South Central Ambulance Service
NHS Foundation Trust

Trust Board Meeting

Meeting in Public

DATE: Thursday 27 July 2023
TIME: 09.30 – 12:30
VENUE: **The Ark Conference Centre, Basingstoke, RG24 9NN - Geneva Room**

Item		Action	Time
OPENING BUSINESS			
1	**Chair's Welcome and Apologies for Absence** Keith Willett	**Verbal** **To note**	09.30
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Keith Willett	**Verbal** **To note**	
3	**Minutes from Meeting on 25 May 2023** Keith Willett	**Page 33** **To approve**	
4	**Board Actions Log** Michael Wood	**Page 42** **To note**	09.40
STRATEGIC OVERVIEW			
5	**Chair's Report** Keith Willett	**Verbal** **To note**	09.45
6	**Chief Executive's Report** David Eltringham	**Page 44** **To note**	09.50
7	**Update to the Public Board on the previous Private Board meeting** David Eltringham	**Page 49** **To note**	10.00
8	**Communications Update** Gillian Hodgetts	**Page 53** **To note**	10.05
9	**Patient Story** Patient Experience Team	**Presentation** **Page 59**	10.10
GOVERNANCE AND RISK			
10	**Risk** a) Corporate Risk Register b) Board Assurance Framework (BAF) Daryl Lutchmaya	**Page 69** **To note**	10.25
11	**Annual Report and Accounts 2022-23** Stuart Rees & Daryl Lutchmaya	**Page 84** **To note**	10.30

Item		Action	Time
12	**Recovery Support Programme/OF 4** Daryl Lutchmaya	**Page 86**	10.40
13	**Governance Update:** a) Annual Members Meeting b) Renewal of 2nd term - Ian Green (NED) c) Response to ICBs for Joint Forward Plan Daryl Lutchmaya d) Quality and Safety Committee Terms of Reference Helen Young	**Page 92** **To note** **Page 94** **Decision**	10.45
	QUALITY AND SAFETY		
14	**Quality and Patient Safety Report** Helen Young	**Page 101** **To note**	10.50
15	**Medical Director's Report** John Black	**Page 112** **To note**	10.55
16	**Quality Account** Helen Young	**Page 125** **To note**	11.00
17	**Annual Safeguarding Report** Helen Young	**Page 127** **To note**	11.05
	COMFORT BREAK 11.10 (5 mins)		
	FINANCE AND PERFORMANCE		
18	**Integrated Quality Performance Report** Mike Murphy & Executive Director Leads	**Page 182** **To note**	11.15
19	**Operations Report – 999, 111 and Other** Paul Kempster	**Page 247** **To note**	11.35
20	**Finance Report – Month 3** Stuart Rees	**Page 257** **To note**	11.40
	PEOPLE, WELL-BEING AND LEADERSHIP		
21	**People Directorate update** Melanie Saunders	**Page 270** **To note**	11.50
22	**FTSU Self-Assessment** Melanie Saunders	**Page 280** **To note**	11.55
	BUSINESS ASSURANCE		
23	**Assurance Reports** a) Mike McEnaney (Audit – 22 June & 13 July 23) b) Les Broude (Finance and Performance – 19 June & 20 July 23) c) Anne Stebbing (Quality and Safety 6 June & 6 July 23) d) Ian Green (People and Culture Committee 1 June & 13 July 23)	**Page 318** **To note**	12.00

Item		Action	Time
	e) Nigel Chapman (Charity – 12 July 23) f) Mike McEnaney (SCFS Update, 28 June 23)		
CLOSING BUSINESS			
24	**Any Other Business** Keith Willett	**Verbal** **To note**	12.15
25	**Questions from observers (items on the agenda)** Keith Willett	**Verbal** **To note**	12.20
26	**NED Review of Meeting** Keith Willett	**Verbal** **To note**	12.25
27	**Date, Time and Venue of Next Meeting in Public** Thursday 28 September 2023 Venue TBC	**Verbal** **To note**	12.30

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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: 26 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 & Council Companies, Member of Oxford City Council Planning Committee
4. Vice Chair of Care International UK
5. Director of Farrar Chapman Ltd*
6. Director Empowering Leadership Ltd
7. Community Governor, New Marston Primary School, Oxford (part of the River Learning Trust).

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

Interests that ended in the last six months

8. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

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

1. Chair of Salisbury NHS Foundation Trust

Current 'Other' Interests

2. Chair of Estuary Housing Association
3. Member of 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

Stuart Rees, Interim Director of Finance

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

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

END

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 25 May 2023**, held at the Ark Conference Centre, Basingstoke.

Board Members Present (14/15)
Professor Sir Keith Willett CBE (Chair); David Eltringham (Chief Executive); Sumit Biswas (NED); Les Broude (NED); Nigel Chapman (NED); Ian Green (NED); Dr Anne Stebbing (NED); Dr John Black (Chief Medical Officer); Paul Kempster (Chief Operating Officer); Jill Lanham (Chief Digital Officer); Daryl Lutchmaya (Chief Governance Officer); Mike McEnaney (NED); Mike Murphy (Director of Strategy and Business Development); Dr Dhammika Perera (NED); Melanie Saunders (Chief People Officer) and Professor Helen Young (Director of Patient Care and Service Transformation).

Apologies

Apologies for absence were **received** from Aneel Pattni (Chief Finance Officer).

In Attendance

Kate Hall (Intensive Support Director, NHSE/I); Michael Wood (Governance Consultant) and Gillian Hodgetts (Director of Communications and Marketing).

OPENING BUSINESS

22/132 – Chair's Welcome and Apologies for Absence
The Chair welcomed all to the meeting, commenting that in future, 48 hours' notice would be required for questions to be posed by members of the public.

22/133 - Declarations – Directors' Interests & Fit and Proper Persons Test

No new declarations were made and the Register of Interests (as at 18 May 2023) was **noted.**

22/134 – Minutes

The Minutes of the meeting held in public on 30 March 2023 were **approved** as an accurate record of the meeting.

22/135 – Board Action Log

The Action Log was **noted**, it being agreed to close Action 3.

STRATEGIC OVERVIEW AND CONTEXT

22/136 – Chair's Report
The Chair presented his report, highlighting that the NHS nationally was experiencing substantial changes in direction, post-pandemic. It was noted that the Chair had been invited to join the National Strategy Group for the NHS.

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

22/137 – Chief Executive's Report

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

- this was the CEO's first public Board meeting since taking up post;
- a number of meetings had been held with both corporate and operational teams and thanks was extended to all concerned;
- the 10-Point Plan provided a platform on which to build the Trust's 3-5 year strategy. It was important to connect with the frontline and more discussions would take place over the summer in this regard;
- in respect of the planned breakeven position for 2023/24, discussions had been held with commissioners in order to be transparent about the risks related to delivering such a challenging financial plan and cost improvement programme;
- the work of the Trust had been featured on a recent 'Good Morning Britain' programme which was well-received;
- a number of Trust staff provided support for the Coronation on 6 May, including support for the Windsor Coronation Concert.

Arising out of discussion, NEDs highlighted that it was important to maintain the quality of service and to carry out careful QIA assessments in respect of a planned the Cost Improvement Programme (CIP). Maintaining staff morale was equally important at this difficult time.

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

22/138 – Strategic Update: BAF

The Board **considered** an updated version of the Board Assurance Framework (BAF), following detailed consideration at the Board Seminar on 27 April 2023. It was **noted** that the overall risk ratings remained unchanged, as set out in the accompanying dashboard. As part of strengthening the assurance process, the Audit Committee would receive periodic reports from other Board committees summarising discussion of remit-specific risks. The Chair of the Audit Committee commented that further work was being undertaken with the Executive to ensure that key actions and controls were recorded in terms of mitigating risk. With regard to Digital Risk 8, the Chief Digital Officer advised that a paper was to be presented to the Finance & Performance Committee with regard to infrastructure investment proposals.

The Chair commended the work of GGI to date in assisting the Board in reviewing and streamlining the BAF, and also thanked the Corporate Risk Manager for his work in this regard.

The Board **approved** the Board Assurance Framework.

22/139 – Volunteer Story

The Board was grateful to Mr Bob Dory (CFR) for sharing his story with the Board which involved a patient with mental health problems having a concealed weapon in their possession. The learning from this story is that it was essential for 'special notes' on patient files to be accurate and to be regularly updated in order for crews (especially sole crew members) not to be placed in a position of danger. The Chair of the Quality & Safety Committee requested that the audit report (carried out by the Health & Safety Officer) on special notes be discussed at a future meeting of the Committee.

The Board **noted** the report.

PERFORMANCE. RISKS, GOVERNANCE AND ASSURANCE

22/140 – Integrated Performance Report

The Board **received** a progress report from the Director of Strategy & Business Development with regard to the Integrated Performance Report (IPR). The Board **noted** that the development of the IPR had been delayed due to a variety of factors, and that high priority was now being accorded to

introducing a new IPR model. Arising out of NED discussion, it was highlighted that it was essential for the Board to receive good quality information and meaningful metrics on which to base its decisions. The current IPR was overly-complex (extending to 80 pages and using both SPC charts and tables) and not easy to digest for assurance purposes. Greater clarity with regard to realistic and achievable targets and trajectories (eg demand and capacity) was required.

The Chair thanked the NEDs for their constructive comments on the IPR and looked forward to the Board receiving an improved version at its next meeting.

The Board **noted** the progress report.

22/141 – Executive Updates

The Chair invited Executive Directors to provide individual progress reports to the Board. With regard to People and Organisational Development, the Chief People Officer reported that the People & Culture Committee had received a report on recruitment and retention which was an improving situation across the Trust, although challenges still remained in certain areas. In the light of budget constraints, revised staffing estimates were currently being developed by the Executive.

The Chief Operating Officer commented that April had been a more stable month in terms of the Trust's operations, with the benefits of additional UEC funding resulting in a mean Category 2 response time of 28 minutes. Staff sickness rates had also fallen during the month under review.

The Director of Patient Care & Service Transformation advised the Board that the Executive team had discussed a range of quality data and related governance issues at a recent meeting. The Chair commented that data would be critical in terms of the Trust's resourcing in the years ahead, so there was a need for this to be as accurate and as reliable as possible.

The Board **noted** the reports.

22/142 - Quality and Patient Safety Report

The Director of Patient Care and Service Transformation presented her report for the period February to March 2023**,** the following key points being highlighted:

- with regard to the Management of Medical Devices and Equipment**,** the Improvement plan progressing with delivery against actions monitored at the Patient Safety Delivery Group;

- AED secondary devices had now been received and allocated to all operational sites;

- with regard to Safeguarding**,** in particular IT system resilience, Level 3 Safeguarding training, and supervision of staff, the improvement plan has received significant system-wide scrutiny and oversight, with significant improvements in all key objectives being achieved;

- the outstanding IPC '*should do'* action relating to the completion of the Microbiology Service Level Agreement (SLA) with Oxford University Hospitals NHS Foundation Trust had now been resolved;

- there had been a reduction in the number of Clinical Incidents attributable to a reduction in demand on services during the reporting period (returning to REAP Level 2), correlating with a reduction in harm-related incident reporting;

- in respect of Non- Clinical Incidents, there had been no significant change in reporting culture with (117) abuse/ abusive behaviour incidents received predominantly by 999 operational staff;

- there had been a 20% increase in the total number of Patient Experience (PE) contacts received during the reporting period, which included cases pertaining to previous months when the Trust was in REAP Level 4;

- 95% of complaints had been responded to within agreed target times for February and 92% for March 2023;

- all Duty of Candour (DOC) incidents were responded to within the 10- day requirement;

- at the year-end (2022/23), the Trust declared (95) Serious Incidents (SIs**)** in line with the (2015) Serious Incident Framework. Four SIs are currently in breach of the 60-day target for completion;

- with regard to the Patient Safety Incident Response Framework (PSIRF)**,** plans are progressing with the appointment of an Implementation Lead;

- an emerging theme concerns patients with chest pain being discharged on scene with re-attendance within 24 hours.

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

22/143 – Operations Report

The Chief Operating Officer provided his Operations Report to the Board, commenting that March had been another challenging month with a deterioration in performance and service capacity, impacted by handover delays and high levels of annual leave. The Trust's performance across many metrics improved in April, including Cat 2 mean, 999 and 111 call answer. The Board **noted** the following key points:

- **Clinical Co-ordination Centres:** in-bound 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%;

- April has shown an improving picture, although in-bound call volumes remain above forecast by circa 7.5% but the mean monthly call answer is currently 16 seconds;

- there are currently 153.5 WTE ECTs within the EOC, but due to training/coaching activities 121 WTEs are working effectively. 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;

- **Urgent & Emergency Care:** SCAS capacity increased due to lower leave levels. The Trust lost 4,400 hours in hospital handover 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;

- **Resilience & Specialist Operations:** 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); on-going Industrial Action; widespread electricity loss and severe weather.

The Board **noted** the report.

22/144 – Finance Report

The Chief Executive Officer presented a summary update report to the Board on the Trust's finances, the following matters being highlighted:

- the reported financial position as at 30 April 2023 was a deficit of £1,829k (£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 in-month variance to plan largely relates to: non-delivery of financial sustainability plans; above budget resource costs within the 999 service and higher activity than planned for 999 and also PTS;

- 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 in April was £258k on an original budget of £250k.

The CEO further commented that given the need to deliver a balanced budget for the year, a financial recovery programme had been established to be led by the Director of Strategy & Business Development Budget. Quality and safety matters remained paramount concerns in carrying out QIAs related to the CIP schemes. It was **noted** that the wider Senior Leadership Group (SLG) was helping to identify in-year cost savings and were being briefed on the Trust's overall performance in this regard.

Arising out of NED observations, it was commented that the largest adverse variance to day appeared to relate to commercial PTS. In response, it was noted that this variance was due largely to the application of a corporate overheads charge in the first month of the year. In respect of the national pay award, the Board was advised that funding to cover 2.3% of the award had been received to date. Any additional pay increases would need to be provided by commissioners.

The Board **noted** the report.

22/145 – 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, Research and Clinical Trials, the following key points being highlighted:

- SCAS was in the upper quartile rating when benchmarked nationally for 7 out of 13 ACQI indicators, 2 better than the last report to CRG;

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

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

- work was progressing with Business Intelligence (BI) colleagues regarding the roll out of an ACQI scorecard, with one element being ready for testing;

- all patient-facing staff working in the E&UC service were receiving an ACQI training session and resuscitation update as part of the 2023/24 mandatory face-to-face clinical update programme;

- the SCAS research team had 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. The Board welcomed this multi-agency working;

- the Trust has published its Research Annual Report which provides further information on the clinical research undertaken by SCAS, including principal publications and presentations. The Report will be considered by the Quality & Safety Committee.

The Board **noted** the report.

22/146 – Provider Licence: Self-Certification

The Chief Governance Officer presented this report to the Board commenting on the requirement of the Trust to carry out this annual self-certification exercise in accordance with its NHS Provider Licence; in particular, relating to Condition G6 (systems for compliance with Licence Conditions and related obligations) and FT4 (Trust governance arrangements).

The Chair commented that, taking all reasonable precautions, the Board was satisfied that the Trust continued to meet its licence conditions.

The Board **approved** the Self-Certification statements for 2022/23.

22/147 – Draft Annual Report & Financial Statements, 2022/23

The Chief Governance Officer presented the draft Annual Report & Financial Statements, 2022/23 to the Board, requesting that delegated authority be granted to the Audit Committee to approve the final version of the Annual Report & Accounts (following auditor sign-off) at its meeting on 22 June 2023, in order to meet the NHSE submission deadline of 29 June. Arising out of discussion, it was **agreed** that all members of the Board should be invited to attend the Audit Committee meeting on 22 June in accordance with established practice in providing due scrutiny.

The Board **noted** the Draft Annual Report & Financial Statements, 2022/23.

22/148 – Governance Update

The Board **noted** the Governance Update, including the Integrated Governance Framework, and welcomed the draft Board Cycle of Business, 2023/24 which should include digital matters. It was commented that the Business Cycle needed to be aligned to the IPR as part of the wider assurance process for the Trust.

22/149 - People & Culture Report

The Director of People presented her report to the Board, commenting that May meeting of the People & Culture Committee had been postponed due to the sad death of Vicky Holliday (Associate Director of Quality). The Board **noted** the following key points:

- **Freedom to Speak Up Self-Assessment:** NHSE had updated its FTSU board self-assessment tool kit, and the Trust was in the process of completing its own self-assessment, to be reviewed by the People and Culture Committee in June 2023;

- **Public Sector Equality Duty:** the Trust is committed to demonstrating '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, summarised in the Trust's Annual Report;

- **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: to eliminate unlawful discrimination, harassment and victimisation and other conduct; to advance equality of opportunity and to foster good relations.

  The *Specific Duty* places a requirement on the Trust to publish: equality objectives (at least every four years); an EDI strategy and information to demonstrate compliance with the equality duty. The Public Sector Equality Duty annual report will be reviewed by the People and Culture Committee at its meeting in June 2023;

- **Equality Impact Assessment Toolkit:** the updated Equality Impact Assessment toolkit will be reviewed by the People and Culture Committee in June 2023.

The Board **noted** the report.

22/150 – Communications & Engagement Report

The Director of Communications presented her report to the Board, commenting as follows:

- the Trust had provided support for the Coronation of Their Majesties King Charles III and Queen Camilla on 6 May 2023;

- communications in respect of on-going industrial action preparations. As a Category 1 responder, the Trust has a responsibility to protect the public and to support its staff, stakeholders and the wider community;

- engagement with communities: the Health and Social Care Act 2022 requires the Trust to meet the requirements of the 'triple aim' duty regarding actions to manage the impact of inequalities on population health. The Business Information team is currently correlating data on demand and areas of deprivation to help 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.

The Chair commented that at a recent meeting of the CoG Membership & Engagement Committee, discussion had centred on how the Council could be more representative of the communities it serves, and that Governors should be closely involved with 'triple aim' duty.

The Board **noted** the report.

22/151 - Board Committee Upward Reports

- ***Quality and Safety Committee***

It was noted that the Committee would next meeting in June 2023.

- ***Audit Committee***

The Committee Chair (Mike McEnaney) informed the Board that all internal audit reviews had been carried out in accordance with the annual plan. Outstanding internal audit actions needed to be followed up and closed as a priority. The Board was informed that Head of Internal Audit's opinion on the 2022/23 year was 'moderate assurance', which would be included in the Annual Report.

- ***Finance & Performance Committee***

The Committee Chair (Les Broude) commented that the Trust faced a challenging year in respect of delivering a breakeven position and implementing a significant cost improvement programme. The Committee would hold a further extraordinary meeting on 19 June to monitor progress.

- ***Charity Committee***

The Board **noted** the Committee's Annual Report, 2022/23. The Committee Chair (Nigel Chapman) reported that given the growth in the size of the Charity, financial management arrangements needed to increase accordingly.

The Board **noted** the Upward Reports.

22/152– Any Other Business

The Chief Executive advised the Board that the Recovery Support Programme (RSP) timetable had changed and that the Trust may not exit NOF4 status by September 2023. There was no other business.

22/153 – Questions from Observers (relating to items on the agenda)

Questions were raised from Governor observers in respect of when the level of support to the Council of Governors would be fully restored. The Chair commented that a substantive Chief Governance Officer (with a wider governance remit) had now been appointed and that he would be very willing to meet with all Governors in the near future. The Director of Strategy & Business Growth commented that it was intended actively to include Governors in the Trust's strategic planning process over the course of the summer. The Lead Governor welcomed this and other developments and commented that she would appreciate additional feedback on the 'special notes' assurance process arising out of the volunteer story.

22/154 - Review of Meeting

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

- healthy critique and challenge by NEDs;
- the need to ensure a balance between cost improvements and patient safety, recognising the impact on staff;
- develop the Trust's role as a leading partner in the local system;
- build on the revised BAF which is now a much-improved document for assurance purposes;
- produce an IPR model which is accessible and provides accurate and reliable data on which to make informed decisions.

22/155 – Date of next meeting: Thursday 27 July 2023 (in-person).

Approved by:

Chair (signature)……

Date:……

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

BOARD MEETING IN PUBLIC – 27 July 2023

ACTION LOG

No.	Minute ref.	Action	Resp	Date Raised	Due Date	Comments / Updates
Board Meeting – 25 May 2023						
1.	**22/147**	All Board members to be invited to attend Audit Committee meeting on 22 June 2023 at which the Annual Report & Financial Statements, 2022/23 will be approved	CGO	25/5/23	**June 2023**	This meeting was cancelled. The Audit Committee convened an extraordinary meeting on 13 July 2023 to approve the Annual Report and Accounts **Propose to close**
2.	**22/138**	BAF: paper on digital infrastructure investment to be considered by Finance & Performance Committee	CDO	25/5/23	**July 2023**	Considered by the FPC on 20 July 2023 **Propose to close**
3.	**22/125**	The Board to consider detailed results of the Staff Survey at a future Development Seminar.	CPO	30/03/23	**September 2023**	Rescheduled for 28 September 2023 **Open**
4.	**22/139**	Quality & Safety Committee to consider H&S audit on 'special notes' at a future meeting	DPCST	25/5/23	**September 2023**	**Open**
5.	**22/153**	Lead Governor to receive additional feedback on 'special notes' assurance process	DPCST	25/5/23	**July 2023**	**Propose to close –** scheduled to be presented at CoG on 31 July 23.

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

BOARD MEETING IN PUBLIC – 27 July 2023

ACTION LOG

No.	Minute ref.	Action	Resp	Date Raised	Due Date	Comments / Updates
6.	**22/150**	Governors to be invited to participate in 'triple aim' duty with regard to community engagement	CGO	25/5/23	**October 2023**	**Open**

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Chief Executive Officer's Report**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**6.0**	
Executive Summary:	This report provides an update on important matters since the last Public Board meeting.			
Recommendations:	The Trust Board is invited to **note** the report.			
Board lead:	David Eltringham, CEO			
Report author:	Daryl Lutchmaya, Chief Governance 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:
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

CHIEF EXECUTIVE'S REPORT

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

Strategy presentations

The 10 Point Plan was launched on 6 June 2023 as part of my 100th day as Chief Executive of SCAS. I will be discussing it further and building the detail for each point over the summer. I am currently undertaking strategy engagement sessions with staff to talk through and explain what it means to them and to seek feedback so that it becomes part of the fabric of the Trust. SCAS exists to care for patients with urgent and emergency illnesses or injuries, to provide telephone advice for urgent but non-life threatening conditions and for those who need help getting to essential appointments. In order to achieve this very important work for our patients, we rely on all our people; frontline and support, paid and voluntary. The ten points cover the things people have told me are important to them. The things we must get right, whether they're supporting everyday jobs or transforming for the future. Getting back to basics and getting these things right will make SCAS the best it can be, for our patients and our people. They're not all easy, but they set our ambition and priorities for the year ahead. We will reconnect these priorities to our long-term strategy through engagement events over the summer and relaunch a 3-5 year plan in the autumn of 2023. Our patients, their families and our people come first. High quality, safe services for patients, and the health and wellbeing of our people must be the focus of everything we do. All ten points link to making sure we achieve this.

Recovery Support Programme

In June 2023, Hampshire and Isle of Wight (HIOW) ICB and its seven NHS Trusts were placed into NOF4 (National System Oversight Framework - segment 4) and so will receive assistance in the form of the Recovery Support Programme specifically relating to Financial Governance. NHS organisations across Hampshire and Isle of Wight have a challenging combined deficit for 2023/2024. Hampshire and Isle of Wight (HIOW) Integrated Care Board (ICB) has begun the journey of significant transformational change, working closely with partners across the Integrated Care System (ICS) to ensure greater efficiency and long-term sustainability of services. Working together to bring the system back into balance and living within the allocations provided is a collective priority. The HIOW ICB is in a good place to do this as our partnerships are already well established and SCAS is already working with people and communities on this journey of transformation.

Given the scale of the challenge, the ICB along with NHS provider Chief Executives sought help from NHS England by proactively seeking to enter the national recovery support programme. This has secured support from NHS England in delivering the scale and pace of transformation needed. This is alongside other key commitments to improve access, reduce waiting times and reduce health inequalities as set out in the ICB response to the 2023/2024 national planning guidance.

In response, the Trust has undertaken a review of its finances and activities to find safe and efficient ways to reduce its costs and to attempt to achieve breakeven. Financial

savings schemes and targets have been assigned to various workstreams which essentially means that every directorate will play a role in the delivery of financial sustainability. The Trust recognises that an iterative approach to saving will be required to deliver financial stability within the organisation. New cost saving ideas will play a pivotal part in achieving the goal. In an effort to monitor performance and to prevent any deterioration in the quality and level of services provided to patients, the Trust is also redesigning its Integrated Quality Performance Report as a tool to measure this..

Integrated Quality and Performance Report

Since the last Public Board meeting in May, we have been actively improving the Integrated Quality and Performance Report (IQPR) and have worked closely with NHSE to design the new version, reflecting best practice in the NHS. I want to ensure that the IQPR is as comprehensive as it can be before presenting it to the Public Board. This important piece of work is part of a larger focus on relaunching the Trust's Improvement Plan over the Summer. This will enable us to better meet the governance and performance criteria as set out in the work we are doing as part of being in NHS Oversight Framework Segment 4 (NOF4).

Adult Critical Care Transport Service

I am pleased to report that we have been speaking to South East Coast Ambulance Service (SECAMB) to try to find a way to deliver the Adult Critical Care Transport Service (ACCTS) in the South East. It is a crucial service in the Region and we are currently exploring more opportunities for collaboration and will share more about this in due course.

Long Service Awards

At the time of writing, I am delighted that the Trust will be holding the annual SCAS Long Service Awards once again on 26 July in Bicester. The ceremony rotates across the core counties we cover and this year it is Oxfordshire's turn to host. The event will celebrate colleagues across SCAS who have undertaken 20 years' service with the ambulance service and the NHS. At the awards the Lord-Lieutenant of Oxfordshire, Mrs Marjorie Glasgow BEM accompanied by me, will present the Queen's Long Service and Good Conduct Medal to colleagues on the frontline 999 service. In addition, the SCAS medals will be presented to all colleagues in SCAS who have achieved 20 years NHS service.

Colleagues from across SCAS who are eligible for their medal have been invited to the event with a guest and we are expecting approximately 100 guests to attend. The awards are a great opportunity for us all to celebrate the long service, good conduct and professionalism of all recipients.

Leadership visibility

It is very important for members of the leadership team to be visible and to engage with staff at all levels across the SCAS geography. I have set the expectation for Directors to visit and to understand how the Resource and Ambulance Centres operate and to meet and engage with staff at least once per month. These visits will also include the Clinical Coordination Centres, corporate support services and NHS 111. During the period since the last Board meeting, I have been involved with the following:

- Attended a Driving Familiarisation Course / day with Driving Education
- SORT Training / afternoon with Specialist Operations

- Executive Development Day at PTS Loverock Road / met team
- Attended Operations Department Performance Review meeting
- Attended BASICS Enhanced Care Training Session
- Spent time with staff in Whiteley Education Centre
- Held several Strategy Engagement Sessions
- Various Surrey/Sussex visits (2 days)
- Spent time with clinical and education staff in Newbury Education Centre
- Met with Finance and Procurement teams
- Met staff at University Hospital Southampton – spent time with HILO and the team cohorting patients at the front door
- Met staff at Hampshire Hospital Winchester
- Visit to Alton Resource Centre
- PTS Ride out – Adderbury

75th Anniversary of the NHS

On 5 July 2023, the NHS marked 75 years of service. Treating over a million people a day in England, the NHS touches all of our lives. When it was founded in 1948, the NHS was the first universal health system to be available to all, free at the point of delivery. Today, nine in 10 people agree that healthcare should be free of charge and more than four in five agree that care should be available to everyone. The NHS belongs to all of us. SCAS and South Central Ambulance Charity marked the event with a range of activities, events and celebrations (more detail can be found in the Communications Public Board Paper)This included five members of staff being invited to join other NHS staff, senior government and political leaders, health leaders and celebrities at a service at Westminster Abbey. Robin Mugridge, volunteer Community First Responder from High Wycombe in Buckinghamshire, was honoured by Their Royal Highnesses The Prince and Princess of Wales at a special NHS Big Tea party. Our South Central Ambulance Charity has been visiting sites across the South Central region and will continue to do so over the next few weeks and celebrating NHS 75 at local Morrisons stores across our SCAS area.

National Chartered Institute of Public Relations (CIPR) Excellence Awards - Finalist

Last but not least, I am delighted to finish on a positive note. With Innovation as one of our Trust values; a campaign led by South Central Ambulance Service (SCAS) Communications team to raise awareness of cardiopulmonary resuscitation (CPR) and access to defibrillators has been shortlisted for both a prestigious national communications excellence award and a regional CIPR PRide award. Entitled ‘Defibrillators’, a deadly game of hide and seek, the award entries covered a range of communications activity carried out over the past year across media, social media, online, design and public engagement.

It was shortlisted in the healthcare campaign category in the Chartered Institute for Public Relations (CIPR) national Excellence Awards 2023 alongside some major national campaigns and organisations including Virgin Media O2, the British Heart Foundation and a number of London-based public relations firms. It has also been shortlisted for the Anglia, Thames and Chiltern 2023 CIPR PRide Awards, due to be presented at the end of September 2023.

The Communications team at SCAS has been excellent in raising awareness and ensuring that messaging remains consistent, so I am extremely pleased to see these efforts recognised at both a national and regional level. It is excellent recognition for our

organisation as a whole and our Communications team to be shortlisted among some very significant national health campaigns but, above all, it is an indication our work in this area continues to have a big and positive impact.

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Summary of business arising out of the private meeting of the Board held on 29 June 2023 at The Hub, Milton Keynes**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**7.0**	
Executive Summary:	This report provides an update on important matters discussed at the previous Private Board meeting.			
Recommendations:	The Trust Board is invited to **note** the report.			
Board lead:	David Eltringham, CEO			
Report author:	Daryl Lutchmaya, Chief Governance 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:				
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				

ICB Joint Forward Plans

The Board considered and **endorsed** the 5-year Joint Forward Plan of the HIOW, BOB, BLMK and Frimley ICBs. The Chair commented that he had attended various chair meetings at which the ICB Plans had been discussed, an increasing emphasis being placed on the need for all parties to work in close partnership moving forward and to engage in radical thinking in addressing key issues.

Emergency Decision under Standing Orders

The Board **approved** the Business Case in respect of the purchase of nine electric vehicles as part of a pre-order arrangement which had been put in place 16 months earlier.

Freedom to Speak Up (FTSU) Self-Assessment Report

The Board considered a FTSU Self-Assessment Report, the first such report to be completed under guidance from the National Guardian's Office. It was noted that the Chief People Officer would reference discussion of the FTSU Self-Assessment within her July report to the Board.

The Board **noted** Section 1 (narrative in respect of 8 FTSU principles) and **approved** Sections 2 and 3 in respect of summary actions.

Quality Account, 2022/23

The Board considered the Quality Account, 2022/23 which had been subject to detailed scrutiny at both the Quality & Safety and Audit Committees, and that there had been a good level of engagement and input from NEDs in producing the Quality Account and in setting objectives for 2023/24.

The Board **approved** the Quality Account, 2022/23.

Draft Annual Report & Financial Statements, 2022/23

The External Auditors presented their Audit Findings Report to the Board. Key points highlighted included:

- there were no outstanding areas of concern that would prevent an unqualified opinion being given on the Accounts;
- there had been no overall change to the Trust's reported deficit as a result of non-material financial changes within the Accounts;
- no issues had been identified with regard to SCFS Ltd;
- no significant issues had arisen in respect of Fraud and Revenue Recognition;
- under IRFS 16 (new this year in relation to property and leases) everything was materially correct.

With regard to the VfM report, the Board commented on the fact that much work had taken place in respect of the Improvement Programme in close dialogue with TPAM which needed to be drawn to the auditors' attention. In addition, following the Board's decision on 3 May to approve a breakeven budget on the year (in the context of intense ICB discussion), a letter had been sent from the CEO to the ICB clearly articulating the consequences of such a decision, including the extent of the Trust's CIP.

It was **noted** that the Board would be advised of a revised schedule for formal approval of the Annual Report & Financial Statements.

HIOW ICB: NOF4 Status

The Board considered a paper which set out the implications for the Trust in the light of HIOW ICB having NOF4 financial undertakings placed upon them. The Board was advised that the situation was still developing and that the current TPAM process would continue for SCAS, with financial undertakings for all partner trusts being subject to system-level monitoring.

The CEO advised that regular CEO meetings were being held and that a system improvement director would be assigned to HIOW.

The Board **approved** the report.

South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Communications, Engagement and Marketing – activity update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**8.0**
Executive Summary:	**NHS 75** With the 75th birthday of the NHS this month, the SCAS Communications team have been supporting a campaign of activities and SCAS staff are attending national events being held to commemorate this historic milestone. **Communications support for the SCAS Charity** The work of the SCAS Charity has never been more important and the communications team have been providing more formal support for PR, internal and external communications. **Supporting high-profile events: Royal Ascot 2023** 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 actively supported our operational teams who were providing medical cover together with partners, at this year's event.		
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

PUBLIC BOARD MEETING PAPER

Communications, Marketing and Engagement update

PURPOSE

1 The purpose of this information paper is to update the Board on 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 **NHS 75**

With the 75th birthday of the NHS this month, the SCAS Communications team have been supporting a campaign of activities locally, regionally and nationally and SCAS staff are attending several events being held to commemorate this historic milestone. This work is encouraging engagement with not only our own staff but also with our communities and with partners and stakeholders.

3 **Communications support for the SCA Charity**

The work of the SCA Charity has never been more important and the Communications team has been providing more formal support for strategic planning PR, internal and external communications to raise the profile of the charity.

4 **Supporting high-profile events: Royal Ascot 2023**

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 actively supported our operational teams who were providing medical cover together with partners, at this year's high profile and prestigious event and worked positively with the media to respond to enquiries about incidents, health issues and levels of healthcare support.

KEY ISSUES

5 **NHS75**

Recognising and rewarding our staff remains a top strategic priority within the Communications Strategy and as such our engagement and profile at these milestone occasions for the NHS is important.

There are several national events taking place to mark the NHS 75th Birthday which have been shared with staff and volunteers. The SCAS Communications team are using national resources to promote local activities and are encouraging our staff and volunteers to participate. Several buildings, historic monuments and other high-

profile sites across the country will light up blue to mark the 75th Birthday; images from those in the SCAS area will be included. Also, NHS England, in partnership with Fujifilm, launched a national photography competition to mark 75 years of the NHS. Several national materials including videos, Microsoft Teams backgrounds and images, will be shared throughout the week, both internally and externally in celebration.

National recognition

Nationally there is a service taking place at Westminster Abbey on 5thJuly, the date of the NHS's 75th Birthday. The Communications team co-ordinated the requested nomination of five staff from across SCAS, our attendees being put forward for their exceptional contribution. They have been nominated from all our key areas and will represent 999, NHS111, Corporate services, Patient Transport Service and Clinical Coordination Centres. An overview and images from the day will be shared through our internal and external communication channels. Although this is nationally led, it supports the Communications strategy in recognising and rewarding the valuable contribution that our staff and volunteers make in the delivery of healthcare across the SCAS area. There is also a special event being held at Number 10 Downing Street and SCAS Communications was successful in a national bid to send one of our Paramedics from Bracknell who will be there representing SCAS.

The NHS Assembly is developing a public report called NHS@75, informed by patients, carers, staff, and the wider health and care community. The details were shared in our staff magazine.

Local

The SCAS Long Service Awards, taking place on 26th July in Oxfordshire, will also acknowledge the importance of this milestone year. The Lord Lieutenant for Oxfordshire, Mrs Marjorie Glasgow, BEM will be presenting, together with our Chief Executive David Eltringham, the Queen's Medal for Long Service and Good Conduct and the SCAS NHS Long Service Award. This is presented to staff who have achieved at least 20 years of continuous service in the NHS. Invitations have been sent and there will likely be over 100 attendees. This is likely to be a poignant ceremony where the Queen's Medal will be presented for those who achieved 20 years up to the day of the Queen's passing.

Partnership and engagement is at the heart of our Communications strategy, not only with other NHS bodies, but also with many other partners. One such established and valued partnership is that which has been formed over many years with the Armed Forces. The SCAS recruitment team is hosting a Military Insight Day for service leaders, including re-signing the Armed Forces covenant, whilst celebrating the NHS 75th Birthday at the same time.

SCAS staff involvement

Much of the 75th Birthday involves stories of individuals and their dedication and commitment to the NHS. We are focusing on individuals' personal stories from across our services including the NHS 111 service and our long-service volunteers.

Park Run for the NHS is taking place on 8th and 9th July and all staff and volunteers are being encouraged to take part. SCAS volunteers, including a small

group of CFRs from Beaconsfield and Chalfont, are planning to take part with Community First Responder, Dee Hartnett, sharing her story in our staff magazine.

Ben Wilson, Real Time Surveillance Practitioner – Suicide Prevention, is attending the Baton of Hope in Milton Keynes on 4th July and will link in with 75th Birthday and International Paramedics Day that take place on Saturday 8th July. SCAS's very own 999 Ted will also make an appearance! Nikhyta Patel, Patient and Public Engagement Facilitator and Saricka March, Learning Disability Specialist, are attending a primary school in High Wycombe with a SCAS ambulance vehicle and our mascot, 999 Ted.

Alongside all these special NHS events, 22nd June marked 75 years of HMT Empire Windrush arriving in Britain. Dipen Rajyaguru, our Head of Equality and Diversity, shared posts on both the staff intranet site 'The Hub' and on our internal staff social media stream Yammer in recognition.

This 75th year milestone occurs during an important year for the UK with SCAS having already been an important contributor to Coronation events in Windsor, prestigious Royal Ascot and now NHS75, ensuring its contribution to supporting the country on a national footprint.

6 **Communications support for SCA Charity**

Since January 2023 the Communications and Engagement team has been giving enhanced support to the South Central Ambulance (SCA) Charity. The additional communications and marketing resource is helping the charity to meet its strategic objectives and support its continuing growth.

In the early part of the year the focus was on developing the charity's vision, mission and key messages. Working with an external facilitator and involving staff and volunteers from the charity, a wide-ranging consultation was conducted, from which came a Mission, Vison and Value statement and key messages to support the above. These will now provide the framework for development of a Communications and Engagement Plan.

This will be backed up by an extensive internal (SCAS) PR plan to share the vision and mission of the charity, highlight the benefits it provides to SCAS staff and increase engagement between staff and the charity.

We have also worked with an external agency to develop a corporate partnership development plan. The outputs from this work are being analysed and will form the framework for an engagement and communication strategy for recruiting potential commercial partners.

The communications and marketing objectives for Q3 and Q4 are currently being developed and will focus on bringing the work so far to fruition, putting the groundwork in place for further development in 2023/24.

Alongside supporting the strategic development of the Charity, the Communications team is planning to bring a higher PR profile to its fund-raising activities. Currently the Charity has planned a bucket collection in partnership with a number of Morrisons stores in July and will mark NHS75 by fundraising. There will be more events to follow.

7 **Royal Ascot Communications – 'Warning and Informing'**

Described as one of the highlights of the horse-racing calendar, Royal Ascot was attended by members of The Royal Family, VIPs and high-profile celebrities and saw over 50,000 spectators arrive each day from 20th to 24th June.

The SCAS Communications team had a significant role to play over the course of the week, working in close partnership with the Royal Ascot Communications team and with SCAS operational teams. As had been the case in recent years, race week took place with searing heat affecting many attendees.

Delivering our 'Warning and Informing' responsibilities, the Communications team ensured that public health messages were posted prior to and during the week, reminding visitors of the need to take precautions to lessen the risk of heatstroke and advising people not to consume excess alcohol or other substances. The team used social media channels and issued a press release ahead of the first day which was picked up by various media outlets and subsequent media interviews followed.

A team of paramedics, specialist practitioners and volunteer community first responders from South Central Ambulance Service NHS Foundation Trust (SCAS) were on-hand to provide emergency medical support at Royal Ascot. Whilst initial first aid was given on-site by trained first responders from two other medical providers, the SCAS team were kept busy with more serious and life-threatening emergencies, as well as undertaking the transfer of patients requiring hospital treatment to nominated local hospitals.

After several years living with Covid restrictions and a reduced requirement for support at events at Royal Ascot, it was back to business as usual with the SCAS medical and communications response for this year's event. This was the first to be attended by His Majesty the King and Her Majesty the Queen in their new roles. There was heightened concern of possible protestor disruption as seen at other sporting venues this year and, as such, planning and preparation were key to anticipating and planning for such an eventuality.

Coordinated by the Resilience and Specialist Operations team (RSO), we had a command-and-control structure in place for the duration of the event. By ensuring we had a team of medics available inside the racecourse, we were able to manage demand early and effectively without impacting upon our resources in the surrounding areas while the event was taking place.

In total, throughout the course of Royal Ascot 2023, SCAS cared for 144 patients with injuries ranging from minor injuries through to falls, limb injuries, chest pains and strokes. Some 90% of those patients with minor injuries were able to be treated on scene by our expert clinicians, while 10% were treated and transferred into the care of hospitals such as Frimley Park, Wexham and Royal Berkshire. The communications team managed associated media enquiries about the range of

health issues that were attended to, abiding by our usual patient confidentiality requirements.

CONCLUSIONS AND RECOMMENDATIONS TO THE BOARD

8 Communications activity within the Trust is intense both internally and externally. Prioritising our activities is a constant necessity and with increasing demand on the team, keeping focused on our strategic aims in supporting the Trust to move forward has been key.

9 With 'Innovation' as one of SCAS's key values, it is worthy of note that the Communications team recently achieved great success in becoming a finalist in the shortlist of the healthcare campaign category, at the national Chartered Institute of Public Relations (CIPR) Excellence Awards. We were recognized for our campaign entitled '*Defibrillators: A deadly game of hide and seek'*, alongside some major national campaigns and organisations, including Virgin Media O2, the British Heart Foundation and a number of London-based public relations firms. The award entry covered a range of communications activity carried out over the past year across media, social media, online, design and public engagement. More on this to follow in the next SCAS Public Board meeting in September 2023.

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

Gillian Hodgetts
Director of Communications, Marketing and Engagement
27 July 2023

Patient Story
SCAS Board
July 2023

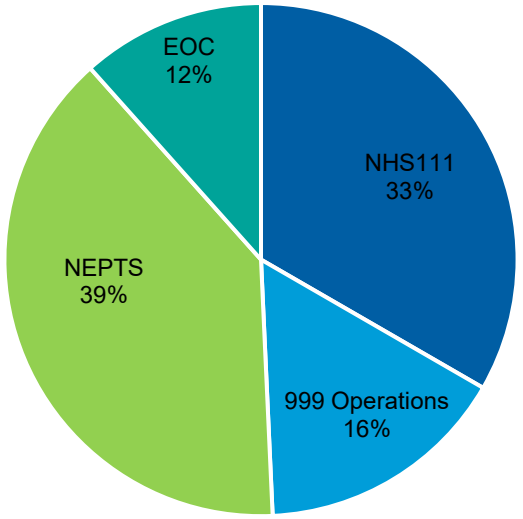
National Patient Safety Conversation

South Central Ambulance Service
NHS Foundation Trust

Communication cases within SCAS

- In April & May 2023 SCAS received 69 PE cases where the main theme was ‘Communication’. Of these 28 were upheld or partly upheld.

Communication PE cases by Service area April & May 2023



Example IUC PE case

- Parents of 2 year old child called 111 as they were concerned about some worrying symptoms. At the end of the first call they were told to contact the Urgent Treatment Centre to get an appointment. They did this and were told they could not do this directly and needed to call NHS111 first. The family explained they had done this.
- They called 111 again and were re-triaged and were sent through to the Out of Hours GP service.
- The handling of the calls and error made caused the parents a lot of concern and frustration and ultimately delayed them getting medical attention for their child

Findings/ Learning

- The calls were audited and the first call was not compliant. The Health advisor has since completed a call review plan.
- The DOS information for the UTC was not correct and has now been updated

South Central Ambulance Service
NHS Foundation Trust

Patient Safety Incidents

- 999 call for a 28 year old female (a nurse) with abdominal pain. She told the call taker she thought she was having an ectopic pregnancy. A category 3 ambulance response was reached for possible ectopic pregnancy.
- The crew reported that the patient was acting erratically, lacked capacity and they thought she may have been 'spiked' (her drink spiked with an incapacitating substance) so administered Narcan. This had no effect, The crew requested attendance from the police
- 2 hours later the patient went in to Cardiac arrest and sadly died.

Trustwide Learning/Actions

- A memo went out to all frontline staff to consider a differential diagnosis in a woman of childbearing age with abdominal pain that pregnancy and more specifically ectopic pregnancy may be the cause.
- There is an ongoing project in place to replace the current MDT system to comply with the Road Traffic Act and the new system will replace the current hardware with new and updated software that will deliver incident updates via a voice rather than text method. The project will also encompass the training and aide memoirs for both frontline crews and dispatchers.

Investigation

- The patient informed the crew she was having an ectopic pregnancy. She was extremely confused and incorrectly told the crew she had not had sexual relationships for 3 'years' when she meant 'months'.
- Despite being made aware verbally that the initial call was for a possible ectopic pregnancy by EOC and the patient directly, the crew discounted this possibility based on the miscommunicated information above and treated the patient for a suspected narcotics overdose. This then extended the period of time they were on scene rather than conveying the patient in a timely manner and providing treatment that may have prevented the cardiac arrest, such as intravenous fluids.
- The attending crew only viewed the nature of call that they were dispatched on, they need to scroll up the page to see the symptoms of any previous calls. In this instance before they arrived on scene, they did not know that the initial presenting symptoms were of abdominal pain and possible pregnancy they were only aware of the breathing difficulties.
- The MDT device which alerts the crews to the information of the event they are being dispatched to also works as a sat nav for the driver to navigate to the event location. The crew member that is not driving is therefore not able to scroll through information that may be provided about previous calls as this would stop the sat nav from being available.

South Central Ambulance Service
NHS Foundation Trust

SCAS Actions and Learning – Communication related cases

Case Description	Learning Completed
Called 999 and crew arrived, allegedly told family that shouldn't have called 999 and should have called 111. Patient later deteriorated and family called 111 on 07.10.22 as advised. Told a Dr would call back. Called 999 again. The patient was found to have sepsis and passed away from organ failure.	A package of learning and development has been implemented to support staff involved to improve their communication skills in line with a Just & Learning Culture.
Feedback on outcome and explore how to better ensure patients feel confident in when to call 999 to prevent significant events whilst waiting call back.	The HA involved in this patient's call has received comprehensive feedback in a one-to-one session with a member of the Auditing Department. They have been provided with a Call Review Plan that identifies required learning materials to be read and digested, and they have completed a reflective practice, highlighting what has been learnt and how this learning will be applied to future calls.
Patient missed appointment due to vehicle breakdown. No contact made to notify of the delay.	Recascade of CD19 - Communicating delays to the CC team reminding them of their responsibility to communicate delays to clinic and patient -Work started on a SOP regarding breakdown of vehicles and the responsibility of the CC team in communicating this.
1. Crew were told HEMS not available & Dispatcher did not P1 back up in notes for HEMS desk and did not advise them of the P1 back up.	Reminder email sent to all CCC staff reminding them to inform HEMS of any direct requests as even if they appear to be committed, there may be additional assets available, or they may not be clinically committed. Email also includes polite request to add P1 BUP requests to ICAD Notes field for visibility

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Patient Story

This is the story of Martha Mills, told by her mother, Merope.

Instead of being a story about something directly involving SCAS, this is part of a National Patient Safety Conversation and highlights the importance of the voice of the patient and their family.

There is clearly a link between communication and patient safety and experience

Our Head of Patient Experience gained permission from Martha's mother to share the story with you.

In this instance, the voice of Martha's parents was unheard.

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Communication with Martha's parents

- Martha's injury was treatable: she became the first child on record at King's to die of it – after the care for her became careless. Her death was an example of what a hospital official described to the family, in a barbarous phrase, as a "poor outcome" – This is a really good reminder about the choice of language we use when communicating to families.
- The family were told every day that Martha's recovery was never in doubt: it was just a matter of time and patience.
- Martha's parents describe feeling they were "judged" in the medical notes: "Mum and Dad pleasant and helpful," reads one entry.
- When Martha's mother communicated with our Head of Patient experience she commented " Afterwards I hated the way the hospital kept saying she was unwell – she was dying!"

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What has happened as a result?

- A National Worry & Concern Group was initiated 2020/21, a sub group of National Acute Deterioration Board.
- 7 regional pilot sites are taking part in a National quality improvement collaborative
- The Collaborative is supporting testing & implementation of two aims:
  1. **Test and implement a reliable method for patients (or their families/carers) to escalate worries and concerns about acute illness and deterioration**
  2. **Test and implement reliable methods for patients (or their families/carers) to routinely input their views regarding their illness and any worries and concerns into the health record**

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- The Florence Nightingale Foundation and King's Fund have been commissioned to carry out a deep dive into cultural and leadership barriers and enablers to raising concerns
- Call 4 Concern (C4C) service has been set up by Royal Berkshire NHS Foundation Trust.

The **Call 4 Concern (C4C) service was initially for patients discharged from Intensive Care then rolled out to the other wards.**

A **Call 4 Concern** can be made directly to the Critical Care Outreach team by a patient, family member or friend if they have any concerns about what is happening to the patient.

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Thank you

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PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Corporate Risks Register – High Risks**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**10.a**
Executive Summary:	Risks rated 25: • 111 Demand The 111 Demand risk is currently being reviewed. Risks rated 20: • Handover Delays – Reduced from 25 (likelihood changed from Almost Certain to Likely due to the ongoing work taking place within Ops and the system to improve delays) • Controlled Drugs • Financial risk – Increased from 16 (Likelihood changed from Likely to Almost Certain due to the ongoing financial challenges experienced by the Trust) Risks rated 16: • 999 Staff Capacity • 111 Staff Capacity • Regulatory Compliance • Safeguarding • ICT Hardware Failure • 999 Delay • EOC Staff Capacity - Reduced from 20 (likelihood changed from Almost Certain to Likely) Risks rated 15: • ICT Software Failure • ICT Resource Previously high rated risks, now rated lower than 15: • Community Disruption: Risk reassessed with rating moved to 4 (Minor x Rare) due to experience of strikes which show limited impact on performance as well as the RCN re-ballot voting for no further action. Consultant and Junior Doctor strikes ongoing. • Medical Devices: Risk reduced as the incidents remain in a positive place and medical devices improvement work		

	continues to embed. With the back-up devices in place the impact has been reduced to Major.			
Recommendations:	The Board is asked to approve the risk register.			
Executive lead:	Daryl Lutchmaya, Chief Governance Officer			
Report author:	Steven Dando, Corporate Risk Manager			
Previously considered by:	None			
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):	Not applicable			
Next Steps (what actions will be taken following agreement of the recommendations): • Any amendments to the risks requested will be completed				
List of Appendices:				

Ref No	Date Identified	Date of Latest Update	Risk Title	Description of Risk	Cause	Consequence / Likely outcome for SCAS	SCAS Objective	Inherent Impact	Inherent Probability	Risk Score	Control Name	Control Description	Control Owner	Frequency	Control Rating	Residual Impact	Residual Probability	Residual Risk Score	Risk Response	Owner Director	Related Issues / Contributing Factor	Issue / Contributing Factor description	Issue / Contributing Factor Rating	Issue /Contributing Factor Owner	Actions	Action Description	Action Owner	Action Due Date	Supporting Evidence for mitigation / Additional Comments
	Date the risk was identified	*When the risk was last updated*	*Name of risk*	*Brief description of risk (IF THEN RESULTING)*	*Potential causes of the risk materialising*	*Potential impacts to SCAS should the risk materialise*	*What SCAS objective does this risk relate to*	*Using the impact table, what would the impact level be should the risk materialise if no controls were in place*	*How likely is it that this risk materialises if no controls were in place, using the probability table*	*Automated risk score*	*Name of control in place to mitigate the risk*	*Description of how the control works*	*Person responsible for the control*	*How often the control is performed*	*How effective is the operation of the control*	*Using the Impact table, what would the impact level be should the risk materialise with controls in place*	*How likely is it that this risk materialises with controls in place, using the probability table*	*Automated risk score*		*The person responsible for the risk*	*Name of issue or contributing factor which impacts the risk*	*Description of the issue or contributing factor which impacts the risk*	*Rating of issue / Contributing Factor*	*Person responsible for resolving the issue*	*Name of action plan*	*Description of actions taken as part of the action plan*	*Person responsible for ensuring the action plan is completed*	*When the action plan is due to be completed*	*Commentary explaining any changes to the risk or relevant information*
1	Rebased risk register November 2021	Apr-23	Handover Delay Risk	IF SCAS are unable to release patients to hospitals in a timely manner **THEN** there is a risk that patients requiring ED assessment will not receive the medical care they need in time **RESULTING** in increased likelihood of patient harm, poor experience and an inability to meet response targets.	**Cause:** - Ineffective Hospital flows - Inability to create spaces within hospital to free ED space - Demand outstrips Hospital supply - Covid required alterations to ways of working result in reduced capacity	Ambulances queuing, fewer resources to allocate to incoming calls Longer run times to incidents as standby points uncovered Patients requiring face-to-face assessment and/or treatment have to wait for a resource to be available Increased patient harm Worse patient experience Reduction in patient experience Negative impact to the Trusts reputation	Service Quality & Patient Experience	Catastrophic	Almost Certain	25	Hospital Ambulance Liaison Officers	Liaison officer to manage queues at the Emergency Department during periods of escalation	Head of Operations	Ongoing	To Be Assessed	Catastrophic	Likely	20	Treat	Paul Kempster	Handover delays	Delays in handing over patients from SCAS to Hospital/Treatment Centre due to capacity/resource constraints. Primarily at the Queen Alexandra Hospital.	Urgent	Mark Ainsworth	Rapid Release Pilot	Pilot aimed at increasing the speed of patient release from hospital to reduce handover times by increasing capacity within the hospital.	Mark Ainsworth	Ongoing	**July 2023 - Handover delays have improved. EUC team continue to monitor and review** **May 23** - Engaging with new electronic Queue management system with PHU, using opportunity to re-establish the patient safety form initiated by PHU when holding. Crews will be asked to complete this when handover delays expected. Much improved H/O delays over past 10-days but will Continue to monitor throughout June '23 to possibly reduce overall risk score **April 2023:** Handover delays decreased slightly in February (2.8k) but increased again in March (3.7k, still lower than anytime since Aug 2021). The percentage of delays attributed to the QA was similar in February as it was in January however it increased to 40% in March. The operations team continue to work with the hospitals to improve performance. **February 2023:** Handover delays increased during December to a record high of 8k hours lost however the significantly improved in January with only 2.8k hours lost (lowest since June 2021). There has been a significant improvement in the performance of the Queen Alexandra with only 800 hours lost in January, accounting for 29% of total hours lost. Operations continue to monitor to gain confidence that this improvement is stable. **December 2022:** Handover policy approved at UEC boards, excluding Portsmouth. Handover delays decreased in November to 4.9k hours but comparable with circa 5.1k lost in September and
											Rapid Release Process	Pilot aimed at increasing the speed of patient release from hospital to reduce handover times by increasing capacity within the hospital.	Mark Ainsworth	Ongoing	Not Effective									Integrated Care System	Heads of Operations work with local care systems to reduce delays and improve efficiencies. Each system has to submit a plan to reduce handover delays	Heads of Operations	<<Due Date>>	
											System Calls	Daily calls between system components to understand current situations and plan mitigations to reduce transfer delays	Heads of Operations	Daily	To Be Assessed									Joint Action Plan	Joint action plan between SCAS and QAH for capacity release which has been approved by commissions and system stakeholders.	Debbie Marrs	Jan-23	
											111 First	Process which opens new pathways for patients to manage the flow of self referrals into EDs to allow for ambulances to release patients.	Luci Papworth	Ongoing	To Be Assessed													
											Handover Policy	Policy agreed by system where an ambulance can release a patient to the Hospital at 30 minutes.	Dan Holliday	Ongoing	Not Implemented Yet													
											Non-Emergency Department Pathways	Agreement to use non-emergency department pathways to release patients to such as SDEC and OSDEC.	Dan Holliday	Ongoing	To Be Assessed													
											Joint Hospital Escalation Plans	Plans between SCAS and Hospitals to manage handover time and provide escalation procedures	Mark Ainsworth	Ongoing	To Be Assessed													
											Operational Calls	Daily operational command calls to manage performance	Mark Ainsworth	Daily	To Be Assessed													
3	Rebased risk register November 2021	Feb-23	111 Demand Risk	IF 111 call demand outstrips available resource, **THEN** there is a risk that patients will have to wait to have their symptoms triaged and/or for a resource disposition to arranged where required; **RESULTING** in increased risk of patient harm, poor experience and inability to meet contracted targets	**Cause:** • Increase of circa 25% demand on 2019 figures • Actual/ perceived access issues to other avenues of care (Primary care, GP's) • Chronic problems (under hospital care) worsening or poorly managed as not able to access routine secondary care in timely manner • Increased mental health and long-covid symptoms in community • Promotion of 111 instead of ED and other services under demand signposting 111 as safety net • Increased sickness and absence in service	Increased wait times for Clinical review Potential increase in patient harm Negative press articles Negative impact to the Trusts reputation	Service Quality & Patient Experience	Catastrophic	Almost Certain	25	Service Improvement	Dedicated service improvement manager with responsibility for delivering improvements in the delivery of service across operations.	Mark Rowell	Ongoing	To Be Assessed	Catastrophic	Almost Certain	25	Treat	Paul Kempster								Recruitment plan	Recruitment of Health Advisors	Pamela Putt	Ongoing	**February 2023:** Demand has reduced back to STP and is inline with budget (SCAS Island) however DHU are covering ~3k calls per week. Overall demand is trending upwards and is above budget. Resource level 4% below requirement. **December 2022:** Service has been significantly impacted by public concern over Strep A and other respiratory illnesses. Demand has increased by 60% in 111. Work continues on the recovery plan. **October 2022:** Demand has been above and below budgeted levels in the period. Work continues with the recovery plan. SVCC was delayed nationally but work is ongoing at local, regional and national levels. IVRs have been mirrored at the national level to ensure a consistent experience. **August 2022:** 111 has been impacted by the national Adastra outage (in August) which meant the service went to back up processes that take longer. Demand was higher than budget for June and July however has decreased in August. This may be as a result of the Adastra outage where callers used other routes.
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed									111 Recovery Programme	Recovery programme aimed at returning the 111 service to meeting national targets.	Ruth Page	Complete	
											Operational Pressures Escalation Levels (OPEL)	National framework aimed at providing a consistent approach to escalation in times of pressure in the NHS	Mark Ainsworth	Ongoing	To Be Assessed									SVCC	National programme to manage 111 demand across services	Ruth Page	Awaiting confirmation from national programme	
											Service Delivery Board	Meeting to discuss and approve actions impacting service delivery including HR/Workforce, Operational updates, 999 updates, 111 updates, EOC updates, Clinical updates, and REAP review.	Paul Kempster	Bi-weekly	To Be Assessed													
											Recruitment	Recruitment process for onboarding new staff	Victoria Dooley	Ongoing	To Be Assessed													
											Daily Operational Performance Report	Daily report which covers call stats	Mark Green	Daily	To Be Assessed													
11	Rebased risk register November 2021	Jul-23	Financial Risk	IF the Trust is not able to operate within the agreed financial budgets **THEN** there is a risk that the Trust recovery action will be needed; **RESULTING** in reduced monies available to directorates and departments and subsequent impact on services and projects	**Cause:** PTS contracts not won at acceptable margins Lose existing contracts resulting in stranded overheads Poor budget management Unforeseen incident occurs that requires significant expenditure (e.g. IG breach/H2O fire) Profitability of current contracts declines as a result of activity or mix changes or other cost pressures Partial Delivery of Cost Reduction Plans Poor share of system funding	Lost autonomy and focus on recovery actions Further scrutiny and regulatory focus / loss of good NHSI rating	Finance & Sustainability	Major	Almost Certain	20	Audit Committee	Committee with oversight of the financial reporting and declarations.	Mike Hawker		Effective	Major	Almost Certain	20	Treat	Aneel Pattni	CQC Improvement Plan	Additional work and resource required to deliver the CQC improvements may increase the Trusts cost base	High	Annel Pattni					**May 2023:** Finance budgets being discussed with NHSE and ICBs. Work to resolve issues is ongoing. **December 2022:** Risk remains elevated with external pressures and influences still impacting the risk. **November 2022:** Risk increasing in likelihood due to emerging situation and potential external influences. **August 2022:** Financials remains stable however there is a potential for the increase in activity and resource required to resolve the actions required by the CQC inspection will impact our ability to deliver the financial plan. This is being monitored by the finance department. Break-even YTD financial position and CIPs on track
											Financial Board Reporting	Regular reporting of financial position to the board.	Aneel Pattni	Monthly	Effective													
											Cost Reduction Board	Monthly meetings to review progress on cost reduction programme with clarify of actions to recover performance, if there is a shortfall.	Aneel Pattni	Monthly	Partially Effective													
											Internal Control Framework	Set of policies, procedures and rules implemented to ensure the integrity of financial and accounting information.	Aneel Pattni	Ongoing	Effective													
											Financial Plan Tracking	Monitoring of financial position against the financial plan, including detailed action plan of the key elements to deliver the budget.	Aneel Pattni	Ongoing	Partially Effective													
											Financial Strategy	5 year strategy showing the key elements of the financials with a view to achieving underlying break even.	Aneel Pattni	Annually	Not Implemented Yet													
15	Rebased risk register November 2021	Jun-23	999 Staff Capacity Risk	IF recruitment and retention activity does not meet the needs of 999 services, **THEN** there is a risk that there will not be enough people to meet the service needs; **RESULTING** in increased agency/ private provision costs and/or reduced capacity to meet demand	**Cause:** High cost of living area Competition for staffing (within and out with health services) Other health providers using paramedics for their service provision Greater flexibility and opportunity for portfolio working with other providers Lack of supply through HEIs Increased demand	Increased use of private provision Gaps on rosters / Reduced staffing Delay in delivery of patient care Potential increase in patient harm Increased cost through additional overtime and incentives	People & Organisational Development	Major	Almost Certain	20	Recruitment Process	Recruitment process for onboarding new staff	Pamela Putt	Ongoing	To Be Assessed	Major	Likely	16	Treat	Melanie Saunders	North East and North North vacancies	High vacancy levels in the North East and North North nodes	Urgent	Melanie Saunders	Recruitment Plan	Recruitment of additional clinical advisors, Clinical Support Desk Practitioners, Nurses and Paramedics.	Pamela Putt	Ongoing	**July 2023: Recruitment is going well however retention did not meet expected targets so risk remains the same.** **June:** International recruitment continues for both ops and CSD. **February 2023:** Risk remains elevated due to the vacancies in the north. Plans to recruit additional ambulance nurses to relieve pressures on crews. **October 2022:** Risk has increased due to the current external climate. Recruitment activity remains ongoing with the team conducting ECA live chats and taking part in a Bicester Open Day. International paramedics starting in November and there is a push for additional CCC candidates before Christmas. **August 2022:** Recruitment work continues with a recruitment activity at the Emergency Services Day and the SCAS Open Day in September. **May 2022:** Risk rating remains the same. Some improvements over year, improves in attrition but impact on recruitment partly due to covid restrictions on class sizes.
											International recruitment	Recruitment of paramedics from other countries such as Australia	Pamela Putt	Ongoing	To Be Assessed													
											Apprenticeship programme											Lack of a direct apprenticeship programme. Existing internal route requires 1 year employment prior	High	Ian Teague	Primary Care	Actively lobby at national level on pace and scale of paramedics in primary care (including development of ICS level workplans)	Melanie Saunders	Ongoing	
											Alternative Duties	Staff have the option of performing alternative duties	Lisa Pickard	Ongoing	To Be Assessed													
											Rotational roles	Specialist Paramedics on rotation to primary care roles. Staff have the option of performing alternative duties	Paula Boughtflower	Ongoing	To Be Assessed													
											Workforce Development Board	Committee with oversight of all aspects of workforce management.	Melanie Saunders	Monthly	To Be Assessed													
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed													
											Private Providers	Use of private providers to fill any gaps in shift cover.	Paul Stevens / Maria Langer	Ongoing	To Be Assessed													
											Health and Wellbeing team support	Health and Wellbeing team who provide support to employees with benefits to help with their mental health and other aspects of life.	Natasha Dymond	Ongoing	To Be Assessed													
											End of shift policy	Policy directing that crews should only be dispatched to a limited number of job types in the last 90 - 60 minutes and 59 - 0 minutes of their shift.	Paul Jefferies	Ongoing	To Be Assessed													
											Meal breaks	Process for ensuring that crews and CCC staff have their meal breaks	Paul Jefferies	Ongoing	To Be Assessed													
											Apprenticships	Apprenticship schemes to recruit and develop staff in specific roles	Ian Teague	Ongoing	To Be Assessed													
											Rota reviews	Ongoing review of rotas to ensure there is a variety of shifts for staff	Neil Cook	Ongoing	To Be Assessed													
16	Rebased risk register November 2021	Jun-23	111 Staff Capacity Risk	IF recruitment and retention activity does not meet the needs of 111 services, **THEN** there is a risk that there will not be enough people to meet the service needs; **RESULTING** in increased agency provision costs and/or reduced capacity to meet demand	**Cause:** Competition for staffing (within and out with health services) Other health providers using paramedics for their service provision Greater flexibility and opportunity for portfolio working with other providers Market forces - competing with retail Labour shortage Increase in demand	Increased use of private provision Gaps on rosters / Reduced staffing Delay in delivery of patient care Potential increase in patient harm Increased cost through additional overtime and incentives	People & Organisational Development	Major	Almost Certain	20	Recruitment	Recruitment process for onboarding new staff	Pamela Putt	Ongoing	To Be Assessed	Major	Likely	16	Treat	Melanie Saunders	New call centre	New call centre opened in Oxford offering day and night shifts	Moderate	Melanie Saunders	Recruitment Plan	Recruitment of additional health advisors, ECTs, ACAs and ECAs.	Pamela Putt	Ongoing	**June 23: Retention plan in draft and due to be signed-off in June 2023.** **February 2023: 111 continues to have large numbers of vacancies, however recruitment is going well. Additional agencies have been engaged to help call centre recruitment. Roadshows have gone well and 111 HA and ECT pipeline for Q4 looks positive.** **December 2022:** Risk remains elevated due to the ongoing vacancies within 111. Recruitment activity continues with January HA course very strong. **October 2022:** Risk has increased. Large number of vacancies across 111. Recruitment activity continues with Open Days and adverts and exploration of alternative routes taking place. **August 2022:** Risk remains elevated and continues to be impacted by a multitude of issues including the ongoing cost of living. **May 2022:** No change in risk rating. Issues impacting staffing levels noted in the Issues Section Recruitment improvements but behind revised trajectory and Attrition continues to be higher than forecast
											Call handler career pathways	Career pathways for staff in the call handler role to progress within the Trust	Debbie Diffey / Pamela Putt	Ongoing	Yet Implemented Yet							Call centre locations	Bicester call centre locations are in a low labour market and high cost of living area.	High	Melanie Saunders	111 Recovery Programme	Programme to improve the service provided by the 111 team	Ruth Page	<<Due Date>>	
											Workforce Development Board	Provides oversight of all aspects of workforce management.	Melanie Saunders	Monthly	To Be Assessed							Cost of Living	Ongoing cost of living crisis including high levels of inflation and increased energy and fuel prices.	Urgent	Melanie Saunders	Retention Improvement Programme	Development of improvement plan to increase employee retention rates	Natasha Dymnond	~~01/06/2023~~ Sept 23	
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed							High attrition in first 6-12 months	Attrition rates are high for new starters within their first 6 - 12 months of service.	Urgent	Melanie Saunders	Call handler development	Career pathways for staff in the call handler role to progress within the Trust	Debbie Diffey / Pamela Putt	Q4 2023	
											Health and Wellbeing team support	Health and Wellbeing team who provide support to employees with benefits to help with their mental health and other aspects of life.	Natasha Dymond	Ongoing	To Be Assessed													
											Service Improvement	Dedicated service improvement manager with responsibility for delivering improvements in the delivery of service across operations.	Rob Ellery	Ongoing	To Be Assessed													
											Service Delivery Board	Meeting to discuss and approve actions impacting service delivery including HR/Workforce, Operational updates, 999 updates, 111 updates, EOC updates, Clinical updates, and REAP review.	Paul Kempster	Bi-weekly	To Be Assessed													
23	Jan-22	Jun-23	Regulatory Compliance Risk	IF we have poor clinical or operational practices **THEN** there is a risk that we will not comply with regulations **RESULTING** in a decrease in patient safety	**Cause:** Failure to achieve the actions within the action plan in a timely way and provide adequate evidence of completion and impact, leading to regulatory action Poor operational practices across or in isolated parts of the trust Inadequate data handling processes Inadequate ground maintenance or design Inadequate training of staff	Further unannounced inspection activity by CQC Team impact of changes and action plan, Trust reputation, threat to 'Good' rating Negative press interest Potential increase in attention from other regulators such as Health & Safety Executive Potential breach of contracts Potential legal claims Potential financial penalties from contracts Potential investigations and fines from regulators	Service Quality & Patient Experience	Major	Likely	16	Staff training	Staff receive training in the Trust's corporate and clinical policies and procedures	Ian Teague	Ongoing	To Be Assessed	Major	Likely	16	Treat	Helen Young	Safeguarding CQC inspection	CQC inspections in November 2021 and April 2022 identified several areas for improvement for safeguarding in SCAS	Urgent	Helen Young	Safeguarding improvements plan	Set of actions following CQC targeted inspection on safeguarding: - Review safeguarding objectives and strategy - Review safeguarding governance structure and reporting from front line to Board - Review Board oversight of safeguarding - Review safeguarding policies and related policies	Helen Young	31-Oct-22	**April 2023: A fuel spill at the Eastleigh site was reported to the Environment Agency as it went into the local waterway. They have investigated along with the Estates team and remedial action is required.** **February 2023:** SCAS have been in contact with the ICO regarding the Adastra cyber incident experienced in the summer due to our role as a data controller and Advances role as a data processor. The IG team have responded to the information request and are waiting to hear back. **October 2022:** Risk has increased due to the volume and scope of the actions required and the uncertainty around delivering to CQC/NHSE expections. Work remains ongoing with PMO support to deliver however staff capacity issues may impact delivery. **August 2022:** Improvement plans for both safeguarding and the most recent CQC inspection to resolve the issues identified in the reports as well as complementary enhancements in SCAS
											Integrated Care Systems	Partnerships of organisations that plan and deliver joined up health and care services in their areas. Systems are made up of Integrated Care Partnerships, Integrated Care Boards, Local Authorities, Provider Collaborations and Place-based Partnerships.	Exec Team	Ongoing	To Be Assessed							CQC Inspection	Well led CQC inspection rated the Trust as inadequate and issued a section 29a warning notice with a list of must do actions.	Urgent	Will Hancock	CQC Improvement Plan	Overall improvement plan to address areas identified during the CQC inspection. 4 overall workstreams - Patient Safety Improvement - Governance - Culture and Staff Wellbeing - Performance Recovery	Mike Murphy	Ongoing	
											Clinical Governance Meetings	Oversight meetings and committees monitoring the clinical performance of SCAS	Debbie Marrs	Monthly	To Be Assessed							Staff Capacity		Urgent	Helen Young	Fuel investigations	The estates team are working with the Environment Agency to investigate and resolve the fuel spill issue.	Mark Finch	TBC	
											Incident Review Panels	Twice weekly group discussing incidents, if any should be classified as a Serious Incident or Detailed Clinical Investigation.	Carol Rogers	Weekly	To Be Assessed							ICO Inquiry / Advance	We have been contacted by the ICO regarding the Adastra outage	High	Mark Northcott					
											Project Management Office	The Project Management Office are managing the CQC Improvement Plan	Helen Young	Monthly	To Be Assessed							Fuel Spillage	There was a fuel spillage/leak at the Eastleigh site which ended up going into the local waterway. This was reported to the EA who have investigated. There is a	Urgent	Mark Finch					

Ref No	Date Identified	Date of Latest Update	Risk Title	Description of Risk	Cause	Consequence / Likely outcome for SCAS	SCAS Objective	Inherent Impact	Inherent Probability	Risk Score	Control Name	Control Description	Control Owner	Frequency	Control Rating	Residual Impact	Residual Probability	Residual Risk Score	Risk Response	Owner Director	Related Issues / Contributing Factor	Issue / Contributing Factor description	Issue / Contributing Factor Rating	Issue /Contributing Factor Owner	Actions	Action Description	Action Owner	Action Due Date	Supporting Evidence for mitigation / Additional Comments
	Date the risk was identified	*When the risk was last updated*	*Name of risk*	*Brief description of risk (IF THEN RESULTING)*	*Potential causes of the risk materialising*	*Potential impacts to SCAS should the risk materialise*	*What SCAS objective does this risk relate to*	*Using the Impact table, what would the impact level be should the risk materialise if no controls were in place*	*How likely is it that this risk materialises if no controls were in place, using the probability table*	*Automated risk score*	*Name of control in place to mitigate the risk*	*Description of how the control works*	*Person responsible for the control*	*How often the control is performed*	*How effective is the operation of the control*	*Using the Impact table, what would the impact level be should the risk materialise with controls in place*	*How likely is it that this risk materialises with controls in place, using the probability table*	*Automated risk score*		*The person responsible for the risk*	*Name of issue or contributing factor which impacts the risk*	*Description of the issue or contributing factor which impacts the risk*	*Rating of issue / Contributing Factor*	*Person responsible for resolving the issue*	*Name of action plan*	*Description of actions taken as part of the action plan*	*Person responsible for ensuring the action plan is completed*	*When the action plan is due to be completed*	*Commentary explaining any changes to the risk or relevant information*
28	May-22	Jun-23	Safeguarding Risk	**IF** SCAS do not adhere to Safeguarding requirements **THEN** there is a risk that vulnerable patients are not identified and processed **RESULTING** in potential patient harm and negative trust reputation	Staff not fully aware of requirement Increase in operational pressures Adherence and attendance to training for Safeguarding (levels 1, 2 & 3) Lack of face to face training.	Potential patient harm Negative impact to reputation Loss of commercial contracts CQC/NHS England action	Service Quality & Patient Experience	Catastrophic	Almost Certain	25	Staff Training	4 mandatory modules on e-learning for adult and child safeguarding with an additional level 3 training course delivered by an external company in a virtual setting.	Ian Teague	Ongoing	To Be Assessed	Major	Likely	16	**Treat**	Helen Young	Safeguarding CQC inspection	CQC inspections in November 2021 and April 2022 identified several areas for improvement for safeguarding in SCAS, including capacity and capability of the Safeguarding team, provision of level 3 training across the Trust, supporting of safeguarding referrals and the boards visibility of safeguarding issues.	Urgent	Helen Young	Safeguarding improvements plan	Set of actions following CQC inspection on safeguarding: - Review safeguarding objectives and strategy - Review safeguarding governance structure and reporting from front line to Board - Review Board oversight of safeguarding - Review safeguarding policies and related policies - Review safeguarding education provision - Review safeguarding team structure/roles & responsibilities - Review safeguarding resources, competence and effectiveness - Review IT systems to ensure they are fit for purpose - Review safeguarding systems and processes	Helen Young	Ongoing	**June 2023: Risk reduced as progress continues with ICT system, team capacity and training.** **December 2022:** Whilst progress has been made against the safeguarding improvement plan, there remains significant issues within the ICT aspect of safeguarding. Specifically, the stability of the system and the ability for PTS referrals to be made. The datacentre improvement project will help with the system stability with a longer-term plan for Doc-works to host the platform. PTS referrals are sent from the Cleric system however there has been considerable downtime over the past couple of months. The safeguarding team have a plan for training their staff on the system and dashboards to improve capability and understanding. **October 2022:** Review of IT systems by BDO completed. Virtual training for Safeguarding level 3 has begun with weekly sessions for staff. Policies have been updated and consultation period completed. **August 2022:** Safeguarding improvement plan continues to progress. Risk likely to remain elevated until further progress is made against the plan. May 2022: New risk added. Safeguarding concerns remain and were raised with the CQC in their visit in May 2022. Work is still remaining on the action plan
											Safeguarding Team	Specific team in place to manage safeguarding referrals and processes.	Helen Young	Ongoing	To Be Assessed						IT Systems	IT systems used for Safeguarding are not robust enough	Urgent	Helen Young	Safeguarding ICT	Project to move safeguarding system to be externally hosted by Doc-works	Sarah Thompson	In progress	
											Safeguarding adult policy	Policy detailing the requirements and criteria for safeguarding adults	Helen Young	Ongoing	To Be Assessed						Operational Pressures	Ongoing operational pressures have reduced ability to release staff for training	Urgent	Helen Young					
											Safeguarding children policy	Policy detailing the requirements and criteria for safeguarding children	Helen Young	Ongoing	To Be Assessed						Safeguarding Leadership Capacity	There is limited capacity of both corporate and safeguarding leadership to attend meetings	High	Helen Young					
											Safeguarding referral process	Documented process for safe to referral safeguarding cases for investigation	Helen Young	Ongoing	To Be Assessed						Talent Pool	Specialist safeguarding professionals are difficult to recruit with a limited talen pool	Urgent	Helen Young					
											Safeguarding Adult Boards	Intra-services board for Safeguarding where SCAS is a member.	Helen Young		To Be Assessed														
32	01/01/2020	Jun-23	EOC Staff Capacity Risk	**IF** recruitment and retention activity does not meet the needs of EOC services, **THEN** there is a risk that there will not be enough people to meet the service needs; **RESULTING** in increased agency provision costs and/or reduced capacity to meet demand	Competition for staffing (within and out with health services) Greater flexibility and opportunity for portfolio working with other providers Market forces - competing with retail Labour shortage Increase in demand Call centre locations High pressure role Low salary	Inability to answer public 999 calls in timely fashion Public perception / Trust reputation Increased pressure on buddy site services Loss of staff motivation Poor staff morale Increased risk of harm to patients from delays incurred Poor patient experience Negative impact on CAT1 performance Negative impact on Trust reputation	People & Organisational Development	Catastrophic	Likely	20	BT call management programme	BT process for repeat calls and long waits on emergency line	Luci Papworth	Ongoing	To Be Assessed	Major	Likely	16	**Treat**	Luci Papworth	Call centre locations	Bicester call centre locations are in a low labour market and high cost of living area.	High	Melanie Saunders	Recruitment Plan	Recruitment of additional ECTs	Pamela Putt	Ongoing	**December 2022:** Risk added to the Corporate Risk Register following escalation from the EOC register. Vacancy rates are high in EOC with required hours consistenly lower than actual hours for both ECT and clinicians.
											Workforce Development Board	Provides oversight of all aspects of workforce management.	Melanie Saunders		To Be Assessed														
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed														
											Health and Wellbeing team support	Health and Wellbeing team who provide support to employees with benefits to help with their mental health and other aspects of life.	Natasha Dymond		To Be Assessed														
											Service Improvement	Dedicated service improvement manager with responsibility for delivering improvements in the delivery of service across operations.	Rob Ellery		To Be Assessed														
											Service Delivery Board	Meeting to discuss and approve actions impacting service delivery including HR/Workforce, Operational updates, 999 updates, 111 updates, EOC updates, Clinical updates, and REAP review	Paul Kempster	Bi-weekly	To Be Assessed														
34	Jul-22	Jun-23	Controlled Drugs Risk	**IF** SCAS do not have a Controlled Drugs licence for the South **THEN** there is a risk that SCAS will be unable to obtain or supply controlled drugs to patients in that area **RESULTING** in patient harm and regulatory action.	There are different controlled drugs distribution models; Lack of understanding of regulations; Lack of adequate estate facilities to licence the Trust	Increased cost of drugs; Regulatory Fines, Removal of ability to give controlled drugs to patients; Inability to obtain controlled drugs; Inability to develop new suppliers for controlled drugs.	Service Quality & Patient Experience	Major	Almost Certain	20	Business Continuity Plan	Business Continuity plan covering the sourcing of controlled drugs via local hospitals (Southampton and Portsmouth have approved) in the event of loss of Nursling site or if we are unable to supply drugs.	Louise Maunick	Ongoing	To Be Assessed	Major	Almost Certain	20	Treat	Louise Maunick / Helen Young	Lack of a controlled drugs license in the South	The trust does not have a controlled drugs license for the South. Should we apply for a license with the current set up we would not be successful	Urgent	Louise Maunick	New Building Move	A new site has been selected, Estates and Pharmacy to design site to meet license requirements.	Louise Maunick	Sep-23	**HART vehicles go with MCV to carry drugs** **Building costs have increased which is causing delays** **April 2023: New site continues to be progressed and communication with the Home Office.** **MCVs are not owned by the Trust so we are not responsible for stocking them.**
																					Mass Casualty Vehicles	Due to the lack of a controlled drugs license, we are unable to restock our mass casualty vehicles with new drugs (either when they are depleted or go out of date)	Low	Louise Maunick					
35	Dec-22	Jun-23	ICT Hardware Failure Risk	**IF** ICT hardware is out dated or not effectively supported **THEN** there is a risk that the hardware could fail **RESULTING** in risk to patient safety and service delivery	Use of end of life hardware Hardware not updated or maintained Physcial damage to hardware	Major system failure on critical systems across the Trust Inability to respond to patients Business Continuity impacted Potential negative impact to the Trusts reputation	Technology Transformation	Major	Almost Certain	20	Technical Design Authority	Technical architecture group who approve changes to the SCAS IT estate.	Steve Clark	Monthly	Effective	Major	Likely	16	**Treat**	Jill Lanham	Supplier contracts	Escalation process and responsibilities for support (including SLAs) in the event of system issues should be clearly defined.	Moderate	Jill Lanham	Digital restructure	The Digital restructure if approved will deliver increased efficiency and additional capacity to improve hardware support	Jill Lanham	TBC	
											Change Control	Change control processes for existing systems where any amendments to platforms must get approved by stakeholders	Kevin Houghton	Ad-hoc	To Be Assessed						Technical Documentation	There is no technical documentation library covering items such as network maps, data maps, application dependencies.	Moderate	Jill Lanham	Hardware replacement programme	Include a higher level of contingency in hardware purchase timelines and project mangement resources to allow for delays	Jill Lanham	Depending on Ops agreement on downtime	
											System architecture	Systems are designed with resilience in mind	Steve Clark	Ongoing	Effective						Hardware Maintenance Schedules	There is limited routine maintenance performed on hardware.	High	Jill Lanham					
											Business Continuity Plans	Recovery plans for operational teams to allow continuity of service	Hollie Bailey	Annually	Partially Effective						Supply Chains	There is a global chipset shortage which is impacting the Trusts ability to obtain certain technology which could impact our ability to deliver against all projects	High	Jill Lanham					
											Supplier Relationship Management	Process for managing the relationship with key suppliers/partners aimed at improving the service provided.	System / Service Owner	Ongoing	Effective														
											Disaster Recovery Tests	Disaster Recovery tests failing over IT and Telephony systems to secondary servers to validate resilience and highlight any issues.	Jason Somerville		Partially Effective														
											Supplier Escalation Process	Technical issues can be escalated to senior representatives at the supplier to resolve issues.	System / Service Owner	Ongoing	Effective														
											Maintenance Schedules	Hardware is maintained in line with best practice	Kevin Houghton	Ongoing	To Be Assessed														
											Alert Programme	Systems have alerts to notify when things such as storage capacity limits are reached	Kevin Houghton	Ongoing	Not Implemented Yet														
36	Dec-22	Jun-23	ICT Software Failure Risk	**IF** ICT software is not maintained within manufacturers support **THEN** there is a risk that the software could fail **RESULTING** in risk to patient safety	Use of unsupported by the manufacturer Failure to apply supplied patches	Major system failure on critical systems across the Trust Inability to respond to patients Business Continuity impacted Potential negative impact to the Trusts reputation	Technology Transformation	Catastrophic	Possible	15	Firewalls	Firewalls are in place	Mark Northcott	Ongoing	To Be Assessed	Catastrophic	Possible	15	**Treat**	Jill Lanham	Safeguarding Referrals	Safeguarding referrals systems are not fit for purpose following a BDO review and team does not have the skills to manage effectively	Urgent	Helen Young	Cleric Improvement plan	Task and finish group established headed by Exec Director of Digital and Director of Commercial services to develop and deliver improvement plan	Jill Lanham	TBC	**June 2023: Safeguarding progress progressing with due date in July.** **April 2023:** Review of options for Safeguarding referrals work. Project in place to move the Doc-works system to externally hosted. As this is cloud based, it is going through IG review and sign-off. Cleric project ongoing with improvements being seen in stability and availability.
											Patching Policy	High level policy detailing minimum requirements for patching	Mark Northcott	Ongoing	To Be Assessed						Cleric Outages	The Cleric system used by PTS has experienced a high level of performance issues includign outages	High	Jill Lanham	Digital restructure	The Digital restructure if approved includes a SQL DBA role	Jill Lanham	TBC	
											Patching Schedule	Patching schedule for routine updates of desktops/laptops and servers to remove identified vulnerabilities	Kevin Houghton	Ongoing	To Be Assessed						Maintenance Schedules	There is no routine maintenance performed on SQL databases.	High	Jill Lanham					
											Penetration Tests	Penetration tests for externally facing systems to test for weaknesses and gaps in cyber security controls	Jill Lanham	Annually	Not Effective														
											Supplier Relationship Management	Process for managing the relationship with key suppliers/partners aimed at improving the service provided.	System / Service Owner	Ongoing	Effective														
											Maintenance Schedules	Software is maintained in line with best practice	Kevin Houghton	Ongoing	To Be Assessed														
											Supplier Escalation Process	Technical issues can be escalated to senior representatives at the supplier to resolve issues.	System / Service Owner	Ongoing	Effective														
37	Dec-22	Jun-23	ICT Resource Risk	**IF** the ICT team do not have the required resource capacity and capability **THEN** there is a risk that ICT process and functions will not be performed **RESULTING** in potential system failures	Insufficient funding Inability to attract staff due to pay restrictions Increased pressure on staff due to home working Increase in Trust staffing levels Increased complexity of IT systems and increased demand on technology solutions	Inability to perform functions or processes Potential negative impact to the Trusts reputation Potential impact to patient safety	Technology Transformation	Catastrophic	Likely	20	Recruitment process	Formal process to recruit staff into the Trust	Pamela Putt	Ongoing	To Be Assessed	Catastrophic	Possible	15	**Treat**	Jill Lanham	Maintenance Schedules	There is no routine maintenance performed on SQL databases.	Urgent	Jill Lanham	ICT restructure	The Digital restructure if approved tries to minimise single points of failure	Jill Lanham	TBC	**June 2023: Clinical Safety Officer now in place along with Clinical Applications Specialist. Contract DBA in place until end of June with substantive role starting in mid-August. Risk expect to reduce once roles embedded and substantive DBA started.** **April 2023:** Clinical Applications Specialist has been accepted from an internal candidate with confirmation of start date due. After 4 rounds of recruitment, an offer has been made for the Clinical Safety Officer, awaiting confirmation of acceptance.
											Contractors	The use of contractors for specific tasks where internal resource is not available		Ad-hoc	To Be Assessed						Clinical Applications	The individual who currently maintains clinical applications is leaving the trust. There is not one with the appropriate skillset within the trust to replace this individual	Urgent	Jill Lanham					
																					Key Person Dependencies	There are a number of single points of failure within the digital team	High	Jill Lanham					
39	Mar-23	Jun-23	999 Delay Risk	**IF** we are unable to reach patients in a timely manner **THEN** there is a risk that we will be unable to effectively manage their care **RESULTING** in patient harm	Increase in demand Lack of staff in call hander, clinical support and paramedic roles Inaccurate demand forecasting End of shift policy Delays caused by system partners Lack of welfare calls	Negative impact to the Trusts reputation Patient harm	Service Quality & Patient Experience	Catastrophic	Almost Certain	25	HALO	Hospital Liaison Officer	Mark Ainsworth	Ad-hoc	To Be Assessed	Major	Likely	16	Treat	Helen Young					Long Waits	Review of jobs which involve long waits	TBC	TBC	
											Workforce Scheduling	Scheduling resource based on demand forecast	Maria Langler	Daily	To Be Assessed										Failer review	Review of incidents involving failers	TBC	TBC	
											Demand Forecasting	Planning model for expected demand for each service	Maria Langler	Ongoing	To Be Assessed										Meal break review	Review of meal break compliance and impact across the Trust	TBC	TBC	
											Incident Review Panel	Forum to review incidents to identify learnings	Debbie Marrs	Weekly	To Be Assessed										Learning from deaths	Specific review covering delays across the system and what learnings can be identified and taken	TBC	TBC	
											System Partner Meetings	System meetings to discuss system risks for patient care	Helen Young		To Be Assessed										Recovery programme				
											Winter Resilience	Set of plans and meetings across SCAS and the system to manage increased demand through the winter period	James Amos	Ongoing	To Be Assessed														
											Management Information	Supply of data covering patient experience, patient safety incidents, staff feedback and HCP feedback	Various	Ongoing	To Be Assessed														

PUBLIC BOARD MEETING SUMMARY SHEET

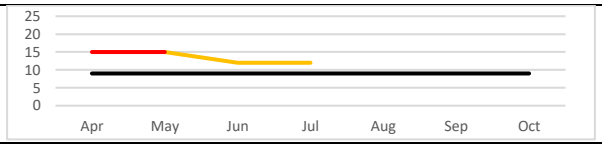
Report title:	**Board Assurance Framework Update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**10.b**
Executive Summary:	The key changes made from the version considered by the Board in May are: **All Risks:** Risk trend graphs have been added to each risks to track changes in the risk rating since the BAF was created in April 2023. **Strategic Risk 1: Ability to provide safe and effective care.** Risk remains at 12 (Major x Possible). Removed "*No Clinical Safety Officer*" from the Gaps in Controls and Assurance section. Updated action for equipment system from "*awaiting approval from ETB in June*" to "*ETB approved, awaiting EMC approval in July*" Removed the "*Recruitment of Clinical Safety Officer*" action as the role holder started at SCAS on 26 June. Updated "*Educational aspects*" in the Gaps in Controls and Assurance section to "*Developing clear strategy for learning from incidents when then feeds into education programmes in the workforce*". **Strategic Risk 2: Ability to meet demand and provide responsive service.** Risk remains at 15 (Catastrophic x Possible). "*Finance & Performance Committee*" added as a source of assurance in the first and section line (internal) assurance section. **Strategic Risk 3: Disproportionate system focus.** Risk score remains at 20 (Catastrophic x Likely) All actions updated with dates "*Q3 23–24*". Action "*HIOW to establish coordinated ambulance commissioning group to include other ICS stakeholders*" updated with "*ICB to set up group, expected to be Q3 23-24*"		

	Strategic Risk 4: Partners not understanding SCAS Added "*Involvement in Joint Forward Plans for each ICB SCAS work with"* to the Controls section. Added action to the Action section "*Role to be advertised to increase capacity for meetings*" with "*Mike Murphy"* as owner and a due date of "*Q3 23-24*" in line with Risk 3 as the action is relevant for both risks. **Strategic Risk 5: Increased cost to deliver services.** Risk remains rated as 20 (Major x Almost Certain). Amended Target Risk Rating to *12* (Major x *Possible*) from *16* (Major x Likely) Amended first Gap in Controls and Assurances item, from "*Unidentified and in-progress plans to deliver cost improvement programme targets*" to "*Unidentified gaps in cost improvement programme targets*". Removed "Limited assurance on specific financial assumptions (e.g., 23/24 AfC pay awards) from the Gaps in Controls and Assurances section. Removed "*Unidentified costs to deliver approved strategies*" from the Gaps in Controls and Assurances section. Added "*(financial sustainability plan)*" to the "*Full-year cost improvement programme in development by the executive team*" action. Updated due date for "*Reporting on run rates etc*" action to "*July 2023*" Updated "*Clarification and confirmation of financial assumptions*" action to Complete from "*TBC*" Updated action owner for "*Negotiation and dialogue with key commissioners*" to "*Mike Murphy*" from "*Aneel Pattni*". **Strategic Risk 6: Insufficient skills and resources to deliver services.** Added "*Quality Impact Assessments*" to the Controls section. Updated "*Development of improvement plan to increase employee retention rates (currently draft)"* due date from "*June 2023*" to "*999 at WFB – July, CCC & PTS – Sept*" **Strategic Risk 7: Staff heeling unsafe, undervalued, and unsupported.** Added "*Active bystander programme*" to the Gaps in Controls and Assurances section. **Strategic Risk 8: Capacity and capability to deliver digital strategy.** Risk remains rated as 20 (Catastrophic x Likely).

