Agenda

Public Trust Board

Date: Thursday 30 May 2024
Time: 9.30 – 12.45
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
Ian Green OBE	Non-Executive Director
Dr Dhammika Perera	Non-Executive Director
Nigel Chapman	Non-Executive Director
Mike McEnaney	Non-Executive Director
Paul Kempster	Chief Transformation Officer
Helen Young	Chief Nurse Officer
Melanie Saunders	Chief People Officer
Mike Murphy	Chief Strategy Officer
Dr John Black	Medical Director

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
Nora Hussein	Interim Assistant Trust Secretary
Susan Wall	Corporate Governance & Compliance Officer

Apologies:

Daryl Lutchmaya	Chief Governance Officer
Melanie Saunders	Chief People Officer

Questions received <u>in advance</u> from Board Members for those items marked as 'For Noting' 8,12, 16, 19, 22 will be received under agenda item 24, and 27, 28 under item 29.

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 28 March 2024** Keith Willett	-	**Page 5** **For Approval**	
4	**Board Actions Log** Kofo Abayomi	-	**Page 17** **For Approval**	09.35
5	**Chair's Report** Keith Willett	-	**Page 19** **For Noting**	09.40
6	**Chief Executive Officer's Report** David Eltringham	-	**Page 22** **For Noting**	09.45
7	**Executive Management Committee Terms of Reference** David Eltringham	-	**Page 29** **For Approval**	09.50
8	**Update to the Public Board on the previous Private Board meeting held on 28 March 2024, 26 April and 1 May 2024.** Kofo Abayomi	-	**Page 39** **For Noting**	-
9	**Patient Story** Helen Young	**SR1 12**	**Page 43** **For Information**	09.55
10	**Integrated Performance Report** Stuart Rees & Executive Director Leads	**SR9 20**	**Page 55** **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.			
11	**Quality and Patient Safety Report** Helen Young	**SR1 12**	**Page 59** **For Assurance**	10.50
12	**Chief Medical Officer's Report** John Black	**SR1 12**	**Page 69** **For Noting**	-

Item		BAF	Action	Time
13	**Fit for the Future Programme Update** Paul Kempster	SR9 20	**Page 75** **For Assurance**	11.05
14	**Quality and Safety Committee Terms of Reference** Dhammika Perera/Helen Young	SR1 12	**Page 79** **For Approval**	11.15
15	**Assurance Report** Quality and Safety Committee, 22 May 2024 Dhammika Perera	SR1 12	**Verbal** **For Noting**	-
	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.			
16	**Finance Report Month 1 Update** Stuart Rees	SR5 20	**Page 92** **For Assurance**	11.20
17	**Finance and Performance Committee Terms of Reference** Les Broude/Stuart Rees	SR5 20	**Page 100** **For Approval**	11.30
18	**Assurance Report** Finance and Performance Committee, 22 May 2024 Les Broude	SR5 20	**Page 112** **For Noting**	-
19	**SCAS Charity Annual Report & Year End Financial Position** Vanessa Casey	SR5 20	**Page 114** **For Approval**	11.35
20	**Charitable Funds Committee Terms of Reference** Nigel Chapman	SR5 20	**Page 124** **For Approval**	11.45
21	**Assurance Report** Charitable Funds Committee Nigel Chapman	SR5 20	**Page 133** **For Noting**	-
22	**Audit Committee Terms of Reference** Mike McEnaney/Stuart Rees	SR5 20	**Page 138** **For Approval**	11.50
23	**Questions submitted by Board Members on agenda items: 8, 12, 16, 19 & 22**	-	-	11.55
	5 MINUTES COMFORT BREAK 12.00			
	People & Organisation – We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			
24	**People and Culture Committee Terms of Reference** Ian Green/Melanie Saunders	SR7 12	**Page 152** **For Approval**	12.05
25	**Remuneration Committee Terms of Reference** Sumit Biswas/Melanie Saunders	SR7 12	**Page 165** **For Approval**	12.10
26	**Assurance Report** People and Culture Committee 16 May 2024 Ian Green	SR7 12	**Page 175** **For Noting**	-

Item		BAF	Action	Time
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
27	**Communications Update** Gillian Hodgetts	SR4 12	**Page 179** **For Noting**	-
28	**Questions submitted by Board Members on agenda items: 24, 27 & 28**	-		12.15
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
	No report		-	
	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.			
29	**Board Assurance Framework** Kofo Abayomi & Executive Director Leads	SR9 20	**Page 185** **For Approval**	12.20
30	**Self-Certification – Licence Conditions** Kofo Abayomi	SR9 20	**Page 205** **For Approval**	12.25
31	**Assurance Report** **Improvement Programme Oversight Board Update 1 May 2024** Mike Murphy	SR9 20	**Page 212** **For Noting**	12.30
	CLOSING BUSINESS			
32	**Any Other Business**	-	**Verbal** **For Noting**	
33	**Questions from observers (items on the agenda)** Keith Willett	-	**Verbal** **For Noting**	12.40
34	**Review of Meeting** Non-Executive Director: Les Broude Executive Director: John Black	-	**Verbal** **For Noting**	12.45
35	**Date, Time and Venue of Next Meeting in Public** Thursday 25 July 2024 at 9.30am Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN	-	**Verbal** **For Noting**	-

Minutes
Public Trust Board Meeting

Date: 28 March 2024
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
Dr Anne Stebbing	Non-Executive Director
Ian Green	Non-Executive Director
Dr Dhammika Perera	Non-Executive Director
Mike McEnaney	Non-Executive Director
Mike Murphy	Chief Strategy Officer
Melanie Saunders	Chief People Officer
Paul Kempster	Chief Transformation Officer
Professor Helen Young	Chief Nurse Officer
Dr John Black	Chief Medical Officer
Craig Ellis	Chief Digital Officer

In Attendance:

Stuart Rees	Interim Director of Finance
Gillian Hodgetts	Director of Communications, Marketing & Engagement
Mark Ainsworth	Director of Operations
Kate Hall	Intensive Support Director, NHSE
Dipen Rajyaguru	Head of Equality, Diversity & Inclusion
Kofo Abayomi	Head of Corporate Governance & Compliance
Nora Hussein	Interim Assistant Trust Secretary
Christine McParland	Deputy Freedom to Speak Up Guardian (item 8 only)

Apologies:

Daryl Lutchmaya	Chief Governance Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	Keith Willett (Chair) welcomed everyone to the meeting. Apologies were noted as above.
1.2	

	The Chair informed the Board that this was Anne Stebbing's last meeting. She had now come to the end of her six year term on the Board. The Chair thanked her for all her hard work and contribution to the organisation.
2	**Declarations of Interests**
2.1	Ian Green informed the Board that he was recently appointed Chair of the NHS Wales Joint Commissioning Committee, effective from 1 April 2024.
2.2	The Board noted the declarations of interests.
3	**Minutes from the meeting held on 30 November 2023**
3.1	The minutes were agreed as an accurate record of the meeting, subject to adding Nigel Chapman as present in the meeting.
4	**Matters Arising and Action Log**
4.1	The action log was reviewed, and the following action was agreed to be closed: • Action 1 (25/5/23) - Governors to be invited to participate in 'triple aim' duty with regard to community engagement • Action 2 – Vehicles off road report to be presented to Board. • Action 1 (25/1/24) – Staff Story deferred to March Trust Board meeting. • Action 9 (25/1/24) – Mark Ainsworth to circulate the SCAS hours analysis to Non-Executive Directors.
5	**Chairs Report**
5.1	The Chair noted that we had come to the end of the financial year, and this was always a busy period for the organisation. He formally recognised contributions of the executive and senior leadership teams for their hard work in managing the Trust's performance levels and finances as the year closes.
5.2	The Board were informed that system pressures continued, and David Eltringham and members of the executive team continued to work with the Integrated Care Boards to provide system support and resilience.
5.3	The Chair summarised his recent compliance/site visits and stated that it was always encouraging to see the level of commitment displayed by staff at various sites. The Chair informed the Board that he visited a sixth form school to talk about the NHS, SCAS and career opportunities. He noted that feedback from this age group was interesting.
5.4	The Board noted that SCAS new governors' induction took place in March. The Chair stated that it was a good session and good to meet new governors helping them understand their role within the organisation and the importance of their contributions.
5.5	The Board **noted** the Chairs Report.
6	**Chief Executive Officer's Report**
6.1	David Eltringham presented key highlights from his Chief Executive Officer's report and asked the Board to note content of the report. In addition to the medals and awards to staff detailed in the report, the Board were informed of the award received by the Trust's safeguarding team.
6.2	David Eltringham gave his personal thanks and gratitude to everyone who works for SCAS, contributing to the Trust's patients and communities.

6.3	Dhammika Perera welcomed the staff wellbeing week, he stated that this was a positive thing. Further to his query whether the event will be held regularly. It was noted that it was a successful event, and more thoughts will be given to the frequency.
6.4	The Board **noted** the Chief Executive Officer Report.
7	**Update to the Public Board on the previous Private Board meeting held on 30 November 2023**
7.1	The Board **noted** the update to the Public Board on the previous Private Board meeting held on 25 January 2024 and 29 February 2024.
8	**Staff Story**
8.1	Melanie Saunders introduced the staff story and informed the Board that the member of staff could not attend the meeting but had provided consent for their story to be shared with the Board. Christine McParland, one of the Trust's Freedom to Speak Up (FTSU) Guardian attended the meeting and shared the story on behalf of the staff. The Board noted that the story related to a FTSU concern 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, the team were able to facilitate and support a resolution in conjunction with the Assistant Director of Estates by escalating the concern to the Chief Executive Officer and Chief People Officer. However even in this process, the team were directed back to the Fixed Asset Management Group who were meeting the following month and would have caused a further delay.
8.2	The Board noted that learnings included review of reasonable adjustments process, publishing of a disability policy; improvements to be made to speaking up, listen up, follow up culture. Melanie Saunders stated that the staff survey showed that there have been improvements in disabled staff experience, but this was not true from FTSU feedback.
8.3	Ian Green was concerned that Non-Executive Directors have been flagging this issue for years and it was positive that this had been resolved but he remained concerned that a simple process had taken so long due to bureaucracy.
8.4	Sumit Biswas was disappointed that this issue had to be escalated for it to get the focus and attention it needed. He welcomed the recently published policy and highlighted that improvements are required in decision making and following through actions. Sumit Biswas advised that appropriate focus is required for what we must do better in future and align these with the fit for future programme. **Action: To review 'disability adjustments' process to allow more local discretion by the Executive Management Committee and outcomes reported to Board**.
8.5	Mike Murphy advised that the Executive Management need to engage more with staff when concerns are raised and for the issues to be proactively addressed.

8.6	Nigel Chapman highlighted that there is a need for discretion to act, he noted that systems in place can sometimes impact progress, consideration should be given to discretion to act. Furthermore, as we progress with fit for the future, cultural issues need to be tackled to prevent reoccurrences.
8.7	Anne Stebbing queried whether the value of investments on access is known. She also advised that managers should be made aware of the discretion to act. Mike McEnaney pointed out that this issue was embarrassing for the organisation and managers should be empowered to speak up for their team. He advised that messaging around the discretion to act should be stronger and response should be quicker so that we can demonstrate that we look after our staff.
8.8	Craig Ellis added that a framework/process should be put in place to address IT complexities so that issues are addressed speedily.
8.9	**The Board noted the Staff Story**.
9	**Integrated Performance Report** The Board noted that executive lead responsibility has moved to Stuart Rees, Interim Director of Finance and thanked Mike Murphy for all his work in developing the Integrated Performance Report. Stuart Rees provided the overview of the IPR and invited Executive Directors to present sections of the Integrated Performance Report.
9.1	**<u>Operational Performance</u>** Mark Ainsworth summarised operational performance for the reporting period. The Board was asked to note the impact of handover delays on Category 2 performance. There was also a decrease in demand due to seasonal variation in 999. Mike Ainsworth mentioned that the easter weekend will be a busy and challenging period for 111 and 999.
9.2	Dhammika Perera pointed out that there was still no firm grasp of IPR indicators, and this had been highlighted at previous board discussions.
9.3	Sumit Biswas advised that the IPR should be used to drive discussions around assurance, and this was still lacking. He sought clarity on the sustainability of the action plans to improve average handle time at Emergency Operations Centre (EOC) and increasing Hear and Treat. Mark Ainsworth explained that the Finance and Performance Committee had requested a detailed report on average handling time at the next meeting in April. He summarised actions in place to improve average handling time and actions to increase Hear and Treat including international nurses' recruitment and full utilisation of clinicians within teams.
9.4	Nigel Chapman sought assurance around the balance of private provider hours and deployment of the trust resources to cover underachievement of private providers and the level of confidence that private providers will start to deliver to target. He also noted that there was an increase in the number of vehicles off the road and sought assurance that this issue was being managed. In response to the query relating private provider hours versus SCAS hours, Mark Ainsworth informed the Board that the four main private providers have increased their hours due to the three months extension noted at the last Trust Board meeting, as a result there is a higher level of confidence in their delivery. Regarding vehicles off the road, it was noted that although there are still significant number of vehicles without relevant engine parts, we are reporting lower lost hours i.e., currently 30 hours lost versus 200 hours previously reported. The Board noted that additional measures are in place to mitigate easter holiday pressures.

9.5	Further to the discussion on handover delays, firebreaks and challenges at the Queen Alexander Hospital, David Eltringham informed the Board that there are ongoing system wide discussions on how to address this issue, these are still at development/diagnostic stages with focused workstreams which will feed into the wider urgent and emergency care improvement piece of work. Nigel Chapman welcomed the update with an expectation that this piece of work would now yield positive and sustainable results.
9.6	Anne Stebbing advised that there should be a focus on what is within the Trust's internal control to improve Category performance and not external aspects arising from the Queen Alexander Hospital.
9.7	Les Broude queried the accuracy of the charts presented in the IPR report, the chart showed limited progress, which was not the case, particularly within the private provider hours. He also noted that performance review linked to the IPR has been positive and advised that the quality and safety section is presented the same way.
9.8	Sumit Biswas sought clarity on call for immediate handovers with providers i.e., whether this was due to mitigating delays or new ways of working. Mark Ainsworth summarised how the Trust implements immediate handovers with providers including challenges of implementation. The Board were informed that immediate handovers were yet to be implemented at Southampton and Hampshire hospitals.
9.9	Mike McEnaney highlighted that the required level of support from the Integrated Care Boards (ICB) and Integrated Care System (ICS) were lacking. He emphasised that SCAS is accountable for areas we need to deliver on and highlight system wide challenges impacting SCAS performance. The ICS and Acute Trusts need to recognise that this a system wide issue. Mike McEnaney advised that there should be a clear separation of internal measures to deliver national targets and delays arising from external factors. David Eltringham welcomed this challenge and reported that there are ongoing internal conversations with consideration for how this is presented to system partners.
9.10	**Quality and Patient Safety** Helen Young provided key highlights within the Integrate Performance Report. The Board were informed that there is targeted work to achieve 90% compliance rate for level 3 safeguarding training. An update on the Trust current position has been reported to the ICB.
9.11	The Board noted that level 1 and 2 adults and children's safeguarding training compliance rate is currently over the 95% target on the Trust's education portal however this excludes students and those on honorary contracts who are trained in their employing organisation. Helen Young highlighted that the IPR data set includes these two additional staff groups and therefore showed a lower level of compliance. The Executive Management Committee are addressing the definitions for inclusion so that accurate and aligned data is seen through the IPR.
9.12	Helen Young reported on the Infection Prevention Control (IPC) and informed the Board that there was an action from the Quality and Safety Committee around IPC KPIs. It was noted that these are being worked through with a plan to identify six key ones for Quality and Safety oversight.
9.13	The Board were informed that there is a continuing focus on reporting incidents, Helen Young highlighted positive aspects of having a safety culture and noted that this provided intelligence to the Trust as we transition to PSIRF. The Board noted that delay in response which could lead to potential harm, has been a consistent theme. Helen Young summarised outcomes of the thematic review carried out and internal control issues impacting delays. Work is ongoing to understand and mitigate internal delays.

9.14	Sumit Biswas was assured that there is a robust plan to achieve level 3 compliance rate safeguarding training by the end of the financial year. Further to Sumit Biswas highlighting the discrepancy in the SPC chart which showed compliance rate of 95% for level 3 safeguarding training, Helen Young explained that the approval was only provided by the commissioners in -year to reduce the target to 90% and this was yet to reflect in reporting.
9.15	In response to Anne Stebbing's query on how the Trust is assured that honorary staff and students have the right training and qualifications. Melanie Saunders explained that universities provide declaration that students have completed relevant training before they begin placements. Bank staff are only offered shifts with relevant training and skills in place. There is ongoing work on honorary contracts, honorary staff status and compliance with statutory and mandatory will be verified and reported separately.
9.16	Anne Stebbing noted that there was no commentary Ambulance Quality Indicators (AQIs) within the IPR. John Black apologised for this oversight and provided a summary of the benchmarking work done at the Clinical Review Group. It was noted that the Trust is currently delivering below the 26 minutes average other ambulance services are getting patients to cath labs. Stroke performance was below average, due to Category 2 challenges already discussed. Board were informed that relevant assurance and details were detailed in the Chief Medical Officer's report.
9.17	Ian Green highlighted the risk around safeguarding training in relation to honorary contracts and sought further assurance on this issue. Mark Ainsworth explained the reason for the decline in safeguarding training in the reporting period and that the number of staff that could be booked on the course was maximised. **Action: To review risks/prioritisation of dropping safeguarding training check for honorary contracts**.
9.18	**Workforce** Melanie Saunders summarised the report and asked the Board to note the report.
9.17	In response to Mike McEnaney's comment on the 180 staff above forecast reported in month 11, the cost and financial position of the Trust, David Eltringham explained that this has been discussed at various oversight forums, the need for a clearer plan was emphasised, i.e., SCAS substantive workforce, additional recruitment requirements, reduction in private provision over time and clarity on the Trust's full time equivalent. Furthermore, a set of trajectories need to be set and accountability of delivery against the trajectories. Mike McEnaney reiterated his concern about the Trust operating in a deficit and in financial recovery for over a year. Nigel Chapman also cautioned against making financial assumptions in light of the Trust's complex financial position.
9.18	**Finance** The Board noted the finance update within the Integrated Performance Report.
9.19	The Board **noted** the Integrated Performance Report.
10	**Quality and Patient Safety Report**
10.1	Helen Young presented the report and informed the Board that the top risks for the Trust continued to be Handover Delays at the Queen Alexandra Hospital, Handover Delays at other hospitals and Safeguarding System Outage. The Board was also asked to note the key points in the report.
10.2	Keith Willett requested an update on DocWorks, an update on the residual safeguarding process attributed to DocWorks and assurance around safeguarding process. Helen Young explained that there is ongoing end process mapping in relation to the risk with oversight by

	the Task and Finish Group. DocWorks have also taken over posting safeguarding application to ensure effective safeguarding referrals. Internally there is an end to end process mapping on each referral to identify any areas of potential weakness. Craig Ellis added that in February 2024, configuration changes to the system, which were successful and since then there have been weekly checks of the system to ensure that the issue was fully mitigated. He assured the Board that the position and risk had now improved since identified in December 2023.
10.3	In response to Ian Green's query about provision for mental health, it was noted that there are ongoing discussions with the Trust's commissioners. Mark Ainsworth summarised both the BOB ICB and HIOW ICB approach. The Trust is yet to recruit resourcing to support the provision due to uncertainty of funding support. It was noted that the Trust is still responding to Section 136 of the Mental Health Act in accordance with the Trust's contracts but there is a gap with secure contract. The Board noted how this currently being mitigated. **Action: Further to discussions, it was agreed that David Eltringham will speak to BOB ICB Chief Executive about the provision of mental health vehicles in the south**.
10.4	Further to the query raised by Les Broude in relation to Infection Prevention Control (IPC), the Board noted that targeted actions are required to improve compliance.
10.5	Sumit Biswas queried an update on the QI strategy, he advised that it would be beneficial for this to be discussed beyond the Quality and Safety Committee, as it would help with staff engagement aspect of the Fit for Future transformation programme. Helen Young provided a brief update and the governance channels, she explained that the strategy will be presented to the Executive Management Committee in April and a timescale will be agreed for Board. **Action: QI programme Methodology to be reported to Board for understanding the implementation**.
10.6	On the transition of PSIRF, Mike McEnaney referred to the CQC inspection and the issue raised that the Board was not sighted on incidents. He sought assurance on how the Board will be sighted once PSIRF is fully implemented and the governance controls in place. Helen Young assured the Board that all steps have been taken to move to the framework, there are regular updates on the SI framework and there are thematic reviews in place. Mike McEnaney was clear on the process but emphasised that assurance should be provided to the Board. **Action: Risk review and mitigation for transition to PSIRF was requested by the Board**.
10.7	The Board **noted** the Quality and Patient Safety Report.
11	**Medical Director's Report**
11.1	The Board received the Medical Director's report.
11.2	Mike McEnaney commended the work highlighted in the research section of report. John Black highlighted key enablers in deploying clinical research. John Black drew the attention of the Board to the research project on intramuscular tranexamic acid for the treatment of symptomatic mild traumatic brain injury in older adults
11.3	Keith Willett highlighted that there was previous Board discussions on alternative pathways and work done regarding SCAS connect, there was a planned report on the each of the pathways and activity. He requested that an update is presented to the Board. **Action: Report to Board activity in alternative pathways as identified by SCAS Connect**.
11.4	The Board **noted** the Medical Director's Report.
12	**Operations Report – 999, 111 and Other**
12.1	

	Mark Ainsworth presented the report, noting that the report provided partial assurance rating due to the unsustainable levels of handover delays impacting on Category 2 delivery.
12.2	Keith Willett commented that the CFR report was well received by the Board. He also queried whether the Trust would receive funding for the Manchester Arena inquiry. It was noted that a bid had been submitted and Stuart Rees awaiting response from NHS England national team.
12.3	Anne Stebbing raised a number of points which included the importance of the Board receiving assurance on Emergency Preparedness Resilience and Response (EPRR), this report had not been present to the Board in recent times and advised that this is factored into the Board agenda forward planning. **Action: Annual Assurance of SCAS EPRR functions to be presented to the Board**. She also mentioned that at the last Board meeting, a question about number of hours lost due to off the road vehicles was asked by a governor and advised that updates on this are included in the report. **Action: Lost hours due to vehicles off the road to be added to the operations report**. Lastly, she queried the risk around the camera replacement programme how the risk is being mitigated. Mark Ainsworth and Craig Ellis confirmed to the Board that actions have been taken to mitigate the risk including testing of standard upgrades made to the system.
12.4	Nigel Chapman sought clarity on the phrase Emergency Operations Centre (EOC) performance improvements. Mark Ainsworth explained work done by AACE to review call handling and benchmarked this against other Trusts, it was established that SCAS has the longest average call handling time. Focus will be on reduction of call handling time, led by team leaders. Mark Ainsworth noted that it was identified that there were not enough team leaders in the EOC, and he summarised the recruitment actions to mitigate this issue. In addition to this, individual behaviour and right leadership in the room to ensure ratios of calls is also important. Mark Ainsworth also informed the Board that an update will be presented to the Finance and Performance Committee.
12.5	Les Broude sought clarification on the improvement of lost hours reported from 200 hours down to 30 hours, he noted that there were still significant number of vehicles off the road due to faulty engine parts. Mark Ainsworth explained that this was due to more vehicles going out earlier in the day and this was making significant impact. Stuart Rees also provided a brief update on the status of vehicles off the road repairs.
12.6	The Board **noted** the Operations Report – 999, 111 and Other.
13	**Fit for the Future Programme**
13.1	Paul Kempster presented the report and asked the Board to note key highlights of the report.
13.2	Further to Keith Willett's query on the proposed approach of the programme, Paul Kempster explained that there will be three to four priorities set out in the proof of concept, which will be tested before additional programmes are added. The KPIs and softer measures will also be developed. The leadership teams will also be engaging with the local systems to improve access to alternative pathways. The Board were informed that the overall programme will be co-produced with staff.
13.3	Sumit Biswas advised that the cultural dimension gets the right emphasis in the business case. He also noted that the five cases model requires hard work and can be challenging to deliver however this was a necessary piece of work and approach. Sumit Biswas further noted that the Trust has been open about the road map, commitments and timeline of delivery evident to staff, he asked whether the timeline is on track and the communication approach to staff. Paul Kempster confirmed that delivery against the road map is progressing and on track. He also stated that communication around modelling/location of the hubs for the large ambulance stations is required. An executive session was held recently to discuss this area, Paul

	Kempster explained that this was a complex piece of work which requires further consideration. There are planned discussions in April to develop the modelling further. These will also be tested as part of the proof of concept therefore there is a risk of slippage in some areas. The Board noted that there is overall confidence in delivery against the road map. Paul Kempster summarised the webinars and engagement sessions.
13.4	For clarity purposes and for benefit of members of the public, David Eltringham explained that proof of concept relates to geographical testing of pieces of the improvement programme.
13.5	Dhammika Perera advised that accountability referred to in the document should be strongly articulated, currently this was light, and more emphasis was needed. He further stated that when the programme is communicated to staff, emphasis should be on what this means for them.
13.6	Anne Stebbing queried the level of confidence delivering the programme and whether the timeframe remained realistic going forward. Paul Kempster explained that this is a huge and complex programme, and it is without risk.
13.7	Nigel Chapman expressed concern about the alignment of the transformation programme to the Trust financial position.
13.8	The Board **noted** the Fit for the Future Programme report.
14	**Assurance Report:** **Quality and Safety Committee 14 March 2024**
14.1	The Board **noted** the Quality and Safety Committee Assurance Report.
15	**Finance Update- Month 11**
15.1	Stuart Rees presented the report and highlighted that the Trust recorded an in-month deficit of £1.3m in M11, increasing the YTD deficit to £19.5m. The underlying factors driving the deficit remain unchanged, noting that the underlying position has improved slightly from the start of the year. The Trust is currently forecasting a year-end outturn of £21.9m deficit.
15.2	The Board discussed the above update and Les Broude provided assurance from the Finance and Performance Committee discussions, he stated that there was confidence in the position although cash will be challenging in 2024/25 if savings are not delivered.
15.3	David Eltringham informed the Board that from a governance perspective, and to have grip and control over the position, a Financial Recovery Group was established, this group meets on a weekly basis and membership includes all Executive Directors and subject matter experts. There is ongoing discussion on resetting the group to consider the cost improvement plan and the target against plan and to ensure delivery against the financial plan.
15.4	The Board **noted** the Finance Update- Month 11.
16	**Assurance Report** Finance and Performance Assurance Committee 19 February and 20 March 2024.
16.1	The Board were informed that an extraordinary Finance and Performance Committee and Board meeting are required to approve the financial and operating plan ahead of the 19 April submission to NHS England.

16.2	The Board **noted** the Finance and Performance Assurance Committee Reports.
17 17.1 17.2 17.3	**SCAS Green Plan 2023 – 2028** The Board received the SCAS Green plan 2023-2028. The Board acknowledged the robustness of the plan and formally recognised the work done by Jonathan Guppy, Sustainability Manager and his team and the support from Nigel Chapman, Non-Executive Director. Stuart Rees summarised the Green Plan and the Board noted key highlights of the plan. Board discussion and points raised by Dhammika Perera and Sumit Biswas included the CQC requirements, areas highlighted during the last inspection, the plan was less detailed on estates in light of the modernisation programme. Mike McEnaney advised that there should be a separate green strategy and within this, a five year plan to achieve zero emission. The Board **approved** the Green Plan and noted that this will be monitored on a quarterly basis.
18	**Questions submitted by Board Members on "For Noting" agenda items:14 and 16** No questions received.
19 19.1 19.2 19.3	**Freedom to Speak up Quarter 3 Report** The Board received the Freedom to Speak up Quarter 3 Report. Assurance and discussions from the People and Culture Committee were noted. The Board were informed that there were now three freedom to speak up guardians, although Simon Holbrook was scheduled to commence a secondment to another NHS organisation, there are ongoing plans for his replacement. The Board thanked Simon Holbrook for all his work and contributions to the Trust's Freedom to Speak Up function. The Board **noted** the Freedom to Speak up Quarter 3 report.
20 20.1 20.2	**National Staff Survey** The Board received the national staff survey result and noted additional input since the embargoed result reported to the Trust Board in private. Melanie Saunders summarised actions arising from the survey results. The Board **noted** the National Staff Survey update.
21 21.1	**Assurance Report** People and Culture Committee 18 January 2024 The Board **noted** the People and Culture Committee Assurance Report.
22 22.1	**Communications Update** The Board **noted** the Communications Update.
23 23.1	**Chief Digital Officer's report** The Board received the Chief Digital Officer's report. Craig Ellis summarised the report stating that the report covered the three months period since he has been in post. The Board were informed of the risks around digital and lack of investment in this area. Craig Ellis confirmed to the Board that there are ongoing discussion with Stuart Rees on the way forward in light of the Trust financial position.

23.2	Mike McEnaney highlighted that from a risk management perspective, a number of concerns were raised in the report and advised that these should be included in the corporate risk register.
23.3	Les Broude welcomed the report, noting that IT investments were made in the past which did not always go as planned and advised the importance of robust business cases and implantation plans to mitigate risks of previous investments. Craig Ellis explained that there are two aspects to digital i.e., the business as usual and transformation aspect including return on investment and advised that these two areas need to be clearly defined.
23.4	Sumit drew the attention of the Board to the slow progress being made in regard to the Trust's information governance statutory training compliance rate reported in the IPR report, he advised that Craig Ellis and Melanie Saunders work together to get the right attention in this area. Melanie Saunders noted that the issue raised around honorary contract was impacting Information Governance compliance.
23.5	Dhammika Perera emphasised the importance of investing in innovation but stated that this should be done in a way that implementation does not hinder business as usual activities. He also advised that consideration should be given to product end of life prior to approval of investments, failure to do this would give rise to unnecessary risks.
	The Board noted that a digital risk report will be presented to the Board in April.
23.6	The Board **noted** the Chief Digital Officer's report.
23.7	
24	**Questions submitted by Board Members on "For Noting" agenda items: 21, 22, 23 & 24**
24.1	No questions received.
25	**Board Assurance Framework**
25.1	The Board received the Board Assurance Framework (BAF) and noted the request from the last Board meeting that deep dive reviews are undertaken of static risks.
25.2	The Board discussed the triangulation of risks from the corporate risk register to the BAF. It was noted that in addition to the work done by the Executive Management Committee, the Audit Committee receives the corporate risk register and BAF regularly.
25.3	Mike Murphy noted that the BAF will be refreshed for 2024/25 and he advised that this should be aligned to the Trust's annual plan. David Eltringham described the plans for the BAF refresh which included a workshop at Executive Management Committee followed by a Board seminar workshop.
25.4	The Board **noted** and **approved** the Board Assurance Framework Update.
26	**Improvement Programme Oversight Board Update 10 January 2024**
26.1	Mike Murphy presented the report and highlighted that there was detailed discussion around the Governance and Well-Led workstream which was now a concern due to lack of tangible progress. There are ongoing discussions on how to move the workstream forward.
26.2	The Board **noted** the Improvement Programme Oversight Board Update- 10 January 2024.
27	**Questions submitted by Board Members on agenda item 26**

27.1	No questions received.
28 28.1	**Any Other Business** No other business was discussed at this meeting.
29 29.1 29.2 29.3	**Questions from observers** Helen Ramsay informed the Board that Governors did not receive the agenda and papers pack in sufficient time to be able to read and raise questions. Further to Helen Ramsay's query about the named Non-Executive Director with operations oversight, Keith Willette stated that this was overall board responsibility. Rachael Cook noted that Governors had discussions about staff well-being and sought assurance that well-being decisions are being cascaded to all staff of the Trust.
30 30.1 30.2	**Non-Executive Director Review of the meeting** Sumit Biswas reflected that: • Timing of the meeting was better managed • Reports were very good particularly the Green Plan • Improvements in executive summary of the cover sheet which are now more informative • Improvement in discussions, Chair's references to issues raised at previous meeting was welcomed • Continued improvement of NED challenge however more input is required from Executive Directors • Clarity required on how actions are taken forward tracked. **Executive Director Review of the meeting:** Mark Ainsworth reflected that: • IPR discussions continues to improve but more discussions at Board Committees level • Clarity on how decisions relating to Fit for the Future programme are taken forward.
31	**Date, Time and Venue of Next Meeting in Public** Thursday 30 May 2024 - Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN.

Board Meeting in Public 28 March 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
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	May 24	Propose to Close	Health inequality Statement (adapted from AACE) *As an Ambulance service SCAS has the aim and duty to; contribute to improving the population outcomes, positively impact on the social determinants of health, reduce demands placed on the sector and support equitable healthcare access, excellent experience, and optimal outcomes for all. We will ensure that this is sustainable by developing collaborative partnerships and identifying the resources needed to support out to work with our ICB's and other key partners.* Board Seminar planned for summer 2024 to identify the metrics.
1	28/03/24	8	To review 'disability adjustments' process to allow more local discretion by the	Chief People Officer	May 24	Open	Awaiting confirmation of timeline from the Chief People Officer's team.

			Executive Management Committee and outcomes reported to Board.				
2	28/03/24	9	To review risks/prioritisation of dropping safeguarding training check for honorary contracts.	Chief People Officer/Chief Nurse	May 24	Open	Verbal update to be provided at the meeting
3	28/03/24	10	Further to discussions, it was agreed that David Eltringham will speak to BOB ICB Chief Executive about the provision of mental health vehicles in the south.	Chief Executive Officer	May 24		David Eltringham has discussed the action with Nick Broughton, who agreed to review the situation. This action was followed up on 22 May with a response that this is still being followed up and a definitive answer will be provided.
4	28/03/24	10	QI programme Methodology to be reported to Board for understanding the implementation.	Chief Nurse	May 24	Open	Verbal update to be provided at the meeting.
5	28/03/24	10	Risk review and mitigation for transition to PSIRF was requested by the Board.	Chief Nurse	May 24	Open	Verbal update to be provided at the meeting.
6	28/03/24	11	Report to Board activity in alternative pathways as identified by SCAS Connect.	Chief Medical Officer	May 24	Propose to close	Information included in Chief Medical Officer's report.
7	28/03/24	12	Annual Assurance of SCAS EPRR functions to be presented to the Board.	Executive Director of Operations	May 24	Open	Ongoing discussion with Head of EPPR for Board forward planning.
8	28/03/24	13	Lost hours due to vehicles off the road to be added to the operations report.	Executive Director of Operations	May 24	Open	Verbal Update to be provided at Board meeting.

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Report Cover Sheet

Report Title:	Chair's Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	5
Executive Summary:	The purpose of the Chair's report is to keep the Board updated of stakeholder engagement and site visits since the Board held in March 2024.
Recommendations:	The Trust Board is asked to note the report.
Accountable Director:	Not Applicable
Author:	Keith Willett, Chair
Previously considered at:	Not applicable
Purpose of Report:	The Board is asked to note the stakeholder engagements and site visits update.
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Not applicable

List of Appendices	Not applicable

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Chair's update
Authors	
Accountable Director	Keith Willett, Chair
Date	30th May 2024

1. Purpose

The purpose of this Chair Report is to inform the Board of stakeholder engagement and site visits since the Board held in March 2024.

Since the last Public Board meeting, I have undertaken the following visits and stakeholder meetings:

April 2024

- SCAS NED interviews
- SCAS Extra-ordinary Finance & Performance Committee
- AACE Chairs meeting
- AACE Council
- SCAS Nomination Committee
- SCAS RSP Meeting
- Chair / CEO Southern Ambulance Collaborative meeting
- SCAS Extra-ordinary CoG Formal Meeting
- OUH (JR) Compliance visit

May 2024

- SCAS Extra-ordinary Board meeting
- Governor Engagement Training Webinar
- BLMK Research and Innovation Network Meeting
- NHS England Chair's Advisory Group
- SCAS Membership and Engagement Committee
- Chair / CEO Southern Ambulance Collaborative meeting
- SCAS / SECAMB Chair and CEO meeting
- SCAS HWBE Forum Group
- SCAS RemCom
- Ride out from Stoke Mandeville

Other

- Monthly: SE Senior Leaders Briefings (Anne Eden)
- Lead Governor meetings

Recommendation

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

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Report Cover Sheet

Report Title:	CEO Briefing
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	6
Executive Summary:	The CEO Report includes the following: • Challenging operating context • Southern Ambulance Services Collaboration (SASC) • Publication of the national UEC plan • HIOW UEC transformation programme • EPRR – Ex Scintilla and D-day 80 • Infected blood Inquiry
Recommendations:	The Trust Board is asked to: Receive and note the report
Accountable Director:	David Eltringham – Chief Executive Officer
Author:	David Eltringham – Chief Executive Officer
Previously considered at:	N/A
Purpose of Report:	For noting
Paper Status:	Public
Assurance Level:	• **Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	

Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	All Quality Domains
Next Steps:	The Chief Executive Officer and Executive Management Team will continue to focus on all agreed organisational objectives
List of Appendices	None

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Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Chief Executive Officer's Update
Author	David Eltringham, Chief Executive Officer
Accountable Director	David Eltringham, Chief Executive Officer
Date	30/05/2024

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 March 2024.

2. Background and links to previous papers

This update is based on information relating to March-May 2024.

3. Executive summary

The CEO Report includes the following:

- Challenging operating context
- Southern Ambulance Services Collaboration (SASC)
- Publication of the national UEC plan
- HIOW UEC transformation programme
- EPRR – Ex Scintilla and D-day 80
- Infected blood Inquiry

Operational Performance

The start of the new financial year has seen the need to carefully balance quality and safety, the health and well-being of our staff, operational performance and the financial position continue. We have continued to see a challenging picture operationally for all our core services, 999, PTS & 111. Our staff continue to work extremely hard, providing care to the communities who utilise our services. We have spent a great deal of time planning our services to ensure we get the right balance of operational hours against the demand we see, while ensuring a tight grip on our financial recovery plan.

Throughout our refreshed and rigorous planning process the Executive Team have maintained a high degree of scrutiny over the decisions we have made to balance demands on the Trust and its services. The Executive Team discuss these issues daily in a Safety Huddle.

I am pleased to report that in April our Category 2 response time was 27m:40s, achieving the 30 minute target. Our mean call answer time was 7 seconds, and therefore under the national 10 second target. We have seen a difficult start to May with Cat 2 performance deteriorating to more than 30 minutes. We are very focussed on making sure that we have sufficient ambulance hours on the road to meet demand and this includes workforce and vehicles. We continue to work closely with our NHS partners and Integrated Care Systems to reduce ambulance handover delays

Southern Ambulance Services Collaboration (SASC)

Last week I was proud to launch the Southern Ambulance Services Collaborative (SASC), alongside my Chief Executive colleagues from the other services who have been involved in this piece of work. This is something we have been working on over the past few months with South West Ambulance Service, London Ambulance Service, South East Coast Ambulance Service and East of England Ambulance Service who along with SCAS formulate the 5 services of the Southern Ambulance Service Collaborative. The collaboration has the intention of bringing benefit to our people and patients through developing common pathways and working together to solve problems once. There are also likely to be opportunities to save money by increasing our collective purchasing power. I am looking forward to exploring the opportunities that this collaboration will bring. This comes at a time when we need to deliver the best possible care to patients and staff, whilst operating in a constrained financial climate.

Following the launch, a workshop is scheduled for 7th June, in which 15 delegates from each organisation will meet face to face to discuss options for collaboration in the initial period. Five break out groups will focus on:

- HR services
- Fleet and Procurement
- CAD & Triage
- Digital & AI
- Clinical Operating Model

The focus of the workshop is to understand practices across the 5 organisations, to collaborate and learn from best practice. Alongside this newly

formed collaboration, we are further strengthening our relationship with the Isle of Wight ambulance service. We will represent them at the collaborative, and they will partner with us on programmes of work when this is appropriate. The Isle of Wight ambulance service is unique in that it is part of a combined Trust with acute services and not a standalone ambulance service.

The five topics set out above are a starting point for discussions and I expect the scope of work to widen over time.

Publication of the National UEC plan

The recent publication of the National Urgent and Emergency Care (UEC) Plan presents a strategic blueprint designed to enhance the efficiency and effectiveness of emergency healthcare services across the country. Key aspects of the UEC Plan and its potential implications for our ambulance service are:

1. **Operational Efficiency:** The integration of services and enhanced use of technology are expected to streamline operations, reduce response times, and improve overall service delivery. Our service will need to invest in new technologies and foster stronger partnerships with local healthcare providers. These are already underway within SCAS with the CAD replacement programme progressing, and we continue to drive positive relationships with partners. Key to operational efficiency is maintaining our Category 2 response time under 30 minutes
2. **Resource Allocation:** Efficient resource management will be critical. This includes optimizing our fleet, and implementing dynamic rostering systems to match demand patterns, which is already underway with Hampshire already transitioning onto their new rosters, and Thames Valley due to transition in the next few months.
3. **Workforce Enhancement:** We must prioritize our staff's development through continuous training programs aligned with the national plan. This also involves supporting their well-being to maintain a motivated and resilient workforce, this will be developed by the appointment of the new Chief Paramedic post.
4. **Quality of Care:** The emphasis on patient-centric care aligns with our mission. We will need to adopt best practices for patient engagement, feedback mechanisms, and continuous improvement processes to elevate patient satisfaction and outcomes.

HIOW UEC transformation programme

Following the publication of the national UEC plan, we have been working closely with Hampshire and Isle of Wight ICS to develop a local system plan which aligns nationally. As we move to greater system working, I have agreed to lead the UEC transformation programme for the Hampshire and Isle of Wight ICS. This is an important step in ensuring SCAS functions and integrates with the system as a whole, helping to shape the whole patient pathway from pick up to drop off. Whilst we work closely with a number of other Integrated Care Systems, Hampshire and the Isle of Wight Integrated Care System are our co-ordinating commissioner, and I am a member of the ICS Senior Leadership Group as a result.

On Tuesday 21st May I joined the Hampshire and the Isle of Wight leadership team at a meeting with the national NHS England Executive Team to talk through our plans. The team were supportive of the proposals we put forward.

EPRR – Ex Scintilla and D-day 80

Maintaining and exercising our ability to respond to a significant emergency forms part of our obligations as a Category 1 responder within the Civil Contingencies Act. I was pleased to see the Trust playing an active part in Exercise Scintilla.

This exercise tested (using an 'Emergo-Train simulation) the need to carry out a full evacuation of a large acute hospital (Queen Alexandra Hospital in Portsmouth). This required a co-ordinated response from SCAS and our partners to transfer patients via ambulance to various receiving hospitals as well as community locations.

SCAS had a full command structure in play from operational and tactical to strategic and this included a real time response from control room colleagues

Many lessons were learned during the day which will help if we have to respond to similar situations in the future and we believe that it's the first time that an exercise using this type of scenario has been undertaken at this scale

The Trust is currently planning to support the remembrance events which will take place on the 5th and 6th June to mark the 80th Anniversary of D-Day and members of the service will play key roles in co-ordinating emergency cover to those events. This will also give us the opportunity to remember those who gave their lives in the pursuit of freedom.

Infected blood Inquiry

Last week, the Infected Blood Inquiry published its final report, marking a significant moment in the history of public health in the UK. The Prime Minister has issued an apology on behalf of successive Governments and the entire British state. Amanda Pritchard, representing the NHS in England, both now and over previous decades, also issued a public apology.

The report is a sobering document, detailing failings over multiple decades and making recommendations across a wide range of areas. While South Central Ambulance Service (SCAS) was not directly involved with the inquiry, it underscores the critical importance of fostering an environment where staff at all levels feel encouraged and safe to speak up and raise concerns. Preventing issues like those documented in the report requires a robust culture of openness and accountability.

The ability to speak up is particularly relevant to ambulance services, and it is imperative that we continue to focus on this area. We are committed to promoting and supporting the excellent work being done by SCAS' Freedom to Speak Up team. Each year, we manage and address more concerns, reflecting our ongoing dedication to transparency and improvement.

We will continue to reinforce and enhance these efforts, ensuring that every member of our organization feels empowered to voice their concerns without fear. This approach is essential to maintaining the highest standards of care and preventing the recurrence of issues similar to those highlighted in the Inquiry’s report.

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Report Cover Sheet

Report Title:	Executive Management Committee Terms of Reference
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	7
Executive Summary:	The Executive Management Committee Terms of Reference has been established as a formal Committee of the Board. The Committee is the primary executive decision-making body of the Trust, with responsibility for: • developing the vision and strategy for the Trust for consideration and approval by the Trust Board of Directors; • providing effective leadership and direction for the Trust and ensuring that the Trust delivers on key national and local targets, and the objectives set out in its strategy and annual business plan. As part of the Board's annual review of governance, all Board Committees are required to review their Terms of Reference (ToR) and recommend any changes to the Trust Board of Directors for approval. A review of the Executive Management Committee ToR has taken place and the Committee is recommending these are approved by the Trust Board of Directors.
Recommendations:	The Board is asked to: Approve the Executive Committee Terms of Reference.
Accountable Director:	David Eltringham, Chief Executive Officer
Author:	Kofo Abayomi, Head of Corporate Governance & Compliance
Previously considered at:	Executive Management Committee
Purpose of Report:	Assure

Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	Publish the Terms of Reference
List of Appendices	Executive Management Committee Terms of Reference

Terms of Reference – Executive Management Committee

May 2024

Document Reference	To be assigned by
Document Status	Draft
Version	
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	
Initiated by	Date & Author(s)
Document Owner	
Recommended at Date	Executive Management Committee 14 May 2024
Approved at Date	
Valid Until Date	
Linked Policy Documents	
Dissemination requirement	
Part of the Trust's publication scheme	

Executive Management Committee Terms of Reference 2024

1.0	**Constitution**
1.1	The Executive Management Committee (hereby know as 'the Committee') is accountable to the Chief Executive, and its remit includes tasks delegated to the Chief Executive, or other executives, by the Trust Board of Directors as documented in the Scheme of Reservation and Delegation.
2.0	**Purpose**
2.1	The Committee is the primary executive decision-making body of the Trust, with responsibility for: • developing the vision and strategy for the Trust for consideration and approval by the Trust Board of Directors; • providing effective leadership and direction for the Trust and ensuring that the Trust delivers on key national and local targets, and the objectives set out in its strategy and annual business plan.
2.2	Sub-committees or groups of the Executive Management Committee may be established to deliver specific programmes or projects of work, linked to the remit of the Executive Management Committee, but overall accountability rests with the Executive Management Committee.
3.0	**Authority**
3.1	The Committee has full powers to make any decision, and investigate any action, within these Terms of Reference. It also has the powers to make any decision that has been reserved to the executive under the Trust's Scheme of Reservation and Delegation, as determined by the Chief Executive.
3.2	The Committee is authorised to seek any further information it requires from any employee, and employees are directed to cooperate with any reasonable request made by the Committee.
3.3	The Committee is authorised to obtain outside legal or other independent professional advice, subject to cost-effectiveness considerations, and to secure the attendance of outsiders with relevant experience and expertise if it considers it to be necessary.
3.4	The Committee may challenge the reports and duties of other executive committees to ensure due and robust business processes are in place.
4.0	**Duties**
4.1	The duties of the Committee are as follows:

4.1.1	Delegated powers from the Board of Directors to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.
4.1.2	Exercise powers and authorities delegated by the Board within the Scheme of Delegation and any other powers or authorities delegated by the Chief Executive under the Standing Orders.
4.1.3	Approve policies for the Trust in accordance with its delegated authorities and the Trust's policy for the approval of policies.
4.1.4	Have operational oversight of the system of internal controls and corporate risk management processes: o Develop the Trust's Assurance Framework and monitor controls to ensure effective and focused risk management processes and procedures. o Develop and monitor the Trust's strategic objectives in respect of risk management. o Review the lessons learned from major incidents and recommend amendments to the Major Incident Plan and Business Continuity Plans as appropriate. o Will receive any risks or issues from Committee(s) and group(s): ▪ Transformation Oversight Group ▪ Financial Recovery Group ▪ Vacancy Control Panel ▪ Digital Committee
4.1.5	Contribute to the development of the Trust's strategic and annual business plans for approval by the Board of Directors.
4.1.6	Regularly review corporate and operational performance against the business plan objectives and key performance requirements and agree actions to improve delivery and performance as appropriate.
4.1.7	Exercise oversight of the Trust's arrangements to ensure compliance with its statutory and regulatory obligations.
4.1.8	Review performance against the Trust's budget and key financial targets including income and expenditure against forecast, and delivery of cost improvement plans.
4.1.9	Exercise its delegated authority in relation to approving capital and revenue expenditure as set out in the Trust's Scheme of Delegation.

4.1.10	Support the Chief Executive in exercising their lead management responsibilities and ensuring compliance with their accounting officer duties.
4.1.11	Review the lessons learned from major incidents and recommend amendments to the Major Incident Plan and Business Continuity Plans as appropriate.
4.1.12	Establish a culture which promotes compassion, inclusion and transparency, enabling and supporting: • The development and talent management of Trust staff. • The right and responsibility for all staff to speak up for safety, for themselves and for others; • Provision of mechanisms to enable staff to provide feedback and to shape services at a local level (including exit surveys), supporting patient care and service delivery; • Fostering learning and growth when things go wrong. Thus ensuring the Trust progresses its ambitions and plans in relation to inclusive leadership, patient experience, employee representation and the safeguarding of employee welfare.
4.1.13	Ensure the Trust has strong relationships with the NHS and other stakeholders, and ensure confidence in our services by public and patients in all we are delivering thus becoming a trusted and valued part of the overall South Central health community (and other health communities in which it is serving)
4.1.14	Provide direct input to issues and decisions to be presented to the Trust Board for approval, as appropriate.
4.2	In delivering the duties set out in 4.1 above, the Executive Management Committee will receive and consider reports/information from executive committees within the Trust, as appropriate.
5.0	**Membership and Quorum**
5.1	The members of the Committee are as follows: a) Chief Executive (Chair of the Committee) b) Chief Nurse c) Chief Financial Officer d) Chief Strategy Officer e) Chief Transformation Officer f) Chief Medical Officer g) Chief People Officer h) Chief Governance Officer i) Chief Digital Officer j) Director of Finance k) Executive Director of Operations

	l) Director of Communications, Marketing and Engagement m) Director of Commercial Services n) Director of Contact Centres o) Director of Communications p) Chief of Staff to the Chief Executive
5.2	Members will each have one vote for decision-making purposes and, in the event that it is required, the Chief Executive will have a casting vote.
5.3	The quorum necessary for formal transactions of business by the Committee shall be four members of the above, to include either the Chief Executive or a deputy nominated by the Chief Executive to chair that particular meeting.
6.0	**Attendance**
6.1	Meetings will be held in person, unless expressly agreed in advance by the Chief Executive. Where attendance is on a virtual basis each member/attendee must be able to make an appropriate contribution to the meeting (e.g., no technological constraints) and comply with good practice in relation to virtual meetings. In any meeting form, members will conduct themselves in accordance with the values of the Trust.
6.2	Members may send their nominated deputy if they are absent through either annual leave or sick leave. The attendance of the nominated deputy must be notified to the Senior Executive Personal assistant to the Chief Executive at least 24 hours in advance of the meeting. The deputy must be of an appropriate standing, and sufficiently briefed, to attend meetings, and they will count towards the quoracy requirements and assume the voting entitlements of the member if required (nominated deputies are shown at Appendix A).
6.3	Other officers of the Trust may be invited to attend meetings for specific agenda items or when issues relevant to their area of responsibility are to be discussed, at the discretion of the Chair for the meeting.
7.0	**Frequency**
7.1	Meetings of the Committee will generally be held weekly on Tuesdays, and additional/extraordinary meetings may be called by the Chief Executive between regular meetings to discuss and resolve any critical issues arising.
8.0	**Reporting and Accountability**
8.1	The Committee is directly accountable to the Chief Executive, and will report on specific issues, as appropriate, to the Board of Directors or a Committee of the Board of Directors and particularly provide assurance to Non-Executive Directors.
9.0	**Committee support**

9.1	The Committee shall be supported by the Senior Executive Personal Assistant to the Chief Executive, and duties shall include: • agreement of the meeting agendas with the Chief Executive; • providing timely notice of meetings and forwarding details including the agenda and supporting papers to Committee members and attendees in advance of the meetings (including uploading to the MS Teams site or equivalent); • promoting a disciplined timeframe for agenda items and papers, (whilst meetings continue to be held on Tuesday mornings, papers will be emailed/made available to all Committee members and other relevant officers by no later than close of business on the previous Friday. Should the normal meeting day change, these timescales will be reviewed); • recording formal minutes of meetings and keeping a record of matters arising and issues to be carried forward, circulating draft minutes to the Chief Executive for approval within three working days from the date of the last meeting and to the wider committee within five working days.
10.2	The Senior Executive Personal Assistant to the Chief Executive will also liaise with the Trust's Company Secretariat to: • Ensure that the forward business programme for the Committee is aligned with the annual work plan of the Board and Committees of the Board; • Advise the Chief Executive as to the fulfilment of the Committee's Terms of Reference, highlighted any areas of non-compliance.
11.0	**Principles**
11.1	A number of principles will underpin the work of the Committee. The Committee will: • lead by example by embodying the values of the Trust in its work; • be an inclusive team, exploiting each other's strengths and demonstrating strong corporate commitment and trust; • work to transparent and clear priorities; • have a bias to action; • have strong communications; • share information and messages from meetings with the wider organisation as appropriate, respecting the need to maintain confidentiality when required; • provide papers and information for the meeting in accordance with the agreed deadlines and in the required format.
12.0	**Review**
12.1	The Committee, led by the Chief Executive, will undertake periodic self-assessments to review its effectiveness in discharging its responsibilities as set out in these Terms of Reference.

12.2	The Committee, led by the Chief Executive, shall review its own performance and Terms of Reference at least once a year to ensure it is operating at maximum effectiveness.

Appendix A – Nominated Deputies

Executive Committee Member	Nominated Deputy
Chief Executive	Nominated Executive Director
Chief Nurse	Deputy Chief Nurse
Director of Finance	Deputy Chief Financial Officer
Executive Director of Operations	Director of Operations, Clinical Coordination Centres
Chief Strategy Officer	Director of Commercial; Transformation Programme Director
Chief Medical Officer	Assistant Medical Director
Chief People Officer	Assistant Director of HR, OD, Education
Chief Transformation Officer	Fit for the Future Workstream Lead
Chief Governance Officer	Head of Corporate Governance & Compliance
Chief Digital Officer	Head of ICT/Head of Critical Systems/Business Portfolio Manager

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Report Cover Sheet

Report Title:	Update to the Public Board on the previous Private Board meeting held on 17 April, 25 April and 1 May 2024
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	8
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 17 April, 25 April and 1 May 2024.
Recommendations:	The Board is asked to note the update.
Accountable Director:	David Eltringham, Chief Executive Officer
Author:	Kofo Abayomi, Head of Corporate Governance
Previously considered at:	n/a
Purpose of Report:	Note
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Not applicable

List of Appendices	Not applicable

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Update to the Public Board on the previous Private Board meeting held on 17 April, 25 April and 1 May 2024
Author	Kofo Abayomi, Head of Corporate Governance and Compliance
Accountable Director	David Eltringham, Chief Executive Officer
Date	30 May 2024

Extraordinary Private Board 17 April 2024

2024/25 Planning – Operational and Finance

The Board considered and approved the 2024/25 Planning: Operational and Finance.

Private Trust Board 25 April 2024

Integrated Performance Report

The Board received the Integrated Performance Report.

Fit for the Future - Operations Modernisation

The Board received the operations modernisation update of the Fit for the Future programme.

Improvement Programme Oversight Board Update

The Board received the Improvement Programme Oversight Board update.

Finance Month Update 12

The Board received the Month 12 report.

Sussex NEPTS Contract Direct Award 2023-25

The Board ratified the Sussex NEPTS contract direct award 2023-25.

Surrey NEPTS Contract Variation for 2023/24 for the SCAS - Surrey NEPTS Service 23-24

The Board ratified the contract variation for 2023/24.

Chief Digital Officer Report

The Board received the Chief Digital Officer's report.

Legal and Regulatory

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

Board Site Visits 2024-25

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

Extraordinary Private Board 1 May 2024

2024/25 Planning – Operational and Finance

The Board approved the updated 2024/25 Planning – Operational and Finance.

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Report Cover Sheet

Report Title:	Patient Story
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	9
Executive Summary:	• This patient story is presented to board by Emma Hunt, the sister in law of the patient. She also works as a Paramedic for SCAS. • She tells the story of her sister-in-law's interactions with SCAS before she very sadly died. • Lots of learning has come from this sad case and this is explained in detail as part of the slides and the story. In summary they are; 1. New work on reviewing the current Falls training package to give crews clearer indication about red flags for all patients, not just those over 65 years old. 2. Work on improving Falls guidance across SCAS. 3. Revised Sudden Death Policy (not strictly linked to this case but this is relevant.)
Recommendations:	The Trust Board is asked to: Note the story, actions and learning that has come about as a result of this complaint.
Accountable Director:	Professor Helen Young Chief Nursing Officer
Author:	Caroline Whitworth Head of Patient Experience
Previously considered at:	Nil
Purpose of Report:	Note
Paper Status:	Public

Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Significant
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:	Nil
List of Appendices	Nil

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Patient Story
SCAS Board
May 2024

999 Operations

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Mandy Ludgate

18/10/1978 - 27/10/2023

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Who was Mandy?

- Mandy was a 45 year old woman.
- Mandy was a Mother, Daughter, Wife, Sister, Niece, Auntie, Cousin.
- Mandy was a patient

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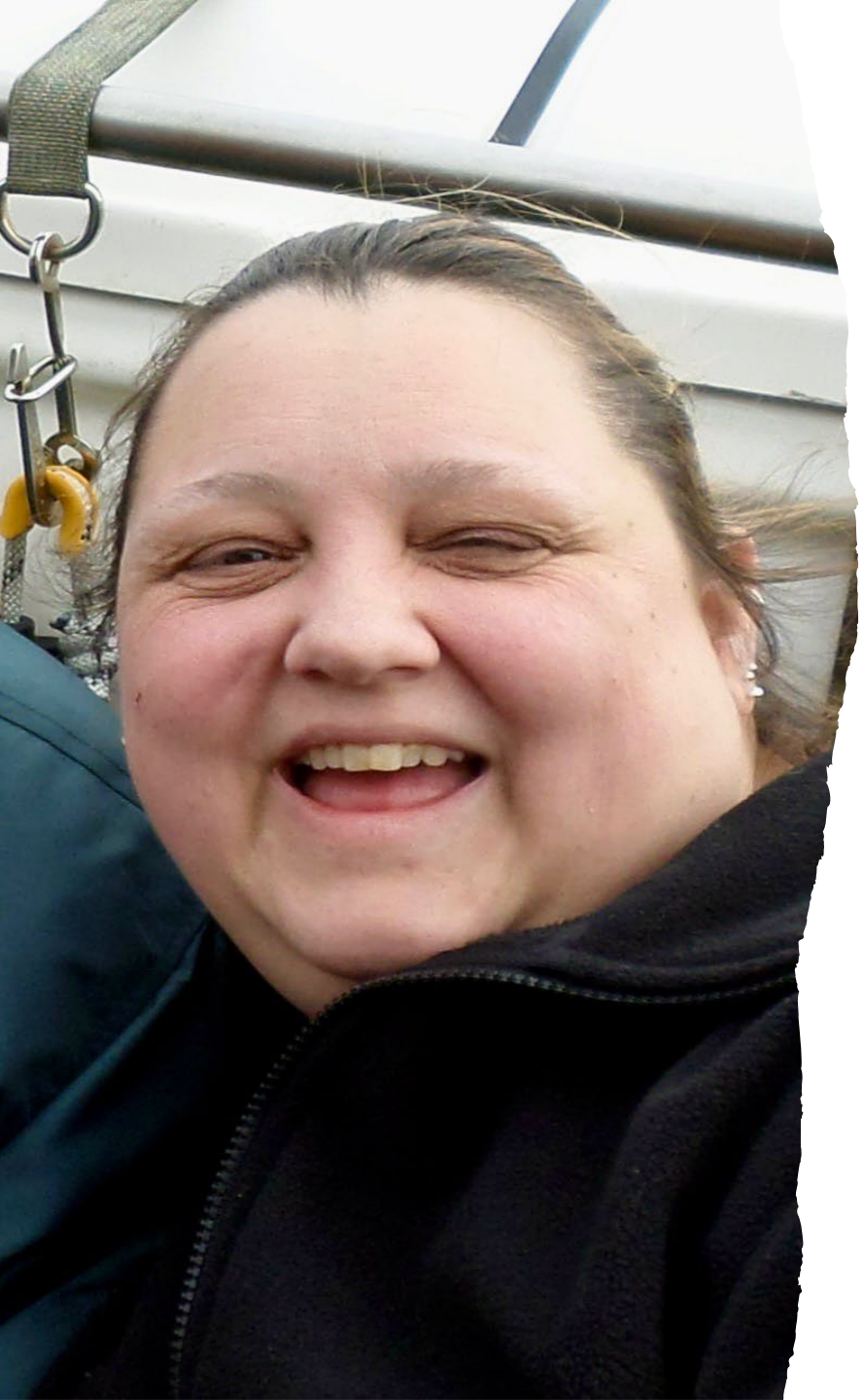
Contact with SCAS

- Mandy, in the last few years developed an addiction to food, this caused her to become morbidly obese.
- Mandy's weight had a negative effect on her general health, sleep apnoea, diabetes. It also exacerbated the existing arthritis in her knees.
- Mandy became a "regular faller"
- She had multiple ambulance attendances in the last ten months of her life due to falling and being unable to get up because of arthritis in her knees.



