South Central Ambulance Service
NHS Foundation Trust

Board of Directors Meeting

Meeting in Public

DATE: Thursday 25 May 2023
TIME: 10:00 – 13:00
VENUE: Geneva Room, The Ark Conference Centre, Basingstoke, RG24 9NN

This meeting will be recorded for the purpose of populating the action and decision log. All recordings will be deleted once this is done. Please raise any objections to this at the start of the meeting

Item		Action	Time
OPENING BUSINESS			
1	**Chair's Welcome and Apologies for Absence** Keith Willett	**Verbal** **To note**	10:00
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Keith Willett	**Verbal** **To note**	
3	**Minutes from Meeting on 30 March 2023** Keith Willett	**Page 21** **To approve**	
4	**Board Actions Log** Michael Wood	**Page 28** **To note**	10:10
STRATEGIC OVERVIEW AND CONTEXT			
5	**Chair's Report** Keith Willett	**Page 29** **To note**	10:20
6	**Chief Executive's Report** David Eltringham	**Page 31** **To note**	10:25
7	**Board Assurance Framework (BAF)** Daryl Lutchmaya / Michael Wood	**Page33** **To note**	10:35
QUALITY AND SAFETY			
8	**Volunteer Story**	**Page 46** **Presentation**	10:50
PERFORMANCE, RISKS, GOVERNANCE AND ASSURANCE			
9	**Integrated Performance Report** Mike Murphy & Executive Director Leads	**Page 47** **To note**	11:10
10	**Quality and Patient Safety Report** Helen Young	**Page 121** **To note**	11:25
COMFORT BREAK 11.35			
PERFORMANCE, RISKS, GOVERNANCE AND ASSURANCE			
11	**Operations Report – 999, 111 and Other** Paul Kempster	**Page 136** **To note**	11:40
12	**Finance Report – Month 1** Aneel Pattni	**Page 145** **To note**	11:50

Item		Action	Time
13	**Medical Director's Report** John Black	**Page 149** **To note**	11:55
14	**a) Self-Certification – Licence Conditions** **b) 2022/23 Annual Report and 2022/23 Financial Statements – Approval Process** **c) Governance Update** Daryl Lutchmaya	**Page158** **Page 170** **Page 172** **To Approve**	12.05
PEOPLE, WELL-BEING AND LEADERSHIP			
15	**People Directorate update** Melanie Saunders	**Page 181** **To note**	12:15
16	**Communications, Engagement and Marketing** Gillian Hodgetts	**Page 185** **To note**	12.20
17	**Charity Annual Report 2022 -23** Vanessa Casey	**Page 192** **To note**	12.25
BUSINESS UPDATES – KEY ISSUES ONLY			
18	**Board Committee Upward Reports** a) Mike McEnaney (Audit – 17 April & 3 May 2023) b) Nigel Chapman (Charity – 12 April 2023) c) Les Broude (Finance and Performance – 19 April & 17 May 2023)	**Page 201** **Page 204** **Page 206** **To note**	12:30
CLOSING BUSINESS			
19	**Any Other Business** Keith Willett	**Verbal** **To note**	12:45
20	**Questions from observers (items on the agenda)** Keith Willett	**Verbal** **To note**	12:50
21	**Review of Meeting** Keith Willett	**Verbal** **To note**	12:55
22	**Date, Time and Venue of Next Meeting in Public** Thursday 27 July 2023 Venue TBC	**Verbal** **To note**	13.00

The Board resolves that in the interests of public order, the meeting adjourn to enable the Board to complete business without the presence of the public.

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

Acronyms

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

A			
A&E	Accident & Emergency	AHSN	Academic Health Science Network
ARC	Audit & Governance Risk Committee	ALOS	Average Length of Stay
AGM	Annual General Meeting	AMM	Annual Members Meeting
AGS	Annual Governance Statement	AO	Accountable Officer
AHP	Allied Health Professionals	ALB(s)	Arms Length Bodies
AHSC	Academic Health Science Centre	AHT	Average Handling Time
ACQI	Ambulance Clinical Quality Indicators	ARI	Acute Respiratory Infection
AACE	Association of Ambulance Chief Executives	ACA	Ambulance Care Assistant
Acorn	Consumer classification that segments the UK population by analysing demographic data, social factors, population and consumer behaviour	AED	Automated External Defibrillator
A PAD	Ambulance Portable Access Devices	ARP	Ambulance Response Programme
B			
BAF	Board Assurance Framework	BAME	Black Asian and Minority Ethnic
BCF	Better Care Fund	BoD	Board of Directors
BMA	British Medical Association	BHF	British Heart Foundation
BOB	Buckinghamshire, Oxfordshire and Berkshire	BAU	Business as usual

BLMK	Bedfordshire, Luton & Milton Keynes	BI	Business Intelligence
C			
CAMHS	Child and Adolescent Mental Health Services	CFO	Chief Financial Officer
CapEx	Capital Expenditure	CMO	Chief Medical Officer
CBA	Cost Benefit Analysis	CNO	Chief Nursing Officer
CBT	Cognitive Behavioural Therapy	CoG	Council of Governors
CCG	Clinical Commissioning Group	COO	Chief Operating Officer
CDiff	Clostridium difficile	CPD	Continuing Professional Development
CE / CEO	Chief Executive Officer	CQC	Care Quality Commission
CF	Cash Flow	CQUIN	Commissioning for Quality and Innovation
CFR	Community First Responder	CSR	Corporate Social Responsibility
CHC	Continuing Healthcare	CT	Computed Tomography
CIP	Cost Improvement Plan	CRR	Corporate Risk Register
CRS	COVID Response Services	CAS	Clinical Assessment Service
CES	Civica Election Services	CCG	Clinical Commissioning Group
COL	Conditional Offer Letter	CC	Contact Centre
CIP	Cost Improvement Programme	CCC	Clinical Care Coordination
CD	Controlled Drugs	CAD	Computer Ambulance Despatch
CRS	Control Room Solution	CFW	Concern For Welfare
CDEL	Capital departmental expenditure limit	Cafcass	Children and Family Court Advisory and Support Service
CAT	Category	CALNAS	Culture and Leadership Network for Ambulance Services
CBRNe	Chemical, Biological, Radiological, Nuclear Explosives	CCAS	Covid Clinical Assessment Service

CETV	Cash Equivalent Transfer Value	COVID-19 / CV19	Coronavirus
COSHH	Control of Substances Hazardous to Health	CPI	Consumer Prices Index
CPR	Cardiopulmonary Resuscitation	CRM	Customer Relationship Management
CRN	Clinical Research Networks	CRASH	Clinical Randomisation of an Anti-fibrinolytic in Symptomatic mild Head injury
CRS	Covid Response Service	CSD	Clinical Support Desk
D			
DBS	Disclosure and barring service	DoF	Director of Finance
DGH	District General Hospital	DPA	Data Protection Act
DHSC	Department of Health and Social Care	DPH	Director of Public Health
DNA	Did Not Attend	DTOCs	Delayed Transfers of waiting Care
DNAR	Do Not Attempt Resuscitation	DTC	Diagnostic and Treatment Centre
DLG	Deputy Lead Governor	DHU	DHU Healthcare
DI	Detailed Investigation	DRC	Depreciated Replacement Cost
DSE	Display Screen Equipment		
E			
ED&I	Equality, Diversity & Inclusion	EOLC	End of Life Care
ED(s)	Executive Directors or Emergency Department	EPR	Electronic Patient Record
EHR	Electronic Health Record	ESR	Electronic staff record
EOC	Emergency Operation Centre	EEAST	
ECA	Emergency Care Assistant	E&UC	Emergency and Urgent Care
ECT	Emergency Care Technician	ESN	Emergency Services Network
EMSCP	Emergency Services Mobile Control Project	EIF	Education Inspection Framework

ESFA	Education Skills Funding Agency	EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
ECA	Emergency Care Assistant	ECT	Emergency Call Taker
EDS	Equality Delivery System	EO	Executive Officer
EDS2	Equality Delivery System 2	EQIA	Equality Impact Analysis
ESPM	Essential Skills for People Managers		
F			
FFT	Friends and Family Test	FT	Foundation Trust
FIC	Finance and Investment Committee	FTE	Full Time Equivalent
FOI	Freedom of Information	FTSU	Freedom to speak up
FPPT	Fit and Proper Persons Test	FAST	Face Arm Speech Test
FS	Functions Skills	FReM	Financial Reporting Manual
FRF	Financial Recovery Fund	FRICS	Fellow Royal Institution of Chartered Surveyors
G			
GMC	General Medical Council	GDP	Gross Domestic Product
GDPR	General Data Protection Regulations	GAD	Government Actuary Department
GAM	Group Accounting Manual	GP	General Practitioner
H			
HCAI	Healthcare Associated Infection	HRA	Health Research Authority
HCA	Health Care Assistant	HSCA 2012	Health & Social Care Act 2012
HDU	High Dependency Unit	HSCIC	Health and Social Care Information Centre
HEE	Health Education England	HTA	Human Tissue Authority
HR	Human Resources	HWB / HWBB	Health & Wellbeing Board
HIOW	Hampshire and Isle of Wight ICB	H&T	Hear and Treat
HSJ	Health Service Journal	HO	Hand Over

HART	Hazardous Area Response Team	HCP	Healthcare Professional
HLO	Hospital Liaison Officer	HM	His Majesty's
HMRC	His Majesty's Revenue and Customs	HR	Human Resources
HSH	Hampshire and Surrey Heath	HSWA	Health and Safety at Work Act
I			
IG	Information Governance	ICU or ITU	Intensive Care Unit Intensive therapy unit
ICP	Integrated Care Pathway/Partnership	IP	Inpatient
ICS	Integrated Care system	IT	Information Technology
ICT	Information Communications Technology	IV	Intravenous
ICB	Integrated Care Board	IPR	Integrated Performance Report
IDACI	Income Deprivation Affecting Children Index	IUC	Integrated Urgent Care
IDAOPI	Income Deprivation Affecting Older People Index	iGAS	Invasive Group A Streptococcus
IRP	Incident Review Panel	IPC	Infection Prevention and Control
IA	Industrial Action	IAS	International Accounting Standard
IFRS	International Financial Reporting Standard	I&E	Income and Expenditure
IO	Intraosseously	IOW	Isle of Wight
IO	Investigating Officer	IWP	Integrated Workforce Plan
K			
KLOE(s)	Key Line of Enquiries	KPIs	Key Performance Indicators
L			
LD	Learning Disability	LOS	Length of Stay
LOSA	Lower-layer Super Output Area	LG	Lead Governor

LFPSE	Learn from Patient Safety Events	LA	Local Authority
LeDeR	A service improvement programme for people with a learning disability and autistic people	LGBT	Lesbian, Gay, Bisexual, and Transgender
LFT	Lateral Flow Test	LRF	Local Resilience Forum
M			
M&A	Mergers & Acquisitions	MRI	Magnetic Resonance Imaging
MHPRA	Medicines and Healthcare Products Regulatory Agency	MRSA	Methicillin-Resistant Staphylococcus Aureus
MIU	Minor Injuries Unit	MSA	Mixed Sex Accommodation
MoU	Memorandum of Understanding	MR	Make Ready
MEC	Membership and Engagement Committee	MDVS	Mobile Data and Voice Solution
MCA	Mental Capacity Act	MACA	Military Aid to Civilian Authorities
MH	Mental Health	MHSG	Mental Health Steering Group
MK	Milton Keynes	MEA	Modern Equivalent Asset
MTA	Marauding Terrorist Attack	MSK	Musculoskeletal
MTA	Must Travel Alone	MNS	Maternity and Neonatal Systems
N			
NAO	National Audit Office	NHSI	NHS Improvement
NED	Non Executive Director	NHSLA	NHS Leadership Academy
NHS	National Health Service	NHSP	NHS Professionals
NHS111	NHS nonemergency number	NHSX	New Joint Organisation for Digital, Data and Technology
NHSBSA	NHS Business Services Authority	NICE	National Institute for Health and Care Excellence
NHSBT	NHS Blood and Transplant	NIHR	National Institution for Health Research
NHSE/I	NHS England / Improvement	NMC	Nursing and Midwifery Council

NRLS	National Reporting and Learning System	NEPTS	NHS Non-Emergency Patient Transport Services
NIF	National Insurance Fund	NBV	Net Book Value
NVBS	National Vaccination Booking Service	NFPS	National Flu Pandemic Service
NCPS	NHS Covid Pass Service	NHUC	North Hampshire Urgent Care
NPMV	Ofsted New Provider Monitoring Visit		
O			
OD	Organisational Development or Outpatients Department	OSCs	Overview and Scrutiny Committees
OOH	Out of Hours	OT	Occupational Therapy
OUH	Oxford University Hospital	OHC	Organisational Health Check
OCI	Other Comprehensive Income	OH	Oxford Health
OP	Outpatients	OH	Occupational Health
OHCA	Out of Hospital Cardiac Arrest	ONS	Office for National Statistics
P			
PALS	Patient Advice & Liaison Service	PHSO	Parliamentary and Health Service Ombudsman
PAS	Patient Administration System	PICU	Psychiatric Intensive Care Unit or Paediatric Intensive Care Unit
PbR	Payment by Results or 'tariff'	PLACE	Patient-Led Assessments of the Care Environment
PCN	Primary care network	POD	People and Organisational Development Committee
PDSA	Plan, do, study, act	PPI	Patient and Public Involvement
PFI	Private Finance Initiative	PTS	Patient Transport Services

PHE	Public Health England	PSIRF	Patient Safety Incident Reporting Framework
PCN	Primary Care Network	PaCCs	Pathways Clinical Consultation Support
PPCI	Primary percutaneous coronary intervention	PE	Patient Experience
PHSO	Parliamentary & Health Service Ombudsman	PDR	Personal Development Review
PAD	Publicly Accessible Defibrillator	PDC	Public Dividend Capital
PFI	Private Finance Initiative	PHL	Partnering Health Limited
PMO	Project Management Office	PPE	Personal Protective Equipment
POSED	Prehospital Optimal Shock Energy for Defibrillation	PSED	Public Sector Equality Duty
PSF	Provider Sustainability Funding		
Q			
QA	Quality assurance	QIA	Quality Impact Assessment
QC	Quality Committee	QOF	Qualities and Outcomes Framework
QI	Quality improvement		
QAH	Queen Alexandra Hospital		
R			
R&D	Research & Development	RoI	Return on Investment
RAG	Red, Amber, Green classifications	RTT	Referral to Treatment Time
RGN	Registered General Nurse	RIDDOR	Reporting of Injuries, Diseases, Dangerous Occurrences Regulations
REAP	Resource Escalation Action Plan	ROSC	Return of Spontaneous Circulation
RECAP	Remote COVID-19 Assessment in Primary Care	RICS	Royal Institute of Chartered Surveyors
RPI	Retail Prices Index		
S			

SALT	Speech and Language Therapist	SLA	Service Level Agreement
SFI	Standing Financial Instructions	SoS	Secretary of State
SHMI	Summary Hospital Level Mortality Indicator	SRO	Senior Responsible officer
SID	Senior independent Director	STP	Sustainability and Transformation Partnership
SIRO	Senior Information Risk Officer	SUI	Series Untoward Incident / Serious Incident
SITREP	Situation Report	SWOT	Strengths, Weaknesses, Opportunities, Threats
SCAS	South Central Ambulance Service NHS Foundation Trust	SWAS	South West Ambulance Service
SOF	System Oversight System	SDEC	Same Day Emergency Care
SECAmb	South East Coast Ambulance NHS Foundation Trust	SPC	Statistical Process Control
S&M	Statutory and Mandatory	S&T	See and Treat
S,T&C		STEMI	ST-elevation myocardial infarction
SAAF	Safeguarding Accountability Framework	SI	Serious Incidents
SAR	Subject Access Request	SEN	Special Educational Needs
SCWCSU	South Central and West Commissioning Support Unit	SDAT	Sustainable Development Assessment Tool
SH	Southern Health	SDMP	Sustainable Development Management Plan
SIRI	Serious Incident Requiring Investigation	SJR	Structured Judgement Review
SOCF	Statement of Cash Flow	SOFP	Statement of Financial Position
SORT	Special Operations Response Team	STEMI	Stroke and ST-Elevation Myocardial Infarction
T			
TTO	To Take Out	ToR	Terms of Reference
TV	Thames Valley	TVIUC	Thames Valley Integrated Urgent Care

U			
UEC	Urgent and Emergency Care	UCD	Urgent Care Desk
UKHSA	UK Health Security Agency	UK	United Kingdom
UKBSA	NHS Business Services Authority	UTC	Urgent Treatment Centre
V			
VTE	Venous Thromboembolism	VfM	Value for Money
VOR	Vehicle Off Road	VCD	
VDRS	Vaccine Data Resolution Service	VBS	Vaccine Booking Service
VAT	Value Added Tax		
W			
WLF	Well Led Framework	WRES	Workforce Race Equality Standard
WDES	Workforce Disability Equality Standard	WTE	Whole-time equivalent
WMAS	West Midlands Ambulance Service		
Y			
YTD	Year to Date		

South Central Ambulance Service
NHS Foundation Trust

BOARD MEMBERS REGISTER OF INTERESTS

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

INTRODUCTION & BACKGROUND

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

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

DOCUMENT INFORMATION

Date of issue: 18 May 2023

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. Executive Coach at ella Forums

Interests that ended in the last six months

4. Senior Independent Trustee for the Royal Hospital for Neuro-disability and Chair of the Audit and Risk Committee

ANNE STEBBING, NON-EXECUTIVE DIRECTOR

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

1. Consultant Surgeon and Associate Medical Director, Hampshire Hospitals NHS Foundation Trust

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

NIGEL CHAPMAN, NON-EXECUTIVE DIRECTOR

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

1. None

Current 'Other' Interests

2. Labour City Councillor for Headington Hill and Northway, Oxford City Council.
3. Oxford City Council – Cabinet Member for Citizen Focused Services, Member of Oxford City Council Planning Committee
4. Vice Chair of Care International UK
5. Director of Farrar Chapman Ltd*
6. Director Empowering Leadership Ltd
7. Community Governor, New Marston Primary School, Oxford (part of the River Learning Trust).

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

Interests that ended in the last six months

8. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

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

1. Chair of Salisbury NHS Foundation Trust

Current 'Other' Interests

2. Chair of Estuary Housing Association
3. Member of Welsh Governments Expert Advisory Group on banning LGBTQ+ Conversion Practices
4. Member of Advisory Group, NHS Patient Safety Commissioner
5. Strategic Advisor, Prevention Access Campaign (US based charity)

Interests that ended in the last six months

6. Chief Executive of Terrence Higgins Trust
7. Chair of HIV Prevention England
8. Director of Terrence Higgins Trust Enterprises
9. Member of the Department of Health and Social Care HIV Action Plan Implementation Group

MIKE McENANEY

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

1. Member of NHS Providers Finance & General Purposes Committee
2. Chair of FTN Limited (Trading subsidiary of NHS Providers charity)

Current 'Other' Interests

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

Interests that ended in the last six months

5. 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

DAVID ELTRINGHAM, CHIEF EXECUTIVE OFFICER

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

1. None

Current 'Other' Interests

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

Interests that ended in the last six months

3. None

PAUL KEMPSTER, CHIEF OPERATING OFFICER

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

1. Managing Director of South Central Fleet Services Ltd

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. Lecturer in Anatomy, St Edmund Hall, University of Oxford, Member of Oxford University Congregation
4. Member National Ambulance Medical Directors Group (NASMeD)
5. Investor Oxford Medical Products Ltd*

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

Current 'Other' Interests

6. None

Interests that ended in the last six months

7. 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)

ANEEL PATTNI, CHIEF FINANCIAL OFFICER

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

1. Director of South Central Fleet Services Ltd.

Current 'Other' Interests

2. Vice chair of the South Central branch of Healthcare Financial Management Association (HFMA). HFMA is a professional body for finance staff in healthcare.

Interests that ended in the last six months

3. None

MIKE MURPHY, DIRECTOR OF STRATEGY AND BUSINESS DEVELOPMENT

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

1. Chair Of Members - Mountbatten Secondary School, Romsey, Hampshire

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

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

JILL LANHAM, DIRECTOR OF DIGITAL

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

1. None

Current 'Other' Interests

2. Trustee for Mental Health Matters

Interests that ended in the last six months

3. None

END

ITEM 3

Unconfirmed Minutes of the meeting 'in public' of the South Central Ambulance Service (SCAS) NHS Foundation Trust Board of Directors ('the Board') held on **Thursday 30 March 2023**, held at the Ark Conference Centre, Basingstoke.

Board Members Present (15/15)
Professor Sir Keith Willett CBE (Chair); Will Hancock (Chief Executive);Les Broude (NED); Nigel Chapman (NED); Ian Green (NED); Dr Anne Stebbing (NED); Dr John Black (Medical Director); Paul Kempster (Chief Operating Officer); Jill Lanham (Director of Digital); Aneel Pattni (Chief Financial Officer); Dr Dhammika Perera (NED); Melanie Saunders (Chief People Officer); Professor Helen Young (Director of Patient Care and Service Transformation).

Apologies

Apologies for absence were **received** from Sumit Biswas, Mike McEnaney (Non-Executive Directors) and Mike Murphy (Director of Strategy and Business Development).

In Attendance

David Eltringham (CEO-designate); Kate Hall (Intensive Support Director, NHSE/I); Michael Wood (Interim Director of Corporate Governance and Company Secretary); Gillian Hodgetts (Director of Communications and Marketing) and Sophie Joseph (Interim Assistant Company Secretary).

OPENING BUSINESS

22/112 – Chair's Welcome and Apologies for Absence
The Chair welcomed all to the meeting, including David Eltringham (CEO-designate) and Dr Dhammika Perera (NED), to their first meeting of the Board.

22/113 - Declarations – Directors' Interests & Fit and Proper Persons Test

No new declarations were made.

22/113 – Minutes

The Minutes of the meeting held in public on 26 January 2023 were **approved** as an accurate record, subject to the following amendments:

(Minute 22/95 refers, para.2): reference to 'core', rather than 'back-up' to be made in respect of the telephony system; the word 'make' to be deleted from para.2, line 4.

(Minute 22/98 refers, para.3): the reduction in the take up of flu vaccinations to be set in the national context of reduced vaccination levels;

22/114 – Board Action Log

The Action Log was **noted**, it being agreed to close Actions 1 and 3. With regard to Actions 2 and 4, it was reported that Board Development Seminars would be held on Committee Effectiveness and Digital matters during the year. In respect of Action 5 and Safeguarding, it was **noted** that the new Integrated Performance Report (IPR) would contain specific metrics for assurance purposes.

STRATEGIC OVERVIEW AND CONTEXT

22/115 – Chair's Report

The Chair presented his report, highlighting that the Trust was facing a particularly challenging year ahead (2023/24) in terms of finances and a lot of focused work was currently taking place with system partners in this regard.

The Board **noted** the Chair's Report.

22/116 – Chief Executive's Report

The CEO provided the following update to the Board, the following key points being **noted:**

- the Trust's phase one improvement work was nearing its conclusion. The Trust was now actively working on phases two and three as part of an exit strategy to meet CQC requirements in full, designed to establish a sustainable future for the organisation in delivering our mission which places the quality of patient care at its core;

- operational performance had improved since January 2023, although there had been particular challenges with 999 and NHS111 performance;

- the impact of industrial action to date had been less acute at SCAS and the Trust was hopeful of a national pay settlement in order to provide stability moving forward;

- the Trust was continuing to work the Integrated Care System in planning for the 2023/24 budget, which has proved challenging for all parties concerned. However, the Trust has adopted a collaborative approach to discussions as they enter a final stage.

The CEO commented that this would be his final meeting of the Board after over 17 years' service to the Trust. The CEO reflected on the national role the Trust had played during the Covid-19 pandemic, commenting that it was a landmark moment in closing the national service files. He paid tribute to the dedicated staff of the Trust over the past 17 years and wished colleagues, including his successor David Eltringham, every success for the future.

On behalf of the whole Board, the Chair warmly thanked the CEO for his valued service to the Trust.

The Board **noted** the Chief Executive's Report.

22/117 – Strategic Update: BAF

The Board **noted** a progress report on the BAF including a dashboard and summary report from GGI on the Board Seminar on Risk (23 February 2023). Discussion centred on the current risk rating (25) assigned to service delivery and demand, it being advised that this related to the fact that demand exceeds capacity rather than failure. With regard to Trust finances and the underlying deficit, it was **agreed** that this was an area which required closer scrutiny in terms of financial risk trends.

The Board also requested more analysis in respect of the risk (16) relating to staff retention and attrition which was felt to be too positive at present. In response to a NED question, it was confirmed that detailed comments related to specific risks discussed at Board committees were subsequently discussed by management and reflected upon. The Chair of the Audit Committee proposed that a simple pro-forma be introduced by way of summarising discussion by Board committees on the BAF, which could then be considered by the Audit Committee in order to achieve consistency of practice with regard to mitigations.

The Board **noted** the progress report.

22/118 - CQC Improvement Programme

The Board **received** updates from Executive Directors in respect of the Improvement Programme. Significantly, it was **noted** that all 10 'must do' CQC recommendations had been completed, with 14 (out of 20) 'should do' recommendations having been fully addressed. This represented c900 actions over four workstreams. The quarterly assurance process with external partners continued to take place, and representatives from the national team had recently visited the Trust (report awaited).

With regard to Safeguarding, the Board was pleased to **note** that was showing a 'green' RAG-rating against the Section 29 notice which demonstrated substantial progress against the national safeguarding framework.

In respect of the Culture & Well-Being Workstream, it was reported that a baseline FTSU assessment would be considered at the May meeting of the People & Culture Committee, following a presentation by the national lead on the Board Seminar on 27 April. A Talent and Succession paper was also being developed post-Covid. It was commented that the Trust needed to understand the data on why staff were leaving which was not always related to pay.

The Board **noted** the progress report.

22/119 – Patient Story

The Board heard a moving safeguarding story involving an elderly female patient where contrary advice had been received with regard to resuscitation. As a result of the important learning from this incident, patient safety protocols had been reviewed and strengthened. The Chair thanked the safeguarding team for their presentation.

The Board **noted** the report.

PERFORMANCE. RISKS, GOVERNANCE AND ASSURANCE

22/120 – Integrated Performance Report

The Chief Finance Officer presented the Month 11 Integrated Performance Report, highlighting that in common with other ambulance trusts, the Trust continued to experience significant challenges in terms of operational delivery across all three core services.

It was **noted** that 999 and NHS111 performance had been greatly challenged, with insufficient capacity to meet PTS demand. The Trust's financial performance for Month 11 remained broadly in line with the planned breakeven level.

Actions were being taken to re-design the IPR report to include the use of SPC charts. Progress was on track in accordance with the IPR development plan, and further staff training and development was being rolled out as part of the transition to the new IPR. As part of governance arrangements, the Chair of the Quality & Safety Committee would attend fortnightly review meetings.

The Board **noted** the progress report.

22/121 - Quality and Patient Safety Report

The Director of Patient Care and Service Transformation presented her report for the period December 2022 to January 2023, the following key points being highlighted:

- significant progress continued to be made against the objectives outlined in the *Patient Safety Improvement Plan.* The areas that currently present the highest risk to patients are the management of medical devices and equipment and Safeguarding (all highlighted in the BAF);

- significant progress made against Patient Safety Improvement Plan- RAG-rated as GREEN. Phase 2 plans are now developed and being finalised;
- significant increase in demand noted which has resulted in an increase in clinical incident reporting;
- an increase in parents contacting community and 111 services was also noted due to concerns relating to Invasive Group A Streptococcus (iGAS);
- a 2% increase in EOC clinical incident and 999 clinical reporting was noted when compared to previous months. All incidents were being investigated;
- abuse/Abusive behaviour incidents remain the top category in 999 Services;
- downward trend of 19% noted in the total number of patient experience contacts from previous report;
- 49% (274) of all PE issues were attributed to delays / non- attendance, a 2% increase from previous months;
- there had been a 46% increase from the previous reporting period in the Patient Transport Services (PTS) feedback regarding delays;
- there had been (94) formal complaints received during the reporting period, reduction on previous reporting period;
- 19 declared as Serious Incidents (SI's)- 51 % conversion rate. This is an increase of (7) from the previous reporting period and correlates with heightened demand, escalation and number of reported delays;
- the Trust received (254) compliments for the care and services delivered by our people during the reporting period.

In respect of the application for a controlled drug licence, it was **reported** that a requirement of the securing the licence was to have new premises which would be inspected. In the interim, a partner acute trust would continue to provide controlled drugs. In the light of rising Covid-19 infection rates with 7.5% of all hospital beds being occupied by Covid patients, it was **noted** that new national IPC guidance for ambulance services would be issued in the near future.

The Board **noted** the Quality and Patient Safety Report.

22/122 – Operations Report

The Chief Operating Officer provided his Operations Report to the Board. It was highlighted that in respect of overall Trust performance, whilst there had been improvements in 111 and 999 responses in January, February had been a more challenging month with a 6% gap between capacity and activity levels. With regard to Category 2 performance, the Trust had been the top performing ambulance service in the country over the period under review. The CEO commented that it was intended that the Trust should aim to achieve a stretch target of 18 minutes in terms of Category 2 response times.

It was **reported** that the Trust had received £7.3m in UEC funding in support of improved performance which was lower than bid for. In response to NED questions on Category 1 performance, it was commented that were the Trust to continue to sustain current Category 2 delivery, then Category 1 performance would be impacted positively as a result. It was **agreed** that more detailed discussion on this matter would take place at the next Quality & Safety Committee.

The Board **noted** the report.

22/123 – Finance Report

The Chief Finance Officer (CFO) presented an update on the Budget, 2023/24 which, consistent with the Plan previously approved by the Board on 20 March 2023, including a planned deficit of £16.4m. It was **noted** detailed discussions were still on-going at a system level in respect of the Trust's budget position.

The Chair observed that this was the first time that the Trust had found itself in a deficit situation. The Chair of the Finance & Performance Committee advised that the Committee had scrutinised the budget in detail, particular consideration being focused on the planned cost improvement programme

(CIP), including important quality impact assessments (QIAs). Given the need to assure the robustness of the Trust's CIP, it was confirmed that a further meeting of the Finance & Performance Committee would be held with a further report being made to a private Board meeting on 27 April.

The Board **noted** the report.

22/124 – Chief Medical Officer's Report

The Chief Medical Officer presented his report to the Board on Ambulance Clinical Quality Indicators (ACQI), Internal Care Bundle Audits and Clinical Trials, the following key points being highlighted:

- when compared with the eleven English Ambulance Trusts (including the Isle of Wight) for the period April 2022 – October 2022, the Trust had performed above the national average in respect of nine indicators, placing SCAS in the upper quartile rating when benchmarked nationally for 6 out of 13 ACQI indicators (the same position as the last report to Board);

- seven indicators had seen an improvement and five marginal deterioration since the last report;

- Sepsis has been retired as an indicator. A pilot ACQI related to the assessment and care of falls in older adults will commence in relation to March 2022 data, although results will not be published nationally whilst NHS Ambulance Trusts are piloting the feasibility of this proposed new indicator;

- a performance recovery programme of work remains in progress to improve operational capacity;

- further developments to the Electronic Patient Record (ePR) tablets to support thorough clinical documentation are on hold whilst two new roles are recruited into the Information Technology team, a clinical safety officer and clinical applications manager;

- Internal care bundle audit indicators are currently performing below the year end position 2021/22, with the exception of Febrile Convulsion. Compliance remains largely unchanged since the last report to board, with marginal fluctuation;

- lower limb fracture remains the lowest performing indicator. Audit fails are most commonly due to non-recording of two pain scores and limb immobilisation.

The Board **noted** the report.

22/125 - People & Culture Report

The Director of People presented her report to the Board, commenting that Ofsted had now published its final report on the Trust's apprenticeship scheme, as previously reported at the private Board in January 2023 and as discussed in detail at the last People & Culture Committee.

With regard to the People Strategy, the following key comments were highlighted:

- the Strategy had been subject to detailed discussion at the People & Culture Committee;
- impact measures needed to be evidenced particularly in respect of the improvement programme and organisational change;
- the term: 'just and learning' culture was to be re-visited and expanded in scope;
- the Strategy needed to have cross-ownership within the Trust for the purpose of effective and consistent organisational delivery;
- extensive stakeholder engagement had taken place and it was planned to engage further with staff in developing implementation plans.

The Board **approved** the People Strategy.

The Board **noted** key findings from the 2022 Staff Survey, it being reported that results were marginally improved over the previous year. The Chair proposed that a Board seminar on the Survey should be held during the year to address particular issues, such as staff health and well-being.

The Board **noted** the report.

22/126 - Board Committee Upward Reports

- ***People and Culture Committee***

The Committee Chair (Ian Green) reported that the People Strategy had been set against the Trust's Corporate Strategy and NHS national people plan in order to ensure that it was clearly aligned with NHS policy. The Committee considered the recommendations of Ofsted's Report on the Trust's apprenticeship provision, and noted the continued challenge with recruitment and retention across the Trust. The findings from the 2022 Staff Survey were also considered.

- ***Quality and Safety Committee***

The Committee Chair (Dr Anne Stebbing) confirmed that the Committee was continuing to provide scrutiny in respect of Safeguarding with a focus on SCAS-wide training requirement and IT infrastructure. The Committee remained sighted on Serious Incidents and the learning from investigations. It was reported that delivery of the national patient safety strategy and timetable in the current year would be challenging.

- ***Audit Committee***

The Committee Chair (Mike McEnaney) informed the Board that an extraordinary meeting had been held to consider the External Auditor's Plan for the year end process which was now almost complete. It was **noted** that the Internal Audit plan was proceeding well, although eight outstanding actions related to the BAF had yet to be closed. The Committee had also reviewed its cycle of business.

- ***Finance & Performance Committee***

The Committee Chair (Les Broude) commented that the Committee had held its inaugural meeting on 16 March at which members had reviewed the Terms of Reference and Committee-specific risks. The Committee had considered the draft budget for 2023/24 in detail and the related CIP process.

- ***Charity Committee***

The Committee Chair (Nigel Chapman) reported that the Charity had agreed a settled budget for 2023/24 with realistic fundraising targets. The Committee was reviewing how best to utilise a major legacy and, following an independent review, was operating a combined unrestricted fund.

The Board **noted** the Upward Reports.

22/127 – National COVID Response Services (CRS) Closure Report

The Director of Patient Care and Service Transformation presented the Closure Report in respect for the National COVID Response Services Report. In paying tribute to the commitment and dedication of all staff involved in the CRS, the Director commented that the service had responded to 3 million calls from patients with Covid symptoms, a record 115,000 calls being handled on a single day, the equivalent of a typical month for the 111 service. In respect of vaccination bookings, a total of 17 million calls were handled.

On behalf of the whole Board, the Chair extended sincere thanks and appreciation to all involved in the CRS at a time of national crisis, and proposed that the report be submitted to NHSE for formal record.

The Board **noted** the Closure Report.

22/128– Any Other Business

There was no other business.

22/129 – Questions from Observers (relating to items on the agenda)

No questions were raised from Observers.

22/130 - Review of Meeting

The Chair summarised actions arising out of the meeting which included:

- A review of key risks with focused discussion;
- Safeguarding was more integrated across the Trust, reference being made to the lessons learned from the Patient Story in this regard;
- The need for further follow up discussion with the system on the Trust's planned budget, 2023/24;
- The approval of the People Strategy which needed to be embedded Trust-wide as part of the transformation and improvement programme.

22/131 – Date of next meeting: Thursday 25 **M**ay **2023 (in-person)**.

Approved by:

Chair (signature)……

Date:……

Agenda Item 4 - Matters Arising/Action log

No.	Minute ref.	Action	Responsible	Date raised	Due Date	Status	Update
30 March 2023							
1.	22/117	In respect of the BAF, closer scrutiny was required with regard to a) financial risk trends; b) staff retention and attrition (Risk 16). A quarterly report to be considered by the Audit Committee summarising Board Committee discussion on committee-specific risk.	Chief Governance Officer	30/03/23	May/June 2023	Open	See agenda item 7
2.	22/122	The Quality & Safety Committee to consider Category 1 performance in more detail at a future meeting.	Chief Governance Officer	30/03/23	May/June 2023		
3.	22/125	The Board to consider detailed results of the Staff Survey at a future Development Seminar.	Chief People Officer	30/03/23	November 2023	Open	A Board Development Seminar to review the Staff Survey will be added to the schedule for November 23.

South Central Ambulance Service
NHS Foundation Trust

Report title:	**Chair's Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**5.0**
Executive Summary:	The Chair has undertaken a range of activities associated with his role since the previous Board meeting. **Appendix 1** sets out a sample of these activities.		
Recommendations:	The Trust Board is invited to **note** the report.		
Board lead:	Professor Sir Keith Willett CBE, Chair		
Report author:	Professor Sir Keith Willett CBE, Chair		
Previously considered by:	N/A		

Purpose of report:	Note ☒	Approve ☐	Assure ☐
Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	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

Justification for the above 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):	Not applicable
Links to BAF risks: (or links to the Significant Risk Register)	Not applicable
Quality Domain(s):	Not applicable
Next Steps (what actions will be taken following agreement of the recommendations): N/A	
List of Appendices: One	

CHAIR'S REPORT

PURPOSE

The purpose of my report to bring the Board up to date on key stakeholder developments and my personal activity on behalf of SCAS.

APPENDIX 1 – SAMPLE OF ACTIVITIES UNDERTAKEN

Activity	Summary	Notes
Board of Directors	• Chaired the Board meeting on 30 March 2023 and an Extraordinary Private Board meeting on 3 May 2023 (to consider the financial plan, 2023/24); • Chaired Board Development Seminar on Risk and finalisation of the Board Assurance Framework (BAF) on 27 April 2023. Future Board development sessions will focus on Board/Committee Effectiveness; Strategy; Quality and Digital (including cyber threats).	
Council of Governors (CoG)	• Liaised with Lead Governor over enhancing the level of support to the Council of Governors and further development opportunities	
Staff	• Catch-up meetings with the Chief Executive, Interim Director of Corporate Governance and new Chief Governance Officer; • CQC Improvement Oversight Board meetings every two weeks. There is now more visible progress in respect of the Trust's Improvement Plan; • Attended Senior Leadership Group event at which the CEO's 10-Point Plan was presented. The Plan now forms the core of the Trust's strategy for 2023/24.	
Meetings with other NHS organisations	• Welcomed the High Sheriff of Hampshire on a visit to Southern House; • Attended BOB System UEC Summit; • Participated in a ride-out; • Attended NHSE NHS@75 System & Provider Leaders' Group meeting. • Attended various ICB Chairs' meetings.	

South Central Ambulance Service
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC 25 May 2023

Agenda item 6- CHIEF EXECUTIVE'S REPORT

The purpose of this CEO Report is to keep the Board abreast of key issues and developments.

Since I joined SCAS at the start of March I have visited and engaged with a wide variety of staff with the main purpose of listening to how they feel about the Trust and how they want things to develop for them.

As a result of these activities and discussions, I formulated a 10-point plan with the intention of leading change at SCAS. The 10-point plan will ensure that we will continue to develop ourselves as the gateway to healthcare providing urgent and emergency care whilst leading the discussion on prevention. We will employ innovation and sustainable solutions to everything we do but we will not do this alone as we embed ourselves further in system thinking and partnership working. The 10-point plan focusses on those things that have been fed through the organisation by our people during listening events and effectively reflect their major concerns.

During May, the Board approved a breakeven budget for the financial year against which performance will be measured. The plan has been agreed with Hampshire and Isle of Wight ICS. The initial plan stating a deficit of £13.4m was agreed by the Board on 30th March 23 but was revised downwards in consultation with the ICS and agreed with the Board in early May 2023. The Financial Sustainability Plans (FSP) will help to deliver the breakeven budget. Senior leadership from all operational and corporate directorates were invited to an all-day workshop on 18th April to generate ideas for FSP schemes. The workshop was attended by 34 senior leaders and generated over 90 ideas.

During the period since the last Board meeting, I have been involved with:

- various internal introductions with staff/teams
- various site visits and ride outs
- SCAS SLG event
- meeting with CEO OUH, Meghana Pandit
- meeting with Oxford Brookes University students
- Steve McManus's (CEO BOB) visit to Bicester and the
- King's Coronation Reception and Concert, Windsor

The Coronation of Their Majesties, The King and The Queen took place at Westminster Abbey on Saturday, 6 May 2023, in the first Coronation Service in almost 70 years. I would like to extend my thanks to all the SCAS staff and volunteers who took part in the response to events in Windsor over the bank holiday weekend.

During early May, we celebrated all nurses and the profession of nursing on the date that Florence Nightingale was born. This year was extra special, as we also marked 75 years of the NHS.

Other interesting events that have taken place since the last Board meeting, include SCAS featuring on the Good Morning Britain (GMB) breakfast show. The show visited Nursling ambulance station, to create a ‘day-in-a-life’ piece as part of a wider NHS focused series looking at individuals in different frontline jobs and how they are coping with the pressures affecting all health and social care services. The GMB team spent time with Kimberley, Paramedic & Clinical Team Educator, and Brian, Emergency Care Assistant, following them for a shift, finding out more about their role and the pressures they face day-to-day.

I would like to thank everyone who was part of the national covid response services which SCAS ran during the pandemic. On the 31 March 2023 the final remaining services transferred to the UK Health Security Agency. The SCAS team were a critical part of the country’s response to Covid, helping millions of people manage symptoms, book vaccinations and arrange Covid passes and medical exemptions. At the height of the pandemic, it was one of the largest call centre operations in the country; and larger than all other parts of SCAS combined.

Report title:	**Board Assurance Framework (BAF)**		
Report to:	**Trust Board**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**7.0**
Executive Summary:	The Board is requested to approve the Board Assurance Framework, subject to any further amendments. The Board Assurance Framework (BAF) was updated by the Good Governance Institute in May 2023 following the April Board workshop and Executive Team review. The key changes made from the version considered by the Board workshop in April include: Strategic Risk 2: Amended the impact from "*Leading to delays in escalating care, operational inefficiency and increased morbidity and mortality.*" to "*Leading to delays in treatment, and increased morbidity and mortality.*" Added "*Quality Improvement Process and Culture*" to Gaps in Controls and Assurances section. Strategic Risk 3: Added "*Monthly report to Board on system activity*" to First and second line (internal) assurances section. Strategic Risk 5: Added "*Lack of cost and productivity data/trends*" and "*Lack of benchmarking data*" to Gaps in Controls and Assurances section. Strategic Risk 6: Removed "*Recruitment and retention KRIs*" and "*Attrition strategy/plan*" from the Gaps in Controls and Assurance section. Amended risk target from 9 (3 x 3) to 12 (4 x 3). Strategic Risk 8: Added "*Chief Digital Officer*" as job title for the Risk Lead. Amended wording for "*Service desk software which no longer meets organisational needs*" in the Gaps in Controls and Assurances section. Added "*Clarify governance structure for digital resulting from the introduction of Finance and Performance Committee and addition of Chief Digital Officer to the Executive team*" to the Actions to address control / assurance gaps section.		

Recommendations:	The Board is asked to: - review and approve the strategic risks included in the Board Assurance Framework.			
Executive lead:	Daryl Lutchmaya, Chief Governance Officer			
Report author:	Steven Dando, Corporate Risk Manager			
Previously considered by:	Previously considered by the Board at the Finance Workshop on 27 April 2023 and subsequently updated by GGI. The Executive Team reviewed the BAF prior to being presented to this Committee. Finance and Performance Committee risks have been reviewed by the finance and Performance Committee on 17 May 2023.			
Purpose of report:	Note ☐	Approve ☒	Assure ☐	
Paper Status:	Public ☒	Private ☐	Internal ☒	
Assurance level:	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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	All BAF risks
Quality Domain(s):	All Quality Domains

Next Steps (what actions will be taken following agreement of the recommendations):

- The Board Assurance Framework will be considered approved.

