South Central Ambulance Service
NHS Foundation Trust

Council of Governors meeting

DATE: Wednesday 31 January 2024
TIME: 6.30pm – 8.50pm
VENUE: **Shaw House, Communities and Wellbeing, West Berkshire Council Shaw House, Newbury, RG14 2DR**

Item		Action	Time
OPENING BUSINESS			
1	**Chair's Welcome and Apologies for Absence** Keith Willett	**Verbal** **To Note**	6.30
2	**Declaration of Interests** Keith Willett	**Verbal** **To Note**	
3	**Minutes from Meeting on 4 October 2023** Keith Willett	**Page 4** **To Approve**	
4	**Action Log** Daryl Lutchmaya	**Page 14** **To Note**	
ACCOUNTABILITY FOR BOARD PERFORMANCE			
5	**Chief Executive's Report** David Eltringham	**Page 16** **To Note**	6.40
6	**Improvement Plan Update** Mike Murphy	**Verbal** **To Note**	6.45
7	**Fit for the Future Programme** Paul Kempster	**Verbal** **To Note**	6.50
8	**Hampshire Together** Elizabeth Kerwood	**Page 21** **To Note**	6.55
9	**Questions from Governors** All	**Verbal** **To Note**	7.25
COMMITTEE UPDATE			
10	**Membership and Engagement update** Mark Davies, Margaret Eaglestone	**Page 66** **To Note**	7.35
ANNUAL BOARD COMMITTEE REPORT			
11	**People and Culture Committee Report** Ian Green	**Page 74** **To Note**	7.40
12	**Quality and Safety Committee Report** Anne Stebbing	**Paper 79** **To Note**	7.45
ITEMS FOR DISCUSSION & NOTING			

Item		Action	Time
These items will be taken as read. Executive Directors will provide any verbal updates as required. Questions from Governors should be submitted to the Company.Secretary@scas.nhs.uk mailbox 24 hours before the meeting.			
13	**Executive Director Updates:** **a) Financial Performance** Stuart Rees **b) Peoples Directorate** Melanie Saunders **c) Quality Directorate** Helen Young **d) Digital Directorate** Craig Ellis **e) Operations Update – 999,111 & Other** Paul Kempster **f) Governance** Daryl Lutchmaya	**To Note** **Page 86** **Page 91** **Page 93** **Verbal** **Page 103** **Page 114**	7.50
14	**Urgent Care/111 Briefing** Ruth Page	**Page 118** **To Note**	8.05
15	**Patient Panel Update** Nikhyta Patel, Anna Clarkson	**Page 134** **To Note**	8.15
Executive Directors to leave			
COG OPERATIONS			
16	**Lead Governor's Report** Helen Ramsay	**Page 146** **To Note**	8.25
17	**NED Report** Mike McEnaney	**Page 150** **To Note**	8.30
CLOSING BUSINESS			
18	**Any Other Business** Keith Willett	**Verbal** **To Note**	8.35
19	**Questions from Members/Observers** Keith Willett	**Verbal** **To Note**	8.40
20	**Review of Meeting** Keith Willett, All Governors	**Verbal** **To Note**	8.45
21	**Date and Time of Next Meeting** Keith Willett **Wednesday 3 April 2024, Venue TBC**	**Verbal** **To Note**	8.50

Please note that some of these agenda items were received by the Trust Board on 25 January 2024.

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

Minutes
Council of Governors Meeting

Date: Wednesday 4 October 2023
Time: 6.30pm - 9.00pm
Venue: MS Teams

Governors present
Helen Ramsay (Lead Governor, Public- Oxforshire); Andy Bartlett (Public Governor – Hampshire); Loren Bennett (Staff Governor); Rachael Cook (Staff Governor); Anne Crampton (Partner Governor - LA); Mark Davis (Deputy Lead Governor and Public Governor – Berkshire); Claire Dobbs (Partner Governor – Air Ambulance) Tim Ellison (CFR Governor, Romsey); Hilary Foley (Public Governor – Hampshire); Mike Charles (Governor-Buckinghamshire); Stephen Bromhall (Public Governor – Buckinghamshire); Charles McGill (Public Governor – Hampshire); David Luckett (Governor-Hampshire); Tony Nicholson (Public Governor – Hampshire); Alan Weir (Staff Governor) Cllr Barry Wood (Appointed Governor); David Wesson (Public Governor- Oxfordshire); Ian Sayer (Staff Governor); Loretta Light (Public Governor- Oxfordshire).

Governors not in attendance
Mark Perryman (Public Governor – Hampshire); Graeme Hoskin (Appointed Governor); Andy Bartlett (Public Governor- Hampshire); Tariq Khan (Staff Governor).

Executive Directors/Others in attendance
Professor Sir Keith Willett CBE (Chair); Sumit Biswas (NED and Deputy Chair); Nigel Chapman (NED); Les Broude (NED); Mike McEnaney (NED); David Eltringham (Chief Executive) item 1-5 only; Professor Helen Young (Chief Nurse Officer); Mike Murphy (Chief of Strategy); Daryl Lutchmaya (Chief Governance Officer); Melanie Saunders (Chief People Officer); Paul Kempster (Chief Operating Officer); Dr John Black (Chief Medical Director); Mark Ainsworth (Director of Operations); Stuart Rees (Interim Director of Finance); Steve Clarke (Senior IMT Business Manager); Nora Hussein (Interim Assistant Trust Secretary); Susan Wall (Corporate Governance & Compliance Officer); Margaret Eaglestone (Membership and Engagement Manager).

Directors / Executives' apologies received.
Aneel Pattni (Chief Finance Officer); Dr Anne Stebbing (NED); Dhammika Perera (NED); Ian Green (NED).

Observers
There were no observers at the meeting.

Item No.	Agenda Item
1	**Chair's Introduction, including Apologies for Absence** The Chair welcomed everyone to the meeting and noted apologies for absence as above. He informed the Governors that the Chief Executive Officer had Covid-19 and so he would present his report and leave the meeting. He also informed the Governors that most of the meeting papers had been presented to the SCAS Trust Board meeting on 28 September 2023.
2	**Declarations of Interests**

	No declarations of interest were received.
3	**Minutes of the meeting held on 31 July 2023** The minutes of the meeting held on 31 July 2023 were **approved**, subject to minor editorial amendments which would be addressed following the meeting: • 6. Improvement Plan update- duplication in wording to be amended **Action 1: Chair to raise at the Stakeholder Oversight Committee Governor involvement within the ICS and that exit criteria to have a strategic focus.**
4	**Action Log** The Council of Governors Action Log was noted. It was agreed to close: • Action 3 - A briefing session on urgent care pathways and on clinical assessments at 111 to be provided to the Governors. Scheduled to be presented at the Autumn Workshop 2023. • Action 4 - Assistant Company Secretary to take forward the arrangements for patient stories be available to the Governors via their portal. Governor Portal now working and Board Patient Story content will be uploaded if received. It was noted that normally it was a verbal report). • Action 5 - There was a request to share the external audit findings on value for money to be circulated to the Council of Governors. On the agenda item 8.
5	**Chief Executive's Report** The Chief Executive Officer informed the Governors that he had spent considerable periods of time out and about working alongside staff and publishing a 10 Point Plan. The Chief Executive highlighted: **Modernisation Programme:** SCAS had 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 SCAS cares for. Whilst recovering its financial position and ensuring optimal operational performance are certainly two of the key drivers for reforming the organisation, SCAS needs to take measures to future proof services, taking account of economic factors, sustainability and environmental responsibilities and changing societal needs. **Electronic Patient Record outage**: SCAS clinical, educational, operational and digital teams have been continuing to work together over the last few weeks to test the Ortivus ePR functionality in advance of a decision to resume services. Operationally, the decision has been taken that all terminals within all Acutes must pass testing prior to the 'go-live'. **Lucy Letby:** 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 SCAS responds 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 Fit and Proper Person Framework and the revised Freedom to Speak Up (FTSU) policy based upon new NHSE guidance. **Operational Performance:** Following a challenging June performance, SCAS saw this continue into July with an category 2 performance at 33 minutes 10 seconds, however there has been 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 were then supported

with short and medium term actions to develop a more sustainable level of operational hours to meet the 999 response demand.

Finance: The Trust's forecast outturn is £38.5m deficit. The forecast deficit has increased by £2.6m from month 4, 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.

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.

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

Level 3 face to face Safeguarding training was suspended for two weeks during the reporting period to release capacity and support operational performance.

There had 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.

People: Following the launch of the Trusts People Strategy; progress against the objectives set for the first 6-18 months of the Strategy include:

- "People Voice" feedback channels have been agreed and a process for collating data, triangulating, acting on feedback and governance is in place. We now need to demonstrate action on feedback and impact.
- Leadership programmes continue, with new modules including the collation of facts investigation training.
- Wellbeing conversation workshops and education are in place.
- Winter wellness pack has been launched, including QR code sticker on vehicles to improve signposting to H&WB portal. A Financial wellbeing guide has also been launched.
- Additional mental health and physio support is available.

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: 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 NHSE National Executive Team met 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. **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. A request was made by an Appointed Governor to receive further information of the Modernisation Programme and changes of the service model to present at the Hampshire and Isle of White Local Government Association. The Chief Executive Officer responded that headlines could be provided. A question was received from an Appointed Governor regarding the £38.5m deficit forecast and what would happen when it becomes the likelihood. The Interim Director of Finance responded that the underlying position would roll over into the following year (2024/25), and that it would remain to be corrected. He further explained that if the position was at £0 cash, then money would be borrowed with the appropriate permissions paid back with £3.5% interest. The Lead Governor thanked the Chief Executive Officer for the detailed report and questioned whether the modernisation work lent itself following on from the Governor Strategy Workshop earlier in the year. The Chief Executive Officer explained that in terms of the building blocks, listening exercises and numerous engagement events have been carried out around the strategy, attaining a "you said" and "we are doing…" roadmap. He explained that all feedback from voices of staff and Governor engagement work is being incorporated into the strategy. **Action 2: The Chief Executive Officer requested that the Modernisation Programme be added as a standing item to the Council of Governors Agenda.** The Council of Governors **noted** the report. *The Chief Executive Officer left the meeting.*
6	**Improvement Plan update** The Chief Strategy Officer welcomed questions from the Council of Governors. In relation to the SCAS Improvement Programme Must do/Should do relating to governance a Public Governor requested assurance on what must be done and when referring to the red action against governance. The Chief Governance Officer responded that there are two aspects to this, firstly Regulation 17 that details managing the risks at the Trust, explaining that over the last few months work has commenced on this and that there is a new SharePoint system in place that flags internal risks on the risk register allowing consideration of risks at Committee and Executive Director level. Secondly, he explained that there is a Risk Management Framework and Risk Management Policy that will be presented next week at the Risk and Compliance Committee which once approved will be presented for approval at the Executive Management Committee and then submitted to Audit Committee as a live document. The Chief Governance Officer informed the Council of Governors that he envisaged that the time frame on delivering this is approximately 6 – 8 weeks and that there is a new refreshed

	Board Assurance Framework (BAF) that is more robust and considered at all the Committees with Executive ownership. He also informed the Council of Governors that flow of information is flowing up through the correct channels via Committees and Board. He explained that as the Governance Team expands further work will accelerate. The Council of Governors **noted** the update.
7	**ICB Update** The Chief Strategy Officer informed the Council of Governors that work alongside ICB partners continues and that there is currently the Modernizing Our Hampshire Hospitals Programme of activity, which relates to looking at the new hospital build in the Basingstoke area. He informed all that work continues with the developments of the Isle of Wight and Healthcare that is provided and work continues to move forward in partnership with Isle of Wight Ambulance Trust. He went to explain that from a system perspective SCAS is very heavily engaged with all of the systems that are involved with winter planning and contract discussions and negotiations that are ongoing and but also with Hampshire and Isle of Wight. He also informed them that SCAS continues to build all on relationships across the ICB and that it is also working very closely with some of its other partners within those as well e.g developing an Adult Critical Care Transfer service with South East Coast Ambulance Service (SECamb). He also updated that SCAS is also looking at other partnership opportunities and in discussion with local acutes with regard to Patient Transport Services and how to operate the service in a more efficient and more effective manner. He explained that there is a risk with these things and that it is reflected on the BAF which is that SCAS might not have the time or the capacity to engage appropriately with systems due to a very large footprint and have 4 ICB's that it needs to engage with. He reflected that there is still a significant challenge, but a lot of good work is happening going on, that SCAS is engaged in. An Appointed Governor questioned who the possible partnership opportunities are with. The Chief Strategy Officer responded that there are opportunities within acutes and the Community Trust. The Chair added that there is a lot of stakeholder opportunities available, and a lot of the acute trusts are getting into partnerships, and that the ICB's are working across them to share resources in financing, HR in logistic supplies starting to merge and making joint appointments, merge sectors, and merge directorates across different organisations. A Public Governor commented that it was good to see the good work and not so good work in partnership working. The Council of Governors **noted** the update.
8	**Follow up on External Audit Findings** The Interim Director of Finance informed all that following the sign off of the financial statements a qualified opinion from the External Auditors was received on the Remuneration and Staff Report. He explained that Value for Money had received a satisfactory opinion

	however the auditors had provided commentary that identified significant weaknesses on arrangements for securing economic and efficient use of money. He explained that it had been agreed to go through the plan which would include the accounts and annual report in detail at Audit Committee, identify owners and produce a checklist. The Chief Governance Officer added that in relation to governance weakness BAF version 9 is being developed that will address the risks pertinent to the improvement programme. He explained that by internalising the risks relevant to the improvement programme into BAF addresses the significant weakness. He also added that there is oversight by the Executive for the Improvement Programme Oversight Board, which feeds into the Executive Management Committee and up to the Board. An Appointed Governor commented that some of the comments within the External Audit Report were not expected and not assuring particularly around there being no medium-term financial plan. The Director of Finance responded that the Council of Governors should be assured that this is being taken seriously by Executive Directors and Non- Executive Directors and that actions are being followed up at Committees. He also informed them that there is a planned Extraordinary Audit Committee to review the financial plan and that a three-year financial recovery plan will be presented to the Board, which is very much based on recurrent underlying savings, not non recurrent savings. He informed all that work on the medium-term financial plan has started but it not yet complete, he explained that the underlying position and service levels of costs have been identified however the work will not be completed until all of the financial plans have been completed. Regarding the comment on no ownership of the Annual Report he informed all that a plan will be put in place of areas of work breaking it down to owners. The Chief Governance Officer responded that the Chair of Audit Committee have requested a plan going forward that enables a high level of control and assurance. The Chair of the Audit Committee informed the Council of Governors that the comments of the External Auditors are being included within the Audit Committee workplan, and that the issues raised are being addressed and assured that they won't happen again. The Chair of the Finance and Performance Committee informed all that the Committee is discssuing how to get SCAS to a break-even position with the support of the Interim Director of Finance. He reflected that the position is not good and that SCAS cannot continue this way. A Non- Executive Director commented that if there is no robust plan, then SCAS can not expect support from NHS England. The Council of Governors **noted** the update.
9	**Questions from Governors** It was agreed that the Council of Governors would ask questions during each agenda item.
10	**Membership and Engagement update** The Deputy Chair of the Membership and Engagement Committee (MEC) informed all the Terms of Reference had been updated and highlighted that it will now be two terms of three years for a Governor to sit on the MEC. She welcomed expressions of interest to be sent to the Membership and Engagement Manager for those wishing to sit on the MEC. She also encouraged all Governors to support SCAS Public and Staff Elections 2023, and also to submit suggestions for Your Health Matters public talks.

	The Council of Governors **noted** the update.
11	**Finance and Performance Committee Report** The Chair of the Finance Performance Committee highlighted the Committee formed in March 2023 and informed all that it had been focused on looking at the one- and three-year financial plan to reach a break-even number. He also informed all that a considerable amount of time had been spent on the Integrated Performance Report which will be presented at the next SCAS Trust Board meeting. He also highlighted that it is a broad Committee covering many areas such as digital and estates. The Council of Governors **noted** the report.
12	**Financial Performance Report** The Interim Director of Finance welcomed questions from the Council of Governors. A Public Governor questioned how SCAS had reached its financial position. The Interim Director of Finance responded that an analysis was carried out up to 2019/20 to 2022/23 to understand the movement each year and in between them to where SCAS is now. He explained that three services 1st, 999111 and PTS income did work across their areas over the years, but costs went up in excess of those income received at the funding. He also explained that Corporate Services costs rose by 46% over that period, this could not be seen as there were non-recurrent items. The Chair thanked the Interim Director of Finance for his diagnostic work and reflected how the figures were not identified by External Auditors. The Lead Governor questioned whether there was any best practice or learning to share with other Trusts to decrease the chance of this happening elsewhere. The Chair responded that there is a Recovery Support Programme that meet with the national team and open frank conversations are held. He also commented that the Health Service Journal (HSJ) had published an article on SCAS, and that the SCAS Trust Board has been transparent at all Public Board meetings. The Chair of the Finance and Performance Committee are working to ensure that the improvements made are recurring as much as possible. The Council of Governors **noted** the report.
13	**People Directorate Report** The Chief People Officer presented an overview of the People Strategy and provided an update on where SCAS are against delivery of the People Strategy. A Non-Executive Director commented that there is huge activity within the culture work and felt assured that staff voices are being heard. He also informed the Council of Governors that the People and Culture Committee scrutinised the head count at its last Committee and spent some time discussing Equality Diversity and Inclusion. A Non- Executive Director also commented that he felt assured as a Non-Executive Director of the People Strategy delivery and the sensible KPI's. he commented that SCAS should be realistic about what it can achieve and what can done about attrition as attrition. A Public Governor questioned whether the sexual harassment cases were picked up by freedom to speak up. The Chief People Officer responded that following the new allegation

	management process within the safeguarding team cases are now managed jointly between HR and Safeguarding. She explained that once an allegation is received there is a tripartite review of that allegation and it is determined how best to move forward. The Chief People Officer informed the Council of Governors that allegations are received by freedom to speak up, safeguarding and grievance, and stated that they would all be treated the same way. The Chair of the People and Culture Committee assured the Council of Governors that succession planning is on the workplan of the Committee. The Council of Governors **noted** the report.
14	**Quality Directorate Update** The Chief Nurse informed the Council of Governors that there is an ongoing issue in relation to safeguarding referrals that have occurred because of the EPR outage. She also informed the Governors that there were 50 cases were there was potential harm to have a client could have occurred because of the delay, but that there were effective mitigations around that. A Public Governor questioned if it has been identified how to avoid potential harm occurring again in the future. The Chief Nurse responded that in the interim, staff make the referrals directly through their Team Leader when they get back to base or approved approach that they have in their team. The Council of Governors **noted** the report.
15	**Digital Directorate Update** The Senior IMT Business Manager informed the Council of Governors that the date for reinstalling EPR is 10 October 2023, and explained that it is currently being tested with an acute trust. He explained that a submission is required to NHS Digital before going live. **The Lead Governor requested that Data Security Protection Toolkit could be made available to Governors. Action 3.** The Lead Governor questioned whether there are any KPI's for the digital piece that could provide assurance to the Governors. The Senior IMT Business Manager responded that currently there is very limited if any KPI's. he informed the Governors that this would change within Digital planning. A Non- Executive Director informed the Council of Governors that a Digital Report is being reported to the Finance and Performance Committee, which has provided assurance to the Non-Executive Directors. A Public Governor and Chair of the National Ambulance Digital Group requested to be sighted on the accreditation of the Data Security Protection Toolkit. The Council of Governors **noted** the update.
16	**Operations Update - 999, 111 & Other** The Chief Operating Officer welcomed questions from the Council of Governors. The Chair commented that the operational plans that were put together and all the work that has been done leading into the year were based on what was required to do, which was to assume a very limited or no growth in demand and the hospital handovers would occur at a certain rate. He reflected that both of those have turned out to be on the wrong side, and that it was going to be a challenging winter.

	The Council of Governors **noted** the report.
17	**Governance Directorate Update** The Chief Governance Officer gave a brief update on the Governor Elections 2023 and the implementation of the Fit and Proper Person Framework. A Public Governor requested regular briefings on SCAS news. The Chief Governance Officer responded that all news and updates will be made available o the Governor Portal that is now working. Governors were informed to contact the Governance Team if they were unable to access the Governor Portal. The Council of Governors **noted** the update. *Executive Directors left the meeting at this point, the Chief Governance Officer remained in the meeting.*
-	A question was received from a Public Governor regarding the historic International Partnership Agreements. A Non-Executive Director responded that the partnerships had now ceased whilst SCAS works to improve its own service. The Chair shared that there was a Young Ambulance Citizens Programme, and that further information could be obtained via the Communications Team.
18	**Lead Governor's Report** The Lead Governor presented an update highlighting the activities carried out within the past three months. The Council of Governors **noted** the report.
19	**NED Report** Non-Executive Director Les Broude provided an update that detailed his role at SCAS, and meetings attended as well as activates that he had participated in. Within his presentation he highlighted his views of areas of opportunity and challenges within SCAS. The Council of Governors **noted** the report.
20	**Council of Governor's Development Action Plan** The Chief Governance Officer informed the Governors that a new Council of Governor's Development Action Plan is being developed and will be shared with the Lead Governor for comment. **Action 4.**
21	**Any Other Business** A Public Governor requested that the Non-Executive Directors look into format of findings/reporting and align. He also commented that the Council of Governors papers were the same as the SCAS Public Trust Board Papers. Comments were received that given the current pressures of the Executive Directors and the close time frame between SCAS Public Trust Board and Council of Governors meeting it was reasonable to use the Board papers for Council of Governors meeting, allowing opportunity of questioning Non- Executive Directors and Executive Directors.

	A comment was received that the papers contained too much detail and that Council of Governor papers should be more succinct. The Chief Governance Officer responded that he would look to reduce the size of the meeting papers. The Chair informed the Governors that the Executive Directors must be supported and not expected to prepare separate reports in order to allow them to deliver their improvement work.
22	**Questions from Members/Observers** There were no questions.
23	**Review of Meeting** There was no review.
24	**CoG Forward Planner** The Council **noted** the CoG Forward Planner.
25	**Date and Time of next meeting** Wednesday 31 January 2024.
-	The meeting closed at 8.50pm.

Council of Governors Meeting 31 January 2024

Key for Status

Action No.	Agenda Item & No.	Detail of Action	Action Owner	Due Date	Status	Progress Update
1	5.Chief Executive's Report	Chair to raise at the Stakeholder Oversight Committee, Governor involvement within the ICS and that exit criteria to have a strategic focus.	KW	31/01/24	Propose to close	Raised at ICS level in BOB and HIOW.
2	5.Chief Executive's Report	The Chief Executive Officer requested that the Modernisation Programme be added as a standing item to the Council of Governors Agenda.	NH	31/01/24	Propose to close	Added to Forward Plan
3	15. Digital Directorate Update	The Lead Governor requested that Data Security Protection Toolkit could be made available to Governors.	SC/BT CE	31/01/24	Propose to close	Sent on 26 January 24.
4		KPI's and milestones for the enabling plans to be shared with the CoG.	MM	3/04/24	Open	KPI's and milestones will be available at the end of the financial year and the conclusion of the budget cycle. 4/10/23 Board Seminar on strategy/annual cycle of business and annual work plan training in March/April 24 to plan KPI's and milestones.
5	20. Council of Governor's Development Action Plan	The Chief Governance Officer informed the Governors that a new Council of Governor's Development Action Plan is being developed and will be shared with the Lead Governor for comment.	DL	3/04/24	Open	The new action plan will be presented at the April meeting.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Chief Executive Officer's Report
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	5
Executive Summary:	The purpose of the CEO report is to keep the Council of Governors updated on key events and messages not covered elsewhere on the agenda The CEO report contains the following: ▪ Site visits and engagements undertaken ▪ Fit for the Future ▪ Operational performance and handover delays ▪ SCAS Charity ▪ Council of Governors elections
Recommendations:	The Council of Governors are asked to note the report.
Accountable Director:	David Eltringham, Chief Executive Officer
Author:	Daryl Lutchmaya, Chief Governance Officer
Previously considered at:	n/a
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable

Justification of Assurance Rating:	Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	n/a
List of Appendices	

Meeting Report

Name of Meeting	Council of Governors Meeting
Title	Chief Executive Officer's update
Authors	Daryl Lutchmaya & Gillian Hodgetts
Accountable Director	David Eltringham, Chief Executive Officer
Date	31 January 2024

1. Purpose

The purpose of this CEO Report is to keep the Council of Governors abreast of key issues and developments

2. Background and Links to Previous Papers

This update is based on information relating to December 2023.

3. Executive Summary

The CEO Report includes the following:

- Site visits and engagements undertaken
- Fit for the Future
- Operational performance and handover delays
- SCAS Charity
- Council of Governors elections

Site visits and engagements

urin ece er I have undertaken the following visits:

5th December: Strategy Refresh Day: Adderbury / Northern House
6th December: Ride out from Milton Keynes Blue Light Hub
20th December: Reading Resource Centre
21st December: Queen Alexandra Hospital
28th December: John Radcliffe / Northern House
29th December: Queen Alexandra Hospital / Winchester and Eastleigh Resource Centre / Southern House
31st December / 1st January: Ride out/night shift from Oxford City
4th January: Queen Alexandra Hospital
11th January: Reading Resource Centre

SCAS Strategy relaunch: 'Fit for the future'

I joined the Trust in March 2023 and embarked on a programme of engagement to get to know the organisation and some of its challenges. In June, a 10 Point Plan was published aimed at getting the organisation to focus on getting the basics right, which sat alongside a review and reconnection exercise with the long-term strategy. In August, an operational recovery and improvement plan was presented to NHS England which the Trust adapted into both a finance and performance recovery programme. All of this, combined with the Trust's ongoing improvement programme (launched as a result of the 2022 Care Quality Commission report) has led to the development of a comprehensive operational modernisation programme to make SCAS 'fit for the future'. Paul Kempster, Chief Operating Officer, was appointed on 1 October 2023 to oversee this programme which will deliver this change, taking up the newly created role of Chief Transformation Officer. Mark Ainsworth joined the Executive Team as Executive Director of Operations and brings a wealth of experience into the team to lead on day-to-day operations.

Strategy relaunch sessions were held on Tuesday, 5 December which were supported by our bi-monthly webinars on the 'Fit for the Future' Programme. Keith Willett SCAS Chair, Executive Directors and I were supported by the Communications Team and visited sites across SCAS and engaged with staff to relaunch the SCAS vision and strategy 2024-2029. This followed on from a number of engagement events that were held over the summer, when I talked to staff across the Trust, identifying challenges as well as areas of good practice.

Operational Performance and Hospital Handover Delays

The HIOW CEOs meet frequently to discuss operational performance that can have an impact on patient safety and ambulance response times. Delayed handovers are recognised as being a system-wide issue and each organisation in the system is required to contribute to helping solve the problem. In future, the system will aim to become better at managing the issues that are contributing to flow and discharge of patients. System leaders are also becoming more involved in the system wide problem.

We are now also engaging with partners to assist with system transformation and partner development which includes participation in:

- HIOW Urgent Care Board and transformation programme
- Local and Place based discussions
- Providing tactical and strategic command training to system leaders

SCAS has regular meetings with the Acute Trusts to understand the causes of handover delays and provides a weekly report to the Integrated Care Boards. The Trust has written to hospitals stating that it will leave patients with the hospital once an ambulance has been waiting for longer than 30 minutes. Hospitals have responded by seeking to make more capacity available at their emergency centres in order to accommodate this as best as possible.

Hospital Liaison Officers have been embedded at various hospital sites to help patient

flow and enabling more efficient patient handovers. They will undertake front door audits to assess the situation as it develops and manage handover delays. Some Hospital Liaison Officers have become embedded within the hospitals' senior management team in order to assist with finding non-emergency department pathways to assist with flow. Through discussion with Queen Alexandra Hospital, we have now placed a paramedic at the hospital who is in embedded to focused on pathways and patient flow.

The Executive team is focused on working to improve ambulance response performance by managing its resources to best effect and anticipating and managing blockages to flow. This is achieved through daily Executive Huddles to review the previous evening's performance and to analyse the performance data to best clinical and operational effect. Whilst these meetings focus on the approach to the day given the previous days' activity, discussion also focusses on the approach and risk for the rest of the week and how the team engages with partners to communicate this. The Executive team also meets on a weekly basis to take decisions relevant to the Trust's current and future operational, clinical and financial position.

The Trust is developing a scorecard of operational Business Intelligence data, drawn from our existing data repositories to allow performance data to more effectively inform decision making and to capitalise on opportunities to drive improvements.

Charity

South Central Ambulance Charity has been shortlisted in the Charity of the Year category for the Thames Valley Business & Community Awards. Our Charity is one of seven shortlisted. These awards celebrate the achievements of businesses, charities and inspirational individuals throughout the region. The awards ceremony will take place on Thursday 25 January at the Hilton Hotel in Reading. The SCAS Charity will be represented at the awards by Volunteer Manager Sarah Callaghan and Community First Responder Nikki Holt. Being shortlisted for this award is a credit to our Charity team but also to the many staff and volunteers who enable the Charity to support patient care.

Elections

I'm pleased to announce that we have had a successful outcome for the Council of Governor elections. 13 constituency seats were elected unopposed, and two seats were successfully filled for the Berkshire constituency. Only three seats are currently unfilled, one in Oxfordshire and two in the staff constituency. The Chief Governance Officer is currently exploring options to fill the vacant seats.

Recommendation

The Council of Governors are invited to **note** this report.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Consultation on proposed changes to acute hospital services in Hampshire
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	8
Executive Summary:	**1 Introduction** Hampshire and Isle of Wight Integrated Care Board is consulting on proposals for changes to services provided by Hampshire Hospitals NHS Foundation Trust (HHFT). We are delighted to be included in the government's national New Hospital Programme. It is a once-in-a-generation opportunity to invest between £700 million and £900 million to improve hospital facilities and hospital services for decades to come. The money will help transform the care and treatment patients receive. It will enable us to meet the changing needs of our growing and ageing population, attract and retain the best staff, provide better and more consistent care, help people stay healthy for longer, and – crucially – provide safe, sustainable, high-quality services for the future. We want to do this by creating two excellent acute hospitals; with significant investment in refurbishing the Royal Hampshire County Hospital in Winchester, and by building a brand-new specialist acute hospital on either the existing Basingstoke and North Hampshire Hospital site, or at a new location near Junction 7 of the M3. We have worked together with patients, local communities, and health and care staff to develop proposals for how we might best use this significant investment. We are now undertaking a public consultation on the proposed options. The consultation began on 11 December 2023 and will run for 14 weeks until midnight 17 March 2024. Accompanying this paper is the summary and full consultation document, providing more detail on the proposals.

2 Rationale for change

There are four key reasons why we are proposing changes to services, rather than simply building a new hospital and continuing to provide services in the same way as now:

- our population is growing and getting older, meaning healthcare needs are changing.
- duplicating services across two acute hospital sites means we can't always consistently deliver great care, because resources – particularly specialist staff – are spread too thinly. This isn't sustainable.
- many of our hospital buildings are approaching the end of their usable lives.
- we are facing a worsening financial position. Money spent on duplicating services and patching up old buildings is money that can't be spent on improving patient care.
-

Pages 10 to 13 of the full consultation document provide more detail on the case for change.

3 The options for consultation

We are consulting on three options for the future of acute hospital services in Basingstoke and Winchester.

In all options there would be:

- a **new specialist acute hospital** that would provide specialist and emergency care, such as strokes, heart attacks, trauma (treating life and limb threatening injuries), emergency surgery, obstetrician-led (specialist doctor) maternity care and a separate children's emergency department. Depending on the option, this would be located either on the site of the current Basingstoke hospital (Option 1) or near to Junction 7 of the M3 (Options 2 and 3)
- **significant investment in Winchester hospital** which would focus on planned operations and procedures and provide a 24/7 doctor-led urgent treatment centre that would see and treat around 60% of the patients who currently go to Winchester A&E, same day emergency care services, doctor-led inpatient beds for care of the elderly and general medicine, and a midwife-led maternity services and birthing unit
- **day-to-day hospital services** for example, clinic appointments, tests, x-rays, scans, and appointments with physiotherapists, occupational therapists or other members of the healthcare team provided at Winchester hospital and the current Basingstoke hospital site, as well as at the site near to Junction 7 of the M3 if either Option 2 or Option 3 is chosen.

Under Option 3, there would also be some nurse-led step-down reablement and rehabilitation beds at the current Basingstoke hospital site.

	The options are set out in detail on pages 26 to 29 of the full consultation document. **4 Potential impact on other providers** In developing our proposals for consultation, we have considered the potential impact on other providers, including South Central Ambulance Service (SCAS). While we know that the decision about which hospital a patient is conveyed to is not based solely on which is nearest (for example we know consideration is given to journey times as well as distance to hospital, waiting times in emergency departments and the specialist services available at particular hospitals), our proposals could impact on SCAS because of longer journeys for some patients. There may also be more patients who would need to be transferred between hospitals by ambulance, for examples people who need to go from Winchester hospital to the new hospital for more specialist care. We have been, and will continue to, work with SCAS (and other nearby providers of acute hospital services) to understand the potential impact our proposals could have on the service, and how this could be mitigated.
Recommendations:	The Council of Governors are asked to discuss.
Accountable Director:	
Author:	Elizabeth Kerwood, Associate Director of Community Involvement Hampshire and Isle of Wight Integrated Care Board
Previously considered at:	
Purpose of Report:	Discuss
Paper Status:	Public
Assurance Level:	• **Significant** – High level of confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	
List of Appendices	

Hampshire Together

NHS
Hampshire and Isle of Wight

A new hospital for Hampshire: proposed changes to acute hospital services in and around Basingstoke and Winchester

Our proposals for consultation

11 December 2023 to 17 March 2024

About Hampshire and Isle of Wight Integrated Care Board

This consultation document has been published by Hampshire and Isle of Wight Integrated Care Board. The Integrated Care Board is the statutory NHS organisation responsible for setting the health and care strategy for this area. It allocates NHS resources and works across Hampshire and Isle of Wight to make sure services meet the needs of local people.

As part of our statutory duties, we are consulting on proposals to build a new hospital for Hampshire, invest in our hospital at Winchester, and change the way acute hospital services are organised. We have been given delegated authority by NHS England to consult on their behalf on proposed changes to the specialised services that they commission from Hampshire Hospitals NHS Foundation Trust, such as neonatal care and some cancer services.