- On 15th October 2023 999 was called for Mandy who had fallen in the early hours of the morning at home.
- The ambulance arrived 3 hours 10 minutes after the 999 call. When the ambulance arrived, she was assessed by the crew and helped off the floor. She was not taken to hospital.
- Later on the same day, Mandy had a 2nd fall. The ambulance crew arrived about 3 hours 30 minutes after the 999 call. She was seen by an ambulance crew, who again helped her up off the floor and did not take her to hospital.
- Mandy was not referred for blood tests to rule out Rhabdomyolosis , the out of hours service was not contacted. There is no written record of worsening advice given.
- Mandy was asked by a member of the crew to consider buying her own equipment to get herself up.

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What happened next?

- On or around October the 23rd Mandy began to suffer incontinence
- Mandy nor her family knew this could be a sign of Rhabdomyolosis.
- Mandy did not know to seek urgent medical advice.
- Mandy did not want to be a bother to people. She was was embarrassed and tried to carry on.

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On October 27 2023, Mandy's husband returned from work.

He was surprised that Mandy and the children were not downstairs.

He went upstairs and found his wife had passed away, she had her six-year-old son by her side, trying to wake up mummy because she was cold.

He called 999 and he explained to the call taker that he didn't think CPR would work.

An ambulance was not dispatched but the police were informed.

Mandy's husband did not take on board the information and waited and waited for an ambulance

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What next?

- Mandy can not be brought back, but we can learn from what happened
- Our Crews need to treat every patient with dignity, respect and professionalism.
- There is more to consider than a patients age when attending falls and long lies.
- Mandy deserved dignity, professionalism and respect. As a family we feel like she did not receive it.

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Findings and learning

- All 999 calls were compliant with NHS Pathways protocols. Unfortunately, due to demand there was a delay in both cases, but the first available resource was sent on each occasion.
- When Mandy had died the call details that the she was cold and stiff. At the time of this call the process for an unexpected death was that the details are passed onto the Police as there are no identifiable live-saving opportunities. All units assigned were therefore stood down when this was apparent, and it was categorised as an unexpected death.
- Since this happened, SCAS has implemented a new Sudden Death Policy and in this instance, a resource would have been sent.
- The patient records were reviewed and there was some key information missing around consideration for a long lay. Further learning has been recommended to take place regarding safeguarding and safety netting policies, with the clinician being monitored by their Clinical Team Educator over the next 6 months with regular EPR reviews.
- Verbal safeguarding and safety netting were carried out; however, the specifics of the conversations were not documented on the Clinical record as they should have been.
- Emma has been working in collaboration with Mark Ainsworth-Smith, our Consultant Pre-hospital Care Practitioner on reviewing the current Falls training package to give crews clearer indication about red flags for all patients, not just those over 65 years old.
- They have also been working on improving the Falls Guidance across SCAS in the form of a revised clinical memo.

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Thank you

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Report Cover Sheet

Report Title:	Integrated Performance Report (IPR) - April 2024 Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	10
Executive Summary:	This is the Integrated Performance Report (IPR) for the period ended 30 April 2024 (Month 1). The report brings information together on: • Performance • Quality • Workforce • Finance. The report is currently being refreshed and will continue to be developed over time, to allow the Trust Board to put the right time and effort into discussing what's contained in its IPR when reviewing the Trust progress in delivery of Trust plans. The key messages are: During April the Trust transitioned to PSIRF. No SI's will now be declared. However, three SI's were reported in the month. One related to a potential incorrect clinical assessment and two related to ambulance delays, of which one was downgraded by the ICB. Safeguarding training sits are 86% a reduction of 1% since the last report. The Board requested a review of what key performance indicators should the IPR contain for Board discussions/review. This month's IPR report contains the revised measures, note the NEPTS measures and the appendices .e.g. activity, demand, etc. are still to be added, which will be within next month report. Before moving onto the Committees reports. The Integrated Performance Report (IPR) for month 1 is attached.

Recommendations:	The Board is asked to: Discuss the content of the report and note the revised measures.
Accountable Director:	Stuart Rees, Interim Director of Finance
Author:	Alan Monks, Deputy Chief Finance Officer
Previously considered at:	Finance & Performance Committee Quality and Safety Committee
Purpose of Report:	For Assurance
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	
List of Appendices	

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Integrated Performance Report
Author	Mike Murphy, Chief Strategy Officer
Accountable Director	Mike Murphy, Chief Strategy Officer
Date	30 May 2024

Finance

The Trust's financial position at month 1 (April) is £1.9 million deficit which is £0.7 million adverse to plan. The Trust has a financial plan for 202425 year of £11.2 million.

The Trust's cash balance at the end of April stood at £27.3 million. There was a net cash inflow in M1 due to the receipt of year end commissioner funding and sales receipts from a sale and leased back arrangement.

The April month end debtors analysis of debts over 90 days old. The over 90 day debt has decreased this month and now stands at £116k (down from £199k in March). This decrease is due to Guys & St Thomas's paying their £52k of secondment recharges and NHS Bedfordshire paying their £23k of ECRs. With the Total Sales Ledger debt has decreased this month and now stands at £1.04 million (down from £1.82 million in March). The 90 day category debt has increased to 11.23% of the total sales debt (up from 10.97% in March).

The Trust's capital spend in the month is £0.3 million. The plan for the month was £2.2 million. The underspend was due to the 22/23 cohort of 53 DCA's being further delayed with only seven chassis's received in April. The capital forecast for the year remains £12.9 million against CDEL and a total of £41.6 million including IFRS16 and PDC funded spend.

The Trust's Financial Recovery Plan includes a net savings target of £27.7 million.

Quality and Patient Safety

During the reporting period the Trust Transitioned to PSIRF on 22 April. No further Sis will now be declared. However, three Sis were reported within the month. Two in

relation to ambulance delay, one of which is a system SI, which will be downgraded by the ICB as further information subsequently became available. The third SI declared was in relation to potential incorrect clinical assessment. As previously reported there will be a requirement to continue to 'dual' report during the transition period. Two Sis remain overdue with approved ICB extensions in place.

There have been two Patient Safety Incidents (PSI) declared.
Since transitioning to PSIRF, the Trust has seen further improvement in the timeliness of reviewing incidents, with the introduction of daily critical reviews with each of our services. Focus continues to be on closing of Sis and tracking of outstanding actions from Sis.

Safeguarding Training at level 1, 2 and 3 have a 90% target as suggested by our ICB commissions to align with targets set with other providers and agreed by the Executive Management Committee. Compliance with levels 1 and 2 is above target and level 3 currently is 86% reduction of 1% since the last report. This is due to some staff coming out of compliance and insufficient numbers of existing staff completing training. These staff are not new starters. This is being closely monitored by Education and Safeguarding colleagues.

The number of IPC vehicle audits is lower than plan. The number of those completed that were non-compliant was 3 with 100 being compliant.

The number of building audits completed was 47 with 42 compliant.

There is an IPC improvement plan in place and a new audit schedule and revised tool commencing in May 2024.

Medicines packing audit results for the month was 100% compliant marking an improvement from 97.5 in previous month. The days of stock available is lower than plan but not at a level that impacted the operational performance.

We have consistently met the overall trust wide target for closing and responding to complaints during the reporting period. However, 111 response rate of complaints fell to 75% - this equates to 2 cases.

PTS complaints response rate was 100% and 999 95%.

80 formal complains were closed in the reporting period compared to 35 last month.

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Report Cover Sheet

Report Title:	Quality and Patient Safety Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	11
Executive Summary:	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 at the Queen Alexandra Hospital (25), Handover Delays at other hospitals (25) and Safeguarding System Outage (25). Progress against actions is monitored through local governance meetings and the committee structure. **Compliance** Recent leadership seminars were held to update the NED/Exec and senior leadership team regarding changes to CQC assessments and discuss the quality statements. **Infection Prevention and Control (IPC)** Vehicle audit compliance (deep cleans) continues to be a concern at (46) % although compliance against the standard remains high at (94) % against a (90) % target. Actions to resolve the issue is being closely monitored through IPC Committee. A compliance action plan tracker will be utilized by all stations to provide the foundation of individual improvement plans, where IPC will be a focus to provide assurance improvements are being completed. **Medical Devices** The Zoll system update has now captured over 96% of devices, an increase of (10) % from previous report. The remainder are being identified as they are not currently on operational vehicles. When the AED roll-out was first implemented as an action from a Serious Incident (SI) it was known that there were not enough to allocate one per vehicle. A process was implemented to ensure all live operational vehicles were supplied with an AED and this was subsequently removed if the vehicle went VOR. This would ensure all operational vehicles had an AED while active. The Trust has since purchased a further (53) additional pieces of kit to accommodate fleet increase.

Safeguarding

The Safeguarding Improvement metrics all remain above trajectory,
Although the year end position for Level 3 face to face Safeguarding training
reached (87) % against (90) % target. Although disappointing it has been
recognised as good practice at Safeguarding Committee by the ICB and system
partners as it represents the highest compliance in the HIOW totality for all
providers

The most significant risk remains the ongoing challenges with the Doc-Works referral system A systematic end to end review of the system and associated processes is in progress by a recently formed Task and Finish group.
Following the latest reconciliation report incident on 3 May 2024, which resulted in a batch of (109) referrals requiring to be checked and processed, this demonstrated that the governance system in place worked and detected anomalies, but it also showed the Trust and Doc-Works processes are not fully effective and could lead to delayed referrals. The Task and Finish Group is addressing this, with oversight from Chief Nursing Officer and Chief Digital Officer .**One referral has been rag rated red (as risk of harm).** This is being assessed with system partners.

Mental Health

MHRV deployment in North has been significantly delayed/halted by ICB funding concerns. ICB has now confirmed that they will not fund a new service.
This will require a service development redesign, options for which are being
reviewed by stakeholders.
The MH&LD Team were recently awarded the winner nomination in the Learning Disability/Autism category in the National Positive Practice in Mental
Health Awards 2024

Clinical/ Non- Clinical Incidents

Reporting of patient safety incidents has decreased overall during the reporting correlating with a reduction in demand and REAP levels. Delay however continues to be the main theme.

PSIRF/ LFPSE

During the reporting period the Trust successfully transitioned to PSIRF on 22 April 2024. There will be a requirement for dual reporting of both (2015) Framework activity and PSIRF until all outstanding actions and reports are completed.

Serious Incidents (SIs)
Year-end (2023-2024) the Trust final outturn position was (81) Serious Incidents declared, with 'Delay' continuing to be the main theme of all Sis
declared, and unchanged from previous reports. This compares to 2022-2023
(94), 2021-2022 (30)
There are (2) SI's currently breaching the 60-day completion target with approved extensions in place and (3) SI's have current "stop the clocks" due to ongoing police investigations and (4) SI closed during the reporting period.

Since transitioning to PSIRF (2 PSIIs) have been identified and relate to potential inappropriate discharge at scene.
There has been (1) after action review undertaken with excellent multi professional representation and relate to care of mental health patient.

The Trust has seen SI's declared in relation to obstetric emergencies. This includes the recognition and management of women experiencing obstetric complications. A thematic review of all maternity cases will be delivered within (Q2).

Incident Review Panel (IRP) Activity
During the reporting period

- 1193 patient safety incidents were identified during the reporting period with most incidents graded as no and low harm.
- 65 patient safety incidents were reviewed at Safety Review Panel (SRP).

29 patient safety incidents were subsequently escalated for further review and decision at IRP

Patient Experience (PE) and Engagement
The SPC reports in the IPR show no significant change (common cause variation) in the number of PE cases received during the reporting period.

All complaints responded to within agreed timescales achieving (95) % target.

PHSO
There is currently one case being reviewed by the PHSO.

Compliments
The trust received (395) compliments which is similar to previous reports.

Patient Engagement

	To date the Trust has held three patient panel meetings which were productive.
Recommendations:	The Trust Board is asked to: Receive the paper and note the key quality and patient safety issues and indicators
Accountable Director:	Professor Helen Young, Chief Nursing Officer / Executive Director of Patient Care and Service Transformation
Author:	Sue Heyes, Deputy Chief Nursing Officer / Director of Nursing and Quality
Previously considered at:	Patient Safety and Experience Committee Quality and Safety Committee
Purpose of Report:	For assurance
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable Overall *:* Partial- Safeguarding Referral System
Justification of Assurance Rating:	Internal and external process of scrutiny against improvements 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 at Patient Safety and Experience Committee and upwardly reported to Quality and Safety Committee.
List of Appendices	

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METING REPORT

Name of Meeting	Board of Directors Meeting in Public
Title	Quality and Patient Safety Report
Author	Sue Heyes, Deputy Chief Nursing Officer
Accountable Director	Professor Helen Young, Chief Nursing Officer / Executive Director of Patient Care & Transformation
Date	30 May 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 report presents the data relating to the period **(February 2024 – April 2024 unless otherwise stated),** and will highlight 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 At the end of (Q4) Safeguarding Level 3 face to face training compliance final outturn position was (87) % against a (90) % target. Although disappointing it has been recognised as good practice by ICB colleagues and system partners as a considerable achievement as it represents the highest compliance in the HIOW totality for all providers.

2.4 The top risks for the Trust continue to be handover delays at the Queen Alexandra Hospital (25), Handover delays at other hospitals (25) and Safeguarding system outages (25). All risks are reviewed through the relevant committee structures.

2.5 During the reporting period compliance visits have increased across the Trust with the intention to provide staff with the opportunity to discuss any concerns and highlight risks and areas of good practice. A regular oversight report is provided to Executive Management Committee.

2.6 During PSIRF transition there will be a requirement to 'dual' report until all SIs and actions are completed.

3. Main Report and Service Updates

Compliance

3.1 Leadership seminar was facilitated to provide an update to senior leaders within the Trust on the changes to CQC assessment and quality statements. An all SCAS webinar and executive huddle are taking place in June 2024

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

Infection, Prevention and Control (IPC)

3.3 IPC Level 2 training compliance has remained static at (87) %. Bespoke training and support continue to be provided to improve the overall audit compliance position. There have been no reported IPC harm related incidents during the reporting period.

3.4 During the reporting period vehicle audit compliance (deep cleans) continues to be a cause for concern at (46) % although compliance against the standard remains high at (94) % against a (90) % target. Actions to resolve the issue is being closely monitored through IPC Committee.

3.5 The IPC audit template and schedule has been revised and communicated with SME support to ensure trajectory is maintained.

3.6 A compliance action plan tracker will be utilized by all stations to provide the foundation of individual improvement plans, where IPC will be a focus to provide assurance improvements are being completed.

Management of Medical Devices

3.7 The roll out of the Zoll software update has now captured over (96) %, previously reported as (87) %, with the remaining pieces of equipment being identified as they are not currently on operational vehicles.

3.8 When the AED roll-out was first implemented as an action from a Serious Incident (SI) it was known that there were not enough to allocate one per vehicle. A process was implemented to ensure all live vehicles were supplied with an AED and this was subsequently removed if the vehicle went VOR. This would ensure all operational vehicles had an AED while active. The Trust has since purchased a further 53 pieces of kit to accommodate fleet increase.

Safeguarding

3.9 The year end position for Level 3 face to face Safeguarding training reached (87) % against (90) % target. Although disappointing it has been recognised as good

practice at Safeguarding Committee by the ICB and system partners as it represents the highest compliance in the HIOW totality for all providers.

3.10 Following the latest reconciliation report incident on 3 May 2024, which resulted in a batch of (109) referrals requiring to be checked for duplication, risk assessed and processed. Although this demonstrated that the governance system in place worked and detected anomalies, it also showed the Trust and Doc-Works processes and interfaces are not fully effective and could lead to delayed referrals. The Task and Finish Group is addressing this, with oversight from Chief Nursing Officer and Chief Digital Officer.

3.11 All the referrals found in the reconciliation report have been assessed and processed through to Local Authorities. Many were found to be duplicated (i.e., already processed automatically through the My Referral App. One referral has been rag rated red (as risk of harm). This is being assessed with system partners.

Mental Health

3.12 MH Response Vehicle deployment in North has been significantly delayed/halted by ICB funding concerns. BLMK ICB has now confirmed that they will not fund a new service. This will require a service development redesign, options for which are being reviewed by stakeholders.

3.13 The MH&LD Team were recently awarded the winner nomination in the Learning Disability/Autism category in the National Positive Practice in Mental Health Awards 2024 for the works that have been undertaken to improve both the care being delivered to those with a learning disability and/or autism, and also in the staff welfare and equality projects that have been undertaken.

Clinical Incidents

3.14 With the introduction of LFPSE in April 2024, reporting of incidents will change and benchmarking through the NHSE website will be visible. Criteria for incident reporting under LFPSE patient safety events is being considered.

3.15 **EOC** during the reporting period there were (105) patient safety incidents reported. This is lower than presented in previous reports and could be attributed to a period of more stable demand on the service, indicated by a return to REAP 3 on the 7 February 2024 and REAP 2 in April 2024. The top three reported patient safety incident categories across both EOCs during the reporting period continue to be Delay, Patient Treatment / Care, and ICT Systems.

3.16 **999/E&UC** during the reporting period there were (918) patient safety incidents reported. April saw a reduction in the number of reported incidents correlating with reduced demand and REAP levels falling. The top subcategories are recorded as potential incorrect clinical assessment/treatment, re-contacted within 24-hour and standard of treatment/care concern. Risk grading for these incidents remains low with most incidents graded as low or minor risk. (36) % of incidents raised under the category of patient care and treatment were directed at other health care professionals external to the Trust.

3.17 **NEPTS** during the reporting period there were (182) patient safety incidents reported remaining within normal variation. Most incidents are graded as no or low harm. The top 3 categories continue to be Slip, trip and fall, Patient treatment/care and ill health.

3.18 **NHS 111** during the reporting period there were (172) patient safety incidents reported remaining within normal variation. The two most prevalent categories remain Delay and Patient treatment/ Care. All incidents are graded as low or no harm.

Patient Safety Incident Response Framework (PSIRF)

3.19 The Trust successfully transitioned to PSIRF on 22 April 2024 and now enters the embedding phase of the project.

3.20 The PSIRF Policy has been submitted to May's Quality and Safety Committee for final approval.

3.21 The process for recruitment and renumeration of the Patient Safety Partners is being finalised with the intention of this being finalised in (Q2).

Learning from Patient Safety Events (LFPSE) /Datix

3.22 LFPSE went live on 22 April 2024.

3.23 A further review of the Risk Assessment for LFPSE is underway to reflect the implementation processes and benchmarking.

Serious Incidents

3.24 Year-end (2023-2024) the Trust final outturn position was (81) Serious Incidents declared,
with 'Delay' continuing to be the main theme of all Sis declared, and unchanged from previous reports. This compares to 2022-2023 (94), 2021-2022 (30)

3.25 There are (2) SI's currently breaching the 60-day completion target with approved extensions in place and (3) SI's have current "stop the clocks" due to ongoing police investigations and (4) SI closed during the reporting period.

3.26 Since transitioning to PSIRF (2 PSIIs) have been identified and relate to potential inappropriate discharge at scene.

3.27 There has been (1) after action review undertaken with multi professional representation and related to care of mental health patient.

3.28 Work has commenced to review all reported SI investigations to ensure that actions from the investigation have been added to the action module on Datix. Currently (49) actions relating to SIs are reporting as overdue, PSMs are now actively following up with the service lines managers to track the action and monitor the status.

3.29 As previously reported the Trust has seen SI's declared in relation to obstetric emergencies. This includes the recognition and management of women experiencing obstetric complications. As such a thematic review of all maternity cases is required to be undertaken and is a priority for delivery within (Q2).

Learning from Experience

3.30 During the reporting period, the following areas have been highlighted for either improvement or good practice, and as such have been reported through the Quality and Safety Committee.

3.31 Emerging recurrent themes from Mental Health incident reports related to delayed police response, restraint and application of the Mental Capacity Act and Mental Health Act.

- SI: Transportation of an infant in a car seat.
- SI: Abdominal Aortic Aneurysm

3.32 **Key learning**

- Training and education MCA, MHA, Lack of policy for restraint.
- There is no Nationally recognised method to transport infants.
- Raise awareness of importance of effective communication with the patient, those in attendance and colleagues when AAA is suspected.

3.33 **Actions**

- Aggregated action plan in place to address all themes identified from MH incident reports.
- Action plan to is in progress to include awareness raising, equipment review, upward reporting and training related transport of infants.
- Thematic analysis of AAA has been completed this will inform next steps.

Incident Review Panel (IRP) Activity

3.34 During the reporting period

- 1193 patient safety incidents were identified during the reporting period with most incidents graded as no and low harm.
- 65 patient safety incidents were reviewed at Safety Review Panel (SRP).
- 29 patient safety incidents were subsequently escalated for further review and decision at IRP due to harm levels, and the opportunity for learning and improvement.

3.35 As part of the PSIRF transition Incident Review Panel merged with Safety Review Panel as such learning responses will be assigned to incidents through this process.

3.36 During the PSIRF transition there is a requirement to ‘dual’ report until all SIs and actions are completed.

Patient Experience (PE) and Engagement

3.37 The SPC reports in the IPR show no significant change (common cause variation) in the number of PE cases received during the reporting period.

3.38 The Trust received 922 PE contacts during the reporting period:

- Formal Complaint – 152
- Concern – 238
- HCP Feedback - 532

3.39 In the same period last year, the Trust received 931 PE cases, so a negligible decrease year on year.

3.40 951 cases were responded to and closed during the same period, of which 65% (614 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.

3.41 Themes of Patient Experience cases remain; inappropriate disposition (NHS111), CPR protocol when a patient has died (EOC), delay in/no attendance of frontline 999 and PTS vehicles and safeguarding referrals that haven't been explained to callers/patients properly.

3.42 A current risk is the fluctuation in survey response rates for NHS111 and PTS surveys. In the past these have been below the NHSE reporting threshold. The PE team have put forward a proposal for SMS based surveys for NHS111 and a digital app to be used by PTS which will increase response rates. Currently a MS Forms survey has been agreed by the IG Team for use.

3.43 **All complaints responded to within agreed timescales achieving (95) % target.**

PHSO

3.44 There is currently one case being reviewed by the PHSO. The trust has received provisional views for one case in the NW 999/HEMS which was not upheld and a NHS111 Thames Valley case which was upheld.

Compliments

3.45 During the reporting period the trust received (395) compliments for the care and service delivered by our staff.

Patient Engagement

3.46 To date the Trust has held three patient panel meetings. The meetings were productive and workstreams for improvement through patient engagement were scoped with panel members outputs will be reported through the Patient Safety & Experience Committee.

Recommendations

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

Sue Heyes, Deputy Chief Nurse

Date: 17 May 2024

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Report Cover Sheet

Report Title:	Chief Medical Officer's Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	30 May 2024
Agenda Item:	12
Executive Summary:	The purpose of the paper is to update the Board on key clinical issues relating to: 1. SCAS Clinical Research 2. Ambulance Clinical Quality Indicators (ACQI) 3. SCAS Clinical Pathways Developments 4. SCAS Clinical Pathway Utilisation
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 Chris Jackson Assistant Senior Operations Manager
Previously considered at:	Not Applicable
Purpose of Report:	Note
Paper Status:	Public

Assurance Level:	**Assurance Level Rating Options -** • **Acceptable** – General confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	Not Applicable
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 Clinical Research Portfolio • Prioritise and monitor new Care Pathways and their utilisation, and share dashboard with System Partners
List of Appendices	Appendix 1: SCAS Clinical Pathways Dashboard Appendix 2: SCAS Pathways Utilisation

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Chief Medical Officer's Update
Author	John Black, Chief Medical Officer Martina Brown, Head of Research Operations Jane Campbell, Assistant Director of Quality Chris Jackson, Assistant Senior Operations Manager
Accountable Director	John Black, Chief Medical Officer
Date	May 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)
- SCAS Clinical Pathways Developments
- SCAS Clinical Pathway Utilisation

2. Executive Summary

Clinical Research Update

2.1 The Research Annual report 2023-24 was presented at CRG along with the Research Annual Plan for 2024-25. The report charts our progress within this context and showcases some of the exceptional research activities undertaken in the last 12 months. The plan supports our aim to offer every service-user and staff member the opportunity to comment on and contribute to clinical research.

2.2 The updated Research Strategy 2024-27 was presented at CRG. This sets out our objectives for the next 3 years divided into six key themes: Research infrastructure; Developing a skilled workforce; Developing collaborations; Aligning research with practice; Disseminating research findings; Sustainability.

2.3 Recruitment to open studies (data cut 14 May 2024): *123 new patients have been enrolled in research studies since the last report.*

- Spinal Immobilisation Study (**SIS**): 92 patients;

- Early surveillance for type 1 diabetes in children (**ELSA**): 413 patients;
- Tranexamic acid for mild head injury in older adults (**CRASH4**): 355 patients;
- Medication route in cardiac arrest (**PARAMEDIC3**): 706 patients;
- Redirection to major stroke centre for thrombectomy treatment (**SPEEDY**): 10 patients

2.4 The PARAMEDIC3 trial will be extended until at least end of July 2024. A decision on a further extension request is pending.

2.5 The CABARET CPR study has experienced delays as approval for a protocol amendment was pending. This has now been obtained. Trial Contracts with UHS have now been approved by FRG.

2.6 Related to the CABARET study, unfortunately we have had an instance where a LUCAS-AD was used on a patient outside of clinical trial. Corrective actions were taken immediately. Full investigation completed and preventative actions taken. No patient harm has arisen.

2.7 Our evaluation of the Take Home Naloxone (THN) project identified that THN kits are rarely left on scene with patients/families. We are working with the medicines team to promote the scheme.

2.8 Staff will have the opportunity to engage in two new survey studies: 1. AMBOFALL exploring the ambulance response to, and decision making of ambulance staff concerning, older fallen patients and 2. A survey on prehospital research culture and capacity building.

2.9 We continue to disseminate our research findings, with two articles published in peer-reviewed journals since the last report.

2.10 The research team have been nominated for and NHS Parliamentary award by 11 local MPs.

Ambulance Clinical Quality Indicators (ACQI)

2.11 SCAS continue to submit audits for the period of the EPR outage and ensure that the audit submissions are completed as per the national timetable.

2.12 Our national clinical performance for December 2023 benchmarks well in comparison to England's other Regional Ambulance Services

ACQIs - Dec '23											
Clinical Quality Indicator	IOW	London	North East	North West	Yorkshire	East Mids	West Mids	East of England	South East	South Central	South West
% Cardiac Arrest ROSC At Hosp	28.57%	26.93%	29.96%	26.95%	28.81%	17.06%	30.50%	27.96%	24.52%	24.45%	26.76%
% Cardiac Arrest Ustein ROSC		50.00%	57.14%	56.25%	52.27%	34.21%	66.67%	41.46%	52.17%	59.38%	46.88%
% Cardiac Arrest Survive At 30 Days	7.14%	7.31%	9.33%	8.92%	7.76%	5.50%	8.06%	6.46%	10.69%	10.95%	5.37%
% Cardiac Arrest Utstein Survive At 30 Days		25.93%	39.29%	27.08%	25.00%	24.32%	35.09%	21.95%	25.53%	40.63%	12.90%
STEMI PPCI Mean Time CTN	213	151	142	157	146	175	136	163	162	149	171
STEMI PPCI 90Centile CTN	213	220	206	223	202	248	207	234	247	246	233
Stroke Mean Time CTD	1:54:30	1:47:24	1:43:18	1:33:48	1:42:12	1:59:54	1:54:36	1:46:54	1:28:18	1:41:30	1:59:30
Stroke 50Centile CTD	1:11:30	1:30:30	1:31:00	1:23:00	1:25:00	1:38:00	1:28:00	1:32:30	1:17:00	1:25:00	1:40:00
Stroke 90Centile CTD	2:53:00	3:01:00	2:37:00	2:30:00	2:52:00	3:05:00	3:14:00	2:49:00	2:08:00	2:44:00	3:05:00
Rag key	1st	2nd	3rd	4th	If highlighted represents within upper quartile						

National Ambulance Service Clinical Quality Group (NASCQG)

2.13 The national group NASCQG met on 2 May 2024. The newly formed Ambulance Data Board is now the overarching approval group for all proposed changes to the suite of ACQIs and planned national audits.

SCAS Clinical Pathways Developments and Utilisation:

2.14 The SCAS Urgent Care Dashboard Board has been updated in May 24 (**Appendix 1**) 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 community UCR Teams)
- Frailty and Falls Services
- Acute Respiratory Infection Hubs.

2.15 Access to these pathways is managed by a clinical pathways team who have reviewed the work program and how it aligns to the updated SCAS Strategy and the 10-point plan.

2.16 The Dashboard illustrates the variability of access for 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 150 pathways across the region that do not necessitate patient admissions via EDs.

2.17 Page 5 of the report summarises the new pathways that have gone live since the last update to the board in January 2024. Other recent initiatives include

issuing guidance to empower SCAS clinicians to be able to access waiting room areas for patients that are stable and 'fit to sit' to support rapid 'drop and go' to improve flows of patients in need of further assessment and care at hospitals and urgent care centers, thereby reducing ambulance hand-over delays.

2.18 Visibility and contact details for these pathways, including hours of operation, is via the SCAS Connect Application which monitors activity, receives feedback and is regularly updated by the SCAS Pathways Management Team as pathways evolve.

2.19 As requested in the March Board, **Appendix 2** report includes high level data and commentary on Care Pathway utilisation across our region for both conveyed and non-conveyed patients, including referral to Non-ED destinations.

2.20 Patient dispositions are recorded from options selected on the Terrafix Mobile Data Terminal (MDT) by the attending SCAS Clinician.

2.21 All data excludes Health Care Professional (HCP) or General Practitioner (GP) Ambulance conveyance requests or Inter-hospital Transfers (IHT).

2.22 The Business Information team are working with the clinical pathway team to develop a dashboard that will allow us to understand with greater granularity the exact locations where our patients are being referred and conveyed. This information will include the ability to be able to filter:

- Referral locations - Hospitals, ICBs, service provider referral teams,
- Refer detail - Resource Centre Localities, Dispatch Node, SCAS operational teams, Skill grade, SCAS individual clinicians
- Referral timeframes - Years, month of year, week of month, day of week, hour of day
- Patient demographics - Age parameters (under 5's / over 65's etc), age range, post code
- Incident Detail - Nature of call, symptom group, performance category.

2.23 This data will help us better manage urgent and emergency care demand and will help us identify gaps in service provision across our four integrated care systems in the months and years ahead.

3. Recommendations

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

John JM Black
Chief Medical Officer
25th May 2024

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Report Cover Sheet

Report Title:	Operations Modernisation Programme (OMP)
Name of Meeting	Public Trust Board
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	OMP update as part of Fit For the Future Programme (FFFP)
Executive Summary:	The attached paper is intended to provide an update on actions taken during May 2024 and planned actions relating to the Operations Modernisation pillar of the Fit for the Future Programme (FFFP).
Recommendations:	The Trust Board is asked to note the report
Accountable Director:	Paper signed off by Michaela Morris – Head of Operational Service Model, acting as deputy to Paul Kempster – Chief Transformation Officer
Author:	Tina Lewis – Programme Manager
Previously considered at:	The paper builds upon discussions and updates that have previously occurred at Trust Board in relation to the Operations Modernisation Programme
Purpose of Report:	Note
Paper Status:	Internal
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	n/a
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	
List of Appendices	

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Operations Modernisation Programme (OMP)
Author	Tina Lewis, Programme Manager
Accountable Director	Paper signed off by Michaela Morris, Head of Operational Service Model, acting as deputy to Paul Kempster, Chief Transformation Officer
Date	30 May 2024

1. Purpose

The purpose of the paper is provide the Trust Board with an update on actions taken during May 2024 and planned actions relating to the Operations Modernisation pillar of the Fit for the Future Programme (FFFP)

2. Background and Links to Previous Papers

This paper builds upon discussions and updates that have previously occurred at Trust Board in relation to the Operations Modernisation Programme (OMP)

3. Rationale for Private Paper

The paper outlines the current status of the Operations Modernisation Programme

4. Executive Summary

Operations Modernisation Roadmap

In December 2023, a roadmap of key deliverables for the Fit For the Future programme (FFFP), was shared across the organisation as part of the SCAS Strategy Refresh. These covered details of activities proposed to commence between QTR 4 23/24 through to QTR 3 24/25. These are based on the seven workstreams:

1. Operations Service Model
2. Contact Centre Service Model
3. Estate / Fleet
4. Digital

5. People and Culture
6. Corporate Services
7. Communications & Engagement.

It has been agreed that “Fit for the Future” is the vehicle for the delivery of the SCAS strategy and with Operations Modernisation delivering the first two workstreams.

To support the delivery of the OMP a revised roadmap is being developed, for use by the programme team / Board, which focuses only on those elements that the programme owns. It incorporates Proof of Concepts (POC’s) and their co-design as the mechanism by which the programme will explore operational, organisational and process opportunities. Quality Improvement methodology will be used to robustly assess the success or otherwise of the Proof of Concepts.

Progress against QTR 1 deliverables

The focus during the last 4 weeks has been:

- Developing the scope of the Proof of Concepts, considering an option for Urgent & Emergency Contact Centre and 999 Frontline operations.
- Progressing options for Organisational structures in line with discussion with the relevant teams.
- Continuation of Hub location modelling, “stress” testing to evaluate the impacts of potential future changes in our demographics and patient mix. Additionally further work has been undertaken to review impacts on factors such as response times, staff over-runs and distance travelled.
- Benchmarking other Ambulance Trusts / Blue light services including:
    - Visit to three hubs belonging to West Midlands Ambulance Service
    - Meeting with Thames Valley Police (TVP) Transformation lead
    - Re-engaging with AACE colleagues with respect to develop our operating model, this his had been on hold awaiting their business case approval. A detailed planning workshop is scheduled for end May.
- Staff engagement
    - Continued visits to Resource Centres to attend team meetings, as well as other 999 and 111 contact centres.
    - Hosted workshop at Shaw House Senior Leadership forum on OMP
    - Held an all Trust webinar focusing specifically on OMP.

Focus for the next period

The primary focus of the OMP during June are:

- Completion of workshop with AACE at the end of May
- Further develop of options relating to the Proof of Concepts and Hub modelling
- Meet with TVP Contact Centre leads

5. Areas of Risk

The only specific risk to share as part of this update is:

1. Due to the announcement of the general election, we have now entered a purdah period which has the potential to delay deliverables within the roadmap

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

The proposals within the paper will support the delivery of the Organisations strategy as part of the Fit for the Future Programme.

7. Governance

Developing the detailed delivery plan associated with the Operations Modernisation Programme and defining and agreeing the scope of the Proof of Concepts will proceed based on approvals via the Programme Board, Executive Management Committee and then to Trust Board.

8. Responsibility

Paul Kempster – Chief Transformation Officer

9. Recommendations

The purpose of this paper is to provide the Public Board with an update of the current status and plans for the next period for the Operations Modernisation Programme.

Report Cover Sheet

Report Title:	Quality and Safety Committee – Terms of Reference
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	14
Executive Summary:	The Committee is responsible for providing assurance to the Board that there is an effective system of quality governance and internal control across clinical activities to ensure patients are treated with compassion, dignity, and respect. To provide assurance that the essential standards of quality and safety are being delivered by the Trust. To provide assurance that the processes for the governance of quality are embedded throughout the organisation to improve the experience of patients. The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board. As part of the Board's annual review of governance, all Board Committees are required to review their Terms of Reference (ToR) and recommend any changes to the Trust Board of Directors for approval. A review of the Quality and Safety Committee ToR has taken place and the Committee is recommending these are approved by the Trust Board of Directors. The attached Terms of Reference has been approved by the Quality and Safety Committee in March 2024.
Recommendations:	The Trust Board is asked to: Approve

Accountable Director:	Helen Young Chief Nursing Officer
Author:	Helen Young Chief Nursing Officer
Previously considered at:	Quality and Safety Committee
Purpose of Report:	Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	Publish the Terms of Reference.
List of Appendices	

Terms of Reference – Quality & Safety Committee

2024 - 2025

Document Reference	To be assigned by
Document Status	Draft
Version	
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	
Initiated by	Date & Author(s)
Document Owner	Chief Governance Officer
Recommended at Date	
Approved at Date	Board of Directors
Valid Until Date	
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Governance Assurance and Accountability Framework
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes

Quality and Safety Committee Terms of Reference – March 2024

1.0	**Constitution**
1.1	The South Central Ambulance Service NHS Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Quality and Safety Committee (The Committee).
1.2	The Committee is constituted as a Standing Committee of the Board.
1.3	The Committee shall have Terms of Reference and powers and will ensure that the Board is able to act in accordance with legislation, compliance, or direction requirements and to be fully appraised of the impact of quality governance, patient safety, clinical effectiveness, and patient experience on the delivery of the Trust's strategic objectives.
1.4	Its constitution and Terms of Reference shall be as set out below; and will be subject to amendments approved by the Board.
2.0	**Purpose**
2.1	The Committee is responsible for providing assurance to the Board that there is an effective system of quality governance and internal control across clinical activities to ensure patients are treated with compassion, dignity, and respect. To provide assurance that the essential standards of quality and safety are being delivered by the Trust. To provide assurance that the processes for the governance of quality are embedded throughout the organisation to improve the experience of patients.
2.2	To enable the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to: i) Promote safety and excellence in patient care ii) Identify, prioritise, and manage risk arising from clinical care iii) Comply with the Care Quality Commission's (CQC) regulations iv) Ensure the effective and efficient use of resource through evidence-based clinical practice
3.0	**Authority**
3.1	The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board.
3.2	The Committee is authorised by the Board to act within or investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
3.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. Any costs incurred must be within the

	remit of the Scheme of Delegation and Standing Financial Instructions.
3.4	The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
3.5	The Committee is authorised by the Board to liaise, as necessary, with other Committees of the Board and the Chairs of the Committees have a responsibility for ensuring that the Audit Committee and the Board are advised of any risks or potential conflicts.
3.6	It is not the duty of the Committee to carry out functions that properly belong to the Board itself or to other Board Committees.
3.7	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.8	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.9	The Board has determined that the Audit Committee will have responsibility for risk management, to gain assurance that appropriate systems of internal control are in place and are operating as intended, and that the Board Committee system is working appropriately. As such the Audit Committee has overall responsibility for the Governance Assurance and Accountability Framework and will delegate any appropriate areas to this Committee as required.
4.0	**Duties and Responsibilities**
4.1	**Governance**
4.1.1	To ensure that all statutory and regulatory elements of clinical governance are adhered to within the Trust.
4.1.2	To approve the Trust's annual Quality and Safety Committee report before submission to the Board.
4.1.3	To receive and approve the Annual Clinical Audit Programme ensuring that it is approved by Board consistent with the audit needs of the Trust.
4.1.4	To oversee the Trust’s policies and procedures with respect to the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act 2018.
4.1.5	To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.
4.1.6	To receive and safely project information and data prior to Board approval.
4.2	**Patient Safety**
4.2.1	To maintain an overview of service compliance against the Care Quality Commission fundamental standards and strategy.
4.2.2	To maintain the Trust’s compliance with the required standards of quality and safety, in order to provide relevant assurance to the Board so that Directors may approve the Trust’s annual declaration of compliance and corporate governance statement. This will be done

	by ensuring that relevant standards are set and monitored, including (without limitation): ▪ Standards outlined in national service frameworks ▪ Care Quality Commission registration criteria to continue to be met ▪ NHS licence requirements relevant to quality and patient safety
4.2.3	To oversee processes to ensure the review of patient safety incidents (including near-misses, complaints, claims and coroner's determinations) from within the Trust and wider NHS to identify similarities or trends and areas for focussed or organisation-wide learning.
4.2.4	To scrutinise the outcomes and monitoring of action plans associated with serious incidents, accidents, claims and litigation and ensure learning is embedded across the Trust.
4.2.5	Receiving assurances, via regular exception reports, that appropriate systems are in place to ensure patient safety and clinical quality.
4.2.6	Monitoring and facilitation compliance against external standards, good practice guidance and legislation.
4.2.7	Providing oversight and challenge of the clinical strategy and related policies and ensuring the Trust's compliance with the relevant regulatory and statutory bodies requirements.
4.2.8	Monitoring levels of risk associated with all external inspections and reviews; in particular to oversee the progress and compliance with NHS Resolution and Clinical Negligence Scheme for Trusts risk management standards and to take action where necessary.
4.2.9	Seeking assurance that the Trust works collaboratively with relevant external statutory bodies in line with national legislation and implements appropriate guidance and requirements e.g., regulatory bodies.
4.2.10	Receiving assurances that appropriate systems are in place for the development and review of care pathways, clinical policies and the implementation of national clinical guidelines from all relevant professional bodies and regulators.
4.2.11	Ensuring that the Trust, by gathering information effectively, analysing and using it appropriately, takes actions to improve patient safety and creates the environment to continuously learn.
4.4.12	To support and monitor within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care in accordance with the Trust's policy on reporting issues of concern and monitoring the implementation of that policy.
4.2.13	To monitor the progress of identified areas for improvement in respect of incident themes and complaint themes from the results of national patient survey and ensure appropriate action is taken.
	To monitor that risks to patients are minimised through the application of a comprehensive risk management system including, without limitation: ▪ ensuring that processes are in place to ensure the escalation of risks from local and clinical unit risk registers to the Corporate

	Risk Register and receiving reports from the Trust's Head of Risk Management ▪ identifying areas of significant risk, setting priorities and actions using the Board Assurance Framework ▪ ensuring that the Trust incorporates the recommendations from external bodies (e.g. the National Confidential Enquiry into Patient Outcomes and Death, HSIB or Care Quality Commission), as well as those made internally (e.g. in connection learning from PSIRF or previously used NHS incident reporting framework), into practice and has mechanisms to monitor their delivery ▪ monitoring implementation of NHSE Patient Safety Strategy requirements ▪ monitoring the implementation of the national Safeguarding requirements through delivery for the National Safeguarding Assurance Framework (SAAF) in order to assure that processes are in place for safeguarding across the Trust ▪ escalating to the Executive Management Committee and/or Audit Committee and/or Board any identified unresolved risks arising within the scope of these Terms of Reference that require Executive action or that pose significant threats to the operation, resources, or reputation of the Trust.
4.3	**Clinical Effectiveness**
4.3.1	To ensure efficient and effective use of resources through evidence-based clinical practice ensuring care is based on evidence of best practice/national guidance.
4.3.2	To ensure that there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance.
4.3.3	To monitor the impact on the Trust's quality of care of cost improvement programmes and any other significant reorganisations (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the Committee) and report any concern relating to an adverse impact on quality to the Board.
4.3.4	Monitoring and evaluating clinical quality and performance within the Trust based on review of a dashboard of agreed performance indicators.
4.3.5	Scrutinising the Trust's Quality Account and recommending it to the Audit Committee and Board for approval, and to monitor the progress of the annual quality priorities.
4.3.6	Ensuring there is a Directorate level review of all enquiries, national service frameworks and other national clinical guidance from the relevant external agencies and regulators and receiving assurances in respect of the Trust's response.
4.3.7	Assessing governance, clinical and quality impact assessments of financial decisions within the Trust.
4.3.8	Approving the Clinical Audit Plan for the year based upon areas of risk, monitor the delivery of the clinical audit plan to ensure quality outcomes for patients.

4.3.9	Reviewing assurance on the outcomes of Clinical Audit (in liaison with the Audit Committee), in particular on how those outcomes relate to Patient Experience.
4.3.10	To ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission).
4.3.11	To assure the implementation of all new procedures and technologies according to Trust policies.
4.3.12	To review the implications of confidential enquiry reports for the Trust and to endorse, approve and monitor the internal action plans arising from them.
4.3.13	To monitor the extent to which the trust meets the requirements of commissioners and external regulators.
4.3.14	To monitor any gaps in the delivery of effective clinical care ensuring progress is made to improve these areas, in all specialities.
4.3.15	To ensure the research programme and governance framework is implemented and monitored.
4.3.16	To ensure that outstanding and effective care and practice is recognised and embedded across the Trust.
4.3.17	To ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.
4.4	**Patient Experience**
4.4.1	Receiving the quarterly Complaints, Litigation, Incidents and Patient Reports to outline learning from themes and trends.
4.4.2	Receiving the summary results of surveys relating to patient experience and action plans in response.
4.4.3	To ensure learning from patient engagement is embedded in day-to-day service delivery, service redesign, transformation, and estates development.
4.4.4	Ensure that patient experience data and information is collected and delivered in a proactive and efficient way, and effectively used to drive improvements in patient experiences.
4.4.5	Receive assurance on progress and the resolution of Complaints cases.
4.4.6	Ensure patient and public involvement is inclusive throughout the Trust and ensure involvement across improvements within our business.
4.5	**Estate Compliance**
4.5.1	Monitoring and evaluating compliance with core estate and maintenance requirements to ensure a safe environment and medical devices to enable staff to deliver the service.
4.6	**Other duties**
	Monitoring quality assurance for all third-party service delivery (e.g. sub- contracted services).
5.0	**Membership and Quorum**

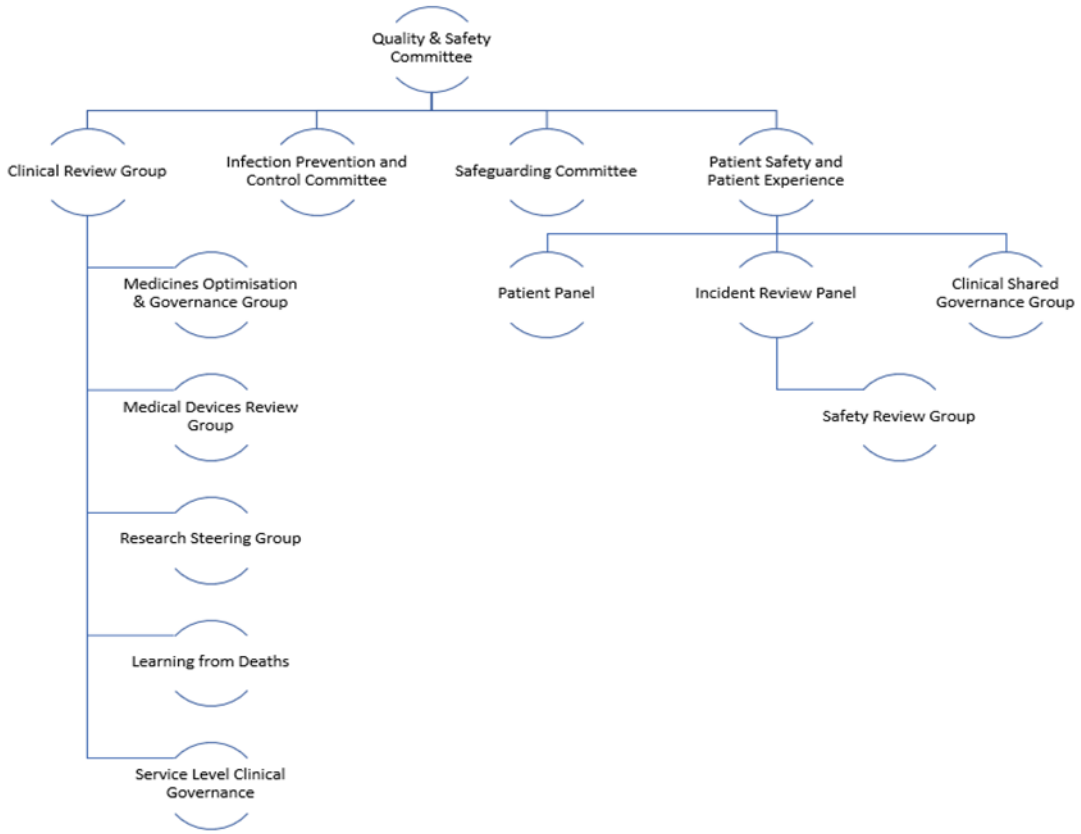
5.1	The Committee membership shall be appointed by the Board from amongst both the Executive Directors and Non-Executive Directors and shall consist of not less than three Non-Executive Directors members, at least one of whom should have recent and relevant clinical or quality experience. One Non-Executive member will act as Chair of the Committee.
5.2	The Committee will consist of the following members: **Non-Executive Directors:** The Quality & Safety Committee shall consist of three Non-Executive Directors. **Executive Directors:** (or their appropriate Deputy) Chief Medical Officer Chief Nurse Officer
5.3	Members are required to attend at least two thirds of the meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Secretary of the Committee in advance.
5.4	In the absence of the Committee Chair, the remaining members present shall elect one of themselves to chair the meeting.
5.5	The Chair of the Board shall not normally be a member of the Committee. He/she will have automatic rights as a member of the Committee at times when the quorum cannot be met or vacancies at Non-Executive Director level warrant temporary Committee membership.
5.6	The Committee will be deemed quorate to the extent that the following members are present: Two Non-Executive Directors and one Executive Director or their appropriate Deputy (ref 5.2). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.
5.7	For the avoidance of doubt, Trust employees who serve as members of the Quality and Safety Committee do not do so to represent or advocate for their respective department, division, or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.
5.8	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
6.0	**Attendance at Meetings**
6.1	Those required at each meeting:

	▪ Chief Operating Officer ▪ Chief People Officer ▪ Chief Digital Officer ▪ Chief Finance Officer ▪ Chief Strategy Officer ▪ Deputy Chief Nurse ▪ Associate Directors of Quality and Safety ▪ Head of Risk Management ▪ Head of Legal Services ▪ Patient representative Those who may also attend if invited or required: ▪ Head of Safeguarding ▪ Patient Safety Specialist ▪ Health and Safety Manager ▪ Head of Infection Prevention and Control ▪ Head of Patient Experience ▪ Chief Pharmacist ▪ Assistant Medical Directors ▪ ICS Observers ▪ Governor Observers ▪ Staff Side Observers
6.2	When an Executive Director, member or essential attendee is unable to attend a meeting, they should appoint a deputy to attend on their behalf.
6.3	Other Board Members, Executive Directors, officers and relevant representatives shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that individual.
7.0	**Meetings**
7.1	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework.
7.2	Meetings of the Quality and Safety Committee shall be held bi-monthly, scheduled to support the business cycle of the Board and at such other times as the Committee Chair shall identify, subject to agreement with the Board Chair.
7.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
8.0	**Reporting and Accountability**
8.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.

8.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.
8.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers outline the framework to be used for escalating an item from the Committee to the Board: i) Non-compliance with compliance indicators for 2 consecutive months, or off track against agreed trajectory ii) Clinical, patient safety risk scoring 15 or higher residually, with inadequate mitigating actions in place, or with actions overdue with no assured plan to resolve.
8.4	The Committee shall be directly accountable to the Trust Board.
8.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.
8.6	The following Sub-Committees shall report to the Committee as the primary reporting line using the standard upward reporting template: • Patient Safety and Experience Committee • Clinical Review Group • Safeguarding Committee • Infection Prevention and Control Committee
8.7	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
8.8	The Committee will report to the Audit Committee on its work in support of the Annual Governance Statement, the Board Assurance Framework, the effectiveness of risk management within the Trust; its view as to whether the self-assessment against the Care Quality Commission Registration is appropriate; and any pertinent matters in respect to which the Committee has been engaged.
8.9	The Quality and Safety Committee will review and update the strategic risks for which it has responsibility and will update the Board Assurance Framework at each of its meetings.
9.0	**Secretary and Committee Support**
9.1	A member of the Governance Team will act as Secretary to the Committee. The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.

9.2	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers, iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.
10.0	**Review, Monitoring and Effectiveness**
10.1	Members of the Committee will monitor the effectiveness of these Terms of Reference by: i) Recording the attendance of members and how often they send a representative. ii) Number and frequency of meetings in line with Quality & Safety Terms of Reference as per section.
10.2	The Trust's Annual Report shall include a section describing the work of the Quality & Safety Committee in discharging its responsibilities.
10.3	The Committee will report on an annual basis to the Audit Committee on its performance against its Terms of Reference and on an ad-hoc basis any risks which have inadequate assurance on performance.
10.4	The Chair of the Board will receive a copy of all meeting papers and will attend at least one meeting per annum for monitoring and assurance purposes.
10.5	The Committee will review its own performance, at least annually, review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
10.6	The Committee shall review its Terms of Reference annually, to be reviewed by the Board recommending any changes to the Board, as appropriate.
10.7	Set an annual Forward plan for its work to form part of the Board's annual Forward Plan and report to the Board on its progress.
11.0	**Strategies ratified and approved by this Committee**
11.1	Strategies: To be inserted by Chief Nursing Officer
12.0	**Policies ratified and approved by this Committee**
12.1	Policies: The Policies ratified by this committee are detailed in the Policy for the Development of Trust Policy

13.0	The Sub-Group structure supporting the flow of assurance to the Quality and Safety Committee



NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	M1 Finance Report
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	16
Executive Summary:	<u>I&E Position</u> This report presents the financial position for the period ended 30 April 2024 (Month 1). As at month 1, the Trust is reporting a year-to-date net income and expenditure deficit of £1.9m, against a planned deficit of £1.2m resulting in an adverse variance of £0.7m. The underlying factors driving the deficit remain unchanged however Non-Emergency Patient Transport Service (NEPTS) is the main driver of the in-month variance. Also, the Thames Valley 111 contract income is not yet agree contributing to the adverse variance. Financial Recovery Plan (FRP) the Trust is continuing to push forward with the delivery of the FRP a net savings target of £27.7m, which is broken down into various schemes spread across all the Trust's divisions. With the Trust through its governance structure continues to monitor and discuss actions needed to deliver the plan. <u>Capital</u> The Trust's capital spend in the month is £0.3m. The plan for the month was £2.2m. The underspend was due to the 2022/23 cohort of 53

	Double-Crewed Ambulances (DCAs) being further delayed with on seven chassis received in April. The capital forecast for the year remains £12.9m against capital departmental expenditure limit (CDEL) and a total of £41.6m including IFRS16 and public dividend capital (PDC) funded spend. <u>Cash</u> The Trust's cash balance at the end of April stood at £27.3m. There was a net cash inflow in M1 of £2.2m due to the receipt of Category 2 call answering funding accrued at year-end and sales cash receipt for the electric vehicles sold and leased back at the end of the last financial year. Moving into 2024/25 additional cash monitoring will be applied and early warning systems maintained in order to assess the ongoing viability of the capital programme and also to ensure the NHSE cash support process is ready if required.
Recommendations:	The Board is asked to note the report.
Accountable Director:	Stuart Rees, Interim Director of Finance
Author:	Alan Monks, Deputy Chief Finance Officer
Previously considered at:	Finance and Performance Committee
Purpose of Report:	For assurance
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Partial
Justification of Assurance Rating:	The Trust is current off plan, with corrective action being introduced, with final plan numbers to be agreed.
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	Board of Directors Meeting in Public
Title	M1 Finance Report
Author	Alan Monks, Deputy Chief Finance Officer
Accountable Director	Stuart Rees, Interim Director of Finance
Date	22nd May 2024

1. Purpose

This report is produced monthly to update the Board on the latest financial position and any risks to the achievement of financial objectives.

2. Background and Links to Previous Papers

The financial environment remains extremely challenging and therefore plans are not completely finalised yet. The Hampshire and Isle of Wight system has recently established its control total, the system partners are current working through the component elements. Currently, this will require the Trust to improve its efficiencies/savings by a range of £0.4m to £1.1m in-year.

With the system working together to develop further opportunities to improve efficiencies within the system. The Trust will

Current Plan

The Trust's current annual financial plan for 2024/25 contains:

- A deficit of 11.2m (Breakeven underlying run rate income and expenditure by year end).
- £41.6m of capital expenditure (including leases accounted for under International Financial Reporting Standards (IFRS 16).

The Trust's 2024/25 planned deficit of £11.2m is an improvement on the 2023/24 outturn position of £21.8m. The plan is phased to deliver monthly deficits in the first six months of the year which will be partly offset by surpluses in the second half of the financial year.

M1 (£000)	M2 (£000)	M3 (£000)	M4 (£000)	M5 (£000)	M6 (£000)	M7 (£000)	M8 (£000)	M9 (£000)	M10 (£000)	M11 (£000)	M12 (£000)	Total (£000)
(1,169)	(1,358)	(1,115)	(542)	(7,982)	(747)	186	50	294	332	476	415	(11,160)

3. Executive Summary

Income and Expenditure

In month 1, the Trust's I&E position shows an in-month deficit of £1.9m against a planned deficit of £1.2m resulting in an adverse variance of £0.7m.

£m	M1
Plan	(1.2)
Actual	(1.9)
Variance to Plan	**(0.7)**

		Month 1			Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
999	Income	18.9	18.8	0.1	18.9	18.8	0.1	226.1	226.1	0.0
	Expenditure	(15.7)	(15.8)	0.1	(15.7)	(15.8)	0.1	(183.9)	(183.9)	0.0
	Contribution	**3.2**	**3.1**	**0.1**	**3.2**	**3.1**	**0.1**	**42.3**	**42.3**	**0.0**
	%	**17.0%**	**16.3%**		**17.0%**	**16.3%**		**18.7%**	**18.7%**	
111	Income	3.3	3.4	(0.1)	3.3	3.4	(0.1)	41.4	41.4	0.0
	Expenditure	(3.1)	(3.0)	(0.1)	(3.1)	(3.0)	(0.1)	(36.5)	(36.5)	0.0
	Contribution	**0.2**	**0.4**	**(0.2)**	**0.2**	**0.4**	**(0.2)**	**4.9**	**4.9**	**0.0**
	%	**6.4%**	**12.8%**		**6.4%**	**12.8%**		**11.9%**	**11.9%**	
PTS	Income	5.3	5.4	(0.1)	5.3	5.4	(0.1)	65.0	65.0	0.0
	Expenditure	(5.5)	(5.0)	(0.5)	(5.5)	(5.0)	(0.5)	(56.0)	(56.0)	0.0
	Contribution	**(0.2)**	**0.4**	**(0.6)**	**(0.2)**	**0.4**	**(0.6)**	**9.0**	**9.0**	**0.0**
	%	**-3.5%**	**7.6%**		**-3.5%**	**7.6%**		**13.8%**	**13.8%**	
Operations Total Contribution		**3.2**	**3.9**	**(0.7)**	**3.2**	**3.9**	**(0.7)**	**56.1**	**56.1**	**0.0**
%		**11.8%**	**14.2%**		**11.8%**	**14.2%**		**16.9%**	**16.9%**	
Corporate		(5.2)	(5.2)	(0.0)	(5.2)	(5.2)	(0.0)	(68.1)	(68.1)	0.0
Surplus/(Deficit)		**(1.9)**	**(1.2)**	**(0.7)**	**(1.9)**	**(1.2)**	**(0.7)**	**(12.0)**	**(12.0)**	**0.0**
Reporting Adjustments		0.1	0.1	0.0	0.1	0.1	0.0	0.8	0.8	0.0
Reportable Surplus/(Deficit)		**(1.9)**	**(1.2)**	**(0.7)**	**(1.9)**	**(1.2)**	**(0.7)**	**(11.2)**	**(11.2)**	**0.0**

Deficit Drivers

The drivers of our financial deficit remain unchanged, the main variances from plan are:

- The shortfall in funding in relation to the Thames Valley 111 contract and extension of Hazardous Area Response Team (HART). The Trust is currently in discussions with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB).
- The Trust continues to face the financial consequences of the high level of hospital handover delays experienced across the patch.
- Cost pressures experienced in the previous year in corporate areas and across the operational areas are still impacting the deficit in the early part of the financial year until the financial recovery plan makes an impact on reducing them.

