Agenda

Public Trust Board

Date: Thursday 25 January 2024
Time: 9.30 – 12.15
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members:

Professor Sir Keith Willett CBE	Chair
David Eltringham	Chief Executive Officer
Sumit Biswas	Non-Executive Director
Les Broude	Non-Executive Director
Dr Anne Stebbing	Non-Executive Director
Ian Green OBE	Non-Executive Director
Dr Dhammika Perera	Non-Executive Director
Paul Kempster	Chief Transformation Officer
Daryl Lutchmaya	Chief Governance Officer
Helen Young	Chief Nurse Officer
Melanie Saunders	Chief People Officer
Mike Murphy	Chief Strategy Officer
Dr John Black	Chief Medical Officer

In attendance:

Stuart Rees	Interim Director of Finance
Mark Ainsworth	Director of Operations
Craig Ellis	Chief Digital Officer
Gillian Hodgetts	Director of Communications, Marketing and Engagement
Kate Hall	Intensive Support Director, NHSE/I
Kofo Abayomi	Head of Corporate Governance & Compliance
Susan Wall	Corporate Governance & Compliance Officer

Apologies:

Nigel Chapman	Non-Executive Director
Mike McEnaney	Non-Executive Director

Questions received in advance from Board Members for those items marked as 'For Noting' will be received under agenda item 24 & 27.

Item		BAF	Action	Time
OPENING BUSINESS				
1	**Chair's Welcome and Apologies for Absence** Keith Willett	-	**Verbal For Noting**	09.30
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Keith Willett	-	**Verbal For Noting**	
3	**Minutes from the meeting held on 30 November 2023** Keith Willett	-	**Page 6 For Approval**	
4	**Board Actions Log** Daryl Lutchmaya	-	**Page 17 For Approval**	09.35
5	**Chair's Report** Keith Willett	-	**Verbal For Noting**	09.40
6	**Chief Executive Officer's Report** David Eltringham	-	**Page 18 For Noting**	09.45
7	**Update to the Public Board on the previous Private Board meeting held on 30 November 2023 and 14 December 2023** Daryl Lutchmaya	-	**Page 23 For Noting**	09.50
8	**Staff Story** Melanie Saunders	**SR7 12**	**Page 28 For Information**	09.55
9	**Integrated Performance Report** Mike Murphy & Executive Director Leads	**SR9 20**	**Page 32 For Assurance**	10.10
	High quality care and patient experience - We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.			
10	**Quality and Patient Safety Report** Helen Young	**SR1 12**	**Page 39 For Assurance**	10.35
11	**Chief Medical Officer's Report** John Black	**SR1 12**	**Page 49 For Assurance**	10.45
12	**Operations Report – 999, 111 and Other** Mark Ainsworth	**SR2 20**	**Page 56 For Assurance**	10.55
13	**Assurance Report** Quality and Safety Committee, 11 January 2024 Dhammika Perera	**SR1 12**	**Page 67 For Noting**	-

Item		BAF	Action	Time
	Finance & Sustainability – We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partner.			
14	**Finance:** Finance Update- Month 9 Stuart Rees	**SR5 20**	**Page 70 For Assurance**	11.05
15	**Assurance Report** Finance and Performance Committee, 18 January 2024 Les Broude	**SR5 20**	**Page 75 For Noting**	-
16	**Assurance Report** Audit Committee, 15 January 2024 Mike McEnaney	**SR5 20**	**Verbal For Noting**	-
17	**Assurance Report** Charitable Funds Committee, 10 January 2024 Nigel Chapman	**SR5 20**	**Page 79 For Noting**	-
18	**Questions submitted by Board Members on agenda items: 13, 15, 16, 17**	**-**	**-**	11.15
	People & Organisation – We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			
19	**Freedom to Speak up Policy** Melanie Saunders	**SR7 12**	**Page 84 For Approval**	11.25
20	**Gender Pay Gap Report** Melanie Saunders	**SR7 12**	**Page 88 For Approval**	11.30
21	**Equality Delivery System (EDS) 2023/24 Report** Melanie Saunders	**SR7 12**	**Page 88 For Approval**	11.35
22	**Assurance Report** People and Culture Committee 18 January 2024 Ian Green	**SR7 12**	**Verbal For Noting**	-
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
23	**Communications Update** Gillian Hodgetts	**SR4 12**	**Page 94 For Noting**	-
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
	No Report	**-**	**-**	-
24	**Questions submitted by Board Members on agenda item: 23**	**-**	**-**	11.40
5 MINUTES COMFORT BREAK 11.55				
	Well Led – We will become an organisation that is well led and achieves all of its regulatory requirements by being rated Good or Outstanding and being at least NOF2.			
25	**Board Assurance Framework** Board Assurance Framework Daryl Lutchmaya & Executive Director Leads	**SR9 20**	**Page 99 For Approval**	11.45

Item		BAF	Action	Time
26	**Assurance Report** Improvement Programme Oversight Board Update 10 January 2024 Mike Murphy	**SR9 20**	**Page 106** **For Noting**	-
27	**Questions submitted by Board Members on agenda items: 26**	**-**	**-**	11.50
CLOSING BUSINESS				
28	**Any Other Business** **Fit for the Future Programme** Paul Kempster	**-**	**Page 108** **For Noting**	11.55
29	**Questions from observers (items on the agenda)** Keith Willett	**-**	**Verbal** **For Noting**	12.00
30	**Review of Meeting** Non-Executive Director: Les Broude Executive Director: Melanie Saunders	**-**	**Verbal** **For Noting**	12.05
31	**Date, Time and Venue of Next Meeting in Public** Thursday 28 March 2024 at 9.30 Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN	**-**	**Verbal** **For Noting**	-

Our Values

Caring:

Compassion for our patients, ourselves and our partners

Professionalism

Setting high standards and delivering what we promise

Innovation

Continuously striving to create improved outcomes for all

Teamwork

Delivering high performance through an inclusive and collaborative approach

Minutes
Public Trust Board Meeting

Date: 30 November 2023
Time: 9.30 – 12.30
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members Present:

Professor Sir Keith Willett CBE	Chair
David Eltringham	Chief Executive Officer
Sumit Biswas	Non-Executive Director
Les Broude	Non-Executive Director
Mike McEnaney	Non-Executive Director
Dr Anne Stebbing	Non-Executive Director
Ian Green	Non-Executive Director
Dr Dhammika Perera	Non-Executive Director
Paul Kempster	Chief Transformation Officer
Daryl Lutchmaya	Chief Governance Officer
Professor Helen Young	Chief Nurse Officer
Mike Murphy	Chief Strategy Officer
Dr John Black	Chief Medical Officer

In Attendance:

Stuart Rees	Interim Director of Finance
Barry Thurston	Interim Digital Chief Officer
Mark Ainsworth	Director of Operations
Kate Hall	Intensive Support Director, NHSE
Caroline Whitworth	Head of Patient Experience
Lewis Clarke	Paramedic Team Leader
Dipen Rajyaguru	Head of Equality, Diversity & Inclusion
Nora Hussein	Interim Assistant Trust Secretary
Susan Wall	Corporate Governance & Compliance Officer

Apologies:
None received.

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence** The Chair welcomed everyone to the meeting. There were no apologies.
2	**Declarations of Interests** Stuart Rees declared that he had been appointed as the SCFS Ltd Managing Director. Ian Green added that some of his declarations were no longer relevant and an updated list will be submitted to the Governance Team.

3	**Minutes from the meeting held on 26 October 2023** - The minutes were agreed as an accurate record of the meeting, following the change: • Ian Green was not present at the meeting and his apologies should be noted.
4	**Matters Arising and Action Log** The action log was reviewed, and the following action was agreed to be closed: • Action 2- Corporate risk on Business Continuity to be added to the Risk Register. There was currently a business continuity risk on the 999 Operations and EOC risk register as well as a Cyber risk (loss of applications due to a cyber-attack).
5	**Chairs Report** Keith Willett drew the Boards attention to the Trusts values and reminded all that the Board must remain focused on those during the challenging times. He informed the Board that NHS England had implemented a savings exercise to identify additional savings of approximately £1.4b in response to the Treasurys request of recuperating industrial actions finances. The Board **noted** the Chairs Report.
6	**Chief Executive Officer's Report** David Eltringham gave a detailed overview of the visits he had undertaken since the last Public Trust Board. David Eltringham recorded his thank to staff for their efforts during the challenging months and added that Executive Directors would continue to be visible and transparent across the organisation. He informed the Board that His Royal Highness the Prince of Wales visited the Milton Keynes Blue Light Hub on 10 October 2023 to highlight the importance of supporting the mental health of emergency responders. He was joined by Broadcaster, Journalist and Psychologist Dr Sian Williams. David Eltringham also informed the Board that he attended the Ambulance Leadership Forum (ALF) Conference 2023 alongside other senior leaders from SCAS. The Board were informed that Luci Papworth, SCAS Director of Operations for our Clinical Coordination Centres, was presented with an award for Exceptional Service. He informed the Board that the refreshed SCAS Strategy – 'Fit for the Future' was due to be launched on 5 December 2023. He added that Executive Directors would be available throughout the organisation to discuss with staff any questions that may arise. David Eltringham also informed the Board that the Adult Critical Care Transfer Service Team had been nominated for an award with the Intensive Care Society. Ian Green advised that it would be beneficial to understand the feedback of the Staff Survey. Regarding the Electronic Patient Record System (EPR) Ian Green reflected whilst it was positive that the system was back up and running, he questioned what processes were in place that would provide assurance of accurate uploading. Helen Young responded that she would respond with the Quality and Patent Safety Report. The Board **noted** the Chief Executive Officer Report.

7	**Update to the Public Board on the previous Private Board meeting held on 26 October 2023** The Board **noted** the update to the Public Board on the previous Private Board meeting held on 26 October 2023.
8	**Integrated Performance Report** Mike Murphy provided the Board with an update on the Integrated Performance Report. The Board were informed that for October 2023: • Category 2 would be a high-profile measure throughout the winter but balance across the delivery of all metrics must be maintained. • Operational hours were increasing which would support the Trust's Category 2 performance. However, handover delays in October added an additional 10 minutes 31 seconds to the Category 2 performance. • The Trust had been collaborating closely with provider partners to reduce delays in November 2023. • Call volumes continued to increase but there were higher abandonment rates due to calls switching to West Midland Ambulance Service (WMAS) who were supporting SCAS at peak times. • The Trust had experienced increases in severe or major harm incidents. Delays in care had been identified as a contributory factor and would be the focus of discussion at the Quality & Safety Committee in November. • Statutory and mandatory training remains below target despite 999 workforces being provided with 'study time' to complete their e-learning. Leadership teams were now tasked with identifying improvement plans to return to expected compliance levels. In addition, compliance data accuracy was also under review to ensure that the Trust were reporting against an accurate count of staff. Mike McEnaney raised concerns that there was a reliance on WMAS, and what plans were in place to either minimise WMAS resources or whether resource planning was required. Mark Ainsworth responded that NHSE had requested that the processes remain whilst testing of Incident Response Plan (IRP) resilience continues. He added that the recruitment profile is expected to be complete by March 2024. David Eltringham assured the Board that the Category 2 performance figures were monitored on a daily basis by the Executive Team at a daily at their huddle meeting. He was assured that Mark Ainsworth had a grip on the performance figures. Les Broude informed the Board that the Finance and Performance Committee received a comprehensive report on the Category 2 performance analysis and were assured by the figures. He questioned how WMAS were able to support SCAS calls as well as their own. Mark Ainsworth responded that WMAS had greater staffing figures in comparison to SCAS. In response to a question around assurance of ambulances arriving at hospital sites at full capacity, Mark Ainsworth responded that there was confidence in system ownership that allowed the ICB to divert patients to other hospitals. He added that there was senior visibility by the Secretary of State, where delays of over 10 hours were reported. In response to a question around assurance of delivering the Queen Alexandra Hospital plans Mark Ainsworth responded that he would provide the Finance and Performance Committee with a monthly analysis of delivery and the impacts of Category 2. He added that the tender had now closed to private providers in relation to hours and four extra ambulances 24 hours a day 7 days a week. He updated the Board that there had been possibly four ambulances recruited from the final tender however there remained a risk of 1000 hours per week on the operational delivery plan.

	Keith Willett highlighted that this was not only a Queen Alexandra Hospital problem but a health pathway problem that could create a pressure point. In response to a question around concerns of delays at hospitals, Mark Ainsworth informed the Board that the Trust would be using the SHREWD Platform that was an NHS monitoring tool that included a dashboard detailing hospitals bed capacity and accident and emergency department waiting times etc that would help route ambulances in future. David Eltringham reemphasised the importance of system working and that SCAS continued to work with several integrated care systems, however due to current pressures focus was currently given to Hampshire and Isle of Wight (HIOW). He added that discussions were required around sharing the risks across the system. Les Broude raised concerns with the statutory and mandatory training figures in regard to patient care. Helen Young responded that alternative ways of training are being explored to ensure staff are trained effectively. She added that equality impact assessments are completed for delayed training to ensure transparency. Sumit Biswas commented that the Integrated Performance Report had lost sight of the patient transport service. Mike Murphy responded that the metrics had been reduced for this month report due to the development of further reporting and will continue to be reported in future reports. Les Broude observed that the report did not document vehicles off road. Stuart Rees responded that an action plan was being developed and would appear within the report in future. He added that he would also bring back to the Board a report on vehicles off road. **Action 1- Stuart Rees, March 2024.** The Board **noted** the Integrated Performance Report.
9	**Patient Story** Caroline Whitworth and Lewis Clarke attended the meeting to present the Patient Story. The Board heard that Mrs North contacted the Patient Experience Team in August 2023 to raise concerns about the clinical assessment and lack of support provided to her late husband in December 2022. The patient, Mr North (62) suffered with chronic obstructive pulmonary disease. He had been an inpatient in hospital frequently throughout 2021 & 2022 with a bacterial infection and was almost bed ridden in pain waiting for a hip replacement. Around mid-December 2022 Mr North fell ill with a ‘norovirus’ type bug. He struggled to make any improvement and within a couple of days he was unable to control his bladder and was unable to get out of bed. The Board heard how Mr North sadly collapsed because of the pain in his hip and because he was very weak. Mrs North felt that the crew let him fall. She said his legs were folded underneath him he was in unbelievable pain. He was too weak to get himself up. The crew then used the Mangar Elk to help Mr North off the ground and at this point he became unresponsive and went into Cardiac arrest.

	Mr North was then treated by the crew appropriately and the decision was made to convey him to hospital as soon as possible. Sadly, Mr North was pronounced dead not long after arriving there. The Board were informed of the learning completed which included: • The crew had been asked to complete a reflective practice in regard to ensuring they correctly read booking notes and if they are faced with any obstacles that may be challenging to safely transport the patient, they should call dispatch immediately for advice. • Team Leaders had cascaded to their crews the use of soft skill techniques to assist in manual handling transfers. • In extensive talks with the crew, they accepted that in hindsight, a better decision would have been to wait upstairs and call for the extra help before attempting to start the transfer. However, they made the initial decision with the intention of minimising any delay getting to hospital. Appropriate risk assessment and decision pathways have been reinforced with this crew following the incident. • Reflection for crew members involved re O2 therapy and need to transfer patient from ambulance to Emergency Dept on trolley. • One of the outcomes included sharing a 'Hot News' to highlight the importance of planning extrication and using the kit available to ensure we reduce stress on time critical patients by asking or encouraging them to mobilise when not necessary. The Board were informed that Mrs North was rightfully upset however wanted learning to be taken away by the Trust to avoid similar situations reoccurring. Keith Willett thanked Mrs North for her strength in raising a complaint which allows the Trust to increase its learning. Anne Stebbing reflected whether the Trust was doing enough training on increasing staff empathy in similar situations. Lewis Clarke responded that it could be useful to include empathy training within e-learning. He added that it was important to note that it was not always possible to monitor staff behaviour of those staff that enter the Trust from external avenues such as universities and stated that it would be important to identify these behaviours during supervised learning. The Board **noted** the Patient Story.
10	**Quality and Patient Safety Report** Helen Young provided the Board with an update on the Quality and Patient Safety Report for the reporting period of August to September 2023. She informed the Board that with the assistance of the local accreditation network and partners at London Ambulance Service a draft accreditation manual had been created. This has been presented to the Executive Management Group and an implementation plan is being completed. She highlighted that there had been no Zoll incidents recorded and added that several vehicles were found not to have secondary AEDS and spare Zoll batteries. A full audit was completed, and audit checklist updated to prevent any further occurrences. The Board were informed that no patient harm was identified. Helen Young informed the Board that the Quarter 2 Safeguarding Improvement metrics remain above trajectory. Level 3 training compliance was 0.75% above trajectory at 60.75%.

	The Board heard that the Serious Incident (SI) relating to the Ortivus outage which was declared on 21 October 2023 was progressing with the internal triage of referrals and associated report being incorporated into the overall SI report. To date no patient harm had been identified. There remained 3 outstanding actions from the Safeguarding Accountability and Assurance Framework (SAAF) including the transition of the server, demonstration of dashboard and access for frontline crews to the Child Protection Information Service system via the EPR (electronic patient records) with functionality expected in January 2024. Nigel Chapman questioned whether there continued to be reluctance of staff wearing body cameras. Helen Young responded that there continued to be reluctance. Mark Ainsworth added that part of the reason was due to the size of the cameras and the straps discomfort, he added that currently there was no monitoring of cameras worn recorded. In response to a question around abuse, Helen Young responded that abusive behaviour was the second highest reported category and were mostly low or no harm incidents, but reporting was encouraged. The sub-category with the highest number of incidents was verbal abuse. Anne Stebbing questioned whether there were any areas of concern regarding the international nurses that had been recruited given English was not their first language when communicating with patients. Helen Young responded that the recruitment had been managed by the 111 area and evaluations had been completed, she added that there had been regular monitoring of their experience and no patient harm had been recorded. She also informed the Board that positive feedback had been received from the support programme. Anne Stebbing advised that consideration should be given to surveying patients experience from the international nurses. Helen Young responded that audits would consider this within the reporting. Mark Ainsworth added that the international nurses would not be working within Category 2 Segmentation, and that it would be covered by experienced nurses. The Board **noted** the Quality and Patient Safety Report.
11	**Medical Director's Report** Anne Stebbing requested that future reports consider the work on clinical pathways. The Board **noted** the Medical Director's Report.
12	**Operations Report – 999, 111 and Other** Mark Ainsworth informed the Board that the focus remained on delivering the category 2 trajectory, however the Trust missed the target of 27:57, achieving 39:51 for the month with a year-to-date (YTD) position of 32:45, with the cat 1 mean at 08:53 YTD. The Board were informed that 62% of its demand was presenting as cat 1 or cat 2 calls, indicating a higher acuity of patients calling 999. The Trust had seen a slight increase in its 999 call answer, however it was still receiving support from WMAS for call handling capacity. Hospital handover delays remained a key risk for the Trust's delivery of its trajectory with delays impacting on cat 2 performance by 10 minutes in October 2023. Anne Stebbing reflected that there should be a risk regarding delays of the new ambulances arriving late. Keith Willett responded that this could be discussed at a later private Board due to commercial sensitivities.

	In response to a question around training, Mark Ainsworth responded that weekly reports are available regarding who had completed training and when. The Board **noted** the Operations Report – 999, 111 and Other.
13	**Operations Modernisation Programme** Paul Kempster informed the Board that a presentation was being developed for the Strategy Re-Launch on 5 December 2023 and that information had been uploaded onto the intranet in preparation. He informed the Board that engagement and analysis work had commenced. Keith Willett advised that it was important to report back to the Board on impact assessments on workforce and equality aspects. Sumit Biswas commented that it was important to recognise the shifts in behaviours and how the strategy is received. Mike McEnaney advised that objective targets including timelines were required and that it should be communicated with staff. David Eltringham informed the Board that it was a timely conversation that was developing on a daily basis. He added that the improvement programme, radical change programme and routine exercises would be aligned resulting with a fit for the future sustainable ambulance service that communities deserve. He informed the Board that the Association of Ambulance Chief Executives would be supporting the Trust during an agreed 18-month pathway. He added that the programme would be governed by an Improvement Transformation Radical Change Board that would report into the Executive Management Committee. The Board **noted** the Operations Modernisation Programme.
14	**Assurance Reports:** **a. Quality and Safety Committee 20 November 23** The Board **noted** the Quality and Safety Committee Assurance Report. **b. Quality and Safety Committee 2022/2023 Annual Report** The Board **noted** the Quality and Safety Committee 2022/2023 Annual Report.
15	**Finance Update- Month 7** Stuart Rees informed the Board that in October, the Trust recorded an in-month deficit of £1.7m, consistent with the improved run rate at September month 6. The Trust year to date deficit was £15.3m, £11.3m off plan. He informed the Board that in early November NHS England announced additional funding for systems to cover the cost of industrial action, with this additional funding and further operational flexibility, NHS England has asked all systems to review and confirm their financial forecasts in line with operational plans. An Extraordinary Board meeting was held on 15th November 2023 at which it was agreed that SCAS would signal a revised year end forecast of £22.3m financial deficit subject to receipt of expected and indicative funding. This was a movement from the previous run rate forecast of £29.3m.

	The Board heard that the Trust's cash balance at the end of October was £33.7m. The Trust's cash balance had decreased by £16.3m since the start of the financial year. The cash forecast had improved due to the planned receipt of additional income. At the current expenditure run rate, the Trust would require cash support from Quarter 4 2024/25 to support continuing operations. Anne Stebbing raised concerns with the delayed delivery of vehicles and advised that learning was required given a similar situation arose in previous years. Mike McEnaney advised that the Board should be cautious not to become accustomed to holding a £1.7m deficit and should assure itself that they are doing all it can to resolve the identified issues. Les Broude advised that the Board and Finance and Performance Committee should consider finding opportunities to identify recurrent savings. David Eltringham informed the Board that there were now stronger internal governance arrangements in place via the Financial Recovery Group that reports to the Executive Management Committee. He advised that plans should remain ambitious, challenging and realistic to deliver. The Board **noted** the Finance Update- Month 7.
16	**Assurance Report** Finance and Performance 20 November 23 The Board **noted** the Finance and Performance Assurance Committee Report.
17	**EDI** **a) WRES Report** **b) WDES Report** The Board were informed that the Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract. The purpose of the indicators was to inform a local action plan that will target specific areas within a given organisation were the treatment or experience of BAME staff was poor. Ian Green informed the Board that the WRES and WDES had been presented to the People and Culture Committee where conversations were held around what it was like for staff with disabilities working for SCAS. Melanie Saunders informed the Board that an action plan would be developed around EDI metrics and that the national staff survey results would be reviewed from an EDI perspective. She added that a lived experience staff story would also be presented to the Board. Mike McEnaney advised that challenge was required about what should be done to improve metrics and that it should be reviewed regularly throughout the year. Nigel Chapman shared that a deep dive session should be considered. Dhammika Perera advised that SCAS should look at the work other Trusts had done and take away some learning. He advised that social economics should also be explored.

	Sumit Biswas echoed Dhammika Pereras learning comments and added that this should not only include NHS Trusts but other organisations. Keith Willett suggested that the Board hold a session/seminar to identify the metrics that are specific to SCAS and develop a health and inequality statement that is relevant to the organisation. The Board agreed with the suggestion. **Action 2, Melanie Saunders.** The Board: • **Approved** the WRES Report for publication as required. • **Approved** the WDES Report for publication as required.
18	**People Directorate Update** Melanie Saunders informed the Board work would be carried out to improve the response figures of the Staff Survey. She informed the Board that she expected to share the results of the Staff Survey results within the January People Directorates report. Les Broude suggested that Executive Directors should raise the Staff Survey to staff within their site visits. Anne Stebbing commented that she had difficulty with accessing the Staff Survey link and that it was worth checking with staff whether they were able to access the link. The Board **noted** the People Directorate Update.
19	**Ofsted Update** Melanie Saunders informed the Board that on the 13th & 14th September the Trust underwent a two-day Ofsted Requires Improvement Monitoring Visit. The visit was focused on monitoring progress against the core 3 recommendations made following the full visit in December 2022. The Board were informed that at the end of the visit the inspectors noted the kindness and professionalism of all staff and apprentices that they came into contact with, noting their commitment to caring for our patients and the public. The Board **noted** the Ofsted Update.
20	**Assurance Report** **People and Culture Committee 23 November 2023** The Board **noted** the People and Culture Committee Assurance Report.
21	**Communications Update** Keith Willett informed the Board that the Covid 19 Public Enquiry Module 3 was due to commence in the spring of 2024. He advised that the Board should anticipate involvement in response should an enquiry is made. Helen Young added that NHSE had not made arrangements for strategic management legacy for how data would be managed, stored and retrieved. She added that the Trust had written to the Health Security Agency to raise this. The Board **noted** the Communications Update.
22	**Technology transformation- No Report**

23	**Questions submitted by Board Members on "For Noting" agenda items: 14a &b,16,19, 20, 26 and 27.** No questions received.
24	**Risk:** **a) Board Assurance Framework including strategic risk 9** Daryl Lutchmaya updated the Board with the changes to the BAF risks. The Board were informed that the BAF included a new BAF risk 9- Scored 20, covering the Trusts improvement programme aligned to the objective of moving to a good outstanding rating. Mike McEnaney requested that future BAF numbers were accompanied by the detail. He added that the BAF should detail the risks aligning with action plans and end dates. Ian Green advised that the BAF links to the initiatives of the development of the annual plan. Nigel Chapman requested that accompanying text was required within the control issues. The Board **noted** and **approved** the Board Assurance Framework Update.
25	**Improvement Programme Oversight Board Update- 1st November 2023** The Board **noted** the Improvement Programme Oversight Board Update- 1st November 2023.
26	**Recovery Support Programme** The Board **noted** the Recovery Support Programme.
27	**Governance Update:** **a) Governor Elections Update** Daryl Lutchmaya informed the Board that the Trust had a successful outcome for the Council of Governor elections and informed the Board that: • 13 constituency seats were elected unopposed, and Governors would take up their seats in March 2024 • 3 candidates would be competing for the two Berkshire constituency seats. Voting closes on 12 December 2023. Declaration of results will be on Wednesday 13 December 2023 • 2 vacancy seats remained unfilled, one in Oxfordshire and one staff constituency - 999 North. The Board **noted** the Governor Elections Update.
28	**Any Other Business** There was no other business.
29	**Questions from observers** Helen Ramsay requested that the Governors could provide input into the EDI work. Melanie Saunders welcomed the request.
30	**Non-Executive Director Review of the meeting** Ian Green reflected that the Board: • Chair gave good overview of change of agenda format • In order to submit questions for noting agenda items, papers should be circulated in goodtime consistently • Challenging to refer to both pack of papers and requested full use of iBabs • Consist use of 3 A's required

	• Good technology **Executive Director Review of the meeting:** Helen Young reflected that the Board: • Appropriate challenge received from NEDs • Executive Director questions required • Papers remain large • Echoed consistent use of 3 A's required • Concerns around lack of time towards end of the agenda
31	**Date, Time and Venue of Next Meeting in Public** Thursday 25 January 2024

Board Meeting in Public 25 January 2024

Key for Status

	Open		Propose to Close

Action No.	Date of Meeting	Agenda Item & No.	Detail of Action	Action Owner	Due Date	Status	Progress Update
1	25/5/23	22/150	Governors to be invited to participate in 'triple aim' duty with regard to community engagement.	Chief Governance Officer	October 23	Open	This is on the Council of Governors Development Plan to be actioned in Q4.
2	30/11/23	8	Vehicles of road report to be presented to Board.	Interim Director of Finance	March 24	Open	This report will present at the meeting on 28th March Board meeting.
3	30/11/23	17	EDI Board Seminar session to be arranged to identify the metrics that are specific to SCAS and develop a health and inequality statement that is relevant to the organisation.	Chief People Officer	February 24	Open	Date to be identified by EDI lead and governance team.

Report Cover Sheet

Report Title:	Chief Executive Officer's Report
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	6
Executive Summary:	The purpose of the CEO report is to keep the Board updated on key events and messages not covered elsewhere on the agenda, since the last Public Board meeting held on 30 November 2023. The CEO report the following: ▪ Site visits and engagements undertaken ▪ Fit for the Future ▪ Operational performance and handover delays ▪ SCAS Charity ▪ Council of Governors elections
Recommendations:	The Trust Board is 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	Public Trust Board Meeting
Title	Chief Executive Officer’s update
Authors	Daryl Lutchmaya & Gillian Hodgetts
Accountable Director	David Eltringham, Chief Executive Officer
Date	25 January 2024

1. Purpose

The purpose of this CEO Report is to keep the Board abreast of key issues and developments since its last meeting in public held in November 2023.

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

Since the last Public Board meeting, 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 Board is invited to **note this report.**

Report Cover Sheet

Report Title:	Update to the Public Board on the previous Private Board meeting held on 14 December
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	7
Executive Summary:	The report details agenda items that were received by the Private Trust Board, decisions made, and items noted at the meetings held on 30 November and 14 December 2023.
Recommendations:	The Board is asked to note the update.
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:	(What actions will be taken following agreement of the recommendations)
List of Appendices	

Meeting Report

Name of Meeting	Public Trust Board
Title	Update to the Public Board on the previous Private Board meeting held on 30 November and 14 December 2023
Author	Daryl Lutchmaya, Chief Governance Officer
Accountable Director	David Eltringham, Chief Executive Officer
Date	25 January 2024

Private Board 30 November 2023

Legal Claims and Inquest Update

The Board received a six-month update on Legal Claims and Inquests, covering period quarter 1 and quarter 2 of 2023/2024.

The Board **noted** the Legal Claims and Inquest Update.

Future of Vehicle Conversion Specialists Limited (VCS)

The Board were informed that on Monday 20 November 2023, Vehicle Conversion Specialists Limited (VCS) had entered administration, which would have a detrimental impact on the National Framework Agreement (NFA) (2020/S 240-594961) Year 2 and the delivery of 72 Double-Crewed Ambulance (DCA) into service.

The Board **approved** the discussion with HIOW ICB and National Team deferment of the Capital Program for DCAs to 2024/25.

Strategy Update

The Board **noted** the Strategy Update.

Legal and Regulatory

The Board received a report that provided an update from the last report presented in September 2023.

The Board **noted** the Legal and Regulatory update.

Non-Executive Director Site Visits 2023 – 24

The Board **noted** the Non-Executive Director Site Visits 2023-24.

Private Board 14 December 2023

Operational Modernisation Programme

The Board heard that on Tuesday, 5 December, David Eltringham relaunched the SCAS Vision and Strategy for 2024-29.

The Board **noted** the Operational Modernisation Programme

Improvement Programme Update

The Board **noted** the Improvement Programme Update.

Finance Month Update 8

The Board **noted** the Finance Month Update 8.

999 Contract

The Board **approved**:

1. Healthcare Contracts Approval Procedure for the approval of the 23 / 24 999 Ambulance Services Contract Agreement

2. Healthcare Contracts Approval Process: TV IUC Lead Provider Contract – Variation for 23/24
3. Healthcare Contracts Approval Process: Change of Contract Terms and Conditions for Sub-Contractors NHUC and PHL

4. Healthcare Contracts Approval Process: HSH IUC Lead Provider Contract – Variations CV01, CV02, CV03, CV04.

SCFS Ltd Annual Accounts 2022/23

Board heard that following a audit of the Statutory Financial Statements 2022/23, SCFS Ltd external auditors Azets were proposing to give an unqualified opinion that the accounts gave a true and fair view of the financial position of the Group and of the Trust as at 31 March 2023.

The Board **approved** the SCFS Ltd Annual Accounts 2022/23 and the Letter of Support.

Charity Annual Report and Accounts

The Board heard that the 2022/2023 South Central Ambulance Charity Accounts had been approved by the Charitable Funds Committee and had successfully gone through an Independent Examination.

The Board **approved** the Charity Annual Report and Accounts whilst considering the reserves policy should be reviewed.

Gender Pay Gap

The Board **noted** the Gender Pay Gap.

Strategy Update

The Board **noted** the Strategy Update

Governance Assurance and Accountability Framework

The Board **approved** the current Governance Assurance and Accountability Framework. noting the three-month review period.

Risk Maturity Assessment

The Board **noted** the Risk Maturity Assessment.

Draft Risk Appetite

The Board **did not approve** the Draft Risk Appetite and noted that it was work in progress.

Report Cover Sheet

Report Title:	FTSU Staff Story
Name of Meeting	Public Trust Board Meeting
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	Item 8
Executive Summary:	• A FTSU concern was received in September 2023, from a concernee who has a disability and had requested reasonable adjustments in 2020 to the toilets within Southern House to meet their needs. • They were asked to approach Access to Work for funding, which was agreed in January 2023. • By September 2023 the concernee was unable to come into work as the adjustments had not been completed, and the request had become stuck in the new financial approval process. • The impact on the concernee was considerable. The stress and anxiety that was suffered due to not having facilities that could be used for her particular needs; leading to a lack of dignity at work; impact on her health and well-being, being forced to work from home which is isolating. • By recording her concern with the FTSU team we were able to facilitate and support a resolution in conjunction with the Assistant Director of Estates by escalating the concern to the CEO and Chief People Officer. However even in this process, we were directed back to the Fixed Asset Management Group who were meeting the following month and would have caused a further delay. • Learning: review of reasonable adjustments process and publishing of Disability policy; To improve the Speak Up, Listen Up Follow Up culture.

Recommendations:	The Trust Board is asked to: Note & Discuss **The process for reasonable adjustment requests and Disability policy**
Accountable Director:	Melanie Saunders, Chief People Office
Author:	Christine McParland, FTSU Guardian
Previously considered at:	NA
Purpose of Report:	Note & Assure
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Significant
Justification of Assurance Rating:	Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable All
Next Steps:	Review of Reasonable Adjustment requests process and Disability policy.
List of Appendices	NA

Meeting Report

Name of Meeting	Public Board Meeting
Title	Staff Story (Freedom to Speak Up)
Author	Christine McParland, FTSU Guardian
Accountable Director	Melanie Saunders, Chief People Officer
Date	25 January 2024

1. Purpose

The purpose of this paper is to share the background to a staff story for the Private Board. On this occasion, the story arises from a Freedom to Speak Up (FTSU) case received in September 2023. The paper is submitted to support the staff story that will be shared during the meeting.

2. Background

A concern was received by the FTSU team in September 2023 from a 'concernee' who has a disability. In 2020, she had requested a reasonable adjustment to the toilet facilities at Southern House in Otterbourne in order to meet her needs.

She were asked to approach Access to Work for funding which was agreed in January 2023. However, by September 2023, the request was still going through the financial approval process, the adjustments had not been made and the concernee was unable to attend work.

The impact on the concernee was considerable. Not only was she stressed and anxious about the practical elements of not having appropriate facilities, there were issues around lack of dignity and the impact on her health and well-being. Added to this, reverting to working from home became isolating.

By recording her concern with the FTSU team, we were able to facilitate and support a resolution in conjunction with the Assistant Director of Estates by escalating the concern to the CEO and Chief People Officer. Despite this, there was still some delay further delay by the case being referred back to the Fixed Asset Management Group who were due to meet the following month.

3. Areas of Risk

Having a truly diverse workforce that is supported with reasonable adjustments in the workplace leads to enabling us to recruit from all areas of society; broadens our understanding of people with disabilities and encourages us to be more inclusive.

- Financial: increase in tribunal cases where people are not supported under the equality act 2010. Cost od absenteeism and replacing diverse leavers.
- Reputational: being viewed as an organisation that does not value or support diversity
- Retention of staff
- Values and Behaviours: demonstrating that all our staff are valued, in how we seek to understand and effect the necessary adjustments

4. Summary

This staff story relates to the reasonable adjustments process within the Trust and how the lack of a slick and compassionate process can create barriers in providing a work environment that encourages and supports a diverse workforce.
In enabling our people to feel valued and part of an organisation that understands their individual needs and is willing to continually support them, the benefit far exceeds the cost of providing these adjustments.

The learning centres around organisational messaging and understanding the process to review reasonable adjustments and put alterations in place as quickly and as effectively as possible. This has also fed into Disability policy revisions.

The Board is invited to note this staff story and discuss the reasonable adjustments process and Disability policy.

Report Cover Sheet

Report Title:	Integrated Performance Report – January 2024
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	9
Executive Summary:	• The January document highlights the following points. o The Trust failed to deliver the ARP standard across all four targets in December. This includes the Cat 2 adjusted target of 30 minutes. The SPC analysis indicates that the Trust will not consistently hit or miss the targets in the short term. Our planning process will consider the operational adjustments required to achieve the performance targets that will be set out in the NHSE Planning Guidelines once they are distributed. o Calls into the 999 service were just below target whilst the number of incidents was close to target levels. In December. Achieving planned levels of resourcing with Private Providers coupled with handover delays were the primary influence on our Category 2 performance. o The Trust continues to work with Private Providers and the hours they can provide is increasing. We are also working with system partners to do all we can to help reduce handover delays and will continue to do so as part of our Winter Planning. o 111 performance for the month was generally favourable despite a c. 7% variance in demand above target. However, a higher than planned volume of calls were transferred to ED/Ambulance. o The total number of patient safety incidents reported was at its highest level seen this year, with correlated rises in incidents where harm to patients is occurring, mainly due to delays being experienced in attendance. o A thematic review of incidents where delays were a significant contributory factor has found a number of themes we need to address. Namely, the vacancy levels of clinical staff, the end of shift policy, meal break policy and hospital handover delays form the rest of the themes

	identified. Improvement plans to address these issues are now being developed and their implementation will be scrutinised and overseen by the Board sub committees. o During December our own workforce reflected sickness levels only slightly above the reported mean. Whilst new staff joining the Trust was lower than planned so staff turnover, across the Trust, has fallen. The net impact has been good staffing levels, but vacancy rates are now on the rise. o The Trust's financial position year-to-date (YTD) at month 9 (December) is £16.8m deficit with the in-month position showing a £1.4m deficit. As a deficit position, it means the Trust is missing one of its statutory duties. However, there is a small improvement in the run rate.
Recommendations:	The Trust Board is asked to: Note/Discuss SCAS performance for the month of December 2023
Accountable Director:	Mike Murphy, Chief Strategy Officer
Author:	Mike Murphy, Chief Strategy Officer
Previously considered at:	Board and Board Sub Committees
Purpose of Report:	Assure
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Partial
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: The development of this document continues. However, feedback from Committees identified improvement in the commentaries. The format of the document was amended but will be embedded by the next production cycle and this coupled with training provided by the "Making Data Count" team will drive improvement in the December document.
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	Public Trust Board
Title	Integrated Performance Report
Author	Mike Murphy, Chief Strategy Officer
Accountable Director	Mike Murphy, Chief Strategy Officer
Date	25 January 2024

Trust Overview

999 Demand for December was close to targeted levels. Performance within the 999 service was challenging as the Trust failed to meet the ARP standards for the month overall. In the main, achievement of the ARP standards was challenged by insufficient hours provided by our Private Provider partners and increased handover delays. Whilst we target reduced conveyance to ED a slight increase in 999 calls coupled with a higher level of acuity resulted in higher than target conveyances overall. As a trust we are aware that conveyance will influence admissions and hence acute occupancy. Hence, we are working with partners to reduce conveyance.

During December our own workforce reflected sickness levels only slightly above the reported mean. Whilst new staff joining the Trust was lower than planned so staff turnover, across the Trust, has fallen. The net impact has been good staffing levels but vacancy rates are now on the rise. As we enter 2024 with the prospect of industrial action and colder weather, we expect performance to continue to be challenging and will focus on maximising the resources at our disposal.

Performance 999 and 111

SCAS category 1 performance for December was 08:54, a 4 second deterioration from November. Category 2 performance also deteriorated to 38:09, which is 7 minutes 15 above our proposed trajectory. Response demand was 1.4% below planned levels at 54,856 responses. However, it was also the highest level since Dec 22. We restrict annual leave levels during the last 2 weeks of December which increased our resource levels and this was also combined with reduced handover delays for these 2 weeks. For the period 1st to 17th December, cat 2 was 49:23 and we lost 5,221 hours at hospital handover, where as the period 18th to 31st we achieved cat 2 at 24:22 and lost 3,092 hours. The higher handover delays impacted on Cat 2 by 5 minutes and the remaining 2 minutes was due to the shortage of SCAS operational hours. Key actions to improve performance are to increase our operational hours. We are circa 1,500-2,000 hours per below

required hours and this is linked to the private providers who continue to not deliver the contracted hours. We have also issued our immediate handover process to release crews quicker from hospitals.

999 call volumes fell for the 3rd month which is linked to a fall in duplicate calls through us responding to the original incident quicker during the second half of December. Call answer for December was 17 seconds.

We took 155,540 111 calls in December which was 9,000 higher than plan but sustained our mean call answer through higher staffing levels and improved AHT.

Vehicles off the Road (VOR) is currently being driven by the increasing age profile of the current fleet due to significant delays in delays in new vehicles from convertors. 53 vehicles were due for delivery in Oct 2023 but delayed to start delivery from Feb 2024. 72 vehicles are also now due from end of July 2024.

Quality and Patient Safety

During December we have seen challenges with increased demand for our services due to the winter pressures and increases acuity of patients needing our services.

The consequence can be seen in some if the quality and safety KPIs namely compliance rates with Safeguarding training for adults and children's level 1 dropping below target, but we are above trajectory on the level 3 training. The major issue and risk in Safeguarding is the continued number of incidents we are seeing relating to the ICT and BI that supports the Safeguarding referral system. A number of 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.

The total number of patient safety incidents being reported is at its highest level seen this year, with correlated rises in incidents where harm to patients is occurring, mainly due to delays being experienced in attendance. A thematic review of incidents where delays were a significant contributory factor has found a number of themes we need to address. Namely, the vacancy levels of clinical staff, the end of shift policy, meal break policy and hospital handover delays form the rest of the themes identified.

The Quality and Safety Committee has reviewed the Safeguarding risks and findings and recommendations of the thematic review into delays and together with Exec Management Committee and the Finance and Performance Committee, will oversee the improvement plans to address these issues.

We have a number of Serious Incident investigations not completed within original time frame but all of these have negotiated extensions.

Infection prevention and control 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 reviewing audits

The complaints response rate is 100% and therefore above the mean of 97%. Performance as expected. Normal fluctuation across the YTD. The Patient

Experience team to maintain work with service colleagues for timely responses. Improvement recognised in 111.

RIDDOR events were within normal variation in December with 8 events. Bi Monthly thematic reviews in place, reporting into the HSRG. New return to work education guidance to reduce a musculoskeletal incident that are RIDDOR reportable.

Finally we have seen an improvement in the measure of unaccounted CD losses which saw a significant decrease due to control measures taken.

Workforce

Staffing dipped for the first time in December following 7 months of growth. Whilst we continue to recruit to frontline positions those non patient facing roles now fall under greater controls in support of the financial recovery of the Trust. Staff turnover fell in December with fewer leavers but also fewer joiners; not unexpected at this time of year. Overall sickness in the Trust also increased in December with long term sickness being a contributory factor.

One of the factors affecting turnover relates to staff wellbeing. For frontline staff overruns continue to be below target however they are rising slightly. We know our end of shift policy has an impact on our ability to meet ARP standards. Poor Category 2 performance subsequently influences our ability to achieve meal break compliance which is still well below target. The trust is engaging with union colleagues with a view to establishing a balance between wellbeing and performance.

Finance

The Trust's financial position year-to-date (YTD) at month 9 (December) is £16.8m deficit with the in-month position showing a £1.4m deficit, although this is a deficit position, meaning Trust is missing one of its duties, this is showing a small improvement in run rate.

The Trust's cash balance at the end of December stood at £31.9m. The Trusts cash balance has decreased by £18m since the start of the financial year, an average monthly net cash outflow of £2m, at this run rate the Trust will require cash support by the end of the Financial Year 2024/25 to support continuing operations.

The over 90-day debt has increased again this month and now stands at £1.5m (up from £1.3m in November). This increase is due to the unpaid Service Level Agreement (SLA) charges to Buckinghamshire Healthcare NHS Trust (BHT) (£895k). With the Non-Emergency Patient Transport Services (NEPTS) SLA, Extra Contractual Referral (ECR) and NEPTS multi-crew charges now account for £1.3m of the £1.5m aged debts. Total Sales Ledger debt has decreased this month and now stands at £2.67m (down from £3.15m in November). The 90-day category debt has increased to 55.58% of the total sales debt (up from 40.18% in November).

Agency controls continue to have a positive impact on spend with the Trust continuing to spend below the planned target set at the start of the year. The weekly Financial Recovery Group will continue to monitor the use of agency staff moving forwards with the aim being to either discontinue agency contracts once completed or convert agency staff into substantive posts where possible.

The Trust continues to forecast £10m of savings from the Financial Sustainability Programme, of which £4.8m (48%) is recurrent, the non-recurrent nature of the program has been taken into account for 2024/25 planning and saving programme.

Report Cover Sheet

Report Title:	Quality and Patient Safety Report
Name of Meeting	Trust Public Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	10
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 Trust Board is 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.

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	January 2024

1. Purpose

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

1.2 The paper covers the reporting period **(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

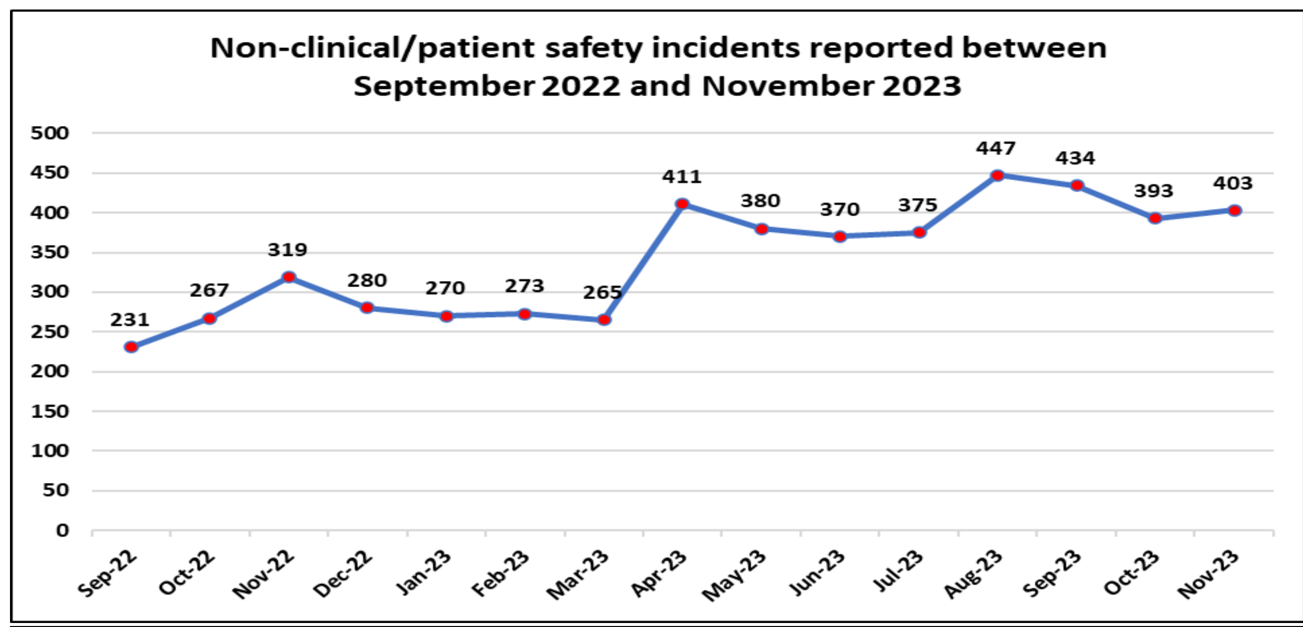
outage occurred. Contingency plans were enacted, and primary care providers supported with clinical queues. No incidents of patient harm have been identified.

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.

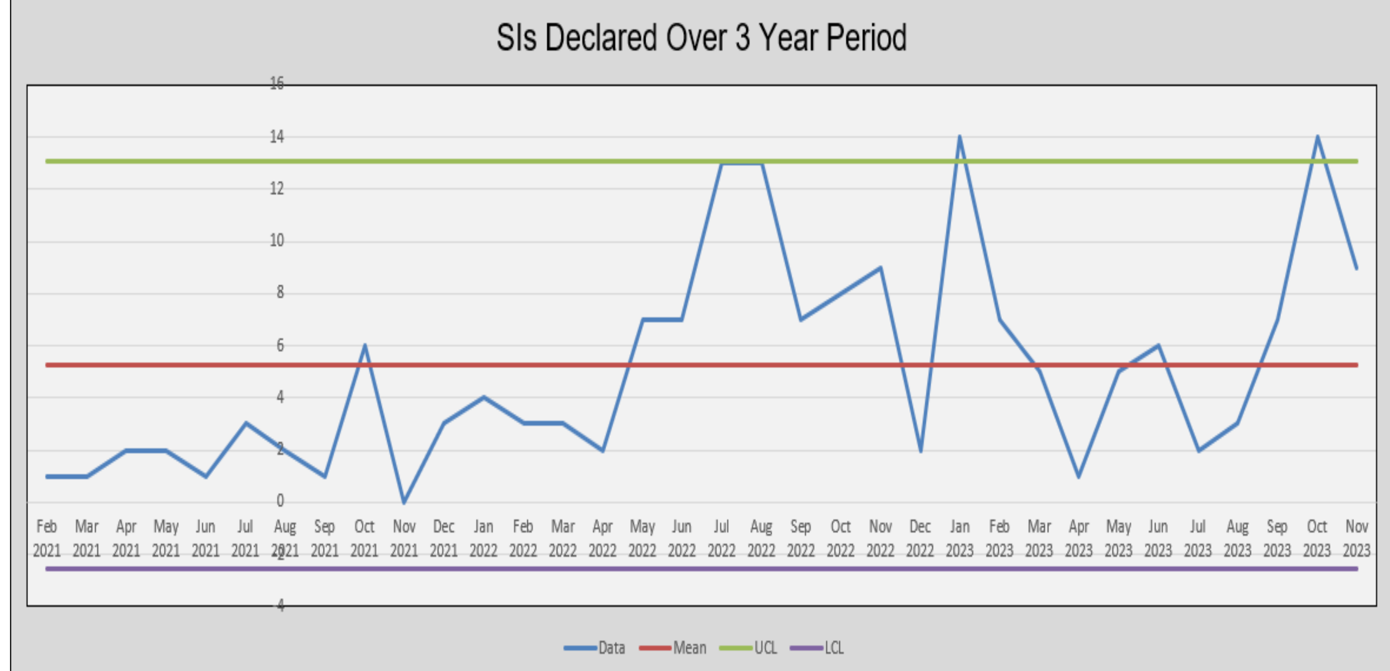
Patient Safety Incident Response Framework (PSIRF)

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 Board is invited to note the content of the report.

Sue Heyes, Deputy Chief Nurse

Date: 11 January 2024

Report Cover Sheet

Report Title:	Chief Medical Officer’s Report
Name of Meeting	Public Trust Board
Date of Meeting:	25 January 2024
Agenda Item:	11
Executive Summary:	The purpose of the paper is to update the Board on key clinical issues relating to: 1. Clinical Research 2. Ambulance Clinical Quality Indicators 3. Out of Hospital Cardiac Arrest Epidemiology and Outcomes in 2022 4. Urgent Care Pathway Developments
Recommendations:	The Trust Board is asked to **note** the contents of the Chief Medical Officer’s report.
Accountable Director:	John Black, Chief Medical Officer
Author:	Martina Brown, Research Steering Group Jane Campbell, Assistant Director of Quality John Black, Chief Medical Officer
Previously considered at:	
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):	High Quality Care & Patient Experience

Links to BAF Risks or Significant Risk Register:	SR1 - Safe and Effective Care
Quality Domain(s)	Clinical Effectiveness
Next Steps:	Continue to expand SCAS research capacity and capability To further improve cardiac arrest outcomes through the digital applications, staff training, development of care pathways with cardiac networks, and evaluation of new cardiac arrest resuscitation techniques. Further expansion of urgent care pathways with focus on frailty, access to Same Day Emergency Care (SDEC) Units and Virtual Wards via Urgent Community Response (UCR) Teams.
List of Appendices	**Appendix 1** – Recruitment into Principle Clinical Trials (CRASH4 & PARAMEDIC 3) **Appendix 2** – Epidemiology and Outcomes for Out-of-Hospital Cardiac Arrest 2022 (Infographics from University of Warwick Clinical Trials Unit OOHCA Registry Data). **Appendix 3** – SCAS Urgent Care Pathways Dashboard December 2023

Public Board Meeting Report

Name of Meeting	SCAS Public Trust Board
Title	Chief Medical Officer's Update
Author	Martina Brown, Research Steering Group Jane Campbell, Assistant Director of Quality John Black, Chief Medical Officer
Accountable Director	John Black, Chief Medical Officer
Date	25 January 2024

1. Purpose

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

- SCAS Clinical Research
- Ambulance Clinical Quality Indicators (ACQI)
- South Central Out-of-Hospital Cardiac Arrest Epidemiology and Outcomes 2022
- Urgent Care Pathways Dashboard

2. Executive Summary

2.1. SCAS Research Trials Updates

New Trials being set up:

- **Specialist pre-hospital redirection for thrombectomy trial (SPEEDY) (IRAS 312053)**
    - A cluster randomised controlled trial to evaluate the clinical and cost-effectiveness of a pre-hospital specialist redirection pathway to Comprehensive Stroke Centres intended to improve the speed and rate of Mechanical Stroke Thrombectomy for acute ischaemic stroke across England
    - Patients in Hampshire will be redirected from scene to UHS for mechanical stroke thrombectomy after remote clinical assessment by Stroke Team as part of a national trial in partnership with the Universities of Exeter, Oxford and Northumbria University Newcastle

- **Cardiac arrest 'Bundle of Care' trial (CABARET) (IRAS329970)**

- Use of **an** Airway Threshold Impedance (ITD), Elegard (Head Elevation) and LUCAS AD Chest Compression Devices (Bundle of Care) in Out of Hospital Cardiac Arrest
- The trial likely to commence in Feb/March 2024.

2.2 Recruitment to Open Studies

Table 1 below shows the participant's recruitment into the currently opened research projects in the trust.

Study title/acronym/IRAS number	Current recruitment/ Participants type [*updated to 28 Dec 2023*]	NIHR endorsement
Randomised controlled trial of the clinical and cost-effectiveness of cervical spine immobilisation following blunt trauma (SIS Trial); IRAS 316755	32 patients	• Non-commercial • NIHR portfolio • Interventional • Pre-hospital speciality
Early surveillance for autoimmune diabetes (ELSA); IRAS 309252	332 patients F-2-F 300 patients online	• Non-commercial • NIHR portfolio • Interventional • Primary care/community speciality
Intramuscular tranexamic acid for the treatment of symptomatic mild traumatic brain injury in older adults: a randomised, double-blind, placebo-controlled trial (CRASH4); IRAS 283157	284/patients **See Appendix 1** Infographic	• Non-commercial • NIHR portfolio • IMP (drug) trial • Pre-hospital speciality
Pre-hospital randomised trial of medication route in out-of-hospital cardiac arrest (PARAMEDIC3); IRAS 298182	601 patients **See Appendix 1** for more detail	• Non-commercial • NIHR portfolio • Interventional • Pre-hospital speciality
Paramedic delivery of end-of-life care: a mixed methods evaluation of service provision and professional practice (PARAID) IRAS:327727	38/ staff respondents	• Non-commercial • NIHR portfolio • Observational /Interventional
A Phase IIIb randomized openlabel study of nirsevimab (versus no intervention) in preventing hospitalizations due	70 patients Study extended (re-consenting of	• Commercial • NIHR portfolio • IMP (drug) trial

to respiratory syncytial virus in infants (HARMONIE) IRAS 1005180)	current pool started)	• Community/Acute speciality

2.4 Collaborative/strategic initiatives leading to an increase capacity and capability of the trust to deliver clinical/non-clinical research

- **Research Emergency Dispatcher** & Research Assistant – 100% externally funded post; with ESR panel now
- Team training events (including webinars) continuously updated with research protocols (in line with new HCPC Standards)
- Hosting medical students / SCAS paramedic apprentices as observers of research RRVs
- Research to feature in Trust Induction (for new starters); research pens with QR code link to research website / contact details will be distributed at each new staff member
- Research Advocate webinars
- Developing model of cross-organisational research delivery: Research Rapid Response vehicles (RRV) to carry out follow up visits for UHS participants at their home (no need to come 'on-UHS-site' for study visit).

3. Ambulance Clinical Quality Indicators (ACQI)

- Work on recovering SCAS encrypted clinical records is progressing well both internally (DocWorks) as well as the clinical records held by Ortivus. This includes assessing the completeness of the recovered records. This may take approximately another 4 weeks to complete.
- Commentary for the time-based elements of ACQIs is included in the IPR.

National Ambulance Quality Group Update

Benchmarking day was held in November 2023 sought to not only revisit the existing ACCIs but progress the pilot Falls Indicator.

In response to the key issues raised on the day, the Technical sub-group have proposed changes to guidance for the Falls pilot indicator, post-ROSC care bundle CQI and STEMI care bundle CQI. These will be considered at CRG internally and comments feedback to national team. The NASCQG will then consider these changes and approve.

Any approved changes to the pilot Falls indicator will then be adopted for the fourth cycle of the pilot (December 2023 incidents for submission by 22 April 2024).

The Technical Sub-group are considering end-of-life care for a national clinical audit. If the NASCQG support this the technical sub-group will work up a proposal in the coming months.

4. Epidemiology of South Central Out of Hospital Cardiac Arrest (OOHCA) and Clinical Outcomes 2022 – University of Warwick National OHCAO Registry Data.

- **Appendix 3** includes five summary infographics of South Central Ambulance patients who suffered an out-of-hospital cardiac arrest during 2022.
- **Summary**: 2666 patients were treated by SCAS with a median age of 71 years, 65% were male, and 80% of arrests occurred at home in England. 90% of cases were presumed to be cardiac in origin. Only 19.4% of patients presented in a more favourable shockable rhythm (ventricular fibrillation). 41.7% of arrests were unwitnessed. 80% of patients with witnessed cardiac arrest received bystander chest compressions (CPR). In England a public access defibrillator was used in 10.6% of witnessed cases. 49.4% of witnessed patients who presented in a shockable rhythm (Utstein comparator group) had a pulse on arrival at hospital. 9.0% of patients survived to 30 days overall. A total of 619 patients had their hearts restarted on arrival at hospital and 238 patients' lives were saved.
- South Central overall survival is just above the national average in England (7.8%) and reflects not only responsive care delivered by the ambulance service but also specialist cardiac/intensive care delivered following admission to hospital.
- Further information is available at: https://warwick.ac.uk/fac/sci/med/research/ctu/trials/ohcao/

5. Next steps:

Our main areas of focus for 20245 to improve survival for this important cohort of patients is to deliver Car 1 performance (7-minute response time), the delivery of annual face-to-face resuscitation update training for SCAS staff, expanding our Community First Responder Schemes, introducing GoodSAM App to improve bystander CPR rates and early access defibrillation, the primary transfer of patients directly to hear attack centres for primary percutaneous angioplasty (pPCI) for those patients with evidence of ST elevation myocardial infarction, including extracorporeal membrane oxygenation (ECMO) where available (currently only at Harefield Hospital), and the evaluation of the effectiveness of a new care bundle including head up mechanical CPR (LUCAS AD) combined with the use of an airway impedance threshold device (ITD) in the hope of improving blood flow to the brain during CPR which may be an important determinant of survival (CABARET Study).

6. Urgent Care Pathways Update.

The SCAS Urgent Care Dashboard Board (**Appendix 3**) provides high-level oversight of Urgent Care pathways availability across South Central Ambulance Service region for patient facing clinicians to refer appropriate patients to. It includes:

- Acute Hospital Pathways
- Community Service Pathways
- Same Day Emergency Care (SDEC)
- Urgent Community Response (UCR)
- Hospital Clinical Pathway Care Navigator 'Call before Convey' Single Point of Access
- Virtual Wards (accessed via UCR Teams)
- Frailty and Falls Services
- Acute Respiratory Infection Hubs.

Access to these pathways is managed by a clinical pathways team who have reviewed the work programme and how it aligns to the updated SCAS Strategy and the 10-point plan. It does illustrate the variability of access our ambulance clinicians to care pathways across our region. It is periodically shared with the ICS and Provider CMOs across the region to help support the further development of care pathways – there are now in excess of 130 pathways across the region that do not route patients unnecessarily through Emergency Departments. Visibility and contact details for these pathways, including hours of operation, is via the SCAS Connect Application which monitors activity, receives clinician feedback and is regularly updated by the SCAS Pathways Management Team as new pathways evolve.

7. Next Steps:

SCAS main focus is to continue to expand the availability of these pathways across our region especially for complex frail medically unwell patients (including those with respiratory infections) who make up the largest cohort of patients who may benefit from direct access to Urgent Community Response (UCR) Teams as they come on stream and assessment in Same Day Emergency Care (SDEC) Frailty Units in both community and secondary care settings when required.

