South Central Ambulance Service
NHS Foundation Trust

Trust Board Meeting

Meeting in Public

DATE: Thursday 28 September 2023
TIME: 09.30 – 12.25
VENUE: **Winchester & Eastleigh Resource Centre, Woodside Road, Eastleigh, Hampshire SO50 4ET**

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 the meeting held on 28 July 2023** Keith Willett	**Page 13** **To approve**	
4	**Minutes from the Annual Members meeting held on 13 September 2023** Keith Willet	**Page 24** **To approve**	
5	**Board Actions Log** Daryl Lutchmaya	**Page 29** **To note**	09.40
STRATEGIC OVERVIEW			
6	**Chair's Report** Keith Willett	**Verbal** **To note**	09.45
7	**Chief Executive's Report** Mike Murphy	**Page 30** **To note**	09.50
8	**Update to the Public Board on the previous Private Board meeting held on 28 July & 24 August 2023** Daryl Lutchmaya	**Page 34** **To note**	10.00
9	**Recovery Support Programme** Mike Murphy	**Page 36** **To note**	10.05
10	**Communications Update** Gillian Hodgetts	**Page 38** **To note**	10.10
11	**Staff/Patient Story** Melanie Saunders, Helen Young	**Presentation** **To note**	10.15
QUALITY AND SAFETY			
12	**Quality and Patient Safety Report**	**Page 44**	10.25

Item		Action	Time
	Helen Young	**To note**	
13	**FTSU response to NHSE Letter** Helen Young, Melanie Saunders	**Page 57** **To note**	10.35
14	**Medical Director's Report** John Black	**Page 65** **To note**	10.40
	GOVERNANCE AND RISK		
15	**Governance Update:** a) Governor Elections Update Daryl Lutchmaya b) Fit & Proper Persons Framework Melanie Saunders, Daryl Lutchmaya	**Page 81** **To note**	10.45
16	**Risk:** a) Risk Register b) Board Assurance Framework (BAF) Daryl Lutchaya & Executive Director Leads	**Page 99** **To note**	10.50
	COMFORT BREAK 11.00		
	FINANCE AND PERFORMANCE		
17	**Integrated Quality Performance Report** Mike Murphy & Executive Director Leads	**Page 126** **To note**	11.10
18	**Operations Report – 999, 111 and Other** Paul Kempster	**Page 192** **To note**	11.20
19	**Finance Report – Month 5** Stuart Rees	**Page 203** **To note**	11.30
20	**2022/23 National Cost Collection** Stuart Rees	**Page 212** **To approve**	11.35
21	**Reinforced Aerated Autoclaved Concrete (RAAC)** Stuart Rees	**Page 215** **To note**	11.40
	PEOPLE, WELL-BEING AND LEADERSHIP		
22	**People Directorate update** Melanie Saunders	**Page 259** **To note**	11.50
23	**SCAS Sexual Safety Charter and Allegations Management- Update on SCAS Progress** Melanie Saunders	**Page 278** **To note**	11.55
	BUSINESS ASSURANCE		
24	**Assurance Reports** a) Mike McEnaney (Audit, 21 September 23) b) Les Broude (Finance and Performance 18 September 23) c) Anne Stebbing (Quality and Safety 7 September 23) d) Sumit Biswas (People and Culture Committee, 21 September) e) Mike McEnaney (SCFS Ltd, 13 September)	**Page 287** **Page 289** **Page 291** **Page 295** **Page 297**	12.00

Item		Action	Time
CLOSING BUSINESS			
25	**Any Other Business** Keith Willett	**Verbal** **To note**	12.10
26	**Questions from observers (items on the agenda)** Keith Willett	**Verbal** **To note**	12.15
27	**NED Review of Meeting/ Feedback using QR Code** Keith Willett	**Verbal** **To note**	12.20
28	**Date, Time and Venue of Next Meeting in Public** Thursday 30 November 2023 Venue: Winchester Resource Centre, Woodside Road, Eastleigh, Hampshire SO50 4ET	**Verbal** **To note**	12.25

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

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

DRAFT 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 27 July 2023**, held at the Ark Conference Centre, Basingstoke.

Board Members Present
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 Murphy (Chief Strategy Officer); Dr Dhammika Perera (NED); and Professor Helen Young (Chief Nurse).

Apologies

Apologies for absence were **received** from Mike McEnaney (NED) and Melanie Saunders (Chief People Officer).

In Attendance

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

OPENING BUSINESS

22/156 – 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.

22/157 - Declarations – Directors' Interests & Fit and Proper Persons Test

No new declarations were made and the Register of Interests (as at 26 May 2023) was **noted.**

22/158 – Minutes

The Minutes of the meeting held in public on 25 May 2023 were **approved** as an accurate record of the meeting.

22/159 – Board Action Log

The Action Log was **noted** and Action 1, 2 and 5 were closed. It was reported (Action 3) that the Board Seminar had been re-scheduled for 28 September 2023.

STRATEGIC OVERVIEW AND CONTEXT

22/160 – Chair's Report
The Chair presented his report, highlighting that the operating environment remained challenging for the Trust and wider system. Staff commitment remained strong and it was pleasing to note that long-service awards had been presented at an event on 27 July to mark the valued service of staff who had worked at SCAS for 20 years or more.

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

22/161 – Chief Executive's Report

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

- the 10-Point Plan, as previously discussed at the Board, had been launched on 6 June coinciding with the first 100 days of the CEO;

- engagement sessions were being held internally with all stakeholders in respect of the Trust's 3-5 year strategic ambitions and priorities, with a view to re-launching the strategy in the Autumn. As part of this process, the Council of Governors would be consulted at the joint meeting of CoG and the Board on 31 July;

- as reported previously, Hampshire & Isle of Wight ICB had now been placed into NOF4 status and this had been extended to all partner organisations (including SCAS) in respect of financial governance. Additional support from NHSE was being provided to the local system and the Trust was collaborating fully with the ICB and partners;

- to mark the 75th Anniversary of the NHS on 5 July, a number of events were held across SCAS which were well-received.

Arising out of discussion, NEDs enquired about the TPAM process and demonstrable progress towards exiting NOF4 status. The CEO commented that there had been more positive feedback from system colleagues, although there was much still to be done in terms of the improvement plan.

The Chief Digital Officer advised the Board of a recent cyber attack on a third-party company who provide a records management system to the Trust. It was noted that the matter had been escalated to NHSE who were directly dealing with the implications of the attack.

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

22/162 – Summary of Private Board Business

The Chief Governance Officer provided a report summarising the main items of discussion at the Private Board meeting held on 29 June 2023, which included: an emergency decision under Standing Orders; consideration of ICB Forward Plans; FTSU Self-Assessment; the Quality Account, 2022/23; Draft Annual Report & Financial Statements, 2022/23 and NOF4 status in respect of the Hampshire & Isle of Wight ICB.

The Board **noted** the report.

22/163 – Communications, Marketing & Engagement Update

The Director of Communications presented an update to the Board on recent developments, highlighting that the Communications Team had been very engaged with the events surrounding the 75th anniversary of the NHS; on-going work in support of the Trust's charity in raising its profile and supporting the Trust's involvement with Royal Ascot as a Category 1 responder.

The Board **noted** the report and welcomed the range of communication and engagement activities which were being undertaken.

22/164 – Patient Story

The Board was grateful to the mother of Martha Mills (deceased) for sharing her story of Martha's treatment at King's College Hospital as part of the National Patient Safety Conversation, highlighting the importance of the voice of the patient and their family.

The Board **noted** the presentation and the messages contained therein.

PERFORMANCE. RISKS, GOVERNANCE AND ASSURANCE

22/165 – Corporate Risk Register (CRR)

The Board **received** a report from the Chief Governance Officer on the Trust's Corporate Risk Register (CRR), the following key points in respect of high-rated Risks being **noted:**

111 Demand: the risk, currently **rated at 25**, is being reviewed;

Risks rated 20:

- handover Delays – reduced from 25 (likelihood changed from Almost Certain to Likely due to the on-going work taking place within Operations and the system to improve delays);
- Controlled Drugs;
- Financial risk – Increased from 16 (Likelihood changed from Likely to Almost Certain due to the on-going financial challenges experienced by the Trust)
- **111 Demand:** the risk, currently **rated at 25**, is being reviewed;

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.

The Board **noted** the report.

22/166- Board Assurance Framework (BAF) Update

The Chief Governance Officer presented a report on significant changes made to the BAF since the last meeting, noting that risk trend graphs had now been added to each risk. The Board **noted** the following updates to strategic risks:

Strategic Risk 1: Ability to provide safe and effective care.

The risk score remained at 12 (Major x Possible).

Strategic Risk 2: Ability to meet demand and provide responsive service.

The risk score remained at 15 (Catastrophic x Possible).

Strategic Risk 3: Disproportionate system focus.

The risk score remained at 20 (Catastrophic x Likely).

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.

The risk remained rated as 20 (Major x Almost Certain).

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.

The risk remained rated as 20 (Catastrophic x Likely).

Arising out of NED discussion, clarity was sought as to whether Board Committees had reviewed the latest risks which were being presented to the Board, given the timings of meetings. It was observed that a number of gaps in controls still had to be addressed. The Chair proposed that the report and the current state of risks be accepted at the present point in time until clarification had been sought in respect of comments made.

22/167 – Annual Report & Financial Statements, 2022/23

The Interim Director of Finance provided an update to the Board with regard to the Annual Report & Financial Statements, 2022/23 as follows:

- the Audit Committee approved the signing of the 2022-23 Annual Report & Financial Statements on 13 July 2023, having been given delegated authority by the Trust Board to do so;

- the External Auditors have given the following opinions:

  a) 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;

  b) a qualified opinion of the Remuneration Report and the Staff Report, based on the following:

    - the Remuneration Report is not complete as it does not include the pension entitlement information for the Medical Director;

    - 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 Board was further advised that the factors underpinning the qualified opinion of the Remuneration Report and the Staff Report were not fully within the Trust's control. 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, which Management had responded to.

The Board **noted** the report.

22/168 – Oversight Framework 4 and Recovery Support Programme

The Chief Executive presented a report in respect of the NOF4 status of the Hampshire & Isle of Wight ICB, it being highlighted that significant transformational change would be required to address the current financial situation, working closely with all system partners, including SCAS.

The Board was advised that given the scale of the challenge, support was being provided by NHS England in delivering the level of transformation needed whilst delivering other key commitments to improve access, reduce waiting times and reduce health inequalities, as set out in the ICB's response to the 2023/24 national planning guidance.

The Board **noted:**

a) that following NHS England's 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, had been moved into Oversight Framework 4/Recovery Support Programme. Formal notification of this move was received on 1 June 2023;

b) that all NHS Boards in Hampshire and Isle of Wight would be asked to agree regulatory undertakings with NHS England, to be discussed in Private Boards with a collective representation being made back to NHS England on behalf of the system.

22/169 – Governance Update

The Board received a report from the Chief Governance Officer in respect of governance matters, the following key points being **noted:**

- the Annual Members' Meeting (AMM) would be held (virtually) on Thursday 6 September 2023, at which Governors will officially receive the Trust's Annual Report & Financial Statements, 2022/23. The AMM provides an opportunity 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, and to pose questions;

- at an extraordinary meeting of the Council of Governors on Friday 30 June, Governors approved the recommendation from the Nomination Committee to appoint Mr Ian Green, Non- Executive Director, for a second term of three years, effective from 1 July 2023;

- 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. The Joint Forward Plans are available on each of the ICBs' websites.

The Board **noted** the update.

22/170 – Quality & Safety Committee Terms of Reference

The Board **approved** the revised Terms of Reference of the Quality & Safety Committee, as considered by the Committee on 6 July 2023.

22/172 – Quality & Patient Safety Report

The Chief Nursing Officer presented the Quality & Patient Safety Report (April – May 2023), the following key points being highlighted in respect of statutory quality and safety processes:

Patient Safety Improvement Plan

The areas that currently present the highest risks to patients include:

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 had 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 receives significant system-wide scrutiny and oversight and has achieved significant improvements in all key objectives.

IPC – Level 3 assurance peer review of IPC was undertaken with South West Ambulance Service (SWAST) and South East Coast Ambulance Service (SECAMB) on 23 May 2023. The initial feedback has been positive and confirmed the issues which the Trust identified itself in terms of embedding IPC practice and local ownership of the process by frontline teams.

In addition, the Board **received** updates in respect of **clinical incidents** (where there had been a reduction in demand); **patient experience** (15% decrease in the total number of PE contacts related to delays and non- attendance); **formal complaints** were comparable to last reporting period; **patient safety & serious incidents –** 24 incidents had been reviewed, 10 of which were declared serious incidents; **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.

With regard to an **emerging theme,** it was reported that there was rising concern over the number of incidents being reported on behalf of mental health patients in relation to Thames Valley Police being early adopters of a national policy the 'Right Care, Right Person' programme. Operational Directors were in constant dialogue with Thames Valley Police Force in order to assess the impact on patients.

The Board **noted** the report.

22/173 – Chief Medical Officer's Report

The Chief Medical Officer presented his report to the Boars 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.

The Board **noted** the report.

22/174 – Quality Account, 2022/23

The Chief Nurse presented the Quality Account (QA), 2022/23 to the Board which is a mandated document for Foundation Trusts. It was reported that the final published version of the QA would be available on the Trust's website in the near future course.

The Board was advised that the QA was produced in accordance with national guidance and included sections on a review of the 2022/23 year in respect of progress against the objectives the Trust set, and a section on the CQC visit, report and subsequent improvement programme. Objectives for 2023/24 would be described and reported on in next year's QA, with the Quality and Safety Committee being provided with in year updates on progress.

Feedback from Quality and Safety Committee, Audit Committee and Private Board meetings had been considered and amendments to the QA had been made, as appropriate. Data has been presented in the published version using formats to meet accessibility standards.

The Board **approved** the Quality Account, 2022/23 and thanked all those involved in its production.

22/175 – Annual Safeguarding Report, 2022/23

The Chief Nurse presented the statutory Annual Safeguarding Report, 2022/23, the following highlights being **noted:**

There had 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 four permanent staff to a team of 10;
- permanent change in leadership in Q3 and Q4.

Three challenging aspects for the year included:

- the work associated from two CQC Inspections;
- the fast turnover of leadership in Q1 and Q2 ;
- the fragility of the server hosting safeguarding referrals.

The most challenging aspects for the coming year included:

- 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).

The Board **noted** the Annual Safeguarding Report, 2022/23.

22/176 – Integrated Performance Report

The Chief Strategy Officer presented the June 2023 version of the Integrated Performance Report (IPR), the following key points being **noted:**

- having taken feedback from the Board in June and following advice from NHSE, the Trust has adopted a format and style for the report which is considered to be sector best practice;

- the report is structured to reflect the Trust's Improvement Programme workstreams and will eventually incorporate the metrics and reporting identified against each workstream;

- a number of amendments have been made to ease information flow and development of reporting;

- timelines are in the process of being aligned with the developing Board/Committee meetings calendar;

- the number of pages in the report has been reduced, and further work is being undertaken to ensure that only essential information for assurance purposes is being reported on, which is being reviewed by the Finance & Performance Committee.

In noting the revised IPR, the Board **agreed** to the proposal to pause for further format development for a period of six months to enable the Trust to focus on effective use of the document and to improve the quality of the commentary provided. The Chair commented that the narrative was maturing within the report which was useful in on-going discussions with the ICB, especially in the context of working with partners to delivery efficiency savings.

22/177 – Operations Report

The Chief Operating Officer presented his Operations Report to the Board, highlighting the following key matters:

- in June 2023, Category 2 performance was adrift of trajectory at 34 mins 8 seconds. Whilst performance was strong for most of June, there was a period between 9 and 18 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, the Trust could not react with the level of hours required to match the demand, consideration having to be given to the on-going financial costs of any large increase in resource hours;

- turnaround time 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 - inbound call volumes decreased in April and May 2023 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;

- staff attrition rates have slowed and recruitment has been positive, but the Trust is approximately 30 ECTs below establishment to deliver sustained performance;

- in 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;

- 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;

- in respect of hospital handovers, the Trust has experienced a continuing reduction with handover delays 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 time spent with each patient.

Arising out of NED comment, it was observed that whilst long wait data was stable, it needed to improve, a subject which had been discussed at the Quality & Safety Committee in relation to Category 2 performance and the impact on Category 1.

The Board **noted** the report.

22/178 – Finance Report

The Interim Director of Finance presented his report to the Board, the following key points being highlighted:

- the Trust reported an actual deficit in month (June) of £2,479k which is £1,479k worse than plan;

- the Trust's 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;

- 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);

- NHS Improvement Use of Resource – overall rating is 2 against a budget rating of 1;

- 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;

- Forecast: the Trust's in-year current run rate with identified action to date resulted in a forecast deficit of £18.6m as of 3 March 2023. The Trust is currently working on its Financial Sustainability Plan to bring the position back to break-even.

The Board **noted** the report.

22/179 – NHS Workforce Plan

The Board **noted** the report for information from the Chief People Officer.

22/180 – Freedom to Speak Up (FTSU) Self-Assessment

The Board **noted** the report from the Chief People Officer.

22/181 - Board Committee Upward Reports

- ***Audit Committee***

    The Board was informed that due to delayed information, necessary to finalise the Accounts & Financial Statements, 2022/23, and the related risks, the External Auditors had further delayed signing the Accounts; the exact date for doing to be determined. It was reported that a draft set of Accounts had been submitted to NHSE who have been kept informed throughout.

The purpose of this additional meeting held on 13 July was to review and, with the authority delegated by the Board, approve the Annual Report & Financial Statements for final signature and submission. Both the Annual Report & Financial Statements (unqualified) were approved subject to finalisation of a few minor issues that remained outstanding.

Given the difficulties experienced with the end of year process, the Board was advised that a joint learning and improvement report would be reviewed at the September Audit Committee meeting, and the Internal Control recommendations would be tracked for progress at future meetings.

- ***Finance & Performance Committee***

The Committee Chair (Les Broude) commented on the Trust's Finance and Financial Sustainability Plan that the year-to-date financial position was providing a significant challenge to achieving the year end break-even target. There was a review of the plans to achieve the year- end target. The Committee gained assurance that actions to ensure grip and control, and the work being planned to address financial sustainability, were underway. In addition, the Committee was advised that discussions were continuing with the HIOW ICB in respect of SCAS' financial position and future plans.

With regard to the Integrated Quality and Performance Report (IQPR), the Committee supported the progress made to date on the report format and content, and particularly the improved executive summary. The Committee was assured that the IQPR, through its continuing development, would start to provide the basis for providing the appropriate information to manage and, therefore, improve performance, quality and patient safety.

In respect of the Improvement Programme, the 'Plans on a Page' and related metrics were reviewed and the Committee was assured that progress was being made in this area. The BAF risks relating to Finance and Performance were reviewed. Overall, the risks were clearly with appropriate controls in place.

- ***Quality and Safety Committee***

The Committee Chair (Dr Anne Stebbing) confirmed that the Committee was continuing to maintain scrutiny across a range of patient quality and safety matters, including patient experience, safeguarding, IPC, mandatory training and serious incidents. It was reported that a procurement process was underway in respect of a new Asset Management system.

The impact on mental health patients as a consequence of Thames Valley Police no longer responding to mental health related calls was being closely monitored.

The Committee had reviewed its BAF-specific risks and supported the reduction in risk ratings for SR1 and 2. The Committee also reviewed its Terms of Reference which were presented to the Board for approval.

- ***People & Culture Committee***

The Committee Chair (Ian Green) commented that the Committee had continued to focus on the Trust's staff retention plan, and had overseen the completion of the first national Freedom-to-Speak-Up Self-Assessment which had been shared with the Board.

It was noted that the Committee had reviewed the Annual Equality Report and the Pay Gap Analysis in relation to the Trust's workforce. The Committee continued to monitor the implementation of recommendations arising out of the NQP audit.

- ***Charity Committee***

The Committee Chair (Nigel Chapman) reported that the Committee had considered a first draft of the new Charity five-year Strategy which it broadly agreed with. It was noted that a five-year financial plan would be developed to accompany the strategy, to be further discussed at the September meeting. The aim was to launch the new strategy at the Volunteer Conference in October 2023.

The recruitment of a Finance Manager remained a priority for the Charity to enable it to move forward with timely financial reporting and planning. It was confirmed that the Charity's Annual Report and Accounts would be presented to the Board in November 2023.

- ***South Central Fleet Services (SCFS) Ltd***

  The Board received a summary of the meeting of the SCFS subsidiary Board held on 28 June. The Trust Board noted the appointment of new Company Directors as follows: Mike McEnaney – Chair; Paul Kempster – Managing Director and Daryl Lutchmaya – Company Secretary. Companies House had been advised of the changes. The SCFS risk register was reviewed further work being required to rationalise the risks, set target risk levels and to clarify the planned mitigating actions.

  The Board reviewed financial reports for both the March year-end and May 2023 were reviewed. It was noted that SCFS Ltd is audited at the same time as the Trust, with SCFS' finances being included within the consolidated annual accounts.

The Board **noted** the Upward Assurance Reports.

22/182– Any Other Business

There was no other business.

22/183 – Questions from Observers (relating to items on the agenda)

Questions were raised from Governor observers in respect of the situation whereby the Police would no longer attend mental health-related call outs which would place great pressure on the Trust and acute providers. The Chief Nurse commented that this matter was being treated as an emerging theme and that incidents would be recorded on the Datix system.

22/184 - Review of Meeting

The Chair advised that in consultation with the Trust's Improvement Director, individual NEDs would be invited to critique Board meetings as part of a process of board development and improvement. This would commence in September.

22/185 – Date of next meeting:

Approved by:

Chair (signature)……

Date:……

SCAS 2022/23 ANNUAL MEMBERS MEETING

Minutes of the South Central Ambulance Service NHS Foundation Trust 2022/23 Annual Members Meeting held on Wednesday 13 September 2023 via Microsoft Teams

Board members
Professor Sir Keith Willett (Chair); David Eltringham (Chief Executive); Sumit Biswas (NED); Les Broude (NED); Dr John Black (Chief Medical Officer); Paul Kempster (Chief Operating Officer); Daryl Lutchmaya (Chief Governance Officer); Mike McEnaney (NED); Melanie Saunders (Chief People Officer); and Professor Helen Young (Chief Nurse).

Apologies
Apologies for absence were **received** from Board members: Nigel Chapman (NED); Ian Green (NED); Mike Murphy (Chief Strategy Officer); Dhammika Perera (NED); and Anne Stebbing (NED).

In Attendance
Mike Appleyard (Public Governor, Buckinghamshire); Andy Bartlett (Public Governor, Hampshire); Martina Brown (Medicines and Research Manager); Mark Davis (Public Governor, Berkshire & Deputy Lead Governor); Charles Deakin (Assistant Medical Director/Research Team Lead); Margaret Eaglestone (Membership and Engagement Manager); Laura Hinsley (Head of Public Sector Audit-England/Public Sector External Audit); Graeme Hoskin (Appointed Governor) Nora Hussein (Interim Assistant Trust Secretary); Loretta Light (Public Governor, Oxfordshire); David Luckett (Public Governor, Hampshire); Anthony Nicolson (Public Governor, Hampshire); Helen Pocock (Senior Research Paramedic); Helen Ramsay, (Public Governor, Oxford & Lead Governor); Stuart Rees (Interim Director of Finance); Ian Sayer (Staff Governor, 999); Nick Smith (Marketing and Communications Manager); Barry Thurston (Interim Chief Digital Officer); Susan Wall (Corporate Governance and Compliance Officer/minutes); Matt Watts (Deputy Director of Communications, Marketing and Engagement); Alan Weir (Staff Governor, Corporate); David Wesson (Public Governor, Oxfordshire); and Barry Wood (Appointed Governor).

Apologies
Apologies **received** from Charles McGill (Public Governor, Hampshire).

The Annual Members Meeting was attended by a number of staff, Governors, volunteers and members of the public.

ANNUAL MEMBERS MEETING

AMM 2022-23/01 Chair's Welcome and Introduction

The Chair welcomed all to the Trust's 2022/23 Annual Members Meeting highlighting it had been a year of considerable challenge and change, referencing that fuller comments were available in the Trust's Annual Report which was on the Trust's website.

AMM 2022-23/02 Declarations of Interest

There were no declarations received.

AMM 2022-23/03 Minutes of the meeting held 28 September 2022

The minutes of the Annual General Meeting 2021/22 were **APPROVED** as an accurate record of the meeting.

AMM 2022-23/04 SCAS Review of the Year

The Trust Chair welcomed the Chief Executive Officer to his first Annual Members Meeting and who presented a review of the year, highlighting in a slide set:

- he had experienced great enthusiasm and compassion from colleagues at site visits he had undertaken across all teams in his first six months at the Trust, which truly demonstrated SCAS values whilst operating under varied pressures and challenges;
- SCAS had made good progress in completing actions required following the disappointing inadequate rating received from the Care Quality Commission (CQC) following its inspection in April 2022. The subsequent Improvement Plan and activities recognised long-term challenges which were linked into the Trust Strategy;
- focus on the Ten Point Plan embedded in the Improvement Plan provided a road map in supporting high quality safe services for patients and the health and wellbeing of people in all activities;
- Category 2 999 performance rate remained below the expected target, however the Trust was committed to achieve the set intermediary standard by March 2024 and as part of the strategy to achieve this, the Care Navigator structure was being employed;
- demand on services had increased and innovations around development of clinical pathways had resulted in a significant number of patients receiving the right treatment more quickly;
- SCAS had been a major support during the pandemic and running the national Covid response services for England;
- Charity and volunteer services, such as Community First Responders provided a range of support in the community;
- the Trust was progressing in its bid to become greener and more sustainable, and a focus on green vehicles would assist this; and
- the Quality Account published at the end of June was available on the Trust website.

The Chief Executive Officer thanked the Board, teams, staff, volunteers and Governors in their hard work and commitment in what had been an on-going challenging environment in balancing operational pressures, quality and safety, workforce, and financials. The Trust Chair acknowledged the comprehensive review provided by the CEO that summarised the breadth of activities undertaken by SCAS within the context of national pressures on the NHS, Public Services, and Local Authorities. Relationships with stakeholders would be central in the provision of the quality of care provided to patients and public more generally.

AMM 2022-23/05 Financial review including the 2022-23 Accounts

The Interim Director of Finance provided an overview of the Trust's position from the Annual Accounts 2022/23 highlighting that the Trust had achieved a £47,000 surplus and had met its statutory financial duties in the reporting period. Updates were provided in relation to income and expenditure, cash, capital and cost improvement programmes. The Interim Director of Finance stated there were on-going challenges arising from the underlying financial position that were being reviewed and addressed in the current financial year and that there was a continuing focus in delivering value for money and in making improvements for the future such as increasing the number of electrical vehicles in the fleet and digital technology.

AMM 2022-23/06 Auditors Report

The Head of Public Sector Audit from the Trust's Auditors detailed the role that the auditors had taken in the process of reviewing the Trust's accounts in accordance with statutory requirements. She stated the Trust accounts gave a true and fair view of the financial position as at 31 March 2023 achieving the positive position of an 'unqualified opinion' and the Annual Auditors Report as a public document was available in full on the Trust website.

It was noted there had been five adjustments made during the audit process, however these had not impacted on the reported surplus position and had been flagged in lessons learned for future attention, with improvement points being overseen by the Trust's internal Audit Committee. Weaknesses in the reporting period related to Value for Money (VfM) around financial sustainability and to governance within the organisation, however matters were continuously improving positively in line with improvement plans whilst recognising there was on-going significant pressure within NHS finance.

A couple of questions were received from the public who asked whether the SCAS financial position had any connotations to other external agencies, Local Authorities or NHS England in relation to VfM and were there implications to SCAS flowing from performance of other systems within the geography necessitating different arrangements or penalties in SCAS achieving their budget; and in relation to governance and Well Led the slow progress for this against the Improvement Programme.

The Head of Public Sector Audit replied that a Foundation Trust was responsible for its own finances which historically had been an advantage, however pressures in the NHS were such that Foundation Trusts as well as other Trusts were experiencing challenges. She referenced that funding was provided from Integrated Care Systems with the provision of ambulance services being across several counties and that there were particular challenges being experienced by the Hampshire and Isle of Wight system. It was noted Trusts within the Hampshire and Isle of Wight system had set break even budgets where possible and that the SCAS Board had discussed and had agreed a break-even position with the Hampshire and Isle of Wight system from their previously reported deficit position. In relation to VfM and from an auditors perspective, they were focussed on arrangements and mitigations being in place to achieve VfM. The process of identifying areas for the significant 11% of savings required in the current financial year was continually being reviewed.

The Interim Director of Finance added that £14.1 million savings had been identified and there were organisational and system challenges to find the remaining £4.4 million savings required, however there were robust financial checks and controls over the Trust's financial position in

place. The Head of Public Sector Audit stated that in relation to Governance and Well Led, there were two areas of consideration. Firstly, addressing the criteria to exit level four of the National Oversight Framework (NOF4) and accountability and clarity in delivery of one formal cohesive Trust wide improvement plan which would be monitored by the Board Assurance Framework system. It was noted that six months on since the end of the reporting period, that progress had been made in recruiting to the Governance team. The Chair added updates on progress would be available at upcoming Trust Board meetings in Public.

AMM 2022-23/07 Research Developments

The Deputy Medical Officer/Research Lead provided an update on research developments covering: research funding; the three main research areas of Emergency research trials, Community research trials, and Staff research trials; and current research and developments.

Key points of note:

- research into ambulance services had developed over the last ten years;
- the main area of research SCAS was involved in was Emergency research trials, the results of which had supported improving patient outcomes and experience;
- research trials also linked with hospital studies in supporting the reduction of hospital admissions;
- results of research studies by SCAS had provided valuable information both nationally and internationally with many publications of research in peer-reviewed journals and presentations at conferences;
- research study results had assisted in the updating of Resus guidelines, mechanical chest compression devices and drug administration in cardiac arrest patients; and
- the Healthcare Professional Council had made it mandatory for paramedics to be involved in research which had been embraced positively by crews in the Trust in the development of research activities.

The Chair thanked the Research Team for their important work and highlighted that their endeavours were testament to SCAS being in the forefront of Emergency Research trials.

AMM 2022-23/08 Council of Governors' Review of the Year

The Chair thanked Barry Wood (former Lead Governor) and introduced Helen Ramsay the new Lead Governor who gave an overview of recent governance changes, the role and duties of Governors, membership update, activities undertaken; and the upcoming Governor elections.

Key points of note were: enhanced collaboration was in place between Governors and relevant Board members; there was a drive to grow staff and public membership to reflect the demographics that SCAS served; and Governors had engaged in supporting further understanding into the access to care in particular in addressing health inequalities.

The Chair thanked all Governors for the important work that they had undertaken in the organisation and for the focus to increase members to represent the diversity of the population the Trust served.

AMM 2022-23/09 Question and Answer Session

A question was received from a member who was involved in voluntary community development about how best to support messaging to a diverse community to assist people about how to access appropriate healthcare. The Chair advised this could be discussed in a

separate meeting following the AMM to explain it in more detail and would be supported by locality statistical data that had been gathered by SCAS. The CEO offered to be the initial referral point.

The Chair thanked all those who had contributed and attended the meeting. He closed by saying the public sector, for a while, had been under significant financial pressure and it was imperative that all in the Integrated Care Systems and Local Authorities understood the pressures and worked together to ensure appropriate and safe healthcare response in emergencies.

AMM 2022-23/10 Closure of Annual Members

Meeting closed at 18:33.

Agenda item 5

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

BOARD MEETING IN PUBLIC – 28 September 2023

ACTION LOG

No.	Minute ref.	Action	Resp	Date Raised	Due Date	Comments / Updates
Board Meeting – 25 May 2023						
1.	**22/125**	The Board to consider detailed results of the Staff Survey at a future Development Seminar.	CPO	30/03/23	**- 2023**	**Propose to close** Future updates will be received through the People Voice and Culture and Wellbeing updates.
2.	**22/139**	Quality & Safety Committee to consider H&S audit on 'special notes' at a future meeting	DPCST	25/5/23	**- 2023**	**Propose to close** this item was received at the Council of Governors meeting held on 31 July 2023
3.	**22/150**	Governors to be invited to participate in 'triple aim' duty with regard to community engagement	CGO	25/5/23	**November 2023**	**Open** scheduled for the next CoG Workshop

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, 28 September 2023**	**Agenda Item:**	**7**	
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:	Mike Murphy, Deputising for 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

PUBLIC BOARD MEETING PAPER

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 held in July.

Change to the South Central Ambulance Service NHS Foundation Trust (SCAS, the trust) planned exit date from the Recovery Support Programme (RSP)

The Trust received notification that the original planned exit date of the end of Quarter 2 2023/24 for SCAS from the RSP, was extended following approval, to the end of Quarter 4 2023/24 by NHS England. This recommendation for extension was also supported by the Hampshire and Isle of Wight Integrated Care Board (HIoW ICB) and SCAS. NHS England national and regional teams and colleagues at HIoW ICB recognised the hard work that has been taking place across the Trust and the progress made to date, especially around the CQC requirements, patient safety and safeguarding. By allowing this extension to the exit date given the recent change in leadership, it is to be expected that the Trust will have sufficient time to deliver on the improvements required across the range of exit criteria.

Hampshire and Isle of Wight system entry into the Recovery Support Programme

In June 2023, HIoW ICB and its seven NHS Trusts were placed into NOF4 (National System Oversight Framework - segment 4) and 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. HIoW 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.

The RSP is a nationally-led programme of mandated, focused and integrated support for Trusts and systems in Segment 4, which works in a coordinated way with system partners and regional and national NHSE teams. What this means in practice is that the national and regional teams will work collaboratively with SCAS and the seven Trusts to agree key drivers of the concerns that need to be resolved.

The system-wide governance and oversight arrangements to lead and oversee recovery progress have been developed with the regional team and shared with NHSE. This includes embedded regional involvement in the ICB's Executive Leadership Group, which will have Chief Executive-level oversight of system recovery. This will be complemented by monthly system oversight led by our NHSE regional team. The entry Meeting with the NHSE National Executive Team will be on Friday 29 September 2023. The exit criteria will include developing a system wide recovery plan, including a financial improvement trajectory, which aims to secure financial sustainability and recovery.

Modernisation Programme

Having joined the Trust in March 2023 and taken over as Accounting Officer on 1st April 2023, David Eltringham embarked on a programme aimed at getting to know the organisation and understanding what was driving some of the key challenges. By early April the Trust declared that it had identified a significant financial challenge, resulting in a projected deficit for the 2023/24 financial year in excess of £30m. Throughout June, David spent considerable periods of time out and about working alongside staff, and publishing a

10 Point Plan. This plan was aimed at getting the organisation to focus on getting the basics right as we undertook a review and reconnection exercise with a long-term strategy. In June and July the Trust failed to meet the targets it had set against the Category 2 mean response time recovery plan leading to further discussions with NHSE's national and regional teams; culminating in the Trust presenting an operational recovery and improvement plan to NHSE. The Trust has committed to simultaneously deal with its financial challenge, to sustain and improve its operational performance, to deliver a high quality, safe service to its patients and to look after its staff.

As a result of these commitments, SCAS has begun an ambitious programme of modernisation which is underpinned by a strategic requirement to ensure the services we provide are 'fit for purpose' and deliver the best possible, high quality and safe services for the communities we care for. Whilst recovering our financial position and ensuring optimal operational performance are certainly two of the key drivers for reforming the organisation, we need to take measures to future proof services, taking account of economic factors, sustainability and environmental responsibilities and changing societal needs.

Senior leaders have already met and engaged in positive initial discussions about what will be needed to deliver this transformation. Setting out the roadmap to achieve sustainable change as quickly as possible will require a structured programme with individuals dedicated to it. Work has also begun on the development of the governance structures required to support this programme.

Internal communications have gone out to staff to raise awareness and ensure staff can contribute to the generation of new ideas as well as the delivery of them. Briefings to our Council of Governors, commissioners, external partners and stakeholders have also gone out and regular updates will be issued. Much of this programme of work cannot be delivered in isolation and SCAS values and appreciates the partnership working that it has in place across the health and social care economy. These relationships will be critical as we transform our patient care offer and work to further develop its care navigator role.

As of 1st October 2023, the current Chief Operating Officer role will be split. The day-to-day operational management role together with the development of the modernisation agenda, is far too great for one role to deliver. Paul Kempster, our Chief Operating Officer, will solely focus on the modernisation programme and Mark Ainsworth will join the Executive Team (initially for three months) in his role of Director of Operations, during this period Mark will also lead the Contact Centres and Planning teams. This change will allow Paul the bandwidth to really embrace and lead the transformation agenda, working closely with Executive colleagues.

Paul will be responsible for planning and implementing a radically different service model through the reconfiguration of the workforce, estate and fleet whilst Mark will have responsibility for the call centres, despatch, planning & scheduling as well as our front-line response. Mark will run the day-to-day operation and ensure that this remains resilient whilst we plan and deliver radical changes to the way we run our services. Both will report directly to the CEO.

We are all committed to traversing the difficult path to financial and operational transformation. It is the right thing to do for the organisation, our staff and our patients but we need to do it carefully, considerately and quickly.

Lucy Letby

Lucy Letby committed appalling crimes and our thoughts are with all the families who are affected and who have suffered pain and anguish. The Trust acknowledges the NHSE letter dated 18th August 2023, Verdict in the trial of Lucy Letby, Publication reference: PRN00719 NHS England, Verdict in the trial of Lucy Letby. The independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester will help to ensure that we learn from this awful case. The Trust is complying with the many safeguards to prevent such patient harm occurring at SCAS including implementing the new Patient Safety Incident Response Framework representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients; the strengthened the Fit and Proper Person Framework and the revised Freedom to Speak Up (FTSU) policy based upon new NHSE guidance.

Adult Critical Care Transport Service

In the last CEO update, we shared that we had 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 were exploring more opportunities for collaboration. Both David Eltringham at SCAS and Simon Weldon at SECAmb, have been working in collaboration to find a workable solution to deliver a South-East region wide Adult Critical Care Transfer Service (ACCTS). The CEOs agreed to work in partnership and to present a workable solution to NHSE in due course. ACCTS is providing the highly specialised coordination, triage, decision-support, and transfer of critically ill patients between hospitals for escalation to specialist care, repatriation and in extreme circumstances capacity reasons. It is primarily focussed on intra region transfers but must be capable of delivering inter regional transfers.

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. We 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.

Annual Members Meeting

The Trust held its 2022/23 Annual Members Meeting on 13 September. It was well attended and the Annual Report and Accounts and Annual Auditors Report were presented to the Council of Governors, members and the wider public.

Council of Governors Elections

The Trust will be holding Governor elections in 17 seats during November and December with the declaration of results due on Wednesday 13 December 2023.

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Summary of business arising out of the private meeting of the Board meetings held on 27 July 2023 and on 24 August 2023**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday 28 September 2023**	**Agenda Item:**	**8**
Executive Summary:	This report provides an update on important matters discussed at the previous Private Board meetings.		
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: N/A

Private Board Meeting held on 27 July 2023

Financial/Sustainability Report
The Interim Director of Finance provided an update to the Board on financial matters, the report including specific reference to the Cost Improvement Programme and its delivery. It would be a very challenging year for the organisation and a number of major decisions needed to be taken to ensure that the Trust was sustainable moving forward.

Improvement Plan & Board Development Update
The Chief Strategy Officer presented an update report on the Improvement Plan and Board Development. The Improvement Plan had been presented by the Executive team to the Tripartite Provider Assurance Meeting in July 2023 and a summary of the Trust's governance structure had been presented, together with a proposed Board Development. The key points to emerge from the meeting centred on Commissioners' concerns over how the Board gained assurance; how the Trust was adapting reporting on the Improvement Plan; and the governance structure being implemented for the Trust to support progress though the Recovery Support Programme.

Make Ready' and Soft FM Contract Award
The Board approved to proceed with a three-year contract with the incumbent providers for the 'Make Ready' and Soft FM.

Private Provider 5-Year Tender Strategy
The Chief Operating Officer presented a report on Private Provider tendering options. The Board approved the proposed Contract Awards in accordance with the principles outlined in the report and as set out in the Private Provider Commercial Strategy (October 2022).

Employee Relations Report
The Board noted the Employee Relations Report for Quarter 1, 2023/24.

Allegations Management Report
The Chief Nurse presented the Allegations Management Report for Quarter 1, 2023/24 which was noted by the Board.

Legal & Regulatory Report
The Chief Governance Officer presented a Legal & Regulatory Report which was noted by the Board.

Digital Update Report
The Chief Digital Officer presented a report on Digital matters which highlighted a number of challenges faced in recent times in delivering the Trust's digital strategy.

Private Board Meeting held on 24 August 2023

Month 4 Finance Update
The Interim Director of Finance provided an update to the Board relating to SCAS's financial position. At month 4 the Trust had recorded an in-month deficit of £3.0m. The Trust's year to date's deficit stood at £9.6m.

Financial Plan-Recovery
The Interim Director of Finance provided an update to the Board. It included that the Trust continued to face a number of significant financial challenges including continued overspend in month and the original commitment to break even. There would be a continued focus on key areas to address the financial concerns.

Integrated Quality Performance Report
The Board welcomed the report explaining the ongoing work to improve the IQPR.

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Recovery Support Programme (RSP)**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**9**
Executive Summary:	**Change to the South Central Ambulance Service NHS Foundation Trust (SCAS, the trust) planned exit date from the Recovery Support Programme (RSP)** • The Trust has received a letter from NHSE on 25 August 2023 confirming the extension of support to the Trust and an approved revised exit date from the RSP as March 2024. • This date is subject to satisfactory achievement of the exit criteria. • The Trust will attend an RSP review meeting with the national team on the 6th October 2023. **Hampshire and Isle of Wight system entry into the Recovery Support Programme (RSP)** • The Trust received confirmation from NHSE on 1 June 2023 that it would be placed into NHS Oversight Framework Segment 4 and so receive support from the RSP as a result of the HIoW system entry into NOF4 for Finance. • SCAS will also join HIoW partners in an RSP entry meeting with the national team on 29th September 2023. The purpose of this meeting will be to review and discuss the system recovery plan, the exit criteria and understand what support the system needs from the national team.		

Recommendations:	The Trust Board is asked to note the receipt of these letters.			
Executive lead:	Mike Murphy Chief Strategy Officer			
Report author:	Mike Murphy Chief Strategy 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)	All BAF risks			
Quality Domain(s):	All Quality Domains			
Next Steps (what actions will be taken following agreement of the recommendations): N/A				
List of Appendices: N/A				

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Communications, Engagement and Marketing – activity update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**10**
Executive Summary:	**Financial and Operational Sustainability programme** SCAS Communications has a vital role to play in this programme of work and of the wider modernisation of services that we are embarking upon. **Public and Stakeholder engagement activity** Departments across the Trust have supported a number of events over the summer and with nominations opening for Governor Elections on the 28th September, there is a strong desire to attract more interested parties to work alongside us. **Electronic Patient Record (ePR) outage** As Cyber security becomes an even greater challenge for organisations, SCAS Communications has been providing comprehensive support to help stand back up the electronic patient record system once again.		
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 ☐	Acceptable ☒	Partial ☐	No Assurance ☐

	High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives	No confidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations):	
List of Appendices:	

South Central Ambulance Service NHS Foundation Trust

Agenda Item: 10.1

PUBLIC BOARD MEETING PAPER

Communications, Marketing and Engagement update

PURPOSE

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

EXECUTIVE SUMMARY / TOP THREE ISSUES FOR BOARD ATTENTION

2 **Financial and Operational Sustainability programme**
SCAS Communications has a vital role to play in this programme of work and that of the wider modernisation of services that we are embarking upon.

3 **Public and Stakeholder engagement activity**
Departments across the Trust have supported a number of events over the summer and with nominations opening for Governor Elections on the 28th September, there is a strong desire to attract more interested parties to work alongside us.

4 **Electronic Patient Record (ePR) outage**
As Cyber security becomes an even greater challenge for organisations, SCAS Communications has been providing comprehensive support to help stand back up the electronic patient record system once again.

KEY ISSUES

5 **Financial and Operational Sustainability Programme**
SCAS has begun an ambitious programme of modernisation to address the many challenges present in healthcare systems currently and to future proof the organisation for the years ahead.

Whilst recovering our financial position and ensuring optimal operational performance are certainly two of the key drivers, it is also very much underpinned by a strategic requirement to ensure the services we provide are 'fit for purpose' and are able to deliver the best possible high quality and safe services for the communities we care for.

Work is well underway in the Trust with the Communications team providing support to ensure staff are well briefed about the challenges and the improvements needed to effect the change required, in a timely but sustainable way.

An initial Communications & Engagement Plan was produced in July 2023 to support delivery of the Financial Sustainability Delivery Group objectives which has since been superseded by a new plan to reflect the inclusion of operational performance objectives into the programme.

The focus of the communications team has been the motivation of staff across the Trust to make improvements that will deliver the recovery that is need. This has required messages that have briefed on the scale of the challenge, the need for swift action and that have promised regular ongoing updates across a number of diverse platforms.

Maximising engagement opportunities and creating ways for staff to get involved and submit improvement ideas, underpinned the re-launch of the 'Bright Ideas' scheme. This channel gives SCAS employees a route for submitting suggestions to address the challenges in financial, performance or any other area of the Trust. This has been publicised through a range of existing internal channels and a new page on 'The Hub' intranet is keeping staff informed of how the programme is developing, with a quick link to 'Bright Ideas' for idea submission. At the time of writing this paper, there had been a positive response with over 60 ideas having been submitted in little over 2 weeks of the relaunch.

Being very conscious of the need to build understanding and buy-in from managers and team leaders so they can successfully engage with frontline staff, Senior Leadership Group and SCAS Leaders briefing sessions have been dedicated to the topic. The September Team Brief gave Team Leaders/managers, useful direction to enable them to brief their teams. A video message from CEO David Eltringham, an 'All SCAS' webinar, 'Message from the Execs' video messages and the weekly staff e-newsletter, are all supporting the conversation and will continue to ensure that this modernisation programme becomes a vital part of everyone's daily work.

Our patients, commissioners, partners and stakeholders are vital contributors to our success in making our services the best they can possibly be. As such, our communications strategy will ensure that all parties will be engaged and involved and informed as we endeavour to address together, the much-publicised issues that the NHS is facing.

6 **Member, Public and Stakeholder engagement**

SCAS events

We have collaborated with several SCAS teams, including Patient Experience, Recruitment and the SCAS Charity, to deliver events over the summer in Hampshire, Berkshire, Oxfordshire and Buckinghamshire. These events are a good opportunity to meet the public to share information about what we do, and to recruit new members, staff and volunteers. We are often joined by the SCAS mascot 999 Ted who helps engage with the public, especially children.
https://www.scas.nhs.uk/get-involved/events/

Foundation Trust Forum

Last year we initiated a round table discussion group with other Foundation Trust membership managers, company secretaries and staff involved in membership matters. This meeting has gone from strength to strength with the SCAS Stakeholder

and Engagement Manager chairing it and now attracting between 30 – 50 NHS staff to the meetings. Paul Balson, from Great Ormond Street Hospital for Children, presented on membership in August. Feedback indicates that this is a useful opportunity to share ideas and best practice and to network.

Stakeholder oversight committee
We have set up a stakeholder oversight committee, chaired by Volker Kellerman, to ensure the stakeholder engagement element of the SCAS communications and engagement strategy is delivered in a coordinated manner, with relevant departments working closely together. The group will have oversight of the management and delivery of stakeholder engagement across the organisation. Trust Chair, Professor Sir Keith Willett will be joining us in October to share his insights at the meeting. In addition, an online stakeholder bulletin is now sent out to partners in the Integrated Care Boards (ICBs), to share key SCAS messages identified via the oversight committee.

Governor Elections
SCAS Governor elections will take place between 17 November to 12 December this year, with nominations open from 28 September to 26 October. We are running a communication and engagement campaign reaching out to staff and public to recruit new Governors and encourage members to vote. This campaign is running using a mix of channels including letters, social media, leaflets for events and sites, local media and the usual internal communications channels.

We have also initiated a data cleanse to ensure that the contact information that we hold for our members is up to date ahead of the elections.

Annual members Meeting (AMM)
The SCAS Annual Members Meeting (previously the AGM) was held on 13 September. We promoted the AMM on social media, the SCAS website, and with local media channels, as well as inviting our members to attend via the membership database. We also developed the slides for Chief Executive David Eltringham's 'Review of the Year' presentation.

The AMM was successful, with around 50 people joining the meeting online.

7 **Electronic Patient Record – outage**
On Tuesday 18 July our SCAS electronic patient report form (ePR) went offline due to a cyber event affecting our ePR provider Ortivus. This meant that our electronic means for recording the care of our patients and sending that, and accompanying information to receiving units, became unavailable. The Trust took swift action and we reverted to using a paper-based system to record instead. The unavailability of the system required many contingency measures to put in place and questions to be answered to ensure that information could continue to be shared with the appropriate people, in a timely manner.

From the initial declaration, SCAS Communications has been heavily involved in providing communications support. The issue was flagged by our on-call director out of hours and as a result, SCAS declared a Business Continuity (BC) incident. This was communicated to all staff in the early hours of the following day. From the 19 July we commenced regular internal and external briefings which are still on-going.

Internal
The ePR system is vitally important to the operation of 999 and supports our frontline colleagues in the delivery of patient care, it is part of their normal day to day working.

As a result, internal communication has been key to ensuring that those impacted have been kept up to date and supported in continuing to do their jobs. Equally it has been important for the wider organisation to be aware that a Business Continuity had been declared. Frequently Asked Questions were put together and updated, processes for the reporting of safeguarding concerns were put in place and new arrangements for the sharing of Electrocardiograms (ECGs) communicated.

External interest

As this was an issue that was affecting not only SCAS, it was important that we kept our partners and other stakeholders informed and that we reassured our regional and national colleagues of the actions that we had taken to manage the situation. We have received a number of local and national media enquiries that were responded to by NHS England regional and national colleagues. We have also been working closely with Ortivus to ensure open lines of communication, to share updates on the latest situation and to provide consistent responses to queries about the issue.

Challenges

This has been a prolonged business continuity incident that initially required intensive communications support to ensure that our staff had all the information they needed to allow them to continue responding to patients. It proved to be an evolving situation, as we worked to understand with our providers and partners what the issues were and the associated impact that these might have.

As we are now in the recovery process, with ongoing testing ahead of standing up ePR once again, communications will continue with all parties as we return to normal functioning once again.

CONCLUSIONS AND RECOMMENDATIONS TO THE BOARD

8 At a time of great pressure on NHS services, the need for Communications to help deliver sustainable change, has never been greater. It's greatest skills in ensuring accuracy, attention to detail and the ability to translate complex information into understandable language must not be lost whilst attempting to spread these across many different work programmes.

9 With multiple priorities and increasing workloads, it is essential that Communications is still able to utilise its expertise in ensuring messages are clear, targeted at relevant audiences via appropriate channels and facilitates two-way dialogue through engagement. For change to be successfully embedded, the delivery of a well-executed Communications strategy is essential.

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

Gillian Hodgetts
Director of Communications, Marketing and Engagement
28 September 2023

NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Quality & Patient Safety Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**12**
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, June 2023 – July 2023. Progress continues to be made against the objectives outlined in The *Patient Safety Improvement Plan.* **Medical Devices** **Two Zoll incidents have been reported** and are currently under investigation with Zoll forensically analysing the devices. An audit of vehicles is in progress to ensure secondary devices are on every vehicle, and secondary devices now included to the critical check list for staff at the start of shift. **Safeguarding** Level 3 Safeguarding training was suspended for a period of two weeks during the reporting period to release capacity and support operational performance. It is anticipated that the target will be achieved at year end following implementation of remedial actions. The **Quarter 1** metrics for Safeguarding are on track with training compliance **above trajectory at 14.75%**, **Level 3 Safeguarding above trajectory at 51%, against the target of 46%, and SAAF above trajectory at 94.5% against the target of 70%.** **Infection Prevention and Control** The IPC Annual Report approved by IPC Committee and Quality and Safety Committee and will be published on the website. Preparation has commenced for International IPC week, 15 – 22 October 2023. **Serious Incidents** **10 Patient Safety incidents identified** and declared as Serious Incidents; • 7 SCAS declared SIs, • 3 System SIs and are currently being investigated in a cross organisational method. • The Trust has seen an increase in the number of SCAS declared SIs in this reporting period. In the last 4 months, 6 system SIs have been declared:		

	• 1 SI is currently breaching the 60-day completion target – with an approved extension in place. • 1 SI has a current "stop the clock" due to an ongoing police investigation. • 9 incidents referred for a detailed investigation (1% of all reported incidents). • 10 Serious Incidents were closed by ICBs across this reporting period. The **main themes** continue to be related to **Delays** with 6 reported. This position remains unchanged from previous reports to the Board. **Incident Review Panel** (4.5%) of total incidents reported were reviewed by the Safety Review Panel during this reporting period. 24 (2.8%) of total incidents reported were escalated for further review by the Executive led Incident Review Panel (IRP). 9 (1%) of total incidents reviewed at IRP have been referred for a local detailed investigation **Patient Experience and Engagement** Trust wide there was a **17% increase** in the total number of PE contacts raised. **90 new formal complaints** were received, **160 informal concerns** and **416 HCP feedback requests**. The Patient Voice panel is open to expressions of interest for Chairs of the group. To date, two Chair applications have been received and 15 others for the consult and participation roles. **Patient Safety Incident Response Framework (PSIRF)** Programme Board inaugural meeting took place on 18 August 2023 and a PSIRF brief was delivered to the Trust Executives. All required work for risk profiling has been obtained, with Business Intelligence supporting this element to ensure this does not impact the submission of the draft PSIRF plan to ICBs. Strategic **Decision Makers training** will take place on **14 September 2023.** Mandatory training for all staff – **HEE Level 1 compliance is currently at 75% and Level 2 at 60%.**		
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 TRUST BOARD PAPER

Title	Quality & Patient Safety Report
Author	Assistant Directors of Quality
Responsible Director	Professor Helen Young Chief Nurse / Executive Director of Patient Care
Date	September 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 (June - July 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 consists of specific workstreams which include, Safeguarding, Patient Safety and Experience, Management of Medical Devices and Equipment, Medicines Management and Infection Prevention and Control (IPC). The actions are managed and monitored through the Patient Safety Improvement Plan which reports and provides assurance to the Patient Safety Delivery Group and the Integrated and Oversight Board.

2.2 All oversight and assurance meetings were held throughout the reporting period and progress against actions and assurance provided.

2.3 **Level 3 face to face Safeguarding training was suspended for two weeks** during the reporting period to release capacity and support operational performance. It is still anticipated that the target will be achieved at year end following the implementation of remedial actions.

2.4 Any requests to suspend or cancel training are formalised through a weekly Executive training review panel and recorded in an action log.

2.5 During July a business continuity incident was declared following the outage of the Electronic Patient Record System. This has required staff to use paper records to record care and manual referral processes have been instigated. We continue to monitor any patient safety incidents or issues as a result of the outage.

3. Main Report and Service Updates

EPR Outage

3.1 On 18th of July 2023 SCAS declares a Business Continuity Incident due to trust wide system outage of the ePR system. A quality impact/ risk assessment was undertaken. SCAS has

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released a number of communications to staff to support them through the business continuity period including hot news updates and FAQ documents.

3.2 Internal business continuity meetings are ongoing. System and regional meetings are also in place to discuss risks, issues and next steps.

3.3 Testing has commenced and to date only a small number of issues have been flagged with many being resolved the same day. A go/no go to reconnection meeting will be held as testing progresses.

3.4 The Clinical Governance Team are reviewing incidents to understand the impact of this to patient safety. To date there have been no reports of patient harm due to this outage but we are monitoring this weekly.

Infection, Prevention and Control (IPC)

3.5 Annual report approved by Infection Prevention and Control Committee and Quality and Safety Committee. This will be published on the website and the action plan monitored by the IPC committee.

3.6 Preparation has commenced for International IPC Week (15-22 October 2023) to follow on from Professional Standards campaign including IPC roadshows.

Management of Medical Devices

3.7 The new asset management system project has been approved by the Executive Transformation Board and Executive Management Committee. Work is ongoing to develop a fully costed business case for presentation on 13th September to the Executive Transformation Board.

There have been two Zoll incidents reported, which are currently under investigation and the devices are being forensically analysed by Zoll.

An audit of vehicles is in progress to ensure a secondary device is on every vehicle. Secondary devices added to the critical check list for staff at the start of shift.

Safeguarding

3.8 The Quarter 1 metrics for Safeguarding are on track with:

- Training compliance above trajectory at 14.75% (target 5% increase per quarter)
- Safeguarding Level 3 above trajectory at 51% (target 46%)
- SAAF above trajectory at 94.5% (target 70%)

3.9 The potential risk to the above will be the effect of the Business Continuity incident at end of Quarter which may impact on the number of referrals and further delays to the transition of the server, as user testing will be delayed during the EPR outage. Any cessation of training will affect level 3 training compliance. There is some mitigation to this as the ECA (Emergency Care Assistant) cohort have been 'frontloaded' in anticipation of winter and staff who have not attended any training will be prioritised by scheduling.

3.10 The number of allegations has increased from 7 at the same time last year to 21 in the same period 2023/24. This shows an increased knowledge of the subject and a willingness for staff to refer to the Safeguarding Service. The role of ECA as the highest referred role and the theme of unprofessional behaviour as the highest theme is constant.

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3.11 Activity of statutory functions is included in this Board report and reported numerically. This reporting will be further developed in future reports to include comparison and learning themes. Numbers provided are from April 1 2023.

- No. Domestic Homicide Reviews (DHR) – 5
- No. Safeguarding Adult Reviews (SAR) – 20
- Homeless Mortality Reviews (HMR) – 3
- Rapid Reviews (RR) – 1
- Section 42 Enquiries – 13
- Child Safeguarding Practice Reviews (CSPR) - from 1st April we have provided information for 17 CSPRs and attended 7 meetings to discuss the cases.
- No. Child Deaths - sadly we have attended 31 JARs (Joint Area Reviews).

Mental Health and Learning Disability

3.12 There are several Mental Health (MH) projects in progress including the NHS Option 2 Project with a soft launch date of December 2023, MH Crisis response trust wide with use of increased fleet of MH Response Vehicles launch end of Quarter 4 and the Right Care Right Person Initiative. These all have a direct affect to performance, finance and patient care. The Executive Team have requested a paper with full details of these initiatives.

3.13 The Oliver Mc Gowan E Learning Programme is above training compliance trajectory. There are examples of good practice in Learning Disability including the creation of an easy read document for inclusion in the ePCR and patient participation and development of a video for use in the community to avoid fear when calling an ambulance.

Complex Care

3.14 The MH, Safeguarding and Complex Care (CC) Team have an awayday in September to discuss how these teams can work more collaboratively in planning care for our most vulnerable patients and to iron out any areas of duplication. It is crucial that Business Intelligence data and information is developed to understand where the contact centre staff can further support operational performance and ensure SCAS is supporting the patient.

Learning from Patient Safety Events (LFPSE)

3.15 The Trust is compliant with the national timeframe – DATIX web is updated (25 July 2023) with the LFPSE upgrade but not yet switched on as per the NHSE guidance and instruction.

3.13 The SCAS internal LFPSE group has completed stage 1 and 2 of local testing with DATIX in March and August 2023. A test case self-assessment for the NHSE team has been commenced prior to September 2023 to ensure Trust compliance with the system as a national requirement.

3.15 NHSE indicated to trusts that National Reporting and Leaning System will not be decommissioned until January 2024, but since have written they would aim to decommission earlier.

3.16 NHSE have indicated that any exports of NRLS data could be sent directly to the NHS England team instead of uploading to the NRLS website if LFPSE has not been switched on in (Quarter 3). Assurance can be given that SCAS are prepared but require national “bug” fixes to be resolved.

Patient Safety incident response framework (PSIRF)

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3.17 Programme Board inaugural meeting took place on 18 August 2023. The internal Programme Team delivered a PSIRF brief to Trust Executives (follow up to July's Trust Board brief). Work is underway to benchmark PSIRF governance against other ambulance trusts.

3.18 All required data for risk profiling has been obtained. Business Intelligence are now supporting risk profiling to ensure this does not impact submission of draft PSIRF Plan to ICBs.

3.19 Strategic Decision Makers training will take place on 14 September 2023. Mandatory training (all staff): HEE Level 1 is 75% and Level 2 is 60%. This is a month on month increase and ahead of trajectory.

3.20 PSIRF Communications and Staff Engagement Plan has been completed and a calendar of staff engagement events to inform, influence and involve staff.

Serious Incidents (SIs)

3.21 Year to date South Central Ambulance Service (SCAS) have identified 21 SIs under the national 2015 SI framework.

3.22 In June and July 2023, 10 Patient Safety incidents were declared as serious incidents (1.1/5 of all reported patient safety incidents)

- 7 SCAS declared SIs
- 3 incidents were declared as System SIs and are currently being investigated in a cross organisational method.

3.23 The Trust has seen an increase in the number of SCAS declared SIs, in this reporting period (4 in the previous reporting period). In the last 4 months 6 System SIs have been declared, demonstrating the increase in pressures being experienced across the system regarding delays.

- 1 SI is currently breaching the 60-day completion target – with an approved extension in place.
- 1 SI has a current "stop the clock" due to an ongoing police investigation.
- 9 incidents referred for a detailed investigation (1% of all reported incidents).
- 10 Serious Incidents were closed by ICBs across this reporting period.

3.24 The main themes continue to be related to Delays with (6) reported. This position remains unchanged from previous reports provided to Board.

3.25 **A thematic analyses of SIs / DIs between April 2022 / March 2023 where the category of incident is delay is currently being undertaken it is anticipated this will inform how we respond to further patient safety incidents reported of this type and will put forward recommendations for improvements.**

Incident review panel (IRP) activity

3.26 40 (4.5%) of total incidents reported were reviewed by the Safety Review Panel during this reporting period.

3.27 24 (2.8%) of total incidents reported were escalated for further review by the Executive led Incident Review Panel (IRP).

3.28 9 (1%) of total incidents reviewed at IRP have been referred for a local detailed investigation.

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Patient Safety Incident themes by Service - Emergency Operations Centre (EOC)

3.29 During the reporting period there were 72 patient safety incidents recorded by EOC. Incident reporting rose by 5% overall when compared to previous reports with the majority relating to EOC South. The top three reported incident categories were Delay, Patient Care Treatment and ICT Systems.

3.30 A **national initiative has proposed the implementation of a revised way to re-route calls nationally to prevent prolonged call answer delays**. The proposal was presented to the EOC Clinical governance meeting, and a paper submitted to 5 July 2023 Clinical Review Group. The proposal was approved by the group, receiving Medical Director Sign off. Final actions to achieve implementation are now underway.

3.31 NHS England have mandated a **Category 2 Segmentation process** which SCAS is to implement by September 2023. This involves urgent clinical navigation and review by a Clinical Validator from the Clinical Support Desk. This urgent review will not prevent dispatch if a resource is available but seeks to improve response times to Category 1 and the highest acuity Category 2 patients. A project group is meeting bi-weekly to progress this work stream and a quality impact assessment has been approved by the EOC Clinical Governance group.

3.32 The Assistant Quality Improvement Manager presented a paper to the Clinical Review Group with a proposal to remove the Neutropenic Sepsis / Addison's Disease SOP, which had already been recommended by the EOC and 111 clinical governance group. The Clinical Review Group noted that NHS Pathways now has a clear system route to process these types of calls to an appropriate outcome and approved the removal.