List of Appendices:
Summary Board Assurance Framework
SCAS Board Assurance Framework

Strategic Risk	Strategic Domain	Strategic Objective	Risk Rating Movement Same ↔ Improved ↓ Worsened ↑	Historic Current Risk Rating				Inherent Risk	Current Risk Apr 2023	Target Risk	Strength of Controls	Strength of Assurance
SR1 **IF** we have insufficient clinical workforce capability or ineffective equipment and vehicles, **THEN** we will fail to provide safe and effective care **LEADING TO** poor clinical outcomes.	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.	↔	APR 15	MAY	JUN	JUL	20	15	9	TBC	TBC
				AUG	SEP	OCT	NOV					
				DEC	JAN	FEB	MAR					
SR2 **IF** we do not have or use effective operational delivery systems, **THEN** we may not be able to meet demand and provide a responsive service to patients in need of emergency care, **LEADING TO** delays in treatment and increased morbidity and mortality.	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	↔	APR 20	MAY	JUN	JUL	20	20	10	TBC	TBC
				AUG	SEP	OCT	NOV					
				DEC	JAN	FEB	MAR					
SR3 **IF** the organisation fails to engage or influence within systems, **THEN** there may be a disproportionate focus in one system over the others and capacity provided may not align with expectations, **LEADING TO** performance that is not achievable or credible and possible poor outcomes for patients and the communities we serve.	Partnership & Stakeholder Engagement	We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans	↔	APR 20	MAY	JUN	JUL	25	20	4	TBC	TBC
				AUG	SEP	OCT	NOV					
				DEC	JAN	FEB	MAR					

Strategic Risk	Strategic Domain	Strategic Objective	Risk Rating Movement Same Improved Worsened	Historic Current Risk Rating				Inherent Risk	Current Risk Apr 2023	Target Risk	Strength of Controls	Strength of Assurance
SR4 **IF** we fail to engage with stakeholders and partners, **THEN** partners will fail to understand who we are and what we do, **LEADING TO** failure to innovate and influence and an inability to identify opportunities within systems.	Partnership & Stakeholder Engagement	We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans		APR 12	MAY	JUN	JUL	12	12	6	TBC	TBC
				AUG	SEP	OCT	NOV					
				DEC	JAN	FEB	MAR					
SR5 **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, **LEADING TO** additional pressures on our ability to deliver a sustainable financial plan and safe services.	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.		APR 16	MAY	JUN	JUL	20	20	16	TBC	TBC
				AUG	SEP	OCT	NOV					
				DEC	JAN	FEB	MAR					
SR6 **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.	People & Organisation	We will develop plans to deliver inclusive, compassionate culture where our people feel safe and have a sense of belonging.		APR 20	MAY	JUN	JUL	20	20	12	TBC	TBC
				AUG	SEP	OCT	NOV					
				DEC	JAN	FEB	MAR					
SR7 **IF** we fail to foster an inclusive and compassionate culture,	People & Organisation	We will develop plans to deliver inclusive, compassionate culture where our people feel		APR 16	MAY	JUN	JUL	20	16	8	TBC	TBC

Strategic Risk	Strategic Domain	Strategic Objective	Risk Rating Movement Same Improved Worsened	Historic Current Risk Rating				Inherent Risk	Current Risk Apr 2023	Target Risk	Strength of Controls	Strength of Assurance
THEN our staff may feel unsafe, undervalued, and unsupported, **LEADING TO** poor staff morale, disengagement, low retention and impacts on patient safety and care.		safe and have a sense of belonging.		**AUG**	**SEP**	**OCT**	**NOV**					
				DEC	**JAN**	**FEB**	**MAR**					
SR8 **IF** we are unable to prioritise and fund digital opportunities, **THEN** we will have insufficient capacity and capability to deliver the digital strategy, **LEADING TO** system failures, patient harm and increased cost.	Technology transformation	We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.		**APR 20**	**MAY**	**JUN**	**JUL**	**25**	**20**	**15**	**TBC**	**TBC**
				AUG	**SEP**	**OCT**	**NOV**					
				DEC	**JAN**	**FEB**	**MAR**					

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 **15**
Strategic Risk No. 1:		
If we have insufficient clinical workforce capability or ineffective equipment and vehicles	***Then*** we will fail to provide safe and effective care	***Leading to*** poor clinical outcomes.

	Impact	Likelihood	Score	Risk Trend
Inherent	5	4	20	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**5**	**3**	**15**	
Target	3	3	9	

Risk Lead	Helen Young, Chief Nursing Officer John Black, Chief Medical Officer	Assurance committee	Quality & Safety Committee

Controls	Assurance
• Clinical 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 • Continuous Professional Development 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 KPIs • Operational escalation procedures (e.g., OPEL, REAP) • Internal training for new paramedics • Equipment training logs	**First and second line (internal) assurances)** Reports to: • Quality & Safety Committee • Patient safety group • Clinical review group • Medicines optimisation and governance group • Workforce Development Board • Integrated workforce planning groups • Medical devices review group • Emergency & Urgent Care Clinical Governance Committee • Infection prevention and control committee • Safeguarding committee **Third line (external) assurances** • Internal Audits • CQC Inspections • Clinical Governance Audits • Commissioner contract review meetings
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Real-time tracking of clinical equipment and medicines • Workforce shortages • Process for developing rotas/review of rotas • Delayed operational responses • Spikes in demand • Handover delays • Variability in pathways • Clinical to digitalise software shifts • No Clinical Safety Officer • Education aspects	• Procure system for managing safe deployment and maintenance of equipment • Implementation of the Patient Safety Strategy from NHS England and the associated Patient Safety Incident Response Framework (PSIRF) to replace the existing Serious Incident policy and process. • New centralised logistics hub being set-up including medicines management (September 2023) • System engagement • Recruitment of clinical safety officer

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

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:	

If we do not have or use effective operational delivery systems	***Then*** we may not be able to meet demand and provide a responsive service to patients in need of emergency care	***Leading to*** delays in treatment ~~escalation of care, operational inefficiency~~ and increased morbidity and mortality.

	Impact	Likelihood	Score	Risk Trend
Inherent	5	4	20	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**5**	**4**	**20**	
Target	5	2	10	

Risk Lead	Paul Kempster, Chief Operating Officer Helen Young, Chief Nursing Officer John Black, Chief Medical Officer	Assurance committees	Finance and performance committee Quality & Safety Committee

Controls	Assurances
• 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 • Collaborative operational management • Cat. 2 response segmentation • Effective local and regional escalation	**First and second line (internal) assurances** Reports to: • Emergency & Urgent Care Boards • Quality & Safety Committee • Integrated performance report • Service Delivery Board • Operational management improvement board **Third line (external) assurances** • ICS system management across region • National performance standards • PTS contractual standards
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Insufficient clinical advisory support (e.g., 111, 999) • Quality Improvement Process and Culture	• Develop a forecast versus actual report based on experience adjusted models

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

Objective 2: Partnership & Stakeholder Engagement: We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans		Risk score **20**
Strategic Risk No 3:		
If the organisation fails to engage or influence within systems	***Then*** there may be a disproportionate focus in one system over the others and capacity provided may not align with expectations	***Leading to*** performance that is not achievable or credible and possible poor outcomes for patients and the communities we serve.

	Impact	Likelihood	Score	Risk Trend
Inherent	5	5	25	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**5**	**4**	**20**	
Target	2	2	4	

Risk Lead	Mike Murphy, Executive Director of Strategy	Assurance committee	Finance and Performance Committee

Controls	Assurances
• Attendance at Integrated Care Systems boards • Attendance at local resilience forums • Attendance at relevant Multi Agency Safeguarding Hub • Urgent & Emergency Care Boards • SCAS membership on Hampshire & IOW ICB committee • SCAS are included in the development of ICB processes, including how risks and issues are escalated across the systems • Attendance at system contract negotiations • System development • Attendance at ICB/Region director meetings	**First and second line (internal) assurances** Reports to: • Finance and Performance Committee • System development board • Monthly report to Board on system activity **Third line (external) assurances** • Monthly tripartite meetings which provides oversight and assurance regarding the Trust's position and performance and includes representation at the provider, ICB, CQC and NHSE/I level
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
No SCAS membership on any ICB boards ICB coordination for contracts Capacity to attend director meetings	• Establish reporting mechanisms from system groups • HIOW to establish coordinated ambulance commissioning group to include other ICS stakeholders

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

Objective 2: Partnership & Stakeholder Engagement: We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans	Risk score **12**
Strategic Risk No. 4:	

If we fail to engage with stakeholders and partners	***Then*** partners will fail to understand who we are and what we do	***Leading to*** failure to innovate and influence and an inability to identify opportunities within systems.

	Impact	Likelihood	Score	Risk Trend
Inherent	3	4	12	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**3**	**4**	**12**	
Target	2	3	6	

Risk Lead	Mike Murphy, Executive Director of Strategy	Assurance committee	Finance and Performance Committee, Trust Board

Controls	Assurances
• Stakeholder management plan • Attendance at Integrated Care Systems boards • Attendance at local resilience forums • Attendance at relevant Multi Agency Safeguarding Hub • Emergency & Urgent Care Boards • Attendance at system strategy groups • System strategy initiatives	**First and second line (internal) assurances)** Reports to: • Finance and Performance Committee • Trust board **Third line (external) assurances**
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Evidence of influence and change in ICS priorities and spend • Provision of senior executive expertise • Capacity to engage – impacted by clashes and meeting overlap across systems	• SCAS-led strategy workshop in Hampshire and the Isle of Wight (in progress) • Consider actions for other systems as above

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

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 **20**
Strategic Risk No. 5:			
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	***Leading to*** additional pressures on our ability to deliver a sustainable financial plan and safe services.	

	Impact	Likelihood	Score	Risk Trend
Inherent	4	5	20	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**4**	**5**	**20**	
Target	4	4	16	

Risk Lead	Aneel Pattni, Chief Finance Officer	Assurance committee	Finance and Performance Committee

Controls	Assurances
• Standing financial instructions and standing orders • Planning and approval process for the Trust's budget • Budgetary management and regular reporting process – act vs plan process • Long term financial planning • Access to national funding for emergency related activity • Budget holders have agreed budgets, including cost improvement programme targets to deliver efficiencies • Alignment with ICB financial plans • Quality Impact Assessment process	**First and second line (internal) assurances** • Finance and Performance Committee • Audit Committee • Executive Management Team meeting • Finance reports • Integrated Performance Report • CIP Quality and staff Impact Assessments **Third line (external) assurances** • External audit • Internal audit • Counter fraud • Commissioners • HIOW ICB
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Unidentified and in-progress plans to deliver cost improvement programme targets • Lack of agreement on key supplier and commissioning contracts • Limited assurance on specific financial assumptions (e.g., 23/24 AfC pay awards) • Unidentified costs to deliver approved strategies • Clear oversight of budget position and spend information • Lack of cost and productivity data/trends • Lack of benchmarking data	• Full-year cost improvement programme in development by the executive team (May 2023) • Negotiation and dialogue with key commissioners (June 2023) • Consider greater delegation of budgets • Clarification and confirmation of financial assumptions • Reporting on run rates etc

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

Objective 4: People & Organisation: We will develop plans to deliver inclusive, compassionate culture where our people feel safe and have a sense of belonging.	Risk score **20**
Strategic Risk No.6:	

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	Risk Trend
Inherent	5	4	20	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**4**	**4**	**20**	
Target	4	3	12	

Risk Lead	Melanie Saunders, Chief People Officer	Assurance committee	People and Culture Committee

Controls	Assurances
• Integrated Workforce Plans for the Trust, including the delivery of a 5-year workforce plan • Workforce reporting (e.g., sickness absence, staff survey, turnover) • 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	**First and second line (internal) assurances)** Reports to: • People and Culture committee • Integrated performance report • Workforce Development Board • Integrated workforce planning groups **Third line (external) assurances** • Commissioner reporting (to ICBs) • Internal audit (BDO) • OFSTED • NHSE/HEE quality assurance visits
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Paramedic rotation • Rota reviews designed to improve work life balance and aid retention and personal development • Design of clear career development pathways • Talent programme • Staff wellbeing metrics • Systematic use of NED and Exec feedback after visits and staff interaction	• Rota review • Develop/review existing career development pathways • Development of talent management and development programme (currently draft) • Explore/review Paramedic Rotation schemes. • Development of improvement plan to increase employee retention rates (currently draft)

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

Objective 4: People & Organisation: We will develop plans to deliver inclusive, compassionate culture where our people feel safe and have a sense of belonging.	Risk score **16**
Strategic Risk No. 7:	

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	Risk Trend
Inherent	4	5	20	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**4**	**4**	**16**	
Target	4	2	8	

Risk Lead	Melanie Saunders, Chief People Officer	Assurance committee	People and Culture committee

Controls	Assurances
• 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 • Communications strategy • Appraisal process	**First and second line (internal) assurances** Reports to • People and Culture committee • JNCC • Workforce Development Board • Staff networks • People Voice feedback • Equality & Diversity Steering Group • 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
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• Support for disabled workforce and other protected characteristics • Lack of peer reviews • Consistent approach to QI/service improvement/transformation	• WRES/WDES Improvement Plans • Delivery of our Sexual safety charter and associated plan • Delivery and embedding Freedom to speak up improvement plan • Delivery and embedding Culture improvement plan • Support of Staff Networks • QI innovation and culture relaunch

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

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. 8:	

If we are unable to prioritise and fund 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	Risk Trend
Inherent	5	5	25	*In future editions this box will include a trend line showing how the score of the risk has changed from month to month*
Current	**5**	**4**	**20**	
Target	5	3	15	

Risk Lead	Jill Lanham, Chief Digital Officer	Assurance committee	Finance and Performance Committee

Controls	Assurances
• Digital strategy • Project prioritisation process through Executive Transformation Board reporting to EMT • Regular digital programme portfolio reporting to executive transformation board • Project management structures in place • Fixed assets/capital committee reporting to EMT • Compliance with cyber security standards	**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
Gaps in Controls and Assurances	**Actions to address control / assurance gaps**
• No KPIs in place • Annual planning cycle • Regular reporting on digital strategy at board level • No asset management software in place to alert on hardware and software which is reaching end of life • Fixed Asset Management Steering Group reporting • Information Technology Infrastructure Library processes • Service desk software which no longer meets organizational needs • Costing strategy	• Develop regular reporting into Finance and Performance committee • Develop KPIs (ongoing) • Develop annual planning cycle to map resources and plan capacity for digital resource (ongoing) • New service desk software awaiting budget approval • Reintroduce digital steering group • Clarify governance structure for digital resulting from the introduction of Finance and Performance Committee and addition of Chief Digital Officer to the Executive team.

Current status – notes

Associated Risks on the Operational Risk Register		
Risk no.	Description	Current score

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BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**Volunteer Story**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**8.0**	
Executive Summary:	Bob Davy, Volunteer Community First Responder, was dispatched to a situation which had previously been identified as unsuitable for solo response. Upon arrival on scene Bob was presented with a patient who had previously been known to 'drawn weapons'. Bob will share his story, along with learning and subsequent support offered during our Public Board session.			
Recommendations:	The Trust Board is asked to note this presentation			
Executive lead:	Melanie Saunders, Chief People Officer			
Report author:	Volunteer Story, presented by Bob Davy			
Previously considered by:	N/A			
Purpose of report:	Note ☒	Approve ☐	Assure ☐	
Paper Status:	Public ☒	Private ☐	Internal ☐	
Assurance level:	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
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Strategic Objective(s):	All strategic objectives			
Links to BAF risks: (or links to the Significant Risk Register)	Risk 3 - Culture and staff experience			
Quality Domain(s):	All Quality Domains			
Next Steps (what actions will be taken following agreement of the recommendations):				
List of Appendices:				

BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**Integrated Performance Report (April 2023 Development Version)**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**9.0**
Executive Summary:	The Integrated Performance Report (IPR) is a significant document for the Trust reporting on, and providing assurance of, Trust performance and improving governance. This document is also published to the public domain hence accuracy and clarity are critical. The need to redevelop the IPR was identified by both the CQC and our subsequent independent governance review not with standing the fact that it had remained unchanged for some years. There were a number of concerns that were raised that are presented in other documents and following discussion at Board in October 2022 a project was established to redevelop the IPR. In addition to the document itself, the project was defined to include communication and learning activities for those staff and members of the Board who would be expected to use the new document given that new methods of reporting were to be included (e.g. SPC etc). This IPR presented to Trust Board (Part 1) presents the revised version which is still in development and amendments will be made over the coming months. This Month 1 document contains live data, commentaries and conclusions and will therefore form a key part of the Part 1 agenda. The format and content of the document will be expected to change considerably as it becomes established and its use understood. A version of this document was presented to the Finance & Performance Committee. This version has been updated and includes additional data, a revised commentary and additional explanatory information.		

	The Trust is working with both NHSE representatives and a development consultancy to develop this document. In part, the purpose of presenting this document in this format is to collect comments, observations and suggestions that will inform the next iteration. It is recommended that a process of continuous improvement be adopted during 2023/24.			
Recommendations:	Board is asked to note the document.			
Executive lead:	Mike Murphy, Chief Strategy Officer			
Report author:	Mike Murphy, Chief Strategy Officer			
Previously considered by:	Previously considered by the Improvement Oversight Board, the full SCAS Board (March 2023) and the Finance & Performance Committee (May 2023)			
Purpose of report:	Note ☒	Approve ☐	Assure ☐	
Paper Status:	Public ☒	Private ☐	Internal ☐	
Assurance level:	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

Justification for the above 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:

This document is in development and has been delayed slightly resulting in some incomplete data/commentaries. This will be rectified in time for the Month 2 report which will be compiled in June 2023.

Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	All BAF risks
Quality Domain(s):	All Quality Domains

Next Steps (what actions will be taken following agreement of the recommendations):

- Continued development of the IPR
- Confirmation of the broader project plan
- Presentation of the next iteration at June Board Seminar

List of Appendices:

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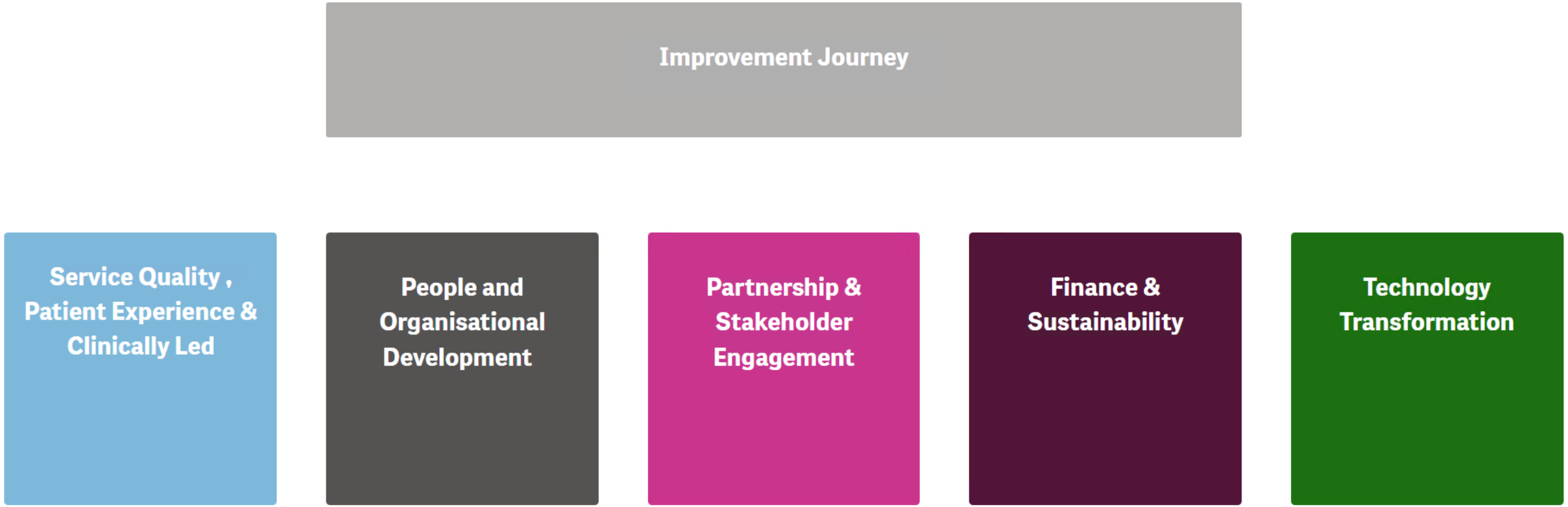
Integrated Quality and Performance Report: Apr-23

Alignment Framework



EXECUTIVE COMMENTARY

Metrics with targets that lack assurance

Figures for April suggest that there is no assurance against the targets that have been set for the following metrics; which may not therefore be achievable.

1. Hospital Delays are targeted at 0 hours when in April the number of hours lost was 3,301. This is consistent with the average for previous months. The target for this metric should be reviewed as either in error or unrealistic.
2. Meal break compliance showed improvement in April at 63% compared with the average over the last 12 months of 60% however, the target for this metric is 85% which, given the minimal movement towards it in April may not be realistic.
3. PTS Calls answered in 60 seconds, which are contractually obliged and planned at 90% were 69% in April. This was slightly lower than the 12 month average. In the main this performance was due to staffing levels and technology issues and will also be influenced by a need to meet financial targets going forwards.
4. See, Treat and Convey (Non ED 1&2) has a target of 5.4% of calls but consistently delivers 4.4% and has done so for the last 12 months giving little indication that this will change despite the efforts of the operational teams. By contrast the figure for ED related calls (51% in April) exceeds the target (47.7%) due to the increased acuity of patients. The issue with this metric may be one of balance between the categories which will be investigated.
5. Total 111 Transfer to Clinician. Only 27% of calls transferred in April against a target of 50%. Over the last 12 months the average performance for this metric has remained at 29%. There is an issue however with recording and reporting actual performance; particularly of the IUC clinicians which is excluded from the data and may explain the low performance.
6. Appraisals trust wide currently stand at 89% in April against a target of 95%. This performance is an improvement against the 12 month average of 82% however. Appraisal rates have increased steadily from a low in December 2021 of 50% back up to 90% in January 2023. For the last 4 months however there has been no further improvement hence the concerns about assurance. performance has been hindered by high sickness but PDRs are being prioritised by staff and a new package to support this is due for rollout in the coming months.

Recruitment

EOC, Frontline and PTS recruitment is a concern with variance from target being only marginal and not enough to mitigate a risk to our ability to achieve our planned workforce levels.

Despite this EOC workforce in April was above target due to planned for sickness levels, and manageable attrition.

Frontline recruitment only achieved an additional 17 FTE compared with a total of 2,327 individuals recruited over the last 12 months. This lower performance in April was in part due to the timescales of courses and issues with C1 licences.

Low recruitment means that the PTS workforce still falls 50 FTE or 7.5% below target. PTS overall workforce has been in steady decline since April 2021 and now stands at 620 staff compared with the 740 at that time; a reduction of 16% at a time when acuity and demand have all increased which inevitably impacts the cost base of the business. PTS attrition is now split between internal (i.e. staff moving within SCAS) and external attrition. Attrition for April was broadly as expected with 17 members of staff moving internally and 6 leaving completely; the target was a total of 20. The movement of staff internally from PTS is both a benefit and risk to the organisation.

EXECUTIVE COMMENTARY (Continued)

Areas of potential concern

Our **clinical** metrics indicated increases against targeted times for STEMI and Stroke responses. These increases against target at this stage are not considered significant statistically but they do raise concerns in terms of our ability to support patients towards quick recovery and may also highlight deteriorating performance which will require investigation and mitigation if it continues.

Our metrics on **physical and non physical assaults** were also increased against target being 24 and 62 in April which is 3 and 12 higher respectively. Whilst this is not significant statistically at this stage it is a matter of some concern.

Hear and Treat variation is also low, with a performance of 10% in April against a target of 13%. H&T performance fell dramatically in January and remains low with little indication of improvement again suggesting a challenge to our ability to meet our target, however statistically the target is assured.

Statutory & Mandatory training figures for April 2023 were below target in all measures with the exception of safeguarding Level 3 (for which no target was set). The month figures will be subject to greater variation but reference to the 90 day average still suggests performance is below target particularly in the areas of Conflict Management and Safeguarding Level 3 where the expectation would be a target consistent with the other categories.

Metrics with targets that have assurance

The targets for 111 Call Answer in 120 seconds and PTS (Patients collected within time) are considered achievable. Whilst we have yet to hit our target our performance continues to improve, in the main due to increased logged in hours and lower sickness.

The PTS metric shows limited but positive variation from the target identifying consistency in performance. In April 92% of patients were collected within time against a target of 90%.

Other highlights

The results for Frontline Attrition were mixed but variance from the targets was not significant and should therefore be considered positive. Work to develop retention plans for 999 is now underway.

Similarly over runs greater than 30 minutes performed well against the target with a performance of 16% against a target of 33%. The figures for both missed breaks and over runs greater than 30 minutes improved significantly from January 2023 and remain low which will need to be explained with greater clarity.

Icon Descriptions

SPC Charts Explanation

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.

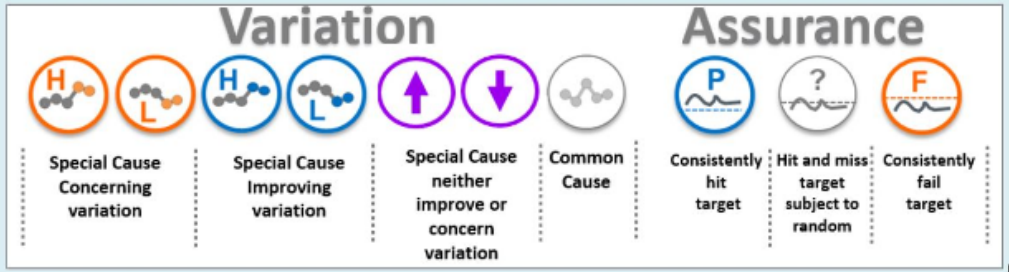
The rules

1) Any single point outside the process limits.
2) A run of 7 points above or below the mean (a shift), or a run of 7 points all consecutively ascending or descending (a trend).
3) 2 out of 3 points within 1 sigam of the upper or lower control limit
4) A large change in the moving range (greater that 3.27 * av moving range)

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 7 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 cautions if you do not know what changed the process.

Icon key



Icon Descriptions

			
	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 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 target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet 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 measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning 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 a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure 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.
			Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

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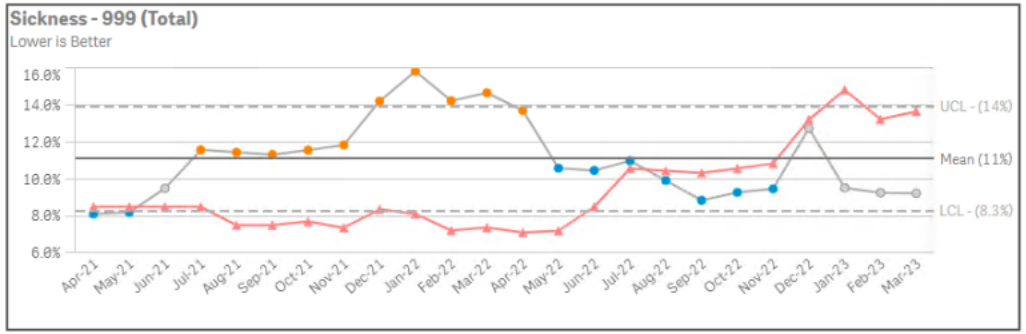
Assumptions:

The below SPC chart shows and example of the metric values per month. The points on the line are coloured orange, grey or blue in accordance with SPC guidelines.
A dashed red line shows the target for the metric, if there is one.
A red line with triangle markers shows the plan projected for the metric, if there is one.
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.



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Service Quality , Patient Experience & Clinically Led

Service Quality , Patient Experience & Clinically Led

Summary

Assurance

April-23 | **No Target**

Variance

				EOC Recruitment Frontline Recruitment H&T - SCAS PTS Recruitment
		Number of SI investigations outstanding after 60 days (excluding events that are officially suspended) SCAS 111 - ED Referrals		
	111 call answer in 120 Secs %	% Cat 1 resulting in LW (> 30 mins) % Cat 2 resulting in LW (> 60mins) % Cat 3 resulting in LW (> 3hrs) % Cat 4 resulting in LW (> 4 hrs) 111 Calls abandoned after 30 secs % 999 % calls from frequent callers 999 Calls abandoned % Building cleanliness completed audits Cardiac Arrest Survival, Utstein Cat 1 90th %ile SCAS Cat 1 Mean SCAS Cat 2 90th %ile SCAS Cat 2 Mean SCAS Cat 3 90th %ile SCAS Cat 4 90th %ile SCAS Clear up Delays - SCAS Complaints - 999 Total % Compliments % Hand Hygiene audit Missed Breaks - SCAS Number of cleanliness compliance audits Number of compliant Hand Hygiene audit Number of compliant Vehicle cleanliness audits Number of compliant cleanliness compliance audits Percentage of compliant Building cleanliness audits Percentage of compliant Hand Hygiene audits Percentage of compliant Vehicle cleanliness audits Percentage of compliant cleanliness compliance audits SCAS 111 - 999 referrals % ST&C (ED 1&2) - SCAS VOR - Other VOR - Planned Maintenance VOR - Total VOR - Unplanned Maintenance Vehicle cleanliness completed audits	Hospital Delays - SCAS Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds ST&C (Non-ED 1&2) - SCAS	111 Calls Offered 111 Complaints response - agreed timescale % 111 PHSO cases - upheld/partially upheld 111 Recruitment 111 Workforce 999 90th Percentile Call Answer Time 999 Complaints response - agreed timescale % 999 Mean Call Answer Time 999 PHSO cases - upheld/partially upheld Cardiac Arrest Post- ROSC care Cardiac Arrest Survival at 30 Days - All Patients Complaints - PTS % per 1,000 Incidents Number of DATIX incidents - non patient Number of DATIX incidents - patient Number of Serious Incidents (SI) reported Number of incidents moderate and above harm Number of no/low harm incidents PTS Complaints response - agreed timescale % PTS Internal Attrition PTS PHSO cases - upheld/partially upheld RIDDOR reportable incidents Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort STEMI - Care Sickness - 999 (Total) Sickness - PTS (Total) Stroke - Care Vehicle deep clean Compliance - A&E Vehicle routine cleans

		S&T - SCAS		EOC Workforce
	Patients Collected within time	EOC External Attrition EOC Internal Attrition Number of compliant Building cleanliness audits Over-runs >30 mins - SCAS Patients Arrived within time	Total 111 - Transfer to Clinician	111 Attrition 111 External Attrition 111 Internal Attrition EOC Attrition EOC Internal Attrition Frontline Attrition Frontline External Attrition Frontline Internal Attrition PTS Attrition PTS External Attrition PTS Workforce Sickness - 111 service (Total) Sickness - EOC (Total)
		Number of Non-Physical Assaults Number of Physical Assaults STEMI - Call to angiography 90th Centile STEMI Call to angiography - Mean Stroke - Call to Hospital arrival 90th Centile Stroke - Call to Hospital arrival Median Stroke Call to Hospital arrival - Mean		
		Number of Never Events (CQC/NRLS reportable)		999 Call Volume Activity (999 Incidents) - SCAS Incidents Growth 999 - SCAS

999 Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Cat 1 Mean SCAS	00:07:00	00:08:14	00:08:41	00:08:14	00:10:02		
Cat 1 90th %ile SCAS	00:15:00	00:15:10	00:15:47	00:15:10	00:18:01		
Cat 2 Mean SCAS	00:18:00	00:25:29	00:28:01	00:25:29	00:36:11		
Cat 2 90th %ile SCAS	00:40:00	00:50:58	00:55:48	00:50:58	01:13:45		
Cat 3 90th %ile SCAS	02:00:00	03:04:33	03:42:20	03:04:33	05:32:19		
Cat 4 90th %ile SCAS	03:00:00	04:21:06	05:11:00	04:21:06	07:01:15		
Vehicle deep clean Compliance - A&E	0%	87%	110.3%	87%	117%		n/a
Vehicle routine cleans	5,561	5,041	15,420	5,041	69,828		n/a
VOR - Unplanned Maintenance	13%	15%	15.3%	15%	14%		
VOR - Planned Maintenance	4%	2.8%	3.5%	2.8%	3%		
VOR - Other	7%	7.8%	7.9%	7.8%	9%		
VOR - Total	23%	25%	26.6%	25%	25%		

999 Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Activity (999 Incidents) - SCAS	52,289		97,553	0	611,460		n/a
Average Hospital Handover Time - SCAS	-		-	-	-	-	-
Clear up Delays - SCAS	00:15:00	00:15:08	00:14:58	00:15:08	00:16:23		
Hospital Delays - SCAS	0	3,301	9,890	3,301	60,664		
Incidents Growth 999 - SCAS	6%		-61.9%	-100%	-52%		n/a
Number of Accidents	-		-	-	-	-	-
S&T - SCAS	34%	34.5%	34.6%	35%	38%		
ST&C (ED 1&2) - SCAS	48%	50.8%	50.3%	51%	53%		
ST&C (Non-ED 1&2) - SCAS	5.4%	4.4%	4.3%	4.4%	4.4%		
Total Task Time - SCAS	-		-	-	-	-	-
-	-	-	-	-	-	-	-

999 Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Sickness - PTS (Total)	8.8%	8.4%	7.1%	8.4%	9.6%		n/a
Total Frontline Workforce	1,796	1,787	5,358	1,787	22,854		n/a
Frontline Recruitment	0	17	704	17	2,327		n/a
Complaints - 999 Total %	3.6%		0.0%	0%	0.052%		
Compliments %	26%		0.2%	0%	0.23%		
% Cat 1 resulting in LW (> 30 mins)	0.29%	0.48%	0.5%	0.48%	0.88%		
% Cat 2 resulting in LW (> 60mins)	2.7%	6.8%	8.6%	6.8%	14%		
% Cat 3 resulting in LW (> 3hrs)	4.9%	11%	15.2%	11%	25%		
% Cat 4 resulting in LW (> 4 hrs)	5.1%	11%	15.9%	11%	22%		
999 Complaints response - agreed timescale %	-	-	-	-	-		n/a
999 PHSO cases - upheld/partially upheld	-		-	-	-		n/a

999 Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
STEMI - Care	-	0.0%	05:00:28	-	05:11:03		n/a
STEMI Call to angiography - Mean	02:04	02:36:00	02:23:20	02:36:00	02:29:05		
STEMI - Call to angiography 90th Centile	02:53	03:40:00	03:28:00	03:40:00	03:27:55		
Stroke - Care	-	0.0%	00:00:00	-	05:52:55		n/a
Stroke Call to Hospital arrival - Mean	01:17	02:05:00	01:48:20	02:05:00	01:49:05		
Stroke - Call to Hospital arrival Median	01:07	01:36:00	01:27:40	01:36:00	01:30:00		
Frontline Attrition	22	19	621	19	2131		n/a
Frontline External Attrition	11	16	465	16	1549		n/a
Frontline Internal Attrition	11	3	156	3	583		n/a
Meal Break Compliance - SCAS	85%	63%	59.4%	63%	60%		
Missed Breaks - SCAS	5%	4.1%	3.9%	4.1%	5.6%		
Over-runs >30 mins - SCAS	33%	16%	16.5%	16%	29%		

999 Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Stroke - Call to Hospital arrival 90th Centile	01:57	03:26:00	02:56:40	03:26:00	02:53:35		
Cardiac Arrest Survival, Utstein	26%	24.2%	33.6%	24%	34%		
Cardiac Arrest Post- ROSC care	-	0.0%	0.0%	0.0%	74.0%		n/a
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients	-	-	-	-	-		n/a
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort	-	-	-	-	-		n/a
Cardiac Arrest Survival at 30 Days - All Patients	-	-	-	-	-		n/a

Service Quality , Patient Experience & Clinically Led
999 Operations

2023-05-12 10:08:24

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*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Cat 1 Mean SCAS	00:07:00	00:08:14	00:08:41	00:08:14	00:10:02		
Cat 1 90th %ile SCAS	00:15:00	00:15:10	00:15:47	00:15:10	00:18:01		
Cat 2 Mean SCAS	00:18:00	00:25:29	00:28:01	00:25:29	00:36:11		
Cat 2 90th %ile SCAS	00:40:00	00:50:58	00:55:48	00:50:58	01:13:45		
Cat 3 90th %ile SCAS	02:00:00	03:04:33	03:42:20	03:04:33	05:32:19		
Cat 4 90th %ile SCAS	03:00:00	04:21:06	05:11:00	04:21:06	07:01:15		

Key Observations:

Overperformed against trajectories.

Reasons & Rationale:

Despite activity/ response demand being over fixed (no growth) budget overall frontline hours were above plan due to lower abstraction particularly A/L targets being missed.

Improvement Actions:

Hours being actively reduced - OT and Bank hours restricted, Private Provider Hours capped at Core, A/L allocated to bring hours in line.

Service Quality , Patient Experience & Clinically Led
999 Operations

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*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Vehicle deep clean Compliance - A&E	0%	87.0%	110.3%	87%	117%		n/a
Vehicle routine cleans	5,561	5,041	15,420	5,041	69,828		n/a
VOR - Unplanned Maintenance	13%	-	15.3%	15%	14%		
VOR - Planned Maintenance	4%	-	3.5%	2.8%	3%		
VOR - Other	7%	7.8%	7.9%	7.8%	9%		
VOR - Total	23%	25.3%	26.6%	25%	25%		
Number of Accidents	-		-	-	-	-	-

Key Observations:

VOR unplanned and other continues to be above plan. Make Ready and deep clean compliance below target.

Reasons & Rationale:

VOR other is driven by accident repairs and supply chain issues in Bodyshops. VOR unplanned is driven by increasing age profile of DCA fleet due to delays with new vehicles and supply chain issues. Delays in vehicle movements is also impacting VOR. Make Ready and deep clean compliance driven by Churchill vacancies in Hampshire.

Improvement Actions:

Plan in review to utilise alternative duties staff to assist with vehicle movements and data review underway to develop predicted demand for VOR to pre-emptively order parts to mitigate delays with supply chain. New DCAs due to start arriving in September with all 135 DCAs due by end of March 2024. Make Ready Contract review process now includes recruitment update.

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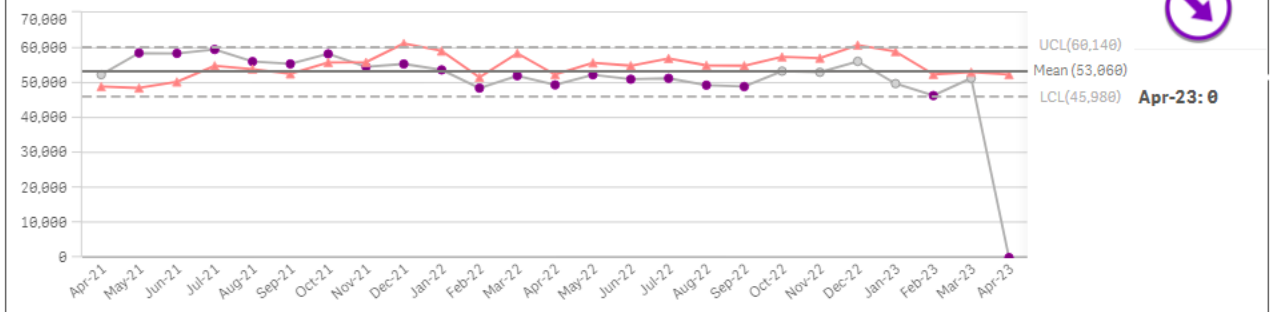
Activity (999 Incidents) - SCAS

N/A



*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Incidents Growth 999 - SCAS	6%	-	-61.9%	-100%	-52%		n/a

Key Observations: Demand remains below plan but within Control Limits	Reasons & Rationale:	Improvement Actions:

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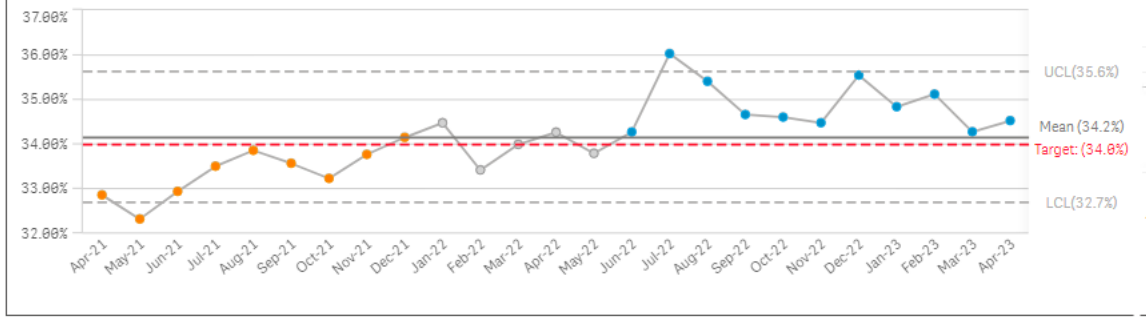
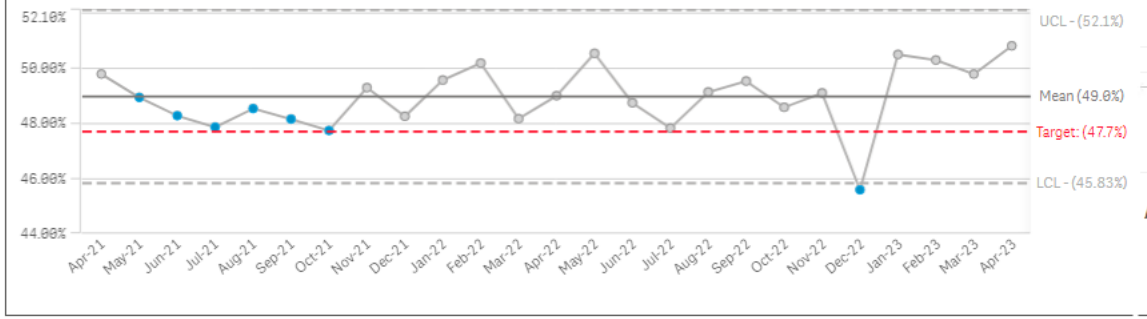
S&T - SCAS
Higher is Better. Target differed in previous years



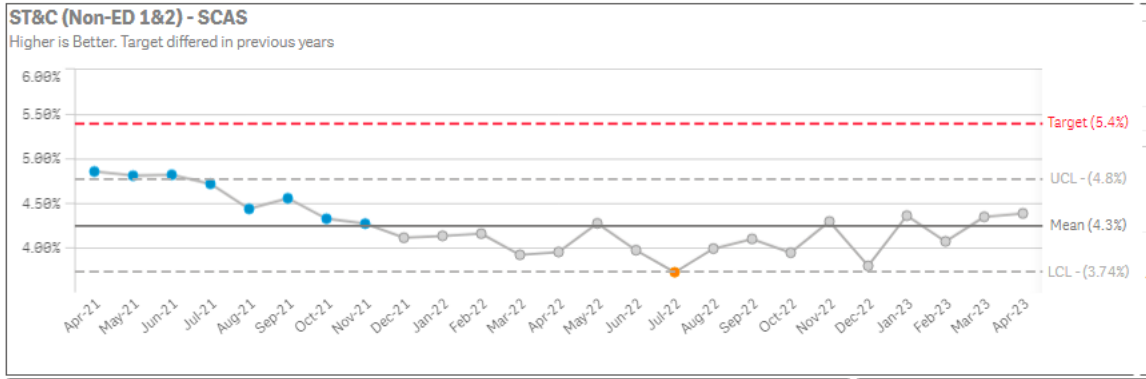
Apr-23: 35%

ST&C (ED 1&2) - SCAS
Lower is Better. Target differed in previous years



Apr-23: 51%

ST&C (Non-ED 1&2) - SCAS
Higher is Better. Target differed in previous years



Apr-23: 4.4%

Key Observations:See and Treat remains the focus of Operational staff to seek alternative pathways for patients. Increase in acuity has seen an increase in the ST&C percentage	Reasons & Rationale:	Improvement Actions:

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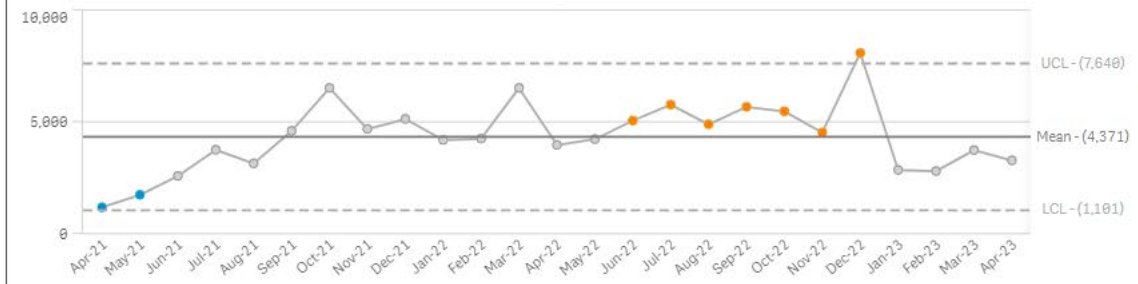
Hospital Delays - SCAS
Lower is Better

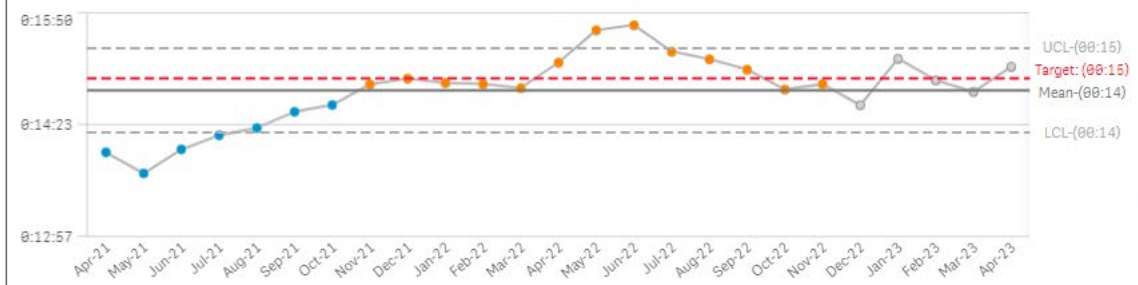


Apr-23: 3,301

Average Hospital Handover Time - SCAS
N/A

There is currently no data to display for this metric.

