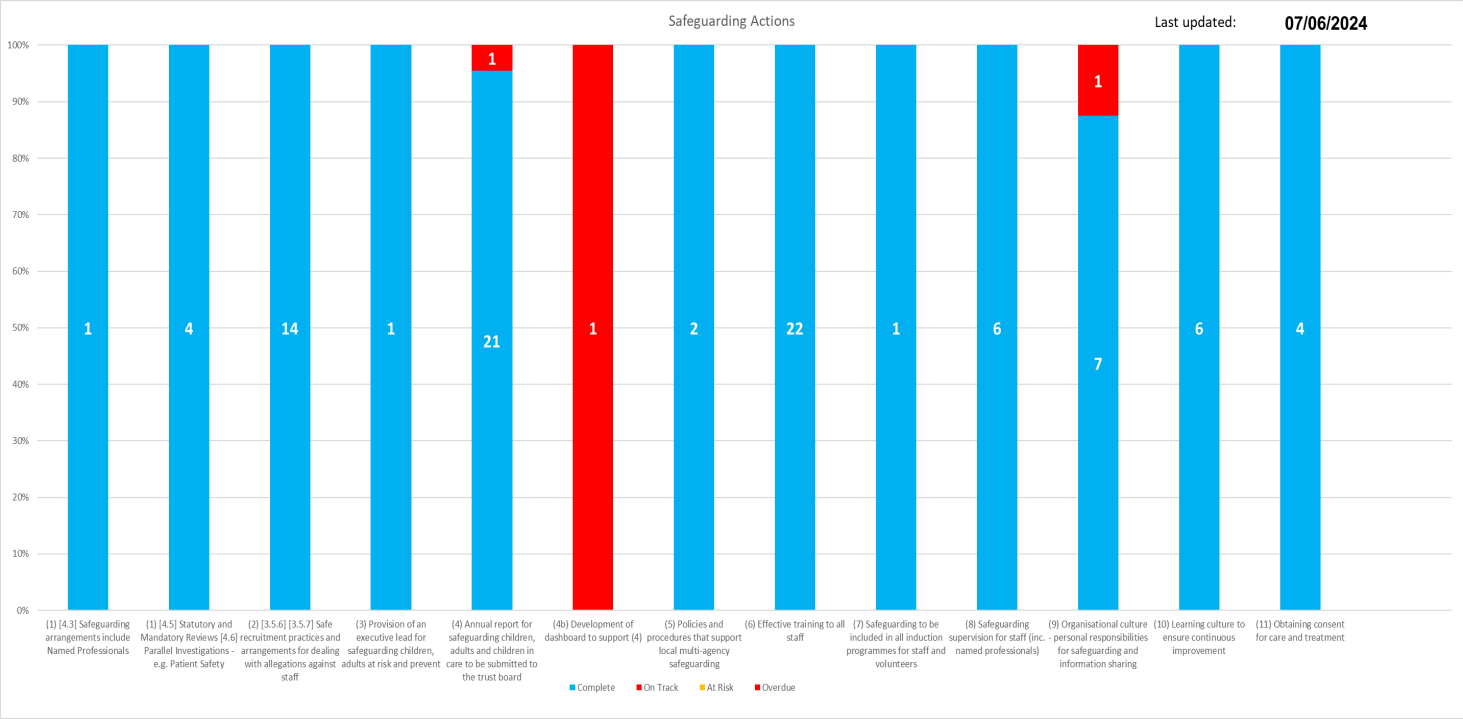
Datix 64432 StEIS 2023 / 11862 – Staff Allegation – Open Police Investigation.

Appendix 1 provides a copy of the Safeguarding Workplan aligned to the 11 criteria within in the Safeguarding Accountability and Assurance Framework (SAAF) July 2022 which has been one vehicle to determine progress against the CQC Inspection. All actions are on track as described in project in a page below (as of 7 June 2024). This is a diagram to demonstrate whether the numerical tasks associated with the 11 criteria are complete (blue), on track (green), at risk (yellow) or overdue (red bar on diagram). The compliance to SAAF has remained static since December 2023 at 97.3%.

2.8 The outstanding actions are:

- Frontline staff access to CPiS
- The alignment of the BI data to the new server
- The Launch of the New Safeguarding Referral Form

Figure 1



In addition, there is a Safeguarding Risk Register which highlights any risks, associate mitigations, and actions. At the time of writing there are 11 risks on the Risk Register. These are:

		Inherent (No Controls)			Residual (AS-IS Controls)			Target Risk (12 - 18 Months)		
RISK	PRIORITY	IMPACT	LIKELIHOOD	TOTAL	IMPACT	LIKELIHOOD	TOTAL	IMPACT	LIKELIHOOD	TOTAL
New Safeguarding Referral Form	URGENT	5	5	25	5	3	15	3	2	6
Incompatability of SCAS BI function with Orivus	URGENT	5	5	25	5	3	15	4	2	8
Quality of Reconcilitation Form	URGENT	5	4	20	4	4	16	3	3	9
Training Compliance of Level 3 Safeguarding	HIGH	4	4	16	4	3	12	3	2	6
Delay in IT developments with CP_IS	HIGH	4	4	16	4	4	16	3	3	9
Relationship with Partner Agencies	HIGH	4	4	16	3	3	9	3	3	9
Safeguarding Leadersip	HIGH	4	4	16	4	3	12	3	2	6
Safeguarding Business Continuity	HIGH	4	4	16	3	3	9	3	2	6
MCA Assurance Risk (embedding only)	MEDIUM	4	3	12	3	3	9	3	2	6
Inconsistent Supervision	MEDIUM	4	3	12	3	3	9	3	2	6
Frequency of Reconciliation Form	MEDIUM	4	3	12	3	3	9	3	3	9

See **Appendix 2** To view the Risk Register in full.

3 Training

3.1 The provision of Safeguarding children and adult training is a statutory requirement of all Acute Health Care Providers. All staff working within SCAS have a duty to safeguard and promote the welfare of children, young people, and adults within the Trust. SCAS assesses the level of Safeguarding children and adult training in line with the Intercollegiate Document (2019).

3.2 Training Compliance (as of 18 June 2024)

Figure 2

Course Title	Target	Actual
Adult SG L1	90%	98%
Children SG L1	90%	98%
Adult SG L2	90%	97%
Children SG L2	90%	97%
SG L3 (Adults and Children)	90%	84%
Basic Awareness Prevent	90%	97%
Awareness Prevent (L3)	90%	90%
MCA Level 1	90%	92%
MCA Level 2a	90%	90%
MCA Level 2b	90%	92%
Oliver McGowan	90%	91%

** To note: Safeguarding Level 3 (L3) compliance was 63.2% April 2023*

3.3 The following safeguarding training programmes were delivered throughout 2022/2023 and will continue to be delivered through 2024 into 2025.

Frontline/patient facing staff, Newly Qualified Paramedics (NQPs), Emergency Care Assistants (ECAs), Associate Ambulance Practitioner (AAPs) and Nurses.

- Previously front line/patient facing staff, (NQP's, Nurses, ECA's and AAP's) attended a safeguarding induction delivered by the Safeguarding Team and then attended a half day level 2 training session delivered by Education Managers during their training. Once operational they would then be scheduled at some point to undertake level 3 training.

- Starting during 2023/2024, level 3 training was delivered by the Safeguarding Team to all new front-line patient facing staff during their training. For the first time, front-line colleagues begin operational duties having already completed 8 hours of level 3 safeguarding training.

- This new safeguarding training replaced safeguarding induction and level 2 in the education training syllabus. Once completed staff are awarded 6 competencies in total, levels 1, level 2 and level 3 for adults and children.

- For existing front line colleagues SG Level 3 training changed significantly during 2023/2024. Initially training was outsourced to an external company called Making Connections who delivered two 4-hour online training sessions most Fridays.

- Commencing 26 May 2023 an 8-hour online training course was developed and delivered by the Safeguarding Team to clinicians (priority group A).

- Making Connections continued to deliver level 3 safeguarding training to ECA's (priority group B). The last Making Connections training course was delivered 11 April 2024.

- The safeguarding training plan for 2024/2025 is driven by the Intercollegiate Documents Children and Adult that require colleagues identified as needing level 3 compliance to complete 16 hours of relevant safeguarding training over a 3-year period. To build on the 8 hours training completed by the staff requiring Level 3 competency, the following training strategy has been implemented:

    - One 4-hour teams training session delivered by the Safeguarding team.

    - 4 hours of safeguarding CPD and/or safeguarding supervision. Colleagues will be required to submit a self-declaration form stating that this requirement has been successfully completed. A safeguarding CPD library of suitable training materials has been developed for colleagues to access.

Patient Transport Service (PTS)

- Due to timetable restrictions the PTS education team deliver a 4-hour combined induction/L2 training during the first week. This includes a 15-question multiple choice exam paper.

- As part of the 2023/2024 PTS F2F training strategy a 4-hour level 3 training package was developed by the Safeguarding Team. However, the F2F requirement for PTS was later reviewed, and the decision taken to cancel the safeguarding part of the F2F training, the last level 3 PTS F2F training was delivered 11 October 2023. PTS education colleagues, operational managers and Team Leaders are still required to complete level 3 training.

- A new updated PTS level 2 presentation has been developed by the Education Team, reviewed by the Safeguarding Team with delivery to start June/July 2024.

CCC Safeguarding Education

- A Safeguarding Induction is delivered to all new starters, the induction is a mixture of a video recorded by the Safeguarding Team and some brief slides to introduce key safeguarding topics.

- The updated level 2 safeguarding presentation developed by the Safeguarding team and CCC Education, has been delivered throughout 2023/2024 with good success. Especially the specific package designed to aid with safeguarding over the telephone.

- This year's CCC F2F training (2023/2024) featured the specifically designed training package for safeguarding over the telephone and was delivered to capture existing CCC staff who had not received this type of safeguarding training before.

3.4 In addition to the standardised programme, the safeguarding team has delivered the additional training as described below:

UCAS Students

There were approximately 128 new paramedic students that started their paramedic degrees with our partner universities in 2023. These include Oxford Brookes, Portsmouth, Bournemouth, and

Buckinghamshire New University. A safeguarding induction was delivered by the Safeguarding Team to all new students.

Safeguarding Supervision

To date there have been 36 safeguarding supervision sessions attended by approximately 300 colleagues. These sessions are for one and half hours delivered in person by the Safeguarding Team, using a reflective model of practice, where colleagues can talk about an incident that involved a safeguarding concern. These supervision sessions can be included as part of the 4-hour CPD requirement.

4. Supervision

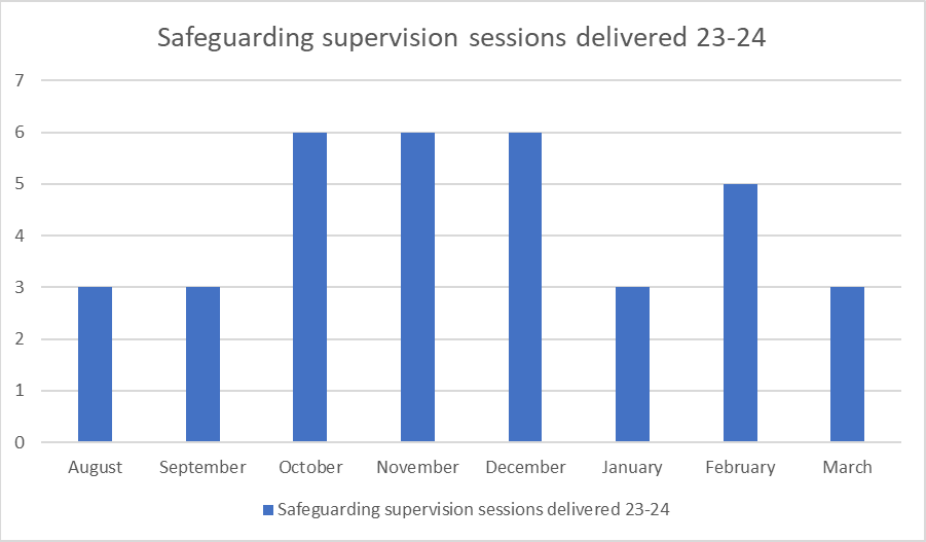
4.1 Safeguarding Supervision is the most influential and effective of all the tasks undertaken by Safeguarding Specialists and Named Professionals. Section 11 of The Children's Act (2004) further applies a duty to organisations, to give practitioners "sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively" and to provide "appropriate supervision and support" for staff.

4.2 Safeguarding Supervision is a formal process, provided by a trusted trained member of staff. This process allows the supervisee to reflect and explore their own practice and develop skills, insight, and knowledge to keep adults at risk and children safe. This protected time is a safe space for challenge and learning and ultimately it aims to improve patient outcomes.

4.3 Safeguarding Supervision was a target delivery for Quarter 2024 for this year. It occurred before this commencing in July 2023.

4.4 During 2023-2024 Safeguarding supervision has been offered and rolled out to all front-line staff. From July 2023-March 2024, 35 safeguarding supervision have been facilitated by the Safeguarding team to front line crews during their Team time.

Figure 3



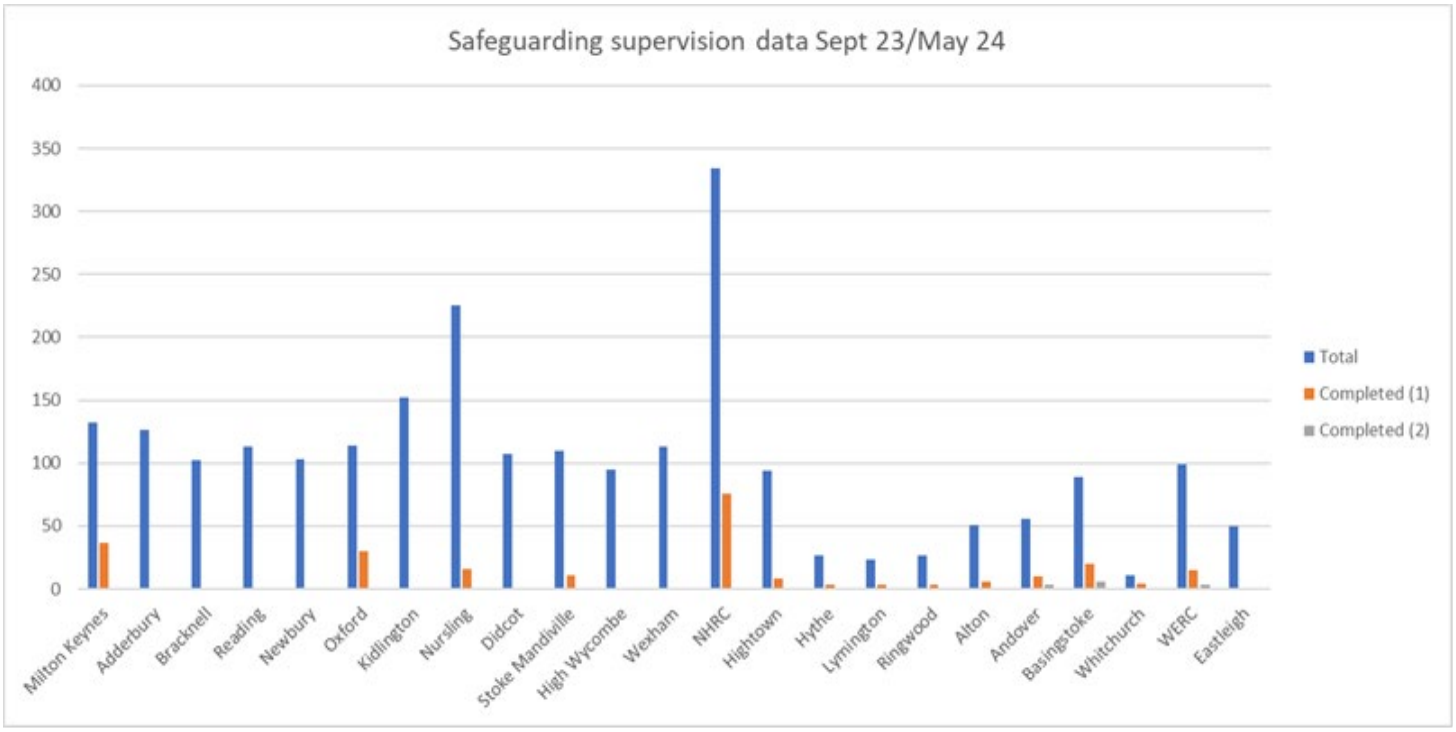
4.5 Topics covered have included Domestic Abuse, hoarding, self-neglect, Mental Capacity, Referral

thresholds, quality safeguarding referrals etc.

4.6 An example in a change of practice is having introduced the Clutter Index rating in to training and supervision, crews can now access the tool kit and the use of the clutter index ratings are being evidenced in Safeguarding referrals.

4.7 The safeguarding team have undertaken peer safeguarding supervision with Milton Keynes MASH team and the safeguarding team at SEACAMB. These supervision sessions are undertaken every quarter for the safeguarding practitioners.

Figure 4



Graph shows how many front line staff within SCAS and how many have received Safeguarding supervision in 2023-2024

4.8 Supervision Plan

Below are the key elements of the Supervision Plan for 2024-2025, with the number of staff in Priority Group being 1,641. The description below identifies those in Priority Group 1.

- Roles in Priority Group - Nurses, Paramedics, Newly Qualified Paramedics, Team Leaders, Clinical Team Educators, Clinical Operations Manager, ECA's and Technicians.
- Quarterly delivery of supervision to the Priority Group.

Safeguarding Supervision will be counted towards staff required CPD hours required for Safeguarding training compliance in 2024/25.

5.0 Mental Capacity Act (MCA)

5.1 The Specialist Safeguarding Family Practicitioner/MCA and Dols Lead has been in post since June 2023. Within this time the below actions have been completed:

a) Roll out of safeguarding training which incorporates mental capacity to the community first response team. A recording of the session is now avaiable and used to deliver training to any new cohort of staff.
b) Supervision sessions to staff are now offered (1 ½ hour sessions in 'team time') using a reflective model of practice and mental capacity is a theme discussed.
c) The MCA Lead attends the Buckinghamshire, Oxfordshire and Berkshire West Health Partners Strategic Committee meeting which is held quarlty. A report is provided to this group on MCA training, audits and celebrated practice.
d) The joint supervision session with SeCAM safeguarding team and to date use reflective practice around safeguarding and MCA.
e) The MCA lead has worked closley with the SCAS mental health team in relation to several serious incidents via patient safety and from this, MCA resources have been updated and shared across the SCAS patch. This includes a new pamplet and SCASCade which is available to complete online.
f) The MCA lead has worked closley with SCAS education team to ensure all mental capacity training resources are up to date and relevant to the service.
g) The MCA lead developed the Level 1 Mental capacity online training for SCAS staff (those who do not have patient contact)
h) The MCA lead presented a safeguarding and mental capacity session at the annual community first response conference.
i) The MCA lead provided MCA training to the new international paramedics over 3 sessions.
j) The MH simulation training was quality assured to include elements of mental capacity, legal framework and whether they are correctly applied.
k) Safeguarding/ MCA training has been delivered to two cohorts of university students at Oxford Brooks and Portsmouth University.
l) The Mental Capacity Act SCAS policy has been updated and ratified.
m) The safeguarding hub page has been updated with resources and articles that relates to mental capacity and DoLS.
n) The new CPD library has all the MCA/ DoLS resources available for staff to access.

MCA Lead Personal Development:

- Completed Best Interest Assessor Masters qualification June 2023.
- Completed a B-Tech Level 3 in Eduation and teaching qualification December 2023.
- Completed SCAS leadership training in May 2024.

MCA training data 20.6.24:

Figure 5

MCA Audit Q1 2024

16 May 2024- 15 records have been audited; the audit will continue to the end of Q1 so that 25 records are reviewed.

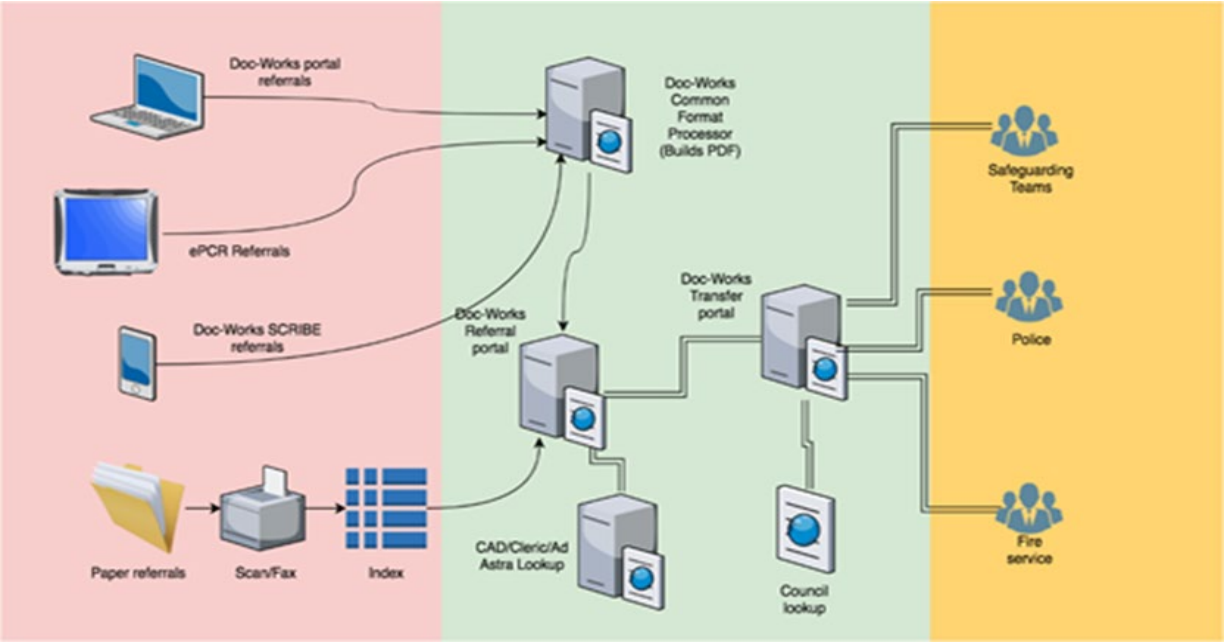
- Recording why MCA is being used.
- Improve the use of the 2- stage test.
- Understand when MCA cannot be used.

6.0 Safeguarding Referrals/Alerts (including IT update)

6.1 SCAS uses a system within the Clinical Directorate called 'Docworks' which is used to support several activities within the organisation. This includes the safeguarding referral process. The system has frequently demonstrated failures and fragility of the current provision. Throughout 2023/24, the ICT (Information Technology) Risk associated with the referral process, has been the highest risk on the Safeguarding Risk Register. It is currently scored at 20 (as of June 2024).

See Risk Register Appendix 2 dated July 2024.

Figure 6 **Referral System Flow diagram**



6.2 The diagram above illustrates an innovative system and allows staff to submit referrals from wherever they work. However, the system has failed on several occasions over the last 2 years resulting in safeguarding referrals being delayed and/or missed with the potential to place patients at risk.

6.3 Over the past year safeguarding system has suffered several patient safety events These have involved human processes breaking down and supplier configuration errors.

6.4 These incidents have involved:

- Paper back up referrals process not being followed.
- Paper back-up referrals process used inappropriately (where an ePR tablet is available).
- Unsent referrals not reviewed from EOC (saved but not sent).
- Paper referrals scanned but not reviewed.
- Wrong local authority email address used.
- Ortivus referral inbox full- referrals unable to be sent.
- Ortivus referrals unsent by DocWorks over 19 days (due to server change).
- Users locked out of accounts by server change/switch over.
- SCAS server outages (now migrated).
- Loss of the Ortivus ePR system for several months, reverting to a paper process.

6.5 In 2023 the Digital Directorate recruited a Clinical Applications Specialist and a Clinical Safety Officer. The Clinical Applications Specialist ensures the safe management and delivery of new clinical applications, changes, upgrades, and commissioning. The Clinical Safety Officer works to ensure is compliant with DCB0160 and related sections of the Health and Social Care Act. They achieve this through the assessment and management of digital clinical risk. They aim to ensure our digital systems help achieve the best patient outcomes. These roles have begun working closely with the safeguarding team to ensure their system is safe for patients.

6.6 In Q3 2023/2024 the safeguarding referrals system was migrated from the SCAS server to a DocWorks hosted and managed solution. Since this there have not been any unexpected server outages. This has helped stabilise the solution.

6.7 The Clinical Safety Officer drafted an operations bulletin for the safeguarding team (OB217) to support the paper referrals process. The Clinical Safety Officer also redesigned the paper form to display the correct process and remove a legacy fax number that caused clinical risk.

6.8 A key priority for the Clinical Safety Officer was to explore the safety of the safeguarding system. An interim Clinical Safety Case Report has been produced to highlight key hazards associated with the system. It has a significant number of mitigations that are required to reduce the unacceptable level of risk. This can be found here: DocWorks Referral Solution Interim Clinical Safety Case Report V1.0.docx – see **Appendix 4.**

6.9 The Safeguarding team have created a role to support some of the work required as highlighted in the Clinical Safety Case Report. This will help ensure the system can be made as safe as possible.

6.10 A Task and Finish group has been established to create process maps of the referrals process. These will display the process from the point of referral through to receipt by the local authority. The task and finish group will add in the identified hazards and link these to the Clinical Safety Case Report.

6.11 Several important mitigations have already been put in place to ensure that patient safety incidents are not repeated:

a) Paper form redesign and operations bulletin simplifying process.
b) SCAS server now migrated onto DocWorks solution.
c) Process created for daily review of EOC unsent referrals.
d) Ortivus referral inbox now autodeletes sent referrals and is regularly reviewed by the Clinical Applications Specialist.
e) The Digital Safeguarding Specialist will work through key mitigations found in the safety case report. They will also work through and escalate any urgent mitigations required by the task and finish group.

6.12 The Clinical Applications Specialist has worked with the safeguarding team to enhance the specification for the new referrals form. Testing will start Q2 24/25.

6.13 CPIS alerting on Ortivus tablets will require NCRS integration. Access to NCRS via the Ortivus ePR is ongoing. This is being completed in collaboration with SWAST. There is a technical challenge relating to allowing access whilst maintaining the levels of security required. Ortivus are developing a proposal to enable both trusts to run NCRS securely. They are aware this is a high priority.

Safeguarding Referral Activity

6.14 The Safeguarding referral numbers are generated form the Computer Assisted Software (CAS) 120 ePCR (Electronic Patient Care Record) by frontline crews and via CAS 120 'scribe' for the rest (PTS and 111).

6.15 Complete referral data for the Annual Report runs from April 1, 2023, to November 2023 due to the fact that SCAS BI has access to the internal Safeguarding data and not the cloud-based solution since the cut over to the new server in November 2023. This is a risk on the Risk Register.

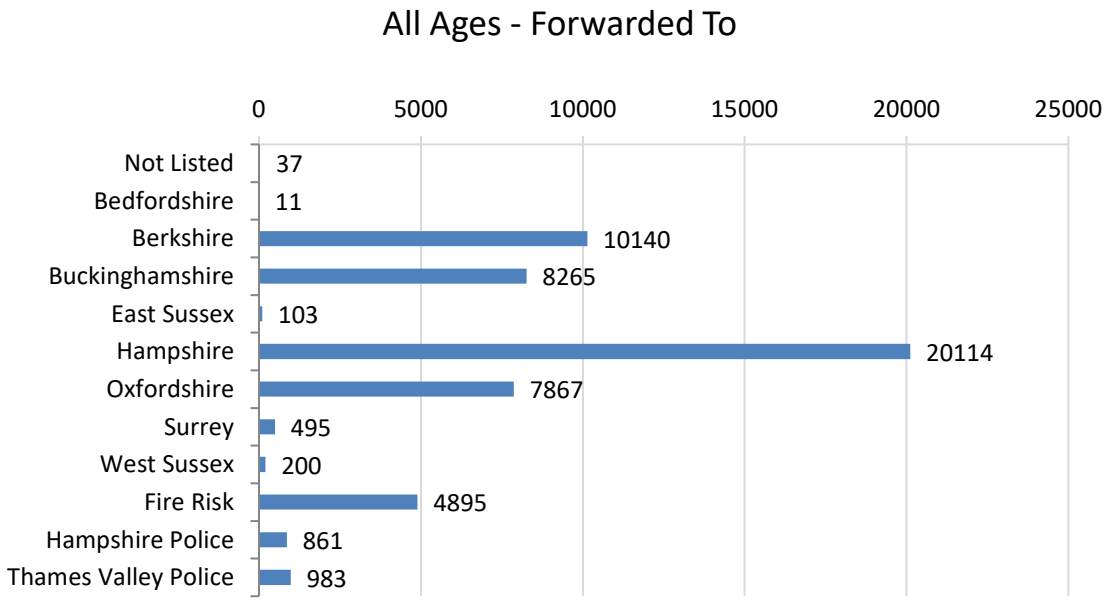
6.16 The Table below taken from the regular reporting at Patient Safety Deliver Group, shows the number of referrals for this year showing a 5% target increase per quarter. Q1 - Q3 Data from SCAS BI and Q4 from Docworks. In total, there is a 60% increase in referrals from Q4 2023. This may be as a result of increased training, visibility of safeguarding service and general awareness.

Figure 7

Aim/ Actual	2022/23		2023/2024			
	Q3	Q4	Q1	Q2	Q3	Q4
Aim	*12761*	*13399*	*14069*	*14772*	*15511*	*16287*
Actual	13728	14221	16311	20458	22267	22773

6.17 The destination of referrals in all ages is demonstrated in the graph below showing that Hampshire is the highest referral destination. (April to November only).

Figure 8



The Highest theme for adult and child referrals is Neglect/Omissions of care as seen below (April to November).

Figure 9

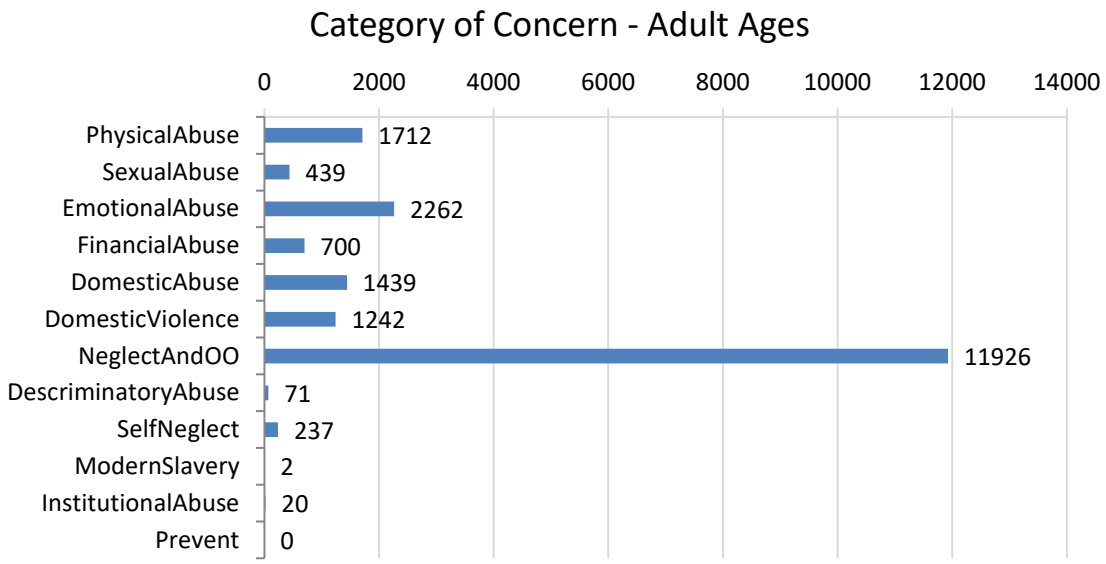
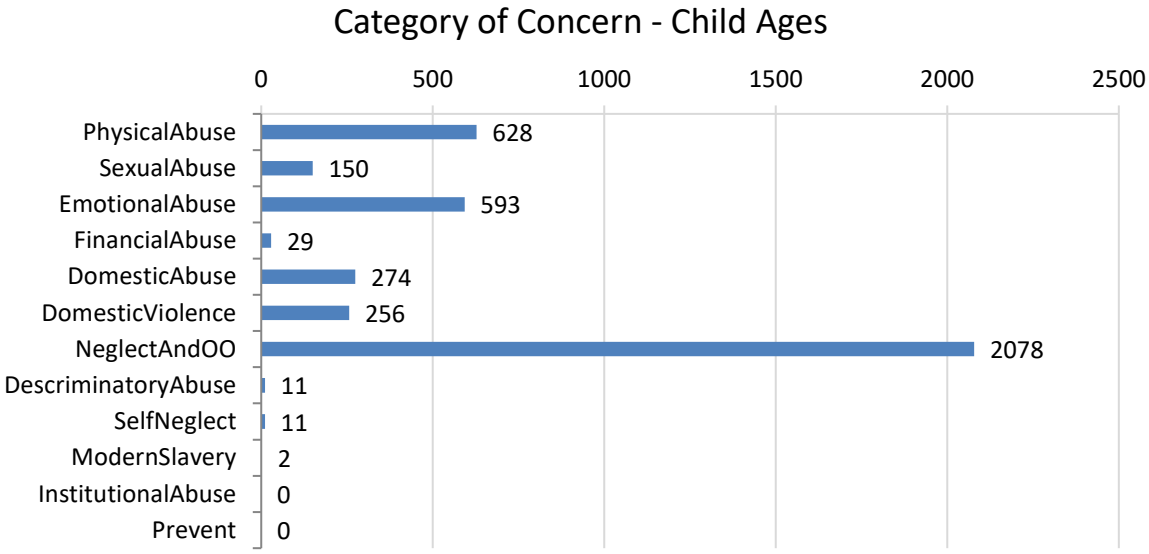
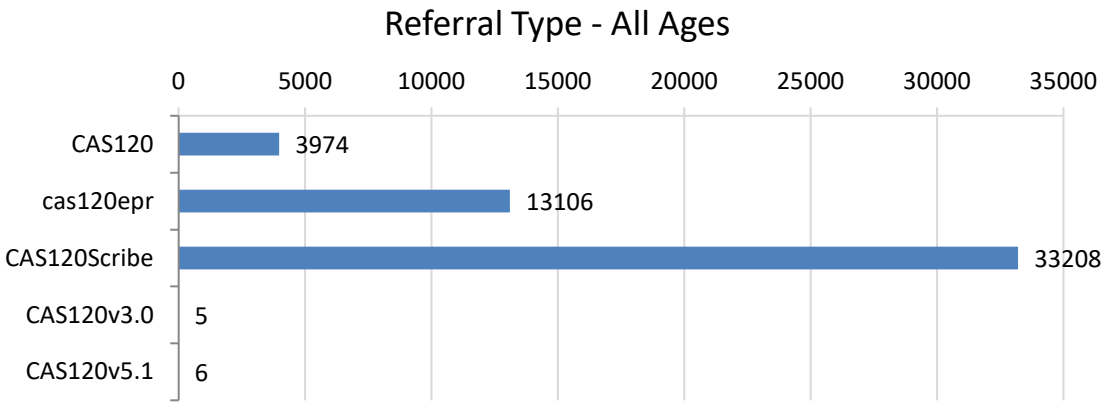


Figure 10



111 and PTS account for 66% of all referrals (April to November)

Figure 11


Referral Type - All Ages
0
5000
10000
15000
20000
25000
30000
35000
CAS120
3974
cas120epr
13106
CAS120Scribe
33208
CAS120v3.0
5
CAS120v5.1
6

7.0 Child Death Reviews

7.1 In line with national guidance, the Safeguarding Service represents SCAS, as a 'health voice' at the trust wide Child Death Overview Panels (CDOP) panels.

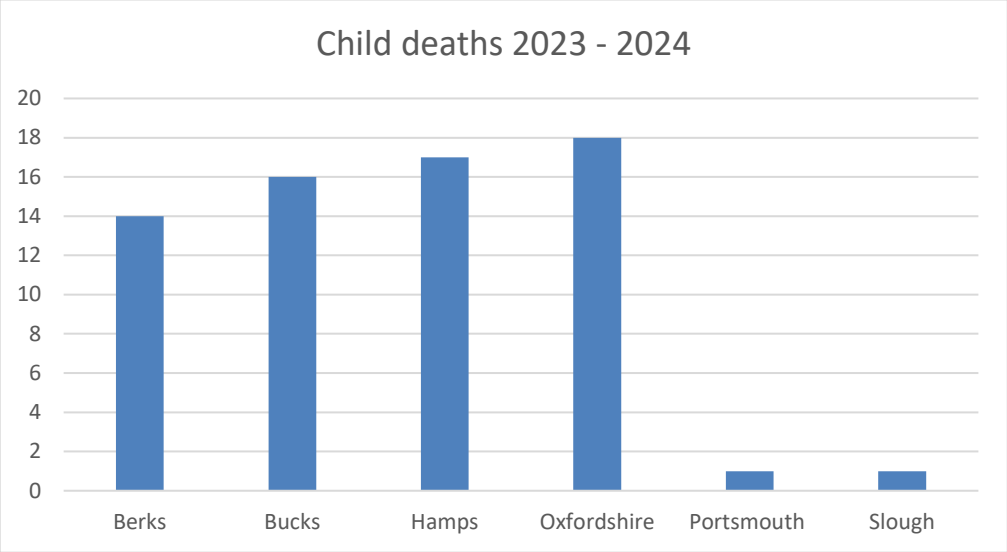
7.2 In addition, the Safeguarding Service represents the Trust at Joint Agency Response (JAR) meetings in response to unexpected child deaths where children are known to reside locally or have been known to SCAS.

7.3 The Named Professional Children is the lead for this area and a standard operation procedure is now in place for child death reviews. Data Collection has improved as a result.

7.4 The Safeguarding Service were made aware of 69 paediatric deaths in 2023-2024, averaging one a week.

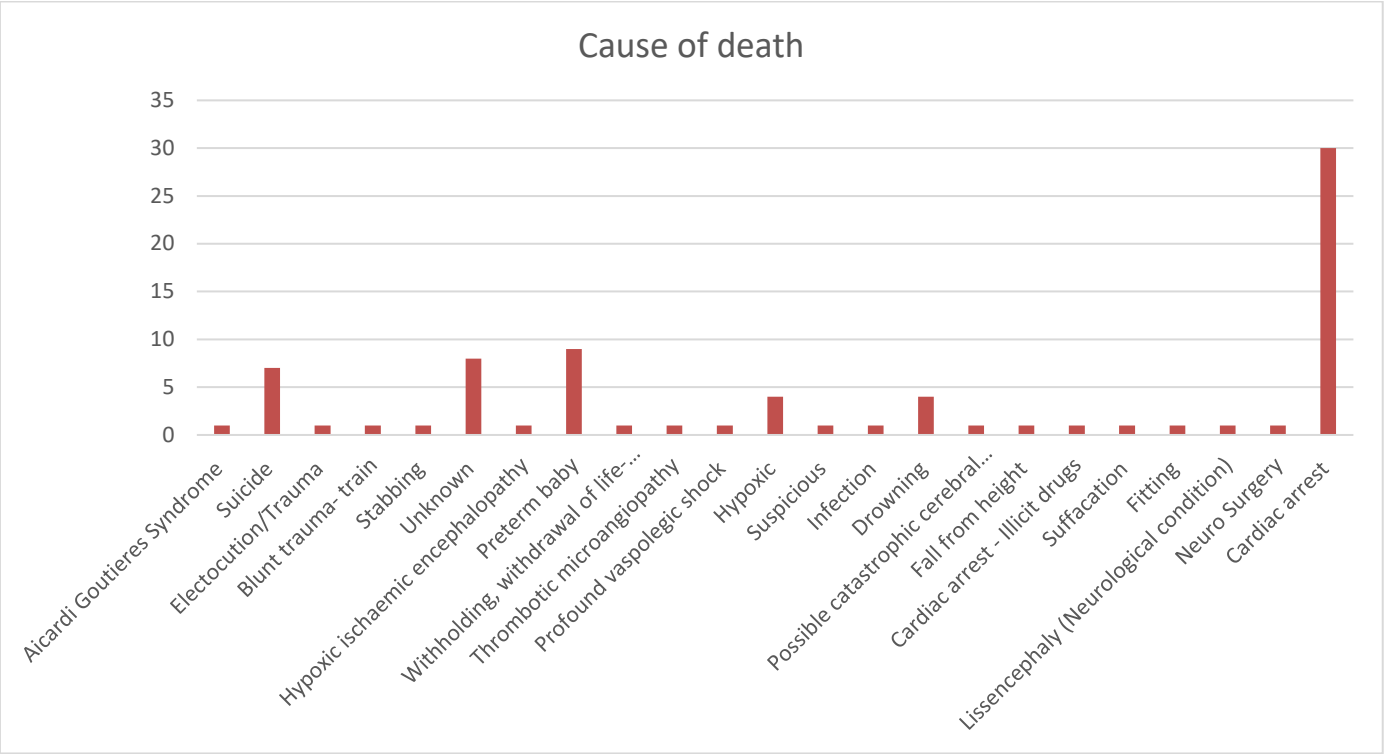
7.5 The graph (10) below shows that Oxfordshire had the highest recorded number of child deaths at 18, Hampshire 17, Buckinghamshire 16, Berkshire 14, Portsmouth 1, and Slough 1. There were none recorded as being Out of Area.

Figure 12



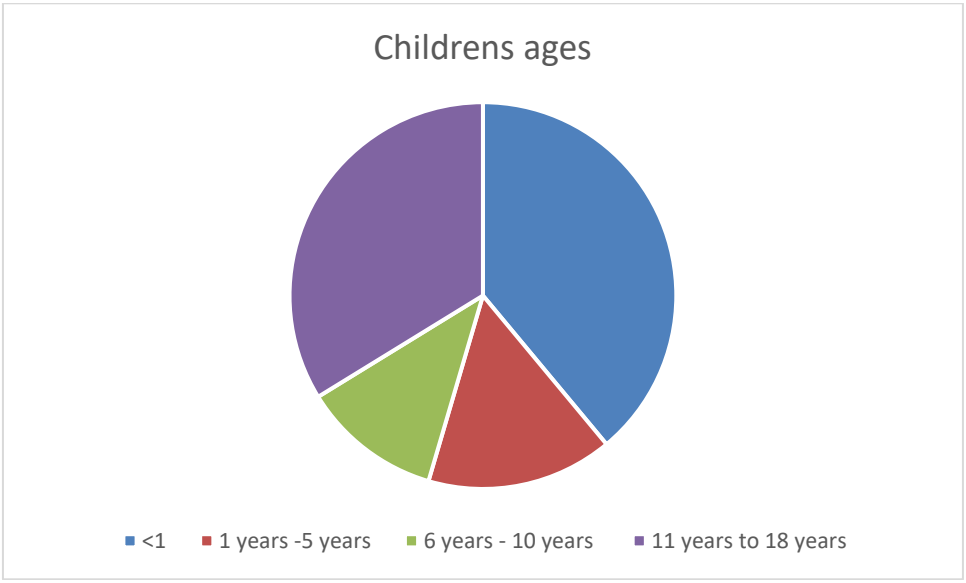
7.6 In addition to improved and more consistent data collection, new processes have been developed such as inviting front line staff to attend JAR meetings, Operational Managers have prioritised these meetings for their teams. EOC staff inform the Safeguarding Service of any child death at the earliest opportunity to enable co-ordination to attend the After Death multi agency review.