Modernising our Hospitals and Health Services programme

This consultation is part of the Hampshire Together: Modernising our Hospitals and Health Services programme of work. The programme is a collaboration of NHS and care organisations in Hampshire, working together to improve NHS services for local people. This work has had input from and involved patients, families, carers, members of the public, local stakeholders, and health and care staff at every stage.

For more details about the range of activities that will be taking place during the consultation, go to ‘Giving Your Views’ on page 50.

In this document we do refer to further information that is available online. However, if you don’t have access to the internet, please call us on **0300 561 0905** and we will arrange for printed versions to be sent to you.

We have tried to use plain English as much as possible in this document. There is a glossary on page 53 which explains some of the terms we use that you may not be familiar with.

Contents

Have your say and help shape tomorrow's hospitals

To find out more visit
www.hampshiretogether.nhs.uk
or scan the QR code

You can also email
hiowicb-hsi.mohhs@nhs.net
call **0300 561 0905**
or write to us at **Freepost HAMPSHIRE TOGETHER**

The location of Hampshire Hospitals NHS Foundation Trust's acute hospitals

Foreword

On behalf of the Hampshire and Isle of Wight Integrated Care Board, we are pleased to set out proposals to build a new hospital for Hampshire, invest in Winchester Hospital and make changes to acute hospital services that would help us deliver the best possible care.

We are delighted to be part of the government's national New Hospital Programme which gives us an amazing once-in-a-generation opportunity to improve our hospital facilities and services for decades to come.

The investment will help transform the care and treatment patients receive. It will enable our NHS to meet the changing needs of our growing and ageing population. It will help us to attract and retain the best staff, provide better and more consistent care, help people stay healthy for longer, and – crucially – provide safe, sustainable, high-quality services for the future. This is part of our ambition to improve health and care across Hampshire and Isle of Wight.

The proposals set out here are part of a longer term vision that would take place alongside wider changes and improvements in health and care services for Hampshire and Isle of Wight over the coming years. These would see organisations working together more closely with the aim of providing seamless care that meets the needs of local people.

Our proposals have patients, their families and staff at their heart and would benefit everyone in our area. Naturally though, there will be many different views about which of our proposed options is the best.

Please tell us what you like and dislike about the proposals, what you think could improve them, and what we could do to reduce any negative impacts you think an option might have. We approach this consultation with an open mind – if there are alternative options you think we should also consider please let us know.

We will only make the final decision once we have considered all the feedback we have received from this public consultation, alongside other evidence and information on clinical best practice, staffing numbers, finances, and our buildings.

We are determined that patients, their families, staff and wider communities benefit from this major opportunity to invest in and redesign services so they can be truly world-class and delivered from new and improved hospital buildings. We look forward to hearing from you.

Lena Samuels
Chair

Maggie MacIsaac
Chief Executive

Dr Lara Alloway
Chief Medical Officer

Hampshire and Isle of Wight Integrated Care Board

At Hampshire Hospitals NHS Foundation Trust, we are delighted to support this consultation about a new hospital for Hampshire, investment in our hospital at Winchester, and proposals to change the way we provide services in the future.

There is widespread support and excitement at our Trust about the potential of this significant investment to upgrade our outdated hospital buildings and transform acute hospital care for local people.

We look forward to hearing the views of our patients, their families and carers and our staff on the proposals set out in this document.

Steve Erskine
Chair

Alex Whitfield
Chief Executive

Dr Nick Ward
Interim Chief Medical Officer

Hampshire Hospitals NHS Foundation Trust

What is this consultation about?

This consultation is about proposed changes to two acute hospitals in Hampshire run by Hampshire Hospitals NHS Foundation Trust – the Royal Hampshire County Hospital in Winchester and Basingstoke and North Hampshire Hospital in Basingstoke.

At the moment these two hospitals provide a range of services, which are summarised below (see our glossary from page 53 for an explanation of these terms).

Current services at Basingstoke and North Hampshire Hospital

- Accident and emergency department with trauma care (e.g., serious injuries following an accident)
- General medical inpatient care, including care of the elderly
- Specialist inpatient care - cardiology
- General and specialist surgery (emergency, planned inpatient and planned day surgery)
- Obstetrician-led birthing unit
- ‘Level 1 plus’ neonatal care
- Children’s inpatient and outpatient care
- Cancer services (including radiotherapy)
- Outpatients, diagnostics and therapies

Current services at Royal Hampshire County Hospital

- Accident and emergency department
- General medical inpatient care, including care of the elderly
- Specialist inpatient care - stroke
- General and specialist surgery (emergency, planned inpatient and planned day surgery)
- Obstetrician-led birthing unit
- ‘Level 1 plus’ neonatal care
- Children’s inpatient and outpatient care
- Cancer servcies
- Outpatients, diagnostics and therapies

Would the proposals mean changes to our community hospitals, health centres and GP services?

This consultation is only about proposed changes to hospital services provided at Basingstoke and North Hampshire Hospital, Basingstoke, and Royal Hampshire County Hospital, Winchester. The proposals do not include any changes to services at Andover Hospital or any other acute or community hospitals in Hampshire and Isle of Wight. Nor do the proposals impact on community, mental health, learning disability and autism services, GP services, or health centres in our area.

In this document we refer to **Basingstoke and North Hampshire Hospital** as **Basingstoke hospital** and the **Royal Hampshire County Hospital** as **Winchester hospital**.

What specialised services are commissioned by NHS England?

NHS England commissions Hampshire Hospitals NHS Foundation Trust to provide a number of specialised services for a small number of people across a large geographical area.

For more information about these services please visit our website at **www.hampshiretogether.nhs.uk** or call us on **0300 561 0905**.

What are ‘acute’ hospitals?

Acute hospitals provide emergency and specialist support and treatment which cannot be provided outside of a hospital setting. This can include complex surgery, care after an accident or during an episode of illness.

Our proposals impact on how these services could be organised in the future.

We are consulting on three options for delivering services in new ways across two main hospitals. We would love to hear your views on these options, or other options you think would help us address the challenges we describe in this document.

An overview of our proposals

Under each of the three options we are consulting on there would be two excellent hospitals for Hampshire. A new specialist acute hospital, and investment to refurbish Winchester hospital and create a planned surgery centre there. A summary of the options is shown here and we give more details under **'The options for this consultation'**, on page 26.

The opportunities of a new hospital for Hampshire

While a new hospital would not be ready until the early 2030s, once built it would:

- provide a fit for purpose building designed for modern healthcare, helping to improve patient outcomes
- offer patients, staff, and visitors environments designed to support recovery and wellbeing, as well as meeting the needs of those with disabilities and additional needs
- help make the most of new technology and reduce carbon emissions to help get to 'net zero'
- offer flexibility for the future giving us space to build further if needed.

We are committed to making sure that our hospitals provide training for the next generation of doctors, nurses, and health professionals, and the right environment for research and innovation. We believe our new hospital building would also help attract health innovators and entrepreneurs, especially in the medical technology and life science sectors. This would be a unique opportunity to create a dynamic and vibrant health and care, wellbeing and life sciences hub that would generate jobs and economic benefits for our area and beyond. We want Hampshire to be at the forefront of developing the health and care of tomorrow, as well as delivering excellence today.

Option 1	Option 2 (preferred option)	Option 3
New specialist acute hospital on the **current Basingstoke hospital site** and refurbishment at Winchester hospital	New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital	New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Services at Winchester hospital in all options:

- 24/7 doctor-led urgent treatment centre and same day emergency care
- Step-up and step-down inpatient beds for general medicine and care of the elderly
- Dedicated planned surgery centre
- Freestanding midwife-led birthing unit
- Outpatients, diagnostics and therapies

Services at the new specialist acute hospital in all options:

- Emergency department with trauma unit, children's emergency department, 24/7 doctor-led urgent treatment centre and same day emergency care
- Specialist inpatient care e.g. stroke and heart attack and inpatient beds, including for general medicine and care of the elderly
- Complex planned and emergency surgery
- Obstetrician-led birthing unit and alongside midwife-led unit
- Conditions for a level 2 neonatal care unit
- Cancer treatment centre
- Outpatients, diagnostics and therapies

Services at the current Basingstoke hospital site:	Services at the current Basingstoke hospital site:
Outpatients, diagnostics and therapies Planned day-case surgery	Outpatients, diagnostics and therapies Planned day-case surgery Nurse-led step-down reablement and rehabilitation beds

We will consider all the feedback we receive about our proposals, alongside other evidence, before deciding how to proceed.

Why do we need to make changes?

There are four main reasons why we must change the way we deliver NHS services in Hampshire. This section gives a summary of our case for change, but there is a lot more detailed information available on our website at **www.hampshiretogether.nhs.uk** or by calling us on **0300 561 0905**.

Population changes

Our population is growing and getting older, meaning health and care needs are changing too. Our health, care and hospital services will have to adapt so they can care for a larger and older population that is likely to have different and more complex health needs in the future compared to now.

The population of Basingstoke **has increased by 60%** since Basingstoke hospital was built[1], and estimates show that the overall population of Basingstoke and Deane, Test Valley, and Winchester will **grow by around 5% over the next 20 years**, which equates to around **23,000 more people.**

While there will be a reduction in people under 18 over the next 20 years, the number of **people over 75 will increase by around 53%** across Basingstoke and Deane, Test Valley, and Winchester. That's around **24,000 more people aged over 75**, compared to now.[2]

The trend in an ageing population is particularly noticeable in Basingstoke. The town expanded rapidly in the 1960s and 70s, so the young families who moved there are now reaching older age. The over 75 population is forecast to increase in Basingstoke and Deane and Test Valley by **over 30%** between 2020 and 2027 alone.[3]

Over **285,000 people** across Hampshire and Isle of Wight have two or more long-term conditions,[4] and in Basingstoke and Deane, Test Valley, and Winchester we have higher than the national average rates of cancer, cardiovascular disease, osteoporosis and depression.[5]

[1] Historical population data for Basingstoke and Deane (Vision of Britain)

[2] Population estimates for the UK, England and Wales, Scotland, and Northern Ireland: mid-2018 (ONS, 2019)

[3] Hampshire Joint Strategic Needs Assessment demography 2021 (Hampshire County Council, 2021)

[4] Hampshire and Isle of Wight ICS JSNA Rapid population health summary analysis (April 2022)

[5] Quality and Outcomes Framework achievement prevalence and exceptions data 2020-21 (NHS Digital)

Quality of care and specialist workforce

Some of our services do not consistently deliver best practice care, despite the efforts of our hard-working staff. Like the rest of the NHS, we face staffing shortages, not because we can't afford to recruit, but because there simply aren't enough specialist doctors, nurses, and health professionals available to employ. Duplicating services across two main hospital sites impacts on the quality of care we provide because our resources – particularly specialist staff – are spread too thinly.

For example:

We are not able to provide a dedicated children's emergency department because of a **lack of staff and space** – this means children have to wait and be cared for close to adult patients in A&E.

Good practice standards for maternity services say there should ideally be 98 hours a week of on-site consultant cover, with a minimum of 60 hours. We currently provide the minimum of 60 hours a week at each of our two sites. If we centralised maternity services we would be able to provide more hours of on-site consultant cover.

As a temporary measure our neonatal units are operating as 'level 1 plus' units (see glossary on page 55) because not enough babies are born in each hospital for staff to maintain the specialist skills needed for a level 2 neonatal unit. This means very sick or premature babies may have to go to hospitals further away.

While we have specialist children's doctors on site, we often **don't have enough specialist neonatal doctors** available, especially at the weekends.

In critical care (ITU or ICU) we only have enough doctors with advanced airway skills to provide dedicated on site cover 12 hours a day, rather than 24 hours a day as recommended by national guidelines.

Following the COVID pandemic, waiting lists for planned operations are growing. In March 2019, there was just one person waiting more than a year for an operation; as of September 2023, this had grown to over **3,600 patients.**

In addition, planned operations are often **cancelled at short notice** because beds, operating theatres and staff are needed to deal with emergency admissions.

In many services, specialist teams need to see enough of certain illnesses or conditions to maintain their expertise. Splitting these services across two sites means that specialists do not always reach the recommended numbers of cases to ensure they can provide the outstanding care we aspire to.

Buildings

Some of our hospital buildings, while much loved, are tired and approaching the end of their usable lives. Parts of the Winchester hospital date back to the 19th century, and almost 50% of the buildings were constructed between 1985 and 1994. At Basingstoke hospital, 80% of the buildings were constructed between 1965 and 1974.

Looking forward, it would cost millions of pounds each year to patch up our buildings, for example it would cost **over £170 million** to bring Basingstoke and Winchester hospitals up to an acceptable standard today, and **over £625 million** in maintenance spend to keep these buildings functioning over the course of the next 15 years. Some examples of the improvements needed include all the operating theatres at Basingstoke hospital require a full refurbishment, and the majority of wards do not have modern medical oxygen pipeline systems. At Winchester hospital, wards are overcrowded, with not enough space between beds.

We want our buildings to be able to make the most of modern technology. We have already made good progress in this area – for example, offering more video and telephone appointments and establishing virtual wards allowing patients to go home more quickly – but new and refurbished buildings will help us do even more and improve the way we deliver services in the future.

Our current estate is inflexible and unable to support the delivery of outstanding patient care and a zero-carbon footprint. For these reasons, a significant and exciting part of our proposals for change include an investment of **between £700 million and £900 million** from the government's New Hospital Programme for a brand new hospital in Hampshire.

Finances

We need to be able to run our hospitals and other health and care services with the money we have available. Not adapting our services to meet a growing and changing population, paying more for locums and agency staff because we need two sets of specialist staff to work at our two hospital sites, and having to maintain old hospital buildings, all contribute to a worsening financial position for the local health and care system.

By the end of the 2022/23 financial year, the NHS in Hampshire and Isle of Wight was **overspent by £83.2 million**

Addressing the challenges

We can provide services safely now, but need to make changes so they are sustainable for the future. Keeping things as they are is not a realistic option. Without changing how we organise care we would not be able to meet the needs of our changing population, provide services that are in line with evidence-based best practice standards and staffing guidelines, provide care in suitable buildings or run our hospitals within the budget we have.

Organising care in different ways in the future and taking the opportunity of government funding to invest in our buildings would allow us to continue to provide safe and excellent care for patients, and to offer staff a fulfilling place to work.

Listening to staff and the public

Throughout the process of developing potential options for the future of local hospital services, we have been listening to the expertise, experience and views of our staff, patients, their families and carers, and communities. What we have heard has influenced the proposals set out in this document.

We have heard from hundreds of people and taken on board their feedback as we have developed our proposals.

Key engagement activities include:

- a public and staff survey
- **10** visioning sessions with clinicians
- **37** clinical service reviews and **10** non-clinical service user reviews
- a number of public listening events and focus groups.

As a result:

- **937** members of the public and **693** members of staff responded to the survey
- **1,718** people from across **323** groups in the community took part in the other engagement activities.

What we heard from patients and the public

- A strong desire to see the different parts of the NHS and social care working together and an overwhelming acknowledgement that changes need to be made
- Specific feedback on clinical services, with a particular focus on A&E, maternity, cancer, and mental health services
- Some people think it is most important to organise services to get the best clinical outcomes, while some people think it is most important to make sure people can access services close to where they live
- Both the public and staff responses showed that some people think services must be invested in, maintained, and developed at Winchester, and some people think there should be a major hospital in or close to Basingstoke.

What we heard from staff

- Our old buildings do not help our teams do their jobs to the standard they would like
- They support the idea of specialist services being brought together on to one site to reduce duplication and waste and to support more workable staffing rotas
- They want as much routine, day-to-day care as possible to be available locally, close to where people live
- Separating planned surgery from emergency surgery would help to organise care more efficiently and reduce cancelled operations

- Making better use of modern technology would improve care
- They would like more opportunities for research, innovative working, training, and education
- There is a strong commitment to improving patient care, ensuring services are delivered in line with best practice standards, getting the best clinical outcomes and on improving the staff experience at work.

What we'd like to hear from you

What we've heard so far has influenced the proposals set out in this document. Over the next few pages we set these out in more detail. Once you've had a chance to consider them, we would welcome hearing your thoughts on:

- Whether you think there are clear reasons to make changes to hospital services in Hampshire
- What you think of our proposed model of care
- Which of the potential locations you think would be best – if either of them – for the new hospital for Hampshire
- What you think about the options we are consulting on
- What you think the advantages and disadvantages could be and how we could reduce any negative impact
- If there are any other options, solutions, evidence, or information we should consider before making our final decision.

How will we continue to engage with local people?

We are committed to continuing to share information and engage with patients, the public, staff, and other stakeholders throughout this consultation. You can find out more about ways to get involved and share your views on page 50 of this document and there is lots more information on our website at **www.hampshiretogether.nhs.uk** or by calling us on **0300 561 0905**.

Our vision and a new model of care

A new clinical model of care for local people

Through our conversations with staff and local people, new potential ways of working have been identified. We refer to this as our 'clinical model of care' because it sets out how services could be organised and delivered, but does not specify where services would be located.

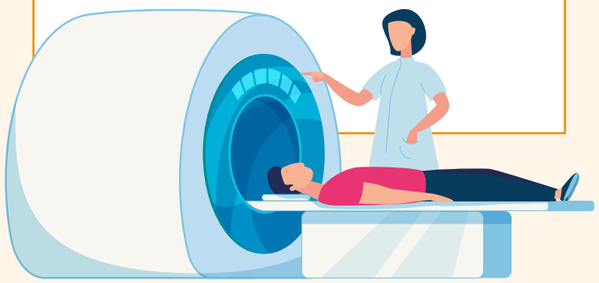
Our proposed new clinical model of care is shown below. It sets out how services should be grouped together and how they could be organised in the future to improve outcomes for patients.

One hospital providing specialist and emergency care - referred to as the specialist acute hospital

- emergency department with trauma unit and children's emergency department, 24/7 doctor-led urgent treatment centre, and same day emergency care
- specialist emergency and inpatient care, e.g. for strokes and heart attacks (as well as other inpatient care),
- emergency and complex planned surgery
- obstetrician-led maternity care, with alongside midwife-led birthing unit
- conditions to retain a level 2 neonatal unit
- inpatient children's services
- a cancer treatment centre
- outpatients, diagnostics and therapies

One hospital with a dedicated planned surgery centre

- 24/7 doctor-led urgent treatment centre, and same day emergency care
- dedicated planned surgery centre providing lower risk planned operations and procedures
- step-up and step-down inpatient beds for general medicine and care of the elderly
- a midwife-led birthing unit
- outpatients, diagnostics and therapies



The key benefits of our proposed new clinical model of care are:

- **Bringing together specialist services for the most seriously ill patients on to one hospital site** would mean patients have better health outcomes and a more positive experience of care as a result of bringing services in line with best practice standards and national clinical guidelines. Doing this would also reduce duplication and make the best use of our specialist staff, equipment and other resources
- **Separating emergency and planned surgery as far as possible** by establishing a planned surgery centre with dedicated surgical staff for lower risk planned surgery and procedures would reduce the number of planned operations and procedures that are cancelled at short notice, it would also improve care and outcomes for patients
- **Doctor-led urgent treatment centres open 24 hours a day, seven days a week** with same day emergency care at both hospitals would be able to deal with most urgent care needs, in addition to an emergency department with a trauma unit at the specialist acute hospital for the most serious conditions
- **Providing holistic maternity care that puts pregnant women and people at the heart of services**, including developing a new alongside midwife-led birthing unit (i.e., one that is next to an obstetrician-led birthing unit) and a new freestanding midwife-led unit to give pregnant women and people more choice about how and where they give birth
- **Creating the conditions to retain a level 2 neonatal unit** (see page 19) that would see enough babies each year to meet national guidelines and have a dedicated rota of specialist neonatal staff, meaning fewer babies would need to go to hospitals outside of our area for care
- **Bringing a dedicated children's service to our area** including a separate children's emergency department, giving children and their families improved quality of care and outcomes, in line with Royal College of Paediatrics and Child Health standards
- **Creating step-up and step-down hospital beds and facilities** to care for people who do not need a specialist hospital environment but who need medical support overnight with a view to getting them well enough to get back home as soon as possible
- **Creating a cancer treatment centre** to provide a fully joined up and multidisciplinary service ensuring equity of care for local people, providing chemotherapy and radiotherapy
- **Providing outpatients, diagnostics and therapies as close to people's homes as possible,** ensuring that people have easy access to the most commonly used, day-to-day hospital services.

The trade-off of these benefits would be that some people would need to travel further for care. Some staff may also have a longer journey to work.

What medical evidence did you consider when developing the model of care?

Senior doctors and other health professionals looked at a wide range of evidence and information to develop our clinical model of care. We considered national clinical best practice guidelines which make evidence-based recommendations on what works best for the treatment of conditions and which services need to be located together in order to run safely and effectively.

What is an urgent treatment centre?

Urgent treatment centres can provide a wide range of care for all but the most serious illness and injury, to people of all ages including babies. This includes, serious but not life-threatening emergencies and injuries, suspected broken bones, cuts, stomach pains, rashes, high temperatures in children and adults, and urgent mental health concerns. Our urgent treatment centres would be run by doctors working with advanced nurse practitioners and other health professionals to provide quick diagnosis and treatment. We estimate that around two thirds of the cases we currently see at our A&E in Winchester could be safely dealt with at an urgent treatment centre.

What is 'same day emergency care'?

Under same day emergency care, patients with relevant conditions, who would otherwise be admitted to hospital can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.

What level of neonatal intensive care would be provided under this model of care?

There are three levels of neonatal care ranging from level 1 for the least unwell babies to level 3 for the most premature or unwell. Our level 2 neonatal units were temporarily changed in November 2023 because they do not see enough babies for staff to maintain the specialist skills needed for a level 2 unit.

If there was just one neonatal unit for our area, it would create the right conditions to retain a level 2 neonatal unit, something we want to be able to offer parents and newborn babies.

What is the wider vision for health and care in Hampshire and Isle of Wight?

Our vision is to improve the health and wellbeing of all our population, throughout their life journey. We believe we have a unique opportunity to ensure that we can meet the needs of our population – both now and for future generations.

Health and care partners have developed a five-year strategy for health, social care, and voluntary services in Hampshire and Isle of Wight to support better health and wellbeing and provide outstanding care for everyone.

You can find out more about this plan at **www.hantsiowhealthandcare.org.uk.**

The wider context

The proposed new clinical model of care would be implemented alongside wider changes to health and care services in Hampshire. These changes would support and enable changes to hospital services but are outside the scope of our consultation. They include:

- **Developing joined-up health and social care services** that will improve the way physical health, mental health and social care services work together. This will allow us to provide seamless care that will help people stay as well as possible for as long as possible and be treated and cared for in the most appropriate place for their needs. In the long term this will mean providing more and better services outside of hospitals. We predict that helping people to stay well, delivering more care out of hospital, and providing world-class hospital-based care will mean we will need the same number of hospital beds in the 2030s as we have today, despite the changing levels of demand

- **Improving the health of our local population** by using data and information to target health care where it is most needed (for example, providing stop smoking services in areas we know have high numbers of smokers), helping to reduce avoidable illness and improve the health of everyone in our area

- **Providing easy access to a range of urgent and emergency care services**, in and out of hospital, 24 hours a day, seven days a week, so that you can get high quality treatment quickly, in the most appropriate place for your needs.

How will you provide more care in local communities?

Work is already underway to increase the amount of care people can have closer to where they live and to help people avoid needing to go into hospital. For example, Hampshire Hospitals NHS Foundation Trust provides a bespoke telemedicine service to support people in care homes when they experience sudden or worsening ill-health. Experienced health professionals can assess patients virtually to reduce visits to A&E for vulnerable residents. The healthcare professionals work closely with the care home staff to monitor patients and can prescribe medicines as needed.

In the twelve months between October 2020 and October 2021 this service completed 1,124 consultations and was able to prevent:

- **131 unnecessary A&E visits**
- **103 unnecessary hospital admissions**
- **191 unnecessary ambulance journeys to care homes**

Have your say and help shape tomorrow's hospitals

To find out more visit
www.hampshiretogether.nhs.uk
or scan the QR code

You can also email
hiowicb-hsi.mohhs@nhs.net
call **0300 561 0905**
or write to us at **Freepost HAMPSHIRE TOGETHER**

You can complete the consultation questionnaire on our website or call us for a paper copy

Developing the proposals for consultation

We have followed a robust and thorough process for developing, considering, and evaluating the proposals we are putting forward for consultation. The process for identifying and evaluating the options was led by senior doctors and involved a wide range of other health professionals and patient representatives.

Having identified a clinical model of care, we looked at possible ways we could organise services in the future.

We concluded that the new hospital should be the specialist acute hospital because we would not have enough money to build a new planned surgery centre and bring our existing hospital buildings up to the required standard for a specialist acute hospital.

The potential locations for a new hospital

Work to identify potential sites for a new specialist acute hospital began in October 2019 and was further refreshed in 2021. A comprehensive search for sites across Alton, Andover, Basingstoke, Eastleigh, Winchester, and the surrounding areas was carried out. Pieces of land that were large enough to house a hospital were assessed for their availability, price, and the current owners' willingness to sell.

The process identified two viable sites. One is located between Basingstoke and Winchester, near to Junction 7 of the M3, near North Waltham and Dummer. The other is based on the current Basingstoke Hospital site with some adjacent land.

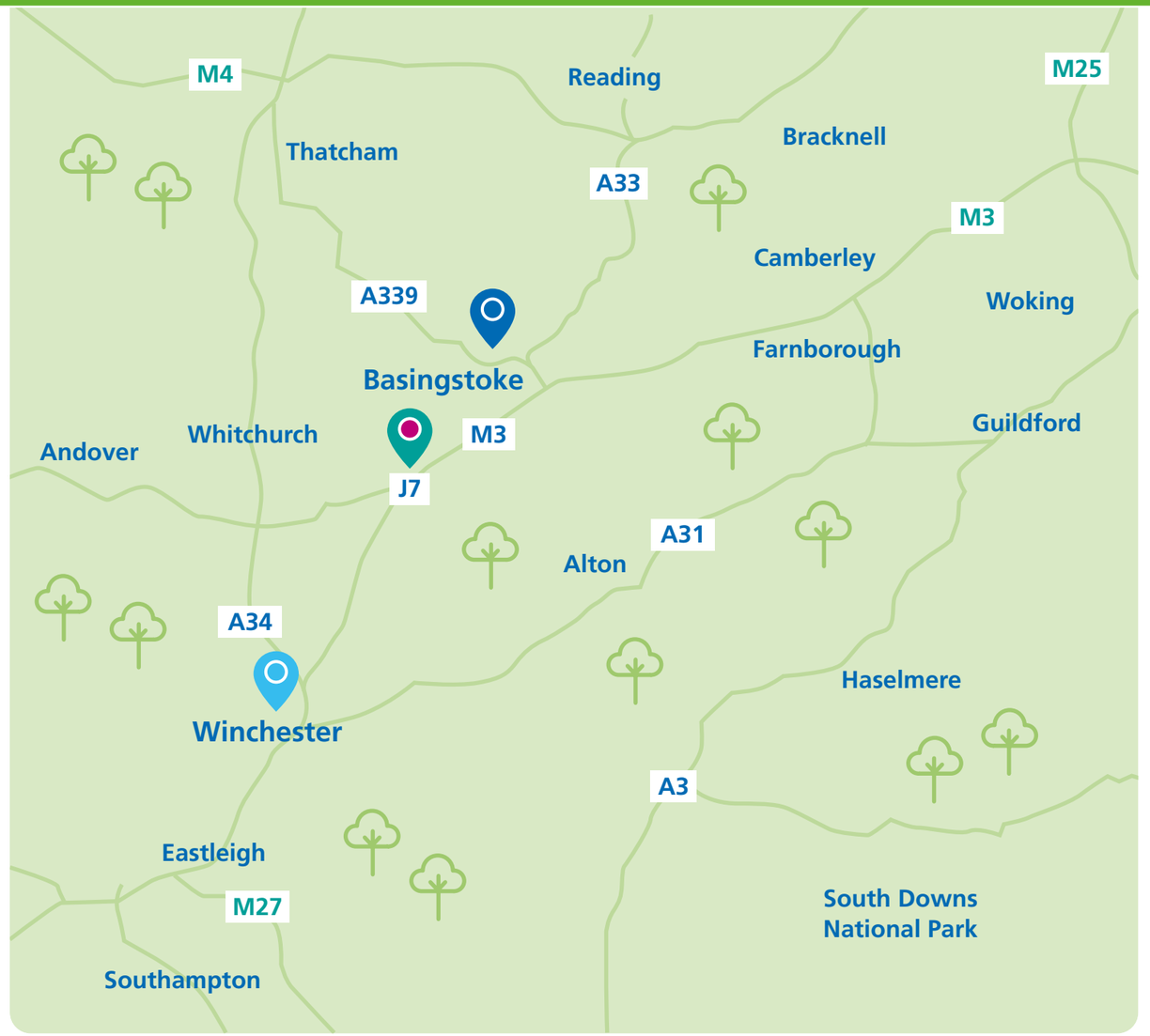
Therefore, we concluded that:

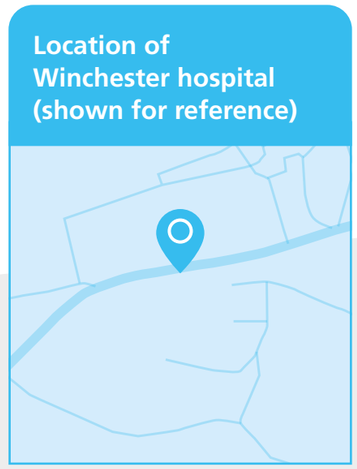
- Winchester hospital would be the best location for the planned surgery centre, along with a 24/7 doctor-led urgent treatment centre and same day emergency care, step-up and step-down inpatient beds, a midwife-led birthing unit and outpatients, diagnostics and therapies
- in any option where the new hospital would be at the site near Junction 7 of the M3, outpatients, diagnostics and therapies would also be provided at the current Basingstoke hospital site, to keep routine care as close to home as possible
- we should evaluate options that included step-down inpatient beds at the current Basingstoke hospital site.

Why can't a new hospital be built in Winchester?

The main reason we cannot build a new hospital on the existing Winchester hospital site is because it is too small to accommodate all the services that would be needed for a specialist acute hospital and there is no adjacent land that we could buy to expand into. We will, however, be investing in our buildings at Winchester hospital to make sure we can deliver services from fit-for-purpose hospital estate in the future.

As part of our search for suitable sites for a new hospital, we assessed multiple potential sites near Winchester, but we discovered that these were either too small or were unavailable for purchase.





The criteria we used to evaluate the options

Having identified how our new clinical model of care could be implemented and potential sites for a new hospital, we had a long list of potential options for further evaluation. We also evaluated an option referred to as 'business as usual', where there would be minimal changes to services and buildings.

We used a number of criteria to evaluate the long list of options which were developed based on national guidance with input from clinicians and patient and public representatives. You can find a full description of the criteria in Factsheet A, but in summary, we considered how well each option would:

- improve patient outcomes, patient experience, and accessibility, by future proofing services for the local population by 2030*
- enhance the clinical sustainability of services provided by Hampshire Hospitals NHS Foundation Trust by 2030*
- provide fit-for-purpose infrastructure that supports the delivery of acute health and care services by 2030*
- contribute to the achievement of long-term financial sustainability by 2030*

We also looked at whether the options would meet business needs, affordability, deliverability, and value for money.

This process showed that 'business as usual' was not a viable option, but we identified a shortlist of three options to take forward for consultation.

*Since the evaluation was done the national timeline has changed and we are now expecting to have a new hospital for Hampshire in the early 2030s

In all options, we would:

- invest in services outside of hospitals and in services to prevent ill-health, to reduce the need for people to go to hospital and provide care nearer to, or in, the home
- invest in digital technology and innovation to support the delivery of modern healthcare, improve record keeping, information sharing and data analysis, allowing more people to access health services remotely
- invest in our workforce to help them develop their skills and expertise, helping to improve staff satisfaction and attract people to work in our hospitals.

The next section of this document explores and explains the options in more detail.

Why haven't you proposed keeping an A&E or emergency department at Winchester?

We have exhaustively explored potential options to keep an A&E at Winchester hospital. Local doctors strongly and collectively believe that an emergency department at both hospitals would not be clinically safe or sustainable because:

- we would have to spread our consultant emergency doctors across two sites, meaning that we would only be able to have consultants on site for 14.5 hours a day during the week and 14 hours a day at weekend, instead of 16 hours a day as we could with one emergency department
- we would not have enough junior doctors to provide sufficient cover at both sites, adding further pressure to stretched consultant resources
- under our new model of care Winchester hospital would not have the support services that are needed for an emergency department, for example critical care and emergency surgery, so patients needing these services would have to be transferred to the new specialist acute hospital. We would not have enough staff to sustainably provide, on both sites, these essential services that need to be located together
- the South East Clinical Senate, an independent panel of senior doctors that quality assure proposed changes to services, expressed "significant concerns" about keeping an A&E at Winchester under our proposed options, and said they were "not confident" it would be safe to do so.

Why haven't you proposed keeping obstetrician-led maternity services at Winchester?

As part of the options development process, we considered options that included obstetrician-led maternity services at Winchester. However, there were a number of factors that meant these options were not taken forward for consultation, including:

- obstetrician-led maternity services need to be located at a hospital that can provide emergency surgery and critical care, which would only be provided at the new specialist acute hospital
- obstetrician-led maternity services also need to be located with neonatal care. As described above, the current neonatal units don't see enough babies a year to meet the requirements for level 2 care, and consolidating services would create the conditions for this, meaning fewer babies need to be transferred out of our area for neonatal care
- the Ockenden report[1] set out a series of recommendations for maternity services, following a review of failing services in Shrewsbury and Telford. While we do currently meet the minimum recommendations for safe staffing levels, if we centralised maternity services we would be able to meet the best-practice recommendations.

[1] www.gov.uk/government/publications/final-report-of-the-ockenden-review

The options for consultation

We have shortlisted three options for consultation, one of which – Option 2 – is our preferred option for the future. This is an overview of the options.