Clear up Delays - SCAS
Lower is Better



Apr-23: 00:15

Total Task Time - SCAS
N/A

There is currently no data to display for this metric.

Key Observations: Clear Up delays remain slightly above average. Handover delays continue to perform below the mean	Reasons & Rationale:	Improvement Actions: Clear up delays continue to be a focus with local management teams

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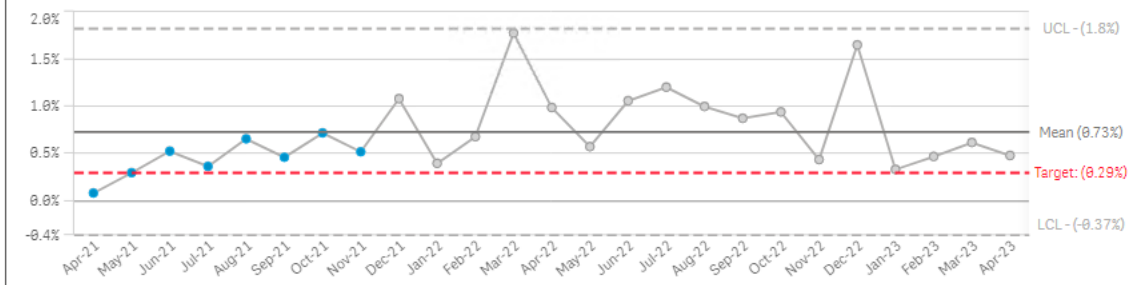
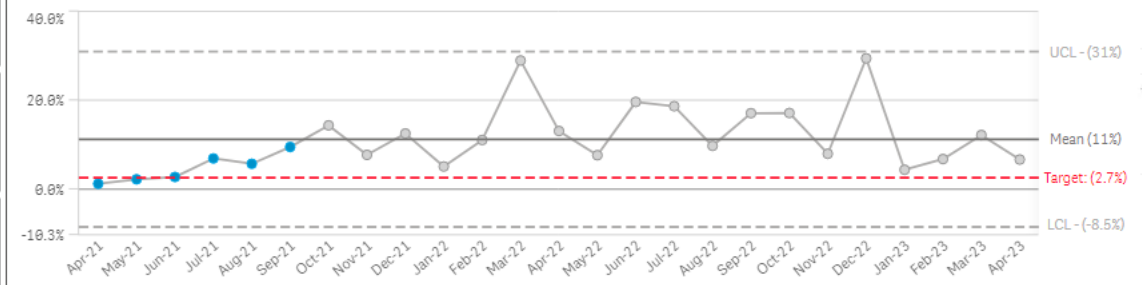
% Cat 1 resulting in LW (> 30 mins)
Lower is Better



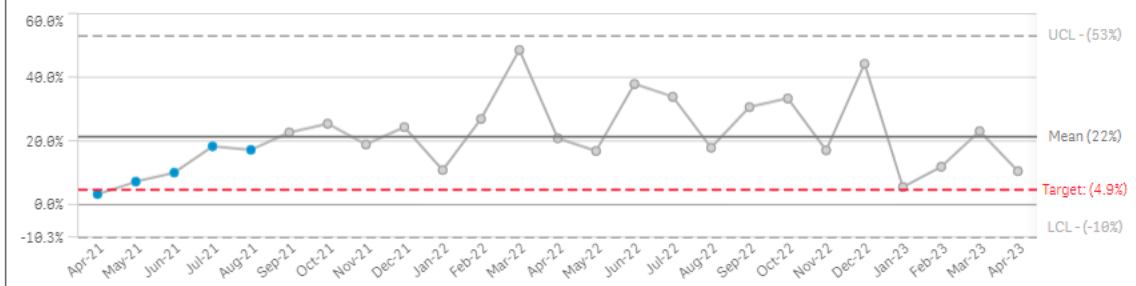
Apr-23: 0.48%

% Cat 2 resulting in LW (> 60mins)
Lower is Better



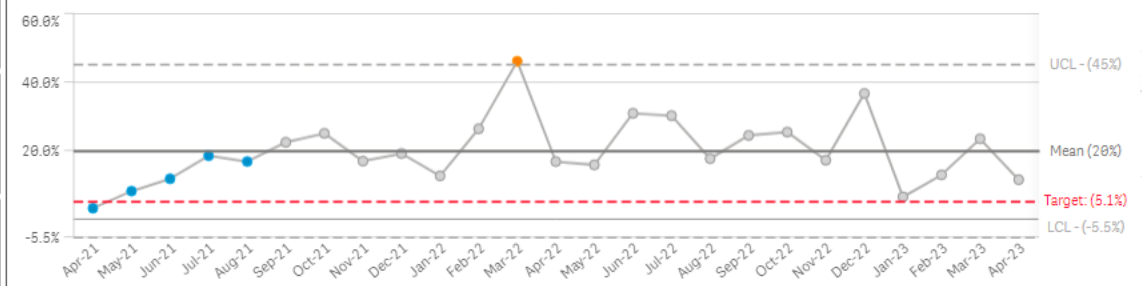
Apr-23: 6.8%

% Cat 3 resulting in LW (> 3hrs)
Lower is Better



Apr-23: 11%

% Cat 4 resulting in LW (> 4 hrs)
Lower is Better



Apr-23: 11%

Key Observations:Long waits below the mean against all categories	Reasons & Rationale:	Improvement Actions:

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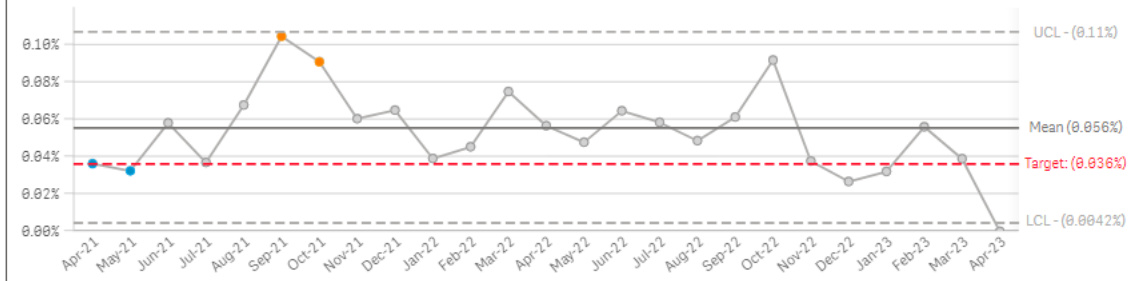
999 Complaints response - agreed timescale %
N/A

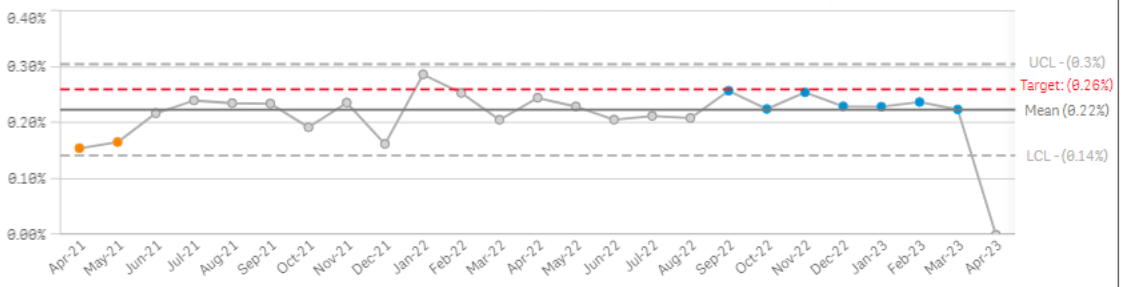
There is currently no data to display for this metric.

Complaints - 999 Total %
Lower is Better



Apr-23: 0%

Compliments %
Higher is Better. Target differed in previous years



Apr-23: 0%

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
999 PHSO cases - upheld/partially upheld	-	-	0.0%	0%	0%		n/a

Key Observations:	Reasons & Rationale:	Improvement Actions:

Service Quality , Patient Experience & Clinically Led
999 Operations

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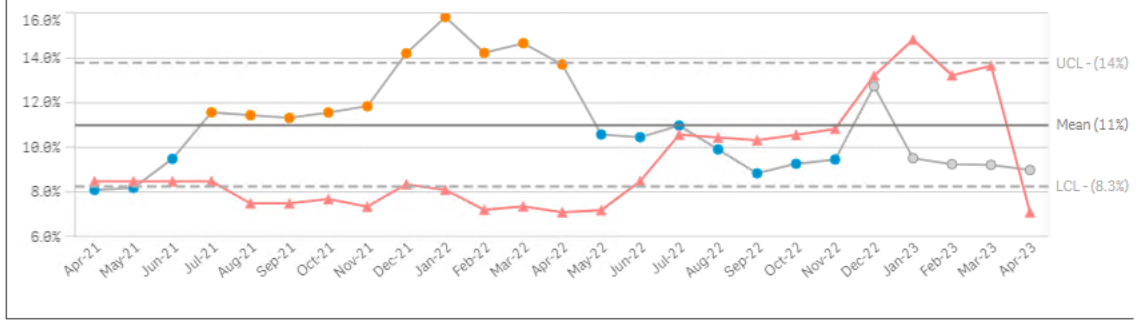
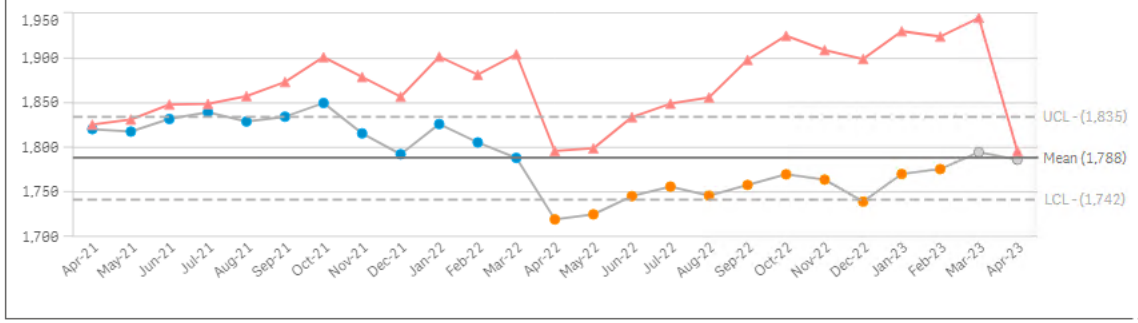
Sickness - 999 (Total)
Lower is Better



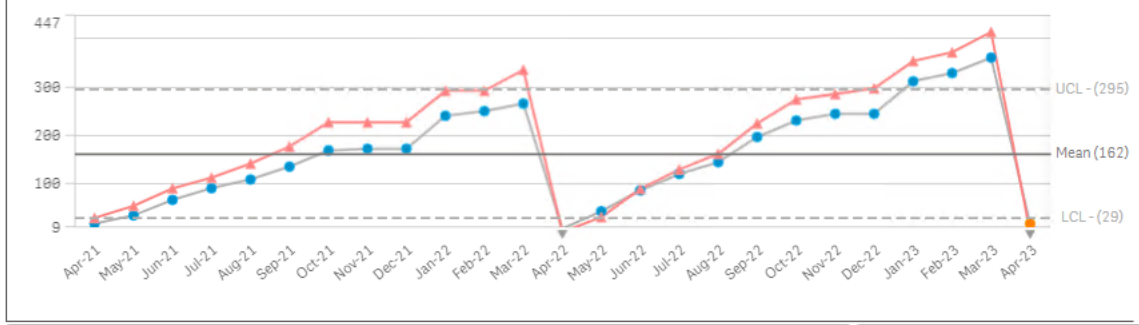
Apr-23: 9.0%

Total Frontline Workforce
Higher is Better



Apr-23: 1,787

Frontline Recruitment
Higher is Better



Apr-23: 17

Key Observations:Recruitment was slightly down as were the workforce numbers.	Reasons & Rationale: The Apprentice AAP course was not filled as expected due to issues with C1 licences and timescales. We are also trying to balance our ECA and clinician numbers so only filled 9 out of 12 ECA spaces this month.	Improvement Actions: Next apprentice course will have a robust attraction plan with enough time to deliver. ECA courses will continue to be monitored until our clinician numbers start to rise. We are reviewing the plan currently for the rest of the year to make sure it is as balanced and appropriate as possible to maximise opportunities.

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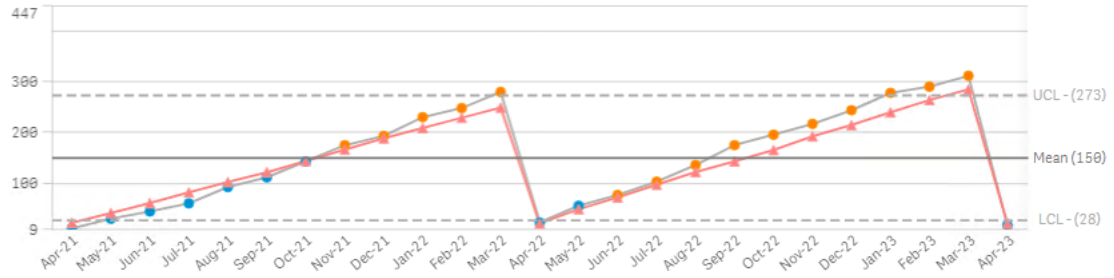
Frontline Attrition

Lower is Better



Apr-23: 19

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Frontline External Attrition	11	16	465	16	2,547		n/a
Frontline Internal Attrition	11	3	156	3	1,278		n/a

Key Observations: Frontline attrition was 18.7 WTE which is lower than forecast

Reasons & Rationale:

Improvement Actions: 999 have a retention group established and are working up a local retention plan

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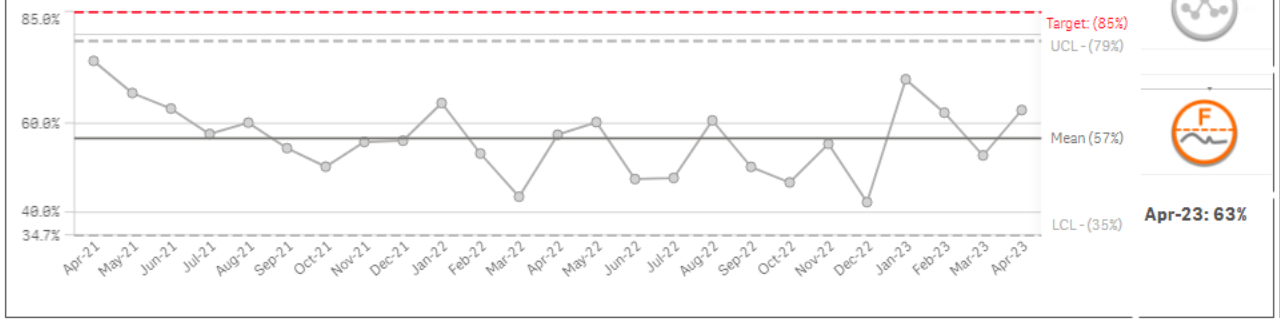
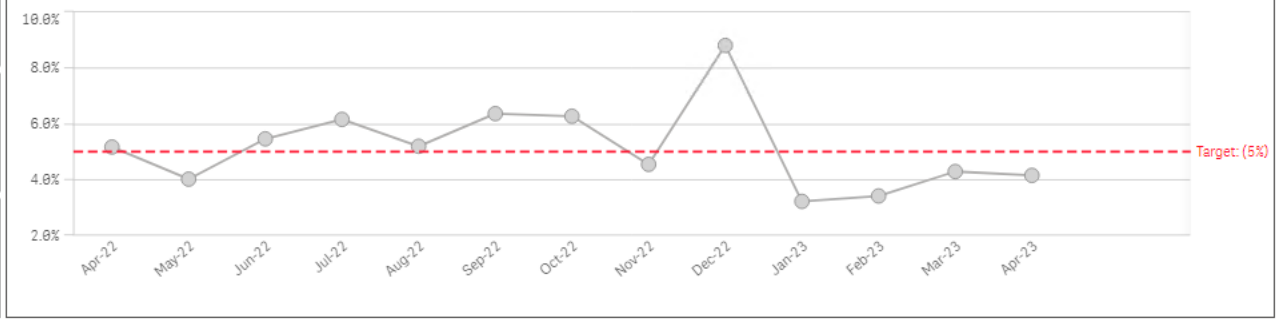
NHS South Central Ambulance Service NHS Foundation Trust

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

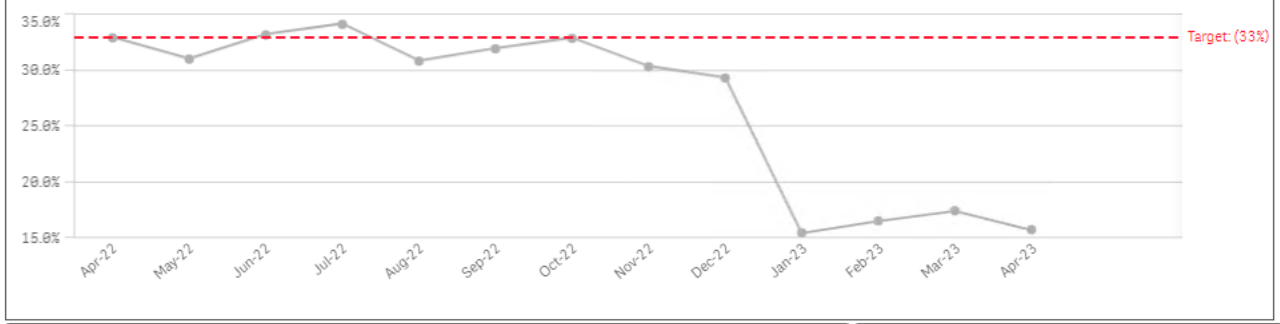


Apr-23: 63%

Missed Breaks - SCAS
Lower is Better. Target differed in previous years



Over-runs >30 mins - SCAS
Lower is Better. Target differed in previous years



Key Observations: Meal Break Compliance remains at the mean levels, missed breaks has been below target for the last two months, and over runs have halved for the last four months	Reasons & Rationale:	Improvement Actions:

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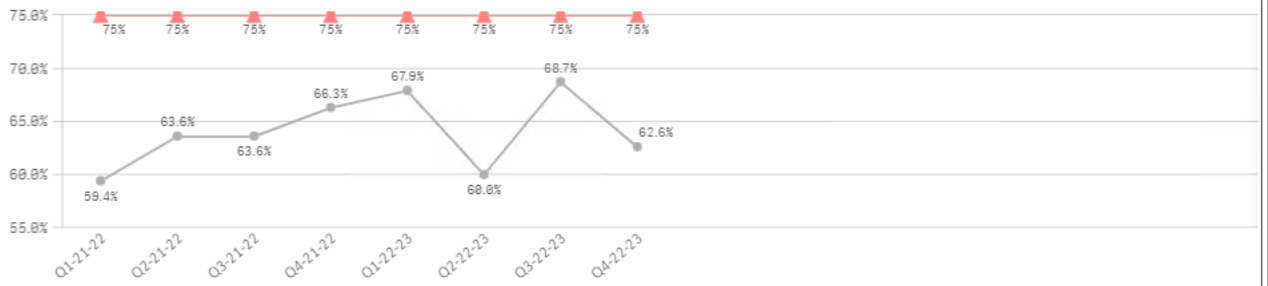
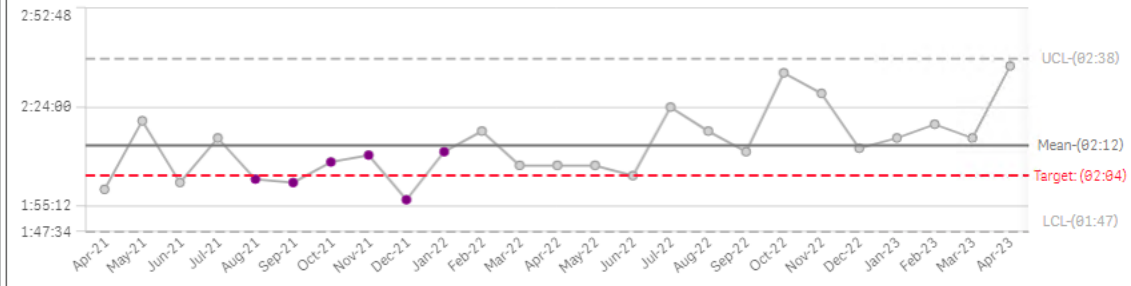
STEMI - Care
Higher is Better

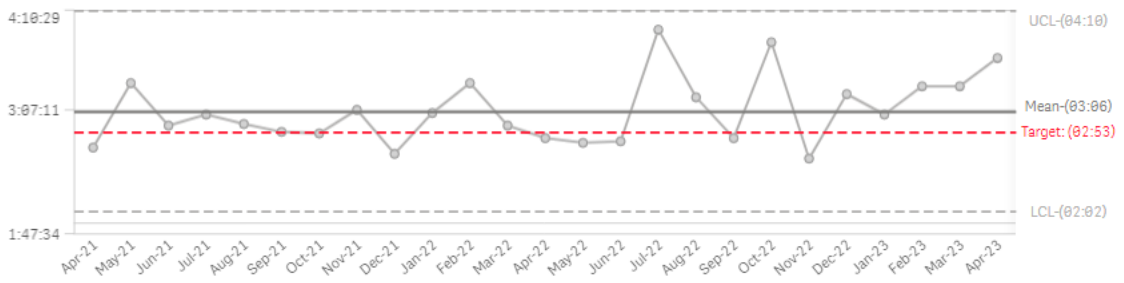


STEMI Call to angiography - Mean
N/A. Target differed in previous years



Apr-23: 02:36:00

STEMI - Call to angiography 90th Centile
N/A. Target differed in previous years



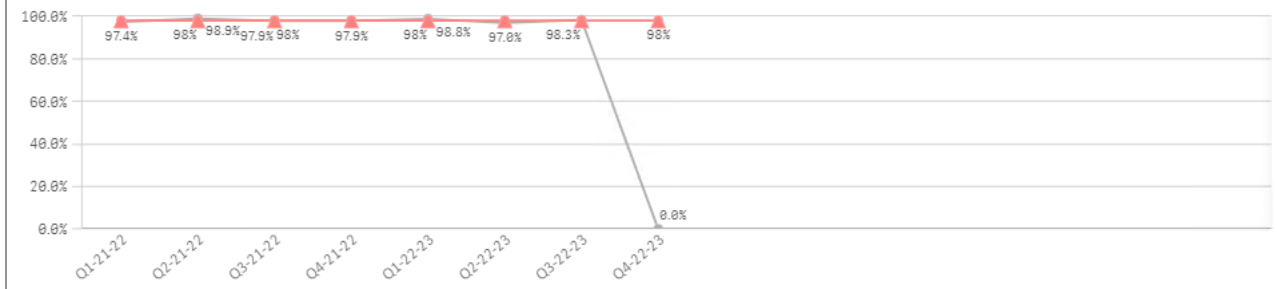
Apr-23: 03:40:00

Key Observations: Latest data shows the performance delivered in December 2022. Mean and 90th percentile response time increased from previous levels, reflecting the severe operational pressures that were experienced at the time	Reasons & Rationale:	Improvement Actions:

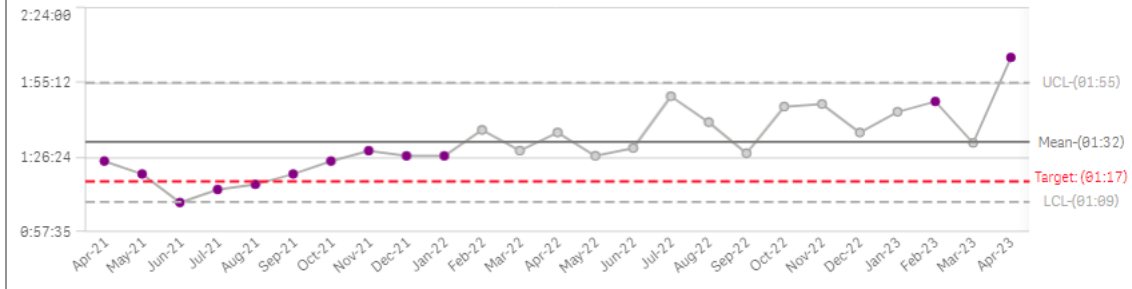
Service Quality , Patient Experience & Clinically Led
999 Operations

NHS South Central Ambulance Service NHS Foundation Trust

Stroke - Care
Higher is Better

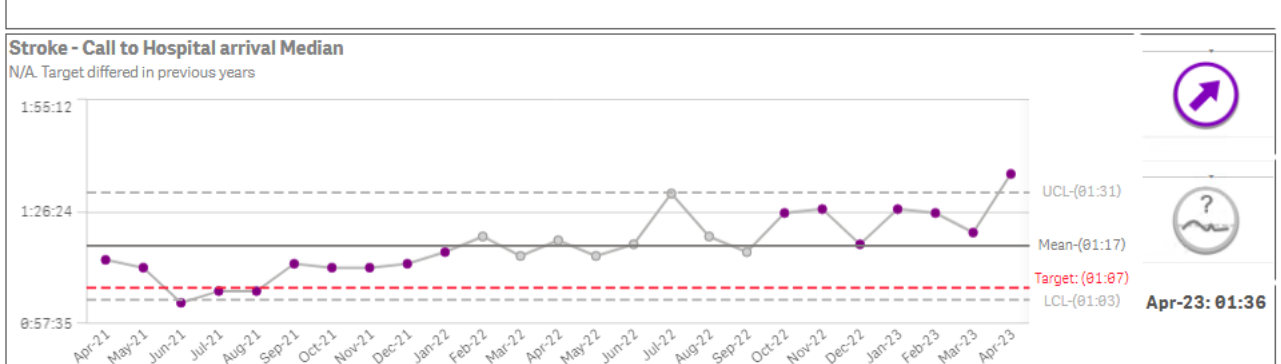


Stroke Call to Hospital arrival - Mean
N/A. Target differed in previous years



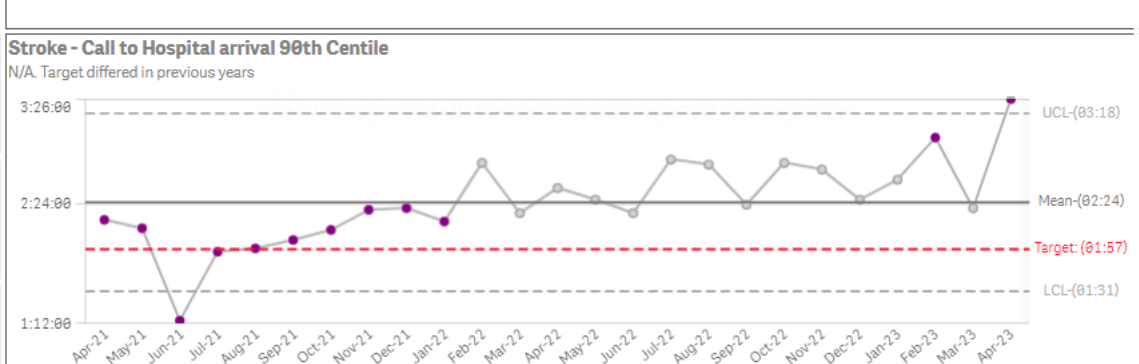
Apr-23: 02:05

Stroke - Call to Hospital arrival Median
N/A. Target differed in previous years



Apr-23: 01:36

Stroke - Call to Hospital arrival 90th Centile
N/A. Target differed in previous years



Apr-23: 03:26

Key Observations: Latest data shows the performance delivered in December 2022. Mean and 90th percentile response time increased from previous levels and exceeded the Upper Control Limits, reflecting the severe operational pressures that were experienced at the time	Reasons & Rationale:	Improvement Actions:

Service Quality , Patient Experience & Clinically Led 999 Operations

NHS South Central Ambulance Service NHS Foundation Trust

Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients

N/A

There is currently no data to display for this metric.

Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort

N/A

There is currently no data to display for this metric.

Key Observations:	Reasons & Rationale:	Improvement Actions:

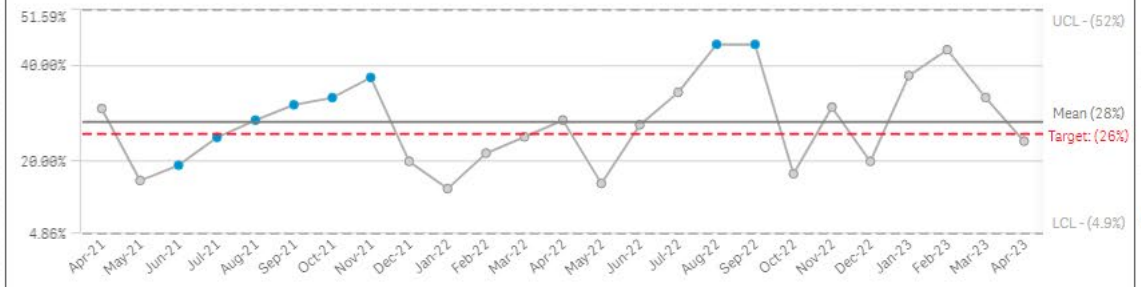
Service Quality , Patient Experience & Clinically Led
999 Operations

NHS South Central Ambulance Service NHS Foundation Trust

Cardiac Arrest Survival at 30 Days - All Patients
N/A

There is currently no data to display for this metric.

Cardiac Arrest Survival, Utstein
Higher is Better. Target differed in previous years



Apr-23: 0.24%

Cardiac Arrest Post- ROSC care
Higher is Better

Key Observations: Quarterly position was not expected this month

Reasons & Rationale:

Improvement Actions:

Clinical Coordination Centre

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Sickness - EOC (Total)	6.8%	6.6%	0.1%	6.6%	9%		n/a
999 % calls from frequent callers	5%	5%	3.9%	5%	3%		
999 Call Volume	0	59,700	187,010	59,700	926,173		n/a
999 Calls abandoned %	2%	3.2%	5.1%	3.2%	8%		
EOC Workforce	264	301	869	301	3,561		n/a
EOC Recruitment	13	16	399	16	1,386		n/a
EOC Attrition	9	12	331	12	1,103		n/a
EOC Internal Attrition	20	5	125	5	434		
EOC External Attrition	35	7	207	7	669		
999 Mean Call Answer Time	-		-	-	-	-	-
999 90th Percentile Call Answer Time	-		-	-	-	-	-

Clinical Coordination Centre

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Sickness - 111 service (Total)	9.6%	0.062%	0.1%	0.062%	0%	L	n/a
111 Calls Offered	124,807	132,109	378,494	132,109	1,746,316		n/a
111 call answer in 120 Secs %	95%	66%	50.8%	66%	48%		P
SCAS 111 - 999 referrals %	10%	8.5%	9.2%	8.5%	10%		?
Total 111 - Transfer to Clinician	50%	27%	26.2%	27%	29%	L	F
111 Calls abandoned after 30 secs %	3%	6.5%	9.5%	6.5%	15%		?
SCAS 111 - ED Referrals	7.5%	12%	11.6%	12%	11%	H	?
111 Workforce	329	285	836	285	3,575		n/a
111 Recruitment	28	20	377	20	1,214		n/a
Complaints - 111 Service %	0.01%		0.0%	0%	0%		n/a
111 Complaints response - agreed timescale %	-		-	-	-	-	-
111 PHSO cases - upheld/partially upheld	-		-	-	-		n/a

Clinical Coordination Centre

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
111 Recruitment	28	20	377	20	1,214		n/a
111 Internal Attrition	4	6	135	6	509		n/a
111 External Attrition	13	10	307	10	1,088		n/a

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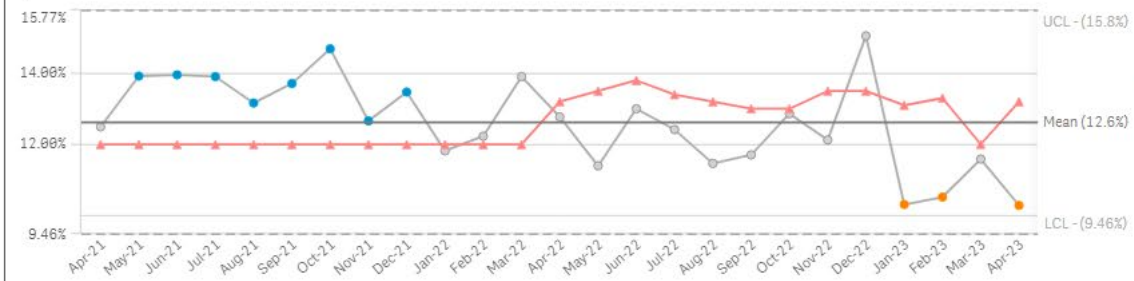
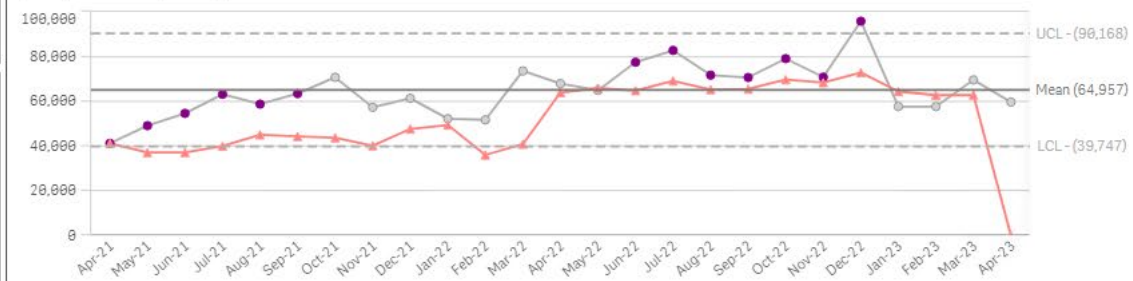
H&T - SCAS
Higher is Better



Apr-23: 10%

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



Apr-23: 59,700

999 Mean Call Answer Time
N/A

There is currently no data to display for this metric.

999 90th Percentile Call Answer Time
N/A

There is currently no data to display for this metric.

Key Observations:inbound call volume demand has reduced from March levels. Hear and Treat although lower than previous month remains within the control limits	Reasons & Rationale:	Improvement Actions: Hear and Treat improvement action plan in development stage

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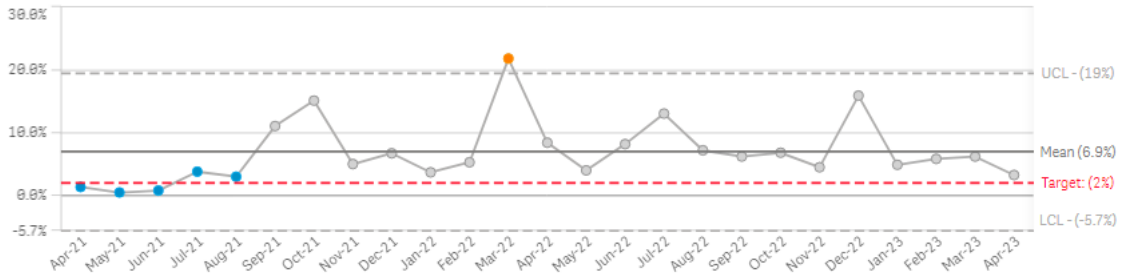
999 Calls abandoned %

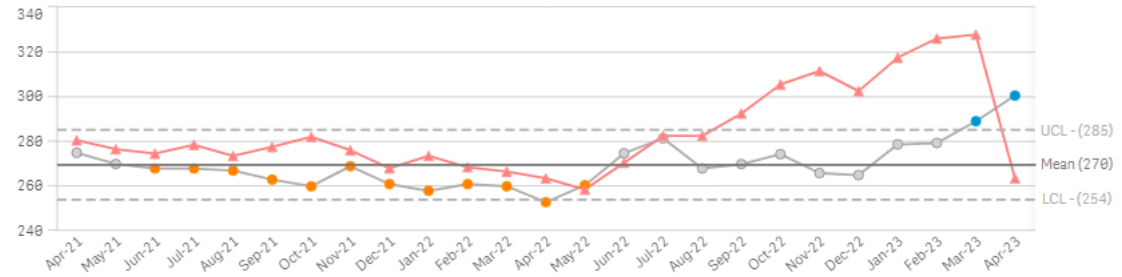
Lower is Better. Target differed in previous years



Apr-23: 3.2%

EOC Workforce

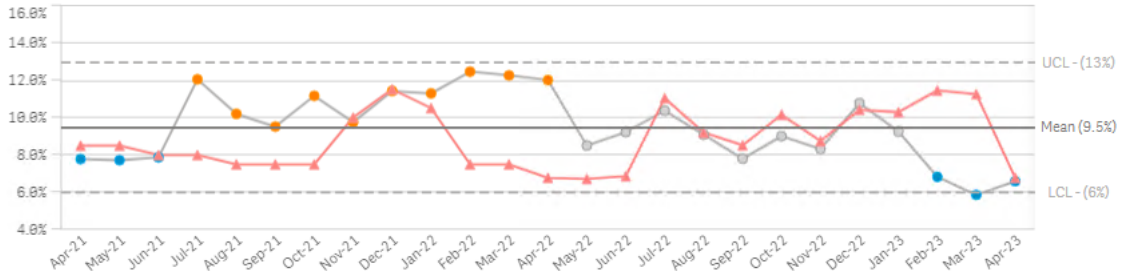
Higher is Better



Apr-23: 301

Sickness - EOC (Total)

Lower is Better



Apr-23: 6.6%

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
999 % calls from frequent callers	5%	5%	3.9%	5%	3%		

Key Observations: Abandonment rate continues to be positive and is reflective of demand reduction, workforce numbers improving and sickness abstraction reducing.

Reasons & Rationale:

Improvement Actions: Continue with IWP, staff performance management and abstraction management.