Patient Safety Incident themes by Service - 111 Narrative

3.33 In the Months of June and July 2023 there were 168 patient safety events reported by 111. This is increase on incidents reported in April and May. **The primary 3 categories remain "Delay" (82), "patient treatment and care" (72) and "ICT Systems" (7).**

3.34 Increased reported incidents during this period of poor patient experience and duplicate 111 calls after directing patients to the Community pharmacy Consultation Service (CPCS). Locality manager assigned to all incidents who is in regular contact with community pharmacy teams and commissioners. The information with the report is being shared monthly with the regional pharmacy commissioning team, to monitor improvement and use of the CPCS scheme. HCP process for pharmacy to contact GP directly has been shared with all CPCS providers.

3.35 NHSE are exploring options for pharmacists and other HCP to use the 111 online function. This stemmed from an incident reported by 111 highlighting a pharmacist attempt to use 111 online to refer in. While this is not currently accepted practice, it was recognised that this is a potential method for onward referral to improve CPCS function with minimal operational and resourcing burden.

3.36 Additional learning actions implemented by EOC/NHS111 during the reporting period include:

a) Shared Learning - Racial Equality Within Healthcare added to CCC educational resources on the hub – 2 June 2023
b) New EOC Directive Issued 5 June 2023 – Directive 10 – 2022 Nature of Call Selection V2. Highlighted a new nationally mandated C1 NoC for an unconscious pregnant patient over 20 weeks gestation.
c) New shared EOC/111 Directive issued 16th June 2023 Directive 4 – 2021 Injury, Bruising to Non-mobile Infants/Children V2. After review by the Safeguarding

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team, this Directive was updated to include any injury to any non-mobile paediatric patient.

d) New shared EOC/111 Directive issued 21 June 2023 Directive 2 – 2023 Safeguarding Child Protection Information Sharing. This Directive was issued outlining the correct departmental processes to identify any potential CP-IS Alert, and the appropriate safeguarding action required.

e) Shared Learning - Anonymised Case Study - Complex Call. Shared 30 June 2023.

f) EOC Quick Quiz in June 2023 – Cascaded 30 June covering Careline contacts, child protection information sharing, safeguarding referrals, injuries in non-mobile infants and other children, unconscious pregnant patients and declared abnormal physiological observations.

g) CCC Education factsheet - NHS launch of a new national shingles vaccination programme from 1 September 2023, shared 6 July.

h) 'Take Note' bulletin disseminated re assessing level of consciousness on 28 July.

i) EOC Quick Quiz in July 2023 – Cascaded 31 July covering the utilisation of declared physiological observations, normal and abnormal physiological observations, the relevance of nausea/vomiting and clamminess/sweatiness during episodes of chest pain, worsening advice, remote observer calls including care line calls, and locating AEDs.

Patient Safety Incident themes by Service - Emergency and Urgent Care (E&UC)

3.37 In total there has been 405 patient safety incidents reported in June (190) and in July 2023 (215) this equates to an increase of 26% from April / May 2023, this is in line with the increasing demand throughout the trust in this period. The higher number of patient safety reports being completed supports an increased confidence in staff to report concerns, with the severity of cases remaining low with 396 incidents being logged as low or no harm.

3.38 **The top three reported categories for 999 patient safety events during June / July 2023 were Patient Treatment / Care, Delay and Medicines**.

3.39 41% 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.

3.40 Reducing delays is an area of focus in the trust and there is a plan monitored as part of the improvement programme.

3.41 The highest number of incidents reported under medicines is the subcategory of missing from modules (stock taking error). In cases of wrong administration of medication risk grading for these incidents remains low with all incidents graded as low or no harm.

Patient Safety Incident themes by Service - NEPTS

3.42 There were a total of 112 patient safety incidents for the months of June and July 2023 with 61 occurring in June and 51 in July. All incidents are graded as low or no harm apart from one injury that has been upgraded following patient outcome information received.

3.43 **The top 3 categories were Slip, Trip and Fall (28), Patient treatment/care (20), Ill Health (14).** Slip, Trip and Fall incidents were low/no harm. 30% falls were patients who had fallen prior to or on arrival of crew.

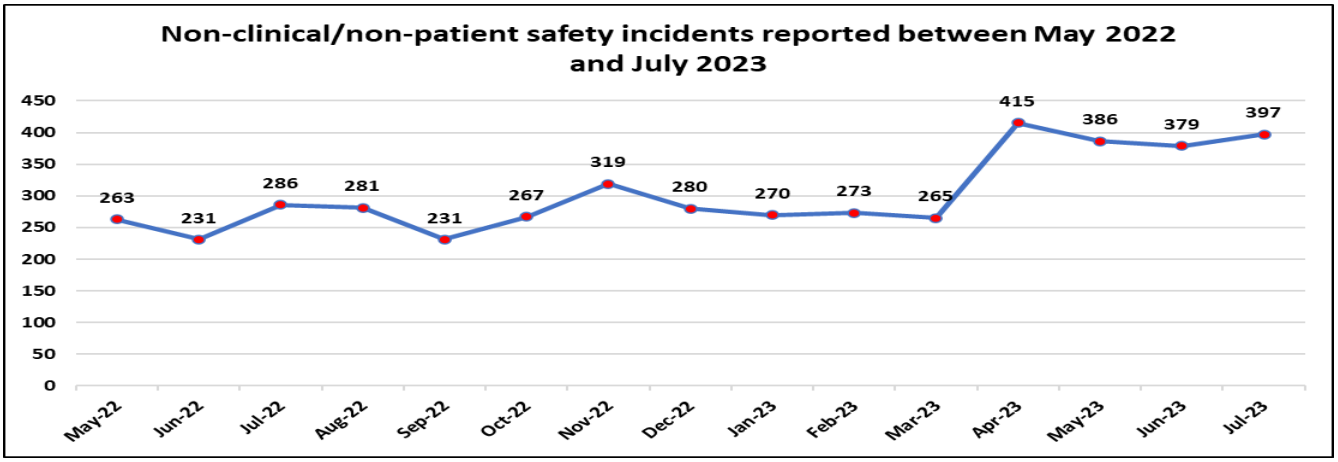
3.44 Patient treatment cases were all low/no harm incidents. Just over half relate to poor standards of care witnessed by crews. 25% relate to failed discharges and the remaining cases relate primarily to lack of information given on the booking.

:

3.45 Ill Health cases were all low/no harm 30% of patients became unwell during conveyance and 50% of patients unwell on arrival of crew, care escalated to 999 as appropriate depending on care setting.

Patient Safety Incident themes by Service - Non-clinical/Non-patient safety incidents

3.46 The number of reported incidents trend is upwards recognising the campaigns to support staff to report.



3.47 **Abuse/abusive behaviour incidents are the top reported category. These are mostly low or no harm incidents,** but reporting is encouraged. The sub-category with the highest number of incidents is verbal abuse.

Health and Safety

3.48 **Utilisation of the body worn cameras is a key focus. Staff feedback on the mounting and fixings and a task and finish group set up to review the camera mounts/ fixings.**

3.49 The trial is in three phases and will conclude in October 2023 and be shared with the Violence Prevention Reduction group.

Patient Experience (PE) and Engagement

3.50 The Patient Voice panel is open to expressions of interest for chairs of the groups on Assemble (volunteer recruitment platform) and social media platforms. To date two chairs applications have been and 15 others for the consult and participation roles.

3.51 Trust wide there was a 17% increase in the total number of PE contacts raised (666) - 335 in June 331 in July when compared with the previous two months (568). The Trust received 90 new formal complaints, 160 informal concerns and 416 HCP feedback requests during June and July 2023.

3.52 652 cases were responded to and closed during the same period, of which 69% (447 cases) were either fully or partly upheld when the investigations were concluded, meaning that in seven out of ten cases the complaint was justified in full or in part.

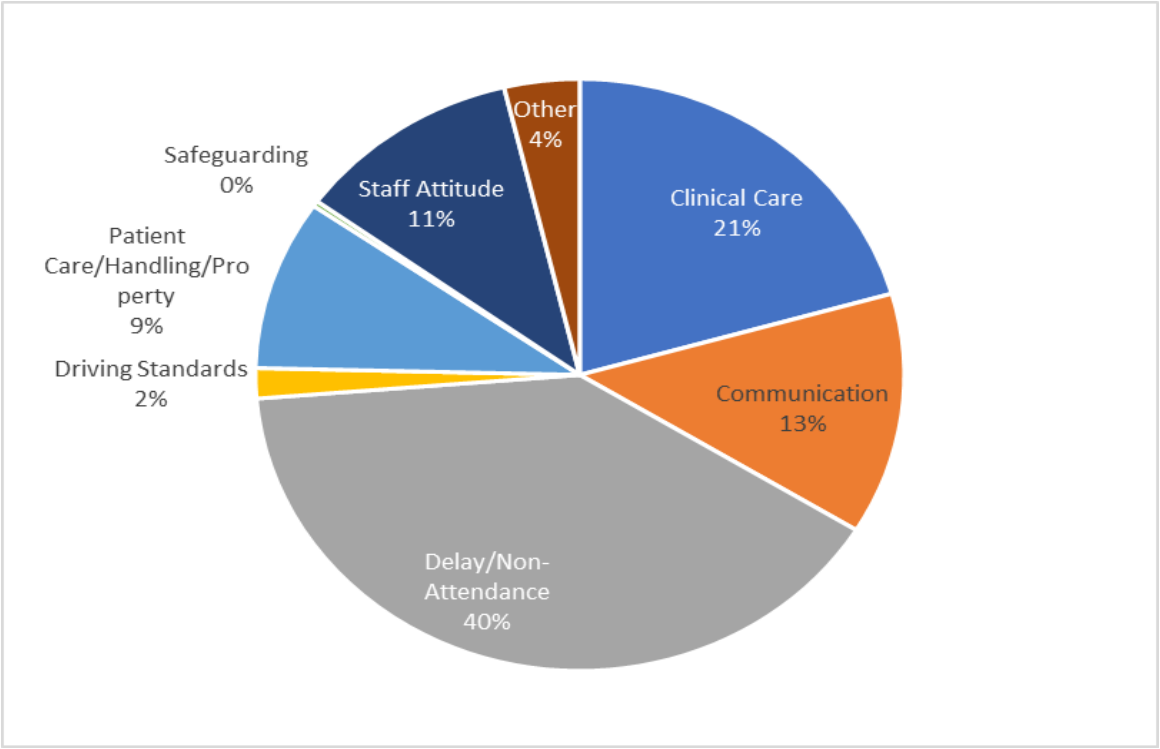
PE Contacts June/July	2022/23	% of Trust Total	% change from previous two months
NHS 111 incl GP CAS pilot	**128**	19	Down 1%

:

PTS – Patient Transport Services	**370**	51	No change
999 Operations	**110**	17	Down 3%
EOC	**56**	8	Up 4%
Mental Health Triage Service	2	0.1	No Change
Trust total	**666**	**100%**	**Up 17%**

3.53 999 Operations - there was a 3% decrease in PE cases raised in this reporting period. 35% of these cases were regarding clinical care. 29% of the cases were regarding Staff attitude and communication, a small increase from the previous two months.

3.54 The chart below shows the % of PE contacts received Trust wide by subject for June and July 2023. The highest proportion (40%) remains delay.



3.55 The graph shows the number of PE contacts received by type.

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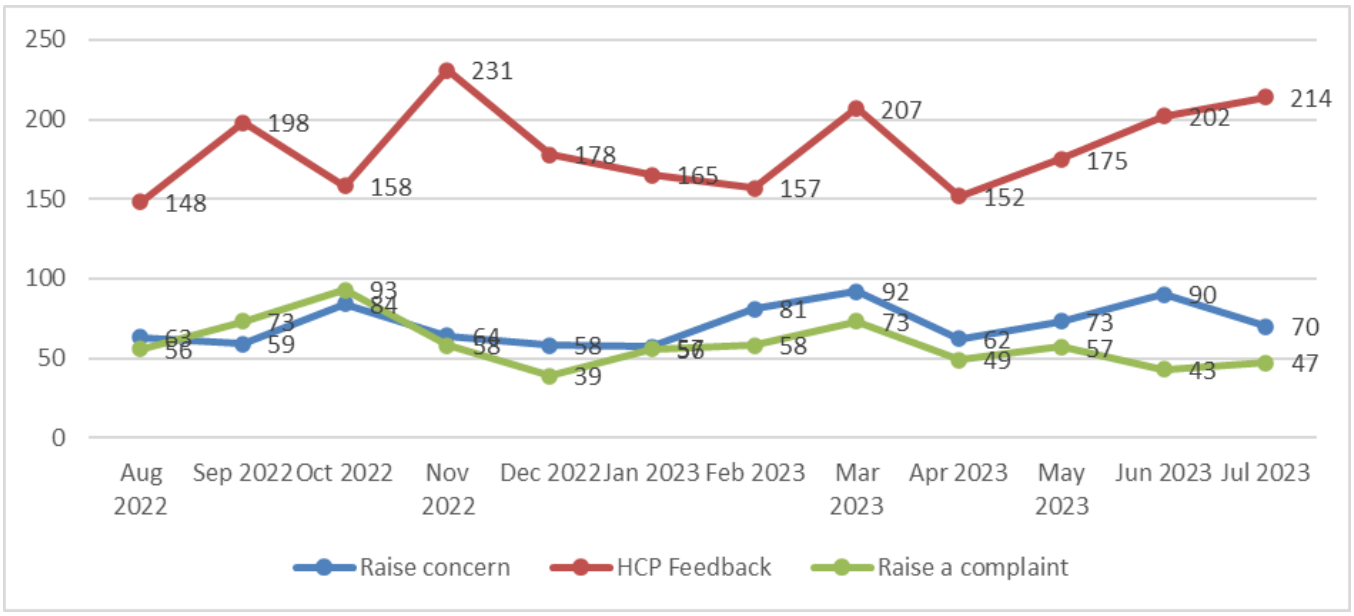
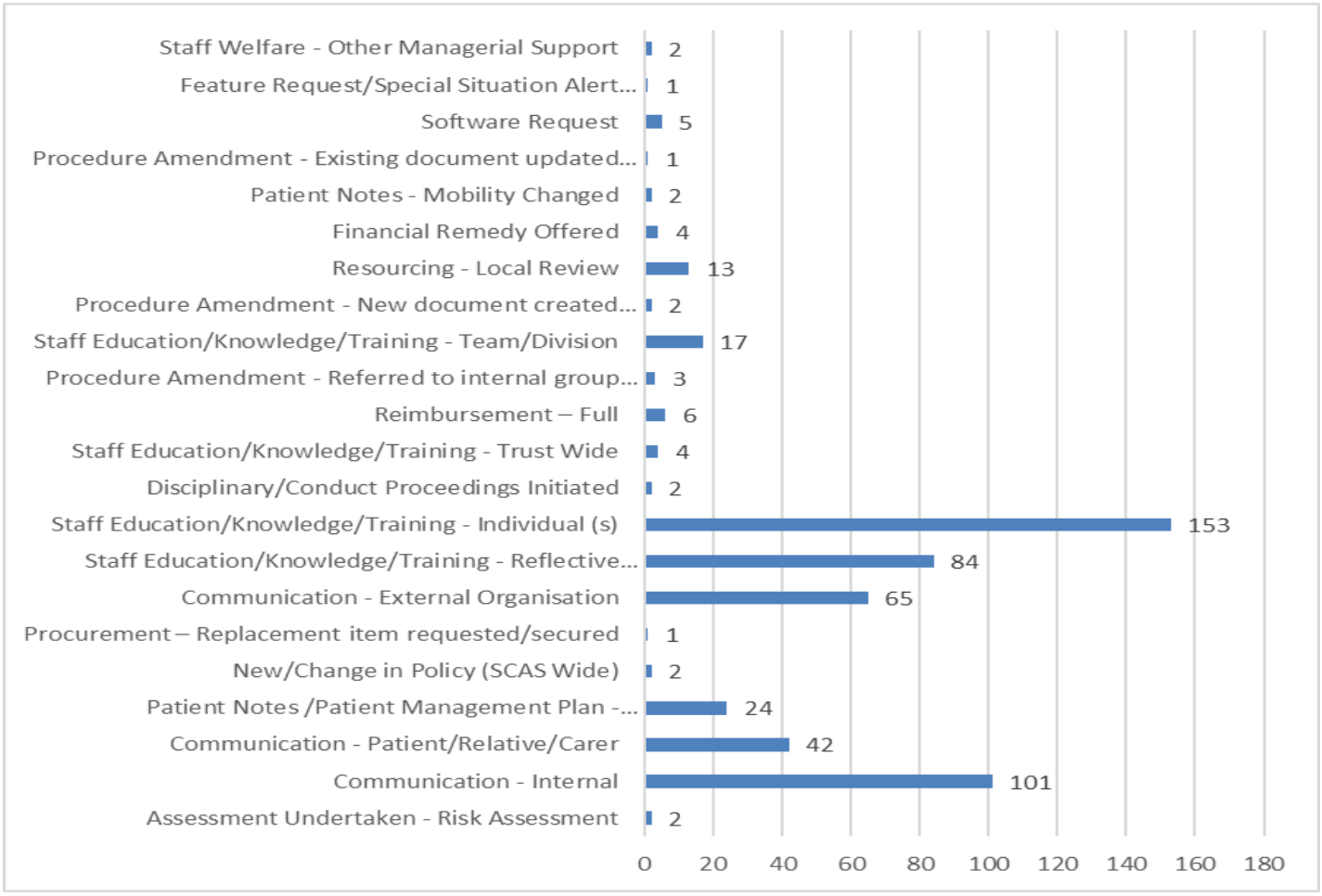


3.56 The table below demonstrates some of the learning outputs and actions taken from feedback.



Parliamentary & Health Service Ombudsman (PHSO)

3.57 The Trust currently have 3 cases with which the PHSO is currently completing a full investigation. This is a decrease on the 7 cases that were being considered.

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3.58 Compliments: the trust received 236 compliments for the care and service delivered by our staff in June and July 2023. Compliments are shared with the staff concerned and their line managers.

4. Recommendations

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

Name and Title of Authors:

Date: September 2023

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**NHS England: Briefing to Board following the NHSE letter re Lucy Letby case (Countess of Chester Hospital case / enquiry)**				
Report to:	**Public Trust Board**				
Date of Meeting:	**Thursday, 28 September 2023**		**Agenda Item:**	**13**	
Executive Summary:	This is to provide Board with an update in relation to the NHSE letter dated 18th August 2023, Verdict in the trial of Lucy Letby, Publication reference: PRN00719 NHS England, Verdict in the trial of Lucy Letby.				
Recommendations:	In response to correspondence received from NHS England (18 August 2023) about the Lucy Letby case, this paper provides assurance to the Trust Board on the policies and processes in SCAS that enable staff to raise concerns without fear of detriment. The paper also outlines the progress in a positive safety culture at SCAS and the implementation of the Patient Safety Incident Response Framework (PSIRF) and the Trust's approach to the Fit and Proper Person Test (FPPT) Framework published by NHS England on 2 August 2023 in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT.				
Executive lead:	Melanie Saunders, Chief People Officer Helen Young, Chief Nursing Officer				
Report author:	Simon Holbrook, FTSU Lead Guardian Helen Young – Chief Nursing Officer				
Previously considered by:	None				
Purpose of report:	Note ☐	Approve ☐	Assure ☒		
Paper Status:	Public ☒	Private ☐	Internal ☒		
Assurance level:	Significant ☐	Acceptable ☐	Partial ☐	No Assurance ☐	

	High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives	No confidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				

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

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

- implement any recommendations as result of these discussions whilst we await a government commissioned review into the LL case (Legal powers given to Lucy Letby inquiry - GOV.UK (www.gov.uk))

List of Appendices:

NHS England » Verdict in the trial of Lucy Letby
NHS England Letter, dated 18th August 2023

Background

In August 2023, the jury in the trial of Lucy Letby, a neonatal nurse at the Countess of Chester Hospital, returned a guilty verdict and a sentence of life imprisonment for murder and attempted murder was handed down by the presiding Judge.

In a statement responding to the verdict, the parliamentary and health service ombudsman said that 'nobody listened' to the clinicians at the trust who had tried to raise concerns. A full public inquiry into the circumstances of the Lucy Letby case has been ordered by the government, which will include the handling of concerns and governance.

On 18 August 2023, the NHS England Executive Team wrote to all Integrated Care Boards and NHS Trusts regarding the outcome of the trial and reiterating the necessity of good governance along with assurance of proper implementation and oversight.

The letter reiterated commitment to prevent 'something like this happening again' and outlined the steps that had already been taken to strengthen patient safety and monitoring, namely the national rollout of medical examiners and the forthcoming implementation of the new Patient Safety Incident Response Framework.

The letter also recognised that NHS Boards must ensure proper implementation and oversight, specifically ensuring the following:

- All staff have easy access to information on how to Speak Up
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to it
- Approaches or mechanisms are put in place to support those members of staff where there may be specific barriers to speaking up. These include cultural barriers, those in lower paid roles who may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or process supporting speaking up
- Methods for communicating with staff to build healthy and supportive cultures where everyone feels safe to speak up should also be put in place
- Boards should seek assurance that staff can speak up with confidence and that whistle-blowers are treated well
- Boards are regularly reporting, reviewing and acting upon available data

The letter also referenced the expectation that by January 2024 all organisations providing NHS services should have adopted the updated, strengthened Freedom to Speak Up policy, and reiterated the obligations of all NHS organisations under the Fit and Proper Person requirements.

Patient Safety Incident Response Framework (PSIRF)

The National Patient Safety Strategy, safer culture, safer systems, and safer patients was launched in July 2019 by NHS England and NHS Improvement. Part of this Patient Safety Strategy was the national development of PSIRF; this was delayed during the pandemic and published in August 2022.

The four key aims of PSIRF are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement.

PSIRF is a contractual requirement under the NHS Standard Contract and will be launched in SCAS during 2024.

Safety Culture

SCAS is on a journey of improvement, including specifically addressing safety culture and implementing a Just and Learning Culture.

The following meetings and reports have been put in place to develop patient safety across the Trust:

- Daily reviews of Datix by Patient Safety Team shared with Clinical Directors
- Weekly safety review panel chaired by DCMO which reviews incidents which may have caused harm
- Weekly Incident Review Panel chaired by Executive Clinical Director to review all incidents which may have met the NHSE criteria for a serious incident
- Learning from Experience reports to Pt Safety and Pt Experience Group and Quality and Safety Committee
- Monthly Pt Safety and Pt Experience Group
- Monthly Safeguarding Committee covering allegations against staff
- Monthly reporting to Board on allegations against staff
- Monthly meeting with CNO and Lead for Professional Standards reviewing open cases pertaining to professional conduct
- CMO chaired learning from deaths review group
- Continue working closely with our FTSU Guardian team and processes

Fit and Proper Persons

NHS England has developed a Fit and Proper Person Test (FPPT) Framework published in August 2023 in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review).

This takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

The framework will introduce a means of retaining information relating to the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a standardise mechanism for completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The Framework will be effective from 30 September 2023.
SCAS Chief Governance Officer and the Chief People Officer have implemented a series of actions to ensure SCAS is compliant.

Actions from letter	SCAS Position
	✓ SCAS FTSU policy was refreshed during Q3 2022/2023

All staff have easy access to information on how to speak up.	✓ FTSU team attend all SCAS and University inductions ✓ Continued increase presence of FTSU team via Walk about Wednesdays, Speakupulance site visits, team meetings and surveys ✓ FTSU Posters and merchandising refreshed and widely available ✓ FTSU Hub, yammer and Viva engage pages regularly updated ✓ SCAS committed to mandating all three NHSE eLearning modules this FY, being tracked and compliance continues to rise. ✓ As of 21/009/2023 compliance was reported as: o All workers (Speak up) = 80% (4116 compliant from 5144) o Managers (Listen up) = 83% (388 compliant from 467) o Managers of managers (Follow up) = 61% (57 compliant from 99)* *NB there have been issues with this module running correctly, it has been confirmed these are national issues. ✓ We have innovated with a step wise approach giving staff 'permission' to have peer to peer conversations ✓ FTSU high level data feeds into people voice repository ***Areas for development:*** Revised Policy based upon new NHSE guidance going to consultation in October 2023 (to coincide with Speak up month) also supported with improvement plan and strategy. Feedback received that policy can be hard to find for some (in the "HR section" and "co-authored by HR"
Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the	✓ SCAS has supported this national scheme since its inception and each round of publicising it, this is publicised by both the FTSU team and the HR teams, the FTSU team have supported individuals to contact the national Speaking Up Support Scheme

national Speaking Up Support Scheme and actively refer individuals to the scheme.	
Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place	✓ FTSU hosted by OD team and work closely with ED&I lead ✓ FTSU member of ED&I steering group ✓ Close active links with Staff Networks ✓ FTSU (focussing on listening up) SCAS leaders module ✓ Managers case template with timelines in use and effective and this will be added in the new policy ✓ Leaders and managers undertaking eLearning, SCAS Leader and ESPM ✓ FTSU Champions recruited from wide range of backgrounds including those from vulnerable groups. 27 in total thus far. ✓ FTSU Telephone management ensures resilience and case balancing ✓ We communicate with people at F2F interactions that we will work flexibly to listen to people. ✓ FTSU team invited to be part of and have been promoting J&L, civility and PSIRF workstreams ✓ FTSU team also work closely with the Safeguarding, Clinical, Health and Wellbeing and HR teams ✓ Amy Edmondson and Megan Reitz models on psychological safety underpin our work, models and processes. ***Areas for development:*** ✓ A historical culture of futility is a barrier we are working hard to reduce.
Boards seek assurance that staff can speak up with confidence and whistle-	✓ FTSU regularly reports to Board and PACC meeting ✓ NHSE self-assessment has highlighted areas of focus including team resources (principle 2 and 6) and detriment (principle 7)

blowers are treated well.	✓ National Speaking Up Support Scheme communicated and supported ✓ We interrogate National Staff Survey & Model Health systems data, both for our services internally and build slides / share information externally with our regions and the AACAE NAN networks ✓ -HIOW FTSU lead independent review of practices and self-assessment as part of our improvement programme. ✓ National Guardian, Dr Jayne Chidgey-Clark, attended trust board in Q1 ✓ BDO report presented to trust board in 2021 ✓ Next external auditors' cycle for FTSU due to start in Q4 ✓ NSS results and sub scores monitored and interrogated ✓ Sub scores will be monitored through year as part of internal surveys ***Areas for development:*** Opportunity for Policy (NHSE) going to consultation in October 2023 (to coincide with Speak up month) also supported with improvement plan and strategy. Following a number of SCAS driven workshop events regionally and nationally, and with consideration of the Protect Guidance purchased, detriment is now included in the policy consultation planned for October 2023 Team resources - in current climate several business cases have been rejected, however the secondment position has been further extended until April 2024 Boards and leaders have opportunity to own / set the tone and drive this into / through the organisation. Independence of the FTSU role FTSU steering group - has been discussed and agreed in principle. Following a number of SCAS driven workshop events regionally and nationally, and with consideration of the Protect Guidance purchased, detriment is now included in the Policy consultation planned for October 2023

	The National Guardian, Dr Jayne Chidgey-Clark is a member of the national steering group and has already highlighted that the forthcoming Leadership Competency Framework, will put listening and learning at the heart of governance.
Boards are regularly reporting, reviewing and acting upon available data.	FTSU report twice a year, more regular reporting is provided to the PACC (board sub-committee). Data triangulated with Model hospital data ***Areas for further development:*** Consider FTSU be present more frequently and at wider group of committees, e.g., EMC, Trust Board Regular communications remain a challenge given capacity Build spec with BI for 'one press' for FTSU data / FTSU dashboards to ease reporting / access to data Board and EMCC to remain inquisitive. New CQC assessment framework

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Chief Medical Officer's Board Report**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**14**
Executive Summary:	The purpose of the paper is to update the Board on key clinical issues relating to: • SCAS Clinical Research Update • Ambulance Clinical Quality Indicators (ACQI) • Adult Critical Care Transfer Services (ACCTS)		
Recommendations:	The Trust Board is asked to note the report.		
Executive lead:	John Black Chief Medical Officer		
Report author:	Jane Campbell - Assistant Director of Quality Martina Brown - Research Manager John Black - Chief Medical Officer		
Previously considered by:			

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

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

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

Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations):	
List of Appendices: **Appendix A: SCAS Adult Critical Care Transfer Service Stakeholder Feedback**	

South Central Ambulance Service NHS Foundation Trust

PUBLIC TRUST BOARD PAPER

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

1. Purpose

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

- SCAS Clinical Research Trials
- Ambulance Clinical Quality Indicators (ACQI).
- Adult Critical Care Transfer Services Stakeholder Feedback

2. Executive Summary

- **SCAS Clinical Research Trials update**

Ongoing trials:

- **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 takes place in non-emergency community setting (nursery schools, GP, community locations) by the SCAS core research team, currently concentrating on enrolments of the lower age group under this protocol.

- **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.
    - Patient enrolment is impacted by ePR/ Business Continuity Incident (BCI) where the 'randomisation to treatment' link was only available on the ePR tablets. On 12 Sep 2023, the remote randomisation model was approved by the research regulator (HRA) in that response, and implemented by SCAS soon afterwards, ensuring minimal disruption to enrolment.

- **CRASH4** (IRAS 283157): Randomised, double-blind, placebo-controlled trial investigating an intramuscular tranexamic acid for the treatment of symptomatic mild traumatic brain injury in older adults in the UK.
    - SCAS is continuously the highest patient recruiter nationally.

- **PARAMEDIC3** (IRAS 298182): Randomised trial designed for an adult out-of-hospital cardiac arrest patients and compares the clinical and cost- effectiveness of intraosseous and intravenous access first strategy.
    - SCAS patient recruitment continues satisfactorily.

- **HARMONIE** (IRAS 100580); commercial sponsor: Randomised clinical trial where 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.
    - All enrolled now in follow up stage.
    - Extension to the follow up stage is expected to be approved by the national regulator MHRA and HRA.

- **PARAID** (IRAS:327727): Paramedic delivery of end-of-life care: a mixed methods evaluation of service provision and professional practice
    - Questionnaire to paramedics staff only.

- **PROMOTED** (IRAS 322930): What are the barriers to health promotion advice delivered by staff working in urgent care and emergency departments?
    - Questionnaire to paramedics staff only.

Collaboration invitations received from partner organisations (to co-author research proposal & funding bid)

- **'STALLED' study**: Safety, clinical, system effects and costs of ambulances queuing with delayed patient handovers at emergency departments.
    Aim: Investigations surrounding reducing delayed handovers at A&E (such as QA Portsmouth)

- **'BETTER' study**: Bringing excellence to the emergency department: a realist evaluation of end-of-life care.
    - Aim: To develop practical guidance for delivering excellent end of life care in ED.

Commissioned Evaluation

- 'Take Home Naloxone (THN) nasal spray pilot' programme has started to be delivered at selected locations across SCAS.
    - The SCAS pharmacy team has secured funding for the supply of the medication (THN nasal spray), at no cost to the Trust.
    - The SCAS research team has secured a consultancy evaluation agreement of this pilot programme, starting in Nov 2023 (duration 1 year).

Published work and authored of academic output in Q2/2023-4

- 'Trends in use of intraosseous and intravenous access in out-of-hospital cardiac arrest across English ambulance services: A registry-based, cohort study' (**Appendix 1**)
    - Co-authored by Prof Charles Deakin and Martina Brown
    - https://www.sciencedirect.com/science/article/pii/S0300957223002654

- 'Cardiac arrest bundle of care trial (CABARET) survey of current UK neuroprotective CPR practice '(**Appendix 2**)
    - Co-authored by Martina Brown, Helen Pocock and Prof Charles Deakin
    - https://authors.elsevier.com/sd/article/S2666520423001157

Business Continuity Incident (Ortivus ePR Failure)

- BCI continues to hinder smooth collection of research data for research projects contracted to be deliver.
- Transcription errors (various data fields machine verified) found in patient documentation (all incidents Datixed)

Funding

Excess Treatment Costs (ETCs) SCAS' threshold for 2023-2024 has been set by the national Integrated Care Board ETC payment system at historical minimum of £1500.

- ETC are the costs incurred by NHS trusts involved in delivering non-commercial clinical research, in particular when the BAU treatments given as part of delivering studies are more expensive than the care/treatment that the participants would have normally received. Therefore, this model 1) assists the trust to have BAU costs reimbursed and 2) the patient receives an opportunity to engage with a research care pathway.
- The 2023-24 is the last financial year when the NIHR CRN Wessex will reimburse the qualifying cost to SCAS. SCAS steering group will seek alternative reimbursement pathways in lieu of this cost.

- **Ambulance Clinical Quality Indicator (ACQI) Exception Report**

The submission for the national ACQIs care bundles has been delayed due to the electronic patient record outage. There is a plan in place so that when records are available all audits will be completed.

The submission can be made when the window for resubmission opens in January 2024.

Commentary for individual ACQIs is recorded in IPR.

- **Adult Critical Care Transfer Services (ACCTS) Stakeholder Feedback:**

A recent Stakeholder survey attracted a 96.6% satisfaction level with the service – see **Appendix A** for details. There were 42 responses across the Wessex/TV area.

Areas for improvement regarded 24 hours access as currently the contract for a 12 hour/day provision (10:30-23:00hrs) and the introduction of an on-line referral system (Referapatient) has generated some user concern, however this may be due to lack of familiarity with the system.

Contract negotiations / service specifications with NHSE in collaboration with SECAMB/BHT are on-going in relation to establishing a substantive service from April 2024.

3. Recommendations

The Board is invited to note this report.

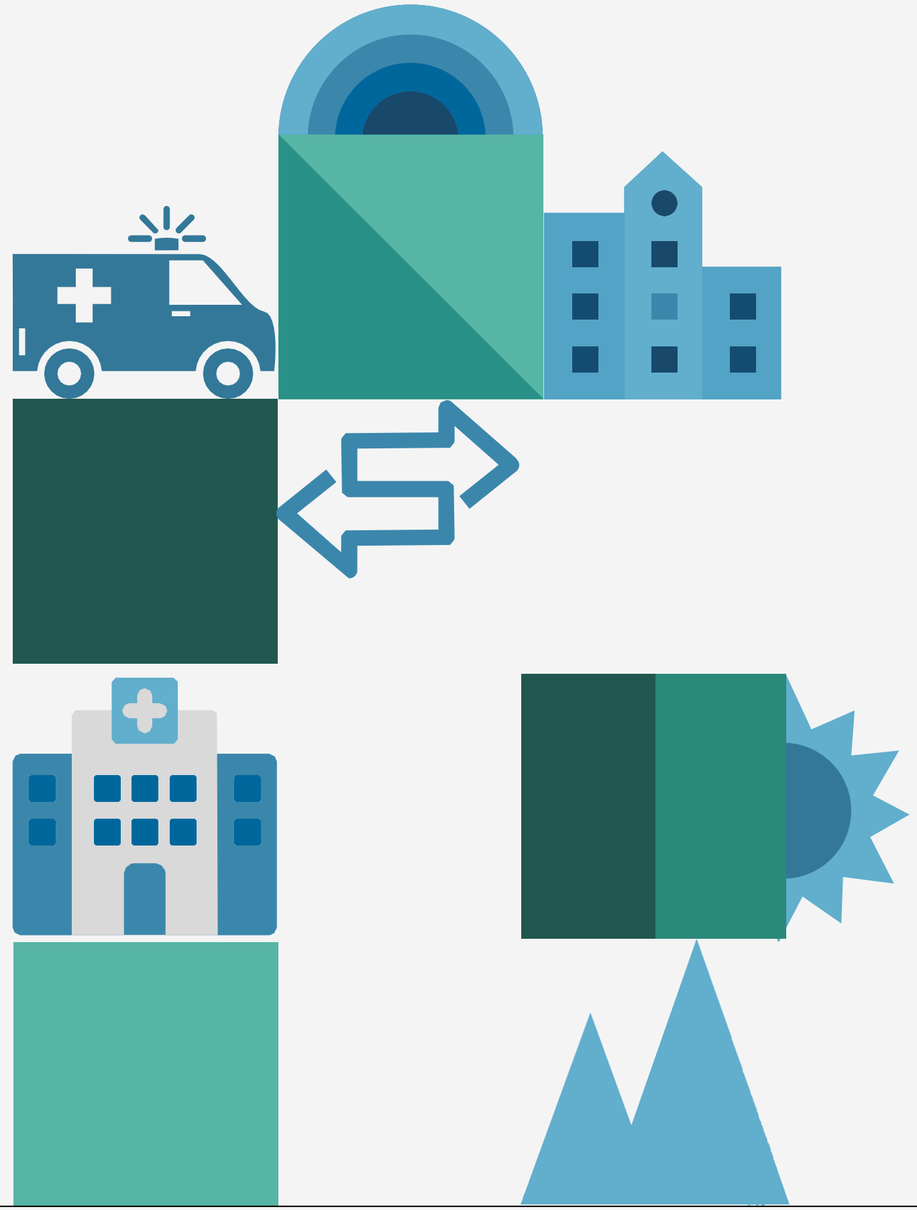
Name and Title of Author:
John Black
Chief Medical Officer

Date:
19th September 2023

Appendix A:
Stakeholder Feedback on SCAS Adult Critical Care Transfer Service

Thames Valley & Wessex
Critical Care Network

DRAFT – ADULT CRITICAL CARE TRANSFER SERVICE

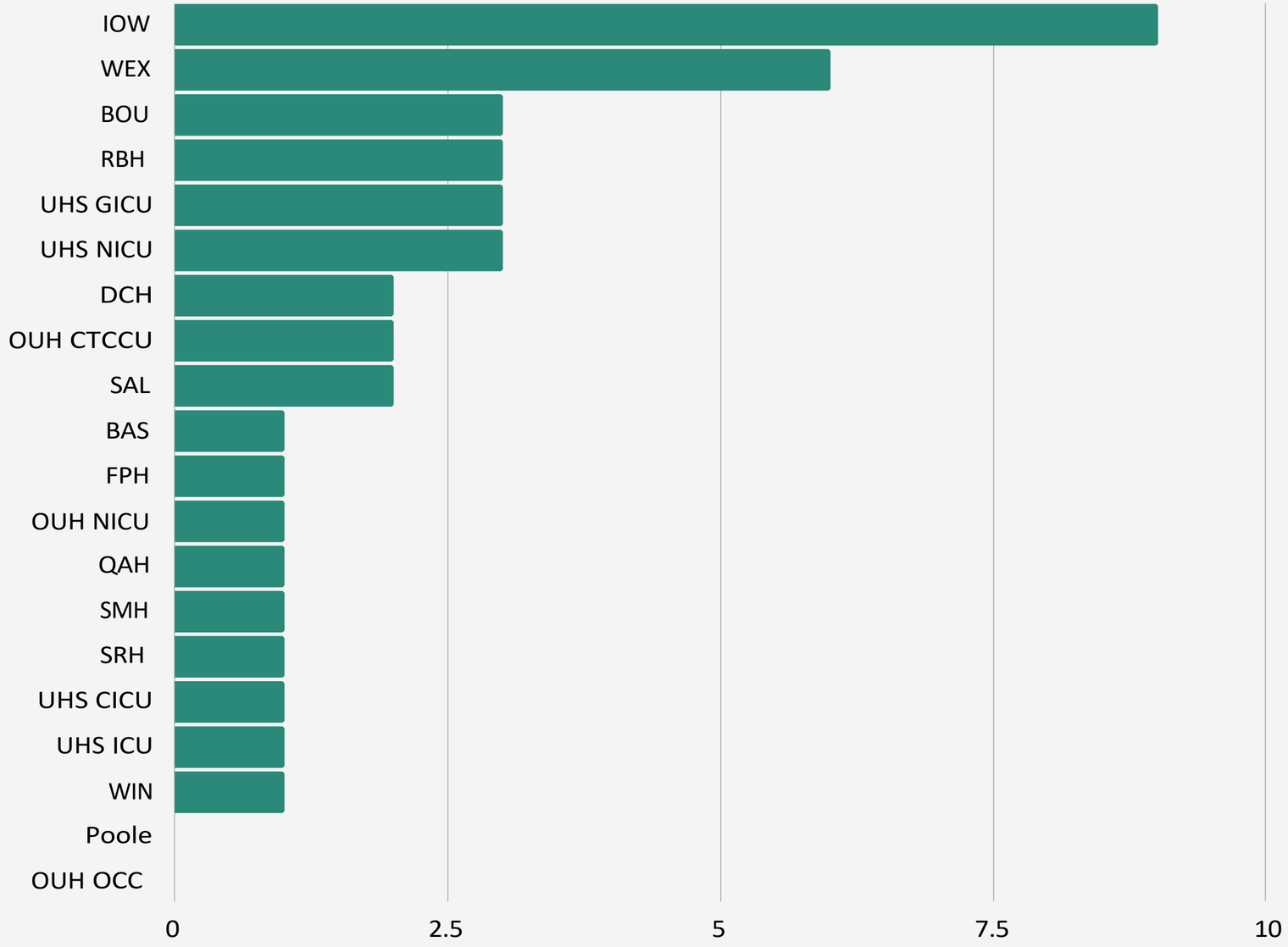


Unit Feedback Survey 2023

Survey Response Rate

Response rate across the network varied with 2 units not responding to the survey at all.

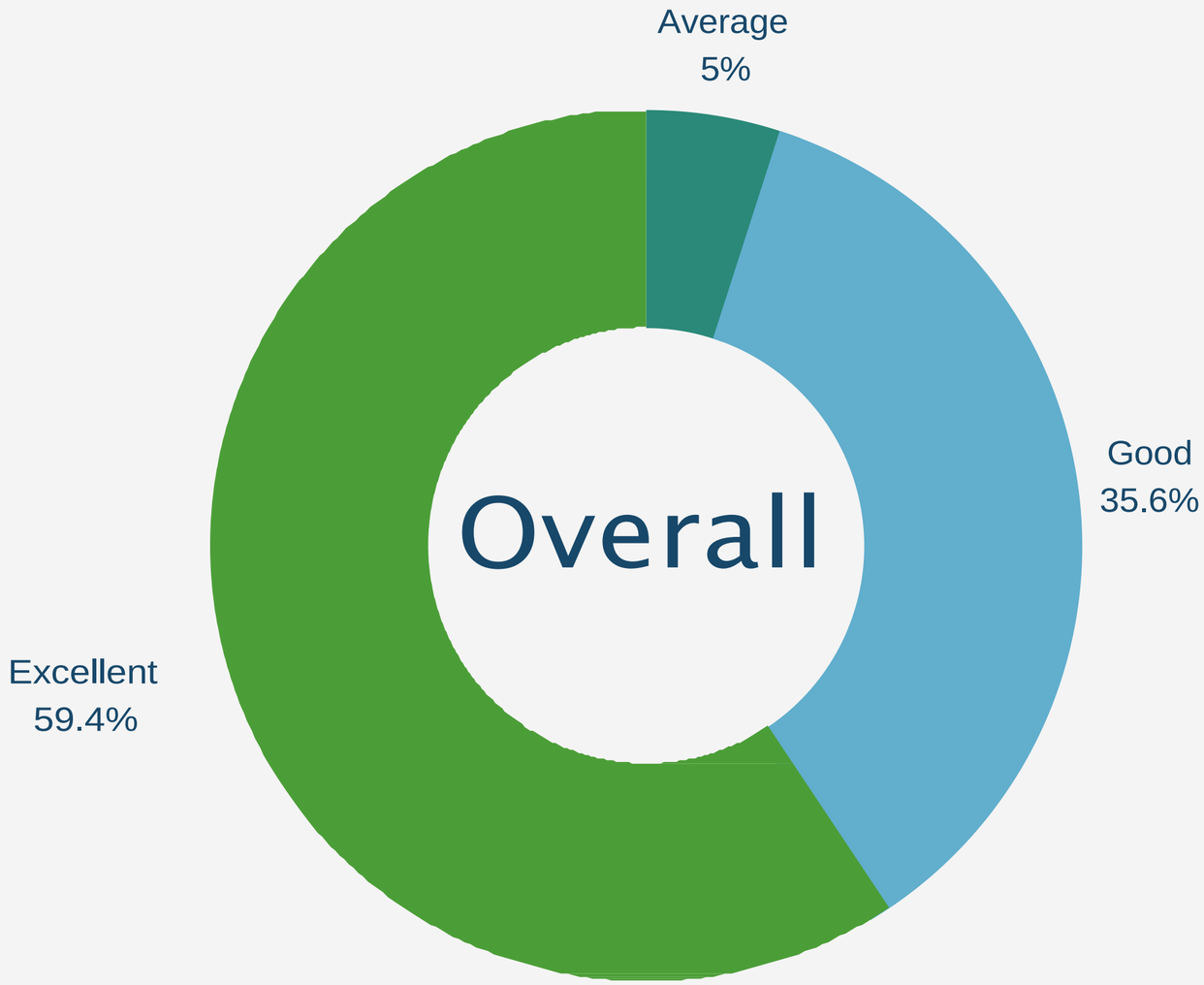
There were 42 responses overall.



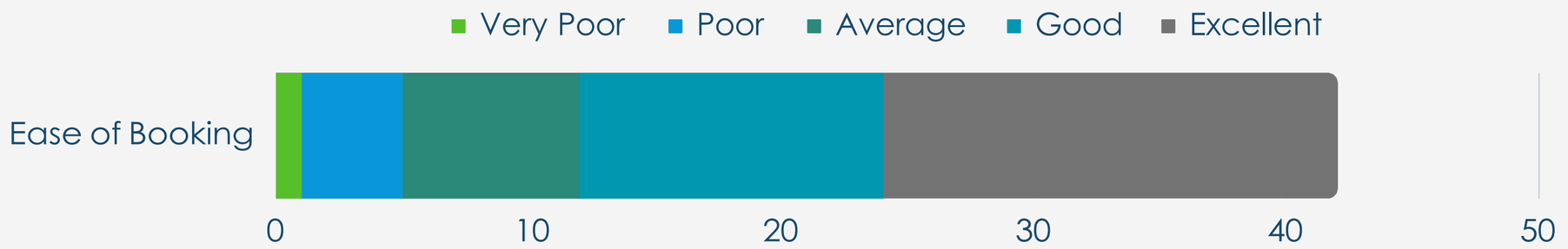
Rate the Service

Overall, every response to the survey rated the service as Average or above. With 96.6% rating it as good or excellent.

Of those who rated the service as Average they encountered some difficulties with Communication, Availability and Out of Hours need.

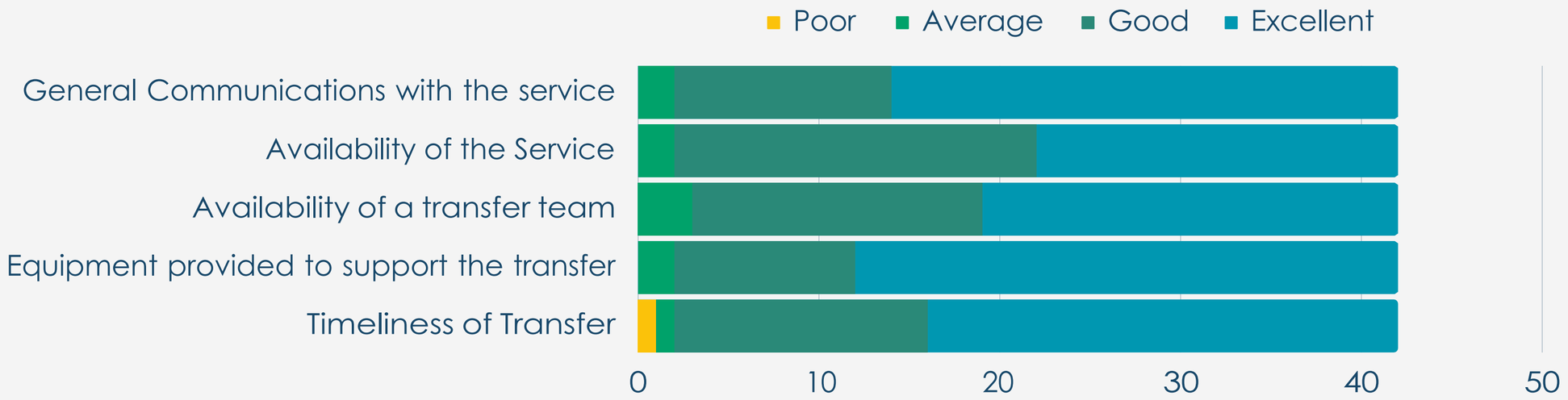


Rate the Service



Ease of booking was rated the lowest of all the assessment categories with 71% of responders rating Ease of Booking as either good or excellent. Comments highlighted that the main problem with booking is the form. This was described as very long and complicated. Also, the need for mobile network when this is not accessible in some hospitals.

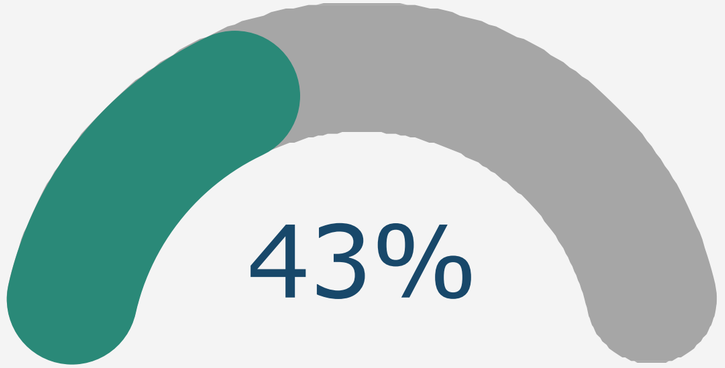
Rate the Service



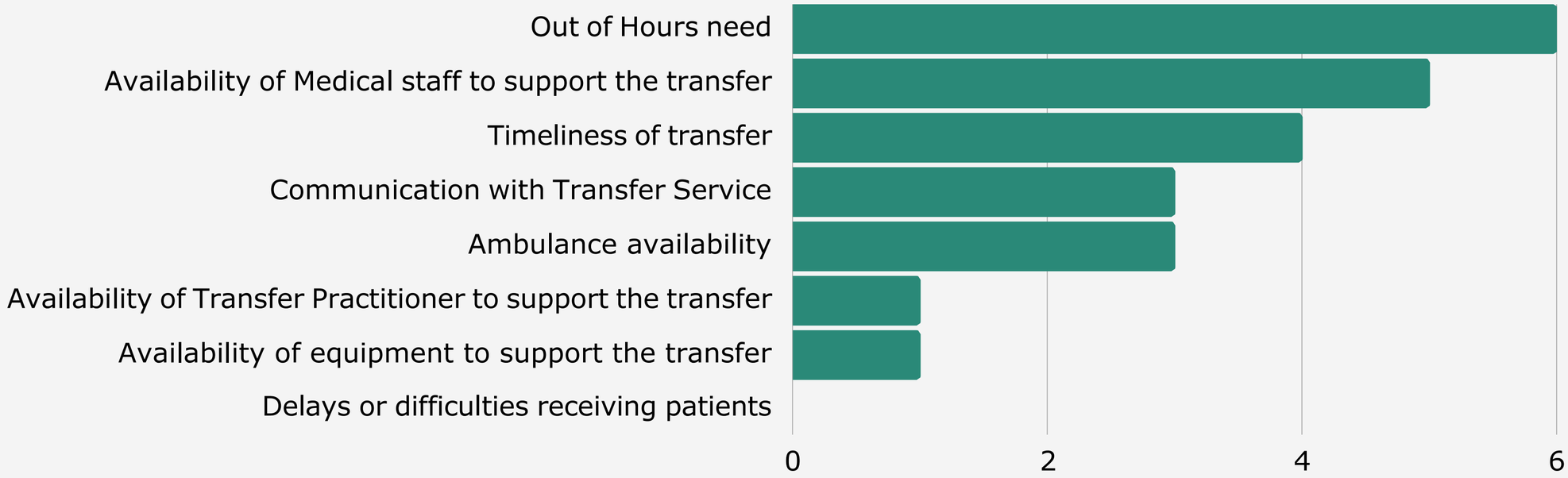
The above 6 assessment categories received a similar rating of good and excellent (around 95%). There was some variation in the split between good and excellent with Equipment receiving the most 'Excellent' ratings and availability receiving the most "Good". Timeliness also received 1 poor rating which specifically focussed around the service start times.

Any Difficulties?

Reported that they encountered difficulties using the Adult Critical Care Transfer Service (within the last year)



Difficulties



Out of hours need was rated as causing the most difficulties, followed by the availability of medical staff. However, it is important to note that there were 7 comments in the "Other" category about the new referral form and how long and time consuming it is.

Benefits

Some of the comments:

- Dedicated team - not losing staff to the transfer
- Skilled and profession team – trust the patient is in safe hands
- Good availability
- Dedicated Equipment
- Reduce variability of care during transfers

Improvements

Some of the comments:

- Improve the referral form
- Extension of hours
- Education - for trainees and unit staff

Additional Comments

Fantastic, helpful team who have really helped us out.
Thank you.

We are very grateful for the transfer team, they have completely saved our unit on many occasion at times of desperate need!

Brilliant service.

Thank you for the service you provide.

This has been a fantastic service

Professionalism of the CC Transfer Service is exemplar

It is an outstanding service that has materially benefitted the patients of TV&W!

Keep up the good work

No other comments. The service overall is great.

The transfer team themselves are skilled and have evolved as a team and so interactions are now smoother.

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Council of Governor Elections**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**15.a**
Executive Summary:	This report provides an update on the Council of Governor elections. Nominations open on Thursday 28 September, voting between Friday 17 November and Tuesday 12 December.		
Recommendations:	The Trust Board is invited to **note** the report.		
Board lead:	Daryl Lutchmaya, Chief Governance Officer		
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: N/A

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING PAPER

Title	Council of Governors Election
Author	Daryl Lutchmaya, Chief Governance Officer
Responsible Director	Daryl Lutchmaya, Chief Governance Officer
Date	28 September 2023

1. Purpose

The Trust holds Governor elections each year to fill any vacant seats on the Council of Governors and/or to open up seats in relation to those Governors whose terms of office are ending. The election is run by an independent, external election company, Civica Elections Service Ltd.

The overriding duty of the Board of Directors is to be collectively and individually responsible for promoting the success of the NHS Foundation Trust so as to maximise the benefits for the members of the NHS Foundation Trust as a whole and for the public. This means the Board is focused on providing high-quality health care to the NHS Foundation Trust's members and the communities it serves. By way of contrast, the overriding role of the Council of Governors is to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors and to represent the interests of Foundation Trust members and of the public.

SCAS's membership community is made up of patients, carers, local residents, staff and the public, with members voting to elect representatives (Governors) onto the Council of Governors. Governors are responsible for representing members and the public and for engaging with them in order to represent and express their views and opinions to the Trust's Board of Directors.

In order to ensure local accountability, there are both elected and nominated Governors. Elected Governors represent members in the public and staff constituencies. Nominated Governors represent the partner organisations that SCAS works with.

2. Executive Summary

The Trust's Council of Governors is made up of 29 Governors namely:

- 16 Public Governors (elected from and by Public Members)
- 6 Staff Governors (elected from and by Staff Members)
- 1 CFR Governor (elected by members of the CFR constituency)
- 6 Nominated (Appointed) Governors (nominated from Clinical Commissioning Groups / commissioners, Local Authorities and Partner Organisations)

The Trust will be holding Governor elections in 17 seats for the following Governor vacancies:

- Public: Hampshire – 5 vacancies (6)
- Public: Oxfordshire – 2 vacancies (3)
- Public: Berkshire – 2 vacancies (3)
- Public: Buckinghamshire – 3 vacancies (3)
- Public: Rest of England -1 vacancy (1)
- Staff: 999 North – 1 vacancy
- Staff: 999 South – 1 vacancy
- Staff: 999 Emergency Operations Centre – 1 vacancy
- Staff: Patient Transport services – 1 vacancy

There are 5 empty seats being elected to; 2 in Berkshire, 1 in Buckinghamshire, 1 in RoE&W and 1 in 999 South. The remaining 12 seats being elected to, are for those current Governors whose terms are ending in February 2024.

The election process will be as follows:
Nominations open on Thursday 28 September 2023
Nominations should be received by Thursday 26 October 2023.
Contested constituencies voting will open on Friday 17 November 2023.
Voting will close on Tuesday 12 December 2023.
Declaration of Results on Wednesday 13 December 2023
Newly elected Governors to attend Induction during January / February 2024
Newly elected Governors take up roles from 1 March 2024.

3. Considerations

It is important that the Trust runs a successful election campaign in order to have full geographical and staff representation on its Council of Governors by having all of its seats filled. Equally important, is for the Trust to focus on continually growing and widening its membership base in order to ensure that those Governors who are elected, are also representative of the demographic population that SCAS serves and will help to strengthen accountability of the Council of Governors and the Trust Board.

4. Recommendations

The Board is requested to **note** this paper.

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Change to Fit and Proper Person Test Framework**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**15.b**
Executive Summary:	✓		
Recommendations:	The Trust Board is asked to:Note Key Points 1. This paper informs the Group of changes to NHS England's Fit and Proper Person Test Framework, which were introduced on 2 August 2023. They must be fully implemented by 31 March 2024. 2. The changes support the implementation of the recommendations from the Kark Review and are mandatory for all Trusts. 3. The updated framework updates existing arrangements and introduces new processes relating to retention of information, standard competencies, and reference checks. 4. The Chair, supported by the Trust Chief Governance Officer are responsible for the ongoing operation of the framework with support from the People & OD team. The Group are asked to note the contents with Board Members noting the impact on their own employment.		
Executive lead:	Melanie Saunders, Chief People Officer		
Report author:	Melanie Saunders		
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):	All Quality Domains

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

Attract, develop and retain a highly skilled, engaged and diverse workforce
Create a safe and high performing organisation based on openess, ownership and accountability

List of Appendices: Appendix A - Definition of a Fit and Proper Person & Appendix B - Fit and Proper Person Test Framework

(Regulation 5 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

South Central Ambulance Service NHS Foundation Trust

PRIVATE TRUST BOARD PAPER

Title	**Change to Fit and Proper Person Test Framework**
Author	Melanie Saunders
Responsible Director	Melanie Saunders, Chief People Officer
Date	7 September 2023

1. Summary

1.1 This paper informs the Board of changes to NHS England's Fit and Proper Person Test Framework, which were introduced on 2 August 2023. They must be fully implemented by 31 March 2024, with some changes from 30 September 2023.

1.2 The changes support the implementation of the recommendations from the Kark Review and are mandatory for all Trusts.

1.3 The updated framework amends existing arrangements and introduces new processes relating to retention of information, standard competencies, and reference checks.

1.4 The Chair, supported by the Chief Governance Officer are responsible for the ongoing operation of the framework with support from the Chief People Officer and People Directorate.

1.5 The Board are asked to note the contents with Board Members noting the requirements in relation to their employment/engagement.

2 Background

2.1 Since November 2014, NHS provider organisations have been required to meet regulatory requirements, in particular to ensure that new director level appointments meet the 'fit and proper persons test' which were integrated into the CQC registration requirements. These requirements fall within the CQC regulatory and inspection approach and are reviewed under the 'well-led' domain. The Trust have complied with this framework since its inception and have an agreed policy setting out SCAS process.

2.2 The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation, and purpose of the existing Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review included looking at how effective the FPPT is: "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors." The review highlighted areas that required improvement to strengthen the existing regime.

2.3 The definition of a Fit and Proper Person is set out in Appendix 1.

2.4 This paper sets out the changes to the existing as well as the new arrangements.

3 NHS England Fit and Proper Person Test Framework for Board Members

3.1 The key highlights of the changes to the FPPT is set out in Appendix 2 with the full framework available here https://www.england.nhs.uk/publication/nhs-england-fit-and-proper-person-test-framework-for-board-members/ . The changes intend to strengthen / reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

3.2 The additions to the existing arrangements are as follows:

- The Electronic Staff Record (ESR) now has functionality to record the testing of relevant information about board members' qualifications and career history. This should be made available to the CQC on request and held in accordance with General Data Protection Regulations.
- A new standard board member reference template for all new appointments has been introduced. For board members who leave their position, organisations must complete and retain locally the new board member reference, irrespective of whether a reference has been requested by a prospective employer. Along with standard information, the reference template includes the following sections: career history (not just current employment), all learning and development undertaken in employment, DBS information (where relevant), appraisal information i.e., summary of the outcome and actions to be undertaken for the last 3 appraisals, any relevant information regarding any outstanding, upheld, or discontinued complaint(s) i.e., grievances, misconduct incl. harassment. Where settlement agreements are in place, there are processes to ensure the obligations of the Trust in adhering to the Framework are met.
- A new NHS Leadership Competency Framework will provide guidance for the competence categories against which a board member should be appointed, developed, and appraised. Due to be released September/October 2023.
- The annual assessment, as carried out by the Chief Governance Officer needs to be in line with the FPPT checklist.
- The duty to store information relevant to the annual assessment (as set out in the checklist) will apply to existing directors (as they will have to comply with the assessment each year) and not only new appointees/promotions.

3.3 The Framework and changes are effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

3.4 This Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board. The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support

and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

3.5 The framework applies to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments
- those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.((a) Director of the service provider, or (b)performing the functions of, or functions equivalent or similar to the functions of, such a director)

3.6 At SCAS, the Framework is deemed to apply to:

Voting Members:	**Non-voting Members:**
Chair	Chief Governance Officer
Chief Executive	Chief Digital Officer
Chief Finance Officer	Interim Director of Finance
Chief Nurse	Interim Digital Director
Chief Medical Officer	
Chief People Officer	
Chief Operations Officer	**Attendees:**
Chief Strategy Officer	Director of Operations
All Non-Executive Directors (x7)	Director of Communications

3.7 Whilst the operation of the Framework is the responsibility of the Chief Governance Officer, the ultimate accountability for adhering to this framework will reside with the Trust Chair, who will also be subject to the Framework. The accountability for ensuring that Chairs in NHS Trusts, meet the FPPT assessment criteria will reside with NHS England Regional Director. Annually, the Senior Independent Director (SID) or deputy chair will review and ensure that the Chair is meeting the requirements of the FPPT. An independent internal audit is required every 3 years.

3.8 The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member. It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

3.9 The Framework, summarised in Appendix 2 sets out:

- When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).
- New appointment considerations (section 3.4).
- Additional considerations in specific situations such as joint appointments, shared roles, and temporary absences (section 3.5).
- The role of the chair in overseeing the FPPT (section 3.6).
- The FPPT core elements to be considered in evaluating board members (section 3.7).
- The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).

- The requirements for a board member reference check (section 3.9).
- The requirements for accurately maintaining FPPT information on each board member in the ESR record1 (section 3.10).
- The record retention requirements (section 3.11).
- Dispute resolution (section 3.12).
- Quality assurance over the Framework (section 4).

4 Changes to Trust processes

4.1 The Head of Resourcing on behalf of the Chief People Officer, will work with the Trust Secretary to implement the updated Framework by 31 March 2024. The arrangements required to be in place by 30 September 2023 are in place.

4.2 The Board can be assured that the annual 'self-attestation' checks for 2023 are almost complete, with a report aimed for the December 2023 Trust Remuneration Committee. The records are being transferred into ESR to ensure compliance with the Framework. However, a review of whether career history for each Director whom this Framework applies, is required to be submitted/recorded.

4.3 New appointments to the Trust will be subject to these arrangements. These

4.4 The reference template for Board Members who leave the Trust will be completed as appropriate.

4.5 The appraisals for each Director will need to be undertaken by 31 March 2024, which will include an assessment against the new NHS Leadership Competency Framework (LCF). A new board appraisal framework will also be published, incorporating the LCF, by March 2024. By the end of Q1 2024, NHS England will require this to be used for all annual appraisals of all Board directors for 2023/24.

5 Areas of Risk

Whilst there is no associated risk with the Board accepting the recommendations in this paper, if the Trust fails to comply with the expectations and adherence to the new Framework, they could be subject to sanctions from the Care Quality Commission, with potential implications to the Trust's operating license.