Option 1	Option 2 (preferred option)	Option 3
New specialist acute hospital on the **current Basingstoke hospital site** and refurbishment at Winchester hospital	New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital	New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Services at Winchester hospital in all options:

- 24/7 doctor-led urgent treatment centre and same day emergency care
- Step-up and step-down inpatient beds for general medicine and care of the elderly
- Dedicated planned surgery centre
- Freestanding midwife-led birthing unit
- Outpatients, diagnostics and therapies

Services at the new specialist acute hospital in all options:

- Emergency department with trauma unit, children's emergency department, 24/7 doctor-led urgent treatment centre and same day emergency care
- Specialist inpatient care e.g. stroke and heart attack and inpatient beds, including for general medicine and care of the elderly
- Complex planned and emergency surgery
- Obstetrician-led birthing unit and alongside midwife-led unit
- Conditions for a level 2 neonatal care unit
- Cancer treatment centre
- Outpatients, diagnostics and therapies

Services at the current Basingstoke hospital site:	Services at the current Basingstoke hospital site:
Outpatients, diagnostics and therapies Planned day-case surgery	Outpatients, diagnostics and therapies Planned day-case surgery Nurse-led step-down reablement and rehabilitation beds

While our proposals would not be implemented for some years, they would mean that:

- A&E would no longer be available at Winchester, although there would be a 24/7 doctor-led urgent treatment centre
- obstetrician-led maternity services would no longer be available at Winchester, but there would be a midwife-led birthing unit and antenatal and postnatal care
- there would be changes to where planned surgery would be provided, with the majority of planned surgery only being available at Winchester
- there would be changes to where some cancer treatment would be provided, with radiotherapy and some types of chemotherapy only available at the cancer treatment centre at the new hospital, but with other cancer care remaining local.

Why is Option 2 the preferred option?

We believe that, while all three options are viable and implementable, Option 2 has significant advantages, and fewer disadvantages than the other two options. Under Option 1 it would be much more complicated and expensive to build a new hospital on the current Basingstoke site, rather than at a new location. Option 1 would also have a higher risk of more people going to other hospitals outside our area putting additional pressure on those hospitals.

Option 3 includes some nurse-led step-down rehabilitation and reablement beds at the current Basingstoke hospital site for patients medically suitable for nurse-led care. While these beds would mean some patients could recover closer to home, which we know is important to people, it would mean we would need more nursing staff, or would have to split our current nursing staff across an additional site, which is more challenging to deliver.

Are these the only options you will consider?

We are open-minded about the potential for there to be other options that we could explore that would address our challenges. We hope that you will share any other suggestions or ideas you have when you respond to the consultation, including possible new options or variations on the options set out here.

Advantages and disadvantages of the options

In addition to the benefits of the model of care shown on page 17, our proposals would mean we could maintain day-to-day hospital services such as outpatients, diagnostics and therapies at Winchester and the current Basingstoke hospital site, as well as near Junction 7 of the M3 under Options 2 and 3, keeping the most frequently used services close to home. All the options would also help to give us a resilient workforce and fewer vacancies and improve the working environment for staff.

Each option has its own advantages and disadvantages that you may want to consider when responding to the consultation. These are summarised here.

Option 1

New specialist acute hospital on the **current Basingstoke hospital site** and refurbishment at Winchester hospital

Advantages

- The NHS does not need to purchase new land to deliver this option
- There are established public transport links to the current Basingstoke hospital site
- There would be less impact on travel times for people living in deprived areas because these areas tend to be in and around Basingstoke

Disadvantages

- Because the new hospital would be less centrally located in our catchment area there is a greater impact on average travel times compared to Options 2 and 3
- Because the new hospital would be less centrally located there is a higher likelihood of people going to closer neighbouring hospitals putting additional pressure on those hospitals, compared to Options 2 and 3
- Building the new hospital at the existing Basingstoke hospital would be more complex and take longer because of the need to deliver existing services on the same site during the build process, which would take several years
- There would be disruption to current services during the build
- There would be less space for further expansion in the future compared to the site near Junction 7 of the M3
- This option has the most expensive capital cost of all three options

Option 2 (preferred option)

New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Advantages

- Because the new hospital would be more centrally located in our catchment area, there is less impact on travel times by car under this option, compared to Option 1
- Because the new hospital would be more centrally located, there is less likelihood of people going to other closer neighbouring hospitals, meaning less impact on those hospitals
- Building a new hospital near Junction 7 of the M3 would not disrupt current care at the existing Basingstoke hospital site during the years of construction
- The potential new site is larger than the current Basingstoke hospital site so offers greater flexibility and opportunity to expand services in the future if needed
- This option has the lowest capital cost of all three options

Disadvantages

- The NHS does not currently own the proposed site near Junction 7 of the M3
- New public transport routes would be needed to enable easy access to the hospital site
- This option has a greater impact on travel times for some people living in deprived areas

Option 3

New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Advantages Same as Option 2 plus:

- Offers nurse-led step-down reablement and rehabilitation beds at the current Basingstoke site for patients medically suitable for nurse led care. This would provide additional access for people near Basingstoke who have been in hospital and still need inpatient care, but do not need the full range of specialist services

Disadvantages Same as Option 2 plus:

- This option splits our nursing staff across an additional site because there would be nurse-led rehabilitation and reablement beds at the current Basingstoke hospital site
- To implement the beds we would need to refurbish additional space at the current Basingstoke hospital site, which would increase the cost of this option

Things to think about when responding to the consultation

This section looks in more detail at the impact of the options, what they might mean for you and your family, the impact on travel and access for local people and the impact on other parts of the health and care system in our area. We also address some of the common concerns we've already heard as we have developed our proposals. We hope this information, along with the descriptions of the options on the previous pages, will help you to form your response to our consultation.

How have you considered what the impact of the changes could be?

To help us understand the impact of our proposals on local communities an interim 'integrated impact assessment' was undertaken by an independent organisation on behalf of the Modernising our Hospitals and Healthcare programme. The interim integrated impact assessment looked at the impact of our proposals on:

- clinical outcomes
- health inequalities
- service accessibility and travel times for all patients and specifically protected groups under the equalities legislation
- other service providers
- sustainability and the environment.

Some of the findings from the interim integrated impact assessment are included in this section. The full report is available at **www.hampshiretogether.nhs.uk** or by phone on **0300 561 0905**.

What could this mean for me and my family?

Over the next few pages, we have a series of patient stories which set out where key aspects of care for a range of conditions would be provided in the future for each option. You can use these to see what our proposals might mean for you or your family. Please note, these stories are examples designed to help you understand more about what the impact of the changes could be. They are not describing real people, and they are not intended to set out every step in a patient journey. The exact care each individual patient would receive may be different to what is described here, depending on their clinical circumstances.

There are several other patient stories in Factsheet B covering the following:

- cancer care
- children's planned inpatient care
- trauma care
- a higher-risk pregnancy
- emergency surgery
- urgent and emergency care
- step-up and step-down care

Planned surgery

Amir is 67, he's generally healthy and active. He has had pain in his knee for some time and his GP referred him to the orthopaedic team at the hospital for further investigation. Amir and the orthopaedic consultant agreed that a knee replacement operation would be the best solution and he is booked in for planned surgery.

Now	Future
After his appointment with the consultant, Amir receives a letter with a date for surgery	At his appointment with the consultant, Amir is booked in for surgery at the planned surgery centre
He goes to his nearest hospital before surgery for his pre-operation checks	He goes to his nearest hospital before surgery for his pre-operation checks
Unfortunately, the day before surgery he is told the hospital has had a lot of emergency admissions and his operation is being put back	Because the planned surgery centre is not impacted by emergency cases, Amir's surgery can go ahead on the scheduled date
He receives a letter with the new date for the surgery	On the day of surgery he is asked to arrive at 8am
He goes to the hospital before surgery for his pre-operation checks	He has some final pre-operation checks and goes to theatre at 9:30am
On the day of surgery he is asked to arrive at hospital at 8am	After surgery Amir spends a night in hospital. The following morning the physiotherapist helps Amir to get up and practise walking
At hospital he waits until almost 2pm to go to theatre because of an emergency case	He is able to go home at 3pm that day where he makes a good recovery
After surgery Amir ends up spending two nights in hospital because of the initial delay to his operation, but goes home on day three and makes a good recovery	

Children's urgent care

Claire, aged 8, lives with her parents and younger brother. Claire injures her ankle while playing football for her local team one Saturday morning. She has no obvious signs of serious injury but is unable to walk. Her dad takes her to the nearest hospital to get checked over. An X-ray at hospital shows that Claire has broken her ankle and needs surgery to repair it. She is admitted to the children's surgical ward and has the operation the next day. She goes home the day after and has some follow up appointments and physiotherapy as she recovers.

	Now	Option 1	Option 2 and Option 3
Urgent care	Claire would go to the A&E department at her nearest hospital (e.g., Basingstoke hospital or Winchester hospital)	Claire would be seen at the urgent treatment centre at either the new hospital on the current Basingstoke site or Winchester hospital – whichever was closest	Claire would be seen at the urgent treatment centre at either the new hospital near Junction 7 of the M3 or Winchester hospital – whichever was closest
Surgery and hospital stay	Claire would have her surgery and hospital stay at Basingstoke hospital	Claire's surgery and hospital stay would be at the new hospital on the current Basingstoke site	Claire's surgery and hospital stay would be at the new hospital near Junction 7 of the M3
Follow up appointments	Follow up appointments would be at Claire's nearest hospital (e.g., Basingstoke hospital or Winchester hospital)	Claire's follow up appointments would be at her nearest acute hospital (e.g., the new hospital on the current Basingstoke site or Winchester hospital), or a community clinic, or by phone or video call	Claire's follow up appointments would be at her nearest acute hospital (e.g., the new hospital near Junction 7 of the M3 or Winchester hospital), or a community clinic, or by phone or video call
Physiotherapy	Physiotherapy would be provided at the acute hospital or by local community services	Physiotherapy would be provided at the nearest acute hospital or by local community services	Physiotherapy would be provided at the nearest acute hospital or by local community services

Life threatening emergency

Mike, aged 57, is an engineer. There is a history of heart disease in the family, as his dad died of a heart attack. Mike develops chest pain in the middle of the night. He feels really unwell and his wife calls 999. The paramedics attend and an ECG shows Mike is having a heart attack. Mike needs to be taken by blue light ambulance to a hospital for an angiogram and for an immediate procedure to open up a blocked artery, known as a primary percutaneous coronary intervention or PPCI. Afterwards he spends some time recovering in hospital before going home. He then has some follow up appointments with his consultant.

	Now	Option 1	Option 2 and Option 3
PPCI centre	Mike would be taken by ambulance to Basingstoke hospital	Mike would be taken by ambulance to the new hospital on the current Basingstoke site	Mike would be taken by ambulance to the new hospital near Junction 7 of the M3
Recovery in hospital	Mike's initial recovery would be at Basingstoke hospital	Mike's initial recovery would be at the new hospital on the current Basingstoke hospital site	Mike's initial recovery would be at the new hospital near Junction 7 of the M3
Step-down care (if needed)	Mike could go to Alton or Andover hospitals for step-down care if needed	Step-down care would be available at Alton, Andover or Winchester hospitals if needed	Under Option 2 step-down care would be available at Alton, Andover or Winchester hospitals, if needed. Under Option 3 Mike could also go to the current Basingstoke hospital site if his needs were suitable for nurse-led step-down care
Follow up appointments	Follow up appointments would be at Mike's nearest acute hospital (i.e., Basingstoke or Winchester, whichever was closest)	Mike would go to his nearest acute hospital (e.g., the new hospital on the current Basingstoke site or Winchester hospital), or to a community clinic, or have appointments by phone or video call	Mike would go to his nearest acute hospital (e.g., the new hospital near Junction 7 of the M3 or Winchester hospital), or to a community clinic, or have appointments by phone or video call

Maternity care: lower risk pregnancy

Jo, aged 28, is expecting her second baby. She has been healthy during pregnancy and had no complications in her previous pregnancy and birth and is assessed as low-risk. During her pregnancy Jo receives care from her community midwife. Jo considered a home birth, but has chosen to give birth in a freestanding or alongside midwife-led unit. After having her baby, Jo would like to receive postnatal care from her community midwife at home. If Jo did go to a freestanding midwife-led birthing unit and difficulties arose during labour she would be transferred by blue light ambulance to an obstetrician-led birthing unit. If her baby needed neonatal care, it would be admitted to the nearest appropriate neonatal unit. Her baby would be transferred by ambulance if the right level of neonatal care wasn't available where Jo gave birth.

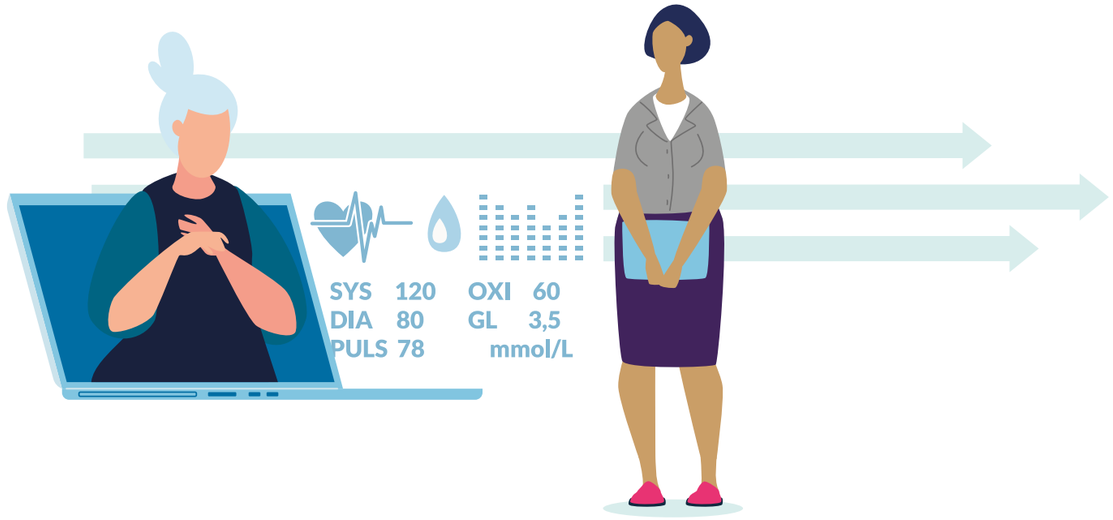
	Now	Option 1	Option 2 and Option 3
Routine antenatal care	Jo would go to her GP practice, community clinic or receive care at home	Jo would go to her GP practice, community clinic, or receive care at home or virtually	Jo would go to her GP practice, community clinic, or receive care at home or virtually
Hospital appointments	Jo would go to her nearest acute hospital (e.g., Basingstoke hospital or Winchester hospital)	Jo would go to the new hospital on the current Basingstoke site or Winchester hospital – whichever was closest	Jo would go to at the new hospital near Junction 7 of the M3, the current Basingstoke hospital site or Winchester hospital – whichever was closest
Midwife-led birthing unit	If Jo wanted to give birth at a midwife-led unit she would go to Andover Birth Centre	Jo could choose the freestanding midwife-led units at Winchester or Andover, or the alongside midwife-led unit at the new hospital	Jo could choose the freestanding midwife-led units at Winchester or Andover, or the alongside midwife-led unit at the new hospital
Obstetrician-led birthing unit	If Jo wanted or needed to give birth at an obstetrician-led unit she would go to Basingstoke or Winchester hospital, whichever is closest	If Jo wanted or needed to give birth at an obstetrician-led unit she would go to the new hospital on the current Basingstoke hospital site	If Jo wanted or needed to give birth at an obstetrician-led unit she would go to the new hospital near Junction 7 of the M3
Neonatal care* (if needed)	Jo's baby would go to Basingstoke or Winchester hospital for level 1 plus neonatal care, or Southampton, Reading or Frimley hospitals for level 2 neonatal care	There would be level 1 neonatal care and the conditions for a level 2 neonatal unit at the new hospital at the current Basingstoke hospital site	There would be level 1 neonatal care and the conditions for a level 2 neonatal unit at the new hospital near Junction 7 of the M3
Postnatal care	Jo and her baby would receive postnatal care at home, GP practice or community clinic	Jo and her baby would receive postnatal care at home, GP practice or community clinic, or virtually	Jo and her baby would receive postnatal care at home, GP practice or community clinic, or virtually

*See glossary on page 55 for a description of neonatal care

Care for a long-term condition

Mary is 78 and has severe heart failure. She has a pacemaker to protect her against life-threatening heart rhythms, and takes a number of different tablets each day.

Mary has home monitoring through her pacemaker so that if she does have any abnormal heart rhythms, even if they don't cause symptoms, the cardiac team will be notified via the internet and will contact her to help. Mary can also contact a specialist heart function team directly Monday to Friday. This team comprises of doctors, nurses, pharmacists and allied health professionals, and she can see the most appropriate person for her needs at her local acute hospital. Her consultant appointments are also at her local acute hospital. Occasionally Mary needs to go into hospital for procedures such as to have the battery changed in her pacemaker.



	Now	Option 1	Option 2 and Option 3
Hospital-based appointments, tests, scans, biopsies	Mary would go to her nearest acute hospital (e.g., Basingstoke hospital or Winchester hospital) or have appointments by phone or video call	Mary would go to go to her nearest acute hospital (e.g., the new hospital on the current Basingstoke site or Winchester hospital)	Mary would go to her nearest acute hospital (e.g., the new hospital near Junction 7 of the M3, or Winchester hospital)
Appointments with nurse, pharmacist or allied health professional	Mary would go to her nearest acute hospital (e.g., Basingstoke hospital or Winchester hospital) or have appointments by phone or video call	Mary would go to go to her nearest acute hospital (e.g., the new hospital on the current Basingstoke site or Winchester hospital), or to a community clinic, or have appointments by phone or video call	Mary would go to go to her nearest acute hospital (e.g., the new hospital near Junction 7 of the M3 or Winchester hospital), or to a community clinic, or have appointments by phone or video call
Appointments with consultant	Mary would go to her nearest acute hospital (e.g., Basingstoke hospital or Winchester hospital) or have appointments by phone or video call	Mary would go to go to her nearest acute hospital (e.g., the new hospital on the current Basingstoke site or Winchester hospital), or to a community clinic, or have appointments by phone or video call	Mary would go to go to her nearest acute hospital (e.g., the new hospital near Junction 7 of the M3 or Winchester hospital), or to a community clinic, or have appointments by phone or video call
Procedures (not surgery)*	Mary would go to Basingstoke hospital	Mary would go to the new hospital on the current Basingstoke hospital site	Mary would go to the new hospital near Junction 7 of the M3

*Cardiac surgery takes place at University Hospitals Southampton or at The Royal Brompton Hospital in London

Travel and access

We know that travel times and access to services is likely to a be an important issue for people when considering their response to this consultation.

Access to services

Our proposals would improve access to many services and provide access to some new services.

Under all three options, outpatient appointments, diagnostic tests, and therapies would continue to be provided at the Basingstoke and Winchester hospital sites. Under Options 2 and 3 these services would be at three locations compared to two now.

Our proposals would reduce waiting times for emergency and urgent care because consultants would be available on site to give a senior clinical opinion for more hours than they are currently, speeding up diagnosis and treatment.

There would be access to some services that are not currently provided locally, for example:

- two 24-hour, seven day a week doctor-led urgent treatment centres and more same day emergency care
- a dedicated planned surgery centre
- a dedicated children's emergency department
- midwife-led birthing units.

The 24/7 doctor-led urgent treatment centre at Winchester would be able to see and treat around three out of five of the current types of patient cases that attend the A&E in Winchester now.

Our proposals would also create the conditions to retain a level 2 neonatal care unit.

The planned surgery centre would provide dedicated operating theatre capacity meaning fewer cancellations because of emergencies, helping to shorten waiting lists. The most complex planned surgery would take place at the specialist acute hospital, with access to critical care facilities, if needed. Outpatient appointments and pre- and post-operative care would be provided in Basingstoke, Winchester, the new hospital, on-line or in GP surgeries.

Refurbishing existing hospital buildings and building a new hospital would improve physical access to services, particularly for people with disabilities and with sensory and information processing differences. We would be able to improve layout, signage and use of digital technology to support people to access and find their way around our hospitals.

Travel times

While our proposals would impact on travel times for some people, It is important to recognise that longer journeys for some people do not mean they no longer have access to services, but that access may take longer or be more costly.

Evidence shows that where there are longer journey times, these would be more than offset by shorter waits to see a senior doctor and for diagnostics on arrival at hospital, more consistent high-quality care, improved outcomes, shorter hospital stays, and services that are sustainable for the long term.

We have, of course, looked at what safe journey times are for life or limb threatening emergencies and have involved South Central Ambulance Service in our discussions about these proposals.

How did you calculate the impact on travel times?

To work out the impact of the options on average travel times, we have assumed that everyone who currently uses hospital services at the current Basingstoke and Winchester sites would continue to do so. For example, we have assumed that someone who lives south of Winchester would travel to the new hospital at either the current Basingstoke site or at Junction 7 of the M3, rather than going to Southampton. This approach means that we are making sure that we consider the impact on people who may choose to travel further or may be directed to the new hospital. Travel times for people who go to another, nearer hospital, would be shorter.

Many of the most specialist services such as stroke, heart attack and trauma care are already only provided from one of our hospital sites, and this would continue to be the case. The impact on travel times for these services would be small. For example, we have looked at the potential impact of moving emergency stroke services from Winchester (where they are currently provided) to the new specialist acute hospital. Everyone in our catchment can currently reach emergency stroke services within 45 minutes by blue light ambulance and would continue to be able to do so, although for some this would mean going to closer neighbouring hospitals.

In addition, we are looking at ways we could reduce the impact of increased journey times for those who may be affected, for example by reviewing our patient transport provision, car parking and staff travel.

Impact on travel times to access specialist and emergency care

Currently many of our most specialist services such as stroke, heart attack and trauma services are already only provided at one of our hospitals. The impact on travel times for those services would be minimal (see page 41). For the services that are currently provided on both sites, all three options would have an impact on travel times for some people in the future, compared to now. There would also be an impact on the travel time and cost for some family and friends visiting patients, and for some staff. Some local people are already travelling up to around 45 minutes by car during off-peak times of the day to reach our current hospitals in Basingstoke and Winchester. Under our proposals, around 90% of people would be able to reach the new specialist acute hospital within 45 minutes by car during off-peak times, and everyone within an hour. The table below shows travel times by car during off-peak times, which is similar to travel time by blue-light ambulance.

	Current	Option 1	Option 2 and 3
Average (approximate)	20 minutes	30 minutes	30 minutes
Maximum (approximate)	45 minutes	60 minutes	50 minutes
Percentage of people who can reach the specialist acute hospital within...*			
0-15 minutes	26%	14%	5%
15-30 minutes	50%	25%	60%
30-45 minutes	23%	51%	31%
45-60 minutes	0%	10%	4%
60+ minutes	0%	0%	0%

*Care for the most serious life and limb threatening emergencies is already only provided at one of our hospitals

Have you considered travel times by public transport to access specialist and emergency care?

Currently, getting public transport to local hospitals is very difficult or impossible from many areas in Hampshire. There is also not currently any public transport to the proposed site near Junction 7 of the M3 as there is currently little reason for people to need to travel there. We have therefore not done detailed calculations about the potential impact of our proposals on access to specialist and emergency services by public transport.

Instead, we have been focussing on discussions with relevant partners about what public transport solutions would be needed, if services were to be provided from a different site in the future.

Impact on travel times to access lower risk planned surgery

Currently people can access planned surgery services by car within around 30 minutes (at off-peak travel times) to around 50 minutes (at peak travel times). Under our proposals, people would be able to reach the planned surgery centre at Winchester for lower risk surgery, and some day case surgery (day case would also be provided at the current Basingstoke site in all options and at the site near Junction 7 of the M3 in Options 2 and 3) within about 70 minutes at off-peak travel times and within about 80 minutes at peak travel time by car. Outpatient appointments and pre- and post-operative care would be provided in Basingstoke, Winchester, the new hospital, on-line or in GP surgeries.
The table below shows these travel times by car.

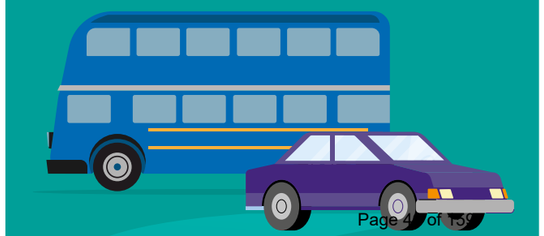
	Current (off-peak)	All options (off-peak)	Current (peak)	All options (peak)
Average (approximate)	20 minutes	40 minutes	25 minutes	40 minutes
Maximum (approximate)	30 minutes	70 minutes	49 minutes	81 minutes
Percentage of people who can reach the planned surgery centre within...				
0-15 minutes	26%	11%	19%	10%
15-30 minutes	50%	26%	47%	22%
30-45 minutes	24%	45%	29%	32%
45-60 minutes	0%	16%	5%	25%
60+ minutes	0%	2%	0%	11%

Have you considered public transport times to access planned surgery?

We have looked at travel times by public transport to Winchester, which show an increase in average travel times (looking at the total catchment population) from around 45 minutes to around 80 minutes.

The people towards the north of the area would potentially be impacted by longer travel times to the planned surgery centre at Winchester and we are exploring ideas to support these populations, including looking at models in place elsewhere, such as volunteer transport schemes and demand response vehicles.

More information about travel times is available in Factsheet C. Factsheets can be accessed at **www.hampshiretogether.nhs.uk** or requested by phone on **0300 561 0905**.



Impact on average travel times for people living in deprived communities and groups protected under equalities law

We recognise that there is the potential for some of our proposals to disproportionately impact people living in deprived areas and/or those who are from groups protected under equalities law (often referred to as protected characteristic groups).

We have looked at the impact on average travel times under each option for the different groups protected under equalities law and people living in deprived communities.

We have also undertaken a detailed analysis of some of the local areas which may be more vulnerable to the potential impact of our proposals. These areas are Andover Newbury Road, Basingstoke Popley, Alton Westbrooke and Eastbrooke, Eastleigh West and Winchester Stanmore.

Our integrated impact assessment gives a lot more detail about the potential impact of our proposals on these groups, and what we would do to try and minimise these impacts.

The integrated impact assessment is available on our website at **www.hampshiretogether.nhs.uk.**

Potential impact on other hospitals

While we know that the decision about which hospital to go to is not based solely on which is nearest (for example, ambulance services consider journey times as well as distance, waiting times in emergency departments and the specialist services available at particular hospitals), our proposals could increase the number of patients going to other closer neighbouring hospitals.

We are working closely with these hospitals to understand the potential impact our proposals could have on them and if this would be manageable in the long term. We have received letters of support to consult on our proposals from the hospital trusts that could experience an increase in patients because of our proposed changes.

South Central Ambulance Service

The proposed changes also have the potential to impact on the South Central Ambulance Service because of longer journeys for some to the specialist acute hospital. There may also be some patients who would need to be transferred between hospitals by ambulance, for example people who need to go from Winchester hospital to the specialist acute hospital for more specialist care.

We are considering how the impact on the ambulance service could be mitigated, working with colleagues at South Central Ambulance Service.

We have received a letter of support for our proposals and options for consultation from South Central Ambulance Service.

Changes to people's nearest hospital

In most cases people who currently use services at Basingstoke and Winchester hospitals would probably access care at either the new hospital or at Winchester hospital. However, all the options we are consulting on might mean a change in some people's nearest hospital for some emergency care. For people going to hospital by ambulance, the paramedics would decide which hospital with appropriate services to take the patient to.

The table below gives more information on the potential changes to people's nearest hospital.

	Option 1	Option 2 and Option 3
	New hospital at existing Basingstoke hospital site	New hospital at site near J7 of the M3
Some emergency and specialist care* (except stroke - see below) and obstetrician-led maternity care and neonatal care	Southampton General Hospital may become the nearest hospital for some people living to the south of Winchester	Southampton General Hospital may become the nearest hospital for some people living to the south of Winchester, but for fewer people than Option 1. The Royal Berkshire Hospital in Reading may become the closest hospital for some people living to the north of Basingstoke. The Great Western Hospital in Swindon may become the nearest hospital for some people living to the north west of Basingstoke
Acute stroke services (currently at Winchester hospital, but not at Basingstoke)	Southampton General Hospital may become the nearest hospital for some people living to the south of Winchester. The new hospital (at either the site near to Junction 7 of the M3 or the current Basingstoke site) may become the closest hospital for people living in north Hampshire, who currently go to Frimley Park Hospital as their closest hospital	

*Care for the most serious life and limb threatening emergencies is already only provided at one of our hospital sites

When you respond to the consultation please let us know what you think we could do to reduce the impact of increased journey times and costs for some patients, visitors and staff.

Financial impact

We have a responsibility to ensure we are spending taxpayers' money wisely and getting the best value for every pound we have. So, in developing our proposals we have considered their overall cost, affordability, and value for money. You may also want to consider some of these factors in your response to the consultation.

Expected cost of each option

The table below shows the expected upfront capital cost of each option. We have been told by the government's New Hospital Programme that the likely allocated budget for us to build a new hospital either near to Junction 7 of the M3 or at the current Basingstoke hospital site, and to carry out refurbishment work at the Royal Hampshire County Hospital at Winchester is between £700 million and £900 million. There is the expectation that each of the options would need to fall within, or close to, this range.

	Capital cost in £millions
Option 1	£948
Option 2	£807
Option 3	£860

While the costs for Option 1 are above the budget range, they are considered to be within an acceptable range, especially as costs are likely to change as the New Hospital Programme develops its approaches to construction and procurement.

It is also important to note that these are indicative costs, based on the best information we have available to us at this time. It is possible the cost may change as final and more detailed plans are developed.

Value for money

While some options would cost less than others to implement, we also need to think about the long-term value for money of each option. We did this by looking at the costs versus the benefits. We looked at two types of benefit:

- 'cash-releasing' benefits such as reductions in energy use for the new hospital and reduction or improved staff retention and recruitment through more attractive work rotas and working environment, reducing the need for agency staff to cover vacancies

- 'non-cash releasing' benefits which contribute to overall societal gain and have a financial value, but do not directly free up money. Examples include more productive ways of working in operating theatres or new facilities reducing the risk of hospital acquired infections.

The cash releasing benefits for all options are around £43 million per year and the non-cash releasing benefits are around £38 million per year.

Concerns we have heard

As set out on pages 14 and 15, we have already listened carefully to what local people have told us and used this feedback to inform our developing plans. We have discussed opportunities and benefits, and concerns, with a wide range of people. This has helpfully informed our thinking. This section of our document describes some concerns about our proposals that have already been raised and our response to those concerns. We are committed to continuing to listen to the views of local people, staff, and partner organisations as part of this consultation.

Balancing the need for improved quality with access to services

People have told us they understand the reasons why consolidating some services on to one site improves the quality and safety of care we can provide. However, they have also told us they are worried about changes to the location of services. In particular people have expressed concerns about potential changes to A&E and maternity services at Winchester.

We are absolutely clear that we are committed to having two excellent acute hospitals for our whole catchment population – one hospital in Winchester and one on the existing Basingstoke site or the site near Junction 7 of the M3. We are also committed to maintaining services at both hospitals.

Under all the options, outpatient care remains at Winchester as well the new hospital site. Under Options 2 and 3 outpatient services would also be provided at the current Basingstoke hospital site so people would be able to receive outpatient care as close to home as possible.

Under all the options, Winchester hospital would have a 24-hour, seven day a week doctor-led urgent treatment centre able to meet all urgent care needs, and a same day emergency care service. Only the sickest patients, with the most serious conditions, would go to the new hospital, with many taken straight there by blue light ambulance.

Consolidating obstetrician-led maternity services and neonatal care, means we are more likely to keep them in this part of Hampshire for the longer term. Leaving them split across two sites could mean we see level 2 neonatal care move out of our area permanently to neighbouring larger hospitals. This ultimately puts some services even further away from our local communities.

Travel times and costs

People have told us they are worried that increases in travel times for some people would be unsafe for critically ill patients in ambulances as well as inconvenient and costly for patients and visitors travelling by car or public transport.

Medical evidence tells us it is better to travel further to the right place if you need very specialist care. Ambulance crews have the skills and equipment to stabilise patients whilst they take them to the most appropriate emergency centre with the right specialist team for their needs. For many years now, some services have been centralised at one or other of our hospitals – including trauma, stroke, and specialist treatment for serious heart attacks – and we have seen benefits to patients of doing this.

Under all the options people would still be able to access doctor-led urgent care 24 hours a day, seven days a week. Urgent care covers a very wide range of illnesses and injuries that are not life or limb threatening but do need same day attention.

We acknowledge that under some options for some services travel may be longer than now and less convenient for some people coming to hospital by car or public transport. We are already working with partners to look at public transport solutions, particularly for the potential site near Junction 7 of the M3, were we to choose that option.

Impact on staff

We recognise that our proposals would have an impact on some staff, potentially changing where they work. Wherever the location, it will be some years before the new hospital opens. We will involve staff in our detailed implementation planning, consult with individuals as needed and support staff through change.

People have also told us they are worried that there are not enough doctors and nurses both in hospital services and in general practice and other community services to cope with these changes.

Centralising some of our specialist services would help to address staffing shortages by bringing staff together onto one site. This would make work rotas more attractive to both current and potential employees, helping us to recruit and retain staff.

We also know health professionals prefer to work in teams where they can provide high quality care to patients, share knowledge and expertise, and undertake research.

Having two excellent acute hospitals in our area would help attract students to the health and care courses run jointly by universities and Hampshire Hospitals NHS Foundation Trust, bringing future health professionals to the area. We know that doctors, nurses, and other health professionals often settle in the area they train in.

When you respond to the consultation please tell us what you think we can do to reduce the impact of these and any other concerns you may have about our proposals.

You can write some notes here before you complete the questionnaire

Giving your views

We would like to know what you think about these proposals before we decide how to proceed. Our consultation runs from 11 December 2023 for 14 weeks, and you can share your views with us until midnight on **17 March 2024**.

Have your say and help shape tomorrow's hospitals

To find out more visit
www.hampshiretogether.nhs.uk
or scan the QR code

You can also email
hiowicb-hsi.mohhs@nhs.net
call **0300 561 0905**
or write to us at **Freepost HAMPSHIRE TOGETHER**

We understand that our views may be different to yours. We need to ensure we are fully aware of the views of local people, that we are not making people who are already living in the more deprived areas of our county worse off in terms of their health outcomes, and that we understand how we can address and reduce any concerns.

We want to hear from a wide range of people who may be impacted by our proposals. We have a wide range of consultation activity planned over 14 weeks that will offer a number of ways to find out more and share your views. Full details can be found on our website or by contacting us on the details above.

Attend a meeting – virtual and face-to-face

We are hosting a series of online and face-to-face meetings and events where you can learn more, speak to the programme's leaders and let us know what you think. All events are listed on our website and will be publicised through the local media, community groups, social media, and in places such as GP surgeries, libraries, and high footfall areas in local communities.