8. Recommendations

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

John JM Black
Chief Medical Officer
17th January 2024

Report Cover Sheet

Report Title:	Operations Report – 999, 111 and Other
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	12
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 Trust Board is asked to note the issues in the 999 and 111 areas of SCAS and the operational support work to help with those challenges.
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	Trust Board
Title	Operations Report – 999, 111 and Other
Author	Mark Ainsworth, Mark Adams, Luci Papworth, Rob Ellery, Ruth Page
Accountable Director	Mark Ainsworth
Date	January 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

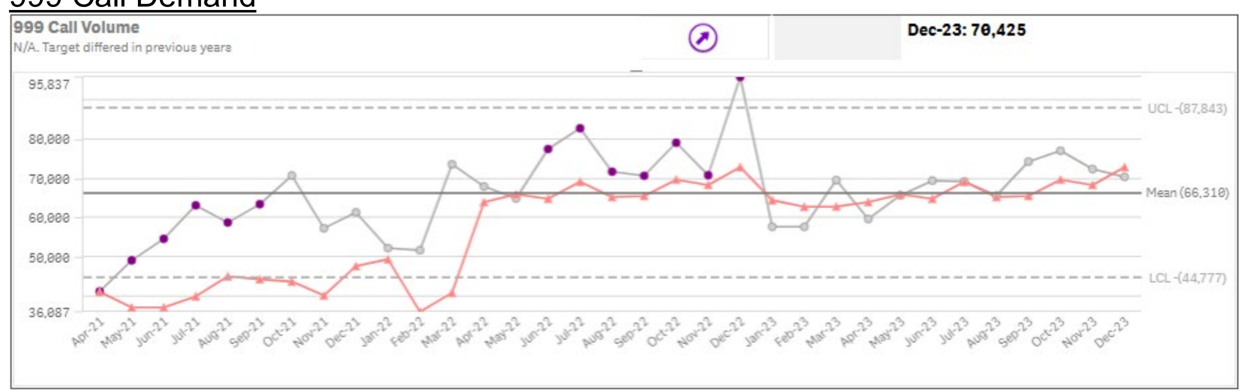
7.1 The Executive Director of Operations is responsible for delivery and monitoring of the improvements within the Operational Board Report.

8. Recommendations

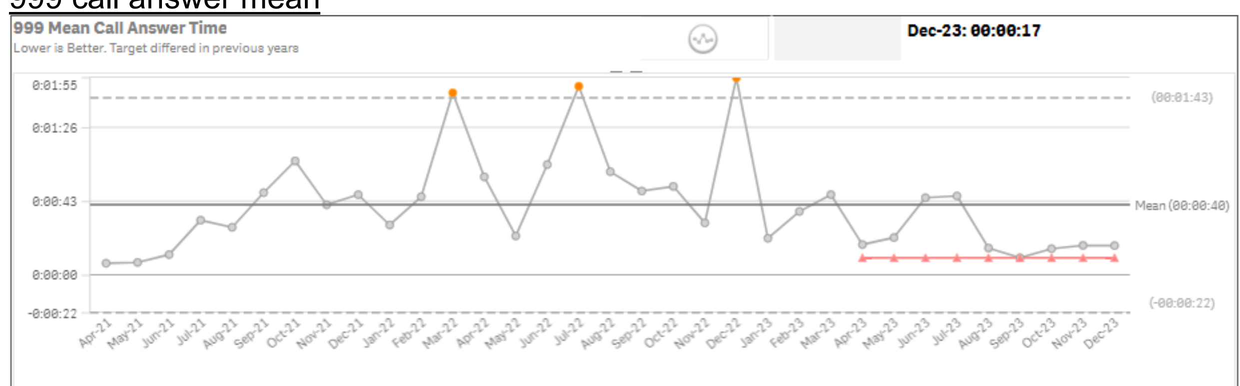
8.1 The Board is asked to **note** the contents of the report.

Appendices

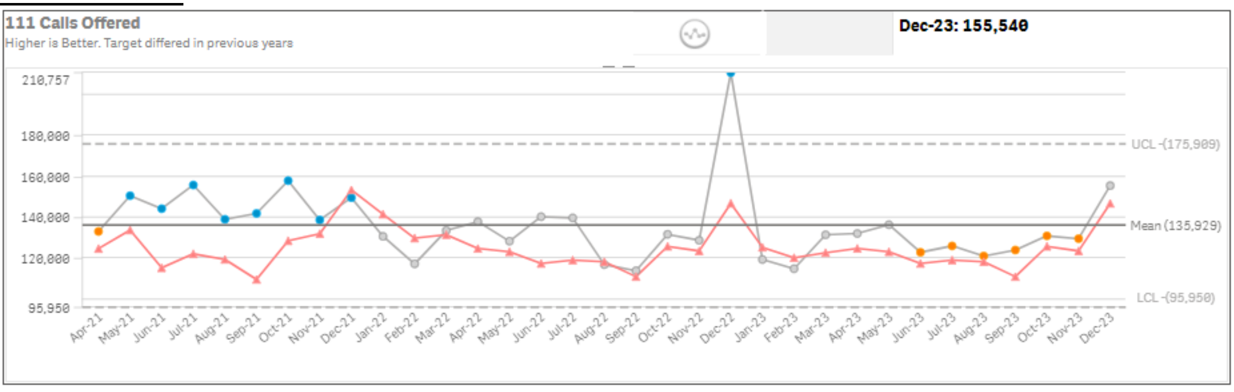
1.1 999 Call Demand



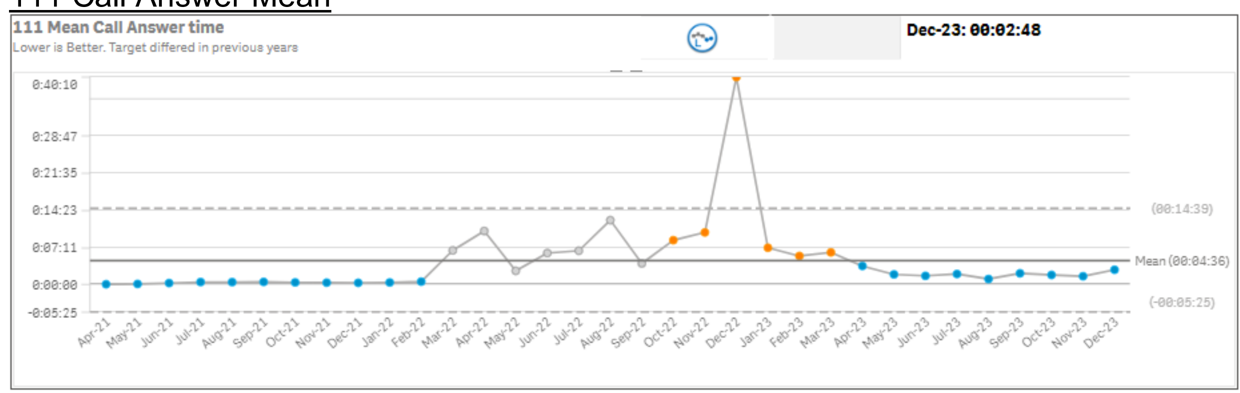
999 call answer mean



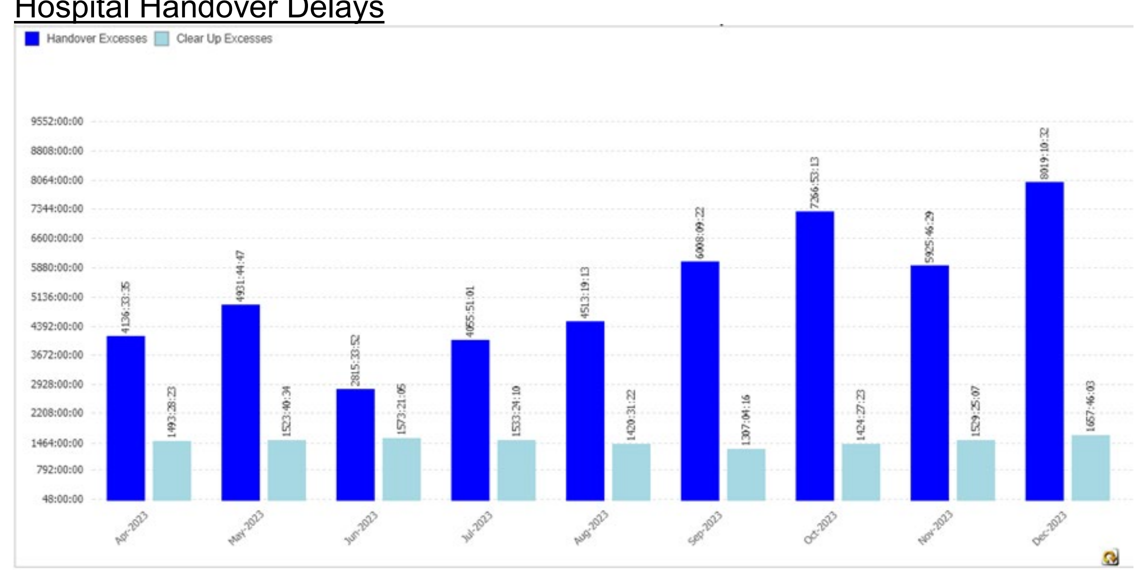
1.2 111 Demand



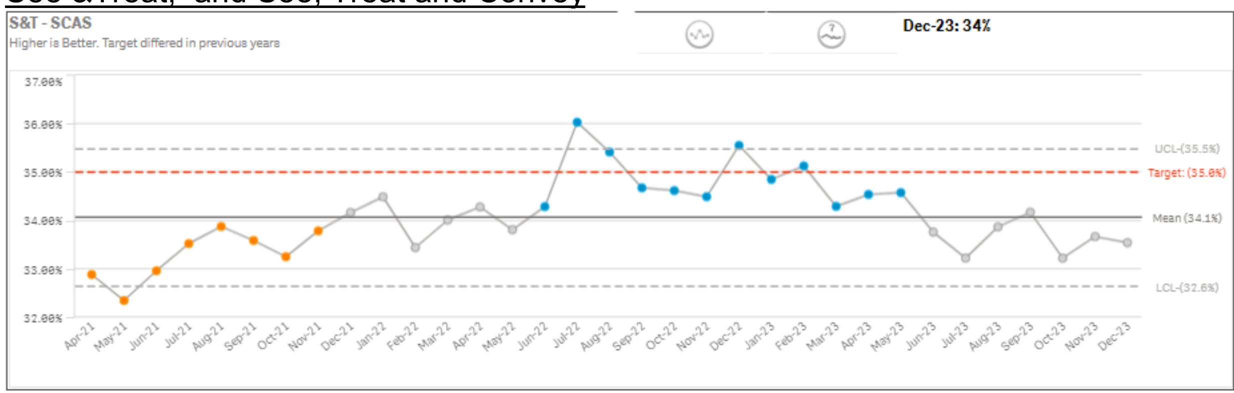
1.3 111 Call Answer Mean

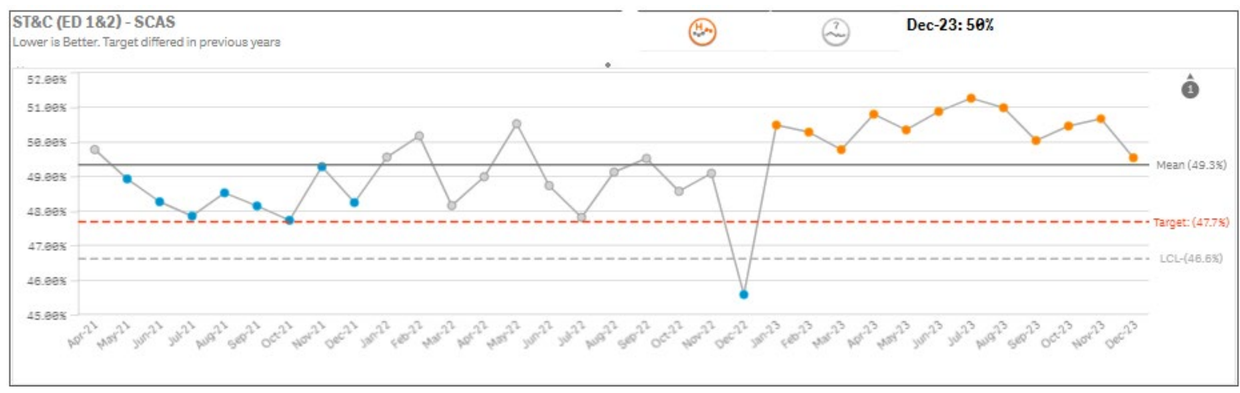


1.4 Hospital Handover Delays



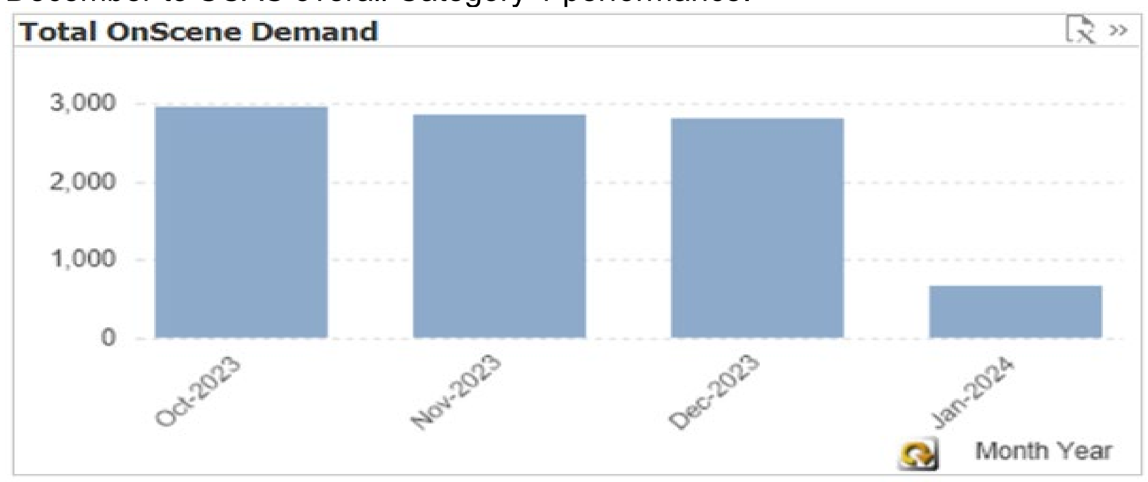
1.5 See &Treat, and See, Treat and Convey





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 by	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.

Upward Report

Name of Committee reporting upwards	Quality and Safety Committee
Date Committee met	11 January 2024
Chair of Committee	Dhammika Perera, Non-Executive Director
Upward reporting to	Public Trust Board

Items	Issue	Action owner	Action update
Points for Escalation			
Findings of the delays' thematic analysis	A thematic analysis relating to delays requested by Berkshire Oxford Buckinghamshire (BOB) ICB was concluded. The analysis found three themes which could potentially lead to avoidable harm and identified potential actions and recommendations.	Chief Nurse	Prepare a short paper for the Board based on the paper on the analysis presented at Q&S also incorporating the feedback given during Q&S.
IT Systems – Level of investment and choice of software	Following discussions of the failures experienced in the new safeguarding IT systems, concerns were raised regarding the trusts level of investment in IT as well as the choice of software where investments were made.	Chief Digital Officer	Request FPC to undertake a deep dive into IT systems in use at SCAS including each software's need for update/replacement and specific concerns related to specific software and software compatibilities.
Key issues / business matters to raise			
The failure of the safeguarding IT systems	The safeguarding/docworks software situation must be corrected and steps taken to ensure there is no repetition.	Safeguarding Lead	Update to be presented at the next Q+S

Areas of Concern and / or Risks	**Keep within the committee…. No action needed at Board level**		
Category 2 call performance / delays / Long waits	Focus on risks affecting SCAS' ability to deliver Category 2 performance. (Focus on the findings of the thematic analysis). There is only partial assurance that we are taking all actions we can to mitigate the relevant risks and improving our ability to respond timelier.	Executive team Q+S	• Regular review of hours available and mitigations to increase these. • Continue working with partner organisation to reduce handover delays. • Increase number of trained staff and reduce reliance on private providers. • Minimize duplication of crews attending calls. • Continue to monitor harm linked to delays and identify other actions for improvement.
Statutory and mandatory training completion	Mandatory training completion targets must be maintained. All training records must be ready for an eventual CQC inspection.	Q+S	
Items for information / awareness			
Clinical Workforce Plan (Thematic Delays Report findings)	Further to discussions relating to Thematic Delays findings, Q&S Committee requested assurance on actions as demand is not being met by SCAS staffing levels and to ensure findings are included in Workforce / PACC.	Assistant Director Quality	
Best Practice / Excellence			
PSIRF plan	Plan will be approved by Q&S committee.	Assistant Director (for PSIRF implementation)	
Patient Panel	Chair appointed and inducted with first meeting at the end of January and two sub group chairs with links to Mental Health and Learning Disability	Assistant Director – Quality (Patient Experience)	
Medicines Management	**The site move to Adanac completed.**		
Compliance with Terms of Reference			
Quorate	The Committee meeting was quorate and complied with its terms of reference.	Q&S Chair	

Author: Dhammika Perera

Title: Chair, Quality and Safety Committee

Date: 18 January 2024

Report Cover Sheet

Report Title:	Month 9 2023/24 Financial Position
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	14
Executive Summary:	**<u>I&E Position</u>** 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. **<u>Cash</u>** 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 Trust Board is 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

Meeting Report

Name of Meeting	Trust Board
Title	Month 9 2023/24 Financial Position
Author	Sam Dukes, Deputy Chief Financial Officer
Accountable Director	Stuart Rees, Interim Director of Finance
Date	Thursday 25th January 2024

1. Purpose

This paper is being presented to update the Trust Board 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 Board is invited to **note** the contents of this paper.

Upward Report of the – Finance & Performance Committee

Date Meeting met	**20 December 2023 & 18 January 2024**
Chair of Meeting	**Les Broude, Non-Executive Director / Senior Independent Director**
Reporting to	**Board of Directors Meeting 25 January 2024**

Items	Issue	Action Owner	Action
Points for escalation			
18 January 2024 – Business Case approvals	Two Business Case were agreed for recommendation to the Board: • Asset Management System Project: this project will introduce an asset management system which will enable better management of clinical assets, thereby increasing operational effectiveness, realising significant financial savings and improving patient safety. • Fournet, the telephony solution for the Trust.	Stuart Rees Craig Elllis	Business Case to be considered by the Board on 25 January 2024. Business Case to be considered by the Board on 25 January 2024.
Key issues and / or Business matters to raise			
20 Dec 2023 - PTS	Dec - The Committee noted that the Non-Emergency Patient Transport Services (PTS) action plan to rebalance the finances of PTS is a critical part of South Central Ambulance Service NHS Foundation	Mike Murphy	

	Trust's (SCAS) financial recovery and the actions necessary for the service to be commercially viable and competitive; particularly when commissioners (Integrated Care Board / ICBs) are expected to initiate procurement processes. Also, the need to monitor the actions to ensure delivery and the need for the cost structure analysis and related actions to address.		
18 January 2024 - IPR	The IPR and content were discussed with a remaining concern about the content, ownership of the various elements within the report as well as the pace of progress.	Mike Murphy	
20 Dec 2023 – Financial planning	Dec - The Committee NOTED the Financial Planning report and discussed the work required to develop not just the financial plan but operational, workforce, etc, plans. The Chief People Officer will be invited to the January committee, which is focusing on planning.	Stuart Rees	
18 January 2024 – 2024-25 Planning	The Committee reviewed and debated the current 2024-25 Planning (including, Operation, Workforce & Financial) Update, noting the timescales, the need for it to be ready by March, with learning from previous year with realism of plans and the need to align the ICBs. The need to develop this into a 3-year plan/medium term plan for the Trust was discussed, to enable the Trust to manage elements of the plan over multi years .e.g., recruitment.	Stuart Rees	
18 January 2024 – Forecast Outturn Review	Re the forecast Outturn Review, following discussions between the HIOW ICS and NHS England, the system has asked to improve its financial forecast. The Committee will make a recommendation for discussion at the Private Board.	Stuart Rees	

Areas of concern and / or Risks			
20 December 2023 – Sustainable measures	There was a discussion on previous plans that have not delivered fully or recurrently and the need for sustainable measures to address not only the financial challenge but the operation reliance on non-recurrent solutions. (e.g., overtime, incentives), PPs and the Trust's workforce plans, and the need for a sustainable plan.	Stuart Rees Mark Ainsworth	
18 January 2024 – Challenge around PP hours	Challenge around PP hours and the assurance required around delivery should noted.	Mark Ainsworth	
18 January 2024 - IPR	Improvement Programme (Performance) was presented and discussed. Concern was raised about embedding with the organisation. Improvement Programme Oversight Board (IPOB) would pick this matter up.		
18 January 2024 – Procurement and contracting capacity	Issues were raised about the capacity within the procurement and contracting area with recent delays in recognising contract end dates and issuing new contracts.		
Items for information and / or awareness			
20 December 2023 & 18 January 2024 – Financial position & operational performance	The Committee NOTED the: • Financial Position at Months 8 & 9 (November & December), and • Operational Performance against national targets and local trajectories for future months.		

Best Practice and / or Excellence			
20 December 2023 & 18 January 2024	The committee felt: • assured by the quality of majority of the reports presented, noting the IPR, and • the challenge and discussion at the committee has improved, with the key issues the Trust is dealing with being debated.		
Compliance with Terms of Reference			
20 December 2023 & 18 January 2024	Both meetings were quorate.		
Policies approved*			

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Les Broude

Title: Non-Executive Director / Senior Independent Director

Date: 19 January 2024

Upward Report of the Charitable Funds Committee

Date Meeting met **10 January 2024**
Chair of Meeting **Nigel Chapman, NED**
Reporting to **SCAS Public Board**

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
Financial Update & Compliance with Reserves Policy	The CFC reviewed the management accounts for M8. The Charity is currently reporting a surplus of £719k for the year compared to the plan of £650k. The surplus is driven by the legacy received although all areas of fundraising are performing well with the exception of corporate fundraising which is well behind where we expected to be. It is not yet clear if the additional c£250k of legacy income will be received in this financial year or next, but the reserves held by the	**Charity Finance Manager**	Month 9 management accounts will include an up to date reforecast.

	Charity are well within the limits set in our reserves policy. Expenditure is slightly above plan by £27k but this is mainly due to items of old stock being written off and stock appearing on the balance sheet when ordered. The reserves policy was reviewed and some amendments will be made. The policy is reviewed annually along with the Charity annual review and a new version will be finalised and signed off in April 2024. Other Charity policies and procedures were reviewed as part of their two-year cycle. Two new policies were introduce around social media and ethical fundraising. The CFC gave comments which will now be incorporated. All policies will be updated by the end of March.	**Charity CEO** **Charity CEO**	CFC comments to be taken on board and policy revised and submitted for sign off at April's CFC meeting. Amendments identified to be made and final policies signed off by 31 March 2024.
Corporate Fundraising	The Charity has this year looked to increase the level of income from corporate fundraising and identified funding to bring in an experienced charity fundraising consultant to work with us on this area. While the groundwork and foundations have successfully been laid the financial results have not yet been realised. The corporate income is behind target. The CFC have requested a full review of this area of work with timelines and progress to be reported at the April meeting.	**Charity CEO** **Senior Fundraising Officer**	The Charity CEO will carry out a review of the corporate plans and identify how this will move forward. The Senior Fundraising Officer who leads on this area of work, will present progress and next steps to the CFC in April.

Volunteer Recruitment & Retention	Q3 saw a total of 1031 volunteers operating across SCAS which is up from 909 in Q2. We had 64 new volunteers and 86 leavers. We advertised 44 new vacancies with 72 applications. Pilot systems have been set up on Assemble to test a new rota system for CFRs to book out DRVs for responding. The volunteer newsletter is developing and the last issue published in December. The new reward and recognition programme was launched and volunteers in 4 categories were put forward. These awards will be presented on 17 January by Nigel Chapman – Outstanding Contribution; Paul Jeffries – Responder of the Year; Paul Stevens – Volunteer Car Driver of the Year and Vanessa Casey – Volunteer Fundraiser of the year. The winners will be awarded a Room for Reward voucher and runners up an Amazon gift card. Our awards programme will continue with informal recognition throughout the year along with formal awards at the Volunteer Conference on 5 October.	**Volunteer Manager**	As we develop the use of Assemble further detail will be provided around the breakdown of areas and roles of new starters and leavers as well as exit reasons.
BASICs Grant Award	Jack Ansell presented to the CFC the role of the SCAS BASICs team. The team have grown over the last three years. Having been loaned a vehicle for two years the sponsor has now asked for the return of the vehicle or the option to purchase. The CFC agreed Charity	**CFC**	

	funding of the £20k cost to purchase the vehicle which will enable the team to continue their volunteer enhanced clinical role.		
Internal Grants Process	The CFC agreed a new internal grants process to be launched in April 2024. Grant applications will open in April and September for small grants (under £5k) and large/multi-year grants (over £5k). Criteria for grants has been agreed and applications will be received by the Charity CEO and assessed by a small team from across SCAS with clinical and non-clinical areas of expertise. Small grants will be awarded by the assessment team. The assessment team will submit recommendations to the CFC for the large grant awards and the final decisions will be made at the CFC meeting. £150k will be set aside for 2024-2025 for this grant programme.	**Charity CEO**	Grant information to be submitted to Staff Matters and made available to all teams across SCAS. Applications to open on 1April 2024.
Areas of concern and / or Risks			
	Corporate fundraising is behind financial plan and is at risk of not achieving target.		
Items for information and / or awareness			
	The Charity is remains in a healthy financial position overall. Currently holding £411k of restricted funds and £720k of unrestricted funds.		
Best Practice and / or Excellence			

Compliance with Terms of Reference			
	Fully compliant with CFC Terms of Reference		
Policies approved*			
	All policies reviewed as per the cycle of review and will be approved in April following final amendments.		

***Note -** The Board Committee will provide an update to the Board about those Policies that it has ratified

Author: Vanessa Casey

Title: Charity CEO

Date: 11 January 2024

Report Cover Sheet

Report Title:	FTSU revised policy
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	19
Executive Summary:	This is the updated FTSU policy, there is a national deadline for this to be in place by 31st January 2024. SCAS inputted in number of ways into this national policy consultation. The national policy has been written based on feedback from a range of stakeholder and has been written to be as accessible as possible. For our policy we also sought advice and input from peers in the South East Guardian Network (circa 260 members) and the AACE FTSU National Ambulance Network. This policy has comprehensive EqIA screening, and has been to consultation, JNCC, Policy Refresh Group and approval sought from EMC and People & Culture Committee.
Recommendations:	The Trust Board is asked to approve the policy for publication.
Accountable Director:	Melanie Saunders, Chief People Officer
Author:	Simon Holbrook, FTSU Guardian Lead
Previously considered at:	Joint National Consultative Committee Policy Refresh Group Executive Management Committee People and Culture Committee – 18.01.24
Purpose of Report:	Approve
Paper Status:	Public

Assurance Level:	**Significant** – High level of confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	All Quality Domains
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	All Quality Domains
Next Steps:	To be published within the Trust and via the Trust
List of Appendices	FTSU Policy- See Supporting Information Pack

Report Cover Sheet

Report Title:	Gender Pay Analysis Report 2023/2024
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	20
Executive Summary:	As of 31 March 2023, the (rounded) gender split remains as **46% male** and **54% female.** • Men have a greater **Mean hourly pay rate** than women by a gap of 5.79%. This is a shift from the previous year when the Mean gender hourly pay gap was 2.41% greater for men (a change of 3.38%). • The **Median hourly pay** is also slightly greater for men by a gap of 0.50% • More men are employed in Quartile 1 (lowest paid) and Quartile 4 (highest paid) but the greatest shift between male and female from the previous year is in Quartile 2 (-36.46%). Quartile 4 had lowest split between the genders with more women. Quartile 2 had the largest split with fewer women. Quartile 3 had a split of 15.24% with fewer women and Quartile 1 had a split of 5.52%% more women in this Quartile.
Recommendations:	The Trust Board is asked to note the contents of the report and approve for publication.
Accountable Director:	Melanie Saunders, Chief People Officer
Author:	Dipen Rajyaguru, Head of ED&I
Previously considered at:	Executive Management Committee Equality, Diversity and Inclusion Steering Commitee People & Culture Committee
Purpose of Report:	Note and approve publication
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)	All Quality Domains
Next Steps:	To publish the report, undertake further analysis to ascertain drivers for the change since 2022 and development of improvement plan.
List of Appendices	Gender Pay Analysis Report 2023/2024

Report Cover Sheet

Report Title:	Equality Delivery System (EDS) 2023/24 report
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	21
Executive Summary:	The EDS is an outcomes framework designed to support NHS organisations to gather effective data, and drive improvement, on equality, diversity, and inclusion (EDI). It forms part of the NHS Standard Contract (SC13.5) and requires NHS organisations to collate evidence against a range of outcomes and present that evidence to a panel of key stakeholders for grading. The Equality Delivery System (EDS) is focused around three ‘Domains’. 1) Commissioned or provided services 2) Workforce health and well-being 3) Inclusive leadership. For each Domain a template is used with a number of outcomes that require evidence. A separate evidence pack was compiled for each Domain to be graded. The purpose of this paper is to: • Summarise the process undertaken to deliver on the Equality Delivery System (EDS) for this reporting year. • Report on the EDS Scores and gradings that have been given. • Outline actions that will be taken to improve on EDS grades.
Recommendations:	Trust Board is asked to: Note & Approve the report prior to publication
Accountable Director:	Melanie Saunders, Chief People Officer
Author:	Dipen Rajyaguru, Head of ED&I

Previously considered at:	ED&I Steering group (11/01/24) EMC (16/01/24) PACC (18/01/24)
Purpose of Report:	Note/Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Significant
Justification of Assurance Rating:	Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this:
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Noting, Approval & Publication
List of Appendices	FTSU Policy and Case Template - see Supporting Information.

Meeting Report

Name of Meeting	Trust Board
Title	Equality Delivery System (EDS)
Author	Dipen Rajyaguru, Head of ED&I
Accountable Director	Melanie Saunders, Chief People Officer
Date	25 January 2024

1. Purpose

The Committee is asked to receive the final and full report from the EDS assessment for 2023 and provide approval for Board ratification prior to the report to be published on the Trust's website

2. Background and Links to Previous Papers

The EDS is an outcomes framework designed to support NHS organisations to gather effective data, and drive improvement, on equality, diversity, and inclusion (EDI). It forms part of the NHS Standard Contract and requires NHS organisations to collate evidence against a range of outcomes and present that evidence to a panel of key stakeholders for grading.

3. Rationale for Private Paper

N/A

4. Executive Summary

The **Equality Delivery System** (EDS) is focused around three 'Domains'.
1) Commissioned or provided services
2) Workforce health and well-being
3) Inclusive leadership.

It is a tool to support the NHS to respond to the Equality Act 2010 Public Sector Equality Duty, is a requirement in the NHS Standard Contract (SC 13.5 Equity of Access, Equality and Non-Discrimination) and is intended to align with the Leadership and Capability and People themes within the NHS oversight framework 2022/23.

This is our first roll out of this 'refreshed' EDS reporting mechanism we have chosen this year two services to review in Domain 1 rather than the 3 expected for future years. Of these two, one was expected to fit under the 5 clinical priorities cited in the *Core20Plus5* and the second was suggested to be an operational business service. We chose the EarLy Surveillance for Auto-immune diabetes study as a good example of innovative programme that meets the health inequalities target for *Core20Plus5* and our Patient Transport Service which is a good example of a service that works collaboratively across the health & social care system.

For each Domain a template is used with a number of outcomes that require evidence. A separate evidence pack was compiled for each Domain. Compilation of evidence packs largely utilised already existing data and reports, with creation of new data being avoided. Visual aids such as graphs were also produced to support interpretation of the data. The original datasets were also

made available for the evaluators so they could conduct their own analysis and then to score, evaluate and grade each Domain outcome. A summary of the evidence collated against each outcome with the feedback and score from the evaluators for each domain is provided in the Evidence Templates for each domain.

The Evaluators (or stakeholders) consisted of 'internal' or those who understand the process or mechanism for Domain and can include service users, Trade unions, staff networks and FTSU guardians. These groups evaluated Domains 1 & 2 (through the ED&I Steering group), Domain 3 required independent or peer reviewers as well as the Trade unions and we were fortunate and grateful to gain the insights of Oxford Health NHS Foundation Trust and BOB ICS to provide a robust review and grade. The templates evidence packs were distributed in early December to the Independent & peer reviewers to submit back to us by 8/01/24 the 'internal' review took place on 11/01/24 at the ED&I Steering group (using slido to collate the score/grade and comments).

Ratings
Overall, the Trust was given a rating of **Developing.** To determine the overall rating, scores provided by evaluators were averaged for each outcome (rounding to the nearest whole number). The average scores across each outcome were then totaled, with the total score being given the corresponding grade as per the EDS Scorecard and Ratings Guidance.

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1 average score: 4 (PTS)+8 (EarLy Study) divided by 2=6
Domain 2 score: 6
Domain 3 score: 4
Total = 16

Summary of Key Findings and recommendations from evaluators
This from the feedback from the evaluators based on the evidence presented and interpreted by them and although it is subjective it does provide an indication and perception of the services.

For Domain1: PTS
- More data needed to have a greater understanding of our service users and their experiences.
- Opportunity to provide data about renal patients and other patients who have higher needs and suffer from Health inequalities.
- Good to see a steady number of compliments, would like to understand the number as a % of patient journeys.
  *NB evidence provided for 1C but not graded due to oversight but no change to average grade.

For Domain1: EarLy Surveillance for Auto-immune diabetes study
- Already met targets initially set to reach by August 2024
- Overall, the team could develop a database on community center's they could access to promote such a valuable service -especially among communities where there is a higher prevalence of diabetes.
- Need to be more proactive in getting feedback.

For Domain 2: Workforce health and well-being
- The Trust offers a range of H&WB support to its staff, unclear from the evidence how much it is accessed or what staff view of the support is.

- Whilst there have been improvements, there are still concerns of negative cultures.
- There needs to be further use/ promotion of MHFAs and HWB champions. Includes more support for those doing the roles (as volunteers).

For Domain 3: Inclusive leadership

- A good amount of work has gone into producing the various reports and analysis with reference to the main national drivers and initiatives with updates to senior leaders. Plenty of published information.
- There is evidence of both equality and health inequalities being discussed in board and committee meetings, but Board members and senior leaders need to be demonstrating and communicating their commitment or allocating resources to health inequalities, equality, diversity and/or inclusion.
- The Staff networks have a senior sponsor who have a defined role to meet and support them. However, no evidence of sponsoring (supporting) religious, cultural or local events and/or celebrations. Staff Networks still need better executive sponsor input.

Conclusion

Whilst the Trust's overall rating was Developing, there were many outcomes where the Trust was perceived to be as achieving. Additionally, even though outcomes in Domain 1 were all rated as Developing, had the EarLy Surveillance for Auto-immune diabetes study been rated in isolation, it would have been rated Achieving for all Outcomes. For Domain 2, the health & well-being team were recognised for their work and enthusiasm to progress and offer more variety of health support when/where they can. For Domain 3, there was some difference relation to how it was scored by the ED&I Steering group and Union representatives who gave a higher score and externally by BOB ICS and Oxford Health NHSFT who gave a lower score. Nevertheless, the average score gave a fair view when taking into consideration the work currently underway that will be evidenced/established next year, such as the Executive Staff Sponsors and the Board Equality objectives.

Many of the recommendations and findings (above) aimed at enhancing EDS performance align closely with existing plans within the Trust, integrated into various ongoing programs. Consequently, the EDS process serves to fortify the Trust's current initiatives, and highlighting potential measures our services can take to meet the needs and expectations of our service users and staff. We should aim to be 'achieving' next year.

5. Areas of Risk

Risk in relation to contractual compliance with NHS Standard Contract (SC 13.5 Equity of Access, Equality and Non-Discrimination), if not published by 28February

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

Mandated through the NHSE EDI Improvement plan linked to the Trust's annual objectives together with links to the related corporate/BAF risks.

7. Governance

Supports Equality Act 2010 Public Sector Equality Duty, the NHS Standard Contract (SC 13.5 Equity of Access, Equality and Non-Discrimination) and the NHSE EDI Improvement plan.

8. Responsibility

Chief People Officer

7. Recommendations

The Board is invited to **note**: the contents of the report.

and **approve** The EDS report (template) for the Board for publication by 28/02/2024.

Report Cover Sheet

Report Title:	Communications, Marketing and Engagement Update
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	23
Executive Summary:	**Winter and Media** The communications team have been working proactively with the media and with partners to help raise awareness of how the public can help support SCAS over this exceptionally challenging period. **SCAS Strategy launch** Following on from several staff engagement events last summer, the Executive Team led the launch of the refreshed SCAS strategy at the beginning of December. Staff, volunteers, partners and stakeholders were briefed on SCAS's aims through verbal and written briefings. **Modernisation programme communications** With the establishment of the Operations Modernisation Programme Board, the Communications team has started to provide a limited amount of input including to the Communications workstream. The extensive remit of this programme will require dedicated and embedded full time support.
Recommendations:	The Board of Directors is asked to: Note the contents of this report.
Accountable Director:	Gillian Hodgetts
Author:	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Previously considered at:	Not Applicable
Purpose of Report:	Note

Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Significant
Justification of Assurance Rating:	Where ‘Partial’ or ‘No’ assurance has been indicated above, please indicate steps to achieve ‘Acceptable’ assurance or above, and the timeframe for achieving this: N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	
Quality Domain(s)	Not Applicable
Next Steps:	Not Applicable
List of Appendices	

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Communications, Marketing and Engagement Update
Author	Gillian Hodgetts
Accountable Director	Gillian Hodgetts
Date	25th January 2024

1. Purpose

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

2. Background and Links to Previous Papers

This Board Paper is an update on the Communication, Marketing and Engagement Paper that is presented Bi-Monthly to the Board of Directors Meeting in Public.

3. Executive Summary

Winter and Media

The last two months have been extraordinarily intense and pressured for the ambulance service. To help support the operational frontline teams and those staff working in the control rooms particularly, the communications team have been working proactively with the media to help raise awareness of how the public can help SCAS over this period. We have received several requests for interviews and many of these we have supported.

Interviews with Wave 105FM, BBC Radio Berkshire, BBC Radio Oxford, ITV News Meridian (TV face-to-face interview), BBC South News, That's Solent TV, Global Radio/Heart FM (Thames Valley & Hampshire) came about following the press release we issued: https://www.scas.nhs.uk/ambulance-service-asks-public-to-make-the-right-call-this-winter/

Paul Jefferies, Assistant Director of Operations reinforced key messages of:

- Only calling 999 for someone with a serious or life-threatening emergency
- Using 111 online for all urgent needs using a self-guided assessment, or calling 111 if online not an option

- Call waiting times for patients calling 111 reduced from high of around 40 minutes last winter to just over two minutes in September
- Getting flu and COVID vaccinations if eligible
- Collecting any repeat prescriptions in advance of Christmas & New Year bank holidays
- Checking in on vulnerable family members, friends and neighbours as temperatures fall
- Downloading the NHS App for trusted information and advice on thousands of conditions and treatments

This release was highlighted by several media outlets including BBC, Daily Echo and Wokingham Today. We were also approached by Metro UK and BBC South Today asking about winter pressures, demand on our frontline ambulance crews and the impact on hospitals who were declaring critical incidents. The request was to interview frontline ambulance crews. NHS England is now taking the lead in responding to these types of requests. Notably there is an even greater emphasis this year on working closely with our partners to produce editorial that looks at pressures across the whole health system, rather than specifically focusing on individual organisations.

In the last couple of years, we have seen increases in respiratory illnesses and as such, millions of children and vulnerable adults have been offered a flu and/or COVID vaccination to protect them from potentially deadly respiratory infections over the winter months. We have been actively supporting these campaigns, which aim to encourage uptake amongst eligible groups.

Media activity with partners and stakeholders

Whilst our focus has most definitely been on signposting the public to the most appropriate services for their needs and on using 999 and 111 services wisely, we have also been working in partnership with both our public and private partners to communicate other initiatives, successes, and national campaigns. Sharing messages and supporting each other is helping to strengthen both the message but also the relationships between our organisations.

A joint press was issued with partners across Buckinghamshire, Oxfordshire and Berkshire (BOB) Integrated Care Board, regarding the launch of the urgent community response and hospital at home services and BBC Radio Berkshire interviewed Laura Mathias following a joint press release issued by Slough Borough Council and SCAS regarding the distribution of publicly accessible emergency bleed kits across the area. Joint messaging with Fire and Rescue services released safety advice for the public, urging them to follow the Firework Code.

A visit to the Blue Light Hub in Milton Keynes on 18 November by the Chancellor and Chief Secretary to the Treasury, Jeremy Hunt, a win at the Ambulance Leadership awards and a fundraiser for the South Central Ambulance Charity with Wycombe Wanderers, all attracted media interest. Regional and national campaigns such as the NHS England prescription saving scheme, NHSE ‘Help Us Help You’ – early symptoms of lung cancer and Road Safety Week’s ‘Let’s talk about SPEED’ were all supported locally by SCAS Communications.

SCAS Strategy relaunch: 'Fit for the future'

On Tuesday 5th December, David Eltringham Chief Executive, Keith Willett SCAS Chair and the Executive directors, supported by the communications team, visited sites across SCAS, engaging with staff to relaunch the SCAS vision and strategy 2024-2029. Sites visited included, Adderbury, Queen Alexandra Hospital Portsmouth, Southern House Emergency Operations Centre, Oxford Radcliffe Hospital, Nursling, Milton Keynes Hospital, 111 Partis House MK, Winchester and Eastleigh. This followed on from a number of engagement events that were held over the summer, when David talked to staff across the Trust, identifying challenges as well as areas of good practice. As a result, the 10 Point Plan was developed to focus on getting the basics right. This sat alongside a review and reconnection exercise with the long-term strategy, to establish if it was still fit for purpose.

The aim of the Strategy launch day was to make staff, volunteers and Trade Union representatives aware of the refreshed strategic ambitions of the organisation, to encourage ownership and to invite questions and discussion. David presented on four webinars, talking about how the strategy refresh focuses on modernising SCAS quickly to make it 'fit for the future'. These ran throughout the day and were attended by both staff and volunteers and for those unable to attend, recordings of the meetings were made available on the SCAS Hub, as well as photos from the day and on the internal social platform, Viva Engage. The Trust's Council of Governors were included in the briefings and other stakeholders and partners were sent communications on SCAS's ambitions, the first of many to come.

Since the launch event, feedback has been captured from the day itself, through a number of SCAS staff webinars, from the 'Freedom to Speak up' team and directly from staff themselves. All the questions asked are being addressed through a comprehensive 'Frequently Asked Questions' document and this is being posted widely to enable as many staff as possible to find answers to the questions they have.

Following this work, it has become clear the Trust's strategy remains the right one but that the organisation needs fundamental reform to be fit enough to deliver it. Challenges with staff recruitment/retention, the changing demands and complexity of the patients we care for, an ageing estate and the ongoing difficulties of financial balance and performance all mean a significant change in the way we operate is needed, if we are to get anywhere close to delivering what we need to in the years ahead.

Over the next few weeks and months, there will be a series of communications both internally and externally to further engage and communicate the plans.

Modernisation programme communications

Significant issues became apparent with SCAS finances and operational performance which led to the need for immediate financial and performance recovery programmes. Whilst several actions were taken quickly, these issues necessitated a longer-term modernisation programme which is sufficiently challenging to be

Report Cover Sheet

Report Title:	Board Assurance Framework
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	25
Executive Summary:	BAF risks have been aligned to high rated risks (15+) in the Trusts risk register. **BAF risk 1: Score 12** Risk remains at 12 (Major x Possible) with actions ongoing to move the Trust to PSIRF ongoing (plan being sent to Programme Board on 25 January and then to the ICB in February). The medicines team have now moved into the new site and have sent the Controlled Drugs license application. **BAF risk 2: Score 20** Risk remains at 20 (Catastrophic x Likely) due to the ongoing operational pressures. Handover delays continue to be an issue impacting performance. A Clinical Pathway lead is embedded in the QA SLT to help develop non-ED pathways and conduct front door audits to help improve overall performance at the hospital. The Trust has switched convertors and expect 53 vehicles to be delivered this Financial Year and an additional 72 in the next Financial Year. **BAF risk 3: Score 12** Risk remains stable at 12 (Major x Possible) with the Trust working with the ICBs and other stakeholders. **BAF risk 4: Score 12** Risk remains stable at 12 (Moderate x Likely) with the Trust working with the ICBs and other stakeholders to ensure that they understand what we are delivering. There are no risks relating to this BAF risk rated 15+ on the Trust's risk register. **BAF risk 5: Score 20**

	Risk remains high (20 Major x Almost Certain) with the multi-year Financial Recovery Plan complete and a medium-term financial plan in progress. Risk is closely monitored by the Interim Director of Finance and the Financial Recovery Group. **BAF Risk 6: Score 16** Risk rating remains high, 16 (Major x Likely), but stable. Work remains ongoing through the Culture workstream. New actions added relating to the approval of a 5-year workforce plan for the Trust and the Trust being an exemplar for employee retention. **BAF Risk 7: Score 12** Risk rating remains stable at 12 (Major x Possible). Sexual safety charter is due to be refreshed and relaunched and a culture diagnostic is due to take place to provide feedback on the Trusts culture and the work taken place. There are no risks relating to this BAF risk rated 15+ on the Trust's risk register. **BAF risk 8: Score 20** Risk to be reviewed with Interim CDO and new substantive CDO once in place to ensure that actions remain relevant now that the interim CDO has reviewed the status. **BAF risk 9: Score 20** Risk is rated 20 (Catastrophic x Likely) however the Governance and Assurance Accountability Framework (GAAF) has been approved at the Board and is now reflected in the controls section.
Recommendations:	The Board is asked to: Approve the Board Assurance Framework update
Accountable Director:	Daryl Lutchmaya, Chief Governance Officer
Author:	Steve Dando, Head of Risk Management
Previously considered at:	Quality & Safety – 11 January 2024 People & Culture Committee – 18 January 2024
Purpose of Report:	Approval
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:	None
List of Appendices	(Board Assurance Framework- see Supporting Information.

capable of delivering radical and long-term change. This will enable the delivery of a modern, sustainable ambulance service capable of providing the best possible care for our patients, populations and communities.

An Operations Modernisation Programme Board has been established. Seven pillars of change have been identified, one of these being Communications and Engagement. A member of the Communications team has started to provide a limited amount of input to the Communications workstream, acknowledging that this programme requires dedicated and embedded full time support.

Communications support has thus far helped to engage SCAS Leaders and staff, via a variety of channels, identified key stakeholders, created content on a dedicated area of the SCAS Hub and new branding has been developed and implemented. Alongside issuing four programme updates, a bi-monthly webinar plan has been drafted and a community group established on Viva Engage for sharing all updates and facilitating ongoing engagement with staff.

A decision will be needed quickly on the request to fund full time dedicated communication resource, to deliver this huge programme of work. There are already many actions that need delivering including:

- Publishing the 'Frequently Asked Questions'
- Crafting 'Message from the Executive',
- Delivering further programme updates and scheduling/delivering SCAS webinars
- Developing the Viva Engage community page
- Further population of the Hub site
- Creating content/presentations for the Council of Governors meetings
- Delivering ongoing and up to date content for the public website

With all the current 'business as usual' pressures, (exacerbated by the Winter but not exclusively so), there is a risk that communications support to the programme may be limited and financial restrictions may also have profound impact on the ability to produce the range of materials needed to support such an extensive programme of modernisation communications.

4. Responsibility

The responsibility for this Board Paper is Gillian Hodgetts, Director of Communications, Marketing and Engagement.

5. Recommendations

Consideration of the need to secure additional dedicated communication resource in order to successfully deliver the modernsiation programme is requested.

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

Strategic Risk	Strategic Domain / Exec Lead	Strategic Objective	Risk Rating Movement Same ↔ Improved ↓ Worsened ↑	Historic Current Risk Rating				Inherent / Current / Target Risk	Oversight Committee / Last Review Date at Committee	Strength of Controls	Strength of Assurance
SR1 **IF** we have insufficient clinical workforce capability or ineffective equipment and vehicles, **THEN** we will fail to provide safe and effective care **LEADING TO** poor clinical outcomes.	High quality care and patient experience Helen Young / John Black	We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.	↔	**APR 15**	**MAY 15**	**JUN 12**	**JUL 12**	**Inherent 20**	**Quality & Safety** **January 2024**	**Partially Effective**	**Partially Effective**
				AUG 12	**SEP 12**	**OCT 12**	**NOV 12**	**Current 12**			
				DEC 12	**JAN 12**	**FEB**	**MAR**	**Target 9**			
SR2 **IF** we do not have or use effective operational delivery systems, **THEN** we may not be able to meet demand and provide a responsive service to patients in need of emergency care, **LEADING TO** delays in treatment and increased morbidity and mortality.	High quality care and patient experience Mark Ainsworth / Helen Young / John Black	We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes	↔	**APR 20**	**MAY 20**	**JUN 15**	**JUL 15**	**Inherent 20**	**Quality & Safety** **January 2024** **Finance & Performance** **November 2023**	**Partially Effective**	**Partially Effective**
				AUG 15	**SEP 15**	**OCT 20**	**NOV 20**	**Current 20**			
				DEC 20	**JAN 20**	**FEB**	**MAR**	**Target 10**			
SR3 **IF** the organisation fails to engage or influence within systems, **THEN** there may be a disproportionate focus in one system over the others and capacity provided may not align with expectations, **LEADING TO** performance that is not achievable or credible and possible poor outcomes for patients and the communities we serve.	Partnership & Stakeholder Engagement Mike Murphy	We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans	↔	**APR 20**	**MAY 20**	**JUN 20**	**JUL 20**	**Inherent 25**	**Finance & Performance** **November 2023**	**Effective**	**Effective**
				AUG 20	**SEP 12**	**OCT 12**	**NOV 12**	**Current 12**			
				DEC 12	**JAN**	**FEB**	**MAR**	**Target 4**			

Strategic Risk	Strategic Domain / Exec Lead	Strategic Objective	Risk Rating Movement Same ↔ Improved ↓ Worsened ↑	Historic Current Risk Rating				Inherent / Current / Target Risk	Oversight Committee / Last Review Date at Committee	Strength of Controls	Strength of Assurance
SR4 **IF** we fail to engage with stakeholders and partners, **THEN** partners will fail to understand who we are and what we do, **LEADING TO** failure to innovate and influence and an inability to identify opportunities within systems.	Partnership & Stakeholder Engagement Mike Murphy	We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans	↔	**APR 12**	**MAY 12**	**JUN 12**	**JUL 12**	**Inherent 16**	**Finance & Performance** **November 2023**	**Effective**	**Effective**
				AUG 12	**SEP 12**	**OCT 12**	**NOV 12**	**Current 12**			
				DEC 12	**JAN**	**FEB**	**MAR**	**Target 6**			
SR5 **IF** demand, operational standards and external factors (such as inflation, interest rates, taxation and cost of living) continue to increase, **THEN** the total costs to deliver our services will increase and result in a deficit, **LEADING TO** additional pressures on our ability to deliver a sustainable financial plan and safe services.	Finance & Sustainability Stuart Rees	We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.	↔	**APR 20**	**MAY 20**	**JUN 20**	**JUL 20**	**Inherent 20**	**Finance & Performance** **November 2023**	**Partially Effective**	**Partially Effective**
				AUG 20	**SEP 20**	**OCT 20**	**NOV 20**	**Current 20**			
				DEC 20	**JAN**	**FEB**	**MAR**	**Target 12**			
SR6 **IF** we fail to implement resilient and sustainable workforce plans, **THEN** we will have insufficient skills and resources to deliver our services, **LEADING TO** ineffective and unsafe patient care and exhausted workforce.	People & Organisation Melanie Saunders	We will develop plans to deliver inclusive, compassionate culture where our people feel safe and have a sense of belonging.	↔	**APR 16**	**MAY 16**	**JUN 16**	**JUL 16**	**Inherent 20**	**People & Culture** **January 2024**	**Partially Effective**	**Partially Effective**
				AUG 16	**SEP 16**	**OCT 16**	**NOV 16**	**Current 16**			
				DEC 16	**JAN 16**	**FEB**	**MAR**	**Target 12**			
SR7 **IF** we fail to foster an inclusive and compassionate culture,	People & Organisation	We will develop plans to deliver inclusive, compassionate culture where our people feel	↔	**APR 16**	**MAY 16**	**JUN 16**	**JUL 16**	**Inherent 20**	**People & Culture** **January 2024**	**Partially Effective**	**Partially Effective**

<table>
<tr><th>Strategic Risk</th><th>Strategic Domain / Exec Lead</th><th>Strategic Objective</th><th>Risk Rating Movement
Same
Improved
Worsened</th><th colspan="4">Historic Current Risk Rating</th><th>Inherent / Current / Target Risk</th><th>Oversight Committee / Last Review Date at Committee</th><th>Strength of Controls</th><th>Strength of Assurance</th></tr>
<tr><td rowspan="2">THEN our staff may feel unsafe, undervalued, and unsupported, LEADING TO poor staff morale, disengagement, low retention and impacts on patient safety and care.</td><td rowspan="2">Melanie Saunders</td><td rowspan="2">safe and have a sense of belonging.</td><td rowspan="2"></td><td>AUG 12</td><td>SEP 12</td><td>OCT 12</td><td>NOV 12</td><td>Current 12</td><td rowspan="2"></td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>DEC 12</td><td>JAN 12</td><td>FEB</td><td>MAR</td><td>Target 8</td></tr>
<tr><td rowspan="3">SR8
IF we are unable to prioritise and fund digital opportunities, THEN we will have insufficient capacity and capability to deliver the digital strategy, LEADING TO system failures, patient harm and increased cost.</td><td rowspan="3">Technology Transformation

Barry Thurston</td><td rowspan="3">We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.</td><td rowspan="3"></td><td>APR 20</td><td>MAY 20</td><td>JUN 20</td><td>JUL 20</td><td>Inherent 25</td><td rowspan="3">Finance & Performance

November 2023</td><td rowspan="3">TBC</td><td rowspan="3">TBC</td></tr>
<tr><td>AUG 20</td><td>SEP 20</td><td>OCT 20</td><td>NOV 20</td><td>Current 20</td></tr>
<tr><td>DEC 20</td><td>JAN</td><td>FEB</td><td>MAR</td><td>Target 15</td></tr>
<tr><td rowspan="3">SR9
IF we fail to deliver the Trusts improvement programme THEN we will not move out of NOF4 or achieve an improved CQC rating LEADING TO a deterioration of the Trust's reputation, additional regulatory oversight and possible further regulatory action.</td><td rowspan="3">Well Led

Mike Murphy</td><td rowspan="3">We will become an organisation that is well led and achieves all its regulatory requirements by being rated Good or Outstanding and being at least NOF2.</td><td rowspan="3">NEW</td><td>APR</td><td>MAY</td><td>JUN</td><td>JUL</td><td>Inherent 25</td><td rowspan="3">Board

January 2024</td><td rowspan="3">Partially Effective</td><td rowspan="3">Partially Effective</td></tr>
<tr><td>AUG</td><td>SEP</td><td>OCT</td><td>NOV 20</td><td>Current 20</td></tr>
<tr><td>DEC 20</td><td>JAN</td><td>FEB</td><td>MAR</td><td>Target 10</td></tr>
</table>

Report Cover Sheet

Report Title:	Improvement Programme Oversight Board Update 10th January 2024
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	26
Executive Summary:	• The IPOB highlight report is attached as an appendix to this paper. The report will also be presented to the Tri Partite Meeting (TPAM) on the 22nd of January. • The Trust has one outstanding Must Do in the Governance workstream, relating to the governance of risks and risk management. Delays with completion had been caused by capacity but recruitment was undertaken, and a successful candidate joined the Trust in December. • In addition, the Governance Assurance and Accountability Framework was approved at the December Board, subject to amendment. It was agreed that quarterly reviews would be undertaken to keep the document live. The subsequent actions to embed the framework will support transitioning the workstream to an amber rag status. • Discussion at IPOB in December exposed a concern about the completeness of Fit and Proper Person test records in the Trust which the Chief Governance Officer has briefed on. An updated policy will be shared at EMC in January. • The Trust has one outstanding Should Do action in the Performance Improvement workstream relating to the way that the Trust monitors outcomes for patients who are not transferred to hospital. The technical solution for this had been delayed by the ePR outage which has now been resolved with testing underway and completion expected imminently. • In December, the full set of IPOB papers were attached as appendices with the explanation that this was to provide an overview but in future only the IPOB report itself would be attached. • The oversight of the Improvement Programme continues to be reviewed. The Chief Strategy Officer met with Kate Hall (ID) on the 16th of January to discuss proposals for a more focussed

	approach to the management of the programme going forward. Changes will be incorporated into our resource plans for 2024. • The Sexual Safety Campaign review was an agenda item at IPOB. The 2 slide presentation is also attached for information.
Recommendations:	The Trust Board is asked to note this paper.
Accountable Director:	Mike Murphy, Chief Strategy Officer
Author:	Mike Murphy, Chief Strategy Officer
Previously considered at:	Updates on the Improvement Programme have been provided to full board and board sub committees
Purpose of Report:	Assure
Paper Status:	Private
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:	
List of Appendices	• IPOB Report Pack 10th January 2024 • Sexual Safety Campaign Review

Report Cover Sheet

Report Title:	Fit for the Future Programme
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 25 January 2024
Agenda Item:	Any other Business
Executive Summary:	The attached slides provide the Board with an update on the implementation of the Fit for the Future programme.
Recommendations:	The Trust Board is asked to note the update on progress with the delivery of the SCAS fit for the future programme.
Accountable Director:	Paul Kempster, Chief Strategy Officer
Author:	Tina Lewis, Senior Transformation Programme Manager
Previously considered at:	None
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	Not Applicable.
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable

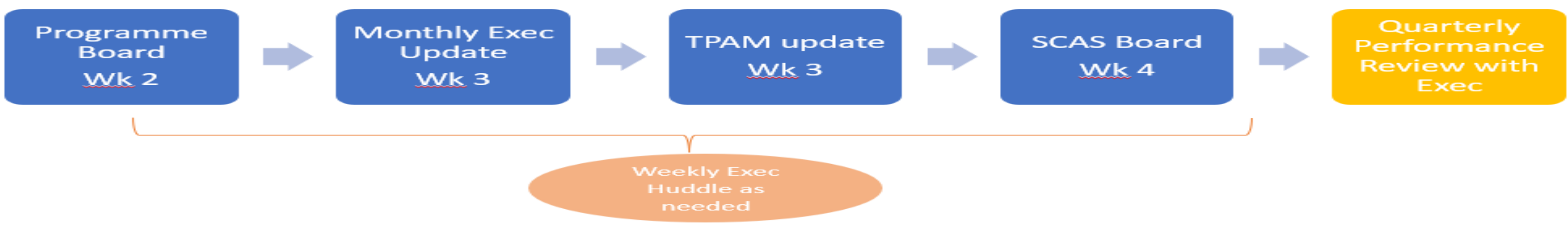
Next Steps:	Delivery plans are being developed to implement the programme
List of Appendices	

Fit For the Future Programme Update

January 2024

Programme Board

- Programme Board schedule and governance route developed



- Principles drafted *
- Risk workshop has been completed with ~ 50 areas identified, with key themes including:
    - Programme resourcing *
    - Stakeholder engagement
    - Scope creep and potential paralysis of change elsewhere
    - Ability to find suitable locations for new Estate / Ability to dispose or redeploy existing
    - Governance process and speed of decision making

The core principles that underline the Fit for the Future Programme are that it….

Staff related:

- Develops a workforce that is correctly qualified and trained, in the right numbers and in the right locations to respond to our community needs across all the services that we deliver.
- Provides a great place to work within an environment in which staff feel happy, safe, supported and have a sense of belonging.

Patients:

- Keeps the care and safety of our patients at the centre of decision making ensuring that any change enhances patient experience.
- Enhances the clinical capability across all elements of Service Delivery

Leadership and Decision making:

- Creates a local, empowered leadership model.
- Enables staff working at all levels to have access to the information, tools and support required to make the decisions that they are accountable for.
- Adopts agile working practices to react to quality and service improvement opportunities in a timely manner.

Transparency:

- Operates a culture of transparency where decisions and ways of working are open to review and challenge.
- Communicates information in a manner that our stakeholders can understand, engage and contribute.

Cost effective / Value for money:

- Works in partnership with internal and external stakeholders to exploit synergies and enhance patient flow across the health economy.
- Invests in processes, technology and relationships that provide excellent patient care and staff wellbeing, whilst representing value for money.

Environmental:

- Enables an Estate, Fleet, Infrastructure and Operational processes that will embed environmental best practice and support the delivery of Net Zero.