Recommendations:	The Board are 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, Risk Manager			
Previously considered by:	Risks were previously considered by the Quality & Safety on 6 July 23, People & Culture on 13 July 23 and Finance & Performance on 20 July 23.			
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:				

Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.		Risk score **12**
Strategic Risk No. 1:	Update: July 2023	
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
Inherent	5	4	20
Current	**4**	**3**	**12**
Target	3	3	9



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

Controls

- 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

Assurance

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

- Real-time tracking of clinical equipment and medicines
- Workforce shortages
- Process for developing rotas/review of rotas
- Delayed operational responses
- Variability in pathways
- Developing clear strategy for learning from incidents which then feeds into education programmes in the workforce

Actions to address control / assurance gaps

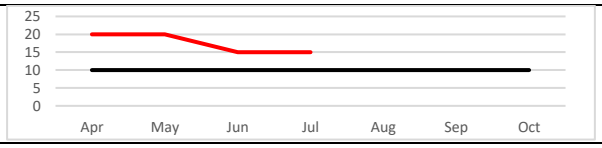
Action	Owner / Due Date
Procure system for managing safe deployment and maintenance of equipment	Jill Lanham / ETB approved awaiting EMC approval in July
Implementation of the Patient Safety Strategy from NHSE and the associated Patient Safety Incident Response Framework (PSIRF) to replace the existing Serious Incident policy and process.	Carol Rogers / April 2024
New centralised logistics hub being set-up including medicines management	Helen Young / September 2023
System engagement	Helen Young / TBC

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 **15**
Strategic Risk No. 2:	Update: July 2023	
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.

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**5**	**3**	**15**
Target	5	2	10



Risk Lead	Paul Kempster, Chief Operating Officer, Helen Young, Chief Nurse, 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 • National REAP process and actions • OPEL escalation plans • Enhanced Patient Safety Procedure • Urgent Care Pathways • Working with systems and UEC Boards	**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

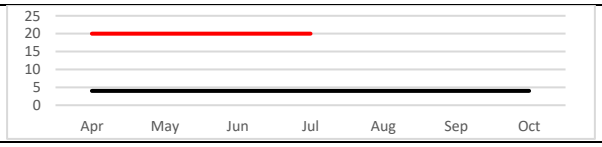
Gaps in Controls and Assurances	Actions to address control / assurance gaps	
	Action	Owner / Due Date
• Insufficient clinical advisory support (e.g., 111, 999, IUC) • Quality Improvement Process and Culture	Develop a forecast versus actual report based on experience adjusted models	Mark Adams / TBC once investigations complete

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:	Update: July 2023	

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
Inherent	5	5	25
Current	**5**	**4**	**20**
Target	2	2	4



Risk Lead	Mike Murphy, Chief Strategy Officer	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

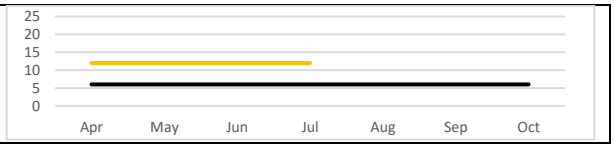
Gaps in Controls and Assurances	Actions to address control / assurance gaps	
• No SCAS membership on any ICB boards • ICB coordination for contracts • Capacity to attend director meetings	Action	Owner / Due Date
	Establish reporting mechanisms from system groups	Mike Murphy / Q3 23-24
	HIOW to establish coordinated ambulance commissioning group to include other ICS stakeholders	Mike Murphy / ICB to set up group. Expected to be completed by Q3 23-24
	Role to be advertised to increase capacity for meetings	Mike Murphy / Q3 23 - 24

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:	Update: July 2023	

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, influence and an inability to identify opportunities within systems resulting in an inability to deliver on our long-term strategy.

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**3**	**4**	**12**
Target	2	3	6



Risk Lead	Mike Murphy, Chief Strategy Officer	Assurance committee	Finance and Performance Committee, Trust Board

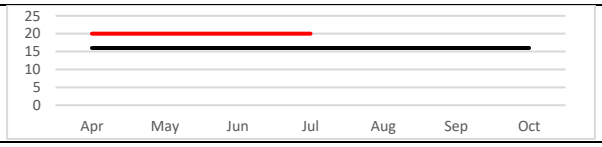
Controls	Assurances
• Stakeholder management plan • Attendance at Integrated Care Systems boards • Attendance at local resilience forums • Attendance at relevant Multi Agency Safeguarding Hub • Emergency & Urgent Care Boards • Attendance at system strategy groups • System strategy initiatives • Involvement in Joint Forward Plans for each ICB SCAS work with.	**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	
	Action	Owner / Due Date
• 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)	Mike Murphy / Q2 2023
	Consider actions for other systems as above	TBC once above action complete
	Role to be advertised to increase capacity for meetings	Mike Murphy / Q3 23 - 24

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:	Update: July 2023	
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
Inherent	4	5	20
Current	**4**	**5**	**20**
Target	4	3	12



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

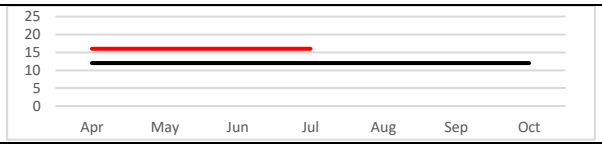
Controls	Assurances
• Standing financial instructions and standing orders • Planning and approval process for the Trust's budget • Budgetary management and regular reporting process – act vs plan process • Long term financial planning • Access to national funding for emergency related activity • Budget holders have agreed budgets, including cost improvement programme targets to deliver efficiencies • Alignment with ICB financial plans • Quality Impact Assessment process • Cost Improvement Programme	**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 gaps in cost improvement programme targets • Lack of agreement on key supplier and commissioning contracts • Clear oversight of budget position and spend information • Lack of cost and productivity data/trends • Lack of benchmarking data	Action	Owner / Due Date
	Full-year cost improvement programme in development by the executive team (financial sustainability plan)	Aneel Pattni / May 2023
	Negotiation and dialogue with key commissioners	Aneel Pattni / June 2023
	Consider greater delegation of budgets	Aneel Pattni / TBC
	Clarification and confirmation of financial assumptions	Aneel Pattni / Complete
	Reporting on run rates etc	Aneel Pattni / July 2023

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.6:	Update: July 2023	
If we fail to implement resilient and sustainable workforce plans	***Then*** we will have insufficient skills and resources to deliver our services	***Leading to*** ineffective and unsafe patient care and exhausted workforce.

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**4**	**4**	**16**
Target	4	3	12



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

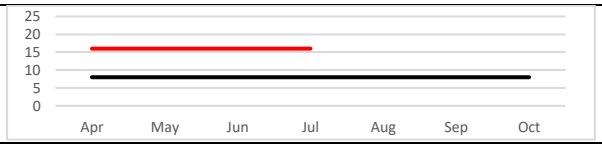
Controls	Assurances
• Integrated Workforce Plans for the Trust, including the delivery of a 5-year workforce plan • Workforce reporting (e.g., sickness absence, staff survey, turnover) • Recruitment & attraction plan and retention plan health and wellbeing plan and flexible working • Apprenticeship programmes • International recruitment programmes • Return to practice programme • Use of private providers to help deliver services, private provider workforce strategy • Quality Impact Assessments	**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	
	Actions	Owner / Due Date
• 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	Mark Ainsworth / TBC
	Develop/review existing career development pathways	Melanie Saunders / Q4 2023/24
	Development of talent management and development programme	Nicky Howells / Complete implementation by Q4 23/24
	Explore/review Paramedic Rotation schemes.	Melanie Saunders / Q4 2023/24
	Development of improvement plan to increase employee retention rates (currently draft)	Natasha Dymond / 999 at WFB – July CCC & PTS - Sept

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:	Update: July 2023	
If we fail to foster an inclusive and compassionate culture	***Then*** our staff may feel unsafe, undervalued, and unsupported	***Leading to*** poor staff morale, disengagement, low retention and impacts on patient safety and care.

	Impact	Likelihood	Score
Inherent	4	5	20
Current	**4**	**4**	**16**
Target	4	2	8



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

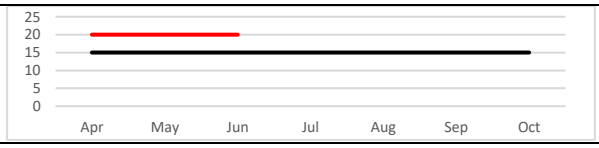
Controls	Assurances
• People strategy, EDI strategy and associated enabling plans • Freedom to Speak Up (FTSU) guardian and supporting programme in place • 'Supporting our people' website, including EAP and Occupational Health • SCAS leader and ESPM leadership training • Sexual safety charter • Allegations 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	
	Action	Owner / Due Date
• Support for disabled workforce and other protected characteristics • Lack of peer reviews • Consistent approach to QI/service improvement/transformation • Active bystander programme	WRES/WDES Improvement Plans	Dipen Rajyaguru / Aug 2023
	Delivery of our Sexual safety charter and associated plan	Dipen Rajyaguru / Launched with embedding during 2023/24
	Delivery and embedding Freedom to speak up improvement plan	Simon Holbrook / Launched with embedding during 2023/24
	Delivery and embedding Culture improvement plan	Nicky Howells / September 2023
	Support of Staff Networks	Dipen Rajyaguru / ongoing
	QI innovation and culture relaunch	Helen Young / TBC

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:	Update: June 2023	
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
Inherent	5	5	25
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	
	Action	Owner / Due Date
• 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 (ITIL) processes • Service desk software which no longer meets organizational needs • Costing strategy	Develop regular reporting into Finance and Performance committee	Jill Lanham / July 23
	Develop KPIs	Jill Lanham / Ongoing
	Develop annual planning cycle to map resources and plan capacity for digital resource	Jill Lanham / Ongoing
	Review service desk software and adoption of ITIL within existing budgets	Jill Lanham / Dec 23
	Clarify governance structure for digital, including steering groups, resulting from the introduction of Finance and Performance Committee and addition of CDO to the Executive team	Jill Lanham / July 23

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

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Annual Report and Accounts 2022-23**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**11.0**
Executive Summary:	The Audit Committee approved the signing of the 2022-23 Annual Report and Accounts on 13th July 2023, having been given delegated authority by the Trust Board to do so. Following completion of the audit of the annual report and accounts, the Trust's external auditors Azets have given the following opinions: • An unqualified opinion that the accounts give a true and fair view of the financial position of the Group and of the Trust as at 31 March 2023 • A qualified opinion of the Remuneration Report and the Staff Report, based on the following: o The Remuneration Report is not complete as it does not include the pension entitlement information for the Medical Director. o The auditors have also been unable to obtain sufficient assurance over the accuracy of the data provided to NHS Pensions for the Chief Finance Officer and the Chief Executive and therefore the associated pension disclosures within the Remuneration Report. The factors causing the qualified opinion of the Remuneration Report and the Staff Report are not fully within the Trust's control, and we therefore cannot guarantee that any further delay to the signing of the Annual Report and Accounts would result in satisfactory resolution of these issues. The Audit Findings Report and Auditor's Annual Report set out two significant weaknesses in relation to value for money and several internal control recommendations. Management responses have been provided for each. As many of the internal control recommendations have been rolled forward from 2021/22, it is proposed that the Audit		

	Committee monitor progress against resolving these recommendations. This was agreed at the Board Seminar on 29th June.			
Recommendations:	The Trust Board is asked to: NOTE the update on the 2022-23 Annual Report and Accounts			
Executive lead:	Stuart Rees, Director of Finance Daryl Lutchmaya, Chief Governance Officer			
Report author:	Sam Dukes, Deputy Chief Financial Officer			
Previously considered by:	Audit Committee, 13th July 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)	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:				

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Oversight Framework 4 and Recovery Support Programme**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**12.0**
Executive Summary:	NHS organisations across Hampshire and Isle of Wight have a challenging combined deficit for 2023/2024. We have begun the journey of significant transformational change working closely with partners across the Integrated Care System (ICS) to ensure greater efficiency and long-term sustainability of services. Working together to bring the system back into balance and living within the allocations provided is a collective priority. We are in a good place to do this as our partnerships are already well established and we are already working with our people and our communities on this journey of transformation. Given the scale of the challenge the ICB along with NHS provider Chief Executives sought help from NHS England by proactively seeking to enter the national recovery support programme. This has enabled the system to secure support from NHS England to support the system in delivering the scale and pace of transformation needed whilst delivering other key commitments to improve access, reduce waiting times and reduce health inequalities as set out in the ICB response to the 2023/2024 national planning guidance. This paper sets out the financial context and recovery approach that the ICS is taking, provides more information about the recovery support programme and what this means, and sets out the governance framework for the system. - NHS organisations across Hampshire and Isle of Wight have a combined financial deficit that is challenging and as a result are implementing a joint recovery plan to transform health and care services. - To support this work all NHS partners made a request to enter the NHS England Recovery Support programme. - Following NHS England Regional and National decision making, all NHS organisations in Hampshire and Isle of Wight have been moved into Oversight Framework 4/Recovery Support Programme. Formal notification of this move was received 1 June 2023. This paper outlines the key next steps following this notification.		

<table>
<tr><td>Recommendations:</td><td colspan="4">The Trust Board is asked to note the paper.

- To note that following NHS England Regional and National decision making (27 April and 16 May respectively), all NHS organisations (including the Integrated Care Board and all of the NHS Trusts within the Integrated Care System, including SCAS, have been moved into Oversight Framework 4/Recovery Support Programme. Formal notification of this move was received 1 June 2023.

- To note that all NHS Boards in Hampshire and Isle of Wight will be asked to agree regulatory undertakings with NHS England. These will be discussed in Private Boards and a collective representation made back to NHS England on behalf of the system.

To note the proposed assurance and oversight structures for the system recovery plan via Integrated Care System architecture.</td></tr>
<tr><td>Executive lead:</td><td colspan="4">David Eltringham, Chief Executive Officer</td></tr>
<tr><td>Report author:</td><td colspan="4">Tara-Lee Baohm, Deputy Director of Assurance, Hampshire and Isle of Wight Integrated Care Board
Daryl Lutchmaya, Chief Governance Officer, SCAS</td></tr>
<tr><td>Previously considered by:</td><td colspan="4"></td></tr>
<tr><td>Purpose of report:</td><td>Note
☒</td><td>Approve
☐</td><td colspan="2">Assure
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<tr><td>Paper Status:</td><td>Public
☒</td><td>Private
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<tr><td>Assurance level:</td><td>Significant
☐
High level of confidence in delivery of existing mechanisms / objectives</td><td>Acceptable
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General confidence in delivery of existing mechanisms / objectives</td><td>Partial
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Some confidence in delivery of existing mechanisms / objectives</td><td>No Assurance
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No confidence in delivery</td></tr>
<tr><td colspan="5">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:</td></tr>
<tr><td colspan="5">Entry into Oversight Framework 4/Recovery Support Programme is being driven primarily on the basis of the combined financial deficit. There are no specific concerns regarding the quality of care for our patient population, that have driven the move into the Recovery Support Programme.

The scale and pace required to return the Integrated Care System to financial balance will be challenging. To support, the system will be provided with improvement support from NHS England. In addition, a new system wide assurance and oversight infrastructure is proposed to maintain grip and control.</td></tr>
</table>

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

Design of a Governance Framework as part of an Integrated Governance function

Following NHS England Regional and National decision making (27 April and 16 May respectively) all NHS organisations in Hampshire and Isle of Wight have been moved into Oversight Framework 4/Recovery Support Programme. Regulatory undertakings will be agreed between NHS England and all NHS Boards.

A system wide financial recovery plan is being implemented. Trust Chief Executives, Chief Finance Officers, and clinical leaders will take key leadership roles across the six key programmes of work which will support delivery of financial recovery and balance.

Delivery of the system recovery plan will be overseen by the Integrated Care System Recovery and Transformation Board.

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING PAPER

Title	Oversight Framework 4 and Recovery Support Programme
Author	Tara-Lee Baohm, Deputy Director of Assurance, Hampshire and Isle of Wight Integrated Care Board Daryl Lutchmaya, Chief Governance Officer, SCAS
Responsible Director	David Eltringham, Chief Executive Officer
Date	27 July 2023

1. Purpose

1.1 NHS organisations across Hampshire and Isle of Wight have a challenging combined deficit for 2023/2024. We have begun the journey of significant transformational change, working closely with our partners across the Integrated Care System (ICS) to ensure greater efficiency and long-term sustainability of services. Working together to bring the system back into financial balance and living within the allocations provided is a collective priority.

1.2 We are in a good place to do this as our partnerships are already well established and we are already working with our staff and our communities on this journey of transformation. Given the scale of the challenge, the Integrated Care Board (ICB) - along with Chief Executives from our NHS Trust providers - sought help from NHS England by proactively seeking to enter the national Recovery Support Programme (RSP). This has enabled the system to secure support from NHS England to help us deliver the scale and pace of transformation needed whilst also delivering other key commitments to improve access, reduce waiting times and reduce health inequalities. These additional commitments are set out in some detail in our response to the 2023/2024 national planning guidance.

1.3 This paper sets out the financial context and the approach to recovery that the ICS is taking. It also provides more information about the recovery support programme and what this means the system governance and sets out the governance framework for the system.

2. Executive Summary

2.1 During NHS organisations across Hampshire and Isle of Wight have a combined financial deficit that is significant and challenging. In order to tackle this we have developed a joint recovery plan to transform health and care services and we are now implementing this.

2.2 The approach to system recovery consists of establishing both grip and control of cost within and across organisations, and the delivery of five transformation programmes to address the operational and financial challenges within the system. We already have some agreed processes in place that provide consistent control for key areas, most significantly the management of temporary staffing spend.

2.3 In addition, a distributed leadership model for delivery of the system recovery plan has been agreed, with Trust Chief Executives, Chief Finance Officers, and clinical leaders, taking key leadership roles across five key transformation programmes of work as follows:

- Elective Care
- Urgent and emergency care
- Discharge
- Local (primary and community) Care
- Workforce

2.4 In addition, each organisation has developed an individual organisation recovery plan. The combined intention of both the system recovery and the individual organisation recovery plans is to ensure financial recovery and longer-term sustainability across Hampshire and the Isle of Wight.

2.5 The ICB Board will receive reports on the system position and its progress towards recovery at each of its meetings.

3. Recovery Support and Exit Criteria

3.1 Following NHS England regional and national decision making, all NHS organisations (the Integrated Care Board and all the NHS Trusts within the Integrated Care System, have been moved into Oversight Framework 4/Recovery Support Programme. We received formal notification of this action on 1 June 2023.

3.2 This NHS England support package will include a System Improvement Director, appointed by NHS England. This Director will work with system partners to develop a detailed support offer and will provide oversight and co-ordination of the support package.

3.3 As a result of entering the Recovery Support Programme, all NHS Boards in Hampshire and Isle of Wight will be agreeing regulatory undertakings with NHS England. These will be discussed in draft, in private board meetings and a collective representation will be made to NHS England, on behalf of the system, for approval prior to formal publication.

3.4 A formal entry meeting into the Recovery Support Programme will take place with the National NHS England team in due course.

3.5 As reflected in NHS England's Recovery Support Programme entry letter, the Hampshire and Isle of Wight system will exit the Recovery Support Programme when we have:

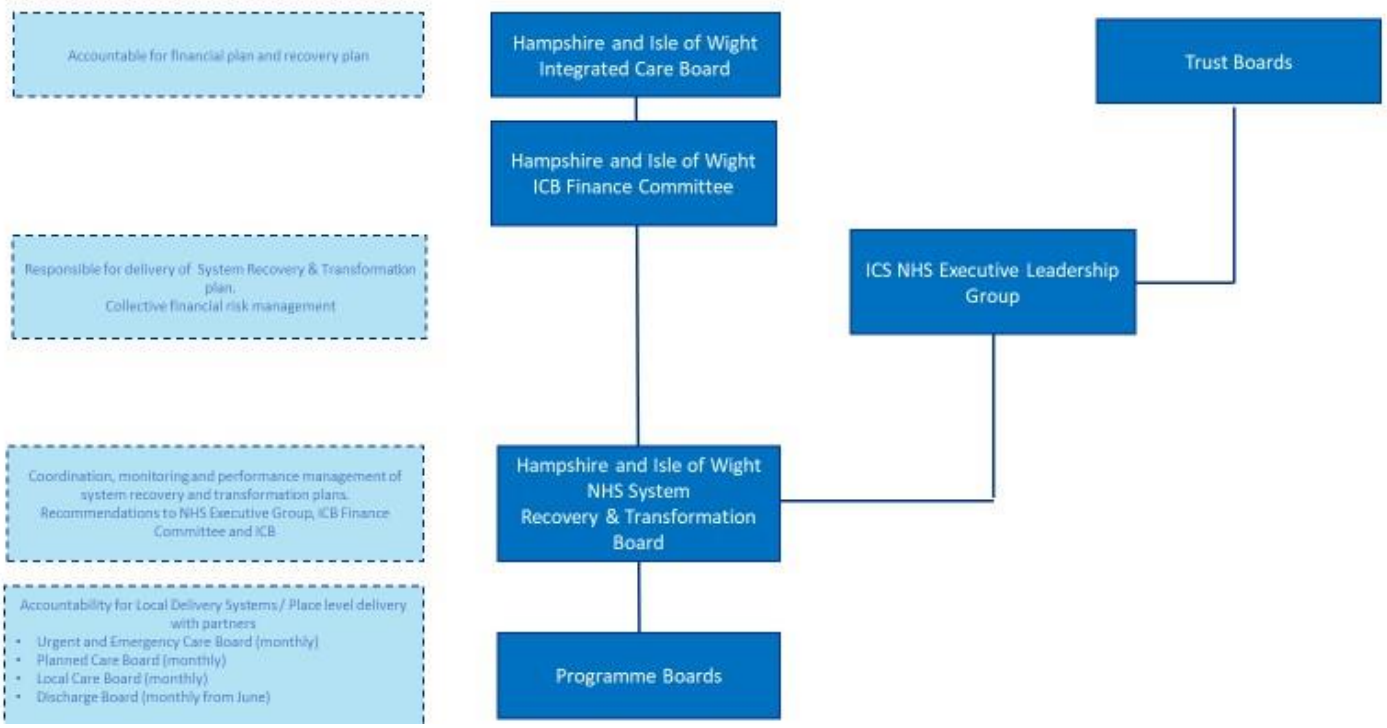
- Developed a system wide recovery plan, including a financial improvement trajectory, which aims to secure financial sustainability and recovery,
- Demonstrated the impact of the HIOW system priority programmes (including but not limited to Urgent and Emergency Care UEC, elective, community and primary care, discharge, and workforce) are contributing to the effective, sustainable delivery of the system-wide recovery plan and the financial improvement trajectory,
- Ensured system-wide governance and oversight processes are in place to oversee delivery of the system recovery plan, and
- Taken all reasonable steps to deliver the milestones and financial improvement trajectory within the agreed system recovery plan without adversely impacting

delivery of other national operational planning priorities (unless specifically agreed with NHSE) or the quality of care for patients.

3.6 As a next stage we will codevelop (between NHS England region and system leaders) the specific evidence that will be required to demonstrate delivery against these exit criteria. Our delivery will then be monitored and tracked through the governance framework set out later in the paper.

4. System Governance

4.1 The proposed assurance and oversight arrangements are set out in the diagram below. This will ensure the system financial recovery plan is jointly owned and overseen by NHS partners across the system.



4.2 Other assurance arrangements will remain in place to maintain assurance and oversight of non-financial operational and strategic priorities. Boards will be provided with updates that set out delivery against the recovery programme. Tri-partite meetings will continue to take place quarterly between Trusts, the ICB and NHS England South East region.

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Governance Update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**13.0**
Executive Summary:	The Board is requested to note this report. **<u>Annual Members Meeting</u>** The Trust will be convening its Annual Members Meeting on Thursday 6 September 2023. The meeting is where the Governors officially receive the Trust's annual report and accounts. The meeting will be held virtually. The Trust is required to hold an Annual Members Meeting within nine months of the end of each financial year. The meeting enables the Board of Directors to present the annual accounts, provide feedback on how the trust has performed over the last year and the challenges and financial plan for the year ahead. The Annual Members' Meeting is a chance for Trust members, staff and members of the public to come together to learn more about the Trust's services, achievements and its future vision. Governors also provide an update of some of their work on the members behalf over the last year and present the Trust Membership Report. There is also a chance to ask questions during the meeting about the information presented. The Annual Members Meeting is open to all members of the Trust, Governors, Directors, representatives of the Trust's auditors and members of the public. **<u>Renewal of 2nd Term – Ian Green</u>** The Trust convened an extraordinary meeting of the Council of Governors on Friday 30 June to consider the Council of Governors Nomination Committee's recommendation to appoint Ian Green, Non-Executive Director for a second term of three years. Ian's first term of service expired on 30 June 2023 and the extraordinary meeting was convened in order to ensure continuity of service. The Council of Governors unanimously approved the recommendation. **<u>Response to ICBs' Joint Forward Plans</u>** At the Trust Board meeting held on 29 June 2023, the four ICBs' Joint Forward Plans (HIOW, BOB, BLMK and Frimley) were received and considered. The Board was satisfied that SCAS had actively been		

	involved in the development of the Joint Forward Plans and endorsed them. Due to the timing of the submission of the ICB's Joint Forward Plans, it had been necessary to consider them at this meeting. The Joint Forward Plans are available on each of the ICBs' websites.			
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				
None required				

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Quality & Safety Committee Terms of Reference**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**13.d**
Executive Summary:	The purpose of the report is to provide the Board of Directors with: • A reviewed and revised Terms of Reference for approval.		
Recommendations:	The Trust Board is asked to receive the upward reports and note the key quality and patient safety items and approve the Terms of Reference.		
Executive lead:	**Professor Helen Young, Chief Nurse / Executive Director of Patient Care and Service Transformation**		
Report author:	**Anne Stebbing, Non Executive Director, and Chair of Quality and Safety Committee**		
Previously considered by:	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 actions will be monitored through the Quality & Safety Committee.	
List of Appendices:	

South Central Ambulance Service
NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

Date issued:	July 2023, Version 2.1
Next Review date:	Annual review due March 2024
Review dates:	September 2022; June 2023
	– approved by Quality and Safety Committee 6 July 2023
Person Responsible:	Non-Executive Director, Chair of Quality and Safety Committee

1. Authority

1.1 The Quality and Safety Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and Terms of Reference shall be as set out below, subject to amendment at future Board of Directors' meetings.

1.2 The Committee is authorised by the Board to act within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience (e.g. external auditors and expertise if it considers this necessary for, or expedient to, the exercise of its functions).

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Role

2.1 To enable the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

2.1.1 Promote safety and excellence in patient care

2.1.2 Identify, prioritise, and manage risk arising from clinical care

2.1.3 Ensure the effective and efficient use of resources through evidence-based clinical practice

2.1.4 Protect the health and safety of Trust employees.

3. Duties

3.1 In respect of general governance arrangements:

3.1.1 To ensure that all statutory elements of clinical governance are adhered to within the Trust

3.1.2 To approve the Trust's annual Quality and Safety Committee report before submission to the Board

3.1.3 To receive and approve the annual clinical audit programme ensuring that it is approved by Board consistent with the audit needs of the Trust

3.1.4 To oversee the Trust's policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 2018

3.1.5 To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference

3.1.6 To receive quality and safety project information and data prior to Board approval.

3.2 In respect of safety and excellence in patient care, in particular:

3.2.1 To maintain an overview of service compliance against the Care Quality Commission fundamental standards and strategy.

3.2.2 To monitor the Trust's compliance with the required standards of quality and safety, in order to provide relevant assurance to the Board so that Directors may approve the Trust's annual declaration of compliance and corporate governance statement. This will be done by ensuring that relevant standards are set and monitored, including (without limitation):

- standards outlined in national service frameworks
- Care Quality Commission registration criteria to continue to be met
- NHS licence requirements relevant to quality and patient safety.

3.2.3 To support and monitor within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting issues of concern and monitoring the implementation of that policy.

3.2.4 To oversee processes to ensure the review of patient safety incidents (including near-misses, complaints, claims and coroner's determinations) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning.

3.2.5 To monitor the progress of identified areas for improvement in respect of incident themes and complaint themes from the results of national patient survey and ensure appropriate action is taken.

3.2.6 To monitor that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation:

- ensuring that processes are in place to ensure the escalation of risks from local and clinical unit risk registers to the Corporate Risk Register and receive reports from the Trust's Corporate Risk Manager
- identifying areas of significant risk, set priorities and place actions using the assurance framework
- To ensure the Trust incorporates the recommendations from external bodies (e.g. the National Confidential Enquiry into Patient Outcomes and Death, HSIB or Care Quality Commission), as well as those made internally (e.g. in connection learning from PSIRF or previously used NHS incident reporting framework), into practice and has mechanisms to monitor their delivery
- To monitor implementation of NHSE Patient Safety Strategy requirements
- To monitor the implementation of the national Safeguarding requirements through delivery for the National Safeguarding Assurance Framework (SAAF) in order to assure that processes are in place for safeguarding across the Trust
- To escalate to the Executive Management Team and/or Audit Committee and/or Board any identified unresolved risks arising within the scope of these Terms of Reference that require Executive action or that pose significant threats to the operation, resources, or reputation of the Trust.

3.3 In respect of efficient and effective use of resources through evidence-based clinical practice:

3.3.1 To monitor the progress of the annual quality priorities.

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3.3.2 To monitor the impact on the Trust's quality of care of cost improvement programmes and any other significant reorganisations (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the Committee) and report any concern relating to an adverse impact on quality to the Board.

3.3.3 To ensure that care is based on evidence of best practice/national guidance.

3.3.4 To ensure that there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance.

3.3.5 To assure the implementation of all new procedures and technologies according to Trust policies.

3.3.6 To review the implications of confidential enquiry reports for the trust and to endorse, approve and monitor the internal action plans arising from them.

3.3.7 To generally monitor the extent to which the trust meets the requirements of commissioners and external regulators.

3.3.8 To monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialties.

3.3.9 To ensure the research programme and governance framework is implemented and monitored.

3.3.10 To ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission).

3.3.11 To ensure that outstanding and effective care and practice is recognised and embedded across the Trust.

3.3.12 To ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.

4. Membership

4.1 The membership of the Quality and Safety Committee shall consist of[1]:three Non-Executive Directors.

4.2 **Essential attendees**: Chief Medical Officer, Chief Nurse, the Chief Operating Officer (or their appropriate Deputy).

4.3 The Committee will be deemed quorate to the extent that the following members are present:

Two Non-Executive Directors and one Executive Director or their appropriate Deputy

(listed in Ref 4.2 Essential attendees)

4.4 For the avoidance of doubt, Trust employees who serve as members of the Quality and Safety Committee do not do so to represent or advocate for their respective department, division, or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

5. Attendance

5.1 List of those required at each meeting:

- Assistant Directors of Quality and Patient Safety
- Corporate Risk Manager

[1] Pursuant to paragraph 15 of Schedule 7 to the National Health Service Act 2006, the powers of the Trust are to be exercised by the Board or to a committee of directors or to an executive director. As such, only individuals meeting that description should be listed as members – others should be listed as mandatory attendees.

- Compliance and Quality Lead
- Patient representatives (e.g. Patient Safety Partner)
- Any nominated deputy attending in place of a member or essential attendee of Committee
- Any other person who has been **invited to attend a meeting by the Committee to assist in deliberations.** This could include the Chief People Officer, the Chief Strategy Officer and the Director of Communications, Marketing and Engagement, Education Lead, Patient Safety Specialist and Subject Matter Expert/s in any relevant area, for **part or all of the meeting required to assist.**

5.2 Members listed at paragraph 4.1 are required to attend at least two thirds of the meetings held annually.

5.3 The Executive Assistant to the Chief Nurse will act as secretary to the Committee.

6. Frequency of meetings

6.1 Meetings shall be held bi-monthly.

6.2 Additional meetings may be held on an exceptional basis at the request of the Chairman of the Committee.

7. Minutes and reporting

7.1 The minutes of all meetings of the Committee may be formally recorded to aid in the production of written minutes and the recording will be deleted in line with Trust guidance.

7.2 The Committee will report to the Board after each meeting by way of an upward report.

7.3 The following sub-committees shall report using the standard upward reporting mechanism to the Executive Management Team as the primary reporting line and will for information purposes send a copy of the upward report to the Committee:

- Patient Safety and Experience Committee
- Clinical Review Group
- Safeguarding Committee
- Infection Prevention and Control Committee

7.4 Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.

8. Review

8.1 The Committee shall review its Terms of Reference at least annually, recommending any changes to the Board, as appropriate.

9. Monitoring

Members of the Committee will monitor the effectiveness of these Terms of Reference by:

9.1 Recording the attendance of members and how often they send a representative.

9.2 Number and frequency of meetings in line with Terms of Reference as per section 6.0.

9.3 Monitor the achievement of the objectives and duties of the Committee as part of a process of annual self-reflection.

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PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Quality & Patient Safety Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**14.0**
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, April- May 2023 (M1-M2). 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. **In April** there was an increase in Zoll therapy cables failing due to bent pins. The issue was identified early, and communications have been sent to staff. **No further** incidents have been reported. **No patient harm identified.** **Safeguarding** (Improvement Plan,IT system resilience, Level 3 Safeguarding training) The improvement plan has significant system wide scrutiny and oversight and has achieved significant improvements in all key objectives. Transition of server delayed by pen testing. Level 3 Training improvement of 5% (Group A 73.2). All priority group trajectories will be available at next Board meeting. Note good practice re Celebration of Innovation Event. **IPC** – Level 3 assurance peer review of South Central Ambulance Service (SCAS) IPC was undertaken with South West Ambulance Service (SWAST) and South East Coast Ambulance Service (SECAMB) on 23 May 2023**. Awaiting final report, but initial feedback was positive and confirmed the issues identified by SCAS in terms of embedding IPC practice and local ownership of the process by frontline teams.** **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 across the Trust.		

	Non- Clinical Incidents – No significant change in reporting culture with abuse/ abusive behaviour incidents received predominantly by 999 operational staff. **Patient Experience** - **There was a 15% decrease** in the total number of Patient Experience (PE) contacts received during the reporting period. The main themes continue to be related to **delays and non-attendance.** **There have been (105) formal complaints** received during the reporting period and (**328) Healthcare Professional feedback requests**. This is comparable to previous reports. **PHSO**- There are currently 7 complaints for which PHSO are completing a full investigation. The Patient and Public engagement facilitator is imminently due to recruit Patient Council Progress will be provided to the Patient Safety and Experience Committee. **Patient Safety & Serious Incidents** **(24) incidents** were reviewed at the Incident Review Panel (IRP). Of these, **The Trust declared (10) Serious Incidents (SI's) during the reporting period** in line with the (2015) Serious Incident Framework. ○ **10** Patient Safety incidents were identified as Serious Incidents (SIs), ○ **7** incidents declared as SCAS SIs ○ **3** incidents declared as system SIs ○ **3** SIs have subsequently been downgraded after review at ICB panels. ○ **1** SI over 60 days **but with an agreed extension in place**. **Duty of Candour (DOC)** - All incidents were DOC applied met the 10-day requirement. On analysis the themes continue to be, patient treatment and care and delay. **Patient Safety Incident Response Framework (PSIRF) -** The internal PSIRF Programme Board Membership has been confirmed and will oversee the current diagnostic and discovery phase leading to the governance and policy development. The PSIRF team are gathering data to support identifying the SCAS top 8-10 patient safety risks. A training needs analysis is being undertaken and training requirements for all PSIRF roles is near completion. **Emerging Theme** **There is rising concern over the number of incidents being reported on behalf of our mental health patients in relation to Thames Valley Police** being early adopters of a national policy the 'Right Care, Right Person' programme. Operational Directors are in constant dialogue with Thames Valley Police Force to assess the impact to patients due to this. Policy. The Clinical Governance team and the Mental Health team will

	review incidents with regards to this concern. **The Trust does not currently have a Violence Prevention Reduction Officer** so the national Violence Prevention Reduction Standards may not be achieved. This post is currently being reviewed.			
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 Nursing Officer / Executive Director of Patient Care and Service Transformation**			
Report author:	**Debbie Marrs, Assistant Director of Quality Patient Experience** **Jane Campbell, Assistant Director of Quality Compliance & Governance** **Sarah Thompson, Associate Director of Safeguarding**			
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:				

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PUBLIC BOARD MEETING PAPER

Title	Quality & Patient Safety Report
Author	Assistant Directors of Quality
Responsible Director	Professor Helen Young Chief Nurse / Executive Director of Patient Care
Date	July 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 (April – May 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 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). 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.

2.2 Level 3 assurance peer review of South-Central Ambulance Service (SCAS) IPC was undertaken with South West Ambulance Service (SWAST) and South East Coast Ambulance Service (SECAMB) on 23 May 2023. SCAS IPC undertook the Welsh Ambulance Service (WAS) peer review on 9 May 2023. Reports and feedback will be available in July and will be presented to the IPC Committee. Initial verbal feedback was positive and confirmed the issues SCAS have raised in relation to embedding IPC practice and audit into the everyday practice of our staff as opposed to relying on the IPC team to come in and “do” this.

2.3 The Trust is compliant with the national timeframe at present with the national transition timescales from the National Reporting and Learning System (NRLS) to the Learn from Patient Safety Events (LFPSE).

2.4 The internal Patient Safety Incident Response Framework (PSIRF) implementation group is overseeing the current diagnostic and discovery phase leading to the governance and policy stage. This includes examining the current incident data and risk profiling exercises to move from current Serious Incidents to proportionate themed learning and improved patient and family engagement.

2.5 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 (19 April to 16 May 2023) which

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correlates with a reduction in the number of clinical incidents and patient experience feedback and complaints reported.

3. Main Report and Service Updates

Infection, Prevention and Control (IPC)

3.1 The **national revised Test and Trace Guidance for Healthcare staff** has been implemented across SCAS. Staff are now not required to test for Covid, but to follow respiratory illness guidance for any absence of being unwell.

3.2 **IPC link practitioners'** campaign has resulted in 12 practitioners requesting to be included with training planned for the end of July 2023.

3.3 **Level 3 assurance peer review of SCAS IPC** was undertaken with SWAST and SECAMB on 23 May 2023. SCAS IPC undertook the Welsh Ambulance Service (WAS) peer review on 9 May 2023. Reports and feedback will be available in July and will be presented to the IPC Committee.

Management of Medical Devices

3.4 In April there was an increase in Zoll therapy cables failing due to bent pins. The issue was identified early, and communications have been sent to staff. No further incidents have been reported. Secondary defibrillators are now on operational vehicles.

3.5 The procurement of the Asset Management system was agreed by the Executive Transformation Board in July 2023, ensuring this important mitigation for patient safety receives PMO support and funding.

Safeguarding

3.6 The Phase 2 Improvement Plan remains on track and has been adopted by NHSE as good practice.

3.7 Within the reporting period Safeguarding Level 3 training has increased to 73.2% for Priority Group A. An increase of 5% within the reporting period.

3.8 This is the final trajectory chart for Priority Group A (Making Connections). This is the last report of the half day iteration before moving to full day. Reports have been paused for June whilst new format, staff groups added and collective graphs constructed.

3.9 IT System – Transition of server delayed to first week in August – described at Safeguarding Committee on June 23. Delay due to Outstanding action regarding penetration testing (requires 3 quotes via Procurement) User testing by LA Fire and Police to take place w/c 24 July 2023.

3.10 Safeguarding Service presented as keynote speaker to the Celebration of Innovation Event NHSE 12 June 2023 on recognition of work associated with allegation management.

Mental Health

3.11 There are 2 high profile projects running in parallel across the trust – 111 Option 2 Project and MH Crisis Steering Group. AD Safeguarding to attend National Group to understand the consequence for SCAS.

Learning from patient safety events (LFPSE)

3.12 The Trust is compliant with the national timeframe at present with the national transition timescales from NRLS to LFPSE.

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3.13 The SCAS internal LFPSE group has completed stage 1 local testing with DATIX in March 2023 and will move to the next upgrade testing at the end of July 2023.

3.14 The software upgrade will be installed by September but not “switched on” until October in line with NHSE requirements.

3.15 A test case self-assessment for the national team will be completed prior to September 2023 to ensure Trust compliance with the system.

3.16 NHSE are currently working nationally to rectify any reporting issues and complete the required drop-down boxes for the new DATIX forms prior to transition.

Patient Safety incident response framework (PSIRF)

3.17 The internal PSIRF Programme Board Membership has been confirmed and will oversee the current diagnostic and discovery phase leading to the governance and policy development. The Trust is fully participative with Integrated Care Boards (ICBs) in partnership planning for implementation.

3.18 The PSIRF team are gathering data to support identifying the SCAS top 8-10 patient safety risks.

3.19 A training needs analysis is being undertaken and training requirements for all PSIRF roles is near completion. Funded or free training for PSIRF specific roles has been confirmed which includes:

- strategic decision makers PSIRF training (Board only)
- oversight training for up to 25 staff
- a business case is in final stage of completion for funding other PSIRF role specific training.

3.20 A communication plan for the patient safety work has been developed, an element of which covers the PSIRF programme of work.

Patient Safety Incident Themes

3.21 The Trust themes of patient treatment/care, and delay categories of patient safety incidents reported, are the highest categories.

Serious Incidents (SIs)

3.22 Year to date the Trust has declared **10 SIs, 3 of which have been downgraded** after review with the ICB. **7 SIs** are currently being investigated. This compares to **4 SI**s in financial year 2022-2023 and **9 SIs** in 2021-2022 across the same reporting period.

- 10 Patient Safety incidents were identified as Serious Incidents (SIs),
- 7 incidents declared as SCAS SIs
- 3 incidents declared as system SIs
- 3 SIs have subsequently been downgraded after review at ICB panels.

3.23 One SI has an approved extension in place and is therefore over the 60 days. Two SIs have current “stop the clock” on them due to ongoing Police investigations.

Incident review panel activity (April and May 2023)

3.24 24 Patient Safety incidents were escalated for further review and investigation at Incident Review Panel (IRP) review due to consider harm levels under the 2015 SI framework.

3.25 5 incidents reviewed at IRP have been referred for a detailed (internal) investigation.

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Patient Safety Incident themes by service

EOC Narrative

3.26 The top three reported incident categories across both Emergency Operations Centres (EOCs) during April and May were Delay, Non-Attendance and Patient Care Treatment. The most common themes for incidents captured under the category of Delay were delayed arrivals at scene, procedures or directives not followed in the call centre or standards of care. All cases reported under standards of care were referred to other agencies namely Police or other provider Healthcare Professionals.

3.27 The most common root causes identified for delayed arrivals at scene were operational resourcing below plan, hospital queuing, demand outstripping available resource and operational policy. There were also cases of dispatch errors, duplication errors and incorrect dispositions. Learning outcomes included internal and external communication/safety huddle highlights and staff education and coaching.

3.28 A series of workshops have commenced to discuss the system requirements from a replacement for the ICAD system. These workshops are involving a broad base across all SCAS services, including Subject Matter Experts as well as operational representatives from 999, CCC, 111 and Patient Transport Services. These are an opportunity to review any concerns raised by incident reporting to ensure new system meets requirements.

3.29 A national initiative already adopted by one Ambulance Trust, has proposed the implementation of a tertiary call answer circuit. The purpose of the tertiary circuit is to prevent calls which have been re-routed to other Trusts for answer, but returned to SCAS unanswered, from re-joining at the back of the queue. The proposal was agreed in principle, with a request that a paper be presented to Clinical Review Group (CRG) for review. A meeting has been held to map the benefits of this change and to plan post implementation audit activity. This will be included in the paper to CRG in July.

3.30 A new process for EOC call takers and clinicians which will alert social care whenever CP-IS (Child Protection Information Sharing service) is accessed, is to be tested and a short training video created to be issued alongside a new directive.

3.31 Following a review of incidents where patients who use Careline Companies to seek help in an emergency, the SOP 2-9 “Care Line / Remote Observer Calls” was updated relating to triage methods, red flag symptoms and Next of Kin contacts.

3.32 A re-audit has found that whilst CCC staff demonstrated an understanding of the revised SOP contents, the amendments made do not appear to have been translated into a consistent change in practice. The task and finish group has reconvened to undertake further work in this area.

111 Narrative

3.33 The top three reported incident categories during April and May were Delay, Patient Care Treatment and Medicines.

3.34 The most common themes for incidents captured under the category of ‘Delays’ were contact centre staff failing to follow procedure, or directives or standards of care. The most common cause relates to patients being sent to the incorrect service.

3.35 The most common themes for incidents reported under the category of ‘Patient Care and Treatment’ were concerns caused by the CPCS referral process. Pharmacies are directing patients to 111 to obtain GP (General Practitioners) input. The pharmacies should be directly contacting GPs on the patient’s behalf. This results in an increase in duplicate calls and poor patient experience. All incidents are being shared with the relevant teams and the process for pharmacy to contact GP directly has been shared with all community pharmacy

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providers. Health advisors are proactive in apologising to patients for experience and reporting incidents so they may be investigated.

3.36 In December 2022, with agreement with ICB colleagues, a pilot was agreed to increase the validation window from 30 minutes to 60 minutes for calls that reached a category 3/4 disposition. An audit of 164 calls was undertaken with the findings showing no patient harm identified, significant difference in outcomes (Conveyed vs. Non-conveyed) between calls passed to 999 with no clinical contact, 89% compliance rate identified in the audit. Themes for improvement identified include insufficient documentation, not asking to speak to the patient (improved safety and potential reduction in call time) and skilful questioning.

3.37 SCAS Oxford medical student cohort presentations were received, and the cohort identified: positive reporting culture, high levels of awareness of clinical governance's purpose and process, spring boarded discussions around use of artificial intelligence, offered insight into managing patient expectations and reducing "churn" and offered insight into support and staff welfare following distressing calls.

3.38 Shared learning implemented by CCC (EOC & NHS111) during the reporting period include:

- Managing Adult Death - CCC Education Workbook released 20 April 2023
- Functional Capacity and Pain assessment - CCC Education Factsheet released 21 April 2023
- Chest Pain and Aortic Dissection - Re-issue - CCC Education Factsheet released 26 April 2023
- Clinical Considerations Assessing Injuries - CCC Education Factsheet released 22 May 2023.

Emergency and Urgent Care (E&UC)

3.39 The top three reported categories for E&UC patient safety events during April and May 2023 were Patient Treatment / Care (173), Delay (42) and Medicines (40). Risk grading for clinical incidents remains low with most incidents graded as low or no harm.

3.40 59% of these concerns that were raised under the category of patient care and treatment were directed at other health care professionals external to SCAS, the majority of these relate to Hospitals, GP's, and Nursing / Care homes. SCAS has a high level of reporting concerns in relation to external health care providers.

3.41 Of the cases that relate to the SCAS EU&C service in this category, the top sub-categories are re-contacted within 24-hours (23), potential incorrect clinical assessment/treatment (18) and standard of treatment/care concern (13). Risk grading for these incidents remains low with most incidents graded as low or minor risk. Following the investigations for these cases, the data is currently providing assurance that crews are reporting in line with our current policies.

3.42 **There is rising concern over the number of incidents being reported on behalf of our mental health patients in relation to Thames Valley Police** being early adopters of a national policy the 'Right Care, Right Person' programme. Operational Directors are in constant dialogue with Thames Valley Police Force to assess the impact to patients due to this policy (Operations Bulletin OB160 - Right care, right person programme to support staff in this change).The Clinical Governance team and the Mental Health team will review incidents with regards to this concern.

NEPTS

3.43 The top 3 categories were Patient treatment/care (26), Slip, trip and fall (15), Ill Health (11). Patient treatment/care - these were all low/no harm incidents where just over half relate to poor standards of care witnessed by crews. 25% relate to failed discharges and the remaining 25% relates primarily to lack of information given on the booking. Slip Trip and Fall – 1 moderate harm fall identified above that was upgraded and will be taken to Safety Review Panel due to further information being available.

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3.44 The Clinical Governance team have received feedback from teams that the advice and language used surrounding infusion devices could be improved. Action includes updating the clinical directive 'CG01CD Clinical Directive - Infusion Devices v3' with clear language and photographs. This has been communicated to all NEPTS staff via the Directors bi-weekly update email in the Learning from Patient Safety incident section produced by the Clinical Governance leads.

3.45 NEPTS Crews occasionally come across incidents in the community and stop to give appropriate help and assistance where they can. A recent incident occurred in Thames Valley where the crew provided great care whilst waiting for assistance. Clinical Memo issue 138 Running calls has been included in the Directors bi-weekly update email in the Learning from Patient Safety incident section produced by the Clinical Governance leads.

Non- Clinical Incidents

3.46 The majority of incidents continue to be reported by 999 operations staff. Abuse/abusive behaviour incidents is the top reported category. The sub-category with the highest number of incidents is verbal abuse.

3.47 Staff are provided with welfare support following an "abusive" incident and where relevant, a special situation feature/alert is placed on the CAD to alert staff.

3.48 The majority of reported non-patient safety incidents are graded by managers as being of minor risk.

3.49 The Risk Assistant (Body Worn Cameras) post was successfully recruited to on 26 June 2023.

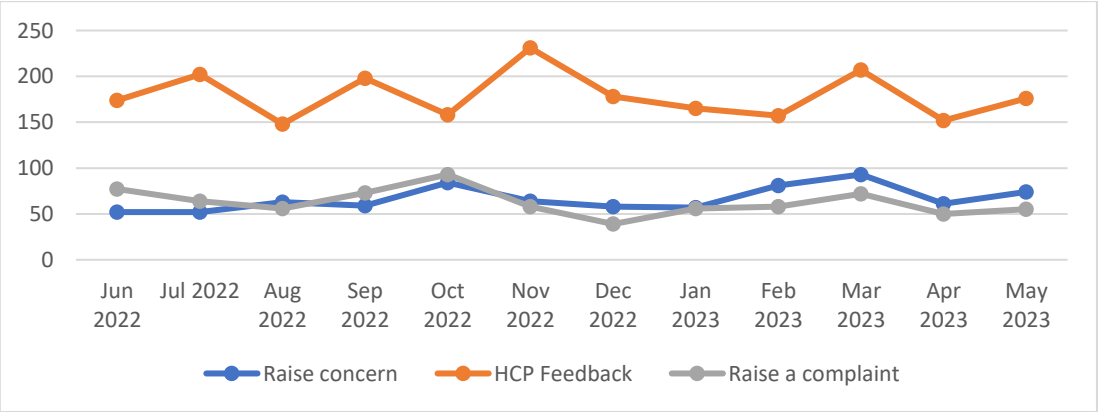
3.50 The Trust does not currently have a Violence Prevention and Reduction Officer so the national Violence Prevention Reduction Standards may not be achieved. This post is currently being reviewed.

Patient Experience (PE)

3.51 In April and May 2023 there was a Trust wide decrease of 15% in the total number of PE contacts raised (568) when compared with the previous two months (668). 263 in April and 305 in May.

3.52 The Trust received 105 new formal complaints, 135 informal concerns and 328 HCP feedback requests during April and May 2023.

3.53 The graph below shows the number of PE contacts received, by type.



3.54 The table below reports PE contacts received for each service.

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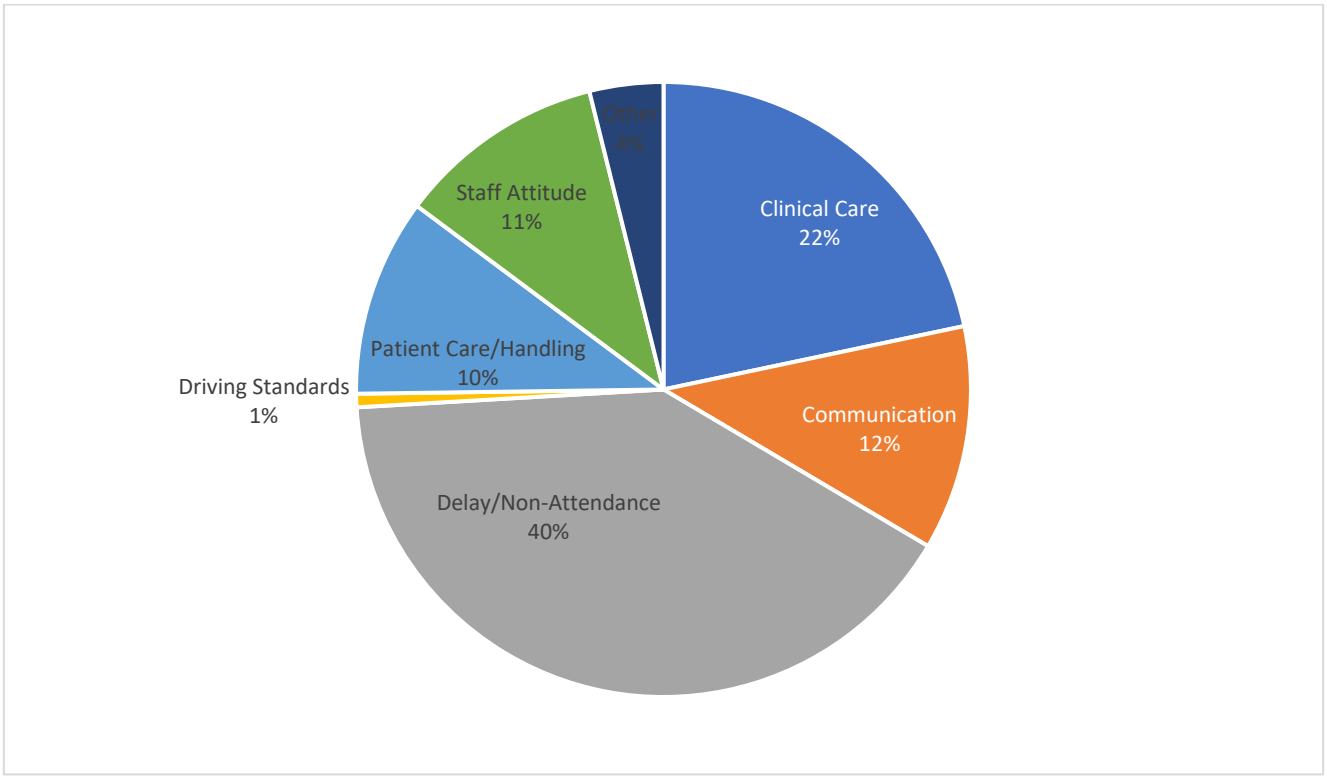
PE Contacts April & May	2023	% of Trust Total	% change from previous two months
NHS 111 incl GP CAS pilot	**116**	20	No change
PTS	**293**	51	Down 3%
999 Operations	**115**	20	Up 2%
EOC	**42**	4	Down 3%
Mental Health Triage Service	2	0.1	No Change
Trust total	**568**	**100%**	**Down 15%**

3.55 The chart below categorises the % of PE contacts received Trust wide, by subject, for April and May 2023. The highest proportion (43%) remains delay.



3.56 40% (230) of all PE issues raised in April and May 2023 were regarding delays or non-attendance as the top theme, this is an 8% decrease from February/March 2023.

3.57 Of the delay's issues raised in April and May 2023, these related to:

- 8% 999/EOC (19)
- 88% PTS (203)
- 4% NHS111 (8)

3.58 A breakdown down of the outcomes/lessons/actions taken from closed cases is below.

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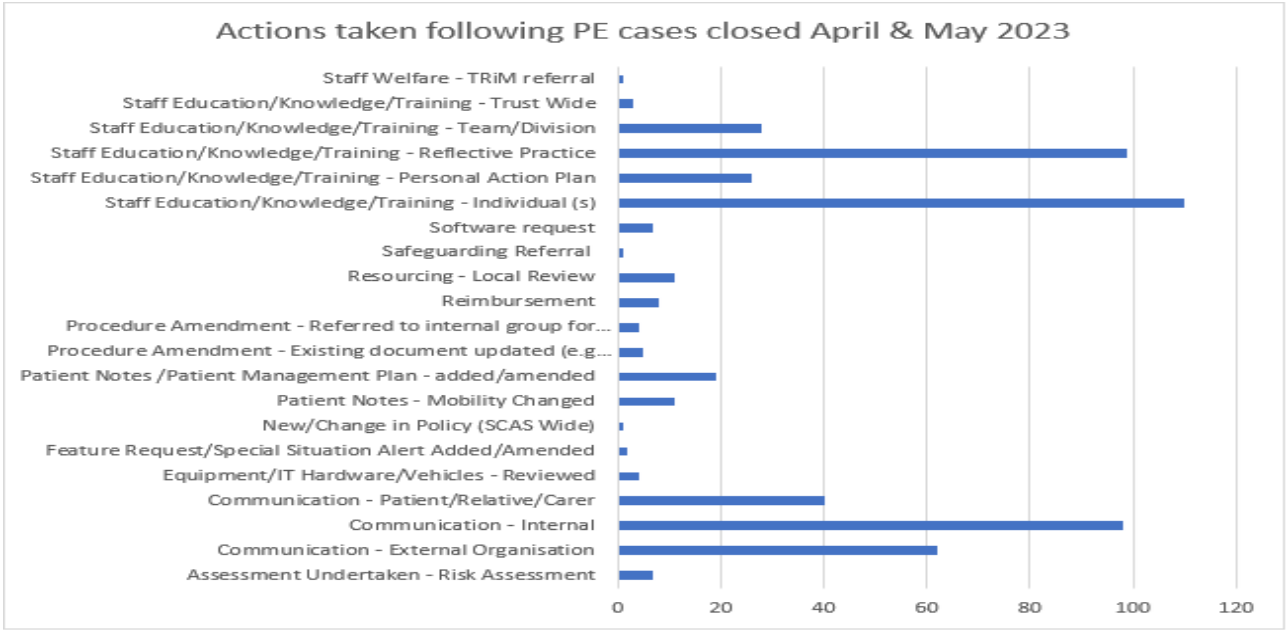

3.59 Parliamentary and Health Service Ombudsman (PHSO) - there are currently 7 complaints for which the PHSO is currently completing a full investigation.

3.60 The Patient and Public engagement facilitator is imminently due to recruit Patient Council members and setting up the co-design and co-production panel and workstreams. Progress will be provided to the Patient Safety and Experience Committee.

4. Recommendations

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

Name and Title of Authors:

Debbie Marrs - Assistant Director of Quality
Jane Campbell – Assistant Director of Quality
Sarah Thompson – Associate Director of Safeguarding

Date: July 2023

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Chief Medical Officers Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**15.0**
Executive Summary:	The purpose of the paper is to update the Board on key clinical issues relating to: • Ambulance Clinical Quality Indicators (ACQI) and Internal Audits. • SCAS Clinical Research Update • Innovation in Acute Stroke Care • Mental Health Rapid Response Vehicles for the Thames Valley		
Recommendations:	The Trust Board is asked to note the report.		
Executive lead:	John Black Chief Medical Officer		
Report author:	Martina Brown - SCAS Research Team Jane Campbell – Assistant Director of Quality 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)	
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations):	
List of Appendices: Appendix A: ACQI Indicators Appendix B: ACQI Monthly Submissions Appendix C: Internal 50 Care Bundle Compliance 2023/24 Appendix D: Crash 4 study enrolment (TXA in mild head trauma); enrolled 223 (data to 22 June 2023) Appendix E: Paramedic 3 enrolment (IV/IO in OHCA); enrolled 477 (data to 21 June 2023)	

South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD MEETING PAPER

Title	Chief Medical Officer's Update Report
Author	Martina Brown On behalf of the Research Steering Group Jane Campbell Assistant Director of Quality John Black Chief Medical Officer
Responsible Director	John Black Chief Medical Officer
Date	July 2023

1. Purpose

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

- Ambulance Clinical Quality Indicators (ACQI) and Internal Audits.
- SCAS Clinical Research Update
- Innovation in Acute Stroke Care
- Mental Health Rapid Response Vehicles for the Thames Valley

2. Executive Summary

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 are reported into the Myocardial Ischaemia National Audit Project (MINAP) system, with an ambulance import/export function.

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

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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.

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. This is likely to shorten time -lag taken for national reporting.

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 been issued from NHSE and will be regularly reviewed.

3. Clinical Performance Exception Report – ACQI

1. SCAS is in the upper quartile rating when benchmarked nationally for 7 out of 13 ACQI indicators, the same as the last report to CRG – **see Appendix A**.

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, 4 show improvement and 2 have remained the same since the last report to CRG.

3. The indicators experiencing a slight deterioration are the Post ROSC Care Bundle, STEMI Care Bundle, the STEMI PPCI time measures and the Stroke call-to-hospital time measures. **Appendix B** has 3 year rolling averages for ACQIs since April 2019.

4. For the year April to December 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.

4. Actions

1. Business Intelligence (BI) have been asked to prioritise the development of the ACQI Dashboard to enable staff members and Clinical teams to obtain feedback on their performance.

2. Communications have been released to ensure operational staff are aware of the care requirements of the new falls ACQI via Staff Matters.

3. The risks in relation to non-conveyance of high-risk chest pain patients and the value of obtaining advice & guidance from primary or secondary care, and the importance of recording reasons for not administering analgesia / pain scoring in ST elevation myocardial infarction (STEMI) was emphasised in CMO message from Exec on 6th July 2023.

5. Clinical Performance Exception Report – Internal Audits

The monthly figures have been produced in **Appendix C** below to show the Trusts position YTD 2022/23.

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Key highlights and risks/issues:

1. The indicators are currently performing above the year end position 2022/23, with the exception of Limb Fracture.

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 June 2023).

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

4. Work 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 our Private Ambulance providers has completed. The full release was made on 23/05/23 to all provider's devices.

5. 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 lead.

6. Actions / Recommendations

1. Continue to undertake and monitor the 50 care bundle audits.

2. Analyse impact of Scribe software update for Private Providers.

3. Briefing material to be cascaded via the operational management teams

7. SCAS Clinical Research Trials update

Newly opened clinical trial to patients' enrolment:

- **ELSA (IRAS 309252): Early Surveillance for Autoimmune diabetes;** Screening children aged 3–13-year-olds for presence of pancreatic antibodies suggesting a type 1 diabetes mellitus diagnosis. Recruitment will take place in non-emergency community setting (schools, communities) by the SCAS research team.

- **SIS (IRAS 316755):** Randomised controlled trial of the clinical and cost-effectiveness of cervical spine immobilisation following blunt trauma. Study aims to determine the effectiveness of immobilisation regimes involving movement minimisation and triple immobilisation (current NHS practice) in patients with cervical spine (c-spine) injury enrolled in a pre-hospital setting. The first patient was recruited into this trial by the research team on the 5th July 2023.

Ongoing research projects (see Appendices D & E for trial recruitment):

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- **CRASH4 (IRAS 283157)** – Tranexamic acid/placebo in mild head trauma

- **PARAMEDIC 3 (IRAS 298182)** - IV/IO access in out of hospital cardiac arrest

Clinical trials – Interim Results:

- **HARMONIE -** randomised clinical trial (IRAS 100580)
  Under this study protocol, the Respiratory Syncytial Virus (RSV) monoclonal antibody nirsevimab was delivered to infants under 12 months of age as a single dose as RSV intervention during Q3 & Q4 2022/23. Study now in follow up stage. SCAS recruited 70 patients into this trial.
    - Interim analysis in May 2023 shows 83.21% (95% CI 67.77 to 92.04; P<0.001) reduction in hospitalizations due to RSV-related LRTD
    - Nirsevimab reduced the incidence of hospitalizations due to severe RSV-related LRTD (patients whose oxygen level is under 90% and require oxygen supplementation) by 75.71% (95% CI 32.75 to 92.91; P<0.001)
    - Nirsevimab demonstrated a reduction of 58.04% (95% CI 39.69 to 71.19; P<0.001) in the incidence of all-cause LRTD hospitalisation compared to infants who received no RSV intervention.

  Please see the attached press release from the investigators for further details:

  - Press Release: Nirsevimab delivers 83% reduction in RSV infant hospitalizations in a real-world clinical trial setting - Sanofi

Health Education England (HEE) / NIHR ICA fellowships

- Helen Pocock (NIHR Clinical doctoral research fellow and Senior Research paramedic at SCAS) presented her own project, the Prehospital Optimal Shock Energy for Defibrillation (POSED- IRAS277693), study delivered in SCAS in 2022-23, and was awarded the 'Best Oral Presentation in the Health Services and Clinical Trials' category at the Warwick Medical School annual Postgraduate Research Symposium. The Symposium showcases the PhD research currently being undertaken; standard of the work that is chosen to be supported, carried out and presented is extremely high.

- We are delighted to announce that the research team supported an application of a SCAS paramedic who was consequently awarded the highly competitive 'HEE/NIHR ICA Pre-doctoral Clinical and Practitioner Academic Fellowship' in the most recent round. The research team continues to support applications of staff considering a research career as facilitated by the HEE/NIHR fellowship scheme via this link, and advertise a variety of opportunities and calls on the SCAS Research HUB - Home (sharepoint.com).

8. Capital funding

- The research team has been awarded £30,000 by the DHSC/NIHR as part of the capital investment into the research RRVs.

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- This award will help increase capacity and capability to carry out clinical research. for the patients' benefit.

9. Acute Stroke Video Telemedicine

SCAS Clinicians from 5th June are now able to directly connect to on-call stroke teams at Frimley Park, Royal Berkshire and University Hospitals Southampton to seek advice and guidance on the onward care of patients presenting with acute stroke symptoms. They can now also connect using video if required via the SCAS ePR system (GoodSam App) that can enable the stroke teams to visually assess these patients remotely whilst under SCAS care in the community. This may help with the identification of patients with acute stroke and differentiate it from stroke mimic syndromes.

This is likely to help improve the appropriate admission of patients to the right care setting when required. As experience develops this may also help with the clinical identification of patients who would benefit for direct admission to Comprehensive Stroke Units for consideration of Mechanical Stroke Thrombectomy, thus avoiding the need for secondary inter-hospital transfer and shortening symptom onset to treatment intervention times.

This is aligned to recommendations made NHS England (2021) Right Care Tool Kit.

10. Mental Health Crisis Transport Vehicles.

SCAS has secured additional funding for additional mental health (MH) care electric vehicles for deployment in the Thames Valley in addition to those already deployed in Hampshire. The purpose designed MH transport vehicles will reduce the need for frontline emergency ambulances to be used for patient transport and will provide a much better transport platform for these patients. This will bring the total number of dedicated MH transport vehicles to 6 and they should become fully operational by Q4 2023/24.

11. Recommendations

The Board is invited to note this report:

John Black
Chief Medical Officer

13th July 2023

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Appendix A:

The table below details the average SCAS performance in comparison to all English Ambulance NHS Trusts average performance, to the end of December 2022. This demonstrates that SCAS are performing in the upper quartile rating for 7 of 13 outcome and time-based indicators which is the same as reported at last CRG.

ACQIs YTD Apr to December 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	7.50%	27.74%	26.44%	29.70%	24.45%	24.95%	26.81%	24.06%	24.78%	23.63%	26.20%
% Cardiac Arrest Ustein ROSC	33.33%	46.19%	54.00%	43.36%	47.18%	43.31%	47.21%	44.84%	47.04%	50.18%	49.41%
% Cardiac Arrest Survive At 30 Days	5.13%	7.50%	7.89%	6.32%	7.28%	8.15%	7.09%	6.14%	9.65%	9.06%	8.59%
% Cardiac Arrest Utstein Survive At 30 Days	33.33%	23.01%	31.84%	19.39%	22.19%	21.83%	24.84%	23.78%	28.65%	32.35%	25.65%
% Cardiac Arrest Resus Care Bundle Achiev	100.00%	83.99%	72.41%	72.12%	62.13%	95.32%	68.72%	97.76%	76.01%	71.69%	69.49%
% STEMI Care Bundle	64.29%	70.51%	87.90%	66.62%	60.86%	81.59%	74.72%	96.30%	76.84%	64.62%	77.88%
% 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	201	159	154	164	147	160	151	171	156	139	176
STEMI PPCI 90Centile CTN	225	229	191	225	211	243	220	247	221	198	268
Stroke Mean Time CTD	1:32:54	1:41:08	1:39:35	1:40:26	1:40:09	2:01:01	1:55:00	1:58:43	1:41:37	1:41:29	2:17:22
Stroke 50Centile CTD	1:17:18	1:26:27	1:25:24	1:24:00	1:23:51	1:35:48	1:26:51	1:34:54	1:22:21	1:23:21	1:44:21
Stroke 90Centile CTD	2:28:36	2:45:00	2:33:36	2:43:42	2:44:30	3:26:24	3:06:03	3:23:21	2:35:18	2:40:18	3:59:30
% Sepsis Care Bundle Received	0.00%	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 dropped to 2nd place nationally. The STEMI call to needle insertion mean measure 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 remaining at 3rd and 4th place nationally.

There are denominator ACQI's which relate to numbers of eligible patients for the cardiac arrest, Stroke and STEMI cohorts. Hence these denominator metrics are not included for performance/quality benchmarking. Neither are the Stroke hospital arrival to scan or thrombolysis measures. Whilst SCAS can influence these measures, they are not directly responsible for patient flow through the hospital.

The table below details average SCAS ACQI performance when compared with the 11 English Ambulance Trusts April-December 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 December 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	7.50%	29.70%	22.20%	24.21%	23.63%	-0.58%	↓	% of Cardiac Arrest patients who ROSC'd at hospital handov
% Cardiac Arrest Ustein ROSC	33.33%	54.00%	20.67%	46.01%	50.18%	4.17%	↑	% ofUtstein patients who ROSC'd at hospital handover
% Cardiac Arrest Survive At 30 Days	5.13%	9.65%	4.52%	7.53%	9.06%	1.53%	↑	% of Cardiac Arrest patients who survive to 30 days
% Cardiac Arrest Utstein Survive At 30 Days	19.39%	33.33%	13.94%	26.08%	32.35%	6.27%	↑	% of Utstein patients who survive to 30 days
% Cardiac Arrest Resus Care Bundle Achiev	62.13%	100.00%	37.87%	79.06%	71.69%	-7.37%	↓	% of Cardiac Arrest patients that received the care bundle
% STEMI Care Bundle	60.86%	96.30%	35.44%	74.74%	64.62%	-10.12%	↓	% 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	201	62	162	139	23	↓	CTN= call to needle (minutes). Lower is better
STEMI PPCI 90Centile CTN	191	268	76	225	198	- 27	↓	Lower is better
Stroke Mean Time CTD	01:32:54	02:17:22	00:44:28	01:48:08	01:41:29	-00:06:38	↓	CTD = Call to door (time). Lower is better
Stroke 50Centile CTD	01:17:18	01:44:21	00:27:03	01:27:41	01:23:21	-00:04:20	↓	Lower is better
Stroke 90Centile CTD	02:28:36	03:59:30	01:30:54	02:56:56	02:40:18	-00:16:38	↓	Lower is better
% Sepsis Care Bundle Received	0.00%	95.12%	95.12%	75.42%	71.23%	-4.19%	↓	% 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 5 indicators and a deterioration in 7. Sepsis has been retired as an ACQI.