The main points to note for Month 1 performance are:

- In the 999 service, expenditure on private ambulance providers is on plan while frontline resource costs were lower than plan in month 1.
- Within the 111 service, additional income was included within the Financial Recovery Plan (FRP) relating to funding the Thames Valley contract to the appropriate level. Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB) commission the service directly with SCAS and they continue negotiating directly with the Trust to determine the next steps. BOB ICB are taking a paper through their internal governance process week commencing 20th May. BOB ICB recognise that there is a gap and have praised the Trust for its openness on the costs and understand them. However, if additional funding cannot be agreed the Trust will need to look to removed costs worth circa £3.6m.
- Non-Emergency Patient Transport Service (NEPTS) resource costs are over budget, primarily through private providers and taxis, vehicle leases & hires are overspent the Trust is putting recovery action into place.

We continue to raise these financial pressures, particularly those linked to unfunded or underfunded services and activity, with our commissioners and hope to resolve these issues or the Trust will need to take further actions to reduce costs.

Financial Recovery Plan (FRP)

The Trust is continuing to push forward with the delivery of the FRP a net savings target of £27.7m, which is broken down into various schemes spread across all the Trust's divisions.

The Financial Recovery Group and Finance And Performance Committee, continue to monitor and discuss actions needed to deliver the plan. These measures include:

- Daily activity and resource management calls
- Introduction of spending controls
- A plan to claw back overspending areas
- Improve productivity reporting.

Capital

The Trust's capital spend for April was £0.3m. The Trust underspent against its Month 1 capital budget by £2.0m, this was due to slippage in capital projects. The receipt of the 2022/23 cohort (53 double-crewed ambulance (DCA's)) vehicles from Venari has not materialized as expected with there being a further delay due to parts required from Italy. There was no expected spend in April for IFRS16 CDEL, the first expected IFRS16 CDEL spend is in July with the expected sale/leaseback of the 53 2022/23 DCA cohort for which the sale cash income is expected to be received in August.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	0.0	0.4	(0.4)	9.4	9.4	0.0
	IFRS16	0.0	0.0	0.0	2.7	2.7	0.0
	Total	**0.0**	**0.4**	**(0.4)**	**12.0**	**12.0**	**0.0**
Digital	Internal CDEL	0.0	1.8	(1.8)	4.3	4.3	0.0
	PDC	0.0	0.0	0.0	1.1	1.1	0.0
	PDC Income	0.0	0.0	0.0	(1.1)	(1.1)	0.0
	IFRS16	0.0	0.0	0.0	0.4	0.4	0.0
	Total	**0.0**	**1.8**	**(1.8)**	**4.7**	**4.7**	**0.0**
Fleet (22/23 DCA Cohort)	Internal CDEL	0.0	0.0	0.0	(1.8)	(1.8)	0.0
	IFRS16	0.0	0.0	0.0	5.4	5.4	0.0
	Total	**0.0**	**0.0**	**0.0**	**3.6**	**3.6**	**0.0**
Fleet (23/24 DCA Cohort)	Internal CDEL	0.0	0.0	0.0	(0.6)	(0.6)	0.0
	IFRS16	0.0	0.0	0.0	7.3	7.3	0.0
	Total	**0.0**	**0.0**	**0.0**	**6.7**	**6.7**	**0.0**
Fleet (24/25 DCA Cohort)	Internal CDEL	0.0	0.0	0.0	0.0	0.0	0.0
	IFRS16	0.0	0.0	0.0	10.2	10.2	0.0
	Total	**0.0**	**0.0**	**0.0**	**10.2**	**10.2**	**0.0**
Fleet (Non-DCA)	Internal CDEL	0.2	0.0	0.2	1.6	1.6	0.0
	IFRS16	0.0	0.0	0.0	2.7	2.7	0.0
	Total	**0.2**	**0.0**	**0.2**	**4.3**	**4.3**	**0.0**
Internal CDEL Total		0.3	2.2	(2.0)	12.9	12.9	0.0
IFRS16 Total		0.0	0.0	0.0	28.6	28.6	0.0
PDC Total	Expenditure	0.0	0.0	0.0	1.1	1.1	0.0
	Income	0.0	0.0	0.0	(1.1)	(1.1)	0.0
Total		**0.3**	**2.2**	**(2.0)**	**41.6**	**41.6**	**0.0**

Key drivers of the current capital position are:

- Delivery of the 2022/23 and 2023/24 DCA cohorts which have been significantly delayed due to supply chain issues affecting the conversion of the chassis into DCAs. The first delivery from the 2022/23 cohort arrived in February, with one vehicle delivered by the end of the 2022/23 financial year. Seven vehicles from the 2023/24 cohort were delivered in April with the remaining 45 expected during May, June and July 2024.
- The delay in delivery of the DCAs means that these vehicles cannot be sold and leased back to SCAS within the months planned, the sale/leaseback transaction for the 53 is now expected in August. This means that costs incurred to date are allocated against internal capital departmental expenditure limit (CDEL) and will be transferred to IFRS16 CDEL upon completion of the sale/leaseback transactions.

Cash

The Trust's cash balance at the end of April stood at £27.3m. There was a net cash inflow in M1 of £2.2m due to the receipt of Category 2 call answering funding accrued at year-end and sales cash receipt for the electric vehicles sold and leased back at the end of the last financial year.

Despite this, there is still an expected deterioration in cash balance in the early part of the year driven by the underlying financial pressures. If there are any delays to, or non-delivery of, the financial recovery plan this could worsen the cash position and potentially reduce interest receivable or need for cash support, further worsening the overall financial position.

2024/25	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income	32.8	28.3	28.3	28.5	33.7	28.3	35.8	28.3	29.4	28.3	28.3	38.4
Expenditure	(30.6)	(30.8)	(33.1)	(29.2)	(36.4)	(36.9)	(28.8)	(28.5)	(29.1)	(31.8)	(29.4)	(37.5)
Cash Support Required												
Net inflow/(Outflow)	2.2	(2.5)	(4.8)	(0.6)	(2.7)	(8.6)	7.0	(0.2)	0.3	(3.5)	(1.1)	0.9
Cash Balance	**27.3**	**24.8**	**20.0**	**19.3**	**16.6**	**8.1**	**15.0**	**14.9**	**15.2**	**11.7**	**10.6**	**11.6**

Moving into 2024/25 additional cash monitoring will be applied and early warning systems maintained in order to assess the ongoing viability of the capital programme and also to ensure the NHSE cash support process is ready if and when required.

The 90-day debtor total improved by £0.1m from March to April and now stands at £0.1m.

4. Areas of Risk

- Delivery of the Financial Recovery Plan.
- Financial implications of availability of funding to cover growth, cost pressures, new activity and handover delays.
- There could be unforeseen consequences on the organisation of remaining within control total.
- If the cash position deteriorates then it will impact the Trusts ability to fulfil its capital plan.

5. Recommendations

The Board is asked to note the finance position and corrective actions being undertaken to correct the run rate.

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Report Cover Sheet

Report Title:	Finance and Performance Committee Terms of Reference
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	17
Executive Summary:	The Finance & Performance Committee has been established as a formal Committee of the Board. Its purpose is to support the Board by providing scrutiny in respect of the delivery of financial and operational performance of the Trust, in accordance with the agreed strategy, plans and trajectories of the Trust. The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board. As part of the Board's annual review of governance, all Board Committees are required to review their Terms of Reference (ToR) and recommend any changes to the Trust Board of Directors for approval. A review of the Finance and Performance Committee ToR has taken place and the Committee is recommending these are approved by the Trust Board of Directors.
Recommendations:	The Board Committee is asked to: Approve the Finance and Performance Committee Terms of Reference.
Accountable Director: **Chair:**	Stuart Rees, Interim Director of Finance Les Broude, Non-Executive Director/ Senior Independent Director
Author:	Kofo Abayomi, Head of Corporate Governance & Compliance
Previously considered at:	Finance & Performance Committee

Purpose of Report:	Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	Publish the Terms of Reference.
List of Appendices	

Terms of Reference – Finance & Performance Committee

May 2024

Document Reference	To be assigned by
Document Status	Draft
Version	
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	
Initiated by	Date & Author(s)
Document Owner	Chief Governance Officer
Recommended at Date	Finance and Performance Committee 22 May 2024
Approved at Date	Board of Directors
Valid Until Date	
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Governance Assurance and Accountability Framework
Dissemination requirement	
Part of the Trust's publication scheme	

Finance & Performance Committee Terms of Reference – May 2024

1.0	**Constitution**
1.1	The South Central Ambulance Service NHS Foundation Trust Board hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee (The Committee).
1.2	The Committee is constituted as a Standing Committee of the Board and may only exercise delegated powers.
1.3	The Committee shall have a Terms of Reference and will ensure that the Board is able to act in accordance with legislation, compliance or direction requirements and to be fully appraised of the impact of finance and performance on the delivery of the Trust's strategic objectives.
1.4	Its constitution and Terms of Reference shall be as set out below; and will be subject to amendments approved by the Board.
2.0	**Purpose**
	The Finance & Performance Committee has been established as a formal Committee of the Board. Its purpose is to support the Board by providing scrutiny in respect of the delivery of financial and operational performance of the Trust, in accordance with the agreed strategy, plans and trajectories of the Trust. The overall responsibility to scrutinise the Trust's finances, estates, and digital matters and operational performance remains with the Board. The Committee is authorised by the Board to investigate any activity within its Terms of Reference and to request any information it requires in order for it to discharge its duties. The Committee is authorised by the Board to obtain external legal, or other independent professional advice, and may invite advisers to attend meetings, as appropriate. As part of an integrated approach, the Committee must have effective relationships with other Board Committees to avoid duplication and seek necessary assurance.
3.0	**Authority**
3.1	The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board.
3.2	The Committee is authorised by the Board to act within or investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
3.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to

	the carrying out of its functions. Any costs incurred must be within the remit of the Scheme of Delegation and Standing Financial Instructions.
3.4	The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
3.5	The Committee is authorised by the Board to liaise, as necessary, with other Committees of the Board and the Chairs of the Committees have a responsibility for ensuring that the Audit Committee and the Board are advised of any risks or potential conflicts.
3.6	It is not the duty of the Committee to carry out functions that properly belong to the Board itself or to other Board Committees.
3.7	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.8	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.9	The Board has determined that the Audit Committee will have responsibility for risk management, to gain assurance that appropriate systems of internal control are in place and are operating as intended, and that the Board Committee system is working appropriately. As such, the Audit Committee has overall responsibility for the Governance Assurance and Accountability Framework and will delegate any appropriate areas to this Committee as required.
4.0	**Duties and Responsibilities**
4.1	**Governance**
4.1.1	To ensure that all statutory and regulatory elements of financial governance are adhered to within the Trust.
4.1.2	To receive the monthly Financial management Report prior to receipt by the Board.
4.1.4	To oversee the Trust's financial, estates and digital policies and procedures
4.1.5	To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.
4.1.6	▪ To review the associated risks contained within the Board Assurance Framework and on the Corporate Risk Register relevant to this Committee ▪ To review Internal audit outcomes and subsequent management actions in relation to the duties and responsibilities of the Committee ▪ To receive Sub-Committee Chairs' reports (e.g. Estates, Digital, Transformation), as appropriate.
4.1.7	The role of the Finance & Performance Committee is to scrutinise and test the robustness of the Trust's finances, performance, estates and digital systems and to provide support to the Board for it to make effective and efficient decisions. The principal duties of the Committee are set out below:

5.2	**Finance**
5.2.1	▪ Oversee and evaluate the Trust's financial strategy ▪ Recommend the annual plan and budget to the Board ▪ Scrutinise proposed annual, three and five-year financial plans and make recommendations to the Board ▪ Recommend the annual Cost Improvement Plan to the Board for a decision ▪ Seek assurance on the delivery of financial performance ▪ Consider financial forecasts and recommend remedial action if necessary ▪ Review and monitor the effectiveness of the annual budget planning cycle ▪ Receive and review relevant NHS benchmarking reports ▪ Seek assurance on the financial position of the Trust including productivity, efficiency and savings plans ▪ Oversee the delivery of the financial sustainability plan ▪ Oversee the movement on reserve accounts, cash flow and balance sheet ▪ Monitor the delivery of capital expenditure plans, including digital infrastructure and the review of significant business cases ▪ Receive assurance on the delivery of the Capital Programme and the escalation of any risks identified and mitigating actions proposed ▪ Review the effectiveness of appropriate policies (including Standing Financial Instructions) within the Committee's remit ▪ Oversee the delivery and planning of the Cost Improvement Programme (CIP) and receive assurance on associated quality impact assessments and risk mitigations ▪ Maintain oversight of the Trust's approach to bidding for new business, via the Commercial strategy
5.3	**Performance**
5.3.1	▪ Review areas of operational performance through deep dives into areas of focus and concern related to the Integrated Performance Report (IPR). This will include reviewing issues and risks for corrective action ▪ Provide information, as appropriate, to other Board Committees on key trends and issues ▪ Seek assurance that the measures incorporated in the Integrated Performance Report to the Board meet both internal requirements and those of external stakeholders to ensure the delivery of safe and effective services
5.4	**Estates**
5.4.1	▪ Monitor progress against the delivery of the Estates Strategy and the associated delivery plan and receive regular reports including exceptions where progress is not in accordance with agreed plans

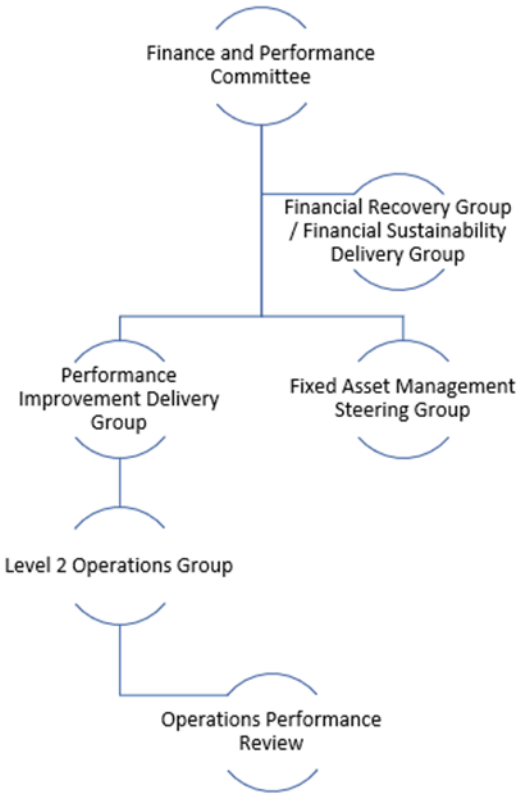
	▪ Monitor the progression of the achievement of the Trust's Estates and Environmental Sustainability Plan. ▪ Property & Asset Strategy: ensure that the strategy reflects the Trust's purpose, aims, strategic and corporate objectives and that the Trust's property and assets are developed and maintained to meet the needs of service models and are sustainable and achieve Value for Money. ▪ New Developments: oversee developments within the parameters set by the Scheme of Delegation ensuring that they are supported by affordable and deliverable Business Cases, with detailed project implementation plans that include key milestones for timely delivery, on budget, and to agreed standards. This will include reviewing all Initial Agreements, Outline Business Cases and Full Business Cases (as per limits indicated by the Scheme of Delegation) and recommend to the Board as appropriate.
5.5	**Digital**
5.5.1	▪ Monitor progress against the delivery of the Digital Strategy and the associated delivery plan and receive exception reports, as appropriate ▪ Consider any digital-related business cases prior to approval ▪ Receive assurance on the delivery of the Trust's digital services ▪ Receive assurance on the quality of data management across the Trust ▪ Receive updates on the demand for digital services and the prioritisation against available resources ▪ Review Management Information Strategy and Cyber Preparedness. ▪ Receive updates on work being undertaken with partner organisations across the ICS in relation to digital solutions
6.0	**Relationship with Audit Committee**
6.1	The Board has determined that the Audit Committee will have responsibility for risk management, to gain assurance that appropriate systems of internal control are in place and are operating as intended, and that the Board Committee system is working appropriately. As such the Audit Committee has overall responsibility for the Governance Assurance and Accountability Framework and will delegate any appropriate areas to this Committee as required.
7.0.	**Membership and Quorum**
7.1	The Committee membership shall be appointed by the Board from amongst both the Executive Directors and Non-Executive Directors and shall consist of not less than three Non-Executive Directors members, at least one of whom should have recent and relevant financial experience and two Executive members. One Non-Executive member will act as Chair of the Committee.

7.2	The Committee will consist of the following members: **Non-Executive Directors:** The Finance and Performance Committee shall consist of three Non-Executive Directors. **Executive Directors:** (or their appropriate Deputy) Chief Finance Officer Executive Director of Operations
7.3	Members are required to attend at least two thirds of the meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Secretary of the Committee in advance.
7.4	In the absence of the Committee chair, the remaining members present shall elect one of themselves to chair the meeting.
7.5	The Chair of the Board shall not normally be a member of the Committee. He/she will have automatic rights as a member of the Committee at times when the quorum cannot be met or vacancies at Non-Executive Director level warrant temporary Committee membership. The Chair of the Board may also attend at other times by advising the Committee Chair
7.6	The Committee will be deemed quorate to the extent that the following members are present: Two Non-Executive Directors and one Executive Director (ref 7.2). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.
7.7	For the avoidance of doubt, Trust employees who serve as members of the Finance and Performance Committee do not do so to represent or advocate for their respective department, division, or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.
7.8	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
8.0	**Attendance at Meetings**
8.1	Those required at each meeting: ▪ Chief Digital Officer ▪ Chief Strategy Officer ▪ Chief Governance Officer Those who may also attend:

	▪ Deputy Finance Officer ▪ Heads of Finance and Finance Managers ▪ Assistant Directors of Operations ▪ Head of Transformation ▪ Assistant Director of Digital ▪ Director of Estates ▪ Chair of the Board ▪ Chief Executive Officer
8.2	When an Executive Director, member or essential attendee is unable to attend a meeting, they should appoint a deputy to attend on their behalf.
8.3	Other Board Members, Executive Directors, officers and relevant representatives shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that individual.
9.0	**Meetings**
9.1	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework.
9.2	Meetings of the Finance and Performance Committee shall be held monthly, scheduled to support the business cycle of the Board and at such other times as the Committee Chair shall identify, subject to agreement with the Board Chair.
9.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
10.0	**Reporting and Accountability**
10.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
10.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.
10.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers outline the framework to be used for escalating an item from the Committee to the Board: i. Non-compliance with indicators for 2 consecutive months, or off track against agreed trajectory

	ii. Performance or finance risks scoring 15 or higher, with inadequate mitigating actions in place, or with actions overdue with no assured plan to resolve it iii. Variation of 10% from target or agreed trajectory iv. Variation from the year end projection v. CIP milestone non-delivery with no clear plan – red RAG rating.
10.4	The Committee shall be directly accountable to the Trust Board.
10.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.
10.6	The following Sub-Committees shall report to the Committee as the primary reporting line using the standard upward reporting template: ▪ Financial Recovery Group ▪ Financial Sustainability Delivery Group ▪ Performance Improvement Delivery Group ▪ Fixed Asset Management Steering Group ▪ Digital Steering Group
10.7	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
10.8	The Committee will report to the Audit Committee on the following areas for assurance: ▪ Work in support of the Annual Governance Statement, the Board Assurance Framework, the effectiveness of risk management within the Trust ▪ Strategic objectives aligned to this Committee ▪ BAF risks monitored by the Committee ▪ Assurances and effectiveness of the Committee
10.9	The Committee will liaise with the Quality & Safety Committee and People and Culture Committee in respect of the review of the Integrated Performance Report, where appropriate.
11.0	**Secretariat and Committee Support**
11.1	A member of the Governance Team will act as Secretary to the Committee. The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.
11.2	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers,

	iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.
12.0	**Review Monitoring and Effectiveness**
12.1	Members of the Committee will monitor the effectiveness of these Terms of Reference by: i) Recording the attendance of members and how often they send a representative. ii) Number and frequency of meetings in line with the Finance and Performance Terms of Reference as per section 9.2
12.2	The Trust's Annual Report shall include a section describing the work of the Finance and Performance Committee in discharging its responsibilities.
12.3	The Committee will report on an annual basis to the Audit Committee on its performance against its Terms of Reference and on an ad-hoc basis any risks which have inadequate assurance on performance.
12.4	The Chair of the Board will receive a copy of all meeting papers and will attend at least one meeting per annum for monitoring and assurance purposes.
12.5	The Committee will review its own performance, at least annually, review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
12.6	Set an annual Forward plan for its work to form part of the Board's annual Forward Plan and report to the Board on its progress.
13.0	**Strategies ratified and approved by this Committee**
13.1	Strategies: • Procurement Strategy • Contract Strategy • Financial Strategy • Performance/Operational Strategy • Estates Strategy • Green / Sustainability Strategy • Digital Strategy
14.0	**Policies ratified and approved by this Committee**
14.1	The Policies ratified by this committee are detailed in the Policy for the Development of Trust Policy.
15.0	**The Sub-Group structure supporting the flow of assurance to the Finance and Performance Committee**


Finance and Performance Committee
Financial Recovery Group / Financial Sustainability Delivery Group
Performance Improvement Delivery Group
Fixed Asset Management Steering Group
Level 2 Operations Group
Operations Performance Review

South Central Ambulance Service NHS Foundation Trust

UPWARD REPORT

Name of Committee reporting upwards:	Finance and Performance Committee
Date Committee met:	22 May 2024
Chair of Committee:	Les Broude, Non-Executive Director/ Senior Independent Director
Reporting to:	Board of Directors Meeting in Public 30 May 2024

1. Points for Escalation

- Following the recent planning meetings with HIOW ICB, the committee recommends the agreement to the system control total and the subsequent Trust control total, noting discussion are on-going on the precise number.
- The committee received the Financial Recovery Plan (FRP) Report and following discussion agreed the need to develop further monitoring for non-emergency patient transport services (NEPTS) financial recovery plan, with a follow-up on assurance at the next meeting. In addition, it was agreed that further regular control and monitoring measure will be introduced within NEPTS.

2. Key issues / business matters to raise

- The committee was presented with the:
  - High Wycombe Development Paper and agreed to the recommendation for approval at the Board.
  - Treasury and Cash Management Policy and agreed to the recommendation for approval at the Board.
- The Committee was taken through the Computer Aided Dispatch (CAD) Business Case, the committee recommended for approval at Board.

3. Areas of Concern and / or Risks

- The Committee along with the report, received presentations on Trust Month 1:
  - Operational Position, the committee requested an analysis of Category 3 and 4 Ambulance Calls to highlight the impact on patients and finances, within the current operating plan. The Committee also a requested to conduct a due diligence on Private Provider contract management,
  - Financial Position, the committee emphased the need for actions to address the current financial run rate, noting the areas of most concern.

4. Items for information / awareness

- The Committee was presented with the Term of reference (ToR) and agreed, with minor amendments, that these be recommended to the Board for approval.
- The committee noted and gained assurance on the progress of the Corporate Review and requested that, in line with the timescale, a report of the outcomes be presented at the next committee and the Board in June. The committee stressed the importance for the Trust to deliver to the level set out in the plan.
- The Committee noted the progress in the development of the Board Integrated Performance Report (IPR).
- The committee discussed the Digital Update Report and requested that a report on the revenue and capital implications, alongside the risks, is received at the next committee (June).

5. Best Practice / Excellence

- The committee was presented with the Action Log & Matters Arising and it noted the improvement in actions completion, which was recognised by the committee.
- The committee received the Fleet Update report and believed it brought the issues alive relating to the strains and complexities that have built up that are currently being faced. There was a request for a report to be presented at the July committee on measures to be introduced to create a compliant and sustainable fleet to put the foundations in place to aide the Trust plans going forward.
- The Committee requested that future Business Cases more clearly reflected, up front, key facts such as costs, benefits, impact on cash flow, risks, impact on staff/patients where appropriate etc, which need to be highlighted to Board and Committees.

6. Compliance with Terms of Reference

- The meeting was quorate for most of the committee and for all the items that needed decisions/approvals.

Author: Les Broude
Title: Non-Executive Director/ Senior Independent Director
Date: 22 May 2024

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Report Cover Sheet

Report Title:	End of year Report of the Charitable Funds Committee 2023-2024
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	19
Executive Summary:	The attached paper provides the end of year report of the work of the Charitable Funds Committee highlighting key areas of focus during the year.
Recommendations:	The Board is asked to: Note the contents of the report.
Accountable Director:	Mike Murphy, Chief Strategy Officer
Author:	Nigel Chapman, Non-Executive Director, Chair CFC
Previously considered at:	Not Applicable
Purpose of Report:	To approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** • **Significant** – High level of confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	Not Applicable
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	

Quality Domain(s)	Not Applicable
Next Steps:	
List of Appendices	Annual Activity Report for 2023-2024

Meeting Report

Name of Meeting	Trust Board of Directors in Public
Title	ANNUAL REPORT ON THE WORK OF THE CHARITABLE FUNDS COMMITTEE 2023-2024
Author	Nigel Chapman, Non-Executive Director, Chair CFC
Accountable Director	Mike Murphy, Chief Strategy Officer
Date	30 May 2024

Purpose

1 The Charitable Funds Committee has prepared its annual report for the 2023-2024 financial year for the attention of the Board. It sets out how the Committee has satisfied its Terms of Reference (ToR) during the year and provides the Board with information relating to its responsibilities.

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

3 The Charitable Funds Committee will produce a more detailed account of activity for the year to accompany the final accounts for the Charity to be submitted to the Charity Commission no later than 31 January 2025.

Overview

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

5 In particular it has sought to:

- Ensure that there is appropriate governance over the activities of the charity.
- Seek assurance that the application and investment of funds is in accordance with the spending priorities, criteria and scheme of delegation set by the Board.
- Confirm that the Charity acts in compliance with relevant legislation.
- Ensure that appropriate arrangements are maintained in respect of financial reporting, accounting and audit, and internal control systems.

- Monitor and review the integrity of the SCAS Charity Annual Financial Statements, including having them independently examined; recommending the Annual Financial Statements to the Board of Directors for approval and ensuring their subsequent submission to the Charity Commission in the required timescale.
- Take day-to-day decisions regarding the application and investment of charitable funds, in accordance with the framework set by the Board.

Key Issues

Membership

6 During 2023-2024 membership of the committee has comprised:

- Nigel Chapman, Non-Executive Director and Chair of the Committee
- Dhammika Perera, Non-Executive Director
- Mike McEnaney, Non-Executive Director

7 Staff required to be in attendance were:

- Mike Murphy, Chief Strategy Officer
- Aneel Pattni, Chief Financial Officer
- Stuart Rees, Interim Chief Financial Officer
- Vanessa Casey, Charity CEO
- Nic Dunbar, Head of Community Engagement and Training
- Andrea Blake, Charity Finance Manager (from January 2024)

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

9 The membership of the Committee changed in March 2023 with a review of Non-Executive responsibilities. The new Committee structure created in March 2023 has seen Mike McEnaney and Dhammika Perera join the CFC and Les Broude and Ian Green move to other Trust Committees.

Compliance with Terms of Reference (ToR)

10 During 2023-24 the Committee has operated in a manner compliant with its Terms of Reference, which were last reviewed in April 2024. In particular:

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

11 Attendance of members is set out below:

	Nigel Chapman	Mike McEnaney	Dhammika Perera	Mike Murphy	Aneel Pattni	Stuart Rees	Vanessa Casey	Nic Dunbar	Andrea Blake
April 12	√	√	√	√	√	-	√	-	-
July 12	√	√	√	√	-	√	√	√	-
September 6	√	√	x	√	-	√	√	-	-
October 11	√	√	√	√	-	-	√	√	-
January 10	√	x	√	x	-	√	√	-	√

12 The committee has fulfilled its objectives effectively. The Committee held one extraordinary meeting during the year on 6th September to discuss the report of the Independent Examiner with regard to the 2022-2023 Accounts.

13 Full committee meetings are supported by regular meetings between the Chair, the Chief Strategy Officer and the Charity CEO.

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

Work undertaken during the 2023-24 year

15 The Charity began the year with a reduction in its unrestricted reserves. Turning this round was a key priority to ensure future sustainability. The receipt of a significant legacy at the beginning of the year has enabled us to build up our reserves and hold cash in a high interest account.

16 Income has steadily picked up over the years since Covid. Community fundraising performed well in the year with some notable successful events such as the Mill Ride Golf Day in Ascot raising £11,122; Denmead Belles WI raising £3,300; Southern Co-op Stores raised £7,332; Outrun an Ambulance which raised £6,290.

17 Fundraising by our volunteer responders ended the year at £86,000. This exceeds the end of year income for 2020 and sees us back at pre-pandemic levels and is a great achievement. Supermarket collections again made a sizeable contribution of £10,370 with 30% of these donations made by contactless payment.

18 We have continued to seek a solution to the Charity's email and IT provision for volunteers and we are working with SCAS to resolve this. The Microsoft grant in place to give free licenses to our volunteer cohort will end in August 2024. Discussions are ongoing.

19 The development grant received from NHS Charities Together enabled us to begin working with Remarkable Partnerships to develop corporate fundraising as an income stream. This embryonic work has yet to realise its full potential and expected income has not been received during the year. There are however some promising leads and work will continue next year to work hard in this area, which is still expected to be a key area of growth.

20 Volunteers' week was celebrated in June with a series of drop-in sessions across the SCAS area. These sessions proved a valuable opportunity for volunteers to share stories and importantly for us to thank them for their valuable contribution all over a cup of tea and a piece of cake!

21 The Volunteer Database Assemble has continued to be embedded across our volunteers and staff and is now used for all volunteer recruitment, providing a simpler, accessible system benefitting applicants and managers a like. The next step will be to further develop the reporting functionality.

22 The Annual Volunteer conference took place on Saturday 7 October at the Ark in Basingstoke. Volunteers from all areas of SCAS joined together and were welcomed by Trust CEO David Eltringham. NEDs Nigel Chapman and Mike McEnaney attended and spoke.

23 The Volunteer Manager continues to work closely with AACE to develop and contribute to national volunteering strategies. In addition, the work with Helpforce on the Volunteer to Career grant was completed and we were successfully able to recruit volunteers to new roles in the CCC as well as help them to understand the future paid employment roles that could be available to them. They have also been working closely with our PTS volunteer car leads to support the recruitment and induction of new Volunteer Car Drivers (VCDs).

24 With the increasing complexity of income streams and the use of digital fundraising platforms along with continued restricted grant funding, the Charitable Funds Committee agreed the recruitment of a Charity Finance Manager. The postholder will be a part of the SCAS Finance team but operationally be a dedicated resource for the Charity. Andrea Blake, started her role in December 2023.

25 The Charity continues to prioritise funding for the vitally important Community First Responder service, working closely with the Community Engagement and Training Team. This year we have supported volunteers by funding:

- £115,000 for the lease costs and vehicle running costs of CFR DRVs
- £18,809 of new volunteer uniforms
- £73,500 of new equipment for our CFRs including the addition of a further 25 Zoll defibrillators to replace some our older G3 models.
- £33,000 for the line rental of the Smartphones in use by our Responders
- £22,000 of restricted grant expenditure was used to fund additional lifting cushions and chairs as well as training manikins for CFRs
- £60,000 for the GoodSAM responder app and integration in to the SCAS system.

26 The Charity has again supported the BASICs advanced pre-hospital care volunteers and was able to fund the purchase of their responder vehicle that was previously on loan. This has helped to secure their continued volunteer role across Hampshire.

27 Other internal grants were made to our Clinical Team Educators to fund additional training equipment for staff. Following on from the full body manikins purchased last year, we were able to add the Shocklink system to allow staff to use a 'live' Zoll in a simulated environment; difficult airway trainers to enable the practice of I-gel, endotracheal intubation and suction as well as chest trainers to allow staff to practice chest decompressions .

28 The Charity continued to support the Health and Wellbeing team with funds donated by NHS Charities Together enabling the recruitment of a 12-month Health and Wellbeing Coordinator for Commercial Services. We also funded additional TP Health practitioner hours to clear the backlog of initial assessments for staff. This enabled staff who needed support to access it without such a long wait time which was crucial for this cohort.

29 The primary activities of the SCAS Charitable Funds subcommittee in 2023-24 have been:

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

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

The Charity Risk Register is a standing item at Committee meetings and risk scores have been robustly challenged and adjusted during the changing economy and emerging opportunities to fundraise.

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

The Committee continues to review financial performance at each meeting and the delegated authorisation limits policy is in place to ensure appropriate protocols for charitable expenditure. The delegated authorisation limits were unchanged during the year. Due to the legacy received in year, the CFC discussed use of these funds and their ability to gain interest for the Charity in the short to medium term. The CFC agreed the movement of £1.2m of funds from the Charity's current account to a Lloyd's Bank treasury account. The account provides instant access to funds allowing a higher amount to be moved over to benefit from the 5.14% interest rate.

III. To take day-to-day decisions regarding application and investment of charitable funds, in accordance with the framework set by the Board

Through the review of the management accounts at each meeting, the Committee continues to ensure the appropriate balance of expenditure on Charitable Objectives. In 2023-2024 the end of year showed a surplus of £781,008 which was a positive variance of £382,858 on budget. Our income showed a positive variance of £343,931 at £1,597,631 and our

expenditure was £39,000 under budget at £816,623. Our surplus was substantially boosted by the legacy received but was also aided by better than expected income from individual giving and grants. The Charity moves forward with unrestricted reserves of £916,000 and restricted reserves of £270,000.

Our annual income is broken down as follows:

£1,214,020	Individual Giving
£ 135,367	Community Fundraising
£ 110,055	Grants
£ 29,063	Corporate Donations
£ 2,281	Gift Aid
£ 33,495	Investment income
£ 73,350	Other income

Expenditure is broken down as follows:

£ 16,389	Fundraising costs
£243,381	CFR Uniform, Equipment& Vehicles
£164,673	Restricted Grant/Project Expenditure
£ 58,251	Internal Staff grants
£ 5,018	Marketing & publicity
£219,631	Staff Salaries
£ 19,246	Volunteer Expenses and annual conference
£ 90,033	Database, legal and other costs

IV. Ensure that appropriate arrangements are maintained in respect of financial reporting, accounting and audit, and internal control systems.

The Harlequin CRM and accounting systems enable the Charity to record and report all income and expenditure accurately. All items are correctly coded according to their area of income or expenditure. Monthly management accounts are produced from Harlequin by the Charity Finance Manager and discussed at quarterly meetings. An internal audit was carried out last year and all actions have been satisfactorily addressed. The Charity will have a full audit for 2023-2024 and have appointed Wenn Townsend as their auditors. The audit is likely to be for only one year, as our income in 2024-2025 will fall back below £1m.

V. Confirm that the charity acts in compliance with relevant legislation.

The Charity CEO continues to monitor the legal and regulatory environment in which it operates, primarily Charity Commission regulation, the policies of the Fundraising

Regulator, Charity SORP and GDPR. The Charity CEO continues to introduce policies and procedures and to review processes.

VI. Monitor and review the integrity of the SCAS Charity Annual Financial Statements, including having them independently examined or audited; recommending the Annual Financial Statements to the Board of Directors for approval and ensuring their subsequent submission to the Charity Commission in the required format and in the required timescale.

The Committee has provided regular assurance reports to the Board of SCAS, (the Corporate Trustee) during the course of the year and approved the annual accounts for 2022-2023 at its meeting of 11th October 2023. These were recommended to the Board and accepted at the November Board meeting. The final management accounts for the financial year 2023-24 have been prepared and will be circulated to the committee for approval. The process to produce the end of year report and accounts has begun and the audit preparation work in progress.

Future plans

30 The Committee considers that it has met its terms of reference for 2023-2024.

31 The Committee has reviewed the budget for 2024-2025 and some reworking is needed prior to final sign off. The CFC continues to approve the Charity's strategic approach to ensure budget can be achieved.

32 The objectives for q1 and q2 of the year will be to:

- To sign off personnel changes in the Charity team to reflect an appropriate ratio of charitable expenditure versus salaries and overheads.
- To recruit a new Community Fundraiser to replace one of the two positions that have been lost.
- To sign off the budget for 2024-2025
- To complete the full audit in July and have the annual report and accounts available for sign off at the October CFC meeting and November Board meeting.
- To successfully launch the new internal grants programme to support staff equipment and projects.
- To successfully recruit additional patient transport volunteers
- To create and implement a growing community fundraising programme, capturing new and existing opportunities for community engagement.
- To continue to develop corporate partnerships and to finalise partnership agreements with two of our top prospects.
- To ensure the corporate defib awareness and CPR training programme thrives and continue to help build new relationships.
- To launch the extended reward and recognition programme for volunteers in Q2 with presentation of the awards at the Volunteer Conference in October.

- To ensure all volunteers have access to a SCAS or Charity email address and access to the SCAS hub.
- To continue to build our supporter base through targeted newsletters, press releases and social media.
- To continue supporting our volunteers with fundraising and engagement opportunities and to build on the success of last year's performance.
- To manage the Charity's financial position in line with the agreed budget for 2024-25.

Action Required	

33 The Board is asked to:

- Note the content of this report.

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Report Cover Sheet

Report Title:	Charitable Funds Committee Terms of Reference
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	20
Executive Summary:	The Charitable Funds Committee reviewed and revised the Terms of Reference at the meeting in April and are attached.
Recommendations:	The Board is asked to: Approve the contents of the report.
Accountable Director:	Mike Murphy, Chief Strategy Officer
Author:	Nigel Chapman, Non-Executive Director, Chair CFC
Previously considered at:	Charitable Funds Committee
Purpose of Report:	To approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** • **Significant** – High level of confidence in delivery of existing mechanisms/objectives
Justification of Assurance Rating:	Not Applicable
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	
Quality Domain(s)	Not Applicable

Next Steps:	Publish the Terms of Reference.
List of Appendices	Charitable Funds Committee Terms of Reference

Terms of Reference – Charitable Funds Committee

2024 - 2025

Document Reference	To be assigned by
Document Status	For approval
Version	
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	Annual update April 2024. Reviewed and agreed at Charitable Funds Committee and submitted for Board approval.
Initiated by	Charity CEO
Document Owner	Chief Governance Officer
Recommended at Date	Charitable Funds Committee 12.4.2024
Approved at Date	Board of Directors
Valid Until Date	1.4.2025
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Governance Assurance and Accountability Framework
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes

Charitable Funds Committee Terms of Reference – March 2024

1.0	**Constitution**
1.1	The South Central Ambulance Service (SCAS) NHS Trust Board hereby resolves to establish a Committee to be known as the Charitable Funds Committee of the Trust Board. The Trust Board is responsible for all the affairs and activities of the SCAS Charitable Trust (reg'd charity no 1049778), in its role as Corporate Trustee.
1.2	The Board has responsibility for setting the strategic direction of the SCAS Charitable Trust. This will include establishing and agreeing an annual plan and budget for the charity (ensuring that there are clear aims and activities) and determining the spending priorities and criteria for the application of charitable funds.
1.3	The Board will receive and approve the Annual Financial Statements of the Charity and will authorise them for submission to the Charity Commission.
1.4	The Director of Strategy and Business Development and the SCAS Charity Chief Executive will be responsible for developing the strategy and recommending it to the Charitable Funds Committee who will then recommend the strategy to the Board for approval.
2.0	**Purpose**
2.1	The primary purpose of the Charitable Funds Committee will be to ensure that there is appropriate governance over the activities of the charity and the stewardship of the Charity's assets.
2.2	The committee will be responsible, with delegated authority from the Board, for:
2.2.1	Seeking assurance that the application and investment of funds is in accordance with the spending priorities, criteria and scheme of delegation set by the Board.
2.2.2	Confirming that the charity acts in compliance with relevant legislation.
2.2.3	Ensuring that appropriate arrangements are maintained in respect of financial reporting, accounting and audit, and internal control systems.

2.2.4	Monitoring and reviewing the integrity of the SCAS Charity Annual Financial Statements, including having them independently examined or audited; recommending the Annual Financial Statements to the Board of Directors for approval and ensuring their subsequent submission to the Charity Commission in the required format and within the required timescale.
2.2.5	Monitoring, reviewing and recommending annual plans and budgets and longer-term strategies as well as the use of funds and applications for funding to the SCAS Board for approval.
2.2.6	Taking some day-to-day decisions regarding application and investment of charitable funds, in accordance with the framework set by the Board (a delegated authority limit for expenditure will be set by the Board and all spending decisions taken by the Charitable Funds Committee should be reported back to the Board as part of an assurance report).
3.0	**Authority**
3.1	The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board.
3.2	The Committee is authorised by the Board to act within or investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
3.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. Any costs incurred must be within the remit of the Scheme of Delegation and Standing Financial Instructions.
3.4	The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
3.5	The Committee is authorised by the Board to liaise, as necessary, with other Committees of the Board and the Chairs of the Committees have a responsibility for ensuring that the Audit Committee and the Board are advised of any risks or potential conflicts.
3.6	It is not the duty of the Committee to carry out functions that properly belong to the Board itself or to other Board Committees.
3.7	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.8	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.9	The Board has determined that the Audit Committee will have overall responsibility for the Governance Assurance and Accountability Framework and will delegate any appropriate areas to this Committee as required.
4.0	**Duties and Responsibilities**

4.1	To ensure that there is appropriate governance over the activities of the charity.
4.2	The Committee's prime purpose will be to oversee delivery of the strategy agreed for the Charity by the Trust Board. Within agreed areas of delegated authority, the Committee will report to the Trust Board on matters arising from its meetings. At a minimum the Committee will provide reports to the Board after each meeting of the Committee. These regular reports will cover:
4.2.1	Progress on delivery of the agreed strategy.
4.2.2	Report on funds raised and disbursed within agreed levels of delegation.
4.2.3	Risks to the delivery of the agreed strategy, and mitigating actions proposed to address these.
4.2.4	New opportunities arising for development of the Charity that the Board may wish to act on.
4.2.5	The Committee will bring requests to approve disbursements from the Charity's funds that exceed agreed levels of delegation to the Board at the first opportunity The Committee will assure the Trust Audit Committee, as required and requested, that an effective system of governance, risk management and internal control is established and maintained for the SCAS Charitable Trust.
4.2.6	Reports to the Board will usually be through the upward report presented at the Board meeting in public. More detailed papers for discussion and approval will be usually be through the Board meeting in public except where there are issues of commercial sensitivity. In these cases, papers will be presented at a Board meeting in private.
5.0	**Membership, and Quorum**
5.1	The Committee membership shall be appointed by the Board from amongst the Non-Executive Directors and shall consist of a minimum of three Non-Executive Members of the Board. One Non-Executive member will act as Chair of the Committee.
5.2	The Committee will be attended by the Director of Business Development and Strategy and/or the Director of Finance; the SCAS Charity Chief Executive and the Deputy Director of Finance or an appropriate deputy and the Head of Community Engagement & Training.
5.3	The Trust's elected Community First Responder (CFR) Governor representative will be invited to attend all meetings of the Charitable Funds Committee in order to represent the views of SCAS CFRs on relevant SCAS Charity issues.

5.4	SCAS Governors are periodically invited to attend meetings as an observer. SCAS encourages Governors to attend sub-committee meetings as an observer to fully understand the decision-making process at this level and in order that the Trust can be fully transparent in decisions made below Board level. Attendance as an observer can also provide greater understanding and knowledge of different areas of the Trust.
5.5	Other officers of the Trust and/or Non-Executive Directors will be invited to attend for specific agenda items as required.
5.6	The Committee shall be quorate if two of the three NEDs who make up the committee are present.
5.7	The Chairman has the casting vote.
6.0	**Attendance**
6.1	When an Executive Director, member or essential attendee is unable to attend a meeting, they should appoint a deputy to attend on their behalf and inform the Chair in advance of the meeting.
6.2	Other Board Members, Executive Directors, officers and relevant representatives shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas that are the responsibility of that individual.
7.0	**Meetings**
7.1	The Charitable Trust Funds Committee will normally meet not less than three times in each financial year.
7.2	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework.
7.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
8.0	**Reporting and Accountability**
8.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
8.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.
8.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair

	shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action.
8.4	The Committee shall be directly accountable to the Trust Board.
8.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.
8.6	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
8.7	The Committee will report to the Audit Committee on its work in support of the Annual Governance Statement, the Board Assurance Framework, the effectiveness of risk management within the Trust.
9.0	**Secretary and Committee support**
9.1	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda with the Charity CEO for agreement with the Committee Chair, ii) collation and circulation of papers, iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.
9.2	The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.
10.0	**Review, monitoring and effectiveness**
10.1	The Committee will review its own effectiveness on an annual basis and will review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
10.2	The Trust's Annual Report shall include a section describing work of the Charity and reporting on the discharging of its responsibilities.
10.3	The Committee will report on an annual basis to the Audit Committee on its performance against its Terms of Reference and on an ad-hoc basis any risks which have inadequate assurance on performance.
10.4	The Chair of the Board will receive a copy of all meeting papers and will attend at least one meeting per annum for monitoring and assurance purposes.
11.0	**Scheme of Delegation**

11.1	Charity funds can be distributed according to the following scheme of delegation: Over £50k SCAS Board Over £10k Charitable Funds Committee Up to £10k Chief Strategy Officer Up to £5k CEO of Charity Up to £2.5k Head of Community Engagement and Training Up to £1.5k CET Operations Managers & Volunteer Manager Up to £250 Community Engagement & Training Officers

Upward Report of the Charitable Funds Committee

Date Meeting met **30 May 2024**
Chair of Meeting **Nigel Chapman, NED**
Reporting to **Board of Directors Meeting in Public**

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
Charitable Funds Committee – Terms of Reference	The CFC Terms of Reference are discussed and revised annually. The TOR were reviewed at the CFC meeting on 11 April and are attached for Board approval.	**Charity CEO**	
Financial Update & Compliance with Reserves Policy	The end of year accounts show a total income of £1,597,631 and total expenditure of £816,623. The end of year surplus of £781,008 was £383,858 ahead of plan. The surplus position was driven by the significant legacy received in year but individual giving and grant both ending the year ahead of plan.	**Charity Finance Manager**	

	In particular we would like to note that CFR fundraising has risen above pre-pandemic levels for the first time since 2020. A total of £86,401 was raised by our volunteers from a combination of community fundraising, corporate donations and grants. The reserves policy has been discussed and final revision agreed to maintain a stretch target going forward. The Charity will carry forward unrestricted reserves of £916,000 and restricted reserves of £270,000 into the 2024-25 financial year. Following further review and discussion Charity policies were amended and approved with the caveat that the Chief Digital Officer have final sign off for the privacy policy.	**Charity CEO** **Charity CEO**	Reports to each CFC meeting on the status of our reserves and ability to maintain a stretch target of £500,000 in unrestricted reserves. Privacy policy to be forwarded to the Chief Digital Officer for sign off. .
Audit options and appointment	With the Charity's income passing the £1m threshold, a full audit is now a regulatory requirement. The Committee were presented with five potential accounting firms with whom the Charity CEO and Finance Manager had met and reviewed. The CFC decided they will appoint Wenn Townsend as the Charity's auditors following receipt of satisfactory references. The audit will begin w/c 15 July.	**Charity Finance Manager**	Sourced references for Wenn Townsend from other Charity clients all of which were very positive.
Volunteer Recruitment & Retention	Q4 saw our total number of volunteers at 877. We recruited 69 new volunteers made up of 57 new responders; 7 patient transport volunteers and 5 patient panel volunteers.	**Volunteer Manager**	We are developing the reporting side of Assemble to enable us to further report on volunteer statistics.

	A total of 53 new opportunities were published and 93 applications received. The new volunteer expenses policy will be trialled by one Hampshire scheme in Q1 and will see the process carried out through Assemble. This will reduce admin time for the processing of expenses Changes to E-learning for volunteers are being explored as SCAS's requirements are not inline with other ambulance trusts or AACE / NHSE requirements. We are in discussions to see if volunteer e-learning can be reduced from the 20 hours currently mandated which is impacting recruitment. We are also looking to see whether areas covered face to face in volunteer induction and initial training can be accepted.	**Volunteer Manager / East Hants CETO** **Volunteer Manager / SCAS HR/SCAS Education**	
Overview of Charity Developments	The major legacy has now all been received and we have £1.2m in a high interest treasury account. This is the legacy plus some surplus funds held in our current account. The Charity's current account is now held at a much lower level that is sufficient for everyday business. The savings account has immediate access whilst still generating 5.14% interest. These funds will allow us to set up and start the new internal grants programme which was launched to staff in April.	**Charity CEO**	

	Our Charity day on 24 April enabled us to promote grant funding to staff and we have begun to receive applications. The spring grant round will close on 30 June. We have had some significant fundraisers for us recently running the London Marathon, an ultra marathon (49km) by a former patient and a CFR challenge in January. These challenges have successfully boosted our end of year and new year community fundraising income. CFR Andy Long in Oxfordshire was presented with a High Sheriff Community award from the High Sheriff of Oxfordshire.		
2024-2025 draft budget	The Charity's 2024-2025 budgetwas discussed. It showed significant deficit as per strategic plan, to allow for continued restricted grant expenditure for which income has been received in previous years, as well as the internal grant programme. The budget deficit was however, higher than strategy and is therefore being revised to reduce overhead costs and ensure a better charitable expenditure to overhead cost ratio. The revised budget will be submitted for agreement at the next CFC.	**Charity CEO**	Revised budget for 2024-2025 will be submitted to CFC for approval.
Charity Risk Register			
Areas of concern and / or Risks			

	Corporate fundraising has not achieved its targets and the ROI expected for this area of work has fallen below an acceptable level.	**CFC / Charity CEO**	CFC and Charity CEO met in private session to discuss a review of this area and to agree next steps.
	Link between Trust Risk Register and Charity risk register to be reviewed	**Charity CEO / Head of Risk Management**	Meeting organised to review.
Items for information and / or awareness			
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 were signed off at the CFC meeting in April.		

***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: 10 May 2024

NHS
South Central Ambulance Service
NHS Foundation Trust

Report Cover Sheet

Report Title:	Audit Committee Terms of Reference
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	22
Executive Summary:	The Audit Committee Terms of Reference has been established as a formal Committee of the Board. Its purpose of the Committee is to provide the Board with a means of independent and objective review of financial, legal, regulatory and corporate governance, internal control, assurance processes and risk management across the whole of the Trust's activities to ensure compliance. The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board. As part of the Board's annual review of governance, all Board Committees are required to review their Terms of Reference (ToR) and recommend any changes to the Trust Board of Directors for approval. A review of the Audit Committee ToR has taken place and the Committee is recommending these are approved by the Trust Board of Directors.
Recommendations:	The Board Committee is asked to: Approve the Audit Committee Terms of Reference.
Accountable Director: **Chair:**	Stuart Rees, Interim Director of Finance Mike McEnaney, Non-Executive Director
Author:	Kofo Abayomi, Head of Corporate Governance & Compliance
Previously considered at:	Audit Committee

Purpose of Report:	Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	Publish the Terms of Reference.
List of Appendices	

Terms of Reference – Audit Committee

March 2024

Document Reference	To be assigned by
Document Status	Draft
Version	
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	
Initiated by	Date & Author(s)
Document Owner	Chief Governance Officer
Recommended at Date	
Approved at Date	Board of Directors
Valid Until Date	
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Governance Assurance and Accountability Framework
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes

Audit Committee Terms of Reference 2023 – 24

1.0	**Constitution**
1.1	The South Central Ambulance NHS Trust Board hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee (The Committee).
1.2	The Code of Conduct and Accountability for Trust Boards sets out that it is a requirement for every NHS Board to establish an Audit Committee to provide an effective and independent check on internal control arrangements. The Board has therefore established a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is a Non-Executive Committee of the Board and does not have any executive powers, other than those specifically delegated in these Terms of Reference.
1.3	The Committee is constituted as a Standing Committee of the Board.
1.4	The functioning of the Audit Committee will take into account the NHS Foundation Trust Code of Governance and other relevant good/best practice; for example, external, independent well-led reviews.
1.5	Its constitution and Terms of Reference shall be as set out below; and will be subject to amendments approved by the Board.
2.0	**Purpose**
2.1	The purpose of the Committee is to provide the Board with a means of independent and objective review of financial, legal, regulatory and corporate governance, internal control, assurance processes and risk management across the whole of the Trust's activities to ensure compliance.
2.2	The responsibilities of the Committee are as follows: i. Ensure that management of the Trust's activities are in accordance with statute and regulations. ii. Ensure the establishment and maintenance of a system of internal control to give assurance that assets are safeguarded, waste or inefficiency avoided, and reliable financial information produced, and that value for money is continuously sought. iii. Provide assurance of independence for external and internal audit iv. Scrutinise the findings of completed audit reports and oversee the delivery of remedial actions. v. Ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the Audit Committee. vi. Ensure that the Trust's systems of governance and risk management are effective and adhered to (e.g. compliance with the Codes of Conduct, Standing Orders, Standing Financial Instructions, maintenance of Registers of Interests).
3.0	**Authority**
3.1	The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board.

3.2	The Committee is authorised by the Board to act within or investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
3.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. Any costs incurred must be within the remit of the Scheme of Delegation and Standing Financial Instructions.
3.4	The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
3.5	The Committee is authorised by the Board to liaise, as necessary, with other Committees of the Board and Chairs of the Committees and have a responsibility for ensuring that the Audit Committee and the Board are advised of any risks, concerns or transgressions.
3.6	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.7	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.8	The Board has determined that the Audit Committee will have an oversight role for all risks, to gain assurance that appropriate systems of internal control are in place and are operating as intended, and that the Board Committee system is working appropriately.
4.0	**Duties and Responsibilities**
4.1	**Governance, Risk Management and Internal Control**
4.1.1	The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that support the achievement of the organisation's objectives. In particular, the Committee will review the adequacy of: i. All risk and control related disclosure statements, in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission Essential Standards, together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. ii. The underlying assurance processes (Board Assurance Framework and Risk Register) that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. iii. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements including the NHS Provider License. iv. The policies and procedures for all work related to fraud and

	corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud and Security Management Service. v. Compliance with Trust Standing Orders and Standing Financial Instructions. vi. The internal controls in place in any subsidiary company of the NHS Foundation Trust (e.g. South Central Fleet Services Limited) vii. The governance arrangements and internal controls in place in the NHS Foundation Trust's Charity. viii. Monitoring and scrutinising the approved risk management framework to ensure that Trust policies, systems and processes are effective in the management of all risks within the Trust and escalating risk management issues appropriately. This should include routine deep dives into specific risk register areas in order to gain assurance on the risk management process. ix. Considering the resource implications for risk control and advising the Board accordingly. x. Monitor the work of the Executive Leadership Team with regard to the finance, governance and mandatory services which form the core of the Trust's business and with regard to the identification, analysis and mitigation of risk and provide independent assurance on both of these areas to the Board. xi. The Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern via the Freedom to Speak Up and other related processes. xii. The accuracy of the data behind the reports received by the Committee and Board to gain assurance of robustness and quality. In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other Board committees, executive directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Board Assurance Framework to guide its work and that of the audit and assurance functions that report to it as well as the reference to the Trust's Risk Register. The Committee shall review every decision of the Board to suspend any one or more of the Trust's Standing Orders.

4.2	**Internal Audit**
4.2.1	The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board. This will be achieved by: i. Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal (including involvement in the selection process when/if a provider is changed). ii. Review and approve the Internal Audit strategy, operational plan, reporting system, and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation. iii. Consideration of the major findings of internal audit work (and management's response), and their implications and monitor progress on the implementation of recommendations. iv. Ensuring, on an on-going basis, the effective operation of internal audit in respect of: a) Its co-ordination with external audit. b) Meeting mandatory NHS Internal Audit Standards. c) Providing adequate independent assurances. d) Having appropriate standing within the Trust. e) Ensuring the management actions are executed to the required deadlines. f) Meeting the internal audit needs of the Trust. g) Receiving and considering the annual internal audit report and Head of Internal Audit opinion statement. h) Ensure that the Internal Audit function is suitably qualified, adequately resourced and has appropriate standing within the organisation. i) An annual review of the effectiveness of internal audit.
4.3	**External Audit**
4.3.1	The Committee shall review the work and findings of the External Auditor appointed by the Trust and consider the implications and management's responses to its work. This will be achieved by: i. Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit. ii. Discussion and agreement with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan and ensure coordination as appropriate with other External Auditors in the local health economy. iii. Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee. iv. Review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter

	before submission to the Board and any work undertaken outside the annual audit plan together with the appropriateness of management response and monitor progress on the implementation of recommendations. v. Develop and implement a policy on the engagement of the eternal auditor to supply non-audit services. In relation to the appointment of the External Auditor, which is a statutory duty of the Trust's Governors; the Audit Committee will work with the Council of Governors to establish the criteria for appointing, re-appointing and removing external auditors.
4.4	**Financial Reporting**
	The Committee shall review the Annual Report and Accounts (ARA) before submission to the Board to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to: i. The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee. ii. Changes in, and compliance with accounting policies, practices and estimation techniques. iii. Unadjusted mis-statements in the financial statements. iv. Significant judgements in preparation of the accounts. v. Significant adjustments resulting from the audit. vi. Letter of Representation. vii. Qualitative aspects of financial reporting. viii. The schedule of losses and special payments. ix. Any reservations and disagreements between the External Auditors and management which have not been satisfactorily resolved. x. Schedules of debtor/creditor balances where material sums are involved or balances are more than six months old. xi. Major judgemental areas (including waiver of competitive tendering).
4.4.1	Annually review the accounting policies of the Trust and make appropriate recommendations to the Board.
4.4.2	Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.
4.5	**Counter Fraud**
4.5.1	Ensure the appointment of the Local Counter Fraud Service provider. Ensure that the provider is adequately qualified, resourced and has appropriate standing within the Trust.
4.5.2	The Committee will receive an update of Counter Fraud activity at each meeting and receive assurances on effectiveness of the service. The Committee approves the Annual Work Plan at the start of the year and also receives an Annual Report of activity. The LCFS will attend alternate meetings and provide a progress report. The Chief Finance Officer will give a verbal update at meetings where the LCFS is not in attendance.