Figure 13



7.7 The above graph shows that the highest number of child death relates to a cardiac arrest. Data does not always hold the information as to why that child has had a cardiac arrest. Therefore, this has a caveat that the cardiac arrest may be as a result of another incident. The second highest cause of death was the birth of preterm babies.

Figure 14



7.8 The graph above gives a detailed overview of the age of the children at their death. SCAS data is consistent with national research showing that children under 1 are at greater risk, with the next age

group being teenagers.

7.9 As part of the child death process, there are quarterly meetings held by the Child Death Overview Panel for each area covered by SCAS. These are attended by the Named Professional Safeguarding or Safeguarding Specialist. This forum provides SCAS with a good opportunity for learning.

8.0 Significant Case Reviews; Including Statutory Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Section 42 enquiries

Section 42 Enquiries (S42)

8.1 A Section 42 (S42) Enquiry may follow a safeguarding concern when the concern reaches the threshold for a full investigation as defined within The Care Act 2014. SCAS works with 24 Multi Agency Safeguarding Hubs (MASH) Teams across the SCAS area who will determine when the threshold for a Section 42 enquiry has been met and will supply the Terms of Reference for the investigation.

8.2 For all Section 42 enquiries that are delegated to the Trust, the Adult Safeguarding Team assist the relevant team leader author in the facilitation and completion of the full Section 42 report.

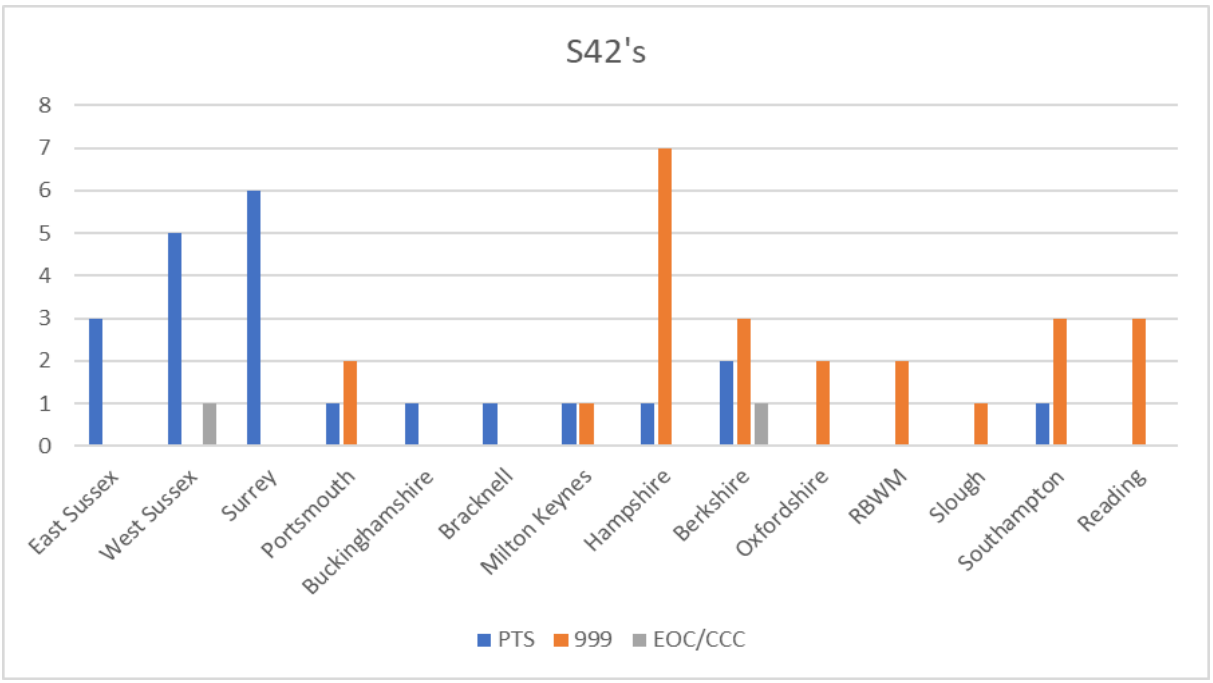
8.3 Each enquiry is taken extremely seriously, an investigation is undertaken, and any identified learning assembled and disseminated.

8.4 All Section 42 enquiries are uploaded onto the SCAS Safety Learning Event (Datix system) The Safeguarding Adult Team offer support to the author of the report for the writing of enquires to ensure the terms of reference are met and to also to ensure the ethos of the Care Act 2014 in that '*Making Safeguarding Personal'* is upheld.

8.5 Training developed by the Safeguarding Team on S42 enquiries (30 minutes) has been delivered approximately 8 times to groups mainly consisting of Team Leaders (TLs), Clinical Team Educators (CTEs) and educational staff.

8.6 During 2023/2024 there were **48 requests** for full Section 42 enquiries. This is a 20% increase in comparison to the previous year (2022/2023). This is positive as it demonstrates more referrals have met the Section 42 criteria. It can also be attributable to the overall rise in referral rates.

Figure 15



Analysis of themes of S42 enquiries

8.7 The main themes which triggered a Section 42 enquiry were:

a) Moving and handling concerns
b) Medication errors due to being left with wrong patient or not locked away.
c) PTS not leaving the patient with their pendant alarms nearby.
d) Alleged injuries from PTS when returning patients home.
e) Staff behavior (rudeness)

8.8 The Safeguarding Adult Specialist provides feedback to the service lines via clinical governance leads and topics are included in safeguarding training programme for 2024/25

The Care Act (2014) Section 44 Safeguarding Adult Review and Serious Case Reviews Children

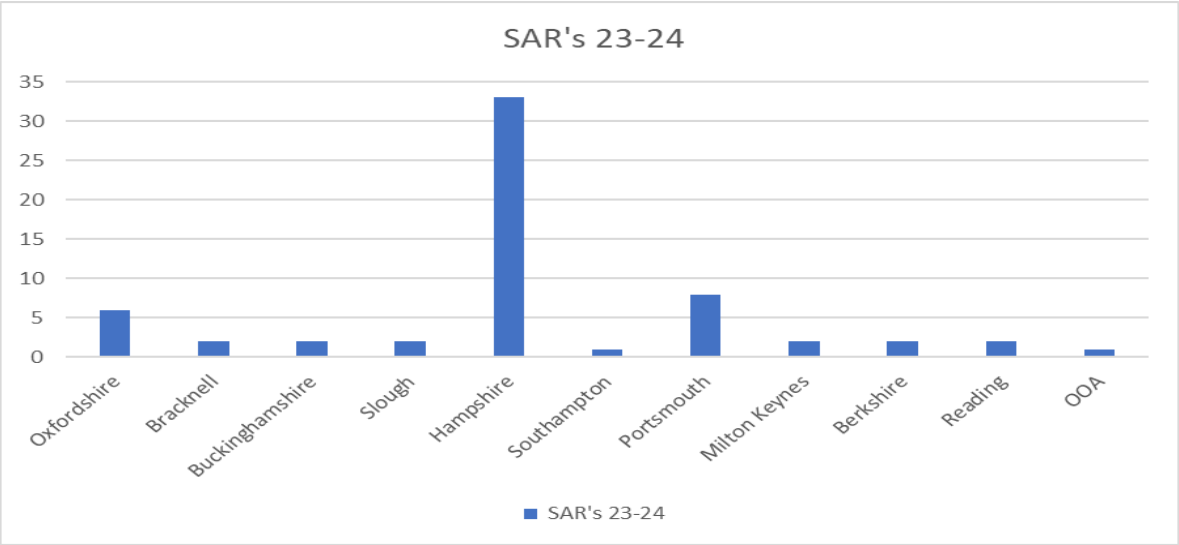
8.9 Safeguarding Adult Boards have a statutory duty under Section 44 of the Care Act (2014) to undertake a Safeguarding Adult Review (SAR) when an adult at risk dies or is seriously harmed and abuse or neglect is suspected and there are lessons to be learned about the way agencies could work together to prevent similar deaths or injuries in the future. The same applies to Children under Working Together to Safeguard Children (2018).

8.10 All SAR and Child Safeguarding Practice Reviews (CSPR) (previously known as Serious Case Reviews) notifications require detailed exploration of Trust IT software systems and clinical records for the relevant adult/child. Statements may be required from key staff involved and on occasions may be followed up with face-to-face interviews.

8.11 The timeframe for each review varies, depending on the nature of risk and the severity of the risk of harm, or the harm caused. The scope period can be in terms of years or months. A detailed chronology is completed, and critical analysis is undertaken. A scoping report is then produced outlining findings and recommendations.

8.12 SAR investigations for 2022/2023 were 59 SAR's and 61 for year 2023/2024.

Figure 16



Learning from Safeguarding Adult reviews (SAR) 2023- 2024

- Fire safety when using emollients
- The use of the Multi Agency Risk Management frameworks.

8.13 SCAS have taken the learning from these SARS and embedded this learning into the level 2 and 3 safeguarding training packages and published links to the reports through internal communications.

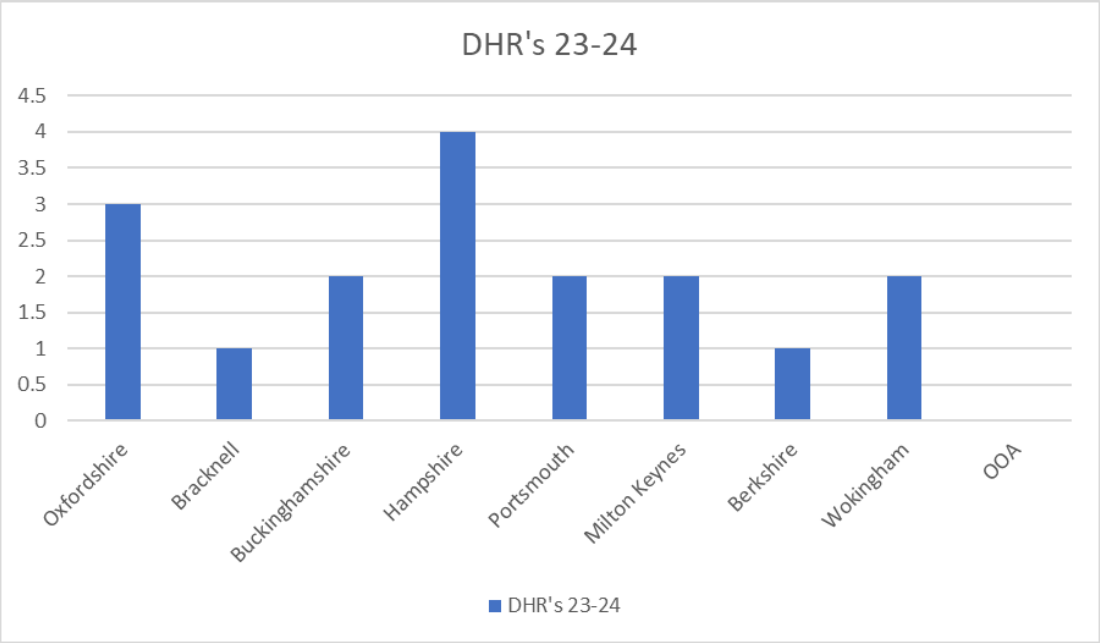
8.14 The toolkits such as Domestic Abuse, Stalking, Harassment and Honour Based Violence (DASH) are already available to crews and the safeguarding team plan to promote these toolkits through supervision and training sessions throughout 2024 and 2025.

8.15 Crews now have access to clutter index ratings and DASH assessments on their electronic portable devices.

8.16 In addition, there have been several examples where themes from SAR have been highlighted in Staff Matters (a SCAS internal communication publication) or Operational bulletins, such as Fire Safety around the use of emollients. These are also embedded into the safeguarding page for staff to access.

8.17 In addition to a SAR process, the Trust has been involved in a total of **17 potential Domestic Homicide Reviews (now changed to Domestic Abuse Related Death reviews).**

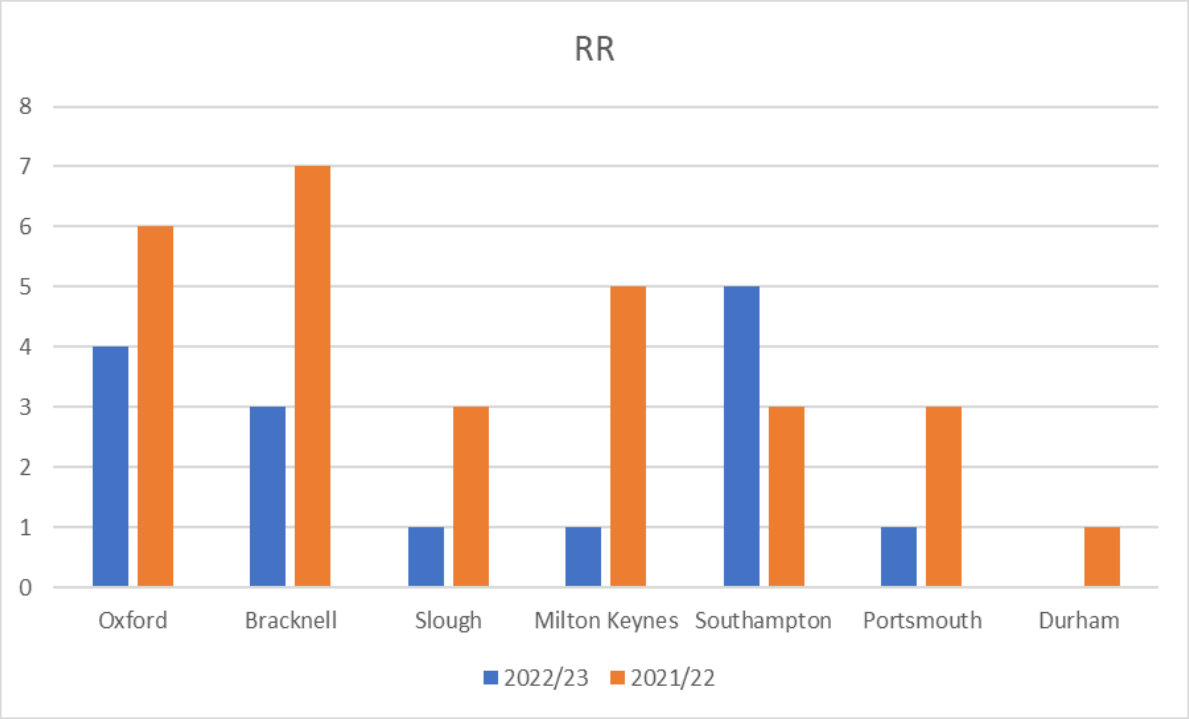
Figure 17



8.19 There were **14 Adult Rapid Reviews**, which met the criteria of Section 44 of The Care Act (2014).

8.20 There have been less Rapid Reviews in this period than last year. Several emerging themes have been identified. These relate to concerns of self-neglect, homelessness, and alcohol/substance misuse. Thematic SAR reviews have been conducted to explore and provide learning with regards to commonalities and differences between cases.

Figure 18



Child Reviews

Analysis of themes of Children's Rapid Reviews and Child Safeguarding Practice Reviews (CSPR)

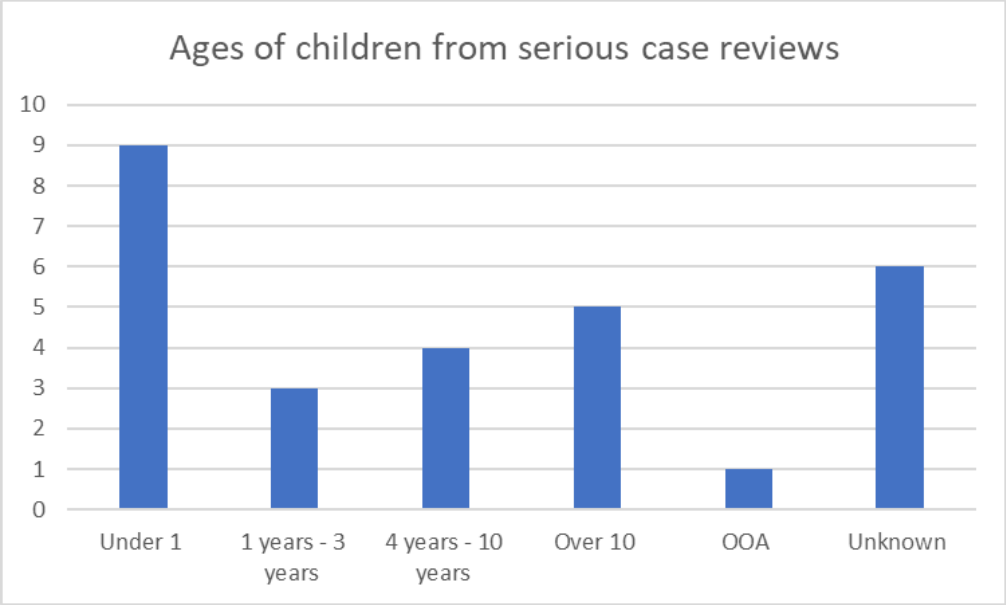
8.21 The safeguarding children's team provides feedback through a scoping of IT systems to the professional requesting the information, usually a local authority.

8.22 SCAS Safeguarding have built up relationships with the 24 local authorities over the last 12 months, and as such the Named Professional Safeguarding Children is asked to provide scoping's and attendance at serious case reviews when a child has died or is injured and there are safeguarding concerns surrounding the incident.

8.23 In most of the cases SCAS have had very little involvement with these children and their families and it is usually the incident itself that is our only contact.

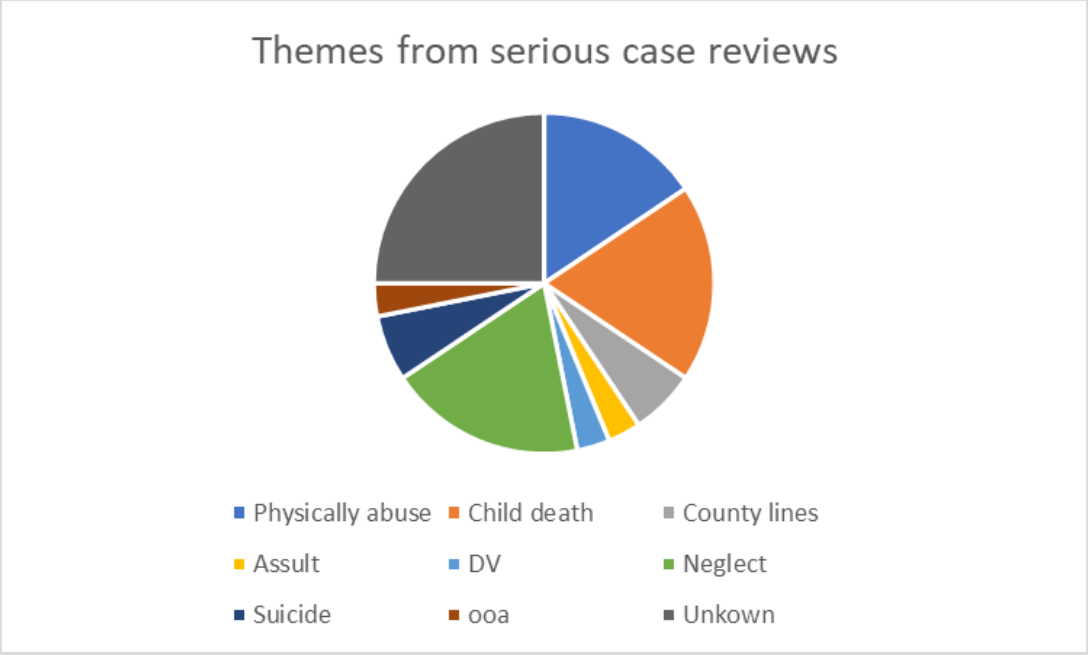
8.24 The below graphs show the ages and themes from the serious case reviews we were asked to attend during 2023-24. As with the previous data children under one are at the greatest risk of abuse and neglect.

Figure 19



The themes from SCR reviews are seen in the diagram below:

Figure 20



Examples of change of practice due to SCR

- Presentation at HSCP meeting of exemplary referral by SCAS crew to safeguard a family.
- Lessons learnt/training added to CPD library for staff to access
- Additions to L3 training on themes from case reviews.

9 PREVENT – National and Local Threat

9.1 As of May 2024, the UK threat level decreased to SUBSTANTIAL (meaning an attack is likely).

9.2 Vulnerability to Radicalisation or V2R occurs when a person, who as a result of their situation or circumstances, may be drawn or exploited into supporting terrorism or extremist ideologies associated with terrorist groups.

9.3 Terrorism means the use of or threat of action which involves serious violence to a person, involves serious damage to property, endangers a person's life (other than the offender) creates a serious risk to the health or safety of the public or is designed to interfere with, or seriously disrupt an electronic system, the use or threat must be designed to influence the government or an international governmental organisation or to intimidate the public or a section of the public, and must be undertaken for the purpose of advancing a political racial or ideological cause.

9.4 It is the role of the Trust to recognise the signs of radicalisation to prevent terrorist behaviours and to enable those at risk to get the support and early intervention needed, to divert them away from a path that can lead to terrorism.

Figure 21

9.5 Alongside awareness of domestic abuse, child sexual exploitation or female genital mutilation, PREVENT awareness must be understood. Without help they might go on to do themselves or society harm. According to research conducted by Counter Terrorism Police 2020 there was a link between hate crime and PREVENT referrals and from a further national review of PREVENT referrals 35% of the sample had a link to domestic abuse.

9.6 The PREVENT Training compliance:

Basic Awareness Prevent	90%	97%
Awareness Prevent (L3)	90%	90%

9.7 Improved PREVENT comprehension was recognised in a high-quality referral resulting in a plaudit for the member of staff (June 2023) when the crew completed a referral with the following concerns:

- There were two approximately 3 litre bottles of Hydrogen Peroxide within the property.
- Furthermore, there were 3 x 30 litre empty containers next to each other.
- There was a hand forged sword
- In addition, there were two bows and arrows.
- The patient was wearing a German military surplus shirt.
- Throughout the conversation, the patient displayed annoyance towards the Government around NHS pay
- The patient had a history of manic depression
- One of the patient's sons was in Russia with his mother and there had been a dispute between them due to the patient's daughter-in-law only getting married and having children for the purpose of gaining citizenship within the UK. This was reported immediately to the Local Authority and Police where the family were supported.

10 Allegations

10.1 There were 65 allegations reported in 2023/24 an increase of 5 cases on the previous year.

10.2 There were 3 designated professionals who work on the allegation management agenda from the Safeguarding Service and a 6 weekly review meeting takes place between HR and Safeguarding to review open cases. The AD Safeguarding has been recognised for work on Allegation management and was invited to speak at the NHSE Conference 'Celebration of Innovation' on this topic in Q1 2023/24.

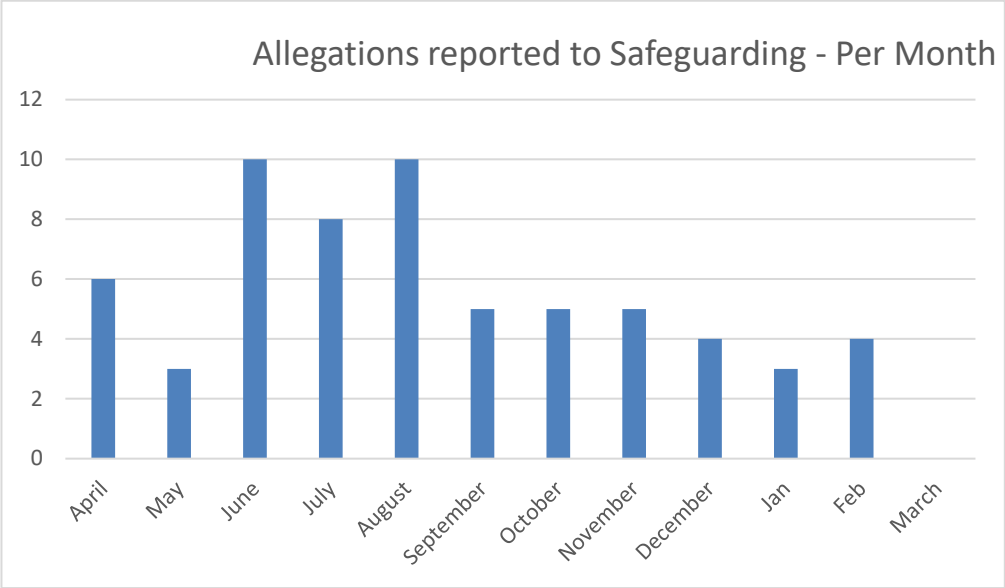
10.3 In addition, an article in the Health Service Journal dated August 2023 described the new focus on allegation management and quoted 'The trust revealed the figures in a new board report and said the rush of new complaints was triggered by a new "allegation management policy" and approach introduced in November. It also coincided with "expanding the safeguarding team, ensuring accurate reporting methods… a drive to encourage staff to speak up about unacceptable behaviour… and the introduction of a sexual safety campaign and charter".' This was positive coverage for the Trust.

Current Trust Position

10.4 In order to understand the significance of the cases, a dataset has been constructed to identify themes, learning, patterns of behaviour or areas which may require additional exploration. The information is taken from the Safeguarding Service Allegation Records.

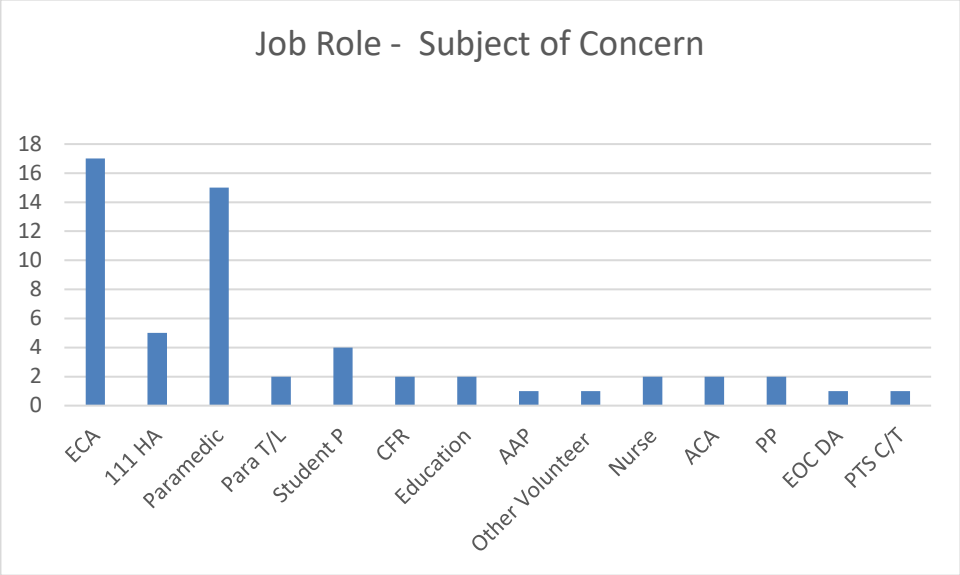
10.5 There was a total of 65 Allegations reported to Safeguarding during the year 2023-24. This is an increase of 5 cases from 2022-23. The fact there were no reported cases to Safeguarding in March 2024 may account for the absence of all 3 allegation Leads in this month. However, there were 15 reported in April 2024 once the Designated Officer for Allegations returned. See Graph below.

Figure 22



10.6 The graph below depicts the job role of the Subject of Concern in the Allegation. Paramedics and ECAs account for almost half of all cases at 49.2 %.

Figure 23



10.7 The graph below depicts the node where the subject of concern works in. From this it shows that NW node and SE node have the highest number of cases.

Figure 24

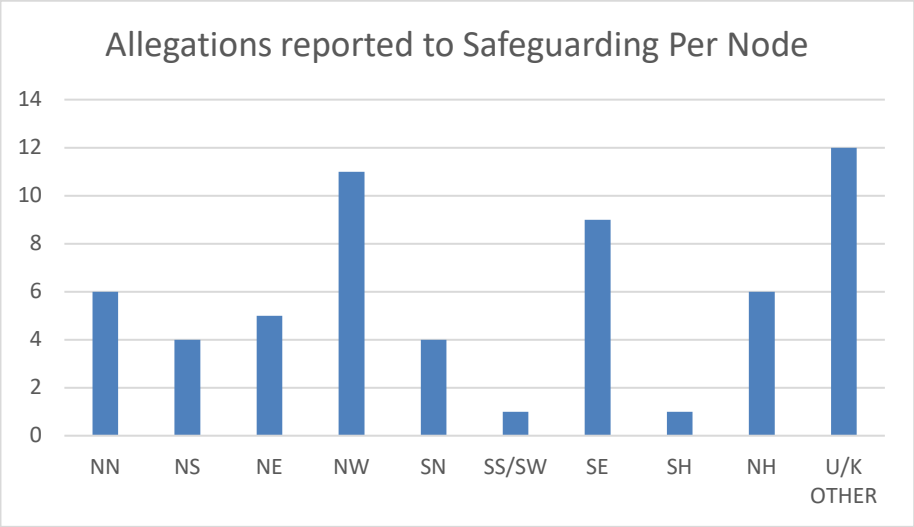
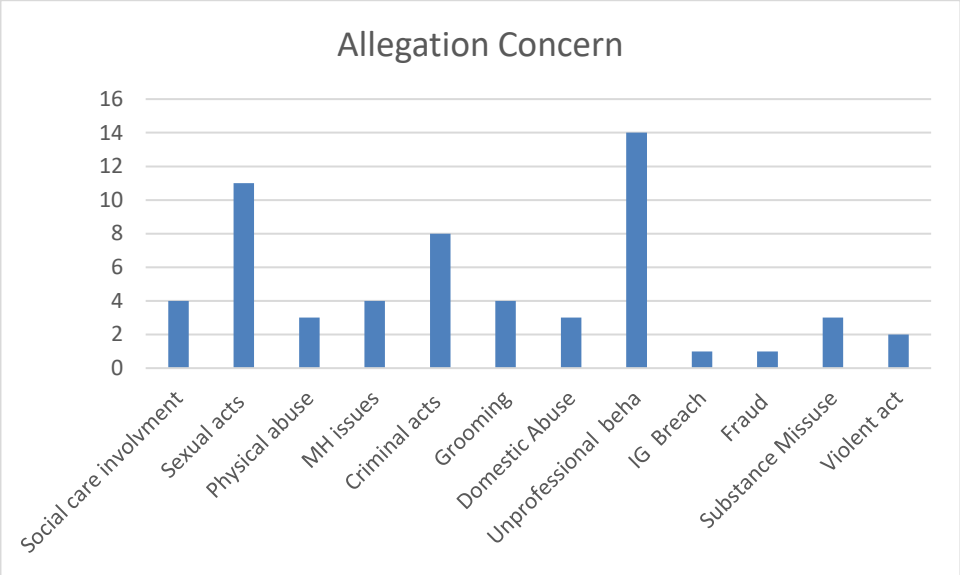
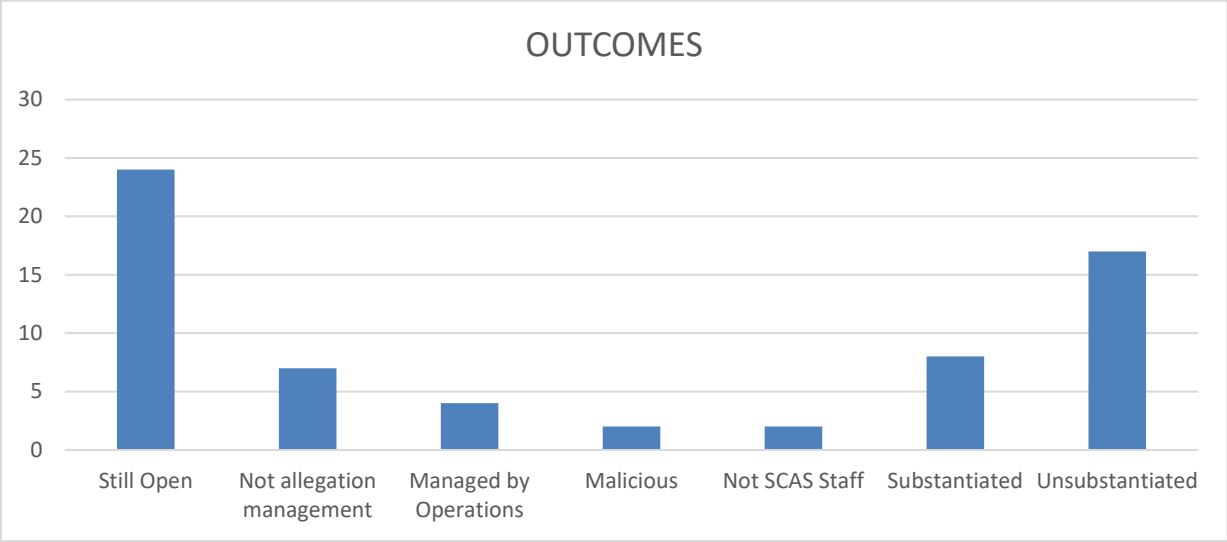


Figure 25



10.8 For every allegation an outcome is recorded as below:

Figure 26



Areas of Risk associated with Allegations

10.9 A hierarchy system of rank (which is present in most uniformed organisations) can present opportunities for exploitation. The tripartite approach to managing these cases (i.e. FTSU, HR and Safeguarding working together) provides confidence to staff groups and demonstrates commitment and rigor by the organisation.

10.10 The North nodes appear to have a greater number of staff allegations. This may be due to an embedded culture and a reticence to report and will be explored further in 2024/2025.

10.11 Sexual behaviour theme is the highest reported theme (an outlier to all themes). It is therefore important that the trust continues with the **Sexual Safety Charter** and review its effectiveness.

10.12 There will always be a dichotomy between the 'fair and just culture' and the need to investigate allegations thoroughly. The consequence of this may lead to an increase in complaints, hearings, tribunal activity for the HR and Safeguarding Service. However, the reputational risk to the trust of non-action carries a greater risk. The allegation process should continue to be embedded in line with other HR processes.

10.13 A priority for next year is to ensure this workstream continues to the same standard due to the loss of expertise of the AD Safeguarding and Named Professional Adult.

11 Key Progress and Achievements 2023/2024

11.1 The Safeguarding Service comprises a team of 10 members of staff – 3 administration staff and 7 trained professionals. The team have successfully managed to achieve the following:

- Commenced and Embedded a Safeguarding Supervision programme – 35 sessions to date
- Cutover to New Server – November 2023
- Received a National Safeguarding Award from NHSE on leadership – February 2024.
- Embedded the MCA Lead role.
- Compliance of Mental Capacity Act training by year end at L1 89%, L2a 85%, L2b 89%
- All SOP's agreed at Safeguarding Committee
- Commenced Volunteer training –9 sessions to date
- Remained in budget.
- AD Safeguarding Keynote Speaker on Allegation Management for NHS England – June 2023
- Positive Peer Review as part of Improvement Journey.
- Key metrics above target – SAAF, training, and referral rate.
- National Safeguarding Week – 8 members of the team visited all areas of trust and were part of the White Ribbon Event for DA – November 2023.
- DBS Team informed Safeguarding Service of an increased number of DBS referrals following DBS training last year.
- Finalised and recorded an induction session for new starters.
- Recruitment team were trained in Allegation Management.
- New Telephone System installed – December 2023
- Ability for crews to access out of hours LA colleagues by use of direct line available in Control Centres – January 24.
- Introduced the 'clutter scale' rating and 'DASH' assessments onto front line devices to make them more accessible for staff to access.
- SCAS Safeguarding Practitioners commenced safeguarding supervision with SECAMB and MK MASH – Jan 2024
- Worked with the University's across the SCAS region to deliver SCAS Safeguarding induction training to all 1st year paramedic undergraduates

12 Priorities for 2024/2025

- Ensure compliance of 90% Safeguarding Level 3 by year end.
- Agree capture and reporting of safeguarding level 3 – 16 hours over 3 years
- To quality assure the Level 2 new training programme and adapt to any feedback on delivery
- Ensure Launch of New Referral Form as a result of the T and F Group actions.
- Involve Local Authority Partners in the testing of the new referral.
- Ensure CPiS is embedded trust wide.
- Ensure Safeguarding App is launched for PTS staff.
- Ensure compatibility and launch of Dashboard.
- Ensure Feedback from Local Authorities is provided to staff.
- To remain within budget and review any opportunity for CIP (cost improvement savings)
- Recruitment of Head of Safeguarding due to retirement of AD Safeguarding August 2024
- Recruitment to Named Professional Adult due to resignation of existing staff member March 2024.
- Agree Safeguarding lead Cover for Allegation Management due to retirement of AD Safeguarding.
- Plan to deliver joint mental health/ mental capacity training with Hampshire Police in July 2024.
- Plan to provide MCA training to Education Team
- MCA Lead to work with Tel Team to complete a bespoke MCA online training.

13 Examples of Good Practice

Case 1 Modern Day Slavery

Background

SCAS crews were called to a patient (after the patient's friend contacted the Ambulance Service) having difficulty breathing and was living in what appeared to be a house of multi occupancy (HMO) with very few and poor facilities. The patient was unable to communicate with the crew due to a language barrier and the crew understood from the patient's friend who spoke English (and acted as interpreter) that the patient had moved from the north of England a few days previously and was awaiting documentation e.g. for NHS details and identification purposes.

Actions

The crew assessed the situation and suspected a potential Modern Day Slavery situation due to the condition of the HMO building and facilities and being advised the accommodation is free as the patient 'does favours for business'.
Thames Valley Police were contacted and concerns about modern slavery passed to their team.
The crew took note of the patient's friend's name and mobile number.
The crew showed diligence, curiosity, and care, to the patient who was living in this challenging situation.

Feedback

The feedback from the Modern-Day Slavery Lead in *Oxfordshire stated how brilliant it was that the crew identified potential modern slavery*. *There have been others in the past too where SCAS have made Safeguarding referrals which shows a clear understanding of modern slavery indicators which is very impressive*. *This case had links as far reaching as Liverpool so will have potentially prevented further abuse*. It appears some of the training from the Metropolitan Police with SCAS team and materials used by crews on this subject made a difference.

Case 2 – Knowledge of MCA

Background

Crew arrived at patients own home. On arrival patient daughter was present. The crew spoke with the patient, and patient stated that they did not want to into hospital for treatment. The crew assumed capacity and had no reason to doubt this. The daughter told the crew that she wanted her mother taken to hospital. The crew advised that she didn't want to go so they were listening to her wishes. The daughter advised that she had an LPA for health and welfare, so they had to do what she wanted.

Actions

The crew challenged this and said that she has capacity so the LPA cannot be used.

Feedback

The daughter made a formal complaint. This was not upheld as the crew had acted within the MCA code of practice.

Case 3 – Knowledge of MCA

Background

Crew phoned the Safeguarding advice line as they had attended a call for a patient with serve facial injuries and wanted to check they had done the right thing. On arrival the patient had severe facial bruising following an alleged fall. The crew contacted the patient's daughter who advised that she did not want her mother going into hospital. The crew were very concerned for the patient as she lived alone with a care package and was locked in the home with cameras watching the patient. The crew were concerned as they felt that the patient needed to go to hospital due to the facial injuries and a fractured jaw. The crew looked around the house and could not see any displaced furniture as to where the patient had fallen. The daughter stated that she had LPA for health and did not want her mum to be taken to hospital. Crew had completed an MCA and the patient lacked capacity. The crew were not sure how the patient had sustained the injury and felt the daughter was not working in her mother's best interest. The daughter was more interested in taking her dogs for a walk than attending her mother's home. Crew decided to take the patients into hospital due to the concerns around her facial injury and the risk to the patient's health if left untreated. Crew completed a safeguarding referral for the concerns noted on scene.

Case 4 – Understanding of Prevent

Background

On 15 May 2023, a crew attended a 111 call which related to an increasing health issue in a 54-year-old male which was dealt with during the course of the afternoon. Following crew's attendance, they highlighted a number of concerns about some things that were noticed whilst at the address of this patient:

- There were two approximately 3 litre bottles of Hydrogen Peroxide within the property.
- Furthermore, there were 3 x 30 litre empty containers next to each other.
- There was a hand forged sword.
- In addition, there were two bows and arrows.
- The patient was wearing a German military surplus shirt.
- Throughout the conversation, the patient displayed annoyance towards the Government around NHS pay.
- The patient had a history of manic depression
- One of the patient's sons was in Russia with his mother and there had been a dispute between them due to the patient's daughter-in-law only getting married and having children for the purpose of gaining citizenship within the UK.

Actions

Crew questioning was kept to a minimum so as not to raise suspicion from the patient that there were concerns. Later, that evening, whilst back on the station, a SCAS safeguarding referral was completed which highlighted PREVENT as being one of the concerns. The referral arrived on the safeguarding server and within 1 minute and 7 seconds it had been sent automatically to the Hampshire Adult Services Vulnerable Adult Team.