5.1 Link to Trust Objectives and Corporate/Board Assurance Framework Risks

5.2 Governance

Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Compliance with FPPT will be reported annually to the Trusts Remuneration Committee and via upward report to the Trust board. Annual accountability statement to be provided.

5.3 Responsibility

The Chair is responsibility for ensuring compliance with Fit and Proper Persons as outlined within the regulations.

6 Next Steps

6.1 The Head of Resourcing will work with the Trust Secretary to ensure they are aware of their responsibilities and actions required for full implementation.

6.2 The Trust's Fit and Proper Person Policy will be reviewed and updated with the changes and will proceed through the due consultation and approval process.

6.3 The self-attestation process for 2023 will be completed in the coming weeks with data recorded in the new ESR module. Directors will be contacted where there are gaps in information that are required to be addressed. A regular report will be available to the Trusts Remuneration Committee to demonstrate compliance with the Framework.

6.4 The Chief Governance Officer will meet with the Chair before 31 March 2024 for them to understand their responsibilities and the process for their own assessment.

7 Recommendation

The Board are asked to note the contents of this paper.

8 Supporting Information

Appendix 1: Fit and Proper Person definition
Appendix 2: Highlights of NHS England Fit and Proper Person Test Framework

Melanie Saunders
Chief People Officer
07 September 2023

Appendix A
Definition of a Fit and Proper Person

In 2014, the government introduced a 'fit and proper person' requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulations').

This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC, which includes all licence holders and other NHS organisations to which licence conditions apply. For the purposes of this guidance, we have referred to these individuals as 'board members'.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a. the individual is of good character.
b. the individual has the qualifications, competence, skills, and experience that are necessary for the relevant office or position or the work for which they are employed.
c. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
d. the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
e. none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

Appendix B
Fit and Proper Person Test Framework

This section sets out an abridged and summarised version of the framework. The full framework (52 pages) should be read to ensure the full requirements are understood. The framework sections are:

A. ***When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).***

A full FPPT assessment will be needed in the following circumstances:

1. New appointments into board member roles, whether permanent or temporary, where greater than six weeks, this covers:
   a. new appointments that have been promoted within an NHS organisation.
   b. temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis.
   c. existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
   d. individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

2. When an individual board member change's role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, e.g., chief financial officer).
3. Annually, that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points 1a, 1b and 1c above (new appointments) the full FPPT will also include a board member reference check (see section 3.9). For points 2 and 3 above, the board member reference check will not be needed.

B. New appointment considerations (section 3.4).

NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process. As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements.

As part of conducting the initial appointment process for a board member, an inter authority transfer (IAT) (e-process through ESR for existing NHS employees) could be submitted to identify any of the applicant's previous or current NHS service/employment history.

C. Additional considerations in specific situations such as joint appointments, shared roles, and temporary absences (section 3.5).

In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the Chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

:

D. The role of the chair in overseeing the FPPT (section 3.6).

Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, Chairs' responsibilities are as below:

a. Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.
b. Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.
c. Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.
d. Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.
e. Ensure an appropriate programme is in place to identify and monitor the development needs of board members.
f. On appointment of a new board member, consider the specific competence, skills, and knowledge of board members to carry out their activities, and how these fit with the overall board.
g. Conclude whether the board member is fit and proper.
h. Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.
i. Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees. In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern. It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting, for information.

Annually, the senior independent director (SID) or deputy chair will review and ensure that the chair is meeting the requirements of the FPPT.

E. The FPPT core elements to be considered in evaluating board members (section 3.7).

NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

:

- **Good character**. This includes any criminal proceedings, action by a professional body, director disqualification, removal as a charity Trustee, DBS check (where relevant to the post), continued professional registration, where relevant.

  Character traits including but it is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law.

  Other considerations: Compliance with the law and legal processes, Employment Tribunal judgements, settlement agreements relating to dismissal or departure from NHS Employment, adherence to the Nolan Principles of standards in public life, openness and honesty with the NHS organisation, if they have been subject of any adverse finding or settlement in civil proceedings (particularly in relation to financial misconduct), if they have been concerned in the management of a business that has gone into administration (within one year), any other information such as an upheld/ongoing or discontinued, disciplinary, grievance, whistleblowing or poor board member behaviour.

- **Possessing the qualifications, competence, skills required and experience.**

  NHS organisations need to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required. For instance, where possible, checking the websites of the professional bodies to confirm that where required the board member holds the relevant and stated qualification. As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships.

  In assessing competence, skills, and experience for the purposes of the FPPT, the NHS organisation should look to use the outcome of their appraisal processes for board members, which will be based on the NHS Leadership Competency Framework (LCF) for board level leaders: a framework that will apply to all NHS organisations. The appraisal process should be of an appropriate frequency and should give due consideration to assessing good character and conduct (that is, a behavioural assessment). The LCF will cover:

  - Setting strategy and delivering long term transformation.
  - Leading for equality.
  - Driving high quality, sustainable outcomes.
  - Providing robust governance and assurance.
  - Creating a compassionate and inclusive culture.
  - Building trusted relationships with partners and communities.

- **Financial soundness.**

  Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency, and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.

F. The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).

Regulation 5 will be breached if:

:

1. A board member is unfit on the grounds of character, such as: – an undischarged conviction – being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries – being prohibited from holding a relevant office or position (see section 3.7.1).

2. A board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity.
3. A board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.
4. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.
5. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.
6. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director or on an ad hoc basis as a case arises.

G. The requirements for a board member reference check (section 3.9).

A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. The aim being that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks.

It is important that board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. However, there are specific arrangements in place where a settlement agreement has been agreed.

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

:

- Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s)

- Any further information and concerns about the applicant's fitness and propriety,
  - Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework).
  - Reckless mismanagement which endangers patients.
  - Deliberate or reckless behaviour (rather than inadvertent behaviour).
  - Dishonesty.
  - Suppression of the ability of people to speak up about serious issues in the NHS.
  - Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, e.g., falsification of records or relevant information.

  The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request.

Where a current board member moves between different NHS organisations, a board member reference form following a standard format should be completed by the employer and signed off by the chair of that NHS organisation.

When obtaining references for new starters to the Board, the Framework sets out the requirements depending on the previous status of the applicant i.e., previous board member, external to the Trust or NHS etc. These requirements will be included in the updated Trust policy.

H. The requirements for accurately maintaining FPPT information on each board member in the ESR record (section 3.10).

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

There should be limited access to ESR in accordance with local policy and in compliance with data protection law. It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

- Chair
- Chief Executive Officer (CEO)
- Senior Independent Director (SID)
- Deputy Chair
- Company Secretary
- Human Resources Director (HRD)/Chief People Officer (CPO) (ESR Administrators).

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Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation.

I. The record retention requirements (section 3.11).

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by each individual NHS organisation.

The NHS Records Management Code of Practice sets out expectations in relation to retaining actual staff documents/records for a period of six years. However, NHS organisational case documents/records may be retained for longer than the standard six years, based on the facts of the case.

J. Dispute resolution (section 3.12).

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance. Where this does not lead to a satisfactory resolution for the board member, there are a number of options available, depending on the role of the individual with a dispute and the reasons for that dispute.

K. Quality assurance over the Framework (section 4).

To ensure that the FPPT is being adequately embedded within NHS organisations there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review.

The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of a board member to the relevant NHS organisation.
The CQC will notify NHS organisations of all concerns relating to their board member and ask them to assess the information received. The board member to whom the case refers will also be informed.

Where the CQC finds that the NHS organisation's processes are not robust, or an unreasonable decision has been made, they will either:

- contact the NHS organisation for further discussion.
- schedule a focused inspection.
- take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.

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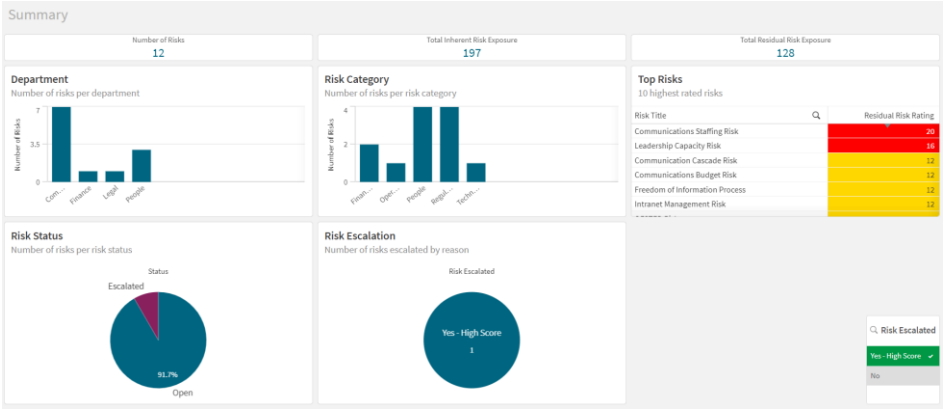
For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually.
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme.

NHS South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Corporate Risk Register**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**16.a**
Executive Summary:	Executive Committee approved the development and implementation of a new Digital Risk Management Platform utilising Microsoft SharePoint and linking to the Trusts BI solution (Qlik). This will allow the Trust to have a single source for risks and develop improved reporting for risks for each committee (example page pictured below)  **To Note:** There has been a cyber event with a supplier leading to an outage of the Trusts Electronic Patient Record system. A paper process is in place and the incident is being managed with testing taking place for the rebuilt system. **New Risks:** None. **Increasing Risks:** **Risk 12: Internal and External Fraud Risk.** Risk has increased from 4 (Major x Rare) to 8 (Major x Unlikely) due to the materialisation of the risk. Improvement work for Declarations of Interest and Gifts & Hospitality are planned as part of the ongoing Governance improvement work. **Risk 17: Training Compliance Risk**: Risk has increased from 8 (Minor x Likely) to 12 (Moderate x Likely) due to the suspension of face-to-face training for 2 weeks (25 people per day). Plan to catch-up sessions and increase compliance rate back to expectation however will be below until caught up. **Risk 19: Leadership Capacity Risk:** Risk has increased from 12 (Major x Possible) to 16 (Major x Likely) due to the Financial Recovery plan requiring significant attention.		

	Decreasing Risks: **Risk 15: 999 Staff Capacity Risk:** Reduced from 16 (Major x Likely) to 12 (Moderate x Likely) as recruitment continues on track and there has been an improvement in attrition rates. **Risks under review** **Risk 2: 999 Demand Risk**. The risk will be reviewed once the output from the Patient Safety incident analysis work has been completed. This will provide the Trust will more assurance that the risk is rated appropriately. **Risk 3: 111 Demand Risk:** The risk will be reviewed once the output from the Patient Safety incident analysis work has been completed. This will provide the Trust will more assurance that the risk is rated appropriately. **Risk 39: 999 Delay Risk:** The risk will be reviewed once the output from the Patient Safety incident analysis work has been completed. This will provide the Trust will more assurance that the risk is rated appropriately.
Recommendations:	The Committee is asked to: - review the risks included in the Corporate Risk Register.
Executive lead:	Daryl Lutchmaya, Chief Governance Officer
Report author:	Steven Dando, Head of Risk Management
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):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): - Any updates will be made to the CRR.	
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	Jul-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	**August 23: Handover delays have increased to 3658 in August with 1720 at QAH. EUC continue to monitor and work with system to improve however there is limited assurance that improvements are working.** **July 2023:** Handvoer 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 pateint 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 atributed 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
											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														
											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														
											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														
2	Rebased risk register November 2021	Jun-23	999 Demand Risk	**IF** 999 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 to attend where required; **RESULTING** in increased risk of patient harm, poor experience and inability to meet ARP targets	**Cause:** • Increase of circa 15% 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 • Increased sickness and absence in service	Patients have to wait longer for face to face assessment Increased patient harm Negative press articles Negative impact to the Trusts reputation	Service Quality & Patient Experience	Catastrophic	Almost Certain	25	BT call management programme	BT process for repeat calls and long waits on emergency line	Luci Papworth	Ongoing	To Be Assessed	Moderate	Possible	9	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	EOC Recovery plan	Recovery programme aimed at returning the 999 service to meeting national targets	Paul Kempster	Mar-23	**August 2023: Risk will be reviewed fully once outcome from Patient Safety team analysis of delay incidents known.** **Jun 2023:** Risk reduced down in line with risk on the EOC risk register. **February 2023:** Response demand 7% below budget but in line with STF. Demand is trending upwards. Duplicate calls have reduced to 11% in January with 13.5% currently in Feb. Average for the year is 18.35%. **December 2022:** Demand has fluctuated between above and below forecast however the forecast predicts demand above the budgeted amount. Actual calls have increased significantly in early December. Duplicate calls have reduced and are lower than the average for the year (November was 14% and December 18% with the average being 20%) **October 2022:** Demand continues to be above budgeted levels. Duplicate calls remain an issue with approximately 20% of calls in September being duplicates. Work continues with the recovery plan.
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed										Intelligent Routing Protocols	Routing system for calls which smooths out demand across areas.	Luci Papworth (SCAS) but nationally run	Awaiting confirmation from national programme	
											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														
											Operational Performance Review	Meeting to discuss operational performance in 999, 111 and EOC.	Paul Kempster	Weekly	To Be Assessed														
											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														
											Intelligent Routing Protocol	Routing system for calls which smooths out demand across areas.	Luci Papworth	Ongoing	Not Implemented Yet														
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	**August 2023: Risk will be reviewed fully once outcome from Patient Safety team analysis of delay incidents known.** **February 2023:** Demand has reduced back to STF and is inline with budget (SCAS taken demand) however DHU are covering ~3k calls per week. Overall demand is trending upwards and is above budget. Resource level 6% 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
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed										SVCC	National programme to manage 111 demand across services	Ruth Page	Awaiting confirmation from national programme	
											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														
											Operational Performance Review	Meeting to discuss operational performance in 999, 111 and EOC.	Paul Kempster	Weekly	To Be Assessed														
											Recruitment	Recruitment process for onboarding new staff	Pamela Putt	Ongoing	To Be Assessed														
											Daily Operational Performance Report	Daily report which covers call stats	Mark Green	Daily	To Be Assessed														
4	Rebased risk register November 2021	May-23	Fleet Capacity Risk	**IF** the fleet is insufficient in number to meet demand, **THEN** there is a risk that crews will not have a suitable vehicle to attend patients in the community; **RESULTING** in wasted resource hours and increased waits for patients	**Cause:** Delays in new vehicle delivery due to conversion delays • Vehicles VOR (Higher in north than south) • Limitations in usable data • Older/ high use vehicles require replacing	Vehicles not available when required Increased wait time for face to face assessment Increased patient harm Negative press articles Negative impact to the Trusts reputation	Service Quality & Patient Experience	Major	Likely	16	Fleet Strategy	The Trust has a strategy for the Fleet Services	Paul Kempster	Ongoing	To Be Assessed	Major	Possible	12	Treat	Paul Kempster	Fleet replenishment delay	Delay in receiving 53 new DCUs from supplier which may lead to an increase in VOR rates as fleet will age above expected rates and vehicles which are written off cannot be replaced	Urgent	Ross Cornett	Replacement vehicle contract management	Investigation and management of the conversion contract to resolve issues and ensure ongoing deliveries of new vehicles	Ross Cornett	TBC based on contract outcome	**May 2023:** Agreement with convertor to receive delivery of 53 DCUs by end of 2023 and addition 11 from them for this financial year with remaining 223/24 contract being completed by a new convertor. Remaining contracted units with original convertor being transfered to YAS. **March 2023:** This years new vehicles have not been delivered by the convertor and they have requested a price increase (per vehicle) to deliver these units during Q2 & Q3 23/24. Contracted parties are in discussion as we cannot accept the pricing increase. No delivery expected until Aug 23 at the earliest. Any vehicle write off will reduce the overall capacity of the fleet and increase the impact of vehicels off road. **February 2023:** Further delays in new fleet arrival due to supply issues and sign-off of modified build. Prototype being demonstrated in February. **December 2022:** Risk remains stable with the make ready contract work continuing. New ambulances are delayed due to supply issues with the converter and the sign off of a modified build. **October 2022:** Risk remains stable. TL vehicles rolled out however there has been a delay arrival of the new DCUs.
											Vehicle Replacement Programme	Programme covering the vehicle lifecycle, replacement and modernisation.	Ross Cornett	Ongoing	Not Effective														
											Mobile Servicing	Ability to provide servicing to vehicles without returing to a central location.	Trevor Thompson	Ongoing	To Be Assessed														
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed														
5	Rebased risk register November 2021	Feb-23	Private Providers Risk	**IF** a 999 private provider does not provide the contracted resource hours; **THEN** there is a risk that significant resource hours will be lost; **RESULTING** in increased waits in the community for an ambulance response.	**Cause:** Lack of Private Provision Strategy including contract managing system Poor supplier / third party management Lack of paramedic capacity in the private sector	Increase chance of patient harm due to inability to reach patients Impact to the Trusts reputation	Service Quality & Patient Experience	Major	Likely	16	Provider onboarding process	Formal process for onboarding Private Provides into the Trust and authorising them to conduct work for SCAS.	Maria Langler	Ongoing	To Be Assessed	Moderate	Likely	12	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	Task time reduction	Operations plan to reduce the current task time (9.5 minutes) by half.	Paul Kempster	In line with the recovery progamme	**February 2023:** Risk remains stable with providers continuing to not full achieve contracted levels. **August 2022:** Risk remains stable with ongoing demand issues. The increase in task time is having an impact on the number of hours required. The new provider strategy has been approved and is about to move to the implementation stage with an anticipated timeframe of 18 months. Looking at obtaining support for delivery. Private providers are currently giving 9k hours leaving a gap of 4k against the expected 13k. This has improved from previous months. **May 2022:** Risk has increased due to the demand in hours increasing from an average of 7,000 hours to 13,000 hours per week.
											Supplier Relationship Management	Process for managing the relationship with key suppliers/partners aimed at improving the service provided.	Maria Langler	Ongoing	To Be Assessed						Task Time Increase	Task time for crews has increased meaning there are more hours required to handle demand	High	Mark Ainsworth	Implementation of Private Provider Strategy	Implementation of the new private provider strategy	Maria Langer	Oct-23	
											Supplier Performance Information	Performance stats for suppliers, based on contracted SLAs and expected performance	Maria Langler	Monthly	To Be Assessed						SCAS CQC Rating	SCAS receive an inadequate rating through the last inspection, this could lead to providers challenging our ability to monitor them from a quality perspective.	Low	Guy Alexander					
											Private Provider Strategy	Overall strategy for how the Trust approaches the use of private providers.	Maria Langler	Annually	To Be Assessed														
6	Rebased risk register November 2021	Jun-23	IPC Compliance Risk	**IF** staff do not comply with IPC policy and practice **THEN** there is a risk that staff and/or patients will be exposed to potential infections **RESULTING** in illness or poor patient outcomes.	**Cause:** - PPE is not available at point of use (Logistics) - PPE is not worn (or worn incorrectly) - Vehicles and/or equipment is not sufficiently well decontaminated/ cleaned between patient use - Routine and deep cleans are not effectively carried out within agreed timeframes - IPC compliance is not sufficiently well supervised/ policed - IPC audits are not carried out within agreed expectations - Long lead in times for PHE publication of ambulance sector guidance - Operational challenges as workload increases as pandemic measures recede, but IPC requirements continue - Difficulties in forecasting when expected IPC measures not ratified nationally (e.g. cohort guidance) - Increased levels of community transmission of COVID-19 or other pathogen - Reduced compliance with public health orders/standards	Ineffective control of infection risk Potential increase in patient harm Increase in demand on Test and Trace services for staff Increased demand for use of 'alternative duty' staff across organisation for project/ support work High levels of staff absence	Clinically-Led	Major	Likely	16	Patient Safety Group	Group responsible for promoting safety in patient care and to identify, prioritise and manage risk arising from clinical care, including Infection Prevention Control.	Helen Young	Monthly	To Be Assessed	Moderate	Likely	12	Treat	Helen Young	IPC System	There is a lag in data transferring between systems (Make Ready and IPC) and there concern over the veracity of the data within the system as well as the design and build of it.	Urgent	Helen Young	New Make Ready Contract	Renewal of the make ready contract following tender.	Phil Pimlott	Q1 2023	**October 2022:** IPC improvement work ongoing and being tracked via the IPC workstream. **August 2022:** Risk has been reviewed and increased due to a number of issues around assurance of IPC practices across the Trust. An Improvement plan has been developed covering the team structure, resource, staff training and the design and build of the system. Ongoing updates to the IPC policy and procedures include the introduction of Bare Below the Elbows (BBE) wef 8 August and the removal of FRSM requirements in cabs wef 4 August. **May 2022:** Risk remains stable with changes it IPC requirements being implemented in May and communicated to all staff. Improved supply chain of PPE Improved IPC compliance and areas of focus highlighted to local teams
											Make ready contract meetings	Contract with Churchill to clean vehicles once every 24 hours and provide a deep clean every 12 weeks	Ross Cornett	Ongoing	To Be Assessed						IPC team capacity	IPC team is not resourced sufficiently to complete required audits	High	Helen Young	IPC Improvement Plan	Improvement plan for IPC covering team resourcing; team structure; a robust training plan for all staff, including Stat/Man and other types of training; hand	Helen Young	Jan-23	
											Audit assurance schedule	Peer reivew of IPC audits conducted across the Trust to highlight any issues.	Claire Ward-Jackson	Ongoing	To Be Assessed						Operational Pressures	Operational pressures reduced the ability to complete level 1 assurance activity	High	Helen Young	Resourcing	Increase in resourcing for IPC team to conduct assurance audits	Debbie Marrs	Q4 2022	
											National Ambulance Service Infection Prevention Control Policy	Policy which details requirements for all staff to adhere to in order to reduce potential infections for both staff and patients.	Claire Ward-Jackson	Ongoing	To Be Assessed										IPC link practitioners	Operational roles within the ops teams to conduct audits. Expression of interest due to go out	Debbie Marrs	Complete	
											AACE/QGARD Meetings	CEO and Director attends the Association Ambulance Chief Executives (AACE) and the National Ambulance Service Quality, Governance and Risk Directors (QGARD) meetings	Will Hancock	Quarterly	To Be Assessed														
											UKSHA	Ongoing close working relationships with SCAS contacts at UKSHA to enable timely dissemination of IPC information to the Trust.	Claire Ward-Jackson	Ongoing	To Be Assessed														
											National Ambulance Infection Prevention Control Forum	SCAS attendance at the National Ambulance Infection Prevention Control Forum where national policy can be influenced and learnings from other Trusts and Services can be shared.	Claire Ward-Jackson		To Be Assessed														
											Test & Trace	Test and Trace programme in place with small number of staff trained in the process. Programme covers identification of contacts, return to work (for both COVID cases and contacts) and root cause analysis.	Claire Ward-Jackson	Ongoing	To Be Assessed														
											Management Information	Test and Trace activity and staff impact numbers, including volume of staff off with COVID-19, those isolating due to close contact etc reported to Service Delivery Board, Patient Safety Group and other key	Claire Ward-Jackson	Ad-hoc	To Be Assessed														
											Service Delivery Board	Oversight of Test and Trace programme	Debbie Marrs	Bi-weekly	To Be Assessed														
											Physical Barriers	Physical barriers located in key operational areas to reduce the spread of infections.	Mark Finch	Ongoing	To Be Assessed														
											IPC link practitioners	Operational roles within the ops teams to conduct audits	Claire Ward-Jackson	Ongoing	Not Implemented Yet														
											Infection Prevention and Control Committee	Committee responsibility for setting policy and practice for IPC along with oversight of IPC activity across the trust.	Helen Young	Bi-monthly	To Be Assessed														
7	Rebased risk register November 2021	Jul-23	Community Disruption Risk	**IF** there is significant disruption to services and organisations in the local health communities, **THEN** there is a risk that analysing, planning and/or improving patient pathways will be affected; **RESULTING** in reduced options available to SCAS and use of inappropriate pathways for patients	**Cause:** System wide issues causing delay, disrupting planning and/or reducing pathways available to SCAS National, Regional or Local industrial action	Excessive Handover delays Performance Impact Excessive Long waits Patient Harm	Service Quality & Patient Experience	Catastrophic	Almost Certain	25	Pathways Development team	Dedicated team for the development of NHS pathways	Debbie Diffey / Dan Holliday	Ongoing	To Be Assessed	Minor	Unlikely	4	Tolerate	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					**July 2023: Risk reduced due to experience of strikes which show lmited impact on performance. Consulatant and Junior Doctor strikes ongoing however RCN ballot voted for no further action.** **May 2023:** Risk remains high due to the ongoing Junior Doctors strikes and the re-ballot of RCN members. Risk is reviewed by the Industrial action group. **April 2023:** Risk increased due to the ongonig action across the Healthcare community. Junior Doctors have been taking strike action and the RCN are due to take more between 30 April and 2 May. Risk reviewed at the Industrial Action group. **February 2023:** Risk continues to be high due to the ongoing industrial action with other ambulance trusts and nurses. 48 hour strike taking place between 1 - 3 March 2023 has been suspended. **January 2023:** Risk remains high with strikes from the RCN taking place on 18/19 January. The strike locations are moving from the North patch to the South patch (Hampshire and Portsmouth). **December 2022:** RCN strike actions taking place on 15 December and 20 December so risk has increased. Command cells will be in place to manage those days and planning meetings are taking place to effectively manage the events.
											Commissioner engagement	SCAS are actively engaged with commissioners and systems to ensure information from across the system is provided to SCAS	Exec Team	Ongoing	To Be Assessed						RCN Industrial Action	RCN have voted to take strike action.	Closed	Mark Ainsworth					
											Representation at local and trust system meetings	SCAS exeutives, directors and staff are part of local and regional groups to enable a joined up approach to issues as well as getting insight into	Exec Team	Ongoing	To Be Assessed						Junior Doctors Industrial Action	Junior Doctors have voted to take strike action	High	Mark Ainsworth					
											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	Exec Team	Ongoing	To Be Assessed														
											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 Implemented Yet														
											Command Cell	Command and Control cell set up to manage strike days	Paul Kempster	Ad-hoc	To Be Assessed														
											Planning Meetings	Regular planning meetings to discuss potential action to enable SCAS to plan around disrupted hospitals	Paul Jeffries	Weekly	To Be Assessed														
											National planning	National guidance and support through NHS Employers	Melanie Saunders	Ongoing	To Be Assessed														
											Business Continuity Plans	Business Continuity plans in place for loss of staff	Hollie Bailey	Annually	To Be Assessed														
											Workforce Management	Ability to cancel annual leave, rearrange training sessions, provide overtime for staff not on strike, providing they do not breach working	All Managers	Ongoing	To Be Assessed														
											Demand Forecasting	Updated forecasting models to include increase handover times and other impacts	Maria Langler	Ongoing	To Be Assessed														

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*
10	Rebased risk register November 2021	Jun-23	Learning Risk	**IF** there are high levels of demand across the Trust **THEN** there is a risk that the Trust will be unable to implement learning from incidents **RESULTING** in potential same issues recurring and opportunities to resolve root causes being missed.	**Cause:** Increased number of SI investigations Team dedicating significant resource to reviewing incidents and data to identify potential harm	Delay in identifying and learning from incidents Increase in potential patient harm	Clinically-Led	Major	Likely	**16**	Serious Incident Policy	Policy detailing the requirements and criteria for determining and investigating a Serious Incident (SI), including roles and responsibilities.	Debbie Marrs	Ongoing	To Be Assessed	Moderate	Possible	**9**	**Treat**	Helen Young	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	Implementation of new Patient Safety Strategy and Patient Safety Incident Response Framework	Implementation of the Patient Safety Strategy from NHS England and the associated Patient Safety Incident Response Framework (PSIRF) to replace the existing Serious Incident policy and process.	Debbie Marrs	Aug-23	**May 2023: PSIRF and LFPSE projects are ongoing** **February 2023:** LFPSE project started with review of requirements and changes made by NHSE and Datix. Review of incident reporting taking place as part of the project to ensure we can meet the national and Trust requirements. **October 2022:** Improvements in the incident management process have begun with changes made to the policy and taking incidents to clinical governance meetings for approval of actions. This aims to ensure that there is focus on the implementation of the learning across the Trust. **August 2022:** Patient Safety and Experience workstream includes work to ensure that the resource and processes to identify and distribute learning is sufficient.
																					Incident Management	Incidents (both clinical and non-clinical) are logged on multiple systems which leads to inaccurate reporting and hinders the Trusts ability to identify trends and understand the complete picture.	Urgent	Ross Cornett	Replacement of NRLS with new national learning system	Ensure our reporting aligns with and is able to upload or record incidents in the new national learning system	Debbie Marrs	Sep-23	
											Serious Incident Process	Incidents rated as Serious are investigated in line with the policy with learnings and actions being identified and implemented.	Paul Cooke	Ongoing	To Be Assessed									Patient Safety and Experience Improvement Workstream	Workstream covering the patient safety and experience aspects of the recent CQC inspection. Workstream also covers learnings.	Debbie Marrs	Moving to phase 2	
											System Serious Incidents	Serious Incidents process which covers incidents which are impacted by multiple components of the Healthcare system, such as hospitals or other healthcare providers.	Debbie Marrs	Ongoing	To Be Assessed													
											Datix	Central logging system for incidents with actions assigned to owners	John Dunn	Ongoing	To Be Assessed													
											Clinical Governance Meetings	Incidents are discussed via Clinical Governance meetings with relevant learning discussed and monitored.	Debbie Marrs	Monthly	To Be Assessed													
11	Rebased risk register November 2021	Aug-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/ICO fine) 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	Loan	Request and approval of a loan from NHSE to resolve cashflow issue	Stuart	Apr-24	**August 2023: Financial risk remains high with financial recovery plans required. Expendature running higher than plan.** **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 clarity 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													
											cash tracking																	
											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													
12	Rebased risk register November 2021	Aug-23	Internal or External Fraud Risk	**IF** the Trust does not not have sufficient fraud processes and procedures **THEN** there is a risk that there will be successful fraud activity **RESULTING** in financial loss to the Trust	Organised crime/ internet based activity Weaknesses in control measures (including IT weaknesses) Inappropriate claims for pay, costs or fraudulent invoicing Authorising payments outside of agreed policy/procedure Poor procurement processes	Financial Loss Negative impact to the Trusts reputation	Finance & Sustainability	Major	Unlikely	**8**	NHS Counter Fraud Authority (NHSCFA) Guidelines	All potential fraud cases are handled in accordance with NHSCFA guidelines	Aneel Pattni	Ongoing	Effective	Major	Unlikely	**8**	**Tolerate**	Aneel Pattni				Gifts and Hospitality	Refresh of Gifts and Hospitality process and reporting as part of overall Governance improvement work;	TBC	TBC	**August 2023: Risk likelihood increased due to recent cases. Improvement work planned for gifts and hospitality as well as Declarations of Interest. Ownership and due dates to be confirmed as part of the Governance work.** RSM new counter fraud provider **Rating Rationales** **Gross:** 4 based on £3m loss from fraud so <1.5% income **Mitigated** Probability cant be less than 1
											Local Counter Fraud Specialist (LCFS)	Team who investigate fraud cases are handled in accordance with NHSCFA guidelines.	Aneel Pattni	Ongoing	Effective									Declarations of Interest	Refresh of Declarations of Interest process and reporting as part of overall Governance improvement work.	TBC	TBC	
											Anti-Fraud & Bribery Policy	Policy detailing the requirements and criteria for, roles and responsibilities for handling fraud and bribery.	Aneel Pattni	Ongoing	Effective													
											Standards of Business Conduct & Conflicts of Interest	Policy detailing the guidelines on and actions to be taken to manage any conflicts of interest.	Aneel Pattni	Ongoing	Partially Effective													
											Fraud Awareness Programme	Fraud awareness programme - internal communications with staff.	Aneel Pattni	Ongoing	Effective													
											Fuel card audits	Audits of fuel card usage to identify cases of non-approved use.	Aneel Pattni	Ongoing	Partially Effective													
											Segregation of duties	Users are not permitted to have toxic permissions (for example, being able to set up a payee an then make a payment to that payee)	Aneel Pattni	Ongoing	Effective													
15	Rebased risk register November 2021	Aug-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	Moderate	Likely	**12**	**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	**August 2023: Recruitment on track with improvement in attrition rates. Reduced impact to moderate** **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	Specialist Paramedics on rotation to primary care roles. Staff have the option of performing alternative duties	Mark Ainsworth	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	
											Workforce Development Board	Committee with oversight of all aspects of workforce management.	Melanie Saunders	Monthly	To Be Assessed						International Recruitment	Paramedic recruitment programme in place for Australia but no agreed programmes beyond that.	High	Pamela Putt / Ian Teague					
											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 revews	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	Aug-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	**August 2023: Risk stable, recruitment under plan but attrition has been ok for 4 months. 136 vacancies.** **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	Not 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 Dymond	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 acsons 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													

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*
17	Rebased risk register November 2021	Aug-23	Training Compliance Risk	**IF** REAP levels and/or IPC restrictions prevent staff attending mandatory training, **THEN** there is a risk that compliance will not be achieved; **RESULTING** in staff not having access to the training content and latest agreed ways of working in key areas.	**Cause:** Reduced compliance with mandatory training requirements Unable to demonstrate mitigation for risks such as Information management, FIRE etc Significant resource requirement when pressures ease to 'catch up' and reduced capacity within annual programme for innovation and other non-mandatory topics.	Reduced opportunity for organisational learning following incidents, changes in guidance and/or policy changes. Patients do not benefit from the latest learning for staff to support their clinical needs. Not meeting contractual requirements Not meeting regulatory requirements Potential increase in patient harm	People & Organisational Development	Major	Almost Certain	20	e-Learning	Online learning platform containing all mandatory training that does not require face to face training.	Ian Teague	Ongoing	To Be Assessed	Moderate	Likely	12	Treat	Melanie Saunders	Safeguarding Level 3	Level 3 safeguarding has not taken place as it is a face to face course. Plan to provide training to all required staff	Urgent	Helen Young	Information Governance training	Action plan to increase completion rates to target levels	Mark Northcott	Q4 2023	**August 2023: Face to face training suspended for 2 weeks due to pressures which has caused compliance rates to reduce. Plan to restart and build back but will be below expection until caught up.** **July 2023:** Stat & Man training levels have reduced therefore likelihood increased. **June 2023:** Risk reduced as staff are released for training, both F2F and online. E-learning rates are good.
											Self-directed educational materials	Staff have access to educational materials	Ian Teague	Ongoing	To Be Assessed						Face to face training	Face to face training did not take place during the pandemic however this has now restarted from April 2022. Safer working restrictions continue in the South East due to increased infection rates.	Closed	Ian Teague	Fire training	Action plan to increase completion rates to target levels	John Dunn	Q4 2023	**February 2023:** As there has been a lack of face to face training during the pandemic, there is a backlog of courses that staff are required to take to maintain compliance. **December 2022:** Progress is being made against training objectives. Safeguarding training taking place and IG and Fire e-learning has improved significantly. **October 2022:** Risk stable as training no longer stops due to REAP 4. E-Learning remains stable with good progress except for Information Governance and Fire. **August 2022:** Risk remains stable, face to face training was reintroduced again following a further suspension with a virtual training sessions starting in September with an external party. REAP levels have reduced to level 3 and IPC restrictions are easing in line with national guidelines. **May 2022:** Overall risk remains stable. Reintroduction of face to face training began in April 2022 with plan to close training gaps. iPad distribution has started to help staff complete eLearning and access guidance material.
											Clinical Review Group	Monitoring of the quality of clinical education	John Black	Monthly	To Be Assessed						Information Governance Training	e-learning modules continue to be under target levels with urgent action required	Moderate	Barry Thurston	Face to face learning trajectory	Develop a trajectory for completion of face to face learning courses	Ian Teague	Sep-23	
											Quality & Safety Committee	Monitors the implementation of relevant policies and guidelines and reviews compliance for Stat and Man training impacting patient care.	Helen Young	Bi-monthly	To Be Assessed						Fire Training	e-learning modules continue to be under target levels with urgent action required	Moderate	John Dunn					
											Integrated Performance Report	Performance report covering training compliance stats	Aneel Pattni	Monthly	To Be Assessed													
											Workforce Development Board	Monitoring of compliance levels through committee	Melanie Saunders	Monthly	To Be Assessed													
19	Rebased risk register November 2021	Sep-23	Leadership Capacity Risk	**IF** there is insufficient leadership capacity (at SLT, directorate and divisional level), **THEN** there is a risk that staff and/or projects will not be sufficiently well supported; **RESULTING** in attrition and inability to meet service/ project needs	**Cause:** Significant increase in services delivered (e.g. CCAS/ national pandemic workstreams) Shift towards ICS working Lean models have limited flex to absorb new projects etc	Mission creep and unplanned work (i.e. not project managed) Significant service redesign internally and externally	People & Organisational Development	Major	Likely	16	Project Management Office	Dedicated project management support for implementation of projects	Heather Moore	Ongoing	To Be Assessed	Major	Likely	16	Treat	Melanie Saunders	CEO Stepping Down	The CEO is stepping down in 2023 after 17 years at SCAS. This is a considerable loss of knowledge, experience and leadership for the Trust.	Closed	Melanie Saunders	Succession Planning	Development of succession plans for leadership and key roles.	Nicola Howells	Part of phase 2	**Sept 2023: Risk increased to 16 due to additional capacity pressures on leadership due to the financial recovery** **June 2023:** CEO now in place and bedded in. Chief Governance Officer now in place. CTO leaving post however interim appointed whilst a substantive role recruited. **February 2023:** Risk is improving as new team members continue to embed and get inducted into the Trust. The new CEO starts March 2023. Whilst there is expected to be a bedding in period, other key roles will have been in place for a longer period to help mitigate the transition. The Interim Director of Corporate Governance and Company Secretary left the role in January however another interim has been employed to provide cover until a permanent role is recruited. Recruitment of this role has started. The risk is expected remain slightly elevated during Q4 and we anticipate it reducing further around Q1 as the new roles will have been recruited and settled in position. **December 2022:** Deputy Director of Finance position has been filled with the person starting in Jan/Feb. CFO has been in place since October and is bedding into the role. The Interim Director of Corporate Governance and Company Sec is leaving on 6 Jan but a new interim joined in December. **October 2022:** Risk now stable with interim CFO handing over to the new CFO in October and a new Director or Corporate Governance in place. CEO recruitment ongoing. Deputy Director of Finance requires backfilling due to the role holder taking a secondment. **August 2022**: Risk has increased due to recent announcements regarding the Trust CEO and Director of Corporate Governance and Company Secretary who are both leaving. The Director of Finance
											Workforce Planning Board	Provides oversight of all aspects of workforce management.	Melanie Saunders	Monthly	To Be Assessed						New CFO (Interim)	The CFO is retiring in August 2022 with a new CFO taking over on an interim basis. This is a considerable loss of knowledge, experience and leadership for the Trust.	Closed	Melanie Saunders					
											SCAS Leader	Programme for leader development across SCAS covering individual management, team management and service development.	Nicola Howells	Ongoing	To Be Assessed						New Company Secretary	The Director of Corporate Governance and Company Secretary is leaving after 10 years. This is a considerable loss of knowledge, experience and leadership in managing the company governance and board agenda.	Closed	Melanie Saunders					
											Succession Planning	Key technical and leadership roles have identified succession plans in plac	Nicola Howells	Ongoing	Not Implemented Yet						CQC Improvement Plan	The CQC improvement plan requires a considerable amount of focus and attention from the Executive and Senior Leadership teams.	Moderate	Mike Murphy					
											Close engagement with Integrated Care Systems structures	Senior leadership are engaged with the ICSs to enable knowledge sharing and support where required.	Exec Team	Ongoing	To Be Assessed						Recovery Plans	The Operational Recover Plans requires a considerable amount of focus and attention from the Senior Leadership teams.	High	Paul Kempster					
											Interim roles	Investment in interim roles where required to provide support during transitions	Exec Team	Ad-hoc	To Be Assessed													
20	Rebased risk register November 2021	Feb-23	PTS Demand Risk	**IF** there is instability in PTS demand **THEN** there is a risk that services will not be configured to deliver to patient needs when required **RESULTING** in ineffective use of resources and/or poor patient experience and/or late or missed appointments	**Causes:** Uncoordinated recovery and service design by acute and primary care partners Requirement to maintain isolation and limited cohort models	Late notice changes and demand Poor or late engagement with PTS services when reconfiguring services Services being configured away from traditional hubs (reducing efficiency)	Service Quality & Patient Experience	Moderate	Likely	12	Commissioner engagement	Stakeholder engagement with commissioners to understand requirements and highlight and issues or concerns.	Mike Murphy	Ongoing	To Be Assessed	Moderate	Likely	12	Treat	Mike Murphy										
											Contract opportunities	Tendering for new private contracts/opportunities	Paul Stevens	Ongoing	To Be Assessed													
											Change management process	Processes can be changed to meet customer requirements	Paul Stevens	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													
											Demand Forecasting	Formal forecasting of demand on a daily/weekly/monthly basis to understand resource requirements per day.	Charlotte Micallef	Ongoing	To Be Assessed													
22	Jan-22	Aug-23	Health & Safety Risk	**IF** SCAS do not adhere to Health and Safety requirements **THEN** there is a risk that staff or patients may be injured **RESULTING** in increased staff absence, increased RIDDOR reportable incidents and potential patient harm and poor patient experience.	**Cause:** Staff not fully aware of requirement Increase in operational pressures Adherence and attendance to training of Health & Safety requirements Dynamic risk assessed care not conducted	Potential injury to SCAS staff or visitors Potential injury to patients Potential loss of life of SCAS staff or visitor Possible Improvement notice from Health & Safety Executive Potential litigation from staff, visitors or patients Additional operational costs due to increased staff absence Damage to the trusts reputation.	Service Quality & Patient Experience	Moderate	Almost Certain	15	Risk Assessments	Risk assessments are undertaken for all activities	John Dunn	Ad-hoc	To Be Assessed	Moderate	Likely	12	Treat	Helen Young					Health & Safety Inspections	Implementation of Health & Safety inspections by the risk team.	John Dunn	TBC	**August 2023: Risks reviewed at Health & Safety Committee. External review has been completed with draft findings due to be presented.** **May 2023:** H&S Risks reviewed in May Health and Safety Committee. Risks remain static. GGI are conducting a review of Health and Safety processes across the Trust. **November 2022:** Health & Safety risk discussed at the Heath, Safety and Risk Group with rating remaining the same. Physical assault risk elevated on the HSRG register. **September 2022:** Risk reviewed at the September Health, Safety and Risk group. Risk remains stable.
											Staff training and records	Staff receive training on Health and Safety matters	John Dunn	Ad-hoc	To Be Assessed										Health and Safety Review	Reiew of Health and Safety processes within SCAS	GGI	Currently taking place	
											Incident Reporting Policy	Policy detailing the requirements and criteria for determining and investigating incidents, including near misses.	John Dunn	Ongoing	To Be Assessed													
											RIDDOR reporting	Reporting requirements for all injuries sustained whilst working for the trust	John Dunn	Ongoing	To Be Assessed													
											Non-clinical incident analysis	Non-clinical incidents are investigated with learnings and actions taken. Analysis of incidents, such as trends monitored with actions identified.	Mathew Kivell	Ongoing	To Be Assessed													
											Health, Safety & Risk Group	Group with responsibility for Health, Safety and Welfare of employees and others who may be affected by the trust's work activities.	Paul Kempster	Bi-monthly	To Be Assessed													
											Incident Review Panels	Group responsible for reviewing and approving patient safety incidents prior to publication.	Helen Young	Monthly	To Be Assessed													
											Patient Safety Group	Group responsible for promoting safety in patient care and to identify, prioritise and manage risk arising from clinical care, including Infection Prevention Control.	Helen Young	Monthly	To Be Assessed													
											Health & Safety Inspections	Inspection audits from the Health & Safety team	John Dunn		Not Implemented Yet													
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	Ongoing	**August 2023: Fuel spill remediation work complete and information requested has been submitted to the Environment Agency. Safeguarding work continues along with the improvement programme (one must do and one should do left to be completed)** **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 to due to the volume and scope of the actions required and the uncertainty around delivering to
											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	Level and volume of immediate improvement works are impacting the ability to deliver existing taks and functions	Urgent	Helen Young	Fuel investigations	The estates team are working with the Environment Agency to investigate and resolve the fuel spill issue.	Mark Finch	Complete	
											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	Closed	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*
24	Rebased risk register November 2021	Jun-23	Cyber Risk	**IF** technology infrastructure and processes are insufficiently robust and succumb to a successful cyber attack **THEN** there is a risk that the Trust will lose use of critical systems and / or data **RESULTING** in reduced ability to provide safe patient care and/or breach of patient data.	Increasing number of malicious actors attacking organisations around the world Desire to break into critical infrastructure to cause civil unrest/ panic Risk that defences do not keep up with ability of hackers/bad agents to exploit weaknesses in systems Increased interconnectivity between health organisations/ providers	Widespread disruption to NHS digital services (e.g. Wannacry 2017) Loss of critical patient management systems (e.g. CAD, Adastra, Clenic etc) Loss of telecoms/ inability to respond to calls Loss of patient record and/or referral systems.(e.g. Scribe, Docworks etc) Loss of patient/ staff identifiable data Potential ICO fines	Technology Transformation	Major	Likely	**16**	Multi-Factor Authentication	Access to SCAS applications requires the user to authenticate their credentials multiple times using username/password and a code from an authenticator app (such as Microsoft Authenticator or Google Authenticator).	Information Asset Owners	Ongoing	Effective	Major	Possible	**12**	**Treat**	Barry Thurston	Technical Documentation	There is no technical documentation library covering items such as network maps, data maps, application dependencies.	Moderate	Barry Thurston	Data Centre Replacement Project	Upgrading current end of life virtual services to new technology	Barry Thurston	Depending on Ops agreement on downtime	~~**Sept 2023:** Cyber incident with EPR supplier resulting in paper back-up process activating. No patient safety incidents identified yet.~~ **June 2023:** Business case for outsourcing security centre work to improve cyber treat identification and increase awareness of the environment. Substantive DBA role starting in August. **January 2022:** Paper to be presented to the Board on the Trusts cyber position. Risk is increasing due to the absence of the Trusts cyber specialist. **August 2022:** Data centre infrastructure upgrade in progress with hardware due to be in place for November with a period of testing to take place before migration of the virtual server estate. Resilience improvement work continues with the VXLAN project. **June 2022:** Rating reassessed with a reduced probability of occurring. **Rating Rationale:** **Gross:** 4 based on service interruption for greater than 24 hours ~~**July 2022: 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.**~~ **May 2023:** Medical devices continues to improve with fewer incidents and better visibility and tracking of devices. Reduced likelihood based on this. **February 2023:** Additional AEDs have been delayed. Supplier has delivered 25 (10%) so far and has not been able to confirm a date for the remainder. ZOLL configuration still outstanding as awaiting for training availability. Bag-valve masks have had more failures so additional suppliers have been saught. Faulty bags are being replaced with the new suppliers as well as all stock on vehicles. Checks on paediatric items to ensure they remain safe. **December 2022:** Equipment audit completed with resulting data validated. Information added to the equipment database so actions can now be closed. Next stage of improvement plan is to validate training levels of staff on equipment and to add course to the induction programme. A new issue with Bag Valve Masks has been identified through incidents and a patient safety notice has been issued to staff. **October 2022:** Improvement workstream work continues with the Medical Devices Review Group now in place, a new policy being finalised as well as a full audit of devices used across the Trust
											IMT Policies	Group of policies covering acceptable use, information security incidents, antivirus, security access, internet usage and network security.	Barry Thurston	Annually	Effective														
											Crisis Management Plans	Plans to help the organisation recover in the event of a crisis	John Amos	Annually	Partially Effective														
											Business Continuity Plans	Recovery plans for operational teams to allow continuity of service	Hollie Bailey	Annually	Partially Effective														
											IT DR Plans	Recovery plans for IT services	Jason Somerville	Annually	Partially Effective														
											Data Security and Protection toolkit	Self-assessment required by NHS digital covering 10 sections (Personal confidential data, staff responsibilities, staff training, managing data access, processes, responding to incidents, continuity planning, unsupported systems, IT protection and accountable suppliers)	Mark Northcott	Annually	Partially Effective														
											Patching schedule	Patching schedule for routine updates of desktops/laptops and servers to remove identified vulnerabilities	Kevin Houghton	Ongoing	Partially Effective														
											Privileged Access Management	Access control over privileged admin accounts	Kevin Houghton	Ongoing	To Be Assessed														
											Penetration Tests	Penetration tests for externally facing systems to test for weaknesses and gaps in cyber security controls	Mark Northcott	Annually	Not Effective														
29	May-22	Jul-23	Medical Devices Risk	**IF** the equipment used by the trust to treat patients is not of sufficient quality and reliability, **THEN** there is a risk that patients will not be able to be treated, **RESULTING** in potential patient harm.	Faulty equipment in SCAS vehicles Equipment not serviced at required intervals Poor procurement process	Potential risk to patients Further CQC action or investigations Deterioration in SCAS reputation Increase in claims against SCAS	Service Quality & Patient Experience	Catastrophic	Likely	**20**	Incident Reporting Policy	Policy detailing the requirements and criteria for determining and investigating incidents, including near misses.	John Dunn	Ongoing	Effective	Major	Possible	**12**	**Treat**	Helen Young	Zoll defibrillators	Zoll defibrillators not displaying a rhythm or shock when using therapy pads. Crews see a 'Lead fault' error message. When devices are used in the AED mode there is a delay to providing the first shock	Urgent	Ross Cornett	Investigation into Zoll equipment	~~Work with Zoll to understand issues and possible resolutions~~ ~~Order supply of single lead cables for Zoll machines to reduce errors in use~~ Reconfiguration of devices to reintroduce monitoring alerts Training for all clinical staff on reconfiguration as display has changed	Ross Cornett	Configuration update by ZOLL dependent on training availability	
											Medical Devices Review Group	Group responsible for the review, implantation, and reconsideration for Diagnostic and Therapeutic Medical Devices	Ross Cornett	Monthly	Effective					ZOLL Consumables	The ability to obtain consumables for ZOLL devices, including the correct type of cable, replacement batteries and adaptors	Closed	Ross Cornett	Portable Ventilator	Ventilators have been received from NHSE stock	Andy Pope	In line with new vehicle delivery	
											Clinical Review Group	Group Responsible for the review of all aspects of Diagnostic and Therapeutic Medical Devices	John Black	Monthly	Effective					Lack of an equipment database	There is no equipment database to allow for tracking of equipment, including medical devices across the Trust.	Closed	Ross Cornett	Medical Devices Improvement Plan	Set of actions to improve the medical devices governance and processes covering capacity and policies.	Ross Cornett	Ongoing	
											Staff training	Staff undergo training on equipment to reduce human error whilst using medical devices	Ian Teague	Ad-hoc	Effective					Portable Ventilators	Existing model of portable ventilator is no longer being manufactured.	Low	Ross Cornett					
											Equipment maintenance schedules (tracking of equipment maintenance timelines)	All medical devices have a maintenance schedule in line with manufactures guidelines.	Andy Pope	Ongoing	Effective					Medical Devices Governance	Governance checks including make ready checks are not working as they should, meaning that there is limited to no assurance over the medical devices on vehicles.	Low	Ross Cornett					
											Asset Database	Asset database with all medical devices listed showing asset ID; purchase date; service date; configuration date etc.	Kevin Mouland	Ongoing	Effective					Operational Support Services Capacity and Competence	The capacity and competence of the Operational Support Services has been highlighted by an external review of the processes	Urgent	Paul Kempster					
											Supplier Management Process	Management of equipment suppliers so issues can be feedbacked and tracked to measure supplier performance.	Andy Pope	Ongoing	Effective													
											Quality & Safety Committee	Monitors the implementation of relevant policies and guidelines.	Helen Young	Bi-monthly	Effective													
											Staff communication	Any updates or notices which staff need to be aware of concerning medical devices is communicated via Staff Matters or Hot News.	Michelle Archer	Ad-hoc	Effective													

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	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*
27	May-22	Jul-23	Legal Risk	IF SCAS does not comply with the duty of care owed to a patient, employee or third party and causes harm to occur **THEN** there is a risk that there will be legal claims made against the trust **RESULTING** in litigation costs, financial claims and reputational harm.	Demand pressures External environment at scene Lack of / poor quality training Poor quality equipment Manual handling Lack of risk assessments	Patient harm caused Financial loss through compensation Deterioration in SCAS reputation Increase in claims against SCAS if published Potential loss of succesful commercial tenders	Service Quality & Patient Experience	Catastrophic	Possible	**15**	Claims Policy	Details claims process	Jennifer Saunders	Ongoing	To Be Assessed	Moderate	Possible	**9**	**Tolerate**	Jennifer Saunders	Face to face training	Face to face training did not take place during the pandemic however this has now restarted from April 2022.	Moderate	Ian Teague					**July 2023: Risk remains stable** **October 2022:** Risk remains stable however reputational impacts have been noted should claims be made against the Trust. This may lead to additional claims or a reduction in the Trusts ability to tender for commercial contracts. **August 2022:** Risk reviewed and reduced due to controls in place which reduce the overall impact such as clinical negligence, liability and property insurance mechanisms. Impact relates to increase in premiums.
											Claims investigations	Claim reviewed by external paramedic (expert) to identify any learnings for the SCAS	Jennifer Saunders	Ad-hoc	To Be Assessed						Response times	Increased response times to patients can lead to high levels of claims	Moderate	Paul Kempster					
											Claims reporting	Reporting on volume of claims to board	Jennifer Saunders	bi-annually	To Be Assessed														
											Communication of learning	Leanings identified through investigations are communicated to relevant parties to reduce the likelihood of reoccurrence	Jennifer Saunders	Ad-hoc	To Be Assessed														
											Clinical Negligence Scheme for Trusts (CNST)	Insurance scheme for NHS Trusts to manage and pay medical negligence claims.	Jennifer Saunders	Annually	To Be Assessed														
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	**August 2023: Face to face training has been cancelled due to REAP levels. QA completed and due to be considered by the Safeguarding Committee** **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.
											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														
30	19-Jul-22	Feb-23	Call Dispositions	IF the disposition category of calls changes significantly **THEN** there is a risk that our planning and forecasting models are incorrect which means we will not have sufficient capacity to reach patients in time **RESULTING** in patient harm.	Change in community behaviours Increased pressure on NHS leading to patients not receiving community or hospital care and then requiring an ambulance	Negative impact to reputation Potential harm to patients Increased use of private providers	Service Quality & Patient Experience	Major	Almost Certain	**20**	Enhanced Patient Safety Procedure	Procedure implemented when service is under extreme pressure to ensure that Category 1 and Category 2 patients receive an ambulance response in a timely manner.	Luci Papworth	Ad-hoc	To Be Assessed	Moderate	Likely	**12**	**Treat**	Paul Kempster	Handover delays	Delays in handing over patients from SCAS to Hospital/Treatment Centre due to capacity/resource constrains. Primarily at the Queen Alexandra Hospital.	Urgent	Mark Ainsworth	Recovery Plan	Comprehensive plan to recover service to meet targets, covering Future CC Strategy, 999 Resource, Recruitment & Training, Staff Retention, Use of Resource, Homeworking, Outsourcing, Sickness and Task Time.	Paul Kempster	Ongoing	**July 2023: Under Review with Ops and BI** **February 2023:** Call dispositions split has improve with YTD 51% **October 2022:** Risk remains stable overall. Call dispositions have fluctuated however the currently are at 55% for C2 with C3 calls reducing. This is being monitored at Service Delivery Board. **August 2022:** New risk identified relating to the change in call dispositions from patients. The percentage of calls categorised as category 2 in 2019/20 was 49% however it is currently 55%. Cat1 and 2 calls have increased with C3/4 and HCP calls decreasing. This means there are more calls requiring a clinical assessment/attendance. August has shown a decrease in this trend with Cat 2 calls returning to historical norms however this may be an anomaly and continues to be monitored.
											Silver Calls	Daily calls looking at potential gaps in calls across all services	Duty Silver	Daily	To Be Assessed						Duplicate calls to CCC	High volumes of duplicate calls into CCC due to the ongoing performance problems experienced across the Trust. Calls are chasers and ETA calls	Urgent	Luci Stephens					
											OPEL review call	Looks at current pressures across all services	Duty Silver	Daily	To Be Assessed						Lack of resource	Resource impacted by high levels of attrition, increased sickness rates and a large volume of vacancies in Ops and CCC (~500 vacancies in Ops)	Urgent	Melanie Saunders					
											Demand Forecasting	Forecasting demand using models which are adjusted based on experience	Maria Langler	Ongoing	To Be Assessed														
											Weekly look forward	Review weekend and following weeks expected demand against resource	Paul Jefferies	Weekly	To Be Assessed														
											Flexible deployment model	Ability to move resources between nodes and North/South where required		Ad-hoc	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														
31	02-Aug-22	Jun-23	OFSTED Risk	IF we do not have sufficient educational capacity to effectively manage our OFSTED inspected programmes **THEN** there is a risk that OFSTED will give us a Inadequate rating **RESULTING** in an inability to run apprenticeship programmes.	Publication of CQC report Individual notification to OFSTED / Student Concern Scheduled full visit Concerns of partners such as ICBs etc sent to OFSTED	**If rating is Requires Improvement** Increased scrutiny of education team and processes Create improvement plans at short notice Improvement work would use educational resources impacting BAU work Possible prevention of enrolling new people on programmes Negative impact on SCAS reputation **If rating is Inadequate** Loss of provider status Loss of input into apprenticeship courses Inability to recruit additional apprentices Potential redundancies for a small number of staff Significant loss of control over training apprentices Loss of finances Loss of recruitment workstream for Emergency Care Assistant and AAP roles linking to workforce planning Transfer of all apprentices to other educational establishments in some circumstances Potential impact to patient safety Significant damage to the morale and effectiveness of the education team Possible loss of educational staff Negative impact on SCAS reputation Inability to reapply to deliver apprenticeships for a minimum of 3 years.	People & Organisational Development	Major	Almost Certain	**20**	Referral process	Process for apprentices or other staff to raise concerns around safeguarding of apprentices	Caroline Robertson	Ongoing	Not Implemented Yet	Major	Possible	**12**	**Treat**	Melanie Saunders	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	Helen Young	Ongoing	**December 2022:** OFSTED audit took place between 30 November and 2 December 2022. Currently awaiting the report. No critical findings have been reported during the visit. **October 2022:** 2 mock inspections have been completed with learnings identified. No critical findings, although safeguarding was not fully tested during the mock visit due to a lack of expertise wih the inspectors. Work is still required through the Safeguarding improvement group to resolve outstanding issues. **August 2022:** Risk raised around the possibility of an early OFSTED full visit (due 24 months after initial monitoring which took place May 2021). Currently resource is thin with support being given to the CQC safeguarding improvement plan.
											Scheme Meetings	Meetings with key parties in the apprenticeship scheme to discuss various aspects of the scheme	Caroline Robertson	Weekly	Effective						Apprentice Work Pressures	Apprentices are experiencing a considerable amount of work pressures due to the current system challenges and complexity of course.	High	Mike Dunford	Continuous Improvement Plan	Ongoing workstream for the ongoing improvement and development of educational work.	Caroline Robertson	Ongoing	
											Progression Board	Meeting where details of individuals' progress can be discussed as well as any wider trends or common themes.	Nick Foster	Monthly	Effective						Limited Resource	There is a limited pool of staff in the education team who support the apprentices from a safeguarding perspective.	High	Melanie Saunders	Education Strategy & Workforce Development Plan	Workforce development plan is discussed between WFDB and IWP	Ian Teague	TBC	
											Apprenticeship Governance Board	Meeting to oversee the whole apprenticeship programme. Includes external representation to ensure best practice is taken into consideration.	Melanie Saunders	Bi-monthly	Effective						Organisational Work Pressures	The Trust is experiences a considerable amount of work pressure impacting the ability for areas to stand down and conduct non-response work.	High	Paul Kempster	Operational Recovery Plan	Comprehensive plan to recover service to meet targets, covering Future CC Strategy, 999 Resource, Recruitment & Training, Staff Retention, Use of Resource, Homeworking, Outsourcing, Sickness and Task Time.	Paul Kempster	Mar-23	
											Quality Improvement Plan (QIP)	Process for highlighting areas for improvement.	Caroline Robertson	Ongoing	Effective														
											National Education Network of Ambulance Services (NENAS)	Sub-group for peer review of schemes and processes with all ambulances services so best practice can be shared.	Caroline Robertson	bi-annually	Partially Effective														
											Regional Groups	Regional groups for peer review of schemes and processes with all system partners so best practice can be shared.	Caroline Robertson	Monthly	To Be Assessed														
											Mock Inspection	Test inspection by the Clinical Governance team against OFSTED guidelines to identify any gaps and provide assurance over SCAS processes.	Ian Teague	Annually	Effective														
32	01/01/2020	Jul-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 consistently lower than actual hours for both ECT and clinicians.
											Recruitment	Recruitment process for onboarding new staff	Pamela Putt	Ongoing	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					
											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														
33	07/11/2022	Aug-23	Industrial Action Risk	IF unionised SCAS employees vote for industrial action **THEN** there is a risk that they will take part in strike action **RESULTING** in patient harm and poor patient experience.	Lack of clinical staff Lack of non-clinical staff Cost of living crisis (including fuel) Inflation Increased work pressure	Industrial action, potential staff walkouts / not turning up for shifts Inability to provide services to patients (either 999, 111, PTS, Logistics or Maternity Line) Inability to answer calls Negative impact on reputation Inability to complete projects or improvement plans Inability to undertake corporate functions. Patient harm, including death due to not attending patients	Service Quality & Patient Experience	Catastrophic	Almost Certain	**25**	Agency staff	Ability to bring in temporary agency staff to perform roles across the Trust	Melanie Saunders	Ongoing	To Be Assessed	Moderate	Rare	**3**	**Tolerate**	Melanie Saunders	Cost of Living	Ongoing cost of living crisis including high levels of inflation and increased energy and fuel prices.	Urgent	Melanie Saunders	Industrial Action Meetings	Actions taken as part of the industrial action meetings to manage the impact of any strike action from staff	Paul Jefferies	Completed	**August 2023: Risk remains stable. Update on legality of using private providers and agency staff to mitigate impact of strikes (cannot be used purely for this however can be used to manage increase in demand or cover sickness).** **May 2023:** The Staff Council has accepted the pay offer and will be applied from June (back dated to April), however Unite have continued to stike with 2 days taking place in May. **February 2023:** Risk has increased following the results of the Unite and Unison ballots. Both have voted for strike action. Unite have ~331 members and Unison have ~1994. Unite strike dates are 6th and 20th March and Unison is 8th March. **January 2023:** Risk reduced at the Industrial Action meeting following evaluation of last strike day and assessment of upxcoming strike days. Next strike day is 11 January.
											Business Continuity Plans	Business Continuity plans in place for loss of staff	Hollie Bailey	Annually	To Be Assessed						North East and North North vacancies	High vacancy levels in the North East and North North nodes	Urgent	Melanie Saunders					
																					Lack of resource	Resource impacted by high levels of attrition, increased sickness rates and a large volume of vacancies in Ops and CCC (~500 vacancies in Ops)	Urgent	Melanie Saunders					
											Union liasions	Recognition of unions and communication with the unions throughout the strike	Stephen Scales	Ongoing	To Be Assessed														
											Communication with staff	Communication with staff to understand what is taking place and how many people may be striking	Michelle Archer	Ongoing	To Be Assessed														
											Workforce Management	Ability to cancel annual leave, rearrange training sessions, provide overtime for staff not on strike, providing they do not breach working practice legislation. Reschedule meetings for non-IA days.	All managers	Ongoing	To Be Assessed														
											Industrial Action Planning Meetings	Weekly planning meetings with internal stakeholders to manage strike days.	Paul Jeffries	Weekly	Effective														
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; 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**	Barry Thurston	Supplier contracts	Escalation process and responsibilities for support (including SLAs) in the event of system issues should be clearly defined.	Moderate	Barry Thurston	Digital restructure	The Digital restructure if approved will deliver increased efficiency and additional capacity to improve hardware support	Barry Thurston	TBC	**August 2022: VXLAN project due to close by 15 September. Isolated telephony failover test due October 2023. Final set of changes required to connect current CAD core switches to the new CAD switches. This is being done as a BAU task. Data Centre replacement pen test taking place at the end of August.** **June 2023:** VXLAN delayed as unable to get downtime for essential maintenance on switches to allow for the VXLAN project to progress and complete. This also delays the Data Centre Upgrade project which depends on the VXLAN project completing. **April 2023:** Data Centre Upgrade project - iSCSI cards connections now in place and the project is on configuration and testing phase. This is due to last until May then move into VX migration phase. VXLAN project due to finish at the end of May. Circuits have been delivered and in operation with decommissioning of previous circuits planned. WAN Aggregation switch migration planned for 26-27 April and switching the Voice and CAD core switch to the new infrastructure is planned for May.
											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	Barry Thurston	Hardware replacement programme	Include a higher level of contingency in hardware purchase timelines and project mangement resources to allow for delays	Barry Thurston	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	Barry Thurston					
											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	Barry Thurston					
											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														

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*
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**	Barry Thurston	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	Barry Thurston	TBC	**June 2023: Safeguarding progress progessing 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	Barry Thurston	Digital restructure	The Digital restructure if approved includes a SQL DBA role	Barry Thurston	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	Barry Thurston					
											Penetration Tests	Penetration tests for externally facing systems to test for weaknesses and gaps in cyber security controls	Mark Northcott	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**	Barry Thurston	Maintenance Schedules	There is no routine maintenance performed on SQL databases.	Urgent	Barry Thurston	ICT restructure	The Digital restructure if approved tries to minimise single points of failure	Barry Thurston	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.
											Continued Professional Development	Staff can undertake continued professional development courses to ensure they remain up to date with latest developments and techniques in the industry			To Be Assessed						Clinical Risk	There is no Clinical Safety officer to undertake clinical risk assessments on new systems or changes to existing systems	Urgent	Barry Thurston					
											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	Barry Thurston					
																					Key Person Dependencies	There are a number of single points of failure within the digital team	High	Barry Thurston					
38	Nov-22	Dec-22	Private Provider Ceasing Trading Risk	IF a 999 private provider ceases trading **THEN** there is a risk that existing resource will be unable to make up the gap in hours **RESULTING** in increased waits and potential patient harm.	Providers going out of business	Increased wait times for patients Decrease in patient safety Potential financial loss	Service Quality & Patient Experience	Moderate	Possible	9	Private Provider Strategy	Overall strategy for how the Trust approaches the use of private providers, including the ability to Tupe staff over to SCAS in the event that the provider goes out of business.	Maria Langier	Ongoing	To Be Assessed	Moderate	Possible	9	Tolerate	Paul Kempster					Implementation of Private Provider Strategy	Implementation of the new private provider strategy	Maria Langer	Oct-23	**December 2022**: One provider ceased trading which has impacted us however they communicated with the team in the lead up and staff have moved to another provider.
											Supplier risk assessments	Risk assessments for each provider including financial monitoring to identify any concerns	Julie Robins	Ad-hoc	to Be Assessed														
											Recruitment offers to staff	Where a private provider goes out of business, the Trust advises of recruitment options for their staff	Recruitment	Ad-hoc	To Be Assessed														
											Monthly Finance checks	Every month procurement check the finincials of all providers. This is incrased to weekly if concern is raised.	Julie Robins	Monthly	To Be Assessed														
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 Liason 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 Langier	Daily	To Be Assessed										Faller review	Review of incidents involving fallers	TBC	TBC	
											Demand Forecasting	Planning model for expected demand for each service	Maria Langier	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	Dawn Chase	Complete	
											System Partner Meetings	System meetings to discuss system risks for patient care	Helen Young		To Be Assessed														
											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														

Report title:	**Board Assurance Framework Update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**16.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 risk to track changes in the risk rating since the BAF was created in April 2023. Layout has been amended to landscape and we have moved the Controls, Gaps in Controls and Actions to one row so it flows better. **Strategic Risk 1: Failure to provide safe and effective care** Risk remains stable at 12 (Major (4) x Possible (3)). Added "**Chief Medical Officer link to local and national forums**" to the Controls section and removed the "System engagement" action as Added "**and data**" to the "**Developing clear strategy for learning from incidents and data which then feeds into education programmes in the workforce.**" in the Gaps in Controls and Assurances section. Amended the action owner for the "**Procurement system for managing safe deployment and maintenance of equipment**" to **Barry Thurston** from **Jill Lanham**. Added "**Development of UCPs in remaining acutes and systems**" as an action to address the "**Variability in pathways**" gap as this team is in place to help develop pathways across the Trusts patch. Added "**Rota review**", "**Explore/review Paramedic Rotation schemes**" and "**Development of improvement plan to increase employee retention rates**" actions to mitigate the "**Workforce shortages**" gap. **Strategic Risk 2: Unable to meet demand and provide a responsive service to patients** Risk remains stable at 15 (Catastrophic (5) x Possible (3)). Added "**Performance Cell**" and "**Private Providers**" as controls in the Controls section. Added "**Rota Review**", "**Explore/Review Paramedic Rotation scheme**", "**Development of improvement plan to increase**		

	employee retention rates" and "**Development of UCPs in remaining acutes and systems**" to the actions section. Added action for a "**Role to be advertised to increase capacity for meetings**" which will resolve the "**Capacity to attend director meetings**" gap. **Strategic Risk 3: Disproportionate stakeholder focus.** Risk score has been reassessed and reduced to 12 (Major (4) x Possible (3)) from 20 (Catastrophic (5) x Likely (3)) as the controls that are in place are working. Amended the action due date for the '**Role to be advertised to increase capacity for meetings**' action from '**Q3 23-24**' to '**On hold due to financial constraints.**' Added '**Review system stakeholder engagement to identify alternative approaches'** as an action with a due date of '**Q3 23-24**'. **Strategic Risk 4: Stakeholder understanding of SCAS.** Risk remains stable at 12 (Major (4) x Possible (3)). Added '**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**' as a Third line (external) assurance in the Assurances section. Removed '**Evidence of influence and change in ICS priorities and spend**' as a gap due to the HIOW system being in the recovery support system and improved information now being available. Amended the '**SCAS-led strategy workshop in Hampshire and the Isle of Wight**' due date action '**Postponed due to pressures in the system – looking for alternative options**' from '**Q2 2023**'. Amended the action due date for the '**Role to be advertised to increase capacity for meetings**' action from '**Q3 23-24**' to '**On hold due to financial constraints.**' **Strategic Risk 5: Increasing costs resulting in a deficit.** Risk remains rated as 20 (Major (4) x Almost Certain (5)). Removed "**Long term financial planning**" from the control section however added "**Cash monitoring**", "**Weekly proxy data used for run rate**", "**Financial Recovery Group spend reviews and monitoring**" and "**Spend validation against peers**". Added "**Financial Recovery Group**" to the First and Second Line (Internal) Assurances section and added "**System Recovery Group (ICB level group)**" to the Third line (external) assurances section. Removed "**Clear oversight of budget position and spend information**" and "**Lack of cost and productivity data/trends**" from the Gaps in Controls and Assurances section. Added "**Lack of medium-term financial plan**" to the Gaps in Controls and Assurances section.