These are currently under review by Unions and Clinical representatives

Resourcing

Dedicated resourcing to develop and deliver plans is tight, with constraints in the following areas:

1. Programme Director, Workstream Project managers, business analyst & overall planning
2. Commercial expertise
3. Estates expertise

Business cases and mitigations are being developed to fill the gaps, but there is a risk to the delivery of an outline business case for approval at the March 2024 board

Progress against roadmap

Based on Q1 2024/25 deliverables

- County based 999 model with scheduling
  - Engagement sessions commenced with 999 Operational teams
  - Initial discussions with scheduling management, workshops now required to work out how to move from existing structure to county-based working, including the movement of staff out to Resource Centres
  - AACE have started working with us on the workstream
- Review 999 structure
  - First draft of Operations management structure completed and discussions with Heads of Operations and Clinical Operations Managers
- Review CC structure and locations
  - CC lead in post part time and initial engagement sessions set up

Progress against roadmap

Based on Q1 2024/25 deliverables (continued)

- Announce Hub locations
  - 3 rounds of modelling have been completed with Optima
  - Model has been developed based on delivering Cat 2 and Cat 3 and maintaining our existing Cat 1 performance
  - An additional 2000 DCA hours is required to deliver performance – for the existing estate footprint
  - Considerations also given to resourcing hours; utilisation, over-runs and mileage
    - A ten-hub model will provide this, with mitigations of some standby points to aid Cat 1 delivery
  - Next stage is to model move to 9 hubs and standby mix

Ops Structure & Scheduling

- Options for structures being designed and discussed with Operational Leadership team (HOOs/COMs)
- Communications and engagement workshops planned with Scheduling teams to better understand job roles and scheduling processes and how these could align to future model
- Potential impact on staff to also be mapped and considered as part of this work once options are more clearly defined

Comms progress

- Content on programme Hub site including workstream lead visibility
- Bi-monthly all staff webinar sessions underway (first delivered on 24 Jan)
- Council of Governor workshop 31 Jan
- Review management comms via EDR/SLG
- Handover document and transition once comms lead departs
- Fleet services and volunteer communications channels to ensure regular contact

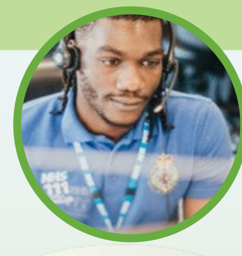
The seven pillars for making SCAS fit for the future

U&E Operations Service Model

- Delivery of the new U&E Operations Model
- Redesign leadership model to reduce layers of hierarchy between CEO and patient
- Increase clinicians to **60-65%** of patient facing teams
- Reduce single clinician dispatches

Contact Centres Service Model

- Design and delivery of the new Contact Centres Operations Model
- Alignment of Contact Centre operating models
- Review of Contact Centres locations
- Redesign of workforce model



Estates/Fleet Redesign

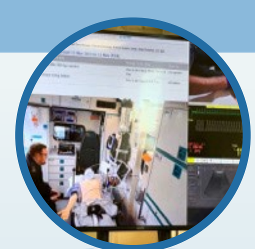
- Design and delivery of the new Estates masterplan focussing on county led hub model
- Operate a **'One SCAS'** model of fleet services delivery based around county led hub model

People and Culture

- Ensure delivery of the Workforce Model through well planned recruitment and retention approach
- Provide support to the programme for all structural design, consultation and delivery of restructures
- Develop the organisational culture to be **'customer and future focussed'**

Digital

- Design and delivery of systems and data that support the organisation to deliver a modernised service
- Redesign Organisational Data and Intelligence to support measurement for improvement
- Consider alignment of systems with other providers to support operational resilience



Support Services

- Align and redesign support services to patient facing operations model
- Develop a partnership approach aligned to county and ICB models
- Operate a **'One SCAS'** model of support services delivery

Comms

- Proactively plan and deliver all internal and external stakeholder engagement for the modernisation programme
- Deliver a robust engagement programme ensuring that stakeholders are aware of improvements and how they can engage in improvement

SCAS ROADMAP

Clinically led navigator

Q4
Urgent Emergency Care (UEC) model

Q4
Urgent Strategy to deliver 60% clinician workforce

Q4
RRVs and standby points

Patients first

Q1
New management structure

Q1
Moving to a county-based model

Q1
Review contact centre structure and locations

Q1
Tactical operations cell

Q1
Review of corporate services

Q1
Announce proposed locations of the hub

Q2
One education team for 999, CCC and PTS

Q2
Fleet structure for 999 and PTS

Modernising

Q2
Publish outline design of the hub

Q3
Align IT systems in 999/111 - replace the CAD

‘One SCAS’

LEADING TO:

- Delivery of a modern sustainable ambulance service
- Fit for the future
- Capable of providing the best possible care for our patients, populations and communities

2023 ← → 2029

Public Trust Board Meeting

Supporting Information

DATE: 25 January 2024
TIME: 9.30 - 12.15
VENUE: **Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN**

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

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Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BOARD MEMBERS REGISTER OF INTERESTS

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

INTRODUCTION & BACKGROUND

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

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

DOCUMENT INFORMATION

Date of issue: 26 May 2023

Produced by: The Governance Directorate

PROFESSOR SIR KEITH WILLETT CBE, TRUST CHAIR

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

1. Professor of Trauma Surgery, University of Oxford
2. Chair of the Chair' Group and Council of the Association of Ambulance Chief Executives (AACE)
3. Retained with NHS England and NHS Improvement to support COVID-19 public inquiry

Current 'Other' Interests

4. Honorary Air Commodore to 4626 Squadron, RAuxAF

Interests that ended in the last six months

5. None

SUMIT BISWAS, NON-EXECUTIVE DIRECTOR / DEPUTY CHAIR

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

1. None

Current 'Other' Interests

2. Director Zascar Ltd (trading as Zascar Consulting)
3. Part owner of Zascar Ltd.

Interests that ended in the last six months

4. None

LES BROUDE, NON-EXECUTIVE DIRECTOR / SENIOR INDEPENDENT DIRECTOR

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

1. None

Current 'Other' Interests

2. Independent member of the Buckinghamshire Healthcare NHS Trust Charitable Funds Committee
3. Senior Independent Trustee for the Royal Hospital for Neuro-disability and Chair of the Audit and Risk Committee

Interests that ended in the last six months

4. Executive Coach at ella Forums

ANNE STEBBING, NON-EXECUTIVE DIRECTOR

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

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

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

NIGEL CHAPMAN, NON-EXECUTIVE DIRECTOR

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

1. None

Current 'Other' Interests

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

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

Interests that ended in the last six months

8. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

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

1. Chair of Salisbury NHS Foundation Trust

Current 'Other' Interests

2. Chair of Estuary Housing Association
3. Member of Advisory Group, NHS Patient Safety Commissioner
4. Strategic Advisor, Prevention Access Campaign (US based charity)

Interests that ended in the last six months

5. Member of Welsh Governments Expert Advisory Group on banning LGBTQ+ Conversion Practices

MIKE McENANEY

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

1. Non-executive director and chair of Audit & Risk Committee – Royal Berkshire NHS Foundation Trust
2. Director of South Central Fleet Services Ltd.
3. Member of NHS Providers Finance & General Purposes Committee
4. Chair of FTN Limited (Trading subsidiary of NHS Providers charity)

Current 'Other' Interests

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

Interests that ended in the last six months

7. None

Dr DHAMMIKA PERERA

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

1. None

Current 'Other' Interests

2. Global Med Director of MSI Reproductive Choices
3. Member of the Clinical Committees on Safe Abortion Care at the WHO and at the International Federation of Obstetricians and Gynecologists (FIGO)

Interests that ended in the last six months

4. None

DAVID ELTRINGHAM, CHIEF EXECUTIVE OFFICER

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

1. None

Current 'Other' Interests

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

Interests that ended in the last six months

3. None

PAUL KEMPSTER, CHIEF OPERATING OFFICER

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

1. Managing Director of South Central Fleet Services Ltd

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

JOHN BLACK, CHIEF MEDICAL OFFICER

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

1. Emergency Medicine Consultant, Oxford University Hospitals NHS Foundation Trust
2. Honorary Consultant Civilian Adviser in Pre-hospital Emergency Care to the Army
3. Lecturer in Anatomy, St Edmund Hall, University of Oxford, Member of Oxford University Congregation
4. Member National Ambulance Medical Directors Group (NASMeD)
5. Investor Oxford Medical Products Ltd*

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

Current 'Other' Interests

6. None

Interests that ended in the last six months

7. None

PROFESSOR HELEN YOUNG, DIRECTOR OF PATIENT CARE AND SERVICE TRANSFORMATION

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

1. Chief Nurse and Trustee for ACROSS (a medical charity taking terminal and very sick travellers on respite breaks travelling on a Jumbulance)
2. Chief Nurse and Trustee for HCPT (a medical charity taking terminal and very sick children and young people on respite breaks to Lourdes)
3. Clinical Advisor for Dorothy House Hospice Care
4. Chair of Soroptimist International (Bath Club) (a charitable organisation that works to empower, educate and enable women and young girls in UK and internationally).

Current 'Other' Interests

5. None

Interests that have ended in the last six months

6. SRO for NHS 111 Covid Response Services (March 2023)

ANEEL PATTNI, CHIEF FINANCIAL OFFICER

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

1. Director of South Central Fleet Services Ltd.

Current 'Other' Interests

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

Interests that ended in the last six months

3. None

MIKE MURPHY, DIRECTOR OF STRATEGY AND BUSINESS DEVELOPMENT

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

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

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

DARYL LUTCHMAYA, CHIEF GOVERNANCE OFFICER

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

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

MELANIE SAUNDERS, CHIEF PEOPLE OFFICER

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

1. Employers representative on the national NHS Employers Staff Partnership Forum

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

Stuart Rees, Interim Director of Finance

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

1. SCFS Ltd Managing Director as of December 2023

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

Craig Ellis, Chief Digital Officer

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

1. None

Current 'Other' Interests

2. I am a Non-Executive Director for the London Cyber Resiliency Centre. I undertook this in Nov-2022 and continue in the role which was declared when undertaking my application.

Interests that ended in the last six months

3. None

Mark Ainsworth, Director of Operations

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

1. None

Current ‘Other’ Interests

2. None

Interests that ended in the last six months

3. None

END

Integrated Quality and Performance Report: Dec-23

Statistical Process Control:

An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data. To help you interpret the data a number of rules can be applied.

The rules:

1) Any single point outside the process limits.

2) Two out of three points within 1 sigma of the upper or lower control limit.

3) A run of 6 points above or below the mean (a shift) .

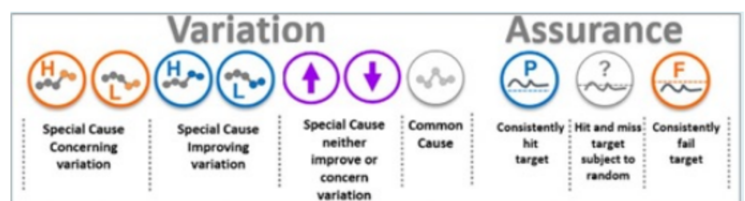
4) A run of 6 consecutive ascending or descending values (a trend).

All these rules are aids to interpretation but still require intelligent examination of the data.

This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration.

If you change in your process and observe a persistent shift in your data, it may be appropriate to change the process limits. A process limit change can be added if the observed change is sustained for a longer period not just 6 points. You should try and find out the cause of the process change before recalculating the limits and annotate this on the chart. Be very cautious if you do not know what changed the process.

Icon Key



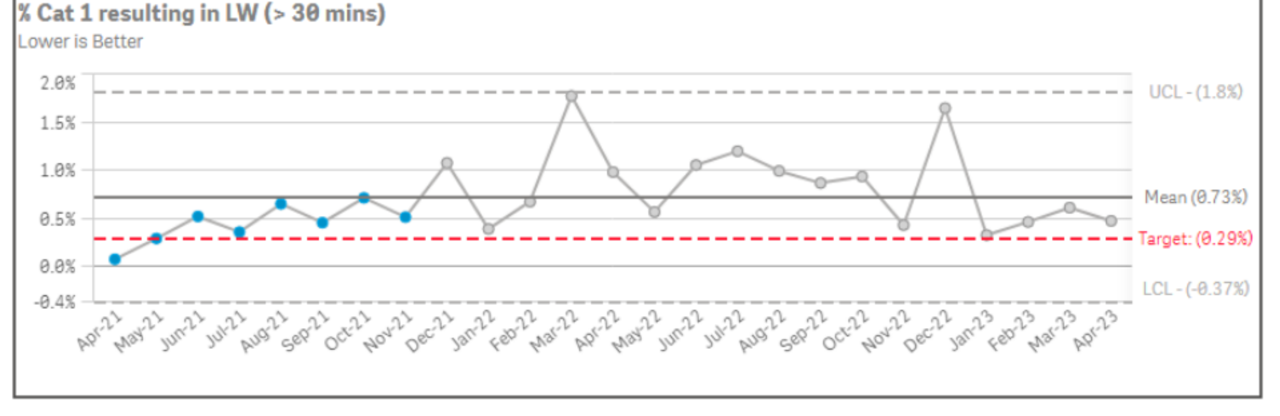
	Pass	Hit and Miss	Fail	No Target
H (blue)	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT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

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

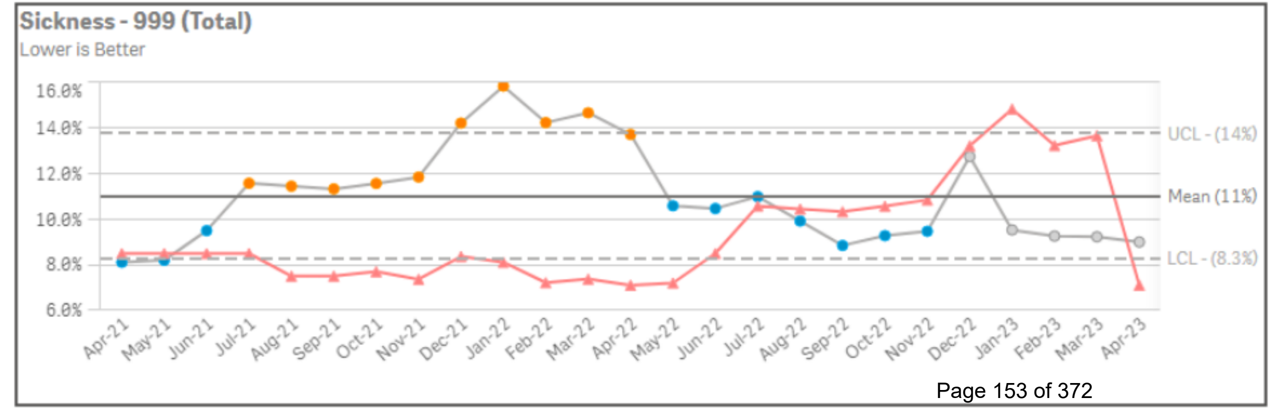
Assumptions:

The below SPC chart shows an example of the metric values per month.
The points on the line are coloured orange, grey, or blue in accordance with the SPC guidelines.
A dashed red line shows the target for the metric if there is one present.
A red line with triangle markers shows the plan projected for the metric if one is present.
The plan is different to a target, as the target is static; the plan can vary each month.
No Assurance Icon will be produced for the metric if no target value is available.
Quarterly Metrics and Metrics without data pre April 2022 will be visualised in a line chart and not an SPC Chart.

Example of Target Line Chart



Example of Plan Line Chart



UCL & LCL:

When the variance in the values is normal within the process (common cause varition) all the points will fall above or below them mean, but within the upper and lower control limits as represented by the lines on the chart.

If values(s) fall above the UCL or below the LCL, then they are statistically not expected, special cause variation.

However, it is important to realise that even if all the points fall within the control limit lines it does not mean the process is in control. Ideally a process should have no variation, the values should all be the same. So it is important to understand what is causing the common cause variation. The wider the gap between the mean line and the control limits, the larger the variance

Executive Summary

Operational Performance

Safety and Quality

Workforce

Finance

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

EXECUTIVE COMMENTARY

Trust Overview

999 Demand for December was close to targeted levels. Performance within the 999 service was challenging as the Trust failed to meet the ARP standards for the month overall. In the main, achievement of the ARP standards was challenged by insufficient hours provided by our Private Provider partners and increased handover delays. Whilst we target reduced conveyance to ED a slight increase in 999 calls coupled with a higher level of acuity resulted in higher than target conveyances overall. As a trust we are aware that conveyance will influence admissions and hence acute occupancy. Hence, we are working with partners to reduce conveyance.

During December our own workforce reflected sickness levels only slightly above the reported mean. Whilst new staff joining the Trust was lower than planned so staff turnover, across the Trust, has fallen. The net impact has been good staffing levels but vacancy rates are now on the rise. As we enter 2024 with the prospect of industrial action and colder weather, we expect performance to continue to be challenging and will focus on maximising the resources at our disposal.

Performance 999 and 111

SCAS category 1 performance for December was 08:54, a 4 second deterioration from November. Category 2 performance also deteriorated to 38:09, which is 7 minutes 15 above our proposed trajectory. Response demand was 1.4% below planned levels at 54,856 responses. However, it was also the highest level since Dec 22. We restrict annual leave levels during the last 2 weeks of December which increased our resource levels and this was also combined with reduced handover delays for these 2 weeks. For the period 1st to 17th December, cat 2 was 49:23 and we lost 5,221 hours at hospital handover, where as the period 18th to 31st we achieved cat 2 at 24:22 and lost 3,092 hours. The higher handover delays impacted on Cat 2 by 5 minutes and the remaining 2 minutes was due to the shortage of SCAS operational hours. Key actions to improve performance are to increase our operational hours. We are circa 1,500-2,000 hours per below required hours and this is linked to the private providers who continue to not deliver the contracted hours. We have also issued our immediate handover process to release crews quicker from hospitals.

999 call volumes fell for the 3rd month which is linked to a fall in duplicate calls through us responding to the original incident quicker during the second half of December. Call answer for December was 17 seconds.

We took 155,540 111 calls in December which was 9,000 higher than plan but sustained our mean call answer through higher staffing levels and improved AHT.

Vehicles off the Road (VOR) is currently being driven by the increasing age profile of the current fleet due to significant delays in delays in new vehicles from convertors. 53 vehicles were due for delivery in Oct 2023 but delayed to start delivery from Feb 2024. 72 vehicles are also now due from end of July 2024.

EXECUTIVE COMMENTARY (Continued)

Quality and Patient Safety

During December we have seen challenges with increased demand for our services due to the winter pressures and increases acuity of patients needing our services. The consequence can be seen in some if the quality and safety KPIs namely compliance rates with Safeguarding training for adults and children's level 1 dropping below target, but we are above trajectory on the level 3 training. The major issue and risk in Safeguarding is the continued number of incidents we are seeing relating to the ICT and BI that supports the Safeguarding referral system. A number of 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.

The total number of patient safety incidents being reported is at its highest level seen this year, with correlated rises in incidents where harm to patients is occurring, mainly due to delays being experienced in attendance. A thematic review of incidents where delays were a significant contributory factor has found a number of themes we need to address. Namely, the vacancy levels of clinical staff, the end of shift policy, meal break policy and hospital handover delays form the rest of the themes identified.

The Quality and Safety Committee has reviewed the Safeguarding risks and findings and recommendations of the thematic review into delays and together with Exec Management Committee and the Finance and Performance Committee, will oversee the improvement plans to address these issues.

We have a number of Serious Incident investigations not completed within original time frame but all of these have negotiated extensions.

Infection prevention and control 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 reviewing audits
The complaints response rate is 100% and therefore above the mean of 97%. Performance as expected. Normal fluctuation across the YTD. The Patient Experience team to maintain work with service colleagues for timely responses. Improvement recognised in 111.
RIDDOR events were within normal variation in December with 8 events. Bi Monthly thematic reviews in place, reporting into the HSRG. New return to work education guidance to reduce a musculoskeletal incident that are RIDDOR reportable.

Finally we have seen an improvement in the measure of unaccounted CD losses which saw a significant decrease due to control measures taken.

EXECUTIVE COMMENTARY (Continued)

Workforce

Staffing dipped for the first time in December following 7 months of growth. Whilst we continue to recruit to frontline positions those non patient facing roles now fall under greater controls in support of the financial recovery of the Trust. Staff turnover fell in December with fewer leavers but also fewer joiners; not unexpected at this time of year. Overall sickness in the Trust also increased in December with long term sickness being a contributory factor.

One of the factors affecting turnover relates to staff wellbeing. For frontline staff overruns continue to be below target however they are rising slightly. We know our end of shift policy has an impact on our ability to meet ARP standards. Poor Category 2 performance subsequently influences our ability to achieve meal break compliance which is still well below target. The trust is engaging with union colleagues with a view to establishing a balance between wellbeing and performance.

Finance

The Trust's financial position year-to-date (YTD) at month 9 (December) is £16.8m deficit with the in-month position showing a £1.4m deficit, although this is a deficit position, meaning Trust is missing one of its duties, this is showing a small improvement in run rate.
The Trust's cash balance at the end of December stood at £31.9m. The Trusts cash balance has decreased by £18m since the start of the financial year, an average monthly net cash outflow of £2m, at this run rate the Trust will require cash support by the end of the Financial Year 2024/25 to support continuing operations.

The over 90-day debt has increased again this month and now stands at £1.5m (up from £1.3m in November). This increase is due to the unpaid Service Level Agreement (SLA) charges to Buckinghamshire Healthcare NHS Trust (BHT) (£895k). With the Non-Emergency Patient Transport Services (NEPTS) SLA, Extra Contractual Referral (ECR) and NEPTS multi-crew charges now account for £1.3m of the £1.5m aged debts. Total Sales Ledger debt has decreased this month and now stands at £2.67m (down from £3.15m in November). The 90-day category debt has increased to 55.58% of the total sales debt (up from 40.18% in November).

Agency controls continue to have a positive impact on spend with the Trust continuing to spend below the planned target set at the start of the year. The weekly Financial Recovery Group will continue to monitor the use of agency staff moving forwards with the aim being to either discontinue agency contracts once completed or convert agency staff into substantive posts where possible.

The Trust continues to forecast £10m of savings from the Financial Sustainability Programme, of which £4.8m (48%) is recurrent, the non-recurrent nature of the program has been taken into account for 2024/25 planning and saving programme.

Overall Summary

December-23
Summary

Assurance

Variance

	Fail	Hit and Miss	Pass	No Target
		999 % calls from frequent callers Debtors > 90 days> 5% total balance ST&C (ED 1&2) - SCAS VOR - Total VOR - Unplanned Maintenance	SCAS 111 - 999 referrals %	1
	Fire Awareness Information Governance	Equality & Diversity H&T - SCAS Health & Safety Infection Control Manual Handling Safeguarding Adults Level 1 Safeguarding Children Level 1	Patients Collected within time	3
	Appraisals - Trust Average Hospital Handover Time - SCAS Hospital Delays - SCAS Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds Patients Arrived within time ST&C (Non-ED 1&2) - SCAS	37	SCAS 111 - ED Referrals	26
		111 Calls abandoned after 30 secs % EOC Internal Attrition		8
	111 call answer in 120 Secs % Conflict Management Total 111 - Transfer to Clinician	Compliments %		5
		Number of Non-Physical Assaults Number of Physical Assaults		9
		Number of Never Events (CQC/NRLS reportable)		12

Metrics:

Hit and Miss Common Cause Metrics:
% Cat 1 resulting in LW (> 30 mins) ; % Cat 2 resulting in LW (> 60mins) ; % Cat 3 resulting in LW (> 3hrs) ; % Cat 4 resulting in LW (> 4 hrs) ; 999 Calls abandoned % ; Building cleanliness completed audits ; Cardiac Arrest Survival, Utstein ; Cat 1 90th %ile SCAS ; Cat 1 Mean SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 3 90th %ile SCAS ; Cat 4 90th %ile SCAS ; Clear up Delays - SCAS ; Complaints - 999 Total % ; EOC External Attrition ; Hand Hygiene audit ; Number of SI investigations outstanding after 60 days (excluding events that are officially suspended) ; Number of cleanliness compliance audits ; Number of compliant Building cleanliness audits ; Number of compliant Hand Hygiene audit ; Number of compliant Vehicle cleanliness audits ; Number of compliant cleanliness compliance audits ; Percentage of compliant Building cleanliness audits ; Percentage of compliant Hand Hygiene audits ; Percentage of compliant Vehicle cleanliness audits ; Percentage of compliant cleanliness compliance audits ; S&T - SCAS ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Total Task Time - SCAS ; VOR - Other ; VOR - Planned Maintenance ; Vehicle cleanliness completed audits

Operational Performance

December-23
Summary

Assurance

Variance	Fail	Hit and Miss	Pass	No Target
H (concern)		999 % calls from frequent callers ST&C (ED 1&2) - SCAS VOR - Total VOR - Unplanned Maintenance	SCAS 111 - 999 referrals %	
L (concern)		H&T - SCAS	Patients Collected within time	1
Common cause	Average Hospital Handover Time - SCAS Hospital Delays - SCAS PTS - Calls answered in 60 seconds Patients Arrived within time ST&C (Non-ED 1&2) - SCAS	17	SCAS 111 - ED Referrals	7
L (improvement)		111 Calls abandoned after 30 secs %		1
H (improvement)	111 call answer in 120 Secs % Total 111 - Transfer to Clinician	Compliments %		2
Increasing				6
Decreasing				3

Metrics:

Hit and Miss Common Cause Metrics:
% Cat 1 resulting in LW (> 30 mins) ; % Cat 2 resulting in LW (> 60mins) ; % Cat 3 resulting in LW (> 3hrs) ; % Cat 4 resulting in LW (> 4 hrs) ; 999 Calls abandoned % ; Cat 1 90th %ile SCAS ; Cat 1 Mean SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 3 90th %ile SCAS ; Cat 4 90th %ile SCAS ; Clear up Delays - SCAS ; Complaints - 999 Total % ; S&T - SCAS ; Total Task Time - SCAS ; VOR - Other ; VOR - Planned Maintenance

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of Incidents	Dec-23	54,856	54,887		n/a	52,042.8	45,733	58,352.7
Cat 1 response time mean	Dec-23	00:08:54	00:07:00			00:08:48	00:06:49	00:10:47
Cat 1 response time 90th	Dec-23	00:15:56	00:15:00			00:15:59	00:12:30	00:19:27
Cat 2 response time mean	Dec-23	00:38:09	00:18:00			00:31:41	00:10:18	00:53:03
Cat 2 response time 90th	Dec-23	01:17:59	00:40:00			01:04:08	00:17:41	01:50:35
Cat 3 response time 90th	Dec-23	06:31:37	02:00:00			04:51:18	00:23:05	09:19:32
Cat 4 response time 90th	Dec-23	08:59:22	03:00:00			06:13:07	00:33:55	11:52:20

NHS

999 - Calls and Outcomes

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of calls (999)	Dec-23	70,425	72,897		n/a	66,310.3	44,777.4	87,843.1
Call answer time mean (999)	Dec-23	00:00:17	00:00:10		n/a	00:00:40	-00:00:22	00:01:43
Call answer time 90th (999)	Dec-23	00:01:10			n/a	00:02:17	-00:00:36	00:05:10
% Calls abandoned (999)	Dec-23	5.5%	2%			7.0%	-4.0%	18.0%
% Hear and treat	Dec-23	12%	12%			12.3%	9.6%	15.0%
% See and treat	Dec-23	34%	35%			34.1%	32.6%	35.5%
% See and convey to ED	Dec-23	50%	48%			49.3%	46.6%	52.1%
% See and convey to non-ED	Dec-23	4.7%	5.4%			4.3%	3.9%	4.8%

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Arrival at hospital to handover mins mean	Dec-23	00:28:38	00:15:00			00:24:17	00:15:32	00:33:02
% Arrival at hospital to handover >15mins	Dec-23	43%			n/a	47.2%	37.8%	56.6%
Total hours lost to hospital handover	Dec-23	7125:48:11			n/a	4860:11:47	420:08:59	9300:14:35

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of calls (111)	Dec-23	155,540	146,857		n/a	135,929	95,950	175,909
Call answer time mean(111)	Dec-23	00:02:48			n/a	00:04:36	-00:05:25	00:14:39
% Calls answered	Dec-23	68%	95%			51.1%	19.7%	82.4%
% Calls abandoned (111)	Dec-23	5%	3%			12.9%	-1.6%	27.5%
% Calls transferred to clinician	Dec-23	46%	50%			42.1%	37.4%	46.8%
% 111 Call back within 20mins	Dec-23	30%			n/a	19.0%	9.6%	28.5%
% Calls to ambulance	Dec-23	11%	10%			11.2%	9.8%	12.6%
% Calls to ED	Dec-23	10%	7.5%			10.6%	8.7%	12.5%
% 111 Calls to self-care	Dec-23	12%			n/a	10.3%	8.3%	12.4%

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PTS Volume - No. of Journeys	Dec-23		71,242		n/a	81,228.9	71,491.8	90,966
Number of calls (PTS)	Dec-23	30,372	31,692		n/a	33,273.1	18,926.5	47,619.6
% Patients arrived in time	Dec-23	83%	87%		F	82.7%	80.0%	85.4%

Fleet

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of vehicle accidents	Dec-23	64		-	n/a	65.1	18.6	112
% Vehicles off the road	Dec-23	29%	23%			0.2%	0.2%	0.3%

Operations - 999 - Volume/ARP

Number of Incidents

N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Improved	-	54,887	54,856

Cat 1 response time mean

Lower is Better. Target differed in previous years

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

Cat 1 response time 90th

Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	Random	00:15:00	00:15:56

Cat 2 response time mean

Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	Random	00:18:00	00:38:09

Understanding the Performance:

Response demand for 999 was split between being below plan for the first half of Dec and above plan over the Christmas period. For the month we were 1.4% below planned response demand. Cat 2 mean for Dec was 07:15 above planned trajectory of 30:54, this being made up of approx. 03:38 from low resource hours (7,508 hours below plan) and 05:01 from excess handover delays, mainly at QA (21:49 above trajectory). Due to lower AL allowance over the Christmas period, available resource exceeded the availability of fleet, so hours were managed in accordance by applying leave and cancelling overtime.

Actions (SMART):

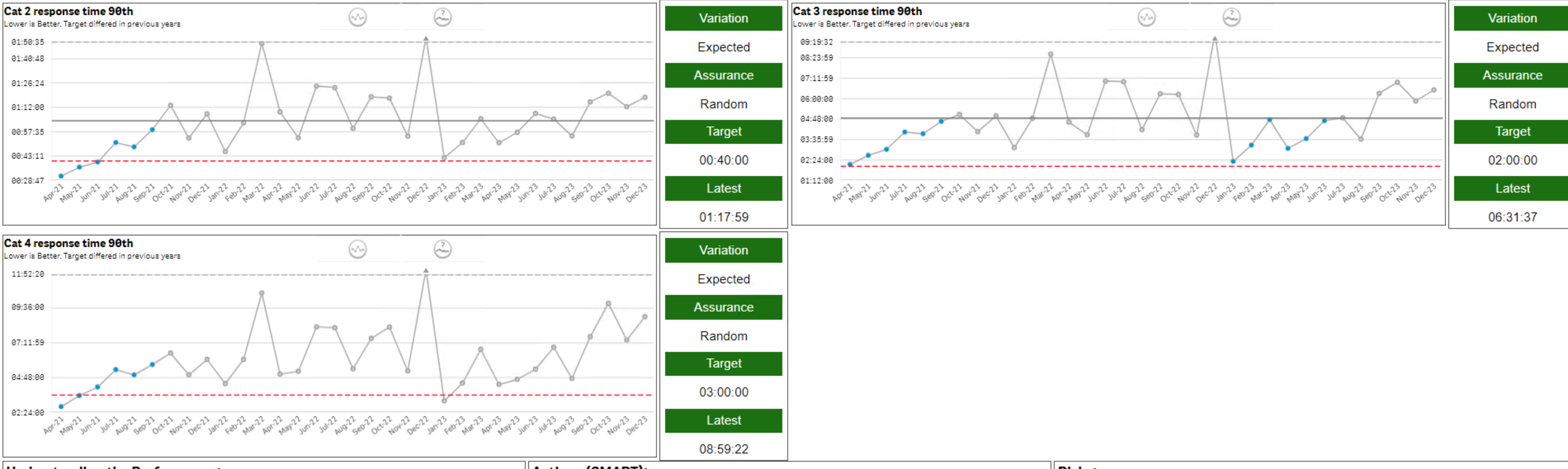
Hours continue to be monitored and managed to maximise productivity. 3 new DCA lines have been added with new PPs to increase resource hours, although these new lines are being ramped up and are not yet at capacity.

Risks:

Handover delays at QA, and low hours from new PP lines

NHS

Operations - 999 - Volume/ARP



Understanding the Performance:

Commensurate with Cat 2 mean, the other categories showed the same trend over the month, ending the month above planned trajectory due to lower than planned resource hours, fleet challenges and high handover delays.

Actions (SMART):

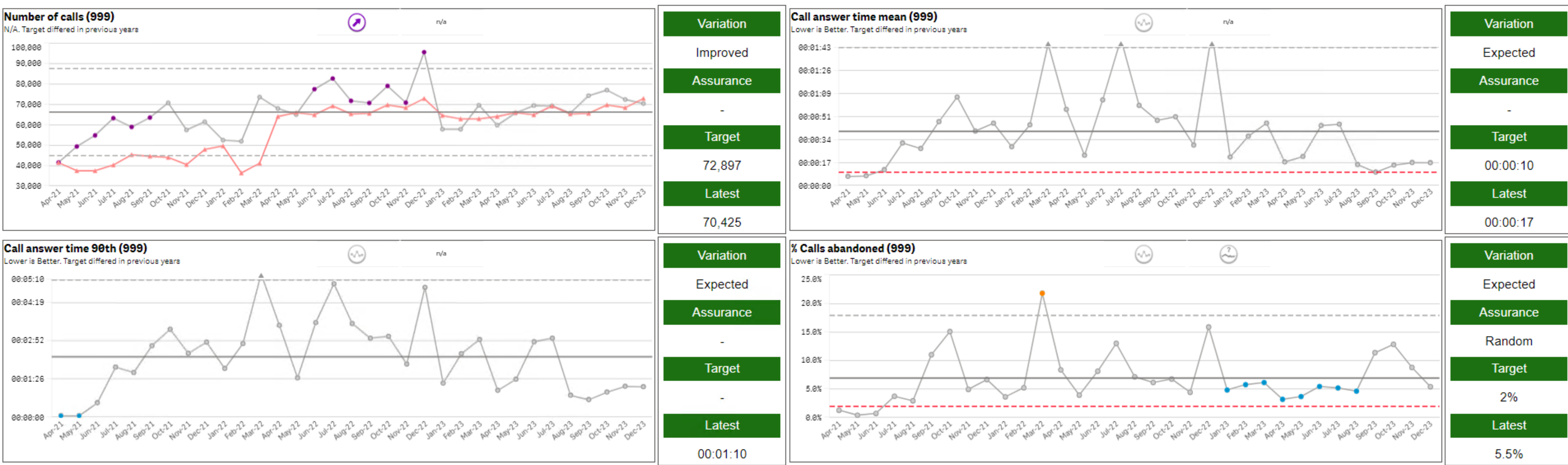
Hours continue to be monitored and managed to maximise productivity. 3 new DCA lines have been added with new PPs to increase resource hours, although these new lines are being ramped up and are not yet at capacity.

Risks:

Demand levels increase above forecast levels requiring additional operational hours. Inability to deliver the required Operational hours from private providers. Increased staff abstraction through higher than forecast sickness levels. Handover delays continue to increase and we do not see the benefit from immediate handover.

NHS

Operations - 999 - Calls and Outcomes



Understanding the Performance:

999 inbound call volumes fell slightly in December, with the number of duplicate calls falling significantly in the middle of the month following improved operational performance. Call answer remained stable, but there was a significant difference in the two halves of the month. There was a 17% drop in demand in the second half of the month which, combined with additional call taking hours saw the average call answer fall from 22 to 11 seconds.

Actions (SMART):

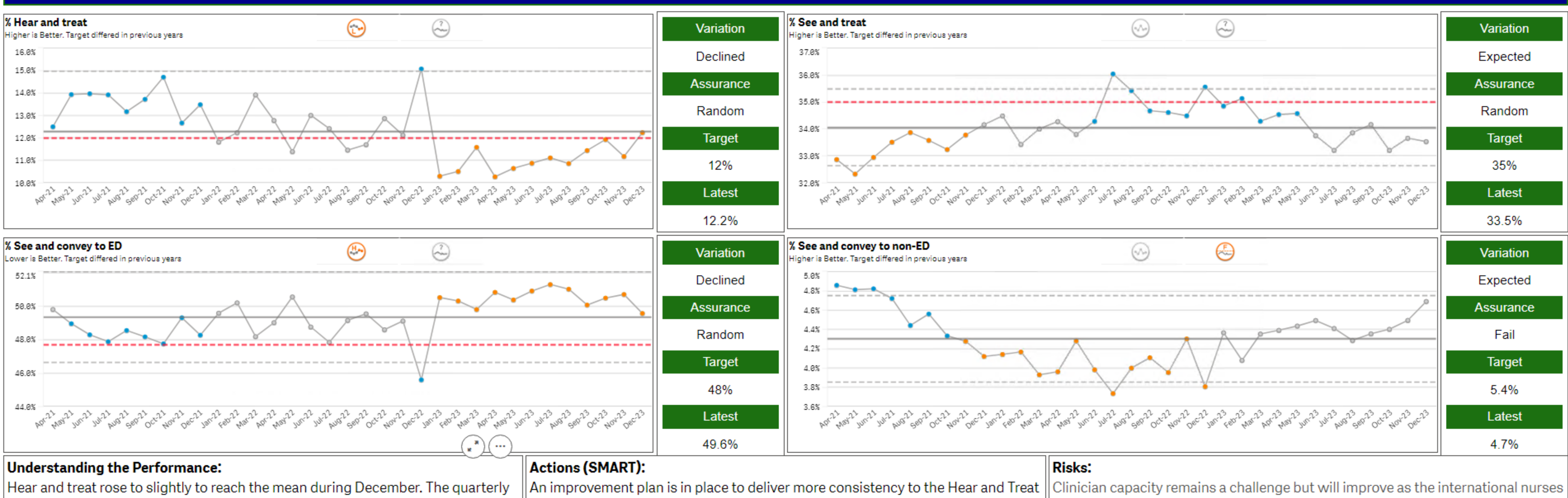
Demand levels over the festive period itself remained lower than planned and coupled with increased ECT staffing during this time with reduced annual leave, kept the mean call answer stable. Average handling time continues to be managed with outliers. West Mids support continues but they are now only taking SCAS calls if the estimated waiting time to be answered is 3 minutes in line with the NHS Digital pilot

Risks:

Demand levels increase above forecast levels requiring additional operational hours. Inability to deliver the required Operational hours from private providers. Increased staff abstraction through higher than forecast sickness levels. Handover delays continue to increase and we do not see the benefit from immediate handover.

NHS

Operations - Calls and Outcomes



Understanding the Performance:

Hear and treat rose to slightly to reach the mean during December. The quarterly target was 12% with the Trust finishing at 11.8%. There was a significant level of variation in daily rates, which was led by the operational pressure experienced on the road. S&T remained below the mean, in part due to higher H&T levels. We had a lower level of conveyance to ED which is now close to mean as well as an increase in conveyance to non ED

Actions (SMART):

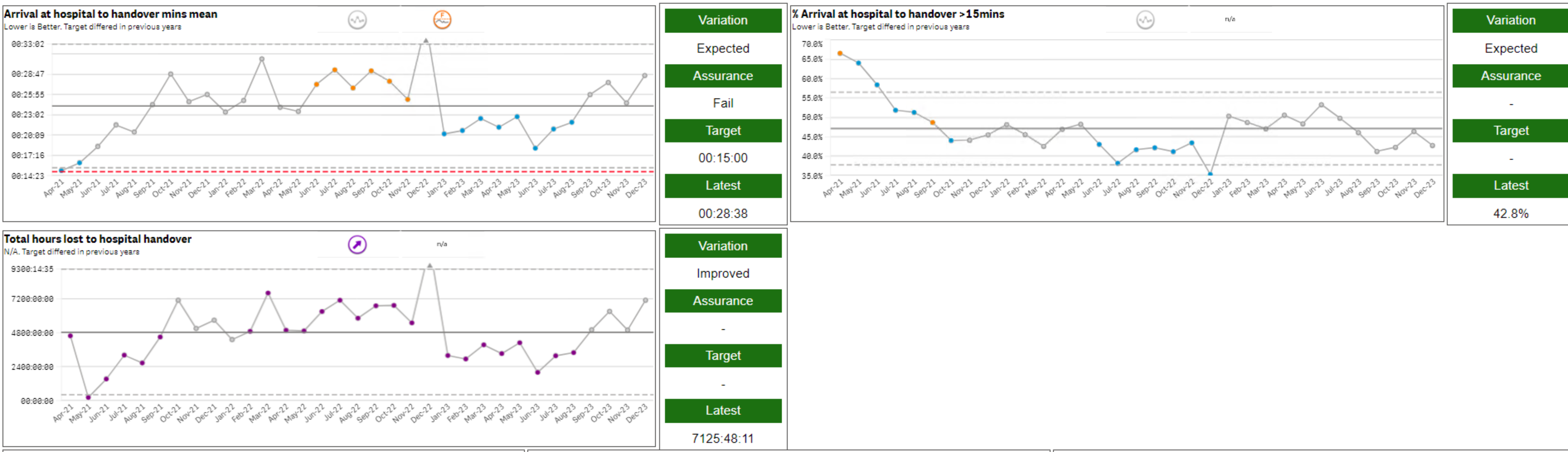
An improvement plan is in place to deliver more consistency to the Hear and Treat out turn whilst maintaining clinical safety . International nurses working through competencies to achieve sign off and progression to band 6 scope of practice. We have embedded a clinical pathways lead in PHT to increase non ED conveyance and ensure staff are conveying appropriate patients.

Risks:

Clinician capacity remains a challenge but will improve as the international nurses are signed off to work at Band 6 level, they are currently band 5 and only manage lower acuity calls. Access to non ED pathways at some acute trusts remain challenged.

NHS

Operations - 999 - System Impacts



Understanding the Performance:

Average handover time increased further in December. We lost 5,221 hours from the 1st to 17th and then 3,092 hours from the 18th to 31st December where most hospitals saw an improvement in delays. The impact on handover delays on cat 2 was 5 minutes against our overall gap to trajectory of 7 minutes 15.

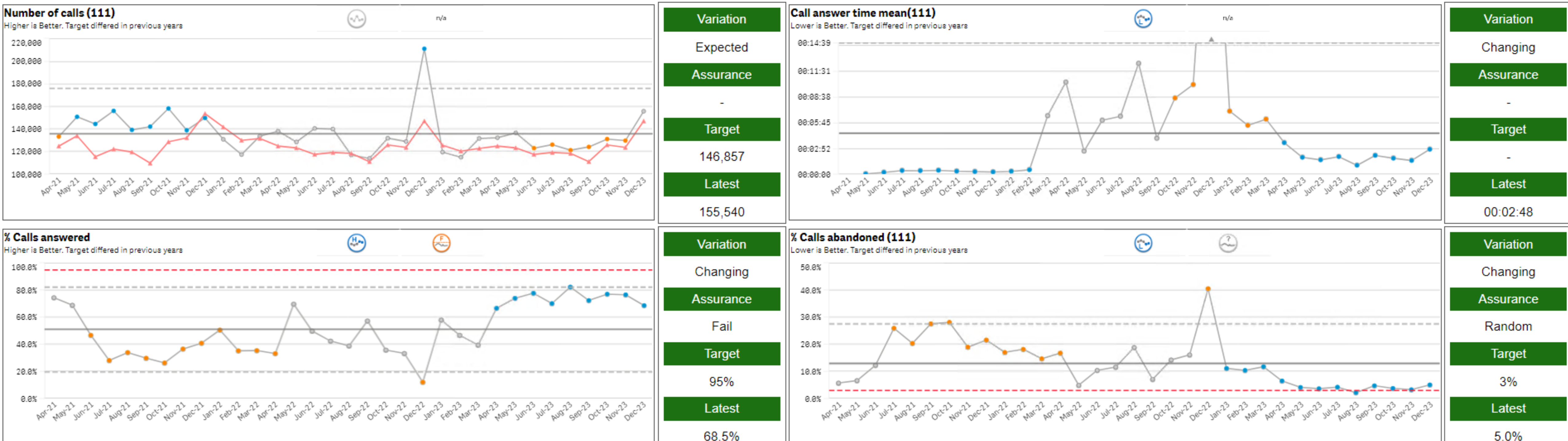
Actions (SMART):

We have issued our immediate handover process to all acute trusts to assist us with releasing crews quicker. This will take a few weeks to bed in at each location and we acknowledge the challenges we will have at PHT with this process. We are working closely with the PHT exec team to ensure we have a safe process where we are protecting patients and staff

Risks:

Lack of support from acute trusts for immediate handover implementation.
Specific challenge with PHT to embed new process

Operations - 111 - Calls and Outcomes



Understanding the Performance:

Calls offered in 111 rose above the mean as one would anticipate in December, with considerable variation in demand across certain days, with some peaks in non bank holiday days. However the increase in logged in hours, improvements in AHT and room management enabled us to sustain above the mean call answer performance reaching 68.18% of calls in 120 seconds, above trajectory but remaining under national target. Abandonment rate (5.84%) and mean call answer time (2 mins 50 secs) remain consistently below the mean and towards the lower end of control limits.

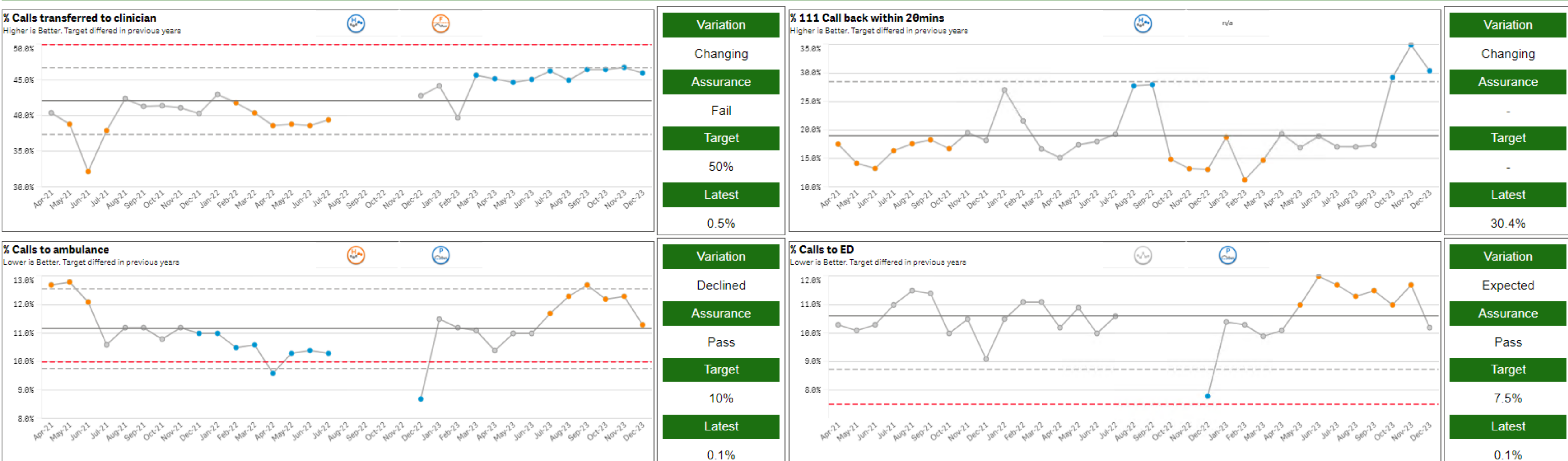
Actions (SMART):

Recruitment and retention remain key focus, working in line with IWP plan, mindful of financial position. Current gap for Health Advisors is 108 WTE against IWP trajectory however offset slightly by improved log in hours and AHT improvements. Recruitment into vacant roster lines continues, due to desk capacity at peak times in SH & Partis House, the focus is on recruitment into NH and increasing home working. Partis House will open 24/7 from end of January 2024 which will enable us to improve roster fill and resilience overnight. We continue with our VASSOS action plan to support improvements in floor management and individual staff metrics. Wellbeing officers and management team continue to support staff to remain well at work, and staff engagement activities are in place.

Risks:

We remain within our busiest period for 111, demand can outstrip capacity resulting in poor call answer performance. There is a risk of long waits for patients/callers at peak times. Increasing seasonal illnesses and COVID may impact demand but also reduce call taking capacity due to increased absence levels.

Operations - 111 - Calls and Outcomes



Understanding the Performance:

Call back from clinician in 20 minutes shows a sharp rise, sitting above upper control limits. This is due to re-mapping of certain disposition codes in line with changes to NHS Pathways earlier this year. Whilst it has increased positively, it remains below target, driven by clinician availability and cat 3 validation timeframe. Transfer to clinician rate is consistent at 45% continuing below target due to IUC make up in TV. The graph demonstrates ED transfer to all ED Types 1-4. ED transfer rates to Type 1/2 are 5.5%. 73% of ED dispositions are validated with 43% offered alternative pathways. 999 transfer rates have dropped below the mean underpinned by a reduction in category 2 referral rates. Validation rates remain strong 93% validated with 60% offered alternative pathways.

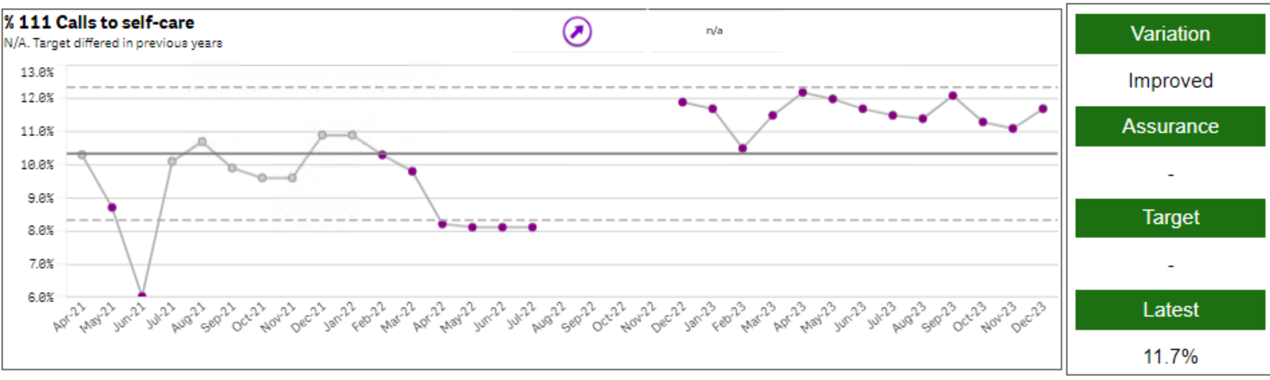
Actions (SMART):

Recruitment of clinicians continues in line with IWP, current gap 30 WTE. International nurses are in training with a further 7 expected at end of January. Continued operational focus on call backs in 20 minutes to improve this metric. Review of clinical floorwalking demonstrates benefits and this needs to be factored into next year's model for clinical advisors. Review of symptom groups and discriminators being sent for ED validation via the DOS is underway, to reduce volume going in to better match capacity but also provide less touchpoints for certain cohorts of patients, where clinical telephone review adds no further value.

Risks:

Through winter demand may outstrip capacity with seasonal illnesses prevalent, this may result in longer waits for call backs.

Operations - 111 - Calls and Outcomes



Variation
Improved
Assurance
-
Target
-
Latest
11.7%

Understanding the Performance:

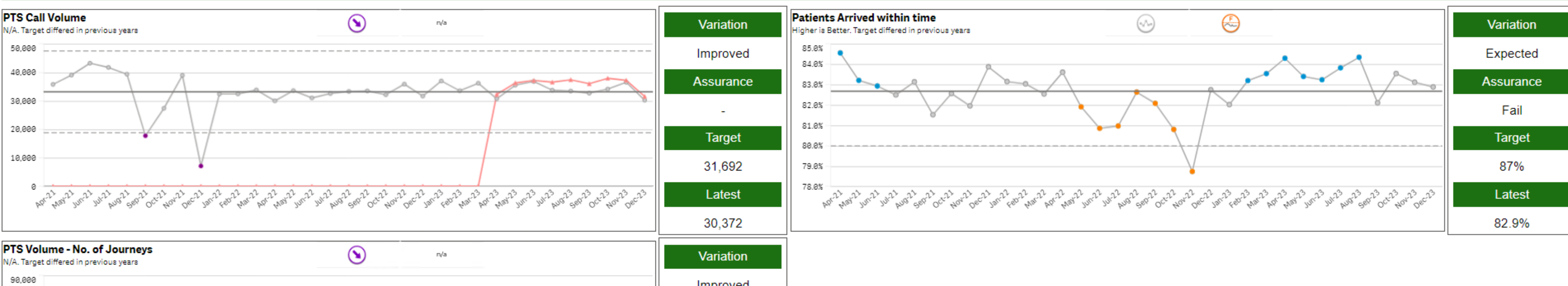
The data in the above chart demonstrates the self care disposition reached by Health Advisors. The national metric which this data should reflect is self care reached following clinical intervention which for SCAS is 11% currently below national target of 15%.

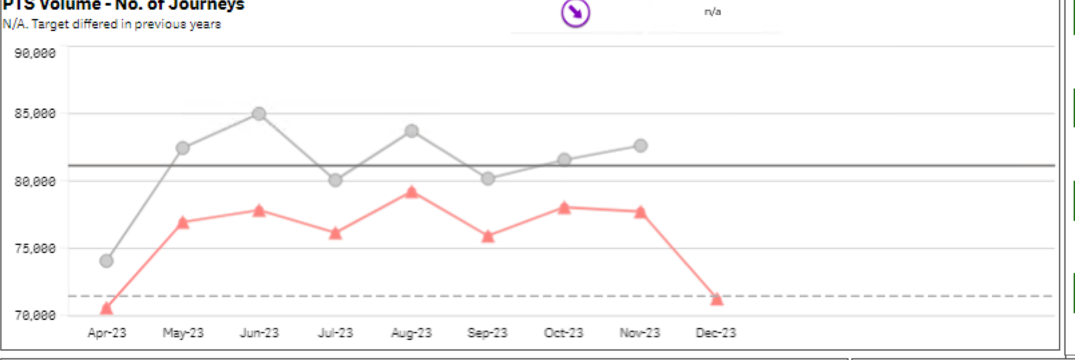
Actions (SMART):

Work with BI to ensure data presented reflects national metric.

Risks:

Operations - PTS - Calls and Outcomes





Variation

Improved

Assurance

-

Target

71,242

Latest

Understanding the Performance:

- Call volumes and PTS volumes decreased from the previous month due to reduced demand through the Christmas break as expected and budgeted. This is mostly due to reduced outpatients between Christmas and New Year.
- There has been a small reduction of Non-Essential outpatients following the introduction of a more robust eligibility criteria in 2 contracts.
- Arrival performance continues around the mean levels, many of those outside of the KPI window are due to dropping the patient off slightly earlier.

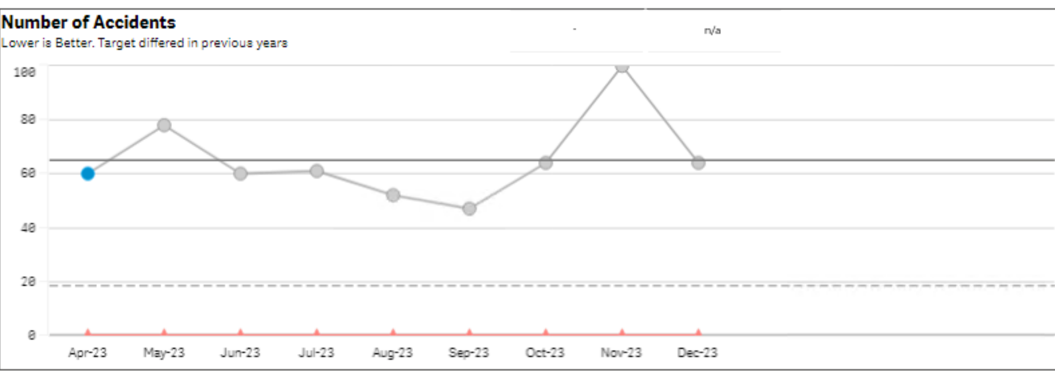
Actions (SMART):

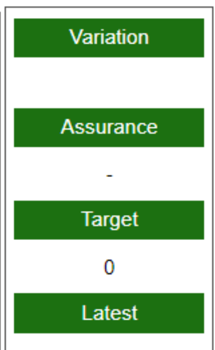
- On going review of recent initiatives introduced for demand and resourcing and as such any cost saving. Currently in one contract activity has slightly reduced in totality but the acuity mix has increased which was a known risk as patients try to get through the more robust eligibility criteria.
- Introduction of a cap of eligibility attempts is being introduced mid January, this is expected to reduce demand at least initially due to the inability for callers to attempt multiple combinations to pass through the criteria. This will start at a cap of 2 attempts and reduce to 1 after 1 month. There will be escalation process in place.
- Continue to review the rate cards and costs of Taxi providers taking improvements forward through the planning teams to try and reduce costs/spends.

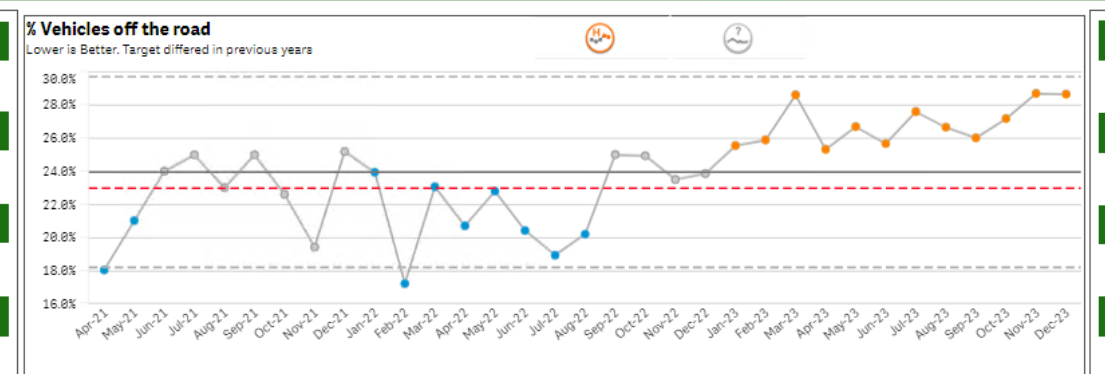
Risks:

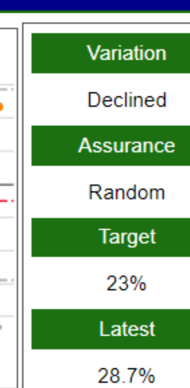
- Continued activity increases in some of the contracts
- Continued underfunding of the PTS contracts
- Staffing challenges within some contracts due to uncertainty of the future of PTS/known loss of contract
- Winter pressures, increase in sickness

Operations - Fleet









Understanding the Performance:

VOR rates have remained 5% above target in December. This is due to our ageing fleet due to the delays in the delivery of the new replacement vehicles. December also saw our highest level of utilisation of our fleet as we maximised our operational hours to meet the predicted demand levels. This put additional pressure on the fleet team to repair vehicles and keep them in operation. The higher utilisation led to vehicles not having time to charge on station which led to a higher battery failure rate. We have also experienced on going delays with the supply of parts for the Fiat Ambulances.