Author: Sarah Thompson
Associate Director Safeguarding
Date: July 2024

APPENDICES

Appendix 1 – NHS England Safeguarding accountability and assurance framework (SAAF)

Appendix 2– Safeguarding Risk Register (as at 16 July 2024)

Risk Title	Risk Description	Date Identified	Cause	Consequence	Inherent Impact	Inherent Likelihood	Inherent Risk Rating	Control 1	Control 2	Control 3	Control 4	Control 5	Strength of Controls	Residual Impact	Residual Likelihood	Residual Risk Rating	Target Risk Rating	Actions	Action Due Date	Risk Owner	Status	Risk Escalated	Escalation Rationale	Risk Response	Risk Category
New Safeguarding Referral Form Risk	IF the Trust does not prioritise the development of a new safeguarding referral form THEN the safeguarding referral form will not be launched by 30th September RESULTING in potential patient harm and deterioration in SCAS's reputation due to a failure in delivery of promises to ICB, Stakeholders, NHSE, and local authority.	25/06/2024	New referral form not being completed and finalised ready for use by the deadline	Potential patient harm, deterioration in reputation	5	5	25	Name: Task and finish group Description: The EMC commissioned a Task and Finish Group to assess the reasons why safeguarding referrals have not been processed as expected. Progress reports from the Task and Finish Group are presented fortnightly at EMC. Owner: Craig Ellis	Name: Weekly reports to EMC Description: Reports are sent weekly for EMC to review Owner:	Name: Dedicated PMO oversight Description: There is a dedicated PMO in place Owner:	Name: Dedicated Safeguarding Professional Description: There is a dedicated Safeguarding Professional who is aliged to the project	Name: Priority 1 for Clinical Applications Dpecalist Description: There is a priority 1 in place for a Clinical Applications Specalist	Adequate	5	3	15	6	Name: Completion of task and finish group Description: Task and finish group to be completed Owner: Helen Young Due Date: 30th September 2024 Name: User testing Description: User testing to take place Owner: Joe Rouse Due Date: 15th June - 6th September Name: Launch of new referral form Description: New Safeguarding referral form to be launched and implemented. Owner: Helen Young Due Date: 30th September 2024	30th September 2024	Sarah Thompson	Escalated	Yes - High Score	Due to the high score and the scrutinity of our regulators this risk needs to be managed and overseen by EMC	Treat	
Incompatability of SCAS BI Function with Ortivus Risk	IF the Trust does not prioritise the development of a compatible BI function THEN the Trust will not be able to produce accurate and timely safeguarding training compliance reports RESULTING in an inability to track staff training	25/06/2024	Non-compatible BI function	Not producing accurate safeguarding training compliance reports therefore inable to track staff training records accurately	5	5	25	Name: Task and finish group Description: The EMC commissioned a Task and Finish Group to assess the reasons why safeguarding referrals have not been processed as expected. Progress reports from the Task and Finish Group are presented fortnightly at EMC. Owner: Craig Ellis	Name: Weekly reports to EMC Description: Reports are sent weekly for EMC to review Owner:	Name: Comissioned report Description: A commissioned report has been requested following escalation at Safeguarding Committee on the 20th June Owner:	Name: Meeting arranged Description: A meeting has been arranged on the 28th June to commence reviews		Needs Improvement	5	3	15	8	Name: Completion of task and finish group Description: Task and finish group to be completed Owner: Helen Young Due Date: 30th September 2024 Name: Commissioned report Description: A commissioned report being presented at Safeguarding Owner: Due Date: 8th August 2024	30th September 2024	Sarah Thompson	Escalated	Yes - High Score	Due to the high score and the scrutinity of our regulators this risk needs to be managed and overseen by EMC	Treat	
Training Compliance of Level 3 Safeguarding Risk	IF SCAS staff do not receive safeguarding training THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm	25/06/2024	Lack of safeguarding training	Potential patient harm	4	4	16	Name: Monitoring of compliance at committees Description: Monitoring of compliance of the training at relevant Committees Owner:	Name: Trajectory plan Description: Owner:	Name: Resources Description: Dedicated training resources Owner:			Adequate	4	3	12	6	Name: ECA training Description: Agree actions on training of ECAs Owner: Due Date: 8th August 2024	8th August 2024	Sarah Thompson	Open	No		Treat	
Delay in IT Developments with CP_IS Risk	IF the CP_IS system is not accessed regularly in the urgent care setting THEN the Trust staff member is not aware if the child has a child protection plan or is a looked after child RESULTING in the assessment of risk will then not be determined accurately.	25/06/2024	Access is not consistent across the Trust	Potential patient harm and poor quality care	4	4	16	Name: Reporting at Committees Description: Regular reporting to be presented at Committees Owner:	Name: CPIS Search Description: 111 and EOC have process to conduct a search on CPIS on every call with a person under 18 or pregnant over 20 weeks. Owner: Ruth Page				Ineffective	4	4	16	9	Name: Front line access Description: Add CPIS visibility to EPR for front line reews to see any safeguarding information needed for the job. Owner: Joe Rouse Due Date: 31st August 2024	31st August 2024	Sarah Thompson	Escalated	Yes - High Score	Risk is escalated due to the high score	Treat	
Relationship with Partner Agencies Risk	IF SCAS do not work effectively with the Safeguarding Children's Partnerships or Safeguarding Adult Boards THEN there is a risk that the Trust do not keep pace with the strategic work undertaken by the partnerships RESULTING in a failure to meet statutory requirements	25/06/2024	Lack of representation at the boards and partnerships Lack of resource to attend the boards and partnerships	Negative impact to the Trusts reputation for Safeguarding Potential to miss out on organisational learning Potential loss of ability to influence the wider safeguarding system Potential to miss out of policy or procedure updates	4	4	16	Name: Quarterly oversight meetings Description: Update to the 24 safeguarding boards from the ICS. Owner: Sarah Thompson	Name: ICB attend all safeguarding committees Description: Boards are invited to the Trusts Safeguarding Committee. Owner: Sarah Thompson	Name: Communication to safeguarding partnerships Description: Following incident on 18th April a communication is required for safeguarding partnerships, CQC, and ICB. Owner: Sarah Thompson	Name: Safeguarding Service meet regularly Description: Safeguarding service meet on a regular basis Owner: Sarah Thompson		Adequate	3	3	9	9	Name: Partner agencies Description: Involve partner agencies in user testing Owner: Joe Rouse Due Date: 9th September 2024	9th September 2024	Sarah Thompson	Open	No		Tolerate	Regulatory
MCA Assurance Risk	IF the Trust does not have the assurance that the MCA training has been embedded THEN the trust will have no oversight of the embedding of MCA in the trust RESULTING in potential failure to demonstrate regulatory requirements	25/06/2024	Lack of assurance around training	Failure to demostrate regulatory requirements	4	3	12	Name: Audits Description: 1st audit has taken place and initial findings known. Audits will be done quartely. Owner:	Name: Case examples Description: Case examples are evident from the audit Owner:	Name: Training compliance Description: High levels of training compliance Owner:			Adequate	3	3	9	6	Name: Quarter 2 audit Description: Quarter 2 audit to be undertaken Owner: Lisa Pearson Due Date: 30th September 2024 Name: Audit learning Description: understanding and implementation and communication of audit learning to be distributed Owner: Lisa Pearson Due Date: 30th September 2024	30th September 2024	Sarah Thompson	Open	No		Treat	
Inconsistent Supervision Risk	IF the Trust has inconsistent safeguarding supervision THEN there is a potential that patients will not be correctly identified RESULTING in potential patient harm.	25/06/2024	Inconsistency with safeguarding supervisions	Potential patient harm	4	3	12	Name: Documentation Description: Documentation of all supervision sessions are kept Owner:	Name: Supervision sessions Description: Supervision sessions take place Owner:	Name: Supervision policy Description: Supervision policy in place adhering to legislation	Name: Regular reporting Description: Regular reports to be presented at Safeguarding Committee		Adequate	3	3	9	6	Name: Report Description: A report to inform communications as to non attendance in area Owner- Jacqueline Osborne Due Date: 31st August 2024	8th August 2024	Sarah Thompson	Open	No		Treat	
Safeguarding Leadership Risk	IF the Trust does not prioritise the recruitment of a Head of Safeguarding THEN the safeguarding team will not have sufficient leadership RESULTING in a lack of an ability to meet objectives and increase the workload of team members, and other clinical directorate leaders.	25/06/2024	Inability to recruit	Objectives not being met, an increase in workload to the safeguarding team and other clinical directorate leaders	4	4	16	Name: Job Description Description: Job description has been approved by ESR panel Owner: Helen Young	Name: ICB Description: ICB have been informed and requested support Owner:				Adequate	4	3	12	6	Name: Recruitment Description: Recuritment taking place for the role of Head of Safeguarding Ownership: Helen Young Due Date: 31st August 2024	31st August 2024	Sarah Thompson	Open	No		Treat	
Safeguarding Business Continuity Risk	IF the Trust does not document it's business continuity plans THEN the team may not be able too implement it's business continuity plan effectively RESULTING in an inability to deliver the service.	25/06/2024	Lack of business continuity plan	Inability to deliver service needs	4	4	16	Name: Task and finish group Description: The EMC commissioned a Task and Finish Group to assess the reasons why safeguarding referrals have not been processed as expected. Progress reports from the Task and Finish Group are presented fortnightly at EMC. Owner: Craig Ellis	Name: SOP Description: A SOP is available for paper processes				Needs Improvement	3	3	9	6	Name: Business continuity plan Description: formalisation of safeguarding business continuity plan Owner: Due Date: 31st July 2024	31st July 2024	Sarah Thompson	Open	No		Treat	
Quality of Reconciliation Form Risk	IF the Trust's BI system and docworks are not compatible THEN the safeguarding team will not be able to accurately reconcile referrals RESULTING in potential missed referrals and inability to meet regulated timescales.	25/06/2024	Lack of compatibility between systems	Potential patient harm, deterioration in reputation, regulatory consequences	5	4	20	Name: Weekly reconciliation form Description: Weekly reconciliation form to be provided by BI Owner:	Name: Weekly audit of reconciliation form Description: Weekly reconciliation form to be audited for accuracy Owner:	Name: Task and Finish Group Description: Reconciliation form to be monitored through the task and finish group Owner:	Name: Regular reporting Description: Regular reporting to the Safeguarding Committee and Quality & Safety Owner:		Needs Improvement	4	4	16	9	Name: BI commissioned report Description: BI will produce commissioned reports that will be presented at Safeguarding Committee Owner: Craig Ellis Due Date: 8th August 2024	8th August 2024	Sarah Thompson	Escalated	Yes - High Score	Due to patient harm and historic serious incidents	Treat	
Frequency of Reconciliation Form Risk	IF the safeguarding team do not have the ability to review the reconciliation form daily THEN the safeguarding team will not be able to reconcile the unsent referrals within 48 hours RESULTING in potential patient harm.	25/06/2024	Lack of frequency with Reconciliation form	Potential patient harm, deterioration in reputation, regulatory consequences	5	4	20	Name: Weekly reconciliation form Description: Weekly reconciliation form to be provided by BI Owner:	Name: Weekly audit of reconciliation form Description: Weekly reconciliation form to be audited for accuracy Owner:	Name: Task and Finish Group Description: Reconciliation form to be monitored through the task and finish group Owner:	Name: Regular reporting Description: Regular reporting to the Safeguarding Committee and Quality & Safety Owner:		Needs Improvement	4	4	16	9	Name: BI commissioned report Description: BI will produce commissioned reports that will be presented at Safeguarding Committee Owner: Craig Ellis Due Date: 8th August 2024	8th August 2024	Sarah Thompson	Escalated	Yes - High Score	Due to patient harm and historic serious incidents	Treat	

Appendix 3– Docworks Referral solution Interim Clinical Safety Report

PLEASE NOTE THIS DOCUMENT IS UNDER REVIEW

NHS
South Central Ambulance Service
NHS Foundation Trust

Microsoft Word - 12-22 (i) Safeguarding Annual Report 2021-22_Final Draft

DocWorks Referral Solution

Document Management

Status:	**Final**	**Version:**	**V1.0**	**Version date:**	**21/03/2024**
Directorate / Programme:	Patient Care/ Safeguarding improvement	**Approved by** This document must be approved by the following people:			
IT Programme	N/A	**Version**	**Name of approver**	**Title**	**Date**
Document Reference	Interim Clinical Safety Case Report	**V 1.0**	**Daniel Dray (fact checked content)**	**Named Safeguarding Professional.**	**21/03/2024**
Director:	Craig Ellis/ Helen Young				
Owner:	Safeguarding				
Authors:	Alex White				

Revision History

Version	Name of reviewer	Title	Summary of changes	Date
V0.1	Alex White	CSO	Interim Safety Case Finalised.	19/03/2024
V1.0	Dan Dray, Alex White	Named Safeguarding Professional, CSO	Wording clarified and amended around Domestic Abuse referrals	21/03/2024

Related Documents

Ref	Doc Reference Number	Title	Version

Contents

Executive Summary

The DocWorks Referral Solution is used in SCAS to process and forward referrals. This includes falls, TIA, safeguarding, welfare, policy, and fire referrals. The system currently sits across two servers (DocWorks and SCAS). This report has been produced in collaboration with the safeguarding and clinical governance teams. The solution has not undergone a Clinical Safety assessment and has been subject to several incidents.

For the DocWorks referral solution 37 hazards have been identified with the risk ratings ranging from Low to Extreme. These hazards have 165 different possible causes. Due to the number of recommendations and severity of the unmitigated hazards this Clinical Safety Case cannot suggest that the system is currently safe. Therefore, the safety case has been produced as an interim report.

In order to reduce the risk of harm to patients to acceptable levels this report provides recommendations to the system owners. This report provides 36 separate recommendations which should be implemented. This report will be reviewed and re-issued when mitigations have been implemented and the risk reaches acceptable levels.

Definitions:

Term	Definition
Approver	Person in the Health Organisation with authority to sign the clinical safety documentation.
Clinical Safety Officer	Person in a Health Organisation responsible for ensuring the safety of a Health IT System in that organisation through the application of clinical risk management.
Clinical risk	Combination of the severity of harm to a patient and the likelihood of occurrence of that harm.
Clinical risk analysis	Systematic use of available information to identify and estimate a risk.
Clinical risk control	Process in which decisions are made and measures implemented by which clinical risks are reduced to, or maintained within, specified levels.
Clinical risk estimation	Process used to assign values to the severity of harm to a patient and the likelihood of occurrence of that harm.
Clinical risk evaluation	Process of comparing a clinical risk against given risk criteria to determine the acceptability of the clinical risk.
Clinical risk management	Systematic application of management policies, procedures, and practices to the tasks of analysing, evaluating, and controlling clinical risk.
Clinical Risk Management File	Repository of all records and other documents that are produced by the clinical risk management process.
Clinical Risk Management Plan	A plan which documents how the Health Organisation will conduct clinical risk management of a Health IT System.

Clinical risk management process	A set of interrelated or interacting activities, defined by the Health Organisation, to meet the requirements of this standard with the objective of ensuring clinical safety in respect to the deployment of a Health IT Systems.
Clinical safety	Freedom from unacceptable clinical risk to patients.
Clinical Safety Case	Accumulation and organisation of product and business process documentation and supporting evidence, through the lifecycle of a Health IT System.
Clinical Safety Case Report	Report that presents the arguments and supporting evidence that provides a compelling, comprehensible, and valid case that a system is safe for a given application in a given environment at a defined point in a Health IT System's lifecycle.
Clinical Safety Team	Members of the IT department with responsibility to plan and coordinate the Clinical Safety Case for a project(s) or programme of work, collate and present the clinical safety documentation for the reviewers and approvers.
Harm	Death, physical injury, psychological trauma and/or damage to the health or well-being of a patient.
Hazard	Potential source of harm to a patient.
Hazard Log	A mechanism for recording and communicating the on-going identification and resolution of hazards associated with a Health IT System.
Health Organisation	Organisation within which a Health IT System is deployed or used for a healthcare purpose.
Health IT System/Application	Product used to provide electronic information for health or social care purposes. The product may be hardware, software, or a combination.
Initial clinical risk	The clinical risk derived during clinical risk estimation taking into consideration any retained risk control measures.
Intended use	Use of a product, process, or service in accordance with the specifications, instructions and information provided by the manufacturer to customers.
Issue	The process associated with the authoring of a document. This process will include: reviewing, approval and configuration control.
Likelihood	Measure of the occurrence of harm.
Lifecycle	All phases in the life of a Health IT System, from the initial conception to final decommissioning and disposal.
Manufacturer	Person or organisation with responsibility for the design, manufacture, packaging or labelling of a Health IT System, assembling a system, or adapting a Health IT System before it is placed on the market and/or put into service, regardless of whether these operations are

	carried out by that person or on that person's behalf by a third party.
Patient	A person who is the recipient of healthcare.
Patient safety	Freedom from harm to the patient.
Post-deployment	That part of the lifecycle of a Health IT System after it has been manufactured, released, deployed and is ready for use by the Health Organisation.
Procedure	Specified way to carry out an activity or a process.
Process	Set of interrelated or interacting activities which transform inputs into outputs.
Release	A specific configuration of a Health IT System delivered to a Health Organisation by the Manufacturer as a result of the introduction of new or modified functionality.
Residual clinical risk	Clinical risk remaining after the application of risk control measures.
Reviewer	Person(s) responsible for reviewing Clinical Safety documentation, should be clinician from team with responsibility for the clinical system.
Safety incident	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare.
Safety Incident Management Log	Tool to record the reporting, management and resolution of safety incidents associated with a Health IT System.
Severity	Measure of the possible consequences of a hazard.
Third party product	A product that is produced by another organisation and not by the Health IT System manufacturer. Examples include operating systems, library code, database and application servers and network components.
Top Management	Person or group of people who direct(s) and control(s) the Health Organisation and has overall accountability for a Health IT System.

Introduction

Currently in South Central Ambulance Service (SCAS) some referrals to other agencies managed by the DocWorks referral solution. DocWorks refer to this solution as scribe, due to SCAS using scribe as a private provider EPR this report will term the solution the DocWorks referral solution for clarity. This solution processes and forwards the following referrals to the correct authorities:

- Falls referrals,
- TIA referrals,
- Fire safety referrals,
- Safeguarding referrals,
- Welfare referrals.
- Domestic abuse referrals.

The referrals solution gathers referrals from multiple sources including the SCAS and private provider EPR devices, and the DocWorks referrals form via web browser (for Safeguarding, Welfare, Domestic abuse (to police) and Fire referrals). This is a legacy solution introduced before the SCAS established a Clinical Safety process and change control.

The DocWorks solution for Safeguarding has been migrated from a historic SCAS server to a DocWorks server. However, TIA and Falls referrals still sit on the SCAS legacy server. The referrals system has been subject to frequent safety incidents. These are recorded in the Datix reports spreadsheet. All supporting documents including Datix reports spreadsheet can be found here: Clinical Safety Case Supporting Documents

This Interim Clinical Safety Case has examined the whole package of referrals, it aims to provide a review of identified hazards within the system. The Interim Clinical Safety Case Report will give recommendations which will help ensure the system is safe for patients and enable a final Clinical Safety Case Report (recommending the system as safe to use) to be created.

Purpose and Legislation

Information standards underpin national healthcare initiatives from the Department of Health, NHS England, the Care Quality Commission, and other national health organisations. They provide the mechanism for introducing requirements to which the NHS, those with whom it commissions services and its IT system suppliers, must conform.

Compliance with DCB0129 and DCB0160 is mandatory under the Health and Social Care Act 2012.

“DCB0160 – Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems” is the

standard that requires a health organisation to establish a framework within which the clinical risks associated with the deployment and implementation of a new or modified health IT system are properly managed.
This document is one of three deliverables mandated by the Information standards as part of the Clinical Safety Case for a Health IT System.

- Clinical Safety Plan
- Hazard Log
- Clinical Safety Case Report

The purpose of a Clinical Safety Case Report is to present the arguments and supporting evidence that provides a comprehensive and valid case that the is safe for a given application in a given environment at a defined point in a Health IT System's lifecycle. It demonstrates the effective clinical risk management carried out by South Central Ambulance Service during the deployment, use, maintenance and decommissioning of Health IT Systems within the Trust and compliance with the above standard.
This Interim Clinical Safety Case Report is not able to make this argument and instead will give recommendations to the trust which will enable the system to be considered safe. Only when these have been implemented could the system be considered safe.
An interim report is an exceptional requirement, this was created due to the number of recommendations requiring implementation.

What is the System/Application?

Description of the Health IT System;

Currently several key referrals from SCAS use a solution provided by DocWorks to process these and forward them to the correct authority. This process current covers the following referrals:

- Falls referrals,
- TIA referrals,
- Fire safety referrals,
- Safeguarding referrals,
- Welfare referrals.
- Domestic abuse referrals (to Police).

The Dochaven server processes referrals from the DocWorks referral portal, the Ortivus EPR, the DocWorks Scribe EPR and paper referrals (sent via email or picture). The server produces a PDF report, identifies the correct

local service, and then forwards the referral to them. Referrals that are not sent automatically have to be sent manually by the safeguarding team.

Identification of Health IT System part and version number;

The DocWorks referral solution is referred to as Scribe in the DocWorks Clinical Safety Case. SCAS already use a Scribe EPR system, therefore this safety case refers to the DocWorks referral solution to avoid confusion. The system is currently in use and the version number is: 2.1.0.2.

This Clinical Safety review was carried out to review the unrecognised Clinical Safety risk in legacy systems. The DocWorks system has a series of legacy paper forms which are used as a business continuity solution (although not supported by a formal plan).

Description of any existing systems it replaces or interfaces with;

The DocWorks referral solution interfaces with several SCAS Systems:

- Ortivus EPR: The referral portal receives, and processes referrals made from the Ortivus EPR by front line ambulance crews. These referrals use an Ortivus safeguarding form which is then broken down and extracted into a DocWorks PDF. It also accepts both falls and TIA forms from the Ortivus EPR, although TIA are manually forwarded.
- Scribe web portal: The web portal allows staff in the Clinical Communications Centre to create and send safeguarding referrals. This includes patients from 111 and 999.
- CAD software (Adastra, ICad, Cleric): The referral solution can offer the ability to match the patient using CAD software. This feature is not currently fully enabled.

Clinical Risk Assessment

The Hazard log highlights identified hazards within the system, reviews existing mitigations and proposes further mitigations to reduce to risk of harm to as low as reasonably possible. The hazard log was constructed through the Clinical Risk Assessment process.

Clinical Risk Analysis

Hazards were identified through:

- Audit of reported Datix incidents
- Manufacturers Clinical Safety Case
- Workshops with SMEs
- SWIFT analysis
- Process mapping
- Review of supporting documents

The identified hazards were reviewed at hazard workshops. These workshops aimed to share knowledge of hazards and gain a shared understanding of the level of risk. The hazards were rated in collaboration with the

Clinical Safety Officer. Once hazards had been scored a series of mitigation workshops took place to consider recommendations and actions which could reduce the risks. The hazard and mitigation workshops are recorded below:

Workshop type	Workshop Date	Attendee(s)
Hazard Workshop	13th December 2023	Named Safeguarding Professional (Adults), Clinical Safety Officer, Clinical Applications Specialist, CCC non-Clinical Education.
Hazard Workshop	9th January 2024	Clinical Governance Leads, Clinical Safety Officer
Hazard Workshop	11th January 2024	Named Safeguarding Professional (Adults), Clinical Safety Officer
Hazard Workshop	25th January 2024	Named Safeguarding Professional (Adults), Clinical Safety Officer
Hazard Workshop	29th January 2024	Clinical Applications Specialist, Clinical Safety Officer
Mitigations Workshop	28th February 2024	Named Safeguarding Professional (Adults), Clinical Safety Officer
Mitigations Workshop	4th March 2024	Clinical Safety Officer, Clinical Applications Specialist, CCC non-Clinical Education.
Mitigations Workshop	7th March 2024	Clinical Safety Officer, Clinical Applications Specialist
Mitigations Workshop	8th March 2024	Assistant Director of Quality, Clinical Safety Officer

Hazard assessment was limited by the lack of design specification or clear system design documents. The Hazard Log was shared with the manufacturer (DocWorks) for comment and input however no response was received by conclusion of hazard/mitigations workshop activity.

Clinical Risk Evaluation

The SCAS risk assessment matrix, likelihood criteria, risk descriptor/severity table and acceptable levels of risk can all be found in the Digital Clinical Safety Policy (approval pending). These criteria are closely linked to the NHS England suggested tables with local adaptations to integrate with existing trust risk policies and processes. It is important to note that in line with NHS England (Formerly Digital) practice for digital clinical risk the likelihood and severity values are not multiplied in the table (see below).

Likelihood						
	Very High	3	4	4	5	5
	High	2	3	3	4	5
	Medium	2	2	3	3	4
	Low	1	2	2	3	4
	Very Low	1	1	2	2	3
		Minor	Significant	Considerable	Major	Catastrophic
		Severity				

The SCAS Digital Safety Likelihood table can be found below.

Likelihood Category	Interpretation
Very high (>60%)	Certain or almost certain; highly likely to occur
High (26-60%)	Not certain but very possible; reasonably expected to occur in the majority of cases
Medium (6-25%)	Possible
Low (1-5%)	Could occur but in the great majority of occasions will not
Very low (<1%)	Negligible or nearly negligible possibility of occurring

The SCAS digital harm severity table has several key differences from other documents used within the organisation, in line with NHS England recommendations. Key changes being the use of multiple patient deaths and the inclusion of psychological trauma. Further in-depth analysis can be found in the SCAS Digital Safety Policy.

Severity Classification	Interpretation	Number of

		Patients Affected
Catastrophic	• Death • Permanent life-changing incapacity and any condition for which the prognosis is death or permanent life-changing incapacity; severe injury or severe incapacity from which recovery is not expected in the short term	Multiple
Major	• Death • Permanent life-changing incapacity and any condition for which the prognosis is death or permanent life-changing incapacity; severe injury or severe incapacity from which recovery is not expected in the short term	Single
	• Severe injury or severe incapacity from which recovery is expected in the short term • Severe psychological trauma	Multiple
Considerable	• Severe injury or severe incapacity from which recovery is expected in the short term • Severe psychological trauma	Single
	• Minor injury or injuries from which recovery is not expected in the short term • Significant psychological trauma	Multiple
Significant	• Minor injury or injuries from which recovery is not expected in the short term • Significant psychological trauma	Single
	• Minor injury from which recovery is expected in the short term • Minor psychological upset; inconvenience	Multiple
Minor	• Minor injury from which recovery is expected in the short term; minor psychological upset; inconvenience; any negligible consequence	Single

The acceptable levels of risk table can be found below. This is an adaptation of the NHS England suggested Digital Risk table with changes to the actions and review of risk to align with trust policy.

Level of risk	Descriptor/Actions	Review of Risk	Frequency of review
Extreme (5)	Unacceptable level of risk. Mandatory elimination or additional control measures. Added to corporate risk register and escalated to executive director. Long term improvement strategy may be required.	Exec Director, Quality and Safety Committee and Clinical Safety Team	Monthly
Very High (4)	Unacceptable level of risk. Mandatory elimination or additional control measures. Added to corporate risk register and escalated to executive director. Long term improvement strategy may be required. Risk benefit analysis required before system adoption.	Exec Director, Quality and Safety Committee. and Clinical Safety Team	Monthly
High (3)	Undesirable level of risk. Attempts should be made to eliminate the hazard or implement control measures to reduce risk to an acceptable level. Shall only be acceptable when further risk reduction is impractical. Root cause analysis may be beneficial.	and Safety Committtee, Head of ICT, SRO and Clinical Safety Team	Every 3 months
Moderate (2)	Acceptable where cost of further reduction outweighs benefits gained or where further risk reduction is impractical	Clinical Safety Team and Stakeholders	Every 6 months
Low (1)	Acceptable, no further action required	Clinical Safety Team and Stakeholders	Every 12 months

The Digital Clinical Safety Policy can be found here: Digital Clinical Safety Policy

Clinical Risk Control

Existing controls are identified during the hazard workshop process and reviewing documentation. Existing controls are deemed adequate where the risk remained moderate or below. Some additional controls are required, and these are discussed in the hazard log section. The aim of applying additional controls to an existing hazard is to reduce the risk to as low as reasonably practicable.

Additional controls were identified during the hazard mitigation workshops. These will be discussed further in the recommendation section. The additional controls/mitigations will require implementation before the system can be considered safe.

Quality Assurance and Document Approval

The Digital Clinical Safety Policy sets out the assurance process in SCAS for providing Digital Clinical Safety assurance. The policy requires the report to be approved by two committees. Due to the interim nature of this report sign off as top management is not required. This would be required if the report recommended that the system was safe.

For accuracy and quality assurance the Interim Clinical Safety Case report has been reviewed by the Named Safeguarding Professional-Adults and the Clinical Applications Specialist.

Configuration Control / Management

The initial configuration and design of the system are unclear. To date, no design documents or system specification has been shared with SCAS. There is no formal change control process between SCAS and DocWorks. This has led to untested change occurring in the live system. The proposed new form has been designed and configured by the safeguarding team. The team have involved external subject matter experts in the design process. This is pending implementation and testing.

The live system has no formal issue escalation process documented. In practice the safeguarding team contact DocWorks directly with issues. The Datix system is for escalating incidents where harm could have or did occur.

Hazard Log

The hazard log highlights hazards identified through the Clinical Safety Process. It is designed to explore the relative risk of these hazards, any existing controls and any mitigations required as to reduce the risk to an acceptable level.

For the DocWorks referral solution 37 hazards have been identified with the risk ratings ranging from Low to Extreme. These hazards have 165 different possible causes. A summary of the different ratings can be seen below. The final risk rating considers the level of harm after the proposed mitigations/recommendations have been implemented. As all of these are pending implementation attention should be drawn to the initial risk ratings. These represent the system in its current state.

The table below reports the highest risk rating from the range of causes attributed to each hazard.

Initial risk rating	**Number of hazards**	**Risk rating after recommendations.**	**Number of hazards**
Extreme (5)	1	Extreme (5)	0
Very High (4)	8	Very High (4)	0
High (3)	15	High (3)	15
Moderate (2)	13	Moderate (2)	19
Low (1)	0	Low (1)	3

Even with mitigations in place a significant amount of risk remains. During the hazard workshops the safeguarding team were able to give instances where death had occurred when the safeguarding process has broken down. Therefore, for the level of harm is major for categories of referral which cover the highest risk patient groups. These are: TIA, Domestic Abuse and Fire risk.

The Hazard Log is updated over the lifetime of the system, this can be triggered as part of a standard review, due to a clinical incident or due to a planned upgrade. The full Hazard Log can be found here: Hazard Log V1.0

Key Hazards

Standard practice in Digital Clinical Safety is to individually highlight and report every hazard of level 3 and higher. Due to the number of hazards this is impractical. A summary will be provided of extreme and very high hazards at initial rating. Key hazards are highlighted below:

Issue Number HAZ-007	**Hazard Name** Referral portal cannot process paper TIA referral.
Hazard Description As a backup process legacy paper TIA referral forms are available on ambulances (CAS 170). These have to be manually scanned or emailed.	
Potential Clinical Impact Patient cannot be appropriately referred to the TIA clinic. They remain at increased likelihood of further TIA events if untreated.	
Possible Causes • Form not filled in correctly leaving vital information missing or illegible handwriting. • Scanner unavailable- form cannot be scanned in. • Photo taken of form poor quality and cannot be processed.	**Existing Controls** • Paper PCR can be reviewed for more details- if it is scanned in timely manner. • Paper can be scanned at Berrywood (would delay referral)
Initial Risk Rating Very High (4)	**Proposed Mitigations/Recommendations** • Update and redesign paper form as part of business continuity plan review. • Ensure existing training packages cover business continuity plan. • Create a formal, written, and tested business continuity plan.

Issue Number HAZ-020	**Hazard Name** Domestic abuse referral unable to be actioned by police/appropriate team.
Hazard Description The Domestic referral is successfully received but is not actioned by the team. The patient is not protected from further harm or assessed.	
Potential Clinical Impact The patient is not protected and remains at high likelihood of violence and/or harm.	

Possible Causes	Existing Controls
• Lack of or incomplete information in the domestic abuse referral • Patient location not captured- unable to follow up. • Incorrect information recorded in referral. • DASH team are unable to contact patient- no contact information.	• Police have ability to contact safeguarding team for further enquiries.

Initial Risk Rating	Proposed Mitigations/Recommendations
Very High (4)	• New form design (designed by safeguarding) to ensure appropriate details captured. • User and quick reference guides created. • Form completion included in training package. • SOP for feedback from partner agency. • SOP for patient location not captured or patients who have no fixed above.

Issue Number	Hazard Name
HAZ-021	Fire safety referral not actioned by fire service

Hazard Description

The fire safety referral is sent to the local fire service when patients are identified who may struggle to exit the building in a fire. They are also identified if they have high fire loading in the property or inadequate fire protection. This hazard considers this referral arriving but not being actioned.

Potential Clinical Impact

The fire safety issues are not actioned by the fire service. The patient remains exposed to likelihood of harm.

Possible Causes	Existing Controls

• Lack of or incomplete information in fire safety referral • Handwriting on paper back up for illegible • Fire service unable to contact patient as contact information missing	• •Fire services do contact SCAS safeguarding team for further information
Initial Risk Rating Very High (4)	**Proposed Mitigations/Recommendations** • New form design, designed by fire service to capture appropriate information. • User and quick reference guide created. • Training package captures key fields. • Creation of business continuity plan.

Issue Number HAZ-025	**Hazard Name** Clinical information missing from display (transferred from supplier hazard log)
Hazard Description Clinical information is missing due to an issue with the Doc-Works platform.	
Potential Clinical Impact Referral destination acts upon incomplete information presented. Causing inappropriate treatment or care.	
Possible Causes • Information not transferred from device application to portal. • Wrong form presented by referral logic (i.e. paediatric form for adults) • Delay in information transfer. • Server downtime	**Existing Controls** • EPR team maintain EPR tablets. • Safeguarding team cannot delete records- only DocWorks.

• Design not tested for safety or usability. • Poor software performance • Poor hardware performance • Record deleted.	
Initial Risk Rating Very High (4)	**Proposed Mitigations/Recommendations** • Program of testing for new form and platform. • Creation of business continuity plan. • Creation of formal issue escalation process. • SGT portal training with user and quick reference guide.

Issue Number HAZ-026	**Hazard Name** Misleading presentation of clinical information. (transferred from supplier hazard log)
Hazard Description Clinical information is presented in a misleading manner due to design or presentation issues within Doc-Works.	
Potential Clinical Impact Referral destination acts upon incomplete or misleading information causing inappropriate treatment.	
Possible Causes • No user testing. • Inappropriate UI design or inconsistent elements • Wrong form presented by referral logic (e.g. paediatric form for adults) • No user training. • Incorrect or inappropriate config	**Existing Controls** • Form can be created with unknown patient details. • NHS number and date of birth captured by form.

• Unknown patient details • More than one patient with the same name.	
Initial Risk Rating Very High (4)	**Proposed Mitigations/Recommendations** • Program of testing for new form and platform. • SOP or process for unknown details. • Creation of formal change process • SGT portal training with user and quick reference guide. • Appropriate training environment • Robust training package capturing hazards.

Issue Number	**Hazard Name**
HAZ-028	User enters incorrect patient information. (transferred from supplier hazard log)
Hazard Description The end-user enters incorrect patient information into the DocWorks referral system. This could lead to the wrong patient being contacted, or the service unable to contact the patient.	
Potential Clinical Impact Referral information entered incorrectly and due to this the patient receives incorrect or delayed treatment/support.	
Possible Causes • No training surrounding referral requirements. • No training surrounding clinical referrals (TIA/Falls) • Poor interface design • Human error without mitigations • Configuration incorrect or inappropriate	**Existing Controls** • Some training regarding system in level two EOC training package.
Initial Risk Rating	**Proposed Mitigations/Recommendations**

Very High (4)	• Program of testing for new form • User and quick reference guides created. • Training package reviewed to capture hazards and processes. • Change control process established.

Issue Number	**Hazard Name**
HAZ-029	Referral not received by DocWorks server. (DATIX 69904 and 68929)

Hazard Description

The referral report created through the DocWorks user portal or an EPR device is not received by the DocWorks server. This in turn means that the referral cannot be processed and sent.

Potential Clinical Impact

Patient is not referred and so remains exposed to harm.

Possible Causes	**Existing Controls**
• Outbound EPR NHS.net email inbox full. • DocWorks email inbox full • Inbox not managed. • No storage on server • Connectivity problems • Incorrect or inappropriate config	• Server now migrated; more capacity available. • Ortivus inbox reconfigured, now does not save notifications. • Data watcher deletes email after data stripped.

Initial Risk Rating	**Proposed Mitigations/Recommendations**
Very High (4)	• Program of testing for new form and platform. • Need for system manager function to maintain and review system and mailboxes. • Formal BCP and review of paper solution. • Change process agreed with DocWorks.

Issue Number	**Hazard Name**
HAZ-034	Referral unable to be made electronically during downtime.

Hazard Description

There is no business continuity plan for the referral server. Paper backups exist for operational forms, however there are no paper backups for EOC/111. Nor is there a business continuity plan for colleagues to follow.

Potential Clinical Impact

Patients are unable to be safeguarded or referred during a system outage. This leaves patients exposed to harm.

Possible Causes	**Existing Controls**
• No business continuity process • Operational paper back up forms misleading and contain out of date fax information. • Paper back up forms not available • Backup forms not available in sufficient quantities	• Team leaders and managers given access to desktop portal. • Informal BCP process in place.

Initial Risk Rating	**Proposed Mitigations/Recommendations**
Extreme (5)	• Creation of user and quick reference guide. • Creation of business continuity process. • Formal business continuity plan and review of paper backup solution.

Issue Number	Hazard Name
HAZ-036	Ortivus referrals not processed through DocWorks referral solution. Datix: IR 69662

Hazard Description

The DocWorks email watcher tool does not extract Ortivus referrals successfully into the DocWorks referral solution. This leads to the Ortivus safeguarding referrals not being sent.

Potential Clinical Impact

Referrals unable to be sent. Patients are unable to be protected from harm.

Possible Causes	Existing Controls
• SCAS unable to monitor referral status. • Human process breaking down	• EPR highlights locally if email is unable to be sent.

Initial Risk Rating	Proposed Mitigations/Recommendations
Very High (4)	• DocWorks status email needs to include digital team. • Referral status report needs to be produced. • Formal BCP • System manager responsibility to include monitoring. • Issue escalation process. • Safeguarding monitoring SOP highlighting expected levels of referrals. • User guide and quick reference guide.

Test Issues

No evidence can be found currently that the SCAS implementation has been tested. This therefore remains a risk. Limited cut over testing with minimal resources and time pressures, took place covering the migration of the system from the SCAS server to the DocWorks server. The testing was limited by the lack of test environment and change control process. The testing did not consider end to end functionality of the system.

Recommendations

A typical Clinical Safety Case Report would seek to provide assurance that a system is safe to use in an organisation. With the number of recommendations, the severity of hazards, and the lack of safety process this is not appropriate. This report will therefore provide recommendations which, if implemented, would allow a future

Clinical Safety Case Report to declare the system as safe to use in SCAS.

Training

Training material exists in several training packages (Safeguarding level 2 and system specific), training was occurring in the live system as part of these packages. This practice is unacceptable and must cease.

- To mitigate hazards the training package needs to be brought together as a single package supported by a user guide and quick reference guide for safeguarding, domestic abuse, fire, and welfare. This will support the safe and effective use of the system.
- For TIA and Falls, the referral process and BCP need to be included in the EPR training packages or condition specific sessions.
- To ensure training can take place effectively, a training environment should be provided.
- Training packages should include business continuity plans and process. This will ensure awareness of business continuity plans.
- A training package and user guide for SGT screen (safeguarding team referral interface) should be provided. This will ensure consistent use of the function.
- Key fields should be highlighted in the training package, to ensure the referrals can be actioned.
- The training package and user guide should highlight process for referring patients who have no fixed abode.
- Training should be audited/ quality assured by the safeguarding team to assure standards.
- Any training packages need to highlight the information that is displayed to the referral receiver (for example which Ortivus fields are included). This will support staff in performing better quality referrals.

Business Continuity

Health IT systems require downtime occasionally to facilitate updates, upgrades, and server maintenance. The Business continuity solution is also required for unplanned downtime.

- A business continuity plan should be created to support safe referrals when the system is not available.
- The business continuity paper forms should be reviewed and updated to ensure currency.
- Staff should be trained on the business continuity solution as part of their systems training. To ensure they can make effective referrals during system downtime.

SOPs and Documents

SOPS and documented processes need to be produced to support the safe use of the system. These should include:

- An account creation SOP (where this does not happen automatically).

- A training SOP. This will explain how to access the training system.
- An issue escalation SOP/Process (to DocWorks). To ensure faults are raised and documented in a precise and timely manner with SCAS oversite.
- A change process should be agreed and documented between DocWorks and SCAS. This process should also cover configuration changes. This will help ensure any future change is planned, agreed, and appropriately tested.
- A SOP/process for unknown patient details and patients of no fixed abode. To ensure this vulnerable patient group is protected consistently.
- A SOP for escalation by third parties (organisations that need information from SCAS in response to a referral).
- A process created to monitor referrals sat in save and not sent.
- An operational bulletin to highlight that referrals should be created and sent straight after completing a call in CCC/EOC. This will ensure CCC referrals are not unduly delayed.
- A process for ongoing mailbox monitoring. To ensure partner agencies are responded to in a timely manner.
- Clear ownership and control of system established, including responsibility for the day-to-day management of the system. To ensure accountability for monitoring and maintenance tasks.
- The SGT screen SOP is complicated, it should be updated, simplified, and included in the user guide.
- A SOP/Process to change and update email addresses within the system. This will help ensure referrals reach the correct location.
- A SOP highlighting expected daily number of referrals and monitoring process. This will help highlight if processes outside the remit of the safeguarding team have broken down.

Design and Test

The degree to which DocWorks referral solution has been tested historically is unclear. The following are important to mitigate hazards and ensure the system works as expected:

- It is recommended that the new safeguarding form is implemented alongside an appropriate program of end-to-end testing.
- The TIA process should be fully digitalised, reducing the risk of human error or process breakdown.
- Consideration should be given to the possibility of single sign on to reduce log in difficulties (use of Microsoft log in credentials to reduce multiple passwords).
- Explore integration with CAD, Adastra and Cleric to ensure correct patient data is transferred onto the form.

- Make post code a mandatory field on the new form. This may reduce the number of referrals needing manual processing.
- Explore removing the manual save (not save and send) function from my referrals. This may reduce the risk of referrals being delayed in CCC.
- Ensure emails containing referrals have a clear point of contact for external partners.
- Multi-factor authentication should be implemented for admin accounts to ensure they are secure.
- The auto filling of referral forms in Microsoft Edge needs solving with configuration changes to Microsoft Edge or the DocWorks referral platform. This will stop incorrect data being automatically inserted into the form by Edge.
- Referral status report highlighting numbers of referrals in different parts of the system. This will enable better oversite and monitoring. This should be shared outside of the safeguarding team to enable greater oversight.

NHS
South Central
Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	IPC Annual Report 2023/24
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	I5
Executive Summary:	**IPC Annual DIPC Report for 2023/24** **Achievements** • A revised and comprehensive Audit Schedule. • Successful transition and Recovery returning to Pre-Pandemic systems and processes. • Implementation of additional IPC Training on Statutory and Mandatory Face to Face Virtual Training Days. • Complete Phase 1 Sluice Upgrade Programme. **Areas of partial assurance/Improvement focus** • Infection Prevention and Control Compliance Audits **Flu vaccination** Number of staff recorded as having had a flu vaccination low in 2023 /24. Barriers to achieving a greater uptake by our frontline staff including: • Vaccine lethargy • Lower levels of circulating flu virus over the past two years • Location and accessibility of the flu vaccination clinics **2024 – 25 IPC work plan approved** • Contains plans to address al areas of partial compliance identified against the IPC BAF
Recommendations:	The Board is asked to note the report.
Accountable Director:	Helen Young Chief Nursing Officer
Author:	Siobhan Fensom - Infection Prevention & Control Lead.