	Closed "**Full-year cost improvement programme**" action and replaced with "**Develop multi-year Financial Plan**". Closed "**Reporting on run rates**" action. Closed "**Sharing information with SECAM to benchmark**" action. **Strategic Risk 6: Insufficient skills and resources to deliver services.** Risk remains stable at 16 (Major (4) x Likely (4)). Added "**via IQPR**" to the "**Staff wellbeing metrics**" item in the Gaps in Controls and Assurance section. Amended the due date for the "**Development of talent management and development programme**" action to include "**depending on budget approval.**" Added "**Embed IQPR into Trust Board and Sub-Committees**" with a owner and due date of "**Mike Murphy / Ongoing**". **Strategic Risk 7: Staff feeling unsafe, undervalued, and unsupported.** Risk has reduced from 16 (Major (4) x Likely (4)) to 12 (Major (4) x Possible (3)) due to the further embedding of controls. Updated the "**Delivery and embedding Culture improvement plan**" action to show the approval of the plan for September 2023 and the embedding of the plan as ongoing. Amended the "**Support of Staff Networks**" action to "**Embed Support of Staff Networks**" in the action section. **Strategic Risk 8: Ability to deliver digital strategy.** Risk remains rated as 20 (Catastrophic (5) x Likely (4)). Risk is currently being reviewed by exec lead.			
Recommendations:	The Trust Board is asked to: - review and approve the strategic risks included in the Board Assurance Framework that fall within the Committee's remit.			
Executive lead:	Daryl Lutchmaya, Chief Governance Officer			
Report author:	Steven Dando, Head of Risk Management			
Previously considered by:	Reviewed individually with risk owners.			
Purpose of report:	Note ☐	Approve ☒	Assure ☐	
Paper Status:	Public ☒	Private ☐	Internal ☒	
Assurance level:	Significant ☐	Acceptable ☒	Partial ☐	No Assurance ☐

	High level of confidence in delivery of existing mechanisms / objectives	General confidence in delivery of existing mechanisms / objectives	Some confidence in delivery of existing mechanisms / objectives	No confidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Strategic Objective(s):	All strategic objectives
Links to BAF risks: (or links to the Significant Risk Register)	All BAF risks
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): - Presentation of the BAF at the Board meeting.	
List of Appendices:	

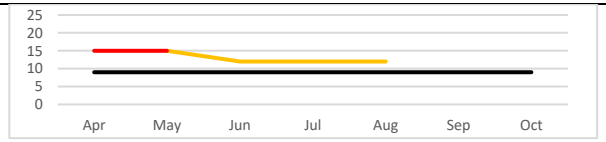
Strategic Risk	Strategic Domain / Exec Lead	Strategic Objective	Risk Rating Movement Same Improved Worsened	Historic Current Risk Rating				Inherent / Current / Target Risk	Oversight Committee / Last Review Date at Committee	Strength of Controls	Strength of Assurance
SR1 **IF** we have insufficient clinical workforce capability or ineffective equipment and vehicles, **THEN** we will fail to provide safe and effective care **LEADING TO** poor clinical outcomes.	High quality care and patient experience Helen Young / John Black	We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.	↔	**APR 15**	**MAY 15**	**JUN 12**	**JUL 12**	**20**	**Quality & Safety** **Sept 2023**	**TBC**	**TBC**
				AUG 12	**SEP**	**OCT**	**NOV**	**12**			
				DEC	**JAN**	**FEB**	**MAR**	**9**			
SR2 **IF** we do not have or use effective operational delivery systems, **THEN** we may not be able to meet demand and provide a responsive service to patients in need of emergency care, **LEADING TO** delays in treatment and increased morbidity and mortality.	High quality care and patient experience Paul Kempster / Helen Young / John Black	We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes	↔	**APR 20**	**MAY 20**	**JUN 15**	**JUL 15**	**20**	**Quality & Safety** **Sept 2023** **Finance & Performance** **July 2023**	**TBC**	**TBC**
				AUG 15	**SEP**	**OCT**	**NOV**	**15**			
				DEC	**JAN**	**FEB**	**MAR**	**10**			
SR3 **IF** the organisation fails to engage or influence within systems, **THEN** there may be a disproportionate focus in one system over the others and capacity provided may not align with expectations, **LEADING TO** performance that is not achievable or credible and possible poor outcomes for patients and the communities we serve.	Partnership & Stakeholder Engagement Mike Murphy	We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans	↓	**APR 20**	**MAY 20**	**JUN 20**	**JUL 20**	**25**	**Finance & Performance** **July 2023**	**Effective**	**Effective**
				AUG 20	**SEP 12**	**OCT**	**NOV**	**12**			
				DEC	**JAN**	**FEB**	**MAR**	**4**			

Strategic Risk	Strategic Domain / Exec Lead	Strategic Objective	Risk Rating Movement Same Improved Worsened	Historic Current Risk Rating				Inherent / Current / Target Risk	Oversight Committee / Last Review Date at Committee	Strength of Controls	Strength of Assurance
SR4 **IF** we fail to engage with stakeholders and partners, **THEN** partners will fail to understand who we are and what we do, **LEADING TO** failure to innovate and influence and an inability to identify opportunities within systems.	Partnership & Stakeholder Engagement Mike Murphy	We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans	↔	APR 12	MAY 12	JUN 12	JUL 12	16	Finance & Performance July 2023	Effective	Effective
				AUG 12	SEP 12	OCT	NOV	12			
				DEC	JAN	FEB	MAR	6			
SR5 **IF** demand, operational standards and external factors (such as inflation, interest rates, taxation and cost of living) continue to increase, **THEN** the total costs to deliver our services will increase and result in a deficit, **LEADING TO** additional pressures on our ability to deliver a sustainable financial plan and safe services.	Finance & Sustainability Stuart Rees	We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.	↔	APR 20	MAY 20	JUN 20	JUL 20	20	Finance & Performance July 2023	TBC	TBC
				AUG 20	SEP	OCT	NOV	20			
				DEC	JAN	FEB	MAR	12			
SR6 **IF** we fail to implement resilient and sustainable workforce plans, **THEN** we will have insufficient skills and resources to deliver our services, **LEADING TO** ineffective and unsafe patient care and exhausted workforce.	People & Organisation Melanie Saunders	We will develop plans to deliver inclusive, compassionate culture where our people feel safe and have a sense of belonging.	↔	APR 16	MAY 16	JUN 16	JUL 16	20	People & Culture July 2023	Partially Effective	Partially Effective
				AUG 16	SEP	OCT	NOV	16			
				DEC	JAN	FEB	MAR	12			
SR7 **IF** we fail to foster an inclusive and compassionate culture,	People & Organisation	We will develop plans to deliver inclusive, compassionate culture where our people feel	↓	APR 16	MAY 16	JUN 16	JUL 16	20	People & Culture July 2023	Partially Effective	Partially Effective

Strategic Risk	Strategic Domain / Exec Lead	Strategic Objective	Risk Rating Movement Same Improved Worsened	Historic Current Risk Rating				Inherent / Current / Target Risk	Oversight Committee / Last Review Date at Committee	Strength of Controls	Strength of Assurance
THEN our staff may feel unsafe, undervalued, and unsupported, **LEADING TO** poor staff morale, disengagement, low retention and impacts on patient safety and care.	Melanie Saunders	safe and have a sense of belonging.		**AUG 12**	**SEP**	**OCT**	**NOV**	**12**			
				DEC	**JAN**	**FEB**	**MAR**	**8**			
SR8 **IF** we are unable to prioritise and fund digital opportunities, **THEN** we will have insufficient capacity and capability to deliver the digital strategy, **LEADING TO** system failures, patient harm and increased cost.	Technology transformation Barry Thurston	We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.		**APR 20**	**MAY 20**	**JUN 20**	**JUL 20**	**25**	**Finance & Performance** **July 2023**	**TBC**	**TBC**
				AUG	**SEP**	**OCT**	**NOV**	**20**			
				DEC	**JAN**	**FEB**	**MAR**	**15**			

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: August 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



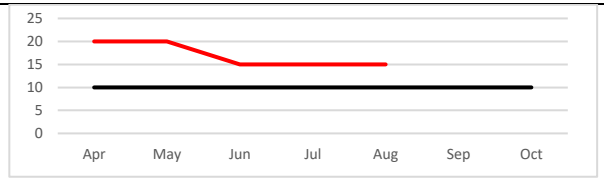
Risk Lead	Assurance Committee
Helen Young, Chief Nurse, John Black, Chief Medical Officer	Quality & Safety Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• 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 • Chief Medical Officer link to local and national forums	• 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 and data which then feeds into education programmes in the workforce.	Procure system for managing safe deployment and maintenance of equipment	Barry Thurston / 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 / October 2023
		Development of UCPs in remaining acutes and systems	Mark Ainsworth / Ongoing
		Rota review	Mark Ainsworth / TBC
		Explore/review Paramedic Rotation schemes.	Melanie Saunders / Q4 2023/24
		Development of improvement plan to increase employee retention rates	Natasha Dymond / 999 at WFB – approved CCC & PTS - Sept

Assurances		Associated Risks on the Organisations Risk Register		
First and second line (internal) assurances Reports to: • Quality & Safety Committee • Patient Safety & Experience Group • Clinical Review Group • Medicines Optimisation and Governance Group • Workforce Development Board • Integrated Workforce Planning groups • 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	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: August 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



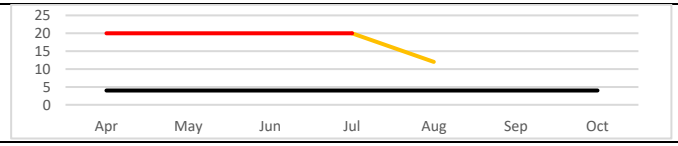
Risk Lead	Assurance Committee
Paul Kempster, Chief Operating Officer, Helen Young, Chief Nurse, John Black, Chief Medical Officer	Finance and performance committee Quality & Safety Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• Demand forecasting and profiling using models which are adjusted based on experience • Daily Operational MI reports detailing performance against set metrics • Mutual aid process exists and works • 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 • Performance Cell • Private Providers	• Insufficient clinical advisory support (e.g., 111, 999, IUC) • Quality Improvement Process and Culture • Urgent Care Pathways (UCPs) are not in place for all acutes and systems.	Develop a forecast versus actual report based on experience adjusted models	Mark Adams / TBC once investigations complete
		Rota review	Mark Ainsworth / TBC
		Explore/review Paramedic Rotation schemes.	Melanie Saunders / Q4 2023/24
		Development of improvement plan to increase employee retention rates	Natasha Dymond / 999 at WFB – Approved CCC & PTS - Sept
		Development of UCPs in remaining acutes and systems	Mark Ainsworth / Ongoing

Assurances		Associated Risks on the Organisations Risk Register		
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	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 3:	Update: September 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	**4**	**3**	**12**
Target	2	2	4



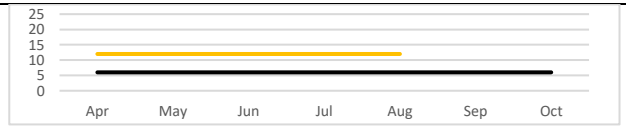
Risk Lead	Assurance Committee
Mike Murphy, Chief Strategy Officer	Finance and Performance Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• 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	• No SCAS membership on any ICB boards • ICB coordination for contracts • Capacity to attend director meetings	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 / On hold due to financial constraints
		Review system stakeholder engagement to identify alternative approaches	Volker Kellerman / Q3 23-24

Assurances		Associated Risks on the Organisations Risk Register		
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	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: September 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



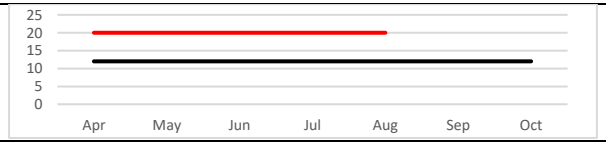
Risk Lead	Assurance Committee
Mike Murphy, Chief Strategy Officer	Finance and Performance Committee, Trust Board

Controls	Gaps in Controls and Assurances	Actions	Due Date
• 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.	• 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	Mike Murphy / Q2 2023 – Postponed due to pressures in the system – looking for alternative options
		Consider actions for other systems as above	TBC once above action complete
		Role to be advertised to increase capacity for meetings	Mike Murphy / On hold due to financial constraints

Assurances		Associated Risks on the Organisations Risk Register		
First and second line (internal) assurances Reports to: • Finance and Performance Committee • Trust board	**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	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: September 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



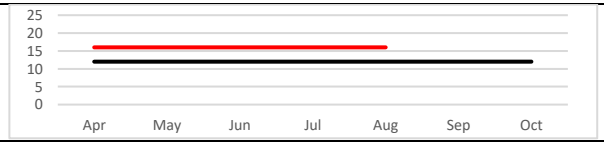
Risk Lead	Assurance Committee
Stuart Rees, Interim Director of Finance	Finance and Performance Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• 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 • 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 • Cash monitoring • Weekly proxy data used for run rate • Financial Recovery Group spend reviews and monitoring • Spend validation against peers	• Unidentified gaps in cost improvement programme targets • Lack of agreement on key supplier and commissioning contracts • Lack of benchmarking data • Lack of a medium-term financial plan	Full-year cost improvement programme in development by the executive team (financial sustainability plan)	Aneel Pattni / Closed – Replaced by Financial Recovery Plan action
		Negotiation and dialogue with key commissioners	Stuart Rees / Ongoing
		Consider greater delegation of budgets	Aneel Pattni / On hold due to additional control measures (SOF4)
		Reporting on run rates etc	Stuart Rees / Complete
		Develop multi-year Financial Recovery Plan	Stuart Rees / Oct 2023
		Sharing information with SECAM to benchmark	Stuart Rees / Complete
		Develop medium-term financial plan	Stuart Rees / Feb 24

Assurances		Associated Risks on the Organisations Risk Register		
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 • Financial Recovery Group	**Third line (external) assurances** • External audit • Internal audit • Counter fraud • Commissioners • HIOW ICB • System Recovery Group (ICB level group)	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: August 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



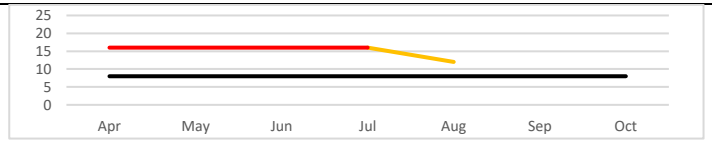
Risk Lead	Assurance Committee
Melanie Saunders, Chief People Officer	People and Culture Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• 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	• 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 via IQPR • 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 / implementation by Q4 23/24 depending on budget approval
		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 – approved. CCC & PTS - Sept
		Embed IQPR into Trust Board and Sub-Committees	Mike Murphy / Ongoing

Assurances		Associated Risks on the Organisations Risk Register		
First and second line (internal) assurances • 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	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 **12**
Strategic Risk No. 7:	Update: August 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**	**3**	**12**
Target	4	2	8



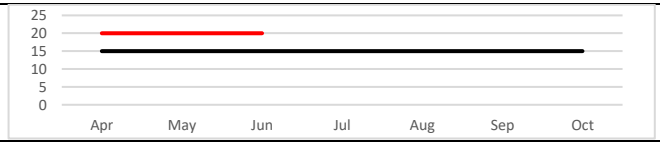
Risk Lead	Assurance Committee
Melanie Saunders, Chief People Officer	People and Culture Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• People strategy, EDI strategy and associated enabling plans • Freedom to Speak Up (FTSU) guardian and supporting programme in place • 'Supporting our people' website, including EAP and Occupational Health • SCAS leader and ESPM leadership training • Sexual safety charter • Allegations management process and associated Employment policies. • Staff forums and TLL relationships • Appraisal process • Communications strategy	• 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 / Approval September 2023 Embedding - ongoing
		Embed Support of Staff Networks	Dipen Rajyaguru / ongoing
		QI innovation and culture relaunch	Helen Young / TBC

Assurances		Associated Risks on the Organisations Risk Register		
First and second line (internal) assurances • 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	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	Assurance Committee
Barry Thurston, Chief Digital Officer	Finance & Performance Committee

Controls	Gaps in Controls and Assurances	Actions	Due Date
• 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	• 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	Barry Thurston / July 23
		Develop KPIs	Barry Thurston / Ongoing
		Develop annual planning cycle to map resources and plan capacity for digital resource	Barry Thurston / Ongoing
		Review service desk software and adoption of ITIL within existing budgets	Barry Thurston / 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	Barry Thurston / July 23

Assurances		Associated Risks on the Organisations Risk Register		
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	Risk No.	Description	Current Score

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Integrated Quality Performance Report (IQPR)**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday 28th September 2023**	**Agenda item**	**17**
Executive Summary:	The Integrated Quality Performance Report for September sets out our performance in August. For the reporting of month 5 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). 2. The report is structured, following feedback from Board, to reflect our Corporate structure; Operational Performance, Quality & Safety, Workforce and Finance. 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 completed alongside the development of individuals in the writing of commentaries which are in the process of improving.		
Recommendations:	The Trust Board is asked to: • Note the report and provide feedback to assist in further development		
Executive lead:	Mike Murphy – Chief Strategy Officer		
Report author:	Mike Murphy – Chief Strategy Officer		
Previously considered by:	N/A		
Purpose of report:	Note ☒	Approve ☐	Assure ☐
Paper Status:	Public ☒	Private ☐	Internal ☐

Assurance level:	Significant ☐ High level of confidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				

Strategic Objective(s):	All
Links to BAF risks: (or links to the Significant Risk Register)	All
Quality Domain(s):	All
Next Steps (what actions will be taken following agreement of the recommendations):	
List of Appendices:	

NHS
South Central
Ambulance Service
NHS Foundation Trust

Integrated Quality and Performance Report: Aug-23

NHS Icon Descriptions

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

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

Executive Summary

Operational Performance

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

Quality & Patient Safety

Workforce

Finance

EXECUTIVE COMMENTARY

Performance 999 and 111

Following a period of poor category 2 performance in July, a comprehensive improvement plan was developed to address concerns about Category 2 and 999 call answer performance. Mean performance for category 2 in July was 33:10 minutes but during August we delivered a significant improvement of 27:33 minutes. A sub 30 minute performance has political significance at this moment in time but more importantly is a stepping stone to achieving the national performance standard of 18 minutes. Our Operational Performance Improvement Plan has delivered a number of immediate actions to increase operational staffing levels and reduce our abstractions which are also supported by short and medium-term actions to increase operational hours to meet 999 response demand. These actions include increasing our private provider hours, increasing SCAS staff hours through overtime, incentivising specific shifts and bank shifts. This plan is being delivered by the senior operations team, with additional action taken to further improve our response for patients, particularly those with high acuity (CAT 1 & 2).

We are still closely monitoring our Cat 1 performance and despatching the closest resource we can to these incidents. This includes active deployment of CFRs and Co responders to these calls.

We have a formal agreement with WMAS to take a percentage of our 999 calls when they breach 60 seconds waiting for SCAS to answer. This is improving our call answer performance along with our own on-going actions to increase ECT staffing levels in our call centres. We recognise that in addition to these actions we need a more sustainable solution and are therefore developing a workforce plan to improve staffing levels.

With relatively low levels of resilience in the staffing model currently, we find ourselves vulnerable to fluctuations in either demand or handover delays. In August we budgeted for an average turnaround time at hospitals of 17 minutes, however due to handover delays the average turnaround time for the month was 22 minutes. Increased turnaround times can have a significant impact on the availability of ambulances to respond to patients. Currently conveyance rates are above target, and the clinical pathways team are now working with acutes to open up more alternative pathways. In addition, we also continue to work with the partners in the Portsmouth system to try to reduce handover delays mindful of the fact that Winter will further expose low levels of resilience if we cannot plan to mitigate them.

EXECUTIVE COMMENTARY (Continued)

Our H&T performance is below plan and is positively impacted by the 111 GP CAS which stops 225 Cat 3&4 incidents per day transferring to 999. We are taking additional steps to improve H&T by introducing Category 2 segmentation at the end of September and a 999 GP CAS in October to focus on revalidating Category 3 incidents generated in 999. Cat 2 segmentation is the process of triaging Cat 2 calls to clinically assess then before offering Hear & Treat, downgrading them to Cat 3 or sending an ambulance. These activities reduce conveyance and demand into acutes. The 111 service is also performing well, with the best call answer performance for 18 months and 999 transfers close to target.

Another issue we are trying to resolve is that of Meal break compliance which remains below target. This metric is impacted by available capacity as a result of handover delays and vacancy rates. The rota review will deliver an improvement to this metric in Q4 because the new rotas will incorporate the need for regular meal breaks and build in overlapping shifts. Delivery delays for the next order of Double Crew Ambulances (DCAs) and engineer vacancies have led to higher levels of VOR in our fleet, but the DCAs will be delivered from October and an increase in engineer staffing levels through agency recruitment will also reduce VOR rates.

Quality and Patient Safety

Meeting the required number of IPC audits in recent months has been a challenge particularly in relation to our buildings and hand hygiene audits. Further work is required to increase the number of audits and compliance rates. IPC leads have been identified in each of the respective services and will work alongside the IPC team to develop plans to address this issue.

We have also experienced an increase in the number of reports of assaults (physical and verbal) against our staff. Unfortunately managing and investigating these incidents is hampered by the reluctance of staff to wear their supplied body worn cameras. There are a number of reasons for this reluctance which include design, comfort and culture. We are working to address this issue both in SCAS and across the sector.

There have also been a cluster of controlled drugs losses which have been investigated and actions taken to prevent further losses.

EXECUTIVE COMMENTARY (Continued)

Workforce

Across the organisation workforce levels are broadly in line with plan with the exception of 999. Recruitment is broadly on target at a Trust level and despite a slight increase in 999 attrition during M5, overall attrition continues to track below forecast in all 3 service lines. Despite a higher than forecast spike in M4, sickness rates have now fallen in M5 and remain below forecast.

Unfortunately, our statutory and mandatory training performance has been in decline for some months and whilst it stabilised in August it is now significantly below target. Our 999 workforce are provided with 'study time' to complete their e-learning, in recognition of the challenges to enable them to complete modules whist on shift. As a means of resolving this issue Leadership teams are being tasked with identifying improvement plans to return to expected compliance levels.

Despite improvements and a period of stability in appraisal rate completion over the last 12 months, performance dropped by 4 percentage points in M5. It is understood that this was due to increased demand/REAP levels and the availability of staff over the summer holiday period. In an effort to resolve this issue leadership teams will be tasked with identifying improvement plans to return compliance (and quality) to our target standard of 95%. The timing of appraisals during holiday periods for staff will be a core consideration.

Finance

As highlighted in the finance section our debtors over 90 days has been above target for some consistent time. This is an issue for the Trust driven by confusion over the payment for Extra Contractual Referrals (ECRs) within PTS. These are journeys that extend across region boundaries and though small in volume, they are lengthy and costly. These journeys were included in the block arrangements set up during Covid but are now paid for separately. This issue was reported to the Audit Committee in September with agreement to write some of the longer standing debts off.

August-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		1
L	Total 111 - Transfer to Clinician	Conflict Management Equality & Diversity Fire Awareness Health & Safety Infection Control Information Governance Manual Handling Safeguarding Adults Level 1 Safeguarding Children Level 1		2
	Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds	39	Patients Collected within time	24
L	Average Hospital Handover Time - SCAS Hospital Delays - SCAS	111 Calls abandoned after 30 secs % 999 Calls abandoned % Complaints - 999 Total %		8
H	111 call answer in 120 Secs % Appraisals - Trust ST&C (Non-ED 1&2) - SCAS			1
↗		Number of Non-Physical Assaults Number of Physical Assaults		5
↘		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 ; 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 ; Patients Arrived within time ; 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 ; Total Task Time - SCAS ; VOR - Other ; VOR - Planned Maintenance ; Vehicle cleanliness completed audits

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Operational Performance

August-23 Summary

Assurance →

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		
L	Total 111 - Transfer to Clinician			1
	Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds	18	Patients Collected within time	7
L	Average Hospital Handover Time - SCAS Hospital Delays - SCAS	111 Calls abandoned after 30 secs % 999 Calls abandoned % Complaints - 999 Total %		1
H	111 call answer in 120 Secs % ST&C (Non-ED 1&2) - SCAS			
↗				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 ; Compliments % ; Patients Arrived within time ; S&T - SCAS ; SCAS 111 - 999 referrals % ; Total Task Time - SCAS ; VOR - Other ; VOR - Planned Maintenance

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Incidents Growth - SCAS	1%	2.57%	-1.50%			n/a
Activity (999 Incidents) - SCAS	49,545	50,528	249,304	602,832		n/a
Cat 1 Mean SCAS	00:07:00	00:08:31	00:08:48	00:09:02		
Cat 1 90th %ile SCAS	00:15:00	00:15:27	00:15:54	00:16:17		
Cat 2 Mean SCAS	00:18:00	00:27:32	00:29:57	00:32:18		
Cat 2 90th %ile SCAS	00:40:00	00:55:01	00:59:21	01:04:57		
Cat 3 90th %ile SCAS	02:00:00	03:37:13	03:59:13	04:42:53		
Cat 4 90th %ile SCAS	03:00:00	04:45:38	05:13:08	06:08:44		
% Cat 1 resulting in LW (> 30 mins)	0.29%	0.5%	0.57%	0.68%		
% Cat 2 resulting in LW (> 60mins)	2.7%	8.1%	9.8%	12%		
% Cat 3 resulting in LW (> 3hrs)	4.9%	14.7%	17%	21%		
% Cat 4 resulting in LW (> 4 hrs)	5.1%	13.3%	16%	19%		

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
H&T - SCAS	11.5%	10.9%	10.8%	11.5%		n/a
S&T - SCAS	35%	33.9%	34%	34%		
ST&C (ED 1&2) - SCAS	48%	51.0%	51%	50%		
ST&C (Non-ED 1&2) - SCAS	5.4%	4.3%	4.4%	4.2%		
Total Task Time - SCAS		01:47:10	01:48:13	01:50:24		
Average Hospital Handover Time - SCAS	00:15:00	00:21:59	00:21:04	00:23:57		
Hospital Delays - SCAS	0	3,659	16,345	49,664		
Clear up Delays - SCAS	00:15:00	00:14:23	00:14:59	00:14:57		
Complaints - 999 Total %	3.6%		0.036%	0.045%		
999 Complaints response - agreed timescale %	95%	100.0%	97%	40%	-	-
999 PHSO cases - upheld/partially upheld		0.0%	0%	0%	-	n/a
Compliments %	26%	0.3%	0.28%	0.25%		

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Meal Break Compliance - SCAS	85%	60%	58%	56%		
Missed Breaks - SCAS	5%	4.4%	4.2%	5%	-	-
Over-runs >30 mins - SCAS	33%	17%	16%	21%	-	-
Vehicle deep clean Compliance - A&E		83%	90%	104%		n/a
Vehicle routine cleans	5,444	5,673	26,683	63,465		n/a
VOR - Unplanned Maintenance	13%	16%	17%	15%		
VOR - Planned Maintenance	4%	4%	3.4%	3%		
VOR - Other	7%	6.6%	6.4%	8%		
VOR - Total	23%	27%	26%	26%		
Number of Accidents		52	311	311	-	n/a

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
999 Call Volume	65,289	65,672	329,802	831,328		n/a
999 Calls abandoned %	2%	4.7%	4.5%	6%		
999 Mean Call Answer Time		00:00:15	00:02:26	00:08:18		n/a
999 90th Percentile Call Answer Time		00:00:51	00:09:10	00:28:44		n/a
999 % calls from frequent callers	5%	4.4%	4.3%	4%		

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
111 Calls Offered	118,301	121,118	638,624	1,589,585		n/a
111 call answer in 120 Secs %	95.0%	82.1%	74.0%	54.3%		
111 Calls abandoned after 30 secs %	3%	2.2%	4.1%	11 %		
SCAS 111 - 999 referrals %	10%	10.2%	9.4%	9.4%		
SCAS 111 - ED Referrals	7.5%	12.8%	13%	12.0%		
Total 111 - Transfer to Clinician	50%	25.7%	26%	25.5%		
Complaints - 111 Service %	0.01%				-	
111 Complaints response - agreed timescale %		85.0%	90%	37.4%	-	
111 PHSO cases - upheld/partially upheld		0.0%	0%	0.0%	-	n/a

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

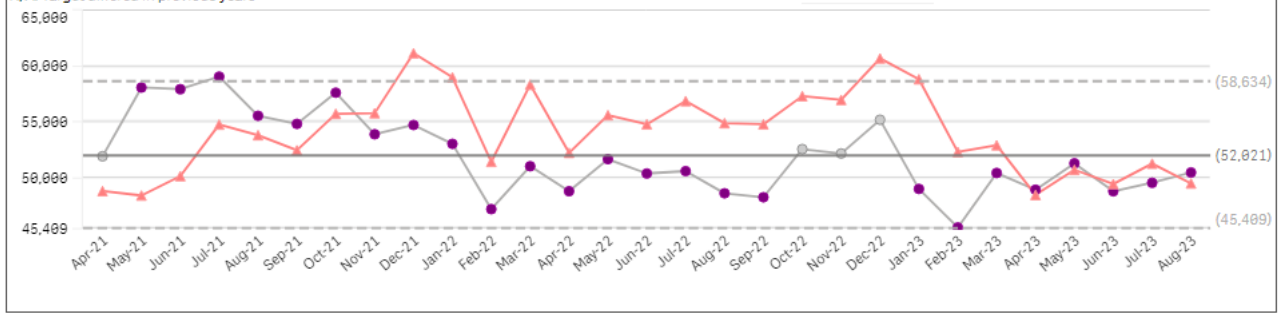
Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
PTS Call Volume		27,079	135,946	323,722		n/a
PTS - Calls answered in 60 seconds	90%	69.8%	67.0%	66.9%		
Patients Arrived within time	87%	88.4%	88.7%	88.6%		
Patients Collected within time	87%	91.0%	91.8%	91.8%		
PTS Volume - No. of Journeys		92,698	446,656	1,037,541		n/a
PTS Volume - No. of Patients Transported		24,494	123,900	294,157		n/a
PTS Complaints response - agreed timescale %	95%	100%	98.4%	41.0%	-	-
PTS PHSO cases - upheld/partially upheld		0%	0.0%	0.0%	-	n/a
Complaints - PTS % per 1,000 Incidents		18%	20.4%	8.5%	-	n/a

National Standards - 999 Activity Levels

Activity (999 Incidents) - SCAS

N/A. Target differed in previous years

Aug-23: 50,528



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

Metric	Monthly Plan / Target	Aug-23	YTD	Variation	Assurance
Incidents Growth - SCAS	1%	2.57%	-1.50%		n/a

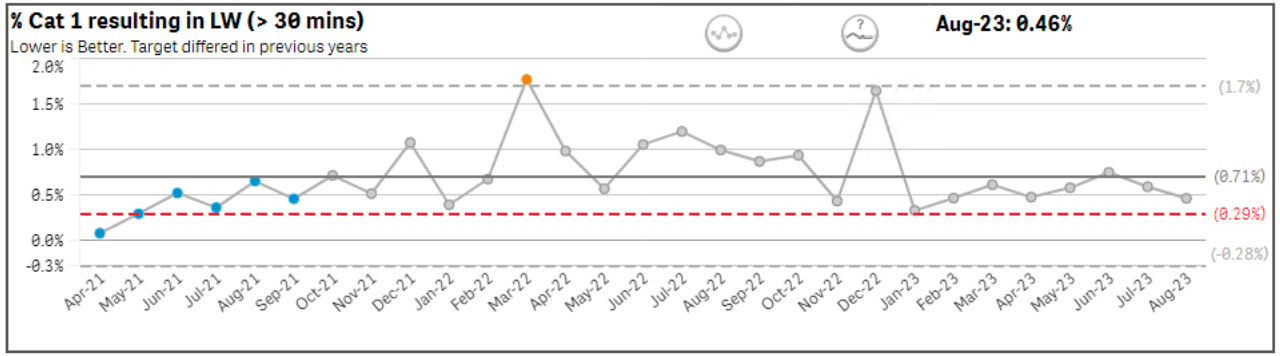
Observation & Explanation:

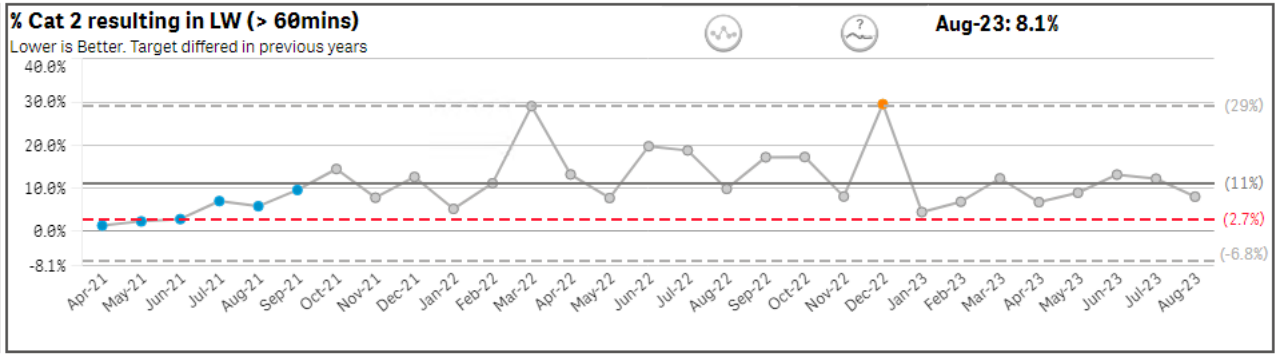
Demand for August was 2% above budgeted forecast in contrast to the profiles seen in recent years. This maintained the recent increasing trend in demand.

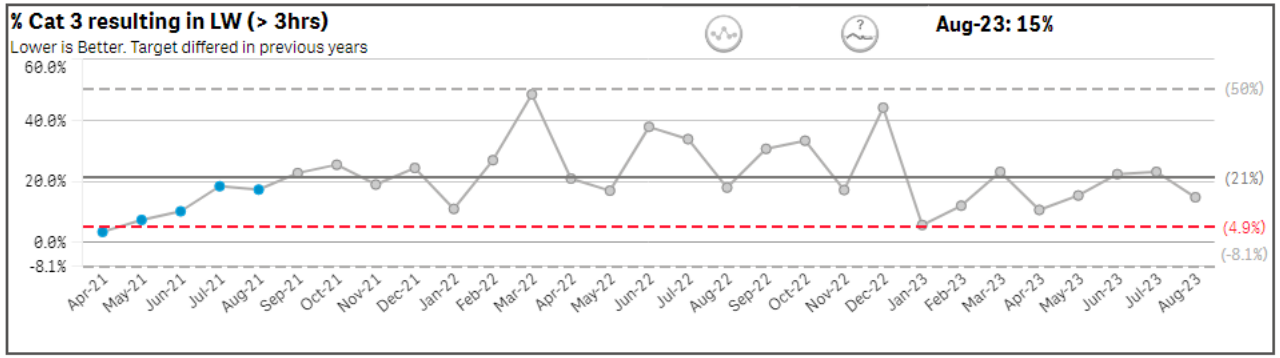
Improvement Actions and Assurance:

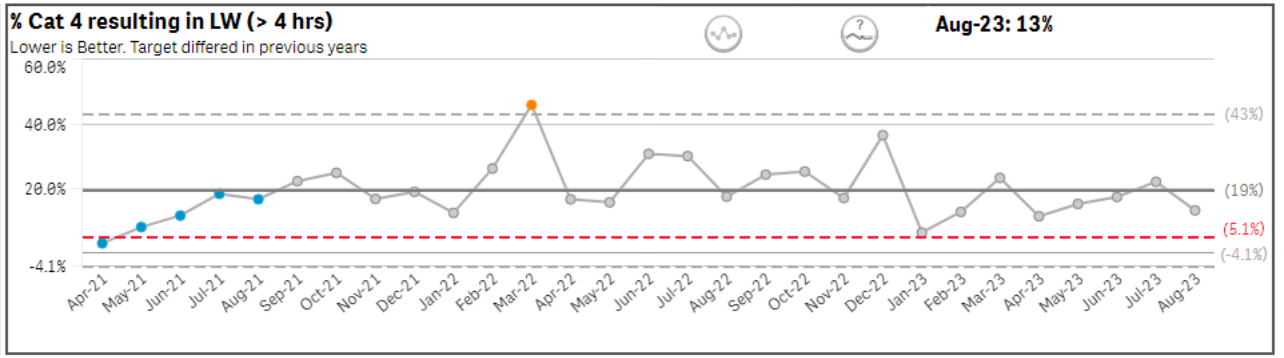
Forecasts are currently being reworked based on the latest data, to give a more up to date and accurate demand forecast for the rest of the financial year

National Standards - Long Waits









Observation & Explanation:

long waits have all reduced below the mean levels in August. This improvement has been achieved through increasing the operational hours to meet the demand. Cat 1 and cat 2 long waits remain our focus and resources are prioritised to these incidents. We are experiencing higher levels of long waits in the south in particular in the early hours

Improvement Actions and Assurance:

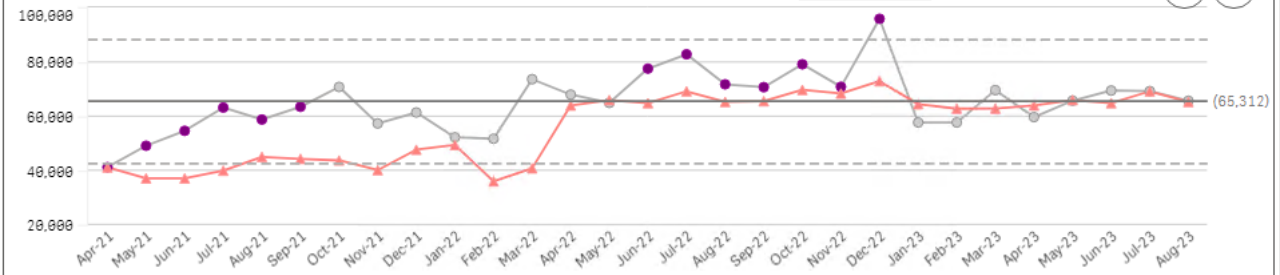
Continue to increase resource levels to meet demand. We have added an overtime incentive for Paramedics for overnight to increase DCA cover overnight. We have also added short shifts in for staff to cover on overtime covering shift change over where we see a spike in long waits. Our end of shift process is also being reviewed with union colleagues to reduce the impact on cat 2 from the restrictions at end of the night shifts

Clinical Coordination Centre - CCC Performance 1

999 Call Volume

N/A. Target differed in previous years

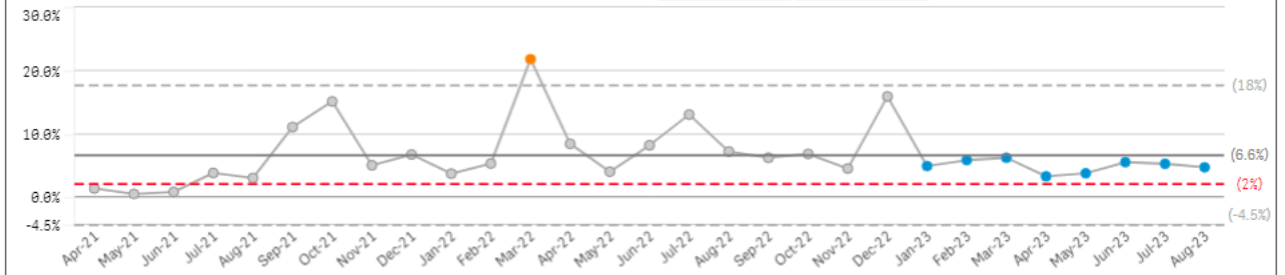
Aug-23: 65,672



999 Calls abandoned %

Lower is Better. Target differed in previous years

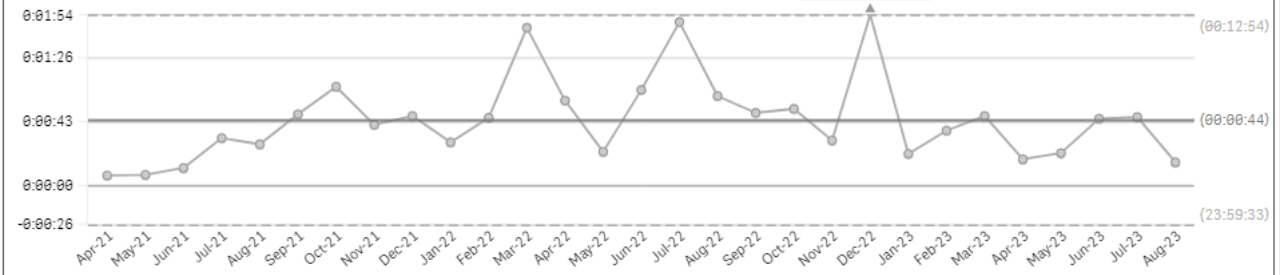
Aug-23: 4.7%



999 Mean Call Answer Time

Lower is Better. Target differed in previous years

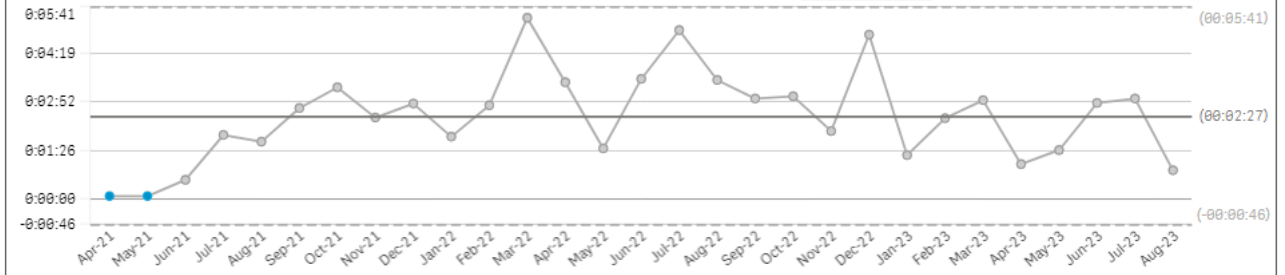
Aug-23: 00:00:15



999 90th Percentile Call Answer Time

Lower is Better. Target differed in previous years

Aug-23: 00:00:51



Observation & Explanation:

Significant improvement in mean call answer performance due to an increase in SCAS ECT logged in hours and calls reaching 60 seconds wit to be answered are transferred to West Mids Ambulance Service. This started on August 11th

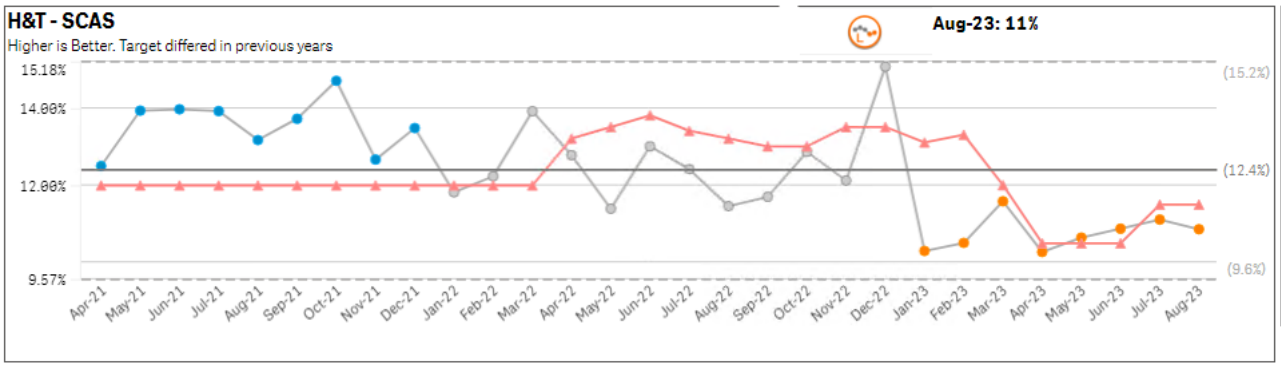
Improvement Actions and Assurance:

Continue with West Mids call answer support in line with SCAS trajectory for work effective , continue with support this is reviewed bi weekly with a potential endpoint end of September

Clinical Coordination Centre - CCC Performance 2

H&T - SCAS

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	Aug-23	YTD	12 Months	Variation	Assurance
999 % calls from frequent callers	5%	4.4%	4.3%	4%		

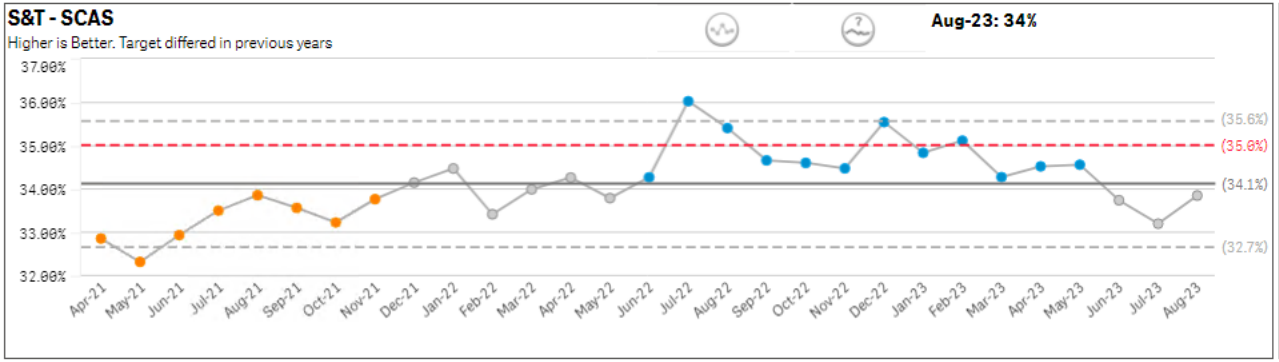
Observation & Explanation:

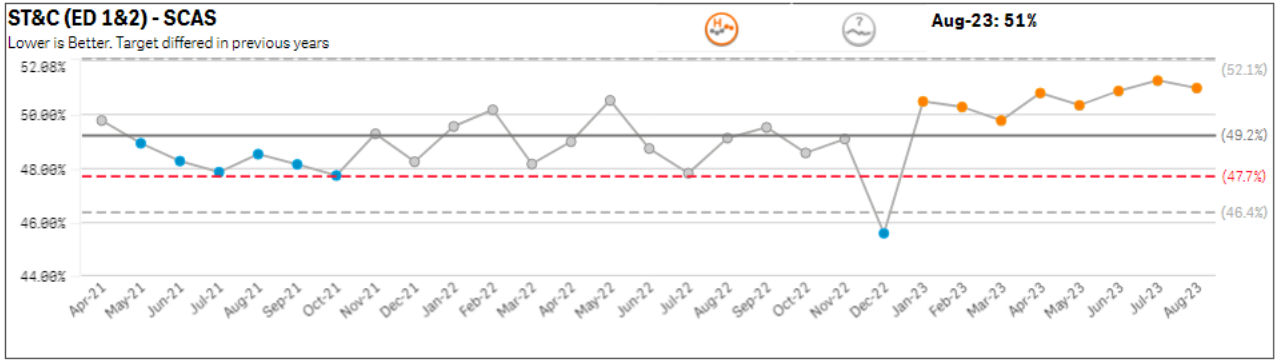
H&T reduced to below plan of 12% due to increase in available SCAS resources on scene., with less Cat 3 and 4 validations undertaken. and also resource driven with numbers of clinicians

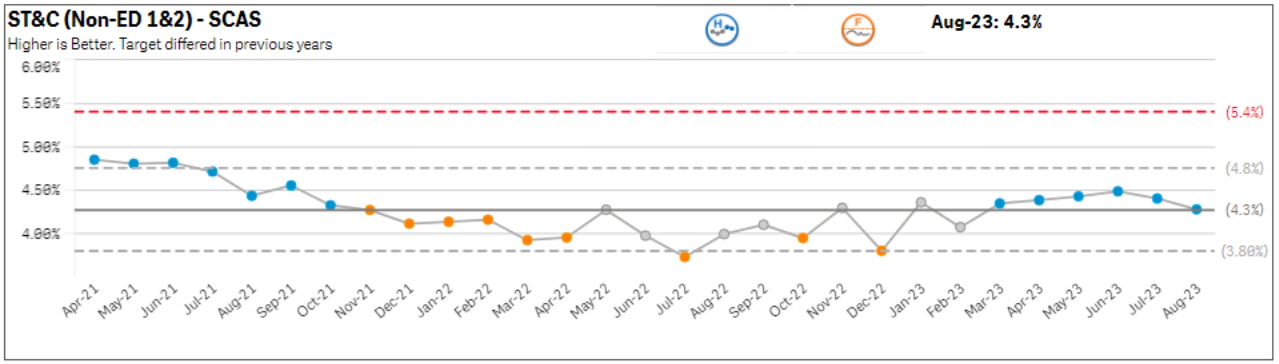
Improvement Actions and Assurance:

incentive in place to increase clinical support in EOC . Cat 2 segmentation going live end September which will drive some improvement in H&T

999 Operations - ST&C







Observation & Explanation:

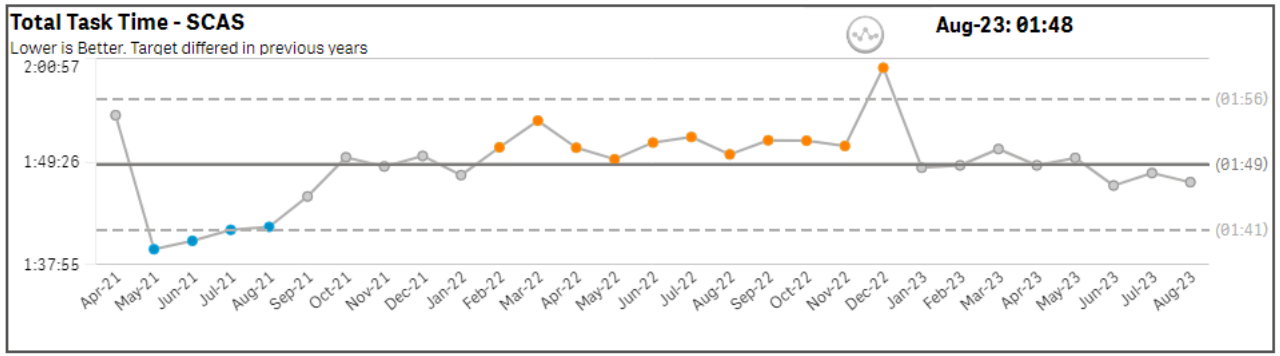
S&T improved in August to 33.8% closer to the mean. Non ED conveyance fell to 4.3% from 4.4% in July caused by a drop in non ED at QAH to 2.8% due to no access to SDEC or other pathways due to high bed occupancy and these areas closing for Ambulance admission. All other hospitals non ED are the same as July. ST&C to ED has dropped in August but is the 8th week above the mean. August ST&C was 51%and reducing this remains the focus of the OPS and Clinical Pathways team

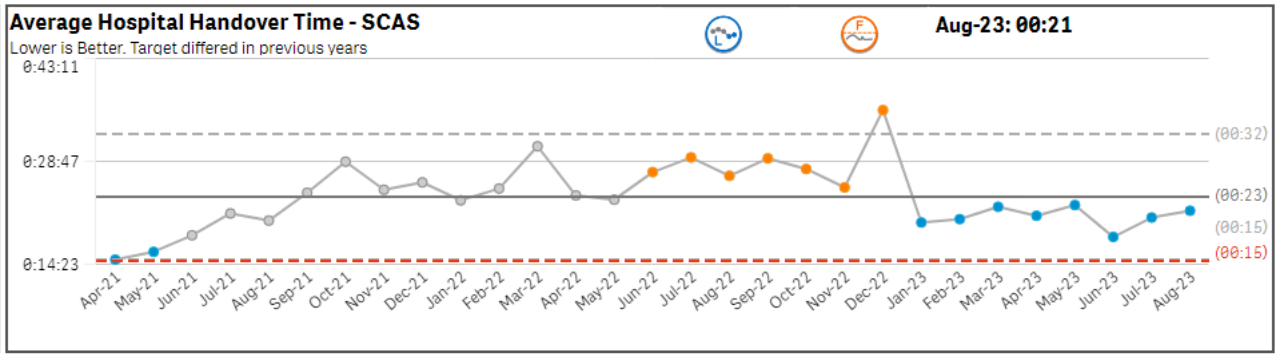
Improvement Actions and Assurance:

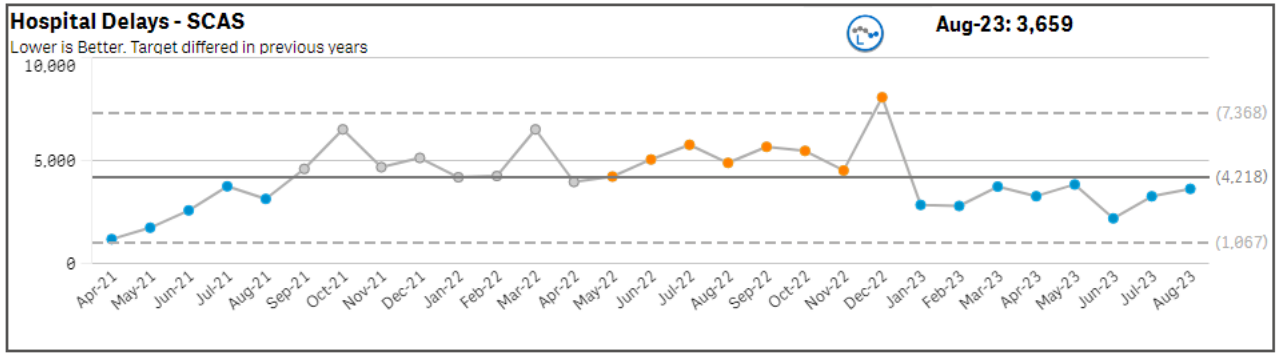
The Clinical Pathways team will be reviewing the use of Non ED pathways as well as community pathways to analyse the higher conveyance rates. • The Clinical Pathway Team have distributed to all operational teams an updated 'Pathway Portfolio' to each area highlighting all available pathways with some notes about reducing call back times for HCPs & GPs. The Clinical Pathway Team are working through a number of key proposals

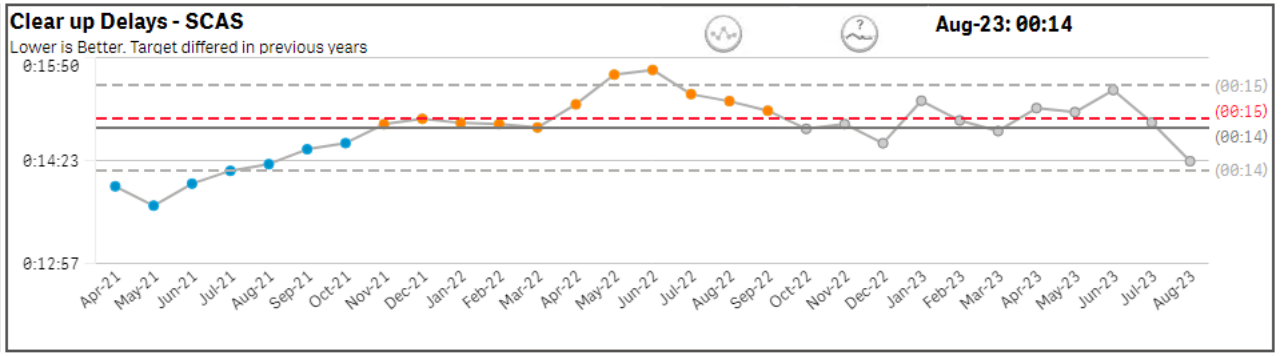
• Clinical Pathway Signposting Guidance
• Rapid Drop & Go for Fit to Sit Patients
• HCP & GP Care Navigation Improvement Plan
- HCP & GP 20:10 Call-Back Guidance
- HCP & GP Conveyance Request Guidance
- GP Triage review
- GP SPOA options across SCAS

999 Operations - Delays









Observation & Explanation:

The Operations teams have had a strong focus on clear up times which are at their lowest since August 21 and reaching the LCL. Average handover time remains below the mean, however this is the 3rd month of increase and is being driven by QAH where average H/O was 38 minutes in August.