If you cannot access the website, please phone the consultation team for details on the number opposite. These will be open meetings, and anyone can attend to give their views, although please note you will need to register to reserve your place.

Invite us to your group

We are happy to come to talk to local community groups about our proposals, either in person or virtually. Please contact the consultation team using the contact details opposite as soon as possible to discuss options.

Read our more detailed documents

As well as a series of straightforward factsheets on particular topics, there are several more detailed documents about our proposals on our website at **www.hampshiretogether.nhs.uk**. These are technical documents with more clinical and financial language, but if you do want to know more, we would encourage you to look at them.

Complete the questionnaire or write a letter

Once you have read or heard enough information to give your opinion you can formally respond to the consultation questionnaire or send a letter or email. We welcome responses from individuals and from organisations.

- Complete the consultation questionnaire on our website **www.hampshiretogether.nhs.uk**, or
- Return a paper copy to our freepost address

Email us or post a letter using the contact details opposite.

Call the consultation team

If you don't have access to the internet and would like more information about the proposals, copies of the consultation document, summary or factsheets, or have any questions you can call us on **0300 561 0905**. We can also arrange for you to complete the consultation questionnaire over the phone if you are not able to complete it online or on paper.

Online, in the news and in your community

Read regular updates on our website, Facebook, X (formerly known as Twitter) and in the local media. Printed information will also be available at GP surgeries, hospitals, libraries, community centres and other high footfall areas in local communities.

Next steps

After the consultation closes at midnight on **17 March 2024** all the feedback we have received will be analysed by an independent research organisation. They will prepare a report for us setting out what people think about the proposals.

We, together with NHS England in relation to specialised services, will consider the feedback from the consultation, along with a wide range of other evidence, information and data to develop a decision making business case and use that to decide which option to implement.

We will continue to share information with staff, patients, local people, and wider stakeholders, including publishing the consultation report and papers that will inform the decision-making. Our final decision-making meeting will be held in public to allow those who are interested to hear the discussion and how the decision is made. We will publish the details of this meeting when they are available.

As we move into the implementation phase we will regularly involve and engage patients, staff and local people to ensure their views continue to inform our work.

The expected timeline is set out below.

11 December 2023
Consultation starts

17 March 2024
Consultation closes

Spring 2024
Analysis of feedback and development of consultation report

Spring/summer 2024
Development of decision making business case

Summer 2024
Decision making meeting of Hampshire and Isle of Wight Integrated Care Board and NHS England

From late 2024
Detailed implementation planning

From mid 2020s
Construction of a new hospital and refurbishment of existing buildings

Early 2030s
New hospital opens

When would a new hospital be ready?

Once a decision has been made on the future of acute hospital services in Hampshire, detailed implementation planning will begin. Subject to planning permission, we expect to be able to open the doors to our new hospital in the early 2030s.

Appendix A

List of factsheets for further information

We have developed a series of factsheets which provide more detailed information about key topics in the consultation document. These can be accessed via our website at **www.hampshiretogether.nhs.uk**. If you don't have internet access and would like the factsheets posted to you, please phone **0300 561 0905**.

- Factsheet A: Detailed overview of the options development process
- Factsheet B: Patient stories
- Factsheet C: Travel time analysis

Appendix B

Glossary

Term	Description
24/7	24 hours a day, seven days a week
Accident and emergency (A&E)	Hospital-based service providing treatment for serious injuries and life or limb threatening emergencies
Acute care	Acute care refers to short term treatment, usually in a hospital, for patients with any kind of illness or injury
Acute hospitals	Hospitals providing acute care
Allied health professionals	A wide range of professions that work with doctors and nurses to provide care and treatment. Examples include dieticians, occupational therapists, physiotherapists, radiographers, speech and language therapists
Cardiology	Care and treatment for conditions that affect the heart and circulatory system
Centralising or consolidating	Bringing the same service/services together on to one hospital site (rather than them being spread over two or more hospital sites)
Commissioning	Commissioning is the process of assessing needs, planning and prioritising, purchasing and monitoring health services, to get the best health for a population
Community services	A wide range of services provided outside of acute hospitals, in or close to home, for example district nursing and health visitors (see also 'local care' below)

Term	Description
Consultant	A senior doctor that has completed full medical training in a specialised area of medicine
Consultant-led service	The consultant will be always available to deliver that service with their clinical team but may not be present in the hospital at all times to do so (i.e., they may be on-call from home)
Deprivation	Deprivation refers to the level of poverty in a particular area. It is measured by the 'Index of Multiple Deprivation' which looks at seven domains to calculate the level of deprivation, these are employment; income; education, skills, and training; health and disability; crime; barriers to housing and services; living environment/conditions
Diagnostics	Tests or procedures used to identify a patient's disease or condition, such as scans, X-rays, ultrasounds, blood tests, biopsies, ECGs (electrocardiogram), etc
Emergency care	Emergency care involves life or limb threatening illnesses or accidents which require immediate treatment from the ambulance service (via 999) and an emergency department
Emergency department	Hospital-based service providing the full range of care and treatment for serious injuries and life or limb threatening emergencies only. This term is increasingly used rather than 'A&E'
Foundation trust	NHS foundation trusts are non-profit making public sector organisations. They are part of the NHS but have greater freedom to decide their own plans and the way services are run. Foundation Trusts have members and a council of governors
General medicine	The care and treatment of patients with a wide range of acute and long-term medical conditions
Inpatient	A patient who is admitted to a hospital for treatment or an operation
Integrated care	Care which is coordinated around the patient, making sure all parts of the NHS and social services work more closely and effectively together
Integrated care system (ICS)	Partnerships of health and social care organisations that work together to plan and deliver joined up health and care services, to improve the lives of people their area
Intensive care unit (ICU)/critical care unit (CCU)/ intensive treatment unit (ITU)	Specialist hospital wards providing care for patients after complex surgery, or patients needing multiple organ support such as ventilation and dialysis
Local authority	A local government organisation, most commonly a local council, made up of councillors elected by the public. They are usually responsible for providing local services such as social care, schools, housing, transport, planning, and waste collection

Term	Description
Local care	Care provided outside of a main (acute) hospital in people's homes, local communities, and in mental health hospitals. It includes services provided by GPs, community nursing, community hospitals, therapies (see glossary), and mental health services, social care, health improvement services and services provided by voluntary and community groups
Long-term condition	A medical condition that cannot be cured but can be managed by medication or other therapies. Examples include diabetes, heart disease, chronic lung disease (COPD), asthma, arthritis, and dementia. People live with long-term conditions every day, as opposed to an acute illness which may start suddenly and will go away following treatment and/or care
Maternity	Relating to pregnancy, childbirth and the time immediately following childbirth
Midwife-led care	Maternity care provided by a midwife or team of midwives
Models of care	The way in which care is provided to a population. A model of care sets out how services should be organised and delivered, and what services need to be grouped together
Multi-disciplinary team (MDT)	A team of health and social care professionals including doctors, nurses, therapists, pharmacists and social workers, working together to plan and provide a patient's care. Sometimes MDTs are made up of professionals from different health and care organisations such as primary, community, mental health, hospital and social care
Neonatal care	The care of new-born babies who need additional support after birth. There are different levels of neonatal care: ▸ Level 1 (known as special care baby units or SCBU): typically for babies born after 32 weeks of pregnancy with the least complex conditions ▸ Level 2 (known as a local neonatal unit or LNU): typically for babies born between 28 and 32 weeks, and those who need more intensive care and support ▸ Level 3 (known as neonatal intensive care or NICU): typically for babies born before 28 weeks, or babies born after 28 weeks with very complex health needs Level 1 plus is not a long-term designation but is being used to reflect the current level of activity in our neonatal units, but with an expectation that there would be a level 2 unit in the future. In this case, level 1 plus provides care for babies at more than 30 weeks' gestation, twins at more than 31 weeks' gestation and only babies born at 1kg and above

Term	Description
New Hospital Programme	The government's New Hospital Programme was set up in 2020 to build 40 new hospitals in England by 2030.The Programme is also intended to transform how NHS hospitals are built, including by standardising hospital design. See: engage.dhsc.gov.uk/nhs-recovery/40-new-hospitals/
NHS England	An executive non-departmental public body of the Department of Health and Social Care. It oversees the budget, planning and delivery of the NHS in England
Obstetrician-led care	Maternity care delivered by a specialist doctor – for example caesarean sections – as opposed to midwife-led care
Outcomes	Health outcomes are the result or impact of care or treatment (for example knee replacement surgery or cancer treatment) or other intervention (for example stop smoking support or a healthy eating awareness campaign) on an individual or population
Outpatient/ outpatient care	A patient who attends an appointment to receive treatment without needing to be admitted to hospital (unlike an inpatient). Outpatient care can be provided by hospitals, GPs and community providers and is often used to agree a course of specialist treatment or follow up after treatment
Paediatric services	Healthcare services for babies, children, and adolescents
Planned surgery (also called planned care)	A planned operation, procedure or medical care. This can include routine investigations such as colonoscopies and operations ranging from relatively simple and low-risk to highly complex. Some planned care does not require a stay in hospital and some more complex care means patients stay in hospital while they recover
Primary care	The first point of contact for health services, mainly provided by GP practice teams. Primary care can also include services provided by dentists, pharmacists, and optometrists
Provider	An individual or an organisation that delivers an NHS or social care health service in return for payment from commissioners
Same day emergency care	Same day care for emergency patients who would otherwise be admitted to hospital. Patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided
Specialised care	Specialised services support people with a range of rare and complex conditions. These services are not available in every local hospital because they have to be delivered by specialist teams who have the necessary skills and experience.

Term	Description
Specialised commissioning	Unlike most healthcare, which is commissioned (planned and arranged) locally, specialised services are commissioned nationally and regionally by NHS England. See: www.england.nhs.uk/commissioning/spec-services/
Specialist care	Care provided by a clinician that targets one area of medicine or surgery, or a particular group or type of patients
Stakeholder	Anyone with an interest in a business or organisation. Stakeholders are individuals, groups or organisations that are affected by the activity of the business or organisation
Step-down beds and facilities	Beds and facilities to help a patient recover when they no longer need the full range of services available in a more specialist setting, but cannot be supported at home
Step-up beds and facilities	Beds and facilities to help a patient recover when they cannot be supported at home but do not need to be under the full range of services available in a more specialist setting
Stroke	A serious medical emergency where the blood supply to the brain is cut off, either by a bleed or clot in the brain
Therapies	Therapies, in the context acute care, cover a wide range of services including physiotherapy, occupational therapy, speech and language therapy, dietetics, podiatry and prosthetics
Trauma/major trauma	Complex injury or injuries usually caused by accidents such as a car crash. Major trauma is where a patient has one very serious injury or a number of injuries which make managing these patients very challenging. They need expert care from a large number of different specialties to give them the best chance of survival and recovery
Trauma unit/major trauma centre	Trauma units are designated hospitals that treat patients who have trauma injuries. Major trauma centres are highly specialist services covering a large population area. There are 27 major trauma centres in England. Our nearest major trauma centre is at Southampton hospital

Do you need this document in an alternative format or language?

If you or someone you know needs this document in an alternative format or language, please contact us on **0300 561 0905** or **hiowicb-hsi.mohhs@nhs.net**

જો તમને અથવા તમે જાણો છો તેવી કોઇ પણ વ્યક્તનિ આ દસ્તાવેજની વૈકલ્પકિ ફોર્મેટ અથવા ભાષામાં જરૂર હોય, તો કૃપા કરીને **0300 561 0905** અથવા **hiowicb-hsi.mohhs@nhs.net** પર અમારો સંપર્ક કરો

यदि आपको या आपके किसी परिचित व्यक्ति को इस दस्तावेज़ की आवश्यकता अन्य प्रारूप या भाषा में है, तो कृपया हमसे **0300 561 0905** या **hiowicb-hsi.mohhs@nhs.net** पर संपर्क करें।

यदि तपाईं वा तपाईंले जान्ने कुनै व्यक्तिलाई यो कागजात वैकल्पिक स्वरूप वा भाषामा चाहनिछ भने, कृपया **0300 561 0905** वा **hiowicb-hsi.mohhs@nhs.net** मा हामीलाई सम्पर्क गर्नुहोस्।

Jeśli Ty lub inna osoba potrzebuje otrzymać niniejszy dokument w innym formacie lub języku, prosimy o kontakt pod numerem **0300 561 0905** lub na adres **hiowicb-hsi.mohhs@nhs.net**

اگر آپ یا آپ کے کسی جاننے والے کو اس دستاویز کی متبادل شکل یا زبان میں ضرورت ہے تو براہ مہربانی ہم سے **0300 561 0905** پر رابطہ کریں یا **hiowicb-hsi.mohhs@nhs.net** پر ای میل کریں۔

Have your say and help shape tomorrow's hospitals

To find out more visit
www.hampshiretogether.nhs.uk
or scan the QR code

You can also email
hiowicb-hsi.mohhs@nhs.net
call **0300 561 0905**
or write to us at
Freepost HAMPSHIRE TOGETHER

Data protection

Any personal information we receive in response to this consultation will be protected and stored securely in line with data protection rules. This information will be kept confidential. There is more information about this on our website, see the consultation privacy notice at **www.hampshiretogether.nhs.uk/privacy.**

Hampshire Together

NHS
Hampshire and Isle of Wight

A new hospital for Hampshire: proposed changes to acute hospital services in and around Basingstoke and Winchester

Our summary consultation document

11 December 2023 to 17 March 2024

About Hampshire and Isle of Wight Integrated Care Board

This summary consultation document has been published by Hampshire and Isle of Wight Integrated Care Board. We are the statutory NHS organisation responsible for setting the health and care strategy for this area. We allocate NHS resources and work across Hampshire and Isle of Wight to make sure services meet the needs of local people.

As part of our statutory duties, we are consulting on proposals to build a new hospital for Hampshire by the early 2030s, invest in our hospital in Winchester, and change the way acute hospital services are organised. We have been given delegated authority by NHS England to consult on their behalf on proposed changes to the specialised services that they commission from Hampshire Hospitals NHS Foundation Trust, such as neonatal care and some cancer services.

Our vision for health and care in Hampshire and the Isle of Wight

Our vision is to improve the health and wellbeing of all our population, throughout their life journey. We believe we have a unique opportunity to ensure that we can meet the needs of our population – both now and for future generations. The proposals set out here are part of this ambition.

Modernising our Hospitals and Health Services programme

This consultation is part of the Hampshire Together: Modernising our Hospitals and Health Services programme of work, which is a collaboration of NHS and care organisations in Hampshire, working together to improve NHS services for local people.

The development of our proposals has involved patients, families, carers, members of the public, local stakeholders, and health and care staff at every stage.

About this document

This is a summary of our full consultation document. It gives a short overview of how we developed our proposals for consultation, the options we are consulting on and differences between them.

If you would like to read the full consultation document or find more detailed information about this consultation please visit our website at www.hampshiretogether.nhs.uk or call us on 0300 561 0905.

In this document we refer to further information that is available online. However, if you don't have access to the internet, please call us on the number above and we will arrange for printed versions to be sent to you.

We have tried to use plain English as much as possible in this document. There is a glossary on our website at www.hampshiretogether.nhs.uk which explains some of the terms we use that you may not be familiar with.

Contents

What is this consultation about?

This consultation is about proposed changes to two acute hospitals in Hampshire run by Hampshire Hospitals NHS Foundation Trust – the Royal Hampshire County Hospital in Winchester and Basingstoke and North Hampshire Hospital in Basingstoke.

At the moment these two hospitals provide a range of services, which are summarised below (there is a glossary at www.hampshiretogether.nhs.uk for an explanation of these clinical terms).

Current services at Basingstoke and North Hampshire Hospital

- Accident and emergency department with trauma care (e.g., serious injuries following an accident)
- General medical inpatient care, including care of the elderly
- Specialist inpatient care - cardiology
- General and specialist surgery (emergency, planned inpatient and planned day surgery)
- Obstetrician-led birthing unit
- ‘Level 1 plus’ neonatal care
- Children’s inpatient and outpatient care
- Cancer services (including radiotherapy)
- Outpatients, diagnostics and therapies

Current services at Royal Hampshire County Hospital

- Accident and emergency department
- General medical inpatient care, including care of the elderly
- Specialist inpatient care - stroke
- General and specialist surgery (emergency, planned inpatient and planned day surgery)
- Obstetrician-led birthing unit
- ‘Level 1 plus’ neonatal care
- Children’s inpatient and outpatient care
- Cancer servcies
- Outpatients, diagnostics and therapies

Would the proposals mean changes to our community hospitals, health centres and GP services?

This consultation is only about proposed changes to hospital services provided at Basingstoke and North Hampshire Hospital, Basingstoke, and Royal Hampshire County Hospital, Winchester. The proposals do not include any changes to services at Andover Hospital or any other acute or community hospitals in Hampshire and Isle of Wight. Nor do the proposals impact on community, mental health, learning disability and autism services, GP services, or health centres in our area.

In this document we refer to **Basingstoke and North Hampshire Hospital** as **Basingstoke hospital** and the **Royal Hampshire County Hospital** as **Winchester hospital**.

Listening to staff and the public

Throughout the process of developing potential options for the future of local hospital services, we have been listening to the expertise, experience and views of our staff, patients, their families and carers, and communities. What we have heard has influenced the proposals set out in this document. You can find out more about how staff and local people have been involved in these proposals, and the feedback we heard, on our website at **www.hampshiretogether.nhs.uk** or by phone on **0300 561 0905**.

What are ‘acute’ hospitals?

Acute hospitals provide emergency and specialist support and treatment which cannot be provided outside of a hospital setting. This can include complex surgery, care after an accident or during an episode of illness.

Our proposals impact on how these services could be organised in the future.

We are consulting on three options for delivering services in new ways across two main hospitals. We would love to hear your views on these options, or other options you think would help us address the challenges we describe in this document.

Have your say and help shape tomorrow's hospitals

To read our full consultation document and find out more visit **www.hampshiretogether.nhs.uk** or scan the QR code

You can also email **hiowicb-hsi.mohhs@nhs.net**
call **0300 561 0905**
or write to us at **Freepost HAMPSHIRE TOGETHER**

Why do we need to make changes?

We are delighted to be part of the government's New Hospital Programme that has given us funding to build a brand new hospital for Hampshire by the early 2030s, and invest in Winchester hospital. To make the most of this once in a generation opportunity, we need to consider how best to organise services in the future to help address some of the challenges we face and improve care for local people.

Keeping things as they are is not an option. There are four main reasons why we must change the way we deliver hospital services. These are sumamrised below.

Population

Our population is growing and getting older, meaning health and care needs are changing. For example, the overall population of Basingstoke and Deane, Test Valley, and Winchester will grow by around 5% over the next 20 years and the number of people over 75 will increase by around 53%. As the population gets older the need for health care will increase and our hospital services will have to adapt to care for more people, and people with more complex health needs.

Buildings

Some of our hospital buildings, while much loved, are approaching the end of their usable lives. Parts of Winchester hospital date back to the 19th century, and almost 50% was constructed between 1985 and 1994. At Basingstoke hospital, 80% of the buildings were constructed between 1965 and 1974. It would cost over £625 million in maintenance alone to keep Basingstoke and Winchester hospitals functioning over the course of the next 15 years.

Quality

Duplicating services across two main hospital sites impacts on the quality of care we provide because our resources – particularly specialist staff – are spread too thinly. Despite the efforts of our hard working staff, we struggle to consistently meet national best practice standards for staffing in key areas of care including maternity services, neonatal care, and critical care. Our neonatal units were both temporarily changed from level 2 to 'level 1 plus' because they do not see enough babies each year. Operations are often cancelled at short notice because we need to deal with emergency admissions, increasing waiting lists.

Finances

We need to be able to run health and care services with the money we have available. The challenges we face all contribute to a worsening financial position. By the end of the 2022/23 financial year, the NHS in Hampshire and Isle of Wight was overspent by £83.2 million.

A new clinical model of care

To address the challenges we face, we need to make changes. Organising care in different ways in the future and taking the opportunity of government funding to invest in our buildings would help us deliver the improvements we want to see.

We have identified a new potential way of providing hospital services. We refer to this as our 'clinical model of care' because it sets out how services could be organised and delivered but does not specify where services would be located.

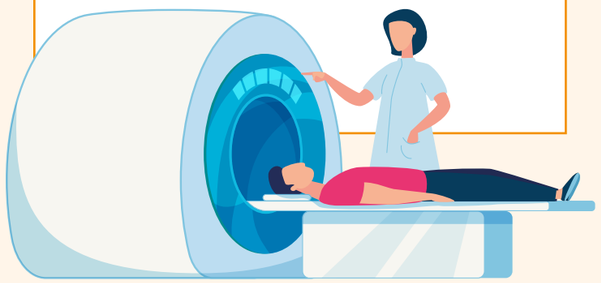
Our proposed new clinical model of care is shown below. It sets out how services should be grouped together and how they could be organised in the future to improve outcomes for patients.

One hospital providing specialist and emergency care - referred to as the specialist acute hospital

- emergency department with trauma unit and children's emergency department, 24/7 doctor-led urgent treatment centre, and same day emergency care
- specialist emergency and inpatient care, e.g. for strokes and heart attacks (as well as other inpatient care),
- emergency and complex planned surgery
- obstetrician-led maternity care, with alongside midwife-led birthing unit
- conditions to retain a level 2 neonatal unit
- inpatient children's services
- a cancer treatment centre
- outpatients, diagnostics and therapies

One hospital with a dedicated planned surgery centre

- 24/7 doctor-led urgent treatment centre, and same day emergency care
- dedicated planned surgery centre providing lower risk planned operations and procedures
- step-up and step-down inpatient beds for general medicine and care of the elderly
- a midwife-led birthing unit
- outpatients, diagnostics and therapies



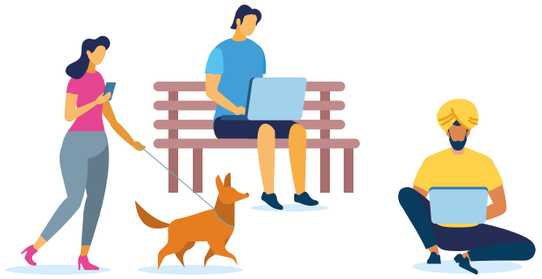
The key benefits of our proposed new clinical model of care are:

- **Bringing together specialist services for the most seriously ill patients on to one hospital site** would mean patients have better health outcomes and a more positive experience of care as a result of bringing services in line with best practice standards and national clinical guidelines. Doing this would also reduce duplication and make the best use of our specialist staff, equipment and other resources
- **Separating emergency and planned surgery as far as possible** by establishing a planned surgery centre with dedicated surgical staff for lower risk planned surgery and procedures would reduce the number of planned operations and procedures that are cancelled at short notice, it would also improve care and outcomes for patients
- **Doctor-led urgent treatment centres open 24 hours a day, seven days a week** with same day emergency care at both hospitals would be able to deal with most urgent care needs, in addition to an emergency department with a trauma unit at the specialist acute hospital for the most serious conditions
- **Providing holistic maternity care that puts pregnant women and people at the heart of services**, including developing a new alongside midwife-led birthing unit (i.e., one that is next to an obstetrician-led birthing unit) and a new freestanding midwife-led unit to give pregnant women and people more choice about how and where they give birth
- **Creating the conditions to retain a level 2 neonatal unit** that would see enough babies each year to meet national guidelines and have a dedicated rota of specialist neonatal staff, meaning fewer babies would need to go to hospitals outside of our area for care
- **Bringing a dedicated children's service to our area** including a separate children's emergency department, giving children and their families improved quality of care and outcomes, in line with Royal College of Paediatrics and Child Health standards
- **Creating step-up and step-down hospital beds and facilities** to care for people who do not need a specialist hospital environment but who need medical support overnight with a view to getting them well enough to get back home as soon as possible
- **Creating a cancer treatment centre** to provide a fully joined up and multidisciplinary service ensuring equity of care for local people, providing chemotherapy and radiotherapy
- **Providing outpatients, diagnostics and therapies as close to people's homes as possible,** ensuring that people have easy access to the most commonly used, day-to-day hospital services.

The trade-off of these benefits would be that some people would need to travel further for care. Some staff may also have a longer journey to work.

Developing the proposals for consultation

We followed a robust and thorough process for developing, considering, and evaluating the proposals we are putting forward for consultation. The process was led by senior doctors and involved a wide range of other health professionals and patient representatives.



Identifying the options

Having identified a proposed new clinical model of care, we looked at the possible ways we could organise services in the future. We looked at where services could be located on our current hospital sites, and the potential locations for a new hospital.

We concluded that the new hospital should be the specialist acute hospital because we would not have enough money to build a new planned surgery centre and bring our existing buildings up to the required standard for a specialist acute hospital.

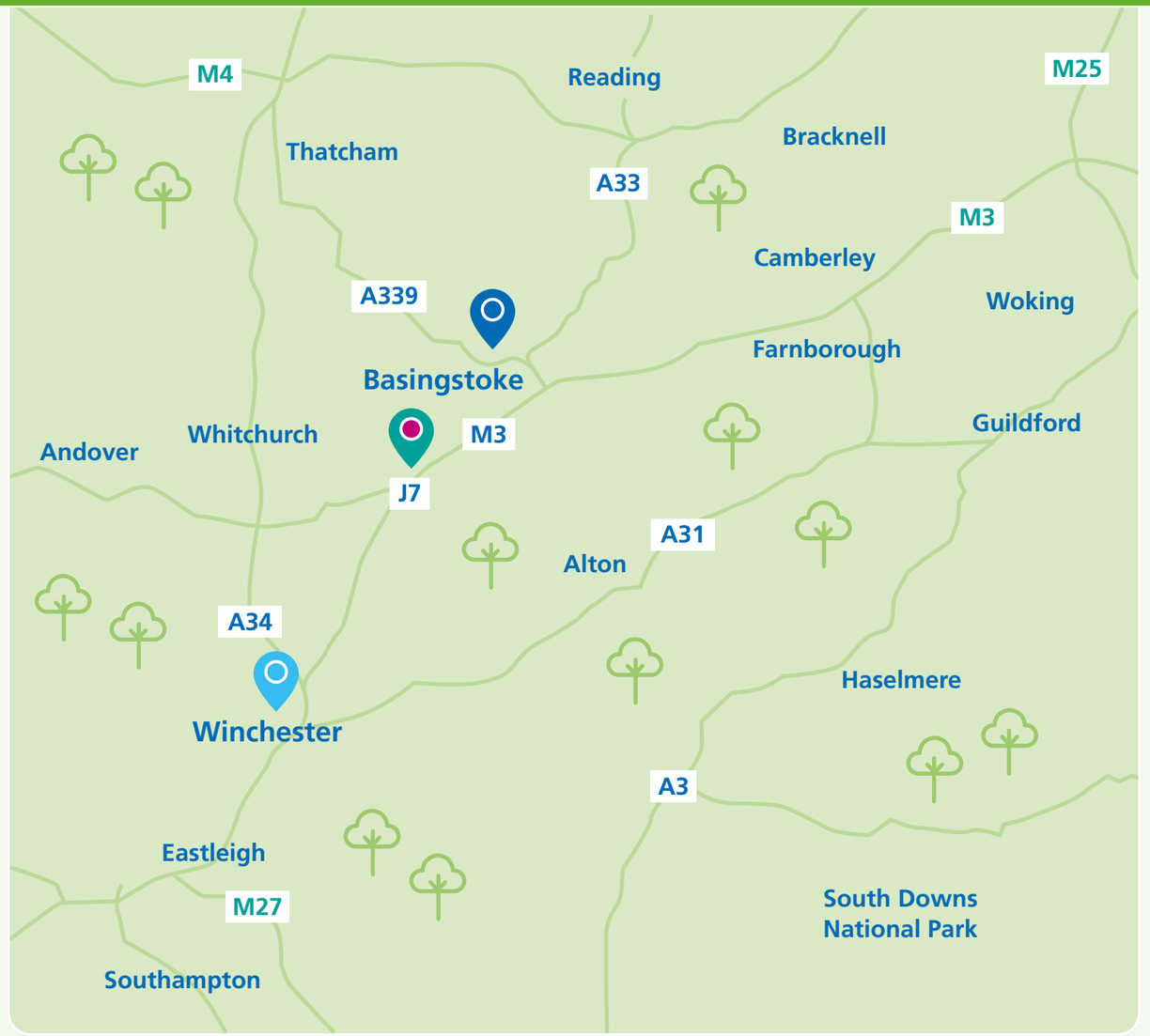
We extensively explored potential suitable locations for the new specialist acute hospital. Through this process, it became clear that the Winchester hospital site is not suitable because it is not big enough and there is no adjacent land to expand onto. There were also no suitable locations near Winchester to build the new hospital.

A more detailed overview of the options appraisal process is set out in a factsheet available at **www.hampshiretogether.nhs.uk** or by calling us on **0300 561 0905**.

We identified two viable sites for the location of a new hospital. One is located between Basingstoke and Winchester, near to Junction 7 of the M3, near North Waltham and Dummer. The other is the current site of Basingstoke and North Hampshire Hospital plus some adjacent land.

Therefore, we concluded that:

- Winchester hospital would be the best location for the planned surgery centre, along with a 24/7 doctor-led urgent treatment centre and same day emergency care, step-up and step-down inpatient beds, a midwife-led birthing unit and outpatients, diagnostics and therapies.
- in any option where the new hospital would be at the site near Junction 7 of the M3, outpatients, diagnostics and therapies would also be provided at the current Basingstoke hospital site, to keep routine care as close to home as possible.
- we should evaluate options that included step-down inpatient beds at the current Basingstoke hospital site.



Potential new hospital at current Basingstoke Hospital site

Potential new hospital near to Junction 7 of the M3

Location of Winchester hospital (shown for reference)

Evaluating potential options

Having identified how our new clinical model of care could be implemented, and sites for a new hospital, we had a list of potential options for further evaluation. We also evaluated an option referred to as 'business as usual', where there would be minimal change to services.

This process showed that 'business as usual' was not a viable option, but we identified a shortlist of three options to take forward for consultation.

The options for consultation

We have shortlisted three options for consultation, one of which – Option 2 – is our preferred option for the future. This is an overview of the options.

Option 1	Option 2 (preferred option)	Option 3
New specialist acute hospital on the **current Basingstoke hospital site** and refurbishment at Winchester hospital	New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital	New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Services at Winchester hospital in all options:

- 24/7 doctor-led urgent treatment centre and same day emergency care
- Step-up and step-down inpatient beds for general medicine and care of the elderly
- Dedicated planned surgery centre
- Freestanding midwife-led birthing unit
- Outpatients, diagnostics and therapies

Services at the new specialist acute hospital in all options:

- Emergency department with trauma unit, children's emergency department, 24/7 doctor-led urgent treatment centre and same day emergency care
- Specialist inpatient care e.g. stroke and heart attack and inpatient beds, including for general medicine and care of the elderly
- Complex planned and emergency surgery
- Obstetrician-led birthing unit and alongside midwife-led unit
- Conditions for a level 2 neonatal care unit
- Cancer treatment centre
- Outpatients, diagnostics and therapies

Services at the current Basingstoke hospital site:	Services at the current Basingstoke hospital site:
Outpatients, diagnostics and therapies Planned day-case surgery	Outpatients, diagnostics and therapies Planned day-case surgery Nurse-led step-down reablement and rehabilitation beds

While our proposals would not be implemented for some years, they would mean that:

- A&E would no longer be available at Winchester, although there would be a 24/7 doctor-led urgent treatment centre
- obstetrician-led maternity services would no longer be available at Winchester, but there would be a midwife-led birthing unit and antenatal and postnatal care
- there would be changes to where planned surgery would be provided, with the majority of planned surgery only being available at Winchester
- there would be changes to where some cancer treatment would be provided, with radiotherapy and some types of chemotherapy only available at the cancer treatment centre at the new hospital, but with other cancer care remaining local.

Why is Option 2 the preferred option?

We believe that, while all three options are viable and implementable, Option 2 has significant advantages, and fewer disadvantages than the other two options. Under Option 1 it would be much more complicated and expensive to build a new hospital on the current Basingstoke site, rather than at a new location. Option 1 would also have a higher risk of more people going to other hospitals outside our area putting additional pressure on those hospitals.

Option 3 includes some nurse-led step-down rehabilitation and reablement beds at the current Basingstoke hospital site for patients medically suitable for nurse-led care. While these beds would mean some patients could recover closer to home, which we know is important to people, it would mean we would need more nursing staff, or would have to split our current nursing staff across an additional site, which is more challenging to deliver.

Are these the only options you will consider?

We are open-minded about the potential for there to be other options that we could explore that would address our challenges. We hope that you will share any other suggestions or ideas you have when you respond to the consultation, including possible new options or variations on the options set out here.

Advantages and disadvantages of the options

In addition to the benefits of the model of care shown on page 7, our proposals would mean we could maintain day-to-day hospital services such as outpatients, diagnostics and therapies at Winchester and the current Basingstoke hospital site, as well as near Junction 7 of the M3 under Options 2 and 3, keeping the most frequently used services close to home. All the options would also help to give us a resilient workforce and fewer vacancies and improve the working environment for staff.

Each option has its own advantages and disadvantages that you may want to consider when responding to the consultation. These are summarised here.

Option 1

New specialist acute hospital on the **current Basingstoke hospital site** and refurbishment at Winchester hospital

Advantages

- The NHS does not need to purchase new land to deliver this option
- There are established public transport links to the current Basingstoke hospital site
- There would be less impact on travel times for people living in deprived areas because these areas tend to be in and around Basingstoke

Disadvantages

- Because the new hospital would be less centrally located in our catchment area there is a greater impact on average travel times compared to Options 2 and 3
- Because the new hospital would be less centrally located there is a higher likelihood of people going to closer neighbouring hospitals putting additional pressure on those hospitals, compared to Options 2 and 3
- Building the new hospital at the existing Basingstoke hospital would be more complex and take longer because of the need to deliver existing services on the same site during the build process which would take several years
- There would be disruption to current care during the build
- There would be less space for further expansion in the future compared to the site near Junction 7 of the M3
- This option has the most expensive capital cost of all three options

Option 2 (preferred option)

New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Advantages

- Because the new hospital would be more centrally located in our catchment area, there is less impact on travel times by car under this option, compared to Option 1
- Because the new hospital would be more centrally located, there is less likelihood of people going to other closer neighbouring hospitals, meaning less impact on those hospitals
- Building a new hospital near Junction 7 of the M3 would not disrupt current care at the existing Basingstoke hospital site during the years of construction
- The potential new site is larger than the current Basingstoke hospital site so offers greater flexibility and opportunity to expand services in the future if needed
- This option has the lowest capital cost of all three options

Disadvantages

- The NHS does not currently own the proposed site near Junction 7 of the M3
- New public transport routes would be needed to enable easy access to the hospital site
- This option has a greater impact on travel times for some people living in deprived areas

Option 3

New specialist acute hospital near **Junction 7 of the M3** and refurbishment at Winchester hospital

Advantages Same as Option 2 plus:

- Offers nurse-led step-down reablement and rehabilitation beds at the current Basingstoke site for patients medically suitable for nurse led care. This would provide additional access for people near Basingstoke who have been in hospital and still need inpatient care, but do not need the full range of specialist services

Disadvantages Same as Option 2 plus:

- This option splits our nursing staff across an additional site because there would be nurse-led rehabilitation and reablement beds at the current Basingstoke hospital site
- To implement the beds we would need to refurbish additional space at the current Basingstoke hospital site, which would increase the cost of this option

Things to think about when responding to the consultation

This section gives a summary of the impact of the options and what our proposals might mean for you, your family, and the wider health and care system.