Previously considered at:	IPC Committee Quality and Safety Committee, 18 September 2024
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Partial
Justification of Assurance Rating:	Assurance Partial due to noncompliance with audit Work plan for 2024 – 25 Audit planner Improvement plan reports to IPC committee and Q&S Committee
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:	Publish and share with ICB.
List of Appendices	Not Applicable

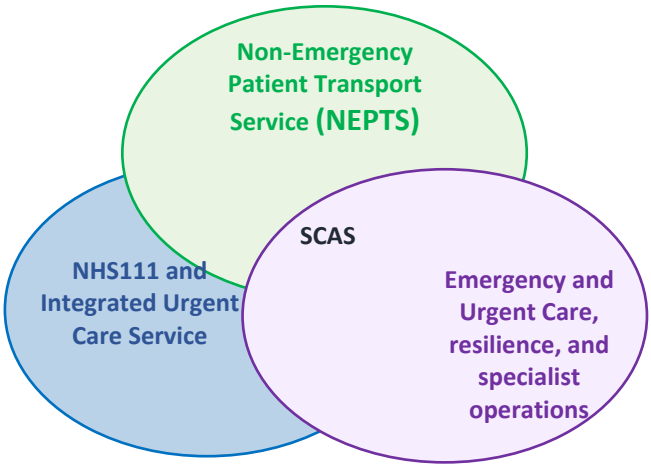
Director of Infection Prevention and Control
Annual Report 2023-2024

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

Contents

1. Overview

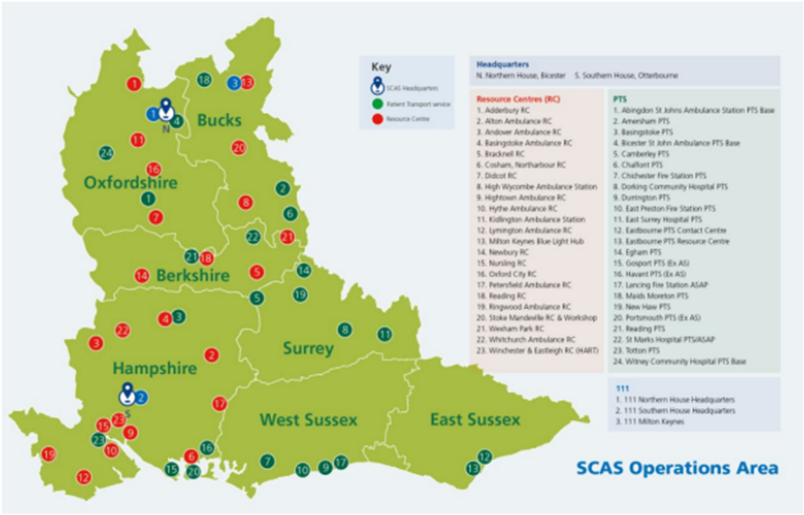
South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). SCAS is one of 10 ambulance services in England and serves the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire.



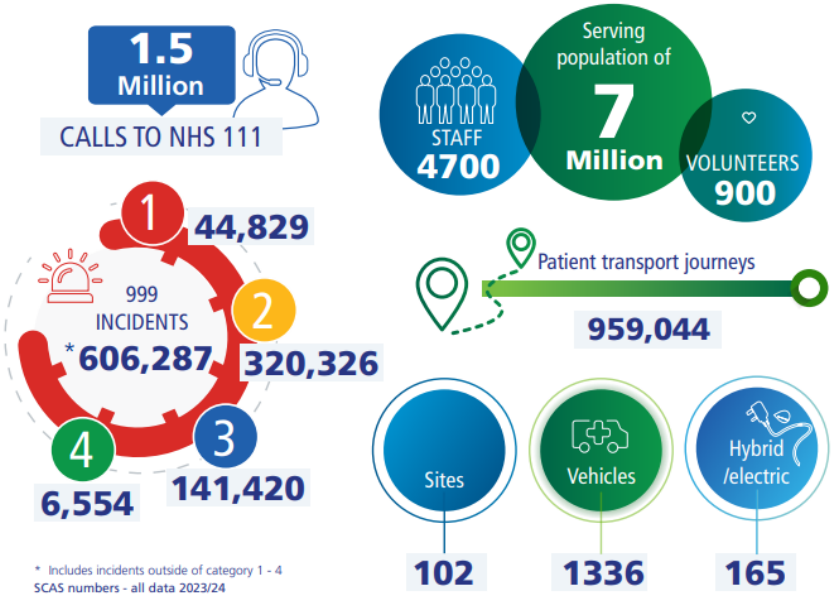
SCAS has over 103 sites across the South-Central area and Non-Emergency Patient Transport Services (NEPTS) in Surrey and Sussex, to support the delivery of our NEPTS contract.

There are headquarters in Bicester, Oxfordshire and Otterbourne, Hampshire. Each of these sites also houses a Clinical Co-ordination Centre (CCC), where 999 and NHS 111 calls are received, clinical advice provided, and emergency vehicles dispatched if needed. There is also a NHS 111 facility in Milton Keynes.

There are three NEPTS Contact Centres and 24 NEPTS bases, and there are 23 Ambulance Resource Centres. The Trust delivers care in the community which means the Trust supports patients at home and in their local area.

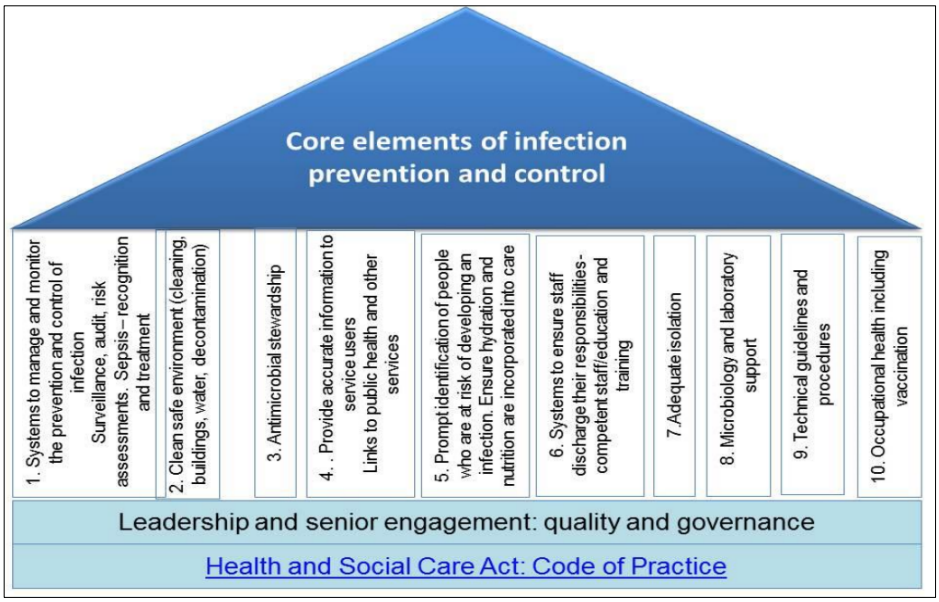


South Central Ambulance Service Summary in numbers:



Executive summary

The Trust is committed to the prevention and control of infection, minimising the risks and impact of healthcare associated infections for patients, staff and the organisation overall. The Health and Social Care Act 2015, Code of Practice on the Prevention and Control of Infections and related guidance updated 2022, states that *good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone*. This approach is implemented across all SCAS services.



This approach remains key. There is a continued requirement for change for day-to-day Infection Prevention and Control (IPC) to return to pre pandemic systems and processes and a risk assessed based approach to IPC measures. There remain areas for improvement and within SCAS there continues to be a committed approach to working in line with the CQC recommended 'should' action for IPC to address the shortfalls after the Care Quality Commission (CQC) inspection in 2022 – in relation to audit assurance, hand hygiene and culture of IPC being 'everybody's business.

Within SCAS, the Trust Board is accountable for ensuring that there are effective IPC arrangements within the Trust. The Board receives an IPC report as part of the integrated governance report which highlights key work streams and areas of risk. The Board also receives and approves the annual IPC report and strategy.

The prevention and control of healthcare acquired infections (HCAIs) is designated as a core part of the organisation's governance and patient safety programmes. IPC is delegated through the Board to the Director of Patient Care and Service Transformation/Chief Nurse and given the role of Director of Infection Prevention and Control (DIPC). The DIPC is further supported by the IPC Lead to embed IPC practices Trust-wide (see appendix 1 and 2).

The Trust receives support from the occupational health service, Optima Health, who provide services to SCAS to aid managing all aspects of staff health and report and advise on occupation-related health compliance.

Compliance with the Health and Social Care Act requires NHS organisations to receive microbiology support for the IPC function. From 2023-2024 SCAS has had a SLA with our acute partner organisation Oxford University Hospital (OUH) to provide this service.

SCAS IPC is part of a wider network of IPC groups, working with our integrated care boards and national partners to ensure learning and developments in IPC are shared. Over the year 2023-2024 SCAS participated and collaborated within the Hampshire and Isle of Wight Integrated Care Board Network and Lead Meetings, and with Berkshire, Oxfordshire, and Buckinghamshire Integrated Care Board (BOB).

SCAS IPC is regulated by Hampshire and Isle of Wight Integrated Care Board, Legislation, the CQC), the Department of Health and NHS England (NHSE). Cleanliness standards are monitored against national cleaning standards and monitored through the Trust IPC Committee and governance framework. Standards are related to policy, procedures, and outcomes, and include the provision of high-quality facilities and standards of practice. The Trust has taken measures to ensure that our policies and processes adhere to the requirements and performance outlined by the following:

- CQC, Fundamental Standards
- The National Infection Prevention and Control Manual for England
- National Cleaning Standards for Healthcare (2021)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 (updated 2022)
- Health and Safety Executive advisory committee on dangerous pathogens
- NICE Guidelines

- EPIC 3 - National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England
- Standard infection control precautions: national hand hygiene and personal protective equipment policy (2019)

Compliance with relevant national and local standards, guidance and policies supports effective infection prevention and control practice Trust-wide. Success depends on personal accountability, skilled and competent staff, transparent and integrated working practices, and clear management processes. IPC practice is integrated into each new employee's induction and is continued throughout their SCAS career with additional e-learning.

Assurance and compliance

IPC compliance is monitored through a live online audit system (Audit Online) focusing on individual staff compliance with hand hygiene, vehicle and building cleanliness. Compliance data from SCAS-specific systems is imported to Audit Online on a weekly basis to ensure staff, vehicle and building data is accurate. The wider quality and compliance team then complete assurance audits and support with agreed actions and recommendations that need to be resolved to ensure a level of compliance is met.

The Datix incident reporting system for patient safety events and non-patient incidents including needlestick injuries, exposure to body fluids and infectious diseases is utilised within SCAS. SCAS promotes an open reporting culture and encourages all staff to report all incidents and near misses.

The IPC Committee (IPCC) meets on a quarterly basis and monitors compliance and completeness of IPC Level 1 audit functions alongside any IPC incidents, estates development, water testing, antimicrobial prescribing and reviews actions taken against the IPC annual work programme. This work programme operates alongside a CQC improvement workstream that continues for IPC during the 2023-2024 financial year to address the recommendations made by the CQC in 2022, with achievements against this being reported to the IPCC. This ensures that all aspects of infection, prevention and control are reviewed by representatives of all services and that the risks are fully discussed, lessons learned and actioned where required. The IPCC upwardly reports to the Trust's Quality and Safety Committee.

Introduction

The annual report provides information and evidence of the Trust's ongoing commitment to IPC, embedding these key principles and practices throughout the organisation. The report identifies the significant improvement the Trust has made within infection prevention and control in all areas of the organisation. This report is the annual report from the Director of Infection Prevention and Control (DIPC). The report will inform the Trust Board of the IPC standards and risks within the organisation.

It will also provide assurance of the progress made against the Health and Social Care Act: *Code of Practice for the prevention and control of infection* and related guidance (July 2015) and the Care Quality Commission (CQC) standards over the last twelve months. The

updated annual work programme for 2024-2025 provides an overview of the priorities for the upcoming year and is attached to this report (Appendix 5).

At the end of the year 2023-2024, SCAS declared compliance in IPC practices. Where IPC non-compliance is demonstrated action plans, recommendations and timeframes are given to service lines to address IPC issues.

The IPC Lead has developed this report on behalf of the Director of Infection Prevention and Control (DIPC). It highlights the development, progress, governance and IPC risks across the Trust and the actions taken to prevent harm to patients in our care during 2023-2024. It also provides assurance of the improvements made alongside the Health and Social Care Act (2008) Code of Practice for the prevention and control of infection (updated July 2022), the CQC standards and the working environment for staff, in line with the National IPC Manual for England (NIPCM).

The table below details the 10 Criterion required for compliance with the Health and Social care Act and the actions, policies, and education in place to ensure these criterions are met.

	Criterion	Achieved through:
1.	Systems to manage and monitor the prevention and control of infection.	Annual Plan, Annual Report, Risk Assessments, Audit Requirements, Training, Policy and Procedures
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Audit programme and completion of action plans generated if non-compliance is reported and actioned. Audit assurance programme requires development
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Use of area specific antimicrobial resistance (AMR) prescribing guidelines
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	Intranet, Policy and Procedures Hospital pre-alert
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Infection status recorded on booking of all NEPTS transfers, risk of infection identified through Emergency Operations Centre dispatch and

		information given to response crews.
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	IPC Trust intranet page Communications plan through 'Hot News', Staff Matters and clinical memos per service requirements
7.	Provide or secure adequate isolation facilities	Process of NEPTS booking allows cohort and isolation of patients with infectious disease. E & UC single patient transfer only
8.	Secure adequate access to laboratory support as appropriate	Microbiology Support SLA provided by Oxford University Hospital (OUH)
9.	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	SCAS IPC Policy and Procedures. Updated 2023, A-Z Guidelines- Updated January 2024.
10.	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Occupational Health services provided by Optima Health.

2. Annual Plan Review

A programme of work was outlined for 2023-2024 in the form of an annual plan. The annual plan has been reviewed and updates provided as Appendix 4.

3. Achievements

Significant achievements were made in the 2023-2024 financial year detailed below:

- A revised and comprehensive Audit Schedule.
- Successful transition and Recovery returning to Pre-Pandemic systems and processes.
- Implementation of additional IPC Training on Statutory and Mandatory Face to Face Virtual Training Days.
- Complete Phase 1 Sluice Upgrade Programme.

4. Infection Prevention and Control Compliance Audits

Maintaining clean clinical and working environments alongside excellent hand hygiene practices are key to the safety of our patients and staff. IPC Level 1 (routine self-monitoring) compliance audits are carried out by Team Leaders and Clinical Team Educators at their

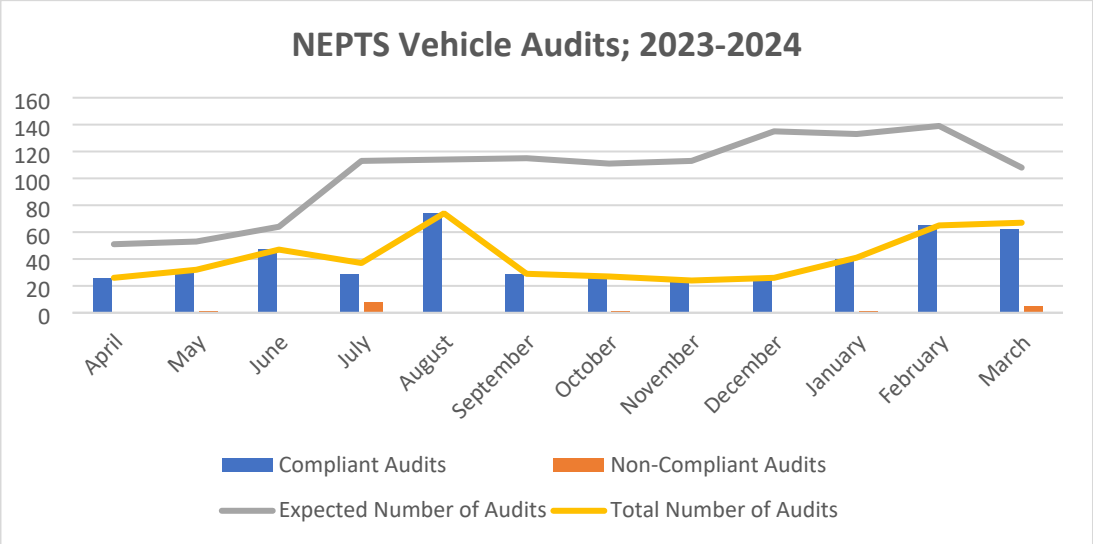
local stations. This audit programme encompasses vehicle, building and hand hygiene audits to ensure IPC standards are being met both within our environments and through good hand hygiene practices.

4.1 Vehicles

Graph 1 below details the number of both compliant and non-compliant audits for the 2023-2024 period. The yellow line shows the number of expected audits each month to ensure all vehicles receive a compliance audit bi-annually for NEPTS and Emergency and Urgent Care (E & UC) as per national cleaning standard (2007) for the year.

During 2024-2025 the number and frequency of audits will increase in line with the National Cleaning Standards (2021) where E & UC vehicles receive an audit bi-monthly. The IPC team have monitored the level of audits completed each month, and where the minimum level has not been achieved, communication with Team Leaders and Senior Operations Managers occurs to ensure the audits are conducted. Monthly variations occur due to level of activity in the service and availability of vehicles for audit as this does not account for vehicles off the road (VOR) and service activity.

Non-Emergency Patient Transport Services

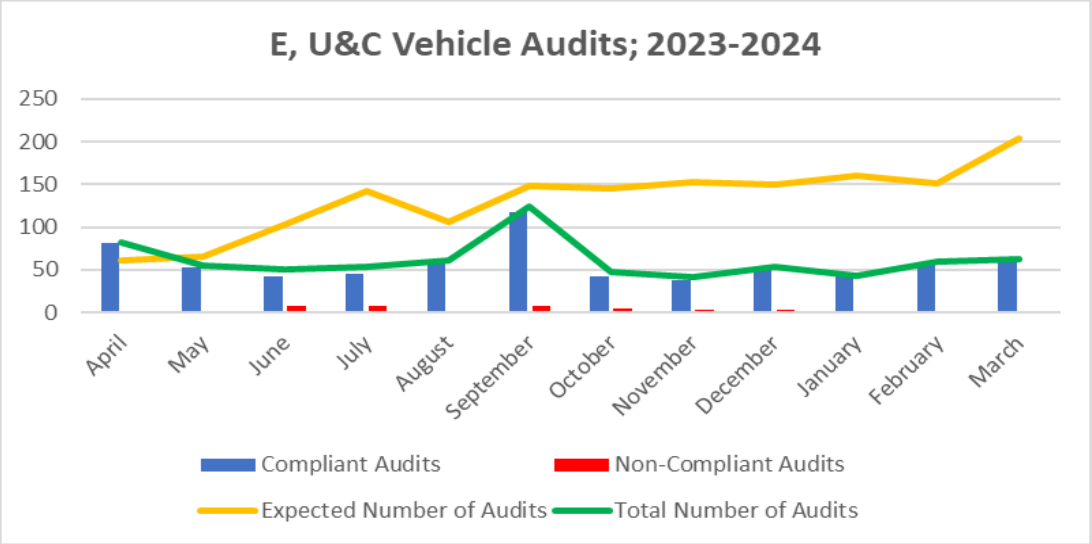


Graph 1

NEPTS vehicles remain as a functional risk category (FR5) within the National Cleanliness Standards and thus requires a compliance target of 80%.

In 2023-2024 a total of 1249 audits were expected to be completed in the year, however only 495 were completed. Of the 429 audits completed 96.8% achieved compliance of a target above 80% with 3.2% achieving non-compliance.

Emergency and Urgent Care Services (E &UC)



Graph 2

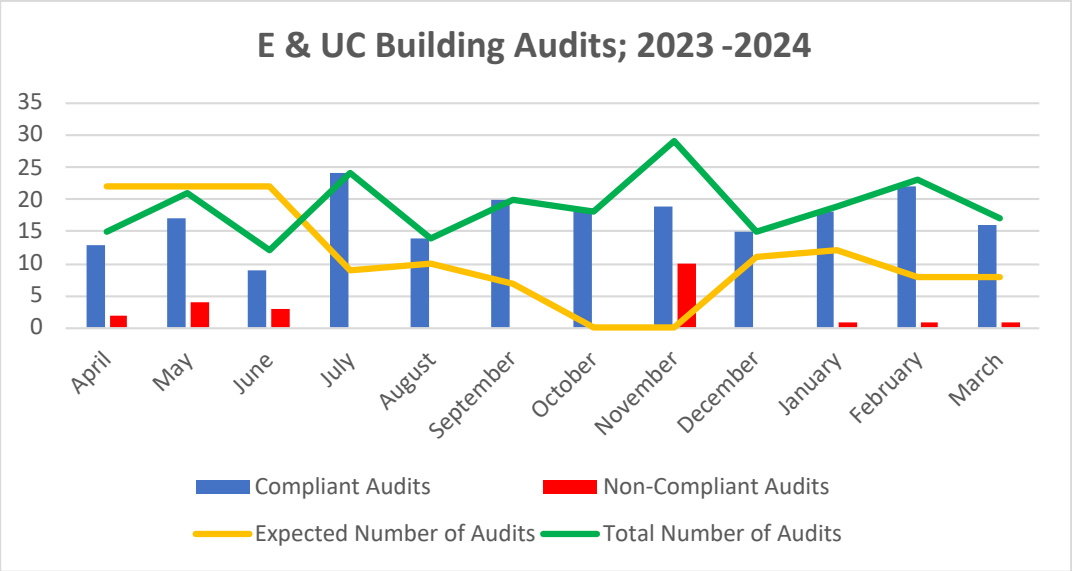
E & UC vehicles are in Functional Risk group (FR3) of the National Cleanliness standards – with a cleanliness compliance target of 90% and an increased audit frequency from bi-annually to bi-monthly as per national cleaning standards (2021). However, audit completion remained bi-annually due to operational service demand and the required improvement work that took place on the Audit Online system. Further specific guidelines for Ambulance Trusts were expected in Summer 2023 and have yet to be published at the time of this report.

SCAS currently has an active Double Crewed Ambulance (DCA) fleet of 280. This figure can fluctuate during the year if a vehicle requires significant repair work and is Vehicle off Road (VOR). Each vehicle is logged by registration number on the hosted Audit Online system to allow accurate tracking and completion of audits. To remain compliant with each vehicle receiving a bi-annual audit in 2023-2024 a total of 1593 audits were expected to be completed. The Trust achieved 734 audits, therefore 46.07% completed.

Of the audits completed, 94% achieved compliance with 6% non-compliant. It is noted the 94% that achieved compliance are above the target of 90% set against the National Cleanliness Standards. Any areas of non-compliance are rectified immediately prior to the vehicle returning to operational use. This is monitored using action plans and through communication with the Operational Support Desk (OSD).

4.2 Buildings

All buildings require bi-annual audits and should reach a compliance score of 80% (Functional Risk Group 5, FR5) in line with National Cleaning Standards. The lower required compliance rate is reflective of these buildings not being clinical environments which provide patient care. No buildings within SCAS treat patients within them. However, the focus of attention is the areas that are utilised to supply and clean all vehicles as this is deemed the clinical environment. SCAS aims to achieve higher compliance rates across its sites to maintain a clean and functioning environment given this clinical element. Graphs 3 and 4 below detail the number of audits completed per service against target and the overall compliance against audit.



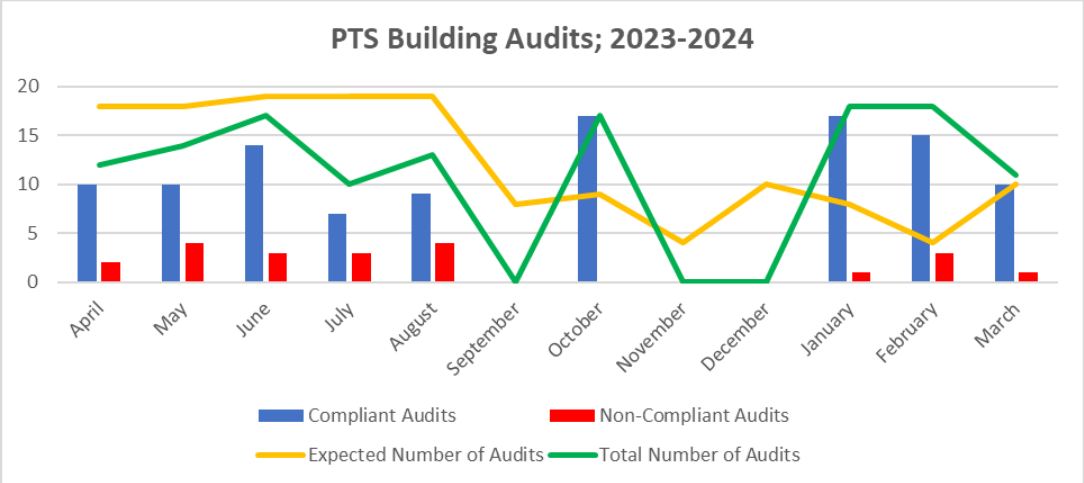
Graph 3

Within E & UC it can be seen the buildings have received a greater level of audit in 2023-2024 than in 2022-2023. The expected total of audits should be 131 and 227 have been completed. The universal compliance team have worked diligently to bring assurance and increase compliance around the fabric of buildings and areas that supply our clinical area. It can be noted of the total audits completed they achieved a compliance rate of 90.3% which is over the required standard of 80 %.

Where non-compliance with an audit was found (in this instance in 9.7% of audits), the issue was rectified immediately where possible, for example immediate decontamination required.

Audits continue to be monitored and highlight when there are improvements to be made to allow compliance with IPC standards such as the identified improvement in sluice standards.

The IPC Lead has completed work with Estates and Facilities Team to redesign sluice areas and remedial works completed on Phase 1 early 2024. Phase 2 is under review/development and a business plan is in progress.



Graph 4

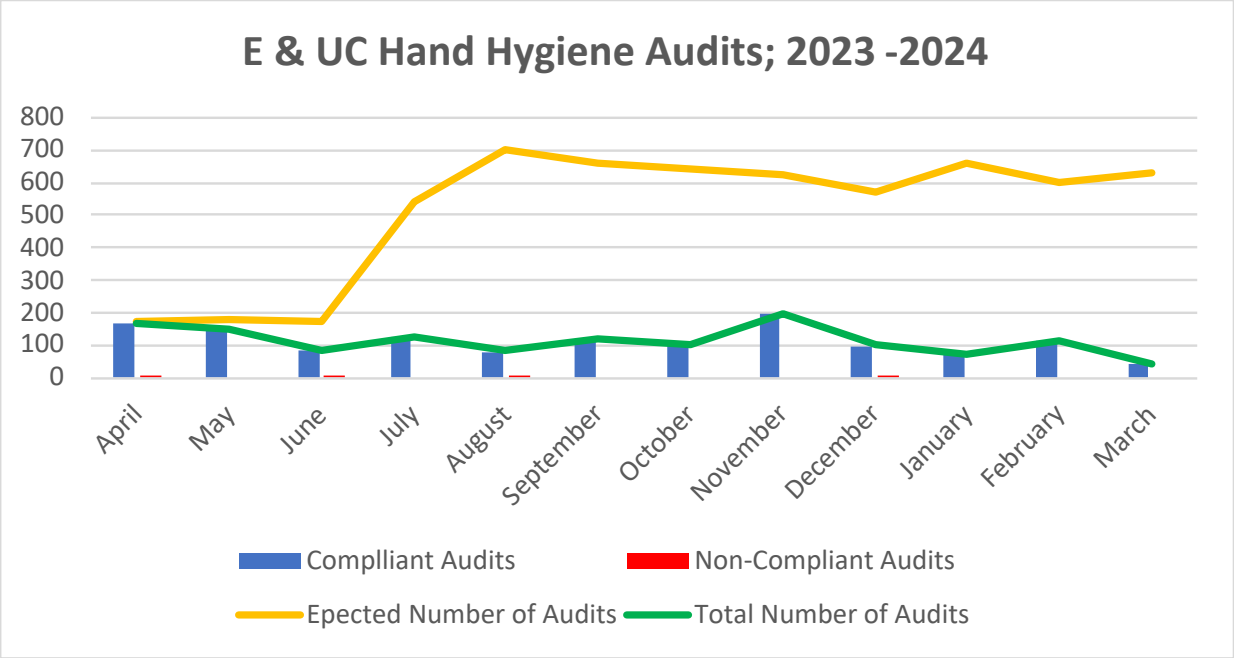
Within SCAS there are combined sites for NEPTS and E & UC with NEPTS also having their own satellite stations.

Within NEPTS a total of 146 audits were expected to be completed. A 89% completion rate was achieved with 130 audits completed. Of the 89% of audits completed 83.8% were compliant, achieving over the required standard of 80%. As with E & UC, audits continue to be monitored and improvement plans developed to improve IPC standards.

4.3 Hand Hygiene Audits

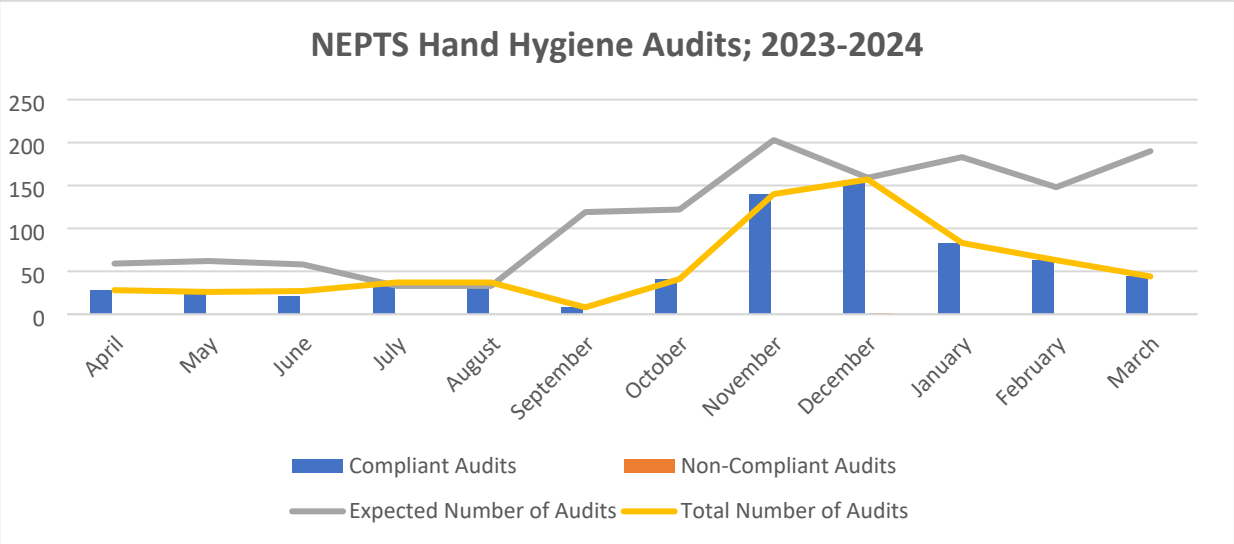
SCAS employs more than 4,400 clinical and non-clinical staff and all are responsible for complying with good IPC practices. It remains imperative that all staff adopt and adhere to IPC practices to protect themselves, their patients, and their colleagues. To ensure compliance with good hand hygiene practice staff who are in patient-facing roles and encounter patients, or work within the environment where patients are seen are audited on an annual basis.

Below Graph 5 details E & UC activity and compliance. This shows that of the expected number of audits (6150), only 22.3% were completed (1371 audits). Of these 99.6% were compliant. There have been exceptional circumstances and operational challenges with high-capacity demand and acuity. The audit programme for 2024-2025 has been amended, with an additional level of hand hygiene audits introduced with completion by the clinical team educators, to significantly increase the number of audits completed to provide our assurance in compliance with meticulous hand hygiene.



Graph 5

Below is the activity for NEPTS hand hygiene audits. Of the expected 1369 audits required, 50.5% were completed, a total of 691 audits. Of the audits completed 99.0% achieved compliance. NEPTS will continue with the audit schedule; the IPC team will share compliance at clinical governance meetings and actions agreed.



Graph 6

Audit Data Summary Table

	Q1-Q4 21-22	Q1-Q4 22-23	Q1-Q4 23-24
Number of Vehicle Audits Required	800	828	1593
Number of Audits Achieved	557	614	734
% of Audits completed	70%	74%	46.1%
Required % score for compliance	90	90	90
Achieved compliance score	94%	95%	94%
Number of Building Audits Required	277	255	131
Number of Audits Achieved	201	201	227
% of Audits completed	73%	79%	173%
Required % score for compliance	80	80	80
Achieved compliance score	75%	77%	90.3%
Number of Hand Hygiene Audits Required	2317	2146	6150
Number of Audits completed	1369	2116	1371
% of Audits completed			22.3%
Achieved compliance Score	99%	100%	99.6%

4.4 IPC Assurance Audits – Level 2 Audit Assurance Programme

An audit assurance programme, developed by the IPC team in response to the CQC 'should' action to address shortfalls in IPC, continued during 2023-2024. The assurance programme was designed for roll out across the SCAS footprint, encompassing NEPTS and E & UC services. The timescales and support staff required to achieve audits of all sites and a statistically significant sample of vehicles is set out in Appendix 3 which the IPC team looked to achieve. Work has been carried out to progress the quality assurance audit

function within Audit Online, including a significant revision with ongoing development completed in 2023-2024 to create and maintain a functional system.

5. Focused Workstreams

5.1 CQC improvement actions

The CQC conducted an inspection of SCAS on the 6th and 7th of April and 10th and 11th May 2022, with the report published 25th August 2022. The report notes that the Trust has updated IPC policies and procedures however says:

Overall statement:

- There was insufficient attention to infection prevention and control measures.

CQC should action:

- The trust should ensure that any shortfalls in infection prevention and control are reviewed, and action taken where needed.

Throughout 2023-2024 the IPC team continued to work on the below actions to ensure the shortfalls in IPC were identified and actioned:

- Improvement plan developed and business case completed to improve buildings and install netting into areas with problematic pigeon infestation. Works completed April 2024.
- Audit
- Sluice programme
- Additional Education in Emergency and Urgent Care. Presentation focuses on Standard Infection Control Procedures, Bare Below the Elbow, Inappropriate glove use and Sharps.
- Link Practitioner Programme commenced in 2023 with low uptake. To be further refreshed in 2024-2025.

The full work programme, integrated into the IPC Annual plan 2023-2024, is available as Appendix 4.

5.2 IPC Policy and Procedures document

The IPC Policy, Standard Operating Procedure Standard Infection Control Precautions and the A-Z of Disease Specific Precautions were reviewed and updated in October 2023 to ensure parity with the National IPC Manual for England. A further amendment of the A-Z of Disease Specific Precautions took place in January 2024 in line with national guidance related to the increase in confirmed cases of measles nationally and the United Kingdom Health and Security Agency (UKHSA) declaring the outbreak in England as a national incident.

5.3 Hand Hygiene

SCAS continued with observational hand hygiene audits after moving away from discussion audits that were carried out in 2021-2022 due to physical distancing measures. It has been acknowledged that, due to operational demand and the way in which the audit schedule has been structured, staff have found it challenging to complete the observational audits.

The audit schedule has been reviewed, amended, and implemented with support from the Quality Compliance Lead. An increase in completed audits will provide assurance of improved compliance.

The SCAS IPC team took part in World Hand Hygiene Day on Friday 5th May 2023. Resources were published through internal communication channels. Interaction with Trust colleagues was gained through published polls on the Yammer page, providing knowledge and education for adherence to good hand hygiene practices.

During International Infection Prevention and Control Week October 15th - 21st 2023, the IPC team attended various sites throughout the SCAS footprint with the Freedom to Speak Up team. The team met with a multitude of staff to refresh individuals IPC fundamentals.

5.4 Vehicle Decontamination Specifications/ Churchill Partnership Working

Ongoing maintenance of a clean clinical environment remains key to keeping our patients and staff safe. Close partnership working has continued with Churchill, our vehicle decontamination providers, to ensure vehicles are decontaminated effectively and to the correct standards both as guided by the National Cleaning Standards 2021.

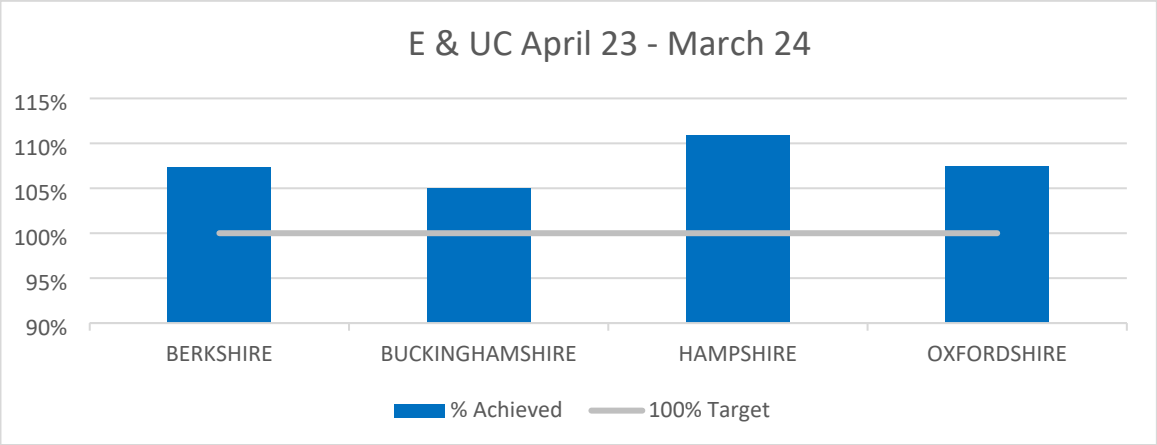
SCAS has provided guidance on required decontamination products and the correct levels of personal protective equipment (PPE) required by staff to carry out decontaminations through sharing of standard operating procedures.

Routine periodic cleans (formally deep cleans) and 24 hour Make Ready services (spot cleans) have been maintained at a high level throughout the last 12 months, with a robust system in place for booking vehicles for enhanced decontamination post aerosol generating procedure or contamination due to infectious disease.

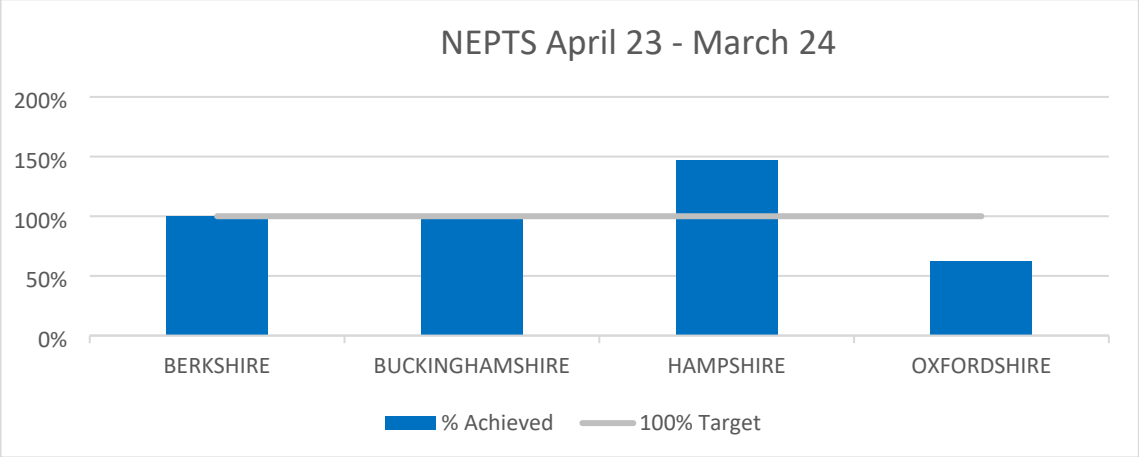
The requirements of specific decontamination post infectious disease are set out in the SCAS decontamination procedures alongside the SCAS A-Z guide of infectious disease, which our partners, Churchill, utilise to guide through appropriate decontamination techniques.

Where vehicles have not been booked off road for the Periodic Clean two weeks prior to their required date, and have missed their clean, due to operational demand, a recovery plan has commenced. This process ensures that vehicles do not exceed their allotted 6 weekly or 12 weekly periodic clean.

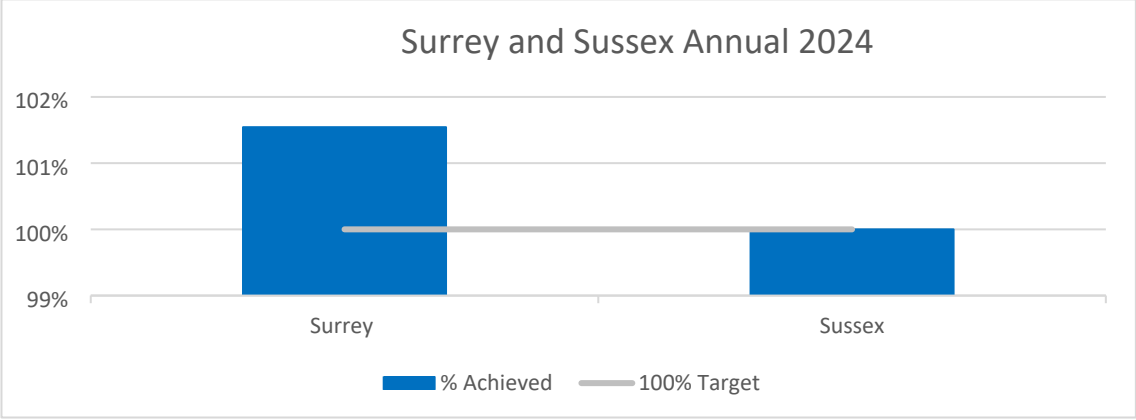
Graphs 7, 8 and 9 below table the overall percentage compliance of Deep Clean vehicles for E & UC and NEPTS and additional Surrey and Sussex vehicles. This notes assurance.



Graph 7



Graph 8



Graph 9

5.5 Estates Cleaning Scores Next Generation Contract

Contractors Nexgen audit conduct self-audits, visit every site monthly, audits are then forwarded, and a sample size are reviewed, and all are filed.

These audit results are included in the Nexgen monthly reporting and presented at a monthly meeting. Work is taking place with Nexgen to make the report more succinct and provide valuable information as detailed within the contract. This includes cleaning scores, attendance, training data, an issues log and resolution information.