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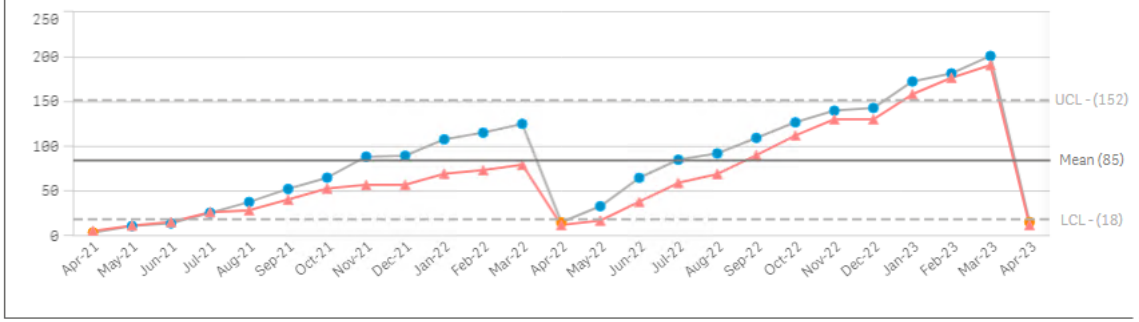
EOC Recruitment

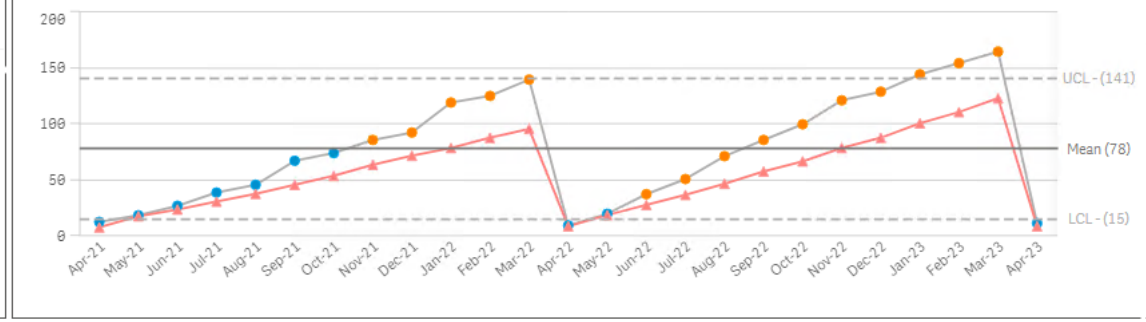
Higher is Better



Apr-23: 16

EOC Attrition

Lower is Better



Apr-23: 12

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
EOC Internal Attrition	20	5	125	5	703		
EOC External Attrition	35	7	207	7	1,291		

Key Observations: EOC attrition is 11.7 WTE for April. slightly higher than forecasted

Reasons & Rationale:

Improvement Actions: EOC are developing a retention plan

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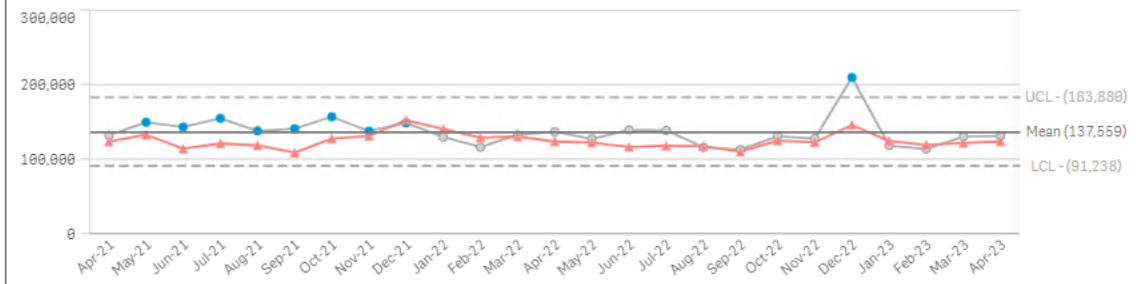
111 Calls Offered

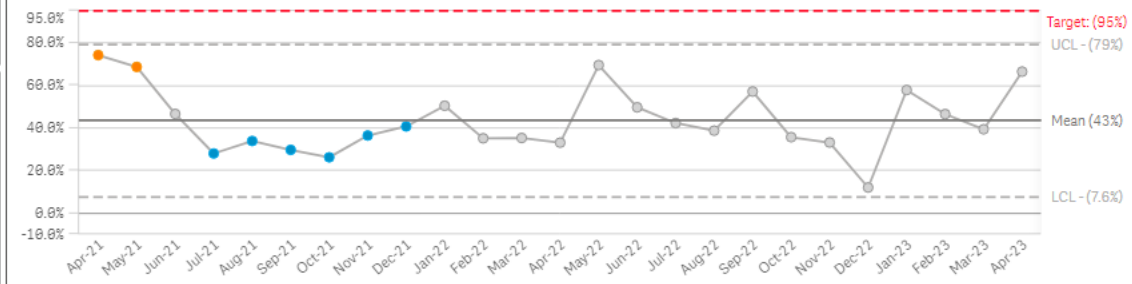
Higher is Better. Target differed in previous years



Apr-23: 132,109

111 call answer in 120 Secs %

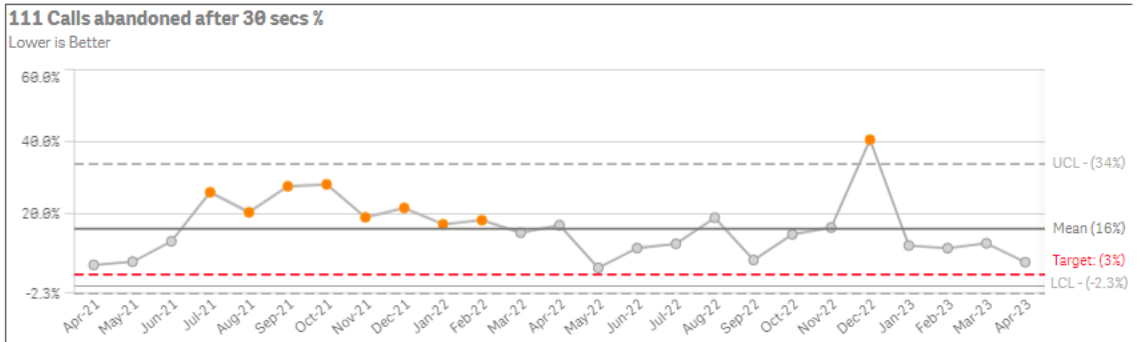
Lower is Better



Apr-23: 66%

111 Calls abandoned after 30 secs %

Lower is Better



Apr-23: 6.5%

Key Observations: April was 4% busier than March when considering calls offered by day average. Call answer in 120 secs (66.49%) and abandonment rates (6.47%) have improved but remain below target levels.

Reasons & Rationale: Improvements in performance have been driven by increased logged in hours underpinned by new starters, reduction in sickness rates, improvements in average handling time but also by decrease in leave being taken by staff.

Improvement Actions: 111 continue to recruit to vacancies, continue to seek efficiencies and improvements in call centre metrics and floor management. Continue to support and engage with the teams to reduce attrition, sickness levels and improve working environment. All will drive increases in these metrics.

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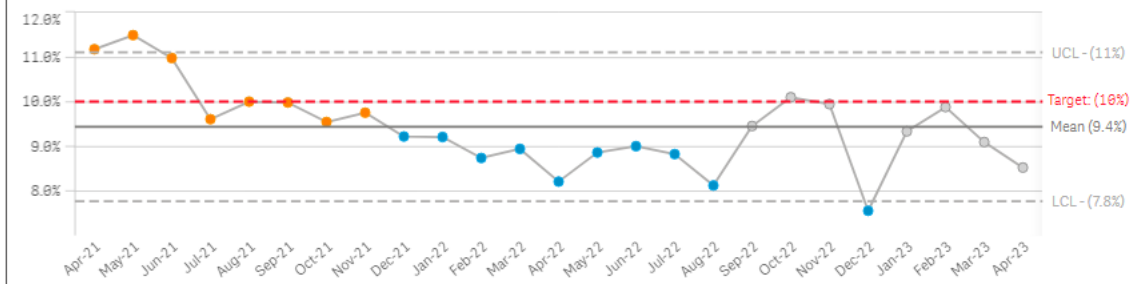
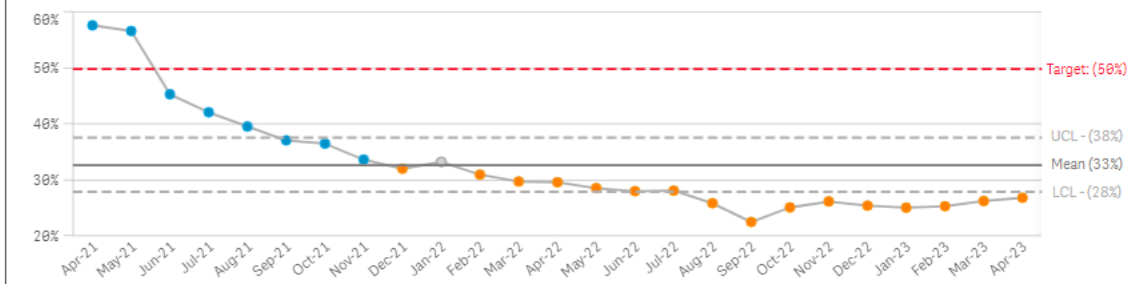
SCAS 111 - 999 referrals %
Lower is Better



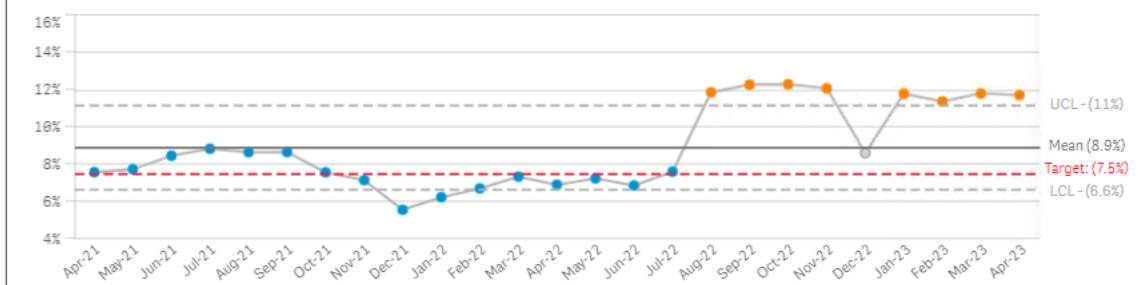
Apr-23: 8.5%

Total 111 - Transfer to Clinician
Higher is Better



Apr-23: 27%

SCAS 111 - ED Referrals
Lower is Better. Target differed in previous years



Apr-23: 12%

Key Observations: This data does not include the work done by any of the IUC clinicians and therefore is not reflective of true referral/transfer rates. This data demonstrates outputs only from clinicians using solely NHS Pathways and not GPs, MHPs, Pharmacists, ANPs, SPs who use PaCCs.

Reasons & Rationale: April data not currently available - awaiting IUC ADC reporting.

Improvement Actions:

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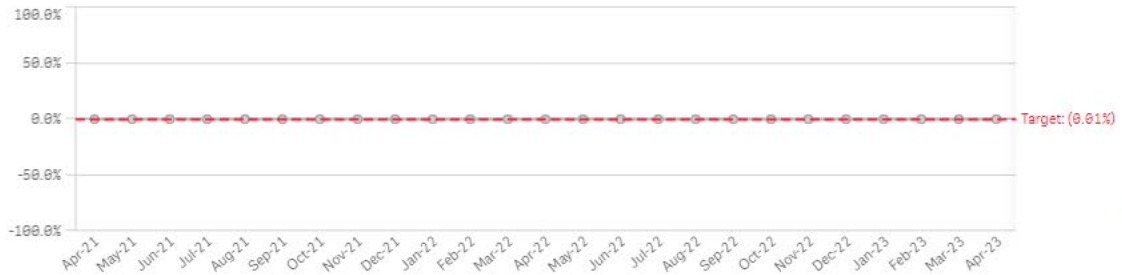
Complaints - 111 Service %

Lower is Better



n/a

Apr-23: 0%

111 Complaints response - agreed timescale %

N/A

There is currently no data to display for this metric.

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
111 PHSO cases - upheld/partially upheld	-	-					n/a

Key Observations:	Reasons & Rationale:	Improvement Actions:

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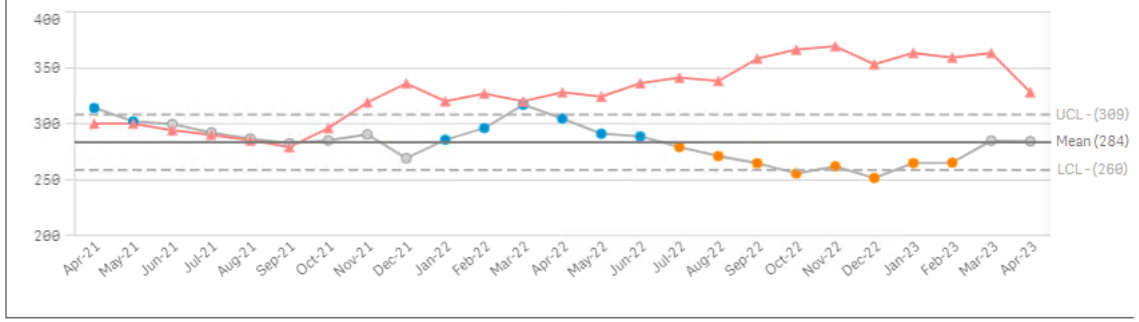
111 Workforce

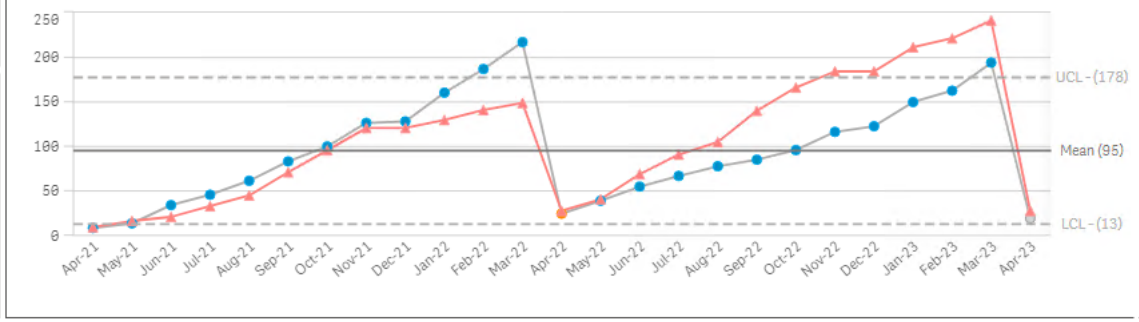
Higher is Better



Apr-23: 285

111 Recruitment

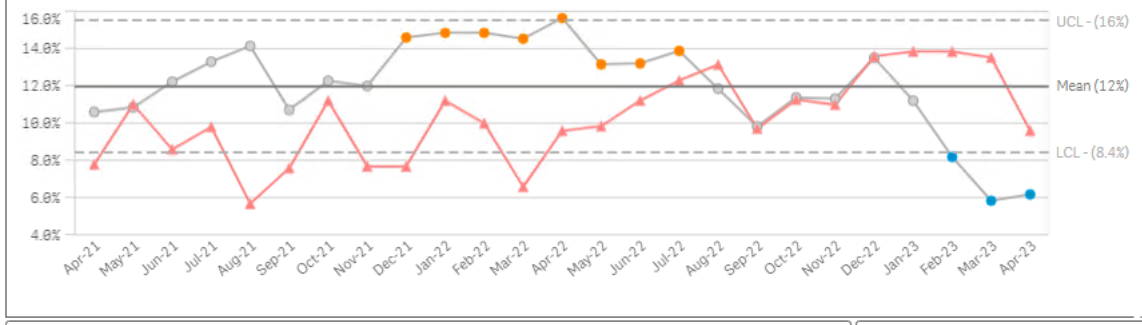
Higher is Better



Apr-23: 20

Sickness - 111 service (Total)

Lower is Better

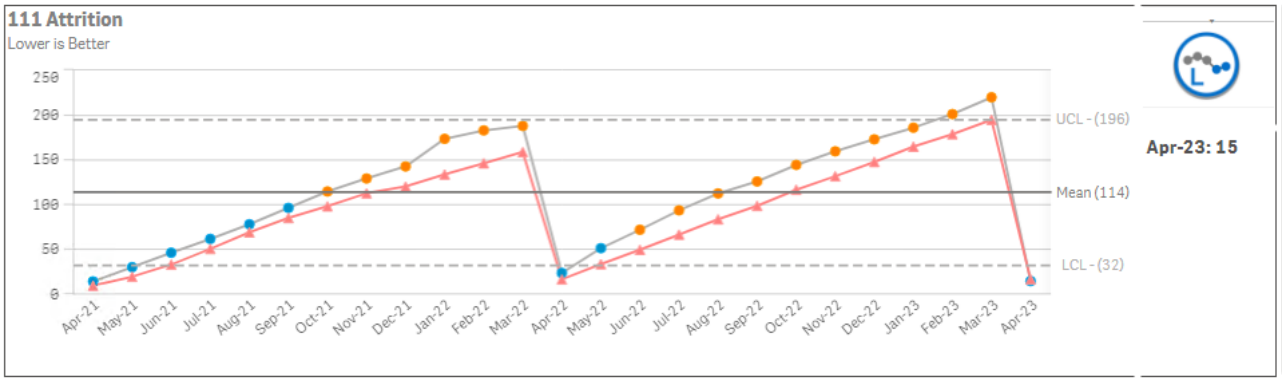


Apr-23: 6.2%

Key Observations: 111 sickness has decreased significantly to 6.2% and is below plan which is positive. Both recruitment and workforce numbers were lower than planned for April.

Reasons & Rationale: A concerted effort to manage sickness has been in place across 111. Recruitment has been very successful in Milton Keynes, but we had to slow down on numbers for that site as there is a lack of space until we move to the new site.

Improvement Actions: Continuing to monitor. Targeted advertising and attraction for Bicester and Otterbourne. Leaflet deliveries around Bicester to try and engage with people who don't see our digital advertising.



Apr-23: 15

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
111 Internal Attrition	4	6	135	6	509		n/a
111 External Attrition	13	10	307	10	1,088		n/a

Key Observations: 111 attrition for April was 15.09, slightly lower than the forecast of 17

Reasons & Rationale:

Improvement Actions: Local retention plans are being developed and retention leads identified.

Quality & Safety

Overview

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

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Building cleanliness completed audits	42	27	95	27	414		
Number of compliant Building cleanliness audits	40	23	69	23	322		
Percentage of compliant Building cleanliness audits	95%	85.2%	73.5%	85%	85%		
Vehicle cleanliness completed audits	145	108	385	108	1,437		
Number of compliant Vehicle cleanliness audits	139	107	346	107	1,354		
Percentage of compliant Vehicle cleanliness audits	96%	99.1%	91.1%	99%	103%		
Hand Hygiene audit	288	198	924	198	3,383		
Number of compliant Hand Hygiene audit	273	197	909	197	3,348		
Percentage of compliant Hand Hygiene audits	95%	99.5%	98.6%	99%	107%		
Number of cleanliness compliance audits	475	333	1,404	333	5,234		
Number of compliant cleanliness compliance audits	452	327	1,324	327	5,024		
Percentage of compliant cleanliness compliance audits	95%	98.2%	94.9%	98%	104%		

Quality & Safety

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Number of Never Events (CQC/NRLS reportable)	0		0	0	1		
Number of Physical Assaults	21	24	56	24	263		
Number of Non-Physical Assaults	50	62	167	62	607		
Number of SI investigations outstanding after 60 days (excluding events that are officially suspended)	0	4	13	4	13		
Medicines modules produced without error %	-		-	-	-	-	-
Days of medicines stock modules in reserve	-		-	-	-	-	-
Number of no/low harm incidents	-	-	-	-	-		n/a
Number of incidents moderate and above harm	-	-	-	-	-		n/a
Number of Serious Incidents (SI) reported	-	-	-	-	-		n/a

Quality & Safety

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
RIDDOR reportable incidents	-					-	-
Number of reported CD incidents – unaccounted for losses	-					-	-
Number of DATIX incidents - patient	-	-					n/a
Number of DATIX incidents - non patient	-	-					n/a

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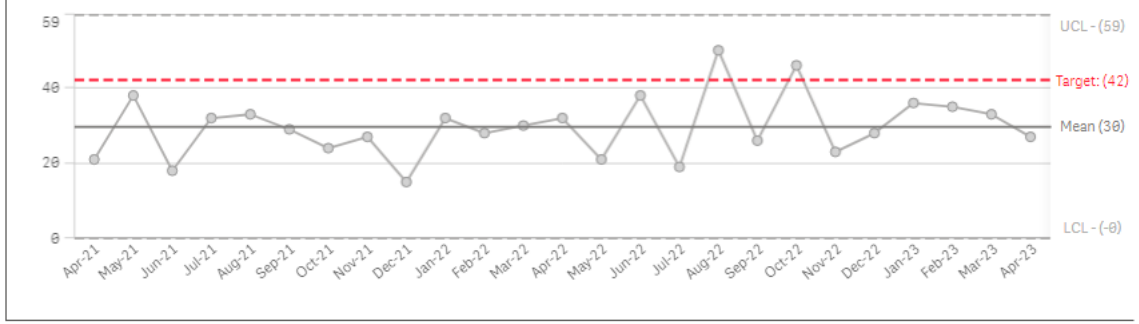
Building cleanliness completed audits

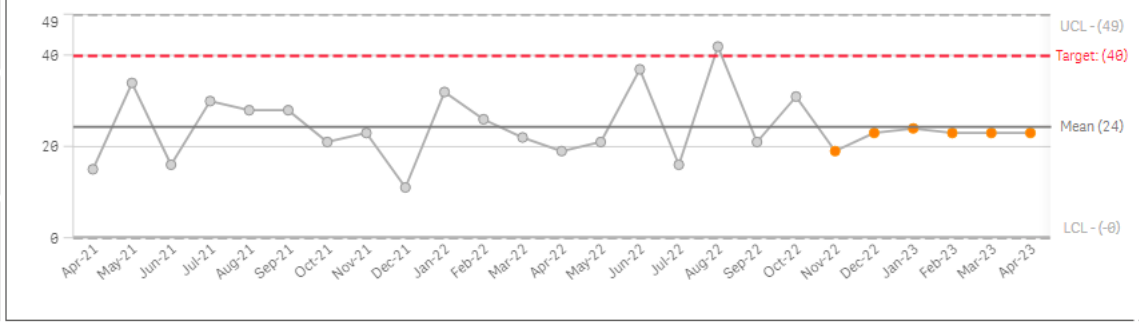
Higher is Better



Apr-23: 27

Number of compliant Building cleanliness audits

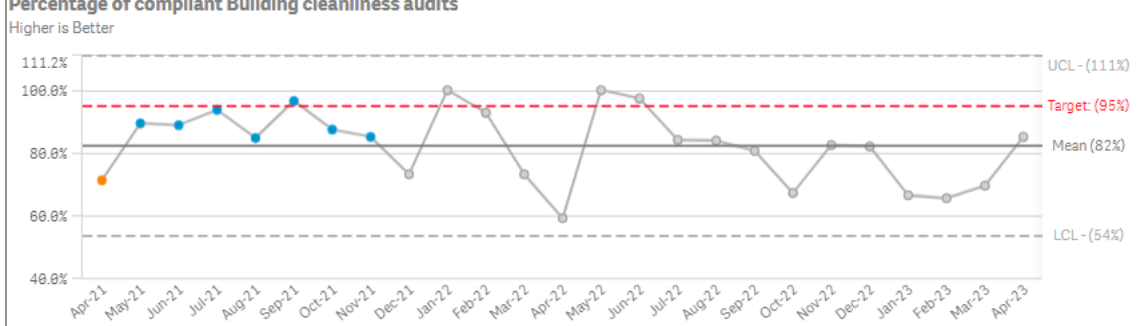
Higher is Better



Apr-23: 23

Percentage of compliant Building cleanliness audits

Higher is Better



Apr-23: 85.2%

Key Observations: EUC building audits below trajectory with 15/22 completed. Compliance above target at 98%. PTS audits below trajectory with 12/18 completed. Compliance above target at 83%. Note IPR data figures are combined PTS and EUC

Reasons & Rationale: Performance fluctuates month on month and will be continuously monitored

Improvement Actions: IPC attendance at EUC clinical governance to discuss audit progress and remind staff of requirement to complete

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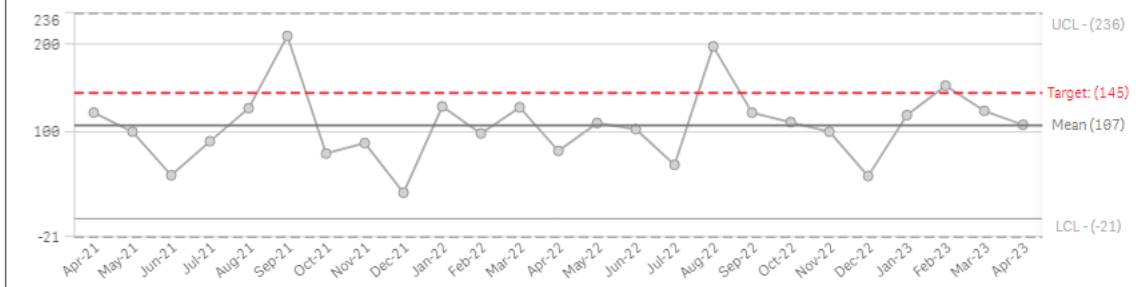
Vehicle cleanliness completed audits

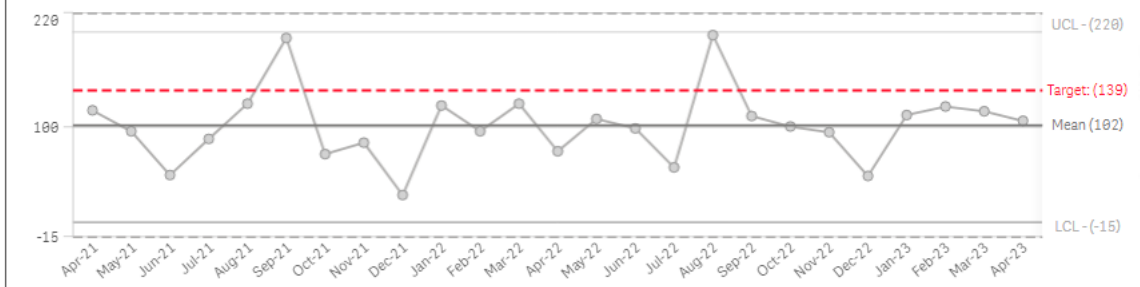
Higher is Better



Apr-23: 108

Number of compliant Vehicle cleanliness audits

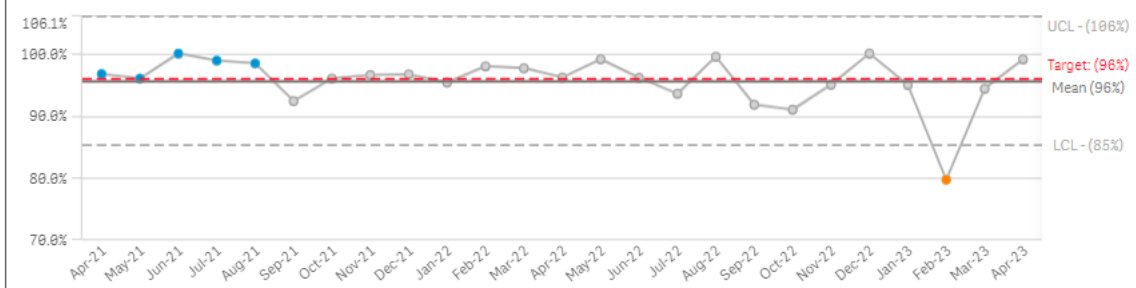
Higher is Better



Apr-23: 107

Percentage of compliant Vehicle cleanliness audits

Higher is Better



Apr-23: 99.1%

Key Observations: EUC vehicle audits above trajectory with 82/61 completed. Compliance above target at 98%. PTS vehicle audits below trajectory with 26/51 completed. Compliance above target at 100%. Note IPR data figures are combined PTS and EUC data. Note also that denominator data figure for compliance requires rectifying on IPR therefore overall target figures not currently displaying correctly

Reasons & Rationale: Performance fluctuates month on month and will be continuously monitored

Improvement Actions: IPC to meet with PTS CG and Leads to highlight areas where audits are required

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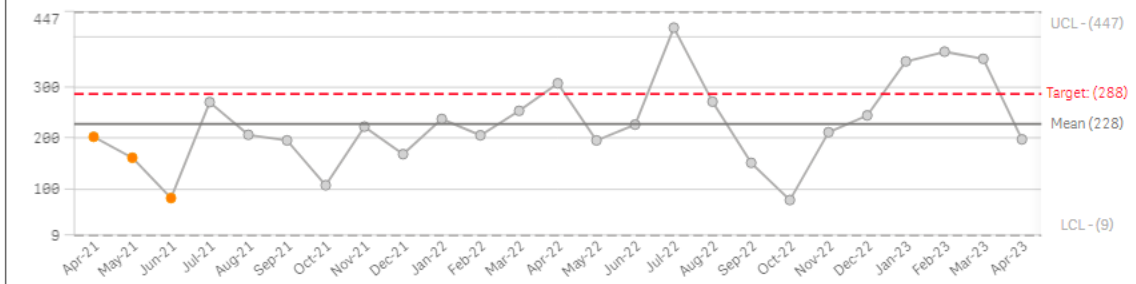
Hand Hygiene audit

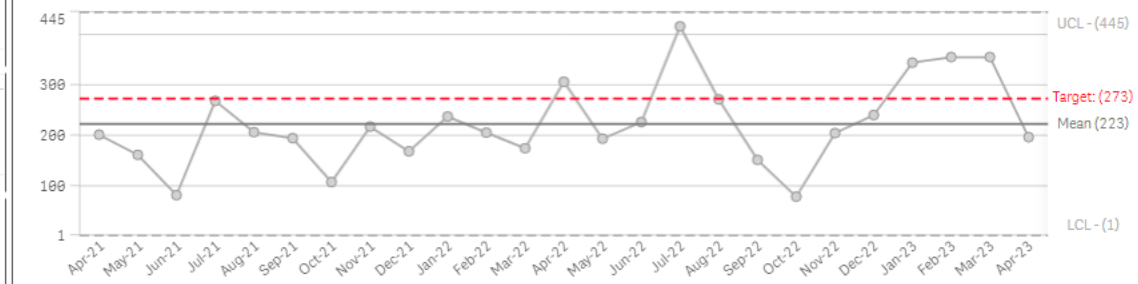
Higher is Better



Apr-23: 198

Number of compliant Hand Hygiene audit

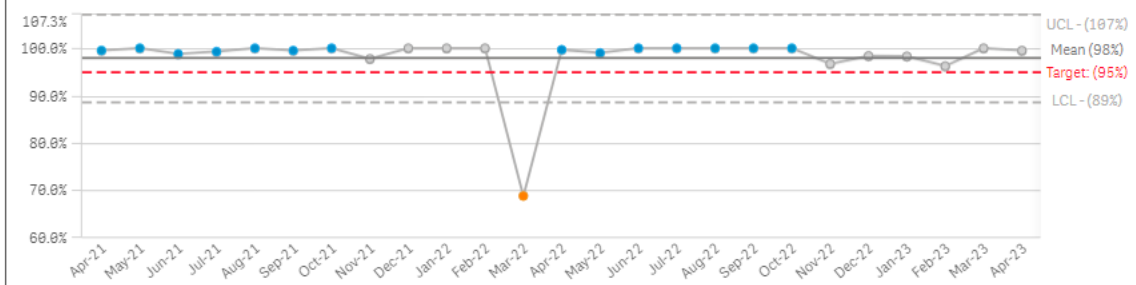
Higher is Better



Apr-23: 197

Percentage of compliant Hand Hygiene audits

Higher is Better



Apr-23: 99.5%

Key Observations: Hand Hygiene Audits EUC slightly under target at 170/171, however excellent performance this month following drive for completion. PTS audits below trajectory with 28/59 completed. Compliance above target at 99%. Figure remains very high whilst observed compliance is lower Note IPR data figures are combined PTS and EUC

Reasons & Rationale: Performance fluctuates month on month and will be continuously monitored

Improvement Actions: Team Leaders and Managers reminded that audits should be completed face to face within PDR or team meetings to ensure practice is observed. IPC to discuss with PTS leads on low performance in April

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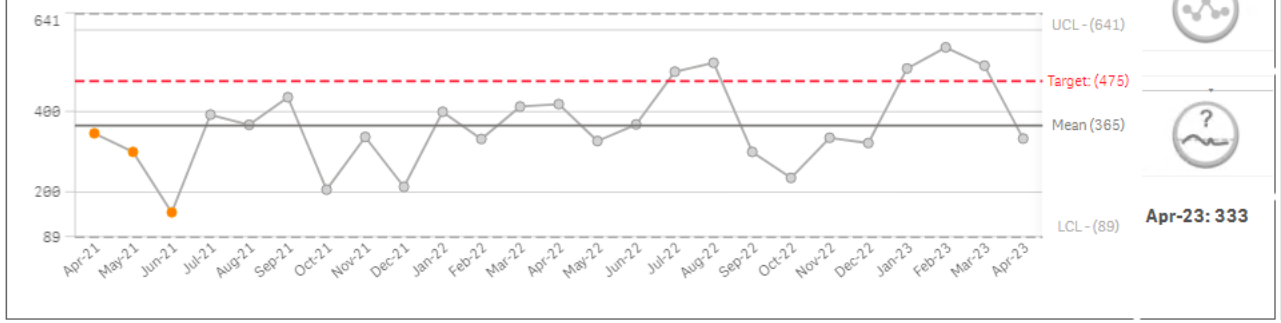
Number of cleanliness compliance audits

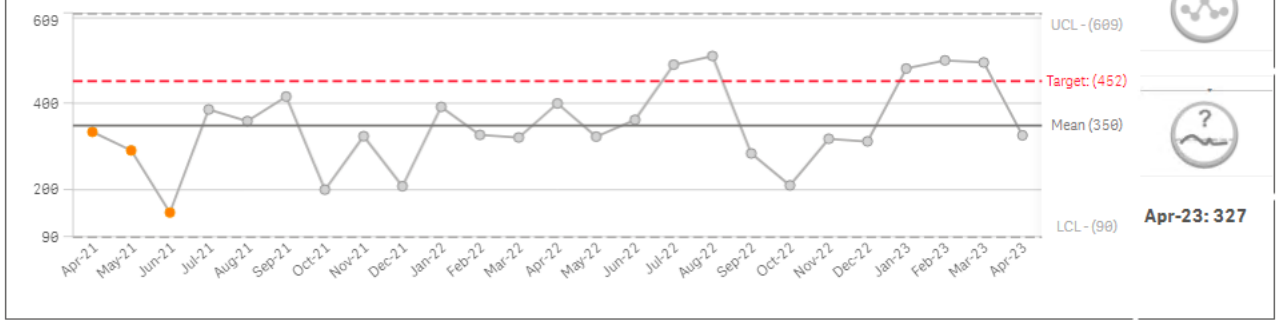
Higher is Better



Apr-23: 333

Number of compliant cleanliness compliance audits

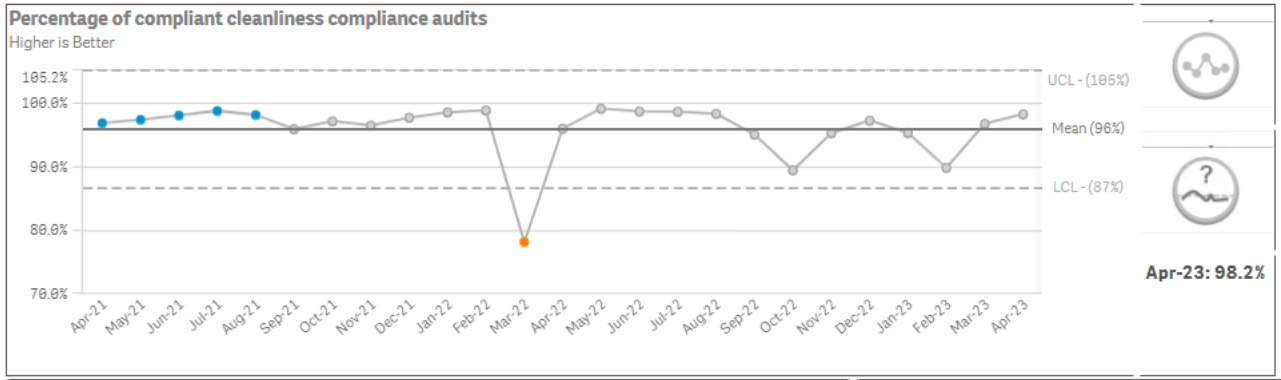
Higher is Better



Apr-23: 327

Percentage of compliant cleanliness compliance audits

Higher is Better



Apr-23: 98.2%

Key Observations:	Reasons & Rationale:	Improvement Actions:

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*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Number of Never Events (CQC/NRLS reportable)	0		0	0	1		
Number of Physical Assaults	21	24	56	24	263		
Number of Non-Physical Assaults	50	62	167	62	607		
Number of SI investigations outstanding after 60 days (excluding events that are officially suspended)	0	4	13	4	13		
Medicines modules produced without error %	-		-	-	-	-	-
Days of medicines stock modules in reserve	-		-	-	-	-	-
Number of no/low harm incidents	-		-	-	-	-	-
Number of incidents moderate and above harm	-		-	-	-	-	-
Number of Serious Incidents (SI) reported	-	-	-	-	-		n/a
RIDDOR reportable incidents	-		-	-	-	-	-
Number of reported CD incidents – unaccounted for losses	-		-	-	-	-	-
Number of DATIX incidents - patient	-	-	-	-	-		n/a
Number of DATIX incidents - non patient	-	-	-	-	-		n/a

Key Observations:	Reasons & Rationale:	Improvement Actions:

NEPTS - Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
PTS - Calls answered in 60 seconds	90%	69.0%	68.4%	69.0%	72.3%		
Patients Arrived within time	90%	89.7%	89.3%	89.7%	96.8%		
Patients Collected within time	90%	92.1%	91.7%	92.1%	99.9%		
PTS Complaints response - agreed timescale %	-	-	-	-	-		n/a
PTS PHSO cases - upheld/partially upheld	-	-	-	-	-		n/a
PTS Volume - No. of Journeys	-	-	-	-	-	-	-
PTS Volume - No. of Patients Transported	-	-	-	-	-	-	-
PTS Call Volume	-	-	-	-	-	-	-
Complaints - PTS % per 1,000 Incidents	-	-	-	-	-		n/a

NEPTS - Operations

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Sickness - PTS (Total)	8.8%	8.4%	7.1%	8.4%	9.6%		n/a
PTS Workforce	675	627	1,892	627	8,361		n/a
PTS Recruitment	14	11	333	11	1,081		n/a
PTS Attrition	20	22	408	22	1,337		n/a
PTS Internal Attrition	5	16	190	16	634		n/a
PTS External Attrition	15	6	217	6	703		n/a

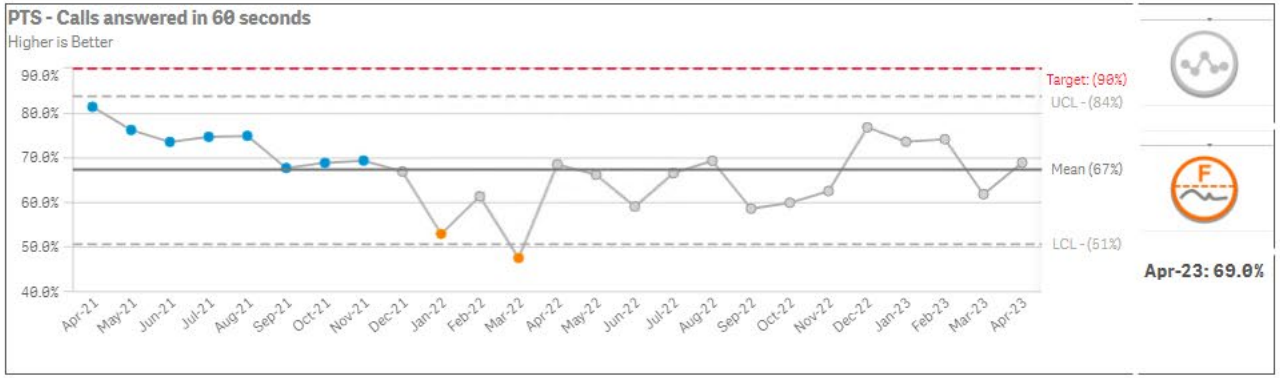
Service Quality , Patient Experience & Clinically Led
NEPTS - Operations

NHS South Central Ambulance Service NHS Foundation Trust

PTS Call Volume
N/A

There is currently no data to display for this metric.

PTS - Calls answered in 60 seconds
Higher is Better



Apr-23: 69.0%

Key Observations: Call Performance continues around the mean levels but significantly below the target. Call volumes were slightly below budget as were call lengths.	Reasons & Rationale: This is due to continued vacancies within the call handlers as well as a level of sickness impacting on operational hours available.	Improvement Actions: Not ready and performance management continues with increased analysis and support from the Continuous Improvement team identifying areas of improvement. On going recruitment challenges to attract staff to the role.

Service Quality , Patient Experience & Clinically Led
NEPTS - Operations

NHS South Central Ambulance Service NHS Foundation Trust

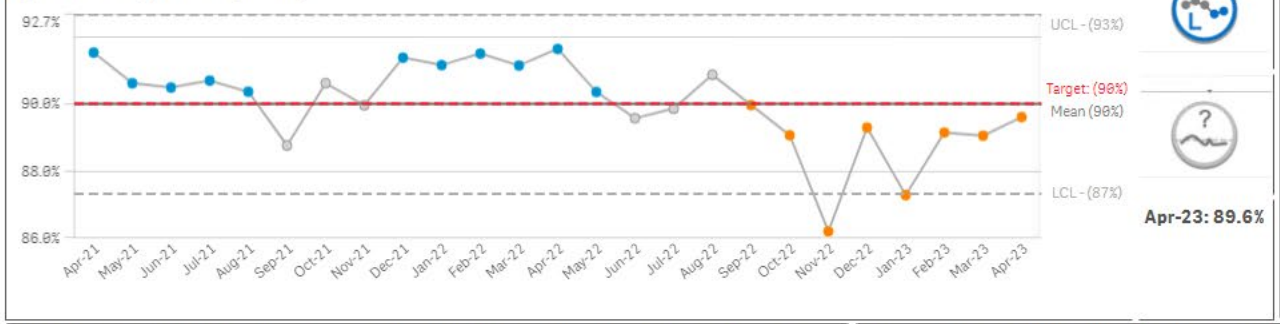
PTS Volume - No. of Journeys
N/A

The calculation condition is not fulfilled

PTS Volume - No. of Patients Transported
N/A

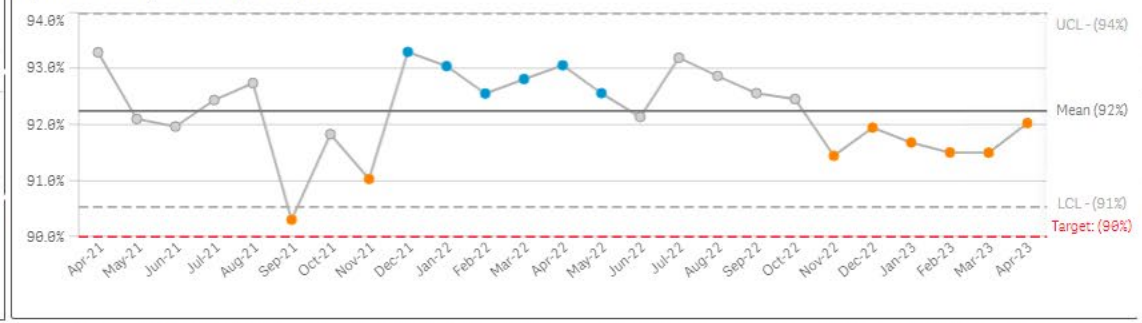
There is currently no data to display for this metric.

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



Apr-23: 89.6%

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



Apr-23: 92.0%

Key Observations: April PTS activity is 4.3% above budget, this is before the on going discussions with Commissioners conclude around rightsizing the contracts to achieve the additional Cost Savings required. Performance is higher than the budgeted target for both metrics due to ongoing commissioner discussions.

Reasons & Rationale: Continued use of forecasting and modelling accurately to achieve the required performance even with continued activity growth.

Improvement Actions: Review outcomes of commissioner conversations and actions to look to achieve the budgeted cost reductions in a timely manner

Service Quality , Patient Experience & Clinically Led
NEPTS - Operations

NHS South Central Ambulance Service NHS Foundation Trust

Complaints - PTS % per 1,000 Incidents
N/A

There is currently no data to display for this metric.

PTS Complaints response - agreed timescale %
N/A

There is currently no data to display for this metric.