The STEMI Care Bundle cohort has seen a slight deterioration in performance since the last report to CRG and the Stroke call to hospital time measures have slightly improved.

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Work 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 has completed. The full release was made on 23/05/23 to all provider's devices.

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 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.

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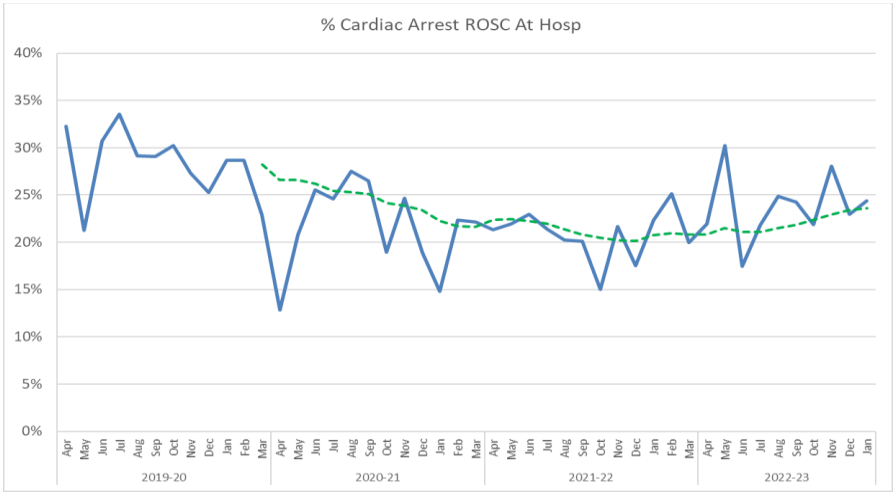
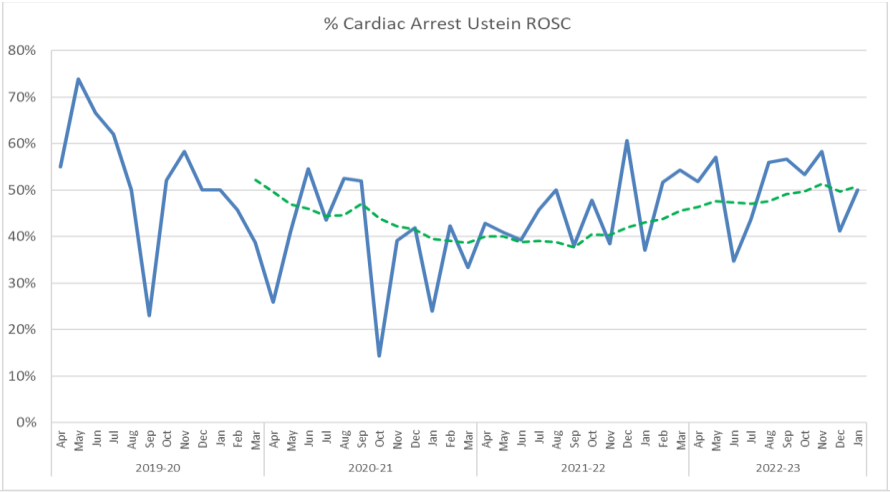
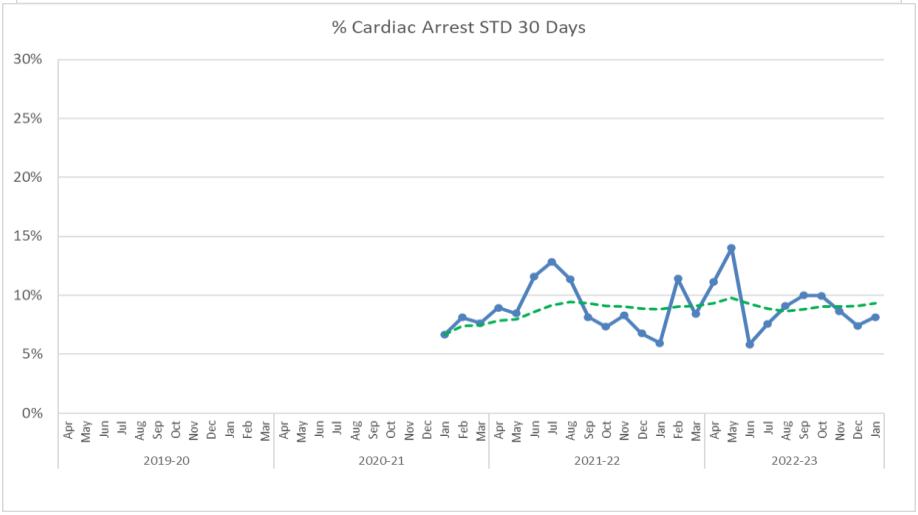
Appendix B:

ACQI monthly submissions

The rolling average charts below detail historic SCAS ACQI compliance from April 2019. These charts demonstrate a general improvement trend across the indicators, with fluctuation across monthly/quarterly datasets.







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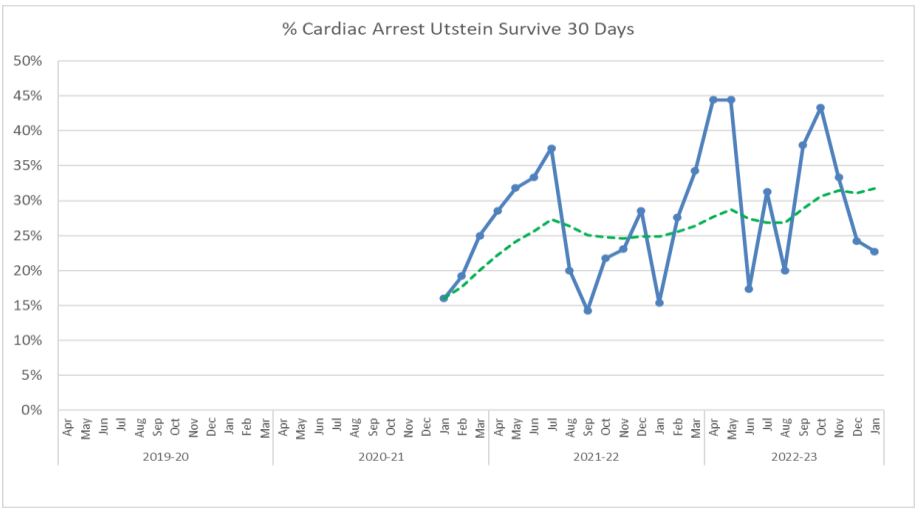
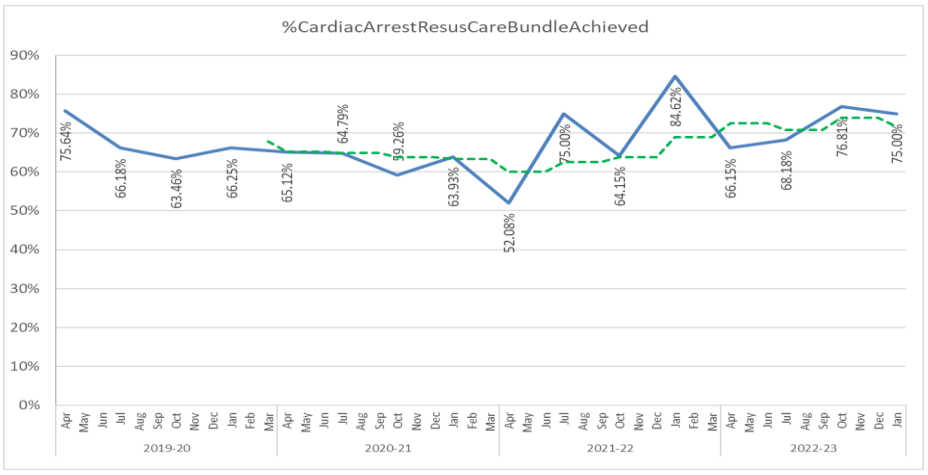

% Cardiac Arrest Utstein Survive 30 Days
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
2019-20
2020-21
2021-22
2022-23


%CardiacArrestResusCareBundleAchieved
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75.64%
66.18%
63.46%
66.25%
65.12%
64.79%
59.26%
63.93%
52.08%
75.00%
64.15%
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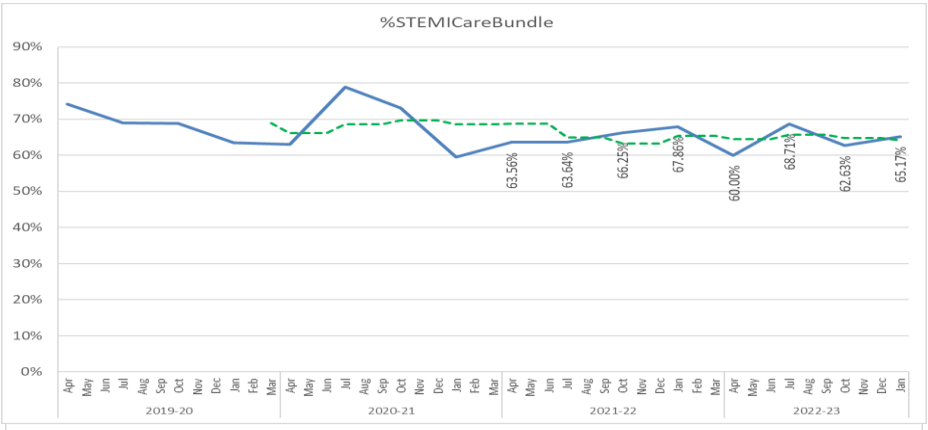
66.15%
68.18%
76.81%
75.00%
2019-20
2020-21
2021-22
2022-23


%STEMICareBundle
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
63.56%
63.64%
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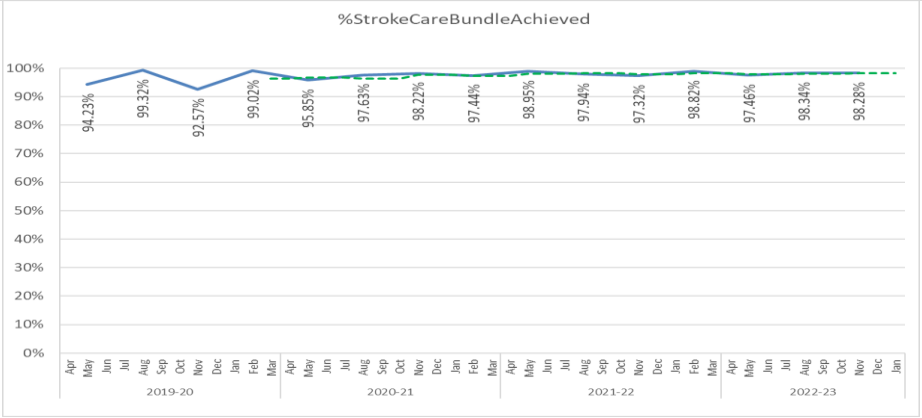
67.86%
60.00%
68.71%
62.63%
65.17%
2019-20
2020-21
2021-22
2022-23


%StrokeCareBundleAchieved
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94.23%
99.32%
92.57%
99.02%
95.85%
97.63%
98.22%
97.44%
98.95%
97.94%
97.32%
98.82%
97.46%
98.34%
98.28%
2019-20
2020-21
2021-22
2022-23

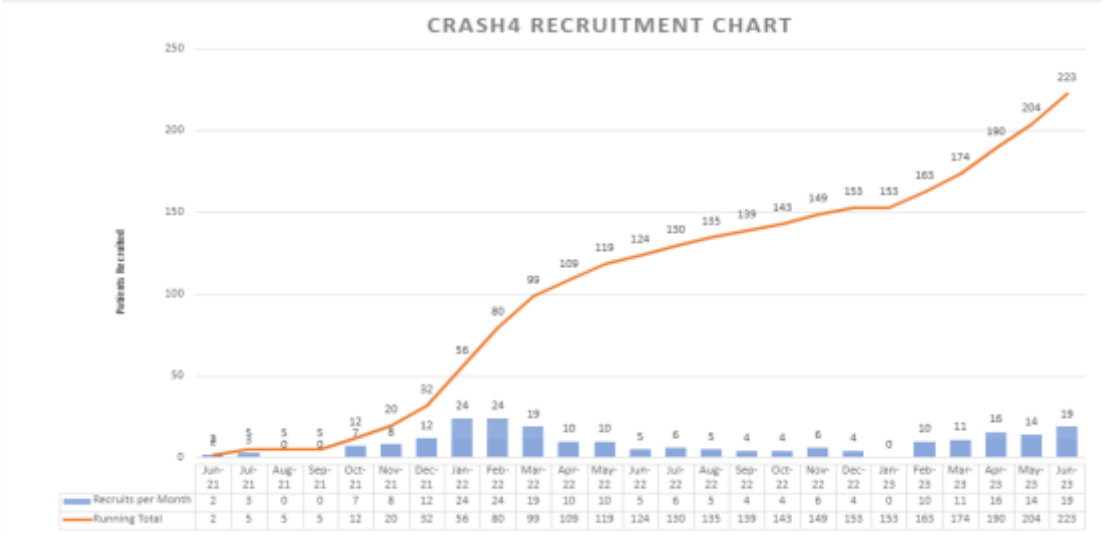
Appendix C:

Internal 50 Care Bundle Compliance 2023/24

NCPI		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD	2022/23
Asthma	Num	N/A	37	N/A	N/A		N/A	N/A		N/A	N/A		N/A	37	131
	Denom	N/A	50	N/A	N/A		N/A	N/A		N/A	N/A		N/A	50	200
		N/A	**74.00%**	**N/A**	**N/A**		**N/A**	**N/A**		**N/A**	**N/A**		**N/A**	**74.00%**	**65.50%**
Limb Fracture	Num	16	12	18										46	192
	Denom	50	50	50										150	600
		32.00%	**24.00%**	**36.00%**										**30.66%**	**32.00%**
Febrile Conv	Num	45	N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A	45	170
	Denom	50	N/A	N/A		N/A	N/A		N/A	N/A		N/A	N/A	50	200
		90.00%	**N/A**	**N/A**		**N/A**	**N/A**		**N/A**	**N/A**		**N/A**	**N/A**	**90.00%**	**85.00%**
Elderly Falls	Num	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	333
	Denom	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	600
		N/A	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**55.50%**

Appendix D:

Crash 4 study enrolment (TXA in mild head trauma); enrolled 223 (data to 22 June 2023)



Appendix E:

Paramedic 3 Trial enrolment (IV versus IO access in cardiac arrest); enrolled 477 (data to 21 June 2023).

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Quality Account 2022 -23**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**16.0**
Executive Summary:	The Quality Account is a mandated document for Foundation Trusts. The final published version will be available on the Trust's website in due course, however an unpublished version is available from the Quality Team upon request. The document follows the national guidance for Quality Accounts and includes the mandated sections. Included is a look back on 2022 – 23 and progress against the objectives the Trust set, and a section on the CQC visit, report and subsequent improvement programme. Objectives set for 2023 – 24 are described and will be reported in next year's Quality Account. The Quality and Safety Committee will be provided with in year updates on progress. Feedback from Quality and Safety Committee, Audit Committee and the Private Board meeting have been considered and amendments made. Data has been presented in the published version using formats that meet the accessibility standards.		
Recommendations:	The Trust Board is asked to note that the Quality Account 2022-23 has been approved.		
Executive lead:	Helen Young, Chief Nurse		
Report author:	Jane Campbell, Assistant Director of Quality		
Previously considered by:	Quality and Safety Committee Audit Committee Board Seminar		
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: Quality Account is available upon request

PUBLIC BOARD MEETING SUMMARY SHEET

<table>
<tr><td>Report title:</td><td colspan="3">Safeguarding Annual Report</td></tr>
<tr><td>Report to:</td><td colspan="3">Trust Board (Part 1)</td></tr>
<tr><td>Date of Meeting:</td><td>Thursday, 27 July 2023</td><td>Agenda Item:</td><td>17.0</td></tr>
<tr><td>Executive Summary:</td><td colspan="3">
The Safeguarding report is a Statutory Requirement and provides the Trust Board, Quality and Safety Committee, ICB (including the Designated Nurses for Safeguarding) and Safeguarding Boards with assurance and understanding of the Safeguarding Activity for 2022/23.

There have been three landmark achievements this year for the Safeguarding Service:

• The Improvement Workplan and alignment to Safeguarding Accountability and Assurance Framework (SAAF)
• The increase from 4 permanent staff to a team of 10
• Permanent change in leadership in Q3 and 4.

The three challenging aspects for this year were:

• The work associated from 2 CQC Inspections
• The fast turnover of leadership in Q1 and 2
• The fragility of the Server hosting the safeguarding referrals.

The most challenging aspects for the coming year will be:

• The exit strategy from Improvement plan work
• The transition to Docworks hosted Server for referrals
• The increase in training compliance at all levels for safeguarding including Mental Capacity Act (MCA).

Highlights from data analysis include:

• 9 Audits were undertaken in 2022/23
• 7 Serious Incidents related to safeguarding in 2022/23 – 6 related to fragility of the server
• SAAF project in page demonstrates actions are on track or completed.

Training

Compliance as of 19 April 2023

<table>
<tr><td>Course Title</td><td>Target</td><td>Actual</td></tr>
<tr><td>Adult SG L1</td><td>95%</td><td>95%</td></tr>
<tr><td>Children SG L1</td><td>95%</td><td>95%</td></tr>
<tr><td>Adult SG L2</td><td>95%</td><td>95%</td></tr>
</table>
</td></tr>
</table>

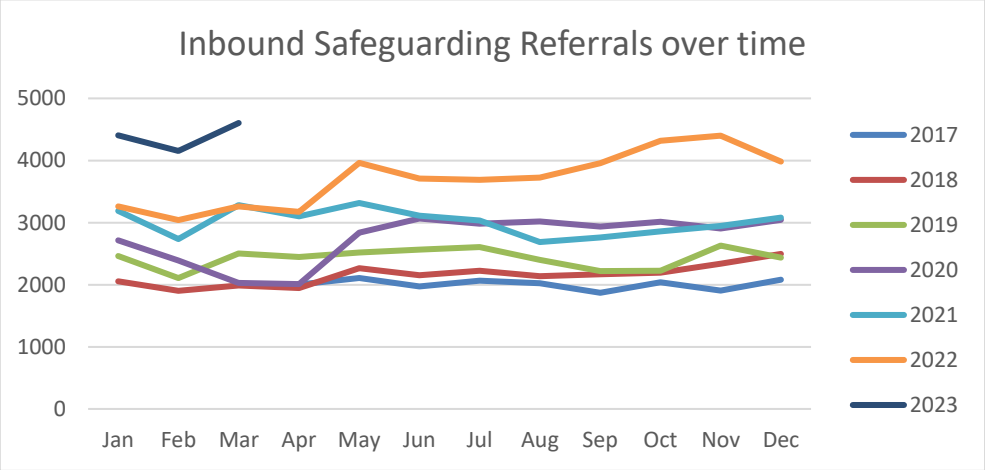
Children SG L2	95%	95%
SG L3 (Adults and Children)	95%	63.2%*
Basic Awareness Prevent	95%	90%
Awareness Prevent (L3)	95%	74%

- Safeguarding Service have delivered bespoke training trust wide
- Level 2 and 3 package has been improved and unified for delivery
- Compliance at all levels is required by March 31 2024.

Referrals

The Server fragility has caused additional capacity issues on the Service due to the need to address immediate risk.

The overall total safeguarding referral activity has **increased by 72%** in the past 4 full years. In the first 3 months of 2023, **there is a 38% increase from the same period last year**.



- Neglect is the highest reported theme for both children and adults
- Hampshire is the highest reporting area.

Learning Disability

- The recruitment of the LD Lead has been instrumental in increasing the work associated with this area.
- Introduction of Oliver McGowan training will raise the profile of LD in staff.

Child Death

- The Safeguarding service responded to 62 child deaths in 2022/23.
- Hampshire had the highest recorded number of child deaths.
- Front Line Staff are now routinely invited to Joint Area Reviews post death.
- Priority for 2003/24 will be work aligned to themes from child death.

Multi Agency Case Reviews including Section 42 Enquiries

- There is a greater ability to capture learning from reviews due to improved centralised record keeping.
- The main themes from Section 42 Enquiries were delays, failed audits from EOC call takers, alleged injuries from PTS when returning patients home, staff behaviour.
- The main themes from Child reviews were domestic abuse, emotional abuse, physical abuse and neglect.

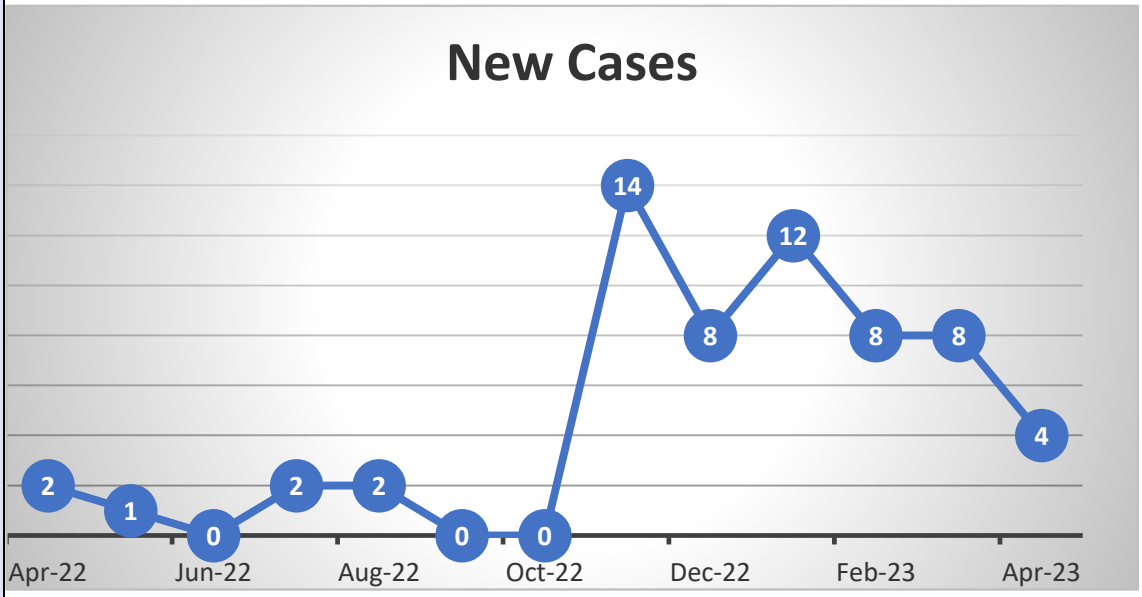
- In total Safeguarding Service has responded to 126 requests from the Local Authority.
- There has been a 135% in requests for Section 42 enquiries.
- Change in practice is evidenced in the report in response to themes.

Prevent

- There have been 2 prevent referrals both related to staff.
- Referrals are nationally low leading to a review of Prevent 2023/24.
- The Prevent compliance is shown below:

Basic Awareness Prevent	95%	90%
Awareness Prevent (L3)	95%	74%

Allegations



- There was a total of 60 allegations in 2023/24
- The highest job role represented was ECA
- 73% related to male colleagues
- 57% related to north operational nodes
- Sexual behaviours account for 51% of the cases
- 28% of cases substantiated and 23% not proven

Key progress and priorities are shown at the end of the report

Examples of good practice/change in practice demonstrated

There are 3 Appendices

1. Benchmarking Document
2. SAAF Improvement Plan
3. Risk Register

Recommendations:	The Committee are asked to note the contents of the report and to understand risk areas as week achievements.			
Executive lead:	Helen Young Chief Nurse			
Report author:	Sarah Thompson, Associate Director Safeguarding			
Previously considered by:	Not reported previously			
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 - Achieving standards and targets
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): Safeguarding Committee upward reports to Quality and Safety Committee, at which the Annual Report is also reviewed.	
List of Appendices:	

South Central Ambulance Service
NHS Foundation Trust

Safeguarding Annual Report 2022 / 2023

Version 1.2

20 July 2023

1. Introduction

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

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

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

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

- CQC Inspection November 2021 – specific focus on Safeguarding
- CQC Inspection April/May 2022 – focus well lead inspection
- Quality Visit completed by representatives of ICB's in December 2022
- Continued NHSE/CQC Scrutiny Group
- NHSE Safeguarding Priority - requests by Safeguarding Boards to provide assurance on improvement work
- NHSE Safeguarding Priority - to sustain the NHS Safeguarding brand and products for all frontline staff, so they can make every contact count to prevent all forms of neglect, exploitation, abuse and violence.
- NHSE Safeguarding Priority - to focus on preventing domestic abuse and violence (DAV); to tackle serious violence (TSV) and to prevent child sexual exploitation (CSE).
- NHSE Safeguarding Priority - to ensure that the long-awaited Domestic Abuse Bill is translated into safeguarding assurance and key messages for safeguarding systems when it becomes legislation.
- NHSE Safeguarding Priority - to continue to profile the voice and lived experience of young carers and care-experienced people in the NHS.
- NHSE Safeguarding Priority - to raise awareness of the vulnerabilities of young people to exploitation and abuse as they develop into adults and/or transition to adult services.
- NHSE Safeguarding Priority - to sustain positive partnership engagement with key stakeholders, to ensure the continuation of robust and transparent conversations in addressing and identifying solutions to rapidly evolving safeguarding issues.
- NHSE Safeguarding Priority - to ensure that the Liberty Protection Safeguards (LPS) are implemented safely by responsible organisations for 16–17-year-olds, as well as any vulnerable adults.
- NHSE Safeguarding Priority - to continue to evolve our Safeguarding Accountability and Assurance Framework; to consolidate our Safeguarding Commissioning Assurance Toolkit; and to explore the benefits of our contextual safeguarding dashboard with partners and ICSs through evaluation and research.

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

- The Improvement Workplan resulting from the CQC inspections.
- The increase from 4 permanent staff in the Safeguarding Service to a total of 10
- The fast turnover of Leadership within Safeguarding team for Quarter 1 to 3, 2022.
- Permanent change in Safeguarding Leadership in Quarter 3, 2022.

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

- The delivery of the Improvement work associated with Safeguarding.
- The transition to a new "hosted" server process for Safeguarding referrals.
- The increase in training compliance at all levels for safeguarding including Mental Capacity Act (MCA).

1.7 This report depicts the work and progress that has been made within the Trust during 2022-2023

1.8 **Appendix 1 contains benchmarking data** which compares data from SCAS against other ambulance safeguarding services. **To note this is 2021/2022 data as the latest figures are not yet available.**

1.9 Areas to note from this report**: SCAS in 2021/2022** – 3rd highest referrer, mid-scale for number of allegations. SCAS was the 13th smallest Safeguarding team out of 14 Ambulance Trusts.

2. Multi-Agency Working

2.1 The Trust is aligned to 24 Adult and Child Safeguarding Boards within the operational area. The Trust maintains relationships with all these organisations in the interests of their responsibility to safeguarding. The Associate Director Safeguarding represents the Trust at all safeguarding boards and delegates responsibility for attendance at subgroups to the respective safeguarding leads or specialist safeguarding practitioners.

2.2 A representative from the Trust's Safeguarding Service attends the following strategic multi agency safeguarding meetings – **a total of 59 meetings** quarterly:

- 4 Local Safeguarding Adult Boards (4LSAB) and 4 Local Safeguarding Children Partnerships (4LSCP) Health Subgroups
- AEMRAC – Adult exploitation
- ACDRP - Association of child death review professionals
- Berkshire Joint agency response meetings.
- Berkshire East health team
- Berkshire West Child death review meetings
- Berkshire Named and designated safeguarding professionals health meeting.
- Berkshire Strategic partners meeting
- West of Berkshire Safeguarding Adult board
- Buckinghamshire, Oxford, and Berkshire (BOB) Child Death Overview Panel (CDOP)
- BOB Integrated Care Board (ICB) Countrywide Safeguarding meeting
- BOB ICB Designated safeguarding professionals meeting.
- BOB ICB Health partners strategic safeguarding committee

- BOB strategic care home performance meeting
- BOB ICB Learning from deaths group.
- BOB DHR Panel
- Bracknell Forest CDOP
- Bracknell Forest QA Group
- Buckinghamshire Safeguarding Children Partnership.
- BSAB – Buckinghamshire Safeguarding Adult's Board.
- Hampshire Safeguarding Adult and Children Boards (HSAB / HSCP) Portsmouth Safeguarding Adult and Children Boards (PSAB / PSCP)
- Hampshire and Portsmouth Safeguarding Adult Review (SAR) & Serious Case Review (SCR) Subgroups
- Hampshire Police Joint Agency Response (JAR)
- Pre-LIG. Health specific discussions of cases in preparation for LIG
- Hampshire Safeguarding Children Partnership Learning and Inquiry Group (LIG)
- Hampshire S42 Adult Safeguarding meeting
- Hampshire Alcohol services task & Finish group
- 4SAB (Hampshire, Portsmouth, Isle of Wight, and Southampton) Safeguarding Adults
- NHS E&I Southeast – HIOW Safeguarding Forum
- Hampshire Safeguarding Children Partnership Learning and Inquiry Group (LIG)
- Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) CDOP
- Milton Keynes Child Death Board
- Oxfordshire Safeguarding Adult's Board.
- Portsmouth Safeguarding Children Partnership Learning from Cases Committee
- Portsmouth Multi agency risk managements
- Portsmouth Alcohol Task Group
- Portsmouth Domestic Homicide Review
- PSCP Learning from Children and Practice Committee.
- Royal Borough of Windsor and Maidenhead (RBWM) Adult and Children Joint Safeguarding Executive Steering Group.
- RBWM Adult Exploitation Subgroup
- RBWM Multiple Agency Risk Assessment Conference (MARAC)
- RBWM Case Review Group
- RBWM Childrens and Adults Safeguarding Case Review Group
- Reading Serious Adult Review Panel
- Southampton Serious Incident and Learning Group (SILG)
- Slough Safeguarding Adults Review Panel
- Slough Asylum Seekers Safeguarding meeting.
- Slough Partnership event
- Slough Tactical group
- Slough Violence workshop
- Southampton Serious incident and Learning Group.
- Southampton City Council Safeguarding Board
- Southampton Safeguarding Adult's Board.
- Southampton Safeguarding Children Partnership.
- Southampton Safeguarding Practice Improvement Group (SPIG)
- Sussex East Operations Subgroup
- Sussex East Safeguarding Adults Board
- Sussex West Learning meetings
- Wokingham Domestic Abuse (DA) Networking Group

2.3 Whilst there is a defined SCAS footprint, the 111 service receives calls outside of this area (15% of calls). If there is a safeguarding issue raised following one of these calls, there is sometimes a requirement for a member of the SCAS safeguarding team to attend meetings in relation to patients out of area.

3. Safeguarding Governance/Accountability Arrangements

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

3.2 In addition, the Associate Director Safeguarding provides a safeguarding report to the Patient Safety Delivery Group, Patient Safety Group, Quality and Safety Committee, the Safeguarding Committee and the Trust Board, this provides safeguarding activity information to these groups, detailing progress against Serious Case Review (SCR) action plans, legislation and Trust safeguarding activity.

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

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

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

3.6 In addition to section 11 audit there have been 9 audits undertaken during the year including:

- Deep Dive into emerging theme of sexual behaviours of staff - February 2023
- Quality of Safeguarding Referral audit – February 2023
- SCAS Self-Assessment Oxfordshire - January 2023
- Non mobile baby Audit – March 2023
- Delayed Referrals Audit – December 2022
- DA referral Audit – February 2023
- BDO Audit – October 2022
- Referral data report – Buckinghamshire February 2022.
- Rapid Appraisal Review undertaken by external Safeguarding specialist – July 2022.

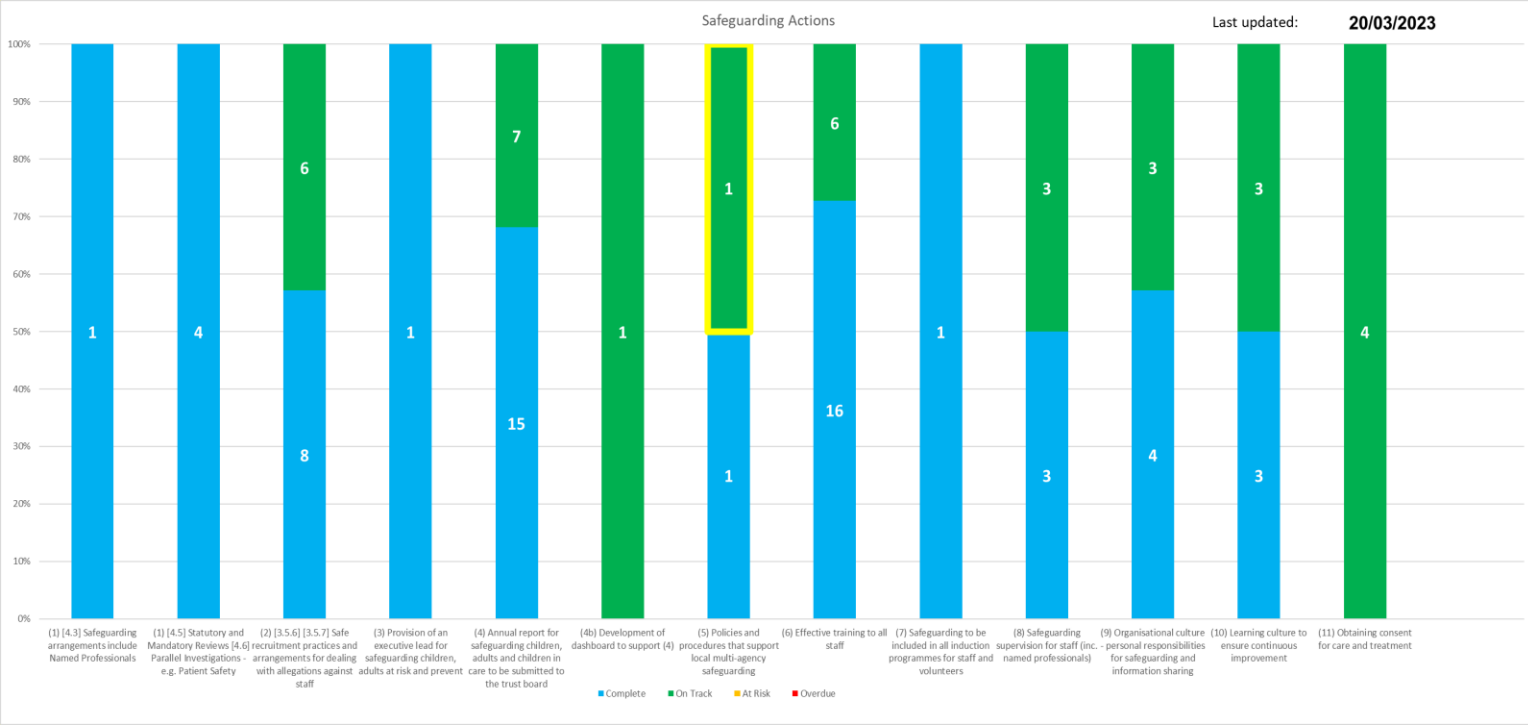
The progress of these is monitored via the Safeguarding Committee and actioned in the Clinical Governance Lead meetings.

3.7 In addition, there have been 7 Serious incidents (SIs) related to safeguarding in 2022/23 with 6 related to missed referrals due to the fragility of the Docworks platform. Docworks collects processes and collates inputs e.g., Safeguarding Referrals for a variety of sources, by the

Common Format processor, which converts all inputs into a common format for creation of a standard PDF output. The PDF is then passed to the Transport Portal to be reviewed and delivered in a controlled, secure and audited fashion to the external parties by emails (Safeguarding teams within Local Authorities, Police and Fire Services). In five cases all actions have been addressed with work associated with the Safeguard Improvement Plan. One relates to 111 and not understanding the bruising protocol - both actions completed. The final case is ongoing.

3.8 **Appendix 2** provides a copy of the Safeguarding Workplan aligned to the 11 criteria within in the Safeguarding Accountability and Assurance Framework (SAAF) July 2022 which has been one vehicle to determine progress against the CQC Inspection. All actions are on track as described in project in a page below (as of 20 March 2023). This is a diagram to demonstrate whether the numerical tasks associated with the 11 criteria are complete (blue), on track (green), at risk (yellow) or overdue (red bar on diagram). The highlighted example (in yellow outline) shows when a new task is added.

Figure 1



4 Training

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

4.2 Training Compliance (as of 19th April 2023)

Figure 2

Course Title	Target	Actual
Adult SG L1	95%	95%
Children SG L1	95%	95%
Adult SG L2	95%	95%
Children SG L2	95%	95%
SG L3 (Adults and Children)	95%	63.2%*
Basic Awareness Prevent	95%	90%
Awareness Prevent (L3)	95%	74%

** To note: Safeguarding Level 3 (L3) compliance was 18.4% September 2022*

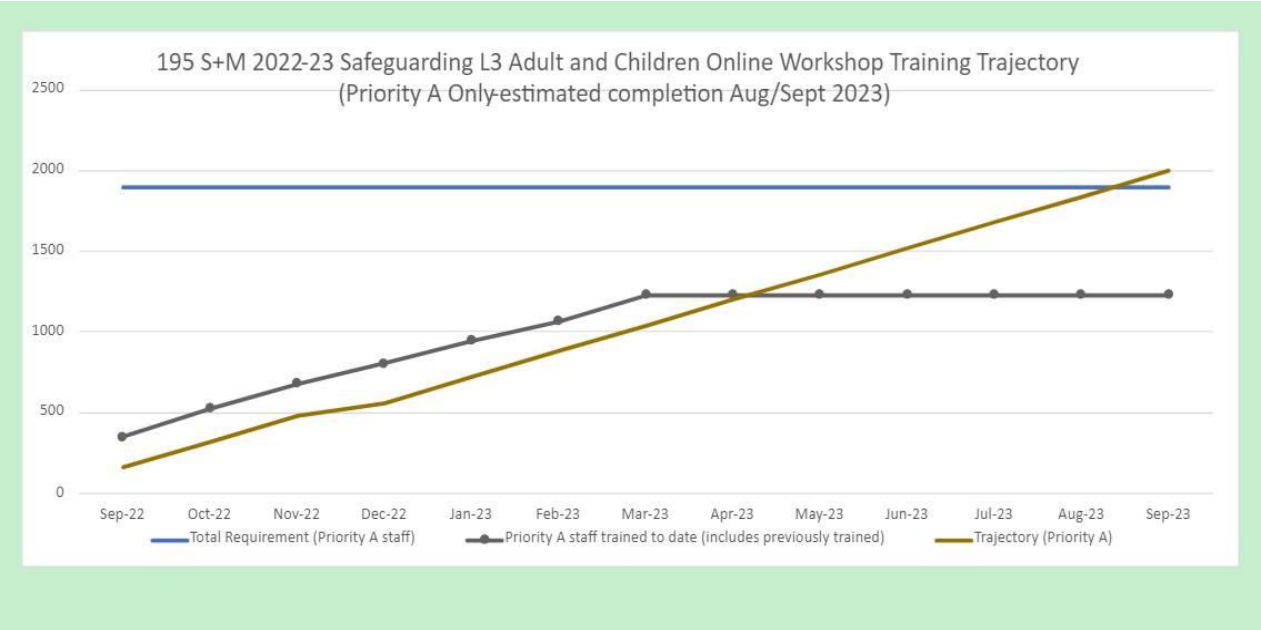
4.3 A Training Strategy and Plan was agreed in November 2022. This plan see a complete review of training packages being delivered across the trust. Following this review, the 6 different variations of the safeguarding level 2 course in circulation across the trust was reduced to one standardised course. This standardised course was modified to reflect current safeguarding guidance and legislation. Additionally bespoke modules tailored to each service line can be added to ensure unique challenges experienced by individual service lines are addressed.

4.4 The following safeguarding training programmes were delivered throughout 2022/23 and will continue to be delivered through 2023 into 2024.

- Safeguarding induction delivered during corporate induction by Safeguarding Team.
- Due to timetable restrictions Patient Transport Services deliver a combined induction/L2 presentation during the first week.
- The emergency of centre (*EOC) staff have a separate safeguarding induction/training programme which is bespoke to the unique requirements of the call centre environment.*
- Frontline/patient facing staff, Newly Qualified Paramedics (NQPs), Emergency Care Assistants (ECAs). Associate Ambulance Practitioner (AAPs) and Ambulance Care Assistants (ACAs) undertake a 3-hour level 2 face to face safeguarding session as part of their training course delivered by education facilitators and managers. These were identified as Priority Group A for training delivery.
- Safeguarding Adult level 1 and Safeguarding Children level 1 accessed via Electronic Staff Reporting eLearning platform which is mandatory for all staff.
- Safeguarding Adult level 2 and Safeguarding Children level 2 accessed via ESR eLearning platform mandatory for specific staff dependent on role.
- Safeguarding Combined Adults and Children level 3 has been delivered to clinical grade staff via Teams by an external company called Making Connections since September 2022.

4.5 The trajectory as of 19 April 2023 was met for Priority Group A – see figure below.

Figure 3



4.6 In addition to the standardised programme, there have also been comprehensive bespoke packages of training delivered as described below:

Allegations and Section 42 Training

4.7 Training developed by the Safeguarding Team on Allegation Management (one hour) and Section 42 enquiries (30 minutes) has been delivered approximately 8 times to groups mainly consisting of Team Leaders, Clinical Team Educators (CTEs) and Educational staff. The plan is to continue delivering this training to all node (geographical operational areas) level one meetings and any other specific groups where it is highlighted that the training would be beneficial.

Local Authority Designated Officer (LADO)

4.8 There has been training delivered by the LADO responsible for the Portsmouth area to the Safeguarding Team and HR colleagues. The training focused on the role of the LADO and when they should be contacted and the reason for their involvement. Further training sessions have been delivered to Operational Managers by the LADO for Bracknell Forest.

Disclosure and Barring Service (DBS)

4.9 Training course delivered to the Safeguarding Team in May 2023 by the Regional Outreach Advisor for the DBS Service on the legal duty to refer. A total of three training sessions have been delivered to SCAS colleagues with further training planned for 2023-2024.

Education CPD Training

4.10 In December 2022 a Continuing Professional Development safeguarding training day was organised by Educational Development and the Safeguarding Team for Education colleagues, The training consisted of:

a) A SCAS safeguarding update from the Named Professional Adult.
b) Process for referring to a Local Authority Designated Officer delivered by the LADO for Bracknell Forest.
c) Domestic Abuse – a survivor's story
d) Modern Slavery – delivered by a Central Specialist Crime Officer, Metropolitan Police.

4.11 A separate bespoke training course was delivered to the Education Driving Team by the Safeguarding Team in January 2023 as part of their CPD day.

UCAS Students

4.12 There are approximately 330 university students across our 4-partner university and the following safeguarding training has been undertaken by the Safeguarding Team:

a) Safeguarding induction to all new students

b) Level 2 training as requested to approximately 45 students

c) Specific training has recently been delivered to approximately 45 Oxford Brookes Year 3 students, further safeguarding training to be offered to all partner universities.

4.13 Significant investment and focus has been given to the delivery of safeguarding training in 2022/2023.

5 Supervision

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

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

5.3 During the financial year 2022-2023, due to pressures to meet objectives as outlined in the Improvement Plan, Supervision has not been a central focus. It has been targeted to achieve delivery by Quarter 4 2023/2024 as part of the SAAF and improvement journey.

Supervision Plan

5.4 Given below are the key elements of the Supervision Plan for 2023/24:

- Number of staff in Priority Group - 1215
- Roles in Priority Group - Nurses, Paramedics, Newly Qualified Paramedic, Team Leaders, Clinical Team Educator, Clinical Operations Manager
- Named Professionals trained in Safeguarding Supervision
- 2 Specialists being trained in June 2023
- Group Supervision – (15 in each group)
- Quarterly delivery of supervision to the Priority Group
- KPI's agreed must attend 75% or three out of four sessions
- Drop in's twice a year for any one.

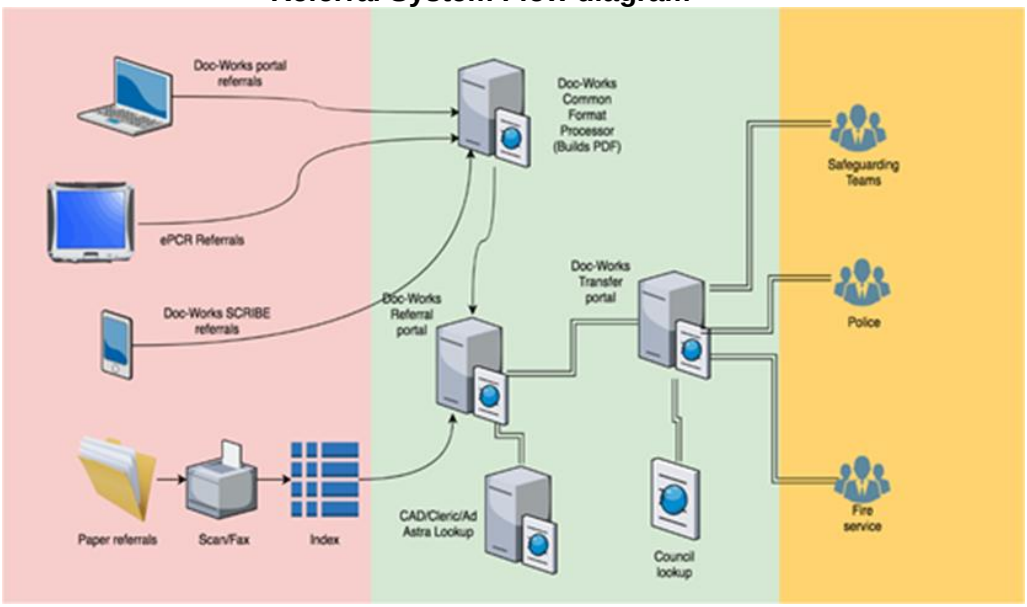
5.5 Until the commencement of formal supervision sessions, the following mitigations are in place:

- Recorded sessions e.g. Those that are discussed and do not reach allegation threshold.
- Ad hoc – advice calls e.g., Staff member victim of DA
- Debrief e.g. After difficult situations.

6 Safeguarding Referrals/Alerts (including IT update)

6.1 SCAS uses a system within the Clinical Directorate called 'Docworks' which is used to support several activities within the organisation. This includes the safeguarding referral process. The system has frequently demonstrated failures and fragility of the current provision. Throughout 2022/23, the ICT (Information Technology) Risk associated with the referral process, has been the highest risk on the Safeguarding Risk Register. It is currently scored at 25 (as of April 2023). **See Risk Register Appendix 3 dated April 2023**

Figure 4 **Referral System Flow diagram**



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

6.3 There are several mitigations in place which have been introduced throughout the year which include:

- Read receipt
- Development of a traffic light system to show any 'held' referrals
- Agreed audit cycle
- Project Manager aligned to the Docworks migration
- Manual referral process instigated by the Safeguarding Service to reduce delay if there is a system failure
- Increased relationship building between Docworks and SCAS.

Additional referral problems - Omission of key data by referrer

6.4 Referrals are sent to the appropriate local authority/agency via the Safeguarding server. The server determines the local authority/external agency location by using a postcode. If any information (postcode/address etc.) is missing then the referrals are held in the server for the SCAS Safeguarding team to review and then send on manually. This causes additional work for the team as there is then a requirement for other SCAS systems to be interrogated for the additional data needed.

6.5 The current Safeguarding referral process has undergone a comprehensive risk assessment and due to the significance of the associated risks relating to this current process to safeguarding adults and children it has a risk score of 25 (as at time of report).

6.6 As a result of this high risk the safeguarding team and DocWorks have undertaken a project to improve the system.

6.7 This project will provide a secure web based "store and forward" system that can take safeguarding (and other referral) forms in a variety of formats. Once in the system, the appropriate checks are done to identify the correct recipients, and if it not 100% clear who they should be sent to, then the form is placed on hold, ready for the Trust's safeguarding team to check, correct if needed and then release.

Safeguarding referral form redesign

6.8 The safeguarding team have developed an algorithm led form which ensures key information is collected and whether the referrals meet the statutory thresholds. This new process also ensures mandatory fields such as postcode are mandatory, and this will reduce the amount of held referrals on the server.

Increased access to the referral system

6.9 This project will also improve functionality across the trust and allow for patient transport team members to move away from calling in the safeguarding referrals and using a third party to complete the web-based form to being able to make the referrals directly from their own handheld device.

6.10 There have been two major reviews of the digital referral system to understand the instability issues. These reviews consisted of a BDO Audit (internal auditors report) - Safeguarding Referrals System Review undertaken in October 2022 and a Technical Assessment Report into DocWorks by the SCAS IT team in November 2022. Action plans have been monitored through the Safeguarding Committee.

6.11 Both investigations recommend moving the digital referral system to a managed service, hosted by Docworks. This is planned for the 12 June 2023.

6.12 In preparation the following actions have been taken:

- Completion and approval of a Standard Operating Procedure for the completion of safeguarding referrals
- Subject Matter Expert input to a referral form that incorporates triage questions and mandatory fields
- Overview by local authority partners to provide input to the completed version
- Completion and approval of three associated Data Protection Impact Assessment (DPIAs).
- Inclusion in Level 2 and 3 safeguarding training in how to complete a referral
- Feedback to staff following audit of referrals
- Introduction of monthly plaudits
- Safeguarding Service team members have received training by DocWorks regarding the referral process.

Child Protection Information System (National)

6.13 The Child Protection-Information Sharing service (CP-IS) helps health and social care professionals share information securely to better protect:

- Children with looked after status
- Those who have a child protection plan
- Expectant women who have an unborn child protection plan.

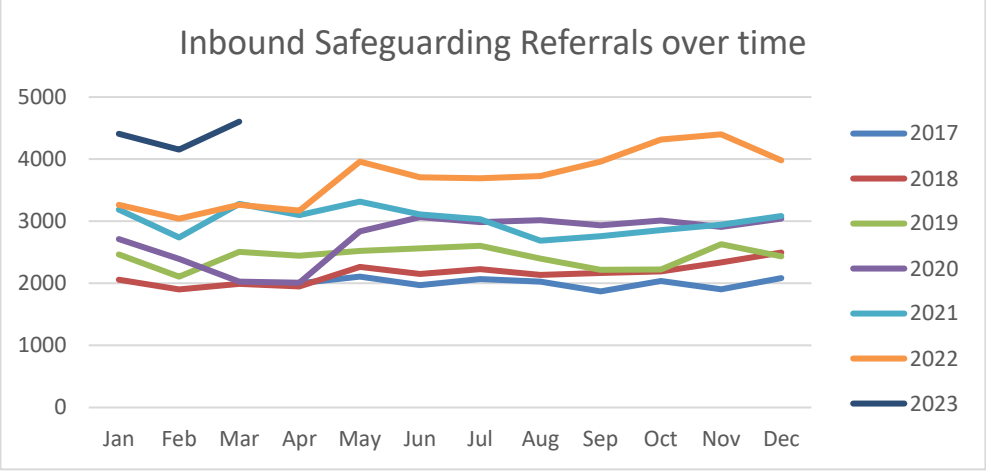
6.14 It is recognised by NHSE as best practice to ensure all health trusts have access to it. SCAS and SWASFT (South Western Ambulance Service Foundation Trust) are in the process of achieving this which was described in Safeguarding Committee on 12 May 2023. This change is planned for release in 2023.

Safeguarding Referral Activity

6.15 The Safeguarding referral numbers are generated form the Computer Assisted Software (CAS) 120 ePCR (Electronic Patient Care Record) by frontline crews and account for 39% of all safeguarding referrals with CAS 120 'scribe' referrals accounting for the rest (PTS and 111). The dashboard used for the data collection has been refined in response to the Rapid Appraisal Review in July 2022. It is at its final stage with user testing to be completed.

6.16 The graph below shows the increase in referrals in the past four years. The overall total safeguarding referral activity has **increased by 72%**. In the first three months of 2023, **there is a 38% increase from the same period last year**.

Figure 5



6.17 A rapid review of the upward trend in 2022 shows a potential improvement following the CQC inspection 'in May 2022, with increased focus on Safeguarding and a potential positive response to the start of Safeguarding Level 3 training which commenced in September 2022.

6.18 Other factors related to an increase in referral are:

- The introduction of a new safeguarding team
- An increase in high profile safeguarding cases within local and national media
- New policies and processes and improvement measures as a result of the CQC report published in 2021/2022

- Increased auditing and feedback from the safeguarding team, new training and other SCAS campaigns.

Current 2022/23 Position

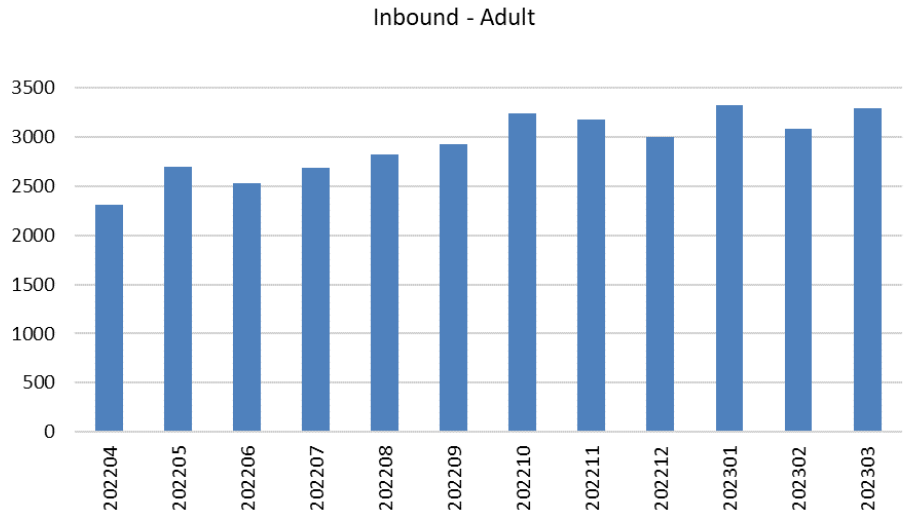
6.19 The Total Safeguarding Referral numbers for 2022/23 are:

- Total Adults 35,086
- Total Child 12,967
- Total not recorded 3,850
  (unable to establish if adult or child due to incomplete referral form)
- **Total for all 51,903**

Safeguarding Adult concerns

6.20 There have been a total 35,086 Adult referrals in 2022/23 with the highest reporting figures being October 2022, January 2023, and March 2023

Figure 6



Adult Referrals

6.21 A safeguarding referral does not necessarily mean there has been abuse, omission of care or neglect but is a concern that there may have been. All adult safeguarding concerns are coordinated by the DocWorks system which gives the SCAS Safeguarding Team data regarding number and type of referral to be collected and analysed.

6.22 Adult safeguarding duties apply to an adult who:

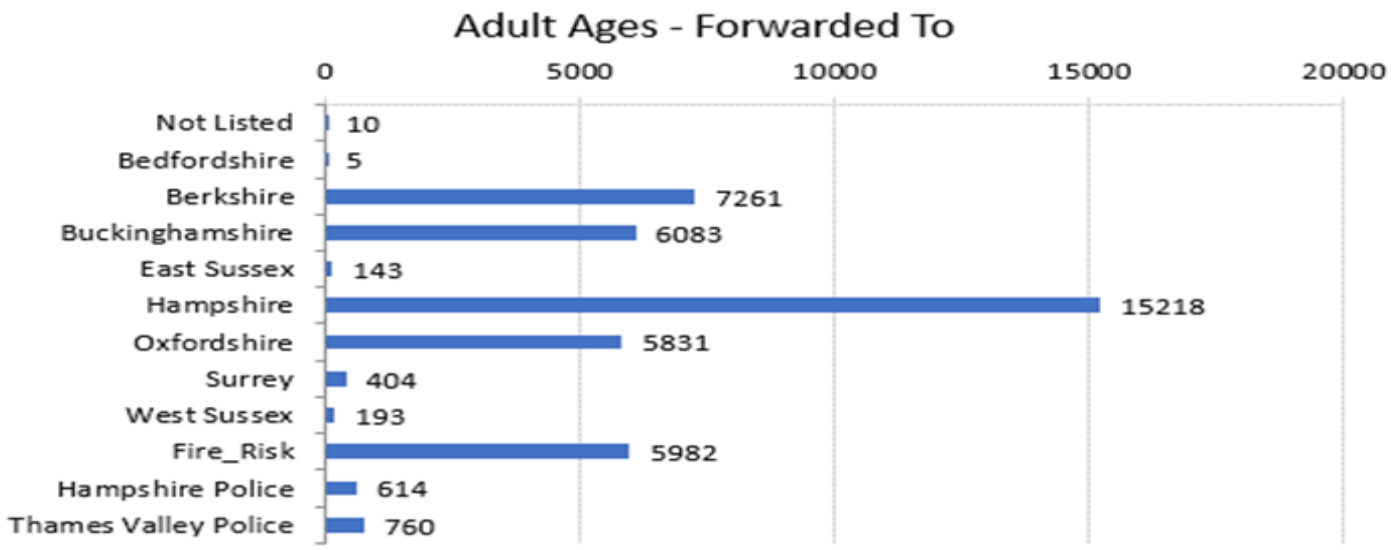
- Has needs for care and support (regardless of if the local authority is meeting any of these needs)
- Is experiencing, or at risk of abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

6.23 Currently SCAS use one referral form for our local authority partners and this can cause challenges as

cases may not meet the criteria for a safeguarding referral instead focusing on the welfare needs of an individual.

6.24 Following audit and closer scrutiny referrals do not always meet the Care Act (2014) thresholds for safeguarding duties and other referral routes may be more appropriate to support the person, for example signposting to other welfare services.

Figure 7 **2022-2023**



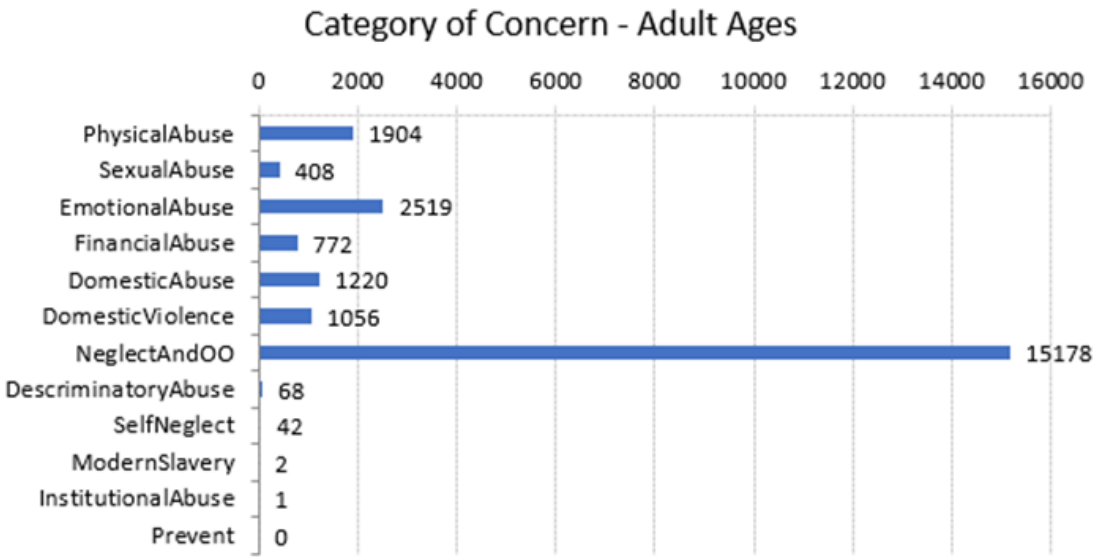
Analysis of referral destinations

6.25 Figure 8 above demonstrates that Hampshire has the highest proportion of safeguarding referrals for adults, and this is aligned to the proportion of children's referrals. It also corresponds to our trust operational delivery where Hampshire has the highest number of calls for a single area. Whilst we have seen a general increase in reporting the distribution of referrals is similar to 2021. This indicates that there is an increase generally but no specific theme or change in a local area.

Referrals data – abuse category – Adults

6.26 The Care Act (2014) categorised the types of abuse adults experience recommended 10 categories of concern for adults. These categories are recorded in the safeguarding referrals.

Figure 8 **2022-2023**



Analysis of Abuse types

6.27 Neglect and acts of omission continue to be the highest area of concern reported. This is in line with other agencies reporting. The significant increase in 2022-2023 compared to 2021-2022 could be attributed to changes in the social economic crisis in the UK with high rates of inflation leading to increased cases of neglect. Reference - Bywaters et al: the relationship between poverty and child abuse and neglect, March 2022.

https://www.researchgate.net/profile/Guy-Skinner-2/publication/359521182_Technical_Report_-_The_Relationship_Between_Poverty_and_Child_Abuse_and_Neglect_New_Evidence/links/6242d09521077329f2dea8af/Technical-Report-The-Relationship-Between-Poverty-and-Child-Abuse-and-Neglect-New-Evidence.pdf

6.28 Domestic Abuse and violence reporting has also increased. This trend has been increasing since the sharp increase during the COVID-19 pandemic. National media campaigns and high profile cases alongside promotional/awareness campaigns by the safeguarding team and the HR department in December 2022 may have contributed to this increase in reporting. Again the cost of living crisis is likely to have an effect on increased cases as families struggle with rising costs. Whilst not included in this paper there numorous scholary articles around the corollation between the cost of living crisis and increased referrals to social care.

6.29 PREVENT reporting remains low in our organisation, however, this is common across all similar agencies (Police/fire/social care) and a recent independent review into the PREVENT system has made recommendations for change around this process. Within SCAS the PREVENT referral pathway is being reviewed and an new process developed along with a focus on increased awarness and reporting.

https://www.gov.uk/government/publications/independent-review-of-prevents-report-and-government-response

Origination of the Referral

6.30 Data recording of origin is the same for both adults and children. CAS 120 ePR are referrals generated by frontline crews and account for 41% of all safeguarding referrals across SCAS with CAS120 scribe referrals made by SCAS Patient Transport Service and clinical coordination centres for 999/111 calls accounting for the rest.

Figure 9

Referral Type		April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023	Total for 12 Month Period
CAS120epr	1434	1701	1568	1541	1671	1636	1930	1997	1904	1974	1811	1879	21046	
CAS120Scribe	2016	2601	2469	2429	2286	2579	2733	2771	2386	2815	2652	3074	30811	

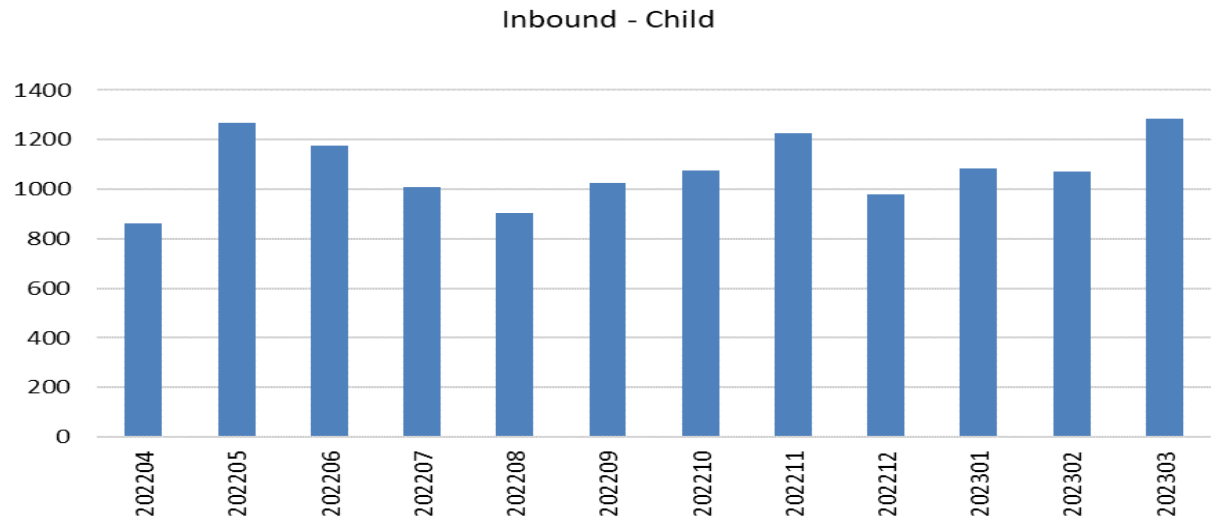
Other Safeguarding referral improvement work for noting

6.31 Safeguarding Level 2 and Level 3 training now includes how to make a high quality referral. This has already been rolled out for EOC/111 staff but will be rolled out across the rest of the trust from the end of May 2023.

Safeguarding Children concerns

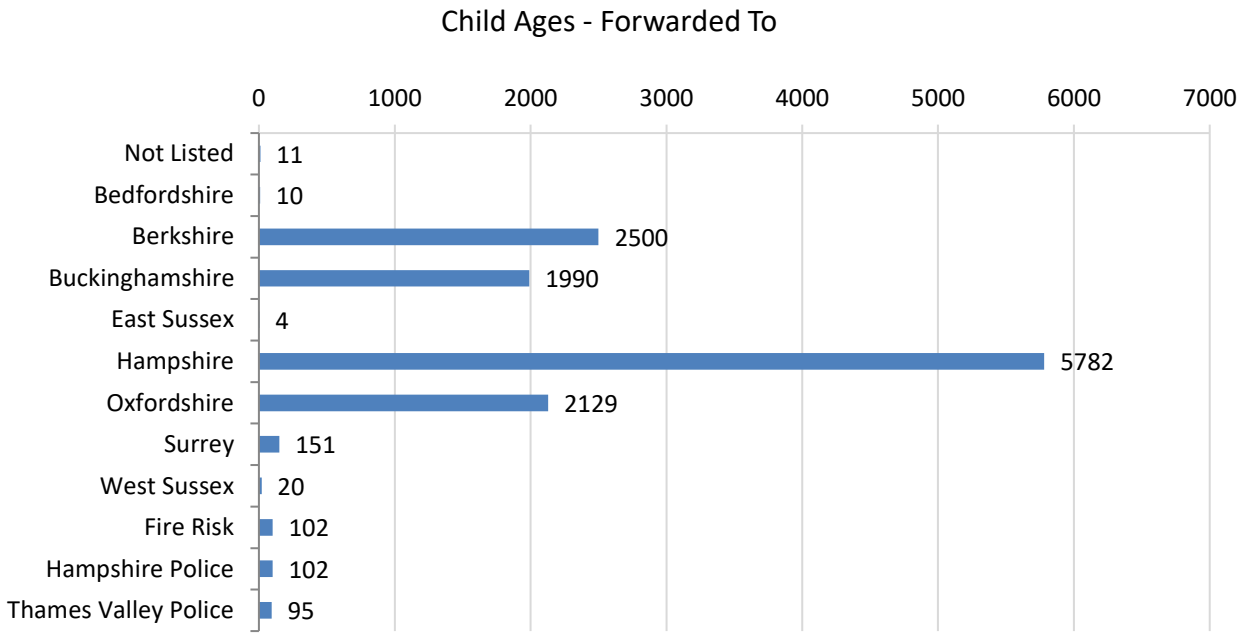
6.32 There have been a total of 12,967 Child referrals in 2022/23 with the greatest reporting months being May 2022, November 2022, and March 2023.

Figure 10



6.33 Hampshire and Berkshire are the biggest areas for referrals for children, with Oxford receiving a significant number. Referrals to Police in both Hampshire and Thames Valley are on par. Fire risks are not as high for children and they are usually counted in the adult safeguarding figures. In addition, data is reliant on the crews inputting the correct data at source.

Figure 11



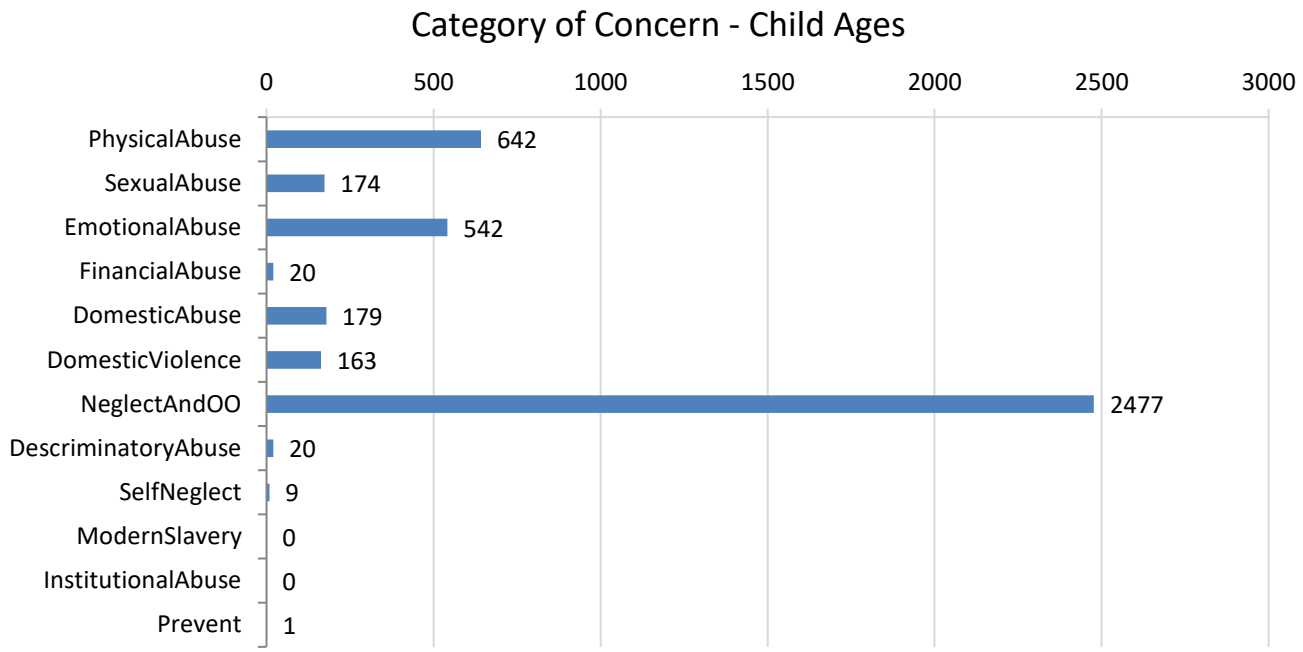
6.34 When viewed across the year 2022/23, referrals sent on to Hampshire are increasing exponentially. There are approximately 322,00 children living in Hampshire, 124,146 children in Berkshire, 161,820 in Buckinghamshire and 167,00 in Oxfordshire. The almost double number of children in Hampshire may explain the large number of referrals being sent to Hampshire Local Authority.

Categories of abuse

6.35 There are four legal categories of abuse for children: Physical, Sexual, Emotional and Neglect. SCAS systems record additional sub catergories as it is recognised that children can be exposed to other types of absue such as modern slavery and radicalisation which generate different referral types for example PREVENT referrals for those children believed to be at risk of radicalisation. This is why figure 13 shows 7 catergories of concern.

6.36 In addition to abuse, as seen in graph below, the highest area of concern for children is that of neglect. Crews often attend homes where there has not been time to ‘prepare’ or clean up before a professional arrives and ambulance staff are in the unique position of seeing how children are spending their everyday life. To address this theme, neglect is included it in training at Level 2 and 3, with slides that discuss child development, Adverse Childhood Experiences (ACEs) and describes factors associated with neglect.

Figure 12



6.37 Feedback from the Local Authorities (LA) to crews through the Safeguarding team in the past has not been consistent. A process for LA feedback will be a priority for 2023/2024.

6.38 There has been some internal feedback provided since December 2022 via a newly formed 'Plaudit' system which recognises 'above and beyond' practice by trust staff. This is sent from the Executive Chief Nurse directly to staff. Staff have been invited to share their stories at Trust Board and Safeguarding Committee.

6.39 In addition, during the audit cycle from December 2022, staff have received feedback as a result of their referral submission, detailed in the random audit cycle. This provides feedback on their 'scoring' as identified by the audit panel as to quality and accuracy of their referral. Staff are also contacted ad hoc for support in providing a referral or for advice.

6.40 To understand if a referral has 'converted' to a safeguarding process or not, is a good measure for SCAS to determine if referrals are appropriate. This will be a priority for 2023/2024 as it will provide a key indicator for the appropriateness and quality of a referral.

7 Learning Disability (also recorded in MH and LD Annual Report 2022/23)

7.1 The Mental Health (MH) and Learning Disability (LD) Team introduced the role of Learning Disability Specialist in November 2022. The priority of this post is to focus on service improvement for learning disability and neurodiverse patients, as well as internally, support for staff with learning disabilities and/or neurodiversity. The key aims are:

- Determining the key strategic priorities for SCAS, incorporating the wider learning disability agenda to deliver vision and the strategic objectives. This will improve the patient experience and journey for those with learning disabilities and those that are neurodiverse.

- Act as the Subject Matter Expert (SME), supporting our colleagues across SCAS to continuously learn and improve service development and delivery; to implement SCAS vision in support of those with learning disabilities and those who are neurodiverse. (We will do this by using learnings from our internal and external complements, complaints, and feedback, ensuring we include the voices of patients, family and carers of people with LD and autistic people.)
- Represent SCAS externally in commissioning and strategic groups, promoting innovative working regarding service improvement and care for those with learning disabilities and those who are neurodiverse; further ensuring any national or regional learnings are adopted throughout SCAS.

Achievements of 2022/2023

7.2 The Learning Disability Specialist role since November 2022.

- Completed 29 out of 32 actions on the Learning Disability Standards action plan that accompanied the Learning Disability Strategy.
- Updated training materials for ambulance crew training and 999 and 111 call handlers, to enable them to better understand how to support patients with learning disabilities and neurodiverse patients.
- Celebrated Neurodiversity Celebration Week in March 2022 with internal Yammer posts and on the intranet.
- Engaged with Learning Disability Partnership Boards and charities across SCAS region to gain patient and family feedback, and work towards co-production.
- Engaged with Learning Disability Liaison nurses in hospitals and community learning disability teams to work together to improve our services for patients when travelling to hospital.
- Engaged with Learning Disabilities Mortality Review (LeDeR) panels across the region.
- Enabling the Oliver McGowan training module to go live on our e-learning platform and is now mandatory for all staff (as of April1 2023).
- Supported SCAS education department to implement reasonable adjustments for staff.
- Undertook an independent audit of our operational ambulances by Autism Champions to look for future opportunities to make our ambulance more accessible and adaptable.

Learning from Lives and Deaths of People with a Learning Disability and autistic people (LeDeR)

7.3 Local Integrated Care Boards (ICBs) are responsible for holding LeDeR reviews to explore areas of learning, opportunities to improve, and examples of excellent practice. As a health trust, SCAS are responsible for providing information for any patient reviews whom we have provided any care and treatment for and be part of any multi-agency discussions about how the trust could contribute to the improvement of services for people with learning disabilities and autistic people.

7.4 Previously, the Safeguarding Service were limited to only supplying information for LeDeR reviews. However, the new Learning Disability Specialist position has enabled SCAS to actively engage with LeDeR panels across all ICBs in our footprint, to ensure SCAS are part of any learning and to support the multi-agency response to improving health inequalities for people with learning disabilities and autistic people.

7.5 Between 2022-2023, SCAS were not directly involved in any LeDeR reviews. This information will now be logged separately.

The Oliver McGowan Mandatory Training on Learning Disability and Autism

7.6 One of the SCAS mandatory e-learning modules for 2023-2024 is The Oliver McGowan Mandatory Training on Learning Disability and Autism. This national module was developed in response to the Health and Care Act (2022), which introduced a requirement that regulated service providers should ensure their staff receive training on learning disability and autism. The training has been co-produced with people with lived experience of learning disability and autism, trialled, and independently evaluated.

7.7 The aim of the training is to reduce health inequalities and improve services. This e-learning module is the first part of a two-tier training programme for health and social care staff. As part of SCAS' commitment to patient care and learning more about learning disabilities and autism, all staff are required to complete the online learning module. The second part of the tier 1 and tier 2 training will be rolled out by local ICBs in future months.

8 Child Death Reviews

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

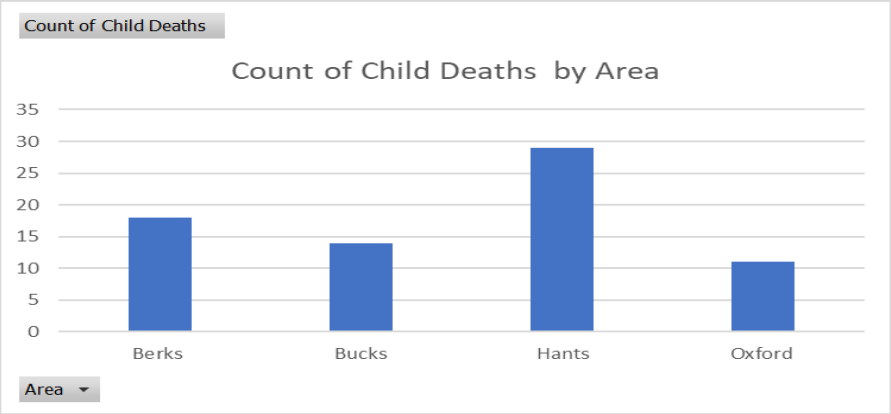
8.2 In addition, the Safeguarding Service represents the Trust at Joint Agency Response (JAR) meetings in response to unexpected child deaths where children are known to reside locally or have been known to SCAS.

8.3 The data collection for child death for 2022/23 has been inconsistent due to several factors; information provided to the safeguarding service as a 'paediatric arrest' being unreliable and the historical lack of a functional working relationship with CDOP's. The Named Professional Children is the lead for this area and a standard operation procedure is now in place for child death reviews.

8.4 Noting the potential unreliability of data, the Safeguarding Service were aware of 69 paediatric cardiac arrests in 2022-2023, averaging one a week. Of these 69, one was an adult, two achieved Return of Spontaneous Circulation (ROSC) and 5 were not recorded on the current systems.

8.5 In total the safeguarding service responded to 62 child deaths. The graph below shows that Hampshire had the highest recorded number of child deaths at 29, Berkshire at 18, Buckinghamshire 14 and Oxfordshire 11. There were none recorded as being Out of Area.

Figure 13



8.6 In addition to improved and more consistent data collection, new processes have been developed such as inviting front line staff to attend JAR meetings, Operational Managers to prioritise these meetings for their teams and EOC staff to inform the Safeguarding Service of any child death at the earliest opportunity.

8.7 Since January 2022, the Named Professional Children has attended every JAR alongside a clinical representative to offer support and develop effective working relationships.

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

8.9 There will be significant work completed in 2022/23 on themes derived from the analysis of recent child deaths such as, an emerging theme of child suicide identified in Q1 of 2023/24

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

Section 42 Enquiries (S42)

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

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

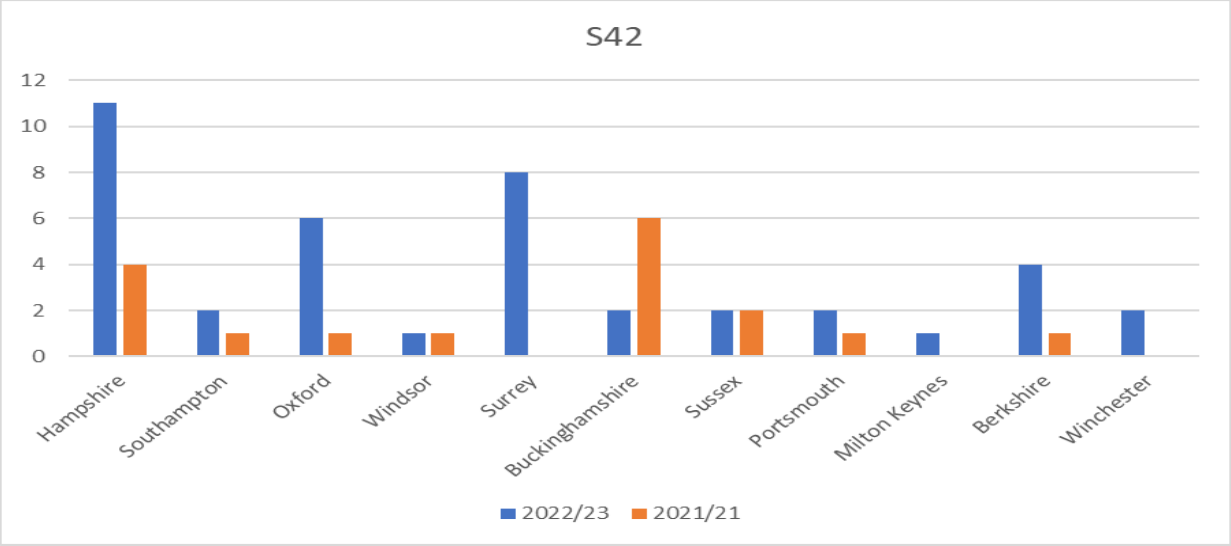
9.3 Each enquiry is taken extremely seriously, an investigation is undertaken, and any identified learning assembled and disseminated.

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

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

9.6 During 2022/2023 there were **40 requests** for full Section 42 enquiries. This is a 135% increase in comparison to the previous year (2021/2022). This is positive as it demonstrates more referrals have met the Section 42 criteria. It can also be attributable to the overall rise in referral rates.