Access to services

We know that the impact of our proposals on travel times and access to services is likely to a be an important issue for people.

Our proposals would improve access to many services and provide access to some new services. Under all three options, outpatient appointments, diagnostic tests, and therapies would continue to be provided at the Basingstoke and Winchester hospital sites. Under Options 2 and 3 these services would be at three locations compared to two now.

Our proposals would reduce waiting times for emergency and urgent care because more consultants would be available on site for more hours than they are currently, speeding up diagnosis and treatment.

More information including patient stories and further detail on travel times is avaialble in our factsheets at **www.hampshiretogether.nhs.uk** or by calling us on **0300 561 0905**.

There would be access to some services not currently provided locally, for example:

- two 24-hour, seven day a week doctor-led urgent treatment centres and more same day emergency care
- a dedicated planned surgery centre
- a dedicated children's emergency department
- midwife-led birthing units.

In addition:

- A 24/7 doctor-led urgent treatment centre at Winchester would be able to treat around 60 percent of the patient cases that currently attend Winchester A&E.
- There would be the conditions to retain a level 2 neonatal unit.
- A planned surgery centre would mean fewer cancelled operations because of emergencies, helping to shorten waiting lists.
- Refurbishing existing hospital buildings and building a new hospital would improve physical access to services, particularly for people with disabilities and with sensory and information processing differences.

Travel times

Currently many of our most specialist services such as stroke, heart attack and trauma services are already only provided at one of our hospitals. The impact on travel times for those services would be minimal. For the services that are currently provided on both sites, all three options would have an impact on travel times for some people in the future, compared to now.

Evidence shows that where there are longer journey times, these would be more than offset by shorter waits to see a senior doctor on arrival at hospital, more consistent high-quality care, improved outcomes, shorter hospital stays, and services that are sustainable for the long term.

The table below shows average travel times to emergency and specialist care* by car during off-peak times, which is similar to travel time by blue-light ambulance.

	Current	Option 1	Option 2 and 3
Average (approximate)	20 minutes	30 minutes	30 minutes
Maximum (approximate)	45 minutes	60 minutes	50 minutes

*Care for the most serious life and limb threatening emergencies is already only provided at one of our hospital sites

The table below shows travel times to access planned surgery services by car during peak and off peak times.

	Current (off-peak)	All options (off-peak)	Current (peak)	All options (peak)
Average (approximate)	20 minutes	40 minutes	25 minutes	40 minutes
Maximum (approximate)	30 minutes	70 minutes	49 minutes	81 minutes

Travel times by public transport

We have not done detailed calculations about the potential impact of our proposals on access to **specialist and emergency services** by public transport because there is currently no public transport to the proposed site near Junction 7 of the M3. We have however, been discussing with relevant partners what public transport solutions would be needed if services change in the future.

We have looked at the impact on travel times by public transport to **access planned surgery services**. This shows an increase in average travel times from around 45 minutes to around 80 minutes. We are exploring ideas to minimise this impact, including volunteer transport schemes and demand response vehicles.

Changes to people's nearest hospital

In most cases people who currently use services at Basingstoke and Winchester hospitals would probably access care at either the new hospital or at Winchester hospital. However, all the options we are consulting on might mean a change in some people's nearest hospital for some care.

This could mean that some people access services at a new, and potentially unfamiliar hospital location. It could also put pressure on other neighbouring hospitals due to increased patient numbers and impact on South Central Ambulance Service because of longer journeys for some to the specialist acute hospital.

We are working closely with other hospitals and the ambulance service to understand the potential impact our proposals would have on them and if this would be manageable in the long term. We have received letters of support to consult on our proposals from hospital trusts that could be impacted and from South Central Ambulance Service.

When you respond to the consultation please let us know what you think we could do to reduce the impact of any concerns you may have about our proposals.

Expected cost of each option

We have been told by the government's New Hospital Programme that the likely budget for us to build a new hospital, and to refurbish Winchester Hospital is between £700 million and £900 million.

The table below gives the expected costs for each option. These are indicative costs, based on the best information we have available to us at this time.

	Capital cost in £millions
Option 1	£948
Option 2	£807
Option 3	£860

While the costs for Option 1 are above the budget, they are considered to be within an acceptable range, especially as costs are likely to change as the New Hospital Programme develops its approaches to construction and procurement and as more detailed plans are developed.

Giving your views and the next steps

We would like to know what you think about these proposals before we decide how to proceed. Our consultation runs from 11 December 2023 for 14 weeks, and you can share your views with us until midnight on **17 March 2024.**

You can read our full consultation document, find out more about our proposals and ways to get involved on our website at www.hampshiretogether.nhs.uk. There are lots of ways to share your views with us. In summary you can:

- email us at: **hiowicb-hsi.mohhs@nhs.net**
- write to us at: **Freepost HAMPSHIRE TOGETHER**
- call us on: **0300 561 0905**
- complete the consultation questionnaire on our website, or complete a paper copy and send it to: **Freepost HAMPSHIRE TOGETHER**
- come to a face to face or virtual public meeting
- invite us to come and speak to your community group

Next steps

After the consultation closes all the feedback we have received will be analysed by an independent research organisation. They will prepare a report for us setting out what people think about the proposals.

We, together with NHS England in relation to specialised services, will consider the feedback from the consultation, along with a wide range of other evidence, information and data to develop a decision making business case and use that to decide which option to implement.

We will continue to engage people and share information about our work, including publishing the consultation report and papers that will inform the decision-making. The final decision-making meeting will be held in public to allow those who are interested to hear the discussion and how the decision is made.

When would a new hospital be ready?

Once a decision has been made on the future of acute hospital services in Hampshire, detailed implementation planning will begin. Subject to planning permission, we expect to be able to open the doors to our new hospital in the early 2030s.

Do you need this document in an alternative format or language?

If you or someone you know needs this document in an alternative format or language, please contact us on **0300 561 0905** or **hiowicb-hsi.mohhs@nhs.net**

જો તમને અથવા તમે જાણો છો તેવી કોઇ પણ વ્યક્તનિ આ દસ્તાવેજની વૈકલ્પકિ ફોર્મેટ અથવા ભાષામાં જરૂર હોય, તો કૃપા કરીને **0300 561 0905** અથવા **hiowicb-hsi.mohhs@nhs.net** પર અમારો સંપર્ક કરો

यदि आपको या आपके किसी परिचित व्यक्ति को इस दस्तावेज़ की आवश्यकता अन्य प्रारूप या भाषा में है, तो कृपया हमसे **0300 561 0905** या **hiowicb-hsi.mohhs@nhs.net** पर संपर्क करें।

यदि तपाईं वा तपाईंले जान्ने कुनै व्यक्तिलाई यो कागजात वैकल्पिक स्वरूप वा भाषामा चाहनिछ भने, कृपया **0300 561 0905** वा **hiowicb-hsi.mohhs@nhs.net** मा हामीलाई सम्पर्क गर्नुहोस्।

Jeśli Ty lub inna osoba potrzebuje otrzymać niniejszy dokument w innym formacie lub języku, prosimy o kontakt pod numerem **0300 561 0905** lub na adres **hiowicb-hsi.mohhs@nhs.net**

ای ل ک ش ل داب ت م ی ک زی وات س دس ا وک ے ل او ے ن ن اج ی س ک ے ک پ آ ای پ آ ر گ ا
ای ر پ **0300 561 0905** ے س م ہ م ر ک ہ ارب وت ے ہ ت رورض ں ی م ن اب ز
hiowicb-hsi.mohhs@nhs.net ۔ں ی ر ک ہ ط ب ا ر ر پ

Have your say and help shape tomorrow's hospitals

To find out more visit
www.hampshiretogether.nhs.uk
or scan the QR code

You can also email
hiowicb-hsi.mohhs@nhs.net
call **0300 561 0905**
or write to us at
Freepost HAMPSHIRE TOGETHER

Data protection

Any personal information we receive in response to this consultation will be protected and stored securely in line with data protection rules. This information will be kept confidential. There is more information about this on our website, see the consultation privacy notice at **www.hampshiretogether.nhs.uk/privacy.**

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Membership and Engagement Committee (MEC) Update
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	10
Executive Summary:	To provide an update on the activities of the MEC.
Recommendations:	The Council of Governors (COG) are asked to: • Give expressions of interest to join the MEC • Give suggestions on topics for public talks
Accountable Director:	n/a
Author:	Margaret Eaglestone, Stakeholder and Engagement Manager
Previously considered at:	n/a
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	• **Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives

Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Please contact Margaret.Eaglestone@scas.nhs.uk with expressions of interest
List of Appendices	Membership and Engagement Update Presentation.

South Central Ambulance Service
NHS Foundation Trust

MEC update

Mark Davis

MEC Chair and Public Governor

Terms of reference update

- A governor can sit on the MEC for 2 x terms (excluding appointed and CFR governor)
- 1 x term is 3 x years in line with Governor term of office
- In light of this, many of our long serving and very committed MEC member governors are at the end of their eligible term which gives the opportunity to other current or new governors to join.
- We would strongly encourage anyone interested in doing so to find out more. Being an active member of MEC is an excellent way to help governors to fulfil their engagement obligations
- **We request expressions of interest from any governor who would like to sit on the MEC.**

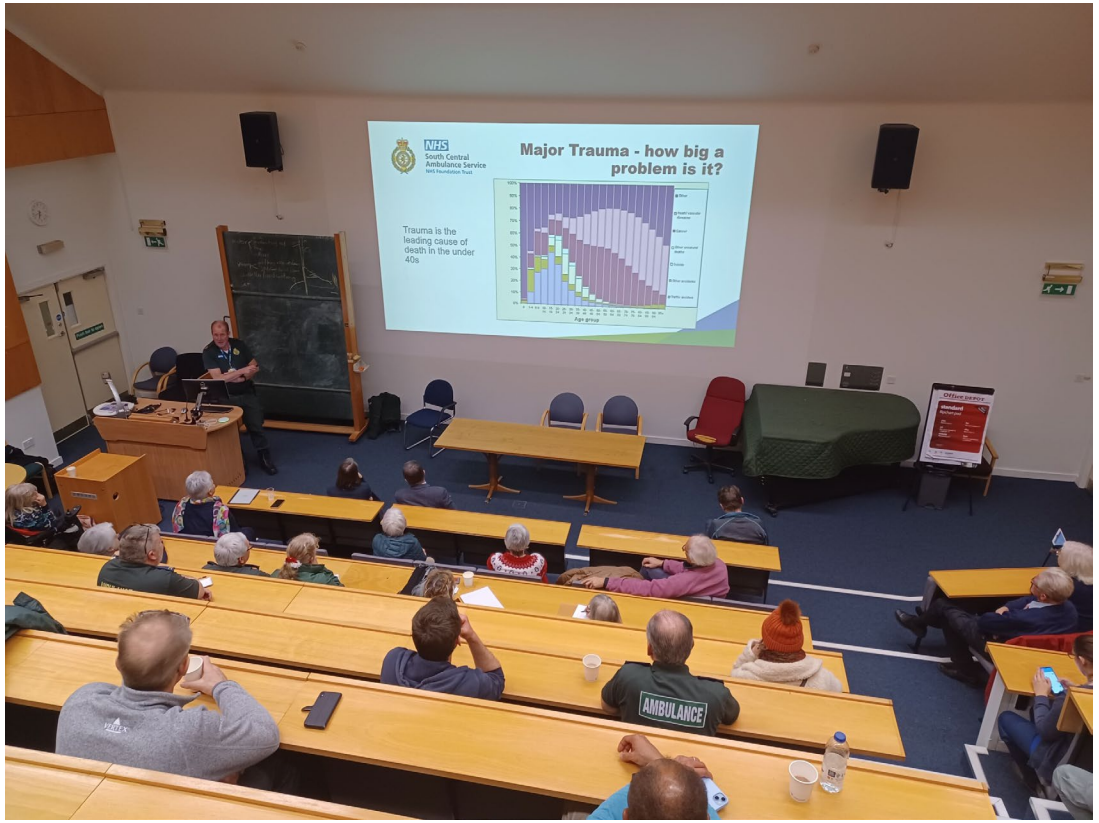
Governor election campaign

- The last MEC was held on October 24 on Teams
- Simon Clarke, Civica Election Services, presented on the election process and the single transferable vote (STV). Simon has provided a paper on the STV on request of the MEC and will present again on the STV at the next MEC in February…
- SCAS elections 2023 communication and engagement campaign ran from September to December 2023, reaching out to staff and public to recruit new Governors across a mix of channels
- **Please see campaign update attached**

SCAS events

Event	Location	Governor
Over 55 information event	MK	Ian Sayer
Diwali	Southampton	Hilary Foley
Remembrance Sunday	Banbury	NA
St Mary's Mosque	Southampton	Hilary Foley
Carers listening event	Southampton	Tim Ellison
Barton Community Larder	Barton	Helen Ramsay
Asylum seeker SCAS information event	Witney	Helen Ramsay Ian Sayer

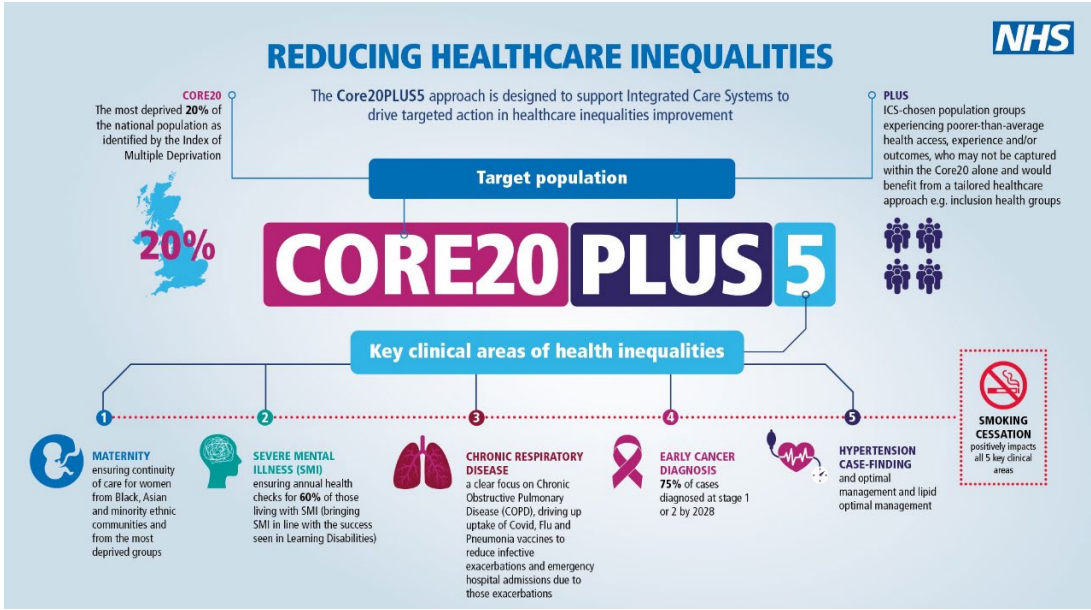
Your health matters – public talk



- The challenge of trauma was part of a series of public talks which feature our expert health professionals
- The talk was delivered in collaboration with Oxford University Hospitals NHS Foundation Trust (OUH) to our members and the public and was held on 13 December from 6:30 pm at the John Radcliffe Hospital in Oxford.
- Helen Ramsay chaired the public talk and coordinated Q&A
- John Black and MaS talked about the challenge of trauma alongside Bob Handley, Consultant Orthopaedic Trauma Surgeon, Oxford University Hospitals NHS Foundation Trust
- Alan Weir, Staff Governor, went over and above to provide CPR demonstrations and answer questions form members and public attending

Health inequalities

- Helen Ramsay and Tim Ellison have set up a working group to explore further opportunities for engagement and determine the most effective approach.
- The working group will align NHSE core 20 plus and AACE priorities https://aace.org.uk/reducing-health-inequalities/ with SCAS population data
- Please contact Helen Ramsay if you want to join the working group



NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	People and Culture Committee Annual Report
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	11
Executive Summary:	To provide an update of the Committees work within the past 6 months.
Recommendations:	The Council of Governors are asked to note the report.
Accountable Director:	Melanie Saunders, Chief People Officer Ian Green, Non-Executive Director, and Chair of People and Culture Committee.
Author:	Ian Green, Non-Executive Director, and Chair of People and Culture Committee
Previously considered at:	Not applicable
Purpose of Report:	To note
Paper Status:	Public
Assurance Level:	**Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	

List of Appendices	

Meeting Report

Name of Meeting	Council of Governors Meeting
Title	People and Culture Committee Annual Report
Author	Ian Green, Non-Executive Director, Chair of People and Culture Committee
Accountable Director	Melanie Saunders, Chief People Officer
Date	31 January 2024

Purpose

The Board of Directors established the Committee of the Board to be known as the People and Culture Committee (PCC) just over 12 months ago. This is the first report of PCC to the Council of Governors.The Committee has no executive powers other than those specifically delegated in these Terms of Reference (ToR).

The main purpose of the People and Culture Committee is to provide the Board with assurance on a range of issues with a people and culture focus including - the Trust's leadership arrangements; behaviours and culture; training, education and development, equality, diversity and inclusion, recruitment and retention, Freedom to Speak up etc

The Committee is chaired by Ian Green with two additional NED members – Sumit Biswas and Dr Anne Stebbing.

The Chief People Officer Melanie Saunders is the lead Executive Director reporting the committee.

Agenda items covered at the most recent meeting

- Review of the relevant sections of the corporate risk Register and BAF
- Consideration of the revised Freedom to Speak up Policy
- Six-month review of our Freedom to Speak up self-assessment
- Equality Delivery System assessment
- Approval of a new placement agreement between SCAS and University of Portsmouth
- Review of month 8 and month 9 metrics including absence, PDRs, sickness, recruitment and retention

- Assurance of updated work force policies

- Review of People and Culture committee elements to the draft Governance Assurance and Accountability Framework

- Presentation on high level embargoed national staff survey results

- Retention exemplar programme update

Matters to highlight

The committee splits its agenda into three key areas – items for approval, assurance and information. The bulk of our time is spent on items for agreement and assurance.

To provide you with a snapshot of how the committee operates I have set out below and overview of the most recent meeting.

At the last meeting we sought assurance in the following areas: -

- Are the actions outlined in the relevant areas of the BAF being progressed in accordance with the set timescales. If not why not and how will the key risks be mitigated?

- Whilst acknowledging the revised FTSU policy is in line with national guidelines some of the language in the appendices are difficult to follow and feedback should be provided to the national guardian's office.

- How are we communicating the revised FTSU policy to staff to encourage people to speak up?

- We noted there had been improvements in our FTSU self-assessment since our last review but were concerned that one area had deteriorated, relating to funding for staffing. We sought and obtained assurance that progress was being made in securing funding through the current budget setting process

- We noted our “Developing” internal assessment as part of the national equality delivery system assessment. In doing so we expressed concern regarding the language and approach outlined in the national document. This would be fed back. We sought assurance on why the section on safeguarding and serious incidents were regarded as “underdeveloped” and feedback was provided outside of the meeting.

- We questioned why the placement agreement with the University of Portsmouth was coming to us as this would appear to be outside of our ToR. It was agreed that a SCAS wide approach to approving SLAs should be considered

- We spent considerable time reviewing the staffing metrics and it was pleasing to note some sustained improvement in both recruitment and retention across the organisation. We were concerned at the dip in appraisal and sought further assurance as to why the reduction had occurred (due to sustained

REAP levels) and what action was being taken to recover this. A report would be brought back to our next meeting.

- The committee receive some assurance on progress in updating the suite of people related policies and asked that further detail is provided in where policies should be approved and that only policies should be included in the spreadsheet

- We considered the P&C elements of the draft Governance and Accountability Framework, highlighting where there were duplicate responsibilities listed and making some suggested changes

- The committee reflected on the early cut of data from the recent national staff survey. A full report would be brought to the March meeting once the data is published.

At every meeting we reflect on how the meeting has gone, what could be improved, and how we might seek further and better assurance.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Quality and Safety Committee 2022/2023 Annual Report
Name of Meeting	Council of Governors
Date of Meeting:	Thursday, 30 November 2023
Agenda Item:	12
Executive Summary:	The Quality and Safety Committee has prepared this Annual Report for the 2022/2023 financial year for the attention of the Board. It sets out how the Quality and Safety Committee has satisfied its Terms of Reference (ToR) during the year and provides the Board with information relating to how it has carried out its responsibilities. Production of a Quality and Safety Committee Annual Report is required as good governance practice and complies with the Quality and Safety Committee's ToR.
Recommendations:	The Council of Governors are asked to note the Quality and Safety Committee 2022/2023 Annual Report.
Accountable Director:	Professor Helen Young, Chief Nurse / Executive Director of Patient Care and Service Transformation
Author:	Dr Anne Stebbing, Non-Executive Director and Chair, Quality and Safety Committee.
Previously considered at:	Quality and Safety Committee
Purpose of Report:	Assure
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options** • **Acceptable** – General confidence in delivery of existing mechanisms/objectives

Justification of Assurance Rating:	Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	(What actions will be taken following agreement of the recommendations)
List of Appendices	(Please list any supporting information accompanying this Summary Sheet and Meeting Report)

Meeting Report

Name of Meeting	Council of Governors eetin
Title	Quality and Safety Committee 2022/2023 Annual Report
Author	r nne te in on ecutive irector an C air ualit an afet Co ittee
Accountable Director	rofessor elen oun C ief urse fficer
Date	1 anuar 2 2

1. Purpose

The Quality and Safety Committee has prepared this Annual Report for the 2022/2023 financial year for the attention of the Board. It sets out how the Quality and Safety Committee has satisfied its Terms of Reference (ToR) during the year and provides the Council of Governors with information relating to how it has carried out its responsibilities.

Production of a Quality and Safety Committee Annual Report is required as good governance practice and complies with the Quality and Safety Committee's ToR.

2. Background and Links to Previous Papers

This report is presented annually.

The Quality and Safety Committee provides independent scrutiny and it focuses on promoting safety and excellence in patient care; identifying, prioritising and managing risk arising from clinical care; and ensuring the effective and efficient use of resources through evidence-based clinical practices.

The Quality and Safety Committee independently reviews, monitors and reports to the Board on matters associated with the attainment of effective clinical care for patients.

3. Executive Summary

<u>Membership</u>

3 e ualit an Safety Committee membership for the 2022/2023 financial year has

- Dr Anne Stebbing, Non-Executive Director (NED) and Chair, Quality and Safety Committee
- Mr Sumit Biswas, NED
- Mr Nigel Chapman, NED
- Dr Henrietta Hughes, NED (until September 2022)

Compliance with the Terms of Reference (ToR)

3.2 During 2022/2023 the Quality and Safety Committee has operated in a manner compliant with its ToR (which were amended in March 2022, to increase meeting frequency to bimonthly) in particular:

- The Committee has met 6 times during the 2022/2023 financial year with a full agenda and attendees.
- The Committee had 1 Extraordinary Safeguarding meeting.
- Meetings have been quorate (at least two members).
- Committee has exercised its full range of responsibilities.
- Upward Reports of the Committee meetings have been circulated to the Board.
- Committee Chair has brought key issues / concerns to the attention of the Board.

3.3 All meetings have continued to be held on Teams rather than in person.

COVID-19 Pandemic

3.4 Quality and Safety Committee continued to receive updates on the additional national services delivered by SCAS during the pandemic (Covid Response Service (CRS 111), Covid Clinical Assessment service (CCAS), Covid Vaccination helpline).

3.5 The Chair of Quality and Safety continued to attend the CRS/CCAS/Vaccination Helpline Board meetings on Teams.

Meetings

3.6 During 2022/2023 the Quality and Safety Committee met 6 times as planned. The attendance of members is set out below:

	A Stebbing	S Biswas	H Hughes	N Chapman
12 MAY 2022	Y	Y	Y	APOLOGIES
14 JULY 2022	Y	Y	Y	Y
8 SEPTEMBER 22	Y	Y	APOLOGIES	Y
3 NOVEMBER 22	Y	Y	N/A	Y
12 JANUARY 2022	Y	Y	N/A	Y
9 MARCH 2023	Y	Y	N/A	Y

3.7 In addition, the Committee held an extra meeting to discuss safeguarding and other issues raised in immediate feedback following the CQC inspection of SCAS in April / May 2022.

	A Stebbing	S Biswas	H Hughes	N Chapman
9 JUNE 22	Y	Y	Y	Y

Governance, risk management and internal control

3.8 The Quality and Safety Committee has received regular reports on the clinical governance, risk management and internal control processes throughout the period.

3.9 There is cross-membership between the Audit Committee and the Quality and Safety Committee. Henrietta Hughes and Sumit Biswas are members of both subcommittees of the Board.

Care Quality Commission (CQC) Inspection April/May 2023

3.10 Following inspection of two cores services (Emergency Operations Centre and Urgent and Emergency Care) and the well-led domain in April / May 2022 the Trust was given an “Inadequate” overall Trust quality rating. All members of the Quality and Safety Committee engaged with oversight of the Trust-wide improvement plan, and the Quality and Safety Service Delivery Group which was established to ensure areas identified by the CQC as needing improvement were robustly addressed.

3.11 In addition, the Quality and Safety Committee continued to seek assurance that actions being taken would address all the concerns raised about safety of patients and staff, and that improvements would be sustained.

To agree Trust-wide clinical governance priorities

3.12 The Trust has a robust and effective process for agreeing the Quality Accounts priorities. The Quality and Safety Committee engaged with setting the priorities for the Quality Account in March 2022, however following the concerns raised by the CQC, some of the priorities received less focus while other improvements were undertaken. The Quality and Safety Committee agreed that during 2022/23 five priorities were delivered, 3 partially delivered and 2 were not delivered.

3.13 The Quality and Safety Committee received annual reports from Infection Prevention and Control, and Patient Experience.

To monitor the Trust’s compliance with the national standards of quality and safety of the Care Quality Commission and NHS Improvement licence conditions

3.14 A compliance paper is a standing item on the Quality and Safety Committee agenda. The progress on actions on the improvement plan have been monitored at each meeting in year.

To monitor within the Trust a culture of open and honest reporting

3.15 At each meeting the Quality and Safety Committee reviewed the summary upward reports for key Executive-chaired groups within the organisation to consider actions, progress, risks and learning. These groups were the Clinical Review Group, Patient Safety Group, Serious Incident Review Group, Patient Experience Review Group, and Education and Training summary along with Commercial Division. Following feedback from the CQC, the Safeguarding Committee, also reports directly to the Quality and Safety Committee for assurance.

3.16 Following the CQC visit SCAS established a People and Culture committee (first meeting 23 June 2022) as a further subcommittee of the Board. Liaison between the chairs of both committees and non-executive membership across both committees has helped ensure oversight is provided at the most appropriate committee, and that where necessary assurance is sought through the perspective of BOTH committees.

3.17 Leadership Walkabout activities re-started during the year enabling members of the Quality and Safety Committee to gain better insight into the culture of the organisation, and in particular to understand the ability to speak up, and for action to be taken (where necessary) to address the concerns raised.

3.18 Internal Audit reports with a quality and patient focus were considered by the Committee.

3.19 Governors have been observers to the committee meetings during 2022 -2023.

Management and Reporting

3.20 The ToR for the Quality and Safety Committee states that the Committee shall request and review reports and positive assurances from Directors and Managers as appropriate.

4. Areas of Risk

No specific risks to escalate from the Annual report.

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

The Trusts mission is to deliver the right care, first time, every time. Recognising and learning from occasions where errors may have been made that have affected or caused harm to a patient, member of the public or staff member is important to ensure that lessons are learned and steps are taken to avoid a reoccurrence.

6. Governance

The Quality and Safety Committee considers that it has met its Terms of Reference for 2022/2023. The ToR for the Quality and Safety Committee were reviewed at July 2023 meeting along with the draft Annual Plan.

7. Responsibility

The Chair of Quality and Safety Committee has responsibility for the Committee meeting Terms of Reference and upward reporting.

Key areas for 2023/2024 are:

- For the Committee to ensure that the high standards of scrutiny and governance are improved and maintained.

- For the Committee to scrutinise and triangulate data and actions from other committees to ensure quality and safety is embedded in the decision making processes.

- To receive assurance that all areas identified for improvement following the CQC visit in 2023 are completed, and the improvement is sustained.

- To receive consistent assurance that the organisation has a robust process of monitoring regulatory compliance. This will be achieved by the reports and action plans generated from the implementation of the Compliance Accreditation System.

- To receive assurance in the form of a report that the Quality Impact Assessment management processes of any schemes are robust and have thoroughly considered the impact on patient safety and quality.

- To continue to receive updates on the implementation of the Patient Safety Strategy.

- To receive reports on the Trust's Quality Improvement strategy and initiatives.

- To receive reports as per the annual workplan and have accountability for the oversight of progress against action plans.

7. Recommendations

The Council of Governors are asked to note the contents of the Annual Report.

Report Cover Sheet

Report Title:	Month 9 2023/24 Financial Position
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	13.a
Executive Summary:	**I&E Position** In December, the Trust recorded an in-month deficit of £1.4m against an in-month forecast deficit of £1.5m. (The Trust YTD deficit is £16.8m). Expenditure is slightly behind expectations due to: • Reduced availability of private provider ambulance capacity than expected. • Slippage in delivery of radio replacement programme. This slippage is a benefit within this financial year but expenditure will slip into 2024/25. The Trust's current run rate forecast remains £22.3m deficit. **Cash** The Trust's cash balance at the end of December is £32.0m. The Trust's cash balance has decreased by £18m since the start of the financial year. The cash forecast has improved due to the planned receipt of additional income and delays to planned capital expenditure on vehicles. At the current expenditure run rate, the Trust will require cash support from Quarter 4 2024/25 to support continuing operations. The cash forecast is sensitive to the timing of receipt of new vehicles and completion of related sale and leaseback transactions. The level of aged debtors over 90 days has remained high in the month due to unpaid invoices with another NHS provider for PTS services. This has been subject to escalation through formal contract meetings.

	Capital Capital spend YTD is £6.8m. The Trust is currently reviewing the capital forecast. Due to the delivery of both the 22/23 and 23/24 DCA cohorts' delays, due to commercial issues affecting the vehicle converters. Of the 53 vehicles expected to be delivered from the 22-23 cohort, only 23 are currently expected to be delivered within this financial year (noting that risk of further slippage exists). The Trust does not expect any of the 23/24 cohort to be delivered this financial year. The overall impact is that £12.8m of capital expenditure requires slipping into 2024/25. Discussions regarding the impact on both this financial year and next continue with NHS England South East Region and the HIOW ICS.
Recommendations:	The Council of Governors are asked to note the contents of this report.
Accountable Director:	Stuart Rees, Interim Director of Finance
Author:	Sam Dukes, Deputy Chief Financial Officer
Previously considered at:	Finance and Performance Committee
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	Finance & Sustainability
Links to BAF Risks or Significant Risk Register:	SR5 - Increasing Cost to Deliver Services
Quality Domain(s)	All Quality Domains
Next Steps:	N/A
List of Appendices	N/A

NHS South Central Ambulance Service NHS Foundation Trust

Meeting Report

Name of Meeting	Council of Governors Meeting
Title	Month 9 2023/24 Financial Position
Author	Sam Dukes, Deputy Chief Financial Officer
Accountable Director	Stuart Rees, Interim Director of Finance
Date	Wednesday, 31 January 2024

1. Purpose

This paper is being presented to update the Council of Governors on the Financial Position of the Trust at Month 9 (up to the end of December 2023).

2. Executive Summary

I&E: 2023/24 In-Year Position

In December (M9) the Trust recorded an in-month deficit of £1.4m. The underlying run rate remains consistent with previous months. The Trust Year to Date (YTD) deficit is £16.8m.

£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
Plan	(1.0)	(1.0)	(1.0)	(1.0)	0.0	0.0	0.0	0.0	0.0	**(4.0)**
Actual	(1.8)	(2.4)	(2.5)	(3.0)	(2.3)	(1.7)	(1.7)	(0.1)	(1.4)	**(16.8)**
Variance	(0.8)	(1.4)	(1.5)	(2.0)	(2.3)	(1.7)	(1.7)	(0.1)	(1.4)	**(12.8)**

The Trust submitted a plan 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 Month 5 to Month 9 the monthly plan is breakeven and the monthly variance to plan has therefore increased significantly.

I&E: 2023/24 Forecast

The run rate forecast for the financial year is a deficit of £22.3m.

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 change, the forecast will be amended.

Financial Sustainability Plans

The Trust continues to forecast £9.9m of savings from the Financial Sustainability Programme, of which £4.8m (48%) is recurrent.

In addition to the £9.9m of savings generated through the Financial Sustainability Programme, the Trust is also showing £6.3m of other benefits to deliver the external plan of £16.2m of cost savings (note: mostly non-recurrent):

- £1.1m South Central Fleet Services Ltd (SCFS) historic accounting review
- £1.2m national funding
- £1.0m other confirmed funding/movements
- £0.6m in-year slippage against radio replacement project
- £2.4m impact of enhanced financial controls on the expenditure run rate

Cash

The Trust's cash balance at the end of December stood at £32.0m. The Trusts cash balance has decreased by £18m since the start of the financial year, an average monthly net cash outflow of £2m.

At the current expenditure run rate and revised forecast, the Trust will require cash support from Quarter 4 2024/25 to support continuing operations. A total of £5.5m cash support would be required in 2024/25. As with the current financial year, balances are sensitive to decisions on buy/lease and plans for 2024/25 Double-crewed ambulance (DCA) Cohort.