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

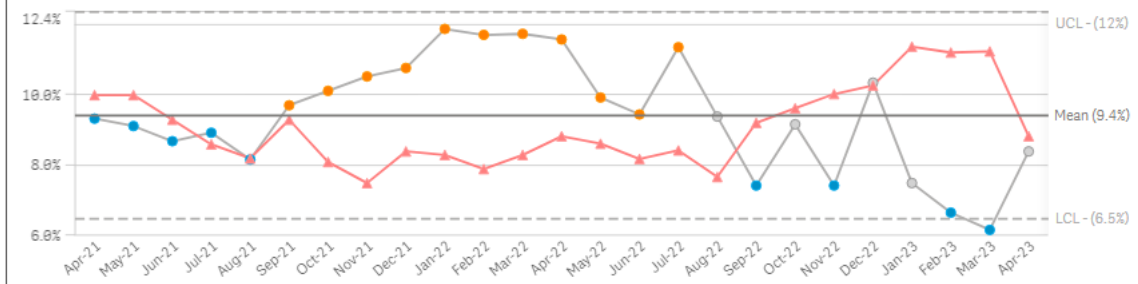
Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
PTS PHSO cases - upheld/partially upheld	-						n/a

Key Observations:	Reasons & Rationale:	Improvement Actions:

Service Quality , Patient Experience & Clinically Led
NEPTS - Operations

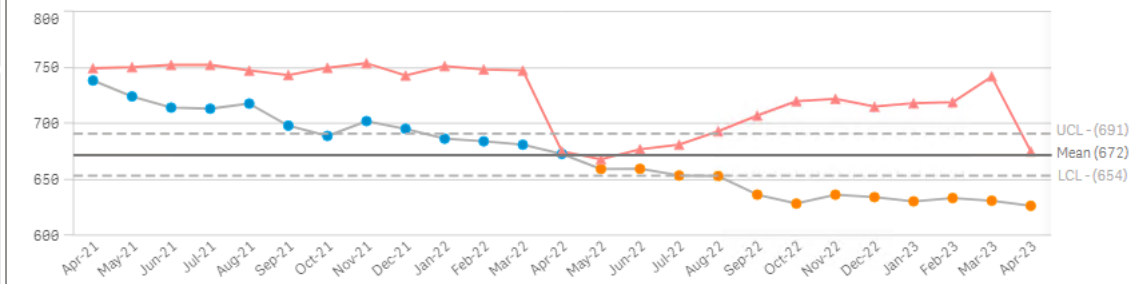
NHS South Central Ambulance Service NHS Foundation Trust

Sickness - PTS (Total)
Lower is Better



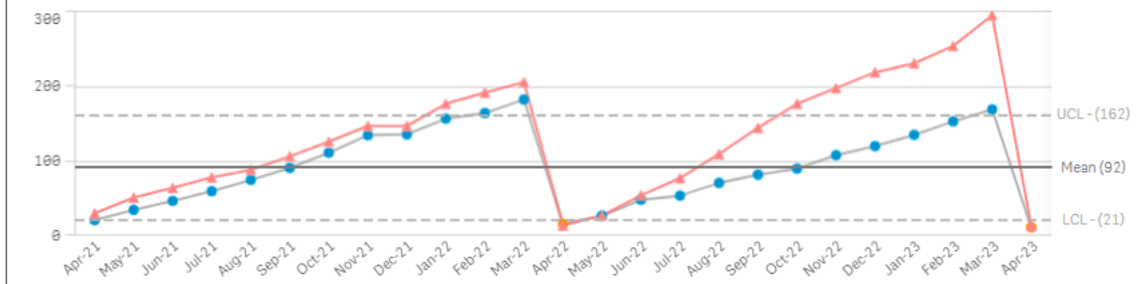
Apr-23: 8.4%

PTS Workforce
Higher is Better



Apr-23: 627

PTS Recruitment
Higher is Better



Apr-23: 11

Key Observations: PTS sickness is 8.4% lower than 9% plan

Reasons & Rationale: It is worth noting that external Covid reporting as stopped.

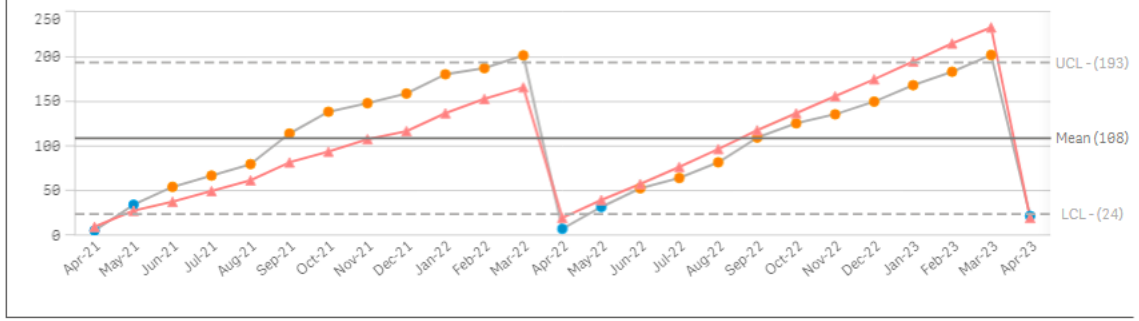
Improvement Actions: Sickness continues to be managed.

Service Quality , Patient Experience & Clinically Led
NEPTS - Operations

NHS South Central Ambulance Service NHS Foundation Trust

PTS Attrition

Lower is Better



Apr-23: 22

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
PTS Internal Attrition	5	17	191	17	1,257		n/a
PTS External Attrition	15	6	217	6	1,453		n/a

Key Observations: PTS Attrition was 22.21 for April slightly higher than forecast

Reasons & Rationale:

Improvement Actions: HR are meeting with local management around designing a local retention plan and action plan

NHS
South Central Ambulance Service
NHS Foundation Trust

Finance and Sustainability

Finance and Sustainability

Summary

Assurance

April-23

No Target

Variance

		Debtors > 90 days> 5% total balance		Agency Spend

Financial Management

Overview

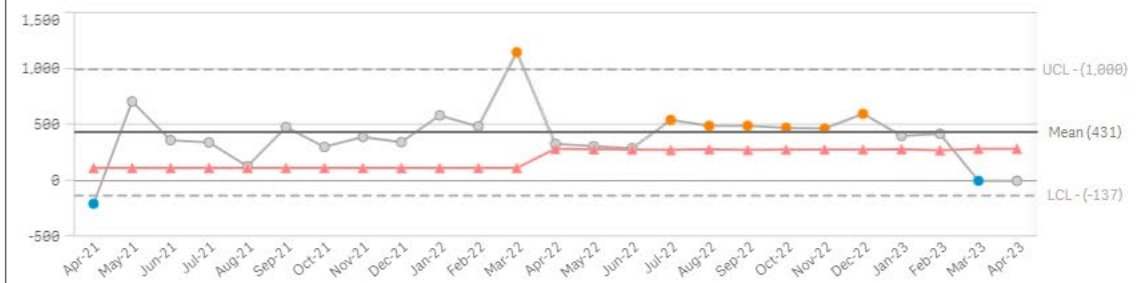
*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Debtors > 90 days> 5% total balance	5%		13.9%	0%	9%		
Agency Spend	287		421	0	4,827		n/a
CIP's Total	-		-	-	-	-	-
Pay Spend	-		-	-	-	-	-

Finance and Sustainability
Financial Management

NHS South Central Ambulance Service NHS Foundation Trust

Agency Spend
Lower is Better

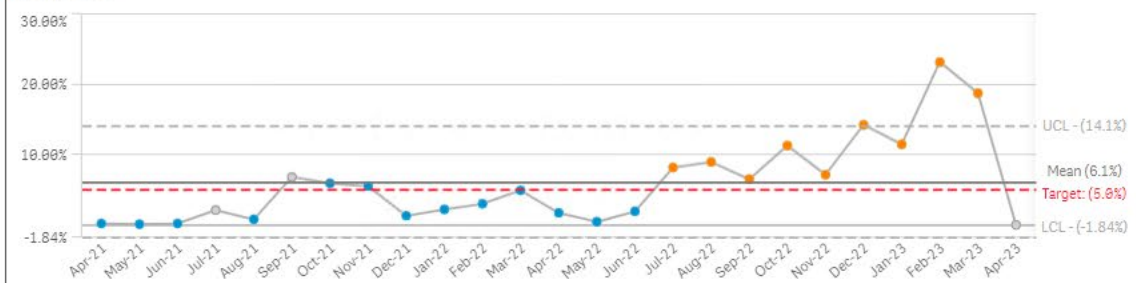


Apr-23: 0

Pay Spend
N/A

There is currently no data to display for this metric.

Debtors > 90 days> 5% total balance
Lower is Better



Apr-23: 0.0%

CIP's Total
N/A

There is currently no data to display for this metric.

Key Observations: Month 1 position is still being finalised, along with target levels for the year. These will be available in next months report, along with the month 2 position

Reasons & Rationale:

Improvement Actions:

NHS
South Central Ambulance Service
NHS Foundation Trust

People and Organisation Development

People and Organisation Development

Summary

Assurance

April-23 | **No Target**

Variance

		Conflict Management Equality & Diversity Fire Awareness Health & Safety Infection Control Information Governance Manual Handling Safeguarding Adults Level 1 Safeguarding Children Level 1		
				Total Frontline Workforce
			Appraisals - Trust	Safeguarding Level 3
				Sickness - Trust (Total)

Sickness & Appraisals

Overview

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

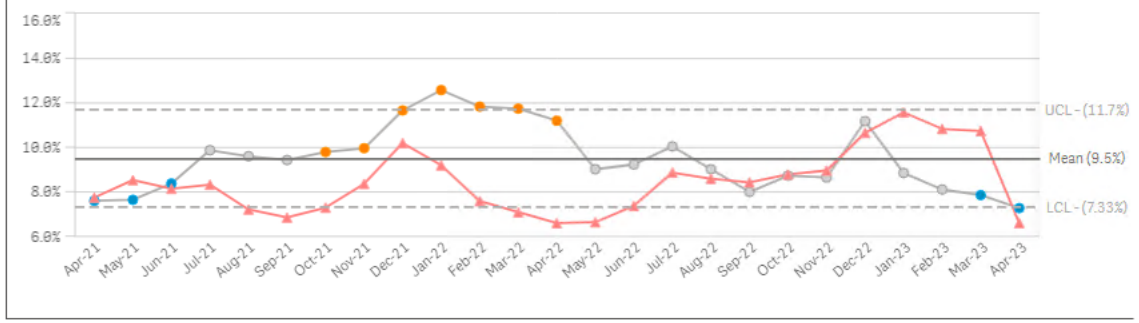
Metric	Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Sickness - Trust (Total)	6.6%	7.3%	7.8%	7.3%	10%		n/a
Appraisals - Trust	95%	89%	88.5%	89%	82%		

People and Organisation Development
Sickness & Appraisals

NHS South Central Ambulance Service NHS Foundation Trust

Sickness - Trust (Total)

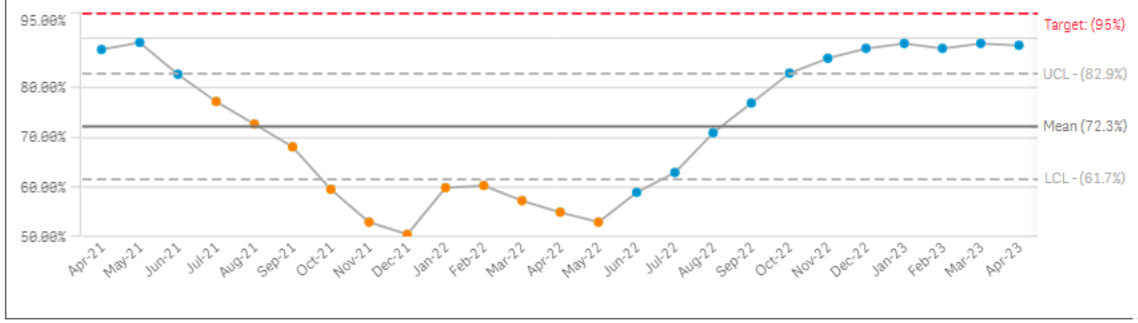
Lower is Better



Apr-23: 7.3%

Appraisals - Trust

Higher is Better



Apr-23: 89%

Key Observations: TW Sickness is 7.3%. Appraisals are 89% which is below the 95% target but a commendable effort considering the pressures the Trust has faced over the last year.	Reasons & Rationale:	Improvement Actions: Personal Development reviews continue to be prioritized and a PDR development package will be rolled out in the coming months.

People and Organisation Development
Statutory & Mandatory Training

NHS South Central Ambulance Service NHS Foundation Trust

*Some of the 90 days, YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Plan / Target	Apr-23	90 Days	YTD	12 Months	Variation	Assurance
Manual Handling	95%	85.00%	92.6%	85%	103%		
Health & Safety	95%	86.00%	92.7%	86%	103%		
Equality & Diversity	95%	86.00%	92.9%	86%	103%		
Conflict Management	95%	41.00%	77.1%	41%	98%		
Infection Control	95%	86.00%	93.4%	86%	104%		
Safeguarding Adults Level 1	95%	84.00%	92.0%	84%	102%		
Safeguarding Children Level 1	95%	84.00%	91.8%	84%	102%		
Fire Awareness	95%	84.00%	90.5%	84%	99%		
Information Governance	95%	82.00%	89.5%	82%	100%		
Safeguarding Level 3	0%	65.00%	69.0%	65%	45%		n/a

Key Observations:	Reasons & Rationale:	Improvement Actions:

Data Quality Reference

South Central Ambulance Service NHS Foundation Trust

Data Quality

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

Metric	90 Days	YTD	12 Months
% Cat 1 resulting in LW (> 30 mins)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
% Cat 2 resulting in LW (> 60mins)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
% Cat 3 resulting in LW (> 3hrs)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
% Cat 4 resulting in LW (> 4 hrs)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
111 Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
111 call answer in 120 Secs %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
111 Calls abandoned after 30 secs %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
111 Calls Offered	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
111 Complaints response - agreed timescale %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
111 External Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
111 Internal Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
111 PHSO cases - upheld/partially upheld	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
111 Recruitment	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
111 Workforce	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
999 % calls from frequent callers	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
999 90th Percentile Call Answer Time	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
999 Call Volume	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
999 Calls abandoned %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
999 Complaints response - agreed timescale %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
999 Mean Call Answer Time	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
999 PHSO cases - upheld/partially upheld	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Activity (999 Incidents) - SCAS	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Agency Spend	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate

Data Quality

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

Metric	90 Days	YTD	12 Months
Appraisals - Trust	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Average Hospital Handover Time - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Building cleanliness completed audits	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Cardiac Arrest Post- ROSC care	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cardiac Arrest Survival at 30 Days - All Patients	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cardiac Arrest Survival, Utstein	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cat 1 90th %ile SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cat 1 Mean SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cat 2 90th %ile SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cat 2 Mean SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cat 3 90th %ile SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Cat 4 90th %ile SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
CIP's Total	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Clear up Delays - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Complaints - 111 Service %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Complaints - 999 Total	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Complaints - 999 Total %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Complaints - PTS % per 1,000 Incidents	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Compliments	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Compliments %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Conflict Management	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Corporate Attrition	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Corporate External Attrition	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Corporate Internal Attrition	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality

Data Quality

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

Metric	90 Days	YTD	12 Months
Corporate External Attrition	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Corporate Internal Attrition	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Corporate Recuitment	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Corporate Workforce	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Days of medicines stock modules in reserve	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Debtors > 90 days> 5% total balance	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
EOC Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
EOC External Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
EOC Internal Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
EOC Recruitment	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
EOC Workforce	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Equality & Diversity	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Fire Awareness	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Frontline Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Frontline External Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Frontline Internal Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Frontline Recruitment	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
H&T - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Hand Hygiene audit	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Health & Safety	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Hospital Delays - SCAS	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Incidents Growth 999 - SCAS	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Infection Control	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality

Data Quality

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

Metric	90 Days	YTD	12 Months
Information Governance	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Manual Handling	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Meal Break Compliance - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Medicines modules produced without error %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Missed Breaks - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of Accidents	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of cleanliness compliance audits	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of compliant Building cleanliness audits	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of compliant cleanliness compliance audits	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of compliant Hand Hygiene audit	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of compliant Vehicle cleanliness audits	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of DATIX incidents - non patient	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of DATIX incidents - patient	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of incidents moderate and above harm	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of Never Events (CQC/NRLS reportable)	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of no/low harm incidents	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of Non-Physical Assaults	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of Physical Assaults	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Number of reported CD incidents – unaccounted for losses	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of Serious Incidents (SI) reported	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Number of SI investigations outstanding after 60 days (excluding events that are officially suspended)	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Over-runs >30 mins - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality

Load more

Data Quality

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

Metric	90 Days	YTD	12 Months
that are officially suspended)			
Over-runs >30 mins - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Patients Arrived within time	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Patients Collected within time	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Pay Spend	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Percentage of compliant Building cleanliness audits	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Percentage of compliant cleanliness compliance audits	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Percentage of compliant Hand Hygiene audits	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Percentage of compliant Vehicle cleanliness audits	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS - Calls answered in 60 seconds	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
PTS Call Volume	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS Complaints response - agreed timescale %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS External Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
PTS Internal Attrition	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
PTS PHSO cases - upheld/partially upheld	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS Recruitment	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
PTS Volume - No. of Journeys	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS Volume - No. of Patients Transported	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
PTS Workforce	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality

Data Quality

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

Metric	90 Days	YTD	12 Months
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
RIDDOR reportable incidents	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
S&T - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Safeguarding Adults Level 1	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Safeguarding Children Level 1	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Safeguarding Level 3	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
SCAS 111 - 999 referrals %	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
SCAS 111 - ED Referrals	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - 111 service (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - 999 (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - EOC (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - PTS (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - Trust (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
ST&C (ED 1&2) - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
ST&C (Non-ED 1&2) - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
STEMI - Call to angiography 90th Centile	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
STEMI - Care	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
STEMI Call to angiography - Mean	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke - Call to Hospital arrival 90th Centile	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke - Call to Hospital arrival Median	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke - Care	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke Call to Hospital arrival - Mean	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality

Data Quality

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

Metric	90 Days	YTD	12 Months
Sickness - 999 (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - EOC (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - PTS (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Sickness - Trust (Total)	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
ST&C (ED 1&2) - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
ST&C (Non-ED 1&2) - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
STEMI - Call to angiography 90th Centile	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
STEMI - Care	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
STEMI Call to angiography - Mean	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke - Call to Hospital arrival 90th Centile	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke - Call to Hospital arrival Median	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke - Care	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Stroke Call to Hospital arrival - Mean	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Total 111 - Transfer to Clinician	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Total Frontline Workforce	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Total Task Time - SCAS	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Vehicle cleanliness completed audits	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
Vehicle deep clean Compliance - A&E	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
Vehicle routine cleans	Inaccuracies in Data Quality	Data Quality Accurate	Data Quality Accurate
VOR - Other	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
VOR - Planned Maintenance	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
VOR - Total	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality
VOR - Unplanned Maintenance	Inaccuracies in Data Quality	Inaccuracies in Data Quality	Inaccuracies in Data Quality

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Assumptions:

- Targets which change monthly are considered as a plan for the metric and no Assurance icon will be produced.
The plan is shown on the SPC charts using a lighter red line.

-Static yearly targets will appear as a red target reference line on the SPC chart and an Assurance icon will be produced.
If the target differs for the previous year then the most current target is used.

-Quarterly metrics will not have an SPC chart and just a line chart to show the values and target / plan if available.

-Metrics without data pre April 2022 will not have an SPC chart and just a line chart to show the values and target / plan if available.

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BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**Quality and Patient Safety Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**10.0**
Executive Summary:	The purpose of the report is to provide the Board of Directors with a summary against the statutory quality and safety processes necessary to deliver safe, effective clinical care to our patients and our people. The report covers the period, February 2023 - March 2023 (M11-M12). Progress continues to be made against the objectives outlined in The *Patient Safety Improvement Plan.* The areas that currently present the highest risks to patients are: **The Management of Medical Devices and Equipment -** Improvement plan progressing with delivery against actions monitored at the Patient Safety Delivery Group. AED Secondary Devices have now been received but were subject to a delay in being deployed. This has since been rectified and secondary devices have now been allocated to all operational sites (May 2023) and are in the process of being assigned to each operational fleet vehicle. **Safeguarding** (IT system resilience, Level 3 Safeguarding training, and supervision of staff). The improvement plan has significant system wide scrutiny and oversight and has achieved significant improvements in all key objectives. Level 3 Training improvement of 10% (Group A 67.9%). **IPC** - The outstanding '*should do'* action relating to the completion of the Microbiology Service Level Agreement (SLA) with Oxford University Hospitals NHS Foundation Trust has now been resolved. **To Note** **Clinical Incidents -** Reduction in demand on services during the reporting period (returning to REAP Level 2) correlated with a reduction in harm related incident reporting in the following services: - 52% ↓decrease in EOC reporting - 66%↓ decrease in 999 reporting - 111/IUC- no significant change in reporting culture - NEPTS- no significant change in reporting culture **Non- Clinical Incidents –** No significant change in reporting culture with (117) abuse/ abusive behaviour incidents received predominantly by 999 operational staff.		

	Patient Experience - There was however a 20% increase in the total number of Patient Experience (PE) contacts received during the reporting period but did include cases pertaining to previous months when the Trust was in REAP Level 4. The main themes continue to be related to delays and non- attendance. Following investigation, it was determined that **66% of all cases received were either partially or fully upheld** and the findings formulated the following trends: - Access and Waiting - Clinical Care - Communication with patients, families and external partners There has been a 7% upward trend noted in contacts received year on year, (6% in month) but with no significant change in themes. There have been (130) formal complaints received during the reporting period, (147) informal concerns and (364) Healthcare Professional feedback requests. This is comparable to previous reports. Complaints responded to within **95% target Feb (92%)- March (95%)** Compliments - (232) received which is comparable to previous reports. **Patient Safety & Serious Incidents** Duty of Candour (DOC) - All incidents were DOC applied met the 10-day requirement. **At year end (2022-2023) the Trust declared (95) Serious Incidents (SI's)** in line with the (2015) Serious Incident Framework. This included (83) specifically declared by SCAS and (12) system SI's that the Trust will support. **During the reporting period** (36) incidents were reviewed at the Incident Review Panel (IRP). (17) SI's declared, (3) of which are recorded as system SI's. (4) SIs have subsequently been downgraded by the ICB following further information obtained through the investigation process. There are currently **(4) SIs breaching the 60-day target** for completion, each of these has an ICB approved extension in place and will meet the extension date. On analysis the themes continue to be, patient treatment and care and delay. **Patient Safety Incident Response Framework (PSIRF) -** plans are progressing with the appointment of an Implementation Lead. Communication and engagement with teams is being arranged and a risk profile and training needs analysis is being completed. **Emerging Theme** An emerging theme of patients with chest pain being discharged on scene with a re-attendance within 24 hours has been identified. An

	immediate response was to reissue Clinical memo 175 - *"The transportation and care of patient who present with chest pain".* Two of these incidents were subsequently declared SI's and are being investigated. **Notable Completed Actions** Clinical Pathway Team are working with stakeholders to increase availability of direct referral pathways. The Clinical Pathway Team Hampshire Hospitals Call Before You Convey Pathway opened to staff on 6 February 2023 for crew support and hospital avoidance.
Recommendations:	The Trust Board is asked to: receive the paper and note the key quality and patient safety issues
Executive lead:	**Professor Helen Young, Chief Nurse / Executive Director of Patient Care and Service Transformation**
Report author:	**Sue Heyes Director of Nursing Quality & Governance/ Deputy Chief Nurse**
Previously considered by:	Patient Safety Group Quality & Safety Committee

Purpose of report:	Note ☒	Approve ☐	Assure ☐
Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	Risk 1 - Poor clinical governance and practices
Quality Domain(s):	All Quality Domains

Next Steps (what actions will be taken following agreement of the recommendations): The recommendations inform the Patient Safety Improvement Plan and will be monitored through Patient Safety Group and Quality & Safety Committee.
List of Appendices:

South Central Ambulance Service NHS Foundation Trust

PUBLIC TRUST BOARD PAPER

Title	Quality & Patient Safety Report
Author	Deputy Director Nursing, Governance & Quality / Deputy Chief Nurse
Responsible Director	Professor Helen Young Chief Nurse / Executive Director of Patient Care
Date	May 2023

1. Purpose

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

1.2 The paper covers the reporting period (February – March 2023), highlights risks, issues and mitigations which are reflected in the Corporate Risk Register (CRR), Integrated Performance Report (IPR) and Board Assurance Framework (BAF). The information provided within the paper demonstrates evidence of compliance against Care Quality Commission (CQC) regulations where appropriate.

2. Executive Summary

2.1 During the reporting period the Trust has continued to make progress against key deliverables and achieved all 8 *'Must Do'* regulatory actions and 1 out of 2 *'Should do'* regulatory actions.

2.2 The remaining should do action relates to the embedding of a robust IPC assurance methodology and the completion of the Microbiology Service Level Agreement (SLA) with Oxford University Hospitals NHS Foundation Trust. The SLA has since been approved (May 2023) and the IPC audits are progressing using a quality compliance tool.

2.3 The actions are managed and monitored through the **Patient Safety Improvement Plan** which reports and provides assurance to the Patient Safety Delivery Group and the Integrated Performance and Oversight Board.

2.4 **The Patient Safety Improvement Plan** is divided in to specific workstreams. Safeguarding, Patient safety and Experience, Management of Medical Devices and Equipment, Medicines Management, Infection Prevention and Control (IPC).

2.5 The areas that currently present the highest risk to the delivery of safe effective care, but are being closely monitored through the Board Assurance Framework (BAF), continue to be:

1. **The management of medical devices and equipment.**
2. **Safeguarding** (IT system resilience, releasing staff to attend training and the release of operational staff for supervision).

2.6 During the reporting period, the Trust has seen a **reduction in demand on services returning to REAP Level 2 throughout most of the reporting period which correlates with a significant reduction in the number of clinical incidents reported.**

2.7 There has however been a **20% increase** in the total number of Patient Experience (PE) contacts raised (668) when compared with the previous reporting period (553). The data does include contacts relating to the previous reporting period, with delays and non-attendance being the highest reporting category. **This is a 6% increase from the previous reporting period.**

3. Main Report and Service Updates

3.1 Patient Safety Improvement Plan

3.1.1 Following the publication of the most recent CQC inspection an improvement plan for the '*must do'*, '*should do',* actions and Section 29a, was submitted in September 2022. An improvement programme had been developed prior to the report publication to address the immediate improvement actions. The Trust wide improvement plan covers the following core workstreams: Governance, Patient Safety, People and Culture (includes staff wellbeing) and Performance Recovery and is governed by internal and external oversight and scrutiny meetings. For Patient Safety Improvement, this includes the Patient Safety Delivery Group and the Quality and Safety Committee.

3.2 Infection, Prevention & Control (IPC)

3.2.1 The Trust IPC Specialist will complete a Level 3 assurance peer review visit to the Welsh Ambulance Service on 9 May 2023.

3.2.2 South-East Coast Ambulance Service will complete SCAS Level 3 peer review assurance visit at the end of May 2023. The findings will be reported through Infection Prevention and Control Committee (IPCC).

3.2.3 The newly released national IPC guidance was issued to staff on 27 April 2023. This is in line with the National IPC Manual on which policies are based. In future there will be risk-based PPE usage and a reduction in the requirement for Covid testing for both staff and patients.

3.2.4 The IPC Assurance Audit Programme commenced in March 2023 utilising a quality compliance (QC) audit tool. This will be used in conjunction with estate visits to assist in addressing any building related issues.

3.2.5 Emergency and Urgent Care (EU&C – 999) vehicles denominator data has been rectified on the IPC reporting system to accurately reflect location and number of vehicles to be audited. It rectifies where vehicles have been moved to enable response/demand and vehicles out of service. This has also been applied to buildings.

3.2.6 The above changes will result in aiding the Emergency and Urgent Care (E&UC) improvement plan for audit completion with the assistance of assurance visits from the IPC Practitioners.

3.2.7 The table below describes the year end position (2022/2023), regarding audit completion and compliance.

Table 1 - Year End Position – Audit completion and compliance

Audit Type	% Audits Completed Against Plan	Compliance of Total Audits Completed
E&UC Vehicles	74% completed	95% compliance
Buildings	79% completed	77% compliance
PTS Vehicles	99% completed	96% compliance
Buildings	84% completed	80% compliance
Hand Hygiene	*139% completed*	100% compliance

Indicates over performance of hand hygiene audits during the reporting period

3.3 Patient Safety

3.3.1 A Patient Safety Incident Response Framework (PSIRF) Implementation Lead commenced in post in May 2023 to lead the Trust in the transition to the National Patient Safety Strategy (2019) replacing the current Serious Incident Reporting framework (2015).

3.3.2 A steering group will commence in May 2023 to revised project plans, undertake risk profiling and a training needs analysis.

3.3.3 A recent safety culture survey was undertaken with a **response rate of 2.8% (*n*-126)**. Results have been analysed and in summary:

a) Almost all respondents (98%) were aware of Datix (incident reporting function), and the majority had received training at induction or other Trust training
b) Four fifths of respondents had reported an incident on Datix. Additional training or guidance notes in the use of Datix was requested by just under two thirds of respondents
c) Respondents highlighted the importance of receiving feedback. Wider dissemination of findings following safety incident investigations was preferred via email or team meetings
d) Two thirds of respondents were aware of duty of candour requirements and respondents suggested various preferred methods for additional training.

3.3.4 The survey has been analysed and key themes were:

a) Training for Datix and Duty of Candour (33%)
b) Provide feedback (25%)
c) Guidance notes on Datix required (17.5%)
d) Simplify Datix form/process (17.5%)
e) Protected time not available to report (7.5%)
f) Supportive culture recognised (2.5%).

3.3.5 A “you said, we will do” action-based plan is in development and results will be triangulated with outputs from *just & learning culture programme* and staff survey.

3.3.6 The Trust is working closely with national partners and the Trust’s incident reporting system supplier (Datix) to make the changes to Learning from Patient Safety Events (LFPSE) replacing the current NRLS (National Reporting and Learning System).

3.3.7 The working group has progressed in testing the new LFPSE system, however, some issues need to be rectified with reporting functionality. NHS England (NHSE) have issued a statement that all Trusts should work towards the September 2023

deadline. However, NRLS will not be removed until all issues are remedied with the new system, and changes to the Datix test environment are complete.

3.3.8 A Learning from Experience Group has recently been established and will be providing a quarterly report to the Quality and Safety Committee. The first meeting on 12 April 2023 was to agree the terms of reference, membership and core agenda items. Meetings will be bi-monthly prior to reporting to Quality and Safety committee.

3.3.9 Triangulation of learning will be through a variety of media. Learning summary sheets will be uploaded to the HUB following a review. Communications will be shared with staff through a variety of platforms including staff matters, governance meetings by service and team meetings. Areas for inclusion (not exclusive) will be feedback/complaints/coroners/Freedom to Speak Up/incidents.

3.4 Patient Experience

3.4.1 The Patient Experience team is responsible for the management of all feedback received by the Trust, encompassing comments, concerns, and complaints (otherwise known as Patient Experiences or 'PE's') and Patient Advice and Liaison Service (PALS) enquiries across all service lines. The management of PE's enables the Trust to analyses themes, trends, and root causes which, in turn, guides service improvement and future service development.

3.4.2 During the reporting period the Trust noted a **20% increase** in the total number of PE contacts raised (668) when compared with the previous reporting period (553).

3.4.3 **43% (289) of all PE issues were attributed to delays / non-attendance, a 6% increase from previous months.**

3.4.4 During the same period last year, the Trust received 625 PE cases. A 7**% upward trend noted year on year.**

3.4.5 During the reporting period (566) cases were responded to and closed **with 66% of cases either being fully or partly upheld.**

Table 2 - Breakdown of Patient Experience (PE) Contacts by Service

PE Contacts February/March	2022/23	% Of Trust Total	% Change from previous reporting period
NHS 111 incl. GP CAS pilot	136	20	↑ 6%
PTS	360	54	↓ 4%
999 Operations	123	18	↑2%
EOC	48	7	↓ 2%
Mental Health Triage Service	1	0.1	-
Trust Total	668	100%	↑20%

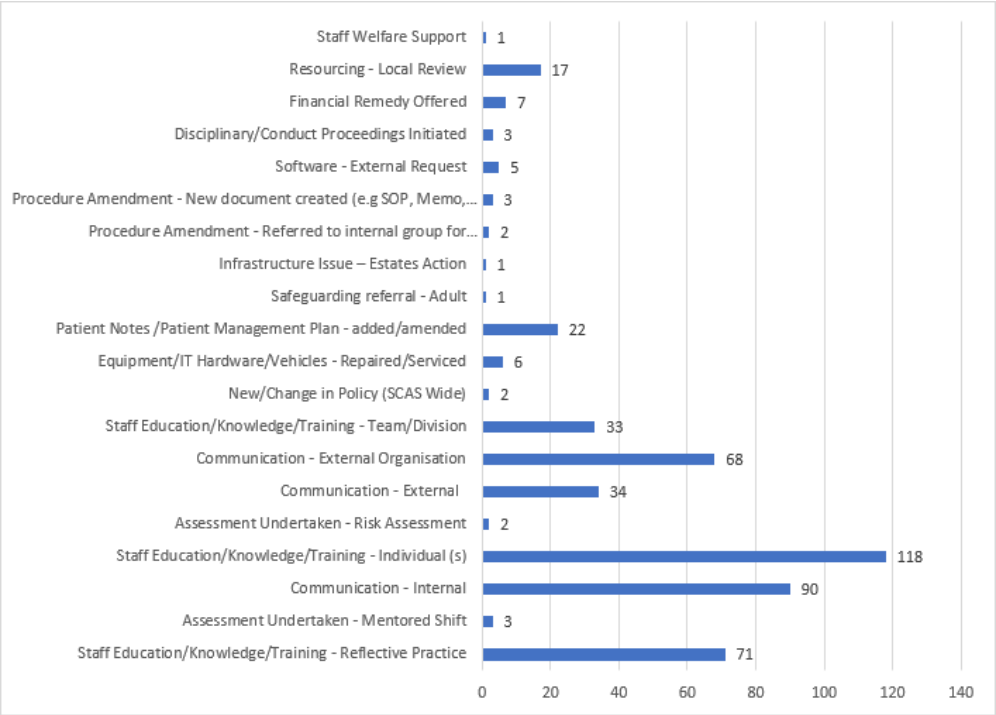
3.4.6 The Trust received 130 new formal complaints, 147 informal concerns and 364 HCP (Healthcare Professional) feedback requests during the reporting period. This is an increase in case numbers in all categories since the last report to the Board.

3.4.7 The concerns raised continue to formulate the following trends:

a) Access and waiting times
b) Clinical care
c) Communication with patients and families and external partners.

3.4.8 The chart below shows the outcomes and actions taken from PE investigations which were completed and closed during the reporting period.

Table 3 – Themes identified on completion of PE investigations



3.4.9 Complaints responded to within agreed **95%** target **February (92%), March (96%).**

3.4.10 The Trust received **232** compliments for the care and services delivered by our people during the reporting period, this is 102 more compliments that complaints received.

3.4.11 **Parliamentary & Health Service Ombudsman (PHSO)** are currently investigating 4 complaints.

3.5 Management of Medical Devices

3.5.1 The management of medical devices and the fragility of the Safeguarding referral systems remains the two highest risks to the delivery of safe effective care but are being closely monitored through the Board Assurance Framework (BAF).

3.5.2 The outstanding secondary Automated External Defibrillator (AED) devices have now been received and a plan has been developed, by the Assistant Director of Support Services and the Equipment Services Manager, to deploy to sites. Secondary devices have now been allocated to all operational sites and are in the process of being assigned to each Operational Fleet vehicle, with a completion deadline of 31 May 2023.

3.5.3 There have been no further Bag Valve Mask (BVM) incidents received during the reporting period.

3.5.4 The procurement of a new Trust wide Asset Management System remains outstanding. Although the Trust has a system it does not have the functionality that provides accurate tracking of individual pieces of kit and servicing information. The new system would ensure the organization can proactively manage and track all

equipment. The impact of the delay has been escalated through the delivery group governance structure.

3.5.5 A new asset management system would ensure that the Trust utilizes the budget more effectively and that devices are in the right place at the right time and are available for the delivery of patient care. The system could also support the delivery of a cost-effective replacement program and end of life disposal plan.

3.6 Medicines Management

3.6.1 The Medical Gas Group have reviewed new guidance *NHS England » Guidance on minimising time weighted exposure to nitrous oxide in healthcare settings in England*. We have risk assessed and can confirm Trust vehicles are more the compliant with the standard 10 air changes/hour.

3.6.2 **Mercedes vehicles** - the extraction fan on this vehicle has an extraction rate of 700m^3/h. Given the volume of the saloon area of the ambulances this equated to over 43 air changes per hour.

3.6.3 **Fiat vehicles** - the extraction fan on this vehicle has an extraction rate of 850m^3/h. Given the volume of the saloon area of the ambulances this equated to over 77 air changes per hour.

3.6.4 The risk may be a greater issue in non-regulated environments such as people's homes. There is not clear guidance in this area. This has been discussed at a national level and the proposal is for a position statement on any actions that may be required.

3.6.5 In the interim it has been advised that the Trust should release a memo to staff advising of the risk and if they need to administer Entonox[1] it should be used in a well-ventilated room (if not on the vehicle) and ensure the mouthpiece is used appropriately.

3.7 Safeguarding

3.7.1 During the reporting period 12 'tasks' have been closed on the Safeguarding Improvement Plan with the 11 action areas either on track or closed.

3.7.2 The Associate Director Safeguarding is reviewing the Safeguarding Supervision model across the Trust. A report will be presented at the May 2023 NHS Oversight and Scrutiny Group.

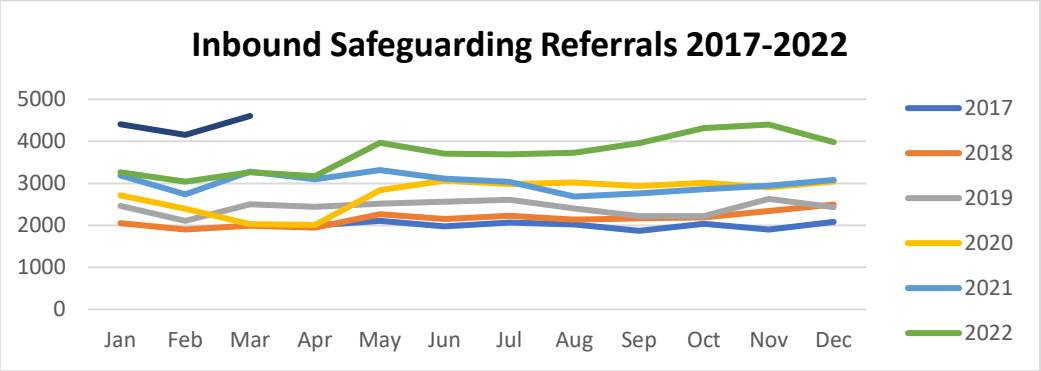
3.7.3 On reviewing the most recent data set and comparing trends over the past 4 years an increase of 72% in safeguarding referral activity has been noted. This is demonstrated in the table below.

Table 4 – Outcomes and actions from PE investigations

[1] *Reference Sources:*

Nitrous Oxide - No Laughing Matter - (birthinternational.com)

EH40/2005 Workplace Exposure Limits (hse.gov.uk)



3.7.4 A rapid review of 2022 data shows an increase in referral activity following the CQC inspection and a focus on improved Level 3 training and awareness raising sessions. This will be fully analysed in the Annual Report Safeguarding Report which **will be presented to Trust Board in July 2023.**

3.7.5 **An increase of 10% in Level 3 Safeguarding training has been achieved** during the reporting period and Priority Group A's total is 67.9%. This is slightly below trajectory and was because of two sessions being cancelled by the external provider. Remedial plans have been actioned to recover the position.

3.8 Mental Health

3.8.1 The Mental Health (MH) and Learning Disability (LD) Team have completed an Annual Report which is to be presented at the MH Steering Group on 12 May 2023. Highlights from the report include:

a) An increase in capacity from 1 (WTE) to 4 (WTE)
b) The development of Suicide Prevention Pathways and programmes of education with internal/external stakeholder collaboration
c) The development of the Crisis Care Pathways including 111 and the Rapid Response Mental Health Vehicle
d) The expansion of the MH Education Programme
e) Improvements in LD awareness, education, audit.

3.9 Complex Care Team

3.9.1 There are currently **341 Patient Management Plans (PMP) 'open'** to SCAS High Intensity Users (patients who call on a frequent basis). The aim of the plans is to ensure timely appropriate support is provided, in the right place, at the right time.

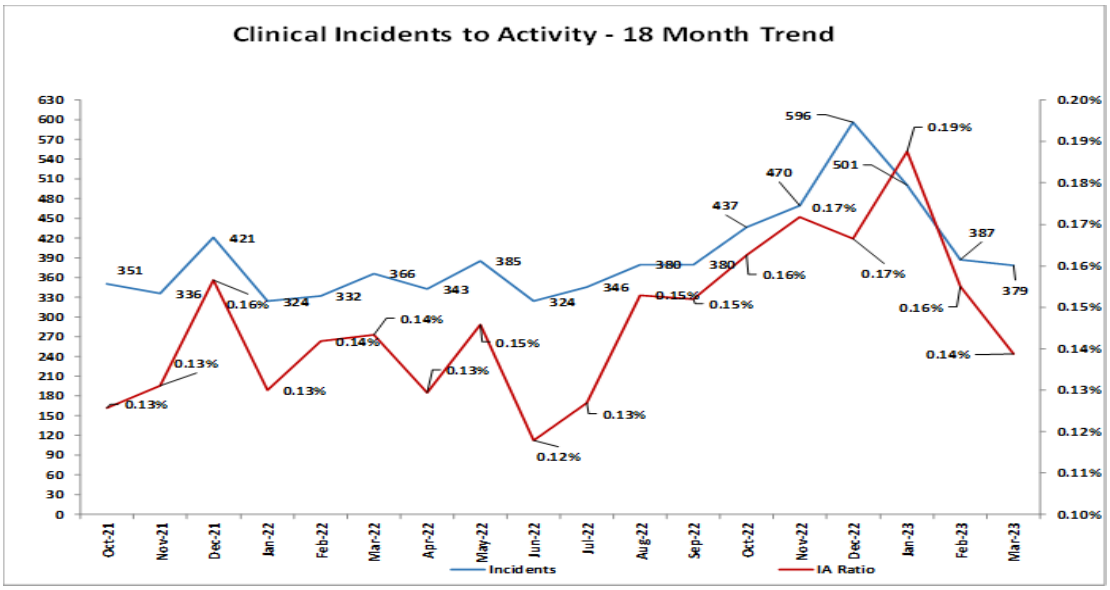
a) 75% relate to patients with a mental health condition.
b) 18% to patients with a physical health condition.
c) 8% of patients with a Learning Disability.

3.10 Incident Themes

3.10.1 A significant decrease in incident reporting has been noted during the reporting period and can be seen in the chart below. This correlated with an overall reduction in the reporting of moderate harms and above.

3.10.2 During the reporting period it is noted there was a reduction in the number of Serious Incidents declared (see table in Section 6.1 of this report).

Table 5 – Incident reporting in all services



3.10.3 A **52% decrease** in **EOC** clinical incident reporting was noted during the reporting period when compared to previous months. This is a significant reduction and reflects a period of more stable demand and the Trust operating at REAP[2] Level 2, rising to REAP 3 on the 2 March 2023. Incident numbers were similar for both EOCs with the South reporting (32) and the North reporting (35).

3.10.4 The top three **EOC** reported incident categories continue to be:

a) Delay
b) Patient Care and Treatment
c) Other (delay in police attending, following a change in procedure by Thames Valley Police).

3.10.5 The most common themes identified to date relate to delays caused by delays arriving on scene due to system demand, contact centre not following procedures, hospital handover delays, as well as inappropriate decisions to discharge patients at scene.

3.10.6 The most common root causes identified for delayed arrivals at scene were operational resourcing below plan, hospital queuing, demand outstripping available resource and adherence to operational policies.

3.10.7 The main reporting themes under the category of patient care and treatment continue to be:

a) Potential inappropriate dispositions
b) Potential incorrect clinical assessments and recontact within 24 hours.

3.10.8 **A significant decrease of 66 %** in **999** clinical incident reporting was noted during the reporting period, correlating with a reduction in system pressure and demand on services.

3.10.9 The top three reported 999 clinical incidents categories continue to be:

1. Patient Treatment / Care (173)
2. Medicines (40)
3. Delay (39).

[2] REAP- Resource, Escalation, Action, Plan provides a framework to maintain an effective and safe operational clinical response for patients.

3.10.10 Risk grading for clinical incidents remains low with most incidents graded as low or minor risk.

3.10.11 There was however, **1 incident categorised as 'death' following a delayed response.** This was reviewed at Incident Review Panel and met the Serious Incident (2015) criteria. Duty of Candour has been undertaken and an investigating officer appointed.

3.10.12 There was no significant change in the total number of Incidents reported in **NHS 111/IUC** when compared to the previous reporting period.