Improvement Actions and Assurance:

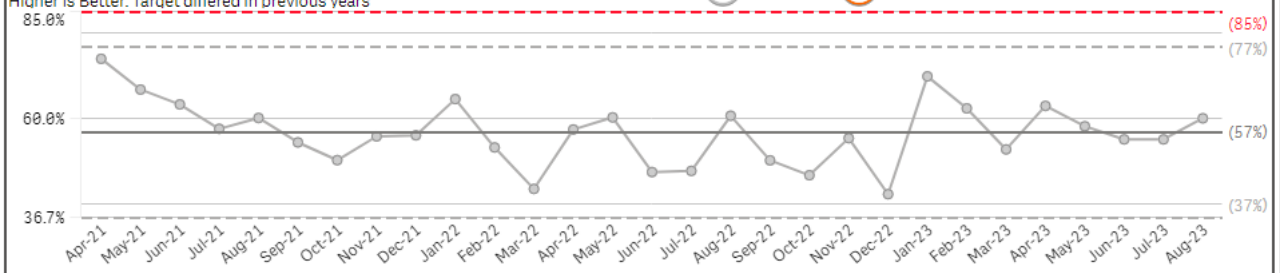
The operations team are maintaining their focus on reducing clear ups with good improvement being seen in north west reducing to 15 minutes from 17 minutes and north east from 15.40 to 14.40. The team are also continuing to push the clinical pathways to avoid ED and reduce ED demand

999 Operation - 999 Workforce Compliance

Meal Break Compliance - SCAS

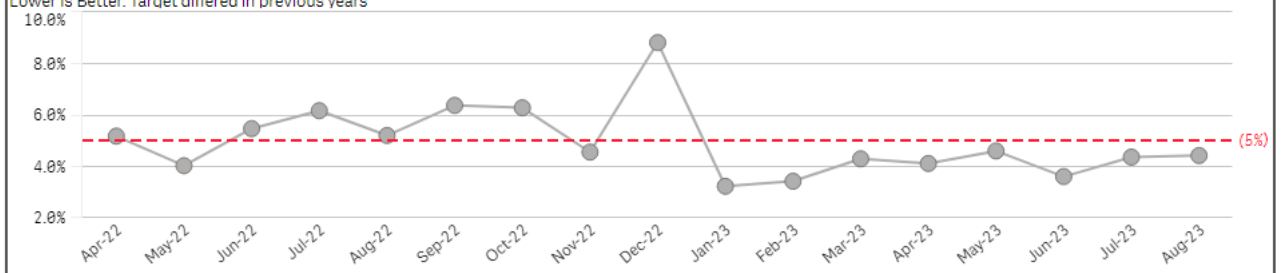
Aug-23: 60%

Higher is Better. Target differed in previous years



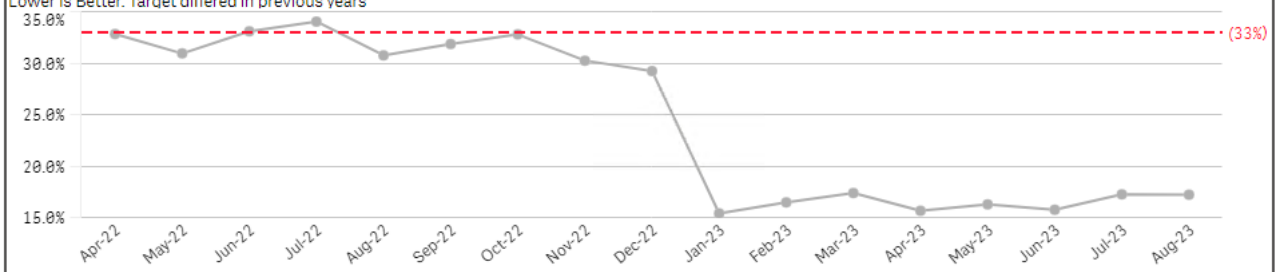
Missed Breaks - SCAS

Lower is Better. Target differed in previous years



Over-runs >30 mins - SCAS

Lower is Better. Target differed in previous years



Observation & Explanation:

We note that meal break compliance is still below the 85% required standard and as such requires further work to improve the compliance.

Improvement Actions and Assurance:

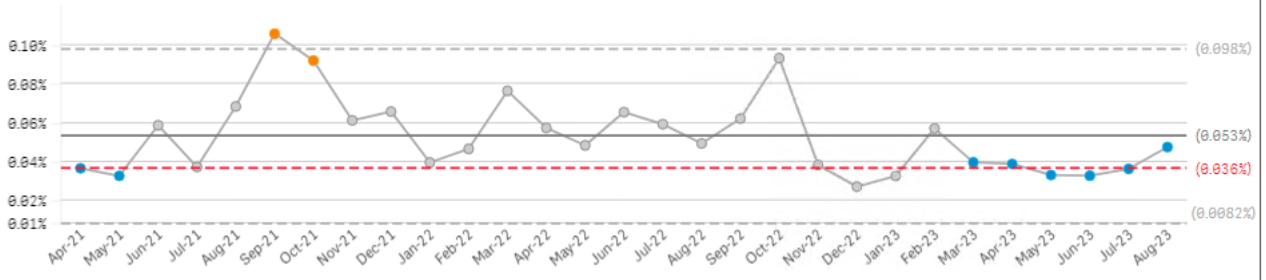
Finance are in the final stages of looking at the costings for paying staff for there meal breaks to enable them to be taken at all/any location.

999 Operations - 999 Complaints

Complaints - 999 Total %

Lower is Better. Target differed in previous years

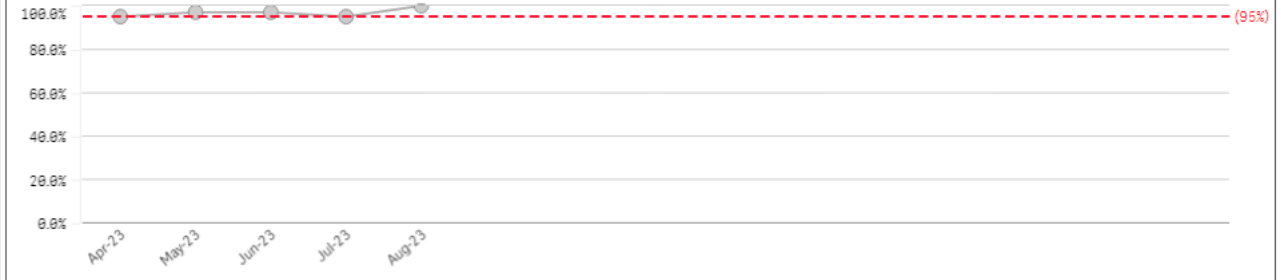
Aug-23: 0.047%



999 Complaints response - agreed timescale %

Higher is Better. Target differed in previous years

Aug-23: 100.0%



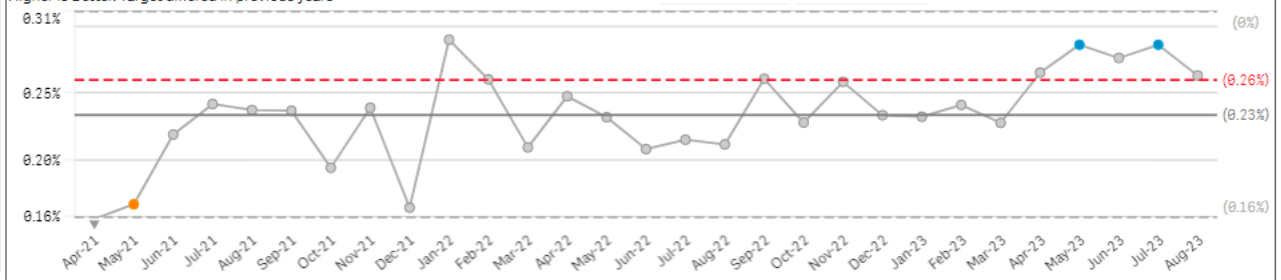
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

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

Compliments %

Higher is Better. Target differed in previous years

Aug-23: 0.26%



Observation & Explanation:

Response to complaints measure has been met. Further increase in compliments received this month

Improvement Actions and Assurance:

Learning from patient feedback and compliments to drive continuous improvement monitored by learning from experience group

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	Aug-23	YTD	12 Months	Variation	Assurance
Vehicle deep clean Compliance - A&E		83.0%	90%	104%		n/a
Vehicle routine cleans	5,444	5,673	26,683	63,465		n/a
VOR - Unplanned Maintenance	13%	16.1%	17%	15%		
VOR - Planned Maintenance	4%	4.0%	3.4%	3%		
VOR - Other	7%	6.6%	6.4%	8%		
VOR - Total	23%	26.7%	26%	26%		
Number of Accidents		52	311	311	-	n/a

Observation & Explanation:

VOR- Improvement made across unplanned and unplanned VOR. This is due to improvements in recruitment of temporary technicians across both workshops. Additional third party providers sourced for minor repairs in locations distant from workshops to prevent delays due to recovery of vehicles. Mobile Technician deployed across Nursling area. Increase in other VOR driven by supply chain issues at body shops for vehicles in for repair following accident damage and Medical device faults.

Deep Clean compliance has reduced over August. This has been due to increased operational pressures and higher vehicle requirements results in reduced vehicle availability for deep cleans to be completed.

Improvement Actions and Assurance:

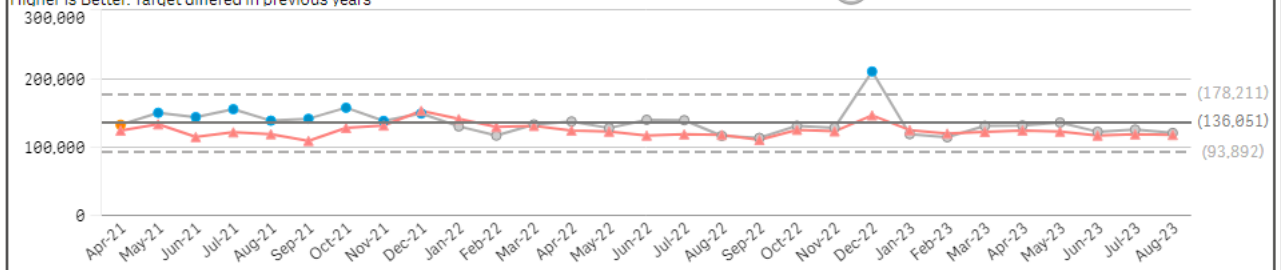
Continued recruitment drives to ensure full time technicians recruited. Recruitment open days planned for both workshops through september. improved process in progress to manage medical device movements and additional spares moved to stations to ensure reduction in VOR of vehicles.

Increased availability due to changes workshop process has seen improvements in VOR rates towards end of August increasing vehicle availability. Deep cleans prioritised throughout september.

Clinical Coordination Centre - 111 Call Performance

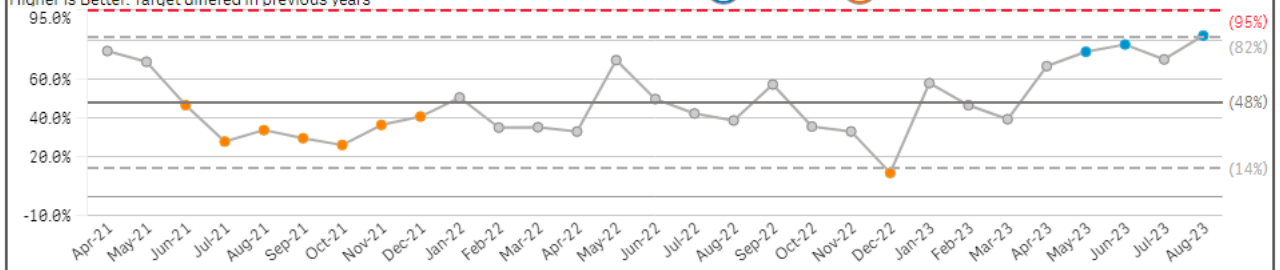
111 Calls Offered — Aug-23: 121,118

Higher is Better. Target differed in previous years



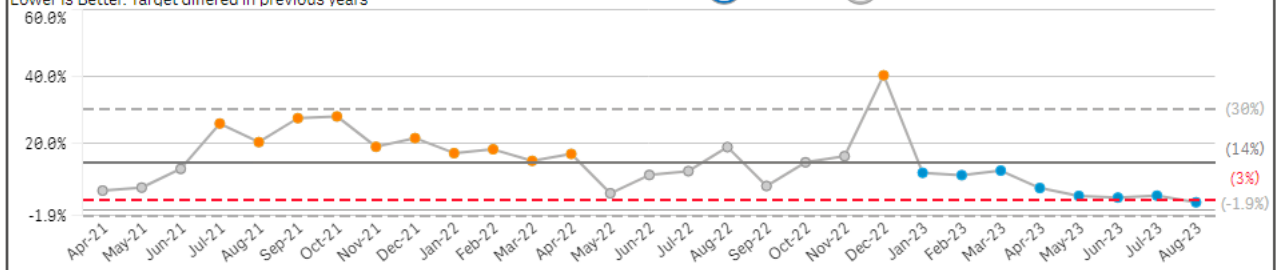
111 call answer in 120 Secs % — Aug-23: 82%

Higher is Better. Target differed in previous years



111 Calls abandoned after 30 secs % — Aug-23: 2.2%

Lower is Better. Target differed in previous years



Observation & Explanation:

Comparison to August 22 difficult due to the Adastra outage last year. Calls offered in August 2023 were slightly below forecast (6% down), but up on this time last year. Call answer performance in August at 81.92% was the highest level of performance achieved since the new telephony reporting in April 22 . Call answer remains above trajectory but below national target. Abandonment rate at 2.42% hit national target for the first time since the new reporting and remains above trajectory.

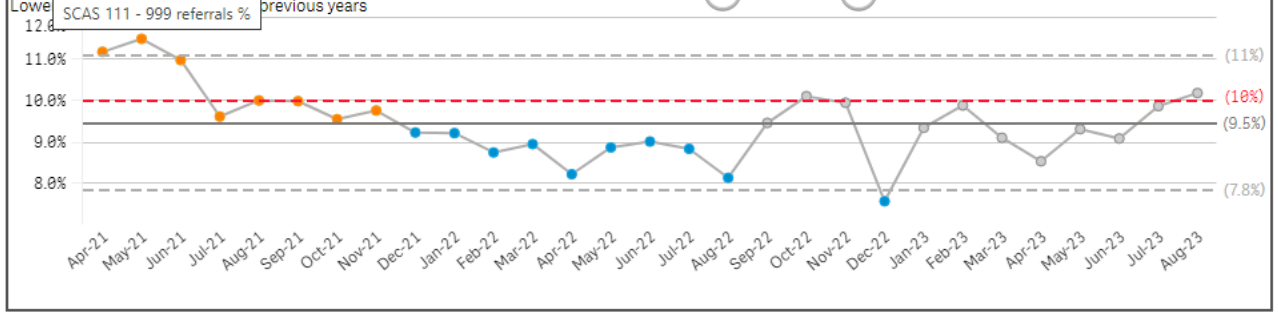
Observation & Explanation:

The team continue to work on the improvement actions detailed in our 111 VASSOS improvement plan - covering recruitment, retention and call centre management to ensure we achieve the best level of performance with the resources we have.

Clinical Coordination Centre - 111 Call Referrals

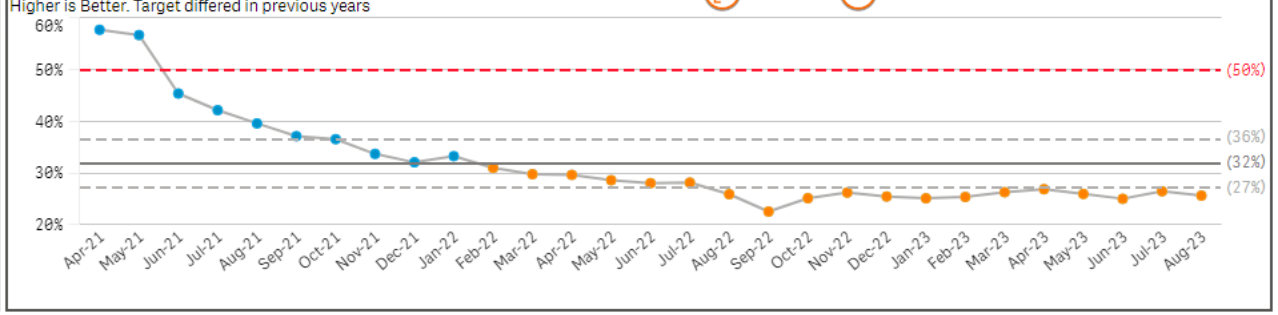
SCAS 111 - 999 referrals % — Aug-23: 10%

Lower is Better. Target differed in previous years



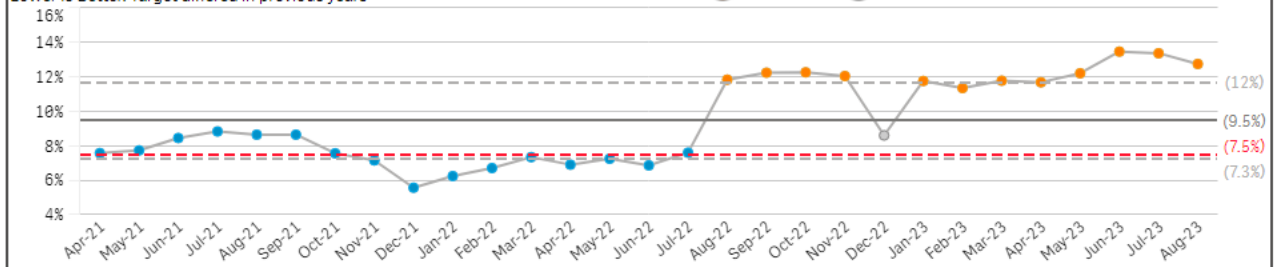
Total 111 - Transfer to Clinician — Aug-23: 26%

Higher is Better. Target differed in previous years



SCAS 111 - ED Referrals — Aug-23: 13%

Lower is Better. Target differed in previous years



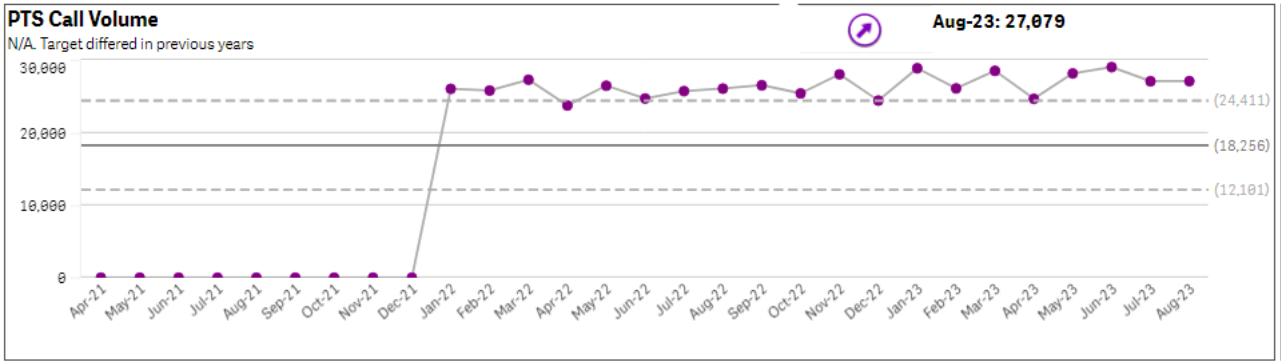
Observation & Explanation:

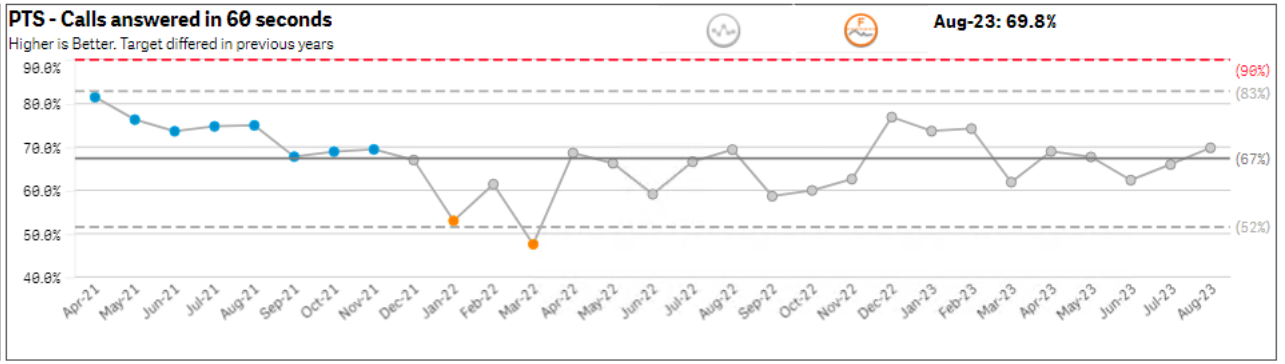
This data only shows SCAS clinicians work and does not show the work done by the CAS providers and therefore the clinical metrics are not accurate. IUC ADC data for August not yet available but based on weekly data transfer to clinician rates in August were circa 45%. Total transfer rate to 999 circa 12%. 90% of cat Cat3/4 calls were validated with 53% offered alternative pathways of care. 70% of ED dispositions were validated with 41% of these patients offered alternatives to ED attendance. Transfer rates to ED Type 1&2 circa 5.3%.

Improvement Actions and Assurance:

SCAS clinical workforce remains below requirement, continue to attract/recruit clinicians - cohort of international nurses being recruited. Work continues to improve clinical call handling metrics. Continue to work with CAS providers to improve shift fill and outputs. Continue to external work to increase referral pathways.

PTS - PTS Call Volume





Observation & Explanation:

- Call volumes remain consistent to previous months, whilst there is an expectation this broadly matches the profile of PTS demand, there have been some small schemes implemented that will result in slightly less call volumes
- Call answer performance did slightly increase on the previous month; however, this is expected to dip back down in September due to high sickness impacting on the operational hours available to take the calls.

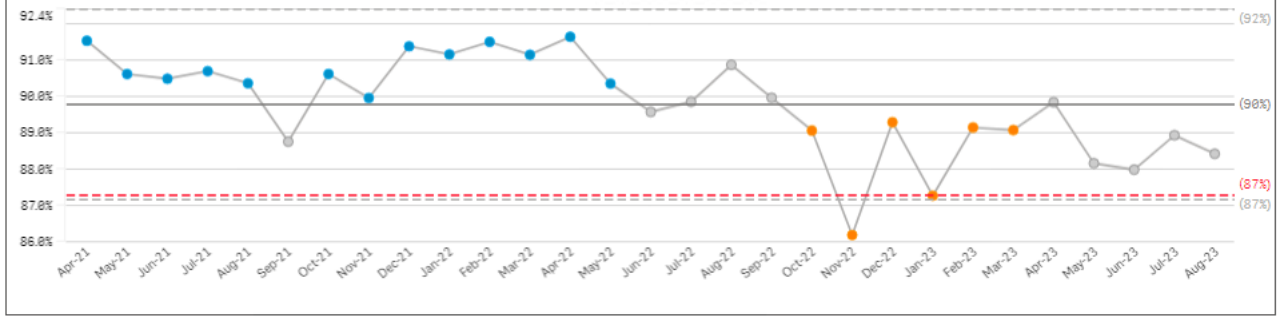
Improvement Actions and Assurance:

- Continued review of sickness management to increase operational hours available
- Continued partnership working with recruitment to fill vacancies and increase operational hours.
- On going performance management of all call handlers, reviewing call length and not ready times, providing additional training and support where required.

PTS - PTS Journeys

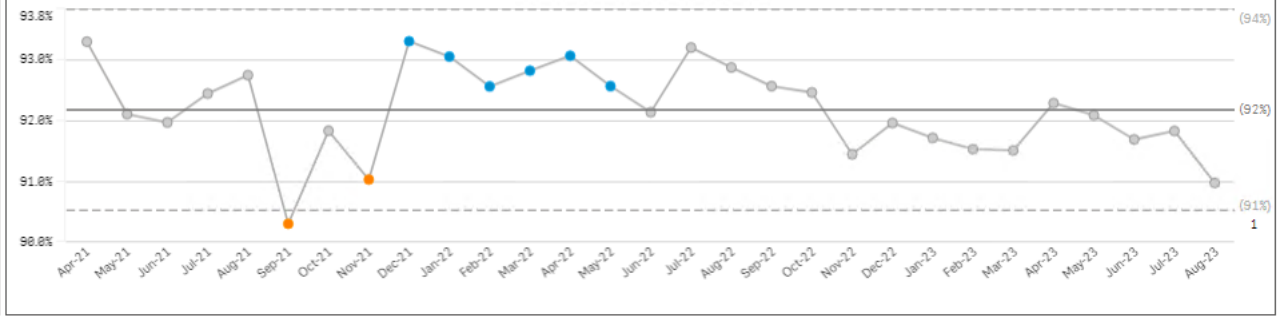
Patients Arrived within time
Higher is Better. Target differed in previous years

Aug-23: 88.4%



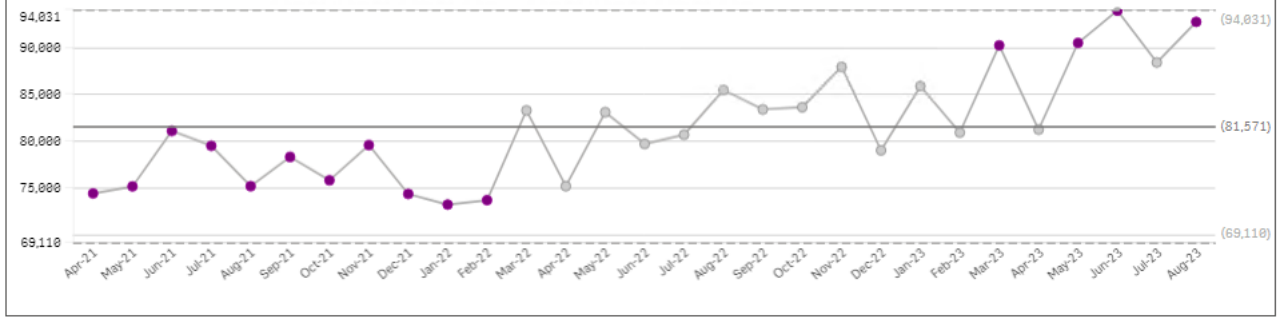
Patients Collected within time
Higher is Better. Target differed in previous years

Aug-23: 91.0%



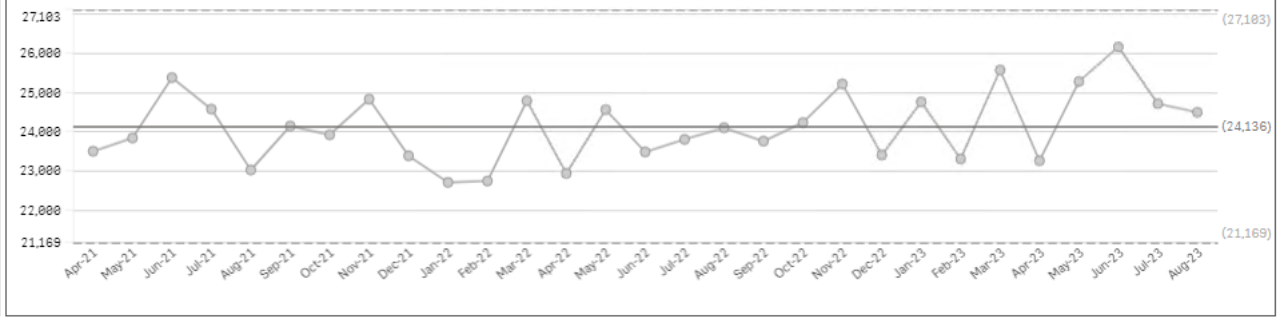
PTS Volume - No. of Journeys
N/A. Target differed in previous years

Aug-23: 92,698



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

Aug-23: 24,494



Observation & Explanation:

- PTS demand continues to remain higher than the mean with a further increase in August. This is unusual as activity historically dropped in the summer holidays months as well as the August bank holiday where activity also drops, however these reductions have been offset by an increased number of weekdays compared to July.
- PTS demand continues to be above the budgeted levels with August demand being 5% above.
- Patients arrival KPI has slightly dropped but not to the lowest levels of 23/24, this is aligned to the reduced budgeted target performance following the modelling amendments.
- Patients collected KPI has dropped from previous months but still remains above the budgeted target

Improvement Actions and Assurance:

- Discussions on going with Commissioners to review demand management and other cost saving schemes with a small number of schemes implemented.
- Continued review of capacity vs demand, review of taxi usage with caps in place, however with the continuing increase in demand this is challenging on performance and patient experience.
- On going work to improve efficiencies and productivity aligned to the financial sustainability programme.
- Push on the Volunteer Car Drivers alongside Charities and Volunteer Manager to try and increase this cadre of resources to help reduce taxi usage. Trial on using Assemble a workforce platform used by CFRs to aid the recruitment and on boarding process.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Patient Safety

August-23 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target	
H					
L					
		19			
L					
H					
↗				1	
↘		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

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
STEMI - Care	75%		65.2%	49.1%	-	n/a
STEMI Call to angiography - Mean	02:04	02:11:00	02:16:12	02:17:55		
STEMI - Call to angiography 90th Centile	02:53	02:59:00	03:08:00	03:10:00		
Stroke - Care			97.5%	73.2%	-	n/a
Stroke Call to Hospital arrival - Mean	01:17		00:59:48	01:23:20		
Stroke - Call to Hospital arrival Median	01:07		00:50:00	01:09:15		
Stroke - Call to Hospital arrival 90th Centile	01:57		01:33:24	02:10:50		
Cardiac Arrest Survival, Utstein	26%		16%	26%		
Cardiac Arrest Post- ROSC care	69%		75.0%	55.0%	-	n/a
Cardiac Arrest Survival at 30 Days - All Patients			5.7%	2.4%	-	n/a
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients			19%	7.9%	-	n/a
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort			39%	16%	-	n/a

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Building cleanliness completed audits	42	30	157	384		
Number of compliant Building cleanliness audits	40	18	120	284		
Percentage of compliant Building cleanliness audits	95%	60.0%	79.3%	74.0%		
Vehicle cleanliness completed audits	145	142	527	1,305		
Number of compliant Vehicle cleanliness audits	139	141	496	1,205		
Percentage of compliant Vehicle cleanliness audits	96%	99.3%	94.8%	92.3%		
Hand Hygiene audit	288	121	797	2,562		
Number of compliant Hand Hygiene audit	273	117	783	2,517		
Percentage of compliant Hand Hygiene audits	95%	96.7%	98.6%	98.2%		
Number of cleanliness compliance audits	475	293	1,481	4,251		
Number of compliant cleanliness compliance audits	452	276	1,399	4,006		
Percentage of compliant cleanliness compliance audits	95%	94.2%	95.4%	94.2%		
Number of Never Events (CQC/NRLS reportable)	0	0	0	1		
Number of SI investigations outstanding after 60 days (excluding events that are officially suspended)	0	1	10	19		

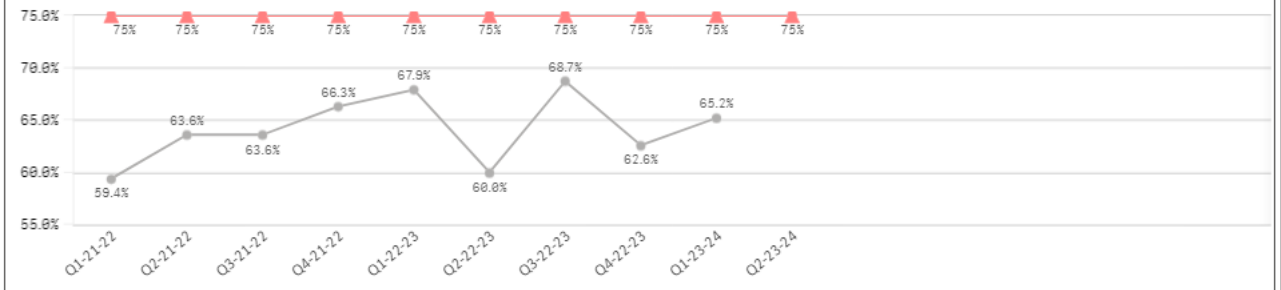
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Medicines modules produced without error %		90%	37%	16%	-	n/a
Days of medicines stock modules in reserve		2	2	2	-	n/a
Number of no/low harm incidents		404	1,930	1,930	-	n/a
Number of incidents moderate and above harm		25	64	64	-	n/a
Number of Serious Incidents (SI) reported		4	20	20	-	n/a
RIDDOR reportable incidents		8	40	40	-	n/a
Number of reported CD incidents – unaccounted for losses		37	81	81		n/a
Number of DATIX incidents - patient		425	1,948	1,948	-	n/a
Number of DATIX incidents - non patient		395	1,914	1,914	-	n/a

Clinical Performance - STEMI

STEMI - Care

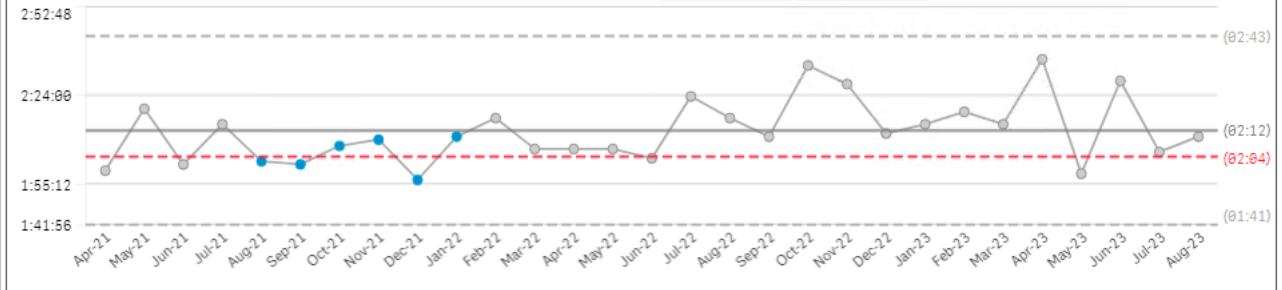
Higher is Better. Target differed in previous years



STEMI Call to angiography - Mean

Aug-23: 02:11

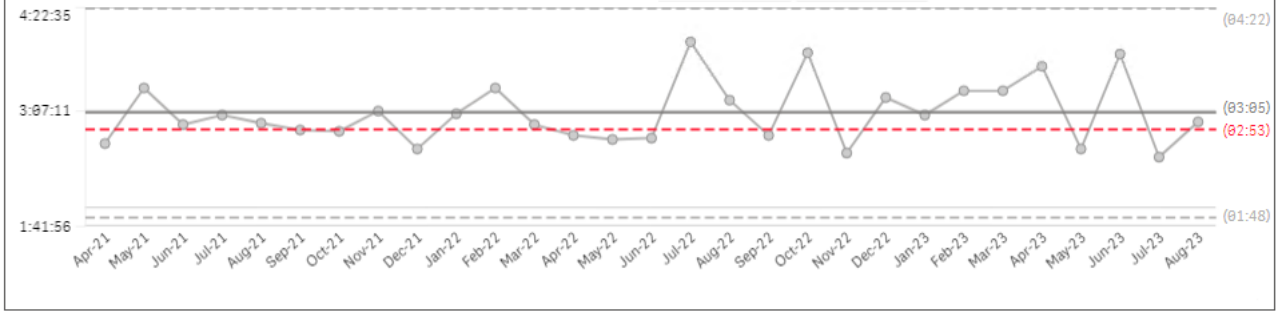
Lower is Better. Target differed in previous years



STEMI - Call to angiography 90th Centile

Aug-23: 02:59

Lower is Better. Target differed in previous years



Observation & Explanation:

values reported this month relate to April 2023 - within expected variation

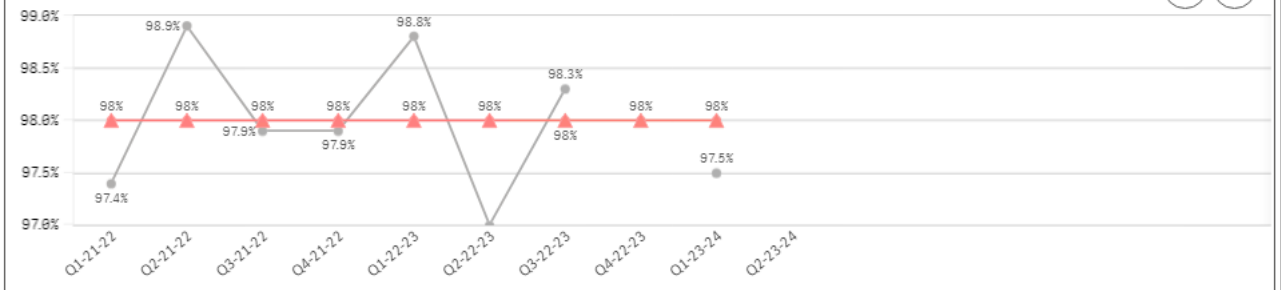
Improvement Actions and Assurance:

England - mean for call to angiography 2:28 (SCAS 2.11) and 90th centile 3:18 (SCAS 2:59)

Clinical Performance - Stroke

Stroke - Care

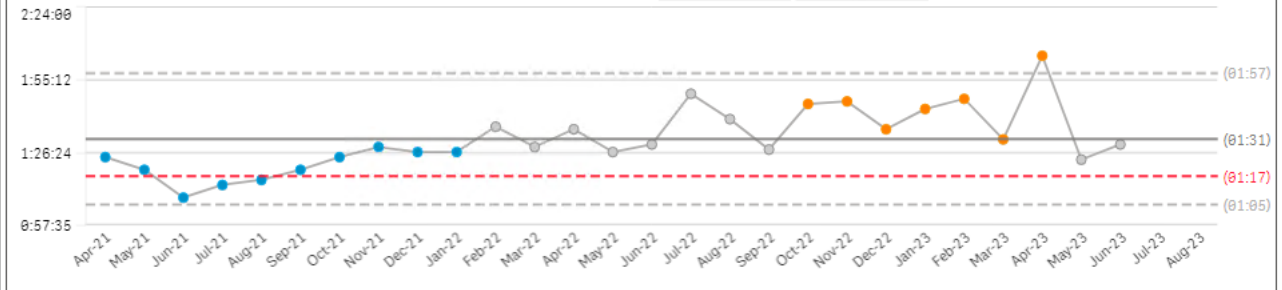
Higher is Better. Target differed in previous years



Stroke Call to Hospital arrival - Mean

Aug-23:

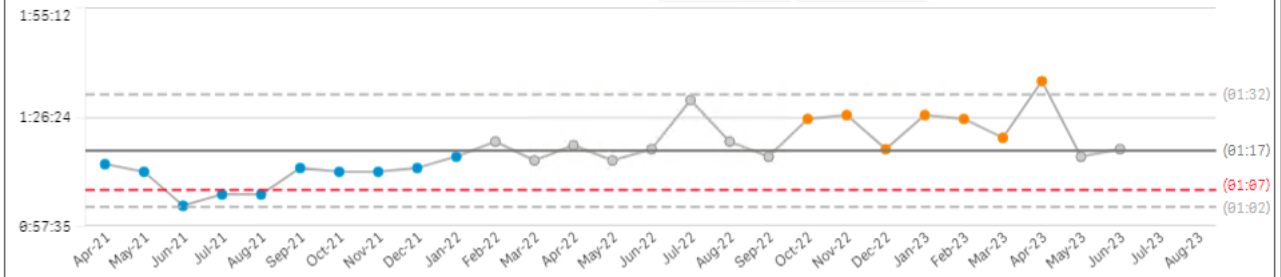
Lower is Better. Target differed in previous years



Stroke - Call to Hospital arrival Median

Aug-23:

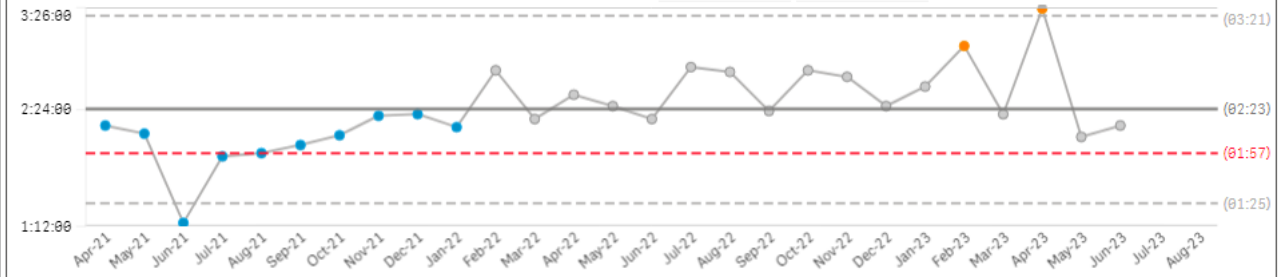
Lower is Better. Target differed in previous years



Stroke - Call to Hospital arrival 90th Centile

Aug-23:

Lower is Better. Target differed in previous years



Observation & Explanation:

Due to the audit cycle timing and national submission window no data available due to EPR outage

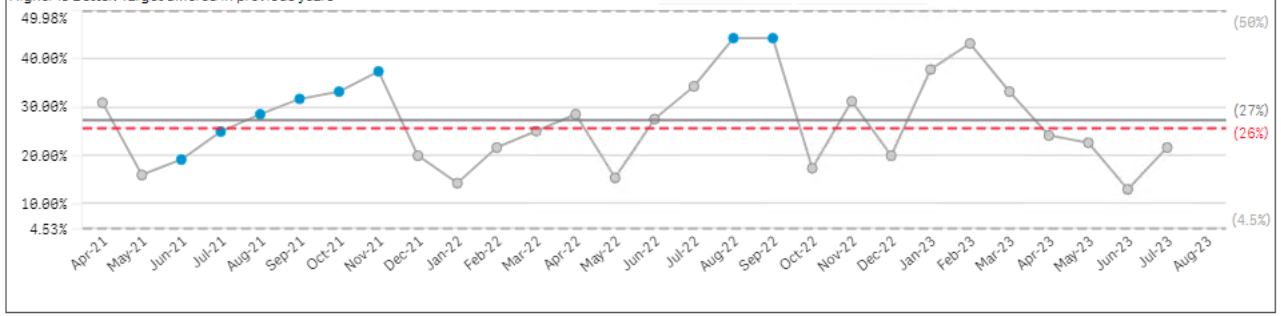
Improvement Actions and Assurance:

Plan in place to ensure audits are completed when records are available and submitted when the national system allows submission

Clinical Performance - Cardiac Arrest

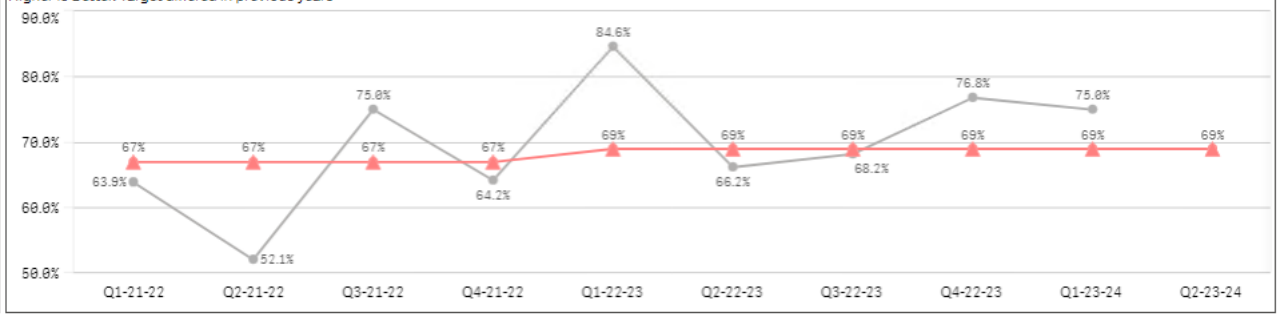
Cardiac Arrest Survival, Utstein — **Aug-23:**

Higher is Better. Target differed in previous years



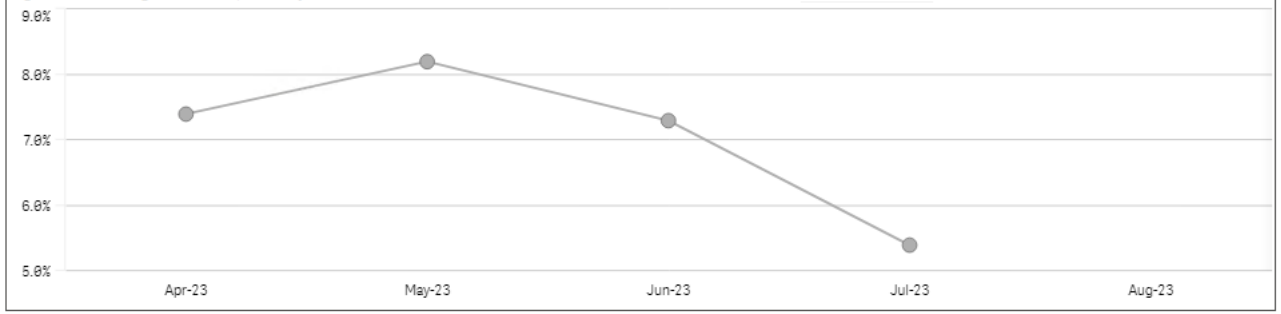
Cardiac Arrest Post- ROSC care

Higher is Better. Target differed in previous years



Cardiac Arrest Survival at 30 Days - All Patients — **Aug-23:**

Higher is Better. Target differed in previous years



Observation & Explanation:

Due to the audit cycle timing and national submission window no data available due to EPR outage

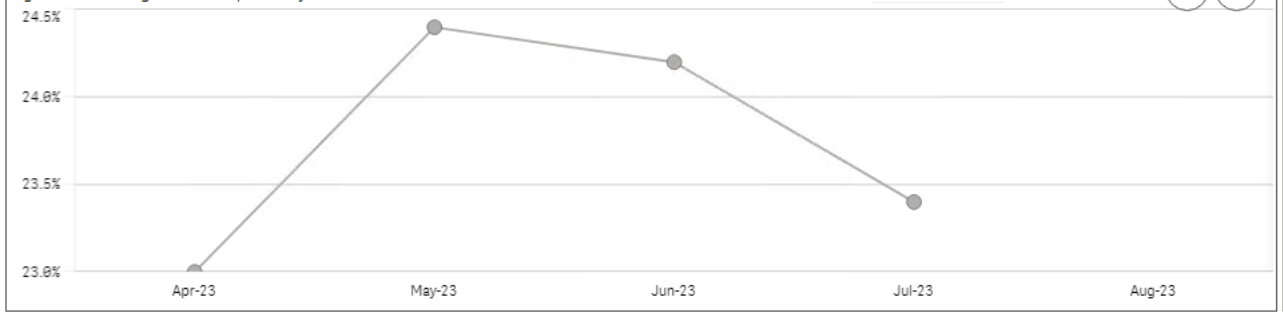
Improvement Actions and Assurance:

Plan in place to ensure audits are completed when records are available and submitted when the national system allows submission

Clinical Performance - ROSC

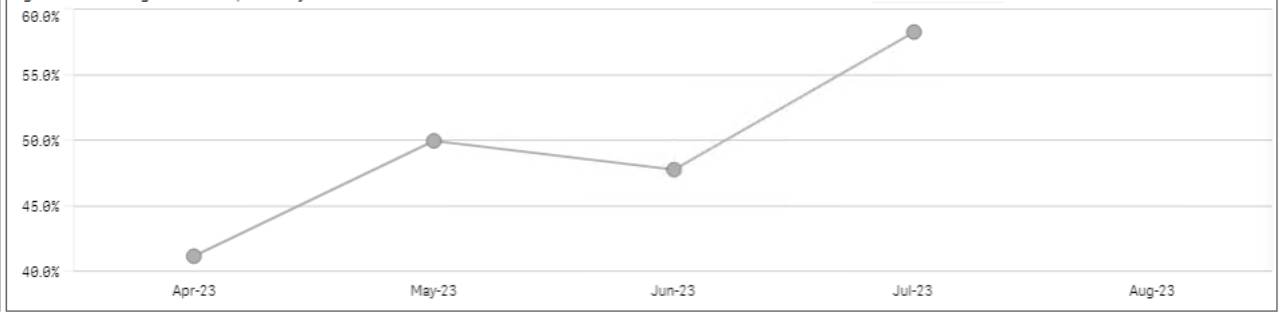
Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients **Aug-23:**

Higher is Better. Target differed in previous years



Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort **Aug-23:**

Higher is Better. Target differed in previous years



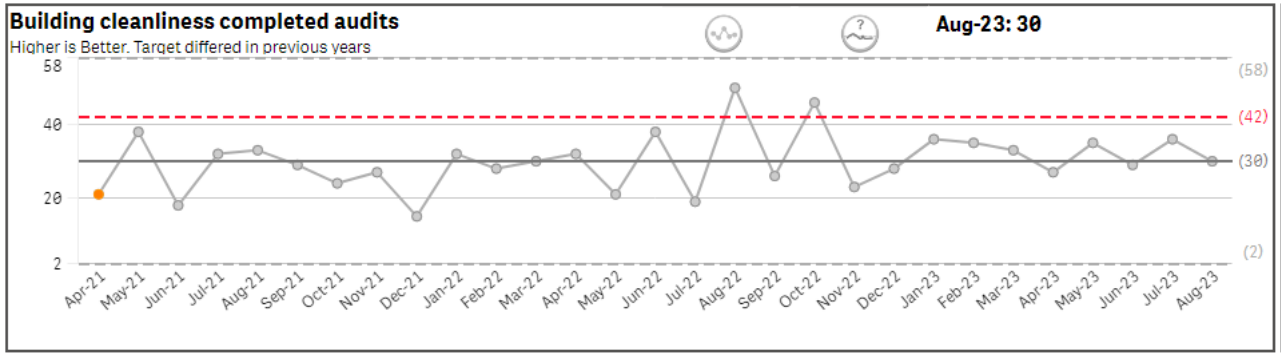
Observation & Explanation:

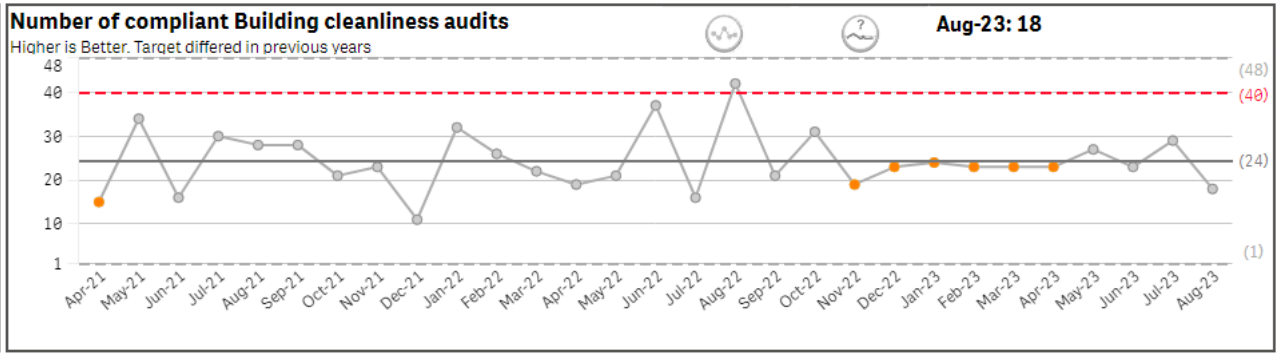
Due to the audit cycle timing and national submission window no data available due to EPR outage

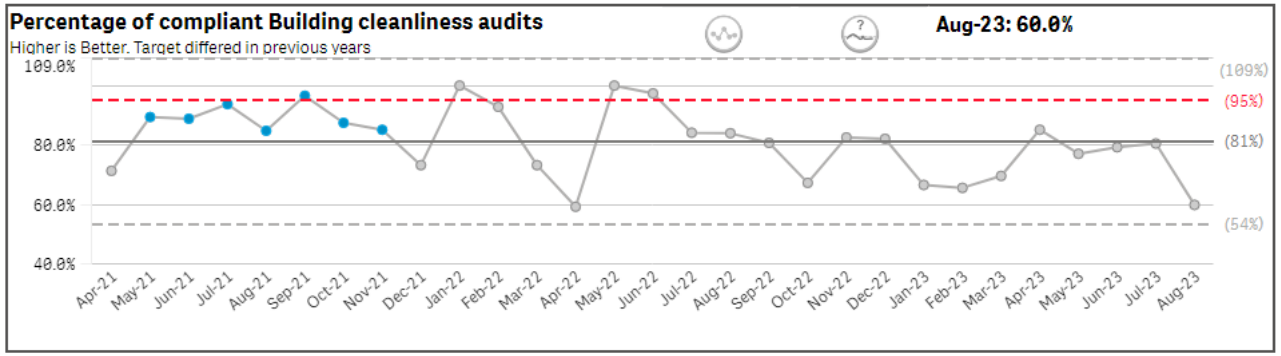
Improvement Actions and Assurance:

Plan in place to ensure audits are completed when records are available and submitted when the national system allows submission

Quality Safety - Building Audits







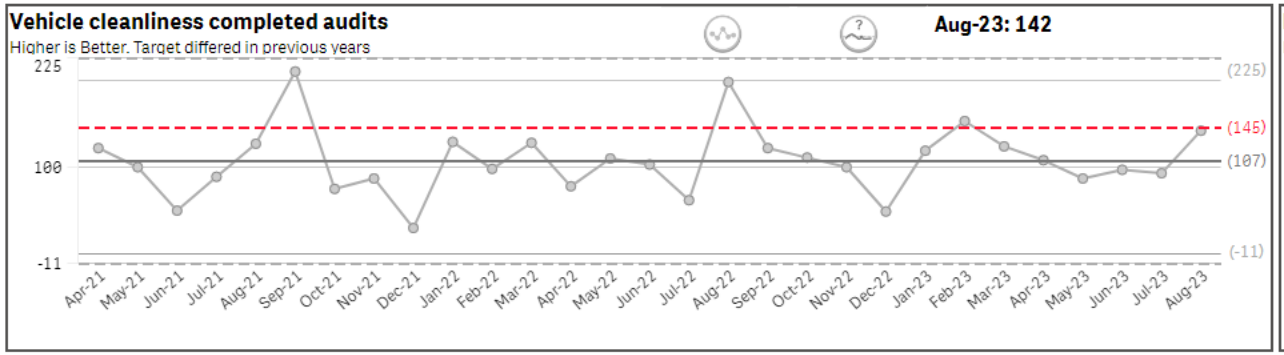
Observation & Explanation:

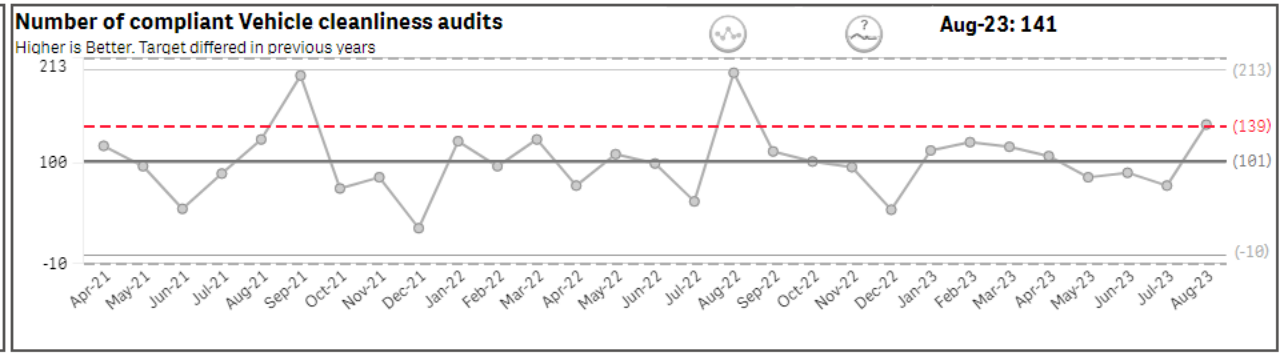
Both services have completed 80% of required building audits in August, however compliance has fallen with required standard. This may be reflective of greater awareness of IPC standards following IPC station visits

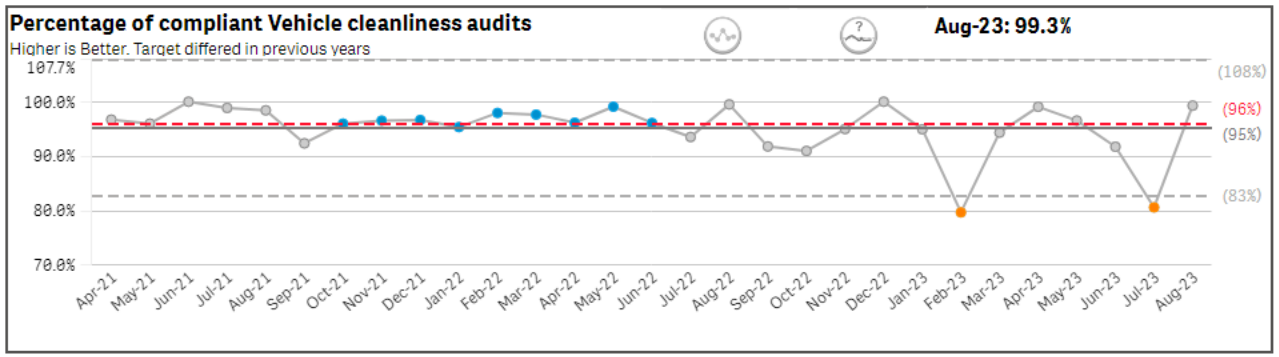
Improvement Actions and Assurance:

Estates improvements work on sluices ongoing to assist in meeting standards and staff reminded or requirements of cleanliness standards

Quality Safety - Vehicle Audits







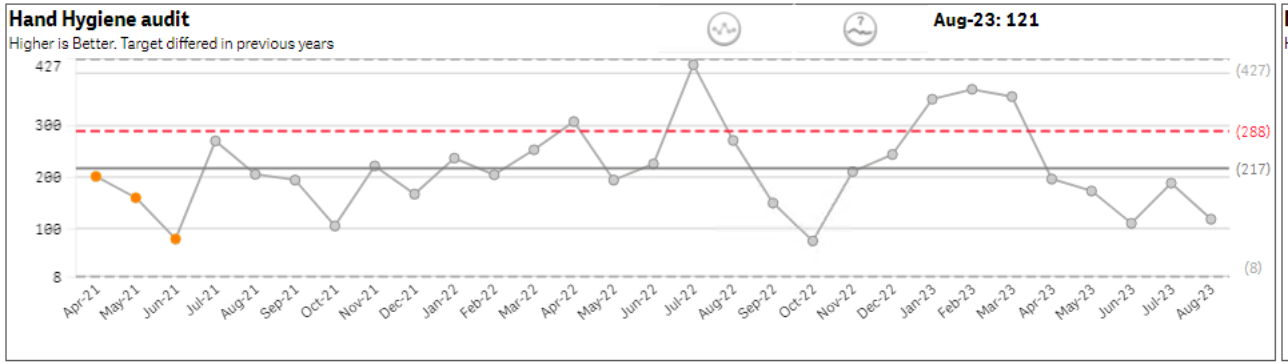
Observation & Explanation:

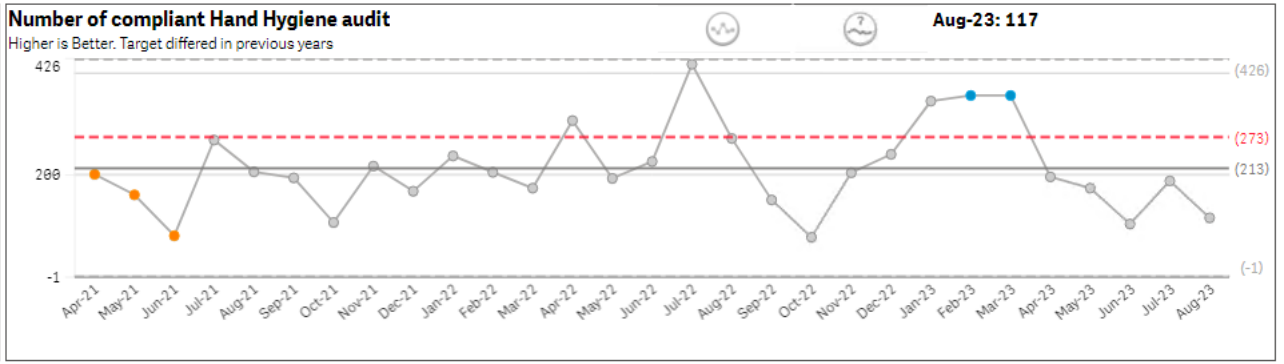
PTS have completed over target on number of vehicle cleanliness audits with 81 audits against 62 required (130%) however 999 service have completed 61 out of the 107 target (57%). This may be attributed to annual leave and current demand. Cleanliness compliance remains high at 99% overall which has been reflected in IPC observation audits

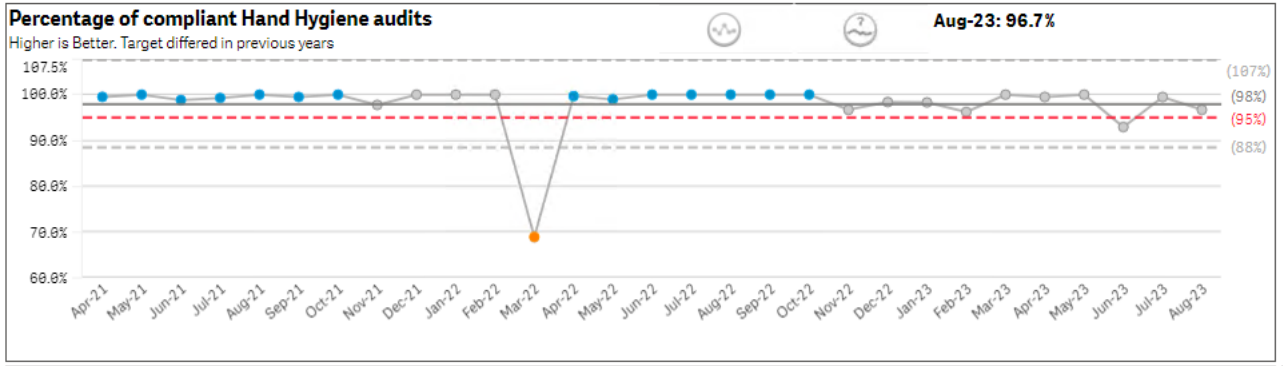
Improvement Actions and Assurance:

IPC continue to attend 999 Clinical Governance to discuss audits, reminders sent via email, triangulation to compliance visits and IPC assurance audits ongoing.