5.6 Estates refurbishment and new build works

The IPC Lead continues to work closely with our Estates and Facilities Team. During 2023-2024 reporting year upgrades to 11 sluice areas across the SCAS estate were completed. Stage 2 of the upgrade sluice programme is currently underway, with a business case in progress.

In addition, the remedial works required for the infestation of pigeons has been completed to secure netting to prevent any infestations within garages occurring in the future.

The IPC team remain actively involved with future site development plans and their progress in collaboration with Estates and Facilities Team.

6. COVID-19

SCAS responded to the change of guidance in managing healthcare staff with symptoms of a respiratory infection in March 2023 where health care staff who have symptoms of a respiratory infection were no longer required to test for COVID 19, and staff who do test positive were no longer required to have two lateral flow tests before returning to work.

Sickness reporting and absence management for COVID19 has fully returned to the responsibility of line managers to follow the Trust's Supporting Attendance policy and procedure.

Actions taken to ensure compliance with changing national guidance have been documented within the IPC Board Assurance Framework (BAF) which has been updated as required by NHSE and signed off through SCAS Quality and Safety Committee for assurance.

The IPC BAF is an activity to assure Board and the public that SCAS had (in line with other ambulance services) clearly adhered to guidance.

7. IPC Monkeypox (MPOX) response

A further notice from UKHSA was circulated in March 2024 after the initial identification of Monkey Pox in May 2022 in the United Kingdom. The alert was to an Outbreak of mpox in the Democratic Republic of the Congo. As requested by UKHSA IPC Lead cascaded to relevant local services.

A Hot News was circulated to include updated information:

- There is now evidence that clade I MPXV is transmitting sexually. Be alert to the possibility of clade I mpox, including in cases of sexually acquired mpox and seek travel histories.

- All mpox positive samples should be sent to Rare and Imported Pathogen Laboratory (RIPL) for clade differentiating tests.

- Clade I MPXV remains a high consequence infectious disease (HCID) in the UK. The operational guidance remains to treat cases with recent travel from Central Africa presumptively as a HCID until clade confirmation is obtained.

8. IPC Measles response

In January 2024 UKHSA declared the outbreaks of measles in England a National Incident. IPC in response to the National Incident completed the following:

- A rapid review of the A-Z Guidelines and update of the PPE requirements in line with the National Manual to ensure the use of FFP3 masks/use of Airbourne Precautions.
- Distribution of Clinical Memo to notify change in SCAS guidance.
- Circulation of SCAS position statement in line with Association of Ambulance Chief Executives (AACE).
- Collaborative working with Health and Wellbeing and occupational health services in relation to SCAS position with Staff Health and Vaccinations Data.
- Further communication of frequently asked questions related to measles and vaccination.

9. Education

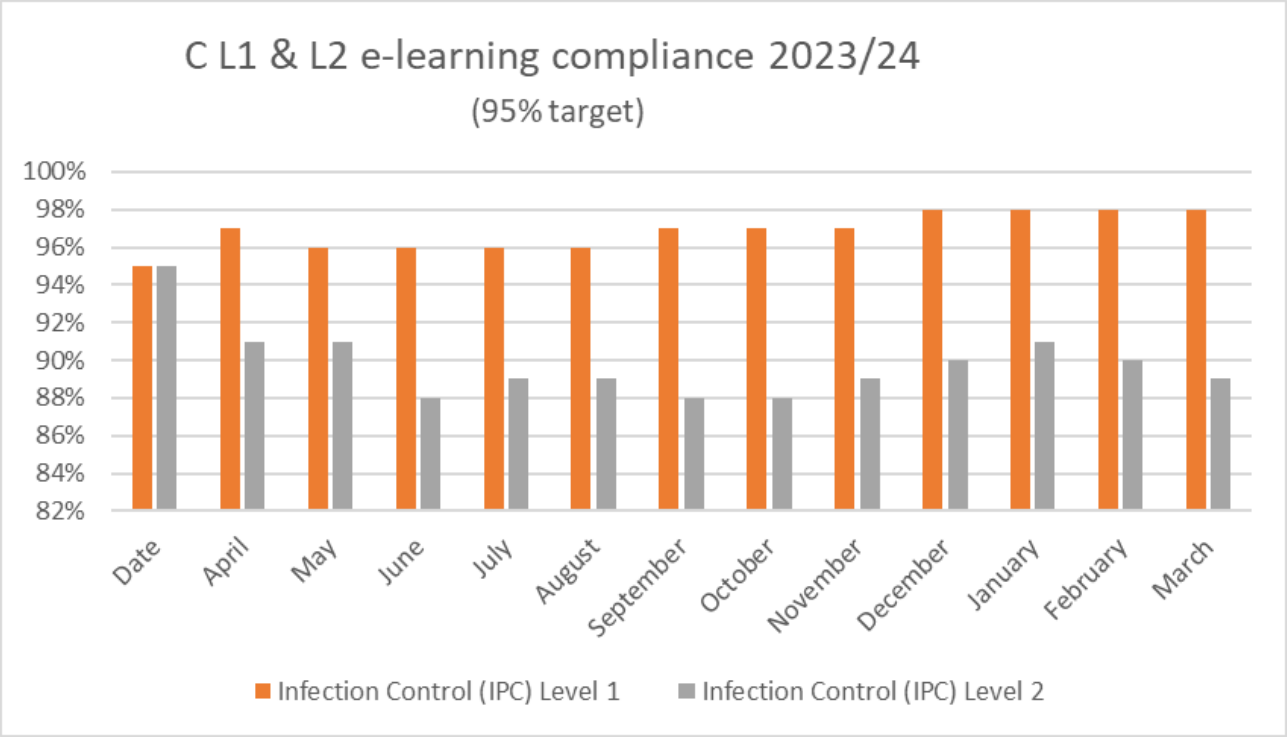
IPC training is included in the SCAS corporate induction provided to all new starters. Training covers IPC Level 1 and Level 2 training. The training packages have been tailored to the various job roles within SCAS and are delivered by the Education department. The content of all material is reviewed and ratified by the IPC Lead and ensures content/material is compliant with Skills for Health Framework, linked to Health Education England, the National Cleaning Standards and complies with the requirements of the CQC Fundamental Standards and the Health and Social Care Act.

Employees remain up to date with IPC learning through mandatory e-learning modules.

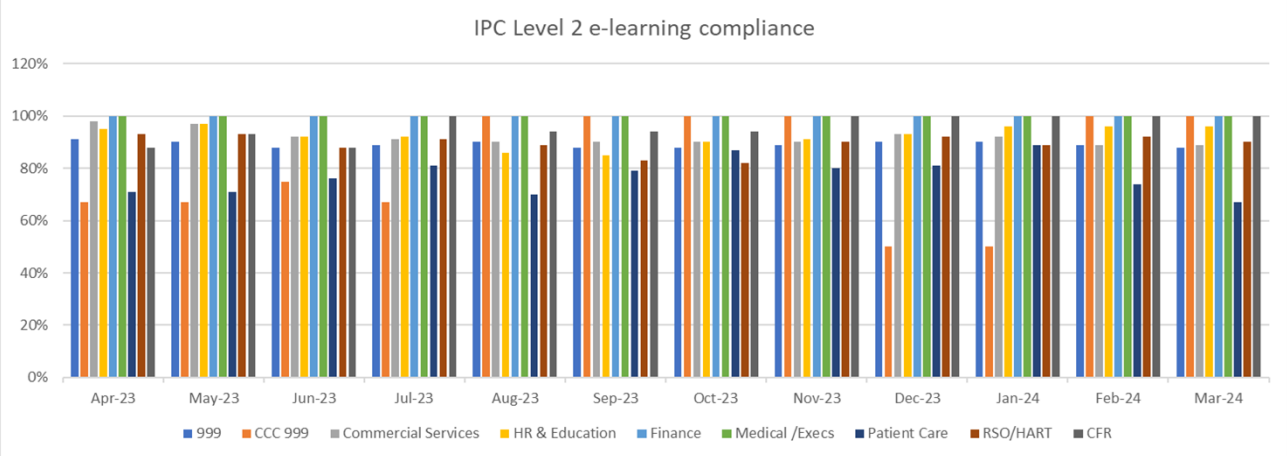
Below Graphs 10 and 11 detail Trust-wide compliance month on month for Level 1 and Level 2 training. Level 1 training has remained compliant with the 95% target.

Level 2 training remains separated from the overall figure to allow monitoring for compliance for clinical staff who require enhanced further IPC training in clinical roles.
Level 2 training remains under the target compliance level, but robust measures are in place to address this. These communicated action plans, working alongside Education to increase compliance.

Additional time will be dedicated to IPC Standard Infection Control Practices in 2024-2025. This will be an extra 30 minutes virtual training for clinical staff to address previous concerns in clinical teams utilising risk assessments and the donning of PPE.



Graph 10



Graph 11

10. Staff Health

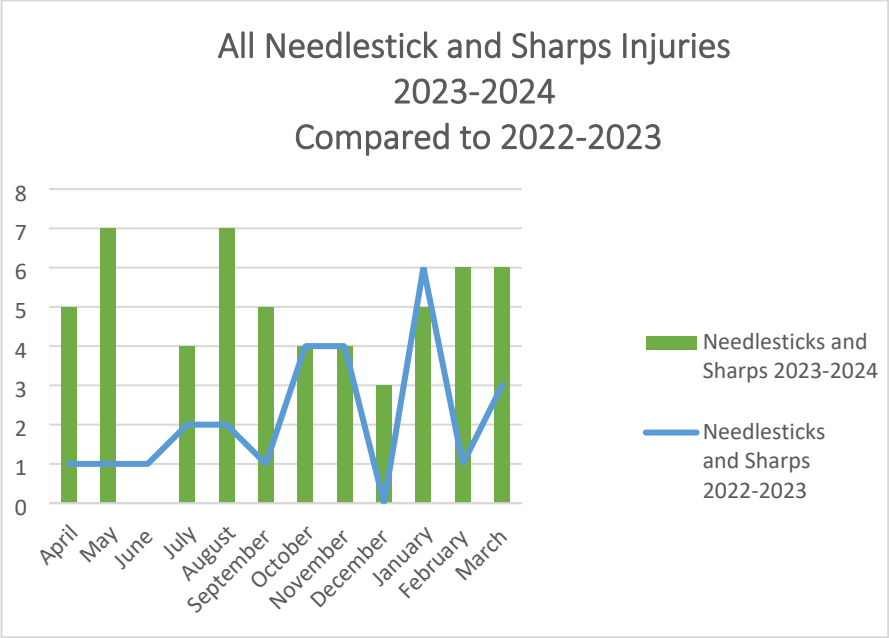
Optima Health was the awarded provider of SCAS Occupational Health Services. Broadly they cover the following:

- Telephone Support Services
- Online Portal
- Referrals from the Trust
- Attendance Management Advice and Assessments
- Attendance Management Reports
- Case Conferences
- Ill Health Retirement
- Pre-Appointment and Pre-Employment Checks
- Surveillance Services
- Fitness for Task and Safety Critical Work Services: Hearing Tests and Baseline Hearing Tests
- Immunisations, Vaccinations, Inoculations, Medications and Blood Tests.
- Health Screening Services
- Publicity and Promotion

10.1 Needlestick and Sharps

It is a requirement under European Union (EU) regulations (2010/32/EU) that all needlestick injuries are reported and investigated. Within SCAS needlestick injuries are investigated by the Team Leader, Optima Health, the Clinical Governance Team and Infection Prevention and Control. All needlestick injuries are upwardly reported through the Health and Safety Risk Group.

Graph 12 details the number of needle stick and sharps injuries for the reporting period of 2023-2024.



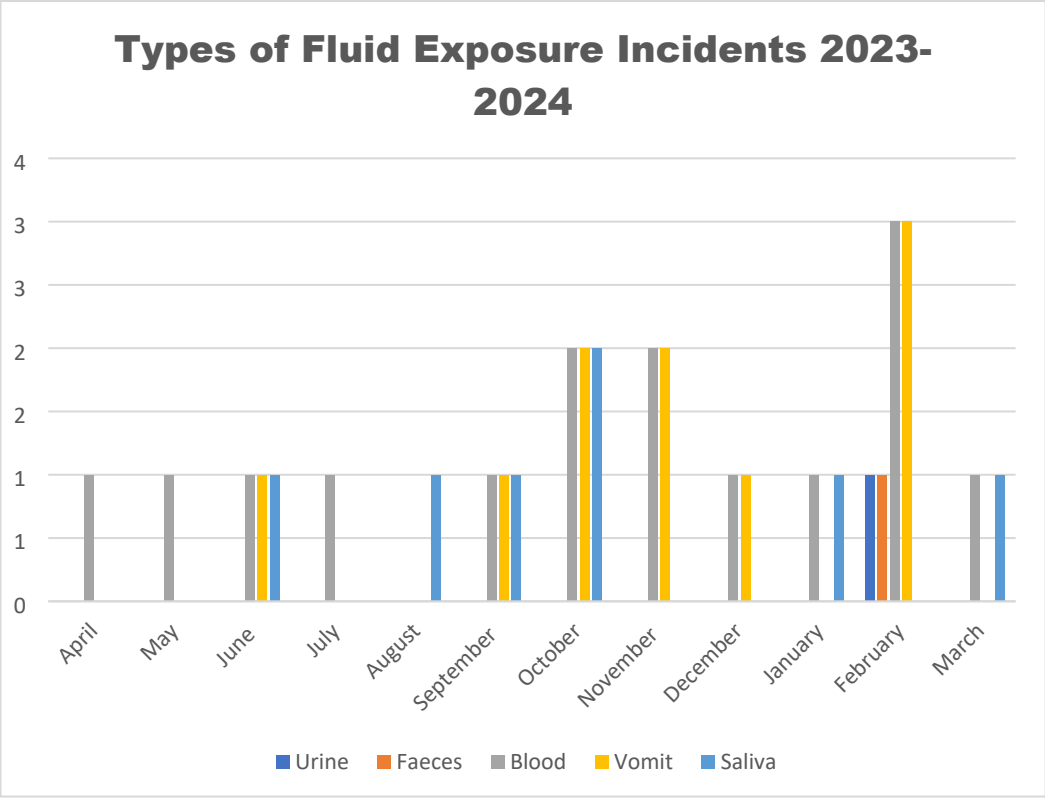
Graph 12

There has been an increase in incidents from 2022-2023 to 2023-2024. Within the year 2023-2024 there was a total of 56 incidents which is an increase of 30 incidents over the previous year. A robust plan is in place to identify and address the increase where the IPC team are delivering additional training and looking at data in more granular detail to ascertain themes/trends or specific areas of incidents. One possible contributory factor for the increase may be greater compliance in line with the safety culture of improving reporting. The IPC lead has worked, and will continue to work, with Optima Health investigating the mechanism of injury, for themes and trends to tailor required education on sharps safety. SCAS has recognised the increased incidence and in response additional IPC education to be given to patient facing clinical staff in 2024-2025 on Standard Infection Control Precautions (SICP) will also include the management of sharps.

10.2 Exposure to blood/body fluid incidents

Graph 13 below highlights the total number of exposures to bodily fluids that have been reported using the Trust's Datix System during 2023-2024. There has been an increase of 8 incidents in 2023-2024, compared to the 26 incidents recorded in the previous year, bringing the yearly total to 34 incidents.

It is noted that the blanket approach to wearing PPE through the pandemic has ceased and will contribute to the increased incidence. However, education on utilising a risk-based approach and the requirement for assessment in relation to PPE has been agreed and is to be delivered additionally during 2024-2025.



Graph 13

Optima Health Reports:

In the past 12 months there have been 78 Blood Borne Viruses logged, out of 68 cases where there is data - 44.1% (30) were classed as high-risk exposures, 48.5% (33) were percutaneous injury, 32.2% (22) were Mucotaneous exposure with the remaining being low risk exposures and low risk body fluids. 80.8% (55) were recommended blood tests. 54 (79.4%) out of 68 cases logged had a low Hazard/Source for patient risk.

10.3 COVID-19 Test and Trace service for staff.

The Test and Trace Service in relation to COVID-19 was dissolved in accordance with the change in national guidance.

10.4 Outbreaks

There were no identified outbreaks in 2023-2024.

10.5 Infectious disease adverse incidents notified to SCAS by UKHSA

- Monkey Pox - As discussed in Section 7
- Measles - As discussed in Section 8.
- Alert Ralstonia Picketti product recall. Investigated with procurement. Not applicable to SCAS as supplier in question not supporting SCAS.

10.6 Influenza Vaccine Campaign

The national flu immunisation programme is essential in protecting vulnerable people and supporting the resilience of the health and care system. The Commissioning for Quality and Innovation (CQUIN) target this season was to achieve 75-80% flu vaccination of all **eligible** staff. Eligible staff are defined as frontline health care workers.

SCAS introduced a hybrid approach to flu vaccination of staff for this year as responsibility for the campaign transitioned from the Patient Care Directorate to Health and Well-Being. The hybrid approach included peer-to-peer vaccination via a reduced number of SCAS flu clinic locations and introduction of a voucher scheme that staff could download and use to be vaccinated at a pharmacy local to them. As in previous years, staff could also be vaccinated via a Covid/flu hub, via their GP or at a community pharmacy. All staff, including those who declined to be vaccinated, were expected to complete a flu vaccination record form.

Overall vaccine uptake in SCAS for eligible frontline staff was 29.9%.

A range of factors have been identified as barriers to achieving a greater uptake by our frontline staff including:

- Vaccine lethargy

- Lower levels of circulating flu virus over the past two years
- Location and accessibility of the flu vaccination clinics

An issues log, which is collaboratively collated by the internal Seasonal Vaccination Team to highlight any lessons learnt, risks and issues, is reviewed, and performance monitored of the flu vaccination campaign annually to determine lessons learnt, identify areas of good practice, and suggest areas for improvement in future campaigns. This will be considered in the 2024/2025 planning.

A survey to ascertain staff experiences and views of the SCAS flu vaccination campaign 2023-2024 was developed using Microsoft Forms. The survey opened on 19 February and closed on 15 March. As of 15 March, 153 staff had responded and a full report of the survey results was prepared. The survey was undertaken to ascertain improvements for future planning of the 2024/2025 season.

Benchmarking

NHS trusts are required to submit data regarding vaccine uptake of eligible frontline staff via Immform each month.

The table below shows the overall percentage vaccine uptake from UKHSA reported for frontline staff by NHS ambulance services in England over the period 1 September 2023 to 29 February 2024. For comparison, the uptake data for 1 September 2022 to 28 February 2023 is also shown.

Ambulance Service	1/9/22 – 28/2/23	1/9/23 – 29/02/24
East of England	no data	no data
London	49.7%	31.8%
East Midlands	82.3%	73.5%
West Midlands	71.6%	61.3%
North East	35.5%	33.2%
Yorkshire	42.1%	32.2%
North West	48.5%	48.1%
SCAS	56.7%	29.9%
South East Coast	56.9%	72.9%
South Western	50.6%	52.2%

In 2023-2024 SCAS was the ambulance service with the lowest reported uptake when in the past the uptake was one of the highest.

At the time of this report the planning for the 2024/2025 season has commenced.

11. IPC Annual Work Programme 2024-2025

The IPC Annual Work Programme can be viewed as a separate detailed document. The fundamental aim of the 2024-2025 IPC work programme will be to continue the promotion of sound Infection Prevention and Control practice in line with the Health and Social Care Act 2008.

In order to facilitate this the IPC team will continue to positively engage with all staff, encourage ownership and provide a forum where good practice is shared. The focus for the 2024 -2025 time period will be the following:

- Ensure rigorous and robust policies and procedures are in place and align with the requirement to transit to the National Infection Control Policy Manual.

- Ensure the Infection Prevention and Control Link Practitioner Programme is enhanced and embedded within the organisation to facilitate sound two-way communication between the care setting and Infection Prevention and Control.

- Delivery of IPC audit schedule, through Level 1, 2 and 3 Audits.

- The successful implementation of electronic assurance audits will support the IPC quality agenda. This will incorporate completion of the audit cycle, widening the dissemination of audit findings and the reporting accuracy of Audit compliance.

- Development and delivery of IPC training across the organisation
  Educational material to be delivered to staff to promote understanding of the basic IPC principles, enhancing learning experiences and promoting a culture of good IPC standards in day-to-day practices alongside development of integration of IPC principles within face-to-face training.

- IPC requirements in new builds and refurbishment works including the Phase 2 Sluice Improvement Programme.

- Work collaboratively within the Integrated Care System (ICS) on current and future work Streams.

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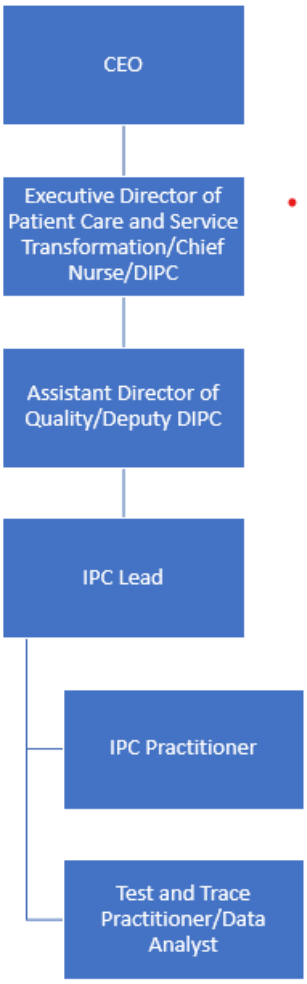
APPENDIX 1 - Infection Prevention and Control Structures

The Trust Board and the Director of Infection Prevention and Control (DIPC) have overall responsibility for patient safety and that all infection prevention and control issues ensuring they are managed safely and appropriately. The DIPC sits on Trust Board and Quality and Safety Committee.

IPC Reporting Structure:

IPC Team Structure



APPENDIX 2 – Infection, Prevention and Control Statement

The SCAS Trust Board- is committed to compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (updated July 2015) and as amended to prevent and control Health Care Associated Infections (HCAI). The Code is presented under three headings which form the basic Code, and the Trust has pledged to undertake these duties by:

1. Management, organisation, and the environment

- Protect patients, staff, and others from HCAI.
- Put in place appropriate management systems to prevent and control infections.
- Assess the risks of acquiring an HCAI in the pre-hospital environment and take action to reduce or control these risks.
- Provide a clean and appropriate environment.
- Provide information on HCAI to patients and the public.
- Provide information when a patient moves from the care of one healthcare body to another.
- Always co-operate with other health care professionals
- Provide facilities to prevent or minimise the spread of HCAI.
- Acquire micro-biology and laboratory support.

2. Clinical care protocols:

- Have in place appropriate evidence-based core policies and protocols that are monitored and maintained to provide clear guidance on the prevention and control of HCAI in the Ambulance Service.

3. Health care workers:

- Ensure so far as is reasonably practicable that ambulance staff are free of and protected from exposure to communicable infections.
- Access to relevant occupational health services is provided to all staff.
- Ensure that all staff are educated in the prevention and control of HCAI.

APPENDIX 3 - Audit schedule

APPENDIX 4 - Review of IPC Annual Plan and IPC workstream 2023-2024.

IPC Annual Work Programme 2023 202

Assure and Action:
Table 1: IPC workstream elements and BDO actions update:

	IPC Workstream Domain	IPC Workstream Element	Total number of elements in section	Number of elements Progressed	Target	Action Required /Taken/Ongoing	Related BDO Action Complete /outstanding
1.	Clinical Practice	Ensure accuracy of current compliance audit programme	6	6	Ensure robust and completed IPC Audit Schedule.	• Building denominator data on system reviewed and reworked. • Vehicle lists sourced, reviewed and reworked to ensure entity types are correct for upload onto Docworks. • Full removal of old data and upload of new for system reset is completed 5th April 2023. • Audit Schedule Reviewed and commenced Apr 2024. • Ongoing management of the data to ensure accuracy. Completed by Data Analyst.	

2.	Clinical Practice	Expand audit assurance programme to include essential IPC clinical audit elements	3	3		BBE, PPE included in the new revised Hand Hygiene Audits. This includes observational Hand Hygiene Audits. Revised Audit Schedule Completed, to include Level 1, 2 and 3 assurance audits.	
3.	Clinical Practice	Implement IPC assurance audit programme of current audits.	5	5	The current audit programme covers compliance audits only with no overarching assurance audit programme therefore an audit assurance programme is required	IPC Assurance Programme in place. Completed within the Wider Clinical Governance Team and IPC. Tagging system added to Audits to ensure IPC Compliance is reported accurately.	

4.	Clinical Practice	Implement IPC Link Practitioners programme	5	4	Link Practitioners are recruited	Link Practitioners recruited, began programme development however successfully implementation did not occur.	**Outstanding:** Successful implemented Link Practitioner Programme.
5.	Education	Develop and implement IPC core standards training sessions for clinical staff	3	2	Rolling programme of IPC practice training and assessment as part of face to face in place, with staff attendance captured.	Training material developed and available from IPC. Discussions have taken place with Education regarding integration of IPC into Face to Face. Successful additional IPC training added to Statutory and Mandatory training with the use of virtual scenarios and break out rooms. .	**Outstanding:** All education material to be reviewed and to follow standardised template.
6.	Education	Develop and implement IPC Link practitioner training programme	4	3	Link Practitioners recruited and in place having received training from IPC	Link practitioner Role 'job description' completed. Introduction to role pack completed. Training programme of content partially completed.	**Outstanding:** As above
7.	Education	Develop and implement IPC training programme for non-clinical staff.	1	1	Nonclinical staff are given IPC training meeting their needs outside	Rolling programme in place with staff attendance captured.	

					of clinical practice		
8.	Leadership and Management	Expand IPC team to ensure IPC programme delivery	1	1	Requirement for further IPC practitioners, auditors and administration support to enable delivery of the IPC programme	IPC maternity cover authorised. IPC Data Analyst Position developed.	**Outstanding:** To secure permanent second IPC Specialist Practitioner and Permanent IPC Data Analyst.
	Totals		28	25			

APPENDIX 5 - IPC Annual work programme 2024-2025

IPC Annual worplan 2024-25 QS.docx

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Upward Report of the Quality and Safety Committee

Date Meeting met **18 September 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			
The IPR not being ready and most indicators remaining in 'Hit & Miss'	This has been a repeating issue. The BI team and the clinical team will need to address this as a matter of urgency. Also, the narratives remain too descriptive, and the Exec summary is too long.	CFO	Include a full and accurate IPR in the next Q+S pack.
Critical training targets missed by large margins	Resuscitation eLearning and practical completion unlikely to be rectified this year	Chief Nurse	Provide plan for reaching mandatory completion rates and an update at September Q+S
Quality related IPR indicators	Q+S relevant IPR summary will be in the Q+S IPR moving forward. That will include the key, quality relevant indicators in one page.	Chief Nurse	Review the Q+S relevant IPR summary and make sure it captures key indicators.
Seeking 'third party' validation of quality improvement work	External assurances/reassurances are needed to corroborate our confidence that QA work and work to address CQC concerns have led to tangible	Chief Nurse	Note all 3rd party opportunities to come in the next 6-9 months and report on their findings on critical QA areas.

	improvements. BDO, Peers, NHS/ICBs etc. should be used to this end		
Items for information and / or awareness			
W45 coming closer to implementation	NHS aim to implement nationally by Nov. SCAS is gathering info and making plans to implement.	COO	Provide update on W45 implementation including safety aspects at next Q+S
Handover of COVID Data	SCAS will hand over all COVID data. The handing back is the right course of action.	Chief Nurse	In collaboration with IT, mitigate against the risks that this process carries.
Improvement reporting	Third party validation/corroboration should be sought	Chief Nurse	Provide assurance that all greens are really done.
BDO Preparedness and Assurance	Q+S relevant BDO audits to be used to get extra assurance	Chief Nurse	Look at BDO audit plan and prepare
Approved*			
Safeguarding Annual Report	No policies approved		
IPC Annual Report			
IPC Work Plan			
Patient Experience Annual Report			
Meal Breaks and End of Shift procedure	A new approach will be trialled to try and shorted delays. OPS and Clinical agree on the way forward	Chief nurse	Update Q+S on the results

Author: Dhammika Perera

Title: Non-Executive Director

Date: 18 September 2024

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Report Cover Sheet

<table>
<tr><td>Report Title:</td><td>M5 Finance Report</td></tr>
<tr><td>Name of Meeting</td><td>Board of Directors Meeting in Public</td></tr>
<tr><td>Date of Meeting:</td><td>Thursday, 26 September 2024</td></tr>
<tr><td>Agenda Item:</td><td>17</td></tr>
<tr><td>Executive Summary:</td><td>The Trust's Month 5 (M5 - August) reported position (before technical adjustments e.g., peppercorn rent, etc) is:

<table>
<tr><th colspan="5">Key Performance Indicators</th></tr>
<tr><th></th><th></th><th>Plan</th><th>Actual / Forecast</th><th>Variance</th></tr>
<tr><td>1</td><td>Surplus / (Deficit) Year to date</td><td>(6.5)</td><td>(6.0)</td><td>0.5</td></tr>
<tr><td>2</td><td>Surplus / (Deficit) In-month</td><td>(1.0)</td><td>(0.9)</td><td>0.2</td></tr>
<tr><td>3</td><td>Surplus / (Deficit) FOT</td><td>(10.1)</td><td>(10.1)</td><td>0.0</td></tr>
<tr><td>4</td><td>Capital Spend YTD</td><td>8.8</td><td>(0.4)</td><td>(9.2)</td></tr>
<tr><td>5</td><td>Capital FOT</td><td>41.5</td><td>41.5</td><td>0.0</td></tr>
<tr><td>6</td><td>Cash - Year to date</td><td>18.4</td><td>20.9</td><td>2.5</td></tr>
<tr><td>7</td><td>Cash - Year In-month</td><td>(0.8)</td><td>4.4</td><td>5.2</td></tr>
<tr><td>8</td><td>BPPC - YTD - Value</td><td>95.0%</td><td>98.1%</td><td>3.1%</td></tr>
<tr><td>9</td><td>BPPC - YTD - Number</td><td>95.0%</td><td>95.3%</td><td>0.3%</td></tr>
</table>

<u>Income and Expenditure (I&E) Position</u>

The Trust recorded an in-month deficit of £0.9m in month 5 (M5), against a planned deficit of £1.0m. Main variances in the month were:
• Non-Emergency Patient Transport Services (NEPTS) had a shortfall of £0.1m against plan
• 111 service that also had a shortfall of £0.2m,
these were offset by 999 delivering a favourable variance of £0.5m.

<u>Financial Recovery Plan (FRP)</u>

The performance to date (M5) against the total cost improvement plan is £6,913k against a plan target of £8,183k. This achievement represents 21.4% of the overall savings target for the year. The current forecast outturn for the year has increased to £25,968k against a plan of £32,261k.</td></tr>
</table>

	Capital The Trust's capital spend to August was £3.7m with £6.8m of vehicle sale and leaseback sales producing a net income of £3.1m. The Trust is underspent against its year-to-date capital budget by £9.4m, this is made up of digital and estates being £4.5m behind plan respectively and the International Financial Reporting Standard IFRS 16 costs of £2.7m related to leaseback arrangements not being in place until September. Cash The Trust's cash balance at the end of August stood at £20.9m, which was £2.5m ahead of plan. The main drivers of this are the receipt of the shortfall in block income and the proceeds from the sale and leaseback arrangements.
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:	N/A
Purpose of Report:	Note
Paper Status:	Internal
Assurance Level:	**Assurance Level Rating:** Partial
Justification of Assurance Rating:	With capital spend and FRP savings behind plan, only partial assurance can be drawn at this point in the year.
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

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Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	M5 Finance Report
Author	Alan Monks, Deputy Chief Finance Officer
Accountable Director	Stuart Rees, Interim Director of Finance
Date	26th September 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 5, the Trust's Income and Expenditure (I&E) position shows an in-month position of £0.9m, which was £0.2m better than plan. This results in a year-to-date (YTD) deficit of £6.0m against a planned deficit of £6.6m.

£m	M1	M2	M3	M4	M5	YTD
Plan	(1.9)	(1.7)	(1.3)	(0.7)	(1.0)	(6.5)
Actual	(1.9)	(1.7)	(0.9)	(0.7)	(0.9)	(6.0)
Variance to Plan	**(0.0)**	**(0.0)**	**0.4**	**0.0**	**0.1**	**0.5**

Financial Position

The month showed a positive variance to plan delivered mainly from Emergency Operations (999), with the 111 and Non-Emergency Patient Transport Services (NEPTS) services still performing behind their YTD budgets.

The 999 service shows a favorable variance of £0.5m, which was offset by the adverse contribution of £0.2m 111s and £0.1m NEPTS in the month to result in an overall £0.1m favorable position in the operational areas.

Corporate areas were underspent by £0.2m in the month.

		Month 5			Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
999	Income	19.3	19.0	0.2	96.0	94.7	1.2	230.2	226.1	4.1
	Expenditure	(15.4)	(15.6)	0.2	(78.9)	(78.5)	(0.4)	(185.5)	(183.7)	(1.8)
	Contribution	**3.9**	**3.4**	**0.5**	**17.1**	**16.2**	**0.8**	**44.8**	**42.5**	**2.3**
	%	**20.0%**	**17.8%**		**17.8%**	**17.1%**		**19.4%**	**18.8%**	
111	Income	3.4	3.5	(0.1)	16.7	17.1	(0.4)	41.4	41.4	0.0
	Expenditure	(3.2)	(3.0)	(0.1)	(15.6)	(15.2)	(0.4)	(37.2)	(36.5)	(0.7)
	Contribution	**0.3**	**0.5**	**(0.2)**	**1.1**	**1.9**	**(0.7)**	**4.2**	**4.9**	**(0.7)**
	%	**7.4%**	**13.1%**		**6.7%**	**10.9%**		**10.2%**	**11.9%**	
PTS	Income	5.3	5.4	(0.0)	26.9	26.8	0.1	63.3	63.2	0.1
	Expenditure	(4.8)	(4.8)	(0.1)	(25.5)	(25.2)	(0.3)	(59.6)	(56.0)	(3.5)
	Contribution	**0.5**	**0.6**	**(0.1)**	**1.4**	**1.6**	**(0.2)**	**3.8**	**7.2**	**(3.4)**
	%	**9.1%**	**11.5%**		**5.2%**	**6.1%**		**5.9%**	**11.4%**	
Operations Total Contribution		**4.6**	**4.5**	**0.1**	**19.6**	**19.7**	**(0.1)**	**52.7**	**54.6**	**(1.8)**
%		**16.4%**	**16.0%**		**14.0%**	**14.2%**		**15.7%**	**16.5%**	
Corporate		(5.5)	(5.5)	0.0	(26.0)	(26.7)	0.7	(63.6)	(65.5)	1.8
Surplus/(Deficit)		**(0.9)**	**(1.1)**	**0.1**	**(6.4)**	**(7.0)**	**0.6**	**(10.9)**	**(10.9)**	**(0.0)**
Reporting Adjustments		0.1	0.1	0.0	0.4	0.4	0.0	0.8	0.8	0.0
Reportable Surplus/(Deficit)		**(0.9)**	**(1.0)**	**0.2**	**(6.0)**	**(6.6)**	**0.6**	**(10.1)**	**(10.1)**	**(0.0)**

The main points to note for Month 5 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 is current moving to arbitration with the BOB ICB element of the contract as an agreement has not been reached. The contract officially ended on 5th September however, the Trust is continuing to provide the service. The Trust has also sent its completed Quality Impact Assessment (QIA) to BOB ICB highlighting the impact on the service and patients on a reduce level to match the funding.

  The expenditure in NEPTS shows an adverse variance of £0.1m in the month, with income £39k behind plan and costs £98k higher than plan. NEPTS resource costs are below plan in the month by £75k offset by £173k of other operating costs including vehicle leases, fuel and staff costs. Month 5 activity was 5.9% down against the month 4 level, and 8.5% below the budgeted activity levels in the month.
- In the 999 service, the total Income and total direct costs were over plan by £0.2m each resulting in a contribution of £0.5m surplus. Emergency Operations Centre (EOC) services was over plan by £0.1m in the month.

Variance to Budget

The year-to-date position is £0.6m favorable to budget despite CIPs under delivering by £1.3m. This is due to additional income within 999 and underspends against resource costs. There has also been a lower level of non-pay spend across the trust specifically within the digital cost centres.

Budget	**-6,951**
Undelivered CIPs	-1,271
Additional Income	770
999 Resource Underspends	456
Lower ICT Spend	312
Other Spend	323
Year to Date	**-6,361**

Forecast

The year-to-date position is currently £6.0m and if this is extrapolated until the year end it would result in a deficit position of £14.4m against the control total of £10.1m. The following review has been developed to understand the possible outcome based on items that will influence the run rate. As can be seen there are some unknown impact at this time and without quantifying these there is a gap of circa £0.7m.

	£m
Current Run Rate	**-14.4**
Potential Improvements	
BOB IUC Full Funding	3.1
BLMK HART / Cat 2	0.3
CIP Run Rate Improvement	7.7
Additional Grip and Control / Adjustments	
	-3.3
Potential Costs	
Corporate Review Costs	**-6.0**
CIP shortfall	**-1.5**
PTS Exit	
Possible Outturn	**-10.8**

Contract Position

The Trust is still working to sign all major contracts. The current contract statuses are:

- 999 is unsigned due to a dispute with BLMK in relation to the HART and Category 2 funding. Both the Trust and BLMK have submitted papers for arbitration.
- HIOW IUC contract is signed by the Trust and HIOW ICB. It is just waiting for Frimley to sign to finalise the contract.
- Thames Valley IUC has not been agreed as BOB ICB have only offered £1.2m of the required £3.6m.
- NEPTS HIOW contract is agreed and signed however due to the activity management within the Trust, the HIOW and Trust and in discussions on possible risk share options.
- Thames Valley NEPTS contract is still not agreed. Frimley have agreed their element of the contract however BOB ICB have not agreed the activity level and are unhappy with the Trusts activity management approach.
- BLMK NEPTS contract has now been agreed and is awaiting signatures on both sides.

Financial Recovery Plan (FRP)

The performance to date against the total cost improvement plan is £6,913k against a plan target of £8,183k. This achievement represents 21.4% of the overall savings target for the year. The current forecast outturn for the year has increased to £25,968k against a plan of £32,261k.

The biggest variances are:

- NEPTS: the Trust is taking action lead by Programme Turnaround Director developing a recovery/mitigation plan to recover the current position, report back to Financial Recovery Group on 24th September.
- The 111-service shortfall is primarily related to the correct funded of the service and is subject to ongoing contract negotiations.
- 999 has one main scheme that is not delivering, this is abstraction reduction.

Schemes have now been identified to achieve the £1.7m previously labelled as unidentified.

Capital

The Trust's capital spend to August was £3.7m with £6.8m of vehicle sale and leaseback sales producing a net income of £3.1m. The Trust is underspent against its year-to-date capital budget by £9.4m, this is made up of digital and estates being £4.5m behind plan and the International Financial Reporting Standard IFRS 16 costs of £2.7m related to leaseback arrangements not being in place until September.

The receipt of the 2022/23 cohort (53 double-crewed ambulances (DCA's)) vehicles from Venari have now been received. The cohort has been split into two tranches of 30 and 23. The first tranche has been subject to a sale arrangement with income of £3.7m recognized in July, with the lease completed in August. The remaining 23 units were subject to a leaseback in September with the sales invoice received in August and the proceeds received in September, the lease will be signed off and completed in September.

There was £3.2m spend up to August for IFRS16 capital departmental expenditure limit (CDEL), the next predicted IFRS16 CDEL spend is in September with the expected completion of leaseback arrangements of the remaining 23 Venari units.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	0.3	3.1	(2.8)	9.4	9.4	0.0
	IFRS16	0.0	0.3	(0.3)	2.7	2.7	0.0
	Total	**0.3**	**3.4**	**(3.1)**	**12.0**	**12.0**	**0.0**
Digital	Internal CDEL	0.2	1.9	(1.7)	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	**0.2**	**1.9**	**(1.7)**	**4.3**	**4.3**	**0.0**
Fleet (22/23 DCA Cohort)	Internal CDEL	(3.9)	(1.8)	(2.1)	(1.8)	(1.8)	0.0
	IFRS16	3.0	5.4	(2.4)	5.4	5.4	0.0
	Total	**(0.9)**	**3.6**	**(4.5)**	**3.6**	**3.6**	**0.0**
Fleet (23/24 DCA Cohort)	Internal CDEL	0.1	0.0	0.1	(2.8)	(2.8)	0.0
	IFRS16	0.0	0.0	0.0	7.3	7.3	0.0
	Total	**0.1**	**0.0**	**0.1**	**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	0.1	0.6	(0.5)	1.6	1.6	0.0
	IFRS16	0.2	0.0	0.2	3.1	3.1	0.0
	Total	**0.3**	**0.6**	**(0.3)**	**4.7**	**4.7**	**0.0**
Internal CDEL Total		(3.1)	3.8	(6.9)	12.9	12.9	0.0
IFRS16 Total		3.2	5.7	(2.5)	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		**0.1**	**9.5**	**(9.4)**	**41.5**	**41.5**	**0.0**

Key drivers of the current capital position are:

- The delay in delivery of the DCAs means that the cohort has been split into two tranches for the purpose of sale and leaseback. The first tranche of 30 has been sold with the leaseback arrangements finalized in August. The remaining tranche of 23 is expected to be completed in September. This means that costs incurred to date are allocated against internal CDEL and will be transferred to IFRS16 CDEL upon completion of the sale/leaseback transactions in September.
- The spend on Digital and Estates projects has been significantly delayed against the original planned timing. Estates took business cases worth £3.0m through the Fixed Asset Management and Strategy Group in August and these were all approved bar one. Therefore, Estates now have approved business cases worth £5.6m against its annual plan of £9.4m.

Cash

The Trust's cash balance at the end of August stood at £20.9m. There was a net cash inflow in month 5 of £4.4m due mostly to the receipt of sale/leaseback monies £3.7m for the sale of 30 of the 53 22/23 ambulance cohort and backdated receipts of £3.1m from BOB ICB, offsetting payments to suppliers. The £2.8m sale and leaseback income for the 23 remaining 2022/23 cohort was expected in August but has now slipped and will be received in September. In September there is a £3m income expectation from the ICB with £0.5m received per month thereafter, culminating in a total additional income of £6m, this has been added to the cash flow forecast.

The year-to-date pay award is now expected to be paid in October with the additional cost over budget of £7.3m for the full year has been added to the pay expenditure within the cash flow forecast. An income expectation of £7.3m has also been included within the cash flow in anticipation of the additional 3.4% pay award being centrally funded, however, at this stage, it is not clear if this will be the case.