Actions (SMART):

Delivery of the first of the 53 new DCAs should commence from late February and these will be fed into the fleet as quickly as possible. The fleet team have also increased capacity for mobile fitters to carry out on site repairs

Risks:

Further delays in fleet delivery will impact on SCAS operational hours . Continuing higher utilisation of fleet will continue to drive pressure into SCFS

Quality and Safety

Quality & Safety – Core Measures Matrix

December-23 Summary

Assurance → Fail / Hit and Miss / Pass

Variance ↓

Variance	Fail	Hit and Miss	Pass	No Target
Special cause – high (concerning)				
Special cause – low (concerning)		Safeguarding Adults Level 1 Safeguarding Children Level 1		
Common cause		16		
Special cause – low (improving)				
Special cause – high (improving)				
Trend up				
Trend down		Number of Never Events (CQC/NRLS reportable)		1

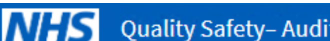
Metrics:

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

Quality Safety– Core Measures Icon Summary

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Building cleanliness %	Dec-23	100.0%	95%			82.6%	49.3%	115.9%
Cleanliness%	Dec-23	98.3%	95%			95.8%	87.5%	104.1%
Hand Hygiene %	Dec-23	98.8%	95%			98.2%	89.5%	106.9%
Vehicle cleanliness %	Dec-23	96.2%	96%			95.0%	82.8%	107.2%
Complaints	Dec-23	22			n/a	27.1	4.1	50.1
Compliments	Dec-23	0.2%	26%			0.2%	0.2%	0.3%
Patient Safety Incidents	Dec-23	504		-	n/a	425	273	577
Moderate and above Incidents	Dec-23	28		-	n/a	19	8.36	29.6
Serious Incidents	Dec-23	10		-	n/a	6.44	-3.53	16.4
CD unaccounted for losses	Dec-23				n/a	15.3	-12.5	43
STEMI Call to angio Mean	Dec-23		2.04			9.2%	7.1%	11.3%
Stroke Call to hosp arr Mean	Dec-23		1.17			6.4%	4.7%	8.1%
ROSC on hospital arrival (All) %	Dec-23			-	n/a	23.8%	21.6%	25.9%
CA survival at 30days (All) %	Dec-23			-	n/a	7.1%	3.9%	10.3%
Safeguarding Level 1 (Adult) %	Dec-23	86.8%	95%			92.7%	89.0%	96.3%
Safeguarding Level 1 (Child) %	Dec-23	86.7%	95%			92.4%	89.0%	95.9%



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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of building cleanliness completed audits	Dec-23	15	21			29.4	1.13	57.7
Building cleanliness %	Dec-23	100.0%	95%			82.6%	49.3%	115.9%
Number of cleanliness compliance audits	Dec-23	352	449			352	102	602
Cleanliness%	Dec-23	98.3%	95%			95.8%	87.5%	104.1%
Number of hand hygiene audit	Dec-23	258	261			217	8.77	426
Hand Hygiene %	Dec-23	98.8%	95%			98.2%	89.5%	106.9%
Number of vehicle cleanliness completed audits	Dec-23	79	167			105	-7.38	218
Vehicle cleanliness %	Dec-23	96.2%	96%			95.0%	82.8%	107.2%

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Call to angio Mean	Dec-23		02:04			02:12	01:42	02:42
STEMI Call to angio 90th	Dec-23		02:53			03:06	01:52	04:19
Stroke Call to hosp arr Mean	Dec-23		01:17			01:32	01:07	01:57
Stroke Call to hosp arr Median	Dec-23		01:07			01:18	01:03	01:32
Stroke Call to hosp arr 90th	Dec-23		01:57			02:24	01:29	03:18
ROSC on hospital arrival (All) %	Dec-23			-	n/a	23.8%	21.6%	25.9%
ROSC on hospital arrival (Utstein cohort) %	Dec-23			-	n/a	49.3%	30.3%	68.4%
CA survival at 30days (All) %	Dec-23			-	n/a	7.1%	3.9%	10.3%
CA survival at 30days - Utstein cohort%	Dec-23		26%			27.3%	4.5%	50.0%

Quality Safety– Complaints and Compliments

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Complaints	Dec-23	22			n/a	27	4.1	50
Complaints per 1000 completed patient contacts	Dec-23	18.0%		-	n/a	19.3%	16.7%	22.0%
Complaints within agreed timescales	Dec-23	100.0%	95%	-		97.0%	88.7%	105.3%
Compliments	Dec-23	0.2%	26%			0.2%	0.2%	0.3%

Quality Safety– Incidents

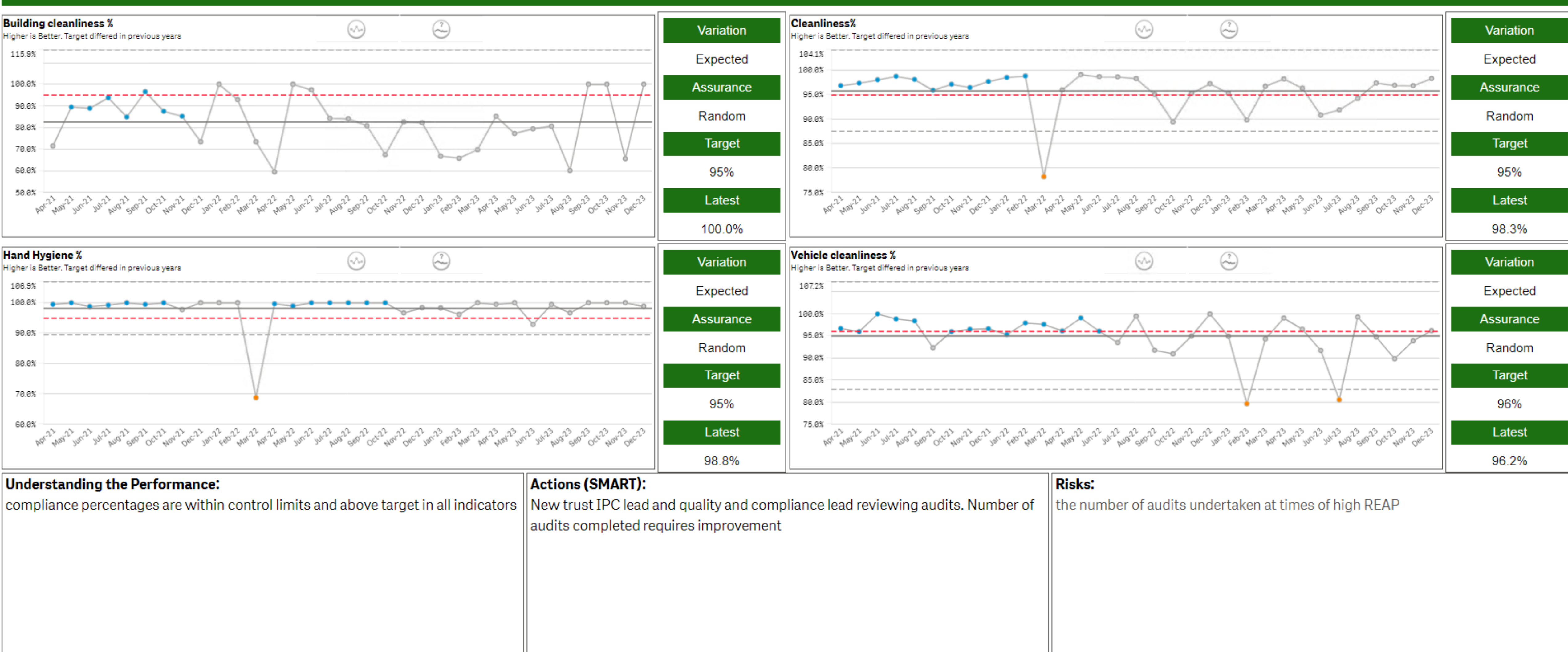
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Patient Safety Incidents	Dec-23	504		-	n/a	425	273	577
Non-Patient Safety Incidents	Dec-23	362		-	n/a	382	336	429
Moderate and above Incidents	Dec-23	28		-	n/a	19	8.36	29.6
Number of no/low incidents	Dec-23	478		-	n/a	412	249	576
Serious Incidents	Dec-23	10		-	n/a	6.44	-3.53	16.4
RIDDOR reportable incidents	Dec-23	8		-	n/a	9.78	2.13	17.4
% Medicines modules produced without error	Dec-23			-	n/a	93.3%	80.0%	106.6%
CD unaccounted for losses	Dec-23				n/a	15.3	-12.5	43
Number of days stock available	Dec-23			-	n/a	1.9	0.836	2.96

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Safeguarding Level 1 (Adult) %	Dec-23	86.8%	95.0%			92.7%	89.0%	96.3%
Safeguarding Level 1 (Child) %	Dec-23	86.7%	95.0%			92.4%	89.0%	95.9%
Safeguarding Level 2 (Adult) %	Dec-23							
Safeguarding Level 2 (Child) %	Dec-23							
Safeguarding Level 3 (Adult) %	Dec-23	70.2%	95.0%	-		46.9%	31.4%	62.5%
Safeguarding Level 3 (Child) %	Dec-23	0.0%	-			-	-	-

Quality & Safety - Audits

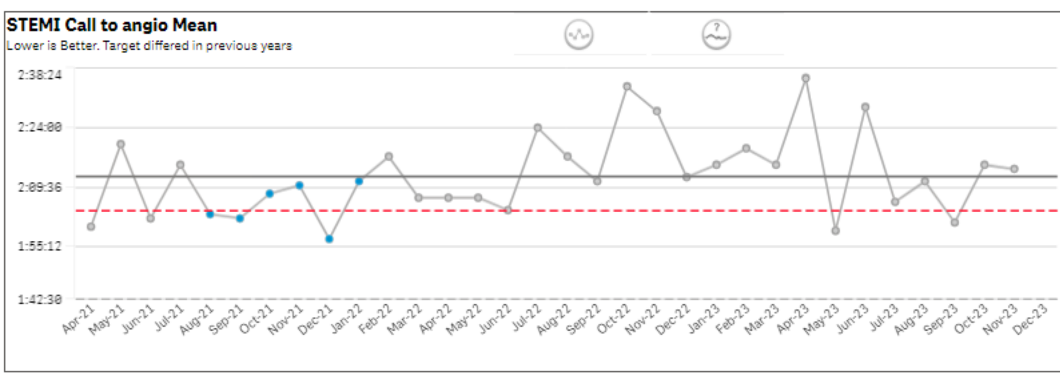


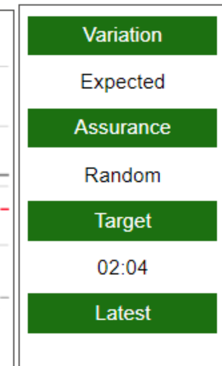
Understanding the Performance:
compliance percentages are within control limits and above target in all indicators

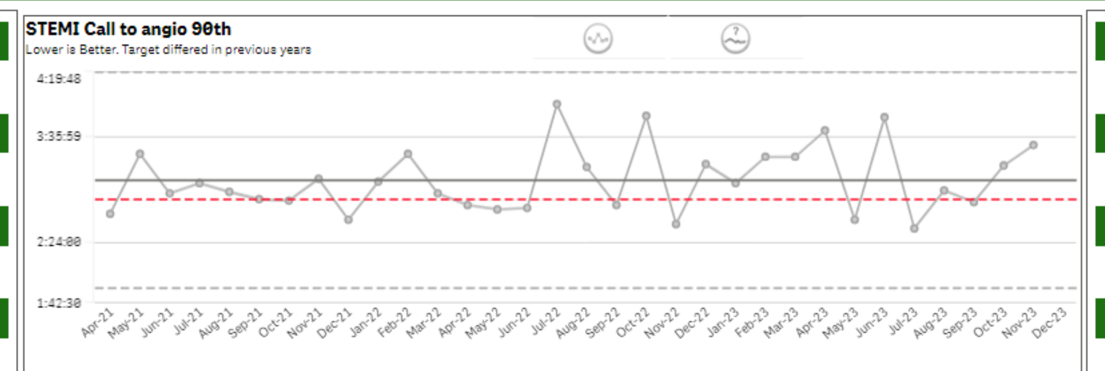
Actions (SMART):
New trust IPC lead and quality and compliance lead reviewing audits. Number of audits completed requires improvement

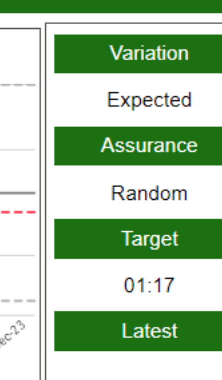
Risks:
the number of audits undertaken at times of high REAP

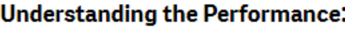
Quality & Safety – AQIs – STEMI










Understanding the Performance:

STEMI call to angiography within variation

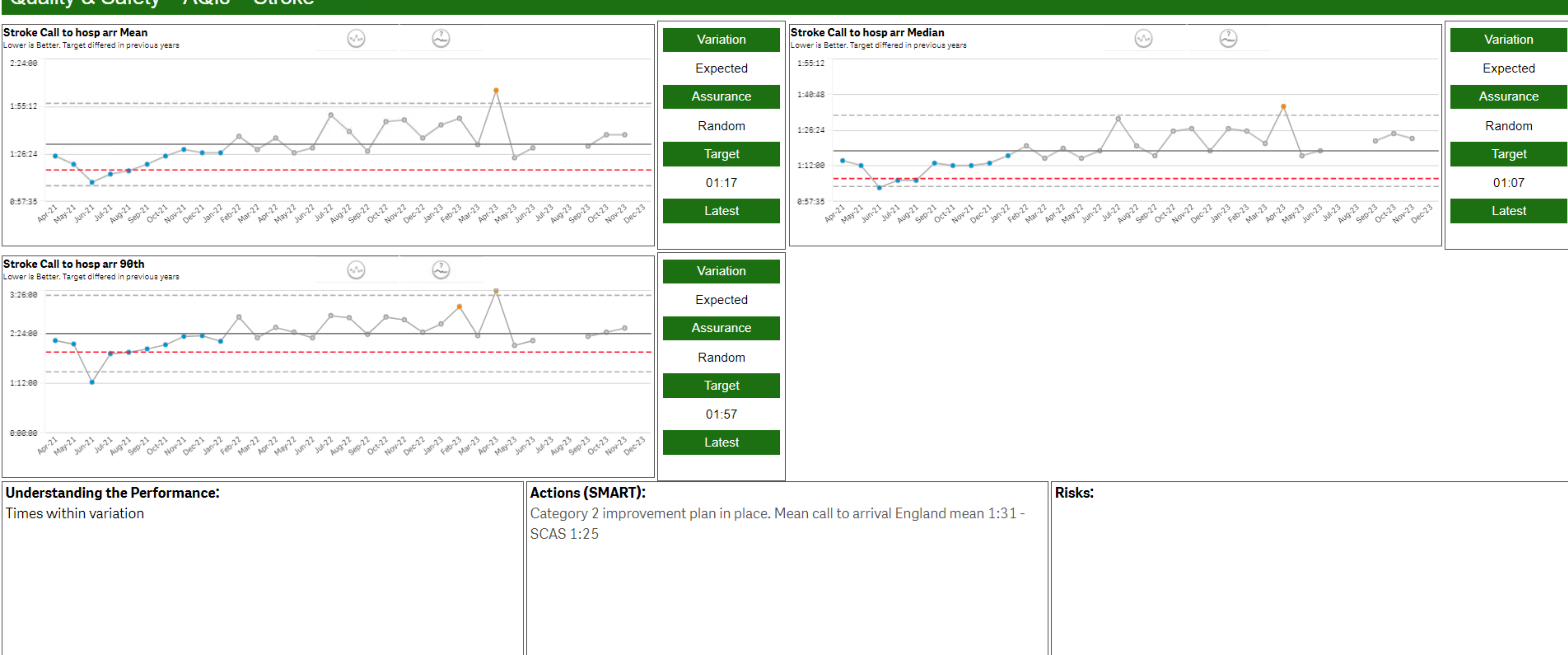
Actions (SMART):

Category 2 call improvement programme in place. England mean 2:24 - SCAS 2:21

Risks:

NHS

Quality & Safety – AQIs – Stroke



Understanding the Performance:

Times within variation

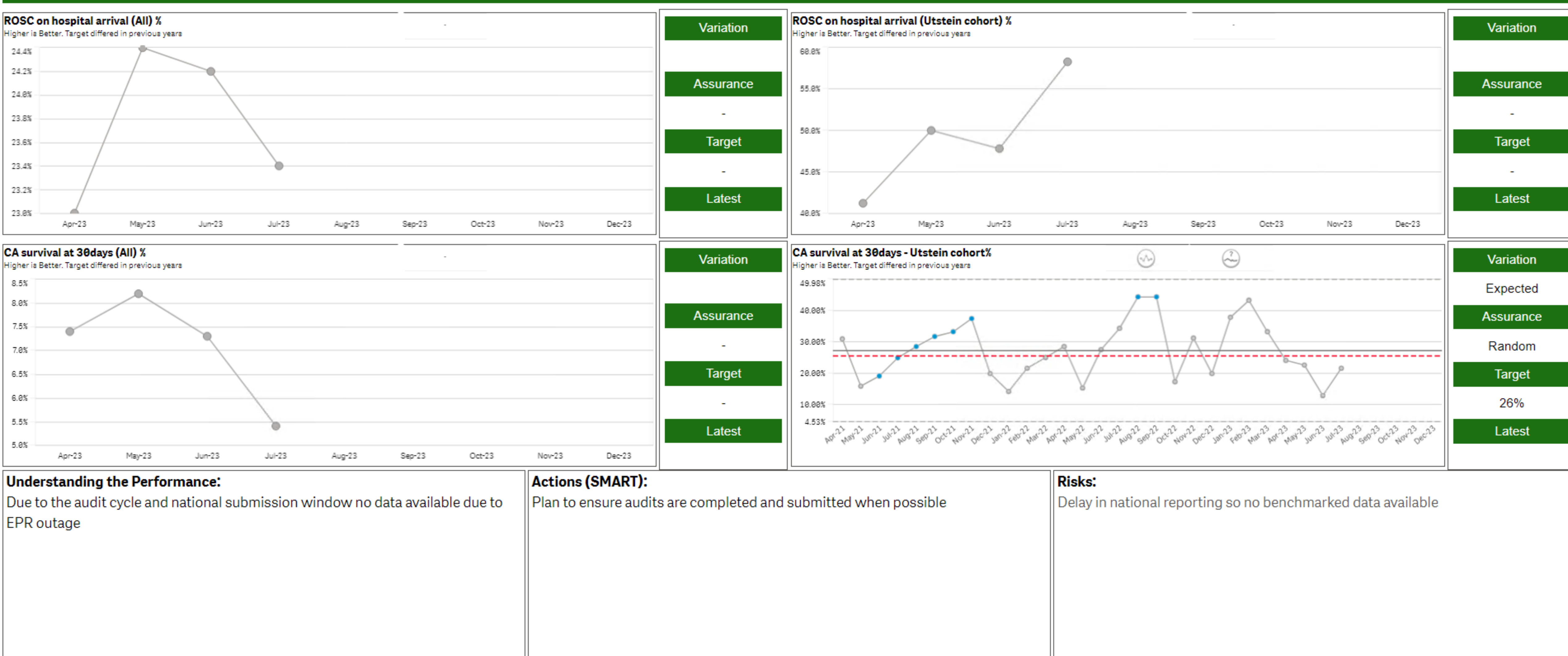
Actions (SMART):

Category 2 improvement plan in place. Mean call to arrival England mean 1:31 - SCAS 1:25

Risks:

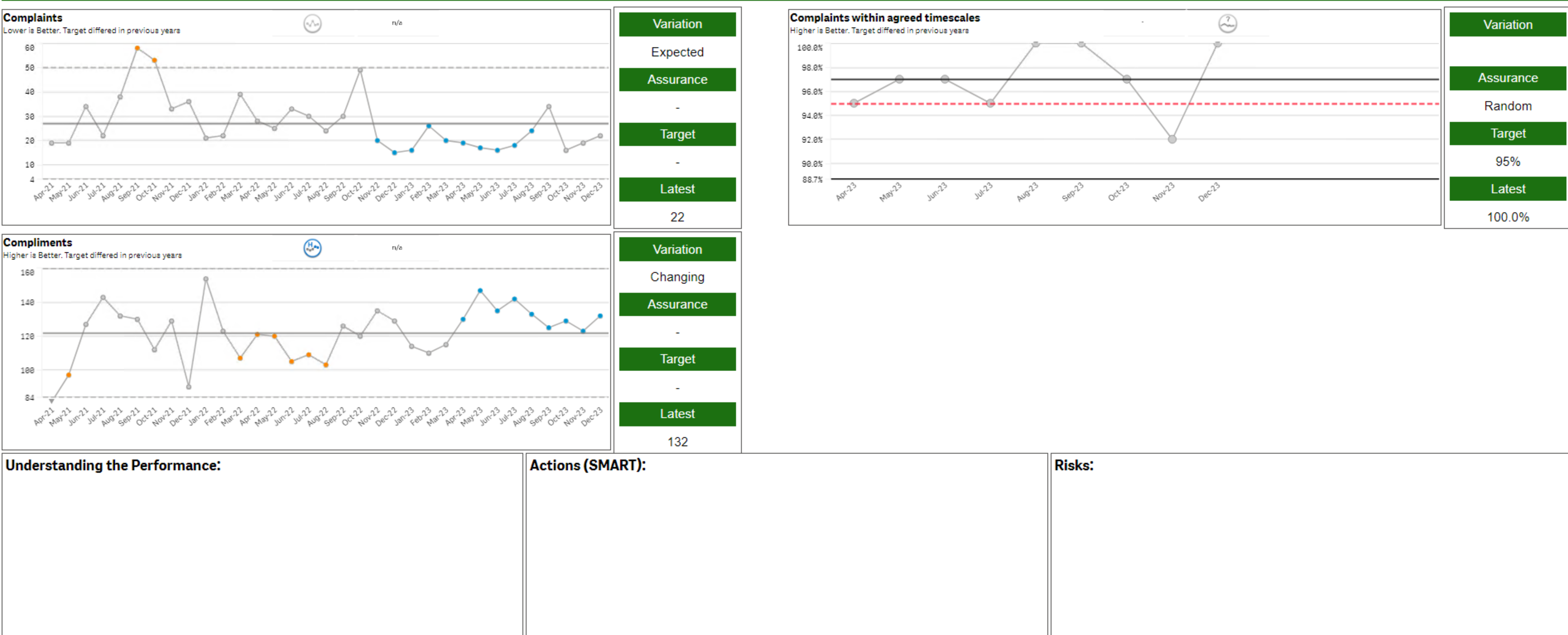
NHS

Quality & Safety – AQIs – Cardiac



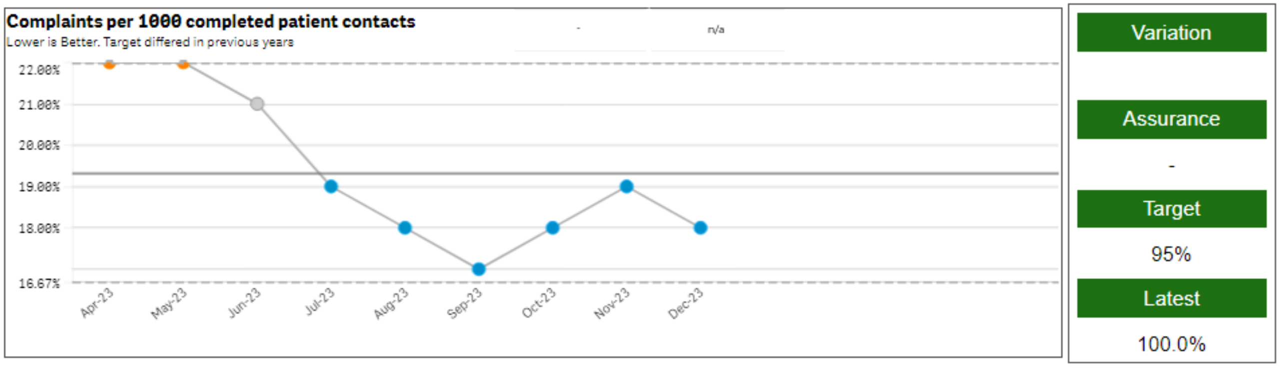
NHS

Quality & Safety – Complaints and Compliments 1



NHS

Quality & Safety – Complaints and Compliments 2



Variation
Assurance
-
Target
95%
Latest
100.0%

Understanding the Performance:

Actions (SMART):

Risks:

Quality & Safety – Incidents

Patient Safety Incidents
Lower is Better. Target differed in previous years

Variation	
Assurance	-
Target	-
Latest	504

Non-Patient Safety Incidents
Lower is Better. Target differed in previous years

Variation	
Assurance	-
Target	-
Latest	362

RIDDOR reportable incidents
Lower is Better. Target differed in previous years

Variation	
Assurance	-
Target	-
Latest	8

Moderate and above Incidents
Lower is Better. Target differed in previous years

Variation	
Assurance	-
Target	-
Latest	28

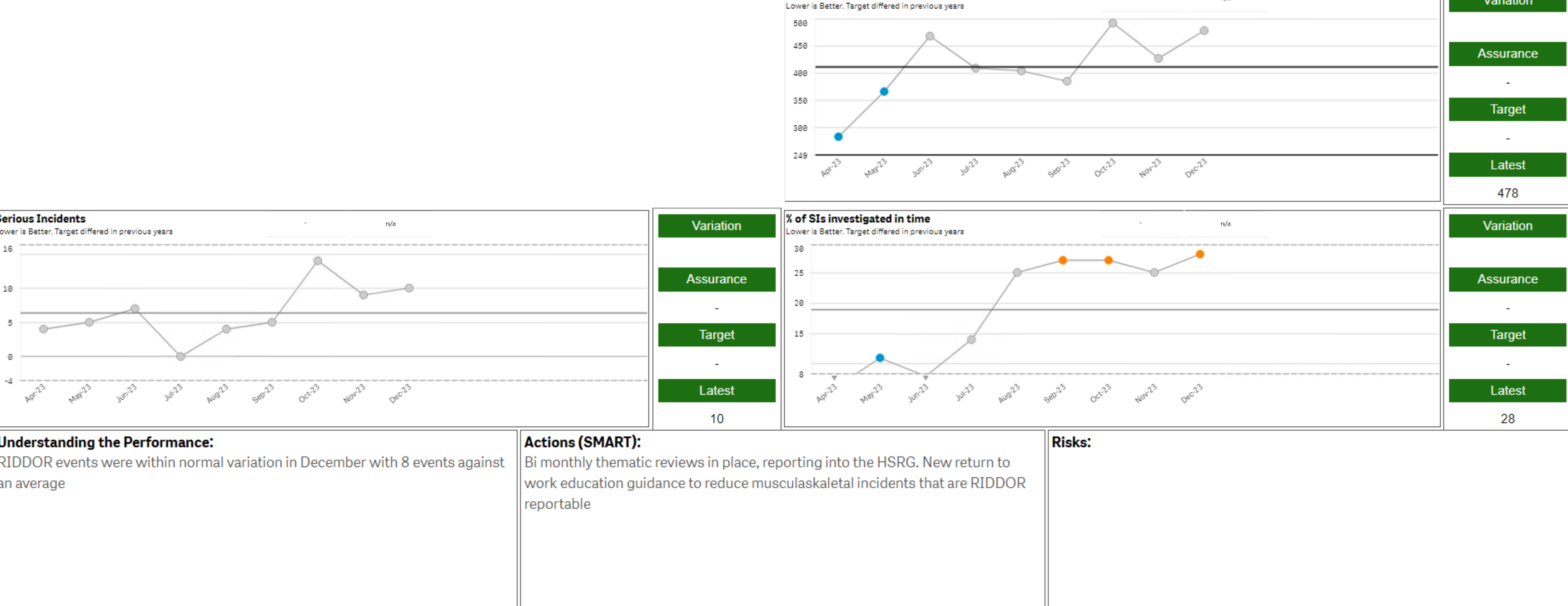
Understanding the Performance:
December seen increase in the overall number of patient safety incidents December has seen the most Patient safety incidents reported in a month this financial year. this may be attributable to winter pressures seen across the system. 10 SIs were identified in December (70%) of the SIs declared were in relation to Delay majority of which were identified as system SIs. 1 SI declared was in relation to chest pain DOS with a re attendance within 24 hrs. The 8th SI declared is in relation to a safeguarding referral not sent due to a problem within DOCworks. there are currently 35 ongoing SI investigations 42% are in relation to Delay. All statutory Duty Of Candour requirements were met within the 10 day time frame in the month of December.

Actions (SMART):
All delay SIs are bench marked against the delays thematic analysis if they meet the criteria they are managed in accordance with the ICB approved templated report and response

Risks:
Continued competing priorities for the AD safety / PSIRF Lead the Trust will see delays in deadlines and time scales for the implementation of PSRIF

NHS

Quality & Safety – Incidents



Understanding the Performance:

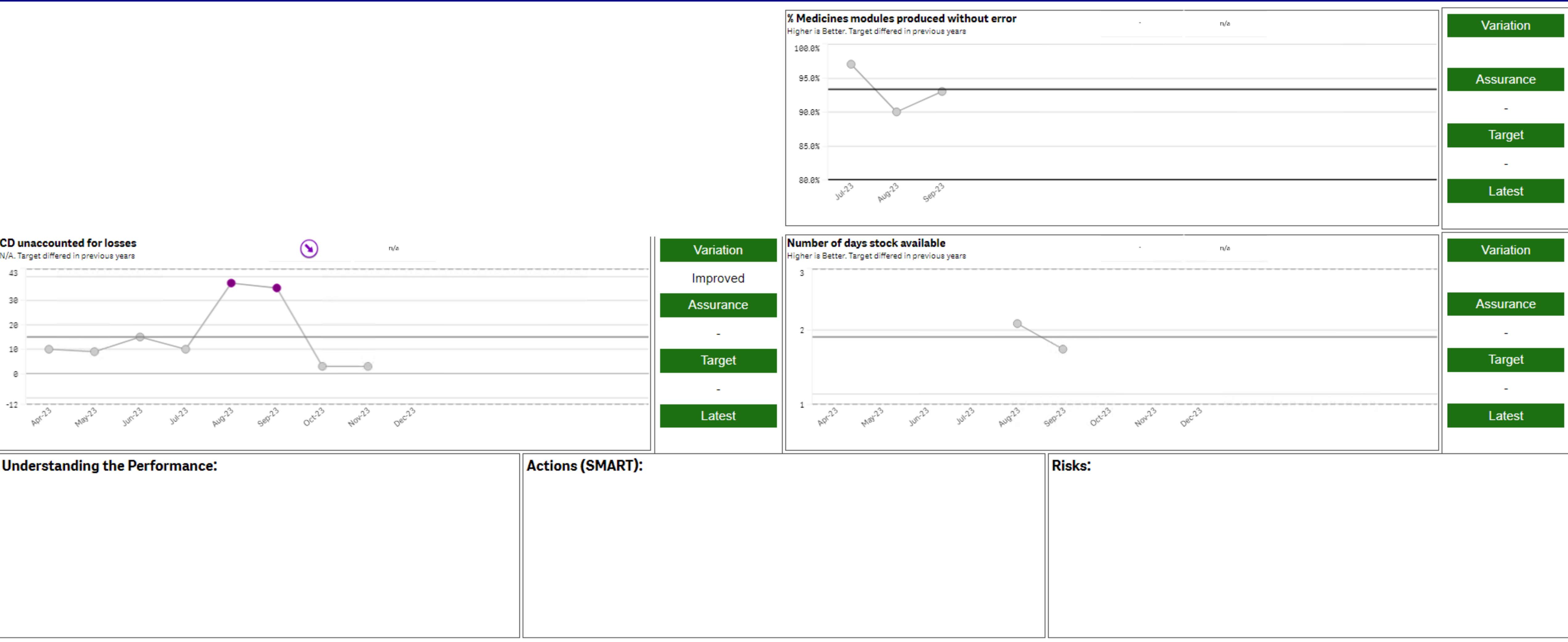
RIDDOR events were within normal variation in December with 8 events against an average

Actions (SMART):

Bi monthly thematic reviews in place, reporting into the HSRG. New return to work education guidance to reduce musculaskaletal incidents that are RIDDOR reportable

Risks:

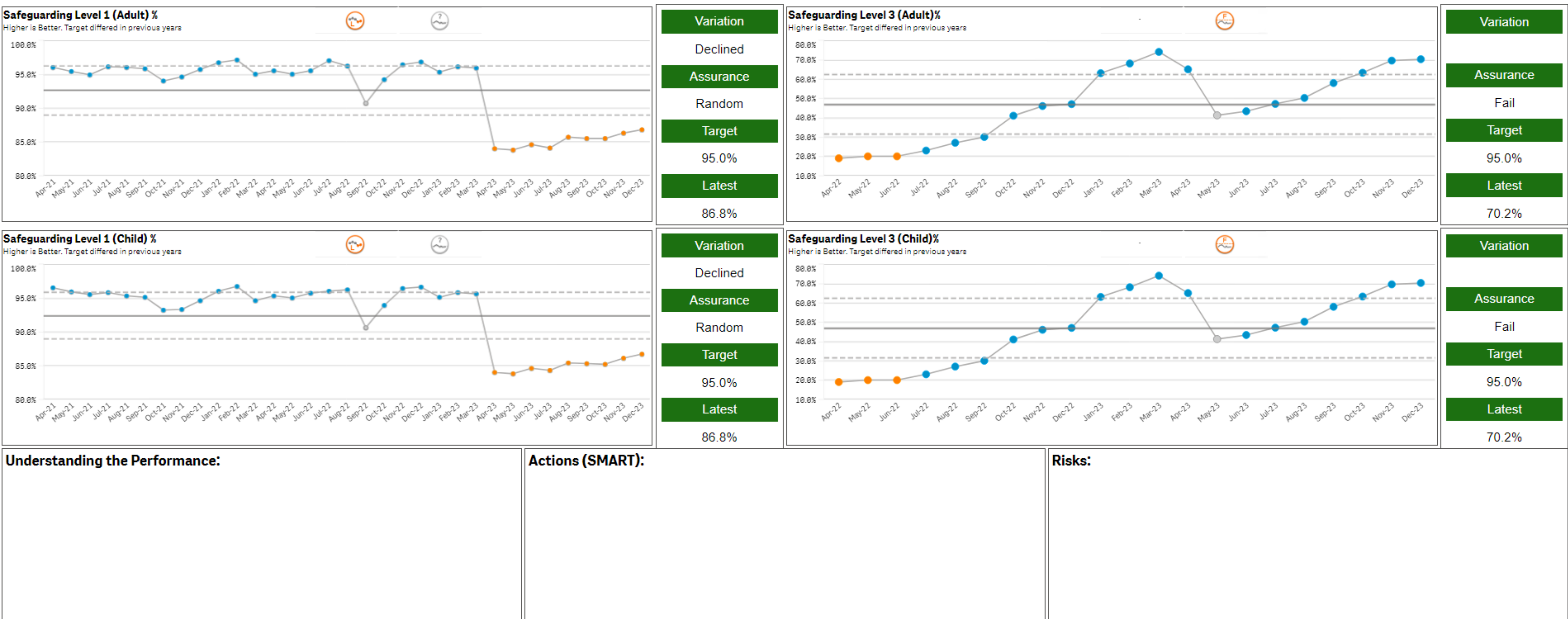
Quality & Safety – Incidents



Understanding the Performance:

Actions (SMART):

Risks:



Understanding the Performance:

Actions (SMART):

Risks:

NHS

Workforce

Workforce Overview

December-23 Summary

Metrics:

Assurance

Variance

	Fail	Hit and Miss	Pass	No Target
H				
L	Fire Awareness Information Governance	Equality & Diversity Health & Safety Infection Control Manual Handling		1
	Appraisals - Trust Meal Break Compliance - SCAS	EOC External Attrition		17
L		EOC Internal Attrition		6
H	Conflict Management			3
		Number of Non-Physical Assaults Number of Physical Assaults		3
				8

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Dec-23	4,323			n/a	4286.4	4234.1	4338.7
% Trust staff who are BAME	Dec-23	6.0%			n/a	5.1%	4.5%	5.6%
% Trust staff who are declared disabled	Dec-23	7.0%			n/a	6.0%	5.0%	7.0%
% Turnover	Dec-23	17.8%			n/a	18.8%	17.3%	20.2%
Number of joiners in month	Dec-23	26			n/a	71.0	20.2	121.7
Number of leavers in month	Dec-23	49			n/a	56.3	35.8	76.8
% Vacancy	Dec-23	9.8%			n/a	10.6%	9.5%	11.7%
Over-runs >30 mins - SCAS	Dec-23	19.7%	33%	-		23.4%	18.1%	28.7%
Meal Break Compliance - SCAS	Dec-23	46.2%	85%			55.3%	36.4%	74.3%

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
% Sickness in month	Dec-23	6.6%			n/a	6.2%	5.6%	6.8%
% Long term sickness	Dec-23	3.9%			n/a	3.7%	3.4%	3.9%
Mental Health	Dec-23	23.2%			n/a	24.6%	17.9%	31.4%
Musculoskeletal	Dec-23	15.8%			n/a	22.7%	9.2%	36.2%
Infectious diseases	Dec-23	2.1%			n/a	11.6%	-1.9%	25.1%
Gastrointestinal	Dec-23	9.4%			n/a	9.5%	7.9%	11.1%
Other Reasons	Dec-23	30.6%			n/a	30.6%	25.7%	35.4%

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Appraisals - Trust	Dec-23	75.2%	95%			74.0%	64.4%	83.6%
Manual Handling	Dec-23	88.1%	95%			93.0%	89.6%	96.3%
Health & Safety	Dec-23	88.0%	95%			93.2%	90.2%	96.2%
Equality & Diversity	Dec-23	88.1%	95%			93.3%	90.2%	96.5%
Conflict Management	Dec-23	57.8%	95%			82.8%	74.5%	91.2%
Infection Control	Dec-23	88.3%	95%			94.1%	90.8%	97.3%
Fire Awareness	Dec-23	88.7%	95%			90.2%	86.0%	94.4%
Information Governance	Dec-23	89.4%	95%			90.0%	85.4%	94.7%

Workforce - Staff in Post

Number of WTE
Higher is Better. Target differed in previous years

n/a

Variation	Assurance	Target	Latest
Changing	-	-	4322.7

% Trust staff who are BAME
N/A. Target differed in previous years

n/a

Variation	Assurance	Target	Latest
Improved	-	-	6.0%

% Trust staff who are declared disabled
N/A. Target differed in previous years

n/a

Variation	Assurance	Target	Latest
Improved	-	-	7.0%

Understanding the Performance:
The number of staff in post were lower - as expected - for the end of December compared with November. This is because we don't have a lot of new starters in December, but we still have leavers. This is built into the plan and happens each year. Focus is on making sure that we have the right staff in the right places. Whilst the graphs for the BAME and Disability figures look like the numbers have changed hugely, please note the scales and the changes are only by around 1 percentage point and therefore not significant.

Actions (SMART):
We are focussing on bringing in clinical or patient facing staff. Courses have been cancelled for some non-clinical roles (ECAs) and vacancy authorisation has been tightened up for non-patient facing positions. Backfill for leavers of corporate staff is not guaranteed. We continue to work on our attraction methodology for widening participation and making our roles as attractive and available to all our communities. This includes using specialist media advertising to increase awareness in our BAME communities about our roles.

Risks:
It is very difficult to attract clinical staff due to a national shortage of paramedics and nurses. International recruitment is helping, but is costly and takes longer than domestic recruitment. A combination of recruitment and retention is required. We would like to do more engagement work with local communities but resources are limited and are being prioritised carefully, therefore there is a risk that we will see no significant change in our BAME or disabled staff numbers in the coming months.

Workforce – Sickness/Absence

% Sickness in month

Lower is Better. Target differed in previous years

n/a

6.6%
6.4%
6.2%
6.0%
5.8%
5.6%

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

Variation
Expected
Assurance
-
Target
-
Latest
6.6%

% Long term sickness

Lower is Better. Target differed in previous years

n/a

3.9%
3.8%
3.7%
3.6%
3.5%
3.4%
3.3%

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

Variation
Expected
Assurance
-
Target
-
Latest
3.9%

Mental Health

N/A. Target differed in previous years

n/a

30.0%
28.0%
26.0%
24.0%
22.0%
20.0%

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

Variation
Improved
Assurance
-
Target
-
Latest
23.2%

Musculoskeletal

N/A. Target differed in previous years

n/a

40.0%
35.0%
30.0%
25.0%
20.0%
15.0%

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

Variation
Improved
Assurance
-
Target
-
Latest
15.8%

Understanding the Performance:

Sickness remains within the expected levels of variation, cold coughs, chest and respriartory problems have increased which is normal considering we are in the Winter season.

Actions (SMART):

Proactive interventions around mental health and musculoskeletal conditions continue (e.g. access to physiotherapy), sickness continues to be monitored and welfare checks are put in place for absent employees.

Risks:

Covid and the spread of covid remains a risk in terms of short term sickness as it continues to be prevalent in the community.

Workforce – Sickness/Absence

Infectious diseases
N/A. Target differed in previous years

Variation
Improved
Assurance
-
Target
-
Latest
2.1%

Gastrointestinal
N/A. Target differed in previous years

Variation
Improved
Assurance
-
Target
-
Latest
9.4%

Other Reasons
N/A. Target differed in previous years

Variation
Improved
Assurance
-
Target
-
Latest
30.6%

Understanding the Performance:
Infectious diseases has decreased significantly, this may be a reflection that staff are building an immunity to some infectious diseases such as Covid.

Actions (SMART):
Continue to support staff absent and welfare with the aim of supporting them to return to the workplace as soon as they are able.

Risks:

Workforce – Turnover/Vacancy

% Turnover
N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Improved	-	-	17.8%

Number of joiners in month
N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Improved	-	-	25.5%

Number of leavers in month
N/A. Target differed in previous years

Variation	Assurance	Target	Latest
Improved	-	-	48.6

% Vacancy
N/A. Target differed in previous years

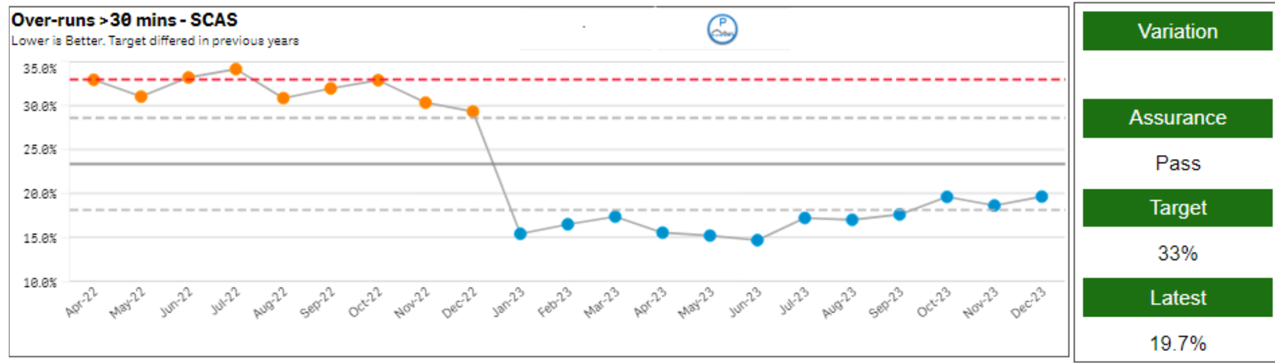
Variation	Assurance	Target	Latest
Improved	-	-	9.8%

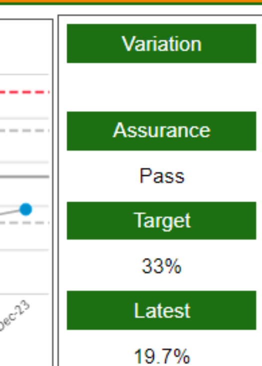
Understanding the Performance:
December joiners are always low and we onboarded the expected numbers. We don't have training courses starting in December so that education colleagues can help with peak times of demand. For leavers this is the 3rd month which sees a reduction. Whilst it is always difficult to completely understand and predict leavers, we are seeing the same reasons coming up as key decision factors - worklife balance is key across all areas.

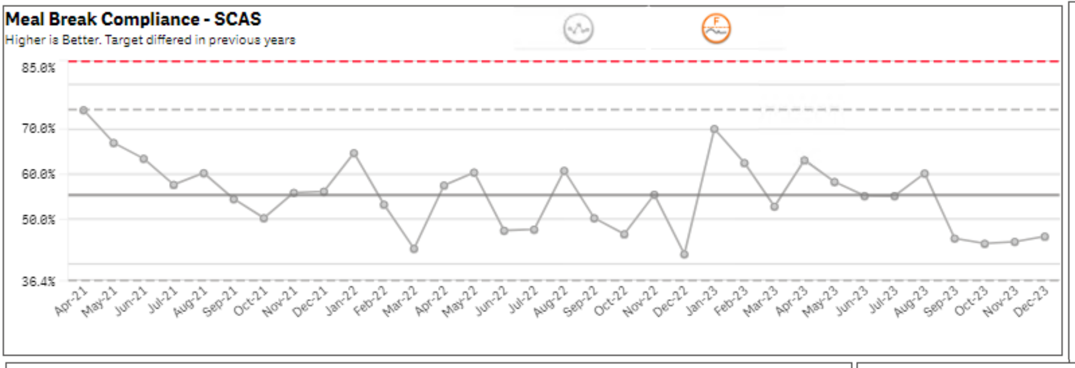
Actions (SMART):
In January we are looking forward to 57 new starters in CCC as well as 12 new Apprentice AAPs. We have the ongoing implementation of the retention plans across all IWP areas.

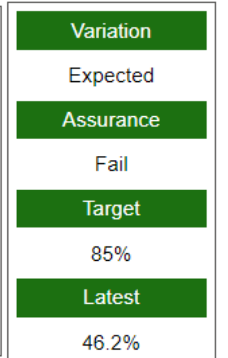
Risks:
During any period of change, there is a risk that staff will decide to leave. We need to continue with our retention plans.

Workforce - Wellbeing









Understanding the Performance:

Meal break compliance is still failing; however, it is within normal variation, but has been below the mean for the past 4 months, due to the operational pressures around handover delays, operational hours and absence levels. The main impact for the south is seen at the QA with handover delays. The handover delays impact on staff health and wellbeing as we have staff not receiving a break which causes a knock on with them having time spent travelling back to base once they are released causing further delay, and some staff then finish 30mins early which impacts on C1 and C2 performance, we have also seen Shift over runs remain significantly below the mean, however the end of shift policy is impacting on our ability to deliver cat 2 improvements.

Actions (SMART):

A meeting was held to undertake a Joint review of end of shift policy with unions, CCC, BI, Ops and patient safety team, to balance staff welfare and ability to respond to patients in a timelier manner. We are mindful of the potential impact on staff so we are looking at the BI data to support a move to Node based EOS process. This is a key action for C2 performance. Although Break compliance in Window is poor we only see about 7% of shifts not getting a break which is an area we are focusing on, this will be linked to handover dalys and demand.

Risks:

Impact on staff well being from any policy changes. Impact on response to patients from current policy.

Workforce – Appraisal / Mandatory and Statutory Training (MAST)

Appraisals - Trust

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	Fail	95.0%	75.2%

Manual Handling

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Declined	Random	95.0%	88.1%

Health & Safety

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Declined	Random	95.0%	88.0%

Equality & Diversity

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Declined	Random	95.0%	88.1%

Understanding the Performance:

The Trust remains below compliance for PDR, a reflection of operational pressures and REAP escalations.

Actions (SMART):

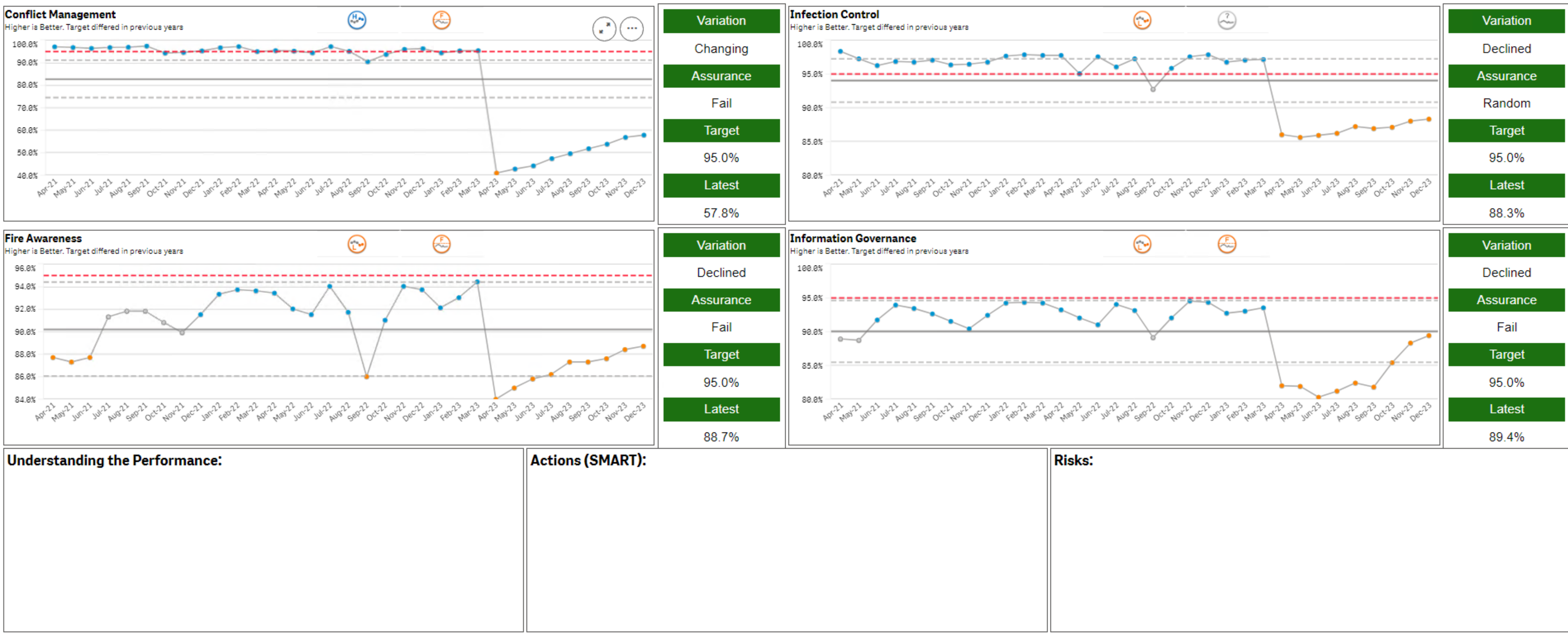
Discussions around the capacity of operational manager's ability to undertake PDR's are taking place and ways to simplify the PDR process are taking place.

Risks:

Staff feel undervalued and uncertain at a time or organizational change when PDRs and meaningful conversations with employees are paramount.

NHS

Workforce – Appraisal / Mandatory and Statutory Training (MAST)



Understanding the Performance:

Actions (SMART):

Risks:

Finance

December-23 Summary

Metrics:

Assurance →

Variance ↓

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

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Debtors > 90 days> 5% total balance	Dec-23	55.6%	5%			12.1%	-1.3%	25.5%
Agency Spend	Dec-23	311	293		n/a	387.242	-104.026	878.511
Overall SOF Segment	Dec-23	4			n/a	2.72727	2.4779	2.97665
CIP's Total	Dec-23	640	3,173	-	-	915.556	-1,779.69	3,610.8
Pay Spend	Dec-23	17,522	17,132	-	-	17,027.9	14,989.7	19,066.1

Finance - Finance 2

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Overall SOF Segment	Dec-23	4			n/a	2.727	2.478	2.977

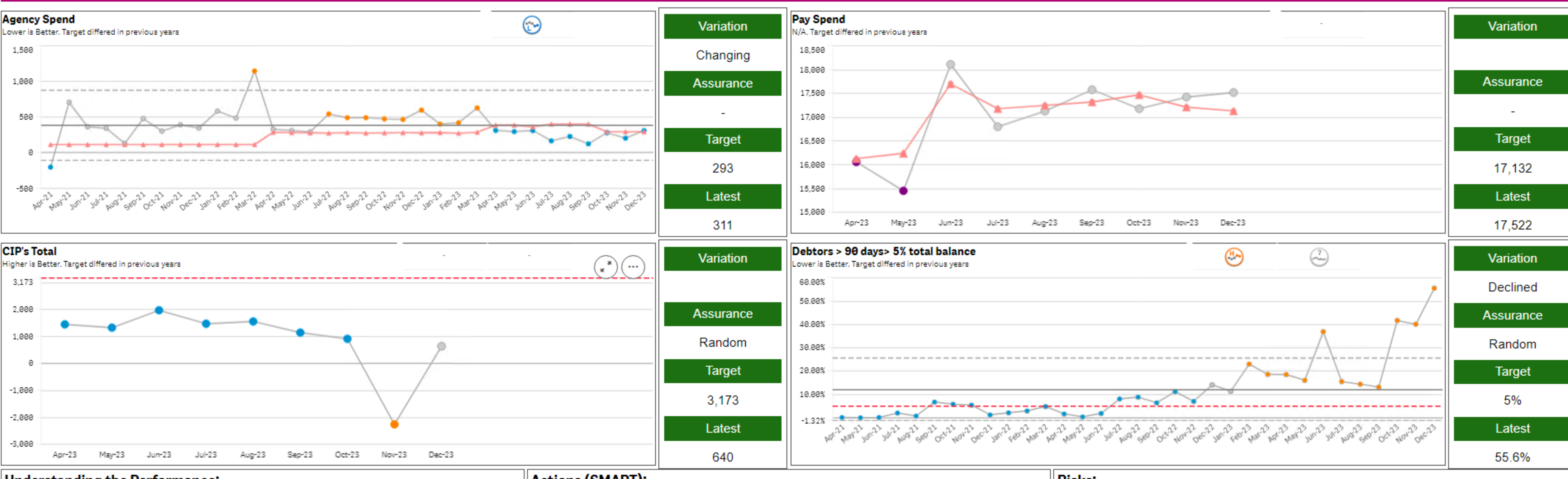
Understanding the Performance:

Actions (SMART):

Risks:

NHS

Finance - Finance 1



Understanding the Performance:

Debtors over 90 days continues to increase due to significant NHS debtors with Buckinghamshire Healthcare NHS Trust (BHT) and Buckinghamshire, Oxfordshire and Berkshire ICB (BOB ICB). Agency spend remains below last year's run rate and continues to be closely monitored by Financial Recovery Group. Delivery of savings through the Financial Sustainability Programme are behind plan but are being supported by other non-recurrent benefits.

Actions (SMART):

Outstanding debtors from BHT and BOB ICB continue to be chased and escalated through formal contractual meetings. The Trust is implementing a Financial Recovery Plan to deliver recurrent savings for the 2024/25 financial year.

Risks:

The outstanding debtors from BHT and BOB ICB are expected to be received, however the Trust's cash flow is impacted by late payment of debtor invoices. This is low risk within this financial year, but will become more significant next year if the Trust's cash flow continues to reduce as expected.

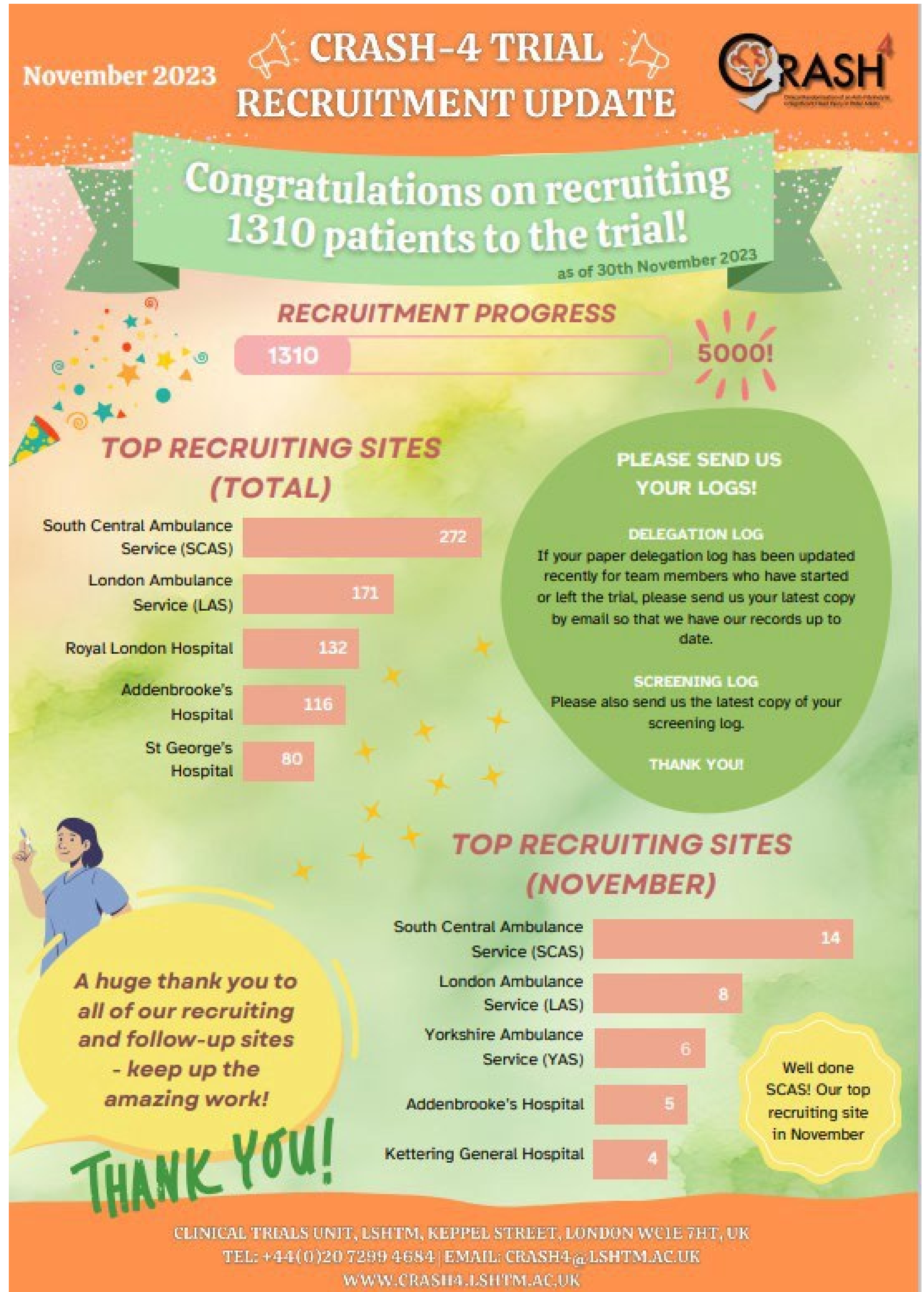
Data Quality Reference

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

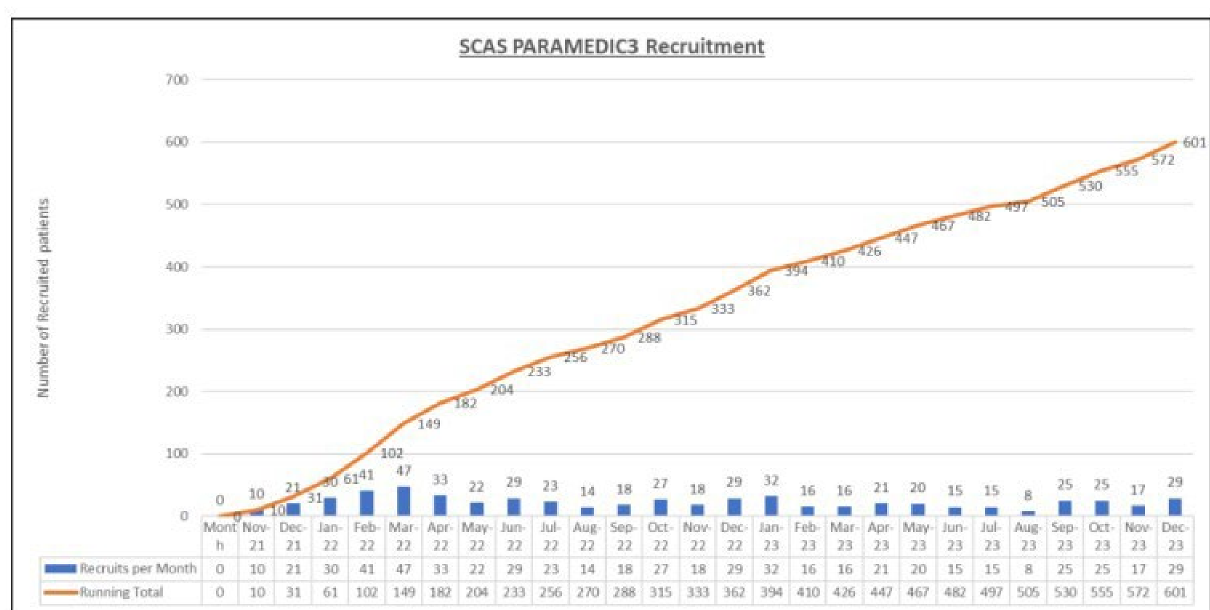
	Accurate Data Quality	Inaccuracies in Data Quality
YTD	73	92
12 Months	73	92

Appendix 1 Principle Clinical Trial Recruitment:

1. Crash-4 Trial Recruitment Update



2. SCAS PARAMEDIC3 Recruitment



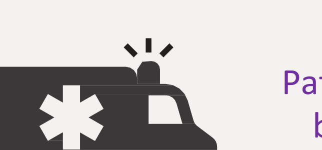
	Month	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Recruits per Month	0	10	21	30	41	47	33	22	29	23	14	18	27	18	29	32	16	16	21	20	15	15	8	25	25	17	29
Running Total	0	10	31	61	102	149	182	204	233	256	270	288	315	333	362	394	410	426	447	467	482	497	505	530	555	572	601

Appendix 2

OHCAO CARDIAC ARREST OVERVIEW SCAS 2022

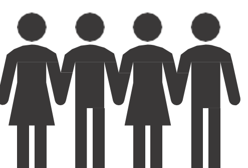
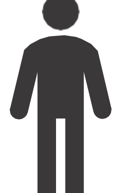
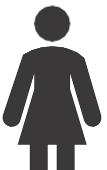
Demographics

4,890
OHCA calls attended



2,666
Patients treated by ambulance service personnel

OHCA incidence (per 100,000)

All cases (Age/gender adjusted)	Males (Age adjusted)	Females (Age adjusted)
		
62.8	87.0	41.2

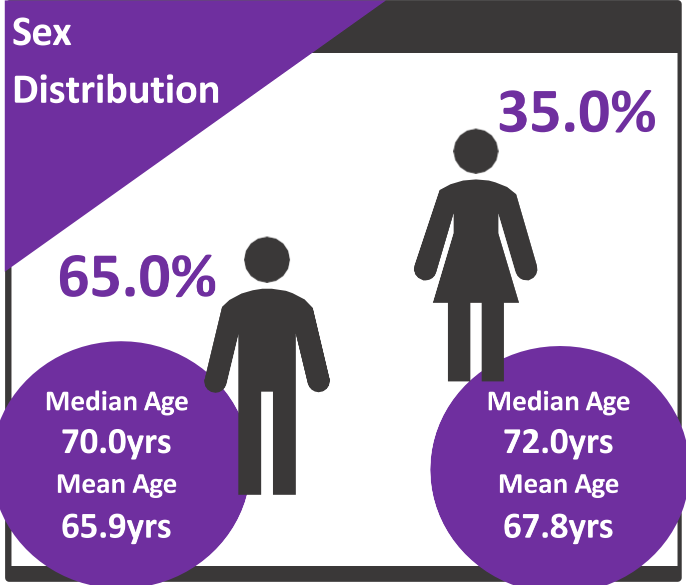
Age of patients

Median Age 71.0yrs
Mean Age 66.5yrs

Age Distribution

1.9%	36.4%	61.7%
<15yrs	15-64yrs	65+yrs

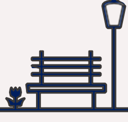
Sex Distribution



OHCAO CARDIAC ARREST OVERVIEW SCAS 2022

Where did people have a cardiac arrest?*

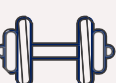
80.0%
Place of residence



12.7%
Public place

1.7%
Workplace

0.1%
Place of education

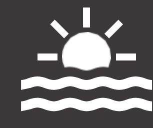


0.9%
Sports and recreation

4.6%
Another location

When did people have a cardiac arrest?