4.5.3	Monitor the performance of both reactive and proactive fraud work in line with the terms of the Standard NHS Contract and in accordance with the NHS Counter Fraud Authority (NHSCFA) Standards for Providers: Fraud, Bribery and Corruption, to ensure that appropriate counter fraud measures are in place. Review the reports from the Counter Fraud service provision, consider the major findings of fraud investigations, and management's response, and ensure co-ordination between the LCFS, internal and external auditors.
4.5.4	Consider the annual report of the Trust to the NHS Counter Fraud Authority. Consider and take appropriate action regarding any NHSCFA quality assurance recommendations arising from the assessment process.
4.6	**Other Assurance Functions**
4.6.1	The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by relevant NHS bodies or Regulators/Inspectors (e.g. NHS England, Care Quality Commission, NHS Resolution etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).
4.6.2	The Committee will review items referred to it and the work of other Committees within the organisation and whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular the Audit Committee will rely on the assurance provided by other Committees in respect of specific sections of the Board Assurance Framework. This will particularly include the Quality and Safety Committee, People and Culture Committee, Finance and Performance Committee, Fixed Asset Management Strategy Group and the Risk, Assurance and Compliance Sub-Committee. In terms of the latter, the Audit Committee will receive a report and/or minutes from the Risk, Assurance and Compliance Sub-Committee as part of its process of seeking assurance over the Executive's management of risk.
4.6.3	In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will seek to satisfy itself on the assurance that can be gained from the clinical audit function. In particular, the Audit Committee will seek assurance that effective and robust clinical audit arrangements are in place for the Trust.
4.6.4	The Committee will review issues around the management of charitable funds and will seek to satisfy itself on the assurance that can be gained from the Charitable Funds Annual Report and Financial Statements before submission to the Board.
4.6.5	The Committee will: i. Examine any other matter referred to the Committee by the Board and to initiate investigation as determined by the Committee.

	ii. On behalf of the Board seek assurance on the appointment of outside contractors for financial services e.g. Internal Audit, Banking, Payroll Services, and procurement compliance matters e.g. Single Tender Waivers. etc
4.7	**Management**
4.7.1	The Committee shall request and review reports and assurances from relevant Directors and Managers on the overall arrangements for governance, policy management, risk management and internal control, including regular updates on the Trust's Assurance Framework and Risk Register. The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.
4.8	**Standing Orders, Standing Financial Instructions, Governance Assurance and Accountability Framework and Standards of Business Conduct**
4.8.1	Review all suspensions of Standing Orders and variation or amendment to Standing Orders.
4.8.2	Review, on behalf of the Trust Board, the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, Governance Assurance and Accountability Framework, Codes of Conduct and Standards of Business Conduct; including maintenance of Registers.
4.8.3	Examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.
4.8.4	Review the Reservation of Powers to the Board and Delegation of Powers
4.9	**Information Governance**
4.9.1	Ensure an effective IG management framework and policies are in place and that assure compliance.
4.10	**Freedom to Speak Up**
4.10.1	The Audit Committee will review the arrangements by which staff and volunteers of the Trust may raise, in confidence, concerns about possible improprieties in matters relating to: ▪ Financial reporting and control ▪ Clinical quality ▪ Patient safety ▪ Staff experience ▪ Other matters The Committee will ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow up action.
4.11	**Other Matters**
4.11.1	On an annual basis, the Committee will review its own effectiveness by reference to the NHS Audit Committee Handbook (latest version – 2018) and the Monitor (now NHS Improvement) Code of Governance.

	These terms of reference should be reviewed annually and will be made publicly available in accordance with the NHS Foundation Trust Code of Governance.
5.0	**Membership and Quoracy**
5.1	The Committee membership shall be appointed by the Board from amongst the Non-Executive Directors and shall consist of not less than three designated members, In line with the Foundation Trust Code of Governance, the Board will satisfy itself that the membership of the Audit Committee has sufficient skills to discharge its responsibilities effectively, including ensuring that at least one member of the Audit Committee has recent and relevant financial experience.
5.2	The Committee will consist of the following members: **Non-Executive Directors:** Three Non-Executive Directors. One of the members will also be a member of the Trust's Quality and Safety Committee, in order to reinforce the relationship between the two committees in respect of seeking assurance over the management of risk and other relevant control issues.
5.3	Members are required to attend at least two thirds of the meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Secretary of the Committee in advance.
5.4	In the absence of the Committee Chair, the remaining members present shall elect one of themselves to chair the meeting.
5.5	The Chair of the Board shall not be a member of the Committee.
5.6	The Committee will be deemed quorate to the extent that the following members are present: Two Non-Executive Directors (ref 5.2). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.
5.8	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
6.0	**Attendance at Meetings**
6.1	Those required at each meeting: ▪ Chief Finance Officer ▪ Chief Governance Officer ▪ External audit provider lead

	▪ Internal audit provider lead ▪ Counter Fraud provider lead Those who may also attend with the committee chair's agreement: ▪ Any Executive or Non-Executive Director ▪ A Governor, or Governors, may also attend and observe a meeting of the Committee, by invitation and with the prior agreement of the Committee Chair, for the purposes of further developing their understanding of SCAS and the NED role. ▪ For clarity, those in attendance are not members of the Committee for the purposes of quorum or decision-making however are expected and welcome to play a full and active part in Committee discussions and considerations. ▪ The Committee may invite other colleagues to be in attendance or attend as appropriate for timed business to provide assurance on key issues. ▪ The Chair of the committee can require the attendance of any director or member of staff.
6.2	When one of those required to attend is unable to attend a meeting, they should appoint a deputy to attend on their behalf.
6.3	Other Board Members, Executive Directors, officers and relevant representatives shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that individual.
7.0	**Meetings**
7.1	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework.
7.2	Ordinary meetings of the Audit Committee shall be held not less than four times a year. Additional meetings may be held; for example, for the purposes of reviewing the draft and audited annual financial accounts. The External Auditor or Head of Internal Audit may request a further meeting if considered necessary.
7.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
8.0	**Reporting and Accountability**
8.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
8.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.

8.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers outline the framework to be used for escalating an item from the Committee to the Board: i) Risks scoring 15 or higher on the Corporate Risk Register that have inadequate mitigating actions in place, or with actions overdue with no assured plan to resolve them. ii) Internal controls that are inadequate and which require strengthening. iii) Any qualified opinion from the External Auditors. iv) Outstanding actions and Limited Assurance arising from any Internal Audit. v) Losses that will have a significant impact upon the Trust. vi) Deviation from information governance compliance targets. vii) Performance of out-of-date policies. viii) Fraud and Anti-Bribery.
8.4	The Committee shall be directly accountable to the Trust Board.
8.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.
8.6	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
9.0	**Secretary and Committee Support**
9.1	A member of the Governance Team will act as Secretary to the Committee. The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.
9.2	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers, iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.

10.0	**Review, Monitoring and Effectiveness**
10.1	Members of the Committee will monitor the effectiveness of these Terms of Reference by: i) Recording the attendance of members. ii) Number and frequency of meetings in line with the Audit Committee Terms of Reference.
10.2	The Trust's Annual Report shall include a section describing the work of the Audit Committee in discharging its responsibilities.
10.3	The Committee will report on an annual basis to the Board on its performance against its Terms of Reference and on an ad-hoc basis any risks which have inadequate assurance on performance.
10.4	The Chair of the Board will receive a copy of all meeting papers.
10.5	The Committee will review its own performance, at least annually, review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
10.6	The Committee shall review its Terms of Reference annually, to be reviewed by the Board recommending any changes to the Board, as appropriate.
10.7	Set an annual Forward plan for its work to form part of the Board's annual Forward Plan and report to the Board on its progress.
10.8	The Committee shall be directly accountable to the Board.
10.9	The Chair of the Committee will produce an Annual Report to the Board on the work of the Committee in its fulfilment of its functions in connection with these terms of reference. The report will support the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission Essential Standards and any pertinent matters in respect of which the Audit Committee has been engaged.
10.10	Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England, via the Director of Finance in the first instance.
10.11	The Audit Committee will report to the Council of Governors (CoG) by exception, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken. The CoG will also have the opportunity to hear from External Audit (i.e. annually) as part of their formal statutory duty of appointing/reappointing the Trust's External Auditors.

Report Cover Sheet

Report Title:	People and Culture Committee Terms of Reference
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	24
Executive Summary:	The purpose of the Committee is to provide assurance to the Board on all aspects of the quality and impact of people (including staff, volunteers and trainees), culture, organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning and employee culture, equality, diversity, and inclusion, and speaking up. To include education supporting the provision of safe, high quality, patient-centered care and support the delivery of the Trust People Strategy and associated delivery plans. As part of the Board's annual review of governance, all Board Committees are required to review their Terms of Reference (ToR) and recommend any changes to the Trust Board of Directors for approval. A review of the People and Culture Committee ToR has taken place and the Committee is recommending these are approved by the Trust Board of Directors.
Recommendations:	The Board Committee is asked to: Approve the People and Culture Committee Terms of Reference.
Accountable Director: **Chair:**	Melanie Saunders, Chief People Officer Ian Green, Non-Executive Director
Author:	Kofo Abayomi, Head of Corporate Governance & Compliance

Previously considered at:	People and Culture Committee
Purpose of Report:	Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	Publish the Terms of Reference.
List of Appendices	

Terms of Reference – People and Culture Committee

May 2024

Document Reference	To be assigned by
Document Status	Draft
Version	
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	
Initiated by	Date & Author(s)
Document Owner	Chief Governance Officer
Recommended at Date	
Approved at Date	Board of Directors
Valid Until Date	
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Governance Assurance and Accountability Framework
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes

People and Culture Committee Terms of Reference 2024

1.0	**Constitution**
1.1	The South Central Ambulance NHS FT Trust Board hereby resolves to establish a Committee of the Trust Board (the Board) to be known as the People and Culture Committee (the Committee).
1.2	The Committee is constituted as a Standing Committee of the Board.
1.3	The Committee has no executive powers other than those specifically delegated by the Board in these terms of reference.
1.4	The Committee shall have Terms of Reference and powers and will ensure that the Board is able to act in accordance with legislation, compliance or direction requirements.
1.5	Its constitution and Terms of Reference shall be as set out below; and will be subject to amendments approved by the Board.
2.0	**Purpose**
2.1	The purpose of the Committee is to provide assurance to the Board on all aspects of the quality and impact of people (including staff, volunteers and trainees), culture, organisational development strategies and the effectiveness of people management in the Trust. This includes but is not limited to recruitment and retention, training, appraisals, employee health and wellbeing, learning and development, employee engagement, reward and recognition, organisational development, leadership, workforce development, workforce spend and workforce planning and employee culture, equality, diversity, and inclusion, and speaking up. To include education supporting the provision of safe, high quality, patient-centered care and support the delivery of the Trust People Strategy and associated delivery plans.
3.0	**Authority**
3.1	The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board.
3.2	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff must cooperate with any request made by the Committee.
3.3	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. Any costs incurred must be within the remit of the Scheme of Delegation and Standing Financial Instructions.
3.4	The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3.5	The Committee is authorised by the Board to liaise, as necessary, with other sub-committees of the Board and Chairs of the formal sub-committees, have a responsibility for ensuring that the Audit Committee and the Board are advised of any risks or potential conflicts.
3.6	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.7	It is not the duty of the Committee to carry out functions that properly belong to the Board itself or to other Board Committees.
3.8	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.9	The Board has determined that the Audit Committee will have responsibility for risk management, to gain assurance that appropriate systems of internal control are in place and are operating as intended, and that the Board Committee system is working appropriately. As such the Audit Committee has overall responsibility for the Governance Assurance and Accountability Framework and will delegate any appropriate areas to this Committee as required.
3.10	The Board has determined that the Committee ensures that the Trust works collaboratively with relevant external statutory bodies in line with national legislation and implements appropriate guidance and requirements e.g. Health and Safety Executive, Equality and Human Rights Commission (EHRC), Health Education England and OFSTED.
3.11	To request specific reports from individual functions within the Trust.
3.12	Obtain such internal and external benchmarking information as is necessary and expedient to its functions.
4.0	**Duties and Responsibilities**
4.1	**Governance**
4.1.1	To ensure that all statutory and regulatory elements of workforce governance are adhered to within the Trust.
4.1.2	To approve the Trust's annual Gender Pay Gap (GPG), Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports before submission to the Board.
4.1.3	To make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference.
4.1.4	Review people related elements of the Integrated Performance Report and seek assurance on the adequacy of the Trust's performance against operational people metrics and seek assurance around any performance issues identified, including proposed corrective actions.
4.2	**Performance and Workforce Planning**
4.2.1	Provide oversight of the Trust's strategic workforce plan, taking into account local, regional and national policies and/or directions, and receive assurance on its implementation with regards safety, affordability, career progression, leadership models and succession planning.

4.2.2	Scrutinise the medium to long-term implications of the integrated care system on the trust's workforce and any relevant policies from Health Education England, and ensure effective plans are in place to respond to any changes that are clear, fair and legally compliant.
4.2.3	Oversee the strategic priorities and investments needed to support the Trust's people and assure the Board accordingly taking into account relevant best practice and alignment with strategic objectives for the Trust.
4.2.4	Oversee the Trust's overarching People Strategy and associated activity/implementation plan to support Trust strategy and relevance to the Trust's vision, values, strategic objectives and impact.
4.2.5	Monitor, review and approve people-related policies to ensure they will positively enhance the Trust's culture and receive assurance on their implementation timeliness, fairness, integrity and consistency.
4.2.6	The Committee will ensure that there are robust policies, systems and procedures to ensure delivery and monitoring of workforce planning, recruitment and retention of people to deliver our People Strategy
4.2.7	Ensure engagement and consultation processes with people and stakeholders reflect the ambition and values of the Trust and also meet statutory requirements.
4.2.8	Review the Trust's workforce performance indicators including but not limited to recruitment, attrition, sickness absence, training, appraisal, bank and agency usage and expenditure and monitor any necessary corrective plans and actions.
4.3	**Culture, Engagement and Health & Wellbeing**
4.3.1	Provide oversight of the Trust's People Strategy and associated delivery plans (e.g. People Voice, health and wellbeing, freedom to speak up, just and learning culture, EDI) and ensures that processes are in place to understand and improve staff experience.
4.3.2	Seek assurance of the establishment of a culture which promotes compassion, inclusion and collaboration, which in turn: ▪ Engages and motivates people to focus on doing their best for patients and each other ▪ Equips and supports the right and responsibility of all staff to speak up, listen and take action in the name of safety ▪ Builds respect, engagement and belonging across a diverse workforce ▪ Provides mechanisms to seek, understand and take action on feedback from all our people with the aim of shaping employee experience and patient-centred service delivery ▪ Enables learning and growth when things go wrong ▪ Identifies, celebrates and nurtures individual talent and potential for growth across our workforce
4.3.3	Receive regular People Voice and annual staff survey results and

	ensure appropriate plans are in place to address issues arising.
4.3.4	To ensure respectful, constructive and mutually beneficial relationships with union representatives and staff network leads are in place.
4.3.5	Ensure the health and wellbeing of our people continues to be held as a Trust priority and that the Trust's activities are systemically and effectively promoting health, safety and wellbeing.
4.3.6	Provide assurance to the Board that the Trust implements a working environment which consistently promotes staff wellbeing, where people feel safe and are able to raise concerns, and where bullying and harassment (incl sexual harassment) are visibly and effectively addressed.
4.3.7	Provide assurance to the Audit Committee that arrangements are in place to allow people to raise in confidence concerns about possible improprieties in financial, clinical or safety matters, and that those processes allow any such concerns to be investigated proportionately and independently.
4.4	**Skills, Capability and Education**
4.4.1	Provide oversight of the Trust's Education plans (including Apprenticeship and Driver training) and ensures that processes are in place to understand and improve student experience, career pathways and quality of patient care. Including but not limited to: ▪ Receive assurance on the implementation of personal development reviews and mandatory training. ▪ Receive assurance on the development of career pathways for all roles, linked to learning opportunities and apprenticeships. ▪ Receive assurance on the provision of high-quality professional under and post graduate education.
4.4.2	Encourage and influence key relationships with educational partners, research institutes and the Academic Health Science Network to maximise the benefit of these relationships to the Trust.
4.4.3	Ensure that the Trust has a comprehensive Leadership Framework programme in place to support all leaders, which is designed to reinforce the culture the Trust is seeking to achieve and will evaluate the effectiveness of the programme to inform further improvements.
4.4.4	Gain assurance from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians and other sources to ensure the Trust is a good place to work, learn and volunteer.
4.4.5	Oversee the Trust's current and future educational and training needs to ensure they support the strategic objectives of the Trust in the context of the wider health and care system.
4.5	**Equality and Inclusion**
4.5.1	Provide oversight of delivery of the Equality, Diversity and Inclusion Strategy on behalf of the Board, ensuring the Trust progress its

	ambitions and plans in relation to inclusive leadership, patient experience, employee representation, and engagement. Including, but not limited to: ▪ Receive assurance that the trust is meeting its legal obligations in relation to equality and diversity and delivers improvement activity as required. ▪ Receives assurance that the Trust is delivering its plans in respect of the Gender Pay Gap, WRES and WDES. ▪ Receives assurance that the Trust is delivering its equality objectives. ▪ Receives assurance that the Trust is addressing bullying & harassment, including sexual harassment both within the workplace and from service users and members of the public.
4.5.2	Oversee the continual development of an inclusive culture in which equality, diversity and inclusion is embedded into all of our people practices.
4.5.3	Maintaining oversight of the Trust's equality, diversity and inclusion agenda and plan.
4.5.4	Ensure the Trust is actively seeking to reduce inequalities in people experience and is promoting equality, diversity and inclusion in a systematic and effective way e.g Gender Pay, WRES, WDES etc
4.5.5	Consider key equality, diversity and inclusion metrics to support analysis of engagement and accessibility for all people.
4.6	**Compliance**
4.6.1	Seek assurance that the Trust is compliant with relevant legislation and regulations relating to people and education matters, for example professional registration and employment checks.
4.6.2	Seek assurance that appropriate action is taken to identify implications for the delivery of workforce, leadership and support plans arising out of recommendations from external investigations of other organisations/systems and processes and benchmarking against other appropriate organisations (eg CQC and/or Ofsted inspections).
4.6.3	Receive and review the findings of relevant internal and external audit reports covering people, education and training and staff engagement and to assure itself that recommendations and appropriately responded to and implemented in a timely and effective way.
4.6.4	To request 'deep dive' reports on any matters arising from within its terms of reference.
4.6.5	Provide assurance to the Board that the Trust has an appropriate pay, reward and recognition system that is linked to delivery of the Trust's

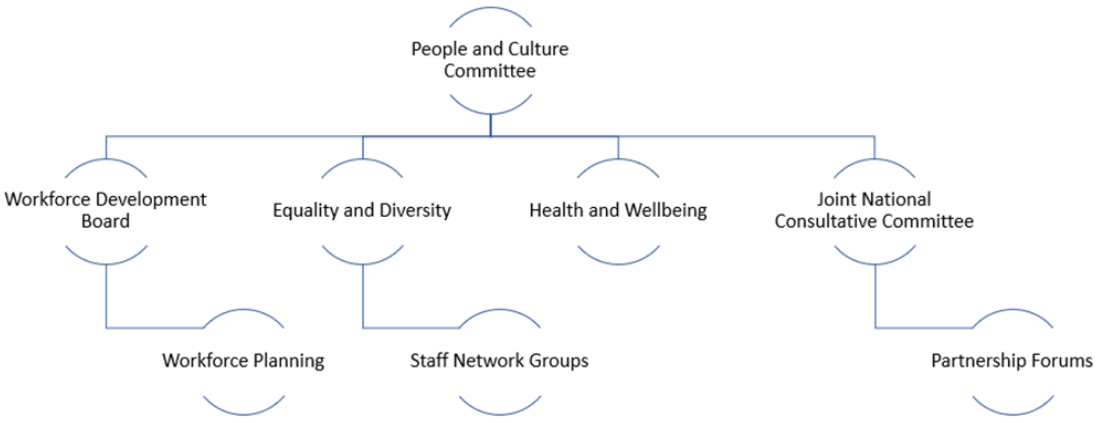
	strategic objectives, outcomes and desired behaviours and is in accordance with national requirements and standards.
4.6.6	Receive assurance reports with regard to professional misconduct, tribunals and offences, including information on strategic themes relating to employment relations and terms of service.
5.0	**Membership and Quorum**
5.1	The Committee membership shall be appointed by the Board from amongst both the Executive Directors and Non-Executive Directors and shall consist of not less than three Non-Executive Directors members, One Non-Executive member will act as Chair of the Committee.
	The Committee will consist of the following members: Non-Executive Directors: The People and Culture Committee shall consist of three Non-Executive Directors. Executive Directors: (or their appropriate Deputy) Chief People Officer Chief Nurse Officer Executive Director of Operations
5.2	In line with the Foundation Trust Code of Governance, the Board will satisfy itself that the membership of the Committee has sufficient skills to discharge its responsibilities effectively, and as such the Trusts nominated NED for Freedom to Speak UP Guardian and the NED for Health and Wellbeing Guardian will be members.
5.3	Members are required to attend at least two thirds of the meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Secretary of the Committee in advance.
5.4	In the absence of the Committee Chair, the remaining members present shall elect one of themselves to chair the meeting.
5.5	The Chair of the Trust shall not normally be a member of the Committee but will attend meetings periodically in order to seek assurance that the committee is operating effectively and will have automatic rights as a member of the Committee at times when the quorum cannot be met or vacancies at Non-Executive Director level warrant temporary Committee membership.
5.6	The Committee will be deemed quorate to the extent that the following members are present: Two Non-Executive Directors and one Executive Director or their appropriate Deputy (ref 5.2). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.

5.7	For the avoidance of doubt, Trust employees who serve as members of the People and Culture Committee do not do so to represent or advocate for their respective department, division, or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.
5.8	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
5.9	One of the members of the committee will also be a member of the Trust's Quality and Safety Committee, in order to reinforce the relationship between the two Committees in respect of seeking assurance over the management of associated risk, quality and other relevant control issues. That member shall ensure that relevant issues considered by the People and Culture Committee will also be escalated to the Quality and Safety Committee, and vice- versa.
6.0	**Attendance at Meetings**
6.1	Those required at each meeting: ▪ ▪ Freedom to Speak up Guardian ▪ Head of Equality, Diversity and Inclusion ▪ Assistant Director of OD ▪ Assistant Director of HR ▪ Assistant Director of Education Those who may also attend: ▪ Chief Executive Officer ▪ Chief Medical Officer ▪ Chief Governance Officer ▪ Chief Strategy Officer ▪ Head of Health and Safety ▪ A Governor, or Governors, may also attend and observe a meeting of the Committee, by invitation and with the prior agreement of the Committee Chair, for the purposes of further developing their understanding of SCAS and the NED role. ▪ For clarity, those in attendance are not members of the Committee for the purposes of quorum or decision-making however are expected and welcome to play a full and active part in Committee discussions and considerations. ▪ The Committee may invite other colleagues, such as Union and Staffside representatives, Chairs of the Integrated Workforce Planning Groups to be in attendance or attend as appropriate for timed business to provide assurance on key issues.
6.2	When an Executive Director, member or essential attendee is unable to attend a meeting, they should appoint a deputy to attend on their behalf.

6.3	Other Board Members, Executive Directors, officers and relevant representatives shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that individual.
7.0	**Meetings**
7.1	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework.
7.2	Meetings of the People and Culture Committee shall be held bi-monthly, scheduled to support the business cycle of the Board and at such other times as the Committee Chair shall identify, subject to agreement with the Board Chair.
7.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
8.0	**Reporting and Accountability**
8.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
8.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.
8.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers outline the framework to be used for escalating an item from the Committee to the Board: i) Non-compliance with indicators for 2 consecutive months, or off track against agreed trajectory ii) Workforce and health and safety risks scoring 15 or higher residually, with inadequate mitigating actions in place, or with actions overdue with no assured plan to resolve. iii) Non-compliance with legislation iv) EDI risks scoring 15 or higher residually, with inadequate mitigating actions in place, or with actions overdue with no assured plan to resolve. v) Deterioration of more than 10% in any of the metrics associated with engagement.
8.4	The Committee shall be directly accountable to the Trust Board.
8.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.

8.6	The following Sub-Committees shall report to the Committee as the primary reporting line using the standard upward reporting template: • Workforce Development Board • Equality and Diversity Steering Group • Health and Wellbeing Group • Joint National Consultative Committee
8.7	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
8.8	The Committee will report to the Audit Committee on its work in support of the Annual Governance Statement, the Board Assurance Framework and the effectiveness of risk management within the Trust
8.9	The People and Cultute Committee will review and update the strategic risks for which it has responsibility and will update the Board Assurance Framework at each of its meetings.
9.0	**Secretary and Committee Support**
9.1	A member of the Governance Team will act as Secretary to the Committee. The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.
9.2	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers, iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.
10.0	**Review, Monitoring and Effectiveness**
10.1	Members of the Committee will monitor the effectiveness of these Terms of Reference by: i) Recording the attendance of members and how often they send a representative. ii) Number and frequency of meetings in line with Performance and Culture Terms of Reference as per section.

10.2	The Trust's Annual Report shall include a section describing the work of the People and Culture Committee in discharging its responsibilities.
10.3	The Committee will report on an annual basis to the Audit Committee on its performance against its Terms of Reference and on an ad-hoc basis any risks which have inadequate assurance on performance.
10.4	The Chair of the Board will receive a copy of all meeting papers and will attend at least one meeting per annum for monitoring and assurance purposes.
10.5	The Committee will review its own performance, at least annually, review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
10.6	The Committee shall review its Terms of Reference annually, to be reviewed by the Board recommending any changes to the Board, as appropriate.
11.0	**Strategies ratified and approved by this Committee**
11.1	Strategies: People Strategy Equality and Diversity
12.0	**Policies ratified and approved by this Committee**
12.1	Policies: The Policies ratified by this Committee are detailed in the Policy for the development of Trust Policy.
13.0	**The Sub-Group structure supporting the flow of assurance to the People and Culture Committee**



Report Cover Sheet

Report Title:	Remuneration Committee Terms of Reference
Name of Meeting	Trust Board
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	26
Executive Summary:	The Remuneration Committee Terms of Reference has been established as a formal Committee of the Board. The purpose of the Committee will be to determine appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (to include voting and non-voting Executive Directors of the Board) and to regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board or NHSE/I as appropriate, with regard to any changes. As part of the Board's annual review of governance, all Board Committees are required to review their Terms of Reference (ToR) and recommend any changes to the Trust Board of Directors for approval. A review of the Remuneration Committee ToR has taken place and the Committee is recommending these are approved by the Trust Board of Directors.
Recommendations:	The Board Committee is asked to: Approve the Remuneration Committee Terms of Reference.
Accountable Director: **Chair:**	Melanie Saunders, Chief People Officer Sumit Biswas, Non-Executive Director
Author:	Kofo Abayomi, Head of Corporate Governance & Compliance
Previously considered at:	Remuneration Committee

Purpose of Report:	Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	Not applicable
Next Steps:	Publish the Terms of Reference.
List of Appendices	

Terms of Reference – Remuneration, Nomination and Terms of Service Committee

May 2024

Document Reference	To be assigned by
Document Status	Draft
Version	V1.0
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	
Initiated by	Date & Author(s)
Document Owner	Chief Governance Officer
Recommended at Date	**Remuneration, Nomination and Terms of Service Committee** **23 May 2024**
Approved at Date	Board of Directors
Valid Until Date	
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Governance Assurance and Accountability Framework
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes

Remuneration, Nomination and Terms of Service Committee - Terms of Reference 2024 - 25

1.0	**Constitution**
1.1	The South Central Ambulance Service NHS Trust Board hereby resolves to establish a Committee of the Board to be know as the Remuneration, Nominations and Terms of Service Committee (The Committee)
1.2	The Committee is constituted as a Standing Committee of the Board and may only exercise delegated powers.
1.3	The Committee shall have Terms of Reference and powers and will ensure that the Board is able to act in accordance with legislation, compliance or direction requirements and to be fully appraised of the remuneration and terms of office relating to the Chief Executive and other Executive Directors on the delivery of the Trust's strategic objectives.
1.4	The Committee is a Non-Executive Committee of the Board and does not have any executive powers, other than those specifically delegated in these Terms of Reference.
1.5	Its constitution and Terms of Reference shall be as set out below; and will be subject to amendments approved by the Board.
2.0	**Purpose**
2.1	The purpose of the Committee will be to determine appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (to include voting and non-voting Executive Directors of the Board) and to regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board or NHSE/I as appropriate, with regard to any changes.
2.2	The Committee is responsible for consideration of succession planning for the Executive Director and Very Senior Manager (VSM) roles to facilitate an effective Board skill mix.
3.0	**Authority**
3.1	The Committee is authorised by the Board to make decisions within its Terms of Reference, including matters specifically referred to it by the Board.
3.2	The Committee is authorised by the Board to make decisions in respect of remuneration and terms of service of the Chief Executive, Executive Directors and other Very Senior Manager (VSM) contract holders in line with current NHS England/Improvement guidance and processes, taking due consideration of market factors in setting remuneration levels for new and existing Directors and Very Senior Managers, and of appraisal and performance review when considering annual uplifts.

3.3	The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
3.4	The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. Any costs incurred must be within the remit of the Scheme of Delegation and Standing Financial Instructions.
3.5	It is not the duty of the Committee to carry out functions that properly belong to the Board itself or to other Board Committees.
3.6	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.7	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.8	The Committee is authorised by the Board to make decisions in respect of termination of the Chief Executive, Executive Directors, and other staff, following best practice guidance as currently laid down by NHS.
3.9	Employers and NHSE process and in accordance with relevant employment law. Any decision to terminate the Chief Executive should be ratified by the Trust board.
4.0	**Duties and Responsibilities**
4.1	The duties of the Committee can be categorised as follows: Determining salaries, provisions for other benefits (including pensions), and arrangements for termination of employment and other contractual terms. The Committee is responsible for ensuring that a policy and process for remuneration and terms of service, and performance review and appraisal, of the Chief Executive, Executive Directors and Very Senior Managers are in place and that they are completed in line with NHS guidance agreed by the Trust Board. The implementation of the policy and processes is the responsibility of the Chair of the Trust in respect of the Chief Executive, and the Chief Executive in respect of other Executive Directors and Very Senior Managers. In particular, the Committee will: i. Consider and agree the remuneration and terms of service of the Chief Executive, Executive Directors and VSM contract holders to ensure that they are fairly rewarded for their individual contributions to the performance of the Trust, having proper regard for the organisational circumstances, and national and local planning and priorities. Where it is deemed necessary, final decisions will not be taken regarding remuneration, terms of service or termination until the Chair of

	the Committee has consulted all Non-Executive Directors who are not members of the Committee. ii. Agree a Remuneration Policy for Very Senior Managers and oversee its application. iii. Monitor and evaluate the performance of the Chief Executive and Executive Directors, in which they will be advised, as appropriate, by either the Chair of the Trust or the Chief Executive. iv. Oversee the development and performance management of very senior management. Normally this will apply to managers reporting directly to Executive Directors. v. Agree and oversee appropriate contractual and terms of service arrangements for the Chief Executive, Executive Directors and VSM contract holders, including the proper calculation and scrutiny of termination payments, taking account of national and other guidance. vi. Agree and oversee any 'non-contractual' payments made in respect of employment tribunal claims. vii. Agree any Redundancy payments arising from organisational change programmes. viii. Receive annual gender and race pay gap report in respect of the Executive and VSM contract holders, oversee any improvement plans designed to improve any identified gap. ix. To receive annual review of performance of the executive team in accordance with the NHS Leadership competencies framework and Trust Performance Development Review programme. x. To seek assurance on annual Fit and Proper Persons test for Executive Directors. xi. Consider internal and external guidance in carrying out its duties, including compliance with the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework; the NHS Codes of Openness, Conduct & Accountability, and Corporate Governance; relevant pay and contractual arrangements for Trust Executive staff; legal compliance, accepted best practice and high standards of probity. xii. Provide the Board with formal reports as required relating to remuneration, terms of service and termination relating to the Chief Executive and Executive Directors xiii. In line with best practice and as recommended by NHS Employers guidance, the committee will follow the same process of scrutiny of termination payments to all Trust employees.
5.0	**Nominations and Appointments**
5.1	The Committee, on behalf of the Trust Board, is responsible for ensuring that a policy and process for the appointment of the Chief Executive and Executive Directors is in place. The implementation of the policy is the responsibility of the Chairman of the Trust for the Chief

	Executive and the Chief Executive in respect of other Executive Directors. In particular the Committee will: i. Ensure an appropriate process is in place for the selection and recruitment of the Chief Executive and Executive Directors and recommend to the Board the appointment of the Chief Executive and Executive Directors. ii. Ensure a succession plan is in place for Executive Directors, taking account of the challenges and opportunities facing the Trust and therefore the skills and expertise needed for the future. iii. When considering new appointments, take account of the required structure, size and composition of the Board, including skills, knowledge and experience.
6.0	**Membership and Quorum**
6.1	The Committee will have 4 core members, including the Chair, other Non-Executive directors will be advised of meetings and agenda and encouraged to attend all meetings.
6.2	The Board will appoint the Deputy Chairman of the Trust as chair of the Committee and another Non-Executive member to be Vice chair from the outset. The Vice chair will automatically assume the authority of the Chair should the latter be absent.
6.3	Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Secretary of the Committee in advance.
6.4	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
6.5	The quorum necessary for the transaction of business is 2 of the 4 core members, with at least the Committee Chair or Vice Chair present. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.
7.0	**Attendance at Meetings**
7.1	Those required at each meeting: ▪ Chief People Officer or Deputy Those who may also attend: ▪ Chief Executive and other Executive Directors but must withdraw when the Committee is discussing their particular remuneration packages. ▪ The Committee may invite other colleagues to be in attendance or attend as appropriate for timed business to provide assurance on

	key issues.
7.2	Any non-member, including the Secretary to the Committee, will be asked to leave the meeting should their own conditions of employment be the subject of discussion.
8.0	**Meetings**
8.1	Meetings of the Committee shall be conducted in private. Only members of the Committee are entitled to be present, although others may attend by invitation of the Committee. The Committee should consult the Chair of the Trust and/or the Chief Executive about their proposals relating to the remuneration of other executive directors.
8.2	Meetings of the Committee shall be formal, minuted and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders, Standing Financial Instructions and Governance Assurance and Accountability Framework.
8.3	Meetings shall usually be held quarterly and not less than twice a year. Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
8.4	Annually the Committee will meet to consider the overall Board composition, Executive Director Performance, and succession planning. All Non-Executive Directors will be encouraged to attend this meeting, which will be scheduled so as to take as inputs the completed annual Performance Reviews.
9.0	**Reporting and Accountability**
9.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
9.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting. Any decisions made by the Committee should be clearly stated with the Trust Board minutes.
9.3	The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers outline the framework to be used for escalating an item from the Committee to the Board: ▪ Skills gap in Board skills matrix ▪ Board succession planning not in place
9.4	On occasions the Committee may take the view that the matter on which it is reporting to the Trust Board should not be openly reported (e.g., the Committee may wish to report on a matter that it considers commercial in confidence, or present information that is person identifiable). In such circumstances the Committee should seek advice as to whether an exemption may be applied from the

	Freedom of Information Act. If so, the Committee should report to the next Trust Board meeting in closed, confidential session, under an exemption that should be clearly spelt out in its report.
9.5	The Committee shall ensure that Directors' remuneration is accurately reported in the required format in the Trust's annual report.
9.6	The Committee shall be directly accountable to the Board.
9.7	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.
9.9	The Committee will report to the Audit Committee on its work in support of the Annual Governance Statement, the Board Assurance Framework, the effectiveness of risk management within the Trust.
10.0	**Secretary and Committee Support**
10.1	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers, iii) Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting. iv) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, v) keeping a record of matters arising and actions to be carried forward, vi) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vii) creating and maintaining a Forward Plan of business to come before the Committee.
11.0	**Review, Monitoring and Effectiveness**
11.1	Members of the Committee will monitor the effectiveness of these Terms of Reference by: i) Recording the attendance of members. ii) Number and frequency of meetings in line with the Terms of Reference.
11.2	The Trust's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.
11.3	The Committee will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
11.4	The Committee shall review its Terms of Reference annually, to be reviewed by the Board recommending any changes to the Board, as appropriate.

11.5	Set an annual Forward plan for its work to form part of the Board's annual Forward Plan and report to the Board on its progress.
12.0	**Equality, Diversity & Inclusion Statement**
12.1	The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. A diverse workforce at all levels is good news for NHS organisations as it enables access to a wider range of skills and talents; good news for patients as a diverse workforce is better equipped to meet the needs of our diverse communities; and good news for staff wellbeing as they enjoy greater workplace opportunities, increased job satisfaction and are better rewarded for their contribution to the NHS. By committing to policies which encourage equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence. The Trust will therefore take every possible step to ensure that remuneration procedures are applied fairly to all employees regardless of protected characteristics (as above); length of service, whether full or part-time or employed under a permanent or a fixed-term contract or any other irrelevant factor. The Trust is striving to reach equality in BME representation across the workforce pipeline by 2028, including at Very Senior Manager and Board level. This the recommended model as set out in the NHS Model Employer Goals; in this area, it aligns with the timeframe announced by the government on this aspiration for the public sector, it is in line with the timeframe for the NHS Long Term Plan.

Upward Report of the – People and Culture Committee

Date Meeting met **16 May 2024**
Chair of Meeting **Ian Green, Non-Executive Director, Chair**
Reporting to **Board of Directors Meeting in Public**

Items	Issue	Action Owner	Action
Points for escalation			
PDR Deep Dive	The Committee undertook a deep dive into the challenges in delivery the PDR targets. A good and honest summary was presented outlining many of the challenges and proposing some action to be taken in 2024/25 to improve the position. The committee asked that a delivery plan be created outlining what could be achieved and what "good" would look like with a successful PDR system for SCAS.	NH	Plan presented to July meeting
Corporate Review	Received a report on Corporate Review. Questions timeline and processes . Where would the governance of this sit?	CPO	Seek clarification from the Board
Key issues and / or Business matters to raise			
Internal Audit Report - EDI	The report was noted. Was keen to be sighted on how recommendations would be		

	implemented, acknowledging that this would be overseen by the Audit committee		
Areas of concern and / or Risks			
Corporate Risk Register/BAF	The committee reviewed the risk register, noting that the BAF is currently being revised. Concern was raised as to the number of overdue risk reviews and ask that a review be undertaken at the September PCC committee	CPO	Consideration at September PCC
Items for information and / or awareness			
2023/24 Metrics	The Committee were pleased to note the improvement in delivery of Workforce Plans and Metrics (see attached chart) with all areas performing well apart from PDRs, IWP recruitment, and BAME workforce. Committee were keen to see the split between clinical and non clinical recruitment and were assured that this would be presented at the July meeting	CPO	July PCC
Best Practice and / or Excellence			
Compliance with Terms of Reference			
Terms of Reference Review	The committee reviewed the draft ToR, suggesting a number of changes that should be incorporated into the final version for presentation to the Board.	Susan Wall	Produce an updated version and seek approval from committee members.

Policies approved*			

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

Author: Ian Green

Title: Non-Executive Director, Chair

Date: 24 May 2024

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2023/24 M12 – Summary

METRIC	YE 2022/23	YE 2023/24	CHANGE
PDR (Appraisals)	89%	80%	
Sickness	7.7%	6.6%	
Sickness LT	3.9%	3.7%	
Sickness ST	3.8%	2.8%	
IWP Recruitment	902	890	
Staff Attrition (FTE)	898	745	
Staff Turnover % Rate	21%	17%	
Staff Retention % Rate	82%	87%	
Staff in Post	4248	4373	
Trust / HIOW % vacancy rate	12.2%	8.8%	
IWP Position % vacancy rate	24%	20%	
Workforce % Disabled	6.4%	7.7%	
Workforce % BAME	5.4%	5.4%	

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Report Cover Sheet

Report Title:	Communications, Marketing and Engagement Update
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	27
Executive Summary:	**Southern Ambulance Services Collaboration (SASC)** On the 22 May, five Southern Ambulance Trusts, including SCAS came together to launch their new collaboration for the benefit of patients, their people and communities. **Modernising SCAS – 'Fit for the Future' (FFF)** Communications has been actively supporting as the programme of work gathers momentum. Engagement and communication are key to its delivery and success. **Digital Communications** Delivery of the Communications, Marketing and Engagement Strategy depends heavily on up-to-date digital technologies, particularly those that are cost effective and that allow us to communicate effectively with different staff groups, 24 hours a day.
Recommendations:	The Board of Directors is asked to: Note the contents of this report.
Accountable Director:	Gillian Hodgetts, Director of Communications, Marketing and Engagement
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:	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	Not Applicable

Meeting Report

Name of Meeting	Board of Directors Meeting in Public
Title	Communications, Marketing and Engagement Update
Author	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Accountable Director	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Date	30 May 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

Southern Ambulance Services Collaboration (SASC)

On 22 May, the launch of the Southern Ambulance Services Collaboration (SASC) between East of England Ambulance Service NHS Trust (EEAST), London Ambulance Service NHS Trust (LAS), South Central Ambulance Service NHS Foundation Trust (SCAS), South-East Coast Ambulance Service NHS Foundation Trust (SECAmb) and South-Western Ambulance Service NHS Foundation Trust (SWAST) took place.

The Chief Executives of these five Southern Ambulance services recognise the value in working together and are establishing the Southern Ambulance Services Collaboration to work collectively to solve some of the biggest challenges the NHS has faced.

The Collaboration is being formed in the context of a challenging operational and financial environment. Our five organisations are ambitious to improve the care and services that we provide to our patients, people and to our communities. We have

been increasingly working together to make these improvements and have identified that now is the right time to formalise our collaboration as many other NHS providers have done.

The initiatives for the Collaboration will be co-produced by our staff working closely together and will enable us to support each other more effectively, share best practice, and work together to provide high quality resilient care at the best value.

The challenges faced include evolving patient demand, a constrained financial environment and ongoing recruitment and retention issues. Additionally, the complexity of patient demand is resulting in a framework that encourages specialism in services and reconfigurations of hospitals and primary care services. More than ever there are multiple pathways of care for patients and ambulance services must respond to these in different ways.

The NHS relies on collaboration between organisations. All ambulance trusts in England work together, on a range of topics at different times. Some of this is through NHS England and some is through the Association of Ambulance Chief Executives (AACE).

Following the pandemic and building on lessons learnt, NHS England provided guidance on the role that provider collaboratives can play in delivering better care. Most acute and mental health providers are in at least one collaborative and have delivered benefits for patients that would not have been delivered by working alone.

4. Fit For the Future Programme (FFFP)

A detailed Comms & Engagement plan for FFFP is under development, with a completion date for the draft of 31 May 2024. A lack of dedicated resource has hindered an earlier delivery of the formal plan document, but communications and engagement activities are proceeding in the meantime.

The structure of the plan is largely in place, and it is currently being populated with detailed content. A stakeholder mapping exercise has been completed, along with high-level timescales linked to the programme road map.

Face-to-face engagement with staff is a vital part of the communications and engagement strategy for FFFP. For a modernisation programme of this scale, it is not enough to solely communicate to staff, it requires deeper two-way engagement to ensure we take staff with us in the significant change journey.

The FFFP team have an extensive ongoing programme of visits to sites and meetings for face-to-face engagement with staff. This was covered in a Hub intranet and Staff matters story on 4 April.

The Team Brief issued in early April instructed Team Leaders and line managers to discuss FFFP directly with staff, answer any questions that they could and direct staff to information sites (such as the intranet section) if necessary. We are currently

working on a feedback loop for TLs and managers to feedback on sessions directly to the Communications and FFFP teams.

Non-Executive Directors are also keen to engage directly with staff on FFFP, and a briefing pack for them and other senior leaders is being developed.

We continue to utilise and develop our digital internal communications channels, with updates to the extensive Hub intranet FFFP site, including a wide-ranging 'frequently asked questions' section.

A key development in FFFP in April and May is the advancement of the 'proof of concept' proposals, with North Harbour and the Northern House Clinical Coordination Centre identified as sites to develop and test proposed new processes and ways of working which can subsequently be rolled out to existing sites across SCAS.

These proposals were discussed at the SCAS Leadership Forum on 1 May and shared with all staff via the Hub intranet page, a Viva Engage discussion and Staff Matters article. The FFFP team will continue to engage with stakeholders and colleagues during May to co-design the proposals, and they will be shared with the SCAS Board for formal approval by the end of June. When agreement to proceed has been secured, the team will develop an implementation plan (including on-going engagement) before anticipated go-live in the autumn.

Although the primary focus is currently on engagement with staff and internal stakeholders, we continue to keep key external stakeholders informed with high-level updates of progress via the SCAS Stakeholder Bulletin, and external engagement will increase in importance as FFFP progresses and plans become more established.

5. Digital Communications development

A significant part of our Communications, Marketing and Engagement Strategy relies heavily on our ability to develop new digital technologies to support and deliver effective communications.

We continue to focus on our usage of digital technology to support our internal communications activities particularly. Working closely with our Information Technology teams, we have been reviewing our current digital internal communications such as digital screens, TEAMS backgrounds, screensavers, and crafting plans to utilise these to support traditional mechanisms of internal communications, such as emails and newsletters. As a result of previous internal communications surveys and learning from the pandemic, such mediums were requested by staff, and continue to be requested to support not only organisational but local communications.

Digital screens were originally trialled in SCAS some years ago, and whilst the technology suited the climate at that point, technology has since moved on. Ideally, larger screens connected to networked boxes on the walls with specialist technology

allowing a direct feed to come from our Office 365 sites, would be the preferential solution. Given the challenges of our current financial situation however, this is looking an unlikely solution as the infrastructure would require significant investment. However, there have been initial discussions to establish if surplus IT kit could be utilised in locations until such times as a permanent solution can be procured.

Whilst investment may take longer than we would wish, there are other digital channels that we can embrace. We have been using screensavers to advertise the launch of FFFP and there are products on the market which would support a series of screensavers to roll through systems. Our current solution relies on people power, both in the planning, designing and broadcast of such screensavers.

Whilst we are limited for investment opportunities at the current time, we will continue to research new products and to identify which ones will provide us with more opportunities to engage more widely, 24 hours a day.

6. Responsibility

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

7. Recommendations

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

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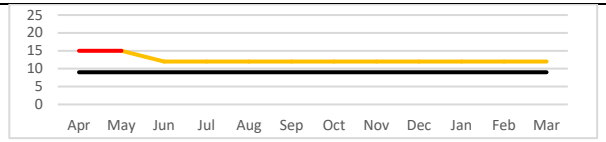
Report Cover Sheet

Report Title:	Board Assurance Framework
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	29
Executive Summary:	The Board conducted a workshop to review and refresh the Board Assurance Framework (BAF) at the end of April to ensure it was in line with the new annual plan and strategic objectives. The output from the workshop is currently with the Executive team to review and finalised. It will then be sent from approval at the Executive Management Committee before going back to the Board for final approval. The closing position of the 2023-2024 Board Assurance Framework is: **BAF risk 1: Score 12 (Helen Young / John Black)** Risk has closed out the year at 12 (Major x Possible). PSIRF was implemented in on 22 April with ongoing embedding taking place. **BAF risk 2: Score 20 (Mark Ainsworth)** Risk has finished the year at 20 (Catastrophic x Likely). Operational pressures and handover delays continuing to be an issue impacting performance. **BAF risk 3: Score 12 (Mike Murphy)** Risk has closed out the year at 12 (Major x Possible) with the continuing to work with the ICBs and other stakeholders. **BAF risk 4: Score 12 (Mike Murphy)** Risk has closed out the year at 12 (Major x Possible) with the continuing to work with the ICBs and other stakeholders. **BAF risk 5: Score 20 (Stuart Rees)** Risk has closed the year at 20 (Major x Almost Certain). The Trust finances continue to be managed through long-term actions such as the development of the medium-term financial plan. Risk is closely monitored by the Interim Director of Finance and the Financial Recovery Group.

	BAF Risk 6: Score 16 (Melanie Saunders) The risk ends the year at 16 (Major x Likely). Work will continue with the development and approval of the 5-year workforce plan. **BAF Risk 7: Score 12 (Melanie Saunders)** The risk has closed out the year at 12 (Major x Possible). The culture diagnostic due to report back to EMC in May which will provide feedback on the current culture. **BAF risk 8: Score 20 (Craig Ellis)** Risk has closed the year at 20 (Catastrophic x Likely). Risk will continue to be managed through the CDO work plan for the Digital Directorate. **BAF risk 9: Score 20 (Mike Murphy)** The risk ends the year at 20 (Catastrophic x Likely). Improvement programme workstreams continue to manage the risk.
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:	None
Purpose of Report:	Approval
Paper Status:	Public
Assurance Level:	**Assurance Level Rating Options -** **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:	None
List of Appendices	Board Assurance Framework

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: March 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

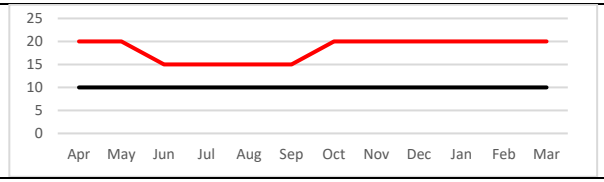
Controls	Gaps in Controls	Actions	Owner / Due Date
• Clinical workforce recruitment programme • Equipment audits and concern reporting process in place • Adverse Incident Reporting Process • Clinical Standard Operating Procedures • Private Provider strategy and governance framework • Continuous Professional 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 – Launched on 22 April.
		Development of CPs in remaining acutes and systems	Mark Ainsworth / Now part of BAU
		Rota review	Mark Ainsworth / Q4 Complete Implementation – end Q2
		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	Lemuel Freezer / Go Live – July 2024

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
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
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

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: March 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	5	25
Current	**5**	**4**	**20**
Target	5	2	10



Risk Lead	Assurance Committee
Mark Ainsworth, Executive Director of Operations	Finance and Performance Committee Quality & Safety Committee

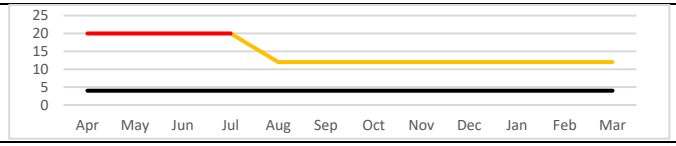
Controls	Gaps in Controls	Actions	Owner / Due Date
• Demand forecasting and profiling using models which are adjusted based on experience • Daily Operational MI reports detailing performance against set metrics • Mutual aid process exists and works • Collaborative operational management • Cat. 2 response 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 & 111 • Performance Recovery Workstream • Clinical Pathways Lead embedded at QAH • 30-minute handover limit – embedding process at each acute Trust. • SOP for deployment of Jumbulance at QAH • SOP for deployment of a patient holding facility	• 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 and fleet increase with aging fleet and increased VOR impacting vehicle availability for any increase in frontline resourcing.	Rota review	Mark Ainsworth / Q4 – Complete Implementation – end Q2
		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 – Now part of BAU
		Improving Pathways & patient flow at Queen Alexandra Hospital	Mark Ainsworth / end Q1 QAH responsible for implementation and to agree timeline.
		Review of Performance Cell	Rob Ellery / DRAFT - December 2023 - Complete Final – Complete Proposal to go to ETB – May 2024
		Delivery of 53 replacement and new DCAs	Lemuel Freezer / Sept 2024

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 • Ops Board • Performance Improvement Delivery Group	**Third line (external) assurances** • ICS system management across region • National performance standards • PTS contractual standards • TPAM • Performance Insight Improvement Group • NHSE Performance Reviews	• Fleet supply assurance	Obtain supplier assurance on delivery	Lemuel Freezer / TBC

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
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
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: March 2024	
If the organisation fails to engage or influence within systems	***Then*** there may be a disproportionate focus in one system over the others and capacity provided may not align with expectations	***Leading to*** performance that is not achievable or credible and possible poor outcomes for patients and the communities we serve.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**4**	**3**	**12**
Target	2	2	4



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

Controls	Gaps in Controls	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 Group set up looking at PTS alternative models.
		Role to be advertised pending review and prioritisation during budget process. Would increase capacity for meetings	Mike Murphy / ~~Feb 24~~ March 2024 – linked to budget cycle.

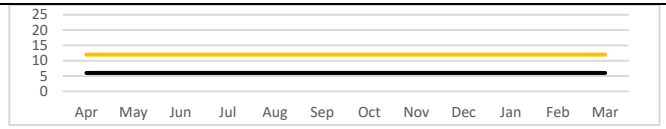
Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Finance and Performance Committee	**Third line (external) assurances** • Monthly tripartite meetings which provides oversight and assurance regarding the Trust's position and	•	Establish reporting mechanisms from system groups	Mike Murphy / Q3 23-24 - Complete
			Continue to engage in annual and strategic planning forums	Mike Murphy / Q4 23-24

• System development board • Monthly report to Board on system activity	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
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: March 2024	
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

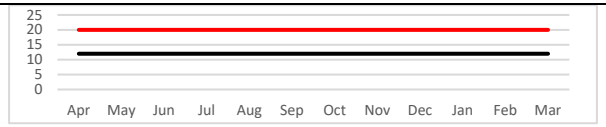
Controls	Gaps in Controls	Actions	Due Date
• Stakeholder management plan • Attendance at Integrated Care Systems boards • Attendance at local resilience forums • Attendance at relevant Multi Agency Safeguarding Hub • Emergency & Urgent Care Boards • Attendance at system strategy groups • System strategy 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	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 Group set up looking at PTS alternative models.
		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~~ March 2024 – linked to budget cycle.

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: May 2024	
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

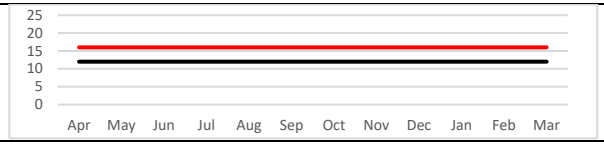
Controls	Gaps in Controls	Actions	Owner / Due Date
• Standing financial instructions and standing orders • Planning and approval process for the Trust's budget • Budgetary management and regular reporting process – act vs plan process • Access to national funding for emergency related activity • Budget 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. • Working capital support will be arranged through agreed loan arrangements. • Monitoring cash report now part of FPC • Financial Recovery Plan • Benchmarked data • Contract Register	• 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 • 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 devolvement of budgets and objectives	Stuart Rees / To be included in the medium-term financial plan (3 year) – July 2024
		Develop medium-term financial plan (Year 1 of plan)	Stuart Rees / Plan completed awaiting NHSE sign-off
		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 – Complete
		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 / ~~Jan 2024~~ Complete
		Implementation of a contract register	Julie Robins / Draft October 2023 - Complete Final January 2024 - EMC 27 Feb 24 - Audit 7 March 24 - Complete

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
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
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
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: March 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

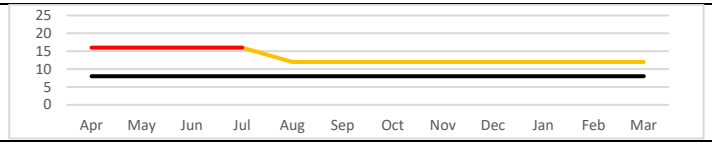
Controls	Gaps in Controls	Actions	Due Date
• Integrated Workforce Plans for the Trust, including the delivery of a 5-year workforce plan • Workforce reporting (e.g., sickness absence, staff survey, turnover) • Recruitment & attraction plan and retention plan health and wellbeing plan and flexible working • 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	Develop/review existing career development pathways	Ian Teague / Q4 2023/24
		Development of talent management and development programme	Nicky Howells / Launch Q1 2024-25
		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 / Q2 2024/25

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
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	16
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
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

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: March 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



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

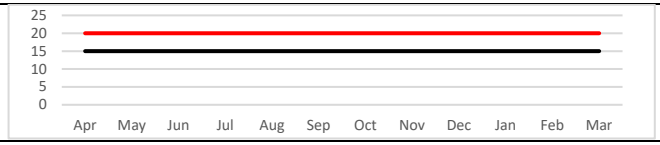
Controls	Gaps in Controls	Actions	Owner / Due Date
• People strategy, EDI strategy and associated enabling plans • Freedom to Speak Up (FTSU) guardian and supporting programme in place • 'Supporting our people' website, including EAP and Occupational Health • SCAS leader and ESPM leadership training • 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 relaunched 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 / Q2 2024-25

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: March 2024		
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 in place across SCAS • Regular Digital Programme Portfolio reporting, and project prioritisation through the Executive Transformation board • Project Management governance controls are in place • Financial reporting up to the Executive Management Team (Fixed assets/capital/revenue) • Compliancy with required NHS Cyber Security Standards (DSPT) • Digital Steering Group in place	• No Digital Annual planning cycle currently in place • No IT Asset Management database in place across SCAS to manage/secure our assets and services accordingly. • No formal Information Technology Infrastructure Library (ITIL) processes in place, with weak internal controls currently in place. • Limited resources in key roles, and an number of single point of failures positions • Limited control around new project initiation or shadow-IT initiatives across SCAS • No resource management process in place across the Digital department • Org Structure inappropriate for Technology Transformation with a number of gaps, and limited definition of roles/responsibilities	Develop annual planning cycle to map resources and plan capacity for digital resource	Craig Ellis / In Progress / Ongoing
		Review service desk software and make a formal decision on renewal.	Craig Ellis / Completed / HoTH to be redeveloped
		To develop an IT Asset Mgmt DB, and a Service Catalogue within the Digital function	Craig Ellis / In Progress / March-24
		To ensure the Digital org is able to deliver core requirements in the near term through interim changes.	Craig Ellis / In-Progress / March-24
		Adoption of core ITIL processes (Incident, Change, Problem) within the Digital Function	Craig Ellis / In Progress / Dec 24

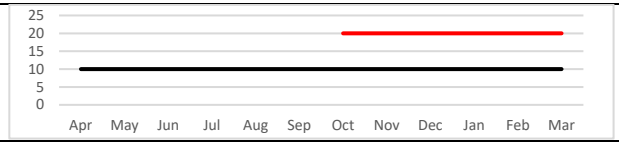
Assurances		Gaps in Assurances	Actions	Owner /Due Date
First and second line (internal) assurances • Reports to Finance and Performance Committee	**Third line (external) assurances** • Internal audit • External audit	• No KPIs in place • Regular reporting on digital strategy at board level	Develop KPIs	Craig Ellis / Ongoing / Feb-24

• Annual report on digital strategy to Trust board • Quality assurance process in PMO • Technical Design Authority • Change Advisory Board	• DSP toolkit • Digital maturity assessments	• Fixed Asset Management Steering Group reporting	To undertake an external assessment of our Cyber	

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
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: March 2024	
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
		Safeguarding ICT Improvement work	Craig Ellis / June 2024

		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 - Launched on 22 April.
		Procure system for managing safe deployment and maintenance of equipment	Lemuel Freezer / Go Live – July 2024
		Development of talent management and development programme	Nicky Howells / implementation by Q4 23/24 – resources now 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	Stuart Rees / Q4
			Development and Approval of Governance Framework	Daryl Lutchmaya / Complete
			Embedding of the Governance Assurance and Accountability Framework	Daryl Lutchmaya / TBC

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

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Report Cover Sheet

Report Title:	**NHS Provider Licence Conditions - Self-Certification**
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	30
Executive Summary:	NHS England (NHSE) oversees compliance with provider licence conditions. South Central Ambulance Service NHS Foundation Trust (SCAS) is required to self-certify that it has complied with the conditions of the NHS provider licence, has in place standards of good corporate governance and has the required resources available if providing commissioner requested services. Self-certification forms part of NHSE's annual risk assessment of trusts. Providers must demonstrate that they have carried out the self-certification process and make the compliance statements available. **What is required:** The Board is requested to approve the two attached self-certified Licence Condition statements. The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. The licence requires NHS providers to self-certify their compliance with Licence Conditions G6 (Systems for compliance with Licence Conditions and related obligations) and FT4 (Trust governance arrangements). As background information, the standard licence conditions are grouped into seven sections (please refer to the end of this paper). The first section, containing the General Conditions, sets out standard requirements and rules for all licence holders. Sections 2 to 5 of the licence are about the Regulator's functions: setting prices; enabling services to be provided in an integrated way; safeguarding choice and competition; supporting commissioners to maintain service continuity and translating the oversight of Foundation Trust governance into the new provider licence. The final section, 7, contains definitions and notes. **Condition G6**

This Licence Condition requires that providers take all reasonable precautions against the risk of failure to comply with the Licence. Providers must annually review whether the processes and systems used to review compliance with this Licence Condition are effective and are required to self-certify this.

Condition G6 requires NHS Trusts to have processes and systems that: identify risks to compliance with the licence, NHS Acts and the NHS Constitution; and guard against those risks occurring.