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	29.9	35.2	36.1	36.4	28.7	34.2	32.2	35.3	34.1
Expenditure £m	(30.6)	(32.5)	(31.4)	(30.9)	(30.8)	(30.0)	(36.0)	(33.8)	(36.3)	(34.0)	(32.5)	(36.7)
Net Inflow/(Outflow) £m	2.2	(5.6)	(4.1)	(1.0)	4.4	6.1	0.4	(5.2)	(2.1)	(1.8)	2.8	(2.6)
Cash Balance £m	27.2	21.6	17.5	16.5	20.9	27.0	27.5	22.3	20.2	18.4	21.3	18.7
Cash Lowest Point	22.0	21.1	17.5	14.9	13.4							

The lowest point of cash in the month was £13.4m which is a reduction from last month of £1.5m. The daily cash balance profile can be seen in **Appendix 1**.

The 90-day debtor total reduced slightly to £0.1m in August (£0.2m in July).

Recovery Support Program (RSP)

The Trust received a letter on 9th August from NHS England detailing funding that is being provided to the Trust for phase 1 and phase 2 of the RSP process.

The funding is subject to evidencing that expenditure and impact, otherwise funding will need to be repaid. There is also a requirement to notify the Audit Committee (or equivalent committee of the Board) of the funding and how it has been spent and the impact it has had. This will be monitored through the Trust Executive Management Committee and Finance & Performance Committee.

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.

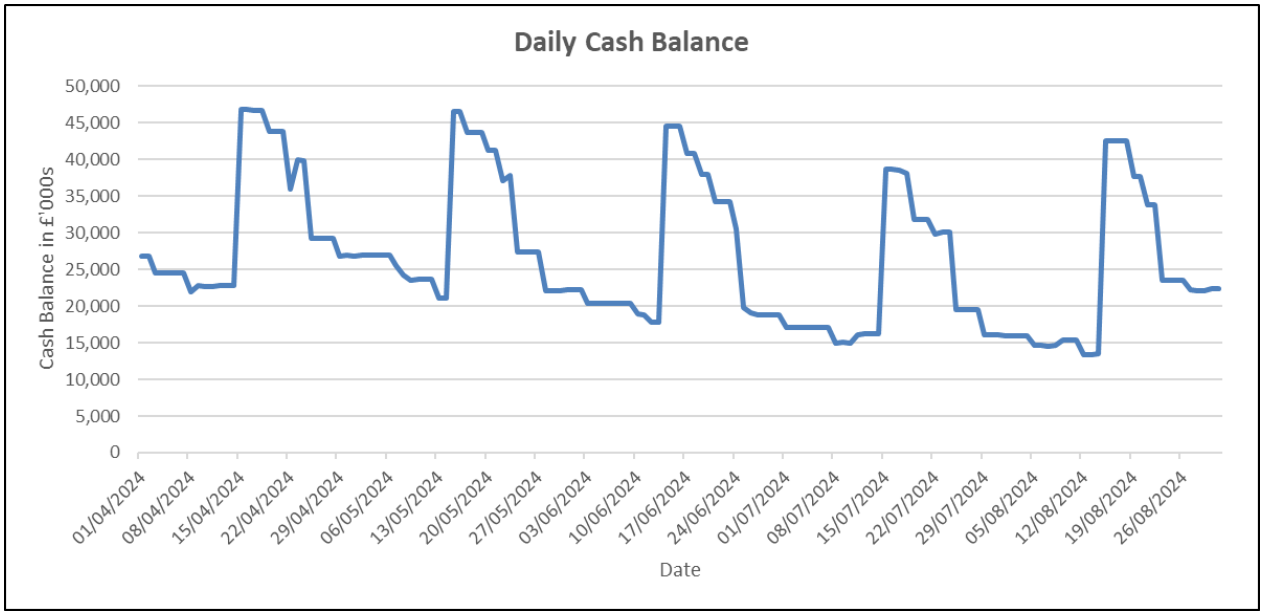
- If the Trust needs to utilise NHSE cash support, there will be additional costs that impact the financial position.
- If the cash position deteriorates then it will impact the Trusts ability to fulfil its capital plan.

5. Recommendations

The Board is asked to note the finance position.

Appendix 1

The cash balance is monitored on a daily basis and this will be forecast forward to understand the daily movement for the remaining part of the year and help to identify any pinch points.



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UPWARD REPORT

Name of Committee reporting upwards:	Finance and Performance Committee
Date Committee met:	19 August 2024 & 19 September 2024
Chair of Committee:	Les Broude, Non-Executive Director/ Senior Independent Director
Reporting to:	Board of Directors Meeting 26th September 2024

1. Points for Escalation

- Aug: The committee received the Financial Recovery Plan (FRP) Report and following discussion agreed the need to develop a recovery plan for non-emergency patient transport services (NEPTS) to bring the service back in line. The committee asked for a report back from Financial Recovery Group.
- Aug: The 111 Service year-to-date was £0.5 million adverse with the main reason being attributed to the BOB 111 contract, with funding below the cost of running the current service, with a QIA to be shared with ICB on the implications.
- Sept: From actions: rostering was carried forward to next meeting, with a request to further understand the effect of and the implementation of the AACE review.
- Sept: The committee received the Financial Recovery Plan (FRP) Report and following discussion agreed to hold a Star Chamber on the Financial Recovery Plan, with Executive Directors for each area to present the year end forecasts and any mitigations
- Sept: There was an update on the fleet plans going forward and a request for the next meeting to receive an understanding of the impact on patients, staffing and Fleet

2. Key issues / business matters to raise

- Aug: The committee was presented with and approval to proceed to Trust Board:
  - Oxford University Hospitals NHS Foundation Trust (OUH) Logistics and Shuttle Bus Services Contracts.
  - Sussex ICB NEPTS Contract Variation for 2024/25.
  - Qlik Services Renewal.
- Sept: The financial position was discussed with the committee agreeing to discuss and play particular attention to the year-end forecast at the October meeting, requesting to be presented with a range of “if statements” .i.e. if this happens then…
- Sept: The committee was presented with and approved:
  - Aylesbury Workshop Business Case
  - DCA replacement programme
  - Bytes Contract Renewal
  - Southern Ambulance Services Collaboration (SASC) 2024/25 Manifesto

- Adult Critical Care Transfer Service – Subcontract arrangements with Buckinghamshire Hospitals NHS Trust and Royal Surrey NHS Foundation Trust
- Credit Card Policy.

Sept: The committee were represented with a plan to progress the Pandemic End of Life Data Strategy, which they supported. The paper included the Business Cases which were approved for:

- a) PHERS Data Repatriation technical specialist Business Case
- b) PHERS interim data protection officer.

3. <u>Areas of Concern and / or Risks</u>

- Aug: The Committee discussed the IPR Trust Month 4 position:
  - With three areas that showed significant decline:
    - Vehicles off the Road (VOR) at 40.2% (target 23%), the committee to have a presentation on Fleet at the September committee.
    - Non-patient transport call answering at 60% (target 95%); and
    - Meal breaks at 36.1% (target 70%), committee noting paper going to EMC for discussion.
  - Concern and discussion on the deterioration in response times could be attributed mainly to handover delays in Hampshire and Isle of Wight Integrated Care Service (HIOW ICS) at 55% above planned handover times with the Queen Alexandra Hospital, Portsmouth (QA) at 103% above plan adding 9:22m.
  - An update on the performance and cost saving plans in PTS was presented and discussed, with a particular focus on cohorting opportunities
  - Sept: The Committee expressed concern about the timing of the circulation of the papers for the committee, recognising that this was a transition month between departments.
  - Sept: The Committee discussed the IPR Trust Month 5 position, the committee questioned and debated, the:
    - Special Cause Variation – Deterioration Target Measure:
      - Meal Breaks Compliance
      - PTS Calls answered in 60 seconds
      - VORs
      - Clear up Delays
      - Patients Collected with time
    - See & Treat Common Cause Variation and Missed Target@
      - Average Hospital Handover Time
      - Cat 1 Mean
      - Cat 2 Mean
      - Cat 3 90th percentile
      - Cat 4 90th percentile
  - Vehicle Audits – this raised a number of concerns for the committee and requested immediate actions to be taken with support for the already steps of implemented of contract management, also, to include for an operational response.
  - Sept: The Business Cases for Operations: UEC funding and PP spend for H2 were requested to be held while some further work on future implications were considered.

4. **Items for information / awareness**
    - August's Committee was a 1 hour meeting due to having a change in date and time due to holiday commitments.
    - Sept: The committee received the updated Fleet report that provided an opportunity to understand future plans and allowed for advantageous discussion. The committee requested a paper reflecting issues/actions to be include in the next report/update.

5. **Best Practice / Excellence**

Good discussion and challenge around key issues and items for approval.

The committee commended the cover sheet of IPR for highlighting the issues, praising the Executive for openness on discussing the issues as well as the overall quality of the papers.

6. **Compliance with Terms of Reference**
    - The meetings were quorate for most of the committee and for all the items that needed decisions/approvals.

Author: Les Broude
Title: Non-Executive Director/ Senior Independent Director
Date: 20 September 2024

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Upward Report of the – Audit Committee

Date Meeting met **18/09/24**
Chair of Meeting **Mike McEnaney, Non-Executive Director**
Reporting to **SCAS Public Board meeting**

Items	Issue	Action Owner	Action
Points for escalation			
Leadership	It was noted that a number of actions had not been carried out and with evidence leading to concerns with cross-function communication and also accountability.	Mike McEnaney	To discuss with the Board.
Key issues and / or Business matters to raise			
Internal audit – action follow-up report	Progress has continued to be made on closing out the overdue actions, which is good, however, some actions in key areas continue to be delayed.	Stuart Rees	To raise the matter with the executive team.
Areas of concern and / or Risks			

Internal audit report – Medical devices	The report was specifically scoped with the Interim CFO to provide clarity on areas of concern. The report concluded with assurance levels: design of internal controls – Moderate and effectiveness of the controls was Limited. This being a direct patient risk is a concern and will also be picked up at the Quality Committee	Stuart Rees	To expedite management actions and risk mitigation.
Counter Fraud training - attendance	Whilst counter fraud actions are generally well managed, there isa noticeable weakness in that staff attendance at awareness training sessions is negligible. A review will take place as to how this can be considerably improved whilst recognising how busy our staff are.	Stuart Rees	
Items for information and / or awareness			
Benchmarking reports	The meeting received reports regarding internal audit, the use of single tender waivers and the management of declarations of interest. These reports were comparing SCAS with 60 other NHS trusts and in general SCAS was positioned such that we gained some assurance that we were performing satisfactorily.		
Best Practice and / or Excellence			
Risk – Deep dive	The committee agreed that the deep dive initiative into key risks on the corporate risk register would be reported to the Executive Management Committee and the Audit Committee would receive a summary of them. The exercise of a deep dive on key risks is an		

	enhancement of ensuring the right controls and actions are in place and tat the risk is properly understood.		
Compliance with Terms of Reference			
Policies approved*			
Gifts, Hospitality and Conflicts of interest policy	The policy, which had been rewritten, was reviewed and 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: 20/09/24

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Upward Report of the – People and Culture Committee

Date Meeting met **9th September 2024**
Chair of Meeting **Ian Green, Non-Executive Director**
Reporting to **Board – 26th September 2024**

Items	Issue	Action Owner	Action
Points for escalation			
Committee papers/administration	The committee asked that work is expedited to develop a common approach to the administration of committees including minute taking, action tracking and quality of papers. Current approach isn't working well.		
Corporate Review	Committee sought assurance that executive members were demonstrating ownership of managing the approved timescales in each division. The impact of slippage in not meeting timescales on individuals impacted by the review was considered as a risk		Chief Executive to seek and obtain assurance from his colleagues that they are prioritising this so timescale are met.
Culture Review	Committee were provided with an overview and update. The importance of creating time for the board to engage was discussed		Urgent session requested as part of a Board session

Key issues and / or Business matters to raise			
Corporate Risk Register/BAF	Further assurance required regarding the timeliness of undertaking mitigation actions in the risk register and BAF – who is accountable?		
PDR	Disappointing that the PDR training event was cancelled. Good practice that an Executive Director from another directorate was acting a executive sponsor for the PDR recovery programme		
Areas of concern and / or Risks			
Items for information and / or awareness			
Statutory and Mandatory Training	Generally good compliance with statutory and mandatory training although some areas of still require improvement		
Best Practice and / or Excellence			
Compliance with Terms of Reference			
Forward Plan	Committee forward plan was approved		
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: 18th September 2024

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Report Cover Sheet

Report Title:	Southern Ambulance Services Collaboration (SASC) – manifesto and priorities
Name of Meeting	South Central Ambulance Service NHS Foundation Trust Board meeting
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	22
Executive Summary:	**The Southern Ambulance Services Collaboration (SASC)** is a Collaboration between East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services. • To develop the manifesto, SASC engaged over 100 people across our five Trusts. • SASC's year 1 ambition is to: - Develop shared procurement capability to attract the best suppliers, purchase the highest quality products and services at the best price and provide a return on investment in year 1. - Identify and develop two to three use cases of AI technology in Emergency Operations Centres - Develop an optimal model for a Double Crewed Ambulance (DCA) shift.
Recommendations:	The SCAS Trust Board is asked to approve the SASC manifesto and priorities.
Accountable Director:	David Eltringham, Chief Executive Officer
Author:	Southern Ambulance Services Collaboration
Previously considered at:	Not Applicable
Purpose of Report:	Approve

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:	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	Document 1 – manifesto poster vfinal

NHS
Southern Ambulance Services Collaboration

Southern Ambulance Services Collaboration (SASC) 2024/25 Manifesto – Board Paper

SASC

Working together for our patients, people and communities

Southern Ambulance Services Collaboration

About this document

This document provides the detail of the 2024/25 Manifesto for the Southern Ambulance Services Collaboration (SASC).

This document contains **part A** (SASC 2024/25 Manifesto outline.

Contents

Part A: SASC 2024/25 Manifesto outline

The Southern Ambulance Services Collaboration (SASC) is a Collaboration between East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services.

SASC's foundational goals are to:

- Support the delivery of consistently high quality frontline care
- Enhance the wellbeing of our staff
- Manage financial constraints
- Develop a culture of 'stealing with pride'

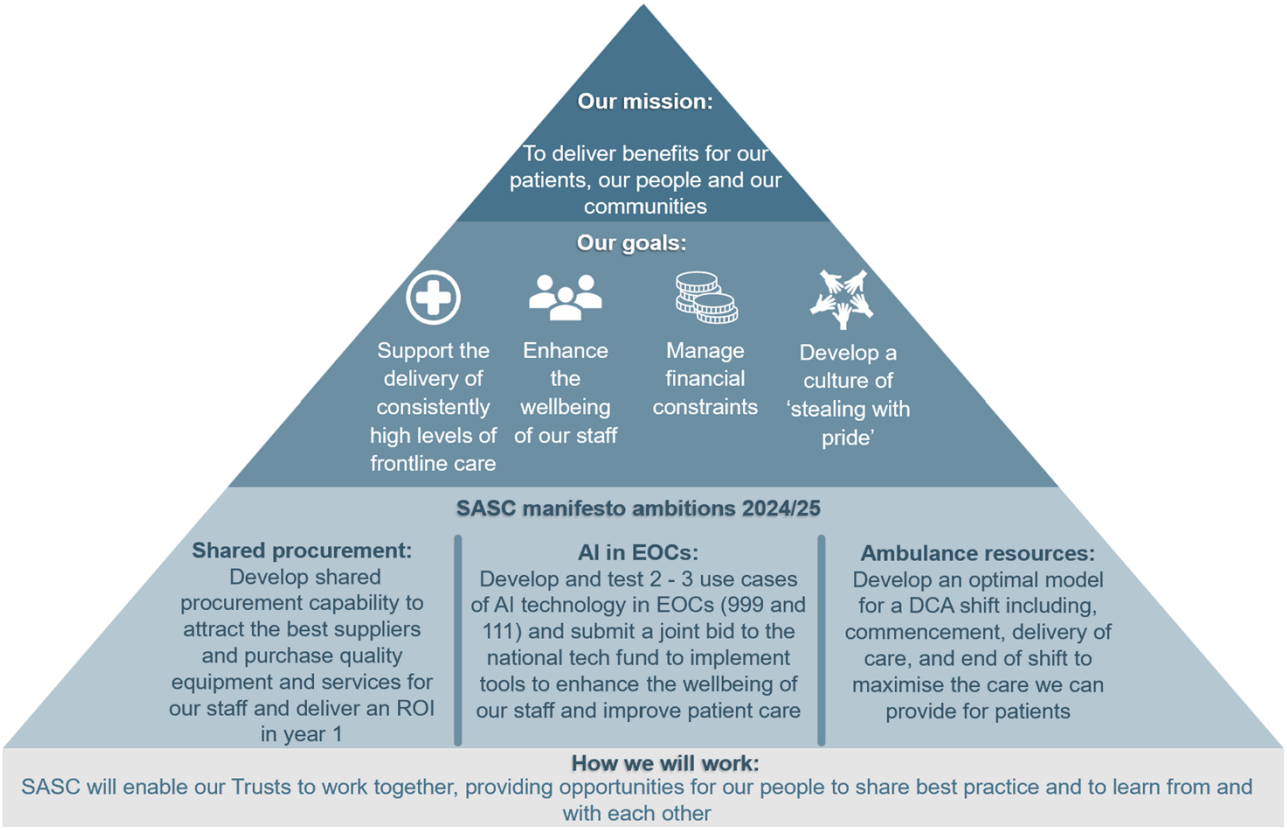
To develop the manifesto, SASC has engaged over 100 people across our five Trusts. The engagement sessions included individual and group CEO and Chair working sessions, problem solving sessions with each Trust executive team, and a workshop with ~100 colleagues across our five Trusts, on the 7th of June 2024. The workshop included five breakout groups, that each generated one to two initiatives. Following the workshop the CEO group selected three immediate priorities for year 1 to deliver improvements for our people, patients, and communities.

SASC's year 1 ambition is to:

- **Develop shared procurement capability to attract the best suppliers, purchase the highest quality products and services at the best price and provide a return on investment (ROI) in year 1.** The overarching principles are (1) the default is shared procurement, and (2) when procuring items, we will first consider how to maximise the net benefits for the collective.
- **Identify and develop two to three use cases of AI technology in EOCs** to improve patient care and support staff wellbeing. Submit a joint bid to the national tech fund. Examples of use cases could include: transcription and summary tools, sentiment analysis, clinical audits, pre-caller ID, etc.
- **Develop an optimal model for a DCA shift.** The focus will be to improve the availability of our ambulance resources by (1) developing best practice processes (e.g., start and end of shift processes, break policies, etc), and (2) optimising how we use and deploy our resources (e.g. what resources and how many we deploy to certain jobs).

The Collaboration will be guided through a governance structure that includes a Collaboration Director, CEO group, and Collaboration board (CEOs & Chairs). Each workstream will be driven forward by a CEO SRO, a director level lead from one of the five Trusts, and a support team where necessary.

Figure 1: Summary of year one Manifesto – programme areas and governance structure



Appendix 1 - SASC 2024/25 Manifesto poster

The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

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What is the Collaboration?

The Southern Ambulance Services Collaboration (SASC) is a collaboration between the East of England (EEAST), London (LAS), South Central (SCAS), South East Coast (SECAmb), and South Western (SWAST) ambulance services.

SASC
Working together for our patients, people and communities

The goals of the Collaboration are to:

- Support the delivery of consistently high-quality frontline care
- Enhance the wellbeing of our staff
- Manage financial constraints by sharing best practice
- Develop a culture of 'stealing with pride'

Our year one manifesto has been co-developed by our people and focuses on three areas of improvement

Our engagement over the past six months

- CEO and Chair working sessions
- Sessions with each Trust's executive team
- Workshop pre-meets for five priority areas involving ~80 staff across the five Trusts
- Workshop with ~100 staff across the five Trusts

From this engagement we identified three priority areas of improvement:

Shared procurement
Develop shared procurement capability

Ambulance resourcing
Implement a best practice model for a DCA shift

AI in EOCs
Implement AI tools in our EOCs to improve patient care and staff wellbeing

The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

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For each area, there are 3-4 priority deliverables…

Shared procurement

Our mission: Develop shared procurement capability, to purchase the best quality products and services at the best price across our five Trusts, and provide an ROI in year 1

Our deliverables:

- **Develop shared procurement approaches** by mapping and aligning our procurement data, systems and processes
- **Identify the items** that will return the highest value and will generate a return on investment in year one
- **Begin joint procurement** in the 2024/25 financial year

AI in EOCs

Our mission: Identify and develop two to three use cases of AI technology in EOCs (999 and 111) and submit a joint bid to the national tech fund to implement tools to enhance the wellbeing of our staff and improve patient care

Our deliverables:

- **Map opportunities** for AI in EOCs to improve patient care and staff wellbeing
- **Develop 2-3 use cases** for AI in EOCs and test across 5 Trusts
- **Place a bid to the National Tech Fund** on behalf of all 5 Trusts
- **Implement at least one AI support mechanism** (e.g., pre caller ID) across all 5 Trusts

Ambulance resourcing

Our mission: Develop an optimal model for a DCA shift including, commencement, delivery of care, and end of shift to maximise the care we can provide for patients

Our deliverables:

- **Map out how time is spent on a DCA shift to** develop a collective understanding of current ways of working
- **Develop a 'common language'** of agreed metrics
- **Identify the priority components** to deliver the greatest collective benefit for patients and staff
- **Develop proposals** to improve these components

The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

NHS Southern Ambulance Services Collaboration

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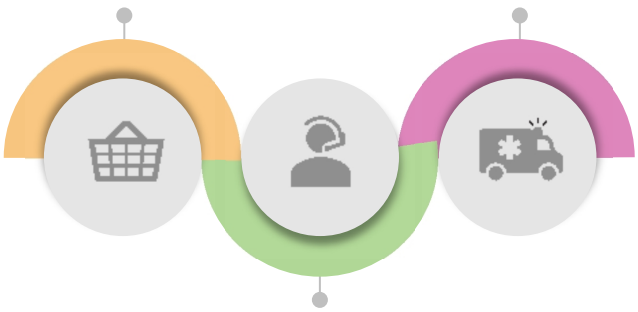

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The Southern Ambulance Services Collaboration (SASC) 24/25 manifesto

NHS Southern Ambulance Services Collaboration

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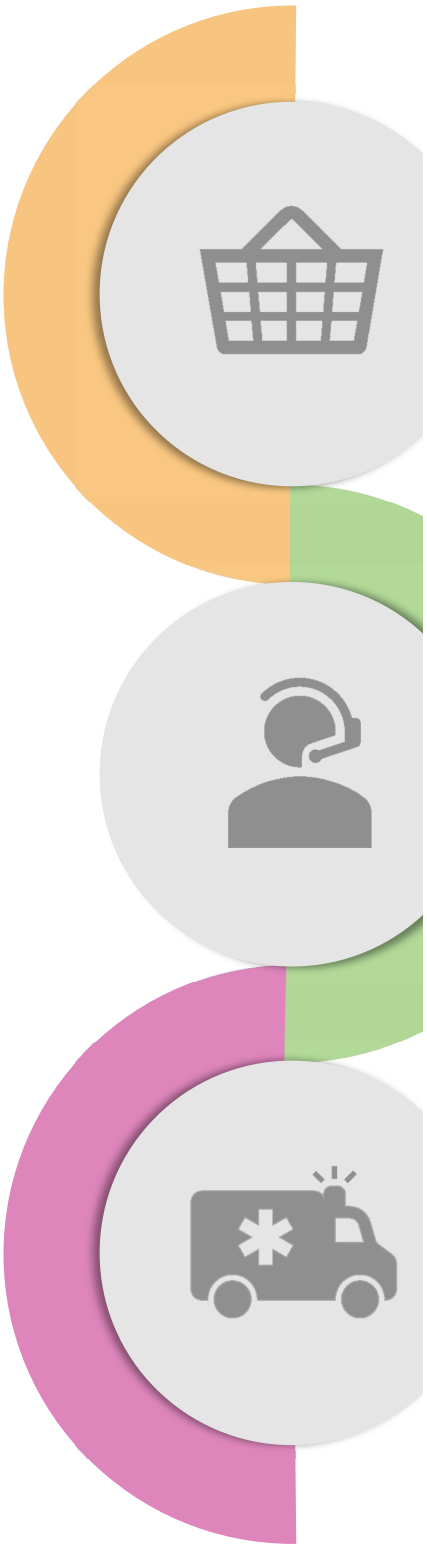

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Report Cover Sheet

Report Title:	Communications, Marketing and Engagement Update
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	23
Executive Summary:	**Media activity – proactive and reactive** It has been a busy summer, supporting operational teams with public information and awareness of using the ambulance service appropriately. The periods of extreme heat and summer bank holidays required appropriate messaging and advice. **Website accessibility improvements** Enhanced accessibility standards for websites come into force in October 2024 and we have been working on compliance of the Trust's site. The Cabinet Office is actively auditing websites of public sector organisations and checking that plans are in place to bring sites up to the latest standards. **Reward and Recognition – Long Service Awards 2024** Valuing and rewarding the significant length of service of many of our staff from across our services, continues to be a highlight of the SCAS calendar. For the first time this year, we also presented the King's Long Service and Good Conduct Medal.
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:	Not Applicable

Purpose of Report:	Note
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:** Significant
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: N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	Not Applicable
Next Steps:	Not Applicable
List of Appendices	None

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Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Communications, Marketing and Engagement Update
Author	Gillian Hodgetts
Accountable Director	Gillian Hodgetts
Date	26 September 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

Media activity - proactive and reactive - September 2024

A key aspect of the Communications strategy is to ensure that we keep the public informed of the pressures upon us and seek their support in using our services carefully, especially during periods of intense pressure. Raising awareness of other services through the media has been key. In order to do this on a regular basis we are widening our pool of senior operational staff to ensure we have a representative group of spokespeople who are willing and trained to undertake media interviews.

Effective use of services

Through August and September, the Trust has secured coverage of a number of proactive media stories and supported reactive requests to cover pressure on ambulance services during heatwave periods and the August Bank Holiday. Heads of Operations provided interviews for ITV regional TV and regional and local radio stations covering our patch. Multiple local online newspapers also picked up our written releases.

https://www.scas.nhs.uk/think-twice-before-calling-999-this-august-bank-holiday-weekend/

Staff safety

Earlier in the summer, we worked with ITV Meridian on a piece highlighting physical assault of ambulance staff, with a member of staff and senior managers interviewed. The piece used video footage from an ambulance dash camera and filmed training sessions that we run to help staff manage aggressive behaviour. The piece aired on 12 August 2024 and was picked up by other online media. Follow up reaction on social media was very supportive.

We are working in collaboration with other ambulance services across the country to communicate our zero-tolerance response to aggression against our staff. The Assaults on Emergency Workers (Offences) Act 2018 has helped to ensure that those committing offences are appropriately held accountable for their actions.

https://www.scas.nhs.uk/abuse-against-staff-is-unacceptable/

Board appointments

Similarly to other ambulance services, SCAS has appointed its first new Chief Paramedic Officer. Duncan Robertson joined the Trust on 16th September on an initial 12 month secondment. His appointment was confirmed in early August with web and social media releases. Coverage was picked up by the trade publication Emergency Services Times.

https://www.scas.nhs.uk/chief-paramedic-appointment/

Patient reunite stories

Much of the work of the Communications team media response, is responding to enquiries from national, regional, local and specialist media outlets. The Communications strategy seeks to balance reactive stories with positive proactive ones, initiated and released by the Trust.

The communications team have been working with operations and patient experience to develop a number of stories of patients meeting up with crews to thank them for their care and support. These stories traditionally get very positive reaction on social media and are picked up by local media. We have around ten such stories confirmed and currently being worked up. They will be released on a phased schedule alongside other proactive stories through the remainder of 2024/25.

4. Website accessibility improvements

Website accessibility improvements

The recent Lord Darzi report on the state of the NHS, highlighted that patients need to be re-empowered to be able to direct and control their care. One area of work that

we have been heavily focused on is improving accessibility to information that we make available on our public website.

Enhanced accessibility standards for websites come into force in October 2024 and we have been working on compliance of the Trust's site. The Cabinet Office is actively auditing websites of public sector organisations and checking that plans are in place to bring sites up to the latest standards.

The Trust's main public website uses a background system that has been in place since 2018. We have implemented updates and added functionality to keep pace with new requirements as much as possible. Where the site's systems cannot fully meet requirements, we have a published accessibility statement and disproportionate burden statement explaining the current limitations and plans we have to address them.

Throughout August and September, we have worked with our external website hosting and support provider to run detailed checks against the accessibility requirements and implement changes.

Changes required range from:

- Minor improvements to content and image tagging to make sure the site works well for people with visual impairments using screen readers.

- Structure changes to make sure people using a keyboard rather than a mouse can navigate through different sections easily.

- Functionality changes to make sure the systems that manage the site in the background use code that takes account of different accessibility needs.

The content and structure changes are work we can do in-house within the communications team. For the functionality changes, some issues can be resolved by our site provider, whilst others need to be raised with the developers of the cores system. We are raising specific issues with the system developer and hope they can be addressed as part of the regular process of updates to the core system, in the meantime they will be noted in our accessibility statement.

The Trust currently has four separate public websites covering different topics:

- The Trusts main corporate website www.scas.nhs.uk
- A recruitment focused site www.scasjobs.co.uk
- Sites specific to children and younger people www.scaskids.co.uk and www.scasyouth.co.uk

As a longer-term objective we are aiming to consolidate the content from all four of these sites onto a single system.

The SCA Charity also has its own website that is linked to from the Trust site but managed separately.

5. Reward and Recognition – SCAS Long Service Awards

Valuing and rewarding the significant length of service of many of our staff from across our services, continues to be a highlight of the SCAS calendar. A key objective of the Communications team, in support of the SCAS corporate strategy is the development of a new reward and recognition plan for 2025/2026. Alongside the more formal recognition presentations, there are proposals for recognition to be continued and enhanced on a more local basis, and not only face to face but through letters, social media, sharing of compliments and personal appreciation from the Chief Executive, Chair and members of the Executive team.

On 30 July 2024 SCAS held our annual Long Service Awards. Every year the ceremony is held in a different county within the SCAS patch. This time the event was held at Farnham Castle, on the edge of the SCAS area, in the beautiful July sunshine. We were joined by just over 100 people, both long service recipients and their guests.

During the event we celebrated frontline colleagues on the 999 service attending to collect their Queen's Long Service and Good Conduct Medal and who had reached their 20-year service milestone during the reign of Queen Elizabeth 2. This year, for the first time we also presented the King's Long Service and Good Conduct Medal. This is the first time we have presented this medal since the coronation of His Majesty the King, with newly produced coins from the Royal Mint.

In addition, we presented the SCAS Long Service Medal for 20 years' long service to the NHS. This was presented to staff from the Patient Transport Service, 111, 999 and corporate teams such as Information Technology and Education, as well as many others, all who have provided dedicated service to the NHS over the last 20 years.

We were honoured to be joined by Colonel Charles Ackroyd TD RD DL, Vice Lord Lieutenant of Hampshire, who presented the medals alongside Chief Executive, David Eltringham. Following the celebration, recipients and their guests enjoyed afternoon tea, shared stories, and celebrated their achievements.

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 Meeting
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	Digital Update
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
Author:	Craig Ellis
Previously considered at:	N/A
Purpose of Report:	Note
Paper Status:	Private

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):	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	(Please list any supporting information accompanying this Summary Sheet and Meeting Report)

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Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Digital Update
Author	Craig Ellis, Chief Digital Officer
Accountable Director	Craig Ellis, Chief Digital Officer
Date	September 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 quieter IT month overall but very challenging given the corporate restructure go-live. The majority of my time has been focused on the consultation, team meetings, one-2-one meetings and ensuring the process has run as smooth as possible in very challenging circumstances and focusing on the Digital staff according. From an IT perspective – one major issue with a National outage on the 111 Telephony platform occurred which was quickly resolved, and now pending a root cause from the centre which we are following up.

System & Partner Engagement: We have began engaging with our colleagues across the South in regard to CAD and strategic options (Shared CAD, Shared Tender Process, Alignment of Programme Resources etc) for which we are drafting an initial brief which will come out in the coming weeks and moved up through the governance processes accordingly.

In addition, I have had further engagement with SECAM CIO around potential collaboration opportunities within the Digital remit, which are currently under

discussion. I am slightly concerned at how the collaboration has been initially initiated and welcome the recent formalisation around a shared executive meeting and board meeting to ensure we are aligned on timelines, priorities and focal areas without individual distraction.

Digital Financial Update: Digital continues to focus on our 24/25 CIP which is currently tracking to forecast, and in addition we are seeking additional saving opportunities aligned to the 2023 EPR outage, and our PHERS IT costs.

We are continuing to work on our capital spend for 24/25 with a view we will be able to consolidate money back to the centre, and a focus is now on building risk mitigation plans for the 5 key areas identified previously (Clinical, Phers, Cyber, Data and IT Business Continuity) with the PHERS plan completed and in for approval in Sept.

Cyber Update
SCAS completed the recent NHSE Cyber Security Maturity assessment focused solely on Ambulance trusts, of which we submitted ahead of time (1st of all trusts) and are now pending the feedback which will be late 2024. In addition we continue to focus on recruitment, producing a strategic plan including investment and getting ready for the upcoming migration from the DSPT to the Common assurance Framework (CAF)

Data/BI Update
No major issues in September, but we do continue to see outages across our Data warehouse and BI systems. A very challenging time right now within the BI team with a growing list of priorities related to the IPR, Internal reporting and maturity but a destabilised team due to the corporate restructure. I am working up a way forward in discussions with Stuart R and Mark A.

Key Achievements

- Completion of the Safeguarding Task & Finish Group (Sep-24). Report now working up through governance paths for noting/approval.

Key IT Issues

- 111 Telephony outage in early September. Issue was a national issue with BT and we are currently pending follow-up as Ambulance Trusts on the root-cause and potential problem management.

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:	Performance and Accountability Framework
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	26
Executive Summary:	Following Board workshop on Risk Appetite which focused on amount and type of risk that the Trust is willing to take to meet their strategic objectives. Discussions on what this would mean and what would be needed to allow the Trust to take the risk it considers necessary to achieve these goals in agreed it would require greater financial controls and a performance and accountability framework. The aim of the Performance and Accountability Framework (PMAF) is to ensure that the necessary processes, procedures and responsibilities are defined and in place to enable the Trust Board and other key personnel to understand and monitor the trust's achievement against quality, operational and financial performance, enabling appropriate action to be taken when performance against set targets deteriorates. To enhance the Trust committed to making performance management a core organisational focus. This document provides a framework for leadership from 'Board to Front-line' and will support effective decision making and ensure that performance management is integral to organisational planning and service delivery. The PMAF sets out the means by which the Board can easily identify areas of excellence for wider sharing and celebration and areas where additional support may be required. It is the framework by which the Board, Executive Leadership Team, Sectors, Nodes, and corporate functions are held to account for their performance. The proposal would be to introduce the PMAF within quarter three of the financial year, this would allow also it play its part in next year planning process.
Recommendations:	The Board is asked to: • Approve the PMAF

Accountable Director:	Stuart Rees, Interim Director of Finance
Author:	Stuart Rees, Interim Director of Finance
Previously considered at:	Executive Management Committee Finance & Performance Committee Audit Committee
Purpose of Report:	• Approval PMAF and its role out.
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** • **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:	Relevant Executive to engage in relevant areas.
List of Appendices	• Appendix A: PMAF

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DRAFT Performance Management and Accountability Framework

DOCUMENT CONTROL

Executive Lead	Chief Finance Officer
Approved By	
Ratified By	
Date of Agreement	
Date of Issue	
Date of Review	

VERSION CONTROL

Version No	Date	Reviewer	Summary of Change
1.1	May 24	EMC	None
1.2	June 24	F&PC	Page 5 – Emphasis on integrated approach across directorates, sector - allow the triangulation between the Service Groups, Sectors and Corporate Directorates and the parts they play in the overall objectives of the Trust. Page 6 - Creating a performance culture - Understand training needed as this will impact on the Culture of Trust. Page 8 – Wording expend on Appraisal and intention to include.
1.3	July 24	Audit Committee	Page 10 – Chief Strategy Office, re-distribution of responsibilities.

Contents

Appendices

1.0 Statement of Intent

South Central Ambulance Service NHS Foundation Trust (SCAS) is committed to ensuring that all services are provided to a high quality and are effective and efficient. The Trust acknowledges that timely access to treatment and other key performance indicators contribute to high-quality patient experience.

The aim of the Performance and Accountability Framework is to ensure that the necessary processes, procedures and responsibilities are defined and in place to enable the Trust Board and other key personnel to understand and monitor the trust's achievement against quality, operational and financial performance, enabling appropriate action to be taken when performance against set targets deteriorates.

We are committed to making performance management a core organisational focus. This document provides a framework for leadership from 'Board to Front-line' and will support effective decision making and ensure that performance management is integral to organisational planning and service delivery.

We consider effective performance and accountability management to be the responsibility of everyone in the organisation, the implementation of this Framework will involve Trust Board Members and all employees, effect all stakeholders and service users. It will be applied to clinical, organisational, financial, human resource and quality systems and processes.

2.0 Introduction

It is the Trust's intention to implement a clear Performance Management and Accountability Framework (PMAF) which sets out the overarching principles and approach to delivering a high performing organisation. This framework aims to ensure that South Central Ambulance Service NHS Foundation Trust (SCAS) successfully delivers national standards for performance and contractual targets agreed with commissioners. This framework document describes how the Trust will utilise improved information management to drive better performance and introduce a tiered performance management process to ensure a rigorous, supportive and consistent approach to performance management is achieved at all levels of the organisation.

3.0 Definition

Performance management and accountability is about establishing a formal, regular and rigorous system of data collection and usage to indicate trends and measure the performance of services. Performance management should be used to help identify areas of best practice, to focus on continuous improvement and delivering improved outcomes, to take action to improve patient care and to ensure that the activities of services are in line with the overall

organisational strategy and priorities. It is the responsibility of all employees to contribute to the effective running of services.

4.0 Aim & Purpose

The framework will provide an integrated approach to managing performance and ensure there is clear visibility and lines of accountability from the Trust's Board down to team level. The PMAF aims to reflect the NHS oversight framework (NHS England » NHS oversight framework) to ensure SCAS is best placed to deliver all required standards. The Integrated care systems (ICSs), together with SCAS's strategic objectives will set out the direction of travel and the PMAF is the mechanism to ensure delivery with the aim of providing internal and external assurance.
The approach to NHS oversight is characterised by the following key principles:

a. working with and through ICBs, wherever possible, to tackle problems
b. a greater emphasis on system performance and quality of care outcomes, alongside the contributions of individual healthcare providers and commissioners to system goals
c. matching accountability for results with improvement support, as appropriate
d. autonomy for ICBs and NHS providers as a default position
e. compassionate leadership behaviours that underpin all oversight interactions informed by Our Leadership Way (an agreed set of behaviours describing what good leadership should look and feel like), the National Quality Board's (NQB's) Our shared ambition for compassionate, inclusive leadership and the NHS board level competency frameworks.

SCAS faces several challenges in the coming years, including establishing organisational design and processes to ensure it is able to deliver high quality services as effectively and efficiently as possible, it is therefore important to have appropriate and transparent mechanisms that enable the Executive Officers, Senior Responsible Officer (SRO) and Programme Managers to deliver the required levels of performance. This document formalises the trust approach to performance and accountability and clarifies expectations, roles and responsibilities. SCAS's Trust Board and Executive Team are accountable for the overall performance of the trust with Directors, Senior Management and commissioning teams responsible for delivery. This is set out in The Framework.

Additionally, the PMAF seeks to encompass achievement of broader strategic objectives contained within the trust's plans and other key enabling strategies. It achieves this by providing a focus on effective and demonstrable delivery of the 'In Year' priorities documented within the Trust's Annual Plan, which underpin our broader aims and objectives across all areas of Trust activity (see Figure 1).

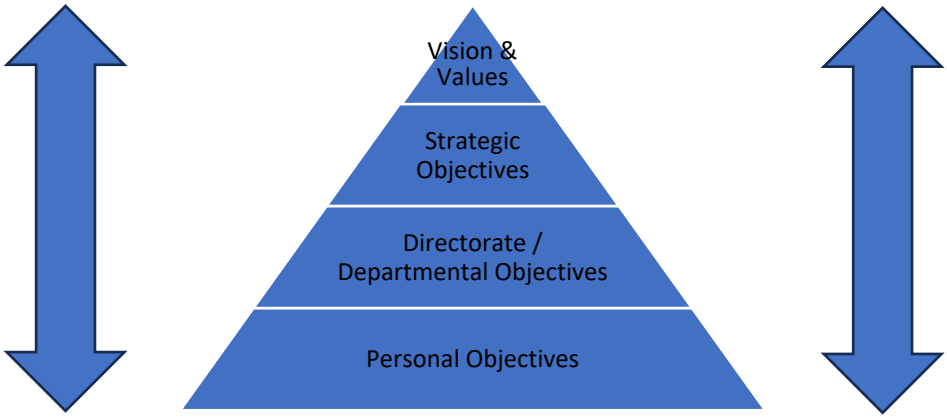


Figure 1 SCAS Strategic Model/Business Planning Activities by Three Years and Annual Plan

The aim and purpose of the PMAF is to ensure alignment between clinical and non-clinical operational performance, activity, quality and finance, training and workforce plans to enable the Board and the Trust's clinical and non-clinical management and staff to:

- Assess performance against clear targets and goals
- Undertake exception-based performance tracking
- Predict future performance and identify key actions
- Put in place effective review meeting structures
- Focus resources and improvement efforts in required areas
- The integrated approach will allow the triangulation between the Service Groups, Sectors and Corporate Directorates and the parts they play in the overall objectives of the Trust.

This framework sets the principles for the PMAF, which in turn sets out the operating procedures and reporting structures through which the implementation of the strategy will be monitored. The Framework is a key mechanism for ensuring all aspects of the trust's activities deliver high quality, well managed, safe, and effective services. It describes the governance, reporting and action planning that operates within the Trust and how clinical and corporate service directorates work together to ensure the Trust is able to clearly demonstrate that it is a high performing organisation.

Its key purpose, is:

- To ensure that the organisation has effective systems and processes in place to provide assurance to the Board and our stakeholders that the organisation is performing to the statutory and regulatory highest standards.
- Ensure arrangements for performance review meetings are described, setting out frequency, attendance and the governance process for recording and managing the actions from these meetings.
- Develop the business intelligence of the trust to inform service improvement, productivity and efficiency increases, including the delivery of cost reduction programmes
- Facilitate a clear process for budget setting and business planning, enabled through service line reporting
- Support the delivery of strategic objectives as detailed within the Board Assurance Framework (BAF), acting as the overarching mechanism for performance management

and accountability across the Trust forming part of the assurance to the Board in regard to achieving the strategic objectives.