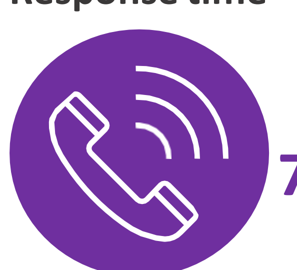
Time of Day



00:00 – 05:59	06:00 – 11:59	12:00 – 17:59	18:00 – 23:59
13.3%	30.2%	31.0%	25.5%

SUN	MON	TUE	WED	THU	FRI	SAT
14.2%	15.1%	14.1%	14.2%	13.2%	14.4%	14.8%

Median EMS Response time



7.3mins

90th percentile time: **16.8** mins

Proportion of cases reached in 7 mins

48.0%

*National averages used as data not available

OHCAO CARDIAC ARREST OVERVIEW SCAS 2022

Aetiology

Medical/Presumed cardiac

89.9%

Trauma

3.2%

Overdose

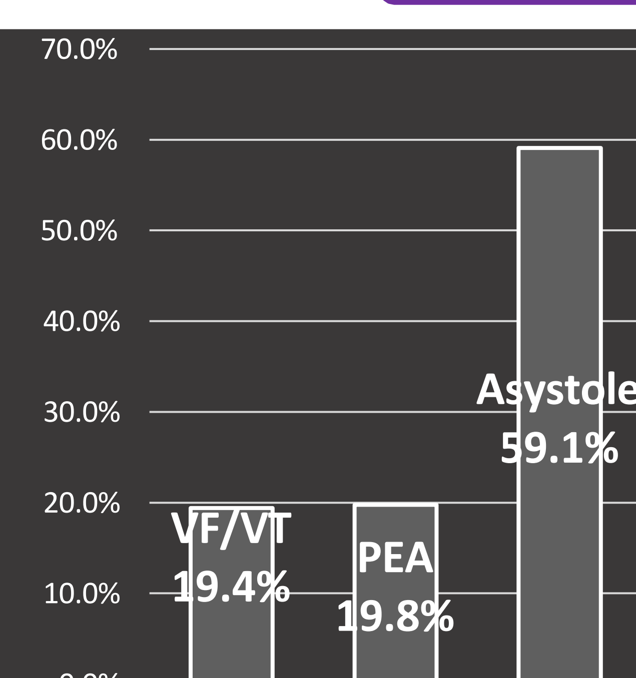
2.1%

Asphyxia

4.4%

Other/missing 0.4%

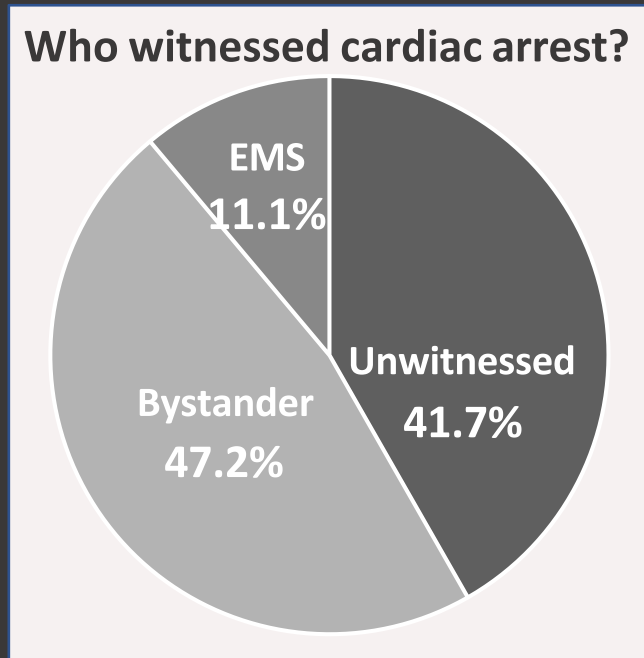
Initial Rhythm

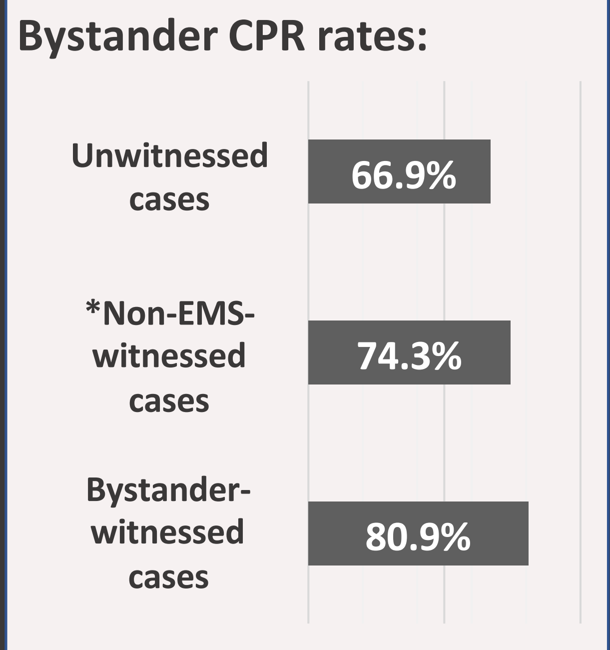


Other/missing 1.7%

OHCAO CARDIAC ARREST OVERVIEW SCAS 2022

Bystander Interventions





*Non-EMS-witnessed cases is the combination of unwitnessed and bystander-witnessed cases

Public Access Defibrillator use*

All cases **8.5%**

Bystander witnessed cases **10.6%**

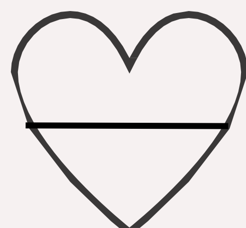
Unwitnessed cases **7.7%**

*National averages used as data not available

OHCAO CARDIAC ARREST OVERVIEW SCAS 2022

Clinical Outcomes

Declared dead on scene



60.9%

Admitted with ongoing CPR

15.9%

Admitted with ROSC

23.2%

Admitted to hospital with ROSC

23.2%

Utstein[x]

49.4%

30-day Survival

9.0%

Utstein[x]

31.2%

Ambulance service personnel successful in restarting 619 hearts

238 lives saved

[x]Bystander witnessed, shockable rhythm

OHCAO British Heart Foundation

OHCAO CARDIAC ARREST OVERVIEW SCAS 2022

Utstein Comparator Group[x] Flow Chart

RESUSCITATION ATTEMPTED
N = 2,666

NOT WITNESSED*
N = 1,112 (41.7%)

*Missing/Unknown
N =2 (<0.1%)

BYSTANDER WITNESSED
N = 1,256 (47.2%)

EMS WITNESSED
N = 296 (11.1%)

INITIAL RHYTHM VF/VT^

OTHER RHYTHM^

^Missing/Unknown
N = 20 (1.6%)

BYSTANDER CPR

310 (87.1%)

BYSTANDER CPR

VED

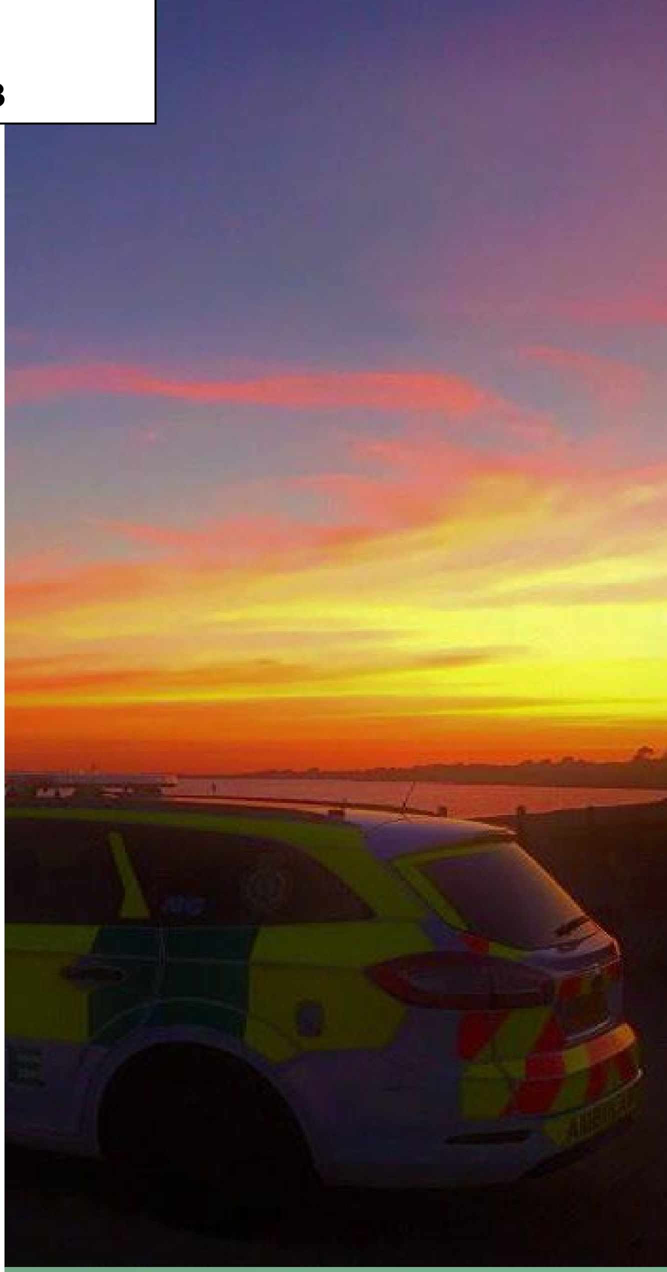
N = 204 (57.3%)

OUTCOME DATA

NO OUTCOM

Appendix 3
SCAS Urgent Care Pathways Dashboard December 2023

Clinical Pathways



Acute and Community Clinical Pathway Services Dashboard

December 2023

Chris Jackson
Assistant Senior Operations Manager

Introduction

This dashboard provides a high-level oversight of Urgent Care Pathway availability across the South Central Ambulance Service region for patient facing clinicians to refer appropriate patients to.

It includes:

1. Acute Hospital Pathways
2. Community Service Pathways
3. Same Day Emergency Care (SDEC)
4. Urgent Community Response (UCR)
5. Hospital Clinical Pathway Care Navigator 'Call before Convey' Single Point of Access
6. Virtual Wards
7. Frailty & Falls Services
8. Acute Respiratory Infection Hubs

Clinical Pathway Care Navigation

The Clinical Pathway Team have reviewed their programme of work and how it aligns with the updated SCAS Strategy and the 10 Point Plan. Following this review and feedback from Emergency Department front door audits of patient outcome, the team have discussed the ideas and plans with a number of staff and teams across the organisation.

The conversations highlighted the need for the clinical pathway workstreams to be aligned to the SCAS principles for us to a Care Navigator across our health care system. To facilitate this, several immediate improvements are required to:

- Referrals made to Health Care Professionals (HCP) and General Practitioners (GP) by our frontline ambulance clinicians.

- How our frontline ambulance clinicians manage the Health Care Professionals (HCP) and General Practitioners (GP) requests to convey patients to hospital.

- How SCAS GP Triage process in SCAS is utilised by our frontline ambulance clinicians and how it is subsequently reported on through our ePR and BI (Business Information) systems.

Detailed proposals of the improvements and requirements will be presented to the clinical Review Group and the Patient Safety and Experience Group for approval in the coming months.

Patient Outcome Feedback Loop

With detailed assessments required to refer a patient to a clinical pathway, it is natural that the referring clinician would want to satisfy their 'clinical curiosity', know if their assessment was correct and the patient benefitted from their initial assessment and referral. This, in turn would lead to experiential learning, confidence in using clinical pathways and further enhance the clinician's knowledge of the wider healthcare system.

As a result of the continued close working relationship between SCAS, Intuiti (MiDoS software developers) and South Central and West Commissioning Support Unit (SCWCSU) the functionality exists to develop a patient outcome feedback loop that will enable:

SCAS Clinician

- Feedback on clinical decision process
- Patient outcome and rationale for care plan provided
- Continued Professional Development
- Identify opportunities to improve clinician experience (SCAS & service provider)
- Greater understanding of integrated system working - improve quality of referrals
- **Reduce impact on unecessary conveyance to Emergency Department**

Clinical Pathway Team

- Identify main patient cohorts referred to a pathway and rationale
- Identify and correct main blockers to referral process
- Improve quality of referrals and referral process
- Qualitative metrics
- Recognise success and duplicate across other areas of SCAS
- Demonstrate success to neighbouring System Partners and other AmbulanceTrusts
- Patient Experience feedback - improve service delivery

Service Provider/Integrated Care System

- Identify areas of good practice and corect areas that require improving
- Foster relationships with SCAS
- Identify opportunties to improve clinican experience (SCAS & service provder)
- Improve quality of referrals
- Demonstrate success to the wider system

Progress

The development of the feedback loop in the SCAS Connect platform, which supports learning from patient outcomes and enables clinicians to reflect on their clinical assessment and decision making, is in the testing phase across SCAS.

There has been some positive feedback from our 999 clinicians who have requested feedback from Clinical Pathway Services about the outcome of the patients they have referred to them.

The pilot testing phase will be extended into 2024 in order to onboard more services, obtain a greater number of requests by staff and returns from service providers to enable a greater analysis prior to a wider rollout.

Rapid Drop & Go for Fit to Sit Patients

Fit to Sit is a concept that is familiar across NHS healthcare settings that encourages all frontline health professionals to put an end to patients lying down on trolleys and stretchers if they are well enough to sit or stand.

SCAS are bringing this into focus across our trust to further support appropriate patients who are 'Fit to Sit' in Emergency Departments (ED). This is alongside the launch of a new 'Rapid Drop & Go' model that enables frontline ambulance crews to clear from acute hospital EDs to attend patients who are waiting for an Emergency Ambulance response.

To support the reduction of patient deconditioning and unnecessary handover delays, we are advising SCAS clinicians that suitable 'fit to sit' patients can be taken directly to the waiting area without the need for a verbal handover to a member of the Emergency Department (ED), Urgent Treatment Centre (UTC), Minor Injury & Illness Centre (MIIU) or similar.

An initial pilot has been proposed for commencing the rapid Drop & Go process at the Queen Alexandra Hospital (QAH) in Portsmouth and Milton Keynes University Hospital (MKUH). The initial pilot will continue for 1 month to collate as much information and detail about the safety of the process for our patients.

Pathway Development Highlights

- Milton Keynes
  - SCAS Urgent Care Desk (UCD) Specialist Practitioners interrogate the Cat 3 & 4 'Falls' incidents in the CCC CAD and direct them to the UCR Team to avoid an Ambulance attendance.
  - In collaboration with CNWL Urgent Community Response (UCR), a Call before Convey model for all urgent care patients is actively being explored. Appropriate patients will be discussed with the UCR before conveyance, to maximise opportunities for admission avoidance / unnecessary conveyance to hospital.
- Buckinghamshire
  - Working with Bucks Urgent Community Response team and Frailty Hospital @ Home, in conjunction with the Single Point of Access (SPA) workstream to develop a Call before Convey model for all urgent care patients.
- Berkshire West
  - Royal Berkshire Hospital are developing a Clinical Care Navigation Single Point of Access (SPA) which will be the access point for all external Health Care Professionals including SCAS into all SDEC Services.
- East Berkshire
  - Frailty SDEC/UCR collaboration - Working with the WPH Frailty team and East Berks Urgent Community Response teams. Referrals to Frailty SDEC may be accepted for assessment in the pan-specialty assessment area on Level 1 or if considered appropriate for community care, the acute Frailty team will liaise directly with the UCR team and *vice versa*, as most appropriate for the patient. This should minimise avoidable conveyance to ED for this vulnerable cohort.

- Minor Illness and Minor Injuries (MIMI) Unit Slough - Establish access for direct referrals from SCAS crews. This should minimise ED attendances for patients with minor injuries and ailments, who do not need to be seen in an acute setting.

- Paediatric Referrals - Working with the WPH Paediatric team to establish direct referrals from SCAS crews. This would enable crews to refer paediatric patient who would otherwise be seen in ED.

▪ North Mid Hampshire

- Stroke Video Triage (medium term goal) - Working with the HHFT Stroke team to roll out pre- hospital Stroke Video Triage for SCAS crews, using GoodSAM. This would facilitate enhanced assessment for stroke patients, supported by the Stroke team.

▪ South West Hampshire

- There are currently discussions with Southern UCR to provide additional care opportunities within the regions community setting to avoid hospital conveyances

- Work is ongoing with UHS Urology Leads to facilitate direct referrals for patients that meet the urology assessment criteria

▪ South East Hampshire

- OSDEC - The team are currently trialling senior nurses taking referral calls at QAH instead of senior Drs in the hope to be able to extend opening hours and/or open access up to us over weekends

- Surgical SDEC - A space may potentially be used by the Surgical SDEC to allow the acceptance of patients that have been administered morphine, which is currently an exclusion for referral. This area equates to 6 spaces with an approximate 14 patient turnaround per day. The timescale of proposed area opening is end of Jan 2024.

  The team are exploring the inclusion and exclusion criteria to support a wider range of referral opportunities.

- Paediatrics - There are discussions with the 'COAST' community service, who accept referrals from GPs & hospital teams to accept referrals from SCAS clinicians. There are concerns as the referring clinician still holds clinical responsibility of the patient, but provider is keen to explore possibilities.

- There are opportunities for referrals to the Childrens Assessment Unit at QAH that allow parent/carer self conveyance following a SCAS referral when clinically appropriate and safe to do so. Currently the CAU only accept SCAS referrals if crew subsequently convey the patient. The QAH Paediatric Team have developed a tool that may support this decision making process for SCAS Clinicians.

Acute Hospital Pathways

Acute Services	Milton Keynes	Buckinghamshire	Oxfordshire	Berkshire West	Berkshire East & Frimley	North & Mid Hampshire	South East Hampshire	South West Hampshire
Medical Assessment SDEC	✓	✓	✓	✗	✓	✓	✓	✗
Surgical Assessment SDEC	✓	✗	✓	✓	✗	✓	✓	✓
Paediatric Assesssment SDEC	✗	✗	✓	✗	✗	✓	✓	✓
Frailty Assessment SDEC	✓	✓	✓	✗	✓	✓!	✓	✓
Early Pregnancy / Maternity / Gynae Assessment SDEC	✗	✗	✓	✓	✗	✓	✓	✓
Urology Assessment SDEC	✗	✗	✓	✗	✗	✓!	✓	✗
Hospital Clinical Pathway Care Navigator - 'Call before Convey' SPA	✗	✗	✗	✗	✗	✓	✗	✗

Key:

***** - Available via Urgent Community Response

! - Available via Hospital Clinical Pathway Care Navigator SPA

Community Service Pathways

Community Services	Milton Keynes	Buckinghamshire	Oxfordshire	Berkshire West	Berkshire East & Frimley	North & Mid Hampshire	South East Hampshire	South West Hampshire
Community Clinical Pathway Care Navigator - 'Call before Convey' SPA	✗	✗	✓	✓	✓	✓	✓	✗
Urgent Community Response	✓	✓	✓	✓	✓	✓	✓	✓
Urgent Treatment Centres / MIU / WIC / FAU / UCS	✓	✓	✓	✓	✓	✓	✓	✓
Community Paediatric Team	✓	✗	✗	✗	✗	✗	✗	✗
Mental Health Team	✓	✓	✓	✓	✓	✓	✓	✓
Diabetes Service	✓*	✓*	✓*	✓*	✓	✓*	✓	✓
End of Life / Palliative Care Team	✓	✓	✓	✓	✓	✓	✓	✓
Community Respiratory Service	✓*	✓	✓*	✓*	✓	✓*	✓	✓*
Cancer & Haematology Service	✗	✓	✓	✓	✓	✓!	✓	✓
Nursing / Care Home / Telemedicine Support Service	✓	✓	✓*	✓*	✓*	✓	✓	✓
Virtual Ward	✓	✗	✓*	✓*	✗	✓	✓	✓

Key:

***** - Available via Urgent Community Response

! - Available via Community Clinical Pathway Care Navigator SPA

Same Day Emergency Care Log

Buckinghamshire, Oxfordshire & Berkshire (BOB) inc. Milton Keynes

Area	SDEC Type	Date of Entry	Progress Log
Milton Keynes			
Milton Keynes University Hospital	Medical	5.4.22	Formally known as AECU Mon-Fri 08-22, Sun 10-18
		31.10.22	Medical SDEC (Maple unit) now open
	Surgical	5.4.22	Mon-Sat 09-20 inc. B/H
		31.10.22	Surgical SDEC (Maple unit) now open
	Frailty	1.7.22	Frailty pathway commenced
		31.10.22	Frailty SDEC (Maple unit) now open
Buckinghamshire			
Stoke Mandeville Hospital	Medical	5.4.22	Temporarily closed
		25.4.22	Engaged with SDEC team to re-open SDEC for SCAS referrals from June '22
		21.11.22	Medical SDEC pathway now available for ambulatory patients only
		15.8.23	Medical SDEC pathway re-launched with SCAS
Oxfordshire			
John Radcliffe, Horton General & Churchill Hospitals	Medical	5.4.22	AAU - JR - 24 hours - Call volume average 200 per day Medical Ref Unit - Horton 24 hours Witney EMU - Mon-Fri 10:00-19:30, Sat, Sun & BH 10-16 Abingdon EMU - Mon-Fri 08:30-19:30 Sat, Sun & BH 10-16 Henley-on-Thames RACU - Mon-Fri 08-18 - New addition to Medical SDEC in April 2022
	Surgical	5.4.22	Surgical Emergency Unit - JR - 24 hours
	Urology	5.4.22	Churchill - 24 hours
	Paediatric	5.4.22	CAU - JR & Horton - 24 hours
	Early Pregnancy / Maternity	5.4.22	MAU - JR 24 hours EPAU - OUH - Mon-Fri 08-18
Berkshire West			
Royal Berkshire Hospital	Surgical	5.4.22	SAU - RBH - 24 hours - BAU
	Frailty	5.4.22	RACOP - Mon-Fri 08-16 - Few referrals to date, reports of referrals being refused due to RACOP amalgamating into Medical SDEC which no current access exists.
East Berkshire			
Frimley Park	Medical	5.4.22	Frimley Park AECU/MAU 24 hours
	Frailty	5.4.22	Frimley Park OPED - Mon-Fri 07-17, Sat, Sun & BH 08-16
Wexham Park	Frailty	3.5.22	Wexham Park Frailty SDEC Mon-Fri 07:30-16:00 (live 11.03.22)

Hampshire & IoW

Area	SDEC Type	Date of Entry	Progress Log
North & Mid Hants			
North Hampshire (Basingstoke)	Medical	03.05.22	Basingstoke Medical SDEC - 08:00-20:00 7 days via SPA
	Surgical	03.05.22	Basingstoke ESAC (Surgical Unit) - 08:00-20:00 7 days via SPA
	Call Before Convey	08.02.23	08:00-17:00 Mon - Fri via SPA
	Frailty	25.09.23	FSDEC 09:00-17:00 Mon-Fri via SPA
Royal Hampshire (Winchester)	Medical	01.11.22	Winchester Medical SDEC - 08:00-20:00 7 days via SPA
	Surgical	03.05.22	Winchester Surgical SDEC - 08:00-20:00 7 days via SPA
South East Hants			
Queen Alexandra Hospital	Medical	5.4.22	AECU - 08-19 7 days
	Surgical	5.4.22	Ambulatory Surgical Assessment Unit - 08-20 7 days
	Frailty	9.9.22	OSDEC available 0800-1600, Monday to Friday.
South West Hants			
Lymington Hospital	Medical	5.4.22	MAU - 08-18 7 days
University Hospital Southampton	Surgical	5.4.22	Acute Surgical Unit - Mon-Fri 08-22
	Frailty	5.4.22	Frailty - 08-22 7 days

Urgent Community Response Log

Buckinghamshire, Oxfordshire & Berkshire inc. Milton Keynes

Area	UCR Type	Date of Entry	Progress Log (Insert a new line for each new entry date)
Milton Keynes	MK Home 1st	5.4.22	Operates 24/7 currently not officially called a UCR
		1.9.22	Now referred to as a UCR (IH)
		17.11.22	Working with UCR to develop opportunities to refer Cat 3/4 calls (IH)
		14.12.22	Delivered 'Falls' training to support UCR managing Level 1 & 2 from SCAS (IH)
Buckinghamshire	Urgent Community Response	5.4.22	No clinical staff in place to operate effectively as a UCR. There is work in progress to recruit clinicians to the roles Operates 08-20 / 7 days
		25.4.22	SCAS provide one Specialist Practitioner 7 days a week for residents registered with a GP in the North Bucks area. SCAS involvement will increase to 3 SP's per day by October, for the whole of the UCR footprint in Bucks
		1.10.22	SP x 3 compliment the UCR clinical cohort (IH)
		9.12.22	Call before Convey' (5th-9th December) pilot completed (IH)
		16.01.23	Reviewing data on 'call before convey' pilot (IH)
Oxfordshire	Oxford Health NHSFT Urgent Community Response	5.4.22	08-20 7 days - SPA HCP line is 24/7 and outside of UCR operational hours calls are diverted to OOH GP service. Daily taskforce in place to implement a 'call before convey' process to capture suitable UCR patients to avoid admission/attendance at ED/SDEC.
		15.8.23	UCR referrals July 181, UCR team keen to take more referrals from SCAS and reviewing patient groups to see where missed opportunities are.
Berkshire West	Berkshire Health Urgent Community Response	5.4.22	08-20 7 days - Outside of these hours West call OOH GP service can discuss patients. Currently working with UCR team to complete CG schedule and update SCAS Connect profile.
		15.8.23	Following call before convey pilot last year, appetite has arisen to look at reinstating this process before winter 23
East Berkshire	Berks Integrated Health Hub	5.4.22	24 hours
	EB (Frimley North) UCR	03.05.22	EB team available 08:00-20:00 7 days (inc. Bank Hols)

Hampshire & IoW

Area	UCR Type	Date of Entry	Progress Log (Insert a new line for each new entry date)
North Hampshire (Basingstoke)	Urgent Community Response	03.05.22	North Hants Team 08:00-20:00 7 days (inc Bank Hols)
Mid Hampshire (Winchester)	Urgent Community Response	5.4.22	Mid Hants Team 08:00- 20:00 7 days (inc. Bank Hols)
		03.05.22	Mid Hants Team 08:00-20:00 7 days (inc. Bank Hols)
South East Hampshire	UCR Portsmouth City	5.4.22	08-20 7 days
	UCR SE Hants, Fareham & Gosport	5.4.21	08-04 7 days
South West Hampshire	UCR Southampton	5.4.21	08-22 7 days

Hospital Clinical Pathway Care Navigator 'Call before Convey' Single Point of Access

	Call Before Convey			Community Single Point of Access (SPA)		
Area	**Call Before Convey in operation**	**Progress on Call Before Convey Development by ICS (Entry Date : Detail)**	**Approx Monthly Referral Numbers**	**Community Single Point of Access (SPA) in operation**	**Progress on Community Single Point of Access by ICS (Entry Date : Detail)**	**Approx Monthly Referral Numbers**
Milton Keynes	No	20.9.23 - ICS want to develop CBC. Waiting for meeting dates to be offered. First phase likely to involve Care Home residents only. 3.10.23 - Initial scoping meeeting arranged for 12.10.23 12.10.23 - CNWL have agreed to support a CbC pilot for Care Home residents in the first instance. CG Schedule in draft. IH		No	20.9.23 - Early stage of discussions within ICS for a community SPA. UCR offer a SPA for 2-hour crisis response but this is not linked to all community services	
Buckinghamshire	No	20.9.23 - Waiting for UCR to complete service restructure before they are willing to review a further pilot.		No	20.9.23 - Early stage of discussions within ICS for a community SPA. ICB working towards a Nov '23 go live date. 19.12.23 - Nov '23 live date missed. Further development meeetings to be scheduled Jan '24. (IH) UCR offer a SPA for 2-hour crisis response but this is not linked to all community services	
Oxfordshire	Yes	December 2023 - Pathway in BAU	180	Yes		
West Berkshire	Yes	Initial pilot went well. Due to be discussed in summer 2023 in preperation for winter. December 2023 - This will form part of the RBH SPA referral criteria inearly 2024	50	Yes	BW investigating developing a BW SPA and moving away from Berjshire Integrated Hub as this is a non clinical telephony service.	
East Berkshire	No	Call before Convey (for UCR) relaunched Sept 2023.		Yes	Berkshire Health Hub acts as SPA for all community pathways in East Berks.	
N & M Hants	Yes	BAU Feb 23 - HHFT based CbC covering direct to specialty, care homes telemedicine, virtual wards and referrals to UCR.	150	Yes	HHFT SPA for onward referral to UCR (if not attempted directly). Hants-wide UCR SPA is available to SCAS Staff	
SE Hants	No	Previous CbC pilot focussed on increasing referrals to UCR. Results showed increased hospital conveyance. No known plan to rerun.		Yes	Hants-wide UCR SPA available to SCAS staff. GP CAS SPA available. No known disucssions re acute SPA.	
SW Hants	No	No disucssions.		Yes	Hants-wide UCR SPA.	

	Acute Hospital Single Point of Access (SPA)			System Single Point of Access (SPA)		
Area	**Acute Hospital Single Point of Access (SPA) in operation**	**Progress on Acute Hospital Single Point of Access by ICS (Entry Date : Detail)**	**Approx Monthly Referral Numbers**	**System Single Point of Access (SPA) in operation**	**Progress on System Single Point of Access by ICS (Entry Date : Detail)**	**Approx Monthly Referral Numbers**
Milton Keynes	No	20.9.23 - MK currently not looking at an acute SPA		No		
Buckinghamshire	No	20.9.23 - Early stage of discussions within ICS for a system wide SPA. UCR offer a SPA for 2-hour crisis response but this is not linked to all community services 3.10.23 - First phase of SPA unlikely to involve Acute services.		No	The Clinical Pathway team are involved and engaged with the ongoing BOB ICB working group discussions about the modelling for a system wide SPA. This is supported by an NHS England SE Regional Task and Finish group.	
Oxfordshire	No	December 2023 - No plans or intention to develop this		No		
West Berkshire	No	BW investigating developing a BW SPA and moving away from Berkshire Integrated Hub as this is a non clinical telephony service. December 2023 - meeting planned for Jan 24 to look at SCAS referrals into SPA.		No		
East Berkshire	No	Early discussions but no plan for acute SPA at this time.		No		
N & M Hants	Yes	HHFT SPA.		Yes	Acute & community referrals via CbC SPA, supported by ICS.	
SE Hants	No	Hants-wide UCR SPA available. GP CAS SPA available. No known disucssions re acute SPA.		No		
SW Hants	No	Hants-wide UCR SPA. No known disucssions re acute SPA.		No		

Virtual Ward Log

Buckinghamshire, Oxfordshire & Berkshire inc. Milton Keynes

Area	Date of Entry	Progress Log
Milton Keynes	4.5.22	Initial discussions taking place. SCAS involved.
	31.10.22	SCAS now represented on VW oversight group
	12.12.22	Meeting to discuss SCAS referral pathway option with VW Clinical Lead requested
	16.01.23	Frailty VW now 'live' in MK with 15 beds. Waiting for meeting with VW lead to discuss SCAS involvement, referrals pathway currently UCR/GP.
	24.01.23	MK operating a VW clinical coordinator model. CGS to be developed to support enrolment of suitable Frailty patients directly on to VW. Draft CGS to be completed by end of January.
	15.03.23	Draft CGS with VW team for review & comment
	Apr-23	Decision made not to develop direct SCAS access to VW. Access to VW will be achieved via UCR. (IH)
Buckinghamshire	22.4.22	Initial discussions taking place, both at Bucks and BOB ICS level . SCAS involved.
	16.01.23	BHT continue to develop VW's (known as H@H). Still confusion regarding 'Who and How' referrals will be actioned.
	23.01.23	Referral route to Frailty H@H (VW) will be via UCR. Planned 'live' date 13th February 2023.
	19.04.23	Recent BOB UEC summit (April 2023) held to discuss strategy for a consistent and unified approach to VW development across BOB. Waiting for update following summit on core offer and further development opportunities.
Oxfordshire	18.22.22	Ongoing discussions with VW steering group, CP Lead involved in conversations and representing SCAS at meetings.
	12.01.23	SCAS access to the Oxfordshire VW is via the UCR service who will assess the patient and perform appropriate diagnostics before deciding suitability for enrolment.
	19.04.23	Recent BOB UEC summit (April 2023) held to discuss strategy for a consistent and unified approach to VW development across BOB. Waiting for update following summit on core offer and further development opportunities.
	15.09.23	SCAS will not admit patients to the VW directly as cannot complete investigative diagnostics to diagnose conditions. UCR/SDEC will enrol patients onto VW following SCAS referral and their own assessment.
Berkshire West	18.11.22	Ongoing discussions with VW steering group, CP Lead involved in conversations and representing SCAS at meetings.
	10.01.23	SCAS will not have direct access to VW as cannot offer appropriate diagnostics to confirm a diagnosis. Access will be via UCR or Medical SDEC when pathway is available.
East Berkshire & Frimley	18.11.22	Ongoing discussions with VW steering group, CP Lead involved in conversations and representing SCAS at meetings.
	19.04.23	Recent BOB UEC summit (April 2023) held to discuss strategy for a consistent and unified approach to VW development across BOB. Waiting for update following summit on core offer and further development opportunities.
Frimley	12.09.23	Access to VW via the UCR team. There is no option for SCAS to refer directly.

Hampshire & IoW

Area	Date of Entry	Progress Log
North & Mid Hampshire	19.10.22	Direct referrals - Live on 19.10.22 Mon-Fri 08:00-17:00 (initially) via SPA
South East Hampshire	12/12/2022	VW are now available, but only via the UCR team. There is no option for SCAS to refer directly. There are no plans for this to be the case at the moment. UCR will act as a SPA
South West Hampshire	12/12/2022	VW are now available, but only via the UCR team. There is no option for SCAS to refer directly. There are no plans for this to be the case at the moment. UCR will act as a SPA
	02/12/2022	There are plans to make a virtual ward with the current service, but this is in early stages with no scope for SCAS at this moment in time

Frailty & Falls Services

Buckinghamshire, Oxfordshire & Berkshire inc. Milton Keynes

			9 Conditions / Requirements covered by UCR Services - Y / N																		
Area	Service Name	Opening Hours	Falls	Decompensation of frailty	Reduced Function / Deconditioning / Reduced Mobility	Palliative / EoL Crisis Support	Urgent Equipment Provision	Confusion / Delerium	Urgent Catheter Care	Urgent Support for Diabetes	Unpaid Carer Breakdown	Does the Service provide a 1st Response to Level 1 Falls (non-injury) Y/N	Does the Service manage patients following a Level 1 Fall (non-injury) Y/N	Does the Service provide a 1st Response to Level 2 Falls Y/N	Does the Service manage patients following a Level 2 Fall Y/N	Can the service lift patients from floor? Y/N	If no - Do they need / want training? Y/N	Does the service manage 'Long Lies' inc. taking bloods? Y/N	Does the Service manage low risk head injuries? Y/N	Does the Service manage head injuries with anti coagulants? Y/N	Is the service on SCAS Connect? (Patient facing Clinician DoS) Y/N
Milton Keynes	UCR (Home 1st) MK	24 hours	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
Buckinghamshire	UCR SCAS Collaboration with SPs	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes
Oxfordshire	UCR - SPA	08:00-20:00 (OOH phone lines divert to OOH GP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	Hospital @ Home	08:00-22:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes
West Berkshire	UCR	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes
	Falls & Frailty Response SCAS Collaboration with SPs	07:00-19:00 Sat, Sun & Mon	Yes	Yes	Yes	N/A	Yes	Yes	Yes	N/A	N/A	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes
East Berkshire & Frimley	UCR East Berkshire	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	No	No	Yes
	Community Outreach Frailty Advice Service - Frimley South (NE Hants)	07:00-17:00 7 days	Yes	Yes	Yes	N/A	Yes	Yes	No	N/A	N/A	No	Yes	No	Yes	No	Yes	No	No	No	Yes

Hampshire & IoW

			9 Conditions / Requirements covered by UCR Services - Y / N																			
Area	**Service Name**	**Opening Hours**	**Falls**	**Decompensation of frailty**	**Reduced Function / Deconditioning / Reduced Mobility**	**Palliative / EoL Crisis Support**	**Urgent Equipment Provision**	**Confusion / Delerium**	**Urgent Catheter Care**	**Urgent Support for Diabetes**	**Unpaid Carer Breakdown**	**Does the Service provide a 1st Response to Level 1 Falls (non-injury) Y/N**	**Does the Service manage patients following a Level 1 Fall (non-injury) Y/N**	**Does the Service provide a 1st Response to Level 2 Falls Y/N**	**Does the Service manage patients following a Level 2 Fall Y/N**	**Can the service lift patients from floor? Y/N**	**If no - Do they need / want training? Y/N**	**Does the service manage 'Long Lies' inc. taking bloods? Y/N**	**Does the Service manage low risk head injuries? Y/N**	**Does the Service manage head injuries with anti coagulants? Y/N**	**Is the service on SCAS Connect? (Patient facing Clinician DoS) Y/N**
North & Mid Hampshire	UCR North Hampshire	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes
	UCR Mid Hampshire	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes
	Falls & Frailty Car (North & Mid Hants) SCAS Collaboration with SPs	08:00-18:00 7 days	Yes	Yes	Yes	N/A	Yes	Yes	Yes	N/A	N/A	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	Yes
South East Hampshire	UCR Portsmouth City	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
	UCR - SE Hants, Fareham & Gosport	08:00-20:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
	UCR - SE Hants, Fareham & Gosport - Twilight Service	20:00-04:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
South West Hampshire	UCR Southampton	08:00-22:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes
	Frailty Support Team - New Forest	08:30-18:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes

Acute Respiratory Infection Hubs

Buckinghamshire, Oxfordshire & Berkshire inc. Milton Keynes

Area		Service Name	Opening Hours	Do SCAS Frontline Clinicians currently have Direct Access to an ARI Hub?	Does the service accept Respiratory Infection referrals?	Does the service accept Covid-19 referrals?	Does the Service accept COPD Exacerbation referrals?	Is there a Paediatric referral service in the area?	Will they accept referrals for Paediatric patients with suspected Strep A?	Notes
Milton Keynes	Acute	Medical SDEC	08:00 - 22:00	No	Yes	No	Yes	No	No	16.01.23 - MKUH reviewing the opportunity of an ARI hub on site. Continue to use Medical SDEC until further notice.
	Community	MKUCS		No				Yes		16.01.23 - Waiting for update on ARI hub service start date and inclusion criteria 16.01.23 - Waiting for response from Children's Primary Care Team
Buckinghamshire	Acute	Medical SDEC	08:00 - 20:00	No	Yes	No	Yes	No	No	16.01.23 - SMH reviewing opportunity of an ARI hub on site. Continue to utilise Medical SDEC until further notice
	Community			No				No	No	16.01.22 - No repsonse from BHT
Oxfordshire	Acute	HGH Medical SDEC JR Medical SDEC	08:00-20:00	No	Yes	Yes	Yes	No	No	ARI patients (adults) are continuing to be seen/referred to the following services: - JR Medical SDEC - Horton Medical SDEC JR site GP stream unit (adult & child) - Again SCAS are streamed from the triage nurse as to suitability as may require flu swab. A dedicated children's unit is being set up as an extension of the GP stream unit on the site which will also be streamed via ED.
	Community	Abingdon EMU Witney EMU Henley RACU Horton UCC JR GP Unit	08:00-20:00	No	Yes	Yes	Yes	Yes	Yes	- Abingdon Emergency Multidisciplinary Unit (EMU) - Witney Emergency Multidisciplinary Unit (EMU) - Henley Rapid Assessment Care Unit (RACU) Children are currently being see/referred to the following: - Horton UCC - This unit is next to ED and has become the Oxfordshire CAS for - 111/999 primary care and ED dispositions. SCAS are streamed from ED which is working well as they have little to no delays.
West Berkshire	Acute	N/A		No						Following discussions with ICB/System partners there is no plan to progress development of ARI Hubs in this area
	Community	N/A		No						Following discussions with ICB/System partners there is no plan to progress development of ARI Hubs in this area
East Berkshire & Frimley	Acute	N/A		No						Following discussions with ICB/System partners there is no plan to progress development of ARI Hubs in this area
	Community	N/A		No						Following discussions with ICB/System partners there is no plan to progress development of ARI Hubs in this area

Hampshire & IoW

North & Mid Hants	Acute			No						
	Community	Basingstoke (Main) ARI Hub	10:00-18:00 Monday - Sunday	No	Yes	Yes	Yes	Yes	Yes	Open from 4th Jan 2023
	Community	Winchester (Main) ARI Hub	10:00-18:00 Monday - Sunday	No	Yes	Yes	Yes	Yes	Yes	Open from 4th Jan 2023
	Community	Andover (Satellite) ARI Hub	12:00 - 18:00 Mon - Friday	No	Yes	Yes	Yes	Yes	Yes	
S E Hants	Acute			No						N/A
	Community	SHPCA	0800-2200	No	Yes	Yes	Yes	Yes	Yes	ARI hubs are open for all ages. SCAS currently do not have access due to the expectation of going via 111. Awaiting feedback regarding this.
S W Hants	Acute			No						N/A
	Community	SPCL	Unknown	No						ARI hub is open and avaliable. SCAS have been given access on 12/01/2023 - clinican governance is beng developed to ensure staff car refer directly. Currently lack details on what will be covered by the hub, have requested them.

SCAS FREEDOM TO SPEAK UP POLICY

Version 5.1 (ratified) December 2023

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients with access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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

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DOCUMENT INFORMATION

Author: Simon Holbrook, Freedom to Speak Up Guardian

Ratifying Committee/Group: EMC, PACC & JNCC

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Version: 5.1

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

A MESSAGE FROM DAVID ELTRINGHAM, CHIEF EXECUTIVE OFFICER

Thank you for taking the time to read and familiarise yourself with our ‘Speak Up’ policy. I’m delighted to be able to say a few words of introduction.

Safe and successful organisations operate with a culture of open-ness and transparency. Every one of us needs to feel safe and empowered to ‘speak out’ and ‘speak up’ when we see something that worries us. This is for the safety and benefit of our patients and our colleagues.

Anyone who speaks up or out should expect that the person they are raising the issue with will ‘listen in’ and ‘listen up’, and that they will then go on to act on the feedback that they have been given.

Finally, there is an obligation to ‘follow up’ which means learning from the experience and sharing that learning.

Please read the policy with these thoughts in mind and go on to use the policy in your day-to-day work. It is so important that together we follow the behaviors set out in the policy. By doing this together, we will create the culture of openness and transparency which we all want to see in our organisation.

Best wishes

David

David Eltringham
Chief Executive Officer

1. SPEAK UP – WE WILL LISTEN

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up. The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete. **Go to https://my.esr.nhs.uk/ then to your Learner Homepage, then select Learning Certifications in the Search section and put 'Freedom' into the search box.**

You can find out more about what Freedom to Speak Up (FTSU) is in these videos

2. THIS POLICY

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

3. WHAT CAN I SPEAK UP ABOUT?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients. Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality) this link will take you to a list of SCAS policy/procedure documents Policies and procedures (sharepoint.com). As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

4. WE WANT YOU TO FEEL SAFE TO SPEAK UP

You speaking up to us is a gift because it helps us identify opportunities for improvement that we may not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up. Employees exercising their rights and entitlements under the regulations will suffer no detriment as a result.

5. WHO CAN SPEAK UP?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

6. WHO CAN I SPEAK UP TO?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you. Our Freedom to Speak Up Champions are located throughout the Trust and are there to listen and guide you also. You can apply to be a Champion by emailing ftsuchampions@scas.nhs.uk

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.

- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) patientsafety@scas.nhs.uk and clinicalgovernanceleads@scas.nhs.uk

- Local counter fraud team (where concerns relate to fraud)

Heather.Greenhowe@rsmuk.com

- Our Freedom to Speak Up Guardian's, Simon Holbrook (Lead), Rebecca Webb and Christine McParland can support you to speak up if you feel unable to do so by other routes. **Email** : ftsu@scas.nhs.uk The Guardians will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. They will also escalate to the Trust Board any indications that you are being subjected to detriment for raising your concern. You can find out more about the guardian role here.

- Our HR team : Natasha Diamond, Assistant Director of HR Operations

- Our Executive Lead responsible for Freedom to Speak Up Melanie Saunders – Chief People Officer - who provides senior support for our speaking-up guardians and is responsible for reviewing the effectiveness of our FTSU arrangements.

- Our non-executive director responsible for Freedom to Speak Up Dhammika Perera – this role is specific to organisations with Boards and can provide more independent support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed.

Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.

- NHS England for concerns about:

  - GP surgeries
  - dental practices
  - optometrists
  - pharmacies
  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
  - NHS procurement and patient choice
  - the national tariff

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a ‘protected disclosure’.

How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.

- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

7. ADVICE AND SUPPORT

You can find out about the local support within SCAS available to you through our intranet link NHS Staff Benefits Portal – NHS Staff Benefits Portal (nhsbenefits.net) Your local staff networks also available on the Trusts Hub/Intranet can be a valuable source of support.

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.

- Looking after you: confidential coaching and support for the primary care workforce.

    - NHS England has a Speak Up Support Scheme that you can apply to for support. You can also contact the following organisations:
    - Speak Up Direct provides free, independent, confidential advice on the speaking up process.
    - The charity Protect provides confidential and legal advice on speaking up.
    - The Trades Union Congress provides information on how to join a trade union.
    - The Law Society may be able to point you to other sources of advice and support.
    - The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

8. WHAT WILL WE DO?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix C.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior leaders' oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

APPENDIX A: WHAT WILL HAPPEN WHEN I SPEAK UP?

We will:

Thank you for speaking up
•
Help you identify the options for resolution
•
Signpost you to health and wellbeing support
•
Confirm what information you have provided consent to share
•
Support you with any further next steps and keep in touch with you

→

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)
•
Referral to HR process
•
Referral to patient safety process
•
Other type of appropriate investigation, mediation, etc

→

Outcomes:

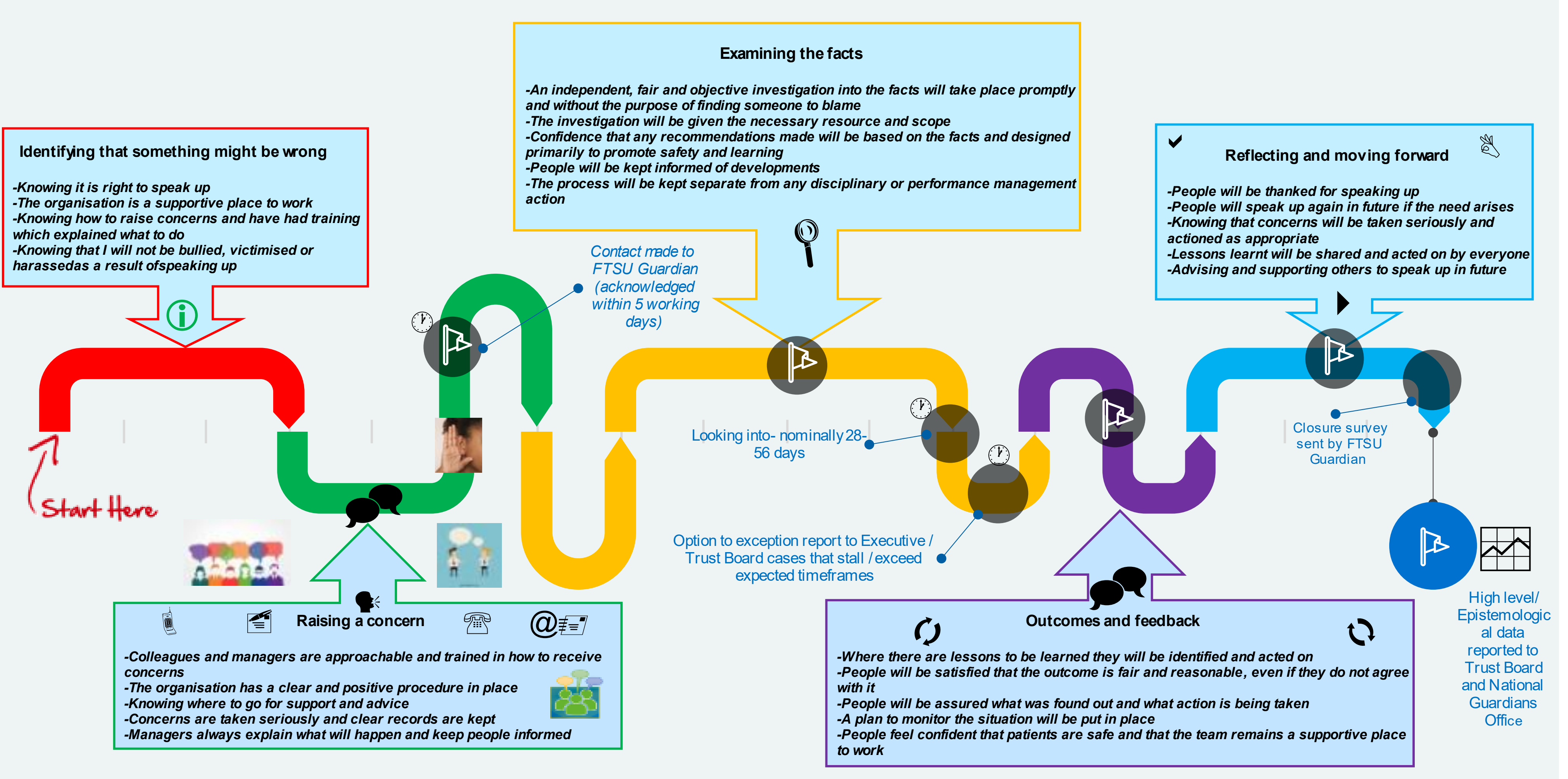
The outcomes will be shared with you wherever possible, along with learning and improvement identified

→

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU (if you are in an NHS trust)

• Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England


The roadmap for people raising and listening to a FTSU concern in SCAS
Identifying that something might be wrong
-Knowing it is right to speak up
-The organisation is a supportive place to work
-Knowing how to raise concerns and have had training which explained what to do
-Knowing that I will not be bullied, victimised or harassedas a result ofspeaking up
Start Here
Raising a concern
-Colleagues and managers are approachable and trained in how to receive concerns
-The organisation has a clear and positive procedure in place
-Knowing where to go for support and advice
-Concerns are taken seriously and clear records are kept
-Managers always explain what will happen and keep people informed
Contact made to FTSU Guardian (acknowledged within 5 working days)
Examining the facts
-An independent, fair and objective investigation into the facts will take place promptly and without the purpose of finding someone to blame
-The investigation will be given the necessary resource and scope
-Confidence that any recommendations made will be based on the facts and designed primarily to promote safety and learning
-People will be kept informed of developments
-The process will be kept separate from any disciplinary or performance management action
Looking into- nominally 28-56 days
Option to exception report to Executive / Trust Board cases that stall / exceed expected timeframes
Outcomes and feedback
-Where there are lessons to be learned they will be identified and acted on
-People will be satisfied that the outcome is fair and reasonable, even if they do not agree with it
-People will be assured what was found out and what action is being taken
-A plan to monitor the situation will be put in place
-People feel confident that patients are safe and that the team remains a supportive place to work
Reflecting and moving forward
-People will be thanked for speaking up
-People will speak up again in future if the need arises
-Knowing that concerns will be taken seriously and actioned as appropriate
-Lessons learnt will be shared and acted on by everyone
-Advising and supporting others to speak up in future
Closure survey sent by FTSU Guardian
High level/ Epistemological data reported to Trust Board and National Guardians Office

Process for Speaking up / Raising concern

You have a concern or you want to raise something

Follow Trust procedures
Which may include reaching out to some of the below support –

- Line manager /Team leader / Duty Manager
- Mentor/education lead
- People directorate/HR
- Clinical lead
- Occupational Health
- Wellbeing Teams
- Patient Safety Team
- Counter Fraud Services
- One of or Subject Matter experts ie Equality Diversity & Inclusion Lead, Safeguarding lead
- A trusted colleague

You may want to discuss your concern with a Freedom to Speak up Guardian
TEL: 0330 1759108
FTSU@SCAS.NHS.UK

This may be because

- You are unsure of where to gain support
- You want to raise the concern confidentially
- You are worried about the impact of raising a concern
- You have raised the concern in the past and you feel the situation is unchanged
- You feel the concern needs to be escalated higher in the organisation

Support may include

- Advice, guidance, and support
- Early resolution or mediation
- Official procedure ie Dispute Resolution
- Incident raised and reviewed
- Occupational health referral (if appropriate)
- Escalation to Board/Senior management
- Signposting to Union
- Support from Clinical body
- Peer support and advice

Support may include

- Providing a safe and confidential environment for concerns to be discussed
- Signposting to the correct support team/lead
- Escalating a concern on behalf or with yourself
- Providing a confidential/anonymous account to the relevant leads
- Giving advice and guidance
- Escalating to board and Senior management team if appropriate

APPENDIX B: MAKING A PROTECTED DISCLOSURE

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the Protect or a legal representative.

APPENDIX C: MANAGERS GUIDANCE

FREEDOM TO SPEAK UP MANAGERS / LEADERS CASE TEMPLATE

This template is intended to support the response to colleagues speaking up via Freedom to Speak Up Guardian (FTSUG) by:

- ✓ Capturing all the essential details of the matter the individual(s) want to raise
- ✓ Providing prompts and a checklist framework to note and record actions
- ✓ Allowing us to collate and celebrate lessons learned as a result of speaking, listening and following up
- ✓ We encourage you to contact the person who has raised the issue ***(as long as they have indicated they are happy to have their identity shared)*** to encourage listening up, and following up., providing them with an acknowledgement that they are being listened to, and feedback. ***6 Coaching Questions*** are also attached to aid you in your meeting if required.
- ✓ Demonstrating we foster a Speaking, Listening and Following up culture*

The table below gives the timescales by which the template needs to be returned. The priority level for this concern has been highlighted as:

Level	Category		Examples	Return action plan (p.3) within…	Return feedback / lessons learned (p.3&4) within…
1	Immediate		• Immediate safety / safeguarding issue • Physical or verbal abuse • Potential criminal offence	24 hours	28 days
2	Urgent		• Quality of care/service • Patient safety • Staff safety	2 days	28 days
3	Standard		• Culture of bullying • Fraud **(if not passed to counter fraud)** • Adherence to policy / procedure • All other concerns	10 days	56 days

FTSU CASE TEMPLATE (completed by FTSU Team)

DETAILS OF MATTERS RAISED	
Case No.	**Date sent:**
Service/Department:	
Nature of Concerns:	
The concern is relating to:	

X	***Something that has / did go wrong***
	Something that might go wrong
X	***Something that is good but could be better***

Perceptions of treatment as a result of speaking up:

The managers/leader responsible for responding :

Person Raisings expected/desired action
(If the person is happy for their identity to be shared with you, please ensure that they have the opportunity to be listened to by you and/or have their concern acknowledged, and feedback is provided to them)

The level of confidentiality agreed is…

X	***Happy for identity to be known to FTSU Team and the manager(s) responding and resolving the matter (Please ensure that contact is made and that the person has the opportunity to be listened to, and/or acknowledged by you, and feedback is provided to them.***
	Identity only known to FTSU Team (confidential concern)
	Anonymous (identity not known to FTSU Team)

Contact details of individual(s) (if consent given):

(NB Water mark to read "sensitive when completed" once live)

ACTION PLAN (completed by manager)

Immediate actions taken: *(Essential for priority 1 / immediate concerns)*
Protections agreed with the individual: *(Essential if individual has reported or is concerned about negative treatment as a result of speaking up)*
What actions do you plan to take ? *(E.g. Informal conversation, mediation, desk top review, investigation, appreciative enquiry, cultural review, Just & Learning decision tree, Detailed Clinical Incident Report (DCI) etc)*
Communications : **Please provide copy of communication circulated to staff if appropriate**

Please email the completed form to the FTSU Team via ftsu@scas.nhs.uk

FEEDBACK / LESSONS LEARNED

FTSU can make a significant contribution to our learning by identifying the themes, lessons learnt and changes to working practice from staff speaking up. To support the focus on quality and drive for continuous improvement please can you give an outline of any lessons learnt as a result of staff speaking up?

The information you give in this section is for understanding and learning, it will not be assessed in any way and will be completely anonymised.

Please complete the sections below and return to the Freedom to Speak Up Guardian within 3 working days of completion of the report.

What changes have been made as a result?
What lessons have been learnt?
How will you ensure learning is embedded and shared?

What learning is transferable across the organisation and how will you share this?
What information will be fed back to the person speaking up?
Is there any feedback that you would like to give the FTSU Team, either for reflection of for wider learning?

*Speak Up & Listen Up eLearning is available:➢Go to “My ESR”, ➢Go to “learner Homepage”,

➢Search course: 000 Speak Up - **Core training for all workers**, ➢Once completed you can search course: 000 Listen Up - Training for all Managers, ➢Once completed you can search for the final course: 000 Follow Up - For Senior Managers

Please email the completed form to the FTSUGs via ftsu@scas.nhs.uk

Speaking-up behaviours for leaders: do's and don'ts

DO...

- ✓ Ask workers for their opinions.
- ✓ Speak up yourself.
- ✓ Measure the impact of change.
- ✓ Show how you value speaking up as an opportunity to improve.
- ✓ Tell stories about the change that has occurred from speaking up stories.
- ✓ Encourage others to speak up and constructively challenge one another.
- ✓ Acknowledge that people face barriers to speaking up, understand where they exist, who they affect and develop actions to reduce them.
- ✓ Be visible and approachable and welcome approaches from workers.
- ✓ Listen with gratitude and respond with curiosity rather than defensiveness.
- ✓ When someone speaks up, listen, thank them, act, provide feedback and ask for feedback yourself.
- ✓ Take a 'learn, not blame' approach to dealing with issues and be willing to embrace new ways of working.
- ✓ Publicly acknowledge any mistakes.
- ✓ Accept your guardian's constructive challenge – they are there to help your organisation be the best it can be.

DON'T...

- ✗ Seek out those who have spoken up.
- ✗ Blame people for things that have gone wrong; instead, learn how to improve processes or behaviours.
- ✗ Focus on the person who has spoken up; focus on the issue.
- ✗ Warn people against speaking up 'outside' the organisation.
- ✗ Take a narrow approach to looking into speaking-up matters. Instead, try to get as much learning as possible.
- ✗ Be defensive and immediately start explaining away rather than listening and acknowledging a person's experience.
- ✗ Be too busy to listen.
- ✗ Talk about how to 'limit the damage' of speaking up. Instead, acknowledge mistakes and embrace the opportunity to learn and improve.

(NHSE & NGO (2022)) Guidance for leaders, Principle 2: Role-model speaking up and set a healthy Freedom to Speak Up culture.

INSERT ORGANISATIONAL LOGO HERE

Responding to experiences of disadvantageous or demeaning treatment as a result of speaking up

A Best Practice Guide developed by representatives in the Freedom to Speak Up Regional Networks

Introduction

Speaking up is a gift – an opportunity for us to engage with colleagues. A chance to hear different ideas and suggestions, enhance worker experience, prevent patient harm, and learn and improve when things don't go to plan or could be better.

One of the biggest barriers to speaking up is a fear of reprisals. Over 600 healthcare colleagues who spoke up in 2020/21, believed they experienced some form of disadvantageous and/or demeaning treatment as a result.

The impact for individuals can be devastating and long-lasting. Our health and wellbeing suffer, and these experiences often lead to sickness absence and resignation. We cannot work at our best when our environment feels psychologically unsafe and this impacts on communication, effective teamwork, and safe patient care. It is important that we hear as soon as possible if someone believes they, or others, are in that position so we can work to resolve the situation.

In our networks, Freedom to Speak Up (FTSU) Guardians have come together to develop this best practice guide to help us respond consistently when colleagues tell us about these experiences. Healthcare organisations are welcome to use this guide to support their own Freedom to Speak Up policy and process.

We call on the support of all healthcare workers to make it as safe as possible for us all to speak, listen and follow up by living our organisational values, treating each other with civility and respect, and creating a safe, just culture where listening and learning happens every day.

Guiding Principles

- We can expect to be thanked and treated with dignity and respect when we speak up
- We expect all colleagues to create a psychologically safe environment where speaking up is business as usual
- We won't tolerate mistreatment or poor behaviour towards colleagues who speak up
- We appreciate speaking up can affect people in different ways and will do all we can to support everyone involved fairly and with compassion
- Our focus will be on learning and improving
- We encourage colleagues to report any concerns about disadvantageous and/or demeaning treatment
- We will refer all concerns about disadvantageous and/or demeaning treatment to the NED lead, Chief Executive Officer / Executive Lead for Freedom to Speak Up /or other nominated Board member
- We will follow our Freedom to Speak Up process to ensure any such concerns are fully explored and any necessary steps taken

- We will keep colleagues informed and updated throughout the process

What we mean by disadvantageous /demeaning treatment

This guide refers to treatment as a result of the act of speaking up, rather than the specifics of the matter raised by speaking up. It can be a deliberate act or a failure to act /omission. Sometimes these actions can be subtle and not always easy to recognise. Whilst behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently.

Such treatment may include: (these are examples and not limited to)

- experiencing poor behaviours not in line with our organisational values e.g., being ostracised, gaslighting, gossiping, incivility (THE HUB - Values-behaviours-2021.pdf - All Documents (sharepoint.com)
- given unfavourable shifts; repeated denial of overtime/bank shifts; being denied shifts in a certain area/department without good reason; changes to shifts at short notice with no apparent reason
- repeatedly denied annual leave; failure on a regular basis to approve in reasonable time; or leave cancelled without good reason
- micro-managing; excessive scrutiny
- sudden and unexplained changes to work responsibilities, or not being given adequate support
- being moved from a team or inexplicable management of change
- being denied access to development opportunities; training or study leave without good reason
- being overlooked for promotion
- Being dismissed, a contract not being renewed or being made redundant
- Receiving a negative performance appraisal or disciplinary action
- Being moved to less-desirable duties or locations, or being demoted or suspended
- Being denied the information or resources to do the job properly
- Being overlooked or denied accesses to promotion or training
- Being criticised for speaking up
- Being refused support to manage the stress associated with speaking up
- Being bullied, excluded or treated negatively
- Being perceived as a troublemaker

Responsibilities

We appreciate that speaking up can at times, feel challenging, particularly when we are involved in the issues that are being raised. However, we rely on each other to do the right thing and we all share a responsibility to speak up when we see something that doesn't feel right. By working together and supporting everyone affected by speaking up, we can prevent colleagues experiencing poor treatment.