Figure 14



Analysis of themes of S42 enquiries

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

- Delays in ambulance attendances, with harm/death coming to some of those patients.
- Failed audits by EOC call takers.
- Alleged injuries from PTS when returning patients home.
- Staff behaviour (rudeness)

9.8 The Safeguarding Adult Specialist provides feedback to the service lines via clinical governance leads and topics are included in safeguarding training programme for 2023/24.

9.9 In addition, there have been several examples where themes from SAR have been highlighted in Staff Matters (a SCAS internal communication publication) or Operational bulletins, such as homelessness.

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

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

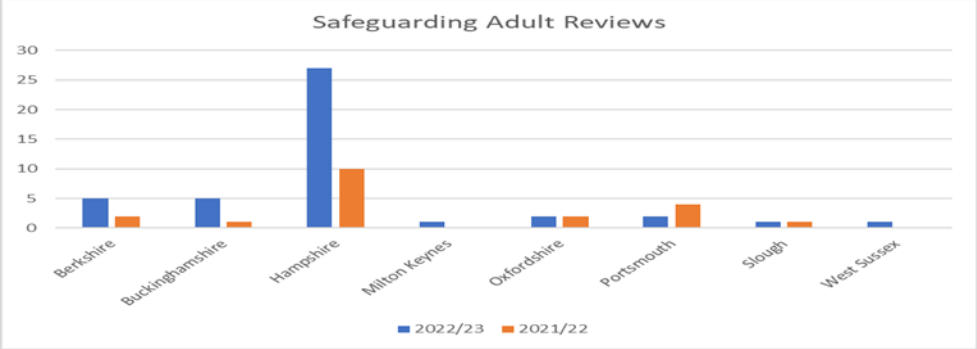
9.11 All SAR and Child Safeguarding Practice Reviews (CSPR) (previously known as Serious Case Reviews) notifications require detailed exploration of Trust IT software systems and clinical records for the relevant adult/child. Statements may be required from key staff involved and on occasions may be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

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

9.13 The total picture for SAR investigations has not changed much since 21/22 – see graph below. The

team contributed to 44 SAR's in 2022/23.

Figure 15



9.14 Learning from Safeguarding Adult reviews (SAR) 2022-2023

In 2022-2023 the safeguarding team contributed to 44 SARs due to the safeguarding team undergoing a period of transition and the varying timescales for SAR publication not all of the SAR feedback has been collated.

What we do have is two SAR cases from 2022-2023 period that have recently been published with the following learning for SCAS:

- There are barriers to effective communication of safeguarding concerns with information sharing across several agencies often be very limited. The SAR's found that Social care services, hospitals and the ambulance service sometimes held individual parts of the picture, but were unable to share this information effectively.
- Current systems and processes prevented members of the public being heard.
- Risk Assessment and making safeguarding personal were not always considered and there is sometimes a lack of professional curiosity and awareness of hidden harms by ambulance crews and other healthcare professionals.
- The impacts of self-neglect and of coercion and control within a situation are not always easy to detect.
- Healthcare professionals do not always understand why victims of domestic abuse may not be easily able to talk about their situation.
- The use of Toolkits such as DASH assessments should be considered when dealing with Domestic Abuse cases.
- Safeguarding referrals should be completed each time a Safeguarding concern is noted by professionals.

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

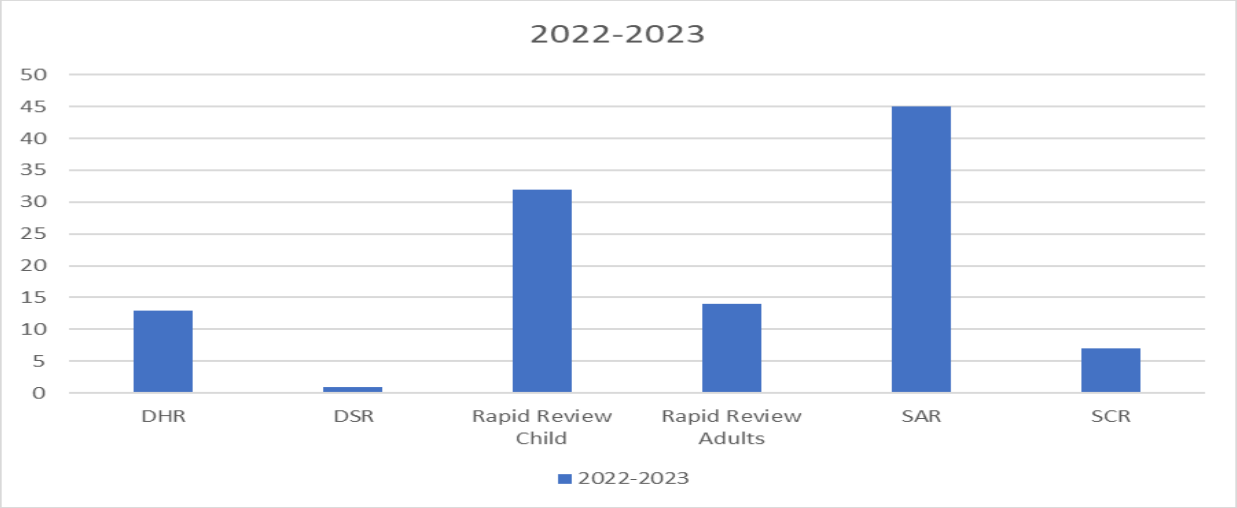
The toolkits such as DASH are already available to crews and the safeguarding team plan to promote these toolkits through supervision and training sessions throughout 2023 and 2024.

9.16 In addition to a SAR process, the Trust has been involved in a total of **45 multi-agency Safeguarding Adult Reviews, 14 Domestic Homicide Reviews and 14 Adult Rapid Reviews,** which met the criteria of Section 44 of The Care Act (2014).

Child Reviews

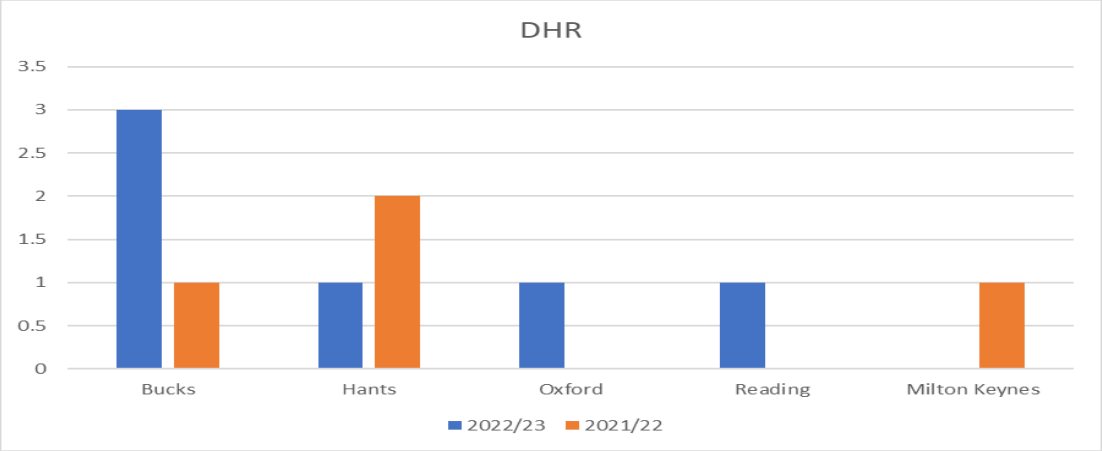
9.17 There have been **7 Safeguarding Children's Reviews and 33 Children's Rapid Reviews**. However, the adult team activity in this area is significantly higher – see below

Figure 16



9.18 The total number of Domestic Homicide Review (DHR) numbers are 14 and spread Trust wide in low numbers.

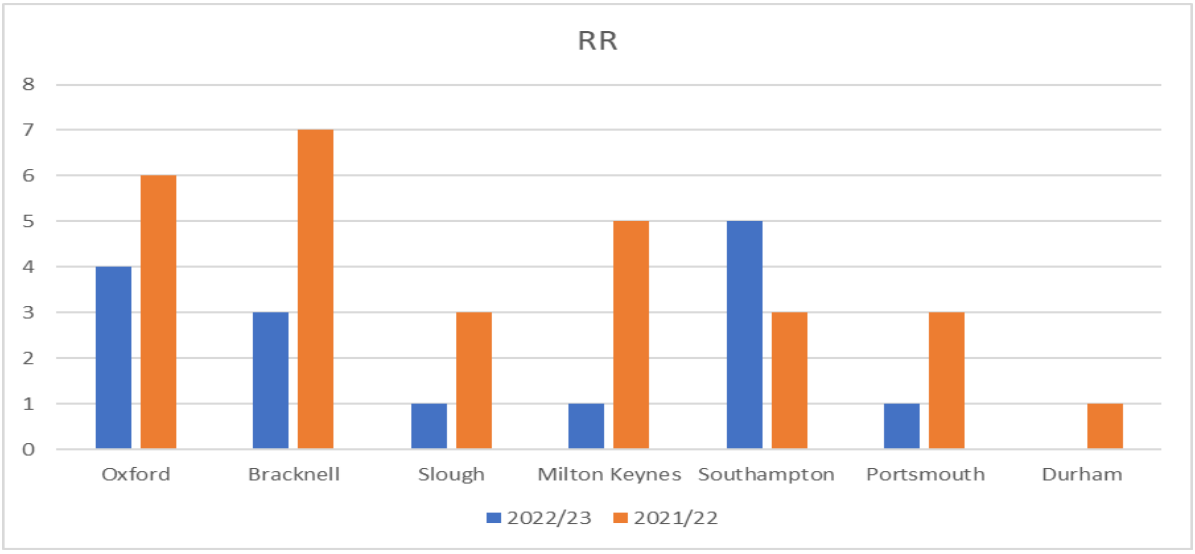
Figure 17



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

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

Figure 18



Child Reviews

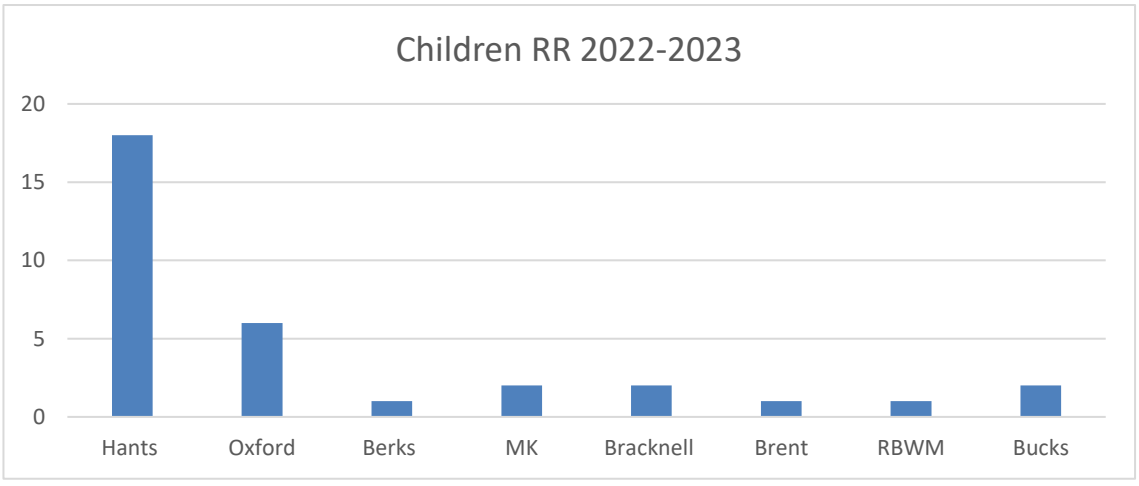
Analysis of themes of Children's Rapid Reviews and Child Safeguarding Practice Reviews (CSPR)

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

9.22 The main themes that triggered Rapid Reviews and CSPR's were domestic abuse, emotional abuse, physical abuse, and neglect.

9.23 Of the **33 Rapid Reviews, 18 were in Hampshire (54%)**

Figure 19



9.24 As a result of themes from all reviews the team have responded in the following ways:

- Included themes in new safeguarding level 2 and 3 training packages
- Provided Section 42 and non-mobile baby training to Level 1 leaders trust wide as a bespoke package
- Provided training on how to complete a high-quality referral to Tier 1 leaders trust wide as a bespoke package

- Invited staff to attend practitioners' events when appropriate hosted by the local authority
- Provided training to Education staff and Tier 1 Leaders on Modern Day Slavery and Domestic Abuse (DA) as a bespoke package
- Provide a monthly cascade on different topics associated with learning
- Attended DA voluntary services for information and 'lip balms' with helpline attached for staff in control rooms
- Approved a DA Policy for staff and patients
- Included DA as a topic in the audit cycle
- Actioned SAR with Oxfordshire around fire safety for vulnerable adults. SCAS working with Royal Berkshire Fire Service to promote their services and provisions to all SCAS staff enabling then to understand what they can offer to Vulnerable adults in the area. This will be delivered at staff meetings at the stations.
- Safeguarding team have implemented the Online reporting form to 101 which front line ambulance crews can now access whilst on the road.

10 PREVENT – National and Local Threat

10.1 As of May 2023, the UK threat level decreased to SUBSTANTIAL (meaning an attack is likely).

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

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

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

Figure 20

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

10.6 The Safeguarding Service have reported **2 PREVENT referrals this year.**

10.7 PREVENT reporting remains low in our organisation however this is common across all similar agencies (Police/fire/social care) and a recent independent review into the PREVENT system has made recommendations for change around this process. Within SCAS the PREVENT referral pathway is being reviewed and an new process developed along with a focus on increased awarness and reporting. https://www.gov.uk/government/publications/independent-review-of-prevents-report-and-government-response

10.8 The PREVENT Training compliance

	Target	2022-2023
Basic Awareness Prevent	95%	90%
Awareness Prevent (L3)	95%	74%

10.9 Improved PREVENT compliance training (target 85%). Prevent is a priority for 2023/2024.

11 Allegations

11.1 In November 2022, there were approximately **10 allegation cases known to the Safeguarding Service.** At year end, there were **60 cases**. An *Allegation Management Policy* was approved in November 2022 and embedded fully with HR and Safeguarding working together on this agenda.

11.2 Both the Safeguarding Service, Operational Leads, Freedom To Speak Up (FTSU) teams, HR and Complex Care Teams have been trained in allegation management with input from the Local Authority Designated Officer (LADO) and the DBS Central Office. Training developed by the Safeguarding Team on Allegation Management (one hour) has been delivered approximately 8 times to groups mainly consisting of TL's, CTE'S and educational staff.

11.3 A thematic deep dive report has been completed and actioned to align with the Sexual Safety Charter agenda. In addition, the Chief Executive Officer, first Senior Lead Group focused on sexism in the organisation in April 2023. This demonstrates a triangulation from three areas – HR, Safeguarding and from Trust Board outlining the seriousness of commitment to this agenda.

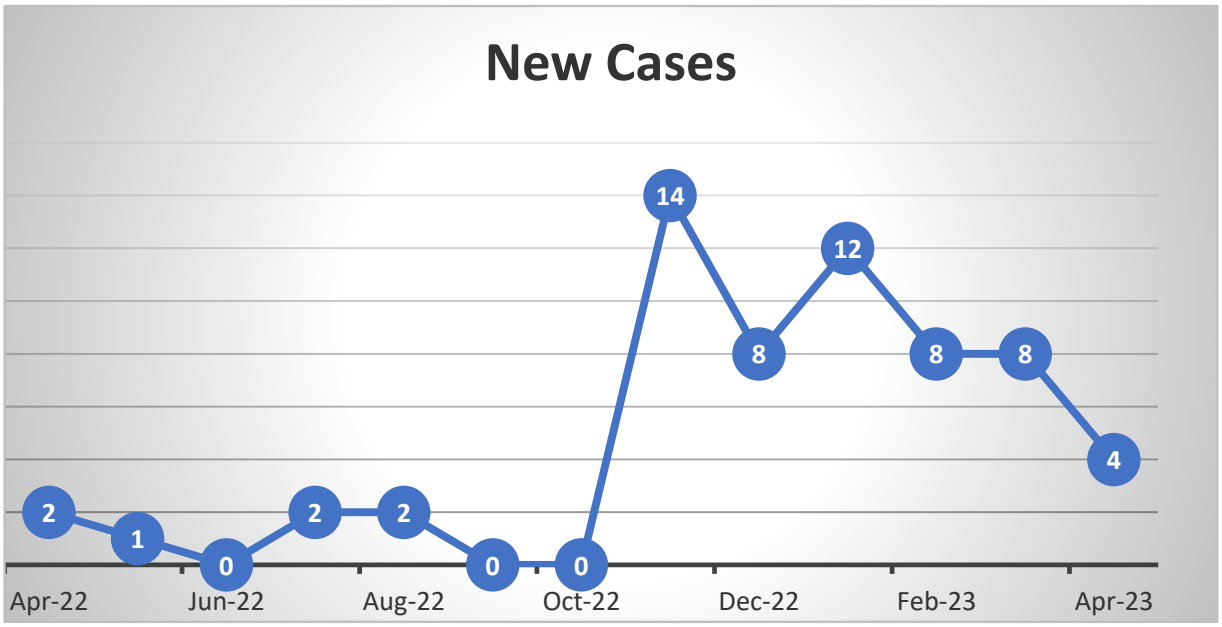
11.4 There are 3 designated professionals who work on the allegation management agenda from the Safeguarding Service and a 6 weekly review meeting takes place between HR and Safeguarding to review open cases. The AD Safeguarding has been recognised for work on Allegation management and was invited to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

Current Trust Position

11.5 In order to understand the significance of the cases, a dataset has been constructed to identify themes, learning, patterns of behaviour or areas which may require additional exploration. The information is taken from the Safeguarding Service Allegation Records. From the graph below **89% of cases** were

reported since November 2022. The transformation of the Allegation process aligns with the increased numbers.

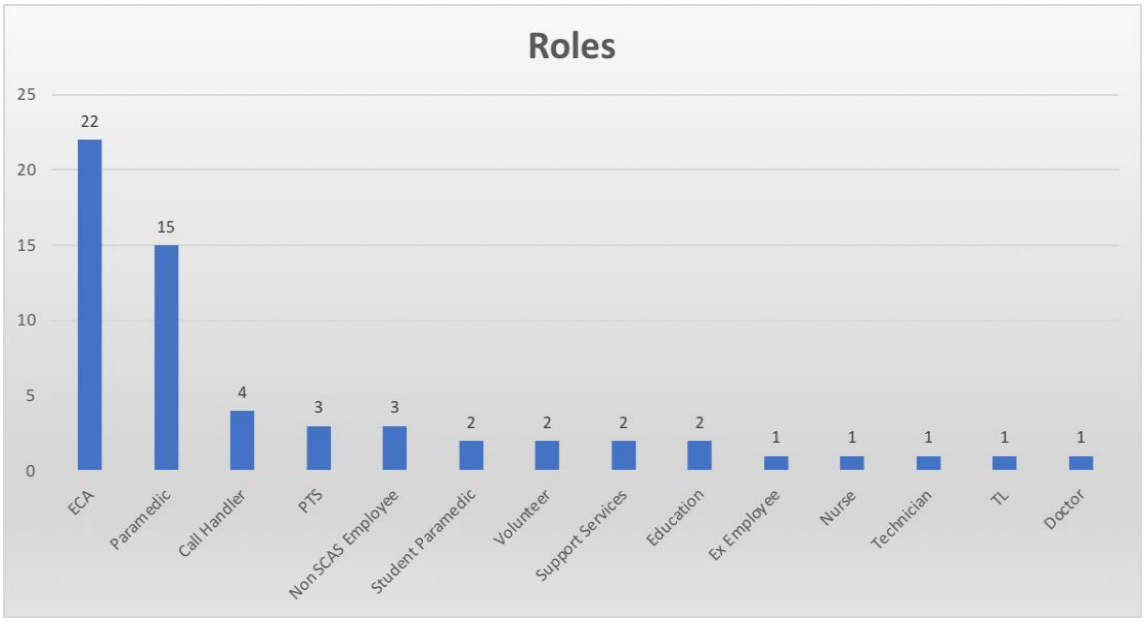
Figure 21



11.6 On review of job role, the highest category represented at **37%, relates to the ECA role.**

11.7 The second highest represented at **25%, relates to the Paramedic role.**

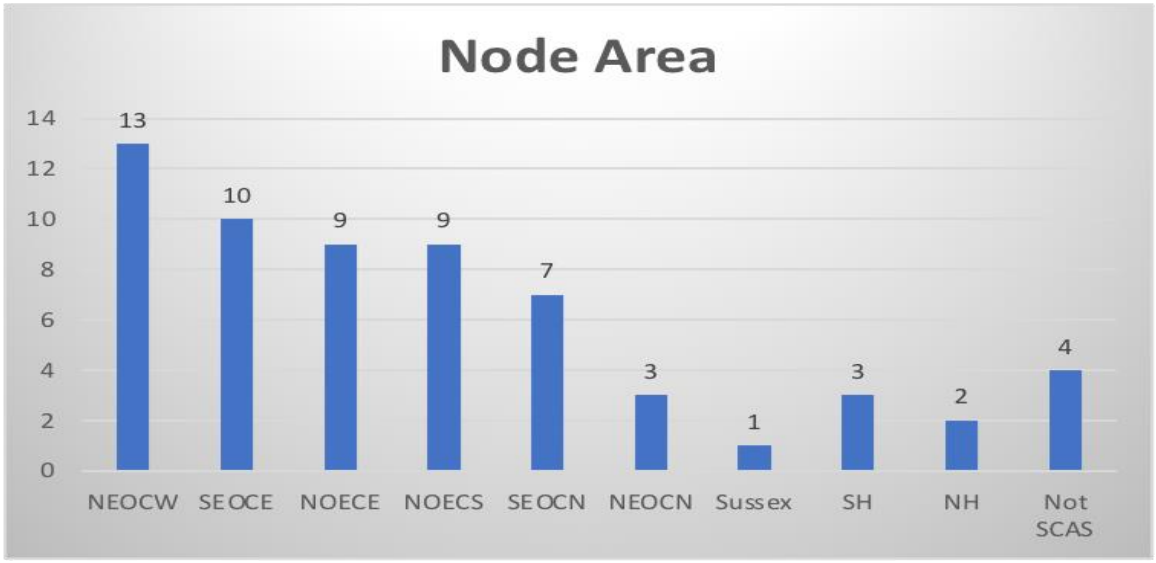
Figure 22



11.8 **73%** of the cases relate to male colleagues.

11.9 **57%** of cases related to the north operational nodes and **28%** related to the south operational nodes The remaining cases were in Northern and Southern House and 4 cases related to non SCAS employees.

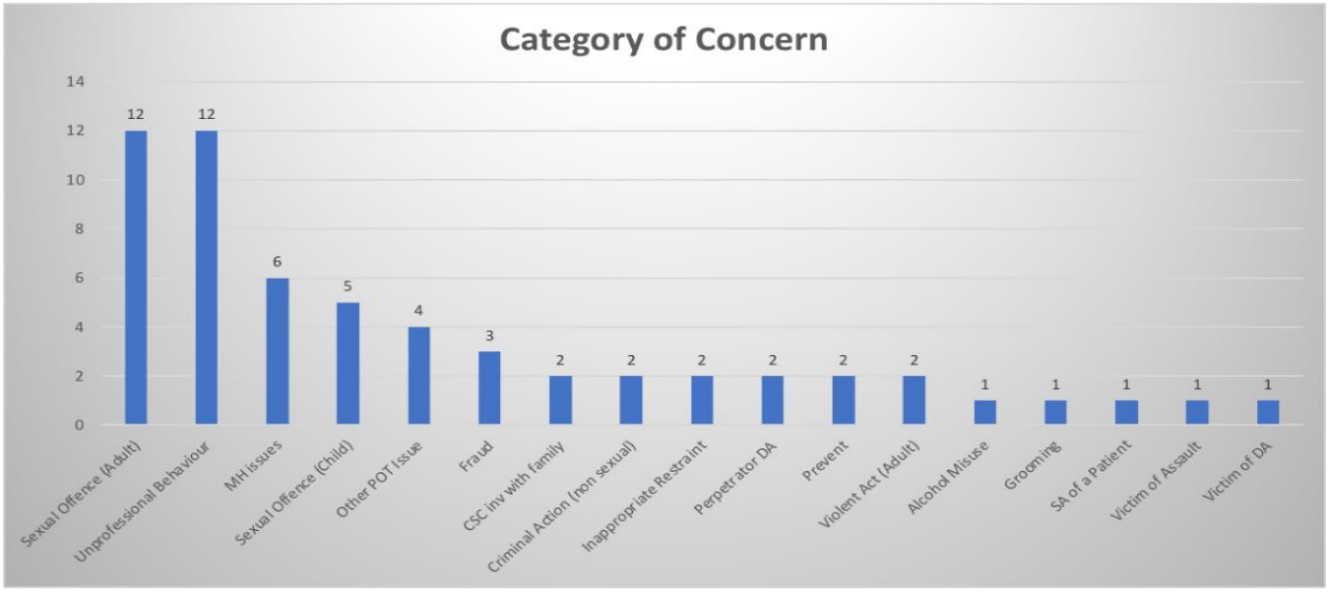
Figure 23



11.10 On combining themes ‘grooming’, ‘sexual offence related to an adult’ and ‘sexual offence related to a child’ the overall highest theme is **sexual behaviours at 30%**

11.11 When adding ‘unprofessional behaviour’ (which may include some sexualised behaviours) this overall sexual theme accounts for **51% of all cases.**

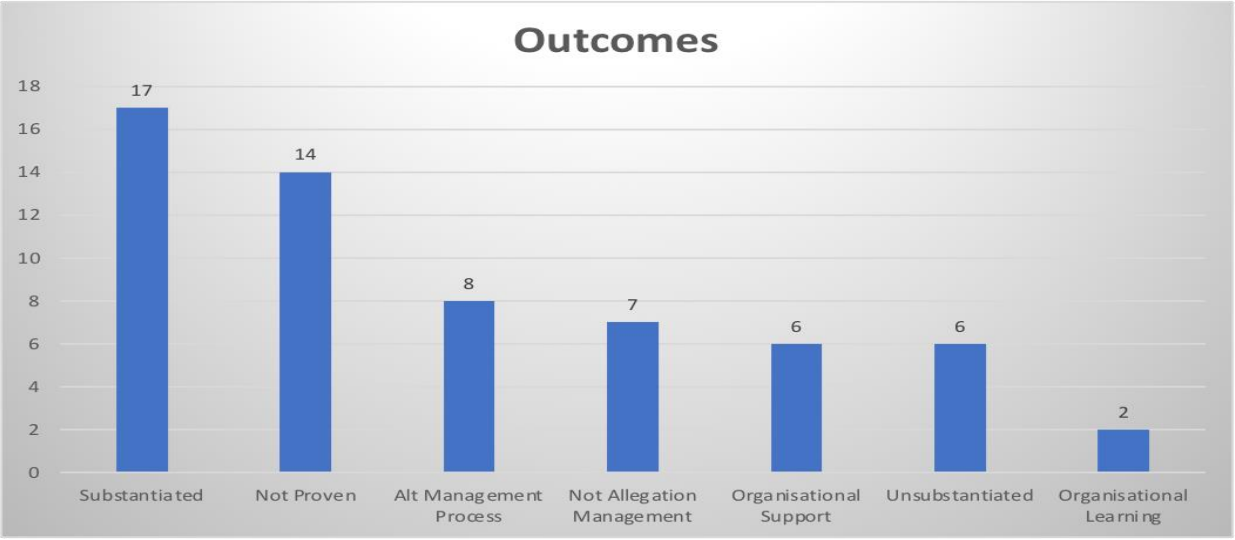
Figure 24



11.12 A Deep Dive **(Appendix 5)** looking into the theme of sexualised behaviours took place in January 2023. There were eight recommendations from this report. At the time of the Annual Report, four recommendations are progressing and four have been closed. This work will continue in 2023/24 and is monitored through the Safeguarding Committee.

11.13 For every allegation an outcome is recorded as below:

Figure 25



11.14 **The highest 'outcome' theme is 'substantiated' at 28% of all cases,** followed by '**not proven' at 23%.** 'Not proven' means the cases either did not have enough evidence at the time or the case may still be 'open' and therefore an outcome of 'substantiated' cannot be made. This may increase the number of substantiated cases.

13% of cases had an alternative management process such as capability, disciplinary etc.
12% of cases did not reach the threshold for allegation management
13% of cases required organisational support or learning either individually or as a trust

Areas of Risk associated with Allegations

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

11.16 The North nodes appear to have a greater number of staff allegations. This may be due to an embedded culture and a reticence to report and will be explored further in 2023/2024.

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

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

11.19 A priority for next year is to establish a Professional Standards forum chaired by the SCAS Chief Nurse and Medical Director. This will align to this agenda by understanding any referrals to professional body.

12 Key Progress and Achievements 2022/2023

12.1 The Safeguarding Service comprises a team of 10 members of staff – 3 administration staff and 7 trained professionals. Until November 2022, the team consisted of 3 permanent members of staff and a succession of interim staff. Despite this the team have successfully managed to achieve the following:

- Completion of all 'must do and 'should do' actions from the CQC Inspections related to safeguarding by December 2022
- Production of the Safeguarding Accountability & Assurance Framework (SAAF) workplan – recognised as good practice by NHSE which remains on track
- Improvement in the workings and reporting of Safeguarding Committee
- **The trust increased safeguarding level 3 training compliance for the 1850 members of staff in priority group A (Paramedics/Nurses/Technicians) from 18.4% in Sept 2022 to 40% next first 6 months of 2022-2023 and at the end of March 2023 had achieved 64.6% compliance.**
- Recruitment to 6 new posts
- Commencement of the Plaudit programme from Executive Chief Nurse
- Commencement of 'Safeguarding huddles' Monday Wednesday and Friday with use of planner to record actions
- Allegation Management Process embedded trust wide
- Adapted Safeguarding Level 2 training to one standard package with specific scenarios for each service line
- Creation of new internal safeguarding Level 3 training package
- Improved partnerships with local authority, NHSE, CQC, Police,
- Improved visibility e.g., Communication cascades, Level 1 Operational Leaders meetings with training, CG Leads meetings, in situ working at Northern and Southern House, reports to Board, Executive and Quality and Safety Committee
- Setting of portfolios for team members with key objectives
- 8 Policies written and approved November 2022
- Active membership of Serious Incident Review Panel
- Board Safeguarding Training – December 2022
- Input to dashboard requirements
- Safeguarding described as 'effective' in Ofsted Inspection December 2022
- Bespoke training package to Level 1 leaders
- DBS and LADO training to HR, FTSU, Education
- Audit Programme.

13 Priorities for 2023/2024

- Ensure compliance of **85% Safeguarding Level 3 Priority Group A by August 2023**
- Ensure compliance of **85% Safeguarding Level 3 Priority Group B by March 2024**
- Ensure compliance **85% Mental Capacity Act training by year end 2024**
- To finalise an improved induction training programme to include DA, Allegation management and suicide awareness
- To embed the Level 2 new training programme and adapt to any feedback on delivery
- To commence and embed the new internal programme delivery for safeguarding Level 3
- To commence and embed the Priority B Group delivery PTS and ECA
- To commence a Professional Standards Forum
- Recruitment Team to be trained in Allegation Management
- Deep Dive exploration with North and South Nodes to understand themes from allegations in these areas

- To continue and complete all actions associated with the Deep Dive Report and Sexual Safety Charter
- Embed a group Safeguarding Supervision Programme for the identified priority group
- Involve Local Authority Partners in the testing of the new referral
- Ensure the new ICT Server is fully embedded
- Ensure adaptations are made to the dashboard i.e., DA and DV combined category, neglect only for children etc.
- Ensure all SOP's agreed at Safeguarding Committee
- Embed new LPS/MCA Role – due to start May 2023
- Create and deliver Volunteer Safeguarding training
- Creation of a Safeguarding Annual Star award at Trust award ceremony
- Consider a format for safeguarding champions
- Stage 2 of the Docworks programme inc. safeguarding app
- Ensure CPiS is embedded trust wide
- Focus on Prevent agenda to increase compliance
- Approve and embed Restraint and Restrictive Practice trust wide
- Ensure CPiS is embedded trust wide
- Ensure Feedback from Local Authorities is provided to staff
- Improve data collection to include 'conversion' rates from Local Authorities trust wide
- Align to CEO 10 point plan.
- To remain within budget and review any opportunity for CIP (cost improvement savings)

14 Examples of Good Practice/Change in Practice

Change of Practice

Example 1

Joint Agency Review meetings are attended by the Safeguarding Team and an invitation to attend sent to the Clinical Operations Managers for that area. North Operations South and East are both proactive in attending these meetings to ensure the clinical information for the patient is provided. South East Operations have also taken on board the need to attend these meetings and are now regularly present.

Example 2

A patient experience complaint was raised in Q4 following concerns by a Health colleague due to a lack of understanding around non-mobile babies and non-accidental injury. From this the Team Leader and Clinical Team Leaader for the clinician involved worked hard to ensure that there was learning and reflection and involved the Named Professional Safeguarding Children to assist in this.

Example 3

Feedback from Police on work with Safeguarding Children Team and Mental Health Team regarding suicide Thanks *so much for bringing this to my attention. Joined up working is so important & I know you care about that too.*

Example 4

The information contained in the ambulance crews safeguarding referral generated a Section 44 Care Act enquiry. This type of enquiry prompts the local authority to investigate the death of a person with care and support needs and brings about a multiagency response.

These enquiries focus on learning and change and the ambulance crew's documentation has attributed to the following changes:

a) The care home has instigated a choking specific policy and protocol that recognises choking as a reversible cause and allows the staff to consider starting cardiopulmonary resuscitation (CPR_ even when a do not attempt cardiopulmonary resuscitation (DNACPR) is in place.
b) The care home has conducted an immediate review of all food served at the care home and a change to diet plans a full assessment of all care home residents by an independent SALT assessor
c) The care home will return to digital record keeping as the paper records were out of date with the patient's preferences suggesting the patient liked tuna sandwiches but the speech and language therapy (SALT) assessment which reviews the patients ability to swallow, suggested the patient was not given bread or solid foods.
d) The care home has commissioned a further independent review of care within the home, to assess for other areas of improvement.

Example 5

Formalising the Allegation Management Process and production of the Deep Dive Report changed the process to include HR regularly

Case Examples

Case 1

The Safeguarding team received an e mail from a very experienced Paramedic, who had been to a call that had "bothered" him and he wanted to touch base to confirm all bases. The call was for a female giving birth at 26 weeks. The baby had been born prior to crew arrival. The property was unfit for human The crew took the baby to the vehicle to check the baby, and to transport to the hospital it appears to be a concealed pregnancy as the staff at labour had no information.

The crew contacted the team to request advice re the animals predominantly, and team responded and asked for an update re the baby. That afternoon the team had an email to say the male on scene was a Registered Sex Offender and that it was a concealed pregnancy and the couple had previously had children removed.

Later we heard that the Local Authority were getting a court protection order to remove this child. This call was hi-lighted to the team due to the Team Leader being "bothered" by a call. The crew knew something was not correct and followed the process and protocol, excellent collaborative working with SCAS, hospital, and LA.

Case 2

Crew called to an elderly lady in cardiac arrest, on arrival the crew were presented with an emaciated, dehydrated elderly female with a pressure sore down to the bone, and the scene is described as horrific. She was in the care of her children. Crew were able to co-ordinate a referral to Police, RSPCA and Local Authority as well as care for the patient and family.

Case 3

Early on a December morning a call was placed from a residential care home to 999 to report a patient was choking, the caller was flustered and unable to provide concise details. CPR instructions were started after ineffective breathing was disclosed and the patient put on the floor, then a voice in the background shouted

the patient has a do not attempt cardiopulmonary resuscitation (DNACPR) and CPR was stopped, then moments later it was established the patient didn't have a DNACPR and CPR instructions started again only for another voice in the background to shout, the patient is fighting back. The call was chaotic and there was also evidence of others swearing and shouting in the background. This was a particularly challenging call for the call taker to manage as changing protocols from CPR to DNACPR and back again isn't easy, the call taker recorded all of this on the 999-call log and even notified the ambulance crew of the concerns.

In addition to the notes the 999 the call taker put on for the crew, a previous concern by the ICB had been raised with the SCAS safeguarding team who worked with the demand practitioners' team to put on a dispatch warning to alert crews to safeguarding concerns at the address. The ambulance crew see the notes enroute and included them in their safeguarding report including a detailed safeguarding referral.

The local authority then raised a request for further details through the ICB who linked in with SCAS safeguarding and then Information Security & Governance team supported the safeguarding team by assessing the legal need for disclosure and rapidly releasing the call recording to the safeguarding team and local authority.

Case 4

Feedback from Oxfordshire Children Board:

Thank you for the return that you submitted on behalf of the South-Central Ambulance Service for the Oxfordshire Rapid Review concerning xxxx. The Rapid Review group was struck by how well you captured Childs voice in the submission. Although it can sound straight forward, it is not always easy to enable children to have a voice when parents are themselves requiring support and help, which was the case for xx. This Rapid Review group found that whilst professionals described what they saw and heard of xx they didn't always fully consider xx experience in his family home or use that to inform actions.

The insight provided by SCAS was therefore powerful as it helped the Rapid Review group understand what it meant for him to live in his family home They understood how he was spoken to, the expectations on where he should sleep and how he reacted to this. Descriptions were given as to how he looked, the actual words used and the concerns this raised with the ambulance crew. The crew are commended for their actions and the submission is commended for bringing this detail and 'sense of the child' into the Rapid Review discussion.

Author: Sarah Thompson
Associate Director Safeguarding
Date: July 2023

APPENDICES

Appendix 1 - National Ambulance Safeguarding Advisory Group (NASAG) Benchmarking report 2022

Appendix 2 – Safeguarding Workstream Improvement Workplan

Appendix 3 – Safeguarding Risk Register

Appendix 1

National Ambulance Safeguarding Advisory Group (NASAG)
Benchmarking Report 2022
Written by Alan Taylor
Chair of NASAG
August 2022

Presented by Alan Taylor

October 2022

Introduction

This benchmarking report details the work of ambulance trusts across the UK.

Whilst it gives comparisons between trusts in a variety of areas, it should be noted that not all trusts manage safeguarding in the same way. For example some trusts have direct referrals from crews to local authorities, some have paper referral process some have telephone or electronic processes.
The work the safeguarding teams undertake also varies across the UK. Some trusts are asked to engage with MARACs, DHR, Child Death's etc. others do not.
Also training delivery is vastly different- LAS safeguarding team deliver all face to face training and develop a blended training programme. Some others do targeted face to face and some do all eLearning. It is for each trust to decide with their commissioners what is acceptable. The three intercollegiate documents that outline the Roles and Competencies for Health Care Staff states Paramedics should be level 3 and that at least 50% of this should be delivered by specialist safeguarding staff face to face.

Also following discussion NASAG have agreed to outline what figures should be captured in each of the questions as across the UK different terms are used for example some trusts report for Safeguarding Child Practice Reviews (SCPR) information/reports provided to aid the decision to hold a SCPR some don't.
Please note there are different practices and legislation in relation to Scotland, Wales & Ni (the devolved powers) and Jersey who is part of a wider NHS Trust for safeguarding. So direct comparisons may also not be appropriate for these trusts.
It should also be noted that Covid19 has impacted some trusts greater than other, with some areas reducing external reviews and some trusts safeguarding teams were redeployed to support operational pressures. It should be noted here that NHSE communicated the importance of maintaining safeguarding functions within trusts and it was for individual trusts to ensure sufficient resources during the pandemic.
Despite all the above having comparisons it is useful, and what is known is that safeguarding workload continues to grow. It is important that the recent investments in safeguarding teams continues to ensure ambulance trusts keep pace and are able to meet there safeguarding responsibilities.

Benchmarking overview of data capture for 2021-22

Trust	Safeguarding Child in Need referral figures	Child Protection referral figures	Total Child referrals for 2021 - 22 financial year	Adult welfare/care concern figures	Safeguarding Adult referrals	Total Adult referrals for 2021-22	Total Trust Child & Adult Referrals	Number of Prevent referrals 2021-22	Number of Child Deaths provided info for	Serious Case Reviews (Child Practice Reviews)	Safeguarding Adult Reviews	Domestic Homicide Review	Number of Multi Agency Risk Assessment Conference (MARAC)	Number of Safeguarding Allegations Against staff	Size of Safeguarding team WTE.	Size of Population Trust serves	Number of patient contacts (hear& Treat/ See & treat)	Number of local Authorities Trust has in area	% of safeguarding concerns/referrals made per contact.	Services Trust provide i.e. PTS/111/IUC/Other
LAS	combined	combined	13,854	8,621	5,826	14,447	30,216 includng other outcomes	29	266	4	23	12	4051	49	12	8.78	1,103,821 face to face, 193,528 hear and treat 1,297,349	33	Total F2F + H&T= 1,207,349. Total concerns / referrals =30,216 % per incident = 2.5%	999, 111, IUC & NETS
WAST	853	1303	2156	3785	1106	4891	7047	0	64	5	3	4	NA	46	8	3.19	29535	22		EMS/UCS/PTS/NHS 111
SWASFT	Categorise in a different way so cannot	Categorise in a different way so	11,923	Categorise in a different way so	Categorise in a different way so	28,247	40,170	7	216	37	31	27	0	54	6	5.61	1469109	14	2.7	1 x MIU
SECAMB	Not Recorded	Not Recorded	4,599	Not Recorded	Not Recorded	19,160	23,759	2	185	54	41	14	Not Recorded	21 (+6 consulte	7.5		2429788	7	0.97%	999 / 111 / IUC CAS
SCAS			9,469	8,156	25,875	34,031	43,500	1	64	16	27	4		25	5	7	H&T - 87712 S&T - 219943 ST&C - 348869 = 656524			PTS/111/IUC/999
EMAS	*2,326	*1,267	*3593	*26,141	*8,409	*34550	**41,460	16	50	23	30	23	NIL	26	6.6	4.8	Hear & Treat: 27,9411 See & Treat: 25,6466 See, Treat and Convey: 454,948 = 990825	12 Local Authority's 10 Safeguarding Adult Boards 10 Children Partnerships	4.2% of all incidents (calls, hear & treat, see & treat, See, treat & convey)	* Does not include Third-Party Provider(TPP) referral numbers ** includes TPP numbers. PTS in two areas.
WMAS	Combined	Combined	15105*	Combined	Combined	38048*	53,153	19	86	40	48	47	Nil	21	3.5	5.93	1139738	27	4.70%	999, PTS and 111 (IUC)
EEAS	520	4030	6167	13487	4459	24587	30754	4	105	14	34	27	555	14	10	6.5	788419	11	3.90%	PTS, A&E
NEAS	1285	1289	2574	7451	2882	10333	12907	3	54	1	12	4	N/A	49	6	2.71	435,765	12	3%	111/999/PTS/dental/AP's/ Community Para's/ end of life / HART / SPEC / Pharmacy / first contact paramedics
NWAS	Combined	Combined	11,068	Combined	Combined	57,661	68,729	22	70	71	112	46	18	11	6.8	7.3 million		23		PES, 111, PTS
SCOT	N/A	N/A	180	N/A	N/A	1060	1240	None	Not recorded by SAS, different law and process in place	Not recorded by SAS, different law and process in place	Not formally recorded	Not Applicable @SAS	Not Applicable @SAS	Not recorded @SAS	5 WTE	5.5	600,000 scheduled and unscheduled care combined	32 Local Authorities	Not Recorded	Hear & Treat, See & Treat, Scheduled and Unscheduled care, Mobile Vaccination Units, Mobuile Testing Units. Air Ambulance and Air Transport unit. NICU transfer services.
YAS	combined	combined	8890	12622	6532	19154	28044	25	191	16 - (4 progress	40	27	N/A	30	8	5.4	849,173	13	3.30%	PTS including NE Lincolnshire/
Jersey	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded	None	0	Not Recorded	Not Record	0	Not Recorded	0	No Safeguarding Full Time	103,267	11,870	1	Not Recorded	999/PTS
NIAS	Do not record	Do not record	200	389	200	589	789	0	2	Do not record	1	1	0	2	1	1.91 Million	322282	5 HSCT	0.25%	A&E, PTS

Child Referrals

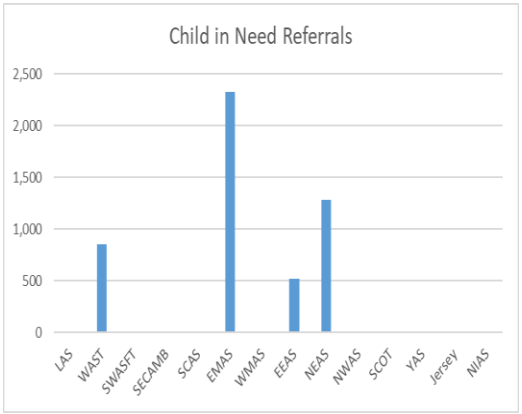
For children there are 2 elements to safeguarding and these relate to Children in Need and Child Protection.

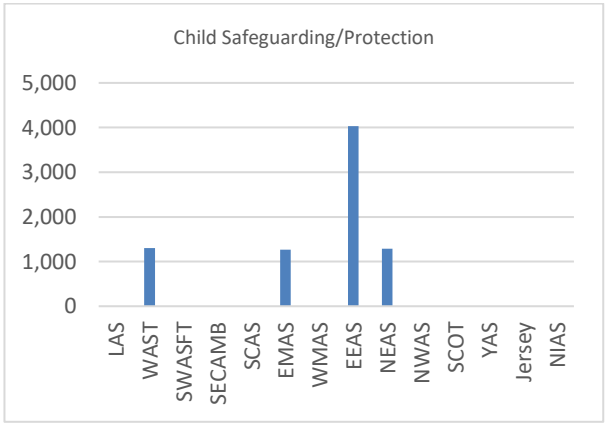
Child in Need -is where the family may need additional support to help keep a child safe.

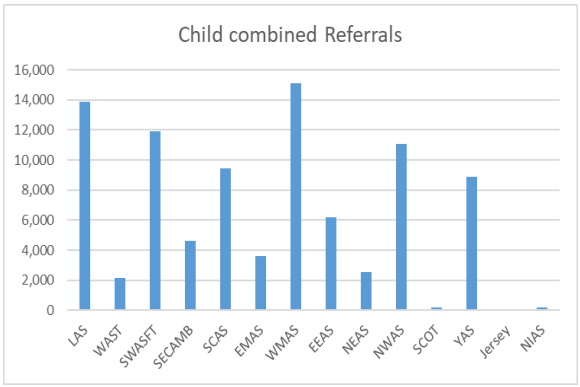
Child Protection- is where there is actual or potential safeguarding concerns.

Some trust distinguish between the 2 types of referrals and some do not.

It would be beneficial for all trusts to be able to identify the difference between a child in need and child protection. This is because the responsibilities and thresholds for partner agencies is different for these. Also the issue of consent is also different. Trust need to consider how they train staff in relation to above and also how they can improve data capture for both types of referrals.







Those trusts with high or low referral numbers should assure themselves that their reporting is proportionate and appropriate.

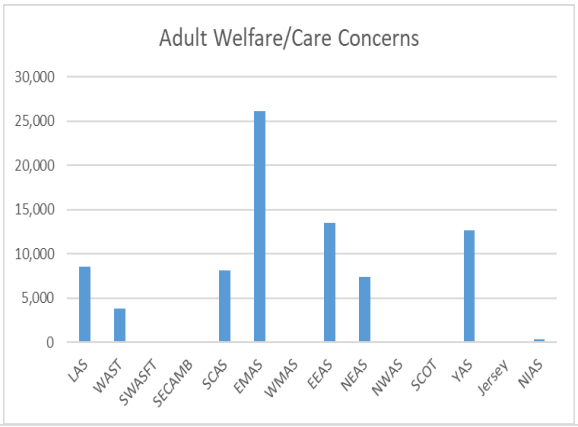
Adult Concerns

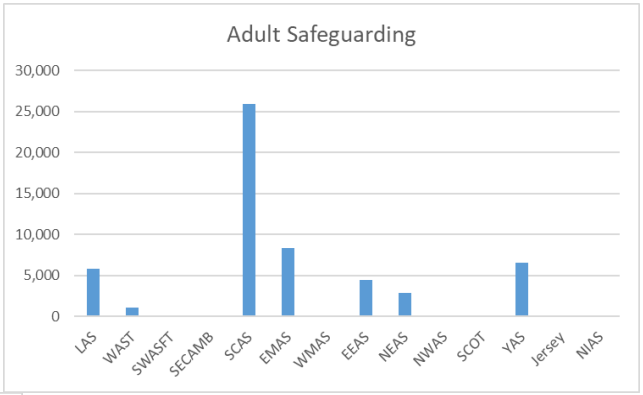
Like child referrals, adult concerns are split into two categories

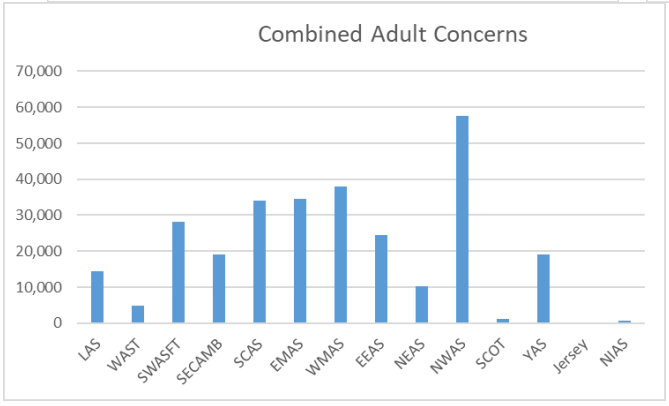
Adult Welfare/Care Concerns- where an adult needs help to keep themselves well and safe i.e. additional support with activities of daily living.

Adult Safeguarding Concern- is being or at risk of being abused, including self-neglect

Some trusts do not distinguish between the two however there are very different responses from partner agencies to these and trust should consider being able to identify these especially as consent requirements and making safeguarding personal is key in adult safeguarding ensuring trusts do what they can to empower adults to take control/decisions about their own wellbeing.



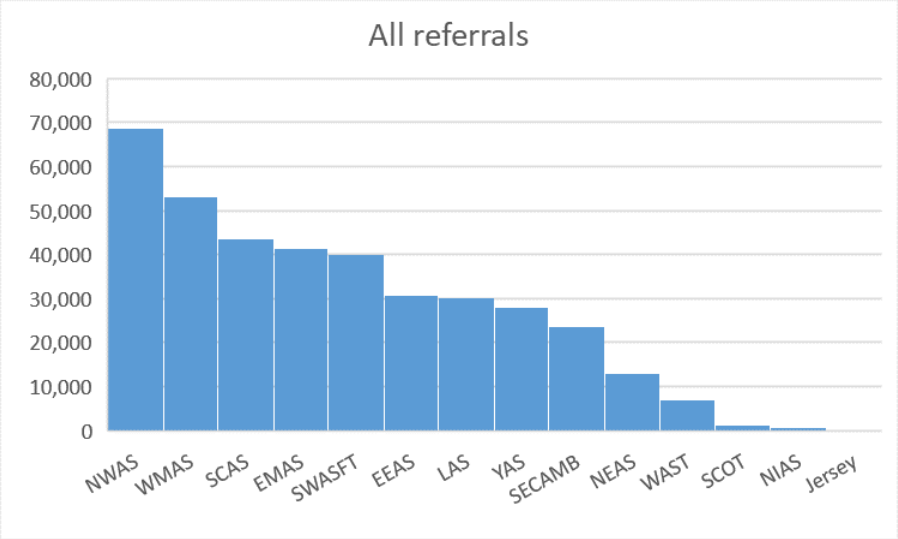




Those trusts with high (> 20,000) or low referral (<10,000) numbers should assure themselves that their reporting is proportionate and appropriate.

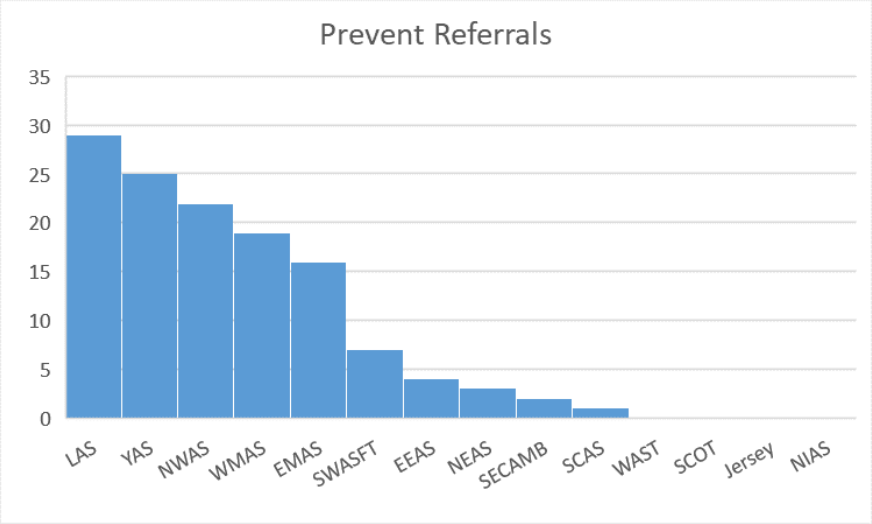
Trusts Total Child and Adult Referrals and Concerns comparison

There are several trusts with considerably higher (NWAS, WMAS) or lower (SCOT, WAST, NEAS) reporting that other trusts. These figures should be viewed with regard to the % of referrals to calls/incidents for trusts to be able to consider if there is action that they need to take to either reduce or improve safeguarding compliance. It would also be useful to discuss with safeguarding partners in local authority to see if they share concerns regarding high or low levels of reporting.



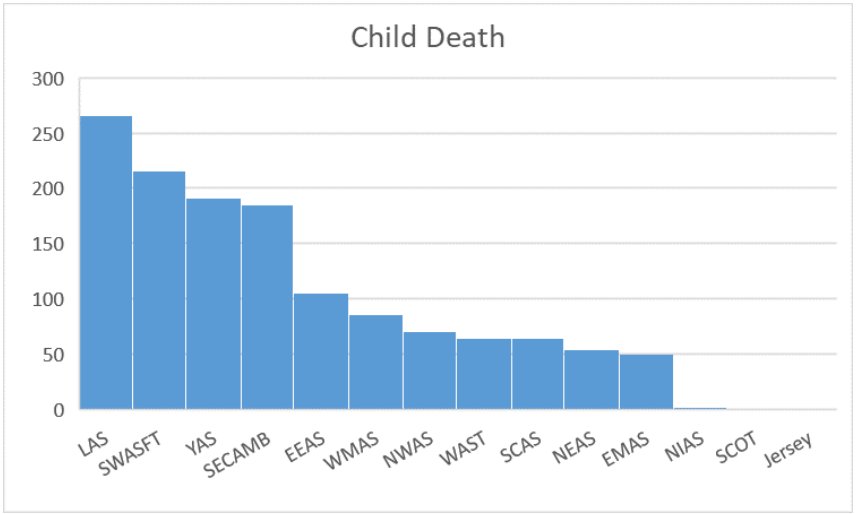
PREVENT Referrals

All ambulance trusts should be raising PREVENT concerns via their agreed pathways. This differs from trust to trust some is via the safeguarding referral pathways and some are direct to Police Prevent teams. Whilst numbers are low there is little we can draw from this chart apart from those with very low or no referrals considering their education with staff to be able to spot concerns.



Child Deaths

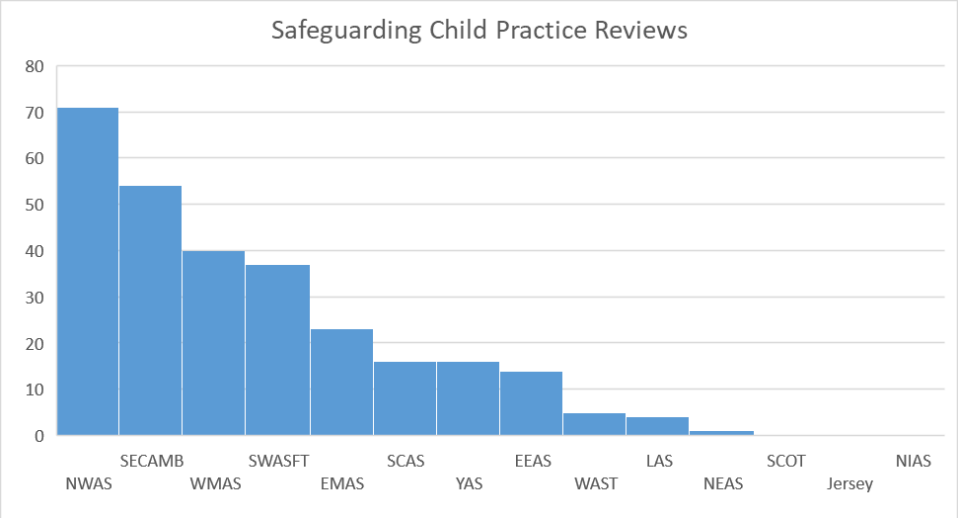
All ambulance trusts have a duty to engage in the Child Death Overview Panel (CDOP) process. Where ambulance staff are the first professionals on scene and they recognition of life extinct they should be reporting the child death to CDOP via their safeguarding process with trust completing a Child Death Notification Form (formally Form A). This starts the child death process and is critical for support to the family and to identify any concerns. If trusts are not completing this they should assure themselves that their process is sufficient for the CDOP.
The figures below relate to safeguarding and CDOP processes only and does not capture all child deaths a trust may deal with.



Safeguarding Child Practice Reviews (SCPR)

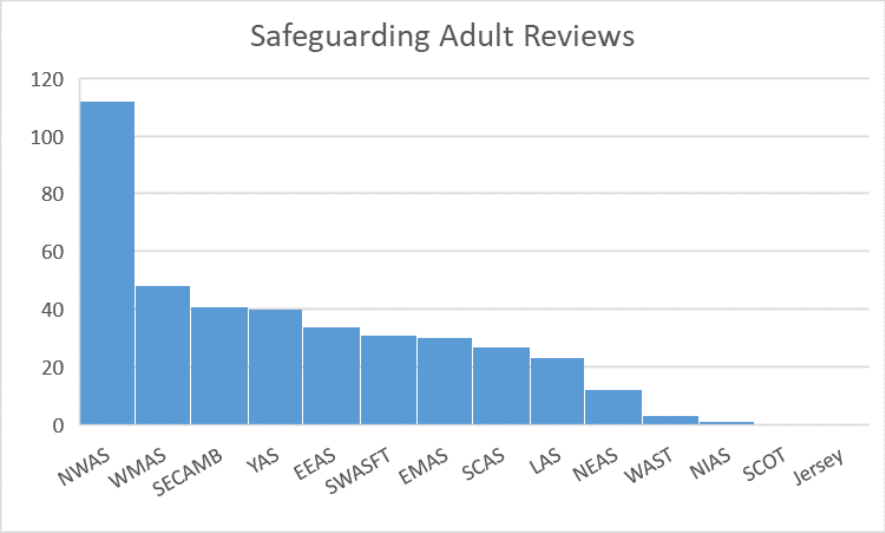
SCPR is decided by the safeguarding boards and ambulance trusts have a duty to engage and provide information and review their own practice when asked by the boards.
This chart relates to the number of SCPR trusts have contributed to. The figure vary as some trusts have

provided figures relating to all contributions to a child review whether it became a formal SCPR or not.
The next years benchmarking report will define what is in scope to enable greater comparisons.



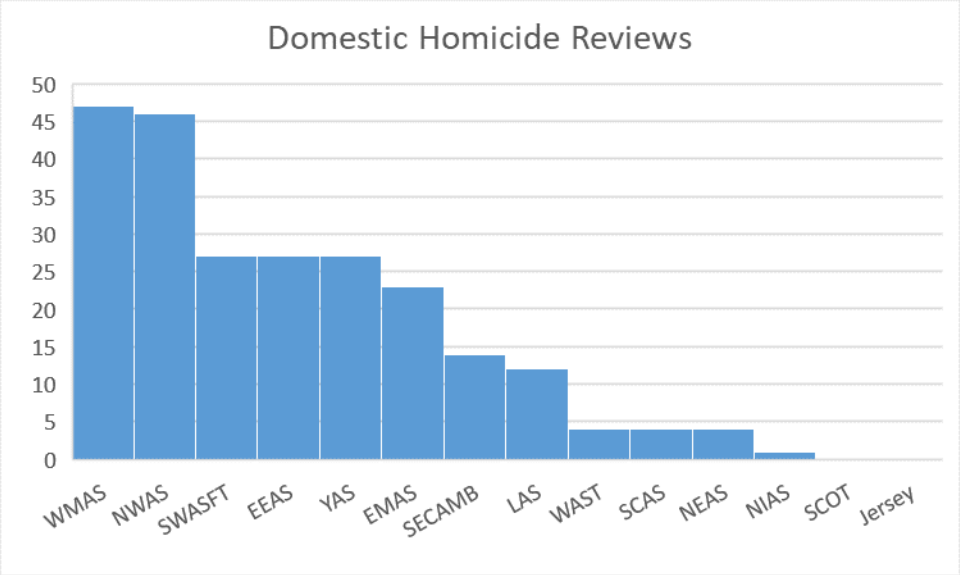
Safeguarding Adult Reviews (SAR's)

SAR's are commissioned by the safeguarding boards where there are concerns that multiple agencies processes may have failed to keep a person safe and there could be learning to safeguard others.
Ambulance trusts have a duty to take part in reviews of their care of patients subject to a SAR and to consider any learning and report to the SAR author on findings.
Similar to SCPR some trusts have reported all contacts for information in relation to adults in this chart and some have just included actual declared SAR's.
The next years benchmarking report will define what is in scope to enable greater comparisons.



Domestic Homicide Reviews (DHR's)

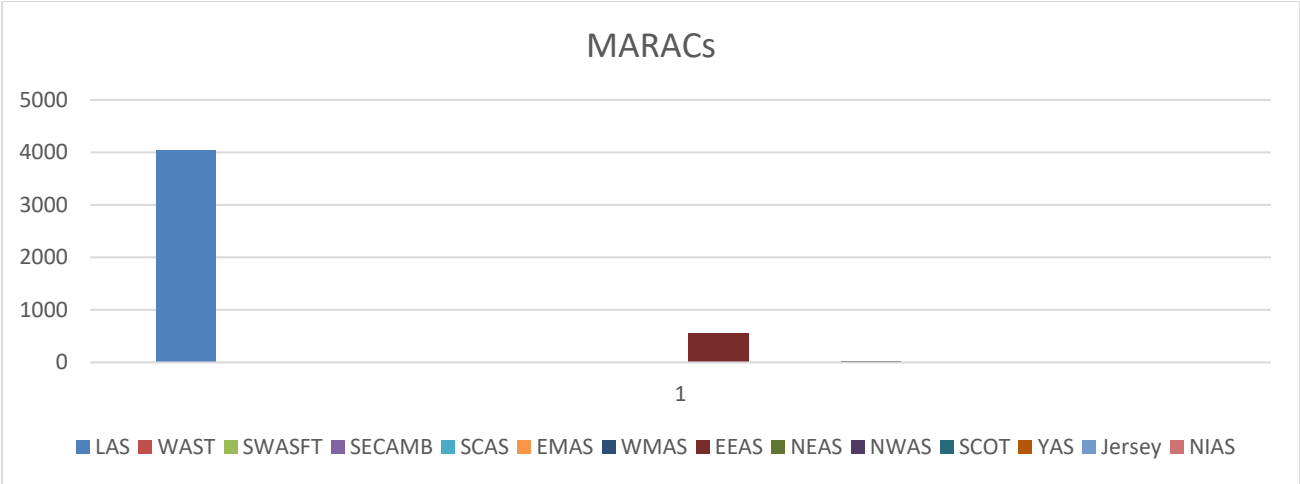
Domestic Homicide Reviews are undertaken on domestic abuse cases and are decided by the DHR panel.
Most ambulance Trusts contribute information to the DHR and some attend the occasional review.
It is not clear why NWAS and WMAS have higher reporting in this area.



Multi Agency Risk Assessment Conferences (MARAC's)

MARAC's are meetings that review high risk domestic abuse incidents with multiple agencies to see what more could be done to protect those families and people at risk to reduce the risk of a domestic homicide.

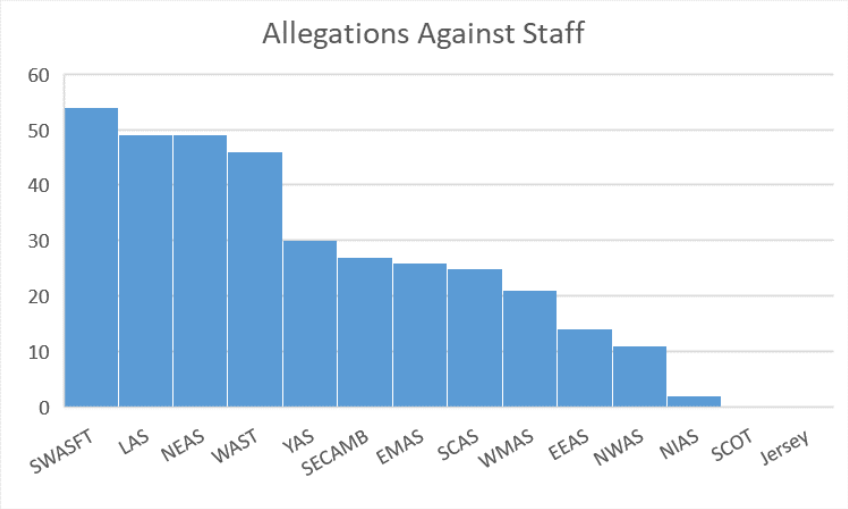
Only 3 trusts contribute information they hold on an address or person to the conference. No trust attends the conference as they are long in duration and would be very time consuming. However it has been proven in LAS that they held important information on families/ address on several occasions no one else at the conference had. Hence why they continue to engage with requests and provide information to the conference for review. Trusts not contributing to MARAC's should consider the benefits and scope to do so.



Safeguarding Allegations against Staff

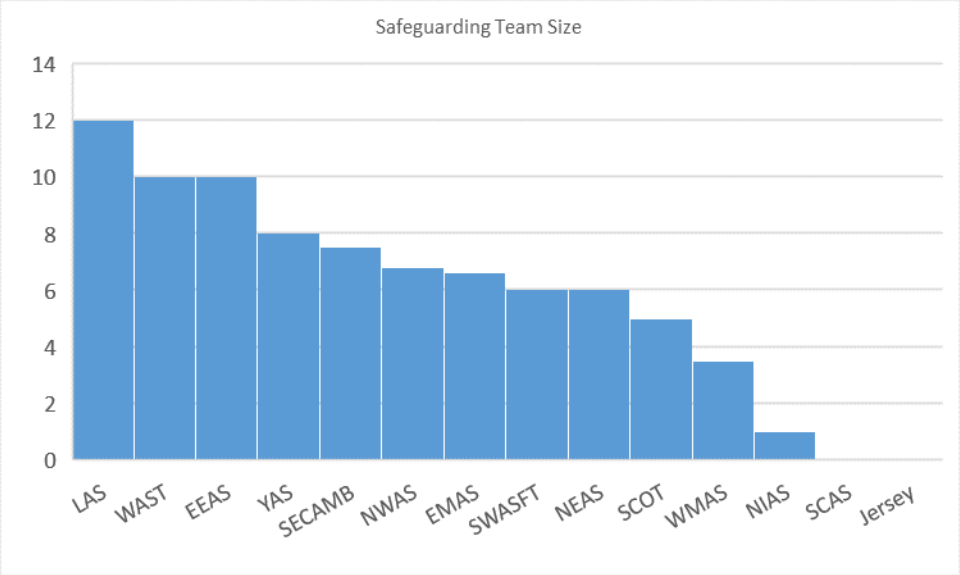
This year we have seen an increased focus in allegations against staff from regulators, AACE, NHSE and College of Paramedic. There is also an issue with sexual safety across UK ambulance trusts and all trusts

should be ensuring they have a zero tolerance to sexual harassment and abuse and have systems in place that support victims and encourage staff to report concerns.
NASAG recommends that all trusts review their processes for allegations against staff and ensure that safeguarding leads are a key partner in allegations. All trusts should have a safeguarding allegations against staff policy, clear processes for risk assessing allegations and processes for managing allegations. Those that go to formal disciplinary hearings NASAG recommends that the Safeguarding Lead should be on the hearing panel as an advisor to the Chair.
Those trusts will low figures should review processes and consider if any further action is required. SWASFT have reported in excess of 50 allegations for a number of years and lead the way in reporting allegations.



Current Safeguarding team size

It is pleasing to see that in recent years most trusts have increased the size of their safeguarding teams. This has happened either due to recognition of the increased workload and requirements or due to CQC inspections and identified gaps in trust safeguarding governance, assurance and processes.
It should be recognised that you cannot view this chart in isolation and should consider population it serves, overall workload and role of the safeguarding team. These differs across ambulance trusts, for example LAS safeguarding team deliver all their face to face training, some other trusts train the trainer and some do minimal face to face training. Some teams manage their referrals others another team oversees this process. NIAS should look to increase their safeguarding team. Jersey should consider having a dedicated person for safeguarding within the Trust.

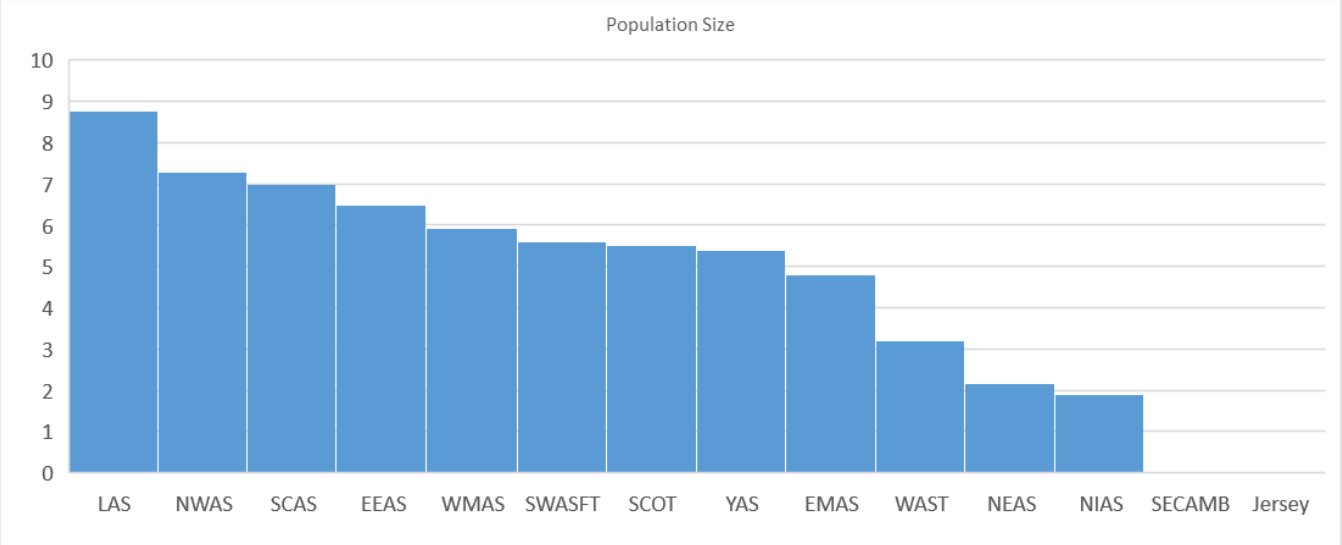


Breakdown of Team roles and banding

Trust safeguarding team size											
Trust	**Team Size**	**Role & Band**	**Head of**	**Deputy**	**leads**	**Specialist**	**Governance & Training**	**Safeguarding officer**	**Admin**	**other roles & Band**	**Any planned recruitment in train**
LAS	12		1 x 8b	1x 8a		5x B7	1xB6	1xB7	1x B5 1xB4	1x B7 LD post	1x B7 Specialist -1 x DA Cordinator externally funded
WAST	10		1x 8b	2x 8A		6x B7			1x B3		
SWASFT	6		1 x 8a			2 x B7			1 x B5, 2 x B4		
SECAMB	7.5		1x8b	0	1x 8a	2x B7				3.5 x B5 Safeguarding Coordinators	Approval from Exec Director sought for development of a business case for an additional x2 wte B5
SCAS	currently going through a restructure and subsequent increase in staffing										
EMAS	6.6		1x 8a		2x B7			1XB4	2.6 xB2		
WMAS	3.5		1XB7 (safeguarding manager)					1 X B5 non clinical 1 x B6 clinical	1 X 0.5 WTE B3		
EEAS	10		1x8a			5 x Band 7 practitioners		1 x B7 Business Manager	1x B4 2x B3		8A planned uplift to 8B Business case planning for additional practitioner post April 23 onwards
NEAS	6				2x 8a	2x B6		1x B4	1xB3		
NWAS	6.8		1 x 8a			4 x B7			2 x B4		
SCOT	5		1x8a	None	3x B7				1x B4		
YAS	8		1x8b			2 x Named Professionals B7 WTE 1 x Named Professional full time temp fixed term (May 23) B7		1 x Paediatric Liaison Nurse full time B6, 1 x safeguarding practitioner B6	1xB4 34 hrs 1xB3		
Jersey	0 (Full time) 2 as part of overall job role		1xWFM-H	1x WFM-E			1 x WFM-E (Deputy role also)				
NIAS	1	8B	1x8a		1					2xPT B5 (TEMP)	1x B5 &1xB7

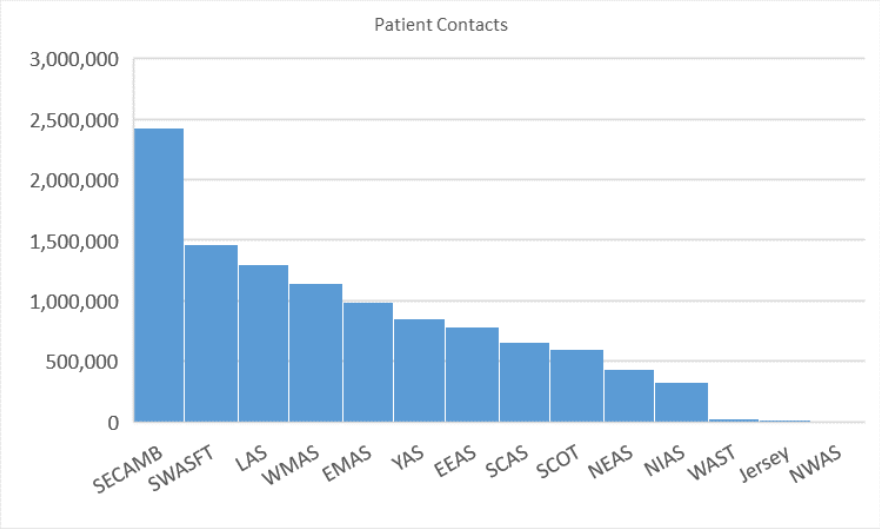
Population Trust serves

The size of the population will have an impact on the workload of the safeguarding team. The intercollegiate documents give an idea of the safeguarding designate resource requirements based on population size. This may also help trusts when looking at their own resource requirements.



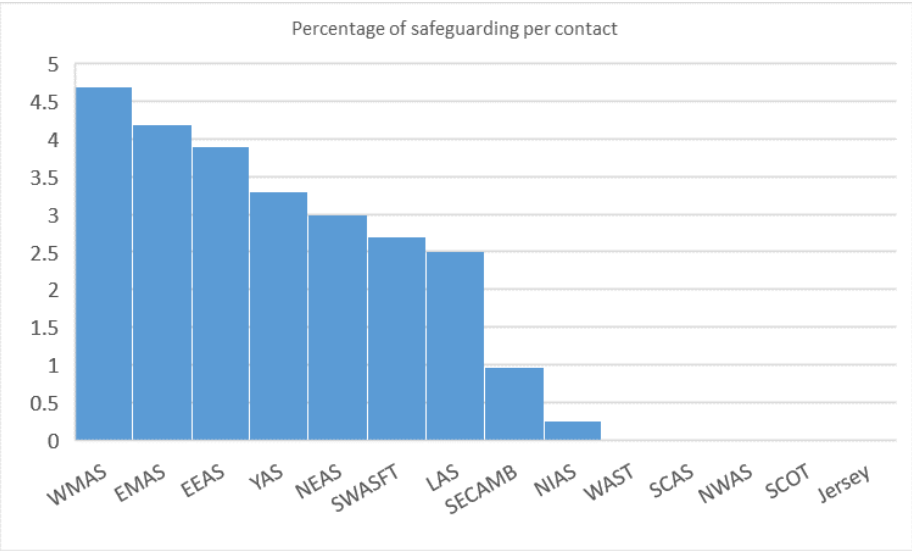
Number of Patient Contacts

The number of patient contacts and the percentage that result in a safeguarding referral or concern will enable trusts to consider if their safeguarding processes are adequate and whether they are over or under reporting.
It will also aid along with the safeguarding workload if you have sufficient resources to adequately provide good governance and assurance of safeguarding.



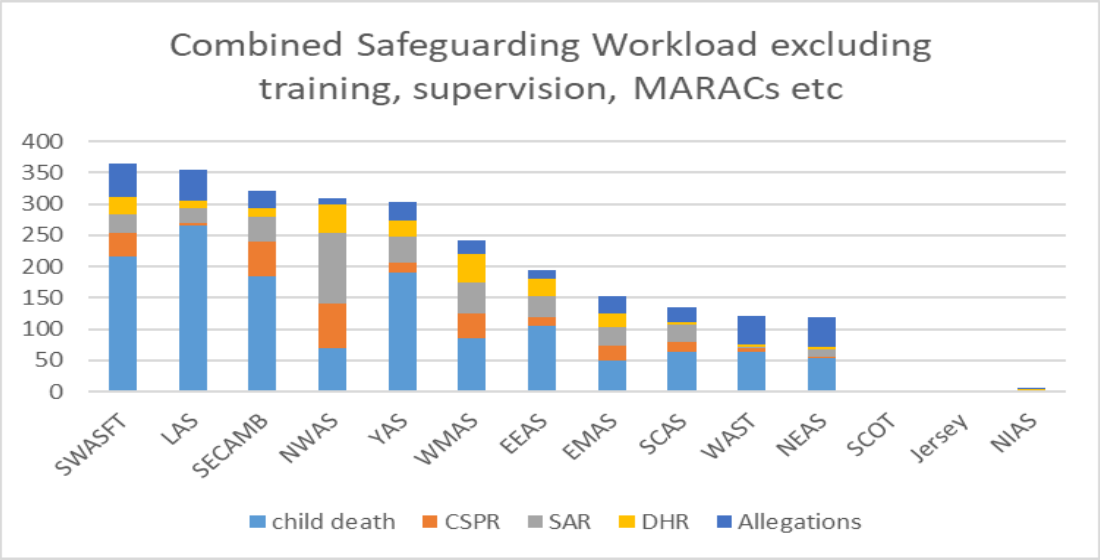
Percentage of Safeguarding Concerns or referrals made per contact

This chart enable trusts to see how many safeguarding referrals they are making in relation to patient contacts.
If trusts do not spilt out wellbeing care concerns from Safeguarding or child in need from safeguarding it is difficult to interrogate figures too much as they may well be over reporting on non-safeguarding incidents mainly adult wellbeing issues where trusts should encourage staff to empower patients to contact the local authority themselves to discuss their care needs rather than the trust raising all concerns thus empowering the patient.



Safeguarding Workload

This chart provides an overview of some of the workload in relation to reports and meetings safeguarding teams engage in. It does not include the work in relation to referrals, MARACs or training, supervision or education.



Discussion points from Benchmark

Whilst trusts all have different processes in relation to safeguarding referrals, data recording and capture, team size and local requirements. It is important that trusts continue to review the data in this report and consider any changes or improvements they can make to improve their safeguarding practice and processes.

The devolved powers have different requirements to English trusts and should consider the information in this report when ensuring they are safeguarding their populations as best as possible.
NASAG recognises some trusts have made changes to process and teams in recent years and a number are currently engaged increasing size of their teams or moving to electronic referrals improving individual ownership of safeguarding.

All trusts should continue to review processes to ensure they are providing a safe, and effective service to patients and the trust.

Trusts who do not currently identify different types of concerns and referrals, i.e. child in need, child safeguarding, adult welfare/care concerns and adult safeguarding need to consider how they can do this and audit these to ensure themselves they are not under or over reporting.