Quality Safety - Hand Hygiene Audits







Observation & Explanation:

The number of audits completed has fallen in the month of August with both PTS and 999 services only completing half the number of audits required. This may be due to a combination of annual leave and increased demand . Reported compliance remains high at 99 - 100% per service . IPC team have shown lower compliance with bare below the elbows when observed practice

Improvement Actions and Assurance:

IPC continue to send reminders and have recommended that hand hygiene audits are completed at staff PDR if outstanding. Level 1 meetings being attended to discuss standards and audits

Quality and 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	Aug-23	YTD	12 Months	Variation	Assurance
Number of Never Events (CQC/NRLS reportable)	0	0	0	1		
Medicines modules produced without error %		90%	37%	16%	-	n/a
Days of medicines stock modules in reserve		2	2	2	-	n/a
Number of no/low harm incidents		404	1,930	1,930	-	n/a
Number of incidents moderate and above harm		25	64	64	-	n/a
Number of Serious Incidents (SI) reported		4	20	20	-	n/a
Number of SI investigations outstanding after 60 days (excluding events that are officially suspended)	0	1	10	19		
RIDDOR reportable incidents		8	40	40	-	n/a
Number of reported CD incidents – unaccounted for losses		37	81	81		n/a
Number of DATIX incidents - patient		425	1,948	1,948	-	n/a
Number of DATIX incidents - non patient		395	1,914	1,914	-	n/a

Observation & Explanation:

4 SIs have been declared in the month of August all are SCAS declared SIs.

Improvement Actions and Assurance:

Patient safety improvement plan in place and being monitored by internal governance groups with external oversight

NHS

NHS
South Central Ambulance Service
NHS Foundation Trust

Workforce

August-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		1	
		EOC External Attrition EOC Internal Attrition		15	
L				6	
H	Appraisals - Trust			1	
↗		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	Aug-23	YTD	12 Months	Variation	Assurance
Conflict Management	95%	49.6%	45%	74%		
Equality & Diversity	95%	87.1%	86%	92%		
Fire Awareness	95%	87.3%	86%	89%		
Health & Safety	95%	87.1%	86%	91%		
Infection Control	95%	87.2%	86%	92%		
Information Governance	95%	82.4%	82%	88%		
Manual Handling	95%	87.3%	86%	91%		
Safeguarding Adults Level 1	95%	85.7%	84%	91%		
Safeguarding Children Level 1	95%	85.4%	84%	91%		
Safeguarding Level 3	95%	50.2%	49%	51%	-	-

Observation & Explanation:

Statutory and mandatory training performance continues to deteriorate.

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	Aug-23	YTD	12 Months	Variation	Assurance
Number of Physical Assaults	21	26	94	225		
Number of Non-Physical Assaults	50	67	262	566		

Observation & Explanation:

Staff assaults both physical and non physical are above expected levels and increasing.

Improvement Actions and Assurance:

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Sickness - Trust (Total)	8.6%	6.7%	6.7%	8%	L	n/a
Appraisals - Trust	95%	81%	85%	85%	H	F

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Total Frontline Workforce	1,843	1,800	8,988	21,362		n/a
Frontline Recruitment	46	28	119	334		n/a
Frontline Attrition	34	24	107	282	L	n/a
Frontline External Attrition	26	19	75	211		n/a
Frontline Internal Attrition	8	5	32	71		n/a
Sickness - 999 (Total)	10%	7.4%	7.4%	8.8%	L	n/a

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Corporate Workforce		1,137	5,732	5,732	-	n/a
Corporate Recuitment		2	37	37	-	n/a
Corporate Attrition		11	50	50	-	n/a
Corporate Internal Attrition		0	11	11	-	n/a
Corporate External Attrition		11	39	39	-	n/a

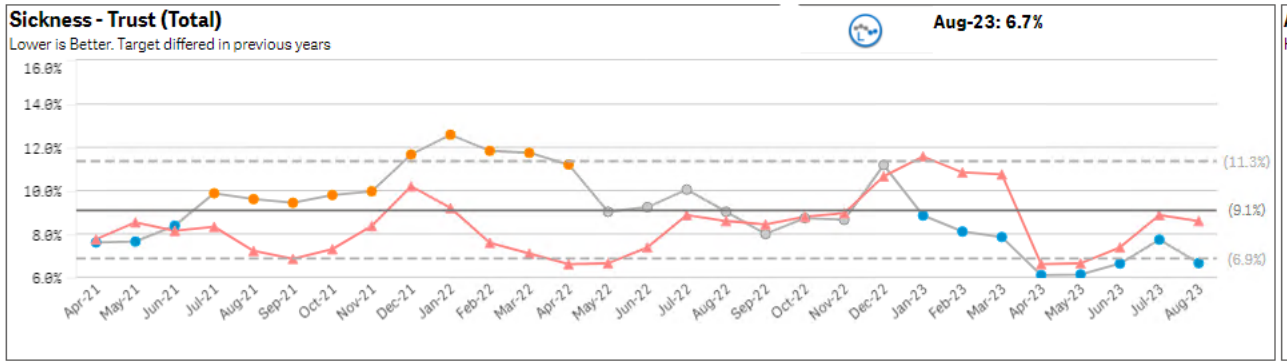
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

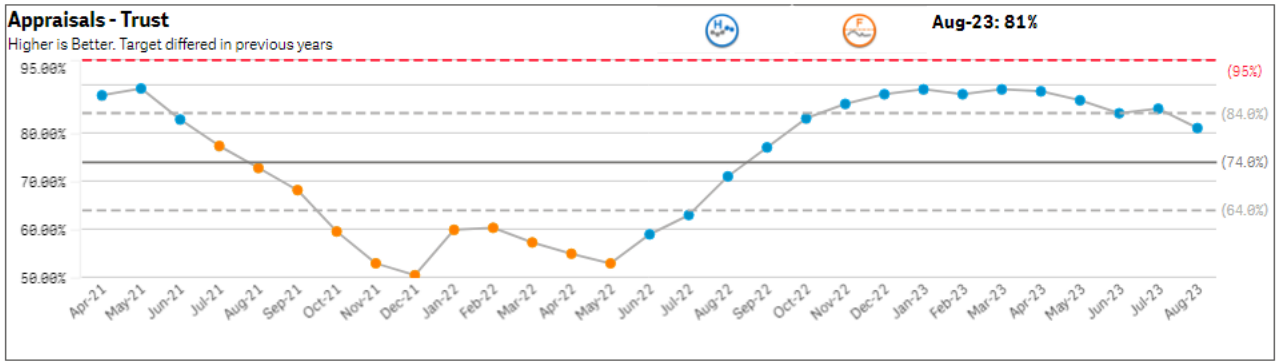
Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
EOC Workforce	293	323	1,540	3,463	H	n/a
EOC Recruitment	14	17	76	185		n/a
EOC Attrition	18	8	50	143		n/a
EOC Internal Attrition	5	1	13	46		?
EOC External Attrition	13	7	37	97		?
Sickness - EOC (Total)	9.2%	6.8%	6.8%	8%	L	n/a
111 Workforce	287	293	1,437	3,289		n/a
111 Recruitment	20	22	91	207		n/a
111 Attrition	20	15	80	187		n/a
111 Internal Attrition	6	1	17	47		n/a
111 External Attrition	14	14	63	140		n/a
Sickness - 111 service (Total)	13%	0.071%	0.071%	0%	L	n/a

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
PTS Workforce	649	656	3,224	7,658		n/a
PTS Recruitment	16	12	86	183		n/a
PTS Attrition	15	10	60	180		n/a
PTS Internal Attrition	7	0	15	69		n/a
PTS External Attrition	8	10	45	111		n/a
Sickness - PTS (Total)	7.7%	7%	7.4%	7.7%		n/a

Sickness & Appraisals - Trustwide Sickness & Appraisals





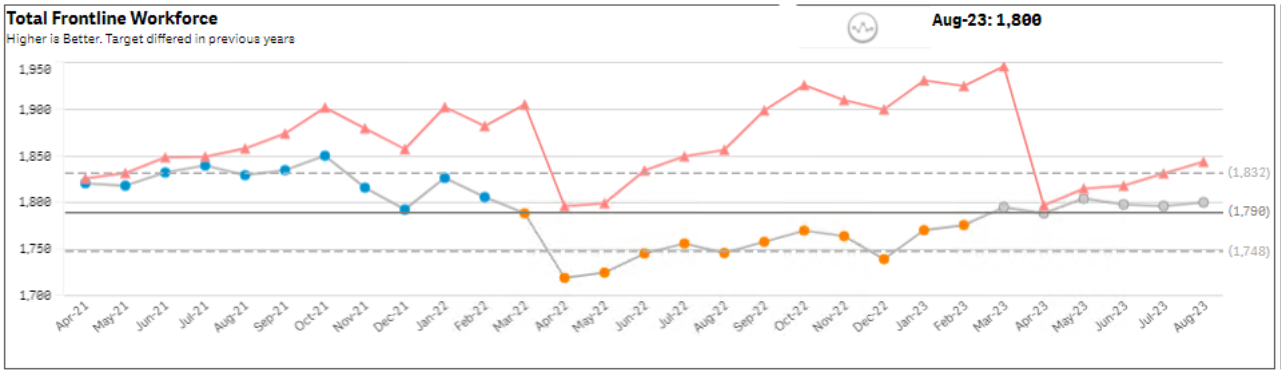
Observation & Explanation:

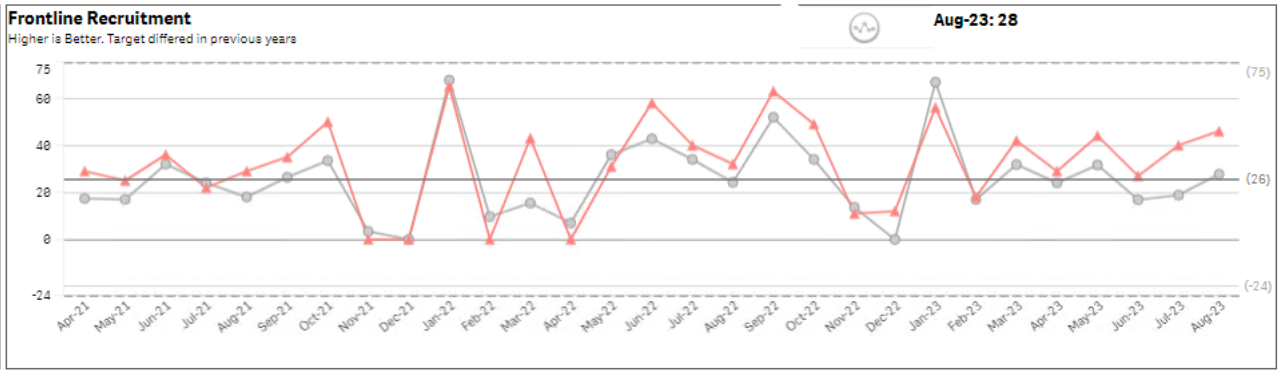
PDR compliance remains high but below target. PDR compliance is consistently below target. Trust sickness remains below plan and decreased between July and August.

Improvement Actions and Assurance:

Welfare calls will continue to be prioritised as we move into winter alongside preventative measures to improve employee well being. REAP levels are likely to be impacting on PDR completion.

999 Operations - 999 Workforce 1





Observation & Explanation:

August is when we start to see the NQPs coming out of university. We had 3 courses planned and recruited 26 WTE for those courses. There were also a couple of bank paramedics started with us. We have removed a number of non-clinical courses from the plan for Q3 and Q4 to focus on clinical recruitment. This was reviewed and approved at IWP and through the quality assurance process.

Improvement Actions and Assurance:

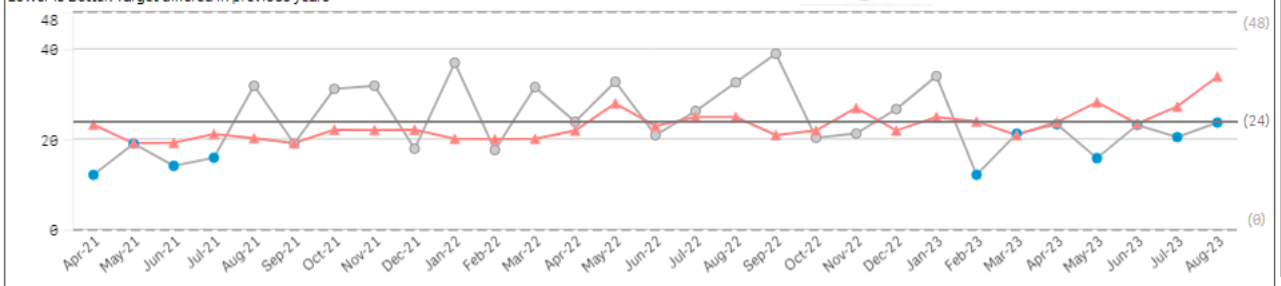
September we have more intakes of NQP and our next internationally educated paramedic course. There have been a number of withdrawals for the internationals which is disappointing, we are trying to link people up once they are job offered so they can improve relationships within their cohorts before they arrive in the UK. We are working on filling international courses for February and March 2024. We are advertising with universities in Australia and doing other direct adverts as well as using NHS Professionals to support our international recruitment. We've got a new film produced and about to be launched on our website and social media to attract internationally educated paramedics. We are starting the planning process for 2024/25 through the IWP group.

999 Operations - 999 Workforce 2

Frontline Attrition

Lower is Better. Target differed in previous years

Aug-23: 24



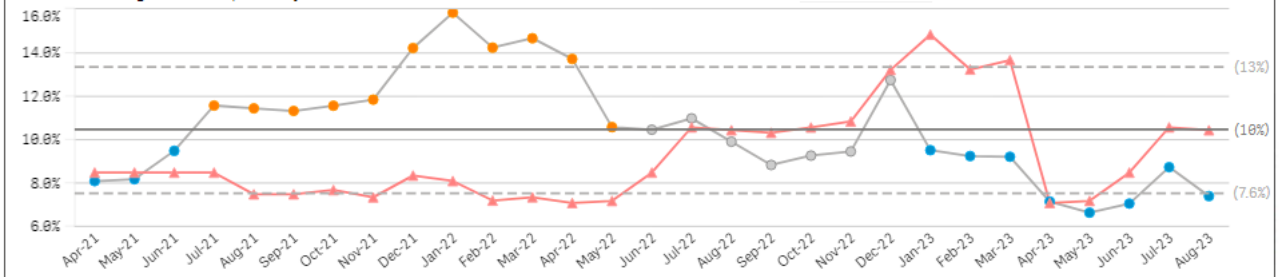
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Frontline External Attrition	26	19	75	0		n/a
Frontline Internal Attrition	8	5	32	0		n/a

Sickness - 999 (Total)

Lower is Better. Target differed in previous years

Aug-23: 7.4%



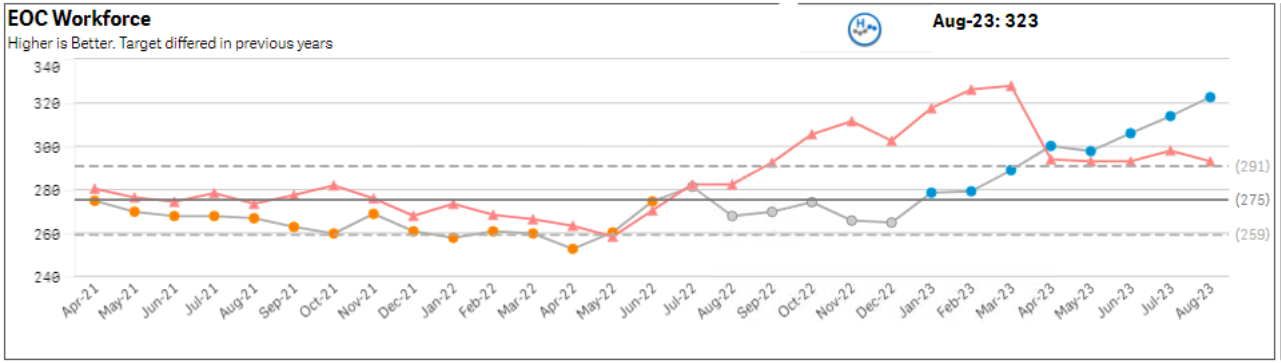
Observation & Explanation:

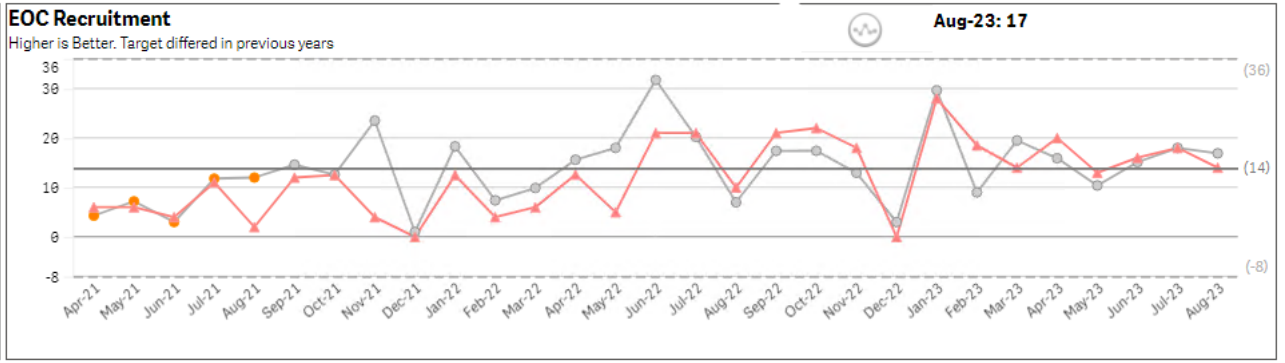
Attrition within 999 remains within expected variation and under plan.

Improvement Actions and Assurance:

999 have attrition plans which are aligned to corporate projects. ECAs move to a band 4 may support front-line attrition. Sickness remains below forecast and we continue to review processes. The managing attendance policy is also under review.

Clinical Coordination Centre - EOC Workforce 1





Observation & Explanation:

Recruitment is progressing to plan for this year for EOC. We've brought in a number of international nurses into Bicester and they are in various stages of becoming fully work effective. Attrition has been lower than expected which has resulted on a positive increase in EOC workforce compared with expected plan. There was a risk that the number of leavers would increase after the June/July pay increases, but we have not yet seen that come to fruition. The recruitment numbers are following the plan for the year. There are big differences between months as new starters are planned against availability of training resource and expected candidate numbers.

Improvement Actions and Assurance:

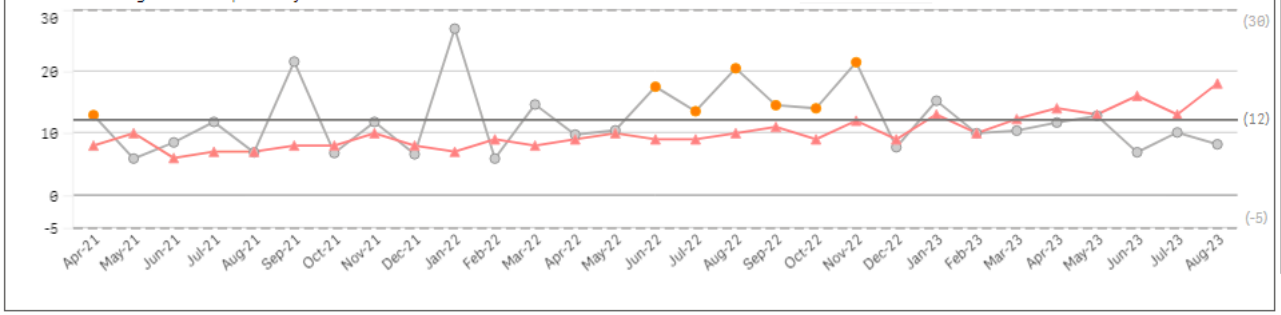
The numbers are monitored closely at monthly IWP meetings and recruitment is adjusted as appropriate. Retention work is also ongoing as we want to retain and grow our existing workforce.

Clinical Coordination Centre - EOC Workforce 2

EOC Attrition

Lower is Better. Target differed in previous years

Aug-23: 8



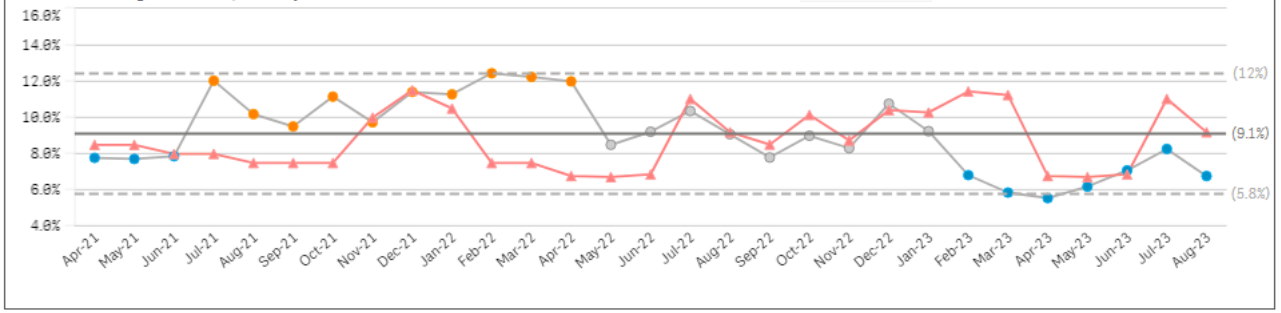
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
EOC Internal Attrition	5	1	13	119		
EOC External Attrition	13	7	37	236		

Sickness - EOC (Total)

Lower is Better. Target differed in previous years

Aug-23: 6.8%



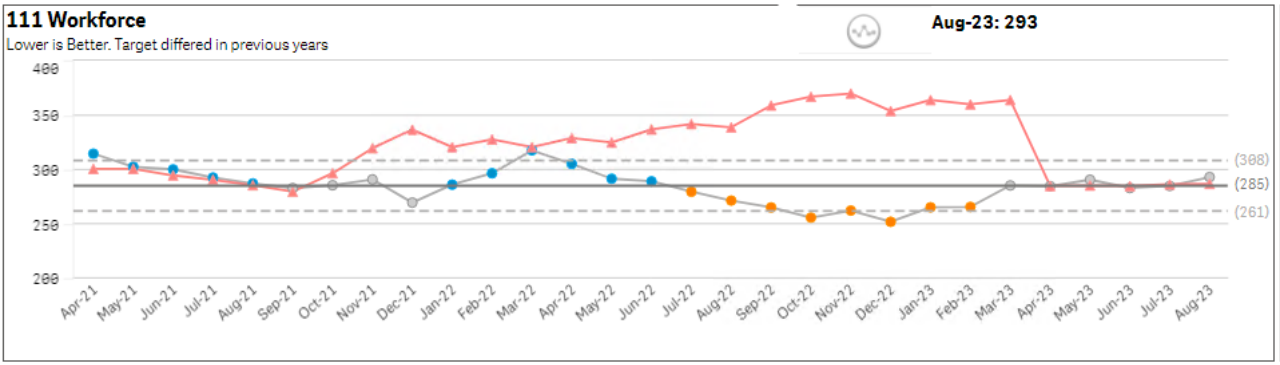
Observation & Explanation:

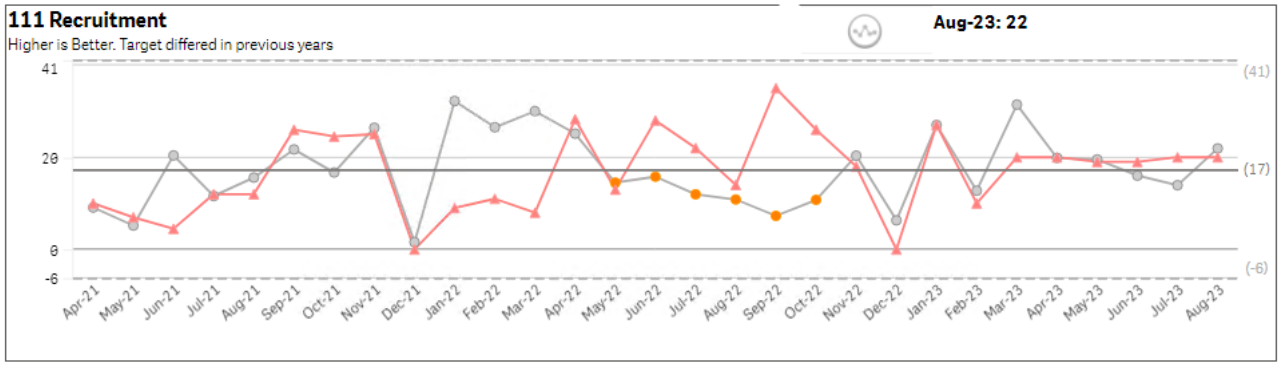
EOC attrition remains within expected variation and has actually decreased over the last month, a reflection of the summer period. After a rising trend in sickness, sickness decreased between July and August.

Improvement Actions and Assurance:

The EOC retention plan will be presented at Septembers IWP. EOC rotas have been agreed which will improve work / life balance for EOC staff and hopefully support retention. Sickness processes continue to be reviewed and monitored. The managing attendance policy is under review.

Clinical Coordination Centre - 111 Workforce 1





Observation & Explanation:

Recruitment and workforce numbers are slightly above expectations for this month which is good news as there was a risk of increased leavers after the June/July payments had come through. We have good plans for the rest of the year for the new site in MK opening. MK has a more active labour market than Bicester or Otterbourne. We are using a variety of recruitment attraction sources. August/September we have attended a number of events such as the Banbury Emergency Services Show and the MK Blue Light Hub event. This increases engagement with the local populations.

Improvement Actions and Assurance:

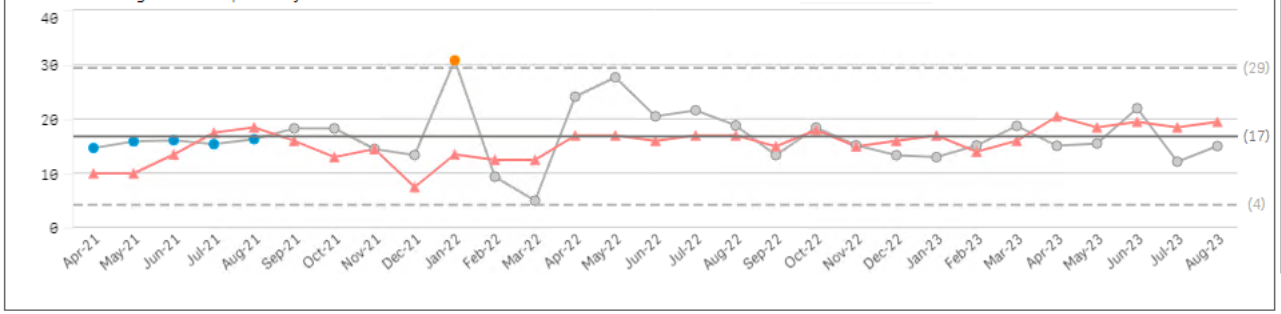
We are working on specific hours and shift requirements. International nurses are planned for Bicester in Q4. The move to Partis House for MK will be positive and enable an increase in workforce numbers at that site.

Clinical Coordination Centre - 111 Workforce 2

111 Attrition

Lower is Better. Target differed in previous years

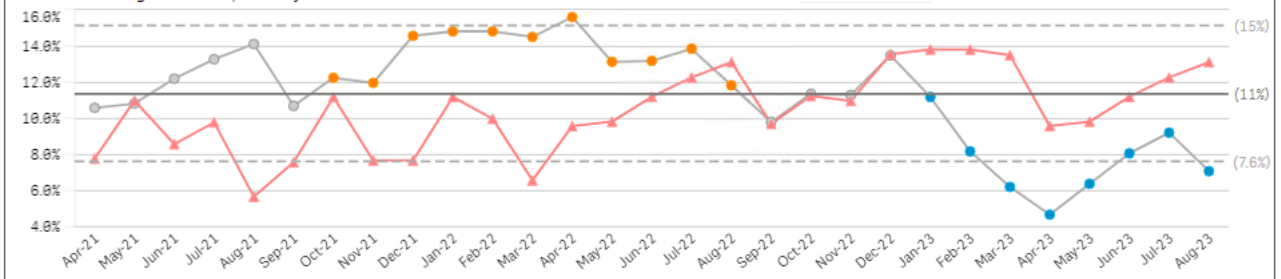
Aug-23: 15



Sickness - 111 service (Total)

Lower is Better. Target differed in previous years

Aug-23: 7.1%



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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
111 Internal Attrition	6	1	17	47		n/a
111 External Attrition	14	14	63	140		n/a

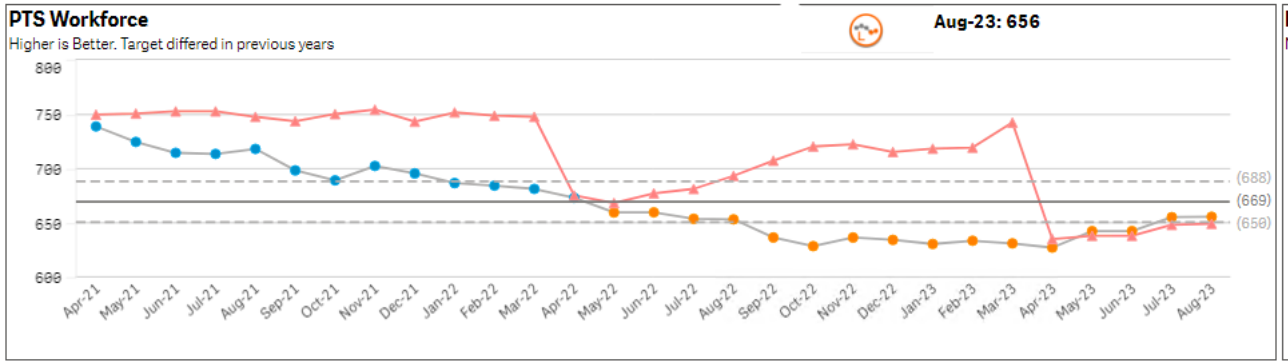
Observation & Explanation:

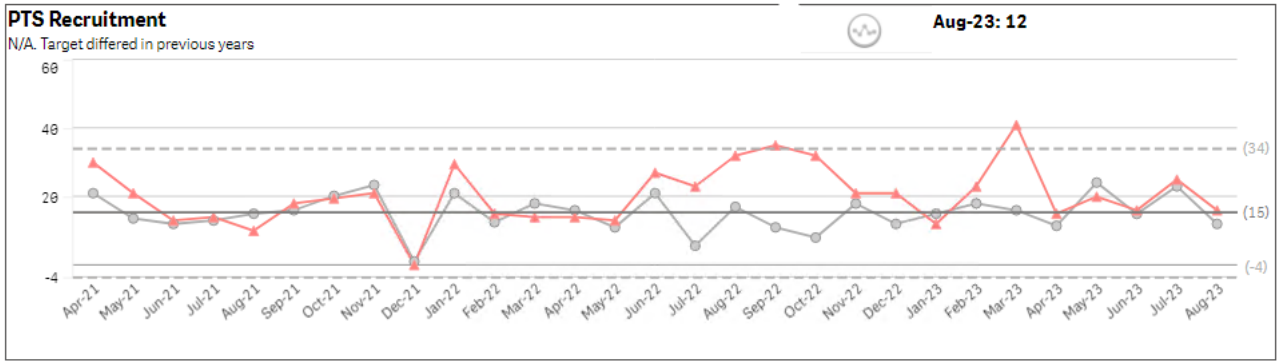
111 attrition continues within expected variation, although decreased between June and July, this is likely to reflect the summer period. Whereas sickness was increasing between April - July, there has been a decrease in absence between July and August.

Improvement Actions and Assurance:

111 attrition plan was not presented at August's IWP but will be presented at this month's IWP for further discussion. It will be presented at Workforce Board in September. Sickness remains a focus to ensure that processes are followed and the Managing Attendance Policy is under review

PTS - PTS Workforce 1





Observation & Explanation:

Recruitment for PTS is just below the plan. With the coming changes to the PTS contracts, we are very closely monitoring and prioritising recruitment areas and these are discussed at the IWP meetings and local recruitment meetings. Workforce numbers are just ahead of plan, but not significantly.

Improvement Actions and Assurance:

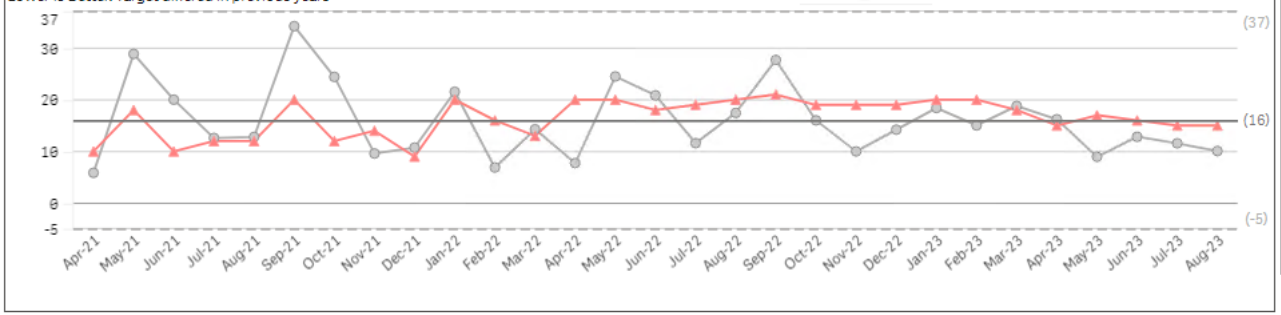
Over the coming months, we will need to consider exactly how many people we recruit and into which areas, this is discussed in depth at monthly IWP meetings.

PTS - PTS Workforce 2

PTS Attrition

Lower is Better. Target differed in previous years

Aug-23: 10



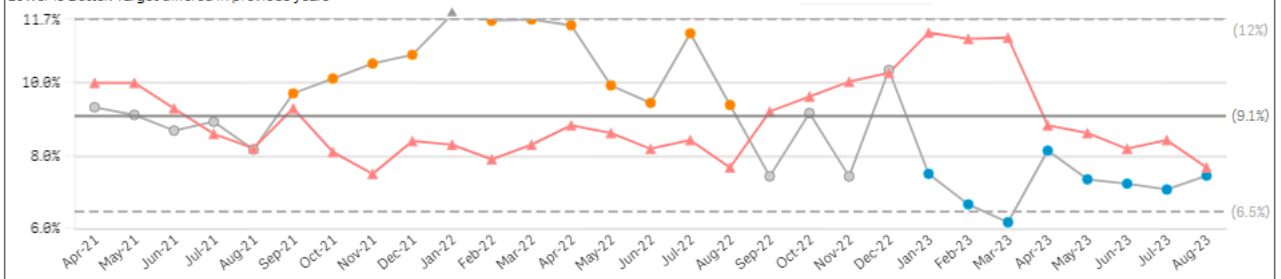
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
PTS Internal Attrition	7	0	15	0		n/a
PTS External Attrition	8	10	45	0		n/a

Sickness - PTS (Total)

Lower is Better. Target differed in previous years

Aug-23: 7.4%



Observation & Explanation:

PTS sickness remain fairly static and has for the last 8 months.

Improvement Actions and Assurance:

Sickness processes continue to be monitored and reviewed. The managing attendance policy is under review.

Finance

NHS Finance Overview

August-23 Summary

Metrics:

Assurance ⇨

Variance ⇩

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

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

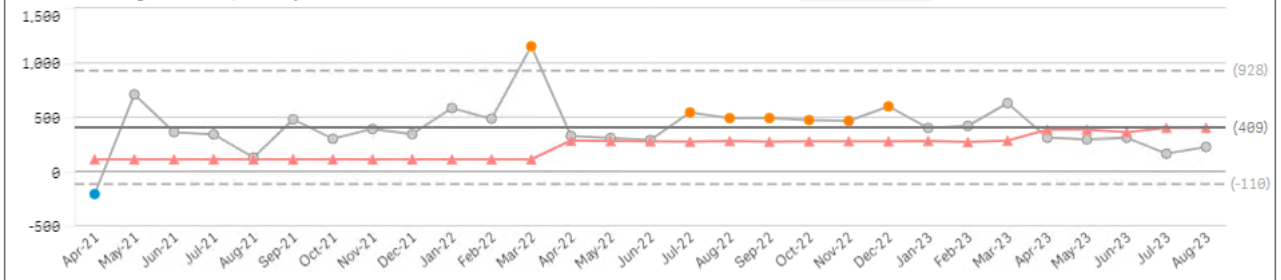
Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Debtors > 90 days> 5% total balance	5%	14.5%	20%	16%		
Agency Spend	403	228	1,316	4,804		n/a
Overall SOF Segment		4	20	46		n/a
CIP's Total	3,173	1,563	7,807	7,807	-	-
Pay Spend	17,251	17,129	83,543	83,543	-	-

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

Metric	Monthly Plan / Target	Aug-23	YTD	12 Months	Variation	Assurance
Overall SOF Segment		4	20	46		n/a

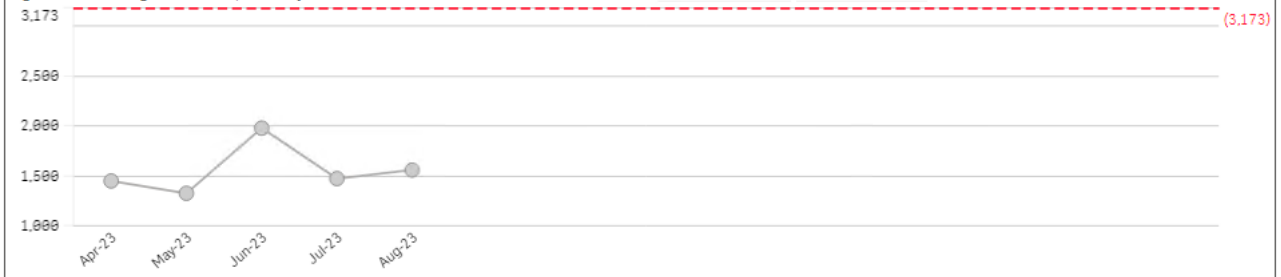
Finance - Finance 1

Agency Spend
Lower is Better. Target differed in previous years
Aug-23: 228

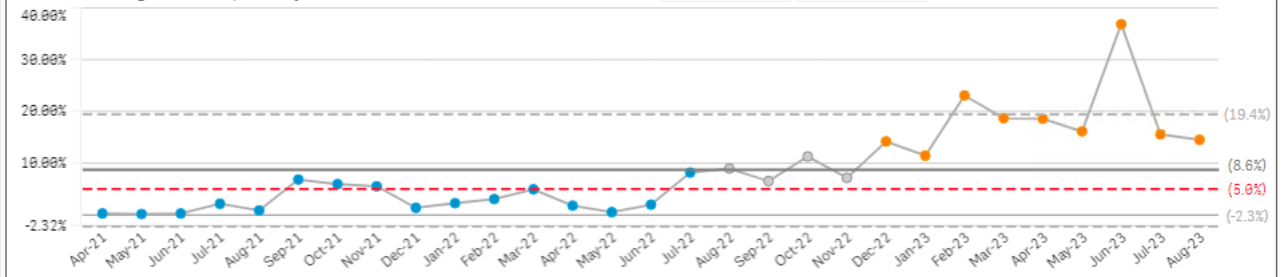


Pay Spend
N/A. Target differed in previous years
Aug-23: 17,129

CIP's Total
Higher is Better. Target differed in previous years
Aug-23: 1,563



Debtors > 90 days> 5% total balance
Lower is Better. Target differed in previous years
Aug-23: 14.5%



Observation & Explanation:

Aged debtors remains an issue, which is largely due to the PTS ECR & Multi-Crew balances remaining unresolved. A number of these balances are in dispute with the ICB & relevant Trusts.

Improvement Actions and Assurance:

The issue will be highlighted at the Audit Committee on a quarterly basis moving forwards, starting this month, with a view being taken on whether we need to write-off any unrecoverable debts.

NHS
South Central
Ambulance Service
NHS Foundation Trust

Integrated Quality and Performance Report: Aug-23

APPENDICES

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) .

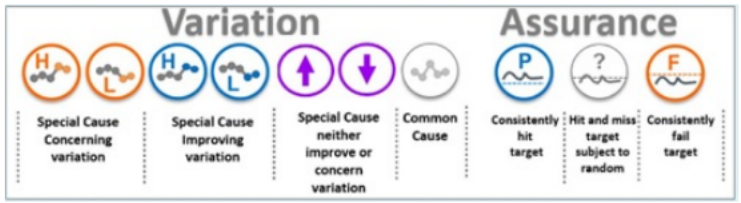
4) A run of 6 consecutive ascending or descending values (a trend).

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.

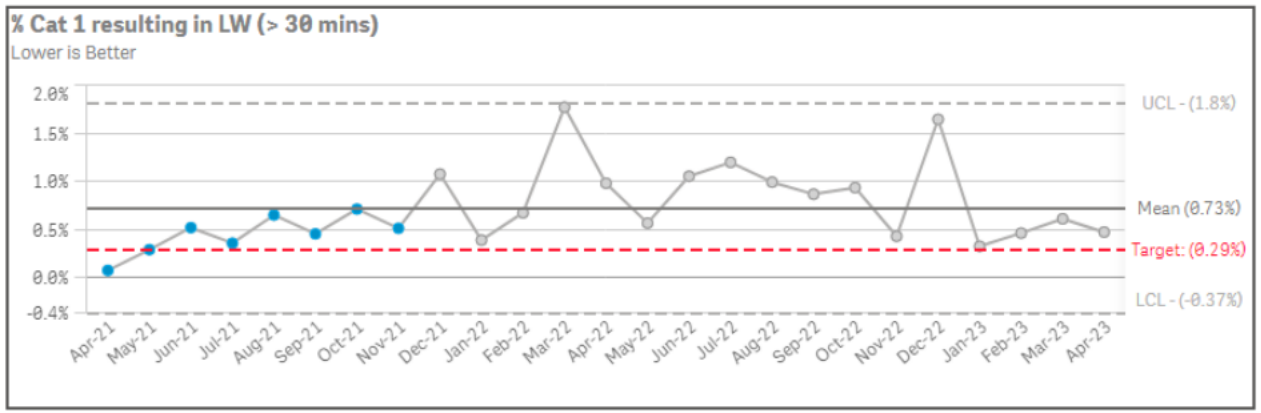
Icon Key



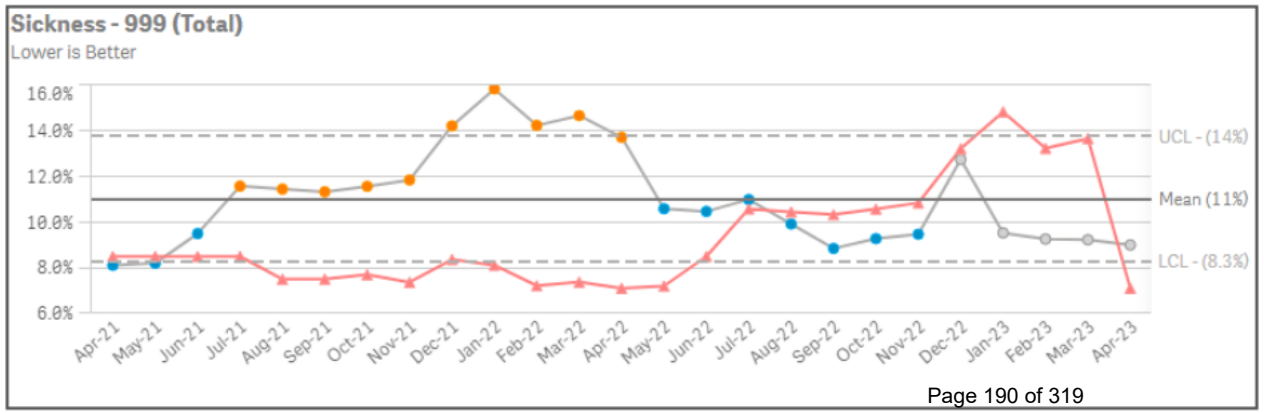
Assumptions:

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

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Operations Report – 999, 111 and Other**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**Thursday, 21 September 2023**	**Agenda Item:**	**18**	
Executive Summary:	A comprehensive performance improvement action plan has been developed to address concerns about Category 2 and 999 call answer performance.			
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:				

BOARD OF DIRECTORS MEETING IN PUBLIC 28TH SEPTEMBER 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. Following a challenging June performance we saw this continue into July with our category 2 performance at 33 minutes 10 seconds, however we have seen a significant improvement in August delivering 27 minutes 33 seconds. This improvement has been achieved following the implementation of the Operational Performance Improvement plan at the start of August. There were a number of immediate actions taken to increase operational staffing levels and reduce our abstractions which are then supported with short and medium term actions to develop a more sustainable level of operational hours to meet the 999 response demand. These actions include increasing our private provider hours, increasing SCAS staff hours through overtime, incentivising specific shifts and bank shifts. This plan is being closely monitored by the senior operations team and additional actions being added. We have also set up a formal agreement with WMAS to take a percentage of our 999 calls when the calls breach 60 seconds waiting for SCAS to answer. This is improving our call answer performance along with on going actions to increase our own ECT staffing levels. 111 performance has remained positive through July and August.

3. Clinical Co-ordination Centres

3.1. In July inbound call volumes and average call answer times remained at the high levels seen in June. In August, call volumes fell by 5% back to May levels. Increases in ECT logged in hours, improvements in average handling time and circa 2% of calls being passed to WMAS, has seen the average call answer time fall to 14 seconds at the time of writing this report.

3.2. We currently have 155.68 WTE ECTs with 124 of these now being work effective which is supporting our improvement with our call answer performance. We have a further 30 staff who are in training. We have also seen a reduction in our attrition which is supporting our work force levels and we remain with 30 vacancies to deliver our full establishment.

3.3. We have implemented an incentive for ECTs covering the overnight periods and this has proved positive with an increase in logged in hours and an improvement in mean call answer performance. West Midlands Ambulance Service call answer support has started again and any call waiting 60 seconds to be answered is automatically transferred to WMAS by BT. We have seen variable levels of calls being taken by WMAS dependant on SCAS demand and our own ECT levels with rates of transfer to WMAS being between 5 to 10% of activity. The continued improvement in average handling time is also delivering improvements in average call answer time.

3.4. Performance in 111 remained strong through July and August. Call answer in 120 seconds for July at 69.61% and abandonment rate of 4.71%. August performance was 81.92% with an abandonment rate of 2.42% which is our strongest performance for some months and the first time we have achieved the national target on abandonment rate. We remain below national targets but above trajectory on these metrics.

3.5. Calls offered has remained either slightly below or at a level in comparison to last year. Meaning that demand is sitting closer to our capacity and therefore sustaining a lower wait to answer time. This is further supported by the continuing improvements in real time management, abstraction levels and average handling time.

3.6. National resilience support ended 10th July 2023. We continue to support our 111 colleagues on the IOW, handling their calls three nights per week. A business case is currently with HIOW commissioners.

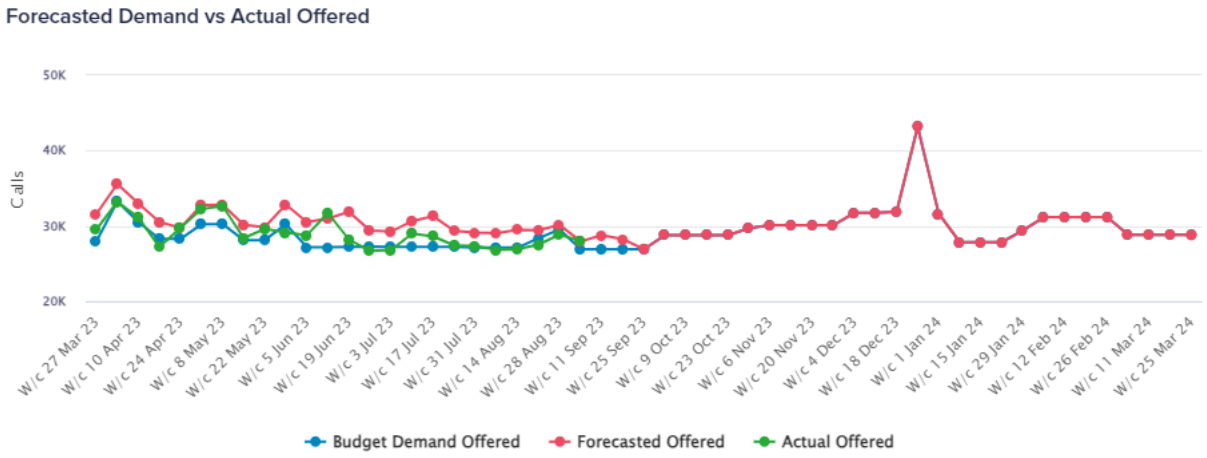
3.7. Current establishment for Health Advisors is 242.34 WTE and for Clinical Advisors 54.53 WTE, leaving a gap of 87.74 WTE and 30.25 WTE respectively to achieve performance. Recruitment currently sits above trajectory, and we continue to show improvements in retention of staff for the fourth month.

3.8. In July, 46.3% of calls had clinical input with 25.6% of these being provided with self-care advice. Validation rates for Cat 3/4 ambulance and ED (Emergency Department) dispositions remain strong; with 62% and 53% of patients, respectively, being offered alternative pathways of care. Data for August not available at time of writing.

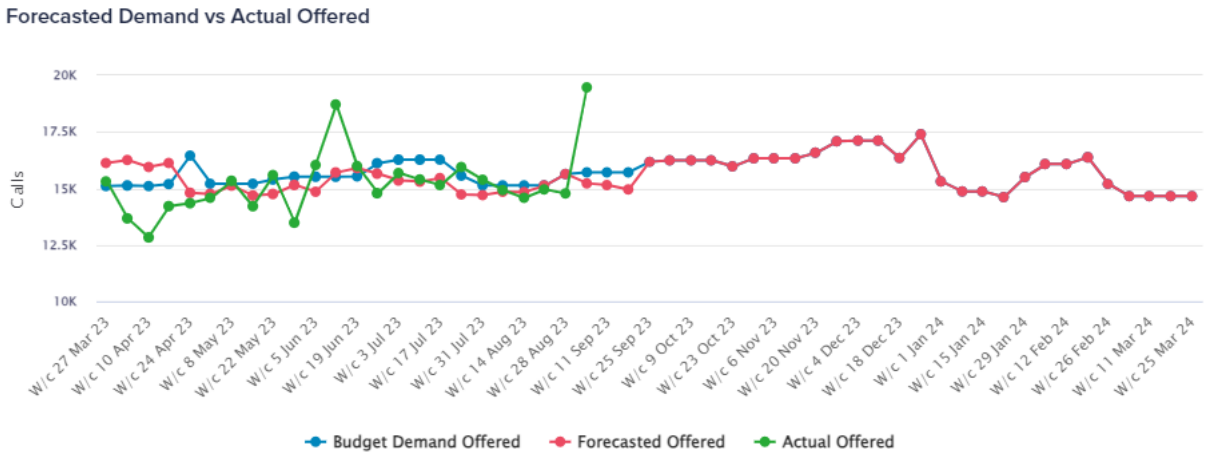
4. Urgent & Emergency Care

4.1. 999 call demand has been consistent with our budget plans during July and August, however, has spiked at the start of September. 999 response demand has however increased above budget levels for the last 6 weeks since the end of July. Through the Operational Improvement Plan actions we have increased operational capacity through increasing the availability of shifts to both SCAS staff and private providers. This allows the ability to review available shifts 28 days in advance which was previously only 7 days. We have also been placing tighter controls on abstraction levels with local managers being held to account for additional annual leave levels as well as senior weekly reviews on training abstractions to balance operational hours with our training requirements. We have issued an incentive for Paramedics on night shifts to increase our night staffing levels and this has had a positive effect in the first 4 weeks also enabling us to reduce the level of TECA crews on overnight. These changes have seen an increase in staff hours, which is positively impacting on Cat 2 performance.

4.2. 111 Call Demand

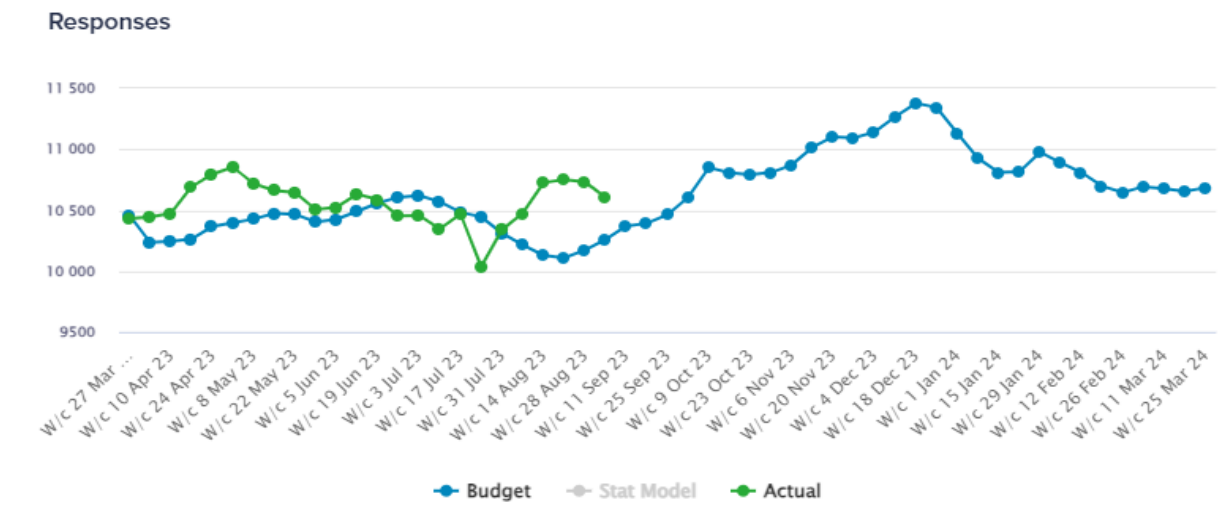


4.3. 999 Call Demand

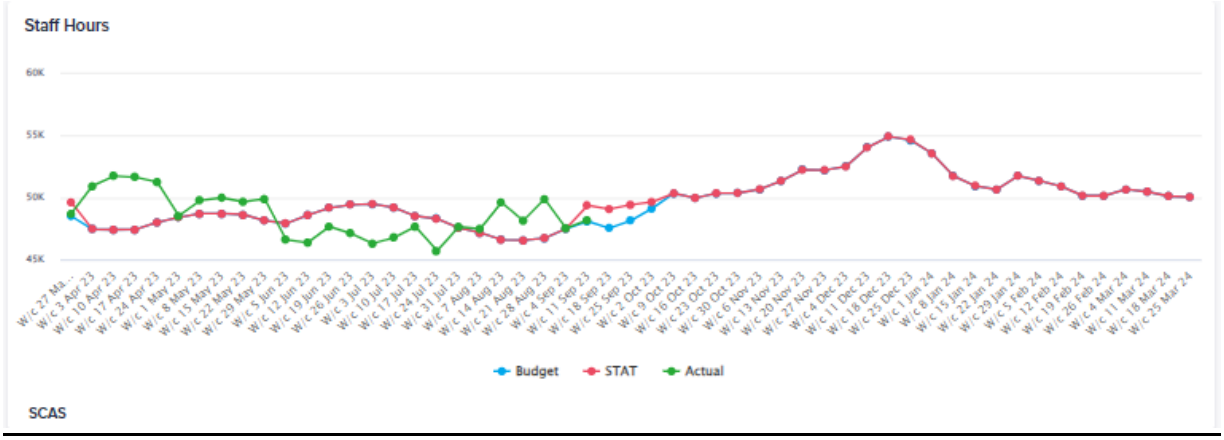


EOC

4.4. 999 Response Demand

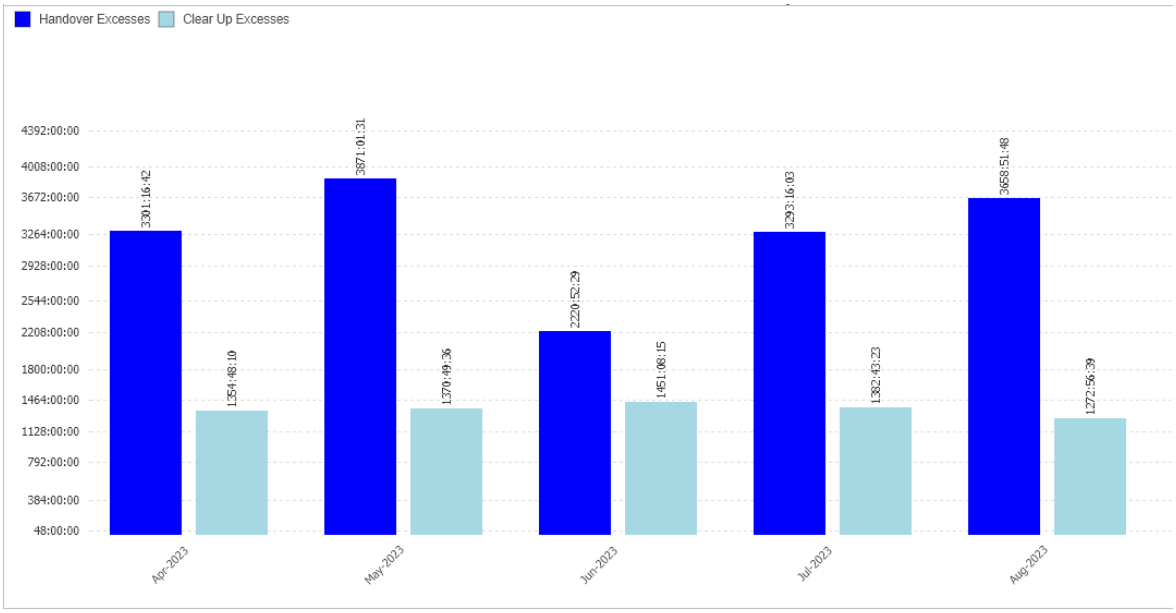


4.5. Operational Hours

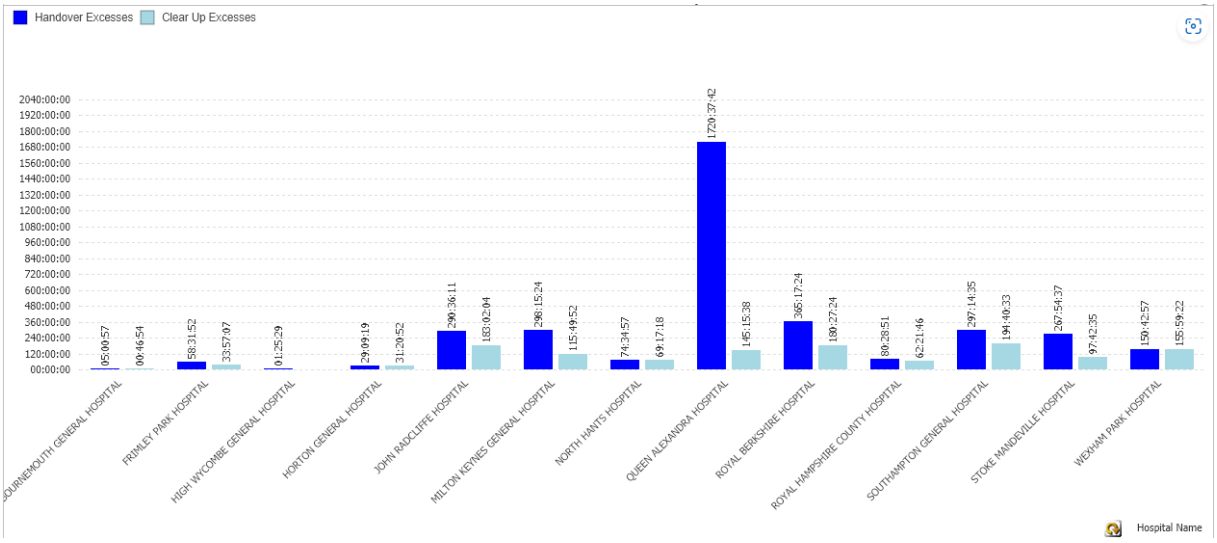


Hospital Handover Delays

4.6. Handover delays increased in August with SCAS losing 3,658 hours during the month. Average handover time has increased to 21 minutes 59 seconds which is 5 minutes above our budget assumption levels.



4.7. The QAH hospital remains the highest concern with us losing 1,720 hours in August with an average handover time of 38 minutes and 2 seconds. We are continuing to work with the QAH team and continue to escalate the delays to the ICB, however we are not seeing any improvement with the level of delays which is impacting on the SCAS performance across the HIOW footprint.



Specialist Practitioners

4.8. We have live recruitment campaigns for new specialist practitioners (SPs) to fill our existing vacancies, provide additional cover on the Urgent Care Desk as well as increasing clinician cover for the implementation of Cat 2 segmentation. We have currently recruited 9 new SPs, of which 3 are external to SCAS and they will commence their educational programme in October 2023. We have a further 12 vacancies to fill and have on going adverts being issued.

Resilience & Specialist Operations

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

- Terrorism.
- Pandemic Influenza.
- The Manchester Arena Inquiry recommendations
- Industrial Action
- Widespread Electricity loss
- Severe Weather

4.10. There continues to be pressure on the HART team due to abstractions above budgeted levels (maternity and long term sickness/alternative duties) with active recruitment in place and HART qualified resilience managers backfilling wherever possible. Work is ongoing with commissioners to enable an uplift in current numbers and bring us to the national agreed reference level of funding.

4.11. The RSO department is working closely with ICT Comms on the recovery from the EPR outage and will manage the learning process as soon as the system is restored.

4.12. The RSO team have delivered team training updates to 28 teams in the last 3 months to ensure they are updated on the current procedures for JESIP, Non-Specialist MTA response, water awareness and the replacement for CBRN Initial Operational Response. This training continues to ensure all 96 teams are fully compliant this year. These training packages have been shared with other ambulance services to assist them in their delivery.

4.13. The team have rewritten and are now delivering SORT training, updated to the recently released new standards, with the first course being delivered w/c 4th September.

4.14. RSO continue to plan and support both local national events including festivals, Royal events and investitures, football matches and are fully involved in the planning and response to the International AI conference recently announced at the beginning of November, with most G7 leaders attending. Planning is also starting for the D-Day 80 celebrations next year which will be a significant worldwide event.

Clinical Equipment

4.15. The new asset management system project has been approved by the Executive Transformation Board and Executive Management Committee. Work is ongoing to develop a fully costed business case for presentation on 13th September to the Executive Transformation Board.

Ambulance Make Ready (MR) Services

4.16. The Tender for the new service is complete and awarded to Churchill Services. The new contract commenced on the 1st September and revised KPIs for the service are included in the contract.

Fleet

4.17. The delivery of the 53 new DCAs has been delayed and deliveries are now due to start in October with completion in January. The prototype has been delayed until 15th September. A site visit to the convertors has been arranged to pick up vehicle and review the conversion process.

4.18. Delivery of 72 ambulances with the new convertor remains on track with deliveries due to start in January and complete by the end of March.

4.19. Currently on track to receive all 125 new DCAs by the end of the financial year.

5. Projects

U&E Ops Roster Review Project

5.1. The Optima analysis has been revisited and the outcomes presented to the Project Board. It has been agreed to progress with the initial profiling once we have roster proposals. All operational nodes are working through the design of new roster patterns, with two nodes having already voted and moved to roster alignment. All workstreams are progressing to offer further guidance to the project and policies surrounding the new roster plans being implemented. The flexible working group has commenced, and this group is meeting fortnightly to establish flexible working processes and ideas that can be delivered. All roster changes are still on track to be implemented during March 2024.

EOC Roster Review Project

5.2. During July, ECT staff consultation has been ongoing with six question and answer sessions hosted, which over 140 staff attended. Further follow up comments have been received and responded to and a frequently asked question document has been shared with the teams.

5.3. Currently the approved options are being voted upon by staff. The vote process closes at the end of August, with approval and the build phases then commencing.

Emergency Services Mobile Control Project (ESMCP) (Radio Replacement)

5.4. The project is currently running to schedule. The Control Room Solution (CRS) configuration is still in development, with firewalls/technical infrastructures still being worked on, to be completed at the end of August. This should then release the Tenant (replacement ICCS) to SCAS for user testing with our third-party provider. The train the trainer course is planned for the end of September 2023.

5.5. The Mobile Data Vehicle Solution (MDVS) continues with the weekly meetings in preparation for the technical infrastructure and installation of vehicles. The National Mobilisation Application (NMA) software has been released and we are working on our configuration and holding a number of workshops to finalise the product for SCAS in early September. This will then release the train the trainer for NMA and the equipment for testing of the product.