As individuals we share a responsibility to:

- create a psychologically safe environment where speaking, listening and following up is business as usual

- treat our colleagues well when they speak up
- speak up and be an ally when we witness disadvantageous and/or demeaning treatment
- listen up and learn from speaking up

As an organisation we have a responsibility to:

- protect workers who speak up from disadvantageous / demeaning treatment
- ensure the working environment is a safe one
- respond to concerns of disadvantageous / demeaning treatment by examining the facts, reviewing outcomes, providing feedback, and reflecting and learning
- When it does occur, it is important that you act – and are seen to act
- to communicate that detriment will not be tolerated
- ensure ideally, a senior speaking-up lead, such as the non-executive director (NED), should have sight of any grievances that involve allegations of detriment.

Recording

- Reports of disadvantageous/demeaning treatment will be recorded by the Freedom to Speak Up Guardian on the central speak up database.
- Information will be kept strictly confidential, only shared on a need-to-know basis.
- Freedom to Speak Up Guardians are required to report speak up activity on a quarterly basis to the National Guardian's Office. The number of people sharing concerns relating to perceived disadvantageous/demeaning treatment as a result of speaking up is included in this data.

What to do

Route 1 .
I /my colleague spoke up and now I believe *I am/my colleague is* experiencing disadvantageous or demeaning treatment as a result.

Speak to a manager or the Freedom to Speak Up Guardian as soon as possible
(or see FTSU policy for other options of who to speak to)

- Your concern will be taken seriously
- You will be supported whilst your concern is reviewed
- You will be kept informed and provided with feedback
- You will be signposted to wellbeing support if needed
- the matter should be looked into by their manager or someone more independent, or through your formal grievance procedure

Route 2
A colleague reports (or thinks they are seeing) disadvantageous or demeaning treatment after speaking up to a manager or the Freedom to Speak Up (FTSU) Guardian

Manager to inform FTSU Guardian

Issue reported to FTSU Guardian

- Clarify matters of confidentiality, what information will be shared and with whom
- FTSU Guardian will undertake a (Protect) risk assessment
- FTSU Guardian will record on the central FTSU database

Within 72 hours

or immediately if significant

FTSU to inform the Non-executive lead *Chief executive officer/ executive lead for speaking up /other

(*delete/amend as

- Consider if any immediate action is required to protect the worker from disadvantageous or demeaning treatment. *(particularly important in the case of perceived bullying and/or harassment)*
- Consider any potential patient safety issues and immediate action required
- Receive assurance line management arrangements are in place to support anyone who might be affected
- Responsible exec to co-ordinate discussion involving FTSU Guardian and appropriate colleagues, for example. Operational colleagues, HR, Patient Safety, Safeguarding, Staff Side

Follow your organisations speak up process

In line with Speak Up Process:

- Clarify matters of confidentiality
- Agree how and what to be explored (terms of reference), and timescales for completion
- Identify independent lead for any review/investigation
- Agree arrangements for monitoring and feedback
- Share and record key actions, outcomes, learning and recommendations.
- Share wider learning across the organisation
- consider signposting the worker to NHS England's Speaking Up Support Scheme

If investigation reveals any unresolved issues relating to individual performance or conduct, consul with human resources colleagues according to local policies/process.

Gender Pay Analysis Report 2023/2024*

***As of 31 March 2023 (snapshot date)**

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1. Introduction

Since April 2017, all organisations with more than 250 employees have been required to publish details of their gender pay gap. Gender pay reporting is different to equal pay which deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. The gender pay gap shows the difference in the average pay between all men and women in an organisation. Although we are only required to report on pay differentials between men and women, we do recognise that Gender is a spectrum that extends beyond the binary definition of male/female and men/women. We hope that national and local data gathering becomes more sophisticated and as more people feel comfortable to define their non-binary status (to prevent identification of individuals) to include and analyse wider (non-binary) pay.
This gender pay gap report for South Central Ambulance Service (SCAS) provides a 'snapshot' on 31 March 2023. The data for this report has been drawn from the organisation's Electronic Staff Records (ESR) and pay roll database.

2. Equality and our Values

At South Central Ambulance Service NHS Foundation Trust (SCAS) we are committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, ethnicity, gender, religion/belief, sexual orientation, gender reassignment, domestic circumstances, social and employment status, political affiliation or trade union membership, HIV status or any other basis not justified by law or relevant to the requirements of the post.
The Trust, therefore, takes every reasonable step to ensure that individuals are treated equitably and fairly, with dignity and mutual respect, and that decisions in recruitment, selection, training, promotion and career management and the right to request flexible working and service provision are based solely on objective organisational factors and job-related criteria.

Our Values Based behaviours:

3. Message from Chief People Officer

"I confirm this report is accurate and reflects a snapshot of our organisation on 31st March 2023. We have identified several actions we will continue to undertake to improve and maintain gender pay parity. We will undertake annual audits and publish data on our website as required by the regulations."

Melanie Saunders, Chief People Officer

4. What this Audit covers

The purpose of a gender pay gap audit is to focus on comparing the pay of male and female employees and shows the difference in the average earnings.
This report provides information on the following indicators:
Mean gender pay gap in hourly pay – adding together the hourly pay rates of all male or female full-pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.
Median gender pay gap in hourly pay – arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of the range.
Proportion of males and females in each pay quartile – ranking all of our employees from highest to lowest paid, dividing this into four equal parts ('quartiles') and working out the percentage of men and women in each of the four parts.
Mean bonus gender pay gap – add together bonus payments for all male or female employees and divide by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.
Median bonus gender pay gap – arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.
Proportion of males and females receiving a bonus payment – total males and females receiving a bonus payment divided by the number of relevant employees.
South Central Ambulance Service NHS Foundation Trust has utilised the standard NHS Gender Pay Report provided as part of the NHS Business Intelligence Tool. This ensures that information is accurate, reliable, and easily contrastable and comparable with other healthcare partners and wider employers.

5. Our Workforce Gender profile

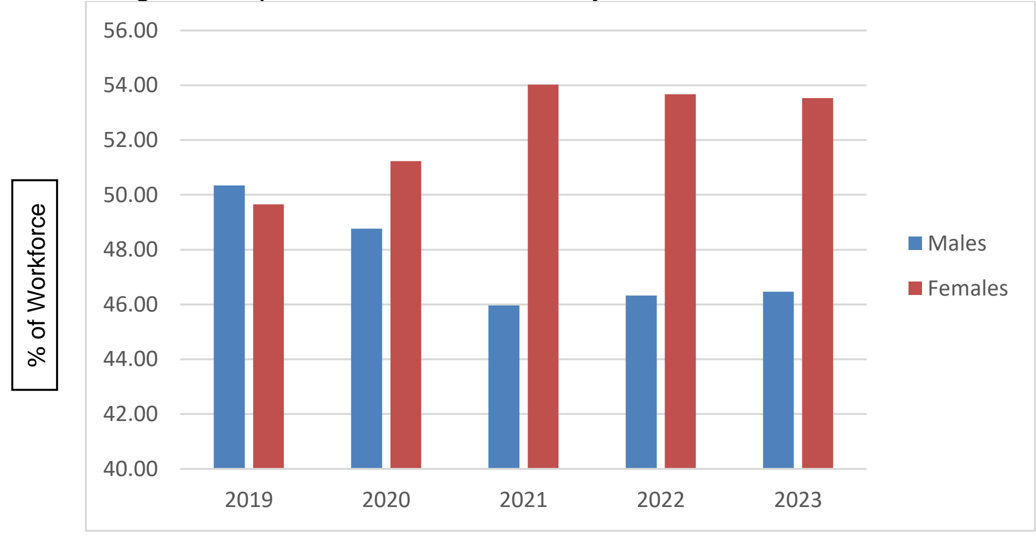
As of 31 March 2023, there were 4777 staff in post (an increase of 87 from the previous reporting period), the rounded gender split remains as **46%** (2222) **male** employees and **54%** (2557) **female**. Table 1 below shows the profile over a 5 year period.

Table 1- Gender split over 5 years.

	2019	**2020**	**2021**	**2022**	**2023**
Males	**50.35**	**48.77**	**45.97**	**46.33**	**46.47**
Females	**49.65**	**51.23**	**54.03**	**53.67**	**53.53**

What is worth noting is the proportion of female workforce has gradually increased over the last 5 years. However, there was a statistically insignificant dip of 0.14% from last year.

Chart 1- the gender split/balance across five years.



6. Our Gender Pay audit

6.1 The Mean and Median gender pay gap

Table 2 - Mean pay gap (hourly rate)

	Male	Female	% Gap
Mean Gender Pay Gap (hourly rate)	**£17.36**	**£16.36**	**5.79%**

The table above shows that men have a greater **Mean** hourly pay rate than women by a gap of 5.79%. This is a shift from the previous year when the Mean gender hourly pay gap was 2.41% greater for men (a change of 3.38%). The changes of the percentage Mean hourly pay gap over a 5 year period show that the gap continues to widen in favour of men. The anomaly in 2020 suggests an impact due to the pandemic and other contributory factors such as the drop in workforce and reduction of national services.

Table 3 -The % changes of Mean Gender Pay Gap (hourly rate) over a 5-year period.

	2019	2020	2021	2022	2023
Mean hourly % pay gap	**2.7**	**0.74**	**-9.7**	**2.41**	**5.7**

The **Median** hourly pay is also slightly greater for men by a gap of 0.50%. However, this is a negligible shift from the previous year when Median hourly rate figure for men was greater at 0.70% (a change of 0.2%).

Table 4 - Median pay gap (hourly rate)

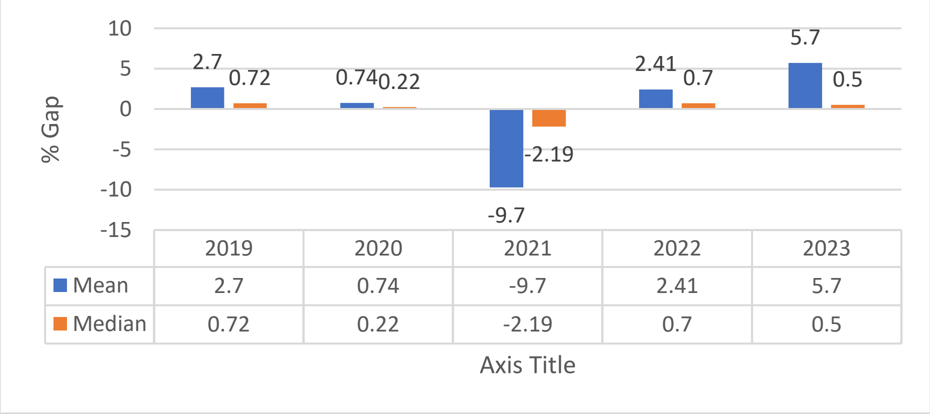
	Male	Female	% Gap
Median Gender Pay Gap (hourly rate)	**£14.55**	**£14.48**	**0.50%**

The changes of the percentage Median hourly pay gap over a 5 year period show that the gap has been reduced in favour of women. The 'blip' in 2020 again, suggests an impact due to the pandemic and other contributory factors such as the drop in workforce and reduction of national services.

Table 5 -The % changes of Median Gender Pay Gap (hourly rate) over a 5-year period.

	2019	2020	2021	2022	2023
Median	**0.72**	**0.22**	**-2.19**	**0.7**	**0.5**

The Chart (2) below combines the Mean & Median Hourly percentage pay gap over a 5 year period.



6.2 Ambulance Trusts Comparison Data

The Office for National statistics (ONS) has reported that among all employees in the UK in all sectors, the gender pay gap decreased to 14.9%, from 15.1% in 2021, and remains below the levels seen in 2019 (17.4%).

Figures from the last audited period 2022/2023 from the Gender Pay Gap service published on the Gov.uk website reveal that of the ten Ambulance services in England SCAS had the third lowest Mean and second lowest Median gender pay gap differential (after North East Ambulance Service NHS Foundation Trust and East Midlands Ambulance Service NHS Trust). However, in the last (2021/2022) reporting period we were the Ambulance Trust with the lowest overall Mean and Median gender pay differential.

The table below provides the last published comparable figures as of 31 March 2022, and were published on 31 March 2023 (1 year in arrears).

Table 6 - 2 year comparison of Mean & Median Gender pay gaps in England

Ambulance Trusts (England) data	% Difference in hourly rate (Mean)		% Difference in hourly rate (Median)	
	2021/2022	2022/2023	2021/2022	2022/2023
South Central Ambulance Service NHS Foundation Trust	-9.7	2.4	-2.2	0.7
London Ambulance Service N H S Trust	13.3	11.4	12.5	17.3
Yorkshire Ambulance Service NHS Trust	6.9	7.7	10.6	10.9
East Midlands Ambulance Service NHS Trust	5.3	1.1	4.8	1.1
North East Ambulance Service NHS Foundation Trust	-1.7	-0.2	-0.4	-1.1
North West Ambulance Service N H S Trust	10.9	9.8	9.3	8.7
South Western Ambulance Service Foundation Trust	6.1	6.2	7.8	6.9
West Midlands Ambulance Service NHS Foundation Trust	10.9	10.2	12.8	9.3
East Of England Ambulance Service NHS Trust	6.6	7.3	3.4	11.9
South East Coast Ambulance Service NHS Foundation Trust	10	10.9	11.1	10.9

6.3 Our Pay Quartiles

This data ranks all our employees (by hourly pay rate) and dividing them into **four equal parts** or quartiles and calculating the percentage of men and women in each of the quartiles. However, this does not include any Over-Time payment (only hourly pay rate not 'take home' pay) or which gender is taking more over-time. Table 7 below contains data that ranks all our employees from lowest (Quartile 1) to highest paid (Quartile 4). The percentage figures given are a breakdown of each quartile gender split. The gender split overall for the Trust is 46% -males and 54% female.

Table 7 – Quartile proportions by gender and % differences over 3 years

	Male	***Female***	***23/24 Difference***	***22/23 Difference***	***21/22 Difference***
Gender Proportions in Pay Quartile 1	**52.76%**	**47.24%**	**5.52%**	**1.62%**	**0.3%**
Gender Proportions in Pay Quartile 2	**39.53%**	**60.47%**	**-20.94%**	**15.52%**	**10.58%**
Gender Proportions in Pay Quartile 3	**42.38%**	**57.62%**	**-15.24%**	**14.74%**	**10.3%**
Gender Proportions in Pay Quartile 4	**51.21%**	**48.79%**	**2.42%**	**-2.56%**	**9.78%**

Over the past 3 years, there has been an increasing trend in the representation of men in Quartile 1 (lowest paid). There are also more men in Quartile 4 (highest paid) but has not remained consistent over this period, this quartile also has the smallest gender split. The most difference in gender representation occurred in Quartile 2 with 20.94% more women followed by Quartile 3 with 15.24% more women. Both Quartile 2 and 3 have had a considerable shift in women representation when compared with the previous years

6.4 Mean and Median Bonus pay gap

The mean bonus gender pay gap adds together bonus payments for all male and female pay and divides this by the respective number of male or female employees. There were no bonus payments made, this because SCAS does pay bonuses as part of the employment terms and conditions.

7. Our 2022/23 Actions

Some actions we have taken to promote and advance gender equality include:

Equality Impact Analysis (EqIA)
We have also developed a new EqiA toolkit with refreshed templates to help guide all of our decisions to pay 'due regard' to the impact of these in relation to gender equality (and all the other protected characteristics). They are also included as part of our governance.

Sexual Safety Campaign
The Campaign creates a positive cultural shift to recognising and challenging inappropriate and sexual behaviour, we launched our Sexual Safety Charter in February 2023. The intended outcome is to empower any vulnerable person at risk of abuse and enable allies and upstanders to reduce the escalation of any harm, seek appropriate resolution and

action. The Campaign consists of several long-term actions and communications to ensure our staff never feel uncomfortable, frightened, or intimidated in a sexual way by the public or other colleagues. Our Sexual Safety Charter is also included in the NHS England repository as a model of good practice.

Staff Networks
We have our Staff networks which have been established to promote inclusion within SCAS. Our Lesbian, Gay, Bisexual and Transgender + (LGBT+) network, Race Equality & Inclusion network, the Multifaith Network, our Disability, Accessibility, Representation & Equality (DARE) network, and our new Women's Network exist to drive gender equality within our workforce and have been active with an increase in membership regular meetings and guest speakers (Laura Bates). The Networks have a role to support and provide opportunities to share their lived experiences, promote diversity and inclusion within our Trust. Each Network now has Executive Director as Sponsors.

Additionally, we have started to develop a Military Champions Network to provide support and a safe space to discuss issues that affect ex-Military personnel particularly in relation to creating a safe space to discuss health and related issues.

Focus on employee health and wellbeing
We understand that taking a holistic approach to our employee health and wellbeing increases our retention rates and improves organisational performance. To further support our female workforce, we are focusing on issues that affect them such as our menopause café that provides a 'safe space' to discuss issues and find support and a new menopause policy. We are hopeful that our newly created Women's Network will help highlight to SCAS and provide guidance to the health & wellbeing needs of women.

Flexible Working
We are committed to ensuring that our staff maintain a healthy work life balance to retain talent. This is a challenge particularly in relation to operational staff and those who work shifts; we know we must do more and encourage open conversations around flexible work with support from managers and leaders.

Developing our people
Compassionate, inclusive and collaborative leaders build resilient and engaging teams. At SCAS we believe in supporting our people through coaching and mentoring so we have our **SCAS Leader programme** and the **Essential Skills for People Managers** (ESPM) as part of our leadership and management offer. These courses continue to provide our growing number of female leaders and managers with the confidence and skills required to build effective teams which drives inspiring and transformational leadership.

8. Our next steps for 2024/25

Objective	Action	Lead	Timeline	Improvement measure
Collate and assess data to build on our positive outcomes and understand any imbalances within our Trust	Continue to undertake further analysis of directorate and departmental data	HR and Head of EDI	Reporting period 2024/2025	Data and reports of and to departments to identify local actions or concerns for action by the WFDB & PACC
Continue to promote positive action to bring about pay equity	Understand and further analyse the actions that we have taken to promote, support more women across the Quartiles and ensure that we safeguard against any bias (conscious or unconscious). Look at positive action measures for retention	HR and Head of EDI	Reporting period 2024/2025	Narrowing of Mean hourly Gender pay gap
Support to advance career opportunities	Promote mentoring/ Coaching Mentors, guidance and advice to women mentee's	OD	Reporting period 2024/2025	More women taking up career opportunity options
Encourage the uptake of flexible working	Advertise and offer all jobs as having flexible working options, such as part-time work, remote working, job sharing or compressed hours Allow people to work flexibly, where possible Encourage senior leaders to role model working flexibility and to	HR and Recruitment	Reporting period 2024/2025	More staff taking advantage of flexible working

	champion flexible working Encourage men to work flexibly, so that it isn’t seen as only a female benefit.			
Maternity & Paternity leavers supported	People who took maternity or paternity and stayed on leave longer than statutory limit are encouraged to come back to the Trust with ‘staged’ support	Recruitment	Reporting period 2024/2025	More staff coming back to the Trust after any prolonged maternity or paternity leave
To understand reasons why women are not applying to more senior positions or receiving same hourly pay as men	Create a survey to get qualitative data to understand any ‘barriers’ or ‘ceilings’ to career or pay progression	HR	Reporting period 2024/2025	A better understanding of issues that prevent career or pay progression to enable action implementation planning
Board Leadership visibility	Continue with Listening events to further engage our female workforce Brief the Board about their PSED responsibilities For Executive Board recruitment the Agencies used to have attraction strategies with a review of how they would be fully inclusive within their recruitment / advertising campaign	CEO/ Executive Board Head of ED&I Recruitment	Reporting period 2024/2025 November 2023 Reporting period 2024/2025	CEO/Executive Board engagement to promote & prioritise Gender Equality To increase applications for Board position from women

Report to the Equality, Diversity & Inclusion (ED&I) Steering Group to act as key conduits in raising gender specific issues	Equality and Diversity Steering Group to oversee trust wide initiatives relating to the Gender Pay Gap.	CEO/CPO & Head of EDI	Reporting period 2024/2025	• Regular meetings • Established governance pathways
Enhance support for all our Staff Networks (they are predominantly led by women)	• To establish 'Protected time' for Chair/Deputy • Communicate network functions • Establish resources to support the work of the network • The Network & Head of EDI promote Sexual Safety Campaigns • To highlight gender pay differentials	Head of EDI	Reporting period 2024/2025	• Ratification from Board • Provide a 'safe space' • Explore and take action to address gender issues experienced by staff to improve staff experience and increase retention
Engagement with the national Ambulance (and other NHS) Staff networks	Further engaging the Women's Network in with other gender staff networks across UK, particularly the NHS to source and adopt good practice.	Women's Network Head of EDI	Reporting period 2024/2025	The Trust adapts and adopts good practice from other Trust's staff Women's/Gender networks
Recruitment and selection practices are inclusive for all staff and of all genders	Analyse recruitment and attrition data to explore rates by roles and service areas Analysis of any gender differentials using staff surveys, People Voice,	Recruitment FTSU Communicatio ns HR Operations	Reporting period 2024/2025	Recruitment policies and literature is reviewed to ensure that all genders feel welcome to apply for roles. To find out and analyse any negative

	FTSU and ER cases Continue to review and analyse inclusivity of recruitment materials (including where adverts are placed)	Recruitment		experiences and seek to reduce them (ER cases)
Explore opportunities for more flexible or alternative shift working across the organisation.	Consider how and impact of flexible working and alternative duties could be introduced equitably into a wider range of roles Ensure equity of pay and training for those who are pregnant and their longer-term career prospects To understand why women have left SCAS	Recruitment HR Equality & Diversity steering group	Reporting period 2024/2025	Flexible working is established, equitably distributed and used to reduce potential discrimination and encourage more diverse applicants To understand and reduce female workforce attrition

Classification: Official

Publication approval reference:

NHS Equality Delivery System

South Central Ambulance Service NHS Foundation Trust

EDS Report

Version 1, 15 August 2022

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Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at: www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report will be submitted via england.eandhi@nhs.net and published on the Trust's website.

NHS Equality Delivery System (EDS)

Name of Organisation		South Central Ambulance Service NHS Foundation Trust	Organisation Board Sponsor/Lead		
			Melanie Saunders, Chief People Officer		
Name of Integrated Care Systems		Buckinghamshire, Oxfordshire and Berkshire West ICB & ICS Frimley ICS Hampshire & Isle of White ICS			

EDS Lead	Dipen Rajyaguru		At what level has this been completed?	
				*List organisations
EDS engagement date(s)	December 2023 – January 2024 (external) 11 January 2024 (ED&I Steering group)		Individual organisation	Oxford Health NHS Foundation Trust
			Partnership* (two or more organisations)	N/A
			Integrated Care System-wide*	Buckinghamshire, Oxfordshire and Berkshire West ICB & ICS

Date completed	January 2024	Month and year published	February 2024
Date authorised		Revision date	

Completed actions from previous year	
Action/activity	**Related equality objectives**
This is a new version of EDS and is the first publication (benchmark)	
The Equality, Diversity & Inclusion Strategy 2022-26 was developed following the last version of EDS and is available on the trust's website	Equality, Diversity and Inclusion Strategy With Equality Objectives 2022-2026 (scas.nhs.uk)

Executive Summary

This is our first roll out of this 'refreshed' EDS reporting mechanism we have chosen this year two services to review in Domain 1 rather than the 3 expected for future years. Of these two, one was expected to fit under the 5 clinical priorities cited in the *Core20Plus5* and the second was suggested to be an operational business service. We chose the EarLy Surveillance for Auto-immune diabetes study as a good example of innovative programme that meets the health inequalities target for *Core20Plus5* and our Patient Transport Service which is a good example of a service that works collaboratively across the health & social care system.

For each Domain a template is used with a number of outcomes that require evidence. A separate evidence pack was compiled for each Domain. Compilation of evidence packs largely utilised already existing data and reports, with creation of new data being avoided. Visual aids such as graphs were also produced to support interpretation of the data. The original datasets were also made available for the evaluators so they could conduct their own analysis and then to score, evaluate and grade each Domain outcome. A summary of the evidence collated against each outcome with the feedback and score from the evaluators for each domain is provided in the (linked) Evidence Templates for each domain.

The Evaluators (or stakeholders) consisted of 'internal' or those who understand the process or mechanism for Domain and can include service users, Trade unions, staff networks and FTSU guardians. These groups evaluated Domains 1 & 2 (through the ED&I Steering group), Domain 3 required independent or peer reviewers as well as the Trade unions and we were fortunate and grateful to gain the insights of Oxford Health NHS Foundation Trust and BOB ICS to provide a robust review and grade. The templates evidence packs were distributed in early December to the Independent & peer reviewers to submit back to us by 8/01/24 the 'internal' review took place on 11/01/24 at the ED&I Steering group (using slido to collate the score/grade and comments).

Ratings

Overall, the Trust was given a rating of **Developing** (score of 16). To determine the overall rating, scores provided by evaluators were averaged for each outcome (rounding to the nearest whole number). The average scores across each outcome were then totaled, with the total score being given the corresponding grade as per the EDS (linked) Scorecard and Ratings Guidance

Summary of Key Findings and recommendations from evaluators

This is from the feedback of the evaluators based on the evidence presented and interpreted by them and although it is subjective it does provide an indication and perception of the services.

For Domain1: PTS

- More data needed to have a greater understanding of our service users and their experiences.
- Opportunity to provide data about renal patients and other patients who have higher needs and suffer from Health inequalities.
- Good to see a steady number of compliments, would like to understand the number as a % of patient journeys.
  *Addendum evidence provided for 1C but not graded.

For Domain1: EarLy Surveillance for Auto-immune diabetes study

- Already met targets initially set to reach by August 2024
- Overall, the team could develop a database on community center's they could access to promote such a valuable service -especially among communities where there is a higher prevalence of diabetes.
- Need to be more proactive in getting feedback.

For Domain 2: Workforce health and well-being

- The Trust offers a range of H&WB support to its staff, unclear from the evidence how much it is accessed or what staff view of the support is.
- Whilst there have been improvements, there are still concerns of negative cultures.
- There needs to be further use/ promotion of MHFAs and HWB champions. Includes more support for those doing the roles (as volunteers).

For Domain 3: Inclusive leadership

- A good amount of work has gone into producing the various reports and analysis with reference to the main national drivers and initiatives with updates to senior leaders. Plenty of published information.
- There is evidence of both equality and health inequalities being discussed in board and committee meetings, but Board members and senior leaders need to be demonstrating and communicating their commitment or allocating resources to health inequalities, equality, diversity and/or inclusion.
- The Staff networks have a senior sponsor who have a defined role to meet and support them. However, no evidence of sponsoring (supporting) religious, cultural or local events and/or celebrations. Staff Networks still need better executive sponsor input.

Conclusion

Whilst the Trust's overall rating was Developing, there were many outcomes where the Trust was perceived to be as achieving. Additionally, even though outcomes in Domain 1 were all rated as Developing, had the EarLy Surveillance for Auto-immune diabetes study been rated in isolation, it would have been rated Achieving for all Outcomes. For Domain 2, the health & well-being team were recognised for their work and enthusiasm to progress and offer more variety of health support when/where they can. For Domain 3, there was some difference relation to how it was scored by the ED&I Steering group and Union representatives who gave a higher score and externally by BOB ICS and Oxford Health NHSFT who gave a lower score. Nevertheless, the average score gave a fair view when taking into consideration the work currently underway that will be evidenced/established next year, such as the Executive Staff Sponsors and the Board Equality objectives.

Many of the recommendations and findings (above) aimed at enhancing EDS performance align closely with existing plans within the Trust, integrated into various ongoing programs. Consequently, the EDS process serves to fortify the Trust's current initiatives, and highlighting potential measures our services can take to meet the needs and expectations of our service users and staff. We should aim to be 'achieving' next year.

EDS Rating and Score Card Guidance

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance to scores are below	
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

NB:
Our independent external assessors were Buckinghamshire, Oxfordshire and Berkshire West ICB & ICS (BOB ICS) for Domains 1 & 3 & Oxford Health NHS Foundation Trust for Domain 3
Our internal assessors were the ED&I Steering Group with support as external assessors by the staff Unions for Domains 1,2 & 3

EDS - Evidence template for Domains 1

Commissioned/Provided service: **Patient Transport Service (PTS)**

Domain	Outcome	Evidence Provided	Score & Lead
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Take up of service analysed by protected characteristics Within Patient Transport Service pre Covid we conducted a free post patient satisfaction survey. These were distributed via the Ambulance Care Assistants. We reported on these quarterly to our contracted Commissioners. Our response rate at this time was averaging around 250 per month. This survey collected captured protected characteristics, **Age, Disability, Gender, Race, Religion or belief** During Covid for Infection prevention and Control all free post surveys had to be removed of all resources. These surveys have now been reissued due to reduce cross contamination. During Covid we conducted a focussed survey regarding the Renal service. Our aim was to survey patients that use the NEPTS for renal patients, to allow focussed improvements for this vulnerable group. The method used to conduct the survey was via a telephone. 297 responses were received. This survey collected captured protected characteristics, Age, Gender, and Race PTS-survey-design Jan-2016.pdf Draft V4 Renal survey.pdf IresPTS-survey-Jan-2016-PRINT.pdf Draft V4 Renal survey.pdf The Trust are looking at different methods to obtain more responses as the return rate has been quite low. A Business case is going to the Board to review a free text survey submission which will be outsourced to a 3rd party to conduct the text survey as the previously used methods are quite dated and time consuming.	

		Take-up by any other inclusion group (e.g., homeless service users) Within the Patient Transport Service, we have not previously taken up any other inclusion group surveys. Accessible Information System alert in place+ Reasonable Adjustments for patients Currently there is no system alert or reasonable adjustments for our surveys, the Business Case for Board approval the 3rd party provider does have an accessibility criterion meets the accessible information standard.	0 – Undeveloped 9% **1 – Developing 64%** 2 - Achieving 27% 3 - Excelling 0% Lead: Patient Experience Team and Commercial services
	1B: Individual patients (service users) health needs are met	Friends and family Test results Accessible Information Standards in place As above in 1A the Friends and Family Test (FFT) is conducted at the start of all Patient Transport Surveys. 1. Q1. Overall, how was your experience of our service? Very Good Good Neither Good nor Poor Poor Very Poor Don't Know 2. Please can you tell us the main reason for the answer you have given? 3. Please tell us what we could have done better? We also monitor diversity via the FFT Question survey card **Please see FFT Questions survey card** FFT Qustion Survey Card V1.pdf FFT Qustion Survey Card V1.pdf **Please see the FFT (excel) monthly report from January to November 2023** FFT Data.xlsx FFT Data.xlsx	0 – Undeveloped 0% **1 – Developing 64%** 2 - Achieving 36% 3 - Excelling 0% Lead: Patient Experience Team and Commercial services
	1C: When patients (service users) use the service,	Serious incidents, never events and complaints. *Addendum The patient safety team review all incidents that are graded as “moderate” or above by the reporter. During this daily review, if the level of harm to the patient is deemed low/no harm, then this is downgraded, and the standard investigation takes place. If it is deemed as a	**0 – Undeveloped 45%** 1 – Developing 36% 2 - Achieving 9% 3 - Excelling 9%

	they are free from harm	moderate or severe, this is then taken to the Safety Review Panel and it is then established whether the incidents is a detailed investigation or a serious incident investigation. If the incident is deemed a detailed investigation/serious incident, the report is taken to the monthly Clinical Governance Meeting, where it is signed off by the service line leads. SCAS also hold monthly Learning from Events meetings where learning can be shared trust wide	Lead: Patient Experience Team and Commercial services
	1D: Patients (service users) report positive experiences of the service	Patient Survey Other forms of patient feedback The Patient Transport Service receive many compliments through via channels. Telephone, Email, Post, verbally and Survey responses. All response where identifiable information is supplied the staff member will be informed of the positive feedback. We also review positive feedback to see if this can be implemented in other areas of Patient Transport to enhance patient experience. **See PTS Compliments** PTS Compliments.xlsx PTS Compliments.xlsx	0 – Undeveloped 9% 1 – Developing 9% **2 – Achieving 55%** 3 - Excelling 27% Lead: Patient Experience Team and Commercial services
Domain 1: Commissioned or provided services overall rating (by stakeholder panel)			**4**

EDS - Evidence template for Domains 1

Commissioned/Provided service: **SCAS research team - EarLy Surveillance for Auto-immune diabetes study**

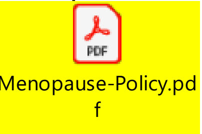
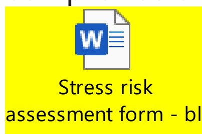
Domain	Outcome	Evidence	Score & Lead
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	The ELSA study (**E**ar**L**y **S**urveillance for **A**uto-immune diabetes) is a research opportunity providing screening for children aged three – thirteen for antibodies that can indicate risk of developing type 1 diabetes. This screening is conducted through collection of small blood spots on a testing card, post finger prick test. South Central Ambulance Service is active in supporting this project and is the only ambulance service trust currently engaged with ELSA. Through the utilisation our innovative 'Research – Rapid Response Vehicle' (R-RRV) team, clinicians are providing opportunities for children to undertake screening at convenient locations such as pre-schools / nurseries, religious events (Hindu temple), public centres, primary schools, and general practices. The aim of using these locations is to try and break down access barriers by taking these opportunities to the patient rather than them be forced to travel. This positive action enables us to reach communities with the greatest health inequalities which may include socio-economic deprivation and coupled with those that may have greater prevalence for type 1 diabetes. We have found that this change in practice means we have been able to reach a wider patient demographic. However, we also have a poster that helps to explain the study (**see poster**) elsa-poster-2-v1.0-14.10.22.png elsa-poster-2-v1.0-14.10.22.png	0 – Undeveloped 9% 1 – Developing 36% **2 – Achieving 45%** 3 – Excelling 9% Leads: Research Operations & Patient experience
	1B: Individual patients (service users) health needs are met	Using our community outreach approach, South Central Ambulance Service have within the first few months of the study already screened significantly over the 300 patients target we were initially set to reach by August 2024. The ELSA statistician team predict that 1 in 100 children will be screened as 'high risk' meaning South Central Ambulance Service has likely already identified at least 3 children who are likely to develop type 1 diabetes.	

		Un-controlled diabetes can cause significant health risks to eyes, heart, Kidneys, Feet, nerves, and gums. With significant life-threatening complications if blood sugar levels rise too high or fall too low. There is also evidence to show that patients with diabetes are at an increased risk of developing some cancers (Diabetes.org.uk). Through early identification of diabetes, patients' local diabetes centres can support regular screening and treatment for these complications alongside their general practitioners. The ELSA Study also allows us to engage with communities and provide health education and support for patents and their families who have been identified as 'high risk'. This education package can help support the psychological effects of chronic disease diagnosis for both patient and family. We also disseminated information about the research through social media and news articles on World Diabetes Day (**see World Diabetes Day social media and news article)** World Diabetes Day.docx World Diabetes Day.docx	0 – Undeveloped 0% 1 – Developing 27% **2 – Achieving 55%** 3 – Excelling 18% Lead: Research Operations & Patient experience
	1C: When patients (service users) use the service, they are free from harm	The ELSA study has a low index of risk, the finger prick test is quick, and the amount of blood required is just 5 small drops per patient onto the testing card. No Serious incidents are expected to occur during this testing. Although low risk, the reassurance of having an ambulance clinical team conducting the testing can reassure the patients and help them feel safe. If the worst were to happen, those you would call, are already present, with all the equipment. This is a level of reassurance no other community-based research delivery team can provide. The study designed a fully online consent module with patient identifiable information and would be difficult to redact effectively enough for publication. (**See consent form)** ELSA Study Parents Consent form.pdf ELSA Study Parents Consent form.pdf	0 – Undeveloped 0% 1 – Developing 27% **2 – Achieving 55%** 3 – Excelling 18% Lead: Research Operations & Patient experience
	1D: Patients (service users) report positive experiences	The patient experience reported so far, has been widely positive. We have utilised the opportunity to conduct public engagement at the events. Using our R-RRVs and un-used trust ambulances, we welcome children and adults from the locations to come and speak to the team and have a look around the vehicles (when no patient present). This has at times included full classes from schools / nurseries being able to sit in the vehicles and others having the opportunity to ask health questions of have general discussions. Patients have been enthusiastic about the opportunity to sit on an ambulance and the provision of stickers	0 – Undeveloped 0%

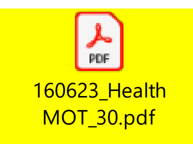
	of the service	after completing the screening means we have had very few leaving the vehicles without a positive experience. The experience of a parent and their child that attended a community event was captured by ITV news (**See link https://www.itv.com/news/meridian/2023-07-31/boy-tells-of-living-with-diabetes-as-study-begins-screening-condition-in-kids**) The Clinical Research Network (CRN) do request feedback opportunities are available and so far, we have handed out feedback questionnaire links to most parents or carers of ELSA screened children, however nationally there is not a great completion rate and ours is no different, since screening started, we have only had 10 responses from our ELSA feedback questionnaires, but all have been positive.	1 – Developing 36% **2 – Achieving 36%** 3 – Excelling 27% Lead: Research Operations & Patient experience
Domain 1: Commissioned or provided services overall rating (by stakeholder panel)			**8**

Domain 2: Workforce health and well-being - Health and Wellbeing Department

Domain	Outcome	Evidence examples	Score & Lead

Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	South Central Ambulance Service NHS Foundation Trust has created a **Health and Wellbeing Portal** to provide colleagues working for SCAS with Health and Wellbeing services, information, and advice to proactively look after your own wellbeing. All webinars and events are added to the portal with a calendar on the home page. We have run webinars on Managing Periods at Work, Diabetes Type 1 & 2, how to manage IBS, expectant parent and emotional eating. Affinity Connect Webinars re: retirement / financial wellbeing and their new pension tax allowance course. We run a monthly hot topic menopause session. The Menopause Café - Let's Talk Menopause café with the first half hour on a Hot Topic, followed by 30 minutes open discussion/café, we also have a dedicated Menopause page on Portal. The SCAS Menopause policy (**see attached**) was released in September to support colleagues and managers.  Menopause-Policy.pdf Menopause-Policy.pdf Mens Health – we have just launched a Mens Health page on the portal to provide support to this group of our staff. The Health and Wellbeing team are continually working to improve what is offered to all SCAS colleagues through research, local and national support, further engagement and communication with everyone and in line with the SCAS People Strategy. The portal can be accessed here - SCAS Staff Wellbeing Portal – SCAS Staff Wellbeing Portal (scasbenefits.co.uk) We have also developed a booklet with most of these support offerings. **(see attached booklet**) Wellbeing offerings booklet (online versio Wellbeing offerings booklet (online version).pdf SCAS currently have approx. 190 stress risk assessors trained to support staff. Stress Risk Assessments and Maternity Risk Assessments are undertaken, data recorded and reported to the Health, Safety and Risk Committee every 6 weeks, to update the group and reassure of compliance and general wellbeing of staff. **(see attached stress risk assessment form)**  Stress risk assessment form - bla Stress risk assessment form - blank.docx	

In conjunction with our Occupational health provider, Optima Health we have run a series of 30 minute Health MOT Checks for staff **(see poster attached)**



160623_Health MOT_30.pdf

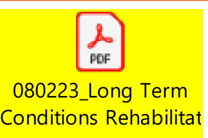
Collaborative working with their Occupational Health provider has made SCAS the first ambulance service nationally to create and successfully implement a Long Covid Programme which has resulted in decreased absence levels and retention of staff.

The Covid Rehabilitation Programme was six-week duration, staff would attend for two hours each week, including an education component involving evidence based CBT based psycho-education delivered by a Psychological Wellbeing Practitioner and Chartered Physiotherapist. This session also included understanding Covid 19 and the psychological implications of Covid-19, such as low mood, fear and anxiety.

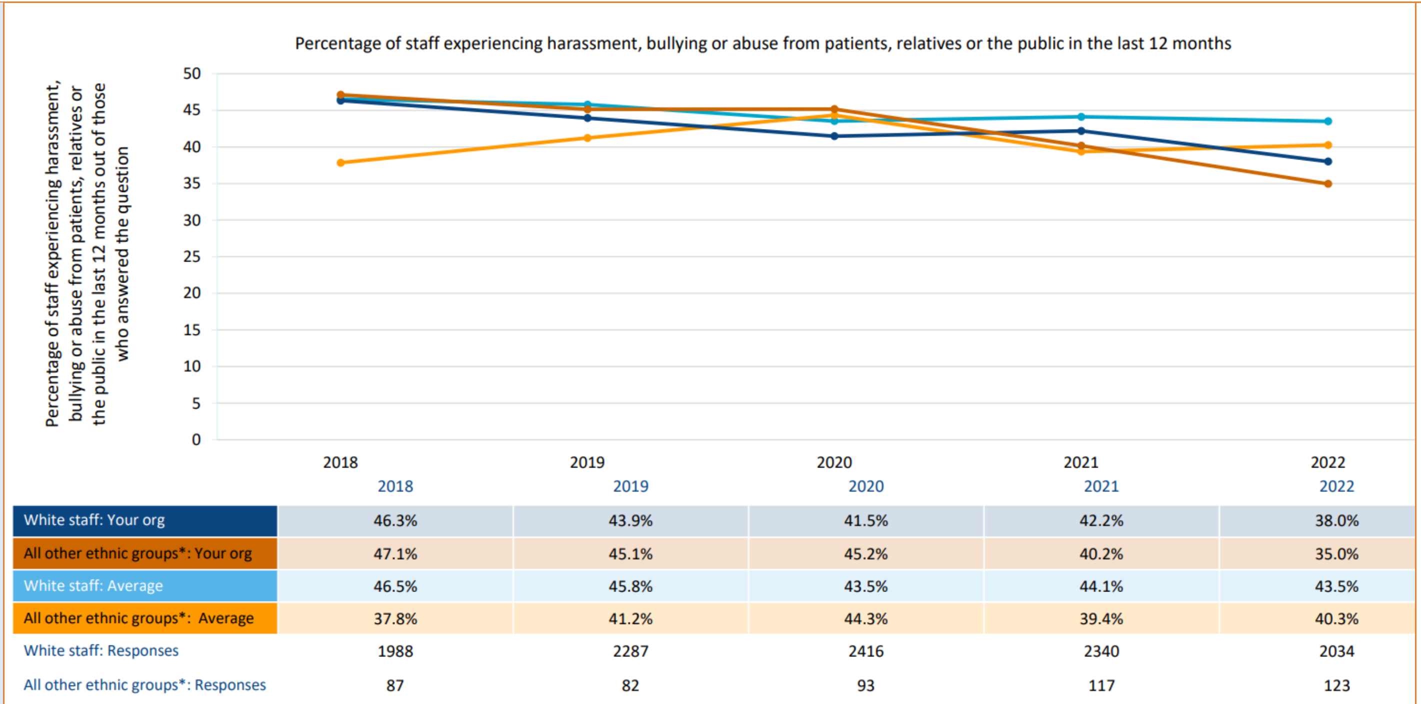
In addition to the education component the programme covered:

•A functional and pulmonary rehabilitation exercise class delivered by a Chartered Physiotherapist
•Mindfulness based relaxation
•Weekly resources to encourage adherence to the programme such as information sheets, podcasts, webinars, mood and exercise diaries as well as a bespoke home exercise programme
•Participants also received a weekly 1:1 consultation with one of the Occupational Health clinicians to discuss any concerns, monitor progress and encourage motivation and adherence to the programme.

We are now providing these staff with an opportunity to attend a long term rehabilitation programme, **(see attached information)** that Optima Health are delivering. A multi-disciplined education and rehabilitation programme will help staff with long term conditions including:
• Mental Health (stress, anxiety and depression)
• Musculoskeletal Health (chronic pain, joint and back pain)
• Post Covid Syndrome (fatigue and mental health)
• Common Long-Term Conditions (diabetes, obesity, fibromyalgia, hypertension, cardiovascularor respiratory diseases)

		 080223_Long Term Conditions Rehabilitation Programme_AACE. Info Sheet.pdf Each participant will be medically screened and assessed by a clinician to ensure they are appropriate and safe to participate in the programme. This will also involve a number of functional tests and outcome measures so that progress can be monitored throughout the programme.	0 – Undeveloped 0% 1 – Developing 25% **2 – Achieving 58%** 3 - Excelling 17% Leads: Health, Wellbeing team & HR

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	The Workforce Race Equality Standard (**WRES**) was mandated through the NHS standard contract from 2015/16. The WRES comprises nine specific metrics to compare the profile and experiences of Black, Asian and Minority Ethnic (BAME) and White staff within an NHS organisation. The WRES is published on our website NHS-Workforce-Race-Equality-Standard-WRES-report-2023.pdf (scas.nhs.uk) The WRES contains two indicators (5 & 6) that focus on bullying & harassment **Indicator 5: percent of staff experiencing harassment, bullying or abuse from patients or public** • There has been a steady improvement in this indicator in the last 4 years. The percentage of BAME staff experiencing harassment, bullying or abuse from patients or the public is **35%,** this a significant drop from 40.2% from last year. We are **better** than the comparable Ambulance Trusts average for BAME staff at **40.3%.** • This compares with experience of white staff at 42.2% last year that also improved this year to **38%.** We are better than the comparable Ambulance Trusts average for white staff at **43.5%.** Chart below shows percent of staff experiencing harassment, bullying or abuse from patients or public over a 5 year period	



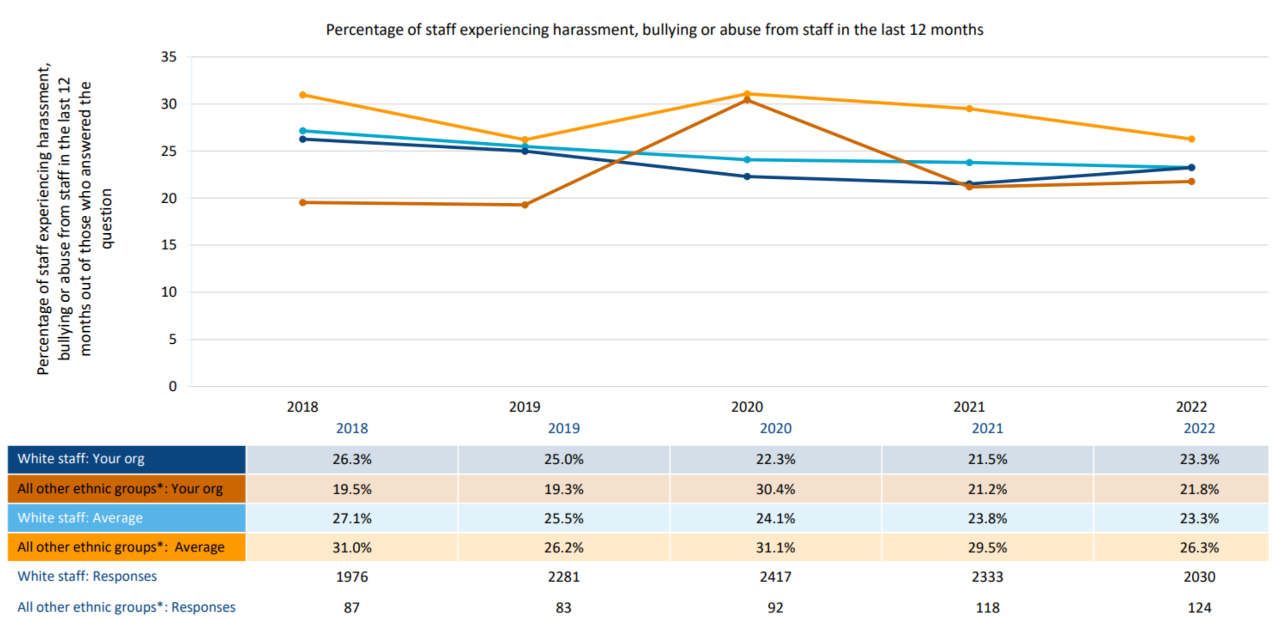
	2018	2019	2020	2021	2022
White staff: Your org	46.3%	43.9%	41.5%	42.2%	38.0%
All other ethnic groups*: Your org	47.1%	45.1%	45.2%	40.2%	35.0%
White staff: Average	46.5%	45.8%	43.5%	44.1%	43.5%
All other ethnic groups*: Average	37.8%	41.2%	44.3%	39.4%	40.3%
White staff: Responses	1988	2287	2416	2340	2034
All other ethnic groups*: Responses	87	82	93	117	123

Indicator 6: Percentage of BAME staff experiencing harassment, bullying or abuse <u>from staff</u>

- There was a drop in the percentage of BAME staff experiencing harassment, bullying or abuse from staff in 2020 (30.4%) to 21.2% in last year. This year figure was **marginally worse** at **21.8%**. Although better than comparable Ambulance Trusts average for BAME staff at **26.3%**

- In comparison white staff have experienced an increase, from 21.5% last year to **23.3%** in the latest staff survey. This same as the comparable Ambulance Trusts average for white staff at **23.3%.**

  Chart below shows the Percentage of BAME staff experiencing harassment, bullying or abuse from staff over a 5 year period



	2018	2019	2020	2021	2022
White staff: Your org	26.3%	25.0%	22.3%	21.5%	23.3%
All other ethnic groups*: Your org	19.5%	19.3%	30.4%	21.2%	21.8%
White staff: Average	27.1%	25.5%	24.1%	23.8%	23.3%
All other ethnic groups*: Average	31.0%	26.2%	31.1%	29.5%	26.3%
White staff: Responses	1976	2281	2417	2333	2030
All other ethnic groups*: Responses	87	83	92	118	124

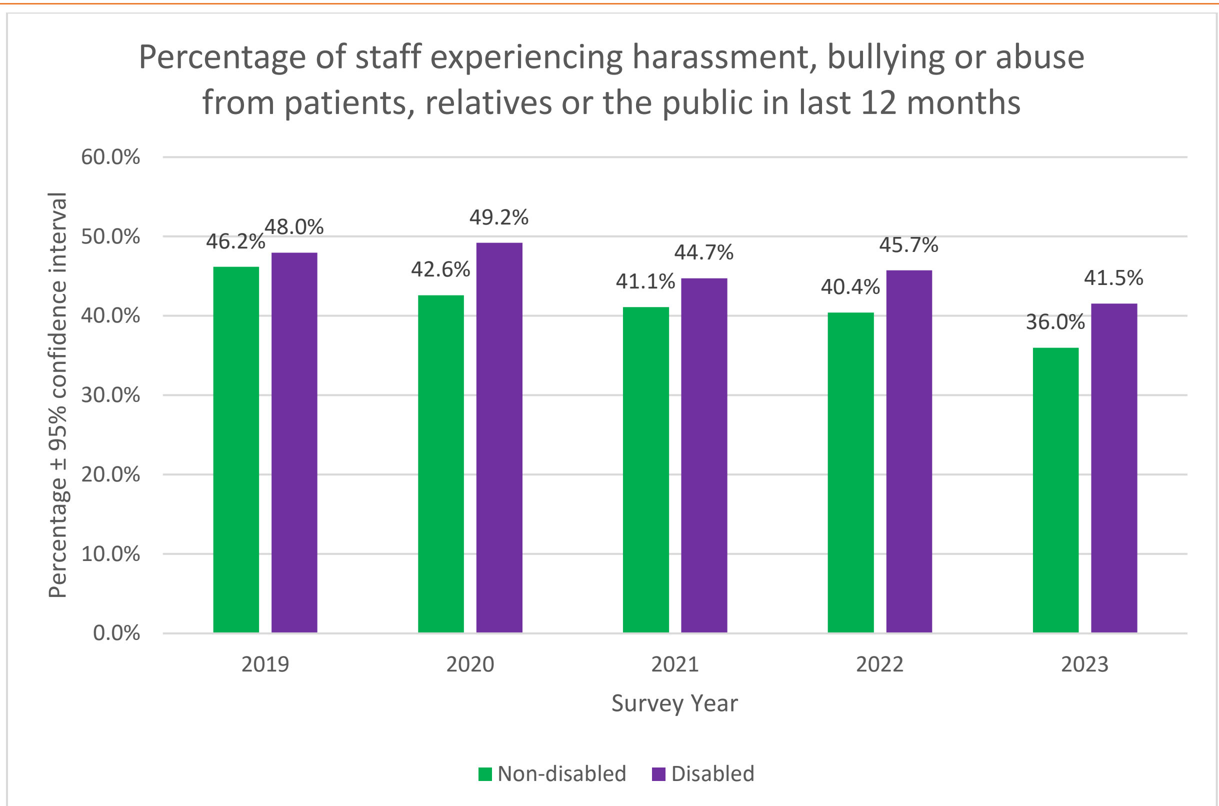
The Workforce Disability Equality Standards **(WDES).** Within this framework, there exist ten workforce metrics, facilitating a comparative analysis of data and responses from both disabled and non-disabled staff. The WDES is published on our website NHS-Workforce-Disability-Equality-Standard-report-WDES-2023-2.pdf (scas.nhs.uk)

The WDES has parts (a, b, c, & d) under Metric 4 that focuses on bullying and harassment:

Metric 4 (a) Percentage of staff experiencing harassment, bullying or abuse from patients relatives, or the public

The percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months was higher for Disabled staff (41.5%) than for Non-disabled staff (36.0%).

Chart below shows the percentage of disabled staff experiencing harassment/bullying or abuse from patients, relatives, or the public over a 5 year period.

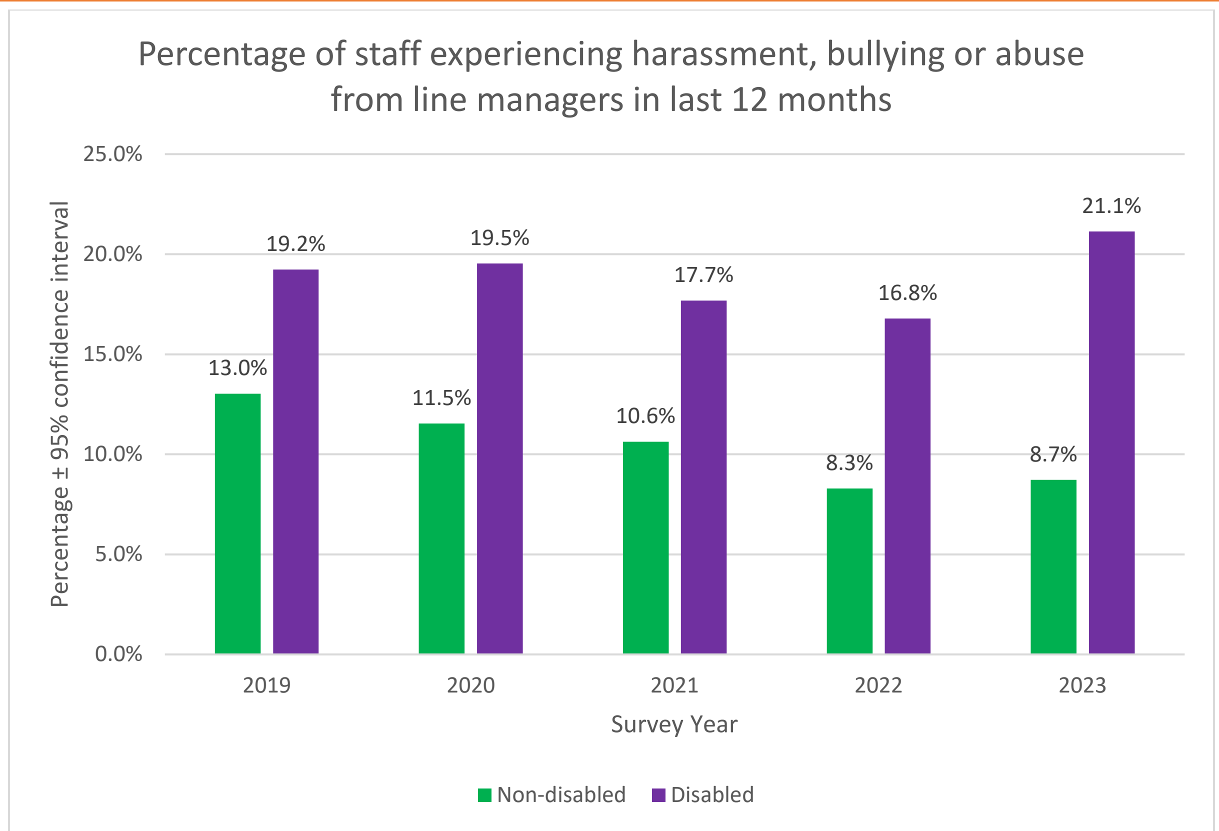


- The percentage of disabled staff experiencing harassment, bullying or abuse <u>from patients, relatives, or the public</u> for during this year's National Staff Survey (NSS) was **41.5%** a drop from the previous year (45.7%). We are also better than the comparable Ambulance Trusts average for disabled/LTC staff at **50.2%.**

<u>Metric 4 (b) Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months</u>

The percentage of staff experiencing harassment, bullying or abuse from line managers in last 12 months was higher for Disabled staff (21.1%) than for Non-disabled staff (8.7%).

The Chart shows the Percentage of disabled staff experiencing harassment, bullying or abuse from managers over a 5 year period

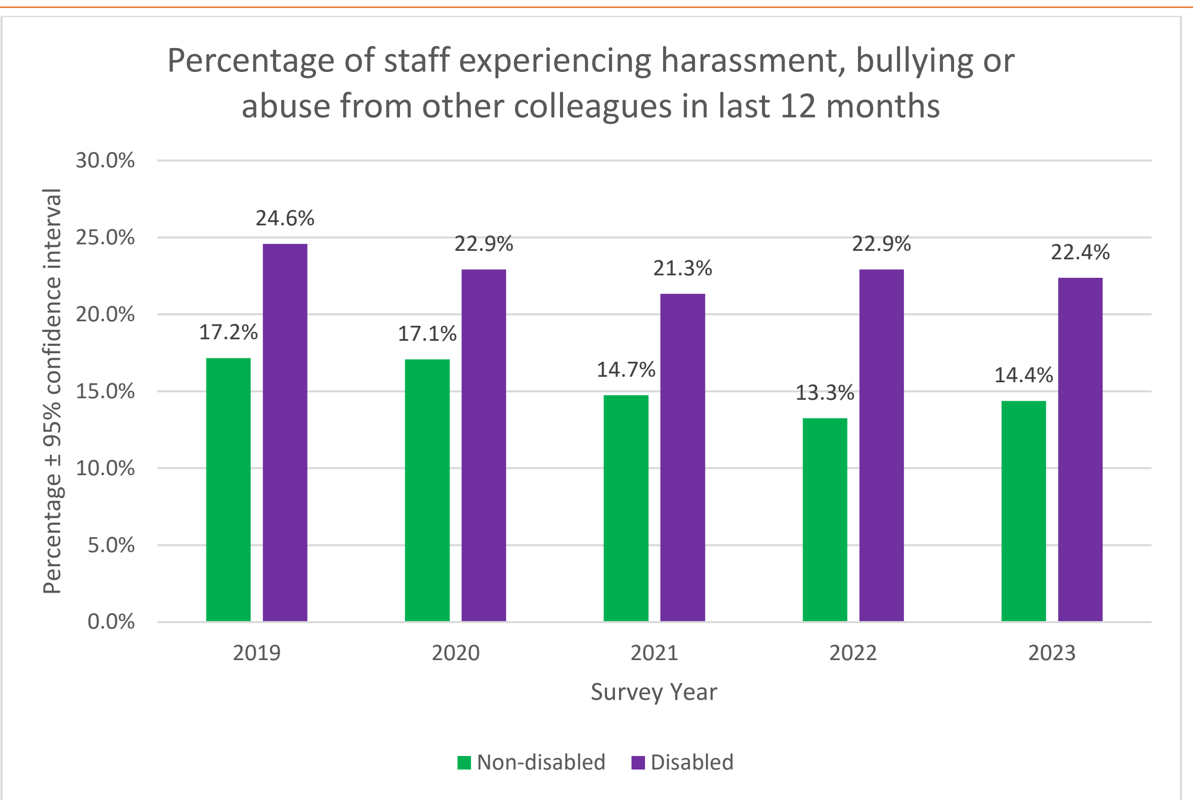


- The percentage of disabled staff experiencing harassment, bullying or abuse from managers was **21.1%** an increase from the previous year (16.8%). We are exactly the same as the comparable Ambulance Trusts average for disabled/LTC staff at **21.1%**

Metric 4 (c)Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

The percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months was significantly higher for Disabled staff (22.4%) than for Non-disabled staff (14.4%).