Team sizes and roles vary across trusts, however a number of roles in Safeguarding appear to have different banding in some trusts. NASAG believe trusts should consider undertaking a job matching exercise to ensure consistency in roles across ambulance trusts. Also some trusts safeguarding teams deliver safeguarding training to staff in accordance with the intercollegiate documents and this requires more resources to deliver. NASAG will continue to consider how it can refine this report for next year to enable greater comparisons across ambulance trusts and encourages safeguarding executive leads and safeguarding teams to consider the findings and whether further resources or processes are required within their trust

Alan Taylor
Chair of NASAG
22nd September 2022

Appendix 2 – Work Plan

Safeguarding & Mental Health Workplan 2023	Last Update:	06/03/2023									
[Aligned to the 11 points within the SAAF July 2022]											
Aim	**Specific**	**Measurable**	**Attainable**	**Relevant**	**Timeline Q1 2023**	**Timeline Q2**	**Timeline Q3**	**Timeline Q4**	**Actions Required**	**Responsibility**	**Progress**
(1) 4.2.1 Identification of a Named Nurse, Named Doctor and Named Midwife (if the organisation provides maternity services) for safeguarding children. Identification of a named nurse and named doctor for children in care. Identification of a named lead for adult safeguarding and a Mental Capacity Act (MCA) lead – this role should include the management of adult safeguarding allegations against staff. This could be a named professional from any relevant professional background.	**4.3** SCAS Safeguarding arrangements must include the following Named Professionals who will provide leadership and promote professional practice and give advice and expertise are listed below: Named Doctor - N/A Named Professional Children - Lynn Lawrence Named Professional Adult - Dan Dray PREVENT Lead - Dan Dray Learning Disability Lead - Saricka March MCA Lead – Steven Jephcote Designated Officer for Allegations - Sarah Thompson Executive Lead Safeguarding - Helen Young Non Executive Director Safeguarding - Anne Stebbing	Section 11 Audit	Yearly Workforce Planning and budget setting.	SAAF July 2022, legislation and mandatory reporting as per chapter 3	✓				Recruitment to final post Band 7 LPS lead. No further actions, milestone complete	Sarah Thompson	20.1.23 All Statutory posts in place
	4.5 Statutory and Mandatory Reviews 4.5.1 Rapid Reviews 4.5.2 Child Safeguarding Practice Review 4.5.3 Child Death Review 4.5.4 LaDeR Review 4.5.5 Domestic Homicide Review 4.5.6 Safeguarding Adults Review 4.5.7 Other Reviews **4.6** Parallel Investigations - e.g. Patient Safety	Annual report and quarterly reports to Safeguarding Committee	Local Authority Partners	SAAF July 2022, legislation and mandatory reporting as per chapter 3	✓				Scope the numbers and purpose of multi-agency safeguarding board meetings across the geography of SCAS. Decide on the priority meetings that must be attended and agree how information taken to the meetings. Ensure all are put into one document to understand RAG rating Ensure the learning is included in level 2 and 3 training Ensure attendance at safeguarding board sub-groups	Sarah Thompson	**November 13 2022** Commenced but not quality assured from boards **Jan 6 2023** Written to each board via ICB requesting any outstanding recommendations for SAR/SCR. Completed a report for Safeguarding Committee re this action - 9 Jan **January 17th 2023** All returns to date - none outstanding **January 20 2023** Case review spreadhsheet in place. Awaiting all returns from partnerships as to any outstanding recoemmndations. **February 14 2023** All partnerships have made a return, there are no outstanding actions.
(2) 4.2.1 Safe recruitment practices and arrangements for dealing with allegations against staff.	**3.5.6, 3.5.7** Close liaison and support from HR and IT to ensure policies and procedures which accord with safe recruitment practices, including DBS and Enhanced DBS checks for new staff and for staff referred following removal or resignation. Allegations framework and procedures in place to repond to allegations against anyone who works in SCAS. Liaison with the appropriate external agencies including LADO, PiPoT Lead in Adult Services, and Police. Close cooperation with HR for allegation management, staff interviews, investigations and reports. Lead by the AD Safeguarding.	To report against the Allegation Management Policy Themes Hotspots Job Role Analysis Numbers	To ensure dedicated administration support to this function to enable chasing, reporting, analysis, and minute taking. HR support	SAAF July 2022, legislation and mandatory reporting as per chapter 3		✓			Agree Allegation management policy Provide training to HR, recruitment teams and appropriate line managers **Embed PA role to support this function** **Align with Prof standards function** Meet with all LADO/PiPOT in all areas Training delivered – Dec 15 Dec 12 and November 11 Set up new system with admin New mailbox **Allegation Management Trust wide** **Review capacity of current team with HR** **Agree Admin function – Business Case** Review Role of Business Manager to support this function Emerging theme report to Safeguarding Committee 1st March **DBS training arranged for 16 March 2023** **6th January 2023** Action complete	Sarah Thompson	**November 13 2022** Report to private board 11 November 2022 Training to HR – 8 Nov – to be launched trust wide **7 December 2022** - Further LADO training to staff on 12 and 15 December. Positive feedback via Leadership webinar. Increase in cases. PA commenced attended awayday **9 Jan 2023** Seen increase in allegation cases – bank admin in post. Dedicated email in place. Report to next Safeguarding Committee March **17th January 2023** Trust Board and Execs more aware of this agenda. Sexual safety charter and staff mental health focus of clinical directorate team meeting. **14 February 2023** Emerging theme report completed and shared with HR and Director of Ops to be incorporated in actions related to the Sexual Safety Charter. Report to be shared at Safeguarding Committee March 1st. Ongoing allegation management training programme continues. **6 March 2023** Week commencing 20 Feb 2023 named professional adults trained in excess of 100 senior leaders in operations on allegation management. DBS training
(3) 4.2.1 Provision of an executive lead for safeguarding children, adults at risk and prevent.	Chief Nurse in post who has Executive responsibility for Safeguarding and PREVENT.	Information within Section 11 Audit	Supported by AD Safeguarding	SAAF July 2022, legislation and mandatory reporting as per chapter 3	✓					Sarah Thompson	
(4) 4.2.1 An annual report for safeguarding children, adults and children in care to be submitted to the trust board.	In close liaison and with the full support of IT and the provison of data analytics from Business Intelligence the AD Safeguarding will lead on the compilation of the annual report to the trust board	Quarterly Reports for contract scheduling Safeguarding Committee Reports Reports to Quality & Safety Committee Reports to Exec Report to Patient Safety Delivery Group Report to Patient Safety Group Risk Register	Support from IT, BI, and administration function	SAAF July 2022, legislation and mandatory reporting as per chapter 3		✓			• Combine all report recommendations related to this subject and action to completion (separate action plan) • Align a project Lead – DD/PP • Ensure Board aware - 3.11.22 • Data every incident where referral delay noted and describe issue – new action • Ensure any harm is identified after the delay and if necessary, alert Execs and provide incident report - new action • PP and DD to visit Wales Amb Service – discussed at conference 11 November • Ensure referral form is fit for purpose • **Ensure SOP for safeguarding team usage** • ST to hold discussion with Wokingham re use of generic referral form • Ensure monthly quality of referral audit • Include quality of referral in training • **Provide an Aide Memoire to staff regarding a 'good quality referral'** • **Ensure with IT that the OOA postcodes are a mandated field** • **Create an internal triage threshold document with associated flowcharts/procedure doc, work with LA's on 2 entry points to LA** • **Routine feedback to staff – daily task** • Ensure all staff are trained by Docsworks compulsory • Create prioritisation tool for returned referrals • Joint working with SWASFT and Welsh amb to produce network meeting – working group • Re design referral form to be algorithm based • **Be a member of the Cleric working improvement group with PTS** • **QA Private Provider referrals and feedback learning to them**	Sarah Thompson	**November 13 2022** IT action plan devised to aid focus to project leads – DD and PP to populate Board aware – Initiated Technical Assessment Report 3/11/22 – draft report available All incidents reported **7 December 2022** Made P1 at Awayday – new tasks added Safeguarding Team to be trained in Docworks – 14,15 or 16 December 2022 **9 January 2023** DD and PP requested to work together with SWASFT and Wales on joint project Meeting with Docworks 5.1.23 – agreed actions fire referrals to be automated with immediate effect – awaiting algorithm from SWASFT to commence with mandatory fields KB audits a secondary held in in boxes - December authored by PP and CF – to Safeguarding Committee 9 Jan. All in boxes now cleared and triage draft SOP written When a referral arrives on server staff do receive a read receipt to say arrived in safeguarding team. **17th January 2023** SWASFT have given permission for SCAS to use their algorithm. PP to speak to DD to see if Docworks have it KB updating Triage SOP following ST's comments PP and KB have completed a first draft for the Aide Memoire PP to send to ST, DD and LL for review AC tasked with OOA Communication Referral form agreed Create audit template for quality of referral audit Internal triage doc in draft PP to attend cleric working group **14 February 2023**
(4b) 4.2.1	Development of Dashboard to assist	Ensure dashboard has all agreed areas as per Rapid Review Report: No. Referrals – child/adult Training compliance Child death rates Referrals broken down to area Referral themes No. Section 42 enquiries and themes No. SAR and themes No. Child Safeguarding Practice Reviews and themes No. Allegation Management cases and themes No. DHR and themes No. LaDer reviews and themes No. fire referrals No. SI's related to safeguarding	Support from BI	SAAF July 2022, legislation and mandatory reporting as per chapter 3		✓			Ensure building of Dashboard	Sarah Thompson	**November 13 2022** 1st draft of amended dashboard available **December 7 2022** Estimate received from 'Differentia' to develop and build the safeguarding dashboards – 20 day estimate. Agreement required from Head of Performance and then start date to be confirmed. Data sophisticated following request from Chief Nurse. **January 6 2023** PP to chase PK Patient Delivery Group made aware – 5 Jan 2023 **January 17th 2023** Phil King has been given access to the Dashboard by the developers. Phil will test it this week and then set some time aside with the senior SG team to demonstrate. Basic Dashboard to be available to SG team with training by 17th February. PP has suggested deadline of 31st March to get all other aspects available on the Dashboard **14 February 2023** Phil King is demonstrating new updated dashboard on the 17th February. **6 March 2023**
(5) 4.2.1 A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.	Review, revision and updating of all safeguarding policies and procedures to support local multi-agency working including ICB's, LA's, Police, Social Care, GP's, SABI's, CSP's and other agencies as may be required.	Audit the quality of safeguarding referrals Regular audit of policies as per audit schedule Attendance at Safeguarding Boards, Sub-Groups, and other multi-agency meetings relevant to SCAS Monthly scrutiny group meetings with ICB NHSE Colleagues Safeguarding Committee	Setting portfolios for responsibility to each member of the Safeguarding Team Inclusion of wider Trust staff to attend multi-agency meetings such as operational staff, HR, Education, Mental Health Team, and Complex Care Team	SAAF July 2022, legislation and mandatory reporting as per chapter 3	✓				Audit of policy as per audit schedule	Sarah Thompson	**14 February 2023** All policies agreed and in place. Audit will become business as usual.
(6) 4.2.1 Effective training of all staff commensurate with their role and in accordance with the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019, Looked After Children: Roles and Competencies of Healthcare Staff 2020 and the Adult Safeguarding: Roles and Competencies for Health Care Staff 2018.	Safeguarding Training Strategy and Operational plan Regular training compliance reports	Monthly training compliance figures against all Safeguarding levels, MCA, PREVENT all levels, and LD	Education required to support delivery of training and training reporting	SAAF July 2022, legislation and mandatory reporting as per chapter 3			✓		• Safeguarding to be included in induction • Agree standardised delivery and content of L1, L2, L3 and L4 Child and adult safeguarding • Agree Prevent training level 1 and 2 • Agree MCA training • Agree bespoke training package • **Agree Volunteer training** • Ensure Board training • **Ensure L&D provide monthly data – fit for purpose** • **Ensure launch of LD – Oliver McGowan training** • Increase L&D team with Safeguarding Leads • Education to be made a priority • **Agree reporting schedule for all areas** • Deliver bespoke package to Education team and safeguarding team to achieve level 3 – Dec 15 • Deliver training on behalf of MC – Dec 2 • Docsworks training to all safeguarding team • Member of safeguarding training sub group • Been part of ofsted inspection • Block with 111 and 999 building level 3 training for foundation training • **Building a uniform package with bespoke element** • Teaching to driving school on 4 Jan for one hour • ST & Southern Health to agree safeguarding reporting Education team to manage logistics	Sarah Thompson	**November 13 2022** Draft training plan agreed – for safeguarding committee 21 November **December 7 2022** AD Education attended Awayday. Agreed as P1 in work plan priorities. Tasks added Board Training to be delivered 15 December by AD Safeguarding Agreed Safeguarding in Education Role – attended awayday Increased capacity in Education team for safeguarding **Jan 6 2023.** AD Safeguarding and AD Education met with actions. Meeting booked for w/c 9 Jan to set timetable for delivery of new curriculum commencing 1 April. Draft uniform Level 2 package completed **January 17th 2023** PP has offered training dates on how to use my online referrals for Southern Health staff. Driver training occurred on 4th January. SG and Education have met. Priority group A will continue with making connections. Priority Group B will commence training with making connections in the new financial year. In parallel with this will be the BAU SG trng programme. Agreement to be sought from workforce committee as to abstraction. MCA training Workforce committee has agreed 4 hours of online MCA trng 2023/2024 **14 February 2023** Additional dates added for the delivery of priority a and b group to improve trajectory. Development of level 2 & 3 continues with deadline of March 31st. The internal delivery will twin track with external company delivery. **6 March 2023** PTS delivery agreed as 3 hours by video, to include scenarios. Delivery plan mid-April to agree dates and venues. Priority A Group plan to continue Fridays and for those who have not attended, plus ECAs, be the priority.
(7) 4.2.1 Safeguarding must be included in induction programmes for all staff and volunteers.	Adhere to Safeguarding training strategy. Accurate records to be kept of staff compliance and training statistics.	Monthly training compliance figures	Education required to support delivery of training and training reporting	SAAF July 2022, legislation and mandatory reporting as per chapter 3	✓				Ensure safeguarding is included in Trust induction	Sarah Thompson	
(8) 4.2.1 Providing effective safeguarding supervision arrangements for staff, commensurate to their role and function (including for named professionals).	Creation implementation and review of Supervision Policy and deal with agreed actions that may arise from implementation at a strategic and operational level Ensuring appropriate supervision is available for named professionals and other staff as may be appropriate Monitor compliance of the supervision and standards in line with the policy Supply an annual report on the Policy and its impact on supervision for staff across the Trust	P3 in workplan, supervision compliance figures per service area	Supervisors will require supervision training, Operational teams will have to agree abstraction and prioritisation tool to determine priority groups	SAAF July 2022, legislation and mandatory reporting as per chapter 3				✓	• Ensure Supervision policy agreed • Prioritise team members receive supervision • Ensure adhoc supervision for complex cases for frontline staff • **Prioritise staff groups for supervision** • **Ensure safeguarding professionals have supervision training qualification before attempting to supervise** • Produce extraction document for Ops	Sarah Thompson	**November 13 2022** All staff members who are substantive receive supervision from ICB colleagues **December 7 2022** Adhoc supervision to be recorded in real time. To commence group supervision for allegation management -P1 Agreed to do an adult and child case at each team meeting **6 Jan 2023** No further progress on this action **17th January 2023** Reciprocal arrangement agreed with LAS. **14 February 2023** Ad Hoc supervision continues. AD Safeguarding has commenced supervision with FTSU team. **6 March 2023** Aligned named professional children and safeguarding specialist children to agree supervision model. L200 paramedics first group.
(9) 4.2.1 Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.	Raising awareness of safeguarding and staff responsibilities to question, report, information share and engage thoughout SCAS. Provision of training, publications, posters together with feedback and plaudits. Team to ensure referrals are complete and timely. Safeguarding to assess referrals and action within target timeframe.	**3.5.3** Ensure by March 2023 CPIS must cover all urgent and emergency care settings Quality of Safeguarding referral audit Safeguarding Stars Feedback from Local Authority Training compliance Safeguarding activity as measured in the weekly planner	Funding to be agreed from Orlivus to enable front line staff to see CPIS from EPR tablet Finance Department and IT Support from Communications Team	SAAF July 2022, legislation and mandatory reporting as per chapter 3				✓	Ensure by March 2023 CPIS must cover all urgent and emergency care settings Quality of Safeguarding referral audit Commencement of Safeguarding Stars **Feedback from Local Authority** **Training compliance** Safeguarding activity as measured in the weekly planner Merging of Sexual Safety Charter and Allegation Management Action Plan	Sarah Thompson	**December 7 2022** Offer from Orlivus to enable FL staff to see CPIS from their EPCR tablet – look up mandatory for all those under 18 years – funding to be agreed **January 6 2023.** SOP draft completed for review Patient Safety Delivery Group made aware 5 Jan **January 17th 2023** PP has shared CP-IS Sop with LL for discussion PP to trace Orlivus **6 March 2023** A change request notice [CCN329] has been raised– Authorised and funded for development by Clinical / Safeguarding Leads w/c 13th Feb. PO raised awaiting final steps Proactis authorisation before being provided to supplier Orlivus for inclusion in next sprint window – commencement date
(10) 4.2.1 Developing and promoting a learning culture to ensure continuous improvement.	Support a strong culture of peer learning and knowledge sharing as a key enabler of organisation-wide improvement. Safeguarding will prioritise efforts that allow staff to come together on a regular basis to share ideas and learning in an open and respectful way. Visible and sustained commitment to improvement programmes from trust leaders is essential Ensuring that improvement priorities and metrics are aligned with agreed safeguarding objectives	Culture assessed by themes in Allegation Management General feedback from staff Evaluation in training	Organisational Development Team Education Team Executive Team support Communications Team	SAAF July 2022, legislation and mandatory reporting as per chapter 3				✓	Ensure all good practice is recorded and reported to ST Safeguarding Star to be agreed monthly and then awarded at trust award ceremony as star of year Safeguarding presentation at every Board and Safeguarding Committee **Review training evaluation monthly and record** Provide examples on changes in practice as a result of learning Associate Director Safeguarding to deliver presentation on behalf of NHSE "Wicked Problem"	Sarah Thompson	**November 13 2022** All good practice kept – yet to establish process formally Jan 3 2023 – PP to include this as decision for December star in next SMT Jan 2023 **17th January 2023** Panel held on Friday 13th. 2 cases agreed One of the cases has seen HY write to all staff involved in that case **20 January 2023** HR meeting to discuss cases together **14 February 2023** See sections 2 and 6 **6 March 2023** Sexual Safety and deep-dive action plan progress
(11) 4.2.1 Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance.	To ensure consent is gained and evidenced within the Safeguarding Referral Form. Staff within the training programme are aware when and when not to gain consent. Staff to be made aware of 'Making Safeguarding Personal' in Adult Safeguarding.	As part of Quality of Referral Audit Measurement of complaints relating to consent	Patient Experience, IT , and Education	SAAF July 2022, legislation and mandatory reporting as per chapter 3	✓				Undertake an audit specifically related to consent in adults and children as part of the quality of referral audit cycle Monitor any patient experience complaints related to consent Review all policies to ensure consent is included	Sarah Thompson	**14 February 2023** The importance of consent is included in the development of the new referral form.

Appendix 3 – Safeguarding Risk Register – updated 1 June 2023 Version 1.2

	SAFEGUARDING RISK REGISTER							
		22/23	Aug-22	Dec-22	Jan-23	Feb-23	Apr-23	Trend
Ref								
	QUALITY OF CARE, PATIENT OUTCOMES, SAFETY, EXPERIENCE AND EXCELLENCE							
SG1	IF SCAS do not work effectively with the Safeguarding Children's Partnerships or Safeguarding Adult Boards THEN there is a risk that the Trust do not keep pace with the strategic work undertaken by the partnerships RESULTING in a failure to meet statutory requirements		**9**	12	12	20	12	NEW
SG2	IF there insufficient specialist safeguarding staff THEN there is a risk that the Trust will be unable to fulfil its statutory safeguarding functions RESULTING in patient harm.		**9**	12	12	20	12	NEW
SG4	IF SCAS staff do not receive safeguarding training THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm		4	16	16	16	16	NEW
SG6	If the CP_IS system is not accessed regularly in the urgent care setting, then the Trust staff member is not aware if the child has a child protection plan or is a looked after child. The assessment of risk will then not be determined accurately.			12	12	12	12	NEW
SG7	The Trust server keeps having regular outages and the safeguarding referrals are potentially delayed in reaching their destination			25	25	25	25	NEW
	EMERGENCY PERFORMANCE, COMMERCIAL VIABILITY AND OPERATIONAL EXCELLENCE							
	STAKEHOLDER PRECEPTIONS AND TRUST REPUTATION							
	COST PRESSURES RELATED TO THE ECONOMIC CLIMATE AND CHANGES IN THE WIDER HEALTH ECONOMY, INTERGRATED GOVERNANCE AND VALUE FOR MONEY							
	WORKFORCE AND DEVELOPMENT, LEADERSHIP AND CULTURE							
SG8	IF SCAS staff do not receive safeguarding training THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm				16	16	16	NEW
SG9	IF SCAS staff do not receive safeguarding supervision training THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm				16	16	16	NEW
	COMMERCIAL VIABILITY							
	Risks closed January 2023: SG3, SG5							

Ref No	Date identified	Date of Latest Update	Risk Title	Description of Risk	Cause	Consequence / Likely outcome for SCAS	SCAS Objective	Inherent Impact	Inherent Probability	Risk Score	Control Name	Control Description	Control Owner	Frequency	Control Rating	Residual Impact	Residual Probability	Residual Risk Score	Owner / Director	Related Issues / Contributing Factor	Issue / Contributing Factor description	Issue / Contributing Factor Rating	Issue Contributing Factor Owner	Actions	Action Description	Action Owner	Action Due Date	Supporting Evidence for mitigation / Additional Comments
	Date the risk was identified	*When the risk was last updated*	*Name of risk*	*Brief description of risk (IF THEN RESULTING)*	*Potential causes of the risk materialising*	*Potential impacts to SCAS should the risk materialise*	*What SCAS objective does this risk relate to*	*Using the Impact table, what would the impact level be*	*How likely is it that this risk materialises if no controls were in*	*Automated risk score*	*Name of control in place to mitigate the risk*	*Description of how the control works*	*Person responsible for the control*	*How often the control is performed*	*How effective is the operation of the control*	*Using the Impact table, what would the impact*	*How likely is it that this risk materialises*	*Automated risk score*	*The person responsible for the*	*Name of issue or contributing factor which impacts the risk*	*Description of the issue or contributing factor which impacts the risk*	*Rating of issue / Contributing Factor*	*Person responsible for resolving the issue*	*Name of action plan*	*Description of actions taken as part of the action plan*	*Person responsible for ensuring*	*When the action plan is due to be completed*	*Commentary explaining any changes to the risk or relevant information*
SG1	Aug-22	Apr-23	Safeguarding System Risk	**IF** SCAS do not work effectively with the Safeguarding Children's Partnerships or Safeguarding Adult Boards **THEN** there is a risk that the Trust do not keep pace with the strategic work undertaken by the partnerships **RESULTING** in a failure to meet statutory requirements	Lack of representation at the boards and partnerships Lack of resource to attend the boards and partnerships	Negative impact to the Trusts reputation for Safeguarding Potential to miss out on organisational learning Potential loss of ability to influence the wider safeguarding system Potential to miss out of policy or procedure updates	Quality of Care, Patient Outcomes, Safety, Experience and Excellence	Major	Almost Certain	12	Partnership Representation	There is a meeting proposed for November 2022, with the HOW ICS and the designated nurses with safeguarding Board representation to discuss how SCAS is best represented and can work effectively with to act on behalf of SCAS	ICB Designated Nurses	Ongoing	To Be Assessed	Moderate	Possible	9	Helen Young	Safeguarding Leadership Capacity	There is a limited capacity of both corporate and safeguarding leadership to attend the meetings.	High	Helen Young	Progress updates	Communication of our progress again our safeguarding improvement plan to all partnerships and boards.	Helen Young	May-23	**April 23: suggest reduction from 20 to 12 due to increased visibility and productivity with Safeguarding Boards. .** **January 2023:** Named Professional Adult, Named Professional Children and Associate Director Safeguarding have attended Safeguarding Board meetings at all levels including JARs, Portsmouth SAB Quality Group, BCB ICB Health Economy Safeguarding Committee, Berkshire West Health Partners Strategic Safeguarding Committee, Slough Safeguarding Partnership, Immigration Hotels meeting. Attendance at these forums provides visibility of SCAS teams and supports priorities for 2023/2024. Quarterly whole System meeting agreed for 7 March 2023. Consideration for reduction in Risk Rating to 12 (from 20) **December 2022:** Meeting held with ICBs and SG boards on 30/11/22. Team away day agreed to prioritise
											7 Minute Briefings	Briefing papers from the Partnerships and Boards on specific cases or learning themes	Partnerships and Boards	Ad-hoc	To Be Assessed													
SG2	Aug-22	Apr-23	Capacity Risk	**IF** there insufficient specialist safeguarding staff **THEN** there is a risk that the Trust will be unable to fulfil its statutory safeguarding functions **RESULTING** in patient harm.	Rapid turnover of staff with high attrition rates Safeguarding resource has been remodelled	Increase in patient harm and poor quality care Negative impact on reputation Staff not clear on safeguarding responsibilities Increased pressures on existing staff Increase in backlog of referrals Failure to meet statutory requirements	Quality of Care, Patient Outcomes, Safety, Experience and Excellence	Major	Almost Certain	12	Interim Roles	We have 3 interim Safeguarding Professionals in place. One is being extended to 31/01/2023. 2 x Light Duties Staff currently in post as additional Safeguarding Practitioners.	Helen Young	Ongoing	To Be Assessed	Moderate	Possible	9	Helen Young	Talent Pool	Specialist safeguarding professionals are difficult to recruit with a limited talent pool	Urgent	Helen Young	Recruitment Plan	Specific safeguarding recruitment plan in place in line with the new safeguarding resource model	Helen Young	Jan-23	**April 2023: suggested reduction from 20 to 12 due to impending resource fulfilment and recent offer to the MCA/LPS role.** **February 2023:** all roles filled (two Band 7s starting February 16 and 28 2023) and one vacancy with interviews held and offer sent out with start date May 2023. Consider changing Risk rating from 20 down to 12 due to impending resource fulfilment. Progress against team growth shared at Quality and Safety Committee (Jan 23). **December 2022:** Advert for B7 SG Specialist (Children) closed 08/12/2022. Shortlisting to take place w/c 12/12/2022. 2 x Light Duties Staff commenced in post as additional SG Practitioners. **November 2022:** Safeguarding Named Professional Adult and AD Safeguarding commenced in role on 7 November. Child Safeguarding Named Professional starts Jan 3, Band 7 Safeguarding child specialist
											Safeguarding Resource Model	Continuous review of the resource model against safeguarding requirements. 1 x permanent Safeguarding Professional (Adults) in post. 1 x permanent Safeguarding Professional (Children), confirmed start date 23/01/2023.	Helen Young	Ongoing	To Be Assessed													
SG4	Aug-22	Jan-23	Training Risk	**IF** SCAS staff do not receive safeguarding training **THEN** there is a risk that vulnerable patients will not be correctly identified **RESULTING** in potential patient harm	Lack of safeguarding training strategy	Staff not clear on safeguarding responsibilities Staff not identifying and raising safeguarding concerns Failure to meeting statutory requirements Negative impact on reputation Increase in patient harm and poor quality care	Workforce and Development, Leadership and Culture	Major	Likely	16	External Level 3 Training	External company to deliver level 3 safeguarding training virtually.	Helen Young	Weekly	To Be Assessed	Major	Likely	16	Helen Young	Operational Pressures	Ongoing operational pressures have reduced ability to release staff for training	Urgent	Helen Young	Safeguarding Training Strategy	Trust wide Safeguarding training strategy approved by Safeguarding Committee. Development of the subsequent training plan by the training subgroup will commence October 2022.	Helen Young	TBC from initial output from subgroup	**April 2023: Training Strategy: consider closing as Training Strategy agreed and in place. New risk opened on Training Delivery and Implementation.** **January 2023:** Training Strategy approved, so request this Risk can be closed (note: new Risk regarding Delivery and Reporting of Training raised ref SG8). **December 2022:** Level 1 ng review complete. Level tng review expected complete w/e 16/12/2022. Priority groups at Level 3 agreed at away day and included in Workforce Board planning for 23/24. **November 2022:** Training Plan agreed at Safeguarding Committee. Priority Group 1 agreed with ECA and PTS Priority group 2 for SGL3 **October 2022:** Level 3 training trajectories and the level 1 / 2 compliance dashboard are reviewed by the Executive Committee and Safeguarding Committee.
											e-Learning	Online learning platform containing all mandatory training that does not require face to face training, including level 1 and 2 safeguarding courses.	Ian Teague	Ongoing	To Be Assessed													
											Training Content Review	Level 1, Level 2 and Level 3 training modules to be reviewed	Safeguarding	Ad-hoc	N/A													
SG6	Oct-22	Feb-23	Systems Risk	If the CP_IS system is not accessed regularly in the urgent care setting, then the Trust staff member is not aware if the child has a child protection plan or is a looked after child. The assessment of risk will then not be determined accurately.	Access is not consistent across the trust	Potential patient harm and poor quality care	Quality of Care, Patient Outcomes, Safety, Experience and Excellence	Major	Likely	12	Access Issue	CP_IS is accessed in some areas of the Trust. Staff are trained to recognise abuse or neglect irrespective of information held on CP_IS	Sarah Thompson	Daily	Partially Effective	Major	Likely	12	Helen Young	IT systems	No accompanying SOP. Lack of training on usage of system	High	Jill Lanham	IT system	Ensure access to CP_IS is consistent across all settings named as "Urgent Care". Ensure staff are aware of their responsibility when accessing CP_IS by use of a SOP	Helen Young	31-Jan-23	**February 2023:** Business Manager to share EOC CP/S SOP with Named Professional Children for agreement and Business Manager to chase Oribus for committed delivery date (if doing shared bid with SWAST). **December 2022:** Offer from Oribus to enable frontline staff access to CP_IS from the SCAS ePR tablets. Funding to be agreed. **November 28 2022**: No futher progress with this item **26 October 2022** 111 have access. EOC have been given access and security tests have been completed. Plan will be for call taker to check CP-IS for all under 18's and details passed to dispatcher and dispatcher to send to staff attending scene. SOP to be written for EOC staff to ensure adequate understanding.
SG7	Oct-22	Apr-23	Safeguarding System Risk	The Trust server keeps having regular outages and the safeguarding referrals are potentially delayed in reaching their destination	Server is not reliable and has regular outage issues	Potential patient harm and poor quality care	Quality of Care, Patient Outcomes, Safety, Experience and Excellence	Catastrophic	Almost Certain	25	Server Issue	Administration staff within the safeguarding team are alerted to any delayed referrals.	Sarah Thompson	Daily	Not Effective	Catastrophic	Almost Certain	25	Helen Young	IT systems	There are too many systems being hosted on a single server.	Urgent	Jill Lanham	IT system	It appears that the server holding the "DocsWorks" system is not prioritising safeguarding in its prioritisation of a critical function.	Helen Young	15/11/2022	**April 2023: Referral system suggested reduction from 25 to 15 due to Docsworks and Safeguarding project work, traffic light system and better understanding in the Safeguarding team - stay at same risk due to recent OOA incident.** **February 2023:** Purchase Order agreed and with Docwerks on 23 January 2023. Awaiting DPIA and approved referral form. Docworks purchasing servers (30 day lead in time). Associate Director requested Project Plan from Docworks as to timescales, tentative agreement for this to be in place by new financial year. New Project Manager (Andy Siddiqi, SCAS) identified, with whom the Referral process has been shared, and a new project group created to enable the migration smoothly. **Propose reducing Risk Score from 25 to 15 due to mitigation from the traffic light system, ongoing work with Docworks and better knowledge within the Safeguarding team.**
SG8	Aug-22	Jan-23	Training Risk	**IF** SCAS staff do not receive safeguarding training **THEN** there is a risk that vulnerable patients will not be correctly identified **RESULTING** in potential patient harm	Change in Safeguarding Training Programme aligned to Inter Collegiate document.	Staff not clear on safeguarding responsibilities Staff not identifying and raising safeguarding concerns Failure to meeting statutory requirements Negative impact on reputation Increase in patient harm and poor quality care	Workforce and Development, Leadership and Culture	Major	Likely	16	External Level 3 Training	External company continue to deliver level 3 safeguarding training virtually.	Helen Young	Weekly	Partially Effective	Major	Likely	16	Helen Young	Operational Pressures	Ongoing operational pressures have reduced ability to release staff for training	Urgent	Helen Young	Delivery of Safeguarding Training Strategy	Agreement of Trust wide content, delivery, reporting of all Safeguarding Training levels. In addition Prevent, Learning Disability (LD) and Mental Capacity Act (MCA) Assessment to be included.	Helen Young	Apr-23	**April 2023: new risk - SG8: Risk Training implementation – suggested Risk Rating 16** **January 2023:** Statutory/Mandatory Education proposal presented by Education at Patient Safety Group (Jan 23) and Chair requested a Working Group to review and agree due to complexity of the paper, with representation from Operational teams as well as Subject Matter Experts. This meeting was held, awaiting sign off from Executive team.
											e-Learning	Online learning platform containing all mandatory training that does not require face to face training, including level 1 and 2 safeguarding courses.	Ian Teague	Ongoing	Partially Effective													
											Training Content Review	Level 1 - agreed Level 2 - pilot delivered 24 January 2023 with some modifications required Level 3 - partly delivered by external company, plus Training from Safeguarding team	Safeguarding Team	Ad-hoc	Partially Effective													
SG9	Nov-22	Feb-23	Training Risk	**IF** SCAS staff do not receive safeguarding supervision training **THEN** there is a risk that vulnerable patients will not be correctly identified **RESULTING** in potential patient harm	Inability to release staff to undertake supervision training	Staff not clear on safeguarding responsibilities Staff not identifying and raising safeguarding concerns Failure to meeting statutory requirements Negative impact on reputation	Workforce and Development, Leadership and Culture	Major	Likely	16			Helen Young	Weekly	Partially Effective	Major	Likely	16	Helen Young	Operational Pressures	Ongoing operational pressures have reduced ability to release staff for training	Urgent	Helen Young	Delivery of Safeguarding Training Strategy	Agreement of Trust wide content, delivery, reporting of all Safeguarding Training levels. In addition Prevent, Learning Disability (LD) and Mental Capacity Act (MCA) Assessment to be included.	Helen Young	Apr-23	**April 2023: new risk** **February 2023:** require mitigations to release staff to undertake supervision training.
													Ian Teague	Ongoing	Partially Effective													

Author: Sarah Thompson
Associate Director Safeguarding
Date: July 2023

BOARD OF DIRECTORS SUMMARY SHEET

Report title:	**Integrated Performance Report (June 2023 Data)**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**18.0**
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 an independent governance review, not with standing the fact that it had remained unchanged for some years. This document sets out performance for June. The following developments have been implemented since the last version. 1. Having taken feedback from the Board in June and followed advice from Sam Riley, NHSE, we have adopted a format and style for the report which is considered best practice (Morecambe Bay). 2. The report is structured to reflect our Improvement Programme workstreams and will eventually incorporate the metrics and reporting identified against each of those too. 3. A variety of format amendments have been made to ease flow and development of reporting. 4. The production timelines are in the process of being integrated with the developing Trust Board calendar. 5. The number of pages has been reduced although further work will be undertaken to ensure that we are reporting only what is essential to be reported. The Morecambe Bay document runs to c. 50 pages (compared with this c. 60 page document).		

	A version of this document was presented to the Finance & Performance Committee. It is proposed that following discussion at Board, further format development is paused for a period of 6 months to enable the Trust to focus on effective use of the document and improvement of the commentaries provided. A plan, with appropriate timescales, to develop and embed a pyramid of similar style reports through the Committee structure and through to local management teams will also be developed.			
Recommendations:	Board is asked to note this document and 1. approve the recommendation for a format/design change moratorium post the implementation of any changes requested during the July Board meeting. 2. Approve the recommendation for a plan to embed a broader reporting mechanism throughout the Trust.			
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 (May 2023), Board Seminar (June 2023) and the Finance & Performance Committee (May & July 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): - Continued development of the IPR - Confirmation of the broader project plan - Presentation of the next iteration at August Board Seminar				

List of Appendices:
Appendix A – IQPR July 2023

NHS
South Central Ambulance Service
NHS Foundation Trust

Integrated Quality and Performance Report: Jun-23

Contents

Section

Summary Of Changes

The Integrated Quality Performance Report for July sets out our performance in June. For the reporting of month 3 performance the following developments have been implemented.

1. Having taken feedback from the Board in June and followed advice from Sam Riley, NHSE, we have adopted a format and style for the report which is considered best practice (Morecambe Bay). For consistency and ease of replication this document is developed using the same reporting platform as the Trust uses (others that are based on a different platform (EEast & SECamb)).
2. The report is structured to reflect our Improvement Programme workstreams and will eventually incorporate the metrics and reporting identified against each of those too.
3. A variety of format amendments have been made to ease flow and development of reporting.
4. A review of sources, owners and targets has been initiated alongside the development of timelines for production which are in the process of alignment with the developing Trust Board calendar.
5. The number of pages has been reduced although further work will be undertaken to ensure that we are reporting only what is essential to be reported. The Morecambe Bay document runs to c. 50 pages (compared with this c. 60 page document).
6. It is proposed that once the document has reached a level of capability that meets the basic requirements of an IQPR, fundamental changes will then be held for a period of 3 months to enable consistency of production and content.

Contents

Section

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

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

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- CCC (EOC and 111)
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June-23 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		999 % calls from frequent callers Debtors > 90 days> 5% total balance SCAS 111 - ED Referrals ST&C (ED 1&2) - SCAS VOR - Total VOR - Unplanned Maintenance		2
L	Total 111 - Transfer to Clinician	Conflict Management Equality & Diversity Fire Awareness Health & Safety Infection Control Information Governance Manual Handling Patients Arrived within time Safeguarding Adults Level 1 Safeguarding Children Level 1		4
	Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds ST&C (Non-ED 1&2) - SCAS	38	Patients Collected within time	21
L	Average Hospital Handover Time - SCAS Hospital Delays - SCAS	111 Calls abandoned after 30 secs % 999 Calls abandoned %		8
H	111 call answer in 120 Secs % Appraisals - Trust			1
↗		Number of Non-Physical Assaults Number of Physical Assaults		4
↘		Number of Never Events (CQC/NRLS reportable)		2

Metrics:

Hit and Miss Common Cause Metrics:
% 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) ; 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 % ; EOC External Attrition ; EOC Internal Attrition ; Hand Hygiene audit ; Number of SI investigations outstanding after 60 days (excluding events that are officially suspended) ; Number of cleanliness compliance audits ; Number of compliant Building cleanliness 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 ; S&T - SCAS ; SCAS 111 - 999 referrals % ; 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 ; VOR - Other ; VOR - Planned Maintenance ; Vehicle cleanliness completed audits

EXECUTIVE COMMENTARY

The Integrated Quality Performance Report for July sets out our performance in June.

The previous page of the Executive Summary reports our metrics as a matrix of assurance vs variance. The majority of metrics fall within the "Hit or Miss" column of assurance which in many cases reflects the fact that we have not collected enough data points (21 is the minimum required for SPC), the frequency of reporting differs or that there is no established or statistically significant trend in the data. This does not mean that conclusions cannot be drawn from the performance of those metrics hence the reporting of them is still valid.

The number of metrics without targets continues to reduce and now stands at 43 compared to 68 in the June report.

Quality and Patient Safety

Whilst the trust has only recorded one never event in the last 12 months a number of other clinical metrics report less favourable results. 7 Serious Incidents were recorded in June bringing the Year to date total to 16. RIDDOR reports (Slips, trips, falls and lifting) also increased with 16 reported in the last month bringing the year to date total to 23. To counter this the Trust continues to train staff on the use of equipment and task based risk assessments regarding lifting and carrying practices.

Clinical metrics, whilst not establishing statistically significant trends are also indicating increased variability. The mean average call to angiography has increased since June 2022. Cardiac arrest survival Utstein has reduced significantly since February 2023 from a peak of 43% to the June figure of 13%. The mean time from stroke call to hospital arrival has also maintained an increased mean over the same time period. The June figure being 1:30 against a target of 1:17.

Building (29 vs 42), Vehicle cleanliness (97 vs 145) and hand hygiene (113 vs 288) audits whilst maintaining performance around their means show no sign of achieving their targeted compliance (June actual vs Target) . Reminders for audit completion are sent by the IPC team where compliance levels are low whilst audits are also discussed during the clinical governance meetings with operational managers who are tasked with improving these figures.

EXECUTIVE COMMENTARY (Continued)

Performance Improvement

999 Operations: June 999 incident levels were 4.8% down on the same month last year. The biggest reduction being in Hear and Treat incidents although as a % of total calls they maintained 11%. The monthly average of 999 incidents has been broadly consistent since February 2022.

With June being the hottest on record it is unsurprising that increased demand was experienced at certain points in the month; particularly during the 11th to 13th. Cat 1 and 2 performance increased by 26 seconds and 6 minutes respectively compared to the previous month. Whilst Cat 2 performance in June was a mean of 34:48, this increased to 78:26 on those 3 hottest days. Cat 3 and 4 performance also increased during this time and was impacted by both hot weather and a need to bring resource levels in line with budget constraints. Our improvement plan focuses on balancing our resource hours with our budget. Hence whilst we focus on delivering our financial plan we must also be cognisant of the impact that it will have on performance.

See and Treat activity fell in June to 33.7%. However, the See, Treat and Convey percentage increased to 50.8%. The ST&C increase reflects the fact that as the number of S&T incidence falls so the proportion of more serious cases that need conveying goes up. In reality we conveyed 1,024 fewer patients in June than in May, the increased % therefore results from a much smaller base. Our improvement actions take place at a local level with leadership teams reviewing performance to understand local changes and access to pathways. In addition the clinical lead meets with counterparts from the other ambulance trusts to learn and share best practice.

Total task time, on the increase throughout 2022 is now decreasing with a significant drop from May to the June figure of 1:46. Average Hospital Handover time is a major factor in this and we continue to work with Acute Trusts. 2,221 hours were lost in June versus a 12 month average of 4,452 hours. Our improvement plans focus on reducing delays whilst also implementing immediate handover at peak times. The benefits we are now experiencing result from our continued partnership working with these providers.

999 attrition and recruitment are broadly on plan although recruitment was under the target (16 actual vs 27 targeted). Our frontline workforce is now broadly in line with plan whilst sickness in the last 3 months has maintained at 8% vs plan levels of 8.5%. Our plan is to continue to deliver well being initiatives for staff as preventative sickness measures.

EXECUTIVE COMMENTARY (Continued)

Meal break compliance and over runs continue to perform below target (55% vs 85% and 16% vs 33%) . New rosters will be introduced in Q4 and meetings are taking place with heads of EOC to identify how compliance can be improved. Unplanned VORs continue to increase with June being 5% higher than the 13% target. Recruitment activity is being increased at our workshops to recruit vehicle technicians.

EOC: 999 call volume was 4,500 calls above plan at 69,458 in June, due to the hot weather which led to increased call to answer times of 45 seconds c.20 seconds higher than May. Abandoned rates were above target at 5.5% but below the 12 month mean (7%). Our Integrated Workforce Plan is flexed to cover vacancy factors and focus on improving average call handling times.

EOC workforce levels are above plan (307 vs 293), with recruitment and attrition also on plan, whilst sickness, increased in the last two months from 6% to 8.4% remains in line with the 12 month average (8%). An EOC retention plan will be presented to the Workforce Board in August.

111: 111 Calls offered (122,929) were lower in June 2023 than in June 2022 and also lower than May 2023 despite the hot weather. Calls abandoned after 30 seconds reduced to 3.6% vs a target of 3%. In addition the % of calls answered in 120 seconds increased and has done so over the last 4 months from 46% to the June figure of 77.3%. We will continue to implement the improvement actions detailed in the 111 VASSOS plan supporting staff and management whilst continuing to recruit vacancies. This performance is supported by workforce metrics that are broadly on target (Recruitment and attrition) and below plan sickness 10% vs 12% which continues to be managed via well being initiatives.

PTS: Call Volumes have increased during 2023 and were 29k in June against a 12 month average of 26k. Call to answer performance was 62% against a target of 90%; influenced by workforce factors and fluctuations in demand. Patients arrived within time continues at below target levels (88% vs 90%) and reflects the increase in journey demand which has increased 3% month on month in June. Patients collected within time by contrast is above target (91.4% vs 90%). Our improvement plans focus on right sizing contracts within financial envelopes offered by commissioners. We are engaging with them to manage demand and reduce the cost burden. Any demand reduction activity cannot be taken unilaterally and must be done with the engagement of partners hence the ability to create a point of inflexion in demand is extremely limited.

PTS attrition remains lower than forecast and recruitment has gone well and we are on our planned workforce. We are developing a retention plan ready for presentation to the August Workforce Board and continue to consider new ways to attract candidates to B2 roles.

EXECUTIVE COMMENTARY (Continued)

Culture & Staff Wellbeing

Trustwide Statutory & Mandatory training in June remained below target levels and the 12 month average. In addition physical (23 vs 21) and non physical (64 vs 50) assaults on staff have increased and are both above target albeit with the majority appearing to be low risk. Our improvement plan in this area had considered the need for a violence prevention and reduction officer position which is now under review.

Trustwide appraisal rates are below target and have reduced from a high in March of c.90% to the June figure of 84%. A new PDR training package is being implemented although capacity to deliver it is causing delays. 3 Wellbeing project coordinators have been appointed who will work with departments to promote healthy lifestyles and ensure early interventions are identified with staff being sign posted to Health and Well Being support where available.

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Quality and Patient Safety

June-23 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L				
		19		
L				
H				
↗				
↘		Number of Never Events (CQC/NRLS reportable)		

Metrics:

Hit and Miss Common Cause Metrics:
Building cleanliness completed audits ; Cardiac Arrest Survival, Utstein ; Hand Hygiene audit ; Number of SI investigations outstanding after 60 days (excluding events that are officially suspended) ; Number of cleanliness compliance audits ; Number of compliant Building cleanliness 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 ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Vehicle cleanliness completed audits

Quality and Patient Safety - Quality Safety

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Number of Never Events (CQC/NRLS reportable)	0	0	0	1		
Medicines modules produced without error %					-	-
Days of medicines stock modules in reserve					-	-
Number of no/low harm incidents		468	1,117	1,117	-	n/a
Number of incidents moderate and above harm		8	25	25	-	n/a
Number of Serious Incidents (SI) reported		7	16	16	-	n/a
Number of SI investigations outstanding after 60 days (excluding events that are officially suspended)	0	2	8	17		
RIDDOR reportable incidents		16	23	23	-	n/a
Number of reported CD incidents – unaccounted for losses					-	-
Number of DATIX incidents - patient		477	1,178	1,178	-	n/a
Number of DATIX incidents - non patient		378	1,120	1,120	-	n/a

Observation & Explanation:

The number of RIDDOR reports has increased this month. Slip trips and falls and lifting and carrying are the highest categories. The incidents are across both E&UC and NEPTS services

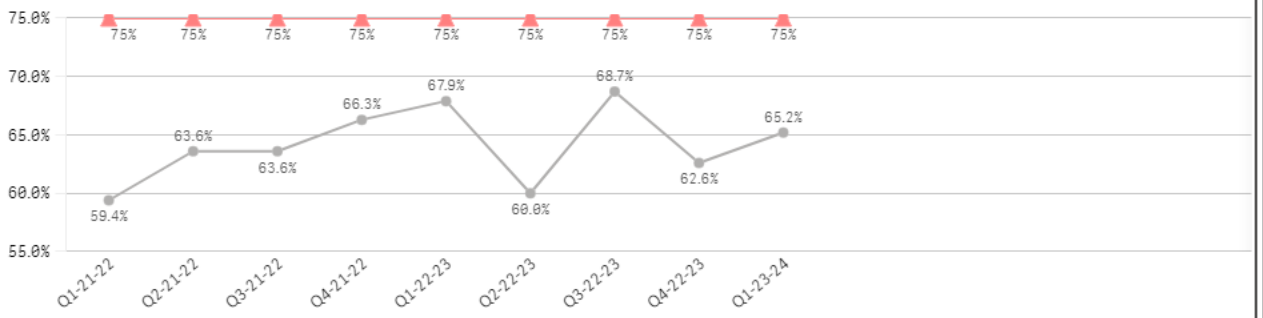
Improvement Actions and Assurance:

Continue training on available equipment, task based risk assessment and lifting and carrying practices.

Clinical Performance - STEMI

STEMI - Care

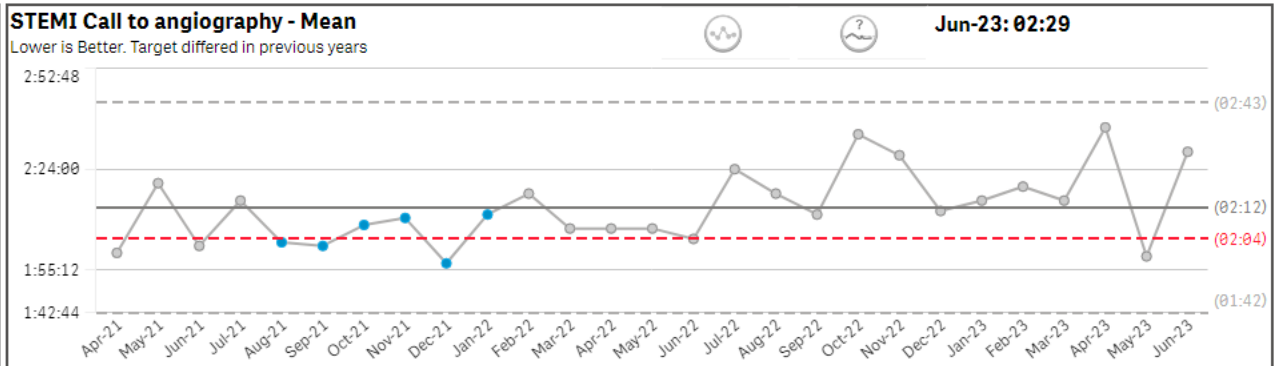
Higher is Better. Target differed in previous years



STEMI Call to angiography - Mean

Lower is Better. Target differed in previous years

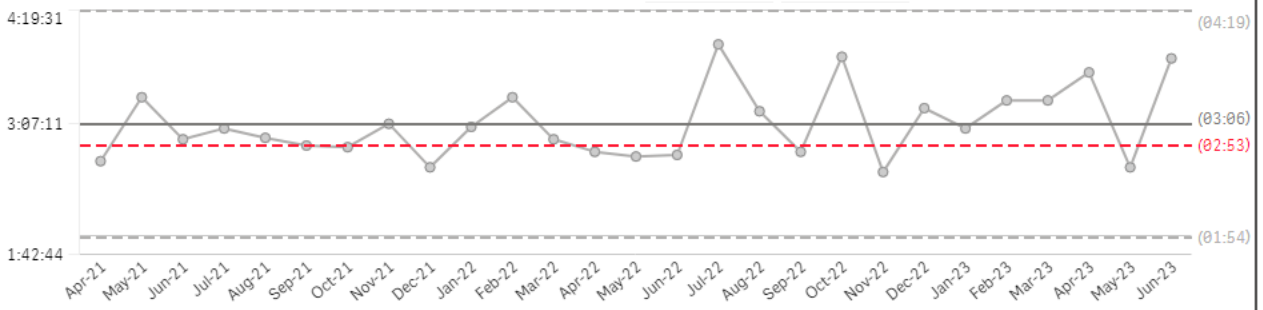
Jun-23: 02:29



STEMI - Call to angiography 90th Centile

Lower is Better. Target differed in previous years

Jun-23: 03:49



Observation & Explanation:

there has been an increase in times as seen in the overall performance response times. STEMI care not due for audit this reporting period

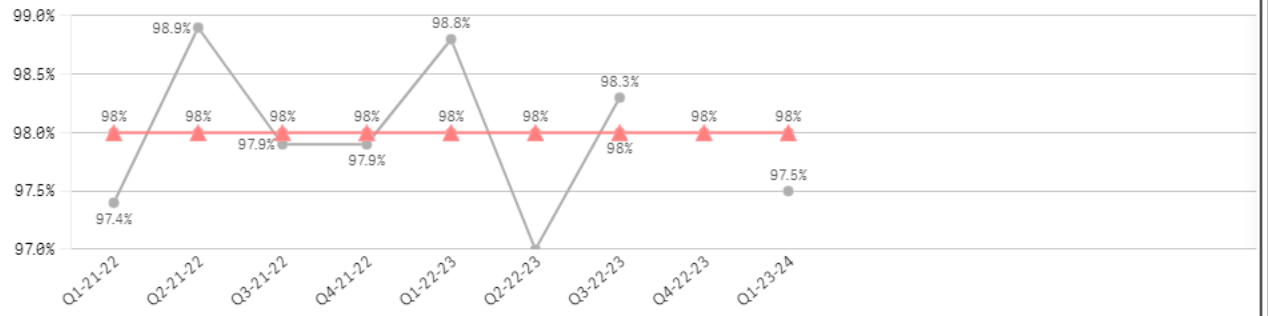
Improvement Actions and Assurance:

continue actions in performance improvement plan

Clinical Performance - Stroke

Stroke - Care

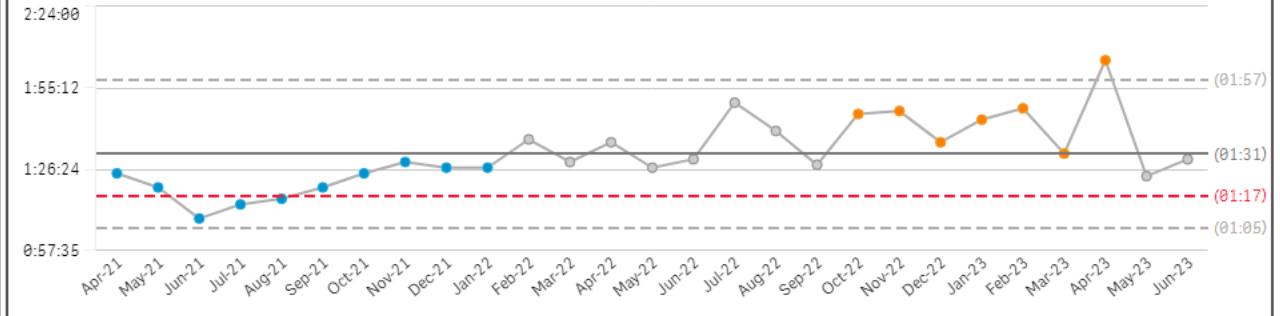
Higher is Better. Target differed in previous years



Stroke Call to Hospital arrival - Mean

Jun-23: 01:39

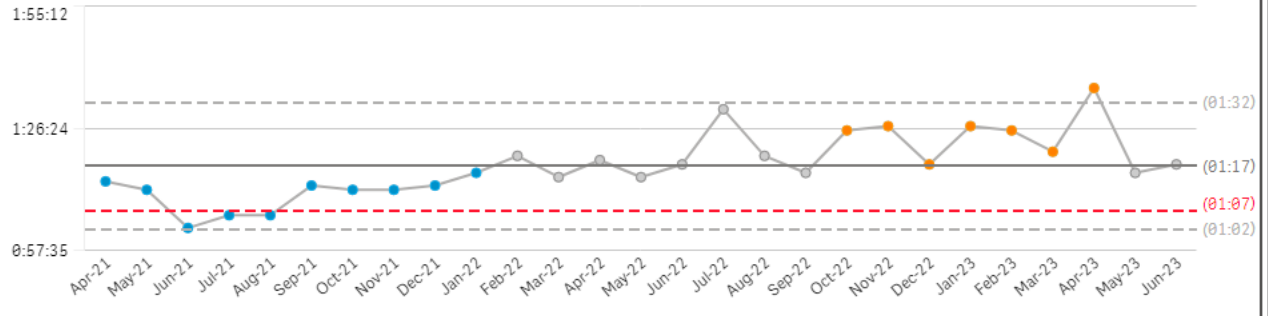
Lower is Better. Target differed in previous years



Stroke - Call to Hospital arrival Median

Jun-23: 01:23

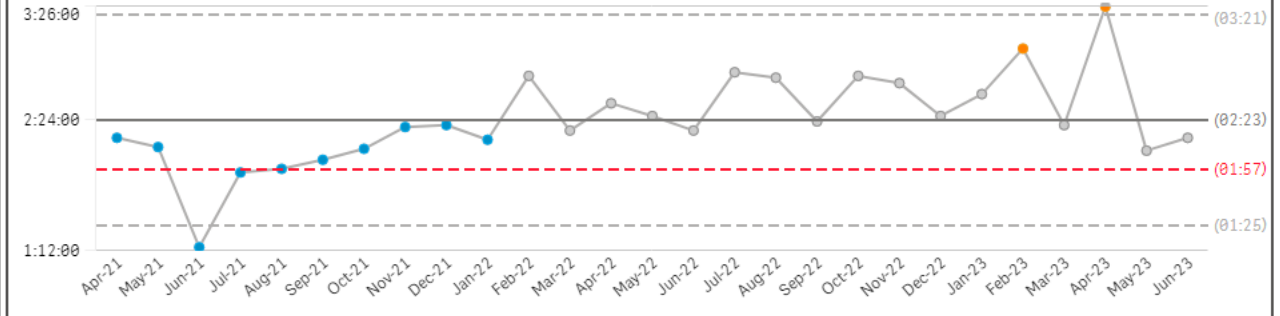
Lower is Better. Target differed in previous years



Stroke - Call to Hospital arrival 90th Centile

Jun-23: 02:35

Lower is Better. Target differed in previous years



Observation & Explanation:

increase in response times this month. Consistent compliance in stroke care

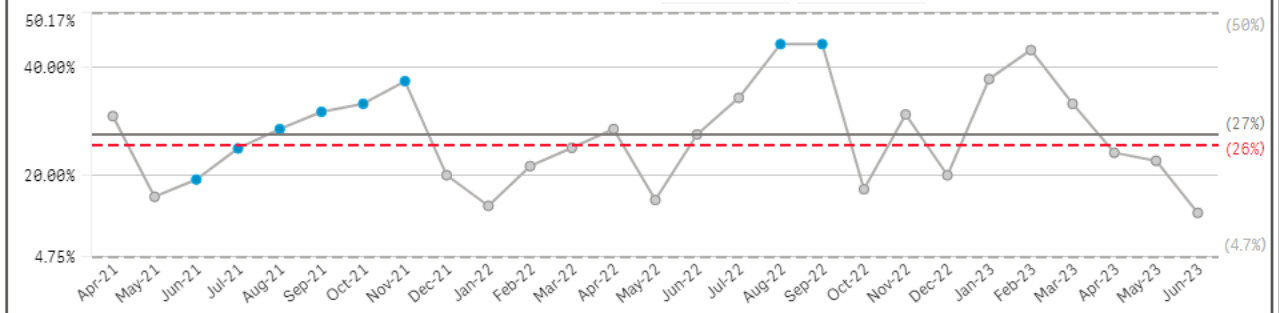
Improvement Actions and Assurance:

Continue with actions in performance recovery plan

Clinical Performance - Cardiac Arrest

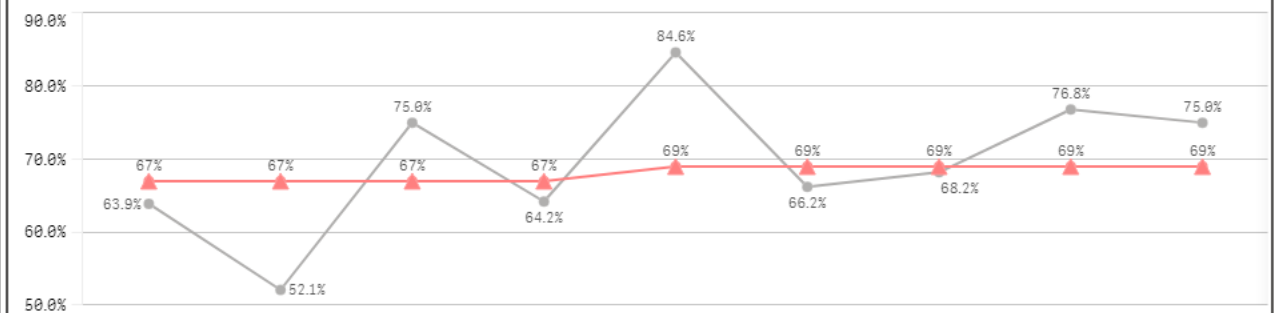
Cardiac Arrest Survival, Utstein — **Jun-23: 0.13%**

Higher is Better. Target differed in previous years



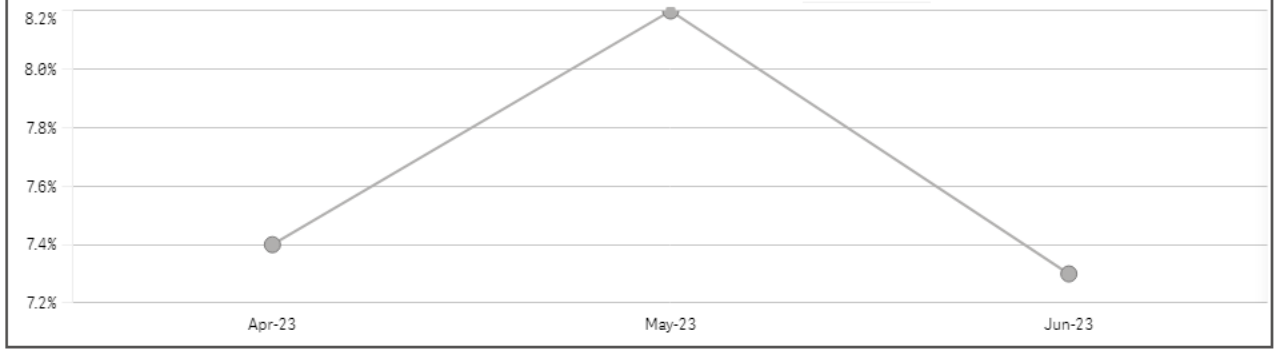
Cardiac Arrest Post- ROSC care

Higher is Better. Target differed in previous years



Cardiac Arrest Survival at 30 Days - All Patients — **Jun-23: 7.3%**

Higher is Better. Target differed in previous years



Observation & Explanation:

After a small increase last month this month there has been a slight decrease

Improvement Actions and Assurance:

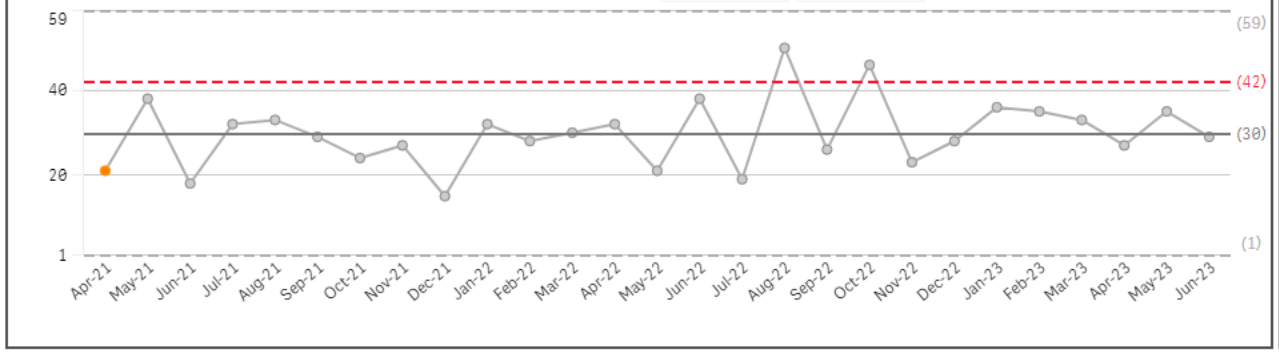
Continue to monitor compliance with resuscitation training on face to face training days this year

Quality Safety - Building Audits

Building cleanliness completed audits

Higher is Better. Target differed in previous years

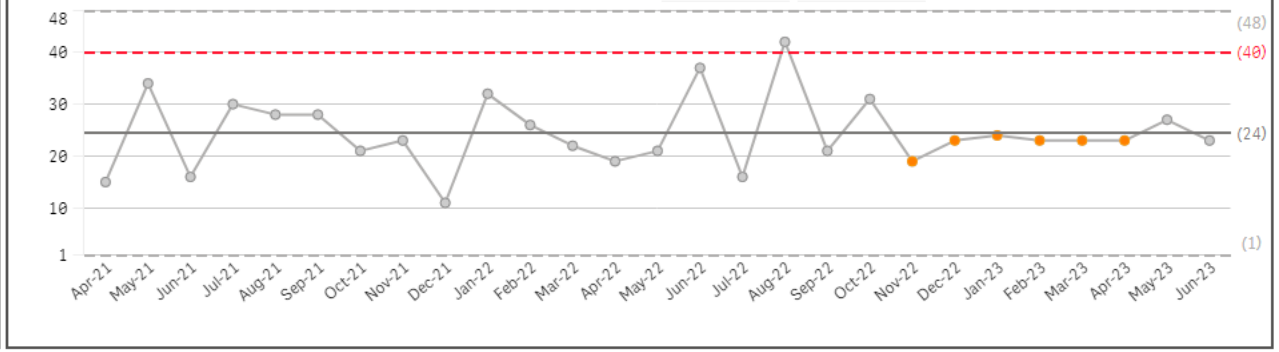
Jun-23: 29



Number of compliant Building cleanliness audits

Higher is Better. Target differed in previous years

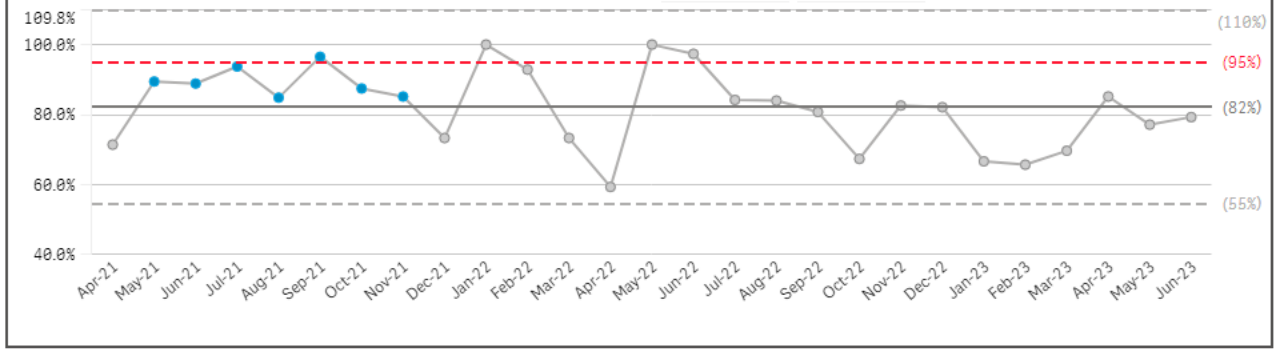
Jun-23: 23



Percentage of compliant Building cleanliness audits

Higher is Better. Target differed in previous years

Jun-23: 79.3%



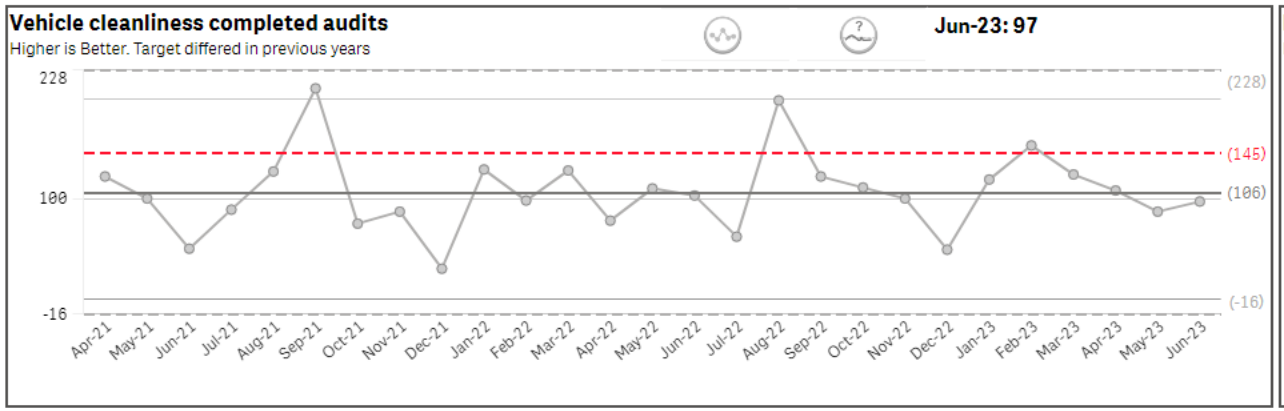
Observation & Explanation:

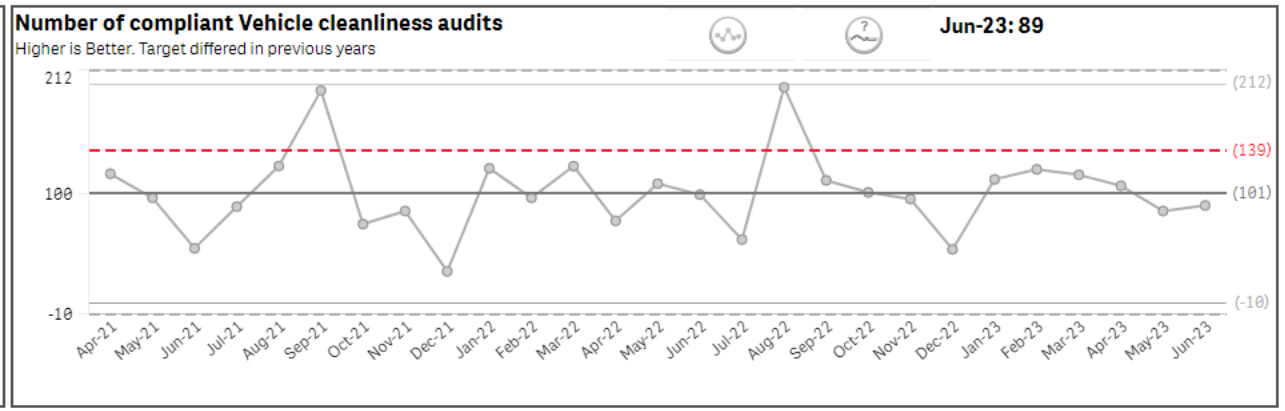
Overall number of building audits has fallen consistently over the last quarter for 999 service, with June being the poorest month for completion. PTS remain under trajectory however number of completed audits has improved in June. Compliance rate of completed audits remains high but not reflective of overall picture due to limited number of audits completed.

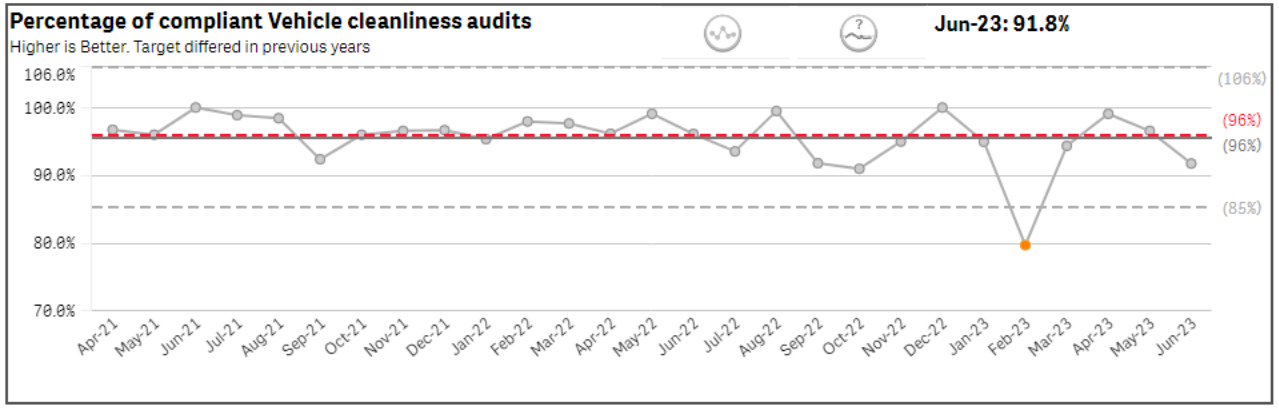
Improvement Actions and Assurance:

Reminders for audit completion are sent by IPC to nodes and counties where performance is poor, this will remain ongoing. Audits discussed as regular agenda item at 999 clinical governance and operational managers have been tasked with improving these figures

Quality Safety - Vehicle Audits







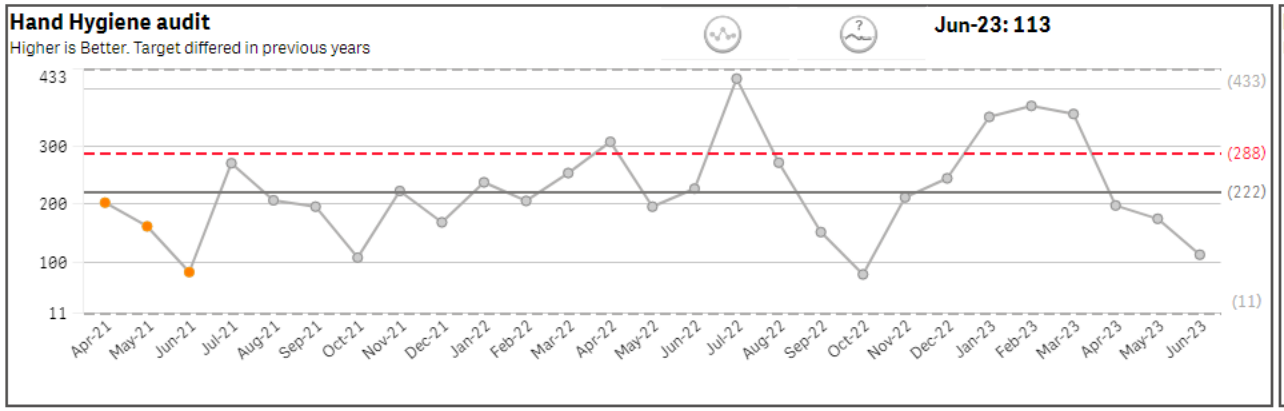
Observation & Explanation:

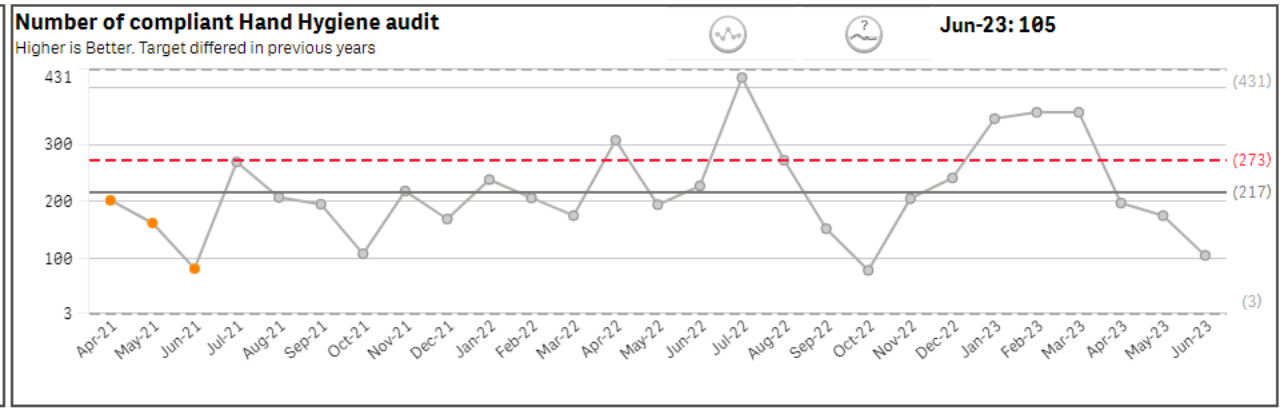
Overall number of vehicle audits has fallen consistently over the last quarter for 999 service, with June being the poorest month for completion. PTS remain under trajectory however number of completed audits has improved in June. Compliance rate of completed audits remains high but not reflective of overall picture due to limited number of audits completed.

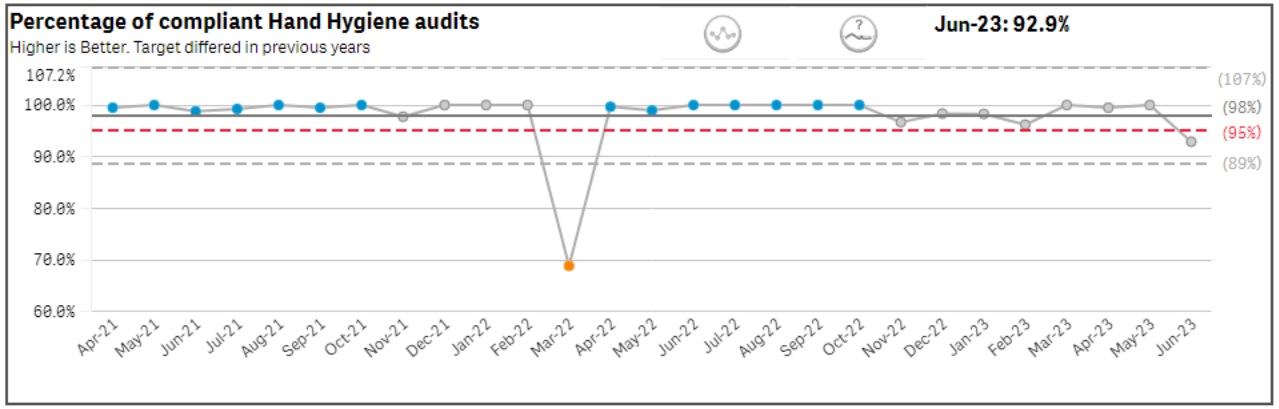
Improvement Actions and Assurance:

Reminders for audit completion are sent by IPC to nodes and counties where performance is poor, this will remain ongoing. Audits discussed as regular agenda item at 999 clinical governance and operational managers have been tasked with improving these figures

Quality Safety - Hand Hygiene Audits







Observation & Explanation:

Overall number of hand hygiene audits has fallen consistently over the last quarter for 999 service, with June being the poorest month for completion. PTS remain under trajectory however number of completed audits remains consistent. Compliance rate of completed audits remains at 100% in 999 and PTS which is an inaccurate representation in comparison to IPC level 2 audits which have demonstrated poor compliance with hand hygiene practices and bare below the elbows for the services

Improvement Actions and Assurance:

Reminders for audit completion are sent by IPC to nodes and counties where performance is poor, this will remain ongoing. Audits discussed as regular agenda item at 999 clinical governance and operational managers have been tasked with improving these figures. Level 2 IPC audits continue, Hand Hygiene and BBE pages live on the Hub with reminders for staff via Yammer.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Performance Improvement

NHS Performance Improvement Overview

June-23 Summary

Assurance ⇨ (F) (?) (P)

Variance ⇩

	Fail	Hit and Miss	Pass	No Target
H		999 % calls from frequent callers SCAS 111 - ED Referrals ST&C (ED 1&2) - SCAS VOR - Total VOR - Unplanned Maintenance		1
L	Total 111 - Transfer to Clinician	Patients Arrived within time		4
	Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds ST&C (Non-ED 1&2) - SCAS	19	Patients Collected within time	20
L	Average Hospital Handover Time - SCAS Hospital Delays - SCAS	111 Calls abandoned after 30 secs % 999 Calls abandoned %		6
H	111 call answer in 120 Secs %			1
↗				4
↘				2

Metrics:

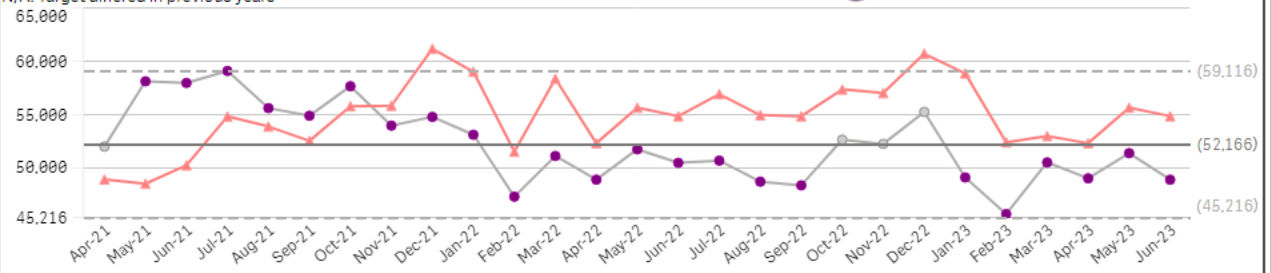
Hit and Miss Common Cause Metrics:
% Cat 1 resulting in LW (> 30 mins) ; % Cat 2 resulting in LW (> 60mins) ; % Cat 3 resulting in LW (> 3hrs) ; % Cat 4 resulting in LW (> 4 hrs) ; Cat 1 90th %ile SCAS ; Cat 1 Mean SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 3 90th %ile SCAS ; Cat 4 90th %ile SCAS ; Clear up Delays - SCAS ; Complaints - 999 Total % ; Compliments % ; EOC External Attrition ; EOC Internal Attrition ; S&T - SCAS ; SCAS 111 - 999 referrals % ; VOR - Other ; VOR - Planned Maintenance

National Standards - 999 Activity Levels

Activity (999 Incidents) - SCAS

Jun-23: 48,847

N/A. Target differed in previous years



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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Incidents Growth 999 - SCAS	9%	-3.15%	-1.22%	-51.5%		n/a

Observation & Explanation:

The number of incidents in June was 4.8% down on the same month last year. This fall was seen across all Categories, but the biggest fall was seen in the number of Hear and Treat incidents. This reduction is down a reduction in the number of welfare checks required due to improved response times. The number of HCP incidents also fell by around 3%

Improvement Actions and Assurance:

National Standards - Cat Mean & 90th

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Cat 1 Mean SCAS	00:07:00	00:09:15	00:08:43	00:09:13		
Cat 1 90th %ile SCAS	00:15:00	00:16:27	00:15:47	00:16:33		
Cat 2 Mean SCAS	00:18:00	00:34:48	00:29:41	00:33:08		
Cat 2 90th %ile SCAS	00:40:00	01:08:26	00:58:52	01:06:53		
Cat 3 90th %ile SCAS	02:00:00	04:42:33	03:48:42	04:56:22		
Cat 4 90th %ile SCAS	03:00:00	05:23:33	04:48:52	06:18:45		

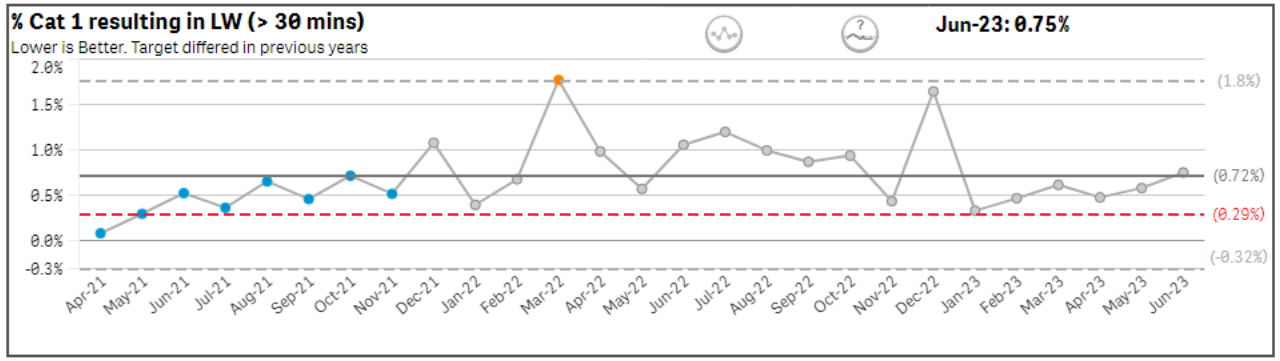
Observation & Explanation:

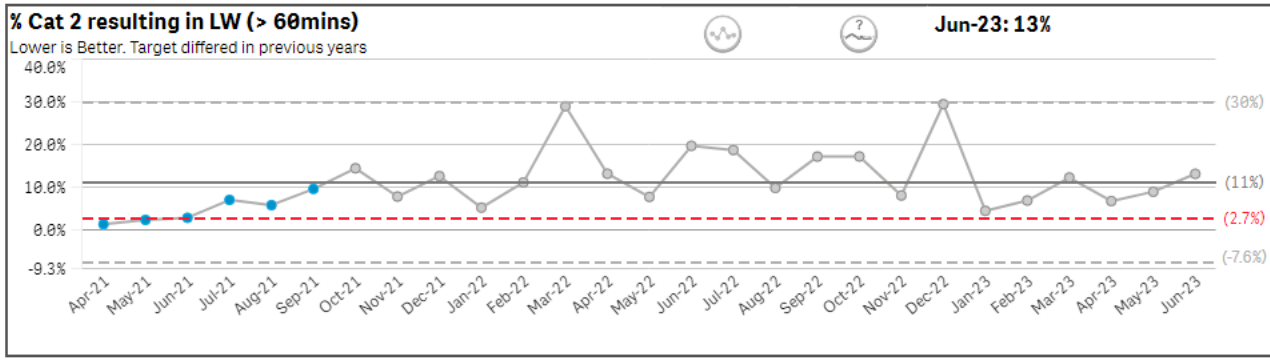
June performance was heavily impacted by the 11th to 13th June where we saw a sudden increase in demand which impacted on all performance measures linked to the hot weather. Cat 1 performance increased by 26 seconds from May and cat 2 performance increased by 6 minutes from May. The cat 2 mean of 34:48 was heavily impacted by the 11th to 13th where cat 2 mean was 78:26. June was also above our trajectory which was set at 27:19. Our cat 3 mean was 26 minutes higher than May and 51 minutes above trajectory. Performance will also be impacted as we bring resource levels in line with budget constraints

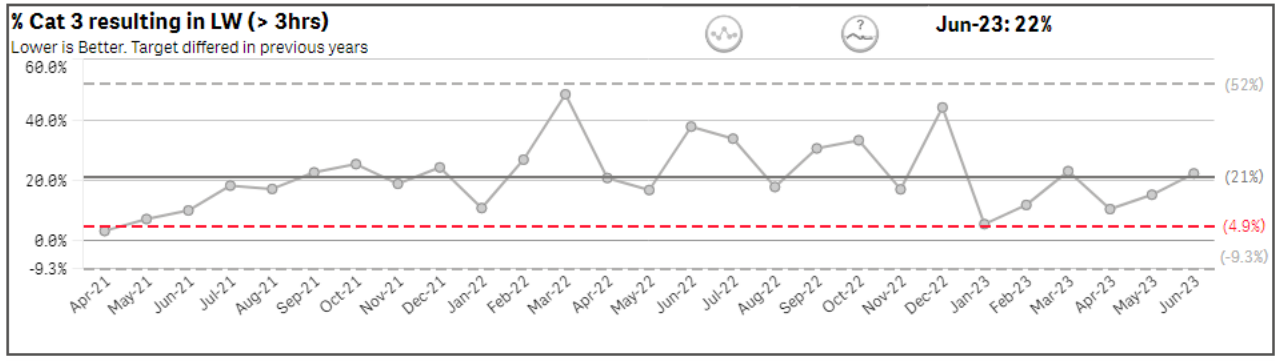
Improvement Actions and Assurance:

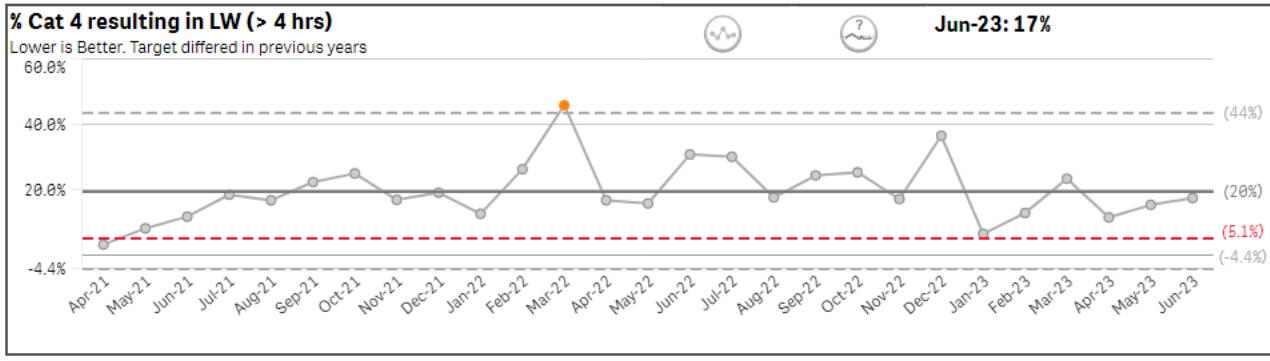
We will continue to implement our performance improvement plan while balancing resource hours against our budget. The improvement plan focus is on balancing our resource hours to budget which will deliver the finance plan, however will impact on our performance delivery.