The cash forecast is particularly sensitive to the timings of capital transactions, including income from sale and leaseback transactions. The uncertainty has been exacerbated due to recent supply chain issues for conversion providers. The cash forecast currently includes costs of the DCA chassis, conversion, and equipment. The likelihood of divergence from the current plan is high. The latest update suggests that we unlikely to incur costs for the conversions on the 2023/24 cohort until 2024/25, and of the 2022/23 cohort we are expecting 20 in 2023/24 and 33 in 2024/25.

The 90-day debtor total stood at £1.4853m at the end of December (up from £1.265m in November) representing 55.58% of total sales debt (up from 40.18% in November).

Of the £1.485m 90-day debtors, £1.2m relates to NHS Non-Emergency Patient Transport Services (PTS) debts including unpaid PTS contract invoices with an NHS provider (£0.9m) and other PTS activity charges. Feedback from Bucks Healthcare indicates that Board approval of spend has been given but internal processes for payment have not been completed. Payment will continue to be chased.

Capital

Total capital spend YTD is £6.8m. The capital plan is phased based on most of the expenditure taking place in the latter months of the financial year due to the timing of expected delivery of DCA vehicles.

The Trust is still formally forecasting to utilise its available capital allocation of £22.8m in full, although this is subject to agreement of reforecasting nationally.

The current assumptions assume delivery from Venari of 20 vehicles from the 2022/23 cohort with the balance of 33 DCAs to be delivered in the new financial year, however, there is a risk that none of the DCA's will be received in 2023/2024 as there are 50 issues with the prototype. The 2023/2024 cohort of 72 is now expected to be received from Wilker after June 2024.

The capital forecast now also includes send of £1.0m on Zolls and consideration of a further £1.4m this financial year.

The Trust intends to complete sale and leaseback transactions on all new vehicles. Following completion of these transactions the vehicles will still be held as assets on the Trust's balance sheet, but as Right of Use Assets (under International Financial Reporting Standard 16 (IFRS16)).

The overall impact is that £12.8m of capital expenditure requires slipping into 2024/25. Discussions regarding the impact on both this financial year and next continue with NHS England South East Region and the HIOW ICS.

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

The risk of not achieving the Trust's financial objectives is routinely monitored as part of the Board Assurance Framework.

4. Recommendations

The Council of Governors are invited to **note** the contents of this paper.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	People Directorate Update
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	13.b
Executive Summary:	During the 25th January Board (public & private sessions) the Board received and approved the following: • Equality Delivery System assessment (EDS) • Gender Pay Gap report for year ending 31st March 2023 • Freedom to Speak Up refreshed policy Each of the above (all available within the public board pack) will be published over the coming weeks. In addition, during private Board session the Board received an overview of the National Staff Survey results for 2022. The results demonstrated some improvements in many of the indicators, full details remain under NHS embargo and will be publicly released during March 2023.
Recommendations:	The Council of Governors *(delete as applicable) are asked to note the update.
Accountable Director:	Melanie Saunders, Chief People Officer
Author:	Melanie Saunders, Chief People Officer

Previously considered at:	Publications outlined above have been considered through: ED&I Steering Group (EDS and Gender Pay Gap only) Executive Management Committee (all) People & Culture Committee (all) Remuneration Committee (Gender Pay Gap only) Public Trust Board (all) Private Trust Board (National Staff Survey results under NHS England Embargo)
Purpose of Report:	Assure
Paper Status:	Public
Assurance Level:	• **Significant** – High level of confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	(What actions will be taken following agreement of the recommendations)
List of Appendices	

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Quality and Patient Safety Report
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	13.c
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. Progress continues to be made against the objectives outlined in The *Patient Safety Improvement Plan.* All oversight and assurance meetings continued during the reporting period. The top risks for the Trust continue to be Handover Delays (25) and Safeguarding System Outage (25). **Compliance** Two pilot sites for accreditation have been identified and visits are planned to be completed by the first week of March 2024. Bespoke Quality improvement training to commence February 2024. Two senior staff are also completing train the trainer courses in (Quarter 3 - Quarter 4). **Infection Prevention and Control (IPC)** The number of audits (building & vehicles) remains under trajectory, but compliance percentages are within control limits which is being monitored. through IPC Committee. **Medical Devices** There have been no Zoll related incidents recorded during the reporting period. The Zoll System software upgrade is going live W/C 15 January 2024, training has been rolled out. The Asset Management System has approval and plans progressing for procurement of appropriate system.

Safeguarding
The Safeguarding Improvement metrics all remain above trajectory.
Level 3 training compliance is has increased against trajectory by 12% to **83%.**
The Safeguarding Peer review was received and main points positive describing clear leadership and accountability with strong senior leader oversight.
The most significant risk remains the ongoing challenges with the Doc-Works referral system with a further Serious Incident declared on 28 December 2023 This correlated with a report of a serious domestic abuse case where harm/death was associated with the delay. This is now subject to a statutory multi- agency review. A systematic review of the system and associated processes is in progress.

Clinical / Non- Clinical Incidents
Reporting of patient safety incidents has increased overall during the reporting period with Delay being the main theme.

PSIRF Plan submitted and approved at PSEC in December 2023, and currently with Chairs Action following recent Quality and Safety Committee for approval. The PSIRF project post remains unfilled and significantly impacting delivery of actions.

Serious Incidents (SIs)
Patient Safety incidents identified and declared as Serious Incidents.

- **Year to date (47) SIs** have been identified under the (2015) National Framework.
- **The Trust has seen an increase** in the number of SCAS declared SIs with 23 (2.5%) of total patient safety incidents being identified as Serious Incidents with "Delay" continuing to be the main theme**.**
    - (13) are SCAS declared SIs.
    - (7) incidents declared is a System SI
    - (3) are being investigated as a cross organisational SI.
- (2) SIs are currently breaching the 60-day completion target – with approved extensions in place due to ongoing police investigations.

The *Thematic Review* commissioned by BOB ICB relating to *Delay* was presented at Quality and Safety Committee in January 2024 with overarching action plan in progress. This will be managed and monitored through committee structures. Themes include: End of Shift Policy, Meal Breaks, Rostering and Clinical Vacancies.

Incident Review Panel (IRP)
A total of 961 Patient Safety Incidents were reported across this period:

- 70 (7.3%) were reviewed by the Safety Review Panel.

	○ 18 (3.1%) were escalated for further review and investigation due to level of harm. **Patient Experience (PE) and Engagement** **Trust wide there was a 7% (697) decrease** in the total number of PE contacts raised from previous report. **94 new formal complaints** were received, 188 informal concerns and 415 HCP feedback requests, during the reporting period. **698 cases were responded to and closed of which 64% were either fully or partly upheld** when the investigations were concluded compared to 69% in the previous reporting period. The inaugural Patient Panel will be held in January 2024.
Recommendations:	The Council of Governors are asked to: receive the paper and note the key quality and patient safety issues.
Accountable Director:	Professor Helen Young, Chief Nurse / Executive Director of Patient Care and Service Transformation
Author:	Sue Heyes, Deputy Chief Nurse / Director of Nursing and Quality
Previously considered at:	Patient Safety and Experience Committee Quality and Safety Committee
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable Overall *:* Partial- Safeguarding Referral System
Justification of Assurance Rating:	Internal and external process of scrutiny against Improvement Plans: Patient Safety Delivery Group, IPOB, TPAM, External peer reviews (ICS) and system partners.
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	All Quality Domains
Next Steps:	Safeguarding System Review has commenced and subsequent actions and recommendations to be managed through Quality and Safety Committee.
List of Appendices	Not applicable.

NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC TRUST BOARD PAPER

Title	Quality & Patient Safety Report
Author	Sue Heyes, Deputy Chief Nursing Officer
Responsible Director	Professor Helen Young, Chief Nursing Officer / Executive Director of Patient Care
Date	31 January 2024

1. Purpose

1.1 The purpose of the paper is to provide the Council of Governors 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 **(October- November 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 Challenges continue with increased demand for our services due to winter pressures and increases in acuity.

2.4 However, Level 3 face to face Safeguarding training was **not** suspended during the reporting period. It is still anticipated that the 90% target will be achieved at year end.

2.5 The major issue and risk in Safeguarding is the continued number of incidents we are seeing relating to the ICT (Information Technology) and BI (Business Intelligence/reporting) that supports the Safeguarding referral system. Several outages or problems in various parts of this system have resulted in delays in referrals going through to the local authorities. A number of these delays have resulted in either harm or a near miss. A comprehensive review is being undertaken with internal and external stakeholders.

2.6 Reporting of patient safety incidents has increased overall during the reporting period with Delay accounting for many incidents.

2.7 The top risks for the Trust are Handover delays at the Queen Alexandra Hospital (25) Handover Delays at other Hospitals (25) and Safeguarding System outages (25).

2.8 The impact of delays is reflected in the number of reported Serious Incidents (Trust and System) and has been explored in detail in the recent Thematic Review. The recommendations and actions from the review and other reports will be incorporated into one overarching action plan, and progress will be monitored through Quality and Safety Committee.

2.9 The thematic review of incidents where delays were a significant contributory factor has found several themes which include the vacancy levels of clinical staff, the end of shift policy, meal break policy and hospital handover delays.

2.10 Infection Prevention and Control (IPC) audits compliance percentages are within control limits and above target in all indicators. The risk is the number of audits undertaken at times of high REAP. The new Trust IPC Lead and Quality and Compliance lead are reviewing the audit process.

3. Main Report and Service Updates

Compliance/Quality Improvement

3.1 Two pilot sites for accreditation have been identified and visits are planned to be completed by the first week of March 2024.

3.2 Directors of Service have met with the compliance team to discuss their service compliance, readiness and areas of risk or concern.

3.3 Action is in progress to refresh the booking processes and collation of feedback from Executive and Non-Executive Director walk-arounds.

3.4 Bespoke Quality improvement training to commence February 2024. Two senior staff are also completing train the trainer courses in (Quarter 3 – Quarter 4).

Infection, Prevention and Control (IPC)

3.5 Reports to IPC Committee and clinical governance meetings regarding vehicle and building audits have been revised to assist with local level visual data.

3.6 The number of audits (building and vehicles) remains under trajectory, but compliance percentages are within control limits which is being monitored through IPC Committee.

Management of Medical Devices

3.7 There were no reported Zoll related incidents or significant failures of any other medical devices during the reporting period.

3.8 Zoll upgrade (Version 2.36) will be going live W/C 15 January 2024.

3.9 Asset management system is now approved internally, and plans are progressing for procurement of appropriate system.

Safeguarding

3.10 All Safeguarding metrics are above trajectory and have supported a decrease in scrutiny from Integrated Care Board (ICB) from monthly to quarterly. However, the metrics and evidence are continually monitored and following recent events a review of the ICT (Information Technology) assurances are being undertaken.

3.11 Safeguarding Level 3 training has increased against trajectory to 83% (↑12%).

3.12 Safeguarding referral rates continue to improve and are at 94.4% against trajectory.

3.13 SAAF compliance rates remain above trajectory at 97.8% which is (↑7.8%).

3.14 The Safeguarding Peer Review report has been received following the assessment that was completed on 6 November 2023 by strategic partners. The main points are positive describing clear leadership and accountability for safeguarding within SCAS with senior leader oversight and scrutiny.

3.15 A new telephone system went live in December 2023 which allows clinicians to access safeguarding advice 24/7 and direct transfer to Out of Hours social work teams.

3.16 The most significant risk remains the ongoing challenges with the Doc-Works referral system with a further Serious Incident declared on 28 December 2023 due to a 19-day delay in referrals. This correlated with a report of a serious domestic abuse case where harm/death was associated with the delay. This is now subject to a statutory multi- agency review.

3.17 The Associate Director of Safeguarding has formally escalated the concern regarding the fragility of the ICT System to Executives, through Incident Review Panel and Quality and Safety Committee. Executives have requested an urgent review of the system and associated processes.

Mental Health (MH)

3.18 The MH Triage and mobilisation model (MHRV- vehicles in North) is anticipated to start in April 2024 in line with the model in HIOW (Hampshire and Isle of Wight).

Clinical Incidents

3.19 **EOC** were (129) patient safety incidents reported by EOC North and South. Patient safety incident reporting increased by 52% when compared to the previous reporting period. The top three reported patient safety incident categories across both EOCs were Delay, Patient Treatment/Care, and ICT Systems.

3.20 **111** there were (138) patient safety incidents. The two most prevalent categories remain *Delay and Patient treatment/care*. During the reporting period an internet

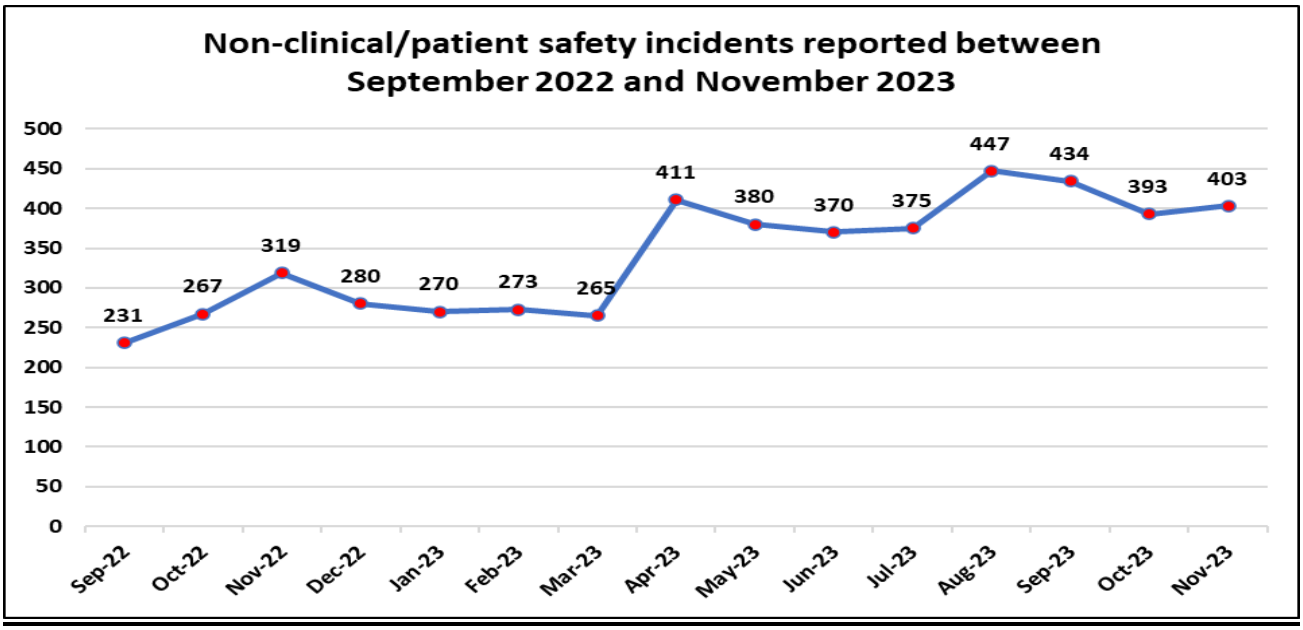
outage occurred. Contingency plans were enacted, and primary care providers supported with clinical queues. No incidents of patient harm have been identified.

3.21 **Emergency and Urgent Care (E&UC)** there have been (452) patient safety incidents reported which equates to an increase of 25% from the previous reporting period. The severity of cases remains low with 434 incidents being logged as low or no harm. The top three reported categories remain *Patient Care, Delay and Clinical Equipment.*

3.22 **Non Emergency Patient Transport Service (NEPTS)** three have been **(**136) patient safety incidents reported. There was 1 incident that was graded as moderate all other incidents are graded as low or no harm. Then top three categories continue to be *Slip, trip, and fall, Patient treatment and care and Ill health.*

Non-Clinical Incidents

3.23 The chart below illustrates the total number of non-clinical incidents reported on the Datix system during the reporting period. The majority of incidents are categorised as low harm.



3.24 Abuse/abusive behaviour is the **highest reported category and are mostly low no harm with verbal abuse being the highest sub-category.**

3.25 Medicines incidents are now the **second highest reported category** having reduced from the previous months report and relates primarily to staff observing that the medicines record has not been completed by the previous crew, so it appears there is a discrepancy.

3.26 The Trust is revising the 'task' based risk assessments and the associated manual handling assessments and personal protective equipment assessments. These are being shared with Trade Union Colleagues for approval and will be uploaded onto The Hub internal SCAS site for staff to access.

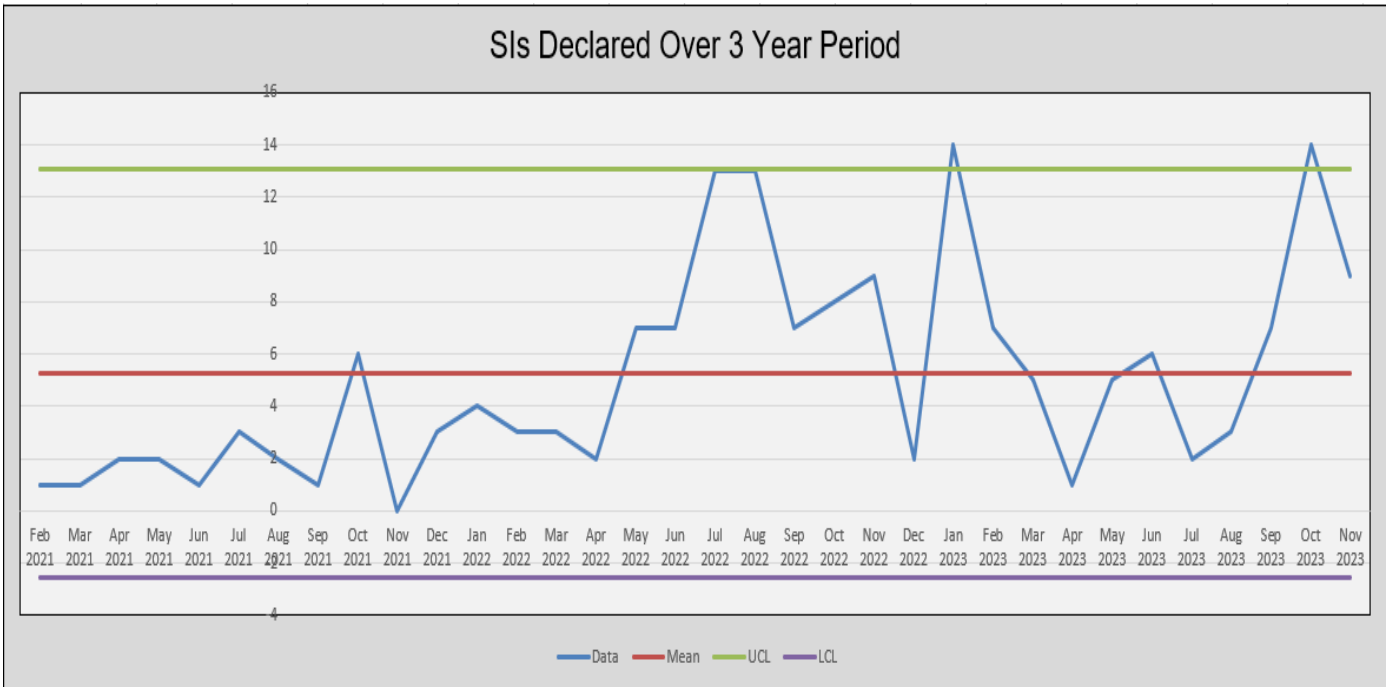
Patient Safety Incident Response Framework (PSIRF)

3.27 Governance – the PSIRF Plan was submitted to Patient Safety and Engagement Committee (PSEC) in December 2023 for approval. The PSIRF Policy is in draft and out for consultation.

3.28 Risk for delivery against plan remains at a 12 (Major x Possible) due to capacity to deliver the project and has been escalated through Quality and Safety Committee and Executive Management Committee.

Serious Incidents

3.29 Year to date Trust **have identified (47) Serious Incidents (SIs)** under the national framework. This compares to (49) in 2022-2023 and (11) in 2021-2022 across the same reporting period.



3.30 The Trust has continued to see an increase in the number of SCAS declared SI's with (23) or (2.5%) of total patient safety incidents being identified as Serious Incidents, with 'Delay' continuing to be the main theme, and unchanged from previous reports.

13 are SCAS declared SIs.
7 declared are a System SI.
3 are being investigated as a cross organisational SI.

3.31 2 SIs are currently breaching the 60-day completion target – with approved extensions in place, 3 SIs have current "stop the clocks" on them due to ongoing police investigations and 4 Serious Incidents were closed by ICBs across this reporting period.

3.32 The Trust continues to see *Delay* being a main theme of all SI's declared.

3.33 38 actions relating to SIs are reporting as overdue on the Datix system. Quality and Safety Committee have requested an updated position statements and action plan at the next meeting in March 2024.

3.34 The Thematic Review relating to 'Delay' was presented to Quality and Safety Committee and will be shared with ICB's to ensure the delivery of recommendations and actions.

Incident Review Panel (IRP) Activity

3.35 A total **of 961 Patient Safety incidents were reported** across this reporting period.
70/961 (7.2%) Patient Safety incidents were subsequently then reviewed at Safety Review Panel (SRP).
30/70 (3.1%) Patient Safety incidents were escalated to IRP review due to level of harm.

3.36 A national benchmarking exercise of patient safety data across Ambulance trusts has recently been completed by NARSF and due to be published in January 2024. This will enable South Central Ambulance Service (SCAS) in the future to benchmark against the sector.

Category 2 Segmentation

3.37 NHS England have mandated a Category 2 Segmentation process in response to a sustained increase in the numbers of Category 1 and 2 events nationally. Case reviews have been carried out and all indications at present suggest there are no moderate or above concerns in relation to patient safety.

NEPTS Ambulance Transport Support to 999 Procedural Review

3.38 Following an incident investigation: an action was given to review the process and procedures relating to the passing of events to the Non Emergency Patient Transport Service (NEPTS) from the 999 service of ambulance transports. The procedure document has been reviewed by both service lines and additional detail which ensures that clinical information generated by CCC clinicians is effectively transferred to the NEPTS' system has been added.

3.39 The confidence of staff to manage maternity and neonatal emergencies is an area of focus. The Trust has an Education Manager Midwife now in post. Bitesize birth webinars will be offered to staff for their CPD and saved for others to review retrospectively. The equipment team have reviewed and updated the maternity bag to include smaller hats for preterm babies.

Patient Experience (PE) and Engagement

3.40 Trust wide there was a 7% decrease in the total number of PE contacts raised (697) when compared with the previous two months (751).

PE Contacts: October/November	2023/24	% of Trust Total	% change from previous report
NHS 111, incl. GP CAS & MHTS	**127**	18	No Change
PTS	**396**	57	↓ 2%
999 Operations	**110**	16	↓1%
EOC	**63**	6	↑ 3%

Trust total	**697**	**100%**	**↓7%**

3.41 In the same period last year, the Trust received (688) Patient Experience (PE) cases, so a small increase of 1% year on year.

3.42 698 cases were responded to and closed during the same period, of which 64% (449 cases) were either fully or partly upheld when the investigations were concluded, **meaning that in just over seven out of ten cases the complaint was justified in full or in part.**

3.43 During the reporting period the Trust received (94) new formal complaints, (188) informal concerns and (415) HCP feedback requests.

- PTS feedback has remained at approximately 60% of the PE workload.
- NHS 111 PE contacts, the Trust received the same percentage of cases in this reporting period compared to August and September 2023.
- In 999 operations there was no change in the percentage in PE cases raised in this reporting period. 50% of these cases were regarding clinical care.
- 29% of the cases were regarding staff attitude and communication, the same as the previous two months.

3.44 Complaints responded to within agreed timescales: October (97%), November (95%). **Target** (95%).

3.45 **The Trust have closed 15% more PE cases in October and November 2023 than in the previous 2 months.**

3.46 HCP (Health Care Professional) feedback is currently around 60% of the PE workload, unchanged from the previous two months. The PE Team have completed an audit of HCPF to determine and ascertain patient safety concerns which require a response and percentage of feedback which does not require a response. The results of this audit will be included at the next PSEC with actions for the system.

3.47 The inaugural Patient Panel will be held in January 2024.

Compliments

3.48 The Trust received 225 compliments for the care and service delivered by our staff across the reporting period which is similar to previous reporting periods.

Recommendations

4.1 The Council of Governors are invited to note the content of the report.

Sue Heyes, Deputy Chief Nurse

Date: 11 January 2024

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Operations Report – 999, 111 and Other
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	13.e
Executive Summary:	This report is to update the board on SCAS 999 and 111 performance for December. Our category 1 performance for December was 08:54, a deterioration of 4 seconds from November, and our category 2 was 38:09, which was 7 minutes above our proposed trajectory. 999 response demand was at the highest level since December 2022, although we did see a drop in the volume of 999 calls and achieved a mean call answer of 17 seconds. The support from West Midlands Ambulance Service continues, however they only take calls from SCAS if we do not answer the call within 3 minutes. We took over 155,000 calls through our 111 service, which was 9,000 above our plan, illustrating the increasing demand on our 111 service. The main issues affecting our category 2 performance are linked to our ability to deliver the required operational hours to meet the demand, combined with the hours we are losing at Hospital through handover delays. Details of the impact and actions being taken are contained within this report update.
Recommendations:	The Council of Governors are asked to note the issues in the 999 and 111 areas of SCAS and the operational support work to help with those challenges.
Accountable Director:	Mark Ainsworth, Executive Director of Operations
Author:	Mark Ainsworth, Executive Director of Operations
Previously considered at:	Operations Reports are presented at every Board meeting in public.
Purpose of Report:	Note/Assure
Paper Status:	Public

Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	High Quality Care & Patient Experience
Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	All Quality Domains
Next Steps:	On going monitoring of progress against the cat 2 trajectory with a focus on reduce handover times and increasing operational hours
List of Appendices	1.1 - 999 Call Demand and call answer mean, 1.2 - 111 Demand, 1.3 - 111 Call Answer Mean, 1.4 – Hospital Handover delays, 1.5 – S&T and ST&C Operational Hours, 1.6 - CET update

Board Meeting Report

Name of Meeting	Council of Governors Meeting
Title	Operations Report – 999, 111 and Other
Author	Mark Ainsworth, Mark Adams, Luci Papworth, Rob Ellery, Ruth Page
Accountable Director	Mark Ainsworth, Executive Director of Operations
Date	31January 2024

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. Background and Links to Previous Papers

2.1 This paper provides an update on key performance measures for 999 and 111 services for December 2023. The paper also updates the board on our delivery against our category 2 trajectory, as well as risks and actions to improve our performance. Additional data charts have been provided as appendices to support the narrative.

3. Executive Summary

3.1 999 call volumes dropped in December to just over 70,000 with the main cause being fewer duplicate calls. Our response demand increased to 54,856 which is the highest level since December 2022 and in line with seasonal variations. We received 155,540 calls through our 111 service which was 9,000 above planned levels, and our mean call answer increased to 2 minutes 48 seconds due to the higher demand. Our category 1 performance was 08:54 which is a 4 second increase from November and our category 2 performance was 38:09 which is 7 minutes above our planned trajectory. Each year we restrict our annual leave levels over the Christmas and New Year period by 50% which provides additional hours in all operational areas. This enabled us to improve our response times to patients during the busiest period of the year with our category 2 performance being 24:22 from the 18th to 31st December, compared to 49:23 for the first 17 days. We were however 7,500 hours below what was required to deliver our trajectory for the month and this impacted on category 2 by 3 minutes. The shortage in hours was caused by the Private Provider companies not delivering contracted hours. We also experienced higher handover delays in the first 2 weeks of December losing 5,221 hours in the first 2 weeks compared to 3,092 for

the remainder of the month. This is the highest level of delays since December 2022 and the impact of handover delays on category 2 was 5 minutes.

Clinical Co-ordination Centres

EOC

3.2 Call answer for December was 17 seconds which is 7 seconds above national target. The reduced annual leave levels over the festive period supported call answer improvements, combined with the lower call volumes. (Appendix 1.1) We continue to receive support from West Midlands Ambulance service, however the point at which they now take our calls has increased to 3 minutes as they now take calls through the national Intelligent Routing Platform (IRP). This is in line with the NHS Digital pilot where the IRP recognises an estimated wait time of 180 seconds and then routes calls to WMAS. We currently have 165 WTE ECTs in post with 131 WTE work effective, with 27 WTE in coaching. We are continuing to work with The Isle of Wight Ambulance Service to increase their contracted staffing levels for SCAS as they currently have 10 vacancies against a requirement of 25. AACE have been into our EOC for 2 days to identify any areas for improvement, and we have asked for them to focus on call answer and hear and treat as two key areas for guidance and support. We are also meeting WMAS in February to review options for any further support while we continue to recruit to our establishment levels.

3.3 Hear and treat levels for the quarter were just below our 12% target at 11.8 %. Category 2 segmentation remains in place, however the clinician capacity to increase the volume of calls to process through category 2 segmentation remains a challenge. There is ongoing recruitment to CSD and the international nurses in CSD North have settled in extremely well. They are currently Band 5 with a limited scope of practice and are all being coached through a competency-based programme to become Band 6 clinicians. Hear and Treat is a further area we have requested AACE to review and provide recommendations.

111

3.4 Demand increased through November and December in line with seasonal variation with us answering 155,540 calls in December. (Appendix 1.2) Call answer performance remained outside of national target, but above trajectory and improved on last year with a mean to 02:48. (Appendix 1.3)

3.5 We remain below workforce requirement to meet performance targets. There are 238 WTE Health Advisors in post with a shortfall of 75 WTE and for Clinical Advisors 63.37 WTE in post and a shortfall of 28 WTE. The shortfall is offset by increased logged in hours, improved room management and reduction in average handling times providing additional hours from our incumbent workforce. Attrition remains below expected levels and we continue to recruit in line with our IWP. Partis House will open 24/7 from the end of January 2024 further increasing capacity overnight. We are also commencing a programme to dual train some of

our 111 Health Advisors in taking 999 calls. This will be on a voluntary basis and will look to support our 999 call answer.

3.6 We have been approached by BOB and Frimley separately to review the options of extending the 111 IUC contract until end of March 2026. This is a great opportunity for SCAS to review our service provision and work with commissioners on a new specification for a new contract post 2026. We are currently working with the contracts team on the options for the extension and will bring a proposal through EMC and Board for ratification.

Urgent & Emergency Care

Hospital Handover Delays

3.7 Hospital handover delays in Q3 totaled 21,210 hours compared to 14,576 hours in Q2. December lost hours were 8,019 with 3,888 hours at Portsmouth Hospital Trust. Our average handover time was 29:49, with PHT being at 1 hour 6 minutes. (Appendix 1.4). We have written to each Chief Executive of the acute trusts across SCAS outlining our position on using Immediate Handover when we are at OPEL 4 and are being delayed at handover greater than 30 mins, in order to reduce the impact of these delays. This process will take time to embed and support us releasing crews from hospitals.

See Treat & Convey (ST&C) to ED

3.8 S&T performance dropped slightly in December to 34% against the target of 35%. (Appendix 1.5). We are continuing to work with providers to develop additional clinical pathways to support increasing S&T levels. We have seen a drop in ST&C to ED which is the lowest level since January 2023. Improving non-ED pathways is key to keeping the ST&C to ED at its lowest levels. Recent audit work undertaken shows that SCAS appropriately conveys patients to ED which might not be the most appropriate location for the patient, but in the absence of other options is the only entry point to care. Our Clinical Pathway team are working with local teams to maximise the use of available pathways whilst developing new ones.

Resilience & Specialist Operations

3.9 **Winter Impacts:** There have been no specific impacts of note in terms of severe weather. We have seen several weather warnings for other events e.g. flood, wind and rain however these have had minimal impacts, and we work alongside both LRFs to mitigate against risks. The latest 3-month weather outlook has been circulated to the command team and the winter oversight board for planning consideration.

3.10 In December we had the Junior Doctors industrial action for a three-day period which passed with minimal impact to the wider health system to include SCAS, however on the 3rd January 2024 a six-day period started which was more impactful as it followed the three-day New Year weekend, with minimal ability of Acute Trusts to discharge ahead of it.

3.11 **Threat Level:** The current threat level to the UK from terrorism is **Substantial (An attack is likely).**

3.12 **Organisational Learning/ Manchester Arena Inquiry:** We are making good progress with our MAI recommendations. We have submitted several Joint Organisational Learning (JOL's) through the system and are awaiting responses from these.

Operational Projects

Roster Review Project

3.13 The Operations Rota review is focusing on the delivery of the south operational nodes currently with the north being paused due to some of the proposed changes within the transformational plan. The south nodes are progressing through the gateway review and onto voting and build programmes over the next month. The plan is to complete the south nodes by April 2024. The EOC call taking staff feedback questionnaire has been completed and fed back to the Project Board with agreement to slightly amend the roster core principles. The staff champions now drafting new revised rosters/patterns for all call taking skillsets before restarting a full consultation, voting and build process during February and March.

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

3.14 The Control Room Solution (CRS) configuration work is almost complete with function/non-function testing by the national team. SCAS will complete the end-to-end testing in February. Staff training for CRS will commence on 17th January until the middle of March 2024. The dates for planned CRS migration are the 12th and 13th March. Mobile Data Vehicle Solution (MDVS) testing has already started and the training solution with U&E Operations and funding approved by the Project Board. Vehicle installation strategy is in development.

999CAD Replacement Programme

3.15 The current 999 CAD solution will be moving to new SQL architecture by March 2024 to ensure the system is stable whilst the replacement work is in track. During December 2023, the Executive Team approved the outlined business case for a replacement 999 system and to proceed to go out to tender at the end of January 2024.

4. Areas of Risk

- **Handover delays impacting on ambulance availability**.
- **Fleet provision to meet increased operational requirement**.
- **Inability to secure required additional Private Provider hours**. We are still seeing shortfalls of 1,500 to 2,000 hours per week.

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

5.1 This paper primarily links with the Trust objective to deliver high quality care and patient experience. The operations team focus is to provide the best possible service to our patients through efficient process in our contact centres and the best care possible from our staff responding to patients. The BAF risk is SR 1 safe and effective care, with our focus on delivering timely and appropriate response to every patient.

6. Governance

6.1 We are required to deliver to the NHSE standards for the Ambulance Response Programme and the Ambulance Clinical and Quality Indicators.