3.10.13 The only three incident categories reported by 111 as clinical incidents during reporting period 'Delay' (64), 'Patient Care/ Treatment' (34), and ICT Systems (5).

3.10.14 There was a decrease in telephony related incidents due to the pro-active work of the operational leadership and education teams supporting manual phone log ins, with only two telephony related incidents in February and March.

3.10.15 The predominant trend within delay was 'Contact centre failed to follow procedure' (17). Seven of these incidents are related to a failed referral review and are individual patients which are being investigated to establish if harm occurred.

3.10.16 Non-Urgent Patient Transport Services (NEPTS) – during the reporting period there was a slight decrease in clinical incidents reported. The top two reported incident categories continue to be Patient Care Treatment and Delay.

3.10.17 Patient Treatment and Care is consistently the highest reported category of clinical incidents reported during 2022-2023 and **has accounted for 70% of overall activity during the reporting period**.

3.10.18 An emerging theme of poor patient treatment and care in acute providers has been raised at the Commercial Division Clinical Governance (CG) meeting. A recommendation has been made to escalate the issue to the Integrated Care Board (ICB) PLACE meeting to discuss next steps.

3.10.19 **Notable Completed Actions**

3.10.20 Due to the increase in hospital's holding ambulances on their arrival to the Emergency Departments during recent months, reducing the capacity in SCAS service delivery and increasing delays to patients in the community. The Clinical Pathway Team have been reaching out to stakeholders to **increase availability of direct referral pathways for staff.**

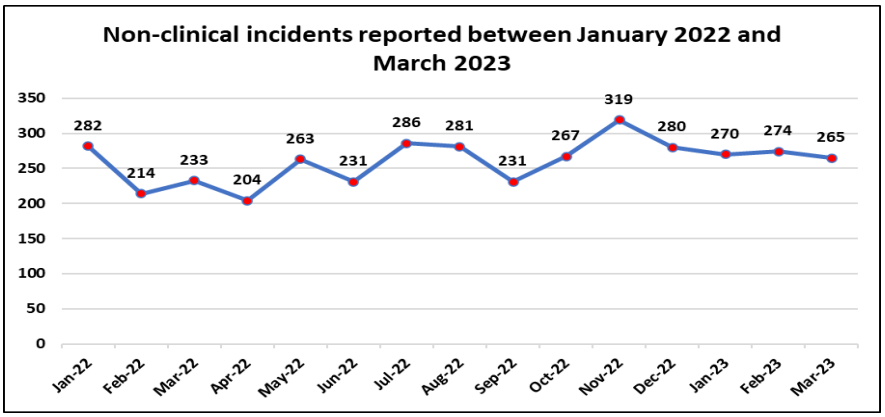
3.10.21 The Clinical Pathway Team **Hampshire Hospitals Call Before You Convey Pathway** open to staff on 6 February 2023 for crew support and hospital avoidance.

3.10.22 The Clinical Pathways team will continue to monitor this closely by viewing feedback from both staff and external stakeholders to ensure pathways are safe for patients, this update will be presented to the Clinical Review Group.

3.11 Non- Clinical Incidents

3.11.1 The chart below illustrates the total number of non-clinical incidents reported on the incident reporting system between February and March 2023, with the trend remaining static.

Table 6 – Non-clinical incidents



3.11.2 The table below illustrates the top ten non-clinical incident categories reported, with Abusive/Abusive behaviour continuing to be the top reported incident.

Table 7 – Non-clinical incidents - Top Ten Categories

Top ten non-clinical incidents reported in February 2023 and March 2023			
Category	**February 2023**	**March 2023**	**Total**
Abuse/abusive behaviour	55	63	**118**
Feature request	33	26	**59**
Manual Handling	34	24	**58**
Slip, trip, fall	28	21	**49**
Physical assault	19	18	**37**
Ill health	18	12	**30**
Contact with/struck by object/vehicle	11	16	**27**
Welfare	12	13	**25**
Vehicle	11	13	**24**
Other	10	13	**23**
Total	**231**	**219**	**450**

3.11.3 The table below illustrates the breakdown of the top three Abuse/abusive behaviour sub-categories illustrating that the sub-category with the highest number of incidents is verbal abuse.

Table 8 – Non-clinical incidents Top Three Abuse/Abusive Behaviour sub categories

Abuse/abusive behaviour incidents (Top three sub-categories) reported in February 2023 and March 2023			
Sub-categories	**February 2023**	**March 2023**	**Total**
Verbal abuse	24	30	**54** ↑
Threatening behaviour	18	21	**39** ↑
Poor attitude	12	12	**24** ↑
Total	**54**	**63**	**117** ↑

3.11.4 Abuse/Abusive behaviour incidents remain the top reported category.

3.11.5 The three top subcategories for abuse remain:

a) Verbal Abuse (54 incidents)
b) Threatening Behaviour (39 incidents)

c) Poor Attitude (24 incidents).

3.11.6 The majority of incidents continue to be reported by 999 operational staff.

3.11.7 Security at sites is being reviewed to ensure the safety of staff, equipment and fleet. Although there has not been an increase in reported security incidents, the Head of Risk and Security and the Health, Safety and Security Officer will carry out crime reduction surveys at Trust premises in this quarter.

3.11.8 To minimise risk of violence against staff from patients released from prison who *may* pose a threat, the head of Health and Safety is working with the Multi Agency Probation and Prison Agency (MAPPA) so if required, a security alert can be added to the SCAS dispatch system.

4.0 Duty of Candour

4.1 All incidents where Duty of Candour applied met the 10-working day requirement.

5.0 Patient Safety Incident Themes

5.1 The Trust continues to see patient treatment/care and delay categories of patient safety incidents being reported.

5.2 During daily critical reviews in the reporting period, identification of an emerging theme of patients with chest pain being discharged on scene with a re-attendance within 24 hours has been identified. An immediate response was to reissue Clinical memo 175 - *"The transportation and care of patient who present with chest pain"*

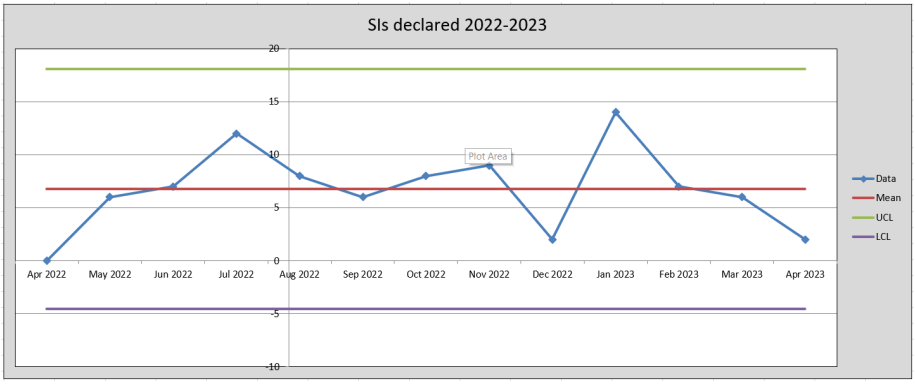
5.3 Two of these incidents were escalated to IRP and subsequently declared an SI.

6.0 Serious Incidents

6.1 At year end (2022-2023) the Trust declared (95) Serious Incidents (SI's) in line with the (2015) Serious Incident Framework. This included (83) specifically declared by SCAS and (12) system SI's that the Trust will support.

6.2 There is no sector SI benchmarking data available yet for 2022/2023. The National Ambulance Risk and Safety Forum will work on this through Quarter 1.

Table 9 – Serious Incidents Declared



6.3 During the reporting period:

a) (36) incidents were reviewed at the Incident Review Panel (IRP)
b) (17) SI's declared, (3) of which are recorded as system SI's

c) (4) SIs have subsequently been downgraded by the ICB following further information obtained through the investigation process.

6.4 The Trust has (2) SI's that are paused due to ongoing police investigations.

6.5 There are currently (4) SIs breaching the 60-day target for completion, each of these has an ICB approved extension in place and will meet the extension date.

6.6 A further (4) incidents have been reviewed at IRP and referred for a detailed investigation (DI). A DI is undertaken when a patient safety incident does not meet the (2015) Serious Incident Framework threshold, but it is found to require further investigation to gain learning.

7.0 Recommendations

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

Name and Title of Author:
Sue Heyes Director of Nursing, Governance & Quality / Deputy Chief Nurse (Interim)
Date: May 2023

NHS
South Central Ambulance Service
NHS Foundation Trust

BOARD OF DIRECTORS SUMMARY SHEET

Report title:	Operations Report – 999, 111 and Other			
Report to:	Trust Board (Part 1)			
Date of Meeting:	Thursday, 25 May 2023	Agenda Item:	11.0	
Executive Summary:	March was another challenging month, where we experienced a deterioration in performance and service levels with capacity impacted by handover delays and high levels of annual leave. Our performance across many metrics improved in April, including Cat 2 mean, 999 and 111 call answer.			
Recommendations:	The Trust Board is asked to note the issues in the 999 and 111 areas of SCAS and the operational support work to help with those challenges.			
Executive lead:	Paul Kempster, Chief Operating Officer			
Report author:	Luci Papworth, Paul Jefferies, Rob Ellery, Ross Cornett, Ruth Page			
Previously considered by:	An Operations Report is presented at every Board meeting in public.			
Purpose of report:	Note ☒	Approve ☐	Assure ☒	
Paper Status:	Public ☒	Private ☐	Internal ☐	

Assurance level:	Significant ☐	Acceptable ☒	Partial ☐	No Assurance ☐
	High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives	No confidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	Risk 1 - Achieving standards and targets
Quality Domain(s):	Patient Safety

Next Steps (what actions will be taken following agreement of the recommendations):

List of Appendices:

BOARD OF DIRECTORS MEETING IN PUBLIC 25TH MAY 2023

OPERATIONS REPORT – 999, 111 AND OTHER – KEY ISSUES

PURPOSE

1 The purpose of the paper is to provide the Board with an update on current performance in 999 and 111 and the delivery of projects to improve operations.

EXECUTIVE SUMMARY

2 March was another challenging month, where we experienced a deterioration in performance and service levels with capacity impacted by handover delays and high levels of annual leave. Our performance across many metrics improved in April, including Cat 2 mean, 999 and 111 call answer.

Clinical Co-ordination Centres

3 Inbound call volumes increased in March and impacted on the mean call answer performance, which rose to 42 seconds and raised the abandonment rate to 4%.

4 April 2023, at the time of writing this report, has shown an ever improving picture. Inbound call volumes remain above forecast by circa 7.5% but the mean monthly call answer is currently 16 seconds.

5 We currently have 153.5 WTE ECTs within the EOC but of these we now have just under 121 work effective. A large number of new starters are currently undergoing training/coaching. Attrition has slowed and recruitment has been positive. The IOW have had some delay with signing off the 26 WTE within their contract due to some sickness and attrition. They now have 21 WTE who are work effective and their recruitment is positive again.

6 Whilst it feels that demand in 111 has become slightly more manageable, telephony demand continues to trend upwards. Online demand has normalised.

7 April although 4% busier than March showed significant increases in performance, but both remain outside target. Support from national contingency remains in place with 5 – 10% of call volume being managed by another 111 provider.

	Call Answer 120 secs (≥95%)	Abandonment rate (≤5%)
March	38.78%	13.06%
April	66.17%	7.27%

8 Improvements in April performance were driven by increased logged in hours underpinned by a number of factors:

- A large number of health advisors being signed off from coaching and commencing rotas
- Sickness levels remain low (5.56% in April)

- The benefits from the work of the teams to improve average handling time is becoming obvious with a 1 minute and 41 second decrease since December.
- Annual leave abstractions were also markedly lower in April suggesting improvements may not be so sustainable. We are working with the teams to support staff with managing their leave allowances in line with policy.

9 Recruitment continues to receive high focus. Currently 243.52 WTE Health Advisors in post with a shortfall to 81 WTE to achieve performance. Clinical advisors 54.98 WTE in post with a requirement of another 26WTE to achieve performance.

10 Home working pilot for Health Advisors has demonstrated benefits and a paper is due to go to ETB in June with recommendations. Partis House project continues to move ahead and the team in MK are looking forward to an improved work environment.

11 The contract in place for the pilot on Cat 3/4 validation ended with SCW/CSU on 26th April. A new service is in place from 1st May 2023 which will provide GP validation of Cat 3/4 dispositions in 111 across the entire SCAS patch.

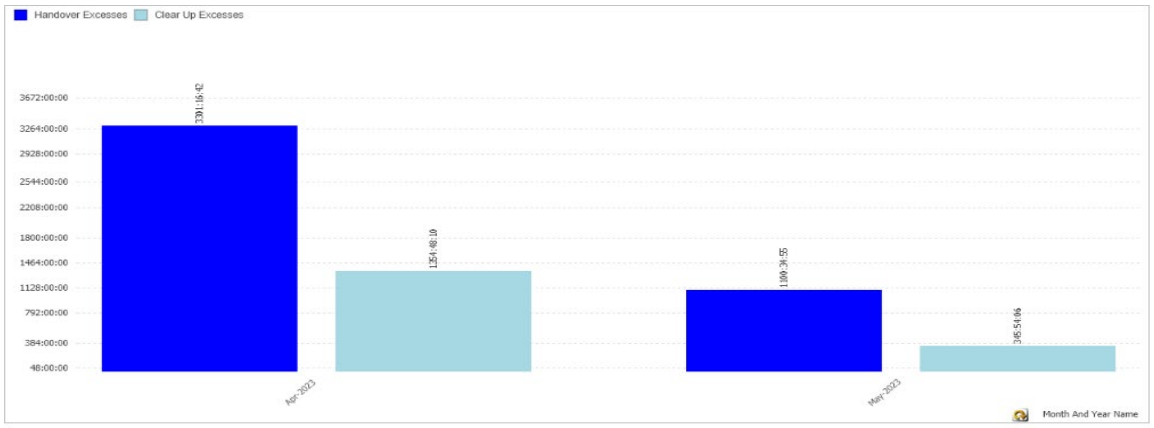
12 The reduction in funding for GP hours has unfortunately impacted our ability to validate emergency department dispositions in the Thames Valley. At time of writing data for April clinical outcomes not available. The review of the symptom groups that we will validate versus those that health advisors will book direct with no clinical input continues in the aim to make validation more efficient.

URGENT & EMERGENCY CARE

13 SCAS capacity increased due to lower leave levels. PP capacity has been reduced to offset SCAS hours and cost pressures.

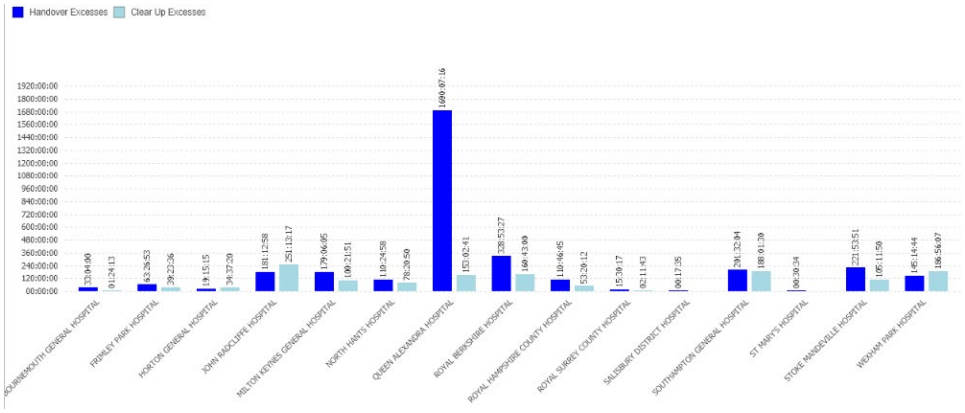
Hospital Handover Delays

14 We lost 4,400 hours during March and April with the average handover time across all hospitals being 37 minutes 12 seconds. This is a 10 second reduction from February, however this is still a significant reduction from the 53 minutes in December.



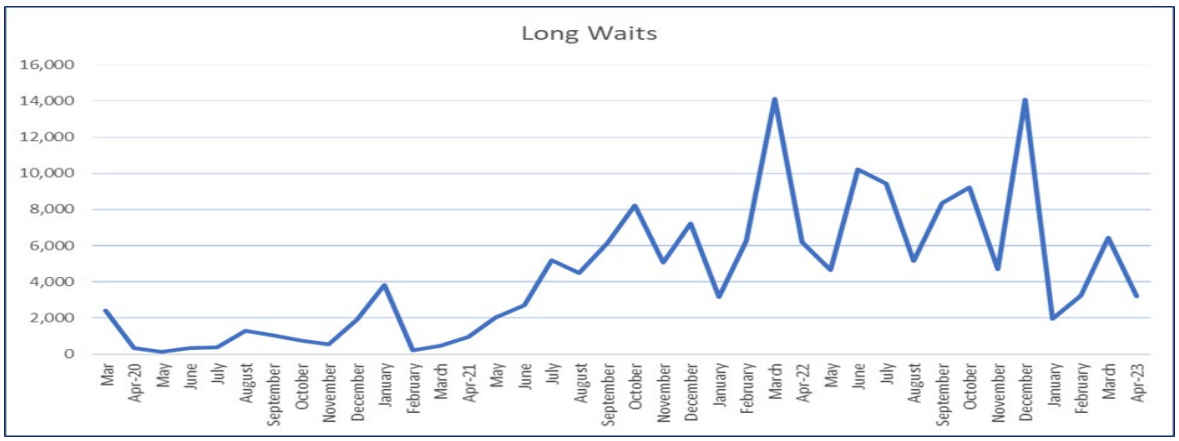
15 The QAH hospital had the highest level of delays at 1,690 hours, which is a slight increase from the previous month. We continue to see an impact from RBH, however

they have improved in the month by over 150 hrs, but we are continuing to work with them to resolve this.



Long Waits (LWs)

16 March has seen an increase in the cumulative total of long waits, almost doubling to **6,435** from 3,258 as recorded in February. This increase in LWs is significantly higher than that seen in overall demand and lost unit hours. Similar spikes have been recorded in each quarter since March 2022. Work continues to monitor trends and risks associated with long waits and the output from the LW governance group upwardly reports to Patient Safety Group.



Resilience & Specialist Operations

17 The top risks to SCAS which are currently being managed by the RSO team are:

- Pandemic Influenza: Currently the top risk on the National Risk Register including the risk of mutation of Bird Flu into Human to Human transmission.

- Industrial Action: Industrial Action in the Ambulance Service, Wider NHS and Emergency services affecting the ability to respond.

- Widespread Electricity loss: Rolling power outages to meet demand or a no notice widespread electricity loss from 24hr to 5-7 days.

- Severe Weather: We have strengthened our Winter and Business continuity plans over the last month to ensure that we are in a good position to deal with these issues and are continuing to work with partners to ensure we are not all drawing from the same resources. In particularly around severe cold, snow and flooding but not restricted to this as Heatwave and wildfire are also included.

18 The team continues to support the Industrial Action response which is ongoing and has plans in place for RGN and Unite action should this be required.

19 Business continuity is high on the agenda with specific planning around widespread electricity loss and its impact on the ability to maintain our services. This has been recently exercised and a number of learning points have been identified within SCAS and the Wider LRF's.

20 The Manchester Arena Inquiry (MAI) recommendations are being collated through the Resilience department and a full action plan is in place. We are fully linked in with the other Emergency Services through the Local Resilience Forum's.

21 Command training continues with both Multi Agency and Single Agency courses in progress through the next quarter.

22 SORT recruitment is still good with our goal of 290 staff in place, fully trained, by the end of March achieved and continuous training of existing staff and new staff ongoing through the year.

Clinical Equipment

23 Zoll incidents remain at lower rate with new moulded cables, although there has been an increase in damage to pins in cables due being inserted incorrectly. Communisations have been sent to ensure staff and Make Ready operatives are aware of the correct process. Zoll are reviewing feedback in order to alter the design to prevent future occurrences.

24 The new asset management project has been delayed due to the financial review and the resources required for project.

25 Secondary AED devices have arrived and are now on all operational vehicles. Guidance has been issued to staff and Make Ready. All devices are asset tagged and registered on the asset management system.

Ambulance Make Ready (MR) Services

26 The Tender for the new service continues and is moving through the competitive dialogue process. Detailed solution dialogue will take place throughout May with final tenders being submitted in June.

27 Work is on going to improve delivery on the current contract to ensure effective transition to the new contract. A Contract Manager role is being created to manage the new contract.

Fleet

28 Work continues with the convertors to ensure delivery of new DCAs. Revised plan has been submitted to the convertors and deliveries are due to start in September, with the full 125 DCAs expected to be delivered by the end of March 2024.

PROJECTS

Single Virtual Contact Centre - NHS 111

29 NHS England Regional Team (RT) have confirmed that from April 2023 funding is no longer available to complete the SVCC project technical work for 111. Following the decision to pause progress on this software development, the RT are now developing an options paper to decide on the benefits to complete these technical changes. Once the options have been reviewed with key stakeholders a decision will be taken on the next steps.

U&E Ops Roster Review & Realignment Project

30 Work has now progressed to the formal consultation phase and documentation has been circulated across front line 999 operations areas, including a specific communication with our band 4 staff on the proposed changes to the U&E model. Initial launch meetings have started, within each nodal area over coming weeks and key 'roster information' has been shared with the local roster champions/managers to help in the design of new rosters.

EOC Roster Review Project

31 Recently the Project Board approved the next steps to help finalise new roster designs and work pattern preferences for the ECT role. Work has also started on reviewing other supporting role selections (Assistant ECTs and Senior ECTs) on their proposed roster options, before launching formal staff consultation, to review and undertake a voting process. This is planned to occur throughout June/July 2023, with an implementation date in October 2023. Work with reviewing EOC Dispatch, CSD roster designs is now also underway.

999 CAD Replacement Programme

32 SCAS procurement colleagues are working with Hexagon, the current supplier of our 999 CAD solution (I/CAD), to ensure the programme benefits for the contract coverage throughout the procurement and implementation timeframe are in place. The current 999 CAD operating servers are nearing their end-of-life phase, and we are working with external partners/SCAS ICT to continue on the best possible solution to mitigate this risk. The Business Analyst has started to run workshops with representatives from across SCAS and IOW teams to document what will be required from the new CAD. An initial budget has been developed and will be submitted for approval once all costs have been fully assessed.

Emergency Services Mobile Control Project – National Radio Replacement

33 A new SCAS project manager has been appointed and the project structure is being set up with the launch meeting planned for the mid-May 2023. There will be two key

workstreams (technical and operational) reporting into the Project Board on a monthly basis.

34 The Control Room Solution (CRS) is the replacement software and hardware used in EOC and we are setting up a test site in Berrywood, with new software delivery expected during May ready for testing. The ASSURE part of programme to assess the SCAS area network radio coverage, the Emergency Services Network is well underway, and we have completed 25% of the site surveys to date. Work is also ongoing to secure premises for MDVS ambulance radio/MDT vehicle installation unit in Fareham with the property owner by July 2023.

CONCLUSIONS AND RECOMMENDATIONS TO THE BOARD

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

Name of author **Paul Kempster**
Job title of author **Chief Operating Officer**
Date paper written **May 2023**

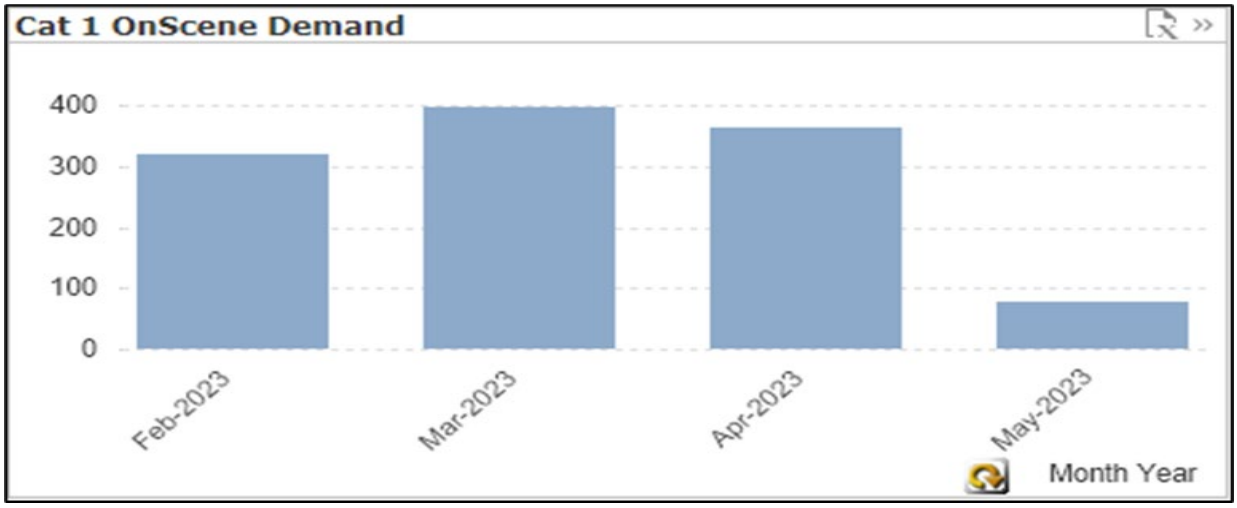
BOARD OF DIRECTORS MEETING IN PUBLIC 30TH MARCH 2023

OPERATIONS REPORT – 999, 111 AND OTHER

APPENDICES

Indirect Resources

1 Attendance has been maintained at a good level from February through to April, with an average CAT1 response totalling 360 attendances per month, peaking in March at 399 and slightly decreasing to 364 attendances in April. May has started as projected with 78 CAT1 incidents attended.



2 The Contribution to CAT1 has remained constant over the last three months with at least 30 secs. February saw an average level of CAT1 calls, with an attendance and stop rate of 69%. March saw an increase to 33 secs, this was due to the increased amount of CAT 1 incidents recorded for the month, leading to CET resources stopping the CAT 1 response time on 69% of CAT 1 incidents they attended. Contribution in April was a slightly lower 28 secs this was due to a reduction on total CAT1 incidents leading to a lower number of CAT1 incidents being stopped by CET resources.

CET Contribution by Month				
Month And Year Name	Feb-2023	Mar-2023	Apr-2023	May-2023
Total Cat 1 Incidents (SCAS)	2,998	3,412	3,352	887
% of Cat 1 Stopped by CET	7.3%	8.1%	7.4%	6.4%
Cat 1 CET OnScene	318	398	364	78
Cat 1 Stopped by CET	218	275	247	57
% of Cat 1 Onscene Stopped b...	68.6%	69.1%	67.9%	73.1%
Cat 1 Mean Stopped by CET	00:08:18	00:08:24	00:07:50	00:07:32
Cat 1 Mean (SCAS)	**00:08:33**	**00:09:16**	**00:08:14**	**00:08:17**
Cat 1 Mean - CET Removed	**00:09:03**	**00:09:49**	**00:08:43**	**00:08:41**
CET Contribution	**00:00:30**	**00:00:33**	**00:00:28**	**00:00:23**

3 Over the last three months total NOC has reduced and then recovered (591 in February, 559 in March, 591 in April). On scene rates have increased slightly to 90% of those NIFs allocated. We have seen an increase in % left with NOC left on scene (66.7% in April vs 65.3% in March) together with a reduction in both RRV and DMA on scene which will contribute to both our CAT3/4 performance and our S&T times.

4 Relocation of our Dynamic Response Vehicles (DRV's) is going well, having relocated a few vehicles we will hopefully see the impact of this soon. We will continue to look at the availability hours and placement of DRV's to ensure we can provide as much falls cover as we possibly can across the day.

Nature of Call - Falls (Cat 3 & 4)

Month	Total NOC	% with NOC left at scene	CET Assign	CET OnScene	Car OnScene	AMB OnScene	% CET on-scene to NOC	CSD / UCD OnScene	% AQI (CET 1st / EOC 2nd)	Cat 3 benefit to 90th	Cat 4 benefit to 90th	Avg Cat 3 Response time for AQI	Avg Cat 4 Response time for AQI	Back up time CET arrive - EOC	Back up time CE arrive - Clinical
Apr	591	66.7%	55	50	2	477	8.5%	34	1.7%	-	-	01:26:49	01:11:04	-	-
May	146	66.4%	16	16	0	112	11.0%	13	6.2%	-	-	01:08:15	02:05:37	-	-
Feb	591	67.2%	41	36	5	468	6.1%	26	1.7%	-	-	01:23:46	01:22:08	-	-
Mar	559	65.3%	56	50	5	433	8.9%	40	2.3%	-	-	01:34:09	01:46:24	-	-

South Central Ambulance Service
NHS Foundation Trust

Report title:	**Month 1 Finance Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**12.0**
Executive Summary:	The reported financial position for the month of April 2023 is a deficit of £1,829k. This is £829k adverse to plan. The budgets for the financial year 2023-24 represent the amended break-even plan as agreed by the Trust Board and submitted to the HIOW ICB in early May 2023. The plan includes targeted financial sustainability plans. The variance in the month to plan largely relates to: • Non-delivery of financial sustainability plans. • Above budget resource costs within the 999 service • Activity was higher than planned for 999 and also PTS. The budget has been profiled to reflect a deficit in the early months of the year whilst plans are developed to deliver efficiencies in the later months of the year. The Trust's cash balance at the end of April stood at £46,541k. A capital plan of £6,531k has been agreed for the financial year. The total capital spend is £258k on an original budget of £250k.		
Recommendations:	The Committee is asked to note the results.		
Executive lead:	Aneel Pattni, Chief Finance Officer		
Report author:	Sam Dukes, Deputy Chief Financial Officer		
Previously considered by:	Finance and Performance Committee		

Purpose of report:	Note ☒	Approve ☐	Assure ☐
Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	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

Justification for the above 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):	Finance & Sustainability
Links to BAF risks: (or links to the Significant Risk Register)	Risk 6 - Sufficient and stable financial resources
Quality Domain(s):	All Quality Domains

Next Steps (what actions will be taken following agreement of the recommendations):

List of Appendices:

Appendix A1: Financial Results for Month 1 ended 30th April 2023

NHS
South Central Ambulance Service
NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE 17 MAY 2023

FINANCE BRIEFING: MONTH 1, APRIL 2023

PURPOSE

1. The purpose of the paper is to present the financial results for April 2023.

EXECUTIVE SUMMARY / MAIN ISSUES

2. The Board have approved a breakeven budget for the financial year against which performance will be measured. The plan has been agreed with Hampshire and Isle of Wight ICS. The budgets outlined in the Month 1 report align to the agreed break-even position and have been profiled in line with a pragmatic delivery trajectory. The plan is set to deliver a £1m deficit a month for the first four months of the year, with financial performance then profiled to recover during the second half of the year.

3. The income budget for 2023-24 has been aligned to commissioner contract offers. For month 1, the actual income reported reflects the value of the contract offers while final agreement of contracts remains outstanding.

4. In month, the Trust reported a deficit of £1,829k which is £829k worse than plan.

		Month			Year to date			Full Year	
		Actual	Budget	Budget Variance	Actual	Budget	Budget Variance	Forecast	Budget
Margin									
999	£k	2,717	2,927	(210)	2,717	2,927	(210)	39,195	39,195
111	£k	236	623	(387)	236	623	(387)	7,120	7,120
National Covid Services	£k	(6)	0	(6)	(6)	0	(6)	0	0
Commercial	£k	120	1,143	(1,022)	120	1,143	(1,022)	11,802	11,802
Total		3,068	4,693	(1,625)	3,068	4,692	(1,625)	58,118	58,118
% Contribution	%	11.7%	17.9%	-6.2%	11.7%	17.9%	-6.2%	18.1%	18.1%
Corporate overheads	£k	4,898	5,693	795	4,898	5,693	795	58,118	58,118
Net Surplus/(Deficit)	£k	(1,831)	(1,000)	(831)	(1,831)	(1,001)	(831)	0	0
Loss/(Profit) on disposal		2	0	2	2	0	2	0	0
Overall Surplus/(Deficit)		(1,829)	(1,000)	(829)	(1,829)	(1,000)	(829)	0	0

5. Income for the Trust in April was adverse to plan by £40k. This reflects some slippage on non-contract income streams.

6. The pay award for 2023-24 has yet to be paid. The financial results assume payment at the budgeted 2.1%. It is anticipated that any variation from this payment will be funded in full by Commissioners.

7. The main driver of overspends in Month 1 is unidentified Financial Sustainability Plans affecting all service lines. The forecast position for the year is set to budget, detailed forecasting will be completed over the coming months,

RISK AND OPPORTUNITIES

17 A key factor to delivery of the budget will be the delivery of the Financial Sustainability Targets. A dedicated work-stream will support Divisional teams to identify and evaluate schemes for delivery. The Executive Team will continue to monitor the position closely.

18 It is intended to continue engagement with Commissioners to ensure activity and delivery plans are aligned to funding envelopes. Deviation from plans will result in financial pressures for Divisions.

CAPITAL AND CASH

19 A capital plan of £6,531k has been agreed for the financial year. The total capital spend is £258k on an original budget of £250k. The Trust's cash balance at the end of April stood at £46,541k.

		Month			Year to date			Full Year		
		Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance to budget
Cash and capital position										
EBITDA	£k	986	800	186	986	800	186	23,294	23,294	0
Working capital mov't	£k	(2,525)	564	(3,089)	(2,525)	564	(3,089)	(678)	1,462	(2,140)
Capital Expenditure	£k	(258)	(250)	(8)	(258)	(250)	(8)	(6,531)	(6,531)	0
IFRS 16 Leases	£k	(836)	(914)	78	(836)	(914)	78	(10,986)	(10,986)	0
Right of Use Asset (RoU)	£k	0	0	0	0	0	0	(14,903)	(14,903)	0
IFRS16 Lease Liability	£k	(841)	0	(841)	(841)	0	(841)	14,903	14,903	0
IFRS16 Peppercorn Reserves)	£k	0	0	0	0	0	0	0	0	0
Capital Sale and Leaseback Ex	£k	(9)	0	(9)	(9)	0	(9)	(3,744)	(4,903)	1,159
Capital Sale and Leaseback Inc	£k	0	0	0	0	0	0	5,884	4,903	981
Capital Disposals	£k	0	0	0	0	0	0	0	0	0
PDC paid	£k	0	0	0	0	0	0	(2,102)	(2,102)	0
PDC Receipt	£k	0	0	0	0	0	0	0	0	0
Cashflow	£k	(3,483)	200	(3,683)	(3,483)	200	(3,683)	5,137	5,137	0
Cash balance	£k	46,541	43,402	3,139	46,541	43,402	3,139	55,161	55,161	0

RECOMMENDATIONS TO THE BOARD

20 The Board is asked to note the results.

Sam Dukes
Deputy Chief Finance Officer

South Central Ambulance Service NHS Foundation Trust

BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**Chief Medical Officer's Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**13.0**
Executive Summary:	The purpose of the paper is to update the Board on key Clinical Issues relating to: • Ambulance Clinical Quality Indicators (ACQI) & Internal Care Bundle Audits Exception Report. • SCAS Clinical Research Updates & SCAS Annual Research Report • Emergency Naloxone packs for patients at risk of opiate overdose		
Recommendations:	The Trust Board is asked to: • To note the actions taken to improve clinical performance and patient safety, and the progress with clinical trial recruitment.		
Executive lead:	John Black Chief Medical Director		
Report author:	Martina Brown Research & Clinical Audit Manager John Black Chief Medical Officer		
Previously considered by:			

Purpose of report:	Note ☒	Approve ☐	Assure ☒
Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	Objective 1 High Quality Care and Patient Experience.
Quality Domain(s):	All Quality Domains
Next Steps :	

List of Appendices:

Appendix 1
SCAS ACQI performance

Appendix 2
Internal Care Bundle Audit Indicators

Appendix 3
New Standards of proficiency for HCPC

Appendix 4
Crash4 study; SCAS patient recruitment

Appendix 5
Paramedic3 study; SCAS patient recruitment

PUBLIC TRUST BOARD PAPER

Title	Chief Medical Officer's Report
Authors	Martina Brown Research & Clinical Audit Manager Louise Maunick Head of Pharmacy John Black Chief Medical Officer
Responsible Director	John Black Chief Medical Officer
Date	10 May 2023

1. Purpose

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

- Ambulance Clinical Quality Indicators (ACQI).
- SCAS Clinical Research Update and Annual Research Report
- Emergency Naloxone packs for patients at risk of opiate overdose.

2. Executive Summary

2.1 ACQI / Internal Care Bundle Audit Compliance

ACQI Background:

ACQI's are reported with a 5-month time lag due to NHSE submission and publishing timescales. Cardiac arrest and time-based STEMI and Stroke metrics are reported monthly, and care/diagnostic bundles are audited and reported one month in three, in line with a pre-determined reporting schedule.

STEMI call to needle inserting indicators is reported into the Myocardial Ischaemia National Audit Project (MINAP) system, with an ambulance import/export function. This means that STEMI time-based measures have been calculated on downloads, verification and uploads completed by ambulance trusts. There is a concern that the current process for uploads entered by the acute trusts is not in line with the monthly ACQI reporting schedule, as Acute Trusts are required to complete their uploads within the quarter. This will mean that not all cases are available for ambulance services to verify at the point of ACQI calculations, and hence it should be understood that the STEMI call to angiography dataset should be approached with caution in terms of accuracy.
For all Stroke time-based ACQI's, data is reported via the Sentinel Stroke National Audit Programme (SSNAP). This means that all the Stroke timeliness measures are based on confirmed Stroke cases.

Cardiac arrest outcomes are reported via the Warwick Out of Hospital Cardiac Arrest Outcome Registry (OHCAO).

In October 2020, the chair of the NHSE/I Ambulance Transformation Forum requested that the members of the National Ambulance Clinical Quality Group lead a review into the current ACQI's and focus on potential indicators that are reflective of the NHS Long Term plan. This work is in progress, and recommendations from the NACQG has been shared with the Ambulance Transformation Forum. Input from SCAS has been included in this review. One of the first changes that has been implemented is that from January 2021 cases, cardiac arrest survival is now measured by survival at 30 days, rather than at discharge. It is also anticipated that the Stroke Diagnostic Bundle will be retired. The Sepsis Care Bundle has now been retired as an ACQI and may become
a national audit. There is also a potential to move away from MINAP and SSNAP use for the STEMI and Stroke timeliness measures, with ambulance trusts identifying the cohorts for these indicators based on pre-hospital clinical impression, rather than confirmed STEMI or Stroke cases.

Care of those over 65 who fall has become a new ACQI requirement in 2023. The first cohort to be audited for this new ACQI will be cases from March 2023 (reported in July 2023 and results published in the August 2023 publication). The Technical Guidance for this care bundle has recently been issued by NHSE.

2.2 Key highlights and risks identified

1. SCAS is in the upper quartile rating when benchmarked nationally for 7 out of 13 ACQI indicators, 2 better than the last report to CRG (**Appendix 1**).

2. The number of indicators performing above or below the national average has not changed since the last report to CRG. 6 indicators have seen a very marginal deterioration and 6 an improvement since the last report to CRG. The indicators experiencing a very small deterioration are the STEMI Care Bundle, the STEMI PPCI time measures and the Stroke call to hospital time measures. The Sepsis Care Bundle has been retired as an ACQI.

3. For the year April to November 2022/23 SCAS is performing above the national average for 9 indicators, the same as reported to last CRG. Improvement has been seen in all audited measures outside of those reported at point 2.

2.3 ACQI Actions / Recommendations

1. Progress/continue work with Business Intelligence (BI) colleagues regards roll out of an ACQI scorecard has progressed. One element is almost ready for testing.

2. All patient facing staff working in the E&UC service are receiving an ACQI training session and resuscitation update as part of the 2023/24 mandatory face to face clinical update programme.

3. Communications to be released to ensure operational staff are aware of the care requirements of the new falls ACQI. This will commence this week (w/c 24/04/2023).

2.4 Key internal care bundle audit indicators highlights, and risks / issues identified

1. The Internal audit indicators are currently performing below the year end position 2021/22, except for Febrile Convulsion (**Appendix 2**).

2. Lower limb fracture remains the lowest performing indicator. Audit fails are most commonly due to non-recording of two pain scores and limb immobilisation. Mandated pain scoring has been implemented within the SCAS ePR system for applicable indicators but has only gone live in October 2022. Initial analysis of clinical records demonstrates that operational

clinicians are still able to close clinical records without completion of two pain scores. Whilst compliance is low for these two elements of the care bundle, compliance with the analgesia element remains high (92% in March).

3. Elderly falls was the next lower performing indicator. Audit fails are most commonly due to no documented history of falls and referral to a suitable Health Care Professional. However, the correct observations recorded were also low at 82% in December due to lack of blood sugar readings. This audit has now been retired and commenced as an ACQI with further elements of care required from March 2023.

4. The main reason for non-compliance in the asthma indicator relates to a lack of peak flow readings without a documented exception.

5. Work is underway to review all the compliance tools in the SCAS Ortivus ePR system and ensure they are mirrored in the Scribe 2 clinical records system used by Private Ambulance providers. The latest Scribe release is ready to go into the Live environment and the software team are liaising with the SCAS Private Provider Clinical Governance Lead to agree a trial plan. Following initial feedback from the trial devices, the software update will be rolled out across all Private Providers during Quarter 4 2022/23.

6. The low compliance for some of these indicators has been discussed at the E&UC clinical governance meeting, whereby there was a request for operational managers to share information and slide decks with their teams. This also includes the SCAS E&UC private provider CG lead.

3. SCAS Clinical Research Trials update

The purpose is to provide the Trust Board on key research issues relating to:

- Research projects being delivered
- Research delivery, including capacity and capability
- Provide key messages as an upward report from the Research Steering Group (RSG)

3.1 Research funding

- SCAS research team has been awarded additional funding (£35000) in response to meeting the commercial and non-commercial recruitment-based Key Performance Indicators (2022-23). This funding will be used to further enhance the capacity and capability of the trust to offer clinical research participation to even more service users.

3.2 New Standards of proficiency for HCPC paramedics

- Section 13.11 of the Standards states that at the point of registration, paramedics must be able to draw on appropriate knowledge and skills to inform practice to “engage service users in research as appropriate’’. (**Appendix 3**)
- CRG has supported the principle that all trust clinicians and non-clinicians are expected to be aware of the trust-approved research projects to appropriately assist and engage the service users in their care.
- Evidence could feed into the staff's annual Person Development Review and bi-annual Continuous Professional Development revalidation portfolio.

3.3 Emergency Operations Centre (EOC) engaged in research

- The EOC staff at Southern House are trialing a new way of identifying patients potentially suitable for research enrolment. Through a series of short questions, the emergency call takers, dispatchers and clinical support desk practitioners can provide answers to eligibility screening questions without delaying patient care. Using a tool (study-specific Customer

Rules Engine), an appropriate dispatch of research rapid response vehicle/clinician can be quickly initiated.

3.4 Ongoing clinical trials, open for participant enrolment:

- CRASH4 (IRAS 283157) This randomised, double-blind, placebo-controlled trial is investigating an intramuscular tranexamic acid for the treatment of symptomatic mild traumatic brain injury in older adults in the UK. SCAS has recruited the most patients into this national trial. (Patient recruitment: see **Appendix 4**).

- PARAMEDIC3 (IRAS 298182). This randomised trial is designed for an adult out-of-hospital cardiac arrest patients and compares the clinical and cost- effectiveness of intraosseous and intravenous access first strategy. (Patient recruitment: see **Appendix 5**).