National Standards - Long Waits









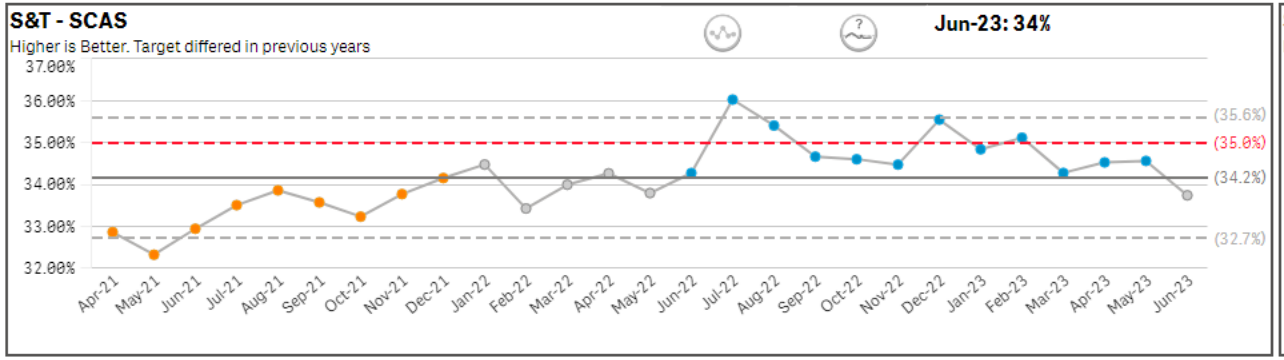
Observation & Explanation:

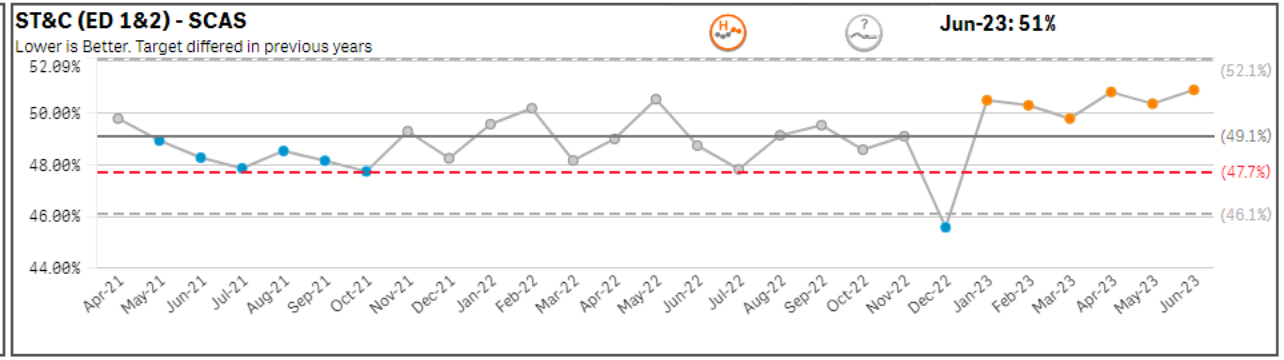
Each measure for long waits is close to or on mean for the measure. As we realign our resource levels in line with budget, this will reduce resources and impact on long waits. We will continue to focus resources on cat 1 and 2, however cat 3 and 4 will be impacted. The poorer performance was impacted by the period 11-13 June where we experienced a sharp spike in demand linked to hot weather.

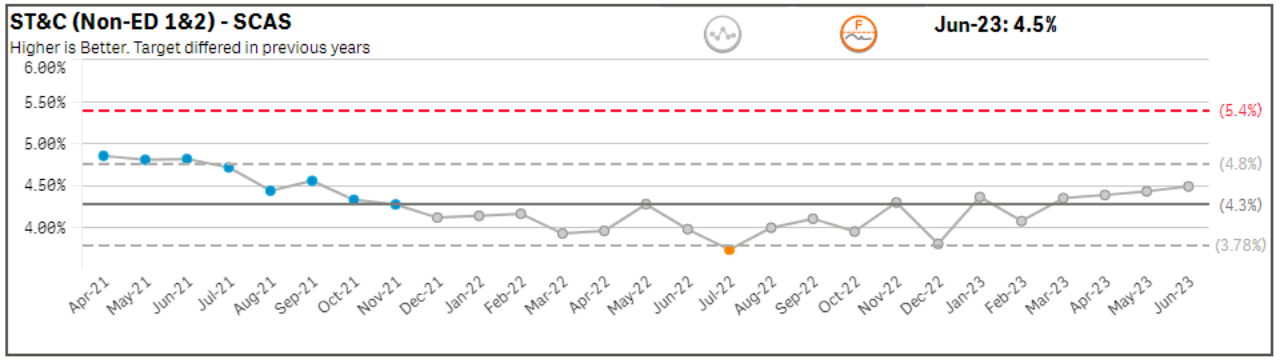
Improvement Actions and Assurance:

On going clinical reviews of long waits to assess any patient impacts through long waits monthly review groups. The long waits review group will identify any patient safety incidents and escalate these as required to provide assurance. This is also supported by the daily patient safety reviews and if any of these involve a long wait they are reviewed by the ops and clinical team for cause and impact.

999 Operations - ST&C







Observation & Explanation:

S&T fell to 33.7% in June with an increase in ST&C percentage to 50.8%. This however doesnt reflect that we conveyed 1,024 fewer patients to ED than we did in May. 0.5% of the drop in S&T is accounted for by the opposite increase with H&T. ST&C to Non ED is at the highest level for the last 18 months as we continue to open new pathways within the acute trusts to avoid ED

Improvement Actions and Assurance:

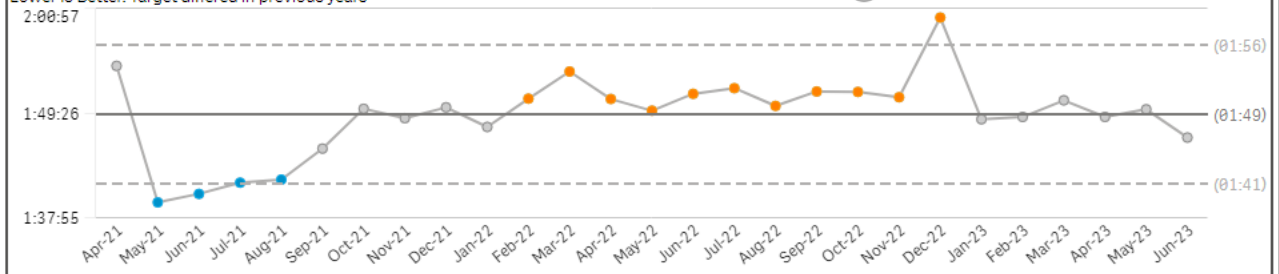
The local area leadership teams are reviewing the performance with their teams to understand any local changes with the access to pathways. the Clinical pathways lead has met with SWAST and EMAS LAS and now meeting with NEAS and YAS to pull together any learning from these trusts around S&T pathways. The findings of this review will be shared through NDOG for all trusts

999 Operations - Delays

Total Task Time - SCAS

Lower is Better. Target differed in previous years

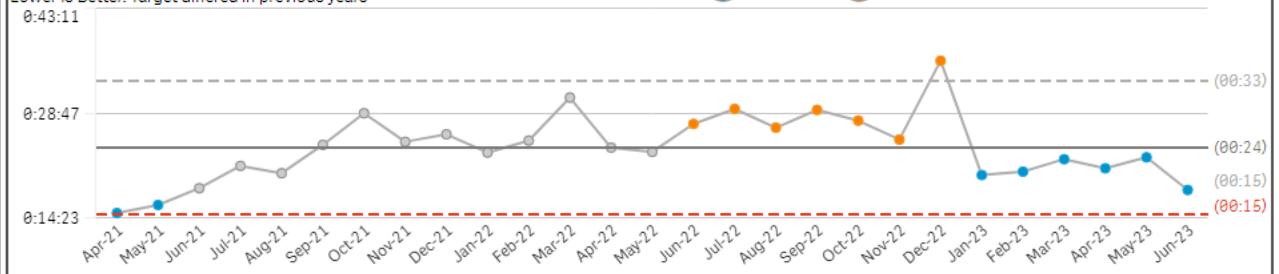
Jun-23: 01:48



Average Hospital Handover Time - SCAS

Lower is Better. Target differed in previous years

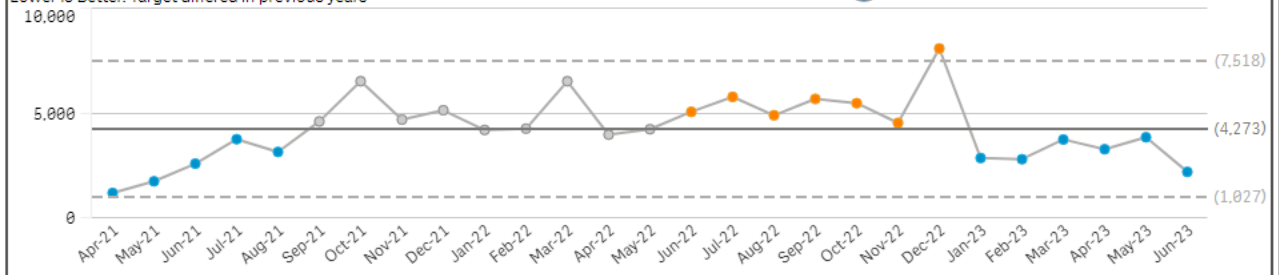
Jun-23: 00:20



Hospital Delays - SCAS

Lower is Better. Target differed in previous years

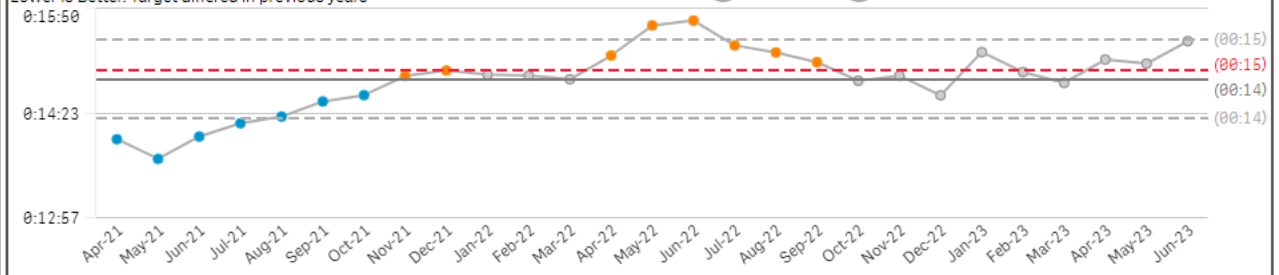
Jun-23: 2,221



Clear up Delays - SCAS

Lower is Better. Target differed in previous years

Jun-23: 00:15



Observation & Explanation:

The level of handover delays dropped in June to 2,221 hours which is the lowest level since December 22 with the average handover also falling to 18:18 from 22:47 in May. Average clear up time has seen a 20 second increase from May which is in part due to faster handover times. Task time has continued to improve linked to the reducing handover delays

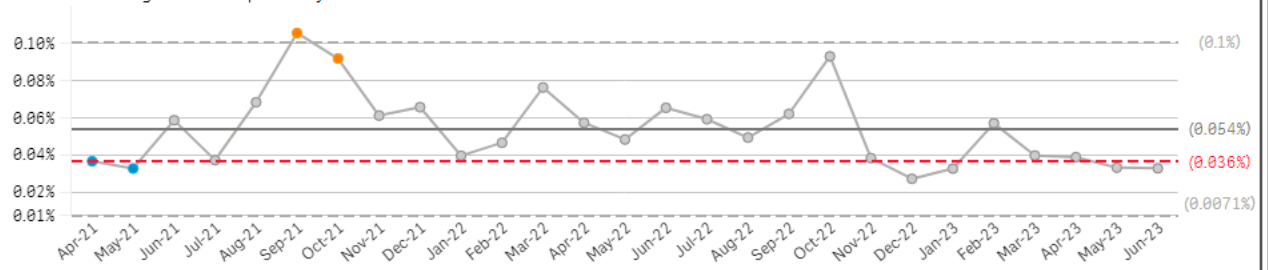
Improvement Actions and Assurance:

We will continue to work with acute trusts to continue reducing delays as well as implementing our immediate handover at peak times. The local Heads of Operations meet regularly with their acute trust to review the performance and identify local improvement plans. The local management teams will continue to challenge outliers with higher clear up times which are also impacting on overall task time. The focus also remains in place with team leaders reviewing their teams performance for on scene times and challenging any outliers.

999 Operations - 999 Complaints

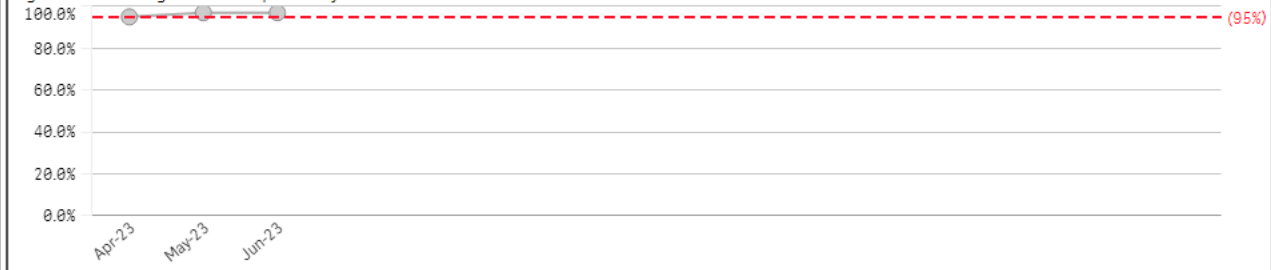
Complaints - 999 Total % — Jun-23: 0.033%

Lower is Better. Target differed in previous years



999 Complaints response - agreed timescale % — Jun-23: 97%

Higher is Better. Target differed in previous years

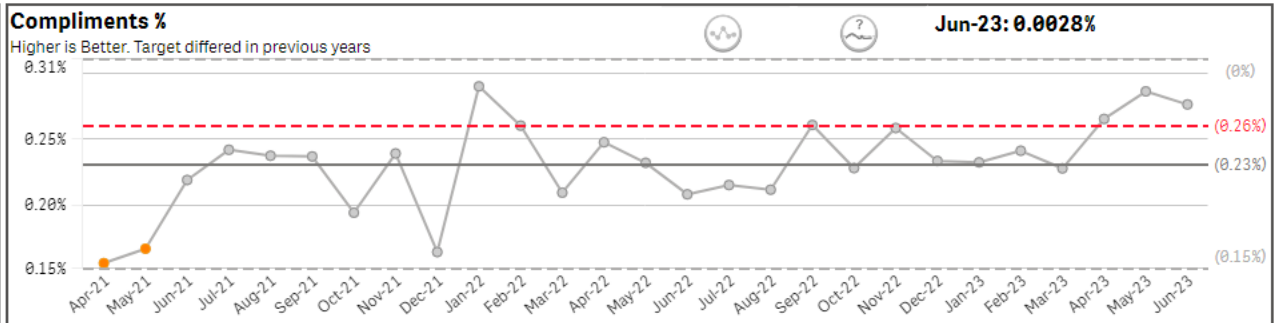


*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
999 PHSO cases - upheld/partially upheld		0%	0%	0%		

Compliments % — Jun-23: 0.0028%

Higher is Better. Target differed in previous years



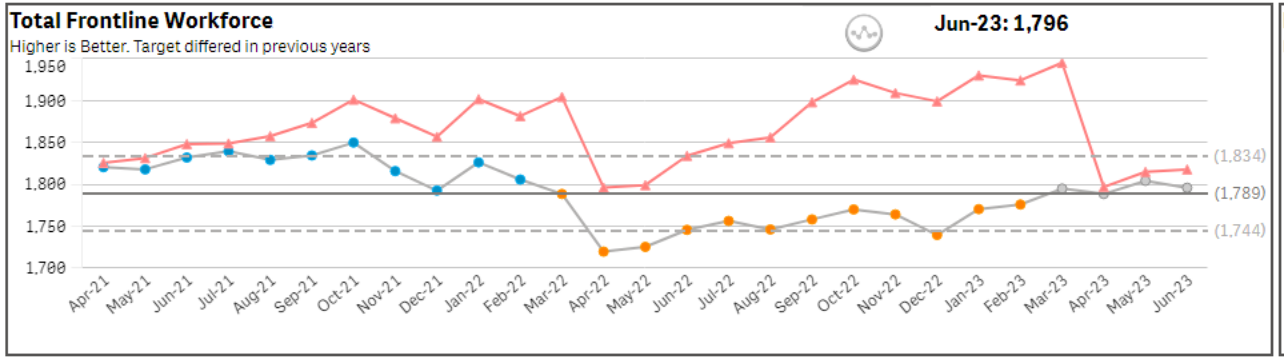
Observation & Explanation:

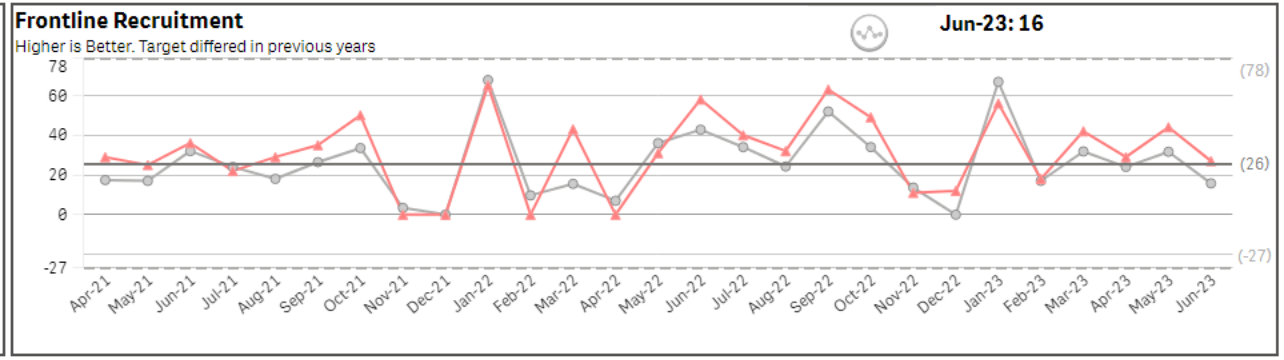
Complaint responses within time continue to be above target. Number of complaints seen a reduction to 16. Top two categories patient care and staff attitude

Improvement Actions and Assurance:

Continue with current practice in response management. Continue with learning from complaints included in learning from experience group with triangulation of themes and actions monitored by the group

999 Operations - 999 Workforce 1





Observation & Explanation:

Recruitment was below plan. This was due to a number of drop outs for international paramedics this month. We are putting plans in place to catch up the numbers later this year. We also had 2 bank paramedics and 2 return to practice paramedics on the June course. Sickness remains below forecast.

Improvement Actions and Assurance:

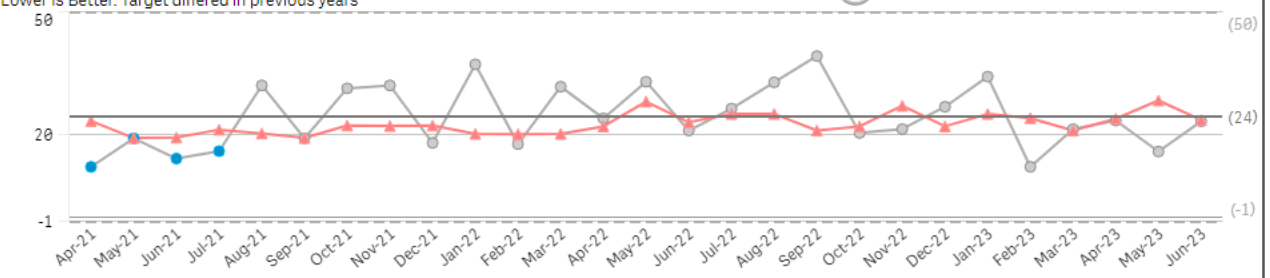
Include enough spaces in the international delivery plan to ensure we meet the year end target of 70 WTE. Focus on well-being initiatives for staff as preventative sickness measures

999 Operations - 999 Workforce 2

Frontline Attrition

Jun-23: 23

Lower is Better. Target differed in previous years



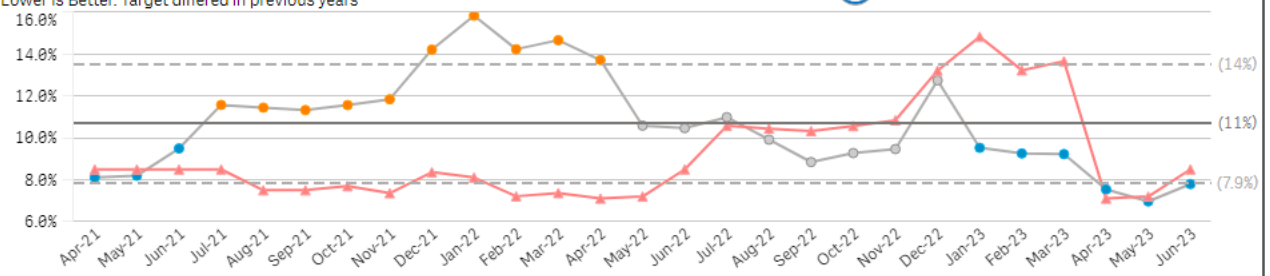
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Frontline External Attrition	18	14	39	0		n/a
Frontline Internal Attrition	6	23	48	0		n/a

Sickness - 999 (Total)

Jun-23: 7.8%

Lower is Better. Target differed in previous years



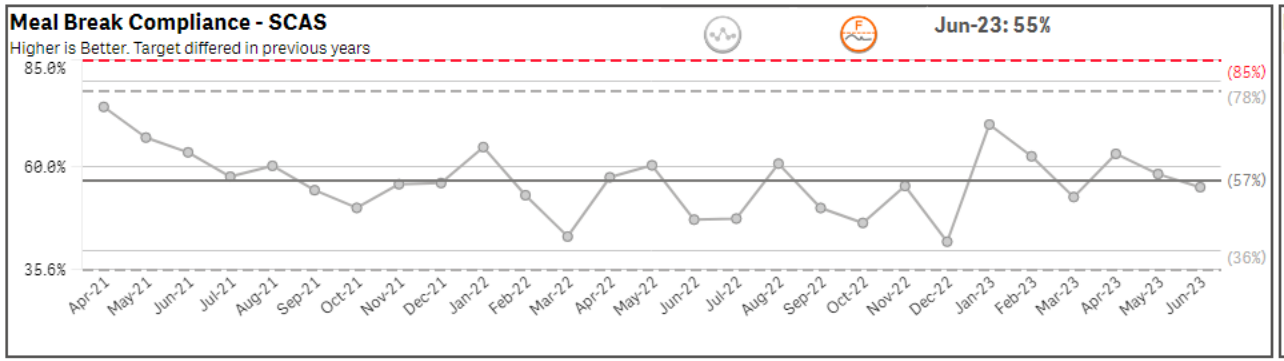
Observation & Explanation:

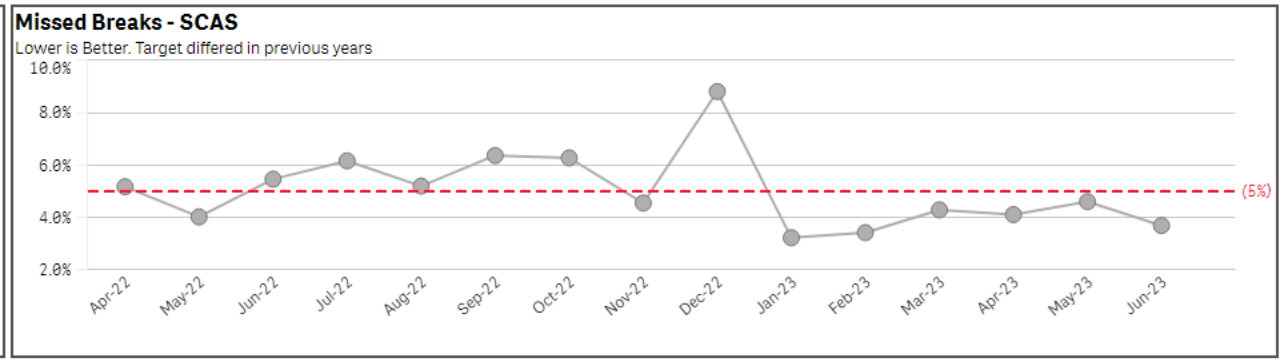
Recruitment was below plan. This was due to a number of drop outs for international paramedics this month. We are putting plans in place to catch up the numbers later this year. We also had 2 bank paramedics and 2 return to practice paramedics on the June course. Sickness remains below forecast.

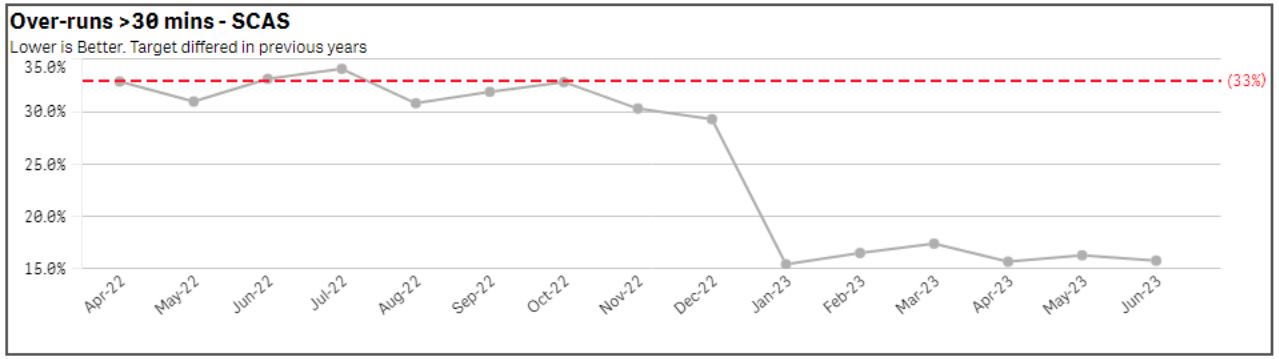
Improvement Actions and Assurance:

Include enough spaces in the international delivery plan to ensure we meet the year end target of 70 WTE. Focus on well-being initiatives for staff as preventative sickness measures.

999 Operation - 999 Workforce Compliance







Observation & Explanation:

Meal Break compliance is still a concern, a meeting has been set up with the heads of EOC to look t how this can be improved.

Improvement Actions and Assurance:

New rosters in Q4, Meeting with heads of EOC to look at how compliance can be improved, Working with finance to look at paid breaks to increase sites where breaks are taken.

999 Operations - VOR & Make Ready

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Vehicle deep clean Compliance - A&E		91.0%	90%	109%		n/a
Vehicle routine cleans	5,502	5,261	15,498	63,627	L	n/a
VOR - Unplanned Maintenance	13%	17.7%	16%	14%	H	?
VOR - Planned Maintenance	4%	2.0%	2.8%	3%		?
VOR - Other	7%	6.0%	6.9%	8%		?
VOR - Total	23%	25.7%	26%	25%	H	?
Number of Accidents		60	198	198	-	n/a

Observation & Explanation:

Unplanned VOR continues to increase which is driven by increase in age profile of current Ambulance fleet due to delays in delivery of new vehicles. Staffing shortages in SCFS has also increased VOR time.

Improvement Actions and Assurance:

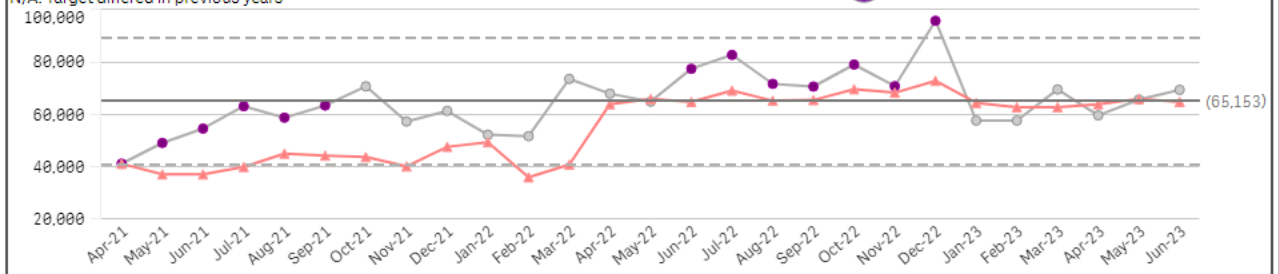
Recruitment days through July and August organised at both workshops to improve recruitment of vehicle technicians.

Clinical Coordination Centre - CCC Performance 1

999 Call Volume

Jun-23: 69,458

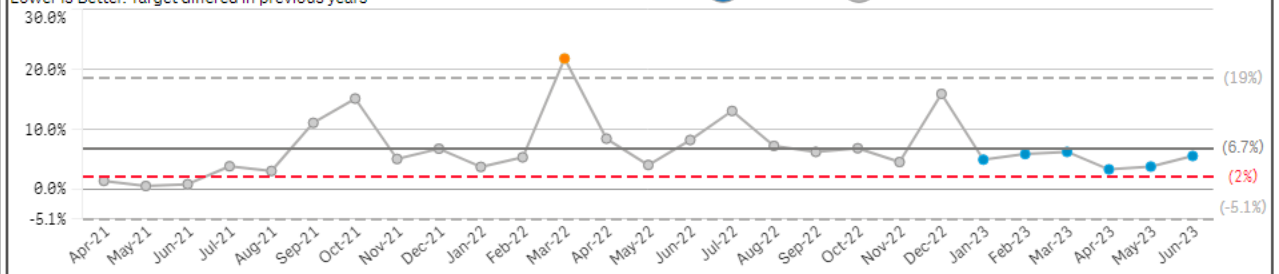
N/A. Target differed in previous years



999 Calls abandoned %

Jun-23: 5.5%

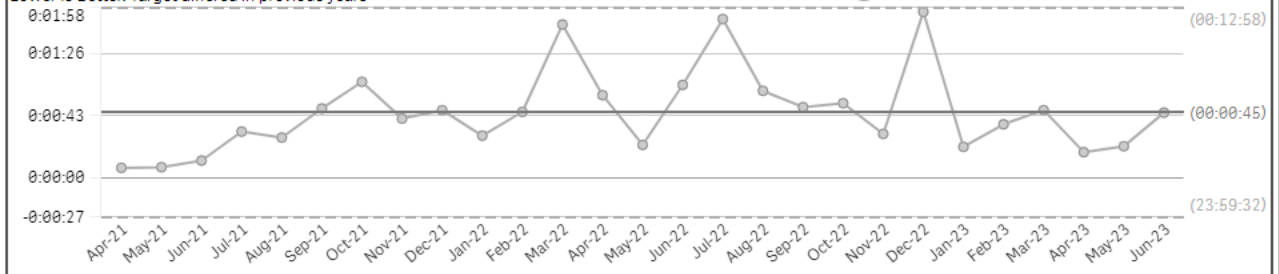
Lower is Better. Target differed in previous years



999 Mean Call Answer Time

Jun-23: 00:00:45

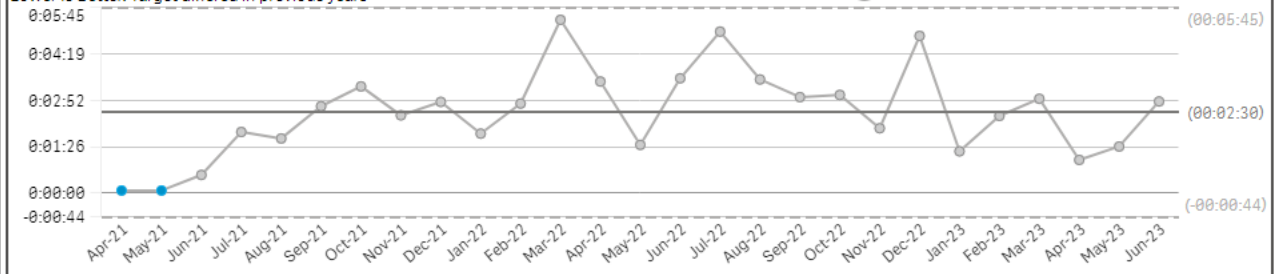
Lower is Better. Target differed in previous years



999 90th Percentile Call Answer Time

Jun-23: 00:02:51

Lower is Better. Target differed in previous years



Observation & Explanation:

Inbound call volumes for 999 increased above the mean and was driven by the extreme weather conditions in the earlier part of the month. The led to deterioration in call answer mean to 41 seconds for the month.

Improvement Actions and Assurance:

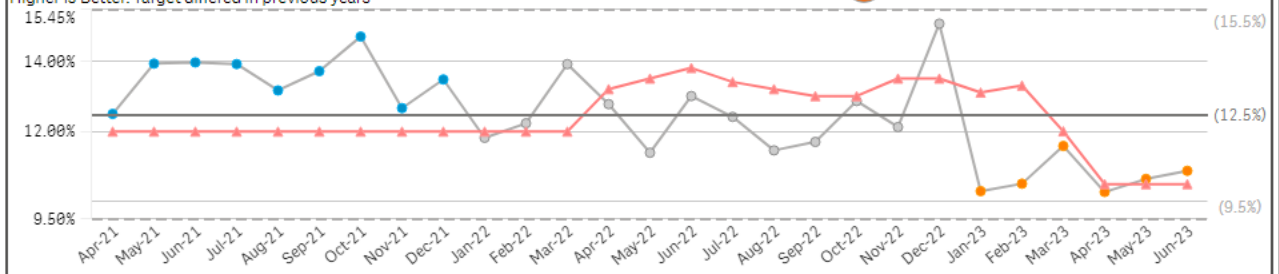
Call centre metrics remain the focus for improvement in average handling time. IWP remains in place to cover vacancy factors, mainly the gap between work effective and non work effective staff.

Clinical Coordination Centre - CCC Performance 2

H&T - SCAS

Higher is Better. Target differed in previous years

Jun-23: 11%



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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
999 % calls from frequent callers	5%	4.2%	4.2%	3%		

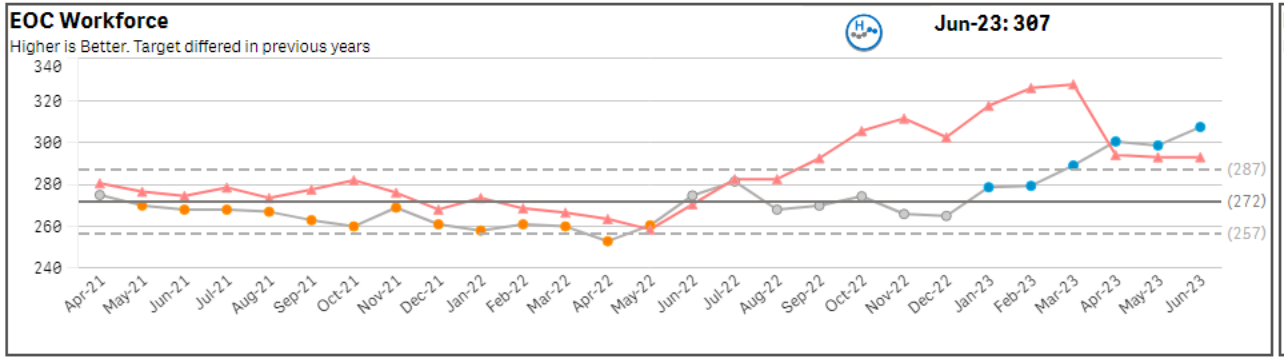
Observation & Explanation:

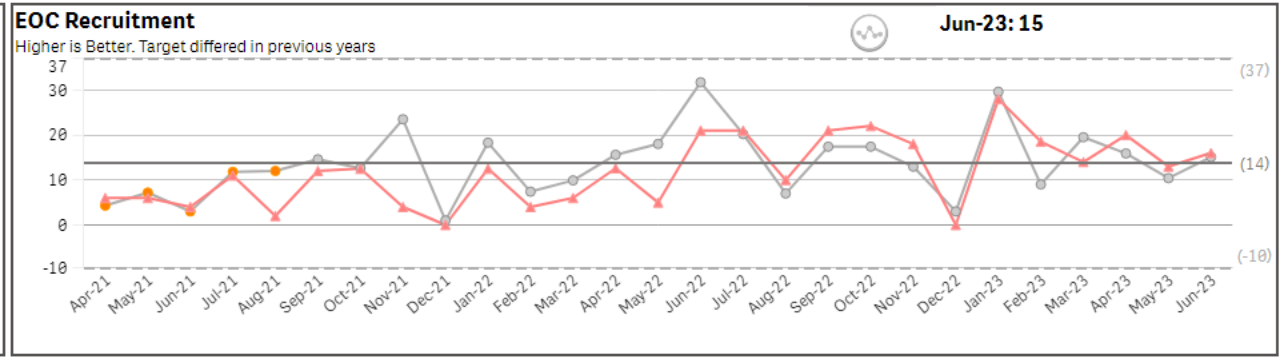
Hear and Treat showed a small increase in June and achieved the UEC quarterly target.

Improvement Actions and Assurance:

Call centre metrics remain the focus for improvement in average handling time. IWP remains in place to cover vacancy factors, mainly the gap between work effective and non work effective staff.

Clinical Coordination Centre - EOC Workforce 1





Observation & Explanation:

EOC attrition remains constant but is below forecast. The EOC retention plan is being developed and operationalized

Improvement Actions and Assurance:

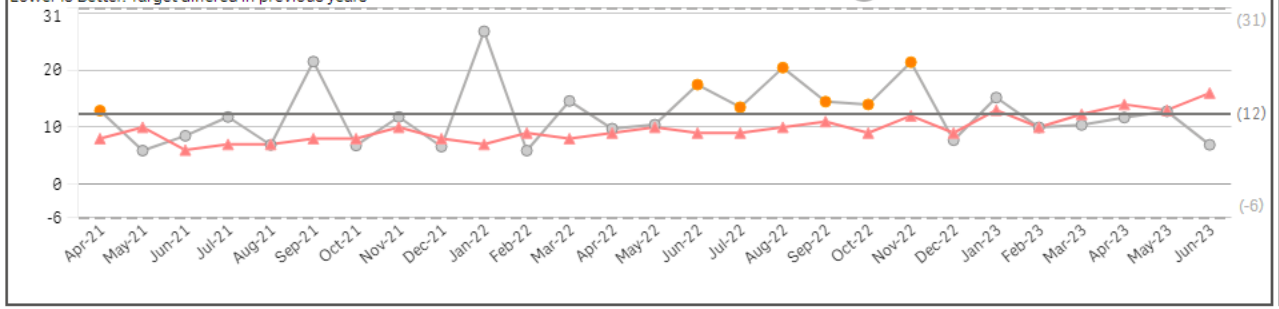
Finalization of EOC retention plan for Workforce Board in August 2023.

Clinical Coordination Centre - EOC Workforce 2

EOC Attrition

Lower is Better. Target differed in previous years

Jun-23: 7



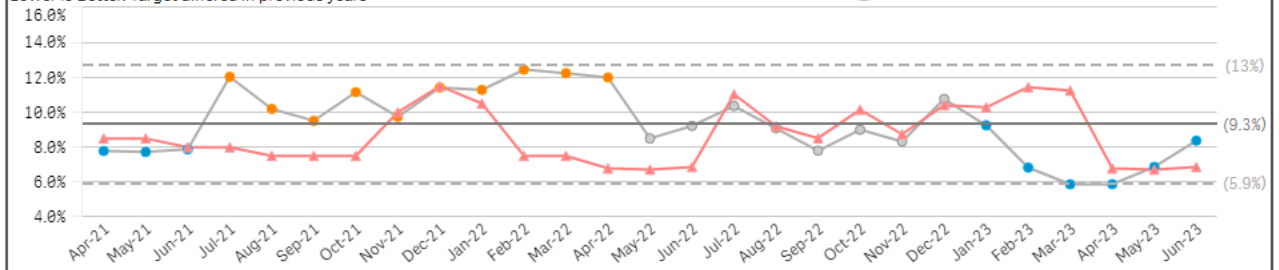
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
EOC Internal Attrition	5	2	11	117		
EOC External Attrition	11	5	21	219		

Sickness - EOC (Total)

Lower is Better. Target differed in previous years

Jun-23: 8.4%



Observation & Explanation:

EOC attrition remains constant but is below forecast. The EOC retention plan is being developed and operationalized

Improvement Actions and Assurance:

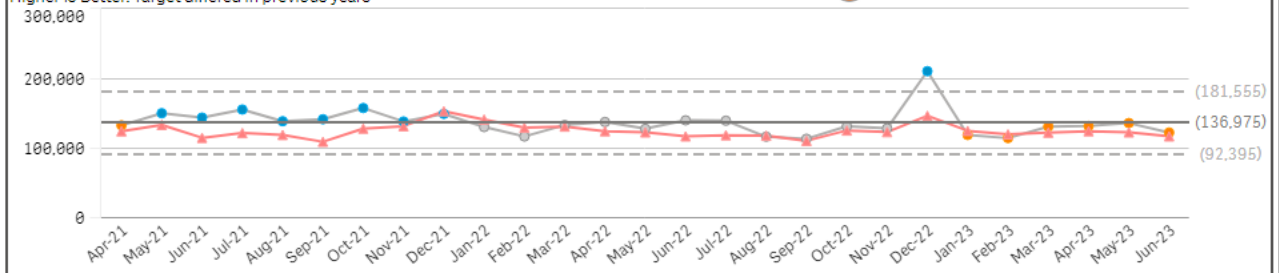
Finalization of EOC retention plan for Workforce Board in August 2023

Clinical Coordination Centre - 111 Call Performance

111 Calls Offered

Higher is Better. Target differed in previous years

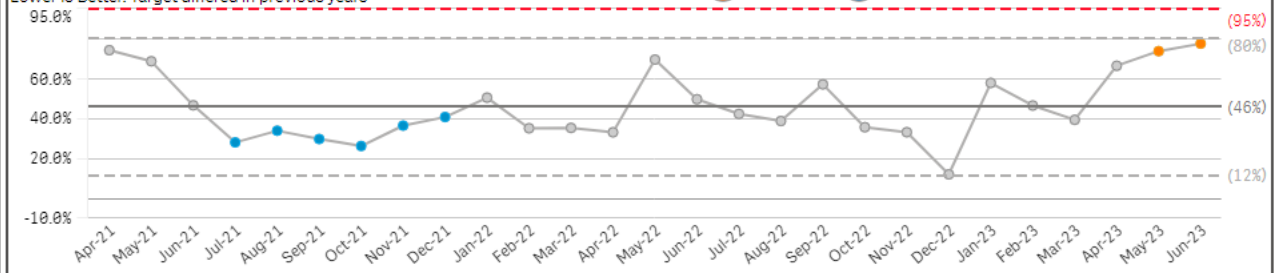
Jun-23: 122,929



111 call answer in 120 Secs %

Lower is Better. Target differed in previous years

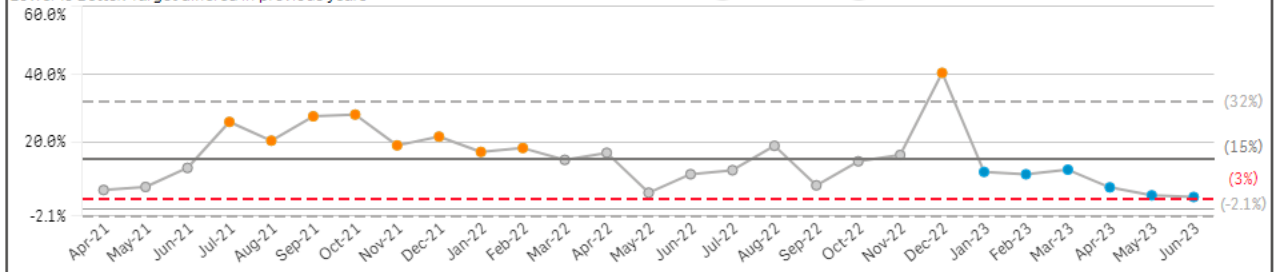
Jun-23: 78%



111 Calls abandoned after 30 secs %

Lower is Better. Target differed in previous years

Jun-23: 3.6%



Observation & Explanation:

Call demand in June 23 was lower than in June 22 and down on previous months. Call answer performance at 77.31% and abandonment rate at 4.09% whilst below target, both continue to show an improvement and are above trajectory. This is the highest level of performance achieved by the 111 team since the move to the new telephony reporting.

Observation & Explanation:

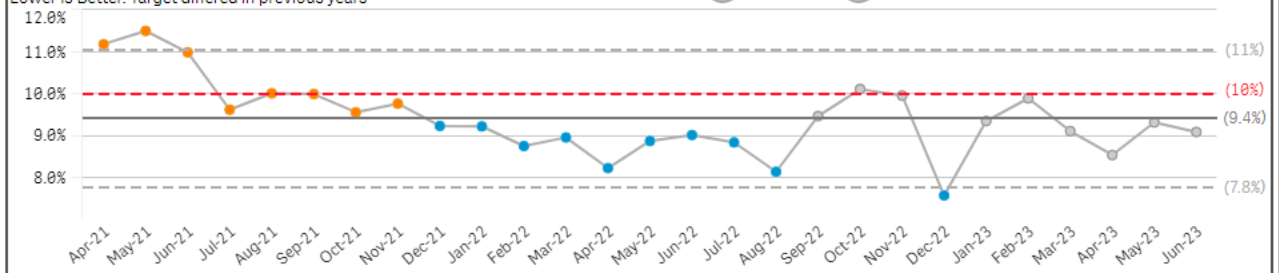
Continue with improvement actions detailed in the 111 VASSOS improvement plan supporting staff and floor management whilst continuing to recruit to vacancies.

Clinical Coordination Centre - 111 Call Referrals

SCAS 111 - 999 referrals %

Lower is Better. Target differed in previous years

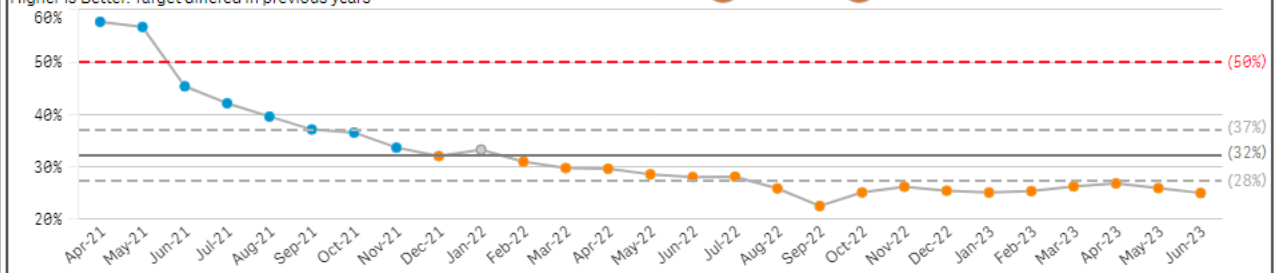
Jun-23: 9.1%



Total 111 - Transfer to Clinician

Higher is Better. Target differed in previous years

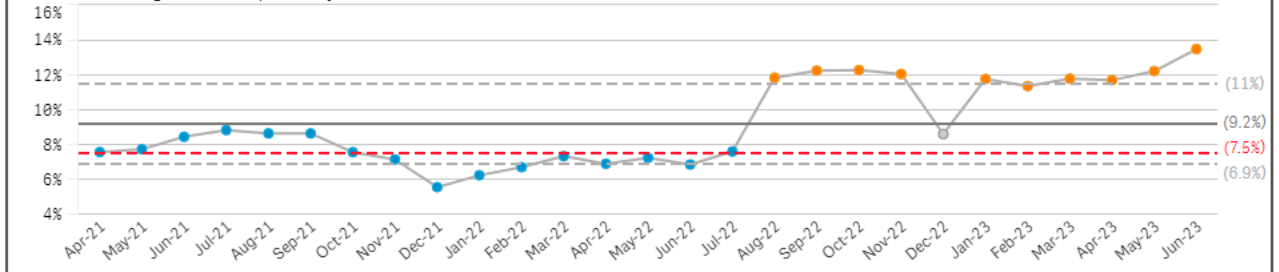
Jun-23: 25%



SCAS 111 - ED Referrals

Lower is Better. Target differed in previous years

Jun-23: 13%



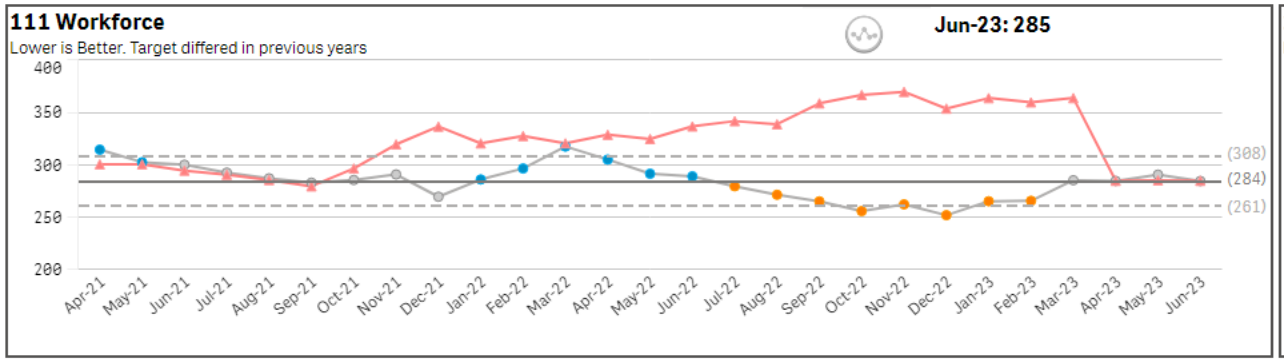
Observation & Explanation:

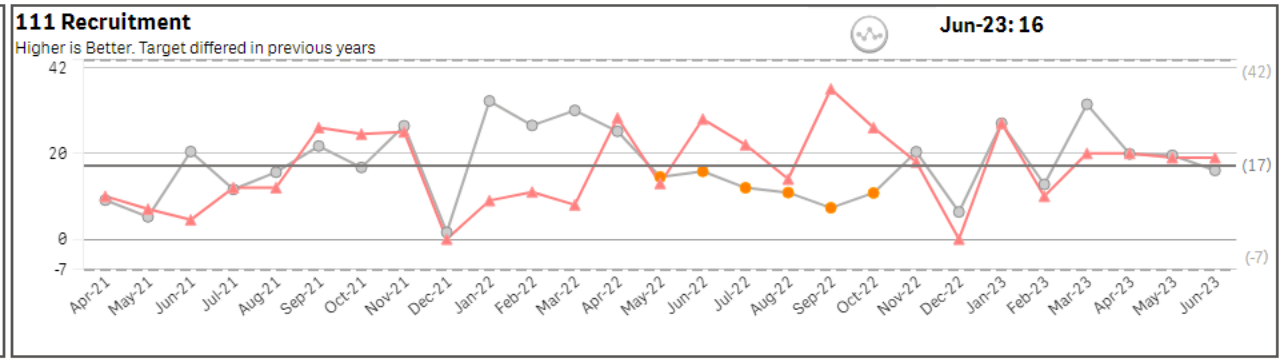
This data does not include any of the work done by the IUC clinicians and therefore is not an accurate reflection of the service and referral rates. IUC ADC data has not yet been produced and therefore I am unable to give accurate referral rates at this time.

Improvement Actions and Assurance:

Validation of Cat 3 & 4 as well as ED dispositions continues. We continue to work with the team to encourage use of alternative services/patient pathways.

Clinical Coordination Centre - 111 Workforce 1





Observation & Explanation:

Sickness remains lower than forecast, although it is rising since April 2023. Recruitment numbers are lower by 3WTE which is not statistically significant. We are working on filling particular rotas at SH and NH. MK vacancies are majority filled until we move to new site. Attrition is lower than planned in CCC, retention plans being developed and operationalized

Improvement Actions and Assurance:

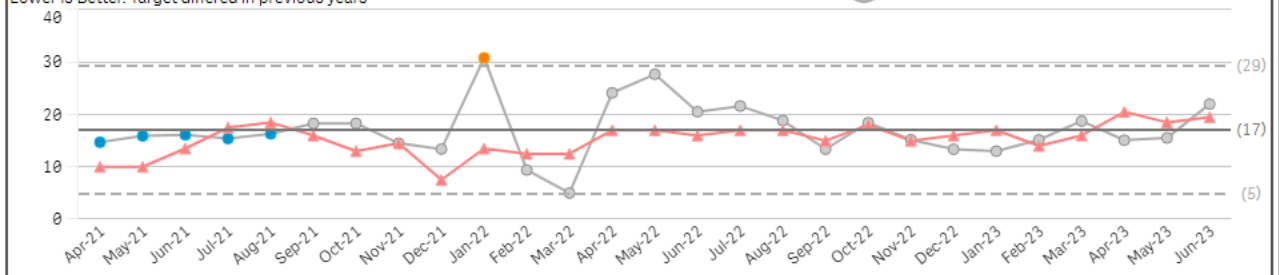
Continue to manage sickness and focus on 111 well-being initiatives. For recruitment, we continue to work on new ways to attract candidates.

Clinical Coordination Centre - 111 Workforce 2

111 Attrition

Lower is Better. Target differed in previous years

Jun-23: 22



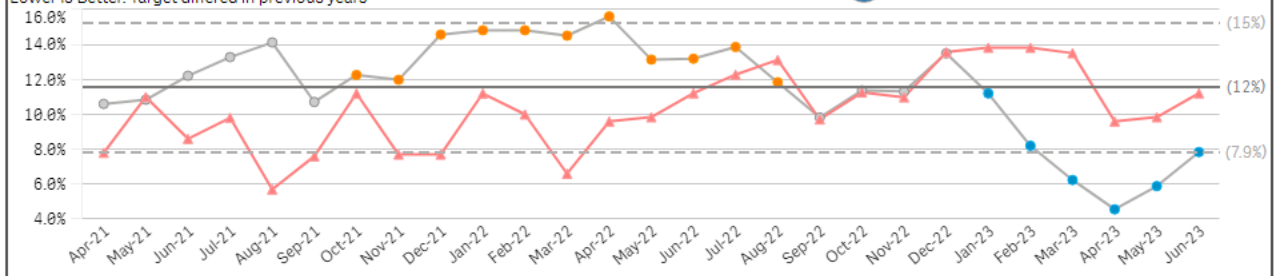
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
111 Internal Attrition	6	5	13	61		n/a
111 External Attrition	14	17	40	145		n/a

Sickness - 111 service (Total)

Lower is Better. Target differed in previous years

Jun-23: 7.8%



Observation & Explanation:

Sickness remains lower than forecast, although it is rising since April 2023. Recruitment numbers are lower by 3WTE which is not statistically significant. We are working on filling particular rotas at SH and NH. MK vacancies are majority filled until we move to new site. Attrition is lower than planned in CCC, retention plans being developed and operationalized

Improvement Actions and Assurance:

Continue to manage sickness and focus on 111 well-being initiatives. For recruitment, we continue to work on new ways to attract candidates.

Clinical Coordination Centre - 111 Complaints

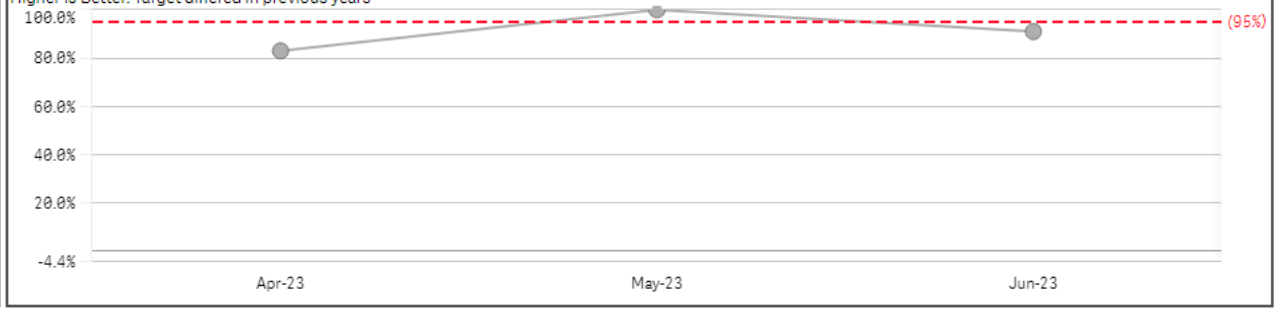
Complaints - 111 Service % **Jun-23:**

Lower is Better. Target differed in previous years

No data for this chart at present

111 Complaints response - agreed timescale % **Jun-23: 91%**

Higher is Better. Target differed in previous years



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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
111 PHSO cases - upheld/partially upheld		0%	0%	0%	-	n/a

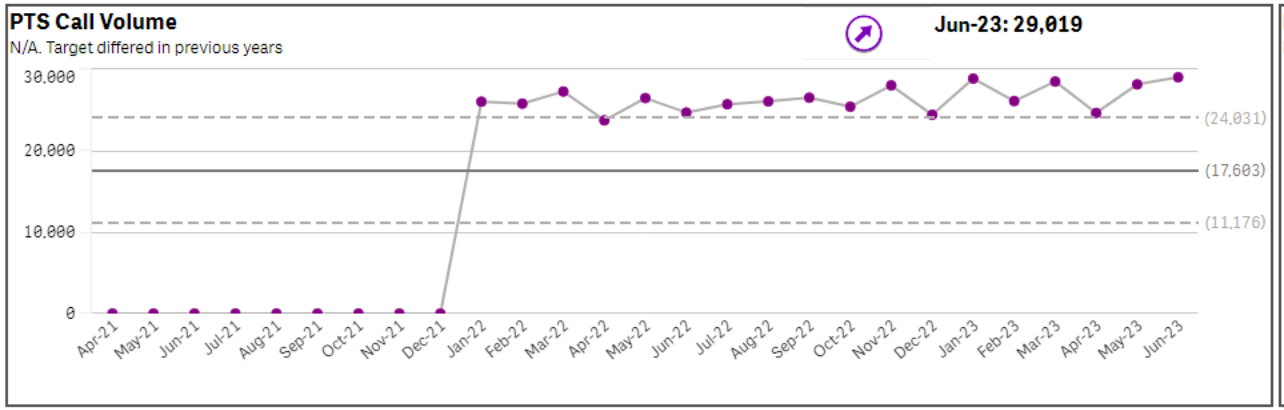
Observation & Explanation:

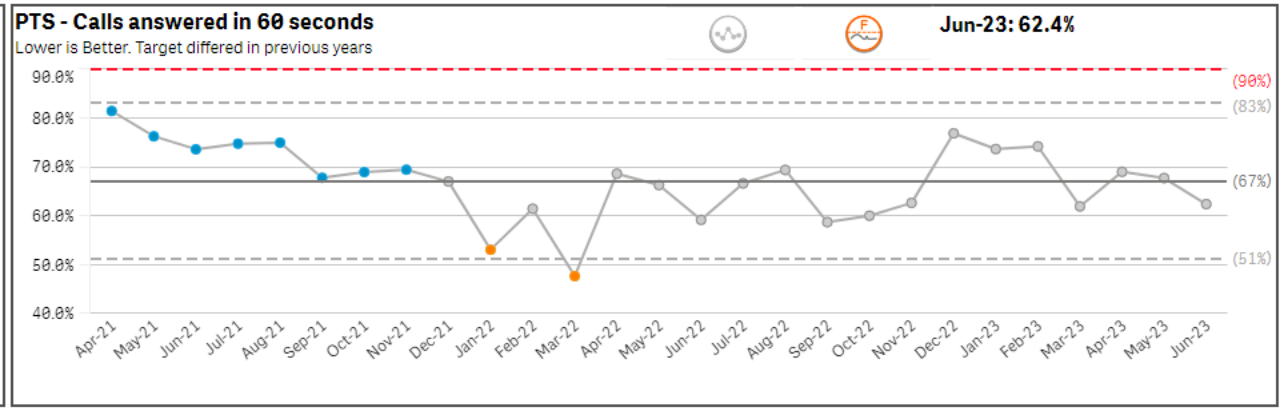
The number of complaints remains very low against activity - 7 received in June. Reduction in responses in agreed timescale to just below the target after being above target last month

Improvement Actions and Assurance:

Ensure complaint timelines continue to be monitored by patient experience team in collaboration with lead for complaint in operational team. Regular touchpoints so completed within time

PTS - PTS Call Volume





Observation & Explanation:

- Call volumes remain broadly consistent over the past 12 months, there is a slight increase in the last 2 months, however this is likely to be due in the most part to the mix of days in the months i.e. weekends and bank holidays.
- There is however continued PTS demand so there would be an expectation that call volumes would follow a similar trend.
- Call Answer performance continues to remain at the average levels of the last 12 months, there has been a slight deterioration due to high levels of sickness and annual leave reducing the

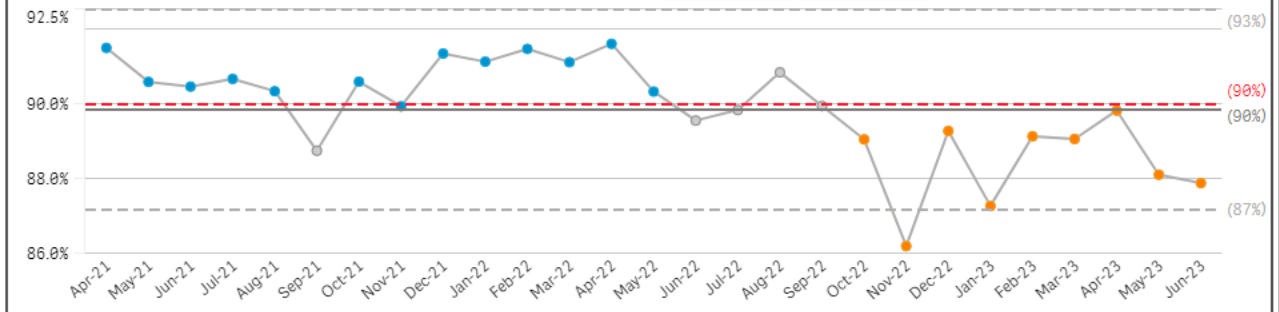
Improvement Actions and Assurance:

- Review GRS annual leave caps and update according to current staffing levels by day of the week
- Continue with sickness management
- Continue with individual performance management reviewing high Not Ready times and increased call lengths
- On going recruitment to
- 7 July cancellation mailbox is decommissioned thus reducing call volumes and reducing lost

PTS - PTS Call Volume

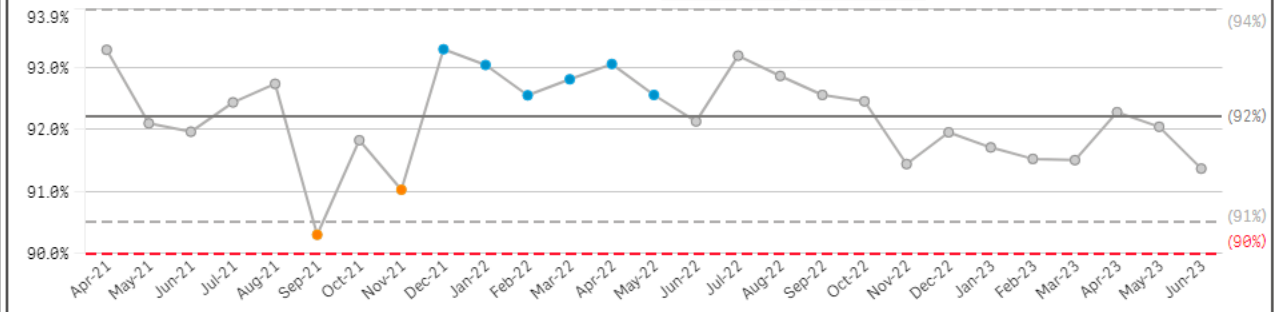
Patients Arrived within time — Jun-23: 87.9%

Higher is Better. Target differed in previous years



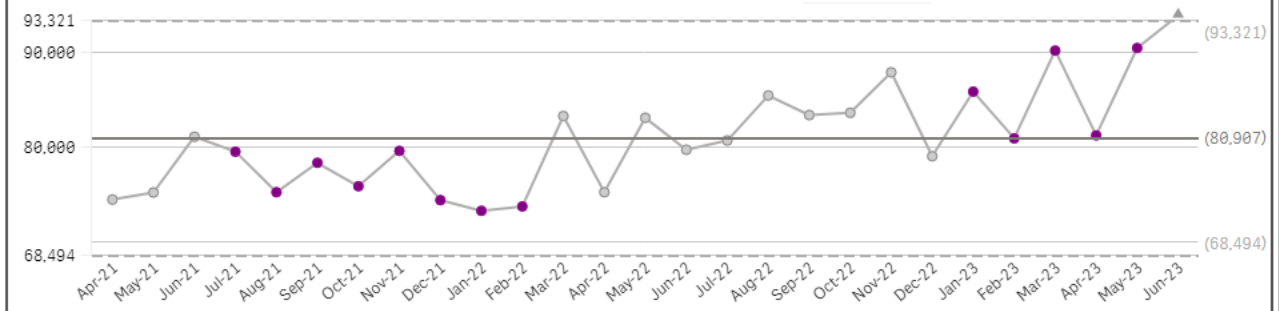
Patients Collected within time — Jun-23: 91.4%

Higher is Better. Target differed in previous years



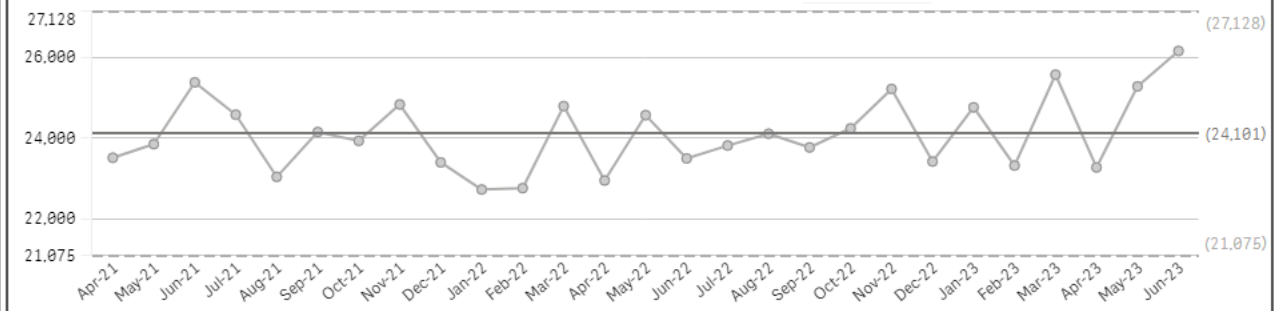
PTS Volume - No. of Journeys — Jun-23: 93,904

N/A. Target differed in previous years



PTS Volume - No. of Patients Transported — Jun-23: 26,155

N/A. Target differed in previous years



Observation & Explanation:

- PTS demand continues to rise with a further 3% increase month on month.
- PTS demand is significantly over the budgeted level and thus an increased costs of servicing this level of demand with a significant reliance on third party providers to provide additional capacity where possible.
- However, due to increasing demand and on-going cost management, we have seen the performance for both arrival and collection fall for the 3rd month in a row.
- The budgeted performance was lower than 90% reported but June's performance continues to

Improvement Actions and Assurance:

- Continue with Commissioner engagement around demand management to reduce the increasing demand and associated costs
- Work through action plans to right size the PTS contracts to the funding received
- Continue to monitor performance against costs to enable cost management aligned with the budgeted assumptions where possible.

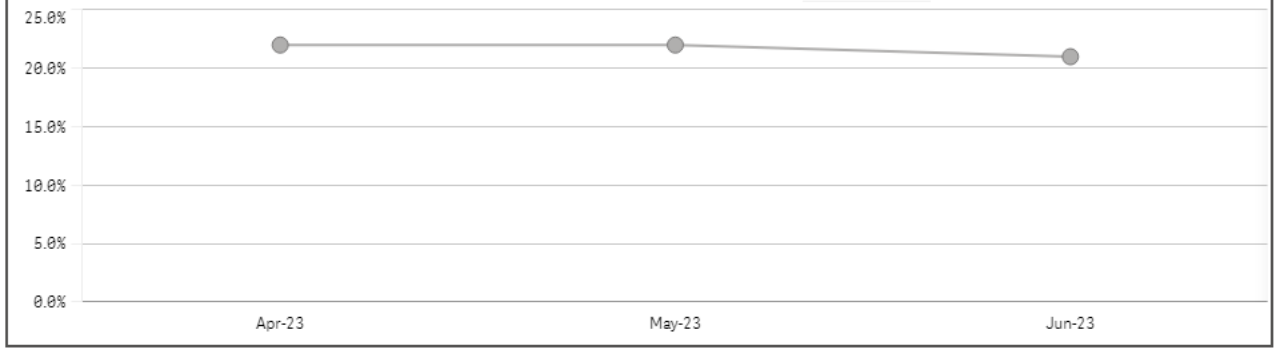
PTS - PTS Complaints

PTS Complaints response - agreed timescale % **Jun-23: 95.0%**

Higher is Better. Target differed in previous years

Complaints - PTS % per 1,000 Incidents **Jun-23: 21.0%**

Lower is Better. Target differed in previous years



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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
PTS PHSO cases - upheld/partially upheld		0%	0%	0%	-	n/a

Observation & Explanation:

Response within agreed timescale is lower than last month but still on target

Improvement Actions and Assurance:

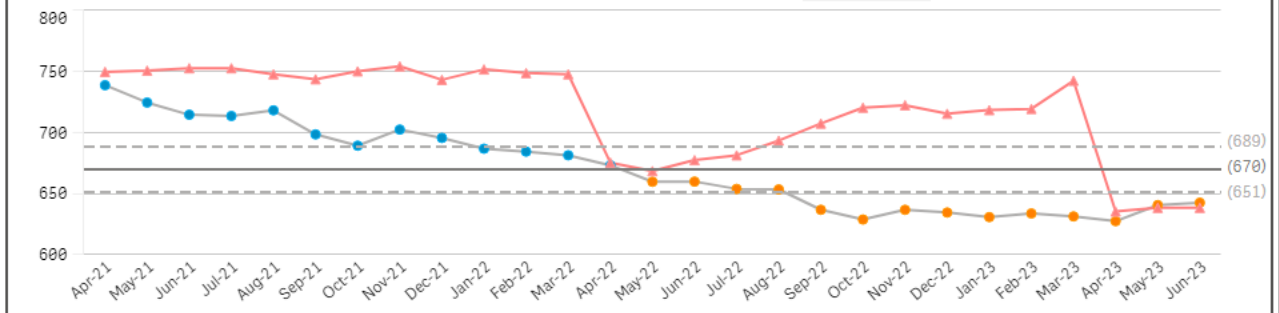
to continue current practices

PTS - PTS Workforce 1

PTS Workforce

Higher is Better. Target differed in previous years

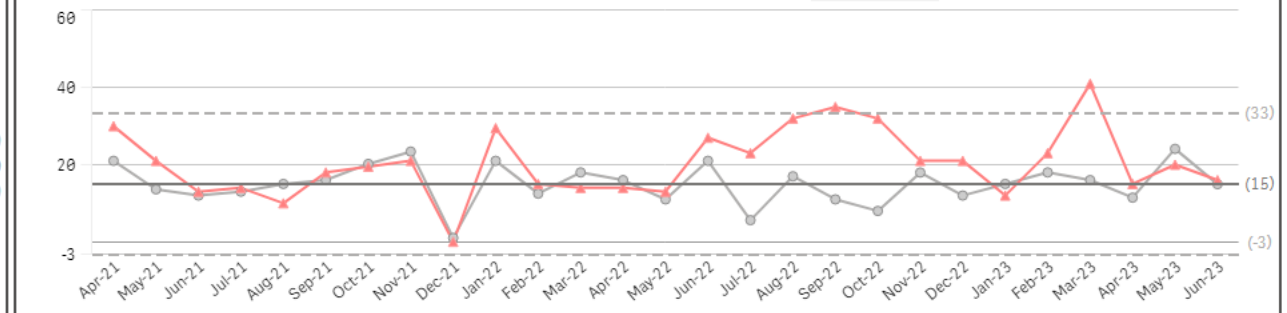
Jun-23: 643



PTS Recruitment

N/A. Target differed in previous years

Jun-23: 15



Observation & Explanation:

PTS attrition remains lower than forecast. Recruitment has gone well for the first three months of this year. We have see the benefits of offering a joining bonus to our Band 2 new starters. Recruitment is looking positive for July as well

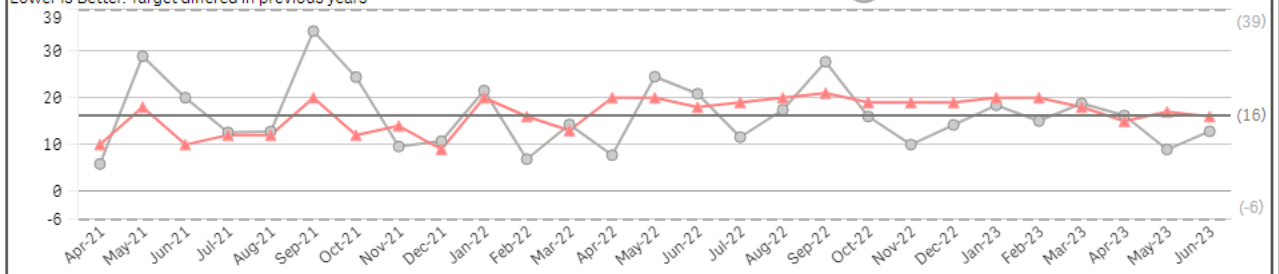
Improvement Actions and Assurance:

Draft and agree retention plan and measures of success ready for presentation at August Workforce Board. Continuing looking at new ways to attract candidates for PTS B2 roles. Consider pre-employment lifting and driving assessments and whether to continue them in their current format

PTS - PTS Workforce 2

PTS Attrition — **Jun-23: 13**

Lower is Better. Target differed in previous years

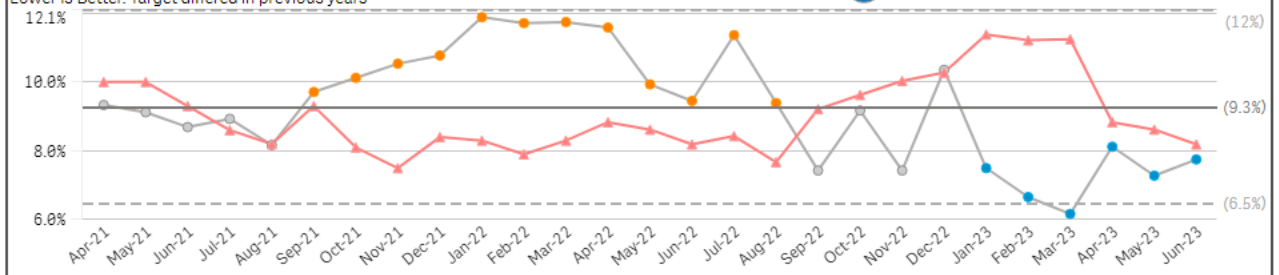


*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
PTS Internal Attrition	7	2	14	0		n/a
PTS External Attrition	9	11	24	0		n/a

Sickness - PTS (Total) — **Jun-23: 7.8%**

Lower is Better. Target differed in previous years



Observation & Explanation:

PTS attrition remains lower than forecast. Recruitment has gone well for the first three months of this year. We have see the benefits of offering a joining bonus to our Band 2 new starters. Recruitment is looking positive for July as well

Improvement Actions and Assurance:

Draft and agree retention plan and measures of success ready for presentation at August Workforce Board. Continuing looking at new ways to attract candidates for PTS B2 roles. Consider pre-employment lifting and driving assessments and whether to continue them in their current format

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Culture and Staff Wellbeing

Culture and Staff Wellbeing Overview

June-23 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L		Conflict Management Equality & Diversity Fire Awareness Health & Safety Infection Control Information Governance Manual Handling Safeguarding Adults Level 1 Safeguarding Children Level 1		
L				1
H	Appraisals - Trust			
↗		Number of Non-Physical Assaults Number of Physical Assaults		
↘				

Statutory and Mandatory Training- Trustwide Training

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Conflict Management	95%	44.2%	43%	82%		
Equality & Diversity	95%	86.0%	86%	93%		
Fire Awareness	95%	85.8%	85%	90%		
Health & Safety	95%	85.8%	86%	93%		
Infection Control	95%	85.9%	86%	94%		
Information Governance	95%	80.3%	81%	90%		
Manual Handling	95%	85.9%	85%	93%		
Safeguarding Adults Level 1	95%	84.6%	84%	93%		
Safeguarding Children Level 1	95%	84.6%	84%	92%		
Safeguarding Level 3	95%	43.3%	50%	47%	-	-

Observation & Explanation:

Improvement Actions and Assurance:

Staff Assaults - Staff Assaults

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Number of Physical Assaults	21	23	47	219		
Number of Non-Physical Assaults	50	64	126	531		

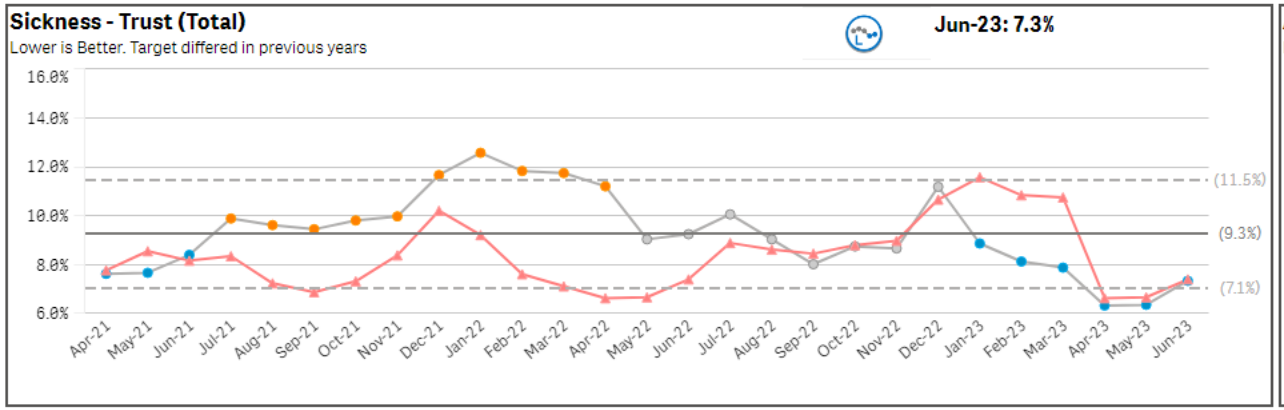
Observation & Explanation:

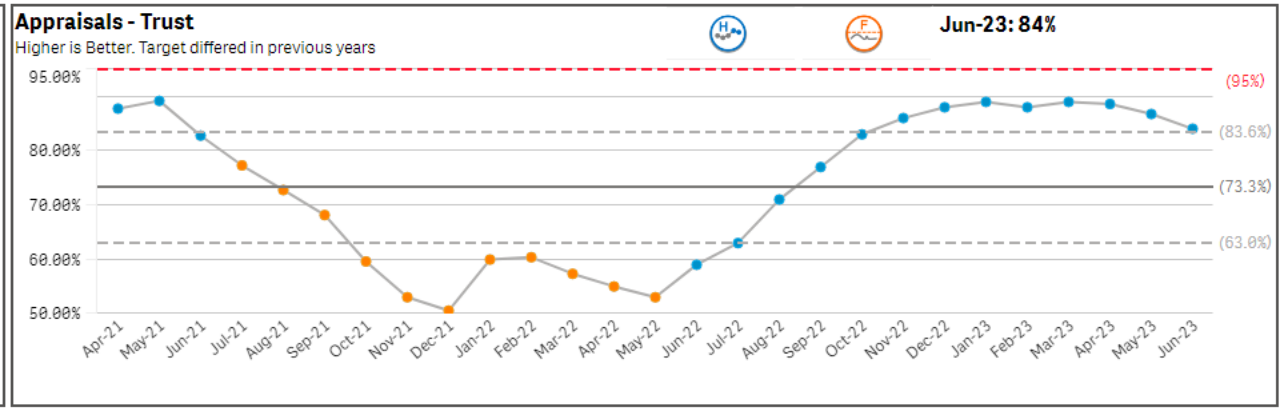
number of physical and non physical assaults have reduced by 1 and 2. Within normal variation of reporting and the majority are low risk

Improvement Actions and Assurance:

Review the need for a Violence Prevention and Reduction Officer post

Sickness & Appraisals - Trustwide Sickness & Appraisals





Observation & Explanation:

Despite increasing appraisal completion since Q3, we have seen a decrease in completion in the last 2 months. There is no specific reason identified for this. Month 3 absence has been affected by an increase in seasonal colds and long term absence, particularly within Commercial Services.