- Describe the escalation levels which can be applied in different scenarios of performance under-delivery. This ranges from a position of earned autonomy to a high level of support and escalation
- Provide assurance that the trust is achieving best value for money in its use of resources
- Clarity on the roles of individuals and teams and how they relate to the overall performance and accountability with the trust.

5.0 Guiding Principles

Every employee from Board to front line teams has a role to play in ensuring that the Trust is regarded as a high performing organisation.

A high performing organisation holds itself to account for all the activities it is required to deliver and for unresolved concerns to be escalated if performance does not meet the required standards. However, staff empowerment is key to success in performance management terms. The structure within which employees work must nurture a culture of collaborative working where solving problems at a local level is the norm and lines of accountability are clear.

The trust encourages a culture of mutual support, particularly between its Service Groups, Sectors and Corporate Directorates, in order to optimise performance.

Performance delivery requirements are set out clearly in the Trust's plan (Annual Plan or where relevant Medium-Term Plan (MTP)) and through the processes in place these requirements are developed and agreed with the trust's Service Groups, Sectors and Corporate Directorates, who have delegated responsibility and accountability for the delivery of those plans. Delivery requirements will be refined through the year to reflect a blend of Trust internally set improvement targets and any emerging expectations from ICB/ICS/NHSE at appropriate points. Noting the delivery requirements will be agreed through discussion with regulators, commissioners and defined internally. Changes will be by exception and discussed with the Trust Board.

6.0 Performance Management Principles

The PMAF is designed to support a culture of continuous performance improvement for the benefit of patients. This is done by a standard approach to performance management supported by tools and a central management team. In particular, the approach provides:

- **Clear objectives**: The Trust Board Plan deliverables are highlighted throughout the PMAF ensuring monitoring and focus on these key deliverables at all levels of the Board.
- **Accountability**: Performance management arrangements in place to clearly identify the Executive and Management leads for any area of performance in the Trust Board.
- **Transparency**: The tools to measure performance and the evidence used to assess performance is clear and staff across the Trust Board understand what is required and will be held accountable through a clear approach which makes clear what is expected when performance drops below an acceptable level. This will be through the Service Groups, Sectors and Corporate Directorates/Departments of the Board. Wherever possible the Board will ensure that tools and information are available to services

enabling them to query and analyse the data on which they are being performance managed.

- **Improvement focussed**: The Performance management approach of the Board will be supportive and focussed on improvements. Services which are identified as underperforming will be offered the tools and resources to improve performance and the responsible individuals will be supported to make improvements.
- **Creating a performance culture**: these arrangements are intended to support the development of a culture of continuous performance improvement, delivered for the benefit of patients. This will be supported by clear objectives at all levels which drive a culture of high performance and accountability, supported by the Personal Development Review (PDR) process. At Sectors, nodes, directorate and service-line level the PMAF should also be used as a driver for cultural change and engagement within areas. This will aid cultural shift/development there will be an approach to training/education as part of this work.
- **Empowerment and delegation**: Areas of the Board which are performing strongly will experience lighter levels of performance management, rewarding and encouraging innovative ways of working. Conversely areas of the Board which are underperforming in key areas will be required to attend more regular formal performance meetings and will be offered greater support in making improvements through an agreed escalation process (set out later in this document).

7.0 Scope of the Performance Management and Accountability Framework (PMAF)

The PMAF seeks to make clear the link between use of resources and outcomes, in terms of clinical quality, operational effectiveness and financial performance and how information about our performance will be used throughout the organisation to inform and drive improvements in cost effectiveness, service quality and outcomes for patients and the public (see Table 2). It does not attempt to describe in detail the performance arrangements that are established in board committees or other meetings in the trust, nor does it cover individual performance management arrangements within the trust.

As well as reporting on financial and clinical outcomes, which reflect consequences of past actions (lag indicators), measures introduced as part of the Trust's PMAF will include lead indicators of future performance such as delivery of strategic objectives and patient satisfaction.

Clinical Quality	Use of Resources	Operational Effectiveness	Workforce and Training
Clinical outcomes	Income	Resource utilisation	Workforce Numbers
Patient satisfaction	Costs, CiPS & FRP	Response times	Sickness management & Abstraction
Compliance with clinical protocols	Growth	Overtime / Incentives	Recruitment & Retention

Table 2: Resource and Outcomes

8.0 Annual Planning and the Performance Management and Accountability Framework (PMAF)

The Trust has embarked on a programme of radical change, Fit for Future (FFF), which will transform services to ensure the trust is able to deliver for the future. This is a significant change piece and will require significant staff engagement to be successful. Together these plans provide an

integrated, coherent and reinforcing framework which will ensure plans and their delivery are embedded throughout the organisation. The PMAF will work both the current and future arrangements as shown in Table 3 below.

Performance & Accountability Management		PROCESSES	PEOPLE	DATA AND SYSTEMS	Performance Improvement
	CORPORATE LEVEL	• Clarity about the roles and responsibilities of the Board, Directors and managers at all levels for performance • A framework which links performance to corporate planning, budgeting and resource management • Chief Executive ownership and active involvement in the Trusts performance review process • Performance review structures which hold staff to account, replicated from top to bottom and across operational and support departments • Recognition of good performance but with a relentless follow-up where performance falls short.	• A culture of continuous improvement throughout the organisation • Clearly articulated priorities which are widely understood by managers and staff at every level • Individual PDR objectives and appraisal linked directly to performance .i.e. the objectives for the area/sector, etc	• Timely, accurate and relevant data is used to inform decision making • Performance data is easily captures and clearly reported	
	SERVICE LINE				
	TEAM				
	INDIVIDUAL				

Table 3: Annual planning and performance & accountability framework

The PMAF ensures that there is a 'golden thread' between the organisational strategy and objectives defined by the Board and the work of every individual employee. To achieve this, the Trust's will:

- Translate its strategy as contained within the Trust's Annual Plan into operational delivery objectives
- Align the organisation to the strategy through common themes and objectives across service lines and support functions
- Communicate the broader strategy and objectives throughout the organisation
- Introduce regular performance meetings between service leads and the Executive team to support open discussion and feedback.

Corporate Level: This describes the arrangements put in place to manage delivery of corporate objectives as set out in the Trust Annual Plan, Medium Term Plan. These arrangements include directorate, node, HUBs, Sectors etc business plans and objectives. Governance arrangements are implemented through the Board which receives a comprehensive Integrated Performance Report (IPR) each month.

Service Line Level: This describes the introduction and maintenance of a Trust wide, minimum data set of key performance indicators with pre-defined performance targets for each service line and support directorate. The performance management by senior management of key performance indicators supports delivery of national and local targets. Governance arrangements are through the Executive Management Committee and the Performance and Accountability Review Meetings (PARM).

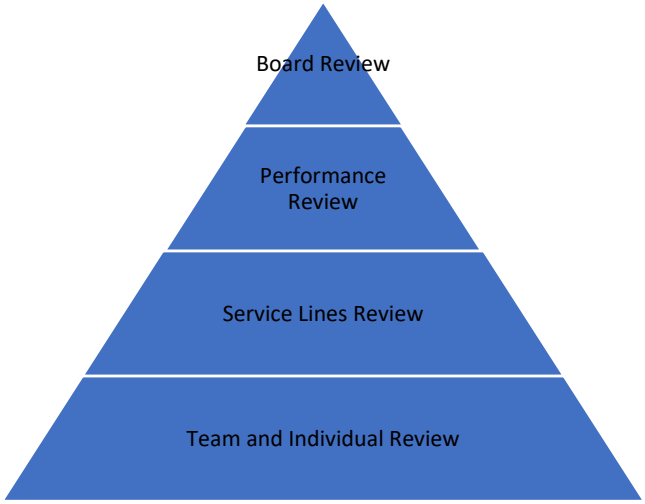
Team Level: This describes the introduction and maintenance of department, directorate, node, sectors, Hub level performance metrics with pre-defined performance targets. Governance arrangements are through the service line and Team Leads.

Individual Level: Employees will be actively involved in performance delivery and improvement and every employee must have a clearly defined role, responsibilities and performance objectives and be clear about the accountability associated with their position. Governance arrangements are through line managers.

The close integration of these processes in Trust systems is key to ensuring that the organisation remains focused on delivery of the key goals and objectives which contribute to the vision for SCAS services now and in the future.

9.0 Summary of Performance Management and Accountability Framework System

The PMAF relies on a hierarchy of performance and accountability management arrangements covering the Board to individuals & line managers (see Governance Assurance and Accountability Framework (GAAF)). This is also represented diagrammatically below:



Actions within the Trust Board's performance reporting system should be SMART (specific, measurable, attributable, realistic and time based) and include remedial actions to remedy underperformance as well as in the performance reports themselves.

10.0 Roles and Responsibilities

Whilst it is everyone's job to manage performance, the Board must drive a culture of performance by providing a clear vision and Trust priorities, goals and objectives and by holding the executive to account for the delivery of strategy.

The Board role is to "add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction (i.e., via approved plans)
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour

- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Trust's performance across all areas (i.e., by receiving reports on performance and from its sub-committees)."

Effective performance management requires defined roles and responsibilities and clear ownership of outcome measures. A summary of these roles and responsibilities is as follows:

Chief Executive Officer

- Overall statutory responsibility for patient safety, governance and performance management.
- Accountable to the Trust Board

The Board has delegated responsibility for Performance Management to the CEO and to discharge this responsibility, the CEO works with the Senior Management Team to ensure effective performance management arrangements are in place across the Trust.

Director of Operations

The Director of Operations holds Service/Teams Groups to account in terms of discharging their respective roles and responsibilities. S/he is the person to whom Service Group related issues should be directed in the first instance prior to consideration via relevant committees.

Chief Finance Officer (CFO)

Leads the development and implementation of the PMAF arrangements and has delegated responsibility for preparing, implementing and updating:

- ensuring that robust systems are in place for the performance and accountability management of national, local and internal targets;
- preparing the Integrated Performance Report (IPR) highlighting to the Board areas of "off plan" performance;
- ensuring that plans to address "off plan" performance are developed and implemented;
- ensuring that governance arrangements to support performance management are in place, robust and effective.

The CFO is responsible for the planning process within the Trust and will oversee the implementation of the Trust's plan.

- Planning is the bedrock of performance management as it ensures clarity on what is required to be delivered, who is accountable for delivery and the timescales for delivery. The CFO will provide quarterly updates to the Trust Board and Finance & Performance Committee on progress in implementing the plan. The quarterly Service Group Performance Review meetings will also receive Service Group updates on plan implementation.

Chief People Officer

Leads the development and implementation of the Individual Performance Review Process that aligns the contribution made by individual staff and departmental line managers to the trust's strategic goals as identified in the Trust Annual Plan. Working closely with the Chief Medical Officer, Chief Nursing and Patient Experience who have individual responsibilities for ensuring

clinically qualified staff have appraisals which deliver their professional standards.

Chief Digital Officer

Leads the Business Intelligence and Digital teams provide the accurate and timeous analysis and interpretation of performance data for performance and accountability review and follow up purposes.

Chief Governance Officer

Lead the manage the meetings and act as secretariat. Information required to inform the meeting will be facilitated through the relevant areas and produced by the Digital Team. The head from the relevant areas is responsible for advising on the process and system of reporting/escalation to the Committees and the Board in line with the PMAF.

Chief Nurse

Lead on the Quality indicators for routinely included in the IPR, for the Hubs, Nodes, Directorates, service Line, etc including measures of patient experience.

Responsible for ensuring the Annual Planning Process enables KPIs and metrics to be developed and agreed relevant to the Trust's priorities and agreed with service areas during the planned period. The Trust IPR will be produced to give a balanced view of performance across all areas of the Trust and, if KPIs are appropriate, interdependencies between indicators which may be causing performance to fail or achieve success will be easier to identify. This approach will be embedded during 2025/26 planning process and a review of Key Performance Indicators will be completed during the planning process for 2025/26. Our KPIs and local indicators should contribute to delivering the outcomes set out in the Trust's Objectives to ensure alignment with NHSE Operating Planning objectives and opportunities should be identified during the planning cycle.

Executive Directors and Senior Managers

Responsible for driving forward the development and embedding performance and accountability management arrangements in their area of service/function, ensuring consistency of approach as defined by in the PMAF, national and local targets, contractual targets agreed with commissioners, internally set improvement targets and any emerging expectations from ICB/ICS/NHSE at appropriate points and regularly contributing to and scrutinising the IPR.

All Staff

All staff contribute towards performance improvement and management by being encouraged and supported to identify improvement opportunities and to take the required action. It is important that staff own the data on their activity and understand how that translates to the corporate performance of the organisation.

11.0 Supporting Documents

The Trust will/has considered and applied published guidance in developing performance metrics for Service Line, Team and Individual levels 2, 3 and 4. The supporting documents used include:

- NHS oversight framework
- Governance Assurance and Accountability Framework (GAAF)
- NHS Handbook

- Resourcing Escalatory Action Plan (REAP)
- Trust's Operating Plan
- Trust's Financial and Control Plan
- Contract Requirements

Performance and Accountability Review Meetings Terms of Reference Appendix A

Purpose of meetings

To enable the Executive Directors to hold the Hubs, Nodes, Sectors, Department, Directorates, Service Divisions to account for delivery of key performance indicators and measures and to share and explore issues associated with delivering service improvement in the context of the Annual Plan, Medium Term Plan, Operating Plan of the Trust. The meetings are also designed to ensure best practice is recognised and shared throughout the organisation. Action notes from the meeting will form the overarching Trust performance management action plan to support service improvement throughout the Trust.

The Performance Management Review Meetings will be initially chaired by the CEO (and in future Chaired by the Chief Finance Officer) and attended by members of the executive team.

The governance/corporate affairs team manage the meetings and act as secretariat. Dashboards to inform the meeting will be produced by the Information Team.

Membership

- Chief Executive Office (Chair)
- Chief Digital Officer
- Director of Operations
- Chief Medical Officer
- Chief Finance Officer (Deputy Chair)
- Chief Nurse
- Chief People Officer

- Chief Governance Officer

In attendance

- Assistant Company Secretary (secretariat)

Frequency

Meetings take place bi-monthly. The frequency of each Service Line's attendance will be determined based on an assessment of performance, operating plan delivery and risk. Corporate Directorates will also be invited to attend on a quarterly basis.

A pack for the Corporate Directorates will be developed and this is likely to reflect the balanced scorecard report although it is acknowledged that there will need to be modifications to reflect the nature of the functions.

Information and Reporting

The Performance and Accountability Review Meetings (PARM) receives a summary dashboard report, which includes detailed KPI's, analysis of trends and exception reporting on key targets not being achieved and an overview on performance and predictive performance against the NHS oversight framework, Trust's Operating Plan, national and local targets, contractual targets agreed with commissioners, internally set improvement targets.

The PARM can require particular management teams to attend where concerns about performance remain unresolved. It would be expected that these issues would first be escalated through the accountable Executives.

Papers and briefings on particular performance issues as required PARM receives more detailed briefings and written updates on request on other performance issues.

The Board will also receive finance and performance exception reports including action plans to correct adverse performance as part of the Part 2 (Private) agenda.

PMAF: Categories of Performance & Consequences Appendix B

The consequences of the different ratings for relevant Divisions, Hubs, Nodes, Sectors, Directorates are:

- **Performing**: 'Earned freedoms' classification. Quarterly performance reviews (performance continues to be measured monthly).
- **Performance Under Review**: Bi-Monthly performance management reviews.
- **Underperforming**: Monthly (By exception Bi-Weekly) performance management reviews.

Earned freedoms and service line management

Directors will hold the primary responsibility for delivery within each Sector, Directorate, Service Line, supported by the Head/Lead…

Directorate, Sectors, Nodes and Service Lines which are 'Performing' have earned freedoms through:

- Less regular and intensive performance management
- Freedom to manage its own internal recruitment and operate within normal delegated financial authorities
- Priority for service development and capital funding.

With the ability to relate income to activity, the Trust intends to develop the concept of earned freedoms further to develop service line management within the organisation as set out in the Service Line Management Implementation Plan.

Performance & Accountability Management Arrangements **Appendix C**

LEVEL 1: Trust Board

Committee	Membership	Reporting Documents
Trust Board	Full Board	Integrated Performance Report (IPR) Other Board sub-Committee supporting information (e.g. compliance from Quality and Safety Committee or Board assurance from Audit Committee)
Finance and Performance Committee	Non-Executive CEO & Directors	In year operational & financial performance variance analysis KPI's Progress against Cost Improvement Plan (CiPs)/ Financial Recovery Plan (FRP)
People and Culture Committee		
Improvement Programme Oversight Board		
Quality and Safety Committee		
Executive Management Committee		
Perormance & Accountability Review Meetings		

LEVEL 2: Directorate Management

Directorate Performance Reviews	Lead Executives, Directorate Management Team Business PartnerS	Detailed Performance & Accountantabilty Management Framework for Directorate Directorate commentary Other issues by exception

LEVEL 3: Service Line / Functional

Functional and departmental review process	Directorate Director, Directorate Management Team, Service Lead	Individual dashboards, locally held performance information Risk assessment and mitigation

LEVEL 4: Team / Individual

Team reviews	Director, HR and Finance Business Managers, Service Lead with Hub/Node Director or equivalent	Station and team level KPIs, budget review and other specific governance indicators. Risk assessment and mitigation
Individual performance management arrangements	Individual and line manager	Agreed objectives Appraisal and PDR documentation

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Report Cover Sheet

Report Title:	Board Assurance Framework
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	27
Executive Summary:	**Board Assurance Framework** Changes are made in Green or ~~Strikethrough.~~ **BAF risk 1, Safe and effective patient care: Score 12 (Helen Young / John Black)** Risk remains stable with work continuing on the delivery of the asset management system. Improvements have been made with Patient Safety where the number of overdue actions from SIs has reduced from 52 to 16. The IV Midazolam risk has reduced from 16 to 12 following a review so it has been removed from the BAF. **BAF risk 2, Ability to meet fluctuating demand: Score 20 (Mark Ainsworth)** Risk remains elevated at 20 with ongoing work within the Operations Directorate to manage and reduce the risk. Two high rated risks have been reduced to target level relating to the age of the PTS fleet as the majority of the older vehicles have been replaced leaving a smaller old fleet and the Resource and Activity risk has improved through the improvement plan activity that has taken place. **BAF risk 5, Financial Control: Score 16 (Stuart Rees)** The risk remains above target at 16 (Major x Likely) and continues to be managed through the development of the medium-term financial plan, which is due in October and the delivery of the Performance Management & Accountability Framework (at Audit Committee for approval in September). The Trust is working with the ICB and the Recovery Programme due to slippage in the Financial Recovery Programme. The Trusts overall financial management and position continues to be monitored and controls closely by the Interim Director of Finance and the Financial Recovery Group.

	BAF risk 6, Sufficient skills and resources: Score 16 (Melanie Saunders) This risk has carried over from the previous BAF and remains rated at 16 (Major x Likely), above the target of 12. The team continue to work on the actions highlighted with delivery of the Workforce plan in Q2 and the people promise throughout the year. **BAF risk 7, Safe, valued and supported staff: Score 12 (Melanie Saunders)** This risk has also carried over from the previous BAF and remains rated at 12 (Major x Possible) against a target of 8. Work continues with culture review and the embedding of support networks for staff. **BAF risk 8, Digital Capacity: Score 20 (Craig Ellis)** This risk remains high at 15 (Catastrophic x Possible). The team have developed the IT Business Continuity plan during August following the business continuity desktop exercise which was conducted in July. A new gap has been identified relating to digital programme assurance and a review will be undertaken to fully understand the position and identify and implement solutions to close the gap. **BAF risk 10, Cyber: Score 20 (Craig Ellis)** The risk remains high at 20 (Catastrophic x Likely) however there is a plan in place to improve the Trust's cyber position. The action to implement Multi-Factor Authentication is ongoing with a formal project team and programme board now in place and a final delivery date of December 2024. The team are working with Information Asset Owners and suppliers to understand what is currently in place and where required, implement solutions. Each application is being risk assessed and requires Information Security and SIRO approval. **BAF risk 11, Modernisation / Fit for the Future: Score 12 (Paul Kempster)** Risk remains stable at 12. Additional controls and actions have been identified and added to the risk, covering the proof of concept for the Hubs, obtaining BI support for model redesigns, alignment of the work taking place with the Southern Ambulance Collaborative and the Ops Modernisation programme. **BAF risk 14, Partnership working: Score 8 (David Eltringham)** Risk remains stable with the scoring remaining at 8 (Major x Unlikely). The Co-Ordinating Commissioner Group has been established under the leadership of HIOW ICS Chief Delivery Officer. The groups work needs to mature during the planning round which is just beginning for 25/26. The HIOW UEC Transformation Programme is established and consists of five workstreams overing Front door Urgent Treatment Centres; Single points of access to alternative pathways; Decision to admit standards and performance management; Same Day Emergency Care pathway utilisation; and W45/Flow Management.

Recommendations:	The Board is asked to: Review and Approve the BAF.
Accountable Director:	Jamie O'Callaghan, Interim Chief Governance Officer
Author:	Steve Dando, Head of Risk Management
Previously considered at:	None
Purpose of Report:	Assure
Paper Status:	Internal
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:	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:	The Board Assurance Framework will be presented to the Board.
List of Appendices	Board Assurance Framework

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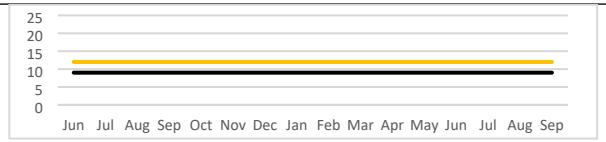
Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.		Risk score **12**
Strategic Risk No. 1: Safe and effective care	Update: September 2024	
If we have insufficiently equipped and trained workforce	***Then*** we will fail to provide safe and effective care	***Leading to*** poor patient outcomes.

	Impact	Likelihood	Score
Inherent	5	4	20
Residual	**4**	**3**	**12**
Target	3	3	9



Accountable Owner	Assurance Committee
Helen Young, Chief Nurse, John Black, Chief Medical Officer	Quality & Safety Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Workforce recruitment programme • Equipment audits and concern reporting process in place • Adverse Incident Reporting Process • Clinical Standard Operating Procedures • Private Provider strategy and governance framework • Clinical training • Safeguarding Improvement Plan • National clinical practice guidelines (JRCALC) • National ambulance standards • PTS contracted standards • Make ready contract and effective contracting • Fleet and make-ready strategy • Fleet and make-ready KPIs • Operational escalation procedures (e.g., OPEL, REAP) • Internal training for staff • Equipment training logs • Chief Medical Officer link to local and national forums • Patient Safety Improvement Workstream • Patient Safety Incident Response Framework Policy and Processes	• Variability in pathways • Developing clear strategy for learning from incidents and data	Development of CPs in remaining acutes and systems	Mark Ainsworth / Ongoing – Now part of BAU
		Rota review	Mark Ainsworth / Implementation – Q1 to ~~Q2~~ 2024-2025 North nodes live by end of Q4

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Quality & Safety Committee • Patient Safety & Experience Group • Clinical Review Group • Medicines Optimisation and Governance Group • Workforce Development Board • Integrated Workforce Planning groups • Finance & Performance Committee • People & Culture Committee • Medical Devices Review Group	**Third line (external) assurances** • Internal Audits • CQC Inspections • Clinical Governance Audits • Commissioner contract review meetings	• Real-time tracking of clinical equipment and medicines • Supplies from external procurement (e.g., vehicles)	Procure system for managing safe deployment and maintenance of medical equipment	Lem Freezer / Go Live – ~~July 2024~~ Feb 2025

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
79	Maintenance for Equipment for Patient Transport and Healthcare Logistics Risk	IF there is not an adequate programme of scheduled equipment Maintenance and where required replacement of equipment THEN there is a risk to safety for both staff and patients RESULTING in patient and staff injury and poor reputation	16
284	Patient Safety Risk	If SCAS do not have adequate governance processes in place to support in the identification, escalation, management, and safety improvement in prehospital maternity care then there is a risk that patient safety will be compromised, resulting in reputational risk to the Trust, and there is a Risk the Trust will not meet regulatory compliance.	16
220	Restrictive Interventions Risk	IF a patient is subject to inappropriate physical or mechanical restrictive interventions THEN there is a risk of harm being caused to the patient or members of staff involved RESULTING IN patient and staff harm	15
335	Thames Valley MHRV service non-implementation Risk	IF there continues to be a lack of investment from ICBs in regard to the implementation of a Mental Health Response Vehicle in the Thames Valley THEN there is an ongoing risk of poor care being delivered to patients in mental health crisis in a pre-hospital care environment RESULTING in potential harm coming to patients and the subsequent negative impact on staff, resource availability and Trust reputation.	15

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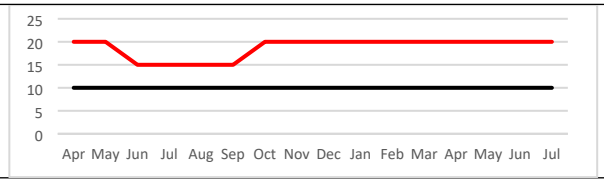
Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.		Risk score **20**
Strategic Risk No. 2: Ability to meet fluctuating demand	Update: July 2024	
If we do not have or use effective and agile operational delivery systems	***Then*** we will not be able to meet demand and provide a responsive service to patients	***Leading to*** delays in treatment and increased morbidity and mortality.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**4**	**20**
Target	5	2	10



Accountable Owner	Assurance Committee
Mark Ainsworth, Executive Director of Operations	Finance and Performance Committee Quality & Safety Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Demand forecasting and profiling using models which are adjusted based on experience • Daily Operational MI reports detailing performance against set metrics • Mutual aid process exists and works • Cat. 2 response segmentation • Effective local and regional escalation • National REAP process and actions • OPEL escalation plans • Enhanced Patient Safety Procedure • Clinical Pathways • Working with systems and ~~UEC Boards~~ Hampshire place based delivery units • Performance Cell • Private Providers • Category 3 GP reviews in 111 • Performance Improvement Workstream • 30-minute immediate handover limit – embedding process at each acute Trust. • SOP for deployment of Jumbulance at QAH • QA – Internal immediate handover process	• Insufficient clinical advisory support (e.g., 111, 999, IUC) • Quality Improvement Process and Culture • Clinical Pathways are not consistently available. • Hospital handover escalation procedures • Fleet controls • Ambulance divert protocols held by ICB	Rota review	Mark Ainsworth / Implementation – Q1 to ~~Q2~~ 2024-2025 North nodes live by end of Q4
		Development of Clinical Pathways in remaining acutes and systems	Mark Ainsworth / Ongoing – Now part of BAU
		Improving Pathways & patient flow at Queen Alexandra Hospital	Mark Ainsworth / end Q1 2024 - 2025 QAH responsible for implementation and to agree timeline.
		Scoping for command cell situated within CCC	Rob Ellery / DRAFT - December 2023 - Complete Final – Complete Proposal to go to TOG – awaiting timeline
		Delivery of 53 replacement and new DCAs	Lemuel Freezer / Sept 2024
		Review clinical capacity in CCC to deliver all clinical functions	Ruth Page / Nov 2024

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Emergency & Urgent Care Boards • Quality & Safety Committee • Integrated performance report • Ops Board • Performance Improvement Delivery Group • Finance & Performance Committee	**Third line (external) assurances** • ICS system management across region • National performance standards • PTS contractual standards • TPAM • Performance Insight Improvement Group • NHSE Performance Reviews			

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
52	QAH Handover Delays Risk	if QAH continue to have increased handover delays over and above agreed parameters then there is a risk to staff not being released resulting in negative impacts to service delivery, end of shift, meal breaks and patient care	25
119	Ambulance turnaround delay at A&E Risk	IF there is a delay in ambulance turnaround at A&E THEN there will be queue of ambulances RESULTING in risk to patient safety	25
91	PTS Resourcing & Activity Risk	IF demand continues to rise with ongoing resource challenges THEN we will see poorer patient experience, reduced morale amongst staff RESULTING in increased costs with use of Private Providers and Taxis and an increase in cancelled journeys	20
210	Supply Chain Risk	IF there is disruption or delays to the supply chain THEN there is a risk that SCFS will not be able to effect repairs or replacements in a timely manner RESULTING in delays to servicing and poor vehicle availability for the customer.	16
78	PTS Old Fleet Risk	IF we don't have adequate programme of scheduled maintenance/repair and replacement THEN there is a risk that there will be an inadequate fleet resource RESULTING in difficulties in delivering the contract	16

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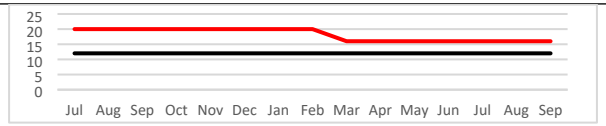
Objective 3: Finance & Sustainability: We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.		Risk score **16**
Strategic Risk No. 5: Financial control	Update: September 2024	
If demand, operational standards and external factors (such as inflation, interest rates, taxation and cost of living) continue to increase	***Then*** the total costs to deliver our services will increase and result in a deficit greater than the control total agreed	***Leading to*** additional pressures on our ability to deliver a sustainable financial plan and safe services.

	Impact	Likelihood	Score
Inherent	4	5	20
Current	**4**	**4**	**16**
Target	4	3	12



Accountable Owner	Assurance Committee
Stuart Rees, Interim Director of Finance	Finance and Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Planning and approval process for the Trust's budget • Budget setting and monitoring processes • Financial plan • Capital programme • Financial governance framework in place • Standing Financial Instructions Reviewed and Updated • Scheme of Reservation & Delegation Written • Financial Recovery Plan approved • Monitoring run rate & cash report now part of F&PC • Financial Recovery Group spend reviews and monitoring (including corporate workforce and Weekly proxy data used for run rate) • Scrutiny from Finance and Performance Committee. • Proactive engagement with regulators and System colleagues. • "Commercial initiatives to increase income and reduce Trust costs."	• Lack of a medium-term plan including Medium Term Financial Plan (MTFP) • Negative impact on ICS's financial position. • Performance Management and Accountability Framework (PMAF) • Business Planning process and objectives not sufficiently aligned with organisation requirements including liquidity / cash support requirements. Cash/liquidity are reported are included as part of normal reporting cycles. • Financial Data in Integrated Performance Report (IPR) needs to capture core metric and financial performance challenges. • The loss/reduction of NEPTS Services and the wider implications require to be worked through. • Slippage in Financial Recovery Programme	Medium Term Financial Plan (MTFP) to developed alongside Trust Medium Term Plan	Stuart Rees / To be included in the medium-term financial plan (5 year) – October 2024
		Process for cost improvement plan linked to system transformation programme to be defined and operationalised	Stuart Rees / ~~In line with ICS timeline~~ Plans now in place, reporting to individual organisations starting in September
		Non-recurrent measures will be utilised to offset slippage experienced against recurrent schemes	Stuart Rees / On-going
		Performance Management and Accountability Framework (PMAF) Developed, now to be for agreement at various committees and recommendations to the Board of Directors	Stuart Rees / EMC / FPC / Audit – Complete Board - Sept 2024
		Core and Performance Financial Data to be incorporated into the Integrated Performance Report (IPR)	Stuart Rees / ~~Oct~~ Nov 2024
		NEPTS loss/reduction to be modelled	Stuart Rees / Sept 2024
		Trust currently working with ICB for support with recovery programme along with actions from FRG to mitigate slippage	Stuart Rees / Oct 2024

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Finance and Performance Committee • Audit Committee • Executive Management Team meeting • Finance reports / Financial position monitored at each meeting of Finance & Performance Committee, including CIP delivery. • Integrated Performance Report • Financial Recovery Group	**Third line (external) assurances** • External audit • Internal audit • Counter fraud • Commissioners • System Recovery Group (ICB level group) • Recovery Support Programme meetings (System) • Monthly financial provider return to NHS England			

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
086	PTS Contracts Contact Centre Risk	IF these contracts are not awarded to SCAS, or extended or SCAS are not able to submit a tender as the incumbent provider THEN there is a risk of not being able to supply PTS services for the remainder of the contract term due to loss of staff with no alternative resources RESULTING in risk to operational staff, increased pressure on reducing staff numbers, reputation damage and impact on patient experience.	20
013	Financial Risk	IF the Trust is not able to operate within the agreed financial budgets THEN there is a risk that the Trust recovery action will be needed; RESULTING in reduced monies available to directorates and departments and subsequent impact on services and projects	16
084	Financial Impact Risk	IF the cost of delivering services are higher than the funding received THEN there is a risk to continued holding of Contracts for both PTS and Logistics RESULTING in poor Trust reputation, increased uncertainty for team members and increased costs exiting contracts increasing costs to other departments and running the services at a loss.	16
121	Financial Targets Not Being Met Risk	IF targets for financial sustainability, performance and cost savings are not achieved THEN there could be NHSI investigations and/or sanctions RESULTING in reputational damage	16
305	Budget Sign-off Risk	IF the annual budget and hours required plans are delayed THEN there is a risk that the planning team will not be able to plan abstractions and determine Private provider hours on time RESULTING in delays to awarding contracts	15

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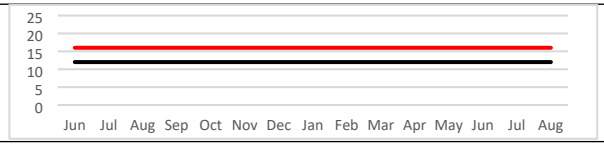
Objective 4: People & Organisation: We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.		Risk score **16**
Strategic Risk No.6: Sufficient skills and resources	Update: August 2024	

If we fail to implement resilient and sustainable workforce plans	***Then*** we will have insufficient skills and resources to deliver our services	***Leading to*** ineffective and unsafe patient care and exhausted workforce.

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**4**	**4**	**16**
Target	4	3	12



Accountable Owner	Assurance Committee
Melanie Saunders, Chief People Officer	People and Culture Committee

Controls	Gaps in Controls	Actions	Due Date
• Integrated Workforce Plans for the Trust, including the delivery of a 5-year workforce plan • Recruitment & attraction plan and retention plan health and wellbeing plan and flexible working • Apprenticeship programmes • International recruitment programmes • Return to practice programme • Use of private providers to help deliver services, private provider workforce strategy • Quality Impact Assessments • Culture and Staff Wellbeing Workstream • Delivery of education and training programmes • People & Culture Committee • Workforce Development Board • Integrated Workforce Planning Groups	• Paramedic rotation • Rota reviews designed to improve work life balance and aid retention and personal development • Design of clear career development pathways • Talent management programme	Communicate and clarify existing career development pathways	TBC / TBC
		Development of talent management and Succession programme	Nicky Howells / Launched Senior Leadership Talent and Succession Q1 2024/25
		NHS England People Promise Exemplar Programme. 12-month programme	Natasha Dymond / Q4 2024/25
		5-year Workforce Plan	Melanie Saunders / Stuart Rees / Q2 2024/25

Assurances		Gaps in Assurances	Actions	Due Date
First and second line (internal) assurances • Integrated Performance Report • Workforce reporting (e.g., sickness absence, staff survey, turnover)	**Third line (external) assurances** • Commissioner reporting (to ICBs) • Internal audit (BDO) • OFSTED • NHSE/HEE quality assurance visits	• Staff wellbeing metrics via IPR	Embed IPR into Trust Board and Sub-Committees	Stuart Rees / Ongoing

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
1	Communications Staffing Risk	IF the communications team does not have sufficient resource, THEN there is a risk that the department will be unable to meet some required processes and will be unable to meet any additional demands RESULTING in a reduced quality communications function and inability to support all teams/programmes	20
142	Pharmacy Operational Staffing and Resilience Risk	IF the Pharmacy workforce is not expanded to meet the demand of the Trust; THEN there is a risk that medicines will not be supplied for clinical use; RESULTING in harm to patients.	20
321	Student Paramedic Placement Capacity Risk	IF there is a continued reduction of CTEs & suitable Clinicians to support students THEN the placement capacity will be insufficient to meet the obligations of the trust as a placement provider for Student Paramedics RESULTING in effecting future workforce numbers, contractual agreements with the Universities, compliance with the National Education contract and the wider NHS workforce plan and impacting the increase of our Clinical workforce.	20
11	Leadership Capacity Risk	IF there is insufficient leadership capacity (at SLT, directorate and divisional level), THEN there is a risk that staff and/or projects will not be sufficiently well supported; RESULTING in attrition and inability to meet service/ project needs	16
225	Key Person Dependency Risk	IF SCAS have a key person dependency THEN there is a risk that that person becomes unavailable RESULTING in potential process failures	16

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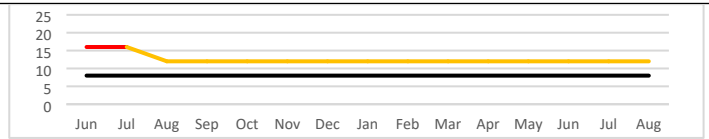
Objective 4: People & Organisation: We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.		Risk score **12**
Strategic Risk No. 7: Safe, valued, and supported staff	Update: August 2024	

If we fail to foster an inclusive and compassionate culture	***Then*** our staff may feel unsafe, undervalued, and unsupported	***Leading to*** poor staff morale, disengagement, low retention and impacts on patient safety and care.

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**3**	**12**
Target	4	2	8



Accountable Owner	Assurance Committee
Melanie Saunders, Chief People Officer	People and Culture Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• People strategy, EDI strategy and associated enabling plans • Freedom to Speak Up (FTSU) guardian and supporting programme in place • 'Supporting our people' website, including EAP and Occupational Health • SCAS leader and ESPM leadership training • Sexual safety charter • Allegations management process and associated Employment policies. • Staff forums and TLL relationships • Appraisal process • Communications strategy • Culture and Staff Wellbeing Workstream • JNCC • People & Culture Committee • Workforce Development Board • Equality, Diversity and Steering Group	• Support for disabled workforce and other protected characteristics • Lack of peer reviews • Consistent approach to QI/service improvement/transformation • Active upstander programme	Delivery and embedding Culture improvement plan	Natasha Dymond / Culture Diagnostic EMC - Completed. Journey refresh Q2 2024
		Embed Support of Staff Networks	Dipen Rajyaguru / ongoing
		QI innovation and culture relaunch	Helen Young / Q2 2024/2025

Assurance		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Staff networks • People Voice feedback • Student placement feedback	**Third line (external) assurances** • Workforce Race Equality Standard & Workforce Disability Equality Standard results • NHS National Staff Survey and Quarterly Pulse Survey • CQC inspections & reports • Internal audits (BDO) • Peer reviews	•		

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
None			

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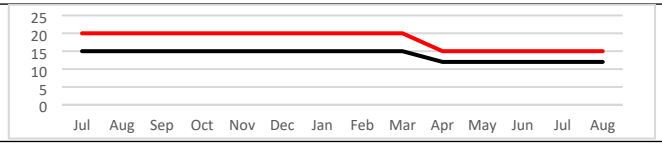
Objective 5: Technology transformation: We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.		Risk score **15**
Strategic Risk No. 8: Digital Capacity	Update: August 2024	
If we are unable to resource required digital opportunities	***Then*** we will have insufficient capacity and capability to deliver the digital strategy	***Leading to*** system failures, patient harm and increased cost.

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**5**	**3**	**15**
Target	4	3	12



Accountable Owner	Assurance Committee
Craig Ellis, Chief Digital Officer	Finance & Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Base Digital Strategy in place across SCAS • Regular Digital Programme Portfolio reporting, and project prioritisation through the Executive Transformation board • IT Project Management governance controls are in place • Financial reporting up to the Executive Management Team (Fixed assets/capital/revenue) • Compliancy with required NHS Cyber Security Standards (DSPT) • Digital Steering Group in place • Technical Design Authority • Control Advisory Board • Digital Annual planning cycle currently in place	• Limited IT Business Continuity capability and a lack of formal testing across SCAS. • No formal Information Technology Infrastructure Library (ITIL) processes in place, with weak internal controls currently in place. • Limited maturity in our BI platform and processes • Limited control around new project initiation or shadow-IT initiatives across SCAS • No resource management process in place across the Digital department • Digital organisational Structure currently inappropriate for Technology Transformation with a number of gaps, and limited definition of roles/responsibilities • Limited maturity in our IT contract management, and a number of contracts at-risk or low governance compliance • IT Risk-management at a low-maturity with regular review not currently in place	Identify the relevant business continuity owners related to IT services and establish a testing regime for the coming year.	Craig Ellis / In Progress / Sep 24
		Deliver core ITIL processes into IT including Change Management, Incident Management and Problem Management,	Craig Ellis / In Progress / Dec 24
		To develop a BI strategy and delivery plan to bring about a long-term maturity in the function.	Craig Ellis / In Progress / March-25
		To ensure the Digital organisation is able to deliver the Technology Transformation needs in the long-term aligned to relevant budgets.	Craig Ellis / In-Progress / ~~Dec 24~~ March 25
		To bring resource management into the Digital Function to enable clearer financial and operational IT management.	Craig Ellis / Pending / Dec 24
		To mature Digital Risk-management in the organisation, with a focus on Residual and Target Score progress and tracking.	Craig Ellis / Pending / March 25

Assurances		Gaps in Assurances	Actions	Owner /Due Date
First and second line (internal) assurances • Reports to Finance and Performance Committee • Annual report on digital strategy to Trust board • Quality assurance process in PMO	**Third line (external) assurances** • Internal audit • External audit • DSP toolkit • Digital maturity assessments	• No KPIs in place • Regular reporting on digital strategy at board level • Fixed Asset Management Steering Group reporting • Limited assurance around digital projects	Undertake review of digital project assurance	Craig Ellis / Dec 24

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
203	System Safeguarding Outages Risk	IF the Trust server keeps having regular outages, THEN the safeguarding referrals are potentially delayed in reaching their destination RESULTING in potential patient harm	25
229	Asset Ownership Risk	IF Information Asset owners do not take responsibility for their asset, THEN there is a risk that the assets become a Information Governance risk RESULTING in potential breaches of security	20
281	DCB0160 Digital Clinical Safety Compliance	IF more resource is not available within the Digital Directorate and the scale of the work continues to increase. THEN compliance with DCB0160 cannot be achieved. RESULTING in lack of compliance with the Health and Social Care act, regulatory consequences, harm to patients (clinical risk not identified and mitigated), reputational damage.	20

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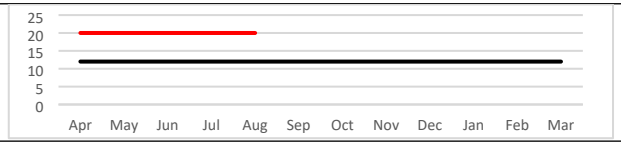
Objective 5: Technology transformation: We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.		Risk score **20**
Strategic Risk No. 10: Cyber risk	Update: August 2024	

If technology, IT applications & services are insufficiently robust and secure	***Then*** there is a risk that the Trust will not be able to operate effectively	***Leading to*** reduced ability to provide a safe service

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**4**	**20**
Target	4	3	12



Accountable Owner	Assurance Committee
Craig Ellis, Chief Digital Officer	Finance and Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Anti-virus software • Standardised Window Builds • Penetration Testing • Privileged Access Management • Patching • Information Security (IS) training. • Yearly DSPT Cyber Security Assurance Testing	• No Cyber Security (CS) Strategy or Programme Plan to date • No external auditing/benchmarking of our overall CS maturity levels • Limited/No investment in appropriate CS Platform • Limited communications to employees on a regular basis • Lack of understanding at a board/executive/senior-manager level on the function or associated high-level CS risks • Limited investment assigned to maturity • CS organisational Structure currently inappropriate for the associated risks with limited resource and overall maturity as a function • Limited maturity in our CS contract management, and a number of contracts at-risk or low governance compliance • CS Risk-management at a low-maturity with regular review not currently in place • Limited assurance in our overall IS assurance training	To establish a CS Strategy and Programme Plan	Craig Ellis / Pending / Dec-24
		To undertake an external audit of our CS capability to date, and a remediation plan	Craig Ellis / In-Progress / July-24 – Oct-24
		To drive overall compliancy in our IS training, and to ensure clear & concise regular communications	Craig Ellis / In-Progress / Dec-24
		To deploy Multi-Factor Authentication onto all our applicable systems and application aligned on the NHS MFA assurance programme	Craig Ellis / In-Progress / ~~July~~ Dec-24

	• Limited Multi-Factor Authentication across the IT Estate		

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Information Security & Governance Steering Group • Digital Steering Group • Finance & Performance Committee	**Third line (external) assurances** • Internal Audit of DSPT • DSPT Submission • External Audit of Cyber Security Function	• Limited board oversight • Limited board challenge • Limited scenario planning • Lack of external best practice	CDO to provide continuous training and briefings to both the execs and board around Cyber Security	Craig Ellis / In-Progress / 2024
			CDO to brief the NCSC Board Toolkit into the SCAS Board to raise challenge and critique capability	Craig Ellis / Completed / August-24
			NHSE Cyber Assurance Assessment of all UK Ambulance Trusts	Craig Ellis / In Progress / Oct 24

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score

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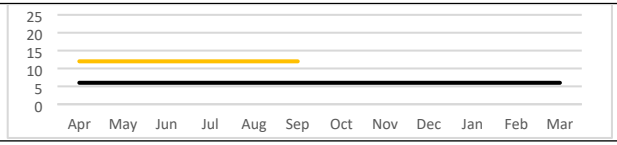
Objective 3: Finance & Sustainability: We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.		Risk score **12**
Strategic Risk No. 11: Modernisation / Fit for the Future	Update: September 2024	

If the Trust does not modernise its structures, systems and support services over the next five years	***Then*** the Trust may not deliver its strategy for a modern sustainable ambulance service that meets the needs of the public, and adoption of relevant government policies	***Leading to*** outdated and inadequate care delivered to patients.