Continuity of services: condition 7 - Availability of Resources

The template also includes a section referred to as 'Continuity of services: condition 7 - Availability of Resources (FTs designated CRS only)' in (section 6 of the licence). The Trust is not required to complete this section as it is not subject to a contractual obligation to deliver a service which is subsequently designated as a Commissioner Requested Service and has been left blank.

NB: A 'commissioner requested service' is a service needing the protection of the continuity of services provisions of the NHS provider licence and include:

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

Certification on training of governors

This statement declares that the Board is satisfied that during the financial year that the Trust has provided the necessary training to its Governors to ensure they are equipped with the skills and knowledge that they need to undertake their roles.

Boards must sign their G6 self-certification by 31 May 2024 and publish it on their websites by 30 June 2024.

Condition FT4

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

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

i. effective Board and Committee structures;

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

iii. clear reporting lines and accountabilities throughout the organisation;

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

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

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

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

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

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

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

Boards must sign their FT4 self-certification by 30 June 2024.

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

1. **The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.**

The Annual Governance Statement describes the high standards of corporate governance employed by SCAS and which are regarded as appropriate for a supplier of health care services to the NHS. The Trust has in place, a governance assurance and accountability framework, a scheme of delegation, standing orders, and a set of standing financial instructions. Board Committees operate within their Terms of Reference and are chaired by a Non-Executive Director. It has the relevant statutory governance requirements in place.

2. **The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.**

The Board's cycle of business allows for good corporate governance guidance issued by NHSE, to be brought to the attention of the Board in a timely manner.

The Trust Board has received development sessions on Risk Management and Risk Appetite to support the principle of good corporate governance and ensuring the Board has the required skills and

	knowledge to fulfil their duties under the license, as well as reviewing and updating the Risk Management Policy and creating a Risk Management Framework. The Board and the Senior Leadership have undertaken a series of training sessions relating to good corporate governance such as effectiveness of a board, effective reporting writing and effective chairing of meetings. Executive and Non-Executive Directors' performance and objectives are reviewed annually through the appraisal system. **3. The Board is satisfied that the Licensee has established and implements:** **(a) Effective board and committee structures;** **(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and** **(c) Clear reporting lines and accountabilities throughout its organisation.** The Trust has effective Board and Committee structures and their responsibilities and accountabilities are clearly detailed in the Governance Assurance and Accountability Framework, Standing Orders and Terms of Reference. The Board Committee Structure reflects the Trust's assurance and oversight requirements and the Committees' Terms of References have been reviewed. The Annual Governance Statement, contained within the Annual Report, sets out developments each year. Executive Director responsibilities are set out in job descriptions & annual objectives reported to the Remuneration Committee and their respective portfolios detailed in the Governance Assurance and Accountability Framework. Non-Executive Directors' performance and objectives are reviewed annually through the appraisal system. **4. The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:** **(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;** **(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;** **(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;** **(d) or effective financial decision-making, management and control (including but not restricted to appropriate systems and/or**

	processes to ensure the Licensee's ability to continue as a going concern); **(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;** **(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;** **(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and** **(h) To ensure compliance with all applicable legal requirements.** The Annual Governance Statement describes: a. systems and processes to ensure compliance with the duty to operate efficiently, economically and effectively; b. systems and processes for timely and effective scrutiny and oversight by the Board of the organisation's operations and for effective financial decision-making and management and control; and c. systems to identify and to manage material risks to compliance with the licence conditions and with all applicable legal requirements. During the year, the Trust achieved the following: a. Production of the Annual Governance Statement contained in the Annual Report which is compliant with regulatory requirements. b. Regular Board and Committee meetings which undertook reviews of planned work and included regular oversight of performance information, financial information and the design of the new BAF. c. Robust external and internal audit processes have confirmed that there are no material concerns about key internal controls and processes. d. Review and update of the Risk Management Policy and creation of a Risk Management Framework. e. Board training sessions on Risk Management and Risk Appetite. The Trust has sufficient skills and capacity at Board level to undertake financial decision making, management and control. The self-certification provides evidence of the Board's review and assessment of its going concern status. The Annual Governance Statement identifies that the Trust Board is well sighted on the issues and risks. **5. The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:**

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

	The Board receives frequent reports relating to patients' experiences at its meetings. Patient involvement and experience is gauged by surveys and other forms of feedback. **6. The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.** Regular Board and Committee reports about the organisation's establishment, recruitment and retention initiatives, safe levels of staffing and succession management and leadership training are received. The Remuneration Committee meets to discuss Executive Directors' performance and Board succession planning. Board members comply with the annual Fit and Proper Person Test.
Recommendations:	The Board is asked to approve the self-certification to be signed by the Chair and Chief Executive Officer.
Accountable Director:	David Eltringham, Chief Executive Officer
Author:	Kofo Abayomi, Head of Corporate Governance & Compliance
Previously considered at:	Executive Management Committee.
Purpose of Report:	Approve
Paper Status:	Public
Assurance Level:	**Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	N/A
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	All BAF Risks
Quality Domain(s)	All Quality Domains
Next Steps:	Submission to Trust Board for approval
List of Appendices	• Self Cert G6 Template • Self Cert FT4 Template

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Report Cover Sheet

Report Title:	Improvement Programme Oversight Board Update - May 2024
Name of Meeting	Board of Directors Meeting in Public
Date of Meeting:	Thursday, 30 May 2024
Agenda Item:	31

Executive Summary:	• This paper covers the Improvement Programme Highlight Report as discussed at the Tripartite Provider Assurance Meeting (TPAM) in May.
	
	• Overall Programme
	  ○ Following a comprehensive review of RAG ratings against a new and more specific approach, a number of programmes have changed their RAG ratings against the must and should do actions and exit criteria. In the main this has led to an improved position.
	  ○ Plans on a Page have been refreshed for the new financial year. Further work is to be done to show the quarterly ambition in more detail
	  ○ The team is currently working on the creation of driver diagrams to better link the activities to the desired outcomes.
	  ○ Finally, we are reviewing the metrics, ensuring linkages to the refreshed IPR and testing that they provide clear assurance on our progress.
	
	• Culture and staff wellbeing
	  ○ As a result of the workstream review, we have increased our confidence in the sustainability of the actions we have taken, particularly around staff raising concerns.
	  ○ Further work needs to be undertaken to recover the metrics associated with appraisal, which have deteriorated through the period of higher operational pressures.
	• Governance
	  ○ Following this month's review of this workstream has identified that the majority of actions related to the

	Governance processes are now part of Business as usual. Consequently, the RAG rating has improved from Red to Amber. ○ We have also increased our RAG rating from red to amber for the work undertaken against quality and safety (regulation 17(1)(2)(a)(b) following the assurance taken from TPAM ○ A full revision of the work programme and metrics is underway to develop quarterly improvement expectations particularly against the well-led domain. • Performance ○ The team has strong performance improvement plans in place to meet the agreed trajectories in the operating plan. The key risk to achieving these remain the impact of delayed handovers at hospital. ○ The ICB proposed grip and control measures bringing together performance, finance and quality will support delivery against this workstream ○ Support for newly qualified staff has again improved. • Patient Safety ○ At the TPAM meeting in May, the progress with the Patient safety workstream was reviewed in depth for a final time. NHSE and the ICB are content that while there remain improvements to be made in this area, the organisation now has the systems and processes in place to make progress without requiring enhanced additional oversight. Of note, the local authorities particularly praised the way in which SCAS is now engaged in partnership working on safeguarding. ○
Recommendations:	The Trust Board is asked to: Note this paper
Accountable Director:	Mike Murphy, Chief Strategy Officer
Author:	Caroline Morris, Transformation Programme Director
Previously considered at:	Updates on the Improvement Programme have been provided to full board and board sub committees
Purpose of Report:	Note
Paper Status:	Public

Assurance Level:	**Assurance Level Rating Options -** **Assurance Level Rating:** Acceptable
Justification of Assurance Rating:	Not Applicable
Strategic Objective(s):	All Strategic Objectives
Links to BAF Risks or Significant Risk Register:	SR9 - Delivery of the Trust Improvement Programme
Quality Domain(s)	All Quality Domains
Next Steps:	Not Applicable
List of Appendices	TPAM report pack (May 2024)

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Tripartite Provider Assurance Meeting (TPAM)

Patient Safety Deep Dive

SCAS Patient Safety & Safeguarding Roadmap

CQC Report Aug 2022

Q2
Patient Safety Workstream established

Q3
Action-focused workplan enacted to address s29a Warning Notice issues

Q3
Enhanced Safeguarding (SG) Service in place (incl. AD & NP (Adults))

Q3
SG scrutiny & oversight meetings commenced (ICB-led)

Q3
Incident Review Panel refreshed (incl. SG & ICB partnership working

Q4
Improved Exec & Board oversight through SG Dashboard developments

Q4
MCA awareness improved & better capture of MCA decision-making on ePR

Patient Safety Board Development sessions commence with SG, led by AD SG, MH & LD

Medical Devices Review Group reinvigorated

Full audit of all SCAS medical devices conducted

Q3
New Allegations Management processes in place

ICB Quality Assurance Visit Dec 2022

Q1
New eLearning launched Trust-wide for PS, MCA & SG (incl. F2F sessions)

MaPSaF Survey 1
3% Response Rate

Additional enhancements to team capacity & specialist expertise incl. NP (Children) & MCA Lead

Q1
Sexual Safety Allegation Management Plan enacted

Q3/Q4
Revised suite of new/refreshed Patient Safety (PS) and SG policies published

Q1/Q2
SG SOPs reviewed, refined and enacted

Q1
Thematic audits of report quality introduced (PS Incident Reporting & SG Referrals)

Q4
National Safeguarding Star Awards for SG leadership (AD, NPs)

Q4
FTSU Policy refresh in line with National Policy (incl. Detriment Process Guide)

Q3
Operation AVOCET partnership working

Transition to new SG server

Q2
AD SG, MH & LD keynote speaker at NHSE Celebration of Innovation (Allegation Management)

MaPSaF Survey 2
22.4% Response Rate

Patient Safety Improvements Continue

Q4/Q1
Successful transition to PSIRF & LFPSE

Q4
SCAS Patient Panel introduced & key members recruited

ICB Quality Assurance Visit Nov 2023

Sexual Safety Board Development session conducted (linked with Culture & Staff Wellbeing)

Q3
Frontline SG Supervision regime in place (35 sessions to-date)

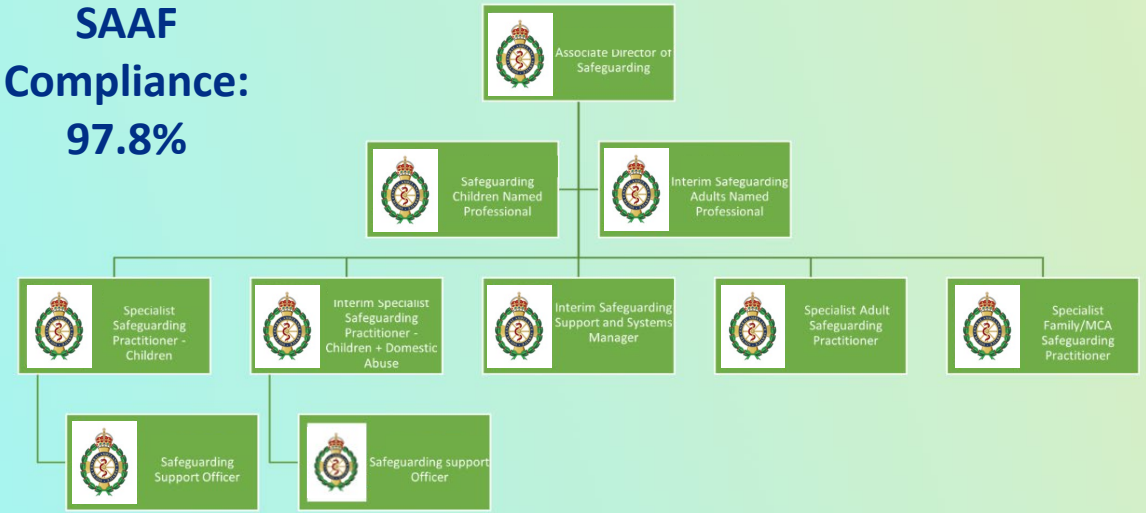
Volunteer (e.g. CFR) SG training introduced

2022 ◄---------- 2023 ----------► 2024

Safeguarding & Mental Health

Embedded section 4.2.1 and the 11 core arrangements within the Safeguarding Accountability and Assurance Framework

SAAF Compliance: 97.8%



October 2023 - Jayne Chidgey-Clark, Chair of Safeguarding Adult Board, Oxfordshire
[I just wanted to give] "*feedback about how good the engagement from SCAS at the Oxfordshire Safeguarding Adults Board has been these last few months and appreciated by myself and the Board. Having [AD Safeguarding] regularly contribute, the assurance updates in terms of progress on your safeguarding improvement plan, the great modern day slavery case study presentation that you gave, has been recognised and is appreciated*".

Safeguarding Supervision for Frontline Staff (Since Jul 2023):

36 Sessions Held
196 Staff Attended

eLearning Module	Compliance
SG L1 Adults	97%
SG L2 Adults	97%
SG L1 Children	97%
SG L2 Children	96%
SG L3 (F2F)	84%
MCA L1	89%
MCA L2a	85%
MCA L2b	88%
LD Core Skills	92%

- Operation AVOCET a real test of improvements, embedding & sustainability
- Partnership working is exemplary, working with ICB and system partners
- Improvements evidenced by multi-ICB Quality Assurance visit reports

***August 2023* - Portsmouth Safeguarding Adults Board on receiving the Safeguarding Annual Report**
"Thank you for the report and summary - these are excellent".

Patient Safety Incident Response Framework (PSIRF)

PSIRF plan developed, approved and published in partnership with the ICB with evidence of delivery against plan

Transition to PSIRF from SI Framework 2015 successfully achieved 22 Apr 2024, incl:

- PSIR Policy in place
- PSIR Plan enacted against agreed timelines
- LFPSE also delivered

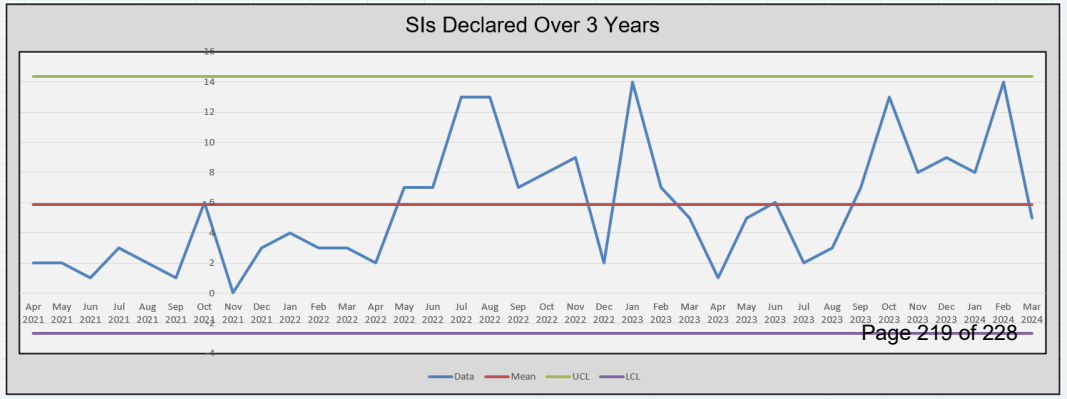
Still requiring development:

- Training Competency Framework – delivering comprehensive and coherent training packages for the following groups (Training Needs Analysis & Business Case for approval):
  - PSIRF Oversight (e.g. Board level)
  - Engagement Leads (compassionate engagement with staff, patients and families – e.g. Duty of Candour)
  - Learning Response Leads
  - Wider patient-facing staff cohorts
- Introduction of Patient Safety Partners (PSPs)

Management of Incidents

Evidenced improved management of SIs

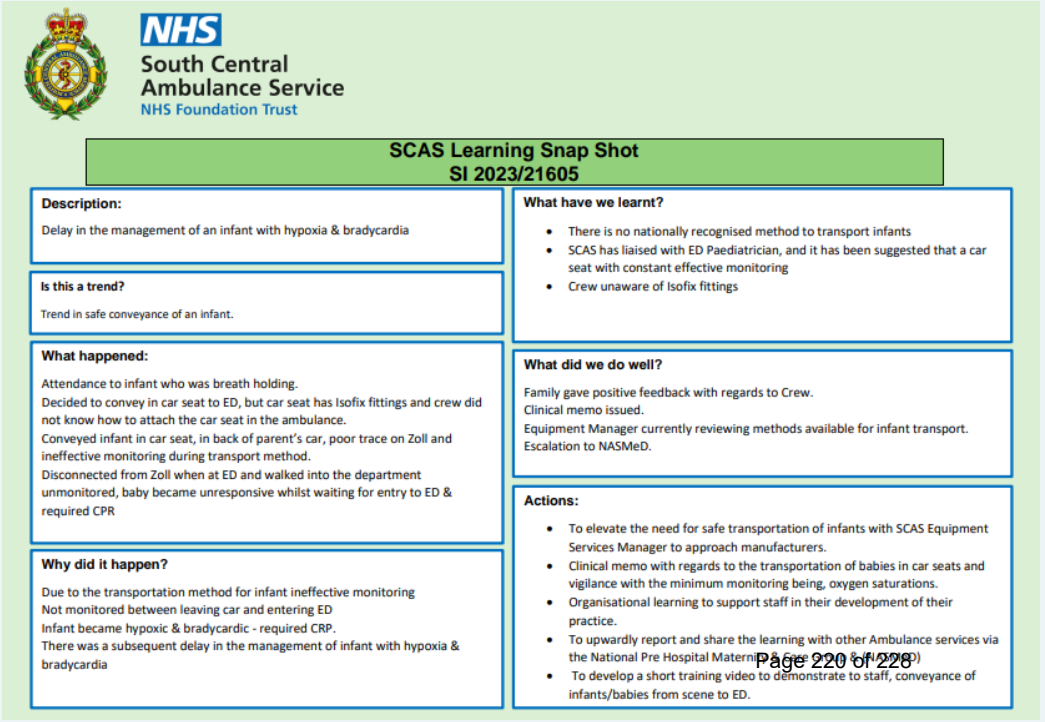
- Improved report flows (*Care to Chair*):
  - Daily Critical Review of Incidents for each service line (Patient Safety Managers (PSMs) aligned), level of harm and opportunity for learning assessed and report circulated up to Exec level, daily. Escalating to,
  - Safety Review Panel (SRP), held weekly with co-chair model of leadership to ensure resilience. ICB participation for best practice and partnership working
  - Weekly SRP report, tracking all reported incidents and outcomes also circulated to Executive level
  - Oversight of all Patient Safety Incident management by PSEC with upward reporting to Board via Q&S
- Introduced Quality Metrics Tool for audit and evaluation of Patient Safety Incident (PSI) responses
- Scheduled, quarterly quality audit of PSI responses using Quality Metrics Tool, reporting quarterly with oversight by PSEC (and Q&SC)
- Improving culture of incident reporting as shown by historical data trend analysis *(pre-PSIRF data, right)*



Learning from Incidents

Demonstrable improvement in learning from SIs (individual, organisation and system-wide)

- Learning from Experience Forum initiated with attendance by:
  - SCAS Education
  - Pre-Hospital Consultant Practitioner
  - Patient Experience
  - FTSU Leads
  - Clinical Governance Leads
  - Patient Safety Managers with
  - Service line representation
- Thematic analysis introduced to analyse groups of individual incidents (of similar categories) with an ongoing plan of activity:
  - Delay (complete)
  - Obstetric/maternity (commissioned)
- Learning snapshots available to all staff via The Hub (intranet)
- Monthly Patient Safety bulletin in Staff Matters (internal comms) & focussed campaigns, e.g. World Patient Safety Day



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SCAS Learning Snap Shot
SI 2023/21605

Description:
Delay in the management of an infant with hypoxia & bradycardia

Is this a trend?
Trend in safe conveyance of an infant.

What happened:
Attendance to infant who was breath holding.
Decided to convey in car seat to ED, but car seat has Isofix fittings and crew did not know how to attach the car seat in the ambulance.
Conveyed infant in car seat, in back of parent's car, poor trace on Zoll and ineffective monitoring during transport method.
Disconnected from Zoll when at ED and walked into the department unmonitored, baby became unresponsive whilst waiting for entry to ED & required CPR

Why did it happen?
Due to the transportation method for infant ineffective monitoring
Not monitored between leaving car and entering ED
Infant became hypoxic & bradycardic - required CRP.
There was a subsequent delay in the management of infant with hypoxia & bradycardia

What have we learnt?
- There is no nationally recognised method to transport infants
- SCAS has liaised with ED Paediatrician, and it has been suggested that a car seat with constant effective monitoring
- Crew unaware of Isofix fittings

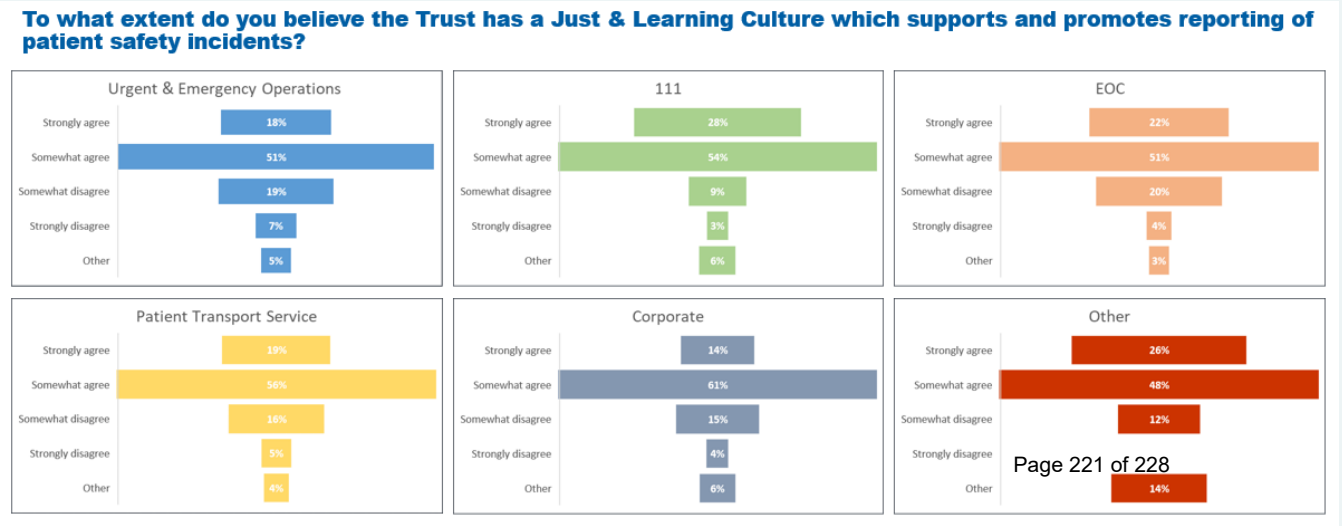
What did we do well?
Family gave positive feedback with regards to Crew.
Clinical memo issued.
Equipment Manager currently reviewing methods available for infant transport.
Escalation to NASMeD.

Actions:
- To elevate the need for safe transportation of infants with SCAS Equipment Services Manager to approach manufacturers.
- Clinical memo with regards to the transportation of babies in car seats and vigilance with the minimum monitoring being, oxygen saturations.
- Organisational learning to support staff in their development of their practice.
- To upwardly report and share the learning with other Ambulance services via the National Pre Hospital Maternity Case Group (NAPHOD)
- To develop a short training video to demonstrate to staff, conveyance of infants/babies from scene to ED.

Improved Safety Culture

Evidence of improvement in Patient Safety and Just Culture

- Significantly improved metrics, e.g. Safeguarding referral and Patient Safety Incident reporting increases
- MaPSaF survey response rates greatly improved following strong communications around Patient Safety Improvements (e.g. whole-trust webinars)
- Reassuring MaPSaF results (example, right) but needs continuing work to ensure sustainability
- Routine reporting with clear lines of communication to the Executive and Board for Patient Safety and Safeguarding , fostering a culture of internal oversight and scrutiny
- Resilience in team structures, reporting mechanisms, facilities and processes providing greater internal assurance
- Revised audit schedules across Safeguarding, Patient Safety, Medical Devices, Medicines and IPC (e.g. analgesia audits showing improvement in appropriate use, for better patient outcomes)



Patient Safety

Executive Lead:	Chief Nursing Officer
Senior Responsible Officer:	Deputy Chief Nursing Officer

Workstream Aims

To strengthen the oversight of Quality and Safety within the Trust by:

- Development of effective and sustainable systems, processes and governance for Patient Safety assurance (Safeguarding and Incident Management)
- Proactive safety culture and supportive learning culture development
- Effective Learning from Incidents (LfE)
- Maintaining the focus on Quality and Safety from point of care to Trust Board

Expected Outcomes

- Consistent Board-level leadership of Patient Safety, Experience & Safeguarding
- Patient Safety and Safeguarding oversight, escalation and improvement is consistently demonstrated in BAF and Corporate Risk Registers and Board papers
- Patient Safety culture maturity consistently demonstrated through internal and external audit, surveys, peer review, learning from patient events and staff engagement and feedback
- Section 4.2.1 and 11 Core Arrangements of the Safeguarding Accountability and Assurance Framework (SAAF) are embedded across the organisation
- Complete the transition to PSIRF to enable the effective management of Patient Safety Incidents
- Evidence of Just and Learning culture embedded across the Trust

Key Risks

- Recurrent impact of operational pressures on Patient Safety assurance activity
- Financial pressures may impact on capacity to fully embed and sustain Patient Safety improvements
- Imminent changes Quality and Safety leadership team disrupts improvement activity

Issues

- Reputation of SCAS (incl. Safeguarding Service) continues to be adversely affected by failures of systems and processes relating to Safeguarding referrals

Key Milestones

2024 / 2025	Q1	• Transition to PSIRF and Learning From Patient Safety Events (LFPSE) systems and processes • Successful resolution of Safeguarding end-to-end referral process Task and Finish Group (recommendations to be implemented Q2-4) • Introduce new IPC Audits (revised content and schedule) • Commencement of new IPC L2 (F2F) for 999/PTS operations
	Q2	• Development of Medicines tracking Business Case • Implementation of Medical Devices Asset Management system • Focus on IPC practice and procedure (e.g. Hand Hygiene/Bare Below the Elbow (BBE))
	Q3	• Evidence of continually improving patient safety culture (third MaPSaF survey to be conducted) • Joint staff engagement events to promote positive Patient Safety culture (in-line with Patient Safety Week/FTSU month) • Enhanced medicines management with potential for in-house medicines packing • Patient Safety Partner (PSP) recruitment
	Q4	• Further demonstrable evidence of embedded and sustained improvement • Review and audit of PSIRF/LFPSE activity (12 months post-implementation)

Appendices

1. Patient Safety Progress & Sustainability Update
2. Patient Safety Improvement Scorecard (Metrics)

SCAS Improvement Programme: Progress & Sustainability Update

April 2024

Patient Safety: *Improvements in patient safety and experience, with evidence of effective systems and process in place around safeguarding and adverse incidents*		Progress	Sustainability
Exit	Embedded section 4.2.1 and the 11 core arrangements within the Safeguarding Accountability and Assurance Framework	⇨	⇧
Exit	PSIRF plan developed, approved and published in partnership with the ICB with evidence of delivery against plan	⇨	⇧
Exit	Evidence of improvement in Patient Safety and Just Culture	⇨	⇧
Exit	Demonstrable improvement in learning from SIs (individual, organisation and system wide)	⇨	⇧
Exit	Evidenced improved management of SIs	⇨	⇧
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*	⇨	⇨

SCAS Improvement Programme Scorecard: Patient Safety April 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
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*	5% target increase per Qtr. Q3. Data from SCAS BI/Doc-Works Q4. Data from Doc-Works
				Actual	13728	14221	16311	20458	22267	22773	TBC		
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. Q4. Impacted by competence expiry/new starters.
				Actual	18%	31%	49%	60.75%	82%	82%	84%		
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. Q4. No change
				Actual	30%	64%	94.5%	94.5%	97.8%	97.8%	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*	*N/A*	*5%*	*N/A*	*7.5%*	Repeated every 6/12. Q4. 1008/4500 respondents. Survey closed 29/02/2024
				Actual	N/A	3%	N/A	N/A	N/A	22.4%	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 SI, DI and Low/No Harm reporting. Q4. On track
				Actual	N/A	N/A	10	10	10	10	TBC		
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 (to >95%) dependent on intro of new Asset Management system. Q4. Current compliance position
				Actual	80%	90%	93%	93.4%	97%	95.4%	96.3%		
7	Decrease in number of medicines unaccounted for/loss	New for 23/24 IPR	<15 (Post Q3 23/24)	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*<15*	*<15*	*<15*	*<15*	IPR compliance data (new for 23/24) Target set following Q3 data and based upon 5 or less losses/month. Q4. Data set complete
				Actual	N/A	N/A	34	82	11	15	TBC		
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. Q4. Data set complete
				Actual	N/A	74%	80%	77.9%	87.3%	92.5%	TBC		
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. Q4. Data set complete
				Actual	N/A	91%	96.5%	93.1%	93.3%	98.5%	TBC		

Review of 2024/25 Board Meetings

Please insert your comments in columns 1,2 and 3 and provide and overall rating using the key below in column 4.

Meeting	Reviewer	1.Timeliness of papers	2.Quality of papers	3.Meeting content	4.Overall Rating	Comments
28 March 2024						
Public Board	**Non- Executive Director** Sumit Biswas	Adequate	Adequate	Adequate	Adequate	• Timing of the meeting was better managed • Reports were very good particularly the Green Plan • Improvements in executive summary of the cover sheet which are now more informative • Improvement in discussions, Chair's references to issues raised at previous meeting was welcomed • Continued improvement of NED challenge however more input is required from Executive Directors • Clarity required on how actions are taken forward tracked.
	Executive Director Mark Ainsworth	Adequate	Adequate	Adequate	Adequate	• IPR discussions continues to improve but more discussions at Board Committees level Clarity on how decisions relating to Fit for the Future programme are taken forward.

						•
Private Board	**Non- Executive Director** Mike McEnaney	Adequate	Adequate	Adequate	Adequate	• Timeliness of papers was good and quality of papers generally good • For contract papers to include a financial summary paragraph at the beginning to enable quick assessment, trends, and risks • The system information was useful • IPR paper showed improvement, however executive introductions could be shortened to allow greater discussion, as matters were described well in the paper Agenda was appropriate, with provision for assurance on matters and actions for further response
	Executive Director Paul Kempser	Adequate	Adequate	Adequate	Adequate	• At lot of detail in the IPR making it challenging to manage length of discussions • Improvement required in the operating of the Finance and Performance Committee especially around information on the management of all Category performances and utilisation of ambulances which would improve IPR reporting • Good challenges

						To link summaries to enable greater triangulation

Key

Overall Rating	Descriptors
Strong	Excellent, forward looking, full assurance and information provided, strategic, succinct, excellent use of data to support reports, papers sent in advance of scheduled time, no vulnerabilities exist, and risks are well-managed. **No room for improvement**.
Effective	Comprehensive, content is good, papers are as expected and contain relevant information to make decisions and to provide assurance, good use of data to support reports, papers met scheduled delivery time, few vulnerabilities exist, and risks are managed effectively. **Minimal room for improvement.**
Adequate	Content is sufficient to make decisions and to be assured. Some use of data where relevant. Length of papers is about right, papers circulated on time, some vulnerabilities exist, and risks are managed. **Some room for improvement**.
Needs Improvement	Content is insufficient to make decisions and to be assured. Length of papers is too long and not succinct. Some papers circulated on time, many vulnerabilities exist, and risks are not evidently managed. **Lots of areas for improvement**.
Ineffective	Content is ineffective and unable to make decisions. No assurance. Length of papers is too long, not succinct. Badly written reports. Little use / evidence of data to support report assertions. Papers circulated late. Lots of vulnerabilities exist, and risks are not managed. **Lots of areas for improvement**.

South Central Ambulance Service
NHS Foundation Trust

Public Trust Board Meeting

Supporting Information

DATE: **30 May 2024**
TIME: 9.30 - 12.45
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

NHS
South Central
Ambulance Service
NHS Foundation Trust

Acronyms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

South Central Ambulance Service
NHS Foundation Trust

BOARD MEMBERS REGISTER OF INTERESTS

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

INTRODUCTION & BACKGROUND

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

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

DOCUMENT INFORMATION

Date of issue: 26 May 2023

Produced by: The Governance Directorate

PROFESSOR SIR KEITH WILLETT CBE, TRUST CHAIR

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

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

Current 'Other' Interests

4. Honorary Air Commodore to 4626 Squadron, RAuxAF

Interests that ended in the last six months

5. None

SUMIT BISWAS, NON-EXECUTIVE DIRECTOR / DEPUTY CHAIR

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

1. None

Current 'Other' Interests

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

Interests that ended in the last six months

4. None

LES BROUDE, NON-EXECUTIVE DIRECTOR / SENIOR INDEPENDENT DIRECTOR

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

1. None

Current 'Other' Interests

2. Independent member of the Buckinghamshire Healthcare NHS Trust Charitable Funds Committee

   Interests that ended in the last six months

3. Executive Coach at ella Forums
4. Senior Independent Trustee for the Royal Hospital for Neuro-disability and Chair of the Audit and Risk Committee

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. Director of Farrar Chapman Ltd*

5. Director Empowering Leadership Ltd
6. Community Governor, New Marston Primary School, Oxford (part of the River Learning Trust)
7. Chair, Elmore Community Services, Oxford

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

Interests that ended in the last six months

8. Vice Chair of Care International UK

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)
5. Chair, NHS Wales Joint Commissioning Committee

Interests that ended in the last six months

6. 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

NHS
South Central Ambulance Service
NHS Foundation Trust

Integrated Quality and Performance Report: Apr-24

Executive Summary

Operational Performance

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

Safety and Quality

People

Finance

Executive Commentary :

The Trust's financial position at month 1 (April) is £1.9m deficit which is £0.7m adverse to plan. The Trust has a financial plan for 2024/25 year of £11.2m

The Trust's cash balance at the end of April stood at £27.3m. There was a net cash inflow in M1 due to the receipt of year end commissioner funding and sales receipts from a sale and leased back arrangement.

The April month end debtors analysis of debts over 90 days old. The over 90-day debt has decreased this month and now stands at £116k (down from £199k in March). This decrease is due to Guys & St Thomas's paying their £51k of secondment recharges and NHS Bedfordshire paying their £23k of ECRs. With the Total Sales Ledger debt has decreased this month and now stands at £1.04m (down from £1.82m in March). The 90-day category debt has increased to 11.23% of the total sales debt (up from 10.97% in March).

The Trust's capital spend in the month is £0.3m. The plan for the month was £2.2m. The underspend was due to the 22/23 cohort of 53 DCA's being further delayed with only seven chassis's received in April. The capital forecast for the year remains £12.9m against CDEL and a total of £41.6m including IFRS16 and PDC funded spend.

The Trust's Financial Recovery Plan includes a net savings target of £27.7m.

Executive Commentary (continued) :

During the reporting period the Trust Transitioned to PSIRF on 22nd April. No further SIs will now be declared. However, three Sis were reported within the month. Two in relation to ambulance delay, one of which is a system SI, which will be downgraded by the ICB as further information subsequently became available. The third SI declared was in relation to potential incorrect clinical assessment. As previously reported there will be a requirement to continue to 'dual' report during the transition period. Two SI s remain overdue with approved ICB extensions in place.

There have been two Patient Safety Incidents (PSI) declared.

Since transitioning to PSIRF, the Trust has seen a further improvement in the timeliness of reviewing incidents, with the introduction of daily critical reviews with each of our services. Focus continues to be on closing of SIs, and tracking of outstanding actions form SIs.

Safeguarding Training at level 1, 2 and 3 have a 90% target as suggested by our ICB commissions to align with targets set with other providers and agreed by the Executive Management Committee. Compliance with levels 1 and 2 is above target and Level 3 currently is 86% reduction of 1% since the last report.
This is due to some staff coming out of compliance and insufficient numbers of existing staff completing training. These staff are not new starters. This is being closely monitored by Education and Safeguarding colleagues.

The number of IPC vehicle audits is lower than plan. The number of those completed that were non-compliant was 3 with 100 being compliant.
The number of building audits completed was 47 with 42 compliant.
There is an IPC improvement plan in place and a new audit schedule and revised tool commencing in May 2024.

Medicines packing audit results for the month was 100% compliant marking an improvement from 97.5% in previous month. The days of stock available is lower than plan but not at a level that impacted the operational performance.

We have consistently met the overall trust wide target for closing and responding to complaints during the reporting period. However, 111 response rate of complaints fell to 75% - this equates to 2 cases.
PTS complaints response rate was 100% and 999 95%.
80 formal complaints were closed in the reporting period compared to 35 last month.

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) .

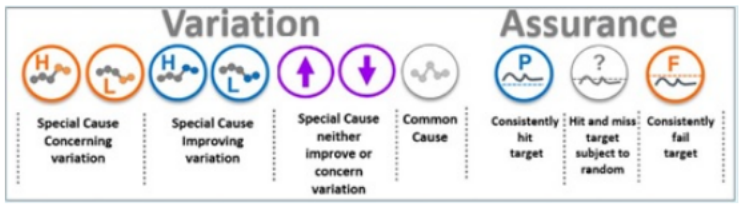
4) A run of 6 consecutive ascending or descending values (a trend).

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



NHS Icon Descriptions

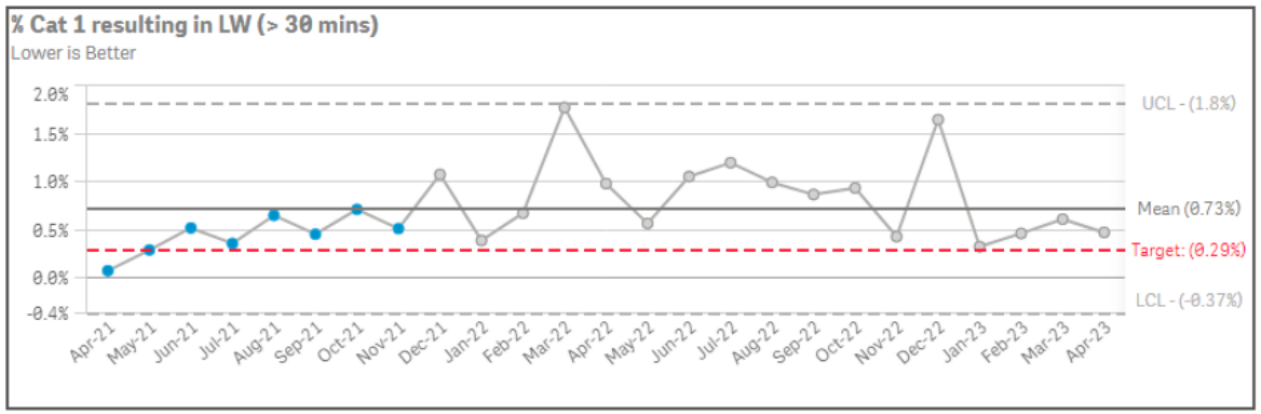
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS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

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

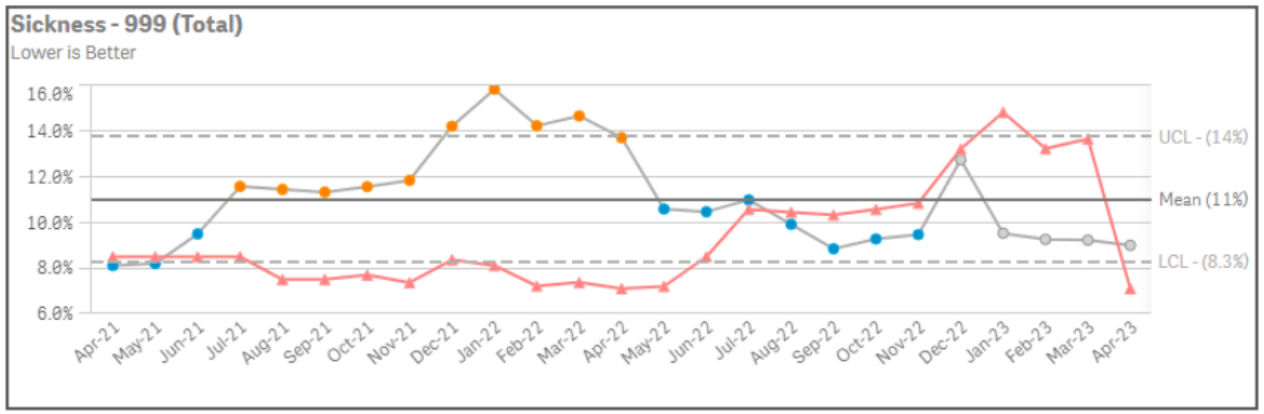
Assumptions:

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

Example of Target Line Chart



Example of Plan Line Chart



UCL & LCL:

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

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

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

NHS Overall Summary

April-24 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		VOR - Total		1
L	Health & Safety Manual Handling Meal Break Compliance - SCAS Safeguarding Adults Level 1 Safeguarding Children Level 1	Equality & Diversity S&T - SCAS		
	Appraisals - Trust Average Hospital Handover Time - SCAS	24	Over-runs >30 mins - SCAS Patients Collected within time Percentage of compliant Hand Hygiene audits	12
L	Cat 1 Mean SCAS	111 Calls abandoned after 30 secs % 999 Mean Call Answer Time Cat 1 90th %ile SCAS		3
H	111 Call back < 20 min 111 call answer in 120 Secs % Safeguarding Level 3	Percentage of compliant cleanliness compliance audits		4
↗				
↘		Number of Never Events (CQC/NRLS reportable) Number of Physical Assaults Number of reported CD incidents – unaccounted for losses		

Metrics:

Hit and Miss Common Cause Metrics:
999 Calls abandoned % ; Building cleanliness completed audits ; Cardiac Arrest Survival, Utstein ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 3 90th %ile SCAS ; Cat 4 90th %ile SCAS ; Clear up Delays - SCAS ; Complaints - 999 Total % ; Compliments % ; Debtors > 90 days> 5% total balance ; H&T - SCAS ; Hand Hygiene audit ; Number of SI investigations outstanding after 60 days (excluding events that are officially suspended) ; Number of cleanliness compliance audits ; Percentage of compliant Building cleanliness audits ; Percentage of compliant Vehicle cleanliness audits ; ST&C (ED 1&2) - 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 ; Vehicle cleanliness completed audits

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Operational Performance

NHS Operational Performance Overview

April-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		VOR - Total		
L		S&T - SCAS		
	Average Hospital Handover Time - SCAS	999 Calls abandoned % Cat 2 90th %ile SCAS Cat 2 Mean SCAS Cat 3 90th %ile SCAS Cat 4 90th %ile SCAS Clear up Delays - SCAS Complaints - 999 Total % Compliments % H&T - SCAS ST&C (ED 1&2) - SCAS	Patients Collected within time	2
L	Cat 1 Mean SCAS	111 Calls abandoned after 30 secs % 999 Mean Call Answer Time Cat 1 90th %ile SCAS		
H	111 Call back < 20 min 111 call answer in 120 Secs %			
↗				
↘				

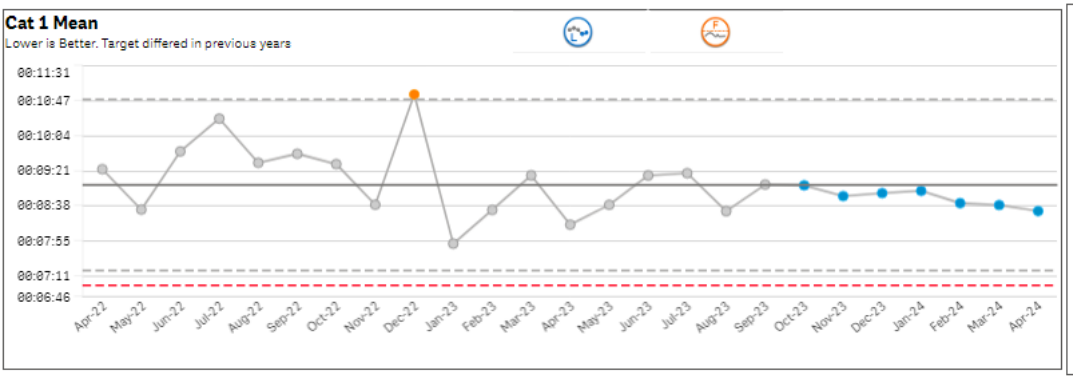
NHS Operations - Response Times/Utilisation/Operations Centre

*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
Cat 1 Mean	Apr-24	00:08:31	00:07:00	L	F	00:09:04	00:07:19	00:10:49
Cat 1 90th %ile	Apr-24	00:15:29	00:15:00	L	?	00:16:20	00:13:15	00:19:25
Cat 2 Mean	Apr-24	00:27:40	00:30:00		?	00:33:48	00:13:57	00:53:38
Cat 2 90th %ile	Apr-24	00:54:34	00:40:00		?	01:08:04	00:24:40	01:51:28
Cat 3 90th %ile	Apr-24	04:33:45	02:00:00		?	05:19:20	00:41:09	09:57:32
Cat 4 90th %ile	Apr-24	05:07:42	03:00:00		?	06:47:38	00:56:53	12:38:22
% Vehicles off the road	Apr-24	0.36%	23%	H	?	0.3%	0.2%	0.3%
Ave Handover	Apr-24	00:24:03	00:15:00		F	00:25:16	00:16:33	00:33:59
Handover > 15mins	Apr-24	47%			n/a	44.8%	35.1%	54.6%
Clear up Delays	Apr-24	00:15:17	00:15:00		?	00:14:59	00:14:18	00:15:39
% See and treat	Apr-24	33%	35%	L	?	34.2%	32.9%	35.6%
% ST&C to ED	Apr-24	49%	47%		?	49.6%	47.1%	52.2%
999 Call Answer	Apr-24	7.2%	10%	L	?	37.5%	-21.5%	96.5%
999 Ab. Rate	Apr-24	2.3%	2%		?	6.6%	-1.5%	14.6%
% Hear and treat	Apr-24	12%	13%		?	11.8%	9.3%	14.3%
111 Call Answer	Apr-24	88%	95%	H	F	58.2%	23.5%	92.9%
111 Ab. Rate	Apr-24	1.4%	3%	L	?	9.2%	-4.7%	23.0%
111 Call backs	Apr-24	43%	95%	H	F	21.9%	11.3%	32.4%

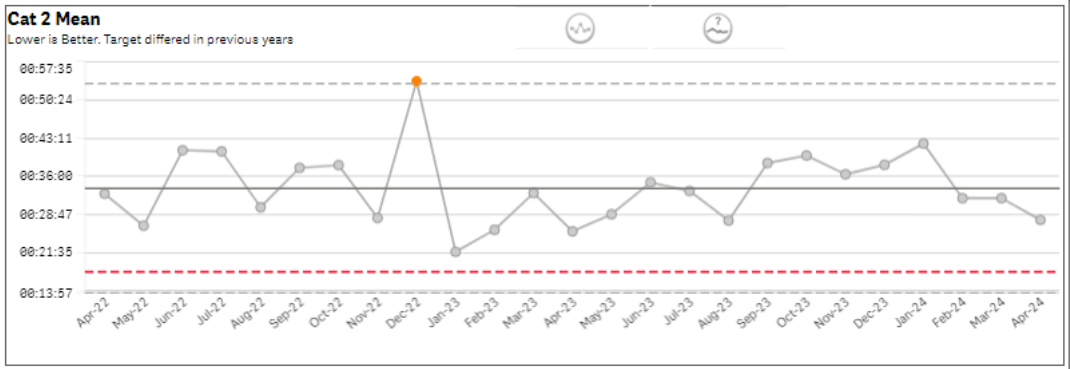
Operations - Response Times

Cat 1 Mean
Lower is Better. Target differed in previous years



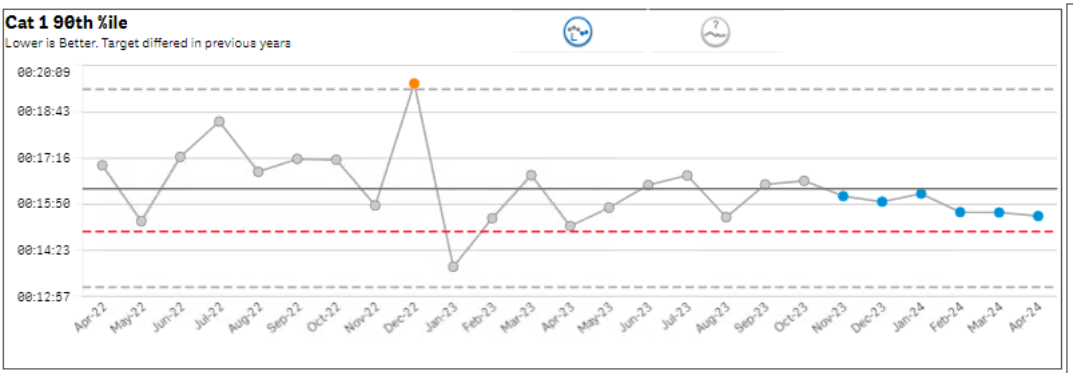
Variation	Assurance	Target	Latest
Improving	Fail	00:07:00	00:08:31

Cat 2 Mean
Lower is Better. Target differed in previous years



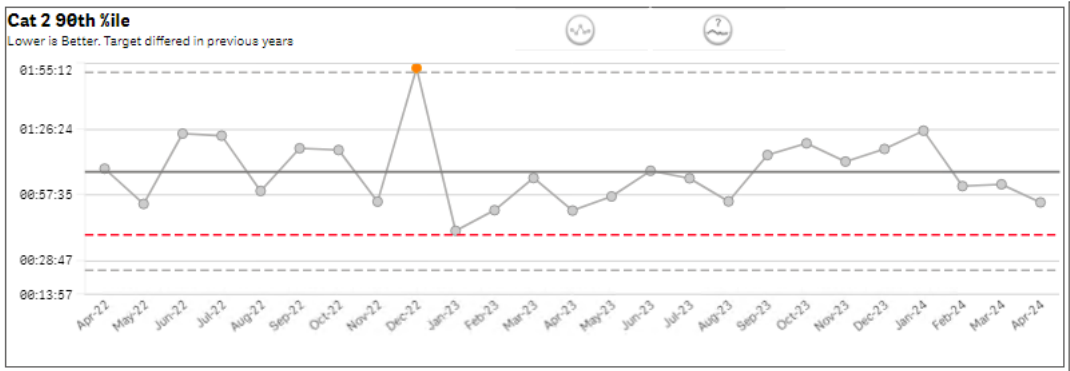
Variation	Assurance	Target	Latest
Expected	Random	00:18:00	00:27:40

Cat 1 90th %ile
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	00:15:00	00:15:29

Cat 2 90th %ile
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:40:00	00:54:34

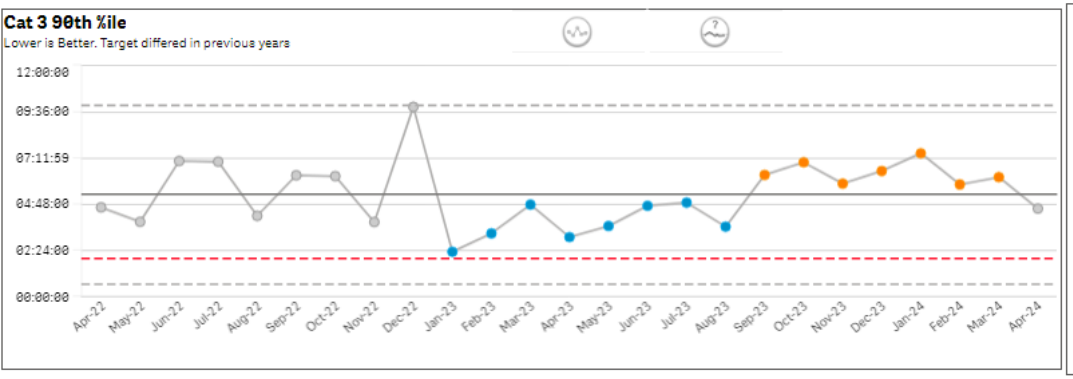
Understanding the Performance:
April saw improved Cat 1 performance for the 4th month in a row finishing 08:31. Whilst it has been below the mean for 7 months it remains above target. Cat 2 mean also improved in April being below the mean for the 3rd month in a row. Performance was below target, at 27:40, For the first time since August 23. These improvements were due to improved hospital turnaround and high staff hours. Hours position driven by low A/L and training abstraction and improved performance from PPs.

Actions (SMART):
Hours managed through allocation of A/L, reduced OT, PP hours managed to core contracts and allocation of eLearning hours.

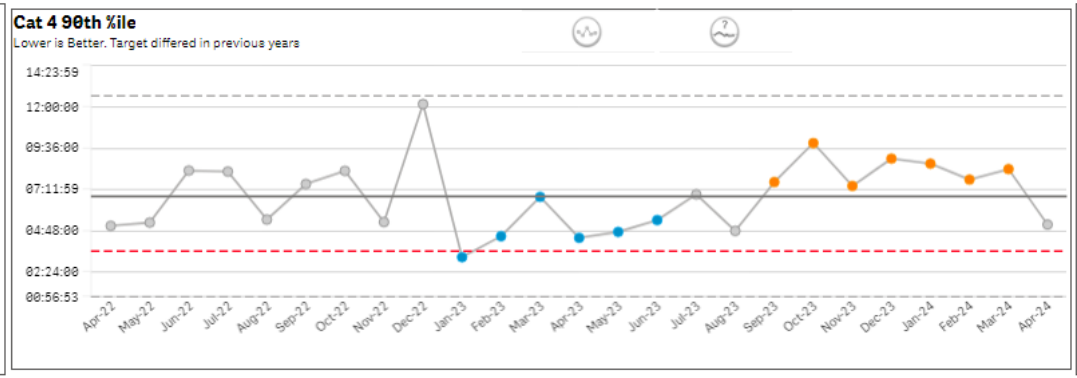
Risks:
As we enter May planned abstractions will increase and we are likely to see increased pressure on performance.

NHS

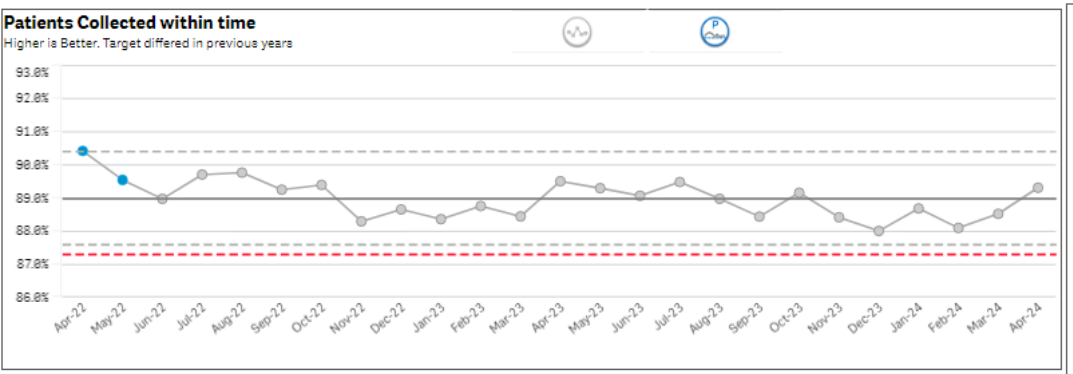
Operations - Response Times



Variation
Expected
Assurance
Random
Target
02:00:00
Latest
04:33:45



Variation
Expected
Assurance
Random
Target
03:00:00
Latest
05:07:42



Variation
Expected
Assurance
Pass
Target
87%
Latest
89.3%

Understanding the Performance:

April saw improved Cat 3 performance for the 3rd month in a row finishing at 04:33 which remains above target but is below the mean which was last achieved August 23. Cat 4 performance improved by over 3 minutes dropping below the mean for the first time since August 23 but remaining above target. The improvements were driven by improved hospital turnaround and high staff hours.

Actions (SMART):

Hours managed through allocation of A/L, reduced OT, PP hours manged to core contract and allocation of eLearning

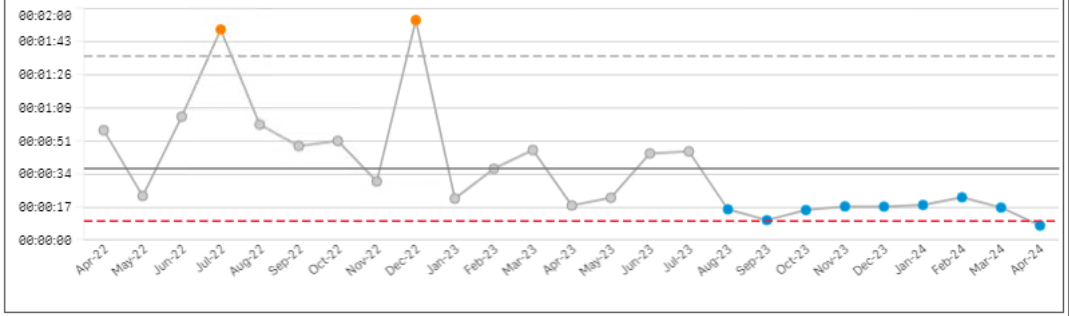
Risks:

As we enter May planned abstraction will increase and we are likely to see increased pressure on performance.

Operations - Operations Centre

999 Call Answer

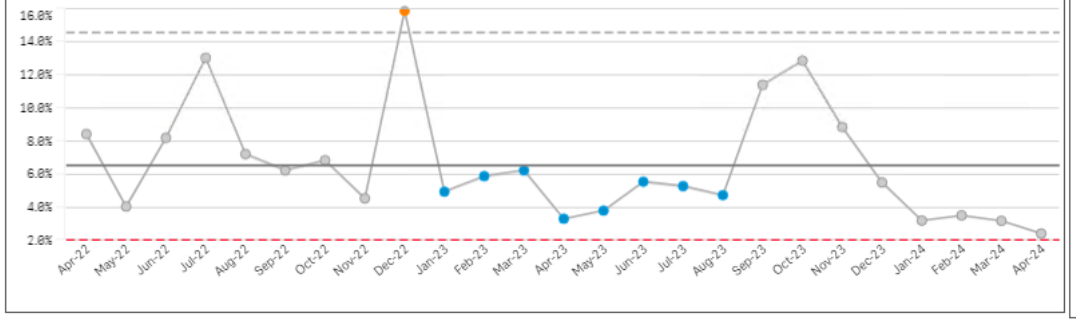
Lower is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	00:00:10
Latest	00:00:07

999 Ab. Rate

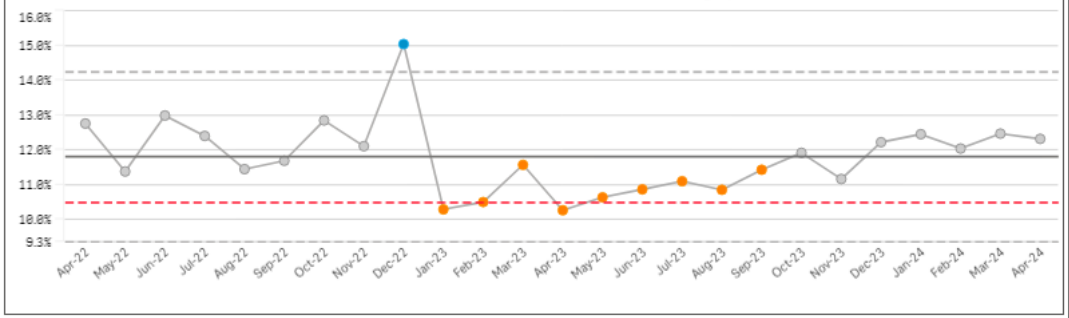
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	2%
Latest	2.3%

% Hear and treat

Higher is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	11%
Latest	12.3%

Understanding the Performance:

Mean call answer remains below the mean at 7 seconds, achieving national target for the first time since May 2021. Correspondingly abandonment rate remained low at 2.34%. These metrics were underpinned by a drop in demand, which fell 8% below short term forecast and therefore coming more in line with call handling logged in hours available. Reduction in annual leave and abstractions for face to face training in the first part of April improving logged in hours. In post currently are 198.87 WTE of which 38 WTE are in training/coaching.