Improvement Actions:

A new PDR training session is ready to be delivered to all leaders, however identifying capacity to deliver is currently causing delays. 3 x Wellbeing Project Co-ordinators have been appointed whose role will be to work with departments to promote healthy lifestyles, ensuring that early interventions are identified and staff signposted along with promoting the range of HWB support already available.

Corporate - Corporate Workforce

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Corporate Workforce		1,155	3,450	3,450	-	n/a
Corporate Recuitment		9	33	33	-	n/a
Corporate Attrition		6	26	26	-	n/a
Corporate Internal Attrition		4	10	10	-	n/a
Corporate External Attrition		2	16	16	-	n/a

Observation & Explanation:

Workforce numbers are staying steady, there is a small increase where we have converted agency workers into FTC or substantive contracts. The majority of corporate attrition is internal movement which is a very positive situation.

Improvement Actions:

We will continue to work on reducing agency spend in the corporate area. The vacancy controls process means that we may see corporate workforce numbers reduce slightly in the coming months in line with budget constraints.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Governance

NHS Governance Overview

June-23 Summary

Metrics:

Assurance →

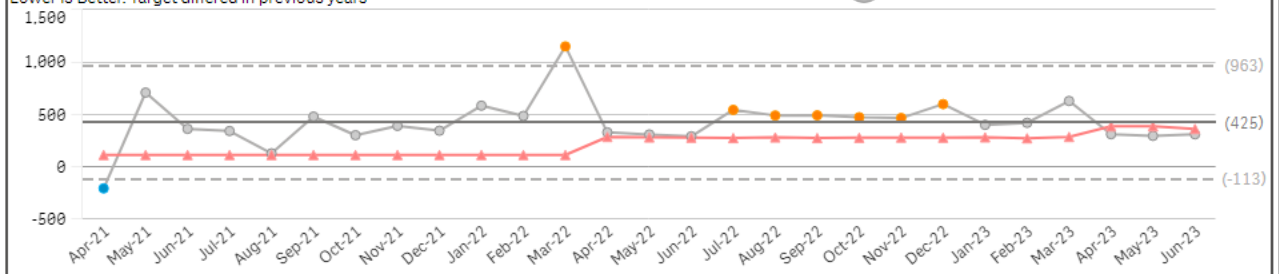
Variance ↓

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

Finance - Finance 1

Agency Spend — Jun-23: 312

Lower is Better. Target differed in previous years

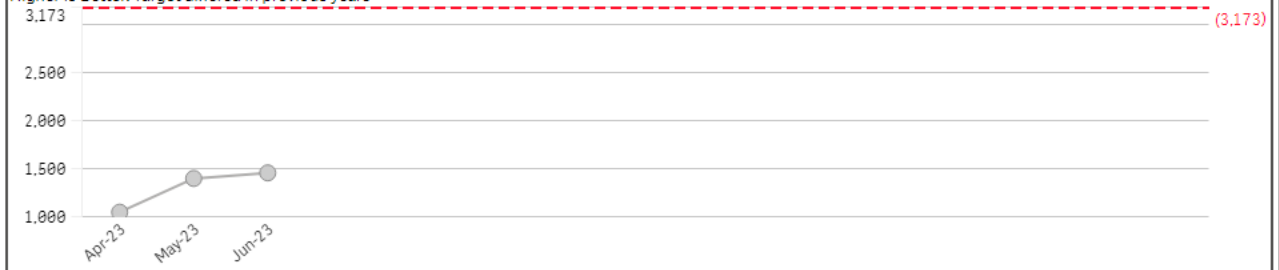


Pay Spend — Jun-23: 18,117

N/A. Target differed in previous years

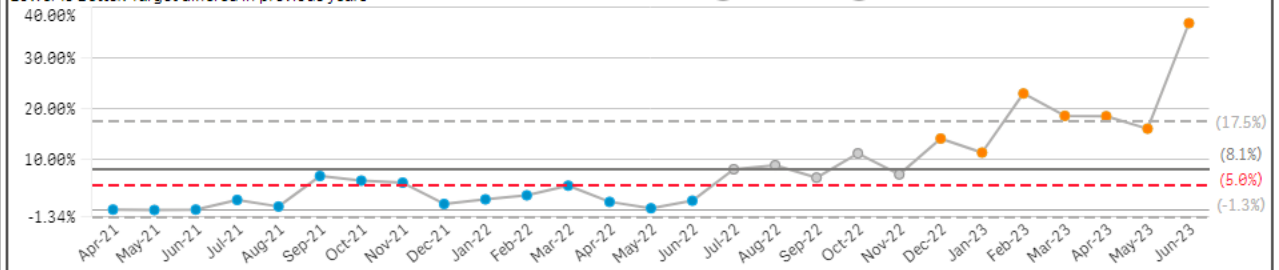
CIP's Total — Jun-23: 1,461

Higher is Better. Target differed in previous years



Debtors > 90 days> 5% total balance — Jun-23: 37.0%

Lower is Better. Target differed in previous years



Observation & Explanation:

Aged Debtors has increased by 21%, from 16% in May to 37% in June. This is largely due to increases across the PTS contracts.

Improvement Actions and Assurance:

The team are aware of the issues and are actively chasing the outstanding payments with the ICB & relevant Trusts.

Finance - Finance 2

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

Metric	Monthly Plan / Target	Jun-23	YTD	12 Months	Variation	Assurance
Overall SOF Segment		4	12	42		n/a

Observation & Explanation:

Improvement Actions:

Contents

Section

Statistical Process Control:

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

The rules:

1) Any single point outside the process limits.

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

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

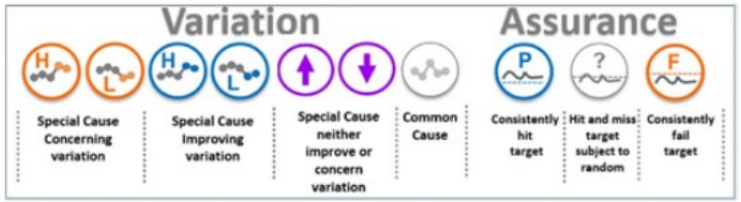
4) A run of 6 consecutive ascending or descending values (a trend).

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

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

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

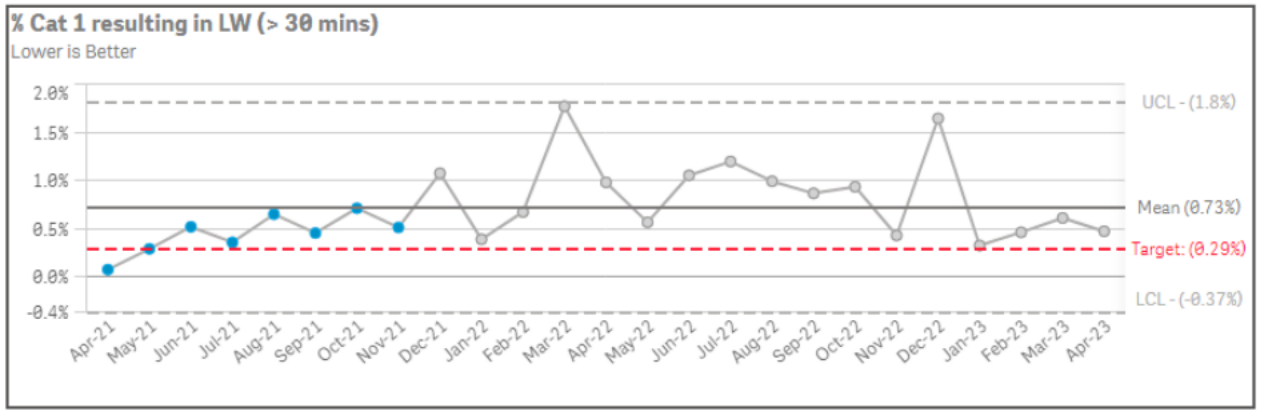
Icon Key



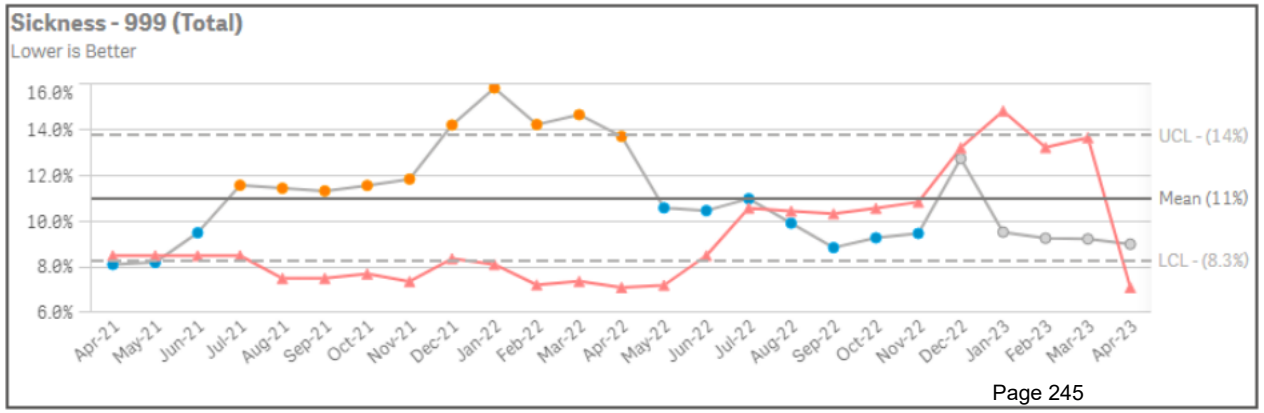
Assumptions:

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

Example of Target Line Chart



Example of Plan Line Chart



UCL & LCL:

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

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

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

NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Operations Report – 999, 111 and Other**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**19.0**	
Executive Summary:	999 performance was impacted by the extreme heat in June, and while demand was lower than planned, acuity was higher with an increase in Cat 1 and 2 demand. 111 performance has continued to improve in June.			
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			
Report author:	Luci Papworth, Mark Ainsworth, Mark Adams, 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 ☐ 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 - Achieving standards and targets			
Quality Domain(s):	Patient Safety			
Next Steps (what actions will be taken following agreement of the recommendations):				
List of Appendices:				

PUBLIC BOARD MEETING IN PUBLIC 27TH JULY 2023

OPERATIONS REPORT – 999, 111 AND OTHER – KEY ISSUES

1. Purpose

1.1. 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.

2. Executive Summary

2.1 In June, Cat 2 performance was adrift of trajectory at 34 mins 8 seconds. Whilst performance was strong for most of June, there was a period between 9th and 18th June where demand and performance presented challenges due to excessive heat and pollen. During this time, additional PP and SCAS hours were added to ease some of the pressure, however due to the sudden increase in demand we could not react with the level of hours required to match the demand. We also had to consider the ongoing financial costs of any large increase in resource hours. In June task time improved and added more available hours. Task time for June was 1:46:34 against a target of 1:48:54. Turnaround time has improved with average handovers in June reducing to 18 minutes compared to 22 minutes in May. The associated reduction in lost hours at handover was 2,237 in June compared to 3,881 hours in May, all of which are reducing our overall task time.

Clinical Co-ordination Centres

2.2. Inbound call volumes decreased in April and May which led to mean call answer performance improvement that was ahead of trajectory at 15 and 19 seconds respectively. However call centre demand increased significantly in June due to the extreme weather conditions and performance deteriorated away from trajectory at 41 seconds.

2.3. We currently have 159.81 WTE ECTs within the EOC but of these we now have 121.81 who are signed off and work effective and this includes the IOW. We have 24 staff currently in coaching phase. Attrition has slowed and recruitment has been positive but we remain approximately 30 ECTs short to deliver sustained performance.

2.4. May 2023 111 calls offered demand was markedly up on May 2022 averaging 4,997 calls per day. June however saw a considerable step down in pressure against the last few months as well as against June of last year, averaging 4,665 calls per day.

2.5. Average wait to answer times continue to trend downwards, sitting now at its best level, under two minutes, for the second time in 15 months. Correspondingly call answer performance in 120 seconds and abandonment rate show improvement for the third month in a row and remain above trajectory and above our position this time last year, although both remain out with the national target.

	Call Answer 120 secs (≥95%)	Abandonment rate (≤5%)
May	73.8%	4.1%
June	77.26%	4.09%
July to date (14th July)	72.66%	4.34%

2.6. Support via national contingency continued through May and June with circa 5% of demand being managed by the provider. This support ended on 10th July. We continue to support the Isle of Wight 111 service three nights a week and a joint business case has been submitted via commissioners to the national team regarding ongoing support to secure necessary funding.

2.7. Across May and June similar levels of clinical validation occurred with 91% of category 3/4 dispositions being validated. Of these 61% were provided with an alternative disposition. In relation to emergency department validation 69% of these dispositions were validated and 52% of these were given an alternative in June.

2.8. For the third month in a row, we have seen improvements in staff retention with the number of leavers sitting below forecast and below the levels seen last year. We do however remain short of workforce to hit performance. Current establishment for Health Advisors 230.98 WTE and for Clinical Advisors 54.77 WTE, leaving a gap of 91.24 WTE and 21.34 WTE respectively to achieve performance.

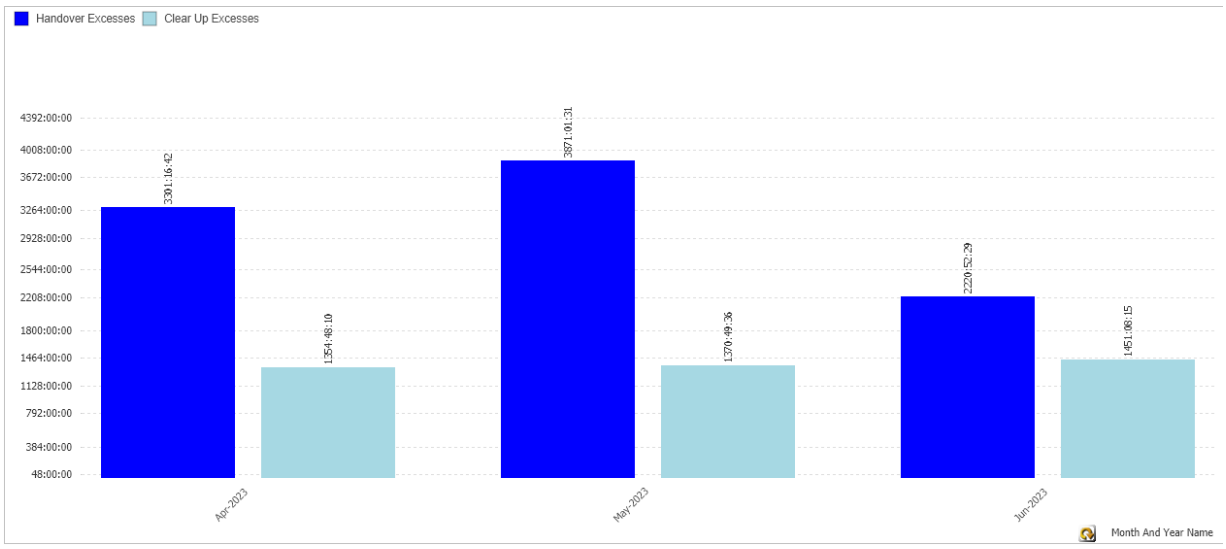
2.9. Service improvement workstreams continue in line with our improvement plan. The home working for the health advisors' pilot was successfully signed off this week at Executive Transformation Board and we look to scope future potential benefits of homeworking both from expanding it internally/externally as well as introducing other skillsets.

3. Urgent & Emergency Care

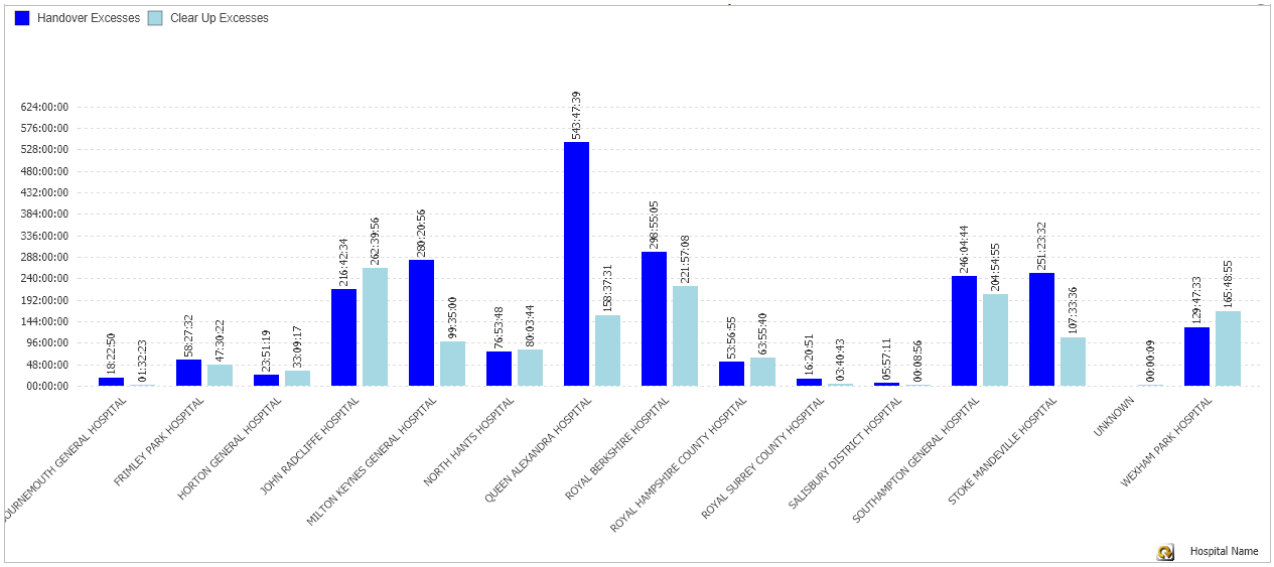
3.1. SCAS capacity reduced due to management of available shifts and a reduction in the availability of overtime. This impacts both internal and PP resource.

Hospital Handover Delays

3.2. We have seen a continuing reduction with handover delays with us losing 2,220 hours in June. The average handover time also continues to reduce and reached 18 minutes 18 seconds, which is the lowest we have seen for the last 18 months. This is freeing up SCAS resource to respond to patients and reducing the SCAS time spent with each patient.



3.3. The QAH hospital had the highest level of delays at 540 hours, however this is significantly better than previous months.



Specialist Practitioners

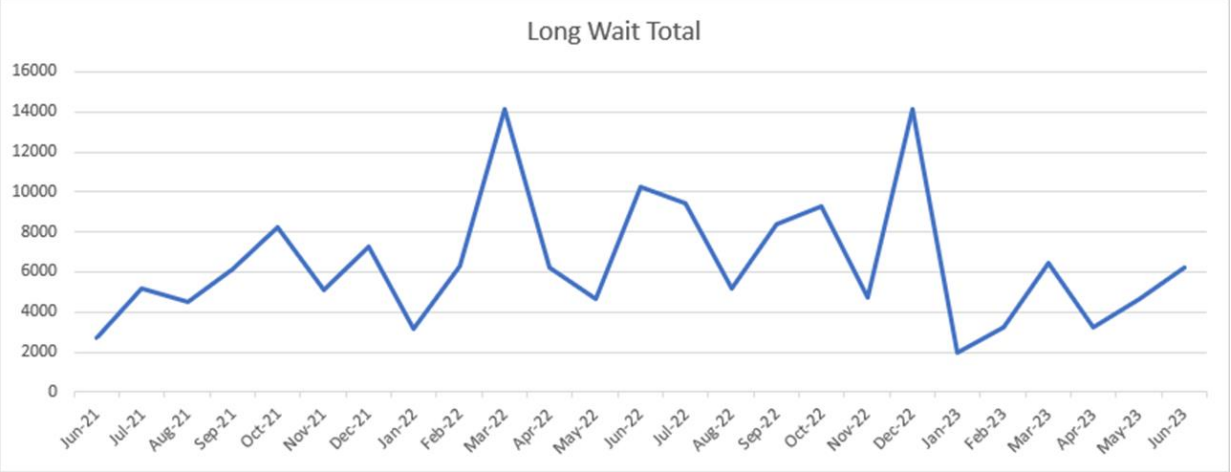
3.4. We are currently out to tender for a Specialist Practice Apprenticeship and will link this to a recruitment drive so that we increase our overall team size to 96. These additional staff will support the work of the Urgent Care Desk and provide further support to our frontline colleagues.

3.5. We will be piloting a ‘Cat 3’ car in the south east so that we can fully utilise our available collaborative working hours. The car will self-deploy to Category 3 incidents and support the referral of patients to the local Urgent Community Response teams. We are in the process of developing a trust wide deployment model to support our frontline operations by ensuring SPs are sent to incidents that are appropriate for their skillset. SPs currently convey 20% less incidents than our frontline crews and we expect this model to deliver similar, if not better, non-conveyance rates; freeing up ambulances to conveyance incidents which will reduce costs and increase our available operational hours.

3.6. We are very proud to share the news that our 'Falls and Frailty Car' project, based in Basingstoke, won the award for **Best Emergency Service Collaboration** at the 7th annual Our Heroes Award ceremony, hosted by Skills for Health, in June 2023.

Long Waits (LWs)

3.7 During June SCAS have seen a continued increase in the total number of long waits 6,235, an increase of 30% from May 4,366. This is however not at the level we experienced through the period of February - December 2022. This increase in long waits is not in relation to the demand on the trust as this has reduced from May 47,437 to 45,077 in June. We have however had to balance our operational hours in line with our revised budget. This gives us less ability to flex our resources and increase them to meet demand. The results from this are reduced response times to patients and an increase in long waits. We have seen an improvement in handover delays which has mitigated some of the impact on long waits, releasing operational hours quicker.



Resilience & Specialist Operations

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

- **Terrorism.**: - A weekly exercise cycle has been ongoing between January- June 2023 which tests several of the risks identified in the National Security Risk Assessment (NSRA) National Risk Register and recommendations from the Manchester Arena Inquiry. Several lessons have been identified which will be published in the post exercise report at the end of the exercise cycle and this report will be submitted through the EPRR delivery board to highlight potential risks in the SCAS response.

- **Pandemic Influenza**: - This remains at a significant impact level on national risk registers as seen in recent years with the COVID pandemic.

- **The Manchester Arena Inquiry recommendations**: - The RSO team have several workstreams related to the Manchester Arena Inquiry including liaison with multi-agency partners and LRF's to ensure that we are responding to all of the recommendations from the Manchester Arena. There is a risk that if these

are not completed to an adequate standard that the trust will be open to criticism and at significant risk of organisational reputational damage.

- **Industrial Action:** - Industrial Action in the Ambulance Service, Wider NHS and Emergency services affecting the ability to respond. The pay award was announced for those under Agenda for Change however we are still planning to support other potential industrial action which can impact on the wider NHS.

- **Widespread Electricity loss:** - Rolling power outages to meet demand or a no notice widespread electricity loss from 24hr to 5-7 days including the lessons identified from the recent pan-England exercise "Mighty Oak".

- **Severe Weather:** - We continue to plan for severe weather with our LRF partners including the production of the Strategic and Operational plan. Despite severe weather (cold) having a minimal impact over the last two years, we have seen an increase in the risks of severe heat as seen last year which saw an increase in water related incidents and wildfires with several fire services declaring major incidents across the UK.

3.9. Command compliance: - Ensuring that all SCAS commanders have appropriate training, portfolios to carry out their function to the national standards.

3.10. 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 several learning points have been identified within SCAS and the Wider LRF's.

3.11. We are still working with NHSE and HIOW ICS to ensure we gain full funding for HART as our current funding is £1.1m short of the allocated national funding and we are therefore at risk of not meeting the core standards for HART if we do not receive full funding.

3.12. The RSO team is working on the NHS EPRR core standards assurance for this year, including ensuring that command standards are maintained against the national standards.

3.13. RSO continue to recruit to the department including HART and SORT staff to meet the national standards, the introduction of the RSO logistics team has allowed for better monitoring of assets and vehicle preparation in response to lessons identified over recent years.

<u>Clinical Equipment</u>

3.14. The new asset management project has been approved by the Executive Transformation Board. Work will progress to ensure a new fit for purpose asset management system is procured to guarantee compliance with regulatory guidelines for management of medical devices.

3.15. Secondary AED devices have been issued to all operational vehicles. In the event of a Zoll failure patients will now receive appropriate care and the Trust meets the requirements set out by the CQC.

Ambulance Make Ready (MR) Services

3.16. The Tender for the new service continues and is moving through the competitive dialogue process. Final solutions from suppliers have been submitted and Executive Transformation Board have approved initial procurement decision and final options will be presented at the next Board meeting.

3.17. Once a supplier has been approved the newly created Contract Manager role will be recruited to in order to manage the new contract.

Fleet

3.18. Work continues with the convertors to ensure delivery of new DCAs. A 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.

4. Projects

U&E Ops Roster Review Project

4.1. It has been agreed to undertake a further review of our staff establishment levels and Optima analysis to further assure the project that demand planning assumptions and staff numbers are accurate. The initial staff consultation has been undertaken, with the common themes being shared as FAQs/feedback with teams. The updated rollout plan has been shared with the nodal teams to facilitate the development and design of new work patterns. This work aligns with the planning/scheduling team to enable roster builds to be implemented over a phased timeframe. The plan is to still implement all new rosters during Q4 of this financial year.

EOC Roster Review Project

4.2. Following the June Project Board, the approval of roster options has been completed for all call handling roles. Work is now underway to launch the EOC call handler staff consultation for 30 days and this is planned to start during July. Staff will then have a voting period on their preferred roster patterns. Discussions to plan the build phases as well as planning the implementation dates is also being progressed. Other reviews for EOC dispatch, CSD staff will continue as planned.

Emergency Services Mobile Control Project (ESMCP) (Radio Replacement)

4.3. The project is still in the development phase, preparing for Control Room Solution (CRS) user testing and train the trainer programmes by early September. We have been provided with new dates from the software supplier (Tenant) to SCAS by 24 July, this date is within the project timelines.

4.4. The Mobile Data Vehicle Solution (MDVS) has also officially launched with the National Team and SCAS with weekly meetings in preparation for the groundwork and technical infrastructure for the installation of vehicle ambulance equipment to begin and looking at the rollout and training of the new National Mobile Application (NMA). The NMA software has been released and we are holding configuration workshops to finalise the product for SCAS. Progress has also been made with securing a vehicle

installation site, Parkgate in Fareham, with legal documentation currently at our solicitors and plan to complete the lease by end of July 2023.

999 CAD Replacement Programme (SCAS & IOW AS)

4.5. The programme is working with ICT to ensure the current system will be available for a period to cover the entire replacement timeline with our current CAD supplier. We are capturing the SCAS & IOW technical/user requirements for a new system; all initial workshops have been held with key stakeholders across both organisations and requirements are being reviewed by other departments to ensure whole-system compatibility.

4.6. An end-to-end mapping process and desktop simulation is also planned for August/early September to go through each CAD call/dispatch flows, this will ensure all requirements can be validated. We also plan to undertake a marketing event with potential replacement CAD suppliers, before we finalise our new specification and before going for formal approval, with a supporting outlined business case being developed during Q3 this year.

5. Conclusions and Recommendations to the Board

5.1. 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 **July 2023**

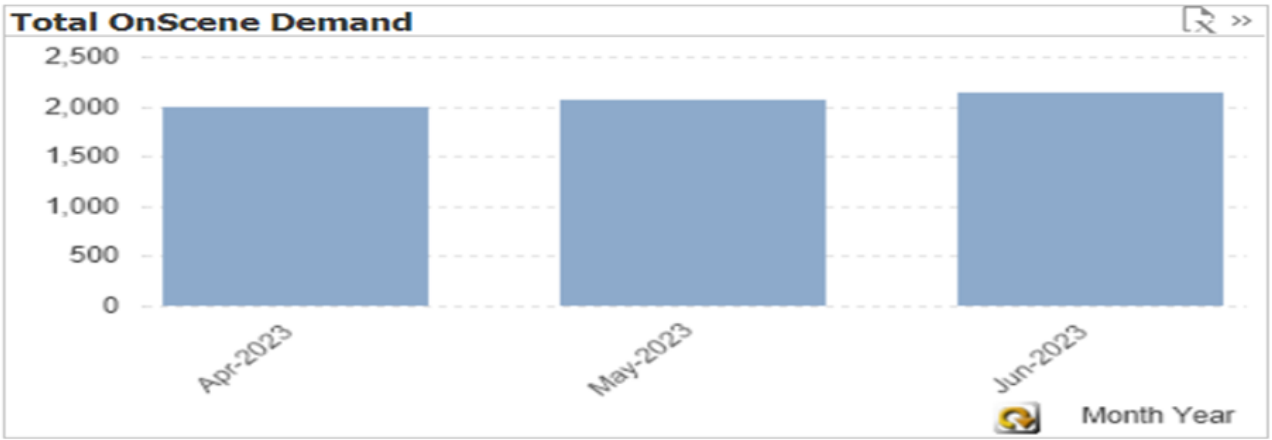
BOARD OF DIRECTORS MEETING IN PUBLIC 27TH JULY 2023

OPERATIONS REPORT – 999, 111 AND OTHER

Appendices

Indirect Resources

1 In the first quarter we have seen a steady increase in the number of incidents on scene whilst seeing a decrease in the hours of volunteer availability. This is mainly due to the increase in some of the long waits on Cat 2 – 4 incidents that the responders have had on scene whilst awaiting a clinical resource and volunteers logging off earlier that in previous months.



Month & Year	Activity Time
Apr-2023	38019:34
May-2023	36994:25
Jun-2023	34148:09

2 We were deployed to fewer Cat 1 calls this month in comparison to previous months with the % of Cat 1 on scene stopped by CET remaining above 69%. The Cat 1 contribution has decreased due to frontline resourcing being available and the time to back them up. We also saw The CCC is making the Indirect desks a priority for cover, so we hope to see better utilisation to Cat 1 in the coming month.

CET Contribution by Month			
Month And Year Name	**Apr-2023**	**May-2023**	**Jun-2023**
Total Cat 1 Incidents (SCAS)	3,352	3,443	3,459
% of Cat 1 Stopped by CET	7.4%	7.0%	7.0%
Cat 1 CET OnScene	364	348	346
Cat 1 Stopped by CET	247	241	242
% of Cat 1 Onscene Stopped by CET	67.9%	69.3%	69.9%
Cat 1 Mean Stopped by CET	0:07:50	0:08:12	0:08:40
Cat 1 Mean (SCAS)	**0:08:15**	**0:08:39**	**0:09:16**
Cat 1 Mean - CET Removed	**0:08:43**	**0:09:08**	**0:09:42**
CET Contribution	**0:00:29**	**0:00:28**	**0:00:26**

3 Attendances to Non-Injury falls remains consistent with an average of 50 activations a month. Concern for welfare attendance on average are 69 and the amendments to the scorecard logic are being amended as the reporting is not correct so I am hoping that next month's update will be reporting on all non-conveyances that the CET attend.

Nature of Call NIF (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)	Avg Cat 3 Response time for AQI
Apr	591	66.7%	55	50	2	477	8.5%	34	1.7%	1:26:49
May	611	66.4%	52	49	2	495	8.0%	36	3.1%	1:48:21
Jun	530	67.0%	58	56	6	424	10.6%	42	2.1%	1:28:08

Nature of Call CFW (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)	Avg Cat 3 Response time for AQI
Apr	622	78.0%	53	49	2	25	7.9%	30	2.3%	1:01:10
May	752	77.5%	72	67	8	22	8.9%	45	2.9%	1:48:27
Jun	666	81.1%	84	82	5	22	12.3%	54	4.2%	1:31:12

4 We are working on the roll out of the new telephone devices now that the funding has been agreed. This will allow us to add the Apps we require to enhance the scope of our responders at incidents.

South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Finance Report for the month ended 30th June 2023**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday 27 July 2023**	**Agend a Item:**	**20.0**
Executive Summary:	1. The Trust reported an actual deficit in month (June) of £2,479k which is £1,479k worse than plan. 2. The Trust financial position for the year to date is a deficit of £6,645k resulting in an adverse variance to plan of £3,645k. This is after profit from disposals of £7k in May and £19k for the period to date. 3. Cash and capital - • The Trust's cash balance at the end of June stood at £45,860k. • The total capital spend is £670k on an original budget of £1,694k. • The 90-day debtor total stood at £458k at the end of June (up from £351k in May) representing 36.97% of total sales debt (up from 16.14% in May). 4. NHS Improvement Use of Resource – overall rating is 2. The budgeted rating is 1. 5. Cost savings – Overall, the savings were £1,851k in the month, £312k below plan in the month. The Financial Sustainability delivery group are progressing plans for delivery. 6. Forecast: The Trust's in year current run rate with identified action to date result in a forecast deficit of £18.6m as of 31st March 2023. The Trust is currently working on its Financial Sustainability Plan to bring the position back to its break-even plan.		
	The Trust Board is asked to: Note the current financial position of the Trust.		
Executive lead:	Stuart Rees, Interim Director of Finance		
Report author:	Nuala Donnelly, Head of Finance		

Previously considered by:	May 2023 and every bi-monthly Board meeting in public			
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 3 ended 30th June 2023
Appendix B: Financial Results for Month 3 ended 30th June 2023 – Income Analysis
Appendix C: Key Operational Spend
Appendix D: NHS Improvement Use of Resource Rating
Appendix E: Cashflow 2023-24
Appendix F: Capital Expenditure 2023/24
Appendix G: Balance Sheet, as at 30th June 2023

South Central Ambulance Service NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC 27 JULY 2023

FINANCE REPORT

PURPOSE

1 The purpose of the paper is to:

- Present an update on the Trust's latest financial position, covering income and expenditure; cash, capital, and liquidity; NHS Improvement financial Use of Resource rating; and cost savings.
- Provide assurance to the Board that actions are in place to address any areas where the Trust's financial performance is adversely behind plan at this stage of the financial year.

EXECUTIVE SUMMARY

2 Income and expenditure – The Trust reported an actual deficit in month (June) of £2,479k in June which is £1,479k worse than plan. The Trust financial position for the year to date is a deficit of £6,645k resulting in an adverse variance to plan of £3,645k. This is after profit from disposals of £7k in May and £19k for the period to date.

3 The Board have approved a break-even plan for the financial year against which performance will be measured. The plan includes organisations CIP (Cost Improvement) and financial sustainability plans of £36.3m.

4 Cash and capital -

- The Trust's cash balance at the end of June stood at £45,860k.
- The total capital spend is £670k on an original budget of £1,694k.
- The 90-day debtor total stood at £458k at the end of June (up from £351k in May) representing 36.97% of total sales debt (up from 16.14% in May).

5 NHS Improvement Use of Resource – the NHS Improvement Use of Resource rating overall is 2. The budgeted rating is 1. This comprises a capital service cover (debt interest cover) rating, which is a 1, a liquidity rating which is a 1, I&E Margin rating is a 2 and I&E Margin variance from plan rating, which is a 1 for June 2023. The Agency Rating is 3.

6 Cost savings – plans to deliver savings of circa £36,000k have been incorporated into the financial plan for the year. Overall, the savings were £1,851k in the month, £312k below plan in the month. The Financial Sustainability delivery group are progressing plans for delivery. Details of the scheme's performance can be found in the integrated performance report.

INCOME AND EXPENDITURE

7 The Trust reported a deficit of £2,479k for the month, £1,479k adverse to plan.

Income was £125k lower than budget in the month. This represents additional income for staff and other recharges.

Overall costs were £1,604k higher than budget. Spend on Emergency services was £723k higher than plan. Spend for 111 Services was above plan by £456k. There was an overspend of £1,342k on non-emergency services. Corporate costs were £917k lower than budgeted.

The detail for the month and the year-to-date position is detailed in the table below.

		Month			Year to date			Full Year	
		Actual	Budget	Budget Variance	Actual	Budget	Budget Variance	Forecast	Budget
Profitability									
SCAS Income	£k	27,907	27,782	125	80,226	80,227	(0)	328,557	328,312
SCAS Contribution	£k	2,721	5,173	(2,452)	8,560	14,945	(6,385)	41,708	59,108
% Contribution	%	*10%*	*19%*	*(9%)*	*11%*	*19%*	*(8%)*	*13%*	*18%*
Corporate overheads	£k	5,207	6,173	965	15,224	17,945	2,721	60,379	59,108
EBITDA	£k	(1,674)	(122)	(1,553)	(4,218)	(365)	(3,853)	(8,709)	10,540
EBITDA %	%	*(6%)*	*(0%)*		*(5%)*	*(0%)*		*(3%)*	*3%*
Net Surplus/(Deficit)	£k	(2,486)	(1,000)	(1,486)	(6,664)	(3,000)	(3,664)	(18,670)	(0)
% Surplus/(Deficit)	%	*(9%)*	*(4%)*	*(5%)*	*(8%)*	*(4%)*	*(5%)*	*(6%)*	*(0%)*
Profit/(Loss) on Disposal		7	0	7	19	0	19	76	0
Overall Surplus/(Deficit)		(2,479)	(1,000)	(1,479)	(6,645)	(3,000)	(3,645)	(18,594)	0

8 The spend includes agency costs to support the operational and CQC related workstreams. For the month, agency costs of £249k represent 1.4% of gross staff costs.

NHS Improvement and HIOW sets expenditure targets on the total amount individual trusts can spend on agency staff across all staff groups, for SCAS this is £2,295k for the year, £44k per week. The Trust performance against its agency target is being monitored.

9 Further information can be seen in the following appendices:

- Appendix A1 – income and expenditure monthly position
- Appendix C – key operational ratios for income and expenditure

CASH AND CAPITAL

10 A capital plan of £6,531k has been agreed for the financial year.

11 Capital spend to date stood at £670k (excluding sales receipts of £780k) against a capital budget of £1,694k.

12 The Trust's cash balance at the end of June stood at £45,860k. Receipts were £38,502k, capital spend was £149k, capital spend on sale and lease back was £0k and payments were £37,954k. Capital cash spend stood at £670k at June (excluding sale receipts of £780k) set against the capital cash budget of £1,694k. Capital spend on the sale and leaseback ambulances stood at £2,149k up to June. The expected sale and leaseback of the 2022/23 cohort has now been pushed back to August 2023 due to issues meeting the BN1789:2020 standard. There was sale and leaseback income of £780k received in May, there is a further sale and leaseback transaction of £541k expected to be concluded during the summer.

The total capital spend is therefore -£129k on an original budget of £1,694k. The year-to-date variance of £1,876k on working capital reflects revised profiling on changes to provisions, payables, and receivables and is in-line with the I&E performance.

		Month			Year to date			Full Year		
		Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance to budget
Cash and capital position										
EBIT	£k	(3,585)	800	(4,386)	(1,647)	2,400	(4,046)	4,700	23,294	(18,594)
Working capital mov't	£k	4,675	565	4,110	(183)	1,693	(1,876)	(1,659)	1,462	(3,121)
Capital Expenditure	£k	(149)	(744)	595	(670)	(1,694)	1,024	(6,531)	(6,531)	0
IFRS16 Lease Liability	£k	(781)	(914)	133	(2,435)	(2,742)	307	(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)	0	0	0	14,903	14,903	0
IFRS16 Peppercorn Reserves)	£k	0	0	0	0	0	0	0	0	0
Capital Sale and Leaseback Ex	£k	0	0	0	(9)	0	(9)	(8,647)	0	(8,647)
Capital Sale and Leaseback Inc	£k	0	0	0	780	0	780	11,768	0	11,768
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	(681)	(293)	(389)	(4,164)	(343)	(3,820)	(13,457)	5,137	(18,594)
Cash balance	£k	45,860	42,859	3,000	45,860	42,859	3,000	36,567	55,161	(18,594)

13 The 90-day debtor total stood at £458k at the end of June (up from £351k in May) representing 36.97% of total sales debt (up from 16.14% in May). The residual debt at risk of falling into the 90-day category is £483k.

- Further information can be seen in the following appendices:
- Appendix D – key financial ratios, including liquidity.
- Appendix F – capital expenditure 2022/23
- Appendix G – balance sheet and budget to 31 March 2023

FUTURE PERFORMANCE

14 The budget for 2023-24 was agreed at the private Board on 30th March 2023 and adjusted in May 2023 to a break-even plan for the year.

15 In reporting to the HIOW system, the Trust continues to report achievement of the break-even plan.

16 The Trust's in year current run rate with identified action to date result in a forecast deficit of £18.6m as of 31st March 2023. The Trust is currently working on its Financial Sustainability Plan to bring the position back to its break-even plan.

17 Forecasts will be updated monthly to reflect any emerging changes and updates in the financial outlook.

RECOMMENDATIONS TO THE BOARD

19 The Board is asked to note the current financial position of the Trust and action to bring the position back to plan.

Stuart Rees
Interim Director of Finance

South Central Ambulance Service NHS Foundation Trust (Appendix A1)

Financial results for Month 3 ended 30th June 2023

	Month			Year to date			Full Year				
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Prior Year	Variance to budget	Variance to Prior Year
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
TOTAL SCAS INCOME	**27,907**	**27,782**	**125**	**80,226**	**80,227**	**(0)**	**328,557**	**328,312**	**353,122**	**245**	**(24,565)**
Emergency Services (inc. 111)											
Income	21,895	21,824	71	62,933	62,993	(61)	259,382	259,379	255,933	3	3,450
Direct costs	18,910	17,735	(1,175)	53,548	51,100	(2,448)	219,082	212,476	213,637	(6,606)	(5,445)
Gross contribution	2,985	4,089	(1,104)	9,385	11,894	(2,509)	40,300	46,903	42,296	(6,603)	(1,996)
	14%	19%	-5%	15%	19%	-4%	16%	18%	17%		
Covid-19											
Income	0	0	0	0	0	0	0	0	9,640	0	(9,640)
Direct costs	(4)	0	4	10	0	(10)	40	0	9,640	(40)	(9,601)
Gross contribution	4	0	4	(10)	0	(10)	(40)	0	(0)	(40)	(39)
Non-Emergency Services											
Income	5,632	5,638	(6)	16,295	16,272	24	65,181	65,087	62,399	95	2,782
Direct costs	5,896	4,553	(1,342)	17,120	13,220	(3,900)	63,773	52,882	55,724	(10,891)	(8,049)
Gross contribution	(264)	1,084	(1,348)	(825)	3,051	(3,876)	1,408	12,205	6,675	(10,797)	(5,267)
	-5%	19%	-24%	-5%	19%	-24%	2%	19%	11%		
Contribution Operational Activities	**2,721**	**5,173**	**(2,452)**	**8,560**	**14,945**	**(6,385)**	**41,708**	**59,108**	**48,971**	**(17,399)**	**(7,263)**
Central Costs											
Clinical Services	601	400	(201)	1,795	1,630	(165)	7,620	6,729	5,631	(892)	(1,989)
Finance	290	297	7	848	880	32	3,511	3,512	3,699	1	188
Estates	995	864	(131)	2,972	2,585	(387)	10,341	10,340	10,557	(0)	216
IM&T	909	978	69	2,672	2,965	293	12,071	12,071	8,937	0	(3,134)
Human Resources	422	392	(30)	1,188	1,122	(66)	4,533	4,489	4,393	(44)	(140)
Education Services	526	518	(8)	1,477	1,467	(11)	5,695	5,695	5,849	0	154
Service Development	243	548	305	851	954	103	3,145	3,145	3,226	(0)	81
Communications & Public Engag't	56	57	1	174	163	(11)	652	652	594	0	(58)
Corporate	149	107	(41)	345	252	(92)	1,009	1,009	900	(0)	(109)
Contingency	203	1,117	914	445	3,242	2,797	1,792	726	(2,724)	(1,067)	(4,516)
Injury Benefit	17	17	0	50	50	0	200	200	0	0	(200)
Depreciation	848	867	20	2,557	2,601	44	10,397	10,405	8,769	8	(1,637)
Financing Costs	(50)	11	61	(149)	34	183	(588)	135	(209)	723	379
Total overhead costs	**5,207**	**6,173**	**965**	**15,224**	**17,944**	**2,719**	**60,378**	**59,108**	**49,621**	**1,270**	**(10,766)**
Net surplus/(deficit)	**(2,486)**	**(1,000)**	**(1,486)**	**(6,664)**	**(3,000)**	**(3,664)**	**(18,671)**	**(0)**	**(651)**	**(18,671)**	**(18,020)**
Profit/(Loss) on disposal	**7**	**0**	**7**	**19**	**0**	**19**	**76**	**0**	**396**	**76**	**(320)**
Surplus/(deficit) for the year	**(2,479)**	**(1,000)**	**(1,479)**	**(6,645)**	**(3,000)**	**(3,645)**	**(18,594)**	**0**	**(255)**	**(18,595)**	**(18,340)**
Depreciation	**848**	**867**	**20**	**2,557**	**2,601**	**44**	**10,397**	**10,405**	**10,608**	**8**	**211**
Public dividend capital	**151**	**151**	**0**	**454**	**454**	**0**	**1,815**	**1,815**	**960**	**0**	**(855)**
Net interest payable	**(201)**	**(140)**	**61**	**(603)**	**(420)**	**183**	**(2,403)**	**(1,680)**	**(49)**	**723**	**2,354**
Profit on disposal	**(7)**	**0**	**(7)**	**(19)**	**0**	**(19)**	**(76)**	**0**	**(396)**	**(76)**	**320**
EBITDA	**(1,674)**	**(122)**	**(1,553)**	**(4,218)**	**(365)**	**(3,853)**	**(8,709)**	**10,540**	**11,543**	**(19,250)**	**(20,252)**
%	-6.0%	-0.4%	0.0%	-5.3%	-0.5%	0.0%	-2.7%	3.2%	3.5%	0%	0%

South Central Ambulance Service NHS Foundation Trust (Appendix B)

Financial results for Month 3 ended 30th June 2023

Income analysis	Month			Year to date			Full Year				
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Prior Year	Variance to budget	Variance to Prior Year
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Emergency Services											
E&U Contract	17,455	17,484	(29)	50,194	50,280	(86)	200,777	201,119	176,021	(343)	24,756
HART income	322	322	0	967	967	0	3,866	3,866	3,708	0	158
111 Service	3,413	3,413	0	9,829	9,828	1	39,311	39,311	37,658	(0)	1,652
National Covid Services	0	0	0	30	0	30	110	0	18,098	110	(17,989)
Public Events	40	44	(4)	79	133	(54)	532	532	251	(0)	281
CBRN/Flu funding	103	103	0	308	308	0	1,231	1,231	897	0	334
RTA Recoveries	26	27	(0)	69	80	(11)	320	320	250	0	70
Training funding from Health Education England	59	44	15	148	133	15	532	532	727	(0)	(195)
Workshop Income	33	15	17	134	150	(16)	677	677	273	(0)	404
Other Income	443	372	72	1,175	1,115	59	12,027	11,790	4,092	237	7,935
AfC Transfer	0	0	0	0	0	0	0	0	0	0	0
Total Emergency Services	**21,895**	**21,824**	**71**	**62,933**	**62,993**	**(61)**	**259,382**	**259,379**	**241,976**	**3**	**17,406**
Covid Recharge	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**17,118**	**0**	**(17,118)**
Corporate Income	**380**	**321**	**60**	**998**	**962**	**37**	**3,994**	**3,847**	**15,495**	**147**	**(11,502)**
Non-Emergency Services											
PTS Hampshire	1,311	1,312	(1)	3,808	3,783	25	15,231	15,133	13,189	98	2,042
PTS Thames Valley	1,409	1,409	(0)	4,080	4,080	(0)	16,319	16,319	13,878	(0)	2,441
PTS OHFT	51	51	0	152	152	0	608	608	797	0	(189)
PTS Call Centre	0	0	0	0	0	0	0	0	0	0	0
PTS Surrey	583	575	8	1,644	1,628	16	6,577	6,513	6,010	64	567
PTS Sussex	1,888	1,888	(0)	5,446	5,442	4	21,784	21,766	19,552	18	2,233
PTS MK	211	224	(13)	625	646	(21)	2,500	2,585	1,660	(86)	839
Logistic Services - Berkshire	0	0	0	0	0	0	0	0	0	0	0
Logistic Services - Ox & Bucks	180	180	0	541	541	0	2,162	2,162	1,832	0	330
Commercial Training	0	0	0	0	0	0	0	0	0	0	0
PTS Other	0	0	0	0	0	0	0	0	0	0	0
AfC Transfer	0	0	0	0	0	0	0	0	0	0	0
Total Non-Emergency Services	**5,632**	**5,638**	**(6)**	**16,295**	**16,272**	**24**	**65,181**	**65,087**	**56,917**	**95**	**8,264**
Total income	**27,907**	**27,782**	**125**	**80,226**	**80,227**	**(0)**	**328,557**	**328,312**	**331,507**	**245**	**(2,950)**

South Central Ambulance Service NHS Foundation Trust

Appendix C

Key Operational Spend (£k)	Actual Jun-23	Budget Jun-23	Variance Jun-23 +/(-)	Actual YTD	Budget YTD	Variance YTD +/(-)	Forecast	Budget	Variance Full Yr +/(-)	Prior year Full Yr
Overtime										
- A&E - North	135	336	201	249	959	710	3,557	3,557	0	3,384
- A&E - South	-63	196	258	198	465	267	1,646	1,914	267	2,463
- A&E - Control	25	59	34	219	171	-48	1,154	1,202	48	682
- A&E - Comm Resp/Emer Plan/Fleet	11	48	37	154	138	-17	499	551	51	634
- Commercial Division - PTS	89	175	86	263	498	235	716	1,946	1,230	1,354
- Commercial Division - non-PTS	1	1	-1	7	2	-5	35	8	-27	34
- Other	162	152	-10	314	437	123	1,642	1,765	123	2,913
Total Overtime	**360**	**967**	**606**	**1,405**	**2,670**	**1,265**	**9,249**	**10,942**	**1,693**	**11,464**
Private Providers										
- A&E - North	1,289	1,454	165	4,161	4,409	248	18,428	18,428	-0	12,823
- A&E - South	517	415	-102	1,535	1,260	-275	5,540	5,265	-275	4,125
- PTS	2,821	2,097	-724	7,331	6,027	-1,304	29,897	23,408	-6,488	15,476
Total private providers	**4,627**	**3,966**	**-661**	**13,027**	**11,696**	**-1,331**	**53,865**	**47,102**	**-6,763**	**32,424**
Fuel										
- A&E	308	417	109	917	1,250	333	4,679	5,001	322	2,636
- Commercial Services	128	194	66	436	596	159	1,571	2,355	784	1,301
- Fleet central	0	0	0	0	0	0	0	0	0	0
- Other	31	54	22	78	161	83	1,181	650	-530	428
Total fuel	**468**	**665**	**197**	**1,432**	**2,007**	**576**	**7,431**	**8,007**	**576**	**4,365**

South Central Ambulance Service NHS Foundation Trust

Appendix D

NHS Improvement Use of Resource Rating

	Jun-23 Actual	Jun-23 Budget	Jun-23 Variance	YTD Actual	YTD Budget	YTD Variance	Full Year Forecast	Full Year Budget	Full Year Variance
Capital Service Cover	1	1	0	1	1	0	1	1	0
Liquidity	1	1	0	1	1	0	1	1	0
I&E Margin	2	2	0	2	2	0	2	2	0
I&E Margin Variance From Plan	1	1	0	1	1	0	1	1	0
Agency	3	1	2	3	1	2	1	1	0
Overall (Financial Sustainability Risk Rating)	**2**	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**0**

	Jun-23 YTD	May-23 YTD	Apr-23 YTD	Last Year Full year	Comments
Better payment practice target					
- Non-NHS by number	96%	97%	97%	95%	
- Non-NHS by £ value	98%	99%	99%	97%	
- NHS by number	97%	97%	95%	96%	
- NHS by £ value	100%	100%	100%	100%	
Debtors > 90 days (£k)	458	351	281	362	
As % of total debts	37.0%	16.1%	18.6%	18.7%	
% cost improvements secured (actual)	11.4%	6.4%		107.7%	
% cost improvements secured (plan)	17.1%	15.4%		100.0%	

South Central Ambulance Service NHS Foundation Trust

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Appendix E

CASHFLOW 2023-24	Apr-23 £000 Actual	May-23 £000 Actual	Jun-23 £000 Actual	Q1 £000 Forecast	Q1 £000 Budget	Q1 £000 Variance	Jul-23 £000 Forecast	Aug-23 £000 Forecast	Sep-23 £000 Forecast	Q2 £000 Forecast	Q2 £000 Budget	Q2 £000 Variance	Oct-23 £000 Forecast	Nov-23 £000 Forecast	Dec-23 £000 Forecast	Q3 £000 Forecast	Q3 £000 Budget	Q3 £000 Variance	Jan-24 £000 Forecast	Feb-24 £000 Forecast	Mar-24 £000 Forecast	Q4 £000 Forecast	Q4 £000 Budget	Q4 £000 Variance
Income																								
SL Receipts	26,183	25,539	28,491	80,213	78,786	1,427	26,712	26,712	26,635	160,272	157,572	2,700	26,511	26,296	26,263	239,342	236,359	2,983	26,262	26,265	26,266	318,135	315,152	2,983
Fixed Asset Receipts	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest	189	191	191	571	420	151	190	190	190	1,141	840	301	190	190	190	1,711	1,260	451	190	190	190	2,281	1,680	601
Capital Lease and Saleback	0	780	0	780	0	780	0	0	0	780	0	780	541	0	0	1,321	0	1,321	5,884	0	5,884	13,089	0	13,089
Other Income/PDC/VAT/RTA	1,310	732	9,820	11,862	1,554	10,308	518	518	518	13,416	3,108	10,308	517	518	517	14,968	4,660	10,308	518	518	517	16,521	6,213	10,308
Other (PDC)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Cash In	27,682	27,242	38,502	93,426	80,760	12,666	27,420	27,420	27,343	175,609	161,520	14,089	27,759	27,004	26,970	257,342	242,279	15,063	32,854	26,973	32,857	350,026	323,045	26,981
Expenditure																								
Pay expenditure	16,275	16,403	22,954	55,632	52,782	(2,850)	18,094	18,094	18,094	109,914	105,564	(4,350)	17,894	17,594	17,594	162,996	158,346	(4,650)	17,594	17,594	17,606	215,790	211,140	4,650
Non Pay expenditure	13,730	10,763	14,163	38,656	23,582	(15,074)	9,925	8,925	7,916	65,422	44,150	(21,272)	8,136	8,776	9,241	91,575	68,737	(22,838)	8,739	8,508	9,257	118,079	85,379	32,700
Capital expenditure	258	263	149	670	1,694	1,024	675	925	857	3,127	3,127	0	300	255	381	4,063	4,063	0	816	900	752	6,531	6,531	0
Dividends on PDC	0	0	0	0	0	0	0	0	1,050	1,050	1,050	0	0	0	0	1,050	1,050	0	0	0	1,052	2,102	2,102	0
Loan Repayment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Lease and Saleback	9	0	0	9	0	(9)	0	2,500	1,235	3,744	0	(3,744)	1,500	1,500	0	6,744	0	(6,744)	1,000	903	0	8,647	0	8,647
IFRS 16 Leases	836	836	781	2,453	2,742	289	916	916	916	5,201	5,490	289	916	916	916	7,949	8,238	289	916	916	916	10,697	10,986	(289)
IFRS16 Interest	57	57	56	170	303	133	101	101	101	473	606	133	171	171	171	986	1,119	133	217	217	217	1,637	1,770	(133)
Total Cash Out	31,165	28,322	38,103	97,590	81,103	(16,487)	29,711	31,461	30,169	188,931	159,987	(28,944)	28,917	29,212	28,303	275,363	241,553	(33,810)	29,282	29,038	29,800	363,483	317,908	45,575
Net Cash In/(Out)	(3,483)	(1,080)	399	(4,164)	(343)	(3,821)	(2,291)	(4,041)	(2,826)	(13,322)	1,533	(14,855)	(1,158)	(2,208)	(1,333)	(18,021)	726	(18,747)	3,572	(2,065)	3,057	(13,457)	5,137	(18,594)
Balance B/fwd	50,024	46,541	45,461	50,024	50,024	0	45,860	43,569	39,528	50,024	50,024	0	36,702	35,544	33,336	50,024	50,024	0	32,003	35,575	33,510	50,024	50,024	0
Balance C/fwd	46,541	45,461	45,860	45,860	49,681	(3,821)	43,569	39,528	36,702	36,702	51,557	(14,855)	35,544	33,336	32,003	32,003	50,750	(18,747)	35,575	33,510	36,567	36,567	55,161	(18,594)

CASHFLOW RECONCILIATION	Apr-23 £000	May-23 £000	Jun-23 £000	Q1 Actl	Q1 Budget	Q1 Variance	Jul-23 £000	Aug-23 £000	Sep-23 £000	Q2 Actl	Q2 Budget	Q2 Variance	Oct-23 £000	Nov-23 £000	Dec-23 £000	Q3 Actl	Q3 Budget	Q3 Variance	Jan-24 £000	Feb-24 £000	Mar-24 £000	Q4 Actl	Budget £000	Q4 Variance
EBITDA	(693)	(2,481)	(6,627)	(6,627)	(2,633)	(3,994)	(5,577)	(7,521)	(9,464)	(9,464)	(3,266)	(6,198)	(9,272)	(11,145)	(10,953)	(10,953)	(2,689)	(8,264)	(15,912)	(16,739)	(16,566)	(16,566)	2,028	(18,594)
Depreciation & Amortisation	843	1,668	2,495	2,495	2,529	(34)	3,372	4,215	5,058	5,058	5,058	0	5,901	6,744	7,587	7,587	7,587	0	8,430	9,273	10,116	10,116	10,116	0
IFRS 16 Depreciation	836	1,671	2,485	2,485	2,504	(19)	3,339	4,174	5,008	5,008	5,008	0	5,997	6,985	7,974	7,974	7,974	0	9,032	10,091	11,150	11,150	11,150	
EBIT	986	858	(1,647)	(1,647)	2,400	(4,047)	1,134	868	602	602	6,800	(6,198)	2,626	2,584	4,608	4,608	12,872	(8,264)	1,550	2,625	4,700	4,700	23,294	(18,594)
Stock (Inc)/dec	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Debtors (Inc)/dec	628	(3,295)	5,418	5,418	(732)	6,150	(976)	(1,220)	(456)	(456)	(456)	0	(775)	(1,094)	(1,357)	(1,357)	(1,357)	0	2,143	979	(655)	(655)	(4,399)	3,744
Creditors Inc/(dec)	(3,033)	(1,481)	(5,459)	(5,459)	2,425	(7,884)	(577)	(267)	(57)	(57)	4,856	(4,913)	(204)	620	(1,177)	(1,177)	2,562	(3,739)	(1,199)	(456)	996	996	7,861	(6,865)
Provisions Inc/(dec)	(120)	(82)	(142)	(142)	0	(142)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2,000)	(2,000)	(2,000)	0
Capital expenditure	(258)	(521)	(670)	(670)	(1,694)	1,024	(2,369)	(2,794)	(3,127)	(3,127)	(3,127)	0	(3,427)	(3,682)	(4,063)	(4,063)	(4,063)	0	(4,879)	(5,779)	(6,531)	(6,531)	(6,531)	0
IFRS16 Lease Liability inc/(dec)	(836)	(1,654)	(2,435)	(2,435)	(2,742)	307	(3,658)	(4,574)	(5,490)	(5,490)	(5,490)	0	(6,406)	(7,322)	(8,238)	(8,238)	(8,238)	0	(9,154)	(10,070)	(10,986)	(10,986)	(10,986)	0
Right of Use Assets (RoU) (Inc)/dec	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(631)	0	(631)	0	(4,831)	(10,000)	(14,903)	(14,903)	(14,903)	0
IFRS16 Lease	(841)	841	0	0	0	0	0	0	0	0	0	0	0	0	631	0	631	0	4,831	10,000	14,903	14,903	14,903	0
IFRS16 Peppercorn Reserves inc/(dec	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital expenditure - Sale and Leaseb	(9)	(9)	(9)	(9)	0	(9)	(9)	(2,509)	(3,744)	(3,744)	0	(3,744)	(5,244)	(6,744)	(6,744)	(6,744)	0	(6,744)	(7,744)	(8,647)	(8,647)	(8,647)	0	(8,647)
Capital disposals	0	780	780	780	0	780	0	0	0	0	0	0	0	0	0	0	0	0	5,884	5,884	11,768	11,768	0	11,768
Free Cashflow pre finance	(3,483)	(4,563)	(4,164)	(4,164)	(343)	(3,821)	(6,455)	(10,496)	(12,272)	(12,272)	2,583	(14,855)	(13,430)	(15,638)	(16,971)	(16,971)	1,776	(18,747)	(13,399)	(15,464)	(11,355)	(11,355)	7,239	(18,594)
Dividends on PDC	0	0	0	0	0	0	0	0	(1,050)	(1,050)	(1,050)	0	(1,050)	(1,050)	(1,050)	(1,050)	(1,050)	0	(1,050)	(1,050)	(2,102)	(2,102)	(2,102)	0
Free Cashflow	(3,483)	(4,563)	(4,164)	(4,164)	(343)	(3,821)	(6,455)	(10,496)	(13,322)	(13,322)	1,533	(14,855)	(14,480)	(16,688)	(18,021)	(18,021)	726	(18,747)	(14,449)	(16,514)	(13,457)	(13,457)	5,137	(18,594)
PDC Payment/(Repayment)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Loan repayments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lease Borrowings	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital Loan from DH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net Cash In/(Out)	(3,483)	(4,563)	(4,164)	(4,164)	(343)	(3,821)	(6,455)	(10,496)	(13,322)	(13,322)	1,533	(14,855)	(14,480)	(16,688)	(18,021)	(18,021)	726	(18,747)	(14,449)	(16,514)	(13,457)	(13,457)	5,137	(18,594)

SOUTH CENTRAL AMBULANCE NHS FOUNDATION TRUST

Appendix F

CAPITAL EXPENDITURE 2023/24

For the period to
31 March 2024

Sale & Lease Back (Included within Expenditure Summary)	Forecast	Original Budget
DCA*	0	0
Vehicles Awaiting Sale/Leaseback**	(2,797)	(3,248)
		0
Total	**(2,797)**	**(3,248)**
Disposal Receipts**	(780)	0
Net Impact to CDEL	**(3,577)**	**(3,248)**

Capital resources available	Forecast	Original Budget
Core Depreciation	6,531	6,531
Disposal Receipts	0	0
Cash Reserves	0	0
IFRS16 Leases	14,903	14,903
Total capital resources used	**21,434**	**21,434**
Total disposal Income	0	0
Net CDEL	**21,434**	**21,434**

Expenditure summary	Forecast	Budget
Training	0	0
Estates	7,927	7,924
Operations**	3	0
Fleet*	126	0
Sale/Leaseback	-3,577	-3,248
IT	1,778	1,172
NHS Digital	752	720
Contingency	(478)	(37)
Total	**6,531**	**6,531**

Scheme Description	Company	Project Code	Budget 2023/24 £000	Actual Spend Profile: April Actual £000	May Actual £000	June Actual £000	July Forecast £000	August Forecast £000	September Forecast £000	October Forecast £000	November Forecast £000	December Forecast £000	January Forecast £000	February Forecast £000	March Forecast £001	**Total £000**
							July	August	September	October	November	December	January	February	March	
ESTATES																
New Build																
High Wycombe	SCAS	986	98		-1				99							**98**
Maintenance																
Didcot PTS	SCAS	TBC	187				187									**187**
Maintenance Programme	SCAS	TBC	1993				250	353	250			301	175	0	-	**1,329**
Medicines	SCAS	TBC	160						160							**160**
SH Desk Replacements CCC	SCAS	847			-1											**-1**
SH East Wing 1st Floor Reconfiguration	SCAS	858			11											**11**
MK CCC Fit Out - Partis House	SCAS	859	3310	73	51	44	726	629	396	690	701					**3,310**
EV Charger Installation	SCAS	861	469				75	75	75	75	94	75				**469**
Adanac North Southampton	SCAS	876	1200	4	15	7	300	296	285	293						**1,200**
Stoke Mandeville Refurbishment	SCAS	894	98	98	-2											**96**
EOC Meeting Room Conversion	SCAS	883	10	10												**10**
OSD Desk Reconfiguration	SCAS	885	18	18	3											**21**
PTS South Oxfordshire & Make-Ready - 5 Moorbr	SCAS	887	1	1	27	3										**31**
Sluices	SCAS	878	380	12	67	43	50	50	50	50	50	8				**380**
Northern House Comms Room	SCAS	905			6											**6**
Wexham RC Flooring	SCAS	917			19											**19**
WERC Kitchen	SCAS	955					61									**61**
Reading Statutory Electrical Works	SCAS	956					259									**259**
Didcot Roof	SCAS	958					128									**128**
Stokemandeville RC Windows Replacement	SCAS	962					18									**18**
Gosport Roof PTS	SCAS	963					135									**135**
OPERATIONS																
EQUIPMENT																
Automated External Defibrillators (AED'S	SCAS	866			3											**3**
FLEET																
Mental Health Response Vehicl	SCAS	965					126									**126**
INFORMATION TECHNOLOGY																
Emergency Services Mobile Communication Programme	SCAS	TBC	298							50	50	50	50	50	48	**298**
Integration Engine and FHIR Messaging	SCAS	TBC	310										310			**310**
Mobile Phones CFR	SCAS	TBC	250				250									**250**
Zoll Defibrillator Data Collection	SCAS	TBC	229						229							**229**
CFR Scribe App	SCAS	TBC	30						30							**30**
Call centre Switch Patching	SCAS	TBC	18								18					**18**
WIFI Enhancements	SCAS	993			1	1										**2**
Hexagon CAD Developer	SCAS	880	13	13	24	25										**62**
Stock Control System	SCAS	872	9	9												**9**
ESMCP (ARP) - CRS	SCAS	855	15	15	3	12										**30**
Avaya Communication Manager	SCAS	966						540								**540**
NHS Digital																
Network Access Control	SCAS	882	1	1	13	4										**18**
Data Centre	SCAS	997		-3	9	9										**15**
Virtual Server Network Upgrade (VXLAN)	SCAS	854	719	-1	5				250	250	215					**719**
Sale/Lease Back																
Ford Tourneo - Sale Leaseback - Chassis x1	SCAS	941	-451		-451											**-451**
Fiat Ducato PTS x 40	SCAS	942			-329											**-329**
Tesla - Replaces KIA EV6 x9	SCAS	943	-541						-541							**-541**
DCA 22/23	SCAS	805	-2256										-2,256			**-2,256**
Contingency																
Contingency IT	SCAS	TBC	-37												- 669	**-669**
Contingency Operations	SCAS	TBC													191	**191**
Contingency Fleet	SCAS	TBC														
TOTAL NON IFRS 16 PROGRAMME			**6,531**	**250**	**-527**	**148**	**2,565**	**1,943**	**1,283**	**1,408**	**1,128**	**434**	**-1,721**	**50**	**- 430**	**6,531**

IFRS 16

DCA 22/23	SCAS	805	4200	9									4,191		0	**4,200**
Ford Tourneo WAV x19	SCAS		0		635											**635**
Equipment			400											400		**400**
Buildings			631									631				**631**
Ambulance Replacement Programme 23-24			4903												4903	**4,903**
Building - High Wycombe			4769											4134		**4,134**
TOTAL IFRS 16 PROGRAMME			14903	**9**	**635**	**-**	**-**	**-**	**-**	**-**	**-**	**631**	**4,191**	**4,534**	**4,903**	**14,903**
Total			**21,434**	**259**	**108**	**148**	**2,565**	**1,943**	**1,283**	**1,408**	**1,128**	**1,065**	**2,470**	**4,584**	**4,473**	**21,434**

BALANCE SHEET As at 30 June 23	Actual As at 30 June 23 (£k)	Audited As at 31 Mch 23 (£k)	Forecast As at 31 Mch 24 (£k)
FIXED ASSETS			
Property, Plan & Equipment	68,609	70,599	69,777
Intangible assets	1,817	1,798	3,914
IFRS 16 RoU Assets	62,132	56,579	50,034
Pension Allowance Charge Compensation Scheme	19	17	20
	132,577	**128,993**	**123,745**
CURRENT ASSETS			
Stocks & Work In Progress	**1,447**	**1,447**	**1,220**
Assets held for resale	0	0	0
Sales Ledger Debtors	1,093	13,104	8,188
Prepayments & Accrued Income	13,842	8,041	7,386
Other Debtors	2,197	1,410	750
Trade & Other Receivables	**17,132**	**22,555**	**16,324**
Cash and cash equivalents	**45,859**	**50,024**	**36,567**
TOTAL CURRENT ASSETS	**64,439**	**74,026**	**54,111**
CREDITORS			
Purchase Ledger Creditors	(4,849)	(6,071)	(7,000)
Accruals & deferred income	(19,894)	(26,452)	(16,461)
Other Creditors Incl Pensions, PAYE & NI	(11,977)	(7,849)	(8,480)
Capital Accruals	(128)	(1,936)	(191)
Borrowings (IFRS 16) < 1 year	(9,326)	(7,265)	(8,819)
Provisions < 1 year	(4,243)	(4,348)	(7,414)
CURRENT LIABILITIES	**(50,417)**	**(53,921)**	**(48,365)**
NET CURRENT ASSETS/(LIABILITIES)	**14,021**	**20,105**	**5,746**
TOTAL ASSETS LESS CURRENT LIABILITIES	**146,598**	**149,098**	**129,491**
Borrowings (IFRS 16)	(41,263)	(37,808)	(41,215)
Provisions	(3,818)	(3,855)	(2,603)
Other Financial Liabilities	0	0	0
Non-Current Liabilities	**(45,081)**	**(41,663)**	**(43,818)**
TOTAL ASSETS EMPLOYED	**101,517**	**107,435**	**85,673**
FINANCED BY:			
TAXPAYER'S EQUITY			
Public Dividend Capital	(66,047)	(66,047)	(66,047)
Revaluation Reserve	(22,120)	(21,497)	(18,448)
Other Reserve	350	350	350
Retained Earnings	(8,045)	(8,044)	(8,044)
I & E YTD	6,610	0	18,594
IFRS 16 I&E	(12,264)	(12,197)	(12,078)
TOTAL TAXPAYERS EQUITY	**(101,517)**	**(107,435)**	**(85,673)**

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**NHS Long Term Workforce Plan**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**21.0**
Executive Summary:	✓		
Recommendations:	The Trust Board is asked to: Note the contents of the NHS Long Term Workforce Plan.		
Executive lead:	Melanie Saunders, Chief Operating Officer		
Report author:	Melanie Saunders, Chief Operating 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:	
Briefing paper only, full impact and assurance to be considered as the plan is considered and reviewed in line with SCAS BAF and SCAS People Strategy	
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):

SCAS People Strategy objectives and priorities to be reviewed alongside the NHS Long Term Workforce plan.

List of Appendices:

Overview of NHS Long Term Workforce Plan (power point)
NHS Long Term Workforce Plan – NHS England Briefing Paper
NHS Long Term Workforce Plan – NHS England Summary
Link to full NHS Long Term Workforce Plan NHS England » NHS Long Term Workforce Plan
Link to NHS Employers Action Plan Key-actions-for-employers-FNL.pdf (nhsemployers.org)

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NHS Long Term Workforce Plan Briefing

Melanie Saunders
Chief People Officer
July 2023

South Central Ambulance Service
NHS Foundation Trust

Executive Summary

The NHS Long Term Workforce Plan considers the challenges facing the workforce over the next 15 years and sets out actions to address them

The first ever NHS Long Term Workforce Plan sets out supply and demand scenarios and projections for key workforce groups and professions. The plan then focusses on the three areas where we will take action to ensure that the NHS has the workforce it needs for the future:

Recruit: Grow the workforce

By significantly expanding domestic education, training and recruitment, we will have more doctors, nurses and other healthcare professionals working in the NHS. We will:

- Increase the number of undergraduate medical school training places, with more medical school places in areas with the greatest shortages to level up training.
- Increase the number of GP training places.
- Increase the number of nurse, midwife and health visiting training places registered nurses qualifying including through apprenticeship routes.
- increasing the number of advanced practitioners, independent prescribers, and Allied Health Professionals acting as senior decision-makers in appropriate settings.
- Increase the proportion of training for clinical staff through apprenticeship routes by 2030,. This will ensure we train enough staff in the right roles and help widen access to opportunities for people from all backgrounds.
- Further expand medical degree apprenticeships.
- Expand dentistry places and consider how to incentivise dentists to offer more work to the NHS.
- Train more NHS staff domestically. This will mean that we can reduce reliance on international recruitment.

Retain existing talent: Embed the right culture and improve retention

By improving culture, leadership, and wellbeing, we will ensure fewer staff leave the NHS over the next 15 years. We will:

- Build on the actions from the NHS People Plan, to make the NHS People Promise a reality for our staff.
- Work to deliver the actions set out in the NHS equality, diversity and inclusion plan.
- Back plans to improve flexible opportunities for prospective retirees and work with government to deliver the actions needed to modernise the NHS pension scheme.
- Ensure NHS organisations across the country, from day one of employment offer people flexible working and the best possible start to an NHS career
- Commit to ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential.
- Reform how the NHS recruits staff, so that we offer a much better candidate experience, and support local jobs

Reform: Working and training differently

Working differently means staff can spend more time with patients, harnesses digital innovations and enables new and innovative ways of working. Training will be reformed, to give learners a better experience. We will:

- Take advantage of digital and technological innovations, such as AI, speech recognition, robotic process automation and remote monitoring to support the NHS workforce.
- Focus on expanding enhanced, advanced and associate roles to offer modernised careers, with a stronger emphasis on the generalist skills needed to care for patients with multi-morbidities, frailty or mental health needs.
- Encourage and support clinically-led work to consider how to make best use of new roles in clinical teams as they are brought on stream, to ensure they are a valued part of the wider multidisciplinary team.
- Explore measures such as tie ins to encourage dentists to spend a proportion of their time delivering NHS care.
- Work with the NMC, GMC and others to reform education and training for doctors and nurses so that learners have a good experience of training that prepares them for work in the NHS.
- Work with medical schools and the GMC to introduce four-year degree programmes and pilot a medical internship programme which could shorten undergraduate training time.

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NHS Long Term Workforce Plan

- Train: Substantially growing the number of doctors, nurses, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.
- Retain: A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.
- Reform: Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

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The plan aims to increase NHS workforce by

- Doubling medical school training places to 15,000 by 2031/32, with more places in areas with the greatest shortages
- Increasing the number of GP training places by 50 per cent to 6,000 by 2031
- Almost doubling the number of adult nurse training places by 2031, with 24,000 more nurse and midwife training places a year by 2031
- Providing 22 per cent of training for clinical staff through apprenticeship routes by 2031/32
- Introducing medical degree apprenticeships with pilots running in 2024/25 so that by 2031/32 2,000 medical students will train by this route
- Training more NHS staff domestically – in 15 years' time, we would expect around 9-10.5 per cent of the workforce to be recruited from overseas compared to nearly a quarter now
- Ensuring that more than 6,300 clinicians start advanced practice pathways each year by 2031/32
- Increasing training places for nursing associates (nas) to 10,500 by 2031/32 – by 2036/37, there will be over 64,000 nursing associates working in the NHS, compared to 4,600 today.