The Chart shows the percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues over a 5 year period

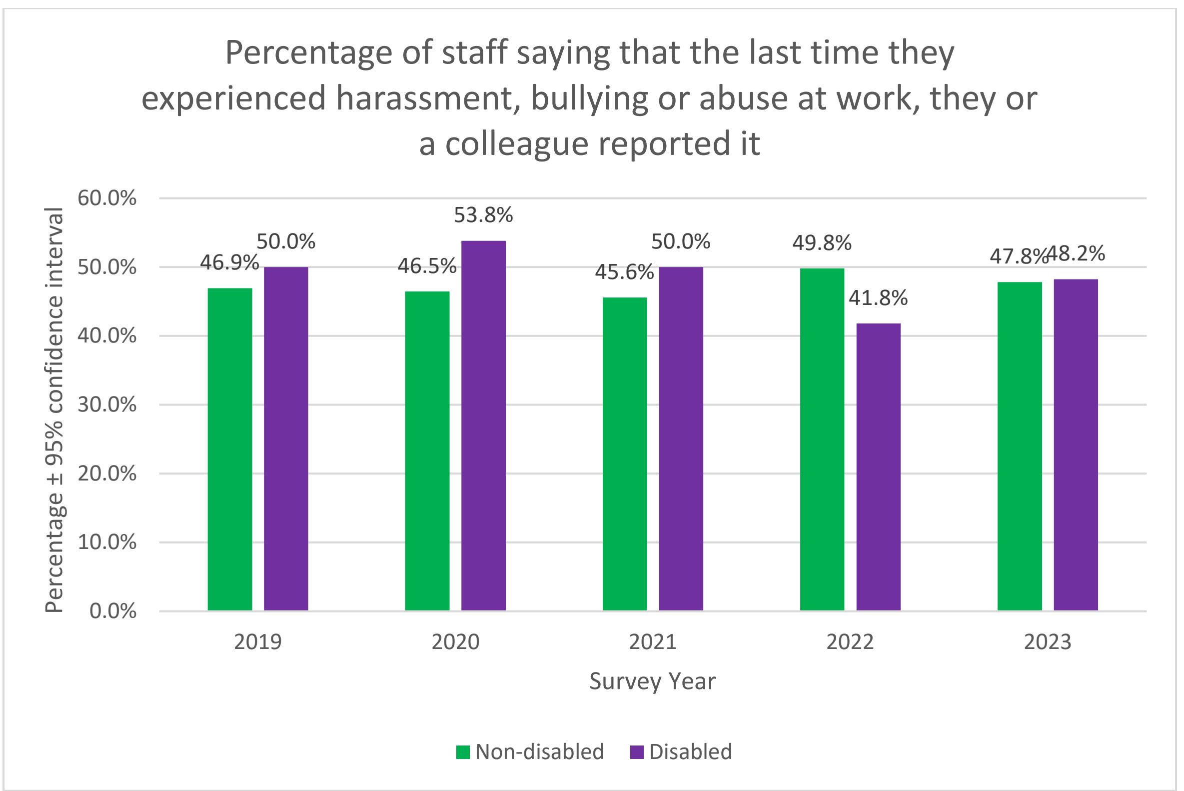


- The percentage of disabled staff experiencing harassment, bullying or abuse from other colleagues was **22.4%** similar to the previous year (22.9%). We are better than the comparable Ambulance Trusts average for disabled/LTC staff at **23.4%.**

Metric 4 (d) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

The percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was similar for Disabled staff (48.2%) and for Non-disabled staff (47.8%).

The Chart below shows the percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it, over a 5 year period

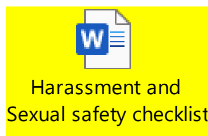
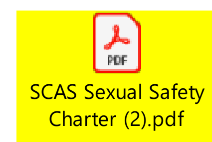


- The percentage of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it was **48.2%**, an increase from the previous year (41.8%). We are better than the comparable Ambulance Trusts average for disabled/LTC staff at **47.3%.**

To ensure that our staff are protected from bullying and harassment from patients, public and staff we are implementing the following in the WRES and WDES action implementation plans 2023.

- To protect our Staff, violence towards any SCAS member of staff is unacceptable we will work with the police to implement and publicise Operation Cavell and use Assaults against emergency workers act 2018 to do so.

We don't think violence towards any SCAS member of staff is acceptable and we need your help! (sharepoint.com)

		• Promote the Harassment and Sexual safety Disclosure checklist to managers & team leads  Harassment and Sexual safety checklist v.2.docx • To develop an Active Bystander Programme to address inappropriate and unacceptable behaviours and support an inclusive culture. • Champion the Just & Learning culture to enhance the Trust's work around perceived bullying, harassment, and abuse at work, ensuring that processes are transparent, and set out the key routes to reporting incidents. We have a Just & Learning culture hub page Learn more about a Just and Learning Culture in SCAS (sharepoint.com) • The roll out of the 'Good Start' induction training programme to address negative cultures and engender inclusion, belonging & reporting • We launched the SCAS Sexual Safety campaign and a dedicated Hub page for further support and guidance Sexual Safety at SCAS - Home (sharepoint.com) a • We also launched and publicised the SCAS 'Sexual Safety Charter' that has also been included in the NHSE Equality repository for NHS organisation to adopt/adapt  SCAS Sexual Safety Charter (2).pdf	0 – Undeveloped 0% **1 – Developing 92%** 2 - Achieving 8% 3 - Excelling 0% Leads: Health, Wellbeing team & HR

| | 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | We have a Wellbeing Champions established network with a diverse mix of champions, approximately 50 wellbeing champions across the Trust, A Health and Wellbeing Champion plays a key role in supporting and developing a culture that contributes not only to improve the physical and mental health and wellbeing of their colleagues but also themselves. The role is to -
• Promote and support our approach to health and wellbeing within SCAS
• Encourage and signpost colleagues to access relevant health and wellbeing information, opportunities and support
• Raise awareness of wellbeing activities by supporting at least 4 events per year; promote healthy lifestyles and positive mental health
• We hold monthly Champions chats where we discuss various topics for the champions to promote and its an opportunity to learn from each other

We have approximately 60 Mental Health First Aiders across SCAS, who have all attended the MHFA England course to achieve certification, to equip them with the knowledge and skills required to undertake this role.

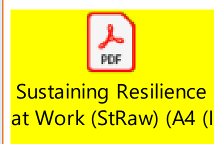
We promote The Ambulance Service Crisis Line and work with TASC reviewing reports of usage anonymised data. Caring For Those Who Care For Us \| TASC (theasc.org.uk)

All managers and leaders undertake a Wellbeing conversations programme, and this equips them to ensure they feel confident to undertake wellbeing conversations within their teams in line with our Just and Learning Culture.

We have just launched Maximus – a cost free mental health support mechanism / coincided with stress awareness day early November. **See attached information.**

 ATWMHSS Employee Poster.pdf

Launch of StRaW – end of November (**see attached information)**

 Sustaining Resilience at Work (StRaw) (A4 (Landscape)).pdf | 0 – Undeveloped 0%
1 – Developing 25%
2 – Achieving 42%
3 – Excelling 33%

Leads: Health, Wellbeing team & HR |

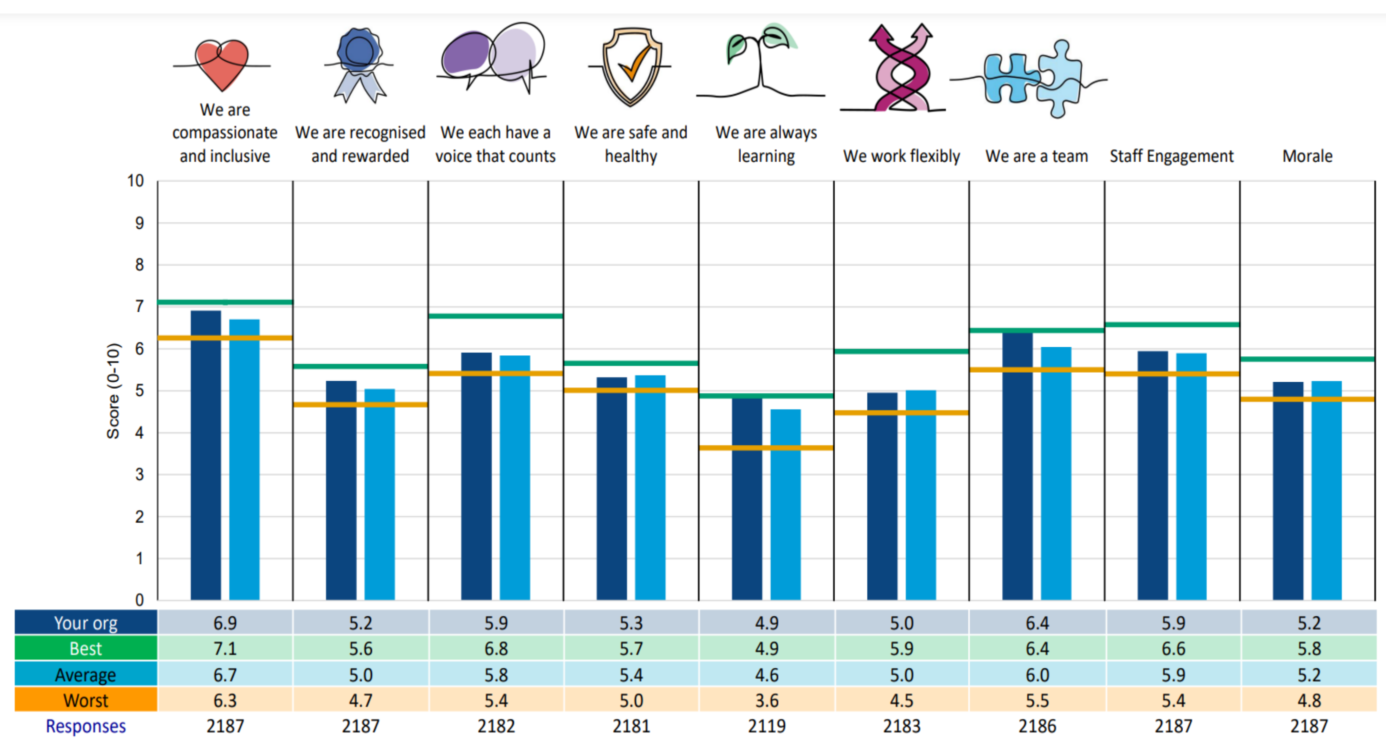
		We also have Occupational Health and the Employee Assistance Programme (EAP) services available for staff. Health, Wellbeing and Benefits - EAP-info.pdf - All Documents (sharepoint.com)	

2D: Staff recommend the organisation as a place to work and receive treatment

The NHS Staff Survey is carried out every year to improve staff experiences across the NHS. The full benchmark report is published by NHS England and can be found below.

RYE-benchmark-2022.pdf

The survey focuses on a range of themes and sub themes aligning with the NHS People Promise. Questions are grouped under the following areas. The Graph shows how we responded (in the last survey) against the areas. All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.

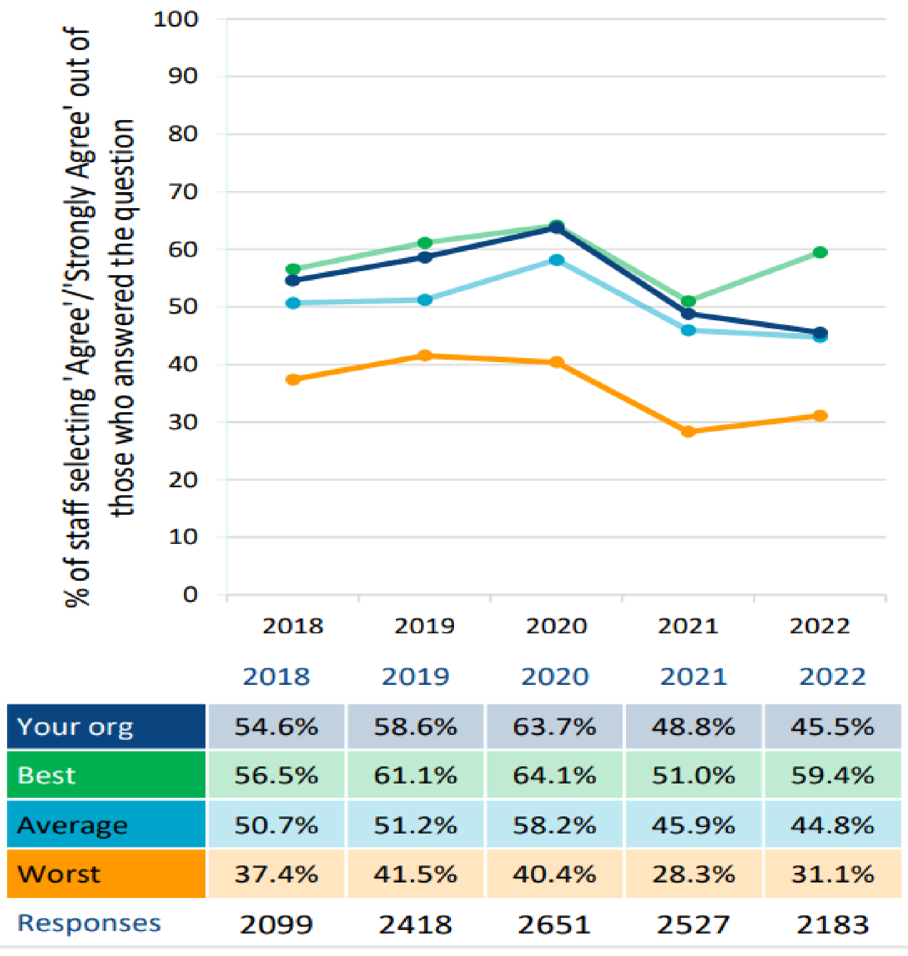


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.9	5.2	5.9	5.3	4.9	5.0	6.4	5.9	5.2
Best	7.1	5.6	6.8	5.7	4.9	5.9	6.4	6.6	5.8
Average	6.7	5.0	5.8	5.4	4.6	5.0	6.0	5.9	5.2
Worst	6.3	4.7	5.4	5.0	3.6	4.5	5.5	5.4	4.8
Responses	2187	2187	2182	2181	2119	2183	2186	2187	2187

We will focus on the specific questions, Q23c *“I would recommend my organisation as a place to work”* and Q23d *“If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”*.

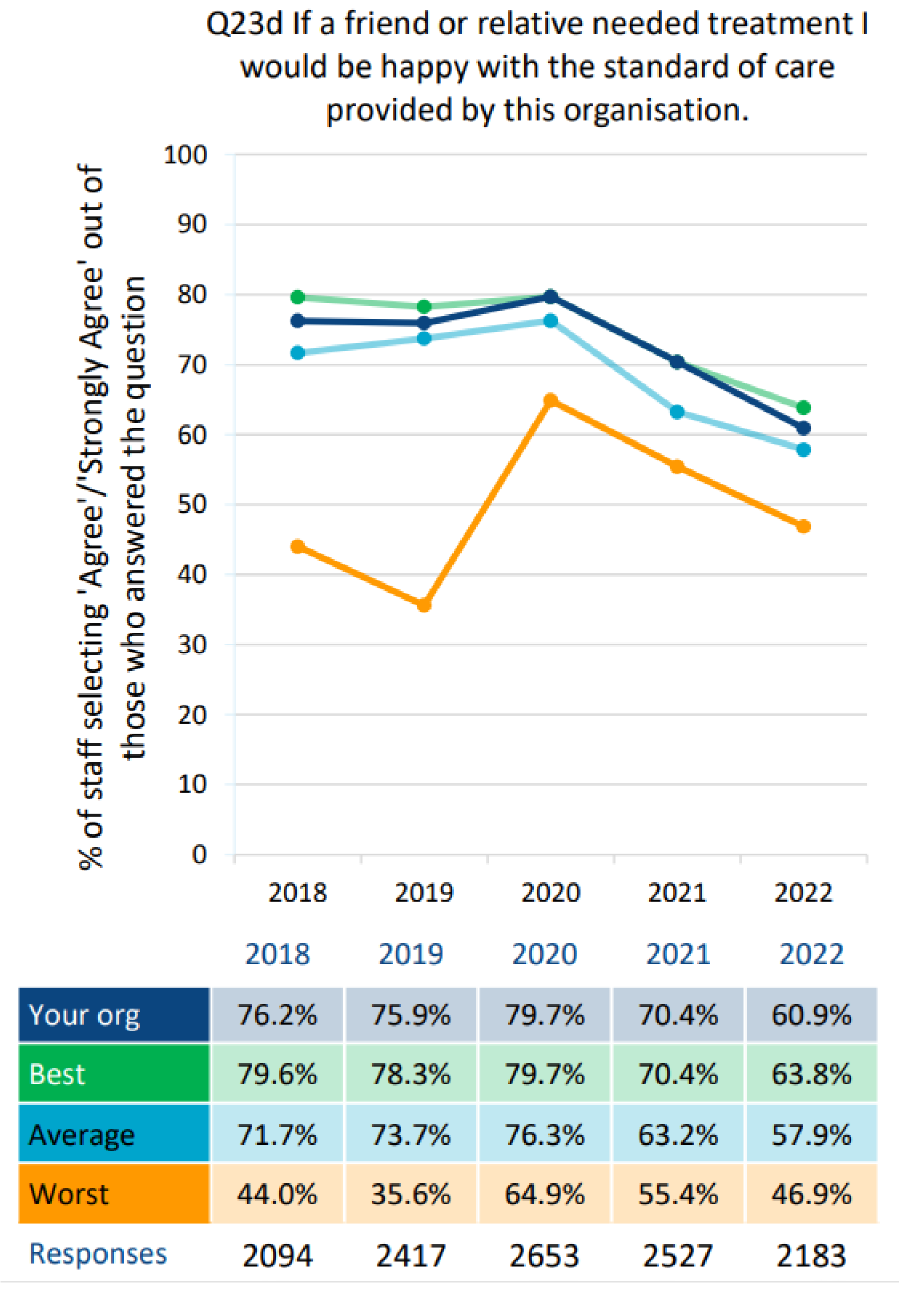
The Chart below shows our staffs response to the statement, “I would recommend my organisation as a place to work”, over a 5 year period.

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	54.6%	58.6%	63.7%	48.8%	45.5%
Best	56.5%	61.1%	64.1%	51.0%	59.4%
Average	50.7%	51.2%	58.2%	45.9%	44.8%
Worst	37.4%	41.5%	40.4%	28.3%	31.1%
Responses	2099	2418	2651	2527	2183

- There has been a decline in the percentage of staff who agreed or strongly agreed to recommending SCAS as a place to work from the previous year. However, this has been a general (average NHS for Ambulance Trusts) positive decline to this question.

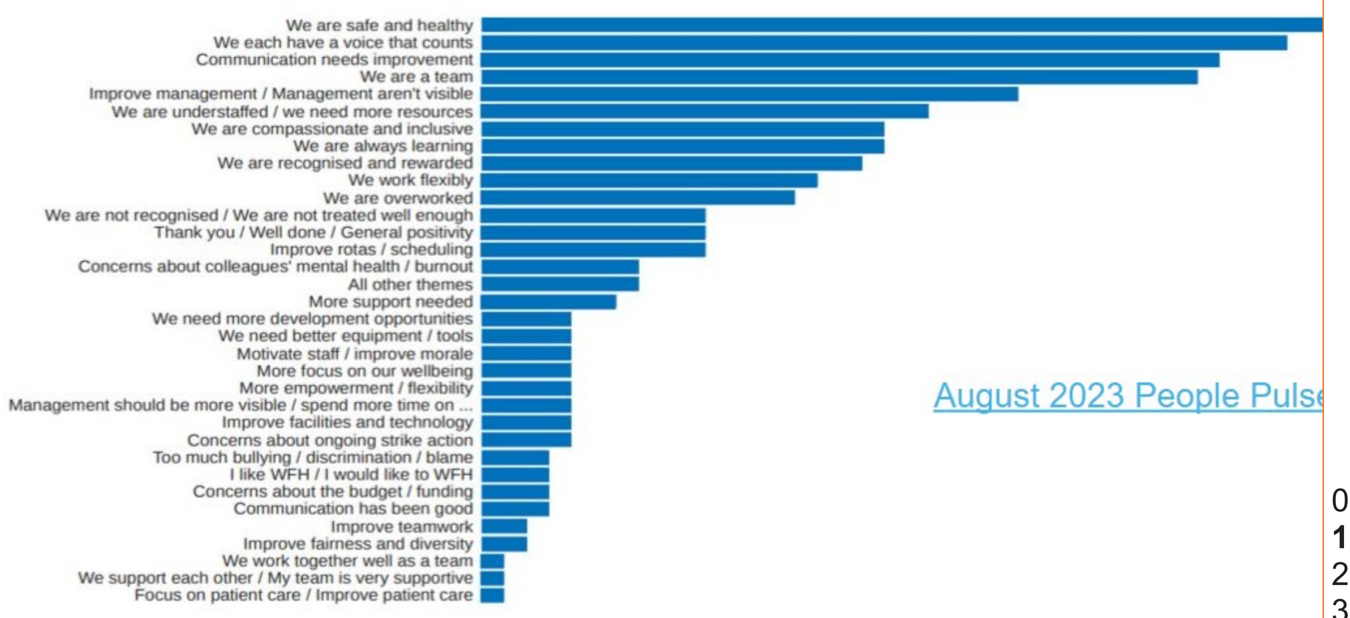


	2018	2019	2020	2021	2022
Your org	76.2%	75.9%	79.7%	70.4%	60.9%
Best	79.6%	78.3%	79.7%	70.4%	63.8%
Average	71.7%	73.7%	76.3%	63.2%	57.9%
Worst	44.0%	35.6%	64.9%	55.4%	46.9%
Responses	2094	2417	2653	2527	2183

- In the previous year, we ranked as the best but there has been a decline in the percentage of staff who agreed or strongly agreed to feeling happy with the standard of care their friend or relative would receive at SCAS. However, we are better than the general (average NHS for Ambulance Trusts).

The **'People's Voice'** Hub collects feedback from colleagues about what affects them at work. This includes through People Pulse surveys, the National Staff Survey, Freedom to Speak Up and employee relations themes, joiners and leavers surveys, student feedback, leadership visits, and Bright Ideas. People Voice - Home (sharepoint.com).

The Monthly **People Pulse Survey** enables free type commentary from this NHSE-owned platform is thematically analysed and where possible, sorted into directorates. We can measure the 'pulse' or mood of our staff regularly and feedback issues or concerns of colleagues. **Example slide below**

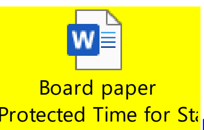
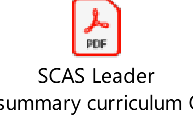
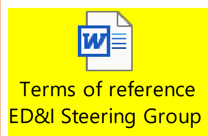
		Feedback to Organis  August 2023 People Pulse	0 – Undeveloped 0% **1 – Developing 55%** 2 – Achieving 45% 3 – Excelling 0% Leads: Health, Wellbeing team & HR

Domain 2: Workforce health and well-being overall rating	**6**

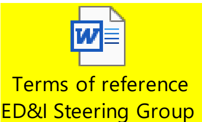
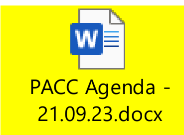
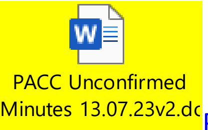
Domain 3: Inclusive leadership

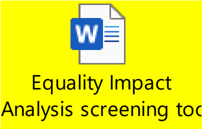
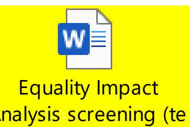
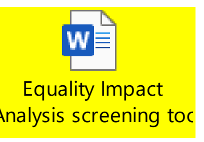
Domain	Outcome	Evidence examples	Feedback and Lead

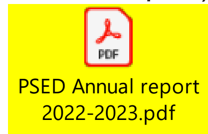
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Embedding and demonstrating Equality, Diversity & Inclusion (ED&I) is not just is not just a legal requirement (Equality Act 2010) it is integrated into the functions and operational objectives of SCAS. However, the commitment to EDI is more than just a legal responsibility it is also about ensuring that the diversity of our staff feel that they 'belong'. The Board has recognised the need to be further involved and engaged with our Staff Networks to deepen their understanding and champion diversity and inclusion. The role and establishment of an **Executive Staff Network Sponsor** is also highlighted in the action implementation plans with the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES) and our statutory Equality Objectives. The Staff Network Executive Sponsors plays an important role in a network to achieve their objectives, champion cause at Executive level and establish themselves within SCAS. SCAS currently has the following Staff Networks each with an Executive Sponsor: 1. Race & Inclusion Network 2. Multi-faith Network 3. DARE Network 4. LGBT+ Network 5. Women's Network 6. Military Champions Network The Executive Staff Network Sponsors have received training as to their role and functions (**briefing paper below)** Executive Sponsors.docx The Board have also understood the time that Staff Network Chairs volunteer to help staff and the organisation and have agreed that 'Protected Time for Staff Networks' is necessary. **See Board paper below**	

		[Board paper Protected Time for Staff Networks v.2.docx] Our internal leadership programme, SCAS Leader, comprises three modules each of which have a separate focus: Module 1: compassion Module 2: inclusion Module 3: collaboration Module 2 specifically explores identity, difference, the benefit of diversity and majority privilege. It looks at group development, the impact of leadership styles on different people and the risk of not listening or paying attention to all of our people. It also summarises for participants what it is to be an Inclusive Leader. **See breakdown of the curriculum** [SCAS Leader summary curriculum Oct22.pdf] To ensure that the Board and management understand and act on EDI and health inequalities the **ED&I Steering Group** has been established and is integrated into the governance process that reports to the People & Culture Committee and the Board. **See Terms of Reference below**: [Terms of reference ED&I Steering Group March 2023.doc] The Board took part in a workshop (30/11/2023) around their EDI responsibilities and setting EDI actions to meet organisational EDI objectives for their own appraisal and to monitor the organisational and their own progress. The workshop also highlighted the SCAS's role in understanding health inequalities and addressing it. The PowerPoint	**Internal (ED&I Steering groups) & Unions:**

		presentation attached taken from the workshop shows the impact of the Wider determinants of health and its impact on the services we deliver. Board Responsibilities & EDI objective setting slides.pptx	0 – Undeveloped 0% **1 – Developing 45%** 2 – Achieving 45% 3 – Excelling 9% **Oxford Health NHS Foundation Trust: Grade for 3A= Developing (1)** **BOB ICS: Grade for 3A= Developing (1)** Leads: Governance & Compliance & ED&I

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	The **ED&I Steering Group** has been established to implement the statutory and mandatory requirement of EDI, the Public Sector Equality Duty (PSED) and support, assure and Advise the Board. **See Terms of Reference below.**  [Terms of reference ED&I Steering Group March 2023.doc] The Steering Group is integrated into the governance process that reports to the **People & Culture Committee** which has EDI as a standing Agenda item. (**see PACC agenda item 7 and minutes below)**  [PACC Agenda - 21.09.23.docx]  [PACC Unconfirmed Minutes 13.07.23v2.docx] In 28/04/2023 the Board approved the new Equality Impact Assessment (EqIA) Toolkit **(see attachment below)**. The EqIA is a way to make sure individuals and teams think carefully about the likely impact of their work on the local population and take action to improve strategies, policies and projects. [EqIA Board report template.docx] An EqIA helps to meet our Public Sector Equality Duty under s.149 of the Equality Act 2010, the EqIA toolkit provides a detailed guide and 'at a glance flow chart' to help staff conduct a EqIA screening or a full EqIA. The Head of EDI 'sense checks' and provides challenge to ensure a robust EqIA. The EqIA toolkit and forms are available on the Hub [Equality and Diversity - Home (sharepoint.com)], **the document is attached blow:**	**Internal (ED&I Steering groups) & Unions:** 0 – Undeveloped 0% 1 – Developing 18% **2 – Achieving 73%** 3 – Excelling 9%

		EqIA Toolkit v.8.pdf Examples of completed EqIAs:  Equality Impact Analysis screening tool & Due regard Category 2 Segmentation Project Draft1 - DR.docx Equality Impact Analysis screening (template) - Accessibility regulations.docx Equality Impact Analysis screening tool & Due regard Partis House project Draft v0.2 DR.docx	**Oxford Health NHS Foundation Trust: Grade for 3B= Developing (1)** **BOB ICS: Grade for 3B= Developing (1)** Leads: Governance & Compliance & ED&I

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	The Board has oversight and ratifies all the statutory, regulatory, and mandatory reporting obligations. The statutory reports are published on our website Equality and Diversity | South Central Ambulance Service (scas.nhs.uk) The reports published are: • The Workforce Race Equality Standard (WRES) scas.nhs.uk/wp- content/uploads/2023/12/NHS- Workforce-Race-Equality-Standard- WRES-report-2023.pdf • The Workforce Disability Equality Standard (WDES) NHS-Workforce-Disability-Equality-Standard-report-WDES-2023-2.pdf (scas.nhs.uk) • The Gender Pay Analysis report Gender-Pay-Analysis-Report-2022-23-1.pdf (scas.nhs.uk) • Annual Public Sector Duty (PSED) Equality report (contained within our organisational Annual report) – **See attached document below**  PSED Annual report 2022-2023.pdf The Board also have to demonstrate their commitment to ED&I as one of the SCAS **statutory Equality Objectives** is '*Inclusive Leadership',* that includes an Action Implementation Plan with 5 specific actions with a direct alignment with this EDS Domain and success criterions to achieve. These Equality Objectives form part of the SCAS **ED&I Strategy 2022- 2026** which further ensures the Boards commitment and understanding of ED&I. The ED&I Strategy and the SCAS Equality Objectives are published on our website SCAS_EDI_V5.pdf The roles of Board members and leaders in taking responsibility and committing to EDI & health inequalities has become increasingly important through the roll out of the **NHS England EDI Improvement plan.** The Board took part in a workshop (30/11/2023) around their EDI responsibilities and setting EDI actions to meet organisational EDI objectives for their own appraisal and to monitor the organisational and their own progress. The **slide**	**Internal (ED&I Steering groups) & Unions:** 0 – Undeveloped 0% 1 – Developing 27% **2 – Achieving 73%** 3 – Excelling 0% **Oxford Health NHS Foundation Trust: Grade for 3C= Developing (1)** **BOB ICS: Grade for 3C= Developing (1)** **Overall Totals: Unions (inc. ED&I Steering group) =5** **Oxford Health NHS FT =3** **BOB ICS =3** **Mean Ave.=3.66 (4) – (Developing)**

below taken from the workshop shows the Boards responsibility to ED&I that are linked to statutory as well as mandatory priorities that will inform their Appraisal objectives.

Board EDI Principles:

Fiduciary Duty: Board members have a fiduciary duty to act in the best interests of the Trust. This involves advancing EDI initiatives to enhance performance and reputation.

Legal Compliance: Boards are legally obligated to ensure that the Trust complies with the **Equality Act 2010, specifically S.149** (PSED)

1.Eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Equality Act 2010
2.Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not.
3.Foster good relations between people from different groups. This involves tackling prejudice and promoting understanding between people from different groups.

Anti-Discrimination: Board members must take proactive steps to prevent and address discrimination.

Governance Oversight: Boards are responsible for setting the tone at the top of the Trust, establishing governance structures, and ensuring the Trust's leadership is accountable for EDI goals.

EDI Strategy '22 - '26 Equality Objective 1: Inclusive Leadership

Having strong, compassionate, inclusive and committed leadership will be critical to our success and achieving the ambitions of this strategy. We will develop, support and hold our leaders to account in managing in a way that embeds and promotes equality, diversity and inclusion. We will continue to ensure that diversity considerations are fully integrated into the "business" of the organisation though our committee structures, documentation, planning processes and the management of risk. We will strive for continuous improvement in all that we do and will benchmark ourselves against best practice. Through fulfilling the Objectives and assessment criteria within the Action Plans.

The case for change:

Staff survey and workforce data reflecting the **lived experience**

WRES The areas for improvement where are doing less well than last year are:

•BME staff appointed from shortlist (indicator 2)
•Percentage of BAME staff experiencing harassment, bullying or abuse from staff, marginally worse but better than comparable Ambulance Trusts average (indicator 6)
•Percentage of staff believing that Trust provides equal opportunities for career progression or promotion, marginally worse but better than comparable Ambulance Trusts average (indicator 7)

WDES The areas for improvement where are doing less well than last year are:

•Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting (metric 2)
•Likelihood of Disabled staff entering the formal capability process (metric 3)
•Percentage of disabled staff experiencing harassment, bullying or abuse from managers (metric 4b)
•Percentage of disabled staff who believe that the trust provides equal opportunities for career progression or promotion (metric 5) but better than the comparable Ambulance Trusts average.
•Percentage of disabled staff satisfied with the extent to which their organisation values their work (metric 7) but Although better than the comparable Ambulance Trusts.
•Percentage of disabled staff with a long-lasting health condition/illness saying their employer has made adequate adjustment(s) to enable them to carry out their work (metric 8) which also worse than comparable Ambulance Trust average
•Staff engagement score for Disabled staff (metric 9) but better than the comparable Ambulance Trusts average

EDI Improvement Plan

High impact action 1:

- Board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. (03/24).
- Leaders to demonstrate compassion and inclusion. Staff will in turn feel more empowered to deliver great care and patient experience. (03/25).
- As highlighted in the Messenger Review, principles of EDI should be embedded. Board members should have distinct objectives or improving inclusion in the Trust and have a personal commitment to mainstream EDI as the responsibility of all, such that the provision of an inclusive and fair culture should become a key metric (BAF) by which leadership at all levels is judged.

Other High Impact responsibilities:

- Fair & Inclusive Recruitment and talent management processes
- Eliminating race, disability and gender total pay gaps
- Address health inequalities within the workforce
- Induction and onboarding for internationally recruited staff

Domain 3: Inclusive leadership overall rating	4

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): As part of & including this year the ED&I Steering group	Independent Evaluator(s)/Peer Reviewer(s): BOB ICS Oxford Health NHS Foundation Trust

EDS Organisation Rating (overall rating): 16 (Developing)

Organisation name(s): South Central Ambulance Service NHS Foundation Trust

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**

Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**

Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**

Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1 average score: 4+8 divided by 2=6
Domain 2 score: 6
Domain 3 score: 4

Summary of Key Findings, actions and recommendations from evaluators

This from the feedback from the evaluators based on the evidence presented and interpreted by them and although it is subjective it does provide an indication and perception of the services.

For Domain1: PTS

- More data needed to have a greater understanding of our service users and their experiences.
- Opportunity to provide data about renal patients and other patients who have higher needs and suffer from Health inequalities.
- Good to see a steady number of compliments, would like to understand the number as a % of patient journeys.

For Domain1: EarLy Surveillance for Auto-immune diabetes study

- Already met targets initially set to reach by August 2024
- Overall, the team could develop a database on community center's they could access to promote such a valuable service -especially among communities where there is a higher prevalence of diabetes.
- Need to be more proactive in getting feedback.

For Domain 2: Workforce health and well-being

- The Trust offers a range of H&WB support to its staff, unclear from the evidence how much it is accessed or what staff view of the support is.
- Whilst there have been improvements, there are still concerns of negative cultures.
- There needs to be further use/ promotion of MHFAs and HWB champions. Includes more support for those doing the roles (as volunteers).

For Domain 3: Inclusive leadership

- A good amount of work has gone into producing the various reports and analysis with reference to the main national drivers and initiatives with updates to senior leaders. Plenty of published information.
- There is evidence of both equality and health inequalities being discussed in board and committee meetings, but Board members and senior leaders need to be demonstrating and communicating their commitment or allocating resources to health inequalities, equality, diversity and/or inclusion.
- The Staff networks have a senior sponsor who have a defined role to meet and support them. However, no evidence of sponsoring (supporting) religious, cultural or local events and/or celebrations. Staff Networks still need better executive sponsor input.

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.			Risk score **12**
Strategic Risk No. 1:		Update: January 2024	
If we have insufficient clinical workforce capability or ineffective equipment and vehicles	***Then*** we will fail to provide safe and effective care	***Leading to*** poor clinical outcomes.	

	Impact	Likelihood	Score
Inherent	5	4	20
Residual	**4**	**3**	**12**
Target	3	3	9

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

Controls	Gaps in Controls	Actions	Owner / Due Date
• Clinical workforce recruitment programme • Equipment audits and concern reporting process in place • Adverse Incident Reporting Process • Clinical Standard Operating Procedures • Private Provider strategy and governance framework • Continuous Professional Development training • Safeguarding Improvement Plan • National clinical practice guidelines (JRCALC) • National ambulance standards • PTS contracted standards • Make ready contract and effective contracting • Fleet and make ready KPIs • Operational escalation procedures (e.g., OPEL, REAP) • Internal training for new paramedics • Equipment training logs • Chief Medical Officer link to local and national forums • Patient Safety Improvement Workstream	• Workforce shortages • Process for developing rotas/review of rotas • Delayed operational responses • Variability in pathways • Developing clear strategy for learning from incidents and data which then feeds into education programmes in the workforce.	Implementation of the Patient Safety Strategy from NHSE and the associated Patient Safety Incident Response Framework (PSIRF) to replace the existing Serious Incident policy and process.	Carol Rogers / April 2024
		New centralised logistics hub being set-up including medicines management	Helen Young / Complete
		Development of CPs in remaining acutes and systems	Mark Ainsworth / Ongoing
		Rota review	Mark Ainsworth / Q4
		Explore/review Paramedic Rotation schemes.	Melanie Saunders / Q4 2023/24 – On-hold due to capacity and competing priorities

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Quality & Safety Committee • Patient Safety & Experience Group • Clinical Review Group • Medicines Optimisation and Governance Group • Workforce Development Board • Integrated Workforce Planning groups	**Third line (external) assurances** • Internal Audits • CQC Inspections • Clinical Governance Audits • Commissioner contract review meetings	• Real-time tracking of clinical equipment and medicines	Procure system for managing safe deployment and maintenance of medical equipment	Barry Thurston / Updated BC at ETB in Oct - Approved

Associated Risks on the Trust Risk Register (15+)			
Risk No.	**Risk Title**	**Description**	**Residual Score**
027	999 Delay Risk:	IF we are unable to reach patients in a timely manner THEN there is a risk that we will be unable to effectively manage their care RESULTING in patient harm	16
089	IV Midazolam Risk	IF Mass Casualty Vehicles are not carrying IV Midazolam THEN this cannot be administered RESULTING in adverse or insufficient patient care	16
126	Paramedic Background Requirement Risk	IF there is an increase in the requirement process requiring a paramedic background THEN it will impact on the ratio of qualified and newly qualified paramedics RESULTING in an impact on patient safety	16
79	Maintenance for Equipment for Patient Transport and Healthcare Logistics Risk	IF there is not an adequate programme of scheduled equipment Maintenance and where required replacement of equipment THEN there is a risk to safety for both staff and patients RESULTING in patient and staff injury and poor reputation	16
147	Workforce Back fill for PSIRF Lead / fixed term contract of PSM ending Risk	IF SCAS do not have in place sufficient PSIRF Lead and PSM lead resource and a minimum of 30 hours AD safety resources, THEN there is an increased likelihood of PSIRP not being delivered in time line agreed as mandated by NHSE. RESULTING in not Achieving the criteria from NOF4	16
204	Staff Training - Intercollegiate Risk	IF SCAS staff do not receive safeguarding training THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm	16

Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.			Risk score **20**
Strategic Risk No. 2:	Update: January 2024		
If we do not have or use effective operational delivery systems	***Then*** we may not be able to meet demand and provide a responsive service to patients in need of emergency care	***Leading to*** delays in treatment and increased morbidity and mortality.	

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

Risk Lead	Assurance Committee
Mark Ainsworth, Chief Operating Officer, Helen Young, Chief Nurse, John Black, Chief Medical Officer	Finance and Performance Committee Quality & Safety Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Demand forecasting and profiling using models which are adjusted based on experience • Daily Operational MI reports detailing performance against set metrics • Mutual aid process exists and works • Collaborative operational management • Cat. 2 response segmentation • Effective local and regional escalation • National REAP process and actions • OPEL escalation plans • Enhanced Patient Safety Procedure • Clinical Pathways • Working with systems and UEC Boards • Performance Cell • Private Providers • Category 3 GP reviews in 999 • Performance Recovery Workstream • Clinical Pathways Lead embedded at QAH • 30-minute handover limit – letter sent 29 December.	• Insufficient clinical advisory support (e.g., 111, 999, IUC) • Quality Improvement Process and Culture • Clinical Pathways are not in place for all acutes and systems. • Hospital Handover Delays • Delayed Fleet Replenishment with aging fleet and increased VOR impacting vehicle availability for any increase in frontline resourcing.	Rota review	Mark Ainsworth / Q4
		Explore/review Paramedic Rotation schemes.	Melanie Saunders / Q4 2023/24 – On-hold due to capacity and competing priorities
		Development of Clinical Pathways in remaining acutes and systems	Mark Ainsworth / Ongoing
		Improving Pathways & patient flow at Queen Alexandra Hospital	Mark Ainsworth / Ongoing
		Review of Performance Cell	Rob Ellery / DRAFT - December 2023 Final – February 2024
		Project to increase fleet size temporarily: • Renting of 10 vehicles - Secured • Purchase / renting of further vehicles. • Contractual management of Convertors - Complete • Review of potential new convertors - Complete	Lemuel Freezer / December 2023

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Emergency & Urgent Care Boards • Quality & Safety Committee • Integrated performance report • Service Delivery Board • Operational management improvement board	**Third line (external) assurances** • ICS system management across region • National performance standards • PTS contractual standards • TPAM • Performance Insight Improvement Group • NHSE Performance Reviews	•		

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
52	QAH Handover Delays Risk	if QAH continue to have increased handover delays over and above agreed parameters then there is a risk to staff not being released resulting in negative impacts to service delivery, end of shift, meal breaks and patient care	25
119	Ambulance turnaround delay at A&E Risk	IF there is a delay in ambulance turnaround at A&E THEN there will be queue of ambulances RESULTING in risk to patient safety	25
91	PTS Resourcing & Activity Risk	IF demand continues to rise with ongoing resource challenges THEN we will see poorer patient experience, reduced morale amongst staff RESULTING in increased costs with use of Private Providers and Taxis and an increase in cancelled journeys	20
127	Private Provider Hours Risk	IF private providers hours are decreased due to finance sustainability, THEN it may be difficult to increase the providers hours during winter RESULTING in poor patient care	16
210	Supply Chain Risk	IF there is disruption or delays to the supply chain THEN there is a risk that SCFS will not be able to effect repairs or replacements in a timely manner RESULTING in delays to servicing and poor vehicle availability for the customer.	16
29	Callback Risk	IF our contracted/non contracted CAS providers or OOH GPs do not contact patients in line with national guidelines THEN there is a risk that the patients will be outside of safe parameters as defined by pathways RESULTING in an increased likelihood of patient harm	16
78	PTS Old Fleet Risk	IF we don't have adequate programme of scheduled maintenance/repair and replacement THEN there is a risk that there will be an inadequate fleet resource RESULTING in difficulties in delivering the contract	16

Objective 2: Partnership & Stakeholder Engagement: We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans		Risk score 12
Strategic Risk No 3:	Update: December 2023	
If the organisation fails to engage or influence within systems	***Then*** there may be a disproportionate focus in one system over the others and capacity provided may not align with expectations	***Leading to*** performance that is not achievable or credible and possible poor outcomes for patients and the communities we serve.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**4**	**3**	**12**
Target	2	2	4

25
20
15
10
5
0
Apr May Jun Jul Aug Sep Oct Nov Dec

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

Controls	Gaps in Controls	Actions	Owner / Due Date
• Attendance at Integrated Care Systems boards • Attendance at local resilience forums • Attendance at relevant Multi Agency Safeguarding Hub • Urgent & Emergency Care Boards • SCAS membership on Hampshire & IOW ICB committee • SCAS are included in the development of ICB processes, including how risks and issues are escalated across the systems • Attendance at system contract negotiations • System development • Attendance at ICB/Region director meetings • Governance and Well Led Workstream	• No SCAS membership on any ICB boards • ICB coordination for contracts • Capacity to attend director meetings	HIOW to establish coordinated ambulance commissioning group to include other ICS stakeholders	Mike Murphy / ICB to set up group. Expected to be completed by Q3 23-24
		Role to be advertised pending review and prioritisation during budget process. Would increase capacity for meetings	Mike Murphy / Feb 24
		Review system stakeholder engagement to identify alternative approaches	Volker Kellerman / Q3 23-24

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Finance and Performance Committee • System development board • Monthly report to Board on system activity	**Third line (external) assurances** • Monthly tripartite meetings which provides oversight and assurance regarding the Trust's position and performance and includes representation at the provider, ICB, CQC and NHSE/I level	•	Establish reporting mechanisms from system groups	Mike Murphy / Q3 23-24

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
53	Safeguarding System Risk	IF SCAS do not work effectively with the Safeguarding Children's Partnerships or Safeguarding Adult Boards THEN there is a risk that the Trust do not keep pace with the strategic work undertaken by the partnerships RESULTING in a failure to meet statutory requirements	16

Objective 2: Partnership & Stakeholder Engagement: We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans			Risk score 12
Strategic Risk No. 4:	Update: December 2023		
If we fail to engage with stakeholders and partners	***Then*** partners will fail to understand who we are and what we do	***Leading to*** failure to innovate, influence and an inability to identify opportunities within systems resulting in an inability to deliver on our long-term strategy.	

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

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

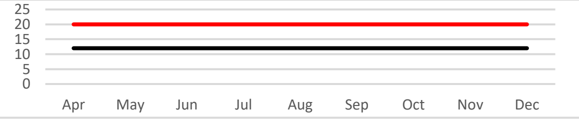
Controls	Gaps in Controls	Actions	Due Date
• Stakeholder management plan • Attendance at Integrated Care Systems boards • Attendance at local resilience forums • Attendance at relevant Multi Agency Safeguarding Hub • Emergency & Urgent Care Boards • Attendance at system strategy groups • System strategy initiatives • Involvement in Joint Forward Plans for each ICB SCAS work with. • Governance and Well Led Workstream	• Provision of senior executive expertise • Capacity to engage – impacted by clashes and meeting overlap across systems	SCAS-led strategy workshop in Hampshire and the Isle of Wight	Mike Murphy / Q2 2023 – Postponed due to pressures in the system – looking for alternative options
		Consider actions for other systems as above	TBC once above action complete
		Role to be advertised pending review and prioritisation during budget process. Would increase capacity for meetings	Mike Murphy / Feb 24
		Review system stakeholder engagement to identify alternative approaches	Volker Kellerman / Q3 23-24

Assurances		Gaps in Assurances	Actions	Due Date
First and second line (internal) assurances Reports to: • Finance and Performance Committee • Trust board	**Third line (external) assurances** • Monthly tripartite meetings which provide oversight and assurance regarding the Trust's position and performance and includes representation at the provider, ICB, CQC and NHSE/I level	•		

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
None			

Objective 3: Finance & Sustainability: We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.			Risk score 20
Strategic Risk No. 5:	Update: December 2023		
If demand, operational standards and external factors (such as inflation, interest rates, taxation and cost of living) continue to increase	***Then*** the total costs to deliver our services will increase and result in a deficit	***Leading to*** additional pressures on our ability to deliver a sustainable financial plan and safe services.	

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



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

Controls	Gaps in Controls	Actions	Owner / Due Date
• Standing financial instructions and standing orders • Planning and approval process for the Trust's budget • Budgetary management and regular reporting process – act vs plan process • Access to national funding for emergency related activity • Budget holders have agreed budgets, including cost improvement programme targets to deliver efficiencies • Alignment with ICB financial plans • Quality Impact Assessment process • Cost Improvement Programme • Cash monitoring • Weekly proxy data used for run rate • Financial Recovery Group spend reviews and monitoring (including corporate workforce) • Spend validation against peers • The annual planning process begins in the autumn and both "top down" and "bottom-up" including consultation with internal and external stakeholders, working with Directorates, aligning priorities with the strategy and developing a Trust-wide Business Plan and Priorities.	• Lack of agreement on key supplier and commissioning contracts • Lack of a medium-term financial plan • Lack of costing, productivity and efficiency across the Trust • Lack of a contract register – system in place, all contracts are now being provided to procurement • Business Planning process and objectives not sufficiently aligned with organization requirements including liquidity / cash support requirements. And cash/liquidity are reported are included as part of normal reporting cycles.	Negotiation and dialogue with key commissioners	Stuart Rees / Ongoing
		Consider greater delegation of budgets	Stuart Rees / ~~On hold due to additional control measures (SOF4)~~ To be included in the medium-term financial plan (3 year) – July 2024
		~~Develop multi-year Financial Recovery Plan~~	~~Stuart Rees / Complete~~
		Develop medium-term financial plan (Year 1 of plan)	Stuart Rees / Feb 24
		Interim Director of Finance working with Chief Strategy Officer to align processes and plans to ensure cash and liquidity are part of planning process.	Stuart Rees / Mike Murphy Feb 24
		Cash/Liquidity Plans along with the Memorandum of Understanding (MOU) and Utilisation form will be completed and taken through Finance and Performance Committee and Board.	Stuart Rees / ~~Dates as Required~~ Jan 2024

		Actions	Owner / Due Date
• Working capital support will be arranged through agreed loan arrangements. • Monitoring cash report now part of FPC • Financial Recovery Plan • Benchmarked data		Implementation of a contract register	Julie Robins / Draft October 2023 - Complete Final January 2024

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Finance and Performance Committee • Audit Committee • Executive Management Team meeting • Finance reports • Integrated Performance Report • CIP Quality and staff Impact Assessments • Financial Recovery Group	**Third line (external) assurances** • External audit • Internal audit • Counter fraud • Commissioners • HIOW ICB • System Recovery Group (ICB level group) • Recovery Support Programme meetings (System)	•		

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
013	Financial Risk	IF the Trust is not able to operate within the agreed financial budgets THEN there is a risk that the Trust recovery action will be needed; RESULTING in reduced monies available to directorates and departments and subsequent impact on services and projects	20
084	Financial Impact Risk	IF the cost of delivering services are higher than the funding received THEN there is a risk to continued holding of Contracts for both PTS and Logistics RESULTING in poor Trust reputation, increased uncertainty for team members and increased costs exiting contracts increasing costs to other departments and running the services at a loss.	16
085	PTS Contracts Operational Risk	IF these contracts are not awarded to SCAS, or extended or SCAS are not able to submit a tender as the incumbent provider THEN there is a risk of not being able to supply PTS services for the remainder of the contract term due to loss of staff RESULTING increased costs of private providers to backfill, reputation damage and impact on patient experience.	20
086	PTS Contracts Contact Centre Risk	IF these contracts are not awarded to SCAS, or extended or SCAS are not able to submit a tender as the incumbent provider THEN there is a risk of not being able to supply PTS services for the remainder of the contract term due to loss of staff with no alternative resources RESULTING in risk to operational staff, increased pressure on reducing staff numbers, reputation damage and impact on patient experience.	20
121	Financial Targets Not Being Met Risk	IF targets for financial sustainability, performance and cost savings are not achieved THEN there could be NHSI investigations and/or sanctions RESULTING in reputational damage	16

Objective 4: People & Organisation: We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			Risk score **16**
Strategic Risk No.6:	Update: January 2024		
If we fail to implement resilient and sustainable workforce plans	***Then*** we will have insufficient skills and resources to deliver our services	***Leading to*** ineffective and unsafe patient care and exhausted workforce.	

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

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

Controls	Gaps in Controls	Actions	Due Date
• Integrated Workforce Plans for the Trust, including the delivery of a 5-year workforce plan • Workforce reporting (e.g., sickness absence, staff survey, turnover) • Recruitment & attraction plan and retention plan health and wellbeing plan and flexible working • Apprenticeship programmes • International recruitment programmes • Return to practice programme • Use of private providers to help deliver services, private provider workforce strategy • Quality Impact Assessments • Culture and Staff Wellbeing Workstream	• Paramedic rotation • Rota reviews designed to improve work life balance and aid retention and personal development • Design of clear career development pathways • Talent management programme	Rota review	Mark Ainsworth / Q4 2023/24
		Develop/review existing career development pathways	Ian Teague / Q4 2023/24
		Development of talent management and development programme	Nicky Howells / implementation by Q4 23/24 – resources no in place and dates being finalised
		Explore/review Paramedic Rotation schemes.	Melanie Saunders / Q4 2023/24 – On-hold due to capacity and competing priorities
		NHS England Employee Retention Exemplar Programme to be implemented. 12-month programme	Natasha Dymond / Q4 2024/25
		5-year Workforce Plan	Melanie Saunders / Stuart Rees / Q4 2023/24

Assurances		Gaps in Assurances	Actions	Due Date
First and second line (internal) assurances • People and Culture committee • Integrated Performance Report • Workforce Development Board • Integrated Workforce Planning Groups	**Third line (external) assurances** • Commissioner reporting (to ICBs) • Internal audit (BDO) • OFSTED • NHSE/HEE quality assurance visits	• Staff wellbeing metrics via IPR	Culture and Staff Wellbeing Workstream	Melanie Saunders
			Governance and Well Led Workstream (IPR updates)	Edward Decesare
			Embed IPR into Trust Board and Sub-Committees	Mike Murphy / Ongoing

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
1	Communications Staffing Risk	IF the communications team does not have sufficient resource, THEN there is a risk that the department will be unable to meet some required processes and will be unable to meet any additional demands RESULTING in a reduced quality communications function and inability to support all teams/programmes	20
70	Recruitment Risk	IF we fail to recruit adequate numbers THEN the service is at risk of failing to fulfil the contracts RESULTING in increased costs and poorer patient experience	20
142	Pharmacy Staffing and Resilience Risk	IF the Pharmacy workforce is not expanded to meet the demand of the Trust; THEN there is a risk that medicines will not be supplied for clinical use; RESULTING in harm to patients.	20
219	IWP Training Space SH	IF there is insufficient training space at Southern House, THIS may result in a limitation of student/new applicant training RESULTING in the inability to effectively achieve the Trust's approved workforce and education plan	20
11	Leadership Capacity Risk	IF there is insufficient leadership capacity (at SLT, directorate and divisional level), THEN there is a risk that staff and/or projects will not be sufficiently well supported; RESULTING in attrition and inability to meet service/ project needs	16
50	ECT Staff Capacity Risk	IF recruitment and retention activity does not meet the needs of EOC services THEN there is a risk that there will not be enough ECTs to meet the service needs RESULTING in reduced capacity to meet performance targets	16
197	Clarity around planning for the future risk	IF there are delays in agreeing plans for next year, or delays in agreeing the 5-year plan, THEN we could need to re-forecast the plans and delay the predicted numbers of new starters, RESULTING in less staff available to help our patients and increased frustration for existing staff.	16
204	Staff Training – intercollegiate Risk	IF SCAS staff do not receive safeguarding training THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm	16
205	Training Risk – Supervision	IF SCAS staff do not receive safeguarding supervision THEN there is a risk that vulnerable patients will not be correctly identified RESULTING in potential patient harm	16
225	Key Person Dependency Risk	IF SCAS have a key person dependency THEN there is a risk that that person becomes unavailable RESULTING in potential process failures	16
30	Insufficient Clinical Resource Risk	IF there is insufficient resource and/or supervision of the Clinician Call Back queues THEN there is a risk that patients are not assessed by a healthcare professional within the agreed timelines RESULTING in untriaged patients waiting in the community without having the benefit of a clinical review and specific advice on actions to take if their condition worsens.	15

211	IWP Insufficient ECT Applicants	IF we do not find enough candidates in our locations that apply for the ECT role, THEN we will not have enough work effective ECTs to manage call volumes RESULTING in potential patient harm.	15
212	IWP ECT Attrition Rate	IF attrition rates increase above planned numbers, THEN there will not be enough work effective ECTs to manage call volumes RESULTING in potential patient harm.	15
213	IWP Quality of ECT Applicants	IF the quality of ECT applicants falls below minimum requirements, THEN there will be insufficient work effective ECTs to manage call volumes RESULTING in potential patient harm.	15

Objective 4: People & Organisation: We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			Risk score **12**
Strategic Risk No. 7:	Update: January 2024		
If we fail to foster an inclusive and compassionate culture	***Then*** our staff may feel unsafe, undervalued, and unsupported	***Leading to*** poor staff morale, disengagement, low retention and impacts on patient safety and care.	

	Impact	Likelihood	Score
Inherent	4	5	20
Current	**4**	**3**	**12**
Target	4	2	8

25 20 15 10 5 0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan

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

Controls	Gaps in Controls	Actions	Owner / Due Date
• People strategy, EDI strategy and associated enabling plans • Freedom to Speak Up (FTSU) guardian and supporting programme in place • 'Supporting our people' website, including EAP and Occupational Health • SCAS leader and ESPM leadership training • Sexual safety charter • Allegations management process and associated Employment policies. • Staff forums and TLL relationships • Appraisal process • Communications strategy • Culture and Staff Wellbeing Workstream	• Support for disabled workforce and other protected characteristics • Lack of peer reviews • Consistent approach to QI/service improvement/transformation • Active bystander programme		
		Delivery of our Sexual safety charter and associated plan	Dipen Rajyaguru / Refresh and relaunch Q4 2023/24
		Delivery and embedding Freedom to speak up improvement plan	Simon Holbrook / Launched with embedding during 2023/24
		Delivery and embedding Culture improvement plan	Nicky Howells / Approved September 2023 Embedding – ongoing Culture Diagnostic to be completed in Q4 2023/24
		Embed Support of Staff Networks	Dipen Rajyaguru / ongoing
		QI innovation and culture relaunch	Helen Young / to be embedded

Assurance		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • People and Culture committee • JNCC • Workforce Development Board • Staff networks • People Voice feedback • Equality & Diversity Steering Group • Student placement feedback	**Third line (external) assurances** • Workforce Race Equality Standard & Workforce Disability Equality Standard results • NHS National Staff Survey and Quarterly Pulse Survey • CQC inspections & reports • Internal audits (BDO) • Peer reviews	•		

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
None			

Objective 5: Technology transformation: We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			Risk score **20**
Strategic Risk No. 8:	Update: December 2023		
If we are unable to prioritise and fund digital opportunities	***Then*** we will have insufficient capacity and capability to deliver the digital strategy	***Leading to*** system failures, patient harm and increased cost.	

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**4**	**20**
Target	5	3	15

Risk Lead	Assurance Committee
Craig Ellis, Chief Digital Officer	Finance & Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Digital strategy • Project prioritisation process through Executive Transformation Board reporting to EMT • Regular digital programme portfolio reporting to executive transformation board • Project management structures in place • Fixed assets/capital committee reporting to EMT • Compliance with cyber security standards • Digital Steering Group	• Annual planning cycle • No asset management software in place to alert on hardware and software which is reaching end of life • Information Technology Infrastructure Library (ITIL) processes • Service desk software which no longer meets organizational needs • Costing strategy • Week internal (IT) controls • Structure inappropriate for function – lack of cyber and network	Develop annual planning cycle to map resources and plan capacity for digital resource	Craig Ellis / Ongoing
		Review service desk software and adoption of ITIL within existing budgets	Craig Ellis / Complete HoTH to be redeveloped
		Clarify governance structure for digital, including steering groups, resulting from the introduction of Finance and Performance Committee and addition of CDO to the Executive team	Craig Ellis / Complete – further review underway – March 24 completion

Assurances		Gaps in Assurances	Actions	Owner /Due Date
First and second line (internal) assurances • Reports to Finance and Performance Committee • Annual report on digital strategy to Trust board	**Third line (external) assurances** • Internal audit • External audit • DSP toolkit • Digital maturity assessments	• No KPIs in place • Regular reporting on digital strategy at board level • Fixed Asset Management Steering Group reporting	Develop regular reporting into Finance and Performance committee	Craig Ellis / Complete
			Develop KPIs	Craig Ellis / Ongoing

• Quality assurance process in PMO • Technical Design Authority • Change Advisory Board				

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
203	System Safeguarding Outages Risk	IF the Trust server keeps having regular outages, THEN the safeguarding referrals are potentially delayed in reaching their destination RESULTING in potential patient harm	25
229	Asset Ownership Risk	IF Information Asset owners do not take responsibility for their asset, THEN there is a risk that the assets become a Information Governance risk RESULTING in potential breaches of security	20
168	GRS System Risk	IF GRS has a poor system performance and function THEN there will be delay/non-completion of basic daily scheduling planning tasks RESULTING risk to clinical performance and patient care	20
223	Patching Risk	IF SCAS do not complete patching where required THEN there is a risk that systems will be vulnerable to attack RESULTING in potential system failure	16
227	Data Access Risk	IF there are inadequate data access management processes THEN there is risk that staff will have access to personal data they are not authorised to have RESULTING in potential breaches or GDPR	15
173	B.I. Issue Risk	IF Unified and verified source of data not available across all Trust reporting platforms and systems THEN there will be a reliance on BI data sets and non-integrated systems which provide inconsistent outputs RESULTING in inaccurate forecasting and performance management	15

Objective 6: Well Led: We will become an organisation that is well led and achieves all its regulatory requirements by being rated Good or Outstanding and being at least NOF2.		Risk score **20**
Strategic Risk No. 9:	Update: December 2023	

If we fail to deliver the Trusts improvement programme	***Then*** we will not move out of NOF4 or achieve an improved CQC rating	***Leading to*** a deterioration of the Trust's reputation, additional regulatory oversight and possible further regulatory action.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**4**	**20**
Target	5	2	10

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

Controls	Gaps in Controls	Actions	Owner / Due Date
• Improvement Programme ○ Patient Safety Workstream ○ Governance and Well Led Workstream ○ Culture and Staff Wellbeing Workstream ○ Performance Recovery Workstream • Financial recovery process • Category 2 Improvement Plan • People Strategy • Clinical Strategy • Risk Management Policy and Framework • Policy Management Policy and Process • Governance Assurance Framework	• Effective recruitment and retainment plans • Talent management programme • Operational development plan • Embedded Safeguarding systems / provisions • PSIRF • Medical Devices	Development and Approval of Governance Framework	Daryl Lutchmaya / Complete
		Delivery of People Strategy	Melanie Saunders / Ongoing
		Develop and approval of Operational Development Plan	Paul Kempster / TBC as part of modernisation plan
		Safeguarding Assurance & Accountability Framework compliance	Sarah Thompson / Ongoing
		Implementation of the Patient Safety Strategy from NHSE and the associated Patient Safety Incident Response Framework (PSIRF) to replace the existing Serious Incident policy and process.	Carol Rogers / April 2024
		Procure system for managing safe deployment and maintenance of equipment	Barry Thurston / Updated BC at ETB in Oct - Approved
		Development of talent management and development programme	Nicky Howells / implementation by Q4 23/24 – resources no in place and dates being finalised

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Board / Committees • EMC • Improvement Programme Oversight Board • Workstream Delivery Groups • Daily Executive meetings	**Third line (external) assurances** • TPAM • CQC • Peer reviews / benchmarking • ICBs • NHSE (Regional / National) • NHSE Intensive Support Team	• Effective IPR • Information flow in accordance with Governance Framework	Development and embedding of IPR	Mike Murphy / Q4
			Development and Approval of Governance Framework	Daryl Lutchmaya / Complete

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
254	Regulatory Compliance Risk	IF we have poor clinical or operational practices THEN there is a risk that we will not comply with regulations RESULTING in a decrease in patient safety	16

Improvement Programme Oversight Board (IPOB)

Improvement Programme Report Pack

10th January 2024

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SCAS IMPROVEMENT PROGRAMME

NHS South Central Ambulance Service NHS Foundation Trust

Programme Overview — December 2023

	Actions	Embedding		Actions	Embedding
Governance & Well Led:	Red	Red	Culture & Staff Wellbeing:	Amber	Amber
Performance Improvement:	Amber	Amber	Patient Safety:	Green	Amber

Improvement Programme Summary:

Key Progress:

- The Governance Assurance and Accountability Framework (GAFF) was presented at EMC and Board the week of 11th December at approved. The embedding of the GAAF will now commence with comms and agenda items at Committee meetings, alongside the flow of information for Committee meetings being aligned to the Board.
- Prioritised piece of work to review the current state of the Fit and Proper Persons information we hold to ensure we are compliant moving forward. Overview provided to EMC on the 11th December. Only two remaining pieces of information are outstanding
- Continued focus on Sexual Safety with it discussed at the Women's network session on 5th Dec and volunteers coming forward to be part of the new reverse mentoring programme. Next steps includes agree programme detail, associated funding, participants and launch, including pairing mentors and mentees and briefing for all.
- Compassionate leadership survey results show starting to see a shift to compassionate leadership but further work to do to move from a blame culture. Number of staff entering formal disciplinary continues to reduce (down to 24 from 47 in 22/23) and a refresh of HR policies is progressing well, those completed are now shorter and incorporate J&LC principles.
- Additional Private provider hours secured to commence end of December adding 3 additional DCA 24/7 by the end of January.
- Review of category 2 performance with an additional action plan to focus on C2 improvement.
- Positive increase in Safeguarding metrics, with SAAF compliance rising to 97.8% with the cut-over to the new Doc-Works SG server successfully completed on 29 Nov 2023
- New Safeguarding telephone system went live 13 Dec 2023. SG advice now available 24/7 with direct transfer to OOH Social Work teams. Communicated to all staff

Key Risks/Issues:

- BAU capacity continues to be a challenge, exacerbated by vacant positions within the workstream delivery space. Operational pressures continue to place BAU resources under significant pressure
- Scale of change across organisation may be unsettling for our staff. Improvement, Modernisation and Financial Recovery programme comms will require careful management to minimise impacts and reassure staff

RAG Assessment:

No change to previous period reporting. Q3 Metric reporting in Feb 2023.