Hear and Treat remained above the mean at 12.38% and just below target of 13%. Ambulance resource availability was improved in April enabling dispatch prior to clinician involvement.

Actions (SMART):

We continue to work on the actions in the call answer improvement plan, making incremental changes, aiming to improve logged in hours and reduce average handling time. Rota review project will start consultation with staff in May, with implementation date early September. Support from WMAS remains in place but transfer of calls has been minimal during April. AACE are reviewing Cat 1 early identification processes in May and will review potential technical solution.

The hear and treat improvement plan has been reviewed and updated. Team are working with complex care team to reduce demand, freeing up clinical capacity to review other types of call. Information has been shared from LAS to support governance framework for CSD.

Risks:

Increasing demand (duplicate calls) is likely to outstrip capacity impacting call answer performance.

Lack of call centre workforce management system inhibits ability to flex hours due to fixed rota patterns to meet any changes in demand, and with current financial pressures ability to offer overtime is limited and therefore performance may be impacted.

Capacity and experience of team may impact ability to deliver call answer improvement and hear and treat improvement plans at pace.

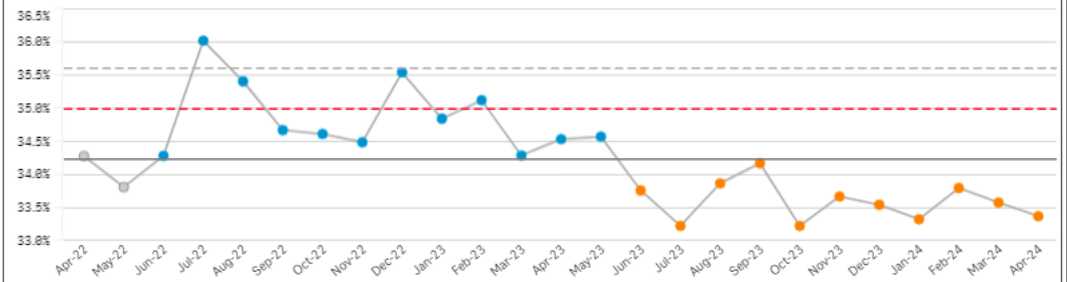
Current rota results in gaps in logged in hours against demand, any delay in implementation will have an impact on our ability to deliver consistent call answer performance.

NHS

Operations - Utilisation

% See and treat

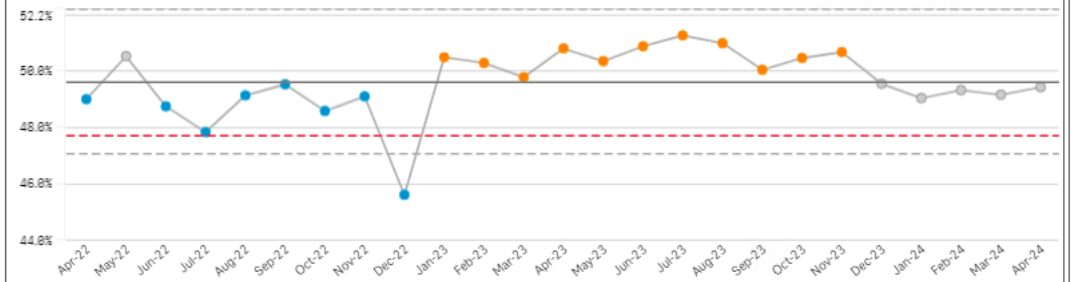
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Random	35%	33.4%

% ST&C to ED

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	48%	49.4%

Understanding the Performance:

S&T has been below the mean now for 11consecutive months but still by less than 1%. We have seen another small decrease in April but counter that to the small increase in H&T it should not be unexpected. ST&C to ED has seen a small rise through April by less than 0.3%. There is a link between increased handover delays and decreased conveyance to EDs which we had during April. The thought is that its a cultural response which the clinical pathway team have as an action to address. Its worth noting that apart from a few variations the convey to ED stays fairly consistent over the two year period.

Actions (SMART):

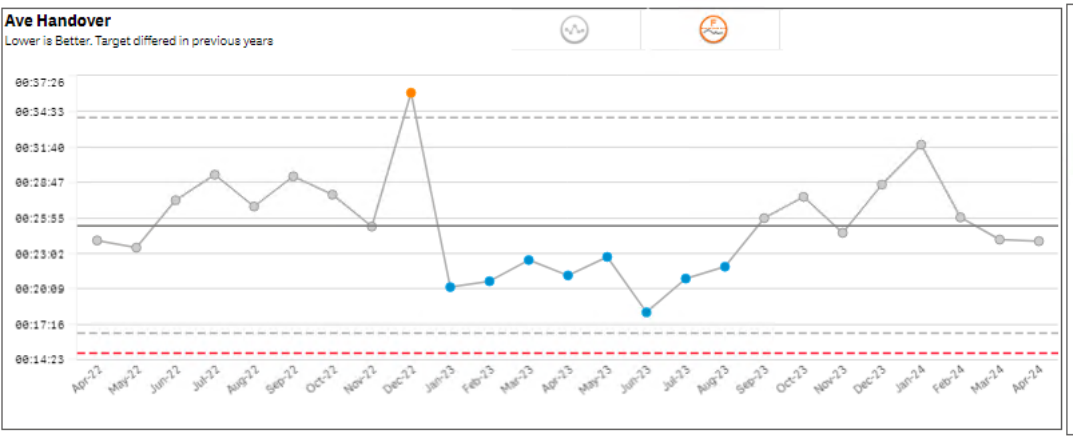
Rapid Drop and Go/Fit to Sit was rolled out across all acutes in SCAS following a successful pilot at QAH and MKGH which will improve turnaround at EDs. Improvements to accessing GPs is being rolled out giving staff better autonomy when attempting to contact primary care which in turn should see S&T numbers improve. Address the cultural influences on decision making which is a significant undertaking educationally.

Risks:

S&T being directly linked to H&T will show a decrease in performance as H&T improves. Spikes in acuity will affect our ability to S&T .

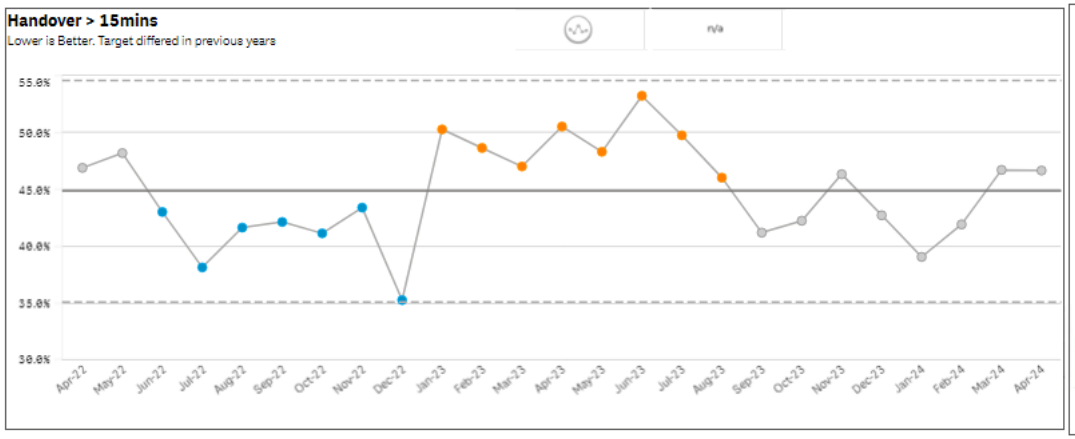
Operations - Utilisation

Ave Handover
Lower is Better. Target differed in previous years



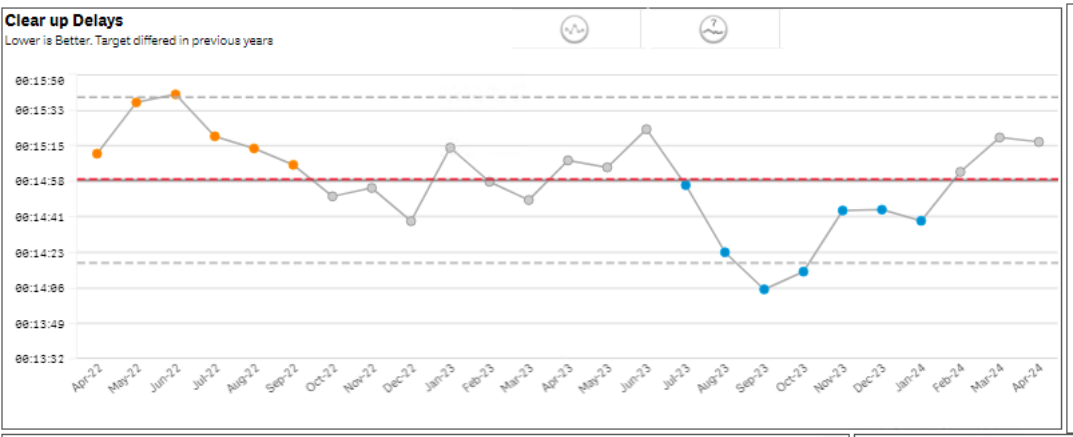
Variation	Expected
Assurance	Fail
Target	00:15:00
Latest	00:24:03

Handover > 15mins
Lower is Better. Target differed in previous years



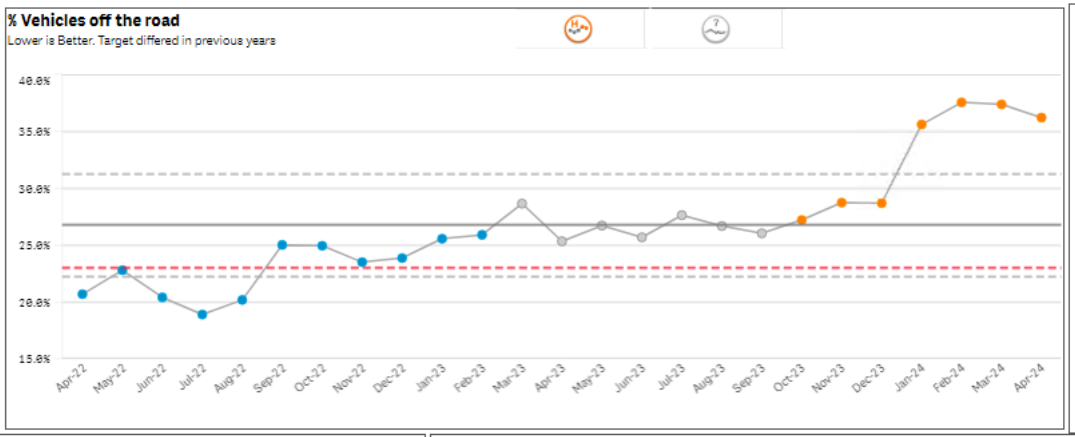
Variation	Expected
Assurance	-
Target	-
Latest	46.7%

Clear up Delays
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	00:15:00
Latest	00:15:17

% Vehicles off the road
Lower is Better. Target differed in previous years



Variation	Declined
Assurance	Random
Target	23%
Latest	36.2%

Understanding the Performance:
April has shown a small improvement in the Hospital handover process as is the case each year for April, having said that the Targets continue to fail for Arrival to Handover in 15mins with March and April sitting above the mean at 46%. As have handover times sat below the mean for the past two months but still exceed the target by some nine minutes. The improvements are linked to demand within forecast and improved operational hours and improved ED flow. VOR performance remains 10% above KPI. This increase is driven by several factors including but not limited to, age of fleet, increased Utilisation from both the change to the DCA deployment model and higher staffing levels to meet demand driving higher usage rates from what is an old fleet profile.

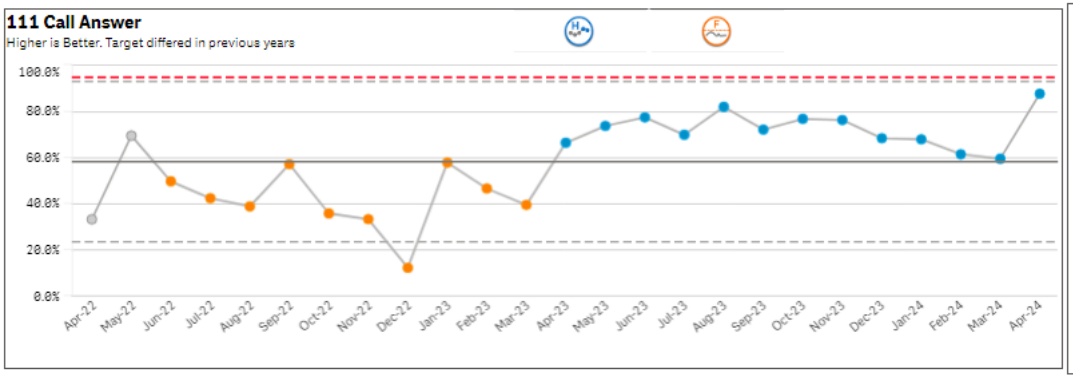
Actions (SMART):
We continue to engage with system partners to improve flow and deploy the Jumbulance and implement immediate handover at not only the QA but all sits that meet the triggers. The uplift DCA fleet is now starting to be introduced into SCAS. This will begin to support the new rotas in the South of SCAS that are being deployed April and May. New work streams are being developed to further increase workshop capacity to support a workshop model that is overwhelmed with the current demand created by the increased utilisation of the DCA fleet.

Risks:
We remain at risk with capacity within the Acutes coupled with a drop in Operational Hrs and F2F training starting that we may see a deterioration in these key PT and staff safety measures. Currently SCAS struggles to provide enough DCA's to support its operational staffing plan. With the current age profile of the DCA fleet and the unreliability issues being experienced with the Fiat fleet there is a risk that VOR further increases unless SCAS supports SCFS expanding its workshop capacity.

Operations - Operations Centre

111 Call Answer

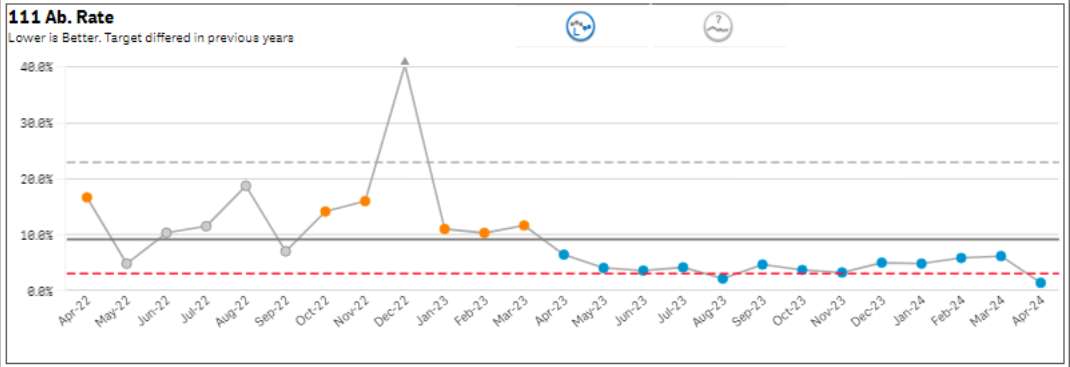
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	95%	87.8%

111 Ab. Rate

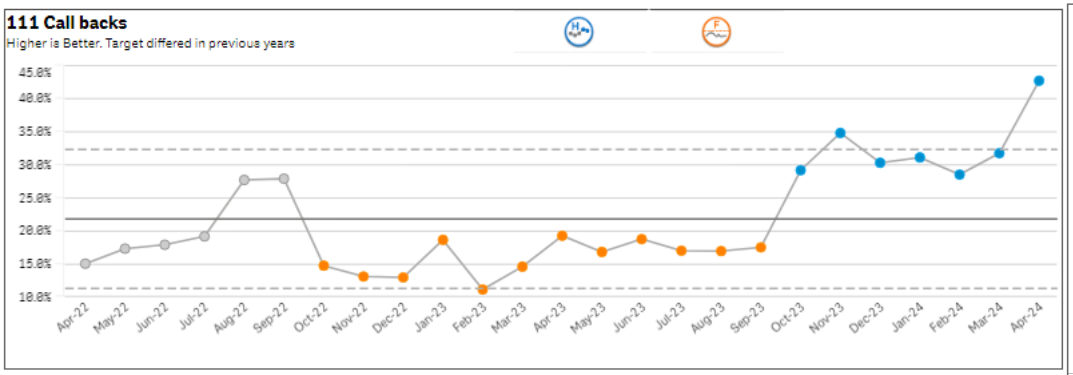
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	3%	1.4%

111 Call backs

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	95%	42.8%

Understanding the Performance:

Call answer in 120 seconds rose above the mean towards the national target and at 87.84% is the highest achieved in the past two years. Correspondingly abandonment rate remained well below the mean, achieving national target at 1.44%. Calls offered 1.4% below short term forecast alongside an increase in logged in hours supporting the improvements in call answer performance. Call back from clinician within 20 minutes rose above the upper control limits at 42.81% however remains outside national target.

Actions (SMART):

Recruitment and retention have been positive with 238 WTE Health Advisors in post, of which 18 WTE are in training. International nurse recruitment has delivered on plan meaning that we have reached budgeted establishment for clinical advisors with 82.8 WTE in post, although training of international recruits continues and will be some time before they are fully operational. The team continue to seek efficiencies in live time floor management and average handling time. Staff absence remains lower and as a result supporting increased logged in hours.

QIA for reduction in ED validation has been through internal processes and shared with ICB, implementation of DOS changes will commence in May, enabling clinical resource to be freed up to improve call back responsiveness.

Risks:

Lack of call centre workforce management system and current fixed rota patterns limits ability to flex to meet any demand increases which may impact ability to rise to demand and hit performance.

Lack of clarity on financial position on one contract limits ability to fully plan workforce requirements for 2024/25.

Current work on reducing agency hours may result in inability to cover shifts at short notice, impacting on clinical metrics.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

April-24 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L	Safeguarding Adults Level 1 Safeguarding Children Level 1			
		13	Percentage of compliant Hand Hygiene audits	
L				
H	Safeguarding Level 3	Percentage of compliant cleanliness compliance audits		
↗				
↘		Number of Never Events (CQC/NRLS reportable) Number of reported CD incidents – unaccounted for losses		

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 ; Percentage of compliant Building cleanliness audits ; Percentage of compliant Vehicle cleanliness 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

NHS 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 %	Apr-24	89.4%	95%			82.2%	51.0%	113.4%
Cleanliness%	Apr-24	98.1%	95%			96.1%	90.2%	102.0%
Hand Hygiene %	Apr-24	100.0%	95%			99.0%	95.1%	103.0%
Vehicle cleanliness %	Apr-24	97.1%	96%			94.6%	80.3%	109.0%
Complaints	Apr-24	28			n/a	24.6	7.49	41.6
Compliments	Apr-24		26%			0.2%	0.2%	0.3%
Patient Safety Incidents	Apr-24	499	425	-		446	323	569
Moderate and above Incidents	Apr-24	16	21	-		20.6	5.99	35.2
Serious Incidents	Apr-24	3	7	-		6.85	-3.57	17.3
Duty of candour in time %	Apr-24							
CD unaccounted for losses	Apr-24	7	15			11.5	-8.27	31.2
STEMI Call to angio Mean	Apr-24	10.3%	2.04			9.4%	7.3%	11.6%
Stroke Call to hosp arr Mean	Apr-24	7.0%	1.17			6.9%	4.7%	9.0%
ROSC on hospital arrival (All) %	Apr-24	24.5%		-	n/a	24.7%	22.1%	27.3%
CA survival at 30days (All) %	Apr-24	10.9%		-	n/a	8.3%	2.4%	14.2%
Safeguarding Level 1 (Adult) %	Apr-24	89.1%	95%			90.5%	86.4%	94.6%
Safeguarding Level 1 (Child) %	Apr-24	89.2%	95%			90.4%	86.5%	94.2%

NHS Quality Safety– Audits

*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	Apr-24	47	21			31.8	-1.08	64.8
Building cleanliness %	Apr-24	89.4%	95%			82.2%	51.0%	113.4%
Number of cleanliness compliance audits	Apr-24	423	449			361	131	590
Cleanliness%	Apr-24	98.1%	95%	H		96.1%	90.2%	102.0%
Number of hand hygiene audit	Apr-24	273	261			222	-6.18	450
Hand Hygiene %	Apr-24	100.0%	95%		P	99.0%	95.1%	103.0%
Number of vehicle cleanliness completed audits	Apr-24	103	167			107	19.6	194
Vehicle cleanliness %	Apr-24	97.1%	96%			94.6%	80.3%	109.0%

NHS Quality Safety– Ambulance Quality Indicators (AQIs)

*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	Apr-24	02:29	02:04			02:15	01:44	02:46
STEMI Call to angio 90th	Apr-24	04:05	02:53			03:12	01:41	04:43
Stroke Call to hosp arr Mean	Apr-24	01:41	01:17			01:38	01:08	02:09
Stroke Call to hosp arr Median	Apr-24	01:25	01:07			01:22	01:05	01:40
Stroke Call to hosp arr 90th	Apr-24	02:44	01:57			02:35	01:35	03:36
ROSC on hospital arrival (All) %	Apr-24	24.5%		-	n/a	24.7%	22.1%	27.3%
ROSC on hospital arrival (Utstein cohort) %	Apr-24	59.4%		-	n/a	54.9%	39.6%	70.2%
CA survival at 30days (All) %	Apr-24	10.9%		-	n/a	8.3%	2.4%	14.2%
CA survival at 30days - Utstein cohort%	Apr-24	40.6%	26%			30.4%	4.4%	56.4%

NHS 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	Apr-24	28			n/a	25	7.5	42
Complaints per 1000 completed patient contacts	Apr-24	17.0%		-	n/a	18.8%	16.3%	21.2%
Complaints within agreed timescales	Apr-24	95.0%	95%	-		95.6%	85.9%	105.4%
Compliments	Apr-24		26%			0.2%	0.2%	0.3%
An FFT % measure	Apr-24							

NHS 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	Apr-24	499	425	-		446	323	569
Non-Patient Safety Incidents	Apr-24	430	382	-		389	327	450
Moderate and above Incidents	Apr-24	16	21	-		20.6	5.99	35.2
Number of no/low incidents	Apr-24	507	418	-		441	306	575
Serious Incidents	Apr-24	3	7	-		6.85	-3.57	17.3
% of SIs investigated in time	Apr-24							
Major/Severe incidents	Apr-24							
RIDDOR reportable incidents	Apr-24	15	10	-		9.92	0.613	19.2
Duty of candour in time %	Apr-24							
% Medicines modules produced without error	Apr-24	100.0%	92%	-		95.6%	86.6%	104.7%
CD unaccounted for losses	Apr-24	7	15			11.5	-8.27	31.2
Number of days stock available	Apr-24	1	2	-		1.87	0.138	3.6

NHS Quality Safety– Safeguarding

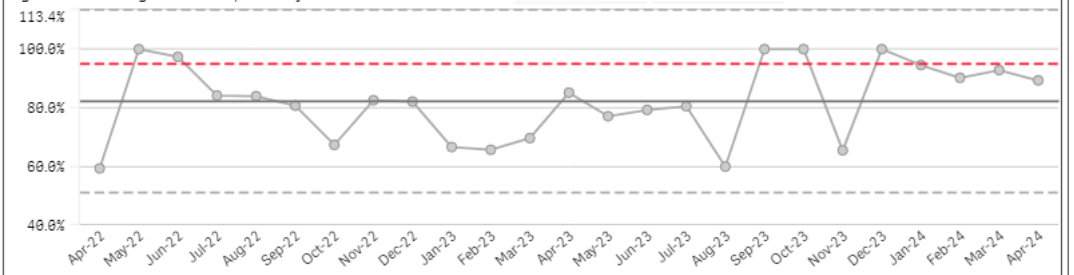
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Safeguarding Level 1 (Adult) %	Apr-24	89.1%	95.0%			90.5%	86.4%	94.6%
Safeguarding Level 1 (Child) %	Apr-24	89.2%	95.0%			90.4%	86.5%	94.2%
Safeguarding Level 2 (Adult) %	Apr-24							
Safeguarding Level 2 (Child) %	Apr-24							
Safeguarding Level 3 (Adult) %	Apr-24	80.6%	95.0%	-		51.6%	37.5%	65.7%
Safeguarding Level 3 (Child) %	Apr-24	0.0%	-			-	-	-

Quality & Safety - Audits

Building cleanliness %

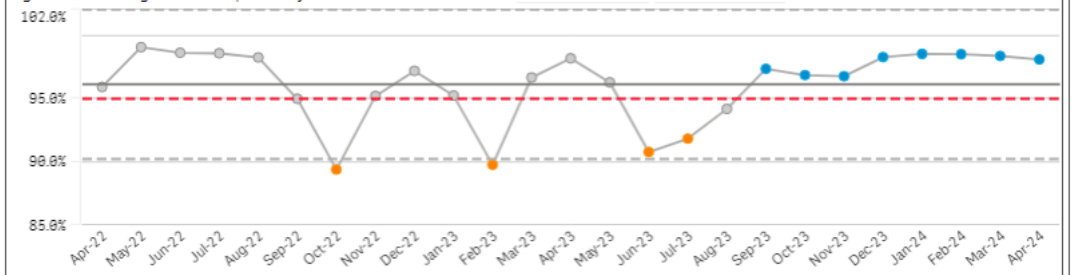
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	95%	89.4%

Cleanliness%

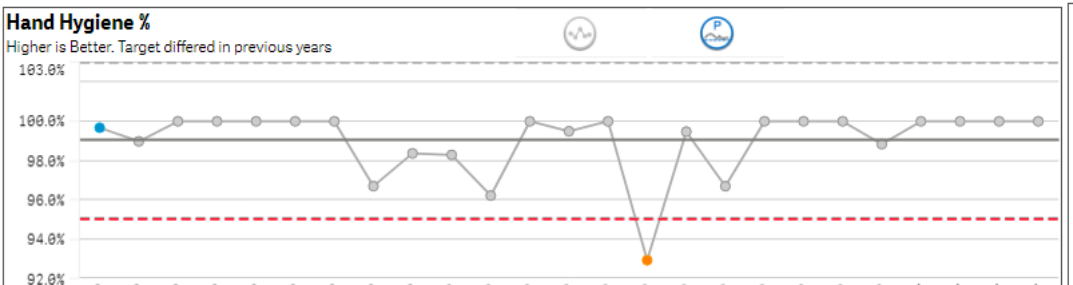
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	95%	98.1%

Hand Hygiene %

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	95%	100.0%

Vehicle cleanliness %

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	Random	96%	97.1%

Understanding the Performance:

vehicle and buildings compliant above mean (non compliant 3 vehicles 5 buildings)

Actions (SMART):

the number of vehicle audits completed is lower than plan. IPC improvement plan in place. New audit schedule and revised tool commencing May 2024.

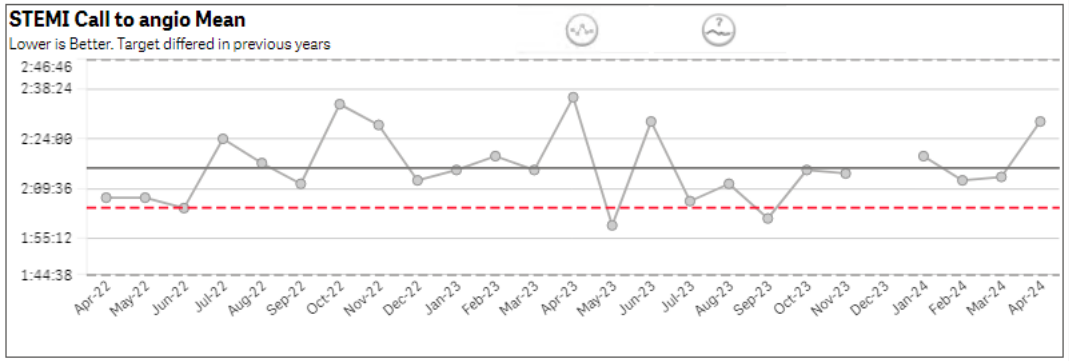
Risks:

IPC standards not maintained

Quality & Safety – AQIs – STEMI

STEMI Call to angio Mean

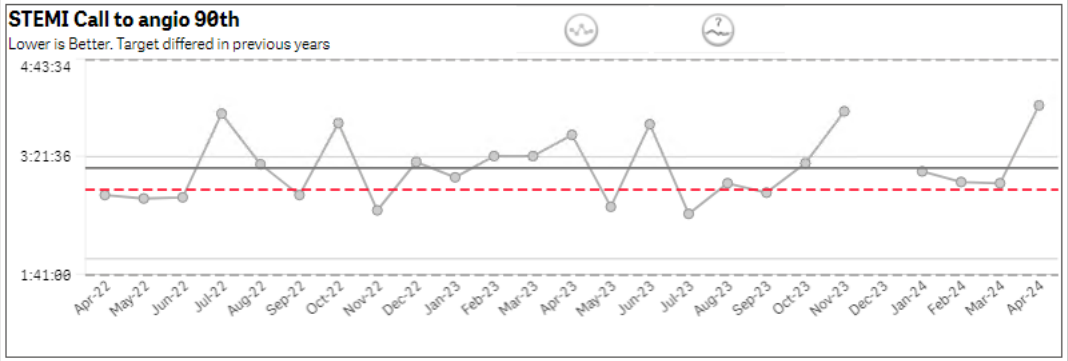
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	02:04	02:29

STEMI Call to angio 90th

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	01:17	01:41

Understanding the Performance:

Within expected variation - December 2023 cases reported this month

Actions (SMART):

Call to angiography mean England 2:36 (SCAS 2:29) 90% Centile England 3:48 (SCAS 4:05) Cat 2 improvement plan in place

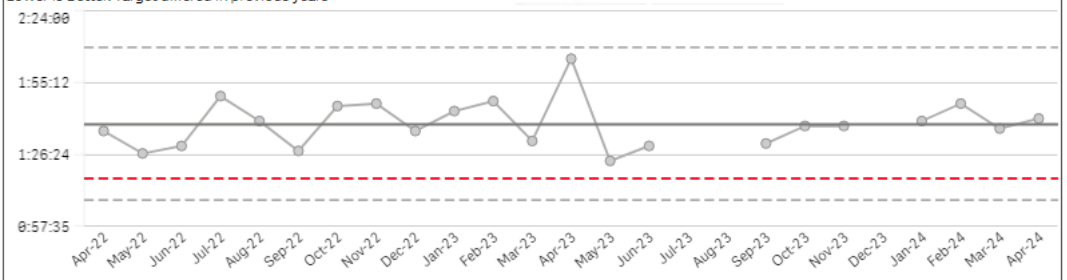
Risks:

time critical care

Quality & Safety – AQIs – Stroke

Stroke Call to hosp arr Mean

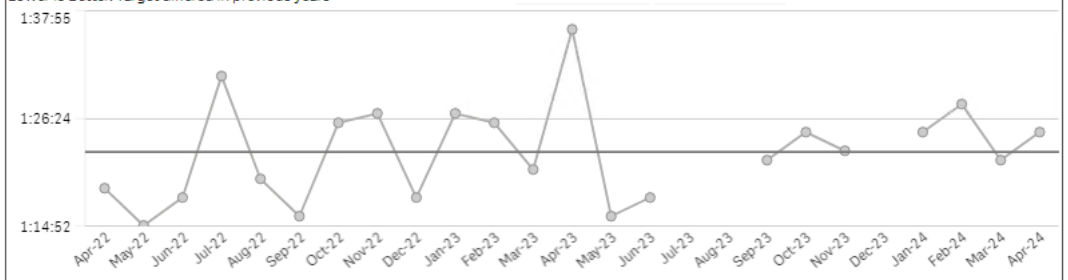
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	01:17	01:41

Stroke Call to hosp arr Median

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	01:07	01:25

Stroke Call to hosp arr 90th

Lower is Better. Target differed in previous years

Variation	Assurance	Target	Latest
Expected	Random	01:57	02:44

Understanding the Performance:

December 2023 cases reported this month - expected variation

Actions (SMART):

All times are below the England average - Cat 2 improvement plan in place

Risks:

Time critical care

Quality & Safety – AQIs – Cardiac

ROSC on hospital arrival (All) %

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
	-	-	25%

ROSC on hospital arrival (Utstein cohort) %

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
	-	-	59%

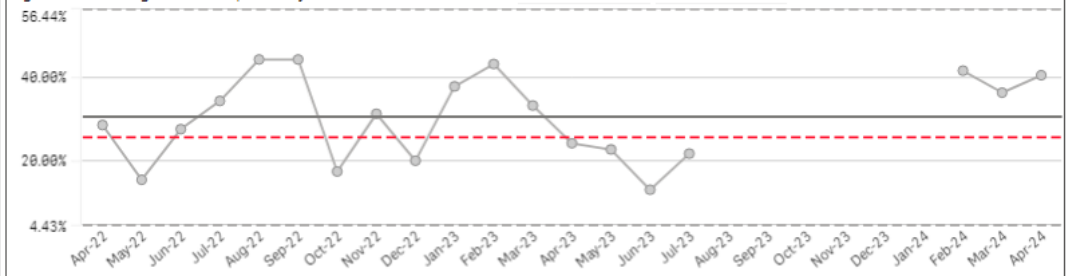
CA survival at 30days (All) %

Higher is Better. Target differed in previous years

Variation	Assurance	Target	Latest
	-	-	11%

CA survival at 30days - Utstein cohort%

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	26%	0.41%

Understanding the Performance:

SCAS data within variation.

Actions (SMART):

England average ROSC on arrival Utstein 51.9% (SCAS 59.4%) survival at 30 days Utstein group England average 27.6% (SCAS 40.6%)

Risks:

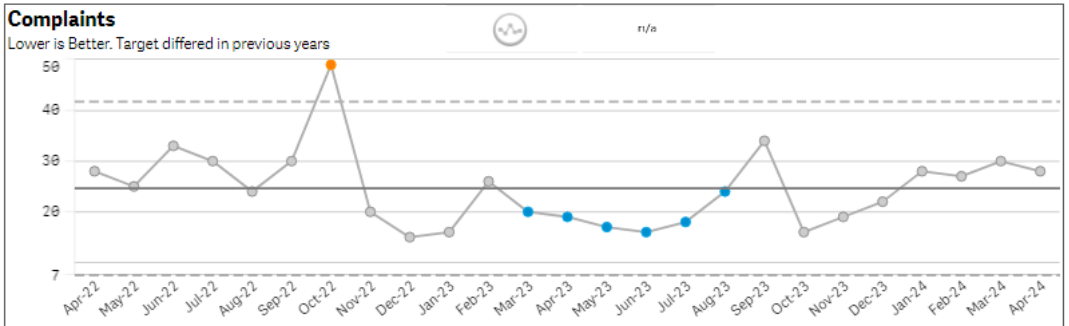
Time critical care

NHS

Quality & Safety – Complaints and Compliments 1

Complaints

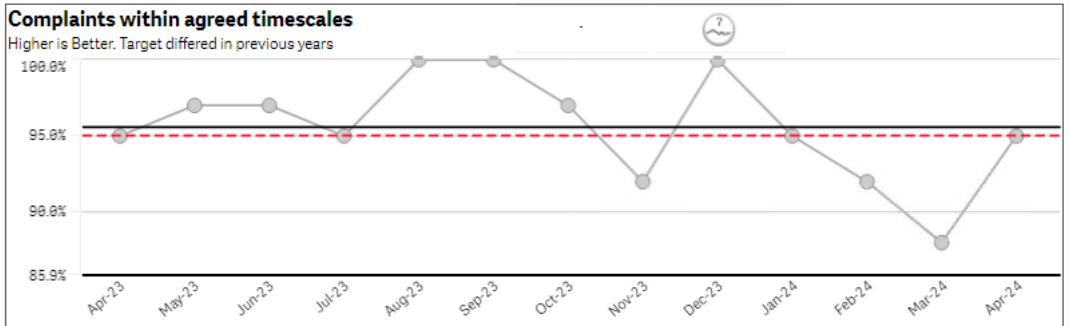
Lower is Better. Target differed in previous years



Variation
Expected
Assurance
-
Target
-
Latest
28

Complaints within agreed timescales

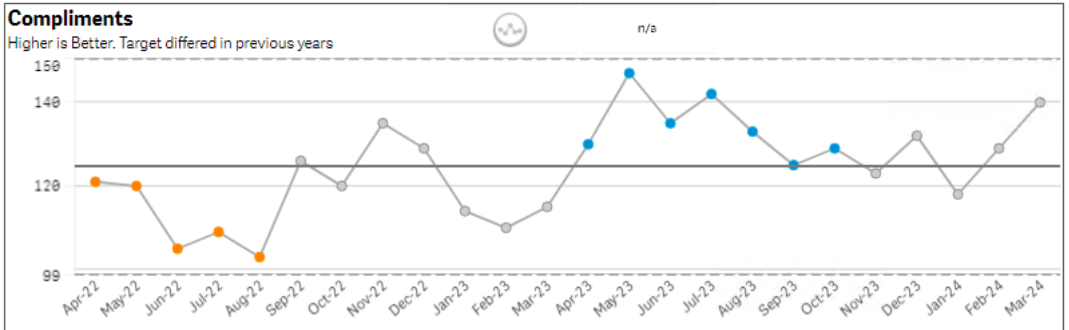
Higher is Better. Target differed in previous years



Variation
Assurance
Random
Target
95%
Latest
95.0%

Compliments

Higher is Better. Target differed in previous years



Variation
Expected
Assurance
-
Target
-
Latest

Understanding the Performance:

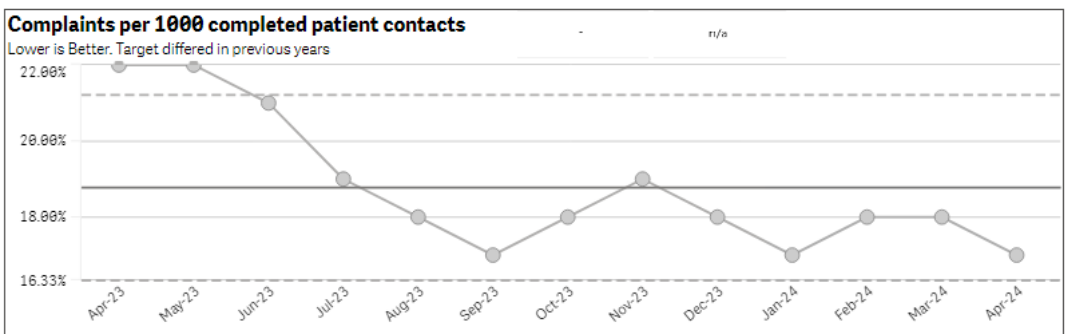
Actions (SMART):

Risks:

Quality & Safety – Complaints and Compliments 2

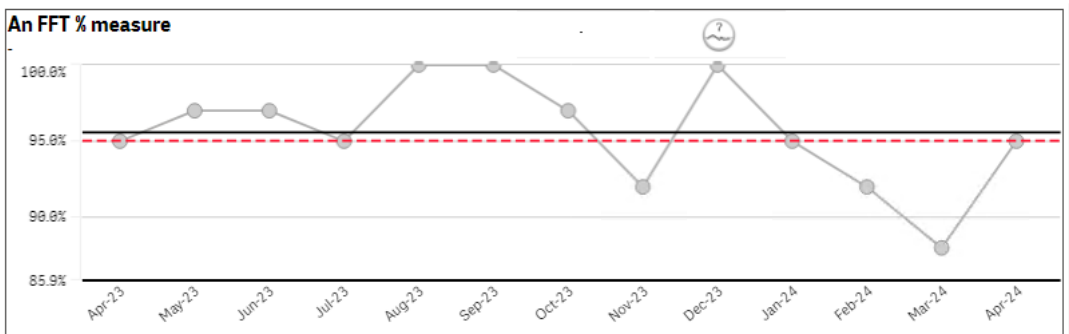
Complaints per 1000 completed patient contacts

Lower is Better. Target differed in previous years



Variation	
Assurance	-
Target	95%
Latest	95.0%

An FFT % measure

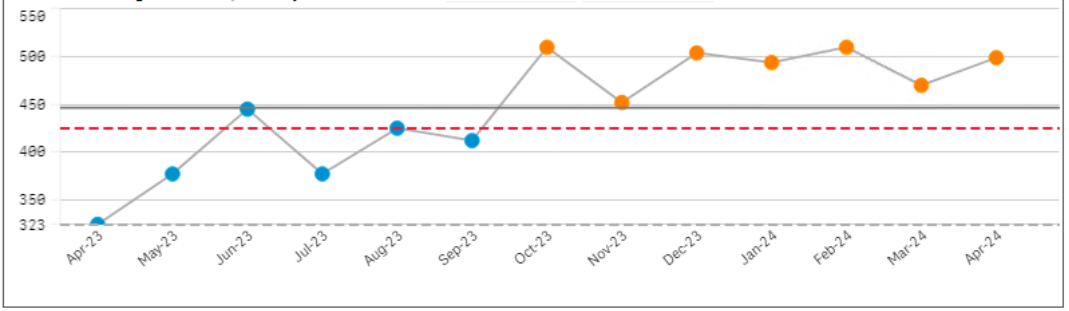


Variation	
Assurance	Random
Target	95%
Latest	95.0%

Understanding the Performance:	Actions (SMART):	Risks:

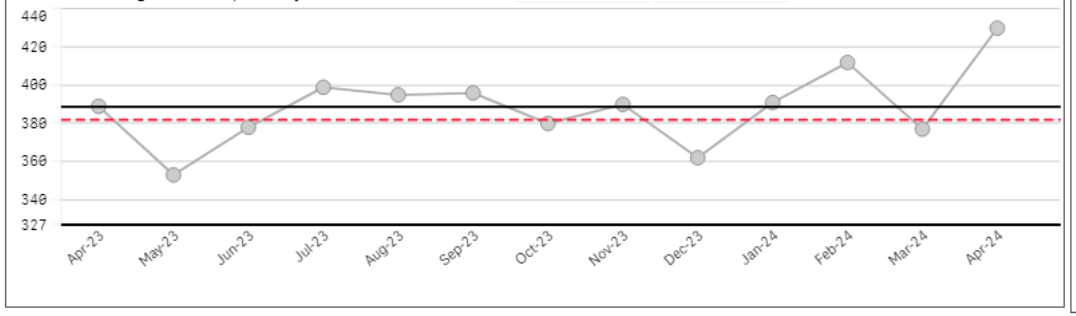
Quality & Safety – Incidents

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



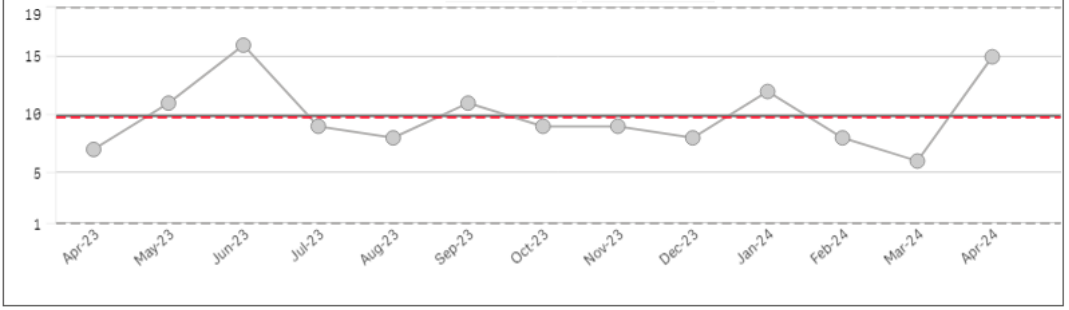
Variation	
Assurance	Random
Target	425
Latest	499

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



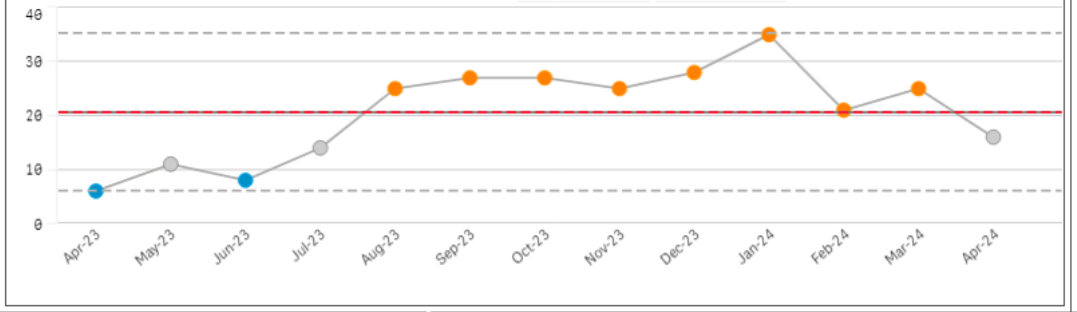
Variation	
Assurance	Random
Target	382
Latest	430

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



Variation	
Assurance	Random
Target	9.8
Latest	15

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



Variation	
Assurance	Random
Target	20.6
Latest	16

Understanding the Performance:

The Trusts has now Transitioned to PSIRF on 22nd April. No further SIs will be declared. 2 of the SIs declared in April were in relation to delay 1 of which is a system SI which we are waiting for confirmation of downgrading from the ICB since further information became available. the 3rd SI was in relation to potential incorrect clinical assessment.

Actions (SMART):

since transitioning to PSIRF we have seen a further improvement in the timeliness of reviewing incidents with the introduction of service involvement in daily critical reviews. Focus continues to be on closing of SIs, and tracking of outstanding actions form SIs.

Risks:

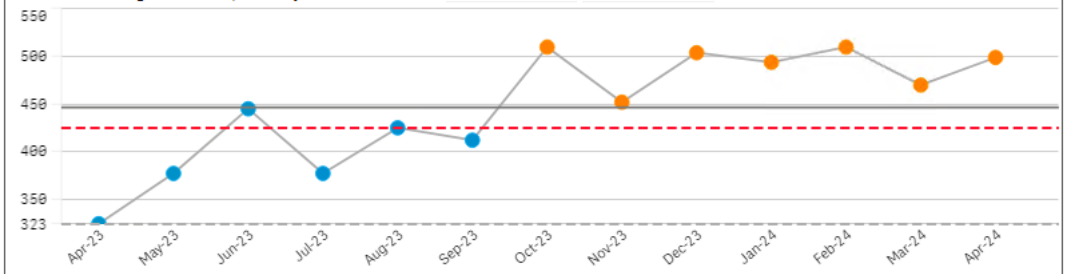
2 SI s remain overdue with extensions in place. moving into May the patient safety team will see a reduction in capacity due to team members leaving and end of contract in the PSIRF personnel along with end of contract for senior leadership within the team. recruitment for the PSRIF role is underway.

NHS

Quality & Safety – Incidents

Major/Severe Incidents

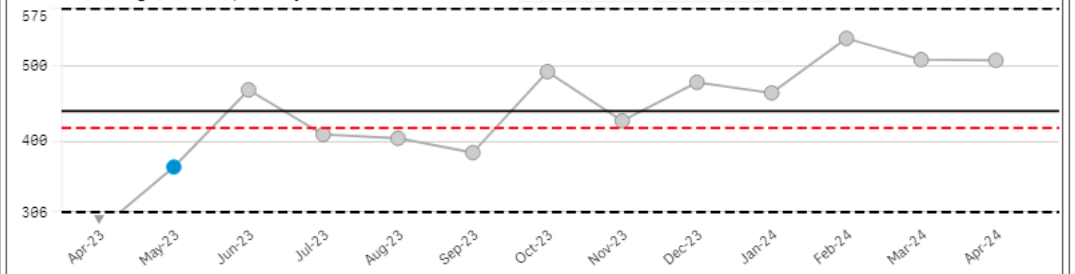
Lower is Better. Target differed in previous years



Variation	
Assurance	Random
Target	425
Latest	499

Number of no/low incidents

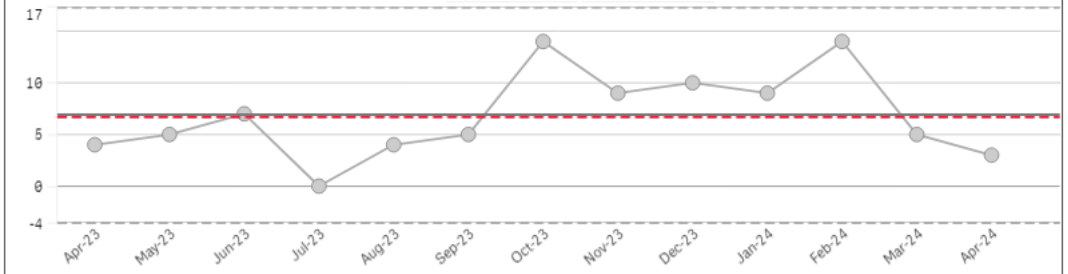
Lower is Better. Target differed in previous years



Variation	
Assurance	Random
Target	418
Latest	507

Serious Incidents

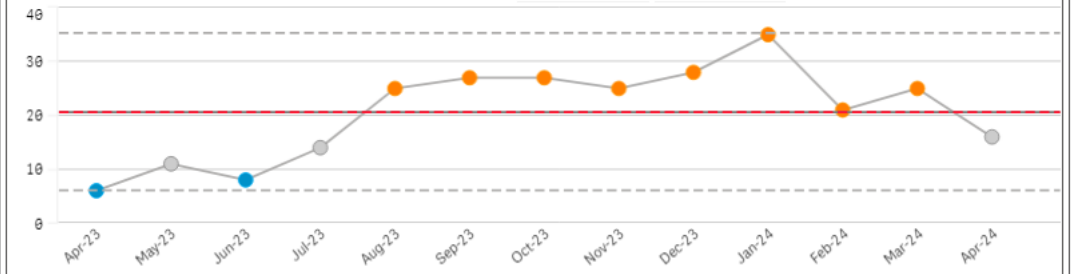
Lower is Better. Target differed in previous years



Variation	
Assurance	Random
Target	6.7
Latest	3

% of SIs investigated in time

Lower is Better. Target differed in previous years



Variation	
Assurance	Random
Target	20.6
Latest	16

Understanding the Performance:

Actions (SMART):

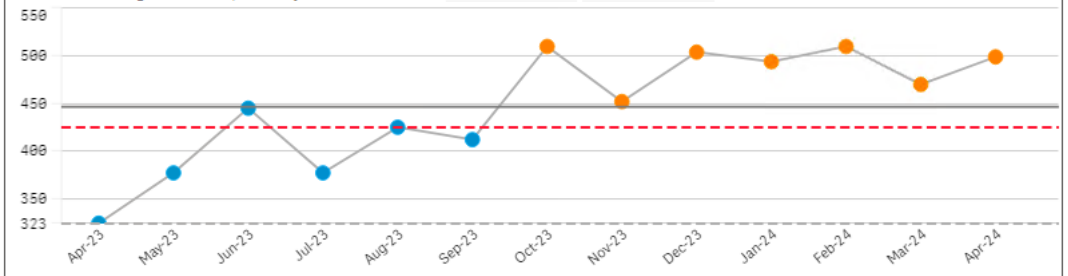
Risks:

NHS

Quality & Safety – Incidents

% Duty of candour completed in time

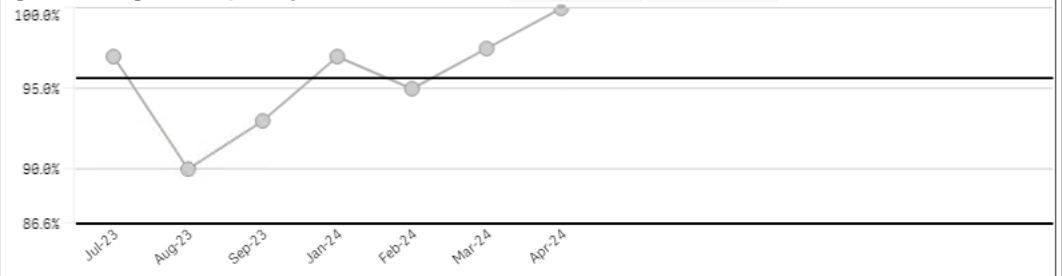
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	Random	425	499

% Medicines modules produced without error

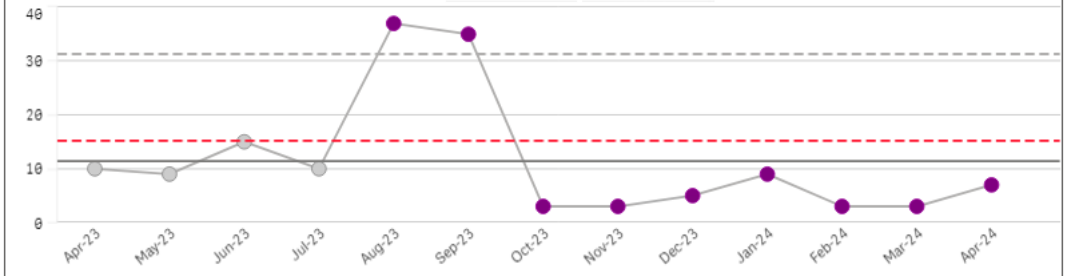
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	Random	92.0%	100.0%

CD unaccounted for losses

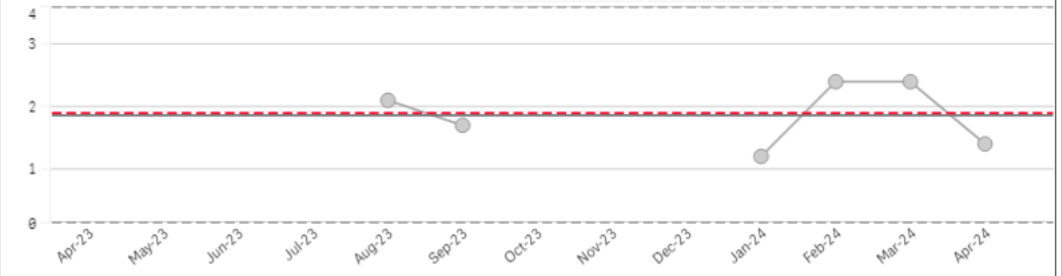
N/A. Target differed in previous years



Variation	Assurance	Target	Latest
Improved	Random	15.2	7

Number of days stock available

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	Random	1.9	1.4

Understanding the Performance:

high compliance (100%) in medicines packing audit this month. Stock lower than target.

Actions (SMART):

Improvement plan in place

Risks:

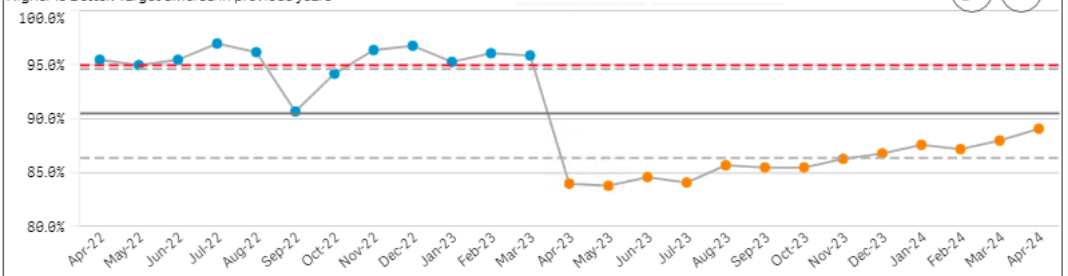
Poor medicine management and lower standards of patient care if medicines not available

NHS

Quality & Safety – Safeguarding

Safeguarding Level 1 (Adult) %

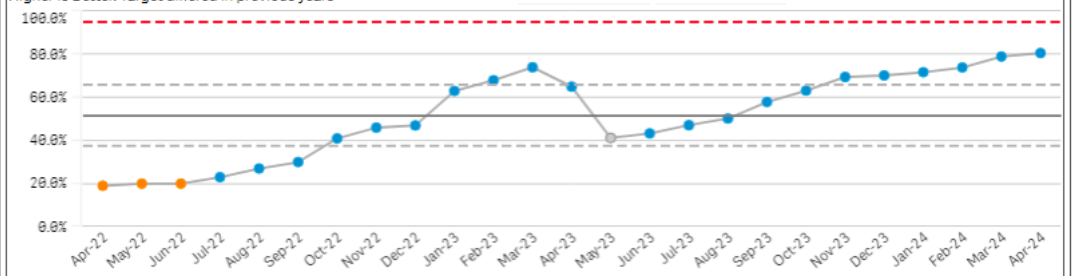
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Fail	95.0%	89.1%

Safeguarding Level 3 (Adult)%

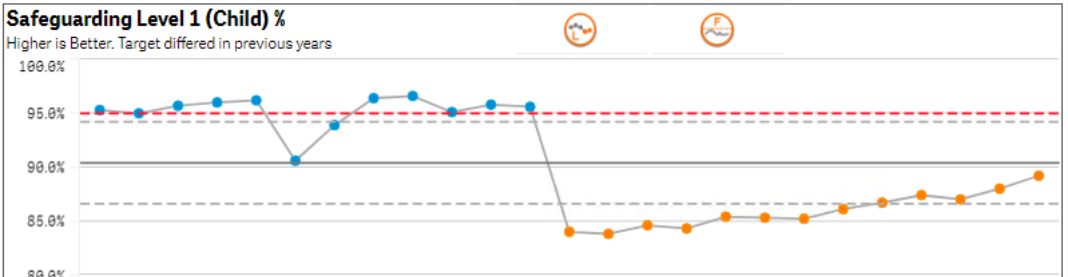
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	95.0%	80.6%

Safeguarding Level 1 (Child) %

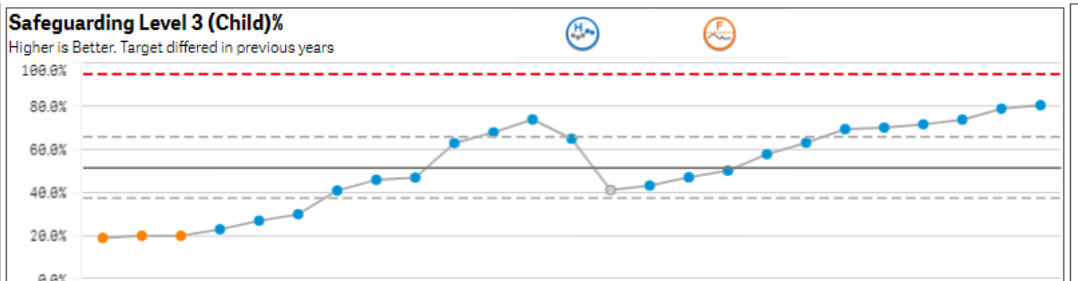
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Fail	95.0%	89.1%

Safeguarding Level 3 (Child)%

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Fail	95.0%	80.6%

Understanding the Performance:

Actions (SMART):

Risks:

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

NHS People Overview

April-24 Summary

Metrics:

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L	Health & Safety Manual Handling Meal Break Compliance - SCAS	Equality & Diversity		
	Appraisals - Trust		Over-runs >30 mins - SCAS	8
L				1
H				2
↗				
↘		Number of Physical Assaults		

People - Workforce, Culture & Employee development, Employee experience

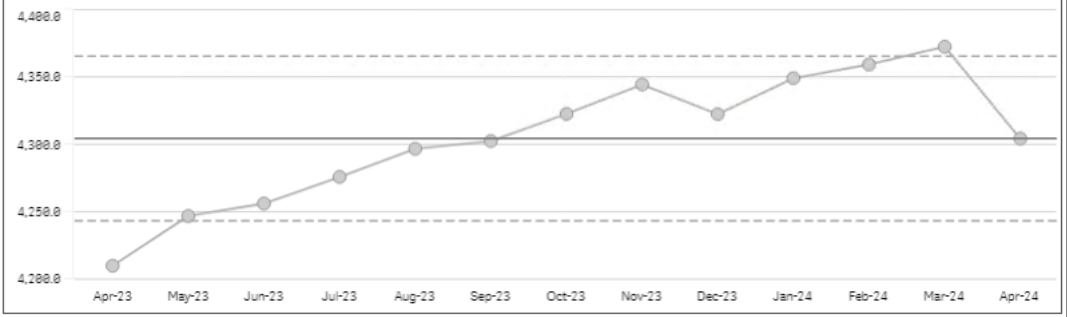
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Apr-24	4,304			n/a	4304.9	4243.8	4366.1
% Trust staff who are BAME	Apr-24	7.1%		H	n/a	5.6%	5.1%	6.1%
% Trust staff who are declared disabled	Apr-24	8.4%		H	n/a	6.7%	5.4%	8.0%
% DBS Compliance	Apr-24	97.2%			n/a	97.2%	-	-
% Turnover	Apr-24	17.9%		L	n/a	18.3%	16.9%	19.7%
% Vacancy	Apr-24	10.8%			n/a	10.3%	8.9%	11.6%
% Sickness in month	Apr-24	6.8%			n/a	6.6%	5.6%	7.6%
% Long term sickness	Apr-24	3.9%			n/a	3.8%	3.5%	4.0%
Appraisals - Trust	Apr-24	80.9%	95%		F	77.3%	69.7%	84.9%
% Stat and Mand Training	Apr-24	78.6%			n/a	78.6%	-	-
Staff Engagement Score	Apr-24			-	-	-	-	-
FTSU Cases	Apr-24	13			n/a	10.8	-2.2	23.9
Meal Break Compliance - SCAS	Apr-24	49.4%	80%	L	F	52.2%	34.3%	70.1%
Over-runs >30 mins - SCAS	Apr-24	17.6%	25%		P	17.4%	15.1%	19.8%
Time to hire	Apr-24	97			n/a	97.0	-	-

People - Workforce

Number of WTE

Higher is Better. Target differed in previous years



Variation

-

Assurance

-

Target

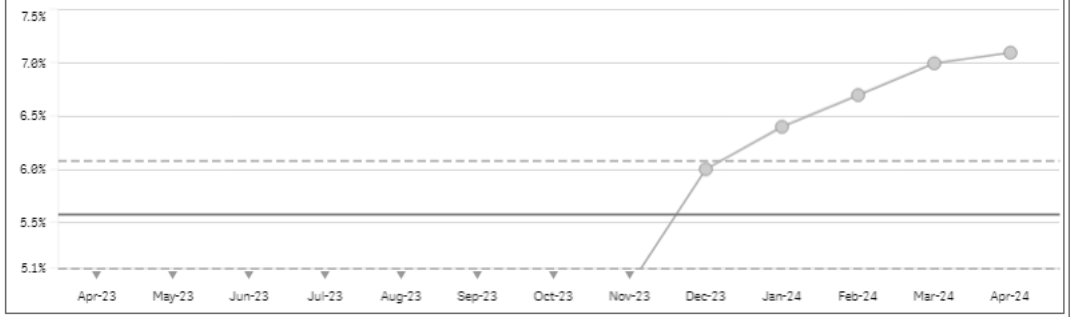
-

Latest

4304.4

BAME Staff %

Higher is Better. Target differed in previous years



Variation

-

Assurance

-

Target

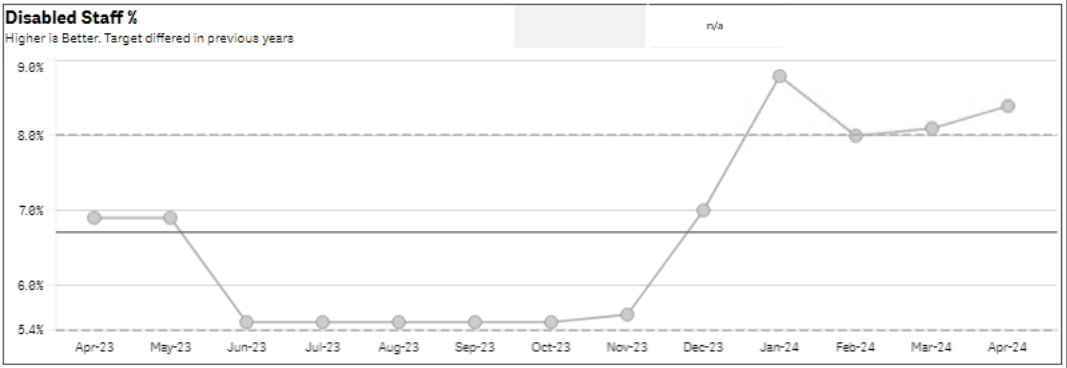
-

Latest

7.1%

Disabled Staff %

Higher is Better. Target differed in previous years



Variation

-

Assurance

-

Target

-

Latest

8.4%

DBS Compliance

Higher is Better. Target differed in previous years

Variation

-

Assurance

-

Target

-

Latest

97.2%

Understanding the Performance:

As we continue to recruit internationally for clinicians, we are seeing the number of BAME staff in our organisation increase. Staffing numbers have increased where we have recruited for patient facing roles. The DBS target is 95% so we are ahead of this, the ones that are not compliant are people who are currently not at work and therefore unavailable to complete their recheck, plus people who we are chasing.