	Impact	Likelihood	Score
Inherent	4	3	12
Current	**4**	**3**	**12**
Target	2	3	6



Accountable Owner	Assurance Committee
Paul Kempster, Chief Transformation Officer	Trust Board

Controls	Gaps in Controls	Actions	Owner / Due Date
• Dedicated team and resource in place • Revised programme governance in place • External SMEs programme support through AACE • Engagement with other ambulance Trusts and collaboration work with SECAmb and the Southern Ambulance Services Collaborative • Incorporation into the five year and annual planning process • Ongoing engagement programme with staff and unions • Modelling of hub locations complete • Detailed proof of concept plans generated, in conjunction with AACE, to improve current operational processes across the virtual EOC • Communication resources in place	• Skills/experience gap within SCAS • Funding gap to support long term change. • Clear scope and plan (feasibility, ERF, finance) • Benefits realisation thesis for Proof of Concept • Public / Political support • Revised Workforce Strategy • Short to medium term Executive leadership	Decision on approach to hubs required	EMC, October 2024
		Alignment to the development of the wider Trust 5-year strategic plan	Caroline Morris, October 2024
		Proof of Concept for a Hub in the South-East sector in development and scheduled for go live in October 2024	Michaela Morris: QTR 3 – 2024/25
		AACE call off contract in place and supporting the Trust to develop scenarios for a new Operational Model	Caroline Morris, ongoing until May 2025
		Negotiate BI support to provide data to inform the operational model redesign	Caroline Morris, October 2024
		Align of SE Ambulance Collaboration and Southern Ambulance Collaboration activities with the Ops Modernisation Programme	Caroline Morris, December 2024
		Additional Executive leadership in place to support programme in short to medium term	Phil Browne, September 2024

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Programme Board • Transformation Oversight Group • EMC • COG Engagement • Board	**Third line (external) assurances** • Recovery Support Programme Oversight meetings (monthly)	• Board sign-off of proof of concept and expected benefit realisation.	Terms of Reference for Operational Modernisation Programme Board and TOG being reviewed to ensure clear escalation and schedule of authority flows	Caroline Morris – October 2024

Associated Risks on the Programme Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
OMP risks: 01023; 01027	Subject Matter Expert Staffing Risk	IF departments are not able to release Subject Matter Experts THEN we may not be able to access the expertise, data and insights to enable modelling to be completed, plans defined and resourced for Proof of Concepts and communications and engagement effectively undertaken RESULTING in the delay or non-delivery of key elements of the Strategic Roadmap	16
OMP Risk: 01011	Leadership Capacity Risk	IF there is insufficient leadership capacity (at SLT, directorate and divisional level), THEN there is a risk that staff and/or projects will not be sufficiently well supported; RESULTING in attrition and inability to meet service/ project needs	16
	ISSUE	We have an “issue” on our log relating to the corporate restructure – which is 3-fold – two are immediate – poor staff motivation during change period, capacity constraint of leadership team. The final part is that elements of the redesign may not work (for e.g. Business partners co-located at Hubs) as proposed structures have removed the posts that would require this to work.	

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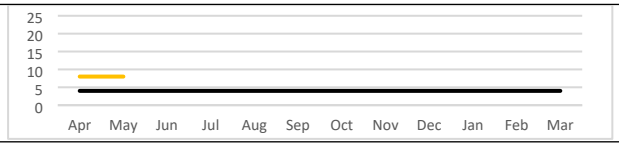
Objective 2: We will engage with stakeholders to ensure SCAS strategies and plans are reflected in systems strategies and plans.		Risk score **8**
Strategic Risk No. 14: Partnership Working	Update: May 2024	

If we don't work collaboratively and have effective relationships with a wide range of stakeholders	***Then*** we will fail to deliver our strategy of being an effective partner and care navigator on behalf of our systems	***Leading to*** poor patient experience and suboptimal outcomes

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**2**	**8**
Target	4	1	4



Accountable Owner	Assurance Committee
David Eltringham, Chief Executive Officer	Trust Board

Controls	Gaps in Controls	Actions	Owner / Due Date
• Formal Moratoriums of Understanding; SLAs and other written agreements • Formal Contracts • Meeting infrastructure • Existing professional relationships • Chairs Network • Chief Exec/ICS Exec Leadership forum • AACE • Southern Ambulance Service Collaborative • Legal duty to collaborate. • Development activities with partners • Internal governance processes • Exec leadership of specific workshops • Commissioner led Co-ordination meeting • Nominated executive lead for each ICB	• Relationships with voluntary sector • Relatively immature system relationships and working arrangements (maturing)	Establish Co-ordinating Commissioner Group and participate in this	David Eltringham – Complete
		CEO Lead HIOW UEC Transformation Programme	David Eltringham – Complete
		Focus on relationships with HIOW as co-ordinating commissioner	David Eltringham - Ongoing
		Establish nominated Execs to relate to BLMK; Frimley and BOB. Use Fit for the Future as vehicle for this	David Eltringham - Complete
		SCAS to participate in the ICS planning work for 2025-26	David Eltringham - TBC

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Board maturity matrix • Report out from meetings / encounters (Chair / CEO reports into board) •	**Third line (external) assurances** • Report out from ICB from provider representatives • Soft intelligence / emotional intelligence • Regulatory reviews (TPAM / NHSE / RSP) • Feedback from RSP and TPAM meetings	• Harder measures (data / intelligence) • Independent scrutiny / assessment and formally report into committee/board • Appraisal processes – external feedback on degree of engagement (Chair / CEO / Officers) • Routine reporting of system interventions into Trust Board.	Continue to develop relationships with HIOW as co-ordinating commissioner Develop stronger relationships with non-HIOW systems Establish a systematic and regular report of progress against the ICS Transformation. Chief Governance Officer to build into regular reporting cycle. ICS to provide report to Boards so that this is consistent. CEO to brief on this at Board and against ICS report	David Eltringham – ongoing David Eltringham – Sept 2024 Dec 2024

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score

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Report Cover Sheet

Report Title:	Improvement Programme Update - September 2024
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 26 September 2024
Agenda Item:	28
Executive Summary:	This paper covers the Improvement Programme Highlight Report for September 2024. • **Overarching Programme Update:** ○ There has been no change to RAG assessments. ○ Following receipt of Revised 'Transition Criteria', agreement was reached in September IPOB to move to using normal governance routes, such as the existing committee structures, to manage reporting and oversight against the transition criteria. Each Executive will remain accountable for delivery of their improvement supported by departmental representatives with clear responsibility for specific delivery and reporting of progress. Support will be provided from the corporate PMO with less reliance on dedicated Project Manager resources. ○ It is therefore anticipated that the October 2024 IPOB will be the last, documenting switch-over to the new governance arrangements. • **Key Risk to Highlight:** ○ Capacity to engage with transformation remains the major risk to delivery of the improvement plan. Impact of the Corporate Review and vacancies in senior leadership positions are being felt across all workstreams. • **Individual Workstream Updates:** <u>Governance</u> ○ Substantive Chief Governance Officer (CGO) appointment made, with interim in post.

	○ Bringing Governance 'back to basics' remains the approach to all workstream delivery. ○ The Governance Hub on SCAS intranet nears readiness for publication. This will provide a single source of governance direction, advice and reference material and will be communicated widely to all staff. ○ Work continues on refining and simplifying the GAAF, ease of access and comprehension of this document will be key to its utility. <u>Culture and Staff Wellbeing</u> ○ The PDR delivery plan has been refined and approved by PACC. ○ Momentum on sexual safety campaign continues, final train the trainer session complete and manager training due to start in Sept. Reverse mentoring is progressing and surveys out to all participants. ○ We have identified the need to review our governance and decision making / internal assurance in support of Equality, Diversity and Inclusion (EDI) requirements. <u>Performance Improvement</u> ○ QIA completed on BOB 111 funding changes and will be taken through SCAS and all 3 ICB QIA panels. ○ Pilot agreed for changes to end of shift procedures following the thematic review into long waits and patient impact. This is being combined with a pilot to improve staff meal break compliance. <u>Patient Safety</u> ○ Safeguarding Referral Task/Finish group entering delivery phase. Training on new form/process to commence from end Aug 24 with a target 'go-live' date of 30 Sep 24. ○ Annual reporting endorsed by respectively committees for Safeguarding, Patient Experience and DIPC with sign-off by Q&S Committee anticipated in Sep 24.
Recommendations:	The Trust Board is asked to: Note this paper
Accountable Director:	Caroline Morris, Director of Transformation (Acting up for Paul Kempster, Chief Transformation Officer)
Author:	Dai Tamplin, Senior Transformation Programme Manager
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:	Not Applicable
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 Report Pack, September 2024

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Improvement Programme Oversight Board (IPOB)

Report Pack

4th September 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: August 2024

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

Key Progress:

- Governance Hub on Intranet is almost ready to be published and engagement plan being developed
- Continued focus on bringing governance 'back to basics'. GAAF remains under review
- PDR & CPD: PDR Delivery plan refined and approved by PACC, new Exec lead agreed. PDR session with SCAS Leaders postponed. HEE CPD funding proposal presented to EMC ahead of full submission
- Momentum on sexual safety campaign continues, final train the trainer session complete and manager training due to start in Sept. Reverse mentoring is progressing and surveys out to all participants
- QIA completed on BOB 111 funding changes and will be taken through SCAS and all 3 ICB QIA panels
- Pilot agreed for changes to end of shift procedures following the thematic review into long waits and patient impact. This is being combined with a pilot to improve staff meal break compliance
- Safeguarding Referral Task/Finish group entering delivery phase. Training on new form/process to commence from end Aug 24 with a target 'go-live' date of 30 Sep 24
- Annual reporting endorsed by respective committees for Safeguarding, Patient Experience and DIPC with sign-off by Q&S Committee anticipated in Sep 24

Key Risks/Issues:

- The level of operational understanding of information flow from EMC to Board (via Board Committees) is leading to poor assurance to the NEDs
- 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. In particular , 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 (AD Patient Safety successfully recruited into post for August).
- Full SAAF compliance will not be achieved until server referral issue is resolved. This results in a potential reputational challenge with wider Safeguarding Boards and ICB/NHSE/CQC.

RAG Assessment:

- No change to workstream RAGs this month

SCAS Improvement Programme: Progress & Sustainability Update

August 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

August 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

August 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:	Jamie O'Callaghan
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*)
	Q2	• Track Progress against implementation of recommendations from the Independent Governance Review *(Was not completed at Q1)* • The GAAF needs to be redeveloped into a shorter document (10-15 pages) • Publish Governance Hub on intranet (will include date planner for meetings, forward planners, ToRs, how to declare interests, FAQ on report writing, how to use iBabs etc) • 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	• Report output of audit (Board Committees agenda & Papers pack) highlighting improvement/areas of weakness and cascade recommendations to relevant stakeholders (moved from Q2) • 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	August 2024	RAG:	Progress	Sustainability

Executive Lead: Jamie O'Callaghan ***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. 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:	Key Activity, Month Ahead:
• Continue to focus on bringing the corporate governance 'back to basics'. • Information flow up to the Board has improved and EMC meetings have been redeveloped to focus on key themes. This will continue with a focus on improving papers and cover sheets.	• Working with NHSE colleagues on how to shift approach based on new Exit Criteria. • Reshaping the Governance Development Group content and attendees.
• Governance Hub on Intranet is almost ready to be published and engagement plan being developed. • GAAF is being condensed into a smaller document to make it user friendly.	• Interim Governance Improvement Lead joining to help with workstream. • Continued focus to challenge the quality of papers, purpose and information flow.
• Governance team now servicing Finance and Performance and Audit Committee. The team are also now present in all Board committee pre-meets to shape agendas and reviewing minutes. • Key performance indicators have been developed for meetings and now need embedding (i.e. timescale for minutes to be circulated)	• Governance Workplan being produced for the Audit committee. • Create governance information flow diagrams and FAQs to assist staff in understanding our governance processes.

What's Gone Well:	What's Not Gone So Well:
• Interim Chief Governance Officer in post and substantive recruited. • New approach to reset and bring governance 'back to basics' • NEDs provided feedback that they now feel the assurance is improving. • Increased challenge at EMC on purpose of papers and focus on governance route to 'avoid surprises' at the board committees. • Positive feedback at Board from NEDs and RSP colleagues.	• Quality of minutes not consistent due to different teams servicing meetings. • Quality of committee papers still not optimal, although NEDs happier with Board papers.

Workstream Key Risks:	Issues for Escalation (Incl. Scope / Milestone Change Requests):
• Lack of admin support within the team due to the Corporate Governance & Compliance Officer (band 5) vacancy not currently in post.	

SCAS Improvement Plan Scorecard: Governance & Well Led — August 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	August 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	*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									August 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. (*In progress)* • Sexual Safety Reverse Mentoring Programme begins. (*Complete*) • Launch of Sexual Safety Allyship training to 999 Ops and CCC. (*Complete*) • Stabilising the resources in the FTSU team (*Complete*) • Appointment of People Promise Manager (*Complete*) • Development of People Promise action plan and review of existing retention plans (*Complete*)
	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 | August 2024 | RAG: Progress | Sustainability

Executive Lead: Melanie Saunders ***Senior Responsible Officer: TBC***

Workstream Summary (Incl. RAG Assessment):

The momentum on the sexual safety campaign continues with manager train the trainer in progress and manager training due to start next month. Reverse mentoring is progressing and surveys out to all participants. Proposal for the People Strategy governance process agreed in principle, the plan includes utilising the existing governance meetings as well as quarterly reports and IPR to track progress and gain assurance. The Culture Workshop with the Board due to take place on 22 Aug has been postponed to a later board date to better align to the culture evidence review being carried out. People Promise programme making good progress on engagement plans and visibility with the trust through observing shifts and listening to feedback. More listening events in the planning. Work on the culture improvement plan next steps is on hold pending the results from the culture evidence review, however initial planning work aligning to People Strategy actions is still in progress. The SRO is leaving SCAS on 23rd Aug, currently no interim cover is planned, this is being considered in the workstream review as part of the move to merge improvement into BAU. Workstream remains Amber, 2 outstanding EC moved from Red to Amber, with 1 due to be closed out this month. 1 other is related to the 5 yr plan which remains red, linked to the corporate restructure, Fit for the Future plans and the new Annual planning process.

Progress Against Key Outcomes / Success Criteria:

- Sexual Safety: final train the trainer sessions happening end Aug / beginning Sept, with manager training starting in Sept. Survey out for the Reverse Mentoring programme and check in session on 4th Sept.
- FTSU: Deputy Guardian due to start 27th Aug. FTSU e-learning figures reviewed (95% for module 1&2, 87% mod 3), reviewing ways to improve completion rates. Planning detail for Speak up Month, well under way.
- EDI: EDS presented at CRG, agreed 4 possible services for domain 1. Service leads to agree which 3 to use.

- Retention: The PPM observed shifts with Ops TL, SECTs and paramedics with rich and engaging conversations taking place. 1st edition of the People Promise newsletter published and well received.
- Recruitment: Paramedic drop in / mini open days complete with good engagement. Reviewed and updated PTS workforce plan to be in line with contract changes.

- PDR & CPD: PDR delivery plan refined, and action detail included, approved by PACC and Craig Ellis is now the Exec lead. HEE CPD funding proposal presented to EMC ahead of full submission.

Key Activity, Month Ahead:

- Sexual Safety: Add resilience pack for trainers and follow up processes to train the trainer support pack. Update the Sexual Safety webpage on the Hub. Develop a session for the volunteer conference in Oct.
- FTSU: Deliver virtual FTSU Champion training (23 Aug), focus on improving e-Learning compliance. Board Seminar focusing on Listening Up (22 Aug).
- EDI: Asses short and long-term plans delineating key initiatives, objectives, and measures and provide insight to the overall EDI agenda / strategy.

- Retention: Completion of refreshed engagement plans & continuation of site visits. Planning for flexible working listening events, Mens' Wellbeing Network follow up and discovery session for a leadership network.
- Recruitment: First Trainee Paramedic cohort starting in September, recruitment starts for Q4 cohort. Review & plan future drop in/mini open days. Review revised trajectories for workforce numbers for H2.

- Circulate PDR quality survey to all PDR recipients in April - July 2024. Continue deep dive into high/low compliance areas, engage with leads, identify themes.

What's Gone Well:

- All reviewees briefed in facilitating career development conversations for talent & succession.
- New FTSU Newsletter well received.
- Successful in gaining grants from SCAS charity for the Staff Networks
- A student paramedic survey is live with over 150 replies, data being reviewed.

What's Not Gone So Well:

- Session to highlight and discuss PDRs via SCAS Leaders was cancelled.
- Lack of engagement in Talent Management by some key stakeholders.
- Defensiveness towards FTSU agenda – understanding 'the why'

Workstream Key Risks:

If plans are not in place to cover the SRO role and responsibilities Then the workstream may experience challenges in decision-making and direction, affecting the quality and progress of activities.

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

- NHSE CPD funding limited to registrants. No funding currently identified for non-registrants.

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

No	Metric/s	Baseline (30/08/22)	End Target	Aim/ Actual	Quarterly Trajectories								Comments
					2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Formal cases of bullying and harassment	1	2	*Aim*	*N/A*	*N/A*	*3*	*3*	*3*	*3*	*2*	*2*	
				Actual	3	2	1	3	1	4	1		
2	Formal cases of sexual harassment	5	2	*Aim*	*N/A*	*N/A*	*5*	*7*	*8*	*8*	*7*	*7*	Q1 Increase in cases expected as the sexual safety campaign continues
				Actual	4	4	4	3	0	0	8		
3	Casework (investigation) completion timeline completion against policy	35	35	*Aim*	*N/A*	*N/A*	*60*	*58*	*50*	*45*	*40*	*35*	
				Actual	41	31	63	43	37	34	47		
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*	Q1 There has been a notable increase in reported cases, particularly in relation to bullying and harassment. Specifically, there were 16 cases of bullying and harassment, including those concerning sexual safety.
				Actual	29	38	27	34	54	29	49		
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*	Due to the increase in FTSU cases and the team that is currently under-resourced by 1 WTE, our primary focus has been on managing these cases. As a result, the team has encountered difficulties in carrying out the usual Walk About Wednesday activities and collecting data for the sub score
				Actual	N/A	N/A	N/A	5.2	6.1	N/A	N/A		

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — August 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*	Q1 There has been a rise in FTSU cases in the first quarter, and the FTSU Team is currently understaffed by 1WTE, which is affecting the completion time for the initial investigation.
				Actual	N/A	N/A	93	80	78	not avail	84		
7	Appraisal with PDR: completion (%)	89	95	*Aim*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	*86*	Q2 – New trajectory as per the PDR improvement plan. Q1 – Continue to work departments leads to prioritise PDR completion
				Actual	88	89	84	75	75	80	82		
8	Would recommend the organisation as a place to work (%)	36.5 (July 22)	59.4	*Aim*	*37*	*38*	39	40	41	42	43	44	Q1 The People Pulse survey is conducted monthly, inclusive of the National People Pulse (NQPS). There is a risk of low response numbers compared to other Ambulance Trusts that run the survey quarterly. Therefore, a review is underway to consider changing the survey frequency to quarterly, in line with other Trusts.
				Actual	46	36	41	35	47	47	24	24	
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*	Q1 The People Pulse survey is conducted monthly, inclusive of the National People Pulse (NQPS). There is a risk of low response numbers compared to other Ambulance Trusts that run the survey quarterly. Therefore, a review is underway to consider changing the survey frequency to quarterly, in line with other Trusts.
				Actual	53	44	46	46	52	52	38	45	
10	Retention / Stability Index Rate (%)	82	82	*Aim*	*82*	*82*	*82*	*82*	*83*	*83*	*84*	*84*	Q1 Small decrease in stability, due to an increased attrition rate across the Trust, particularly within our commercial sector.
				Actual	82	82	84	85	85	87	85		
11	Vacancy Rate (%)	15	10	*Aim*	*13*	*14*	*14*	*13.5*	*12*	*11*	*10*	*10*	Q1 The trust remains slightly behind plan in quarter 1. Recruitment pipelines for are healthy for Q2, and Q3.
				Actual	13	13	11	10	10	9	11		

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	Issues
• Financial sustainability • Changing demand within the system might create additional pressure • Failure to recruit to workforce plan • High dependency on interim leadership positions. • Attrition rate increases • Political and economic position	• Capacity within the wider team to deliver • Handover delays • Financial position • Fleet availability • "shrinkage" on planned staff hours to actuals • MB/EOS Policy

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	• 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. • SP deployment model.
	Q4	• Paramedic dual role (EOC & OPS) implemented. • 111 Dual skill pilot complete. • North rosters implemented.

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

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

Workstream Summary (Incl. RAG Assessment):

Cat 2 performance in July was 40.00 which was below the plan of 33:01. Hospital handover delays impacted category 2 in the south by 10 minutes 51 secs with a further 9 mins 22 secs from QAH. North handover were 56 seconds worse than plan. Staff hours were slightly down across the month by 267 hours. SCAS hours were 6014 above plan with PPs 6281 below plan. Both groups actively being managed to match resource to budget.
We continue to see delays at acutes (July 2024) reducing the ability to effectively utilise resources with the top 5 acute's being, QAH - 2866hrs, RBH – 487, JRO - 345hrs, SMH – 306 and MKUH - 257.
999 mean call answer time increased by 16 seconds in July to 28 seconds, which was caused by an increase of 6% of calls above planned levels, combined with WMAS ceasing their support to SCAS. There was also an additional 5,000 duplicate calls in July compared to June.

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

- Focus continues to be on Cat 2 response and EOC call answer:
  - Cat 2 Mean – June 29:38 , July 40.00, MTD Aug (20/08)31.37, QTD: 36.58
  - Call Answer Mean – July 28 secs, MTD Aug (20/08) 10 secs
  - H&T 14% for July. MTD Aug (20/08) 12.6%.
- QIA completed for BOB 111 reduced service
- Meal Break changes to improve staff welfare agreed with unions and Chief Nurse. This will now go to EMC for sign off
- End of Shift changes agreed to go to pilot stage to reduce risk of patient harm from 0200-0600 hours. This will now go to EMC for sign off
- North operational rota proposals for 2 areas have been through gateway review, however not yet finalised
- AACE workshop reviewed progress against improvement plans and identified further areas of focus for dispatch and H&T
- Review of HIOW ICC to be hosted in Otterbourne

Key Activity, Month Ahead:

- BOB 111 QIA to be processed through all ICB QIA panels
- Implement Pilot for Meal breaks
- Implement pilot for end of shift
- Review proposed structures for U&E operations
- Review proposed structures for EOC
- Ongoing delivery of Ops Improvement plan
- Local HOO attendance at HIOW delivery units
- Progress conversations with all ICBs and acute trusts on W45 handover process
- Agree capacity modelling criteria with AACE
- Commence build of EOC rotas
- Recruit to key ADO role

What's Gone Well:

- AACE workshop was very productive and engaged wider team with additional performance improvements
- H&T action plan delivering ahead of schedule in July
- Finalising the meal break and end of shift options

What's Not Gone So Well:

- Handover delays - impacting resource availability
- Deterioration in all performance measures in July. (linked to increased delays)
- Variability in 999 call answer performance linked to staffing levels and volume of duplicate calls linked to levels of handover delays
- On going fleet challenges although availability has improved through August
- CAD replacement programme remains paused following challenge
- Over delivery of operational hours in August adding financial pressure

Workstream Key Risks:

- Capacity within the wider team to deliver against actions in Improvement Plan
- 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	August 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	Category 2 target for July was 33:01 and we were 06:59 above this target Cat 2 performance in Q1 at 30:31 - above the plan for the quarter.
				Actual	00:40:33	00:26:53	00:29:42	00:33:09	0:38:09	0:35:57	0:30:31	0:36:58 to date	
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%	July H&T 14%. H&T Q1 at 12.9% against 13% target
				Actual	13.4%	10.8%	10.6%	11.1%	11.8%	12.3%	12.9%	13.5%	
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%	32.7%	
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	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	0:0:10	

SCAS Improvement Programme Scorecard:	Performance Improvement	August 2024

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					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 a such we are now focusing on the monitoring the number of Breaks in the window, as we have more overlaps and increased numbers of vehicle available at periods of peak demand. Unions hav agreed in principle a set of trial criteria which wi need to be agreed at EMC.
				Actual	48.1%	61.5%	58.7%	53.8%	45.3%	42.8%	42.7%	32.8%	
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 EMC.
				Actual	69.0%	83.0%	84.0%	82.3%	80.5%	81.5%	81.4%	82.9%	
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			Development of SE Proof of Concept continues, and a working group has been set up. Draft structures for Operations have been provided to the Director of Operations for review and comment. Benefits analysis work is continuing using the Logic Model and linking to IPR metrics. Dispatch Model design workshop to take place 8th August. Support has/is also being undertaken within the team for the Corporate Restructure, a finance benefit sprint and NHSE operational reporting.
				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 (*Initial transition complete*) • Successful resolution of Safeguarding end-to-end referral process Task and Finish Group (recommendations to be implemented Q2-4) (*ongoing*) • 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 | August 2024 | RAG: Progress | Sustainability

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

Workstream Summary (Incl. RAG Assessment):

Annual reports now drafted and approved by respective committees for Safeguarding, Patient Experience and DIPC. Safeguarding Task/Finish group for referrals enters delivery phase with Train the Trainer and User training commencing in late August – a significant number of personnel will require training completion ahead of the 30 Sep 24 'go-live' date for the new referrals form/process. Staff resource capacity remains a challenge (incl. at AD level and above).

Progress Against Key Outcomes / Success Criteria:

- Safeguarding Referrals Task/Finish continues. External partner user testing completed 22 Aug 24. Anticipated launch date 30 Sep 24. Strategic oversight by CNO
- Safeguarding Annual Report, Patient Experience Annual Report and DIPC Annual Report signed-off by respective committees
- SG Level 3 training at 87% compliance (towards >90% target for Q2-end)
- Historic SI open actions reduced further to 19 from 29.
- BDO audit of SI processes – identified actions all completed
- Patient Safety Partner (PSP) framework approved at PSEC
- In-house Medicines Packing project continues
- ToRs for PSIRF Panels/Groups approved by PSEC. To be taken to service line CG meetings for approval/implementation

Key Activity, Month Ahead:

- Continue Safeguarding task and finish group to complete process mapping in all stages
- Safeguarding referral training. Train the Trainer from 27 Aug 24 and user training from 2 Sep 24
- Safeguarding, Patient Experience and DIPC Annual Reports for Q&S sign-off
- Patient Safety Partner (PSP) framework for approval at Q&S (September)
- Completion of the TNA to support assurance of quality of learning responses within PSIRF
- IPC Lead working with operational team to increase the number of vehicle and hand hygiene audits undertaken
- Updated Duty of Candour Policy to PSEC for approval (PSIRF amendments)
- Peer review (system approach) of PSIRF responses to be held (BOB/HIOW)
- Pharmacy Strategy presented to MOGG/CRG and will be presented to EMC on 10 Sep 24
- Planning for Pt Safety campaign (September), to coincide MaPSaf survey to staff groups

What's Gone Well:

- IPC vehicle audits on target for July
- Interim Head of Safeguarding in place with appointment made to substantive post. Start date TBC
- Closure of last remaining open SI. No SIs remain open with commissioners, fully transitioned to PSIRF reporting

What's Not Gone So Well:

- MaPSaf plan remains outstanding – to be developed in readiness for Sep 24 Pt Safety campaign
- Development/build of clinical dashboards is not priority work on BI workplan. Escalated to EMC 3 Sep 24

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
- Corporate Review consultation may present a risk with loss of experience and continuity/capacity
- Pharmacy staffing capacity remains low due to maternity leave and leavers
- Pharmacy team heavily focussed on Medicines Packing project due to timeline of new service commencing (Nov 24)

Workstream Issues:

- Potential emerging issue related to the number of staff required to complete a learning response v number of trained staff at approved grade/level
- Capacity of Safeguarding Service to provide training of new form to Contact Centre Staff in August/September and the release of staff to attend (large volumes in short timeframe)

SCAS Improvement Programme Scorecard: Patient Safety August 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	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*	Q1 Upward Referral trend continues.
				Actual	13728	14221	16311	20458	22267	22773	23178		
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%*	Level 3 training data has been reviewed to ensure consistent BI and Educational data.
				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. Q1. 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.
				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. Q1. Quality and Maturity audits not completed due to team capacity.
				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. Q1 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. Q1. Theft have led to an increase this quarter. Track and trace BC has been developed
				Actual	N/A	N/A	34	82	11	15	19		
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. Q1 IPC lead working to support Ops to embed and complete improvement actions. Working with and monitoring quality within contract meetings for make ready/cleaning with documented monitored actions
				Actual	N/A	74%	80%	77.9%	87.3%	92.5%	83%		
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. Q1. As above actions
				Actual	N/A	91%	96.5%	93.1%	93.3%	98.5%	92%		

Transition Criteria

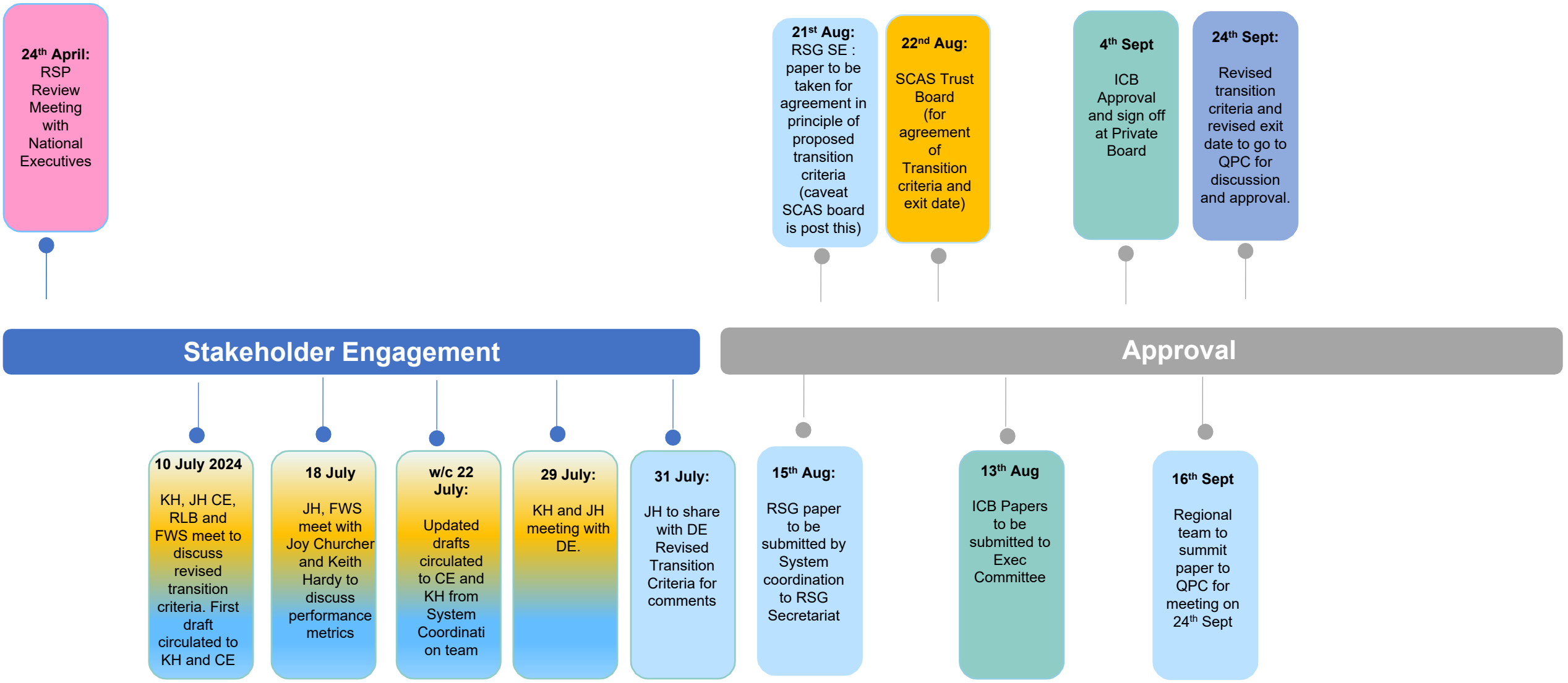
[For Discussion]

Transition Criteria 2024/25

South Central Ambulance Service

Collaborative document worked up between:
South Central Ambulance Service
NHSE Recovery Support Team
NHSE Regional Team
Hampshire and Isle of Wight Integrated Care Board

SCAS Recovery Support Programme Revised Transition Criteria and Exit Date Governance Timeline



Key:

Region | All | ICB | National | NRS

Segment definition and expectations

Aim for NOAF Segment 3 by September 2025

NOAF	Segment Description – Trust	How NHS will support	How NHS will drive improvement	How NHS will intervene
3	ICB or provider and/or wider system are significantly off-track in a range of areas. We lack confidence in the capability to respond to challenges without support.	Support needs are diagnosed together and delivered through local support offers, defined national support programmes and bespoke regional interventions.	Receives enhanced scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed upon and proactively monitored.	We may apply interventions and/or direct an organisation to take specific actions related to diagnosed issues. Enforcement action may be taken where required.
4	There have been multiple serious failures of patient safety, quality, finance, leadership, or governance or the ICB or provider and NHS system face serious, long-standing and complex issues requiring an intensive co-ordinated response	The Recovery Support Programme (RSP) supports the ICB or provider in undertaking a full diagnostic to identify support needs and develop a full recovery plan in collaboration with system partners	We appoint an improvement director to intensively support the organisation to meet improvement goals. Increased scrutiny to ensure delivery of the agreed recovery plan and meet transition criteria to transition to segment 3.	Entry into the Recovery Support Programme (RSP) and subsequent enforcement action are agreed through relevant executive governance group. Transition out of RSP into segment 3 requires transition criteria to be met.

Source: NHS Oversight and Assessment Framework 2024

- For South Central Ambulance Service (SCAS) to be considered for transition from mandated intensive support segment 4 to segment 3 by September 2025, SCAS must demonstrate continual sustainable improvement against the Transition Criteria. NHS England must also be confident that improvements will be sustained. The NHS Oversight & Assurance Framework (NOAF) will continue to be followed in Segment 3.
- Oversight of the Transition Criteria by NHSE SE will adhere to the good governance principles.
- NHSE SE and Hampshire and Isle of Wight Integrated Care Board evaluation of meeting the Transition criteria will be a mixture of both objective and evidenced judgement.
- In some incidences exact metrics and evidence suggested may vary dependent on other issues arising prior to September 2025 i.e., Operational Planning Guidance.
- The Transition Criteria are there to enable sustainable improvement across the organisation which will enable transition to NOAF3.

Integrated quality and clinical governance across all programmes to provide safe and quality care that fosters and embeds a sustained learning and improvement culture.

Transition Criteria

Governance and Well Led

1. Clearly defined and approved executive team structure, substantive recruitment taken place and evidence of working effectively as a team
2. Effective governance systems and processes in place, with evidence of a developing culture of governance
3. Clearly defined and Board approved strategic direction of the organisation, including clarity around scope of Fit for the Future Programme; short- and medium-term collaboration with SECAMb and efficiency gains through the Southern Ambulance Services Collaborative and other NHS partners.

Culture and Leadership Development

4. Senior leadership development programme in place at sub executive level with evidence of strengthening organisational leadership, effective delegated responsibility, and improved accountability
5. Improved culture throughout the organisation including safety and safeguarding culture and workforce engagement in improvement

Performance Improvement

6. Delivery of Cat 2 mean operational plan trajectory
7. Sustainable Demand and Capacity modelling completed and compliance with the improvement trajectory for hear and treat

Integrated quality and clinical governance across all programmes to provide safe and quality care that fosters and embeds a sustained learning and improvement culture.

Governance & Well Led

	1	2	3
Transition Criteria:	Clearly defined and Board approved strategic direction of the organisation, including clarity around scope of Fit for the Future Programme; short- and medium-term collaboration with SECAMb and efficiency gains through the Southern Ambulance Services Collaborative and other NHS partners.	Effective governance systems and processes in place, with evidence of a developing culture of governance	Clearly defined strategic direction of the organisation, including clarity around alignment of Fit for the Future programme and collaboration with SECAmb, approved by the Board
Evidence:	Executive team structure identified with clear timeline and plan on appointments Executive portfolios clearly identified Evidence of effective executive team working	Evidence of Board oversight of regulatory actions with clear improvement plans, and use of BAF Evidence of effective decision making to enable flow of information through the organisation Evidence of IPR driving performance throughout the organisation Evidence of good governance practice being used in the organisational operational business	Trust organisation strategic direction developed with evidence of clinical and stakeholder engagement. Evidence of development of a plan for implementation commenced. Evidence of alignment with the Fit For the Future programme and strong collaboration and alignment with SECAmb Evidence of consideration and approval by Board
Metrics/ Evidence:	Executive structure and recruitment plan Recruitment to Board posts Board development plans Quarterly BAF Update Risk Register Well Led framework adherence	Board post recruitment Board and leadership development plans Quarterly BAF Update Risk Register Well Led framework adherence IPR effectiveness	Strategic Direction document Plan for implementation and delivery of strategic direction Board papers

Integrated quality and clinical governance across all programmes to provide safe and quality care that fosters and embeds a sustained learning and improvement culture.

Culture & Leadership Development

Transition Criteria:

Senior leadership development programme in place at sub executive level with evidence of strengthening organisational leadership, effective delegated responsibility, and improved accountability

4

Improved culture throughout the organisation, including safety and safeguarding culture and workforce engagement in improvement

5

Evidence:

Effective delegation throughout the organisation evidenced through the performance and accountability framework

Capability and capacity of senior leaders to enable delivery (right people, right skills and competence approach) as evidenced through a formal work review (supportive assessment centre).

Evidence of improved and effective engagement of staff, patients and wider stakeholders

Evidence of increased staff participation and engagement in trust improvement programmes

Evidence of learning from statutory and other reviews (to be inclusive of all the non-statutory incidents reviewed as part of a wider learning culture)

Evidence of co-ordinated work between patient safety, safeguarding and improvement teams.

Metrics:

Board and Senior Management leadership development plans
Quarterly BAF Update
Risk Register
Well Led framework adherence
Performance and Accountability Framework

Staff survey and other regular surveys
Staff Engagement Score
Staff voice (i.e. FTSU/engagement)
CQC reports, letters and notices
Board reports and outcomes from Board discussions
Safety Culture Assessment e.g. Manchester Patient Safety Framework
Numbers of staff actively engaged in improvement
Numbers of staff trained in Quality Improvement
Clear Quality Improvement plan

Integrated quality and clinical governance across all programmes to provide safe and quality care that fosters and embeds a sustained learning and improvement culture.

Performance Improvement

Transition Criteria:

Delivery of Cat 2 mean operational plan trajectory

6

Sustainable Demand and Capacity modelling completed and compliance with the improvement trajectory for hear and treat

7

Evidence:

- Clear trajectory and evidence to deliver against Cat 2 mean plan
- Evidence of improved % rate of validation of calls
- Evidence of continued reduction in mean call answer time with the aim of achieving under 5 seconds
- Evidence of improved % rate of validation of calls
- Evidence of improvement across all pathways, with clear mitigations in place to sustain improvements
- System wide alignment to drive improvement through partnership working and commitment to Cat 2 performance delivery

- Clear trajectory and evidence to deliver against the Hear and Treat plan with aim of minimum percentage increase of 3% by September 2025
- Hours on road in line with the operational plan and financial plan
- Capacity and demand modelling
- Evidence of improvement across all pathways, with clear mitigations in place to sustain improvements

Metrics:

- Cat 2 mean time
- Mean call answer times
- Call validation rate
- Hear and Treat and See and Treat metrics

- Hours on road
- Hear and Treat and See and Treat metrics