7. Responsibility

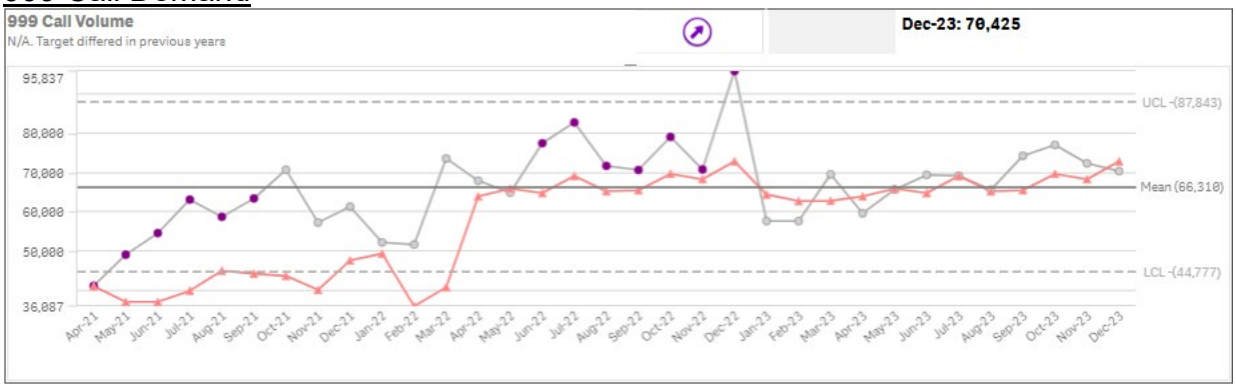
7.1 The Executive Director of Operations is responsible for delivery and monitoring of the improvements within the Operational Board Report.

8. Recommendations

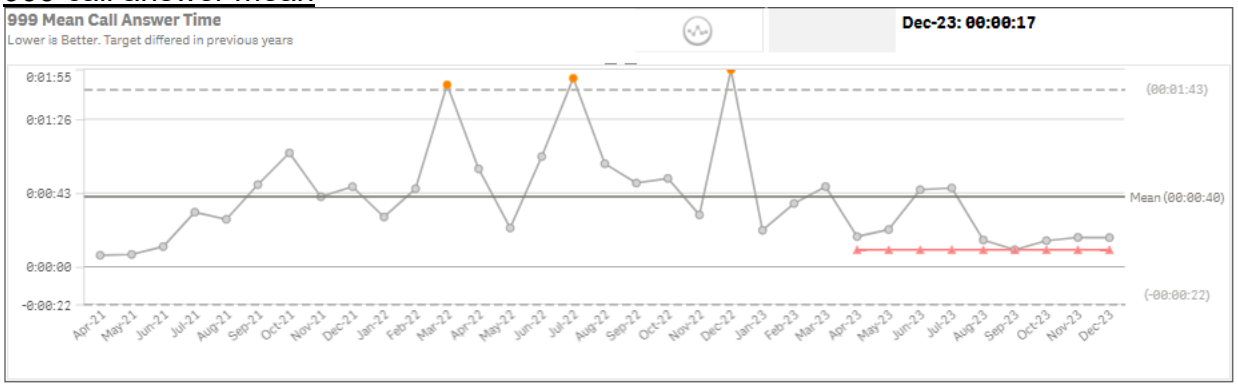
8.1 The Council of Governors are asked to **note** the contents of the report.

Appendices

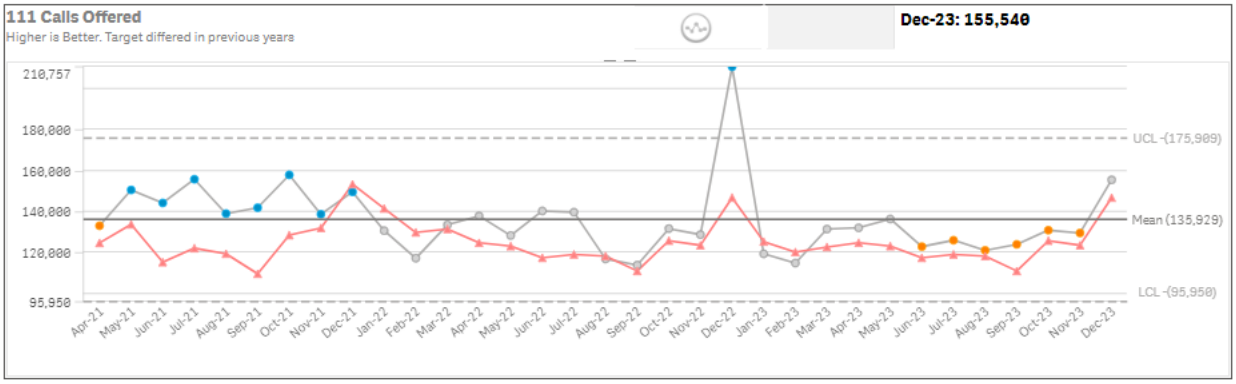
1.1 999 Call Demand



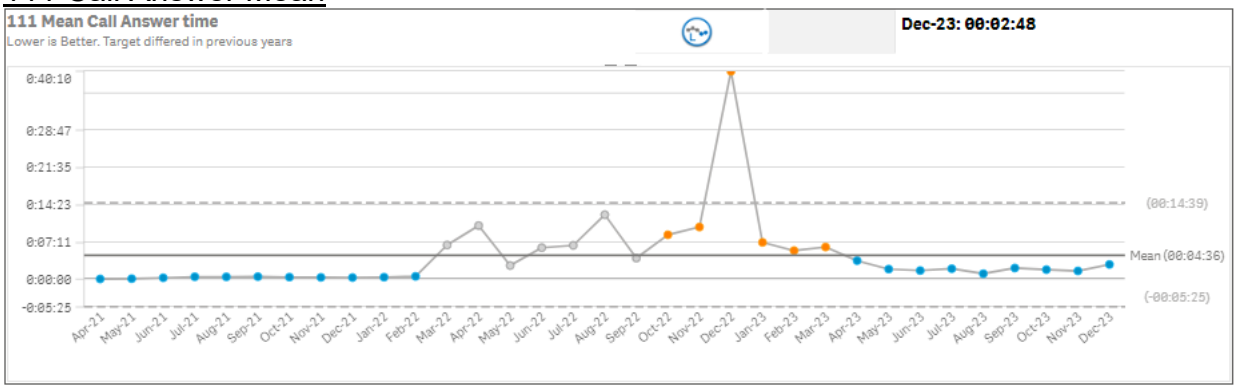
999 call answer mean



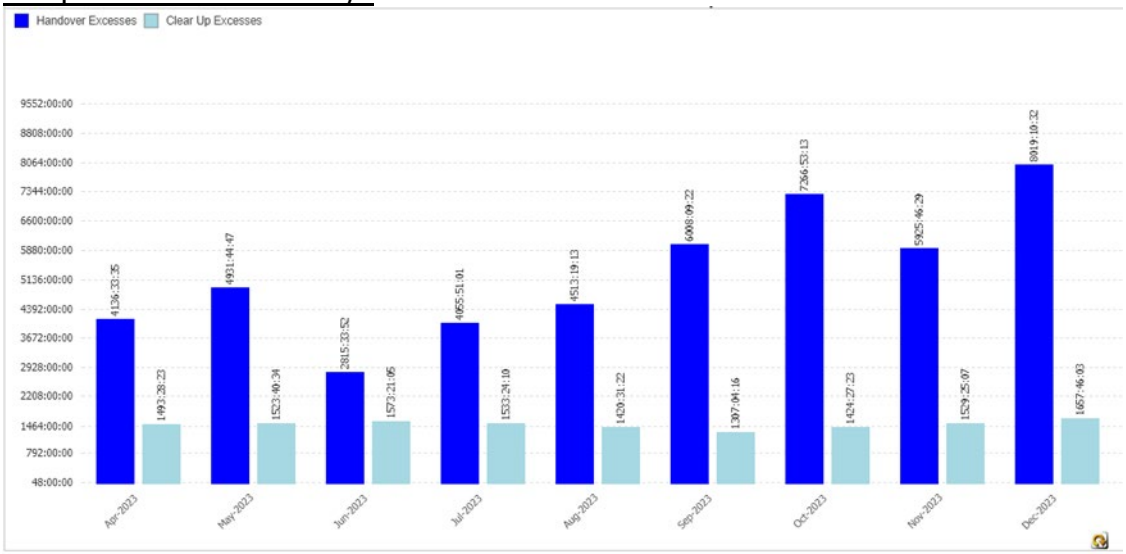
1.2 111 Demand



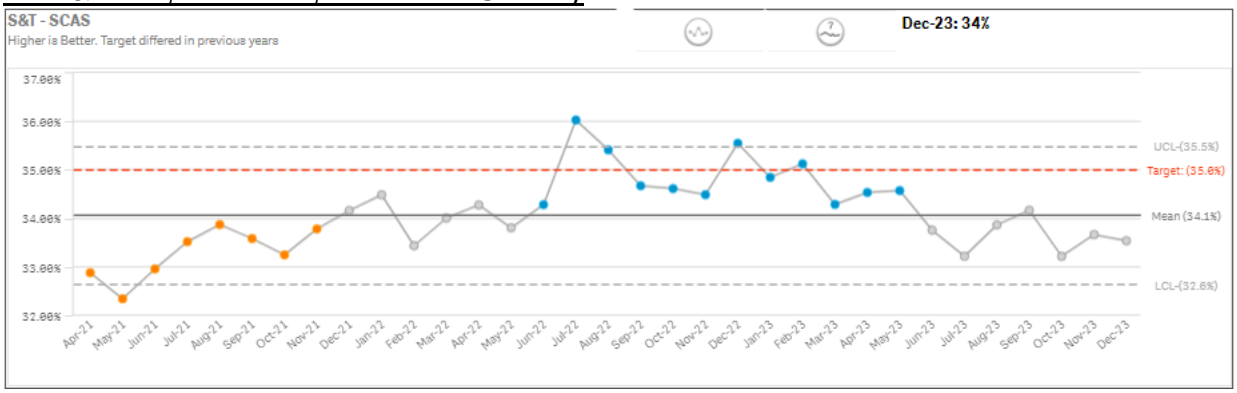
1.3 111 Call Answer Mean

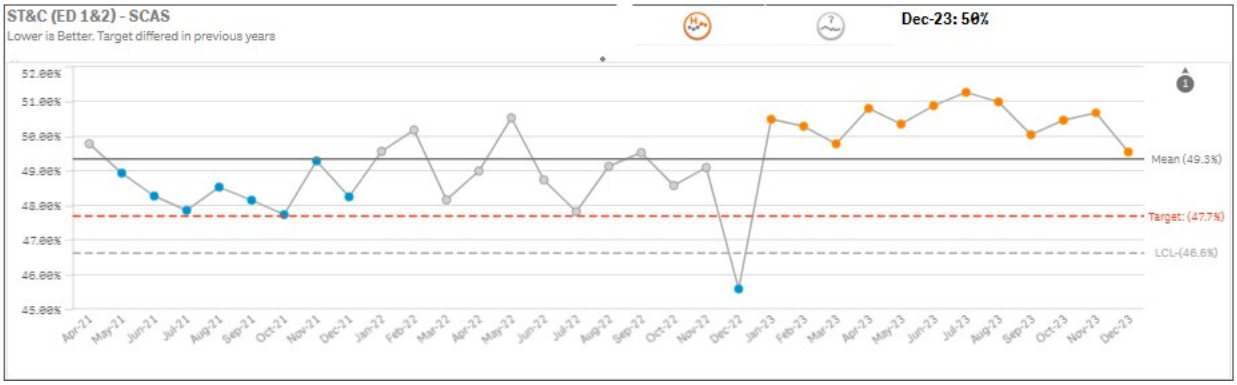


1.4 Hospital Handover Delays



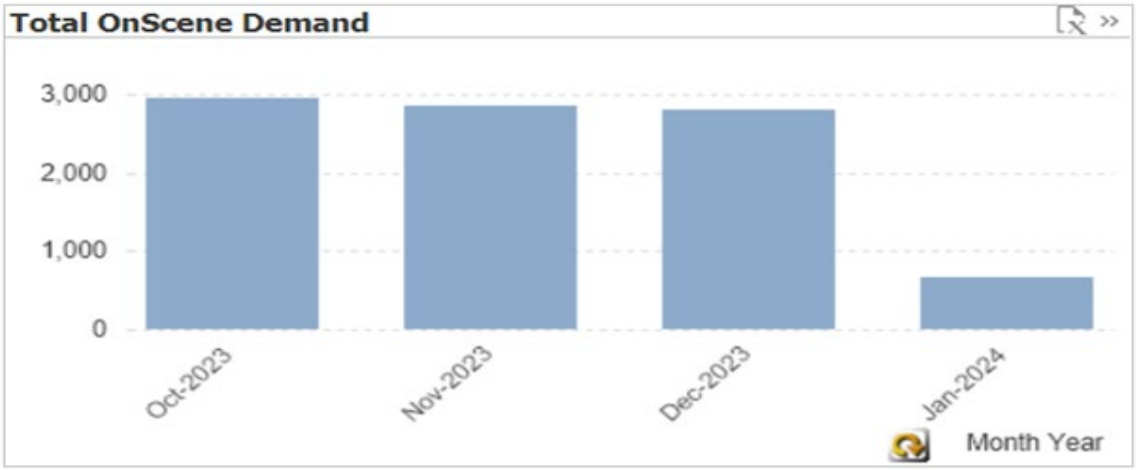
1.5 See &Treat, and See, Treat and Convey





1.6 Indirect Resources

The total number of all incidents our responders are being sent to has slightly decreased from 2,840 in November to 2,795 in December. This is mainly due to the school holidays and Christmas period as we always see a slight reduction in our volunteer's availability. However, we did see our attendance to Category 1 calls increase from 417 to 457 over the same period providing a contribution of 28 seconds in November and 30 in December to SCAS overall Category 1 performance.



Month & Year	Logged Hours
Oct-2023	42285:43:22
Nov-2023	40624:46:37
Dec-2023	39333:18:41
Jan-2024	7088:04:01

On average our volunteers are providing over 40,700 hrs of cover each month and are attending over 400 category 1 calls which in turn is delivering the Trust with over 30 seconds of contribution, they are also first at scene 71% of the time.

CET Contribution by Month				
Month And Year Name	Oct-2023	Nov-2023	Dec-2023	Jan-2024
Total Cat 1 Incidents (SCAS)	4,018	4,028	4,350	933
% of Cat 1 Stopped by CET	8.1%	7.2%	7.4%	8.6%
Cat 1 CET OnScene	464	409	440	111
Cat 1 Stopped by CET	324	291	324	80
% of Cat 1 Onscene Stopped b	69.8%	71.1%	73.6%	72.1%
Cat 1 Mean Stopped by CET	0:08:36	0:08:22	0:08:22	0:07:39
Cat 1 Mean (SCAS)	**0:09:04**	**0:08:50**	**0:08:54**	**0:09:02**
Cat 1 Mean - CET Removed	**0:09:38**	**0:09:19**	**0:09:25**	**0:09:35**
CET Contribution	**0:00:34**	**0:00:28**	**0:00:31**	**0:00:34**

The departments biggest challenge is being able to utilise volunteers to attend category 3 and category 4 calls as each call needs to have a clinical input before a volunteer can be allocated. Our specialist paramedics have many other responsibilities as part of their role and so their time to specifically identify calls within the CAD and send a CET resource can be a challenge. However, in resolution we are in discussion with EOC regarding the coding of certain incidents as being suitable for immediate CFR deployment and/or other locally commissioned falls responses to minimise unnecessary patient delays and an unnecessary clinical validation burden. These code sets are in conjunction with the AACE Falls Response Governance Framework which our current algorithm is based on.

As part of our CQC recovery we were tasked with ensuring that all responders had appropriate Level 3 safeguarding face to face training. We can report that 85% of our responders have had this and we will continue to factor this in with the help of our safeguarding team.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Governance Update
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	13.f
Executive Summary:	This report provides the Council of Governors with an update relating to developments in governance since the last Council of Governors' meeting in October 2023: ▪ Governors Induction ▪ Update on NED recruitment ▪ Frequency of workshops and quarterly meetings / Future meeting dates ▪
Recommendations:	The Council of Governors are asked to note this report.
Accountable Director:	Daryl Lutchmaya, Chief Governance Officer
Author:	Daryl Lutchmaya, Chief Governance Officer
Previously considered at:	Not applicable
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives

Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Not applicable
List of Appendices	Not applicable

Meeting Report

Name of Meeting	Council of Governors Meeting
Title	Governance Update
Author	Daryl Lutchmaya, Chief Governance Officer
Accountable Director	Daryl Lutchmaya, Chief Governance Officer
Date	31st January 2024

1. Purpose

This report provides the Council of Governors with an update relating to developments in governance since the last Council of Governors' meeting in October 2023.

2. Executive Summary

Governors Induction

We have had a successful outcome for the Council of Governor elections. 13 constituency seats were elected unopposed, and two seats were successfully filled for the Berkshire constituency. Only three seats are currently unfilled, one in Oxfordshire and two in the staff constituency. The Governance team will consider options to fill the vacant seats.

The in-person induction of the newly elected Governors will be held on 6 March 2024 at Northern House, Bicester. An induction pack is being prepared for them so that they feel familiar with SCAS processes and systems when they join. On the day, an induction presentation will be made by the Chairman and a number of other senior staff to help familiarise the newly elected Governors with SCAS. They will also be introduced to the Governance team and plans are underway for those Governors who are interested, to join a ride-out and to visit the EOC at Bicester.

As of 1st February 2024, all Governors, including those who have been recently elected, will have been issued with a SCAS email account to ensure that they automatically receive relevant internal all-staff emails and to ensure that information is shared in a secure format rather than using Governors' private email accounts. Plans are also being made to issue Governors with SCAS ID cards.

Update on NED recruitment

Anne Stebbing will be stepping down as a Non-Executive Director on 31 March. The recruitment process to find her replacement is underway. An agency has been appointed to help SCAS with the search process, with the view to interviewing and making an appointment in March. Members of the Council of Governors Nominations Committee will be involved in the interview and selection process with the view to

making a recommendation to the full Council of Governors at its meeting on 3 April 2024.

Frequency of workshops and quarterly meetings

It is proposed that workshops will in future be held on the same days as those on which SCAS holds the quarterly Council of Governors meetings. This is in order to ensure that the widest in-person attendance is achieved by Directors and Governors. Holding both the workshop and meeting on the same day and at the same venue also helps to achieve financial savings rather than having separate meetings and workshop events.

Future meeting dates are as follows and invitations will be shortly sent out:

- 3 April 2024
- 29 July 2024
- 30 September 2024
- 3 February 2025

3. Responsibility

The Chief Governance Officer is responsible for implementing actions and developments relating to the Council of Governors.

4. Recommendations

The Council of Governors are invited to note this report.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Urgent Care/111 Briefing
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	14
Executive Summary:	To brief the Council of Govenors on Clinical Assessments in NHS 111 and Integrated Urgent Care (IUC).
Recommendations:	The Council of Governors are asked to note the Patient Panel Update.
Accountable Director:	Mark Ainsworth, Executive Director of Operations
Author:	Ruth Page, Director of Operations
Previously considered at:	
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	Significant
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	N/A
List of Appendices	Urgent Care/111 Briefing Presentation

Agenda Item 14

South Central Ambulance Service
NHS Foundation Trust

Clinical Assessments in NHS 111 & Integrated Urgent Care (IUC)

Ruth Page – Director of Operations (CCC)
Joanne McPartlane – Head of NHS 111 & IUC Services

111 Assessments

- Undertaken by Health Advisors who are non-clinicians, trained in NHS Pathways.
- Calls can be closed by Health Advisors – for example referred to other services - appointment booked with GP practice, advised to contact pharmacy, or healthcare advice.
- Certain calls are referred to Clinical Advisors also trained in NHS Pathways including a clinical module.
- Certain calls are referred directly to specialities within 111/IUC e.g. pharmacists, mental health practitioners, dental nurses using PaCCs (Senior Clinician NHS Pathways product).

NHS Pathways

- NHS Pathways telephone triage system is a clinical decision support system (CDSS) supporting the remote assessment of callers to urgent and emergency services.
- The symptom-based triage pathways are the same in 999 and 111
- It is also used in the following settings:
  - NHS 111 and NHS 111 Online
  - 999
  - Integrated Urgent Care Clinical Assessment Services
  - To assist in the management of patients presenting to urgent care or emergency departments
- SCAS and other services using pathways feed into NHS Pathways any findings from: complaints, investigations, audits, or feedback from users and other HCPs to continually improve the software. Updates are released every 8 – 12 weeks which will include updates relating to change in national guidance or user feedback.

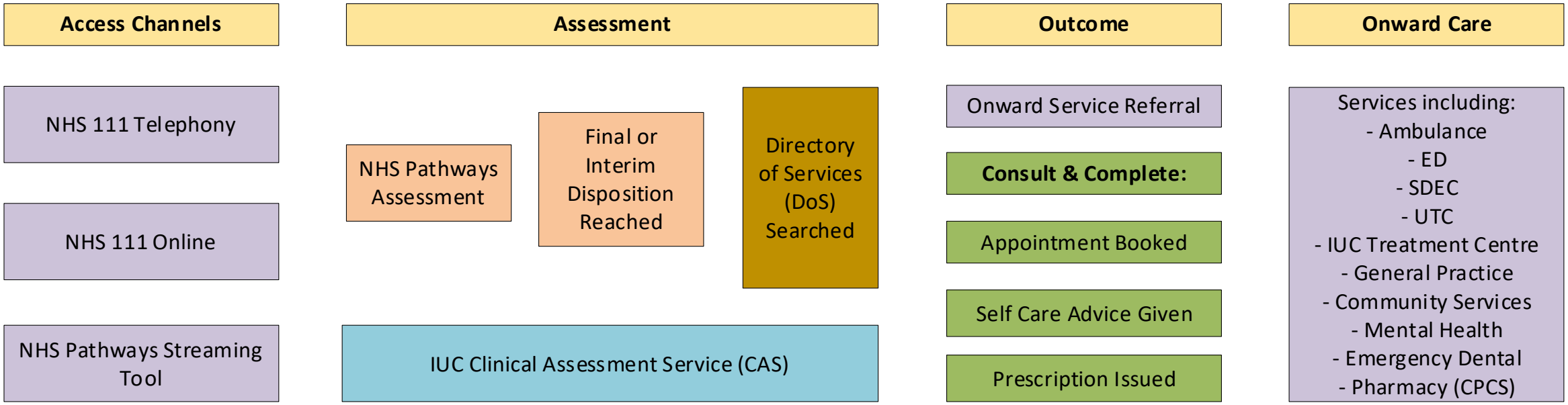
Skillsets within 111/IUC

Region	Hampshire Surrey Heath	HSH %	Thames Valley	TV%
Calls assessed by a general practitioner	19829	52.8%	4989	21.2%
Calls assessed by an advanced nurse practitioner	531	1.4%	0	0.0%
Calls assessed by a mental health nurse	1124	3.0%	334	1.4%
Calls assessed by a nurse	6588	17.6%	6335	27.0%
Calls assessed by a paramedic	429	1.1%	1014	4.3%
Calls assessed by a dental nurse	3396	9.0%	5	0.0%
Calls assessed by a pharmacist	41	0.1%	143	0.6%
Calls assessed by another type of clinician	5587	14.9%	10659	45.4%

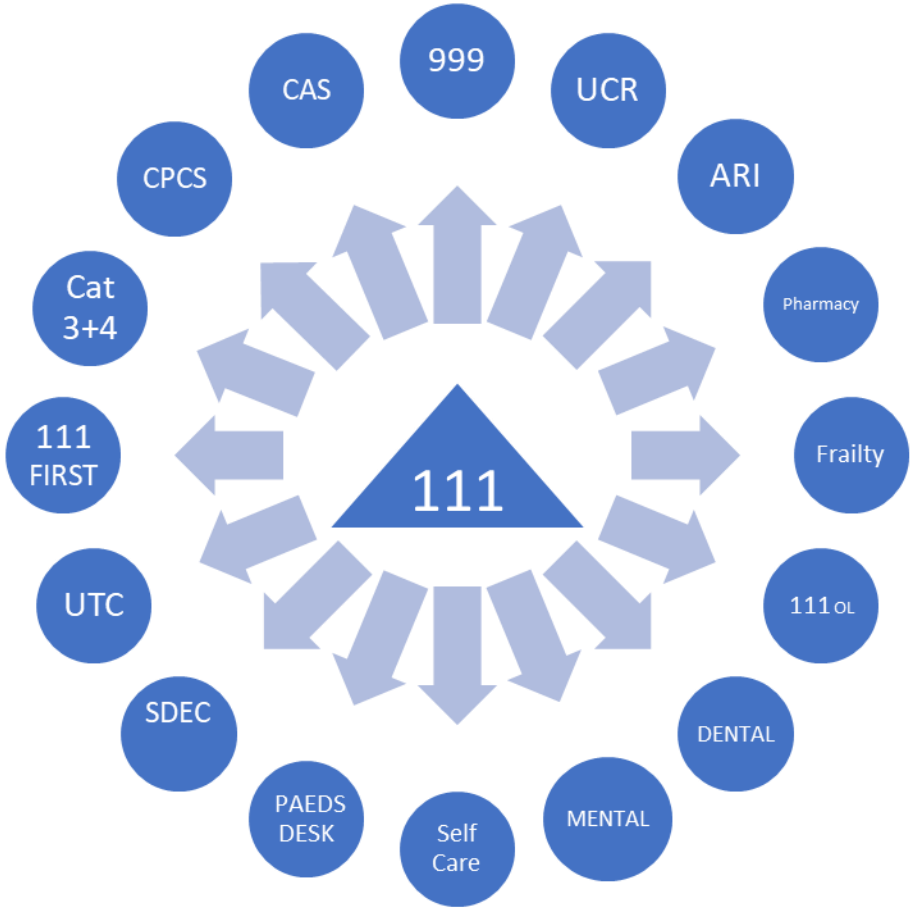
When describing "another type of clinician" these are mainly roles such as Clinician, Senior Clinician, Clinical Advisor. Some are truly unknown, around 1 in 4, most of which sit with CAS externally.

Dec 2023 data

Patient Journey



111 in the Integrated Care System

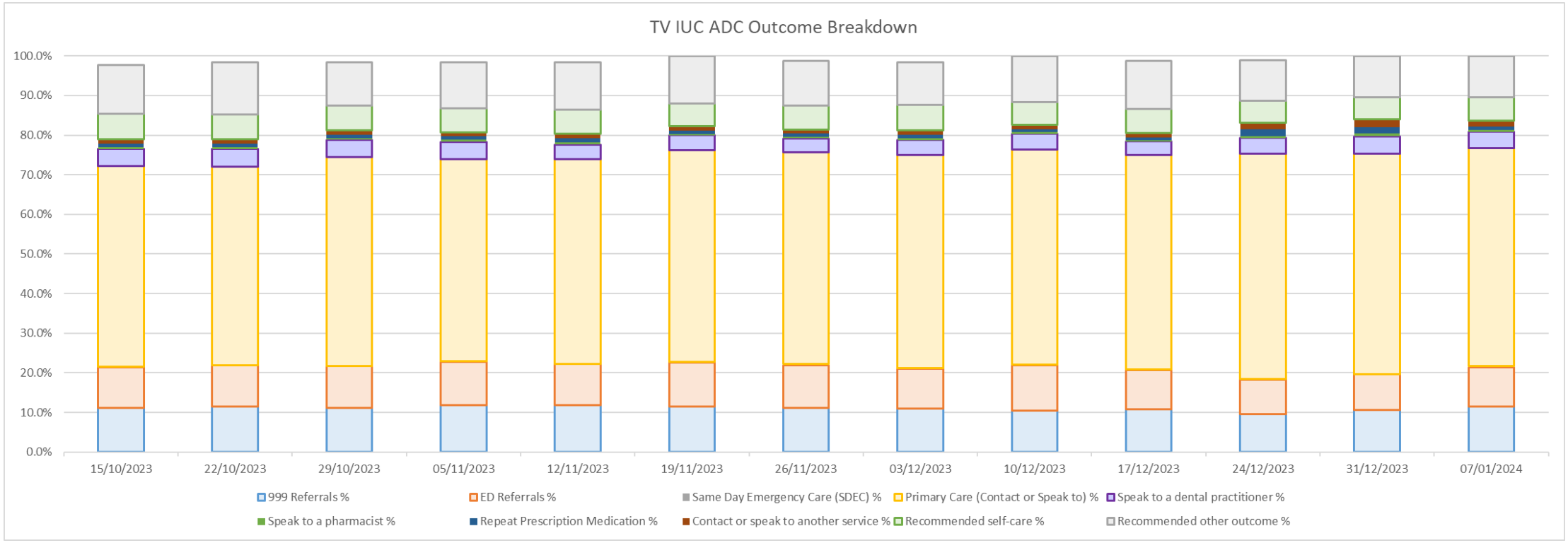


Facts and Figures: 111 Call outcomes

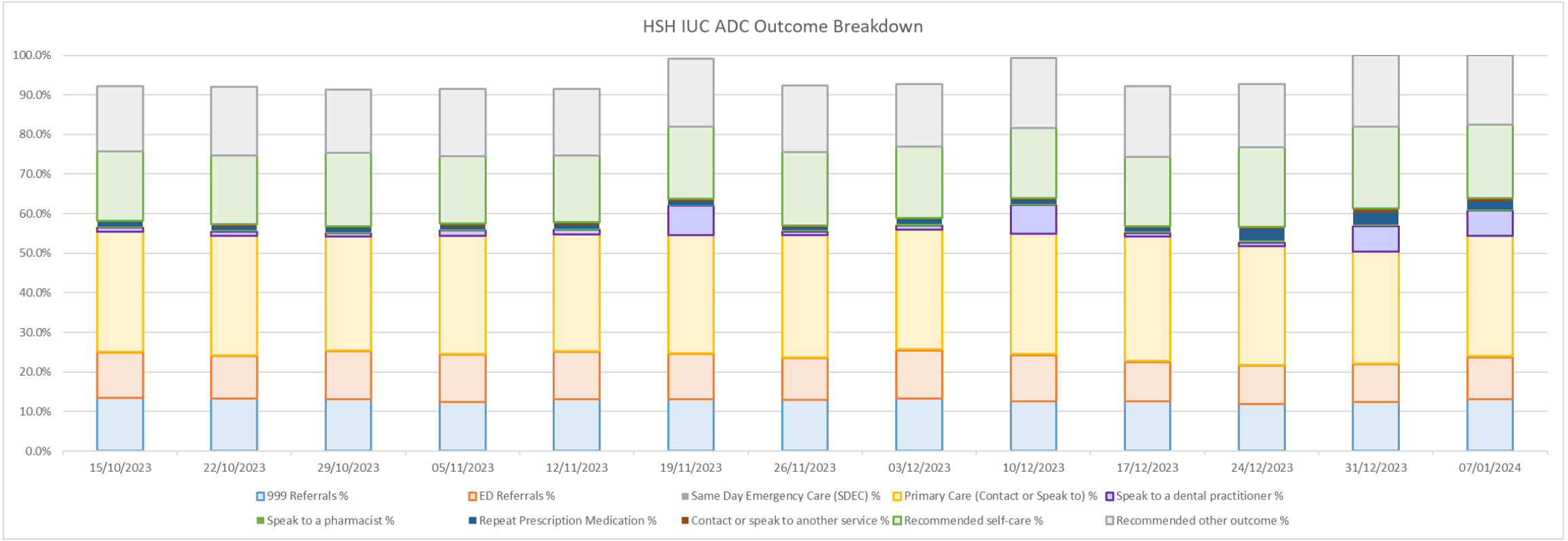
111 Calls outcomes (Week ending 21st January 2024)

- Primary Care – **42.5%**
- Other (HCP calls, Closed no further action, Report of lab results etc) – **15.3%**
- 999 (All categories) – **12%**
- Self-care (Home management) – **11.3%**
- ED (All types) – **11%**
- Dental outcome – **5%**
- Repeat prescription Medication – **1.3%**
- Speak to Pharmacist – **0.4%**
- Same Day Emergency Care (SDEC) – **0.2%**