Actions (SMART):

We continue to advertise on job boards that are specifically targeting people from a BAME background and we have ongoing reviews of our adverts to check for best practise. Workforce numbers are monitored by IWP and will continue to be reviewed and adjusted in line with agreed workforce targets. We want to move onto the DBS auto-update service which will eliminate the need for re-checks and will reduce the chasing process down considerably.

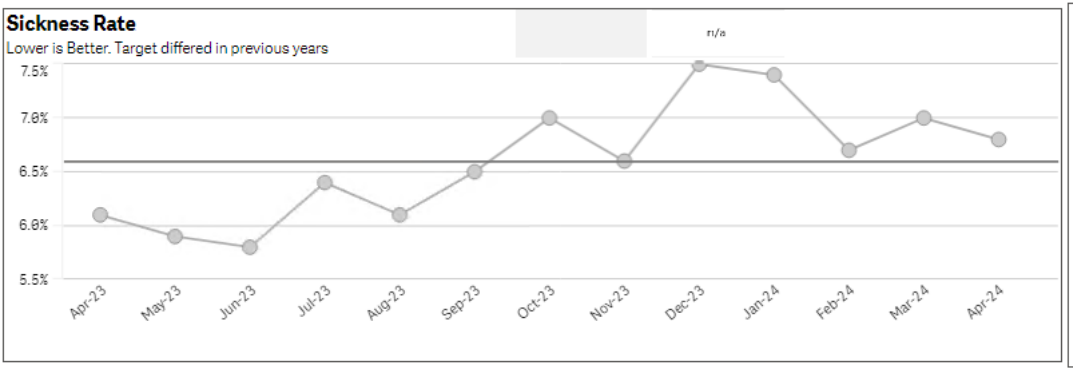
Risks:

Change is unsettling and we may see that levels of attrition increase above our plans for this year which could impact on patient facing roles. We have a stretch target for international recruitment of clinicians and there is a risk that we don't meet the numbers if people decide not to relocate. We have actions in place to try and increase our BAME workforce and improve our disability reporting, but there is a risk that with the corporate restructure we may not have the people in place to follow through with these actions.

People - Workforce

Sickness Rate

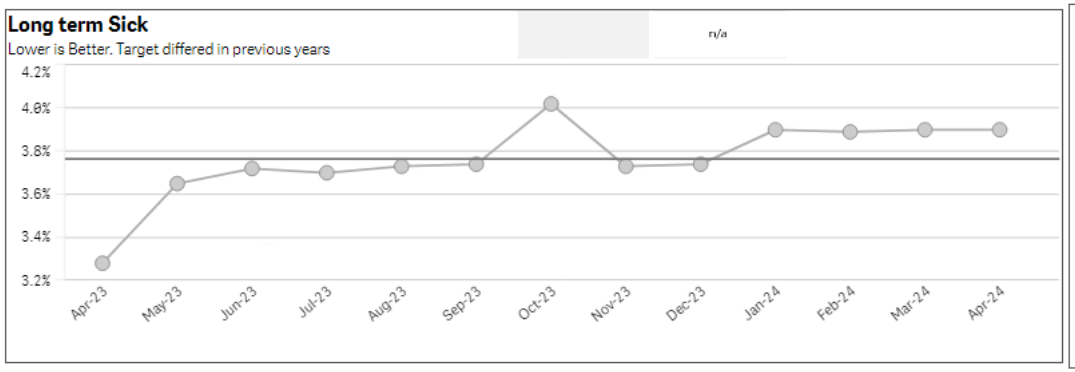
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	6.8%

Long term Sick

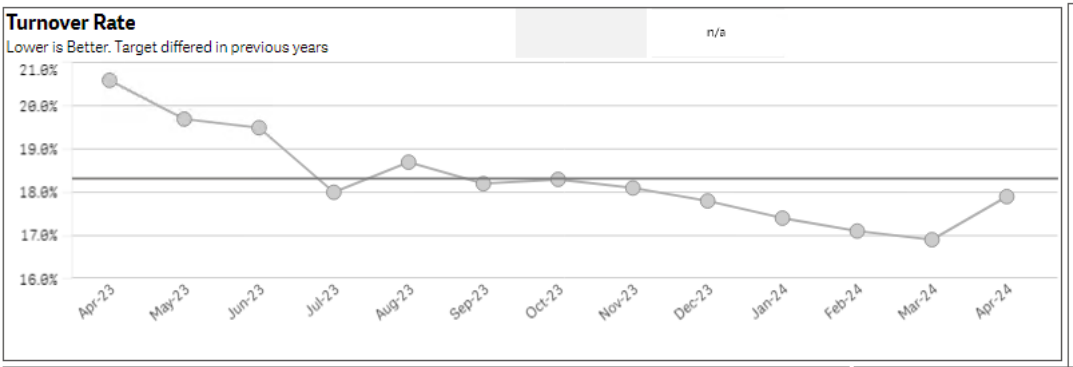
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	3.9%

Turnover Rate

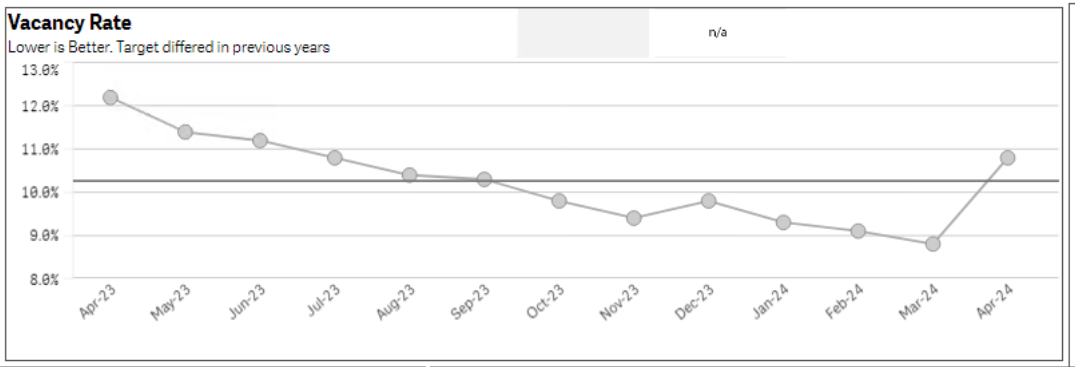
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	17.9%

Vacancy Rate

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
-	-	-	10.8%

Understanding the Performance:

Vacancy rates have increased - but this is often the case as we review and reset the workforce requirements for the Trust in April. Sickness absence rates remain consistent, the sickness cell and RTW compliance remain in place. Sickness rates are the lowest they have been in 4 years. RTW information is as accurate as it has been in years.

Actions (SMART):

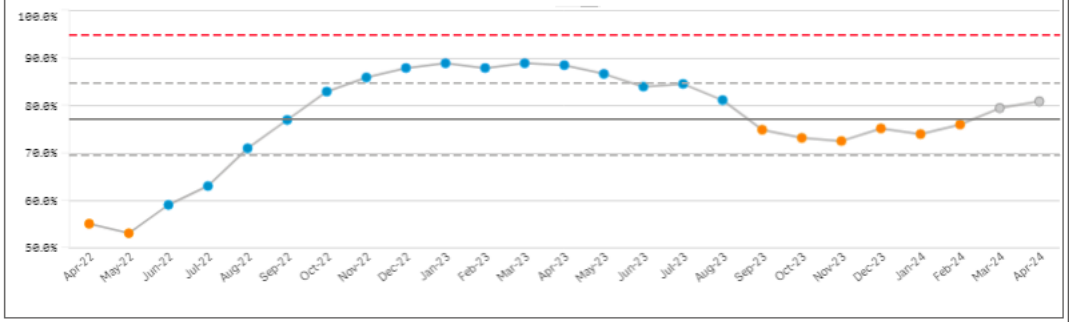
There is ongoing work around the establishment figures that are required in each area. RTW compliance continues to be monitored and chased which has resulted in improvements especially in North Operations.

Risks:

Delays in agreeing establishments could end up with more - or less - people in post than required which could then impact on patient facing and corporate functions. Wellbeing Coordinator fixed term contracts are coming to an end and this will impact on the HWB teams capacity to support sickness compliance processes.

People – Culture & employee development

Appraisals
Higher is Better. Target differed in previous years



Variation	Expected
Assurance	Fail
Target	95.0%
Latest	80.9%

Stat and Mand Training
Higher is Better. Target differed in previous years

Variation	Expected
Assurance	-
Target	-
Latest	78.6%

Staff Engagement Score
Higher is Better. Target differed in previous years

Variation	-
Assurance	-
Target	-
Latest	

FTSU Cases
Lower is Better. Target differed in previous years

Variation	Expected
Assurance	-
Target	-
Latest	13

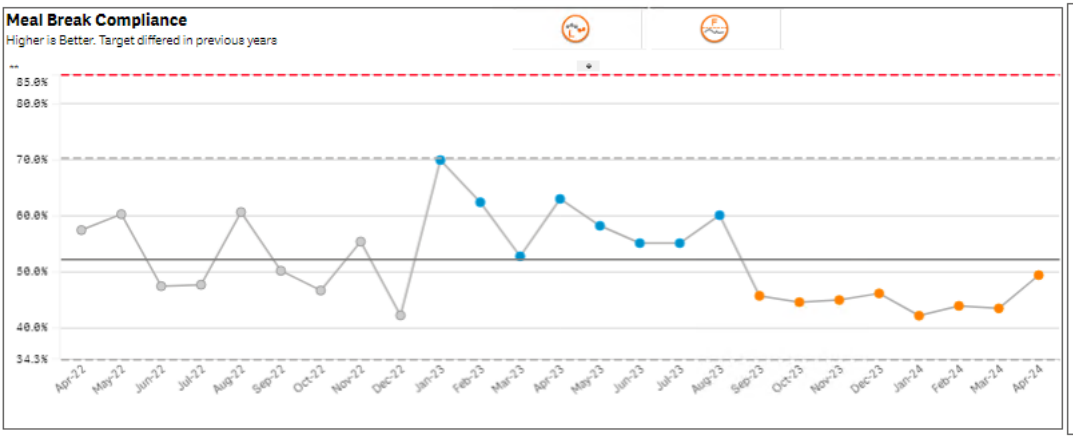
Understanding the Performance:
Statutory and Mandatory overall is a new metric for the Trust which enables our organisation to consider the total number of employees who are compliant against the total number of modules that that individual has to complete. As this is the first time we have provided this figure, we do not have historical data to provide trends or identify key concerns. Future data submissions will enable us to analyse and report compliance levels with details about trends. The minimum number of modules that anyone in the Trust has to complete is now 15, it used to be 10. For example a newly qualified paramedic has 42 learning modules plus an additional four patient group direction (medicines).

Actions (SMART):
OD are currently reviewing if the current PDR process is fit for purpose to ensure a greater ability to both complete the process and for it to add value. As we are at the beginning of the reporting year, there is time to ensure compliance increases to the required standard.

Risks:
If the Trust introduces new modules for any staff groups, such as patient safety, this will see an immediate decline in compliance against overall requirements as all staff members will show as non-compliant on the date that it is added to their profile. Due to the cyclical nature of the introduction of new modules we will inevitably see dips in compliance as those modules come up for renewal by the whole Trust. e.g. April 2025 will see a large number of modules expire after 3 years of compliance in those areas.

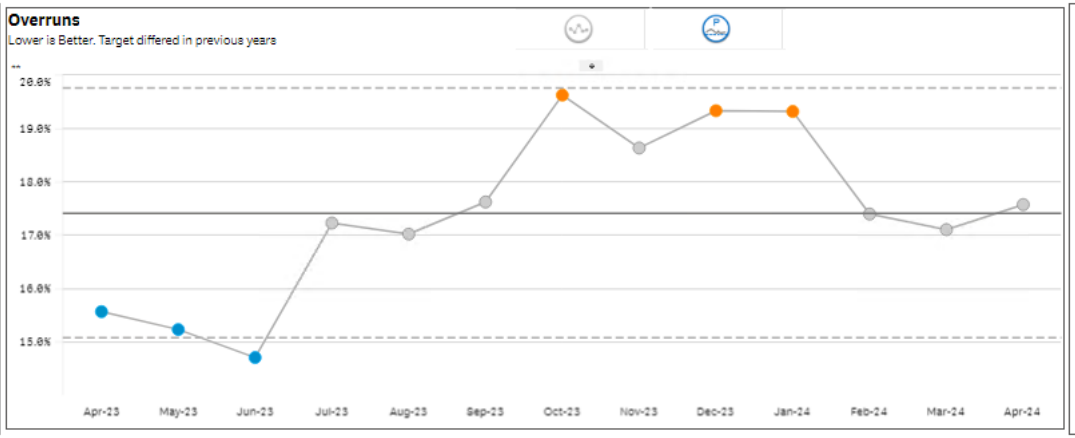
Workforce - Employee Experience

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



Variation	Declined
Assurance	Fail
Target	85%
Latest	49.4%

Overruns
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Pass
Target	33%
Latest	17.6%

Time to Hire
Lower is Better. Target differed in previous years

Variation	Expected
Assurance	-
Target	-
Latest	97

Understanding the Performance:
Meal breaks continues to fail and has been below the mean for eight months now. April saw just over 6% improvement in the month with the percentage of breaks in window rising to 49.43% which reflects the positive position of operational hours and lower C2 demand and reduced handover delays in the south. Overruns saw a 0.4% deterioration in the month linked to northern ED's (RBH, MK). Overall, in April 95.9% of crews received a break just not within the window.
This is the first month of reporting time to hire and this is the average number of days from an advert closing to the employee starting work with SCAS. These numbers can be skewed as depending on the courses, people can wait several months for the relevant course. EOC Call Takers took 53 days and bank paramedics took 196 days.

Actions (SMART):
Unions met with the Executive Director of Operations as well as the clinical team and are in the process of writing up a proposal to trial to improve compliance for both breaks as well as change the criteria for the end of shift process. Time to hire - We are expecting the numbers to fluctuate hugely each month depending on which courses have start dates.

Risks:
The main risk sits with the proposal from staff side not meeting the required changes to enable us o see an improvement is compliance and a reduction in risk to patients with the EOS process. The time to hire figure are produced manually, so there is a risk that they may not be accurate, we are endeavouring to work with the candidate tracking system supplier to find a solution to this.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Finance

NHS Finance Overview

April-24 Summary

Metrics:

Assurance →

Variance ↓

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

*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	Apr-24	11.2%	5%			17.4%	-3.1%	37.9%
Agency Spend	Apr-24	146	388		n/a	340.36	108.275	572.445
Overall SOF Segment	Apr-24	4			n/a	3.52	3.29833	3.74167
CIP's Total	Apr-24		3,173	-	-	801.75	-1,371.23	2,974.73
Pay Spend	Apr-24	16,998	16,125	-	-	17,832.4	12,462.3	23,202.5

Finance - Finance 2

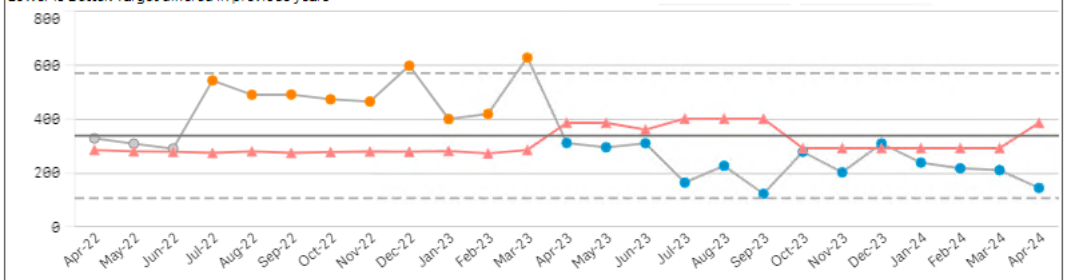
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit	
Overall SOF Segment	Apr-24	4			n/a	3.52	3.298	3.742	

Understanding the Performance:	**Actions (SMART):**	**Risks:**

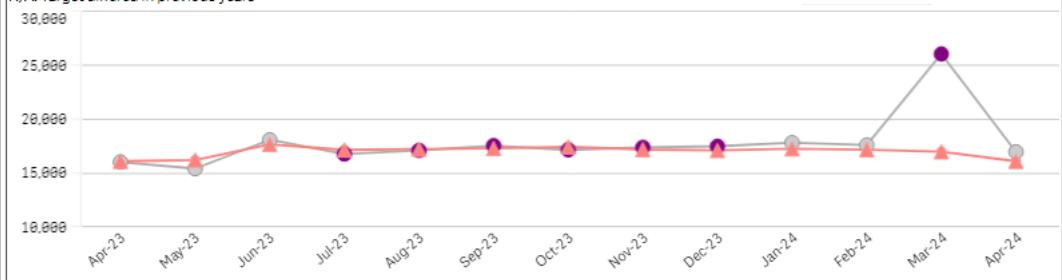
Finance - Finance 1

Agency Spend
Lower is Better. Target differed in previous years



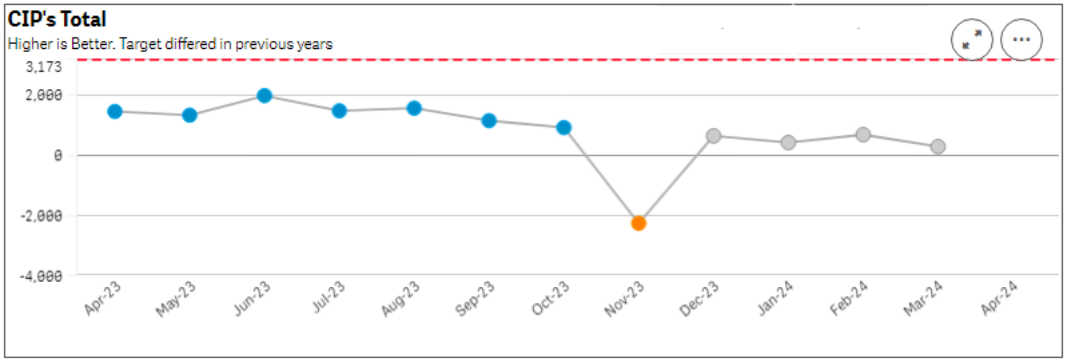
Variation	Assurance	Target	Latest
Improving	-	388	146

Pay Spend
N/A. Target differed in previous years



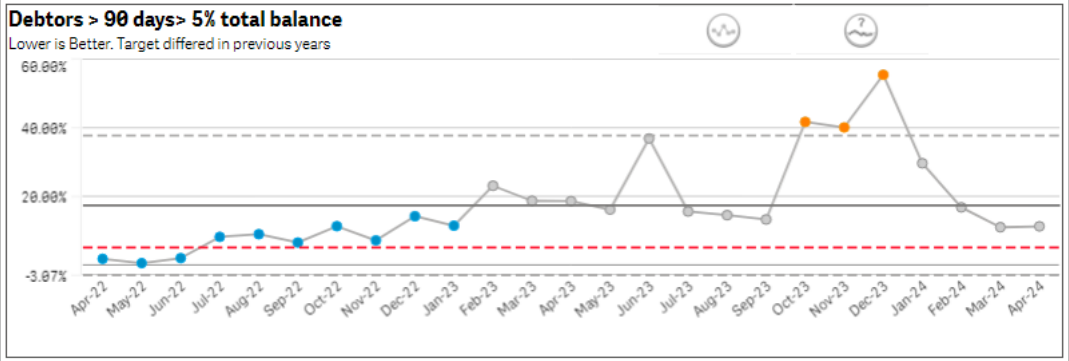
Variation	Assurance	Target	Latest
	-	16,125	16,998

CIP's Total
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	Fail	3,173	

Debtors > 90 days> 5% total balance
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	5%	11.2%

Understanding the Performance:
Agency spend reduced in April and continues to be below plan. Debtor balances >90 days improved in absolute terms but increased as a percentage of overall debt. Pay expenditure saw a reduction in the month but was slightly above plan.

Actions (SMART):
The Financial Recovery Plan is being implemented as part of the 2024/25 financial plan. It sets out recurrent savings to return the Trust back to underlying breakeven performance by March 2025

Risks:

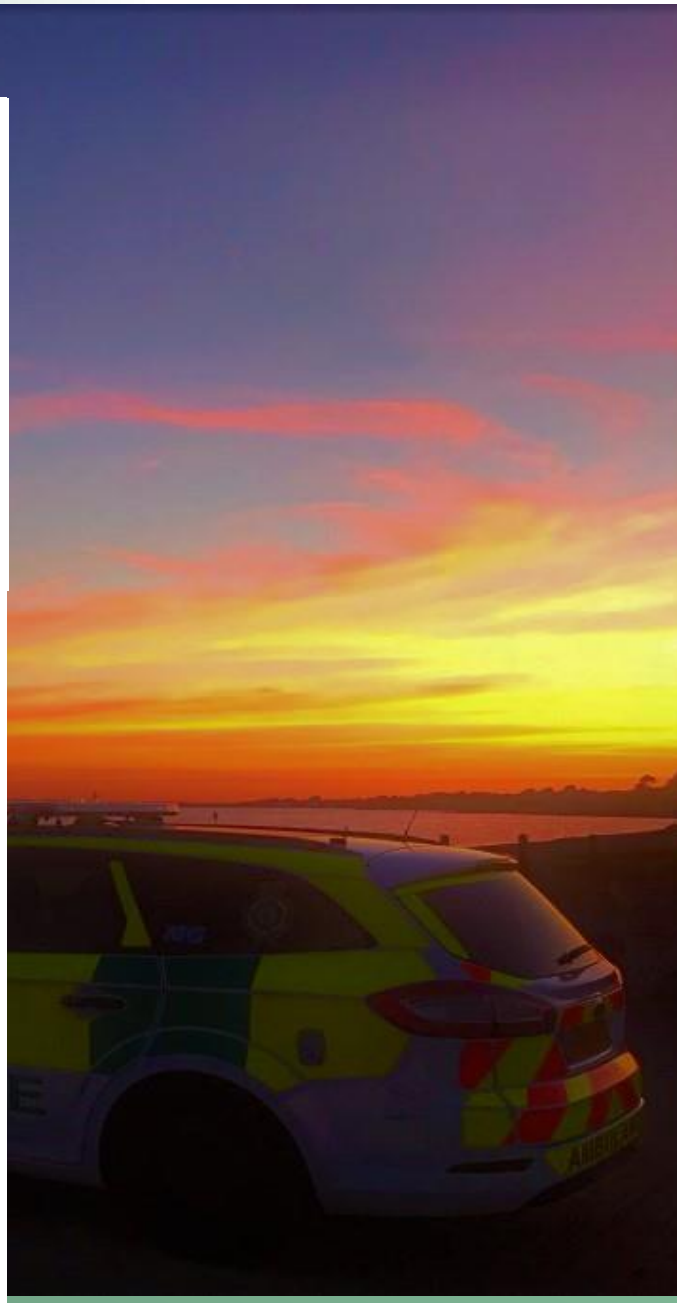
Data Quality Reference

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

	Accurate Data Quality	Inaccuracies in Data Quality
YTD	30	49
12 Months	30	49

NHS
South Central Ambulance Service
NHS Foundation Trust

Clinical Pathways



Acute and Community Clinical Pathway Services Dashboard

May 2024

CLINICAL PATHWAYS
Ensuring our patients get the Right Care: First Time - Every Time

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 developed new guidelines for its frontline patient-facing staff to align to the SCAS principles for us to be a Care Navigator across our health care system.

- 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.

Detailed proposals of the improvements and requirements were presented to the Clinical Review Group which were subsequently approved. New guidelines were published to staff on 7th May 2024.

Alongside this, work is continuing to update the SCAS GP Triage process and how it is utilised by our frontline ambulance clinicians and subsequently reported through our ePR and BI (Business Information) systems.

Proposals for changes to fields in the ePR platform have been submitted for review by the digital team and software developers. These improvements will allow SCAS to better record and report on SCAS strategy as a 'Clinical Navigator' as well as the implementation of new guidelines, processes and updates to the clinical pathway policy

There is a risk that the time available to the SCAS digital team coupled with costs for implementing the required changes onto the ePR, may result in the proposed changes not being made. We will be unable to accurately report patient S&T / Non-ED outcomes, understand barriers to referrals, challenges to referral acceptance and auditing of referral pathways until those changes are made in ePR.

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 have brought 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.

Following the successful pilot at the Queen Alexandra Hospital (QAH) in Portsmouth and Milton Keynes University Hospital (MKUH) Rapid Drop & Go was implemented across the SCAS footprint at all acute hospital EDs.

Stroke Pre-Hospital Video Triage (PVT)

Research conducted in London and Kent during the Covid-19 pandemic showed that specialist stroke assessment using pre-hospital video triage (PVT) improved stroke assessment and time to treatment (with associated improved clinical outcomes), for stroke patients. PVT was also found to aid identification of patients who did not require stroke treatment and who may be better served on non-stroke pathways, supporting more appropriate referrals to Hyper Acute Stroke Units (HASU).

SCAS has established stroke pre-hospital video triage (PVT) with three NHS England (NHSE) pilot sites - Frimley Park Hospital, University Hospital Southampton and the Royal Berkshire Hospital. Following the pilot phases John Radcliffe, Royal Hampshire County and High Wycombe Hospitals are all prospective acute hospital sites where Stroke PTV are being considered.

SCAS Connect

- **SCAS Connect Patient Outcome Feedback Loop**. A feedback loop to support learning from patient outcomes and enables clinicians to reflect on their clinical assessment and decision making, is being piloted across SCAS. Providing feedback on referred patients to UCR teams by SCAS clinicians. This feedback will support personal CPD (SCAS and UCR clinicians), improve the quality of referrals, improve understanding of how SCAS fits in to the wider NHS (understanding what happens to the patient after an onwards referral). Challenge - lack of use by SCAS clinicians. Communications to be developed to improve awareness of feedback loop.

- **Emergency Pathway telephone numbers** - To enhance the delivery of patient care and improve swift access to emergency pathways for time critical patients, we have developed an emergency pathway telephone directory, complete with 'quick-link' phone numbers.

Pathway Development Highlights

- Milton Keynes

  - 24/7 Mental Health crisis support. Currently there is no pathway for SCAS to utilise other than Fri & Sat evenings and access to a crisis cafe for low acuity presentations. Initial conversations via email were promising but have now stalled. Challenges - There has been a lack of engagement from CNWL & SCAS MH, leads will be escalating to ICB.

  - Surgical SDEC - Working with service provider to enhance pathway to include further specialities including general surgery, Urology, ENT and Orthopaedics.

  - Urgent Community Response (UCR) Team

    1. Category 3 & 4 patient transfer to UCR - SCAS are continuing to explore opportunities to enhance the transfer of suitable 'low acuity' patient groups directly from the ambulance control room to UCR negating the requirement for ambulance dispatch. This includes the Urgent Care Desk (UCD) Specialist Practitioners who interrogate the Cat 3 & 4 'Falls' incidents in the Clinical Control Centre (CCC) Computer aided Dispatch (CAD) system and direct them to the UCR Team to avoid an Ambulance attendance.

    2. In collaboration with CNWL 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

  - Single Point of Access (SPoA) - SCAS is a member of the BOB ICB stakeholder group developing a SPA that will provide access to community and acute services, providing appropriate admission avoidance opportunities and access to acute specialities.

  - Frailty - The team are finalising a robust referral pathway to same/next day MuDAS access for suitable patient groups. Work is also continuing enhance access opportunities to the Frailty SDEC unit.

- Oxfordshire

  - SPoA - As in Buckinghamshire, SCAS is worked with partners within Oxford Health to ensure the successful development of a SPoA by continuing to promote the successful rollout of the 'call before convey' process established between SCAS and UCR.

- Berkshire West

  - Royal Berkshire Hospital (RBH) SPoA went live on 11th March 2024 - 7 days/week for direct access to all SDEC services. Referrals are accepted from all Health Care Professionals, GPs and SCAS clinicians. The initial 3-week pilot focused on GP/HCP conveyance requests, before extending to all conveyances that do not require 'resus' level care.

- RBH Stroke Pre-hospital Video Triage (PVT) went live for PVT-First (first means of contacting the stroke team) on 15th April. This service is available Mon-Fri 08:00-17:00. PVT has resulted in an improvement in time to assessment, treatment and to ward for stroke patients, has increased the number of non-stroke patients seen in ED (rather than by the stroke team) and facilitated conveyance avoidance for patients booked into TIA clinics, or otherwise referred for community follow up.

- East Berkshire

  - Wexham Park Hospital (WPH) Frailty SDEC went live on 4th January. If the patient is considered appropriate for community care, the acute Frailty team will liaise directly with the UCR team. Whilst this should minimise avoidable conveyance to ED for this vulnerable cohort, one of the early concerns noted with this pathway is that referred patients are seen in ED due to bedding of the pan-specialty assessment area.

  - Frimley Park Hospital (FPH) Stroke Pre-hospital Video Triage (PVT) went live for PVT-First on 1st March. This service is available 24-hours 365 days/year. PVT has resulted in an improvement in time to assessment, treatment and to ward for stroke patients, has increased the number of non-stroke patients seen in ED (rather than by the stroke team) and facilitated conveyance avoidance for patients booked into TIA clinics, or otherwise referred for community follow up.

  - Minor Illness and Minor Injuries (MIMI) Unit Slough - Discussions are in continuing to 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 - The team are collaborating with the Wexham Park Hospital (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

  - Completion of the 'Hampshire Together' Modernising our Hospitals and Health Services (MoHHS), the Government's new hospitals building programme. SCAS were involved in face-to-face and online public consultation listening events. The consultation period ended on 17th March.

- South West Hampshire

  - University Hospital Southampton (UHS) went live with PVT-1st on 1st February. The service is available 7 days/week 08:00-20:00. PVT has resulted in an improvement in time to assessment, treatment and to ward for stroke patients, has increased the number of non-stroke patients seen in ED (rather than by the stroke team) and facilitated conveyance avoidance for patients booked into TIA clinics, or otherwise referred for community follow up.

  - Urgent Community Response - The UCR referral pathway was launched on 1st March 2024 . This service, which has seen a steady referral rate from SCAS staff, provides additional care opportunities within the regions community setting to avoid hospital conveyances.

- Urology Assessment SDEC - Work is ongoing with UHS Urology Leads to facilitate direct referrals for patients that meet the urology assessment criteria - There has been a lack of contact and engagement from the UHS team which has delayed the development of this referral pathway

- South East Hampshire

  - Hip Fracture Trauma Line - This pathway was launched on 25th March 2024. Following the initial review with the service provider team there has been a good referral rate with no issues or concerns reported.

  - Adult Safe Haven - This pathway covering the Southern Health region (not Solent region at the moment) is in the final stages of development and should be introduced for access to patients referred by SCAS clinicians soon.

  - Palliative Care - There is a new clinical hub based at the Rowans Hospice where patients who are at the end of life as well as their relatives, can be supported with all aspects of care. The teams are reviewing the clinical governance process for our SCAS staff to make appropriate referrals.

  - Over the past few months, SCAS participated in a series of 'Firebreak' weeks aimed at reducing occupancy levels within Queen Alexandra (QA) Hospital and improve flow across the Portsmouth and South East Hampshire health and social care system. Following this Initiative, the Clinical Pathway team identified some opportunities to improve access to referral pathway.
  -
    - OSDEC - Senior nurses taking referral calls at QAH instead of senior Drs in the hope to extend opening hours and/or open access up to us over weekends

    - Surgical SDEC - Developing space 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 team are also 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.

    - Currently the Childrens Assessment Unit at QAH only accept SCAS referrals if crew subsequently convey the patient. The QAH Paediatric Team have developed a tool that may support parent/carer self conveyance following a SCAS referral when clinically appropriate and safe to do so.

    - Potential introduction of a 'Chest Pain' specific referral pathway.

We will be working closely with the QA hospital teams to develop these improvements so patient outcomes can be optimised.

Core Hospital & Community Pathway Services

Acute Hospital Pathway Services	Milton Keynes	Buckinghamshire	Oxfordshire	Berkshire West	East Berkshire & 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								
Community Service Pathways	**Milton Keynes**	**Buckinghamshire**	**Oxfordshire**	**Berkshire West**	**East Berkshire & 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	*	*	*	*		!		

Red = No Pathway - Amber = Pathway in development/Challenges/Blockers - Green = Pathway in place
* = Provided by UCR - ! = Access via SPoA

Same Day Emergency Care Log

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

Area	SDEC Type	Date of Entry	Progress Log (Insert a new line for each new entry date)
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
		4.9.23	Medical SDEC pathway re-launched with SCAS
	Surgical	Nov '23	First meeting to develop SDEC pathway - BI request for 12-month data to identify demand submitted
	Frailty	04.04.22	Frailty line (Acute & Community) available to SCAS Mon - Fri 0800 -1700hrs.
		04.06.23	Frailty H&H added to Consultant Connect telephony system for SCAS crews to access.
Oxfordshire			
John Radcliffe & Horton General Hospitals	Medical	5.4.22	AAU - JR - 24 hours - Call volume average 200 per day which is unmanageable, working closely with UCR on 'call before convey' process. Medical Ref Unit - Horton 24 hours - BAU Witney EMU - Mon-Fri 10:00-19:30, Sat, Sun & BH 10-16 - BAU Abingdon EMU - Mon-Fri 08:30-19:30 Sat, Sun & BH 10-16 - BAU Henley-on-Thames RACU - Mon-Fri 08-18 - New addition to Medical SDEC in April 2022. - BAU
	Surgical	5.4.22	Surgical Emergency Unit - JR - 24 hours
	Urology	5.4.22	Churchill - 24 hours - BAU
	Paediatric	5.4.22	CAU - JR & Horton - 24 hours - BAU
	Early Pregnancy / Maternity	5.4.22	MAU - JR 24 hours - BAU EPAU - OUH - Mon-Fri 08-18 - BAU
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.
	Medical	01.04.24	Medical SDEC now accessed via SPA 07:00-19:30, 7 days a week using a call before convey model
East Berkshire			
Frimley Park Hospital	Medical	5.4.22	~~Frimley Park AECU/MAU 24 hours~~
		17.01.24	No direct access to Medical SDEC.
	Frailty	5.4.22	~~Frimley Park OPED - Mon-Fri 07-17, Sat, Sun & BH 08-16~~
		17.01.24	Frailty pts can be referred but will be seen in ED
Wexham Park Hospital	Frailty	3.5.22	~~Wexham Park Frailty SDEC Mon-Fri 07:30-16:00 (live 11.03.22)~~
		17.01.24	Wexham Park Frailty SDEC Mon-Fri 08:00-18:00 (relaunch 04.01.24)

Hampshire & IoW

Area	SDEC Type	Date of Entry	Progress Log (Insert a new line for each new entry date)
North & Mid Hampshire			
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 (F3 ward) 09:00-17:00 Mon-Fri via SPA~~
		17.01.24	FSDEC pilot ended. Can refer via SPA only.
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 Hampshire			
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 avaliable 0800-1600, Monday to Friday.
South West Hampshire			
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 aUCR (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 effectivly 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 invovlement will in crease 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
		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 disuss 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 & Frimley	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 Hants (Basingstoke)	Urgent Community Response	03.05.22	North Hants Team 08:00-20:00 7 days (inc. Bank Hols)
Mid Hants (Winchester)	Urgent Community Response	03.05.22	Mid Hants Team 08:00-20:00 7 days (inc. Bank Hols)
SE Hants	UCR Portsmouth City	5.4.22	08-20 7 days
	UCR SE Hants, Fareham & Gosport	5.4.21	08-04 7 days
SW Hants	UCR Southampton	5.4.21	08-22 7 days
	UCR Southern	08.05.24	0800-2000 7 days

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

	Call Before Convey	
Area	**Call Before Convey in operation**	**Progress on Call Before Convey Development by ICS (Entry Date : Detail)**
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 Jan '24 - CbC not progressed at this time. To be be discussed with ICS 18.1.24. (IH)
Buckinghamshire	**No**	20.9.23 - Waiting for UCR to complete service restructure before they are willing to review a further pilot. Jan '24 - CbC pilot not progressed with UCR at this time. To be discussed 23.1.24. (IH)
Oxfordshire	**Yes**	December 2023 - Pathway in BAU
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
East Berkshire & Frimley	**No**	Call before Convey (for UCR) relaunched Sept 2023.
N & M Hants	**Yes**	BAU Feb 23 - HHFT based CbC covering direct to specialty, care homes telemedicine, virtual wards and referrals to UCR.
SE Hants	**No**	Previous CbC pilot focussed on increasing referrals to UCR. Results showed increased hospital conveyance. No known plan to rerun.
SW Hants	**No**	No disucssions.

	Community Single Point of Access (SPA)	
Area	**Community Single Point of Access (SPA) in operation**	**Progress on Community Single Point of Access by ICS (Entry Date : Detail)**
Milton Keynes	**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 - 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**	
West Berkshire	**Yes**	BW investigating developing a BW SPA and moving away from Berjshire Integrated Hub as this is a non clinical telephony service.
East Berkshire & Frimley	**Yes**	Berkshire Health Hub acts as SPA for all community pathways in East Berks.
N & M Hants	**Yes**	HHFT SPA for onward referral to UCR (if not attempted directly). Hants-wide UCR SPA is available to SCAS Staff
SE Hants	**Yes**	Hants-wide UCR SPA available to SCAS staff. GP CAS SPA available. No known disucssions re acute SPA.
SW Hants	**Yes**	Hants-wide UCR SPA.

	Acute Hospital 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)**
Milton Keynes	**No**	20.9.23 - MK currently not looking at an acute SPA
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.
Oxfordshire	**No**	December 2023 - No plans or intention to develop this
West Berkshire	**Yes**	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. SPA open March 2024
East Berkshire & Frimley	**No**	Early discussions but no plan for acute SPA at this time.
N & M Hants	**Yes**	HHFT SPA.
SE Hants	**No**	Hants-wide UCR SPA available. GP CAS SPA available. No known disucssions re acute SPA.
SW Hants	**No**	Hants-wide UCR SPA. No known disucssions re acute SPA.

	System Single Point of Access (SPA)	
Area	**System Single Point of Access (SPA) in operation**	**Progress on System Single Point of Access by ICS (Entry Date : Detail)**
Milton Keynes	**No**	
Buckinghamshire	**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**	
West Berkshire	**No**	
East Berkshire & Frimley	**No**	
N & M Hants	**Yes**	Acute & community referrals via CbC SPA, supported by ICS.
SE Hants	**No**	
SW Hants	**No**	

Virtual Ward Log

Buckinghamshire, Oxfordshire & Berkshire inc. Milton Keynes

Area	Virtual Ward Type	Date of Entry	Progress Log (Insert a new line for each new entry date)
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)
Bucks		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 consistant 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 consistant 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. (August 2023)
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 diagnosics to confirm a diagnosis. Access will be via UCR or Medical SDEC when pathway is available.
East Berkshire		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 consistant and unified approach to VW development across BOB. Waiting for update following summit on core offer and further development opportunities.

Hampshire & IoW

Area	Virtual Ward Type	Date of Entry	Progress Log (Insert a new line for each new entry date)
Frimley	Frailty Virtual Ward	12.09.23	Access to VW via the UCR team. There is no option for SCAS to refer directly.
North & Mid Hants	Frailty Virtual Ward	19.10.22	Direct referrals to VW - Mon-Fri 08:00-17:00 via SPA
SE Hants	Portsmouth & SE	12/12/2022	VW are now avalaible, 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
SW Hants	Southampton City	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
	Forest Frailty	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	Yes	No	Yes	No	No	Yes
	Community Outreach Frailty Advice Service - Frimley South (NE Hants)	07:00-17:00 7 days	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	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	Yes	No	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	Yes	No	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	Yes	No	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

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
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.

NHS
South Central Ambulance Service
NHS Foundation Trust

Clinical Pathways

Patient Care Pathway Utilisation / Patient Dispositions

May 2024

CLINICAL PATHWAYS
Ensuring our patients get the Right Care: First Time - Every Time

Chris Jackson
SCAS Assistant Senior Operations Manager

1. Introduction

Since 2019 the Clinical Pathway team have introduced a large number of clinical pathways that our patient facing clinicians are able to refer and convey patients to. The data here indicates the high level total numbers of referrals and conveyances to community teams and various hospital locations across SCAS.

Patient dispositions are recorded from options selected on the Terrafix Mobile Data Terminal (MDT) by the attending SCAS Clinician.

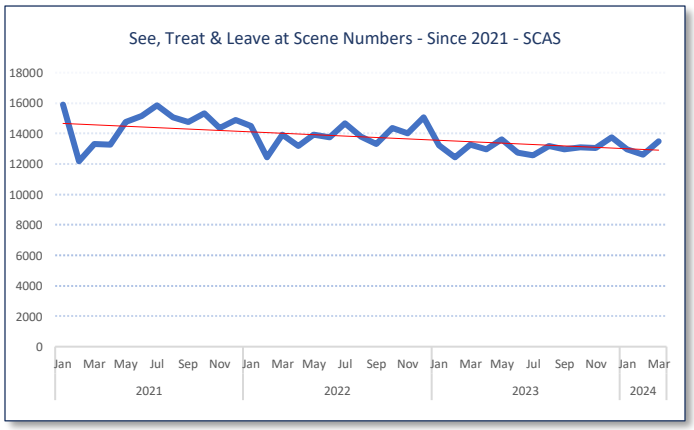
All data below excludes Health Care Professional (HCP) or General Practitioner (GP) Ambulance conveyance requests or Inter Hospital Transfers (IHT).

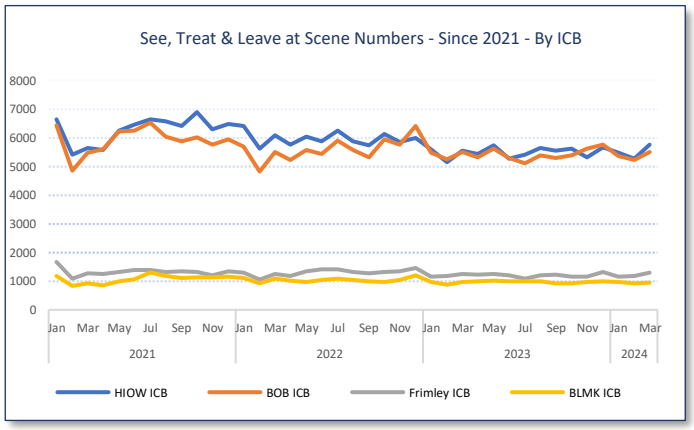
The Business Information team are working with the clinical pathway team to develop a dashboard that will allow us to understand with a greater breakdown of the exact locations where our patients are being referred and conveyed. This information will include the ability to be able to filter:

- Referral locations - Hospitals, ICBs, service provider referral teams,
- Refer detail - Resource Centre localities, Dispatch Node, SCAS operational teams, Skill grade, SCAS individual clinicians
- Referral timeframes - Years, month of year, week of month, day of week, hour of day
- Patient demographics - Age parameters (under 5's / over 65's etc), age range, post code
- Incident Detail - Nature of call, symptom group, performance category

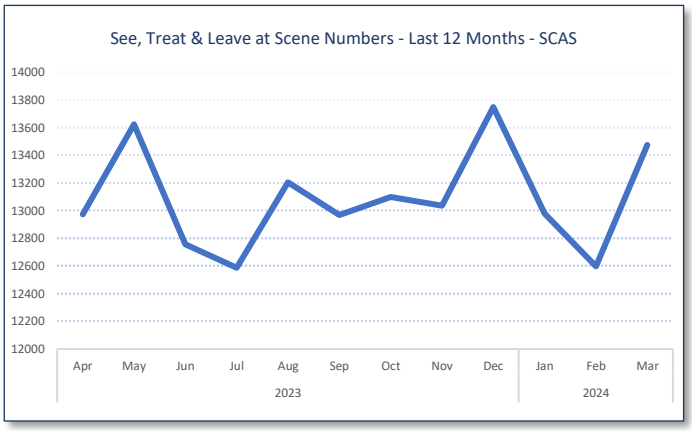
2. Non-Conveyance - See, Treat & Leave at Scene

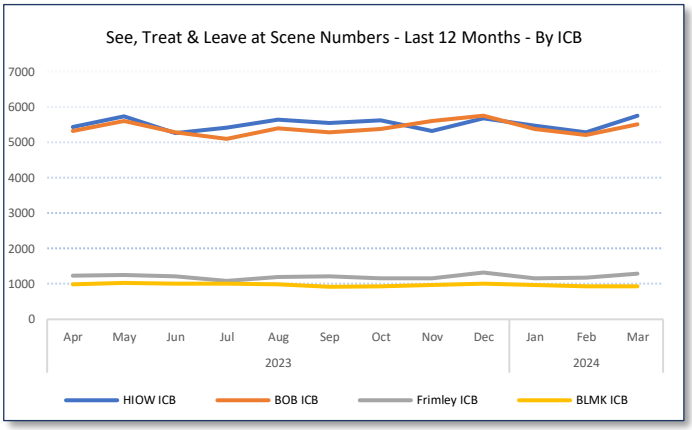
These are incidents where a frontline SCAS Clinician resource has attended an incident, assessed the patient and a decision made that they do not need to be conveyed to hospital or referred to another team for further assessment, treatment or management. This may have been for a range of reasons including, but not limited to; not requiring any treatment, been treated directly the clinician, other agency dealing (e.g. Fire or Police Service), patient deceased.





- There has been a gradual, steady overall decrease in patients who were managed at scene and not conveyed or referred to hospital or a community team since 2021.
- In 2021 the total was 174,000, it was 166,000 in 2022 and then 156,000 in 2023.
- In July 2021, 15,855 patients were left at scene with 13,474 in March 2024.
- See & Treat has remained above 12,000 patients per month since January 2021.
- The pattern of this See & Treat measure appears to be consistent across all ICB regions in SCAS, with peaks occurring alongside demand increases.

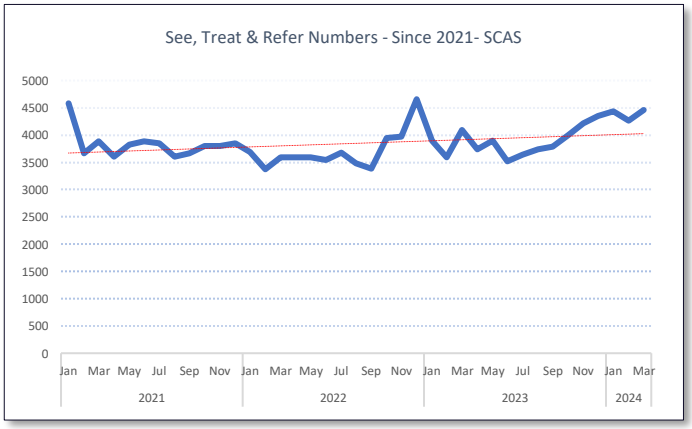


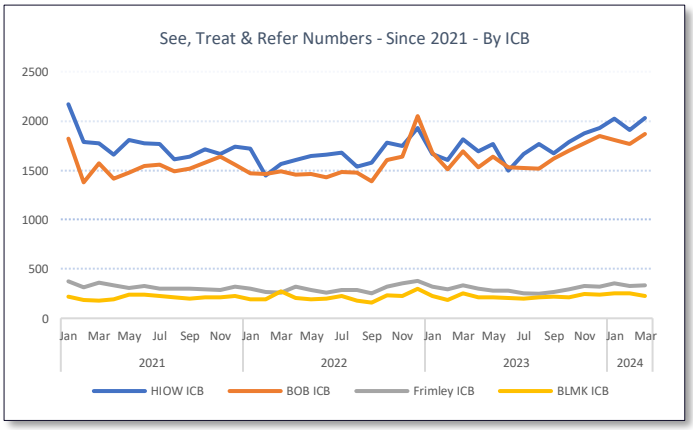


- There is no discerning pattern with this patient outcome measure over the last 12 months. There have been fluctuations between just over 12,500 and 13,700.
- There have been an increase in patients who are managed effectively by clinicians in the SCAS 111 and 999 Clinical Co-ordination Centre who are given advice and referred directly over the telephone. Previously these patients may have received an Ambulance disposition with the greater possibility for being discharged at scene with safety-netting worsening advice.
- Again, the pattern for this cohort of patients is similar across each of the ICB regions.

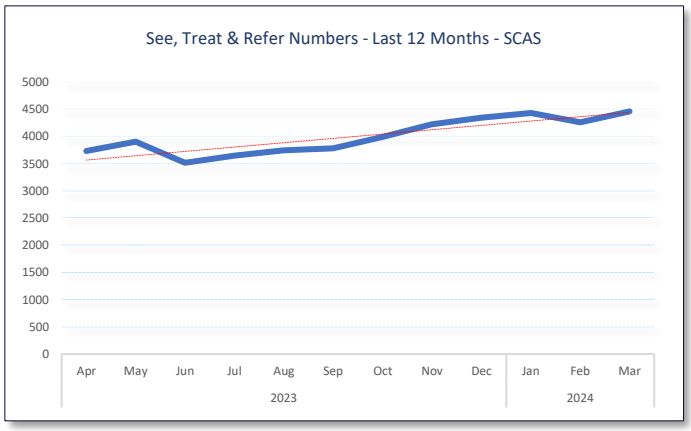
3. Non-Conveyance - See, Treat & Refer to a Hospital or Community Pathway

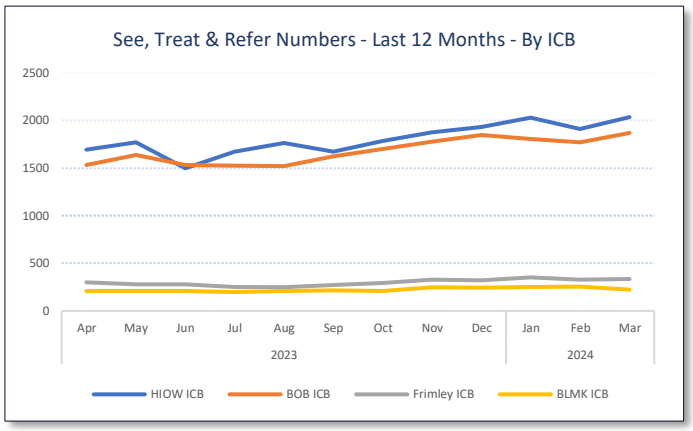
These are incidents where no conveyance has taken place by a SCAS 999 resource, but the patient has been referred to either a hospital or community team for ongoing care or treatment by the attending SCAS clinician.





- These charts show the total number of patients who were not conveyed by an attending SCAS resource but signposted or referred directly to a Non-ED service at hospital or to a Community team.
- Largely remaining relatively consistent until 2023, non-conveyance referrals were between approximately 3,400 to 4,000 per month.

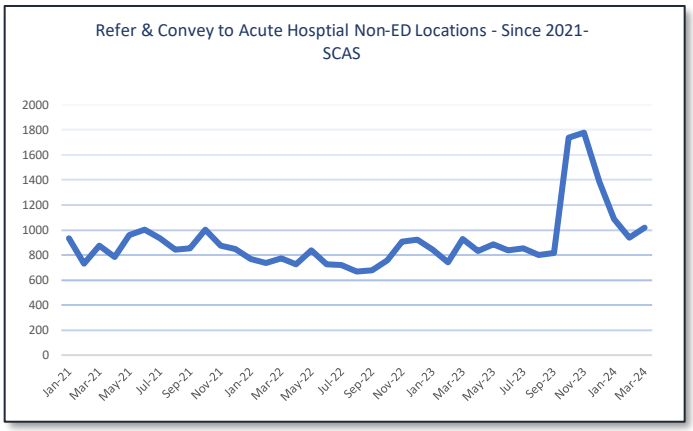


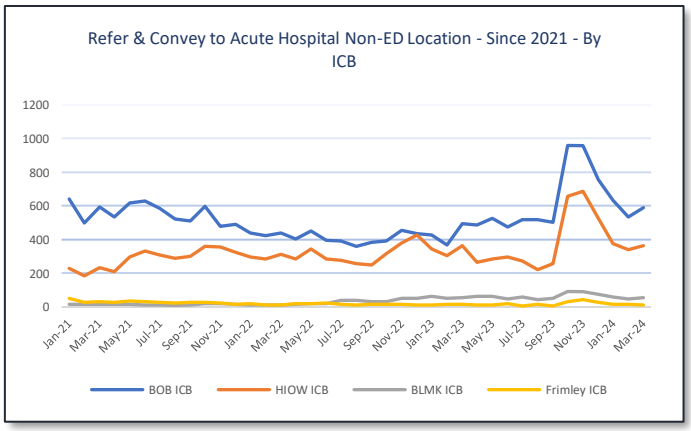


- Since June 2023, as new opportunities for referrals to clinical pathways, such as Urgent Community Response teams, have become available, there has been a gradual increase in the number of referrals to community teams to 4,459 in March 2024.
- This was a consistent picture across HIOW and BOB ICB regions, with improvements required in both Frimley and BLMK ICB regions.

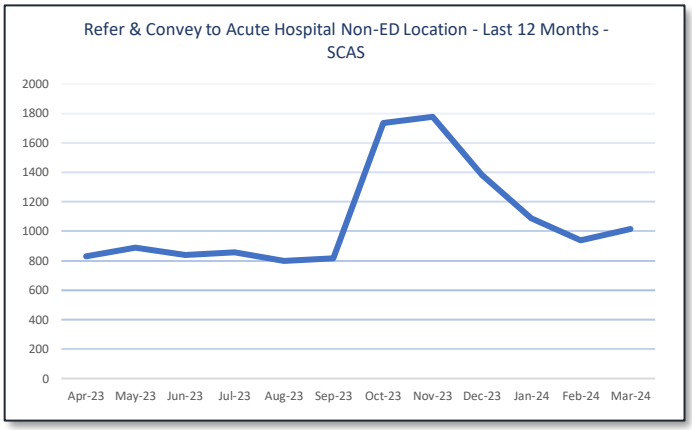
4. Refer & Convey to Acute Hospital Non-ED Location

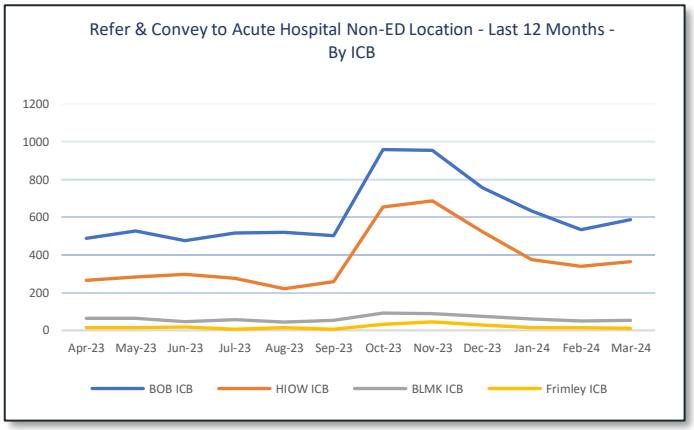
These are incidents where a SCAS clinician has made a successful referral from the incident scene and conveyed the patient directly to a Non-ED pathway in an acute hospital.