3.5 SCAS Annual Research Report

- SCAS has just published its **Research Annual Report** which provides further information on the clinical research undertaken by the Trust including principle publications and presentations. This can be accessed via this link: https://www.dropbox.com/l/scl/AAAwvshy29SilOW5KRFmILZBzX0GX9kTTbY

4. Emergency Naloxone packs for patients at risk of opiate overdose.

SCAS has embarked on a project with Oxford Public Health to improve safety in patients at risk of opioid overdose. Naloxone is an opiate antidote that quickly reverses opiate induced ventilatory failure and can be administered via the nose in an emergency where the drug is rapidly absorbed across the nasal mucosa.

Emergency naloxone nasal administration pack

SCAS has engaged all Local Authorities across the South-Central region and established an agreement and funding to supply take-home emergency naloxone kits that will be packed on all frontline ambulances.

We are aiming to launch this initiative at the end of May, starting with a focus on delivery by the Milton Keynes Resource Centre (Blue Light Hub) before rolling the project out trust wide.

The SCAS Research team have been commissioned to monitor the project and establish the benefits of the initiative. We are hoping that this will improve the safety of our patients in the community following accidental overdose through bystander administration (e.g., by family

members/carers) before the arrival of the ambulance service. The initiative has been funded for one year initially at the end of which the project effectiveness will be reviewed.

5. Recommendations

The Board is asked to note the actions taken to improve clinical performance and patient safety, and the progress with clinical trial recruitment that is helping to drive clinical innovation within our ambulance service.

Name and Title of Author:
John JM Black, Chief Medical Officer

Date:
10 May 2023

Appendix 1

The table below details the average SCAS ACQI performance in comparison to all English ambulance NHS Trusts average performance, to the end of November 2022. This demonstrates that SCAS are performing in the upper quartile rating for 7 of 13 outcome and time-based indicator which is 2 better than reported at last CRG.

ACQIs YTD Apr to November 2022/23											
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	12.50%	28.33%	27.49%	29.59%	24.36%	24.68%	27.32%	24.31%	25.19%	23.65%	26.89%
% Cardiac Arrest Ustein ROSC	33.33%	47.16%	53.13%	42.30%	46.69%	44.44%	48.32%	45.60%	46.98%	51.60%	50.87%
% Cardiac Arrest Survive At 30 Days	6.67%	7.32%	8.33%	6.79%	7.94%	8.51%	7.51%	6.23%	9.83%	9.50%	9.07%
% Cardiac Arrest Utstein Survive At 30 Days	33.33%	22.62%	32.26%	20.82%	24.58%	23.00%	24.73%	23.12%	27.55%	34.56%	26.40%
% Cardiac Arrest Resus Care Bundle Achiev	100.00%	86.52%	75.12%	73.28%	60.27%	94.85%	70.00%	97.72%	77.99%	70.50%	69.37%
% STEMI Care Bundle	66.67%	70.38%	87.36%	68.46%	58.39%	81.32%	75.04%	96.84%	76.98%	64.37%	78.76%
% Stroke Care Bundle Achieved	95.65%	96.10%	98.54%	96.67%	93.17%	98.54%	93.90%	99.70%	96.96%	98.04%	98.85%
STEMI PPCI Mean Time CTN	196	159	146	163	146	158	151	173	155	139	173
STEMI PPCI 90Centile CTN	225	231	188	226	209	239	216	253	222	200	262
Stroke Mean Time CTD	1:31:40	1:41:55	1:38:28	1:40:19	1:39:19	1:57:46	1:52:36	1:56:05	1:40:55	1:40:34	2:11:31
Stroke 50Centile CTD	1:17:15	1:27:15	1:24:45	1:23:37	1:23:23	1:35:00	1:26:26	1:34:22	1:21:49	1:22:41	1:41:19
Stroke 90Centile CTD	2:26:34	2:46:22	2:28:30	2:43:37	2:41:22	3:17:53	2:59:23	3:15:30	2:35:53	2:38:45	3:44:23
% Sepsis Care Bundle Received		95.12%	84.16%	67.34%	80.56%	93.12%	90.18%	92.75%	87.13%	71.23%	68.06%
Rag key	1st	2nd	3rd	4th	If highlighted represents within upper quartile						

Since the last report to CRG, the Cardiac Arrest survival at 30 days Utstein measure has stayed at 1st place nationally. The STEMI call to needle insertion mean measure also remains in 1st place nationally. General survival at 30 days has stayed at 2nd. ROSC on hospital arrival (Utstein) has remained in 2nd. The Stroke call to hospital arrival mean remains out of the upper quartile, with the median times improving to 3rd and 4th place nationally.

The table below details average SCAS ACQI performance when compared with the 11 English Ambulance Trusts April-Sept 2022-23. The Stroke hospital arrival to scan and thrombolysis elements are not included due to the limited influence that SCAS can have on these indicators.

ACQIs YTD Apr to November 2022/23 Against Average								
Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Difference	Greater or lower than Average	Comments
% Cardiac Arrest ROSC At Hosp	12.50%	29.59%	17.09%	24.94%	23.65%	-1.29%	↓	% of Cardiac Arrest patients who ROSC'd at hospital handov
% Cardiac Arrest Ustein ROSC	33.33%	53.13%	19.80%	46.40%	51.60%	5.20%	↑	% ofUtstein patients who ROSC'd at hospital handover
% Cardiac Arrest Survive At 30 Days	6.23%	9.83%	3.60%	7.97%	9.50%	1.53%	↑	% of Cardiac Arrest patients who survive to 30 days
% Cardiac Arrest Utstein Survive At 30 Days	20.82%	34.56%	13.74%	26.63%	34.56%	7.93%	↑	% of Utstein patients who survive to 30 days
% Cardiac Arrest Resus Care Bundle Achiev	60.27%	100.00%	39.73%	79.60%	70.50%	-9.10%	↓	% of Cardiac Arrest patients that received the care bundle
% STEMI Care Bundle	58.39%	96.84%	38.45%	74.96%	64.37%	-10.59%	↓	% of patients that received the care bundle
% Stroke Care Bundle Achieved	93.17%	99.70%	6.53%	96.92%	98.04%	1.12%	↑	% of patients that received the care bundle
STEMI PPCI Mean Time CTN	139	196	57	160	139	- 21	↓	CTN= call to needle (minutes). Lower is better
STEMI PPCI 90Centile CTN	188	262	74	225	200	- 25	↓	Lower is better
Stroke Mean Time CTD	01:31:40	02:11:31	00:39:51	01:46:28	01:40:34	-00:05:54	↓	CTD = Call to door (time). Lower is better
Stroke 50Centile CTD	01:17:15	01:41:19	00:24:04	01:27:05	01:22:41	-00:04:24	↓	Lower is better
Stroke 90Centile CTD	02:26:34	03:44:23	01:17:49	02:52:34	02:38:45	-00:13:49	↓	Lower is better
% Sepsis Care Bundle Received	67.34%	95.12%	27.78%	82.97%	71.23%	-11.74%	↓	% of patients that received the care bundle

Four indicators are performing below the national average, which is the same as the last report to CRG. There has been marginal improvement in the YTD performance of 6 indicators and a deterioration in 4. Sepsis has been retired as an ACQI.

The STEMI Care Bundle cohort has seen a small deterioration in performance since the last report to CRG, as have the Stroke call to hospital time measures.

Work has commenced to review all of the ACQI compliance tools in the Ortivus ePR and mirror them in the Scribe clinical records system used by our private providers. The latest Scribe release is ready for releasing into the Live environment and the software team are liaising with the SCAS Private Provider Clinical Governance Lead to agree a trial plan. Following initial feedback from the trial devices, the software update will be rolled out across all Private Providers during Quarter 4 2022/23.

An ACQI training package which details the elements of care required for each care bundle has been developed and is being delivered in the mandatory 2023/24 face to face clinical update training programme, as is resuscitation training. This supports clinicians to deliver the required elements of care, in line with best practice guidance.

The SCAS Business Intelligence and Clinical Audit team have undertaken a review of the requirements of the new falls ACQI. Whilst there is no anticipated problem with the capture of eligible records, there is not an ePR data field to capture all elements of care without use of free text boxes, specifically 'head to toe' assessment. It was agreed at the last CRG to not amend ePR whilst this new indicator is in trial.

Appendix 2

Care Bundle Compliance 2022/23

NCPI		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD	2021/22
Asthma	Num	N/A	33	N/A	N/A	32	N/A	N/A	32	N/A	N/A	34	N/A	131	188
	Denom	N/A	50	N/A	N/A	50	N/A	N/A	50	N/A	N/A	50	N/A	200	250
		N/A	**66.00%**	**N/A**	**N/A**	**64.00%**	**N/A**	**N/A**	**64.00%**	**N/A**	**N/A**	**68.00%**	**N/A**	**65.50%**	**75.20%**
Limb Fracture	Num	14	20	15	19	14	14	14	14	21	17	13	17	192	208
	Denom	50	50	50	50	50	50	50	50	50	50	50	50	600	518
		28.00%	**40.00%**	**30.00%**	**38.00%**	**28.00%**	**28.00%**	**28.00%**	**28.00%**	**42.00%**	**34.00%**	**26.00%**	**34.00%**	**32.00%**	**40.15%**
Febrile Conv	Num	43	N/A	N/A	43	N/A	N/A	41	N/A	N/A	43	N/A	N/A	170	119
	Denom	50	N/A	N/A	50	N/A	N/A	50	N/A	N/A	50	N/A	N/A	200	153
		86.00%	**N/A**	**N/A**	**86.00%**	**N/A**	**N/A**	**82.00%**	**N/A**	**N/A**	**86.00%**	**N/A**	**N/A**	**85.00%**	**77.77%**
Elderly Falls	Num	28	24	30	30	29	26	31	31	27	31	26	20	333	385
	Denom	50	50	50	50	50	50	50	50	50	50	50	50	600	600
		56.00%	**48.00%**	**60.00%**	**60.00%**	**58.00%**	**52.00%**	**62.00%**	**62.00%**	**54.00%**	**62.00%**	**52.00%**	**40.00%**	**55.50%**	**64.16%**

Appendix 3

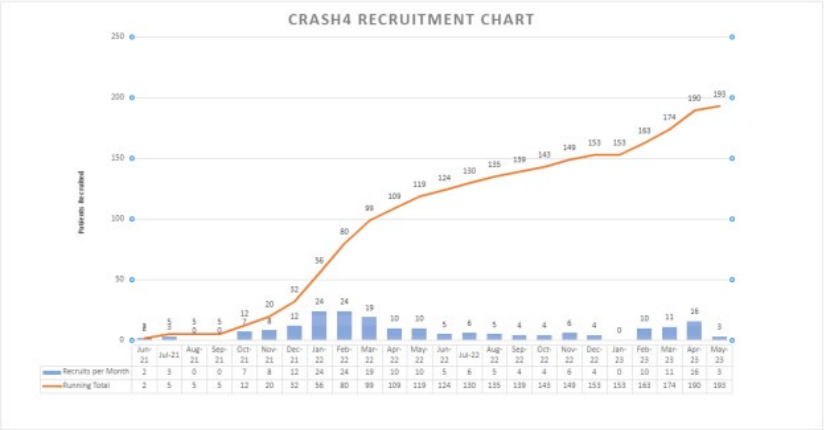
New Standards of proficiency for HCPC

paramedics---new-standards.pdf (hcpc-uk.org)

paramedics---sop-changes.pdf (hcpc-uk.org)

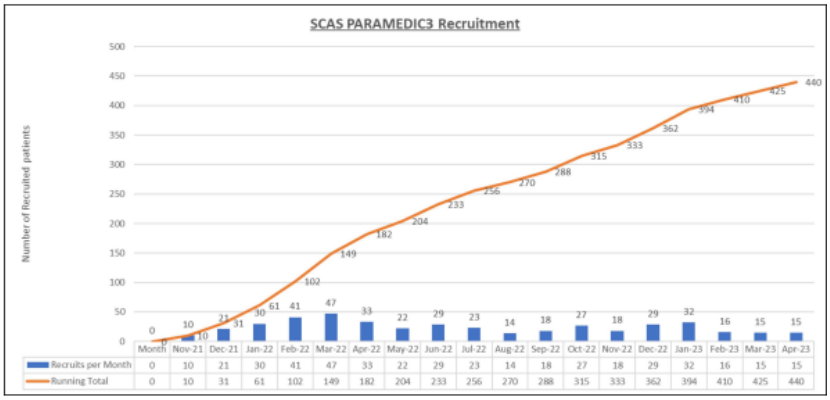
Appendix 4

Crash4 study; SCAS patient recruitment



Appendix 5

Paramedic3 study; SCAS patient recruitment



TRUST BOARD MEETING SUMMARY SHEET

Report title:	**Self-Certification**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**14.0a**
Executive Summary:	The Board is requested to approve the two attached self-certified Licence Condition statements. The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. The licence requires NHS providers to self-certify their compliance with Licence Conditions G6 (Systems for compliance with Licence Conditions and related obligations) and FT4 (Trust governance arrangements). As background information, the standard licence conditions are grouped into seven sections (please refer to the end of this paper). The first section, containing the General Conditions, sets out standard requirements and rules for all licence holders. Sections 2 to 5 of the licence are about the Regulator's functions: setting prices; enabling services to be provided in an integrated way; safeguarding choice and competition; supporting commissioners to maintain service continuity and translating the oversight of Foundation Trust governance into the new provider licence. The final section, 7, contains definitions and notes. **<u>Condition G6</u>** This Licence Condition requires that providers take all reasonable precautions against the risk of failure to comply with the Licence. Providers must annually review whether the processes and systems used to review compliance with this Licence Condition are effective and are required to self-certify this. Condition G6 requires NHS Trusts to have processes and systems that: identify risks to compliance with the licence, NHS Acts and the NHS Constitution; and guard against those risks occurring. **<u>Continuity of services: condition 7 - Availability of Resources</u>** The template also includes a section referred to as 'Continuity of services: condition 7 - Availability of Resources (FTs designated CRS only)' in (section 6 of the licence). The Trust is not required to complete this section as it is not subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service and has been left blank. NB: A 'commissioner requested service' is a service needing the protection of the continuity of services provisions of the NHS provider licence and include:		

- there is no alternative provider close enough
- removing them would increase health inequalities
- removing them would make other related services unviable
-

Certification on training of governors

This statement declares that the Board is satisfied that during the financial year that the Trust has provided the necessary training to its Governors to ensure they are equipped with the skills and knowledge that they need to undertake their roles.
Boards must sign their G6 self-certification by 31 May 2023 and publish it on their websites by 30 June 2023.

Condition FT4

Condition FT4 requires that Trusts review their governance systems to ensure that they meet the standards of good corporate governance required of a supplier of health care services to the NHS.

Condition FT4 relates to the establishment and implementation of corporate governance systems and processes to ensure that it has:

i. effective Board and Committee structures;

ii. clear responsibilities for the Trust's Committees reporting to the Board and for staff reporting to the Board and to those Committees;

iii. clear reporting lines and accountabilities throughout the organisation;

iv. compliance with the duty to operate efficiently, economically and effectively;

v. effective scrutiny and oversight by the Board of the organisation's operations;

vi. management of material risks to complying with the Licence Conditions and other legal requirements;

vii. sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

viii. planning and decision-making processes that take timely and appropriate account of quality-of-care considerations;

ix. engagement on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate, views and information from these sources and that there is clear accountability for quality of care throughout the organisation; and

x. in place personnel on the Board, reporting to the Board and within the rest of the organisation, who are sufficient in number and appropriately qualified to ensure compliance with the Licence Conditions.

Boards must sign their FT4 self-certification by 30 June 2023.

For the ease of reference, the responses contained in the FT4 self-certification to are repeated below:

1. The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate

	governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The Annual Governance Statement describes the high standards of corporate governance employed by SCAS and which are regarded as appropriate for a supplier of health care services to the NHS. The Trust has in place, a scheme of delegation, standing orders, and a set of standing financial instructions. Board Committees operate within their Terms of Reference and are chaired by a Non-Executive Director. It has the relevant statutory governance requirements in place. **2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.** The Board's cycle of business allows for good corporate governance guidance issued by NHSE, to be brought to the attention of the Board in a timely manner. The Trust Board has received development sessions on Risk Management and Risk Appetite to support the principle of good corporate governance and ensuring the Board has the required skills and knowledge to fulfil their duties under the license, as well as reviewing and updating the Risk Management Policy and creating a Risk Management Framework. The Board and the Senior Leadership have undertaken a series of training sessions relating to good corporate governance such as effective reporting writing and effective chairing of meetings. Non-Executive Directors' performance and objectives are reviewed annually through the appraisal system. **3. The Board is satisfied that the Licensee has established and implements:** **(a) Effective board and committee structures;** **(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and** **(c) Clear reporting lines and accountabilities throughout its organisation.** The Trust has effective Board and Committee structures and their responsibilities and accountabilities are clearly detailed in the Standing Orders and Terms of Reference. The Board Committee Structure reflects the Trust's assurance and oversight requirements and the Committees' Terms of References have been reviewed. The Annual Governance Statement, contained within the Annual Report, sets out developments each year. Executive Director responsibilities are set out in job descriptions & annual objectives reported to the Remuneration Committee. Non-Executive Directors' performance and objectives are reviewed annually through the appraisal system. **4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:** **(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;**

	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; **(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;** **(d) or effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);** **(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;** **(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;** **(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and** **(h) To ensure compliance with all applicable legal requirements.** The Annual Governance Statement describes: a. systems and processes to ensure compliance with the duty to operate efficiently, economically and effectively; b. systems and processes for timely and effective scrutiny and oversight by the Board of the organisation's operations and for effective financial decision-making and management and control; and c. systems to identify and to manage material risks to compliance with the licence conditions and with all applicable legal requirements. During the year, the Trust achieved the following: a. Production of the Annual Governance Statement contained in the Annual Report which is compliant with regulatory requirements. b. Regular Board and Committee meetings which undertook reviews of planned work and included regular oversight of performance information, financial information and the design of the new BAF. c. Robust external and internal audit processes have confirmed that there are no material concerns about key internal controls and processes. d. Review and update of the Risk Management Policy and creation of a Risk Management Framework. e. Board training sessions on Risk Management and Risk Appetite. The Trust has sufficient skills and capacity at Board level to undertake financial-decision making, management and control. The self-certification provides evidence of the Board's review and assessment of its going concern status. The Annual Governance Statement identifies that the Trust Board is well sighted on the issues and risks.

	5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: **(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;** **(b) That the Board's planning and decision-making processes take timely and appropriate account of quality-of-care considerations;** **(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;** **(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;** **(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and** **(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.** Please refer to the Annual Governance Statement. The Trust has systems and processes to ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided, that the Board's planning and decision-making processes take timely and appropriate account of quality-of-care considerations, and that there are systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate. The Trust Board concerns itself with quality of care at each Trust Board meeting including starting the substantive agenda with patient, staff and volunteer stories, and through its Committee structure; The Trust Board and Committees receives intelligence on staff and patient experience through a number of routes during the year - annual staff survey, Friends and Family test, Patient Experience, complaints and serious incident reporting. Quality issues are standing items on Board agendas. The Board receives reports from the Quality and Safety Committee and/or substantive items being presented. The Quality and Safety Committee is a Board Committee which meets to consider and to oversee patient and wider quality issues. There is an established governance framework which considers clinical and quality governance and information governance. The Board receives frequent reports relating to patients' experiences at its meetings. Patient involvement and experience is gauged by surveys and other forms of feedback. **6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are**

	sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. Regular Board and Committee reports about the organisation's establishment, recruitment and retention initiatives, safe levels of staffing and succession management and leadership training are received. The Remuneration Committee meets to discuss Executive Directors' performance and Board succession planning. Board members comply with the annual Fit and Proper Person Test. For the Board's information, the 2022-2023 licence headings have been included below: **Section 1 – General Conditions** G1: Provision of information G2: Publication of information G3: Payment of fees to Monitor G4: Fit and proper persons G5: Monitor guidance G6: Systems for compliance with licence conditions and related obligations G7: Registration with the Care Quality Commission G8: Patient eligibility and selection criteria G9: Application of Section 5 (Continuity of Services) **Section 2 – Pricing** P1: Recording of information P2: Provision of information P3: Assurance report on submissions to Monitor P4: Compliance with the National Tariff P5: Constructive engagement concerning local tariff modifications **Section 3 – Choice and competition** C1: The right of patients to make choices C2: Competition oversight **Section 4 – Integrated care** IC1: Provision of integrated care **Section 5 – Continuity of Services** CoS1: Continuing provision of Commissioner Requested Services CoS2: Restriction on the disposal of assets CoS3: Standards of corporate governance and financial management

	CoS4: Undertaking from the ultimate controller CoS5: Risk pool levy CoS6: Cooperation in the event of financial stress CoS7: Availability of resources **Section 6 – NHS foundation trust conditions** FT1: Information to update the register of NHS foundation trusts FT2: Payment to Monitor in respect of registration and related costs FT3: Provision of information to advisory panel FT4: NHS foundation trust governance arrangements			
Recommendations:	The Trust Board is asked to approve the paper.			
Executive lead:	Daryl Lutchmaya, Chief Governance Officer			
Report author:	Daryl Lutchmaya, Chief Governance Officer			
Previously considered by:	The self-declaration statements have been shared with the Executive Directors and members of the Audit Committee.			
Purpose of report:	Note ☐	Approve ☒	Assure ☐	
Paper Status:	Public ☒	Private ☐	Internal ☐	
Assurance level:	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
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Strategic Objective(s):	All strategic objectives			
Links to BAF risks: (or links to the Significant Risk Register)				
Quality Domain(s):	All Quality Domains			

Next Steps:

- Boards must sign their G6 self-certification by 31 May 2023 and publish it on their websites by 30 June 2023.
- Boards must sign their FT4 self-certification by 30 June 2023.

List of Appendices:

- Corporate Governance Statement – FT4

- General condition 6 and Continuity of Service condition 7 – G6

Worksheet "FT4 declaration" | Financial Year to which self-certification relates | 2022-2023

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Annual Governance Statement describes the high standards of corporate governance employed by SCAS and which are regarded as appropriate for a supplier of health care services to the NHS. The Trust has in place, a scheme of delegation, standing orders, and a set of standing financial instructions. Board Committees operate within their Terms of Reference and are chaired by a Non-Executive Director. It has the relevant statutory governance requirements in place.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board's cycle of business allows for good corporate governance guidance issued by NHSE, to be brought to the attention of the Board in a timely manner. The Trust Board has received development sessions on Risk Management and Risk Appetite to support the principle of good corporate governance and ensuring the Board has the required skills and knowledge to fullfil their duties under the license, as well as reviewing and updating the Risk Management Policy and creating a Risk Management Framework. The Board and the Senior Leadership have undertaken a series of training sessions relating to good corporate governance such as effective reporting writing and effective chairing of meetings. Non-Executive Directors' performance and objectives are reviewed annually through the appraisal system.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has effective Board and Committee structures and their responsibilities and accountabilities are clearly detailed in the Standing Orders and Terms of Reference. The Board Committee Structure reflects the Trust's assurance and oversight requirements and the Committees' Terms of References have been reviewed. The Annual Governance Statement, contained within the Annual Report, sets out developments each year. Executive Director responsibilities are set out in job descriptions & annual objectives reported to the Remuneration Committee. Non-Executive Directors' performance and objectives are reviewed annually through the appraisal system.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Annual Governance Statement describes: a. systems and processes to ensure compliance with the duty to operate efficiently, economically and effectively; b. systems and processes for timely and effective scrutiny and oversight by the Board of the organisation's operations and for effective financial decision-making and management and control; and c. systems to identify and to manage material risks to compliance with the licence conditions and with all applicable legal requirements. During the year, the Trust achieved the following: a. Production of the Annual Governance Statement contained in the Annual Report which is compliant with regulatory requirements. b. Regular Board and Committee meetings which undertook reviews of planned work and included regular oversight of performance information, financial information and the design of the new BAF. c. Robust external and internal audit processes have confirmed that there are no material concerns about key internal controls and processes. d. Review and update of the Risk Management Policy and creation of a Risk Management Framework. e. Board training sessions on Risk Management and Risk Appetite. The Trust has sufficient skills and capacity at Board level to undertake financial-decision making, management and control. The self-certification provides evidence of the Board's
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Please refer to the Annual Governance Statement. The Trust has systems and processes to ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided, that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations, and that there are systems and processes for escalating and resolving quality issues including escalating them to the Board where appropriate. The Trust Board concerns itself with quality of care at each Trust Board meeting including starting the substantive agenda with patient, staff and volunteer stories, and through its Committee structure; The Trust Board and Committees receives intelligence on staff and patient experience through a number of routes during the year - annual staff survey, Friends and Family test, Patient Experience, complaints and serious incident reporting. Quality issues are standing items on Board agendas. The Board receives reports from the Quality and Safety Committee and/or substantive items being presented. The Quality and Safety Committee is a Board Committee which meets to consider and to oversee patient and wider quality issues. There is an established governance framework which considers clinical and quality governance and information governance. The Board receives frequent reports relating to patients' experiences at its meetings. Patient involvement and experience is gauged by surveys and other forms of feedback.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Regular Board and Committee reports about the organisation's establishment, recruitment and retention initiatives, safe levels of staffing and succession management and leadership training are received. The Remuneration Committee meets to discuss Executive Directors' performance and Board succession planning. Board members comply with the annual Fit and Proper Person Test.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Name** Professor Sir Keith Willett CBE

Signature _____ **Name** David Eltringham

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A Further evidence of the SCAS's work in risk management is considered by the Risk Register and by the Board Assurance Framework which is available from the Trust's website in the Public Board meeting papers.

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | **2022 -2023**

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Professor Sir Keith Willett CBE	**Name**	David Eltringham
Capacity	Chairman	**Capacity**	Chief Executive Offier
Date	25 May 2023	**Date**	25 May 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A:

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2022 - 2023

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. — **Confirmed**

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Professor Sir Keith Willett CBE	**Name**	David Eltringham
Capacity	Chairman	**Capacity**	Chief Executive Offier
Date	25 May 2023	**Date**	25 May 2023

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

TRUST BOARD MEETING SUMMARY SHEET

Report title:	**2022/23 Annual Report and 2022/23 Financial Statements – Approval Process**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**14.0b**
Executive Summary:	The Board is requested to delegate authority to approve the 2022/23 Financial Statements and the text of the 2022/23 Annual Report to a Special Trust Board meeting to be held on 22 June 2023 comprising the members of the Audit Committee. The approval of the Annual Report and approval of the Annual Financial Statements are powers that are reserved to the Trust Board. The Department of Health and Social Care timetable requires that the audited 2022/23 Financial Statements and the text of the 2022/23 Annual Report are submitted to NHSE no later than midday on Friday 30 June 2023. The June Trust Board is to be held on Thursday 29 June 2023; the day before the deadline for submitting the 2022/23 audited accounts and text of the Annual Report to the Department, which does not allow sufficient time for any amendments arising from the external audit and discussion at the Board to be addressed. It is therefore proposed that a Special Trust Board be convened on Thursday 22 June 2023, the day on which the Audit Committee is planned to meet, to approve the 2022/23 Financial Statements and text of the Annual Report. This Special Trust Board to comprise the members of the Audit Committee. To enable Trust Board members to review the 2022/23 Financial Statements and the text of the 2022/23 Annual Report, it is being presented to the meeting of the Trust Board on 25 May 2023 Trust Board meeting for comment. Any comments including those from the external audit, can then be taken into account at the Special Trust Board meeting to be held on Thursday 22 June 2023 where the Financial Statements and Annual Report will be approved.		
Recommendations:	The Trust Board is asked to approve the paper.		
Executive lead:	Daryl Lutchmaya, Chief Governance Officer		
Report author:	Daryl Lutchmaya, Chief Governance Officer		
Previously considered by:	The Chair, CEO, CFO and members of the Audit Committee have been consulted and support the proposal.		
Purpose of report:	Note ☐	Approve ☒	Assure ☐

Paper Status:	Public ☒		Private ☐	Internal ☐
Assurance level:	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
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Strategic Objective(s):	All strategic objectives			
Links to BAF risks: (or links to the Significant Risk Register)				
Quality Domain(s):	All Quality Domains			
Next Steps The Audit Committee will convene a Special Trust Board meeting on 22nd June to consider the 2022/23 Financial Statements and the text of the 2022/23 Annual Report.				
List of Appendices:				

TRUST BOARD MEETING SUMMARY SHEET

Report title:	**Governance Update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**14.0c**
Executive Summary:	The Board is requested to note this report which describes how governance will be operationalised at the Trust to provide an effective integrated governance function, the aim of which will be to provide the Board with assurance that there is effective and high-quality management that is operating consistently throughout our Trust at all levels. The phasing in of an integrated governance function will be gradual but firmly embedded in the organisation. Early evidence of good governance being operationalised at the Trust will: - be that governance becomes routine and will form part of our daily work; - be embedded within our policies and procedures; - support meetings to operate effectively and efficiently; and - provide a line of sight from non-clinical and clinical operational management through to the Board.		
Recommendations:	The Trust Board is asked to note the paper.		
Executive lead:	Daryl Lutchmaya, Chief Governance Officer		
Report author:	Daryl Lutchmaya, Chief Governance Officer		
Previously considered by:			

Purpose of report:	Note ☒	Approve ☐	Assure ☐
Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	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

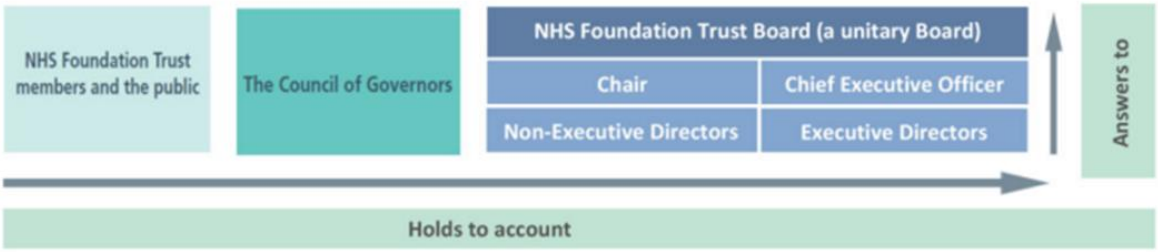
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	
Quality Domain(s):	All Quality Domains
Next Steps Design of a Governance Framework as part of an Integrated Governance function	
List of Appendices: **Integrated Governance** **Draft Board Agenda Planner**	

Integrated Governance

Corporate Governance is only one strand within the remit of governance. The term 'Integrated Governance' actually provides a more holistic approach to organisational governance which is more appropriate to the level of governance maturity that exists at SCAS.

The Department of Health in 2006 defined 'integrated governance' as the 'systems, processes and behaviours by which Trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations.'

As a Foundation Trust, SCAS is not only a provider to various integrated care systems and has external reporting requirements; it also must meet the reporting needs of the Council of Governors and must engage with its members and wider public. Fundamental to SCAS's governance structures and roles is the chain of accountability as shown in the diagram below.



NHS Foundation Trusts are public benefit corporations and their Boards of Directors have a framework of local accountability through members and a Council of Governors. The NHS Foundation Trust Council of Governors is responsible for holding the Non-Executive Directors individually and collectively to account. In turn, NHS Foundation Trust Governors are accountable to the members who elect them and must represent their interests and the interests of the public.

Arguably, Integrated Governance can be delivered through an internal control framework which is based on four strands; focused on a number of systems, processes and controls that work alongside and support each other whilst being integrated to deliver a robust organisational governance structure.

NHS South Central Ambulance Service NHS Foundation Trust

Internal Control Framework

Governance Framework

Constitution, Standing Orders, Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation

Well-Led Review and compliance with the Code of Governance

Board (recruitment, development and training of NEDs, effectiveness, secretariat support, Forward agenda plans, etc.)

Committee Reporting Structure (membership, Terms of Reference & workplans, effectiveness, alignment of forward agenda plans etc.)

Council of Governors (elections, support and training, secretariat support, membership engagement etc.)

Corporate Affairs (policies management, risk management, conflicts of interests management, etc.)

Internal processes and escalation (procurement and tenders, business cases, risk registers, incident reporting, contract register, information governance, legal, annual planning process, strategy reviews etc.)

External communication with stakeholders

Accountability Framework: Members, Council of Governors, Non-Executive Directors & Board

Assurance Framework

1st Line – Operational
Provides operational leadership, holds Senior Leadership Team to account on specific issues, escalates risks and problem solves.

Performance Reporting: operations, finance & budget, Incidents, recruitment, staffing, training, clinical and quality, risk registers etc.

2nd Line – Management
Provides strategic leadership, holds Executive leadership to account, unblocks and assists with problem solving.

Decision and 1st line oversight: IPR, business cases, strategies, options appraisals, performance management etc.

2nd Compliance Function
Oversight 1st line & internal control: internal audit actions, regulatory actions, policies, fit and proper persons, conflicts of interests, external and clinical regulatory actions, risk registers, FoIs, SARs, DSP Toolkit etc.

3rd Line - Committees
Seeks and receives assurance, provides challenge, escalates risks to Board, but does not take decisions.

Oversight and 2nd line oversight / upward assurance: Business cases, BAF, IPR, nominations and remuneration, surveys, strategies, performance reports, oversight of compliance function etc.

4th Line - External
Receives assurance, provides challenge and strategic leadership, holds to account for performance and standards.

Oversight and Strategic Decisions reserved for the Board: Commissioners / ICS, Business cases, BAF, IPR, annual report and accounts, nominations and remuneration, strategies, performance reports, Board Committee reports, external audits and regulatory matters etc.

Internal Control

To ensure that systems and processes are in place to manage:

Annual Planning cycle: business and review of strategy, objectives and strategic risks & annual budget setting etc.

External & Regulatory reports and actions management – CQC, NHSE etc.

Well-led implementation and the Code of Governance

Declarations of conflicts of interest

Management of Fit and Proper Persons

Policy Management Process

Fraud and Anti-bribery

Health and Safety

Emergency Preparedness

Governor elections

Committee Structure: Terms of Reference, effectiveness reviews, membership etc.

Procurement and Tendering Process

Risk Management Framework

Incident reporting

DSP Toolkit

Freedom to Speak Up

Compliance

Overseen by the Audit Committee (3rd line assurance)

Ensures that actions emanating from Internal Control are managed and followed up:

Compliance with Annual Planning cycle timeline and deliverables

Compliance with responses to external and regulatory actions

Ensuring that systems are working relating to declarations of conflicts of interests, policy management, DSP Toolkit etc.

Ensuring that risk registers & BAF are being reviewed at the appropriate levels

Ensuring that Trust wide strategies are being revised on a timely basis

Ensuring that Board and Committee Effectiveness reviews are being undertaken

Terms of Reference are up to date

Ensuring that Internal Audit Actions are being actioned and managed

Ensuring that the constitutional documents and Board owned policies and strategies are being reviewed as required

Ensuring that receiving quotations and tendering processes are following the appropriate routes

Overseeing the declarations of interests of members serving on procurement panels and ensuring

Understanding the reasons for Single Tender Waivers

Ensuring that all Contracts are signed and a register is in place

Committee Reporting Structure

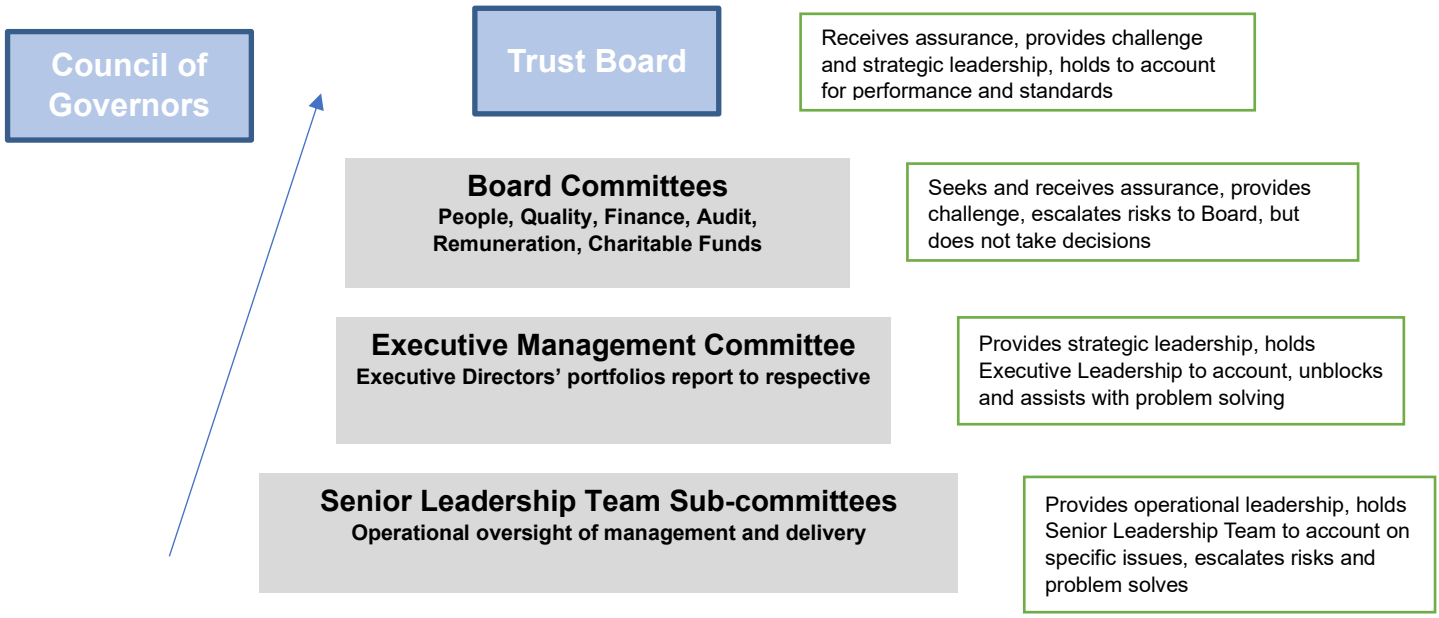
The purpose of this report is to share with the Board that work is starting on ensuring that reporting will follow the Assurance Framework depicted above.

Relevant reports which are yet still to be decided on, but will naturally include the IPR, financial reporting and business cases, will gradually over time (over the next 6 weeks as the process beds down) be escalated from the operational level (1st line) where reports tend to be much more detailed and are considered by sub-committees which are normally attended by senior leaders, to the Executive Management Committee (2nd line) for consideration and discussion to ensure that they are accurate, fit for purpose and have been accordingly approved.

The intention will be to use the Risk Assurance Compliance Committee to perform a support function to the Executive Management Committee, where detailed actions that need to be tracked, and for it to flag non-performance or problems to the Executive Management Committee.

Relevant reports that will be presented to Board Committees in due course, will have been considered by the Executive Management Committee before being received and a firm recommendation made regarding their status.

Reports being received by the Board, will have either been considered by one (any of the Board Committees) or two of the Board Committees (the Executive Management Committee and the overseeing Board Committee).



NB: The Board and Committee Forward Agenda Plans will need to be aligned in order to facilitate the flow and timeliness of reports.

SCAS BOARD PLANNER
CYCLE OF BUSINESS 2023/24 (DRAFT)

Item (x Public Board / x Closed Board)	Item Detail	Lead	July 23	Sept 23	Nov 23	Jan 24	Mar 24	May 24	July 24
Strategic Overview									
Chair's Report & CEO's Report		Chair and CEO	xx	xx	xx	xx	xx	xx	xx
Patient, Staff, Student or Volunteer Story		Guest	x	x	x	x	x	x	x
Strategy									
Strategy Update		Chief Strategy Officer	xx	xx	xx	xx	xx	xx	xx
CQC Improvement Programme Update		Chief Strategy Officer	xx	xx	xx	xx	xx	xx	xx
Feedback from patients, public and other stakeholders on the strategy development process (TBC)		Chief Strategy Officer	x	x	x	x	x	x	x
Annual Planning - Strategy and objectives - Risk Appetite - BAF Strategic Risks		Chief Strategy Officer				x	x	x	
Annual Budget		Chief Finance Officer				x	x	x	
Quality & Safety									
Quality & Patient Safety Report	Incident and Safeguarding	Executive Director of Patient Care and Service Transformation/Chief Nurse	xx	xx	xx	xx	xx	xx	xx
Medical Directors' Report		Chief Medical Officer	x	x	x	x	x	x	x
Trust Annual Quality Account		Executive Director of Patient Care and Service Transformation/Chief Nurse & Chief Medical Officer							x
Quality Priorities 2024/25		Executive Director of Patient Care and Service Transformation/Chief Nurse & Chief Medical Officer					x		

SCAS BOARD PLANNER
CYCLE OF BUSINESS 2023/24 (DRAFT)

Item (x Public Board / x Closed Board)	Item Detail	Lead	July 23	Sept 23	Nov 23	Jan 24	Mar 24	May 24	July 24
Clinical Audit and Research Annual Reports • STEMI Annual Report • Stroke Annual Report • Cardiac Arrest Annual Report (TBC)		Executive Director of Patient Care and Service Transformation/Chief Nurse & Chief Medical Officer			x				
People, Well-being and Leadership									
People Directorate Report		Chief People Officer	x	x	x	x	x	x	x
Employee Relations Update		Chief People Officer	x		x		x	x	
Freedom to Speak up Report		Chief People Officer	x			x			
Staff Survey Results		Chief People Officer				x			
People Voice		Chief People Officer	x			x			
Workforce Race and Disability Equality Standards Report		Chief People Officer		x					
Equality Delivery System		Chief People Officer		x					
Public Sector Equality Duty		Chief People Officer		x					
Communications Report		Director of Communications	x	x	x	x	x	x	x
Financial Operations									
Financial Performance Report		Chief Finance Officer	xx	xx	xx	xx	xx	xx	xx
Financial Recovery Action Plan		Chief Finance Officer	x	x	x	x	x	x	x
Operational Performance									
Integrated Performance Report		Chief Strategy Officer	x	x	x	x	x	x	x
Operations Report – 999, 111 & Other		Chief Operating Officer	x	x	x	x	x	x	x
Estates Report		Chief Finance Officer	x	x	x	x	x	x	x

SCAS BOARD PLANNER
CYCLE OF BUSINESS 2023/24 (DRAFT)

Item (x Public Board / x Closed Board)	Item Detail	Lead	July 23	Sept 23	Nov 23	Jan 24	Mar 24	May 24	July 24
Emergency Preparedness, Resilience & Response (EPRR) Workplan (TBC)	The Civil Contingencies Act (2004) requires NHS organisations to show that they can deal with such incidents while maintaining services.	Chief Operating Officer				x			
Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance Statement (TBC)	The Civil Contingencies Act (2004) requires NHS organisations to show that they can deal with such incidents while maintaining services.	Chief Operating Officer				x			
Approval of the Health and Safety Policy and the Risk Management Policy		Chief Operating Officer & Chief Governance Officer			x				
Governance, Risk & Assurance									
Board Assurance Framework		Chief Governance Officer	x	x	x	x	x	x	x
Board Upward Reports		Chairs of Committees	x	x	x	x	x	x	x
Legal Claims and Inquest Update		Executive Director of Patient Care and Service Transformation/Chief Nurse			x			x	
Approval of Board Committees' Terms of Reference / Auditor Panel Terms of Reference		Chief Governance Officer						x	
Review of Committee Effectiveness		Chief Governance Officer					x	x	
Board Effectiveness Review		Chief Governance Officer					x	x	
Review of Constitutional Documents	Standing Orders and Reservation & Delegation of Powers & Standing Financial Instructions (after consideration at the March Audit Committee meeting)	Chief Governance Officer					x		
Review of South Central Ambulance Charity Annual Accounts 2022/23		CEO of Charity			x				
Annual Report and Financial Statements - Approval Process	The Board delegates approval to the June Audit Committee meeting	Chief Governance Officer					x		

SCAS BOARD PLANNER
CYCLE OF BUSINESS 2023/24 (DRAFT)

Item (x Public Board / x Closed Board)	Item Detail	Lead	July 23	Sept 23	Nov 23	Jan 24	Mar 24	May 24	July 24
Annual Report and Accounts	Draft Annual Governance Statement and draft Financial Accounts	Chief Governance Officer and Chief Finance Officer						x	
Annual Self-Declarations	Compliance with the NHS Provider Licence Conditions FT4 / G6	Chief Governance Officer						x	
To ratify the proceedings of the Special Trust Board meeting held to approve the ARA		Chief Governance Officer							x
Annual External Audit Letter		Chief Finance Officer							x
Risk Management Strategy and Policy		Chief Governance Officer					x		
Anti-Fraud and Bribery		Chief Finance Officer						x	

South Central Ambulance Service NHS Foundation Trust

BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**People Directorate Update**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**15.0**	
Executive Summary:	Following the postponement of the People and Culture Committee (now scheduled for 1st June 2023) the attached update provides a summary of initiatives being considered by the Executive Team/People and Culture Committee.			
Recommendations:	The Trust Board is asked to: Note			
Executive lead:	Melanie Saunders, Chief People Officer			
Report author:	Melanie Saunders Chief People Officer			
Previously considered by:	N/A			
Purpose of report:	Note ☒	Approve ☐	Assure ☐	
Paper Status:	Public ☒	Private ☐	Internal ☐	
Assurance level:	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
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Strategic Objective(s):	All strategic objectives			
Links to BAF risks: (or links to the Significant Risk Register)	Risk 3 - Culture and staff experience			
Quality Domain(s):	All Quality Domains			

Next Steps (what actions will be taken following agreement of the recommendations): Following postponement of the People and Culture Committee in May 2023, the committee will take place 1st June 2023.
List of Appendices:

BOARD OF DIRECTORS PAPER

Title	People Directorate Update
Author	**Melanie Saunders, Chief People Officer**
Responsible Director	**Melanie Saunders, Chief People Officer**
Date	**25th May 2023**

1. Purpose

Following the postponement of the May 2023 People and Culture Committee this summary update provides an overview of papers due to be considered/approved by the People and Culture Committee in June 2023.