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Key actions for SCAS

- Continue to upscale apprenticeship offers for clinical roles
- Increase and improve placement offers and experience for our students
- Increase domestic recruitment through access to employment programmes, support worker roles, talent attraction
- Support Paramedic students to enter the register within 2 years
- Focus on retention and flexible working offers, including flexible retirement
- Continue to develop wellbeing support and occupational health services

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Key actions for SCAS cont.d

- Continue to develop fair, compassionate and inclusive culture built on civility and respect
- Provide team development
- Continue to improve FTSU
- Provide clear pathways for progression and development
- Provide robust preceptorship programmes
- Expand on Advance Practice roles
- Use technological innovation in education
- Reduce temporary staffing
- Reduce administrative burden

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Next steps

- Utilise NHS Employers ‘action plan’ to benchmark current progress against the recommendations
- Identify any gaps within the existing People Strategy objectives and adjust improvement plans accordingly
- Continue to work with ICB & Ambulance partners on the development of system/sector workforce plans and schemes

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Thank you

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Freedom to Speak Up (FTSU) self-assessment**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 27 July 2023**	**Agenda Item:**	**22.0**
Executive Summary:	The paper is the Freedom to Speak Up self-assessment which we have completed for the first time as part of the National Guardian's Office (NGO) guidance. Section 1 contains the 8 principles each comprising several sub sections with associated narrative. Sections 2 and 3 are a summary of the short and longer term actions around our gaps and strengths highlighted by the assessment in Section 1.		
Recommendations:	The Trust Board is asked to: • Section 1 - note the self-assessed narrative against the 8 principles • Sections 2 & 3 – note the high level summary of actions presented and agreed at the private Board meeting in June 2023.		
Executive lead:	Melanie Saunders, CPO		
Report author:	Nicola Howells / Simon Holbrook		
Previously considered by:	People & Culture Committee, Executive Management 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 3 - Culture and staff experience
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): The actions in sections 2 & 3 will be captured in the ongoing FTSU action plan and the overarching Culture improvement plan. They will also be reflected in the team and individual objectives being set with the team in Q1.	
List of Appendices: No appendices but note the summary of short and longer term actions in Sections 2 & 3	

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

1 = significant concern or risk which requires addressing within weeks
2 = concern or risk which warrants discussion to evaluate and consider options
3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach
4 = an evidenced strength (e.g., through data, feedback) and a strength to build on
5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

a) Statements for the senior lead responsible for Freedom to Speak Up to reflect on		Score 1–5 or yes/no
i.	I am knowledgeable about Freedom to Speak Up	5
ii.	I have led a review of our speaking-up arrangements at least every two years	5
iii.	I am assured that our guardian(s) was recruited through fair and open competition	5
iv.	I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
v.	I am regularly briefed by our guardian(s)	5
vi.	I provide effective support to our guardian(s)	4

Enter summarised commentary to support your score.

i) ***Score 5 –*** *in August 2022, the Assistant Director of OD became the FTSU senior lead with the Chief People Officer as the Executive Lead. Irrespective of the previous organisational structure, the OD Lead actively has supported and met with the FTSU Guardian since 2018; completed HEE elearning; reads & shares professional articles; attends learning events with the Guardian (eg. Chris Turner seminar on civility); ensures FTSU content is included, updated and understood by facilitators of leadership training; meets with FTSU Guardian to discuss themes, data, developments, ideas; and ensures FTSU representation is present and participating in relevant Board, Committee and other fora. Exec Lead, has completed FTSU e-learning, has monthly 1:1 with the FTSU Guardian and sourced ICB support for FTSU policy review and advice. Ensured previous National Guardian attended Board seminar and that current national Guardian delivered further Board session in April 2023 focussed on roles & responsibilities. Executive also member of national FTSU Executive lead group, has attended national FTSU conference 2023.*

ii) ***Score 5 -*** *In 2022, the FTSU function was significantly expanded and moved from the clinical directorate into Organisational Development (OD). This not only provides greater independence from clinical services and Human Resources (HR), but also aligns it with Diversity & Inclusion (ED&I) and the leadership & cultural work.*
- Board self-review undertaken 2020/21 & refreshed 21/22. NGO gap analysis undertaken 21/22 & refreshed 22/23.

- in Q1 22/23 NHSE published updated self-review guidance with a recommended 2 year window to complete, this was started it in Q3 22/23 and is ongoing
- FTSU is included in Executive job descriptions. Named Exec and Non-Exec leads.
- FTSU elearning modules on speaking, listening and following up mandated for all staff including Board members
- National Guardian, Jayne Chidgey-Clark, delivered session at Board seminar on 27th April 2023

iii) ***Score 5 –*** *in 2018 the lead FTSU Guardian was recruited on a fixed term basis but was subsequently recruited to the permanent role using a fair and open competitive process in accordance with the example job description and other guidance published by the National Guardian Office, NHSE/I, NHS Employers. In 2022, a further fair and competitive recruitment campaign led to the appointment of 2.0wte Deputy FTSU guardians (1.0wte substantive, 1.0wte fixed term until Oct 23).*

iv) ***Score 3 –*** *From 2018 to 2022, the FTSU Guardian role was fulfilled by a single postholder. The growth of the role, operational restrictions on travel during the pandemic and the improving culture of speaking up led to an urgent review of the resource in the team. The appointment of 2.0wte Deputy FTSU Guardian posts (1.0wte fixed term until Oct '23) has substantially improved diversity, visibility, availability, capacity and resilience within the FTSU function. It has also allowed differentiation of tasks between the lead and deputy roles to ensure individual cases, governance and service development can each be given better attention. However, the FTSU process of speaking, listening and following up currently remains administratively time consuming, not least because NHSE/NGO guidance dictates it can only be done by a trained FTSU Guardian. Recent (temporary) administrative support proved advantageous but only a small element of the work could be shared with the role. Though much improved, capacity and resilience is still a risk for the team and one that will increase if the fixed term 1.0wte Deputy post ends in Oct 2023. Given FTSU case numbers are rising and can be expected to continue to do so, this is an area that requires focused planning and consideration including how we might continue with 3.0wte and ways to streamline and automate administrative tasks where possible.*

v) ***Score 5 –*** *OD is largely a virtual/mobile team with no on-site work base. Consequently, we hold fortnightly 1:1s and weekly team meetings focussing on both individual support and the FTSU work as an integral part of the OD agenda. In addition, when the Lead Guardian is away, the OD Lead meets directly with the two deputies to understand, support and unblock any issues. In addition, all three guardians freely contact the senior lead on an ad hoc basis when required. Whilst maintaining confidentiality of individual cases, the regular briefings serve to triangulate the themes between FTSU cases and other sources of organisational intelligence (People Voice). Executive FTSU lead (Chief People Officer) will be attending FTSU team meetings on a twice yearly basis. The Lead Guardian also holds daily catch ups with the two deputies and face to face team meetings on a weekly basis.*

vi) ***Score 4 –*** *as above, the FTSU Lead and deputies have regular and ad hoc meetings with the OD lead and wider OD team. Annual objectives have been agreed with the team in Q1 2023/24; 1:1s, PDRs and a mid-year refresh have all been booked with*

protected time for the coming year. Notwithstanding recent expansion and initial training, consideration is yet to be given to ongoing development for the current team as well as further career pathways and succession planning. As with all our people, the team has access to a full suite of Health & Wellbeing support. The team sits within the OD function alongside the E,D & I Lead and two OD practitioners which is proving to be a supportive and inclusive environment for them despite the often isolating nature of their role. The FTSU team is networked regionally and nationally, however we have yet to establish regular and independent clinical supervision for our FTSU Guardians. Various options have been considered and trialled but is not yet embedded.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item iv (score 3)

- *administrative automation and/or streamlining within NGO confidentiality guidelines*
- *options analysis for the fixed term 1.0wte Deputy FTSU role currently ending Oct 2023*

Item vi (score 4)

- *regular psychological supervision for the team to be established*
- *further development for the current team as well as ongoing career pathways and succession planning*

b) Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on		Score 1–5 or yes/no
i.	I am knowledgeable about Freedom to Speak Up	5
ii.	I am confident that the board displays behaviours that help, rather than hinder, speaking up	4
iii.	I effectively monitor progress in board-level engagement with the speaking-up agenda	4
iv.	I challenge the board to develop and improve its speaking-up arrangements	5
v.	I am confident that our guardian(s) is recruited through an open selection process	5
vi.	I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
vii.	I am involved in overseeing investigations that relate to the board	4

viii. I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

i) ***Score 5*** *- the current NED FTSU lead is the Trust chair. He actively supports the FTSU function, has completed the HEE elearning and shares / reads professional articles*

ii) ***Score 4 –*** *the FTSU Guardian is required to deliver a quarterly report to Trust Board and the People and Culture Committee (PACC) and has been invited to join the ED&I steering group. If public disclosures or courageous feedback is given at Board, the individual is explicitly thanked eg. Women's network staff story to the Board in 2022. Further work is underway regarding Board and Executive development which includes behaviours around healthy conflict, trust and psychological safety all of which play into a speaking up culture.*

iii) ***Score 4 –*** *The FTSU Guardian regularly attends Board and has 1:1s with the NED Lead. I am not aware of any specific monitoring of speaking up but, as the Chair, the NED FTSU lead is actively leading, appointing and developing the NEDs.*

iv) ***Score 5 –***
- Board self-review undertaken 2020/21 & refreshed 21/22. NGO gap analysis undertaken 21/22 & refreshed 22/23.
- in Q1 22/23 NHSE published updated self-review guidance with a recommended 2 year window to complete, this was started it in Q3 22/23 and is ongoing
- FTSU is included in Executive job descriptions. Named Exec and Non-Exec leads.
- FTSU elearning modules on speaking, listening and following up mandated for Board members
- The previous National Guardian attended a Board seminar in the past three years
- current National Guardian, Jayne Chidgey-Clark, delivered a session at Board seminar on 27th April 2023

v) ***Score 5 –*** *in 2018 the lead FTSU Guardian was recruited on a fixed term basis but was subsequently recruited to the permanent role using a fair and open competitive process in accordance with the example job description and other guidance published by the National Guardian Office, NHSE/I, NHS Employers. In 2022, a further fair and competitive recruitment campaign led to the appointment of 2.0wte Deputy FTSU guardians (1.0wte substantive, 1.0wte fixed term until Oct 23).*

vi) ***Score 3 –*** *The growth of the role, operational restrictions on travel during the pandemic and the recent focus on our speaking up culture led to an urgent review of the resource in the team. Though much improved, capacity and resilience remain a risk with the fixed term 1.0wte Deputy post due to end in Oct 2023. As FTSU case numbers are rising and can be expected to continue to do*

so this requires planning and consideration to ensure sufficient resource can be sustained and efficient administrative processes are utilised

vii) ***Score 4 -*** *Our flow charts and escalation processes clearly demonstrate that the non-Executive lead would be involved if concerns were raised about the Board or if other organisational concerns needed to be escalated beyond the Guardians or Exec Lead.*

viii) ***Score 4 -*** *The FTSU Guardian and NED lead meet regularly to ensure the Board remains informed on key themes raised*

c) High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item ii (score 4)

- *Executive and Board development around trust, conflict and psychological safety which impact a speak up culture*

Item vi (score 3) (as per previous section)

- *administrative automation and/or streamlining within NGO confidentiality guidelines*
- *options analysis for the fixed term 1.0wte Deputy FTSU role currently ending Oct 2023*

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

a) Statements for senior leaders		Score 1–5 or yes/no
i.	The whole leadership team has bought into Freedom to Speak Up	3
ii.	We regularly and clearly articulate our vision for speaking up	3
iii.	We can evidence how we demonstrate that we welcome speaking up	3
iv.	We can evidence how we have communicated that we will not accept detriment	2
v.	We are confident that we have clear processes for identifying and addressing detriment	2
vi.	We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3
vii.	We regular discuss speaking-up matters in detail	3

Enter summarised evidence to support your score.

i) ***Score 3 –*** *when a concern arises, the FTSU team pass it to the relevant senior lead to pursue. In the majority of cases, this has worked well and senior leaders have acted promptly to resolve the concern. Both previous and current CEOs have demonstrated good role modelling in publicly thanking people for speaking up and raising questions. We want to ensure this is replicated through all our leaders and that all senior leaders understand the importance and benefit of listening and following up.*

ii) ***Score 3 –*** *The newly published People Strategy prioritises speaking up and this is a key workstream in the improvement plan. Listening exercises were held in the autumn to invite people to speak up about what gets in the way of their best work – these were framed as being part of the speak up culture we wish to develop. Speaking up (which includes FTSU) is central to our work on People Voice and in ensuring the organisation hears frontline views and concerns. This work is ongoing and is not yet fully embedded.*

iii)	***Score 3 -*** *Starting to happen. We have shared some 'you said we did' items (sexual safety) but need to do more on this including in clinical/patient safety examples*
iv)	***Score 2 –*** *the refreshed policy is clear and explicit on detriment. We now need a process to ensure the reality matches it.*
v)	***Score 2 -*** *the refreshed policy is clear and explicit on detriment. We need a process / system to ensure reality matches it.*
vi)	***Score 3 –*** *the FTSU questions in the annual staff survey are a benchmark for workforce confidence in speaking up. We monitor this closely every year in addition to other People Voice data. Case closure surveys demonstrate satisfaction with the process, however, response rates are low (~7%) and only capture reported FTSU cases not the wider workforce*
vii)	***Score 3 -*** *FTSU is a standing agenda item at PACC and recently included in the EDI steering group. We do not yet have a specific FTSU steering group.*

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

Item i (score 3)

- *All line managers are mandated to complete the relevant FTSU elearning modules for their level to increase understanding*

Item ii (score 3)

- *Continue to embed People Voice and FTSU as a specialist element within this*

Item iii (score 3)

- *Continue to develop a robust 'you said, we did' feedback loop including specific examples around clinical/non-clinical FTSU cases*

Item iv & v (score 2)

- *seek wider guidance on safeguarding against detriment ie. Protect & Institute for business ethics for guidance*

Item vii (score 3)

- *consider the need for a FTSU steering group and progress accordingly*

b) Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
i. I am knowledgeable about Freedom to Speak Up	5

ii.	We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	4
iii.	We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3
iv.	We support our guardian(s) to make effective links with our staff networks	3
v.	We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3

Enter summarised evidence to support your score.

i) ***Score 5 -*** *The OD lead is also the senior lead for FTSU – see Principle 1 section a.*

ii) ***Score 4 -*** *The newly published People Strategy prioritises speaking up as a key element and this is a key workstream in the improvement plan over and above the FTSU function. Listening exercises were held in the autumn to invite people to speak up about what gets in the way of their best work – these were framed as being part of the speak up culture we wish to develop. Speaking up (which includes but is not restricted to the FTSU function) is central to our work on People Voice and in ensuring the organisation hears frontline views and concerns. This work is ongoing and is not yet fully embedded but it is certainly included.*

iii) ***Score 3 –*** *in 2022/23 over 300 managers have attended training on Just and Learning Culture and civility. This complements the SCAS Leader programme (launched April 2019), which focuses on compassionate, inclusive and collaborative leadership. The impact on the organisational culture is starting to show with a marked reduction in employee relations cases but there is still work to be done to ensure the relevant behaviours are truly embedded.*

iv) ***Score 3 -*** *During September/October 2022, the FTSU portfolio transitioned to the OD team within the People Directorate. The decision to align FTSU within OD places it alongside the Equality, Diversity & Inclusion (ED&I) lead, the culture and leadership work and a direct link to staff networks. When staff network events have happened, eg. International Women's Day, our FTSU team have been key contributors. The FTSU Guardian is an active member of the EDI steering group with all the networks and we are supporting the networks to make more use of the EDI, FTSU and OD functions.*

v) ***Score 3 –*** *the FTSU Guardian is an active member in the People and Culture Committee (PACC) and the Patient Safety Group (PSG). FTSU themes are shared with OD, ED&I and the Safeguarding team. This intelligence is fed into training material and case studies in addition to cross-referencing particular cases or clusters within an area.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
Item iii (score 3) • *Continue to develop and reinforce compassionate leadership behaviours including JLC, civility, inclusion and collaboration*	
c) Statements about how much time the guardian(s) has to carry out their role	**Score 1–5 or yes/no**
i. We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
ii. We have reviewed the ringfenced time our Guardian has in light of any significant events	4
iii. The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	4
iv. We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	2

Enter summarised evidence to support your score.

i) ***Score 3 -*** *From 2018 to 2022, the FTSU Guardian role was fulfilled by a single postholder. The growth of the role, operational restrictions on travel during the pandemic and the improving culture of speaking up led to an urgent review of the resource in the team. The appointment of 2.0wte Deputy FTSU Guardian posts (1.0wte fixed term until Oct '23) has substantially improved diversity, visibility, availability, capacity and resilience within the FTSU function. It has also allowed differentiation of tasks between the lead and deputy roles to ensure individual cases, governance and service development can each be given better attention. However, the FTSU process of speaking, listening and following up currently remains administratively time consuming, not least because NHSE/NGO guidance dictates it can only be done by a trained FTSU Guardian. Recent (temporary) administrative support proved advantageous but only a small element of the work could be shared with the role. Though much improved, capacity and resilience is still a risk for the team and one that will increase if the fixed term 1.0wte Deputy post ends in Oct 2023. Given FTSU case numbers are rising and can be expected to continue to do so, this is an area that requires focused planning and consideration including how we might continue with 3.0wte and ways to streamline and automate administrative tasks where possible.*

ii) ***Score 4 –*** *as above – the FTSU resource and capacity started being reviewed in early 2022 and the CQC report in the spring lent further weight to this. The CQC feedback demonstrated that having 1.0wte Guardian did not allow staff sufficient access to share and progress their concerns in a timely manner without the Guardian carrying a greatly excessive workload. The appointment of two deputies has greatly improved this but will remain a risk if the seconded 1.0wte deputy role is removed in October '23.*

iii) ***Score 4 –*** *as above – the FTSU resource was discussed by the senior team and much of the immediate improvement work was focused on getting the extra FTSU resource appointed as quickly as possible. The risk around continuing capacity has been and will continue to be highlighted. The new National Guardian attended the Board seminar in April 2023 to discuss roles and responsibilities around FTSU.*

iv) ***Score 2 –*** *as above – 1.0wte Lead and 1.0wte Deputy roles are permanently established in the OD budget. The second deputy has been extended to Oct '23 using external HEE funding carried over from 2022/23. The Exec Lead recommends that the Trust follows the guidance within the National Ambulance FTSU review of appointing 3wte guardians, however there is currently no funding secured to make the third role permanent. In addition, there is no budget for FTSU merchandise, design work, travel/subsistence costs across the SCAS area or maintaining the Speak-up-ulance vehicle which has proven key to their connection with the frontline.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item iv (score 2)

- *a business case will be required to ensure the team has enough resource to maintain the service after Oct '23, including the maintenance of the Speak-up-ulance*

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

a) Statements about your speaking-up policy	Score 1–5 or yes/no
i. Our organisation's speaking-up policy reflects the 2022 update	3
ii. We can evidence that our staff know how to find the speaking-up policy	3

Enter summarised evidence to support your score.

i) ***Score 3 -*** *Our FTSU Policy was updated recently in light of CQC feedback with assistance from H&IOW ICB. It does not yet fully encompass the 2022 update but is part of the improvement work and will do so by the deadline of Jan 2024.*

ii) ***Score 3 –*** *the annual staff survey (NSS22) demonstrates that respondents (50% response rate) know how to speak up. The question remains whether most of them could find the policy as the Hub is not always familiar to some of our workforce. However, we are developing a range of Supporting Our People webpages that will signpost to the FTSU site and the associated policy. This work is part of the SCAS improvement plan and new People Strategy.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item i (score 3)

- *Refresh the policy to reflect the 2022 update following consultation in Q2 '23/24*

Item ii (score 3)

- *Continue to build Supporting our People webpages which signpost to the FTSU site and associated policy*

b) Statements about how speaking up is promoted	Score 1–5 or yes/no
i. We have used clear and effective communications to publicise our guardian(s)	4
ii. We have an annual plan to raise the profile of Freedom to Speak Up	4
iii. We tell positive stories about speaking up and the changes it can bring	3
iv. We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

i) ***Score 4 -*** *we have a mixed media approach including posters on locations, all staff newsletters, merchandise, mention in welcome letters, Hub, Teams and Yammer pages & a dedicated session on induction for patient facing roles. The CQC improvement work and listening exercises emphasised the increased investment in the team. They have regularly been out in the Speak-up-lance, do Walkabout Wednesdays on different sites and offer manager virtual drop-ins once a month.*

ii) ***Score 4 –*** *we have a newly published People Strategy which prioritises the FTSU work as part of People Voice and developing a compassionate culture of speaking up. The People Directorate, and OD in particular, are now setting annual objectives for 2023/24 which will dictate the annual plan around the FTSU work. A key part of this is to continue to raise the profile of the new team.*

iii) ***Score 3 -*** *we have developed training materials in leadership and management courses around FTSU including the purpose, the barriers and the benefit. We have also trained 3 cohorts of FTSU champions to be change leaders in their areas of work. We have yet to develop a robust 'You said, We did' pipeline for all People Voice themes including FTSU - this will build workforce confidence in a positive outcome.*

iv) ***Score 3 –*** *we have started to measure the effectiveness of our internal communications as an organisation but not specifically wrt FTSU. However, the annual staff survey demonstrates awareness of the FTSU team and function which we monitor and report each year.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item iii & iv (score 3)

- *Build a 'You said, We did' process to explicitly demonstrate positive outcomes of speaking up.*
- *Monitor NSS23 for an improvement in workforce confidence in speaking up – in 2022 this dropped for the first time in 5 years*

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

a) Statements about training	Score 1–5 or yes/no*
i. We have mandated the National Guardian's Office and Health Education England training	3
ii. Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
iii. Our HR and OD teams measure the impact of speaking-up training	3

Enter summarised evidence to support your score.

i) ***Score 3 –*** *from April '23, FTSU elearning has been mandated for all staff as part of the stat/mand training requirements. A system for actively monitoring and reinforcing uptake is the next step.*

ii) ***Score 4 -*** *FTSU Guardian attends as many inductions as possible we have a video of the induction presentation to play in any absences. An enhanced FTSU/EDI/Staff engagement session is being designed for all new recruits as part of a refreshed induction called A Good Start.*

iii) ***Score 3 -*** *the annual staff survey demonstrates an awareness of and confidence in the FTSU function which we monitor and report each year. The team have set up their own case closure surveys although these have a low response rate (~7%). We also have access to other People Voice data sets such as student placement feedback, new starter and exit interviews as well as speak up training forming part of the SCAS Leader programme. We are still developing how we use these data sources to interpret training impact.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item i (score 3)

- *Actively monitor elearning compliance across SCAS and set a realistic timeline to achieve 95% org compliance on Module 1 – Speaking Up*
- *Actively monitor elearning compliance in the strategic leadership group (SLG) and set a realistic timeline to achieve 95% compliance on Modules 1-3 – Speaking, Listening & Following Up*

b) Statements about support for managers within teams or directorates	**Score 1–5 or yes/no**
i. We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3
ii. All managers and senior leaders have received training on Freedom to Speak Up	2
iii. We have enabled managers to respond to speaking-up matters in a timely way	2
iv. We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3

Enter summarised evidence to support your score.

i) ***Score 3 –*** *Speaking up is a key element in our leadership and management development courses where we discuss why it is hard and what gets in the way of doing it well. Listening and thanking people who speak up has been explicitly role-modelled by the previous and current CEOs in all SCAS meetings and when FTSU cases are fed back to senior leaders, the approach taken is supportive of managers who understandably might initially feel defensive or threatened. As an historically hierarchical organisation based on command structures, this is a key part of our desired culture shift which will take perseverance and frequent reinforcement to embed.*

ii) ***Score 2 –*** *The HEE eLearning is a mandatory requirement for all staff (Module 1); all line managers (Modules 1-2); and for all managers of managers (Modules 1- 3). The modules have been uploaded to ESR/OLM and set as a mandatory competency for the whole organisation. We now need to establish a trajectory for the increasing compliance and, once achieved, a method for ongoing monitoring. This has some challenges as we cannot currently identify between a manager and a manager of managers on ESR.*

iii)	***Score 2 –*** *As soon as a case is reported and taken on by the FTSU team, it is passed to the manager of the relevant team to pursue and investigate as necessary. This allows a quick response for the concernee and usually results in swift resolution. We have not yet introduced specified timescales for responding to a case (equivalent to FOI or patient complaint targets) as they vary widely. However, the risk is that this introduces a delay in resolving some issues and increases the administrative burden.*
iv)	***Score 3 -*** *This is stronger in some areas than others. Although many managers consider themselves open to speaking up and responsive to their teams' concerns, the reality in many cases is that factors such as psychological safety, busy schedules, high demand and stress levels, historic ways of working and human nature can all conspire against us in getting it right. We are improving as evidenced by the increasing frequency of formal and informal examples of speaking up but there is some distance to go.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item ii (score 2)

- *Clarify process for monitoring compliance and an ambitious but realistic trajectory to 95% compliance in Module 1 (all staff) and senior managers (modules 1-3)*

Item iii (score 2)

- *To consider implementation of a specified timeline requirement for all, or part, of the FTSU process to improve user experience and lessen the administrative burden of delayed actions*

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

a) Statements about triangulation	Score 1–5 or yes/no
i. We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	2
ii. We use triangulated data to inform our overall cultural and safety improvement programmes	3

Enter summarised evidence to support your score.

i. ***Score 2 –*** *All cases are logged and cross-referenced with other FTSU cases to ensure any repeated areas, practices or individuals of concern are identified and followed up accordingly. The administrative processes are currently cumbersome and time consuming but these are improving. There is now a central FTSU number that diverts to the on call FTSU Guardian and each case is dealt with by the same Guardian wherever possible. Our Guardians have access to all managers at all levels and can expect a prompt and constructive response when required. When this hasn't been the case, the senior lead for FTSU has stepped in to address ineffective behaviours as necessary.*

ii. ***Score 3 –*** *Triangulation of data has the potential to be one of our principal strengths. The People Voice portfolio aims to triangulate feedback and themes from many (11) different feedback channels including FTSU. We currently have an example of sexual safety concerns coming through several People Voice channels which, despite the sensitivities, are requiring triangulation to take coherent and appropriate action. The analysis and output from People Voice data is still being developed hence the mid-level score. The FTSU Guardian also attends safeguarding and clinical governance meetings to ensure cross-referencing of themes and enhance organisational learning.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item i (score 2):

- *Streamline administrative tasks and processes thereby releasing more time to respond and follow up on cases*

Item ii (score 3):

- *Establish method to analyse and triangulate data and themes within the constraints of confidentiality*

b) Statements about learning for improvement		Score 1–5 or yes/no
i.	We regularly identify good practice from others – for example, through self-assessment or gap analysis	5
ii.	We use this information to add to our Freedom to Speak Up improvement plan	4
iii.	We share the good practice we have generated both internally and externally to enable others to learn	3

Enter summarised evidence to support your score.

i) ***Score 5 -*** *We can evidence monitoring of good practice via the refresh of board self-assessments and gap analyses, shared with others in the sector and our regional ICBs.*

ii) ***Score 4 -*** *We have an overarching FTSU action plan which includes standards and requirements from the national FTSU review; external reviews and advice from ICB and NHSE FTSU experts; our 2022 CQC visit and subsequent improvement plan; and from our newly published People Strategy.*

iii) ***Score 3 -*** *In addition to being an integral member of PACC, the EDI steering group and the OD culture work, the FTSU Guardians attend safeguarding and clinical governance meetings to ensure cross-referencing of themes and inputs to organisational learning. Our Guardian holds a national co-chair role in the ambulance sector FTSU network which ensures external sharing and learning. We have recently created a wider Learning from Events (LfE) forum focussing on patient safety in which the OD Lead and the FTSU Guardian participate.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item iii (score 3)

- *FTSU and OD to attend new LfE meetings and ensure patient and workforce themes are cross-referenced and triangulated for organisational learning*

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

a) Statements about how our guardian(s) was appointed		Score 1–5 or yes/no
i.	Our guardian(s) was appointed in a fair and transparent way	5
ii.	Our guardian(s) has been trained and registered with the National Guardian Office	5

Enter summarised evidence to support your score.

i) ***Score 5 -*** *The FTSU Guardian role started as a fixed term secondment in 2019 but was subsequently recruited to the substantive post using a fair and competitive process in accordance with the example job description and other guidance published by the National Guardian Office, NHSE/I, NHS Employers. The two deputies were also recruited via a fair and competitive process in 2022.*

ii) ***Score 5 -*** *Our Lead and Deputy guardians are all compliant with the latest NGO guidance. We are now training cohorts of FTSU champions to be change leaders in their areas of work. This includes an enhanced mental health awareness module.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Previous actions cover the work needed in this section ie. continued career development/succession

	b) Statements about the way we support our guardian(s)	Score 1–5 or yes/no
i.	Our guardian(s) has performance and development objectives in place	4
ii.	Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
iii.	Our guardian(s) has access to a confidential source of emotional support or supervision	2
iv.	There is an effective plan in place to cover the guardian's absence	4
v.	Our guardian(s) provides data quarterly to the National Guardian's Office	4

Enter summarised evidence to support your score.

i) ***Score 4 -*** *The team have regular 1:1s, annual and mid year PDRs, and '23/24 objectives are being set in Q1. The team are also working through the NGO FTSU Guardian's education and training guide to ensure all areas are covered.*

ii) ***Score 5 -*** *All the guardians have regular 1:1s with their respective line managers, with the senior lead & Exec lead. The team are also well networked across the region and nationally for specialist support.*

iii) ***Score 2 -*** *As with all of SCAS, the full health & wellbeing offer is available to the FTSU Guardian team. The team have trialled internal supervision with the safeguarding team but would like to seek independent external psychological supervision if possible. This seems to be a challenge for neighbouring trusts too but a solution is being sought. In the meantime, the team are personally supported within the OD team and well networked regionally and nationally for specialist support.*

iv) ***Score 4 –*** *The increased resource to 3.0wte has ensured effective resilience and continuity of service during periods of Guardian absence. This is an area of marked improvement in the recent 12mths but the risk remains if the fixed term deputy post is removed in Oct '23. In an emergency, the Exec lead has access to the root file on the secure server.*

v) ***Score 4 –*** *There have been some delays in this financial year but the local data is available and will be updated in accordance with NGO recommendations when the data window opens*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Item iii (score 2): • *Establish regular and independent psychological supervision for the team*

	c) Statements about our speaking up process	Score 1–5 or yes/no
i.	Our speaking-up case-handling procedures are documented	4
ii.	We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
iii.	We are assured that confidentiality is maintained effectively	5
iv.	We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	2
v.	We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2

Enter summarised evidence to support your score.

i) ***Score 4 –*** *Our case handling procedure is in line with current national best practice, guidance and information governance (IG) regulations. With greater resource in the team, there is now sufficient capacity to complete the required records in a timely manner and set realistic goals/trajectories of case numbers over the coming year. We are also looking to audit the timeline from reporting to closing a case. We have consulted with other ambulance trusts on how to do this effectively. An internal audit in November 2020 gave a good level of assurance both for design & operational effectiveness which would be worth repeating three years on.*

ii) ***Score 3 -*** *Following feedback, we produced a manager investigation guide and are now teaching all managers the principles of civility and a Just and Learning Culture. This forms part of the Essential Skills for People Managers (ESPM) suite and complements our first line leadership programme, SCAS Leader. Launched in April 2019, SCAS Leader contains a specific section on FTSU, what gets in the way and the role of the inclusive leader in speaking, listening and following up.*

iii) ***Score 5 -*** *Our case handling procedure, including standards of confidentiality, is in line with current national best practice, guidance and information governance (IG) regulations. With greater resource in the team, there is now more diversity and sufficient capacity to hold the cases amongst themselves. This ensures a consistent approach and allows the service to remain fully functioning even during team member absence. With a single postholder, this was harder to deliver given the very stringent rules on sharing FTSU information. An internal audit in November 2020 gave a good level of assurance both for design & operational effectiveness which would be worth repeating three years on.*

iv) ***Score 2 –*** *With increased resource, there is improved capacity to progress cases as they arise and the team are good at sharing the workload between them. However, we do not currently have an audit trail which can evidence the timeline from a case opening to closing. This is an area for development.*

v) ***Score 2 –*** *much work has gone into raising awareness of the benefits of FTSU, civility, Just & Learning Culture and compassionate leadership. All staff have been mandated to do the HEE elearning pertinent to their level of management and we are starting to demonstrate improvements in employee relations cases. The FTSU cases are rising and several have explicitly thanked the team for resolving their concern. That said, we have some way to go before we can be "confident of a consistently positive experience" in every case. It will remain hard to hear difficult things and leaders will require continuous reinforcement and support to embed this mindset shift into our everyday culture. Thanking individuals, publicising positive outcomes, and role modelling and rewarding the desired behaviour will help to reinforce it.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item iv (score 2)

- *Develop an audit of the time taken from first receiving a case to resolution and closure*

Item v (score 2)

- *Build a 'You said, We did' process to explicitly demonstrate positive outcomes of speaking up*

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

a) Statements about barriers		Score 1–5 or yes/no
i.	We have identified the barriers that exist for people in our organisation	3
ii.	We know who isn't speaking up and why	3
iii.	We are confident that our Freedom to Speak Up champions are clear on their role	3
iv.	We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

i) ***Score 3 –*** *increasing to 3.0wte has had the added benefit of introducing greater diversity within the team in addition to increasing their visibility, accessibility and capacity for conversations with staff around the week. These were some of the barriers articulated in the CQC report which have been improved. In addition, moving FTSU into OD has provided greater independence from the clinical directorate and human resources both of which had been reported as a barrier to speaking up for some. However, these are undoubtedly only part of the story and work is still required to effect greater change with regards to cultural barriers, psychological safety and workforce engagement all of which get in the way of speaking, listening and following up. The extensive work around People Voice, civility, Just & Learning Culture, use of champions, understanding diversity, role modelling and the HEE elearning are all aimed towards reducing the barriers.*
The FTSU team have undertaken enhanced NGO training to provide insights, knowledge, skills, tools, and techniques specifically to improve the Speaking Up culture for black and minority ethnic staff in healthcare organisations. This has led to diverse representation within the FTSU champions which will help to lower barriers to speaking up locally.

ii) ***Score 3 –*** *We know from Edmondson's work (1999) that the teams* reporting *fewer errors do not correlate with the teams* making *fewer errors and therefore it is vital we understand which teams are not appearing in the data and why that might be. Where available, we monitor the source and spread of FTSU cases to capture the clusters but it also forms only one part of the People Voice data set. People Voice data comes from 11 different sources designed to be diverse in terms of respondents. It includes new starters, leavers, students, bank/volunteers, ER and FTSU cases as well as monthly and annual whole workforce surveys*

	which can be analysed by protected characteristics. The next step is to consider where we might have voices that could be described as 'seldom heard' or 'easy to ignore'.
iii)	***Score 3 -*** *we have trained two cohorts of FTSU Champions with a third due in June. The group are diverse in organisational spread and personal demographics. They have a full day of FTSU training using the latest NGO guidance but also participate in a specialist module on mental health awareness both for their own benefit and for those around them who may need immediate support.*
iv)	***Score 3 –*** *the impact of the extensive work surrounding speaking up throughout the year will be measured in the annual staff survey in terms of workforce confidence in speaking up. The rising number of cases is appositive sign that there is an impact but we would expect there to be more to come. The NSS22 metrics around confidence in speaking up dropped significantly from 2021 to 2022. If this was associated with the CQC focus on safeguarding and FTSU then we would hope to see a recovery in 2023 as the impact of all the work starts to be realised.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Item iii (score 3) • *Appraise People Voice inputs and outputs for diversity of voices and any gaps*
Item iv (score 3) • *monitor workforce confidence and faith in speaking up in NSS23*

Statements about detriment		**Score 1–5 or yes/no**
i.	We have carried out work to understand what detriment for speaking up looks and feels like	2
ii.	We monitor whether workers feel they have suffered detriment after they have spoken up	2
iii.	We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	2

iv.	Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	2

Enter summarised evidence to support your score.

i – iv) ***Score 2 –*** *Our refreshed FTSU policy makes it clear that detriment will not be tolerated but currently we cannot provide assurance that this is the experience people have when they speak up in SCAS. We have some understanding of what detriment looks and feels like from People Voice comments and from anecdotal stories in our leadership and management training courses. However, we have yet to introduce formal monitoring or an investigatory approach where it is reported to have happened. For the same reason, our NED for FTSU is not yet involved in reported detriment. This is a clear priority for development.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item i – iv (score 2)

- *Understand the work that is required to ensure detriment from speaking up does not occur*
- *Explore and understand what detriment looks and feels like in SCAS*
- *Develop a method to monitor any detriment as part of the casework timeline*
- *Clarify an investigation process where this is felt to have happened*
- *Agree NED involvement in allegations of detriment*

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

a) Statements about your speaking-up strategy		Score 1–5 or yes/no
i.	We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
ii.	We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
iii.	We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
iv.	Our improvement plan is up to date and on track	4

Enter summarised evidence to support your score.

i – ii) ***Score 5 -*** *Our newly published People Strategy is a comprehensive piece of work that prioritises the creation of a compassionate culture of speaking up, including but not restricted to the FTSU function. The People Strategy, CQC improvement work and the SCAS 10 point plan are being aligned into one coherent approach and, with regards to FTSU, this also includes the recent NGO review. FTSU is one of the four principle themes of the immediate improvement work with clear tasks and timelines identified in the plan.*

i) ***Score 3 –*** *whilst we do have access to some qualitative and quantitative FTSU measures, there is still work to be done to evaluate the FTSU strategy and provide clear assurance at Board level beyond the principle themes in each quarter.*

ii) ***Score 4 –*** *As per i-ii, the culture improvement work (incl FTSU) is being aligned into one coherent plan with dedicated project managers overseeing and supporting progress as part of the overarching delivery of the People Strategy. Despite temporary absence of the Lead Guardian, the increased resilience in the team has meant that the work has largely remained on track.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Item (score 3) • *Develop a trajectory of improvement using qualitative and quantitative measurements that provide evaluation of the strategy and clear assurance at Board level*

b) Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
i. We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
ii. Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	5
iii. Our speaking-up arrangements have been evaluated within the last two years	5

Enter summarised evidence to support your score.

i) ***Score 4 –*** *The annual staff survey (NSS) has specific questions around confidence and faith in the speaking up process which we monitor every year and will continue to do so as a clear indicator of the impact of the FTSU work. Once developed, triangulation of the data in the People Voice portfolio has the potential to provide good intelligence on how safe and confident people feel on an ongoing basis and the FTSU team regularly run their own polls when on site around the Trust.*

ii) ***Score 5 –*** *PDSA methodology of continuous improvement is part of the SCAS Leader programme. The FTSU team have all attended the programme and understand the principles of Lean methodology, process mapping, root cause analysis and PDSA. The recent selection and training of successive champion cohorts was a good example where PDSA was used and applied to the second and third iterations.*

iii) ***Score 5 –*** *the FTSU arrangements in SCAS have been evaluated more than once in the last three years with the latest being the CQC visit in 2022. This provided some valuable feedback and impetus to support the improvement now underway. The*

FTSU Guardian remains in contact with the NHSE FTSU team and has been the co-chair of the National Ambulance FTSU Network which has given opportunities for informal peer review and consultation.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Previous actions cover the work needed in this section ie. completion of People Voice

	c) Statements about assurance	**Score 1–5 or yes/no**
i.	We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
ii.	We have evaluated the content of our guardian report against the suggestions in the guide	5
iii.	Our guardian(s) provides us with a report in person at least twice a year	5
iv.	We receive a variety of assurance that relates to speaking up	4
v.	We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3

Enter summarised evidence to support your score.

i) ***Score 4 –*** *Reports are provided to the Board each quarter. They have been well-received but would benefit from a review to understand what more could be included to provide greater transparency without risking a breach of confidentiality*

ii) ***Score 5 –*** *the current structure of the report meets the recommended requirement*

iii) ***Score 5 –*** *the FTSU Guardian attends the Board meetings when required, and at least bi-annually, to present the upward report*

iv) ***Score 4 –*** *in addition to the quarterly FTSU reports, the Board receive an analysis of the annual staff survey (NSS) which always highlights the FTSU questions, regular staff stories and feedback from leadership visits. The People and Culture Committee also receive assurance around the wider People Voice themes.*

v) ***Score 3 –*** *the new Learning from Experience (LfE) forum is led by the clinical quality team and attended by the FTSU and OD leads. This allows cross-referencing and application of learning across both the people and culture work and patient safety. There is still work to do in ensuring awareness and providing assurance about this at Board level.*
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
Item v (score 3) • *Ensure organisational learning and FTSU-inspired improvement are captured on Board reports and shared on a quarterly basis*

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1. Detriment • Understand the work that is required to ensure detriment from speaking up does not occur • Explore and understand what detriment looks and feels like in SCAS • Develop a method to monitor any detriment as part of the casework timeline • Clarify an investigation process where detriment is felt to have happened • Agree NED involvement in allegations of detriment	By end of Q4	FTSU Guardian (SH)
2. Plan and take necessary action to sustain FTSU performance after October 2023 • Evaluate the 2nd deputy role and the likely impact of reducing to 2.0wte • Streamline administrative processes to free up more time	Oct 2023	FTSU Guardian (SH) and Senior Lead (NH)
3. Regular psychological supervision for the team to be established	By end of Q4	FTSU Guardian (SH)
4. Develop a robust 'you said, we did' feedback loop including specific examples around clinical/non-clinical FTSU cases	By end of Q2	FTSU Guardian (SH) & Comms (TS/MA)
5. Monitor completion of HEE elearning • Actively monitor elearning compliance across SCAS and set a realistic timeline to achieve 95% org compliance on Module 1 – Speaking Up • Actively monitor elearning compliance in the strategic leadership group (SLG) and set a realistic timeline to achieve 95% compliance on Modules 1-3 – Speaking, Listening & Following Up	By end of Q2	FTSU Guardian (SH) and Education Compliance, Assurance & Technologies (JS)

6.	Develop an audit of the time taken from first receiving a case to resolution and closure	By end of Q2	FTSU Guardian (SH)
7.	FTSU and OD to attend new LfE meetings and ensure patient and workforce themes are cross-referenced and triangulated for organisational learning		FTSU Guardian (SH) and OD Lead (NH)
8.	Refresh the policy to reflect the 2022 update following consultation in Q2 ‘23/24		

Development areas to address in the next 12–24 months		Target date	Action owner
1.	Further development of current team including ongoing career pathways & succession planning	Mar 24	SH/NH
2.	Monitor NSS23 for improvement in workforce confidence in speaking up – in 2022 this dropped for the first time in 5 years	Jan 24	SH/NH
3.	Develop a trajectory of improvement using qualitative and quantitative measurements that provide evaluation of the strategy and clear assurance at Board level	Jan 24	SH
4.	Continue to build Supporting our People webpages which signpost to the FTSU site and associated policy	Mar 24	CJ

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. The increased diversity, visibility, accessibility and capacity in the FTSU team is a strength. They are energetic, impassioned, dedicated individuals who hold themselves to a high standard of care and confidentiality and who strive to innovate and improve team performance on a continuing basis. They should each be encouraged to consider next steps both in terms of annual team objectives and of succession / personal career plans.	In 2023/24	FTSU team
2. Triangulation of People Voice themes, including FTSU cases. We still have some work to do on this to analyse feedback fully and collate the output but this is an area of potential strength.	Q3 23/24	ODBP - CU
3		
4		
5		
6		
7		
8		

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	Audit Committee
Date Committee met:	22 June 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Board of Directors Meeting 27 July 2023

1. Points for Escalation

- Both the Annual Report and the Annual Accounts remained incomplete as a result of SCAS staff availability issues, additional audit work required and the absence of some information. Consequently the Board meeting that had been scheduled for the approval of the Annual Report and Accounts was stood down and the NHSE were informed that they would not be submitted by the required date of 30 June.
- Internal Audit Recommendations Follow-up Report. Whilst a lot of progress has been made actioning and closing the overdue recommendations there remains 1 from 2020/21 and 8 from 2022/23, all of which have had a number of revised completion dates. The Audit Committee has required these to all be completed by the next AC meeting on 21 September 2023 otherwise the responsible Executive will be invited to attend the meeting to provide an explanation of the situation.

2. Key issues / business matters to raise

- The final Internal Audit report from the 2022/23 programme was presented and agreed. The Data Security & Protection Toolkit audit outcome reported a moderate overall risk assessment and high overall confidence in the DPST submission. One recommendation of medium risk was made relating to continuity planning.
- The draft Quality Account was reviewed and subject to some identified changes was approved for submission to NHSE.

3. Areas of Concern and / or Risks

- A report on policy management was received and it was noted that there is work to be done to implement an effective policy control process. The Committee was informed that work is underway to establish the control process and will be reviewed at the September AC.

4. Items for information / awareness

- The Corporate Risk Register was reviewed and a number of improvements and amendments were requested.

- The BAF with the latest changes was reviewed and it was noted that good progress is being made with the assessments and reviews of the risks and associated mitigation activities.
- A review by the AC of the overall risk management system was requested.

5. Best Practice / Excellence

- Completion of the 202/23 Internal Audit Programme to schedule.

6. Compliance with Terms of Reference

The meeting was quorate and fully attended. Although the workplan for the year is still being developed (by September AC), the matters considered by the meeting were all essential items within the Terms of reference.

Author: Mike McEnaney
Title: Chair of Audit Committee
Date: 19 July 2023

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	Audit Committee
Date Committee met:	13 July 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Board of Directors 27 July 2023

1. Points for Escalation

- Due to delayed information, necessary to finalise the Accounts and Annual Report, and the related risks, the external auditors have further delayed signing the accounts; the exact date for doing so is being discussed. A draft set of accounts have been submitted to NHSE who have been kept informed throughout.

2. Key issues / business matters to raise

- The purpose of this additional meeting was to review and, with the authority delegated by the Board, approve the Annual Report and Accounts for final signature and submission.
- Both the Annual Report and the Annual Accounts (unqualified) were approved subject to finalisation of a few minor issues that remained outstanding.

3. Areas of Concern and / or Risks

- The Audit Findings report identified a number of Audit Differences that fell below the limit of materiality, hence no change to the accounts was required, however, this did give rise to 7 Internal Control recommendations.
- Some pieces of information were late in being provided to the auditors due to an audit/year end schedule that lacked sufficient detail.
- A joint learning and improvement report will be reviewed at the September AC and the Internal Control recommendations will be tracked for progress at the future committees. The audit/year end schedule will be added to the AC work plan with specific focus on the detail.

4. Items for information / awareness

- The audit and finance teams were thanked for their commitment and hard work through a difficult year end.

5. Best Practice / Excellence

-

6. Compliance with Terms of Reference

The Committee had full attendance and was quorate. The special agenda was fully aligned with the terms of reference.

Author:	Mike McEnaney
Title:	Chair of Audit Committee
Date:	19 July 2023

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	Finance and Performance Committee
Date Committee met:	19 June and 20 July 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Board of Directors 27 July 2023

Extraordinary Finance and Performance Committee Meeting 19th June 2023

1. Key issues / business matters to raise:

There is a concern that the programme needed to find more opportunities and to be implementing the ideas urgently since many projects take time after implementation to deliver the benefits.

2. Key points for escalation:

This extraordinary committee meeting was arranged in order to review the governance and planned outputs around the Financial Sustainability Programme, given the challenge to achieve a year end breakeven position for SCAS.

The organisation, governance and reporting arrangements were presented and comments were provided back to the project team.

At the point in time that the presentation was made, the value of the projects highlighted raised a concern from the committee that progress in this area needed to be stepped up to provide any real opportunity to achieve the year end target.

Finance and Performance Committee Meeting 20th July 2023

1. Key issues / business matters to raise:

Financial risks in achieving the year-end financial target are a significant challenge.

Management of the current run rates and continuous focus on the improvement plan to deliver the year-end financial position are key.

The IQPR is still under development. The proposal for a moratorium phase was agreed as appropriate.

A more detailed review with the BAF of actions to mitigate gaps in assurance and controls need a further review.

There appear to be significant challenges in the digital area and a priority list of requirements need to be developed.

2. Key points for escalation:

Finance and Financial Sustainability Plan

The year-to-date financial position is providing a significant challenge to achieving the year end break-even target. The primary influencing factors were discussed. There was a review of the plans to achieve our year end target and the committee gained assurance that agreed actions to ensure grip and control and the work being planned to address the organisation financial sustainability was underway. In addition, the committee were provided with confidence that discussions were continuing with the HIOW ICB to update them with SCAS' financial position and future plans.

Integrated Quality and Performance Report

An updated version of the IQPR was presented. The committee supported the progress and particularly the improved executive summary. The plan to provide additional training was received well and a request to make training an ongoing process with SPC experts being trained to be available to present to teams and individuals as required, was well received. The committee was assured that the IQPR, through its continuing development will start to provide the basis for providing the appropriate information to manage and therefore improve performance, quality and patient safety.

Improvement Programme

The Plans on a Page and related metrics were reviewed. The committee were assured that progress was being made in this area. There was a review of the Standing Financial Instructions and it was agreed that this would be reviewed and updated as appropriate.

Risk Management

The BAF risks relating to Finance and Performance were reviewed. Overall, the risks were clearly defined with controls, assurance, with gaps highlighted although some risks controls

and gaps needed further strengthening. Hence, it was considered that the actions to address gaps need to be reviewed.

Digital Update

There was a review of the digital activities which reflected both the significant developments completed as well as highlighting the work still required to develop the digital rather than technology and information governance focus for SCAS. The Committee were informed that the interim CDO will be having meetings with Jill Lanham to understand the issues and consider options for going forward.

Summary of Upward Reporting: Issues identified.

Upward reporting from the: **Quality and Safety Committee (Q&S)** **to:** SCAS Trust Board July 2023

Date of meeting: **1st June 2023 (postponed from 11th May)**

Items for escalation	**Issue**	
None		
Areas of Concern/Risk	**Issue**	**Action Taken**
1. Finance and Staffing	Continued risks (as per BAF) affecting several areas across the organisation, including the need to review prioritisation of specific roles previously identified a necessary to deliver improvements.	NEDs and Executive Directors to ensure the potential impact of these risks on quality and safety are considered at board level discussions.
2. IT resilience and capacity	Q&S noted this continues to be a risk in many areas, with associated patient safety concerns.	
3. Medical Equipment	Trust financial position has led to a pause in the procurement of an asset management system. This has now been de-coupled from the IT asset management need. Noted that if do not proceed, the mitigation will be continued use of a manual system, which is labour intensive and more prone to errors. In addition, an automated system (perhaps including RFID (radio frequency identification) has potential to produce savings on physical assets.	Decision awaited from Executive Transformation Board. Q&S asked that future reports include metrics to provide assurance that medical equipment is being well managed, e.g., percentage complaint with service plans, number of incidents reported and the timeliness of reporting and action to mitigate future risks.
4. Safeguarding (SG)	Increasing assurance through progress against SAAF Level 3 training for registrants is slightly behind trajectory	Q&S noted additional training places have been added to get back on track.

	Introduction of Mental Capacity Act training delayed due to software compatibility issues. Continued risks regarding IT systems support for safeguarding, due to SCAS and Docworks resource challenges.	Q&S noted only partial assurance that new completion of end of June would be delivered.
5. Patient Safety	Plan for implementation of PSIRF progressing including HEE e-learning modules being part of mandatory training, and plans for Board training. PSIRF is a huge change programme, particularly focusing on a learning culture. This will require on going resources to implement, including the switch from current national system for reporting incidents to the new Learning from Patient Safety Events (LFPSE). This is also dependent on supplier system upgrades (Datix). Patient and Partner Engagement work is commencing recruitment.	Q&S noted patient safety culture survey results have been analysed and “you said / we did” style communication package has been developed to try and build confidence that actions follow feedback.
6. Infection Prevention and Control (IPC) Concerns	Microbiology SLA contact has now been signed. An assurance visit by colleagues from SECAMB had provided positive initial verbal feedback. Continue poor compliance with number of Level 2 audits had received detailed discussion at the IPC committee.	IPC team and operations colleagues looking at different models for conducting audits, given ongoing capacity issues.
7. Medicines Management	Q&S received assurance on progress against the improvement plan and that evidence had been submitted to the programme team for completed actions. Planned move to new medicine distribution centre continues with some changes of specific dates.	Q&S noted that this and received assurance that while plans are being reviewed for any potential savings there is no risk to completion of the project and that staff have received communication about the move.
8. Statutory and Mandatory training	Q&S noted improved compliance with e-learning training. Face to face (F2F) training remains below target, except in PTS.	

9. Clinical Audit Plan	It was noted that work on this needs to be re-allocated within the Clinical Directorate team and was not included in this meeting.	Plan to be agreed at future Clinical Review Group and then presented to Q&S for approval
Items for awareness/assurance	**Item**	**Action taken**
10. Quality and Safety Committee Terms of Reference (ToR) and Annual Work Plan	These have been reviewed and updated to reflect current role titles.	Q&S discussed the ToR and made some suggestions for change. Chief Nurse and Chair of Q&S to review further and to seek input from Chief Governance officer to ensure they align with Trust-wide governance requirements. It was agreed that standing items at each meeting would include review of IQPR (Integrated Quality and Performance Report) as recently agreed at Trust Board.
11. Interim AD of Quality	Chief Nurse indicated shortlisting was underway to provide support to the team to cover vacant post.	
12. BAF / Risk Register	Q&S discussed the current BAF and Corporate Risk Register (CRR). Concerns were raised that 5 significant risks on CRR have been static with a high-risk score for many months. Associate Director of Safeguarding acknowledged that Safeguarding risk could be reduced	Corporate Risk Manager asked to specifically discuss those 5 risks with relevant Executives, their Deputies and Assistant / Associate Directors.
13. Category 1 and 2 performances	The Board had asked Q&S to seek assurance on the effect of targeting a 30-minute Category 2 response.	Q&S noted and discussed the slides provided. Q&S noted that changing utilisation rate to ensure delivery of 30 mins Cat 2 response would result in a Cat 1 response of about 8.5 minutes (compared to target of 7 minutes). This would still be an improvement on the previous year.
14. Financial Stability Plans	Q&S received a verbal report on the plans for quality impact assessment of new financial plans both from a patient and staff perspective.	

15. Patient Safety and Learning from Experience report	Increase in SI's and lower harm incidents is suggestive of a more positive reporting culture. Weekly harm review panel is enabling quicker review of incidents and learning. Difficult to benchmark with other ambulance trusts as every Trust is configured differently.	NEDs requested graphs used to present data are reviewed to provide greater assurance. NEDs also requested more detail to be provided on the breakdown of sub-categories in the patient care category to aid their understanding
16. Quality Account	Q&S received the draft Quality Account.	This was approved in principle but Q&S asked that the following points be considered for amendment: a) Include reasons for not achieving 2022/2023 priorities b) Include what impact each 2023/2024 priorities might have c) Identify where items are also part of the improvement plan for clarity d) Reduce the amount of detail included for publication and presentations, to first author and title only.
17. Upward reports from other committees	Q&S received and discussed upward reports from: Safeguarding Education and Training summary Clinical Review group Patient Safety Group Commercial Division Infection Prevention Control Committee	Q&S noted that CRG are concerned about the potential clinical and safety impact of decommissioning of the clinical assessment service which may affect SCAS response times and flow to hospitals.
Compliance with terms of reference		
	Q&S were quorate for this meeting Q&S covered the standing agenda items and reports expected from the workplan Q&S continues to meet bi-monthly Next meeting 6 July 2023	Next meeting will include further review of ToR and Annual reports from Safeguarding and Patient Experience.

Summary of Upward Reporting: Issues identified.

Upward reporting from the: **Quality and Safety Committee (Q&S)** **to:** SCAS Trust Board July 2023

Date of meeting: **6th July 2023**

Items for escalation	**Issue**	
None		
Areas of Concern/Risk	**Issue**	**Action Taken**
1. Patient Safety Workstreams update	Clear summary sheet complemented this section of meeting. Key concerns / previous issues mentioned below.	Noted that this alone provided greater assurance than previous papers. Q&S requested that in future more detailed slides are produced to give greater assurance, rather than just an update on actions.
2. Medical Equipment	Replacement asset management system project has passed through Gateway 0.	
3. Safeguarding (SG)	Level 3 training for registrants has now reached 73% compliance. Mental Capacity Act and Learning disability training now released.	
4. Patient Safety	Level 1&2 Patient Safety Training at 55% and 40% respectively. Trust aims to be at 95% by end of Q2. HSIB Level 2 training commenced Patient safety members to be recruited in Q2 to support co-design. PSIRF programme board commenced, but replacement implementation lead required.	Q&S noted Board training scheduled for 12 October 2023. ICS partner has offered to help support this. Clinical Directorate to discuss further how this can be facilitated. Q&S noted programme will identify key risks against successful delivery. These should come to future Q&S.

5. Infection Prevention and Control (IPC) Concerns	The assurance visit report by colleagues from SECAMB had been received on the day of Q&S and would be reviewed at IPC Committee next week. Verbal report was received on IPC vehicle and building audits and noted improvement and that details would be seen in future in the IQPR.	Q&S asked to see a summary of findings at the next meeting.
6. Medicines Management	Repeat analgesia and pain score audit due to be performed in July. Pharmacy technician (6 months) in post to aid with production of SOPs for new distribution centre. Make ready medicine packing service to be separate from main contract to ensure meets GPHC standards.	Q&S asked that future updates included clearer outline of the aim of the steps being undertaken, clear evidence of the actions to provide greater assurance. This could include details of finding of audits and the interval for re-audit.
7. Statutory and Mandatory training	Q&S noted new e-learning modules introduced (referred to elsewhere), which are not yet achieving compliance. The remainder continue to show 94/95% compliance. Q&S noted that 13 hours has been agreed for e-learning for frontline staff. Face to face (F2F) training remains below target but is improving.	Q&S asked how much time is required to complete all the e-learning modules, i.e., is 13 hours sufficient? Q&S requested that the next (and future) reports include trajectories for the face to face training compliance, including safeguarding, with clear sight of actions being taken to improve.
Items for awareness/assurance	**Item**	**Action taken**
8. Quality and Safety Committee terms of reference (ToR)	These have been reviewed again and the further changes were discussed by Q&S. It was noted there had been discussion at the recent Board meeting about the need to standardize the description of members and attendees at Board subcommittees. In addition, it would be good governance to have similar standards for denoting a meeting quorate. Until further Trust wide discussion on this have taken place it was agreed to leave the quoracy for Q&S at a minimum level. It was noted that the Chief of Governance had broadly agreed with the ToR prior to the discussions at the recent Board.	Agreed that Patient Safety Partner representative would attend, initially as an attendee, and then from 1 April 2024 as a member (this is a requirement of PSIRF). Agreed that the FTSU guardian was not a standing member but could attend any Q&S meeting, as needed, and that the FTSU guardian now attends People and Culture Committee. Agreed that the IQPR would be discussed at each Q&S, with a summary overview from the Deputy Chief Nurse / Director of Nursing and Quality.

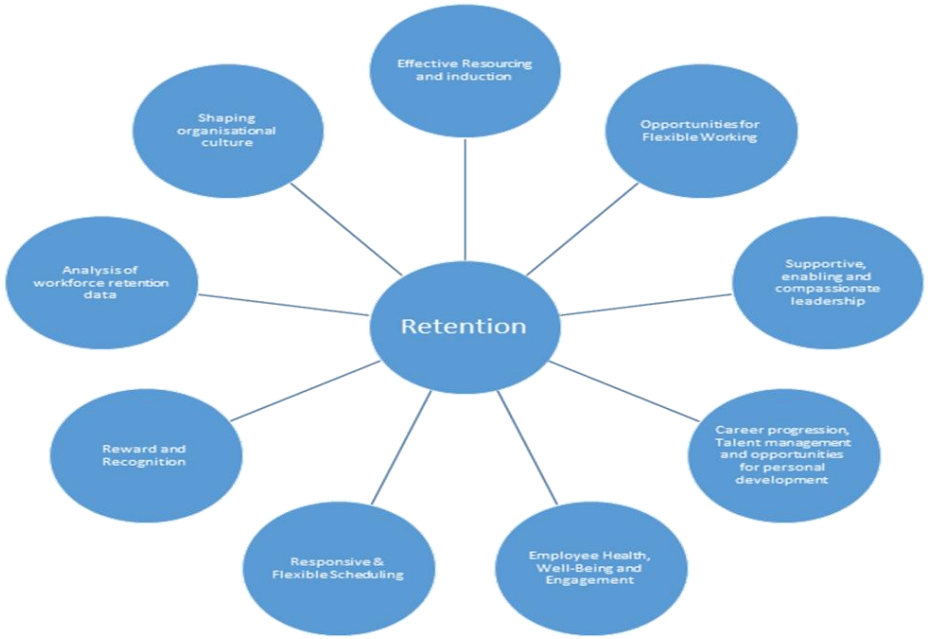
		Agreed that the Education and Training report should remain a standing item, as compliance with statutory and mandatory training has a direct impact on safety and quality. However, it was agreed that the upward report from the Commercial division would be more appropriately considered at Financial and Performance (F&P) committee. Chief Nurse to discuss with Director of Strategy, and Chair of Q&S to discuss with Chair of F&P. ToR to be forwarded to next Board for approval, noting that further changes would be required at end of March 2024.
9. Interim AD of Quality	It was noted that this post hade been filled.	
10. BAF / Risk Register	Q&S discussed the current BAF, in particular SR 1 and 2 and noted these have both been reduced since last review. SR1 had reduced as back up defibrillators (AEDs), are now available on vehicles. (The risk had been increased while the back up AEDs were not available). In addition, SR4 - stakeholder engagement was discussed and Q&S noted that while SCAS is not a member of ICB Boards, it does participate in other senior fora, such as the Chief Medical Officer Group, and is able to influence this way. Some risks on the CRR remain at 25.	It was noted that there were many more components to SR1 in addition to the risk from Zoll failure, and the Corporate Risk Manager was asked to further review this risk with Executives to ensure the reduction in risk was appropriate. Corporate risk Manager was asked to ensure this was considered when SR4 is next reviewed. Q&S asked to see clearer evidence of plans / trajectory to improve these high risks on CRR. Q&S noted that some are due for review in the next month.
11. Patient Experience Annual Report	This report was received and commended.	It was suggested that some benchmarking with other ambulance trusts regarding the number of patients providing feedback, and the number of cases being investigated by the Ombudsman would be helpful. With this possible amendment, the report was approved.

12. Safeguarding Annual Report	This report detailing the journey SCAS has been on over the last 12 months was commended by NEDs and external partners present. It provides a huge amount of detail regarding the safeguarding service, improved training and performance, and much clearer governance.	It was noted that the appendix detailing work regarding allegations might benefit from editing to ensure adequate anonymity. The report was approved subject to correction of a few minor typographical errors, minor suggestions from the Chair, and review of the appendix as above and will be presented to the next public board.
13. Patient Safety and Learning from Experience report	Q&S noted the Learning from Experience group has now been established and the report included a greater variety of sources of learning for the organization. It was noted that the cases studies were helpful in showing how learning is applied.	The Chair asked that when reviewing incidents, complaints etc., for possible learning, that the group should challenge itself to truly identify the learning, rather than just re-state the facts that have occurred.
14. Upward reports from other committees	Q&S received and discussed upward reports from: Safeguarding Education and Training summary Clinical Review Group Patient Safety Group Commercial Division Infection Prevention Control Committee	Q&S noted that CRG are concerned about the potential clinical and safety impact of decommissioning of the Clinical Assessment Service which may affect SCAS response times and flow to hospitals.
Compliance with terms of reference		
	Q&S were quorate for this meeting. Q&S covered the standing agenda items and reports expected from the workplan. Q&S continues to meet bi-monthly. Next meeting 7 September 2023.	Next meeting will include Annual report from IPC Committee.

Summary of Upward Reporting: Issues identified.

Upward reporting from the: **People & Culture Committee** **to:** SCAS Trust Board June 2023

Date of meeting: **01 June 2023**

Areas of Concern/Risk	Issue	Action Taken
Retention Plan	Key retention enablers were discussed  • Trust wide / Corporate over-arching retention plan has been agreed	Committee to continue to monitor retention and report back any risks or concerns

	• Meetings with stakeholders across Trust to finalise delivery plans, 1 plan to be designed for each service line, aligned to the overall Trust plan. • Progress reporting on implementation of plans, including impact on retention to be reported via IWPs and Workforce Development Board.	
FTSU self-assessments & FTSU resources	Freedom to Speak Up self-assessment has been completed for the first time as part of the National Guardian's Office (NGO) guidance. Section 1 contains the 8 principles each comprising several sub sections with associated narrative. Sections 2 and 3 are a summary of the short- and longer-term actions around our gaps and strengths highlighted by the assessment in Section 1. Key actions proposed for 2023/24 include: 1. Detriment • Understand the work that is required to ensure detriment from speaking up does not occur • Explore and understand what detriment looks and feels like in SCAS • Develop a method to monitor any detriment as part of the casework timeline • Clarify an investigation process where detriment is felt to have happened • Agree NED involvement in allegations of detriment 2. Plan and action to sustain FTSU performance after October 2023 • Evaluate the 2nd deputy role and the likely impact of reducing to 2.0wte • Streamline administrative processes to free up more time	NH/MS to ensure that the next iteration on scoring had more clarity or rationale and any scores that do not look right conversation were had to change them. Peer support for the guardians within the trust, needs to be reviewed and how this would work/fit within the implementation plan
Items for awareness/assurance	**Item**	**Action Taken**

Revised EQIA	The EqIA focuses on assessing and recording the likely equalities impact of a strategy, policy or project. There is a focus on assessing the impact on the Protected Characteristics. It involves gathering evidence and data, anticipating the consequences of policies and projects on these groups, and making sure that, as far as possible, any negative consequences are eliminated or minimised (or explanation for any justifications) and opportunities for promoting equality are maximised. The EqIA is initially carried out by completing a screening template (Stage 1). The screening template is used for a preliminary screening (for any adverse impact) of the policy or project, this would inform whether the proposal requires any changes/amendments. The EqIA screening should be carried out at the planning and development stage of the project, strategy or policy. An EqIA provides some assurance that our strategic objectives do not discriminate and help meet patient care, identify and target any health inequalities. The EqIA are integrated into SCAS's Equality Objectives (2022-2026) within our Equality Strategy	Committee to work with team and continue to seek assurance on a number of areas: - To have a look at the ESR system and see if there are any available free text boxes that we could utilize for this purpose and start recording if that is possible for staff who are gender diverse -As part of the national redesign of the ESR, perhaps put some pressure on to make sure that this system has the correct definitions for all of the protected characteristics in order that we can effectively capture and monitor those statistics and the impacts of our workforce plans of our underrepresented groups -Drill down into the differences between workforce disability declaration and National Staff Survey respondents who declare and what there is to learn in that

<table>
<tr><td></td><td></td><td>difference to the point of 30% of our respondents declare.</td></tr>
<tr><td>-</td><td>The purpose of Annual Equality (PSED) report 2022-2023 to publish our Equality information (information to demonstrate our compliance with the general equality duty), this is the requirement under Regulation 4 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

As of 31 March 2023, the Trust employed a total of 4601 staff of those:
• 54% of our workforce are women (Table 1 male & female (declared) headcount)
• 5.4% of our staff are from Black, Asian, or Ethnic (BAME) and mixed heritage backgrounds (Table 2)
• 92% of our staff are aged between 20 and 60 years old (Table 3)
• 6.4% of our staff declare a disability at the point of recruitment (Table 4)
• 7.2% of our staff are Lesbian, Gay, Bisexual, Transsexual (LGBT+) (Table 5)
• 80.4% of staff follow a religion/belief (including atheism) (Table 6)
• Men have a greater Mean hourly pay rate than women by a gap of 2.41% (Table 7) and the Median hourly pay is also slightly greater for men by a gap of 0.70% (Table 8)

<u>Gender (male/female)</u>

Table 1 breakdown of staff in the Trust by Male & Female
<table>
<tr><th rowspan="2">Gender</th><th>Headcount</th><th>%</th><th>Headcount</th><th>%</th></tr>
<tr><th colspan="2">31/03/2022</th><th colspan="2">31/03/2023</th></tr>
<tr><td>Female</td><td>2376</td><td>54%</td><td>2516</td><td>55%</td></tr>
<tr><td>Male</td><td>2036</td><td>46%</td><td>2085</td><td>45%</td></tr>
<tr><td>Total</td><td>4,412</td><td></td><td>4,601</td><td></td></tr>
</table>
</td><td>Committee sought assurance on:

-Development of training/support to help staff complete and monitor the assessments

-Integrate the assessments into all trust templates

-Review and implement, how to evaluate, collate, link, and monitor assessments completed

-Help make the toolkit more user friendly – last page and perhaps having that located centrally for access</td></tr>
</table>

Ethnicity

Table 2 Breakdown of staff in the Trust by Ethnicity

Ethnic Group	Headcount	%	Headcount	%
	31/03/2022		31/03/2023	
A White - British	3762	85.3 %	3829	83.2 %
B White - Irish C White - Any other White background	215	4.9 %	239	5.2 %
D Mixed - White & Black Caribbean E Mixed - White & Black African F Mixed - White & Asian G Mixed - Any other mixed background	62	1.4 %	75	1.6 %
H Asian or Asian British - Indian J Asian or Asian British - Pakistani K Asian or Asian British - Bangladeshi L Asian or Asian British - Any other Asian background	76	1.7 %	78	1.7 %
M Black or Black British - Caribbean N Black or Black British - African P Black or Black British - Any other Black background	59	1.3 %	75	1.6 %
R Chinese S Any Other Ethnic Group	15	0.3 %	19	0.4 %

Z Not Stated	223	5.1 %	286	6.2 %
Total	**4,412**		**4,601**	

There has been an increase in relation to the Black, Asian & Minority Ethnic (BAME) from 4.8% last year to 5.4% this year (0.6% increase)

Age

Table 3 Age profile of staff in the Trust

Age Profile	Headcount	%	Headcount	%
	31/03/2022		31/03/2023	
<20	62	1%	86	2%
20-30	1093	25%	1148	25%
31-40	1035	23%	1089	24%
41-50	994	23%	980	21%
51-60	932	21%	993	22%
61-70	282	6%	292	6%
71+	14	0%	13	0%
Total	**4,412**		**4,601**	

The majority of our staff are aged between 20 – 60, with the highest proportion in the 20 – 30 age bracket.

Disability

Table 4 breakdown of staff in the Trust by Disability

Disability	Headcount	%	Headcount	%
	31/03/2022		31/03/2023	
Yes	240	5.4%	295	6.4%
No	3668	83.1%	3751	82%
Not declared	504	11.4%	555	12%
Total	**4,412**		**4,601**	

The declaration rate for Disability has increased by 1% from last year. However, the total number of staff not declaring a disability or not has also increased by 0.6% from last year.

Sexual orientation

Table 5 breakdown of staff by sexual orientation

Sexual Orientation	Total	% Staff
Heterosexual or Straight	3653	79.4%
Gay or Lesbian	208	4.5%
Bisexual	115	2.5%
Other sexual orientation not listed	10	0.2%
Undecided	9	0.2%
Not stated	606	13.2%
Grand Total	**4,601**	

The majority of staff are heterosexual/straight (79.4%) but a 1% drop from last year. The number of LGBT+ staff has gone up by 0.5% to 7.2% this year although an increasing number of people have not stated their sexual orientation, 13.2 % compared with 12.9% last year.

Religion & Belief

Table 6 breakdown of the most held religions/belief at the Trust

Religious Belief	Total	% Staff
Christianity	1929	41.9%
Atheism	1217	26.5%
Islam	37	0.8%
Hinduism	21	0.5%
Buddhism	14	0.3%
Sikhism	8	0.2%
Judaism	7	0.2%
Other	458	10.0%

Not declared	910	19.8%
Grand Total	**4,601**	

Over 80% of staff held a religious or philosophical belief.

Gender Pay analysis

As of 31 March 2022, there were 46% (2173 staff) male employees and 54% (2517 Staff) female employees.

	Male	Female	% Gap
Mean Gender Pay Gap (hourly rate)	**£16.02**	**£15.64**	**2.41%**
Median Gender Pay Gap (hourly rate)	**£13.46**	**£13.36**	**0.70%**

Table 7: Mean & Median pay gap (hourly rate)

The table above shows that men have a greater **Mean** hourly pay rate than women by a gap of 2.41%. This is a shift from the previous year when for the first time there was negative Mean hourly rate figure for men at -9.70% (a change of 12.11%), the table (8) shows the changes over a 5-year period. We are returning to 2019 levels, which could suggest an impact due to the pandemic and other contributory factors such as the drop in workforce and reduction of national services.

The **Median** hourly pay is also slightly greater for men by a gap of 0.70%. Again, this is a shift from the previous year when (for the first time) there was negative Median hourly rate figure for men at -2.19% (a change of 1.49%)

TU Facilities Time	Trade Union (Facility Time Publication Requirements): Following the introduction of the Trade Union (Facility Time Publication Requirements) Regulations 2017 there has been a legislative requirement on SCAS	Committee will continue to monitor

	to collate and publish, on an annual basis, a range of data on the amount and cost of facility time as per table The information is published in SCAS Annual report and on the UK Gov. website **Facility Time Reporting 2017-2023** The TU disclosure figures for all trusts are uploaded in July each year and published by year end. Each year the ambulance figures are reviewed and tabulated to benchmark costs.	
Policy Reviews	The Policy Refresh meetings continue to be held monthly. An extraordinary full day meeting was held in early April to push progress which has resulted in 6 policies being thoroughly discussed and reviewed and some finalised for consultation. • 4 completed, agreed and issued • 4 ready for signoff in June JNCC • 3 need final agreement at May meeting then out to consultation	Committee will continue to monitor

TU Facility time	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
No of employees	63	61	61	70	65	72
FTE	60.35	45	45	68.3	60.4	67.8
% spent on facility time	No of reps	No of reps	No of reps	No of reps	No of reps	No of reps
0%	13	10	11	29	24	31
1-50%	49	48	48	38	39	38
51%-99%	1	3	2	3	2	3
100%	0	0	0	0	0	0
Total cost of facility time	£179,464	£252,796	£259,280	£255,147	£178,120	£193,244

	• 2 at final draft • 2 first draft completed • 10 early-stage discussions but work in progress • 6 to commence/agree responsibility (will be issued in May meeting) • 17 procedures and best practice guidances to review	
NQP Audit	**AREAS OF STRENGTH** ➢ Responses received from the University students were generally positive, confirming their willingness to stay with the Trust when they graduate ➢ Most apprenticeship paramedics and University students confirmed that the training programmes helped them meet their skills and competence needs ➢ The majority of apprenticeship students and NQPs confirmed they have a designated CTE to support and supervise their training courses and signing off portfolios ➢ The majority of CTEs are confident in providing support to the NQPs and students and are willing to carry out the role in the foreseeable future. **AREAS OF CONCERN** Survey results also indicated the following: ➢ The Apprenticeship Programme has not been well structured to provide adequate study time for students, and a balanced shift pattern ➢ The COL portfolio has not been designed properly to add value to NQPs work experience, instead many felt it is irrelevant to the practical standard they should be working towards ➢ There is lack of detailed guidance provided to apprenticeship students and NQPs on what expectation they should have from the CTEs and where to seek support from ➢ The lack of CTEs and practice educators at the Trust has resulted in some apprenticeship students, University students and NQPs feeling they did not receive the support and supervision required ➢ A lack of capacity CTEs have to balance between their operational workload and supervision needed for students and NQPs. Therefore, CTEs require more support and guidance on how to guide and mentor others, with sufficient time built in their rota and expectations included in the annual objectives.	Committee to continue to monitor progress of recommended actions.

CONCLUSION

- Overall positive responses were received from apprenticeship paramedics and university students that the training programmes helped them meet their skills and competence needs, and good support has been received from the Trust's clinical teams.
- There are some areas that require further investigation and review from the Trust to ensure CTEs are well supported and trained to provide proper supervision to all students and NQPs with a balanced shift schedule.

RECOMMENDATION

- The common trends noted above should be reviewed by management and the leaders of the apprenticeship programme. Lessons learned should be collated from the above and actions should be set on how the Trust plan to improve the delivery of the apprenticeship programme with Cumbria University
- The Trust should review the structure of the apprenticeship programme to ensure students are given adequate time to study with a balanced workload and shift pattern (permanent relief shifts were raised as an issue multiple times)
- The Trust should communicate better with the University to plan blocked study periods and provide better and more consistent support to the students throughout the course
- There should be an increased focus on Students' health and wellbeing whilst on the apprenticeship programme.

MANAGEMENT RESPONSE

- The Trust has welcomed the feedback from this report and will work with Cumbria University and the Trust, including the Operational Directorate to continue to improve the quality of the apprenticeship programme.
- Study time has recently been reviewed with additional time being allocated.
- The Trust is currently reviewing shift rotas, apprenticeship feedback regarding blocks of study leave and relief shifts will be considered as part of the shift review process.
- The Trusts range of H&WB support is available equally to all staff, the H&WB forum will review the specific feedback from apprentices to ensure they are fully aware of the support available and how to access it.

South Central Ambulance Service NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC July 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 July 2023

EXECUTIVE SUMMARY / TOP THREE ISSUES FOR BOARD ATTENTION

2 Financial Update
3 Fundraising Update
4 Charity Strategy

KEY ISSUES

Financial Update

5. Draft M12 accounts were reviewed at the meeting. The end of year position Is a worse than budget position with a £116k deficit. This deficit increased in M12 due to stock adjustments made that are still being reviewed for accuracy. Unrestricted reserves have dropped to a very low level of £35k. This will improve significantly early in the 2023-24 year due to receipt of the unrestricted legacy, which will amount to over a £1M in total.
6. The main disbursement of the Pain legacy has now been received with a residual c£250k still to be received when the Estate accounts are finally closed.
7. Management accounts for the 2023-24 were not available, and the CFC expressed its concerns about the speed of production of monthly accounts. A new fund structure has been created and implemented to give greater clarity and easier management of restricted expenditure against income going forward. M1-3 management accounts will be distributed to the Committee as soon as they have been completed.
8. The Finance Manager post for the Charity will be reviewed by Stuart Rees to enable recruitment to begin as soon as possible. The post will be funded by the Charity but will sit in the Finance team to ensure professional support and management but will only work on Charity finance work.
9. The CFC agreed a high interest deposit account should be opened as soon as possible and the legacy funds received moved to that account. Investment opportunities will be pursued in the longer term.
10. The annual report and accounts will be circulated to the CFC in advance of an additional meeting in September to review. The internal examiner will then review the accounts prior to sign off at the October CFC meeting. They will then go to the November Board meeting for final sign off by the Board. The deadline for submission to the Charity Commission is 31 January 2024.

Fundraising Update

11. Restricted grant income expected at the end of last year has now been received. These are the final NHSCT grants of £49,500 for Health and Wellbeing and the final £12,805 from BLMK for stage 2 projects. We still have high levels of unused funds from these projects including £100k set aside for the GoodSAM element of Out of Hospital Cardiac Arrest project which has not yet moved forward.

12. The new year has started well with the corporate development work now taking shape and plans coming together to begin approaching carefully selected potential corporate partners/donors in August/ September.
13. Community fundraising has had an excellent spring and early summer with many CFRs involved in events and collections across SCAS. The NHS Big Tea to celebrate NHS75 this year benefitted from a national corporate partnership with Morrisons. We were able to work with our CFRs to organise collections at various stores over a two-week period and to raise over £6000.

Charity Strategy

14. A first draft of the new Charity 5-year strategy was discussed and it was agreed it included broadly the right content. The CFC discussed how the document should be formatted to clearly show issues that needs resolving; identification of the current weaknesses and clear information on how the strategy would be driven forward. This is the next step in its development..
15. A five-year financial plan will be created to accompany the strategy and further discussed in September.
16. The aim will be to launch the new strategy at the Volunteer Conference in October.

CONCLUSIONS AND RECOMMENDATIONS TO THE BOARD

17. The recruitment of the Finance Manager is now a priority for the Charity to enable us to move forward with timely financial reporting and planning. This will be advertised as soon as possible.
18. The annual report and accounts will be presented to the Board at the November meeting for final sign off.

Nigel Chapman
Non-Executive Director
20 July 2023

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	South Central Fleet Services Ltd
Date Committee met:	28 June 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Board of Directors 27 July 2023

1. Points for Escalation

- None

2. Key issues / business matters to raise

- Confirmed company director appointments – Mike McEnaney - Chair, Paul Kempster – Managing Director, Daryl Lutchmaya – Company Secretary. Companies' House has been duly informed.
- The SCFS risk register was reviewed with some updates made. Further work requires to rationalise the risks, set target risk levels and to clarify the planned mitigating actions.
- SCFS – Fleet Operation Performance and Finance Report. The reports for both March year end and May 2023 were reviewed in some detail and contain a large amount of information. It is in the the process of development and will be key to driving the productivity and quality performance of the fleet. It is to be noted that SCFS Ltd is audited at the same time as SCAS as the finances are fully consolidated into SCAS annual accounts.
- SCFS – Workforce Report – Recruitment and retention of skilled fleet engineers is difficult whilst absence levels remain within target.
- SCFS – Annual Salary Reviews covering 2022/23 and 2023/24. SCFS employees are on non-Agenda-for-Change terms and conditions although a small number who TUPEd across from SCAS are on similar terms to NHS staff. The paper considered the NHS settlement, the median pay increases and the market rate for fleet engineers.
- SCFS – A paper considering rebasing of SCFS salaries to harmonise legacy staff (those who TUPEd from SCAS) with staff directly recruited into SCFS on SCFS terms and conditions was reviewed and it was agreed further work was required.
- SCFS Budget 2023/24 was presented and reviewed. This budget is already incorporated within the overall SCAS budget and includes £500k CIP. The budget was approved.
- SCFS – Strategy update was presented and noted. Further development is required.

3. Areas of Concern and / or Risks

- The ageing fleet and the delay in bringing on the new vehicles leads to increased quantity and complexity of repairs which impacts fleet availability.
- Resolving the harmonisation of staff terms and conditions to enable SCFS to recruit and retain key engineering staff and avoid expensive third-party outsourcing.
- SCFS needs to ensure that it is providing a high quality and value for money service to SCAS – the reporting of performance and budgets needs to reflect this.

4. Items for information / awareness

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5. Best Practice / Excellence

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6. Compliance with Terms of Reference

All Directors and required senior management were in attendance – the meeting was quorate.

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Date:	19 July 2023