- The total number of these patients who have been referred and subsequently conveyed to a Non-ED location across SCAS reduced during 2022 compared to 2021.
- Since the latter part of 2022 there has a general increase in the number of referrals and conveyances with a marked spike in October & November of 2023 .

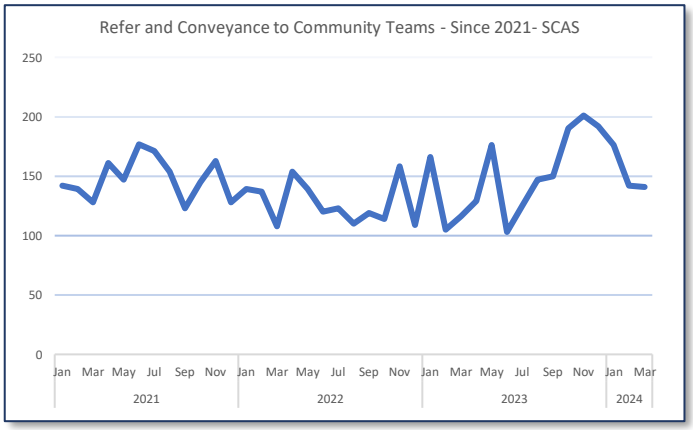


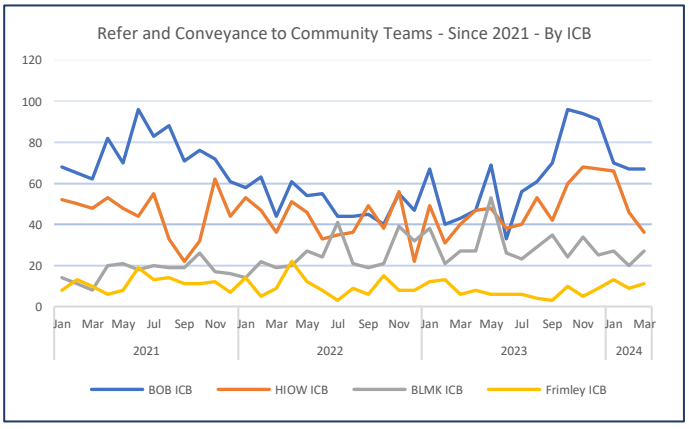


- Following a relatively consistent start to the last 12 months (average 838 per month) and following a surge of referrals during the winter period, the numbers of referrals and conveyances to Non-ED pathways currently remain consistently higher in the latter part of the year in 2024 (average n1,013 per month)
- Figures for the BLMK ICB include referrals and conveyances into Milton Keynes University Hospital only.

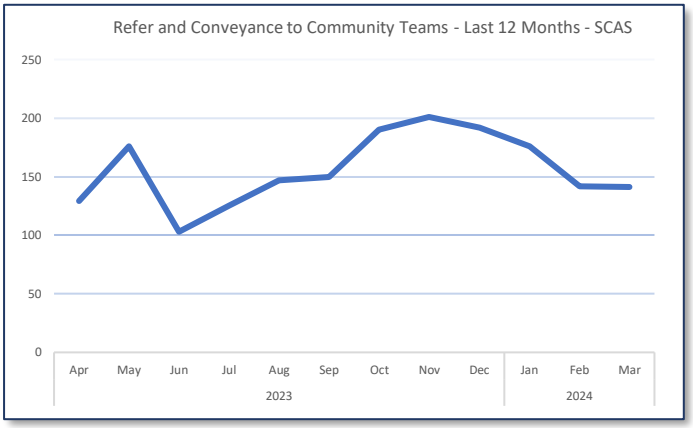
5. Refer & Convey to Community Team

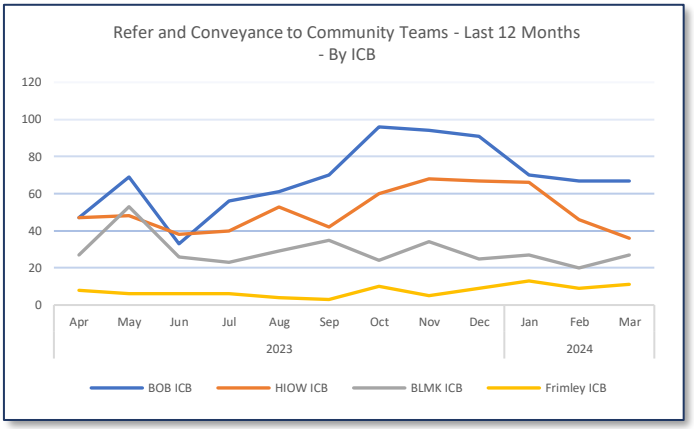
These are incidents where a SCAS clinician has made a successful referral from the incident scene and conveyed the patient directly to a clinical pathway team located in a community setting outside of an acute hospital.





- The actual number of referrals with a subsequent conveyance to a community team is relatively low across the SCAS footprint. This is expected as there aren't many community services that require an Ambulance conveyance as most community teams travel to the patient and usually manage patients in their own home.
- The average number of these has dropped in 2022-2023 compared to 2021-2022, but as is consistent with other referrals to clinical pathways, there has been an increase since the latter part of 2023 and into 2024.





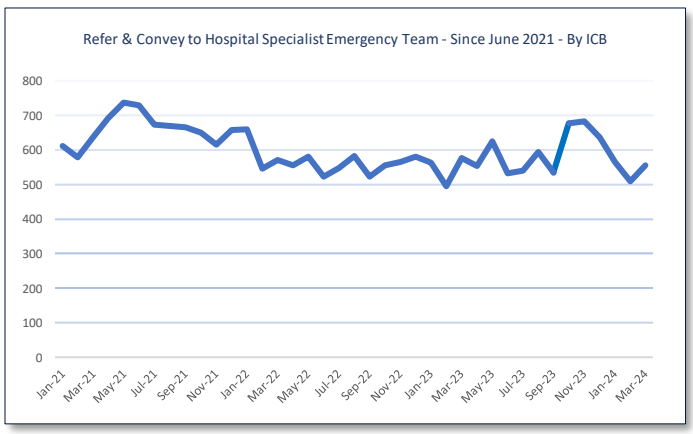
- There has been some relative stability over the last 12 months with overall referral number fluctuating between 103 at its lowest and 201 at its highest.
- The Frimley ICB has seen a general reduction in referrals of this type, however as the numbers a so low, it's not considered to be statistically significant.
- Conversely, the BLMK region has seen a general increase but with numbers again being low, it's not statistically significant.

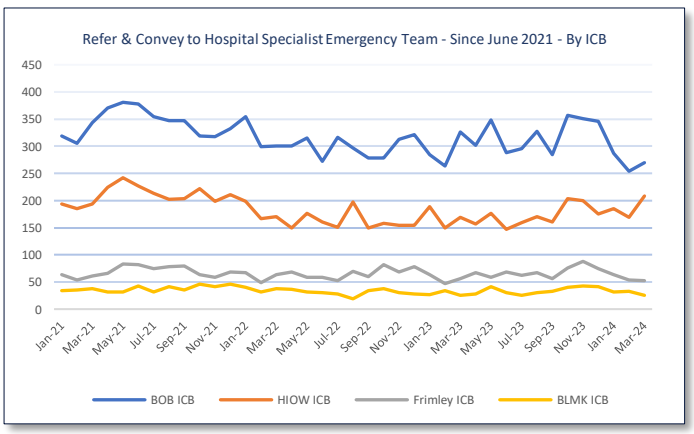
6. Refer & Convey to Hospital Specialist Emergency Team

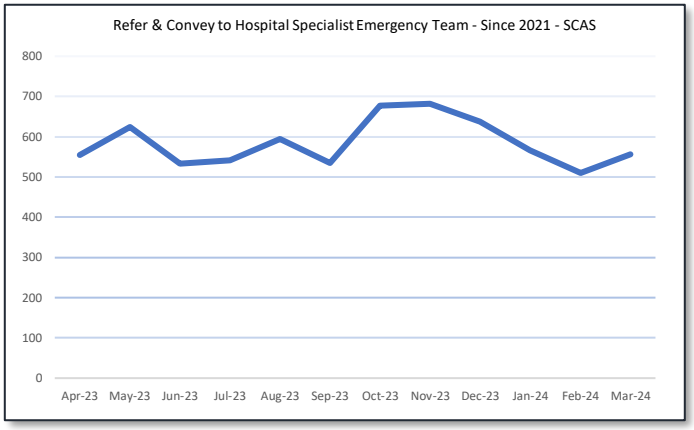
These are incidents where a patient has been referred and conveyed to a specialist emergency team following an assessment and emergency treatment at the incident scene. These include:

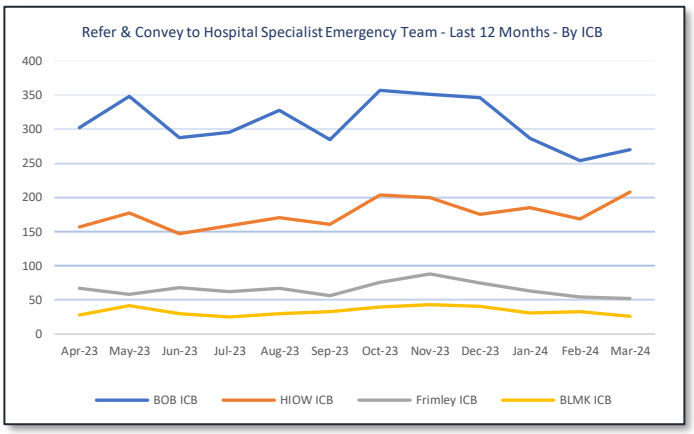
- Acute Stroke Unit (ASU) or Comprehensive Stroke Center (CSC)
- Primary Percutaneous Coronary Intervention (PPCI)
- Major Trauma Centre (MTC) or Trauma Unit (TU)
- Emergency Vascular Centers
- Maternity Delivery Suites / Maternity Asessment Units

The referral team often initially receive the patient in the Emergency Department. In these circumstances, SCAS operational staff are advised to record on the Terrafix MDT that the patient handover was to the team the patient was referred to rather than the physical location they were conveyed to.









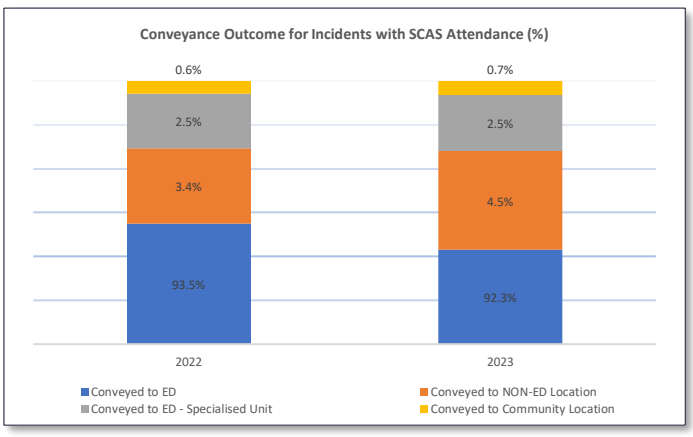
- The last 12 months has seen a fluctuating number of referrals to Emergency Speciality teams which is consistent with other acute hospital conveyances.
- The majority of referrals and subsequent conveyances are much higher in the BOB & HIOW regions as the John Radcliffe Oxford (JRO) and University Hospital Southampton (UHS) take all emergency specialities as well as being MTCs for the region. All other areas have a range of these units and accept referrals from our frontline patient facing clinicians.

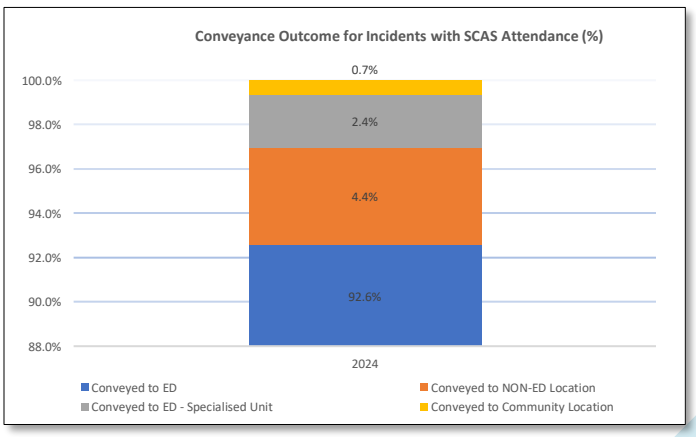
7. Refer & Convey to Emergency Department (ED)

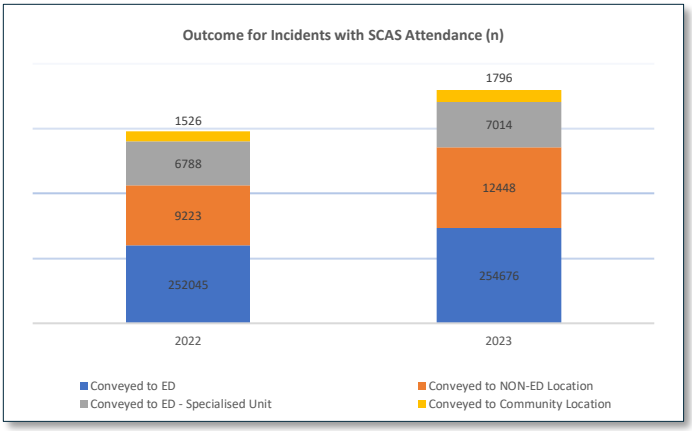
These are incidents where the patient was conveyed by a SCAS resource directly to an acute hospital or community hospital or unit and handed directly over to a member of the team or taken to the respective waiting area. These include:

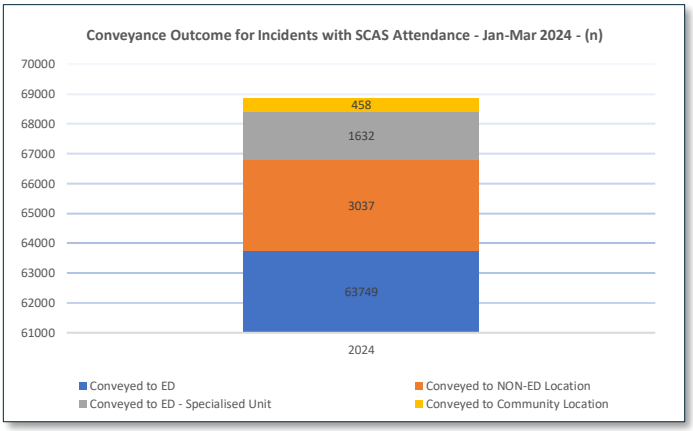
- Acute Hospital EDs
- Acute Hospital Specialist Emergency Unit/ Same Day Emergency Care Unit (SDEC) or Ambulatory Unit
- Acute Hospital Non-ED specific ward or Assessment Unit
- Community Hospital Ward or Assessment Unit

The graphs below represent the percentage and number breakdown of the outcome of all patients who are conveyed to an acute hospital or community hospital / unit location.



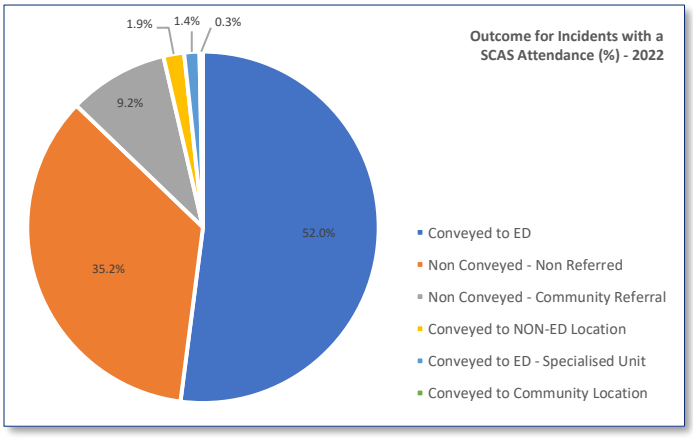


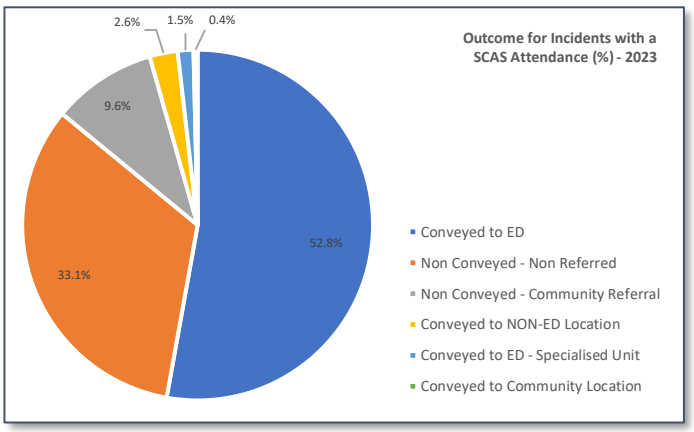


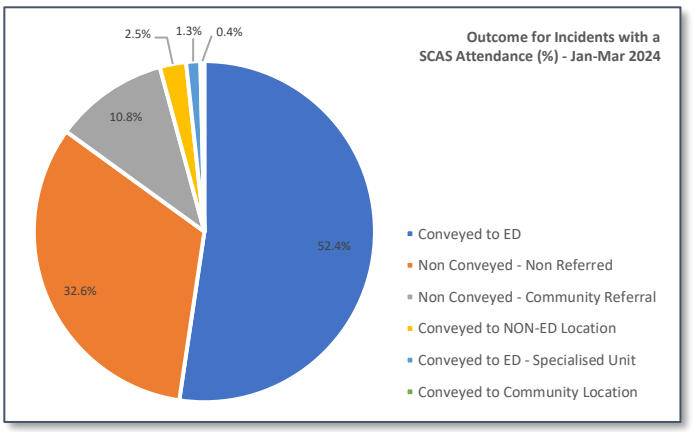


- Conveyance numbers to all teams increased to all acute hospital and community departments and teams from 2022 to 2023.
- The largest percentage increase from 2022 to 2023 was to Acute Hospital Non-ED locations which saw an increase of 1.1%
- The conveyance percentage to an ED only dropped by 1.2% from 93.5% to 92.3%
- The percentages have remained relatively similar into the first quarter of 2024

The graphs below show a breakdown of the outcome of all patients with a face to face attendance following a call to SCAS 999 or 111 services, but excludes all GP or HCP referrals and Inter Facility Transfers.







- National reporting includes the 'Conveyed to ED - Specialised Unit' which, if included in this data set, would show an increase in ED conveyances to:
  - 52.3% for 2022
  - 53.2% for 2023
  - 53.7% for Jan-Mar 2024

- Across SCAS, when comparing all patient outcome data between 2023 and Jan-Mar 2024, there has been a:
  - 0.4% decrease in ED only conveyances
  - 0.1% decrease in referrals and conveyances to Non-ED locations
  - 1.2% increase in non-conveyance referrals to a community team
  - 0.5% decrease in patients who were not conveyed with no onward referral

8. Actions to support improvements inpatient outcome referrals and conveyance

- As part of the most recent Operational Recovery and CQC action plans, the Clinical Pathway Leads have, where possible, discussed the status of all the current live clinical pathways with the service provider lead. A review was carried out to understand concerns, issues, challenges and blocks to successful referrals.
  - Improvement actions will continue to be monitored locally between service providers and the SCAS Clinical Pathway Leads.
  - Issues unable to be resolved locally will be escalated to acute hospital managers, local community service leads and the relevant ICB leads.
  - Specific discussions are ongoing with Same Day Emergency Care (SDEC) and Urgent Community Response teams to improve provision and access for SCAS clinicians.

- Where there is a current gap in service provision for a Clinical Pathway in the teams active portfolio, the Clinical Pathway Leads have been discussing the potential for SCAS frontline clinicians making direct referrals with the service provider leads

- A high level dashboard highlighting service provision and gaps is shared with the Senior Operations Leadership Team, Local ICB Leadership teams and NHS England partners.
- A tailored 'Clinical Pathway Area Update' document has been created by the Clinical Pathway Leads. This will be published and made available for sharing with the Senior Operational Leadership Team and will include details surrounding:
    - Development Opportunities (highlighting the top three)
    - Challenges, issues and blockers
    - Current actions being taken
    - System meetings, service provider meetings and working / delivery group meeting in attendance by the Clinical Pathway Leads
- The Senior Operations Leadership team are in regular active discussions with ICB Leads at local and regional system meetings about service gaps, development of new pathway opportunities and increasing usage of current pathways
- There are active discussions across the SCAS footprint about developments of regional Single Point of Access opportunities so simplify and improve referrals into acute hospital and community pathways.
- 'Clinical Pathway Portfolios' are sent out locally to operational staff reminding them of the local pathways that are available to make direct referrals.
- SCAS Operational Leadership Teams have been tasked with completing local actions with Team Leaders, Clinical Team Educators and individual clinicians to ensure more clinical staff are using the available clinical pathways where appropriate for their patients.

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 March 2024	Partially Effective	Partially Effective
				AUG 12	SEP 12	OCT 12	NOV 12	Current 12			
				DEC 12	JAN 12	FEB 12	MAR 12	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 25	Quality & Safety March 2024 Finance & Performance March 2024	Needs Improvement	Adequate
				AUG 15	SEP 15	OCT 20	NOV 20	Current 20			
				DEC 20	JAN 20	FEB 20	MAR 20	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 March 2024	Effective	Effective
				AUG 20	SEP 12	OCT 12	NOV 12	Current 12			
				DEC 12	JAN 12	FEB 12	MAR 12	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 March 2024	Effective	Effective
				AUG 12	SEP 12	OCT 12	NOV 12	Current 12			
				DEC 12	JAN 12	FEB 12	MAR 12	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 March 2024	Partially Effective	Partially Effective
				AUG 20	SEP 20	OCT 20	NOV 20	Current 20			
				DEC 20	JAN 20	FEB 20	MAR 20	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 March 2024	Partially Effective	Partially Effective
				AUG 16	SEP 16	OCT 16	NOV 16	Current 16			
				DEC 16	JAN 16	FEB 16	MAR 16	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 March 2024	Partially Effective	Partially Effective

Strategic Risk	Strategic Domain / Exec Lead	Strategic Objective	Risk Rating Movement Same ↔ Improved ↓ Worsened ↑	Historic Current Risk Rating				Inherent / Current / Target Risk	Oversight Committee / Last Review Date at Committee	Strength of Controls	Strength of Assurance
THEN our staff may feel unsafe, undervalued, and unsupported, **LEADING TO** poor staff morale, disengagement, low retention and impacts on patient safety and care.	Melanie Saunders	safe and have a sense of belonging.		AUG 12	SEP 12	OCT 12	NOV 12	Current 12			
				DEC 12	JAN 12	FEB 12	MAR 12	Target 8			
SR8 **IF** we are unable to prioritise and fund digital opportunities, **THEN** we will have insufficient capacity and capability to deliver the digital strategy, **LEADING TO** system failures, patient harm and increased cost.	Technology Transformation Barry Thurston	We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.	↔	APR 20	MAY 20	JUN 20	JUL 20	Inherent 25	Finance & Performance March 2024	TBC	TBC
				AUG 20	SEP 20	OCT 20	NOV 20	Current 20			
				DEC 20	JAN 20	FEB 20	MAR 20	Target 15			
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.	Well Led Mike Murphy	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.	↔	APR	MAY	JUN	JUL	Inherent 25	Board March 2024	Partially Effective	Partially Effective
				AUG	SEP	OCT	NOV 20	Current 20			
				DEC 20	JAN 20	FEB 20	MAR 20	Target 10			

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2023-2024 Please complete the explanatory information in cell

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

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

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

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

Confirmed — OK

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

EITHER:

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

OR

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

OR

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

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

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

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

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

Signature		**Signature**	
Name	Professor Sir Keith Willett CBE	**Name**	David Eltringham
Capacity	Chairman	**Capacity**	Chief Executive Officer
Date	30 May 2024	**Date**	30 May 2024

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

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2023-2024** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

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

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

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

Signature	**Signature**
Name Professor Sir Keith Willett CBE	**Name** David Eltringham

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

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates 2023-2024

Certification on training of governors (FTs only)

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

Training of Governors

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

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

Signature		**Signature**	
Name	Professor Sir Keith Willett CBE	**Name**	David Eltringham
Capacity	Chairman	**Capacity**	Chief Executive Offier
Date	30 May 2024	**Date**	30 May 2024

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

A

South Central Ambulance Service
NHS Foundation Trust

Tripartite Provider Assurance Meeting (TPAM)

RSP Report Pack

16th May 2024

Contents

RAG Refresh & Definitions

	Definition	Actions Required
Red	**One or more of the following:** A. Initiative requirements have not been clearly defined/accepted. B. Implementation is highly problematic - for instance actions no longer deliverable, delay exceeds agreed risk tolerance level. C. Failure is highly likely and/or intervention has not had desired effect. D. Resolution is not within team control and requires escalation. E. Anticipated change has become demonstrably unsustainable.	• Detailed Recovery Plan to be agreed by appropriate governance forum, breaking down actions into timed, risk assessed interventions
Amber	**One or more of the following:** For new initiatives: A. Requirements are not well defined with limited/no arrangements for delivery and reporting in place. For established initiatives: A. Implementation is problematic - for instance time slippage / resource issues / material change of specification. B. Unforeseen circumstances have arisen, or requirements have changed, but is recoverable with the right level of resources. C. Area of concern is not necessarily within the improvement team control and others need to be aware of the difficulties. D. Concerns about the sustainability of the change are beginning to emerge, for instance through use of QI tools	• Project initiation to be reviewed, gaps identified and reworked or • Detailed Recovery Plan to be agreed by relevant delivery group and summary of key risks and mitigations to appropriate governance forum
Green	**All of the following that apply:** For new initiatives: A. Requirements are well defined with evidenced arrangements for delivery and reporting in place. For established initiatives: A. Implementation is on track as per agreed plan. B. Implementation is aligned to agreed business case. C. Evidence to support change is being gathered.	• Ensure project/initiative plan is maintained and • Ensure systematic approach to evidencing change is in place
Blue	Expected change has been delivered and is evidenced as sustained >6 months	• Ensure BAU reporting in place.

Improvement Programme Summary

Including Progress & Sustainability Updates

Improvement Programme Summary: April 2024

	Progress	Sustainability		Progress	Sustainability
Governance & Well Led:	⇧	⇧	Culture & Staff Wellbeing:	⇨	⇨
Performance Improvement:	⇨	⇨	Patient Safety:	⇨	⇧

Key Progress:

- Governance resources have been a challenge over this period, but a long-awaited review of metrics and deliverables has begun with the support of NHSE RSP colleagues
- There is renewed focus on providing triangulated assurance of Governance progress-to-date and reviewing plans to deliver the requirements of NOF 4 Exit Criteria by Sep 2024, alongside evidence of embedded and sustainable change with effective measures of an improving culture of governance
- Sexual Safety training for 999 Ops and CCC is finalised and will begin early May and 7 mentoring pairs are agreed for the reverse mentoring programme starting in May.
- Speak Up Sub Score (from NSS) has increased from 5.9 to 6.1, tracking ahead of trajectory and meeting best in sector figures (6.1), well above sector average of 5.96.
- Cat 2 performance in March was 31:48 which was above the plan of 29:45. Hospital handover delays impacted category 2 by 4 minutes 14 with 3 minutes 42 coming from QAH, where average handover times were 22 minutes above target. As a comparison Handover times across all north hospitals were 2:28 above target and impacted category 2 by 32 seconds.
- Call answer improvement plan fully developed with action owners identified and actions underway. Weekly team update meetings commenced.
- PSIRF and LFPSE went live across the Trust on 22 Apr 24, as planned. This provides the platform for further development of the Patient Safety improvement agenda with acknowledgement that some time for bedding in will be required
- We have seen an improvement in Patient Safety Stat & Mand compliance with notable success across Patient Safety, MCA and SG eLearning. Further work is required to achieve the 90% compliance marker for SG L3 training but it is notable that the current 87% compliance is well ahead of system partners and mitigations in place are likely to achieve compliance in the short term

Key Risks/Issues:

- Significant pressure on staff resources across all workstreams due to BAU pressures, live issues (e.g. SG referrals), absence and vacant positions. Situation being actively managed at a senior level with escalation to EMC as required
- SAAF compliance directly linked to resolving server/referral issues. Full SAAF compliance will not be achieved until this is resolved. This results in a potential reputational challenge with wider SG Boards and ICB/NHSE/CQC (exacerbated with continued challenges around SG referral processes)

RAG Assessment:

Revised RAG definitions have led to a review of gradings across all workstreams with direction of travel added to make it easier to assess progress. Progress and Sustainability updates now include a composite of Exit Criteria and Must/Should Dos with a shift in focus to assessing ‘progress’ and ‘sustainability’. RAG summaries included above by workstream. Q4 metric reporting included in workstream highlight reporting.

SCAS Improvement Programme: Progress & Sustainability Update

April 2024

Governance & Well Led [Daryl Lutchmaya]: *Substantive improvement in governance and leadership with evidence of improved assurance and accountability*		**Progress**	**Sustainability**
Exit	Improved board effectiveness; use of Board Assurance Framework and significant progress in embedding recommendations from the governance review	⇧	⇨
Exit	Improved assurance through effective corporate governance structures and information flows between committees and board	⇧	⇧
Exit	Board development programme in place including senior leadership review completed with plan signed off and progressing	⇧	⇨
Exit	Evidence of strengthened partnership working	⇨	⇨
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]: *Board approved culture improvement programme in place, with evidence of improved engagement and experience from all staff including volunteers*		**Progress**	**Sustainability**
Exit	Revised and approved People and OD Strategy to ensure SCAS has the necessary infrastructure to meet future need	⇧	⇨
Exit	Culture Improvement Programme in place, including evidence of improved engagement	⇧	⇨
Exit	Clear recruitment and retention plan, with agreed timeline and evidence of delivery to support the revised operating model (see below)	⇨	⇨
Exit	Approved FTSU plan (strategy, process and function) with evidence of delivery against plan and impact	⇨	⇨
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*	⇨	⇨

SCAS Improvement Programme: Progress & Sustainability Update

April 2024

Performance Improvement [Mark Ainsworth]: *Board approved plan for performance recovery and future operating model*		**Progress**	**Sustainability**
Exit	A clear plan for performance recovery which includes representation from quality, finance, contracting and human resources / workforce	⇨	⇨
Exit	Demonstration of improvement against performance recovery plans	⇨	⇧
Exit	Demonstration of continued and sustained improvement in operational performance to be in line with the agreed trajectories in hear & treat and see & treat rates	⇨	⇧
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*	⇨	⇨
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*	⇨	⇨

SCAS Improvement Programme: Progress & Sustainability Update

April 2024

Patient Safety [Helen Young]: *Improvements in patient safety and experience, with evidence of effective systems and process in place around safeguarding and adverse incidents*		**Progress**	**Sustainability**
Exit	Embedded section 4.2.1 and the 11 core arrangements within the Safeguarding Accountability and Assurance Framework	⇨	⇧
Exit	PSIRF plan developed, approved and published in partnership with the ICB with evidence of delivery against plan	⇨	⇧
Exit	Evidence of improvement in Patient Safety and Just Culture	⇨	⇧
Exit	Demonstrable improvement in learning from SIs (individual, organisation and system wide)	⇨	⇧
Exit	Evidenced improved management of SIs	⇨	⇧
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*	⇨	⇨

Plans on a Page

2024/25 Refresh

Culture & Staff Wellbeing

Executive Lead:	Melanie Saunders
Senior Responsible Officer:	Nicola Howells

Workstream Aims

To develop a culture of engagement, inclusivity and safety within the organisation by:

- Improved focus on staff engagement and feedback from the board and wider teams to the frontline
- Focus on appropriate / acceptable behaviours and evidence of addressing issues in a timely way
- The development of both accountability and support through appraisals, PDR and development opportunities
- Improved culture being part of everyone's roles, every day
- Development of Trust wide and localised Recruitment plans and Retention schemes

Expected Outcomes

- Culture improvement programme in place with clear methodology to improve trust-wide engagement and board ownership
- Completion of organisational-wide review of operating model, including benchmarking
- Clear recruitment plan and retention scheme and recruitment timelines
- FTSU policy, function & process approved by board and firmly embedded
- Sexual safety campaign

Key Risks

- Volume of improvements mean capacity to focus on improvements required is impacted.
- Financial constraints may impact delivery of some improvements (resources).
- Upcoming change in the organisation may affect staff morale / wellbeing / engagement impacting culture change benefits.

Issues

- Capacity and existing infrastructure of the People Services Directorate not able to manage the scope of improvement required

Key Milestones

2024 / 2025

Q1	• Culture Diagnostic by Real World HR complete and output report. • Reset of culture improvement plan & culture journey. • Leadership development, through pathway of development of leaders and talent management. • Sexual Safety Reverse Mentoring Programme begins. • Launch of Sexual Safety Allyship training to 999 Ops and CCC. • Stabilising the resources in the FTSU team
Q2	• Tender process for new paramedic apprenticeship providers begins. • Implement ESR Manager Self Service. • Sexual Safety Allyship training extends to line managers and Leaders. • Finalise FTSU Dashboard
Q3	• Implement the blended apprenticeship programme (AAP and paramedic) • Present 5yr plan for Ops to Trust Board. • Implement reviewed PDR process. • CPD funding secured. • Good Start programme moved into BAU.
Q4	• Implement changes to ECA apprenticeship (removal of PTS placements & shorten course). • People Voice process & flow fully established, feeding back to staff.

Performance Improvement

Executive Lead:	Mark Ainsworth
Senior Responsible Officer:	Ruth Page / Dan Holliday

Workstream Aims

To strengthen the operational performance of the trust through:

- An agreed operational improvement recovery plan, including benchmarking delivery and resource with others
- An operational improvement development programme (care pathways, infrastructure, support) to be developed and delivered.
- Improve Ambulance Clinical Quality Indicators (ACQI) therefore improving quality of patient care.

Expected Outcomes

- Plan in place for performance improvement meeting timelines and targets
- Improved staff satisfaction and engagement (sickness and retention)
- Improved accountability and performance, using agreed trajectories to deliver performance
- Right care, right person delivery of care.
- Reduced handover times through partnership working with acute trusts, releasing time to care.
- Improved ACQI metrics.

Key Risks

- Financial sustainability
- Failure to recruit to workforce plan
- Fleet availability
- Capacity within the wider team to deliver
- High dependency on interim leadership positions.
- Attrition rate increases
- MB/EOS Policy

Issues

- Changing demand within the system might create additional pressure
- Handover delays

Key Milestones

2024 / 2025	Q1	• South's roster fully implemented. • Rapid drop and go implemented across all acutes. • Immediate handover policy agreed by all sites. • AACE review of dispatch processes.
	Q2	• North's roster fully implemented. • Review and update daily shift working policy. • Performance cell implemented. • Implement recommended changes from AACE Dispatch report. • EOC rosters fully implemented.
	Q3	• H&T increase to 14%. • Implementation of new BOB 111/IUC contract
	Q4	• Training and familiarisation of new CAD system. • 111 Dual skill pilot complete.

Plan on a Page 2024 / 2025

Patient Safety

Executive Lead:	Helen Young
Senior Responsible Officer:	Sue Heyes

Workstream Aims

To strengthen the oversight of Quality and Safety within the Trust by:

- Development of effective and sustainable systems, processes and governance for Patient Safety assurance (Safeguarding and Incident Management)
- Proactive safety culture and supportive learning culture development
- Effective Learning from Incidents (LfE)
- Maintaining the focus on Quality and Safety from point of care to Trust Board

Expected Outcomes

- Consistent Board-level leadership of Patient Safety, Experience & Safeguarding
- Patient Safety and Safeguarding oversight, escalation and improvement is consistently demonstrated in BAF and Corporate Risk Registers and Board papers
- Patient Safety culture maturity consistently demonstrated through internal and external audit, surveys, peer review, learning from patient events and staff engagement and feedback
- Section 4.2.1 and 11 Core Arrangements of the Safeguarding Accountability and Assurance Framework (SAAF) are embedded across the organisation
- Complete the transition to PSIRF to enable the effective management of Patient Safety Incidents
- Evidence of Just and Learning culture embedded across the Trust

Key Risks

- Recurrent impact of operational pressures on Patient Safety assurance activity
- Financial pressures may impact on capacity to fully embed and sustain Patient Safety improvements
- Imminent changes Quality and Safety leadership team disrupts improvement activity

Issues

- Reputation of SCAS (incl. Safeguarding Service) continues to be adversely affected by failures of systems and processes relating to Safeguarding referrals

Key Milestones

2024 / 2025	Q1	• Transition to PSIRF and Learning From Patient Safety Events (LFPSE) systems and processes • Successful resolution of Safeguarding end-to-end referral process Task and Finish Group (recommendations to be implemented Q2-4) • Introduce new IPC Audits (revised content and schedule) • Commencement of new IPC L2 (F2F) for 999/PTS operations
	Q2	• Development of Medicines tracking Business Case • Implementation of Medical Devices Asset Management system • Focus on IPC practice and procedure (e.g. Hand Hygiene/Bare Below the Elbow (BBE))
	Q3	• Evidence of continually improving patient safety culture (third MaPSaF survey to be conducted) • Joint staff engagement events to promote positive Patient Safety culture (in-line with Patient Safety Week/FTSU month) • Enhanced medicines management with potential for in-house medicines packing
	Q4	• Further demonstrable evidence of embedded and sustained improvement • Review and audit of PSIRF/LFPSE activity (12 months post-implementation)

Governance & Well-led

Executive Lead:	Daryl Lutchmaya
Senior Responsible Officer:	Kofo Abayomi

Workstream Aims

To ensure robust internal assurance and leadership is in place through:

- Improved governance processes and procedures enabling effective passage of information from Point of Care to Trust Board, to inform better strategic decision-making
- Clear accountability structures throughout the organisation to ensure effective performance management
- A culture of governance and the associated behaviours are in evidence throughout the organisation

Expected Outcomes

- Effective Board Assurance Framework (BAF) in place with regular Board review and scrutiny
- All Board and Executive members attend development programme
- Regular Executive & NED assurance visits conducted
- All governance recommendations embedded into BAU
- Improving Partnership and Provider Survey results (engagement and feedback)
- Revised IPR in place

Key Risks

- Engagement of key individuals in improvement efforts
- Volume of BAU and improvement mean capacity to deliver is limited

Issues

- Resource and changing personnel impact on improvement delivery
- Board Development Programme identifies further areas requiring development
- On-going concern around effectiveness of internal governance through key assurance meetings (TPAM / RSP)

Key Milestones

2024 / 2025	Q1	• Review Governance Assurance & Accountability Framework (GAAF), develop clear plan of action for development and publication • Review and refine ongoing plan of improvement activity
	Q2	
	Q3	
	Q4	

Appendices

Workstream Highlight Reports & Scorecards:

1. Culture & Staff Wellbeing
2. Performance Improvements
3. Patient Safety
4. Governance & Well-led

1. Culture & Staff Wellbeing

Highlight Report: Culture & Staff Wellbeing | April 2024 | RAG: Progress | Sustainability

Executive Lead: Melanie Saunders ***Senior Responsible Officer: Nicola Howells***

Workstream Summary (Incl. RAG Assessment):

Significant progress made with the Sexual Safety Campaign, training material for 999 operations and CCC developed and ready to launch mid-May. Invited to brief BLM ICB on SCAS sexual safety journey. Culture Diagnostic continues with report due in May which will inform the culture improvement plan refresh, benchmarking against the national review is underway. The workstream remains at 93% complete and evidence collation continues. Exit criteria 3.3 and 3.4 evidence prepared for review by the SRO and Exec Lead and tracking Amber overall.

Progress Against Key Outcomes / Success Criteria:

Sexual Safety

- Posters have been distributed to all sites
- Manager training design: Character building and filming completed.
- Sexual Safety training material for CCC and 999 Ops has been developed.
- Reverse mentoring: 7 pairs will take part in the programme, due to launch in May
- Presented campaign progress and lessons to BLM ICB.

FTSU

- Recruitment of FTSU Lead Guardian is underway. Advert closed; shortlisting completed
- NGOs are leveraging the SCAS detriment work as a cornerstone for national guidance
- Staff survey data analysed, and output shared with OD team
- Benchmarking against the national ambulance culture review is underway.

EDI: PSED report submitted

Talent Management: Initial communication on Talent Management programme sent to SLG

Key Activity, Month Ahead:

- Manager training: develop roll out plan and facilitator content
- Finalise the bystander toolkit and agree comms & engagement plan.
- Mentor and mentee briefing sessions scheduled for W/C 13th May to review the aims, expectations, frequency of meetings etc
- Attend Frimley ICS Sexual Safety steering group.
- Deliver TTT session for CCC. Training to commence on 11th May 2023
- Conduct interviews for FTSU Lead Guardian
- FTSU to present staff survey analysis at EMC
- Talent Management launch planned with SLG at Shaw House on 1 May 2024

What's Gone Well:

- Sexual Training is now accessible through four separate avenues. Frontline staff have been allocated designated slots in the Face-to-Face training sessions. Meanwhile, Leader and Managers Training is currently development and expected to commence end of May. Additionally, the FTSU team is actively conducting workshops in Tier 1 meetings.

What's Not Gone So Well:

- Collating metrics is still manual and has been challenging due to capacity constraints and reporting limitations. Work ongoing to develop a future dashboard to automate metrics.

Workstream Key Risks:

- If the FTSU vacancy isn't filled before the current post holder departs, the team will operate at reduced capacity.

Issues for Escalation (Incl. Scope / Milestone Change Requests):

- CPD for all staff has limited funding for registrants and no funding for other staff.

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — April 2024

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	
1	Reported cases of bullying and harassment	1	2	*Aim*	*N/A*	*N/A*	*3*	*3*	*3*	*3*	*2*	*2*	Q4. We continue to place emphasis on mediation (where appropriate) and there were 5 new mediation cases recorded in Q4.
				Actual	3	2	1	3	1	4			
2	Reported cases of sexual harassment	5	2	*Aim*	*N/A*	*N/A*	*5*	*7*	*8*	*8*	*7*	*7*	Q4. No new formal sexual harassment cases reported in the quarter which, in addition to no cases in Q3, was significantly below what we were expecting to see in light of the sexual safety campaign.
				Actual	4	4	4	3	0	0			
3	Casework (investigation) completion timeline completion against policy	35	35	*Aim*	*N/A*	*N/A*	*60*	*58*	*50*	*45*	*40*	*35*	Q4 Not including cases with police involvement. We were anticipating an increase in Sexual Harassment cases which involve outside agencies & take longer but this has not occurred.
				Actual	41	31	63	43	37	34			
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*	Q4 drop back to more average level of cases after the increase in volume from Speak up month in Oct / Nov pushing up Q3 figures.
				Actual	29	38	27	34	54	29			
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*	Q4 Limited opportunities to complete questionaries F2F during Q4, the walk about Wednesday questions were updated in Q4 (to v4.1) now reflects the new NSS 17 a&b questions , in the limited opportunities for F2F we received 33 responses but non for the sub score question set- seems to be human error. Figures in Q3 has been updated with the recently released NSS results, showing our sub-score increased to 6.1 this puts us above the ambulance benchmark of 5.96, on a par with best in sector (6.1) and ahead of trajectory. 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	6.1				

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — April 2024

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*	Q4 manual metric gathering is becoming increasingly challenging and as such no figures are available for this quarter. It is now dependent on the new automated Dashboard which is in the final stages of build specification with BI and 3rd party. Continue to engage for updates and an eta delivery date.
				Actual	N/A	N/A	93	80	78	not avail			
7	Appraisal with PDR: completion (%)	89	95	*Aim*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	Q4 – decrease overall and below trajectory for the quarter however M12 figures show a slight increase which may indicate the trend turning and improvements anticipated to continue.
				Actual	88	89	84	75	75	80			
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	Q4 - There has been an increase in engagement scores . The NSS (2023) sector average on this is 47.08%, SCAS scored 47.08% . Our aim is to keep improving above our sector average . The best in sector was 67.50%. We have also gone above our aim .
				Actual	46	36	41	35	47	47			
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*	Q4Q4 - We have an increase in staff engagement scores from the NSS survey . SCAS Scored 52.17% which is above the sector average sitting at 50.50% . The best in sector is 75.11% . We have achieved our aim score.
				Actual	53	44	46	46	52	52			
10	Retention / Stability Index Rate (%)	82	82	*Aim*	*82*	*82*	*82*	*82*	*83*	*83*	*84*	*84*	Q4 – maintaining from Q3
				Actual	82	82	84	85	85	87			
11	Vacancy Rate (%)	15	10	*Aim*	*13*	*14*	*14*	*13.5*	*12*	*11*	*10*	*10*	Q4 – on track with workforce plan
				Actual	13	13	11	10	10	9			

2. Performance Improvement

Highlight Report: Performance Improvement | April 2024 | RAG: Progress | Sustainability

Executive Lead: Mark Ainsworth ***Senior Responsible Officers: Ruth Page, Dan Holliday***

Workstream Summary (Incl. RAG Assessment):

Cat 2 performance in March was 31:48 which was above the plan of 29:45. Hospital handover delays impacted category 2 by 4 minutes 14 with 3 minutes 42 coming from QAH, where average handover times were 22 minutes above target. As a comparison Handover times across all north hospitals were 2:28 above target and impacted category 2 by 32 seconds.

- Fit to Sit/Rapid Drop and Go live across all acutes as of 15th April. This provides a greater number of ambulance crews to be able to turnround more quickly at EDs.
- UHS and HHFT the final two acutes to agree Immediate Handover and work continues with an expected completion date of mid-April '24.
- Increase in work effective ECTs supported improvement in call answer performance in March.

Progress Against Key Outcomes / Success Criteria: QTR 4/1

- Focus continues to be on Cat 2 response and EOC call answer: As of 18/04/24
  - Year end - 34:14 Cat 2 Mean – MTD 26:59 QTD: 26:59
  - Call Answer Mean – 16 seconds for March. April MTD 8 seconds
- Call answer improvement plan fully developed with action owners identified and actions underway. Weekly team update meetings commenced.
- CCC coaching processes and timeframes reviewed and changes becoming live through April.
- BI review of CSD undertaken, informed additional actions and those have been added to the Hear and Treat and Call Answer improvement plans.

Key Activity, Month Ahead:

- Continue to deliver against "exit criteria" performance targets
- Develop an overarching Operations Improvement Plan for 24/25
- Finalise trajectories for 999 call answer improvement in line with new financial year's establishment figures
- Continue with actions as detailed in call answer and hear and treat improvement plans.

What's Gone Well:

- Fit to Sit/ Rapid drop and Go pilots went live as planned in MKGH and PUH. No reported patient safety issues and the feedback meant we were able to launch the process across all acutes in SCAS.
- Changes to coaching process and joint working between CCC Education and operational teams.

What's Not Gone So Well:

- Handover delays – significant delays at QA and RBH
- Software development in ePR to monitor F2S/RDG not live or in testing due to competing priorities.
- WMAS confirmed no capacity to offer any long-term contractual call handling support

Workstream Key Risks:

- Capacity within the wider team to deliver against actions in Cat 2 recovery plan
- Fleet capacity to be able to manage with an increase in staff hours
- Clinical capacity for Cat 2 Segmentation, as well as delivering BAU Clinical Support Desk requirements
- There is a risk around the current MB/EOS policy and its impact on PT care and staff H&WB.

Workstream Issues:

- None identified at present.

SCAS Improvement Programme Scorecard: Performance Improvement — April 2024

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories / To be updated									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
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	End of year position for Cat 2 performance was 34.14 so we failed to reach the stated aim of sub 30mins. This was in part due to a significant increase in handover delays. We also provided more hours than plan (+2,049hrs) from an improving PP picture. PP hours are now planning 7000 to 8,000 per week, which is around 80% coverage of required hours.
				Actual	00:40:33	00:26:53	00:29:42	00:33:09	0:38:09	0:35:57	00:27:00		
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%	Awaiting AACE review of CSD/Hear and Treat. We continue with our actions on the internal improvement plan for H&T.
				Actual	13.4%	10.8%	10.6%	11.1%	11.8%	12.3%	12.2%		
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%	S&T remains below trajectory but is stable and only seeing a 0.7% drop over the year. Acuity ultimately defines what we can H&T, S&T. Understanding the link to both H&T/S&T is vital. When we see H&T increase the knock-on effect is a decrease in S&T.
				Actual	34.9%	34.7%	34.3%	33.7%	33.5%	33.6%	33.8%		
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	Call answer improvement plan is in place and the team are working through the actions. Improvements made to coaching process and timeframes which are being rolled out through April. March saw an improvement in work effective staff at circa 150 WTE, with 198 WTE in post.
				Actual	00:01:06	00:00:32	00:00:25	00:00:22	00:00:17	00:00:18	00:00:06		

SCAS Improvement Programme Scorecard: Performance Improvement — April 2024

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories / To be updated									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					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%	The new rosters are now live in Hampshire and as such we are now focusing on the monitoring the number of Breaks in the window, as we have more overlaps and increased numbers of vehicles available at periods of peak demand.
				Actual	48.1%	61.5%	58.7%	53.8%	45.3%	42.8%	50.8%		
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%	A meeting is taking place on the 30/04/24 with the Executive Director of Operations, Chief Nurse, AD-ops and Unions to affirm the importance and need for changes to the MB/EOS policy to reduce patient risk/harm.
				Actual	69.0%	83.0%	84.0%	82.3%	80.5%	81.5%	82.8%		
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			The Strategic Case for Change associated with Fit for the Future (FFF) has been presented and reviewed at EMC and Trust Board in March 2024. This outlined the key drivers for change and the anticipated benefits of addressing them. During Qtr1 24/25, a detailed delivery plan associated with the Operational Modernisation element of FFF is being developed. It has been agreed that moving forwards, Operational Modernisation and specifically the delivery of a Board approved plan will be reported separately within the Improvement Programme, to enable increased focus.
				Actual	*N/A*	*N/A*	Complete	Complete	Complete	On track			

3. Patient Safety

Highlight Report: Patient Safety	April 2024	RAG:	Progress	Sustainability

Executive Lead: Helen Young ***Senior Responsible Officer: Sue Heyes***

Workstream Summary (Incl. RAG Assessment):

An overall positive picture but disappointing that SG L3 training compliance has not been achieved against trajectory, despite additional measures put in place. This will likely be achieved in short order, aided by an improving operational picture (as will other metrics, e.g. audit compliance), the continued provision of incentives and a final scrub of SG training data. PSIRF and LFPSE have now gone live across the Trust but it acknowledged that there is an ongoing programme of work to ensure these changes become embedded and sustainable for the long-term. Revise RAG definitions combined with additional progress have seen the workstream RAG improve to Green for both Progress and Sustainability overall, and a renewed focus will be given to ensuring assurance is proved to ICB/national partners through TPAM.

Progress Against Key Outcomes / Success Criteria:

- PSIRF & LFPSE went live on 22 Apr 24 as planned
- SG L3 trg below trajectory at 87% compliance but this is well ahead of neighbouring trusts, as reported at SG Committee, 11 Apr 24. In real terms, 78 more individuals are required to achieve 90% compliance. A final data cleanse will also be conducted which may improve compliance
- MCA eLearning compliance currently at:
  - L1: 89% / L2a: 83% / L2b: 87%
  - Increased sustainability RAG to GREEN

Key Activity, Month Ahead:

- Further work to continue embedding of PSIRF/LFPSE
- Continue 12-week task and finish group to address SG referral challenges (anticipated conclusion 19 Jun 24)
- Develop restructure of SG Service in anticipation of impending retirement of AD SG/MH/LD & recruit to Named Professional (Adults) appointment (currently vacant)

What's Gone Well:

- MCA audit completed and will continue monthly, with audit forward planner in place (MCA Lead to conduct)
- Pt Safety Incident Reporting Policy approved at PSEC
- Pt Safety Partner business case prepared, renumeration and employment issues being explored options being developed prior to submission to FRG
- IPC lead working with compliance lead on reviewing audit template and schedule for 2024/25 against National Manual (NIPCM)

What's Not Gone So Well:

- Whilst SG server/referrals have experienced no further outages, wider SG Boards levels of assurance remain low with a high degree of nervousness around referral process robustness
- Personnel resources continue to prove challenging in Pharmacy. Additional Band 3 post(s) rejected. Potential for risk of delay to improvements/impact on frontline with requirement to collect CDs from LPU
- L3 SG training has not met projected trajectory by mid-Apr as previously reported. Additional measures still in place to improve compliance (e.g. overtime availability for completion)

Workstream Key Risks:

- SAAF compliance directly linked to resolving server/referral issues. Full SAAF compliance will not be achieved until this is resolved. This results in a potential reputational challenge with wider SG Boards and ICB/NHSE/CQC
- Team capacity affected by bereavement and vacant positions. Effective mitigations in place
- Operational pressure (REAP/OPEL) has continued to affect numbers of audits being completed although compliance remains high. Operational picture improving

Workstream Issues:

- Nothing for escalation

SCAS Improvement Programme Scorecard: Patient Safety April 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
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*	5% target increase per Qtr. Q3. Data from SCAS BI/Doc-Works Q4. Data from Doc-Works
				Actual	13728	14221	16311	20458	22267	22773	TBC		
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. Q4. Impacted by competence expiry/new starters.
				Actual	18%	31%	49%	60.75%	82%	82%	87%		
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. Q4. No change
				Actual	30%	64%	94.5%	94.5%	97.8%	97.8%	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*	*N/A*	*5%*	*N/A*	*7.5%*	Repeated every 6/12. Q4. 1008/4500 respondents. Survey closed 29/02/2024
				Actual	N/A	3%	N/A	N/A	N/A	22.4%	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 SI, DI and Low/No Harm reporting. Q4. On track
				Actual	N/A	N/A	10	10	10	10	TBC		
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 (to >95%) dependent on intro of new Asset Management system. Q4. Current compliance position
				Actual	80%	90%	93%	93.4%	97%	95.4%	96.3%		
7	Decrease in number of medicines unaccounted for/loss	New for 23/24 IPR	<15 (Post Q3 23/24)	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*<15*	*<15*	*<15*	*<15*	IPR compliance data (new for 23/24) Target set following Q3 data and based upon 5 or less losses/month. Q4. Data set complete
				Actual	N/A	N/A	34	82	11	15	TBC		
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. Q4. Data set complete
				Actual	N/A	74%	80%	77.9%	87.3%	92.5%	TBC		
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. Q4. Data set complete
				Actual	N/A	91%	96.5%	93.1%	93.3%	98.5%	TBC		

4. Governance & Well-led

Highlight Report: Governance and Well-Led	April 2024	RAG:	Progress	Sustainability

Executive Lead: Daryl Lutchmaya ***Senior Responsible Officer: Kofo Abayomi***

Workstream Summary (Incl. RAG Assessment):

Whilst workstream resources have been a challenge over this period, a long-awaited review of metrics and deliverables has begun with the support of NHSE RSP colleagues. The newly appointed SRO is keen to focus on providing triangulated assurance of progress-to-date and develop planning for delivery of NOF 4 Exit Criteria by Sep 2024. Workstream planning is expected to go beyond this date, to provide embedded and sustainable change with evident measures of an improving culture of governance.

Progress Against Key Outcomes / Success Criteria:

- Board committees' feedback on GAAF now received. Awaiting review and inclusion in GAAF
- Board Sub-Committee ToRs continue to be standardised and will be presented to Board for approval in May 2024
- Fit & Proper Persons (FPP) Policy in place (previously ratified by EMC) but requires final approval by Rem Com (expected May 2024). Following audit of FPP in Dec 2023, we have been able to chieve compliance with new national framework (Mar 2024); on track to make mandatory submissions to NHSE Regional colleagues in Jun 2024

Key Activity, Month Ahead:

- There will be a necessary focus on delivery of a compliant Annual Report and accounts over the coming month. Both workstream and PMO resources will be required to contribute to coordination and delivery
- SRO, Improvement Programme Lead and Transformation Programme Director will continue to work with NHSE and ICB colleagues to reprioritise workstream activity, contributing to Must/Should Do and Exit Criteria delivery
- Potential Review of GAAF and requirement to align all forward planners for committees
- Ongoing review of Independent Governance Review actions with a focus on collation of assurance/evidence of progress

What's Gone Well:

- Work in progress with NHSE RSP colleagues to reset workstream planning and delivery, with renewed focus on achieving Ext Criteria for NOF 4 by Sep 2024.
- Additional work to be undertaken to revise workstream metrics to provide better insight into progress, and provide triangulated evidence of delivery on a whole-Trust basis

What's Not Gone So Well:

- Absence of CGO has required reprioritisation of workloads amongst Governance team members, with a newly appointed SRO in place. Support from NHSE RSP colleagues is in place and additional PMO resource is being provided to ease admin burden
- Proposed planning of remaining workstream activity (particularly Exit Criteria) has not taken place but work is ongoing to reset and provide better assurance on Governance/Well-led deliverables

Workstream Key Risks:

- Team capacity is already reduced with the absence of the CGO and there is a requirement for Head of Corporate Governance/Compliance to cover Exec-level meetings. The Corporate Governance Manager has also given notice and the post is expected to become vacant in the next month. The workstream will continue to be provided with PMO support in the short term to maintain progress

Issues for Escalation (Incl. Scope / Milestone Change Requests):

SCAS Improvement Plan Scorecard: Governance & Well Led — April 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
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 and details provided from EA's. January: Board (8 responses, 5 NED, 2 ED) – 88% PACC (1 response) – 100% F&P (1 response) – 0% Q&S (3 responses) – 100% Audit (1 response) - 0% Rem Com (1 response) – 100% This question has now been removed from the QR code survey and will be solely based on EA feedback to remove any ambiguity. EA feedback for January is 33%.
				Actual	N/A	N/A	50%	55%	78%	33%			
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 January: Board (8 responses, 5 NED, 2 ED) – G PACC (1 response) – G F&P (1 response) – E Q&S (3 responses) – G Audit (1 response) - G Rem Com (1 response) - G
				Actual	N/A	N/A	-	G	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	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%) Yes (100%)	Minimal Q3 22/23	Yes	*Aim*	*N/A*	*N/A*	*95%*	*95%*	*95%*	*95%*	*100%*	*100%*	For January 1 action was due and evidence for closure has been provided to Internal Audit.
				Actual	Minimal	Minimal	Partial 76%	No 8%	No 0%	Yes 100%			

SCAS Improvement Plan Scorecard:	Governance & Well Led	April 2024

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
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 January: Board (8 responses, 5 NED, 2 ED) – G PACC (1 response) – E F&P (1 response) – G Q&S (3 responses) – A/G Audit (1 response) - E Rem Com (1 response) - E
				Actual	N/A	N/A	-	G/E	G	G/E			
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. January - A The GAAF was presented and approved at EMC and Board week of the 11th December. It is now under review with Board Committees and will be updated when feedback is received. The document will then be published with associated comms.
				Actual	N/A	N/A	P	P	P/A	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)	Yes Q1 23/24	Yes 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. The Board agenda is prioritised in alignment to BAF risks.
				Actual	N/A	N/A	Y	Y	Y	Y			
10	Board development attendance	60% Q4 22/23	85% Q1 23/24	*Aim*	*N/A*	*N/A*	*100%*	*100%*	*100%*	*85%*	*85%*	*85%*	Percentage of eligible colleagues that attend Board Development sessions. January - 15 of 18 attendees present.
				Actual	N/A	N/A	71%	94%	89%	83%			

SCAS Improvement Plan Scorecard:				Governance & Well Led									April 2024
No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
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. SCAS Leader is only measurable quarterly due to the time it takes to complete the course. Reduction in completion is due to a change in reporting which has made the data gathering more accurate.
				Actual – SCAS Leader	N/A	N/A	47%	48.5%	58%	N/A			
				Actual - ESPM	N/A	N/A	61%	85%	88%	86%			
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	4.26	4.41			
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. January - 100% 9 out of 9 expected visits were completed.
				Actual	N/A	N/A	63%	85%	93%	100%			
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. January - 50% 4 out of 8 expected visits were completed.
				Actual	N/A	N/A	42%	13%	29%	50%			