2. Overview

Freedom to Speak Up Self Assessment

In the summer of 2022 NHSE updated its FTSU board self-assessment tool kit, we are now in the time window to complete our own self-assessment. This is also timely considering our move to phase two of our improvement plan.

The purpose of this paper is to introduce the P&CC to this new process and provide an update on progress made to date.

NB although the phraseology used is “Speaking up”, this guide is intended to cover and be read in the wider aspects of Speaking, Listening and Following up as a whole.

The guide, and the accompanying self-reflection tool*, will help us to:

- ✓ build a culture and behaviours that is responsive to feedback from workers
- ✓ ensure that our organisation focuses on learning, to continuously improve quality of care and the experience of staff, patients, and service users alike
- ✓ improve staff survey scores and other worker experience metrics

- ✓ demonstrate to regulators or inspectors the work we are doing to develop our speaking-up arrangements

The self-assessment is due to be reviewed and approved by the People and Culture Committee in June 2023.

Public Sector Equality Duty

We are committed to demonstrating our 'due regard' to the Public Sector Equality Duty (general duty) to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between different groups. There are various ways we meet our statutory, NHS and organisational obligations. Our Annual Report provides a summary, and more detail can be found on our website to meet our specific duty under the Equality Act 2010 to publish the information.

Overview of the requirements of the PSED and the General Duty

The Equality Act 2010 defines the Public Sector Equality Duty (PSED) which has two parts: General Duty and Specific Duty. The *General Duty* has three aims:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct
- Advance equality of opportunity
- Foster good relations

The *Specific Duty* places a requirement on the Trust to publish:

- Equality objectives, at least every four years EDI strategy
- Information to demonstrate compliance with the equality duty, annually

The Public Sector Equality Duty annual report will be reviewed by the People and Culture Committee in June 2023.

Equality Impact Assessment Toolkit

The Equality duties (Equality Act 2010, S.149) provides the legal framework for South Central Ambulance Service (SCAS) to conduct its functions more effectively and to tackle discrimination in a proactive way, ensuring that equality considerations are consistently integrated into its day-to-day business. This process is a way to provide ‘due regard’ of the impact of its functions on the protected characteristics (listed below, table 1) through an Equality Impact Analysis (EQIA). This will not only engender legal compliance, but also help to ensure that Trust services best support the healthcare needs of the local population.

The updated Equality Impact Assessment toolkit will be reviewed by the People and Culture Committee in June 2023.

3. Recommendations

The Board is asked to note this update.

South Central Ambulance Service NHS Foundation Trust

BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**Communications, Engagement and Marketing – activity update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 25 May 2023**	**Agenda Item:**	**16.0**
Executive Summary:	**High-profile events** • Supporting events for the Coronation of King Charles III and Queen Camilla • On-going industrial action preparations As a Category 1 responder we have a responsibility to protect the public and to support our staff, stakeholders and the wider community. The communications team has been actively supporting these media worthy events on the SCAS patch. **Engagement with communities** The Health and Social Care Act 2022 requires us to meet the requirements of the 'triple aim' duty regarding the actions required to manage the impact of inequalities on population health. Our Business Information team is currently correlating data on demand and areas of deprivation to help us to understand which communities are most profoundly affected by health inequalities so that we can engage with them for feedback and share information on access to services. **Development of the SCAS public facing website and the staff intranet** Following a recent survey and valuable feedback, much work is underway to improve not only the intranet site, The Hub but also the public facing website.		
Recommendations:	The Trust Board is asked to note the contents of this report.		
Executive lead:	David Eltringham, Chief Executive Officer		
Report author:	Gillian Hodgetts, Director of Communications, Marketing and Engagement		
Previously considered by:	A paper is presented to the Board at each Board meeting		
Purpose of report:	Note ☒	Approve ☐	Assure ☐

Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	
Quality Domain(s):	All Quality Domains

Next Steps (what actions will be taken following agreement of the recommendations):

List of Appendices:

South Central Ambulance Service
NHS Foundation Trust

Agenda Item: 16.1

BOARD OF DIRECTORS MEETING IN PUBLIC 25 MAY 2023

Communications, Marketing and Engagement update

PURPOSE

1 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.

EXECUTIVE SUMMARY / TOP THREE ISSUES FOR BOARD ATTENTION

2 High-profile events

- Supporting events for the Coronation of King Charles III and Queen Camilla
- On-going industrial action preparations

As a Category 1 responder we have a responsibility to protect the public and to support our staff, stakeholders and the wider community. The Communications team has been actively supporting these media-worthy events on the SCAS patch.

3 Engagement with communities

The Health and Social Care Act 2022 requires us to meet the requirements of the 'triple aim' duty regarding the actions required to manage the impact of inequalities on population health.

Our Business Information team is currently correlating data on demand and areas of deprivation to help us to understand which communities are most profoundly affected by health inequalities so that we can engage with them for feedback and share information on access to services. So far, we have data on 999. Data on 111 and PTS will be available soon.

4 Development of the SCAS public facing website and the staff intranet

Following a recent survey and valuable feedback, much work is underway to improve not only the intranet site, The Hub but also the public facing website.

KEY ISSUES

5 High profile events

- The Coronation of King Charles III and Queen Camilla
- ongoing industrial action

The Coronation of King Charles III and Queen Camilla

The Coronation of King Charles III and Queen Camilla took place on Saturday 6 May and over the weekend in London and Windsor. Since SCAS covers that area, we were on hand to provide care for patients who may have required an ambulance response.

The Communications Team was part of the significant planning in the run up to that historical weekend, both locally within SCAS and also as part of the Local Resilience Forum in the Thames Valley. We routinely work with other communications colleagues in NHS Trusts and partner organisations including Police, Fire, Coastguard, local authorities across the two local resilience forums we serve, Thames Valley and Hampshire and the Isle of Wight. We planned and worked with others to ensure that we were up to date with the state of play to keep our communities, our patients and our staff safe.

We were proud and excited to be part of history and support people in Windsor as they celebrated the coronation of the new King and Queen. Due to the possibility of a significant increase in pressure on our services in the area during that time, we kept our social media messaging up to date, letting people know when and how they could get help, particularly on Sunday 7 May, when the Coronation concert took place in Windsor. It was important to share the communications from partner agencies to keep everyone venturing into Windsor safe.

Throughout Saturday and Sunday, the Communications Team played an active part in multi-agency calls with communications teams in other organisations, helping us to keep up to date with everything that was going on and ensure that our messaging was relevant and timely. We also visited the operational frontline teams in-person in Windsor on Sunday.

Our teams were proud to be part of this memorable event, providing medical support alongside colleagues in St John Ambulance. We were able to capture the occasion with some excellent pictures taken by our teams, which we are sharing through our Trust communications channels.

The ambulance service covering the Royal County of Berkshire has a long history of successfully providing medical support at many royal occasions and our new Chief Executive, David Eltringham, represented SCAS at a formal reception at Windsor Castle and at the concert, alongside colleagues from Police and Fire services.

Industrial Action

Since late last year, NHS Trusts have been preparing and responding to the impact and interest generated by industrial action. Whilst supporting our Staff's right to take industrial action, we have striven to provide uninterrupted access to our vital 999, Patient Transport Service and 111 services.

The Communications Team has played an active role ensuring staff, stakeholders and patients are regularly updated and has also shared knowledge, learning and updates with NHS colleagues, both locally and regionally. This has helped us to be as prepared as we can be, to understand and mitigate the impacts and to plan for adjustments to ways of working during strike action. We work collectively to construct useful information and content which we can distribute in several ways.

Our staff has been receiving regular updates on upcoming action (useful information should they choose to take part) and more recent updates on the national pay offer.

Externally, we have been releasing briefings to our stakeholders, either issued by members of the Communications Team or by the leads of our respective services. Additionally, we have been preparing information for our public facing website and social media channels, in order to keep members of the public and potential users up to date with levels of service activity. We highlight other ways of accessing treatment and care during times of increased pressure on ambulance services.

While many Unions have now accepted the national pay offer, meaning that they will not be undertaking further industrial action, there are other unions where action is likely to continue.

We will therefore continue to engage in scenario planning, communications and response, in and out of hours, seven days a week.

6 Engagement with under-represented populations across the SCAS area to address health inequalities

Working with under-represented people has always been a priority for the SCAS Communications team and much work is underway to improve the way SCAS engages with these communities. There are 7 domains of deprivation which combine to create the index of multiple deprivation (The English Index of Deprivation, 2019). The indices rank small areas of England from most deprived to least deprived. 80% of SCAS population is in the upper ranks but 4% is in the lowest rank. The areas with the highest deprivation are within the South-East of Hampshire; deprivation is typically clustered in urban areas and the highest population areas in SCAS are in Milton Keynes, Oxford, Portsmouth and Southampton.

Health inequalities

Health inequalities such as deprivation, low income and poor housing have always meant poorer health, reduced quality of life and early life-expectancy for many people. The Covid-19 pandemic has starkly exposed how these existing inequalities and the interconnections between them such as race, gender or
geography, are associated with an increased risk of becoming ill with a disease such as Covid-19. NHS England, ICS, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022. This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas:

- **a.** health and wellbeing for people, including its effects in relation to inequalities;
- **b.** quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services;
- **c.** the sustainable use of NHS resources.

To ensure that SCAS complies with its new duties, the engagement lead in SCAS is working closely with Integrated Care Board partners to build networks and explore opportunities for partnership building with under-represented communities and address health inequalities. This includes a partnership with the Academic Health Science Network (AHSN) Wessex on the Innovation for Healthcare Inequalities (InHip) programme which will be delivered in areas of deprivation in Southampton and Portsmouth.
Much work is also underway with Portsmouth and Southampton local authorities, planning activities in partnership with "Stronger Communities", in addition to regular engagement meetings with the Hampshire and IOW ICB engagement network. SCAS is involved in an engagement collaborative within Bedfordshire, Luton and Milton Keynes, exploring opportunities for engagement with under-represented communities in areas of deprivation. Our engagement lead has met with local MK Healthwatch, is talking to Oxfordshire Healthwatch and is meeting with MK local authorities.
The approach is based on co-production i.e., asking communities what they want and taking engagement to them rather than expecting them to come to us. The above engagement activities are in addition to ongoing coordination of multi-service events throughout the year.

Governor involvement

Governors attending the Membership and Engagement Committee on 18 May will participate in a workshop with data on demand and deprivation presented by Simon Mortimore, Business Information, and led by Professor Sir Keith Willett, SCAS Chair, to explore engagement opportunities and develop a plan to engage with under-represented communities.

7 Development of the SCAS public facing website and the staff intranet

The challenge of distributing information internally, to a large workforce and externally to a huge geographical area is never easy. As part of our organisation's CQC recovery plan, the Communications Team were tasked with looking at how, when, why, and what, should take priority in our digital communications.

Intelligence gathering

We undertook a survey on the electronic information on offer from SCAS and as a result have had some very useful feedback, both about our public facing website as well as our internal staff facing intranet. This will enable us to make improvements in how we communicate in the future,

A more accessible Internet
Our Internet site has proved to be a stable and crucial information source all through the Covid-19 pandemic, during the recent phases of industrial action and during periods of excessive demand on our services, helping to signpost patients and the public to the range of health care support available.

At this time of heightened cybersecurity and risks to digital communications around the world, the challenge of making information accessible and safe remains significant, hence our need to work closely with the Information Governance team. The feedback we received highlighted areas for improvement and indeed are already being worked on:

- Valuable feedback indicated that our website was inaccessible to disabled users;
- Staff identified that our policies and procedures differed on our internal system from our external system, and this was causing confusion;
- Partners and stakeholders didn't receive regular electronic updates.

In the past 6-12 months we have made some significant improvements regarding accessibility of our website and some of our documents contained within it. We continue to make improvements to our public facing website to ensure that information is accessible to all sectors of our community.

We are working with our hosting company to make sure that our site conforms to the next level of compatibility for our blind and partially sighted users. This will bring us in line with rules recently introduced by the Cabinet office.

Our policies and procedures are now handled centrally by the Corporate Governance team and specialist training has been given to ensure that accessibility standards are consistent. This will also enable internal and external policies to be synced together so there is a single point of management for all of these documents going forward.

We have also introduced an electronic 'Partners and stakeholders' bulletin to keep everyone up to date on all our news. This is distributed widely and we will be seeking feedback in due course to ensure it is providing stakeholders with the news and information they are seeking.

Staff Intranet – The Hub
Our staff Intranet, the 'Hub', was set up during the pandemic to meet the needs of all staff, with increased recognition of the challenges for staff who were working from home. We are working on plans to personalise news on the site so that it is more targeted to individuals' own knowledge requirements and interests and maximises tools promoting two-way communications, such as Yammer.

Following on from the staff survey we have now asked each department to nominate two people who will look after their respective areas. Training will be given to make sure that the whole Intranet site is consistent, compliant and enables our staff to make the best use of the technology which is available to communicate to our staff across the Trust.

CONCLUSIONS AND RECOMMENDATIONS TO THE BOARD

8 The breadth of communications activity within the Trust is wide ranging and ever increasing. Balancing the demands for succinct and multi-channel internal communications whilst managing the heightened media and public interest across our services, requires regular review of our strategic aims, re-prioritising frequently.

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

Gillian Hodgetts
Director of Communications, Marketing and Engagement
15 May 2023

Agenda Item 17

BOARD OF DIRECTORS MEETING IN PUBLIC – 25 MAY 2023

ANNUAL REPORT ON THE WORK OF THE CHARITABLE FUNDS COMMITTEE 2022-2023

PURPOSE

1 The Charitable Funds Committee has prepared this annual report for the 2022-2023 financial year for the attention of the Board. It sets out how the Committee has satisfied its Terms of Reference (ToR) during the year and provides the Board with information relating to its responsibilities.

2 Production of a Charitable Funds Committee Annual Report represents good governance practice and complies with the Committee's Terms of Reference.

3 The Charitable Funds Committee will produce a more detailed account of activity for the year to accompany the final accounts for the Charity to be submitted to the Charity Commission no later than 31 January 2024.

Overview

4 The Committee continues to act with delegated authority from the Trust Board, in its role as Corporate Trustee, on all issues relating to the administration and use of Trust funds. It also seeks to support the Charity CEO in defining the strategic direction of the Charity.

5 In particular it has sought to:

- Ensure that there is appropriate governance over the activities of the charity.
- Seek assurance that the application and investment of funds is in accordance with the spending priorities, criteria and scheme of delegation set by the Board.
- Confirm that the charity acts in compliance with relevant legislation.
- Ensure that appropriate arrangements are maintained in respect of financial reporting, accounting and audit, and internal control systems.
- Monitor and review the integrity of the SCAS Charity Annual Financial Statements, including having them independently examined; recommending the Annual Financial Statements to the Board of Directors for approval and ensuring their subsequent submission to the Charity Commission in the required timescale.
- Take day-to-day decisions regarding application and investment of charitable funds, in accordance with the framework set by the Board.

Key Issues

Membership

6 During 2022-2023 membership of the committee has comprised:

- Nigel Chapman, Non-Executive Director and Chair of the Committee
- Mike Hawker, Non-Executive Director (until December 2022)
- Les Broude, Non-Executive Director (Until April 2023)
- Ian Green, Non-Executive Director (until March 2023)
- Mike McEnaney, Non-Executive Director (from March 2023)

7 Staff required to be in attendance were:

- Mike Murphy, Executive Director of Strategy & Business Development
- Alan Monks, Deputy Director of Finance (until December 2022)

- Vanessa Casey, Charity CEO
- Nic Dunbar, Head of Community Engagement and Training
- Aneel Pattni (from January 2023)

8 David Ross, the Governor representing Community First Responders, attends meetings of the Charitable Funds Committee and other Governors are invited to observe meetings. Other members of the Charity team are invited to present papers as appropriate.

9 The membership of the Committee changed in December 2022 with Mike Hawker reaching the end of his NED term. Alan Monks also left SCAS in December 2022. Aneel Pattni, Chief Financial Officer has attended the CFC in place of Alan Monks and is represented by Nicola Bateman, Chief Accountant or Ellis Rush, Financial Reporting Manager in his absence. The new Committee structure created in March 2023 has seen Mike McEnaney and Dhammika Perrera join and Les Broude and Ian Green leave the CFC.

Compliance with Terms of Reference (ToR)

10 During 2022-23 the Committee has operated in a manner compliant with its Terms of Reference, which were last reviewed in April 2022. In particular:

- To meet not less than three times a year
- All meetings have been quorate (2 out of 3 Non-Executive Directors have been present)
- The committee has exercised its full range of responsibilities.
- An upward report summarising key material from each committee meeting has been presented to the Board.

11 Attendance of members is set out below:

	Nigel Chapman	Mike Hawker	Les Broude	Ian Green	Mike Murphy	Alan Monks	Vanessa Casey	Nic Dunbar	Aneel Pattni	Mike McEnaney
April 13	√	√	√	√	√	√	√	√	-	-
July 8	√	√	√	√	√	√	√	×	-	-
October 6	√	√	√	√	√	√	√	×	-	-
November 18	√	×	√	√	√	√	√	√	-	-
January 11	√	-	×	√	√	-	√	√	√	-
March 17	√	-	√	-	×	-	√	√	√	√

12 The committee has fulfilled its objectives effectively. The Committee held two extraordinary meetings during the year on 18th November to discuss the report of the Independent Examiner with regard to the 2021-2022 Accounts and on 17th March to finalise the 2023-24 Charity budget.

13 Full committee meetings are supported by regular meetings between the Chair, the Executive Director of Strategy and Business Development and the Charity CEO.

14 The Committee retains the required minimum of three Non-Executive Directors.

Work undertaken during the 2022-23 year

15 Following Board sign off of the new Volunteer Strategy for SCAS we successfully recruited a Volunteer Manager to join the Charity. Their role is to oversee the development of volunteering and to support volunteer managers in the Trust with recruitment, policies and other areas. A new Community Fundraiser and a Fundraising and Database Administrator were also recruited to replace leavers from the organisation.

16 The annual CFR conference this year took its first step towards being a Volunteer conference with some Volunteer Car Drivers and welfare volunteers joining us. The event will continue to run annually and will develop as a key event for all volunteers across SCAS.

17 The pandemic, Brexit and the cost-of-living crisis all played a part during the year and while events and community engagement continue to pick up income is still below pre-Covid levels. We did however organise another successful Outrun an Ambulance fundraiser as well as successfully winning some smaller corporate partnerships with Co-Op stores and Coventry Building Society and launching our new Basic Life Saving Awareness Training for corporates.

- CFR generated income increased from £17,500 last year to £51,200 this year which moves us back nearer to our pre-Covid income of £80,000 from CFR fundraising. While we are moving in the right direction we know it will likely be 2024-2025 before we are fully back and past our previous level.

- We received one significant legacy during the year of £18,000 to support our Community First Responders in Chalgrove, Oxon.

- A new online donation portal was setup on the Charity's website and is now seeing consistently growing number of digital donations as well as regular givers giving each month.

- We introduced contactless donation terminals for the first time this year and are seeing a constant increase in donation being made at events using these devices. CFR Ian Taylor in West Hampshire in particular made excellent use of these raising almost £10,000 from supermarket collections using a mix of traditional buckets and contactless terminals.

- We were able to promote the Charity on our PTS vehicles for the first time this year and the new design on the back doors is very impactful while posters inside the smaller 'taxi' style vehicles have generated text donations and helped to build awareness.

18 We continued to receive multi-year grant funding from NHS Charities Together as well as a new grant for mental health and wellbeing. Funds received this year included:

- £46,000 from Buckinghamshire Healthcare Trust as part of the BOB ICS community grants programme

- £26,000 from Bedfordshire Hospitals NHS Charity representing the BLMK ICS community grants programme for projects in Milton Keynes.

- £49,500 from Southampton Hospitals Charity representing the HIOW ICS, to support our three projects across Hampshire.

- The grant applied for last year for the Mental Health and Recovery of our staff and volunteers was awarded and the first instalment of £49,500 was received. The second instalment for the same amount will be received early in 2023-24. The grant will fund some Long Covid Rehabilitation, bereavement counselling, mental health first aid and the Sustaining Resilience at Work programme.

- We also applied for a £30,000 development grant to support the Charity to improve its infrastructure and to support fundraising initiatives. This was awarded and received in March 2023.

19 The Charity continues to prioritise funding for the vitally important Community First Responder service, working closely with the Community Engagement and Training Team. This year we have supported CFRs by funding (as at M11):

- £96,729 for the lease costs and vehicle running costs of CFR DRVs
- £15,000 of new CFR uniform including newly designed polo shirts with additional CFR epaulettes
- £75,000 of new equipment for our CFRs including purchasing new Zoll defibrillators to replace some our oldest FR2 and G3 models and new paediatric pulse oximeters for the kits in our DRVs. Additional mangar elk lifting cushions and some Raiser Chairs were also purchased to support non-injury falls.
- £35,000 for the line rental of the Smartphones in use by our Responders
- £85,000 of restricted grant expenditure was used to support the three projects funded by NHSCT

20 Our Volunteer Manager started in April and began by developing the use of the Assemble database and working across all volunteers at SCAS. All volunteers including CFRs, VCDs, welfare, IRD and Charity volunteers are now recorded on Assemble.

- Recruitment took place for volunteers to take on a despatch role for CFRs in the South. We now have 5 volunteers in this role, all of whom also do other roles in SCAS.
- Welfare vehicles and volunteers continued last year but some challenges were faced around costs and availability of vehicles, supply of refreshments and the support and management locally of the volunteers. A business case was submitted to SCAS from the Operations Department to look at the way forward. This remains a service that is valued by staff but the original grant funding has now ended.
- A £25,000 grant was secured from HEE to support a volunteer to career programme at SCAS. This began at the end of the year and will continue. The funding was awarded to fund a one-year seconded post to support the Volunteer Manager in implementing the volunteer programme.
- During the year we have worked closely with Helen Vine at AACE on their volunteer strategy and are working as part of a number of task and finish groups for volunteering.
- We have begun to work more closely with our PTS colleagues, in particular to support the recruitment of Volunteer Car Drivers.

21 The primary activities of the SCAS Charitable Funds subcommittee in 2022-23 have been:

i. To ensure that there is appropriate governance over the activities of the charity

The Committee has continued to ensure there is an appropriate level of governance for the Charity, supporting the operational activity of the Charity CEO and robustly discussing and agreeing future changes and developments for the way forward.

The Charity risk register remains a standing item at Committee meetings and has been robustly challenged and adjusted during the changing economy and opportunity to fundraise during the pandemic.

The Committee reviews and discusses financial performance of the Charity at every meeting. Regular reforecasting has been an important element this year with changing opportunities and fortunes during the year.

ii. To seek assurance that the application and investment of funds is in accordance with the spending priorities, criteria and scheme of delegation set by the Board

The Committee continues to review financial performance at each meeting and the delegated authorisation limits policy is in place to ensure appropriate protocols for charitable expenditure. The delegated authorisation limits were unchanged during the year.

iii. To take day-to-day decisions regarding application and investment of charitable funds, in accordance with the framework set by the Board

Through the review of the management accounts at each meeting, the Committee continues to ensure the appropriate balance of expenditure on Charitable Objectives. Based on M11 accounts, the end of year 2022-23 will show an overall income of £426,374 and an expenditure of £542,939 giving an overall deficit of £116,565. Our deficit has been created due to the overall downturn in unrestricted donations as well as the timing of expenditure related to projects where funding was received last year. Our Surplus of £102,000 at the end of last year, related to income received for projects that have now shown expenditure in the current year. Overall this year our unrestricted reserves dropped by c£90,000.

Annual Income at Month 11 is broken down as follows:

£ 41,359	Individual Giving
£ 92,025	Community Fundraising
£207,789	Grants
£ 60,204	Corporate Donations
£ 2,332	Gift Aid
£ 22,660	Other income

Expenditure at Month 11 is broken down as follows:

£ 8,981	Fundraising costs
£235,494	CFR Uniform, Equipment & Vehicles
£ 93,861	Restricted Grant/Project Expenditure
£ 2,740	Internal Staff grants
£ 7,313	Marketing & publicity
£171,552	Staff Salaries
£ 9,791	Volunteer Expenses and other expenditure

iv. Ensure that appropriate arrangements are maintained in respect of financial reporting, accounting and audit, and internal control systems.

The Harlequin CRM and accounting systems enable the Charity to record and report all income and expenditure accurately. All items are correctly coded according to their area of income or expenditure. Monthly management accounts are produced from Harlequin by the SCAS Finance team and discussed at quarterly meetings. Particular care has been taken this year to manage our unrestricted reserves position to ensure reserves are maintained at

an adequate level. An internal audit was carried out this year for the Charity and actions put in place to improve recording of donations and financial transactions in some areas.

v. Confirm that the charity acts in compliance with relevant legislation.

The Charity CEO continues to monitor the legal and regulatory environment in which it operates, primarily Charity Commission regulation, the policies of the Fundraising Regulator, Charity SORP and GDPR. The Charity CEO continues to introduce policies and procedures and to review processes.

vi. Monitor and review the integrity of the SCAS Charity Annual Financial Statements, including having them independently examined; recommending the Annual Financial Statements to the Board of Directors for approval and ensuring their subsequent submission to the Charity Commission in the required format and in the required timescale.

The Committee has provided regular assurance reports to the Board of SCAS, (the Corporate Trustee) during the course of the year and approved the annual accounts for 2022-2023 at its meeting of 18th November 2021. These were recommended to the Board and accepted at the November Board meeting. The final management accounts for the financial year 2022-23 are now being prepared and will be circulated to the committee for approval. The process to produce the end of year report and account will then begin.

FUTURE PLANS

22 The Committee considers that it has met its terms of reference for 2022-23.

23 The Committee has agreed the budget for the Charity for 2023-2024 and the outline fundraising and communications plan in place to achieve the budget.

24 The objectives for q1 and q2 of the year will be to:

- To complete the stage 2 and 3 projects funded by NHS Charites Together
- To create the framework, MOU and job description for the Charity Finance Manager and work with the Finance team to recruit and implement the way forward
- To focus our fundraising around securing and increasing unrestricted donations paying particular attention to our individual giving
- To realise the Pain legacy gift and work with the CFC and Finance on the management and investment opportunities of the gift
- To develop and implement as full as possible a programme of community engagement events over the Summer to maximise income possibilities.
- To work with Remarkable Partnerships to develop to build a compelling proposition, identify corporate leads and begin building corporate relationships.
- To continue building the corporate defib awareness and CPR training programme.
- To continue to grow current income streams with a particular focus on corporate, individual giving and community fundraising.
- To continue to create and maximise PR opportunities for the Charity working closely with the Marketing & Communications Manager as well as working with the Charity team to produce external supporter newsletters and social media posts.
- To continue to support all CFR schemes with fundraising and community engagement opportunities and to seek ways to ensure we give clear messages around both how our CFR schemes are funded and where that funding comes from.
- To further develop the Charity website to ensure it is fully engaging for those who visit and to develop our merchandise portal.

- To create and implement at least one significant fundraising event during the year attracting external participants.
- To manage the Charity's financial position in line with the agreed budget for 2023-24.

ACTION REQUIRED	

25 The Board is asked to:

- Note the content of this report.

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

Charitable Funds Committee – Terms of Reference

The Terms of Reference were last reviewed by the Committee in April 2022 and no changes were deemed necessary.

1. The remit of the Trust Board

1.1 The Trust Board is responsible for all the affairs and activities of the SCAS Charitable Trust (reg'd charity no 1049778), in its role as Corporate Trustee.

1.2 The Board has responsibility for setting the strategic direction of the SCAS Charitable Trust. This will include establishing and agreeing an annual plan and budget for the charity (ensuring that there are clear aims and activities), and determining the spending priorities and criteria for the application of charitable funds.

1.3 The Board will receive and approve the Annual Financial Statements of the Charity and will authorize them for submission to the Charity Commission.

1.4 The Director of Strategy and Business Development and the SCAS Charity Chief Executive will be responsible for developing the strategy and recommending the strategy to the Board for approval and implementation.

2. The remit of the Charitable Trust Funds Committee

2.1 The primary purpose of the Charitable Funds Committee will be to ensure that there is appropriate governance over the activities of the charity. The committee will be responsible, with delegated authority from the Board, for:

2.1.1 Seeking assurance that the application and investment of funds is in accordance with the spending priorities, criteria and scheme of delegation set by the Board.

2.1.2 Confirming that the charity acts in compliance with relevant legislation.

2.1.3 Ensuring that appropriate arrangements are maintained in respect of financial reporting, accounting and audit, and internal control systems.

2.1.4 Monitoring and reviewing the integrity of the SCAS Charity Annual Financial Statements, including having them independently audited; recommending the Annual Financial Statements to the Board of Directors for approval and ensuring their subsequent submission to the Charity Commission in the required format and in the required timescale.

2.1.5 Taking some day-to-day decisions regarding application and investment of charitable funds, in accordance with the framework set by the Board (a delegated authority limit for expenditure will be set by the Board and all spending decisions taken by the Charitable Funds Committee should be reported back to the Board as part of an assurance report).

3. Membership/Attendance

3.1 Membership of the Committee shall consist of a minimum of three Non Executive Members of the Board.

3.2 The Chair of the Committee will be a Non-Executive Director, appointed by the Board of Directors of the Trust.

3.3 The committee will be attended by the Director of Business Development and Strategy and/or the Director of Finance; the SCAS Charity Chief Executive and the Deputy Director of Finance or an appropriate deputy and the Head of Community Engagement & Training

3.4 The Trust's elected Community First Responder (CFR) Governor representative will be invited to attend all ordinary meetings of the Charitable Funds Committee in order to represent the views of SCAS CFRs on relevant SCAS Charity issues.

3.5 SCAS Governors are periodically invited to attend meetings as an observer. SCAS encourages Governor's to attend sub committee meetings as an observer in order to fully understand the decision making process at this level and in order that the Trust can be fully transparent in decisions made below Board level. Attendance as an observer can also provide greater understanding and knowledge of different areas of the Trust.

3.6 Other officers of the Trust and/or Non Executive Directors will be invited to attend for specific agenda items as required.

4. Quorum

4.1 The Committee shall be quorate if two of the four NEDs who make up the committee are present.

4.2 The Chairman has the casting vote.

5. Frequency of Meeting

5.1 The Charitable Trust Funds Committee will normally meet not less than three times in each financial year.

6. Reporting Arrangements

6.1 The Committee's prime purpose will be to oversee delivery of the strategy agreed for the Charity by the Trust Board.

6.2 Within agreed areas of delegated authority the Committee will report to the Trust Board on matters arising from its meetings. At a minimum the Committee will provide reports to the Board after each meeting of the Committee. These regular reports will cover:

- 6.2.1 Progress on delivery of the agreed strategy.
- 6.2.2 Report on funds raised and disbursed within agreed levels of delegation.
- 6.2.3 Risks to the delivery of the agreed strategy, and mitigating actions proposed to address these.
- 6.2.4 New opportunities arising for development of the Charity that the Board may wish to act on.

6.3 The Committee will bring requests to approve disbursements from the Charity's funds that exceed agreed levels of delegation to the Board at the first opportunity The Committee will assure the Trust Audit Committee, as required and requested, that an effective system of governance, risk management and internal control is established and maintained for the SCAS Charitable Trust.

6.4 Reports to the Board will usually be through the upward report presented at the Board meeting in public. More detailed papers for discussion and approval will be usually be through the Board meeting in public except where there are issues of commercial sensitivity. In these cases papers will be presented at a Board meeting in private.

7. Other Matters

7.1 In accordance with all other Committees of the Board, the Committee will review its own effectiveness on an annual basis.

8. <u>Scheme of delegation</u>

Charity funds can be distributed according to the following scheme of delegation:

Over £50k	SCAS Board
Over £10k	Charitable Funds Committee
Up to £10k	Director of Finance or Director of Business Development and Strategy
Up to £5k	CEO of Charity
Up to £2.5k	Head of Community Engagement and Training
Up tp £1.5k	Operations Managers, Community Engagement & Training Team; Volunteer Manager and Senior Fundraising Officer
Up to £250	Community Engagement & Training Officers
Up to £50	CFR scheme leaders

Next review date April 2024

UPWARD REPORT

Report to Board Meeting – 25 May 2023

Name of Committee reporting upwards:	Audit Committee
Date Committee met:	17 April 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Trust Board 25 May 2023

Internal Audit

- Audit plan progress report – all planned audits completed for 2022/23 with the Data Security & Protection Toolkit due and on target for completion by June 23.
- Reports received by the committee for:
    - Urgent Care Pathways (Medium assurance), requested to be shared at the Finance & Performance committee
    - Overtime Management (Medium assurance)
    - Newly Qualified Paramedics and Apprenticeships Programmes (advisory only), requested to be shared at the People & Culture committee.
- Follow-up Report
    - After the request to complete and close overdue actions some progress was noted. However, 3 items from 20/21 and 2 from 21/22 remain outstanding and from 22/23, 10 remain outstanding and it was noted all have revised completion dates.
    - The committee requires all Executives responsible for overdue actions to attend the next Audit Committee to confirm the status and provide reassurance that these actions will be completed on time.
- 2023/24 Annual Audit plan and Strategic Plan 2023/26
    - The finalised plan was presented and approved.
- Head of Internal Audit Opinion 2022/23
    - Moderate Assurance – the final opinion given, however, with the CQC outcome, the delayed closure of outstanding audit actions and the trend of reducing assurance in the Internal Audit ratings we need to improve the robustness of our procedures and processes as well as how well we effectively adhere to them.

External Audit

- 31 March 2023 Year End Audit Plan and Accounts timetable – these were reviewed and approved.

Assurance & Risk

- Progress on the development of the Board Assurance Framework was discussed and noted and the committee were assured that appropriate actions were in place to finalise the BAF.
- The Corporate Risk Register was reviewed noting some very high residual risks which require further assessment.

Counter Fraud

- The Counter Fraud annual plan and fraud risk assessment was received and reviewed. The committee was assured by the activities taking place and the review of the incidents. A request was made to review the numbers of staff receiving/attending counter fraud training and the self assessment to be submitted was amended down to amber with regards the levels of training.

Losses & Special Payments

- The report was noted with no concerns.

SCAS Policies Report

- A summary of policies overdue for review was presented. The committee expressed concern over the delays and with the overall organisation and control of policies. The committee has requested the Governance team to expedite the work to improve these controls.

Board Committee Upwards Reports

- A report was received from the Quality & Safety Committee and the committee felt it provided reassurance.

Year End Related Papers

- A number of draft papers relating to the year end accounts process were reviewed.

UPWARD REPORT

Name of Committee reporting upwards:	Audit Committee
Date Committee met:	26 April 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Trust Board 25 May 2023

Review of Financial Accounts

- The draft financial accounts and commentary were presented, reviewed and amendments noted. Approval was given to submit the draft accounts to NHSE and to the external auditors.
- The draft Annual Governance Statement was reviewed and comments for change noted.
- The draft Directors' Report was reviewed and comments for change noted.
- The detailed Accounts Timetable was reviewed and noted.

South Central Ambulance Service NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC May 2023

Charitable Funds Committee – Upward Report

PURPOSE

1 This paper seeks to update the Board on the key issues for the Charity as recently discussed at the CFC meeting on 12 April 2023

EXECUTIVE SUMMARY / TOP THREE ISSUES FOR BOARD ATTENTION

2 Financial Update
3 Fundraising Update
4 Volunteer Strategy

KEY ISSUES

Financial Update

5. M11 accounts were reviewed at the meeting. The likely outcome for the 2022-2023 financial year is a deficit of c£120k. The fundraising climate remains difficult and while we have continued to benefit from restricted grants unrestricted income is down on previous years.
6. The 2023-24 budget was agreed at an extraordinary finance meeting in March. The budget shows a significant end of year surplus position due to the legacy we will receive in year. The legacy income is unrestricted and some funds will be invested to support the Charity going forward. Outside of the legacy income generation will continue to be challenging. The income from grants will decrease significantly and our priority will be to grow the corporate sector income.
7. The Charity has grown over the last few years and overall the income and size of the charity has increased. There is a need for greater financial support and governance of the Charity to ensure it continues to operate and report in line with the Charity Commission and other regulations. The Charity has therefore agreed to fund a new finance manager post to sit within the Finance team but to solely work on Charity finance. The postholder will report in to the finance team but also have a close working relationship with the Charity CEO and team. This will address areas of concern around the anticipated full audit next year, the financial governance of the Charity to ensure all processes and practises are compliant as well as managing gift aid, stock, financial planning, investments and financial risk.

Fundraising Update

8. We have started working with Remarkable Partnerships to develop our corporate fundraising.

9. The Charity team along with 5 CFRs and the team from Remarkable took part in a proposition workshop to create a couple of key propositions for the Charity when working with corporate partners. We heard some very powerful stories for our CFRs about the impact they have with patients which will be key to us making an impact.
9. The CFC agreed to fund a new Dacia Duster lease for the Chalgrove CFR scheme in Oxfordshire. This has been funded for the next five years by a legacy received restricted to this area.

Volunteer Strategy

10. Sarah Callaghan presented an update to the CFC on the Volunteer Strategy.
11. We are keen to ensure that our volunteer profile is raised both internally and externally and that we give credit for the amount of support which volunteers provide and to ensure they are fully embedded into SCAS.
12. The use of the volunteer database, Assemble is developing and the functionality will allow better reporting once it is being fully used. It is also now used for recruitment with the recruitment portal about to be embedded into the Charity website.
13. The bi-monthly volunteer newsletter is developing and providing a platform to share volunteer stories, events, acknowledgements and other messages
14. The volunteer conference will this year be at the Ark Conference Centre in Basingstoke on 7 October.

CONCLUSIONS AND RECOMMENDATIONS TO THE BOARD

12. The financial governance and reporting for the Charity is a key area to move forward over the next couple of months and the Charity CEO will be working with the Finance Team to implement this.
13. The Board is asked to note the report.

Nigel Chapman
Non-Executive Director
16 May 2023

NHS
South Central Ambulance Service
NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	Finance & Performance Committee
Date Committee met:	17 May 2023
Chair of Committee:	Les Broude
Reporting to:	Trust Board 25 May 2023

1. Points for Escalation

- Need to quantify FSP programme and start to deliver tangible cost efficiencies in order to deliver a breakeven budget for the year

- Need to introduce and embed new-style IPR as a priority for assurance purposes

2. Key issues / business matters to raise:

a) Financial Plan, 2023/24

Issue: Implications of setting a breakeven budget. The strategy is to operate with a deficit for the first 4 months of the year, and then to breakeven during August and December, with a forecast £4m surplus in Quarter 4.

Action Taken: Detailed delivery plans being developed Trust-wide, at service and operational levels, to ensure a breakeven position.

b) Financial Sustainability Plan (FSP)

Issue: Trust needs to deliver efficiency-savings of %38.5m. As at 30/04/2023, the Trust had a deficit of £1.8m, partly attributable to not meeting FSP targets.

Action Taken: Until detailed plans are put in place, FSP targets have been allocated as reductions to expenditure across all service areas contributing to overheads. A total of 40 potential schemes have been identified for which QIAs need to be carried out. A wider review of cost-saving opportunities is also being considered by the Financial Sustainability Delivery Group (First meeting 22/05/2023).

c) Integrated Performance Report (IPR)

Issue: The IPR is critical to the Board's ability to understand the Trust's performance and to take the assurance (or otherwise) that strategic targets are being met. There have been delays in introducing the new-format IPR.

Action Taken: The Executive are placing a high-priority in producing an IPR which provides added value and assurance to the Board in monitoring Trust performance.

d) Board Assurance Framework (BAF)

Issue: Following the Board Development Seminar on 27 April 2023, core strategic risks (2,3,5 and 8) were updated. With regard to Risk 3: Finance and Sustainability, the Committee confirmed the current risk score as 20.

Action Taken: The Board will receive the finalised BAF on 25 May 2023.

e) Compliance with Terms of Reference

The Committee was quorate and addressed key items of business as per the workplan. Given the nature of the financial issues under discussion, an Extraordinary meeting of the Committee will be held on 19 June 2023, prior to the sign-off of the Annual Report & Accounts for 2022/23.

UPWARD REPORT

Name of Committee reporting upwards:	Extraordinary Finance & Performance Committee
Date Committee met:	19 April 2023
Chair of Committee:	Les Broude
Reporting to:	Trust Board 25 May 2023

3. Points for Escalation

- Need to finalise Financial Plan, 2023/24 in discussion with the ICB;
- Need to quantify CIP programme and start to deliver tangible cost efficiencies.

4. Key issues / business matters to raise:

a) CIP Planning

Issue: The Committee received a CIP planning update in the current context of the ICB having proposed a 5% CIP target, which the Trust had modified to 4% based on realistic deliverability, impact and quality and safety.

Action Taken: The challenge was to formulate credible plans around the 4% target and agree a process that engaged senior leadership teams and operational teams. It was noted that arising out of a workshop, 70 potential CIP schemes had been identified. The Committee requested clear dates needed to be attached to deliverables so that progress on the projects could be monitored.

b) Financial Plan, 2023/24

Issue: The Committee was advised that the current overall system deficit was £189.7m and that NHSE continued to reinforce the message that every organisation was expected to

breakeven. Further urgent meetings were planned at system and national level in this regard.

Action Taken: The challenge for the Trust was to quantify the impact of having to adopt a breakeven position, whilst maintaining patient quality and safety.

c) Investment Plan, 2023/24

Issue: The Committee noted that opportunities for investment (c£9.7m) required to be considered in tandem with the work on workforce, CIP planning and PTS improvement opportunities.

Action Taken: A rapid piece of work was required to be undertaken in relation to the Investment Plan, and also to develop a set of principles to be considered by the Board for assurance purposes.

d) Compliance with Terms of Reference

The Committee was quorate and addressed key items of business as per the workplan.