Clinical Outcomes TVIUC



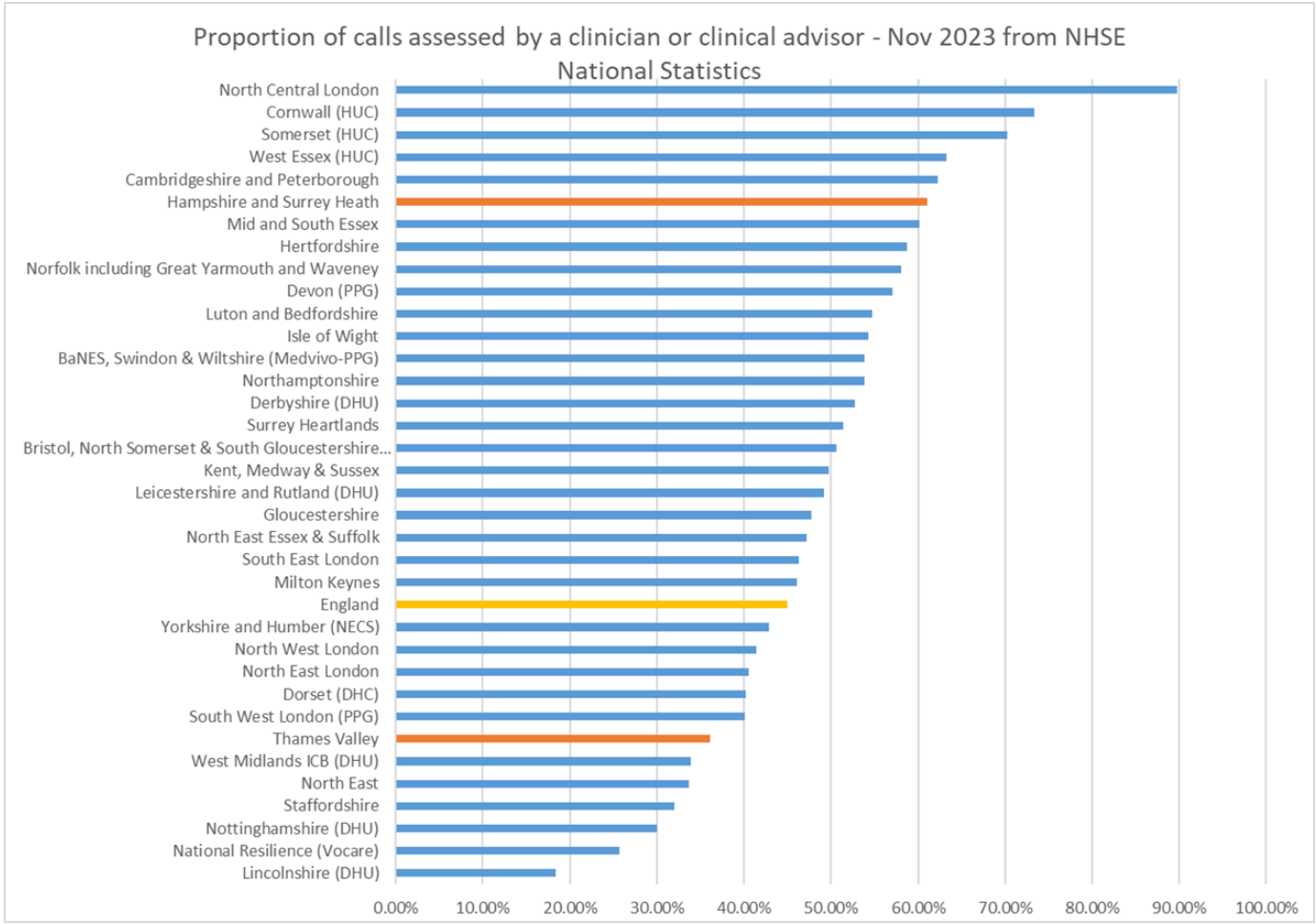
Clinical Outcomes HSH IUC



IUC KPIs

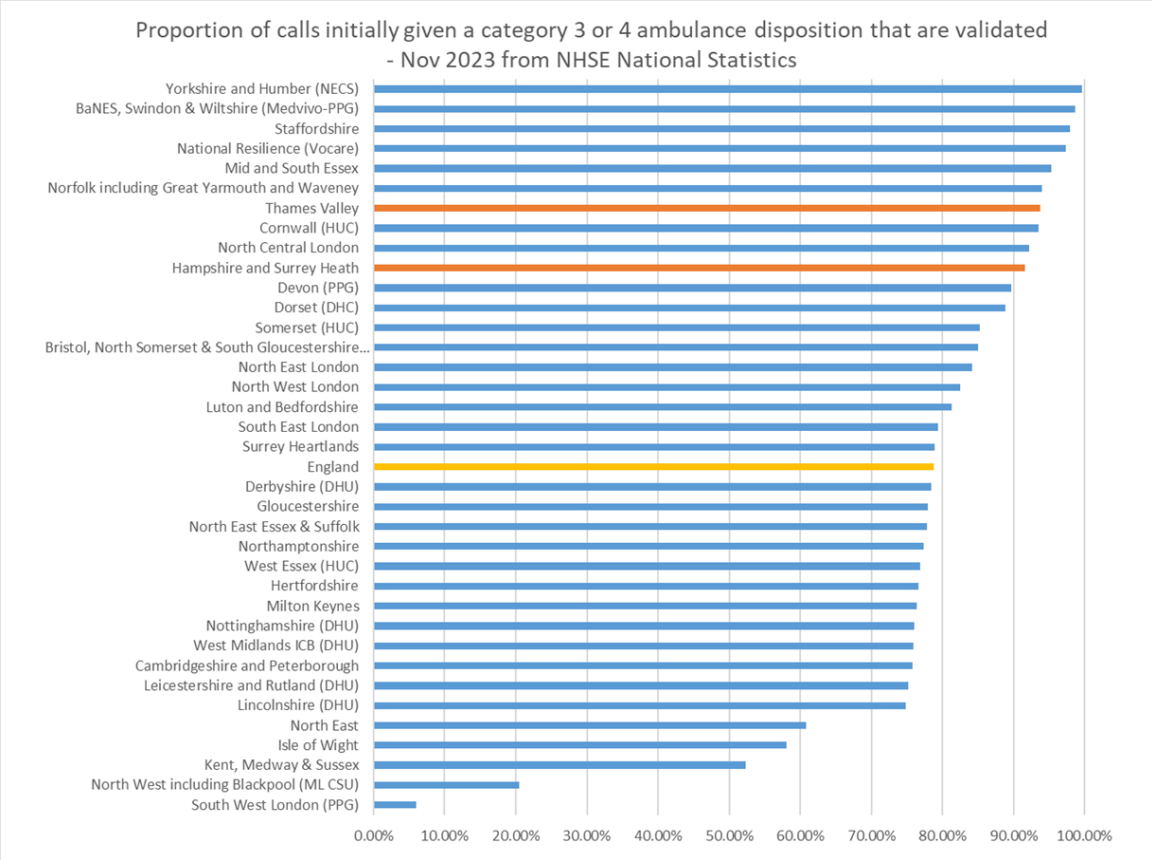
KPI	Title	Standard
1	Proportion of calls abandoned	≤3%
2	Average speed to answer calls	≤20 seconds
3	95th centile call answer time	≤120 seconds
4	Proportion of calls assessed by a clinician or Clinical Advisor	≥50%
5a&b	Proportion of call backs assessed by a clinician in agreed timeframe	≥90%
6	Proportion of callers recommended self-care at the end of clinical input	≥15%
7	Proportion of calls initially given a category 3 or 4 ambulance disposition that receive remote clinical intervention	≥75%
8	Proportion of calls initially given an ETC disposition that receive remote clinical intervention	≥50%
9	Proportion of callers allocated the first service type offered by Directory of Services	≥80%
10	Proportion of calls where the caller was booked into a GP practice or GP access hub	≥75%
11	Proportion of calls where the caller was booked into an IUC Treatment Service or home residence	≥70%
12	Proportion of calls where the caller was booked into a UTC	≥70%
13	Proportion of calls where caller given a booked time slot with a Type 1 or 2 Emergency Department	≥70%
14	Proportion of calls where the caller was booked into a Same Day Emergency Care (SDEC) service	Not applicable

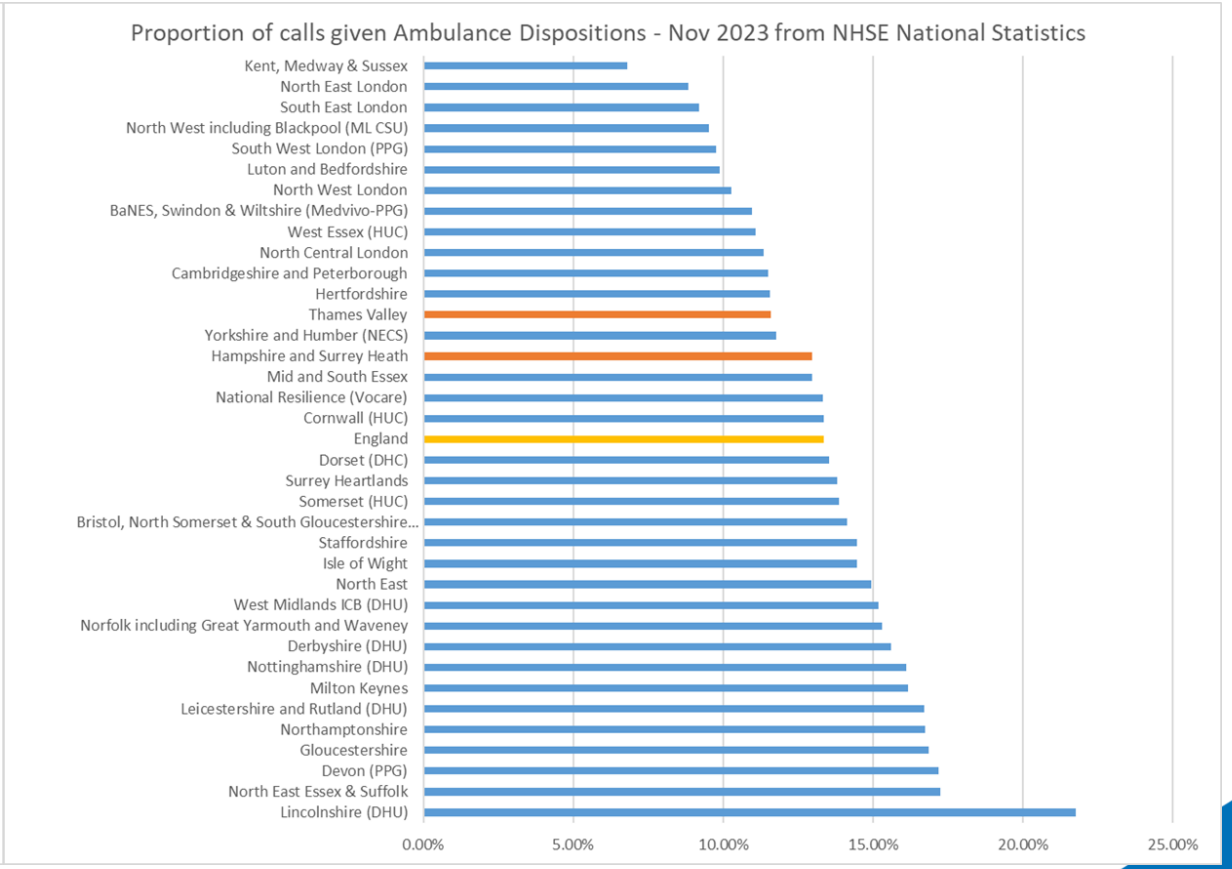
Proportion of calls assessed by clinician (KPI 4)



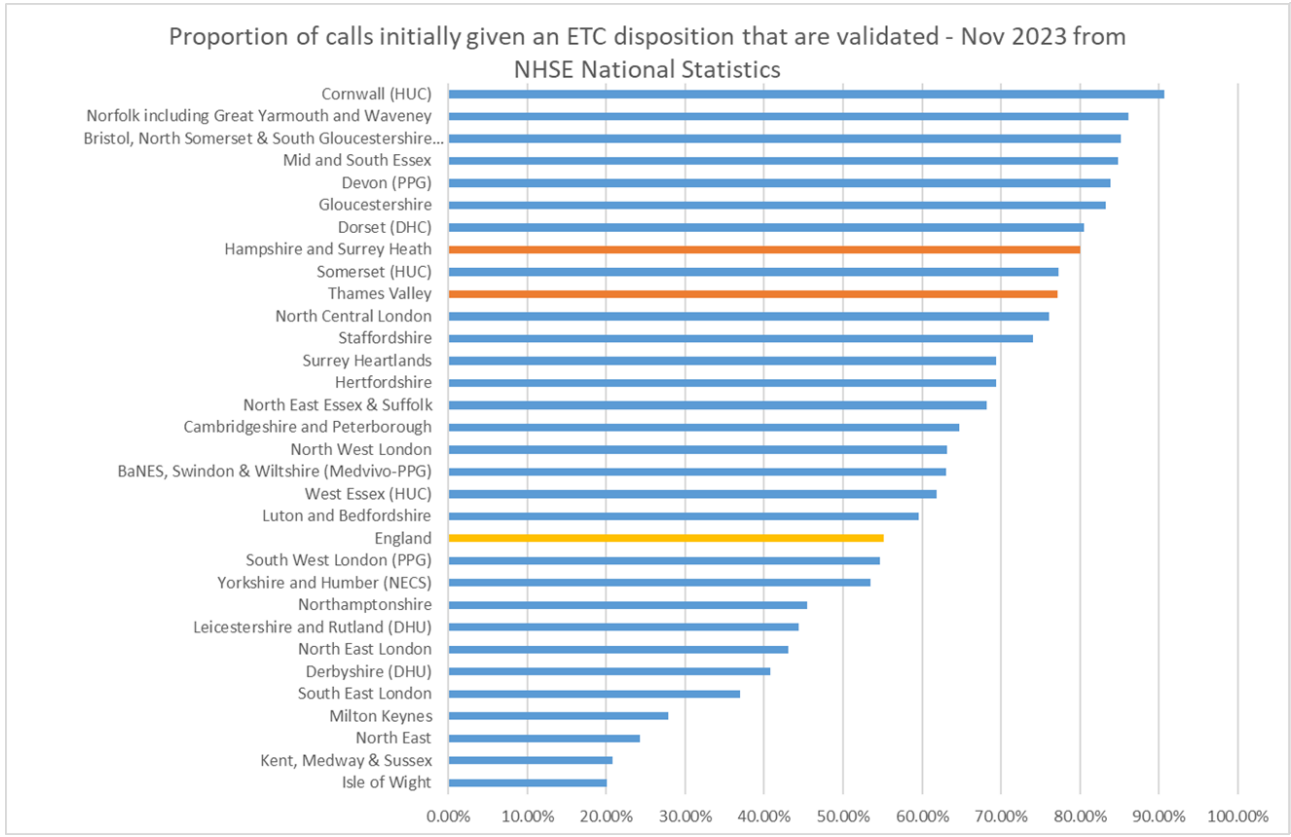
- **HSH: 61%**
- **TV: 36.1%**

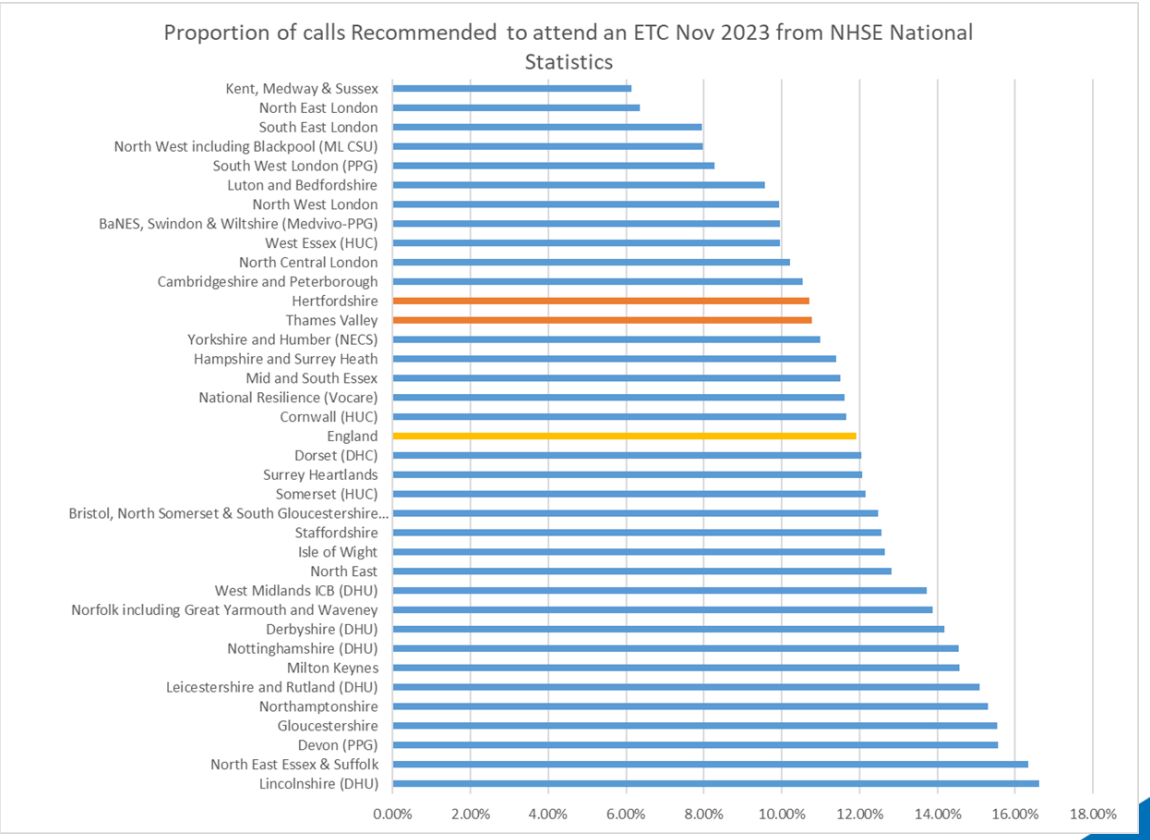
Management of Urgent Patients – Cat 3/4 Ambulance Validation and Referrals



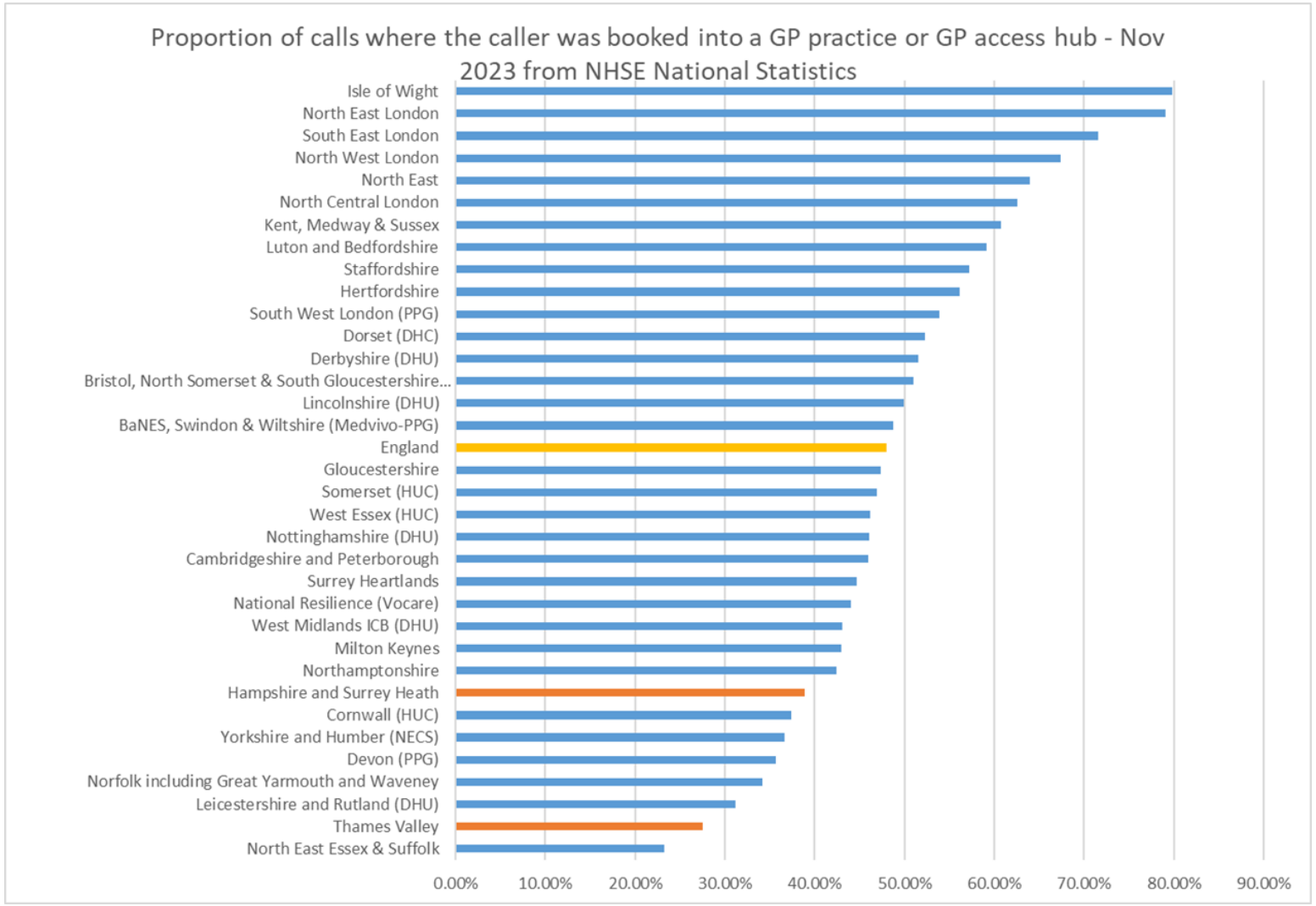


Management of urgent patients – ED validation and referrals





Proportion of calls where patient is booked into a GP practice or access hub



HSH: **38.9%**
TV: **27.6%**

Challenge = GP appointment provision issues.

Any questions?

Report Cover Sheet

Report Title:	Patient Panel Update
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	15
Executive Summary:	Information on the Patient Panel for the Council of Governors to include: • What is a Patient Panel • Eligibility criteria • Structure of the Patient Panel and levels of involvement • Aims of the Patient Panel • Compliance with NHS Requirements for organisations to have a Patient Panel and SCAS Annual Plan
Recommendations:	The Council of Governors are asked to note the Patient Panel Update.
Accountable Director:	Helen Young, Chief Nurse Officer
Author:	Nikhyta Patel, Patient and Public Engagement Facilitator
Previously considered at:	Patient Safety and Experience Committee
Purpose of Report:	Note
Paper Status:	u lic
Assurance Level:	**Significant –** i level of confi ence in eliver of e istin ec anis s o ectives
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives

Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	N/A
List of Appendices	Patient Panel Presentation

South Central Ambulance Service
NHS Foundation Trust

Patient Panel

by Nikhyta Patel, Patient and Public Engagement Facilitator

Contents

What is a Patient Panel

We want to identify what matters most in our local communities and the Panel will give members of the public a voice to have their views acknowledged and where possible acted on.

We are planning on focusing on two specific user groups for which we will create subgroups initially these will be, Learning Disability and Mental Health.

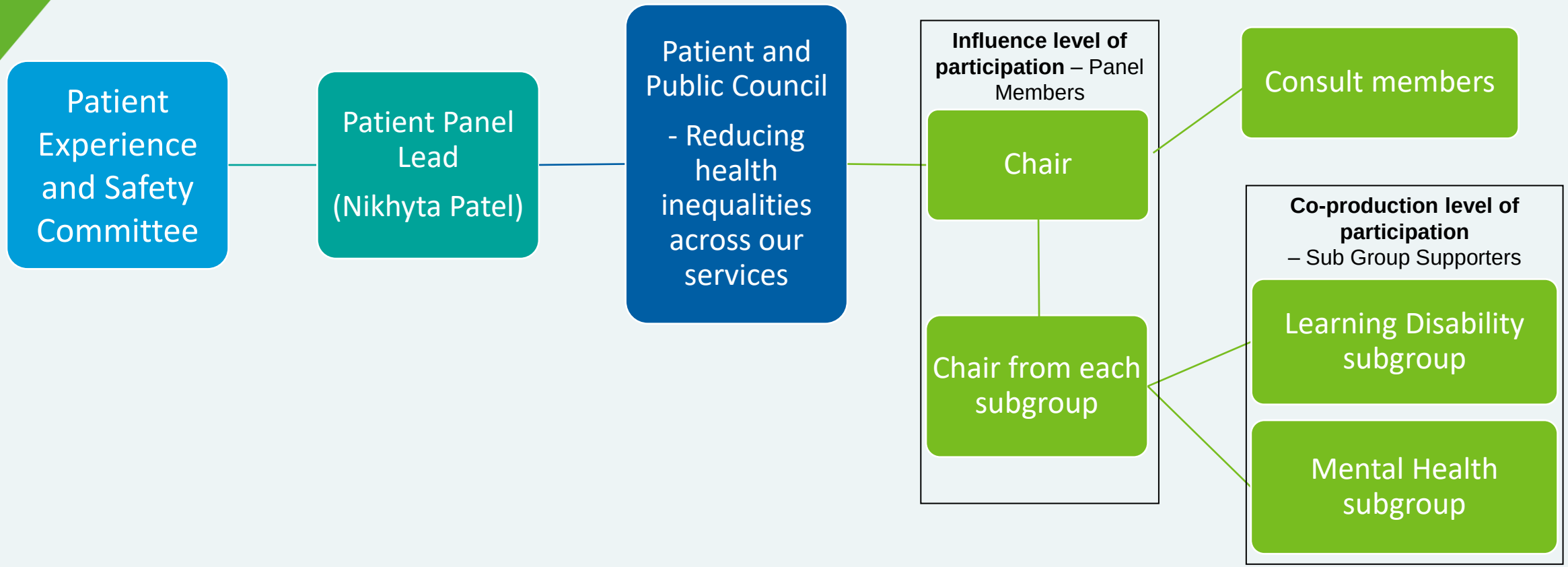
These groups will assist SCAS in co-production of Policies, Procedures and design and implementation of SCAS Services.

A Patient Panel gives patients and their relative/carers a voice to influence how SCAS services best suit their user groups.

Eligibility Criteria

- Must be 16 years of age or older (18 years or older for some roles)
- Must not be a current employee of SCAS, however our volunteers are welcome
- Must live in Buckinghamshire, Oxfordshire, Berkshire, Hampshire, Surrey, or Sussex
- Must be able to listen and discuss different perspectives with others in a constructive way
- Must have lived experience, either personally or as a relative/carer, of the two categories currently being recruited to (Mental Health or Learning Disability),

Patient Panel Structure



Aims of the Patient Panel

- To use the Patient Panel, experience as a patient relative/carer to support and advise SCAS on activities, policies and procedures that will improve Patient Safety and high-quality care
- To contribute towards the development of Trust policies and procedures
- To consider and prioritise the patient, carer and family perspective and champion a diversity of views
- Obtain feedback on the quality and provision of services to help support decision-making
- To understand and challenge where necessary the plans, procedures, and methods of the Trust with a view to assisting in the improvement of those plans, procedures, and methods
- To consider patients' feedback highlighting good practice and making recommendations for improving services for patients
- To monitor the Trust's service standards and make recommendations to the Trust (Quality) Management Team based on experiences, ideas and needs of the patients and the public

Why does SCAS need a Patient Panel?

NHS Requirements for SCAS to have a Patient Panel:

- NHS Five Year Forward View (NHSE, 2014)
- The Kings Fund (2016)
- NHS Long Term Plan (NHSE, 2019)
- NHS Patient Safety Strategy (2019)
- CQC Patient Safety and Improvement

SCAS Annual Plan

The SCAS Annual Plan 2019/20 set out clear areas of focus for the organisation and includes a commitment to engaging more patients in helping design new services and improve the delivery of existing ones.

There is already a programme of patient engagement activities undertaken within SCAS. Whilst they give a valuable opportunity to engage with the public and talk about the services we provide; they have historically given minimal opportunity for service co-design.

NHS
South Central Ambulance Service
NHS Foundation Trust

Any questions?

NHS
South Central
Ambulance Service
NHS Foundation Trust

Thank you

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Lead Governor's Report
Name of Meeting	Council of Governors Meeting
Date of Meeting:	31 January 2024
Agenda Item:	16
Executive Summary:	To present a report from the Lead Governor, highlighting key activities since the Council of Governors' meeting in October 2023. The report summarises the highlights from the previous two months as lead governor such as the launch of the refreshed strategy, the recent outreach events with Oxford University Hospital, the link with other lead governors and meeting the chair of the new patient panel and thanking the outgoing governors coming to the end of their term and welcoming the newly elected governors.
Recommendations:	To Note
Accountable Director:	Daryl Lutchmaya, Chief Governance Officer
Author:	Helen Ramsay, Lead Governor
Previously considered at:	
Purpose of Report:	To Note
Paper Status:	Public
Assurance Level:	Not applicable
Justification of Assurance Rating:	
Strategic Objective(s):	Not applicable

Links to BAF Risks or Significant Risk Register:	Not applicable
Quality Domain(s)	Not applicable
Next Steps:	
List of Appendices	

Meeting Report

Name of Meeting	Council of Governors Meeting
Title	Lead Governor's Report
Author	Helen Ramsay, Lead Governor
Accountable Director	Daryl Lutchmaya, Chief Governance Officer
Date	31 January 2024

Launch of refreshed SCAS Strategy – 'Fit for the Future'
Over recent weeks, SCAS has been under huge pressure to meet demand and manage handover delays, and as governors, we are very aware of how hard our colleagues are working within the Trust and have huge respect for staff dealing with the impact of the many challenges that the Trust is facing. As governors, we are a link between SCAS and the wider membership and members of the public and we continue to work on ways to help improve the two-way communications including those on operational updates.

In December, there was an opportunity for governors to be part of the briefings on the launch of the refreshed SCAS strategy. The role of governors in helping to shape this and to be able to feedback and help engage SCAS members and other stakeholders and members of the public will be key in its successful implementation.

Governor Engagement work highlights
The past three months have been very active in many ways – there has been a lot of engagement work as highlighted in the Membership and Engagement Committee report. We have set up a small working group of five governors who are actively identifying KPIs and ways for us to make a specific difference in health inequalities through our engagement work as governors.

There was an excellent and well-attended joint engagement event with Oxford University Hospital organised by Margaret Eaglestone which I was lucky enough to chair where SCAS had two excellent speakers on trauma in John Black and Mark Ainsworth-Smith and where Alan Weir, one of our staff governors, provided brilliant CPR demonstrations alongside colleagues.

ICBs/Lead Governors/Patient Panel
On the 14th December, governors were invited to attend the BLMK ICB update which has led to follow up questions and engagement. As part of the BOB ICB, there are ongoing discussion with other lead governors with the next being held on 29th

January which provides helpful links across the region. There is also a National Lead Governor Association of which both myself and Mark Davis as Deputy Lead Governor are a part; this provides a way to share ideas, challenges and best practice across the lead governors of different trusts.

In December, David Luckett and I also met with Roger Batterbury, Chair of the newly formed Patient Panel. We are looking forward to working with Roger in the future.

Incoming/outgoing governors
I would like to take this opportunity to give my own personal thanks for all the help and support from fellow governors who are leaving SCAS at the end of their term. Loretta Light has been an inspiration for me since I joined SCAS as a public governor for Oxfordshire in 2020, she initially showed me the ropes when I joined and decoded many of the acronyms, meetings and topics allowing me a way to contribute and supporting me throughout – Loretta always provides candid and wise insights into a whole range of topics at Council of Governor meetings, at the Member and Engagement Committee and at the Governor Advisory Council where she represents Ambulance Trusts nationally and her wealth of experience in healthcare has benefited SCAS in so many ways, she will be very much missed as a governor and I wish her every happiness in the future. And also I would like to personally thank Stephen Bromhall who has given many insights to the Trust particularly with regard to the IT opportunities and challenges from his work across other ambulance trusts.

I would also like to welcome the newly elected and appointed governors who are just about to start their term, there is a whole range of new experience that will be brought into the Council of Governors through them and I thank them very much for putting themselves forward for the governor role and look forward to working with them.

I continue to meet regularly with Sir Keith Willett and to work with Daryl Lutchmaya and his Governance team to address governor concerns as much as possible. Through the informal governor WhatsApp group, governors are able to reach out and support each other. I endeavour to provide the Council of Governors with monthly updates on the topics being discussed and the progress being made.
I would like to thank the governors very much for both their support and their hard work and particularly those who have stood for re-election and been reappointed, your commitment and contributions to the Trust are very much appreciated. Thank you.

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Non-Executive Director Update
Name of Meeting	Council of Governors Meeting
Date of Meeting:	Wednesday, 31 January 2024
Agenda Item:	17
Executive Summary:	To provide the Council of Governors with an update on activities undertaken by Mike McEnaney in his role as a SCAS NED, the issues and opportunities faced by the Trust.
Recommendations:	The Council of Governors are asked to note the Non-Executive Director Update.
Accountable Director:	n/a
Author:	Mike McEnaney, Non-Executive Director
Previously considered at:	
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	Significant
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable

Next Steps:	N/A
List of Appendices	Non-Executive Director Update Presentation

South Central Ambulance Service
NHS Foundation Trust

Non-Executive Director Update

Mike McEnaney
Non-Executive Director
Council of Governors Meeting
31 January 2024

NHS
South Central Ambulance Service
NHS Foundation Trust

Executive summary

The Non-Executive Directors have undertaken a range of activities associated with their role since the previous Council of Governors meeting.

This presentation highlights activities undertaken by Mike McEnaney in his role as a SCAS NED, the issues and opportunities faced by the Trust and Mike will invite questions from the Governors.

South Central Ambulance Service
NHS Foundation Trust

Mike McEnaney

- I joined SCAS as a NED in December 2022 and my current term of office ends December 2025
- I chair the Audit Committee and am a member of the Charitable Funds Committee
- I am a director of and Chair South Central Fleet Services Ltd, a subsidiary company of SCAS which is responsible for the acquisition, disposal and maintenance of the ambulance fleet
- Portfolio champion for risk management, internal control and fleet
- My focused area for stakeholder engagement is Hampshire and Isle of White ICS
- I am the NED buddy for Tim Ellison and Claire Dobbs

South Central Ambulance Service
NHS Foundation Trust

Selection of Q3 activities undertaken

Board/Board Committee/CoG meetings

I attended the following meetings:

- Board Meetings on – 30 November
- Board Seminar on – 26 October, 14 December
- Audit Committee on – 6 December, 15 January
- Finance & Performance Committee – 18 January
- Charitable Funds Committee – 11 October
- Council of Governors meeting - 4 October
- SCFS Ltd Board Meeting – 11 December

South Central Ambulance Service
NHS Foundation Trust

Selection of Q2 activities undertaken

Other SCAS activities

- Meeting with Bedford, Luton and Milton Keynes Audit Committee – 17 October
- BLMK ICS NED briefing – 30 November
- CFR Volunteer Conference – 7 October
- Kept in touch with my Governor buddies
- Disciplinary appeal hearing – 23 November
- Attended Newbury station for the new Strategy launch – 5 December
- Attended Didcot PTS – 23 January
- Patient Safety Incident Response Framework (PSIRF) Programme Board – 19 December
- Various meetings with CFO, Fleet Director and Auditors

South Central Ambulance Service
NHS Foundation Trust

My current view on areas within my NED portfolio

I hold the NED portfolio role for:

Risk management and internal control

- Support the Executive Team in ensuring SCAS has robust arrangements in place to identify and manage risks, that support the delivery of the Trust's strategy and business objectives, and a sound system of internal control

Fleet

- Ensure that SCAS, through the support of the subsidiary company (SCFS Ltd), has a high quality fleet available to support the delivery of patient care

South Central Ambulance Service
NHS Foundation Trust

My views on the main challenges (risks) and opportunities for the Trust

Areas of Challenge

- Establishing the tight internal controls and high levels of governance and risk management necessary to support SCAS in achieving its strategic objectives

- Delivering the service improvements and transformation plans and maintaining quality whilst coping with the ever-increasing patient demand and a financial deficit

- Creating a Quality Improvement (QI) culture and maintaining staff morale

South Central Ambulance Service
NHS Foundation Trust

My view on the main opportunities and risks facing the Trust

Areas of Opportunity

- The implementation of a new operating model that will provide improved quality, productivity and financial sustainability
- Restructuring the ambulance and PTS station nodes providing a more effective service, improved teamworking and creating development opportunities for staff
- Being a valued partner to all ICSs in which we operate by delivering quality and value for money and through taking a lead in developing the Urgent Care Pathway
- Being a truly great place to work