5.6. We have secured the vehicle installation site, Parkgate in Fareham. The lease has been agreed and signed. We should take possession of the site in early September to conduct the initial works to ensure the site is fit for purpose.

999 CAD Replacement Programme (SCAS & IOW AS)

5.7. The programme team is continuing to work with ICT to maintain operational performance of the current solution for the duration of the replacement timeline. The addendum for the extension of the current CAD contract is nearing completion.

5.8. The longlist of system requirements for the new solution has been assembled from all SCAS and Isle of Wight Ambulance Service teams. The entire end-to-end process has been mapped to ensure that all requirements have been gathered and that all risks have been appropriately mitigated. This will be reviewed by a range of different stakeholders as part of a desktop simulation, this work will be completed with key EOC users in the coming weeks once day to day operational pressures eases.

5.9. Documentation for soft market engagement events has been drafted with a view to host demonstration events by potential suppliers, this will help ensure new technical specification are aligned with their software offering/capabilities.

5.10. An initial outline business case has been drafted and the programme plan and potential budgetary requirements are in the process of being reviewed.

6. Conclusions and Recommendations to the Board

6.1. 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 **September 2023**

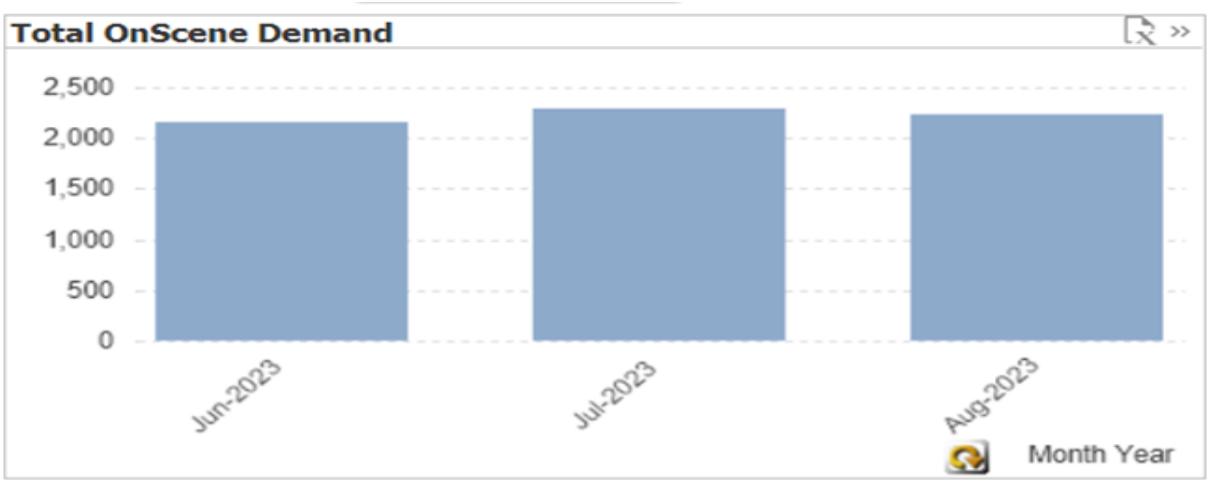
BOARD OF DIRECTORS MEETING IN PUBLIC 27TH JULY 2023

OPERATIONS REPORT – 999, 111 AND OTHER

Appendices

Indirect Resources

1. We continue to see an increase in the number of incidents on scene and the hours of availability have remained fairly consistent even with the summer holidays which usually would have had an impact.



Month & Year	Activity Time
Jun-2023	34598:34:03
Jul-2023	39615:51:30
Aug-2023	35076:23:05

2. We saw an increase in the number of Cat 1 attendances which has resulted in a 30 second contribution for August with 65% of those incidents being stopped by a CET resource. This is slightly down on previous months as we have seen more frontline resources due to the REAP actions.

3. We have an advert out to recruit IR desk volunteers for both Bicester and Otterbourne so that we can maintain the number of deployments to incidents when staff attrition in our control rooms is a challenge.

CET Contribution by Month			
Month And Year Name	Jun-2023	Jul-2023	Aug-2023
Total Cat 1 Incidents (SCAS)	3,459	3,374	3,241
% of Cat 1 Stopped by CET	7.0%	6.9%	7.7%
Cat 1 CET OnScene	346	351	381
Cat 1 Stopped by CET	242	234	251
% of Cat 1 Onscene Stopped b	69.9%	66.7%	65.9%
Cat 1 Mean Stopped by CET	0:08:40	0:08:38	0:08:16
Cat 1 Mean (SCAS)	**0:09:16**	**0:09:19**	**0:08:33**
Cat 1 Mean - CET Removed	**0:09:42**	**0:09:46**	**0:09:03**
CET Contribution	**0:00:26**	**0:00:27**	**0:00:30**

CET Contribution by Breakdown			
Month Year	Jun-2023	Jul-2023	Aug-2023
Cat 1 demand - total	3459	3374	3241
Time to allocate to 75% (all Resources)	00:03:40	00:03:39	00:02:45
% Auto Dispatch	40.2%	39.5%	43.2%
Number were CET on-scene	346	351	381
% On-scene first	69.9%	66.7%	65.9%
Time to back up CET	00:06:04	00:06:12	00:06:14
Contribution	00:00:26	00:00:27	00:00:30

4. We now will report on all attendances to Cat 3 and Cat 4 incidents by month. On average we are deploying our responders to over 325 incidents and over 63% of the calls they are deployed to by either UCD or CSD are seen and treated without the requirement for a clinical resource to attend scene.

Nature of Call All C3 & C4 Call								
Month	Total NOC (all responders)	% with NOC left at scene (all responders)	CET Assign	CET OnScene	Car OnScene	AMB OnScene	CSD / UCD OnScene	% CET on-scene and see & treat
Jun	15321	42.9%	397	356	38	202	167	65.4%
Jul	15673	42.7%	362	301	41	164	165	63.5%
Aug	15544	44.1%	380	319	23	190	192	63.6%

NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Finance Report for the month ended 31st August 2023 (Month 5)**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**19**
Executive Summary:	**<u>Agreement of Financial Forecast</u>** The Trust has secured agreement to formally move its year-end financial forecast off plan. This requires SCAS Board sign-off in September followed by HIOW ICS board sign-off in October. The Trust's forecast outturn is £38.5m deficit. The forecast deficit has increased by £2.6m from M4, mostly driven by a re-alignment of income assumptions to exclude all non-confirmed income. In addition, the current forecast does not include any costs of organisational structure changes that may be required as part of the financial recovery plan. £8.5m of potential but unconfirmed income is excluded from the financial forecast. £7.9m of this income is related to increased costs forecast to improve Category 2 performance. This income will continue to be excluded until it is confirmed in writing by NHS England. **<u>I&E Position</u>** In August, the Trust recorded an in-month deficit of £2.3m. This was a decrease of £0.7m from the £3.0m deficit recorded in July. The Trust YTD deficit is £11.9m. The Trust's Financial Recovery Group meet weekly to oversee implementation of financial grip and control measures to manage the financial run rate. The impact to date is considered to have held the position, with no significant reductions in run rate yet to be realised. **<u>Cash</u>** The Trust's cash balance at the end of August at £36.1m. The Trust's cash balance has decreased by £13.9m since the start of the financial year. At the current expenditure run rate, the Trust will require cash support from July 2024 to support continuing operations. This forecast is contingent on the timely completion of sale and leaseback transactions		

	related to new fleet in Quarter 4. Should these transactions by delayed, the Trust could require cash support from as soon as February 2024. **<u>Capital</u>** Capital spend YTD is £3.9m. The capital plan is phased based on most of the expenditure taking place from August onwards, particularly for IFRS16 leases. The Trust is still forecasting to utilise its available capital allocation of £22.8m in full, although this is dependent on expected delivery times for new vehicles in Quarter 4 being met.
Recommendations:	The Trust Board is asked to: • NOTE the current financial position of the Trust. • APPROVE a formal notification to HIOW, in October 23 as part of the Month6 reporting cycle, to revise the Trust forecast from the current break-even target to a deficit of £38.5m.
Executive lead:	Stuart Rees, Interim Director of Finance
Report author:	Nuala Donnelly, Head of Finance
Previously considered by:	Finance and Performance Committee, 18th September 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):	Finance & Sustainability
Links to BAF risks: (or links to the Significant Risk Register)	Risk 6 - Sufficient and stable financial resources
Quality Domain(s):	Not applicable

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

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BOARD OF DIRECTORS MEETING IN PUBLIC 28 September

2023 FINANCE REPORT

EXECUTIVE SUMMARY

1 Underlying financial performance has deteriorated since 2019/20 due to the Trust increasing its recurrent expenditure rate without a corresponding increase in recurrent income. A financial deficit has materialised in 2023/24 as non-recurrent measures previously used to manage performance are no longer available.

2 In August, the Trust recorded an in-month deficit of £2.3m. This was a decrease of £0.7m from the £3.0m deficit recorded in July. The Trust YTD deficit is £11.9m.

	M1	M2	M3	M4	M5	YTD
Plan (£m)	-1.0	-1.0	-1.0	-1.0	0.0	-4.0
Actual (£m)	-1.8	-2.4	-2.5	-3.0	-2.3	-11.9
Variance to Plan (£m)	**(0.8)**	**(1.4)**	**(1.5)**	**(2.0)**	**(2.3)**	**(7.9)**

3 The August plan was a breakeven plan. The Trust planned for a breakeven financial position in 23/24 based on a profile of £4m YTD deficit at Month 4 to be recouped with a surplus plan from Months 10 to 12. From August onwards the monthly plan is breakeven and the monthly variance to plan will therefore increase significantly.

4 Year to date we have recorded £7.8m of benefit from the Financial Sustainability Plans. Of this only £2.6m (33%) is recurrent, the remaining being non-recurrent benefits.

5 Adjusted for non-recurrent benefits already accounted for in the year-to-date position, the Trust's extrapolated outturn using the current run rate would be £29.5m deficit. Incorporating the impact of FSP profiling and known investments planned for later in the year, the forecast outturn is £38.5m.

6 The forecast of £38.5m reflects a worsening of the forecast from the previous month of £2.6m. The changes are detailed in the table below.

	£m
Forecast (Mth4)	(35.9)
Income for Cat 2 costs removed from forecast - not secured	(1.7)
Forecast (Mth4) - assumptions as mth5	**(37.6)**
PTS income to contract values	(0.3)
Depreciation charges - to recognise Audit recommendations	(0.6)
Reduced attrition for 111 - additional staff costs	(0.3)
Increased costs for Make Ready contract	(0.7)
Forecast run rate improvement (mth5 actuals)	1.0
Forecast (Mth5)	**(38.5)**

7 The forecast of £38.5m includes costs of £15.2m to increase capacity to improve Category 2 response time performance and 999 call answering times, as agreed by NHS England.

	Costs of Investment	Income in forecast	Net Impact	Comment
UEC Allocation : Ambulance Capacity Funding	(7.3)	7.3	0.0	Income received under HIOW contract, recurrent funding
Cat 2 Improvement: as per NHSE	(3.1)	0.0	(3.1)	Funding yet to be secured
Cat 2 Improvement: as per NHSE, additional measures	**(4.8)**	**0.0**	(4.8)	Funding yet to be secured
TOTAL	**(15.2)**	**7.3**	**(7.9)**	£7.9m opportunity to improve forecast if received

£7.3m of funding has already been secured to meet these costs. The balance of £7.9m from NHS England has not yet been included in the forecast as it is still subject to confirmation. There are also opportunities to secure additional income of circa £1m from Isle of Wight NHS Trust for 111 call handlers and from ICBs that commission PTS services from SCAS for additional activity. Should all these opportunities be realised, the forecast deficit would reduce to £29.6m.

	£m
Forecast (Mth5)	(38.5)
Additional Income NHSE	3.1
Additional Income NHSE	4.8
111 Service - IOW for call handlers	0.5
PTS - additional income for activity (tbc)	0.5
"Upside" Forecast (Mth5)	**(29.6)**

8 From September onwards the monthly spend and variance to plan will increase significantly. Whilst measures continue to manage spend through “grip and control” processes, this will be offset by additional spend in relation to the investment profile primarily for the performance improvement programme which will result in forecast additional spend.

9 The forecast will be reviewed monthly. The current forecast does not yet include any costs of organisational structure changes that may be required as part of the financial recovery plan. As plans are developed and implemented to support, the forecast will be amended and would need to be notified (Schemes may require NHSE Agreement).

10 Externally the Trust continues to forecast achievement of the break-even plan. The Trust has informally indicated to both HIOW ICB and NHS England that this will not be met. The Trust will formally submit a revised forecast to the ICB at Month 6 (at the end of September 2023). The Finance and Performance Committee and the Board are asked to agree to the revised forecast.

11 The Trust's cash balance at the end of August stood at £36.1m. The Trusts cash balance has decreased by £13.9m since the start of the financial year, an average monthly net cash outflow of £2.8m.

12 The average monthly net cash outflow is expected to increase as most of the Trust's capital expenditure is phased into the second half of the year, as table below.

2023/24	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income	27.7	27.2	38.5	29.4	28.3	28.3	28.6	27.6	27.6	34.1	27.6	39.2
Expenditure	(31.2)	(28.3)	(38.1)	(35.6)	(31.8)	(32.2)	(34.5)	(33.1)	(31.1)	(35.7)	(36.1)	(32.3)
Net inflow/(Outflow)	(3.5)	(1.1)	0.4	(6.2)	(3.5)	(3.9)	(5.9)	(5.5)	(3.5)	(1.6)	(8.5)	6.9
Cash Balance	**46.5**	**45.5**	**45.9**	**39.7**	**36.1**	**32.2**	**26.3**	**20.8**	**17.2**	**15.7**	**7.1**	**14.0**

13 At the current expenditure run rate, the Trust will require cash support from July 2024 to support continuing operations. A total of £27.9m cash support would be required in 2024/25.

2024/25	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income	27.6	27.6	27.6	27.6	27.8	27.8	27.8	27.8	32.8	27.8	27.8	27.8
Expenditure	-30.7	-30.7	-30.7	-31.7	-31.7	-35.2	-32.2	-32.2	-31.2	-32.2	-32.2	-32.2
Cash Support Required					0.6	7.3	4.3	4.3	0.0	2.7	4.3	4.3
Net inflow/(Outflow)	-3.1	(3.1)	(3.1)	(4.1)	(3.3)	0.0	(0.0)	(0.0)	1.7	(1.7)	(0.0)	(0.0)
Cash Balance	**13.8**	**10.9**	**8.1**	**4.3**	**1.0**	**1.0**	**1.0**	**1.0**	**2.7**	**1.0**	**1.0**	**1.0**

14 The cash forecast is sensitive to the timings of income receipts. In the last quarter of 2023/24, £14.5m of income receipts have been assumed in relation to sale and leaseback agreements for new fleet deliveries. Slippage to these receipts could result in the Trust requiring cash support from as early as February 2024.

15 Capital spend YTD is £3.9m. The capital plan is phased based on most of the expenditure taking place from August onwards, particularly for IFRS16 leases. The Trust is still forecasting to utilise its available capital allocation of £22.8m in full, although this is dependent on expected delivery times for new vehicles in Quarter 4 being met.

Capital	Allocation	Spend YTD	Forecast
Internal CDEL	6.5	3.2	6.5
Public Dividend Capital	1.4	0.0	1.4
Leases (IFRS 16)	14.9	0.7	14.9
Total Capital	**22.8**	**3.9**	**22.8**

16 There is £1.8m of Internal CDEL allocation and £9.0m of IFRS16 leases allocation currently uncommitted (although £8m earmarked for 2023/24 DCAs) and therefore available to be allocated against schemes via the Fixed Asset Management Steering Group.

17 The 90-day debtor total stood at £498k at the end of August (down from £571k in July) representing 14.5% of total sales debt (down from 15.58% in July). The residual debt at risk of falling into the 90-day category is £36k.

INCOME AND EXPENDITURE DETAIL

18 The Trust reported a deficit of £2.3m for the month. This was against a break-even plan.

19 For the month, the main factors of the variance to plan can be attributed to:

- Slippage against the FSP (Financial Sustainability Plans) - circa £1.6m.
- PTS contracts operating above budgeted levels – circa £0.8m.
- Higher than budgeted resource cost for 999 – circa £0.4m

Offset by

- Depreciation, interest receivable and other underspends - £0.5m

20 Income for the Trust in June was below plan by £0.3m in the month, due to the timing of the recognition of the £7.3m UEC income. Contract income has been assumed at contract levels. BOB (Buckinghamshire, Oxfordshire, and Berkshire) ICB are not yet paying to contract levels pending the outcome of contract negotiations. £1.4m has been assumed in the month but not yet paid.

21 Externally the Trust continues to forecast achievement of the break-even plan. The Trust has informally indicated to both HIOW ICB and NHS England that this will not be met. A bottom-up assessment of the forecast outturn, based on month 1-5 actual income and spend and best estimates for the remainder of the year, gives a forecast deficit to plan of £38.5m.

22 The forecast position represents a deterioration from the current financial trajectory which, on a straight-line basis, would represent a deficit of circa £29.5m. Additional spend has been forecast for 999 performance that is not all matched by income, the spend on projects is forecast to increase from current run rate and the trajectory of FSP achievement is forecast to worsen over the remainder of the year due to the non-recurrent nature of FSP in the months to date.

23 For the Operational areas, the contribution by service is detailed below.

Service Line	Month			Year to date			Full Year				
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Prior Year	Variance to budget	Variance to Prior Year
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Emergency Services											
Income	17.9	18.5	-0.6	88.8	90.2	-1.4	220.6	220.1	205.6	0.5	15.0
Direct costs	15.6	15.2	-0.5	75.3	73.7	-1.6	193.0	180.4	170.8	-12.6	22.2
Gross contribution	2.3	3.3	-1.0	13.5	16.5	-3.0	27.6	39.7	34.7	-12.1	-7.2
Gross contribution (%)	13%	18%	-5%	15%	18%	-3%	12%	18%	17%		
111 Service											
Income	3.3	3.3	0.0	16.4	16.4	0.0	39.3	39.3	41.5	0.0	-2.2
Direct costs	3.1	2.9	-0.2	15.2	14.5	-0.7	36.6	34.9	36.6	-1.7	0.0
Gross contribution	0.2	0.4	-0.2	1.2	1.8	-0.7	2.7	4.4	4.9	-1.7	-2.2
Gross contribution (%)	6%	11%	-5%	7%	11%	-4%	7%	11%	12%		
Non-Emergency Services											
Income	5.7	5.4	0.3	27.4	27.1	0.2	66.6	65.1	62.4	1.5	4.2
Direct costs	5.4	4.4	-1.0	28.7	22.0	-6.7	71.4	52.9	55.7	-18.5	15.7
Gross contribution	0.2	1.0	-0.8	-1.4	5.1	-6.4	-4.8	12.2	6.7	-17.0	-11.5
Gross contribution (%)	4%	19%	-14%	-5%	19%	-24%	-7%	19%	11%		
Other (Covid)											
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	18.5	0.1	-18.4
Direct costs	0.0	0.0	0.0	0.1	0.0	-0.1	0.1	0.0	15.8	-0.1	-15.7
Gross contribution	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.7	0.0	-2.7
Gross contribution (%)											
Contribution Operational Activities	2.8	4.7	-2.0	13.3	23.4	-10.1	25.4	56.3	49.0	-30.8	-23.5

Emergency Services (999)

24 The 999 business (excluding 111) made a contribution of £2.3m in the month, which was £1.0m adverse to plan.

25 Staff costs for the month were £0.4m higher than budget. Lower than planned attrition for non-clinical staff continues to be a factor underlying the above budget spend.

26 Abstractions for the month 2.21% below the planned levels.

27 Activity was 2.01% above plan in the month, with an overall demand of 50,539 incidents. Response demand was 3.46% above plan.

28 Performance remains a challenge with national targets missed across all categories. Cat 2 performance for the month was behind trajectory at 27 minutes 32seconds. NHS England have asked the Trust to increase capacity to improve Cat 2 performance and 999 call answering times. This is forecast to worsen the run rate in Emergency Services in coming months.

29 The income and spend in relation to UEC monies have been recognised in line with actual delivery. Year to date, there has been slippage with only £0.3m of spend being incurred to date. The forecast assumes spend of £7.3m in line with funding received

to date. Further spend has been forecast for additional initiatives but income recovery has not yet been confirmed.

30 For August, £0.4m of savings have been reported including: reduced spend against budgets on fuel budgets, slippage on lease spend and reduced sickness for 999 and EOC. In month, the delivery of savings was £0.4m lower than the target.

31 In month, additional costs of £0.3m were included to reflect the revised costs of the make-ready contract.

111

32 The NHS 111 service reported a contribution in month of £0.2m which was £0.2m adverse to plan.

33 The service is experiencing lower than planned attrition for Health Advisors, and this is driving pay costs above previously forecast levels.

34 NHS 111 activity of 117,247 calls for the month was 1% below plan and performance for the month was 81.92% against the target of 95.0% within 120 seconds (up from 69.61% in July). The average handling time for the month was 10 minutes 53 seconds.

Non-Emergency PTS

35 The Commercial Division contribution was adverse to plan by £0.8m for the month and £6.4m adverse year to date.

36 The spend in the month was £0.4m less than was forecast for the month. Costs for the make-ready contract were revised downwards by £0.3m in line with the revised contract and there was a release of excess miles provision for returned vehicles of £0.1m.

37 Overall activity for the month was 5% higher than planned. Costs of activity delivery are increasing with use of private providers and taxis to cover demand. There has been no impact to date from engagement with Commissioners on right sizing activity.

Corporate

38 Corporate budgets were £0.4m adverse to plan in the month, as table below. The main driver of this is Estates where there was higher than budgeted costs for utilities (£164k) and unmet savings targets. Within contingency, there are unmet savings targets.

Service Line	Month			Year to date			Full Year				
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Prior Year	Variance to budget	Variance to Prior Year
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Clinical Services	0.5	0.6	0.1	2.8	2.8	-0.1	7.5	6.7	5.6	-0.7	1.8
Finance	0.3	0.2	-0.1	1.1	1.0	-0.1	2.7	2.4	3.7	-0.3	-1.0
Estates	1.1	0.9	-0.3	5.3	4.3	-0.9	12.5	10.3	10.6	-2.2	2.0
IM&T	0.9	1.0	0.1	4.6	5.0	0.4	12.3	12.1	8.9	-0.2	3.3
Human Resources	0.4	0.4	0.0	1.9	1.9	-0.1	4.8	4.5	4.4	-0.3	0.4
Education Services	0.6	0.5	-0.1	2.5	2.4	-0.1	6.4	5.8	5.8	-0.5	0.5
Service Development	0.3	0.4	0.1	1.8	2.1	0.3	3.8	4.3	3.2	0.5	0.5
Communications & Public Engag't	0.1	0.1	0.0	0.3	0.3	0.0	0.7	0.7	0.6	0.0	0.1
CEO	0.1	0.1	0.0	0.4	0.3	-0.1	0.7	0.6	0.9	-0.1	-0.2
Corporate	0.0	0.0	0.0	0.2	0.2	-0.1	0.5	0.4	0.0	-0.1	-0.4
Contingency	0.0	-0.2	-0.3	0.3	2.8	2.5	1.2	-2.3	-2.7	-3.5	3.9
Injury Benefit	0.0	0.0	0.0	0.1	0.1	0.0	0.2	0.2	0.0	0.0	0.2
Depreciation	0.8	0.9	0.1	4.2	4.3	0.1	11.0	10.4	8.8	-0.6	2.2
Financing Costs	-0.1	0.0	0.1	-0.3	0.1	0.3	-0.2	0.1	-0.2	0.4	0.0
Total Overhead Costs	5.1	4.7	-0.4	25.2	27.4	2.2	64.0	56.3	49.6	-7.7	13.5

RECOMMENDATIONS TO THE BOARD

38 The Board is asked to note the current financial position of the Trust and approve a revised forecast to be submitted to the HIOW system at the end of September 2023.

Stuart Rees
Chief Finance Officer

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Approval to Submit 2022/23 National Cost Collection**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**20**
Executive Summary:	The National Cost Collection is an annual exercise mandated by NHS England to assign NHS provider costs against individual activity types to produce average unit costs. The submission is used to inform national tariff prices and to benchmark provider productivity. In previous years, this submission only required sign-off from the Chief Financial Officer prior to submission. This year, NHS England is requiring Board approval for the submission. The submission window opens on 16th October 2023. The data to be submitted will not be available until the first week of October. The Trust Board is therefore asked to delegate authority to approve the submission of the 2022/23 National Cost Collection to the Executive Management Committee. As part of the submission, the Trust are required to provide assurance that: • The costing process has been approved ahead of the collection. • The return has been prepared in accordance with the Approved Costing Guidance, which includes the combined costs collection guidance. • Information, data and systems underpinning the combined costs collection return are reliable and accurate. • There are proper internal controls over the collection and reporting of the information included in the combined costs collection, and these controls are subject to review to confirm that they are working effectively in practice. • The costing team is appropriately resourced to complete the National Cost Collection return, accurately within the timescales set out in the guidance.		

	• Any actions from previous NHS costing assurance process (CAP) reviews of costing or data quality have been formally followed up and completed (as appropriate). • The information included in the submission – both cost and activity – have been reviewed and verified as accurate. • All mandatory and significant non-mandatory validations have been reviewed and verified. • Any significant areas where the trust has varied from the mandation (ie unable to submit at patient-level or issues around activity or methods of apportionment) have been agreed with NHS England and have been reported to the Board. The Trust expects to be able to meet all assurance points. The output of the Trust's National Cost Collection will be shared with the Finance and Performance Committee in November, with onward reporting to the Trust Board where agreed by the committee.			
Recommendations:	The Board is asked to APPROVE the delegation of authority to the Executive Management Committee to approve the submission of the 2022/23 National Cost Collection on behalf of the Trust Board.			
Executive lead:	Stuart Rees, Interim Director of Finance			
Report author:	Sam Dukes, Deputy Chief Financial Officer			
Previously considered by:	Finance and Performance Committee, 18th September 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):	Finance & Sustainability			
Links to BAF risks: (or links to the Significant Risk Register)	Risk 6 - Sufficient and stable financial resources			

Quality Domain(s):	Not applicable
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 SUMMARY SHEET

Report title:	**Estates Assets: Reinforced Autoclaved Aerated Concrete (RAAC)**			
Report to:	**Trust Board (Part 1)**			
Date of Meeting:	**28th September 2023**	**Agenda Item:**	**21**	
Executive Summary:	A structural survey was commissioned of CBRE in March 2020. The survey reported the absence of RAA at nine identified sites. There were two sites where this was not categorical: Gosport and Petersfield. We have an active project to replace the roof at the Gosport PTS site. We are presenting a further comprehensive review of the estate to meet the latest guidance. The brief is attached and costs £81,152 Inc VAT for all 55 sites (three levels of identified and categorised risk).			
Recommendations:	The Trust Board is asked for approval to: commence surveys in line with national requirements and the latest guidance so as to have acceptable assurances.			
Executive lead:	Stuart Rees			
Report author:	Mark Finch			
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)	All BAF risks
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): Instruct Surveyors upon approval.	
List of Appendices: SCAS – RAAC Letter Report Survey 11_03_2020 SCAS – RAAC Surveys Quotation 13_09_2023	

Agenda item 21

To:
- All NHS trusts:
  - chairs
  - chief executive officers
  - estates leads

cc.
- Integrated care boards:
  - chairs
  - chief executive officers
  - estates leads
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

5 September 2023

Dear Colleagues,

Reinforced aerated autoclaved concrete (RAAC)

Last week new guidance was published by the Department for Education regarding the approach to the presence of RAAC in the school estate. This has generated heightened public interest in the presence of RAAC in the NHS estate, and a number of questions from colleagues.

You are all aware of the risks associated with RAAC as part of the extensive programme of work undertaken over recent years. We are writing to reiterate the position in the NHS estate, and to outline actions you should be taking to assure yourselves as far as possible that RAAC is identified and appropriately mitigated, to keep patients, staff and visitors safe.

To provide co-ordination to these actions, we will be communicating via regional operations centres. **Please therefore ensure that appropriate arrangements are made within your organisation to be able to respond to communication from your regional operations centre (ROC) on this subject.**

Guidance on RAAC identification, monitoring and remediation

All guidelines on RAAC are based and driven by expert advice from the Institute for Structural Engineers (IStructE). There has been no change in IStructE guidance, which government has confirmed continues to be the basis of action to manage the situation in the NHS and wider public sector. We continue to work closely with government departments and technical advisory groups and have asked to be made aware of any changes to the guidance so that we can share these with you immediately.

Following an alert issued by The Standing Committee on Structural Safety (SCOSS) in 2019, the NHS in England put in place a now well-established programme to identify RAAC, support providers to put appropriate mitigations in place, and plan for eradication. We have worked closely with the trusts managing the 27 previously identified sites, including securing funding for investigative, safety/remedial and replacement work, with three of those sites now having eradicated RAAC.

As part of this ongoing work, in May 2023 NHS England sent out additional guidance to organisations including all provider trusts (including mental health, community and ambulance) following updated national guidance from IStructE on RAAC identification, management and remediation and Further Guidance on Investigation and Assessment (April 2023).

Identification of RAAC

We asked trusts to assess their estate again based on this updated guidance. Initial assessments of additional sites identified through this process are already being undertaken and are expected to be completed by the end of this week. The national RAAC programme team are collating information from these assessments, including where appropriate mitigation plans and the steps necessary to remove this material from use.

Given the importance of this work, we ask that – in any instances where this has not already been the case – boards ensure they support their estates teams and review the returns they provided to assure themselves that the assessments made were sufficiently thorough and covered all buildings and areas on your estate (including plant/works, education and other non-clinical areas/buildings).

ICBs will want assurance about the primary care estate and should work with their local primary practices and PCNs to ensure you have confirmation that no RAAC has been identified or, where it has, on the identification and management of RAAC. Guidance for the primary care estate was circulated in January of this year, which ROCs can reshare.

Management of identified RAAC

Trusts which have previously identified RAAC will have put in place management plans in line with the IStructE guidance.

In light of the need to maintain both the safety and confidence of staff, patients and visitors, **we recommend that in those organisations where the presence of RAAC has been confirmed and is being managed, boards take steps now to assure themselves that the management plans in place for each incidence – and particularly where panels are currently subject to monitoring only – are sufficiently robust and being implemented.**

Where you think you require assistance in completing this work, please contact: england.estatesandfacilities@nhs.net.

Planning for RAAC incidents

Effective management of RAAC significantly reduces associated risks; but does not completely eliminate them. Planning for RAAC failure, including the decant of patients and services where RAAC panels are present in clinical areas, is therefore part of business continuity planning for trusts where RAAC is known to be present, or is potentially present.

A regional evacuation plan was created and tested in the East of England. Learnings from this exercise have been cascaded to the other regions.

We would recommend that all boards ensure that they are familiar with the learning from this exercise and that they are being incorporated into standard business continuity planning as a matter of good practice.

This exercise is, however, essential for those organisations with known RAAC, and should be done as a matter of priority if it has not already been completed.

Thank you to you and your teams for the work on this to date, particularly in those organisations where RAAC has been found and management/remediation plans have been enacted. As mentioned above we will communicate further information through ROCs.

Yours sincerely,

Jacqui Rock
Chief Commercial Officer

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11 March 2020

Crawford Thomson
South Central Ambulance Service (NHS) Foundation Trust Limited,
Units 7 & 8 Talisman Business Centre,
Talisman Road,
Bicester,
Oxfordshire, OX26 6HR

By Email

Dear Crawford,

REINFORCED AUTOCLAVED AERATED CONCRETE (RAAC) SURVEYS
VARIOUS RESOURCE CENTRES ACROSS THE SOUTH OF ENGLAND

Executive Summary

There has been no RAAC identified in any of the nine sites inspected by Scott White and Hookins (SWH) structural engineers. Upon each inspection the engineer has identified other items as a matter of due diligence, whilst most items identified fall under the category of regular maintenance, the Oxford Hospital site and Gosport PTS site were identified as requiring more short term action.

The Gosport site was noted to have possible localised subsidence which we recommend is monitored over a length of time to determine the severity and whether it is still actively occurring. It was also noted that there was roof leaks and severe mould growth in the garage areas.

The Oxford Hospital site was noted to have two buildings, Workshop and Goods-In, where the structural integrity of the concrete columns was questioned. The Goods-In building was in a worse condition but both structures have been advised to be replaced in the short to medium term by the appointed structural engineer. We understand that SCAS are looking to sell this site so replacement is likely not to be a viable option however a further structural engineer report dedicated to this matter should be commissioned and proposals on remedial works identified.

The full structural engineer report from SWH dated February 2020 is appended to this letter for reference.

Background

CBRE building consultancy were appointed to co-ordinate structural engineer surveys to determine the presence and condition of any RAAC within the buildings structure at the following Ambulance Resource Centres (ARCs).

1. Andover ARC, Charlton Road, Andover, SP10 3LB.
2. Basingstoke ARC, Aldermaston Rd, Basingstoke, RG24 9LY.
3. Didcot ARC, Broadway, Didcot, OX11 8RY.
4. Gosport (PTS), Privett Road, Gosport, PO12 3SR.
5. Hythe ARC, Beulieu Rd, Hythe, Southampton
6. Oxford City ARC, Churchill Hospital, Churchill Drive, Headington, Oxford, OX3 7LH.
7. Petersfield ARC, 3-4 Readon Close, Petersfield, GU31 4BN.
8. Reading ARC, North Street, Reading, RG1 7DA
9. Totton (PTS), Testwood Lane, Totton, SO40 3AP.

Scott White Hookins Limited (SWH) were appointed to carry out the surveys and the above properties were inspected over a period of 2 weeks between the 14th and 28th of January 2020 with the structural engineer's report issued on the 28th of February 2020, documenting their findings.

The surveys carried out were of a non-intrusive nature and therefore SWH have confirmed they were unable to visually inspect any part of the property's structure which was covered, unexposed or inaccessible.

Findings of Survey

Scott White Hookin's final report is appended to this letter for information and reference but we have summarised their findings as set out below.

Firstly, SWH have found that no RAAC units were identified in the nine sites inspected, with the majority of the properties having a typical in-situ or pre-cast reinforced concrete structure or steel framed structure. Although they were not able to categorically rule out RAAC present in the roof deck to Gosport and Petersfield they have confirmed that they do not suspect this to be present based on no evidence of deflection or spalling to the concrete which are signs of RAAC construction.

SWH have identified that Woodwool slabs are present in the roof deck at the Basingstoke and Didcot sites, these are not a cause for concern however they should be regularly inspected as they can be prone to deterioration if they become saturated. Although deemed satisfactory to walk over these roofs should be deemed as 'semi-fragile' and not subjected to any abnormal loadings.

SWH have introduced a RAG (Red Amber Green) system to identifying defects with each buildings structure. This is contained on page 4 of their appended report and extracted below

Site	Main Frame	Roof structure	Columns	Walls	RAAC	Roof deck
1. Andover	Steel	Steel / timber	Steel	Concrete	No	Metal
2. Basingstoke	Steel / SCOLA	Steel / Space frame	Steel / Concrete	Brickwork	No	Woodwool
3. Didcot	Steel	Steel / timber	Steel	Blockwork	No	Woodwool / Timber
4. Gosport	Steel	Concrete	Encased?	Brickwork	No?	Concrete
5. Hythe	SCOLA	Steel / timber	Steel	Tile Hanging	No	Timber
6.1 Oxford - Workshop	Steel / Concrete	Steel / Concrete	Concrete	Blockwork	No	Steel
6.2 Oxford - Goods-in	Steel / Concrete	Steel / Concrete	Concrete	Blockwork	No	Asbestos
6.3 Oxford - Training centre	Masonry	Steel / Concrete	Encased?	Blockwork	No	Concrete / timber
6.4 Oxford - Garage	Steel	Steel	Steel	Brickwork	No	Metal
7. Petersfield	Masonry	Steel / timber	N/A	Brickwork	No?	Timber?
8. Reading	Steel	Steel	Steel	Brickwork	No	Asbestos
9. Totton	SCOLA	Steel	Steel	Brickwork	No	Timber

As you can see from the table above significant defects were highlighted to the main structure of two buildings at the Oxford Hospital site. Generally SWH have advised that the concrete columns used in the original construction of both the Goods In and Workshop buildings are slender and potentially undersized. This has caused the carbonation of the metal reinforcement bars and spalling of the concrete to multiple areas, leading to a weakening of the concrete. It was also observed on site that the concrete columns are subjected to impact damage through vehicle movement which further weakens the concrete columns.

SWH's report notes that due to the damage to the concrete columns the structural integrity of both buildings has been compromised and they have recommended that buildings are replaced in the short to medium term.

The highlighted amber sections in the table above are of less concern and SHW's findings to each site is summarised below:

Andover Resource Centre

Localised areas of spalling are present to the Pre-Cast Concrete (PCC) cladding panels and displaced in isolated areas. There is also some corrosion to the fixing bolts and bracketry securing the PCC cladding to the steel frame.

Basingstoke Resource Centre

The SCOLA construction of the staff area has potential for wall tie failure where the brickwork walls are not sufficiently tied/fixed to the frame. Whilst this has not been expressly identified here SWH have identified this as a potential defect which may materialise in the future.

Gosport PTS

Roof leaks have been identified and there is extensive mould build up in the garage space. Brickwork and concrete spalling has been identified in certain areas. Localised subsidence has also been highlighted.

Hythe Resource Centre

Although this has been identified as SCOLA construction it is an earlier type are unlikely to suffer the potential defects described for Basingstoke above. Localised damage to hanging tiles and timber windows have been identified.

Totton PTS

This has been identified as a SCOLA construction of the same age as Basingstoke Resource Centre and similar potential defect has been advised regarding the wall ties.

Recommendations and Next Steps

Oxford Hospital Site

The two buildings at Oxford Hospital used as a Workshop and Goods-In area require remedial measures to ensure the structural stability and integrity of the concrete frame. SWH have made the following recommendations regarding this.

Spalled Concrete Columns to Workshop Building and Goods-In Building:

"Consideration is required to the life of the building. Concrete patch repairs could be carried out however these would be extensive and considering the slender sections patch repair is unlikely to reinstate the structural integrity of the columns."

Spalled Concrete Purlins to Workshop Building:

"As only occasional purlins are affected; it may be possible to replace individual purlins with alternative steel purlins."

From the comments above it would be prudent to have a detailed structural survey carried out with remedial measures specified by a qualified structural engineer. As SWH's have eluded to in their report, owing to the amount of repairs required and that a repair method may not be feasible, it may be more economical to replace the building in full or demolish and leave.

We understand that SCAS are planning to install measures to try and prevent further impact damage but we advise that a further-more detailed structural survey should be carried out on these two buildings.

The Training Centre at the Oxford Hospital site should have remedial brickwork repairs undertaken to the chimney stack and the debris fallen from the projecting canopy roof to the rear of the building cleared away.

Gosport PTS Site

Localised subsidence has been reported and this should be explored further by initially monitoring any movement over a period of 12 months to determine whether this is a current issue or historic one.

Roof leaks should be identified and repaired to prevent further water ingress into the building. Localised spalling and masonry repairs should also be picked up as part of the building's maintenance regime.

Other Sites

The other items identified in the SWH report are considered relatively minor and although require action to prevent further deterioration can be undertaken as part of the planned maintenance regime for the properties.

I trust this letter satisfies your requirements and is informative enough to allow you to consider the next steps. If there are any queries arising from the report, please do not hesitate to contact the undersigned.

Yours sincerely

Derek Johnson MRICS – Associate Director
For and on behalf of: CBRE LIMITED

Cc: Paul Cross – SCAS

Encl: Scott White and Hookins Report dated 28th February 2020

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South Central Ambulance
Site Inspection Report

February 2020

Project No. W02756
Revision: 2

Prepared by: .....
Mike Lakey CEng MIStructE

Reviewed by: .....
Gordon Lockheart BEng MEng CEng MICE

- Structural Engineering
- Civil Engineering
- CDM Consultants
- Sustainability and BREEAM
- Traffic and Transport
- Flood Risk Assessments
- Highway Engineering
- Event Engineering

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Issue and Amendment Record:

Revision	Comment/Amendment	Prepared	Reviewed	Approved	Date
1	For comment	M Lakey			
2	Final issue	M Lakey	G Lockheart	G Lockheart	27 Feb 20

Contents

1.0 Introduction

1.1 This report has been prepared on the instruction of Derek Johnson of CBRE in respect to the inspection and assessment of the condition of nine Ambulance Resource Centres. The main focus of the inspection is the condition of the pre-cast concrete (PCC) elements, in particular to determine if any of the units are constructed using Reinforced Autoclaved Aerated Concrete (RAAC) slabs. Within recent years there have been two reported collapsed of roofs constructed with RAAC slabs within the South Central Ambulance portfolio of buildings.

1.2 The report is based on a walk-over visual survey of each property. No opening up works were undertaken except for lifting of occasional ceiling tiles.

1.3 Survey observations with a commentary of defects with photographs for each building can be found in Appendix A.

1.4 We have not inspected parts of the structure which are covered, unexposed or inaccessible and are therefore unable to report that any such part is free from defect; neither have we inspected any part of the building which is not mentioned in this report. This report must not be assumed to be a full structural survey, such as that defined by the Royal Institution of Chartered Surveyors.

1.5 Establishments surveyed are listed below.

LOCATION	Address	AREA	TYPE	Survey Date
Andover Ambulance Resource Centre	Charlton Road, Andover, Hants, SP10 3LB	S	RC	14/01/2019
Basingstoke Ambulance Resource Centre	Aldermaston Road, Basingstoke, Hants, RG24 9LY	S	RC	14/01/2019
Didcot Resource Centre	Broadway, Didcot, Oxon, OX11 8RY	N	RC	28/01/2019
Gosport PTS (Ex AS)	Privett Road, Gosport, Hants, PO12 3SR	S	PTS	21/01/2019
Hythe Ambulance Resource Centre	Beaulieu Road, Hythe, Southampton, Hants,	S	RC	21/01/2019
Oxford City Resource Centre	Churchill Hospital, Churchill Drive, Headington, Oxford, Oxon, OX3 7LH	N	RC	28/01/2019
Petersfield Ambulance Resource Centre	3-4 Readon Close, Petersfield, Hants, GU31 4BN	S	RC	14/01/2019
Reading Resource Centre	North Street, Reading, Berks, RG1 7DA	N	RC	28/01/2019
Totton PTS	Testwood Lane, Totton, Hants, SO40 3AP	S	PTS	21/01/2019

2.0 Summary

2.1 No RAAC units were identified in the nine sites inspected. Although some structural elements were not exposed during the walk over inspection. Several sites have normal weight PCC roof planks. Some remedial concrete patch repairs are required due to age / weathering. No major risk was noted specifically to these roof panels.

2.2 Woodwool slabs were identified in several of the buildings. These are of wood strands cast in a concrete cement matrix. They are satisfactory to walk on and for normal roof loads. However, they can be susceptible to deterioration if they become saturated and are prone to fracture if subjected to impact or heavy concentrated loads. Therefore, Woodwool slabs should be considered as semi-fragile roofs.

2.3 The table below outlines in visual format the construction type of the structural elements associated with the Ambulance Resource Centres. The table is presented using the same traffic light colour system that has been used in the observation sheets in order to show the condition of the structures to facilitate future works.

Site	Main Frame	Roof structure	Columns	Walls	RAAC	Roof deck
1. Andover	Steel	Steel / timber	Steel	Concrete	No	Metal
2. Basingstoke	Steel / SCOLA	Steel / Space frame	Steel / Concrete	Brickwork	No	Woodwool
3. Didcot	Steel	Steel / timber	Steel	Blockwork	No	Woodwool / Timber
4. Gosport	Steel	Concrete	Encased?	Brickwork	No?	Concrete
5. Hythe	SCOLA	Steel / timber	Steel	Tile Hanging	No	Timber
6.1 Oxford - Workshop	Steel / Concrete	Steel / Concrete	Concrete	Blockwork	No	Steel
6.2 Oxford - Goods-in	Steel / Concrete	Steel / Concrete	Concrete	Blockwork	No	Asbestos
6.3 Oxford - Training centre	Masonry	Steel / Concrete	Encased?	Blockwork	No	Concrete / timber
6.4 Oxford - Garage	Steel	Steel	Steel	Brickwork	No	Metal
7. Petersfield	Masonry	Steel / timber	N/A	Brickwork	No?	Timber?
8. Reading	Steel	Steel	Steel	Brickwork	No	Asbestos
9. Totton	SCOLA	Steel	Steel	Brickwork	No	Timber

3.0 Conclusion and Recommendations

3.1 Andover Ambulance Resource Centre

3.1.1 The building is steel frame clad in PCC cladding panels. The concrete is in good condition with only localised areas of spalling. However, the panels are displaced in places and, where exposed, the cladding fixing bolts and brackets to the steel frame are corroded. There was no indication of failure at the few locations visible. The garage area appeared under-utilised with several small rooms formed in blockwork and a workshop bay all dis-used. We were not able to gain access to the first-floor plantroom; this was only accessible from the roof.

3.2 Basingstoke Ambulance Resource Centre

3.2.1 The garage building structure has a space frame roof, which is unusual in a workshop environment. The struts are not uniform three-dimensional modules, indicating one-directional span. Also, there are some potentially missing struts close to supports; these are in a symmetrical layout, so anticipated to be purposefully omitted as part of the frame design, although confirmation of this would require detailed assessment. The perimeter columns are concrete with only localised areas of spalling. The internal floor area is small for the size of modern ambulances. It was suggested by staff that the internal curb adjacent to the ambulance bays could be removed to increase the parking width. However, removing this upstand may be more complicated than anticipated, because this is part of the internal building floor. Investigations would be required to determine how this is constructed and if the floor is monolithic with the building walls and foundations.

3.2.2 The staff area is of SCOLA construction. The writer is aware of a known issue within Hampshire schools, where the brickwork is not adequately tied to the frames. A programme of remedial ties was undertaken by Hampshire County Council. This is only single storey so low risk; however, it may be prudent to investigate if this is an issue at this site.

3.3 Didcot Resource Centre

3.3.1 Generally, the building is in good condition with some localised structural defects and maintenance issues. The garage building is a steel frame with Woodwool slab roof.

3.4 Gosport PTS (Ex AS)

3.4.1 The building is a hybrid loadbearing masonry and framed structure. The roof is of PCC planks, these do not appear to be RAAC units. However, it was not possible to determine categorically. Although the units show no signs of deflection / spalling defects associated with RAAC units. There are roof leaks and generally, the garage area is black with mould

and damp. The building appeared poorly maintained with issues of localised subsidence, concrete spalling to canopy and brickwork / lintel issues.

3.5 Hythe Ambulance Resource Centre

3.5.1 The building is SCOLA Mark 1, clad in tiling, so not presenting the same tying issue as masonry walls. Generally, the building is in fair condition with some localised structural defects and maintenance issues.

3.6 Oxford City Resource Centre

3.6.1 The main workshop building has slender precast concrete I-Section columns and eaves beams and L-shaped concrete purlins. There are numerous areas of spalling / damage; the majority appear to be impact damage to the slender sections. The corrosion induced spalling was not to a frequency that may be expected for pre-cast units containing calcium chloride admixtures, common in precast units of this age, although testing is recommended prior to any patch repairs. The concrete sections are so slender, that it is likely that carbonation has reached the entire area of reinforcement again testing could be undertaken to confirm this. The spalling to the slender sections is sufficient to reduce the integrity of the frames. Also the sections are clearly prone to impact damage and there is a risk that any significant impact onto a column could cause a disproportionate collapse. Patch repair of the concrete could be undertaken subject to testing and a treatment regime. However, considering the slenderness of the sections it is unlikely that the integrity of the sections could not be fully reinstated. The columns could potentially be replaced with new steel columns. Extensive temporary support will be required to the structure to remove and replace the columns or to effect repairs to the defective concrete. Considering the potential for carbonation / chloride contamination, providing treatments to replenish the concrete's protective properties are unlikely to prove satisfactory in the longer term. Therefore, consideration should be given to the replacement of the building.

3.6.2 The goods-in store building is of the same construction as the main workshop building but in a worse condition. The columns are significantly damaged with areas of de-bonded reinforcement such that the columns cannot be considered as adequate. Therefore, we cannot confirm the structural integrity of the building in its current condition. It will be difficult to temporarily prop the building to replace the columns as the asbestos sheeting will not tolerate any movement or differential deflections without disturbing the asbestos. Also, the goods-in building generally is very poorly maintained and in poor condition. Therefore, it is considered prudent to arrange for replacement of the building in the short to medium term.

3.6.3 The Training Centre is of unusual structural form with the upper floor raised above and spanning over the ground floor construction. Externally the building is poorly maintained. Concrete repair is required to the externally exposed concrete elements and some masonry repairs are required including urgent work to the boiler flue. The escape stair is

showing signs of corrosion and a more detailed inspection is required to determine the extent of remedial repairs.

3.6.4 The steel framed garage was not inspected internally, we understand this building is currently mothballed. Externally the building appeared to be a steel portal frame, where no concrete elements are expected.

3.7 Petersfield Ambulance Resource Centre

3.7.1 The building is primarily loadbearing masonry with steel lattice trusses over the garage. The garage is too small to accommodate modern ambulances. The structure was not fully exposed so it was not possible to determine categorically that RAAC roof units were not present. However, the roof shows no signs of deflection / spalling defects attributable to RAAC units and the building size and construction does not match that where RAAC would be anticipated.

3.8 Reading Resource Centre

3.8.1 The garage area is of steel portal frame. The roof is clad in asbestos sheeting, which was being cleaned and overcoated with a Ruberoid finish at the time of the inspection. We have not seen any details associated with the works, so do not know how the cleaning is being undertaken without abrading the asbestos sheets and releasing fibres. The roof is considered a fragile roof.

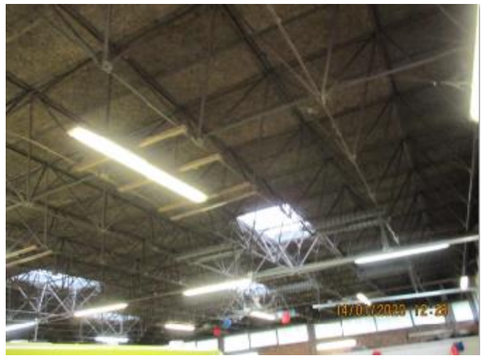
3.9 Totton PTS

3.9.1 The building is a SCOLA Mark 1 frame. The building is clad in brickwork, so the issue of wall ties discussed above would apply. Generally, the building is in good to fair condition with some localised structural defects and maintenance issues.

Appendix A
Building Defect Observation Sheets

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
1. Andover The main roof structure is of primary steel frame supporting profiled metal roof deck. The walls are of exposed aggregate precast concrete cladding panels, supported off the steel frame. The internal walls to the staff areas were generally stud partitions and face painted blockwork to the garage areas.  	1a. Primary Steel Frame	**Observations: The perimeter columns are obscured by the wall linings and cladding; where exposed at the roller shutter door positions, some corrosion was observed at the column bases and to the connection brackets where externally exposed at roller shutter door positions.** ***Recommendations: Corrosion treatment is required with specialist steel paint system.***	 
	1b. Roof structure *Steel lattice roof trusses supporting profiled metal deck*	**Observations: The main workshop roof is steel lattice trusses supporting profiled metal deck. This generally appeared in good condition. No RAAC roof slabs were observed.**	
	1c. Walls *Large format exposed aggregate precast concrete wall panels with full height glazed panels*	**Observations: Ivy has previously grown into the joints between the PCC concrete panels and windows causing displacement of the panels and glazing. The movement joints were not adequately sealed. Generally, the concrete panels are in good condition; some spalling was noted to the bottom edge of the cladding above the door openings.** ***Recommendations: Work has been undertaken to clear the ivy some additional removal is required particularly in the joints and then re-seal the joints. There is a risk that the displacement has reduced the integrity of the panel fixings. In the long-term consider replacing the PCC panels with a more insulated walling system.***	

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
1. Andover   	1d. General structural defects	**Observations: There appears to be water damage to facias and staining / algae growth to the rear elevation, which may suggest ponding and overtopping to the upper roof.** ***Recommendations: It would be prudent to undertake inspection of the plantroom and upper roof areas. Builders assistance may be required to gain access. The inspection could be undertaken in conjunction with access for plant maintenance.***	
	1e. External features *There is a steel framed canopy structure, which appears to for vehicle maintenance.*	**Observations: The base of the canopy columns have heavy corrosion with some surface delamination. A section of the soffit cladding is missing exposing the underside of roof structure.** ***Recommendations: The structure appears to be redundant it is recommended to plan for demolition of the canopy structure and removal of associated steps.***	 
	1f. Non-structural defects	**Observations: The PVC rooflights have been damaged / discoloured by sun exposure. These do not appear to be man-safe.**	

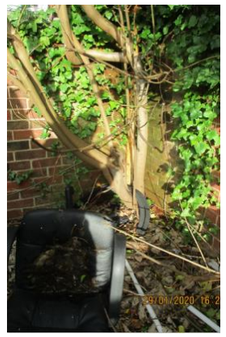
Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
2. Basingstoke The main roof structure is of steel space frame supporting edge reinforced Woodwool slabs. The walls are of face brickwork externally and face brickwork internally to the garage area. The staff area is of SCOLA steel frame construction with steel lattice trusses supporting Woodwool slabs.   	2a. Primary Steel Frame to garage with pre-cast concrete columns only. The columns are externally exposed within the brick elevations.	**Observations: The perimeter columns are in good condition generally one large piece of concrete spalling was observed to the front entrance door column; the loose section was removed during the inspection for safety.**	 
	2b. Roof structure *The steel lattice space frame roof trusses supporting Woodwool slabs.*	**Observations: The main workshop roof *appear in good condition*. No RAAC roof slabs were observed.**	
	2c. Walls *External face brickwork with curtain wall glazing panels.*	**Observations: The main garage area walls are in good condition. There are sections of missing horizontal pointing to the brick walls of the SCOLA building brickwork and some horizontal cracking and slight bulging to the SCOLA building.** ***Recommendations: A known latent defect with SCOLA buildings is lack of tying of brick panels to the steel frame. There is the potential that wall tie corrosion has occurred. Further investigation would be needed to determine the cause of cracking, including removal of occasional bricks or inspection using an endoscope.***	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
2. Basingstoke	2d. General structural defects	**Observations: No major structural defects are observed to the building.**	
	2e. External features *There is a steel framed canopy structure, which appears to for vehicle maintenance.*	**Observations: There are some loose and displaced paving slabs to the rear footpath. Adjacent to the manhole the underlying soil appears to have eroded away possibly into the drain.** ***Recommendations: To locally relay the paving including to inspect the subbase adjacent to the manhole for suspected void.***	 
	2f. Non-structural defects	**Observations: The is damp staining to the ceiling tiles, which could indicate roof leaks. We understand that these have not increased in recent years.** **The fascia at the front of the building has water staining and algae growth.** ***Recommendations: It would be prudent to undertake inspection of the roof areas for blockages. Builders assistance may be required to gain access.***	

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
3. Didcot The main garage structure is steel portal frame supporting edge reinforced Woodwool slabs. The staff area is of loadbearing masonry construction with timber flat roof construction.  	3a. Primary Steel Portal Frame.	**Observations: The steel frame appeared to be in good condition.**	
	3b. Roof structure *Steel lattice roof trusses supporting profiled metal deck*	**Observations: The main workshop roof is steel lattice trusses supporting profiled metal deck. This generally appeared in good condition. No RAAC roof slabs were observed.** **Recommendations; There is a service supply reel connected to the Woodwool slabs; it is not good practice to fix to the Woodwool so confirmation is required that the capacity of the fixings was confirmed before install or the unit relocated.**	 
	3c. Walls *The walls are face painted blockwork externally and internally to all areas. There is a precast concrete fascia feature above the windows.*	**Observations: There is a stepped diagonal crack above the roller shutter door both front and back. This appears to be associated with where the steel door frame is built into the masonry and bridging the wall movement joints, some corrosion expansion appears to have occurred and possibly some lateral movement of the frame, causing displacement and tracking to the wall. There is one section of spalled concrete to the rear door fascia.** ***Recommendations: A detailed assessment of the frame structure around the door to determine the likely remedial work; this may include replacing the steel door frame.***	   

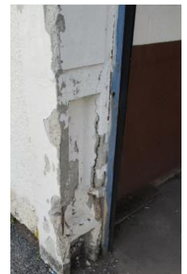
Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
3. Didcot   	3d. General structural defects	**Observations: There is a large masonry boiler chimney. It was not possible to inspect the chimney during the inspection.** ***Recommendations: It would be prudent to undertake close inspection of the chimney, using access equipment.***	
	3e. External features	**Observations: There is a large galvanised steel frame, open canopy structure, to the rear. This was not inspected in detail but appeared to be in good condition.**	
	3f. Non-structural defects	**Observations: An area of external hardstanding is breaking up / sunken around an external road gulley. There is a RWP gulley that is not adequately sealed.** ***Recommendations:*** **The road gulley should be rebuilt and the RWP fully sealed.**	

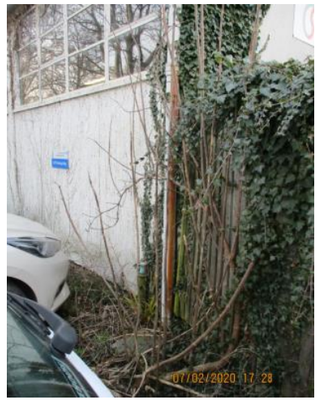
Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
4. Gosport The building is primarily loadbearing masonry with flat roof of precast concrete panels. The building has two small extensions; 1) A small older extension to the rear with face painted blockwork internally and brickwork externally, housing the locker room. 2) A new modern brick flat roof extension to the right-hand side housing the staff room.  	4a. Primary Steel Frame *The roof panels to the garage are supported on a grillage of downstand concrete beams. The crossbeam supports are on steel columns with adjoining steel beam over the doors; The roof beam grillage may be of concrete encased steel beams, or could be insitu reinforced concrete.*	**Observations: There is consistent horizonal cracking to the walls, at the corners just below the roof slab. There is also disturbance / cracking between the roof slab and the walls. This is caused by differential thermal expansion between the concrete roof and the masonry walls. The steel beam above the rear door has some surface corrosion.**	
	4b. Roof structure *The roof is formed in narrow module PCC units notionally 300mm wide. The concrete roof slabs units were exposed externally to form the eaves projection. There is a recess to the edge of the units forming a drip detail.*	**Observations: The external joints between units are cracked with damp and rust staining. No major spalling was noted to the units so it was not possible to determine if the units were RAAC. However, no excessive deflection was observed.** **Recommendations: *We do not believe the roof has RAAC units, to make 100% sure it would be necessary to locally cut out a small section to expose the concrete. This could be done during the canopy repairs so the exploratory hole can be patch repaired.***	
	4c. Walls *The walls are of face brickwork externally and painted brickwork internally to the garage area.*	**Observations: There are stepped diagonal cracks to the walls internally and externally, including;** **1. Below the rear windows of the garage.** **2. To the external rear wall of the locker room.** **3. Above the lintel to the locker room extension.** **4. The wall around the boiler flue is cracked and shoved in.** ***Recommendations: Brickwork repairs require to be carried out in conjunction with repairing drains and investigating lintel supports.***	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
4. Gosport 	4d. General structural defects	**Observations: There is a precast concrete canopy structure bridging the garage doors. Localised areas of spalling were observed.** ***Recommendations: The canopy concrete should be patch repaired with a concrete repair mortar and a Fairing coat applied to the external surface to provide some protection to the concrete.***	 
	4e. External features	**Observations: There is a small tree growing through the gulley to the rear corner of the garage. There was also ivy growth to the front and rear corner of the garage. The front RWP was leaking with rust staining.** ***Recommendations:*** ***It is very likely that the RWP gulley is severely damaged by the tree roots. The tree should be dug out and the gulley replaced. The Ivy growth should be removed and the steel RWP's replaced.***	 
	4f. Non-structural defects	**Observations: Internal water leaks were noted particularly at the junction between the original concrete eaves, which is exposed internally at the junction with the extensions. Water is also leaking through the eaves soffit externally. The underside the of the roof slab has extensive black mould / damp.** ***Recommendations: A building surveyor should investigate the roof leaks and source or damp.***	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
5. Hythe The station garage and staff areas are of SCOLA Mark 1 steel frame construction with steel lattice trusses supporting timber roof joists.   	5a. Primary Steel SCOLA Mark 1 Frame.	**Observations: The primary frame appears to be galvanised and where exposed is in good condition.**	
	5b. Roof structure *Steel lattice roof trusses supporting timber roof joists and deck.*	**Observations: The main workshop roof generally appeared in good condition. No RAAC roof slabs were observed.**	
	5c. Walls *The external walls were of lightweight studwork construction with large areas of curtain wall glazing and tile hung wall elevations where not glazed. There are some areas of timber wall framing to the corners and edges of the tile panels.*	**Observations: To the side elevation at the front corner, ivy has grown into the joint between the glazing and the corner timber panels, which has displaced the corner panel and window unit. Decay was noted to the external timber framing at the corners. There are several areas of localised damaged tile hanging** ***Recommendations: Some remedial works are required to the external elevation to replace decayed timber framing, damaged tiles and reinstate flashings. Work has been undertaken to clear the ivy some additional removal is required to the corner joint.***	   

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
5. Hythe  	5c. Cont.	**Observations: The curtain wall glazing is connected to the main frame using bolts drilled through the window frames with clamp brackets inside and out. The external clamp brackets were corroding.** ***Recommendations: A curtain wall specialist should inspect the cladding fixings and advise if the detail is satisfactory.***	 
	5d. External features	**Observations: One of the paving slabs to the entrance steps was loose** ***Recommendations: Lift and relay slabs.***	
	5e. Non-structural defects	**Observations: At the front left-hand corner a foul drain outlet is displaced with separation gap between the pipe and the below ground drainage. Such a gap can be a pathway for rats from the mains sewer. At the left-hand rear corner, the storm water drain was also displaced and disconnected.** ***Recommendations:* The drain / outlets should be rebuilt fully sealed.**	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
6.1 Oxford City - Workshop Building The main structure is of precast concrete columns, supporting steel roof truss frames, in turn supporting profiled metal roof deck on precast concrete or cold rolled steel purlins. The garage / workshop building was divided into three areas; ambulance garage, storeroom and workshop. The storeroom and workshop appeared under-utilised. The workshop bay appeared dis-used. There was also a vehicle spray booth, this was not accessible so was not inspected.   	6.1a. Primary Steel roof truss structure supported on Pre-cast concrete columns. The columns are essentially "I" sections with spaced solid sections to stiffen the flanges.	**Observations: The primary columns are spalled, with the exposed reinforcement in some locations heavy corroded, becoming severe at the base. The columns have also suffered from minor vehicle impacts, which have cause additional spalling and section loss. There are also regularly spaced horizontal cracks to the columns externally, which is an indication of corrosion of the steel link bars.** ***Recommendations: Consideration is required to the life of the building. Concrete patch repairs could be carried out however these would be extensive and considering the slender sections patch repair is unlikely to reinstate the structural integrity of the columns.***	    
	6.1b. Roof structure *The main ambulance garage roof was of precast concrete purlins. The workshop and store area roof are steel cold rolled purlins, assumed to be replacement. It is likely that the roof steel metal deck covering is also a replacement of asbestos roof sheeting.*	**Observations: The roof was covered with netting internally to deter pigeons; this did slightly restrict the view. The concrete purlins have areas of spalling exposing reinforcement. Occasional purlins have spalled to the extent that their structural integrity is of concern.** ***Recommendations: Only occasional purlins are affected; it may be possible to replace individual purlins with alternative steel purlins.***	 
	6.1c. Walls The external walls are of single skin concrete block panels with textured render externally.	**Observations: There are areas of spalled render, damp / rust staining and some spalled render. The internal wall adjoining the jet-washing area is damp and suffering from erosion / chemical attack to the mortar joints. However, the walls appeared structurally stable.** ***Recommendations:***	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
6.1 Oxford City - Workshop Building    	6.1d. General structural defects	**Observations: The surface water drainage gullies and downpipes are in poor condition** ***Recommendations:*** **Some clearance work would be prudent, however the issues to the primary structure will take precedence with the future maintenance of the building.**	 
	6.1e. External features	**Observations: A tall communication tower, a fuel tank, shelter and a modular building were present adjacent to the main building. No inspection was undertaken to these structures.** **A concrete fence post to the rear has been struck and was leaning over.**	
	6.1f. Non-structural defects	**Observations: There is rising damp and water staining to the floor in the store area.** ***Recommendations:*** ***Remedial works to the drainage and rainwater goods will reduce the water ingress. However, the external walls are of single skin block so the building should not be considered suitable as a habitable space and the installation of plasterboard wall linings avoided. The mould affected plasterboard should be removed for health reasons.***	 
Building Structure and General Description	**Structural Element and Description**	**Observations and Recommendations**	**Photos**