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

Update on CQC Must and Should Dos

SCAS Improvement Programme: Must Do / Should Do Update

December 2023

Governance & Well Led [Daryl Lutchmaya]:		Actions	Embedding
Must	The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)		
Should	The trust should consider how to improve communication and relationships between staff and senior leaders		
Should	The trust should review methods of communication between senior executives and call takers in the EOC to ensure important information is received and understood		
Should	The trust should consider asking staff and patients with less positive experiences to present to the board to allow more opportunities for learning		

Culture & Staff Wellbeing [Melanie Saunders]:		Actions	Embedding
Must	The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. This to include where staff have raised concerns relating to bullying, harassment and sexually inappropriate behaviours. Regulation 17 (2) (b)		
Must	The trust must ensure that it listens and responds to staff who raise concerns in line with their own policy and the Public Interest Disclosure Act (1998)		
Should	The trust should ensure it provides appraisals and continuous professional development to all staff		
Should	The trust should ensure that staff complete mandatory training appropriate to their roles and responsibilities		
Should	The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale		
Should	The trust should ensure all staff receive a timely appraisal to assure leaders that competency is maintained		
Should	The trust should review the arrangements for the role of the Freedom to Speak Up Guardian to improve the speak up culture		

Performance Improvement [Mark Ainsworth]:		Actions	Embedding
Should	The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times		
Should	The trust should consider ways to monitor outcomes for patients who are not transferred to hospital to ensure the pathways are used effectively and that decisions are made in the patients' best interest		
Should	The trust should consider revising their diversion policy to ensure they are transferred to hospital care in a timely way		
Should	The trust should ensure ambulances are staffed by appropriately skilled crews		

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Programme: Must Do / Should Do Update

December 2023

Performance Improvement [Mark Ainsworth]:

		Actions	Embedding
Should	The trust should ensure that staff have enough time to report adverse incidents		
Should	The trust should ensure that staff, particularly newly qualified staff, receive appropriate clinical support and supervision to enable them to provide safe patient care		
Should	The trust should continue to identify ways to recruit staff according to their current strategy in order to improve the call handling times		
Should	The trust should improve response times in line with the Ambulance Response Programme		
Should	The trust should act to ensure the clinical welfare calls are completed within the targeted timeframes		
Should	The trust should optimise information systems to make less labour intensive for staff and improve efficiency in reporting		

Patient Safety [Helen Young]:

		Actions	Embedding
Must	The trust must ensure all staff complete safeguarding training at the role appropriate level and any additional role specific training in line with the trust target. Regulation 18 (2) (a)		
Must	The trust must ensure that incidents are identified, reported and investigated in line with the NHS Serious Incident Reporting Framework, that action is taken to mitigate risks and that learning is shared across the organisation. Regulation 17 (2) (b) (e)		
Must	The board must be sighted on accurate information about serious incidents occurring at the trust to enable strategic oversight and planning. Regulation 17 (2) (b) (e)		
Must	The trust must ensure that where trends in adverse incidents are known that these are fully investigated, and action is taken to reduce future risks. 17 (2) (b) (e)		
Must	The trust must ensure that it meets the statutory requirements of the duty of candour. Regulation 20		
Must	The trust must provide a separate Mental Capacity Act (2005) Policy and ensure that staff understand the principles and application of the Mental Capacity Act (2005) Regulation 17 (1)		
Must	The trust must ensure medicines are managed in accordance with the national guidance and that only authorised persons have access to controlled drugs. Regulation 12 (2) (7)		
Must	The provider must ensure that systems and processes for managing safeguarding within the trust are adequately resourced, effective and monitored by the board. Regulation 13 (1) (2) (3)		
Should	The trust should ensure that medicines are always kept safely, whether in stations or on vehicles		
Should	The trust should ensure that any shortfalls in infection prevention and control are reviewed, and action taken where needed		

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

Update on MD/SD Actions Rated RED

Governance & Well Led [Daryl Lutchmaya]:		Delivery	Embedding
Must	The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)		
Explanation: While the Regulation 17 gap analysis has now been completed and recorded the overall governance and risk processes of the Trust are not fit for purpose. Limited resource capacity within the teams has meant action completion has been delayed.	Mitigation: The Governance Assurance and Accountability Framework was approved at the December Board, and it was agreed that frequent reviews would be undertaken, and some amendments would be made. The subsequent actions to embed the framework will support transitioning the workstream to an amber rag status.		

Performance Improvement [Mark Ainsworth]:		Delivery	Embedding
Should	The trust should consider ways to monitor outcomes for patients who are not transferred to hospital to ensure the pathways are used effectively and that decisions are made in the patients' best interest		
Explanation: Technical solution delivery has been delayed due complexity of challenge/systems involved. Further delay experienced due to ePR outage affecting the conduct of end user testing (now resolved and complete).	Mitigation: User testing of the SCAS Connect solution was successfully completed in early Nov 2023 and full roll-out to the MK UCR footprint now complete. Wider roll-out delayed due to issues caused by a supplier software update but expected to resume in Dec 2023.		

Update on Exit Criteria

SCAS Improvement Programme: Exit Criteria Update

December 2023

Governance & Well Led:	*Substantive improvement in governance and leadership with evidence of improved assurance and accountability*	**Daryl Lutchmaya**
1	Improved board effectiveness; use of Board Assurance Framework and significant progress in embedding recommendations from the governance review	
2	Improved assurance through effective corporate governance structures and information flows between committees and board	
3	Board development programme in place including senior leadership review completed with plan signed off and progressing	
4	Evidence of strengthened partnership working	
Culture & Staff Wellbeing:	*Board approved culture improvement programme in place, with evidence of improved engagement and experience from all staff including volunteers*	**Melanie Saunders**
1	Revised and approved People and OD Strategy to ensure SCAS has the necessary infrastructure to meet future need	
2	Culture Improvement Programme in place, including evidence of improved engagement	
3	Clear recruitment and retention plan, with agreed timeline and evidence of delivery to support the revised operating model (see below)	
4	Approved FTSU plan (strategy, process and function) with evidence of delivery against plan and impact	
Performance Improvement:	*Board approved plan for performance recovery and future operating model*	**Mark Ainsworth**
1	A clear plan for performance recovery which includes representation from quality, finance, contracting and human resources / workforce	*[Paul Kempster]*
2	Demonstration of improvement against performance recovery plans	
3	Demonstration of continued and sustained improvement in operational performance to be in line with the agreed trajectories in hear & treat and see & treat rates	
Patient Safety:	*Improvements in patient safety and experience, with evidence of effective systems and process in place around safeguarding and adverse incidents*	**Helen Young**
1	Embedded section 4.2.1 and the 11 core arrangements within the Safeguarding Accountability and Assurance Framework	
2	PSIRF plan developed, approved and published in partnership with the ICB with evidence of delivery against plan	
3	Evidence of improvement in Patient Safety and Just Culture	
4	Demonstrable improvement in learning from SIs (individual, organisation and system wide)	
5	Evidenced improved management of SIs	

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

Improvement Programme
Highlight Reports and Scorecards

Improvement Programme Highlight Report: Governance and Well Led | December 2023 | RAG:

Executive Lead: Daryl Lutchmaya | *Senior Responsible Officer: Daryl Lutchmaya* | *Programme Manager: Amy Carden*

Workstream Summary (Incl. RAG Assessment):

The Governance Assurance and Accountability Framework was presented at EMC and Board the week of the 11th December and approved. The embedding of the GAAF will now commence with comms and agenda items at Committee meetings, alongside the flow of information for Committee meetings being aligned to the Board. These steps will transition the workstream to an amber rag status.

Progress Against Key Outcomes / Success Criteria:	Key Activity, Month Ahead:
• Fit and Proper Persons policy in the process of being created and scheduled for approval at EMC on the 16th January.	• Funding received from South East Leadership Academy to support the development of the talent management piece.
• Prioritised piece of work to review the current state of the Fit and Proper Persons information we hold to ensure we are compliant moving forward. Overview provided to EMC on the 11th December. Only two remaining pieces of information are outstanding.	• Full review of ToR's scheduled for January and February, following the approval of the GAAF.
• Risk maturity assessment (conducted by BDO) presented to Audit Committee on the 6th December and the Board on 14th December, along with a risk framework training session for Board members.	• Drafting of risk reporting through Qlik and NPrint functionality.
• A draft risk appetite statement was presented at Board on the 14th December with further development to take place.	• Creation of additional training material for all staff on Risk.

What's Gone Well:	What's Not Gone So Well:
• New members of staff in the OD Team and Governance Team have commenced employment with the Trust.	• Exec feedback on the QR code for November Board was low. This has been followed up with a reminder of the importance of feedback being provided and the insight it gives.
• Progress has been made on the structure and Executive Portfolios area of the hub improvements. The Comms team are working with the Chief People Officer to make the final updates.	• Not all areas have inputted their risks onto the new platform. Prompts have been given and where required escalation at RACSC and Committee meetings will take place.
• Substantial progress made with the internal audit actions tracker. This will provide the ability to report progress monthly and upward report into EMC.	
• A further increase on the updating of out-dated policies, with 75% of policies now being in date.	

Workstream Key Risks:	Workstream Issues:
• Although recruitment to the Governance Team is complete and will support achieving accelerated progress towards implementation of key governance actions, a period of embedding will be needed.	• None for escalation

SCAS Improvement Programme

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Plan Scorecard: Governance & Well Led — October – November 2023

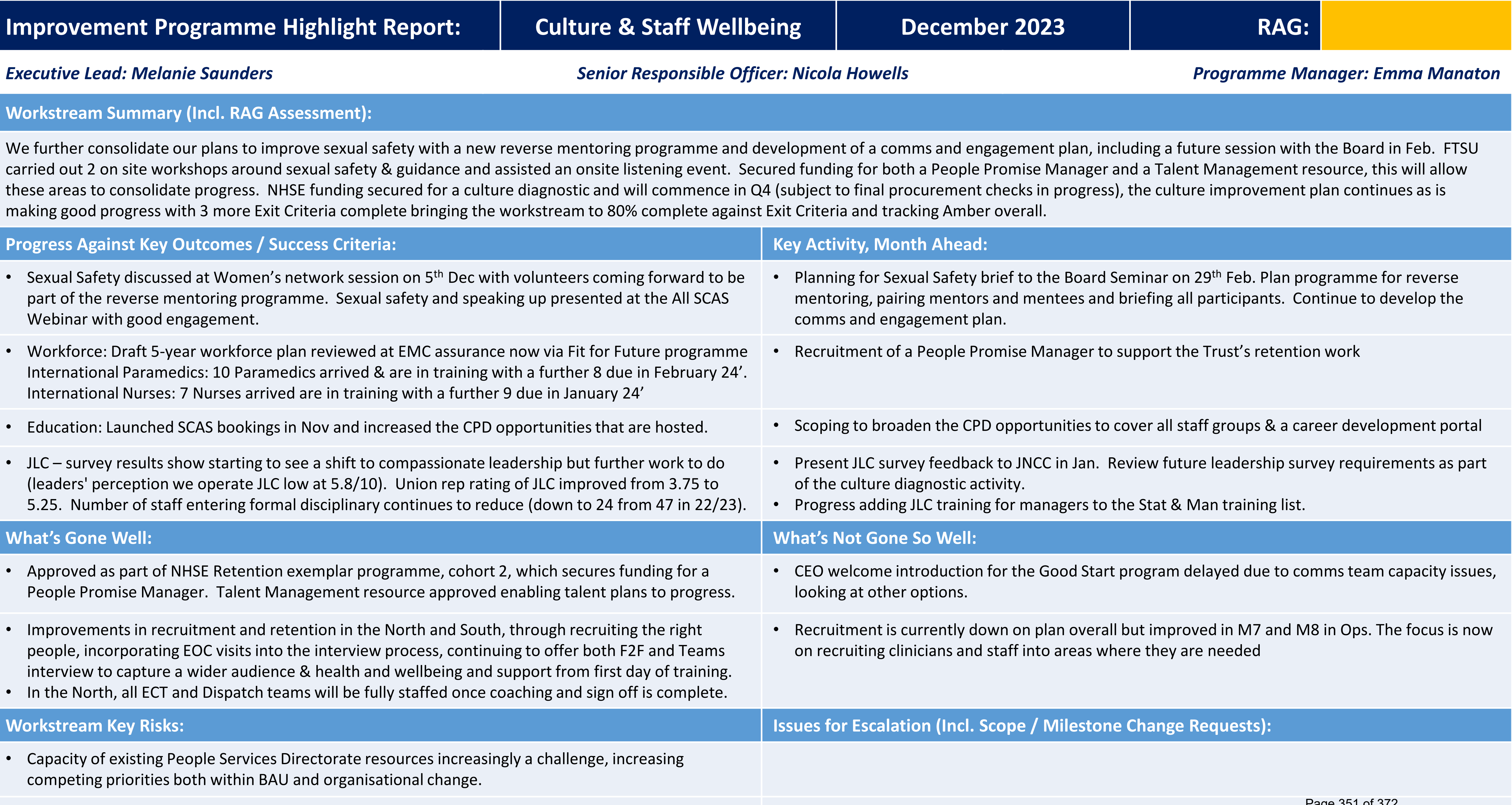
No	Metric/s	Baseline (Date)	End Target (Date)	Aim/ Actual	2022/23 Q3	2022/23 Q4	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	2024/25 Q1	2024/25 Q2	Comments
1	Average timeliness of papers received by the Board and Committees per month (5 working days before meeting)	50% Q4 22/23	90% Q1 24/23	*Aim*	*N/A*	*N/A*	*50%*	*80%*	*80%*	*80%*	*90%*	*100%*	Data collected from QR code feedback October: Board Seminar (1 response) – 100% November: Board (7 responses, 5 NED, 2 ED) – 100% score PACC (1 response) – 100% score F&P (3 responses) – 67% score Q&S (2 responses) – 100% score
				Actual	N/A	N/A	50%	55%	100%				
2	Quality of papers for Board and Committees (as above) ('P' – Poor; 'A' – Average; 'G' – Good; 'E' – Excellent)	Average Q4 22/23	Excellent Q2 24/25	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Data collected from QR code feedback October: Board Seminar (1 response) – E November: Board (7 responses, 5 NED, 2ED) – ED G/E NED G PACC (1 response) – G F&P (3 responses) – G Q&S (2 responses) – G
				Actual	N/A	N/A	-	G	G				
3	Board Effectiveness review by survey Quality of papers for Board and Committees (as above) ('P' – Poor; 'A' – Average; 'G' – Good; 'E' – Excellent)	Average Q4 22/23	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*E*	*N/A*	*N/A*	*N/A*	Well-led review in Q3 - Focus: Strengths of the board/ Composition of the Board/Ability to resolve conflicts/ Regular reviews and reflections/vision, goals and focus of the Board/ Clear definition of roles & responsibilities / Level of constructive challenge.
				Actual	30%	64%	N/A	N/A	N/A				
4	Partners' satisfaction with joint working from SCAS (from 6 monthly survey) (Dissatisfied – 'D', Satisfied – 'S', Very Satisfied – 'V')	Satisfied Q4 22/23	Very Satisfied Q3 23/24	*Aim*	*N/A*	*N/A*	*S*	*N/A*	*VS*	*N/A*	*VS*	*N/A*	This metric will be reviewed following the decision on the approach the Trust will take to measure partnership working. Initial plans are currently being reviewed.
				Actual		3%	-	-	-				
5	Internal audit activities are being completed to plan No (<50%) Minimal (50% - 74%) Partial (75% -89%) Substantial (90% - 99%)	Minimal Q3 22/23	Yes	*Aim*	*N/A*	*N/A*	*95%*	*95%*	*95%*	*95%*	*100%*	*100%*	For Q2 1 of 12 due audit actions was completed. Metric is only measurable quarterly.
							Partial	No					

SCAS Improvement Plan Scorecard: Governance & Well Led — October – November 2023

No	Metric/s	Baseline (Date)	End Target (Date)	Aim/ Actual	2022/23 Q3	2022/23 Q4	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	2024/25 Q1	2024/25 Q2	Comments
6	Effectiveness of committees ('P' -Poor, 'A' - Average, 'G' -Good or 'E' - Excellent)	Average Q4 22/23	Excellent	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Data collected from QR code feedback October: Board Seminar (1 response) – E November: Board (7 responses, 5 NED, 2ED) – ED G/E NED A/G PACC (1 response) – G F&P (3 responses) – G/E Q&S (2 responses) – G
				Actual	N/A	N/A	-	G/E	G				
7	Effective accountability structures through organisation (link to performance improvement) ('P' -Poor, 'A' - Average, 'G' -Good or 'E' - Excellent)	Poor Q4 22/23	Excellent Q2 24/25	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Chief Governance Officer's view based on progression of Governance Framework implementation. October – P November – A The GAAF was presented and approved at EMC and Board week of the 11th December.
				Actual	N/A	N/A	P	P	P/A				
8	Governance modules completed as part of leadership development	40% Q4 22/23	95% Q1 24/25	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*100%*	There is appetite for some Governance modules to be added to various development courses. These are not likely to be put into place until next year.
				Actual	N/A	N/A	-	-	-				
9	Monthly updating of the BAF ensuring links to extreme risks ('Y' -Yes, 'N' - No)	Poor Q1 23/24	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	Monthly updating of the BAF has been completed, with an additional BAF risk created in relation to the overall Improvement Programme.
				Actual	N/A	N/A	Y	Y	Y				
10	Board development attendance	60% Q4 22/23	100% Q1 23/24	*Aim*	*N/A*	*N/A*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	Percentage of eligible colleagues that attend Board Development sessions. October - 17 of 17 attendees were present. November - 18 of 18 attendees were present.
				Actual	N/A	N/A	71%	94%	100%				

SCAS Improvement Plan Scorecard: Governance & Well Led — October – November 2023

No	Metric/s	Baseline (Date)	End Target (Date)	Aim/ Actual	2022/23 Q3	2022/23 Q4	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	2024/25 Q1	2024/25 Q2	Comments
11	Number of attendees at Leadership Development sessions?	80% Q4 22/23	95%	*Aim*	*N/A*	*N/A*	*60%*	*75%*	*75%*	*75%*	*95%*	*95%*	Percentage of eligible colleagues that have completed or are in the process of completing/booked on SCAS Leader and ESPM. Unable to measure SCAS Leader for Q3 currently due to resource constraints.
				Actual – SCAS Leader	N/A	N/A	47%	48.5%	51%				
				Actual - ESPM	N/A	N/A	61%	85%	87%				
12	Feedback from Leadership Development sessions (Feedback score marked out of 5)	Average Q4 22/23	Excellent Q1 24/25	*Aim*	*N/A*	*N/A*	*3*	*3*	*4*	*4*	*5*	*5*	Data provided is feedback from ESPM only. It is currently being reviewed how feedback from both SCAS Leader and ESPM can be collated collectively, and this will be added when available. November saw a reduction in the score from October. Some of the feedback suggests that actions within the Trust do not reflect what is being taught in the modules and this is reflective in the feedback.
				Actual	N/A	N/A	-	4.64	4.27				
13	Numbers of Executive visits to sites/ride outs per month (expectation is one visit per month by each) (9 Executives)	50% Q4 22/23	95% Q1 24/25	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*100%*	Tracked through completion of online forms and EAs calendar feedback. October – 8 of 9 visits complete 89%. November - 8 of 9 visits complete 89%.
				Actual	N/A	N/A	63%	85%	89%				
14	Number of NED visits to sites/ride outs (8 NEDs – expectation is one visit per month by each)	Poor Q1 23/24	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*95%*	Tracked through reports provided to Marie Gittings. October – 3 of 8 visits complete 37.5%. November – 2 of 8 visits complete 25%.
				Actual	N/A	N/A	42%	13%	31%				


Improvement Programme Highlight Report:
Culture & Staff Wellbeing
December 2023
RAG:
Executive Lead: Melanie Saunders
Senior Responsible Officer: Nicola Howells
Programme Manager: Emma Manaton
Workstream Summary (Incl. RAG Assessment):
We further consolidate our plans to improve sexual safety with a new reverse mentoring programme and development of a comms and engagement plan, including a future session with the Board in Feb. FTSU carried out 2 on site workshops around sexual safety & guidance and assisted an onsite listening event. Secured funding for both a People Promise Manager and a Talent Management resource, this will allow these areas to consolidate progress. NHSE funding secured for a culture diagnostic and will commence in Q4 (subject to final procurement checks in progress), the culture improvement plan continues as is making good progress with 3 more Exit Criteria complete bringing the workstream to 80% complete against Exit Criteria and tracking Amber overall.
Progress Against Key Outcomes / Success Criteria:
• Sexual Safety discussed at Women's network session on 5th Dec with volunteers coming forward to be part of the reverse mentoring programme. Sexual safety and speaking up presented at the All SCAS Webinar with good engagement.
• Workforce: Draft 5-year workforce plan reviewed at EMC assurance now via Fit for Future programme International Paramedics: 10 Paramedics arrived & are in training with a further 8 due in February 24'. International Nurses: 7 Nurses arrived are in training with a further 9 due in January 24'
• Education: Launched SCAS bookings in Nov and increased the CPD opportunities that are hosted.
• JLC – survey results show starting to see a shift to compassionate leadership but further work to do (leaders' perception we operate JLC low at 5.8/10). Union rep rating of JLC improved from 3.75 to 5.25. Number of staff entering formal disciplinary continues to reduce (down to 24 from 47 in 22/23).
Key Activity, Month Ahead:
• Planning for Sexual Safety brief to the Board Seminar on 29th Feb. Plan programme for reverse mentoring, pairing mentors and mentees and briefing all participants. Continue to develop the comms and engagement plan.
• Recruitment of a People Promise Manager to support the Trust's retention work
• Scoping to broaden the CPD opportunities to cover all staff groups & a career development portal
• Present JLC survey feedback to JNCC in Jan. Review future leadership survey requirements as part of the culture diagnostic activity.
• Progress adding JLC training for managers to the Stat & Man training list.
What's Gone Well:
• Approved as part of NHSE Retention exemplar programme, cohort 2, which secures funding for a People Promise Manager. Talent Management resource approved enabling talent plans to progress.
• Improvements in recruitment and retention in the North and South, through recruiting the right people, incorporating EOC visits into the interview process, continuing to offer both F2F and Teams interview to capture a wider audience & health and wellbeing and support from first day of training.
• In the North, all ECT and Dispatch teams will be fully staffed once coaching and sign off is complete.
What's Not Gone So Well:
• CEO welcome introduction for the Good Start program delayed due to comms team capacity issues, looking at other options.
• Recruitment is currently down on plan overall but improved in M7 and M8 in Ops. The focus is now on recruiting clinicians and staff into areas where they are needed
Workstream Key Risks:
• Capacity of existing People Services Directorate resources increasingly a challenge, increasing competing priorities both within BAU and organisational change.
• Upcoming change in the organisation may affect staff morale / wellbeing / engagement which may in turn impact attrition, the staff survey results, increase in FTSU cases. Careful management of staff
Issues for Escalation (Incl. Scope / Milestone Change Requests):
Complete &
Off Track (<1 month),

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — December 2023

No	Metric/s	Baseline (30/08/22)	End Target	Aim/ Actual	2022/23 Q3	2022/23 Q4	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	2024/25 Q1	2024/25 Q2	Comments
1	Reported cases of bullying and harassment	1	2	*Aim*	*N/A*	*N/A*	*3*	*3*	*3*	*3*	*2*	*2*	Q2. We continue to place emphasis on mediation (where appropriate) and have seen an increase in cases dealt with under mediation, Q1 – 5, Q2 – 5. Comparably mediation cases for Q4 -3 and Q3 – 2. We can conclude from this that more cases are being resolved under mediation rather than proceeding to a formal process.
				Actual	3	2	1	3					
2	Reported cases of sexual harassment	5	2	*Aim*	*N/A*	*N/A*	*5*	*7*	*8*	*8*	*7*	*7*	Q2. Reported numbers lower than forecast, production of posters has been delayed, new supplier being sought. Q3 renewed focus of the campaign.
				Actual	4	4	4	3					
3	Casework (investigation) completion timeline completion against policy	35	35	*Aim*	*N/A*	*N/A*	*60*	*58*	*50*	*45*	*40*	*35*	Q2. Decreased timescales due to a number of cases being resolved following a shorted collation of facts, where individuals have taken accountability for their actions.
				Actual	41	31	63	43					
4	FTSU: case numbers (overall and across service areas)	36	N/A	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	Q2- overall quarter similar to previous quarters', however during Q2 saw significant spike in July and Aug, numbers bucking previous trends, likely due to national FTSU exposure due to Countess of Chester coverage and other instabilities from change programmes, financial pressures and focus on increasing performance. As agreed, speak up sub score will be used to measure speak up culture, therefore no trajectory on this metric.
				Actual	29	38	27	34					
5	FTSU: Freedom to Speak Up Sub Score	5.9 (Oct 22)	6.4	*Aim*	*N/A*	*N/A*	*N/A*	*5.9*	*5.9*	*6.0*	*6.0*	*6.1*	Q2 sees a drop in sub score, questionable if this reflects the true view of organisation as initial response rate was 35. Surveys not collected over the full quarter due to delays. Will monitor during Q3, encouraging engagement during F2F interactions but without diluting the NSS message. Sub score is nationally recognised as not exclusively FTSU, ie EPR outages and issues with safeguarding referrals may have impacted the scores. Baseline is NSS from Oct 22 (5.9). Forecast Q2 24/25 (6.1) is best in sector, end target (6.4) is national average. We are already ahead of sector average (5.8).
				Actual	N/A	N/A	N/A	5.2					

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — December 2023

No	Metric/s	Baseline (30/08/22)	End Target	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
6	FTSU: audit of time taken to complete initial investigation (% within guidelines)	93 (Q1 23 figures)	93	*Aim*	*N/A*	*N/A*	*N/A*	*93*	*86*	*86*	*93*	*93*	Q2 – drop to 80%. The expected drop to 86% in Q3 has, in practice, been brought forward by the spike in cases because of national Countess of Chester coverage as well as environmental impact to managers such as performance pressures and finance sustainability. Baseline figures are Q1 23 (not measured previously). No guideline for this figure, suggest we maintain at this level while we build data. Forecast: drop to 86% is potential combination of winter pressures on managers & possible increase in FTSU cases during / after speak up month in Oct (86% is 2 cases breaching).
				Actual	N/A	N/A	93	80					
7	Appraisal and PDR: completion (%)	89	95	*Aim*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	Q2 – decrease and below trajectory; PDRs paused during September due to demand/performance pressure, have now recommenced from October. Reviewing trajectory to recover back to 90 and to 95%.
				Actual	88	89	84	75	73				
8	Q21c – would recommend the organisation as a place to work (%)	36.5 (July 22)	59.4	*Aim*	*37*	*38*	39	40	41	42	43	44	Q2- uncertainty around financial constraints may be impacting this quarters figures. Forecast: Q2 24/25 is sector average (44%), end target is best in sector (59.4%). 46% in Q3 due to higher survey completion rate as NSS - suggesting NQPS may not be a true reflection of staff view & to treat as indicative only.
				Actual	46	36	41	35					
9	Staff feeling able to make suggestions to improve the work of their team/department (%)	47.7 (July 22)	61.7	*Aim*	*48*	*48*	*50*	*50*	*50*	*52*	*52*	*54*	Q2 – continue to recover towards trajectory, introduced Bright Ideas initiative and ongoing work on speak up culture. Forecast: Q2 24/25 is sector average (54%), end target is the best in sector (61.7%). 53% in Q3 due to higher survey completion rate as NSS, suggesting NQPS may not be a true reflection of staff view & treat as indicative only.
				Actual	53	44	46	46					
10	Retention / Stability Index Rate (%)	82	82	*Aim*	*82*	*82*	*82*	*82*	*83*	*83*	*84*	*84*	Q1 Improved by 2%, staff turnover has seen a steady improvement, rising to 85% in month Q2.
				Actual	82	82	84	85	85				
11	Vacancy Rate (%)	15	10	*Aim*	*13*	*14*	*14*	*13.5*	*12*	*11*	*10*	*10*	Q2 – is on-track with workforce plan and controlled improvement since Q1
				Actual	13	13	12	12	11				

Improvement Programme Highlight Report: | Performance Improvement | December 2023 | RAG:

Executive Lead: Mark Ainsworth | *Senior Responsible Officers: Luci Papworth, Mark Ainsworth* | *Programme Manager: TBC*

Workstream Summary (Incl. RAG Assessment):

As the Fit for the Future Programme is now fully in the mobilisation phase it is being governed separately and no update is included

Feedback loop through SCAS Connect now live across SCAS with no reported issues with the technology. Continuing to work with providers on capturing feedback themes and then understanding if there are actions needed from the feedback.

Progress Against Key Outcomes / Success Criteria:

- Focus continues to be on Cat 2 response and EOC call answer times (as at 31 Dec 2023):
  - Cat 2 Mean – QTD: 00:38:09
  - Call Answer Mean – QTD: 00:00:17
- Agreement received to extend Cat 3/4 (GP) Validation pilot

Key Activity, Month Ahead:

- Continue to monitor PIP actions for timely delivery and increase PP hours in line with new contracted hours
- Embed immediate Handover process across all Acute Trusts
- Further develop Cat 2 recovery plan

What's Gone Well:

- The Performance Improvement Plan is reviewed weekly for progress against each action. Positive feedback from NHSE on the PIP and actions included
- Cat 2 Segmentation -4,962 calls appropriate Segmentation Clinical Navigation:
  - 18.7% of eligible C2 Calls underwent Clinical Navigation
  - 38.8% of these remained on the C2 dispatch stack with 57.9% going for Clinical Navigation
  - Of these sent for Clinical Navigation 52.9% received Clinical Validation
  - Of these 23.4% were Closed as Hear and Treat – of these 62% were closed as refer to ED / 20.6% were closed referring to GP
- SCAS Connect User Testing (non-ED conveyance feedback loop) has been completed within the MK UCR footprint with no issues. Has now also made it across the SCAS footprint so believe we are able to close (CQC_39)

What's Not Gone So Well:

- Due to capacity constraints, there is no dedicated programme / project support
- A significant level of excess handovers (~6700 hrs in December) have negatively impacted on our ability to deliver performance

Workstream Key Risks:

- New private provider contracts commenced 2nd October. After showing improvement in fill %, current fill has returned to 80% due to the inclusion of new contracts for 3 DCA lines, which are currently ramping up
- Clinical capacity for Cat 2 Segmentation, as well as delivering BAU Clinical Support Desk requirements

Workstream Issues:

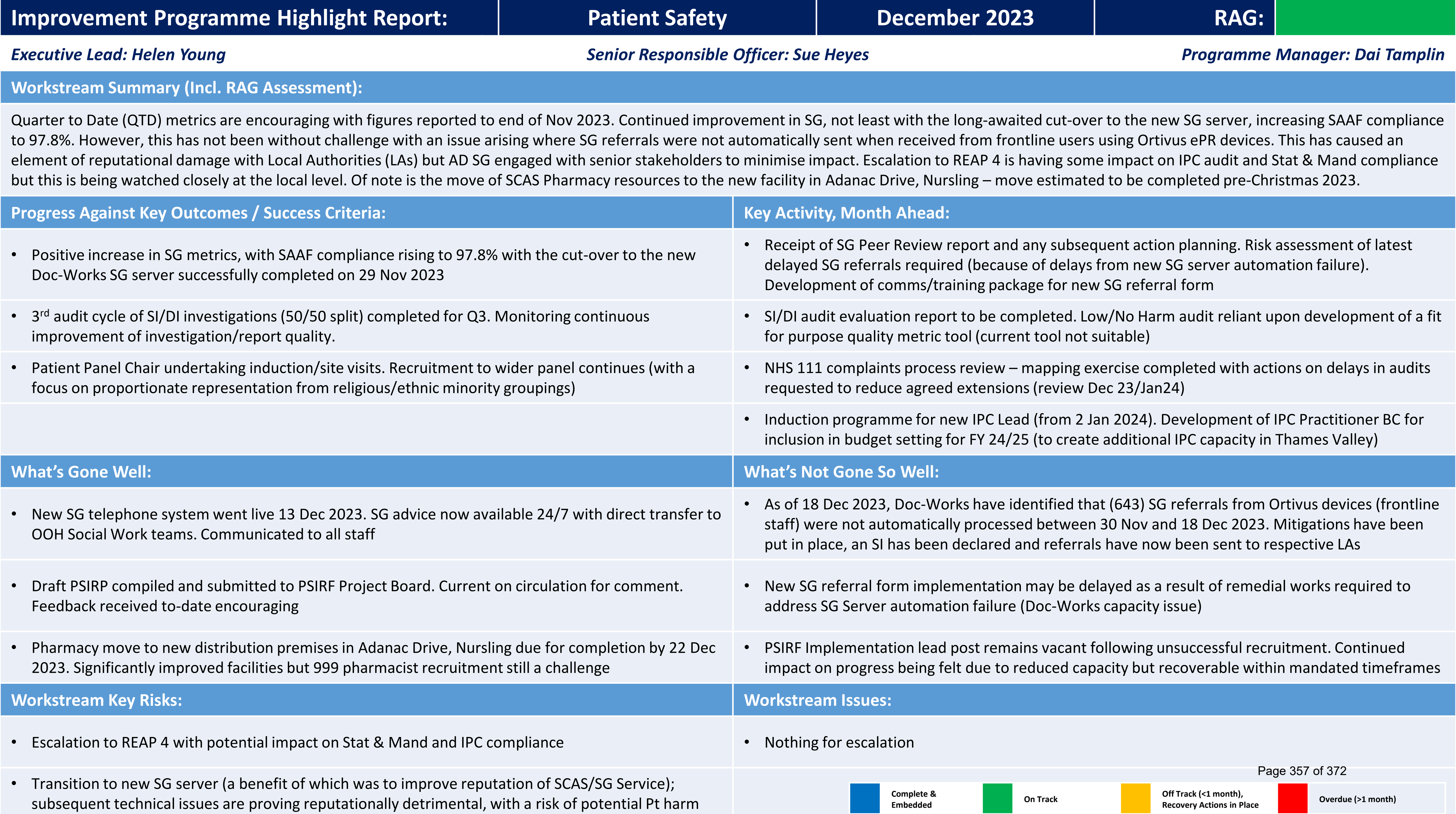
Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Programme Scorecard: Performance Improvement — November 2023

No	Metric/s	Baseline H2 – 22/23	End Target	Aim/ Actual	2022/23 Q3	2022/23 Q4	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	2024/25 Q1	2024/25 Q2	Comments
1	Improved category 2 ambulance response times	00:34:08	00:18:00	*Aim*	00:18:00	00:18:00	00:27:59	00:26:43	00:28:56	00:29:37	00:25:00	00:20:00	Assumptions behind these trajectories include no demand growth and hospital delays at agreed levels. Revised trajectory has been shared with Exec and board and being presented to NHSE on 5th October prior to submission
				Actual	00:40:33	00:26:53	00:29:42	00:33:09	0:38:09				
2	Increase in Hear and Treat rates	12.20%	14%	*Aim*	13.5%	12.5%	10.5%	11.5%	12.0%	12.5%	14.0%	14.0%	Cat 2 Segment now live (as per NHSE directive) with the 9s GP CAS also live from 28th Sept. Review of H&T improvement plan following AACE review
				Actual	13.4%	10.8%	10.6%	11.1%	11.8%				
3	Increased See and Treat rates	34.8%	35%	*Aim*	34.0%	34.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	Higher acuity in 999 calls is affecting the ability to S&T higher number of patients. 63% of demand C1 and C2 in Sept an increase of 5% from August
				Actual	34.9%	34.7%	34.3%	33.7%	33.5%				
4	Improved Mean 999 call answer time	00:00:51	00:00:10	*Aim*	00:00:10	00:00:10	00:00:24	00:00:11	00:00:20	00:00:11	00:00:10	00:00:10	Q2 performance behind plan. WMAS support commenced 11.08.23. Review of IOW staffing levels as below agreed levels.
				Actual	00:01:06	00:00:32	00:00:25	00:00:22	00:00:17				

SCAS Improvement Programme Scorecard: Performance Improvement — November 2023

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
5	Improvement in % of staff having meal breaks	54.9%	85%	*Aim*	85.0%	85.0%	63.0%	64.0%	65.0%	66.0%	75.0%	80.0%	Changes are being planned to re-design of seven SCAS operational nodes, to implement new work patterns during Q3/Q4 2023-24, that will support improving meal break "windows" built into the rosters.
				Actual	48.1%	61.5%	58.7%	53.8%	45.3%				
6	Improvement in % of staff shifts finishing no later than 30 minutes past finish time.	71.8%	90%	*Aim*	66.0%	66.0%	85.0%	85.0%	87.0%	88.0%	89%	90%	Project to design new rosters to incorporate 'overlapping shifts patterns' across all 23 resource centres is underway, this will support improved resource cover throughout the 24/7 period, so that 'oncoming shifts' will aid staff finishing on time at the end of their shift in Q3/Q4 - 2023/24. Review of EOC process for night shifts with unions has failed to reach agreement for change. QIA also rejected due to staff impact. Negotiations with unions to continue
				Actual	69.0%	83.0%	84.0%	82.3%	80.5%				
7.	Progress against infrastructure development programme			*Aim*	N/A	N/A	Programme Brief	Programme Plan	Initial Board Approval of Plan	Final Board Approval of Plan			An operational development plan for SCAS 999 Ops Services is now in development with project workstreams, as part of the Trust improvement programme. Performance Improvement Plan 2023-24 actions approved by Exec.
				Actual	*N/A*	*N/A*	Complete						



Improvement Programme Highlight Report: | Patient Safety | December 2023 | RAG:

Executive Lead: Helen Young | *Senior Responsible Officer: Sue Heyes* | *Programme Manager: Dai Tamplin*

Workstream Summary (Incl. RAG Assessment):

Quarter to Date (QTD) metrics are encouraging with figures reported to end of Nov 2023. Continued improvement in SG, not least with the long-awaited cut-over to the new SG server, increasing SAAF compliance to 97.8%. However, this has not been without challenge with an issue arising where SG referrals were not automatically sent when received from frontline users using Ortivus ePR devices. This has caused an element of reputational damage with Local Authorities (LAs) but AD SG engaged with senior stakeholders to minimise impact. Escalation to REAP 4 is having some impact on IPC audit and Stat & Mand compliance but this is being watched closely at the local level. Of note is the move of SCAS Pharmacy resources to the new facility in Adanac Drive, Nursling – move estimated to be completed pre-Christmas 2023.

Progress Against Key Outcomes / Success Criteria:

- Positive increase in SG metrics, with SAAF compliance rising to 97.8% with the cut-over to the new Doc-Works SG server successfully completed on 29 Nov 2023
- 3rd audit cycle of SI/DI investigations (50/50 split) completed for Q3. Monitoring continuous improvement of investigation/report quality.
- Patient Panel Chair undertaking induction/site visits. Recruitment to wider panel continues (with a focus on proportionate representation from religious/ethnic minority groupings)

Key Activity, Month Ahead:

- Receipt of SG Peer Review report and any subsequent action planning. Risk assessment of latest delayed SG referrals required (because of delays from new SG server automation failure). Development of comms/training package for new SG referral form
- SI/DI audit evaluation report to be completed. Low/No Harm audit reliant upon development of a fit for purpose quality metric tool (current tool not suitable)
- NHS 111 complaints process review – mapping exercise completed with actions on delays in audits requested to reduce agreed extensions (review Dec 23/Jan24)
- Induction programme for new IPC Lead (from 2 Jan 2024). Development of IPC Practitioner BC for inclusion in budget setting for FY 24/25 (to create additional IPC capacity in Thames Valley)

What's Gone Well:

- New SG telephone system went live 13 Dec 2023. SG advice now available 24/7 with direct transfer to OOH Social Work teams. Communicated to all staff
- Draft PSIRP compiled and submitted to PSIRF Project Board. Current on circulation for comment. Feedback received to-date encouraging
- Pharmacy move to new distribution premises in Adanac Drive, Nursling due for completion by 22 Dec 2023. Significantly improved facilities but 999 pharmacist recruitment still a challenge

What's Not Gone So Well:

- As of 18 Dec 2023, Doc-Works have identified that (643) SG referrals from Ortivus devices (frontline staff) were not automatically processed between 30 Nov and 18 Dec 2023. Mitigations have been put in place, an SI has been declared and referrals have now been sent to respective LAs
- New SG referral form implementation may be delayed as a result of remedial works required to address SG Server automation failure (Doc-Works capacity issue)
- PSIRF Implementation lead post remains vacant following unsuccessful recruitment. Continued impact on progress being felt due to reduced capacity but recoverable within mandated timeframes

Workstream Key Risks:

- Escalation to REAP 4 with potential impact on Stat & Mand and IPC compliance
- Transition to new SG server (a benefit of which was to improve reputation of SCAS/SG Service); subsequent technical issues are proving reputationally detrimental, with a risk of potential Pt harm

Workstream Issues:

- Nothing for escalation

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Programme Scorecard: Patient Safety — December 2023

No	Metric/s	Baseline (Date)	End Target (Date)	Aim/ Actual	2022/23 Q3	2022/23 Q4	2023/2024 Q1	2023/2024 Q2	2023/2024 Q3	2023/2024 Q4	2024/25 Q1	2024/25 Q2	Comments
					Quarterly Trajectories								
1	Increased number of Safeguarding referrals indicative of +ve reporting	12153 (30/09/22)	17956 (30/09/24)	*Aim*	*12761*	*13399*	*14069*	*14772*	*15511*	*16287*	*17101*	*17956*	Baseline Q2 2022 figures. 5% target increase per Qtr. Q3. QTD, 94% of trajectory
				Actual	13728	14221	16311	20458	14637				
2	Compliance against trajectory of Level 3 Safeguarding training	6% (30/09/22)	90% (31/03/24)	*Aim*	*20%*	*30%*	*46%*	*60%*	*70%*	*90%*	*>90%*	*>90%*	Trust-wide compliance figure (Clinician + ECA) Q3. QTD, 12% above trajectory
				Actual	18%	31%	49%	60.75%	82%				
3	Self-assessed compliance against SAAF to safeguard children, young people & adults	20% (30/09/22)	100% (Q4 23/24)	*Aim*	*30%*	*60%*	*70%*	*80%*	*90%*	*95%*	*>70%*	*>80%*	Calculated percentage against tasks aligned to SAAF Q3. QTD, 7.8% above trajectory with transition to new SG server
				Actual	30%	64%	94.5%	94.5%	97.8%				
4	Improvement in Patient Safety Culture Survey (MaPSaF) response rates	3% (28/02/23)	7.5% (30/09/24)	*Aim*	*N/A*	*3%*	*N/A*	*N/A*	*5%*	*N/A*	*N/A*	*7.5%*	Repeated every 6/12 Next report post Q3
				Actual	N/A	3%	N/A	N/A		N/A	N/A		
5	Incident report audit using a Quality & Maturity tool to evidence Well Led and cultural change	0 (31/03/23)	40 (31/03/24)	*Aim*	*N/A*	*N/A*	*10*	*10*	*10*	*10*	*10*	*10*	Audits to assess quality of SIs, DIs and Low/No Harm reporting Q3. 10 x Low/No Harm audits complete
				Actual	N/A	N/A	10	10	10				
6	Medical Device Audit – % compliance against schedule (Zoll X-Series)	Not Known (30/09/22)	>95% (Q1 24/25)	*Aim*	*>80%*	*>90%*	*>90%*	*>90%*	*>90%*	*>90%*	*>95%*	*>95%*	Increase dependent on intro of enhanced Asset Management system Q3. QTD, 6% above trajectory
				Actual	80%	90%	93%	93.4%	96%				
7	Decrease in number of medicines unaccounted for/loss	New for 23/24 IPR	TBC (Post Q3)	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*TBC*	*TBC*	*TBC*	*TBC*	IPR compliance data (new for 23/24) Trajectory TBC after Q2 data Q3. QTD, reduction following known incident under investigation in Q2. Trajectory to follow
				Actual	N/A	N/A	34	82	6				
8a.	IPC audit: % compliance against buildings cleanliness target	80% (30/09/22)	95%	*Aim*	*N/A*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	IPR compliance data Q3. QTD, below trajectory. Impacted by operational pressures
				Actual	N/A	74%	80%	77.9%	84.4%				
8b.	IPC audit: % compliance against vehicles cleanliness target	91% (30/09/22)	95%	*Aim*	*N/A*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	IPR compliance data Q3. QTD, below trajectory. Impacted by operational pressures
				Actual	N/A	91%	96.5%	93.1%	91.7%				

Sexual Safety Update

18th December 2023

Sexual Safety Campaign - Reflection

A recent reflection session was carried out in November to review what went well, areas for improvement and next steps to reinvigorate the campaign:

What went well	What could do better
• Sexual Safety Charter developed and released in Feb 2023 • Allegation management process proving to be effective • Formation of the Women's Network steered by Charter & Pulse data. • Dedicated Hub page for the charter, key policies and links to support agencies. • Campaign Launch and good discussions to raise awareness during Speak Up Month 2022.	• Communication of the Campaign, Speak up month 2022 was effective, momentum has reduced over time. • Understanding the impact of the Charter and allegation process , being more transparent re results (ie, dismissals / suspensions) • Optimise the Improvement Programme Oversight Board to overcome challenges • Increase internal awareness of the work done to date.

Looking forward: What do we want to achieve

Charter pledge:

Never tolerate, ignore or excuse harmful sexual language, behaviour and attitudes

Do everything we can to make sure people are heard, believed and feel safe

Take clear and prompt action about any sexual harassment, violence, or intimidation

How

- Educate the workforce on the Clumsy, Creepy, Criminal spectrum
- Educate Team Leaders to recognise behaviours within their team and how to act once identified
- Create awareness so the workforce know we are taking a stand to create a safe working environment
- Reinforce procedures in place for allegations to be processed appropriately
- Reverse mentoring. Lived experience mentors and Senior Leaders

Sexual Safety – Next Steps

Current Actions:

- Reverse mentoring – discussed sexual safety and the Reverse Mentoring Programme with the Women's network on 6th Dec, well received with a good number of volunteers coming forward. Next steps include agree programme, associated funding, participants and launch, including pairing mentors and mentees and briefing for all.
- Awareness workshops & Listening events - FTSU ran sexual safety awareness workshops on 2 sites identified by feedback data collated during Speak Up month and assisted an onsite listening event around sexual safety discussion. Also presented to the All SCAS webinar on speaking up and sexual safety.
- Walkabout Wednesday - Sexual Safety questions included in the FTSU Walkabout Wednesday feedback surveys and continue to monitor and act on data.
- Local Leadership Feedback – collating the sexual safety feedback from Speak Up month, and feeding these anonymised comments back to leaders of local sites they are related to. Next steps include agreeing comms to leaders and including various support links / documents to assist leaders with next steps.
- Sexual Safety Poster Campaign – posters in final design iteration, next steps: finalise the poster design, approvals and publishing.

Planned Actions:

- Sexual Safety Training – working with provider Conflict Master, roll out Upstander training to all line mangers, Jan – Mar 24. Budget agreed, Scoping conversations underway.
- Sexual Safety session at Board Seminar 29th Feb, highlighting lived experiences, focus on ownership and campaign plan including presentation from Bron Biddle (Welsh Ambulance Service SME sexual safety / FTSU guardian).
- Comms & Engagement - Plan a calendar of comms and engagement for next 12 months to refresh the campaign and raise awareness. including circulating posters to all sites & varied comms methods.
- Sexual Safety & Domestic Abuse / Domestic Violence Podcast - Collaboration with Safeguarding DA & DV team to develop a podcast series around education and awareness.
- Development of toolkits – guideline toolkits to assist managers and leaders with how to appropriately and fairly deal with a disclosure, including creation of a safe space for staff to feel free to speak up.
- Review Support – undertake review to ensure support systems provided include colleagues under gender reassignment & gender reidentification.
- Sexual safety SME within the FTSU team - exploring options for a dedicated post that triangulates sexual safety between, EDI, Safeguarding and FTSU. Mirror and learn from WAS and LAS in combining these 2 roles.

Culture Improvement Plan

Overview & Timeline

18th December 2023

Overview

Aim: One of the Culture Workstream Exit Criteria is to ensure Exec awareness and agreement of the Culture Improvement Plan (CIP) implementation timeline. Execs are invited to review the CIP over the next few slides.

Culture Improvement Plan (CIP) Overview:

- The CIP is aligned to the SCAS People Strategy (PS) and the 4 pillars of the NHS People Plan. All the short-term PS actions (6-18 month) are included in the CIP. Long term actions (18 month to 3 yr.) will be phase 2 of the CIP planning.
- All the People Directorate Objectives are aligned to the People Strategy & CIP actions, as such most plan actions are worked on as part of the directorate's BAU activities with project support / additional funded resources where needed.
- This is the high-level view of the CIP, with a detailed workplan sitting underneath for each of the top-level objectives.
- Progress of elements of the CIP are reported to the various BAU governance meetings (SCAS Board, Workforce Delivery Board, People & Culture Committee, EDI Steering Committee, HR directorate meeting).
- This pack details the current CIP, a further piece of NHSE funded Culture Diagnostic work will be undertaken in Q4, after which the CIP will develop to a further iteration.
- For ease of reading, the plan has been split into the 4 pillars with each pillar on a slide.

Looking After our People

Providing quality health & Wellbeing support for everyone.

◆ Milestone

Objective	Start Date	Due Date	Action Owner	Quarter 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24
1.0 Looking after our people							
Embed Peoples voice channels and feedback loop into BAU	01-May-23	03-Sep-23	Christine Uko				
Continue delivery of our SCAS Leader and Essential Skills for People Manager programmes	29-Aug-22	31-Mar-24	Carol Johnson				
Integrate civility and respect within all work areas across SCAS to promote a culture where staff feel safe, suppc	01-Jan-23	31-Mar-24	Judith McMillan / Simon Holbrook				
Improve 1:1 conversations with particular focus on Health and Wellbeing and access to 1:1s for all staff	01-Apr-23	31-Mar-24	Rachael Clarke				
Deliver Health and Wellbeing plan with focus on mental health and a healthy working environment	01-Apr-23	31-Mar-24	Rachael Clarke				
Just and Learning Culture – developing and embedding	01-Jul-23	30-Sep-23	Judith McMillan				
Attendance Management	01-Apr-23	30-Sep-23	Lisa Pickard / Rachael Clarke				

Belonging in the NHS

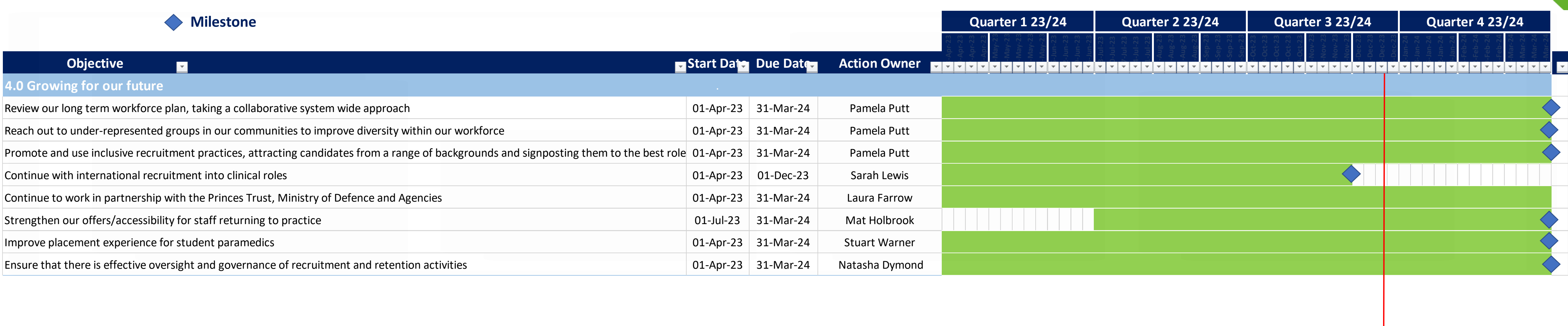
Creating a culture where everyone feels they belong.

Milestone

Objective	Start Date	Due Date	Action Owner	Quarter 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24
2.0 Belonging in the NHS							
Publish and promote our Equality, Diversity and Inclusion (EDI) strategy at every level	01-Sep-23	30-Mar-24	Dipen Rajyaguru				
Deliver Recruitment and Selection training to promote consistency, fairness and inclusion on interview panels	01-Apr-23	30-Sep-24	Pamela Putt				
Develop resilience, resourcing and visibility of our Freedom to Speak, Listen and Follow Up team	01-Jul-23	31-Aug-23	Simon Holbrook				
Strengthen and consolidate partnership working with our Trade Union colleagues and staff networks	01-Jun-23	31-Mar-24	Dipen Rajyaguru				
Take action to improve sexual safety across the organisation	01-Feb-23	31-Oct-23	Dipen Rajyaguru				
Continue with a calendar of events to promote diversity and support under-represented groups	01-Apr-23	31-Mar-24	Dipen Rajyaguru				
Ensure that equality impact assessments are undertaken on all board papers and business cases	01-Jun-23	31-Mar-24	Dipen Rajyaguru				
Improve access to Freedom to Speak Up e-learning, encourage completion and develop a dashboard for monitoring this	03-Jun-23	31-Mar-24	Simon Holbrook				

Growing for the future

How we recruit and keep our people



Objective	Start Date	Due Date	Action Owner
4.0 Growing for our future			
Review our long term workforce plan, taking a collaborative system wide approach	01-Apr-23	31-Mar-24	Pamela Putt
Reach out to under-represented groups in our communities to improve diversity within our workforce	01-Apr-23	31-Mar-24	Pamela Putt
Promote and use inclusive recruitment practices, attracting candidates from a range of backgrounds and signposting them to the best role	01-Apr-23	31-Mar-24	Pamela Putt
Continue with international recruitment into clinical roles	01-Apr-23	01-Dec-23	Sarah Lewis
Continue to work in partnership with the Princes Trust, Ministry of Defence and Agencies	01-Apr-23	31-Mar-24	Laura Farrow
Strengthen our offers/accessibility for staff returning to practice	01-Jul-23	31-Mar-24	Mat Holbrook
Improve placement experience for student paramedics	01-Apr-23	31-Mar-24	Stuart Warner
Ensure that there is effective oversight and governance of recruitment and retention activities	01-Apr-23	31-Mar-24	Natasha Dymond

New ways of working and delivering Care

Making effective use of our people's skills and experience.

Milestone

Objective	Start Date	Due Date	Action Owner	Quarter 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24
3.0 New ways of working							
Embed our new Personal Development Review (PDR) forms	01-Apr-23	31-Mar-24	Carol Johnson				
Develop an annual planning process with cascading objectives	01-Apr-23	31-Mar-24	Carol Johnson and Emma Manaton				
Improve access to paid development/learning opportunities across our workforce (coaching, leadership development)	01-Apr-23	31-Mar-24	Rachel Newell				
Provide fully regulated courses with high quality teaching	29-Aug-22	31-Mar-24	Mike Dunford / Caroline Robertson				
Develop Digital Education and simulation facilities to improve learning and development opportunities	01-Apr-23	01-Jul-26	Rachel Newell				
Improve the welcome programme for new joiners (Good Start)	01-Apr-23	30-Sep-23	Christine Uko				

Strategy Enablers

Factors that will facilitate effective delivery of our People Strategy.

◆ Milestone

Objective	Start Date	Due Date	Action Owner	Quarter 1 23/24	Quarter 2 23/24	Quarter 3 23/24	Quarter 4 23/24
5.0 Enablers							
Develop automated Business Intelligence reports that give access to good quality people data	01-Apr-23	31-Mar-24	James Wise				
Improve our people administrative processes, ensuring better access, responsiveness and resilience	01-Oct-23	31-Mar-24	Natasha Dymond & Lisa P				
Build our Supporting Our People intranet site ensuring that people can easily access the help/support that they need in one place	01-May-22	31-Mar-24	Ashna / Carol				
Improve the recruitment process, seeking feedback from candidates/managers and developing clear Key Performance Indicators (KPIs)	01-Apr-23	31-Mar-24	Pamela Putt				

Questions & Approval of CIP timeline

Ask Execs to approve the CIP timeline.

Sexual Safety Update

18th December 2023

Sexual Safety Campaign - Reflection

A recent reflection session was carried out in November to review what went well, areas for improvement and next steps to reinvigorate the campaign:

What went well	What could do better
• Sexual Safety Charter developed and released in Feb 2023 • Allegation management process proving to be effective • Formation of the Women's Network steered by Charter & Pulse data. • Dedicated Hub page for the charter, key policies and links to support agencies. • Campaign Launch and good discussions to raise awareness during Speak Up Month 2022.	• Communication of the Campaign, Speak up month 2022 was effective, momentum has reduced over time. • Understanding the impact of the Charter and allegation process , being more transparent re results (ie, dismissals / suspensions) • Optimise the Improvement Programme Oversight Board to overcome challenges • Increase internal awareness of the work done to date.

Looking forward: What do we want to achieve

Charter pledge:

Never tolerate, ignore or excuse harmful sexual language, behaviour and attitudes
Do everything we can to make sure people are heard, believed and feel safe
Take clear and prompt action about any sexual harassment, violence, or intimidation

How

- Educate the workforce on the Clumsy, Creepy, Criminal spectrum
- Educate Team Leaders to recognise behaviours within their team and how to act once identified
- Create awareness so the workforce know we are taking a stand to create a safe working environment
- Reinforce procedures in place for allegations to be processed appropriately
- Reverse mentoring. Lived experience mentors and Senior Leaders

Sexual Safety – Next Steps

Current Actions:

- Reverse mentoring – discussed sexual safety and the Reverse Mentoring Programme with the Women's network on 6th Dec, well received with a good number of volunteers coming forward. Next steps include agree programme, associated funding, participants and launch, including pairing mentors and mentees and briefing for all.
- Awareness workshops & Listening events - FTSU ran sexual safety awareness workshops on 2 sites identified by feedback data collated during Speak Up month and assisted an onsite listening event around sexual safety discussion. Also presented to the All SCAS webinar on speaking up and sexual safety.
- Walkabout Wednesday - Sexual Safety questions included in the FTSU Walkabout Wednesday feedback surveys and continue to monitor and act on data.
- Local Leadership Feedback – collating the sexual safety feedback from Speak Up month, and feeding these anonymised comments back to leaders of local sites they are related to. Next steps include agreeing comms to leaders and including various support links / documents to assist leaders with next steps.
- Sexual Safety Poster Campaign – posters in final design iteration, next steps: finalise the poster design, approvals and publishing.

Planned Actions:

- Sexual Safety Training – working with provider Conflict Master, roll out Upstander training to all line mangers, Jan – Mar 24. Budget agreed, Scoping conversations underway.
- Sexual Safety session at Board Seminar 29th Feb, highlighting lived experiences, focus on ownership and campaign plan including presentation from Bron Biddle (Welsh Ambulance Service SME sexual safety / FTSU guardian).
- Comms & Engagement - Plan a calendar of comms and engagement for next 12 months to refresh the campaign and raise awareness. including circulating posters to all sites & varied comms methods.
- Sexual Safety & Domestic Abuse / Domestic Violence Podcast - Collaboration with Safeguarding DA & DV team to develop a podcast series around education and awareness.
- Development of toolkits – guideline toolkits to assist managers and leaders with how to appropriately and fairly deal with a disclosure, including creation of a safe space for staff to feel free to speak up.
- Review Support – undertake review to ensure support systems provided include colleagues under gender reassignment & gender reidentification.
- Sexual safety SME within the FTSU team - exploring options for a dedicated post that triangulates sexual safety between, EDI, Safeguarding and FTSU. Mirror and learn from WAS and LAS in combining these 2 roles.