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
6.2 Oxford City – Goods-in / store building The main structure is a continuation of the main workshop building however the roof remains clad in the original asbestos.   	6.2a. Primary Steel roof truss structure supported on Pre-cast concrete columns. The columns are essentially "I" sections with spaced solid sections to stiffen the flanges.	**Observations: The primary columns are even more extensively spalled, with exposed and de-bonded reinforcement. In some locations heavy corrosion was noted to the exposed rebar. The external columns have suffered from multiple minor vehicle impacts, which have caused diagonal shear cracks, spalling and section loss. The frame has concrete eaves beams of similar cross section; these too have spalling. Part of this building is used for jet-washing so is saturated. The building is not considered suitable for jet-washing.** ***Recommendations: Consideration is required to the life of the building. Considering the slender sections and extent of damage; concrete patch repair will not reinstate the structural integrity of the columns.***	    
	6.2b. Roof structure *The main roof structure is of precast concrete purlins as the ambulance garage roof but with the original asbestos roof sheeting.*	**Observations: The concrete purlins to this area appear in fair condition. No RAAC roof slabs were observed. The lining board is damp and severely decayed.** ***Recommendations:*** **The issues to the primary structure will take precedence with the future maintenance of the building.**	
	6.2c. Walls The external walls are of concrete block panels with textured render externally.	**Observations: The walls are generally weathered with defects as the main workshop, overall, they appeared structurally stable. Spalling was noted to the concrete window sills.** ***Recommendations:*** **The issues to the primary structure will take precedence with the future maintenance of the building.**	

6.2 Oxford City – Goods-in / store building  	6.2d. General structural defects	**Observations: One of the steel trusses has a lifting hoist, indicating a 1 ton load capacity.** ***Recommendations: The load capacity of the frame has not been verified. We recommend that the hoist is not used considering the condition of the building structure.***	
	6.2e. External features	**See main building.**	
	6.2f. Non-structural defects	***The issues to the primary structure will take precedence with the future maintenance of the building.***	

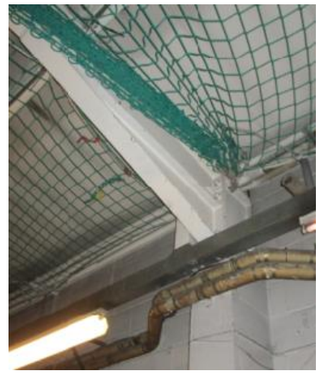
Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
6.3 Oxford City – Training Centre The main structure is of hybrid framed structure with loadbearing masonry ground floor, with precast concrete lower roof and floor constructions. The upper roof is of, steel trusses, supporting Woodwool slabs.   	6.3a. The building is an unusual structure with the first floor raised above the ground floor roof, supported on an externally exposed frame. The only link is at the internal stair core. It is possible that the upper floor is a later extension built to straddle over the original ground floor construction.	**Observations: The external columns and floor beams are rendered, so it was not determined if these are steel or concrete column elements. There are no signs of defects to the frame elements where exposed. The underside of the first-floor pre-cast units is exposed concrete there are no major visual defects to the slabs where exposed.**	 
	6.3b. Roof structure *The roof is formed in narrow module PCC units notionally 300mm wide. The units were exposed externally to formed the projecting concrete eaves roof slabs; the units have two small drip detail.*	**Observations:** **The lower roof Pre-cast roof slabs are exposed externally. There is extensive spalling to the exposed concrete soffit and fascia.** ***Recommendations: The exposed concrete eaves should be repaired with a concrete repair mortar and treatments applied to the external surface to provide protection to the concrete. Prior to concrete repairs, testing should be undertaken to determine the extent of any carbonation and chemical attack and a specialist concrete repair scheme prepared based on the findings.***	   
	6.3c. Walls The external walls are of masonry with textured render externally.	**Observations: There are areas of spalled / cracked render. However, overall the walls appeared structurally stable.**	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
6.3 Oxford City – Training Centre   	6.3d. General structural defects	**Observations: There is a large brick plantroom / tower to the front of the building with a brick flue projection above the roof. There is damage to the brick flue with some missing / loose brick.** ***Recommendations: There is a risk of falling masonry so the flue should be inspected closely and any loose / defective brickwork rebuilt.***	
	6.3e. External features	**Observations: There is a small timber escape stair onto the front flat roof, leading to a steel main stair to the ground level. There was extensive corrosion to the escape stair.** ***Recommendations: A detailed structural assessment is required to the stairs,***	
	6.3f. Non-structural defects	**Observations: There is a projecting canopy roof to the rear flank wall of the building, clad in fibre cement sheeting. Part of this was damaged and lying on the floor. It is possible that this contains asbestos.** ***Recommendations: The damaged section and debris from the floor should be removed.***	 
Building Structure and General Description	**Structural Element and Description**	**Observations and Recommendations**	**Photos**

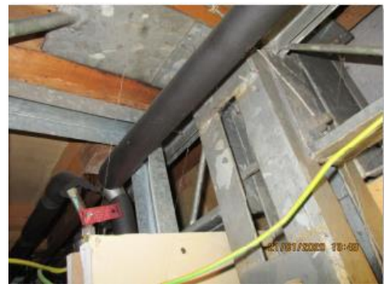
6.4 Oxford City - Garage Building We understand that this garage building is currently out of use. No internal inspection was undertaken. However, the building style with the curved eaves structure and profiled metal cladding is very typical of a 1980's steel portal frame. We would expect the cladding is supported on cold rolled steel purlins.   	6.4a. Primary Steel portal frame structure	**Observations: Not inspected internally.**	
	6.4b. Roof structure *Profiled metal cladding on steel frame.*	**Observations: No major external defects observed.**	
	6.4c. Walls The external walls are of face brickwork.	**Observations: No major defects were observed to the external walls.**	
	6.4f. Non-structural defects	**Observations: Typically, the curved eaves would conceal a hidden gutter. In this instance there appears to be a small gutter channel externally. This was leaking causing damp staining and algae growth to the external walls.**	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
6. Petersfield The building is a loadbearing masonry structure with some frame elements. The building is small scale in comparison to other Resource centres.   	7a. Primary Frame The building is primarily loadbearing masonry with steel lattice roof trusses over the garage area.	**Observations: There was a continuous concrete beam / padstone supporting the truss bearings. Hairline cracks were noted at the truss support locations.** ***No action is proposed.***	
	7b. Roof structure The garage roof is mono-pitched with steel lattice trusses laid to the slope. A particle board ceiling was in place so the roof deck was not exposed. The staff area is flat roof, the structure was not visible in any location.	**Observations: The garage ceiling has the tell tail ghosting dirt staining indicating the roof deck is likely to be poorly insulated timber joists.** **Recommendations; In order to confirm for definite that no RAAC roof slabs are present a small section of ceiling would need to be removed in both areas.**	
	7c. Walls *The walls are of face brickwork externally and face brickwork internally to the garage area.*	**Observations: There are several stepped diagonal cracks to the brickwork inside the garage. There was no obvious corresponding cracking externally.** ***Recommendations: There is the slight possibility of some foundation movement causing the cracking. In the absence of any cracking externally we would recommend the cracks are monitored by repair using deep pointing*** **and then investigations undertaken if cracking recurs.**	

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
7. Petersfield	7d. General structural defects	**Observations: Cracking was noted to the front entrance door beam bearing. A horizontal cracking was noted to the brickwork at the RWP, which appeared to be due to corrosion expansion of the fixings. Some individual bricks were frost damaged.** ***Recommendations: Some localised brick repairs could be undertaken as part of ongoing maintenance.***	
	7e. External features	**Observations: There is a brick retaining wall separating the property from the adjacent Children's Centre. There were several stepped / vertical cracks through the wall with some lateral displacement at crack locations.** ***Recommendations: The cracks did not affect stability so it is recommended that the wall is monitored.***	 
	7f. Non-structural defects	**Observations: The finish is peeling off the main entrance door.**	

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
8. Reading The main garage roof structure is of steel portal frame supporting profiled asbestos roof deck.   	8a. Steel portal Frame	**Observations: The perimeter columns wee obscured, where exposed at the roller shutter door positions, some corrosion was observed at the bases.**	
	8b. Roof structure *Steel portal rafters supporting cold rolled steel purlins supporting profiled asbestos roof sheet deck. The office areas are of timber joist*	**Observations: The main building was scaffolded with work being undertaken to the roof finish at the time of the inspection. From discussions with the contractor the works are to clean the asbestos sheeting and provide a Ruberoid sealant finish. No RAAC roof slabs were observed.**	
	8c. Walls	**Observations: The walls were generally in good / fair condition. Erosion of pointing and some frost damage was noted to the external brickwork below ground. Some localised stepped / vertical cracks were noted to the internal blockwork.** ***Recommendations: Repointing and some local rebuilding is required to the external brickwork below DPC.***	   

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
8. Reading	8d. General structural defects	**Observations: There are some external brickwork defects where flashings have been removed and where corroding fixings are causing cracks to the brickwork.** ***Recommendations: These are not critical but could be repaired when repairing walls below DPC.***	 
	8e. External features	**Observations: There is a dis-used brick external walled "shelter". The brickwork is becoming lose with weathering and frost action.** ***Recommendations: It would be prudent to plan for demolition of the structure. Note electrical supply is connected to the structure.***	 
	8f. Non-structural defects	**Observations: Some areas of the ceiling to the office areas are of slatted ceiling board, in places the panels were becoming detached. There are areas of water staining / algae growth to the walls of the office.** ***Recommendations: If this is not included as part of the current remedial works, then it would be prudent to take down and replace the ceiling.***	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
9. Totton The station garage and staff areas are of SCOLA Mark 1 steel frame construction with steel lattice trusses supporting timber roof joists.  	9a. Primary Steel SCOLA Mark 1 Frame.	**Observations: The primary frame appears to be galvanised and where exposed is in good condition.**	
	9b. Roof structure *Steel lattice roof trusses supporting timber roof joists and deck.*	**Observations: The main workshop roof generally appeared in good condition. No RAAC roof slabs were observed.**	
	9c. Walls *External face brickwork with curtain wall glazing panels.*	**Observations: The brickwork shows some signs of weathering and erosion of joints.** ***Recommendations: A known latent defect with SCOLA buildings is lack of tying of brick panels to the steel frame. Further investigation would be needed to determine if adequate ties have been provided. Including removal of occasional bricks and inspection using an endoscope.***	 

Building Structure and General Description	Structural Element and Description	Observations and Recommendations	Photos
9. Totton	9d. General structural defects	**Observations: No major issues were noted beyond those described above.**	
	9e. External features	**Observations: No major issues were observed.**	
	9f. Non-structural defects	**Observations: The top cladding rail to the front elevation is displaced and sagging.** ***Recommendations: This requires inspection by a specialist window supplier.***	

Table Key

	Urgent remedial works to be undertaken.
	Remedial works to be undertaken as part of ongoing maintenance.
	No remedial works required before next inspection

SERVICES AND FEE PROPOSALS

Client: South Central Ambulance Service NHS Foundation Trust, Units 7-8 Talisman Business Centre, Talisman Road, Bicester, Oxfordshire OX26 6HR

Professional Services: Premises RAAC idnetification surveys and reports.

Services:

We have reviewed the list of properties provided in “Estates Site List - RAAC Surveys.xls” and “Properties List Age etc.pdf” along with a Google Maps satellite review of the buildings. From this initial level assessment we have divided the properties into three risk categories based upon the age and nature of the construction:

Category 1: RAAC may be present (29 no. total)
Category 2: RAAC is unlikely but cannot be ruled out (8 no. total)
Category 3: RAAC can likely be ruled out (18 no. total)

Structural Engineers, Perega, working as our supply chain partners will undertake visual reconnaissance surveys of each of the sites with the objective of confirming if RAAC is present or not and also where possible from a visual survey give an opinion as to the likely extent of it. They will attend site with an engineer with a surveyors ladder to enable them to lift ceiling tiles where it is safe to do so, but we will need confirmation that areas are free from asbestos in advance. The surveyors ladder is a straight ladder so any access using it will be limited to room perimeters where it can bear onto a wall. If the ceilings are solid or too high to access safely, this will be recorded and presented as part of the resultant report. Further action to address access restrictions would be part of the scope of subsequent surveys where applicable.

SCAS will need to provide floor plans for each of the sites that can be used to annotate survey findings. If floor plans are not available, we will need to review the methodology as this will be difficult without a graphical aid to record areas inspected.

A report will be prepared for each of the sites using the annotated drawings and text indicating the likely form of the structure based on the survey observations, where RAAC panels have been identified, where it is considered that RAAC may be present but unidentified and where it is considered to be unlikely that RAAC panels will be found. Inspections will consider floors, walls and roof structures.

The report will also describe the next steps required for to conclude for as far as possible that RAAC is or is not present within the building together with a scope of work that will need to be undertaken to allow this conclusion to be formed. The further intrusive investigations would be subject to additional fees.

The preparation of scopes of work for surveyors to map RAAC planks and measure the plank deflections as per the DFE guidelines, which are recognised as current industry best practice, would be a separate exercise undertaken once the extent of the RAAC panels was fully understood so that appropriate scopes of work and deliverables can be established.

Fees:

A fee breakdown per building is provided separately. All surveys will take place during normal working hours (Monday to Friday 8am-8pm).

Fee summary

Surveys and reports for the:

29 no. Category 1 buildings	**£34,804.00 + VAT.**
8 no. Category 2 buildings	**£10,678.00 + VAT.**
18 no. Category 3 buildings	**£22,145.00 + VAT.**

Programme:

We will need two to three weeks lead in prior to commencing the surveys. We will prioritise surveying Category 1 buildings, followed by Category 2 and 3 if instructed.

Contract:
The contract between SCAS and WT will be a call-off instriuction from the ESPO framework contract.

Conditions:
Fees would be charged based upon the price per building for each completed report issued.

Should works be involved which are beyond the scope of the services and fees proposal above such works will be charged at the following rates unless otherwise agreed:

Director	@ £110.00 per hour (plus VAT)
Associate Director	@ £95.00 per hour (plus VAT).
Senior Surveyor	@ £70.00 per hour (plus VAT)
Surveyor	@ £60.00 per hour (plus VAT).

Fees and services are based on the following:

1. They **exclude** VAT which is charged at the standard rate.
2. They **include** all *usual* expenses such as printing and postage. Extraordinary expenses such as multi-copying or courier post will be charged separately.
3. All *usual* travelling expenses to the site (and surrounding locations) are **included** but travelling to other locations and extraordinary visits to site would be charged separately at a rate of 45 pence per mile.
4. Fees **exclude** fees for specialist services which may be necessary in support of the commission.
5. Fees **exclude** any negotiations with landlords following completion of the dilapidations surveys.
6. Should the project be aborted at any stage, fees will be payable based on the extent or part of surveys completed, plus an abortive cost for not proceeding with the entire programme.
7. WT operates an RICS approved Complaints Handling Procedure (CHP) which can be issued on request.

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**People Strategy Update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**22**
Executive Summary:	Following the launch of the Trusts People Strategy this update provides a high-level overview of progress against the objectives set for the first 6-18 months of the Strategy.		
Recommendations:	The Trust Board is asked to: Note the progress against the 6-18 month objectives as set out in the Trusts People Strategy.		
Executive lead:	Melanie Saunders, CPO		
Report author:	Melanie Saunders, CPO		
Previously considered by:	The Board approved the Trust People Strategy in March 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 7 - Inability to recruit and/or retain non-clinical staff
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): Progress against the strategy to continue to be monitored via the Trusts Workforce Development Board and People & Culture Committee.	
List of Appendices:	

NHS
South Central Ambulance Service
NHS Foundation Trust

Our SCAS People Strategy

2023-26

Creating a workplace where people feel appreciated, valued, supported and encouraged every day…

Our SCAS Corporate Strategy 2022/27

Our Mission
Why we are here

We deliver the right care, First time, Every time

Our Vision
Where we want to go

To be an outstanding team, delivering world leading outcomes through innovation and partnership

Our Values
How we are

Caring

Professional

Innovative

Teamwork

Our Strategic Themes
The core strategic challenge

Our Enabling Plans
How we will deliver our vision

Our Strategic Themes	Our Enabling Plans
Clinically-Led	Clinical / Research
Service Quality & Patient Experience	Commercial / Procured Services
	Core Service Delivery Operations
	Quality Improvement
People & Organisational Development	Our People
	Volunteers
Partnerships & Stakeholder Engagement	Communications & Stakeholder Engagement
Technology Transformation	Digital & Management Information
Finance & Sustainability	Finance
	Sustainability (Inc. Estates)

All KPIS / Milestones

The National Context: The NHS People Plan for 2022/2023 and beyond

Looking After Our People:

Quality Health and Wellbeing support for everyone. Focusing on the actions we must all take to keep our people safe, healthy and well – both physically and mentally.

Belonging in the NHS:

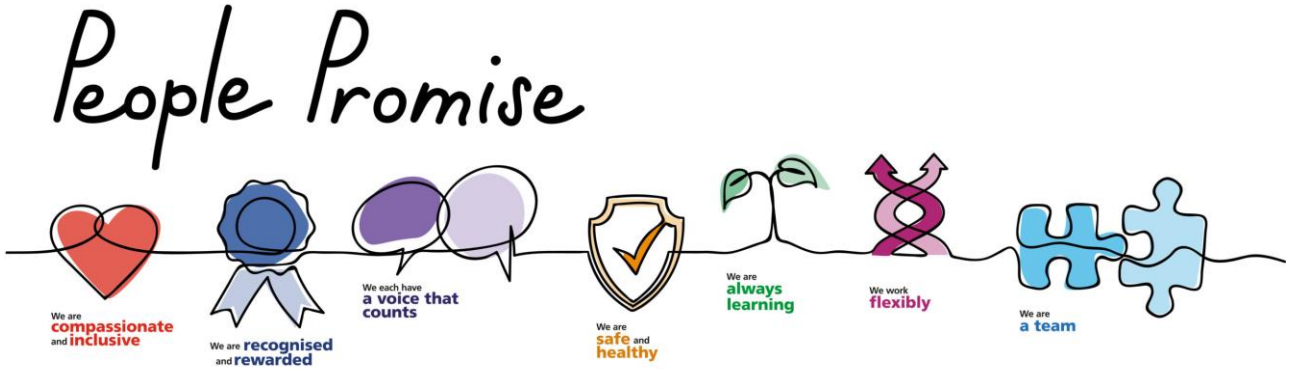
Highlighting the support and action needed to create an organisational culture where everyone feels they belong with a particular focus on tackling the discrimination some staff face.

New Ways of Working and Delivering Care:

Emphasising the need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care.

Growing for the Future:

How we recruit and keep our people. Building on the renewed interest in NHS careers to expand and develop our workforce as well as retaining colleagues for longer.



The plan includes a **"people promise"** which sets out in their own words, what our NHS people said would make the greatest difference in their working lives…

Looking After Our People

Long term vision

Our people are led by skilled leaders who demonstrate civility, respect and compassion

Our people feel physically and psychologically safe in the workplace

Our people have greater flexibility in how, where and when they work

We have a healthy workforce who feel well supported

We have a culture in which we learn from events that haven't gone to plan

Measures of Impact:

- Staff survey results concerning compassion/caring
- Sickness absence rates and reasons
- Number of formal employee relations cases
- People Voice narrative describing working environment and culture
- Benchmarking against other Trusts

Looking After Our People:

Quality health & wellbeing support for everyone

Short term actions:

(6 – 18 months)

- Establish/consolidate our “People Voice” feedback channels to improve how we listen to our people and how we act on feedback
- Continue delivery of our SCAS Leader and Essential Skills for People Manager programmes
- Improve 1:1 conversations with particular focus on Health and Wellbeing and access to 1:1s for all staff
- Continue to deliver our Health and Wellbeing plan with focus on mental health and a healthy working environment
- Integrate civility and respect within all work areas across SCAS to promote a culture where staff feel safe, supported, valued and respected and engage our leaders (at all levels) in the development of a Just and Learning Culture

Progress:

- “People Voice” feedback channels agreed process for collating data, triangulating, acting on feedback and governance is in place. Now need to demonstrate action on feedback and impact.
- Leadership programmes continue, new modules include collation of facts investigation training.
- Wellbeing conversation workshops and education in place.
- Winter wellness pack launched, including QR code sticker on vehicles to improve signposting to H&WB portal. Financial wellbeing guide launched.
- Additional MH and Physio support in situ, along with CRUSE, MHFT and REACT training.
- Continuing to engage leaders in developing compassionate culture, through development of communications, education, coaching & JLC toolkit.
- Close collaboration between PSIRF and HR leads in respect of impact of culture on patient safety.

Belonging in the NHS

Long term vision

All our people feel safe and respected to deliver high quality patient care

We employ people with a range of knowledge and experience to deliver the best patient care

Our workplace is free from discrimination

We attract talented people from all backgrounds and parts of the community

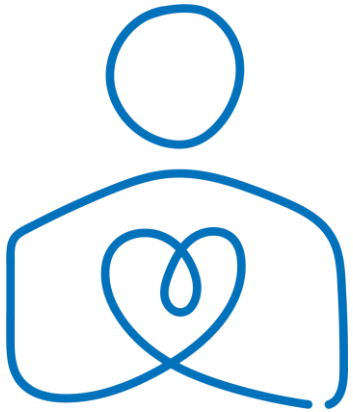
Colleagues from all backgrounds agree that there are equal opportunities for progression and development

Measures of Impact:

- Staff survey results: We each have a voice that counts
- People Voice: evidence that feedback comes from diverse sources and describes a safe, inclusive culture
- Appointments to roles reflect the diversity of our communities

Belonging in the NHS:

Creating a culture where everyone feels they belong



Short term actions:

(6 - 18 months)

- Publish and promote our Equality, Diversity and Inclusion (EDI) strategy at every level
- Deliver Recruitment and Selection training to promote consistency, fairness and inclusion on interview panels
- Develop resilience, resourcing and visibility of our Freedom to Speak, Listen and Follow Up team
- Improve access to Freedom to Speak Up e-learning, encourage completion and develop a dashboard for monitoring this
- Strengthen and consolidate partnership working with our Trade Union colleagues and staff networks
- Take action to improve sexual safety across the organisation
- Continue with a calendar of events to promote diversity and support under-represented groups
- Ensure that equality impact assessments are undertaken on all board papers and business cases

Progress:

- ED&I Strategy launched
- Recruitment and Selection training module within leadership development programme.
- FTSU team increased, including development of 27 champions across the Trust
- E-learning compliance continues to improve across all FTSU 3 modules
- New partnership agreement being developed in conjunction with our TUs.
- Staff Networks benefiting from Cherron Inko-Tariah development sessions and each network now has an Executive sponsor
- Improved allegation management process demonstrating results in addressing inappropriate behaviours.
- New EQIA assessment process developed and implemented.

Long term vision

New ways of working and delivering care

Our people choose to stay with us as they develop (in their roles and beyond)

We have credible successors to business-critical roles up to and including Board/Director roles

Our people are happy, fulfilled, motivated and provide high quality patient care

People at all levels and in all parts of the organisation understand what their job/role is and how to perform well in it

People are recognised for the talents they bring and can pursue a rewarding career path

Measures of Impact:

- Performance Development Review (PDR) compliance rates
- Staff Survey results: career development and PDRs
- Number of employees progressing into different roles
- Number of staff accessing learning and development
- Attrition (not associated with positive progression)

New ways of working and delivering care:

Making effective use of our people's skills & experience

Short term actions:

(6 – 18 months)

- Embed our new Personal Development Review (PDR) forms
- Develop an annual planning process with cascading objectives
- Improve access to paid development/learning opportunities across our workforce (coaching, leadership development)
- Provide fully regulated courses with high quality teaching
- Develop Digital Education and simulation facilities to improve learning and development opportunities
- Improve the welcome programme for new joiners

Progress:

- PDR leadership module in place
- Annual planning process under development
- All programmes with the exception of 1 now fully regulated.
- Virtual teaching on some programmes has commenced, including Nurse and International programmes
- 'A good start' programme ready to launch.

Growing for the Future

Long term vision

We have a robust workforce pipeline that encompasses diverse talent pools

We retain our staff by looking after our people, developing skills/experience and focusing on a sense of belonging

We have an embedded brand and reputation as a great place to work

We have the right number of skilled people in the right locations to deliver outstanding patient care

We have a comprehensive, competitive offer to employees, attracting (and retaining) a diverse pool of applicants

Measures of Impact:

- Vacancy rates
- Numbers of applicants to roles and course fill rates
- Time taken to recruit to roles
- Acceptance rates of recruitment offers
- Attrition (not associated with positive progression)

Growing for the future:

How we recruit and keep our people

Short term actions:

(6 – 18 months)

- Review our long term workforce plan, taking a collaborative system wide approach
- Reach out to under-represented groups in our communities to improve diversity within our workforce
- Promote and use inclusive recruitment practices, attracting candidates from a range of backgrounds and signposting them to the best role
- Continue with international recruitment into clinical roles
- Continue to work in partnership with the Princes Trust, Ministry of Defence and Agencies
- Strengthen our offers/accessibility for staff returning to practice
- Improve placement experience for student paramedics
- Ensure that there is effective oversight and governance of recruitment and retention activities

Progress:

- Long term workforce plan under-review.
- Retention plan in place.
- Flexible working reviews in place alongside rota reviews for UEC and EOC
- Recruitment linking with recently re-launched staff networks to work on developing positive media presence and stories regarding diversity.
- Started process of EQIA for each recruitment process.
- International recruitment continuing and expanding.
- Prince's Trust courses delivered around CCC and Operational and PTS roles.
- First paramedics returning to practice started with SCAS this year.
- Review of Workforce development board structure to be completed. People & Culture committee in place

Strategy Enablers

Long term vision

Our people can quickly get support when they need it

Our people (and their ability to deliver first class patient care) will be at the heart of decisions made by the organisation

We have the right roles sustainably in the right places within the People Directorate

Our people know how to contact HR and can access accurate people information/data easily

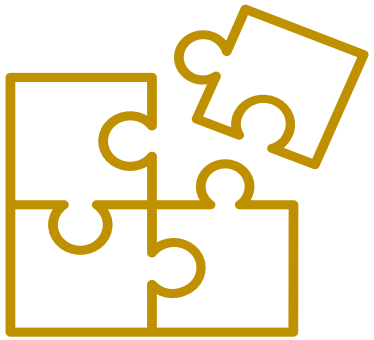
We will have easy to follow, efficient, value-added processes and systems

Measures of Impact:

- "Customer" feedback
- Staff Survey results from People Directorate
- Availability of People data at key meetings/forums

Strategy Enablers:

Factors that will facilitate effective delivery of our People Strategy



Short term actions:

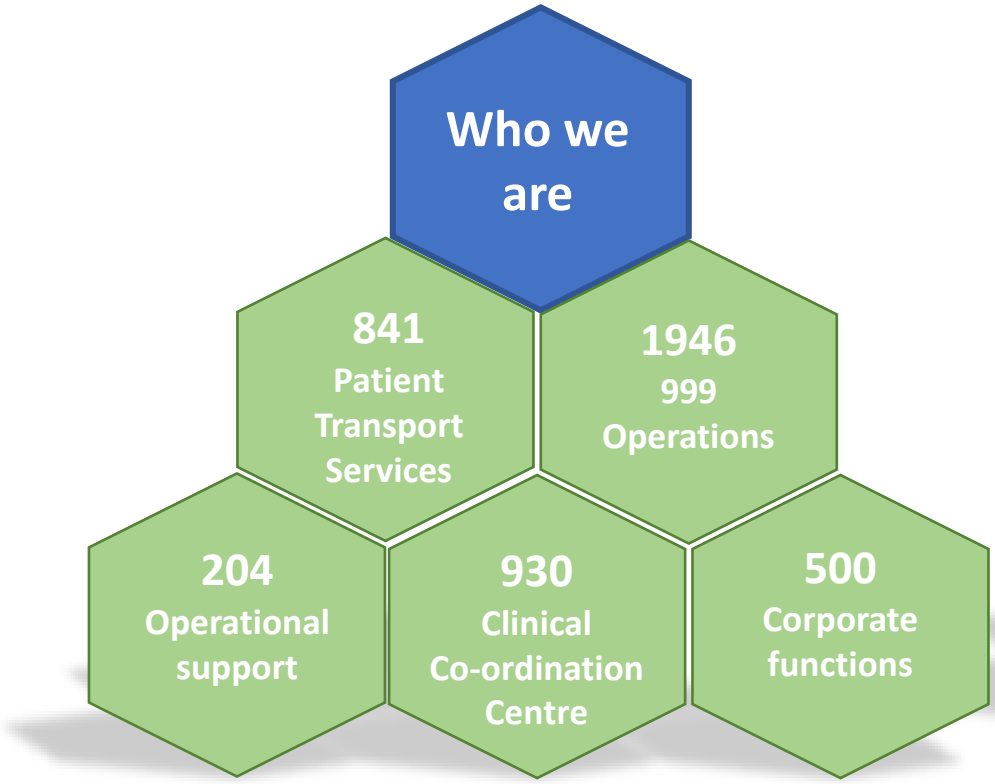
(6 – 18 months)

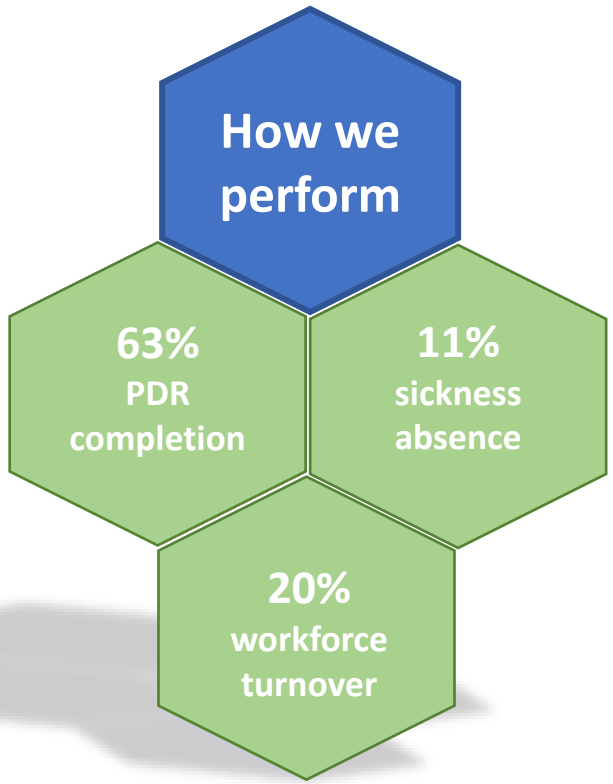
- Develop automated Business Intelligence reports that give access to good quality people data
- Improve our people administrative processes, ensuring better access, responsiveness and resilience
- Build our Supporting Our People intranet site ensuring that people can easily access the help/support that they need in one place
- Improve the recruitment process, seeking feedback from candidates/managers and developing clear Key Performance Indicators (KPIs)
- Review our people governance committees to ensure appropriate leadership of our people agenda and oversight of key activities

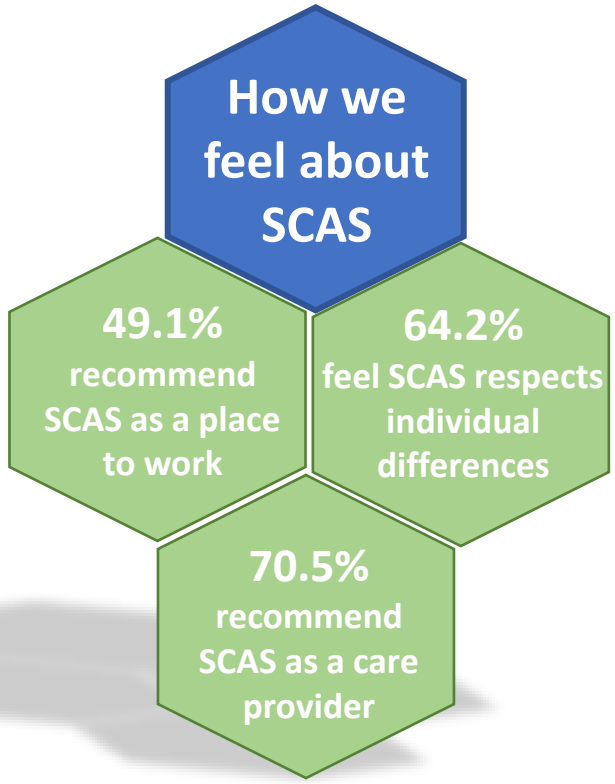
Progress:

- IQPR under-development
- Supporting Our People hub refreshed., dedicated hub pages sign-posting support for staff experiencing inappropriate behaviours.
- Recruitment processes have been reviewed and refreshed. Feedback is provided by candidates during the process and on starting. KPIs in place for time to hire.
- Workforce development board to be reviewed, People & Culture committee in place.
- Ofsted visit taken place (Sept 23) outcome awaited.

Where were in February 2023







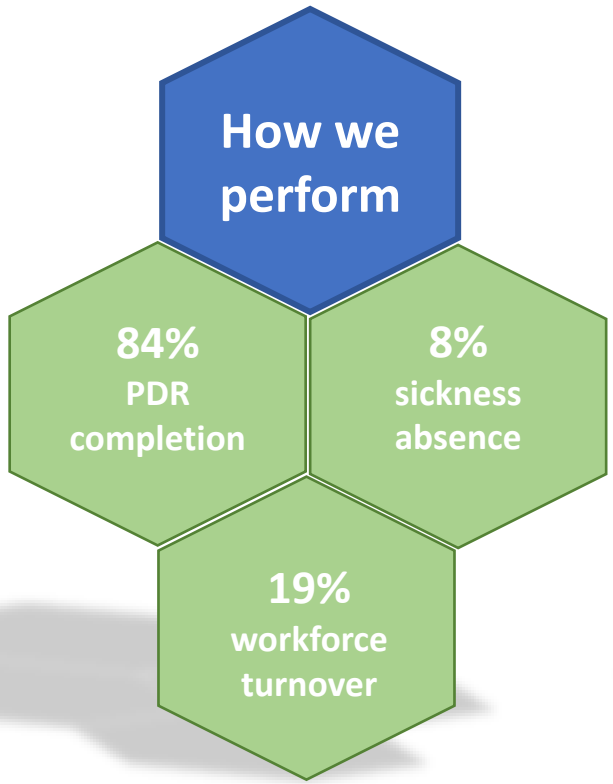
We are made up of approx. 4400 staff and over 1000 volunteers delivering a broad range of clinical and non-clinical services across the south central area

We want all of us to have high quality performance and development reviews (PDRs) that support our wellbeing, performance and development within and beyond our current roles

We want more of us to recommend SCAS as a place to work & to receive care and we want to attract & retain a more diverse workforce who feel welcome and respected

Where are we now (September 2023)

We are made up of approx. 4600 staff and over 1000 volunteers delivering a broad range of clinical and non-clinical services across the south central area



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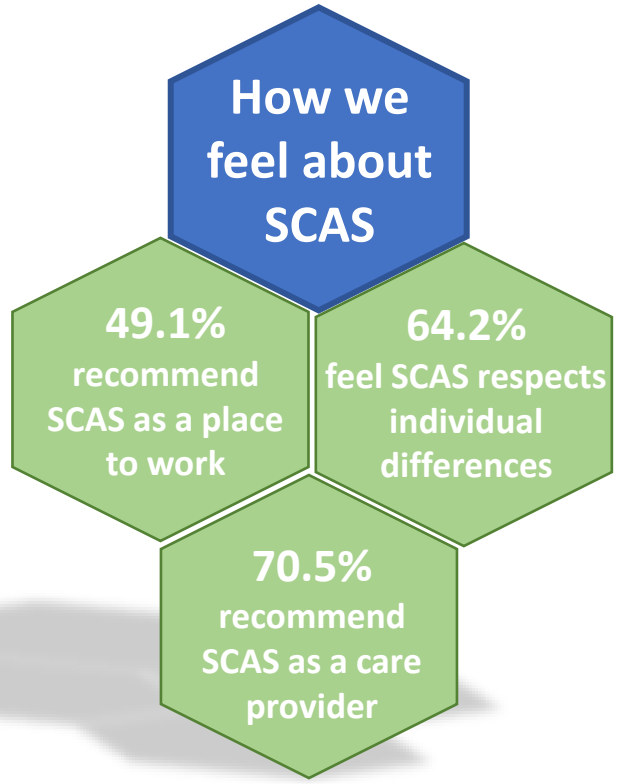

We want more of us to recommend SCAS as a place to work & to receive care and we want to attract & retain a more diverse workforce who feel welcome and respected

Assuring delivery of this strategy…

The People Directorate will continue develop detailed annual plans aligned to this strategy and the Trusts 10-point plan, working closely with stakeholders, which will detail the actions and programmes of work which will contribute to the delivery of our vision by 2026.

Progress will be monitored through regular review of our Measures of Impact which will be developed into a framework aligned to the Trusts revised IQPR that we monitor alongside progress of our plans.

Assurance on progress will be provided to the Board through these reporting lines/mechanisms:

- Through the People and Culture Board Sub-committee meetings
- Through sub-groups that report into the People and Culture Committee
- Through annual plans and cascaded team objectives for delivery by members of the People Directorate

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NHS Foundation Trust

Right care
First time
Every time

South Central Ambulance Service NHS Foundation Trust

PUBLIC BOARD MEETING SUMMARY SHEET

Report title:	**Sexual Safety Update**		
Report to:	**Trust Board (Part 1)**		
Date of Meeting:	**Thursday, 28 September 2023**	**Agenda Item:**	**23**
Executive Summary:	Following the launch of the Trusts Sexual Safety Charter in February 2023 the attached provides a high-level overview of progress against the objectives set to improve Sexual Safety within SCAS.		
Recommendations:	The Trust Board is asked to: Note progress to-date and to continue to actively support the ongoing development of our Culture so as to ensure our staff are safe and free from inappropriate behaviours, abuse and/or harassment in the workplace.		
Executive lead:	Melanie Saunders, CPO		
Report author:	Melanie Saunders, CPO		
Previously considered by:	Executive Committee and Trust Board		

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 7 - Inability to recruit and/or retain non-clinical staff
Quality Domain(s):	All Quality Domains
Next Steps (what actions will be taken following agreement of the recommendations): Progress against the Charter to continue to be monitored via the Trusts Workforce Development Board and People & Culture Committee.	
List of Appendices:	

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Sexual Safety Board Update

Melanie Saunders
Chief People Officer

September 2023

South Central Ambulance Service NHS Foundation Trust

Sexual safety
The issues

CQC must do:

Take staff's concerns seriously and take demonstrable action to address their concerns. This to include where staff have raised concerns relating to bullying, harassment and sexually inappropriate behaviours. Regulation 17(2)(b).

Concerns raised:

Ensure camaraderie does not tip over into inappropriate behaviours

Staff feel unsafe, unsupported and vulnerable when coming to work

Ensure that all sexual harassment cases are thoroughly investigated

Staff said they had been accosted by others in carparks

Staff said they did not feel safe in certain sites

It was felt that there were instances where staff who act and behave inappropriately were not managed appropriately

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Sexual safety

Our charter, launched February 2023

You have the right to feel safe from sexual harm

You should never feel uncomfortable, frightened, or intimidated in a sexual way by the public or other colleagues. It is also essential that we do not tolerate or accept language, behaviour and attitudes that negatively affect the sexual safety of our colleagues or patients. The charter aims to increase our awareness of the need to promote respect and actively support sexual safety for all. We recognise that sexual harassment can happen across all genders and sexualities.

Our pledge

- Never tolerate, ignore or excuse harmful sexual language, behaviour and attitudes
- Do everything we can to make sure people are heard, believed and feel safe
- Take clear and prompt action about any sexual harassment, violence, or intimidation

Our expected behaviours

- To be conscious at all times of how our behaviour makes others feel and accept it if someone tells us it makes them uncomfortable
- To speak out when we witness someone being upset, harassed, or assaulted
- To understand that intimate relationships should only ever be with mutual consent and never to manipulate others or abuse a position of trust

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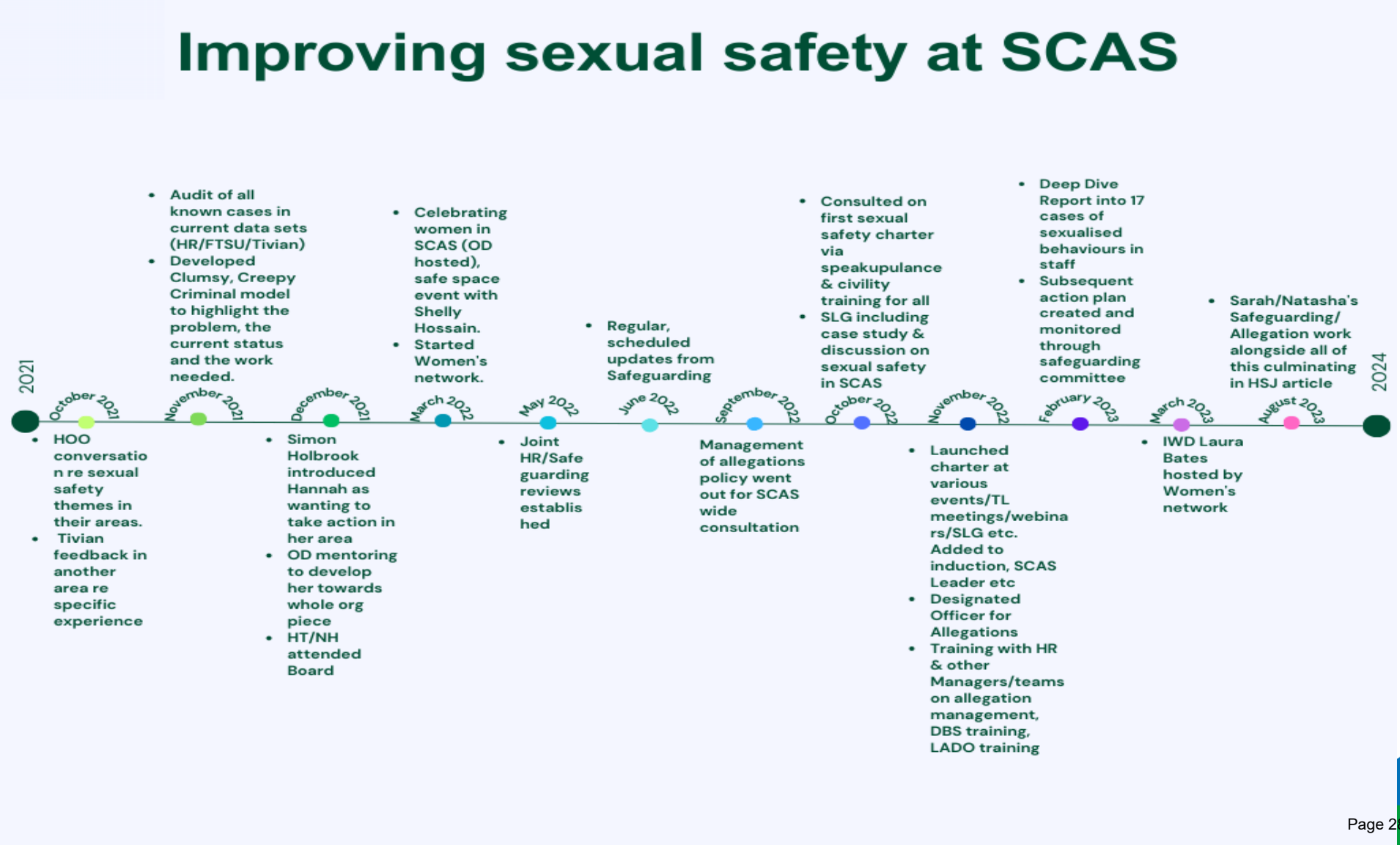
Our journey



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Sexual Safety
Improving awareness

Charter

- Soft launched sexual charter in Sexual Abuse and Violence week (6-12 Feb)
- QR code signposts to the sexual safety page on the Hub
- Promotion through internal channels

Impact:

- The charter binds SCAS to a position of accountability
- Charter is a preventative measure to improve the working environment and stop potential perpetrators
- Escalation route for anyone affected
- Assurance to staff that the trust is acting and inappropriate behaviour will not be tolerated

Training

- Sexual safety included in induction training and leadership training
- Use of scenarios in other areas of training that have sexual safety within case studies
- Preparation and development of specific training

Impact:

- Educating our workforce
- Providing the workforce with the tools to speak up
- To embed the knowledge and training into BAU

Staff engagement

- October 2022 raised awareness by opening conversations around sexual safety across SCAS directorates
- Co-design of charter
- Dedicated internal comms plan on sexual safety campaign

Impact:

- Providing a safe space to speak up through FTSU, EDI, Managers and HR
- Awareness raising through the comms plan and campaign
- Ongoing leaning to move towards just and learning culture

Staff networks

- Revitalised women's network.
- Introduction of staff networks for all protected characteristics
- Championing of networks to encourage membership

Impact:

- Providing representation across all staff groups including students and volunteers
- Provides a safe space to discuss issues and provides guidance
- Alert organisation of issues and concerns through the EDI steering group that reports to the board

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Sexual Safety
We said, we did

- Signatories to the NHSE Sexual Safety in Healthcare Charter NHS England » Sexual safety in healthcare – organisational charter
- Promoted and expanded our dedicated section and sexual safety page of the intranet - Sexual Safety at SCAS - Home (sharepoint.com).
- Collaboration with FTSU, promotional awareness of clumsy, creepy, criminal via SpeakupUlance and FTSU visits.
- Monthly case management reviews (HR, Safeguarding)
- Recruitment Team have been trained by Named Professional
- Teams trained in allegation management:
  - Level 1 Leaders
  - FTSU
  - HR
  - also included as part of the SGL3 training
- DBS and LADO training provided to Safeguarding and HR teams
- Developing closer relationships with professional bodies such as NMC via regular re

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Sexual safety
Next steps

- Launch Harassment and Sexual safety Disclosure checklist
- New poster campaign planned for October 2023
- Continue to promote and expand the networks dedicated section and sexual safety page of the intranet
- Continue to highlight the channels of reporting
- Make upstander and allyship training available to all staff
- Explore the introduction of a dedicated support line

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	Audit Committee
Date Committee met:	21 September 2023
Chair of Committee:	Mike McEnaney
Reporting to:	Board of Directors Meeting 28 September 2023

1. Points for Escalation

- In light of the recovery situation that SCAS is in and the turnaround programme that is being implemented, a number of themes were evident in the reports we were reviewing that related to weaknesses in governance and control.
    - Late management responses to internal audit reports
    - Late completion of internal audit actions and continued failure to deliver on revised completion dates
    - Low level of management engagement with the internal auditors to agree findings and actions
    - Out of date policies and a lack of knowledge of what policies we have and their ownership
    - The two internal audit reports reviewed today highlighted a lack of disciplined schedules for review and maintenance of issues leading to a reactive culture, rather than proactive delivery and improvement and a lack of clarity as to responsibility and governance escalation (which board committee has oversight?).
- All of these issues suggest a theme of a culture that lacks a certain precision, ,lacks the focused and timely execution of activity to professional standards and the proactive drive to improve. A discussion is required as to how we can ensure all of the Board committees and the executive committees can drive the discipline and rigour from the top to improve the performance culture of SCAS.

2. Key issues / business matters to raise

- The final Internal Audit progress report for the 2023/24 programme is on plan. Two reports were presented to the meeting – IT Resilience (medium assurance) and Driver Training Compliance (medium assurance).
- The Internal Audit follow-up report on outstanding actions showed slow progress and the executives present confirmed the matter would be on the EMT meeting agenda and they would be completed to the most recent dates provided.
- BDO provided a useful report on Environmental Sustainability planning which will be utilised in the development of the SCAS Green plan.
- External Audit. As requested, Azets and the finance team produced a joint “lessons learned” report regarding the 22/23 Annual Accounts, including audit and

the Annual Report. The committee was assured by the report and will monitor progress at future meetings.

- RSM presented a comprehensive report on counter fraud issues and actions taken in the year with no specific concerns highlighted. Benchmark reports were produced regarding fraud and tender waivers and SCAS compared well.
- Reports on aged debtors/creditors, losses and special payments and tender waivers were presented and reviewed.

3. Areas of Concern and / or Risks

- Policy management was reviewed again and the expected controls and policy to manage policies was not completed and will be reviewed at the December meeting.

4. Items for information / awareness

- The Corporate Risk Register was reviewed and a number of improvements and amendments were noted.
- 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. It was agreed that an additional risk, no 9, should be added in relation to achievement of the recovery program and moving to NOF3 for agreement at the Board.
- A review by the AC of the overall risk management system was requested at the last meeting.

5. Best Practice / Excellence

- The quality of the reports was very good.
- The Annual Accounts lessons learned report showed good collaboration and clarity.

6. Compliance with Terms of Reference

The meeting was quorate and fully attended. The workplan for the year has been further developed to ensure all matters within the remit of the committee are properly addressed within the year.

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:	18th September 2023
Chair of Committee:	Les Broude, Non-Executive Director/ Senior Independent Director
Reporting to:	Board of Directors Meeting 28th September 2023

1. Points for Escalation

- The Committee recommended to the Board of Director a formal notification to Hampshire and Isle of Wight Integrated Care Board (HIOW ICB), in October 23 as part of the Month 6 reporting cycle, to revise the Trust forecast from the current break-even target to a deficit of £38.5m, subject to formal notification of further funding and some non-recurrent expenditure items to address the underlying financial position.

2. Key issues / business matters to raise

- The Integrated Performance Report (IPR) was discussed with recommendation for update for the Board of Directors meeting on 28th September 2023.

3. Areas of Concern and / or Risks

- There was a discussion on the timing of the Committee to allow reflection and reviewing of papers before the meet and allow the committee's effectiveness to be enhanced. The committee has asked that the future dates of the committee to be reviewed and moved to a more suit time to allow papers to be circulated with adequate time for production and review.

4. Items for information / awareness

- The Estates Strategy and Green Plan were discussed, with agreement that these were a good start and recommendations to further sections to added .e.g., affordability. And these then need to go through the due governance process.
- A Digital Update was provided to the committee with a recommendation that this comes back to the Committee and possible inclusion into a Board of Director seminar.

5. Best Practice / Excellence

- The committee on behalf of the board, provided in-depth and focussed scrutiny on the financial numbers and forecast including current run rate and underlying position and is escalating the forecast (note Points for Escalation) change need with challenge on timescales for the recovery plan include one-off items that would be need to address the position and risks associated, with the need for this to be clearly understood.

6. Compliance with Terms of Reference

- The meeting was quorate.

Author: Les Broude
Title: Non-Executive Director/ Senior Independent Director
Date: 20TH September 2023

South Central Ambulance Service NHS Foundation Trust

Summary of Upward Reporting: Issues identified.

Upward reporting from the: **Quality and Safety Committee (Q+S)** **to:** SCAS Trust Board September 2023

Date of meeting: **7th September 2023**

Items for escalation	**Issue**	
None.		
Areas of Concern/Risk	**Issue**	**Action Taken**
1. EPR outage	Continued outage of EPR and reliance on paper systems. Q+S discussed and provided challenge over adequacy of mitigations. No patient safety issues identified so far. Prompt availability of paper records allows review of cases where possible concern. Effect beyond direct patient care noted too, e.g. safeguarding (SG) referrals having to be generated by safeguarding team. Drop in numbers of SG referrals in August, and the number of incidents reported.	Briefing note on this to be circulated to Q+S, and topic to be covered in Quality and Safety paper from Chief Nurse at next board. Risk manager asked to review IT software risk on Corporate Risk Register in light of significant impact of this event and length of time before service restored.
2. Significant operational pressures impacting on response times	Q+S noted that improvement in response times performance earlier in the financial year had not been maintained and a considerable number of actions were being taken to try and improve this. This has resulted in increased long waits, but as yet no increase in the number of harm incidents reported.	
3. ICT risks	Q+S continues to note issues concerning IT hardware, software and resource are impacting on several domains across safety and quality, and the ability to deliver adequate assurance.	Board members are asked to note these concerns.
4. Patient Safety Workstreams update	Q+S noted the summary sheets of progress in the patients safety workstreams: medical devices, safeguarding, patient experience, infection prevention and control, patient safety and the PSIRF implementation programme.	

	○ Zoll compliance remains >90%, but two recent failures had occurred and in one case a secondary AED was not in the vehicle. ○ Safeguarding risks continue to be high due to delays in resolving the IT issues and the impact on level 3 training from recent operational pressures. ○ Good progress being made for establishment of a patient panel and developing additional ways to obtain feedback from our patients. ○ PSIRF programme making progress but need to be aware of operational pressures impacting engagement across the wider organization.	
5. Infection Prevention and Control (IPC) Concerns	The assurance visit report by colleagues from SECAMB was presented and discussed. Q+S raised concerns that some of the points raised in the report suggested possible problems with support for the IPC function. Q+S noted that the report had been discussed in some depth at the IPC Committee and a detailed summary with actions and resolutions of issues raised had been presented to the Executive Management Committee (EMC). Triangulating from various papers to this Q+S meeting there was concern about low compliance with IPC audits, and a mismatch between audit compliance and findings at some recent resource centre compliance visits.	Q+S asked to see the summary presented to EMC. Q+S noted that the EMC are aware of the risks regarding IPC, and these risks are shared across the whole organization, as safe delivery depends on all employees, with expert advice and assurance being provided by the specialist team within the Clinical Directorate.
6. Statutory and Mandatory training	Q+S noted that the report provided did not include trajectories for all face to face training to demonstrate progress, or when SCAS anticipates returning to satisfactory compliance with these key clinical safety training modules. Good progress with increasing compliance for the newer on line training modules noted, but not yet achieving satisfactory levels of compliance.	Chair of Q+S to arrange a discussion with Assistant Director of Education to help clarify what is required to provide assurance.
Items for awareness / assurance	**Item**	**Action taken**
7. Improving the Integrated Quality	Q+S received a presentation on the continued development of the IQPR, and the wish to focus on the Quality and Safety section of the report, to consider which indicators need to be considered at	Q+S noted that the comparison with others provided by Making Data Count was very helpful, but that it is important for SCAS to ensure it considers the right metrics for its own

and Performance Report (IQPR)	Board and which at Q+S; whether indicators currently included in operations and workforce sections such as complaints and training, would be better considered within the Q+S section; what indicators might be missing and how does the SCAS report benchmark against other ambulance trust board metrics. Q+S noted that the continued development of the IQPR depends on key enablers including further training regarding data interpretation and reporting for assurance, and the Business Intelligence function of the Trust and its external providers.	assurance, focusing on those that are a) mandated, b) helping to monitor developments / changes, and c) those that inform about key risk areas. It was agreed that the Deputy Chief Nurse would work with colleagues in the clinical directorate, NHSE Improvement Director and Making Data Count to improve this section of the IQPR for the September / October Board meetings.
8. Q+S committee annual report	Q+S annual report discussed, and approved subject to a few amendments.	Annual report to be presented to Board in September 2023.
9. Infection Prevention and Control Annual Report	Annual Infection Prevention and Control report discussed and approved subject to minor amendments.	Report will be added to SCAS website.
10. Clinical strategy	Clinical Strategy (2023-2028) presented and approved. Widespread consultation over this strategy noted and commended.	Q+S requested that a summary on a page be considered, including an indication of priority actions and timescales, e.g. when improvements would be delivered and how would we know the aims had been achieved.
11. BAF / Corporate Risk Register (CRR)	Q+S discussed the current BAF, Strategic Risks 1 and 2. Improved description of controls, assurance and actions to address gaps in controls / assurance was commended. Q+S noted that CRR Risk 34, Controlled Drugs risk has remained at score of 20 for over 18 months.	Q+S requested that the details provided on actions should also include by when, and what improvements are anticipated. Q+S heard that this relates to being unable to apply for a licence until the new distribution centre is up and running, and then can be inspected for approval, so this risk will remain high until this achieved. (Move to new unit expected October 2023).
12. Quality Impact Assessments (QIAs) of Financial Sustainability Programme	Q+S received a presentation on the QIAs performed so far on items raised as part of the financial sustainability plan. Q+S noted a risk stratified approach was being taken, with very straightforward schemes being given immediate approval after discussion with the Clinical Directorate, and more complex proposals, and those with greater risk being discussed at a panel that is now meeting 3 times a month, to speed progress. Some proposals had been rejected, and others needed additional information.	Q+S noted that the presentation provided assurance of appropriate review of finance savings schemes, and of appropriate involvement of ICS partners, where the impact might fall on another organisation.

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 organisation. 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 upward reports from: ○ Safeguarding (verbal comments only as met 3 days prior to Q+S) ○ Education and Training summary ○ Clinical Review Group ○ Patient Safety and Experience Committee ○ Commercial Division ○ Infection Prevention and Control Committee	Q+S noted that going forward it would receive an Operations report, covering 999, 111 and PTS, aiming to provide assurance regarding quality and safety within the three services, and highlighting key risk and mitigations. The Chief Nurse explained that she had discussed with the relevant Executive Director colleagues and agreed that the operational component would be discussed at Finance and Performance Committee.
Compliance with terms of reference		
15.	Q+S were quorate for this meeting. Q+S covered the standing agenda items and most reports expected from the workplan. Q+S continues to meet bi-monthly. Next meeting: 20 November 2023.	The Clinical Audit Annual Plan is to be discussed at Clinical Review Group before coming to Q+S and will be on the November 2023 agenda.

UPWARD REPORT

Name of Committee reporting upwards:	People and Culture Committee
Date Committee met:	Thursday 21 September 2023
Chair of Committee:	(On behalf of regular Chair) Acting Chair: Sumit Biswas
Reporting to:	SCAS Board, 28 September 2023

1. Points for Escalation

There are no points for escalation to the Board.

2. Key issues / business matters to raise

Received assurance that various retention plans in place, approved (PTS, next week). Ongoing monitoring through Workforce Board. Alert noted that female attrition appears higher, now to be tracked and understood better.

Staffing: 'Stability index' – staff who remain with us more than 12 months is an important predictor across our services. Target 90% (eg currently 88% in 999s).

Further understanding needed on 111 Staffing Plan to provide assurance, without additional data necessarily.

We recognised the centrality of People Voice work to our SCAS-wide culture change efforts, and need to make sure wide visibility of this – beyond PACC. A helpful framework on the feeds, process and channels was shown and discussed by the committee.

PTS morale challenge noted, exacerbated by contract uncertainty. HR Team response has been to shape an 'engagement plan'.

Greater clarity was requested on how we are 'closing the loop' on changes – helping awareness and behaviours with staff.

Education: The Committee was assured about progress following the BDO Audit on education and that we were close to concluding on the two outstanding follow-up actions.

3. Areas of Concern and / or Risks

Workforce data indicates staff attrition risk is under plan for several months across service lines.

More to be done to confirm attrition data - trend solidity, SPC assurance, explainability - before we might reduce the risk. If continuing resultant positive benefit to SCAS staffing is significant.

DBS compliance data being checked, possible anomalies surfaced.

Recruitment somewhat behind, but attrition lower than expected – so net position (staff in post) is close to plan. We understood that planned staff levels includes allowance for expected vacancies.

Stat and Mand training – this risk is being watched in case of deterioration due to recent pull back on training.

EDI: We were briefed on the new framework arriving (EDS3) but (a) data standards set nationally preclude ideal presentation of data (b) we need a keen focus in our action plans on why we are not improving as much as we would like.

Committee requested a specific update on the plan and how we are updating the drivers as part of RES and WDES action planning.

4. Items for information / awareness

Education: Recent Education Ofsted visit in September – whilst anecdotally feel went well, we await the report, due in the next 30 days or so.

EDI: Networks – PACC was interested and requested to understand progress of the staff networks on occasional basis (strength, participation, any support needed). Some replacement Chairs to be appointed.

Education: The Committee approved the Education self-assessment submission and were provided assurance that supporting information was available if needed.

5. Best Practice / Excellence

We welcomed:

- National awards received for the work of our LGBT Network.
- Big push to reach staff. Creation of a “Health MOT Check” initiative very well received. 50 attendees so far, PTS Sussex the most popular area.
- Did Not Attend rate on Occupational Health bookings has been halved, to both staff and financial benefit.

6. Compliance with Terms of Reference

Overall, improving papers, but more to be done on framing the content/delivery as assurance.

The work of the Committee was in line with its Terms of Reference.

The meeting applied considerable time onto those high priority SCAS risks which apply to this Committee. A monthly review of the BAF risks is in place with the Chief People Officer.

Sumit Biswas, Acting Chair
People and Culture Committee
21 September 2023

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	SCFS LTD
Date Committee met:	13 September 2023
Chair of Committee:	Mike McEnaney
Reporting to:	SCAS Public Board 28 September 2023

1. Points for Escalation

There are no points for escalation to the Board.

2. Key issues / business matters to raise

Double crewed ambulance vehicle off road (VOR) rate for the last six months exceeded the SCFS target of 18%, with an average VOR of 20.08%. this is mainly due to an ageing fleet as a result of delayed delivery of the replacement Fiat vehicles.

The August YTD operating financial position on an external reporting basis is a surplus of £245k, above the budget expectation of £84k.

Recruitment and retention of technical staff remains a problem leading to the utilisation of external services and impacting the VOR.

Improvement activities are being progressed to reduce the off road time with regards pick-up and return.

3. Areas of Concern and / or Risks

The Board reviewed and discussed the three red risks on the risk register:

- If there is disruption or delays to the supply chain, then there is a risk that SCFS will not be able to effect repairs or replacements in a timely manner resulting in delays to servicing and poor vehicle availability for the customer.
- If planned replacement vehicles do not arrive in line with capital plan then SCAS is at risk of increased vehicle downtime and increased costs resulting in lost unit hours, delay to reduction in age profile and increased operating costs.
- If SCFS are not seen as an employer of choice, then there is a risk that SCFS will be unable to recruit staff resulting in an inability to service vehicles.

The Board were assured that the risks were being managed.

4. Items for information / awareness

The Board discussed the SCFS Ltd Annual Planning 23/24 and SCFS Business Revenue Model. The Board noted the Draft Statutory Financial Statements Year ended 31st March 2023 and HR Board Report.

Overall SFCS is stable and working to improve the efficiency of its operational delivery. It has been requested that performance and cost is benchmarked with outside providers to confirm tht value for money is being provided to SCAS.

5. Best Practice / Excellence

The Board provided in-depth and focussed scrutiny on the financial numbers and operational performance and recognised that the reporting and analysis is developing well.

6. Compliance with Terms of Reference

The Board was quorate and well attended by relevant colleagues.

Author: Mike McEnaney

Title: SCFS Upward Report

Date: September 2023

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